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FINANCIAL ANALYSIS OF HEALTH SYSTEM SHIFTS IN EGYPT: *SEARCHING FOR “GRATUITOUSNESS” AND THE RIGHT TO HEALTH*

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About the Author

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Cover Photo: An ambulance entering Al Arish Hospital in North Sinai, March 20, 2022, © EPA/Khaled El Fakih

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Introduction

Throughout the formation and development of the modern state of Egypt,¹ health policies played two key roles: First, the state played a powerful and efficient role in the provision of medical services through facilities funded by public treasury revenues. Secondly, it strived to provide these services at the lowest possible costs or free of charge in what is known as the “gratuitousness” policy.

Like many other free social policies that took root during the interwar period and were given new impetus with the advent of Arab socialism in the 1960s, the “free public hospital” principle was a subject of conflict between two movements that fiercely competed to control public policy in recent decades. The first movement defended the “gratuitousness” policy through tax-based expansionary fiscal policies targeting the wealthiest segments of society — a model similar to the welfare state adopted in some Western European countries. The second movement believed that tax reduction and redistribution policies in general were of vital importance to help the country attract investments and achieve the highest possible rate of economic growth and capital accumulation — in parallel with the rise of neoliberalism globally.

The second movement recommended fiscal policies aimed at reducing the budget deficit, claiming that the latter affects investment opportunities in a multitude of ways. For example, it contributes to the rise of inflation rates, not to mention that public debt crowds out private borrowing opportunities, etc. This movement calls for transforming the interwar and Arab socialism policy legacy into a new pattern relying less on the public treasury and more on middle-class contributions, with “gratuitousness” policies being restricted to the poorest segments of society. This system requires continuous updates to the citizens’ income distribution database to help identify affluent and disadvantaged groups.

This movement managed to gain traction in Egypt thanks to two major financial crises in the country. The first took place in the late 1980s with the steep rise in external debt, which led Egypt to adopt economic liberalization policies in the early 1990s known as stabilization and structural adjustment programs, which were supported by the International Monetary Fund (IMF) and the World Bank. The second crisis happened when the global financial crisis reached Egypt and political instability following the 2011 revolution, with the subsequent emergency of a black market for hard currency in 2016, leading to a new phase of financial and monetary policies with the support of the IMF and international donors. During the two crises, international financial institutions were reinforcing their policies in Egypt, particularly the scaling down of social protection policy costs covered by the public treasury.

In this context, a new health insurance law was introduced and approved in 2018. The provisions of the new law represented a major transformation in the role of the state in the health sector in Egypt.

The law is the first piece of legislation aimed at restructuring the health insurance system in Egypt since the 1960s. In essence, it aims to reduce dependency on “gratuitous hospitals funded by the public treasury” model and, instead, to adopt a new model that is more reliant on the middle-class to fund the public health system via deductions from their income. This model could improve public health services, while enabling the state to maintain its social role in supporting the disadvantaged.

As the new health insurance law created a major shift in the history of health policies in Egypt, it also sparked widespread controversy. It is likely to stir even more controversy during its 15-year implementation period. So

1 The “modern state” refers Muhammad Ali’s reign, which began in 1805, while the “nation state” refers to the 1923 Constitution era, promulgated after the recognition of Egypt as a sovereign state.

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far, the law has only been applied in a small number of the least populated governorates.²

This research paper is not biased towards either of the two abovementioned movements, as both of them entail numerous contradictions. The “gratuitous” hospital model funded by the public treasury has long been criticized for the poor quality of services, even during its beginnings in the 1960s. The movement defending this model also did not propose any broader perceptions on distributive tax policies to increase public treasury resources, and it focused on the improvement of medical services.

Moreover, while the reduction of the budget deficit – which the new model aspires to achieve – is a major step forward, its heavy reliance on the middle-class instead of the public treasury to finance public health policies will essentially result in the erosion of the middle class. The efforts to embellish these policies by claiming that the funding would target disadvantaged groups will also contribute to the renewed erosion of the middle class, coupled with the lifting of subsidies on fuel, energy, and many other public services.

The new law also aims to transform the Health Insurance Authority into a body that collects contributions and contracts public and private hospitals for service provision, while pricing services at an acceptable profit margin. There are some legitimate concerns that the private sector or even public hospitals – once they become for-profit entities – will play an influential role in raising the cost of treatment within the insurance system, thus raising the contributions or charges imposed on patients.

The main objective of this research paper is to provide an analysis of the political economy of these major health policies shifts in Egypt, based on the history, roots, and evolution of “gratuitousness” policies and their ability to achieve their intended goals. The paper focuses on “gratuitousness” because it represents the primary role of the state in the health sector, according to millions of welfare state supporters and Egyptian citizens, especially since it dates back to the formation of the nation state in Egypt.

The paper also seeks to peruse the pressures that gratuitousness policies have been exposed to, in an attempt to reduce the public budget deficit.

We also seek to understand how limiting expansionary fiscal policies was a primary motive for the enactment of the new health insurance law, aimed at relying more on middle-class funding of the public health system through insurance premiums.

The aim of this analysis is to encourage a deeper discussion of the role of the state in the health sector, by looking at the “financial factors” that prevented previous versions of gratuitousness policies from achieving their goals and undermined the success of the new health insurance scheme.

The research paper is based on historical documents related to the origins of gratuitous health policies in Egypt and on an analysis of global data on health expenditure from official local and international sources. It also includes interviews with doctors working in free public hospitals concerning their relevant work experience and some foundational literature in the health sector.

2 Governorates included in the first phase of the universal health insurance scheme: Port Said, Luxor, Ismailiya, South Sinai, Aswan, and Suez.

Theoretical Review of Major “Gratuitousness” Global Trends

The United Kingdom’s experience is the most inspiring when building a model based on providing citizens with free or low-cost health services funded by tax revenues. The UK system is based on the National Health Service (NHS), established by the British Labour Party in 1946. The NHS is a model for what is commonly referred to in Egypt as the “free hospital.”

This model seeks to achieve “competency” and “fairness” simultaneously. By having the state control the health sector, while at the same time entrusting its management to experts, the UK managed to ensure the rational use of resources, while reducing competition in the market. The medical services offered by this system also contributed to improving the health of the working class, thus promoting production. The system was also fair, as it ensured equality by making services available on the same terms for all.³

However, this model’s dependence on state revenues causes strong pressures in times of low revenues. The lack of resources becomes more evident in developing countries that have adopted this model. Cuba is considered the most advanced case, as it has harnessed all possible means to ensure the success of this policy and has achieved impressive results. However, there is a clear gap between the stated goals and the level of service on the ground due to funding problems. Anthropologist Shane Brotherton provides many examples on this gap through his 10-year experience in Cuba and his interviews with dozens of health workers or contacts there.⁴

While the British model is considered a non-contributory health system (i.e. its beneficiaries do not contribute to its financing directly, but it is rather financed from public revenues), other health care systems are contributory (i.e. beneficiaries directly contribute to these systems by income deductions, which are typically referred to as “health insurance”).

During the last century, the state strived to ensure health

coverage to all citizens. As a result, many systems emerged, combining aspects of both contributory and non-contributory financing systems. In the case of developing countries, the spread of informality was a major obstacle to their ability to resort to the contributory financing model.⁵

In light of the contradictions between the two models, Adam Wagstaff, a prominent economist at the World Bank, conducted an extensive review of 179 countries. He tried to measure the success of contributory and non-contributory health systems and the relevance of each system to the circumstances of each country.⁶

Wagstaff reviewed the various positions on the advantages of contributory systems, including their non-volatile financial resources, contrary to government decisions on public spending, which change from year to year. Accordingly, workers’ contributions are usually more stable. Moreover, many people are willing to pay health insurance fees because they are aware of the service they will receive in exchange for their contributions. Even if part of these contributions funds solidarity schemes are benefitting their colleagues in the broader insurance system, this model is more acceptable than the idea of solidarity with society as a whole through taxes.

However, health insurance contributions have many drawbacks, including the limited segment from which deductions can be made. These systems usually focus on formal employment and struggle to integrate informal employment.

Formal employment contributions are not entirely immune to crises, as they could witness drops due to unemployment. In addition, attempts to extend coverage beyond the scope of formal employment is met with several challenges. For example, if informal workers are given the full freedom to remain uninsured, incentives for informal employment will increase. If a unified subscription fee is imposed on this segment, as their real incomes are not known, insurance will cost less under informal employment arrangements in certain cases, which would also increase the incentives for informality.

Accordingly, Wagstaff believes that the contributory model might not be appropriate in many countries, especially developing countries, characterized by high rates of

3 Rudlof Klein, *The Politics of Ideology vs. the Reality of Politics: The Case of Britain’s National Health Service in the 1980s*. Centre for the Analysis of Social Policy, University of Bath, 1984.

4 P. Sean Brotherton. *Revolutionary Medicine Health and the Body in Post-Soviet Cuba*. Duke University Press Durham and London, 2012.

5 Abdo S. Yazbeck, et al. *The Case Against Labor-Tax-Financed Social Health Insurance for Low- and Low-Middle-Income Countries: Global Health Policy*. The People-to-People Health Foundation, 2020.

6 Adam Wagstaff – “Social Health Insurance Reexamined,” *Health Economics*, Vol. 19/5, 2009, Wiley InterScience, 2009.

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informality. He states that most countries that purely rely on health insurance are industrialized countries, with the exception of Costa Rica. This proves that the health insurance system requires a combination of public sector control and advanced systems of income tax on self-employed workers.

In short, the conflict between contributory and non-contributory models remains unresolved in global literature, despite the long history of both systems. While ongoing calls for the implementation of contributory systems in developing countries such as Egypt are still rising, as we will point out later, some experts question the ability of developing countries to fully rely on this kind of health protection, considering the high rates of informality.

The Long History of Gratuitousness in Egypt

The establishment of the modern health system in Egypt is closely related to the modern state. Its first iteration was built under Muhammad Ali's reign. He was concerned with developing health services to serve the army on the one hand, and to improve school students' health and prepare them to serve as the main cadres in Egypt's future bureaucracy on the other.⁷

The period following independence from Britain, in 1923, was marked by the rise of the nation state and the institutionalization of the health sector in Egypt. The Public Health Authority – established in 1868 as an entity affiliated with the Ministry of Interior – was turned into the Ministry of Health in 1936. This is mainly due to the fact that the “country was in dire need for a long-term health policy,” as the Ministry's founders believed at the time.⁸

In the 1920s, the state established several hospitals in different regions, starting with local public hospitals, horizontally spread in order to ensure basic treatment services in major cities. The goal was to establish a large public hospital in the capital of each district, in addition to ophthalmology hospitals, schistosomiasis and fever hospitals, children's

clinics, and others.⁹

Those hospitals offered some gratuitous services. For instance, a decision was issued in 1925 prohibiting the charging of any fees for outpatient consultations at hospitals, including minor consultations. Another decision was issued in 1926 calling for the treatment of “lowest class” patients in public hospitals for free as well, as most of the patients who request these services are usually poor.¹⁰

However, the ability to provide services to citizens remained an obstacle to the spread of gratuitous hospitals. In 1927, the Public Health Authority stated that “public hospitals affiliated with the service are unable to meet the population needs.”¹¹

This does not contradict the fact that the first decades post-independence served as a starting point towards the establishment of the welfare state in Egypt. The annual report of the Ministry of Health in 1952 reveals that the state was able to form a wide network of public hospitals across the country, as the number of public hospitals in major cities reached 22, and the number of central hospitals in major centers reached 68.¹²

The 1940s also witnessed an important development related to the primary health services spread in the countryside. In 1942, a law was promulgated calling for the establishment of a “free medical clinic”¹³ in every group of villages with a population of 15,000.

Nasserism and the Shift towards a State-controlled Health Sector

With the advent of the Nasser era, the public health system was shifting to a path similar to the British system (National Health Service). This similarity was reflected by the state's

7 Médecines et médecins en Egypte: construction d'une identité professionnelle et projet médical, Sylvia Chiffolleau, translated by Magda Abaza, The National Project for Translation, 2005.

8 Cabinet memorandum regarding the 1936 Law on the Establishment of the Ministry of Public Health.

9 Ministry of Interior, Public Health Authority, Health reform program approved by the Health Advisory Board, 1927.

10 Ibidem.

11 Ibidem.

12 Ministry of Public Health, Annual Report, 1952.

13 Law No. 46 of 1942 on the Improvement of Rural Health.

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tendency to control most health services, financing them from tax revenues and providing them to citizens at subsidized prices or free of charge.

The state's tendency to control health services was embodied in the 1964 procedures on the nationalization of civil society hospitals, referred to as "charities" at the time.¹⁴ These charities were a main provider of treatment services to citizens, alongside public hospitals. The number of nationalized hospitals at the time reached about 40 hospitals, spread across several governorates.

However, the Nasserist regime remained unable to expand health services in line with its aspiration to provide all citizens with free healthcare. The quality of services in hospitals was subject to criticism, even from within the regime itself. The fact-finding commission formed by the National Assembly in 1966 published a report regarding Qasr Al Aini Hospital, one of the oldest hospitals in Cairo. Although the report focused on mismanagement, it also referred to weak financial resources, or at least the misappropriated use of resources. For example, the report mentioned poor wages, stating that: "The nursing staff is incapable... unqualified... has lost most of its competencies because of mismanagement and numerous tasks, with very low remuneration."¹⁵

The "gratuitousness" policy was faced with constant pressures due to financial obstacles. As a result, the state had to implement a gradual process of privatization of public hospitals, under the guise of "affordable treatment." It aimed to provide paid services to citizens able to afford them in order to improve the hospital's resources and enable it to survive.

In 1965, a presidential decree acknowledged the right of public hospitals affiliated with the localities to establish funds to improve services, provided that paid treatment constitutes one of the funding sources for the funds.¹⁶ In 1975, an amendment related to the hospitalization system was issued, allowing the provision of "affordable treatment" services, provided that the number of beds allocated for this type of treatment does not exceed 20% of the total beds. These beds were divided into class I, class II, and inferior class II.¹⁷

14 Hospitals were nationalized by virtue of Law No. 135 of 1964.

15 What did the National Assembly Fact-Finding Committee say in its report on Qasr Al Aini Hospital?, Al Ahram, April 8, 1966.

16 Presidential Decree No. 2444 of 1965 on the Organization and Management of Hospitals and Units Affiliated with Local Councils, Article 4.

17 Decision of the Minister of Health and Minister of State for Local Government No. 447 of 1975 amending the provisions of the Basic Regulations for Hospitals and Medical Units Affiliated with Local Councils, Article 6.

In 1988, another decision on the hospitalization system was issued, allowing the provision of class I and class II services. However, the percentage of these beds was set at 30%.¹⁸ This decision was replaced by another system in the late 1990s, raising the percentage allocated to class-based patient beds to 40%. This decision also allowed hospitals to provide new services, such as the establishment of a "hotel treatment department."¹⁹

In the year 2000, another decision amended the pricing policy. Accordingly, some public hospitals affiliated with localities were subject to a regulation²⁰ stipulating that the treatment cost shall be calculated on the basis of the "economic and social conditions" prevalent in the region where the hospital is located. Nonetheless, the regulation did not clearly define the criteria for assessing the standard of living or set a margin for the increase in the price of services.

Moreover, new regulations for public hospitals were issued, allowing them to abandon the gratuitousness policy. The trend to establish specialized centers within public hospitals by virtue of presidential decrees is a clear example in this regard. Under the pretext of "specialization," these centers were turning to a new pricing pattern, allowing them to increase prices while providing more distinguished services.²¹

Financial Barriers to Improving Public Hospitals

All attempts to increase public hospital resources failed to improve the free treatment system. The reputation of hospitals with low-cost services was blemished by the poor quality of services or the lack of treatment supplies, given that health was not at the forefront of public spending.

18 Decision of the Prime Minister and Minister of Local Government and Minister of Health No. 3H of 1988 on issuing the Basic Regulations for Hospitals and Medical Units Affiliated with Local Government Units.

19 Decision of the Minister of Local Administration and Minister of Health No. 239 of 1997 on issuing the Basic Regulations for Hospitals and Medical Units Affiliated with Local Administration Units, Articles 7 and 13.

20 Regulation No. 120 of 2000.

21 E.g. Presidential Decree No. 365 of 1996 on establishing specialized centers at the Nasser Institute and Al Haram Hospital, which was followed by many similar decisions. Currently, there is a "Specialized Centers Sector" at the Ministry of Health governing such centers.

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State spending on health as a percentage of the overall state spending
Source World Bank data



The figure above shows the decline of government spending on health compared to overall public spending, at a time when there was significant criticism of insufficient spending in this sector, despite the deterioration of its services, as well as calls to give the health sector priority in public spending and budgeting.²²

One of the most prominent indicators of the deterioration of public health services is the share of out-of-pocket spending in total health spending in Egypt (see the figure below). This indicator monitors citizens' spending ratio compared to state spending and private sector spending ratios. The higher the ratio, the higher the commercial nature of health services and the more limited state spending are.

The percentage of out-of-pocket spending in Egypt amounts to 62%, according to 2018 data, almost double the global average.²³

In addition, doctors' low wages had a great impact on the quality of health sector services. After protests from doctors affiliated with the Ministry of Health, the state approved to accord them additional incentives to improve their wages

in 2014.²⁴ These incentives represented a percentage of the basic wage – that is, its increase was related to a wage increase. However, since the enforcement of the new Civil Service Law in 2016,²⁵ incentives have become lump sums and not a variable percentage, making their real value decline with time, due to exchange rate depreciation and the high cost of living.²⁶

When taking a closer look at the public spending distribution on state hospitals in recent years, we find that the compound annual growth rate (CAGR) of the allocated public spending reached 7.4% during the last six years, i.e. the half of the CAGR of total budget expenditure, which reached 14.8%²⁷ during the same period. This shows how expenditures on the health sector have been increasing at a slower pace than the increase in overall government spending.

22 Mona Mina: The Health Budget Must Be Increased: The poor service is caused by a lack of capabilities, Shaimaa El-Leithi, Masrawy, June 2015, https://www.masrawy.com/news/news_egypt/details/2015/6/9/597614.

23 UNDP, Egypt Human Development Report 2021, p. 85.

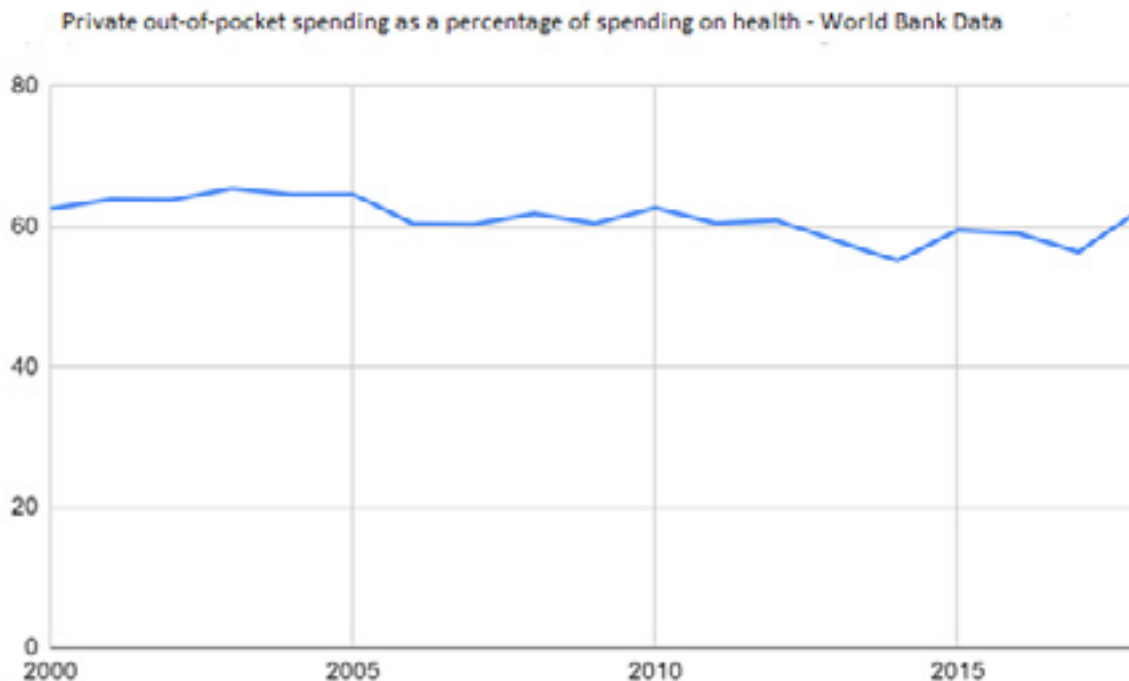
24 The President's decision to issue Law No. 14 of 2014 on regulating the affairs of medical professionals working in entities affiliated with the Ministry of Health and Population who are not covered by special laws or regulations.

25 Civil Service Law No. 81 of 2016.

26 Article 15 of the General Budget Law of 2016-2017. The observation about the deterioration of the incentive value was extracted from an interview conducted by the researcher with a Medical Syndicate official.

27 The researcher's calculations from the data of the 2014-2015 and 2019-2020 budgets.

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The period, between 2015 and 2020 witnessed high inflation resulting from the floating of the Egyptian pound in November 2016, which contributed to the growth of the nominal values of various government expenditures. However, expenditures allocated to health were limited. The impact of inflation was evident on doctors' wages. It also became more difficult for hospitals to purchase imported supplies.

"During the course of my work at the hospital since the end of the 1990s, I noticed how allocations for radiology inks purchase have been gradually declining. Initially, the inks ran out in the last two months of the year. Later, they became available for 6 months only after the increase in the cost of imported inks. When the currency was floated, they became available for one or two months throughout the year. The rest of the year, we ask patients to purchase inks at their own expense," says a doctor at the radiology department at Qasr Al Aini Hospital, a public hospital affiliated with the higher education sector, detailing her experience.

Qasr Al Aini is one example of public hospitals that still maintain the gratuitousness policy. The hospital was renowned for its affiliation with the higher education sector, considering the expertise of the doctors at the Faculty of Medicine at Cairo University and the young people's keenness to train at the hospital and benefit from these experiences. However, the hospital faces many hardships for being one of the few government facilities that has good expertise and provides its services for free, as it does not have sufficient

funding, which undermines its ability to serve all patients and exacerbates the lack of funding.

"You can book an appointment for an outpatient examination for a small fee (about 5 Egyptian pounds). If your condition requires an overnight stay, you will be referred to benefit from a free in-hospital bed. But in practice, outpatient clinics and inpatient beds are so overcrowded that in some departments two patients share the same bed and others sleep on the floor," said the doctor. "Sometimes I see patients who came from Aswan to Cairo. This long journey for a patient with poor health indicates the low-level services in the patient's area of residence, which encourages them to travel this distance."

In many cases, overcrowding in highly-experienced hospitals causes delays in service, as patients have to wait for a long time, which affects their health. Moreover, the lack of financial resources forces doctors to ask patients to provide certain supplies, imposing an implicit fee for the health service in a supposedly free hospital. "Sometimes, doctors donate sums of money to some patients whose income levels do not allow them to bear these costs," said the Qasr Al Aini doctor.

The lack of supplies is a common problem at many hospitals. "Admission to the operating room at Beni Suef Hospital is available at low prices. However, the patient needs to purchase unavailable supplies, such as plates for orthopedic cases, catheters, various surgical supplies, and incubator supplies," says a doctor at Beni Suef Specialized Hospital.

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Another aspect of the lack of resources is the scarcity of hospitals in areas far from major cities. A doctor working at the Sixth of October Central Hospital tells us that three public hospitals are available in the city. However, some services are not available in any public or private hospital. “For example, if a patient goes into a hepatic coma, they cannot be treated anywhere in the Sixth of October city.”

The common problem between all hospitals remains the lack of intensive care units, which is due to the lack of sufficient equipment, as well as the lack of medical experts willing to work in the public sector at lower wages, compared to the private sector.

Reports indicate that a great number of Egyptian doctors have immigrated due to weak employment incentives in their home country. As a result, hospitals are witnessing a severe shortage in medical staff.²⁸

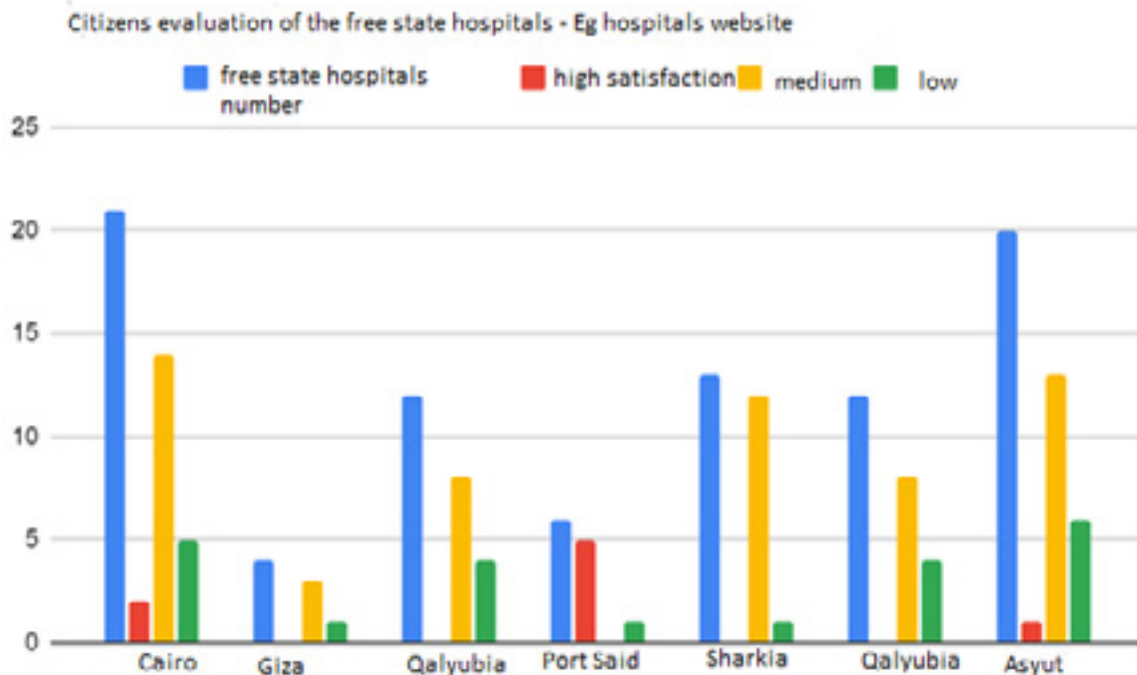
These problems are reflected in citizens’ satisfaction level with public hospital services. Figure 3 is based on data collected by a civil society initiative to build a database on citizens’ satisfaction with hospital services. As shown in the figure, the level of satisfaction in free public hospitals is low or medium at best, and rarely high.

The Fight for Health Insurance: Current Situation in Egypt

In 2017, a new health insurance law aiming to gradually cover all Egyptians over 15 years of age was the subject of a heated debate.

The most prominent change suggested by this law is that it ends the current role of the Health Insurance Authority as a dual-mandate authority: collecting subscriptions and providing services through its affiliated hospitals. The Authority’s role was limited to collecting subscriptions and competition between all hospitals – both public and private – was allowed. As a result, it became possible to choose the best offers in terms of the level of services when contracting hospitals.

Advocates of the new law believed that separating funding from service provision is the best guarantee to improve the level of treatment in the public health insurance system. Its opponents, meanwhile, believed that the new system would



28 Doctors’ Immigration: A stab in the heart of the health system, Ahlam Allawi, Al Masry Al Youm, October 2021, <https://www.almasryalyoum.com/news/details/2449601>.

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contribute to the deterioration of the tax-funded public hospital system, as the integration of these hospitals with health insurance hospitals and forcing them to compete with the private sector will lead to various scenarios. Either many public hospitals would be out of service due to their inability to compete, or they would tend to raise prices in order to be able to secure funding and improve the level of service to survive amid the new insurance system. As a result, they would lose their “gratuitous” nature.

In order to analyze and understand this conflict, before evaluating the new insurance law approved following a heated debate in 2018,²⁹ it is necessary to review the history of the health insurance system in Egypt that precedes the new law and to map out its strengths and weaknesses. This history runs parallel to the history of free hospitals discussed above.

The state implemented the citizens’ health insurance policy in 1959 through the Labor Law,³⁰ before moving to modernize this system in 1964 by virtue of Laws No. 75 and Law No.63. These laws provided for the insurance of workers in state-owned hospitals, as well as in the public and private sectors. They also marked the beginning of the health insurance policy in Egypt.

When the Health Insurance Authority was established in the mid-1960s, it was opposed to the idea of relying on public hospitals to provide protection against the risks of disease. Authority leaders believed that their role was the basis for protection and that public hospitals play a complementary role in this regard. This is contrary to the prevailing perception that the Nasserist regime was biased in favor of hospitals funded by the public treasury and that any deviation from this pattern was deemed as a form of privatization.

The Health Insurance Authority stated in a handbook issued nearly 10 years after its founding: “It has been proven to the whole world that free hospitals usually face multiple problems preventing them from performing their mission. Sums allocated to them are insufficient to meet the increasing demand for hospital services and people’s needs to benefit from adequate levels of medical services.”³¹

The Authority considered that the compulsory subscription to the health insurance system was the only way to secure sufficient funding, in order to avoid a lack of resources at

public hospitals. Since then, the Authority has aspired to gradually expand its services and to include all citizens, as a direct and publicly declared goal.³²

As a result, the insurance system established in the 1960s appears to be very similar to the system established by virtue of the 2018 law, as they both consider universal coverage and compulsory subscription as the only way to solve the funding problem.

The Authority also stated that free hospitals were just a transitional stage and that insurance is the best way to sustainably protect citizens from the risks of disease. However, Egypt has never shifted to universal coverage, and the number of people covered by the insurance system remained very limited. Thus, the system’s ability to mobilize funding and expand its services also remained limited.

Overall, health insurance covers about half of the population, which is a low rate compared to the successful experiences of other countries covering more than 90% of their population. More importantly, however, is the fact that the total number does not reflect the real coverage; as it includes large segments that pay symbolic contributions, while the labor force contribution to this system has remained very limited.

A more detailed analysis indicates that the total number of persons covered by health insurance in 2018 reached about 55.5 million, with the largest group being school students (23.3 million).³³ This category has been integrated into the insurance system as a mandatory requirement since 1992.³⁴ The students’ families didn’t object, given that the imposed subscription was very symbolic. At the beginning of its implementation, it was equal to 4 Egyptian pounds for every child and 10% of the tuition fees in the case of private school students with a maximal limit of 50 pounds annually. Fees increased in 2017 to reach 12 pounds for students of public and private schools).³⁵ The rest of the funding is secured by the public treasury.

Newborns come next at 15.8 million.³⁶ They were integrated into the system by virtue of a decision by the Minister of

29 Universal Health Insurance Law No. 2 of 2018.

30 Labor Law No. 91 of 1959.

31 100 Questions and Answers about Health Insurance: A Handbook by the Health Insurance Authority, General Authority for Amiri Press Affairs, 1975, p. 3.

32 Ibidem.

33 Annual Bulletin of Health Services Statistics for 2018, Central Agency for Public Mobilization and Statistics, November 2019, Table 43.

34 Law No. 99 of 1992 on Students’ Health Insurance.

35 Law No. 3 of 2017 amending several laws, including Law No. 99 of 1992 on Students’ Health Insurance.

36 Annual Bulletin of Health Services Statistics.

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Health in 1997,³⁷ and their inclusion became a mandatory requirement by virtue of a law issued in 2012. It applies to children under the age of basic education, who are also insured at a symbolic subscription of 8 pounds annually,³⁸ increased in 2017 to 12 pounds.³⁹

These two categories likely do not constitute a significant burden on the insurance system, given their a much lower risk of illness compared to the elderly. If this assumption is true, it would be clear why it was easy for the Authority to integrate them in exchange for symbolic contributions, enabling it to maximize the number of people benefitting from the health insurance system.

As for workers subscribed to the system, their number is only 12.3 million,⁴⁰ or about 22% of the total number. These include government employees and public and private business sector employees, who pay a percentage of their income in accordance with the relevant laws in force.

The labor force is the cornerstone of any health insurance system, as it is the most capable of generating income and financing system contributions. However, its meager contribution to the Egyptian insurance system explains the system's inability to generate sufficient revenues needed to develop its services to the intended level.

The limited contribution by workers to the insurance system becomes clear upon calculating the percentage of subscribed out of the total labor force, which amounts to 44%,⁴¹ or less than half. This low percentage could be attributed to the spread of informality or to unemployment.

Another reason why the system suffers from insufficient funding is that workers who are subscribed to the health

insurance system do not necessarily pay contributions commensurate with their real income, as many businesses, as well as some employees, try to reduce the wage value subject to deduction. Employers try to lower the cost of their insurance contribution to boost their profits, while workers try to achieve a lower wage due to their low income, the absence of union representation for many businesses, and the lack of a strong minimum wage policy.

Another factor leading to the low demand on subscription is that the state's own policies discouraged people from subscribing. "Treatment at the state's expense"⁴² was provided since the 1970s. This is a kind of free treatment for groups that the state deems deserving of support. Thus, the state was providing citizens with a free alternative that guarantees them protection in the case of severe illness. As a result, some people were discouraged from paying insurance contributions.

An additional reason was the multitude of insurance service providers, whether private insurance companies or other forms of insurance provided by government bodies to their employees and their families, such as hospitals affiliated with certain ministries. These insurance alternatives prevented the public system from expanding the coverage to the largest possible number of citizens, thus limiting its ability to secure more funding in order to improve the level of services.

Moreover, free public hospitals, especially those with expert cadres, competed with the health insurance system, despite the fact that they were operating with limited capabilities. Millions of Egyptians considered institutions like Qasr Al Aini or the National Cancer Institute as a last resort in cases of severe illness, even if they had to wait in long queues or bear the cost of missing treatment supplies due to poor budgets. In short, the health insurance system failed to provide the universal coverage it had aspired to since its establishment. Despite its attempts to cover larger numbers of people since the 1990s, such as students and children, the working class, which is the group most capable of contributing to funding the system, remained largely reluctant to participate.

This contributed to the limited funding available for the insurance system, which naturally affected the quality of its services. This does not negate the fact that the system has been able to provide services that are sometimes better than free hospitals, as its services are not available to everyone. "The total cost of catheterization in private hospitals ranges between 30,000 and 50,000 Egyptian pounds. This cost is fully covered under the insurance system. As for the price of catheter medicines, it is reduced from 205 to 40 pounds and

37 Decision by the Minister of Health and Population No. 380 of 1997 on the Health Insurance System for Children.

38 Law No. 86 of 2012 on Health Insurance for Children under School Age.

39 Law No. 3 of 2017 amending several laws, including Law No. 86 of 2012 on Health Insurance for Children under School Age.

40 Bulletin of Health Services Statistics.

41 Individuals within the labor force are those who actually work and those who wish to do so but cannot find an opportunity to work. Their number in the fourth quarter of 2018 reached roughly 28 million, according to data from the Central Agency for Public Mobilization and Statistics in the Quarterly Labor Force Bulletin for 2018. It is important to point out that there are many who leave the labor force against their will because they lose hope in finding a job opportunity. Many of them are women. These also need health and social insurance, but they do not figure in the official data.

42 Presidential Decree No. 691 of 1975 on the Treatment of Workers and Citizens at the Expense of the State.

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from 350 to 60 pounds,” says a doctor at the Nasr City Health Insurance Hospital.

In light of the above, it can be said that the new health insurance system was established to address the problems of the previous system and integrate aspects of the gratuitousness model. In the following sections, we will present an overview of the controversy over the universal health insurance system since the beginning of the 1990s, followed by an analysis of the new system and its ability to achieve its stated goals.

Transformations Instigated by the New Law

Since the 1990s, several attempts have been made to revive the concept of citizens’ universal insurance coverage, especially with the deterioration of the level of service at public hospitals caused by the 1991 fiscal austerity and stabilization and structural adjustment policies, which marked the beginning of neoliberalism in Egypt.

The World Bank, as one of the most prominent donors for health reform projects in Egypt, tried to contribute to the expansion of health insurance coverage by recommending a new legislation to achieve this goal within a program it financed in 1998.⁴³ However, this legislation did not pass, and the Bank’s position was criticized by many opponents who saw it as an attempt to privatize health insurance.

In a later report, the World Bank presented its position on health insurance more clearly, focusing on separating funding from service provision: the authority responsible for financing would reinforce the flow of resources, and the authority responsible for services would manage quality improvement. In parallel, public and private bodies would be given the opportunity to provide competitive health insurance services.⁴⁴

In 2018, a new health insurance law was issued in Egypt which largely adopted the World Bank’s position, stirring controversy among opponents of the World Bank’s vision,

43 World Bank health sector reform 1997, <https://projects.worldbank.org/en/projects-operations/document-detail/P045175?type=projects>.

44 World Bank, A Roadmap to Achieve Social Justice in Health Care in Egypt, p. 10.

who felt that the law’s objective was to restrict the gratuitous system (the non-contributory system).

Specifically, three bodies would be established under the new law: The first is the Universal Health Insurance Authority, tasked with receiving contributions and managing the financial affairs of the health insurance system, specifying the cost of services provided by the insurance system,⁴⁵ and contracting treatment service providers. The law opens the door for contracting government bodies or other parties.⁴⁶ The second authority is the Healthcare Authority, which would be responsible for providing medical services to the insured, whether at health insurance hospitals or hospitals affiliated with the Ministry of Health. The Healthcare Authority would also undertake the rehabilitation of private sector hospitals so they could integrate into the service provision process.⁴⁷ The third authority undertakes health accreditation and control in order to ensure the quality of treatment services.⁴⁸

Thus, the new law allows the public hospital system, or a large sector thereof, to be gradually directed to the health insurance service. Opponents of the law believe that some public hospitals will not be able to join the health insurance system due to the deterioration of their standards and will therefore be neglected, deprived of funding, and shut down.⁴⁹

Opponents of the law also warn of the private sector’s role in setting the cost of the insurance service. The law gives the Health Insurance Authority the right to appoint no more than a quarter of the Service Pricing Committee members from private sector service providers.⁵⁰ The Authority is also required to purchase health services at a “fair profit margin,” without indicating what a fair margin would look like.⁵¹ Opponents also believe that this will lead to increased service costs and profits.

Advocates of the law respond to these criticisms by claiming that there is no justification for the state’s monopoly on all

45 Articles 4 and 9 of the Universal Health Insurance Law No. 2 of 2018.

46 Article 11 of the Health Insurance Law.

47 Article 16 of the Health Insurance Law.

48 Article 27 of the Health Insurance Law.

49 Three Issues Spark Controversy over the New Health Insurance System, Mohamed Gad, Masrawy, 2017, https://www.masrawy.com/news/news_economy/details/2017/4/19/1063698.

50 Article 9 of the Health Insurance Law.

51 Article 11 of the Executive Regulations of the Health Insurance Law of 2018.

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health insurance services. The private sector already owns multiple outpatient clinics offering primary care services, especially considering the poor level of government primary care units, and the concentration of public investments on high-quality, specialized services requiring significant funding.⁵²

However, this debate did not focus on the significant problem of funding. The new system will mainly provide funding through citizens' contributions, by imposing new taxes on all forms of individual income. Advocates of the law did not accord sufficient attention to this main issue, as the law was based on the hypothesis claiming that citizens would easily agree to disclose their income once services quality increases, as a result of the private sector competing with public hospitals. Will this hypothesis become reality?

In the section below, we will try to analyze the funding structure of the new health insurance system and determine the likelihood of its success or failure.

Financial Analysis of Health System Transformations

Since 2015, Egypt has adopted various policies aimed at achieving the vision of international financial institutions, especially the International Monetary Fund, concerning the decrease of the public budget deficit. Among these policies are energy price liberalization, the enactment of a new law on consumption taxes (value-added tax), and the country's official exchange rate liberalization, while aiming at transforming various forms of subsidies (commodity and cash) into schemes that target the poorest segments and exclude the middle classes. These measures have been clearly commended by international institutions as tools for reducing the fiscal deficit and maintaining a financially balanced framework, which would encourage greater foreign investments.

With the stifling 2016 financial crisis, as well as the emergence of a very active parallel market for the US dollar outside the banking sector, the Egyptian economy became in dire need of the so-called "certificate of confidence" from international financial institutions in order to restore trust in the local currency. As a result, USD speculation stopped, and the country's ability to reintegrate into global financial system was reinforced.

52 An interview conducted by the researcher, author of the paper, with a former official in charge of health affairs at the World Bank, 2021.

In this context, several international financial institutions, led by the International Monetary Fund, joined forces to give Egypt this confidence in 2016. The state became more committed to following public spending policies that contribute to reducing the fiscal deficit. As a result, the state was encouraged to enact legislation that it had seemed reluctant to issue since the 1990s.

In our opinion, the universal health insurance law was reinforced by this financial vision, as it includes ambitious goals to improve health protection and extend the safety network to cover wider disadvantaged groups, heavily relying on subscriber financing, rather than on the public treasury – as was the case of the gratuitous system.

To elucidate our financial analysis of recent developments relating to public health policies in Egypt, we need to delve into the sources of funding for the new health system, as stipulated in the law approved in 2018.⁵³ These are as follows:

1. Contributions paid by insured individuals, which will likely constitute the major source of funding for the system, because they will be imposed as a compulsory requirement, effectively representing a new tax. Individuals who fail to pay these contributions will be identified, and legal action will be taken against them. Moreover, they will be forced to pay interest on the arrears.⁵⁴

What is noteworthy is that the income that the Health Insurance Law refers to is not limited to one job. If the worker has two or more jobs, all of their incomes will be subject to the insurance premiums calculation.

Moreover, workers will have to pay contributions on behalf of their unemployed wives for the first time. They will also have to insure their children, although this tradition has been followed since 1992. However, under the new law, the contributions will be increased. They will also be deducted from the income of the head of the household.

This applies to workers in the private and public sectors. In addition, the law requires wage-earners to pay the contribution, as well as wage earners under Law No. 112 (i.e. groups that work in jobs that did not allow them to benefit from the insurance system, such as newsagents, shoes shiners, and others). The law also requires Egyptians working abroad to pay contributions.

53 Article 40 of the Universal Health Insurance Law of 2018.

54 Article 55 of the Executive Regulations of the Universal Health Insurance Law of 2018.

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2. In addition to the deductions, the insured individual will pay a fee upon receiving the service. This fee is a percentage of the cost of the treatment they receive. This means that the higher the cost of the service offered by the contracted hospital to the Health Insurance Authority, the higher the contribution will be.
3. As for the resources that will be collected from the business community, deductions will be imposed on those who were subject to Law No. 108 of 1976. This law is applicable to self-employed workers and to those who run small enterprises. The income of entrepreneurs will also be subject to deductions, in addition to the contribution made by the employer on behalf of the insured.
4. The law also imposes deductions on companies, but at a marginal rate: 2.5 per mille of annual revenues.
5. Public treasury contributions to support those who cannot afford to join the new health insurance system. This is the more specific role of the public treasury in the new system. This contribution is limited to the payment of 5% of the minimum wage for each subscriber, in addition to the funds that will be collected by government bodies to finance this system, such as taxes on cigarettes, fees imposed on car licenses, and financial stamps.
6. Traditional sources of funding, such as the returns on investment of the Authority funds, grants, and donations.

As evidenced by the analysis above, the new insurance system heavily relies on contributions by the middle class for its financing, by monitoring the total income for workers with more than one job and requiring them to pay contributions for their entire family. In parallel, strict limits on the treasury's financing of the system were set, restricting it to financing the disadvantaged, defined according to non-transparent and complicated criteria.

Consequently, the ability of this system to succeed is facing major challenges, considering the state's limited ability to monitor income and tax collection, a problem that is clearly evident in the low income tax revenues out of total tax revenues (37%) during the fiscal years 2016-2020.⁵⁵

Perhaps this limitation is what prompted legislators to secure funding through some easy-to-collect consumption taxes, despite their negative social impact on consumers.

In fact, the limited ability to monitor income has long been a problem in Egypt, and it most likely contributed to the failure

⁵⁵ Ministry of Finance Monthly Financial Report for the month of August 2021, p. 28.

of the 1960s state in integrating the majority of citizens into the insurance system. During that era, taxes were imposed on income and wealth at very high rates. However, in practice, the state was unable to track income and wealth. Therefore, the actual share of these taxes in overall tax collection was very low.⁵⁶

The tax system is still unable to make significant progress in monitoring income. This is clearly reflected in the high rates of tax evasion among professionals and merchants,⁵⁷ not to mention the informal business transactions.

Accordingly, Ministry of Finance disclosures about the rates of citizens' participation in the new health insurance system seem unrealistic. The Ministry claims that it has registered 85% of citizens in the governorates included in the first phase of the universal insurance system: Ismailia, Port Said, Aswan, Luxor, Suez, and South Sinai.⁵⁸ Was it really able to bypass all the previous tax evasion problems and register the income of most citizens in these governorates? Or was it only able to register with the disclosed parts of this income?

Most likely, the health insurance system still depends on the categories it already covered, i.e. public sector workers and workers covered by the insurance system. The concept of wages is still the same as in the old system, especially since the executive regulations of the new insurance law were not issued until October 2021.

Although the law seeks to expand the coverage of disadvantaged groups, it is important to scrutinize its definition of the "disadvantaged." A decision issued by the Prime Minister in 2019⁵⁹ makes the definition clearer, as it included certain criteria that seem fair and truly aimed at integrating wide categories, such as people with special needs who are unable to work and who live in social care institutions.

However, other criteria seem ambiguous, such as the

⁵⁶ For more details on the history of taxation in Egypt, see "Who Do Taxes Benefit?" by Muhammad Gad et. al., Dar Al Maraya, 2020.

⁵⁷ For example, in the fiscal year 2020, the value of taxes collected from non-commercial professional activity amounted to 2.7 billion Egyptian pounds, a negligible value out of the total public tax proceeds, exceeding 382 billion Egyptian pounds.

⁵⁸ 85% of Targeted Individuals in the Governorates of the First Phase of Universal Health Insurance Registered, Masrawy, October 2021, <https://shorturl.at/tCEPU>.

⁵⁹ Prime Minister's Decision No. 1948 of 2019 on the identification of the disadvantaged and the conditions for exempting them from universal health insurance system costs.

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entitlement of each head of household who is unable to provide the basic needs of their family to state support for health insurance system coverage. The meaning of “basic needs” was not clearly defined in the decision. Were these needs calculated based on the cost of living in the region where the family resides? And do they take into account the rapid price fluctuation?

The decision also makes a reference to the eligibility of beneficiaries from Takaful and Karama pensions. Most likely,

these categories will be among the first to join because the state already has databases about them. However, these pensions have not been legalized since their implementation in 2015: they are enforced by virtue of ministerial decisions, and no relevant laws have been issued by the House of Representatives, not to mention that no deliberations have been undertaken to determine the categories that are eligible to join. In fact, the state did not announce transparent criteria for eligibility and exclusion from this system, which seems to be strict in terms of accepting new individuals in many cases.

Conclusion

Although the World Bank has significantly contributed to the conceptualization of the new health insurance law, it cannot be said that the law was the result of foreign intervention. In fact, the state has recognized the need to provide all citizens with health insurance coverage and the need to consider free hospitals as a complementary contributor or a transitional stage in the field of health protection since the 1960s.

The new insurance law also represents a rupture with the previous health protection system and its many flaws, including the multiplicity of government bodies, sometimes with conflicting roles, and the limited ability of the previous insurance system to collect subscriptions and funds from citizens.

However, the new law faces challenges mainly based on the dilemma that Adam Wagstaff had raised. This refers to the attempts of developing countries to rely on contributory health systems at a time when the state is unable to raise funds from the working class, in addition to the burden that the contributory system imposes on the middle classes at a time when they are experiencing pressures from the lifting of subsidies.

The financial analysis of the financing pattern of the new health insurance system reveals many risks that may hinder the ability of this system to achieve its health and social goals:

1. The risks of focusing on clients known to the state:

In the event that the state is unable to monitor incomes, the subscriptions imposed will be unfair, as the focus will be on deductions from the categories known by the state, i.e. workers registered in the old insurance system. Meanwhile, the informal sectors will exit the system or declare a limited part of their income, while keeping the remaining part undisclosed.

2. The risk of limited funding:

The current insurance system might reach the same impasse as the previous system, by being unable to collect sufficient funding to achieve its goals of providing a high-quality health service to all Egyptians. In this case, the scope of its services would remain limited, and the only development that would be achieved is to raise the level of service for some citizens and integrate certain disadvantaged groups in the system.

3. Private sector control over service pricing:

There is no doubt that the cost of service from within health insurance system will be lower than obtaining it directly from the market. However, this does not mean that the service cost will remain stable within the insurance system, as it is always subject to change, especially in case the parties that sell their services to the Insurance Authority raise their prices.

While the law provides for the purchase of services at costs with a “fair” profit margin, it does not offer any further clarity in this regard. It also allows the private sector to influence service pricing, which may expose the insured to an accelerated increase in contributions, even if the cost remains less than that imposed directly by the private sector.

4. The system's inability to achieve its goals due to the shortage of doctors:

Based on the early iterations of the system, doctors are apparently still dissatisfied with their wages, although they have increased under the new insurance system to nearly 10,000 Egyptian pounds. One possible reason for this dissatisfaction is that the new insurance system transferred a large number of doctors from major governorates such as Cairo to remote governorates such as Port Said due to the lack of medical personnel there. In Cairo, doctors depend not only on their wages from the hospital, but also on their income from their private clinics. When doctors are forced to leave their clinics in order to move to a governorate like Port Said, their net income is no longer sufficient for them to stay.

5. Elimination of the public sector:

Under the new system, the Insurance Authority will only be responsible for contracting services. As such, its monopoly on the direct provision of services to citizens under the old system will end. In fact, other public hospitals that were not under the mandate of the previous Insurance Authority framework will seek to integrate into the system of service providers contracted by the new Insurance Authority. In order to be able to integrate into this system, they were allowed to modify their prices in order to achieve greater financial returns that would help them develop.⁶⁰ If the negative scenarios mentioned above come true, in terms of the insurance system's inability to integrate large groups of citizens and the private sector's control over pricing, the final outcome would be the eradication of the "free hospital" model, without replacing it with the "universal insurance" model.

In light of the analysis above, there is a need for the state to decide upon the adoption of a contributory or non-contributory system based on realistic data. It should also determine the extent of its ability to collect contributions and integrate new numbers into the insurance system. The public should be informed of data that reflects the extent of citizens' response to the new system during the first stages of its implementation. In addition, a social dialogue on this issue should be undertaken.

Health protection covering the highest possible number of citizens should be a priority, while the objective of reducing the financial burden on the public treasury should take second place. Accordingly, if the success of the new system requires greater support for the disadvantaged or for the middle class by lowering their subscriptions, or even the support of public hospitals to enable them to play their role in the new system, spending should be increased, and new public resources should be secured through the tax system.

Finally, the non-contributory system should remain a viable alternative, in case the contributory system cannot be implemented or in case its disadvantages appear to be greater than its advantages.

60 In Preparation for their Integration into the Health Insurance System: Several hospitals transferred to the the Secretariat of Specialized Medical Centers, Mohamed Sami, Masrawy, May 2021, https://www.masrawy.com/news/news_egypt/details/2021/5/5/2017605/.

Are Egyptian Public Hospitals Reserved for the Affluent?, Suhad Hassan, Raseef 22, June 2021, <https://raseef22.net/article/1083026>.

About the Arab Reform Initiative

The Arab Reform Initiative is an independent Arab think tank working with expert partners in the Middle East and North Africa and beyond to articulate a home-grown agenda for democratic change and social justice. It conducts research and policy analysis and provides a platform for inspirational voices based on the principles of diversity, impartiality, and gender equality.



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