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Political Economy of Universal Health Coverage in Egypt - Universality Versus Equity?

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POLITICAL ECONOMY OF UNIVERSAL HEALTH COVERAGE IN EGYPT - UNIVERSALITY VERSUS EQUITY?

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Part IV: Human and Social Development in Egypt, Section 2: Health and Economic Development.

Objectives

- Understanding the institutional framework and the political economy setting of the UHC system in Egypt.

- Outlining the main institutional challenges facing the new UHIS that would have health equity implications.

Content

- Introduction
- Evolution of the UHC system in Egypt
- The Current versus the New UHIS
- Universality versus Equity
- Conclusion and Policy Implications

Introduction

- There is a growing literature employing political economy approach to study such a link, yet a meager number of studies have been applied on the Egyptian case.

- Egypt's journey toward Egypt's UHC is complex being shaped by political and institutional dynamics.
  - Kingdon's model: "problems," "policies," "politics" in agenda-setting; stakeholder conflicts and public mistrust as barriers.
  - Path dependence theory: historical institutional legacies shape outcomes; locked the HCS in a paralyzed state; need for active stakeholder engagement.

High Aspirations, Limited Results

- ❑ 1956 Constitution
- ❑ Socialist ideology; Centralized, state-controlled health system
- ❑ HIO in 1964
- ❑ Financial unsustainability; shortages and service quality decline, weak (0.045%) and biased coverage
- ❑ As a tool to legitimize the system

Persistent Downward Trajectory (1981-2011)

- ❑ Weak financial contributory role for the gov.
- ❑ crowding out beneficiaries; fragmented system.
- ❑ new business class arose; maintain the status quo
- ❑ IFIs had more room and voice; Skepticism among politicians, healthcare professionals and civil society activists
- ❑ government had room to postpone reforms
- ❑ Weak political will to reform the sector

Before 1952

Monarchy

Nasser (1952-1970)

Sadat (1970-1981)

Mubarak (1981-2011)

The Foundation

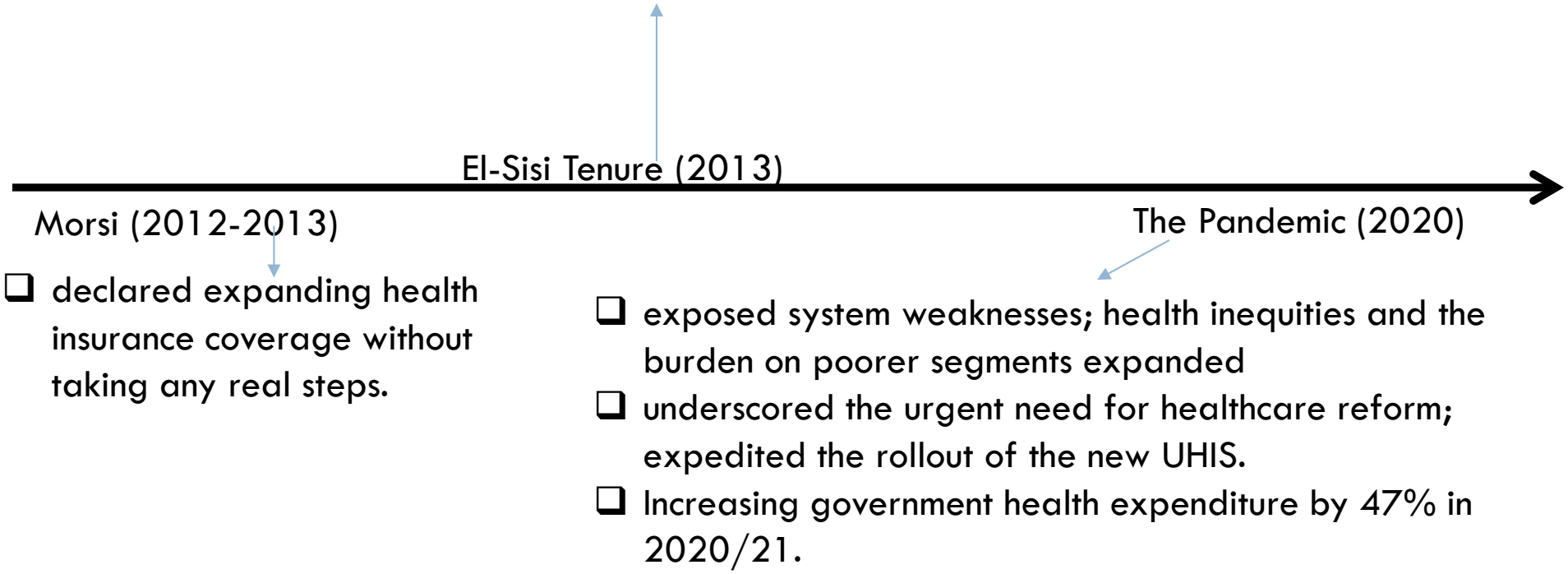
❑1936 Law

❑MOH, public hospitals, and medical education institutions

Expanding Coverage, Increasing Strain

- ❑ Dichotomy (capitalist model X the HCS was still sticking to the socialist framework)
- ❑ Intrusion of IFI
- ❑ Laws 32 & 79 expanded coverage
- ❑ shifted from full to partial funding, leading to increased OOPPs.
- ❑ A sedative to contain social unrest

- **"Right to Health" provision of the 2014 Constitution**
- The government adopted **a collaborative approach during drafting and preparing the UHI Law (2/2018)**
- A major change compared to the previous situation where the government was the sole drafter.



2011 Onward: Redefining Egypt's Healthcare Amidst Turbulences

The social upheaval in 2011 as well as COVID-19 acted as catalysts, opening a window for substantial dynamic changes enforcing inevitable reform.

The Current versus the New UHIS

Is Health a Priority?

- **Article 18 in 2014 Constitution;** increase public spending on health to 3% of GDP; **Presidential announcements** of squeezing the implementation; **Ministerial affirmative declarations** of sticking to the plan despite economic stringencies

- The threshold has never been reached 2000-2021 (1.5% of GDP, lower than the 2.2% average in LMICs) + inadequate share of health expenditure within its budget (5%) +GHE reached 32% of CHE (41% in LMICs); relies heavily on households, corporations, and non-profit organizations for healthcare funding (private health expenditure 70%).

- Germany and Turkey allocate about 20% and 12% ; GHE represented over 78% of CHE. OOPPs have remained around 12% in Germany and 16% in Turkey in the last two decades

The Current versus the New UHIS: Coverage

	Current	New
Population Coverage	☐ occupational and societal status ☐ substantial gap between "de jure" (58%) and "de facto" coverage rates (only 6% use the services). ☐ Urban and higher-income groups receiving better services than rural and lower-income segments	☐ gradual geographical coverage. ☐ replacing health related regulations that are dispersed across more than five separate health insurance laws. ☐ family is the main insurance coverage unit. ☐ cover the informal sector as contributors; cover the poor
Services Coverage	☐ like population, though gaps narrowed significantly ☐ Service provision is fragmented ☐ The MOHP is the primary provider of nationwide health services; subsidized and mostly provided free of charge; encompassing curative and preventive health care. ☐ HIO second major provider. ☐ Due to low quality and insufficiencies in the public sector, the private sector and civil society filled the gap.	☐ Will cover all health services, with the exception of preventive services to be freely covered for all citizens, and fully-funded and provided by MOHP

The Current versus the New UHIS: Structure

Current	New
☐ is intricate, involving government, parastatal, and private entities as both purchasers and providers of services.	☐ Streamlined decision-making and planning, pre-payment, risk pooling, solidarity, and separating the funding from the provision of service. ☐ Replaces the complex scattered structure with three main autonomous agencies: ☐ General Authority for Universal Health Insurance (GAUHI) (financial sustainability), ☐ General Authority for Healthcare (GAHC) (service provision), ☐ General Authority for Healthcare Accreditation and Regulation (GAHAR) (the accreditor).

The Current versus the New UHIS: Finance & Financial protection

Current	New
☐ Lacks progressive financing mechanisms ☐ OOPPs are the major source of finance ☐ with disproportionate burden on lower-income groups. ☐ fell to 55% in 2020/21, coinciding with the implementation of the new UHIS and the pandemic. ☐ significant increase in catastrophic health expenditure; has also pushed a considerable % of the population below poverty line. ☐ HCS as a whole can be classified as a regressive one. ☐ With the exception of SHI and PHI, all sources of funding are regressive (earmarked cigarette tax, direct and indirect taxes)	☐ increases solidarity; SHI should represent almost half of the sources of funding. ☐ combat the restrictive underfunding by generating new funding sources (road tolls, fees on cars and drivers licensing); extending the base of contributors (informal and self-employed); designed rates for the mandatory contributory schemes. ☐ subsidize the unemployed and those with chronic diseases, funded through general budget transfers (5% of the minimum monthly wage). ☐ Theoretically, aligns with successful solidarity-based UHC models (Germany and Turkey) focusing on risk pooling and diversification over reliance on general taxes.

Universality versus Equity

Structure and Governance Challenges

•Integration Issues:

•Vague roles for HIO and MOHP lead to disintegration and overlapping responsibilities; MOHP remains the principal regulator, but lacks clarity on implementation and policy tools; Limited decision-making power with only one vote in the GAUHI board.

•Discrepancies in payment rates by the same provider might lead to biasness towards those covered by the UHIS….. "preferred risk selection"/ "cherry picking" exacerbating health disparities.

•Even in successful UHC models like Germany, differential payment rates incentivize preference for privately insured patients, contributing to health inequities.

•Stakeholder Representation:

•Concerns about bias in pricing committee; unclear government/public sector representation.; Limited civil society involvement; only two representatives on the GAHC board.

Universality versus Equity

Structure and Governance Challenges

- **Privatization Risks:**
- Potential for private providers to dominate healthcare.

- Brazil's system, facing underfunding, has experienced increased private involvement that jeopardized financial protection and health equity.

- Turkey and Germany limit private insurance's role through extensive public funding, resulting in minimal OOPPs and catastrophic spending.

- Germany's equitable system, private involvement service provision led to health inequities and cream-skimming of patients

- **Administrative Costs:**
- New and existing entities necessitate close control of governance and administrative costs; governance expenditure in the new UHIS was 9 times higher than in the HIO.

Universality versus Equity

Service Provision and Accessibility Challenges

Service Coverage Expansion Challenges

- ***Access issues:*** waiting lists and service shortages.
  - **HTP in Turkey: "Quick-Win" Approach:** Focuses on visible outcomes by expanding services in underserved areas and enhancing primary healthcare and emergency transportation.

- Potential segregation and distortions in service provision; resources shift towards more profitable curative services at the expense of the less profitable preventive ones.

- Addressing remuneration gaps between current and new insurance UHIS over 10-15 years is crucial to prevent further health inequities.

Universality versus Equity

Service Provision and Accessibility Challenges

- Surveys revealed that around 80% of physicians oppose the new UHIS due to financial and administrative constraints
  - **HTP in Turkey: Employed a "know thy enemy"** strategy through stakeholder analysis to counter opposition, introduced incentive-based pay-for-performance for public sector physicians, sanctions like revoking memberships for less threatening groups.

Referral System Limitations

- Administrative hurdles in accessing care; echoing past healthcare reforms' struggles in the late 1990s; Risk of "passive privatization".

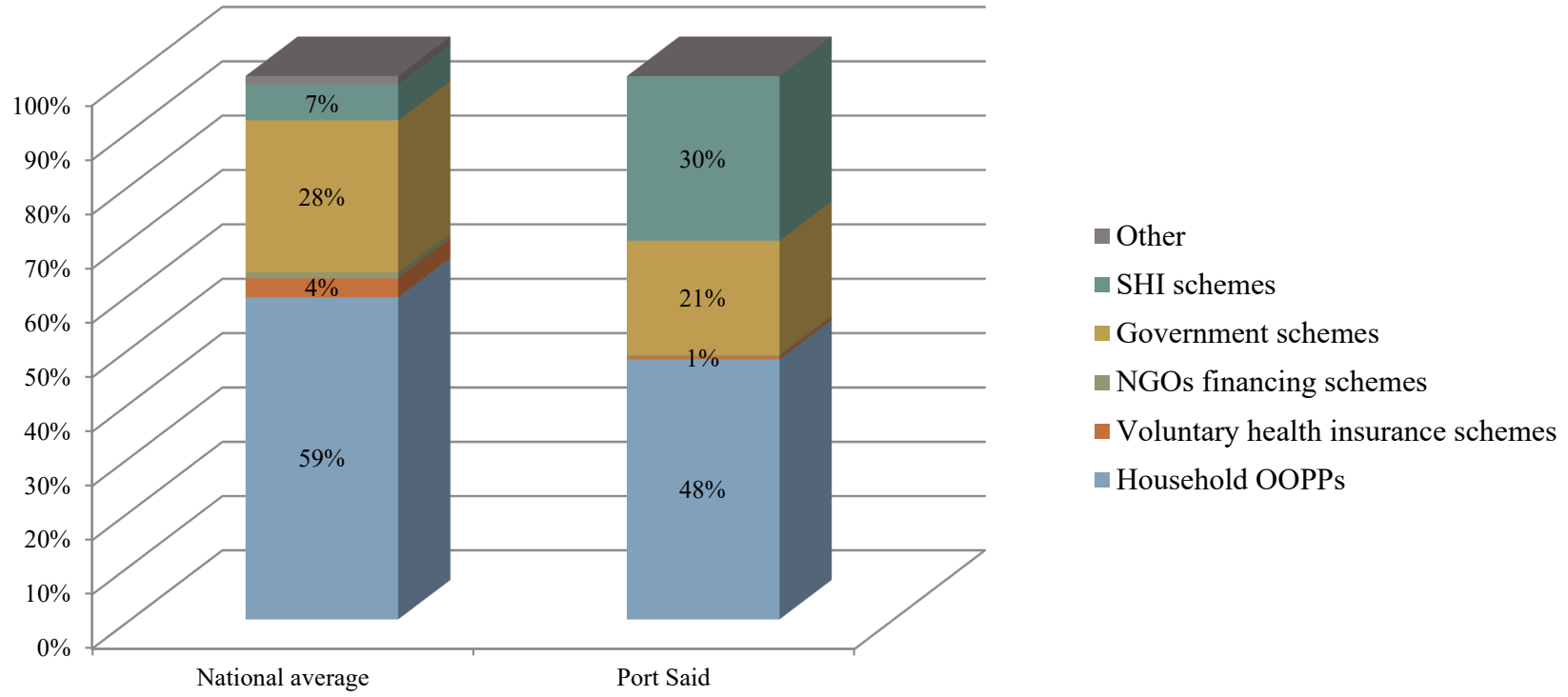
- no spending directed from UHI to medical retailers and pharmacies (In 2019/20 98% of retail pharmaceuticals is financed by OOPPs)
  - Turkey reduced OOPPs by nearly 21 percentage points from 2003 to 2011 by negotiating with pharmaceutical companies and lowering VAT on pharmaceuticals.

Universality versus Equity

Financial Protection Challenges

- OOPPs level in the pilot governorate are very near the national level in percentage terms and even exceeded the national average in absolute.

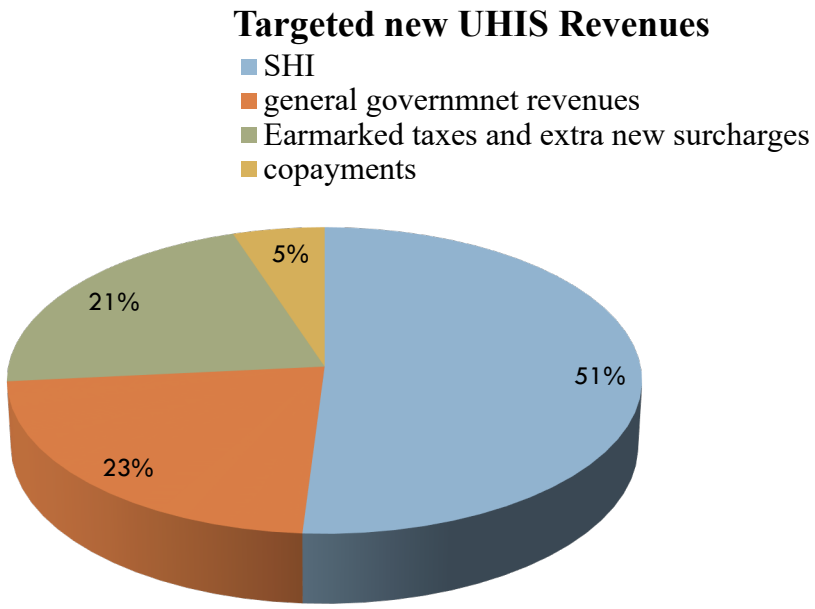
Share of CHE per capita by Financing Scheme in 2019/20

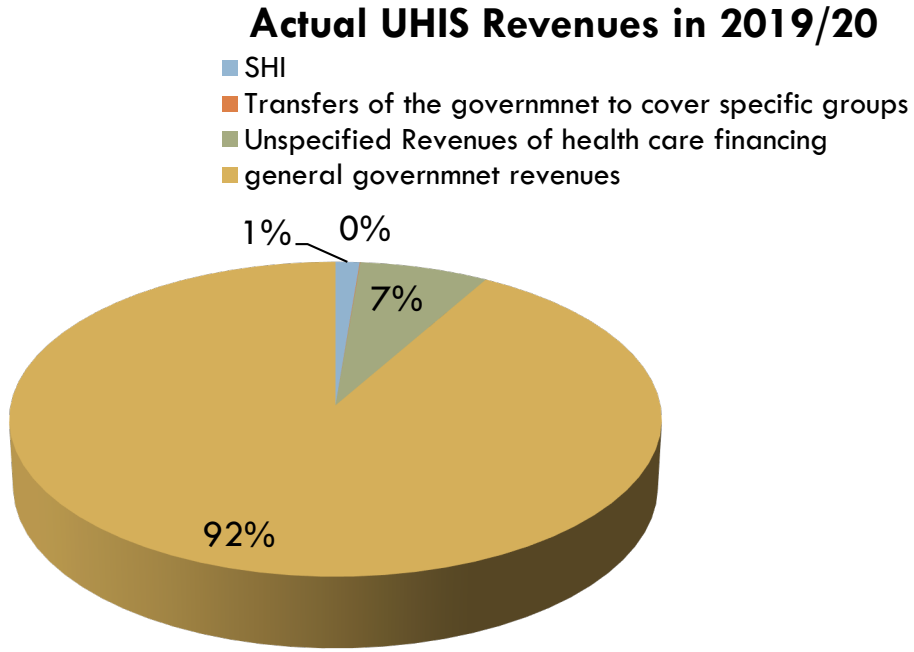


Source: WHO, MOHP and MOF (2023). Egypt National Health Accounts, Establishing an expenditure baseline to support Egypt's health care reform 2019/2020.

Universality versus Equity

Financial Protection Challenges





Sources: WHO, MOHP and MOF (2023). Egypt National Health Accounts, Establishing an expenditure baseline to support Egypt's health care reform 2019/2020; Mathauer, I., A. Y. Khalifa and A. Mataria (2019a). Implementing the Universal Health Insurance Law of Egypt: What are the key issues on strategic purchasing and its governance arrangements?, Health Finance Case Study No. 13., WHO/UHC/HGF/HF Case Study/19.13

difficulty of identifying those belonging to the informal sector and the marginalized groups, as well as to the potential limited fulfillment of contributions by the formal sector

Universality versus Equity

Financial protection Challenges

Beneficiaries

- **Regressive Financing**: New fixed surcharges on tolls and licenses unrelated to income levels.
- **Employer Contribution**: Premiums rise from 3% to 4%.
- **Employee Cost Burden**: Contributions can reach 7% of income, up from 1%.
- **Uniform Premium Rates**: New rates apply equally across income brackets, calculated on total income (rather than basic income).
- **Copayments**: remain regressive due to uniform application, ambiguity in exempted conditions and medications.

Medical Facilities

- **Regressive Contracting Fees**: Imposed on pharmacies, labs, and hospitals, hindering smaller entities from joining the system.
- **Licensing Burden**: Uniform fee per hospital bed disproportionately regressive and puts higher burden on public ones already suffering from underfunding.

Universality versus Equity

Inclusivity Challenges

- **Informal Sector:**
  - In 2018, accounted for 63.3% of Egypt's employment and ~60% of GDP.
  - Workers contribute 5% of income (up to 7% for households); Article 60 outlines eligible professions (e.g., craftsmen, street vendors).
  - Many are vulnerable and likely eligible for contribution exemptions, but informality complicates eligibility, risking exclusion.

- **Marginalized Groups:**
  - Government covers 5% of the minimum wage for those unable to pay; unclear if families are covered; the situation if treatment costs exceed this amount; .
  - UHI registration is by the male head of household, potentially denying access to unemployed women and their children.
  - Employees in UHI areas but residing elsewhere face additional challenges.

Conclusion and Policy Implications

•Egypt's healthcare system (HCS) has been shaped by historical sociopolitical factors, including stakeholder interests and governance fragmentation, and distrust in reform intentions leading to persistent health inequities.

•External shocks like the 2011 social upheaval and the pandemic spurred temporary increases in government health spending and reductions in OOPPs, hinting at potential system shifts.

•The system remains susceptible to reverting to its previous trajectory if institutional restrictions were not constructively addressed

Conclusion and Policy Implications

•UHIS increases financial burden with higher contributory rates and regressive components.

•SHI in the new UHIS can be a source of financial regressive stress rather than a proportional one as in the current system.

•Key sources of OOPPs include the referral system and pharmaceutical expenditure.

•OOPPs in pilot governorate reached concerning levels.

• Pilot phase revealed difficulties in identifying informal workers and marginalized groups

•Risks of treating informal category as a homogenous group.

Conclusion and Policy Implications

•Segregating the health services market could weaken the service provision for preventive less profitable services as opposed to curative ones.

•Aligning financing, purchasing, and payment structures; ensure clear, non-conflicting responsibilities across parallel systems; essential to avoid widening health disparities

•Improve stakeholder inclusion and civil society representation in governing boards; include competition authority and consumer protection agency in pricing committees for better financial protection.

•Increase awareness of the system's benefits while delivering quick, tangible outcomes.

•Foster a responsive political environment with strong public support, adaptable to threats.

Thank You