Ministry of Health

- Health Sector Modernisation Programme -

SYR/AIDCO/2001/0215

Funded by the European Union

برنـــــــــــامج تطويـــــــــــر القطـــــــــــاع الصحـــــــــــي
بتمويـل من الاتحـــــاد الأوروبـي

Health financing in Egypt

National health accounts, health insurance and family health funds Lessons for the Health Sector Modernisation Programme of Syria?

Result six of the HSMP: sustainable health financing

Final version

Assignment from 1st – 7th April 2006 in Egypt

Detlef Schwefel

Schwefel 10

Consortium GTZ / EPOS / OPTIONS

gtz

EPOS Health Consultants

Options

Detlef Schwefel was contracted by German Development Cooperation (GTZ)

ACKNOWLEDGEMENT

This report rests on an information tour of a delegation from the Ministry of Health and the Ministry of Finance of the Syrian Arab Republic to Egypt. The information tour implements one of the activities of the Annual Workplan 2005 for result 6 of the Health Sector Modernisation Programme (HSMP). It addresses the international training of trainers on national health accounts and public expenditure reviews. At the same time it focuses on health insurance as a specific option for fair financing for health and health care. This activity represents one of the first steps in using the support funds of HSMP in the hands of the Ministry of Health (MoH).

The current mission's report is based on a very good interaction and a fruitful cooperation with the leading counterparts from the Ministry of Health, especially Viceminister Dr. Deep Hazimeh and the Director for Planning Dr. Mahmoud Dashash. The Director of Health of the Governorate of Al Raqqa, Dr. Abdul Fattah participated in the tour as well as two leading partners of the health financing team of MoH, Mrs. Roula Kaderi and Mr. Mhd Hadi Fadda. The Ministry of Finance was represented by Mr. Osama Khayat. All six aforementioned personalities participated in the one week information tour to Egypt.

The assignment report rests furthermore on nine previous assignments of the consultant since the year 2003. Nevertheless, all information and advice still is given in the context of uncertainty. One week is not sufficient to explore all the many details of health care financing in Egypt. Information sources were scarce and sometimes contradictory. Errors and mistakes might be eradicated step by step through further reading, studies and exchange of experiences.

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CONTENT

ABBREVIATIONS

Abbreviation	Explication	التوضيح
AWP	Annual work plan	خطة العمل السنوية
EC	European Commission	المفوضية الأوربية
EMRO	Eastern Mediterranean Region Office	مكتب أقليم شرق المتوسط
EU	European Union	الاتحاد الأوربي
EUR	Euro	اليورو
GDP	Gross Domestic Product	الناتج المحلي الإجمالي
GNP	Gross National Product	الناتج القومي الإجمالي
Gov.	Governorate	محافظة
GTZ	German Development Cooperation	التعاون التطويري الألماني
HI	Health insurance	الضمان الصحي
HIO	Health Insurance Organization	هيئة الضمان الصحي
HSMP	Health Sector Modernisation Programme	برنامج تحديث القطاع الصحي
HSRP	Health sector reform programme	برنامج اصلاح القطاع الصحي
MoD	Ministry of Defence	وزارة الدفاع
MoF	Ministry of Finance	وزارة المالية
MoH	Ministry of Health	وزارة الصحة
MoHP	Ministry of Health and Population	وزارة الصحة و السكان
MoSAL	Ministry of Social Affaires and Labour	وزارة الشؤون الاجتماعية و العمل
n.a.	Not available (data)	غير متوفر(معطيات)
NGO	Non Governmental Organisation	مؤسسة غير حكومية
NHA	National Health Accounts	الحسابات الصحية الوطنية
ny	No publication year mentioned	سنة النشر غير مذكورة
OECD	Organization for European Cooperation and Development	منظمة للتعاون و التطوير الأوربي
PBI	Performance based incentive	الحافز بناءا على الأداء
PHC	Primary health care	الرعاية الصحية الأولية
SAR	Syrian Arab Republic	الجمهورية العربية السورية
SHIP	Schoolchildren health insurance programme	برنامج الضمان الصحي لتلامذة المدارس
STE	Short term expert	خبير قصير الأمد
UNICEF	United Nations International Children's Emergency Fund	صندوق رعاية الطفولة الدولي للأمم المتحدة
USAID	United States Agency for International Development	وكالة الولايات المتحدة للتطوير الدولي
WB	World Bank	البنك الدولي
WHO	World Health Organization	منظمة الصحة العالمية

ABSTRACT & SUMMARY

National health accounts, public health insurance and family health funds in Egypt present interesting examples for enriching the health sector modernisation debate in Syria.

- Egypt conducted national health accounts since 1991 and allowed methodological refinements. They provide increasing transparency on the health system and its components. They foster health policy debates. Egypt puts national health accounts into a wider context of health systems research from the point of view of health economics and health financing.
- Various public health insurance programmes cover close to 50% of the population, especially employees, retired, children but not their families. Most programmes are financially not sustainable even if they do benefit the better-off and not the poor, the self-employed and the informal sector of society. Health insurance in Egypt needs reform and expansion.
- Family health funds expand the coverage of public primary and secondary health care beyond the boundaries of existing health insurance. They separate purchasing and provision of health care and give financial incentives for good quality and a rational demand for health care. This system is rather based on cost-sharing than on the principles of public health insurance.

Developing a master-plan for health financing in Syria can benefit from experiences abroad. This plan could address a fair cost-sharing for primary health care as well as health insurance for catastrophic and chronic cases. It has to be based on good data and information. And it shall benefit the vulnerable and the poor, especially.

ملخص / خلاصة

تقدم لنا الحسابات الصحية الوطنية و التأمين الصحي العام و صناديق صحة الأسرة في مصر أمثلة هامة من أجل أغناء النقاش الدائر في مجال تحديث القطاع الصحي في سوريا.

- تتعامل مصر مع موضوع الحسابات الصحية الوطنية منذ عام 1991 و سمح ذلك بحدوث تحسينات منهجية. تقدم تلك الحسابات المزيد من الشفافية للنظام الصحي و مكوناته و تواكب حوارات السياسة الصحية. لقد و ضعت مصر الحسابات الصحية الوطنية في سياق و مضمون أوسع في بحث أنظمة الصحة من وجهة نظر أقتصاديات الصحية و التمويل الصحي.
- تصل نسبة تغطية العديد من برامج الضمان الصحي العام الى ما يقارب ال 50% من السكان و خاصة الموظفين و المتقاعدين و الأطفال و ليس عائلاتهم. و معظم البرامج غير مستدامة ماليا حتى اذا ما كانت تفيد ذوي الدخل المعقول و ليس الفقراء و أصحاب المهن الحرة و القطاع الغير رسمي من المجتمع. يحتاج الضمان الصحي في مصر الى اصلاح و توسيع.
- وسعت صناديق صحة الأسرة مجال تغطية الرعاية الصحية الأولية و الثانوية العامة الى ما دون حدود الضمان الصحي القائم. أنهم يفصلون ما بين شراء و توفير الرعاية الصحية و يقدمون الحوافز للجودة الأفضل و الطلب العقلاني على الرعاية الصحية. و يعتمد هذا النظام على التشارك في الكلفة أكثر منه على مبادىء و قواعد الضمان الصحي.

أن تطوير خطة عامة للتمويل الصحي في سوريا يمكن أن يستفيد من الخبرات الخارجية. يمكن لهذه الخطة أن توضح المشاركة في الكلفة بالنسبة للرعاية الصحية الأولية و الضمان الصحي للأمراض المزمنة و الكارثية. يجب أن تستند الى معلومات و معطيات جيدة. و ستفيد الفقراء و المعوزين بشكل رئيسي.

Health financing in Egypt

National health accounts, health insurance and family health funds Lessons for the Health Sector Modernisation Programme of Syria?

The Health Sector Modernisation Programme of the Syrian Arab Republic is funded by the European Union. It aims at increasing equity, efficiency, effectiveness and quality of health services. At the same time it intends to achieve a maximum of transparency and accountability in public spending. This is to be supported by one of its six results, i.e. “framework for sustainable financing of health sector in place”.

1. Terms

In this context the short-term assignment of the short-term expert (STE) was to participate in one of the key activities of the annual workplan 2005 so to get information on and prepare advice for the topics as highlighted in the following table, according to his terms of reference.

Table 1 Annual workplan 2005

Annual plan 2005 for result 6 of HSMP: “sustainable health financing”		
	Product	Activities planned
A: National health accounts and public expen-diture reviews	Product 1: Intensified training on NHA and on expanded budget / expenditure reviews	Compile, publish and use as training material relevant data for NHA, including budget and expenditure data, and disseminate to beneficiaries
		Training and training of trainers nationally and internationally
		Evaluate the trainings and adjust the curriculum and the training materials to further expansion of training
	Product 2: Recommendations to improve routine information systems	Review routine information systems and identify approaches for improvement
		Hold workshops to discuss the results of the reviews
		Develop implementation plans and start implementation in pilot areas
B: Options for fair resources genera-tion, including national health insurance	Product 1: Studies on household expenditure, willingness and ability to pay for health are executed	Develop methodologies to study household expenditure, willingness and ability to pay for health and health insurance
		Execute studies
		Analyse data and draft recommendations
		Hold workshops to build consensus around the results and recommendations
	Product 2: Provider studies are executed	Develop methodologies for health provider studies at micro level
		Execute the studies in pilot areas
		Analyse data and draft recommendations
		Hold workshops to build consensus around the results and recommendations
	Product 3: Existing insurance schemes evaluated and approaches for integration into a unified or coordinated system proposed	Review existing insurance schemes and insurance options and proposals, including satisfaction of members
		Develop documents on their strengths, weaknesses and proposals for their coordination or integration
		Hold consensus building workshops and conferences to discuss the results and proposals

Table 1 Annual workplan 2005

Annual plan 2005 for result 6 of HSMP: "sustainable health financing"		
	Product	Activities planned
C: Options for fair allocation of funds	Product 1: MoH Staff trained on fair financing	Identify potential beneficiaries at all levels and develop training materials, e.g. by compiling and/or undertaking cost-effectiveness studies
		Conduct trainings with appropriately modified manuals for different groups of trainees and trainers
		Evaluate the trainings and adjust curriculum and training materials to further expansion of training
	Product 2: Studies on provider payment, user fees, hospital autonomy and fair financing mechanisms executed	Develop methodologies for these provider studies at macro level
		Execute studies
		Analyse data and draft recommendations
		Monitor the fairness of examples of resource allocation at various levels, e.g. local, intermediate and macro
		Advise on fair allocation of resources based on NHA and other relevant data
		Hold workshops and conferences to build consensus around the results and recommendations

The terms of reference stipulated:

(1) Participation in study tour on national health accounting and health insurance to Egypt for a delegation from the Ministry of Health of SAR

(2) Daily discussion with participants on messages received and their implications for Health Sector Modernisation Programme in Syria

(3) Short report on possibilities of a knowledge transfer from Egypt to SAR regarding health insurance and national health accounting (to be delivered two weeks after returning from Egypt).

2. Health financing

Egypt has a long tradition in national health accounting. National health accounts were done in 1990-91, 1994-95 and 2001-02. Various international partners and donors participated in these exercises, e.g. the Harvard School for Public Health, the United States Agency for International Development (USAID) and especially Abt Associates Inc. was very helpful in producing, distributing and sharing internationally the results. Egypt was one of the international pilot areas for developing and streamlining an internationally disseminated methodology for national health accounting. Standards for national health accounting are nowadays formulated by the Organization for Economic Cooperation and Development (OECD) and by the World Health Organization (WHO).

Furthermore, some specific tools for and applications of national health accounting were developed in Egypt: the budget tracking methodology for getting regularly routine data on health care expenditure and a methodology for designing health finance reform and projection models based on national health accounts. Health accounting can be considered to be a tool for describing and understanding the health care system of a country with its many actors and agents. In Egypt, for example, 29 fragmented public agencies are involved in health services. National health accounting brings transparency into the health system and into policy making.

Table 2 presents some results of the most actual national health accounts of Egypt for the financial year of 2001-2002.

Table 2 Some results of national health accounting in Egypt, 2001-2002

Who pays for health?

Sources	%
Households	61
Government	29
Private employers	6
Public employers	3
Donors	1
Total	100

Who manages health care expenditure?

Managers	%
Households	60
Government	30
Health insurance	10
Total	100

Where do households spend for health care?

Providers	%
Government	9
Health insurance	1
Private hospitals	8
Private clinics	36
Pharmacies	43
Other	3
Total	100

What was and is the public and private share of health expenditure?

Sources	1994-95	2001-02
Public	46	31
Private	51	68
Donors	3	1
Total	100	100

Source [8]

Total health expenditure achieved a level of close to 6% of GDP in 2004. Many more details are given in the national health accounts reports of Egypt.

It is especially interesting in the most recent report, that additional sources of data are used for sketching a more political rather than technical health care financing report on Egypt. Sometimes such additional data are most revealing, e.g.

- 77% of all hospital admissions are in the public sector, 66 % of outpatient care is given by the private sector. This figure serves as justification that outpatient health care demand should be rationalized by health insurance and family health funds.
- Household expenditure: food 36%, education 9% and health 8 % - 12 % in the poorest and 7% in the richest quintile. This figure serves to pinpoint at the equity concern in combination with the estimate that 17 % of population lives below poverty level.
- Occupancy rate in government sector is at 40 %. Inefficiencies in health care provision by public agencies are a mayor concern for policy making in the health sector.

- Expenditure in pharmacies as percentage of total health expenditure is at 23,2 %. This figure is underestimated as it does not include drugs administered in facilities but only those sold in independent pharmacies. Total pharmaceutical expenditure amounts to 37.2 %. 32 % of the drugs are bought by the public sector and 68 % by the private sector.
- The share of MoH central administration expenditure increased from 11 to 44 % from 1990 to 2001/02 as compared with regional expenditure. Central health expenditure spending rose since drugs are bought nationally to get better prices and due to the national financing of centres of excellence.
- During the period 1993 to 2002 the budget of MoH increased higher than the budget of the government and of the GDP.
- Data on the Ministry of Defence, Ministry of Interior were not included in the national health accounts nor estimated, since there was political pressure to do so. It is estimated that the private share of health care financing would decrease to 51% of overall expenditure if such missing data would be taken into account.

It seems to be a bit problematic that NHA data are not available for every year and that it takes quite some efforts to collect them. They are available only after several years, e.g. now for the fiscal year of 2001-2002 only. It would be preferable to get regularly reasonable proxy data. The same applies to household health expenditure surveys, which are needed urgently and which should be conducted according to varying methodologies and by different agents so to check their reliability and validity. The last household survey on health expenditure in Egypt used the following recall periods: two weeks for outpatient care, one month for drugs and one year for hospital care.

National health accounting should not be seen just as a tool for collecting and comparing internationally some basic data on sources, agents and functions of health care and health care financing. They are just one part of a larger scale compilation of evidences on structure and function of the health system. A wider scale health systems research should embed national health accounting. In the latest Egyptian report [8] there is a larger chapter on “expenditures at the subsystem level” which expands data analysis beyond the narrow scope of national health accounting. Throughout the report there is furthermore a discussion on the international comparability of NHA data and the internal policy relevance of data. One example is the issue of expenditure for drugs. Whereas international comparability focuses on inpatient and outpatient care including drugs, it might be needed, too, to reveal the total expenditure for drugs, i.e. separating pharmaceutical expenditures from inpatient and outpatient care and combining it with expenditure done at independent pharmacies. A proper NHA data collection should be able to accommodate both points of view. Another example is the distinction between primary, secondary and tertiary care that is politically relevant in Egypt’s health policy making but not included into a NHA that strictly adheres to the standards of OECD and WHO.

3. Health insurance

Health insurance was established in Egypt by Presidential Decree in 1964. It covers now close to 50% of the population, which is currently estimated at 74 million

inhabitants. Health benefit and insurance schemes of private and public employers, spending 6% and 3% of the national health expenditure, are partly linked to the public health insurance. Private health insurance covers currently less than half a percent of the population, i.e. 300.000 Egyptians. It is considered to be detrimental for public health because of its cream skimming characteristics, i.e. undermining the global solidarity principle that is needed for a proper public health insurance.

The Health Insurance Organization (HIO) of Egypt manages various public health insurance programmes: “The HIO was established in 1964 as the institution in Egypt responsible for social health insurance, providing compulsory health insurance to workers in the formal sector. The HIO is an independent government organization under the supervision of the Minister of Health and Population. It finances health care services through a combination of payroll and other taxes. It delivers health care services through its own network of hospitals, clinics, and pharmacies, as well as by contracting private sector providers. HIO headquarters in Cairo is directed by the Chairman of the Board. The HIO started operations in the governorate of Alexandria. The original intent was to expand social health insurance to the entire population, but for various reasons, this did not happen. Instead, coverage has been extended to four major groups of beneficiaries under different legislation:

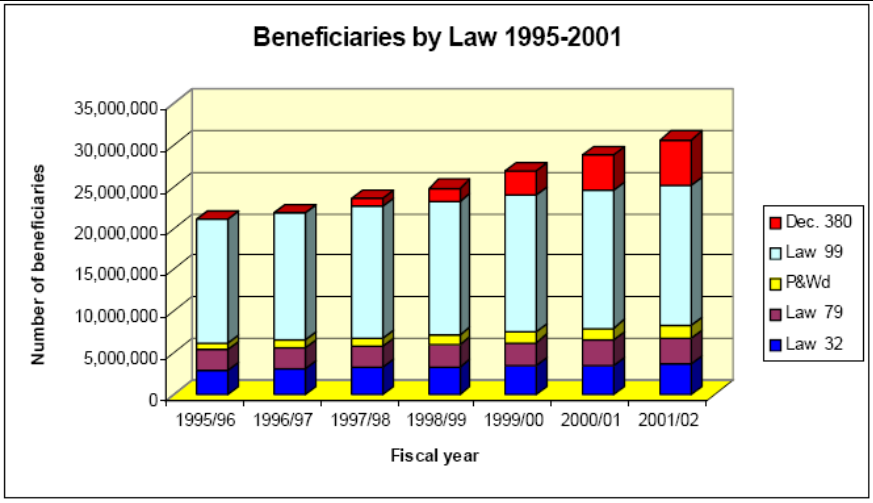
- Government employees (Law 32 enacted in 1975)
- Government, public and private sector employees, widows and pensioners (Law 79 enacted in 1975)
- School children (Law 99 enacted in 1992)
- Newborn children

Coverage of workers does not include their families.” [8,48] The ‘newborn‘ were added in 1997 by a Ministerial Decree and they comprise all up to 6 years old.

3.1 Status

The following figure shows the proportion of the various beneficiaries of public health insurance schemes in Egypt.

Figure 1 Public health insurance beneficiaries



Red = Infants and children
Green = school-children
Yellow = pensio-ners & widows
Brown = 1+3% employees
Blue = 0.5 + 1.5% employees

Source [8]

A rather comprehensive benefit package is being provided to the insured, as shown partly in the following table. Even plastic surgery and treatment abroad is included, without any reasonable ceilings.

Table 3 Benefit packages of health insurance

Table 4. Benefit Package to which HIO Beneficiaries are entitled

Services	Employees (Law 32 and 79)	Students (Law 99)	Pensioners and Widows (Law 79)
Curative Care			
General Practitioner Service	Yes	Yes	Yes
Specialist Services	Yes	Yes	Yes
Dental	Yes	Yes	Yes
Home Visits	Yes	Yes	Yes
Inpatient Care	Yes	Yes	Yes
Surgical and Medical	Yes	Yes	Yes
Radiology, Lab, other Invest.	Yes	Yes	Yes
Medicines (Drug benefit)	Yes	Yes	Yes
Ante, Natal, Post-natal care	Yes	Yes	No
Prosthesis and physiotherapy	Yes	Yes	Yes
Overseas Treatment	Yes	Yes	No
Preventive Care			
Annual medical exams (at the start of the school year)	No	Yes	No
Immunization	No	Yes	No
Periodic medical exam	No	Yes	No
School hygiene	No	Yes	No
Health education	No	Yes	No
Nutrition supervision	No	Yes	No

Source [1,6]

Financing this benefit package is done by contributions, co-payments and governmental subsidies as shown in the following table. Additionally an earmarked cigarette tax of 10 Piaster per pack is given to the health insurance programme for the schoolchildren.

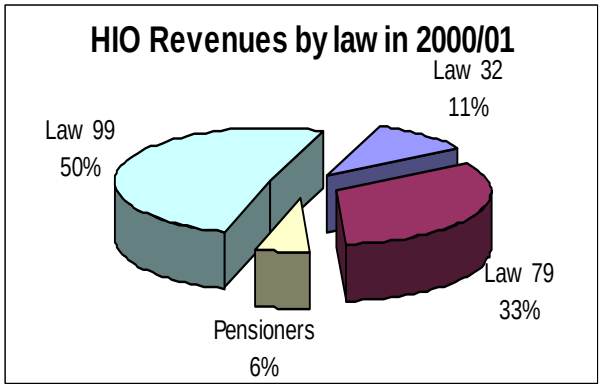
Table 4 Contributions and co-payments

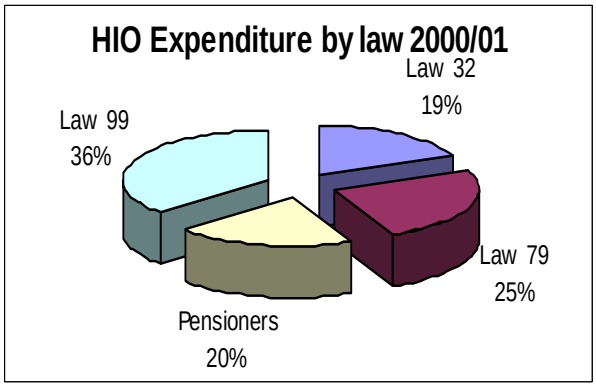
	Law 32 / 1975	Law 79 / 1975 "Workers"	Law 79 / 1975 "Pensioners & Widows"	Law 99 / 1992	Ministerial Decree 380 / 1997
Beneficiaries	Government employees	Government employee (labor force)	Pensioners & Widows	Students up till high school	Newborns up till school age
Beneficiaries' annual premium	0.5% of basic salary	1% of total salary	1% of pensions	4 LE	5 LE
Employer/Gov. share (Prem.)	1.5% of basic salary	3 % of salary Additional 1% and 2% for, public or private, labor accident		12 LE plus Earmarked taxes (0.10 LE per cigarette packet)	No government share
Co-payments	0.05 LE per visit to general practitioner 0.10 LE per specialist visit 50% of drug and investigations cost or price to maximum of 1 LE	No co-payments	No co-payments	1/3 drug price	0.5 LE per visit 1/3 drug price
Flow of fund	Employers' checks	SIO	SIO	Ministry of Education & MOF	Stamps

Source [8]

Revenues and expenditures of the Health Insurance Organization do not tally properly for the different groups of beneficiaries.

Table 5 Revenues and expenditure

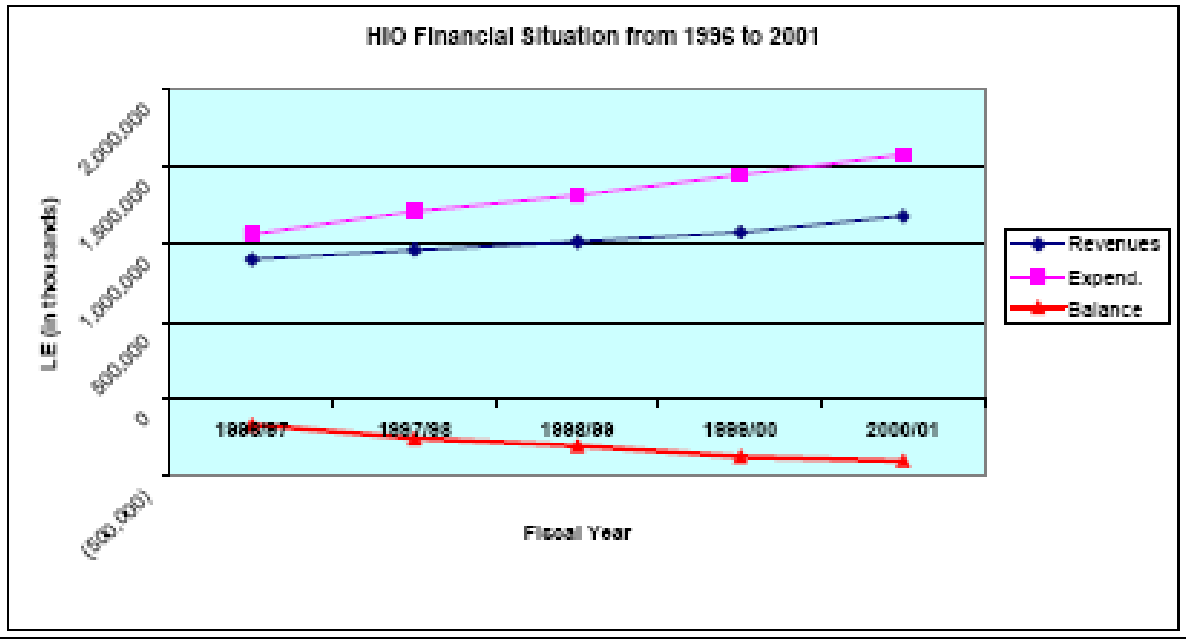




Source [8]

There was nearly always a deficit of the HIO since its very existence as can be seen in the following figure which shows the development of revenues, expenditure and deficits since 1996.

Figure 2 Health insurance deficits



The pattern of sources of funds for HIO is given in the following table. It shows that private firms do have the largest share with 40% and that households and government have equal shares of 22% each.

Table 6 Sources of health insurance funds

Sources	Amount (in LE)	Percent
MOF	514,146,806	22%
Public firms	356,593,794	15%
Private firms	949,610,580	40%
Households	525,996,676	22%
Non-profit institutions serving households (Zakat)	10,073,900	<1%
Total	2,356,421,756	

Source [8]

These funds were used:

- 43% for inpatient care
- 18% for outpatient care
- 30% for drugs
- 6% for administration
- 3% for capital formation.

A more detailed pattern of using HIO funds is shown in the following table. 60% of the services are given by facilities owned by the HIO and 40% of the services are contracted out to other providers of health care.

Table 7 Uses of health insurance funds

Uses	Amount (in LE)	Percent
MOHP hospitals	210,840,719	9%
CCO hospitals	21,584,654	1%
THIO hospitals	36,792,400	2%
Other ministries' hospitals	511,777	0%
HIO hospitals	1,058,174,628	45%
Private hospitals	35,721,732	2%
Overseas hospitals (treatment abroad)	601,429	0%
MOHP health centers	33,914,674	1%
HIO health centers	31,626,260	1%
Pharmacies	701,653,559	30%
Administration	152,088,918	6%
Others	72,911,006	3%
Total	2,356,421,756	

3.2 Challenges

There are various problematic aspects of the Egyptian public health insurance schemes

- Health insurance benefits individuals and not families: 23% of families do not have any member which is covered and another 23% of families get their schoolchildren covered by health insurance, only. Most public health insurances in other countries cover the families and not the employees only. Employees do usually not have the highest health risk in a family and in view of this the contribution rates in Egypt are rather high than low and therefore the deficits of HIO not explainable by income but rather by expenditure.
- The schemes for employees and school children are mandatory; those for the retired, widows and newborn are voluntary. HIO can not manage a unified programme but different ones with quite diverse beneficiaries, contributions and benefits.
- HIO was producing regularly deficits until cost-containment and benefit-reduction measures were employed. Inefficiencies in health care provision should be addressed more extensively. Anyway, a public health insurance scheme is usually bound to need subsidies from the government and a full cost-recovery might be utopia.
- The health insurance for schoolchildren might get a problem with long term sustainability but this scheme is a really interesting approach for a specific target group.[1]
- Private companies that opt out from covering their employees and paying premiums pay waivers that are revenues for health insurance. This option of opting out is detrimental for public health insurance.
- HIO has no autonomy to determine premiums, co-payments and other revenues.
- There is a lack of managers within HIO trained and experienced in managing health insurance according to the state of the art of the various scientific and practical disciplines working for it.
- The acceptability of health care provision by HIO facilities is not high. Only 6% of the insured use outpatient services of HIO and 12% their inpatient services. 7% of members use HIO benefits and 50% of the population pays for it. Patient satisfaction should be increased.
- Self-employed and those working in the informal sectors of society are not covered by the existing public health insurance.
- HIO owns its own facilities and this contradicts the modern principle of a separation of financing and provision functions in health insurance.
- Equity concerns can be raised with the present set-up of public health insurance, as can be seen in the following table.

[1] “Our findings show that the SHIP significantly improved access by increasing visit rates and reducing financial burden of use (out-of-pocket expenditures). With regard to the success of targeting the poor, conditional upon being covered, the SHIP reduced the differentials in visit rates between the highest and lowest income children. However, only the middle-income children benefitted from reduced financial burden (within group equity). Moreover, by targeting the children through school enrollment, the SHIP increased the differentials in the average level of access between school-going children and those not attending school (overall equity). Children not attending school tend to be poor and living in rural areas. Our results also indicate that original calculations may underestimate the SHIP financial outlays, thereby threatening the long run financial sustainability of the programme.” [19,207]

Table 8 Health insurance and equity

Location	Proportion of Households.	Standard Error
Urban	37.9%	1.1%
Rural	53.5%	0.9%
Most Educated Member of Household		
Primary	66.0%	1.0%
Secondary	44.9%	0.9%
University	26.4%	0.9%
Consumption		
Lowest	64.1%	1.2%
	51.2%	1.2%
Middle	44.0%	1.3%
	36.9%	1.2%
Highest	35.4%	1.3%
Presence of children		
No one under 17	55.2%	1.3%
One or more children present	43.0%	0.8%

Proportion of households in which none of the adults are covered by insurance, by social and economic characteristics, 2002 Source [8]

As early as 1997 the problems of public health insurance in Egypt were analysed by an international team. Their conclusions read as follows:

“Many factors contribute to the lack of financial viability and equity in HIO programs:

- . Contribution rates and co-payments are low relative to current levels of household spending and have remained unchanged since their enactment.
- . Employers are able to opt out of HIO coverage for employees if they purchase similar coverage elsewhere, paying only 1 percent employer premiums.
- . Financing is not equitable, with beneficiaries in regions with lower incomes bearing a larger burden than those living in regions with higher incomes.
- . Beneficiary coverage fragments households and services. For example, employees are covered but their families are not, school children are covered whereas their parents might not be.
- . Management of HIO programs is inefficient. The management of SHIP is separate from other HIO programs. This not only precludes pooling of risk across age groups but also leads to duplication of administrative functions and service delivery.
- . Due to pressures to maintain hospital services and invest in new technology, scarce HIO resources are being diverted to hospital-based services.
- . The HIO faces significant problems in controlling drug costs. They account for 69 percent of expenditures on widows and pensioners, 50 percent of expenditures on employees, but only 28 percent of expenditures under SHIP. The expenditures under SHIP are low primarily because there is a co-payment for drugs.

The HIO is rapidly becoming a purchaser of health services, instead of a supplier of health services, through increasing use of contracted private providers in order to meet the needs of its beneficiaries. Today, 65 percent of physicians under SHIP are contracted. Forty-one percent of hospital admissions under Law 32 and 79 and 58 percent of admissions under SHIP occur in contracted facilities. Admissions at contracted hospitals account for 61 percent of inpatient costs under Laws 32 and 79 and 60 percent of inpatient costs under SHIP. The HIO reimburses contracted providers largely on a fee-for-service basis, which may encourage over-provision of services and contribute to higher costs. For example, HIO spends 2.5 times more per admission in a contracted facility as compared with the cost per admission at its own facility." [1,21]

4. Family health funds

In 1997 the reform strategy for Egypt started focusing on primary health care (PHC), primarily. For HIO it was recommended: "all Egyptians should be assured coverage for a basic set of primary care services" [7] .

"The reform strategy has four elements:

1. *Develop a single basic benefits package*: Development of a basic benefits package must consider the prevalence of disease in the community, the common causes of mortality among different population subgroups; and the common causes of morbidity (non-fatal health problems). The package should cover preventive care, primary health care, curative care, diagnostic procedures, and drugs.
2. *Restructure financing to achieve sustainability and equity*: Separate financing and purchasing, create a fund-holding entity, develop a financing strategy for long-run sustainability, develop a financing strategy to improve equity, and develop incentive payments for providers.
3. *Reorganize coverage and service delivery to obtain greater efficiency and quality*: Make families the focus of service provision, permit consumers to choose their providers, restructure the public provider market, and promote quality in the private provider market.
4. *Strengthen the HIO organizationally*: Unify the social insurance laws; invest in HIO information systems, creating capacity in policy development and analysis, planning, and budgeting; develop a detailed investment plan; and develop an appropriate public–private partnership.

Given the magnitude of reform, it is recommended that the new approach be designed and piloted in a few geographic areas." [7]

Strengthening primary health care was one of the key intentions of the Health Sector Reform Programme (HSRP) of Egypt, starting in the late nineties. HSRP was supported by USAID, World Bank, African Development Bank and European Community. Participatory planning and focus group discussions with the main stakeholders guided the development of the reform strategy. National health accounts had clearly shown that 77% of hospital admissions are in the public sector and 66% of outpatient care is given by the private sector. The relatively high out-of-pocket spending for health by families was not a rational health care expenditure. These two findings backed up a drive towards strengthening public primary health care in Egypt.

The Health Sector Reform Programme had 5 main principles whose first one shows quite clearly its intention to improve and expand the existing public health insurance in Egypt:

- Universal insurance access
- Efficiency
- Quality
- Equity
- Sustainability.

To realize HSRP it was very clearly stressed, that three different layers should be separated quite clearly:

- Regulation by the government
- Purchasing by a health care financing authority
- Provision by public and private health care services.

Such a separation was meant to improve quality and cost-effectiveness of health care delivery in Egypt. The separation of financing from provision of health care is mentioned as the first building block of the HSRP. Modern messages of health economics and health financing started to lead a national public health reform programme.

To build up family health funds (FHF) was an idea generated in 1999 with participation of all relevant stakeholders. Since its origin FHF was thought to be a pilot-test for health insurance, especially for testing the “concept of a separation of health insurance payer functions from service provider roles” [4,xvi]. It was decided to start FHF as a “quality contracting agency” (ibid.) in Alexandria as first pilot area. Various options for linking primary health care to HIO were discussed. Later on it was thought to develop the family health funds as a fund-holding agency and a financing agency. FHF was defined as a “contracting agent to purchase health services for families in order to separate service finance from provision and to insure its quality and sustainability”.

Thirteen focus group sessions looked into characteristics of family health care from the point of view of patients, providers and other stakeholders [17], especially:

- Patient satisfaction with PHC
- Patient willingness and ability to pay
- Professional quality of PHC
- Provider willingness to contract FHF

Better provider satisfaction and better patient satisfaction are the aims of the primary health care reform programme of Egypt.

The improvement of PHC through family health funds had two most essential elements:

- Quality of provision: accreditation of providers according to agreed upon standards should bring back the trust of customers lost in public health care provision. The availability of doctors and other key personnel in the centres was seen as decisive and introduced e.g. by a three shift system in some facilities of PHC.
- Quality of demand: adherence to a good referral system and the prescription of drugs from the essential drug list was considered to be two milestones in

this direction towards rationalizing demand and withdrawing it from the uncontrolled private sector.

Economic incentives were needed to achieve both:

- Incentives for the providers: performance based payment incentives on the basis of sophisticated computerized information systems allowing the scoring of the availability and quality of physicians' services. Disincentives like "hire and fire" are not yet been practiced. Apart from the performance based incentives various payment schemes were designed for different types of providers: payment per visit (e.g. for university facilities), payment per capita (e.g. for non-governmental organizations), global budgets (e.g. for district provider organizations), prospective budgets (e.g. for surgical cases in secondary hospitals), retrospective budgets (e.g. for non-surgical cases).
- Incentives for the patients: a 66% discount of the market price for all prescribed essential drugs for those patients and families who are registered with the family health fund and a 50% discount of fees for inpatient services in secondary hospitals. Co-payment for drugs was intended to bring about a year long availability of drugs in primary health care facilities.

Financing of this system was to be done by four partners:

- Government, especially MoH and MoF for covering deficits and for supporting activities that should be exempted from co-payments, e.g. national programs, emergencies, chronic diseases, poor areas and poor people.
- Health Insurance Organization: paying 13 Egyptian Pounds per year per insured as registration fee for the FHF
- Co-payment of the patients: 10 Pound per person (maximum for one family: 30 Pound) registration fee per year, an entry fee of 3 Pound per visit, one third of the drug prices, planned reduced fees for laboratory tests, etc. Different fee levels are being experimented in different regions.
- Donors: especially the European Community, for a certain time period, only.

The political back-up of the system was given by Ministerial Decree 147 that introduced cost sharing into public primary health care provision in Egypt. Cost-sharing was seen as a mechanism to rationalize health care demand, to add to the meagre public health budgets and to avail of funds for giving incentives to providers' quality and performance. This ministerial decree regulated exemption policies, at the same time.

Various challenges and problems can be encountered with family health funds:

- FHF is a voluntary scheme that attracts sick and relatively well-off people, for the time being.
- A registration fee of 10 Pound per year is much too low to be considered as a nucleus for a health insurance premium. It was intended to be the cornerstone for financial sustainability of the scheme, to be converted later on into a real prepayment.
- The share between regular prepayment and payment in case of need is not in favour of an insurance-like regular prepayment. Out-of-pocket expenditures of patients prevail in case if illness.
- Family health funds do not deal with catastrophic illnesses and their impacts on entire families.

- The scheme is using its funds mainly for incentive payments for physicians and less for buying good services from competing providers of the best quality available.
- Actually just public provider networks are contracted and not providers from the private sector. Public providers have a monopolistic position in rural areas. Competition of providers is not yet used in search of efficiencies. This is explained by the lack of information and knowledge on availability and quality of private providers.
- Incentives are given mainly for doctors and not for all health staff categories in an equitable way.
- There is not a waiting period for availing of health services after registration. Therefore paying a registration fee might result from a rational calculation for getting cheaper prices rather then from opting in favour of health insurance. One example: the price for a certain amoxicillin is 26 Pound; when paying a registration fee of 10 Pound, a ticket for 3 pound and a third of the drug price, then altogether less than 22 Pound are payable, i.e. it pays off to calculate such fees and prices to get a better price in case of need.
- Rather than being an insurance programme, the FHF can be seen as a marketing tool for public government services in competition with private providers of outpatient care. It might increase trust in government services at the expense of government subsidies for drugs for the patients and for incentives for the physicians, mainly.

In spite of all these problems and challenges, the FHF expand the coverage of the health insurance programmes into rural areas and for self-employed and part of the informal sector. In Guysna town in Manoufia governorate, for example, 50% of the clients of the PHC centre are reported to be covered by HIO, 20% by registering with FHF and 30% still remain uncovered. With highly subsidised drug provision it will be not too difficult to expand even further. Additionally a special programme for exempting the poor from premiums and co-payments has to be strengthened. Even as a voluntary scheme, FHF can expand the coverage of health insurance.

Nevertheless, it is not addressing the catastrophic and chronic cases, and this is a mayor fault of the system, for the time being. Therefore, FHF can not be considered as the pilot-testing of a new health insurance system as declared by the HSRP. It is rather a system of introducing cost sharing into primary and secondary health care.

In the presidential campaign of 2005 health insurance played a certain role. “Health insurance of all” was the political motto announced by the Egyptian President in 2005. It is planned to achieve universal coverage within five years. This is still a long and difficult way for Egypt.

5. Lessons

Catastrophic cases and chronic conditions ask for a health insurance, mainly. Such cases shall be covered by small prepayments of all to benefit those who are severely ill and sick. At the same time some fair cost-sharing for less dramatic conditions could rationalize the use of public health services. These two principles might guide the development of health financing and health insurance in Syria.

Any kind of reform needs good information on critical issues. National health accounting and applied health systems research in the areas of health economics and health financing should complement epidemiological and medical evidence needed for modernizing the health system in Syria.

Syria hitherto went a different way as compared to Egypt. In terms of health financing it gave some financial autonomy to selected hospitals but it did not do so in view of introducing elements of a health insurance system. Cost sharing for primary health care was not done systematically but informally through the shortage of drugs and medical supplies; when supply runs out, patients have to buy it themselves. Health benefit and insurance schemes developed unsystematically and without any networking of their various experiences in public and private companies. A master-plan for a health financing reform is not yet existent. Such topics have to be addressed openly and transparently.

Comparing these needs with some experiences in Egypt and in other countries it is a good chance to pilot-test some elements of a new health care financing in Syria, especially in the governorates of Dara'a, Lattakia and Al Raqqa, as for example with one or more of the following options:

- Analysis of existing health benefit and health insurance schemes and replication of the best schemes
- Pilot-testing of a new outpatient clinic in Al Raqqa as "autonomous" unit with some fair cost-sharing elements
- Organization of drug funds in primary health care by rationing rationally the available drugs in PHC facilities
- Exemption of payments for the poor by introducing a poor man's card given by the authorities
- Exemption schemes for special diseases and conditions, including the free supply of drugs etc.

Such pilot-testing will benefit a health care financing strategy in Syria.

6. Literature

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Annex 1 Schedule of meetings and visits

Month	Day	Hour	Institution	Topics
April	**1**	5:30	From home	Flight to Cairo via Frankfurt
		14:30	Hotel Safir	Arrival in Cairo
	2	9:15	Hotel Shepheard	Meeting of Syrian partners
		10:15	Ministry of Health	Warm up meeting at the ministers office
		11:00	Ministry of Health	Technical Support Unit portfolio
		11:45	Ministry of Health	Primary health care strategy
		12:30	Ministry of Health	Egypt's health care profile
		14:00	Ministry of Health	National health accounts, 3rd cycle 2001
	3	9:30	Syrian team	Status and perspectives of HSMP R6
		10:00	Ministry of Health	Government budgets for health services
		12:00	Ministry of Health	Health financing in Egypt
		12:45	Ministry of Health	Family health funds and financing
		14:00	Ministry of Health	Generalities on health financing
	4	10:00	Menoufia Gov.	Primary Health Care Centre visit
		11:00	Menoufia Gov.	Secondary hospital visit
		11:40	Menoufia Gov.	Briefing at Family Health Fund office
		14:30	Menoufia Gov.	Governorate health director courtesy call
	5	10:00	Ministry of Health	Briefing by McKinsey on insurance options
		12:30	WHO-EMRO	Health insurance options for Syria
	6	10:00	HI Organization	Health insurance in Egypt
		12:15	EC Delegation	Briefing and debriefing
	7	11:30	Hotel Safir	Departure to Germany
		21:45	Home	Arrival in Berlin and end of mission