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Financing Health Care in Egypt: Current Issues and Options for Reform

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Overview – Financing health care in Egypt

- Introduction
- Comparison of financing options
  - Efficiency
  - Equity
  - Feasibility
- Conclusions

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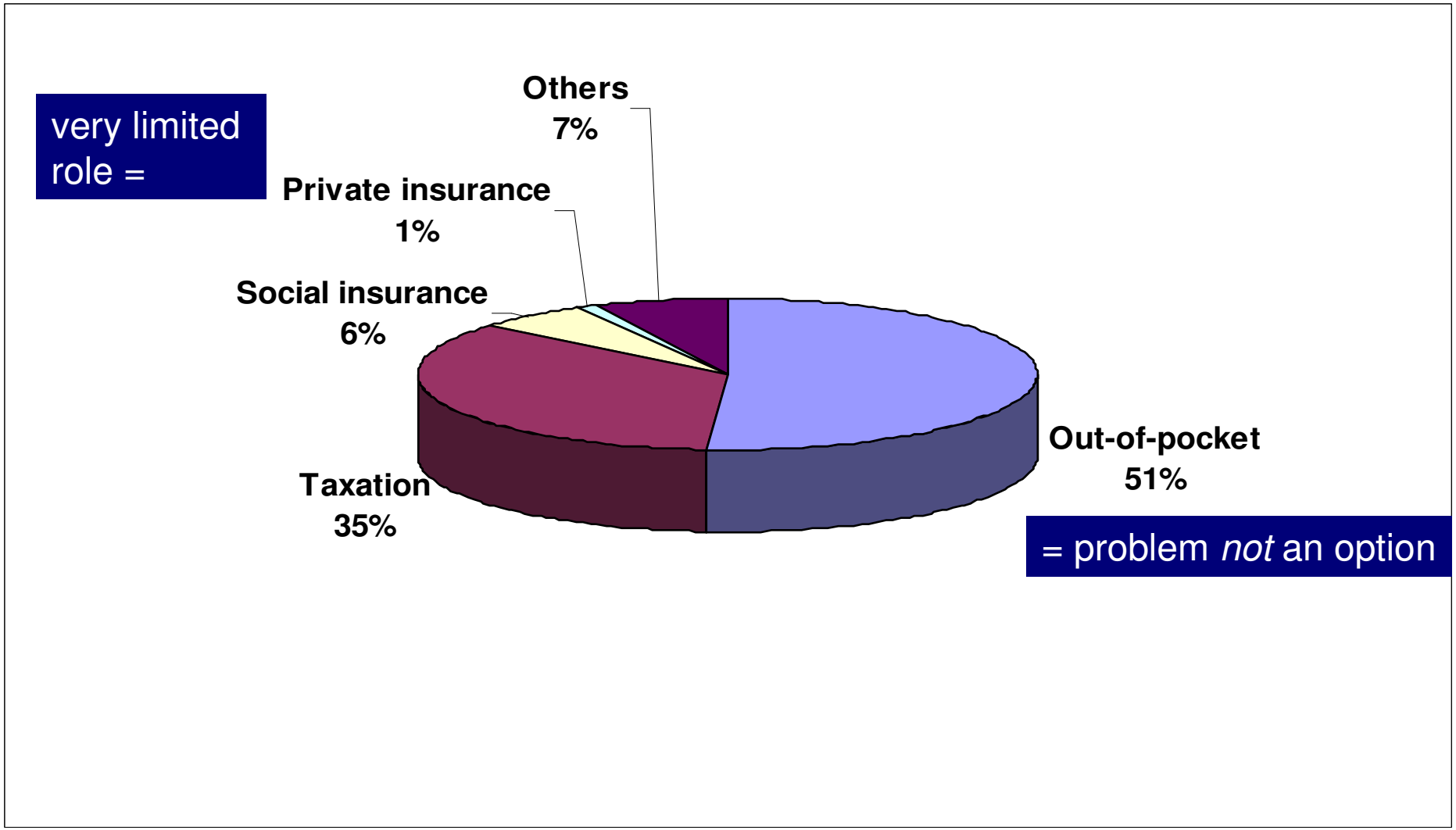
Key question in health care financing: Source of funding

Was it wise to expand the role of social insurance in Egypt‘s Health Sector Reform Programme?

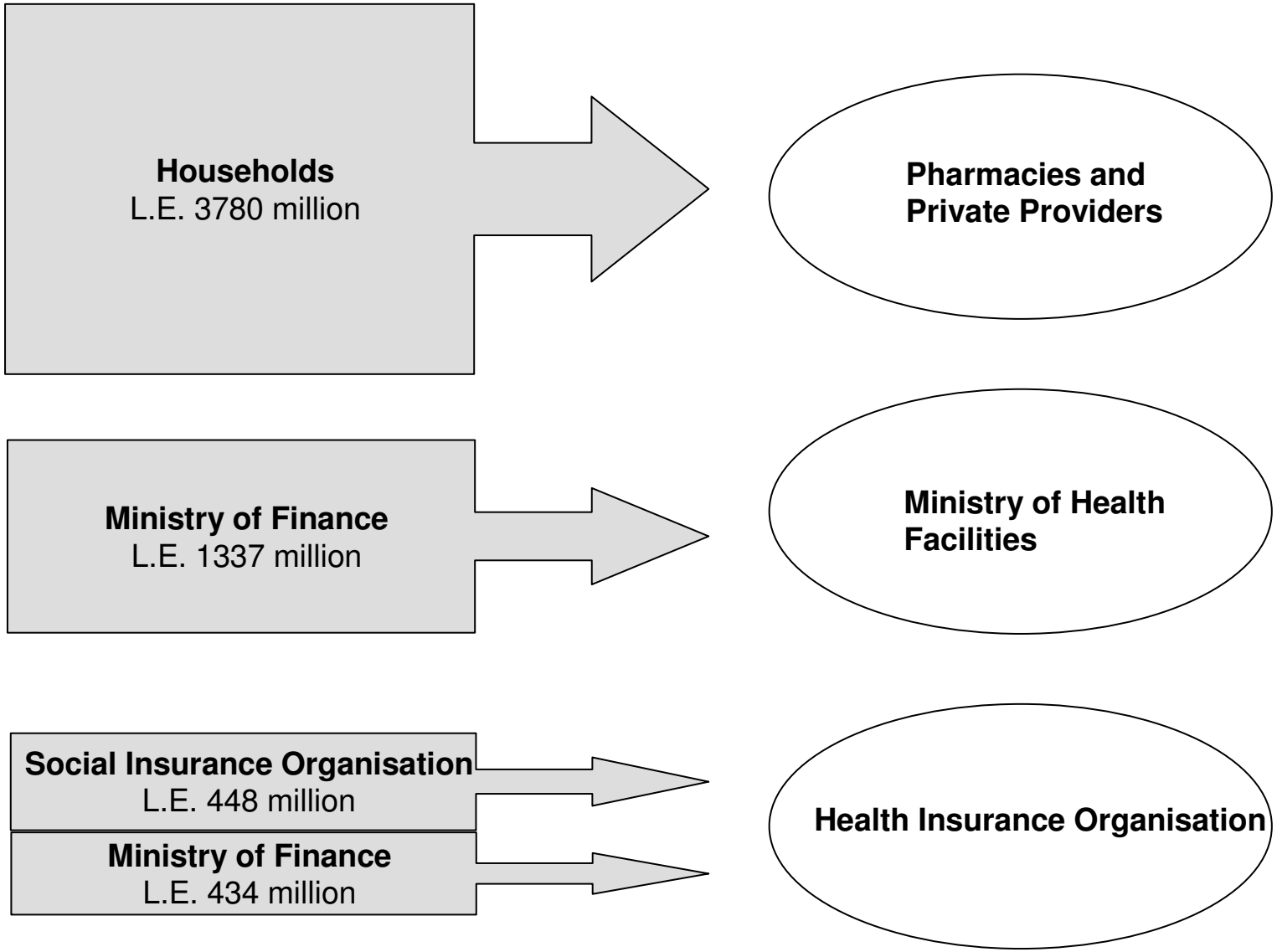
- **Many countries in the Middle East & North Africa face similar decisions**
- **Possibility to learn from the Egyptian experience**

Sources of financing health care in Egypt



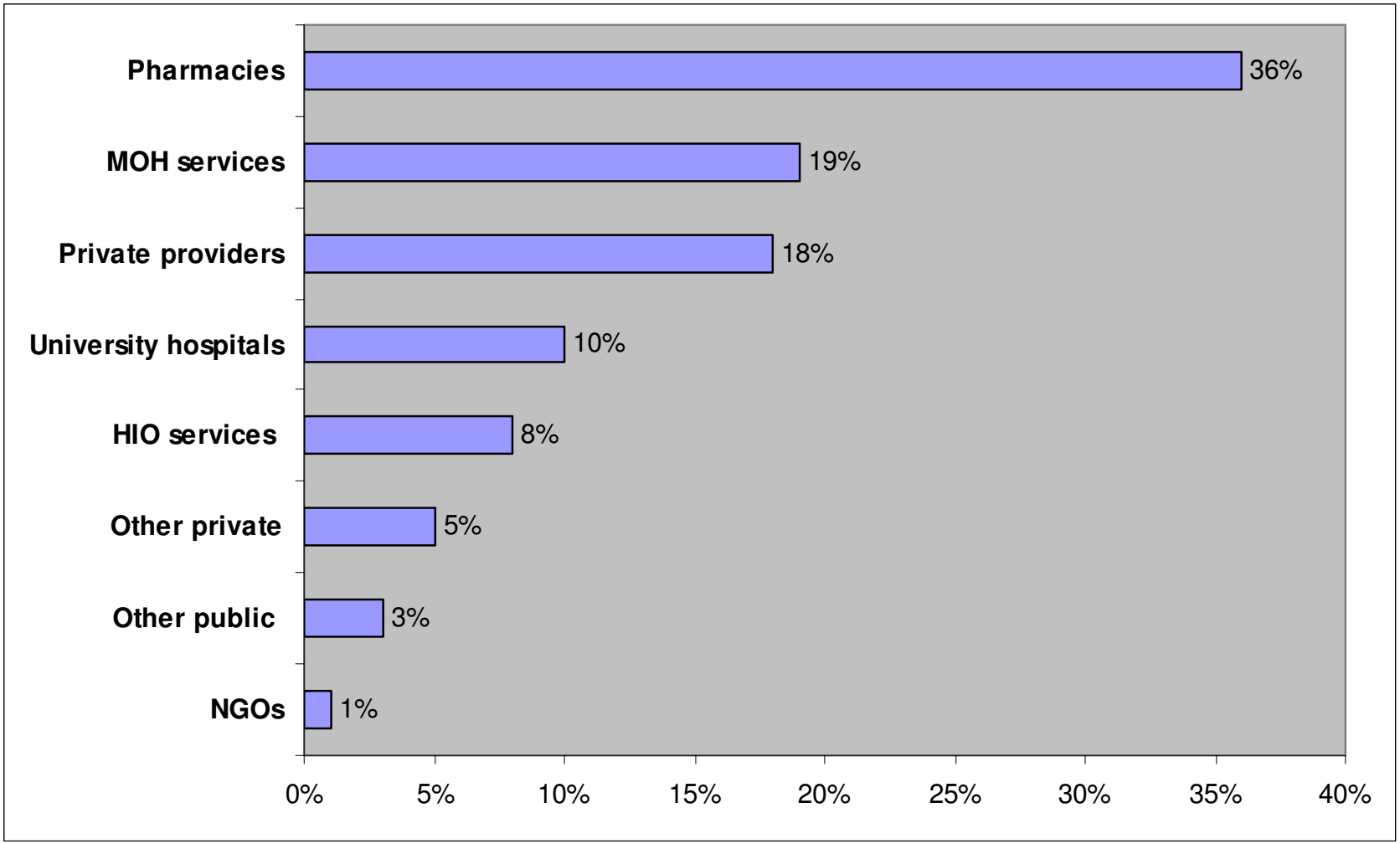
Source: Own illustration, data from Rannan-Eliya et al 1998, Rafeh 1997

Main health financing channels



Source: Own illustration, data from Rannan-Eliya et al 1998

Health care expenditure in Egypt



- 35% of revenues come from taxation, *but* MOH facilities only receive 19% of funding

Source: Own illustration, data from Rannan-Eliya et al 1998

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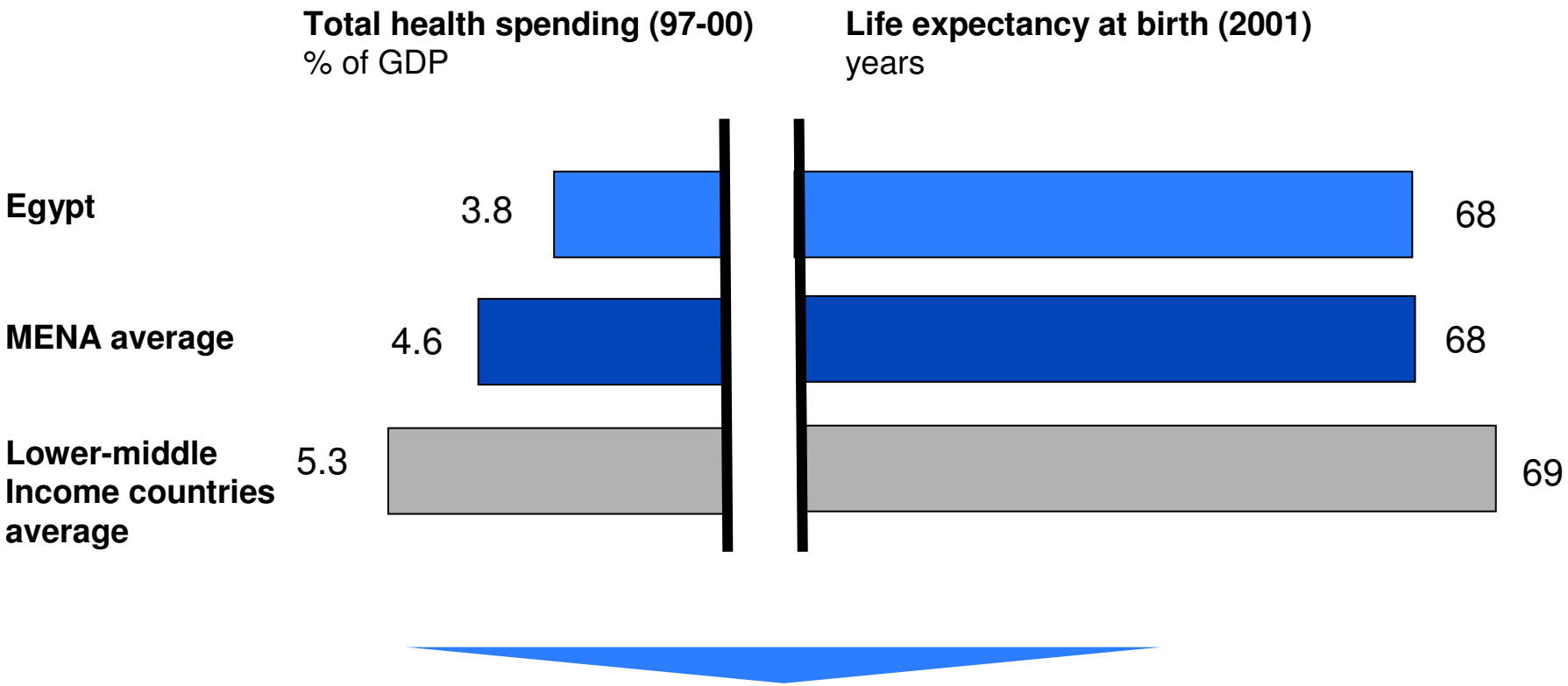
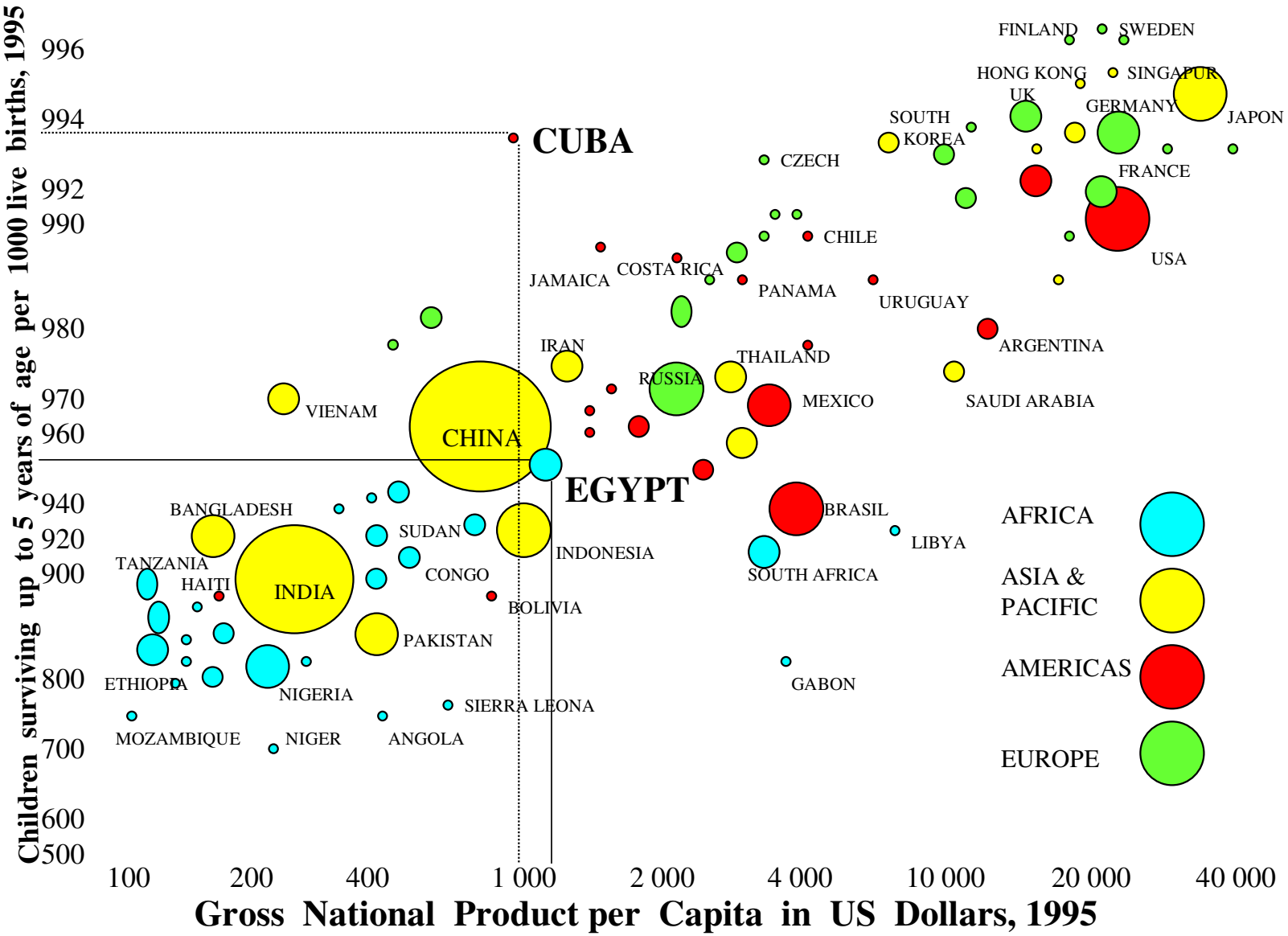
Macro-efficiency: Issues



- **Total health care spending in Egypt (3.8% of GDP) is lower than low income countries average (4.3% of GDP)**
- **Health status is relatively low for level of income**

Source: own illustration, data World Bank, HNP statistics 2004

Correlation between Health Spending/Under-5 survival



Source: modified after Rosling, Karolinska Institute, 2002

Macro-efficiency: Evaluation

Taxation	Social insurance
+	+
• Cost containment	• Less political resistance to raise contributions
-	-
• Raising revenue for health more difficult from general taxes *but* hypothecated taxes more acceptable (SHIP-tobacco tax)	• Increase in labour costs • Loss of governmental control of expenditure (CEE and CIS example)

Taxes earmarked for health are best option

Micro-inefficiency: Issues

- Fragmented financing & management: 29 public agencies
  - Precludes efficient & equitable risk pooling
  - Precludes consistent policy focus or incentives for efficiency
  - Service provision is linked to specific financing scheme:

  Average hospital occupancy rate is below 50%

- Low quality of government and other public services
  - 30 to 40% nosocomial infections in hospitals
  - 50% of deaths in emergencies thought to be due to improper case management

- Public health provision poorly targeted – focus is tertiary care
  - Primary care left to private sector
  - Oversupply of doctors – with insufficient training
  - 80% of doctors conduct private clinics besides public employment
  - Too many specialists vs. primary care physicians
  - Pharmaceutical spending is 50% higher than in comparable countries

Micro-efficiency: Evaluation

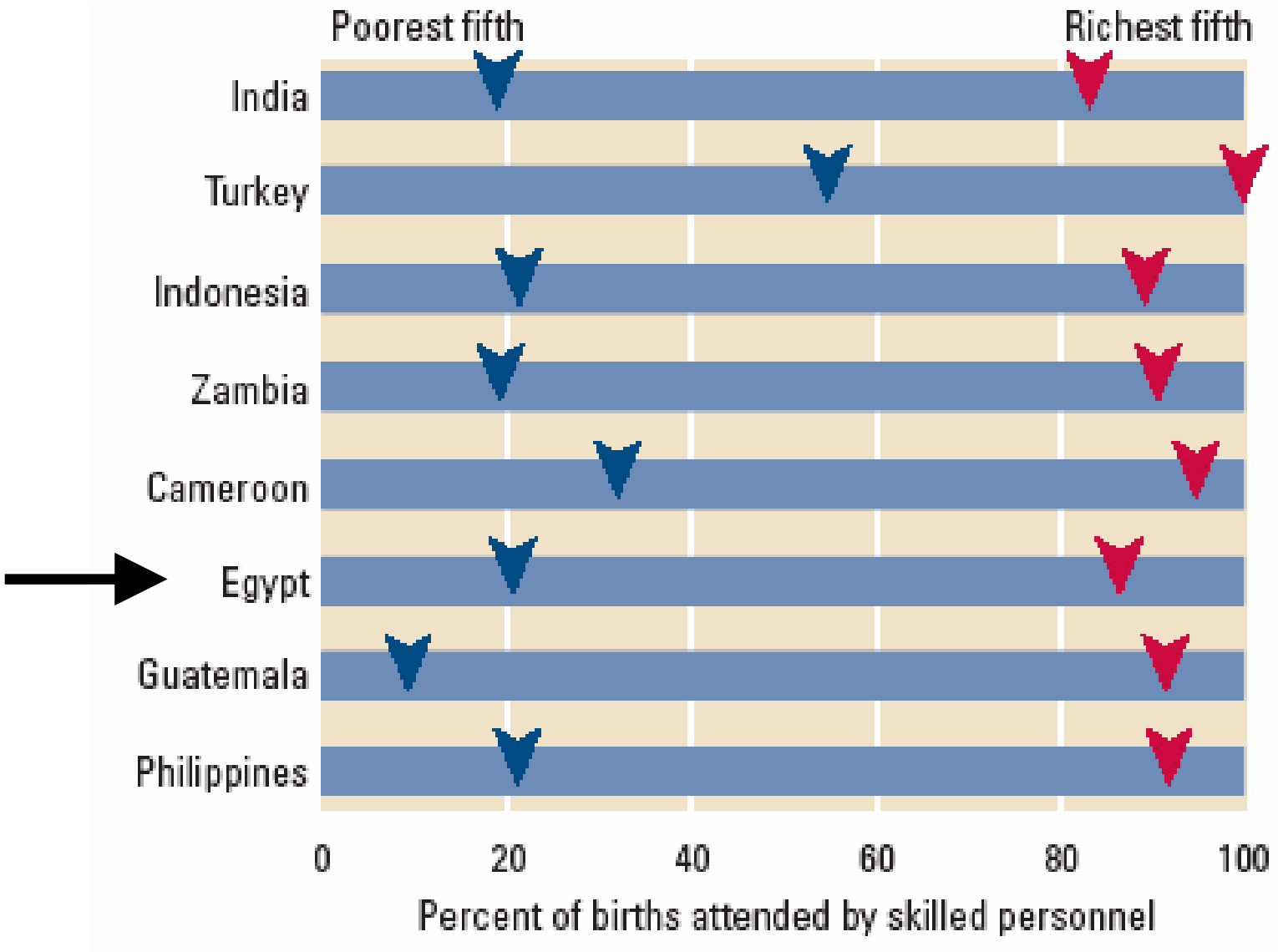
Taxation	Social insurance
+	+
• Addressing fragmented financing & management easier	• High quality care (in richest countries – causality?) • Consumer choice
-	-
• Classic quality issues due to *public provision* and incentives for efficiency *not* source of finance (purchaser-provider split, provider competition, autonomy)	• Consumer & provider moral hazard *but* due to *FFS* (HIO) • Multiple funds create problems of adverse and risk selection (Germany) • Higher administrative costs

Single funding agency recommended – quality issues need to be addressed at proper level (incentives for efficiency)

Equity: Issues

- Huge disparity in financial access to care
  - Household burden on out-of-pocket spending higher than in any other MENA country (except Yemen)
  - Financing is highly regressive
  - Social insurance is rather a subsidised public finance scheme (50% from general taxation) than an insurance *but* only benefits 15% of adults – all formal sector workers and schoolchildren
- Huge geographic disparity in access to care
  - Utilisation rates are double in urban compared to rural areas – both for outpatient and hospital services

Financial barriers to care: Attended births



Source: WDR 2004

Equity: Evaluation

Taxation	Social insurance
+	+
• Entitlement based on citizenship/residence	• Contributions usually related to income – ability to pay
• Universal coverage & risk pooling usually achieved	-
• Financial burden depends on progressivity of tax system	• Flat % of salary and ceilings are regressive
• No formal financial barriers to care	• Universal coverage often not achieved
-	• Targeting the poor is not a strength
• General funding restriction may lead to neglect of poor rural populations	• Multiple funds with different benefits packages inequitable

•Taxation in general more progressive than social insurance
•Universal coverage & risk pooling easier to achieve with taxation

Feasibility: Evaluation

Taxation

+

- Technical feasibility excellent
- Political feasibility depends on acceptability of taxes
- Earmarking of taxes can increase acceptability
- Counter-balance to market oriented reforms increases acceptability in People's Assembly and electorate

Social insurance

-

- For every worker in formal sector there are 5 non-contributing individuals
- Payment compliance problems are likely
  - CEE & CIS example
- Administrative capacity is very limited
  - IT systems
  - Insurance management
  - Regulatory framework
  - Institutional infrastructure (bank accounts!)

Both technical and political feasibility clearly favour taxation

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Was it wise to expand the role of social insurance in Egypt‘s Health Sector Reform Programme?

Taxation is clearly the technically superior option

Recommendations for reforming health financing in Egypt

Macro-efficiency:	• Increase taxes earmarked for health • Increase overall health spending *but* retain control over costs
Micro-efficiency:	• Recycle different financing streams (incl. OOP) in single, fundholding agency • Address quality and efficiency issues at the level of provision
Equity:	• Aim for progressive taxation system • Taxation guarantees maximal risk pooling • Aim for universal coverage
Feasibility:	• Build institutional capacity to improve efficiency & equity of public provision and regulation of private sector

Why has the Government of Egypt decided to expand social insurance instead?

External “technical advice” is often ideology-driven

- Independent advisors? (USAID, EU, World Bank)
- Experience of advisers? (PHI, taxation, social insurance)
- Internal capacity to analyse and judge external advice?

Solution 1:
Get independent advice

Solution 2:
Get independent *from* advice

Middle Eastern - European Network for Health Policy

Aims:

- Creation of a knowledge-base for independent health policy decision-making in the MENA region:
  - up-to-date country health care systems profiles
  - book series on priority topics
  - executive digests for policy decision-makers
  - internet documentation
- Build capacity in health policy analysis in MENA region
  - learning from intensive collaboration/author-editor interaction
  - training workshops/summer schools/new post-graduate programmes
  - formal exchange of researchers

Funding:

- EU 6th Framework Programme – Research funding (independent)
- Partners: Academic Institutions in MENA and EU, MENA governments, Foundations, Professional Associations, WHO, World Bank

Middle Eastern - European Network for Health Policy

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