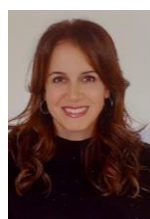


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## Can Universal Health Coverage Systems (UHCs) Achieve Health Equity? Institutional Lessons Learnt from a Set of Countries to the Newly Born System in Egypt

in collaboration with:



by Dina Atef Mandour, Assistant Professor FEPS, Cairo University

### 1. Summary

*This policy brief outlines the main institutional factors that can help in incorporating the health equity dimension within the newly born universal health insurance (UHI) system in Egypt. This is particularly needed during the ongoing health crisis created by the COVID-19. It focuses mainly on three main institutional pillars, namely population and services coverage, means of finance, and structure that are of paramount importance to ensure the success or failure of any UHC while encompassing the equity dimension. Such institutional aspects have their origins embedded in the political system and historical evolvement of health systems in general. Thus understanding the workings of the system within this context is vital as an initial point for real reform. This is addressed in a comparative framework where a set of divergent non-homogenous countries is chosen to underpin the importance of political economy in explaining the UHC's performance while focusing on equity.*

### 2. Introduction

Health equity is considered to be an expected outcome of universal health coverage systems (UHCs) being regarded as a framework that encompasses all people, guaranteeing accessibility and affordability of proper quality health services without being exposed neither to financial stress nor to any kind of logistic restrictions. However, health inequity could remain ignored if the UHC had the limited goal of only improving the prevailing health systems in absolute terms whereas the distributional impacts remain unaddressed (O'Connell et al., 2013). Affordability has been a main prerequisite to receive proper health care in many countries which clearly demonstrates biasness against the poor and marginalized groups even if those countries seem to be heading towards UHC. Thus the mechanism and structure of health financing within such UHC systems define their equity outcome to a great extent (Alami, 2017).

Global databases as well as empirical country evidences have revealed inconclusive criteria for identifying the main variables associated with having comprehensive UHC systems or distinguishing equitable ones. For example, higher GDP per capita does not necessarily mean having higher health expenditure where countries with relatively high GDP per capita (e.g. UAE, Saudi Arabia, Qatar) still allocate a small share of GDP to health expenditure<sup>1</sup>. Moreover, a general positive relationship between UHC and GDP per capita can be inferred, yet the existence of a number of outliers draws doubts on an exact affirmative relationship. Gambia, Uzbekistan and Rwanda have relatively low GDP per capita and nearly full population coverage<sup>2</sup>. This draws attention to the importance of intangible factors that outline the political economy framework of the system. Those factors include; political will, enforcement of rules and regulations, scope and sequence of implementation, power of counter vested interests, and the role of interest groups and main key actors (Saleh et al., 2014, Maeda et al., 2014, and Alami, 2017). Such institutional aspects are embedded in the political system and historical involvement of the health system in any country.

### *The Egyptian Case*

The origin of Egypt's health system is embedded in the 1962 National Charter, which reflected the 1952 revolution principals. The increasing challenges associated with population rapid growth and difficulties in finance accompanied by inflexibility of the system led to the failure of the system in achieving its objectives (Fouda and Paolucci, 2017). The ad hoc slow pace of reforms in the health financing structure in Egypt kept the main system ongoing to preserve the socialist political ideology, regardless of how efficient it is. Among the other reasons for the failure of piecemeal reform trials were the disagreements between the key players in the reform process per se and the intrusion of international organizations and private sector which has been regarded with skepticism as another disguised mean of privatization that would lead to higher degree of catastrophic spending and impoverishment (Ismail, 2018).

The main point of weakness in the Egyptian system arose from the fragility of its financial system suffering from complexity, lack of sustainability, fragmentation, pluralism, underfunding, and low quality of services (Ahmed et al., 2019; Gericke, 2005). Most of the reform endeavors didn't devote serious steps to free the system from such entangled institutional ties which resulted in almost complete lockage in one ill performing path. Such a system helped to lessen the financial burden on the central government where the parallel bodies catered for their own beneficiaries (including the different non-parastatal ministries and the private sector). Accordingly, the fragmented system provided policy space for postponing the political decision to undertake a comprehensive reform (Saleh et al., 2014; Ismail, 2018).

The social upheaval that took place in Egypt in 2011 carried social justice, health rights within, as a main slogan. This provided a chance for an open "window" to change and deviate from the persistent stagnant path. Indeed, three years later this was explicitly translated into the "Right to Health" provision of the 2014 Constitution which placed health as a national priority while stressing the right to access quality health care services and committing to increase public spending on health to 3% of GDP with the ultimate aim of reaching UHC (WHO EMRO, 2020).

This was associated with institutional progress on two main grounds: the strong political will and the avoidance of the previous coordination problems across various stakeholders, in addition to giving more space for mutual interaction and effective roles for various interest groups. Political leadership in Egypt has recently showed considerable interest and tangible efforts in promoting awareness and enhancing the health status in the country. The climax of this direction was evident when the new UHI Law (2/2018) was approved by the parliament and promulgated by the President in January 2018. The Law is considered to be an unprecedented attempt to establish rigorous reform in the health system and finally establish a UHC that caters for all segments of the society while paying due attention to equity issues. A new orientation was

1 <https://ourworldindata.org/grapher/healthcare-expenditure-vs-gdp?stackMode=absolute>.

+2 <https://ourworldindata.org/grapher/health-coverage-vs-gdp-per-capita-simple>

pursued by the government by following a collaborative approach during drafting and preparing of a new Law. All related stakeholders including services' providers, private sector, relevant trade unions, different categories of beneficiaries or their representatives, etc. were consulted. Based on such consultations, a number of the Law provisions were amended in response to objections and reservations from some interest groups<sup>3</sup>. The interest groups worked within a formal structure where a national joint committee was established, through which they mutually and fruitfully interacted to draft the Law. This is a major change, where previously the Law has been drafted mainly by the government (Saber and Gomaa, 2020).

### 3. Approach and Results

By following an institutional approach, Egypt is compared with a set of countries that have adopted different approaches to establish their UHC, these include Brazil, Germany, and Turkey. The choice of these three countries is based on having a large population, a wide geographical area, and different development and income status to understand the main factors framing the evolvement of equitable UHC irrespective of economic and/or demographic aspects. Since there is no blueprint for a successful institutional framework that outlines an equitable UHC, the diverse experiences of these selected countries would be beneficial to understand the main common factors that are essential to have an equitable system. The main common aspect across the countries is that the UHC in all of them emerged in the wake of political transformations.

In order to achieve health equity within UHC, three main institutional pillars need to be rightly set, namely; coverage, finance, and structure.

#### *Coverage*

The main value added of the new UHC system in Egypt is the inclusion of long neglected marginalized categories. Those include the informal sector (casual workers), an active newly captured contributing category, and those belonging to the poor vulnerable strata of the population who will be fully subsidized within the new system. The latter category is expected to reach 30-35% of the population (Mathauer et al., 2019; The Official Journal, 2018). This is a major breakthrough, especially when considering the chaotic status of handling Covid-19 cases in such vulnerable strata of the society, where tests and treatment are not affordable for a wide range of the society including not only the poor but the middle class as well (United Nations, 2020). In addition, the Law covers foreigners and refugees living in Egypt.

The Law entered its gradual implementation phase in 2019 and should be accomplished by 2032. It follows a geographical sequence that aims at covering the whole population. The first phase includes three out the four urban governorates in Egypt, whereas Cairo comes in the final stage (Hassan, 2019; Devi, 2018). The geographical approach adopted by the Law ensures equality in a pragmatic manner, yet the choice of governorates didn't give high priority to the most disadvantaged regions (The Official Journal, 2018; Hassan, 2019). Regarding service coverage, the covered packages are very wide-ranging and generous. The Law basically covers all health services, with the exception of specific services such as general health services, emergency services, and family planning services that are covered by other laws (Saber and Gomaa, 2020).

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<sup>3</sup> An example for this was the objections that were raised by the division of pharmacy owners during the discussion of the draft which were positively contained and responded to by relevant amendments in the Bill (Saber and Gomaa, 2020).

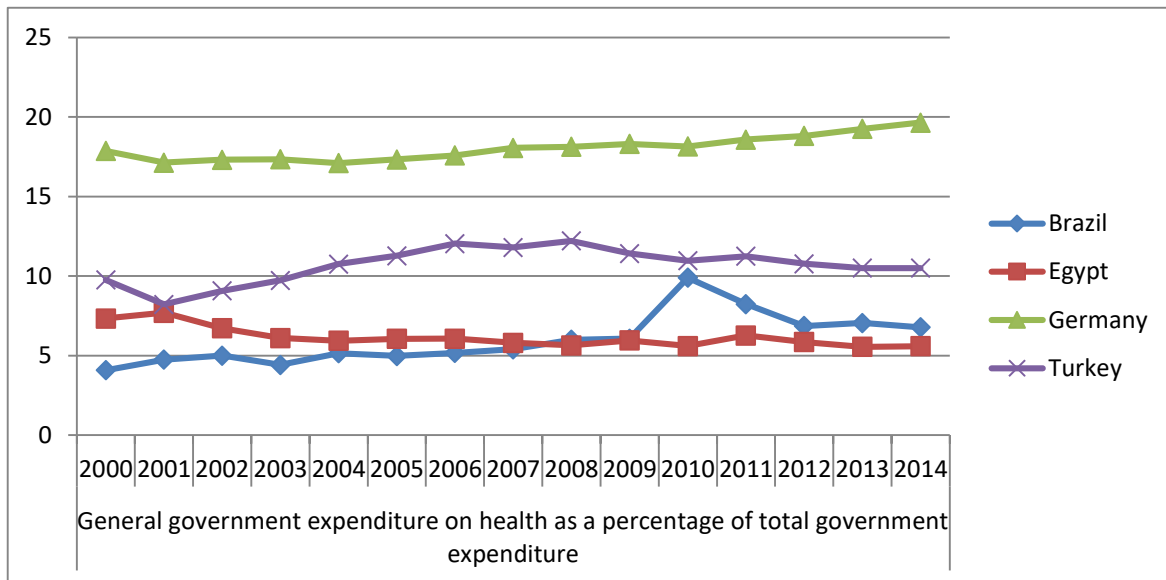
**Germany** followed a gradually expanding occupational population coverage approach to cover all population categories, a process that lasted almost a century. By the mandate of a Law issued in 2009, health insurance became compulsory and hence provided de facto universal coverage (99.9%), with 85% of the population being covered by public insurance or social health insurance (SHI), 11% by private health insurance (PHI), and the rest 4% enjoying a special governmental scheme (WHO, 2014). In spite of being one of the most equitable health systems, some minor coverage gaps in population as well as in service coverage have been noted. In 2015 an estimated 0.1% of the population was not insured for administrative, financial, or cultural related reasons. Recent legislations addressed such cavities illustrating the adaptive nature of the system (OECD and WHO, 2019).

**Brazil** adopted an occupational approach to ensure universal coverage. A public decentralized system aiming at universal comprehensive free provision of health coverage, Sistema Único de Saúde (SUS), was introduced in 1990 by including formal sector workers and then was extended to cover around 75% of the population (Scheil-Adlung, 2014). It was then complemented by a fast growing private insurance coverage system where it increased from 18% in 2000 to cover around 25% of the population in 2014. The Brazilian system, however, suffers from wide degree of coverage disparities where many disadvantaged populations still lack access to high-quality care and even proper primary care through the Family Health Strategy (Massuda et al., 2018). The lower middle income class was left with limited ability to join private health insurance ending up paying proportionally higher out of pocket payments (OOPP). The overuse of the private sector led to a crowding out phenomenon that withdrew financial and human resources from SUS resulting in higher degrees of inequity (Marten et al., 2014).

### *Finance*

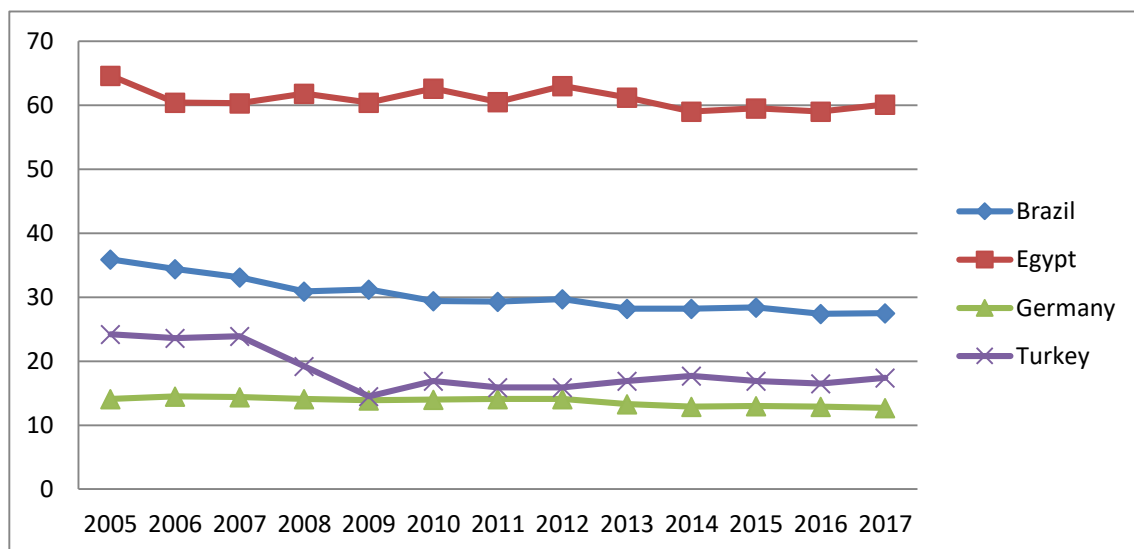
The weak commitment of the Governments of Egypt and Brazil in putting health as a main priority within its outlays is reflected in the meager share of health expenditure within its budget as shown in Figure 1. The situation comes at odds with a country like Germany giving a high priority to health considerations where around one fifth of the government budget is allocated to serve such objective, more than triple the shares in Brazil and Egypt. The same picture is confirmed knowing that more than three-quarters (77%) of total health expenditure (THE) came from public sources in Germany and Turkey in 2017 whereas only the third and less than half prevailed in Egypt and Brazil respectively in the same year (WHO, 2020).

**Figure 1: Domestic General Government Health Expenditure as a Percentage of Total Government Expenditure in Brazil, Egypt, Germany and Turkey (%)**



Source: WHO (2020); <https://apps.who.int/gho/data/node.main.HEALTHFINANCING?lang=en>

**Figure 2: OOPP as Percentage of THE in Brazil, Egypt, Germany and Turkey (%)**

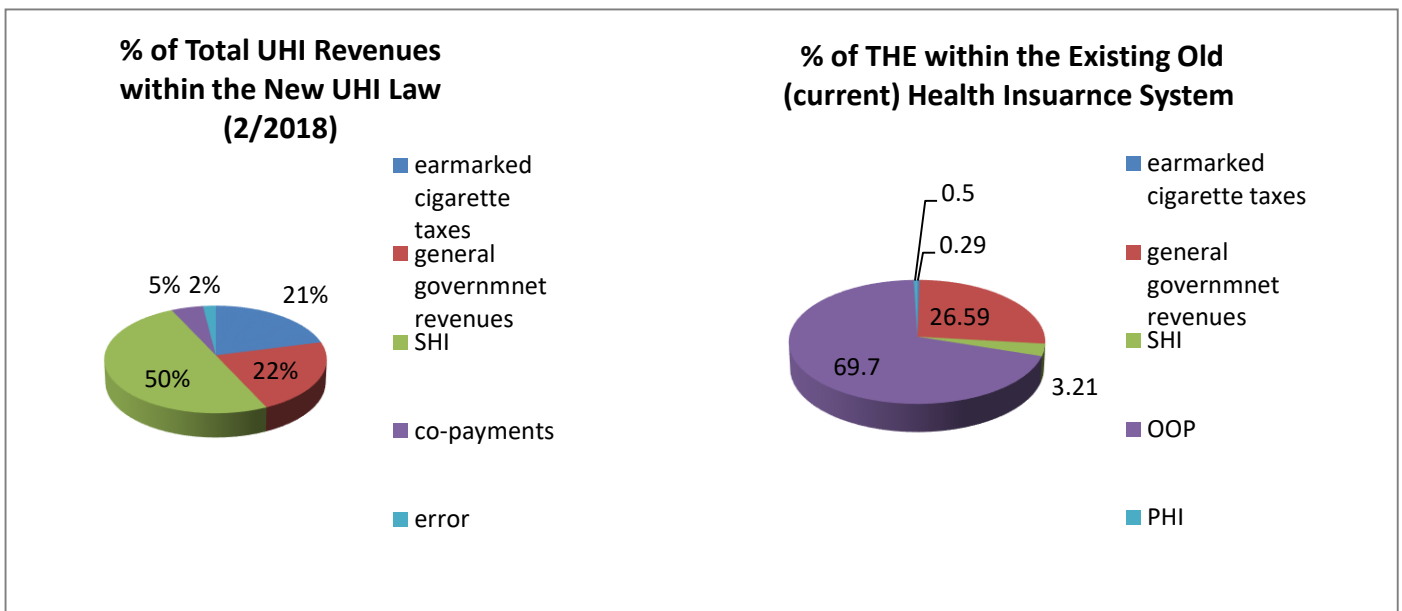


Source: WHO (2020), <https://apps.who.int/gho/data/node.main.HEALTHFINANCING?lang=en>

Households formed the major source of funding to cover health expenditure in Brazil and Egypt where almost one third was financed by OOPP in Brazil and more than half in Egypt in 2017. Meanwhile, OOPP never surpassed the 15% and 18% thresholds in Germany and Turkey respectively since 2009. Evidence from the comparator countries identifies that countries that have succeeded to significantly lower or sustain low levels of OOPP and catastrophic spending are those countries which had highly committed governments putting health as a main priority.

The new UHI Law in Egypt intends to replace the high OOPP by generating a spectrum of new funding sources and extending the base of contributors and designed rates for the mandatory contributory system imposed on both the employer and the employee. It also adds new forms of fees, surcharges and taxes including, among others, additional taxes on tobacco products as well as the increase in toll fees for using some highways. The Law will work on increasing the solidarity of the whole system by allowing for a remarkably higher share for social health insurance to represent almost half of the sources of funding (Figure 3). This is a major step as underfunding was a major restriction that faced previous coverage widening trials.

**Figure 3: Egypt: Sources of Finance in the Current System versus the New UHI Law (2/2018)**



Sources: Mathauer et al. (2019) (for the new Law) and Ahmed et al. (2019) (for the current “old” System).

## Structure

The consolidation of the system at the level of planning and decision making is key to ensure UHC while attaining health equity. Contrary to Egypt where at least 29 public agencies have been involved in the management and finance decisions of the public health system (Gericke, 2005), Turkey and Germany have one integrated system for management and decision making. The Health Transformation Program adopted in 2003 in Turkey separated the service provider, mainly Ministry of Health and private sector providers, from the financing arm. The program consolidated the decision making process and the various social security funds to ensure pooling of funds (OECD, 2016). Germany followed suit to a large extent. The decision making process in the German system is shared among three main players, namely the federal government, the states’ governments, and civil society organizations (Busse and Blümel, 2014). Brazil, adopted a similar approach where it consolidated the previously existing multiple programs into the SUS (Scheil-Adlung, 2014).

One of the major potential virtues the UHI Law in Egypt (2/2018) is the replacement of the complex pluralistic fragmented structure with a more consolidated one represented in three main autonomous agencies. This has high potential, at least theoretically, in narrowing health disparities that had long



diagnosed the Egyptian society. The articles of the Law build on the basic principles to achieve financial protection, namely pre-payment, risk pooling, solidarity, and separating the funding from the provision of service. The Law had thus set an overhaul institutional change with respect to population and services coverage as well as financial structure of the system.

#### 4. Conclusions and Policy Recommendations

Main common grounds existing across the diverse systems in comparator countries revealed a number of opportunities as well as evitable challenges to achieve health equity that the Egyptian system can leverage on, among which are the following:

- **Strong adaptive political will and leadership** is the main common aspect that characterized the three benchmark countries. Such a system clearly identifies the problems and reaches a point of agreement among the key actors and interest groups on their prioritization. Identifying the existing and potential opponents of the system and working on their inclusion within the beneficiaries is another virtue. This would be possibly achieved by unfolding the benefits or even creating new ones to tackle specific opponents or vested interest groups. Having a floor for the public support to the system is crucial in the success of the system. The experience of Turkey is remarkable in this matter where the reform team followed a “know thy enemy” approach by clearly identifying their set of opponents and breaking up their ties to effectively move forward. Outlining the proper respective means and policies to address and limit the opposing power of each group emerged accordingly.
- Only those countries that have put **health on top of the list of their developmental agenda** proved to have stronger more equitable systems. This is mainly translated in having relatively high weights for health expenditure within the government budget that had been simultaneously associated with minimal tolerable levels of OOPP, catastrophic spending or impoverishment rates due to health spending (case of Germany and Turkey).
- **Consolidation on the level of planning** and decision making within the financial structure is an important institutional pillar for attaining equity within UHC systems that all comparator countries followed. Fragmented system does not allow for efficient risk pooling as the system will discriminate following a pure risk lessening perspective, hence depriving people from accessing the services, and keeping the high risk people outside the system, hence eroding health equity (case of Egypt).
- A solidarity-based UHC that depend highly on **risk pooling and diversification** rather than being highly funded from general taxes has resulted in intensifying financial protection (case of Germany and Turkey).
- Disparities in service coverage were much milder than those of population coverage (case of Egypt and Brazil), yet having ambitious generous targets for **widening services packages** should be always regarded with caution. They can result in implicit rationing in the form of waiting lists or shortages ending up with higher degrees of inequity.
- Direct taxes are not always the best equitable means of finance since their superiority hinges on other variables as well. Experiences of other countries point out that financing through direct taxes might lose its significance if demographic changes have tilted the population pyramid towards aging segment of the population (Germany), or it might not reflect the equity element if a large proportion of the population is in the informal sector or if the tax base and tax collection system suffer from equity considerations (case of Egypt).
- **The involvement of the private sector is controversial and must be carefully assessed if equity of UHC is aimed for.** The Brazilian system has been suffering from underfunding problems which led to widely

expanding private sector involvement that ended up in jeopardizing financial protection and health equity all over the country. Turkey and Germany, on the other hand, have restricted and limited the role of private insurance by ensuring extensive funding through public resources to cover health care. Still, Germany's main source of health inequity originated from this sector. Germany applies differential remuneration schemes across public and private sectors that have led to clear financial incentives for physicians to opt for privately insured patients which make them receive better service and thus became a source of health inequity.

Within Egypt, the January 2011 revolution, the macroeconomic distress the economy has been facing as well as the need for political stability and public support for the system formed the main driving forces which led finally to the birth of a promising UHI Law. Ironically, the implementation of the Law was postponed due to the Covid-19 crisis, whereas it would have been able to lessen the fatalities caused by the pandemic if it would have been in place. It would have also played a role in complementing the social safety net for vulnerable groups affected by the crisis and its unfolding health and financial effects.

The new UHI Law in Egypt had set the legal framework that caters for health equity overcoming many of the constantly neglected issues. It resulted in an overhaul institutional change with respect to population and services coverage as well as financial structure of the system. However, some cavities still need to be constructively addressed. To address such institutional loopholes identified in the new UHC system while ensuring the equity dimension, a number of steps and measures need to be undertaken including the following:

- Promoting awareness about the program and its benefits is an issue that should not be underestimated. Through the new sources of funding, the Law imposes more financial pressure on the people. Thus, unfolding the benefits of the system at this stage is crucial as it would help to avoid the creation of new opponent groups that could jeopardize the smooth flow of the system as planned.
- More attention should be given to tangible outputs, in the same notion as with the case of “quick wins” in Turkey, an approach which focused on widening population as well as service coverage by considering the very visible outcomes like giving higher priority to areas with the least services and significantly increasing number of emergency transportation facilities. This has resulted in creating a large number of beneficiaries who provided support for the reform team in confronting any opposition for the new reform act. Egypt suffers from non-efficient ambulance system, long waiting times at hospitals, and other obstacles that can be quickly addressed and have visible impact.
- Egyptian households have been shouldering a significant part of the costs of healthcare with the highest portion of OOPP directed to pharmacies. Integrating cost-effective policies for medication within the new health insurance schemes should work on lowering such a burden. Turkey, for example, has succeeded in significantly lowering OOPP by reducing value-added tax on pharmaceutical products, an experience that the system in Egypt could build upon.
- The problem of low remuneration for health staff should be seriously addressed. The experience of Turkey could be beneficial in this respect by tying performance to income where it implemented a payment scheme for physicians that succeeded in establishing the needed incentives that induced them to serve in underprivileged areas.
- Some void still exists in the new Law regarding a number of institutional considerations. For example, it still misses a clear definition for the responsible entity that should constantly review the list of the generous entitlements within the benefit health services packages covered by the new system. Full comprehensive review mechanism needs to be also set at the early stages of implementation to allow for early corrections, to avoid adopting a wrong path.
- Underfunding has always rendered many reform trials in vain. The new Law postulates several new



sources of finance to overcome this problem and guarantee its sustainability, at least in theory. Most of the new means of finance have a progressive nature, yet some still needs extra scrutiny on their equity implications. Those basically include all non-income related payments like co-payments, ear-marked cigarette taxes and toll fees on highways. Moreover, driving and car licenses fees include elements of inequity as it increases the burden on the middle class versus rich and poor classes without logical economic justification. Imposing fees on hospitals, as a new source of funding, might not be regressive but might have a kind of substitution effect on hospitals where they would have to forgo better quality service. The design, bracketing, and rates of direct and indirect taxes have to be revised as they tend to under-tax higher income groups and thus form a main regressive financial source of the health system. Equity dimension is highly preserved through aiming at giving a higher weight for contributory schemes within the structure of financial sources.

To conclude, an equitable UHI system requires a continuously prudent and alert political system that is always aware of existing and potential opponents, that always includes stakeholders and key actors as main co-partners in policy design and that has the target of having sound public support. The window of opportunity

should be always utilized in an efficient manner to establish a sustainable system, from an institutional perspective, with health equity at its core. The Egyptian new system seems to have adopted a hybrid approach based on the review of the comparator countries, at least in its design, while catering for sustainable sources of finance, paying due attention to equity, and adopting a pragmatic approach in reaching full coverage. Yet, such design will be subject to testing in implementation, especially in light of the aforementioned institutional challenges and loopholes.

*\* This policy brief is based on: Mandour, Dina (2020), "Can Universal Health Coverage Systems Achieve Health Equity? Institutional Lessons Learnt from a Set of Countries to the Newly Born System in Egypt", a study submitted to the EMR-SDG Learning Platform, Social Research Center of the American University of Cairo.*

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*Its main objectives are:*

- to contribute to the reinforcement of dialogue on economic and financial issues in the Euro- Mediterranean partnership, within the framework of the European Neighbourhood Policy and the Union for the Mediterranean,*
- to improve the understanding of priority stakes in the economic and social spheres, and their repercussions on Mediterranean partners in the framework of implementation of EU Association Agreements and Action Plans,*
- to consolidate the partners of the network of research institutes capable of North-South and South-South interactions, while it sets into motion a transfer of know-how and knowledge between members.*

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