

Partners and Counterparts Event on Implementation of the Social Health Insurance Law: Minutes of the event

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Ministry of Finance, Cairo

Health system in Egypt and its reform

Based on the work of three task forces on Social Health Insurance (SHI) design and implementation as well as two subsequent workshops carried out in June and December 2015, the Ministry of Finance had invited the Development Partners (DPs) to the Ministry of Finance premises to get a clear and unified view on the technical and financial support that DPs can offer to the Government of Egypt.

The draft SHI law has now almost been finalized and the Government has taken the decision to start preparing for its implementation. However, although the law was supposed to be adopted by the Parliament in January, this has not yet been the case. There are currently 300 other laws pending, but it was emphasized that the SHI law is a top priority with enormous political support.

As to the implementation and transitional phase of the SHI that is now supposed to start in July and in preparation of the meeting, a concept note was circulated among DPs. Therein several areas where support may be needed and be most useful were identified:

1. Health service delivery strengthening

Extending health insurance coverage does not necessarily mean that more people will also have access to quality health care. It will be crucial to also strengthen the supply side of services and invest in the availability of quality health care, particularly in underserved rural areas. DPs will continue their support on health service delivery improvement and facilitate/catalyse the national policy dialogue on the provider set-up for the SHI rollout.

2. Purchasing, pricing, contracting and provider payment mechanisms

The draft law is clear on the introduction of a purchaser-provider split and the fact that contracting will take place with both public and private providers. However, the technical details on how services will be purchased and priced need to be settled. DPs could engage in a costing exercise that provides evidence for pricing discussions and estimates unit costs for primary, secondary and tertiary care. Moreover, technical support in provider payment design as well as capacity development in purchasing and contracting with both public and private providers may be requested.

3. Benefit package

It was suggested that the SHI rollout should rely on a clearly defined benefit package rather than considering the advantages of defined contributions. Technical support of DPs may be needed to further develop related approaches.

4. Ensuring financial sustainability

In 2008, an actuarial review of the SHI system in Egypt was conducted by the consultancy firm Aon Hewitt. This model needs to be updated by the same firm. Reviewing this model is crucial for the decision-making process and hence the acceptance of the SHI law by the Government of Egypt and the Parliament as it sets the contribution rates to be paid by employers and employees as well as the government subsidy. Moreover, complementary studies on fiscal aspects and projections based on different scenarios may be needed. Also, a strategy for phasing out the current opt-out system should be developed.

5. Identification of the poor and vulnerable

The current draft SHI law is still not clear about the questions of how the poor and vulnerable will be identified and who exactly will be eligible for the subsidy. Analytical studies on the possible ways to target and enrol those who would need to be partially or fully covered by state subsidies may be needed.

6. Building linkages with other social protection areas

Since other social protection initiatives such as on-going cash transfer programmes have linkages with the SHI reform, coordination is important. The Assessment-based National Dialogue (ABND) process on establishing a Social Protection Floor (SPF) in Egypt provides opportunities for policy dialogue on different branches of social protection.

7. Information system development for SHI

The development of a well-functioning information system for both the purchaser and the providers will be essential when extending the SHI. DPs could help to build such a system and provide technical and financial support for all its sub-areas (e.g. billing systems, resource management and medical records). This would also include the establishment of an M&E framework for the SHI.

8. Communication Plan

DPs could provide technical support in developing a communication strategy that presents the objective of the SHI reform and its benefits to the population.

Aon Hewitt was contracted by the Egyptian Government to assess the Egyptian health reform project for US\$1 million. The company has now been contracted again to update the previous study based on latest available data. The necessary funding has a ceiling of US\$250,000 and will be provided by the World Bank and the African Development Bank.

Partners and Counterparts Event

The Partners and Counterparts Event at the Ministry of Finance started with a presentation on the new SHI system. The overall government budget for 2016 was 625 billion Egyptian Pounds (EGP), of which EGP244 billion go into subsidies including on pensions and health. From the health budget, however, 65 per cent goes to salaries. In some governorates this figure raises to 90 per cent, although usually 40 per cent of the health budget should be spent on drugs.

The most pressing challenges in the current SHI system include that the current law is not universal and only covers segments of the population, which sum up to only half the population. Moreover, 60 to 70 per cent of the country's total health expenditure is paid out-of-pocket each year and fragmentation in the health system is high. Also, no separation of functions exists, which has resulted in inefficiencies. Satisfaction with the public system is low and so are user rates.

The draft SHI law will establish three institutions to replace the current ones:

- Public purchaser for revenue raising, fund management, pricing and purchasing of private and public sector services (including contracting-in from university and military hospitals)
- Public provider organization that will have branches in each governorate and gradually include the five different public providers and their 550 public hospitals
- Standard-setting organization for licensing as well as enforcement of laws and regulations

It was added that the most important questions at the moment are the following: How much will the implementation cost? What is the financing gap? What will be the burden for the people?

WHO briefly presented the DPs' concept note and emphasized that supply-side strengthening and a focus on primary health care will be important.

It was highlighted that support of DPs will be particularly needed in the following areas:

- Developing regulations,
- Defining benefit packages and pricing systems,

- Preparing the transition from the current system of line-item budgeting to programmatic budgeting which is supported by the World Bank (fee-for-service rather than annual transfers from state budget),
- Establishing medical records for all households,
- Providing financial resources to update the actuarial model.

Further, a broad roadmap with milestones could be developed clearly indicating what could be done by the government itself and where support of DPs is required.

World Bank funding equals US\$5 million available for the health-care quality project, of which US\$1 million can be used to fund the new actuarial study, in continuation of the support to the actuarial study in 2011.

AFD could finance a complementary study if necessary. Moreover, AFD's focus on working with private sector providers and on the question of how effective public-private partnerships could be established was highlighted.

It was further highlighted that complementary to the Aon Hewitt study, ILO's set of actuarial projection models could be applied to estimate the costs of extending SHI coverage to those currently left out. Also, a review on the modelling approach that is undertaken by Aon Hewitt was proposed. Moreover, it was suggested to undertake a study measuring health access deficits due to insufficient numbers of health workers in each governorate based on ILO indicators and with an emphasis on rural areas.

ILO's suggestions to support the actuarial valuation would be considered and a follow-up done once the Government receives the actuarial study by Aon Hewitt in March 2016. There will be further detailed discussions with the Ministry of Health so that a more concrete request may come. Furthermore, ILO support on costing and pricing of health services/benefit packages would be welcome as well. There will be a task force to determine the formulation of a pricing mechanism that is acceptable for both public and private providers. Capacity building is needed in this context.

The UK Embassy would work with the World Bank on targeting mechanisms and capacity building of new staff.

The general coordination role of WHO was emphasized and it was highlighted that like ILO, technical support but no financial support would be provided. This could include a secondary assessment complementary to Aon Hewitt's study as well and/or a costing study on determining price levels. Such a study would also cover related questions on budgeting, purchasing and provider payment. Moreover, WHO will provide capacity building on purchasing, provider payments, health management and establishing an improved medical

information/records file. In terms of health-care delivery, WHO will particularly seek to improve the Egyptian family health model.

It was emphasized that strengthening the health-care delivery in Upper and Lower Egypt will be crucial. Moreover, the identification of the poor and vulnerable would need to be consistent within an overall approach to poverty alleviation. Current social protection programmes are “targeting too low” and focus on the extremely poor. Moreover, there have been problems with the proxy means testing method currently being applied.

However, resource constraints would not allow for other thresholds. If the fiscal space situation changes in future, other income segments could be subsidized. Moreover, consistency is indeed important because if people under the SHI would be identified as being poor while being classified as non-poor in other social protection schemes, these people would go to court and demand additional benefits. This will require further discussions.

Universal Health Coverage is a priority for Japan and the topic may be discussed when President al-Sissi visits Japan this month. In due course, there may be a grant available for the Egyptian health reform project.

The Health Insurance Organization (HIO) emphasized that the starting transformation period requires capacity training within the organization, particularly on pricing and costing. A registration system for data collection of patients’ records is currently being tested for implementation.

Follow-up

A follow-up meeting with DPs at the Ministry of Health is planned in the second half of March, when the actuarial study of Aon Hewitt has been finalised and a more concrete view evolves of what kind of DP support will be needed. Any work will be closely coordinated with ILO’s work in other social protection areas and within the ABND process that was started in November 2015.