



Egyptian Initiative for Personal Rights

Committee for the Defense of the Right to Health

Preliminary Analysis of the New Health Insurance Bill

Draft 16, Published in *al-Masry al-Youm*, 21 October 2009¹

¹ The draft contains 32 articles in five chapters; the published version does not contain Articles 12, 16, 19 and 21. No reason was given for the gap, which may have been a publishing error.

• Introduction •

→ The history of health insurance in Egypt began with the establishment of the General Health Insurance Organization in 1964. It was then followed by the issuance of several laws created to gradually guarantee the right to health insurance to all citizens. The underlying principle governing all these laws stemmed from the need to balance the efficient provision of services and a comprehensive health care package, with the fair distribution of the financial burden of illness through the establishment of social and health insurance funds and risk-pooling.

Since the mid-1990s, repeated attempts have been made to reform the entire health system, starting with the health insurance system. However, 50 years after its establishment, the health system still suffers from several weaknesses. Most significantly, citizens are not satisfied with the level of services offered or with the efficiency of those who provide them. In addition, there is a shortage in the availability of insurance services in rural areas compared to urban areas. Insurance coverage is limited to no more than 54% of the population.

The issue of health expenditure remains at the heart of the existing challenges. Official studies have found that out-of-pocket spending, from both insured and non-insured citizens, accounts for more than 60% of total health expenditure. In addition, public health care spending remains exceedingly low at less than 5% of the total state expenditures.

Over the last decade, several health insurance bills have been drafted, all essentially lacking the comprehensive vision necessary for the nature of change needed to truly reform the health insurance system. None of them fully explored the links between the health insurance system in Egypt with social insurance laws issued at nearly the same time. They also lacked provisions for a fair distribution of the cost of the burden of disease between citizens and state resources. It could have been possible to fund a system that would embody the principles of social solidarity, equity and accessibility in providing insured health protection to all segments of society through the imposition of direct or indirect taxes.

The last two years have seen intensive efforts to finalize a new bill, dubbed by the government, “the universal social health insurance bill.” It is considered

to be one of society's major goals on the road to development and justice. The health system is in dire need for real reform and an alternative, universal insurance system that meets the standards of justice, accessibility, efficiency and quality. Moreover, the reform of the health system should not neglect the link between health insurance and social insurance systems.

Within this context, and before commenting on the latest published draft of the bill, it is important to refer to the "Declaration of Principles" issued by the Committee to Defend the Right to Health in November 2009. In the "Declaration of Principles", we outlined the principles that govern our stance towards the law, or any other law, and we warn against the dangers contained in some of its provisions.

Hence, we wish to place emphasis on the following:

1. The general principles and objectives to be achieved by the new law must be thoroughly explained; and the terms and concepts used must be clearly defined. The bill should be put forward for a broad public debate involving civil society, political parties, professional syndicates and citizens before being presented to the People's Assembly. The bill should not pass directly from the State Council (the judicial body tasked with reviewing legislations prior to their promulgation) to the Council of Ministers without first being made fully available to all different social sectors. In an undemocratic, non-transparent move, the government has thus far refrained from releasing the text of the new bill, which differs substantially from the last draft released in 2007. As a result, we have been compelled to deal with the incomplete version of the bill as leaked to *al-Masry al-Youm*, which may differ slightly or substantially from the final version of the bill.

2. Citizens' right to health must be respected, including the right to fair, insured health coverage through risk-pooling the burden of disease. Citizens' right to social insurance as guaranteed by social insurance laws in effect for more than 50 years (Law 79/1975 and its amendments, Law 112/1980 and Law 108/1976 and its amendments) must be protected. These rights must not be eroded by any new health insurance reforms.

3. The government must assume its responsibility to increase public health expenditure to internationally recommended levels (7-10 % of state spending). The published statement of principles for the 2010-11 state budget sets care

for the low-income segments of the society as one of its objectives, but it does not address health care as one of the principal budgetary objectives. This is proof of the state's desire to place the burden of the new insurance system on citizens.

4. We warn against adopting multiple insurance packages under the pretence of new terminology, such as the "catastrophic illness package", which would deny beneficiaries the rights guaranteed to them by social insurance laws (against disability, sickness, old age, unemployment, workplace injury and death).

5. Any health insurance system must rely on fair, fixed premiums. No additional fees and payments should be levied that obstruct access to services, particularly in hospitals (including for the cost of tests, X-rays, surgery and hospital stays). The state's budget contribution to the new health insurance system must not be limited to covering only those segments of society which the government considers economically disadvantaged, thus cutting down the state's actual contribution to the school students' insurance scheme (Law 99) or the program of state-funded treatment (*barnamaj al-'ilaaj 'ala nafaqat al-dawla*).

6. We affirm our support of an integrated health system and universal coverage that does not change the ownership of public health institutions under various guises.

7. We support a fair wage structure for all medical personnel (doctors, nurses and staff) that would guarantee them a dignified life. This is both a basic right and a necessary means of improving the quality of health services.

When these principles are applied to the bill published on 21 October, it becomes clear that the new government bill contains many of the dangers we have cautioned against. We stress the need to introduce fundamental reforms and amendments to this bill as a national duty, whether inside the cabinet or after the bill's referral to the People's Assembly and Shura Council. We urge all social movement to reject this bill if the government insists on submitting it in its current form.

• **Comment on the Bill** •

→ Notwithstanding the serious shortcomings of the published bill, it does contain some positive aspects that cannot be overlooked when compared to the 15 drafts that preceded it. Such positive aspects are a result of several factors, the main one being the pressure exerted by civil society and human rights groups on the executive bodies to ensure that health insurance reform does not take place at the expense of Egyptians' ability to bear the cost.

The positive components of the bill include the following:

1. For the first time, the new bill links the health insurance system with existing social insurance systems and laws (Law 79/1975 on social insurance and its implementing regulations, Law 108/1976 on employers and Law 112/1980 on insurance for those not covered by pension laws). This reflects the proper respect for the long legacy of social and economic rights of various classes of people who have been covered by these laws for more than half a century.
2. The law appears to back down from any reference to the establishment of a health care holding company, due to enormous pressure from human rights organizations and civil society groups to contest this idea. It is also due to the successful lawsuit filed by a group of organizations against the 2007 prime ministerial decree establishing the holding company, which ultimately suspended the establishment of the company and the attendant measures to turn the social health insurance system into a for-profit scheme.²

² On 4 September 2008, the Court of Administrative Justice decided in favor of a lawsuit filed by the EIPR demanding the suspension of Prime Minister Decree 637 issued in March 2007, which establishes a Health Care Holding Company. The company, as decreed, would work in parallel with the publicly-owned Health Insurance Organization (HIO) while assuming control over the assets of the HIO hospitals, labs and clinics. The HIO is currently the main health insurance provider in the country, covering approximately 54% of the Egyptian population. It offers a full package of services for those insured at service cost, which is considerably lower than the cost of services offered by private, non-HIO outlets. According to the Prime Minister's decree, the HIO would remain the body in charge of financing health services for the insured, while the holding company will procure the health services from the HIO hospitals and clinics, as well as non-HIO hospitals and clinics. It is by law a for-profit company and would therefore offer services at a for-profit margin. It would also have the jurisdiction to sell the hospitals and clinics to private investors. The HIO hospitals and clinics have been constructed and continue to operate largely from the premiums of the beneficiaries and therefore do not belong to the government to dispose of them as it sees fit.

3. The law addresses the premiums for those already insured and beneficiaries to be covered by the new system in a balanced and pragmatic manner.

Despite these positive aspects, there are still several problems in the bill, which can be grouped into three main categories: the package of health services covered by the insurance system, funding mechanisms for the new system and the agency responsible for providing health services.

A. Health Services Insurance Package

→ The package of health services that will be covered by the new bill raises several questions. The published text indicates that these services will be defined by a prime ministerial decree, but will include the package of services currently offered by the General Health Insurance Organization up until the date the law is issued. It adds that the services offered might be reconsidered, as needed, by adding new services to the package.

A straightforward reading of this article seems to be cause for optimism, but, in fact, its intent is cleverly concealed. The article refers to the health services currently provided, not the services stipulated by existing health insurance laws (Law 79/1975 on social insurance and its implementing regulations, Law 32/1975 and Law 99/1992). This means that the authority to define the package of insured services rests fully with the executive branch. This strips the law of its most important components as it allows the executive branch to assume legislative authority, which is a grave threat to beneficiaries' right to consent to pay for services.

Within this same context, the executive authority (the Ministries of Health, Finance and Social Solidarity) will determine what constitutes the "catastrophic illness package" with no clear guiding reference for it in the text of the law. The published bill simply defines it as a sudden, life-threatening illness that requires the exhaustion of all personal financial resources. As written, the article is not precise enough in defining what illnesses these are, other than sudden, serious and life-threatening. For example, although kidney failure is a serious disease, it is preceded by several stages of illness and thus cannot be considered sudden. The same is true of liver failure. The

question, then,³ is will the new health insurance system cover these illnesses? Or will they simply be considered personal catastrophes?

This is different than the working definition of the WHO, which defines a catastrophic illness in relation to a household's capacity to pay for health care. A health expenditure is considered catastrophic if it exceeds 40% of the household income, irrespective of the nature or chronicity of a disease.⁴

Moreover, these ill-defined catastrophic illnesses will not be fully covered in all cases. This raises questions regarding the specific package of services that the law will consider “catastrophic illnesses”, the citizen’s share in the cost of treatment for these illnesses and the portion of the cost of treatment to be covered by the insurance fund. Most importantly, however, is that the article puts these determinations beyond the reach of the legislative authority and places them under the discretion of the aforementioned ministries.

The bill also fails to discuss cases of partial or total disability and the medical committees that determine the degree of disability under social insurance laws, which raises doubts about the government’s intent to observe these rights.

B. Funding

→ In Chapter 3, Article 8, the bill defines the sources of funding as follows:

Premiums from beneficiaries of social insurance under Law 79/1975, calculated as 1% of the monthly wage (the base wage as well as incentives and bonuses), and under Law 108/1976 and Law 112/1980, they are calculated as 4% and 2%, respectively, of the average monthly social insurance wage. Premiums for other members of the families (children, students and spouses, including homemakers) are the responsibility of the head of the household and are calculated as 0.5% of the monthly wage for each child dependent and 2% for the non-working wives. Premiums for dependents not covered by social insurance laws come to 0.5% of the average social insurance wage for each child and 2% of the average social insurance wage for each non-working spouse. Premiums for members of professional syndicates are 5% (this class

³ In an interview with *al-Masry al-Youm*, the Minister of Health stated that a cardiac catheter for treatment or testing purposes is included in catastrophic illnesses. Magdi al-Gallad and Tariq Amin, “D. Hatim al-Gabali fi hiwar shamil,” *al-Masry al-Youm*, 25 October 2009.

⁴ The World health Report 2000: Health Systems. Geneva: World Health Organization; 2000.

includes the free professions which are not covered by social insurance laws, including lawyers, merchants, doctors and the self-employed). The share paid by employers is 3%. Pensioners' premiums are calculated at 1% of the monthly pension (or 2% if the monthly pension exceeds the average monthly social insurance pension). Premiums for widows and others eligible for social insurance pensions are calculated at 2% of the monthly pension.

Premiums and payments from the state treasury are the primary means of funding the system in a way that does not undermine the right to health care. Overall, they are balanced as premiums that are deducted from monthly wages, as a model of mixed funding that includes insurance premiums and revenues from the state treasury to provide continued financial support to the system. This is with the exception of pensioners, the class of citizens most in need of health care, and whose premiums must not exceed 1–2% under the new law.

The same article sets the state contribution for the economically disadvantaged segments of society at LE15 per month per person. There is, however, some ambiguity here in the language. The law does not define what is meant by “economically disadvantaged segments”. Instead, it leaves this to the executive authority, to be elaborated upon by a separate decree issued by the Prime Minister, after a review by the Minister of Finance and the Minister of Social Solidarity.⁵

A more accurate term would be “individuals and groups most in need of health care”. This should be determined using the wealth indicator which has been defined, according to a report issued by the Cabinet’s Information and Decision Support Center, as “an approximate measurement of the family’s standard of living. It is calculated using data such as family ownership of durable goods and other particularities of economic status.”⁶ In addition, other examples of studies issued by public research centers on the

⁵ In his interview with *al-Masry al-Youm*, the Health Minister stated that this class includes those who receive pensions from the Ministry of Social Solidarity, as well as the poor. All told, he estimated the size of the economically disadvantaged segment at 22 million persons. Using this estimate at LE15 per person, the government will contribute LE330 million every month or LE3.9 billion annually. See Magdi al-Gallad and Tariq Amin. “D. Hatim al-Gabali fi hiwar shamil,” *al-Masry al-Youm*, 25 October 2009.

⁶ “Al-malaamih al-sihhiya li-l-atfaal fi Misr: hal taghayyarat?” Report issued by the Cabinet’s Information and Decision Support Center, August 2008.

socioeconomic classes and their ability to contribute financially to the new health insurance system should be utilized.

At the same time, it is evident that the government intends to maintain its meager level of state funding for the program. In fact, the state contribution will not exceed present state contributions made (essentially towards state-funded treatment of citizens and health insurance for students), although they will be allocated for the new, ill-defined "economically disadvantaged" segments.

As for fees and co-payments, the bill offers the following two alternatives for setting user fees when receiving the health service; i.e. additional fees beyond set premiums:

First Alternative: No more than 30% of the cost of medication and out-patient treatment, as well as 5% of the cost of hospital care will be paid.

Second Alternative: A fee will be paid when receiving the health service (LE5 for general practitioners, LE7 for specialists, LE10 for consultants and LE20 for home visits). In addition, there will be: (1) a fee for in-patient hospital care, not exceeding LE50 or 5% of the cost, (2) 30% of the value of out-patient medication, up to LE40, and (3) one-third of the price of out-patient tests, up to LE50.

As a whole, both alternatives reflect confusion about the role of co-payments in health insurance systems, which are imposed and carefully regulated, in order to address misuse of the services by those who are healthy among the insured population.⁷ As such, these fees are levied only at the entry points of the system; i.e. in exchange for primary health services and outpatient clinics and in such a way that does not preclude access by those who truly need them. Since these fees are not monthly or annual, they are only paid when receiving services. Moreover, they are not levied for bedside or hospital services because this will obstruct access to these services. They also should not constitute the most significant share of insurance funding, which must rely on proportionate payments from the rich and the poor in the form of set premiums. Finally, collecting these fees creates an additional, costly

⁷ In other words, the fees are used to avoid moral hazards in the system, where the healthy seek to take advantage of insured services, which has negative repercussions for resources and the truly sick. Such advantages may include seeking unnecessary sick leave or obtaining insured medications for resale at a higher price.

administrative burden and thus should be reduced as much as possible. None of these standards are met by the fees and co-payments mandated by the new bill.

Another major risk in the article is the reference to the need to raise both the minimum and maximum premium ceilings, as well as co-payments from beneficiaries, in accordance with annual inflation rates. However, the article does not show any regard for the concomitant need to raise beneficiaries' wages by the same percentage. This is vital to ensure a fair distribution of the burden of insurance costs. In its current form, the article will place additional burdens on beneficiaries that are not suited to current wage and pension levels.

C. Health Service Providers

→ Article 3 of the bill mandates the establishment of a public economic agency to manage Ministry of Health hospitals and other hospitals designated by prime ministerial decree after certification.

The article contains no reference to hospitals which are currently subsidiary to the General Health Insurance Organization. These are 41 hospitals that are not owned by or directly subsidiary to the Ministry of Health. This may reflect an intent to dispense with these hospitals, which again raises concerns about sale or privatization.

• General Conclusions •

→ The Egyptian Initiative for Personal Rights and other organizations affiliated with the Committee to Defend the Right to Health reiterate their stance on the need for all social movements to take part in a debate on the new health insurance system. They also reject the harmful elements of this latest bill, which threaten to achieve universal insurance coverage in name only, without the provision of real, fair insured care. In addition to the aforementioned recommendations, we stress the following:

1. The need for the new law to invest the legislative authority with its proper right to approve all the relevant details, particularly regarding the package of insured services and premium payments.

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2. The need to place the entire text of the bill before society for extensive debate before submitting it to the legislature.
3. The need to raise the contribution of the public treasury to appropriate levels, no less than 10% of the public budget, in order to achieve fair, comprehensive health development, which provides insurance protection for all.
4. The need to find fairer means of funding coverage for “catastrophic illnesses”, rather than leaving them at the absolute discretion of the executive authority, which threatens the right to life for a broad class of citizens.

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Publisher: Egyptian Initiative for Personal Rights (EIPR)

National Library Registration no.:

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