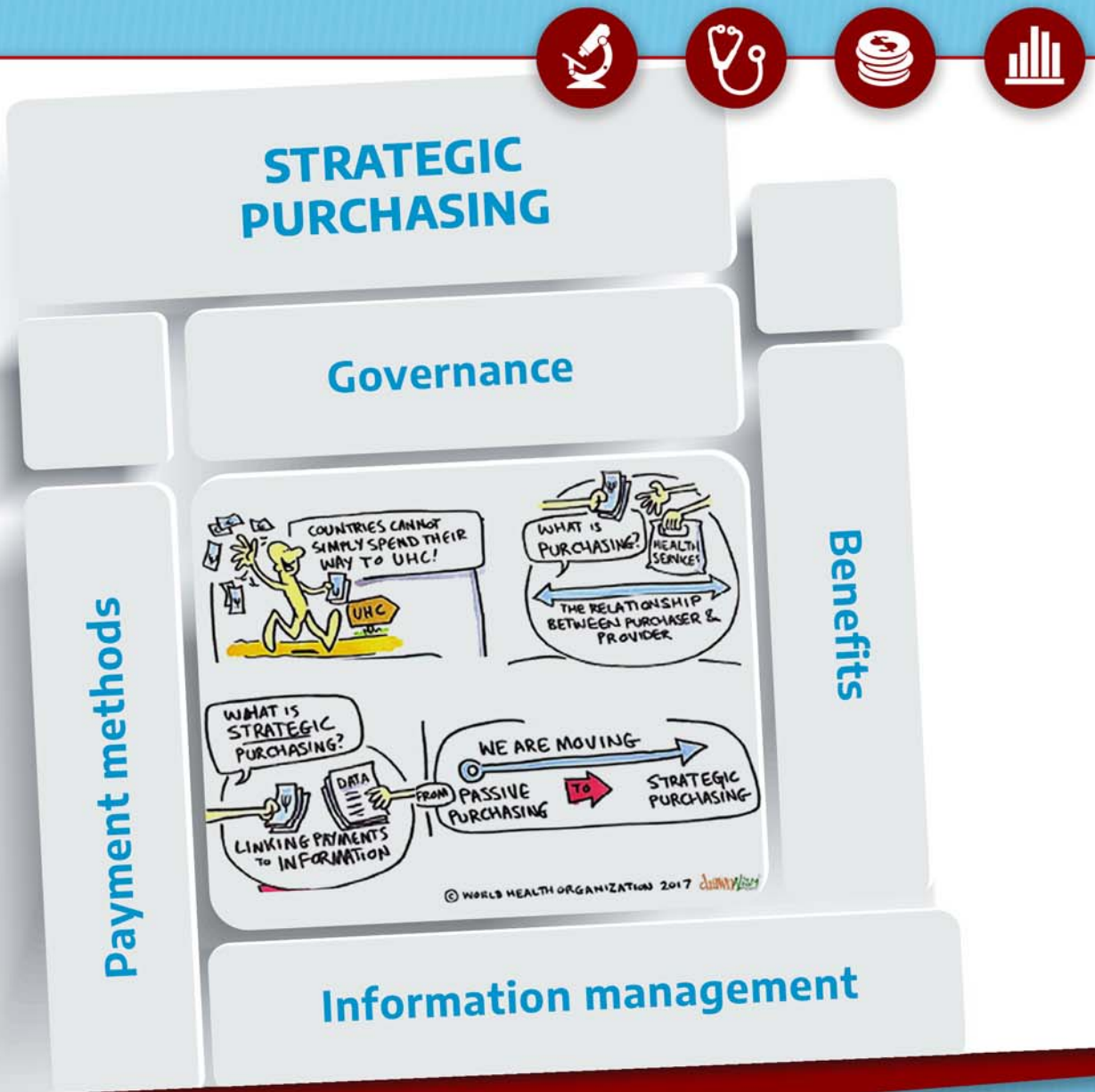
HEALTH FINANCING CASE STUDY NO. 13

IMPLEMENTING THE UNIVERSAL HEALTH INSURANCE LAW OF EGYPT:

WHAT ARE THE KEY ISSUES ON STRATEGIC PURCHASING AND ITS GOVERNANCE ARRANGEMENTS?



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FORWARD

The New Universal Health Insurance Law puts Egypt on the road towards progressive realization of Universal Health Coverage. It entails covering all the Egyptian population with the health services they need without suffering financial hardship.

Within the implementation process, purchasing of health services is considered as a very critical function, since it implies making deliberate decisions on behalf of the population on which services to purchase, how to purchase and from whom.

This assessment serves to inform the implementation process of the Universal Health Insurance Law in Egypt by anticipating the strengths and possible challenges as well as providing options to support a shift towards more strategic purchasing. It also analyses the envisaged governance arrangements related to purchasing.

This document proposes high-level action points to facilitate the implementation of the UHI law; specific action points on the main strategic purchasing areas e.g., benefit design operationalization, provider payment methods, information management systems and related governance arrangements, as well as specific options on various technical aspects.

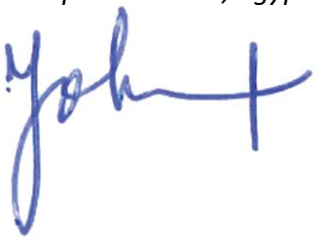
This report demonstrates the collaborative efforts between the World Health organization and the Government of Egypt to ensure successful implementation of the Universal Health Insurance Law.

I would like to express my sincere appreciation for the constructive efforts within the Ministry of Health and Population and beyond to strengthen the health system in Egypt in order to make progress towards achieving Universal Health Coverage.

The WHO remains committed to support the Government of Egypt in its pursuit to achieve Universal Health Coverage. We are willing to further expand our technical support and address current and upcoming challenges drawing on the wealth of our technical expertise and building on lessons learned from international experiences.

Dr. Jean Yaacoub Jabbour

WHO representative, Egypt



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LIST OF ACRONYMS

CAPA	Central Administration for Pharmaceutical Affairs
CCO	Curative Care Organization
CHE	Current Health Expenditure
CoS	Council of State
DHA	District Health Authority
FFS	Fee-For-Service
FHC	Family Health Centre
FHU	Family Health Unit
GGHE	General Government Health Expenditure
GOTHI	General Organization for Teaching Hospitals and Institutes
HIO	Health Insurance Organization
HMIS	Health and Management Information System
HO	Health Office
HTA	Health Technology Assessment
MCIT	Ministry of Communication and Information Technology
MOD	Ministry of Defense
MOHE	Ministry of Higher Education
MOHP	Ministry of Health and Population
MOHP DH	Ministry of Health and Population District Hospitals
MOHP GH	Ministry of Health and Population General Hospitals
MOF	Ministry of Finance
NGO	Non-governmental Organization
OOPs	Out of Pocket payments
OPD	Outpatient Department
PFM	Public Financial Management
PHC	Primary Health Care
PHI	Private Health Insurance
PTES	Programme for the Treatment at the Expense of the State
SMCs	Specialized Medical Centers
UHC	Universal Health Coverage
UHI	Universal Health Insurance
UHIO	Universal Health Insurance Organization
WHO	World Health Organization
VHI	Voluntary Health Insurance

EXECUTIVE SUMMARY

The promulgation of the new Universal Health Insurance UHI Law stimulates major progress towards achieving Universal Health Coverage UHC. By the full implementation, it is envisaged that all Egyptians will be covered with quality health services while ensuring adequate level of financial protection. Moving along the gradual implementation process would entail major institutional transformation and coordination between the old and new system. Hence, for effective implementation, it is crucial to anticipate implications from the application of the legal provisions and to develop possible options to address potential challenges or bottlenecks that may arise.

Purchasing of health services, which is the focus of this document, is a very critical function since it implies making deliberate decisions on behalf of the population on which services to purchase, how to purchase and from whom. Various key aspects related to purchasing, e.g., benefit design operationalization, provider payment methods, information management systems and governance arrangements, however, were not sufficiently specified in the new UHI Law issued in 2018 and its related Bylaw. As such, it remains somewhat unclear how to implement. There is a need to clarify various institutional aspects related to purchasing in order to move forward with its implementation.

This document aims to inform the implementation process of the UHI by anticipating the strengths and possible challenges as well as developing options to support a shift towards more strategic purchasing.

As per the UHI law, the covered benefit package is broad and generous. Experience from other countries suggests that if a benefit package remains rather broad and unspecified, implicit rationing (e.g. waiting lists, shortages) may arise or continue to prevail. However, as per the legal provisions, **it remains unclear which body/actor/committee will be in charge of defining and revising the benefit package or establishing this list of medical services.**

The new health system architecture may lead to an even more explicit separation of curative services (financed through the UHI system) versus preventive and promotive services (financed by the Ministry of Health and Population (MOHP)). This may not help promote a focus on integrated people-centred health services geared towards care coordination and care continuity.

As per the UHI Law, the three new Organizations will not fall under the application of the Treasury /Budget Law. **Not having to follow a line-item budget structure logic will be of advantage as it gives more flexibility in introducing**

and operating output-oriented payment methods. Such payment methods are more conducive to strategic purchasing.

While it is envisioned that the MOHP will maintain its role as the principle regulator of national health policies and steward for the whole health system, it is yet unclear how the MOHP will undertake this role within the new framework of the UHI system and by which instruments. Problems may arise when national health policies contradict or are not in compliance with the newly established Organizations' individual direction. For example, a profit maximization behavior from providers may focus on providing more profitable curative services as opposed to a national policy that focuses on early detection and preventive measures. The MOHP still has sufficient authority to initiate laws or enact decrees, yet it could have a minimal influence, if any, in decisions related to, for example, pricing, payment system, benefit package design, etc. Such decisions should not be regarded merely as technical exercises that are based on evidence generation on cost or budgetary impact and negotiation between the purchaser and provider. Instead, an active/strategic purchasing role implies that purchasing decisions are guided and in compliance with the national priorities and health policies.

The law does not mention specifically the UHI Organization to be a strategic purchaser, yet it provides the legal provisions to undertake such a role. The law establishes the UHI as a single purchaser for all UHI covered services creating a potentially large enough pool that could influence the healthcare market with its purchasing power and increased efficiency. The Law has also minimized the compliance with rigid public financial management PFM rules and regulations in that regard, giving more flexibility towards output or performance-based financing. **Nonetheless, it would be useful if the Bylaw or another policy document would clearly spell out a mandate for the UHI Organization to be a strategic purchaser and clarify that the objective of expanding coverage and improving financial protection is equally important as achieving a financial balance.**

Action points in brief:

The document provides three types of recommendations; high level action points to facilitate the implementation of the UHI law; specific action points on the four main strategic purchasing areas e.g., benefit design operationalization, provider payment methods, information management systems and governance arrangements; and specific options on technical aspects.

Ad 1) High-level action points

High-level action points	*S	M	L
1. Establish a National high level multi-task force which clarifies a range of issues and takes decisions along the start of the implementation on core policy aspects			
2. Set up an implementation working group on strategic purchasing that reviews, discusses and further develops the proposed high-level action points as well as the specific action points			
3. Develop a joint and integrated implementation plan for all ministries and organizations involved in purchasing			
4. Develop a comprehensive capacity strengthening plan related to strategic purchasing and governance			
5. Communication and engagement plan with key stakeholders and the public			
6. Launch a comprehensive organizational development of the UHI Organization with clear mandates, organizational structures, duties and responsibilities.			
7. Alignment of the reforms related to the purchasing function with changes in revenue raising and pooling as well as the four strategic purchasing components			

*S: Short term, M: Medium term, L: Long term

Ad 2) Specific action points related to key decisions to take

Benefit package design	*S	M	L
Establish a benefit package committee in charge of defining, specifying/ operationalizing and over time reviewing the benefit package			
Define the process and the criteria for defining and specifying benefits and consider how to involve citizen / patient representatives in this process			
Expand the current HTA work and organize it independent from a purchaser or from providers and pharmaceutical actors			
Referral system			
Further specify the referral lines from lower to higher levels and from primary care level to specialized private doctors			
Specify which hospital types will shift under the Healthcare Organization and consider potential harmonization needs across different hospital types to facilitate contracting and transparency			

Ad 2) (cont.)

Cost-sharing	*S	M	L
Consider the reduction of copayments for generic (therapeutic equivalent) medications to induce more efficient use of resources			
Further differentiate and set lower Copayments for specific population groups (e.g. children) or for priority services			
Consider adjusting cost ceilings with income level, rather than being the same across all income groups			
Payment methods			
Explicitly specify (through executive regulation) the procedures for determining and reviewing the payment methods and rates whether by an independent multi-stakeholder commission or in negotiation between the UHIO and the Healthcare organization/providers			
Clarify (through Executive Regulation) the composition process of the standing pricing committee to ensure diverse expertise beyond cost accounting			
Align the funding streams for preventive and promotive care (line-item budgeting) and curative care (UHI payment methods) so as to avoid distortions in provider behaviour			
Consider (through executive regulation) the distinction between personal versus population-based services, where all personal based services (whether promotive, preventive and curative) are paid for by the UHI organization			
Address managerial aspects related to payment and contracting			
Health and Management Information System			
Strengthen the institutional home for the design and implementation of HMIS and its governance within the MOHP, MCIT with strong focal points in relevant ministries and organizations			
Establish a Steering Committee to coordinate, during preparation and early implementation period, across all ministries and actors involved and affected by the information management system. The focal points in each ministry should have a very high-level attachment			

Ad 2) (cont.)

Governance Arrangements for Purchasing	*S	M	L
Clearly specify and give strengthened role to the MOHP as a steward that is in charge of regulation and overall supervision and ensuring public health functions			
Further formalize the coordination responsibilities and coordination structure across the “old” and “new system” during the implementation phase			
MOHP to continue to supervise and regulate quality of providers that are not contracted with the UHI system			
Set up a health services delivery map including all providers to help improve equal distribution of health service provision across the country that is in line with population need			
Further specify the complimentary and supplementary role of PHI and to align the UHI and PHI benefit packages. Cost sharing at higher level of care through bypassing PHC, if allowed, should not be covered by PHI			
Higher quality/special hotel related aspects of hospitalization beyond the basic quality standards and necessities should be covered by the patient (through out-of-pocket or through supplementary PHI)			
Assess implications of the 15 years implementation plan and consider expediting the implementation period and/or consider transitional solutions in the governorates prior to implementation. Port Said could serve as a pilot, followed by implementation of stages 2-3, with adjustments, then move quickly to stages 4-6			
Strengthen participation and accountability mechanisms towards the public, through the establishment of a feedback mechanism within or outside the UHI Organization			
Consider the organization of citizen consultations on a regular basis to gather views from the population			
Spell out and specify the objectives and mandate of the UHI Organization, mentioning both a financial equilibrium as well as expansion of coverage and improvement of financial protection			
Establish a performance contract for the Chief Executive Officer of the UHI Organization to strengthen accountability and achievement of objectives of the Organization			

*S: Short term, M: Medium term, L: Long term

Ad 3) Proposed options on specific technical aspects

Benefit package design
Cover all health services provided at primary care level and establish positive or negative lists for the covered higher level care services
Make health services at higher level of the health system only accessible on the basis of a strict referral process
If access to higher level of care is permissible under certain circumstances, higher copayment rates are to be imposed for bypassing the primary care level
Payment methods
For outpatient care:
Apply a blend of partial capitation and FFS for priority interventions (e.g. early detection, hypertension management, antenatal care) plus performance payment
When capitation payments are applied: introduce risk-adjusted per capita payment for age, sex and other morbidity characteristics of the catchment population
Combine partial capitation with provider choice for a defined period (e.g. 6 months, or 1 year)
For inpatient care:
If case-based payment is chosen, start implementing a case-based payment system using existing data on procedures/diagnosis and cost
Treat and pay for cases where there are consistent outlier costs differently
Incrementally refine the case-based payment system over time to adjust for severity and other aspects
Pay the same case-based payment rate for the clinical intervention to all hospitals, and pay separately for costs and price differences (outside the case payment)
Pay incentives for patient safety (pay for performance) as an add-on payment element, and pay differences in hotel side aspects separately, whilst considering potentially increased ALOS
If indeed FFS is chosen, Set a budget ceiling, either for types of hospitals or for health services
In any case: Prohibit or strongly limit/regulate balance billing and effectively enforce it
Build upon and expand the existing practice of treatment protocols for various diseases

1. INTRODUCTION

Egypt has identified Universal Health Insurance (UHI)[1] as its way to achieve Universal Health Coverage (UHC). The new UHI Law established the legislative structure for an overall health system overhaul that fulfills the constitutional mandate[2] set forth in the country's new Constitution of 2014 and will be an important instrument to make UHC a reality. Properly implemented, as envisioned, it will provide the means to ensuring that everyone will have access to quality health services, they need, without suffering financial hardship. As indicated in the UHI Law and Bylaw, the implementation process will be phased on a period of maximum 15 years. The first phase will start with Portsaid governorate by mid-2019 and then gradual geographic expansion will follow until full implementation by 2032.

Universal Health Insurance per se, however, does not automatically lead to UHC[3] (Kutzin, 2013). Therefore, towards reaching UHC, and within the UHI implementation process, Egypt has to make concrete implementation decisions that are in line with the overall UHC objectives. These decisions would cover the operationalization of various health system functions, which include health system financing, governance arrangements, health service delivery, health information systems, health workforce, access to essential medicines. The preparatory phase for UHI implementation, currently undergoing, is thus very critical and requires a wider multi-stakeholder collaboration to address several potential bottlenecks and challenges.

Health system Financing is one of the key instruments towards achieving UHC. In principle, its key functions are; revenue raising (sources of funds, contribution methods and collection arrangements); pooling (accumulation of prepaid funds on behalf of the population); and Purchasing (the allocation of the prepaid resources from the pool to the providers for the provision of service benefits) (McIntyre & Kutzin, 2016).

Purchasing of health services, which is the focus of this document, is a very critical function since it implies making deliberate decisions on behalf of the population on which services to purchase, how to purchase and from whom. Various key aspects related to purchasing, however, were not sufficiently specified in the new UHI Law issued in 2018 and its related Bylaw. As such, it remains somewhat unclear how to implement. There is need to clarify various institutional aspects related to purchasing in order to move forward with its implementation.

The purpose of this work is, thus, to assess the envisaged purchasing and payment arrangements as well as its governance

[1] The new Social Health Insurance Law in Egypt is called Universal Health Insurance.

[2] Article 18 of the Egyptian constitution "*…The state commits to the establishment of a comprehensive health care system for all Egyptians covering all diseases. The contribution of citizens to its subscriptions or their exemption therefrom is based on their income rates…*"

[3] For more information read: Kutzin, J. (2013). Health financing for universal coverage and health system performance: concepts and implications for policy. *Bulletin of the World Health Organization, 91*, 602-611.

arrangements according to the new UHI Law and Bylaw. This document aims to inform the implementation process of the UHI by anticipating the strengths and possible challenges as well as developing options to support a shift towards more strategic purchasing.

This report starts with a brief note on the conceptual framework and methods used. It then presents the current health financing setup and what is expected to be different under the new UHI Law. This is followed by a detailed analysis on the implications of the legal provisions and possible options of the specific purchasing arrangements, namely benefit design, provider payment methods and the health and management information system. The following section assesses the envisaged governance arrangements in relation to purchasing. Finally, in the Conclusion section, we present recommendations and proposed action points.

2. METHODOLOGY

Conceptual framework[4]

Strategic purchasing means active, evidence-based engagement in defining which services are bought, from whom, how these services are paid for and at what price in order to maximize societal objectives. The allocation of funds from purchasers to health service providers, therefore, needs to be guided by information on aspects of provider performance, health needs of the population whom they serve and the services that best meet these needs (Mathauer, Dale & Meessen, 2017; WHO 2010).

Moving towards more active/strategic purchasing role can improve efficiency by making better use of limited health funds to get more value for money and effectively managing expenditure growth, so as to free up resources to expand coverage. It also serves to enhance transparency and accountability of providers and purchasers to the population. As the nexus between pooling and service provision, it thus contributes to the ultimate UHC goals such as improved quality in health services, reducing the gap between utilization and needs, as well as financial protection and equity in financing (McIntyre & Kutzin, 2016).

In practice, purchasing is neither fully passive (which is characterized by resource allocations to providers without distinction or selection, unrelated to provider performance, and for a benefit package that is poorly defined) nor completely strategic, instead it is about engaging in more strategic purchasing along a continuum, and countries at all income levels may constantly progress along this continuum.

Strategic purchasing consists of the following core elements:

- Benefits design: which services to cover and from which providers to offer these services;
- Provider payment methods: how to pay providers for these covered services;
- Information management systems: how to generate, manage and analyse data for strategic purchasing decisions (e.g. on resource allocation, payment system design, performance monitoring and accountability);
- Governance arrangements[5]: how to exert oversight of individual purchasing agencies and how to coordinate across different purchasing agencies; how to setup and align with other support mechanisms that strengthen accountability and performance (e.g. accreditation and contracting, including selective contracting) (Mathauer, Dale, Jowett & Kutzin, 2019).

[4] For more information on the conceptual background for this document, please refer to the document: Mathauer I, Dale E, Meessen B. Strategic purchasing for Universal Health Coverage: key policy issues and questions. A summary from expert and practitioners' discussions Geneva: World Health Organization; 2017.

[5] Governance can be defined as "ensuring strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system-design and accountability" (WHO 2007). It is an overarching health system function, which is of particular relevance for purchasing to be strategic.

Methods:

A mission from the three levels of the WHO organization (Country office, Eastern Mediterranean Regional Office, and Headquarters,) was commissioned to undertake this work during the period of 22nd – 26th of July 2018. Prior to the mission, the team reviewed the UHI Law and Bylaw as well as other relevant studies from the government, donors or published literature around health financing and purchasing. The following guidance material was used for this work:

- Strategic purchasing assessment guide, jointly developed between WHO, Institute of Tropical Medicine (ITM) and the Strategic Purchasing Collectivity
- WHO analytical guide to assess a mixed provider payment system (Mathauer & Dkhimi, 2019)
- WHO analytical framework to assess governance for strategic purchasing (WHO 2019).

This was then followed by in-depth individual discussions with key stakeholders and actors in charge of purchasing and governance, e.g. MOHP, MOF, HIO, private sector representatives, costing/pricing committee, etc. A full list of key informants is available in annex 1.

3. OVERVIEW OF THE CURRENT AND THE NEW HEALTH FINANCING SETUP

3.1. CURRENT HEALTH FINANCING SETUP

Egypt's health care system is largely financed through household out of pocket payments (OOPS). According to the latest National Health Accounts data, around 59% of the Current Health Expenditure (CHE) comes from OOPS, 32% as general government health expenditure (GGHE) and the rest are from firms and NGOs. The budget execution rate is rather low and budgets provided to governorates often come back to the central level. Due to the overreliance on OOPS, most of the funds are directly paid to providers with no real mechanism for cross subsidies among different population groups exposing population to serious financial hardships. Based on 2017 UHC Global Monitoring Report, 26.20% and 3.90% of the population are faced with catastrophic expenditure, at 10% and 25% thresholds respectively; and 1.07%[6] are impoverished due to direct OOP payment. The rest of funds, however, are managed within fragmented pools and flows through silos with limited redistributive capacity even within the same organization (see Figure 1). For example, the Health Insurance Organization (HIO), which is the main public insurer and covers 59% of the population, has separate fund pools for the different population groups they cover, e.g. Civil servants, retired civil servants, widowers of insured, pre-school and school children and female-headed households. Cross subsidies across these separate pools are restricted and subject to the MOF approval according to its Public Financial Management rules and regulations. Other Health Financing schemes/pools also exist such as Program for the Treatment at the Expense of the State (PTES), MOHP, MOHE as well as other ministries, firms, syndicates and private/voluntary insurance arrangements.

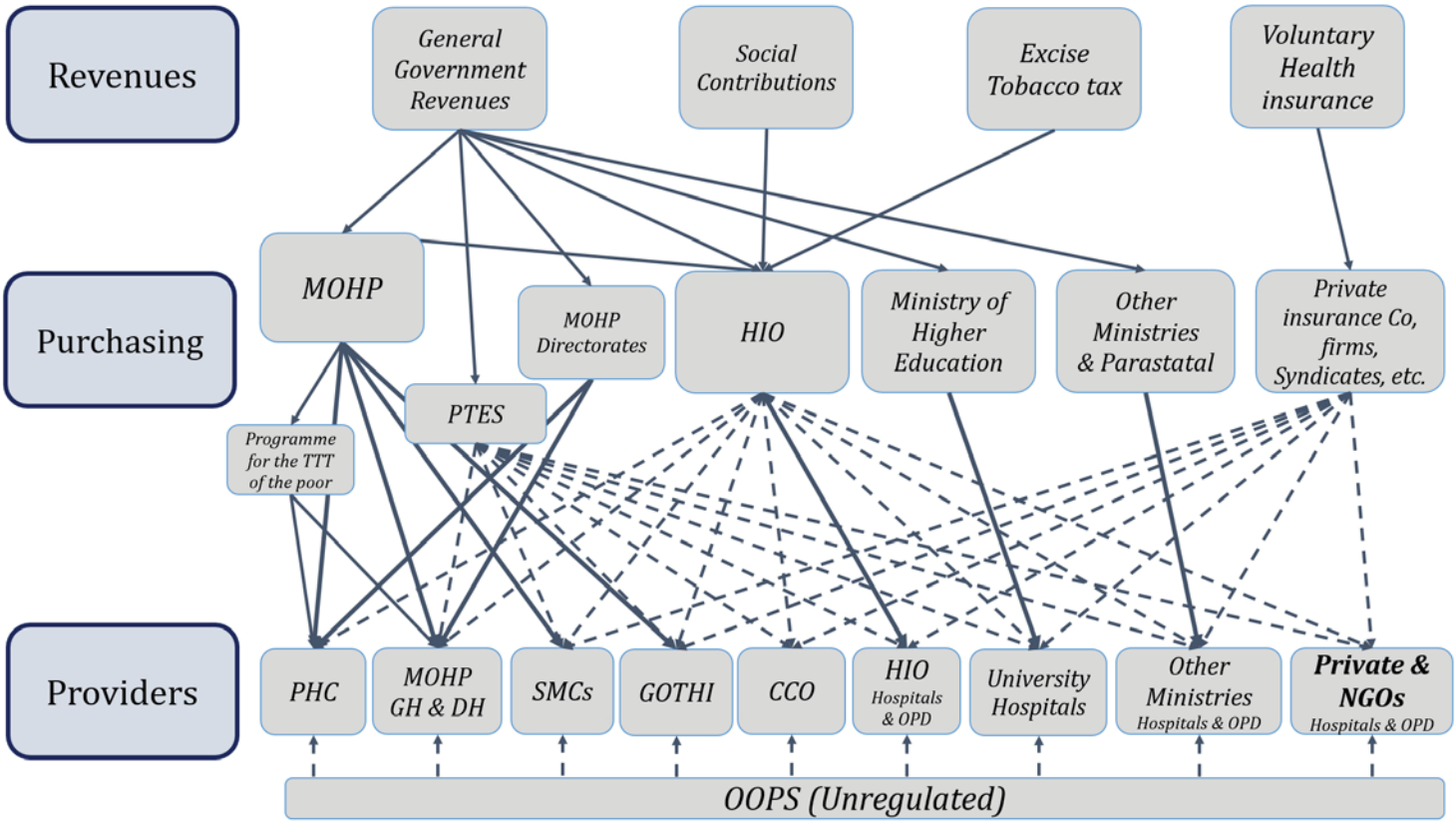
The nature of the healthcare provision market is even more fragmented with a multitude of public, private and semi-autonomous providers involved, each with its own set of rules and internal regulations. The private sector is very dominant and growing in size.[7] The current referral system does not work well. Patients tend to go directly to the hospital level, as there is little recognition of PHC facilities and general practitioners. Also, patients seek to visit a specific doctor rather than choosing the hospital. See Annex 2 for more detailed structure of the service delivery in Egypt.

Fee-for-service (FFS) is is the prevailing method of payment by purchasers in the private sector. In the public sector, purchaser-provider integration is the

[6] Poverty line: at 2011 PPP $3.10-a-day

[7] For inpatient services, in 2016, private sector facilities represent around 61% of total facilities or 26% of total bed capacity (CAPMAS 2018). Moreover, on the outpatient utilization level, almost three quarters of visits are made to the private sector (Rafeh 2011).

Figure 1: Current health financing system architecture and funding flows*



Source: Authors.

*: Solid lines indicate Line-item payment method. Dotted lines, except for OOPS, indicate a contractual arrangement with an output-oriented payment method (most likely case-based payment and/or fee-for-service). For acronyms, see the list of abbreviations. TTT: treatment.

dominant arrangement, in which flow of funds is not usually linked to any performance indicators. MOHP funds flow through its integrated system by a rigid line-item budgeting based, in most cases, on historical trends, i.e. passive purchasing. The fund receivers, e.g. hospital managers, have no to minimal autonomy on their internal financial resources. Similarly, HIO payment system follows line-item budget to most of its integrated hospitals' network, with the option of contracting-out for some selected services, from the private sector as well as other public entities, through case-based payment or FFS.

As seen in Figure 1, most of the health services providers receive multiple funding streams, at least four, with different payment methods, contractual modalities and loosely defined non-uniform benefit package. These features, among others, contribute to the inconsistency and variation in health care cost and quality across providers.

The level of financial autonomy varies across the MOHP affiliated entities. It ranges from non-autonomous entities, e.g. MOHP general and district hospitals; semi-autonomous, e.g. Specialized Medical Centers (SMCs); or fully autonomous, e.g. Curative Care Organization CCO. All public facilities are able to raise and hold additional revenues, through what often called economic departments or the special fund for service improvement. Spending therefrom, however, is restricted to PFM rules in this regard.

3.2. THE NEW HEALTH FINANCING SETUP AND THE NEW LAW: WHAT WILL BE DIFFERENT?

The new UHI Law constitutes a great achievement and brings high hopes to address many of the long-standing health system challenges in Egypt. It entails institutional transformation that can be considered highly conducive to UHC when they are effectively implemented. All Egyptians will be covered on a mandatory basis through family membership. The state shall subsidize the poor and vulnerable population upon a decree from the Prime Minister defining exemption controls, with an envisaged 30% to 35% of the population being subsidized. A large and generous benefit package shall be provided with low cost-sharing rates coupled with relatively low ceilings. The poor and vulnerable as well as those with chronic conditions will be exempted from cost-sharing. The new Law shall also be based on separating the funding from the provision of the service (Article 2 UHI Law). For that matter, three autonomous organizations are created:

- *Universal Health Insurance Organization (UHIO)*: Under general supervision of the Prime Minister. It manages prepaid funds and purchases health services on behalf of the insured population (Article 4 UHI Law);
- *Healthcare Organization:* Under general supervision of the Minister of Health. It owns HIO and MOHP affiliated facilities and is considered as the state's main instrument in controlling and regulating the provision of health insurance services (Article 15 UHI Law);
- *Accreditation and Supervision Organization:* Under general supervision of the President of the Republic of Egypt. It aims to control and regulate the provision of UHI covered services[8] in accordance with specific criteria for quality and accreditation. It also seeks to regulate the health sector to ensure its safety, stability, development and quality improvement, and work to ensure balance in the rights of all stakeholders (Articles 26,27 UHI Law).

While these are promising steps to overcome the deeply rooted fragmentation in the current system, great attention needs to be paid to ensure streamlined processes and avoid overlaps between the new organizations (see section 5 for more details).

The following section provides a brief summary of the main aspects along each health financing function in view of the UHI Law. An in-depth analysis on health purchasing related components, in particular, is provided in sections 4 and 5.

Revenue raising for UHI:

The new system will predominantly rely on public sources of funds. It assigned increased revenues for health with diversified funding mechanisms. According to the publicly available actuarial projections, mandatory UHI contributions, which are proportional to the level of individual's income, accounts for almost 50% of total UHI revenues. Contribution rates, in the new Law, will be based on total income as opposed to the current system, which is based on basic salary (Article 40 UHI Law). Various

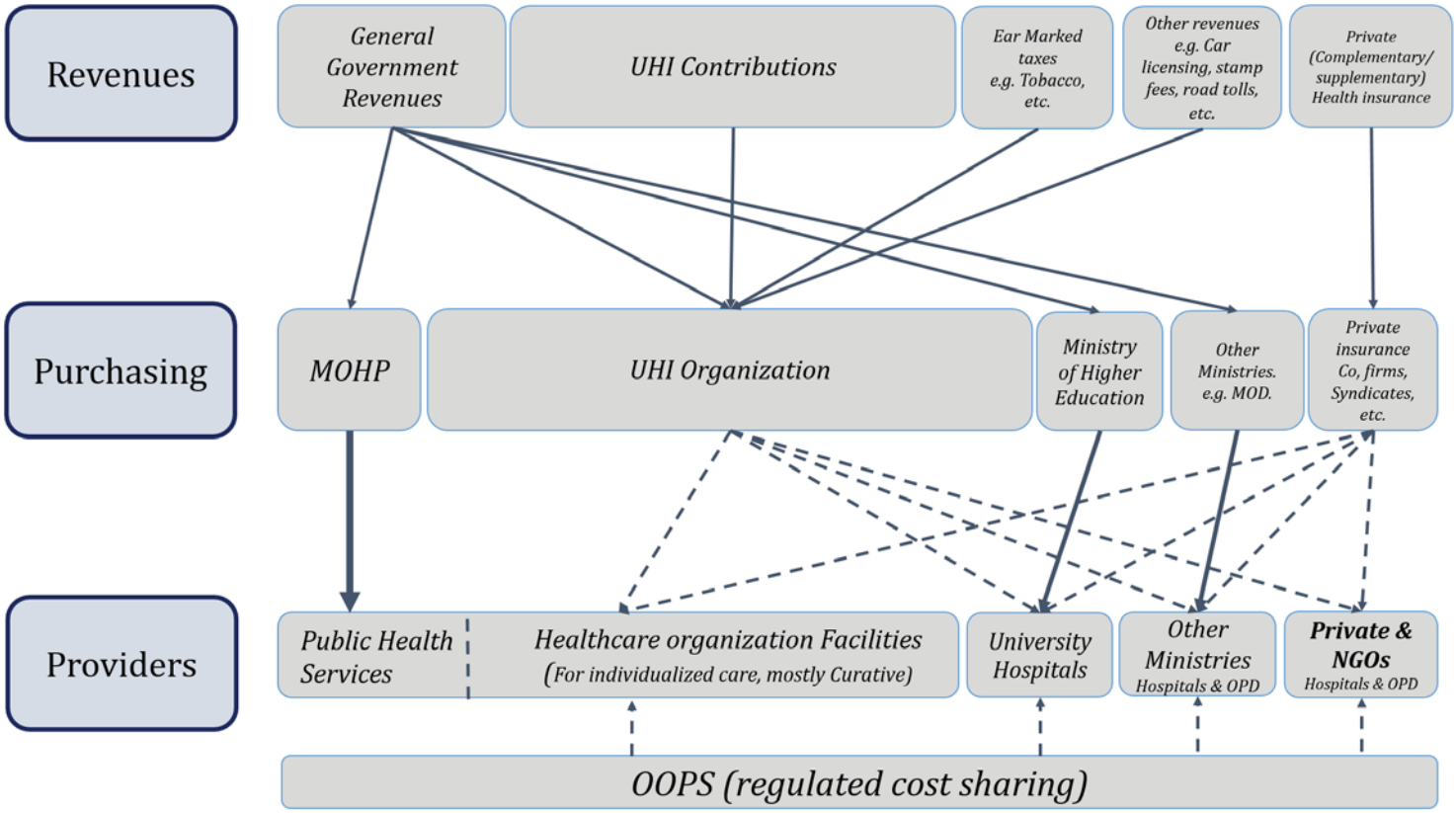
[8] In this report, we refer to all health services provided under this Law as UHI covered services, which is curative individualized services. In the English version of the Law, it is called health insurance services.

population groups in the informal sector, who are ineligible to exemption criteria, will be subject to mandatory contributions. The Law indicates in several articles the contribution collection mechanisms from certain groups. As per key respondents, it is also envisioned that interactions with any state authority, e.g. license issuing, national ID renewal, etc. will be used to check that contribution payments are made. Other sources of revenues include; the share of general budget allocations to subsidize the contributions of poor and vulnerable population, (around one third of the population) estimated at 22% of UHI revenues; earmarked taxes such as Tobacco taxes and others estimated at 21%, while copayments accounting for only for 5% of total UHI revenues. All revenues will be collected nationwide from the start, except for the UHI contributions which will be collected on residential basis in accordance with the Law geographic implementation plan.

Pooling:

The new system merges various pools into a single pool for UHI, thus leading to considerable defragmentation and allowing for better risk diversity, redistributive capacity, purchasing power and increased efficiency (see Figure 2). Unlike the current system, no opting out is allowed. All Egyptians will be part of this pool, except for staff and families of the Military.

Figure 2: New health financing system architecture and funding flows as per the new UHI Law*



Source: Authors.

*: Solid lines indicate Line-item payment method. Dotted lines, except for OOPS, indicate a contractual arrangement with most likely output-oriented payment methods. For acronyms, see the list of abbreviations.

Purchasing:

The UHI Organization will be the main purchaser for UHI covered services. The MOHP, however, will remain responsible for providing the public health, ambulance, preventive and mental health services through separate funding streams (Article 2 UHI Bylaw). Their payment methods and related aspects of purchasing are discussed in more details in the following section.

Other purchasers namely the Ministry of Higher Education and the Health Military services will continue funding tertiary/ university hospitals and military health services through budget allocations. Private health insurance schemes also continue purchasing services, often from contracted private providers.

Provision (service delivery):

All public and private facilities shall fulfill the required accreditation criteria, within three years of Law implementation within their respective governorate, in order to be contracted by the UHIO (Article 31 UHI Bylaw). In that context, the state shall be responsible to upgrade hospitals prior to the Law implementation through line item budget allocations on investments from the General Budget (Article 3 UHI Law).

All health facilities owned currently by the Health Insurance Organization as well as MOHP and its affiliated health facilities will be transferred to the new Healthcare Organization. Primary health care (PHC) facilities will provide both preventive and curative services and thus will receive two main funding streams (see Figure 2 and section 4.2 for more details).

In the new system, while patients can choose freely between providers (at the secondary and tertiary level), the entry point should be through the family physician in the PHC facility. Within the PHC facility, a package of curative and preventive services will be provided. A challenge, however, would be how to ensure the right distribution of healthcare facilities and health professionals that is responsive to the population needs and disease burden. Aspects related to the Benefit package provided in the new system and referral system are discussed in more details in the following section.

4. DETAILED ANALYSIS OF THE PURCHASING ARRANGEMENTS: IMPLICATIONS OF LEGAL PROVISIONS AND POSSIBLE OPTIONS

This chapter presents a detailed analysis on various purchasing arrangements, namely benefit design, provider payment methods and health and management information system. It looks into the strengths of each of the purchasing arrangements, potential challenges that may arise from the application of the Law and proposed options to overcome it.

4.1. BENEFITS DESIGN

4.1.1. Defining the entitlements (UHI covered services)

As per the UHI Law, the covered benefit package is broad and generous: it contains "all diseases for diagnostic, therapeutic or rehabilitative purposes or medical or laboratory tests". The UHI Law also mentions oral and dental medicine and surgery, and home care. For rehabilitation services and physical therapy and prosthetic devices, a basic list is to be issued by a specialized committee. The same applies to medicines and other medical supplies. Treatment abroad for services not available in Egypt is included in principle, if authorized, based on the rules and procedures to be defined by a committee (Article 3 UHI law).

Experience from other countries suggests that if a benefit package remains rather broad and unspecified, implicit rationing (e.g. waiting lists, shortages) may arise or continue to prevail. Thus, in view of this broad definition, it is critical and positively noted that various committees have met with the purpose of specifying the package (e.g. a committee chaired by MOHP (PHC) looked at services to be included, based on MOHP decree, in order to specify the package). There are several annotations in the Law that refers to list or package of services (e.g. Articles 3, 9 UHI Law, articles 3, 12 UHI Bylaw), suggesting that there is a potential legal entry points for turning the broad benefit package into a more concrete list of defined services. However, as per the legal provisions, it remains unclear which body/actor/committee will be in charge of defining and revising the benefit package or establishing this list of medical services.

Notably, the UHI benefit package does not cover prevention and does not mention explicitly early detection of diseases. The new health system architecture may lead to an even more explicit separation of curative services (financed through the UHI system) versus preventive and promotive services (financed by the MOHP), which may not help promote a focus on integrated people-centered health services geared towards care coordination and care continuity. Given the high morbidity related to chronic diseases,[9] a close alignment with prevention will be critical so as to shift attention to prevention and early detection of diseases and to overcome such a dichotomy.

In view of the fact that diagnostic health services are covered, it is also noted that there is a potential entry point to strengthen individual preventive services.

Proposed actions for the benefit design process:

- It is suggested to establish a benefit package committee within the Ministry of Health that is in charge to take decisions on defining and specifying/operationalizing the benefit package and reviewing it on a regular basis in line with the 3D-principles (e.g. Data, Dialogue and Decision), see Box 1. This should also involve the establishment of a process as well as criteria setting that reflect the policy priorities for the benefit package. It is important that the dialogue around benefits design also involves citizen / patient representatives and that the final decision taken by this committee also represents the views of various population groups.
- Using Health Technology Assessment (HTA) evidence will be critical, and it is proposed to expand the current HTA work in Egypt that is currently undertaken by Central Administration for Pharmaceutical Affairs. As in other countries, a unit/department/organization in charge of HTA that is independent from a purchaser or from providers and pharmaceutical actors is important and would have to be institutionalized. It would fit under the new role of the Ministry of Health in charge of stewardship and regulation.

Proposed options on the benefit package content:

- Initially, the following approach might be useful: all health services provided at primary care level are covered, including health promotion and education, immunization, family planning and NCD prevention. Higher level care services can be specified by a negative or positive list.

Box 1. Benefit design process

Experience from other countries points to the importance of establishing priority-setting processes to define (and revise) benefits more explicitly, and in line with fiscal realities. This involves the generation of evidence or data in relation to a set of defined criteria (e.g. cost-effectiveness, equity impact, budget impact), a forum for dialogue which brings together key stakeholders to debate this evidence and competing policy priorities, and finally a political decision to establish citizen entitlements and related conditions of access (cf. Terwindt, Rajan et al. 2016).

[9] As an example, it is noted that about 25% of PTES funds go to renal dialyses. This number is increasing further and will put additional financial constraints on the health financing system (on both PTES as well as the UHI) (based on key informant information).

4.1.2. Defining the conditions related to entitlements

Providers in charge of the UHI covered services and the referral system

The new system implies a major shift in the referral practice. The UHI Bylaw (Article 2) specifies the type of health care providers that will be able to provide the benefit package for the insured. In particular, it determines the entry points and levels of care. It is envisaged that patients can only access into the system through Primary HealthCare (PHC) facilities which provide primary package of services or which refer to higher levels, as outlined in Table 1 below.

Annex 3 provides a graphical visualization of the referral paths. Beneficiaries will be mainly assigned to PHC facilities administratively by the UHI branches according to geographical distribution (Article 17 UHI Bylaw). For higher levels of care, however, beneficiaries would have the right to choose between different providers taking into consideration the gradual referral between different levels (Article 2 UHI Bylaw).

Table 1: Types of providers to provide UHI package as per the UHI Law

	Primary Healthcare facilities	Secondary Healthcare facilities	Tertiary hospitals and/ or specialized centers
Access to health services	First level of health service providers and entry point to the system. Beneficiaries are assigned to facilities based on where they live and the catchment area of facilities.	Through referral: Second level of healthcare service providers	Through referral
Services provided	Primary health services Therapeutic Diagnostic Reproductive health Emergency first aid services Referral to higher levels If specialized doctors available: specialized services Preventive health services (financed through MOHP)	Therapeutic Diagnostic Emergency aid services Referral to higher levels Specialized health services	Not directly specified. Treatment, inpatient stay in hospital or specialized centre and surgery and other types of treatment
Provider type	Public and private	Public and private	Public and private
Relationship with UHI	Contracted	Contracted	Contracted
Population served	A number of families residing in the geographical area of the unit	Patients are free to choose their provider	Patients are free to choose their provider

As per the legal provisions, specialist private solo practitioners cannot constitute the entry point into the system. Private facilities will have to meet the criteria for primary and family health center or for a specialized centre. Therefore, there needs to be more clarity about the roles of specialized solo practice physicians to ensure care coordination across all levels.

It remains a challenge whether people will accept these new "gate keeping" rules and enter the health system at the lowest level. Previous studies indicate the overwhelming

preference among Egyptians who seek specialist care as their first point of entry – 62% seek specialist care, whereas only 5% go to general practitioners (GPs) or family health specialist (Rafeh et al. 2011). Key respondents, however, were optimistic that such new referral practices would be accepted, in view of earlier experiments in pilot governorates of the Family Health Model reform in which referral practices were largely complied.

The role of family physician has to be strengthened to ensure effective referral system. It will be challenging how to rightly allocate family practitioners across PHC units and centers given that the current ratio of family physicians to population is only at 0.5/10,000 (WHO 2016). It is of high concern how the current capacities in PHC facilities would be able to respond to the expectedly higher demand of healthcare by the start of implementation. It needs to be ensured that quality health services are provided in an effective manner with available and well-qualified staff and that PHC facilities would not turn into an administrative referral unit to meet the overwhelming demand.

Proposed actions regarding the conditions of access:

- It is suggested to further define the referral lines from lower to higher levels and from primary care level to specialized doctors (in the private sector). This will help clarify the opportunities of private providers for operation under the new UHI as well as the degree of choice that people have in choosing their providers.
- It is suggested that all higher-level care is based on a clear and strictly enforced referral process which also focuses towards care continuity and care integration.
- It will be important to specify which hospital types will shift under the Healthcare Organization, and also whether and how the different hospital types are possibly being harmonized to simplify the contracting and process of setting payment rates for these different types of hospitals.
- If direct access to higher level of care is allowed under certain circumstances, higher copayment rates are to be imposed for bypassing the primary care level.
- It is also suggested that private health insurance should not be allowed to cover cost of bypass to enforce a strong referral system.
- The role of solo office based private clinics should be clarified along the patient pathway and to be integrated with necessary HMIS tools to ensure care coordination across all levels.
- It is necessary also to ensure better quality at the PHC level and to allow for competition between PHC through periods of open enrollments (see section 4.2.1).
- There is a need for a wide community-based awareness on the entitlements as well as rules and referral regulation.

Box 2. Other issues/questions to address:

- There are currently about 5,300 PHC facilities, yet, as per the key respondents, not all would move under the new Healthcare Organization. What will happen to those facilities that do not fit under the accredited model of family health unit or centre?
- Does it make sense to transform outpatient clinics of hospitals into family health units/ centers?

Cost-sharing

In the UHI Law, cost sharing is considered a policy tool to curb overuse and enhance efficient use of health resources rather than a revenue raising mechanism. As mentioned earlier, this is apparent from the results of the actuarial study where the total share of copayments is estimated to be around only 5% of total UHI revenues. The Law does not require cost sharing at the primary care level or for consultations at higher levels of care, except for medications, medical imaging and laboratory tests as well as relatively low copayments for the inpatient departments. This cost-sharing arrangement will contribute to improving financial protection.

The Law exempts poor and vulnerable population from cost sharing, in addition to their contributions already being subsidized from the general budget allocations. This is particularly relevant to ensure financial protection for these groups and to enhance equitable access to health services. Likewise, patients with chronic diseases and tumors are exempted from any cost sharing. Moreover, the Law puts a ceiling on cost sharing to minimize the negative impact on access to health services as well as to improve financial protection. Detailed cost sharing values are indicated below.

Table 2: Cost-sharing mechanism

Medical Services	Cost-sharing rates and ceilings*
Home visit	100 EGP
Medications (except for chronic diseases and tumors)	10% up to a ceiling of 1,000 EGP. The percentage rises to (15%) in the tenth year of implementation of the Law.
Radiology and all types of medical imaging (not related to chronic diseases and tumors)	10% of the total value up to a ceiling of 750 EGP per case.
Medical and laboratory tests (not related to chronic diseases and tumors).	10% of the total value up to a ceiling of 750 EGP per case.
Inpatient departments (except chronic diseases and tumors).	5% for a ceiling of 300 EGP per admission.

*1 USD= 17.8 EGP (Egyptian pound). August 2018.

To facilitate implementation, the time period for ceiling amounts indicated above needs to be specified. For medications, for example, it is not clear whether the ceiling amount refers to a time period of one year, or less, or per one encounter. There is also a need to explicitly specify the list of chronic conditions that are exempted from copayments, with its related list of medications, to avoid inconsistencies across providers at the point of service. This all has to be linked and embedded within the business rules of the envisioned automated HMIS.

In general, return on healthcare investment is higher for cost-effective high priority services, as well as certain population groups, e.g. children. Thus, lowering or eliminating the cost sharing would be advisable in these cases.

Proposed options regarding cost-sharing mechanisms:

- Cost-sharing could be lower for generic (therapeutic equivalent) medications to induce more efficient use of resources, while strictly ensuring quality and effectiveness of generic medicines. This could be done in conjunction with wider pharmaceutical policies for rational use of medicines.
- Cost-sharing rates could be differentiated according to population groups or priority services, e.g. there could be lower or no copayments on children.
- It would be useful to specify which chronic conditions and which related services would go without cost-sharing.
- Cost-sharing ceilings should be ideally related to income, rather than being the same across all income groups. This could be considered as a medium to long-term goal that takes into consideration the development and integration of national registries from, e.g. National Organization of Social Insurance, General Tax authority, into the HMIS.
- Cost sharing could be used as a policy tool to influence the health seeking behavior and enforce referral system regulations.
- For the set cost sharing mechanisms to have an impact on financial protection and equitable access to health services, it will be crucial to prohibit or at least limit balance billing.

4.2. PROVIDER PAYMENT METHODS

4.2.1. Payment methods for UHI covered services

As per the UHI Law, e.g. articles 6, 11, 18 and 30, and information from key respondents, the three new Organizations will not fall under the application of the Treasury / Budget Law. This is of advantage with respect to not having to follow a line-item budget structure logic, which will give them more flexibility in introducing and operating output-oriented payment methods. Such payment methods are more conducive to strategic purchasing.

Even though the Law and the Bylaw do not specify the payment methods for UHI covered services, there seems to be an implicit understanding of using case payment for inpatient care (as is already the case to some extent in HIO and other institutions). The Law/Bylaw also foresee that beneficiaries register with a primary healthcare and/or family health unit/centre. This may suggest an implicit leaning towards some form of capitation payment for the primary level.

It is noted that the temporary pricing committee had enormous expertise in accounting, but there are rather few experts on health economics and payment methods for health services specifically. With a view of setting payment rates, several costing studies have been undertaken. But many inclarities remain without a clear specification of the payment method, e.g., what to cost, how to cost, what to include, etc. Another core challenge is the huge quality differences among hospitals and the related questions of how to pay hospitals and how to account for differences both in clinical quality as well as in process quality/hotel aspects.

As per the legal provisions (Article 9 UHI Law), a standing committee shall be established in the UHI organization that is responsible for pricing the list of medical services contracted for. The Healthcare Organization's Board has the task to study and propose the fees of medical services, proposed by the Healthcare Organization's branches and hospitals, and to coordinate with this pricing committee to determine the prices of services provided by the healthcare organization. This suggests that there will be a negotiation process between those two actors.

Whereas the process of setting payment rates is specified by the legal provisions, this is not the case with respect to defining (or reviewing and revising) the actual payment method. There is no multi-stakeholder body (other than the Board of the UHIO) to discuss and decide on the payment methods, or in charge to revise/review these over the years.

Box 3. Open issues/questions to address:

- How will payment methods be determined? Who will revise them?
- How will payment rates be set? Which actors will and should be involved in setting and revising payment rates?
- Does the private sector accept the proposed payment rates?

Proposed actions regarding the process of determining the payment methods and rates:

It is suggested to explicitly specify the procedures for determining and reviewing the payment methods and rates whether by an independent multi-stakeholder commission or in negotiation between the UHIO and the Healthcare Organization/Providers. This may also require an addition/amendment to the bylaws.

It is also suggested to further specify the composition process of the standing pricing committee so as to ensure diverse expertise going beyond accounting and a stronger focus on payment method issues. At the same time, it will be useful to engage in a skills-building exercise for the members of the pricing committee and to expose them to international evidence on payment rate setting.

Proposed options for payment methods:

For outpatient care:

- For outpatient care, it is suggested to apply a blend of partial capitation and FFS for priority interventions (e.g. early detection, hypertension management, antenatal care) plus performance payment.
- To reduce the incentive of under-provision, capitation rates can eventually be risk adjusted for age, sex and other morbidity characteristics of the catchment population.

  Capitation as a payment method can in principle also work for a family doctor operating in the private sector.

  If the chosen payment method is (partial) capitation, it should be combined with provider choice for a defined period (e.g. 6 months, or 1 year).

For inpatient care:

- Case-based payment has been increasingly adopted as an alternative to FFS or per-diem payment in the inpatient sector to improve the efficiency of providers. Rather than starting with a very sophisticated case-based payment system, it is suggested to start implementing a simpler version, in terms of the number of cases and rate setting. Cases with outlier costs can be treated differently. Such a system can be further and incrementally refined over time to adjust for severity, etc.
- The case payment rate (price) for the clinical intervention should be the same for all hospitals. Other costs and price differences, e.g. related to hospital accommodation, should be kept outside the case payment. These can be accounted for through adjustment factors (e.g., for teaching hospitals or other specific types of hospitals, for remote hospitals). The price differences relating to varying hotel and amenities aspects should be paid for differently (e.g. extra-billing to be covered through out-of-pocket expenditure or via supplementary PHI insurance, see section 5.4 on the need to closely align the public UHI and PHI package).

  Specific consideration will need to be placed on how to account for the huge differences in drugs and medical supplies prices between the public and the private sector.
- The existing practice of treatment protocols for various diseases, e.g. in the PTES, is a viable strength to build upon and to be further expanded.
- Likewise, financial incentives for patient safety could also be designed as an add-on performance payment element. Hotel side aspects could be remunerated through a separate case payment rate.
- If indeed FFS is applied, it is strongly suggested to put a cap on it (i.e. a volume or a budget ceiling).
- Last but not the least, the overall objectives of the UHI, namely access to health services and financial protection, can only be achieved when balance billing is prohibited or at least successfully limited.

Across levels of care:

- Since a new referral system will be built and will need strengthening, there is also a potential for introducing financial incentives for care coordination across levels and across sectors.
- Once the final mix of payment methods is decided and finalized, it will also be important to assess their actual set of incentives they create to anticipate potential undesirable effects on provider behaviour. Potentially undesirable provider behaviour as a result of incoherent incentives resulting from this mix can be addressed through better alignment of the payment methods for outpatient and inpatient care and through care coordination incentives.

International experience also suggests that for purchasing to be more strategic, it is important to move away from facility line-item budgets to global budgets or to case payment with a cap for inpatient care.

4.2.2. Payment methods - funding for preventive and promotive care

In contrast to the health services provided under the UHI, preventive and promotive health services financed via the MOHP will continue to fall under the current Budget Law and public financial management rules, which follow an input-oriented, line item-based budget logic. Nonetheless, there are ongoing reflections on whether and how to introduce a program budgeting logic. The Government of Egypt is working on the transition towards program-based budgeting. Apparently, the government budget is presented along a program-based logic, but actual approval by the parliament is still on a line-item basis.

But as curative health services will be paid through output-based payment methods (fee for service payment or preferably case payment), whilst preventive and promotive health services will be funded (and paid) through line item budgets, health facilities (and staff) may very likely find the former more attractive (see Box 4 below on the effects of non-aligned payment incentives on provider behaviour). Generally speaking, health workers often prefer the provision of curative care over preventive and promotive care, and hence the existing imbalance in funding and attention by health workers in favour of curative care will further increase.

Box 4. Potential effects on provider behaviour due to non-aligned incentives resulting from a mixed payment system:

The MOHP will continue to provide budget allocations along a line-item basis to those "government" facilities providing preventive and promotive care. As the same health facility and in fact a same health worker will provide both curative and preventive services and as there will be hence at least two funding streams, there is a risk that this leads to undesirable provider behavior, namely resource shifting to the curative care provision (staff time, attention, medical supplies, etc.), leading to resources shortages (staff time hence longer waiting time, lack of supplies etc.) for preventive care.

Proposed actions on payment methods:

- It is suggested to align the funding streams for 1) preventive and promotive care (line-item budgeting) and 2) curative care (UHI payment methods) so as to avoid distortions in provider behaviour. If moving away from a budgeting approach based on line items for preventive and promotive care is not feasible within short time, it is suggested to add a pay for performance component to give incentives to health workers to put more emphasis on such services.
- To facilitate implementation of payments and to ensure non-conflicted set of incentives at the provider level, it is also suggested to consider making a distinction through the benefit package between Personal Vs Population based services, where the personal services whether promotive, preventive or curative are paid for by the UHI organization. This may require an amendment to the executive regulation or the UHI Bylaw.

4.2.3. Managerial aspects related to payment methods

The contracting and payment of health providers by the UHI will require various adaptations at the managerial and operational level. Government health providers will generate much more of their "own revenue" through the UHI remuneration. Currently, the collection of user charges (cost-sharing) goes to a special fund at either the facility or the District level, where PFM rules exist on how to spend these funds, including on how much of this can be used for extra payment and financial incentives of health workers. There is a range of questions to be addressed (see Box 5 below), and each of them has implications on efficiency, but they also need to be addressed in view of the facilities' managerial and financial capacity.

Box 5. Open issues/questions on managerial aspects related to payment methods to address:

- Will contracts be with health care facilities or with Healthcare Organization?
- Will facilities be able to keep their revenues (from UHI payments and cost-sharing) or will they transfer this (or a part of it) to the Healthcare Organization or to the District level, and what are the implications of these different options?
- Will each facility, especially at the PHC level, have its own bank account?
- Can they decide themselves on the use of the payments received by the new UHI?
- Do they have sufficient financial and managerial capacity to engage in billing and claims management, accounting, budgeting to manage their new revenues?
- How will government health workers be remunerated? Will the salary costs be included in the payment method(s) or will there be a separate budget line for staff salaries from the UHI? Similar questions arise for the facilities currently owned and managed by the HIO.
- Will claims be sent from hospitals directly to the UHI, or through the Healthcare Organization?
- If providers are being contracted by the UHIO and if this is meant to make purchasing more strategic, there is need to increase financial autonomy of providers. How does it match with these providers being "owned" or being "under" the Healthcare Organization?
- When hospitals become unprofitable and cannot continue to operate, what will happen to them and what will happen to the civil servants?
- Also, what hospitals are allowed to do under hospital autonomy needs to be well regulated to avoid that they focus on profit maximization and high-cost service provision?

Proposed actions:

- It is suggested to assess various scenarios and options related to the questions above to anticipate and understand potential implications, such as advantages and disadvantages, or possible provider behaviour and reactions. The Law and the Bylaw should in principle provide answers to these issues or outline the mechanisms to address these.

4.3. THE HEALTH INFORMATION MANAGEMENT SYSTEM

The current health information management system (HMIS)[10] is fragmented across levels and functions as well as organizations, with no effective overall governance. Available information also seems to be insufficiently used. Moreover, the current sub-systems are mostly paper-based and with only few software applications that would allow for inter-operability through HL7. Furthermore, most information sub-systems do not include a purchasing module. Other weaknesses include limited use of web technologies and limited skills of staff or resistance to adapt their habits to an electronic medium.

However, there is a strong emphasis in the new UHI Law to upgrade and unify the Health management information system. A huge transformation and in fact creation of a new comprehensive, integrated health information management system is in planning to encompass the three new Organizations and reflections on its design are underway. Current investments in the infrastructure renovations ensure that all facilities are equipped with software and hardware platforms and data networks that are necessary for HMIS operations.

Nonetheless, it could be challenging to completely shift from mostly non-interoperable paper-based system, to a fully automated system all at once. Many of the information system challenges were attributed to the system fragmentation that leads to duplication, waste of resources and inconsistent information (WHO 2015).

Furthermore, the information management system of the UHI Organization[11] and the Healthcare Organization needs to be in line with the payment methods used. The data requirements may differ according to the payment method, e.g. fee-for-service payments would require detailed information on services provided, whereas a per-capita method of payment would rather be more oriented towards population needs. Importantly, provider payment methods can stimulate improvements of the information system, e.g. by requiring detailed, accurate and timely data to link to payment system (Mathauer, Dale & Meessen 2017). It is thus advisable to consider the proposed payment methods for the UHI covered services as well as the preventive and promotive health services early on at this planning stage to facilitate HMIS customization.

There is also a need to specify the governance structure relating to the overall information management system to ensure continuous improvement, access to the information across the three agencies, and avoid potential fragmentation in the future.

Proposed actions regarding the HMIS:

- There is need to strengthen the institutional home for the design and implementation of health information management system and its governance within the MCIT, MOHP with strong focal points in relevant ministries and organizations.
- There is a need to establish a Steering Committee to coordinate, during preparation and early implementation period, across all ministries and actors involved and affected by the information management system. The focal points in each ministry should have a very high-level attachment.

[10] More information on HMIS and in-depth assessment of the current situation can be found in WHO 2015 (An Assessment of the Egyptian Health Information System).

[11] Moreover, the new UHI organization (UHIO), will register beneficiaries, collect contributions and receive state budget transfers, manage funds, pay providers and evaluate contracts as the principal purchasing agency. As such, the UHIO Information System will need to be designed to undertake all of these administrative and management functions with interfaces with the providers and the Healthcare Organization enrolled into the UHI system.

5. GOVERNANCE ARRANGEMENTS FOR PURCHASING

5.1. GOVERNANCE OF THE PURCHASING MARKET

Oversight structures of the three organizations and their respective relationships

When the new health system is fully implemented as per the new UHI Law, it will be much less fragmented and segmented in both financing and provision. Importantly, the UHI Law outlines in detail the oversight structures and accountability lines, which is a great strength. Nonetheless, the governance architecture, while reshuffled, continues being highly fragmented, as further outlined below and as Figure 3 reveals.

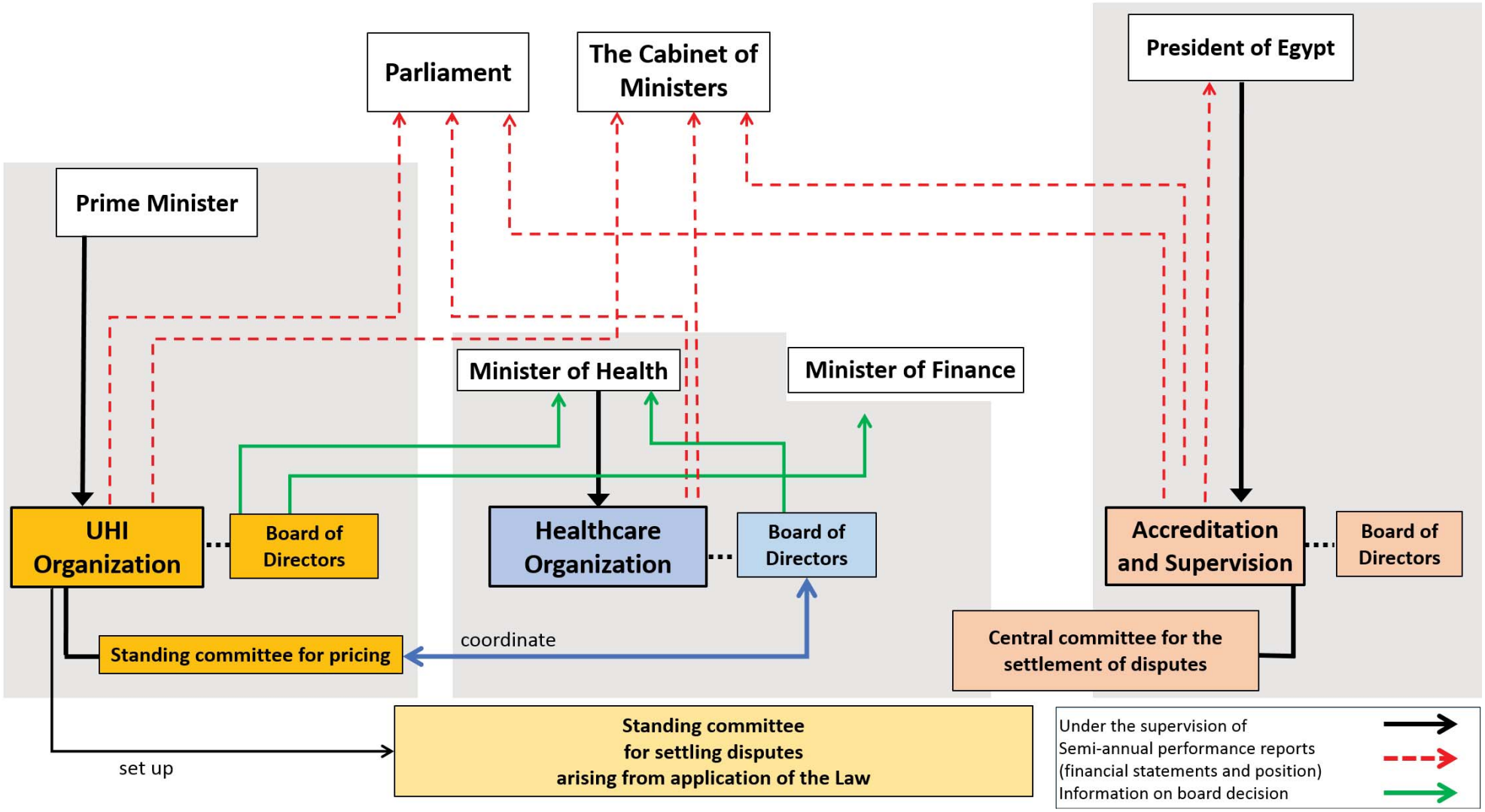
During the 15-years or so implementation phase of the Law in all governorates, the current health financing and purchasing setup will prevail and co-exist in the other governorates prior to implementation along the new system in the implementation governorates. As this will increase fragmentation and complexity during this period, there is need for strong coordination across the "old" and the "new" system with clear, properly planned, managed and integrated transitional arrangements to manage this complexity. The MOHP, the UHIO, the HIO, the MOF and others will have to closely coordinate and interact, and there will be even a greater demand for a strong stewardship role of the MOHP, while at the same time considering that the MOHP's overall role and stewardship function will be modified within the UHI context. This will provide a great challenge.

After full implementation, there will hence be two main purchasers, i.e. the UHIO for curative services and the MOHP for surveillance, preventive and promotive health services, apart from the MOHE and the Ministry of Defense, which still purchase a considerable share of health services. However, a high-level /inter-ministerial commission will still be needed to ensure governance of the purchasing market, i.e. coordination and harmonization across different schemes primarily as to payment methods and rates, benefits and regulation of service providers as well as shaping the interactions between these schemes.

The UHI Law and Bylaw outline in detail the specific roles, level of autonomy, governance and oversight arrangements for each organization. Figure 3 below visualizes the new structure.

According to the legal provisions, all three organizations enjoy a great level of autonomy. Each of the newly established organizations have an independent legal character and budget (UHI 4, 15, 26). The decision-making power across the three organizations stems from its board of directors. For all three organizations, the board of members is the supreme authority in charge of developing and implementing its policies without the need to be approved by any other body (Articles 6, 18, 30 UHI Law). Annex 4 provides more details on the boards' composition and their functions and roles. After the Boards have taken their decisions, these board decisions and resolutions have to be forwarded for information to the Minister of Health and the Minister of Finance in the case of the UHI organization, and to the Minister of Health in the case of the Healthcare organization.

Figure 3: New governance structure of the UHI system, as per the UHI Law



Source: Authors

The Law prescribes multiple accountability lines aimed at balancing the increased level of autonomy, as outlined below:

Universal Health Insurance Organization:
- Falls under the general supervision of the Prime Minister (Article 5 UHI Law).
- The organization shall submit performance reports on the financial position, after they are approved by its board, to the Cabinet of the Ministers and the Parliament (Article 14 UHI Law).
- The Board is required to publish semiannual performance report on the financial position in widely circulated newspapers (Article 48 UHI Bylaw).
- Regular audits will be performed.

Healthcare Organization:
- Falls under the general supervision of the Minister of Health (Article 15 UHI Law).
- The organization shall submit semi-annual performance reports on the medical services as well as financial statements, after they are approved by its board, to the Cabinet of the Ministers and the Parliament (Article 24 UHI Law).
- The Board is required to publish semiannual performance report on the financial position in widely circulated newspapers (Article 48 UHI Bylaw).

Accreditation and Supervision Organization:
- Falls under the general supervision of the president of the republic (Article 26 UHI Law).
- The executive director shall submit an annual report on the results of its work, after they are approved by its Board, to the President of the Republic, the Cabinet of the Ministers and the Parliament (Article 38 UHI Law).
- The Board is required to publish semiannual performance report on the financial position in widely circulated newspapers (Article 48 UHI Bylaw).

Additionally, as most public entities in Egypt, the three organizations are subject to the supervision of both the Ministry of Finance and the Accountability State Authority (Article 58 UHI Law).

In sum, the Law and Bylaw are very specific on the oversight and accountability arrangements, and this is a strength. Nonetheless, these governance arrangements are complex in that a multitude of actors are involved. It will have to be seen in practice that the multiple actors find a functional division of labour and an effective mode of collaboration.

While it is envisioned that the MOHP will maintain its role as the principle regulator of national health policies and steward for the whole health system, it is yet unclear how the MOHP will undertake this role within the new framework of the UHI system and by which instruments. As explained, while the MOHP is the general supervisor of the Healthcare organization, all decisions are taken by its independent board members. Moreover, across the boards of the three organizations, it is noted that the MOHP can provide only one vote, as outlined in Annex 4. As such, the MOHP's influence and voice on the UHI Organization becomes relatively weak.

The MOHP budget structure and sources will tremendously change (and possibly reduce): the funds for salaries, operational costs and supplies for curative care that were part of the MOHP budget will be removed after a transition period. This has also implications on the self-conception of the MOHP.

Problems may arise when national health policies contradict or are not in compliance with the newly established Organizations' individual direction. For example, a profit maximization behavior from providers may focus on providing more profitable curative services as opposed to a national policy that focuses on early detection and preventive measures. While the MOHP still has sufficient authority to initiate laws or enact decrees, it could have a minimal influence, if any, in decisions related to, for example,

pricing, payment system, benefit package design, etc. Such decisions should not be regarded merely as technical exercises that are based on evidence generation on cost or budgetary impact and negotiation between the purchaser and provider. Instead, an active/strategic purchasing role implies that purchasing decisions are guided and in compliance with the national priorities and health policies, e.g. to incentivize practices on early detection, and dis-incentivize overprovision of certain services, such as overuse of C-section.

On the other hand, it is noted that the Boards' composition does not have sufficient civil society or patient group representation. The Law foresees only two members in the Healthcare Organization from the civil society, one of them to be a professor from a medical school. However, a representative from academia, which is very important and recommendable, is not to be equated with a civil society representative. This could be initially a good start, but ideally more representation for civil society and patient groups would be suggested, not just for the Boards but also to have a role in other committees such as those related to benefit entitlements.

In anticipation of the disputes that may arise from the application of the Law, it is positively noted that the establishment of a standing committee for the settlement of disputes is possible. It would be chaired by one of the vice presidents of the Council of State and with representation from all three organizations and the party of conflict (Articles 60 UHI Law and 69 UHI Bylaw). This committee will presumably focus on major issues such as pharmacy practice, private insurance status, etc.

Proposed actions regarding the governance of the purchasing market:

- It is suggested to clearly specify and give a strengthened role to the MOHP as steward that is in charge of regulation and overall supervision and ensuring public health functions (surveillance, prevention and promotion)
- While the MOHP is in charge of coordinating the preparations of the implementation, it is suggested to further formalize the coordination responsibilities and coordination structure across the "old" and "new system" during the implementation phase.
- There is need for a high-level commission, preferably chaired by MOHP, for coordination and mediation across the Organizations and for taking decisions on key policy issues that will arise during the implementation of the Law and thereafter. In particular, there is continued need to steer the purchasing market (with the key purchasers being the UHI Organization, the MOHP, the MOHE, the Ministry of Defense as well as PHI schemes), for which a coordination body is required.

5.2. GOVERNANCE OF THE UHI ORGANIZATION

Moving towards a more strategic role for the UHI organization would require a clear mandate and legal provisions to do so. While the Law does not mention specifically the UHI Organization to be a strategic purchaser, it provides the legal provisions to undertake such a role. The Law establishes the UHIO as a single purchaser for all UHI covered services creating a potentially large enough pool that could influence the healthcare market with its purchasing power and increased efficiency. The Law

has also minimized the compliance with rigid public financial management PFM rules and regulations in that regard (Article 11 UHI Law), giving more flexibility towards output or performance based financing. Nonetheless, it would not harm if the Bylaw or another policy document would clearly spell out a mandate for the UHI Organization to be a strategic purchaser and clarify that the objective of expanding coverage and improving financial protection is equally important as achieving a financial balance.

The UHI fiscal space will be constrained as per the multi-year trajectory based on the 15-year actuarial estimates. As per these estimates, it is envisioned that during the implementation period, the UHIO will be able to meet its commitments to providers while maintaining its actuarial balance.

According to the Law, the financial status of the UHI system shall be reviewed actuarially at least once every four years. The UHI Organization shall be "committed to taking all possible measures to ensure the annual financial balance of the system". In case of a deficit, the review should be presented to the parliament to consider any amendments to overcome budget shortfalls on the revenues or expenditures side (Article 44 UHI Law). In addition, the Law also strengthen the position of UHIO by obligating timely revenue collection as well as penalties on delayed payments from concerned entities and individuals (Articles 42 and 43 UHI Law). Overall, this suggests that the UHIO is faced with a credible budget constraint to meet its obligations.

In principle, the UHI Organization also requires a reasonably stable and predictable expenditure pattern. This may include a multi-year contractual agreement and/or a multi-year agreement on provider payment methods to bring about improvement in performance at both provider and purchaser sides. It may be understandable, however, that it will be hard to commit to such medium- or long-term agreements during pilot governorate and perhaps the first stage of implementation, but this should be regarded as a medium to long-term objective.

The reporting lines have been presented in Section 5.1 and are geared towards ensuring accountability towards various key government actors. It will be important that the multiplicity in reporting lines will lead to reinforced accountability rather than weakening it. Likewise, the oversight arrangements of the UHI Organization have been discussed in Section 5.1. Regarding the composition, from the 15 oversight board members, 5 are state representatives, 3 are representatives of employers and employees, 3 are called upon as technical experts. The UHI Organization has two seats; the Healthcare Organization and the private sector have each one seat. As noted, the MOHP is only represented with one seat, as such not giving it a strong role. It is noted that there is no direct representative from beneficiaries/members as such. Hence, persons from the informal economy that are outside organised trade union structure have no specific voice. Participation and accountability towards the public could also be enhanced through the establishment of a feedback mechanism within or outside the UHI Organization. Citizen consultations are another option to gather views from the population. Finally, experience from other countries suggests that focus needs to be placed on the functionality of the Board that sets strong and clear strategies ex-ante rather than turning into a mere formal control organ of the UHI Organization. The Law prescribes and specifies a variety of roles and tasks of the oversight board, which suggests that indeed this Board should take on a very strong role in steering and guiding the operations of the Organization.

The legal provision provides flexibility and influence for the UHI organization to shape the healthcare market. In this context, the Law strengthened the role of the Board of

UHIO in the decision process of determining the benefit package and pricing of services, etc. (Articles 3, 6 UHI Law) (see also sections 4.1.1 and 4.2.1 for detailed recommendations). The Law also grants the UHIO to engage in selective contracting of health providers. As envisioned, the UHIO contracts with health facilities for a period of three years and contracts are renewable subject to fulfilment of agreed quality and other performance standards. The UHIO is also granted the judicial police status to be able to check the books and records of providers and to ensure that a provider complies with contractual agreements. This also allows for competition between all facilities whether or not they belong to the healthcare organization (see also next section).

The increased level of autonomy of the UHI Organization has to be commensurate with its capacity as well as with an increased level of accountability. In practice, HIO personnel who performed relevant functions will be transferred to the new UHI Organization (Article 8 UHI Law). Therefore, it would be necessary to consider a comprehensive capacity building to staff to ensure smooth transition to respond to the new shift in responsibilities. Finally, experience suggests that a performance contract for the Chief Executive Officer is a useful tool to strengthen accountability and achievement of objectives of the Organization.

In sum, there are many strong elements for good governance of the purchasing function, but more is feasible and needed within the given context.

Proposed actions regarding the governance of the UHI Organization:

- It is proposed to strengthen participation and accountability mechanisms towards the public, e.g. through the establishment of feedback mechanisms within or outside the UHI Organization.
- It is suggested to organize citizen consultations on a regular basis to gather views and suggestions from the population.
- It would be useful to further spell out and specify the objectives and mandate of the UHI Organization, mentioning both a financial equilibrium as well as expansion of coverage and improvement of financial protection.
- It is proposed to use a performance contract for the Chief Executive Officer of the UHI Organization as a way to strengthen accountability and achievement of objectives of the Organization.

5.3. GOVERNANCE ARRANGEMENTS RELATED TO THE PROVIDER LEVEL

The provider market structure under the new Law will be reshaped by the creation of the new Healthcare organization. It will consist of the new healthcare organization facilities (those formerly owned by the HIO or Affiliated to MOHP) as well as health facilities from the private sector, university hospitals under the MOHE, and health facilities belonging to the armed forces and the police, etc. Only healthcare organization facilities will fall under the general supervision of the Healthcare Organization and will fall under its judicial and administrative inspection, whereas the other health facilities mentioned above will maintain its independent status. The board of directors for the Healthcare Organization will contribute to major managerial decisions with regards to the conglomerate of hospitals that fall under its supervision,

such as establishing the system of wages, propose the fees of medical services, adopting the organizational structure, etc. Therefore, the level of financial and managerial autonomy given to hospitals under the Healthcare Organization needs to be clarified for smooth transition phase.

For those hospitals not falling under the Healthcare Organizations (University Hospitals, Police and Army Hospitals, private and NGOs hospitals), it will be important to ensure harmonizing quality standards. Ideally, they would all fall under the same quality standards and follow the same regulations for UHI.

In general, health care professionals working both in the public and private sector have to get licensed by the MOHP and registered with their relevant syndicates in order to practice their profession. Since joining the new system as a provider will be on voluntary basis and since some providers may still operate outside the new system, the current practice under the old system will continue in this regard. With the introduction of the new Law, both health facilities and health professionals need to be accredited/registered by the Accreditation Organization in order to join the UHI system. Accordingly, they fall under the supervision and monitoring of the Accreditation Organization and are subject to its administrative inspection (Article 28 UHI Law). In addition, health facilities shall fall under the judicial and administrative inspection by the UHI organization (Article 19 UHI Bylaw).

In principle, there needs to be a clear separation of roles and authority between the regulatory bodies. In this case, the MOHP, the medical syndicates, the UHI Organization and the Accreditation Organization were all given the supervision and control, though each with a slightly different mandate. Hence, the institutional and functional relationships between different regulatory bodies need to be very clear so as to avoid potential incoherences and conflict between these parties.

Furthermore, private sector facilities, which play an important role in healthcare provision, are subject to various regulatory bodies within the health sector and beyond, according to the type of facility and economic orientation, i.e. for profit, not-for-profit (WHO 2014, p.17). A complete assessment of the private sector regulation is available in the WHO report (WHO 2014).[12]

This new market for healthcare provision will require major changes and increase the autonomy, in particular to some of the Healthcare organization hospitals (formerly General and District MOHP hospitals) since these hospitals used to have little autonomy in the old system. This level of increased autonomy, in principle being a favorable condition for strategic purchasing to be able to respond to signals from the purchaser, has to be balanced with close supervision and monitoring by the Healthcare Organization and the MOHP as well as effective upward accountability mechanisms.

Therefore, apart from the settlements dispute committee as in article 60 UHI Law and article 69 Bylaw, there also needs to be an established patient appeal mechanism to report on issues, e.g., balance billing practices, patient discrimination, etc. The Law granted certain channels through the UHIO branches, for patients to complain or report certain incidences that may occur during the interaction with system (Article 17 UHI Bylaw). For an effective patient complaint or grievance redress mechanism, it needs to be more detailed, perhaps in further internal regulations or Bylaws, to ensure the proper operationalization.

[12] Assessing the regulation of the private health sector in the Eastern Mediterranean Region, Egypt" accessed from: http://applications.emro.who.int/dsaf/EMROPUB_2014_EN_1757.pdf?ua=1 .

One important measure, among others, to strengthen the monitor and control to providers, is that the Law also grants the Accreditation Organization the right to publish information on the quality and performance of health facilities and make it accessible for the public.

Again, there are many important arrangements in place to govern the provider market, but more is feasible and needed in the given context.

Proposed action points regarding the governance of the provider market:

- It is suggested to put continued attention on supervision and regulation of the quality of private sector providers through the MOHP, also for those not contracted by the UHI Organization.
- There is need to set up a health service delivery map with all providers that will help to improve the equal distribution of private sector providers across the country to be more in line with need.

5.4. REGULATION AND SPECIFICATION OF THE ROLE OF PRIVATE HEALTH INSURANCE

The UHI Bylaw (Art. 18 - paragraph 1) prescribes complimentary and supplementary roles to private health insurance (PHI)[13]: *"All natural, legal persons or administrative bodies may enter into contracts with private insurance companies located within the Republic to take advantage of them to pay the difference in the prices of the cost-sharing borne by the patient or the difference in the cost of the insurance class for a stay in hospital or receipt of other supplementary services."*

Table 3 below translates this into the various roles of PHI. Annex 5 provides more detailed definitions of the different roles of PHI.

Table 3: Definitions of various roles of private health insurance

Difference in the prices of the cost-sharing borne by the patient	= complementary PHI (for user charges of services covered by the UHI)
Difference in the cost of the insurance class for a stay in hospital	= supplementary PHI (for a higher level of inpatient amenities)
Receipt of other supplementary services	= complementary PHI (for services that are not covered by UHI)

This Article is important and strengthens the UHC orientation of the new Law by defining the envisaged roles for PHI. However, a pre-requisite for complementary and supplementary voluntary health insurance (VHI) roles to be conducive for UHC is a "health financing policy framework that provides clarity on what will be publicly funded so that the space for the VHI market to be able to provide *additional* coverage is identified, with the aim of VHI funds being complementary to public funds" (Mathauer & Kutzin 2018). It will also be critical to explicitly limit subsidies to better-off people for PHI premiums. Further regulation, in particular on payment methods and rates, can help restrain potential cost escalations. When payment methods and rates paid

[13] The actual technical term as per the System of Health Accounts is voluntary health insurance (OECD/Eurostat/WHO 2011). However, in this report, we use the term "private health insurance", as this is the term used in the Law and in policy discussions.

by PHI are much higher than those by the UHI system, potential side effects of an increasing PHI market are spill-over effects on the entire health system, such as a brain drain of health workers from the public to the private sector.

Moreover, while benefitting its members, PHI may negatively affect the health system by contributing to or reinforcing a two-class system because people with PHI coverage have enhanced access to larger benefits including privately delivered health services. Finally, it will be important to carefully consider whether complementary PHI (cost-sharing) should be allowed to cover the full cost-sharing part.

There is also some concern about the second paragraph of Art. 18 of the Bylaw: *"The authority shall purchase health services for the owners of the insurance systems or private health programs, whether the service is provided in the authority's hospitals or the hospitals of these systems."*

This provides room for interpretation: Do the owners of a PHI policy pay contributions to UHIO, but will continue getting their benefit package as defined by their PHI? Does it mean that the new UHIO will purchase these health services, assumingly at higher provider payment rates to (private) hospitals under or contracted by PHI at higher quality standards? In other words, while these affiliates would pay the same contributions rates to UHIO, their benefits will be more costly in that segment of service provision. This may lead to some undesirable cross-subsidization by the UHIO to PHI policy holders, i.e. their average p.c. health expenditure will be higher than the average p.c. health expenditure for ordinary UHI members, assuming that health risks of the former are the same or even lower than the latter's.

PHI is supervised and regulated by the Egyptian Financial Regulatory Authority, whilst there is a General Private Health Insurance Law under development, but this is not yet endorsed. At the same time, it will be important that health stewardship actors are more involved in the supervision and regulation of private health insurance.

Overall, various issues and questions remain open, but should be addressed rather soon, as outlined in Box 6.

Box 6. Open issues/questions to address

- How to continue working with PHI companies and private companies that have offered so far substitutive coverage? How to continue working with private companies offering care to their employees?
- Will higher prices/remuneration rates be paid to Parastatal based or private hospitals?
- How to regulate payment methods and reimbursement rates of private sector providers so as to avoid spill-over and distortive effects on the overall health system?
- How to ensure that providers do not prioritise and prefer to treat patients with PHI coverage that often comes along with higher provider payment rates ("cream-skimming")?
- How to ensure that data on service use and payments for PHI patients are reported in national health information systems?
- How to limit inequities in access to health services between those with PHI coverage and those without, especially if this is just for the rich?
- In the case of complementary coverage (for user fees), how can unnecessary service use be managed?

Proposed action points regarding PHI regulation:

- The UHI benefit package needs to be clearly defined for the PHI market to provide additional and appropriate coverage.
- There is a strong need to further specify the complementary and supplementary role of private health insurance (PHI) to align UHI and PHI benefit packages. Specifically, cost-sharing at higher level through bypassing PHC should not be covered by complementary health insurance.
- Aspects related to higher quality/higher accommodation classes of hospitalization beyond the basic quality standards and necessities should be covered by the patient (through out-of-pocket or through supplementary PHI).

5.5. IMPLEMENTATION PROCESS ASPECTS RELATING TO PURCHASING AND GOVERNANCE

The UHI implementation is incremental in view of the geographical extension, starting with one governorate and including a limited number of governorates every couple of years. Nonetheless, within a governorate, the envisaged transformation of the health systems is massive, requiring enormous modification, adjustments and alignment across functions within that geographical area.

It is also noted that the envisaged implementation period of 15 years is long. The current ("old") system will continue to be in place for the whole implementation period (in increasingly fewer governorates, but central/headquarter functions will have to exist until the very end). And they will have to co-exist with the "new" organizations and structures. This may likely create huge coordination and transaction costs. The long implementation period may create risks for potential distorting effects among providers, patients/citizens as well as among the "old" organizations versus the "new" ones:

- Private providers (e.g. laboratories, radiologists, specialists in their private office and new hospitals) may equally prefer to focus their service provision on governorates that are under the earlier stages of implementation. This may affect the existing service provision in these governorates, but possibly also lead to insufficient availability in those governorates of later implementation stages.
- The population may be dissatisfied with a relative increase in inequities between those covered already by the new UHI and those still having to wait. Key informants raised the concern that people may want to move to those governorates under UHI implementation.
  Importantly, for people under the new Scheme, but seeking care outside their governorate, special arrangements will be set up to ensure access to the new UHI, and this is an important trust building aspect. Nonetheless, such arrangements will contribute to the complexities of running to parallel systems.
- Of high concern is also the fact that this long implementation period will imply that the "old" and the "new" system will continue to exist in parallel for a very long time. This will create

enormous coordination costs, but also increase overall (administrative) costs as two parallel systems will co-exist for 15 years. It may also lead to a further mix in payment methods and thus set less coherent incentives for provider behaviour than desired. Box 7 below illustrates such potential effects.

Finally, one specific concern relates to the PTES in the remaining governorates waiting for implementation. Over the course of the 15 years, there will be price increases, and so the PTES would also require an increased budget, since it is already suffering from funding gaps towards the 4th term in the year.

Box 7. Potential challenges of a non-aligned provider payment mix – the example of University Hospitals:

Under the new system, the University Hospitals will continue to get their funds from MOHE through line item budgets, from UHI payments for patients under the new UHI system, as well as from the HIO for patients that are not yet covered under the new scheme, (in case the University hospital is covering several governorates that are under different stages in the UHI implementation plan). The payment rates of the various purchases vary: those under the UHI system are higher (in principle a good development), but as such they are hence quite likely more attractive for providers who may start preferring to treat UHI patients (cream skimming) and engage in resource shifting for this patient group.

It is noted that the UHI Bylaw foresees the establishment of several inter-ministerial committees to manage specific issues relating to the transition, e.g., articles 5, 50, 51, but none of them mentions specific purchasing related arrangements such as the setting of payment methods.

Proposed action points regarding the implementation process:

- It is suggested to assess the implications of the 15 years implementation period and to possibly consider expediting the implementation period and/or consider transitional solutions in the governorates prior to implementation. Also, comprehensive transitional arrangements need to be in place with efficient planning, management and coordination.

  Port Said could serve as a pilot, followed by implementation of stages 2-3, with adjustments, then move quickly to stages 4-6.

6. CONCLUSIONS

6.1. SHORT SUMMARY

The promulgation of the new UHI Law stimulates major progress towards achieving UHC. By the full implementation, it is envisaged that all Egyptians will be covered with quality health services while ensuring adequate level of financial protection. Moving along the gradual implementation process would entail major transformation and coordination between the old and new system. Hence, for effective implementation, it is crucial to anticipate implications from the application of the legal provisions and to develop possible options to address potential challenges or bottlenecks that may arise. The following sections provide a summary of recommendations on strategic purchasing and governance of strategic purchasing to inform the UHI implementation process.

6.2. PROPOSED WAY FORWARD

This section consists of three types of recommendations:

1) High level action points to facilitate the implementation of the UHI Law and the transformation of the health system
2) Specific action points on the four strategic purchasing areas (benefits design, payment methods, information management systems, governance arrangements for strategic purchasing).
3) Specific options on technical aspects

All action points are categorized into short-term, medium-term and long-term orientations.

Ad 1) High-level action points

1. **Establishment of a National high-level multi-stakeholder commission which clarifies a range of issues and takes decisions along the start of the implementation on core policy aspects**

A high-level multi-stakeholder/inter-ministerial commission will be needed to complete the needed specification for the UHI Law implementation. The most important specifications relate to the benefit package design process and the setting of payment methods and rates and the ultimate revision process required over time, for which the existence of specific independent committees would be advisable (see the next section for details).

Some of the core decisions as well as open issues/questions presented in Chapter 4 could be taken by the Standing Committee as foreseen by article 69 of the Bylaw. However,

we propose a higher-level commission to decide on critical and path-defining policy issues that is chaired by the MOHP.

2. **Setting up of an implementation working group on strategic purchasing that reviews, discusses and further develops the proposed high-level action points as well as the specific action points**

The objective is to feed into the development of the implementation plan and to support the actual implementation. This working group would also ensure follow-up and seeking of technical support to various action points where needed.

3. **Development of a joint and integrated implementation plan for all ministries and Organizations involved in purchasing, including a monitoring & evaluation plan**

There are several implementation plan initiatives and numerous committees working on various threads. It will be important to bring together all of these initiatives into one joint and integrated implementation plan for all ministries and organizations.

4. **Development of a comprehensive capacity strengthening plan related to strategic purchasing and governance**

The UHI implementation implies major transformations and changes of the health system. Overall, more knowledge and expertise in strategic purchasing will be required. A capacity strengthening plan needs to be developed based on needs assessment for various sectors and functions (e.g., for claims management by providers, hospital financial management, pricing committee, IT skills of various staff on the purchaser and provider side).

There is also need to accompany and support the organizational transformation via institutional-organizational capacity strengthening. Making use of existing expertise and skills in and outside of government will be valuable, for example the collaborations and use of the existing capacities in private health insurance companies to support certain functions, or the use of managerial capacities in semi- and fully-autonomous MOHP hospitals.

5. **Communication and engagement with all stakeholders and above all the public on the Law and its implications related to purchasing**

The people of Egypt need to understand what services are covered, what cost-sharing rules and referral mechanisms apply (including the rules relating to balance billing). They also need to know of their rights in terms of providing upward feedback and raising complaints. The Law needs to be communicated in a clear and simple way to get people's buy in and support. Increased acceptability and understanding of the UHI Law will also enhance and facilitate enrolment and payment of contributions to UHI.

Likewise, a comprehensive communication strategy needs to engage the wide-range of health services providers, especially those outside the umbrella of the healthcare organization, such as private hospitals, NGOs, Solo practitioners, etc. This needs to clarify the roles and responsibilities of the providers as well as the requirements to join the new system.

6. **Launching a comprehensive organizational development of the UHI Organization with clear mandates, organizational structures, duties and responsibilities.**

For the UHI Organization to be ready when the actual implementation starts, its actual organizational structure and respective tasks, responsibilities and operations of the various departments and units need to be specified and filled with skilled staff.

7. **Alignment of the reforms related to the purchasing function with changes in revenue raising and pooling as well as alignment across the four strategic purchasing components (operationalisation of benefits, payment methods, information management system, and governance arrangements for purchasing)**

Alignment means that reforms and improvement measures relating to the revenue and pooling function are also assessed in relation to their implications and impact on the purchasing arrangements, and vice versa. Likewise, changes in the payment system will have implications on the information management systems and potentially require supportive governance related measures. The inter-actions and various effects of one measure across other areas of health financing and purchasing thus need to be well anticipated and accordingly addressed where needed.

High-level action points	S	M	L
1. National High Level Multi-Stakeholders Commission	■		
2. Strategic purchasing technical working group to discuss and develop action points	■		
3. Joint, integrated implementation plan		■	
4. Development of a comprehensive capacity strengthening plan	■	■	■
5. Communication plan with key stakeholders and the public	■	■	■
6. Comprehensive organizational development of the UHI Organization	■		
7. Alignment of the reforms across functions and SP components		■	■

*S: Short term, M: Medium term, L: Long term

Ad 2) Specific action points related to key decisions to take

This section summarizes all action points from Section 4 and 5 into the table below and gives in indication of their time-horizon (short-, medium-, or long term).

Benefit package design	*S	M	L
Establish a benefit package committee in charge of defining, specifying/ operationalizing and over time reviewing the benefit package			
Define the process and the criteria for defining and specifying benefits and consider how to involve citizen / patient representatives in this process			
Expand the current HTA work and organize it independent from a purchaser or from providers and pharmaceutical actors			
Referral system			
Further specify the referral lines from lower to higher levels and from primary care level to specialized private doctors			
Specify which hospital types will shift under the Healthcare Organization and consider potential harmonization needs across different hospital types to facilitate contracting and transparency			
Cost-sharing			
Consider the reduction of copayments for generic (therapeutic equivalent) medications to induce more efficient use of resources			
Further differentiate and set lower Copayments for specific population groups (e.g. children) or for priority services			
Consider adjusting cost ceilings with income level, rather than being the same across all income groups			
Payment methods			
Explicitly specify (through executive regulation) the procedures for determining and reviewing the payment methods and rates whether by an independent multi-stakeholder commission or in negotiation between the UHIO and the Healthcare organization/providers			
Clarify (through Executive Regulation) the composition process of the standing pricing committee to ensure diverse expertise beyond cost accounting			
Align the funding streams for preventive and promotive care (line-item budgeting) and curative care (UHI payment methods) so as to avoid distortions in provider behaviour			
Consider (through executive regulation) the distinction between personal versus population-based services, where all personal based services (whether promotive, preventive and curative) are paid for by the UHI organization			
Address managerial aspects related to payment and contracting			

Health and Management Information System	*S	M	L
Strengthen the institutional home for the design and implementation of HMIS and its governance within the MOHP, MCIT with strong focal points in relevant ministries and organizations		■	
Establish a Steering Committee to coordinate, during preparation and early implementation period, across all ministries and actors involved and affected by the information management system. The focal points in each ministry should have a very high-level attachment	■		
Governance Arrangements for Purchasing			
Clearly specify and give strengthened role to the MOHP as a steward that is in charge of regulation and overall supervision and ensuring public health functions	■		
Further formalize the coordination responsibilities and coordination structure across the “old” and “new system” during the implementation phase	■		
MOHP to continue to supervise and regulate quality of providers that are not contracted with the UHI system	■	■	■
Set up a health services delivery map including all providers to help improve equal distribution of health service provision across the country that is in line with population need	■		
Further specify the complimentary and supplementary role of PHI and to align the UHI and PHI benefit packages. Cost sharing at higher level of care through bypassing PHC, if allowed, should not be covered by PHI	■		
Higher quality/special hotel related aspects of hospitalization beyond the basic quality standards and necessities should be covered by the patient (through out-of-pocket or through supplementary PHI)	■		
Assess implications of the 15 years implementation plan and consider expediting the implementation period and/or consider transitional solutions in the governorates prior to implementation. Port Said could serve as a pilot, followed by implementation of stages 2-3, with adjustments, then move quickly to stages 4-6	■	■	■
Strengthen participation and accountability mechanisms towards the public, through the establishment of a feedback mechanism within or outside the UHI Organization	■	■	■
Consider the organization of citizen consultations on a regular basis to gather views from the population	■	■	■
Spell out and specify the objectives and mandate of the UHI Organization, mentioning both a financial equilibrium as well as expansion of coverage and improvement of financial protection	■	■	■
Establish a performance contract for the Chief Executive Officer of the UHI Organization to strengthen accountability and achievement of objectives of the Organization	■	■	■

*S: Short term, M: Medium term, L: Long term

Ad 3) Proposed options on specific technical aspects

Benefit package design
Cover all health services provided at primary care level and establish positive or negative lists for the covered higher level care services
Make health services at higher level of the health system only accessible on the basis of a strict referral process
If access to higher level of care is permissible under certain circumstances, higher copayment rates are to be imposed for bypassing the primary care level
Payment methods
For outpatient care:
Apply a blend of partial capitation and FFS for priority interventions (e.g. early detection, hypertension management, antenatal care) plus performance payment
When capitation payments are applied: introduce risk-adjusted per capita payment for age, sex and other morbidity characteristics of the catchment population
Combine partial capitation with provider choice for a defined period (e.g. 6 months, or 1 year)
For inpatient care:
If case-based payment is chosen, start implementing a case-based payment system using existing data on procedures/diagnosis and cost
Treat and pay for cases where there are consistent outlier costs differently
Incrementally refine the case-based payment system over time to adjust for severity and other aspects
Pay the same case-based payment rate for the clinical intervention to all hospitals, and pay separately for costs and price differences (outside the case payment)
Pay incentives for patient safety (pay for performance) as an add-on payment element, and pay differences in hotel side aspects separately, whilst considering potentially increased ALOS
If indeed FFS is chosen, Set a budget ceiling, either for types of hospitals or for health services
In any case: Prohibit or strongly limit/regulate balance billing and effectively enforce it
Build upon and expand the existing practice of treatment protocols for various diseases

REFERENCES

Central Agency of Public Mobilization and Statistics (2018). Egypt in Figures. CAPMAS

Kutzin J (2013). Health financing for universal coverage and health system performance: concepts and implications for policy. Bulletin of the World Health Organization, 91, 602-611.

Mathauer I, Kutzin J (2018). Voluntary health insurance: potentials and limits in moving towards UHC. Health financing policy brief No. 5, Geneva: World Health Organization. http://www.who.int/health_financing/documents/voluntary-health-insurance/en/

Mathauer I, Dale E, Jowett M, Kutzin J (2019) Purchasing of health services for Universal Health Coverage: How to make it more strategic? Policy Brief, Department of Health Systems Governance and Financing, Geneva: World Health Organization. (WHO/HGF/PolicyBrief/19.6).

Mathauer I, Dale E, Meessen B (2017). Strategic purchasing for universal health coverage: key policy issues and questions: a summary from expert and practitioners' discussions. World Health Organization. http://www.who.int/health_financing/documents/strategic-purchasing-discussion-summary/en/

Mathauer I, Dkhimi F (2019). Analytical guide to assess a mixed provider payment system, Guidance Document, Department of Health Systems Governance and Financing, Geneva: World Health Organization (WHO/UHC/HGF/Guidance/19.5).

McIntyre D, Kutzin J (2016). Health financing country diagnostic: a foundation for national strategy development. WHO: Geneva (WHO/HGF/Guidance Document/16.1), http://www.who.int/health_financing/documents/country-diagnostic/en/

OECD, Eurostat, WHO (2011). A System of Health Accounts: 2011 Edition: OECD Publishing.

Rafeh N, Williams J, and Hassan N. (2011). Egypt Household Health Expenditure and Utilization Survey 2010. Bethesda, MD: Health Systems 20/20 project, Abt Associates Inc.

Thomson S (2010). What role for voluntary health insurance? In: Kutzin J, Cashin C and Jakab M (Eds) Implementing health financing reform: lessons from countries in transition: 299-326.

Terwindt F, Rajan D, Soucat A (2016). Priority-setting for national health policies, strategies and plans. Chapter, in Schmets G, Rajan D, Kadandale S. (eds): Strategizing national health in the 21st century: A handbook. A UHC Partnership Resource, Geneva: World Health Organization.

World Health Organization (2014). Assessing the regulation of the private health sector in the Eastern Mediterranean Region: Egypt. World Health Organization. Regional Office for the Eastern Mediterranean.

World Health Organization (2015). Assessment of the Egyptian Health Information System. World Health Organization. Representative office in Egypt.

World Health Organization (2016). scaling up family practice: progressing towards universal health coverage (No. EM/RC63/Tech. Disc. 1 Rev. 1). World Health Organization. Regional Office for the Eastern Mediterranean.

World Health Organization (2019). Analytical framework to assess governance for strategic purchasing, Guidance document, Geneva: World Health Organization (WHO/UHC(HGF/Guidance document/19.6).

ANNEXES

Annex 1: Full list of key respondents

Ministry of Health and Population (MOHP)

Dr. Ahmed Mohie El Kased	Undersecretary Curative sector MOHP
Eng. Dr. Mohamed Abdel Rahman	Project manager for Portsaid project for Infrastructure
Eng. Wael Shehata	Head of the National Information Center for Health and Population
Dr. Emad Kazem	Head of the Programme for the Treatment at the Expense of the State (PTES)
Dr. Mona El Naka	Former head of the Central Administration of Primary Care
Dr. Gihan El Sissy	Former head of the Pharmaco-economic unit in the Central Administration of Pharmaceutical Affairs (CAPA)
Dr. Nevine El Nahas	Assistant Minister and head of the Technical Office of the Minister of Health and Population

Health Insurance Organization (HIO)

Dr. Mohsen George	Former vice president of the Health Insurance Organization

Ministry of Finance

Dr. Ehab AbouAish	Vice Minister of Finance for Public Treasury
Ms. Mai Farid	Assistant Minister for Economic Justice
Mr. Ali El Sissy	Head of General Budget Sector

Private Sector

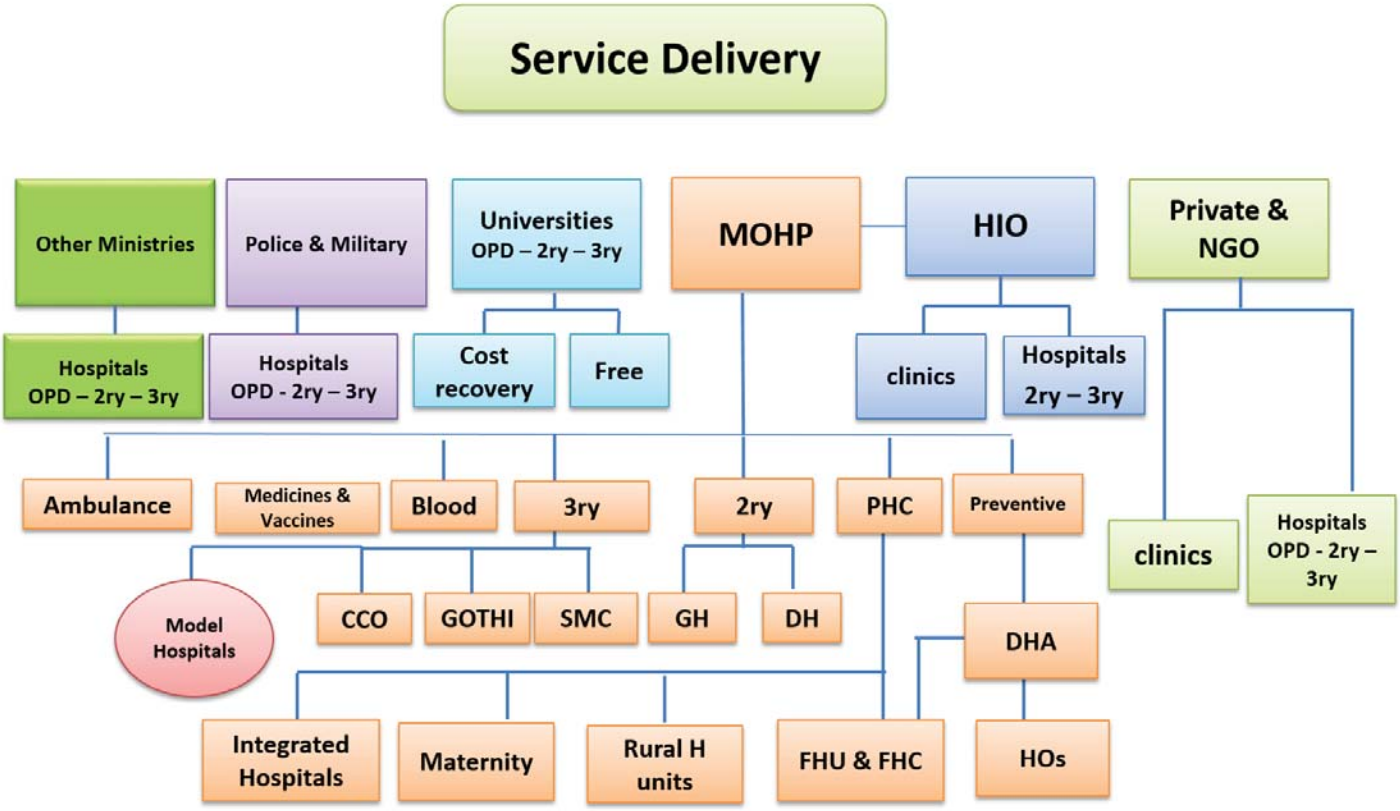
Dr. Alaa Abdel Meguid	Head of the Chamber for Health Private Providers

Consultants/ Experts

Dr. Magdy Bakr	WHO Consultant on Health Systems Strengthening
Dr. Gasser Gad El Karim	Technical Officer, Health Systems Strengthening,WHO Representative office Egypt
Dr. Wagida Anwar	Representative of the UHI Law drafting committee
Dr. Sahar Ezz EL Arab	WHO HIS consultant

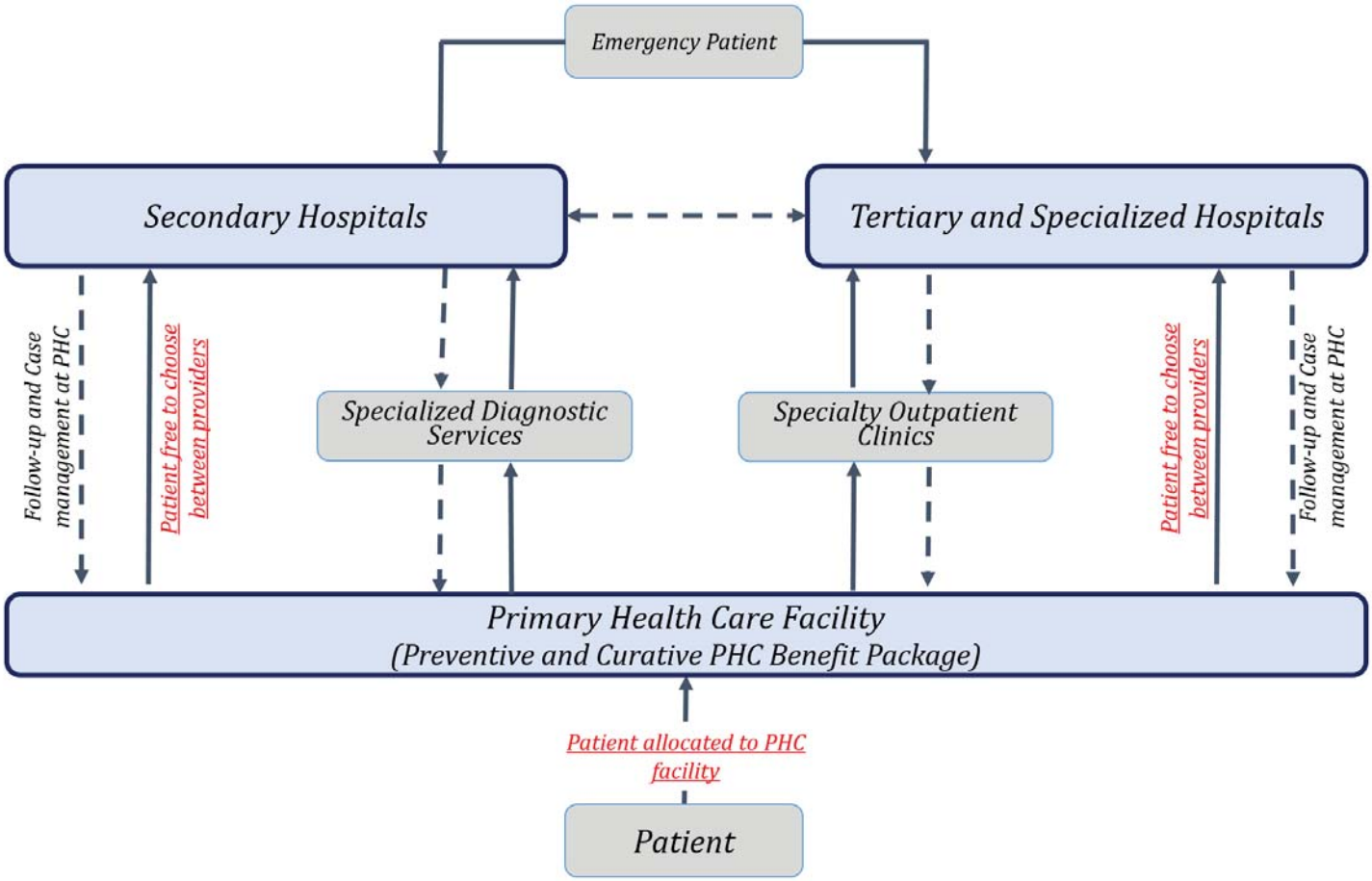
Costing/Pricing Committee Members

Annex 2: Overview of service provision in Egypt



Source: Bakr 2018. For acronyms, see the list of abbreviations.

Annex 3: Referral path



Source: Authors

Annex 4: Composition and tasks of the Boards of Universal Health Insurance Organization, Healthcare Organization and Accreditation Organization

Universal Health Insurance Org.	Healthcare Organization	Accreditation organization
Board composition		
– President (Pres) of the UHI Org – Vice-President (VP) of the UHI Org – President of the Healthcare Org. – 1 of the VPs of the Council of State (CoS) selected by the CoS President – President of the Trade Unions – President of the Federation of Chambers of Commerce – President of the Federation of Industries – President of the State Budget Sector at the MOF – 1st Undersecretary of MOHP – 1st Undersecretary of the Min of Social Solidarity – 1st Undersecretary of the Min of Manpower – A service provider rep in the private sector – A health economics expert – 2 finance and investment experts, one being an actuarial healthcare expert	– President and Vice President (VP) of the Healthcare Org. – VP of the UHI Org – 1 of the VPs of the CoS selected by the Pres of the CoS – Pres of the Egyptian Medical Syndicate – Pres of Egyptian Pharmacist Syndicate – Pres of the Egyptian Dental Syndicate – Pres of the General Physical Therapy Syndicate – Pres of the Egyptian Nursing Syndicate – A health cost accounting expert – A health economics expert – 2 members of the civil society with experience in healthcare management, one of them to be a professor at a medical school	– President of the Accreditation and supervision org. – Deputy to the Accreditation and supervision President – Seven members of the specialists in the field of quality of health services and those with expertise in the medical and legal fields

Annex 4 (cont.)

Universal Health Insurance Org.	Healthcare Organization	Accreditation organization
Core tasks of the board		
Supervise the work of the authority, review and approve its various policies and strategies in all fields **Issue** regulations and decisions regulating the financial, administrative, and technical affairs of the authority without complying with the regulations in force in the administrative apparatus of the state **Approve** the draft budget and final account of the authority **Discuss and approve** the actuarial reports of the authority to ensure the financial balance of the system **Approve** the price lists of medical services provided **Approve** the investment strategy of the system's funds according to the rules determined by the executive regulations of this law **Issue** rules for the use of local and foreign expertise to assist the authority in carrying out its work **Approve** the financial reports and accounts that the authority is committed to submitting to the various entities **Express** opinions on draft laws and regulations related to the authority's work system and related activities **Express** opinion in relevant international treaties, conventions or covenants **Review and evaluate** the effectiveness of the management and performance of system application programs **Propose** loans to finance programs and projects that meet the objectives of the authority	**Develop** the general strategy of the healthcare authority and its executive policies and monitor their implementation **Develop** regulations and decisions related to financial, administrative, technical, personnel affairs and other matters, without complying with the applicable governmental rules and regulations **Approve** the draft budget and final account of the healthcare authority **Approve** periodic reports on the progress of work in the healthcare authority and its regions **Study and propose** the fees of medical services proposed by the branches, hospitals, and units within the framework of the contracts and general rules established by the healthcare authority **Establish** a system of wages for doctors contracted with the healthcare authority **Accept** donations and grants and propose the necessary loans to finance all programs and projects it needs in accordance with established procedures **Adopt** the organizational structure of the healthcare authority, its branches, hospitals, and healthcare units **Express** opinions on all forms of contracts with the healthcare authority or with any other parties prior to their entry into force **Examine** and approve financial accounts, internal regulations, and medical treatment regulations of the affiliated territories **Coordinate** with the pricing committee to determine the prices of services provided by the healthcare authority **Set** the rules for using local and foreign expertise to help the healthcare authority to carry out its work **Express** opinions on the draft laws and decisions related to the work of the healthcare authority and related activities **Propose** loans to finance programs and projects that meet the objectives of the healthcare authority **Look** into issues brought up by the minister of health falling within the remit of the healthcare authority	**Establish** quality standards for health services and apply them to medical care facilities **Accredit and register** medical establishments that meet the quality standards referred to in the pre-mentioned item. The accreditation and registration period shall be four years, renewable for similar periods **Supervise and monitor** all medical establishments and members of the medical professions working in the medical service sector in accordance with the provisions of this Law **Conduct** periodic administrative inspection on the establishments approved and registered to work in the system **Suspend or cancel** the accreditation or registration if the medical establishment violates any of the accreditation or registration **Accredit and register** members of the medical professions according to the various specialties and levels of the system, and conduct periodic inspection on bodies accredited and registered to work in this system **Suspend or cancel** the accreditation or registration of members of the medical professions if they violate any of the accreditation or registration requirements **Provide** the means to ensure the efficiency of the system and transparency of the activities and the issuance of rules and regulations necessary for that **Coordinate** and cooperate with overseas medical oversight bodies, and international associations and organizations that bring them together or organize their work **Coordinate** with medical establishments to ensure access to an integrated system of standards, development comparison rules and performance measurement mechanisms in accordance with international standards **Support** the capacity of medical facilities to carry out self-evaluation **Raise** awareness and inform the community about the quality of services in medical facilitiesc

Annex 5: Key features of the different voluntary health insurance roles

VHI role	Key features
Substitutive	Covers population groups that are excluded from publicly financed coverage or allowed to take their mandatory contributions out of the compulsory insurance system ("opting out")
Complementary (user charges)	Pays for some of the costs for services that are covered by the statutory system (typically patient co-payments)
Complementary (services)	Pays for services that are explicitly excluded from the statutory system's package of benefits
Supplementary	Provides enhanced access (e.g. jumping queues/waiting lines), a higher level of inpatient amenities or greater user choice of providers in comparison to those covered by the statutory system Usually, supplementary VHI gives access to health services in the private sector and increases care seeking at private providers

Source: adapted from Thomson (2010)

World Health Organization

For additional information, please contact:

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