6 HEALTH CARE FINANCE AND EXPENDITURE

6.1 Health Expenditure Data and Trends

Table 6-1 Health Expenditure

Indicators	1990	1995	2000	2004	2005
Total health expenditure/capital, $	30	-	-	192 (02)	-
Total health expenditure as % of GDP	4.7	3.7 (94-95)	2.4 (00-01)	1.9 (01-02)	3.43
Investment Expenditure on health	-	-	-	-	-
Public sector % of total health expenditure	-	44 (94-95)	42 (00-01)	-	-

Source: Egypt Human Development Report,2003,04
Egypt National Health Accounts, for the year 2001-2002,puplished in 2005

Table 6-2 Sources of finance, by percent

Source	1990	1995	2000	2004
General Government				
Central Ministry of Finance	28.98%	35%	29%	-
State/Provincial Public Firms Funds	2.04%	5%	3%	-
Local	-	-	-	-
Social Security	8.89%	6%	-	-
Private				
Private Social Insurance	-	-	6%	-
Other Private Insurance	-	-	-	-
Out of Pocket	55.73%	51%	61%	-
Non profit Institutions	-	-	<1%	-
Private firms and corporations	-	-	-	-
External sources (donors)	4.35%	3%	1%	-

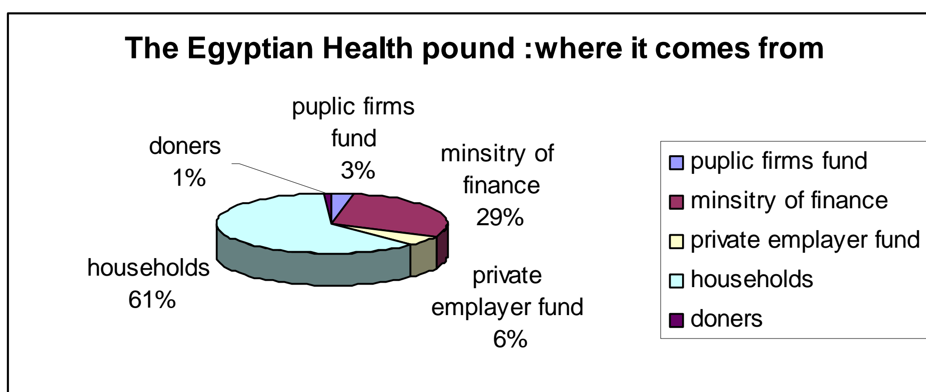
Source: Egypt National Health Accounts, for the year 2001-2002, published in 2005.

Trends in financing sources

Figure 2 summarizes the relative contributions of different financing sources to health care financing in Egypt. The single largest source of financing is direct private household spending which accounted for 51% of the total expenditure. Private sources also included spending by private firms, which accounted for another 5% of the total spending. Public sources of financing included 31% from the general revenues (through

Ministry of Finance [MOF]), 10% from the social insurance financing mechanism, and 3% from the donor support. This totals 44% of all funding sources for the health sector. Government spending on health, excluding HIO which is an extra budgetary item, accounted for less than 3% of the total government budget. Including the HIO, government spending on health was about 4% of the total government budget. As a percentage of GDP, total public financing comes to 1.6% of GDP, while private financing amounts to 2.1% of GDP.

Figure 2. Sources of Health care funding in Egypt , 2002



Source: NHA, 1995

Health expenditures by category

Budget Tracking System, which shows expenditure by type of services, was done once for the MOHP budget of 1992 – 1993.

Table 6-3 Health Expenditures by Category

Health Expenditures	1992	1995	2000	2004	2005
Total Expenditure (only public) Million LE	-	3.196	8.123	-	5.889
Per Capital expenditure LE	-	56	124	-	-
% by type of service:					
Curative care	51.33	-	-	-	-
Rehabilitative care	-	-	-	-	-
Preventive care	14.60	-	-	-	-
Primary/MCH	5.04	-	-	-	-
Family planning	1.20	-	-	-	-
Administration	27.83	-	-	-	-
% by item					
Staff costs	65.45	-	-	-	-
Drug and supplies	9.26	-	-	-	-

Investments	11.45	-	-	-	-
Grants transfer	4.17	-	-	-	-
Other	9.6	-	-	-	-

Source: Egypt's Health Sector Reform and Financing review, World Bank Report, February 2004
Budget Tracking System, Final Report, MOHP, 1996, MOF.2005

Table 6.3.1 below summarizes the types of services and benefits to which different subpopulations of the Egyptians have access or are eligible. The table identifies different benefits and eligibility in terms of coverage of services and choice of providers. As shown, the Egyptians are, in principle, guaranteed comprehensive and subsidized benefits through the government delivery system. In reality, access to these services are indirectly rationed through under financing which leads to shortages in drug supplies, absence of qualified staff, and unavailability of quality services. Social insurance coverage is restricted to eligible workers (excluding dependents), pensioners, widows and school children. Curative Care Organization (CCO) provide services primarily to the employees of the firms that have a contract with the CCO.

Table 6.3.1. Health care financing in Egypt: coverage, eligibility and benefits

Population coverage/eligibility	Benefits	Main sources of financing	Main providers
Government health services: all citizens eligible for free subsidized care in the following public delivery systems: a. MOHP (central/ governorate level) b. THOs c. University hospitals	Comprehensive: primary preventive and curative care, hospital inpatient care, drugs, laboratory and diagnostic services, dental care, chronic care, referrals to tertiary care providers, and limited number of overseas treatment.	a. General revenues, central government budget allocated to MOHP (central and governorate). b. Direct budget transfers from MOF. Budget transfers from Ministry of Higher Education and user fees.	Government primary health care units and hospitals of MOHP. For tertiary care, THIOs and university hospitals.
Social Health Insurance (HIO): public and private employees of formal sector, excluding dependents and school children (infants under the new law).	Comprehensive: primary care of GP and specialist services, including home visits, dental, drugs, hospital inpatient care, prosthesis, and physiotherapy.	Employee and employer contributions (payroll tax), tobacco consumption tax for SHIP, household premium (LE4), co-payments, and general revenues (MOF).	HIO facilities, HIO contracted GPs, specialists, clinics and hospitals, including CCOs, MOHP, and private providers.
CCO patients: a. Employees of companies with CCO contracts b. Accident cases	Services limited to those available within the CCO network, which includes comprehensive curative care.	Government grants for poor patients, service fees and contracts with private enterprises, and HIO.	CCO facilities.

c. Private patients (fee for service) Limited number of poor patients (MOHP grant)			
Armed forces, Ministries of Interior and Transport.	Not available.	Government budget.	Military hospitals and facilities.
Private sector: Households willing to pay for private services.	Variable and is dependent on individual's ability to pay and availability of services in the provider market.	Direct household out of pocket payments, limited insurance premiums, and corporate contributions.	Mainly ambulatory care provided by private physicians and clinics and more limited numbers of private/NGO hospitals

6.2 Tax-based Financing

Egypt's tax structure mirrors that of other countries in the Middle East. The system relies heavily on customs duties and general sales taxes and relatively little on personal income taxes. Personal income tax yield in 1999 was 0.8% of GDP and customs duties represented 3.3% of GDP compared with 7.4% and 1.2% in OECD countries respectively (World Bank, 2001). The National Health Accounts (1995) estimated total health care spending in Egypt to have been LE7, 516 million in the financial year 1994/1995. This was equivalent to 3.7% of GDP, or LE127 per capita, or US$38 in exchange rate-based dollars and approximately US$200 in PPP. Since 1991, using the GDP deflator, per capita health spending in inflation adjusted terms has increased by 15%, or at a compound annual rate of growth of 3.5%.

Ministry of Health and Population has developed the Family Health Fund (FHF), which is a recent innovation in health financing in Egypt. At present, it act only as payment center, located in each of the five pilot governorates. They pay performance-based incentives to health workers. The FHF business plans highlight the challenges of sustaining these incentives and other expenditures in the short term, let alone the long term. A key objective of the HSRP is to put in place measures that promote long-term financial sustainability of the health system. The FHF is currently a financial intermediary. The FHF is permitted to contract with a range of public and private providers. The entity is currently in a transition phase where it is contracting with accredited providers and paying staff incentives based on a limited range of performance indicators. The incentives are intended to replace existing incentives and provide a net increase in remuneration.

6.3 Insurance

Table 6-4 Population coverage by source

Source of Coverage	1990	1995	2000	2004
Social Insurance	10%	37%	45%	51%
Other Private Insurance	-	-	-	-
Out of Pocket	-	-	-	-
Private firms and corporations	-	-	-	-
Government	-	-	--	-
Uninsured/Uncovered	90%	63%	55%	49%

Source: Health Insurance Organization reports, 2005

Trends in insurance coverage

Health Insurance Organization (HIO) beneficiaries were less than 5 million until 1993 when Law 99 for the year 1992 was implemented that increased beneficiaries to be slightly less than 20 million. This number increased above 20 million in 1995 and started moving up to hit 30 million in 2002 after the issuing of ministerial decree no. 380 in 1997, as illustrated in Table 6.4.1 and Figure 3.

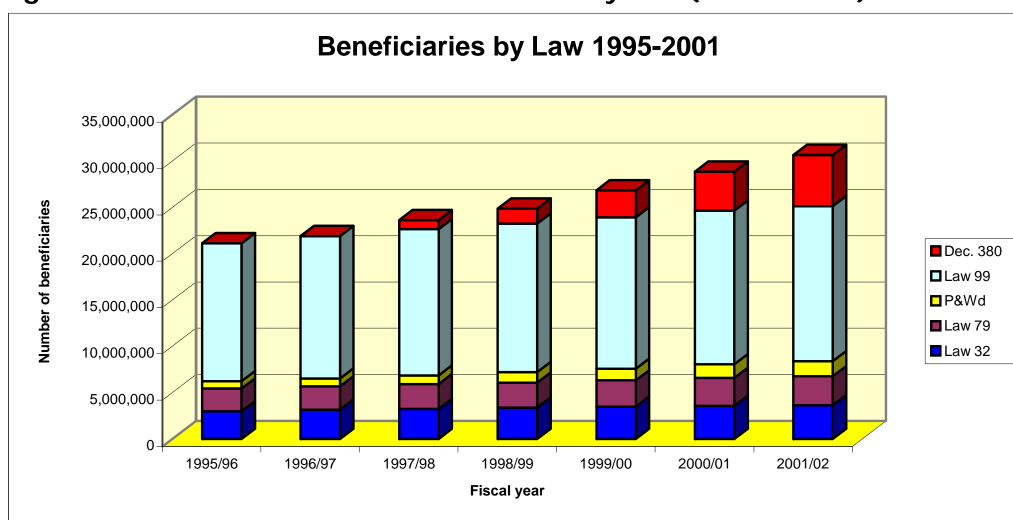
Health Insurance Organization covers over 30 million population in 2001/2002, or roughly 45% of the total population, and accounts for 10% of the total health spending. As such, it represents the largest health financing organization after the MOF, but it has not yet fulfilled its function of providing universal coverage. At the end of financial year 2001/2002, HIO beneficiaries comprised nearly 17 million school children, 5.5 million newborn, 6.7 million workers, and some 1.6 million pensioners and widows.

Table 6.4.1: Distribution of HIO beneficiaries by law (1995-2002)

Law	1995/1996	1996/1997	1997/1998	1998/1999	1999/2000	2000/2001	2001/2002
	2,961,000	3,129,000	3,251,000	3,367,000	3,462,000	3,550,000	3,629,996
Law 79	2,492,000	2,551,000	2,638,000	2,693,000	2,844,000	3,022,000	3,121,529
P& Wd	768,000	840,000	958,000	1,133,000	1,259,000	1,462,000	1,617,923
Law 99	14,890,000	15,370,000	15,771,000	16,039,000	16,345,000	16,584,000	16,740,022
Dec. 380	N/A	N/A	1,000,000	1,600,000	2,924,000	4,219,000	5,525,125
TOTAL	21,111,000	21,890,000	23,618,000	24,832,000	26,834,000	28,837,000	30,634,595

Source: HIO 2002

Figure 3: Distribution of HIO beneficiaries by law (1995–2002)



Source: HIO 2002

Some of key features for HIO are summarized below.

- The benefit package guaranteed under HIO is comprehensive, and includes transplants, plastic surgery, and treatment abroad. The package has no limits either on quantity of services provided or costs, and there is no effective mechanism in place to rationalize the use of health services by the beneficiaries or by the providers.
- The scheme covers, with the exception in Alexandria, benefits only for the primary beneficiaries (meaning the workers) and does not extend to other members of the family. Thus the covered adult population is highly skewed towards urban male workers. This is an unusual arrangement as most social insurance programs around the world include dependents in their coverage.
- All formally employed workers are required to participate in the HIO, but companies are allowed to opt out of the system by paying in 1% premium on worker wages. Many of the large companies have chosen to opt out, as is evident from the National Health Account data which show that spending by private firms outside of the HIO scheme accounted for about 5% of the total health expenditures. This clause raises serious questions about the sustainability and viability of the HIO in the long run if the more affluent workers are allowed to opt out of the system for very low premium contribution.
- Choice of provider is restricted to HIO facilities or to providers that have a contractual arrangement with HIO, but in reality there seems to be few restrictions placed on the choice of providers, especially for school children.
- The coverage extends only to the formal sector where at present there is no plan in place to extend the coverage to the self-employed or the informal sector workers who account for the majority of workers. There is a separate social insurance program for the self-employed (Law 108) and agricultural workers (Law 112), but these do not yet include contributions to health insurance.
- The School Health Insurance Program (SHIP) is managed and funded separately from the other beneficiary categories. SHIP collects premium contributions are fixed at LE4 from households and LE12 from GOE, and not indexed to inflation or cost of

living. In addition, SHIP receives revenues from consumption tax on cigarettes, which is an innovative means of generating additional revenues for the program.

- HIO receives transfers from the MOF from time to time to cover operational losses. The largest such transfer being considered is that of LE430 million to the HIO in 1997 to deal with its accumulated deficit, raise the standards of services provided by the HIO, and undertake pilot projects to expand coverage.

A number of new legislative initiatives are under consideration by the government that will have a profound effect on the HIO. The government is considering a legislation to unify Laws 32 and 79, which will bring into consonance the two categories of workers under a common scheme of premiums and co-payments. This will result in the doubling of premium payments by workers formerly covered under Law 32, and will raise the drug co-payment rates to one third of the total drug cost, which is the same rate charged to the school children.

Social insurance programs: trends, eligibility, benefits, contributions

The Egyptian Health Insurance Organization (HIO) was created after the enactment of the Health Insurance Law in 1964, with the mission of coverage of the entire Egyptian population within 10 years.

There are four broad classes of HIO beneficiaries:

1) Employees covered through Law 32 of the year 1975 (all employees working in the government sector).
2) Employees covered through Law 79 of 1975 (some public and private sector employees), and pensioners and widows.
3) Beneficiaries of the Student Health Insurance Program (SHIP) introduced In February 1993 and covering more than 14 million students, thus increasing the total beneficiary population from 4.895 million in 1992 to 20.67 million in 1995 (Egypt National Health Accounts, 1995).
4) Newly-born children up to age five years, according to ministerial decree number 380 for the year 1997, an action that has increased the beneficiary population by some 9 million, to include approximately 55% of the Egyptian population.

HIO is a public institutional, government-owned entity under the Egyptian Minister of Health and Population. As such, the final decision on major policy, or structural and managerial changes rests with the Ministry. As a government-owned entity, governmental decrees and laws also govern the HIO.

Since it was founded in 1964, HIO has functioned as both a payer and a provider of health care. The HIO is organized into three structures: a management structure, a service delivery structure and a referral structure.

Since 1999, HIO has been engaged with the MOHP through the HSRP in the formation of pilot Family Health Funds (FHF). This is achieved through contracting with the provider organizations to deliver this agreed package through accredited facilities prepared to accord with the agreed family health model.

HIO management structure

The HIO is divided into eight regional administrative branches. The branches manage the HIO service delivery units, as well as managing the contracts with private sector providers, primarily for school children, special medical procedures and highly specialized surgeries.

As a *payer* of health care, HIO functions as a staff model Health Maintenance Organization (HMO), running a prepaid managed care plan whereby it provides comprehensive curative and preventive benefits to its beneficiaries through the hospitals and clinics it owns, and the physicians it employs. However, with the addition of the students to HIO beneficiaries, the organization has found it necessary to contract for services from other provider organizations, using a variety of payment mechanisms ranging from fee-for-service to time-based reimbursement.

Revenue for HIO comes from four primary sources: the Social Insurance Organization (SIO), as a proportion of employees' salaries; the Pensioners' Insurance Organization (PIO), as a proportion of pensioners' allowances; a fixed amount of school registration fees, as a contribution to the SHIP; and the government subsidy from general and earmarked tax revenues (e.g., cigarette tax). HIO also receives some revenues in the form of co-payments, primarily from government employees.

HIO service delivery structure

As a *provider* of health care, HIO manages about 808 General Practitioner (GP) clinics inside and outside factories, 601 specialist clinics or polyclinics, 7117 school health clinics and 37 hospitals (HIO data, 2005).

The HIO was founded primarily as a provider of health services to its beneficiaries, and its organizational structure and staffing reflect this function. Since the expansion of the program to include the school and pre-school children, HIO has *de facto* become a major purchaser of services as well, although its staffing and organizational capacity do not reflect this major shift in the scope and focus of its work. In the meantime, management and administration of the extensive network of HIO hospitals and clinics continue to occupy a large part of HIO management's focus and energy. Moreover, the addition of the SHIP and the administration of newborn-to-5-year-old programs under its supervision have greatly expanded the size and scope of its administrative structure.

HIO referral structure

The HIO outpatient care structure acts as a gatekeeper to promote the more efficient use of resources. At this level, GPs refer patients to more resource-intensive specialist care or hospital care, as needed. While the referral system is formally in place, it is not strictly followed except in relation to the school health insurance system.

HSRP-related HIO organizations

One of the key objectives of the HSRP has been to achieve universal insurance coverage for all Egyptians. To this end, the HSRP proposes a gradual and phased expansion of social health insurance coverage: in the first phase, the HSRP will extend a primary health care benefits package to all families living in pilot geographical areas (Alexandria, Menoufia, Suez, Qena and Sohag governorates). The introduction of these core insurance functions through the HSRP will lay the foundation for a future unified National Health Insurance Fund that will extend comprehensive insurance coverage to all Egyptians.

Family Health Fund (FHF)

The FHF was established according to ministerial decree no. 294 for the year 1999, stating the opening of a bank account named "Family Health Fund of the Health Sector Reform Program". This was followed by the ministerial decree no. 160 for the year 2001 regarding the constituency of the governing bodies of the Fund. Five pilot FHFs have been established, one in each of the governorate sites where HSRP is currently being piloted. FHF is responsible for providing insurance coverage to beneficiaries through

contracting and purchasing primary health care services from Family Health Units (FHUs) and Family Health Centers (FHCs) that are owned by the public sector or HIO providers, and have fulfilled the family medicine accreditation requirements. Currently the pilot FHFs are contracted with accredited family health facilities that provide family health services to the registered population and are finalizing the enrolment of NGO healthcare providers into the family health facilities it contracts with.

Strengths of the HIO

- The large number of beneficiaries enrolled under this single insurance organization and its growing mandate to provide health care to a larger portion of the population gives the HIO a significant role in shaping the future health care delivery system of Egypt.
- HIO is unique in Egypt as a large staff model Health Maintenance Organization (HMO) with capitated financing, gate-keeping, and referral functions already in place. This gate-keeping/referral function, whereby general practitioners in ambulatory care are used to provide access to specialists through referrals, is important in reducing unnecessary specialty and inpatient care.
- Although HIO contracts with other providers lack the utilization management features of managed care arrangements, the organization has the potential to improve its contracting capabilities, use its economic power in the health care market place, and shape its contracts.
- HIO is probably the only public sector health care organization utilizing integrated management information systems throughout most of its organizations. The information systems are currently being enrolled in a process of development and upgrade through the HSRP. In addition to their value to HIO, the systems have potential application throughout the Egyptian health care system.

Constraints of the HIO

- As with many organizations in Egypt, the HIO has grown over the years, but its organizational structure has failed to cope with its complex management tasks. The headquarters organizational structure shows an absent middle management level, ill-defined accountability lines and unmanageable span of control.
- The HIO currently faces a number of serious constraints that limit its capacity to expand coverage. Besides its accelerated expansion of coverage combined with the low and fixed premium structure, the extensive benefits package, the poor institutional capacity and the inadequate HIO information systems.
- Although, HIO purchases around 40% of its services from providers outside of the HIO-owned network of providers, it lacks the systems to track and control utilization and costs through contracts, payment and monitoring systems. This is leading to serious cost-escalation problems, due to excessive and inappropriate utilization of services and fraud, and rapidly widening operating deficits in all aspects of the HIO services. The HIO segments the beneficiary coverage into groups that have different contribution and benefits plans, and breaks up family members into different categories of coverage. This adds to the administrative costs and complicates the task of integrating the different benefits plan into a universal coverage based on the family as the primary beneficiary unit. This has left HIO with millions of Egyptian pounds in cumulative deficit.
- The organization urgently needs to develop both the human resources and the information systems necessary to control expenditures and ensure quality and appropriateness of services.

- The HIO does not have an institutionalized structure to undertake strategic planning and policy development. Its cost accounting, insurance management (contracting, fraud control, actuarial, and containment functions) are under-developed.
- Like the MOHP, HIO is currently undertaking the roles of planning, budgeting, financing, resource allocation, regulation, monitoring and evaluation as well as health care service delivery. This lack of differentiation of roles is leading to inefficient and of poor quality in delivery of health services. The HIO needs to restructure to separate is purchaser and provider roles.
- HIO, theoretically a public institutional organization, functions as a government entity with no control over setting premiums, fixing benefits, and setting up co-payments. This has lead to diminished revenues necessary for efficient and effective management of its resources, maintenance and upgrading and expansion of its facilities, and the provision of quality care.
- A large organization spread throughout Egypt, HIO lacks "standard" policies and procedures on the management of the organization outside of the headquarters. This lack of standards for managing and monitoring branches and their affiliated facilities has impaired the quality and cost of HIO services. At present, all major decisions regarding services, purchasing, finances and the direct operation of the health care facilities emanate from the HIO headquarters. The centralized operational style allows the headquarters very little time for its strategic and policy-making roles and allows the branches no autonomy or incentive to run efficient operations.
- HIO costs are high, its benefits are, in theory, very comprehensive and its premiums, which are set by the government, are low and not adjustable to inflation. As a result, HIO is running in deficit, and its cumulative deficits to date are estimated in millions. In addition, HIO is reimbursed through a capitated system whereby the premiums it receives are fixed for each beneficiary and not based on the individual's likelihood of using health care.
- As a provider, the health care structure of HIO is fragmented with no continuity between direct and indirect care. HIO has few effective mechanisms to manage and control the utilization and costs of its services, thus contributing further to its financial losses. Failure to control drug consumption in particular is causing HIO significant financial losses. Also, a large proportion of HIO beneficiaries consider its services to be of inferior quality and refuse to use the facilities.
- HIO lacks the human resources and institutional capacity to design a benefits package, to establish a purchasing agency, and design and implement a provider payment system determine appropriate premiums and co-payments, and conduct actuarial analysis of the beneficiary population.

In the financial year 2000/2001 the workers' scheme is operating in the deficit of about LE174 million, part of which is made up by contributions from accident insurance and companies who opt out of the system. The School Health Insurance program (SHIP) is currently breaking even, but is expected to begin running deficits within the coming years. This increase in premium and co-payment collection rate by the unification of Laws 79 and 32 will go some length towards covering part of the operating deficits in the program, but will not be sufficient to cover the costs either in the short or medium-term. Addition of infants aged under one year, by the ministerial decree no. 380, increase the operating deficit of the HIO since this group of beneficiaries incur very high unit cost of care compared with the workers and school age children. Since ministerial decree no. 380 is not a law, it is not obligatory neither to the MOF did not pay its share,

which is 12 LE per newborn, as planned to the HIO nor to the newborn to participate in that scheme.

Law 79, concerning pensioners and widows, is the most under funded one, as illustrated in Figure 6, since beneficiaries pay only 1% of their basic pensions to the HIO and no one for them as employer. The SIO should carry its responsibility toward this category by paying 3% of their basic pensions to aid in decreasing this huge deficit.

Private insurance programs: trends, eligibility, benefits, contributions

Under the current regulatory environment, private health insurance does not represent an attractive business opportunity for enterprisers. In fact it is quite hard to make money on private health insurance in Egypt. Premiums are regulated and too low in comparison to the costs. Another constraint is that an insurance law guarantees employees the right to refuse to participate in a co-payment mechanism.

Overall, health insurance in Egypt is regulated by more than 30 applicable laws and decrees (Kemprecos, 1995). Any insurance company, which develops a health insurance plan, has to have the plan reviewed by the Misr Reinsurance and the Insurance Review Organization, an independent public sector body that has review authority over insurance contracts and negotiations.

In the fiscal year 1995 there were 11 insurance companies in Egypt, three of which offered health insurance. The three insurance companies, which provide health insurance, are the largest in Egypt, and are all government-owned parastatal organizations (Al Shark, Misr and Al Ahlyia companies).

The largest company offering health insurance in Egypt – Al Shark – continues to lose money under these policies. Although health insurance is only a small part of the company's portfolio, it causes a disproportionate amount of problems, and might ultimately force Al Shark to withdraw from the health insurance business altogether.

Over the past few years and as part of the structural adjustment process, the private insurance environment started to become less restrictive. A new law was passed to allow the opening of private foreign insurance companies. Under the General Agreement on Trade and Tariffs (GATT), the minimum capital needed to start an insurance company has also been decreased.

A private health insurance program "Medicare" was introduced a few years ago by the "Nile Badrawi" Hospital. The program has most of its beneficiaries from the upper-middle and upper classes; it charges reasonable premiums and has a co-payment ingredient. In addition, a European private insurance firm has recently been allowed to operate in Egypt. Egyptians of upper-income level basically purchase the insurance. The firm's operations are handled through a Cairo office and its services are provided through Egyptian private sector providers.

6.4 Out-of-Pocket Payments

Table 6.4.2: Comparison between 2002 and 1995 estimates

Sources	2001-2002	1994-1995
Ministry of Finance	29%	35%
Public Firms funds	3%	5%
Social Insurance Organization	-	6%
Private Employer Funds	6%	-
Household Funds	61%	51%
Non Profits Organizations	<1%	-
Donors	1%	3%
Total Health Care Expenditure	L.E. 23,087 million	L.E. 7,516 million

Source: Egypt National accounts – DRAFT (May 2005)

Households are the largest financiers of health care in Egypt. In table 6.4.2 , a comparison of source of funding between the two rounds of National Health Accounts reveals that the public contribution declined from 46 percent in 1995 to 32 percent in 2002. This decline in public spending is compensated by the substantial increase in the contributions of households in 2002. The proportion of household contribution has increased substantially to 61 percent.

(Direct Payments) Public sector formal user fees: scope, scale, issues and concerns

There is a formal user fees at each of outpatient/inpatient public services. MOHP facilities are the lowest in price followed by others (HIO, CCO, THOs). Revenues generated from user fees do not exceed 10% of the service cost. Table 6.4.3 presents expenditures and subsidies from MOF to hospital services, financial year 2004/2005

Table 6.4.3: Comparative expenditures and subsidies from MOF to hospital services, financial year 2004/2005

Provider category	Expenditure per bed (LE)	Average subsidy per bed (LE)	Subsidy per bed (%)
MOHP	6,000	5,800	97
THOs	14,400	13,500	94
University hospitals	22,200	19,100	86
HIO	24,721	6,600	27
Cairo CCOs	17,100	500	3
Private hospitals	20,700	0	0

Table 6.4.3 above indicates the level of dependence on MOF transfers (subsidies as a percentage of total expenditure) by categories of government and public hospitals. As can be seen, the MOHP facilities are most dependent on MOF budget for revenues, although among the government providers (others being the THOs and university

hospitals) it receives the lowest amount of subsidies per bed. THOs and university hospitals receive the highest level of subsidies from MOF, and are generally known to provide good quality of care.

Cost Sharing

Ministerial Decree 147, issued in 2003, is step toward outpatient treatment cost sharing at the accredited MOHP PHC facilities, which provide BBP. The patient pays 1/3 the price of the medication and 3 L.E. per visit (now represents a 300% increase compared to previous price). The Decree included an exemption clause for patients who cannot afford it.

6.5 External Sources of Finance

External sources of financial assistance for the health system (loans or grants from bilateral or multilateral organizations) presents between 1-3 percent of annual health care funding. See table 6.4.2.

6.6 Provider Payment Mechanisms

The LE7, 516 million mobilized in the health sector (National Health Accounts 1994-1995) did not just pass directly from the ultimate sources to their final uses. Much of the money first passes through financial intermediaries, which in turn transfer resources on to the providers of care. For all sources of funding, money is transferred to more than one financial intermediary and provider. The major intermediaries in the flow of funds are MOHP and other ministries, HIO, and private insurance schemes. However syndicates and households pass much, if not most, of their funding directly to the providers of care.

- The first pathway consists of MOF funding, which goes principally to other ministries, which in turn transfer the money to government providers of care. Donor funding shows a similar pattern, although a larger proportion of it goes to MOHP. Very little of the MOF and donor funding is transferred to the various insurance intermediaries, and virtually none ultimately passes to private sector providers. Together general revenue financing and donor support account for approximately one third of total health sector resources.
- The second major pathway consists of social insurance. The bulk of funding from firms and a small proportion of household funds pass to Social Insurance Organization (SIO) and Pensioners' Insurance Organization (PIO), which in turn fund HIO. HIO acts essentially as a combined provider and financier, using half its revenues to finance services provided by itself, and the rest to purchase services and goods from private and other public providers. Just under one seventh of total health sector funding passes through this social insurance mechanism.
- The third pathway consists of direct household funding. More than 90% of household funding passes directly to private sector health care providers, without any financial intermediaries. These private sector providers consist of NGOs, private clinics and hospitals, pharmacies, and other profit providers. Slightly more than half of all health sector funding consists of these household payments direct to private providers. A small percentage of private spending is organized through the employers who purchase health care services directly from providers on behalf of their employees or through private insurance. These organized sources of private financing account for less than 1% of the total health expenditure.

It is important to note that the direction of the flow of funds varies greatly depending on its source, and that the different intermediaries are funded by quite different sources. The flow of funds shows considerable verticality with very limited transfers of money between three major pathways of funding. The one major exception to this segmentation of financing occurs from the HIO, which purchases services across sectors, including private providers, MOHP, CCOs, and subsidizes part of the drug purchases.

Within the existing framework of the MOF budget allocation and integrated delivery system, there is little scope for introducing more effective provider payment mechanism. There is some flexibility being introduced through the self-funding scheme, which might serve as an entry point for introducing a more flexible payment system with productivity incentives. Unless these activities are monitored, however, there is a danger that these economic units could divert resources toward the more lucrative services which may not necessarily be in the best interest of the public.

Hospital payment method (piloted in Menofia now)

The payment mechanism for hospital is done according to what is documented in the contract with it as follow:

Out patient services: (specialists)

FHF/DPO pays 9 L.E for each registered referred case for getting the following advantages:

- No additional ticket for specialist examination
- 25% discount of lab. Investigations and X-ray cost
- Providing the medications with just only one third of their retail prices

Inpatient services (In transitional Period):

- Prices of medications prescribed in the patient admission file are determined by their tender prices (not retail prices).
- Prices of surgical interference according to the list annexed with the contract.
- Prices of non surgical interference according to the patient's bill .
- Patient will pay only 50% of the total his admission bill (out of pocket).

The FHF/ DPO pays 75% of total patient admission bill to be assured that they receive good quality services as well as encourage the hospital staff to cooperative with the family medicine referral system.

Payment to health care personnel

Currently the "reformed" model of family health services is funded by multiple payers: the MOHP, HIO and FHF. Health Sector Reform Program (HSRP) public health facilities are funded by two main sources. The MOHP/HIO fund salaries and medicines, whilst the FHF funds staff incentives. The dominant cost for both sources is labor.

Increase in cost, at present, reflects increased labor costs and the administrative costs of paying these incentives through a new agency. There is a lot of confusion over the net financial impact of the reforms as various incentives are being paid through different vertical programs. This system facilitates uncoordinated purchaser and provider behavior, is costly to administer, and may promote competing incentives – which leads to inefficiency and unsustainable health care provision. In short, the current system of financing in the three pilot governorates undermines stated HSRP policy goals.

A single payer system is likely to be less costly to administer than a multiple payer system and can improve efficiency. The development of a single payer system also allows the development of a provider payment system that is based on the number and profile of patients registered with a facility. A single payer would begin to address many of the problems of the current system. The FHF is in use to test the single payer concept at the district level. The single payer approach would require all district resources to be earmarked and channeled to the FHF. Earmarked resources would be based on an analysis of the previous year's MOHP/HIO accounts; donor funds would also need to be determined. The FHF would contract with providers to provide a level of benefits to the insured and uninsured populations. The percentage of incentives is determined based on the monthly performance of the health team whose performance is appraised through a set of Performance Indicators (PI), see table 6.4.4. These covers all aspects of service provision, whether the curative or the preventive, and maintains the efficiency and quality. There are eleven Performance Indicators; each one has a weight and standard as follows:

Table 6.4.4: Performance Indicators

	Indicator	Target	Standard
1	Number of Visits/ shift /Physician	20-30	100%
2	Number of drugs / prescription	<= 2	100%
3	% of Referral cases to the total ones	6-10%	100%
4	Patient satisfaction %	>= 90%	100%
5	Family Planning (All or Non)	>= 50%	100%
6	Immunization	>=95%	100%
7	Completion of medical records data	>= 90%	100%
8	Quality standards	>= 90%	100%
	Patient rights patient care Facility management Pharmacy Laundry Lab. Cleaning services Q.I Program Emergency room Employee health program Environmental safety	Family medicine model Information management X-ray Department Sterilization Infection control	
9	Files fees Revenue Percentage	According to rostered population	
10	Uninsured Tickets Revenues	According to rostered population	
11	Utilization in relation of population rostered on the facility		

Source: Manual of FHF

- Immunization and family planning are all –or none performance indicators as
- The other ones are graduated according the percentage of achievement as follow

> = 90% -100% 100%

> = 80% - >90% 75%

> =70% - 80% 50%

< 70 % 0

- the indicator of completion of medical records is graduated as follow

> = 90% 100%

85% - 90% 75%

80% - <85 50%

<80% 0

Patient waiting time is not applicable till now because to get exact time you must have most recent technology that is not available