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The Case of Egypt

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How Can We Measure Progress on Social Justice in Health Care?

JHSR Manuscript

How Can We Measure Progress on Social Justice in Health Care? The Case of Egypt

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Abstract

Social justice, broadly defined as providing equal access to liberties, rights, and opportunities especially for the least advantaged members of society, is a priority of several governments in the Middle East and North Africa (MENA) post–Arab Spring as well as globally. Achieving social justice in the field of health care is consistent with the principles of universal health coverage and is an important means to achieve this aim. To translate this abstract concept into concrete action, we propose a novel diagnostic method and then apply it to the case of Egypt, a country with a stated goal of achieving social justice in health care. This allows us to assess progress and then suggest targeted recommendations through which to improve social justice in health care. Through a comprehensive analysis of primary and secondary qualitative and quantitative data sources, we first identify six disadvantaged groups in Egypt and then analyze the status of these groups with respect to the three objectives of a health system—improving health outcomes, financial protection, and public satisfaction. Our results suggest that Egypt

faces 11 challenges to achieving social justice in health care which can be addressed through 14 short- and medium-term recommendations drawn from global evidence of what works. Implementing these health system changes can help advance social justice in health care in Egypt.

Keywords

Social justice; Egypt; health care; diagnostic [4/5 key words]

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Introduction

Social justice, broadly defined as providing equal access to liberties, rights, and opportunities especially for the least advantaged members of society, is a priority of several governments in the Middle East and North Africa (MENA) as well as globally.¹ Achieving social justice within the field of health care is an important means to realize this aim. We propose that a health system can be considered to have achieved social justice if the most disadvantaged person has equal access to the same services as the average person—that is, each person has the same “equality of opportunity” with respect to health care, regardless of geography, income, gender, or race.² For example, we believe that in a “socially just” system, a male and female diabetic patient would have access to the same high quality treatment, regardless of their gender. The same would be seen for patients who have the same medical condition, but differ in terms of socioeconomic status, geography, or race.

Achieving social justice in health care is also consistent with the principles of universal health coverage (UHC). UHC is defined as all people receiving quality health care services that meet their needs without being exposed to financial hardship in paying for the services.³⁻⁵ Given resource constraints, this does not entail all possible services, but a set of prioritized services with mechanisms to ensure that disadvantaged groups are not left behind.⁴ To achieve UHC, countries must advance in at least three dimensions-- expand priority services, expand populations covered, and reduce out-of-pocket (OOP) payments .⁴ In each of these dimensions, countries are faced with a critical choice: Which services should be expanded first? Which populations should be included first? How can payments be shifted from OOP expenditure to a pooled prepayment scheme? Applying a lens of “social justice” is a critical way to ensure that the most disadvantaged are not left behind on any of these dimensions—that health coverage is

universal. In order to achieve this, certain disadvantaged groups may need to be initially prioritized to ensure universal effective service delivery.

How does one determine if social justice in health care has been achieved? To answer this question, we have developed a novel diagnostic method which first identifies the potentially “disadvantaged groups” in a society and then evaluates their status on the three objectives of a health system— improved health status, financial protection, and public satisfaction.⁶ Based on the gaps in achieving these outcomes, recommendations are made towards realization of social justice in health care drawing from global evidence of what works. In this way, the abstract concept of “social justice” can be systematically disaggregated, evaluated, and translated into discrete health policy changes that make incremental improvements for disadvantaged groups and thereby improve society.

In order to illustrate this diagnostic method and show how it can be applied, the case of Egypt is presented. Like many MENA countries post–Arab Spring, achieving social justice has been a pressing priority for both the people and the government of Egypt. The call for social justice was the rallying cry heard from Tahrir Square in 2011 (“*Aish, Horreya, Adala Egtema'eya*”) and this call has continued through successive political transitions, as enshrined in Egypt’s Constitution (see **Error! Reference source not found.**). Analyzing the progress of the Egyptian health care system towards the goal of social justice is important to help policy makers develop appropriate programs that best respond to this call and help achieve the goal of UHC to which Egypt is committed. However, the diagnostic method and recommendations presented have implications beyond the context of Egypt and can be applied to many countries that are working to improve social justice in the health system.

Materials and Methods

Diagnostic

To assess if the abstract principle of “social justice” is being achieved in the health sector, we have developed a novel diagnostic method to analyze the health system through the lens of the disadvantaged (See Fig 1). The first stage of the diagnostic method is to identify groups which can be considered “disadvantaged” in terms of the health care system. Depending on the country context this could include groups disadvantaged because of gender, race, geography (urban/rural), ethnicity, socio economic status and can be verified by analyzing disaggregated health outcomes (if available) or known proxies for poor health outcomes (e.g., low maternal education is usually correlated with high infant mortality rate). For example, in many contexts, geography plays a major role in determining health status—rural areas and ‘lagging regions’ tend to have poorer access to quality health care and as a result have poorer health outcomes. In this case, populations living in “lagging regions” could be considered disadvantaged.

The next step of the diagnostic method focuses on how these identified disadvantaged groups are faring in terms of social justice in health. Given that the term “health” is very broad, we look at how these groups fare in terms of the three aims of a health system. Every health system can be thought to have three objectives as outlined in the Flagship Framework—to improve health status, to provide financial protection, and to ensure public satisfaction.⁶ Health status refers to the level and distribution of health outcomes among citizens; financial protection is the degree to which citizens are protected from financial risks; and public satisfaction is the degree to which citizens are satisfied with the services provided by the health sector.⁶ For each objective, we evaluate how disadvantaged groups are doing compared to their peers on key metrics.

The third stage is to then delve further and within each objective and examine progress on sub categories to determine status and identify key challenges. Under health status we evaluate how disadvantaged groups do in terms of outcomes related to communicable diseases, non communicable diseases (NCDs), injuries, nutrition, and mental health. Under financial protection, we analyze how the three actors of the health system—patient, purchaser, and provider—are oriented to provide financial protection to disadvantaged groups. This includes understanding how patients from disadvantaged groups fare in terms of financial coverage (number of people covered, number of services covered, level of services covered); how the payer is organized in terms of pooling and purchasing services for these groups; and how providers are organized to supply services to these populations. Under public satisfaction, we look at the demand side in terms of citizen’s engagement and human resources for health in areas with disadvantaged groups. While not perfect proxies to capture the different dimensions of public satisfaction, these are often areas in which data are available and so can be assessed. These also are inputs that contribute to levels of public satisfaction.

In the final step, we analyze policies and programs within each sub category to determine if there are gaps in achieving social justice. If so, we highlight groups to be prioritized and recommend more inclusive programs for them based on global practice. Conducting this kind of analysis helps understand a country’s progress towards social justice in health care as well as presents concrete ways to address any gaps.

Data sources

Both qualitative and quantitative data are used in the application of this diagnostic method. When possible, data are disaggregated by socio economic status (income, education, age, sex); geography (urban, rural, other traditionally “lagging regions”); race/ ethnicity/ caste (if relevant).

Qualitative data are also collected to better understand the reasons for variations by different groups so as to develop more detailed recommendations.

In the case study of Egypt, we looked at both primary and secondary data. In terms of primary data, we analyzed quantitative survey data from several rounds of the Demographic and Health Survey (DHS); Household Health and Expenditure Survey (HHEUS); National Health Accounts (NHA) and the Global Burden of Disease Study (GBD). In terms of qualitative data, we conducted several focus groups and indepth interviews with patients classified as belonging to disadvantaged groups; providers; payers; policy makers; civil society organizations; non government organizations; donors; and government officials (Ministry of Health, Ministry of Finance). In terms of secondary data we analyzed the published literature on health care in Egypt; government health plans and policies; and the grey literature in terms of reports by donors, bilaterals, UN agencies, CSOs and NGOs on health care in Egypt. The findings of our analysis were shared with all groups consulted who verified the results and agreed with the proposed recommendations. The entire process took a year and helped ensure that the diagnostic method was comprehensive, accurate, and had buy in and ownership from the implementers.

Results

Health system in Egypt

Egypt has a diverse health care system, with different public and private providers and financing agents. Health services in Egypt are currently operated and financed by agencies in all three sectors of the economy—government, para-statal, and private. The government sector encompasses ministries that receive funding from the Ministry of Finance (MOF). As in many

countries, the government health services are structured as an integrated delivery system in which the financing and provider functions are included under the same organizational structure.

The parastatal sector is composed of quasi-governmental organizations in which government ministries have a controlling share of decision-making, including the Health Insurance Organization (HIO), the Curative Care Organization (CCO), and the Teaching Hospitals and Institutes Organization (THO). It's worth noting that HIO covers nearly 58 percent of the population but is rarely utilized by its own beneficiaries. Special funds named Family Health Funds (FHF) were created to support a system of cost recovery for primary health care services, but are only functioning in some governorates. The private sector comprises of for-profit and nonprofit organizations ranging from, private community pharmacies, private doctors, and private hospitals of all types and sizes.

Identification of disadvantaged groups

The key to achieving the three overarching health system objectives is successfully identifying disadvantaged groups and then targeting programs and policies to address their unique needs. Based on an analysis of the nationwide survey data on health status and financial protection (customer satisfaction data is harder to find), groups in Egypt that can be considered disadvantaged include:

1. Households in the lowest wealth quintiles
2. Populations situated in certain geographic locations or “lagging regions” such as rural Upper Egypt and the Frontier Governorates (and in certain habitations like slums)
3. Populations with low parental education, particularly with respect to mother’s education

4. Workers in the informal sector who are specifically not covered through health insurance schemes
5. Women (for specific health outcomes related to maternal and reproductive health, malnutrition, etc.)
6. Disabled populations

For example, for the purpose of this paper, the least advantaged individual could be defined as a woman with illiterate parents, from the poorest wealth quintile, living in rural Upper Egypt.

Challenges to achieving social justice in health care

Based on the diagnostic method, 11 challenges need to be addressed to ensure that progress is made in improve social justice in health care—the challenges are listed in no particular order and all carry equal weight. For each challenge, there are particular groups who are particularly vulnerable; to assist them, additional effort is necessary (see Figure 2).

Objective 1: Improve the health of disadvantaged groups

With respect to health status, in the last 20 years, Egypt's population has become healthier, with an increase in overall life expectancy from 64.5 years to 71 years, though the benefits have not accrued equally.⁷ Due to expansions in availability of basic health services including for maternal child health (MCH), Egypt has reached the Millennium Development Goal (MDG) related to child mortality (MDG 4) and was very close to achieving the goal linked to maternal health (MDG 5); however, disparities in achievement of these targets exist across geographic regions and income quintiles such as in rural Upper Egypt.^{8,9} On closer examination by governorate, Cairo, Alexandria, and Port Said have not met the target for child mortality and

Sharkia, Kalyoubia, Beni Suef, and Minya are were also unable to meet the target for maternal mortality.¹⁰

Challenge 1: Poor maternal and child health (MCH) inequitably distributed in rural, remote, and slum areas

Egypt has seen gains in MCH outcomes, as demonstrated by reductions in the last 10 years in the maternal mortality ratio by nearly half, from 100.0 to 52.0 maternal deaths per 100,000 live births; and the under-five mortality rate by also half, from 41.9 to 22.0 infant deaths per 1,000 live births. However, differences in health outcomes between least and most disadvantaged groups persist especially in rural, remote and slum populations (see Figure 3). Concurrently, Egypt is witnessing an increase in fertility with a decline in the contraceptive prevalence rate. In addition, rates of female genital mutilation/cutting (FGM/C) remain extremely high, with 87.2 percent of all women aged 15-49 circumcised.¹¹ To address MCH issues, Egypt has started an ambitious program to operationalize and raise the quality of family health care services offered at the level of the primary health care facilities, especially in poorer areas and in Upper Egypt.

Challenge 2: High burden of Hepatitis C overall with increased prevalence among poor, rural, and low-education populations

Egypt has the highest prevalence of Hepatitis C virus (HCV) globally, with the prevalence rate among 1- to 59-year-olds estimated at 4.4 percent.¹¹ Groups with higher prevalence rates include lower educated populations, rural populations, low-income groups, and men.^{12,13} Based on a synthesis of several studies, the overall Hepatitis C prevalence in rural areas averaged about 20 percent, higher than the national average.¹³ A high prevalence of HCV among pregnant women and children was found with a reported prevalence of about eight percent among pregnant

women in Assuit and Benha, and as high as 15.8 percent in rural villages of the Nile Delta.¹³ Egypt developed a Plan of Action for the Prevention, Care and Treatment of Viral Hepatitis (2014-2018) with several international best practices in place pertaining to prevention, treatment, screening, and surveillance. The plan is currently undergoing a revision and is being costed. To our knowledge, the prior strategy on which this was based (2007-2012) has not yet been formally evaluated and as a result, potential lessons that could have been learned have not been captured.

Challenge 3: High rates of undernutrition across wealth quintiles and geography

In terms of macronutrient deficiencies, around one in five children under the age of five are classified as stunted and one in ten are classified as severely stunted.⁸ Wasting (weight-for-height) increased in the last 15 years, while the rate of underweight (weight-for-age) children saw no significant change.⁸ More than one in four children in Egypt suffer from some degree of anemia, and rural children are more likely to be anemic than urban children (29 percent and 23 percent, respectively).⁸ As a result, Egypt is not on target to meet the World Health Assembly nutrition targets. Presently, Egypt has a 10-year Food and Nutrition Policy and Strategy (2007–2017) in place MOHP has recently established a nutrition unit to tackle the problem.

Challenge 4: Rising burden of non communicable diseases (NCDs), with higher prevalence of risk factors by gender and income

Egypt is undergoing an epidemiological transition, with 72 percent of all mortality and morbidity in 2010 (captured in units of disability-adjusted life-years, or DALYs) due to NCDs.¹⁴ The distribution of NCDs tends to be concentrated in older and wealthier populations, though a latent undiagnosed burden of NCDs is likely in poorer, less educated groups, who have reduced access

to health services. Risk factors differ by gender and age—for example, three fourths of all women aged 15-59 are considered overweight or obese.¹¹ Presently, Egypt does not have a unified and costed national NCD plan and does not collect regular data on NCD risk factors, prevalence, and complications.

Challenge 5: Increasing prevalence of substance abuse and mental health issues, especially by gender

Unipolar depressive disorders and anxiety are among the main causes of disability and death (as measured in DALYs) among women aged 15-49¹⁴ while addiction, often a coping mechanism for mental health conditions, is rising among men.¹⁵ The lifetime prevalence of substance abuse is thought to vary between 7.3 and 14.5 percent with a prevalence of 13.2 percent in males and 1.1 percent in females.¹⁵ The government's national mental health plan, developed in 2003, needs to be updated to reflect current needs.¹⁶ In addition, mental health services are underfinanced and make up only two percent of the total government health budget; only five percent of undergraduate training hours at medical school are devoted to mental health teaching.¹⁶

Challenge 6: High burden of disabilities especially among illiterate and rural populations

Estimates of disability in Egypt vary from 0.7 percent¹⁷ to 10 percent of the population with up to 25 percent of the population thought to be indirectly affected either as family members or as caregivers.¹⁸ Disabled populations are more likely to be male, unmarried, illiterate, and rural.¹⁸ Egypt has a national council on disabilities and provisions in the Constitution to address

disabilities, but implementation of a national strategy has been weak. While disabled populations are entitled to certain services, disadvantaged disabled populations tend to be excluded.

Objective 2: Increase financial protection for disadvantaged groups

Similarly, with respect to financial protection, while more than half of the population has access to some form of health insurance, 61 percent of all health care costs are still covered out of pocket.¹⁹ The current insurance scheme excludes the poor as well as those in the informal sector. In addition, there is inequity in access within programs devoted to provide coverage for the uninsured, such as the Program for Treatment on the Expense of State (PTES). The groups with the highest coverage rates include those-- aged 5-15 (93.5 percent); in the highest wealth index (66.8 percent); residing in urban Lower Egypt (56.4 percent); and living in urban areas (54.4 percent).²⁰

Challenge 7: Limited coverage of health care costs for disadvantaged patients

Egypt spends less on health care than its regional peers, resulting in high OOP expenditures. Despite the presence of multiple public and semi-public health providers, around half of the population does not enjoy any type of formal coverage.²¹ In recent years, the Ministry of Health and Population (MOHP) introduced interventions aiming to provide better access to health services targeted to disadvantaged groups (Health care Program for the Poor), but they are yet to materialize into effective financial protection (see Figure 4).

Challenge 8: Lack of a strategic purchaser to enable a transition to SHI coverage for disadvantaged groups

Egypt's current health system is fragmented with a number of financing agents. Four key financing players are present and were designed to complement each other; in some cases, there

are overlaps of coverage and provision of different packages of health services. The fund for the poorest (PTES) only covers 1.7 million Egyptians and has accumulated a half billion pound (approximately 50 million US dollar) deficit limiting its ability to serve the most disadvantaged.

Challenge 9: Lack of provider readiness for a strategic purchaser of services

Significant centralization, line item budgeting, and lack of service costing mechanisms have made providers unresponsive to local needs. Fund allocation for providers does not reflect burden of disease in the catchment areas. Even with the creation of a strategic purchaser as envisioned under SHI, most public providers lack the ability to interact with that purchaser in terms of claims management, management information systems, and contracting capabilities. This is especially true in areas with already weak capacity such as lagging areas.

Objective 3: Improve Public Satisfaction

With respect to public satisfaction, over 60 percent of surveyed representatives stated they were “completely satisfied” with the quality of health services received.²⁰ On closer examination, variation exists in the level of satisfaction by type of facility: 66.4 percent of patients were completely satisfied with service delivery at MOHP hospitals compared to 76.0 percent of patients using private hospitals.²⁰ However, publicly-funded health care services showed much lower utilization rates than those in the private sector. Further, the lowest utilization rates were among the poor.¹ Inpatient services provided at Health Insurance Organization (HIO) facilities were characterized as having the lowest levels of responsiveness compared to outpatient and

¹ 16 percent of the poorest quintile did not seek care for acute illness and 18 percent did not seek care for chronic illness because it was considered costly compared to 0.7 percent for acute illness and 4 percent for chronic illness among the wealthiest quintile [20].

inpatient services in the private sector.²² Human resources for health and citizen participation are important inputs for public satisfaction and they have been examined more closely below.

Challenge 10: Lack of responsiveness of health systems to disadvantaged groups

Public health facilities are not considered responsive to patients, leading patients to pay for private sector care. Inequities persist by income, across governorates, and by gender (see Figure 5). Supply-side payment mechanisms along with low wages for physicians and other health staff provide little incentive for better performance. Dual practice remains a pressing problem, with almost 80 percent of doctors working in both the public and private sector.²³

Challenge 11: Limited citizens' participation, including lack of grievance redress mechanisms at facility, district, governorate, or national levels

Citizens' participation in the delivery of health services is limited, hampered by the absence of formal grievance redress mechanisms (GRMs). While some facilities have complaint boxes or Patient Bill of Rights (PBRs), this is not uniform across all public facilities and ways of dealing with complaints or infringements of rights are *ad hoc*. No medical malpractice law exists and if a patient has a grievance with a physician, his complaint is usually referred to the Doctors Syndicate, a semi-autonomous union of all doctors, which may lack the impartiality necessary to assess such cases.

Discussion: How can Egypt achieve social justice in its health care system?

Thus across all three objectives of the health system—health outcomes, financial protection, and public satisfaction—disadvantaged groups have limited access and quality of care and interface with less efficient systems. As a result, social justice in health care can be improved by

implementing fourteen targeted evidence based reforms which are organized around the objective of the health system they address (see Figure 2).

Recommendations to improve the health of disadvantaged groups

Recommendation 1: Creating or supporting targeted national plans to tackle high-priority health concerns

Ensure that national action plans addressing high-priority health status challenges include a renewed focus on disadvantaged groups instead of universal targeting and distribution of resources. Attention will also need to be paid to reporting on the progress of disadvantaged groups and regions. A good example is the existing National Acceleration Plan for Child and Maternal Health in Egypt. Other existing plans need to follow this example such as the Plan of Action for the Prevention, Care and Treatment of Viral Hepatitis in Egypt. Other plans need to consider this focus as they are developed such as the National Action Plan for control of NCDs.

Recommendation 2: Supporting an integrated family health services model of care with appropriate referral mechanisms, with a focus on disadvantaged groups

Provide an integrated package of family health services which is prioritized to first cover disadvantaged groups and then scaled up universally. This would require revision of the expanded primary (family) health care service delivery model proposed in 1999 that included a basic minimum package of services for MCH, NCDs, nutrition, mental health, and disabilities to better meet the needs of the population.

Recommendation 3: Monitoring and surveillance of high-risk groups

It is important to ensure that reliable, up-to-date estimates of baseline disease prevalence and changing trends in incidence especially those affecting the disadvantaged groups is available. These need to be representative at the governorate and, if possible, district level, and available for vulnerable subgroups. For example, this would include a perinatal and neonatal surveillance system for maternal deaths; surveillance of NCDs (both risk factors and disease prevalence), nutrition, mental health, and disabilities; continued national surveillance of HCV among general and high-risk groups as part of the Demographic and Health Survey (DHS); and creation of a national registry of disabled persons.

Recommendation 4: Supporting key risk factor specific interventions among disadvantaged populations

Apart from the general recommendations, each disease also requires risk factor specific actions among disadvantaged populations. Some examples include: awareness campaigns around FGM/C, disabilities, mental health, and addiction; distribution of new chemotherapies and promotion of infection control and blood safety for HCV; continuing food fortification programs for iron and Vitamins A and D in government food subsidy; and increasing the number of training hours devoted to mental health and the number of nutritionists and dieticians to deal with the growing dual burden of under nutrition and obesity.

Recommendations to increase financial protection for disadvantaged groups

Recommendation 5: Separation of purchasing and provision functions to increase accountability and efficiency for disadvantaged populations

Separation of functions aims to improve efficiencies in service delivery. During the transition, HIO should separate its internal payment and provision functions. The “Payer” division would

assume the roles of contributions management, provider management, claims processing, utilization management, and reporting. The “Provider” division would work on achieving efficient and quality services in HIO facilities. While this separation is challenging in a fiscally constrained environment, it must be prioritized to increase efficiencies in the system and allow for transition to a strategic payer. The new SHI organization should be established to assume the responsibilities of a payer without service provision.

Recommendation 6: Reforming existing payers who provide coverage to disadvantaged populations

A multipayer scheme, based on a unified risk pool, could be introduced to upgrade the existing payers in preparation for a future merge into a strategic purchaser. During the transition, HIO could continue as the payer for formal sector workers, while another payer could be responsible for the poor and informal sector workers. The latter could be the Program for Treatment at the Expense of the State (PTES) as it was established to serve the uninsured. This requires introducing short- to medium-term reforms in all these organizations. In the long term, these two payers could be merged once their packages and rules and regulations are unified. This system is similar to ones used in other countries that have worked towards achieving UHC, such as Mexico, Chile, Thailand, and Colombia.

Recommendation 7: Defining and costing price of package of services, especially for health care needs of disadvantaged populations

To increase efficiencies in the system, costing of the different components will need to be revisited to determine actual unit costs that could be translated into programmatic budgets through MOF allocations. In addition, the package should be upgraded to meet the new health

needs of Egypt including prevention and treatment of NCDs, disabilities, and mental health conditions.

Recommendation 8: Defining provider payment mechanism, especially for services required by disadvantaged groups

It is recommended that primary care services be paid in fixed capitation amounts that cover the fixed costs of operations; while a complementary pay-for-performance scheme finances the variable costs based on volume, quality, and incurred hardship for services provided.

Recommendation 9: Preparing providers for contracting, especially those targeting disadvantaged groups

To be able to contract with private and non profit providers, health facilities must train fiduciary staff and introduce health management information systems (HMIS) to track expense and capture physician behavior, prescribing practices, and ancillary costs.

Recommendations to improve quality of care in health care facilities, especially in lagging regions

Recommendation 10: Training of providers in line with new health care demands, especially in lagging regions

The current skill mix of Egypt's medical workforce may not allow them to adequately respond to increasing health care demands, therefore task shifting and retraining is necessary especially in lagging regions. In Upper Egypt, where physicians' availability is lowest, nursing staff and community health workers could be further trained to perform basic procedures to improve health outcomes, after appropriate training and legal frameworks are in place. Training providers

on domains of responsiveness is essential to increase patient satisfaction. Dual practice can be regulated through different staggered “global fixes” such as allowing private practice in public hospitals, increasing basic wages and incentives, and then gradually banning dual practice.

Recommendation 11: Attaining independent accreditation for public facilities, especially those in lagging regions

Egypt should start working towards at least foundation-level accreditation for its public providers to ensure better quality and as a prerequisite for eventual contracting with a strategic payer(s), while planning to introduce higher level of accreditation. Only facilities that meet at a minimum the Foundation Accreditation Level for hospitals and the Provisional or Full Accreditation Level for primary health care units and centers will be eligible for contracting.

Recommendation 12: Scaling up performance-based financing and other incentives, especially in lagging regions

Structuring a payment system with performance-based incentives for providers has been shown to be successful at improving quality of care.²⁴ Through the reforms introduced as part of the Family Health Model in 2001, Egypt integrated pay-for-performance incentives in FHF-contracted facilities in five governorates, which was shown to be successful in improving the quality of care and resulted in increased satisfaction levels for both health care providers and beneficiaries.²⁵ Other positive incentives include accelerated career progression, exposure to training facilities at nearby centers of excellence, and government-guaranteed and pre-negotiated contracts for working within or outside of the country for higher pay after a set number of years in service. Negative incentives to discourage professionals from working in non-lagging regions

include caps on available job openings, frequent staff rotations, and stipulation of service in a lagging region for a set period of time as a precondition for eligibility for payment bonuses.

Recommendation 13: Creating avenues for citizens' participation in service delivery, especially in lagging regions

Citizens' participation in service delivery can be increased by drafting a national strategy for citizens' engagement in health care that includes creating an office for engagement with civil society at the national level and establishing a Committee for Patient Rights at the facility level. Information on performance must be linked with mechanisms that allow citizens, service providers, and officials to share and act on it. Collecting feedback on public services from users, benchmarking service delivery and local governance performance and disseminating information on performance can also provide a rigorous basis for citizen action.²⁶

Recommendation 14: Establishing grievance redress mechanisms and progressive legislature such as a Patient Bill of Rights

Legislative recommendations should be considered to provide grievance redress, including considering the development of a medical malpractice law, creation of a uniform Patient Bill of Rights (PBR), and harmonization of existing laws and decrees related to health. Based on global best practice, the PBR should consider including areas on patients' right to accurate and easily understandable information; choice of health care provider; emergency services; taking part in treatment decisions; respect and nondiscrimination; confidentiality and privacy of health information; and fair, fast, and objective review.

Conclusions

Despite gains in health care in recent decades, Egypt still confronts many challenges to ensure that progress is made towards achieving social justice in health care. While Egypt recognizes the “Right to Health” in the new Constitution, health outcomes continue to be unequally distributed and certain populations (defined by income, education, gender, or geography) remain excluded from gains in health outcomes, increases in financial protection, and improvements in health care quality. Based on evidence from pilots in Egypt and global evidence about effective interventions, this paper proposes 14 short- and medium-term recommendations to improve health system performance and advance social justice in health care in Egypt. We believe that these recommendations, if prioritized by policy makers, can contribute to enhanced social justice in the Egyptian health system.

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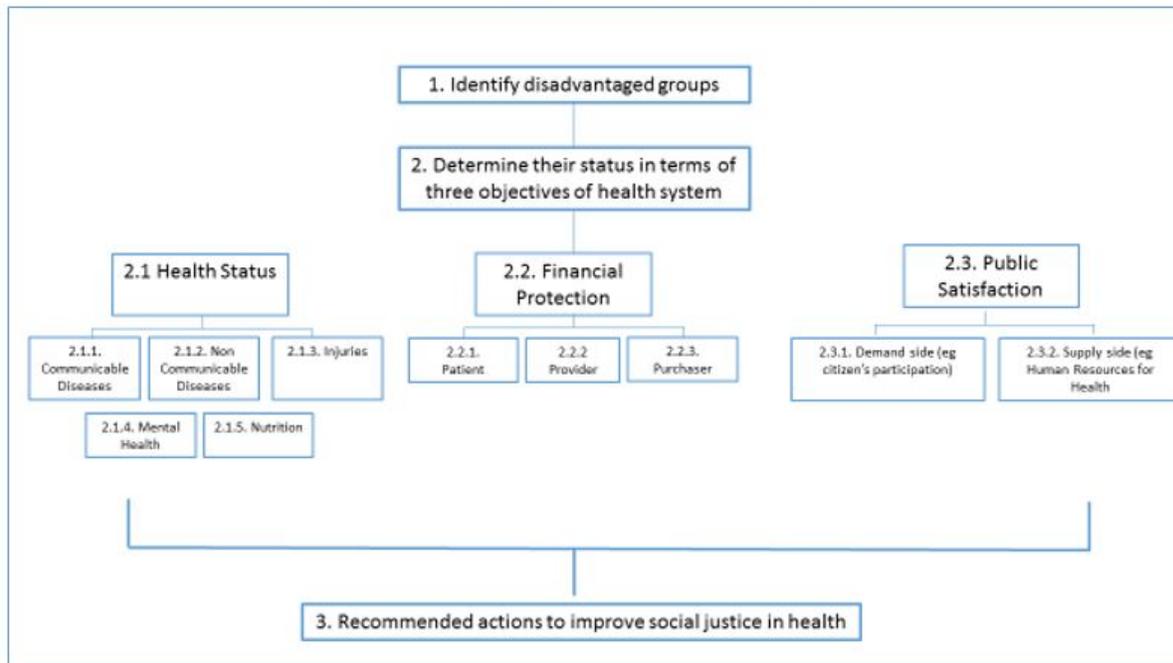


Figure 1: Schematic of diagnostic developed to evaluate social justice in health

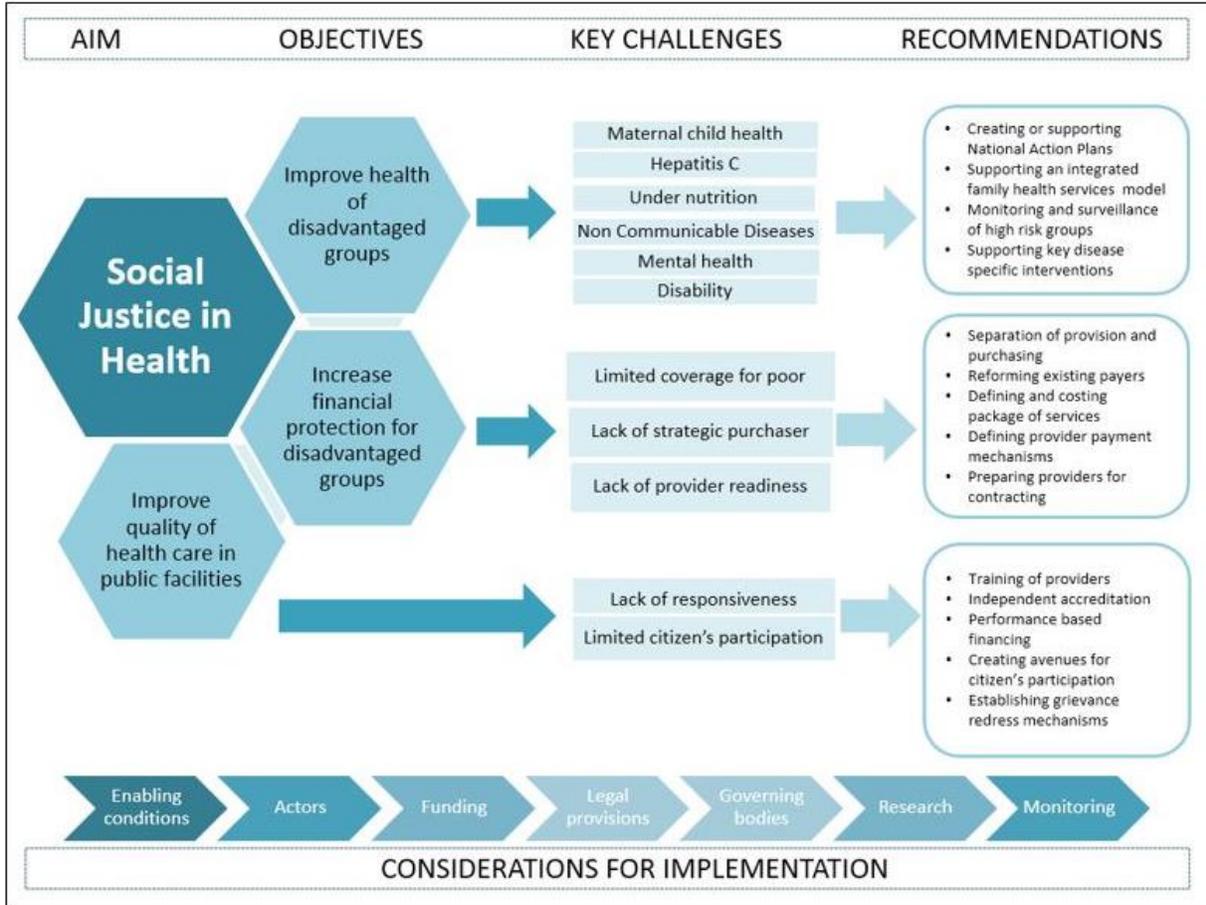
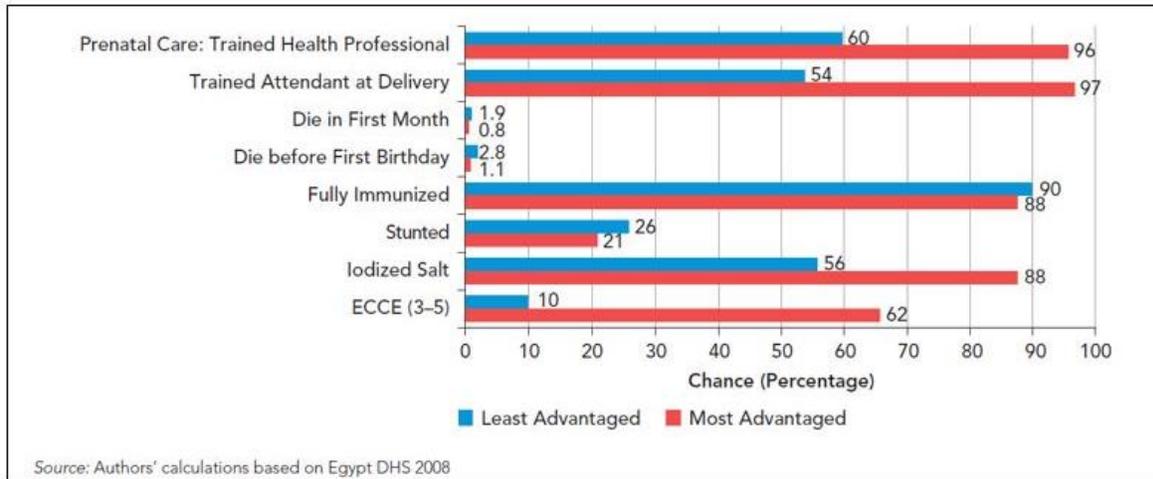


Figure 2: Results of diagnostic and proposed recommendations for Egypt to achieve social justice in health care

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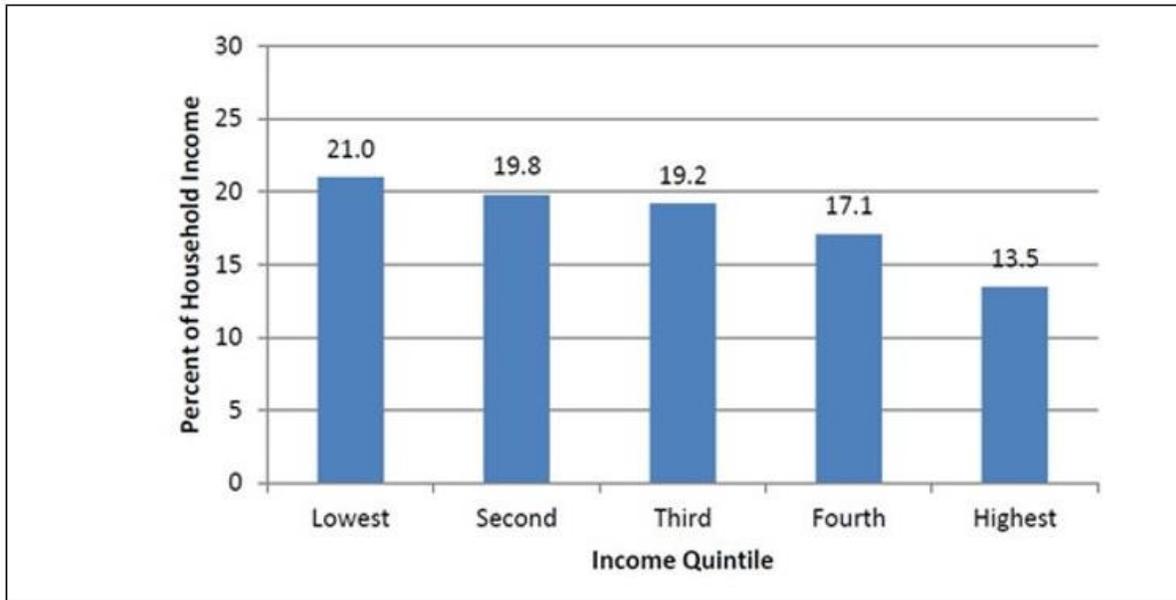


Note: ECCE stands for Early Childhood Care and Education.

Source:[27].

Figure 3: Differences in MCH outcomes between most and least advantaged, Egypt

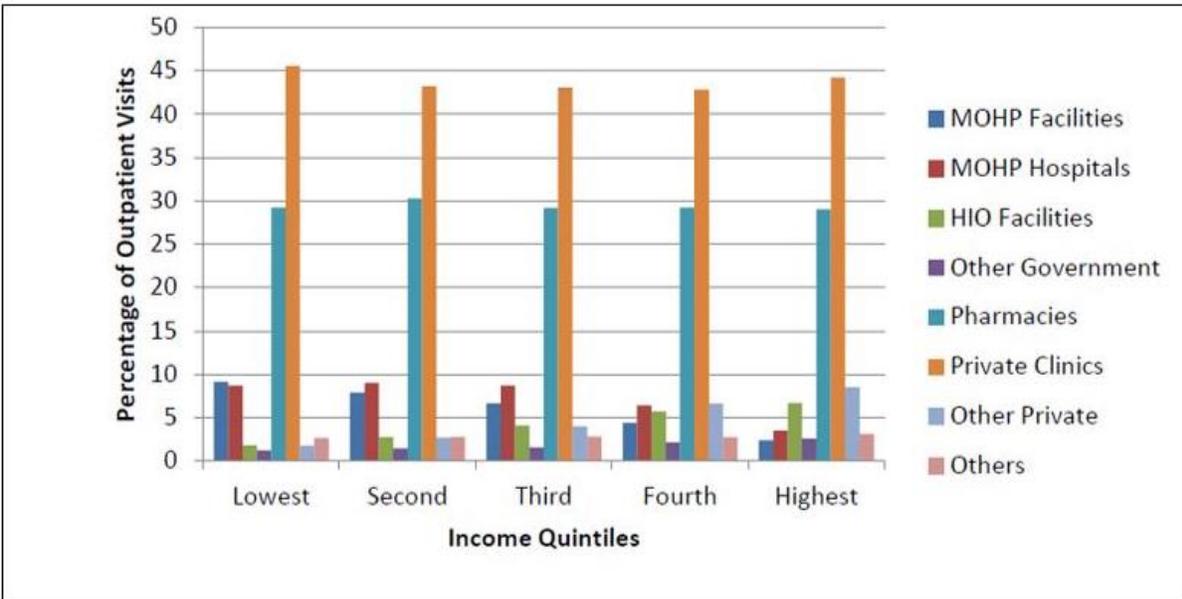
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Source: [20].

Figure 4: Percent of household income spent on health care by income quintile, Egypt

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Source: [28].

Figure 5: Choice of providers for outpatient care by income quintile

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Box 1: The “Right to Health” as captured in Egypt’s Constitution of January 2014

The commitment to achieving social justice in health care is coined in Egypt’s new Constitution of January 2014. Article 18 enshrines the “Right to Health” and ensures that “every citizen is entitled to health and to comprehensive health care with quality criteria. The state guarantees to maintain and support public health facilities that provide health services to the people, and work on enhancing their efficiency and their fair geographical distribution.” To ensure this commitment is translated into action, the state has committed to allocating a percentage of government expenditure of no less than 3 percent of GDP to health, almost double its current allocation. The percentage is expected to increase gradually to reach global rates with improvements in the economy and better targeting of subsidies to the poor.

Right to Health in the Egyptian Constitution: Article 18

- “Every citizen is entitled to health and to comprehensive health care with quality criteria. The state guarantees to maintain and support public health facilities that provide health services to the people, and work on enhancing their efficiency and their fair geographical distribution.
- The state commits to allocate a percentage of government expenditure that is no less than three percent of Gross Domestic Product (GDP) to health. The percentage will gradually increase to reach global rates.
- 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. Denying any form of medical treatment to any human in emergency or life-threatening situations is a crime.
- The state commits to improving the conditions of physicians, nursing staff, and health sector workers, and achieving equity for them.
- All health facilities and health related products, materials, and health-related means of advertisement are subject to state oversight. The state encourages the participation of the private and public sectors in providing health care services as per the law.”