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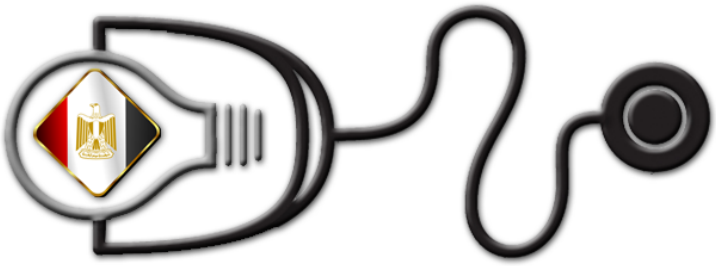
# Citizens-Conceived

# Healthcare System Re-Structuring

# for Post-Revolution Egypt



## Master Thesis

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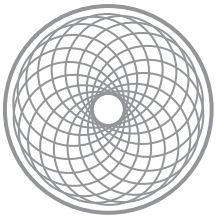

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The paper has not been submitted for evaluation to another examination authority or has been published in this form or another.

To my first thimble, the memory of a hero, an iron lady, the guru next door, the youngest LEO and the night companions.

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Mohamed El Sada

Tahrir Loung

The MCI Team

The Family Clinic Team

The Egyptian Initiative for Personal Rights

Every Revolutionary Egyptian Soul

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# List of Abbreviations

**GNI**: Gross National Income

**NHA:** National Health Accounts

**GDP:** Gross Domestic Product

**EGP:** Egyptian Pounds

**MOH:** Ministry Of Health

**WHO:** World Health Organization

**EMRO:** East Mediterranean Regional Office

**HIO:** Health Insurance Organization

**EIPR:** Egyptian Initiative for Personal Rights

**MCI:** Management Center Innsbruck

**HSRP:** Health Sector Reform Program

**NGO:** Non-Governmental Organization

**NHS:** National Health System of the United Kingdom

**PPOs:** Preferred-Provider Organizations

**Health Co-ops:** Health cooperatives

**ROSCAs:** Rotating Savings and Credit Associations

# English Abstract

Egypt has gone through decades-long unfruitful healthcare reform processes that failed to deliver the system that would respond to the population's needs since almost devoid of any real public dialogue. Grasping the collective and participatory spirit following the Egyptian uprising that began in 2011, this study attempts to enable Egyptian voices from every corner of the country to have a say in the way the new healthcare system re-structuring should look like.

Through the results of this qualitative inductive narrative field research, the collected citizens' views constitute the hard skeleton for an innovative proposed healthcare system that also takes into account other countries experiences, key stakeholders' feedback, expert opinions and literature review. The study aims at developing a system that has the biggest chances of being successful in achieving the highest degree of citizens' satisfaction since, after all, it has been created by these same individuals.

Based on the analysis of the study findings, a comprehensive plan is proposed which seeks a gradually implemented, deep community-rooted, dynamic system that accounts for the scarce resources and available infrastructure. A system that is custom-designed and managed by communities, possesses the flexibility to adapt to each community's preferences and needs, insures choice of providers, guarantees work sustainability, pushes towards accountability to patients and quality improvement. A system that operates with the highest degree of independence from the government, uses market dynamics in pushing for better service delivery whilst being directly regulated, monitored and partly subsidized by the state and that still benefits from nation-wide risk-pooling and cost-sharing mechanisms.

The different components of this structure are explained together with references on their alignment with the study results.

Finally, practical recommendations and considerations to take into account about the potential implementation of this plan concludes the paper.

# Arabic Abstract - ملخص البحث


مرت مصر عبر سلسة من المحاولات الفاشلة لإصلاح القطاع الصحي والتي استمرت لعقود من الزمن كان الشعب المصري في أمس الحاجة فيها لحياة كريمة لا تُمتهن فيها كرامته بشتى الصور ومنها خدمة صحية رديئة المستوى وقلق دائم مما يخفيه القدر من أمراض قد تعصف باستقرار أسرته وأمنها المادي في أية لحظة.

وكان من أهم أسباب فشل تلك المحاولات الإنعدام الكامل لحوار مجتمعي حقيقي يكشف عن الاحتياجات الحقيقية ويراعي الامكانيات المادية لأهم عضو مؤثر في القطاع الصحي وهو المواطن ذاته.

هذا البحث هو محاولة لاستلهام الروح التشاركية للثورة المصرية في نقل صوت المواطنين من شتى أركان البلاد وتصوراتهم عن نظام الصحة الأمثل لهم وكيفية إدارته باختلاف امكانياتهم المادية وأعمارهم واتجاهاتهم السياسية وطبيعة عملهم.

تُكَوِن نتائج هذا البحث الميداني الكيفي أساساً يُبنى عليه نظاماً مقترحاً لإدارة الخدمة الصحية في مصر يأخذ في الإعتبار التجارب والأبحاث العالمية في هذا المجال ويوظفها في نظام مبتكر يهدف إلي تحقيق أكبر قدر من الرضا للمواطنين بما أنه نتاج إبتكارهم بأنفسهم.

بعد عرض وتحليل نتائج البحث الميداني، يتم عرض مقترحاً لنظام الصحة يتم تنفيذه تدريجياً يبدأ من عمق المجتمع المصري بطريقة تفاعلية تضع في الحسبان الموارد المحدودة والبنية التحتية المتوفرة. نظاماً تقوم المجتمعات المختلفة بصياغته وإدارته ذاتياً. نظاماً لديه القدرة علي التأقلم للاحتياجات والامكانيات المختلفة لكل مجتمع مع ضمان حرية المواطن في اختيار مقدم الخدمة وضمان استمراريته ودفعه المستمر نحو رقابة وتحسين الجودة وتمركز الخدمة حول المواطن. نظاماً يعمل بأكبر قدر من اللا تبعية للحكومات دون تمصلها من دورها في الحفاظ علي حق المواطنين في الصحة ويوظف القطاع الخاص لابتكار طرق وحلول جديدة لتحسين مستوي الخدمة في مناخ من الرقابة والدعم الفني والمادي من الدولة.

أخيرا، يقدم البحث عرضاً لبعض الاعتبارات العملية وآلية مرتبة للتطبيق علي أرض الواقع.

> When you know your term as “minister of health” will not exceed a couple of years and that the work you want to accomplish will take much more than that, the smartest thing to do is to shift to the co-pilot seat and bring the “People” in front of the steering wheel. This way, no matter how much the co-pilot changes, the plane will still go for the same goal, in the same direction. The “People” will make sure it does so.

# I. Background

## ▪ Country Overview

Egypt has been the host of undoubtedly the oldest and most diverse civilizations in human history. Its people are a complex amalgam of cultures, religions and age-old traditions, some of them traceable to the pharaonic times. Yet, its estimated total population of 83 million people[1] have suffered tremendously from repeated foreign occupations and autocratic governments. Today, Egypt is considered a lower middle income country, with a Gross National Income (GNI) per capita of $2,440 in 2010 and a Poverty headcount ratio at national poverty line (% of population) of 22% in 2008.[2] Ranked 112 in human development index rank, out of 177 countries, it has an adult (15+) literacy rate of 71.4%.[3]

With an estimated total life expectancy at birth of 72.3 years in 2008[4] and an infant mortality rate of 19 per 1000 live births[5]. The general health profile of the Egyptian population is characterized by considerable discrepancies and lack of equality both in access to care and quality of services.

## ▪ Current Healthcare Infrastructure

Egypt's healthcare system is a very pluralistic one. It relies on many sources of funding with healthcare expenditure up to 72% of total health spending incurred by households from 60% in 2007-2008. The National Health Accounts (NHA) for the fiscal year 2007/08 estimate that Egypt spent 42.5 billion Egyptian Pounds (EGP) on healthcare, representing 4.75% of the country's gross domestic product (GDP). This translates to a per capita health spending of 566.4 EGP.[6]

Financing of healthcare is characterized by mutually exclusive tracts (silos) and a multitude in sources of financing, making the coordination and effective management of the healthcare sector a heavy burden across the public and private funders and providers.

The healthcare providers' market is even more fragmented: A network of in-patient and out-patient facilities are owned by the Ministry of Health (MOH) in addition to public sector facilities operated by

[1] Source: *Egypt*, World Health Organization (WHO), www.who.int/countries/egy/
[2] Source: *Egypt country data*, The World Bank, www.data.worldbank.org/country/egypt-arab-republic
[3] Source: *Egypt Country Cooperation Strategy at a Glance*, WHO, 2009
[4] Source; *Egypt country profile*, WHO-EMRO, www.emro.who.int/emrinfo/index.aspx?Ctry=egy
[5] Probability of dying between birth and age 1 per 1000 live births
[6] Source: *Ministry of Health, Egypt, and Health Systems 20/20*, National Health Accounts 2007/2008: Egypt. Bethesda, MD: Health Systems 20/20 project, Abt Associates Inc, September 2010

the Health Insurance Organization, the Curative Care Organization, Universities and Teaching Hospitals and Institutes as well as exclusive facilities managed and owned by the police and the military forces. There is also a heavy reliance on a growing private market of hospitals, outpatient clinics, pharmacies, and traditional healers.[7]

Contrary to global homologues, out-of-pocket spending in relation to total healthcare spending has been dramatically increasing over the past decade.

It may be true that there is a pressing need to increase the state healthcare spending to cope with the persistence of infections diseases and high burden of chronic conditions on the population's welfare, but it is important to note that even without raising the government's investments in health, there is much to be done in terms of efficient use of the currently available resources through radical restructuring of the healthcare sector that, if done properly, is capable of achieving outstanding results in terms of outcomes, decreased burden of disease and cost-savings.

### ▪ A New Page in History, a New Healthcare System

Post-Popular-Revolution Egypt has a craving need for freedom, social equity and better living conditions for all. People took matters into their own hands to reach out for better lives for themselves, their families and the future generations. Proper healthcare is an integral part of this equation. It is no longer acceptable for any Egyptian to receive anything less than decent healthcare services that he / she can afford.

Recently, newly formed political parties featured their own views on how to achieve that in their programs and candidates made shining promises about the future of the Egyptian healthcare system. Yet, before jumping to how these promises can be achieved, it is vital to lay out the proper foundations of a healthcare system capable of meeting people's real aspirations. ■

[7] Source: *Ministry of Health, Egypt, and Health Systems 20/20*, National Health Accounts 2007/2008: Egypt. Bethesda, MD: Health Systems 20/20 project, Abt Associates Inc, September 2010

# II. Problem Definition

Throughout the decades-long rather unsuccessful process of healthcare reform that took place in Egypt, one key defect was persistently present throughout the process:

*The absolute lack of community communication, participation and debate about the proposed laws.*

The "subjects" of the law (being the entire Egyptian population) were almost completely prevented (and sometimes, forbidden) from being exposed to the suggested new laws. The civil society had to go through heroic stunts to get the least amount of information on what is being prepared behind closed doors. This constantly put the civil society organizations concerned with an equitable and accessible healthcare system for all, in the position of the antagonist: always objecting, criticizing and sometimes having to file law suits against the government officials who almost never managed to listen to them as in the case of the September 2008 court verdict against the intended privatization of the state-owned Health Insurance Organization (HIO) that was planned by the government and which put a halt to the healthcare reform plan it was going through.[8]

Reality is different now, it is highly expected that the healthcare reform file together with the education reform one, are going to erupt on the surface of society's concerns as soon as the country has passed the current political transitional phase. When the issue of healthcare reform is to be opened, it is no longer going to be acceptable to have a paternalistic government, that thinks it knows what is best for the people, to act on its own according to what it sees suitable.

The transition from a severely debilitated healthcare system, with limited access to care, major inequity, deficient outcomes, significantly poor general satisfaction and increasing public costs to a healthcare system that truly meets people's expectations can only be concretized through unprecedented community participation that leads to core-restructuring arising from the bottom up.

Just like the constitution of the country, the voice of the people must be the origin of all needed reforms in the upcoming period. Healthcare reform is no exception.

*People decide how they want to be governed, officials make it happen: This is how it should work!*

■

[8] A law suit was filed by the Egyptian Initiative for Personal Rights (an Egyptian civil society organization) in protection of the constitutional government responsibility to deliver healthcare to the population in 2007. www.eipr.org

# III. Selected Review Topics

## 1. Attempts of healthcare system reform in Egypt

The Egyptian healthcare system went through repeated attempts of reforms over the past three decades. Stagnant politics and a very centralized decision making process lead to the fact that none of the attempted reform efforts ended up seeing the light of day.

| In 1997, the government of Egypt launched the Health Sector Reform Program (HSRP). Under the program, persistent needs in maternal and child health were addressed through an emphasis on primary health care, as well as through the introduction of the family health model as the principle of primary care. The HSRP was introduced in a first phase in the pilot governorates of Alexandria, Menoufia and Sohag (1998-2004) and subsequently extended to Qena and Suez (2004-2005). This pilot phase addressed both the delivery and the financing of primary health services and came to a close in 2006. | [9]

This long reform plan included a number of interventions targeting service delivery, namely:

- Training in family medicine,
- Restoration of buildings and equipments renewal,
- Setting up of a set of accreditation standards.

The financial model it proposed hoped to re-channel national health funds to local “Family Health Funds”, imposing a mandatory insurance with an invariable premium, co-payments and state subsidy of premiums for poor segments upon individual case assessment.

Results from the first pilots were incorporated in modifications of the system that were tested again till the program was permanently stopped in 2006.

Official reports following the pilot trials state that the HSRP showed | some Successes. | [10] describing a | noticeable shift from secondary to primary care in child treatment for fever/cough, an increase in

[9] R. Grun, J. Ayala, *Impact Evaluation of the Egyptian Health Sector Reform Project Pilot Phase*, The International Bank for Reconstruction and Development / The World Bank, 2008

[10] G. Gaumer, N. Rafeh, *Strengthening Egypt’s Health Sector Reform Program: Pilot Activities in Suez*, Abt. Associates Inc., 2005

the child vaccination rate, an increased use of modern family planning and a reduction in female malnutrition. [11]

However, the quantitative method used in coming up with these conclusions revolved around specific health indicators of individuals consuming the services. It failed at giving any hints about results with those who failed to access the services and, most importantly, it did not describe or reflect citizens' satisfaction from the healthcare system.

However, in a qualitative study[12] that aimed at measuring the general satisfaction of the population after the pilot phase through eighteen focus groups in the city of Suez, results were strikingly different. A generally predominant dissatisfaction from the services presented, the financing scheme and the added financial burden that the citizens had to incur without any tangible improvement were described by most participants. Most of them described the system as one relying on untrained, commonly unavailable health providers showing no care to the patients they are treating, following a chaotic financial system, all in "nice looking buildings! [13]

Today, it does not need lots of research work to realize how much this system has publicly failed. It may have been constructed in a way that might end up delivering better services for the population but, the absolute lack of public dialogue and involvement of the healthcare system stakeholders in the process might have been enough to label it as "failed attempt". The same is bound to happen if this lesson is not accounted for in the future.

## 2. Propaganda versus real community policy dialogue

Politicians in democratic societies often find the need to transmit a certain believe in their policies or decisions to the people that elect them. Long unilateral speeches have long ceased to exist as a competent method to make people feel involved. More sophisticated, indirect tools are being used to evoke a sense of involvement which may be real or simply an illusion.

Although the word "propaganda" evokes deception and lying to crowds, definitions of the word in literature often exclude this negative connotation. This deliberate, systematic attempt to shape perceptions, manipulate cognitions, and direct behavior to achieve a response that furthers the

[11] G. Gaumer, N. Rafeh, *Strengthening Egypt's Health Sector Reform Program: Pilot Activities in Suez*, Abt. Associates Inc., 2005
[12] S. Kahla, Z. Mostafa, *Report on focus groups following healthcare system reform pilot in Suez*, Suez city records, 2005
[13] S. Kahla, Z. Mostafa, *Report on focus groups following healthcare system reform pilot in Suez*, Suez city records, 2005

desired intent of the propagandist [14] is often the real aim of public dialogues carried out by governments to promote their policies.

Real public dialogue however should have an entirely different aim: a genuine quest for better reciprocal understanding to reach mutually beneficial results. It no longer becomes a necessary instrument for the state and the authorities [15] for the same reason. It is no longer about promoting pre-made policies but actually about **creating** those policies in the first place.

One also needs to differentiate between political communication and government public relations. The first is defined as the persuasive communication coming from politicians explicitly or implicitly striving for political, image and electoral points. [16] On the other hand, government public relations evokes more neutral communication efforts in which the government/administration tries to be non-partisan, balanced and concise. These efforts are not aimed to put a political party or politician in the picture, but focus on the interest of the receiving citizen who needs to be informed. [17]

What is relevant in this critical time of Egypt's political scene and elsewhere is that governments should not only use public relations to publicize decisions, but that public relations are needed throughout the policy process. [18] This is specially true for healthcare system policy dialogue. Not only should it take place extensively and on repeated intervals. It is additionally most important for it to be done with the right mindset: To create policy and truly reflect people's stated expectations and wishes. To truly put citizens in command of the reform effort, and not only as passengers.

In addition, governments should systematically assess the communication needs of citizens and their preferences about potential policies. This would entail answering questions about how frequent citizens would like to communicate on the issue, as well as which medium they would prefer, the length and style of the messages, and so forth. [19]

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[14] P.M. Taylor, *Munitions of the mind: A history of propaganda from the ancient world to the present day (3rd ed.)*, Manchester, UK: Manchester University press, 2003, P. 6
[15] J. Ellul, *Propaganda: The formation of men's attitudes*, New York: Vintage Books, 1965/1973, P. 121
[16] H. Vandebosch, *Reader government policy and communication Cursustekst overheidsbeleid en communicatie. Antwerpen: University of Antwerp*, 2004, P. 10
[17] H. Vandebosch, *Reader government policy and communication Cursustekst overheidsbeleid en communicatie. Antwerpen: University of Antwerp*, 2004, P. 11
[18] D. Gelders, G. Bouckaert and B. van Ruler, *Communication management in the public sector: Consequences for public communication about policy intentions*, Government Information Quarterly, 24(2), 2007, P. 326–337.
[19] D. Geldersa, Ø. Ihlenb, *Government communication about potential policies: Public relations, propaganda or both?*, Public Relations Review 36, 2010, P. 59–62

## 3. " Free " healthcare

Political programs and strong resonating promises of politicians in Egypt repeatedly talk about "Free healthcare as a right". Aside from the poetic impracticality of such promises in a country where three quarters of the total healthcare expenditures are out-of-pocket household expenditures, the question we ask is: **"Is Free healthcare" a notion worthy of dreaming of in the first place?**

| For many, free medical care embodies a "right to medical care", irrespective of whether cost sharing affects health status or not. Such individuals should ask themselves what is really being bought by medical care that is free at time of treatment. Clearly free care is costly because of the additional use it stimulates. What benefits are bought for these extra costs? |[20]

The RAND Health Insurance Experiment is the largest and longest running social science research project ever completed. Approximately 2000 non-elderly families from 6 different regions in the U.S. were assigned to insurance plans that varied the price of services and the "packaging".

The study's results clearly show that the "Free care" option ended up not offering added benefits to the average person. In addition, the study argues that | the increased inappropriate care in case of "Free care" was not just zero-benefit care; it actually had negative effects. Examples of such care include prescribing antibiotics for viral infections, thus incurring side effects in some fraction of cases for no gain; inappropriate hospitalization; and labeling effects. |[21] Other studies tend to align with this argument in stating that | one sixth to one third of certain medical procedures do not produce a benefit sufficient to justify the clinical risk |[22] and that | close to 4 percent of hospital admissions result in iatrogenic treatment or induced injury that prolongs the stay or causes a disability that lasts past the stay. |[23]

It is therefore a necessity to reconsider with a critical eye the value of "free medical care" for what it truly delivers. One needs to consider two arguments in this perspective: | 1) The issue is the efficacy of the **additional** medical services induced by free care, not the efficacy of **any** medical service and 2) Although medical services are beneficial in many instances, in some instances they are not. Just as a right to food does not preclude overeating, a right to medical care does not preclude over treatment. |[24] ■

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[20] J. P. Newhouse and the Insurance Experiment Group, *Free for all?", Lessons from the RAND health insurance experiment,* A RAND study, Harvard University Press, 1993, P. 356
[21] J. P. Newhouse and the Insurance Experiment Group, *Free for all?", Lessons from the RAND health insurance experiment,* A RAND study, Harvard University Press, 1993, P. 357
[22] Chassin, Mark, et al., *Does inappropriate use explain geographic variations in the use of Health Care Services? A study of three Procedures*, Journal of the American medical association 258, 1987, P. 2533-37
[23] Brennan, Troyen A., et al., *Incidence of adverse events and negligence in hospitalized patients: Findings from the harvard medical practice study*, New England journal of medicine 324, 1991, P. 370-376
[24] J. P. Newhouse and the Insurance Experiment Group, *Free for all?", Lessons from the RAND health insurance experiment*, A RAND study, Harvard University Press, 1993, P. 358

# IV. Study Goals

This study is aiming at capturing the essence of the revolutionary spirit Egypt is currently enjoying, in creating a proposed re-structuring of the Egyptian healthcare system that is conceived directly by the Egyptian people, built according to their specific vision of how they want their country to operate and grasps the different expectations and needs of the people regarding healthcare.

The essence of the literature and situation review described earlier was used as the proxy towards reaching a common basic understanding that all study subjects can understand and relate to.

Using the collected citizens' views as the hard skeleton of the proposed structure, other countries' experiences, key stakeholders' feedback, expert opinions and literature review, the study aims at developing a system that has the biggest chances of being successful in achieving the highest degree of citizens' satisfaction since, after all, it has been created by these same individuals.

The study also sheds the lights on how different variables such as socio-economic level, occupation, geography and political views affect the way people perceive the state's responsibility in regards to healthcare delivery.

The study displays different spearheaded tools for popular dialogue that can be used by governments and organizations for more productive and relevant public dialogue.

Finally, the study presents the general outlines and specific ideas of a formulated sustainable, yet, citizens-conceived healthcare system re-structuring covering the different elements of the process of healthcare delivery.

■

# V. Study Method: Citizens Involvement

## ▪ Study type

This study is an empirical, systematic, narrative, inductive, qualitative, field research covering clustered samples from different segments of the Egyptian population with the following structural variables:

- Income levels
- Genders
- Age-groups
- Occupations
- Geographic locations
- Ethnicities
- Political views
- Education and Access to technology
- Needs and links to healthcare delivery.

| Qualitative research designs can be deductive or inductive. That is, it can aim to test a hypothesis or to develop one. | [25] Although there exists a deductive component in this research, yet, results of this component are not the most relevant and will not be presented or discussed in extensive details as, the importance of this component is intentionally to serve the principal, inductive component of the study which pushes the audience to develop a new healthcare system that serves their needs.

## ▪ Why Narrative research?

| Qualitative methods permit the evaluator to study selected issues in depth and detail. Approaching fieldwork without being constrained by predetermined categories of analysis contributes to the depth, openness and detail of qualitative inquiry. | [26]

| In qualitative research, behaviors, understandings, actions and experiences are not measured using statistical analysis as in quantitative research. | [27] [28] | Instead, detailed written descriptions and

[25] J. W. Cresswell, *Research design: qualitative, quantitative and mixed methods approaches*, Sage Publications, Thousand Oaks, California, 2003, P.6
[26] M. Q. Patton, *Qualitative evaluation and research methods*, Second edition, Sage Publications, Newbury Park, California, 1990, P. 13
[27] K. Devers, *How will we know "good" qualitative research when we see it? Beginning the dialogue in health services research*, Health Services Research, vol. 34, no. 5, 1999 P. 1153-88
[28] S. Sofaer, *Qualitative methods: what are they and why use them?*, Health Services Research, vol. 34, no. 2, 1999, P. 461-83

explanations of the phenomena under investigation are produced. Qualitative methods are those that collect data in the form of talks, words, observations, visual images and documents. [29]

When our ultimate goal is to create a truly citizens-based proposed restructuring of the healthcare system, one cannot deal with quantitative data because it simply defies the purpose. In such social research we are first and foremost driven by:

1. An interest in people's lived experiences and an appreciation of the temporal nature of that experience.

2. A desire to empower research participants and allow them to contribute to determining the most salient themes in the area of our research.

3. An interest in process and change over time.

4. An awareness that the researcher him or herself are also narrators. [30]

In our reliance on narrative in this type of research, we are attempting to explore the perspective of those who are directly involved when it comes to healthcare reform, the primary stakeholders of the healthcare delivery machine: **The citizens**. We therefore believe that qualitative research methods are well suited for investigating the meanings, interpretations, social and cultural norms and perceptions that impact on health-related behavior, medical practice and health outcomes. [31]

This applied research is therefore specifically designed to be problem solving and to have an outcome which is expected to be of immediate relevance. [32]

## ▪ Preparation

The following steps were followed for the preparation of the qualitative research:

Step 1: Identification of the research questions and ultimate study goal.

Step 2: Literature review and refinement of the research questions.

Step 3: Development of the research outline including research subjects, sampling, required resources, field researchers and ethical issues.

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[29] E. C. Hansen, *Successful Qualitative Health Research*, Open University Press, 2006, P.4
[30] J. Elliott, *Using Narrative in Social Research*, Sage Publications, 2005, P. 6
[31] C.F.C. Jordens, M. Little, *"In this scenario I do this, for these reasons": Narrative, genre and ethical reasoning in the clinic*, Social Science and Medicine, vol. 58, no. 9, 2004, P. 19635-45
[32] D. Royse, B.A. Thyer, D.K. Padgett. T.K. Logan, *Programme evaluation: An introduction*, 3rd edition, Wadsworth Books / Cole Social Work, Belmont, 2001

## ▪ Design

The research is designed in an interactive format where the researchers play an important facilitatory and steering role for the discussion. It is a two to three hours process that alternates between basic data and explanations given by the researchers and discussions and interactions from the subjects that covers both individual experiences and collective reasoning. Narration and story-telling are the key foundations of the data collection. The process went through seven consecutive steps (Table 1).

Table 1: Study focus group steps

| | Steps | Activity | Tools |
|---|---|---|---|
| 1 | **Audience preparation** | Introduction, background briefing and purpose of study | Dialogue |
| 2 | **Three questions** | 1) What is your age, social status, occupation and average monthly earning?<br>2) What do you think is the role the ministry of health should provide?<br>3) What are your personal experiences with the healthcare system? | Printed form<br>Written documentation<br>Video / Audio recording |
| 3 | **Basic foundations for the discussion** | Explanation of the definition of health, the role of the government in healthcare delivery, government expenditures in healthcare | Presentation or verbal communication, according to settings |
| 4 | **Four questions** | 4) What is your opinion about the current healthcare system in Egypt?<br>5) Which services do you commonly consume? How do you pay for these services?<br>6) Which healthcare services do you see satisfactory? Why are they so? | Written documentation<br>Video / Audio recording |
| 5 | **Simple overview of healthcare systems around the world** | Explaining of functioning, advantages and disadvantages of four distinct examples of healthcare systems | Presentation or large printed graphical representations |
| 6 | **Three questions** | 7) What makes a "successful" healthcare system in your opinion?<br>8) Which of these healthcare systems are you favoring more?<br>9) Are you willing to pay a set percentage of your monthly income in return for a comprehensive health insurance for you and your family? How much are you willing to pay? | Written documentation<br>Video / Audio recording |
| 7 | **Collective design of the most favorable healthcare system** | 10) How do you want the Egyptian healthcare system to be like? | The Art of hosting<br>Written documentation<br>Video / Audio recording |

### i. Audience preparation:

Before any data collection is carried out, special care is given to the preparation of the subjects of the study. Once the right social setting has been insured, an interactive briefing is given including simplified background information about the researchers and the purpose of the study.

**ii. Collection of responses to three questions**

*1) What is your age, social status, occupation and average monthly earning?*

This question is asked through individual questionnaires to be filled by each individual or through direct questioning by the researchers for illiterate subjects.

*2) What do you think is the role the ministry of health should provide?*

*3) What are your personal experiences with the healthcare system?*

These two questions are asked by the researchers and subjects are encouraged to tell their own individual impressions and stories.

**iii. Presentation and explanation of the basic foundations for the discussion**

The researchers begin explaining in a simplified manner the definition of health, the role of the government in regards to healthcare delivery as well as some data about the government expenditures in healthcare. Remarks and reactions of the audience during this display are recorded.

**iv. Discussion and collection of responses to four questions**

*4) What is your opinion about the current healthcare system in Egypt?*

*5) Which services do you commonly consume? How do you pay for these services?*

*6) Which healthcare services do you see satisfactory? Why are they so?*

These questions are asked and answered in rather collective manners where individuals are encouraged to add and comment on each other's responses. Individual reactions are recorded as well as collective ones.

**v. Simple overview of healthcare systems around the world**

The researchers begin explaining in a simple, every-day language, four distinct general systems of healthcare financing around the world, sorted by increasing degree of social solidarity involved. Four countries of the world are featured to illustrate these different systems (Bulgaria, the United States, France and the United Kingdom). The key differences, advantages and disadvantages of each are discussed with the audience in regards to effectiveness, degree of social solidarity and cost. This part is explained used a portable projector or large printed graphical representation .

Depending on the audience and their educational level, more details are given to illustrate the functioning of the macro-economic model of each system. Responses and remarks of the audience are recorded.

**vi. Discussion and collection of responses to three questions**

*7) What makes a "successful" healthcare system in your opinion?*

*8) Which of these healthcare systems are you favoring more?*

*9) Are you willing to pay a set percentage of your monthly income in return for a comprehensive health insurance for you and your family? How much are you willing to pay?*

**vii. Collective design of the most favorable healthcare system**

In this final component, the audience is invited to answer the final question:

*10) How do you want the Egyptian healthcare system to be like?*

A fluid, collective group discussion is steered with the ultimate goal of designing a healthcare system that meets the expectations and capacities of every single member of the audience. Natural leaders are encouraged to chair the discussion and to make sure every person is represented in the final outcome. Anecdotes are occasionally given to illustrate potential pitfalls as the discussion moves on. The discussion, keywords mentioned, their frequency and the final outcomes are recorded.

## ▪ Data Collection Tools

Several data collection tools have been designed specifically for each focus group to fit the subjects attention span, settings of the data collection and size of the needed data.

The most commonly used format was extended, 10 to 15 people multidisciplinary focus groups. In some specific cases, individual interviews were resorted to. The study design, supportive materials and an instructional video were created and put to the disposal of volunteers around the country who were encouraged and supported in carrying out their own focus groups following the study design. Discussions and results were recorded and collected.

A new focus group tool was designed for one specific type of audience which is the revolutionary youth who are avid users of Twitter. “Tweet-Nadwa”, is an extended focus group format first implemented by Egyptian political activist Alaa Abdel Fatah. It enables a deeper, wider scope of possibilities to participate into the discussions in a faster, more concise, more diverse environment.

## ▪ Study subjects

Subjects of the research were Egyptian citizens from all walks of life. Since the research is not a quantitative one, correct sampling of the Egyptian population was not a goal. Instead, particular care was spent in forming multi-cultural discussion groups that would enable the highest degree of interaction between the group members, mimicking the cultural richness of the Egyptian society.

In addition and for comparison purposes, additional discussion groups were formed covering distinct common cultural backgrounds, geographical areas, educational levels and political views.

In total, sixteen focus groups were created sharing the same steps discussed earlier and varying in terms of the tools used for each as well as in the depth of the discussions and details of the data supplied by the researchers. Gender equal representation was sought throughout the study.

Table 2: Study focus groups composition details

| | Focus Group Name | Composition | Number of individuals | Focus Group location |
|---|---|---|---|---|
| 1 | **Multi-Disciplinary-1** | ▸ Mixed occupations<br>▸ Mixed religions<br>▸ Mixed political views | 40-50 live, 70-100 through Twitter | Tweet-Nadwa, near Tahrir Square |
| 2 | **Multi-Disciplinary-2** | ▸ Mixed occupations<br>▸ Mixed income levels<br>▸ Mixed habitat<br>▸ Mixed age groups | 24 | Individual online contributions and personal interviews |
| 3 | **Left** | ▸ Representatives from different Left political parties<br>▸ Non-party Linked left-oriented individuals | 10 | The center for socialist studies, Cairo |
| 4 | **Liberal-Right** | ▸ Representatives from different Liberal-Right political parties<br>▸ Non-party linked Liberal-Right oriented individuals | 7 live, 70-100 through twitter | Tweet-Nadwa in Cairo down-town |
| 5 | **Islamic-Right** | ▸ Representatives from different Islamic-Right political parties<br>▸ Non-party linked Islamic-Right oriented individuals | 6 | Individual interviews |
| 6 | **Rural** | ▸ Randomly selected individuals from a rural community | 15-20 | Popular café in the village of Ein El Seleen - Fayoum |
| 7 | **Students** | ▸ Randomly selected university students | 12 | University students in long private shuttle trip from the Red sea till Cairo |
| 8 | **Business** | ▸ Randomly selected individuals working in the private / business / investment sector | 14 | Hotel meeting room in Guiza |
| 9 | **Medics** | ▸ Multi-Age-groups healthcare workers | 18 | Kasr-El Ainy hospital |
| 10 | **Tribal** | ▸ Randomly selected individuals from a desert tribal community | 6 | Fire camp in Sinai |
| 11 | **Government-Officials** | ▸ Employees at the Egyptian ministry of health | 5 | Individual interviews |
| 12 | **Revolutionary-Youth** | ▸ Randomly selected youth involved in action or in spirit to the revolutionary movement | 40-50 live, 70-100 through Twitter | Tweet-Nadwa near Tahrir Square, Cairo |
| 13 | **NGOs** | ▸ Randomly selected workers in the civil society | 14 | Hotel meeting room in Cairo |
| 14 | **Pilot-Suez** | ▸ Beneficiaries from the pilot trial of the previously government-tested healthcare system reform in the city of Suez | 40 | City of Suez |
| 15 | **Academia** | ▸ Randomly selected academic individuals | 6 | Individual interviews |
| 16 | **Independent-Workers** | ▸ Randomly selected independent / non-contract / day workers | 8 | Alamein - The North coast |

## ▪ Researchers' Role

Two field researchers were involved in this study, playing a participatory, collaborative role rather than adopting an "expert" persona found in traditional research. In this type of studies, the researcher plays a pivotal role in the outcome of the results. | Qualitative researchers try to gather and analyze their own data rather than working with anonymous data collected by other people. They recognize that they are an integral part of the research process. Their skills, attributes, personal characteristics, interests and views will to some degree impact on the data collected. | [33]

## ▪ Data analysis

Data analysis has been done bearing in mind the large variety and narrative quality of the data collected. Conversion of qualitative findings to numerical data has been intentionally avoided due to the nature of the study and the possible influence by the way data has been collected. The purpose of this study goes beyond statistical findings about people's responses, it reaches out for the applicable statements that truly reflect the general population's expectations and vision for the Egyptian healthcare system and that can be included in the healthcare system's new structure.

Although the outcome of the discussions can be affected by the way the researcher is steering the conversation, it was of marked importance for the researchers to omit their own personal views about the matter and to report the results of the study without jumping to any conclusions in advance. In fact, | one of the good reasons for believing what people tell us, as researchers, is a democratic one: who are we to know any better than the participants when it is, after all, their lives? If we are prepared to disagree, modify, select and interpret what they tell us, is this not an example of the kind of power that we as researchers have that should be kept in check by being faithful to the voices of those we are researching? | [34]

## ▪ Reliability, Validity, Generalizability

| While reliability is generally defined as the replicability or stability of research findings, validity refers to the ability of research to reflect an external reality or to measure the concepts of interest. | [35] In other words, | the commonest definition of validity is epitomized by the question: "are we measuring what we think we are measuring?" | [36]

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[33] Morse, J.M. & Field, P. *Nursing research: The application of qualitative approaches,* second edition, Chapman & Hall, London, 1996

[34] W. Hollway, T. Jefferson, *Doing Qualitative Research Differently,* Sage Publications, 2001, P. 3

[35] W. Hollway, T. Jefferson, *Doing Qualitative Research Differently*, Sage Publications, 2001, P. 22

[36] F.N. Kerlinger, *Foundations of Behavioral Research*, New York: Holt, Rinehart and Winston, 1973, P. 456

"Measurement" suggests that qualitative research escapes from worry about validity since, after all, there are no real "quantitative measurements". In fact, "measurement" does not really work well together with narratives about in depth, detailed accounts of individuals' stories, experiences and reasoning patterns.

| However, even if the focus is shifted from measurement to description, the research must still confront the question of whether the accounts produced in a qualitative interview study are "accurate" or "valid" representations of reality. | [37]

Repeating patterns of concerns, experiences and sometimes, even keywords noticed during the study suggest a considerable degree of validity of its results. In different circumstances, with different group formations, different individuals share some strikingly common perceptions and wishes for their healthcare system.

| The scope or specificity of the description is another important issue to address. In qualitative studies it is common to interview a small, relatively homogenous sample of individuals living in a specific geographic area. This immediately raises questions about the extent to which descriptions based on those interviews can ben extended to cover a wider population. | [38] This is precisely why heterogeneity of the groups were a key concern in the groups formation. On most occasions, a "mini-society" was being attempted to be recreated inside the groups with the goal of studying and recording the interactions, predominant ideas, the ease or difficulty of reaching consensus and the final outcome of the discussion.

In this study, depth of the data and representativeness were favored over size, the ultimate goal being to | create a deeper and richer picture of what is going on in particular settings |. [39] Yet, this precisely means that all results are most definitely "context specific". Results are therefore far-away from trying to produce "law-like" statements and the scope of application of the recommendations is highly related to the socio-economic and political contexts of the study. The results and recommendations' potential of generalization are left to the judgement of the reader who is invited to decide on how the results collected align with the analysis and the proposal presented and to decide on to what extent they can be replicated in similar societal circumstances. ■

[37] W. Hollway, T. Jefferson, *Doing Qualitative Research Differently*, Sage Publications, 2001, P. 22
[38] W. Hollway, T. Jefferson, *Doing Qualitative Research Differently*, Sage Publications, 2001, P. 23
[39] J. Goodwon, R. Horowitz, *Introduction: the methodological strengths and dilemmas of qualitative sociology*, Qualitative Sociology, 2002, P.33-47

# VI. Citizens Opinions: Results and Findings

Due to the qualitative nature of the data collected, results are presented in the form of the most noticeable observations from the different focus groups, the most frequent priorities mentioned in the narratives and the noted relation with the features of each group. Findings were collected by two researchers and results were compared for validity. Only markedly repeated and agreed upon findings are presented.

### ▪ Question 1: What is your age, social status, occupation and average monthly earning?

Together with the segmentation principles of the targeted population, the rationale behind this question was to ensure the largest possible degree of representation of the Egyptian community in this research.

In terms of age groups (Table 3), gender representation (Figure 1) and revealed monthly earning (Figure 2), it can be said that the, over 230 individuals involved in this study, give a considerably representative account of the largely different demographics in the Egyptian diverse society.

It is to be noted though that the revealed monthly earning is usually less than the actual one. This is partly due to cultural considerations that associate talking about one's wealth or income to bad luck and partly to the considerable tax evasion that is endemic on all levels and the general suspicion associated with that.

Table 3: Distribution of the study subjects over age groups in percentage of sample

| Age groups | Number of individuals | Percentage |
|---|---|---|
| 0 to 20 years | 52 | 22% |
| 21 to 40 years | 88 | 38% |
| 41 to 60 years | 64 | 27% |
| 61 to 80 years | 27 | 11% |
| Above 80 years | 4 | 2% |

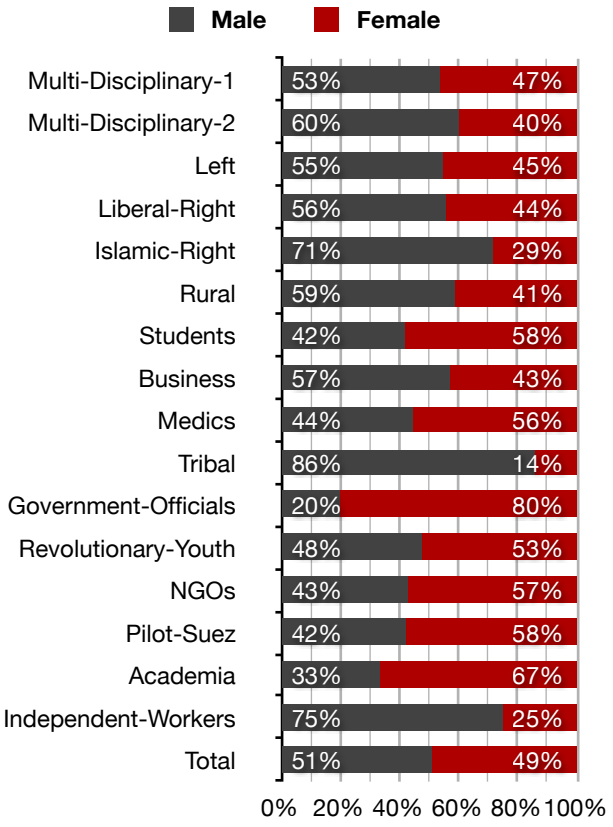



Figure 1: Gender distribution of the study subjects in percentage of each focus group

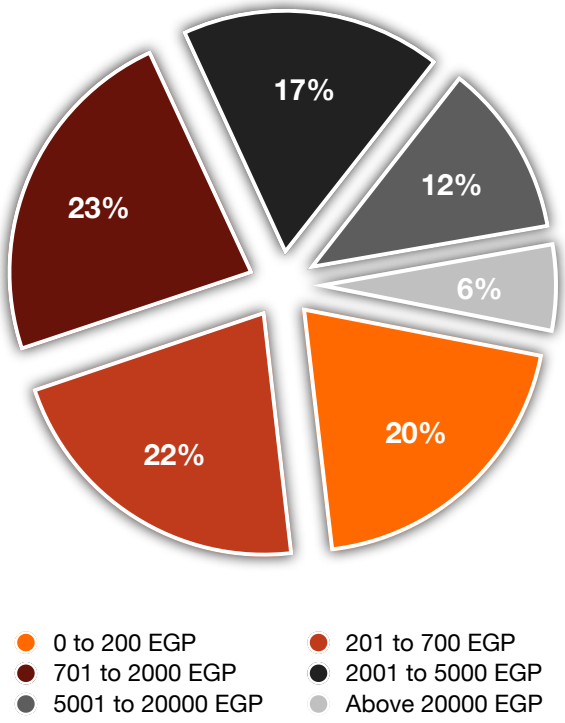



Figure 2: Distribution of the study subjects over monthly income in EGP in percentage of sample

### ▪ Question 2: What do you think is the role the ministry of health should provide?

This question was designed in order to elicit interest in the topic and to initiate the conversation about the state's role in healthcare provision. In all focus groups, the reply was "Treatment of patients". In the "Medics" focus group, "disease prevention" was added. Afterwards, the researchers begin revealing the five key roles that the ministry of health is mandated to provide to the population.

Table 4: Explained mandated role of the ministry of health in Egypt

| | |
|---|---|
| 1 | Making healthcare service available for all citizens. |
| 2 | Community health maintenance through prevention, awareness, disease control, health crisis management...etc. |
| 3 | Regulating healthcare financing, expenditure and quality of services and products |
| 4 | Insuring the provision of all key components for adequate healthcare services delivery (qualified human resources, equipments, infrastructure, medications, etc.) |
| 5 | Coordinating with all other government bodies and institutions with repercussions on citizens' health. |

### ▪ Question 3: What are your personal experiences with the healthcare system?

Individuals' narratives about their personal and family experiences with the healthcare system in Egypt were very revealing to the nature of the perceived problems. Naturally, almost all stories took the form of complaints about a seemingly "nightmarish" healthcare system. Although the nature and the severity of those "nightmares" differed considerably from rural to urban, from different income levels and according to occupation, yet one can synthesis four common observations on which everyone seemed to agree upon:

1) Severe, deep-rooted corruption that descends from higher management and finds its way till the lowest front-line healthcare workers also seemingly not sparing any profession, physicians and nursing staff included.

2) Absolute lack of any price-control authorities, regulating pricing of the private healthcare delivery, leading to expensive, commonly unaffordable services.

3) Lack of quality control measures over state-provided healthcare services. Common unavailability of needed materials and functioning equipments in these hospitals, forcing patients to purchase their own materials and medications out-of-pocket. This low quality of services coupled with the need to pay leads to general evasion from state-operated hospitals to the private sector, even if more expensive and even for low-income individuals and families who might end up borrowing money from families and neighbors in order to pay for private healthcare.

4) Very low consumption of the social health insurance services provided for government employees for the same reasons stated in the previous point.

### ▪ Question 4: What is your opinion about the current healthcare system in Egypt?

It was relatively striking to realize that seemingly all Egyptians, no-matter where they live and how much they earn, are extremely dissatisfied from the healthcare system in Egypt. The marked inequality does not seem to provide "acceptable" services even for the very well to do. Those who can afford it seek cross-border care and those who can't, suffer in terms of morbidity and mortality.

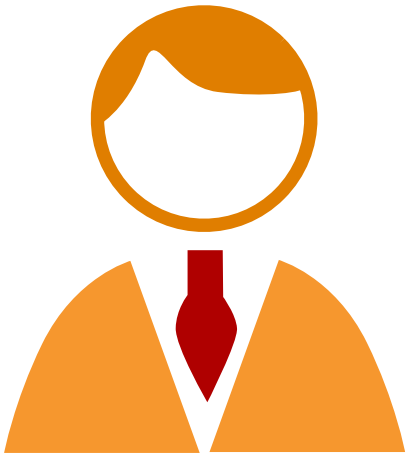
In gathering the data for this question, the researchers paid a special focus on commonly repeated "keywords". It may be possible to distinctly identify three groups of stakeholders with a set of "revealed priorities" that could be obtained from those keywords. (Figure 3)

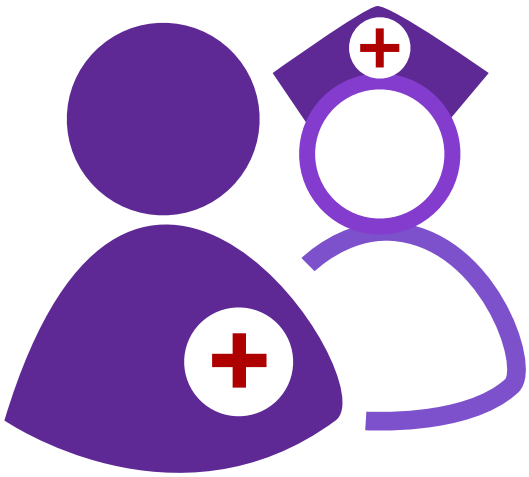
**Citizens / Patients**

| Rank | Priority |
|---|---|
| 1 | Access |
| 2 | Affordability |
| 3 | Safety from harm |
| 4 | Quality |
| 5 | Choice of providers |
| 6 | Human care |
| 7 | Financial self-sufficiency |

**State / Government**

| Rank | Priority |
|---|---|
| 1 | Affordability |
| 2 | Results / Delivery of promises |
| 3 | Highest attainable general stakeholders' satisfaction |
| 4 | Meeting international Commitments |





**Healthcare workers**

| Rank | Priority |
|---|---|
| 1 | Suitable Compensation |
| 2 | Impact on patients |
| 3 | Comfort |
| 4 | Education and Training |
| 5 | Choice of working place |
| 6 | Safety |
| 7 | Financial self-sufficiency |

Figure 3: Ranked stakeholders' priorities in healthcare systems

### ▪ Question 5: Which services do you commonly consume? How do you pay for these services?

Certain patterns of consumption of healthcare services, preferred points of services and mode of payment could be detected. It was noticed though that preferences in points of services are usually set based on capacity to pay and not a genuine choice based on quality of service sought.

Table 5: Preferred points of services and most common payment mode by consumer type

| Healthcare service | Consumers | Most likely point of service | Payment mode |
|---|---|---|---|
| **Primary healthcare / Family medicine** | Low income / Remote / Rural | Rarely use it / national Primary Healthcare centers (PHC) | Free |
| | Middle income / Urban | None - Go directly to specialist | - |
| | High income | None - Go directly to specialist | - |
| **Immunization** | Low income / Remote / Rural | National PHCs / vaccination campaigns | Free |
| | Middle income / Urban | National PHCs / Private | Free / co-payment |
| | High income | Private out-patient clinics | Private / out-of-pocket |
| **Child labor** | Low income / Remote / Rural | Private out-patient clinics | Private / out-of-pocket |
| | Middle income / Urban | Private hospitals | Private / out-of-pocket |
| | High income | Private hospitals | Private / out-of-pocket |
| **Maternity and child health** | Low income / Remote / Rural | National PHCs | Co-payment |
| | Middle income / Urban | Private out-patient clinics | Private / out-of-pocket |
| | High income | Private out-patient clinics | Private / out-of-pocket |
| **Acute care** | Low income / Remote / Rural | University hospitals if accessible | Free / co-payment |
| | Middle income / Urban | Private hospitals | Private / out-of-pocket |
| | High income | Private hospitals | Private insurance |
| **Inpatient services** | Low income / Remote / Rural | University hospitals if accessible | Co-payment |
| | Middle income / Urban | Private hospitals | Out-of-pocket / Insurance |
| | High income | Private hospitals | Out-of-pocket / Insurance |
| **Catastrophic illnesses** | Low income / Remote / Rural | Seeking state-funded care if accessible | State-funded / co-payment |
| | Middle income / Urban | Seeking state-funded care if accessible | State-funded / co-payment |
| | High income | Private hospitals / Abroad | Private / out-of-pocket |
| **Medications** | Low income / Remote / Rural | State dispensary if available | Co-payment |
| | Middle income / Urban | Private pharmacies | Out-of-pocket / private / insurance co-payment |
| | High income | Private pharmacies | Out-of-pocket |
| **Investigations** | Low income / Remote / Rural | Private centers | Out-of-pocket |
| | Middle income / Urban | Private centers | Out-of-pocket / private insurance |
| | High income | Private centers / Abroad | Out-of-pocket |

### ▪ Question 6: Which healthcare services do you see satisfactory? Why are they so?

The most noticeable and agreed upon observation, specially among those living in rural and remote areas, is that immunization is carried out in a satisfactory way. This mirrors actual efforts that took place to control the spread of preventable diseases through robust vaccination campaigns funded and organized by the government that actually succeeded in eradication of small pox and close from doing the same with poliomyelitis.

This in turn translates that success is felt and seen by citizens when it is reached. Even more, when asked about their interpretation of what made such services satisfactory and capable of reaching their goal, rural citizens could identify the reason behind this in no time: the ministry of health carries out periodic "door-to-door" campaigns where nurses track the vaccination schedules of children and immunizes them at home and this, in return for a "per-capita" bonus paid by the ministry. The nurses have an incentive for making sure all vaccines are given at the right time without missing any child. A successfully implemented performance-based payment with measurable and trackable goals and results.

### ▪ Question 7: What makes a "successful" healthcare system in your opinion?

This is an introductory question to begin putting the study subjects in the policy-maker's shoes. It initiated discussions that established a solid foundation for the presentation of four examples of distinct healthcare systems around the world, their functioning, advantages and disadvantages of each. No specific results were revealed from this question. Comments erupting during the explanation were noted for further development. The diagram in (Figure 4) was used to facilitate the process in the form of a projected presentation or a large printed cardboard according to the suitability of the settings of the focus groups.

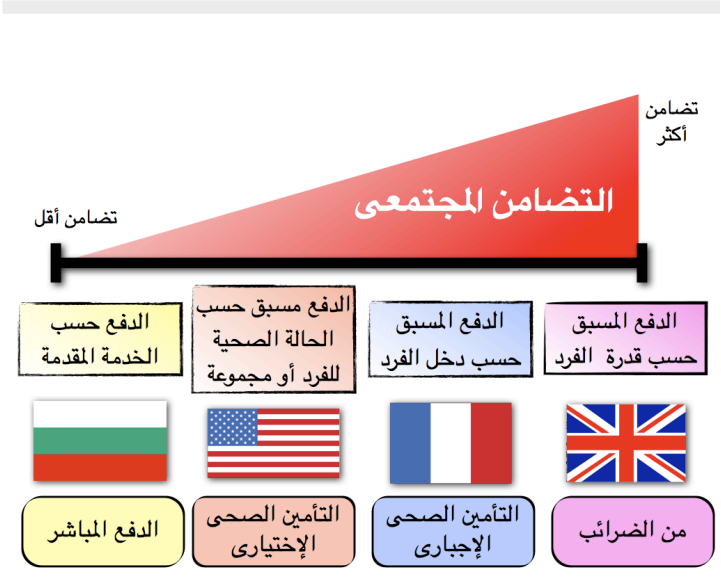



Figure 4: Graphical representation used with the focus groups to discuss the different healthcare systems

English translation of the diagram (Figure 5) illustrates how the four chosen distinct healthcare systems vary according to the extent of social solidarity in the financing of the system. The countries that were brought as illustrating example do not necessarily apply a raw financing scheme as it is shown in the figure. In fact, all healthcare systems have a certain degree of mixtures of the different systems. This simplification of matters was done intentionally to make the debate and discussion with the focus group individuals easier, since they mostly do not have any background knowledge about the subject. Also the choice of the countries and their flag considered the potential influence of individuals' feelings towards specific countries and its potential effect on their choices. No bias of this sort was felt through the research process of this study.

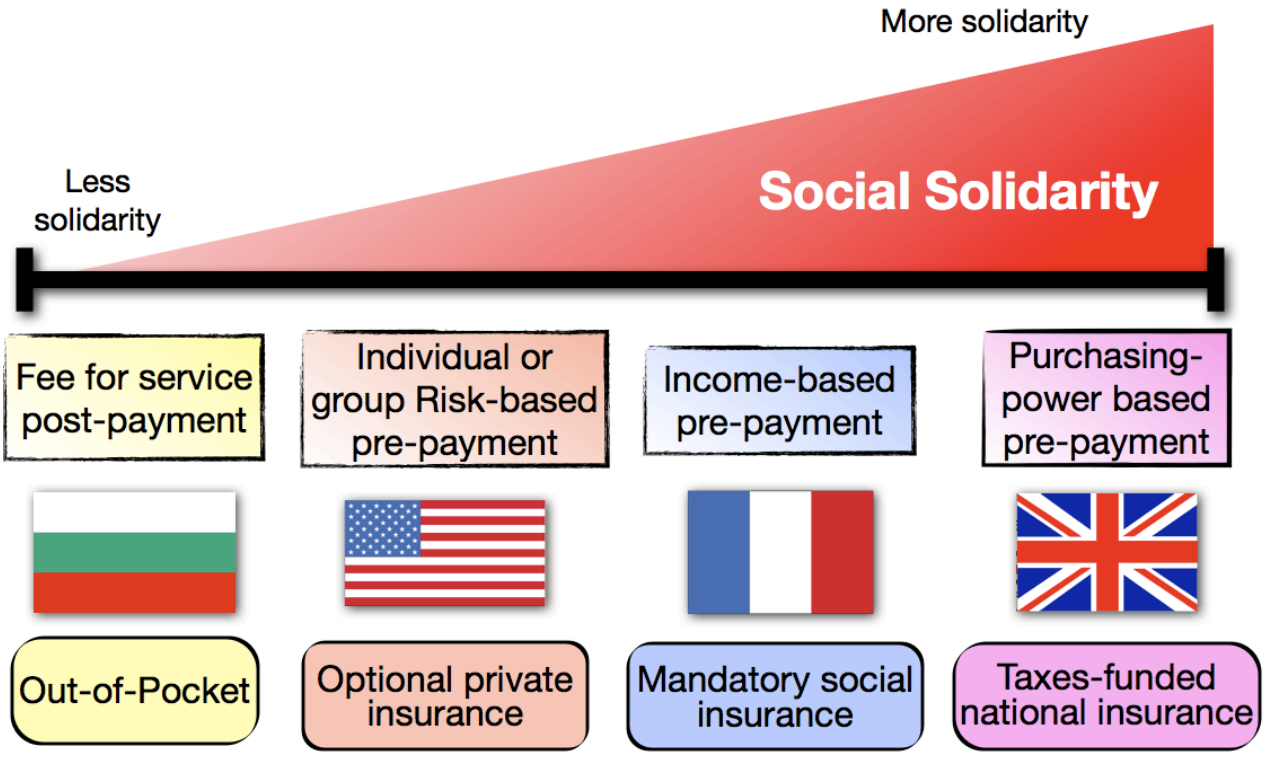



Figure 5: English translation of the graphical representation used with the focus groups to discuss the different healthcare systems, ranking the different systems in order of extent of social solidarity they deliver

- **Question 8: Which of these healthcare systems are you favoring more?**

When individual replies were collected, the answers to this question differed from individual to the other mainly following the income-level and the political orientation of the individual.

Obviously, from a political perspective, Left-minded individuals were more leaning towards the NHS, tax-funded system and the social health insurance system while Right-minded people, specially those

working in the business sector were very keen on preserving their right of choice of providers and healthcare plan.

From an income-level point of view, there were surprisingly no major differences between the individuals. The Fee-For-Service scheme was rarely mentioned. Few people from high income levels preferred the US optional health insurance model while the biggest majority was preferring either the National Health Insurance scheme or social health insurance.

Further discussion and exploration of these choices revealed three important observations:

1) Very few people want "Free" healthcare. This is due to significant lack of trust in the state management of healthcare, the poor quality associated with it and the fact that people end up having to go through lots of informal payments anyway.

2) Choice is an important requirement from all consumers, whether rich or poor and regardless of the political orientation.

3) The higher the income level, the bigger the value of choice of providers and of services. The lower the income level, the bigger the value of social solidarity. (Figure 6)

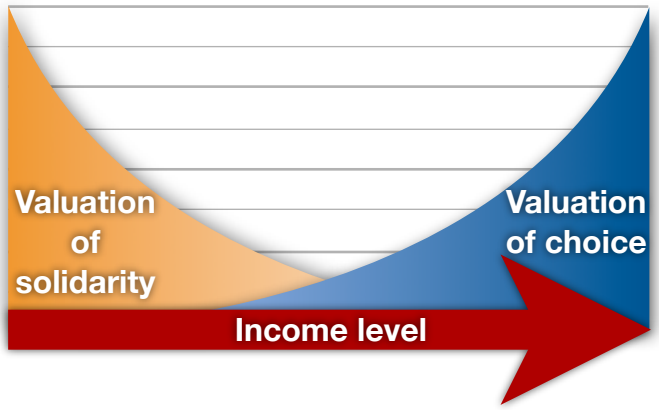



Figure 6: Graphical representation of relation between income level, individual valuation of 'Choice' versus individual valuation of 'Solidarity'

**▪ Question 9: Are you willing to pay a set percentage of your monthly income in return for a comprehensive health insurance for you and your family? How much are you willing to pay?**

A no-exception observation: all study subjects expressed firm willingness to pay a monthly premium that is dependent on their income if it guarantees quality, accessible healthcare services for themselves and their families. It seems that the insurance notion has a large popularity among the population and is only awaiting a real, transparent and systematic implementation for it removes the burden of anxiety and worry about what the future will bring and whether families will be able to afford responding to the risk of disease.

However, the percentage of their monthly income they are willing to allocate for such an insurance package was difficult to assess and largely depended on their monthly earnings: An independent tomato sales widow in a remote village, earning an average of 120 EGP per month stated she is willing to pay up to 20% of her total income for insurance for herself and her children. Employees at the stock exchange are willing to go up to 5% of their income.

### ▪ Question 10: How do you want the Egyptian healthcare system to be like?

In depth discussions and collective thinking took place for this last question where each focus group designed their preferred health care system that fits their needs.

A rule of consensus was put. Meaning that the system to be designed has to reach the satisfaction of all members of the focus group. Occasional conflicts of interests arose specially in heterogenous groups which were composed of individuals with different income levels. The most difficult conflict to solve was between those in favor of a private, optional insurance system and those who prefer a social health insurance scheme. This conflict was usually solved by a proposed variant of an opt-out option or by imposing any insurance package (whether social or private) on all.

The Islamic-Right focus group were keen on putting organized charity as a cornerstone for social solidarity, creating a very private health system for the larger mass of the population with a solidarity based, tax and charity funded health insurance system to cover the poor only. When presented to other groups, this model was judged to be not sustainable and some in fact saw it as if it was designed in a way that attempts not to solve the real problem of poverty in the first place. A key concern of some was whether the proposed system followed Sharia law.

The rural communities were hoping for a national tax-funded healthcare system but, when confronted with the possible manifestation of raised taxes, they settled with a social health insurance system for starters to be gradually shifted to an NHS like model. This, provided that the government covers the premiums of un-employed individuals.

Healthcare workers proposed a basic, social health insurance package for all and a potential supplementary private insurance package that provides a larger scope of services and in other points of service presenting higher quality in terms of hosting.

At the end, the importance of reducing the role of governments in delivering healthcare services was numerously stressed upon. This, it was said, might change if more proficient officials took the helms of this highly distressed sector that is suffering from the bureaucracy, waste of public funds, corruption and loss of strategic vision.

Table 6: Designed healthcare systems by different focus groups

| | Focus Group | Composition | Designed healthcare system | |
|---|---|---|---|---|
| 1 | **Multi-Disciplinary-1** | Mixed occupations, religions, political views | Social health insurance with opt-out option |  **+ Opt-Out** |
| 2 | **Multi-Disciplinary-2** | Mixed occupations, income levels, habitat, age groups | Social health insurance |  |
| 3 | **Left** | Left political parties, Non-party Linked left-oriented individuals | Tax-Funded National health insurance |  |
| 4 | **Liberal-Right** | Liberal-Right parties, Non-party Liberal-Right oriented individuals | Private insurance with tax-funded insurance for the poor |  |
| 5 | **Islamic-Right** | Representatives from Islamic-Right political parties, Non-party linked Islamic-Right oriented individuals | Fee-for-service with tax-funded insurance and organized charity for the poor, Sharia law |  **+ Charity** |
| 6 | **Rural** | Randomly selected individuals from a rural community | Social health insurance with state support for the un-employed as a step to a Tax-funded system |  |
| 7 | **Students** | Randomly selected university students | Social health insurance |  |
| 8 | **Business** | Private / business / investment sector | Social health insurance with opt-out |  **+ Opt-Out** |
| 9 | **Medics** | Multi-Age-groups healthcare workers | Social health insurance with supplementary private option |  |
| 10 | **Tribal** | Randomly selected individuals from a desert tribal community | Social health insurance |  |
| 11 | **Government-Officials** | Government employees | Social insurance with possible substitution with private insurance |  |
| 12 | **Revolutionary -Youth** | Young revolutionary movement | Social health insurance |  |
| 13 | **NGOs** | Civil society workers | Tax-funded, National health insurance |  |
| 14 | **Pilot-Suez** | Subjects of pilot of the previous system reform in the city of Suez | Social health insurance with opt-out option |  **+ Opt-Out** |
| 15 | **Academia** | Randomly selected academic individuals | Tax-Funded National health insurance |  |
| 16 | **Independent-Workers** | Randomly selected independent / non-contract / day workers | Social health insurance with state support for the un-employed as a step to a Tax-funded system |  |

# VII. Discussion of Findings and Analysis

The findings presented earlier together with the literature review and success stories in healthcare systems around the world constitute the base for some important observations that governed the formulation of the proposed re-structuring of the healthcare system presented later on in this study and that need to be strongly considered when approaching healthcare system reform in Egypt.

### ▪ What are we really trying to achieve?

Whether this is in a political party, in a parliament committee, the formulating team of a presidential bid program or a policy maker's meeting room, a moment of truth is in order before any conversation is initiated, answering one simple question: **" What are we really trying to achieve ? "**. Answering this question first sets a strategic direction for any work being done. Possible answers include:

1) **A "Space-filling" plan:** Some reform plans are made only to fill in a certain space under the "health" section in a political program. It is therefore designed primarily to illustrate that a party or candidate have something to do say about healthcare.

2) **A "Professional-looking plan":** Some reform plans aim at simply "looking-professional". In these cases, political parties or governments hire "experts in the field" to write down a sophisticated looking plans that may indeed have essence in them, but they rarely account for the opinion of the most important stakeholders in the process of healthcare reform: The citizens.

3) **A plan that realizes a specific political or economic dogma:** Some plans are derived from a specific political model and are therefore merely an attempt to illustrate the success of this model. A capitalist, communist, socialist, conservative, islamic or liberal healthcare plan does not primarily aim at providing better access to quality services for all. It aims at proving that the model it is adopting is the best to do so, and these are two distinctly different goals.

4) **An "Innovative plan":** Innovation should be a mean to reach tangible deliverables citizens can feel and not an aim in itself. Yet, we are living in extra-ordinary times with a complex present healthcare infrastructure and citizens' expectations. This requires a real paradigm shift in the way such plans are being formulated. To account for international experiences in the field without being limited by them. To creatively think of ways to use the current infrastructure in reaching the needed results while remaining aware of the scarce resources at hand.

5) **A plan with sustainable deliverables:** Some reform plans aim at delivering long term sustainable improvements in healthcare. These deliverables are more difficult to feel on a popular level and assume the risk of being discontinued in case of changes in the political scene. When conceiving such plans, policy-makers should design them in a way to guarantee the continuity of their execution and that there is sufficient general consensus on them to give them the needed momentum to continue even when those who created those plans are no longer in power.

6) **A plan with "Quick wins":** Short term deliverables are the shortest routes to public satisfaction and sharing a feeling of success that can be very useful in pushing policy makers to achieve more successes. It is important though to note that any "quick win" should at least be aligned with a holistic vision. The political dangers of needing to dismantle a component that is winning for a longer term bigger success are not small to dismiss. A government that builds hundreds of new hospitals will have a very hard time dealing with the public if they end up having to shut these hospitals down for a more sustainable and cost-effective healthcare delivery model.

Proceeding in healthcare system planning without having this "purposefulness" presents a growing risk to fall into cycles of meetings, conferences and repeated efforts that never pass the "planning" phase. In fact, shifts in the purposes of the healthcare reform process lead to wasting public funds, experts time and efforts for decades, trying to formulate a healthcare reform plan. Ending by repeated dismissals, "starting from scratch" and frustration of generations of health policy makers and experts who never saw any of their efforts flesh-up into concrete actions.

### ▪ Urban legends in healthcare reform

At the time of writing this paper, regular meetings and conferences are being held to discuss the topic of healthcare system reform, mainly in Cairo but also in other cities. These events are usually organized by medical universities, mostly the public health department. Although these discussions reveal a genuine quest for making a difference, we believe these closed meetings often lack the multi-stakeholder participation that is needed in carrying out reforms in a sector that affects 82 million Egyptians with no exception, and not only physicians. In addition, together with many political parties and presidential bid programs, they almost always fall victim of some, if not all of the most common "illusions" of healthcare system reform in Egypt. These most prevailing notions are what we call "The Healthcare Reform Urban Legends". Findings of this study make it even more clear how far-removed from reality these notions truly are. (Figure 7)

These famous "Clichés" are extensively used (and abused) in both political and expert debates and reflect, among other things, a serious lack of commonly agreed-upon direction or strategic goal, discontinuity in knowledge transfer and an absence of innovation and creativity in the process.

**1**

**" We need to increase the 5% allocated to healthcare in the state budget "**

Although there is a real need to increase the national budget allocation to the health sector, yet, presenting this as **the** solution is a problem by itself. Partly because increasing those 5% would mean taking away from another state budget item which is not likely to happen easily due to popular pressure, but mainly because the problem is not only reduced resources, **it is primarily poor utilization of these resources.**

**2**

**" These Things take time "**

Giving up to the notion that healthcare reform is a time consuming process that takes years, even decades to see the light of day, is often taken as an open invitation to dwell on things. Although research and planning are important when dealing with such a matter, yet, the current situation of the healthcare system is in need of drastic, serious and timely intervention. Each **day** wasted brings more degradation in the services provided and therefore, moves us even farther from achieving anything. We should realize that whichever system that is to be created, will need to evolve and maybe even to be re-structured later on in order to accommodate the changing times. It is therefore important **not to dwell trying to plan for perfection without ever taking the plunge of realization**.

**3**

| " The Market Solution " | " The State Solution " | " The Charity Solution " |
|---|---|---|
| The inherent market failure in healthcare and the priorities set by the population make it clear that un-regulated market dynamics alone are not suitable for a sustainable healthcare system that provides access to affordable quality services for all. | As the services provided by the state do not constitute more than one quarter of total healthcare and as the trust in state-owned services declines due to the degrading quality of services; the assumption that a "State-delivered" solution, similar to the British NHS system will solve the problem, is far-removed from reality. | Capturing religious and cultural drives towards solidarity through charity has been a resort for faith-based organizations to provide basic services for the under-privileged. Yet, relying on it as a full-scale solution promises sustainability only in poverty and increasing financial dependence on charity. |

**4**

| " Special healthcare programs for the poor " | " Merge it all into one big system " |
|---|---|
| Segmenting problem solving into programs targeting specific communities is commonly sought to reach access to basic services. Yet, this is not even close to achieving quality of services or equality among citizens. Consideration of individual financial capacities should be an integral component of a comprehensive system not as separate initiatives segregating individuals and therefore, will not be popularly accepted. | Governments in Egypt are and have been bluntly incompetent in addressing the population's needs in healthcare. The current multi-faced system emerged to fill this gap. By attempting to centralize service provision under one management. Risks of catastrophic failure become too great to accept. |

**5**

**" Free Universal Quality Healthcare For All "**

Most political programs have been promising this ultimate urban legend to citizens. This is not only economically and logically not possible, it is also not a guarantee for better health outcomes as discussed in the literature review of this study. It may be time to reconsider promises that are, by far, not-achievable.

Figure 7: "Urban Legends" in the healthcare reform process

### ▪ The issue of trust in authorities

There is a significant, unshakable lack of trust from the general population in governments and authorities. The highly understandable public observations of waste of public funds, improper use of resources, disturbed priorities and impending corruption make the gain of this trust a long term process that can and should be initiated as early as possible. Yet, it is important to understand that any work in changing this will not be rewarded by a most significant or rapid improvement in public trust to an extent that can be depended upon for healthcare delivery. In other words, **any** healthcare reform plan that depends on "authorities" for collection of premiums, processing of claims or service delivery is highly unlikely to succeed at this stage.

### ▪ The role of the government and the market

The larger the degree of independence from governments and bureaucracy, the highest the chances of success. This is highly related to the marked dissociation that people have between their private earnings and public money (which they don't associate to themselves).

The burden of healthcare delivery cannot be thrown entirely on the government. Governments should focus on the most important role of regulating and monitoring the healthcare delivery system as well as directly managing and pushing forward preventive care. But, total dependence on the government in actual healthcare delivery is what countries have thrived to escape from due to its impending failure.

Although healthcare delivery in Egypt can resort to market dynamics to offer better quality and access to services, yet, market solutions can not be resorted to on a wide scale or without significant quality standards and regulations. Market solutions should only be resorted to as potential tools to improve aspects of the healthcare delivery within a restricted and highly monitored environment. A well regulated Public Private Partnerships model should be considered in some of the sectors.

### ▪ Decentralization and diversity

Decentralization is key. Merging all healthcare providers under one big umbrella is a disastrous recipe for failure.

Diversity and multitude of healthcare providers have saved Egyptians from the repeated and debilitating failures of the governments. Any reformed system that would impose the cancellation or direct affection of any of these delivery channels without providing a publicly acceptable alternative **first** will simply "kill" instead of "save" people.

### ▪ Intelligentsia, Experts and "the People"

Any well crafted healthcare reform plan done by "experts", party committees, parliament committees or policy makers are most likely to not reach their planned goals if no **real** dialogue with stakeholders

takes place. Contrary to common belief, primary stakeholders in the healthcare field are not physicians or university professors. Primary stakeholders should always be the primary beneficiary of the services, namely the patients / citizens and those people should have a real and direct say in the way the healthcare system is going to be structured and not just for public relations purposes.

Experts should not be making the plans. Experts should be counseling and advising the planners. Plans should be directly derived from the people if we truly seek real reform.

### ▪ Money is not the issue

Blaming defects in the healthcare system on small budget allocations for the health sector looks nice on paper, but it is very far removed from the real problem. Although it is important to fix this, yet, there are many ways to carry out significant reforms in the healthcare sector without requiring exorbitant budget allocations the state can not necessarily afford to carry out drastically. The statement given by the parliament healthcare committee on the 26th of February 2012 announces that | Healthcare system reform in Egypt requires a budget of 42 billion EGP |[40] (which is more than double the allocated state annual budget for healthcare) only signals how limitation of resources is and has been used as an excuse to do nothing.

### ▪ Attitude towards insurance

People of all socio-economic classes are ready to pay fixed amounts of money each month as long as they are sure to receive the healthcare services they need in due time and with satisfactory quality. Perceived quality improvement of services should come **first** before asking for any money from the people. This is very important in view of the lack of trust described earlier.

From four general concepts of healthcare systems (Direct payment (fee for service), Personal or community risk-based optional insurance, income-based obligatory social health insurance and purchasing-power based tax-funded National Health Insurance), preferences vary according to socio-economic class, age, health condition, political views, geographical distribution as well as needed services. Although there is a general leniency towards social / community income-based health insurance as system of choice, yet, it would be immature to think that total reliance on this system and generalization on all citizens will solve the problem. Extremes (low and high) in poverty / risk are likely to refuse this system or find it unfit to their needs.

### ▪ Accountability to consumer versus accountability to manager

The accountability sequence in the Egyptian healthcare system has always given the upper hand to top management (heads of departments, hospital directors, government officials, ministers of health).

[40] El Dostour news paper, February 26th 2012 issue, http://dostorasly.com/

Lower levels of healthcare deliverers (who directly provide the service), have to obey, report to these top managers and follow their instructions whether it is about healthcare delivery, financial constraints or policy. An entire paradigm shift in this perspective is in order: To completely **inverse** this scheme turning the primary stakeholder (the patient) on top of this sequence, having top managers seeking to satisfy his/her needs reaching the highest level of the minister of health, becoming the ultimate obeyer and servant to the entire system, instead of the primary focus of attention and respect. (Figure 10)

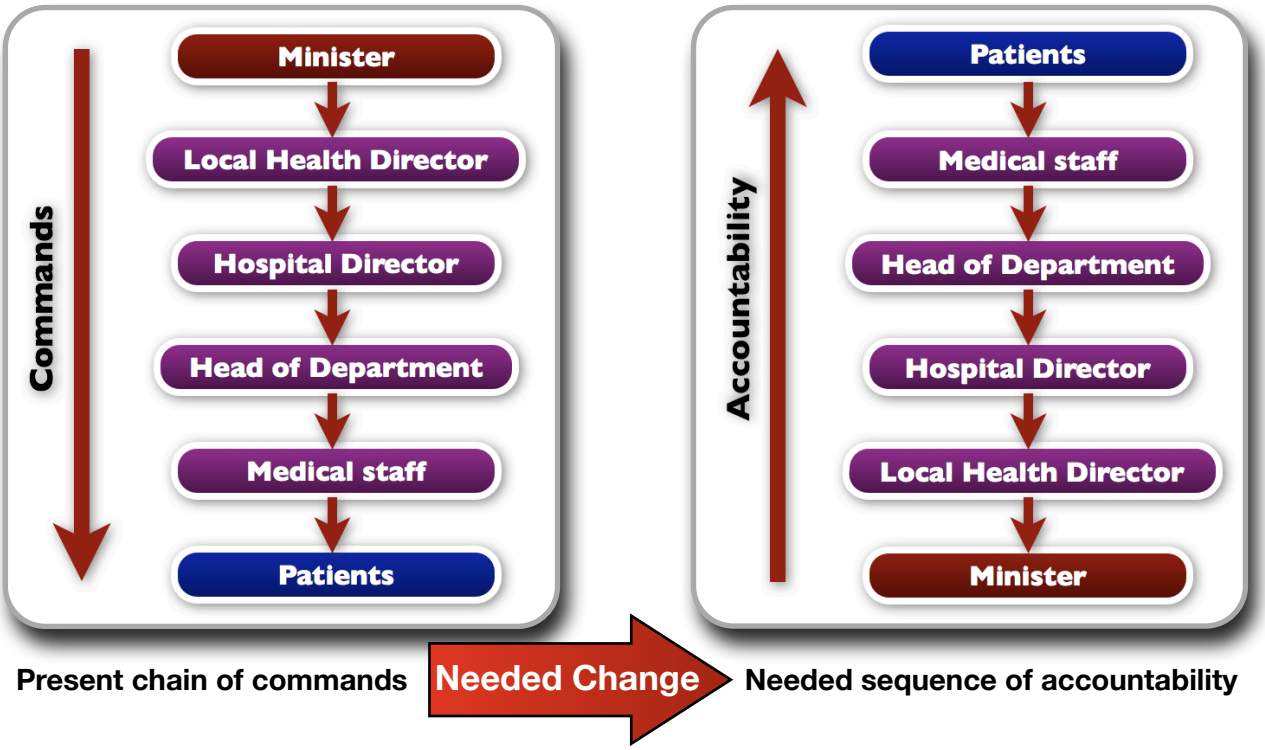



Figure 8: Present chain of commands versus the needed sequence of accountability

## ▪ Consumer choice

There is a large thrive towards choice of service point and providers. Among the reasons of failure of the private insurance market in Egypt (other than its high price-tag) is the limitation in the individuals capacity to choose. Although this is particularly true in high income levels, it is also present on all other socio-economic levels even among low-income individuals. In some cases, choice even comes ahead of financial sustainability. One commonly sees individuals and families going in debts and risking financial catastrophes in order to afford being treated in private settings of their choices. Any healthcare reform that will not deliver a considerable degree of consumer choice may not succeed in functioning properly. ■

# VIII. Conclusion: Proposed System Re-Structuring

Based on the research findings, the outline of a proposed re-structuring of the healthcare system is presented in this section. Though directly derived from the systems formulated by the different focus groups and the remaining of the study findings, yet, this proposed structure presents a personal interpretation of these findings. A combination of the expressed wishes and stated priorities into a concept that seems to be most likely to function.

This section describes the components and notions around which the proposed structure revolves. A full book can be written about each of these components, but this very summarized presentation intends to draw the picture about how they can interact and complete each other to meet the expectations and expressed preferences through this study. Specific notes and recommendations about application of this new structure are presented in the “recommendations” section of this paper.

## ▪ Foundations

Before building a new healthcare system structure, strong foundations must be laid out to support it. In this context, the most important foundations upon which this proposed structure relies are:

**1) Generic systems will not work**

Although healthcare systems used around the world were of value to explain the differences between each and to make the discussion easier with the focus groups, yet, it is important to note that not one system can be implemented “as is” with marked success in Egypt. The obvious reason behind this is the difference in the resources available as well as the specific country circumstances that Egypt has. The more subtle, yet, more critical reason however is that, as seen through the findings of this study, sixteen focus groups ended up with different preferences and conceived systems for managing the healthcare sector. Each of these proposals uniquely corresponds to the expectations and rank of priorities of those who made them. Each translates a different set of needs and resources to spare and, although there is a strong leniency towards the social health insurance system, yet, this is far from unanimous and only translates a certain preference to income-adjusted social solidarity in assuming health risks rather than a tax-based or a risk-adjusted system.

By all means considering a pre-conceived model, any model, as “the best fit for Egypt” is not only restricting in the creative process but it also dismisses the peculiarities and specificities of the Egyptian situation. The other extreme is equally unacceptable: re-inventing the wheel without taking into account other nations’ failures and success stories may be a strong waste of others experiences and practical knowledge.

**2) “One-size-fits-all” will not work**

Imposing a universal system through legislation and expecting people to comply with it, is by far not the solution. The different expectations, resources and needs of people who live in utterly different conditions are a strong call for a system with the flexibility and adaptation ability to fit these differences. A mandatory, universal social health insurance for all will not work because many will still not trust in the way such system is governed by the state and therefore will not trust their lives with it, while for example a fully private health insurance system will not fit the resources and the specific needs of others and therefore, if implemented on a national scale, will not work either.

**3) The system should literally make sure everybody is satisfied**

This may look as an impossible task, but it is an absolute necessity when dealing with something as organic and complex as a healthcare system that only functions through the consumption of its services through citizens’ participation and usage. Any majorities or minorities, no matter how numerically insignificant, that will not be satisfied with a proposed system will simply not comply to it. It will be therefore difficult to address their needs and the financial model of that system that relies on the participation of all, will fail. It is therefore not a matter of simple luxury to **condition** the success of a healthcare system on its capacity to satisfy all. Like writing a new constitution, a healthcare system should highlight the areas of common needs and expectations, but also allow for a true representation of all with all their differences. This social contract that is a healthcare system, cannot function without all stakeholders being part of its formulation and ending with their signatures. **All of them.**

**4) The system should be designed to be sustainable**

A healthcare system is no matter of changing governments every couple of years. A successful healthcare system must be designed from starters to be sustainable, independently from changing politics. Achieving this is definitely no easy task when it relies on a top policy maker, like a minister of health, to address healthcare system reforms, simply because policy makers change. The idea is that the system should literally arise from the people for the policy makers to be only concerned with making it happen and regulating it. The protection of a healthcare system by its primary stakeholders in a truly democratic country, is the safest and surest way of guaranteeing its continuity without interruptions, falls or midway loss of direction.

**5) The system should deliver "Quick Wins"**

The first years, even the first months of implementation of a healthcare system are the most critical in its lifetime, yet, the real results of any healthcare system can hardly be delivered within years, sometimes even decades. Together with directly involving the primary stakeholder in the formulation of a healthcare system, the direct delivery of a set of "Quick Wins" that people can directly see and feel, is a most important measure to guarantee a long life for a healthcare system. These "Quick Wins" have the capacity of showing to all that this plan is "on the right track" and that there are more successes to come. A plan that projects too much into the future without satisfying the direct, immediate needs of a failing healthcare system will fail before it even starts.

**6) The system should involve and rely on the citizens in its operation**

The role of the citizens should not stop in the involvement of structure formulation. They should be an integral part of its implementation. By empowering non-experienced citizens to lead the changes they want to see in their healthcare system, by turning them into the eyes and ears of the inner functioning of this system, by opening many channels of direct communication and feedback provision, citizens become a motor in the process instead of an obstacle the process has to confront. They become more aware of the available resources, more vigilant to poor quality or waste of resources. With this notion in mind, patients can be involved in a number of areas including monitoring and quality control, premium collections, system improvement, cost-containment, etc.

**7) Out-of-the box**

It is high time to shake away all frames of thought and to truly think creatively. To consider uncommon ideas to solve urging problems. To resort to innovative solutions that make use of the available resources to solve problems in the best possible way. This is no more a luxury. Only out-of-the-box solutions can actually succeed in fixing the dreadful condition of healthcare delivery in Egypt.

**8) Use of current infra-structure**

The proposed plan should hold into account the available healthcare resources and infrastructure that are already present and accommodate itself to be able to integrate this infrastructure and the current resources (namely human) in the proposed healthcare system. Coming up with a new system without making sure it will not start from scratch, will save the proposed structure from a disturbed start that might even lead to its abortion if the size of stakeholders' affection is large enough.

**9) The system should account and acknowledge two sets of failures**

No successful healthcare system can be created in Egypt unless it admits and moves on from two sets of failures that govern the healthcare system management in Egypt. The proposed system should arise as a natural evolution in this context:

- Government failure to collect taxes and organize public finance, to provide social protection for vulnerable populations and to exercise oversight of the health sector.

- Market failure to offer an effective exchange between supply and demand, partly because of the gap between needs, demand, and ability to pay and partly because of the prevalence of non-monetary transactions in the informal sector. [41]

On the other hand, the proposed system should be capable of using the areas of strength in both the capacities of the market and the state in delivering better services to the population but through different dynamics.

## ▪ Proposed system goal

The proposed healthcare system re-structuring seeks a gradually implemented, deep, community-rooted, dynamic system that accounts for the scarce resources and available infrastructure, is custom-designed and managed by communities, possesses the flexibility to adapt to each communities' preferences and needs, insures choice of providers, guarantees work sustainability, pushes towards accountability to patients and quality improvement. A system that operates with the highest degree of independence from the government, uses market dynamics in pushing for better service delivery whilst being directly regulated, monitored and partly subsidized by the state and that still benefits from nation-wide risk-pooling and cost-sharing mechanisms.

## ▪ Blueprint of the proposed structure / Idea in short

The proposed structure can be shortly described as follows:

> *Multiple,* ***communities'*** *designed / funded / managed,* ***government*** *supported / regulated, selective, non-profit, income-measured, risk-distributed, preferred providers* ***micro-insurance*** *with a layer of overlying, proportionate, non-profit, mandatory, national, social* ***reinsurance*** *scheme.*

(Figure 9) graphically illustrates the roadmap for the functioning of this system. More details about cost-sharing, the exact role of each component and the purpose of each is explained further on.

[41] D.M. Dror, A.S.Preker, *Social Reinsurance: A new approach to sustainable community health financing*, The International Bank for Reconstruction and Development / The World Bank and the International Labour Organization, 2002, P. 1

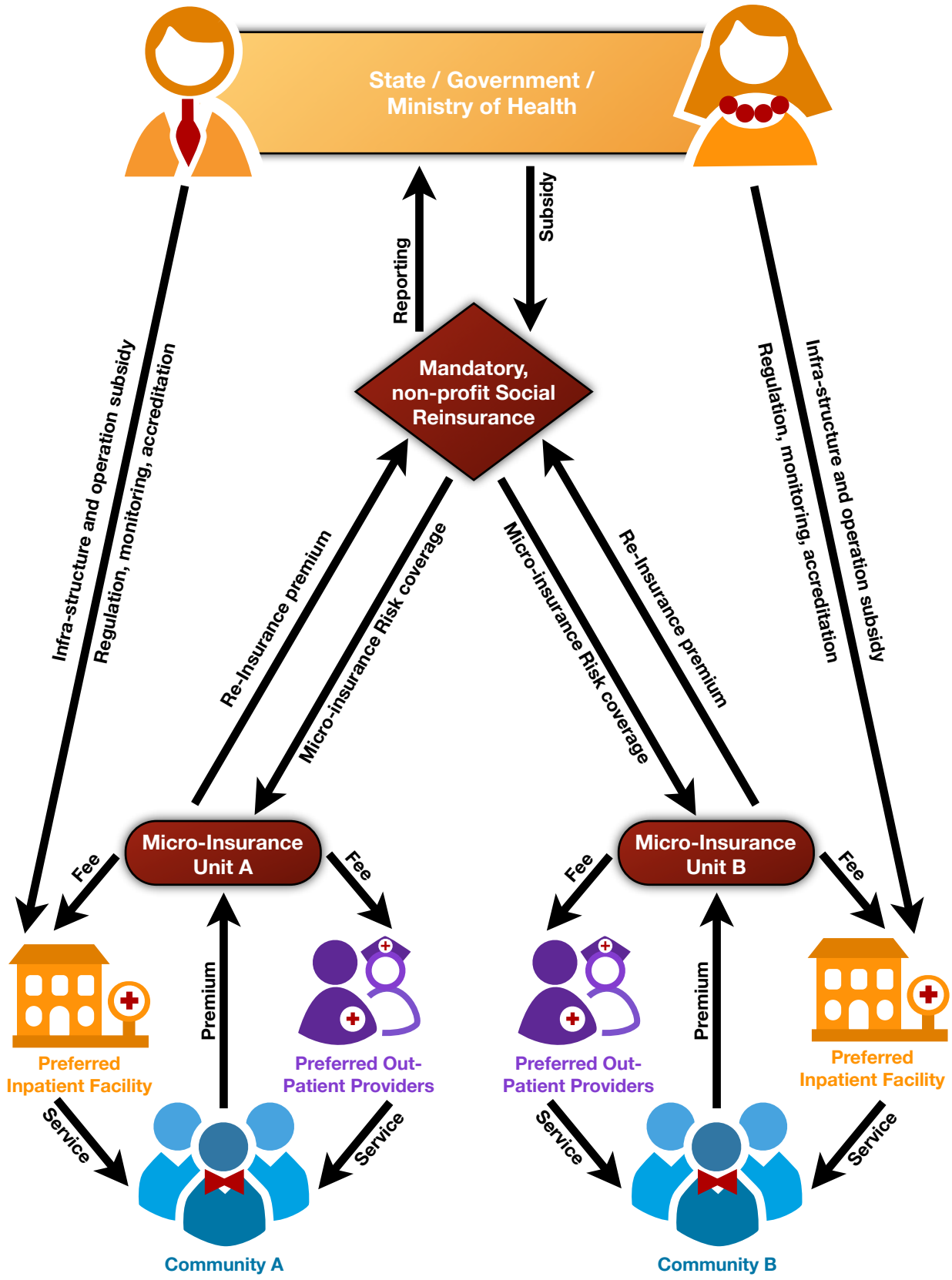



Figure 9: Graphical representation of the highlights of the dynamics of the proposed healthcare system structure and the roles of its major components

## ▪ Building blocks

**1) Preferred-Provider Networks and Health Cooperatives (health co-ops)**

Preferred-Provider Organizations (PPOs) are a variant of health service coverage that is largely used in the western world. They are usually privately run organizations that group individuals under a list of preferred providers and can therefore provide better prices for its members with the option of using services outside of these selected preferred providers but at higher prices.

Health co-ops are usually non-profit organizations that service a group of people that own and manage their organizations through an electoral process. A health co-op pools purchasing power of its members in order to negotiate more affordable prices for them.

What is proposed through the first building block of this proposed structure is a component of preferred-provider network that mainly targets the uninsured Egyptians, providing them with a simple, "smart" financing scheme that maximizes purchasing power for more affordable access to services through:

i. Grouping individuals and families belonging to specific communities around common lists of preferred healthcare service providers of their own, collectively agreed upon, choices.

ii. Negotiating considerably reduced fixed service prices and mass-contracting with the chosen providers.

iii. Enabling changes in preferred providers, updating quality of services, offering additional health maintenance services that target these communities including micro-insurance schemes as detailed later in this paper.

These networks are to be created through civil society initiatives with the aim of providing more affordable services, more consumer choice, better documentation of community clinical needs, sustainable income for local healthcare providers, patient-centered quality of care and more efficient market dynamics directed towards better customer satisfaction and reduced out-of-pocket spending incurred by individuals and families.

They also provide a strong foundation for the implementation of community micro-insurance schemes with a more complex financial structure.

**2) Community Micro-insurance**

| Micro-insurance schemes are programs and institutions that adapt traditional insurance mechanisms (pre-payment, risk-pooling and coverage guarantees) to the informal sector, providing services to beneficiaries that are commonly excluded from formal insurance. | [42]

| Communities are encouraged to assume the responsibility of delivering universal coverage through *their ownership and control of their own endeavors and destinies.* | [43] Through local, community management of these insurance schemes in a non-profit environment, individuals regain the control of their health plans, reduce their risks through a risk-sharing mechanism and reduce their household expenditures. They also become capable of covering segments of their community which could not access the needed healthcare services before.

| In Community-based / Mutual insurance schemes, the members are both the insured and the insurer and they govern and administer their scheme democratically. | [44] This is very different from private, corporate micro-insurance schemes that are sometimes offered by the private sector.

Collective actions enable a community to receive healthcare services by directly putting this community directly in charge of three key tasks of the micro-insurance management process:

1) Design of the micro-insurance unit, setting services included and contribution amounts.

2) Collection of contributions in an informal or semi-formal environment.

3) Allocation and purchasing of services based on preferences and needs.

4) Supervision of the financial management of the micro-insurance unit.

Unlike private insurance packages, marketing, overhead costs and profits are to be kept to a bare minimum and calculation of contributions should not be based on individual risk assessment but rather on average risk of the community. This puts a focus on preventive and risk-reduction measures for the entire community as an attempt to reduce average risk and therefore, individual contributions.

It also brings back services to a patient-centered approach where only high quality, affordable and accessible services will be chosen by the micro-insurance unit.

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[42] E. Morelli, G.A. Onnis, W.L. Ammann, C. Sutter (Eds), *Micro insurance - An Innovative tool for risk and disaster management*, Global Risk Form GRF Davos, Davos, 2010, P. 8

[43] *The Ottawa Charter: Health promotion*, 1st International conference on Health promotion, Ottawa, World Health Organization,1986

[44] E. Morelli, G.A. Onnis, W.L. Ammann, C. Sutter (Eds), *Micro insurance - An Innovative tool for risk and disaster management*, Global Risk Form GRF Davos, Davos, 2010, P. 9

In short, | the common denominator of micro-insurance is its proximity to clients and its limited financial turn-over. | [45]

In order for a micro-insurance scheme to function properly, it | must be sensitive to three conditions: it needs to be **simple**, **affordable** and located **close to members** | [46]

In addition, its self-management capacity is a key characteristic that must be present in the community micro-insurance unit. Through its community base, it becomes "the enterprise of the community". Through a democratic process, members define their needs and packages of services without having an insurer determining that with profit-making in mind as it is the case with private insurance, and without policy makers deciding, on their behalf, about what they "think" is best for the whole population without addressing specific needs of individual communities. It enables them | to act as a cohesive social unit that can fulfill a role no one else can do better: relate needs and priorities to their prevalent activity, location-specific conditions, the level of resources, etc. | [47] It also introduces transparency as a necessity in its proper functioning, corruption and abuse of the system no longer need to be confronted: they are simply innately discouraged through the nature of the design of the system. In addition, it is particularly innovative in the way it builds rather complex health insurance notions on familiar social interactions, pushing through a families and communities' rooted strive for better service quality, more competent financial schemes and coverage of excluded individuals.

### Micro-insurance and Rotating Savings and Credit Associations (ROSCAs)

We strongly believe that the micro-insurance model has high potentials of success in the Egyptian community for many reasons. The most prominent of those reasons is the wide-spread presence of Rotating Savings And Credit Associations (ROSCAs).

ROSCAs are grass-root micro-finance bodies that are created within small communities of families, friends, co-workers or neighbors, to share common resources in order to address the specific timely financial needs of its members. Run on a volunteer, collective base, members of these associations do not sign contracts and these informal agreements cannot be enforced through legal proceedings. Their functioning relies solely on mutual trust and the best interest of each member of these associations to make them work. Failure to abide to the agreed upon conditions of these associations

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[45] E. Morelli, G.A. Onnis, W.L. Ammann, C. Sutter (Eds), *Micro insurance - An Innovative tool for risk and disaster management*, Global Risk Form GRF Davos, Davos, 2010, P. 8

[46] D. Dror, C. Jacquier, *Micro-insurance: Extending health insurance to the excluded*, International Social Security Review, 2001, P. 13

[47] D. Dror, C. Jacquier, *Micro-insurance: Extending health insurance to the excluded*, International Social Security Review, 2001, P. 15

result in some sort of social exclusion that becomes the unwanted punitive aspect of non-abidance, which is more than often sufficient to ensure compliance. All capital of ROSCAs are internal and, through them, communities can sometimes address individuals' special financial needs such as weddings, new births, etc. ROSCAs have become an integral part of the common Egyptian culture and are almost always resorted to on all socio-economic levels, from the very rich to the poorest of communities. This success story provides a rich soil for implementation of community health micro-insurance which relies on the same principles of solidarity and collective community management.

**"One size fits all" no longer a problem**

Among the major benefits of applying micro-insurance as a building block for a national healthcare system is the way it deals with specific communities' needs and expectations. Since it is specifically designed and managed by a community, a micro-insurance model can be created in a way that accounts for the differences in choices of the preferred healthcare system detailed in the study findings.

**Micro-insurance and Risk-pooling**

The idea behind the proposed micro-insurance model is to collect contributions on a income-measured basis and regardless of individual risks, and then, through the risk-pooling mechanism of the micro-insurance scheme, resources are distributed over the individuals based on their needs and their actual risks (Figure 10). This dictates however an "all-or-none" principle where communities have to understand that all members of their communities must be part of this scheme in order for it to function properly.

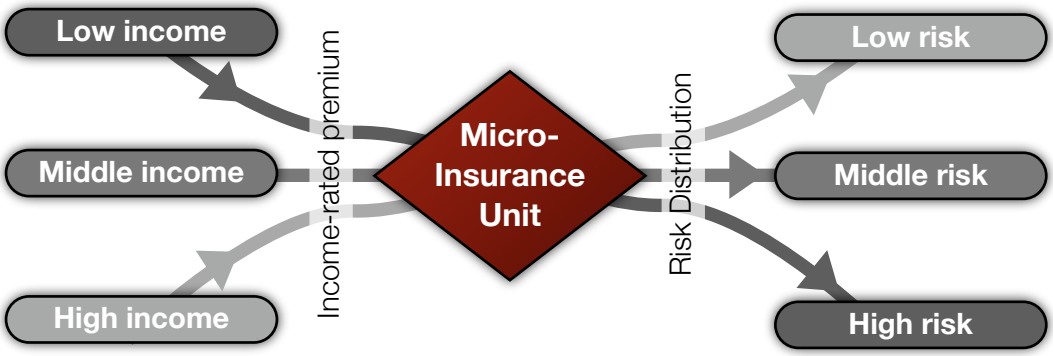


Figure 10: Graphical representation of the flow of funds in the proposed micro-insurance model through income-rated premiums and risk-based distribution

On the other hand, the biggest and most noticeable defect in the implementation of a micro-insurance scheme on a large, national scale is the fact that the enabling of community management and funding of these schemes does come with a price, which is the **limited risk-pooling** between a small number of individuals and the presence of cross-subsidies only within the members of the micro-insurance unit. It delivers solidarity inside each community but it completely detaches it from other communities. In addition, lower income communities will be most liable to suffer from a full disruption of their micro-insurance scheme in case of catastrophic illnesses or public health hazards. This is where the social re-insurance component comes to action.

### 3) Social Re-insurance

Sometimes, the risks that an insurance (or micro-insurance) scheme has to deal with become too large to be assumed through one entity. In addition, if micro-insurance schemes group people with different income levels and risk profiles under one pool, it is expected that there will be different micro-insurance units with different average income levels and different collective risk profiles. Re-insurance pools these different average incomes and risk profiles of the micro-insurance units for an added layer of risk-pooling, inter-communities' cross-subsidy and national-scale solidarity. | Reinsurance, simply defined, is the transfer of liability from the primary insurer (the company that issued the insurance contract) to another insurer (the reinsurance company). | [48]

> *One single, non-profit, publicly owned re-insurance entity should be created with the goal of diversifying risk of micro-insurance units and with a mandatory enrollment by all of the established micro-insurance units.*

By devising a proportionate re-insurance premium collection model, the risk-pool that was atomized through the micro-insurance schemes for the sake of consumer choice, community management and improved quality of care, is re-instated through a national, collective, mandatory re-insurance scheme that allows cross-subsidy between rich micro-insurance schemes and poorer-ones and between high-risk profile communities and lower-risk ones.

Although independent from government, this re-insurance entity should be run on a non-profit base and should be entirely publicly owned.

[48] D. Dror, A. S. Preker (Eds), *Social reinsurance: a new approach to sustainable community health financing*, The World bank and the International Labour Organization, 2002, P. 59

In addition, this re-insurance entity should play an additional, critical role in sustaining micro-insurance units. | Simply stated, operating re-insurance would entail not only developing the financial instrument but also enhancing considerably micro-insurers' capacity to register, analyze and transmit data. | [49]

This role should revolve around four distinctive components that the re-insurance facility should play as shown in (Table 7).

Table 7: Components of an integrated reinsurance-based approach for micro-insurance sustainability

| | Component | Areas of Coverage |
|---|---|---|
| 1 | Reinsurance | Financing<br>Program-management capacity<br>Stabilization against fluctuations<br>Catastrophe protection [34] |
| 2 | Package Enhancement | Improving the "packaging" of the services presented through the re-insurance scheme to counteract the technical complexity and difficulty in explaining its value to the public |
| 3 | Knowledge transfer and consultancy | Providing the micro-insurers with better information management tools, capacity building, expert assistance and consultancy |
| 4 | Connection with the national health financing and service providers | By bridging the gap between the informal and the formal sectors through maintaining communication and creation of public private partnerships that would benefit the micro-insurers |

However, re-insurance alone will not be a remedy for all problems of micro-insurance if implemented in Egypt. The private resources spent through individuals' contributions to their micro-insurance units will not suffice for all inpatients services, catastrophic illnesses and in case of epidemics. In addition, the model only addresses areas of stated individual needs of services. It does not cover most public health concerns, preventive services or other components of healthcare provision that cannot be addressed through the informal sector. This is where the government should play a role.

**4) Government role**

The main building blocks of this proposed healthcare system rest on the notion | that even poor households can and do pay for healthcare, and that their community can generate income to cover

[49] D. Dror, A. S. Preker (Eds), *Social reinsurance: a new approach to sustainable community health financing*, The World bank and the International Labour Organization, 2002, P. 59

the recurrent costs of basic health units, to complement or replace weak public institutions. [50] This means a major shift from centralized, government decision-making to a lower, bottom-up healthcare delivery, financing and management through communities.

Yet, this in no means indicates that the government should renounce on its mandated duty to preserve the population's health. What this system re-structuring proposes is a more strategically calculated role of the government in the healthcare sector.

In this proposal the government has 7 key roles to play:

### i. Funding:

The state should continue funding the healthcare system and increase its allocated budget for this very sensitive sector. However, the government funding is no longer the main pillar behind the functioning of the system: it plays a supportive role that primarily supports and protects against any defects of the community-run scheme. Government funding should take place from both directions of the healthcare system:

- **Top-down subsidy:** Allocated to the re-insurance organization, allowing lowering of re-insurance premiums and better integrated support of the micro-insurance schemes.

- **Bottom-up subsidy:** By directly subsidizing the point of services, specially inpatient facilities, expensive medications and centers managing catastrophic illnesses and disabilities.

### ii. Quality control, quality improvement, regulation and accreditation, legislative support:

This highly important role can only be played by the government. It includes implementing nation wide quality improvement programs, creating and applying regulatory measures to ensure quality of care and access to medications, developing accreditation standards and awarding accreditation labels to healthcare facilities and providers and also legislating relevant laws that facilitate the work and the sustainability of the micro-insurance units.

### iii. Community health maintenance:

Through prevention, health awareness, disease control, health crisis management...etc.

### iv. Production, procurement and insuring availability of resources:

Insuring the provision and availability of all components and needed resources for adequate healthcare services delivery. This includes qualified and trained human resources, equipments, infrastructure, medications and properly procured consumables.

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[50] The Bamako Initiative, *Women's and children's health through funding and management of essential drugs at community level*, World Health Organization, 1986

**v. Inter-sectoral coordination:**

Coordinating with all other ministries and government bodies in areas of potential repercussions on population's health.

**vi. Crisis relief and disaster management protocols, infrastructure and resources**

**vii. Decentralizing decision-making:**

This needs to be done within all elements of health provision to the local level, encouraging and facilitating direct purchaser / provider communication under a regulated environment.

### 5) Market role

It has been widely agreed upon that healthcare systems left to function according to market forces alone do not result in socially optimal quantity, quality or distribution of healthcare. [51] Yet, in this proposed scheme, the private sector plays a pivotal role in healthcare provision. In fact, such scheme opens the doors wide open to investment in the healthcare sector without compromising access to affordable services and while addressing the biggest areas of market failures in the healthcare sector.

By being responsive to the community needs expressed through the different micro-insurance units, the market can provide service bundles, health management schemes, packages of preferred providers and facilities and micro-insurance supportive services. Innovative business can invest in the new set of community needs that will erupt as well as in the more structured organization of the private and public resources in the healthcare sector.

At the end of the day, this proposed system returns the choice of services and providers directly to the patient and to the community and therefore, the market dynamics have better chances of moving things forwards.

### 6) Social sector role

The social and civil sector has an important role in the implementation of this system. NGOs, faith-based organizations, syndicates and local communities are best placed for the education, spread, implementation and administration of the micro-insurance component.

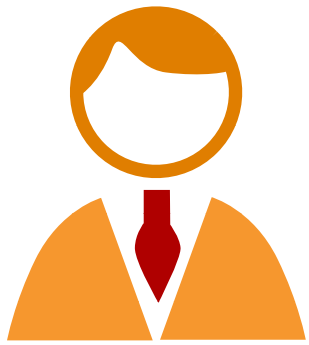
[51] J.F. Outreville, *The health insurance sector: Market segmentation & international trade in health services*, 1998, P. 111-124

## ▪ Alignment with study findings

Built on the findings of this study and the stated priorities of the different focus groups, it is claimed that this proposed system perfectly satisfies the stated priorities by the major stakeholders of the healthcare delivery process and is highly capable of meeting their expectations. (Figure 11)

**Citizens / Patients**

| Rank | Priority | Alignment with proposed structure |
|---|---|---|
| 1 | Access | Micro-insurance with state funded re-insurance |
| 2 | Affordability | |
| 3 | Safety from harm | Government focus on regulation, quality improvement and accreditation |
| 4 | Quality | |
| 5 | Choice of providers | The preferred provider network component |
| 6 | Human care | Choice of provider will lead to better customer care |
| 7 | Financial self-sufficiency | Risk-pooling, income-based premiums |



**State / Government**

| Rank | Priority | Alignment with proposed structure |
|---|---|---|
| 1 | Affordability | Reliance on citizen's contribution through micro-insurance |
| 2 | Results / Delivery of promises | Empowered citizens, in charge of making the difference |
| 3 | Highest attainable general stakeholders' satisfaction | • Large reliance on regulated market dynamics and civil society |
| 4 | Meeting international Commitments | • Capacity to focus on regulatory efforts, quality improvement and public health issues |

**Healthcare workers**

| Rank | Priority | Alignment with proposed structure |
|---|---|---|
| 1 | Suitable Compensation | Preferred provider network and state-supported micro-insurance, sustainable income, patient-focus. |
| 2 | Impact on patients | |
| 3 | Comfort | No need for multiple jobs, limits stress and insecurity |
| 4 | Education and Training | State becomes directly responsible for continuous education and capacity building |
| 5 | Choice of working place | State-independently run healthcare system |
| 6 | Safety | Group contracting through preferred provider networks and micro-insurance coverage |
| 7 | Financial self-sufficiency | |

Figure 11: Alignment of proposed structure with stated priorities

# IX. Recommendations about Practical Application

Realization of this plan can take place through different sectors and stakeholders. The following steps describe in a simplified sequential way, the proposed realization sequence from the recommended civil sector's perspective.

## ▪ Realization sequence and considerations

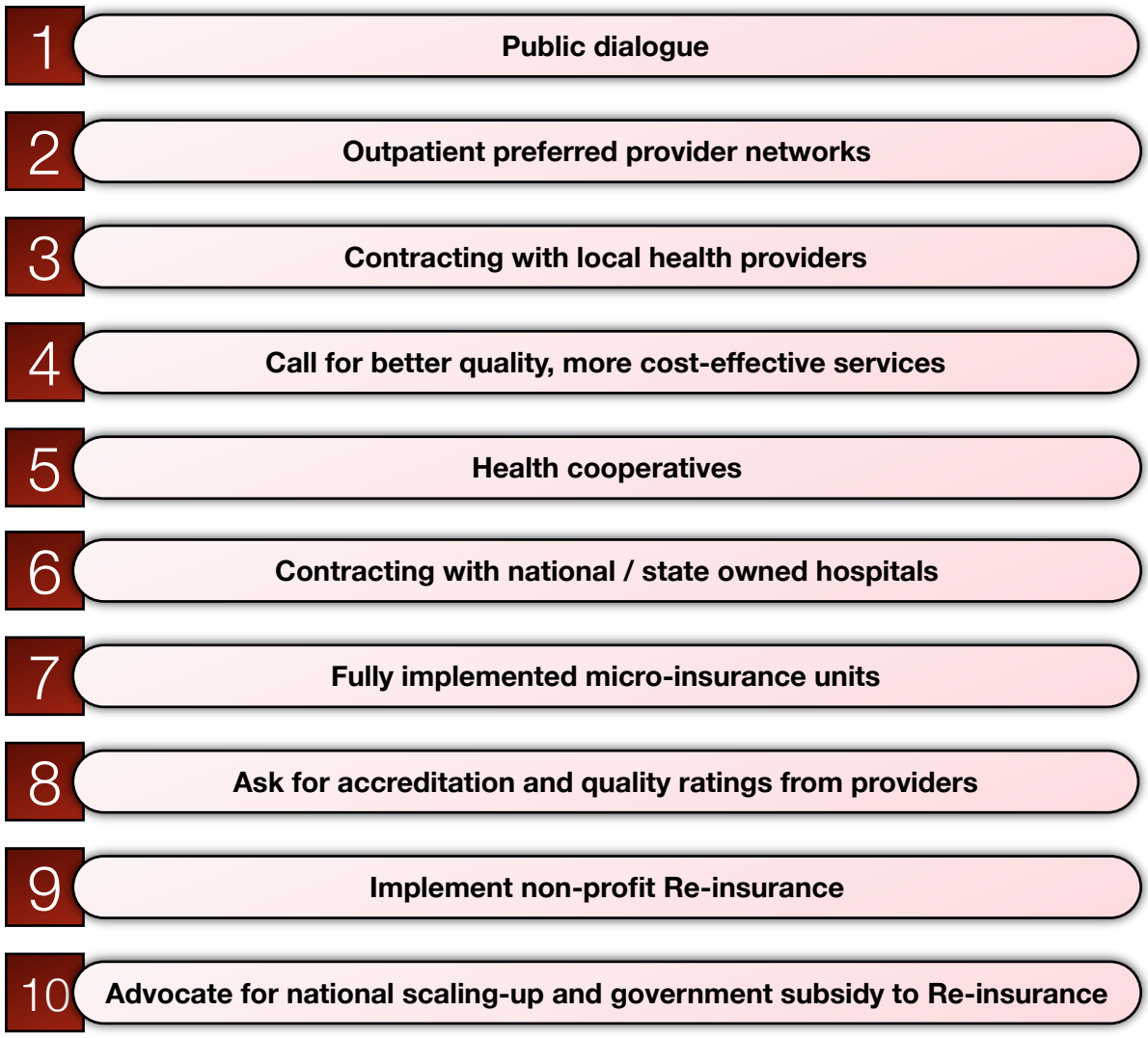



Figure 12: Proposed realization sequence

**Step 1: Public Dialogue**

The first step of implementing this plan is a genuine public dialogue. A real multi-sectorial involvement that directly puts the citizens in control; to understand their immediate and long term needs, financial capacities and wishes in terms of their desired services.

This is the tool through which the ideas of micro-insurance and health cooperatives are to be introduced, explained, acted through role plays and delivered in a simple language that excludes all unnecessary confusing details.

**Consideration 1: " Involve young volunteers "**

*By beginning with "selling" the idea to networks of young people who have the energy and the motivation to work on the ground in such initiatives as volunteers, they will be able to invest their energy and time to deliver change through their networks all over the country in a record time, investing in the benevolent spirit that these young people have in this critical time of Egypt's history.*

**Step 2: Outpatient preferred provider networks**

This is to be done through establishing networks of individuals sharing similar socio-economic conditions and who agree on lists of preferred providers for out-patient services. By having these networks, the purchasing power of this group of people can be used for mass-contracting with providers.

**Consideration 2: " Begin simple "**

*Going through full implementation of the micro-insurance scheme carries high risks of failure due to the complexity of the scheme. It is important to always be reminded that the success of this plan relies on satisfaction of the public and word-of-mouth spread. Failure or collapse of a poorly conceived micro-insurance unit that fails to deliver its promises will directly affect people's lives and will therefore lead to great difficulties in mending the loss of public support it will lead to. By beginning with a preferred provider network that only covers outpatient services, expectations will be limited, much easier to satisfy and matters can be built upon the earned trust at a later stage.*

**Step 3: Contracting with local health providers**

Using the mass purchasing power developed through the preferred provider networks, mass contracting with local health providers can be carried out at severely discounted prices since there is a volume guarantee that the providers receive. These discounted prices will be a **tangible** deliverable

that the citizens will feel, raising satisfaction and the sense of achievement, knowing that they brought this improvement through their collaborative work.

**Consideration 3: " Delivery has to come before the money"**

*It is very important to consider that the severe lack of trust in anything that tackled healthcare services before, whether it is from the private or public sector, has created a general skepticism towards anything new. It is therefore very important not to begin the application of this plan (or any plan for that matter) by asking for contributions. People need to see a real deliverable first and then, they will be willing to pay once they have realized this is actually meeting their expectations. By beginning with preferred-provider networks and mass contracting with providers, no pre-payments will be required from the members of the schemes and they will therefore be able to access these large discounts without having to pay anything before hand.*

**Step 4: Call for better quality, more cost-effective services**

The mass purchasing power of the created networks and their growth would enable the quest for higher quality of services, more integrated health management schemes and more cost-effective ways of managing people's health that fits their needs.

**Consideration 4: " Involve family physicians, civil society and the private sector "**

*It will soon be realized that applying a gate-keeping healthcare delivery mechanism, involving civil society in healthcare delivery and the innovative capacity of the private sector can all play significant roles in providing services that increasingly provide better results and lower costs. It is therefore important to directly partner with these sectors and to continuously keep them in touch to be sensitive of the market potentials.*

**Step 5: Health cooperatives**

Once the preferred provider networks have created the initially vital trust that is needed, introduction of pre-payment schemes through public dialogue and the initiation of the micro-insurance models can take place. Implementation of health cooperatives will be a good start to get communities going with democratically managed informal entities that manage their preferred provider networks.

**Consideration 5: " Rely on young, educated locals "**

*Having dedicated young locals with the sufficient education to facilitate and coordinate the process of managing health cooperatives will enable more sustainable results, better sense of ownership and more accountability towards their community.*

**Step 6: Contracting with national / state owned hospitals**

Although some of these hospitals are supposedly "Free", yet, due to the limited state-allocated resources, poor management and little motivation for customer care, services provided end up being of low quality and not "Free" at all. By arranging mass contracts between the health cooperatives and these hospitals, an additional, quality and performance dependent source of income will be secured for their budgets in return for better standards of service. These additional resources can be locally allocated to increase salaries, fix and update equipments, purchase needed consumables and therefore provide a better quality of care to the patients.

**Consideration 6: " Use government facilities "**

*Specially for costly, in-patient services, government facilities present a considerable opportunity for healthcare delivery. They are fully established delivery points with infrastructure, state-funding and human resources but lacking the incentives and the needed resources to provide better services and better customer care. There is absolutely no point in investing in building new hospitals and recruiting new qualified human resources. Lean management dictates taking this available skeleton and building upon it. It also directly creates the needed bottom-up state subsidy discussed earlier without the government officials even needing to sign one paper.*

**Step 7: Fully implemented micro-insurance units**

Once contractual arrangements have been carried out with out-patient and in-patient service providers, the full scale micro-insurance units can be established. A thorough, community-conducted contribution collection process needs to be established with competent and transparent documentation and accountability. Continuous improvement of these processes is important for the natural evolution of these schemes from small, limited, informal micro-insurance units to formalized, large, reliable units.

**Consideration 7: " People manage, local organizations administer "**

*Local civil society and local organizations already possess a certain administrative infrastructure for financial and legal administration. Involving them in the process will enable their employment in the technical administration of the micro-insurance units. Although management and decision making should be directly derived from a democratic process, it is important to delegate the administration of these units to organized structures that are accountable in front their stakeholders: a separation that is only a matter of good local governance.*

**Step 8: Ask for accreditation and quality ratings**

Contracted providers and service delivery points have to be continuously challenged and asked to improve their services. Micro-insurance units can begin requesting national accreditation and ratings of quality of services that can affect the consumers choices of preferred providers.

**Consideration 8: " Push the government to play its real role "**

*This is a component that governments can significantly contribute in. Having a public push for it to create standards, award accreditation to providers and continuously monitor the quality of service providers, will reinstate the real role of the government in controlling, regulating and maintaining the quality of services provided to its citizens.*

**Step 9: Implement non-profit Re-insurance**

Once a considerable number and diversity of micro-insurance units have been developed and before even considering covering catastrophic illnesses, a separate, non-profit, publicly owned, health re-insurance entity must be created with mandatory participation of all micro-insurance units, paying proportionate re-insurance premiums that realize the national-scale solidarity and risk-pooling needed for further growth of the system.

**Consideration 9: " Keep administrative cost of re-insurance to a bare minimum "**

*It is vital that the re-insurance premium does not present a significant load on the micro-insurance units. This re-insurance entity has to make sure that the largest portion of the re-insurance premiums are indeed used in cross-subsidy not in administrative, marketing and most definitely not in profit margins.*

**Step 10: Advocate for national scaling-up and government subsidy to re-insurance**

At this final stage, the government will be able to see a tangibly successful model that has succeeded in meeting its stakeholders' expectations and that have reduced the burden from the state resources and bureaucracy. This would finally be the time for real advocacy for better legislative support, government subsidy to the re-insurance entity, point-of-service subsidy to in-patient services and medications, and a larger role in regulation, accreditation and quality improvement.

**Consideration 10: " Share your success "**

*At this stage of advocacy, it is important to truly make everybody feel that success of this model is only the success of its stakeholders. These include the citizens, the providers, civil society and yes, even the government. This will make things much easier later on.*

## ▪ Requirements for application

Just like the study itself, application of the proposed healthcare system also takes place following a bottom-up approach, yet, some requirements and suitable environment settings need to be set for the sake of a successful, timely realization.

### A. Government alignment with vision

Such healthcare system does not need to be directly implemented by a political party or a ministry of health. In fact, its entire philosophy relies on its independence from authorities, political shifts of power and government control. However, for this plan to be implemented, this system requires a certain degree of alignment with its vision from the government. Important areas of alignment include:

1) Non-exclusivity of the national system (if any): The government or legislation should not impose total reliance on one mandatory, national government system for healthcare delivery. The citizen should be able to resort to other schemes that fit him/her best. The government should insure its actions do not restrict consumer choice.

2) Establishment of the needed infrastructure for any healthcare system to function: This includes applicable quality standards, accreditation platforms, safety and infection controls, patient documentation, training and continuous education of healthcare human resources.

3) Development of local governance infrastructure and decentralization of bureaucracy and decision making.

4) Establishment of infrastructure and administrative flexibility that enables local, community, informal arrangements in a sustainable, easy to operate manner.

### B. Legislation

This is a major role that the parliament and political parties must play as it lies in their core functions. Three phases of legislative support are proposed, aligned with the progress of the on-the-ground implementation process of the proposed system.

- Phase 1: Protection against *destructive* legislation
- Phase 2: Formulation and advocacy of *supportive* legislation
- Phase 3: Formulation and advocacy for *scaling-up* legislation.

## Areas of legislation that require attention:

### 1) Laws governing the formation of insurance entities:

- The currently used law is the "*Law number 156 for the year 1998 for the regulation of insurance and re-insurance entities in Egypt*". It has been written with the assumption that only for-profit insurance providers exist. It absolutely restricts the insurance activity to giant companies, imposes a large amount of administrative expenditures that end up being deducted from the insured in the form of premiums.
- It restricts licensing and actuarial approval on one single government body and a limited group of actuarial experts, who fully control the entire process with seemingly absent accountability involved.
- It denies the right of formation of reinsurance companies with local capital.
- It allows private investments in public insurance organizations which, as stated by the law, automatically turns them into for-profit companies that obey to the investment and trade laws.
- It limits insurance companies to the stock company format which restricts heavily the growth of this sector.

### 2) Laws governing NGOs formation and functioning:

- The current law is the "*Law number 84 of NGO affairs for the year 2002"*. It highly restricts the formation of NGOs to specific domains of work.
- It obliges NGOs to await for administrative governmental approvals for every single action they take from establishment to functional activities to recruitment, elections, etc.
- It allows the government to directly interfere in the internal functioning of NGOs which absolutely defies the purpose of making a Non-Governmental Organization in the first place.

### 3) Laws governing financial transactions and banking laws:

- The current law is the "*Law number 88 of the year 2003 promulgating the law on the central bank, the banking machinery and exchange with its executive statutes".* It directly prevents the growth of online banking and accountability tools for individuals and companies which wastes a significant amount of opportunities and resources.

- It limits the establishment of popular, informal initiatives that do not want to go through the burden of creating formal NGOs or companies. This is very important to fix as the proposed system highly depends on informal initiatives and entities and, if the law is not flexible enough to allow for this sort of local, community activities, populations will carry out their transactions in cash and through personal routes which would affect the accountability, compliance and reliability of the system and would waste significant investment opportunities for these funds.

**In addition, new laws need to be created and amended covering, among others, the following fields:**

- Public-Private Partnerships with publicly owned healthcare delivery sites,
- Formation of nursing homes that satisfy the need for elderly care in a more health-effective and cost-effective manner,
- The right of proper documentation of patient health condition,
- Procurement and purchasing laws for publicly owned institutions,
- Laws allowing local spending of local taxations for communities in order to foster decentralization of services in general and in healthcare in specific,
- Patient privacy laws regulating the flow of sensitive patient information,
- Organs donation law.

Most importantly, a new legislation must be devised covering medical malpractice and its compensation since, up to this very moment, malpractice law suits have to follow the regular criminal law which is highly inappropriate for the nature of medical malpractice cases and therefore, most patients do not receive their due rights in cases of medical malpractices and most cases of real malpractice go unpunished.

Above all, real multi-sectorial dialogue and collaborative efforts between the state, political parties, the private sector and the civil society must be initiated without delay. ■

# X. Closing Remark

When it comes to realization, this proposed structural reform of the healthcare system has the peculiarity of not depending on the government per say to carry out the implementation. In fact, its success relies on a real bottom-up, step-by-step, building up of the operating processes related to its functioning. An advantage of this peculiarity is that this is not a plan to "sell" to governments, parties or ministers of health: **What you are holding in your hands is primarily a proposal for citizens**: real people with real needs, real expectations and genuine willingness to create the change they want to see. Most of the application procedures are relying on the local, civil, societal and private effort rather than policy efforts. Another advantage is that this plan is not markedly affected by political shifts and not liable for discontinuation in case of replacement of officials.

On the other hand, having governments and policy makers "on track" and sharing this vision is of great value to smoothen the process and make it reach its deliverables in a shorter interval, more solid grounds and more consistent steps.

A key practical component in the realization process is a philosophy of "lean management": The best use of all the available resources, the heavy reliance on volunteers and on local civil society and the maximization of the utility and integration of all already available healthcare infrastructure, resources and man-power.

This plan is not made to drastically abort all existing healthcare systems and delivery channels. It is designed to complement, reframe, and push the already present services and service providers towards improved quality, better affordability and more access under a more sustainable, quantifiable and organized financing scheme.

> *In short, this plan will only work as well as the people want it to. Its success is their success. Its failure is theirs.*

■■■

# References


- *4th International Micro insurance Conference Report, Making insurance work for the poor*, www.microinsuranceconference.org/2008, November 2008
- *6th International Micro insurance Conference Report, Making insurance work for the poor*, www.microinsuranceconference.org/2010, November 2010
- A. Duran, J. Kutzin, J.M. Martin-Moreno, P. Travis, *Understanding health systems: scope, functions and objectives*, Health Systems, Health and Wealth Figueras et al. (eds.), Cambridge University Press, 2010
- A. Gawande, *The Checklist Manifesto*, Metropolitan Books, 2009
- The Bamako Initiative, *Women's and children's health through funding and management of essential drugs at community level*, World Health Organization, 1986
- B. Fonteneau, B. Galland, *The community-based model: Mutual health organizations in Africa*, Protecting the poor - A micro-insurance compendium, Geneva, ILO, 2006, P. 378-400
- Brennan, Troyen A., et al., *Incidence of adverse events and negligence in hospitalized patients: Findings from the harvard medical practice study*, New England journal of medicine 324, 1991, P. 370-376
- C. Doyle, P. Panda, E. Van de Poel, R. Radermacher and D. Dror, *Reconciling research and implementation in micro health insurance experiments in India: study protocol for a randomized controlled trial,* Doyle et al. Trials 2011, 12:224, http://www.trialsjournal.com/content/12/1/224 , 11 October 2011
- Center for Co-operation with Non-Members, I*nsurance Regulation and Supervision in Asia*, OECD, 1999
- C.F.C. Jordens, M. Little, *"In this scenario I do this, for these reasons": Narrative, genre and ethical reasoning in the clinic*, Social Science and Medicine, vol. 58, no. 9, 2004
- Chassin, Mark, et al., *Does inappropriate use explain geographic variations in the use of Health Care Services? A study of three Procedures*, Journal of the American medical association 258, 1987, P. 2533-3722

- D. Dror, A. S. Preker (Eds), *Social reinsurance: a new approach to sustainable community health financing*, The international bank for reconstruction and development / The World bank and the International Labour Organization, 2002
- D. Dror and C. Jacquier, *Micro-Insurance: Extending Health Insurance to the Excluded*, Social Protection Workshop 5: Protecting Communities: Micro and Area-Based Schemes, Asia Pacific Forum on Poverty: Reforming Policies and Institutions for Poverty Reduction, Asian Development Bank, http://ssrn.com/abstract=180448 , 2001
- D. Dror, *Community-based microinsurance: Innovations on the education of the poor to manage their risks*, www.asiainsurancereview.com, July 2011, P. 96-97
- D. Dror, R. Radermacher, R. Koren, *Willingness to pay for health insurance among rural and poor persons: Field evidence from seven micro health insurance units in India*, Health Policy, doi: 10.1016.j.healthpol.2006.07.011 , 2006
- D. Dror, *Why "one-size-fits-all" health insurance products are unsuitable for low-income persons in the informal economy in India*, Micro-insurance Academy, http://ssrn.com/abstract=1017094
- D. Geldersa, G. Bouckaert and B. van Ruler, *Communication management in the public sector: Consequences for public communication about policy intentions*, Government Information Quarterly, 24(2), 2007
- D. Geldersa, Ø. Ihlenb, *Government communication about potential policies: Public relations, propaganda or both?*, Public Relations Review 36, 2010
- D. Royse, B.A. Thyer, D.K. Padgett. T.K. Logan, *Programme evaluation: An introduction, 3rd edition*, Wadsworth Books / Cole Social Work, Belmont, 2001
- E. C. Hansen, *Successful Qualitative Health Research*, Open University Press, 2006
- *Egypt Country Profile*, The World Bank, http://api.worldbank.org, 2011
- Egyptian Initiative for Personal Rights, *Treatment on the state's expenses: Origins and what has been reached*, First edition, www.eipr.org , December 2010
- El Dostour news paper, February 26th 2012 issue, http://dostorasly.com/
- Emerging economies transition, *Insurance Regulation and Supervision in Latin America: A comparative assessment*, OECD, 2003

- E. Morelli, G.A. Onnis, W.L. Ammann, C. Sutter (Eds), *Micro insurance - An Innovative tool for risk and disaster management*, Global Risk Form GRF Davos, Davos, 2010
- F. Lee, *If Disney Ran Your Hospital - 9 1/2 Things You Would Do Differently*, Second River healthcare press, 2009
- F.N. Kerlinger, *Foundations of Behavioral Research*, New York: Holt, Rinehart and Winston, 1973
- G. Gaumer, N. Rafeh, *Strengthening Egypt's Health Sector Reform Program: Pilot Activities in Suez*, Abt. Associates Inc., 2005
- Health and Human Rights Program, Egyptian Initiative for Personal Rights, *Challenges Facing Health Expenditure in Egypt, Report on the proceedings of a roundtable discussion*, www.eipr.org , September 2009
- H. Vandebosch, *Reader government policy and communication Cursustekst overheidsbeleid en communicatie*. Antwerpen: University of Antwerp, 2004
- I. Dror, K. Jenkins, K. Motegi, J. Sitanen, *A landscape study of Micro Insurance education*, Micro Insurance Academy, June 2011
- J. Elliott, *Using Narrative in Social Research*, Sage Publications, 2005
- J. Ellul, *Propaganda: The formation of men's attitudes*, New York: Vintage Books, 1965/1973
- J. Figueras, M. Mckee, S. Lessof, A. Duran, N. Menable, *Health systems, health and wealth: Assessing the case for investing in health systems*, World health Organization, Europe, 2008
- J. Goodwon, R. Horowitz, I*ntroduction: the methodological strengths and dilemmas of qualitative sociology*, Qualitative Sociology, 2002
- J.F. Outreville, *The health insurance sector: Market segmentation and international trade in health services*, International trade in health services: A development perspective, United Nations and World Health Organization, 1998, P. 111-124
- J. P. Newhouse and the Insurance Experiment Group, *"Free for all?, Lessons from the RAND health insurance experiment*, A RAND study, Harvard University Press, 1993
- J. W. Cresswell, *Research design: qualitative, quantitative and mixed methods approaches*, Sage Publications, Thousand Oaks, California, P. 6, 2003

- J. Wipf, D. Garand, *Performance Indicators for Micro-insurance: A Handbook for Micro-insurance Practitioners,* ada Micro-finance expertise, 2008
- K. Devers, *How will we know "good" qualitative research when we see it? Beginning the dialogue in health services research*, Health Services Research, vol. 34, no. 5, 1999, P. 1153-88
- L.M. Franco, L. Marquez, *Effectiveness of collaborative improvement: evidence from 27 applications in 12 less-developed and middle-income countries*, *BMJ Qual Saf*, doi:10.1136/bmjqs.2010.044388, 2011
- M. Gautham, E. Binnendijk, R. Koren, D. Dror, *"First we go to the small doctor": First contact for curative health care sought by rural communities in Andhra Pradesh & Orissa, India*, Indian J Med Res 134, November 2011, P. 627-638
- Micro Insurance Innovation Facility, *Protecting the working poor, Annual report 2011*, International Labour Office, 2012
- Ministry of Health, Egypt and Health Systems 20/20, *Cost and cost analysis report for seven hospitals*, Bethesda, MD: Health Systems 20/20 project, Abt. Associates Inc. December 2010
- J.M. Morse, P. Field, *Nursing research: The application of qualitative approaches*, second edition, Chapman & Hall, London, 1996
- M.Q. Patton, *Qualitative evaluation and research methods*, Second edition, Sage Publications, Newbury Park, California, 1990, . 13
- M.R. Massoud, K.L. Donohue, *Options for Large-scale Spread of Simple, High- impact Interventions: Technical Report*, USAID Health Care Improvement Project. Bethesda, MD: University Research Co. LLC (URC), 2010
- *The Ottawa Charter: Health promotion*, 1st International conference on Health promotion, Ottawa, World health Organization,1986
- P.M. Taylor, *Munitions of the mind: A history of propaganda from the ancient world to the present day (3rd ed.)*, Manchester, UK: Manchester University press, 2003
- R. Grun, J. Ayala, *Impact Evaluation of the Egyptian Health Sector Reform Project Pilot Phase*, The International Bank for Reconstruction and Development / The World Bank, 2008
- Right to Health Staff, *Health Insurance Case 2008*, The Egyptian Initiative for Personal Rights, 2008

- R. P. Rannan-Eliya, C. Blanco-Vidal, A. K. Nandakumar, *The Distribution of Health Care Resources in Egypt: Implications for Equity,* United States Agency for International Development - Partnerships for Health Reform Abt Associates Inc.
- S. Leatherman, T. G. Ferris, D. Berwick, F. Omaswa and N. Crisp, *The role of quality improvement in strengthening health systems in developing countries,* International Journal for Quality in Health Care, 2010
- S. Régent, S. Chauliac, B. Rigollet, *Micro insurance, What do we know? Micro finance and micro insurance learnings from Market studies in Latin America and Africa*, PlaNet Finance, PlaNet Guarantee, www.planetfinance.org , 2011
- S. Sofaer, *Qualitative methods: what are they and why use them?*, Health Services Research, vol. 34, no. 2, 1999, P. 461-83
- S. Thomson, T. Foubister, E. Mossialos, *Financing healthcare in the European Union, Challenges and policy responses*, European Observatory on Health Systems and Policies, Observatory Studies Series N. 17, 2009
- T. J. Johnson, *Market Failure, Encyclopedia of Health Services Research*, Volume Two, Sage, P. 709-713
- W. Hollway, T. Jefferson, *Doing Qualitative Research Differently*, Sage Publications, 2001
- World Health Organization, *Egypt Country statistics*, Global Health Observatory Data Repository, http://apps.who.int/ghodata/, 2011
- W. Schäfer, M. Kroneman, W. Boerma, M. van den Berg, G. Westert, W. Devillé, E. van Ginneken, *The Netherlands Health System Review*, Health Systems in Transition, European Observatory on health systems and policies, Vol. 12 No. 1 2010

Keep Moving Forward

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