Can Universal Health Coverage Systems Achieve Health Equity? Institutional Lessons learnt from a set of Countries to the Newly Born System in Egypt

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Introduction

Universal Health Coverage (UHC) is a concept which has regained high attention in political and diplomatic circles on national and global levels. Health equity is an expected outcome of universal health coverage systems, but yet not a guaranteed one. The study informing this brief adopts a political economy/institutional approach while applying a comparative analysis for Egypt with a number of countries including Germany, Turkey, and Brazil. Building on the experience of those countries, the study delves in the institutional aspects to arrive at the points of weakness and strength in building an equitable universal health coverage system.

The study argues, following Kingdon's model and path dependence theory (two commonly used political economy approaches in studying the health sector), that the formal trials of health reform that Egypt has followed was not a choice but rather an inevitable outcome due to entangled set of institutions that created a momentum that kept the system locked in a stagnant path. Yet, a "window of opportunity" has been created in the wake of January 2011 revolution that led to the final birth of a promising universal health insurance law in 2018. Using Kingdon's terminology, the "problems" have been finally correctly realized and priorities agreed upon across the key actors within the sector. The "politics" related to harmonizing the heterogonous interests of the whole set of players and interest groups succeeded in getting out a Law that the main actors took part in its design and formation. Such window of opportunity should be rightly

used and consolidated by institutional pillars regarding structure, means of finance, and coverage if the system is to reflect a sustainable equity dimension.

Main Findings and Their Policy Implications

The study showed that all four countries, Egypt, Brazil, Germany and Turkey, experienced socio-political events that tilted their development and political agenda towards UHC as a main goal within the health spectrum. However some were trapped into a stagnant static "performance dependence path" whereas others followed a stochastic dynamic one. Broadly reviewing the UHC with its three institutional pillars (coverage, finance and structure) in Egypt and comparator countries highlighted common grounds that most health equity alert systems share as areas of opportunities or as sources of challenges to avoid:

- Strong adaptive political will and leadership is the main common aspect that characterized the three benchmark countries. Such a system clearly identifies the problems and reaches a point of agreement and compromise among the key actors and interest groups, efficiently handling the "politics" by including stake holders as co-designers of the "policies". Identifying the existing and potential opponents of the system and working on their inclusion within the beneficiaries by unfolding the benefits or even creating new ones to tackle specific opponent or vested interests groups is another virtue. The experience of Turkey is remarkable in this matter.
- Only those countries that have put health on top the list of its developmental agenda proved to have stronger more equitable systems. This is mainly translated in having high government health expenditure within the government budget that had simultaneously the lowest levels of OOPP, catastrophic spending or impoverishment rates due to health spending (Case of Germany and Turkey).
- Consolidation on the level of planning and decision making within the financial structure is an initial important institutional pillar for attaining equity within UHC systems that all comparator countries followed. Fragmented systems do not allow for efficient risk pooling as the system will discriminate following a pure risk lessening perspective, hence depriving people

from accessing the services, and keeping the high risk people outside the system, hence eroding health equity (case of Egypt).

- Solidarity-based UHC systems that depend highly on risk pooling and diversification rather than being highly funded from general taxes have resulted in intensifying financial protection (Case of Germany and Turkey).
- Disparities in service coverage were much narrower than those of population coverage (case of Egypt and Brazil). Yet, having ambitious generous targets for widening services packages should be always regarded with caution. They can result in implicit rationing in the form of waiting lists or shortages ending up with higher degrees of inequity.
- Experience of other countries point out that financing through direct taxes might lose its significance if demographic changes have tilted the population pyramid towards aging segment of the population (Germany), or it might not reflect the equity element if they are designed in a regressive way that put a higher burden on low and middle income groups (case of Egypt).
- The involvement of the private sector and the role it plays in the financing structure is debatable and must be carefully regulated if equity of UHC is aimed for. The Brazilian system has been suffering from underfunding problems which led to widely expanding private sector involvement that ended up jeopardizing financial protection and health equity all over the country. Germany's main source of health inequity originated from this sector. Germany applies differential remuneration schemes across public and private sectors that has led to clear financial incentives for physicians to opt for PHI patients which make them receive better service and became a source of health inequity.

Towards an Equitable System for Universal Health Coverage in Egypt

The new Universal Health Insurance (UHI) law in Egypt has tried to rigorously address the main institutional loopholes in the long existing health insurance system and was institutionally successful especially during the formation phase. The law had set the legal framework that caters for health equity overcoming many of the constantly

neglected issues. It resulted in an overhaul institutional change with respect to population and services coverage as well as financial structure of the system. This has high potential, at least theoretically, in narrowing health disparities that had long affected the Egyptian society. However some cavities still need to be constructively addressed. Promoting awareness about the program and its benefits is an issue that should not be underestimated. Unfolding the benefits of the system at this stage is crucial as it would help to avoid the creation of new opponent groups that could jeopardize the smooth flow of the system as planned. Moreover, more attention should be given on tangible outputs, in the same notion like the case of "quick wins" in Turkey. More attention should be paid to other non-health related aspects like upgrading infrastructure especially in rural areas that aided for long in the discriminative health outputs favoring urban areas. The new law postulates several new sources of finance that guarantees its sustainability, at least in theory. Most of the new means of finance have a progressive nature, yet some still needs extra scrutiny on their equity implications.

An equitable UHI system requires a continuously prudent and alert political system that is always aware of existing and potential opponents, that always includes stakeholders and key actors as main co-partners in policy design, that has the target of having sound public support, and that is highly adaptive and responsive to any threats to the system. Full comprehensive review mechanism needs to be also set at the early stages of implementation to allow for early corrections and to avoid adopting wrong path dependence. The window of opportunity should be always utilized in an efficient manner to establish a sustainable system, from an institutional perspective, with health equity at its core.