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Feasibility study on the enrolment of refugees and asylum seekers in the Egyptian Universal Health Insurance Scheme (UHIS)

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Foreword

The inclusion of persons of concern (PoC) – refugees and asylum seekers – in the national social and health protection systems is a crucial step towards promoting their basic human rights, ensuring their access to healthcare services and fostering social cohesion. However, many countries face challenges in including PoC in their social and health protection systems owing to various factors, including limited resources and bureaucratic hurdles.

This study presents a review of the situation of PoC in Egypt to assess the feasibility of including them in the universal health insurance scheme (UHIS) launched in 2018. As the UHIS is being rolled out in the Phase 1 governorates, the review of including PoC under the new scheme is timely and essential, given the increasing vulnerability levels of PoC and escalating healthcare costs. The study highlights the willingness of senior officials at the Ministry of Social Solidarity and the Universal Health Insurance Authority to support the inclusion of PoC in the new UHIS, but also identifies implementation challenges that need to be addressed.

The proposed long-term PoC inclusion strategy presented in this study aims to ensure equal treatment of PoC at par with Egyptians and is grounded in sound economic policy options. It also presents data for policymakers and international agencies to make well-informed policy decisions, calling for intensive advocacy efforts with the Government of Egypt and strategic implications for the health programme.

This study is a timely and valuable contribution to the global efforts towards promoting the inclusion of PoC in national social and health protection systems. It underscores the urgent need for action to ensure that PoC are not left behind and highlights the importance of fostering social cohesion by providing equal access to healthcare services for all.

We hope this study will be a useful resource for policymakers, international agencies and other stakeholders working towards promoting the inclusion of PoC in national social and health protection systems.

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Table of contents

Foreword 2

Acknowledgments 5

Acronyms 6

Executive summary 7

1. Introduction and background 8

1.1. Introduction and background *8*
1.2. The global context of refugees' inclusion in social health protection *8*
1.3. Assessment framework, methodology and tools *9*
1.4. Data gathering *10*

2. Feasibility assessment: findings and options 11

2.1. Health system in Egypt *11*
2.1.1. Overview of the current social health protection mechanisms in Egypt 11
2.1.2. Egypt's new Universal Health Insurance Scheme (UHIS) 14
2.1.3. Population groups under the UHIS 17

2.2. Health coverage of refugees in Egypt and current gaps *18*
2.2.1. Profile of refugees in Egypt 18
2.2.2. Contribution rates for UHIS – implications for refugees 21
2.2.3. Current social health protection coverage of refugees 22
2.2.4. Current gaps in the PoC health service coverage 23

2.3. Practical considerations for PoC inclusion in the UHIS *23*
2.3.1. The proposed PoC inclusion strategy (2022–2032) 23
2.3.2. UHIS operational considerations for POC inclusion 24
2.3.3. Operational modalities of POCs inclusion 27
2.3.4. Roles and responsibilities of partners 27

2.4. Parallel measures to complement the UHIS enrolment *29*

3. Conclusion 30

References 31

List of tables and figures

- **Table 1:** Provides a summary description of the key actors in the current public social health protection system. 12
- **Table 2:** Phases of UHIS rollout as determined by the GoE 15
- **Table 3:** Co-payments 16
- **Table 4:** Scheme design parameters under UHIS established on legal basis 17
- **Table 5:** Distribution of PoC in the governorates of Egypt 19
- **Table 6:** Average predicted consumption levels of PoC (UNHCR 2018). 21
- **Table 7:** UHIS rollout plan 25
- **Table 8:** Geographic distribution of PoC according to the UHIS governorates rollout plan 26
- **Table 9:** Main responsibilities of different partners 27
- **Figure 1:** Steps for assessing the feasibility and possible inclusion of refugees in national health protection 9
- **Figure 2:** The UHIS benefit package 16
- **Figure 3:** Map of PoC distribution in Egypt as of December 2021 (UNHCR 2021) 25

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Acronyms

AFD	Agence française de Développement
CAPMAS	Central Agency for Public Mobilization and Statistics
CBI	Cash-based Intervention
CCO	Curative Care Organization
EASPMTM	Egyptian Authority for Standard Procurement and Medical Technology Management
EPI	Expanded Programme on Immunization
EVAR	Egypt Vulnerability Assessment for Refugees
FGDs	Focus group discussions
GAHAR	General Authority for Healthcare Accreditation and Regulation
GAHC	General Authority of Healthcare
GoE	Government of Egypt
HIO	Health Insurance Organization
IFC	International Finance Corporation (World Bank Group)
ILO	International Labour Organization
KII	Key informant interview
MoE	Ministry of Education
MoF	Ministry of Finance
MoFA	Ministry of Foreign Affairs
MoHP	Ministry of Health and Population
MoI	Ministry of Interior
MoSS	Ministry of Social Solidarity
MoU	Memorandum of Understanding
NCD	Non-communicable disease
NGO	Non-governmental organization

NOSI	National Organization for Social Insurance
OoP	Out-of-pocket (health expenditure)
PHC	Primary healthcare
PoC	Persons of Concern (refugees and asylum seekers)
PTES	Program of Treatment on the Expense of the State
SCI	Save the Children International
SHIP	School Health Insurance Programme
THIO	Teaching Hospitals and Institutes Organization
UHIA	Universal Health Insurance Authority
UHIL	Universal Health Insurance law
UHIS	Universal health insurance scheme
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Executive summary

The inclusion of persons of concern (PoC) – refugees and asylum seekers – in the national social and health protection systems is a global priority, a basic human rights entitlement, a cost-effective and sound economic policy option, and contributes to social cohesion. In this study, the situation of PoC in Egypt was reviewed to assess the feasibility of including PoC in the universal health insurance scheme (UHIS) launched in 2018, with a six-phase rollout plan targeting nationwide rollout by 2032.

As the UHIS has been rolled out in the Phase 1 governorates, the review of including PoC under the new scheme is crucial and timely, given that their vulnerability levels have been increasing, healthcare costs are escalating and public hospitals under the new UHIS will focus on treating the insured population, leaving PoC behind, without social health protection, and putting them at increased risk of impoverishment. Such a situation will further limit access to healthcare services among PoC, as is the case now in Port Said, one of the governorates in Phase 1 of the UHIS rollout plan.

Key informant interviews (KIIs) with senior officials at the Ministry of Social Solidarity (MoSS) and the Universal Health Insurance Authority (UHIA), and focus group discussions (FGDs) with PoC, highlighted a willingness to support their inclusion in the new UHIS. However, key informants have also highlighted challenges in the implementation of the UHIS in the two governorates which need to be addressed to make the UHIS functional in practice, especially for vulnerable households and workers in the informal economy. This includes clear contribution rates for different population groups linked to defined eligibility criteria, a strategy for identification of various groups that go beyond self-identification, as well as contribution collection mechanisms.

The study proposes a long-term PoC inclusion strategy (2023–2032) with different implementation modalities. The costing for the inclusion has been removed for this publication. The proposed inclusion is grounded in equal treatment of PoC at par with Egyptians and aims at analyzing and presenting data for policymakers and international agencies such as the United Nations High Commissioner for Refugees (UNHCR) and the International Labour Organization (ILO) to make well-informed policy decisions.

PoC inclusion in the UHIS calls for intensive advocacy efforts with the Government of Egypt (GoE) and will have strategic implications for the health program of the UNHCR, where the role of UNHCR and NGO partners will be redefined. Such a role might be operationalized through a move from the existing complementary PoC health support to a broader role of advocacy for PoC health rights, promotion of health-seeking behaviour, awareness-raising on the rational use of health services, enhanced PoC human capital, and possible strengthening of the national health systems to enable inclusion of PoC.

1 Introduction and background

The PROSPECTS Partnership of the ILO, UNHCR, UNICEF, International Finance Corporation (IFC), and the World Bank aims to develop inclusive, comprehensive and durable development programmes for protracted displaced populations and their host communities. The partnership has a component on strengthening social protection and social health protection for PoC – refugees and asylum seekers – and host communities, focusing on extending social health protection coverage to currently uncovered population groups.

1.1 Introduction and background

PROSPECTS in Egypt is evaluating the feasibility of enrolling PoC in the new UHIS, which is being rolled out progressively until 2032. The joint ILO and UNHCR feasibility study reviews the current Egyptian health system, the current health provisions for PoC, the national plan to roll out the UHIS in the next decade, and the existing barriers to accessing health care for PoC, including legislative and administrative issues. Based on the findings, the study recommends mechanisms for extending social health insurance to PoC in Egypt under the new UHIS.

1.2 The global context of refugees' inclusion in social health protection

International and regional human rights instruments, such as the 1948 Universal Declaration of Human Rights, the 1966 International Covenant on Economic, Social and Cultural Rights, the 1989 Convention on the Rights of the Child, and the 1981 African Charter on Human and Peoples Rights, established the universal human right to social security and, by extension, to social protection. While refugees are covered by these general human rights instruments, the more specific international treaties protecting them provide for their right to access social protection. The 1951 Convention relating to the Status of Refugees has specific provisions relating to refugees' access to social security and to public relief. Most recently, the New York Declaration in 2016 and the Global Compact on Refugees in 2018[1] called for the inclusion of refugees in social protection systems.

The Global Compact on Refugees outlines a multi-stakeholder approach to better respond to refugee situations and achieve protection and solutions, while easing the burden on host communities and promoting self-reliance. Social health protection is one tool that can be part of a broader health and social protection platform to improve the health and socio-economic situation of refugees.[2]

Social protection aims to ensure access to healthcare and income security for all along the life cycle. It provides for households when subjected to events that affect their needs in terms of access to health care and income, for example being sick, unemployed, injured, pregnant or too old to work. The ILO Social Security (Minimum Standards) Convention, 1952 (No. 102) defines nine life contingencies for which all members of society need to be protected along the life cycle through a rights-based approach: healthcare, sickness, maternity, unemployment, disability, death of the breadwinner, employment injury, old age and maintenance of children.

[1] UNHCR, Global Compact on Refugees – Booklet.
[2] ILO and UNHCR, Handbook on Social Health Protection for Refugees, Approaches, Lessons Learned and Practical Tools to Assess Coverage Options, 2020.

ILO standards on social protection recognize equality of treatment and non-discrimination as key principles. Convention No. 102 applies without any restrictions to specific groups of the population. Convention No. 118, which addresses specifically equality of treatment (social security), applies to refugees and stateless persons without any condition of reciprocity. The integration of refugees into national social protection programmes can provide sustainable and cost-effective solutions to transition from humanitarian assistance, particularly in protracted situations.

Integration and inclusion of refugees into national health systems is one of the strategic approaches of the UNHCR Global Strategy for Public Health 2021–2025, which embodies the human rights-based approach to health. The strategy's primary goal is *"Refugees, and other persons of concern to UNHCR, access the preventive, promotive, curative, palliative and rehabilitative health services they need, at an affordable cost and of sufficient quality to be effective, in order to lead healthy and productive lives".*[3]

The UNHCR has been using social health protection schemes as one option to improve access to health services and has pursued this in several countries. Since 2014, the ILO and UNHCR have been collaborating on extending social health protection. In 2016, the UNHCR and ILO signed a memorandum of understanding (MoU), launching a new phase of cooperation between the two organizations on eight common priorities, including expanding social protection. Both organizations aim to explore the means of obtaining social protection benefits, including social protection health schemes.[4]

WHO's Global *Framework on Promoting the Health of Refugees* and Migrants states that access of refugees to preventive, promotive, curative, rehabilitative and palliative healthcare services, without any financial hardship and with sufficient quality to be effective, is the key to promoting the health of refugees and migrants.[5]

1.3 Assessment framework, methodology and tools

The stepwise approach, which the ILO and UNHCR have jointly identified in the Handbook on Social Health Protection for Refugees,[6] guided the study. This approach consists of five steps to lead the process to extend health coverage to people of concern on a national level (see figure 1).

Figure 1: Steps for assessing the feasibility and possible inclusion of refugees in national social health protection

- Step 1: Identify available national health coverage mechansims and their effectiveness to provide access to health care for the currently enrolled population.
- Step 2: Analyse current coverage of refugees including gaps.
- Step 3: Assess the available health coverage options.
- Step 4: Engage in advocacy with national authorities.
- Step 5: Prepare for implementation and monitoring

The stepwise approach stipulated in the assessment framework[7] guided the study questions. In addition, the assessment study used a mix of qualitative and quantitative tools, including desk review, KIIs and FGDs.

[3] UNHCR, Global Public Health Strategy 2021–2025.
[4] ILO and UNHCR, Handbook on Social Health Protection for Refugees, Approaches, Lessons Learned and Practical Tools to Assess Coverage Options, 2020
[5] https://www.who.int/migrants/about/framework_refugees-migrants.pdf?ua=1.
[6] ILO and UNHCR, Handbook on Social Health Protection for Refugees, Approaches, Lessons Learned and Practical Tools to Assess Coverage Options, 2020
[7] Handbook on social health protection for refugees: Approaches, lessons learned and practical tools to assess coverage options (ILO). 2020 .

1.4 Data gathering

From December 2021 until February 2022, the study team conducted a desk review of recent studies, technical and programme reports, and statistical records of the PoC in Egypt, provided by the ILO and UNHCR teams and by other partners. In addition, the team conducted a series of meetings and in-depth interviews with representatives from the PROSPECTS Partnership (ILO, UNHCR and UNICEF) and other partners, WHO, Save the Children International (SCI), and Caritas, as well as senior government officials at the Ministry of Health and Population (MoHP), the CEO of UHIA, and MoSS (assistant of the Minister for Social Protection). With the support of UNHCR and Caritas staff, field visits were made to Alexandria and Port Said to conduct four FGDs with representative groups of PoC in both governorates.

2 Feasibility assessment: findings and options

2.1 Health system in Egypt

2.1.1. Overview of the current social health protection mechanisms in Egypt

Egypt is a populous African country with around 102 million people and a Gross Domestic Product (GDP) per capita equal to US$3500 in 2020.[8] It is a lower middle-income country with a fragmented health system consisting of a wide range of public and private health providers and financing bodies.

The primary source of financing is out-of-pocket spending (OOP), representing 63 per cent of current health expenditure in 2019.[9] According to the Global Monitoring Report on financial protection in health,[10] the incidence of catastrophic expenditure reached 26.5 per cent at OOP spending on health, at more than 10 per cent of household consumption, and 3.9 per cent at more than 25 per cent of the household's total consumption in 2012, which is higher than the average of the surrounding countries[11] (WHO 2020, World Bank 2018).

The second source of financing is the Ministry of Finance (MoF), which accounts for nearly one third of total health spending in 2022. On the other hand, private health financing represents around 3 per cent (Fasseeh et al. 2022). The limited public spending on health and the high percentage of OOP spending hugely affects the accessibility and availability of healthcare services and led to inequity in access to services.

The MoHP is the primary government service provision agent for preventive and curative services, including primary, secondary and tertiary services. Primary health care (PHC) is provided through PHC centres and units located over the whole country, including urban and rural areas. Most PHC services are provided free of charge to the whole population, including POCs.

[8] According to World Bank Indicators.
[9] WHO Global Health Expenditure Database (GHED): https://apps.who.int/nha/database.
[10] WHO, Global monitoring report on financial protection in health 20192020 ,. World Development Indicators. Retrieved 17 August 2021, from https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS?locations=EG.
[11] The indicator used is "catastrophic health spending" which means SDG indicator 3.8.2, defined as out-of-pocket health spending exceeding 10 or 25 per cent of total household consumption or income.

The primary financing agencies are the governmental sector represented by the MoF and other ministries and departments of the government. For the curative and hospital sector, the MoHP is a significant and direct funder of parastatal organizations, including the Curative Care Organization (CCO) and the Teaching Hospitals and Institutes Organization (THIO). Another source of financing is the co-payments and user fees that people inside MoHP hospitals are paying (Mathauer et al. 2019, Fasseeh et al. 2022). Additionally, private organizations such as private insurance companies, unions, non-profit organizations and, most importantly, households are considered self-funders and constitute the highest percentage of current expenditure (Gericke et al. 2018).

There is a growing private-for-profit sector, mostly in tertiary care and for specialized health services in large urban areas. The presence of the private sector in PHC as well as in poor rural areas remains negligible. Many non-governmental organizations (NGOs), including religiously affiliated clinics and other charitable organizations, also provide private not-for-profit services. Egypt also uses the Program of Treatment on the Expense of the State (PTES) to provide health care coverage for the uninsured poor and the informal sector (not accessible to refugees). The PTES uses a fully automated network in all the governorates through 27 sub-medical councils, 12 major hospitals, and a total of 400 local hospitals. The scheme has a well-defined and costed benefit package that caters for inpatient and outpatient treatment for Non-Communicable Diseases (NCDs), surgical packages and oncology treatments.

Table 1: Provides a summary description of the key actors in the current public social health protection system.

Key actors in the Govt healthcare system								
Agency	Description	Management body	Oversight	Type of scheme	Targeted population	Percentage covered	Financing	Refugees eligibility
HIO	The Health insurance Organization (HIO) is an independent cavernment organization operating under the supervision of the Minister of Heath	General Authority for Health insurance	MoHP	Social health insurance	Formal sector employees Health services for civil servants and preschool and school children (around 58 percent ofthe population) It provides services for percent ottne population)	55% of whole population	Premiums, taxes, sin taxes, co-payments	No
CCO	The Curative care organization (CCO) is a nonprofit gove mental organization supervised by the MoP	Curative care organizati on (Hospitals)	MoHP	Provides secondary hosptal services to both public and private health insu rance beneficiaries	It provides services for employees of companies with dedicated contracts It also covers accident cases private patients, and a limited number of impoverished patients through MoHP grants		co-payments general tax, and user fees	
THIO	THIO is separate under the Minister of Health authoriv with is own network of hospitals and specialized institutes		MoHP	Provides tertiary care and treats non-HIO insured ndividuals		Half of THIO's services are free of charge	MoнP (70.8%), for-fee healthcare services to institutes and individuals	
PTES	Program for the Treatment at the Expense of the State (PTES)	Teaching Hospitals and Institutes Organizati on (Hospitals)		The Ministry of Health and Poculation (MOHP) has sienifican t decision-making authority over the parastatas desolte thai -autonomous Status	The PTES utilzes a fully automated network in all the governorates through 27 sub-medical councils, 12 major hospitals, and a total of 400 localhosoitals. The scheme has a well-defined and riced benefit packame that caters for incatient and outostient treatment for NCDs, surgical packages, and oncology treatments			No

UHIS (the new scheme)	Universal Health Insurance System	Universal Health Insurance authority	Prime Minister	Social Health Insurance Scheme plus subsidization scheme for vulnerable population	Whole population (100% by 2030)	Geographic al expansion to include whole population by 2030	(a)contributions / pre miums (b) earmarked fees and taxes including. among others, contributions from toll road fees, car licensing fees, and tobacco taxes and (c) co-pavments paid by beneficiaries at the point of service Various entities wil be involved in revenue collection, including the MOHP, MOF, Ministry of Transportation Ministry of the Interior. Tax Authority, Social Insurance Fund, UHIA, and service providers.	Not yet

Health Insurance Organization (HIO)

A social health insurance scheme was introduced in 1964 by presidential decree to provide compulsory insurance to formal sector employees, but with an opt-out strategy. The primary sources of funding are employee and employer contributions. Other funding sources include co-payments, national taxes, payroll taxes, tobacco earmarked tax, and government subsidies of some population categories, such as students and children under 7. Evidence has shown that HIO covers around 55 per cent of the Egyptian population (Fasseeh et al. 2022, Gericke 2006).

However, expanding the health coverage to include the whole population encountered challenges because the scheme is not designed to include the informal sector and self-employed. In addition, the vulnerable population could not pay to join any health insurance schemes, which resulted in suffering from OOP expenditures and limitation to access to healthcare services (Shawky 2010, Devi 2018).

2.1.2. Egypt's new Universal Health Insurance Scheme (UHIS)

Egypt has embarked on a major reform in the health sector. The transformational universal health insurance law (UHIL), issued by the President of Egypt in January 2018, reshapes the social health insurance set up in Egypt, in line with the health pillar of Egypt's 2030 Sustainable Development Vision and the Egyptian Constitution (Article 18, "Every citizen is entitled to health and to comprehensive health care with quality criteria'').

The UHIL envisions mandatory coverage for all citizens in the country, including vulnerable groups — approximately 30 per cent of the population — who will be subsidized by the government. In addition, the UHIL allows: (a) optional coverage for Egyptians living abroad; and (b) coverage for all foreign residents, subject to reciprocal agreements with their respective countries. Successful implementation of this programme has support at the highest levels of government.

The new UHIS addresses the flaws of the existing health system in Egypt and introduces major structural and functional changes in healthcare financing, delivery and regulation. The UHIS will be implemented through four newly established independent agencies: UHIA as the "purchaser or financier"; the general authority of healthcare (GAHC) as the public "provider" of services; the General Authority for Healthcare Accreditation and Regulation (GAHAR) as the "accreditor or regulator", and the Egyptian Authority for Standard Procurement and Medical Technology Management (EASPMTM) as the central supply procurer.[12]

The implementation of the UHIS will be completed in six phases over a 15-year period, with the aim of expanding the coverage to the whole population by the end of 2032. Phase 1 has started in the governorates of Port Said, Ismailia, Suez, South Sinai, Luxor and Aswan. The new UHIS aims to mitigate against high OOP health expenditures, as well as to boost equitable access of all Egyptians to quality health services. The UHIS provides for enrolment, through different mechanisms, of non-Egyptian persons – including POCs – so that they can benefit from the improved health services and financial protection that the UHIS will offer. It is worth noting that Article 68 of the UHIS Bylaws (issued by Prime Minister Decree 909 in February 2018), provides room for establishing special arrangements to include refugees.

[12] Egypt - Supporting Egypt's Universal Health Insurance System Project (English). Washington, D.C., World Bank Group. Available at: http://documents.worldbank.org/curated/en/528341591123310893/Egypt-Supporting-Egypt-s-Universal-Health-Insurance-System-Project.

Table 2: Phases of UHIS Rollout as determined by the GoE

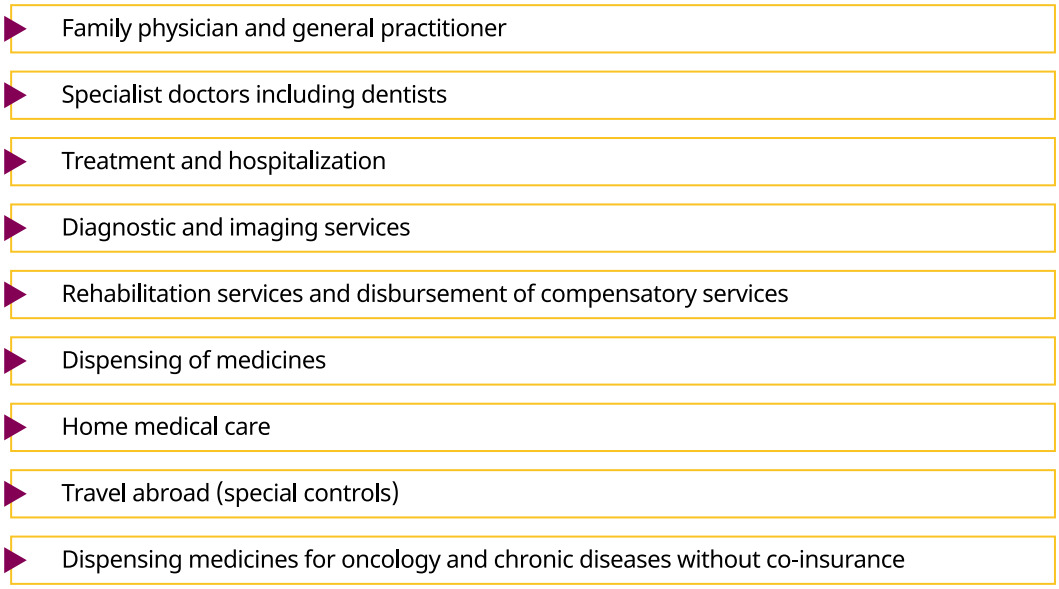
Phase	Governorate	Poverty Level (%)[a]
1	Port Said	7.6
	Ismailia	32.4
	Suez	20.0
	South Sinai	51.5
	Luxor	55.3
	Aswan	46.2
2	North Sinai	51.5
	Matrouh	51.5
	Qena	41.2
	Red Sea	51.5
3	Damietta	14.6
	Alexandria	21.8
	Beheira	47.7
	Kafr El Sheikh	17.3
	Sohag	59.6
4	New Valley	51.5
	Minya	54.7
	Fayoum	26.4
	Beni-Suef	34.4
	Assyut	66.7
5	Dakahlia	15.2
	Gharbia	9.4
	Menoufia	26.0
	Sharqia	24.3
6	Cairo	31.1
	Giza	34.0
	Qalioubiya	20.1

The benefit package

The new UHIS is a family-based health insurance system, which extends coverage to the whole family and not only individuals. The scheme is characterized by a comprehensive benefit package which includes all diagnostic, curative, rehabilitative and palliative health services that are provided through family physicians in PHC centres, outpatient clinics or hospitals. The benefit package also includes admission to secondary and tertiary hospitals, medication and home visits when needed. On the other hand, preventive and promotive health services such as vaccinations, family planning, emergency services (excluding hospital admissions) and pandemic-related health services are financed through the MoHP and are free of charge to Egyptians and refugees according to the MoHP decree.

Further, the UHI law outlined the benefit package (see figure 2) for UHIS members and has given a brief description of the healthcare services that insured patients can use, paying only the amount of co-payment at the point of care stated by the law. The new UHIS is more comprehensive and organized than the current fragmented health system.

Figure 2: The UHIS benefit package



The new UHI system in Egypt introduced co-payments for medications, laboratory tests and medical imaging (see table 3). Although the cost-sharing mechanism can affect the financial protection aspect and decrease the equity and access to healthcare, the law has removed co-payments for patients with chronic diseases and has added an upper ceiling for them to decrease the financial burden.

Table 3: Co-payments

Home visit	Co-payment of E£100 per episode.
Medications	Co-payment of 10% with a maximum of E£1000.
Laboratory tests	Co-payment of 10% with a maximum of E£750 per test.
Medical imaging	Co-payment of 10% with a maximum of E£50 per test.
Hospital admission	Co-payment of 5% with a–– maximum of E£300 per admission.

2.1.3. Population groups under the UHIS

The basic scheme design parameters under UHIS, including population groups and their respective contribution rates, are summarized in table 4, based on the different Egyptian laws governing contribution rates.

Table 4. Scheme design parameters under UHIS established on legal basis

Population	Contribution rate(s)	Benefit package
Civil servants and employees in public and private sector .	1% of insurable salary + 3% for unemployed spouse + 1% for each child.	Diagnostic, curative, rehabilitative and palliative health services that are provided through family physicians in PHC centres, outpatient clinics or hospitals. The benefit package also includes admission to secondary and tertiary hospitals, medication and home visits when needed.
Formally employed workers	1% of insurable salary + 3% for unemployed spouse + 1% for each child from employee. 4% of insurable salary by employer.	
Vulnerable groups	Subsidized by the Public Treasury at a rate of 5% of minimum wage (E£2400 monthly as of May 2022).[13]	
Migratory workers, temporary workers and small-scale self-employed workers (like street vendors, car parking assistants, newspaper distributors, shoe shiners)	Cumulative contribution rate of: 5% of insurable salary + 3% for unemployed spouse + 1% for each child or depend Up to a maximum of 7% for each household for this specific category	

As the new UHIS main revenue-raising policies are based on collecting the contributions through payroll taxes from people working in the formal sector, challenges are encountered on expanding the health coverage and raising revenue from the informal sector[14] (casual workers), unemployed, self-employed, refugees and disadvantaged marginalized groups.

According to Article 68 in Law 2 for 2018, the government can design a new scheme or programme to include refugees in the national insurance scheme (Law 2/2018 on Universal Health Insurance, 2018). However, this expansion needs different policy changes, the availability of institutional capacity and financial resources. The ILO and UNHCR advocate for equal treatment in access to healthcare services for PoC and nationals, in line with international human rights; different financing modalities will be proposed based on the equal treatment of refugees as nationals.

The UHI law and bylaws defined the contribution rates for Egyptians living in the country, including the contributions, co-insurance percentage and the co-payment amount for receiving services and medication. The insurance unit is the whole family, and the contributions are calculated based on a percentage of the family's monthly income (Law 2/2018 on Universal Health Insurance, 2018). In addition, the UHIS documents and sources describe the health services (UHIA Official Website, 2020).

In practice, the UHIA is struggling in the implementation of UHIS in the two governorates with regards to the identification of different population and occupation groups, the application of the contribution rates in the law and the collection of contributions. The UHIA has outsourced the collection of contributions to the National Organization for Social Insurance (NOSI), which is using contribution rates and income estimations that are not governed by the UHIA. Further KIIs have reported that some workers in the informal economy have been registered but are currently not paying contributions. Vulnerable households are also supposed to self-identify to receive subsidies, which only few households have done in practice.

[13] The minimum wage has been increased to E£2,700 since the study was conducted.
[14] The strategies envisaged by the government to collect contributions from workers in the informal sector are not defined yet; and this area will be subjected to intense investigation in the study.

The reported challenges need to be urgently addressed for all residents of Egypt to ensure that the UHIS is properly implemented and can effectively protect the entire population in case of ill health.

Vulnerable population according to the UHIS

Under the UHIS, beneficiaries are categorized into "vulnerable" and "non-vulnerable" groups. Vulnerable groups will be subsidized by the public treasury and were defined as listed below under the Prime Minister Decree (No. 1948/2019).

The public treasury will cover UHIS contributions for vulnerable groups[15]

- The person or family is entitled to cash support provided by the Takaful and Karama cash transfer programmes and the older social security programme;
- The unemployed person or family head is ineligible or has exhausted his/her eligibility period to receive unemployment benefits, including every dependent person in the same family;
- The person or family head with no income, who lacks family support and resides in a social or healthcare facility;
- The disabled person or family head who cannot earn money or who does not have any source of income, without prejudice to the Law on the Rights of Persons with Disabilities;
- Persons and families who reside in specific geographic areas and are temporarily experiencing a natural or manmade disaster; and
- The person or family head whose average income does not satisfy his/her own needs or his/her family members' essential needs determined after appealing to a dedicated board.

According to the UHIL, these eligibility criteria will be amended at periodic intervals of not more than three years. The way, the government will identify and implement the subsidy scheme for vulnerable individuals and household needs to be studied in more detail.

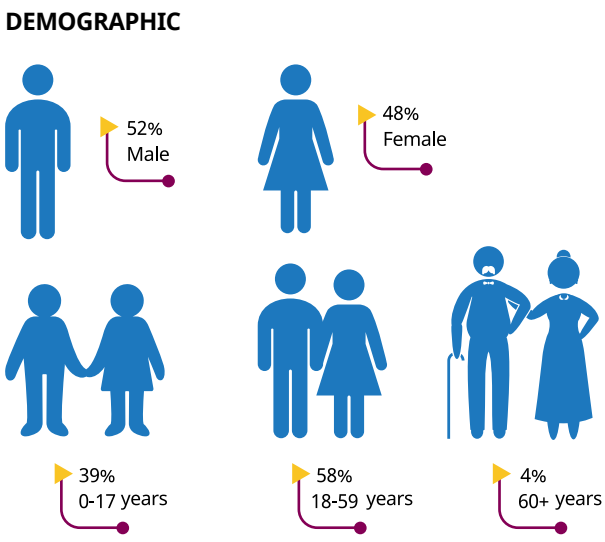
2.2 Health coverage of refugees in Egypt and current gaps

2.2.1. Profile of refugees in Egypt

Demographic profile

According to UNHCR records as of 31 December 2021, the total number of registered refugees and asylum seekers in Egypt is 271,102, with 78 per cent refugees and 22 per cent asylum seekers. Syrian refugees represent 50.5 per cent (136,727) of the refugee population, while other nationalities represent 49.5 per cent (134,375) mainly from Sudan, South Sudan, Eritria, Ethiopia, Yemen, Iraq, Somalia and other countries.[16]

According to UNHCR records, almost all PoC in Egypt live in urban areas distributed all over the country. However, the major concentrations are in Greater Cairo (Cairo, Giza and Qalyubia) and in Alexandria governorates (see table 5).[17]Around 9 per cent of this population is aged between 0 to 5 years.[18] According to UNHCR 2021 records,[19] 48 per cent of the refugees were females and 39 per cent were children (0–17).



[15] https://www.elwatannews.com/news/details/4974711
[16] Monthly-statistical-Report_December-2021.pdf (unhcr.org).
[17] UNHCR Egypt Monthly Statistical Report.October 2021.
[18] Population breakdown by age group. UNHCR Statistics records (as of 31 August 2021).
[19] UNHCR Egypt Newsletter | December 2021 (campaign-archive.com)

Table 5: Distribution of PoC in the Governorates of Egypt

Governorate	Syrian	Other	Total	Percentage
Cairo Office				
Giza	38.186	56.872	95.058	35.06%
Cairo	23.561	70.810	94.371	34.81%
Kalyoubia	19.663	580	20.243	7.47%
Sharkia	10.825	558	11.382	4.20%
Menoufia	2.468	76	2.544	0.94%
Suez	190	873	1.063	0.39%
Ismailia	912	81	993	0.37%
Red Sea	666	38	704	0.26%
Assiut	386	53	439	0.16%
Menia	416	4	420	0.15%
Beni Suef	299	28	327	0.12%
Fayoum	296	23	319	0.12%
Suhag	171	23	194	0.07%
Luxor	160	4	164	0.06%
Aswan	17	113	130	0.05%
Qena	89	16	105	0.04%
South Sinai	65	30	95	0.04%
North Sinai	13	11	24	0.01%
New Valley	4	1	5	0.00%
Total	**98.386**	**130.194**	**228.580**	**84.32%**
Alexandria Office				
Alexandria	21.459	3.476	24.935	9.20%
Damietta	9.277	63	9.340	3.45%
Dakahlia	3.586	427	4.013	1.48%
Gharbia	1090	96	1.159	0.43%
Behera	921	82	1.003	0.37%
Matrouh	970	33	1.003	0.37%
Kafr EI-Shikh	675	29	704	0.26%
Port Said	363	2	365	0.13%
Total	**38.341**	**4.181**	**42.522**	**15.68%**

Vulnerability profile

Currently, the Government of Egypt does not include refugees and asylum seekers in national household surveys. The UNHCR therefore remains the main data collector with regards to assessing the vulnerability of PoC.

The UNHCR has conducted regular vulnerability assessments to collect information and identify the socio-economic status of refugees and asylum seekers living in Egypt. The assessments have demonstrated a constant increase of vulnerability levels over the last years. Unlike the previous vulnerability assessments, which only covered Syrian refugees, the Egypt Vulnerability Assessment for Refugees (EVAR) covered PoC from 38 different countries.[20] The survey covered a total of 1,389 households and 4,652 individuals. Considering this sample, the average refugee and asylum seeker household had three members, and 45 per cent of them were headed by females.

Employment status

The assessment identified the unemployment rate to be 29 per cent for the assessment sample. Out of the 71 per cent employed, around 50 per cent had temporary wage employment, and only 3 per cent were self-employed in small businesses. Moreover, 77 per cent of the surveyed households had difficulties meeting their basic needs, and the economic vulnerability reported among non-Arabic-speaking refugees had a higher incidence than Syrian refugees and other Arabic-speaking refugees.

Although the GoE allows refugees and asylum seekers registered with the UNHCR to apply for six-month renewable residence permits, only 37 per cent of vulnerability assessment respondents had a valid residence permit. Securing and renewing residence permits is a cumbersome process, which has negative implications on the livelihood and employability of the refugees. It is even more challenging, if not to say impossible, for PoC to obtain work permits in Egypt; hence there were no respondents engaged in formal employment.[21]

In response to refugees' vulnerability and needs, the UNHCR, along with its partners, continues to provide several programmes in legal support, basic needs and livelihood, food security, protection, education, health and cash-based interventions. Around 34 per cent of households had received cash from the UNHCR.

Distribution of refugees per poverty status

Under UNHCR social protection programmes, PoC are categorized into four groups, namely, extremely poor, poor, near poor and non-poor. According to the latest UNHCR vulnerability assessment (2018),[22] 19.3 per cent of refugees were considered extremely poor; 20.3 per cent poor; 33.2 per cent near poor; and 27.3 per cent non-poor.

There are differences in the levels of poverty status across governorates. Poverty is more prevalent among refugees residing in Cairo, followed by Giza. Although Cairo governorate accounts for 38 per cent of the refugees in Egypt, it is the home of more than half of the extremely poor refugees (56 per cent). Similarly, the poor and extremely poor are over-represented among the refugees in Giza governorate.

Income

According to the UNHCR, the estimated "PoC consumption/expenditure" is used as a "proxy income", given the inherent difficulties in getting accurate data on income. Currently, no estimations of the average predicted consumption of PoC per poverty status exist. As such, proxy income data for all four PoC categories are classified according to threshold levels corresponding to the upper limit per capita of the predicted monthly consumption (according to HIECS 2017).

For this assignment, upper limit threshold values were used to estimate the average monthly consumption per capita for each PoC group. Threshold data only exists for three vulnerability statuses, namely, extremely poor, poor and near poor. The national minimum wage of E£2400[23] per month is also assumed in this assessment as the average income for the non-poor.

[20] UNHCR Egypt Newsletter | December 2021 (campaign-archive.com)
[21] UNHCR.2018. Vulnerability Assessment for Refugees in Egypt.
[22] UNHRC, 2019. Vulnerability Assessment of Refugees in Egypt: Risks and Coping Strategies.
[23] The minimum wage has been increased to E£2,700 since the study.

Table 6: Average predicted consumption levels of PoC (UNHCR 2018).

		Extremely poor	Poor	Near poor
UNHCR		EGP per month	EGP per month	EGP per month
	Average predicted consumption (EGP)[24]	554	868	1106

PoC used multiple coping mechanisms, such as borrowing money, to overcome their unmet needs, including access to healthcare and medication. The COVID-19 pandemic deepened the vulnerability situation of PoC and also limited access to decent jobs.

According to the latest income and expenditure survey of CAPMAS (2021), the national adjusted poverty line for individuals (2019/2020) is E£858 per month (E£10,300 annually).

2.2.2. Contribution rates for UHIS – implications for refugees

Given the income data in the section above, it is apparent that extremely poor and poor refugees will not be able to contribute to the UHIS. The near-poor group of refugees, with an average predicted consumption of E£1,106 per month, also falls short of the minimum expenditure basket set at E£1,603 per month, which is defined as what a household requires to meet its basic needs. Consequently, their inclusion as a vulnerable group will be crucial, as currently this group cannot afford to meet its basic needs. Moreover, this group earns only half of the minimum wage set at E£2,400. Setting contribution rates as a percentage of the minimum wage will make the contribution rates unaffordable for near-poor households. Too high monthly contributions and out-of-pocket payments related to co-payments and co-insurances under the UHIS will put near-poor households at risk of falling into poverty. In line with international social security standards, notably the ILO Social Protection Floors Recommendation, 2012 (No. 202), social health protection systems should embed solidarity in financing at the core of their schemes design, taking into account the contributory capacities of different population groups (Para. 3(h) and 11). As such, the inclusion of the near poor into the vulnerable group is in line with international social security standards. Representing the largest PoC group (33.2 per cent), their exclusion from the vulnerable group risks the creation of a "missing middle", as the largest population of PoC will be subjected to contribution rates they might not be able to afford. It is recommended to lower contribution rates for the near-poor population to make them more affordable, as per their predicted consumption rates.

This is an important point for Egyptians as well: as long as the income calculation for the non-vulnerable populations under GoE regulations assumes a minimum wage of E£2,400, which might be well over what is truly earned by a segment of the population of nationals, the monthly contributions for this segment of the population will become unaffordable. It is, therefore, important to consider whether groups that are near poor in the general population should be partly subsidized by the government in order to make contributions more affordable. The ILO stands ready to support the government with technical assistance in this respect.

[24] Based on latest EVAR. UNHCR. 2018. Vulnerability Assessment for Refugees in Egypt.

It is also important to note that subsidies for vulnerable groups is calculated on an individual basis rather than the household level. A three-person household would have to be subsidized with E£120 times the number of household members, adding up to E£360 per household, while contributions (9 per cent of the minimum wage) for the same household would only be E£216. This should be considered in further policy discussions.

It is recommended to conduct a detailed costing once the parameters have been agreed upon, factoring in the specific regions in which UHIS is already implemented. This costing should also take into account the actual poverty rates in the different governorates, which are considerably higher in the greater Cairo region than the rest of the country.

2.2.3. Current social health protection coverage of refugees

Different ministerial decrees have regulated the inclusion of refugees in the Egyptian health system. In 2016, the Ministry of Health and Population and the UNHCR jointly signed two MoU granting refugees and asylum seekers of all nationalities equal access to public primary, secondary and emergency health care as Egyptian citizens. Although the government has initiated different mechanisms to enhance the inclusion of refugees in the health system, refugees currently depend heavily on the subsidiary schemes offered by the UNHCR through its NGO partners.

Several NGOs are currently partnering with the UNHCR to respond to the PHC and the secondary and tertiary health needs of the PoC on a referral basis. NGOs include implementing partners (such as Save the Children, Caritas-Egypt, Refugee Egypt) and operational partners (such as Egyptian Red Crescent, Médecins du Monde, Médecins sans Frontières, Saint Andrew's Refugee Services). Among these NGOs, the main two implementing partners are Save the Children and Caritas-Egypt, which provide outpatient and inpatient health services.

Caritas is the leading implementing partner for providing complementary primary health and outpatient services that PoC have limited access to through the public system. Caritas has two main offices in Greater Cairo and North Coast that run eight clinics, serving an average of 9,000 PoC across several governorates. One of the main functions of Caritas is to build partnerships with different community pharmacies and partially subsidize the cost of chronic medication with different co-sharing percentages based on the vulnerability assessment. As a result, the PoC who suffer from chronic diseases will currently pay from 0 to 20 per cent of the medicine cost, depending on their socio-economic status (extremely poor 0 per cent, poor 10 per cent, near poor 20 per cent, and non-poor 20 per cent).

In addition, Save the Children is working with the UNHCR on two main projects. The first is the mainstreaming of PoC to use the public health system by mobilizing refugees to start family files and consultations at public PHC centres. In addition, technical support is being provided to the health workers to provide better quality services for PoC. The second project provides secondary and tertiary services through contracts with public, private or non-profit hospitals. In addition, physicians need referrals to access secondary and tertiary services through Save the Children.

2.2.4. Current gaps in the PoC health service coverage

According to the Health Access and Utilization Survey Among Refugees in Egypt,[25] an average of 61 per cent of the respondents prefer to receive healthcare services through private facilities, despite being more expensive. The survey highlighted that an estimated 41 per cent of the households surveyed sought care at a public facility and had to pay an average of E£980 (US£62.57). By comparison, of those who sought care at a private facility, 33.9 per cent paid an average of E£1,228 (US$78.41). Chronic disease expenditures are considered one of the challenges that refugees are facing in the country, as the respondents elaborated that the average E£400 (US$25.5) was paid monthly for chronic medication, with around 30.64 per cent of surveyed household members unable to access such medication because they could not afford it.

There are still considerable gaps in access and availability of health services. The UNHCR, because of limited resources, has to restrict the services available through its programmes and focus on selected critical conditions. Refugees with needs that fall outside the criteria of the UNHCR programmes depend on NGOs or private and public Egyptian health-care providers. Also, within UNHCR programmes, people may experience barriers. One example is the lengthy process between the initial examination, diagnosis and dispensing of drugs for chronic disorders. PoC might have to go through three different stages; first to their physician's clinic at a primary health care clinic (PHCC) or a hospital, then to the Caritas office to obtain approval for the drugs, and then to the pharmacies. This lengthy process acts as a barrier to healthcare access and may lead to interruption of treatment and additional expenses for transport or loss of income. Moreover, there are some challenges of PoC not accepting generic drugs approved by the UNHCR, and paying OOP for the brand-name drugs prescribed by their physicians instead.

Another problem is that PoC often have negative perceptions about public hospitals, preferring to pay OOP at private hospitals, which can impose substantial financial hardship.

A recent study on *Inequity and Benefit Incidence Analysis in Healthcare Use among Syrian Refugees in Egypt*[26] found that without equitable subsidy and efficient allocation, poor refugees could not afford healthcare services (Fares and Puig-Junoy 2021). Furthermore, the study indicated that the richest had more advantages than the poorest in the probability of access to healthcare services. The main contributor to inequality in access to health services is socio-economic status, with other elements such as large families, the presence of chronic disease, being female and the duration of asylum in Egypt further contributing to inequality.

As the implementation process of the UHIS continues, all public hospitals under the supervision of the MoHP will be transferred management by the GAHC. These hospitals will start treating only the insured population, leaving uninsured PoC no choice but to pay out of pocket. Such a situation will limit the access to healthcare services among PoC, as is the case in Port Said.

According to the 2021 study of Fares and Puig-Junoy,[27] a comprehensive social policy that encompasses education and employment opportunities for refugees, as well as pro-poor welfare, is needed.

2.3 Practical considerations for PoC inclusion in the UHIS

2.3.1 The proposed PoC inclusion strategy (2022–2032)

The proposed strategy for including all PoC in the national UHIS has the following features.

- The PoC inclusion in the UHIS should be based on a policy decision by the GoE to actualize Article 68 of the UHIS by-laws (Decree 909/Feb 2018), which provides room for such inclusion. Furthermore, a new Prime Minister Resolution will be issued to elaborate on the decision's operational details and authorize the relevant UHIS agencies (UHIA and HCO) to implement them.

[25]UNHCR, Health Access and Utilization Survey among Refugees in Egypt, March 2021.
[26]Fares, Hani & Puig-Junoy, Jaume (UNHCR). 2021. Inequity and benefit incidence analysis in healthcare use among Syrian refugees in Egypt. Conflict and Health. .
[27]Fares, Hani & Puig-Junoy, Jaume (UNHCR). 2021. Inequity and benefit incidence analysis in healthcare use among Syrian refugees in Egypt. Conflict and Health. .

- Advocacy efforts with the government officials are needed to release a high-level decree concerning the inclusion of PoC in the national insurance system, alongside the inclusion of nationals and the same geographical expansion that is already in place.
- The inclusion in the Phase 1 governorates (2023–2025) provides a good pilot to test all legal, operational and financial modalities. This idea of field-testing the enrolment was welcomed by the senior UHIA and MoSS officials and the PoC interviewed. This will only enrol around 1 per cent of the PoC population in Egypt.
- For the Phase 1 governorates, an agreement protocol should be issued between the government (representing the UHIA, GAHC, MoH and MoF) and the UNHCR to guide the implementation process.
- The modalities for policy decisions will be identified on how contribution rates for PoC will be set, how income will be assessed for PoC, who will cover PoC without contributory capacity, and how the vulnerable PoC will be subsidized.
- Depending on these modalities, the operationalization, financing arrangements and roles of the GoE and UNHCR and other partners will have to be adapted.
- The UHIS should issue a Health Insurance Card for PoC (with an identifiable number) to access health services in all health facilities, guided by the current practice in Phase I governorates. It would be important not to connect the card's validity according to the residency period; otherwise, it would be too hectic for PoC to go through frequent renewal processes.
- Table 11 demonstrates that the major concentration of PoC in Greater Cairo governorates (around 77 per cent of the PoC population) will not benefit from the UHIS Phase 6, which calls for immediate actions to mitigate the current pressing health needs that result in high OOP spending. One measure could be the inclusion of PoC school students in the school health insurance by HIO under Law 99/1992 (the old insurance scheme).
- Moreover, programmes on the national level need to support livelihood opportunities and poverty-reducing measures to enable non-poor PoC to contribute to the UHIS. Engagement of PoC in MoSS and other NGO capacity-building and human capital development programmes that enhance employability and economic self-reliance opportunities should be considered.

2.3.2 UHIS operational considerations for POC inclusion

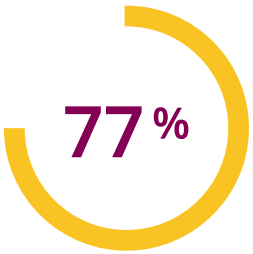
Geographic distribution

According to the UNHCR database, the total number of PoC by the end of December 2021 is 271,102, unequally distributed among all governorates. While 77 per cent of the PoC live in three central governorates – Cairo, Giza, and Qalyubia – these governorates are supposed to be included under the UHIS rollout plan in Phase 6 (2030–2032). As mentioned earlier, the implementation of the UHIS will be geographically expanding to include the whole population by the end of 2032.

The total number of PoC by the end of December 2021

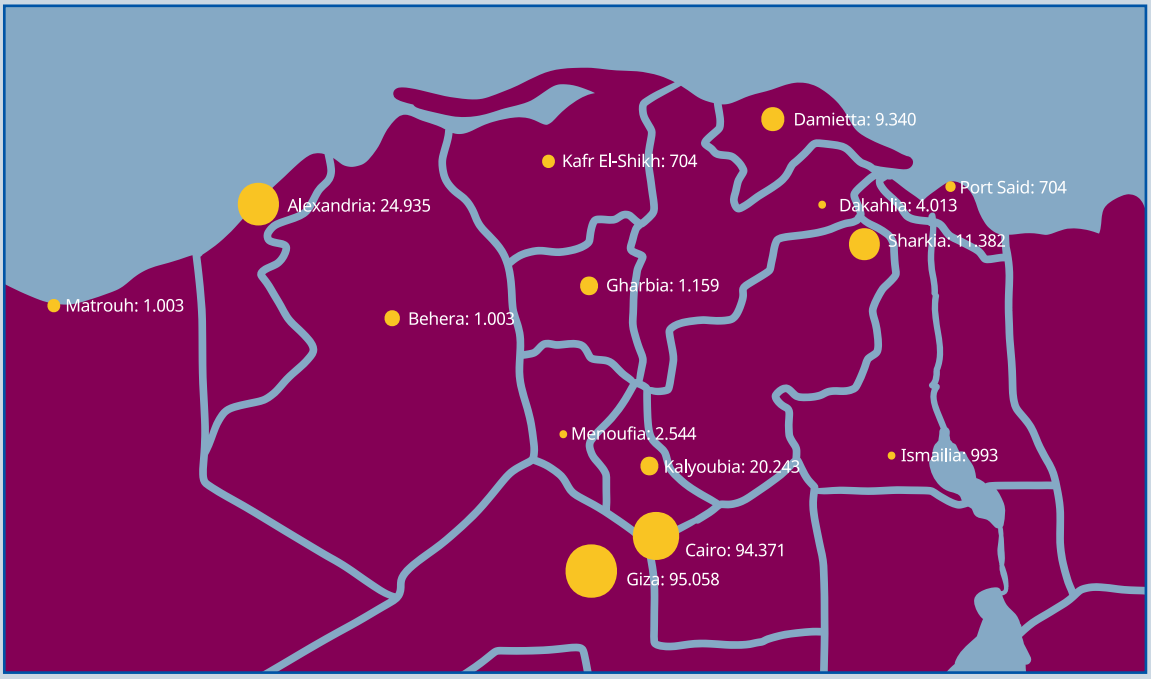
271,102

unequally distributed among\ all governorates.



of the PoC live in three central governorates – Cairo, Giza, and Qalyubia

Figure 3. Map of POC distribution in Egypt as of December 2021 (UNHCR 2021).



- **Giza:** 95.058
- **Cairo:** 94.371
- **Alexandria:** 24.935
- **Kalyoubia:** 20.243
- **Sharkia:** 11.382
- **Damietta:** 9.340
- **Dakahlia:** 4.013
- **Menoufia:** 2.544
- **Gharbia:** 1.159
- **Matrouh:** 1.003
- **Behera:** 1.003
- **Ismailia:** 993
- **Kafr El-Shikh:** 704
- **Port Said:** 365

Table 7: UHIS rollout plan

Phase 1: Port Said, Suez, Ismailia, South Sinai, North Sinai
Phase 2: Aswan, Luxor, Qena. Matrouh, Red Sea
Phase 3: Alexandria, Beheira, Damietta, Sohag, Kafr EI-Sheikh
Phase 4: Assiut, New Valley, Fayoum, Menia, Beni Suef
Phase 5: Dakahlia, Sharqia, Gharbia, Menoufia
Phase 6: Giza, Cairo, Qalyubia

During implementation, the operational plan of Phase 1 governorates changed, leading to an updated list including Port Said, Suez, Ismailia, South Sinai, Aswan and Luxor (Law 2/2018 on Universal Health Insurance, 2018). Only 1.04 per cent of all PoC residing in Egypt live in the Phase 1 governorates; thus, for the first phase, 2810 PoC would have to be enrolled in the UHIS.

Table 8: Geographic distribution of PoC according to the UHIS governorates rollout plan

Governorate	Syrian	Other	Total	Percentage
Phase 1 (updated)				
Port Said	363	2	365	0.13%
Suez	190	873	1,063	0.39%
Ismailia	912	81	993	0.37%
South Sinai	65	30	95	0.04%
Luxor	160	4	164	0.06%
Aswan	17	113	130	0.05%
Total	1707	1103	2810	1.04%
Phase 2				
North Sinai	13	11	24	0.01%
Qena	89	16	105	0.04%
Matrouh	970	33	1,003	0.37%
Red Sea	666	38	704	0.26%
Total	1738	98	1836	0.68%
Phase 3				
Alexandria	21,459	3,476	24,935	9.20%
Behera	921	82	1,003	0.37%
Damietta	9,277	63	9,340	3.45%
Suhag	171	23	194	0.07%
Kafr El-Shikh	675	29	704	0.26%
Total	32,503	3,673	36,176	13.34%
Phase 4				
Assiut	386	53	439	0.16%
New Valley	4	1	5	0.00%
Fayoum	296	23	319	0.12%
Menia	416	4	420	0.15%
Beni Suef	299	28	327	0.12%
Total	1401	109	1510	0.56%
Phase 5				
Dakahlia	13	427	4,013	1.48%
Sharqia	89	558	11,382	4.20%
Gharbia	970	69	1,159	0.43%
Menoufia	666	76	2,544	0.94%
Total	1738	1,130	19,098	7.04%
Phase 6				
Giza	38,186	56,872	95,058	35.06%
Cairo	23,561	70,810	94,371	34.81%
Qalyubia	19,663	580	20,243	7.47%
Total	81,410	128,262	209,672	77.34%
Total	**136,727**	**134,375**	**209,672**	**100.00%**

2.3.3 Operational modalities of POCs inclusion

Vulnerability assessment

As previously stated, the GoE does not collect data on refugees. The UNHCR remains the main data collector with regards to the income and consumption levels of PoC, which are required to cost their annual contribution base. As such, vulnerability assessments of PoC have only been carried out by the UNHCR.

It is to note that the latest EVAR was conducted in 2018, and as such, vulnerability levels can be assumed to be underestimated, particularly since the aftermath of the COVID-19 pandemic is expected to have exacerbated the vulnerability of PoC. Consensus between the GoE and other social partners will be required to establish a common vulnerability assessment method for PoC, as well as nationals working in the informal economy, to properly assess their vulnerability status and contributory capacity. Having different brackets of contributions according to ability to pay is particularly important for near-poor households, to enable them to join the scheme without financial hardship.

During implementation, an agreement should be reached between the UHIA and UNHCR on whether the UHIA will perform the vulnerability assessment to identify vulnerable PoC (as per the UHIA policy and procedures),[28] or if the assessment responsibility will stay with the UNHCR, as is currently the practice. Another option would be to develop a joint identification mechanism between the GoE and UNHCR. Identifying vulnerable PoC will be challenging, particularly with their fluctuating economic situation and uncertain livelihood conditions.

Income of PoC

The non-vulnerable population should apply at the UHIA governorates offices to join, and the contributions will be calculated based on income and the number of household members. However, as PoC usually work in the informal economy, it is also a long process to verify the predicted consumption and expenditure (as proxy income). It might be challenging to prove their income, considering PoC have no bank, post office or other saving and credit accounts; they do not generally have contracts and are paid in cash. Also, in many cases, this "income" is not stable, so that it might vary every month.

2.3.4 Roles and responsibilities of partners

Table 9: Main responsibilities of different partners

Role of the GoE	• Policy changes with the necessary legal, operational and financial arrangements at par with Egyptians • Gradual phase-in to include all PoC nationwide • Potentially covering costs by subsidizing vulnerable refugees
Role of UNHCR	• Advocacy with GoE and UN partners, awareness raising with PoC • Co-sign MoU with the government (regarding the role of UNHCR in the PoC inclusion) • Gradual phase-out of the existing complementary healthcare coverage for all PoC and move to a new role • Redefined roles in the PoC health programme (next country multi-year plan) • Potentially covering costs by subsidizing vulnerable refugees
Role of PROSPECTS partners (including NGOs)	• Advocacy, technical support, PoC awareness raising, gradual phase-out • Redefined roles in PoC health support

When including PoC into the Phase 1 governorates, the roles and responsibilities of all stakeholders need to be redefined in terms of financing and operational arrangements.

[28] UHIA request form link.

Role of UHIA and MoF:

- Take a decision on pilot enrolment of all PoC in the six governorates of Phase 1; and arrange with the healthcare delivery actors (GAHC);
- Develop MoU with UNHCR for mutual roles and responsibilities;
- Set and announce clear operational guidelines for all parties concerned;
- Lead the operational aspects with the service delivery components and with the healthcare authorities;
- Enrol the PoC vulnerable population as per the vulnerability criteria applied under the UHIS, which are guided by the Takafol and Karam MoSS cash transfer programmes, with the necessary modifications and adaptations of variables specific to PoC.
- Cover the contributions on behalf of the poor citizens.

Role of UNHCR and ILO:

- support the operational enrolment;
- raise awareness of the PoC to encourage them to enrol in the UHIS;
- support the economic activities and other cash-based interventions for the PoC;
- liaise with MoSS for inclusion of PoC in the social protection schemes and the economic capacity development programmes.

Role of international donors:

- Possibly covering contributions for vulnerable refugees;
- Support the GoE to strengthen the UHIS.

Role of NGOs:

- Support the UNHCR in preparation of the field operations;
- Raise awareness among PoC to promote the demand on enrolment and active engagement, and rational use of the offered medical services.

Role of POCs:

- Actively engage and fulfil the enrolment requirements;
- Actively enrol on a contributory basis (those that can afford to).

The inclusion of PoC in the UHIS should focus on policy changes and legislative amendments that allow them to be treated at par with the Egyptians (on a contributory and non-contributory basis). The implementation of such inclusion requires advocacy and policy changes to release an additional prime minister decree stating that the GoE will treat PoC at par with Egyptians under the new UHI law. At the same time, partners will have to invest to raise awareness among PoC regarding the new UHIS and their role as contributors. As part of this, messaging needs to be clear and easy to understand for beneficiaries who will have to contribute and who will be considered for subsidies.

2.4 Parallel measures to complement the UHIS enrolment

School Health Insurance Programme (SHIP)

Parallel to the advocacy efforts to reach the fully fledged inclusion of PoC in the UHIS, there is urgent need to mitigate the current pressing health needs which result in high OOP spending. As most PoC will only benefit from Phase 6 of the UHIS rollout (as they reside in the Phase 6 governorates), one possibility presented by government partners during the KIIs is to include all PoC children attending school in the School Health Insurance Programme (SHIP). The SHIP is implemented by the Health Insurance Organization under the Law No. 99 and provides a possibility to include young PoC in health insurance before the UHIS is rolled out.

PoC students are enrolled in different types of schools (public, private and community). Given such a wide variety, the UNHCR education programme can review the current database of PoC students (their numbers, type of schooling and any form of school healthcare they receive) and, in consultation with the MoE, can discuss the entitlement status of the children for school health insurance.

Livelihood opportunities and further social protection extension

In parallel to enrolling PoC in the new UHIS, partners should continue to work towards their improved integration, better livelihood opportunities and inclusion in other social protection schemes. This last includes engagement with MoSS on possibilities to extend their social protection and human capital development programmes to PoC.

Partners can continue to support PoC in accessing decent jobs and improving their access to available job opportunities based on their skills, or they can support skill development matching the Egyptian job market. Improving livelihoods and access to decent jobs will enable PoC to contribute to the UHIS and other contributory social protection schemes.

3 Conclusion

The inclusion of PoC in the Egyptian UHIS is crucial and timely. This report advocates the pressing need to consider the early and complete inclusion of all PoC in the Egyptian UHIS at par with Egyptians. However, to effectively cover PoC, the UHIS scheme needs to be strengthened in its implementation to reach universal coverage of the entire population. Currently, challenges have been raised in the two governorates regarding the enrolment of vulnerable households (vulnerability assessment) and workers in the informal economy.

Analysis of the current healthcare coverage gaps of the PoC and the current rollout of the new UHIS point to the imperative inclusion of the PoC in the UHIS for the following reasons.

- The new UHIS is replacing the current social health insurance provisions in Egypt, and PoC in Phase 1 governorates are already excluded from some public hospitals, a situation that will exacerbate as more governorates roll out the UHIS.
- The vulnerability of PoC is constantly increasing and poverty levels are rising, because of the economic situation and the aftermath of COVID-19.
- The cost of healthcare, especially in the private sector, is escalating.
- The level of global funding is decreasing because of donor fatigue and changed priorities, making pooling of funds more essential than before.

The current situation will escalate the OOP spending to access healthcare, put PoC at high risk of financial hardship, and deprive them of a fundamental human right. Therefore, full inclusion of all PoC in the UHIS is a must, as other solutions for the existing health coverage gaps PoC face will continue to be disintegrated and become unsustainable.

Moreover, there is evident readiness to support the inclusion from both the supply and demand sides. Analysis of the in-depth interviews with the seniors of the UHIA and MoSS and the FGDs with the PoC sample in Alexandria and Port Said reveals a general willingness to engage in advocacy dialogue to take concrete steps toward the inclusion of PoC. However, many implementation modalities need to be decided at the policy level, including how contributions for the UHIS will be set, how income for workers in the informal economy will be assessed, how vulnerable groups will be identified, and who will pay on behalf of the PoC who are unable to contribute themselves.

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