Challenges Facing Health Expenditure in Egypt

Report on the proceedings of a roundtable discussion

Health and Human Rights Program

Egyptian Initiative for Personal Rights

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List of participants in the roundtable proceedings

Primary speakers

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2. Dr. Alaa Ghanaam, director of the Health and Human Rights Program, Egyptian Initiative for Personal Rights

Experts

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2. Dr. Ishaq Nagib al-Munaqabadi, Family Health Fund, Ministry of Health and Population
3. Dr. Samer Suleiman, professor of political economy, American University in Cairo
4. Mr. Helmi al-Rawi, Budgetary and Human Rights Observatory
5. Mr. Abd al-Muwalli Ismail Mohamed, Association for Health and Environmental Development
6. Dr. Mohamed Hassan Khalil, heart disease consultant, Association for Health and Environmental Development
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"Evidence shows that when citizens have access to information and opportunities to participate in the budget process they are able to improve the decisions made about what to spend public money on and the quality of how the money is actually spent. That means that the allocation of scarce public resources is more equitable and effective."[1]

[1] Press statement from the International Budget Partnership on the release of the *Open Budget Survey*, 2008.

Preface

In August 2008, the EIPR's Health and Human Rights Program organized a roundtable discussion for a group of public-health policy experts to give them the opportunity to exchange views on public and total health expenditure and its impact on health systems and citizens' health. Participants explored ways of improving the status quo and guaranteeing citizens' rights to integrated, humane health care.

The EIPR adopts a rights-based approach grounded in international treaties that uphold the right to life and health as two fundamental human rights that must be respected and protected by the state. The right to health is not fulfilled by the mere provision of medical treatment and preventive health-care services but guarantees the right of every person to a standard of living adequate to ensure every individual's health and welfare. State parties to international conventions are obligated to respect, protect and enable the right of every person to the highest attainable standard of physical and mental health.

In recent decades, governments around the world have reformed and restructured their health systems. They have developed new insurance systems and ways of offering basic health-care services, and the administration of government health services has been decentralized to make it more efficient and equitable. Nevertheless, many of these efforts have had disappointing results.[2] Patients still complain of poor services; doctors still complain of low salaries; and state budget drafters still complain of resource shortages and rising health costs. Some countries, among them Egypt, have attempted reform through ministerial decrees and other policy changes; others have been struggling to implement plans on the ground; and still others are standing still, unsure of the next step.

What concerns the EIPR's Health and Human Rights Program, in addition to analyzing and monitoring health policies and measures, is assessing the impact of these policies on citizens' health in light of their right to comprehensive health care. (It should be noted that over the last two years, the state has increasingly shirked its fundamental role to provide and fund insured, equitable and fair health care for all citizens.)

[2] Marc Roberts, William Hsiao, Peter Berman and Michael Reich, *Getting Health Reform Right: A Guide to Improving Performance and Equity*. Oxford University Press, 2004.

Health expenditure—both public (government) spending and total spending on health—thus acquires exceptional importance when attempting to evaluate health systems and policies. In turn, a review of government spending in various sectors, among them health care, requires a reasonable degree of transparency and access to information and data. As the International Budget Partnership states, the budget "is a government's plan for how it is going to use the public's resources to meet the public's needs. Transparency means all of a country's people can access information on how much is allocated to different types of spending, what revenues are collected, and how international donor assistance and other public resources are used."[3]

In this context, the EIPR organized the roundtable to discuss the mechanisms of public and total health expenditure and its sources, disbursement and results. We seek to visualize and elaborate a general course that can be offered as a holistic alternative to the violations of Egyptians' right to health that currently exist on the ground. This process will be aided if we adopt an approach that sees the health system as a means of achieving a particular end, evaluate our health system based on the concrete results of policies and identify problems using indicators such as equitability, access and efficiency—all of which are quantitative and qualitative indicators of the right to health. Through this dialogue we hope to understand the political context of the health system in order to reform it, as well as understand that alternatives will undoubtedly entail moral and legal choices and challenges.

The roundtable featured two primary speakers: Abd al-Fattah al-Gebali, the head of the Economic Research Unit at the Ahram Center for Political and Strategic Studies and a former consultant to the finance minister, examined public spending on health care; Dr. Alaa Ghanaam, the director of the EIPR's Health and Human Rights Program and the former director-general of policies and strategies in the Health Ministry's Health Sector Reform Program, examined total health expenditure as reflected in Egypt's National Health Accounts.

To put these two talks in a broader context and facilitate a better understanding of the issues raised by the debate, we have added an introduction presenting the basic facts, figures and background relevant to discussions of health expenditure.

[3] International Budget Partnership, op. cit.

Introduction to health expenditure in Egypt

Under the Constitution, the Ministry of Health and Population is responsible for the health of all Egyptian citizens, meaning that it shall work to improve all citizens' health without discrimination, in particular by reducing the mortality rate of infants, mothers and pregnant women; limiting the impact of uncontrolled population growth; and reducing the burden that illness places on society, its productivity and its development.

In early 1996, the Ministry of Health and Population reevaluated the health sector, a step that made clear the need for comprehensive health reform. The same year saw broad debates that addressed the government's ability to provide comprehensive care (preventive, primary care as well as curative care for all citizens). In November 1996, the Minister of Health and Population formed a committee to lead health reform and coordinate the efforts of the competent authorities to determine how to begin the process of reform.

This committee submitted a basic document for the Health Sector Reform Program, which identified the following goals:

- The institution of phased-in, full state insurance coverage for the entire population through the establishment of a national health insurance fund
- The restructuring of health-service provision through both the public and private sectors, using a system based on the family health model
- Decentralization in the provision of services by reverting the planning and administration of these services to the provincial level
- The provision of health services—preventive, primary and curative—through family health units and centers and district hospitals
- The integration of health services in primary health-care units through a family doctor who acts as the gatekeeper to the health system
- Choice and competition between health-service providers in the public and private sectors
- Development of the necessary administrative and organizational systems and structures to implement reform
- A commitment to provide basic medications to all Egyptians at affordable prices[4]

[4] Analysis of the Health Sector and Future Strategies in Egypt, basic document for the Health Sector Reform Program, 1996 (updated in 2001 and 2003).

In order to begin implementing these reforms, the ministry needed a realistic assessment of expenditure on health care to use as the basis for strategic planning, and it developed the National Health Accounts (NHA) for this purpose.[5] In addition to being a tool of strategic planning, the NHA provides a comprehensive description of sources of expenditure (public and private), how funds move through the health system, the agencies administering them and intermediary players in the system. It is thus an analysis of total expenditure on health care, including public (government) spending, private spending and insurance spending.

Private expenditure consists of:

1. Out-of-pocket spending
2. Some part of insurance premiums, private and public
3. Insurance co-payments
4. User fees, public and private
5. Out-of-pocket spending on medication

Public expenditure includes spending on health services and care from the state treasury, and it represents a percentage of the annual state budget.
Insurance expenditure on health care includes funds paid by citizens (which are considered private expenditure), and this is the larger portion, as well as funds from the public treasury, the percentages of which are determined by insurance laws currently in force. The best example is Law 99/1992 for student insurance. Under that law, the student pays an annual premium of LE4 (private spending) as well as a co-payment of one-third the cost of medication (also private spending), while the government pays an annual premium of LE12 for each student (public spending from the state treasury).

To round out the description and analysis of the NHA, the ministry used data from the state treasury and the Ministry of Finance on funds allocated to health care through the Ministry of Health and other ministries that offer health services, such as the Ministry of Higher Education and the Ministry of Defense. It also relied on data about health spending from the Household Survey (a measure of private spending based on fixed samples) in order to

[5] Although there is no universally accepted definition of what constitutes health expenditure, the NHA document of 1995 adopted the following definition, which will be used by this report: "Health expenditure is all expenditure on preventive care, training, rehabilitation, and health care, including population and food programs and emergency programs aimed at improving the health of individuals and the entire population. The report does not include expenditures on medical education and university training, but it does include training in the health sector of the Ministry of Health and Population."

assess the size and type of private expenditure and the components of out-of-pocket spending.

In its conclusion, the NHA report offers the following general recommendations to decision makers and strategic planners in the health-care sector:

- Reform the health sector
- Restructure the sector to achieve integration
- Reorganize health expenditure and its structures within the framework of comprehensive insurance
- Redirect public and private expenditure on health care into a unified national fund to bear the risk of illness

Remarkably, the report did not discuss several issues that lie at the heart of existing challenges, such as the fact that health-care spending as a percentage of the public budget is less than average in countries of the same socioeconomic level (the appropriate average is 8% to 10% according to the World Health Organization). In addition, steadily rising out-of-pocket spending has exceeded internationally acceptable rates, particularly for private clinic services and pharmacies—a reflection of the health system's inefficiency and the disarray and lack of regulation in the medical market, which does not achieve the objectives of equitability and availability and leads to violations of the right to health. This is in addition to the substantial gap in the availability of health services between rural and urban areas and north and south.

The debate published here by the EIPR on health expenditure raises several questions about measures and policies implemented by the Ministry of Health, and whether they ensure the Egyptian citizen's right to quality, efficient, equitable and accessible health care. There is also the basic question as to whether strategic planners and decision makers have benefited from the findings of the NHA report. It is clear that the study's findings have been ignored when drafting and implementing policies in the decade since the Health Sector Reform Program was created, which has undermined and violated citizens' right to equitable, accessible, comprehensive health care.

The following pages contain a summary of the discussion that took place in the EIPR offices. The debate, titled "The Challenges Facing Health Expenditure in Egypt," was organized by the EIPR's Health and Human Rights Program on Tuesday, 26 August 2008, with the participation of several experts in health and economics, as well as the EIPR's staff.

Welcome and introductions

Mr. Hossam Bahgat, the director of the EIPR

We are speaking today about health expenditure in Egypt, the current reality of it and the challenges it faces. This meeting will mark the beginning of a series of activities sponsored by the Health and Human Rights Program in coordination with the Committee to Defend the Right to Health.[6] For us, the issue of public health expenditure is a long-standing one, but that makes it no less pressing.

Long-standing is relative, of course, but our interest in health expenditure goes back a few years. In 2006, for example, we issued a statement when the current Minister of Health was appointed in which we expressed our support for demands from the Minister of Health and the Chair of the Health Committee in the People's Assembly to increase allocations for health in the budget that year; both the MP and the minister had complained of a decrease in spending. Before that, in 2005, we made efforts to acquaint ourselves with the technical issues involved in budgets and budget analysis and their relationship to the defense of social and economic rights by participating in several training workshops organized by the International Budget Project, one of the first organizations doing this sort of work in the field of human rights.

But the issue of public expenditure on health in Egypt is at the same time a pressing, current issue, as illustrated by the forceful debates over the reform of the health sector in the last two years. We have observed that the conversation about health reform in Egypt and the steps taken on the ground or changes in the official discourse have not addressed the level of public health expenditure but instead focus on restructuring and reorganization, whether at the policy or legislative level. Indeed, when health expenditure is mentioned, it is usually limited to a reference to out-of-pocket spending, and not with a view to reducing it, just restructuring it.

We believe the time is right to advance the debate on health expenditure in Egypt. Our meeting today is distinguished by the presence of our two primary speakers, both well-known policy experts. Mr. Abd al-Fattah al-

[6] The Committee to Defend the Right to Health is an umbrella organization of more than twenty groups and agencies, among them the EIPR. Formed in May 2007 immediately after a prime-ministerial decree established the Egyptian Holding Company for Health Care—which absorbed all national insurance hospitals—the committee opposes the decree and subsequent plans to privatize health insurance.

Gebali is an expert in financial policies, and Dr. Alaa Ghanaam is an expert in public health policies. Both men also have experience with the executive authorities and decision makers, Mr. al-Gebali through his relationship with the Ministry of Finance and his work as an advisor on the state budget, and Dr. Ghanaam through his position as the director-general of policies and strategies in the Health Reform Sector Reform Program of the Ministry of Health and Population until April 2008, when we were honored to have him join us at the EIPR as the director of the Health and Human Rights Program.

I believe that our speakers today have much of importance to say. It is not merely policy analysis but also a conversation growing out of their own experiences with the state executive authorities.

I would again like to thank you all for attending. We will first hear from Mr. al-Gebali, followed by Dr. Ghanaam, after which there will be time for questions and discussion.

Intervention by Mr. Abd al-Fattah al-Gebali

Head of the Economic Research Unit at the Ahram Center for Political and Strategic Studies

I would first like to thank the EIPR, Mr. Hossam Bahgat and Dr. Alaa Ghanaam for the kind invitation to participate. I think that issues of health and education are the most important issues in Egypt today, and we must pay close attention to the latest developments, in particular the evolving role of the state in both of these fields, because they are the most important pillars of human and national development. Issues related to the health of individuals have a direct impact on society's productivity. Thus, improvements to quality of life and other issues of human development are all closely linked to health expenditure.

In fact, spending on health achieves several basic development objectives by bringing health services to villages and hamlets across Egyptian society, which necessarily benefits larger segments of the population. Public spending on health is reflected in vaccination and other preventive programs and treating the spread of illness and endemic diseases, as well as fostering the Egyptian family's ability to obtain treatment. All of this illustrates that health spending plays a very important role within development expenditure.

There has been a debate in Egypt recently on economic policies and which entity is best able to provide health services. Should it be the government or the private sector? Some are of the opinion that the private sector is best able to provide health services. To support their views, they look at economic growth rates. If the growth rate goes up, they believe it will necessarily have a positive impact on society as a whole and thus a positive impact on public health in general.

I do not believe this is all correct. The effect of growth is not distributed equally throughout society in the form of egalitarian income distribution, as it varies across different segments of the population. That is, we can achieve high economic growth rates without a broad segment of the population benefiting, and so it does not accurately reflect citizens' ability to bear the costs of treatment. Secondly, a higher growth rate does not necessarily entail a positive impact on all aspects of health-care, which is more dependent on a general set of health policies.

It is for this reason that public finance describes health services as public goods, which are simply those goods that the government and state must play a fundamental role in administering, particularly because all development programs have shown that relying on the market alone has more negative effects than positive ones. Thus, the idea that the state, in some form or another, should abandon or reduce public health expenditure is unacceptable. Indeed, improving health and making health services available to all citizens must be a fundamental objective of government in any society, regardless of the country's economic system.

I have closely followed public expenditure in Egypt, and so I will speak only about that. I will leave the topic of total (social) spending on health to Dr. Ghanaam. What I mean by public expenditure is expenditure from the closing accounts of the state budget, and this type of spending can be read as an expression of state health policy and its objectives. Regarding public health spending, there are two major objectives that must be addressed if we are to evaluate public health spending in Egypt: First of all, how do we facilitate citizen access to the basic basket of health services? And secondly, how do we guarantee health protection for the poor and spread health services across society, throughout the villages and hamlets?

The ideal level of public health spending depends on the level of social development. We should not address this issue in terms of the budget deficit or the relationship between health spending and the deficit but in terms of the relationship between health expenditure and prevailing socioeconomic conditions. Budget deficits can be discussed elsewhere, but when dealing

with health expenditure, the issue is: How appropriate are spending levels to the nature of existing health problems and the structure of health expenditure itself? Health expenditure might be high, but at the same time, the structure of spending might not be conducive to efficient health expenditure.

There are several questions that can be raised here: What standards and criteria are used when we discuss government expenditure on health? How can this expenditure be funded? What are the impacts of government investment programs in the field of health? Which segments of society will benefit from government spending programs in the health sector? Finally, how can we better allocate public health expenditure in general?

It is not the case that more public spending on health automatically means a healthier society. On the ground, the services provided might be less efficient or of substandard quality, meaning that there is a substantial waste of resources. The key here is the structure, development and nature of spending.

When we look at the development of public health expenditure in Egypt, we find that the most recent state budget [2008–09], currently in effect, allocated LE12.1 billion to health in total public spending. Total spending on health came to only 3.6% of public spending in the state budget of 2008–09; it was only 1.2% in the state budget of 2001–02. If we examine this number—LE12.1 billion—we will find that most of it goes to pay salaries. Salaries and wages are the single largest subset of health expenditure, accounting for 50% of all health spending. Although this percentage could suggest that the wages of health-sector workers are high, in fact, they are not. Thus, there are two problems here: the high level of spending on wages as an element of public health spending, and the insufficiency of wages to guarantee a dignified life for health-sector workers, which has a negative impact on government performance.

In the health sector, we find a high rate of absenteeism in health units, particularly in rural and peripheral areas; we also find that health-sector workers hold down more than one job at a time to make a decent income. There are many other problems as well in rural health units, all of which, in my opinion, are largely attributable to low incomes.

At the same time, the money allocated for the purchase of materials and medications is not enough. For example, allocations for basic materials did not exceed LE1.6 billion, and only LE600 million was allocated to medications; an additional LE200 million was earmarked for patients' food needs, in addition to a very small percentage for serums and vaccines. These meager sums are wholly inadequate to these institutions' needs for medications and

necessary serums. As a result, when patients go to the hospital, they are obliged to purchase their own syringes and other basic necessities. This is due not only to the low levels of spending allocated in the budget for purchasing materials, but perhaps even more to the purchasing system itself, which substantially raises the cost of materials and replaces some goods with cheaper ones (at the expense of quality) in government tenders. This is a point where we can do a great deal.

Now let's turn to public investments, which have been decreasing annually for reasons linked to the government's debt obligations to contractors and companies. In short, most companies refrain from bidding for the Ministry of Health tenders or substantially inflate their prices in order to make up for the gap between delayed payments from the Ministry and the receipt of required funds, which ultimately inflates the costs of services.

Regarding the details of public spending, we find gaps in public health spending between urban and rural areas of Egypt. Although Upper Egypt has a higher number of individuals who cannot afford health care, it does not receive the majority of health spending; on the contrary, a higher percentage of spending goes to Egyptian urban areas. The gap between spending in urban and rural areas is clear—roughly 67%. In addition, the lowest income bracket receives only 16% of public health spending, while the highest income bracket takes about 24%. If we add the private spending that goes to this highest income bracket, we find that this segment of society is the single largest recipient of health spending.

To recap, most public spending goes to wages; as a result, preventive medical services, curative services and other matters that shape health policy are unable to achieve health policy objectives in accordance with social public spending and budget analysis.

The basic issue here can be summarized in two points. First, how can we achieve effective public spending? In other words, how can this LE12 or 13 billion be used to benefit the greatest number of Egyptians? Public expenditure must be allocated in accordance with targeted objectives. Secondly, how can public health expenditure be increased in the state budget to become a priority? Of course, this is linked with the more general question of how the public budget can be shaped by society, and how civil society and NGOs like the EIPR can influence this process.

We have an advantage created by the recent constitutional amendments, one of which allows the legislative authority, represented by the People's Assembly, to amend the state budget in full. This could be an important tool

for civil society and NGOs if they become capable of understanding the budget and know exactly what they want to change. When the budget is up for discussion in parliament, civil society can exercise pressure on the legislature, by addressing parliament, by speaking in parliamentary committees, or through other channels. As such, civil society can restructure spending by demanding specific changes to certain articles and redirect public spending to achieve what it views as necessary objectives. It can exercise pressure in some form or other in this field.

Intervention by Dr. Alaa Ghanaam

Expert on health policy and director of the EIPR's Health and Human Rights Program

Total (social) spending on health in Egypt is the other side of the coin as addressed by Mr. al-Gebali in his talk on public health spending and which lies at the core of ongoing debates over how to fund health care in Egypt.

Some time ago, the Ministry of Health had a planning department, but their work essentially consisted of figuring out another way to divide the cake. They maintained the same budget used in previous years, but allocated 5% or 10% more to investments than the previous year, and most of these funds were spent on projects carried over from previous years. As for strategic planning—the more important issue—in my opinion, it has not been on the Ministry of Health's agenda since its establishment.

It was against this background that the Health Sector Reform Program was created in 1997. Initially involved in preliminary research, by early 1999 it was developing models and carrying out experimental studies. The program worked on what I see as two major tools for strategic planning in the health sector: the National Health Accounts and a Household Survey on family spending and the use of health services. These two tools were in use since the early 1990s, but they were developed and used to greater benefit after the Health Sector Reform Program was initiated. Fortunately, Egypt was one of the few countries in the region that carried out three surveys of the National Health Accounts (NHA), the first in the early 1990s, the second in 1994 and 1995, and the third in 2001 and 2002, which was published in 2005.

The project was carried out by the Ministry of Health with an international institution that included several internationally recognized experts in health

reform. The methodology used in the survey, which is considered a tool of strategic planning, was a comprehensive description of health-care funding channels, the agencies that engaged in spending and the purposes to which spending was put.

The NHA raised several important questions: Is Egypt spending an adequate amount on the health of its citizens? Is total expenditure being put to efficient and effective use? Is spending distributed fairly across different segments of society? Is spending adequately distributed between preventive care, curative care and public health in a way that insures the effectiveness of spending? These are some of the issues raised by the NHA.

It must be said that some experts have raised doubts about the methodology used in these reports, on the grounds that it is descriptive and may include certain biases. The report is available to all, and we at the EIPR prepared a translated summary, although we recommend that all parties interested in health spending in Egypt read the original report.

In brief, the NHA report for 2001 and 2002, published in 2005, found that total expenditure in the health sector in Egypt (including both public and private spending) came to about 6% of GDP. In 1994 and 1995 it accounted for 3.7% of GDP, which means that the intervening years saw an increase in total expenditure of nearly 200%. The report attributes this increase to two principal factors: the rising cost of service and increased demand, particularly in the private sector.

Funding channels include health insurance in all its forms[7], as well as numerous health-care systems, such as the services offered by the Ministry of Defense and the Ministry of Interior. We have services provided by the Ministry of Health and Population, which, theoretically at least, cover all citizens by constitutional mandate regardless of income. We also have the health-care systems of various trade unions and other ministries, including university hospitals, which are subordinate to the Ministry of Higher Education, as well as the private insurance sector. Finally, we have what is now the most important segment of health spending: out-of-pocket spending by citizens.

[7] More than 52% of all Egyptians are covered by a social health insurance plan that is overseen by the Health Insurance Organization, which both finances and provides the services for the beneficiaries. It offers a full package of services for those insured, at service cost. The beneficiaries under this plan are currently civil servants, pensioners and their widows, schoolchildren and infants.

We should also note that the data given here is from 2001 and 2002 and published in 2005, which means that we have no data more recent than 2005. Regrettably, these reports—three of them issued over a decade—have not been put to use, though they were issued over the years in which health reform gathered steam in Egypt.

The 2005 report notes that total expenditure on health came to LE23 billion, up from only LE7 billion in 1994 and 1995. This represents a 200% increase in spending. As Mr. al-Gebali noted, Ministry of Health spending accounted for 4.4% of the state budget. Spending on medications and related items accounted for approximately LE8.5 billion—a whopping 37.2%—of the LE23 billion in total expenditure. Of course, a certain degree of estimation is involved in calculating total expenditure since the methodology relies on a collection of available data, followed by a Household Survey conducted on a periodic basis by experts in the field. Although at times these figures may be over- or underestimates, which leads to errors in the sample on which we base our general assumptions, they nevertheless provide a strong indication of private spending when we compare the sources of health-care funding in 2001–02 with 1994–95.

Comparing the data sets, we find that public spending in 1994–95 accounted for 46% of total health expenditure, but only 31% in 2001–02, which means that there were reductions in public spending. In contrast, private sources of funding were 51% of total expenditure in 1994–95, compared to 68% in 2001–02. In addition, donor agencies provided 3% of the funding in the 1994–95 budget, but only 1% in 2001–02.

The resources come from the following sources: 29% from the public treasury, 61% from families, 3% from public companies and 6% from private entities.

Financing agents include the following: the Ministry of Health, which spends and administers 21% of these resources, and the Health Insurance Organization, which spends and administers 10%. Out-of-pocket spending by citizens accounts for 60% of spending. This means that citizens, the Ministry of Health and insurance together administer 90% of these resources. Other ministries administer 7% of resources, public companies 1%, educational institutions 1%, the Curative Care Organization (an agency that includes several self-managed private hospitals that offer treatment services but are supervised by the Ministry of Health) less than 1%, trade unions less than 1% and civic associations less than 1%.

But how are health-care resources used in Egypt? Some 25% go to Ministry of Health facilities (that is, about one-fourth of total health expenditure is used

in Ministry of Health facilities). Some 5% goes to social health insurance facilities, 6% to private hospitals, 25% to private clinics and 23% to private pharmacies.

The 2005 NHA report contains an important observation on the role of private clinics and pharmacies in expenditure on medication. Total expenditure on medication constitutes 37% of total health expenditure (LE8.5 billion of LE23 billion). Out-of-pocket spending on medication comes to LE4.6 billion, or 58% of total spending on medication. This is an extremely high rate and very worrying given the lack of any real regulation or oversight on the dispensation of medications in private pharmacies.

The infrastructure of health care consists of 1,250 public hospitals with about 116,000 beds and 1,200 private hospitals with 23,000 beds.

The NHA report also states that citizens visit clinics on average 3.7 times a year and hospitals less than once a year (0.89 visits a year on average). Some 84% of hospital visits take place in public facilities belonging to the Ministry of Health, social insurance and educational hospitals (that is, public facilities), while 55% of clinic visits are to private clinics.

We can summarize the problems of health expenditure in Egypt as illustrated by the NHA report as follows:

1. Egypt spends less than the average on health care when compared to other countries in the same socioeconomic bracket.

2. A comparison of the two NHA reports shows an increase of family out-of-pocket spending on health care, particularly on medication.

3. Funding for health care in Egypt is still not unified, which leads to inefficiency and ineffectiveness.

4. There are imbalances in the distribution of health expenditure and provision of health services, particularly between urban and rural areas and north and south Egypt.

Regrettably, in conclusion, the NHA report simply recommends a restructuring of out-of-pocket spending—which represents more than 60% of total expenditure—in an insurance framework to cover the risks of illness and achieve just and comprehensive coverage. It recommends redirecting public and private health spending to a unified, national insurance vessel such as a national health insurance fund.
I will conclude with six observations on the report:

1. We must ask why out-of-pocket spending, particularly on medication and in private clinics, has continued to rise.

2. The study shows quite meager sums devoted to curative care as compared to preventive treatment. Why is that?

Distribution of out-of-pocket spending by service provider
Private hospitals and clinics receive nearly 50% of out-of-pocket spending (41.9% to private clinics and 9% to private hospitals)
Ministry of Health hospitals: 3.5%
University hospitals: 3.1%
Other public hospitals: 0.9%
National insurance hospitals: 0.8%
Ministry of Health centers: 3.2%
Medication: 33%

3. We notice a shortfall in total expenditure as a percentage of GDP when compared to international standards/benchmarks. Other countries spend 9–14% of GDP, and the Abuja Declaration of 2001 requires members of the African Union—among them Egypt—to work toward allocating 15% of GDP to health expenditure.

4. Unfortunately, the report attributes the increase in total expenditure to the rising costs of service and increased demand in the private sector. This point requires a discussion of possible causes. Is inflation one cause? Is the market out of control? Is false demand being created for unnecessary needs in health care in Egypt? Are profits being made in the various intermediate sub-systems within the overall system? These questions require a discussion.

5. When the report observes that 84% of visits to hospitals take place in public hospitals, this means that any encroachment on public hospitals would be tantamount to a crime against the Egyptian people.

6. The report only notes the importance of restructuring out-of-pocket spending but does not mention the need to increase public spending as a state

priority or as a major pillar of real development and investment in health in Egypt, as stressed by Mr. al-Gebali in his presentation.

Discussion

Low levels of health expenditure and the vital role of advocacy groups

When the floor was opened to questions and comments, **Dr. Samer Suleiman**[8] stated that whereas an economist looks at a budget through the prism of public finance, political scientists approach it as a political document indicative of changing circumstances—a mirror that reflects existing power balances in society.

"When we look at the Egyptian budget in the 1980s and '90s, we see a sharp increase in allocations to the Ministry of Interior, a reflection of the struggle between Islamist groups and the state at that time," he said. "The question is why has the share for health declined to such low levels in the budget?

"The sectors that receive the largest shares of the public budget are—to a great extent—the stronger political forces. In short, the budget share of any particular sector is determined according to two basic factors: the will of the political leadership and government, which depends on how much the political system stands to benefit from a particular sector, and the ability of a particular sector to exert pressure and extract the required allocations.

"For example, if we look at increased government spending on the military, it is obvious to any political analyst that the army is the strongest institution in Egypt, along with the Ministry of Interior and other security institutions.

"So, when we see how low health allocations in Egypt are, we should ask about the political influence of the group to which these allocations are directed. Of course, patients are the primary beneficiaries of health expenditure—in other words, the entire population benefits from an increase in health expenditure, but the 'population' never acts as a political lobby group. The other direct beneficiaries are health workers—doctors, nurses and civil servants; this is the group that is best able to defend health allocations. We must focus, then, on the role of advocacy groups such as the doctors' and

[8] Professor of political economy, American University in Cairo.

nurses' syndicates. There is a strong connection between increased spending on health and improved conditions for health workers, which, in turn, leads to better performance and better service.

"The problem is that the Doctors' Syndicate, like other trade unions and syndicates, suffers from political polarization and has been negatively affected by the power struggles between the regime and the Muslim Brotherhood. And this has hindered the syndicate's ability to advocate for greater health expenditure, and, thus, to increase the efficiency of health services."

Dr. Suleiman concluded by focusing on the important role that the Doctors' Syndicate and other groups that represent doctors (such as Doctors Without Borders) can play in any discussion of health expenditure in Egypt.

Economic development indicators do not necessarily reflect the reality on the ground

Mr. Abd al-Mewalla Ismail[9] agreed that the public budget is first and foremost a political document. "When we speak about the economy, we must connect it to the political context and social balances," he said. "This is very important when reading any number. Hence, when we talk about the budget, we must have a methodology that governs the way these numbers are read and the significance of the budget. Isolated, abstract numbers have no meaning for the economist or politician."

Mr. Ismail referred to the point made by Mr. al-Gebali that economic growth rates do not necessarily reflect the real state of development: "For example, if the Egyptian government manages to bring spending to 15% [of GDP]—which it could do if it wanted—as recommended by the Millennium Development Goals, it would not necessarily mean that any real development would be achieved in the health sector."

Commenting on Mr. al-Gebali's observation that nearly 50% of government spending is devoted to wages and salaries, Mr. Ismail stated that this substantial percentage does not reach all workers in the medical structure. "In a statement issued by the Committee to Defend the Right to Health, we find a huge gap in the average wages of workers at the lower end of the health

[9] Association for Health and Environmental Development.

employment structure and the very small group that constitutes the high leadership in the health sector—a ratio of about 1:400," he said.

Mr. Ismail concluded by expressing his doubts about official numbers, which can often be inaccurate. To him, this is a dilemma that requires further consideration of the significance of the numbers instead of simply dealing with them as abstract values.

Criteria used to determine public spending and benefiting from current spending levels

At the beginning of her comments, **Dr. Ragia Elgerzawy**[10] asked for a clarification on the issue of expenditure on medication. According to Mr. al-Gebali, current expenditure on medication is only LE600 million (LE656 million to be exact), but according to Dr. Ghanaam's report, expenditure on medication accounts for 30% of all health spending. She said that there are always calls to rationalize the consumption of medication, and doctors are advised to prescribe only two kinds of medication per patient and limit the dosage to the patient's actual needs.

In response to the question, **Dr. Ghanaam** stated that there is a difference between total spending on medication and government or public expenditure. The number cited by Mr. al-Gebali (LE656 million) represents only government expenditure on medication—clearly, a very low sum compared to the out-of-pocket spending by citizens, which brings spending on medication to 30% of total health expenditure in Egypt.

Dr. Elgerzawy then raised several questions about health expenditure:

Why is there no mention of the relationship between inflation and nominal increases in public expenditure? Current spending may be much higher than in previous years, but, in fact, spending has declined once inflation and currency devaluation are factored in.

What are the standards and criteria that should be used to determine public expenditure? On what basis should we ground our demands for increased public expenditure?

[10] Health and Discrimination Officer for the EIPR's Health and Human Rights Program.

How can current expenditure be put to better use? Where are the gaps that lead to waste in current expenditure?

This information is good, but how can we put it to practical use?

Dr. Youssef Wahib[11] commented on Dr. Elgerzawy's question regarding the relationship between budget numbers and inflation, noting that inflation does indeed mean that health expenditure has remained stable over the years despite nominal increases in health allocations. More important, per capita share of health expenditure has declined, rather than increased, with time.

Mr. Hossam Bahgat asked about the space available for action given the current situation, the perpetuation of existing government policies and the lack of fundamental change in the direction of state policy. "Is there a real possibility for change on the ground?" he asked. He also asked whether the government is truly constrained by the numbers discussed here and has little choice in dealing with the crisis at hand, or whether the situation is, in effect, a reflection of a political choice that makes the numbers (and hence, the crisis of health spending) what they are.

Credibility of government figures and the percentage of government spending

Dr. Mohamed Hassan Khalil[12] reiterated Dr. Samer Suleiman's point that doctors and health workers are particularly important as an advocacy group that can play a vital role in improving professional conditions and health services and forwarding demands for increased public health expenditure. Dr. Khalil gave the example of the doctors' struggle in the late 1950s, when some 1,200 doctors staged a sit-in at the Doctors' Syndicate after the government retracted its commitment to appoint recently graduated doctors. The struggle had undeniable effects on the future of health in Egypt and, at the time, created a pioneering example unprecedented in other autocratic societies. When the doctors waged their struggle then, their demands were not merely narrow parochial or material concerns, but rather they linked people's right to treatment with doctors' right to work.

[11] Professor at the Faculty of Medicine, Suez Canal University.
[12] Heart disease consultant at the Health Insurance Organization and a member of the Association for Health and Environmental Development.

Dr. Khalil added that we must foster doctors' attachments to their institutions. At the same time, we must improve conditions for doctors so that we can contain the private sector's encroachment on health care and thus reduce out-of-pocket spending by citizens. This is a major step needed to confront the privatization of health services, which is proceeding apace.

Dr. Khalil also expressed doubts about the credibility of government figures. Public expenditure is estimated to be 29% of total health expenditure in Egypt, but he believes that 9–10% of this amount is actually private expenditure. He believes the government makes a flagrant error in considering the existing social health insurance plans to be public spending when it is actually private spending, since it is funded by beneficiaries' premiums. He explained that even insurance payments made by civil servants should not be considered public spending because they are deducted from workers' wages.

Mr. al-Gebali countered that health-insurance spending "is not considered part of public health expenditure in the budget," noting that the NHA reports, as presented by Dr. Ghanaam, differ from the state budget in that the NHA include total expenditure and not only government or public expenditure from the state budget.

Dr. Ghanaam explained that spending on health insurance is divided between public and private sources. Part of the cost is paid by the beneficiaries and part by the state. For example, in the student insurance program, the state pays LE12 per student from the public budget, while students pay LE4 in annual premiums, which is considered private expenditure. Students also pay one-third the cost of medication, which is considered out-of-pocket spending (also private expenditure). Thus, the percentage noted by Dr. Hassan Khalil, which is a very important observation, is partly allocated from the state budget and partly subsumed under private and out-of-pocket spending in total health expenditure.

Dr. Youssef Wahib commented that the budget for public agencies (like the Health Insurance Organization) is not included in public expenditure from the state budget. But there is an important point here: the 10-piaster tax on each pack of cigarettes (20 cigarettes) which contributes to public expenditure for the student insurance program), and which comes to about LE300 million a year in the form of an indirect tax, in addition to the LE12 the state pays for each student. The tax revenue on cigarette sales and the LE12 premium for each student is subsumed under public expenditure. In contrast, the insurance premiums that the state pays for civil servants is not subsumed under public

expenditure because in this case, the state is the employee and the premiums paid by the state as an employer are not part of public expenditure.

Commenting on this, **Mr. al-Gebali** said, "It's important in our analysis of the state budget to make a distinction between a functional division of allocations and an economic division. The latter is what I discussed—for example, wages, support for investments and other things. In contrast, a functional analysis of the health sector would require a detailed analysis of every hospital, every administrative department, every region, etc."

Dr. Khalil turned to the problematic distribution of out-of-pocket and government spending. If out-of-pocket spending currently constitutes 60% of health spending while other private and government spending is 40%, he said, the government might logically believe that out-of-pocket spending should be reduced to 40% with the remaining 60% to come from the government. This would seem to be a step toward rationalization. But, Dr. Khalil continued, "If we look at it from a sectoral perspective, however, we find that most out-of-pocket spending goes to private clinics and pharmacies, which is the least costly type of health expenditure. Let's look at the most expensive type of health care, namely, second- and third-degree care in hospitals. According to available data, only 6% of surgeries are undertaken in private hospitals, although they contain 16% of total available beds. It is important to ask, who is treating Egyptians? Who bears the main burden of treatment in Egypt? If we analyze this, we will end up completely eliminating two sub-sectors of the treatment sector from the equation—the private sector, which provides only 6% of the costliest, most advanced treatment, and the government sector (i.e., Ministry of Health hospitals), which is experiencing a total breakdown, with an occupancy rate of only 20% and a very low level of services." The low occupancy rate of private hospitals is attributable to the fact that few Egyptians are able to afford them, whereas the low occupancy rate of Ministry of Health facilities (which account for 55% of hospital beds in Egypt) is due to their relative incompetence—no doubt a result of their lack of funding.

Dr. Khalil concluded that the lion's share of treatment for Egyptians is provided by a collection of nonprofit agencies such as the Health Insurance Organization, the Curative Care Organization, the Agency for Hospitals and Educational Institutions and Egyptian universities. He described this as a grave situation, and one that could grow worse as state policies aim to transform these nonprofit facilities into profitable enterprises—such as the prime-ministerial decree transforming the Health Insurance Organization into the Egyptian Holding Company for Health Care. Dr. Khalil stated that this

severely harms the interests of millions of citizens who receive treatment and care mostly at these nonprofit facilities.

Reading and understanding budgets

Dr. Mohamed Nur al-Din[13] said he fears that the government intentionally complicates the state budget, thus requiring experts in budget and national accounts and other sectors—such as the health sector—to engage in studies, analysis and data collection to make it comprehensible, particularly given the absence of accurate data and statistics.

Dr. Nur al-Din said that there is a need for analysis and research that explain, with accurate data, various aspects of health expenditure in Egypt, whether public expenditure or otherwise. "Many agencies have actually been excluded from the public budget but still continue to play a vital role in health-service provision," he said. "There are also many services intimately linked to health, such as the provision of potable water and sewage systems and other environmental services. To what extent can these be included in health expenditure? What are the parameters determining priorities in public expenditure? Are wages and goods the priority, to which most public health expenditure is directed?"

Dr. Nur al-Din called on experts to prepare studies that identify the types of treatment services to which health expenditure is directed, the quality of treatment and the percentage of spending on preventive health; how this is related to the public budget, the per capita share of health expenditure and health spending as a percentage of per capita income; and how this stacks up internationally.

He also referred to the role of international financial organizations such as the International Monetary Fund (IMF), noting that the IMF records bank loans to the public sector as loans for private-sector enterprises, which may distort the findings of research if this is not carefully accounted for.

Dr. Nur al-Din also expressed doubts that total health expenditure in Egypt rose 200% from 1994 to 2001. He concluded by saying that the debate on health expenditure in Egypt and its connection to the state budget marks the beginning of increased effort and systematic analysis of this important

[13] Independent economist and economic researcher.

subject. This was reiterated by **Dr. Ghanaam**, who said that there must be further debate on the topic**.**

Out-of-pocket expenditure at 60% to 63% in 2002; currently more than 70%

Dr. Ishaq al-Munaqabadi[14] made several points:

1. How should we read the numbers? Regarding health insurance and the Patient Treatment at the Expense of the State program (PTES), for example, if we say that spending on these two items comes to LE4.6 billion (LE2.6 billion for health insurance and LE2 billion for PTES) and that together these two sectors account for 80% of all surgical operations conducted in Egypt, this is not a complete reflection of the reality on the ground. There is a problem because of the adoption of a debt-transfer system. For example, if the Health Insurance Organization treats a case that requires a bone-marrow transplant, it refers the case to the Nasser Institute and pays out LE75,000. Yet, in 2002, the same operation cost the Ministry of Health some LE125,000 and is currently estimated at LE200,000. This means that we have transferred the social insurance debt to the Ministry of Health. The same thing is true of the PTES—it's all about debt transfer. Thus, when we deal with these figures, we must realize that the true cost of the service is, in fact, much higher.

2. We must create a strong role for market regulators. The market is a relationship between three parties: the service provider, the service receiver/buyer and the regulator, the last of whom must supervise market activity and ensure that it runs smoothly. Our problem in Egypt is that we have applied a market system without regulation. We must establish a strong regulatory system, particularly in the health sector, which cannot be left open to the unreliability of the market.

3. We must restructure the health sector to ensure effectiveness and an efficient use of resources. This was perhaps one of the goals of the Health Sector Reform Program, and it made great strides up to 2006, but after that date, due to a lack of clear policy, restructuring has proceeded in an increasingly haphazard and piecemeal way. For example, since 2006, five decrees have been issued to improve the income of doctors, but in the end, all of them have simply led to a further breakdown and disintegration of the

[14] Ministry of Health and Population's Family Health Fund.

health system. They have ruined the process of health reform as a whole and have reduced, and even destroyed, efficient, sound resources. There must be a general plan or study before any decrees are issued.

4. If we were to issue a new edition of the NHA today, what would it look like? The numbers would be truly startling. If in 2002 we spent LE23 billion on health, we can guess that the number is no less than LE60 or 70 billion today. In mid-2007, we said that health expenditure had reached LE40 billion; adjusted for inflation, that would mean no less than LE60 billion today. Given that government spending and health insurance spending have not increased, who is paying this amount? We'll find that we are placing the burden of illness on citizens and that out-of-pocket spending, which was no more than 63% percent of spending in 2002, would currently be more than 70%. The question here is: Is it acceptable for out-of-pocket spending on health to constitute more than 70% of total health expenditure? Globally, the figure is no greater than 24% and in the Eastern Mediterranean (which includes the Arab world), it is no higher than 50%. There must be a clear political vision that determines what the acceptable level of out-of-pocket health expenditure in Egypt is, and it should take into account population increases, the burdens it creates, and the weakness of the social welfare system.

State priorities in budget expenditures and the problem of unfair distribution of health services

Mr. Helmi al-Rawi[15] summarized his view of the problems with health spending in Egypt in the following points:

1. The public budget shows that the state's priority is not, in fact, the fulfillment of its legal and political obligations to its citizens or the international community, as decreed by the Egyptian constitution and international human rights treaties. State spending priorities as reflected in the public budget are as follows:

> a. The greatest portion of spending in the public budget (some 50%) is devoted to general public services (the presidency, representative bodies and the Ministry of Foreign Affairs) and the general security apparatus, defense, national security and the Ministry of Interior. These are the government's major priorities when allocating public spending; this makes it clear that the primary concern of public spending is to

[15] Budgetary and Human Rights Observatory

strengthen and preserve the political regime through institutions that represent it abroad and those that defend it domestically.

b. Some 25% of government spending in the state budget goes to servicing debt, both foreign and domestic.

c. Only the remaining 25% is directed to spending on citizens' economic and social rights, including health, education, housing and the environment. This illustrates an extremely regressive level of social spending and a lack of concern for social development and welfare.

2. Government policy and new laws aimed at liberalizing the market and strengthening the private sector have, ultimately, placed the lion's share of the cost of health services on citizens.

3. A lack of prioritization of spending within the health sector means that the greatest percentage of spending is directed to treatment rather than preventive services.

4. A high percentage of expenditure is directed to administrative costs, but the administrative system remains inefficient.

5. Finally, there are extreme discrepancies and inequity in the distribution of health services across various social sectors:

a. The poorest 20% of society utilize only 19.3% of Ministry of Health services while the richest 20% of society utilize the same percentage (19.3%).

b. The poorest 20% of society utilize only 17.5% of health insurance services for students while the richest 20% utilize 20.5%.

c. The poorest 20% of society utilize 14.5% of services from the Health Insurance Organization while the richest 20% utilize 33.6%.

d. The poorest 20% of society utilize only 13% of services offered by other ministries and agencies while the richest 20% utilize 25.3%.

Addressing the general point of priorities as reflected in the budget spending, **Dr. Youssef Wahib** commented that while some believe that allocations to the Ministry of Defense and the armed forces take a huge share of the budget, this is not accurate. Spending on these sectors constitutes no more than 7% of total government expenditure in the state budget. In addition, this spending helps reduce unemployment, and it includes expenditure on health through facilities under the armed forces**.**

Numbers and efficiency

Dr. Mahmoud Khayyal[16] commented that he was greatly troubled by the reality of health expenditure in Egypt as elaborated by the speakers, adding that the issue requires many more seminars and much broader debate. "The country is failing, and there appears to be no one in the ruling authority who cares," he said. "We need to work persistently and cooperatively to come up with solutions."

Dr. Khayyal focused on several major points involving problems in health expenditure:

1. We must read into the significance of the numbers carefully, particularly regarding spending on medication. Generally speaking, the numbers must be linked to real performance so as not to be misleading.

2. Regarding pharmaceutical treatment, we should look not only at the quantity of expenditure but at the efficiency and performance of spending. Does the patient recover after his treatment with medication, or does he die because of improper medication regimes? For example, in Egypt, 20% of liver patients are treated with medication that harms the liver, and it is senior medical professors who prescribe these drugs. In addition, 18% of patients with kidney failure suffer from this ailment due to improper drug treatment.

3. The Doctors' Syndicate should not limit itself to defending the interests of doctors but should also hold them professionally accountable as part of its defense of citizens' right to health. Dr. Khayyal stated that many serious mistakes are made every day by doctors because they are not up to par professionally and academically; indeed, many have not read an academic paper in the last decade**.**

Expenditure on health and expenditure on health services

Dr. Youssef Wahib gave his view of several issues involved in health spending in Egypt:

[16] Professor of pharmacology, Azhar University.

1. There is a difference between spending on health and spending on health services, and it is a mistake to believe that everything spent on health services ultimately leads to a tangible improvement in health in Egypt.

2. It is not necessarily true, as some believe, that public expenditure on health services benefits the poor while private expenditure benefits the rich. In fact, the rich benefit most from services paid for by public expenditure, and a large portion of public spending does not go to the poor.

3. There is an important point to be made about medication: While the NHA say that some LE650 million is spent on medication in Ministry of Health facilities and a similar amount is spent on medication in the Health Insurance Organization—a total of roughly LE1.3 billion—data from other reliable sources indicates that total spending on medication in Egypt is approximately LE20 billion. Dr. Wahib attributed the difference to a lack of accounting for medications smuggled or brought into Egypt by individuals.

4. Regarding the number of hospital beds in the government and private sector, he stated that the numbers are always inaccurate. We often find estimates of the number of hospital beds in both government and private hospitals to be inflated for various reasons. In the end, the lack of accuracy in the number of beds leads to clear errors in other data and indicators.

5. On the issue of performance and the allocation of a greater share of the health budget to wages, it is not necessarily true that every spending increase leads to an improvement in performance. The same is true of wages. What complicates the matter further, as Mr. Abd al-Muwalli Mohamed pointed out, is that the biggest portion of the budget allocated to wages goes to the upper cadres within the health sector while the wages of the general ranks of doctors and health workers are among the lowest of any state workers.

Conclusion

The two main speakers offered closing remarks at the end of the roundtable:

Dr. Alaa Ghanaam

This was a fruitful discussion from which we will benefit greatly. The fact of the matter is that studies of the burden of disease are essential to the process of strategic health-care planning; without them, all our efforts are useless.

The distribution of limited resources, or what is termed allocative efficiency, depends on research into the disease burden, which allows us to identify society's real needs in health services. Health outcomes in any society are the basic scientific measure for identifying what kind of spending increases on health care we really need, and how to manage that spending efficiently, based on priorities that are consistent with society's needs.

Mr. Abd al-Fattah al-Gebali

I'm very pleased with all the comments; despite disagreeing with many, I have benefited and learned from them. I think that as Mr. Hossam Bahgat said, the first objective of the discussion is to open up all the points of debate around the topic. In fact, government discussions of the budget are not as complicated as my friend, Dr. Mohamed Nur al-Din, suggests. Rather, it is simply a matter of sufficient awareness, information and seriousness. One of the most important foundations for drafting a government budget is transparency, which means it should be disseminated widely with all the relevant data and information, and civil society should participate in the discussions. Transparency is one of the indicators used by the World Bank to evaluate state budgets. In the end, a debate about the public budget is a priority for society.

Yes, the budget is a political document. The legislature must examine and discuss the budget item by item because it, along with civil society, is a basic component of the power structure, and it is very important to create a balance in society, as Dr. Samer Suleiman said. Nevertheless, I disagree with Dr. Suleiman in his focus on doctors as the strongest lobby for increased health spending, because it is not they, but citizens, who are the primary recipients of health services. As Dr. Mohamed Hassan Khalil said, all of society must be involved in the two issues of education and health, in one form or another.

This is where an organization such as the EIPR plays an important role, initiating discussions on an issue like the health or education budget in an academic or technical way, as Dr. Alaa Ghanaam said, rather than simply using political statements, which can often conceal important truths.

The budget always has some aspect of subjective estimation open to interpretation and difference, but the state closing accounts and the monetary data issued by the Central Auditing Organization do not contain any misguiding information or data, and the numbers are not manipulated as some have said. What is important is how we read and interpret these numbers.

Regarding my point of disagreement with Dr. Khalil about budget divisions, there is a functional division, there are financial asset holdings, there is loan servicing and there is the total deficit. Regarding the functional division, which many do not read, there is the division of the World Bank, which involves ten major divisions, each with several subdivisions. Within this functional division, we find the details of expenditure. So, for example, in the ophthalmology hospital, there are allocations for medication, academic research, wages and more.

Here the dispute on the issue becomes clear. If we look for social health insurance, we will find it in a certain line in the budget. I would give Egypt a transparency rating on the public budget of 54 out of 59.

Another important principle is that of the unified budget, which means that one cannot allocate a resource for a particular type of spending—I cannot, for example, impose a sales tax for health spending or a general tax for health expenditure. Rather, all state resources are collected in one vessel that enters the state treasury; resources then leave the state treasury in accordance with public spending priorities determined by society, among them, of course, health services.

This is why I wrote an article in *al-Ahram* about the subsidy debate. Some were talking about funding for subsidies, and I cautioned against this narrow perspective because it undermines the principle of a unified budget.

So, there are basic principles of the budget: first of all, comprehensiveness; secondly, a unified budget. In this context, I disagreed with some ministers who were saying, "We sold this so we could fund that," because it is more proper to say that resources enter the state treasury and then are spent as prioritized according to importance.

The state budget is formulated in parliament, with its existing political alignments and through various tools of pressure, as well as in the various parliamentary committees, including the Budget and Planning Committee. But this is an incomplete picture given the absence of advocacy groups, particularly from civil society and human rights groups. As a result, the budget is only amended according to the efforts of a few experts, who simply increase public expenditure by LE3 or 4 billion annually. This point in particular, and the role of civil society in impacting the budget drafting process, is what I came to this roundtable to discuss.

Regarding Dr. Mahmoud Khayyal's comment, there is, in fact, support within the government to amend the basis on which the budget is drafted, using a

program and performance budget. But four years have passed, and we have not yet begun to work on a program and performance budget. With what we have now, we can evaluate spending effectiveness in the sense that we can determine if we spend X pounds, we can renovate X hospitals, but we do not yet know if and how this improves health outcomes, and we need to know.

A program and performance budget is very complex, and we need a capable system to administer it. We did start this, but stopped for several reasons. A program and performance budget will achieve efficient expenditure, which I believe is an important future challenge that could fulfill what you discussed in your comments.

These are some of the primary issues. There is another major issue, that of wages, which is multifaceted and complex. Expenditure on wages is very high. In the current year, it comes to LE76 billion of a total of LE343 billion, which is enormous. At the same time, wages are still low despite budget increases. We also have 6.5 million government employees, and we have inflation. It is a problem with dimensions that must be examined and compared based on current prices or fixed prices and against growth rates. In any comparison, current prices must be set against current prices or fixed prices against fixed prices.

Speaking of the distribution of public expenditure, a functional division of the budget shows that the Ministry of Interior receives only LE9 billion. Meanwhile, LE126 billion goes to subsidies, and LE35 billion to education.

Regarding the gap between the lowest and highest wages, the difference is attributable to funds from sources other than the budget, such as private funds and distribution of incentives and profits, all of which are set according to the various laws regulating them. This is the reason for wage gaps, not monies from the public budget. Thus, the most positive recent step has been a move toward a unified treasury with financial oversight of all expected resources by the Central Auditing Organization, which itself did not know the number of private funds and accounts. This new system has two advantages:

1. It creates what is known as state liquid funds (flat money).

2. It places all resources in private funds at the Central Bank, which allows borrowing for current expenses like wages. This reduces borrowing and realizes some revenue for the state.

Regarding Mohamed Hassanein Heikal's remarks about the public budget and statements from others in the press that expenditure on the Ministry of Interior is greater than expenditure on the armed forces—this is false. The

Ministry of Interior receives LE9 billion while the Defense Ministry receives LE21 billion. This is what I wrote in *al-Ahram* a short time ago. It is important to verify information before publication and dissemination, and it is important to read it as well. This is what I was saying to Mr. Bahgat and Dr. Ghanaam—that it is important to base an analysis on accurate information. Of course, this is not the end of the debate.