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**The American University in Cairo**  
**School of Global Affairs and Public Policy (GAPP)**

**AN ASSESSMENT OF THE EGYPTIAN GOVERNMENT ALTERNATIVE  
HEALTHCARE COVERAGE SYSTEM:  
“TREATMENT AT THE EXPENSE OF STATE”**

**Thesis Submitted to**  
**Department of Public Policy and Administration**

**in partial fulfillment of the requirements for**  
**the degree of Master of Public Administration**

**By**  
**Rasha Radwan**

**Under the supervision of Dr. Laila El Baradei**  
**Professor of Public Administration & Associate Dean**  
**School of Global Affairs and Public Policy (GAPP)**

**Spring 2013**

## **ABSTRACT**

The Program of Treatment at the Expense of State (PTES) is the main alternative available for underprivileged Egyptian patients who cannot otherwise afford to pay for adequate medical treatment. Therefore, it is important to investigate whether or not it fulfills this role and reaches its intended beneficiaries. This research discusses the administrative as well as the financial framework of the PTES and investigates its effectiveness, efficiency and responsiveness. Although the system is openly criticized, the perceptions differ according to the roles and experiences of the different stakeholders. A number of interviews were conducted with officials in the Ministry of Health, the Specialized Medical Councils, as well as patients and doctors, in order to assess the benefits of the PTES and its deficiencies. Officials maintain that strict rules and regulations were lately implemented to insure the effectiveness and efficiency of the system. Patients acknowledge that the PTES is providing them with the medical services that they cannot otherwise afford, however, they point out to some deficiencies in the system such as the time it takes to get the approval and to renew it and the insufficient funds allocated per patient in some cases. Creative ways to increase the funds of the PTES are recommended such as fundraising campaigns and partnerships with the NGOs. Better and faster communication with the patients is recommended as well as more flexibility in dealing with severe cases.

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## **INTRODUCTION**

Adequate health care is a basic need for everyone. Under the Egyptian Law, all citizens are entitled to adequate health care services. These services are either provided by the private sector, the non-governmental sector, or by the public sector. Although the services provided by the private sector are much better, however, due to the low-income level of most Egyptians, the majority of the population cannot afford the private sector. According to a survey administered by the Central Agency for Public Mobilization and Statistics (CAPMAS), 25.2% of Egyptians live under poverty line, and 4.8% live in severe poverty (CAPMAS, 2010/2011). Furthermore, paying for medical services in the public sector becomes sometimes unaffordable for many underprivileged patients, especially in case of severe or chronic diseases that require long-term treatment or surgical intervention. Free or at least subsidized medical services become the only resort.

In general, in most countries, the poor receive adequate treatment through the state medical insurance system, which is considered the main mechanism whereby patients can receive adequate and affordable treatment. In Egypt, although there is a relatively well-established medical insurance system providing medical services through a large number of public facilities; however, it does not cover the whole population. In order to be under the umbrella of the state medical insurance system, one has to be either a school student or a government employee. Accordingly, the high school dropout rate coupled with the high unemployment rate in the formal economy; mainly in the low-income level households have led to a high percentage of underprivileged patients who

are uninsured. These patients pay out of their pockets when in need for any medical intervention even if it just an X-ray or a lab test, let alone medicines and operations. These out of pocket expenses represent a real burden. A report published by the World Health Organization in 2011, notes that insurance does have a positive impact on out of pocket spending at an aggregate level, reducing the burden for insurance holders. “The insured spent 536 LE per capita annually, compared with 760 LE for the uninsured” (Health Systems Profile, p.34).

In order to solve this problem, the Egyptian Government had to find an alternative mechanism whereby patients who are not covered by the medical insurance and cannot afford to pay for medical services are offered subsidized treatment. Starting in the 1950s, there were some attempts at providing subsidized health care for those who cannot afford it, however it was in 1975, that a presidential decree was issued detailing the Program of Treatment at the Expense of State (PTES). This decree is still effective till today with minor changes introduced over the years. (Appendix 1&2)

Although this system is supposed to be directed towards those from the lower-income levels to guarantee that all Egyptians are receiving appropriate treatment in a fair and equitable way, many argue that this is not the case raising concerns about equity, accessibility and transparency. Every now and then, the Egyptian public opinion raises some questions about its funding and to what extent it really benefits those who are supposed to benefit from it. Lately there were some concerns as to whether the final decisions are made based on the patient’s real needs or based on whether he/she has been recommended by an influential government official or a member of parliament. Moreover, in 2010, after thorough investigation, the Public Monies Intelligence Unit and the Central Accounting Agency announced the names of some parliament members who



were found guilty of misusing the system (Ghareib, 2010). They received a number of decrees to get treatment at the expense of state and used them in their election campaigns giving them to key people in their governorates to gain their support irrespective of eligibility.

As for the decrees issued for treatment outside Egypt, they are supposed to be issued only for limited cases. These cases should go through a detailed medical examination to prove that they need critical treatment that is unavailable in Egypt. Although the initial intention of this system was to benefit those who really need to travel abroad and cannot afford it at their own expenses, in reality, this was not always the case. The system was criticized for issuing decrees to ineligible individuals, namely parliament members and ministers who are financially affluent and do not need to be treated at the expense of the state. In some cases the decrees were even issued for simple surgeries and basic treatments that could have been performed in Egypt. In 2010, the Egyptian media disclosed a major corruption case involving some ministers who abused their position and received treatment at the expense of the state abroad for themselves and their spouses. Two of these cases were Youssef Boutros Ghali, Minister of Finance and Hatem El Gabaly, Minister of Health (Leila, 2010). Both of them were ministers in the government of the former ousted president, Hosny Mubarak.

Due to the importance of this system in helping Egyptians receive medical services that would have been otherwise unaffordable for them, its efficiency and effectiveness have to be adequately studied. Patients who are eligible to receive this treatment should apply through recognized public medical establishments according to specific policies and procedures. The complexity of the process is manifested in every stage. It starts even before applying since the choice of the hospital through which to

apply could represent a challenge. The amount of documents and reports required, the time needed to get the approval and the paper work involved make the whole process a nightmare for patients. These policies and procedures get even more complicated in case of applying to receive the treatment outside Egypt when it is not available locally. Although the patients suffer in order to get the approval, this system has become the only resort for millions of Egyptians.

This research aims at conducting an overall assessment of the Program of Treatment at the Expense of State (PTES) in Egypt through investigating the different aspects of the system, to try to get a more in depth picture of the real problems facing those who are receiving treatment, providing the services, and supervising its everyday implementation. The main research question is: *“To what extent is the PTES in Egypt characterized by efficiency, effectiveness and responsiveness?”*

This main research question is then broken into a number of investigative questions:

- \* (1) Does PTES actually reach those most in need for it?
- \* (2) Are the funds allocated to PTES used efficiently?
- \* (3) Are the funds allocated per patient adequate to the required expenses?
- \* (4) Are the policies and procedures followed in an impartial and objective way to guarantee fair access to all?

## **BACKGROUND**

Egypt has a relatively well-established medical insurance system; however it does not cover except some segments of the population. The Egyptian Health Insurance Organization (HIO) was created after the enactment of the Health Insurance Law in 1964, with the mission of coverage of the entire Egyptian population within 10 years (Health System Profile, 2012, p. 35). Unfortunately this goal was not achieved; only around 51% of Egyptians are covered by state health insurance, mainly government employees and school students. Although some Egyptians might enroll in private insurance plansthrough Egyptian or international providers, however, the majority of the uninsured cannot afford to do so. Accordingly, the financial burden they endure in case of any illness is enormous, especially that the percentage of the uninsured is higher among females, rural areas' residents and those in the lowest socio-economic levels (Egypt Household Health Expenditure and Utilization Survey 2010).

According to clause No. 16 in the 1971 Egyptian Constitution, the state has to provide adequate health services to all citizens. The new constitution that has been draftedalso stresses the right of all citizens to receive healthcare. Article 62 in the 2012 Constitution states thathealthcare is a right of every citizen, and the State shall allocate a sufficient percentage of the national revenue to cover the expenses for those who are unable to pay. Although there is a new medical insurance law that is being discussed these days in order to introduce a universal medical coverage to all Egyptians, however, until this law is approved, the Program of Treatment at the Expense of State (PTES) will

remain a very important option.

The PTES is a system managed by the Ministry of Health (MoH) designed to provide subsidized health care services to uninsured Egyptian citizens, especially those who cannot afford to pay on their own. The first presidential decree issued stating the regulations of the PTES, was in 1975. Decree 691 for year 1975 stipulated the formation of the Specialized Medical Councils in the different medical specializations. These Councils examine the cases of those applying for the PTES and recommend the adequate treatment and the needed funding whether inside Egypt or abroad in case the treatment was unavailable in Egypt. The Councils' headquarter is in Nasr City, a suburb of Greater Cairo. They are formed of specialists from the medical faculties of the different public universities, as well as from the public hospitals and the military hospitals (Appendix 3). In the same year, the Ministry of Health (MoH) issued a supplementary decree specifying the policies and regulations governing the process. One of the restrictions is that the treatment at the expense of state is not to be received except by those who are not covered by any insurance. The funds for this system are separate from the budget of the MoH; it is allocated directly from the general budget.

The Program of Treatment at the Expense of State (PTES) is a comprehensive system designed to provide subsidized treatment to uninsured patients who cannot afford to pay for adequate health services. The World Health Organization's report "*Egypt National Health Accounts: 2008-2009*", published in 2011, states that "The PTES is affiliated with and operated by the MOHP; it is not a completely autonomous entity like the HIO. It is a special discretionary fund that provides a safety net to cover the uninsured for a certain package of services. The PTES covered about 2.5 percent of the population

and spent over three billion LE in 2008/09” (p.16). It has two components; providing treatment inside Egypt for underprivileged patients and providing assistance to travel abroad in case the adequate required treatment is not available in Egypt. In the latter case, some exceptional cases might be granted approval even if the patient is insured, as long as it is confirmed that the treatment is not available in Egypt, and that it will be very costly for the patient to pay for it on his own. Patient’s condition and required treatment are studied and assessed on a case-by-case basis and the decision is made according to specific rules and regulations.

Patients who are not covered by any health insurance are eligible to apply to this system through a public or a university hospital as well as a police or a military hospital. The case is reviewed by a committee formed of three specialists who examine all tests and x-rays to determine the eligibility of the patient to receive treatment at the expense of the state. In case the request is approved, the committee’s recommendation is sent to the Specialized Medical Councils, which is the only official body authorized to give the final approval specifying the maximum amount allocated and the duration of the decree. The patient does not receive any cash money; the approval is sent back to the hospital to start providing the necessary treatment either in the form of medicines and equipment or surgical intervention. When the amount allocated is consumed by the hospital or the duration of the decree is expired, whichever comes first, the treatment is stopped and the hospital sends all the bills to the Ministry of Health to get reimbursed. In this case, the patient has two options; either to pay from his pocket to continue the treatment - which usually represents a cumbersome option - or to wait until the decree is renewed. To renew the approval, the patient has to start the process all over again (Egyptian Initiative for Personal Rights Report, 2010).

In its initial form, Decree 691 for year 1975 maintained that treatment should be in a public medical facility; Ministry of Health hospitals, military and Police hospitals, teaching hospitals and public universities' hospitals. Because of the lack of adequate equipment and preparations required for some critical surgeries or special treatment in these hospitals, some private hospitals were added to the list at a later stage. However, this was for a short time, since in 2010 and after many corruption allegations, the MoH decided to restrict the provision of the PTES to the initial categories of hospitals and take the private sector off the list of providers except in rare cases such as the kidney dialysis. In all cases, the treatment is received after the approval of the Specialized Medical Councils. The Minister of Health should sign for the final approval to be executable (Egyptian Initiative for Personal Rights Report, 2010).

In 2009, in order to regulate the implementation of the system, The Ministry of Health issued a ministerial decree enforcing that the designated committees formed by specialists in the hospitals supervising the patient should give their recommendations on a special template with a water mark to prevent forging. The final approvals also have to be systematically documented and archived to keep records of the patients' history. This control was further enforced in 2010 by a new decree stipulating that final approvals are to be issued according to a specific coding system, whereby each kind of treatment has a unique code associated with a predetermined allocated amount. This system was intending to prevent misuse of approvals since they do not specify the amount allocated, rather they include codes that are only meaningful to the certified service provider.

Before 2010, there were no restrictions on the kinds of medical conditions to be covered by the PTES. In early 2010, a new ministerial decree; Decree no. 290, was

issued limiting the medical conditions that are eligible to receive treatment at the expense of state to six conditions; heart diseases, tumors, kidney failure, hepatitis C (liver diseases), high blood pressure and diabetes (Program of Treatment at the Expense of State Report, 2010). The same decree included other cases of a lesser priority, such as non-cancerous blood diseases, immunity-related illnesses and chronic psychological and nervous cases. In May 2012, the MoH issued a supplementary decree to add a number of medical cases to the list. These included post-operative infections, Crohn syndrome, burns, multiple sclerosis, brain clotting, Cataract, and inflammation of the thyroid gland. Each of these conditions is allocated a predetermined amount of money according to the rules and regulations governing the system.

## **LITERATURE REVIEW**

Treating the uninsured underprivileged patients at the expense of the state is a system introduced by the Egyptian Government that is not implemented in many other countries. Therefore, it was translated in the literature under different names including State Financed Treatment, State Funded Treatment and The Program of Treatment at the Expense of State. I chose to use the latter since it was most commonly used in the official reports published by prestigious international organizations such as the World Bank and the World Health Organization. The literature reviewed in this paper is dated from 2000 onwards.

There were very few scholarly articles written about this topic in specific. Most of the literature review will be based on reports prepared, funded and/or published by Egyptian and international organizations as well as by the Egyptian Ministry of Health. Most of these reports used statistical indicators based on surveys. Personal interviews with the different stakeholders; patients, doctors, system administrators and officials were not used in any study, despite the importance of such personal insight. This paper will try to close this gap through conducting a number of face-to-face interviews with stakeholders in addition to discussing a number of qualitative indicators published by the different Egyptian and international agencies about numbers of beneficiaries and amounts spent on the PTES. A large number of newspaper and magazine articles discussed PTES; however, in the literature review they are only used as a background for the research. The review will be divided in three parts; an overview of the Egyptian Health System, a more in-depth discussion of the State Health Insurance System and then an analysis of the Program of Treatment at the Expense of State.



### **A. The Egyptian Health System:**

The Egyptian Health Care System is very complicated in terms of organization and funding. Most research agrees that this complexity is preventing the different health sectors from reaching their potential. In terms of organization, according to a policy brief published in 2005 based on the Egypt National Human Development Report, the health system in Egypt includes more than 29 different public entities that are involved in direct health related services, including The Ministry of Health, the Health Insurance Organization, the Teaching Hospitals Organization, the Curative Care Organization (UNDP, 2005, p.2).

As for financing, the main source of funding is the Ministry of Finance that finances health care through general tax revenues. Other sources include private out-of-pocket spending and donors. As mentioned earlier, many researchers heavily criticize the financing mechanism of the health system in Egypt. The Health System Profile of Egypt (2012) argues that the present financing system has significant systemic inefficiencies and inequities that severely limit the effectiveness of the health system as a whole. It concludes that “attempts to expand the scope of services or increase the revenues and expenditures on health care without first addressing these systemic bottlenecks in the health financing system will result in further exacerbating the inefficiencies and inequities in the system” (p.8)

Although Egypt’s public spending on health increased from 1.9% to 2.2% of GDP between 1996 and 2004, this level remains low relative to other countries of comparable income levels, “this trend reveals a low level of risk pooling arrangement, which exposes the population to potentially catastrophic and impoverishing effects of adverse health events” (Salah, 31-32). The share of the health sector in the general budget has always

has been a concern. As shown in table (1), the share in 2012/2013, reached only 5.14 %, which proves that the health sector is not given the appropriate weight it deserves.

**Table 1**  
**The State Public Expenditure on Health According to the State Budget**  
**(2011/2012 – 2012/2013)**

Million LE

	11/12	12/13
The State Public Expenditure	490589.7	533784.8
Public Expenditure on Health	23782.5	27413.1
Percent of Public Expenditure on Health to Public Expenditure (%)	4.84	5.14

Source: CAPMAS, 2013. Egypt in Figures 2013

A report prepared by the WHO on Total expenditure on health as % of Gross domestic product (Table 2), more than 200 countries were divided into six regions; African Region, Region of the Americas, Eastern Mediterranean Region, European Region, Western Pacific Region and South East Asia Region (Global Health Expenditure Database, 2013). Comparing the 2011 percentage, Egypt (4.9%), ranked 11th among the 20 countries in the same category (Eastern Mediterranean Region), while Afghanistan ranked 1<sup>st</sup>, with nearly the double (9.6%). Looking at the trend in Egypt for the last seven years, it is clear that it is relatively stable. However, comparing 2005 (5.1%) to a 2011 (4.9%), it is noted that the percentage decreased. This is very disturbing since it should be expected to find a significant increase in seven years.

**Table 2**  
**Total Expenditure on Health as % of Gross Domestic Product (2005-2011)**

Countries	Total expenditure on health as % of Gross domestic product						
	2005	2006	2007	2008	2009	2010	2011
Eastern Mediterranean Region							
Afghanistan	6.4	6.5	7.6	7.7	8.0	10.4	9.6
Jordan	8.7	8.0	8.3	8.8	9.5	8.3	8.4
Sudan	4.0	4.8	6.0	6.9	7.2	7.2	8.4
Iraq	4.8	3.6	4.9	4.9	8.5	8.5	8.3
Djibouti	7.2	7.0	7.7	7.2	7.7	7.9	7.9
Lebanon	8.1	8.0	8.2	7.4	7.1	6.2	6.3
Tunisia	5.6	5.6	5.6	5.6	5.8	5.7	6.2
Morocco	5.1	5.2	5.5	5.4	5.6	5.9	6.0
Iran (Islamic Republic of)	5.8	5.6	5.5	5.8	5.8	5.3	6.0
Yemen	4.9	5.3	5.3	5.4	6.0	5.6	5.5
Egypt	5.1	5.3	4.9	4.8	5.0	4.7	4.9
Libya	2.4	2.2	2.2	2.0	3.1	3.0	4.4
Bahrain	3.8	3.6	3.6	4.1	4.5	4.3	3.8
Syrian Arab Republic	4.1	3.8	3.8	3.4	3.5	3.4	3.7
Saudi Arabia	3.5	3.7	3.7	3.1	4.1	4.0	3.7
United Arab Emirates	2.3	2.3	2.5	3.0	4.4	3.7	3.3
Kuwait	2.4	2.3	2.1	1.9	3.8	2.6	2.7
Pakistan	2.8	2.8	3.0	3.3	2.9	2.8	2.5
Oman	2.6	2.3	2.5	2.1	3.0	2.7	2.3
Qatar	3.0	2.6	2.3	1.9	2.6	2.1	1.9

Source: World Health Organization, 2013. Global Health Expenditure Database.

**Figure 1**  
**Total Expenditure on Health as % of Gross Domestic Product in Egypt (2005-2011)**



The direct result of this relatively low level of state spending on health is the increased financial burden imposed on the patients themselves. The UNDP estimates the share of out-of-pocket in financing health care in Egypt to be around 61%, followed by the Ministry of Finance and donors(UNDP, 2005, p.1).

Most reports and reviews discussed deficiencies and inadequacies of the health system in Egypt; however, they did mention some areas of strength. Infrastructure and sheer numbers of health personnel, regardless of the condition of the former and the qualifications of the latter, are among the strength mentioned. According to Gerick (2006), the Egyptian health system has a strong infrastructure of physicians, clinics and hospitals, availability of technology and pharmaceuticals and excellent physical access to care, with 95 percent of the population being within five kilometers of a medical facility (p.31). It was recommended that for any reform program to succeed, the government has to capitalize on these areas by improving the infrastructure of the health facilities, including the physical condition of the hospitals and the medical centers, especially in rural areas and by investing in the professional development of the large numbers of physicians, nurses and technicians.

On the other hand, the review prepared by the World Bank in 2004, argues that “the health sector had many structural and functional issues that resulted in inadequate health outcomes; inequity in access, use and cost; inefficiency; low quality and clinical ineffectiveness; and lack of long-run financial sustainability (World Bank, 2004, p.6). Other studies, discussing health care services in developing countries, argue that although health care systems suffer from underfunding, system performance is a more direct outcome of how funds are allocated rather than the amount of funds itself. According to

this view inefficiency is not necessarily related to lack of funds, rather it is an indication of how these funds are utilized. In Egypt, this is clearly the case since not all the problems faced by patients in the public hospitals are of financial nature. In a policy brief published in 2005 based on the Egypt National Human Development Report maintained that there are many reasons behind poor health provision; “one reason lies partially in underutilized capacity and administrative overstaffing rather than in shortages” (UNDP, 2005,p.2).

Many other studies disagree with this view and suggest that the insufficient fund allocated to the Egyptian health care system is the main reason for most of the major problems (Gericke, 2006; Salah, 2007). One of the consequences of lack of funds is the inability to offer adequate subsidized treatment. This deficiency in the system is publicly discussed and different solutions are investigated. Gericke (2006) recommended that, “to address some of the health care financing issues reviewed, the Government of Egypt will have to raise public health expenditure substantially to finance care at an adequate level” (p.17). Better financing mechanisms are needed in order to improve the subsidized services that are offered by the government. The main two mechanisms through which the Egyptian Government is offering subsidized treatment to needy patients are the State Health Insurance and the Program at the Expense of State. The first depends on the contributions of those covered by the system, whereas the second is fully funded from the general state budget.

## **B. State Health Insurance System:**

The social health insurance system in Egypt is managed by the Health Insurance Organization (HIO), which operates under the Ministry of Health. In its present state the system does not cover except about half of the population. The UNDP policy brief criticized this system by pointing out that “at the present time, an insurance scheme is not available to the very poor or to people who are not in formal or in organized occupations, or to the unemployed and housewives” (UNDP, 2005, p.1). Based on this, one can deduce that uninsured Egyptians are from the most vulnerable social and economic classes. Also, since the insurance scheme is individual-based rather than family-based, it is common to find in an average Egyptian family the father who is a government employee and the younger son who is enrolled in school to be covered by health insurance, while the mother who is a housewife and the older son, a university student do not have any insurance.

Many studies are calling for expanding the health insurance to cover the whole population or at least those underprivileged individuals who need to be part of a risk poolingsystem (National Health Accounts 2007/2008, 2010; Salah, 2007). There are many problems with this initiative. The main problem is that most of the uninsured are either unemployed or work in the informal sector, and in many instances, they participate in a barter economy rather than the cash economy. Therefore, it is difficult to determine their economic status and ability to afford health insurance. Moreover, due to the fact that the insurance system is usually calculated as a percentage of salary, as mentioned in the review published by the World Bank, “collecting insurance premiums from people who live outside the cash economy would be difficult even under the best of circumstances” (2004, p. 76).

The other problem is that although the government employees are required to participate in health insurance system, the private companies are allowed to opt out of the system by paying in 1% premium on worker wages. This exemption encouraged many of these companies and their employees, who are usually from the middle and upper classes, to join other health schemes offered by private providers or even resort to direct out-of-pocket spending. They choose these options in order to avoid receiving medical services in public facilities and to be able to receive better services and treatment in the private sector. This problem “raises serious questions about the sustainability and viability of the HIO in the long run if the more affluent workers are allowed to opt out of the system for very low premium contribution” (Health System Profile, 2012, p. 34).

To sum up, a good health policy should find ways to cover the uninsured individuals by providing them with some form of health security, particularly to protect them from paying for catastrophic health problems. However, many studies argue that “Social health insurance institutions are a very limited source of health care spending in low-income countries, they accounted for only some 2 percent of total spending on health in low-income countries, 15 percent in lower-middle income countries” (Gottret&Schieber, 2007, p. 6). This applies to Egypt since as discussed earlier, a big percentage of the citizens are not insured. Actually according to Gericke, finding ways to cover the uninsured in Egypt will remain a major challenge since “for every contributing individual working in the formal sector, there are five non-contributing individuals” (2006, p.33). Under these circumstances, it is advisable to find other alternatives to complement the State Health Insurance System in order to guarantee equal access to all those in need for treatment and cannot afford it.

A complete assessment of the health insurance system's financial, governance, and service provision is beyond the scope of this study. However, it was important to give a brief background and to point out to its deficiencies in order to demonstrate the importance of further studying the other alternatives or parallel supporting systems, specifically the Program of Treatment at the Expense of State, which will be the focus of this research paper.



### **C. Program of Treatment at the Expense of State**

As discussed earlier, when assessing the best alternative for providing affordable health care services for the uninsured in Egypt, most studies agree that State Health Insurance System is inadequate in its current state. To compensate for its deficiencies, the Egyptian government has introduced a mechanism whereby it offers subsidized treatment to those who are uncovered by the medical insurance; the Program of Treatment at the Expense of State. This program “extends financial assistance to all Egyptian citizens forexpenses incurred for the treatment of costly chronic diseases and catastrophic illnesses,including treatment abroad for specialized services not available in Egypt” (Salah, 2007, p.28).

The Program of Treatment at the Expense of State in Egypt has not been thoroughly researched. It was the main topic of very few articles, reports and reviews. It is mostly mentioned as an alternative or a complementary program to the state health insurance system. The reports prepared by the Ministry of Health in 2010 and the Egyptian Initiative for Personal Rights were the main sources of information about its history, organization, rules and regulations as was discussed earlier in a previous section of this study. As for the number of beneficiaries and their breakdown, the study will depend mainly on the figures published on the Information and Decision Support Center (IDSC) and the Central Agency for Public Mobilization And Statistics (CAPMAS) websites.

The few reports that mentioned PTES point out to the fact that this program has expanded tremendously over the last two decades. According to The World Health Organization’s report, Egypt National Health Accounts: 2008-2009, published in 2011, “the number of PTES beneficiaries has increased dramatically since 1994, when there

were approximately 39,000, to 2008/09, when there were over 1.9 million” (p.32). This demonstrates the growing reliance of Egyptians on such scheme and its importance for large segments of the population who cannot afford to pay for adequate health care. On the other hand, these same reports criticized the lack of transparency when it comes to the financial transactions of this program. The National Health Accounts: 2007-2008 clearly stated that, “obtaining information on spending under PTES is extremely difficult due to a lack of transparency” (2010, p.14). Therefore, there is an urgent need for further research in this area in order to get accurate and solid figures and indicators.

The PTES has two components; treatment inside Egypt and treatment abroad. To get an approval to receive treatment at the expense of state abroad, the patient has to go through a series of medical examinations to prove that his/her treatment is not available in Egypt. The patient has to apply through the Specialized Medical Councils, which decide the eligibility of the request. These centers have played a significant role in controlling the numbers of decrees issued for treatment abroad resulting in a decrease of the PTES expenditures on treatment abroad from 25 million LE in 1997 to 1.8 million LE in 2003. This reduction in expenditures allowed the government to increase its expenditures on the domestic program over the same period from 215 million LE for 100,000 patients to 1.3 billion LE for almost 1.2 million patients (Mapping Healthcare Financing, 2007, p. 34).

Table 3, gives a slightly different set of numbers, but follows the same trend. The amount spent on the treatment inside Egypt increased systematically from 1996 to 2009. However, in 2010, it witnessed a substantial drop; from around four billion LE in 2009, to less than two billion LE in 2010. As for the treatment outside Egypt, the amounts did

not follow a specific trend; however, there was a significant decrease in 2011, probably as a result of the corruption cases that were disclosed in 2010.

**Table 3**  
**Cost of Citizens Treatment at the Expense of State Inside Egypt and Abroad**  
**(1996 – 2011)**

	<b>Treatment Inside</b>		<b>Treatment Abroad*</b>		
<b>Year</b>	<b>Patients (000)</b>	<b>Costs (Mil. LE)</b>	<b>Patients (No.)</b>	<b>Dependents (No.)</b>	<b>Costs (Mil. LE)</b>
1996	84	205	715	610	64
1997	136	321	744	569	69
1998	201	456	790	632	81
1999	369	649	616	434	62
2000	491	790	461	238	33
2001	750	1038	348	156	26
2002	907	1194	220	115	14
2003	1015	1284	229	134	20
2004	1156	1644	240	164	20
2005	1265	1625	149	94	12
2006	1420	1746	214	158	22
2007	1602	2030	285	176	35
2008	1681	2477	245	183	33
2009	2155	3918	240	193	28
2010	1217	1986	149	102	21
2011	1198	2059	46	35	4

\* According to treatment Decisions issued by Cabinet of Ministers and Ministry of Health and Population

Source: Ministry of Health and Population, Egypt in Figures 2013

The efficiency, effectiveness and responsiveness of the Program of Treatment at the expense of State in Egypt were briefly discussed in some reports prepared by international organizations such as the WHO and the World Bank. They agree that the program is crucial in a country like Egypt where there is a large uninsured population, the majority of which is from the most vulnerable. However, its organization and management have been heavily criticized. Lately, there have been many corruption allegations against this system. The National Health Accounts: 2007-2008 (2010), argues that, “while there are policies and procedures for how these benefits can and should be accessed, recent developments indicate a possibility that this scheme is being misused” (p.14). This alleged abuse of the system has to be further investigated.

One of the major drawbacks of this system is that it usually covers only part of the total cost of treatment; the patient pays the rest. As mentioned above, each of the six health conditions covered by the PTES is allocated a pre-determined amount of money. In case the expenses exceed this amount, the patient has two options; either to stop the treatment until the decree is renewed, or pay the difference out of his/her own pocket (Egyptian Initiative for Personal Rights Report, 2010). Patients usually do their best in order not to stop the treatment because of all the potential complication. This added financial burden that the patients have to carry cuts into their already slim budget, which defeats the purpose of the program. Accordingly, the system in its present form is not very effective in providing full health coverage for the uninsured. However, because there is no available data about this out-of-pocket spending associated with PTES, it is difficult to assess the magnitude of the problem. Studies concluded that “this interaction between private and public spending on health care is an important aspect of health

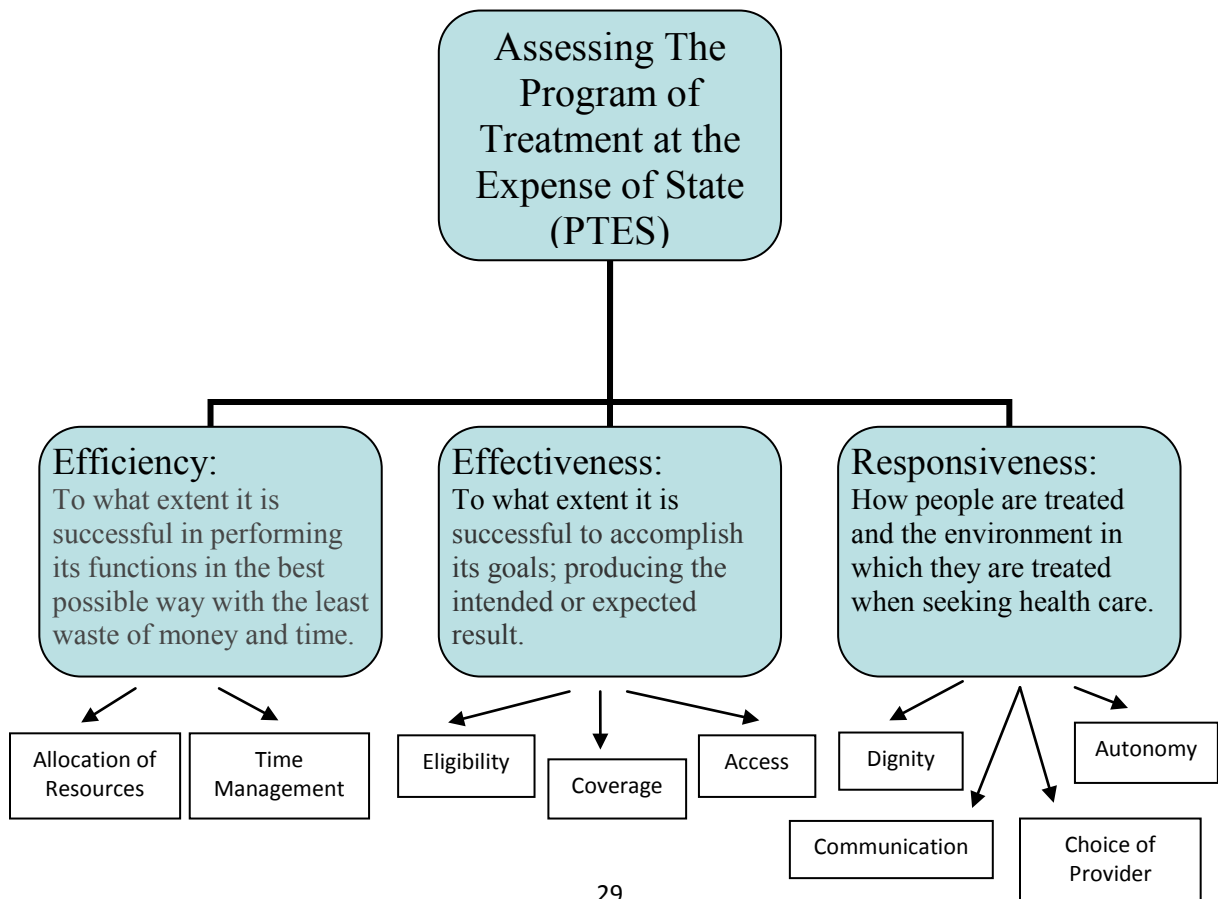
expenditures that will require a more detailed analysis based on the availability of an appropriately disaggregated data (Mapping of Healthcare Financing, 2007, p.35).

For all of the above, the Egyptian Ministry of Health has formed a committee in 2011 to study the rules and regulations governing the PTES. Until this committee reaches some realistic recommendations, reformers and researchers have been arguing that there is a pressing need to conduct more research on PTES to assess its efficiency and effectiveness. According to the Egyptian National Health Accounts 2008-2009, *“this research is needed to ensure that future program reforms allow the efficient use of available PTES funds to provide protection from catastrophic health spending while reining in costs; that is, to improve the extent and efficiency of the financial risk protection that PTES provides”* (2011, p.31).

## METHODOLOGY

Examining the efficiency, effectiveness and responsiveness of the Program of Treatment at the Expense of State (PTES) is a very sensitive issue since it deals with the suffering and the health conditions of the patients on one side, and with the public funding and budget allocation on the other. The method of choice for conducting the assessment of the PTES in Egypt is based on a qualitative analysis. In order to get an in depth insight about the efficiency, effectiveness and responsiveness of the program from all perspectives, a series of semi-structured interviews were conducted with the different stakeholders. Figure 2 explains the different criteria of assessment and the elements used to assess each one.

**Figure 2**  
**Assessment of the Program of Treatment at the Expense of State (PTES) in Egypt**



The number of interviews depended on the amount and quality of information, and continued until no further insights could be developed. The minimum number of interviews was intended to be two interviews with two government officials in the Ministry of Health and the Ministry of Finance, two interviews with staff members working in the administration of the PTES, two interviews with doctors and eight interviews with patients. This methodology was more suitable than structured questionnaires since some of the patients interviewed were not proficient in reading and writing. Also, since the goal is to examine the system from the different angles, and get to the roots of the problems faced by patients, structured questionnaires are very restrictive.

I was introduced by someone working in the Ministry of Health to all of my informants as a researcher who is doing a research about the PTES, its efficiency, effectiveness and responsiveness. All the interviews were conducted within three weeks. One of the problems faced in arranging for the interviews, especially with officials, was the fact that they had to be in the morning, so I had to take some days off from work. In one of the scheduled visits, I had to wait for an hour for one of the MoH administrators who was held up in an unexpected meeting. I conducted the interviews during six on-site visits.

All the interviews I conducted with patients were in the hospitals where they received their treatment. As mentioned earlier, due to the sensitive nature of the issue, I expected some resistance from patients to talk openly about their problems, so I had to be very cautious in asking the questions and made it very clear that they can decline answering any question whenever they felt uncomfortable. The duration of each interview varied according to the patient's readiness to talk, ranging from 10 to 30

minutes. Some patients were very eager to talk about their case and the problems they faced, volunteering to give details, others answered to the point and I had to make an extra effort to make them answer all the questions. In some cases I was left alone with the patient, in other cases, and upon the request of the hospital's manager, a staff member or a doctor accompanied me. Although, this did not make a big difference, however, in general, the patients felt more at ease when we were left alone.

I also expected that officials would be suspicious and cautious while answering the questions. I had to guarantee confidentiality and anonymity by using pseudonyms in my report so nothing can be traced back to them. All of them - except one of the hospitals' directors - were easy to talk to and ready to answer the questions. Doctors on the other hand, were very cooperative and, in most cases, they were my escort during my interviews with the patients. They also gave me very important insight on the day-to-day operations of the system; details that were not usually mentioned by neither patients nor administrators. Therefore, the interviews with the doctors were more or less an open discussion during which they commented on the patients' answers or clarified medical and administrative details mentioned by them.

My informants represented<sup>3</sup> different groups of stakeholders as follows. Table 4 summarizes the actual numbers under each category.

1. External Stakeholders: Two top officials in the Ministry of Health and the Ministry of Finance were interviewed in order to get general information about the funding of PTES and the broad framework of the whole system,

2. Internal Stakeholders: Staff members working in the Ministry of Health in charge of administering and supervising the system were interviewed as well as staff working in the Specialized Medical Councils responsible for issuing the decrees to



discuss the legal and administrative framework and the bureaucratic process required to be eligible for the system. Also, doctors from different specializations working in the public sector who deal closely with the patients applying to the system were interviewed to get more information about the cases they attend to and the types of illnesses most commonly treated by the system. Moreover, a number a series of semi-structured interviews were conducted with a number of patients mainly to assess the responsiveness of the system. The interviewees were divided into four groups; the first two were those who applied to the PTES in Egypt; interviews were conducted with patients who were granted a decree – i.e. approval - and are currently receiving treatment and with those who failed to get a decree. The other two groups were those who applied to receive treatment outside Egypt. They were divided into two subgroups; those who actually travelled abroad and those whose applications were rejected.

**Table 4**

**Numbers of Interviews by Category of Informants**

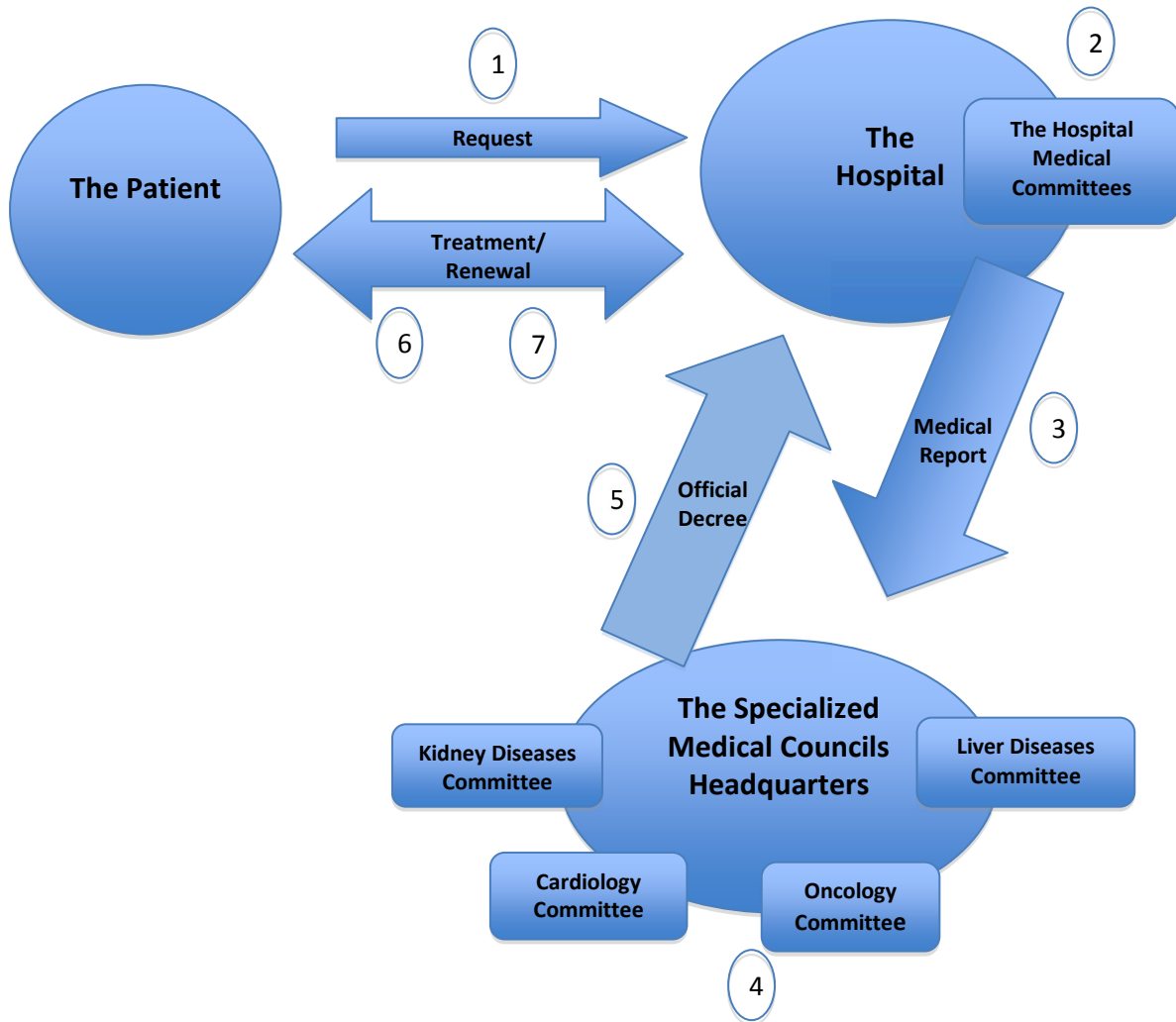
<b>Category</b>	<b>Subcategory</b>		<b>Number of interviews</b>
<b>External Stakeholder</b>	Ministry of Health Administrators		<b>1</b>
	Ministry of Finance Administrators		<b>1</b>
<b>Internal Stakeholder</b>	Ministry of Health Officials		<b>1</b>
	Specialized Medical Councils officials		<b>2</b>
	Doctors/Hospital staff		<b>5</b>
	Patients Inside Egypt	Approvals granted	<b>7</b>
		Approvals refused	<b>1</b>
	Patients Abroad	Approvals granted	<b>1</b>
		Approvals refused	<b>1</b>
<b>Total</b>			<b>20</b>

## **FINDINGS AND DISCUSSION**

Findings from the interviews were consolidated into two main topics: the administrative framework of the Program of Treatment at the Expense of State (PTES) inside Egypt and abroad, the financial allocation and transactions of the system. Then a discussion will follow to assess three different aspects of the system: the efficiency of the program in managing its inputs and outputs, its effectiveness in serving its purposes and reaching those most in need for it and its responsiveness in providing the treatment in an adequate environment. Throughout the discussion, the corruption allegations recently directed towards the system are investigated.

**A.I.The Business Process of the Program of Treatment at the Expense of State (PTES) Inside Egypt:**

**Figure 3**  
**The Business Process of the Program of Treatment at the Expense of State (PTES)**  
**Inside Egypt**



### **\* Applying through the hospital**

As a general rule, in order to be eligible to receive treatment at the expense of state, the patient should not be a beneficiary of any medical insurance scheme. Insured individuals are not eligible to receive the State Financed Treatment. Many argue that this is very fair especially that in Egypt, only students and employees who are part of the formal economy are covered by the state medical insurance. The majority of poor citizens are either unemployed or part of the informal economy therefore are not medically insured. Whereas those who enlist themselves to a private insurance company are presumably well off in order to be able to pay the insurance contributions, consequently they do not deserve to be funded by the state in case of illness. As an administrator in the Specialized Medical Councils puts it “using the limited funds available to us, we try to help patients who cannot afford to pay for their treatment to get the best possible service, it will be unfair to use these funds to pay for those who are already covered by medical insurance” (Soliman, Specialized Medical Councils administrator, 55 years).

On the other hand, many argue that it is unfair to exclude insured patients from benefitting from this program since the medical insurance system in Egypt is not that developed and patients suffer in order to receive adequate treatment. Patients whose application was rejected simply because they are medically insured argue that in order to be covered by the state medical insurance, they have to contribute part of their monthly salary that they worked hard to get. For them, it is unfair that just because someone is unemployed, he/she receives the required medical services completely for free. They even go further by pointing out to the fact that the funds allocated to the PTES come from the taxes *they* pay. As a Hepatitis C patient who could not get treatment at the expense of

state because he works in the public sector exclaimed, “government employees pay taxes plus a significant part of their salary for insurance, but who benefits at the end?” He then answers his own question “street vendors and the unemployed who spend their time on cafés” (Adel, patient with Hepatitis C, 42 years). What he meant was that since a part of his salary is deducted to pay for the health insurance, he deserves to get an adequate and timely treatment in a well equipped facility and to be treated in a respectful manner by the medical staff and the administrators. He believes that this is not what he gets in return to what he pays. Although one can understand this point of view, however, the solution should be to improve and reform the Health Insurance System rather than to criticize the PTES since it is the only alternative for the uninsured.

To prove that the patient is not covered by any medical insurance, a copy of the patient’s national ID card has to be included in the file. The assumption is that since the person’s occupation is supposed to be written on the ID, so if there is no occupation mentioned, this proves that he is not insured. Although this is considered the only control measure, unfortunately according to an administrator in the Ministry of Health,

“Some people used to get around this by using a corrector pen to hide the occupation before photocopying the ID, however, now it is getting better since the medical committees in the hospitals ask the patient to show the original ID before signing the medical report because the doctors in these committees became more aware of their legal and ethical responsibility to follow the rules and regulations ” (Sayed, Ministry of Health official, 50 years).

Assuming that the patient is not covered by any medical insurance, therefore, eligible to apply for the PTES, the first step is go to a hospital to be diagnosed by

specialists. Originally, the private health sector was not included in the PTES, then, it was added later to the list of providers. However, in October 2010, following the corruption allegations mentioned earlier, the private hospitals were no longer allowed to provide any treatment under this program. Accordingly, at present, the patients can go to a public or an educational hospital, a military hospital, or a hospital affiliated to a public university. A MoH administrator argues that this was a very wise decision, “at least now, the government’s money goes back to hospitals owned directly or indirectly by the government, so it is like an internal transfer of money” (Ahmed, MoH administrator, 59 years).

The selection of the hospital is very important since decrees are always issued with the name of the hospital that issued the initial medical reports. Accordingly, the patient has to be sure that the selected hospital has the equipment and the technical know-how required for his/her treatment. One of the patients interviewed who suffers from kidney failure and has been treated by kidney dialysis for the last 10 years recalls that the first time she applied for PTES, she waited for more than a month to get the approval, but had to restart the whole process all over again when she discovered that the hospital did not have enough dialysis machines, “the other alternative was to have only one session a week, while I had to have three per week, so I had to go to another hospital and start the whole process to have the decree issued with the name of the new hospital” (Azza, kidney failure patient, 47 years old).

Once the patient is settled on a hospital, he/she is required to go through a series of lab tests, x-rays and analysis as relevant to the medical case. The hospital medical committees, comprising of three specialized doctors, use these tests and x-rays to prepare the medical reports. In some cases, the committees request additional documents and/or

tests. In case of Rh injections given to pregnant women, “the couple has to present the marriage certificate and a copy of the husband’s ID in addition to the normal requirement for the patient’s ID, who is the wife in this case” (Sayed, Ministry of Health official, 50 years). In case of kidney or liver transplantation, the patient has to present a proof that the donor is a first-degree relative to make sure that the operation is not part of the illegal organ trading. Also, he/she has to do some specific tests that are not normally requested such as a tissue analysis to make sure that the tissues of the donor and those of the recipient are compatible.

According to the ministerial decree issued in 2010, the PTES covered mainly six main medical cases; heart diseases, tumors, kidney failure, liver diseases (namely Hepatitis C), high blood pressure and diabetes. However in May 2012 a large number of additional cases were added to the list including bone fractures, paralysis, cataract and burns among many others. These additions were a relief for many patients who used to suffer because their diagnosed case was not originally covered by the program. One of these patients, who needed to do a cataract operation in her left eye since 2010, but could not afford it, explained

“I could not pay for the operation, so I had to suffer in silence, until my neighbor, who works in a hospital told me that my case is now eligible to receive treatment at the expense of state, it was a miracle from God to see clearly again, the government is responsible to treat all Egyptians, it has to help all poor patients regardless of their cases” (Ashgan, patient treated from Cataract, 62 years).

### **\* Assessment by the hospital medical committees**

The committees formed by the hospital assess the tests and the analysis, are the first gateway to receive treatment at the expense of state. They are responsible to see the patient, check the documents and prepare the medical report that will be sent to the Specialized Medical Councils to get the final approval. Each of these committees is responsible to review a specific group of cases according to their specializations. Each is composed of three specialists who are responsible for reviewing and scrutinizing the patients' reports and give their recommendation specifying the required treatment. This committee usually asks to examine the patient in person, to make sure that the person asking for the treatment is actually present and is eligible to get it. This was implemented after they discovered that in some cases, and because of the corruption of some hospital staff, they received forged test results and reports that do not really reflect the reality of the case. As a doctor who served in one of these committees explains "once we received reports showing that the patient is suffering from rheumatoid, his son told us that he could not come because he's in pain, but when we insisted, and physically examined him, I discovered that it is just Osteoporosis, which isn't covered by the program" (Amal, doctor, 40 years). According to her and many other members in these committees, asking to see the patient in person is very important since the Specialized Medical Councils depend on the reports issued by the hospital committees when determining the amount of money allocated to each case, "it is a huge responsibility" she added.

On the other hand, for most patients who really suffer from serious cases, having to go to the hospital on specific days when the specialized committee is in session is a nightmare. Karim, the son of an elderly patient explains his dilemma,



“My father is very old and was diagnosed with lung cancer 5 years ago.

On the day of the hospital committee, he could not move to go to the hospital, so I went instead of him, but the doctors insisted that he has to come and rescheduled his appointment which delayed the whole process and negatively affected him” (Karim, son of a cancer patient, 68 years).

He understands that these are the rules and that everyone has to follow them, but doctors have to be merciful and more understanding, especially that those who cannot go because of serious health problems are those in most need for immediate treatment. He also admits that there are some unethical people who misuse the system, but insists that it is unfair that honest patients with severe cases pay the price.

#### **\* Sending the medical report to the Specialized Medical Councils**

Once the hospital committee issues the medical report, it is sent to the Specialized Medical Councils. This is the most critical stage of the whole process since this is the authority that gives the final approval and decides the amounts to be allocated to each case and the time frame for each decree. Figure 3 illustrates the business process in the Specialized Medical Councils, which is the sole governmental body authorized to give the decrees for the PTES. The reports prepared by the hospital committees are periodically sent from all over Egypt to the head quarter of the Specialized Medical Councils in Cairo. There are presently three ways to send the reports;

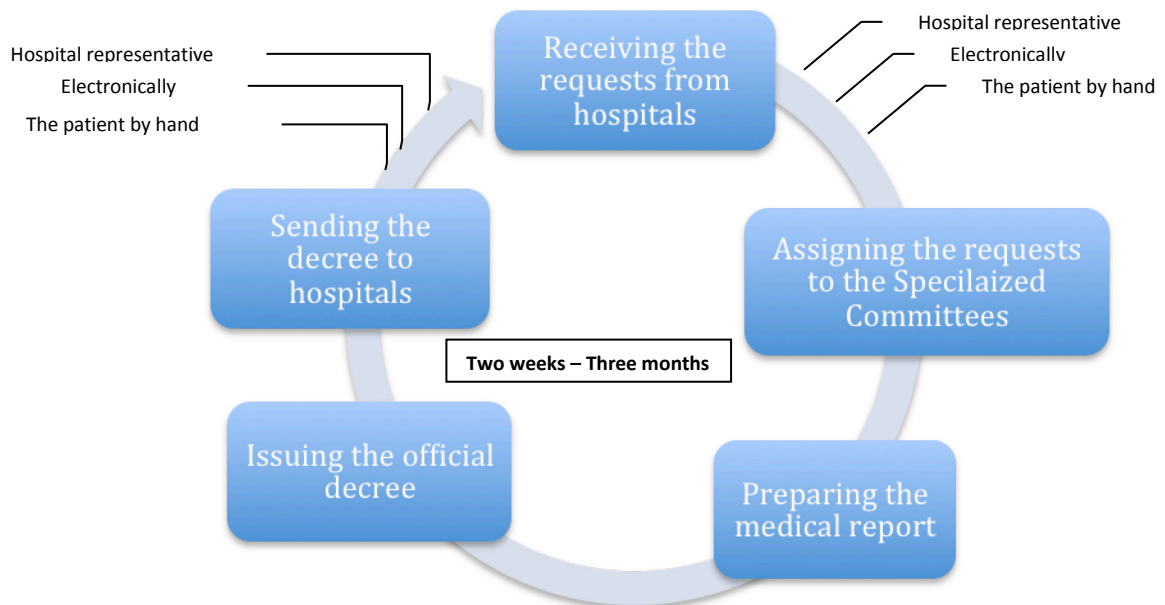
“Either by hand with a hospital representative and this is the traditional way, or patients themselves take the sealed and stamped report to present it in person, and this is the fastest way, or most recently, the report is

sent electronically through the internet using the newly established communication network between the Councils and the hospitals”

(Laila, Specialized Medical Councils official, 34 years).

In case of a hospital representative or through the Internet, the hospital sends the reports in periodic batches.

**Figure 3**  
**Business Process in the Specialized Medical Councils**



Since the Specialized Medical Councils is a centralized authority that deals with patients from all governorates, a system had to be put in place to facilitate the process. According to one of the Councils administrators, a number of hospitals in the governorates are now connected to the MoH network, however the majority is not. He explains “each governorate has a local medical center responsible to collect all the reports and the required documents from the hospitals in the governorate to send them to the

Cairo headquarters” (Soliman, Specialized Medical Councils administrator, 55 years). He claims that although this system might result in a delay in processing the request, however it guarantees transparency and equity since everyone is treated the same regardless of their status or family affiliation in their governorates. The Specialized Medical Councils is supposed to act as a filter implementing the rules away from any pressure or influence that might be exerted on local authorities in the governorates.

#### **\* Assessment by the specialized medical committees**

Once the Specialized Medical Councils receives the reports and the attached documents, the cases are assigned to specialized committees. These committees are usually formed of highly reputable specialists or consultants; in some cases they may request the expertise of a specialist from a military or a University hospital. The committees meet periodically on specific days and sometimes twice a week. For the relatively straightforward cases such as diabetes and blood pressure, the approval does not take a long time; it is granted through the regular committees. However, for serious cases, where the treatment is very expensive, such as tumors and liver and kidney transplantation, the case is transferred to a higher committee. A liver specialist who once served in one of these committees explained “I am a consultant in the National Liver Institute and was asked to serve in the committee of liver transplantation, it is a serious decision to approve of such operation; it is dangerous for both the patient and the donor and too expensive, so they need an expert input” (Ashraf, liver specialist, 60). Although, the normal procedure is that they do not ask to see the patient in person and they depend on the reports sent from the hospitals, however, in these same cases, they sometimes, ask for a personal appointment to review the case.

Each request is thoroughly evaluated and a decision is made. The final decision can either be a firm approval whereby the decree is issued with the predetermined amount as will be discussed later in more details, or in some cases, the patient is asked to come in person to the Councils. In other cases, the committee refuses the request and an official letter is issued stating the reason for refusal. According to the Councils administrator, “we receive around 500 requests on average per day, if all the documents are complete, the medical report prepared by the hospital committees is clear and accurate and the patient is not requested to come in person, I can safely say that 100% of the cases are granted an approval” (Laila, Specialized Medical Councils official, 34 years).

Traditionally, the approval document used to include the amount allocated to the case, so the patient used to know how much money was at his/her disposal, however, for the last couple of years, a new system was introduced using codes for each case. When the Specialized Medical Councils issues the approval, the amount allocated to the case is not written; a number “code” replaces it representing a combination of both; the diagnosis and the amount allocated. According to the MoH administrator, this new system proved to be very effective. He explains

“Every hospital has a CD with all the codes; it is distributed to all sections

and departments, so that when they receive the approval, the case is

automatically assigned to the appropriate department for the specialized

doctors to attend to it” (Ahmed, MoH administrator, 59 years).

He also added that this helped in fighting corruption and protected patients from being manipulated since the whole process is automated using the codes.

### **\* Sending the official decree back to the hospital**

In most cases, the committee's decisions are communicated back to the patient in the same way the hospital report was originally sent to the Councils; the hospital representative receives them by hand, through the internet directly to the hospital or in some cases the patients themselves or their first-degree relatives go in person to get the approval. Although theoretically, once the committee reaches a decision it has to be immediately sent to the hospital in order to inform the patient, however, this is not always the case in real life. One patient argued that she did not receive any feedback for more than two months,

“I used to ask in the hospital every other day, until someone advised me to go and ask for it myself in the Specialized Medical Councils... my son went because I was very sick and with some effort and persistence, he was able to get the approval on the same day, this means that the approval was ready, but they were late in sending it to the hospital” (Zeinab, a heart patient, 60 years).

The inconsistency between what is officially announced by the Councils administration and what the patients experience in reality is very obvious. One area where this inconsistency is very pronounced is the time period between applying for the PTES and actually sending the approval back to the hospitals. As previously explained, going in person to get the approval is the fastest way, but it is a hassle to go all the way to the headquarter in Nasr city, it is also time, money and effort consuming. So, most patients wait for the approval to be sent back to the hospital. This process officially according to the Councils administration, should not take more than 2-3 weeks.

However, when asking patients, their experiences were very different. In most cases, it took between 4-6 weeks.

**\* Problems faced by patients while receiving the treatment**

Receiving the approval is not always the end of the patient's suffering. In some cases, the amount of money allocated is insufficient; it doesn't cover all the required medical intervention whether an operation or otherwise. The two cases that suffer most from this problem are patients who need either liver or kidney transplant. These operations are very expensive, so the PTES pays only a partial contribution; 75,000 LE for liver transplant, which actually costs around 300,000 LE, and 50,000 LE for kidney transplant, which costs around 90,000 LE. A patient who was waiting for his turn to get a liver transplant explained how he was disappointed when he went to the National Liver Institute and was informed that although he got the approval, however he has to pay the difference " I had to pay more than 200,000, I borrowed from all my relatives and friends, but it was not enough, so the staff in the Institute advised me to go to the Egyptian Association for Liver Patients' Friends, and other NGOs that can help me, I am still trying to collect the money while waiting for my turn" (Yassin, liver patient, 48 years). He added that he is also afraid of what will happen after the operation since he will have to remain on medication for a long time and he is not sure he can afford it.

Asking the MoH official about the money needed for the follow up and the post-operative care, he explained that in most cases, especially in case of organ transplant, the hospital sends a report to the Specialized Medical Councils with all the required treatment, "a new decree is issued with the annual treatment, which is usually with the amount of 20,000 LE per year, and it is renewed for three to five years" (Sayed, Ministry

of Health official, 50 years). In order to be objective in discussing this point, it has to be mentioned that in most cases, the amount of money allocated is enough to cover the treatment. This is especially true for patients who only need medicines or standard medical intervention such as those who need medicines for diabetes, high blood pressure or hepatitis C, as well as those suffering from cancer and need to receive chemotherapy or those who need kidney dialysis sessions. According to the coding system mentioned earlier, once the approvals for these patients reach the hospitals, they go regularly to receive the treatment or get the medicines with no extra charge, since the code indicates the dose and the frequency needed.

Another problem related to the allocated amount appears when the doctor supervising the case prescribes a certain drug that is believed to have the best results. However, because it is not on the list issued by the MoH and the Specialized Medical Councils, the hospital pharmacy refuses to give it. When asked about it, both sides defend their point of view. The Specialized Medical Councils official argues that,

“We are restricted by a budget and we have to serve millions of people every year, so the Ministry issues a comprehensive list of drugs that cover all medical cases, however, not necessarily the most expensive ones in case there are alternatives, the doctors in the hospitals have to abide by this list, or else it will be difficult to control the whole process”  
(Laila, Specialized Medical Councils official, 34 years).

On the other hand, doctors maintain “although we know that we should follow the rules and abide by the list of drugs provided by the Ministry, however, sometimes we feel ethically obliged to prescribe a drug that we know is more effective hoping that they would make an exception for the sake of the patient” (Hala, oncologist, 37 years).

The problem is that once the patient is aware that a specific drug is more effective for him, it becomes very difficult to convince him to take an alternative just because the first one is not included in “the list”. In most of these cases, the patient gets in trouble with the hospital administration, which in turn has two options; “either to give the prescribed drug knowing that it will not be reimbursed for it, or tries to explain that these are the rules and if the patient wants to file a complaint or a petition, it should go to the Ministry of Health or the Specialized Medical Councils. As the MoH administrator puts it “they come to us very angry asking for an exception to take the prescribed drug, when we refuse, it gets very bad and sometimes they attack us, so we always insist and repeat over and over again that it is the responsibility of the doctors to abide by the list to save all of us the trouble” (Ahmed, MoH administrator, 59 years).

#### **\* Renewing the decree**

The other major hurdle faced by most patients is the fact that the approval is limited to a specific duration, after which, it has to be renewed. Decrees are typically granted for sixmonths or in specific cases for one year depending of the case. The duration is written on the decree when issued by the Specialized Medical Councils. The expired decree has to be renewed in order to continue the treatment. As was the case with the issuing of the initial decree, the inconsistency in determining the time it takes to get a renewal is significant between the officials in the Specialized Medical Councils and the patients themselves. One patient with kidney failure explains “I have been undergoing kidney dialysis for the past six years and it is a dilemma every time the decree has to be renewed, my last decree finished more than months ago, and although the hospital sent for a renewal, there was no answer so far” (Heba, kidney patient, 38). She complained



that, although the hospital did not stop the dialysis sessions, which would have been fatal for her, however it stopped giving her any drugs until it receives the renewal. This simply meant that she had to pay for the medicines, which was a huge financial burden for her. On the other hand, officials in the Councils argue that it is now renewed automatically; the hospital sends a notice before the end date of the decree and the renewal is sent in no time, the patient does not feel any gap and the treatment is unaffected according to them.

In general, the renewal process does not require the patient to do any tests as a prerequisite for the renewal, the Specialized Medical Councils considers the request for renewal sent by the hospital as a good enough proof that the patient is still eligible. However, in some cases, as judged by the medical teams in the hospitals, patients are asked to do some analysis and present reports with the new results, to prove that they are still need the treatment. In these cases, continuing to provide the treatment while waiting for the renewal depends on many factors; the seriousness of the case, the amount of money left in the patient's account and the availability of the treatment in hospital. A number of patients agree that this is a logical and fair requirement as long as it does not delay the renewal process or stop the treatment. Some even argue that it is in their favor so that they get an updated feedback on their situation; the dose needed and/or the frequency of the treatment might change, "my doctor asked me to do some lab analysis before my last renewal and he discovered that I needed to increase the dose of my medicine... it saved my life" (Zeinab, a heart patient, 60 years).

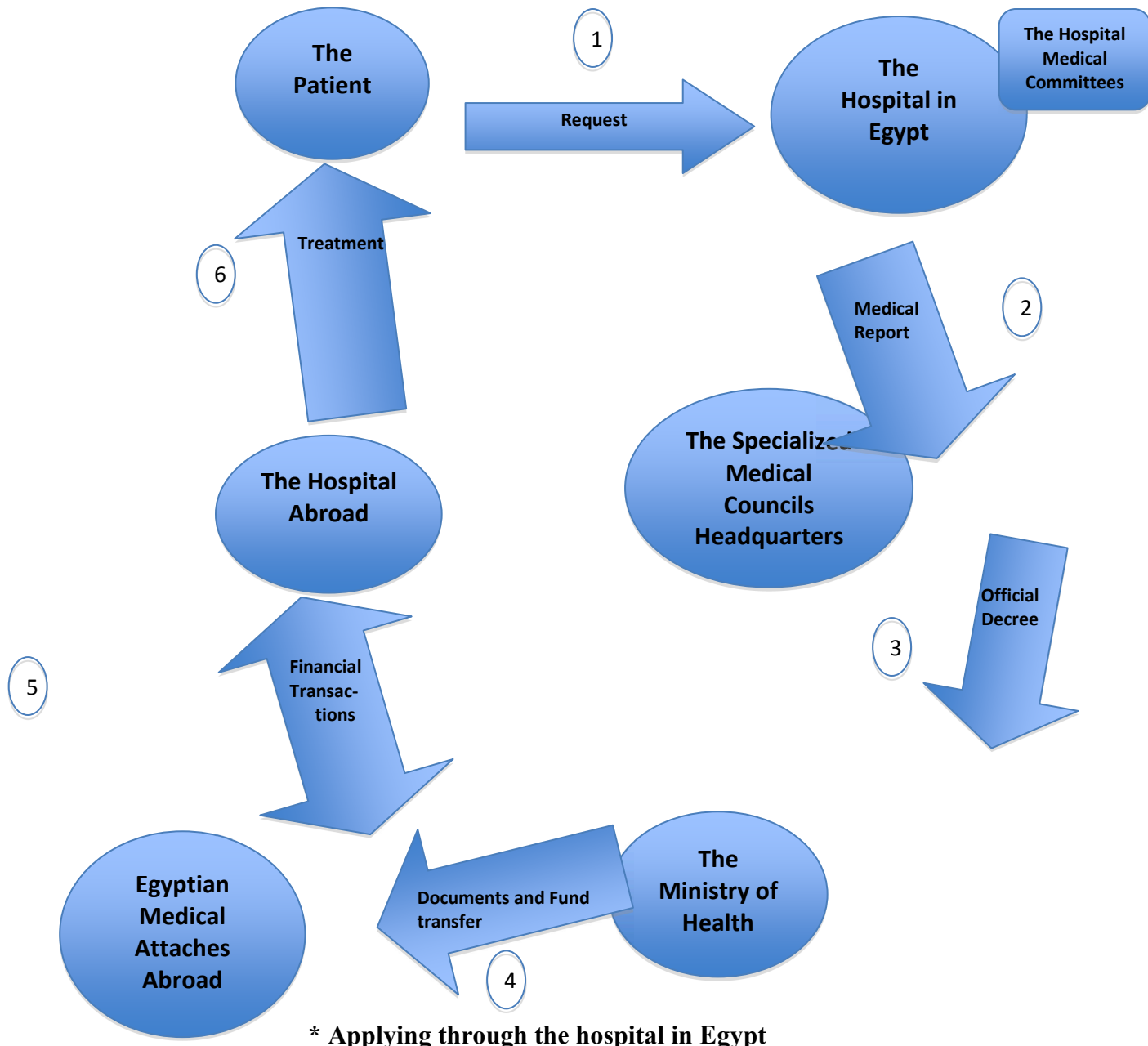
Moreover, in case a new medical problem rises while receiving the treatment, the patient has to go through the whole process with new reports and test results from the hospital showing that he/she deserves to have a supplementary decree to deal with the

new condition. This process takes time and delays the adequate medical intervention. For doctors, it is frustrating to know that they should give a certain medicine to deal with a newly discovered problem, but since they are restricted by the rules and regulations, they have to wait until the patient gets the approval to add the new treatment to his protocol. One oncologist explained

“Sometimes during the chemotherapy, the patient suffers from an unexpected side effect and needs a certain medicine, if we act on impulse and give the it, we are reproached by the hospital administration since no treatment is reimbursed by the Ministry unless administered according to the specified code on the decree in case of emergency we give the medicine, but we have to present a strong medical evidence that it was crucial”  
(Hala, oncologist, 37 years).

**A.II. The Business Process of the Program of Treatment at the Expense of State (PTES) Abroad:**

**Figure 5**  
**The Business Process of the Program of Treatment at the Expense of State (PTES) Abroad**



So far, this research has been discussing the PTES inside Egypt. As for applying to receive treatment at the expense of state abroad, although the initial process is very similar, it is much more difficult with some additional requirements. There are two basic conditions; that the treatment is not available in Egypt and that there is a high success rate for the case if treated abroad. To satisfy the first condition, patients have to be reviewed by the medical committees in one of the hospitals certified by the MoH to issue official reports. They have to present all the necessary tests, X-rays, and lab analyses to be assessed. The patient has to undergo a very thorough examination by the committee to ascertain that the diagnosis is correct and the treatment is not available in Egypt. As for the second condition, the patient has to present his correspondence with the hospital abroad and any other documents clarifying the steps of the medical intervention planned, the exact cost and the expected outcome including success rate, complications, required follow up, and any related information. A cardiologist explains the rationale behind these strict rules,

“Everyone is drawing from the same budget, to travel abroad is very expensive, so patients who apply for treatment abroad have to present what proves that they really deserve to be allocated this money, or else it will be unfair to other patients, since the same amount could be used more efficiently to treat tens of patients in Egypt” (Mohamed, cardiologist, 43 years).

**\* Sending the medical report to the Specialized Medical Councils**

The cases approved by the committee are mostly critical surgical interventions. Once the tests and the hospital correspondence are accepted by the committee as solid evidence that the patient is eligible for treatment abroad, the approval is stamped and sent to a special committee in the Specialized Medical Councils, which is the only responsible agency to issue all approvals for treatment abroad, even for those covered by health insurance. Specialists assigned by the Councils reassess the reports to make the final decision.

#### **\* Administrative Procedures in the Ministry of Health**

In case the decision is to approve the request, a series of administrative procedures start. The approval is sent to the MoH (not to the hospital as in the case of treatment inside Egypt) and from then on, the Ministry becomes responsible for the whole process. There is a special unit in the Ministry that is responsible for dealing with the cases that were granted the approval to receive their treatment abroad. All subsequent communications have to be through this unit. The hospital is contacted to get its final approval to administer the treatment, with specific dates and timeline. The MoH then sends all documents to the Egyptian Embassy or the medical attaché in the country where the treatment will take place. This is important in order to issue the visa and to help in other logistics.

#### **\* Fund Allocation and Financial Transfers**

As for financial allocation, there is one fixed amount for all cases; 12,000 Euros or 12,000 Dollars or 12,000 Sterling Pounds. Although the actual value of these amounts is different compared to the Egyptian Pound, however, this is the rule set by the MoH.

This amount is not given to the patient; rather it is transferred through the Egyptian Central Bank to the Egyptian Embassy with the name of the patient. In order to make sure that the MoH will not be asked to reimburse any additional expenses later on, the patient has to sign a statement before traveling, stipulating that he/she will pay any extras. According to Rania, the parent of a child who traveled to have a critical brain surgery, she had to sign the statement although she knew that it would be a problem for her later on if she is asked to pay any money. It is up to the patient to use the whole amount for the medical intervention, or take part of it to purchase the ticket, and/or as a per diem for the person accompanying the patient (only in this case, the person receives this amount in cash). In case of Rania, she explains “I borrowed the price of the ticket for me and my daughter and searched for a very cheap hotel near the hospital to save all the amount for the treatment” (Rania, mother of a six year old patient, brain tumor). All these details are spelled out in the official decree issued by the MoH.

Once the patient travels abroad and all the administrative procedures are settled, different outcomes may arise. The simplest outcome is to finish the treatment within the amount allocated and come home safely with no need to travel again for any follow up. In some cases however, there is a need to travel again after a certain period of time, in this case, if the patient still has money with his/her name from the first decree, he/she can use it; a new decree is issued automatically with the remaining amount. However, as the MoH administrator puts it “it gets complicated if the patient had spent all the money in the first trip; he/she has to apply from the start and go through the whole process, although it usually takes less time” (Soliman, Specialized Medical Councils administrator, 55 years). The most problematic outcome is when the whole amount is spent, but the treatment cost increased while the patient is still abroad due to an

unforeseen complication or any other reason, in this case the patient sends a new request “for completion of treatment”. If it is approved, the money is sent to the embassy, if not the patient has to pay the difference according to the agreement signed with the MoH.

In most cases however, the request to receive treatment at the expense of state abroad is refused. This is usually because the committee decides that the treatment can be provided in Egypt. For some of these rejected cases, the committee advises the patient to wait for a renowned expert who is expected to come to Egypt on a specific date to perform critical surgeries. It allocates money for the patient to be treated in a specific hospital by this consultant. Maher, father of a newborn with a heart defect explains,

“My son was born with a heart problem, doctors here in Egypt agreed that he needs a very critical operation and it is better to take him abroad, but when I applied, the committee informed me that an expert is coming to one of the military hospitals to perform such operations and granted me a decree to treat my son at the expense of state” (Maher, father of new born boy with heart problem).

In other cases the refusal is due to the fact that the case is hopeless. The Councils administrator recalls that this happened recently with one of the martyrs of the 25<sup>th</sup> of January revolution. The medical committee decided that sending him abroad will not make a difference, so it refused to give the approval. One of the NGOs payed for his travel and surgery abroad, but according to an administrator in the Specialized Medical Councils, he came back in a worse shape, and the person who sponsored his case was very furious with the NGO because it wasted the money that could have helped many other people on a hopeless case.

## **B. The financial allocation and transactions of the Program of Treatment at the Expense of State (PTES)**

The financial framework of the PTES is very unique. Although it is funded from the general budget under the budget of the Ministry of Health, however, it is a separate subcategory that is distinct and non-transferable. As explained by Osman, an official in the Ministry of Finance, “the budget for the Program of Treatment at the Expense of State is in a way separate from the budget of the Ministry of Health in the sense that it cannot be used except for this purpose; the Ministry cannot use it for salaries, equipment, or any administrative expenses, not even to finance the free medical services offered in the public hospitals” (Osman, Ministry of Finance official, 53 years). He added that there was once a proposal from one of the health ministers to incorporate the PTES budget into the general budget of the Ministry, but it was strongly opposed within the Ministry and eventually refused.

Although the PTES budget reached three billion LE this year, all of it dedicated to treatment decrees, however, this amount does not cover the whole treatment for all the applicants. As mentioned earlier, a new coding system was introduced whereby the patients do not get any cash money or medicines in their hands; rather it is an automated system. It is basically “a financial transaction between the MoH and the hospitals; MoH is the fund manager and the hospitals are the providers of the services”(Osman, Ministry of Finance official, 53 years). Each approval letter allocates a certain amount of money to be spent on the patient for a specific duration. The hospitals are asked to provide the treatment or do the operation as indicated within the amount specified. Each hospital is then requested to file all the invoices to the Ministry of Health to be reimbursed for the services provided.



Theoretically, this financial scheme seems very simple and uncomplicated; however, in practice it is not functioning properly. According to an official in the MoH “currently, the Ministry owes the hospitals millions of pounds; as an example we owe the military hospitals 27 million and The French Kasr El Eini Hospital 20 million” (Sayed, Ministry of Health official, 50 years). He points out that due to this deficit, many of these hospitals stopped accepting new PTES cases.

When asked about the origin of the problem, most officials argue that corruption was the main cause. According to an accountant in one of the hospitals

“The problems started when decrees were issued with no limits to the members of the Parliament and other powerful individuals, who used to get hundreds of approvals every year with exaggerated amounts to use them in their governorates. The system was misused and there was no control” (Ismail, hospital accountant, 31 years).

However, he added that, now since the system is more controlled, these overdue amounts are being reimbursed retroactively in order to settle the accounts. Each year a percentage of the old indebtedness is paid with the amount due for that year.

As for the PTES outside Egypt, as explained earlier, the amount allocated is constant and any additional expenses are supposed to be paid by the patient. However, in some rare cases, the patient leaves the hospital without settling the account. The official in the MoH explained that “some countries prevent the hospitals from detaining the patient after the treatment is finished even if the bills are not paid, and since in case of the PTES, all correspondence is with the Egyptian Embassy or the medical attaché, the hospital comes back to us asking for the remaining money” (Sayed, Ministry of Health official, 50 years). He went on to explain that the Ministry communicates with the

patient when he/she comes back, and asks for the money. In case the patient does not pay back the difference, the Ministry is forced to take legal action.

### **C. Efficiency of the Program of Treatment at the Expense of State**

The efficiency of the PTES is seriously questioned. The different stakeholders perceive it in various ways. Patients believe that the most important inefficiency is in time management. They complain that it takes a long time to receive the approval decree as well as to get the renewal letter. Officials, on the other hand, argue that the insufficient funds are the main reason for all inefficiencies in the system. Moreover, the corruption cases revealed in 2010 still have a negative effect on how the PTES is perceived in terms of efficient allocation of funds.

One can argue that in terms of money, the most significant sign of inefficiency in the PTES is the large amounts of money that is overdue to the hospitals. As pointed out in the previous section, the MoH owes the hospitals millions of pounds in return for their medical services provided to the patients under the PTES. Although the MoH is trying to reduce this indebtedness by paying the hospitals their outdated dues in installments, however, it has already negatively affected the reputation of the whole system. This mismanagement of the funds also had a negative impact on the patients since some of these hospitals stopped accepting PTES patients.

Under this mismanagement and until very recently, large amounts of money were allocated to undeserving individuals who used their political power to get the approvals. Ministers were allowed to get approvals to travel abroad to get treatment for themselves and their spouses, spending large amounts of money on simple operations that can be performed locally. They used to get the approval directly from the Council of Ministers

without going through any administrative or medical checkpoints. However, in 2010 and after a series of scandals involving a number of ministers, as was mentioned earlier, stricter rules were implemented. According to an official in the Specialized Medical Councils, “now, only less than 10% of the cases that travel abroad go through the Council of Ministers, which is a major improvement” (Laila, Specialized Medical Councils official, 34 years).

As for MPs, it was a common practice for a member of the parliament to get tens of approvals at a time with different names and different illnesses. They used these approvals to gain the support during elections, by distributing them in their local constituencies. As mentioned by a doctor who once served on the medical committees, “they used to get approvals with unlimited amounts without even presenting the required documents to support their requests” (Amal, doctor, 40 years). She explained that neither the doctors nor the administration could refuse, or else they would be panelized.

The good news is that after these corruption cases were discovered and disclosed in the media, new more controlled measures were enforced. At present, some MPs still go straight to the MoH or the Specialized Medical Councils to present the cases of patients from their governorates. However, this is considered just a service offered by the MP to his community; instead of sending the requests through the hospital or the internet, he delivers them by hand to accelerate the process. Officials claim that,

“No exceptions are made, the required documents have to be complete including the reports from the local hospitals, the cases are assessed according to the rules and in case they are approved, the decree is issued according to the official coding system with specified amounts of money” (Soliman, Specialized Medical Councils administrator, 55 years).

To what extent this is true, only an official investigation can judge after auditing the decrees issued the last couple of years to decide whether or not they followed the rules and regulations.

Another major inefficiency that was recently rectified was the fact that the amount allocated to each patient was clearly written on the approval document, which opened the door for the so-called ‘brokers’. These brokers “used to approach the patient who is applying to receive the treatment and offer to help him/her in getting a quick approval in return for a percentage of the money that will be allocated” (Ismail, hospital accountant, 31). They used to work with corrupt individuals working in the Specialized Medical Councils to facilitate their mission. This has significantly diminished due to the new coding system discussed earlier, whereby the amount is not mentioned on the document, but linked to a specific code that is meaningful only to hospital administrators.

A related area where there was a significant waste of government money pertains to the medicines prescribed to the patient. Many of the patients especially those lucky ones who used to get an approval with no ceiling through the MPs, used to take the medicines from the hospital and sell them to pharmacies which in turn resell them at market price making huge profits. This was especially true with expensive medicines such as cancer drugs. Again, this is fixed now; patients have to receive the treatment in the hospital, they do not take the medicines in their hands. Moreover, all medicines used for the PTES, have the sentence “exclusive for the Ministry of Health” and are only released through the hospitals’ pharmacies.

The other criterion to be used for efficiency is time management. As in the case of fund management, according to officials in the MoH, and the Specialized Medical Councils, efforts are underway to minimize the amount of time it takes to issue a decree,

to send it back to the hospitals, to inform the patients and more importantly to renew the approval. However, patients do not feel the results of these efforts, as discussed in the findings.

As previously mentioned, once the hospital medical committees prepare the reports, they are sent to the Specialized Medical Councils for final approval. Since it is a centralized authority that serves the whole country, it receives hundreds of requests daily from all the governorates. Although, the administration claims that it does not take more than three weeks to issue the initial decree and a couple of days in case of standard medication such as diabetes or blood pressure, most patients mentioned that it took them much longer to hear back from the Councils; two months in some cases. During this period the patient may get worse especially that many of those applying have severe conditions. Moreover, decrees have a validity period of three months, after this, a new one has to be issued.

Officially, the decrees are sent to the hospitals either by hand with the hospitals' representatives or through the internet using the newly installed network which connects a large number of hospitals to the Councils. Logically, one should expect that sending through the internet should be the fastest way, however, since the hospitals' infrastructure and technical expertise of the staff are not up to the level, this is not always the case. Sometimes the Councils send the approval through the internet, but due to technical problems, the hospital does not receive it which means extra waste of time until the problems are solved. Also, because of the delays, in many cases, patients or their first-degree relatives are forced resort to a third way to get the approval, they go in person to the Councils asking for the decree. What raises more questions about efficiency is that

when they go to the Councils, they sometimes, find the decree ready, but for unknown reasons it was not sent.

Renewing the approval document is another disturbing sign of inefficiency in terms of time management. Most decrees are issued for a period of six months, except for very specific cases where they are issued for one year. Officially, the hospital is responsible to send a request to the Specialized Medical Councils asking for the renewal, and as claimed by the officials, the renewal is granted automatically without disturbing the treatment. Meanwhile, patients maintain that nothing is performed automatically; everything takes a long time. They have to remind the person in charge at least a month before the expiry date since no one is really keeping track. A diabetic patient complains,

“It was my first renewal and was not aware that I have to remind the hospital to send a renewal request, only when the decree has expired that they sent the request. It is true that the hospital did all the paper work, but it took a month to get the renewal, and had to pay for my medicines during this time” (Samira, diabetic patient, 50 years).

#### **D. Effectiveness of the Program of Treatment at the Expense of State**

The Program of Treatment at the Expense of State is a system designed to reach the uninsured, underprivileged patients who cannot otherwise afford to pay for adequate treatment. So the question is; does it really fully benefit this category of Egyptians in an adequate manner? Most respondents across all groups of stakeholders agreed that the major concern is the degree of coverage. The officials admit that the funds are not sufficient to fully cover all the cases. The patients on the other hand complain that having to supplement the allocated amount in order to cover the expenses is a financial

burden they cannot bear. However, they also point out to some signs of effectiveness such as the implementation of the coding system and the addition of a number of medical conditions to the list of covered cases.

The main stipulation to be eligible to receive treatment at the expense of state is to be uninsured. The rationale behind this is that insured citizens are already covered by a medical system that is supposed to provide them with adequate health care, whereas the PTES is directed to those needy citizens who are not covered by any type of medical insurance. However, such argument assumes that all uninsured citizens are in need for financial support in case of health problems, and that being covered by medical insurance automatically guarantees good, affordable and timely health care when needed. Unfortunately, this double-folded assumption is not always accurate. Most self-employed businessmen, owners of one-man shops, technical workers such as plumbers and carpenters are usually uninsured, but this does not necessarily mean that they are in need of financial help. Moreover, the private sector is allowed to opt out of the system by paying in 1% premium on worker wages. Therefore, theoretically, employees in private sector who receive relatively high wages are eligible to apply to the PTES.

On the other hand, and since we cannot generalize, it can be argued that these uninsured individuals might be actually in need for financial assistance. Here comes one of the most criticized deficiencies of the system; there is no social or financial check on the background of the applicant. One of the doctors interviewed expressed his concerns that, since there is no social research to check the patient's socio-economic status, the system does not always benefit those who are in real need. To prove his point, he added, "once I had a patient who was a well-off fruit merchant, I was surprised that his request for treatment at the expense of state was approved just because he proved that he had no

medical insurance” (Mohamed, cardiologist, 43 years). The problem here is that since the budget of the program is limited, any money allocated to an underserving individual automatically decreases the chance of a real needy patient.

The only reference used to decide whether the person is insured or not is the national ID. The committee assumes that if there is no occupation mentioned on the ID, so this automatically means that the person is not insured. Again, that is not always the case since only employees in the government and the public sector are required to mention their occupation on the ID. This fact can lead to the same result; patients, who are not really in need of financial support, are granted decrees to be treated at the expense of state, just because they do not have an occupation mentioned on their IDs.

Conversely, as mentioned earlier, the State Medical Insurance System in Egypt is not very developed and efficient. Many of those enrolled in this system suffer when they are in need for medical intervention. Long waiting lists, unavailable medicines, untrained staff, insufficient hospital beds and nonoperational equipment are among the many problems faced by patients in the hospitals under the State Medical Insurance System. Patients covered with medical insurance complain that they spend their life paying their dues to the system, and when they need its services, they rarely get the adequate treatment in a dignified manner, while those who are uninsured, automatically get free services under the PTES.

Another major deficiency that raises concerns about the effectiveness of the system is the degree to which the whole treatment is really “at the expense of state”. When the patient first applies to the system, and since at that stage, he/she is not yet covered, he/she is asked to pay for all the tests and x-rays needed, which constitutes a huge financial burden. One of the doctors interviewed said that he once had a patient



who had to do an open heart operation, and since he could not afford to pay for it, “I advised him to apply for the Program of Treatment at the Expense of State, however she was so poor that she could not pay for the preliminary tests and had to borrow the money” (Mohamed, cardiologist, 43 years).

Out-of-pocket spending is also significant when discussing the amount allocated in the decrees. Some patients, doctors and even ministry administrators agree that it is sometimes not enough and does not cover the whole treatment. The difference is more pronounced when the patient is in need for a critical operation like in the case of liver or kidney transplant. As discussed earlier, the decree is usually issued with just a portion of the required amount. Patients are asked to pay the rest of the cost, so they usually resort to family, friends and NGOs for help. The rationale behind these relatively limited amounts is according to an official in the Specialized Medical Councils “it is better to give a part of the cost to all patients, than to give the whole amount to a few of them” (Soliman, Specialized Medical Councils administrator, 55 years). The amount of out-of-pocket spending by patients under the PTES raises some concerns about the effectiveness of the system.

Patients also noted that prescribing and receiving the effective drugs and medicines, is another problem. As previously mentioned, the MoH periodically issues a list of drugs that can be prescribed by doctors for each medical condition. Doctors are left with two choices, either to abide by the list, even if the drug is not the most effective, or insist to prescribe the more effective ‘unlisted’ medicines, knowing that the hospital’s pharmacy would refuse to give them to the patient. It is a dilemma for most doctors, especially when the effective treatment is expensive such as the drugs for cancer. To complicate matters, even if the patients manage to get the medicine from any pharmacy,

many hospitals refuse to administer the treatment; the drug has to come from the hospital's pharmacy, which does not give except listed drugs. So, patients find themselves in a vicious circle. In most cases, they end up taking the available treatment, even while knowing that it is not very effective. Providing ineffective treatment, even under the pretext of following the rules is a serious downfall of the system that contradicts its mission.

It is worth noting, that while officials repeatedly confirm that now the rules and regulations are being strictly implemented and no undeserving individual gets an approval to receive treatment at the expense of state, some people, mainly patients who suffered to get an approval, have a different opinion. They believe that decrees are still issued to ineligible persons just because they are well connected to MPs or other influential figures. They even claim that,

“Since the decrees are issued based mainly on the reports sent by the medical committees in the hospitals, hospital administrators sometimes use their collegial relationship with the doctors on these committees to get recommendations for their relatives and friends who might not be actually in need” (Adel, patient with Hepatitis C, 42 years).

The last major criticism to the PTES is related to the approvals granted to patients to travel abroad at the expense of state. According to the father of a young boy who had a brain tumor, and had to do a major operation back in 2005, if it were not for his relationship with a high ranked government official, his son would not have had the chance to go abroad. He explained that after doing all the required tests and analyses, and communicated with the hospital abroad, he gave the file to his friend to present it directly to the Prime Minister, who gave his approval, “all what we were asked to do is to

present the bills when we come back” (Sherif, the father of a 12 years boy with brain tumor). On the other hand, officials responsible for granting the approval for the treatment abroad insist that this has completely changed; the percentage of those who get the approval using their connections or status has become insignificant compared to those who go through the official channel.

On a brighter note, one of the major improvements that were successfully implemented is the addition of new diseases and medical conditions to the list of cases covered by the PTES. Until 2010, only six cases were covered; tumors, kidney problems, liver problems, heart problems, diabetes and high blood pressure. In 2012, a large number of diseases were added which was a major relief for millions of patients.

There was another attempt to improve the performance of the system. A resolution was introduced stating that the PTES should cover emergency situations, such as in the case of accidents. Hospitals would provide the treatment to accidents’ victims without asking for any money or documents, and then file later to be reimbursed as part of the PTES. Doctors and officials maintain that they perform vital surgeries and major operations without waiting for the bureaucratic procedures required to issue the approval.

Also, the implementation of the coding system, whereby each medical condition has a code written on the approval letter sent to the hospital was a positive improvement. This system guarantees to a great extent the fairness and objectivity of the program. It also prevents any misuse of authority or favoritism. As explained earlier, these codes are only meaningful to the hospitals’ administration and doctors, which puts more control on the whole process.

### **E. Responsiveness of the Program of Treatment at the Expense of State**

The World Health Organization uses eight criteria to assess the health system in general; autonomy, choice of provider, dignity and clarity of communication (World Health Survey Technical Consultations on Health Systems Performance, 2001, p.2). This paper selected the first four criteria to assess the responsiveness of the PTES as mentioned in the methodology section. When asked about their experiences in respect to these criteria, patients had many complaints. However, to be objective, it has to be noted that the first two criteria are actually restricted by the controlled nature of the PTES. Therefore, although respondents were not very satisfied with the general environment in which the treatment is provided, it is very difficult to change some of its aspects since they are the indirect consequences of implementing severe controls and regulations to improve the administration of the system.

The term autonomy refers to the extent of patients' involvement in the decision making process and their right to make informed choices. Since the whole PTES system is highly centralized and governed by a strict coding system, the patients have nearly no control over their treatment; the case is diagnosed by the hospital medical committee, the treatment is decided by the Specialized Medical Councils, then the coded decree is sent to the hospital for the treatment to be administered. Moreover, as mentioned earlier, in some cases, when the most effective medicine is not included in the list provided by the MoH, the doctors are not authorized to prescribe it. The patients do not have the right to object, they are forced to take the listed medicine. Even if the patients manage to buy it from somewhere else, it is forbidden to administer any treatment purchased by the patients from an outside pharmacy.

Examining the ability of the patients to choose the provider of the medical service, all respondents pointed out that this is governed by two rules limiting this choice. Although the patient is free to choose the hospital in the first place, it has to be a public hospital, a military hospital or a hospital affiliated with a public university. Private hospitals were removed from the list after the 2010 corruption allegations. Second, the decree is issued with the name of the hospital that sent the initial medical report. In case the patient wants to receive the treatment in another hospital, he/she has to restart the whole process. This rule was implemented in order to be able to hold each hospital responsible for the reports issued by its doctors.

As for dignity, it implies a respectful treatment for patients. To assess dignity, PTES patients were asked whether or not doctors, nurses and administrative staff treated them differently than the other patients. Most of the patients agreed that they did not receive any deferential treatment, however, they pointed out that the treatment in general, especially by the administrative staff, is not always friendly. According to them, the treatment in the public hospitals is worse than in other hospitals for *all* patients regardless of their status. Some of them even went as far as implying that “they respect you if you give them money, and only then, you receive the required attention” (Azza, kidney failure patient, 47 years old).

The last criterion to be assessed is the clarity of communication between the health care provider and the patients and their families. To improve the communication between applicants and the Specialized Medical Councils, and to facilitate the process, a new proposal was discussed to use SMS to inform the patients of the decision of the Specialized Medical Councils. According to its administration, there was an agreement back in 2010 between the Councils and the Egyptian Telecommunication Company to

send an SMS to the patients. However, none of the patients interviewed received such message or even heard about the service. So far, the only way to know whether or not their request was approved is to keep asking in the hospital until they are informed that it was received. Also, when dealing with patients who suffer from serious diseases and are in dire need to receive the treatment as soon as possible, clear and prompt feedback is critical. Investing in a communication network to connect the hospitals to the Specialized Medical Councils was a very important step towards decreasing the duration of the whole process. Although some hospitals are still not connected to the network, and technical problems sometimes slow down the process, however, in general it is considered a positive step forward.

## **CONCLUSION**

The Program of Treatment at the Expense of State is the only available option for millions of patients who cannot afford to pay for the adequate treatment. Although it has major deficiencies and is publicly criticized for being inefficient and ineffective, introducing some administrative reforms can rectify many of these deficiencies. The MoH has recently enforced a series of rules and regulations to improve the business process. Most of the stakeholders; patients, doctors and administrators believe that the newly introduced changes have a positive effect, however, the corruption cases that were discussed in the media in 2010 are still lingering in the back of everyone's mind.

In general, out of the three main categories of stakeholders interviewed in this research, the doctors were the most critical of the system, pointing out to its deficiencies. Probably this is because they are caught in the middle between the other two groups; the government officials on one hand and the patients on the other hand. The staff and administration in the MoH and the Specialized Medical Councils were more theoretical in answering the questions; they replied with the 'politically correct answer' in most cases. Unless asked a very specific direct question, they rarely mention the drawbacks of the system.

As for the patients, although they were much more open in discussing the problems they face, however, being the beneficiaries of the system, they were hesitant to overemphasize its deficiencies. Patients who needed organ transplantation complained mainly about the amount of money allocated being insufficient. For most of the other patients, the main problem was the time they have to wait to get the initial approval as

well as the subsequent renewals. Since the majority of these patients are from low-income level households, for them this system is a life savior. In most cases they insist that despite all its deficiencies, if it were not for this program, they would not have been able to get any treatment.

One can argue that, the MoH is trying to regulate the allocation of the available funds for the PTES and implement the rules and laws that guarantee an efficient use of these funds. However, the Ministry has to periodically assess the system's performance, since the existing rules and regulations are sometimes overlooked. There has to be a clear and transparent process by which all patients receive approvals in an impartial and equitable manner.

The whole system has to be revisited by decision makers and policy planners. Despite all its downfalls, this system remains the only resort for millions of patients. However, any attempt to improve the system has to deal with all the problems in a comprehensive way while addressing the major bottlenecks in the Egyptian health system. Trying to solve each problem separately will result in further aggravating the already existing deficiencies in the system.



## **RECOMMENDATIONS**

Based on the findings and the discussion, some recommendations can be proposed.

### **1. Increasing the efficiency of the Program of Treatment at the Expense of State (PTES):**

- Funds reserved for the Program of Treatment at the Expense of State in the general budget have to increase. However, this might be difficult under the present circumstances due to the economic problems facing the Egyptian government. Out-of-the-box' solutions can be implemented to supplement what the government spends on the PTES.
- Establishing partnerships between the PTES on one hand and the NOGs and charity organizations on the other to help the patients in case the amounts allocated does not cover the whole treatment.
- Launching a fund-raising campaign encouraging individuals to donate for the PTES. The campaign should aim at raising awareness about the importance of the PTES and its benefits to millions of needy patients.
- To have a separate fund to finance the pre-approval tests, since most of the applicants to the program are supposed to be from the low-income level households, it can be safely assumed that they cannot bear any extra financial burdens. This can be a sub-account of the main budget of the PTES.
- The amount allocated to the treatment abroad should not be a constant amount. Each case should be individually assessed and funds allocated accordingly.

- Reducing the amount of time it takes for the approval to be sent back to the hospitals from the Specialized Medical Councils is vital to improve the efficiency of the system.
- The information network that was designed to connect the hospitals to the Specialized Medical Councils has to be periodically upgraded and maintained.
- The hospitals that are not yet connected should be integrated in the system in order to speed up the process.
- The administration of the Specialized Medical Councils has to oversee the implementation of strict rules and regulations that guarantee that the initial decree is issued and, more importantly, sent to the hospitals within maximum ten days.
- The renewal process has to be an automatic process; the patient should not be involved, the treatment should be affected and the letter should reach the hospital before the previous approval expires.

## **2. Increasing the effectiveness of the Program of Treatment at the Expense of State (PTES):**

- A more controlled mechanism has to be implemented to filter the applicants. As pointed out, being uninsured is not always an indication of financial need. A basic socio-economic background check should be part of the process. The applicant can be asked to present documents that support his/her claim that he/she deserves to be treated at the expense of state.
- The role of the Specialized Medical Councils as the sole agency authorized to grant the final approvals has to be reassessed; there has to be a degree of decentralization. Instead of sending all the requests from all over Egypt to the

Councils' headquarters in Cairo, local medical centers in the different governorates should be authorized to grant the approvals. They can be restricted to give approvals for the residents of the governorate and only in the local hospitals.

- The local medical centers in the different governorates should become connected to the headquarters, whereby, in case of serious conditions that required expensive or long-term treatment, the requests can be sent to the headquarters for further assessment.
- The recently imposed rules and regulations, the introduced changes, as well as any new development that might come into effect in the future should be closely monitored and assessed. Periodic unannounced revisions by the auditing authorities have to take place to go through the applications, the attached documents and the subsequent approvals and renewals.
- More thorough inspection on the files and decrees in the last couple of years is important to make sure that the rules are being correctly implemented. This is the only way that the efficiency and effectiveness of the PTES can improve. Moreover, the results of this inspection should be publically announced in a transparent manner.

### **3. Increasing the responsiveness of the Program of Treatment at the Expense of State (PTES):**

- Providing a better treatment to the patients in public hospitals and dealing with them in a respectful manner is a general recommendation that is not specific to the

PTES. Patients deserve to be treated with dignity; give them the attention they need, answer their questions and offer to help them.

- Patients deserve to be examined in privacy, stay in a clean room, and have friendly and committed medical and administrative staff attending to their needs.
- Some flexibility in administering the coding system is recommended. Although implementing the strict coding system, as well as issuing a list of authorized drugs, guarantee that everyone is treated equally and is getting the same treatment for the same case, severe and critical cases should be assessed separately.
- In case the patient cannot afford to pay the difference in expenses, such as in case of organ transplant, a supplemental decree can be issued to complement the amount allocated.
- In case the patient needs a specific drug that would be more effective than the listed drugs, the case could be reassessed.
- To guarantee that any proposed flexibility would not be a back door for exceptions and favoritism, the MoH can enforce strict conditions and stipulations restricting these procedures.
- Implementing better communication channels with patients is very important to improve the system's responsiveness. Operationalizing the agreement signed with the Egyptian Telecommunication Company to send SMS to patients informing them of the decision of the Specialized Medical Councils would be very effective.

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**Appendix 1**  
**President of the Arab Republic of Egypt**  
**Decree No. 691 of 1975 regarding the treatment of workers and citizens**  
**at the expense of the state**

After observing the Constitution and the presidential Decree No. 3183 of 1966 in regarding the treatment of workers and citizens abroad, and after the approval of the Councils of Ministers and based on the view of the State Councils,

The President decided:

**Article (1):** The decision of the treatment of workers and citizens inside and outside the republic has to be in accordance with the provisions of the decree

**Article (2):** Upon a decree from the Minister of Health, Specialized Medical Councils will be formed, in different branches of medicine from the faculty members in the faculties of medicine and specialists at the Ministry of Health and the armed forces and others whose expertise is valuable and representatives from the public administration of the medical boards.

**Article (3):** The above mentioned Councils will be responsible to examine the health status of applicants for the Program of Treatment abroad for the following categories and provide their recommendations: (a) State employees, in the government, local administration, public institutions and public sector units. (b) Citizens asking for treatment at the expense of the state. (c) Citizens asking for treatment abroad at their own expenses.

**Article (4):** The Councils recommend the treatment of the patient abroad if the treatment is unavailable in Egypt and the case requires it.

**Article (5):** In case of approval, the Councils refer their reports and recommendations for treatment abroad for those paying for their own expenses to the Immigration and Nationality Authority and Cash Authority and other involved authorities to make the necessary arrangement for their travel.

Also, they refer their recommendations regarding treatment at the expense of state to the Minister of Health to obtain a decision from the Prime Minister

**Article (6):** The decision of treatment at the expense of the state is by a decree from the Prime Minister. In case the patient falls under item (a) of article (3), the patients' expenses are covered by the social insurance and pensions systems in Egypt or abroad, otherwise, the State bears all or some of the costs according to the social status

**Article (7):** The Minister of Health shall issue the decisions necessary for the implementation of this resolution

Issued in the Presidential headquarter, 1st of Rajab, 1395 (10 July 1975)

**Appendix 2**  
**Prime Minister's decision**  
**No. 1699 for the year 1987**  
**Authorizing the Minister of Health in the approval of the treatment at**  
**the expense of the state at home and abroad**

After observing the Constitution, Law No. 42 of 1967 on the terms of delegation of authority and on the Presidential Decree No. 691 of 1975 on the treatment of workers and citizens,

The Prime Minister decided:

**Article (1):** The Minister of Health is authorized to pursue the Prime Minister's authority to give approvals for the treatment at the expense of the state at home and abroad stipulated in the Presidential Decree No. 691 of 1975, except in cases of direct treatment performed without the recommendation of the Specialized Medical Councils or the social research.

Issued by the Councils of Ministers on 20 Safar1408 (13 October 1987)



**Appendix 3**  
**Ministerial Decree No. (337) for the year 1975**  
**on the formation of the Specialized Medical Councils**  
**as stipulated by the Presidential Decree No. 691 for the year 1975 on the**  
**treatment of workers and citizens at the expense of the state**

After observing the Presidential Decree No. 691 of 1975 and Ministerial Decree No. 144 of 1975,  
the Minister of Health decided:

**Article (1):** The Specialized Medical Councils are to be formed according to Article (2) of the Presidential Decree aforementioned from specialists as attached.

**Article (2):** The Specialized Medical Councils are held upon an invitation from the Director General of the General Directorate of the Medical Boards. The Directorate is responsible for preparing and implementing all what applies to the Presidential Decree 691 for the year 1975 on cases requiring a check up. The Director General of the Medical Boards participates in the membership of these Councils as a Specialist from the Ministry of Health.

**Article (3):** The decisions of these Councils are valid if at least three members are present

**Article (4):** The members of these Councils are given two LE as a bonus for each member for each case they check

1975/9/4

## **Appendix 4**

### **Interview Questions**

#### **Questions for the Administrators in the Ministry of Health / PTES**

1. Would you please give me a brief description of the Program of Treatment at the Expense of State in Egypt and abroad?
2. Who is eligible to receive this treatment?
3. How is it financed?
4. What does a patient need to do to receive State-Financed Treatment?
5. Can you give an approximate percentage of the cases that receive an approval?
6. What medical cases are covered by this system?
7. When and how does the patient know that he/she did get the approval?
8. In case, the patient is granted an approval, does the system cover all the expenses?
9. Who decides the amounts allocated to each patient?
10. Does the patient take the money, or does the Ministry administer the whole process?
11. Is the approval renewed automatically, what is required to renew it?
12. Would you explain the financial relation between the Ministry of Health and the hospitals?
13. What is the role of the Specialized Medical Councils?
14. In case of surgical intervention, does the patient get any money afterwards for medicines and follow ups?
15. Do you think that the program is really covering those who deserve to be treated on the expense of state?
16. What about giving special approvals to those who can otherwise afford to pay?
17. As an administrator in the Ministry of Health, how do you evaluate this system in terms of efficiency and effectiveness?
18. Do you have any suggestions for improvement?

***Extra question for MoH administrator***

1. Will the new Medical Insurance Law, which -as planned- will cover all Egyptians, replace the PTES?

### **Questions for the Administrators in the Ministry of Finance**

1. What is the share of the Ministry of Health in the general state budget?
2. Is the fund allocated to the PTES part of the Ministry of Health fund, or is it separate?
3. In case it is part of the MoH fund, is it the MoF or the MoH that determines it?
4. How the amounts are determined, as a constant amount each year, or a percentage of the general budget?
5. The PTES has two components; in Egypt and abroad. Do you allocate separate funds for each component?

### **Questions for the Doctors**

1. What is your specialty?
2. What are the medical conditions where you suggest to the patient to apply for the PTES?
3. Do you usually help the patient to receive the approval?
4. What does a patient need to do to receive the approval?
5. Can you give an approximate percentage of the cases that receive an approval?
6. What does the program usually cover in terms of the different treatment items (medicines, lab tests, X-rays...)?
7. In case of a surgery, does the patient get any money afterwards for medicines and follow-ups?
8. Have you ever served on a hospital committee that prepares the medical reports to be sent to the Specialized Medical Centers for approval?
9. If yes, what are the procedures followed by these committees?
10. Have you ever worked in the Specialized Medical Centers?
11. If yes, what are the procedures followed by these centers to approval or refuse a case?
12. What are the regulations that guarantee that the approvals are granted to those who deserve them?
13. As a doctor who works with patients under this program, how do you evaluate this system in terms of efficiency and effectiveness?
14. Do you have any recommendations for improvement?

**Questions for the Patients who were granted an approval (in Egypt)**

1. What are you suffering from and since when?
2. How long have you been receiving treatment under this program?
3. How did you apply for the program? What is the process and what are the required documents?
4. How long did it take to get the approval?
5. Did you get a recommendation from someone influential, such as a member in the parliament?
6. Did anyone ask you for any money (as a bribe) to help you receive the approval?
7. What about the amount allocated, was it enough to cover all expenses?
8. What exactly does it cover; hospital accommodation, surgical interventions, medicines, consultations, lab tests, X-rays?
9. Have you already applied for a renewal?
10. In case of renewal, was it easier and/or faster to get the approval the second time? Was the amount allocated the same?
11. Were you treated differently in the hospital when you became a beneficiary of the PTES?
12. Do you think that the program is really covering those who deserve to be treated on the expense of state?
13. As a beneficiary of the program, how do you evaluate it in terms of efficiency and effectiveness?
14. Do you have any recommendations for improvement?

**Questions for Patients who were granted an approval (abroad)**

1. What were you suffering from and for how long?
2. When did you apply for the program?
3. Who decided that you were eligible to receive treatment abroad at the expense of the state?
4. How did you apply for the program? What was the process and what were the required documents?
5. How long did it take to get the approval?
6. Did you try to get a recommendation from someone influential, such as a member in the parliament?
7. Did anyone ask you for any money (as a bribe) to help you receive the approval?
8. What about the amount allocated, was it enough to cover all expenses?
9. What exactly did it cover; travel, hospital accommodation, surgical interventions, medicines, consultations, lab tests, X-rays?
10. Was it possible to ask for extra amounts if your treatment took longer than expected?
11. Who handled the finances; did you receive the money and settle the account when you returned, or was it handled through the Ministry of Health?
12. Do you think that the program is really covering those who deserve to be treated abroad on the expense of state?
13. As a beneficiary of the program, how do you evaluate it in terms of efficiency and effectiveness?
14. Do you have any recommendations for improvement?

**Questions for Patients who could not get an approval**

1. What are you suffering from and since when?
2. Did you apply for treatment in Egypt or abroad?
3. Did you ask to make sure that you are eligible to apply for the program?
4. How did you apply for the program?
5. How long did you wait to get the reply?
6. Were you informed of the reason for not granting you the approval?
7. Did you try to get a recommendation from someone influential, such as a member in the parliament?
8. Did anyone ask you for money (as a bribe) to help you receive the approval?



## Appendix 5 Institutional Review Board Approval

CASE #2012-2013-070



To: Rasha Radwan  
cc: Enas Abdel Azim  
From: Atta Gebril, Chair of the IRB  
Date: February 19, 2013  
Re: Approval of study

This is to inform you that I reviewed your revised research proposal entitled “An Assessment of the Egyptian Government Alternative Health Care Coverage System: “Treatment at the Expense of State”,” and determined that it required consultation with the IRB under the "expedited" heading. As you are aware, the members of the IRB suggested certain revisions to the original proposal, but your new version addresses these concerns successfully. The revised proposal used appropriate procedures to minimize risks to human subjects and that adequate provision was made for confidentiality and data anonymity of participants in any published record. I believe you will also make adequate provision for obtaining informed consent of the participants.

Please note that IRB approval does not automatically ensure approval by CAPMAS, an Egyptian government agency responsible for approving much off-campus research involving surveys and interviews. CAPMAS issues are handled at AUC by the office of the University Counsellor, Dr. Amr Salama. The IRB is not in a position to offer any opinion on CAPMAS issues, and takes no responsibility for obtaining CAPMAS approval.

This approval is valid for only one year. In case you have not finished data collection within a year, you need to apply for an extension.

Thank you and good luck.

Atta Gebril

A handwritten signature in black ink, appearing to read "Atta Gebril", written over a horizontal line.

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A logo consisting of a yellow square followed by a dark blue rectangle.

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