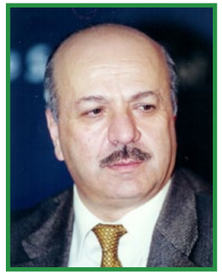
The Health System in Egypt: An Overview



Dr. Abdo Jurjus
Lebanese Health Society
Global Health International Association

The structure of the Egyptian Government is a democracy in transition, having recently elected a president; with all political authority is vested in the Government in Cairo. Cairo, with a per-capita income of US$ 6,141is ranked 112 out of 186 countries in Human Development Index dropping from 101 in 2010. The Gender Inequality Index for Egyptians is 0.590 with a ranking of 126, and 63% of females over 15 are literate.

Poverty has declined over the past few decades; however, there is disparity - poverty in Upper Egypt increased from 29 to 34% in rural areas and from 11 to 19% in urban areas. Although Egypt has experienced a rapid transition to lower fertility. It is the second most populous country in the WHO Eastern Mediterranean Region, with 43% of the population living in urban areas and overcrowded conditions. The continuously increasing population has impacted the per capita share of renewable water resources which is currently 750m3/capita/year and is expected to reach 250m3/capita/year in 2050.

The Egyptian health care system faces multiple challenges in improving and ensuring the health and well-being of the Egyptian people. The system faces not only the burden of combating illnesses associated with poverty and lack of education, but it must also respond to emerging diseases and illnesses associated with modern, urban lifestyle.

A high birth rate combined with a longer life expectancy is increasing the population pressure on the Egyptian health system. By the year 2020, it is estimated that the population of Egypt will have grown to about 92 million people.

This article provides a brief overview of the health system in Egypt as it relates to health facilities and outpatient services.

Information is presented with respect to:

- **General organization of the health system**
- **The package of health services provided at different facility levels**
- **Issues related to the health system and quality of care.**

1. General Organization of the Health System

Egypt has a highly pluralistic health care system, with many different public and private providers and financing agents. Health services in Egypt are currently managed, financed, and provided by agencies in all three sectors of the economy: government, parastatal, and private.

The government sector represents activities of ministries that receive funding from the Ministry of Finance (MOF). As in many lower- and middle-income countries, the government health services in Egypt are organized as an integrated delivery system in which the financing and provider functions are included under the same organizational structure. This means that government providers receiving budgetary support from the government general revenues (MOF) are also subject to the administrative rules and regulations that govern all civil service organizations. For example, staff is subject to the Civil Service Employment Law, and remuneration is based on the civil service salary scale determined by the Central Agency for Organization and Administration (CAOA).

Government providers are permitted to generate their own income through various means, including charging user fees in special units or departments known as economic departments. Income from these non budgetary sources is classified as "self-funding."

The parastatal sector is composed of quasi-governmental organizations in which government ministries have a controlling share of decision making, including the Health Insurance Organization (HIO), the Curative Care Organization (CCO), and the Teaching Hospitals and Institutes Organization (THO). Although the distinction between the government sector and the parastatal or quasi-governmental sector is usually made when describing the Egyptian health sector, both sectors are run by the state. From an operational and a financial perspective, the parastatal sector is governed by its own set of rules and regulations, has separate budgets, and exercises more autonomy in daily operations. However, from a political perspective, the Ministry of Health and Population (MOHP) has a controlling share of decision-making in parastatal organizations.

The private sector includes for-profit and nonprofit organizations and covers everything from traditional midwives, private pharmacies, private doctors, and private hospitals of all sizes. Also in this sector are a large number of nongovernmental organizations (NGOs) providing services, including religiously affiliated clinics and other charitable organizations, all of which are registered with the Ministry of Social Affairs (MOSA).

2. Organization of the Ministry of Health and Population

The organizational structure of the MOHP consists of two functional structures: the administrative structure and the service delivery structure.

2.1 Administrative Structure

The administrative organization of the MOHP comprises the central headquarters and the governorate-level health directorates. The main functions of the central headquarters include planning, supervision, and program management. The population portfolio, which was previously an independent Ministry, was merged into the Ministry of Health in 1995.

All functions of the central headquarters are divided into five broad sector divisions: 1) central administration for the minister's office, 2) curative health services, 3) population and family planning, 4) basic and preventive health services, and 5) administration and finance.

There are 13 headquarter undersecretaries in charge of various functions reporting to the minister. The responsibilities of these undersecretaries include preventive care, laboratories, primary health care, endemic diseases, curative care, research and development, pharmaceuticals, dentistry, family planning, and nursing. On average, about 30 to 35 functional areas and specialized units, headed by the general directors and directors, are grouped under each sector area headed by an undersecretary.

The sector-level model is replicated at each governorate level. The governorate-level health directorates report to the MOHP on technical matters, but they report to the governorate administration headed by the governor on administrative and day-to-day activities. Each governorate health directorate is headed by an undersecretary or a general director who reports to the minister, who in turn supervises the health district directors.

Reporting to the governorate health directorates are 230 health districts. Each district has a director, who is sometimes the district hospital director.

2.2 Service Delivery Structure

The MOHP is currently the major provider of primary, preventive, and curative care in Egypt, with around 5,000 health facilities and more than 80,000 beds spread nationwide. There are no formal referral systems in the MOHP delivery system. The MOHP service delivery units are organized along a number of different dimensions. These include geographic (rural and urban), structural (health units, health centers, and hospitals), functional (maternal child health centers), or programmatic (immunization, and diarrheal disease control).

Specifically, with respect to inpatient services, the MOHP is the largest institutional provider of inpatient health care services in Egypt. It has about 1,048 inpatient facilities, accounting for more than 80,000 beds. Hospital services are provided through the following types of facilities.

Integrated hospitals are small, 20- to 60-bed hospitals providing primary health care and specialized medical services in the rural areas. Integrated hospitals contain well-equipped surgical theatres, X-ray equipment, and laboratories and are responsible for serving a catchment population of between 10,000 and 25,000 people.

District hospitals are 100- to 200-bed hospitals that provide more specialized medical services and are available in every district. District hospitals are responsible for serving a catchment population of between 50,000 to 100,000 people in the urban district area.
General hospitals contain more than 200 beds and contain all medical specialties. General hospitals are available in every capital of a governorate.
Integrated, district, and general hospitals were included in the ESPA and were categorized as general service hospitals for this report.

Specialty hospitals are located in urban areas and include specialties such as eye, psychiatric, chest (34), fever (88), heart ophthalmology (31), tumors, and gynecology and obstetrics. Specialty hospitals are available in all governorates. Fever hospitals were the only type of specialty hospital included in the ESPA.
The private sector has 2,024 inpatient facilities, with a total of about 22,647 beds. This accounts for approximately 16 percent of the total inpatient bed capacity in Egypt.

3. MOHP Public Health Programs

The MOHP has attempted to target many health priorities in Egypt through vertical programs that rely heavily on donor assistance. These programs include the following

3.1. Population, Reproductive Health, and Family Planning Program

As early as 1953, a "National Committee for Population Matters" was established to review population issues. This committee developed three successive population policies: the first was enacted in 1973; the second was enacted in 1980, which saw the creation of the National Population Council in 1985; and the third was enacted in 1986. In 1991, the National Population Council developed specific objectives for population activities through the introduction of a population strategy. Throughout these years, the population program has continued to develop with varying degree of success and with the support of various donors, principally the U.S. Agency for International Development (USAID) and the United Nations Population Fund (UNFPA).
Donor assistance has mainly concentrated on providing supplies and technical support. Donors have provided more than 50 percent of the funding for public-sector population program activities and almost 70 percent of the

funding for these activities in the private sector.

3.2. Control of Diarrheal Diseases and Acute Respiratory Infections Programs

The Control of Diarrhea Diseases (CDD) and Acute Respiratory Infections (ARI) programs were components of projects supported by USAID. The CDD program is older by a few years and has its own department in the MOHP. It has benefited from having been a priority since the 1980s. It was only in the late eighties that the ARI program gained impetus with the development of World Health Organization (WHO) programs focusing on ARI.
Both the CDD and ARI programs have adopted WHO case definitions and case management protocols. In principle, standardized treatments are available in health facilities, and a high proportion of the staff has been trained.
The CDD program has been effective in reducing infant mortality caused by diarrheal diseases; they are now in second place as a cause of infant deaths.

3.3. Expanded Program on Immunization

The Expanded Program on Immunization (EPI) is probably the most accessible, available, and utilized of all public health programs in Egypt. According to health officials, many parents do not request health services for themselves or their children, but they do have their children vaccinated. The program has been quite effective in reducing the incidence of some vaccine-preventable diseases, such as diphtheria and poliomyelitis.

3.4. Maternal Health

The government of Egypt has demonstrated continued political commitment to improving maternal and child health. In 1994, as host nation of the International Conference on Population and Development, the government of Egypt endorsed a comprehensive approach to women's health with a focus on reducing maternal mortality. Reducing maternal mortality was also a key goal of the National Five-Year Plan (1998-2002) of the MOHP.

The national program to reduce maternal mortality is overseen and implemented by the Directorate of Maternal and Child Health Care (MCH) under the Division/Sector of Primary Health Care of MOHP. The MOHP used the conclusions and recommendations of the 1992-1993 National Maternal Mortality Study (NMMS) to design and implement interventions (Maternal Care Program Development and Implementation Process) during the past decade. Particular attention has been paid to improving the quality of delivery care as well as to encouraging appropriate care-seeking behavior. All public health facilities provide maternal and child health services.

At the national level, the MCH directorate has defined a package of MCH services, which includes basic and comprehensive essential obstetric care for normal delivery and management of obstetric complications. Clinical protocols and service standards for essential obstetric care (EOC) and competency-based training curricula and materials have been developed and officially approved for national use. Quality of care has also been addressed through a series of administrative decrees covering issues such as the presence of senior obstetricians during deliveries, midwife training and licensing, improvement in blood services, and use of facility-generated revenues for local service improvement. More than 170 maternity centers have been upgraded in the underserved urban and rural areas to provide safe and clean normal delivery services and to be able to refer pregnant women with complications. Seventy-five rural and postnatal care (PNC) units have also been upgraded to offer normal delivery care and to improve linkages with referral centers.

4. Health Sector Reform Strategy

The government of Egypt has articulated as its long-term goal the achievement of universal coverage of basic health services for all of its citizens. It has also stated the importance of targeting the most vulnerable population groups as its priority.
Major components of the strategy include
• Expanding the social health insurance coverage from 47 percent (in 2003) of the population to universal coverage based on the "family" as the basic unit. An affordable and cost-effective package of basic health services based on the priority health needs of the population will be provided.
• Reorganizing services so that they are provided through a holistic family health approach. Provision of the basic package will be based on competition and choice among the different public and private service providers, under a single Public and Health Insurance Fund (PHIF) using incentive-based and other provider payment mechanisms. The MOHP service provision management will be decentralized to the district level (the district management approach), in the transition period until the MOHP phases out its service delivery function.
• Strengthening management systems and developing a regulatory framework and institutional relationships to ensure quality of care and to support the reform of the health sector.
• Developing the domestic pharmaceutical industry and reducing government involvement in the production of pharmaceuticals while strengthening its role as a financier.
The health sector reform strategies are assisted through the Health Sector Reform Program (HSRP).

5. Other Government and Public Sector Agencies

Many other ministries operate their own health facilities that cater to their employees. The most important is the Ministry of Interior, which operates health facilities for police and the prison population; the Transport Ministry, which operates at least two hospitals for railway employees; the Ministry of Agriculture; the Ministry of Religious Affairs; and the Defense Ministry, which is responsible for health facilities run by the Armed Forces.
Egypt has 14 medical schools (Faculties of Medicine), affiliated with the major universities and 36 university hospitals. University hospitals are regarded as secondary and tertiary care facilities and tend to be much more advanced in terms of technology and medical expertise in comparison with MOHP facilities. Cairo University, with a new modern hospital, is considered the largest and most sophisticated hospital in this group. These university hospitals are operated under the authority of Ministry of Higher Education.

6. Parastatal Sector

Parastatal organizations are governmental establishments operated through the MOHP or other ministries. They include the Teaching Hospitals and Institutes Organization (THO), the Health Insurance Organization (HIO), and the Curative Care Organization (CCO).

6.1. General Organization of Teaching Hospitals and Institutes

THO includes nine institutes and nine hospitals distributed over Egypt. The nine THO hospitals are distributed as follows: four hospitals in Cairo, two hospitals in Upper Egypt governorates, and three hospitals in Lower Egypt governorates.

6.2. Health Insurance Organization

The Egyptian Health Insurance Organization was created in 1964. It is a parastatal government-owned entity under the Minister of Health and Population. There are four broad classes of HIO beneficiaries: all employees working in the government sector, some public and private sector employees, pensioners, and widows. In February 1993, the Student Health Insurance Program (SHIP) was introduced to cover 15 million students and school age children, thus increasing the total beneficiary population from 5 million in 1992 to 20 million in 1995 (Rannan-Eliya et al., 1997). The 1997 Ministerial Decree 380 extended coverage to newborns (under one) and, by 2002, had increased the eligible beneficiary population to more than 30 million.

The HIO revenues come from four primary sources. The Social Insurance Organization (SIO) and the Pensioners Insurance Organization (PIO) receive contributions as a proportion of employees' salaries, SHIP receives contributions through a fixed amount from school registration fees and from government subsidy. HIO also receives some revenues in the form of copayments, primarily from government employees. As a provider of health care, the HIO manages 39 hospitals, general practitioner clinics inside and outside factories, as well as the following:

- 7,141 school health clinics
- 1,040 specialist clinics or polyclinics
- 51 owned and 49 contracted pharmacies

6.3. The Curative Care Organizations

The Curative Care Organization (CCO) is a nonprofit system established in 1964 under the ultimate authority of the MOHP. CCOs operate 11 hospitals, which together account for about 1.5 percent of Egypt's total hospital beds. Each CCO is run independently on a nonprofit basis, with surplus revenue being invested into service improvement. In general, the 11 hospitals are high-quality "middle- and top-of-the-market" institutions, providing a full range of quality curative care services and programs. In 2002, the CCOs operated facilities with 2,127 beds.

7. Private and Nongovernmental Sector

Private-sector provision of services includes everything from traditional healers and midwives, private pharmacies, private doctors, and private hospitals of all sizes. Also in this sector are a large number of NGOs providing services, including religiously affiliated clinics and other charitable organizations, all of which are registered with the Ministry of Social Affairs.

7.1. Private Practices

Physicians represent the most powerful professional group in the health sector. Doctors are permitted to work simultaneously for the government and in the private sector. Those who are employed by the government but run a private practice because of their low salaries account for a large portion of private providers. Many other physicians, however, cannot afford to open their own private clinics and work in more than one nongovernmental religious or private facility in addition to their government jobs.

The Egyptian National Health Care Provider Survey (Nandakumar et al., 1999) showed that 89 percent of the physicians with private clinics had multiple jobs. Seventy-three percent of the physicians had two jobs (i.e., they had another job outside their private clinic), 14 percent had three jobs, and 2 percent had four jobs.

The MOHP employs 53 percent of physicians with multiple jobs, followed by universities with 14 percent, and HIO with 11 percent. The remaining physicians include well-established and qualified senior physicians who are usually faculty members in the major medical schools or shareholders in modem private hospitals. These physicians have the technology, the resources, and the visibility required to run very successful and profitable private practices.

7.2. Private Facilities

After the declaration of an open economic policy in 1974, the private health sector began to grow. Between 1975 and 1990, the total number of private beds rose significantly (Kemprecos and Oldham, 1992). Private care facilities in Egypt range from hospitals that are large, modern, and sophisticated to smaller hospitals, day care centers, and polyclinics.

7.3. Private Voluntary Organizations

In the private sector, there are also many private voluntary organizations (PVOs) providing care through polyclinics and small hospitals that are usually affiliated with charitable or religious organizations. Among the various PVOs, the mosque clinics, operated by Muslim social agencies, are perceived to be popular and successful providers of ambulatory health care in Egypt and have become the stereotype for nonprofit organizations.
The PVO health sector is financially self-supporting through user fees. Small PVO clinics, however, are generally losing financially on current operations and are vulnerable to service disruption and failure.

7.4. Nongovernmental Organizations

Nongovernmental organizations (NGOs) provide many developmental, social, and health care services, including reproductive health and family planning service delivery. Reproductive health and family planning services are delivered through the Egyptian Family Planning Association (EFPA), the Clinical Services Improvement (CSI) project, and other NGOs that are able to provide health services (e.g., mosque health units, church health units, and other NGO clinics). The CSI clinics are funded by USAID as a special program.

According to the 2000 Egypt Demographic and Health Survey, the public sector is providing 49 percent of family planning services in Egypt, and the private sector is providing 44 percent. PVOs/NGOs were found to be providing 7 percent of family planning services.

The MOHP seconds physicians and sometimes nurses to NGOs (if requested) to work either part-time or full-time; however, the MOHP has no authority to force these staff to work with the NGOs.

There is a system of supervision and monitoring based on a regular follow-up for the NGO clinics. Supervision is conducted at two levels: supervision from local directors at clinics and supervision from the central staff. The administrative supervision for EFPA is conducted by the staff working in the branch of the EFPA at the governorate level, and the medical supervision is conducted by the health directorates at the governorate level.

Conclusion

The health system in Egypt is fragmented. Universal coverage is far from being a reality. Many challenges await the recently emerging goverment as outlined in the table below.

OPPORTUNITIES	CHALLENGES
• Initiation of a universal coverage scheme by the Ministry of Health and Population. • Existence of a sturdy health system infrastructure with an extensive primary care network; • Availability of a strong human resource workforce in health. • A large presence of donors, external support agencies and a strong UN presence; • Favorable political climate for donors, specifically bilateral donors who have pledged US$ 10 billion in soft loans since the newly elected president took office; • Recognized WHO presence, within government, for a stronger inter-sectoral collaboration and partnership for health.	• Need for a strengthened regulatory body overseeing the health system; • Need for a more effective intra and inter-sectoral collaboration; • Existence of a high out-of-pocket expenditure on health and low government expenditure; • Need for more equitable basic health services and better planning for human resources for health.. • Lack of harmonization between international cooperation and the national health agenda; • Enforcing accountability for results as part of support; • Need to strengthen the Ministry of Health and Population's capacity to exert effective leadership dealing with national and international partners; • Overcoming bureaucratic red-tapes for partnership.