

The Egyptian health 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. Emerging access to global communications and commerce is raising the expectations of the population for more and better care and for advanced health care technology.

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.

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.

The Egyptian government is implementing Health Sector Reform Program measures, with the help of external funding and technical assistance, notably from the World Bank, the U.S. Agency for International Development (USAID), and the European Commission. The plan is to provide services using a family health model, where maternal, child, reproductive tract, and infectious disease services are offered as a package of services in one facility. Providers are trained to provide services in an integrated manner, and family health records are maintained.

This chapter provides a brief overview of the health system in Egypt as it relates to health facilities and outpatient services. The chapter provides a context in which to view the findings of the Egypt Service Provision Assessment (ESPA) survey.

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.

2.1 General Organization of the Health System

Egypt has a highly pluralistic health care system. Health services in Egypt are currently managed, financed and provided by various sectors of the government, under different ministries and different laws, operating with variable levels of independence. Services are also provided by the private sector by providers of variable qualification and variable levels of services.

2.1.1 Public Sector

“Public sector” refers to both the governmental and institutional public sectors. Differentiation of the two categories is based on the ownership and the degree of operational independence granted to them by law; however, both categories are considered governmental.

Public Governmental Sector. The Public Governmental 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 are 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). The governmental providers who receive funds primarily from MOF include the Ministry of Health and Population (MOHP), the Ministry of Higher Education (MOHE), the Ministry of Scientific Research, ministries that provide some health services for their employees (agriculture, teachers, railway, electricity, and others), and facilities of the Teaching Hospitals Organization (THO).¹ THO includes nine institutes and nine hospitals distributed throughout Egypt.

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. These university hospitals are operated under the authority of MOHE.

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 nonbudgetary sources is classified as “self-funding.”

Public Institutional Sector. The Public Institutional Sector is composed of quasi-governmental organizations in which government ministries have a controlling share of decisionmaking, including the Health Insurance Organization (HIO), the Curative Care Organization (CCO), and other public sector organizations providing mainly hospital services. 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, in practice, run by the state. From an operational and a financial perspective, the parastatals are governed by their own set of rules and regulations, have separate budgets, and exercise more autonomy in daily operations. However, from a political perspective, MOHP has a controlling share of decisionmaking in parastatal organizations.

CCO is a nonprofit system established in 1964 under the ultimate authority of MOHP. There are six CCOs operating 12 hospitals, accounting for about 4 percent of Egypt’s total hospital beds. These hospitals are located in Cairo, Alexandria, Kalyubia, Damietta, Kafr-El Sheikh, and Port-Said, with none in Upper Egypt.

The Egyptian HIO was created in 1964. It is a parastatal, government-owned entity under MOHP. 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, 1997). The 1997 Ministerial Decree 380 extended coverage to newborns (under one year) and by 2002 had increased the eligible beneficiary population to over 30 million.

HIO revenues come from four primary sources. The Social Insurance Organization and the Pensioners Insurance Organization receive contributions as a proportion of employees’ salaries. SHIP receives con-

¹ The Ministry of Defense and the Ministry of Interior also receive a budget to provide health services to their staff, but they are not included in the discussion because of their limited scope.

tributions 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, HIO manages 39 hospitals as well as—

- General practitioner clinics inside and outside factories
- 7,141 school health clinics
- 1,040 specialist clinics or polyclinics
- 51 owned and 49 contracted pharmacies

(MOHP, 2003).

2.1.2 Private Sector

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 MOHP as well as the Ministry of Social Affairs (MOSA).

2.1.3 Professional Syndicates

Professional Syndicates are health care providers financed through an insurance scheme consisting of a percapita fee combined with copayment from beneficiaries. The services they may provide are restricted, and there is an agreed upon ceiling per contract period on the amount they may charge.

2.1.4 Other Bodies Influencing Legislation and Health Policy

Other Bodies Influencing Legislation and Health Policy include many professional associations, as well as a number of independent bodies functioning in advisory or legislative capacities to provide input to, review, and/or approve health policies, including the Committee for Health and Environment of the People's Assembly; the Health, Population, and Environment Committee of the Shura Council; and the Supreme Council for Health.

The People's Assembly, or the Parliament, is an elected body consisting of 444 members (in addition to a maximum of 10 members appointed by the President). It is the legislative body, making laws and approving taxes and international agreements. In addition to its legislative function, it has a supervisory monitoring function. Laws, before going to Parliament in its plenary sessions, are referred for preliminary study to the relevant specific committees. There are currently 22 of these committees. One of these is the Committee for Health and Environment. This committee, consisting solely of members of Parliament, often invites “experts” to its meetings for the purpose of obtaining a more comprehensive view of topics under study. The committee influences health policy plans for the future.

The Shura Council was established constitutionally in 1980 and is mainly a “think tank” to advise the Governmental National Policies. The Shura Council's Health, Population, and Environment Committee examines issues relevant to those areas prior to its discussion in the Shura Council's plenary sessions.

Although it does not have a direct legislative role, laws impacting significantly on government policy are required to be discussed by the Shura Council before being passed to the People's Assembly.

2.2 Organization of the Ministry of Health and Population

MOHP operates through functional structures, with administrative and technical personnel at four levels. These are the central level, governorate level (Health Directorates), health district level, and the health care provider level.

2.2.1 Central-Level Organizational Structure

MOHP was formed through a merger of the former Ministry of Health (established in 1936) and the former Ministry of State for population. The MOHP central organizational structure is headed by the Minister of Health and Population, employing almost 5,000 personnel, including professionals and supporting staff, who are in charge of central functions, such as planning, supervision, and program management.

The MOHP is divided into seven broad functional divisions:

- 1) The Minister's Office Affairs Sector
- 2) The Training and Research Sector
- 3) The Health Care and Nursing Sector
- 4) The Preventive Affairs and Endemic Diseases Sector
- 5) The Curative Health Sector
- 6) The Health Regions Sector
- 7) The Central Department for General Secretariat.

The Central Department for General Secretariat is directly accountable to the Minister of Health and Population.

The seven functional divisions embrace 23 central departments and 73 general departments at the central level. The seven sectoral heads report directly to the Minister of Health and Population. In addition, the central department heads for preventive care, laboratories, primary health care, endemic diseases, curative care, research and development, pharmaceuticals, dentistry, family planning, and nursing report directly to the Minister of Health and Population.

In addition to these functional units, the central organization structure includes certain policymaking, planning, and advisory bodies, such as councils, executive committees, and advisory committees. In general, this central structure includes 103 sectoral, central, and general departmental units integrated under the Minister of Health and Population, who constitutionally is the key policy formulator and decision-maker.

2.2.2 Governorate-Level Organizational Structure

The previously described central organizational level is replicated at the governorate level. The governorate-level health directorates are responsible to the Minister of Health and Population on technical functions, but report to the Governorate Executive Council, headed by the Governor, for day-to-day management of activities throughout the governorate.

Egypt has 26 governorates. There are, however, 27 Health Directorates in operation because Luxor has a separate Health Directorate, despite being administratively part of Qena Governorate.

Each Governorate Health Directorate is headed by an Undersecretary or a Director General called “the Director of Health Affairs,” whose functional grade differs according to governorate size. The Director of Health Affairs supervises the Health District Directors.

2.2.3 District-Level Organizational Structure

The district-level organizational structure is simply a replication of that of the governorate, except that the basic functions are implemented on a smaller scale.

Each of the 235 health districts report to their Governorate Health Directorates. Each district has a Director, who is sometimes also the District Hospital Director, supervising a team of physicians, nurse supervisors, and administrators.

2.2.4 MOHP Service Delivery Structure

MOHP is currently the major provider of primary, preventive, and curative care in Egypt, with more than 3,645 health facilities and 66,440 beds spread nationwide. There are no nationwide formal referral systems in the MOHP delivery system. Rather, there are a number of pilot referral systems, in some districts under various health projects.

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, MOHP is the largest institutional provider of inpatient health care services in Egypt. Hospital services are provided through the following types of facilities:

- Integrated hospitals are small (20 to 60 beds) hospitals providing primary health care and specialized medical services in the rural areas. Integrated hospitals contain well-equipped surgical theaters, x-ray equipment, and laboratories, and they are responsible for serving a catchment population of between 10,000 and 25,000 people.
- District hospitals (100 to 200 beds) provide more specialized medical services and are available in every district. District hospitals are responsible for serving an average catchment population of between 50,000 and 100,000 people in the urban district area. Some districts are significantly larger, covering 300,000 people.
- General hospitals (more than 200 beds) contain all medical specialties. General hospitals are available in every capital of a governorate.
- Integrated, district, and general hospitals were included in the ESPA sample and were categorized as general service hospitals for this report.
- Specialty hospitals are located in urban areas and include such specialties as eye, psychiatric, chest (34), fever (88), heart, ophthalmology (31), tumors, gynecology, and obstetrics. Specialty hospitals are available in all governorates. Fever hospitals are the only type of specialty hospital included in the ESPA sample.

- The private sector has 2,024 inpatient facilities, containing about 22,647 beds. This accounts for approximately 16 percent of the total inpatient bed capacity in Egypt.

2.3 MOHP Public Health Programs

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

2.3.1 Population, Reproductive Health, and Family Planning Programs

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 USAID, UNFPA, and the Social Fund for Development.

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.

2.3.2 Control of Diarrheal Diseases and Acute Respiratory Infection Programs

The Control of Diarrheal Diseases (CDD) program and the Acute Respiratory Infection (ARI) program were components of projects supported by USAID. The CDD program is older by a few years and has its own department in 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 the second leading cause of infant deaths.

2.3.3 Expanded Program on Immunization

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

2.3.4 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 MOHP.

The national program to reduce maternal mortality is overseen and implemented by the Directorate of Maternal and Child Health Care under the Division/Sector of Primary Health Care of MOHP. 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 (MCH) services.

At the national level, the MCH directorate has defined a package of MCH services, which includes basic and comprehensive essential obstetric care (EOC) for normal delivery and management of obstetric complications. Clinical protocols and service standards for 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 transfusion services, and use of facility-generated revenues for local service improvement.

A Women's Health Project was implemented from 1995 to 2001, funded partially by the Social Fund for Development, in cooperation with MOHP. The project objectives were to upgrade maternity services in almost 300 health units in all governorates, training physicians, nurses, and social change agents to improve competencies in the area of maternal and reproductive health. The goal was both to improve technical competencies and to influence the health beliefs and behaviors of the beneficiaries.

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 been upgraded to offer normal delivery care and to improve linkages with referral centers.

2.4 Health Sector Reform Program

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.

In addition to the reform and expansion of social health insurance functions, the Health Sector Reform Program (HSRP) includes the following elements:

- Redefining the role of MOHP to develop regulatory functions, notably to establish quality norms and standards and to establish a mechanism of accreditation and licensure to enforce those standards, and to consolidate the multiple vertical public health programs
- Strengthening the program for training and retaining of family health care physicians, nurses, and allied health professionals; with greater emphasis on preventive health care
- Decentralizing management of the government health delivery system to the governorate and district levels, and introducing greater managerial autonomy at the facility level
- Rationalization of public investment in health infrastructure and health manpower, based on governorate and district health plans, and identifying the actual needs and availability of resources to sustain the investment.

The first phase of the HSRP was developed as a program jointly financed by the Government of Egypt, the World Bank, the European Union, and USAID. In 2000, the African Development Bank joined the financial stakeholders of the program.

Upgrading Health Services I and II as well as Development of Human Resources in the field of Family Medicine are projects that were partially funded by the Social Fund for Development, in cooperation with MOHP in the late 1990s under the umbrella of HSRP.

2.5 Private and Nongovernmental Sector

Private-sector provision of services includes everything from traditional healers and midwives, to 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 (MOSA).

2.5.1 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 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.

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 modern private hospitals. These physicians have the technology, the resources, and the visibility required to run very successful and profitable private practices.

2.5.2 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 (Kempres 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.

2.5.3 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.

2.5.4 Nongovernmental Organizations

NGOs provide many developments, social, and health care services, including reproductive health and family planning services. Reproductive health and family planning services are delivered through the Egyptian Family Planning Association (EFPA), the Clinical Services Improvement (CSI) project, and other NGOs (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 2003 Egypt Interim Demographic and Health Survey, the public sector is providing 56 percent of family planning services in Egypt, and the private sector is providing 44 percent. Classified as private sector, PVOs/NGOs were found to be providing less than 6 percent of family planning services.

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

There is a system of supervision and monitoring based on regular followup 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.