The road to recovery: Egypt’s healthcare reform

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SUMMARY

As many industrial and third-world countries recover from the severe economic crisis of a global recession, they continue to struggle with its negative effect on their healthcare systems. Healthcare reform has become a leading policy agenda item for most countries. This is especially true for countries in the developing world who are struggling to allocate very limited resources to meet the growing health needs of their residents and the expectations of global health. In the late 1990s, the Egyptian government, in conjunction with the United States Agency for International Development, initiated a Health Sector Reform Program (HSRP) to completely reform the way healthcare was financed, organized and delivered with the intent to extend healthcare coverage to all of its citizens. Although some successes have resulted from the HSRP, Egypt’s new government leaders will need to be informed on policies that may more effectively improve the health of the Egyptian population. Copyright © 2011 John Wiley & Sons, Ltd.

KEY WORDS: Egypt; Family Health Funds; healthcare reform; Health Insurance Organization; Health Sector Reform Program

INTRODUCTION

The wealth of a nation lies within the health of its people. In order for citizens of any country to lead healthier lives, access to a basic standard of healthcare is necessary. However, for many countries, especially those in the developing world, healthcare is often characterized by inadequate financing and barriers to care. International organizations led by the World Bank have encouraged these countries to undertake health sector reforms. Such reforms typically focus on improving the financial strength and assuring the equity of healthcare delivery in third-world countries through the development of policies that target the quality and efficiency of their healthcare systems (Hardee and Smith, 2000).

For some countries, such as Uruguay and Uganda, reform resulted in the development of national healthcare packages that provide for a level of healthcare services that have been determined as “necessary” (Ensor et al., 2002). These packages, called essential services packages (ESP), are funded by the government and aimed at providing an integrated set of basic medical services to the population.

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In Bangladesh, for example, under the Health and Population Sector Program (HPSP) of 1998, an ESP was created that included maternal health, family planning, management and prevention of sexually transmitted diseases and human immunodeficiency virus/acquired immune deficiency syndrome, adolescent and child health and the treatment of certain communicable diseases (Hardee and Smith, 2000, pp. 10).

Egypt is a third-world tourism destination with a population estimated at 81 million people. However, with such a large resident population and an economy that is dependent on tourism dollars, Egypt’s spending on healthcare is notably low with only 3.7% of the GDP ascribed to healthcare (World Bank, 2010). Of this percentage, approximately 57% was attributed to private providers and only 43% to the public healthcare system in 2004 (Fouad, 2005). In addition, approximately half of Egypt’s public health facilities are experiencing significant shortages of medical equipment and primary care clinicians (Nandakumar et al., 1999). These shortages are of particular concern considering Egypt’s lower average life expectancy of 59 years and high prevalence of infectious diseases, such as schistosomiasis, hepatitis C, trachoma, acute diarrhea and respiratory infections (WHO, 2004). Furthermore, there are no health insurance schemes available to the economically disadvantaged or for those who are not in formal or organized occupations (United Nations, 2009). Therefore, the Egyptian government began developing healthcare reform policies with the premise of providing and financing a basic level of health care services for its population.

As the world transitions toward a more global economy, there is an essential need for countries to review their healthcare policies to meet global expectations (Haley et al., 2010). It is of particular global importance and concern to understand the health policy of countries that are considered tourist destinations, such as Egypt. Unfortunately, there is a significant gap in literature regarding Egypt’s healthcare system and its movement toward healthcare reform.

As the country experiences government and political change, it is critical to evaluate existing policies and to identify additional policies to inform Egypt’s new leaders on how they may improve the financing and access of healthcare to its resident and tourist populations. This paper explores the development of healthcare reform in Egypt and provides important insight into implications of reform. Public policy focusing on the financing, delivery and access to healthcare services will be explored and may be used to inform and guide Egypt’s new leaders.

HEALTHCARE FINANCING AND DELIVERY

The Egyptian healthcare system may best be described as multifaceted and disjointed as a result of the various levels of government agencies and private organizations that comprise this system of care. Healthcare providers in the government sector are the Ministry of Health and Population (MOHP), teaching and university hospitals, Health Insurance Organization (HIO) and the Ministries of Interior and Defense (Gericke, 2004). Egypt’s MOHP is currently the primary provider of preventive and curative care, composed of approximately 5000 health
facilities and more than 80,000 beds nationwide (Ministry of Health and Population et al., 2005).

The HIO is a governmental social insurance organization supervised by the MOHP. It was created in 1964 to provide compulsory health insurance to businesses for its employees. In 1992, the HIO was expanded to include widows, pensioners and school children under the Student Health Insurance Program (SHIP). Payroll and cigarette taxes levied by the government are the main source of financing of healthcare services provided through a network of HIO hospitals, clinics, pharmacies and contracted private-sector providers. The HIO is divided into eight regional branches with the head office located in the capital city of Cairo (Abd El Fattah et al., 1997). At present, it is the largest health insurer in Egypt with a total of 30 million enrolled members (El-Saharty, 2004).

Egypt’s private healthcare sector consists of both non-profit and for-profit providers, such as private clinics, hospitals, pharmacies, mosques and churches (Haley et al., 2010; Hein and Kohlmorgen, 2003). However, statistics on the delivery of care within Egypt’s private sector are generally more difficult to quantify because the financing of private health services occurs as out-of-pocket payments by the patient and on a fee-for-service basis to the provider for both ambulatory and inpatient care (Haley et al., 2010, pp. 9). Best estimates indicate that the private sector is composed of approximately 2024 inpatient facilities with an estimated 22,647 beds. These private, physician-owned and managed facilities represent a sizable 16% of Egypt’s total inpatient bed capacity (Ministry of Health and Population et al., 2005, pp. 18). This growing sector is having a significant impact on Egypt’s government healthcare system. For example, despite an extensive network, MOHP facilities are often under-utilized with over 60% of all primary care visits taking place in private sector facilities. This is because private sector facilities often rate much higher in terms of quality, clinical effectiveness and consumer satisfaction, relative to MOHP facilities (El-Saharty, 2004, pp. 4). On the other hand, government-sponsored healthcare facilities, particularly those in non-urban areas, often lack the resources and training needed to effectively provide healthcare services. Furthermore, provider salaries are much lower within the government sector with the majority of physicians supplementing their MOHP salary with a private practice (Gericke, 2004, pp. 18). This type of bifurcated system of care has been shown to negatively impact the delivery of care as it can encourage providers to practice lower quality care in the public setting to gain referrals to their private healthcare practice. Moreover, this system can potentially increase absenteeism and corruption, further depreciating the quality of healthcare (Berman and Cuizon, 2004).

Although healthcare in Egypt’s urban areas is readily accessible and relatively modern, it is far less developed in lower-income areas and rural regions (El Hadidi, 2004). Most rural villages lack basic services such as healthcare centers, family planning units, governmental hospitals and ambulance centers as these are primarily concentrated in metropolitan areas (Handoussa, 2008). For example, approximately 90% of large inpatient facilities were found in urban areas with urban residents receiving approximately 81% of total physician working hours, although they account for only 44% of the total population (McEuen, 1997). Whereas urban

regions have access to all areas of specialization, rural populations have very few specialists. There are no cardiologists, ophthalmologists or orthopedists in rural Lower Egypt, whereas in rural Upper Egypt, there are no neurologists, dermatologists or psychiatrists (Nandakumar et al., 1999, pp. 48). General practice is the only specialty where there are more physicians in rural Egypt than in urban Egypt, but many have insufficient experience or qualifications (Nandakumar et al., 1999; Serag et al., 2007).

THE HEALTH SECTOR REFORM PROGRAM

During the 1970s and 1980s, Egypt’s health status measures indicated a significant need for improvement. The under-five and infant mortality rates stood at approximately 235 and 157 deaths per 1000 live births, respectively, whereas life expectancy was at 52 years (Okail, 2003). With the recognition that these population health measures were low, the institution of a new health minister, the availability of a significant amount of foreign aid and the relatively stable political environment created a window of opportunity in the late 1990s for health sector change. This resulted in the formulation and launch of the Health Sector Reform Program (HSRP) in 1997 (WHO, 2006). The underlying aim of the HSRP was to address the aforementioned inefficiencies in Egyptian healthcare and completely transform the way it was financed, organized and delivered.

As a result, the following six levels of reform were proposed by the MOHP (McEuen, 1997):

• Reducing the percentage of the government budget allocated to financing curative care and increasing the resources available for preventive and primary healthcare (PHC). The implementation of this reform would halt the construction of unnecessary hospitals and transfer existing MOHP hospitals to organizations such as the HIO.
• Expanding the role of the MOHP in providing and financing primary healthcare services, creating incentives to attract healthcare professionals to specialize in PHC and family medicine, increasing resources in maternal and child health programs and conducting cost-effectiveness analyses to help formulate a viable ESP (called a basic benefits package or BBP).
• Restructuring the MOHP staff policies, including ending guaranteed employment for all medical school graduates, decreasing the total number of staff, allocating staff on a needs basis and creating incentives to attract staff to work in underserved and remote areas.
• Increasing the MOHP capacity for national health needs assessment, sectoral strategic planning and policy development. In addition, for better planning and policy decision making, the national health information system would be upgraded.
• Establishing policies for continuing medical education and licensing of physicians and enhancing the role of the MOHP in regulation, accreditation and quality assurance by creating national health standards of practice and health facility accreditation.
Transforming the role of the HIO into a purely financing organization and expanding the social health insurance coverage.

This program was funded jointly by the United States Agency for International Development (USAID), the World Bank, the European Union, the African Development Bank, and the Austrian government (WHO, 2006). The HSRP hoped to bring about overall improvement in the health status of the population, i.e., reducing the infant, under-five, maternal mortality and population growth rates and the burden of infectious disease, by focusing on primary healthcare.

IMPLEMENTATION OF THE HEALTH SECTOR REFORM PROGRAM

Health Sector Reform Program is based on a social insurance model that attempts to integrate the fragmented financing structure of Egypt’s government healthcare sector into a single National Health Insurance Fund (NHIF). Governorate-level divisions of the NHIF called Family Health Funds (FHF) were developed to separate financing from provision. The FHF established contracts with the government and public and private/NGO providers with the intent of delivering a basic benefit plan to registered beneficiaries. The FHF were created to act as insurance agencies that would collect health insurance funds from the beneficiaries, the individuals insured by the HIO and the MOHP for the needy and uninsured. Thus, the FHF was organized to model a single-payer approach and remedy the fragmentation in financing (El-Saharty, 2004, pp. 9). It was envisioned that the NHIF would evolve from, and eventually have accountability for, the financing and purchasing functions of the HIO (El-Saharty, 2004, pp. vi).

In the first phase, pilot projects were initiated for the implementation of the HSRP. Egypt is divided into 26 governorates plus the city of Luxor. The four urban governorates (Cairo, Alexandria, Port Said and Suez) have no rural areas. Each of the remaining 22 governorates is characterized with urban and rural areas. Nine of these governorates are located in the Nile Delta (Lower Egypt), and 8 are located in the Nile Valley (Upper Egypt). The governorates are divided into 230 districts with a district town, sub-districts and villages (Henawy, 2000). Pilot phases of the HSRP were conducted in 1999 in the three governorates of Alexandria, Menoufia and Sohag. During this phase, primary healthcare facilities were upgraded, new management systems implemented, and family health staff trained in the Family Health Model. The Family Health Model is a holistic approach that aims to provide a basic primary care package to members of a family irrespective of age. Family Health Units (FHU) were developed as basic primary care units in all districts to provide general outpatient services as specified in the BBP. The FHUs were staffed by family physicians, several nurses, paramedics and administrative staff (Berman et al., 1997).

Additionally, facility directors were given basic training in accounting, human resource management, continuous quality improvement and managing medical records. In May 1999, the first MOHP pilot site at Seuf in Alexandria began receiving patients. By November 2003, the HSR Pilot Project had a total of 66
operating FHU — 16 in Alexandria, 25 in Menoufia and 25 in Sohag. As of 2008, 643 FHUs have been setup, and this number is expected to have increased to 2500 by the end of 2010. According to estimates provided by the MOHP, approximately 2.5 billion Egyptian Pounds will be spent to expand the HSRP in all 26 governorates (Abdel-Rahman, 2009).

Egypt is also in the process of implementing a BBP and expanding health insurance to cover all Egyptians regardless of their financial status. The content of the BBP has been the result of several discussions held at the national level in Cairo and the governorate level in Alexandria. These discussions involved key MOHP staff, including representatives of the Technical Support Office, the Primary Healthcare and the Maternal/Child Health Directorates, Program Managers, members of the Quality Improvement unit, as well as technical staff from the World Bank and the European Union (Nandakumar et al., 1998). As of October of 2009, the Minister of Health, Hatam El-Gabaly, has already put BBP into implementation in Suez, and around 12,000 people have enrolled for experimental coverage. This service is expected to be expanded to provide coverage in Sohag in 2010 and Alexandria in 2011 (May, 2009).

It is important to note that the HSRP was an initiative undertaken by the MOHP under the government of then President Hosni Mubarak. However, in January of 2011, protests in several Egyptian cities ultimately resulted in the end of the 30-year rule of President Mubarak. Although his eviction was welcomed by the people of Egypt, the protests had severe economic repercussions. Tourism, the heart of Egypt’s economy, has suffered tremendously as tourists were evacuated from the region, and many banks, stores and factories were closed (Karlsson, 2011). The current political instability is expected to have long-lasting and negative effects on Egypt’s economy, particularly on the medical tourism market. It is anticipated that tourists will choose to avoid Egypt for an indefinite period of time, which will further exacerbate the condition of Egypt’s economy. Studies have shown that civil warfare and unrest produce long-term damage to public health and medical systems that extend well beyond the period of active unrest (Ghobarah, 2004). It is highly probable that the protests will negatively impact the amount of resources available for healthcare. Although it is currently uncertain what effect the ousting of President Mubarak will have on governmental programs that were being implemented under his rule, it is safe to assume that the instability in the region will be an added setback to the implementation of the HSRP that was underway in Egypt.

POLICY IMPLICATIONS OF HEALTHCARE REFORM

Some components of the HSRP program have resulted in positive healthcare outcomes for the residents of Egypt. For example, health status indicators have improved significantly, and Egypt’s health profile is now increasingly similar to that of some developed countries. According to MOHP estimates, in 2006 the under-five mortality rate was 25 deaths per 1000 live births, indicating an 89% decrease since 1970 (El-Gabaly, 2007). This comes as a direct result of initiatives undertaken under the HSRP that include the implementation of policy resulting in improvements in
the quality of clinics and hospital obstetrics wards, the introduction of training programs for medical professionals and the institution of FHU.

Furthermore, since 2006 three healthcare reform conferences and training programs for hospital managers have been conducted. Hospital managers have been sent to MBA programs in the USA with funding provided by USAID. Additional healthcare management training for MOHP personnel is being developed in conjunction with faculty from prominent American universities (El-Gabaly, 2007). The FHUs have been credited with improving the health of the population. These entities offer integrated services under one roof for the entire family requiring less time and transportation and offering better quality. Studies have found that both physicians and patients have been very satisfied with the continuity of care provided and the unified medical record (WHO, 2006, pp. 103). The implementation of policies that improve financing, access and resources for healthcare improves not only the delivery and integration of care for the Egyptian population but also the care provided to those who visit this country and creates new opportunities to provide healthcare services to a global market (Haley et al., 2010, pp. 8–10).

Although Egypt’s healthcare reform efforts have had some success, policies should also be considered that address the financing needed to more effectively implement the HSRP. The FHFIs have been faced with legal hurdles because of laws prohibiting any agency outside of the HIO from collecting premiums or capitated payments from individuals or families. In 1999, FHFIs were established in the pilot governorates by the MOHP by the Ministerial Decree 294. However, the costs of providing services and the payments made by patients go directly from the MOHP or HIO to the provider, completely bypassing the FHFIs and failing to achieve the envisioned “single-payer” model. In 2003, the Ministerial Decree 147 was passed to allow the FHFIs to collect fees and copayments from enrolled members. Although not fully implemented, even this decree is not expected to bring about substantial improvement or remedy to the financial instability of the FHFIs since the cost of providing services far exceeds the revenues generated from patient fees. Moreover, only a small portion of payments made by beneficiaries is actually used to cover the administrative costs of the FHUs (WHO, 2006, pp. 104).

CONCLUSION

The reform of Egypt’s healthcare sector is an evolving process that requires a significant investment of time, public policy, financial and human resources. Egypt’s Health Sector Reform Program began in 1997 and was expected to reach completion by 2015 under former President Hosni Mubarak (WHO, 2006, pp. 106). Thus far, the HSRP has resulted in what may be considered significant improvements in both the health of the Egyptian people and its healthcare infrastructure. However, as a result of the country’s recent political unrest, it is anticipated that Egypt’s health sector reform will be negatively impacted.

It is imperative for Egypt’s new government to plan for and invest in improving the health of its citizens. Moreover, additional public policy must be considered to overcome the persistent challenges that will continue to result in Egypt's
increasingly bifurcated public and private healthcare systems. Policies that address physician salaries and the establishment of appropriate funding levels of healthcare services should also be considered. Policies must also be established that prevent the shift of limited resources from the public healthcare system to fund a private system that often caters to a wealthier population and encourage the redistribution of resources for all to realize the potential benefits of international standards, technology and revenue.

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REFERENCES


May T. El-Gabaly talks healthcare at economic forum.
thedailynewsegyp.com [accessed on 10 July 2010].
Reform Strategies in Egypt: a Summary of PHR
www.abtassociates.com/reports/19978744914991.pdf
[accessed on 21 November 2009].
Ministry of Health and Population, El-Zanaty Associates,
ORC Macro. 2005. Egypt Service Provision Assessment
and ORC Macro, Calverton, Maryland, USA.
Costing the Basic Benefits Package in Egypt.
Technical Report 32, Partnerships for Health Reform
Project, Abt Associates Inc., Bethesda, MD.
Nandakumar AK, Berman P, Fleming E. 1999. Findings
of the Egyptian Healthcare Provider Survey. Technical
Report 26. Partnerships for Health Reform Project,
Abt Associates Inc., Bethesda, MD.
Okail N. 2003. A Socio-economic Profile of Egypt:
Healthcare (1980–2002). PEMA Study No. 5. Center for
www.pema.gov.eg/FileUpload/Publication/Files/110.pdf
[accessed on 13 May 2010].
Voices from Urban Settings in Egypt: a Report to the
Knowledge Network on Urban Settings. WHO Com-
who.or.jp/knusp/Voices_from_Urban_Settings_in_Egypt.pdf
[accessed on 24 September 2009].
United Nations. 2009. Egypt National Human Devel-
Program. http://www.undp.org/LinkClick.aspx?
fileticket=EQRvEElk7EY%3D&tabid=187&muid=675
[accessed on 30 September 2009].
WHO. 2006. Health systems profile — Egypt. World
Health Organization, Regional Health Systems Ob-
servatory. http://gis.emro.who.int/HealthSystemObserv-
atory/PDF/Egypt/Full%20Profile.pdf [accessed on
20 September 2009].
data.worldbank.org/datacatalog/world-development
indicators?cid=GPD_WDI [accessed on 13 May 2010].