BJÖRN BENTLAGE

THE EGYPTIAN HEALTH CARE SYSTEM.

STRUCTURES AND REFORM.

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The Egyptian Health Care System

Structures and Reform

by
Björn Bentlage

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Abbreviations

CAOA	Central Agency for Organization and Administration
EU	European Union
FCM	Family Care Model
FGM	Female Genital Mutilation
FHF	Family Health Fund
FHM	Family Health Model
FHU	Family Health Unit
GDP	Gross Domestic Product
HIO	Health Insurance Organization
HSRP	Health Sector Reform Program
IPR	Intellectual Property Rights
L.E.	Livre égyptienne (Egyptian Pound)
MENA	Middle East and North Africa
MOF	Ministry of Finance
MOFP	Ministry of Family and Population
MOH	Ministry of Health (and Population)
MP	Member of Parliament
NDP	National Democratic Party
NGO	Non-Governmental Organization
THE	Total Health Expenditure
TRIPs	Trade Related Aspects of Intellectual Property
UN	United Nations
USAID	United States Agency for International Development
WHO	World Health Organization

Introduction

This text was prepared for print shortly before the dramatic events in Egypt of January and February 2011 that I hope will develop in a peaceful way that nevertheless leads to a brighter future without any further detours.

In this publication, I want to give an overview of and an introduction to the Egyptian health care system with a focus on its institutional and economical setup. My main purpose is to facilitate future research on current developments in Egypt, for which, I think, the health care sector is one of several influential domains to consider. However, health care is often overlooked, both as a topic in its own right and as a factor in broader developments. If this was partly because the health care sector in Egypt is heterogeneous and maybe even confusing with regard to its organization, then I hope that this text makes it somewhat easier to recognize and include health care in future works on Egypt. In other words, this text is meant as a starting point for other researchers and wants to promote their interest into the cross-section of Egyptian economic, social, and political life that is the Egyptian health care sector.

The setup of this paper was influenced by existing descriptions of the health care sector and the reform program.[1] The first chapter outlines the existing structures and includes subchapters on the provision of service, funding mechanisms, an extra chapter on the pharmaceutical sector, problems in health care and the public perception; it thus largely follows the macro level perspective of the *Regional Health System Observatory* 2006. The second chapter describes the ongoing reforms in the health sector, including subchapters on the main goals of reform, the actual developments and components of the reform as they unfolded since the 1990s, and a special subchapter on the associated legislative processes. In the third and last chapter, I mean to provide a somewhat wider context by discussing the situation of doctors and by relating health care re-

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[1] Most notably: Gaumer/Rafeh 2005-10; Gericke 2005; wizārat al-ṣiḥḥa wa-l-sukkān 2005-04; *Regional Health System Observatory* 2006.

form to a framework of large-scale state-policies, i.e. Egypt's Five-Year-Plans for Investment.

In accord with its purpose, the representation of the health sector in this paper aims to be compatible with various interests and angles. And due to its way of production, it is largely an assembly and rearrangement of information already published in journals, books and Egyptian newspapers.[2] The predominant theme in most texts utilized was Egypt's Health Sector Reform Program, which, seen as a narrative, is a story of problems and corresponding solutions. Since this paper is based on texts employing this theme, the paper itself must be expected to replicate it to some extent and reinforce the logic of it. I try to counter this bias somewhat in chapter three.

And although I do rely heavily on existing research, I also introduce details and topics not found in the literature so far (take for example the description of the modes of public funding in subchapters "Treatment on the State's Expense", p. 29 and "Free Treatment", p. 32, or the description of the legislative process — "Legislation", p. 53 — and the doctors' endeavor to press for better income, see "Doctors", p. 70).

The idea for this paper originated within a research project on bioethical issues in Islam at the Ruhr-University of Bochum.[3] I had joined the project as a research assistant just as it entered the final year of its funding period. Thomas Eich, who had been conducting fabulous research working in this project for years, had just moved on to the University of Tübingen (and is now Professor for Islamic Studies in Hamburg). He gave me the idea of looking into health care reform in Egypt. An initial research showed that it could be useful to carry on with the task of grasping the health care sector's organization for the reasons named above.

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[2] Another side effect of this approach is, that stylistically the paper appears less as a truly cohesive text than as a construction of topics, each of which is dealt with and presented in its own way, for example the part on funding health care with a perspective on macro-level structures as opposed to the subchapter on the public perception with an interest for stereotypical and less tangible notions, as compared to the subchapters on doctors, that highlights a political contestation.

[3] See < http://dbs-lin.ruhr-uni-bochum.de/bioethik/ >.

The research for this paper was mostly text-based and almost all sources that I used are easily available via libraries or the internet. They can be roughly divided into four groups. First, there are a few descriptions and analyses of the Egyptian health care system. Most of them are funded by NGOs, government agencies, or international organizations who engage in reforming the system. Exceptions are the papers by Christian Gericke, who writes with an academic interest in health policies. Second, there are some anthropological studies, which focus on how people make use of the health care system and how their lives are afflicted by it. Often, these studies focus on singular issues like abortion, contraception, or traditional medicine. And third, there are newspaper articles. They offer a true wealth of information, and although scattered into little bits, it is very much worth to piece them together. In my research, the most important additions to and modifications of the existent descriptions were mostly based on information gathered from newspapers.

Apart from textual sources, I also went on a (too) short research trip to Cairo and Suez in April 2009. Although the trip's timing was rendered inappropriate when the presentation of the new health insurance draft law was once again postponed, I was able to conduct a series of informative conversations in Cairo and Suez. I'd like to thank the Konrad-Adenauer-Foundation's and the Friedrich-Ebert-Foundation's offices in Cairo for their help, just as I'd like to express my gratitude to the Egyptian Doctors' Syndicate and its head Dr. Ḥamdī al-Sayyid for receiving me, and Professor Gamal Serour of the Al-Azhar University's International Islamic Center For Population Studies and Research for his generous and patient reception as well as a frank and informative conversation.

In general, I want to thank Thomas Eich for guiding and promoting me, just as I am thankful to Gerhard Endreß and Stefan Reichmuth for their support. Finally, I want to thank Professor Ute Pietruschka and I thank Professor Jürgen Tubach (Martin-Luther-University Halle-Wittenberg) for accepting this text into the "Hallesche Beiträge zur Orientwissenschaft" and for Daniel Haas for his indispensable help and tireless accuracy during the final redaction of the text.

Transliteration was originally made according to the standards of the "Deutsche Morgendländische Gesellschaft" and later adapted to the American-English convention. Slight corruptions between both quasi-standards are therefore possible. Many of the sources used in this study were found online; unfortunately, a good share of those is not available anymore. I have tried to provide all the information necessary to access the sources I used (links, retrieval dates, new links where identifiable), but where these attempts fail, I am happy to provide access to my local copies of the sites and pages that I used.

1 Current System

Egypt, with a population of roughly 80 million, has a large and rather complex health care sector with a vast infrastructure and a high number of employees. In 2007, there were 1,878 hospitals, about 200,000 doctors and an overall staff of more than 400,000 doctors, nurses, midwives etc. (al-jihāz al-markazī 2009; *al-dustūr* 2009-07-22; *Regional Health System Observatory* 2006, p. 47). Over 90% of the population live within 5 km of a health care facility (el-Henawy 2000), and the ratio of doctors to population is about 2 per 1,000, as compared to 1.4 per 1,000 in the United Kingdom (Gericke 2005, p. 1081; *Al-Ahram Weekly* 2001-04-05, p. 4). However, these numbers tell us nothing about how the system functions, about actual availability of health care to citizens, let alone the quality of services or how people interact with and utilize the system. To get a better understanding of these aspects, I'll describe Egypt's health care system from various angles throughout this first chapter. The first two subchapters deal with the fundamental functions of providing and funding services, followed by a subchapter on the pharmaceutical sector that figures as an independent yet related subsystem and demands exclusive consideration. The fourth and fifth subchapters fall out of line a bit, as they are not describing structures as much as perceptions; nevertheless they are quite essential, I feel, in order to understand the impetus of health care reform in Egypt that is described in chapter two.

1.1 Service Providers

The Egyptian health care system is quite heterogeneous, consisting of a government sector, a public and a private sector. The government sector is made up of the Ministry of Health and Population (MOH),[4] the Ministry of Higher Education and Scientific Research

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[4] Since March 2009, the official designation has changed to Ministry of Health (MOH), due to reorganization, when responsibility for population issues had been transferred to the reintroduced Ministry of Family and Population (MOFP) (*al-maṣrī l-yawm* 2009-03-12a; *al-maṣrī l-yawm* 2009-03-12b). From here on, I will

— responsible for teaching and university hospitals — and some other ministries delivering health care services to their staff. The public sector[5] comprises organizations owned by the government but financially autonomous such as the Health Insurance Organization (HIO) or the Curative Care Organization. The private sector is made up of non-profit as well as profit oriented actors: syndicates and unions, NGOs, private clinics and hospitals. In the last decade or two, clinics associated with mosques became quite popular, many of them funded by the outlawed Muslim Brotherhood (Gericke 2005, p. 1074f.; *Al-Ahram Weekly* 2001-04-05; wizārat al-ṣiḥḥa wa-l-sukkān 2005-04, p. 13f.; *Al-Ahram Weekly* 2007-09-06).

1.1.1 The MOH

The main provider of primary, preventive, and curative health care services in Egypt is the Ministry of Health, which owns and runs its own facilities and has been continuously expanding its vast network over the last years. The number of MOH-hospitals increased from about 570 in 2000 to 1,021 in 2007, which makes up for over 55% of all government hospitals (el-Henawy 2000; al-jihāz al-markazī 2009). A health system profile report published in 2006 spoke of 4,506 medical facilities altogether (*Regional Health System Observatory* 2006b:, p. 18), compared to the 3,645 reported in a newspaper article in the year 2000 (el-Henawy 2000).

The MOH tries to offer all kinds of medical services. Because of that, its network comprises quite diverse units:

> MOH-facilities may be classified according to structure (health units, *waḥda, waḥdāt ṣiḥḥiyya*; health centers, *markaz ṣiḥḥī, marākiz ṣiḥḥiyya*; hospitals, *mustashfā, mustasfayāt*), their function (e.g. maternal and child health centers, *markaz, marākiz riʿāyat*

use the designation MOH indiscriminately.

For a full list of Egypt's current 33 ministries, including the cabinet headed by the Prime Minister, see "dalīl al-wizārāt" 2009.

[5] While the government sector is directly controlled by the responsible ministries and entirely funded through the Ministry of Finance, the public sector is governed by different laws and regulations and has independent budgets with more diversified resources. Still, decisions in this formally autonomous sector are heavily influenced and controlled by state politics (wizārat al-ṣiḥḥa wa-l-sukkān 2005-04, p. 13f.).

> *umūma wa-ṭufūla*), or programs (e.g. immunization or the fight against diarrheic diseases).
>
> (wizārat al-ṣiḥḥa wa-l-sukkān 2005-04, p. 17)

Another distinction concerning health units and health centers that is often made — and not only in the press but also in government statistics — is between urban (*ḥaḍarī*) and rural (*rīfī*) (el-Henawy 2000). Hospitals on the other hand are subdivided into the categories of:

> – integrated hospitals (*mustashfayāt al-takāmul*), which are smaller hospitals with 20–60 beds that offer primary and secondary services in rural areas. Integrated hospitals have fully equipped operating rooms, X-rays, and laboratories. They offer their services to a population of 10,000 to 25,000.
>
> – district general hospitals (*mustashfayāt markaziyya*) with 100–200 beds and which offer more specialized treatment and are found in each center of an administrative district. This kind of hospital is responsible for the provision of health care to 50,000–100,000 people in rural centers, some of which are clearly bigger and cover up to 300,000 people.
>
> – general hospitals (*mustashfayāt ʿāmma*) have more than 200 beds, offer all medical specializations and are found in the capital of each governorate. [...]
>
> – specialized hospitals (*mustashfayāt takhaṣṣuṣiyya*) are found in rural areas and offer all kinds of specializations, like [specialists for] eyes, mental illnesses, the chest, fevers, the heart, tumors, gynecology and child birth. Specialized hospitals are found throughout all governorates. [...]
>
> (wizārat al-ṣiḥḥa wa-l-sukkān 2005-04, p. 17)

Besides the provision of health care, the MOH has a limited role in funding (see sections "Treatment on the State's Expense", p. 29 and "Free Treatment", p. 32), it is responsible for the licensing of facilities and drugs, and it exerts some control over the semi-independent institutions adhering to it, like the Health Insurance Organization (see subchapter "The HIO", p. 11) and the Curative Care Organization (see subchapter "Other Public and Governmental Providers", p. 17). However, most of all, it has an administrative and regulatory function for the entire health sector, governmental, public, and private (see section "Redefining Regulations", p. 38). It controls and enforces legal standards and guidelines and is often delegated by

legislation the task of setting their details through ministerial decrees.

Just one example would be the law 2004/157 on medical facilities (amending 1981/151), that prescribed additional and modernized technical equipment for all medical facilities, independent of whether they were big hospitals or smaller clinics offering basic health care services only. It is up to the ministry to control and enforce this regulation and possibly even close facilities that fail to meet the standards. But also, the MOH was delegated by law 2006/141 the decision on whether to extend the transition period of five years after it ends in 2011, that is to say that it is to some extent setting legal norms as well (*al-maṣrī l-yawm* 2009-07-20; *al-maṣrī l-yawm* 2009-07-27).[6]

To cope with its multiple responsibilities, the MOH today has a functionally and regionally differentiated organization. On the central level, there are altogether nine offices:[7]

1. The Office for the Affairs of the Minister's Office (*qiṭāʿ shuʾūn maktab al-wazīr*)
2. The Central Department for the General Secretariat (*al-idāra al-markaziyya li-l-amāna al-ʿāmma*)
3. The Health Regions Office (*qiṭāʿ shuʾūn al-aqālīm al-ṣiḥḥiyya*)
4. The Training and Research Office (*qiṭāʿ al-tadrīb wa-l-buḥūth*)
5. The Family Planning Office (*qiṭāʿ tanẓīm al-usra*)
6. The Health Care and Nursing Office (*qiṭāʿ al-riʿāya al-ṣiḥḥiyya wa-l-tamrīḍ*)

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[6] Another example for a ministerial decree (*qarār wizārī*) is the decree 2002/167, in which the MOH sets conditions for the licensing of private hospitals and clinics for renal dialysis, namely that the building be separated and independent from any residential building and that it have a separate entrance (wizārat al-ṣiḥḥa wa-l-sukkān 2002-06-13).

[7] With the following list, I follow the organizational structure as described in the MOH's own chart (wizārat al-ṣiḥḥa wa-l-sukkān 2009). Translation of the Arabic terms follows *Regional Health System Observatory* 2006b, p. 17f., except for *qiṭāʿ*, which I render as "office" instead of "sector". Also, I am not following on the differentiation between functional and other divisions (see *Regional Health System Observatory* 2006b, p. 17f. and wizārat al-ṣiḥḥa wa-l-sukkān 2005-04, p. 15f.) because, quite frankly, it did not add up to a proper designation of all nine central structures. See also WHO EMRO 2008.

7. The Preventive Affairs and Endemic Diseases Office (*qiṭāʿ al-shuʾūn al-waqāʾīyya wa-l-amrāḍ al-mutawaṭṭina al-ṣiḥḥiyya*)
8. The Curative Health Office (*qiṭāʿ al-riʿāya al-ʿilājiyya*)
9. The Office for Technical Support and Projects (*qiṭāʿ al-fannī wa-daʿm al-mashrūʿāt*)

On the next level, that is in the governorates, the structural division of the central administration is mirrored in the Health Directorates (*al-mūdiriyya, al-mūdiriyyāt al-ṣiḥḥiyya*), which are headed by the Health District Directors (*mudīr, mudarāʾ al-shuʾūn al-ṣiḥḥiyya*) who are undersecretaries (*wakīl, wukalāʾ*) of the Minister of Health. For all daily and administrative purposes, the Health Directorates report to an office of the Governor (*al-muḥāfiẓ, al-muḥāfiẓūn*); it is only with professional issues (*umūr fanniyya*), that they adhere to the MOH.[8]

The next level below the Health Directorates is that of the Health Districts:

> Reporting to the governorate health directorates are 255 health districts [*al-idārāt al-ṣiḥḥiyya*]. Each district has a director [*mudīr*] who is sometimes also the District Hospital Director [*mudīr al-mustashfā l-markazī*] (seconded to take over both jobs). The health districts (and to some extent the health directorate) work, in theory, according to the organizational structure and staffing patterns authorized by the CAOA.[9] However, in reality, there is a great degree of variability in these structures and patterns.
>
> (*Regional Health System Observatory* 2006, p. 18; additions in square brackets are taken and transliterated from wizārat al-ṣiḥḥa wa-l-sukkān 2005-04, p. 16)

The last and lowest organizational level is that of the in-house administrations of MOH-facilities (wizārat al-ṣiḥḥa wa-l-sukkān: 2005-04, p. 17).

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[8] This paragraph sticks closely to *Regional Health System Observatory* 2006b, p. 17f. and wizārat al-ṣiḥḥa wa-l-sukkān 2005-04, p. 15f., the former, at least in this section, being an English translation of the latter. Since I wanted to include not only the transcriptions of Arabic terms but also to rearrange some sentences, I preferred not to make this a formal quotation.

[9] That's the Central Agency for Organization and Administration, an authority independent of the MOH (*Regional Health System Observatory* 2006, p. 46).

1.1.2 The HIO

A second large provider of health care services is the Health Insurance Organization (*hayʾat al-taʾmīn al-ṣiḥḥī*). Although technically a branch of the MOH, the HIO has its own independent budget and is therefore reckoned a public non-profit organization rather than part of the government sector (see subchapter "Service Providers", p. 11). The designation "insurance organization" is somewhat misleading, because in addition to administrating the public health insurance scheme (see subchapter "Health Insurance", p. 24), it has been an integral part of the organization's purpose and role description to establish and manage a network of facilities ever since it was founded in 1964 by presidential decree No. 1209: the HIO is to ensure a reasonable access to medical services and medication by founding, operating, or contracting hospitals, clinics, and pharmacies, integrating all elements of health care and working towards a distribution that levels geographic constrains of access to these services and goods (wizārat al-ṣiḥḥa wa-l-sukkān 2007-04). Today the HIO runs about 40 hospitals, 600 specialized or polyclinics, 800 general practitioner clinics, over 7,000 school clinics and some pharmacies (al-jihāz al-markazī 2009; *Daily News Egypt* 2008-10-18; wizārat al-ṣiḥḥa wa-l-sukkān 2005-04, p. 14f.; *Regional Health System Observatory* 2006, p. 36).[10]

Its role as a main provider of services still reflects in the HIO's organizational setup and staffing where the service delivery structure dominates over the branches responsible for management and referral, although recent developments (see subchapter "Health Insurance", p. 24) have led to the organization's contracting function gaining importance (*Regional Health System Observatory* 2006, p. 35f.).[11]

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[10] Figures for the number of HIO-pharmacies are unsure: it's either 500 pharmacies (*Daily News Egypt* 2008-10-18) or just about 50 (wizārat al-ṣiḥḥa wa-l-sukkān 2005-04, p. 14f.).

[11] In 2001 about a third of the HIO's budget of 2 billion L.E. was spent on its own facilities or those rented from the MOH (*Al-Ahram Weekly* 2001-04-05).

1.1.3 Other Public and Governmental Providers

It has already been mentioned that the government sector includes, in addition to the MOH, several other ministries (see subchapter "Service Providers", p. 11). Most important among these is the Ministry for Higher Education and Scientific Research that runs 54 university hospitals (al-jihāz al-markazī 2009). They receive better public funding than both MOH and HIO facilities,[12] and are equipped and staffed to provide high-level health care services (wizārat al-ṣiḥḥa wa-l-sukkān 2005-04, p. 13f.). Accordingly, a position in a university hospital is far more prestigious than in other government or public facilities and higher posts are often held by doctors who also have successful private clinics (see subchapter "Public Perception of Medicine and Doctors", p. 43).

The other government providers of health care services are relatively unimportant in so far as they account for only a small share of government spending on health care and because they provide services to their employees only (*Regional Health System Observatory* 2006b, p. 17). What makes this phenomenon noteworthy, however, is that it adds to the existing complexity yet another group of entities. For example, the Ministries of Interior Affairs and Defence entertain their own hospitals and clinics, as do the Ministry of Agriculture and Land Reclamation, the Ministry of Education, the Ministry of Electricity and Energy, etc.[13] The same is true for several government authorities like the Prison's Authority, and the Railway Authority (*Al-Ahram Weekly* 2001-04-05; wizārat al-ṣiḥḥa wa-l-sukkān: 2005-04, p. 13f.; *al-ahrām* 2009-05-12). The case of Egypt's Post Authority (see section "Other Providers of Health Insurance", p. 26) demonstrates that these ministries and authorities, although they are all part of the government and the executive branch, may act independently of state policy to further their own interests. In other words, the heterogeneous and even fractionated

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[12] For instance, university hospitals receive an average subsidy from the MOF of 19,100 L.E. per hospital bed compared to only 5,800 for MOH and 6,600 for HIO hospitals (that's for the fiscal year 2004/05, *Regional Health System Observatory* 2006, p. 40).

[13] I could find no definite information about how many of Egypt's currently 34 ministries (i.e. in February 2011) do have their own facilities.

assembly of government health care providers limits and may sometimes hinder effective central planning and development of the health sector in Egypt.

Public providers of health care are those state authorities that have an independent budget. Apart from the HIO mentioned above these include the Teaching Hospitals and Institutes Organization and the Curative Care Organizations (WHO EMRO 2008; wizārat al-ṣiḥḥa wa-l-sukkān 2005-04, p. 13f.). The former runs 49 teaching hospitals (*mustashfayāt taʿlīmiyya*) which, regarding public funding, equipment and prestige, come close to university hospitals,[14] and the Curative Care Organizations is a non-profit organization that had been established in 1964 and as of 2004 ran 12 hospitals (wizārat al-ṣiḥḥa wa-l-sukkān 2005-04, p. 14).

In March 2009 Minister of Health Ḥātim al-Jabalī decided to establish the Egyptian Ambulance Authority (*hayʾat al-isʿāf al-miṣriyya*), yet another public non-profit organization adhering to the MOH. The purpose of outsourcing ambulance services to an independent authority is to give it an organizational structure with a central administration that allows for a quicker and more efficient development of these services that are to cover all Egyptian territory (*al-ahrām* 2009-03-06).

A last way of delivering health care services that must be mentioned here are medical caravans that tour the rural areas of Egypt. In 2006/07, there were 739 caravans, which provide both basic and specialized treatment (al-hayʾa al-ʿāmma 2008).

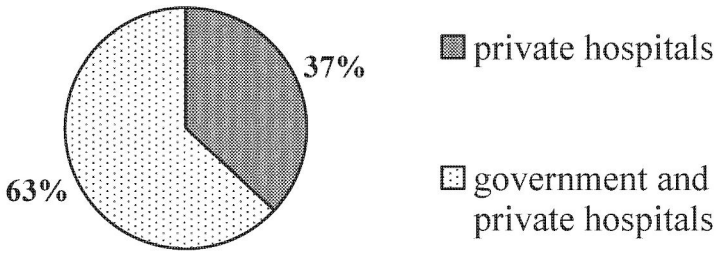
1.1.4 Private Sector

In addition to the government and public sector, there is a large variety of private providers of health care services. Although all facilities and individual providers have to register with and be licensed by the MOH, there seems to be no statistical information that would allow outlining the private sector as a whole. That's due to the het-

[14] Teaching hospitals, in the fiscal year 2004/05, received an average subsidy of 13,500 L.E. per bed compared to 19,100 L.E. for university hospitals, 6,600 L.E. for HIO facilities and 5,800 for MOH hospitals (*Regional Health System Observatory* 2006, p. 40).

erogeneous makeup of this category, which comprises everything from traditional midwifes, small clinics and pharmacies to hospitals and chains (wizārat al-ṣiḥḥa wa-l-sukkān 2005-04, p. 15). Therefore, the following paragraphs in no way claim to be representative of the sector in its entirety; but they do trace some of its characteristics and sketch a few developments.

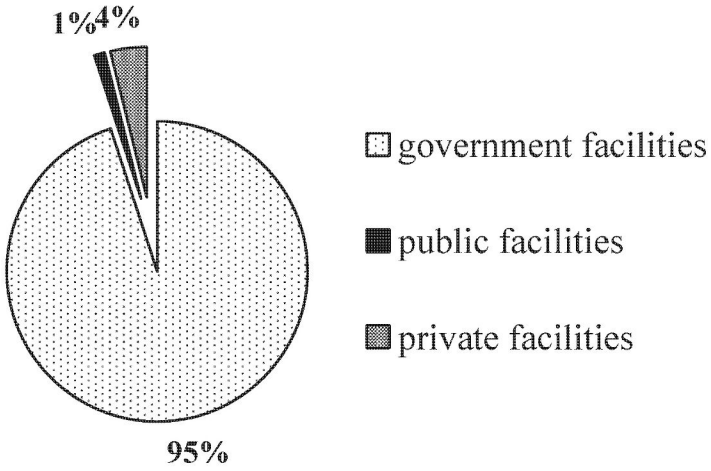
Sizing up the private sector, different perspectives lead to dissimilar impressions. That is to say that looking at infrastructure, the government and public sectors clearly outweigh the private branch, while a survey of expenditures indicates otherwise: In 2007 there were 679 private hospitals employing 11,000 doctors compared to 1,179 government hospitals with a staff of 46,653 doctors (al-jihāz al-markazī 2009), while in the category of smaller facilities[15] 174 private clinics stand against 3,772 government units and a gross of 3,874 units (al-jihāz al-markazī 2008a). Converted into percentages and put into pie charts, the private sector appears to be dominated by its governmental counterpart with regard to hospitals and actually dwarfed and insignificant when it comes to smaller facilities:



Number of hospitals according to sector 2007[16]

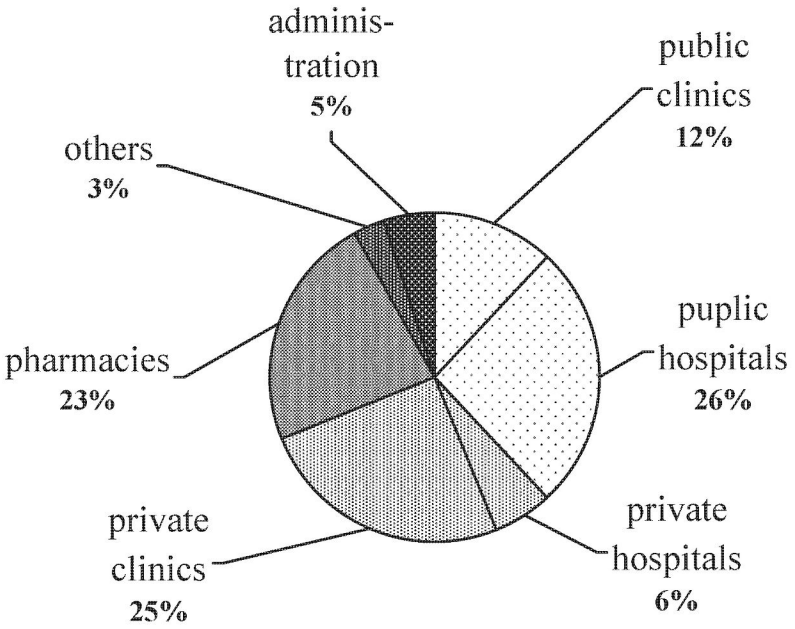
[15] The category is named "curative facilities that have no inpatient departments" (*al-munshaʾāt al-ʿilājiyya allatī laysa bi-hā ʿiyādāt dākhiliyya*) according to the Central Agency for Public Mobilisation and Statistic's definitions. These used to be available until recently (summer of 2010) under < http://www.capmas.gov.eg/nashrat19H.htm >. I can provide a local copy of the file once hosted under this address if needed.

[16] Based on al-jihāz al-markazī 2009.



Number of curative facilities without inpatient treatment 2007[17]

But if we look at expenditure, the picture changes and private clinics receive a quarter of overall spending on health care, which is twice as much as public clinics get, while public hospitals attract a larger share of spending than their number would suggest.



Distribution of Health Expenditures by Type of Provider[18]

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[17] Based on al-jihāz al-markazī 2008a.

[18] As in Figure 4.3, Fouad 2005-11, p. 29. Information on expenditures is for the year 2001/02 and cannot be analytically compared with the numbers of facilities for the year 2007. Here, the show-together of both data sets has a demonstrative

To sum things up, private providers play an important and even dominating role in the segment of outpatient clinics, despite their relatively small number concentrated in urban areas, whereas they contribute much less to the hospital segment, where public facilities remain the most important provider both in number and in expenditures received, due to the fact that hospitals are more costly to maintain (Fouad 2005-11, p. 29).

The statistical information on health care expenditure that I used here is from 2001/02. So there is a good possibility that the situation just described may have changed somewhat, because larger private providers have entered the market (see also chapter "Other Providers of Health Insurance", p. 26). The General Agreement on Trade and Services that the Republic of Egypt is a signatory to and which came into effect in 2005 has liberalized the health sector and made it easier for foreign investors to enter the market. But even before, private hospitals felt financial pressure to seek foreign funding and consider merging (*Al-Ahram Weekly* 2000-12-21).

Traditional Medicine

Although Egypt, other than India and China for example, did not see the rediscovery or reinvention of an indigenous medical tradition, and there seems to be no real contender for biomedicine in the Egyptian context, midwifes or obstetricians (*dāya*, pl. *dāyāt*), herbalists (*ʿaṭṭār*) and others up until today perform medical services and therefore should be included in the list of private providers. Despite the historic existence of several medical traditions in Egypt and traces of all of them in today's traditional practice, there is no real continuity. Rather, Egyptian ethnomedicine is most accurately described as heterogeneous, syncretic, and supplementary to biomedicine (Hamdy 2006, p. 270; Inhorn 1994, p. 85. 87f.).[19]

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purpose only.

[19] Other than midwifes and herbalists — the latter are mostly tradesmen and maintain some medical knowledge as a sideline while working closely with midwifes — there are some other groups offering ailments for medical problems: ghost-healers (*munajjim*, pl. *munajjimūn*) and Sufi Shaykhs (*shaykh*, pl. *shuyūkh bi-l-baraka*), who will not be discussed here (Inhorn 1994, p. 103–10). Only midwifes are partially regulated by the MOH.

In western academics, barbers and midwifes are most prominently associated with the practices of female genital mutilation (FGM) and traditional methods to induce abortions. After FGM became a national issue in the aftermath of 1994's International Conference on Population and Development, a tentative legal ban left a loophole for doctors to perform the practice as cosmetic surgery if they deemed it medically indicated, whereas midwifes and barbers were prohibited in general (niqābat aṭibbāʾ miṣr 2007; *al-maṣrī l-yawm* 2007-06-24). This did not result in a decrease of FGM rates but had the effect, that by 2005 75% of all FGM operations were conducted by medical personnel (*al-maṣrī l-yawm* 2006-12-24).[20] Since 2008 however, when a national campaign in the wake of a young girl's death led to the first comprehensive legal ban of FGM in Egypt (*Al-Ahram Weekly* 2008-03-13),[21] medical personnel and barbers and midwifes fall under the same legal constraints once more. It remains to be seen what effect the legislation will have to bring down the percentage of FGM in Egypt that has been somewhere in the high eighties or nineties at the time of the legislative action (*al-maṣrī l-yawm* 2007-08-10).

The case of illegal abortions illustrates the limitations of some legal prohibitions. Egyptian law prohibits abortion unless medically indicated to save the mother's life ("1937/58: qānūn al-ʿuqūbāt", § 61, p. 260f.; Lane/Madut Jok/El-Mouelhy 1998, p. 1092). Whereas this provision is closely followed in public facilities, it's rather uncomplicated to have an illegal abortion in some private clinic, the names of doctors willing to perform such operations being spread around. This leaves women without the financial means to go to a private clinic in a kind of predicament and traditional medicine as a way out. However, traditional means of inducing abortions can be measured on a scale from useless to harmful, and even the latter often fail to induce a full abort. Rather, women consciously take the risk because after a partially induced abort they must be treated at

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[20] Some examples of investigations against barbers and midwifes because of FGM: *al-maṣrī l-yawm* 2007-08-23; *al-maṣrī l-yawm* 2007-09-02; *al-maṣrī l-yawm* 2007-09-04.

[21] A verdict of Egypt's Supreme Constitutional Court on the constitutionality of the law is still pending (*al-maṣrī l-yawm* 2008-12-17).

public hospitals where the abortion is completed on the grounds of medical indication (Lane 1997; Lane/Madut Jok/El-Mouelhy 1998).[22]

However, traditional remedies (*waṣfa baladī*, pl. *waṣfāt baladī*) mean much more than FGM and abortion and would be misrepresented by a too strong focus on these two contexts. For example, Marcia C. Inhorn describes the main business of a "house of midwives" (*bayt al-dāyāt*, transcription B.B.) in Alexandria as delivering children and offering ailments for infertility. The house was once led by a trained midwife and then taken over by a younger woman who used to work as an aid in a gynecological clinic (Inhorn 1994, p. 85–87). Women who consult her mostly combine biomedical and ethnomedical approaches, seeing them not as competing but as supplementary practices maximizing their chance of success (Inhorn 1994, p. 88–90).[23] All in all, despite growing rejections of traditional medical practices from several sides, gynecology remains a focal point of traditional or ethnomedicine until today and most of the poorer rural and urban women consult a traditional midwife — Inhorn gives the estimate of 10,000 active *dāyāt* in the mid-1990s — at least once in their life (Inhorn 1994, p. 97. 101).

1.2 Funding

The funding of the health sector can be looked at in two different ways. The first major distinction concerns the sources of revenues that is where the money spent on health care is ultimately coming from. From the second point of view, it is the channeling of money that is of interest, i.e. the path money takes from its source to the final provider of services and the mechanisms for its distribution.

Over the past decade or so, roughly 40% of total expenditure on health care has come from the state, the remaining 60% being payments by the private sector, that is mostly private households who have contributed for over 90% of the private funding (National Health Account Series 2009-03). Only a few percent of private expenditure come from private insurances — mostly purchased by

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[22] See also Bentlage 2009.

[23] For examples of traditional treatments of infertility see Inhorn 1994, p. 81–85. 88–90. 100.

companies to provide a health care scheme to their employees — non-profit institutions and external donors. State funding is about 70% tax money and general revenues distributed by the Ministry of Finance (MOF), another 23% deriving from social insurance payments and the remaining 6–7% percent coming from donors (*Regional Health System Observatory* 2006, p. 29ff.).

The remainder of this subchapter will look at the different mechanisms by which revenues are distributed: health insurance, out-of-pocket payments, and public funding.

1.2.1 Health Insurance

One major mechanism to pay for health care services is through insurance schemes, which are provided by several institutions, both private and public.

National Health Insurance

The Health Insurance Organization, which administers the national health insurance scheme, was founded by a presidential decree in 1964 and is a product of the socialist policies of that decade. The National Charter of 1962, that spelled out and defined what Arabic Socialism was to mean, stated the aim to provide health insurance coverage to all citizens. But apparently the opponents of socialized medicine — a slogan that led to the nationalization of hospitals and the extension of the network of government-run rural clinics — had convinced state leadership that a broader national health insurance scheme would lead to financial disaster. So when the HIO was eventually founded, it started out as a compulsory insurance for employees in the public sector only (*Al-Ahram Weekly* 2001-04-05; *Al-Ahram Weekly* 2007-07-19; Moore 1975, p. 69–72).

Since its founding days, coverage through the HIO has been extended gradually. Until the early 1990s there were less than 5 million beneficiaries, including all government employees (as detailed in law 1975/32), widows, pensioners, and some employees in the public and private sector (law 1975/79). The HIO covers employees only, not their families. New legislation (1992/99) took in students and pupils between six and eighteen years, increasing the number of beneficiaries to roughly 20 million in 1995. By 2002, the number

had risen to over 30 million, due to ministerial decree 1997/380 that extended coverage to children under school age (*Regional Health System Observatory* 2006c, p. 33. 35). In 2009 Dr. Saʿīd Rātib, head of the HIO, spoke of 40 million beneficiaries or 45% of the population (*al-ahrām* 2009-01-03).[24] Still, the national health insurance scheme covers employees in the formal sector only, excluding the self-employed and workers in the informal sector "who account for the majority of workers" (*Regional Health System Observatory* 2006c, p. 34).

Sustaining and extending national health insurance is no simple task. Premiums have to be paid by both the employee and the employer.[25] Therefore including new groups of beneficiaries — if not covered through the social insurance system as was the case with students and children[26] — happens by establishing contracts between the HIO and employers. Moreover, although eligibility to health insurance is defined by laws, there is considerable leeway for private companies that are in principle obliged to provide health insurance. They may opt out of the national system by paying a 1% premium on wages, an option that many employers find attractive and make use of. In that course, it's employees with good income especially that are dropping out of the system and put further strain on its financial basis (*Regional Health System Observatory* 2006c, p. 34).[27]

This system covers a broad and comprehensive spectrum of health care services, ranging from primary care to operations, plastic surgery, and even, if necessary, treatment outside of the country. However, these services can only be obtained through facilities ei-

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[24] See *Al-Ahram Weekly* 2007-07-19, where a figure of 37 million is given for 2007.

[25] See, for example, *majallat rūz al-yūsif* 2009-02-07.

[26] Another example for extending the coverage through social insurance is the inclusion of 50,000 poor families in 2008 or plans by the National Council for Children and Motherhood to insure newborns while they are in the hospitals (*al-maṣrī l-yawm* 2008-11-26; *al-maṣrī l-yawm* 2009-02-09).

[27] The importance of private sector employees for the funding of health insurance is illustrated by the fact that 5.65 million government employees generate a mere 38.8 million L.E. of insurance premiums while 767,190 private sector employees pay 4.5 billion L.E. (*majallat rūz al-yūsif* 2009-02-07).

ther owned or contracted by the HIO, severely limiting the choice of provider (*Regional Health System Observatory* 2006, p. 34f.).

Other Providers of Health Insurance

The national health insurance system suffers from various flaws and shortcomings (see subchapter "Problems in Health Care", p. 40) and does not cover the entire population. Accordingly, there is demand for additional or alternative insurance schemes, which is answered by very different providers.

First, there is professional organizations, that is syndicates and unions. In 1988, the four syndicates of the Medical Union, that is the syndicates of physicians, dentists, pharmacists and veterinarians, implemented an insurance scheme for its current and former members as well as their families. Although membership was not compulsory, by 1990 62% of all doctors were registered in the insurance program, which has since served as a model for other syndicates (*Regional Health System Observatory* 2006b, p. 21f.; Abdo 2000, p. 93f.).

Second, there is private health insurance. As with the national program, private health insurance is tied to the work place and is no individual insurance. So usually private health insurance means that an employer buys insurance coverage for his employees. Current legal regulations prevent insurance companies from turning health insurance into a profitable product. For example, employees have a right to refuse co-payment and premiums are regulated. Accordingly only few insurance companies offer health insurance at all, and in 2007 only 350 million L.E. were spent on private health insurance premiums (*Regional Health System Observatory* 2006, p. 39ff.; *al-ahrām* 2007-02-12).

However, private providers of health services may offer something very similar to actual health insurance without falling under these regulations. They offer treatment in their facilities against regular payments, are allowed to demand co-payments, do not have to get approval by the state agencies controlling the insurance companies, and can make do with lower premiums. This kind of service may be offered by single facilities like the "Nile Badrawi" hospital or bigger providers with their own infrastructure of medical centers.

In 2007, there were about 80 private providers on the Egyptian market (*al-ahrām* 2007-02-12). In 2009, the National Post Authority (*al-hayʾa al-qawmiyya li-l-barīd*) was the first public entity to offer their members such a private semi-insurance contract additional to the national scheme — at a time when an overhaul of the national health insurance was seemingly underway. The authority contracted a private provider who will build a chain of 50 medical centers all over Egypt to service the 50,000 employees of the Post Authority against a payment of 20 million L.E. (*al-ahrām* 2009-05-23; *al-maṣrī l-yawm* 2009-05-13a).[28]

Nevertheless, these private business models currently contribute very little to the overall spending on health care. All the organized private spending through employers combined accounted for less than 1% of total expenditure on health care in 1995 and has not developed much since (*Regional Health System Observatory* 2006, p. 41ff.; Fouad 2005-11, p. 27).[29]

1.2.2 Out-of-Pocket Payments

The largest share of spending on health care services comes directly from private households. In 1994/95, private households paid for about 50% of overall health care expenditure. This figure has risen to and remained at roughly 60% (58.2%–65.5%) throughout the next decade and until 2007 (*Regional Health System Observatory* 2006c, p. 40; National Health Account Series 2009-03).

Almost 60% of out-of-pocket payments in 2001/02 were spent on outpatient care in private clinics, followed by 34% on medication. As to private hospitals, only 9% of out-of-pocket payments are being spent there, because inpatient care is far more costly and most patients (almost 76.5%) fall back on the free or heavily subsidized public and government facilities, who, despite limited user fees and

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[28] The *al-maṣrī l-yawm* speaks of 35,000 beneficiaries (*al-maṣrī l-yawm* 2009-05-13a).

[29] Prepaid and risk pooling plans fell from 1% of private expenditure on health care in 1995 to 0.2% in 2007. See also the percentage of private spending by private households that rose from 89.6% in 1995 to 94.9% in 2007 (National Health Account Series 2009-03).

co-payments, receive 8.3% of out-of-pocket payments (Fouad 2005-11, p. 45f.).

User fees at public facilities do not exceed a share of 10% but ultimate amounts may vary greatly between public providers due to different service costs, facilities of the MOH being the cheapest.[30] Since 2003, there is a special cost sharing mechanism for MOH clinics offering primary health care — a key component of current attempts to reform the system — charging a fee of three Egyptian pounds per visit to the clinic and a third of the medication costs (*Regional Health System Observatory* 2006c, p. 40; *majallat rūz al-yūsif* 2009-02-07). However, the public sector attracts only a small portion of direct payments by private households. Over 90% of the latter go to private facilities, doctors and pharmacists (*Regional Health System Observatory* 2006c, p. 41).

1.2.3 Public Funding

In 2007, public funding contributed 39.5% of overall expenditures or almost 18 billion L.E. on health care services (National Health Account Series 2009-03). This money, coming from either the social insurance organizations or the Ministry of Finance, is passed on and distributed by different intermediaries, reaching the actual providers of health care through disparate channels and mechanisms. Money from the social insurance organizations, i.e. the insurance fees of the national insurance scheme, is passed on to the HIO who in turn uses it to maintain its own facilities or issues it to contracted providers as payment for services (see subchapter "The HIO", p. 16); all other public funding is allocated by the MOF.[31] Surprisingly (and according to the WHO's National Health Account of 1995) less than 60% of MOF's spending is allotted to the MOH (19% of Total Health Expenditure, i.e. THE), the Ministry of

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[30] Table 6.4.3., *Regional Health System Observatory* 2006c, p. 40.

[31] In the early 1990s, HIO funds accounted for about 11% of total health expenditure (THE), the MOF contributing 29% (*Regional Health System Observatory* 2006, p. 29). In 2004, the figure for the HIO had decreased only slightly (11.8% in 1995 > 9.9% in 2004), as had the MOH funds' share of THE (21% > 18.9%), which suggests that the percentage of MOF spending on health care as percentage of THE may have stayed relatively stable as well (National Health Account Series 2009-03).

Higher Education and Scientific Research receives a little over 30% (10% of THE), and about 9% (3% of THE) go to other ministries (*Regional Health System Observatory* 2006, p. 29f. 41; Gericke 2005, p. 1075).

These other ministries are those that maintain their own facilities to offer health care services to their employees only. The Ministry of Higher Education and Scientific Research is responsible for running university and teaching hospitals and hands down the money to them (see subchapter "Other Public and Governmental Providers", p. 17). Apart from paying for the infrastructure and staff wages of its vast network of clinics and hospitals (see subchapter "The MOH", p. 12), the MOH has put into action two more mechanisms to finance health care services: treatment on the expense of the state and free treatment.

Treatment on the State's Expense

With only about half of the population covered by health insurance, Egypt acknowledges the dilemma of poorer citizens and in 1975 has implemented a system for "treatment on the expense of the state" (*al-ʿilāj ʿalā nafaqat al-dawla*), that is free health care services, mostly in facilities of the Ministry of Health (wizārat al-ṣiḥḥa wa-l-sukkān 2009a, p. 3).[32]

As opposed to "free treatment" (*al-ʿilāj al-majānī*, see section "Free Treatment", p. 32), "treatment on the expense of the state" covers only expenses for patients lacking health insurance and/or the financial means to pay for a necessary treatment themselves. This does not restrict the circle of eligible beneficiaries to the low-income strata though, since the system may also cover, if necessary, specialized treatment abroad, which can easily topple even sound family budgets (*al-ahrām* 2003-02-15; *al-ahrām* 2007-06-11).

The system does not cover citizens directly. Rather, requests for the state to pay for a treatment have to be made for each treatment

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[32] In late 2009, the MOH announced a new system that allows for treatment on the state's expense in private facilities as well without any form of co-payment and which shall be introduced along with the new health-insurance system (*al-ahrām* 2009-08-19).

individually. Either the patient himself, his family, or, in case of emergencies, the hospital may put forth such a request. The decisions are made by the MOH's Medical Councils (*al-majālis al-ṭibbiyya*) which were established in 1975 to medically examine patients applying for treatment on the state's expense. From the individual patient's point of view, the matter is much more complicated because there is a variety of ways through which requests may be channeled to the decision making Councils: one can visit the Councils in person to be examined there, hospitals and clinics nowadays may send recommendations via fax or internet, for the treatment of tumors and some other diseases there are 13 specialized branches of the Medical Councils, and members of both houses of parliament are allowed to send recommendations as well. In addition, media coverage of individual cases has at times led to the MOH reconsidering a request or to initiate the procedure in the first place and medical caravans play an important role in delivering treatment on the state's expense in rural areas, with 739 caravans in 2006/07 and 49,000 decisions for such treatment (*al-ahrām* 2003-02-15; wizārat al-ṣiḥḥa wa-l-sukkān 2009a, p. 3; al-hayʾa al-ʿāmma 2008).[33]

As other segments of the health sector, this system faces administrative challenges and has been undergoing structural reforms throughout the last years. The Medical Councils, administered by the Medical Council Administration (*idārat al-majālis al-ṭibbiyya*), witnessed a steep increase in the number of patients in the late nineties as the public was made aware of this program through media campaigns: beneficiaries in 1996 were 69,506 compared to 751,926 in 2001 while the budget rose from 170 million L.E. to over a billion (wizārat al-ṣiḥḥa wa-l-sukkān 2009b).

To cope with this development, new Special Councils were established, fax machines were issued to Councils in the governorates, and the central administration in Cairo received computers and training of their staff to better coordinate with the local Councils and the ministry. The proclaimed aim of all reforms is to limit the time-frame needed for a decision by the system to about 24 hours — this being the period for which any patient has the right to be

[33] See *al-ahrām* 2007-06-11; *al-maṣrī l-yawm* 2009-01-29.

treated in a hospital free of charge. Apparently, some patients have to wait up to a month before a decision is made (wizārat al-ṣiḥḥa wa-l-sukkān 2009b; *al-ahrām* 2003-02-15).

Because the decision making process has to be based on a medical examination, in recent years the focus of developing the system has moved from equipping the Medical Councils to furthering cooperation with clinics and hospitals to make the diagnosis and forward all necessary information to the administrative branch in Cairo. In addition, the system has opened up to work together with teaching and university hospitals, facilities owned by other government institutions like military hospitals, and even the private sector. This went along with another shift in the Medical Councils' function, which now includes touring local hospitals and clinics to report misuse of the system and deviance from standard procedures (*al-ahrām* 2007-08-27; *al-ahrām* 2005-05-03).[34]

If a patient requires medical care for which Egyptian clinics lack the equipment, Medical Councils can grant treatment abroad on the expense of the state up to a limit of 12,000 L.E. Also, foreign specialists are invited to perform operations in Egyptian hospitals if proper treatment is otherwise prevented by a lack of expertise (*al-ahrām* 2007-06-11; *al-ahrām* 2003-02-15). Since the 1990s, the number of cases as well as the expense for treatment abroad has decreased (686 beneficiaries and expenses of 4,768,000 L.E. in 1980, 854 beneficiaries and 57,248,000 L.E. in 1994, and 285 beneficiaries with costs of 35,407,000 L.E. in 2007). In the current reforms, costs are to be reduced even further by better coordination with international partners before the patient's travel (wizārat al-ṣiḥḥa wa-l-sukkān 2009b; al-jihāz al-markazī 2008b).

From its beginning, the system of treatment on the state's expense was meant as a temporary solution to provide some sort of affordable health care for the poor until a universal coverage through the national health insurance program was achieved. Over time, however, it has evolved into a quite elaborate system, and has been criticized repeatedly from various sides, some even calling for

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[34] Apparently, the health council administration seeks further responsibilities transcending the system of treatment on the expense of the state (*al-ahrām* 2005-05-03).

its immediate abolishment. Time and again it is pointed out that the system is unfair in so far as it allows for favoritism and corruption (especially through the recommendations by members of parliament)[35] and in general falls short of the citizens' right to affordable health care services. Having no real proponents praising the system for its own sake, its defenders in the abolishment debates stress its temporary nature and the rather large role it currently plays in providing at least some health care to the poor (*al-maṣrī l-yawm* 2009-05-13b; *al-maṣrī l-yawm* 2009-08-02). Both the number of beneficiaries as well as the expenses for this program have been rising almost every year, starting with 3,480 beneficiaries and costs of about 6.5 million Egyptian pounds (6,456,000 L.E.) in 1980 and reaching more than one and a half million beneficiaries (1,602,545) with state expenses of more than 2 billion L.E. in 2007 (al-jihāz al-markazī 2008b).[36] The largest share of expenses (40.4%) in 2007 was allocated for heart and internal diseases, followed by kidney failure (23.8%) (al-jihāz al-markazī 2008c).

Free Treatment

Yet another variant of public funding for health care services is "free treatment" (*al-ʿilāj al-majānī*). This program is not targeted at any specific group of people (as is the case with "Treatment on the State's Expense", see p. 29) but provides free treatment for certain kinds of diseases and illnesses regardless of the patient's income. For example, kidney failure, tumors, and operations of the heart are far too expensive to burden upon regular patients and their families and can be obtained free of charge, and since 2004 patients suffering from AIDS receive free medication (*al-ahrām* 2005-02-09; *al-ahrām* 2004-07-07).

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[35] An example of how easy it is for members of parliament to misuse the system would be the case of 11 MP that the MOH accused of usurping treatment on the state's expense worth 11 million L.E. each month (*al-maṣrī l-yawm* 2010-01-18).

[36] Compare to *al-ahrām* 2003-02-15 and *al-ahrām* 2005-02-09 for the years 2001 and 2004.

1.3 The Pharmaceutical Sector

So far, we have looked at the providers of medical services proper and the mechanisms of paying for them. Another integral part of the health sector is engaged in the production and dispersion of medical products, i.e. the pharmaceutical sector. Similar to the former, competition in the pharmaceutical sector is not primarily based on price. With doctors and hospitals, the patient's choice of provider is often limited to a certain range of facilities contracted through his insurance or corporatist organization. And even among private clinics, price is a limiting factor. Nevertheless, among the options available the actual choice for a doctor will most likely be based on trust (see subchapter "Public Perception of Medicine and Doctors", p. 43). With pharmaceuticals on the other hand, it will in general be the doctor filling out the prescription, or the pharmacist choosing a product, not the consumer himself, thus severing the link of supply and demand that is usually involved in price formation. This leads to a heightened importance of brand marks and promotion as means and ways to stimulate the demand. Another formative characteristic of the pharmaceutical sector is the high cost of research and development for new products, which makes pharmaceutical companies rely on patents to safeguard their profits. Furthermore, the industry relies on pre-manufactured raw materials. In short, the general characteristics of the pharmaceutical sector favor large companies over smaller ones and industrialized countries over developing states and nations.[37]

The production of biomedical pharmaceutics in Egypt started in the first half of the 20th century, with first small yet specialized factories springing up during the 1930s and 1940s. However, foreign companies and capital maintained their hegemony that had existed since the European invasions until the Suez crisis of 1956 tipped relations between post-revolutionary Egypt, Western Europe and North America. Gradually, measures of centralized control and planning were introduced that eventually led to full-scale nationalization of the pharmaceutical sector. First, in 1957, the Supreme Or-

[37] The reasoning in this paragraph is based on the line of thought in Chudnovsky 1983, p. 187.

ganization of Drugs was founded in order to oversee and plan medical imports and the distribution as well as the development of a local industry. Next, in 1960, existing private structures were nationalized in order to monopolize imports and distribution. The socialist turn of Egyptian politics was followed by mandatory state participation in all larger pharmaceutical companies in 1961, which brought 90% of the local production under government control and reduced foreign imports by 25%. Finally, in 1962, the Egyptian General Organization for Drugs, Chemicals and Medical Appliances was established under the control of the MOH, realizing a state monopole on imports, production, and distribution of pharmaceutics (Galal 1983, p. 237f.).[38]

The politics of nationalization continued well into the 1970s. Between 1952 and 1974, drug consumption expanded from 4.8 million L.E. to 72.8 million L.E and the share of local production rose from 10% to 86.5%. On the other hand, nationalization didn't come without problems. Often enough, politics beat economics when it came to the pricing of products, the selection of the management, hiring policies or the planning of industrial development. Over time and enhanced by a neglect of training, quality became a major problem of locally produced medicine and international brands could build up trust for their products in comparison (Galal 1983, p. 238f.).

A chronic conflict of interests between developing countries such as Egypt and the industrialized countries hosting the big international (or rather transnational) pharmaceutical companies is intellectual property rights (IPR), that is in this case the protection of patents and brand marks. For Egypt and other countries, reducing the dependence on high-priced imports and boosting its local economy is essential to keep health care expenditures manageable. And lax

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[38] Essam Galal, the author of the article, played an important role in the pharmaceutical sector during the socialist era and is openly biased in the way that he defends the initial goals and good will of the measures introduced in that phase. His tone, to today's reader, is somewhere between enthusiastic and indoctrinated at times. However, Galal is a very informed observer with a wealth of insight, and his detailed critique of both the socialist and the post-Nāṣir era make him a valuable source whose descriptions and conclusions should not be disregarded lightheartedly.

patent rights were a key element for that strategy, given that the high research and development costs as well as excluded the possibility of developing an industry independently, because this allowed local companies to focus on generics and repackaging. The interest of developed nations to protect the benefits of one of their larger industrial sectors is self-explanatory (Chudnovsky 1983, p. 187–190).

Accordingly, Egypt didn't have a strict patent legislation when it entered into the era of President al-Sādāt's *infitāḥ*-policies of liberalizing markets, but couldn't yet benefit from that fact. For several years, the transition from centralized planning to a market economy was rather problematic for the pharmaceutical sector. While the nominal drug-consumption increased once again, this was largely due to higher prices. The share of local products decreased from 88.2% in 1973 to 73.8% in 1980, while the reliance on licensed drugs (those protected by patent rights) increased dramatically. Main problems on the Egyptian side were the difficulty of attracting capital and the necessary technical knowledge, especially in the now neglected public sector, as well as the general issue of low productivity due to bad management (Chudnovsky 1983, p. 189; Galal 1983, p. 240).

The worrisome reliance on international companies led to a change of action in the mid-1990s. In 1995, Egypt implemented a combined strategy (the "National Strategy for Genetic Engineering and Biotechnology") to promote biotechnology with a huge impact on the pharmaceutical sector. It included educational programs to spur the flow of knowledge from universities to the industry, the establishment of research centers, manufacturing plants and both public and private investments. Also, regulation by the MOH, although not altered in substance or principle, did change in the way of the ministry showing a generally favorable attitude. The rather lax patent law of 1949, that did not permit the protection of products and allowed patents on technology to expire after ten years, played a key role at this point as generics, either in the form of local manufacturing or repackaging, became a hall-mark of local production. For example, local manufacturers were able to end the almost absolute dependence on imported insulin (90%) by recombining imported raw materials within just a few years. Egypt's Health Sys-

tems Profile of 2006 stated that 93% of all pharmaceutical products were produced locally by a total of 82 companies (nine of which are in public domain and eight belong to multinational companies) (Abdelgafar et al. 2004-12; *Regional Health System Observatory* 2006, p. 94).[39]

1.3.1 TRIPs

Clearly, Egypt has been able to benefit from its lenient patent protection for some time. It should be noted however, that permissive IPR laws alone do not suffice, as the experience of the period 1975–1995 has shown. Also, it stands out that while a generic industry sprang up in Egypt, this did not leave multinational companies without a chance to make profits. Rather, the generic-based pharmaceutical sector in Egypt heavily relies on foreign licenses and patents and 85% of all raw materials are being imported (*Regional Health System Observatory* 2006, p. 89).[40]

However, Egypt's further integration into the worldwide market also meant that it takes over free-market policies with regard to patent protection. As a founding member of the World Trade Organization, Egypt had to implement new patent laws in the spirit of the agreement on Trade Related Aspects of Intellectual Property (TRIPs). This basically meant that Egypt provides enhanced protection of patents, brands, designs, etc. and broaden the scope of things and ideas falling under this protection. The agreement took effect in 1995 but developing nations were granted transitional periods, in the case of Egypt until 2005. To prepare its full implementation, a new intellectual property rights law was passed in 2002, extending the patent protection to 20 years and specifically including the protection of the final product, not just its formula. The new law placed several restrictions on patents; it prohibits patents on biological

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[39] The article *Al-Ahram Weekly* 2004-12-30 states that 90% of the production of medical products would be in public domain, which is not correct. Probably, what was meant is that about 90% of all medical products sold in Egypt are produced locally, compare *Regional Health System Observatory* 2006, p. 94; *al-jumhūriyya* 2009-03-07. The share of public domain producers is actually about 20% (*al-ahrām* 2007-01-13).

[40] This development has been aptly described and predicted by Daniel Chudnovsky in the early 1980s (Chudnovsky 1983).

matter to which no innovation has been applied and for any means or methods for the production of animals and plants. Also, the MOHP has tight control over all patents related to public health. It must approve of all drug pricing and can issue compulsory licenses for non-commercial use (Abdelgafar et al. 2004-12, p. DC 29; *Al-Ahram Weekly* 2004-12-30).

1.3.2 Recent Developments

The new IPR legislation of 2002 and the end of the grace period in 2005 has given rise to fears that the local industry would fall apart, multinational companies dictate higher prices and Egypt finds itself in a vicious circle of increasing dependency and financial ineptitude to steer its own course of development. The demeanor of large companies to bully for their interests via their home countries' embassies did not help in this respect (*Al-Ahram Weekly* 2005-04-07; *al-maṣrī l-yawm* 2008-02-07). A particular problem for local companies is that their products are received to be of lower quality than those of large international brands — an impression that transnational companies allegedly try to strengthen by costly smear campaigns.[41] The policy of the MOH to increasingly cover international brand products via health insurance puts further stress on local producers in this regard (*al-maṣrī l-yawm* 2008-02-07).

Granting that stricter IPR protection will eventually benefit transnational companies, several factors may lessen or even counter that effect. First, the new regulations will only apply to new patents, meaning that existing generics should not be affected and new, more expensive drugs with a longer period of patent protection enter the market gradually only. Second, the local pharmaceutical sector is in rather good shape and may develop by virtue of its own merits. For example, Egypt has been exporting locally produced (or repacked) pharmaceuticals to neighboring countries, supplying 30%

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[41] A somehow related example, although this time directed against the internationals, is the media coverage of the Center for Protection and Support of Pharmaceutical Production (*markaz ḥimāyat wa-da'm ṣinā'at al-dawā'*), a registered NGO, warning citizens of illegal drug experiments performed on patients in public hospitals by international companies (*al-maṣrī l-yawm* 2009-12-14a; *al-maṣrī l-yawm* 2009-12-14b; *al-maṣrī l-yawm* 2009-12-25).

of the market in the MENA region. Due to low costs and a large potential to expand consumption within Egypt, the industry is not unlikely to continue to attract investment capital (American Chamber of Commerce in Egypt 2006-12). Third, the MOH is still exercising a strong regulatory function that it is improbable to forfeit.

Redefining Regulations

As a remainder of socialist policies of the past, the MOH has maintained a broad spectrum of regulatory functions in order to manage and restrain some of the unwanted effects of liberalizing the economy and the pharmaceutical sector. Most important, all drugs have to register with the ministry. In 1998, an "Essential Drug List" was drawn up. All medication on the Essential List is controlled directly by the ministry, which basically means that it sets the price according to a certain procedure. As to medication not on the Essential List, there are two groups. For one, the ministry controls prices not of every individual product, but fixes the price of one or two products in every category of medication, guaranteeing the existence of low-cost drugs while allowing for more costly alternatives. Second, products considered non-vital may be priced free of government interference (*Al-Ahram Weekly* 2006-06-08).

The ministry's functions of registering and pricing have the most immediate affect on the pharmaceutical sector, which is why these two functions have been and are being revised over the last years in order to further the development of the sector. The main goals are to satisfy local demand for medication, to control state expenditure, and to advance the local economy. Regarding the registration, simplifying and speeding up the process is the main issue. The MOH is seeking to implement new regulations that would curtail the duration of the procedure to six months. Part of the registration process is that the producing or importing company proves the safety of the product and applies the ministry's quality standards. For transnational companies this poses no problem, as the admission of a medication in many other countries (mostly industrialized nations) is considered valid in Egypt as well. For local companies, quality standards are a cost factor while a lack of trust in local produce is admittedly a problem (*al-maṣrī l-yawm* 2008-11-12a).

As to pricing, the social concern to insure availability stands against the profit interest of producers that must not be neglected if the industry is to develop. It clearly is a sensitive issue, because raising prices on medication makes headlines, as past neglect to gradually adapt pricing to changed circumstances has repeatedly led to the necessity of drastic and abrupt adjustments (*al-maṣrī l-yawm* 2008-11-08). But allowing producers to determine the prices of some categories of products by themselves has no doubt attracted much needed investment (*al-ahrām* 2007-01-13). On the other hand, cost controlling essential drugs, especially for the widespread diseases of Hepatitis C and diabetes, is socially mandated and has led to the ministry even lowering prices for some products (*al-maṣrī l-yawm* 2008-12-02).

To strike a balance in coming up with a new set of regulations and procedures, the ministry engaged in discussions with producers during the planning period. Main concerns of local producers were that the cost of raw materials be part of the calculation and that the pricing of already registered products be renegotiated more easily. Negotiations with transnational companies mostly concerned the method of price regulation after a patent protection has expired (*al-maṣrī l-yawm* 2008-11-12a). Before a patent expires, subsidizing a vital medication is the only way to bring down costs for the consumers.[42] For example, medication for Hepatitis C and some types of cancer are being subsidized by the MOH after negotiations with the producing companies (*al-maṣrī l-yawm* 2009-06-14). Following a trend to delegate ministerial responsibilities to more independent structures, plans exist to establish a new authority that would combine the functions of registration, pricing, quality control and research (*al-maṣrī l-yawm* 2008-10-22).

Other than the MOH and its adherent authorities, there are some more actors that can shape the national strategy. Chief among those is the Holding Company for Pharmaceuticals (*al-sharika al-qābiḍa li-l-adawiyya*) that owns and controls the eight public pharmaceutical companies, followed by the Egyptian Trading Company for Pharmaceuticals that centralizes the marketing and trading of the

[42] Unless the MOH made use of its right to issue licenses for non-commercial production, which is unlikely unless in cases of emergency.

public companies' products. A future focus of both institutions lies on medication for the treatment of cancer and Hepatitis (*al-maṣrī l-yawm* 2009-03-09; *al-maṣrī l-yawm* 2009-03-17b).

Despite TRIPs and transnational companies' influence, about 93% of all medication consumed in Egypt is produced locally, the producing sector employing 40,000 people (*al-maṣrī l-yawm* 2008-02-07; *al-jumhūriyya* 2009-03-07).

1.4 Problems in Health Care

1.4.1 Quality

A particular problem, and not only in public clinics, is the poor quality of health care. There are many aspects contributing to this and a lot of them start with medical education that suffers from high enrollment figures[43] paired with limited financial resources and outdated bylaws. School and university teachers in general are underpaid and have to rely on private lessons, which of course reflects on the quality and extensiveness of their regular teaching and greatly disadvantages poorer pupils and students. The case is similar with the 50% of doctors employed by the MOH. The basic salary for doctors in state service is low, not directly linked to their performance. Therefore most take up more than one job — a factor that disadvantages villages and rural areas because of their scarce job opportunities. Nevertheless, positions at public or university hospitals contribute to the professional prestige of their holders and their ensuing ability to earn good money in private clinics, so that senior and successful doctors show no intention of rendering positions in state service to more junior physicians (*Al-Ahram Weekly* 2001-04-05; Hamdy 2006, p. 304ff.: Abdellah/Taher/Hosny 2008; see also subchapter "Doctors", p. 70).

As to the shortage of guidelines and equipment, especially rural health units suffer from a lack of medication, simple consumable goods like soap and one-way gloves as well as guidelines (wizārat

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[43] The medical professions enjoy a high prestige and admittance to public universities is for those with top grades only. However, private medical schools accept students with lower grades and thus further contribute to the problem (*Al-Ahram Weekly* 2000-04-13; Hamdy 2006, p. 304f.). See subchapter "Doctors", p. 70.

al-ṣiḥḥa wa-l-sukkān 2005-04, p. xxiv–xxvii). Considering motivation, the practical training of future doctors is symptomatic. Both the mandatory pre-resident year and the three resident years that 80% of the graduates spend in Teaching Hospitals affiliated with the MOH are burdened by busy superiors responsible for far too many aspiring doctors and who have no incentive to either teach or provide treatment in public facilities since neither has any effect on their income. This outset, combined with the lack of a formalized training program, often leads to young doctors being neglected and kept away from patients (*Al-Ahram Weekly* 2000-04-13; Hamdy 2006, p. 304ff.).

The ministry has tried to cope with the problem by establishing training programs. It also issued rules on how to assess the quality of health care facilities. Some of these measures, e.g. the program to fight tuberculosis or the improvement of quality in family planning centers, have been successful in raising the quality of health care provided by participating personnel. However, they only reach a limited number of students and doctors and until recently, the MOH was more concerned with extending health care services than with raising its quality.

In 2006, shortly after current Minister of Health, Ḥātim al-Jabalī, took office, several cases of neglect and mistreatment made headlines. As a reaction to that, he obliged officials to pay surprise visits to public hospitals and actually made some himself (*Al-Ahram Weekly* 2006-01-19; *al-maṣrī l-yawm* 2008-12-03). In 2007 30,000 contaminated blood bags were delivered to MOH facilities and provoked a national scandal (*Al-Ahram Weekly* 2007-12-27), dozens of private clinics were shut down because they failed to meet standards of hygiene (*Al-Ahram Weekly* 2008-10-30), contaminated anesthetic gas forced the MOH to ban the use of a certain brand in all of the nation's hospitals and operation rooms in 2008 (*al-maṣrī l-yawm* 2008-11-01; *al-maṣrī l-yawm* 2008-11-03a), which in turn led to an alarming shortage of anesthetics in large government hospitals (*al-maṣrī l-yawm* 2008-11-03b). Several deaths in a public hospital in al-Fayyūm at the beginning of 2009 were later explained by the failure of new medical instruments that had cost several million pounds but were neglected and eventually malfunctioned because a necessary paraphernalia not worth more than a hundred L.E. had

been missing (*al-maṣrī l-yawm* 2009-02-12; *al-maṣrī l-yawm* 2009-02-13). The list could be extended.

Particular outrage is caused by organ theft, in which sometimes hospitals and doctors are involved. Egypt, as of late 2009, lacks appropriate legislation to regulate organ transplantations with several draft laws failing to find approval in parliament of the last years. In the meantime, criminal organizations and individuals take advantage of the situation with actions that range from tampering with paper work (*al-maṣrī l-yawm* 2008-11-24a) to outright organ theft (*al-maṣrī l-yawm* 2008-11-24b; *al-maṣrī l-yawm* 2008-12-06; *al-maṣrī l-yawm* 2009-09-03a; *al-maṣrī l-yawm* 2009-09-03b) and even murder (*Tagesschau.de* 2009-05-26; *Al-Ahram Weekly* 2008-11-27).

1.4.2 Distrust in the Public Health Care System

Therefore, it does not surprise that there is a general distrust in health care. It is the public sector that lacks credence foremost. People are reluctant to visit HIO clinics and hospitals for fear of negligence and protracted procedures. A study of the Theodore Bilharz Research Institute situated in Imbāba, a Cairo district, showed that patients of public health care services are especially dissatisfied by the briefness of consultation, lack of explanations, long waiting periods, and complained about deficient cleanliness and maintenance of sanitary facilities. Even poor people try to save money to go to private clinics instead of public facilities, due to mistrust and bad experiences. (*Al-Ahram Weekly* 2000-04-13; *Al-Ahram Weekly* 2001-04-05; Hamdy 2006, p. 307).

Besides these massive flaws, some less grave circumstances contribute to the general preference of patients for private clinics: flexibility of opening hours, waiting time, the furnishing and cleanliness of facilities as well as the social conduct with patients (Zaky/Khattab/Galal 2007-05; *al-maṣrī l-yawm* 2008-09-30).

However, distrust is not limited to the public sector. Patients are low on confidence for the medical profession as a whole, and it's especially doctors in private clinics who are suspected of corruption and greed and exploiting their patients, with malpractice and neglect often not accounted for (Hamdy 2006, p. 271f.).

1.5 Public Perception of Medicine and Doctors

Yet the perception of doctors and the health sectors is not determined by distrust and scandals alone. Media can provide insights into a society's perception, although the relation between depiction and alienation in fictional representation is often complex. For example, Sherine Hamdy shows how the ideal of the 'doctor of confidence' emerged in nationalist discourse and in literature. It is often linked to the topos of the 'returning doctor', either putting the knowledge acquired abroad to the service of his country or, alienated by his foreign education, causing harm by disrespecting local morals and circumstances. Hamdy then traces the function of these literary topoi in recent events and discussions concerning surrogate mothers, sex change operations, and organ transplantation (Hamdy 2006, p. 294–305).

The fears and distrust regarding health care provision are countered by the high prestige of biotechnology and the ideal of the 'Muslim doctor of confidence' — "a homeland oriented, righteous, upstanding physician who assesses what is good about medicine and brings it to his or her people" (Hamdy 2006, p. 271). Doctors played an essential role in the establishment and acceptance of biomedicine in Egypt, which today, contrary to other formerly colonized cultures, is seen as the only responsible way to deal with one's body.[44] The nationalist discourse saw no contradiction between science and religion. Still, as universal science is not linked to any particular set of moral values, it fell upon the doctor of confidence to implement modern medicine in a way beneficiary to his homeland and in accordance with Egyptian morals. He, or she, thus acts as a filter between morally neutral science and a level of application independent of it and specifically Egyptian. In the nationalist discussions at the end of the colonial period — about whether sciences perceived to be of western origin should be adapted for the sake of development — the ideal of the doctor of confidence functioned as a safeguard against fears of science undermining values. This ideal was evoked by scientists, politicians and religious schol-

[44] For examples to the contrary, or rather a more differentiated statement, see section "Traditional Medicine", p. 21.

ars alike and helped to establish the image of biomedicine as efficient, scientific and developed — notions pitched against traditional medicine as backward and possibly harmful (Hamdy 2006, p. 270ff. 280–94).

> If modernist Islam conflates secular fields of knowledge with sacred knowledge by claiming that they are all ʿilm, and that all ʿilm leads to the divine reality, the role of the doctor of confidence is to reconnect the secular with the sacred through his own moral his own moral conscience and ethical virtue.
>
> (Hamdy 2006, p. 299f.)

Today, the paradoxical situation is that it is the general distrust in health care provision and the lack of standards and supervision that highlight the importance of an individual doctor's moral and thus help to keep the ideal of the doctor of confidence alive (Hamdy 2006, p. 308).

Many of the above observations about the perceptions of health care provision and doctors can be verified by recent fictional media as well. Take for example 2007's Ramadan series "qaḍīyat raʾy ʿāmm" ("A Public Case"), by Jordanian director Muḥammad ʿAzīziyya, first aired on Dubai television and repeated on the satellite channels Orbit and ART (*Al-Ahram Weekly* 2007-09-20). The broad story deals with rape and ensuing injustices, raising the question of whether abortion after rape is permissible or not (*al-maṣrī l-yawm* 2007-10-11). What interests us here, however, is the representation of the story's heroine, a young pediatric doctor. In the first episode of the series, which serves as an introduction of characters, hence the depiction of the heroine can be expected to be thematic and in tune with common perception and stereotypes, geared towards identification and relating to viewers' pre-knowledge and observations. Dr. Habla, as she is named, works in a hospital during the day and in her private clinic in the evening. At the hospital, a corrupt superior wants to meddle with the evaluation of assistant doctors, putting his son in a more favorable position, but Dr. Habla does not tolerate that. Little later, she faces first sanctions when she is told not to participate in a conference in Sharm el-Sheikh. Things in her private clinic don't go smoothly either; she catches her receptionist taking small bribes from patients to let them skip the queue — and obviously not for the first time either. But Dr. Habla herself

is depicted as a morally sound and brave person (standing up to a corrupt superior and scolding her bribed receptionist), tender and caring for her patients (returning to the hospital late at night to see after a sick boy), competent (a scene of her rushing through the crowded hospital floors, followed by assistant doctors) and financially well off ("qaḍīyat raʾy ʿāmm" 2007).

2 Reform of the Health Sector

Like with probably any complex system in a modern society, reforms are nothing new to the Egyptian health sector. However, during the 1970s and 1980s the main concern lay on expanding infrastructure to rural areas and combating child mortality, whereas the reforms currently implemented can be rightfully described as a fundamental overhaul of Egypt's health care system.[45]

The current plans originated in the mid-1990s, when the MOH recognized the need for comprehensive reform. In 1997, government formally adopted a medium- and long-term (10–15 years) strategy for reform, the Health Sector Reform Program (HSRP) (*Regional Health System Observatory* 2006, p. 101f.; Gaumer/ Rafeh 2005-10, p. 3).

From early on, Egypt cooperated extensively with international and foreign organizations, most notably the World Bank, but also the United States Agency for International Development (USAID), the African Development Bank, and the European Commission. With these and other partners, the MOH's Office for Technical Support has initiated pilot projects in several health districts and governorates. The World Bank had been advising Egypt and neighboring countries on the development of their health sectors throughout the 1990s. It started to directly contribute to the HSRP in 1998 and has since granted loans of roughly 96 million US $ (World Bank 2008-10-11, p. 3; *Regional Health System Observatory* 2006, p. 102; Barnard 1997-08-30; Gericke 2005, p. 1074).[46]

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[45] For some of the MOH's past programs see wizārat al-ṣiḥḥa wa-l-sukkān 2005-04, p. 17f.

[46] Another 100 million € were granted by the European Commission in 1999 for a period of 5–7 years (EU/Egypt Programmes).

2.1 Main Goals of Reform

The chief aim of the HSRP is to provide affordable primary[47] health care services to all citizens in order to improve the health status of the population. Supplementary goals are high quality, financial sustainability, efficiency, and equality. As to actual steps and measures to be taken, the two key elements of the HSRP are, for one, a redefinition of the state's role in health care,[48] shifting from provision to regulation and financing, and second the expansion of public health insurance. Decentralization and the idea of institutional specialization — that is to delegate separate functions to separate organizational structures — serve as guiding principles for the entire reform (*al-ahrām* 2004-12-22; Gaumer/Rafeh 2005-10, p. 3; *Regional Health System Observatory* 2006, p. 9; barnāmij al-raʾīs 2005-08; *Al-Ahram Weekly* 2006-06-08).

2.2 The Stages and Components of Reform

The HSRP went through several distinctive phases. The planning period started in 1994 and consisted of detailed analyses and studies on the basis of which a reform strategy was formulated that the Egyptian government officially adopted in 1997 (*Regional Health System Observatory* 2006, p. 9f.).

The three components of the HSRP that had been conceptualized in the planning period were, first, the development of the service infrastructure through the Family Health Model project, second, the reorganization of the MOH, and third, the introduction of a universal health insurance (*Regional Health System Observatory* 2006, p. 10).

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[47] The concept of *primary health care* is similar to that of the *family doctor* or the *general practitioner*. Basically, primary health care services are non-specialized, ambulant services as opposed to treatment by specialists or in-house care in a hospital clinic, which are termed secondary and tertiary care. See, for example: Summary *Primary Care* 1996, p. 3.

[48] This falls in line with the World Bank's recommendations of 1997 (Barnard 1997-08-30).

The planning period was followed by a series of pilot projects in several provinces during which the Family Health Model was implemented. The gathered experiences led to a redefinition of the HSRP in 2003. By 2005, the new system covered 15 governorates. The other two components of the HSRP — restructuring the MOH and introducing universal health insurance — depend on new legislation to be passed which has been stalled several times (see chapter "Legislation", p. 53). Although the legal conditions have not been established, a new health insurance system is being tried out in a pilot project in Suez since April 2009 (al-taʾmīn al-ṣiḥḥī 2009). This is considered a last preparatory phase for the final stage of national implementation of the full HSRP (*Regional Health System Observatory* 2006, p. 9f.; wizārat al-ṣiḥḥa wa-l-sukkān 2005-04, p. xxiii; *al-maṣrī l-yawm* 2009-03-23).

2.2.1 The Pilot Projects: 1994–2005

The HSRP, in cooperation with its international partners, started to implement pilot projects, first in a single facility and then in five governorates (Suez, Alexandria, Souhag, Menoufiyya, Qena).[49] The pilot phase consisted mainly in the implementation of the Family Health Model (FHM, also FCM for Family Care Model), a preliminary step to engaging the HSRP's aims.

The Family Health Model

The FHM is the unit of the HSRP that targets the structures of service delivery. It itself consists of several components.

The first component of the FHM is the rationalization of investments based on Health Master Plans, which were designed for each pilot district or governorate. Master Plans measure the actual demand for health care facilities on a local level and project maintenance costs.[50] The second element is the separation between the

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[49] The World Bank is sponsoring the pilot projects in Alexandria and Manūfiyya (World Bank 2008-10-11, p. 3), the European Commission in all five pilot governorates (EU/Egypt Programmes) as did USAID (World Bank 1998-05-22).

[50] Whether the Master Plans should be installed on the district level or that of the governorate is a practical question and depends on the size of the governorate. For example, in the small governorate of Suez, Master Plans on the district level

functions of financing and provision of health care. For financing, Family Health Funds (FHF) were installed in each of the governorates. The original plan was that all funds — insurance premiums, benefits, direct payments by patients, and tax money — should be channeled to them. The FHF then contracts providers of health care, both public and private, based on the demand spelled out in the local Master Plan.

The model's third dimension relates to the HSRP's aim of universal coverage. The FHM wants to provide comprehensive primary health care for the entire family, fully covered by health insurance. Accordingly, the health care facilities contracted by the FHF need to be staffed with family practice doctors and community nurses who have received special training and have been provided with guidelines for treatments. They offer primary care for the entire family under one roof and are termed Family Health Units (FHUs), also functioning as entry points for the referral system to secondary and tertiary care. The treatment provided is defined in the Basic Benefits Package, accompanied by an Essential Drug List. Families get registered with an FHU in their area for one year, during which their treatment is covered by health insurance. Poorer patients, unable to pay the minimum fee, can be exempted — with a ratio limit of 15% of overall patients. Quality, the enhancement of which is another key feature of the FCM, is secured by an accreditation process for FHUs prior to them being contracted. Also, there is a system of incentives paid by the FHFs based on performance (*Regional Health System Observatory* 2006, p. 9. 36f. 102ff.; Gaumer/Rafeh 2005-10, p. 3f. 19; wizārat al-ṣiḥḥa wa-l-sukkān 2005-04, p. 19).

Implementing the FHM

Implementation in pilot governorates highlighted several problems that led to adaptations of the HSRP. For example, a report by USAID about their experiences in the Suez governorate (–2002) named the following issues: (1) a lack of doctors and nurses trained

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proved problematic and led to an ill distribution of health care facilities because patients moved frequently beyond their district to obtain health care (Gaumer/Rafeh 2005-10, p. 11f.).

in family medicine and primary health care, impeding a quick realization of the FHM; (2) the acceptance was limited to poorer patients, while those financially able prefer private clinics even if they have health insurance; this bias against public facilities is paired with a higher status ascribed to specialists; also, patients are used to choose freely among clinics and hesitate to enroll with one facility for a longer period; (3) a reluctance of private providers to get accredited as FHUs, mainly due to high investment costs and the ensuing limitation to patients registered in the FCM after accreditation; (4) the Basic Benefits Package was defined too narrowly, not even covering all of the procedures and treatments most FHUs offer; (5) finally, the intended separation of financing from provision had failed. Egyptian law does not allow anybody except the HIO to collect premiums or capitations. Therefore, the Family Health Funds in the pilot governorates had to be established in the legal form of bank accounts of the HIO, although they are, institutionally, part of the MOH's Office for Technical Support. Their only function is the payment of incentives to contracted facilities, covered by funds of the European Commission and the Ministry of Finance. All other flow to Family Health Units comes directly from the MOH and the HIO, who also receive the patients' out-of-pocket payments generated by FHUs. A decree (No. 143 2003) was not expected to change this (Gaumer/Rafeh 2005-10, p. 4f.; *Regional Health System Observatory* 2006, p. 36f. 103f.).[51]

These experiences instigated several changes to the HSRP. The USAID team responsible for the pilot project in Suez adjusted their concept that was also to serve as a blueprint for the nationwide implementation of HSRP. They did so based on a market evaluation, combining data obtained through the MOH, interviews with relevant professional groups, and a household survey. The clearly ar-

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[51] Other actors report similar experiences. The World Bank described the progress of its own pilot projects in Alexandria, Menoufiyya, and Souhag as unsatisfying since 2002 and accordingly revised its strategy together with the MOH in 2004. The main problem, according to the World Bank, lay with the legislative branch that did not pass necessary laws and amendments, particularly with regard to universal health insurance. The World Bank opted for dropping the objective of universal coverage for this pilot project and limited it to two (Alexandria and Menoufiyya) instead of three governorates (World Bank 1998-05-22, Schedule 2; World Bank 2004-06-04).

ticulated wish of patients to freely choose clinics and doctors necessitated structural changes. A central database was introduced in Suez that allowed families to get registered once and then visit a clinic of choice regardless of district borders. Two other changes regarded the administrative level on which rules should be applied and decision-making processes take place. The 15% limit for the exemption of patients from premiums and fees was moved from the level of individual clinics to the level of the governorate, because the distribution of wealth and accordingly of the demand for such exemptions tends to be clustered in certain areas. The second change opted for a switch from a District Provider Organization to a Governorate Provider Organization, owing to the relative small size of Suez and the proximity of its districts. The market analysis had shown that overall enough doctors and facilities existed but that they were distributed unevenly. The previous district model had not taken into account how freely patients moved across district borders. Another important aim of the reformed HSRP was to attract families with higher incomes. For this, the contracting of private clinics was to be encouraged and the regulations so far hindering the participation of private clinics revised. Also, knowledge of the existence of the FCM was low, so that a campaign to reach out to relevant target groups was planned. Measures of secondary care were added to the Basic Benefits Package additional to the installment of a referral system to hospitals and specialists — who were to be included and accredited in the FCM — in order to remove further limiting factors for the attractiveness of the program. Finally, the legislative problems regarding FHFs were communicated to policy makers in Cairo (Gaumer/Rafeh 2005-10, p. 13–19).

2.2.2 Preparing for National Implementation: 2005–2015

As far as the outcome of the pilot projects are concerned, the stage of full national implementation of the HSRP could have begun in 2004 (wizārat al-ṣiḥḥa wa-l-sukkān 2005-04, p. xxiii).

Although the international partners involved in the pilot projects showed some disappointment at the lack of progress on the legislative side, the HSRP has been adopted and more and more integrated into a net of political planning and commitment. After the original

adoption in 1997, it was one of the top issues on the second annual conference of the governing party in September 2004 as well as President Mubārak's election program of 2005. Also, it is interwoven with attaining the Millennium Goals that the UN had proclaimed as well as with Egypt's five-year investment plans. While progress may seem painstakingly slow, it seems unlikely that the issue would be dropped entirely. Recently, with incumbent Minister of Health Dr. Ḥātim al-Jabalī being a staunch proponent of the reform, first legislative (although ill advised) steps have been taken in 2007 and Gamāl Mubārak, deputy general secretary of the NDP, presented the project personally to the basis of the party. So perhaps, there is some momentum building up to move ahead in the years 2009/10, as will be described in the following subchapters (*al-khiṭṭa* 6 2007c, p. 53ff.; *al-khiṭṭa* 6 2007e, p. 155; *Regional Health System Observatory* 2006, p. 104; *al-ahrām* 2007-04-04).

2.3 Legislation

Two of the three main components of the HSRP rely on new or amended legislation. First, the redefinition of the state's role demands a new functionary division of the MOH and its adhering institutions that transcends the authority of guidelines and ministerial decrees and has to be mandated by the legislative. Second, the ambitious aim of providing universal health insurance requires the revamping and unification of several laws that have been passed over the last decades to gradually add to the circle of insured citizens.

2.3.1 The Division of Functions

The division of service provision on the one hand and financing and regulation on the other hand is a key component of reform. It is meant to facilitate competition among service providers and enable the state bureaucracy to focus its resources. In the current system, institutions like the HIO or the MOH are burdened by a grown complexity of responsibilities and tasks that were often not accompanied by an adjustment of staffing patterns. A structural division along the lines of function is meant to facilitate such adjustments and make it easier to introduce efficient managing techniques (*Al-*

Ahram Weekly 2007-07-19; *Regional Health System Observatory* 2006, p. 26. 36f.).

The HSRP envisions the HIO to develop into an authority solely responsible for the financing of health care services in the way of contracting providers. To achieve this, the facilities currently owned by the HIO have to be dealt with in some way. So, in March 2007 Prime Minister Aḥmad Naẓīf issued the decree 637 that established a holding company, to which all of the HIO's 40 hospitals, 600 clinics, its health units and employees were to be transferred. The administrative responsibilities of setting guidelines, contracting and managing premiums were to remain with the HIO itself (*Al-Ahram Weekly* 2007-07-19; *al-maṣrī l-yawm* 2007-05-28).[52]

The decree reverberated among those fearing the privatization of the health sector and an ensuing rise in the cost of health care because the holding company was to be a private, profit oriented entity (*Al-Ahram Weekly* 2007-05-17; *al-ikhwān al-muslimūn* 2007-08-09; *Al-Ahram Weekly* 2007-09-06; *al-maṣrī l-yawm* 2007-09-29). The MOH and the HIO tried to counter such fears, denied any intention of privatization and Minister of Health al-Jabalī proposed to explicitly prohibit the selling of the holding company within a new health insurance law (*al-maṣrī l-yawm* 2007-10-10).[53] Even the Doctors' Syndicate called for the abrogation of the decree, although it supported the division of functions in principle (niqābat aṭibbā' miṣr 2007-08-16). Eventually a coalition of 20 NGOs brought forth a claim against the ministerial decree and an administrative court suspended it in September 2008. The court denied the Prime Minister's right to transfer the HIO's property to a private company that could be sold on the grounds that the facilities were established and maintained with the premiums of the insured (*al-maṣrī l-yawm* 2008-09-05; *Al-Ahram Weekly* 2007-05-17; *Al-Ahram Weekly* 2008-03-13; *Daily News Egypt* 2008-10-18; *Daily News Egypt* 2008-09-

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[52] *Al-Ahram Weekly* 2007-05-17 mentions that a law of the same effect was passed in May 2007. I could not find any indication elsewhere that such a law was indeed passed, discussed or even proposed.

[53] Dr. Ḥamdī al-Sayyid, head of the Doctors' Syndicate, spurs such fears and openly calls for the government to discontinue its own facilities (*al-maṣrī l-yawm* 2007-10-10).

05). The verdict coincided with developments in the long story of passing a new health insurance law.

2.3.2 The Health Insurance Law

Looking back at the last fifteen years or so, the most remarkable thing about this new law is that it seems to persist in a state of imminence, often entrenched in some sort of timetable detailing just how little remains until a draft is finalized and introduced into the legislative process, but never quite getting there. In the following, I'll give a brief sketch of this development with a focus on recent developments since 2007.

To provide health insurance coverage to all Egyptian citizens has been an intention ever since the HIO was founded in the 1960s (*Al-Ahram Weekly* 2001-04-05). First plans to make health insurance universal were drawn up in 1979 under President Anwār al-Sādāt (1970–1981) but put aside after his assassination in 1981 (personal interview with Dr. Ḥamdī al-Sayyid). Then, since the 1990s, coverage has been extended to include more segments of society and the adoption of the HSRP in 1997 put the aim of universal coverage back on the list of concrete goals of state policy (McEuen 1997-08, p. 3). A preliminary draft existed as early as 2001 (*Al-Ahram Weekly* 2001-04-05), strategy papers for the reform of the health sector were presented on the NDP's first annual conference in September 2003 (*al-ahrām* 2004-12-22), discussions in the parliament's health committee and between the HIO and the Doctors' Syndicate continued during 2004 (*al-maṣrī l-yawm* 2004-12-27) and the issue was part of President Mubārak's election program in 2005 (barnāmij al-raʾīs 2005-08), when a preliminary draft was introduced into parliament by a member of the opposition party *al-tajammuʿ* (niqābat aṭibbāʾ miṣr 2008-03-16). Top level discussions within the NDP about health insurance took place in June 2006 which aimed for universal coverage by 2010 (*Al-Ahram Weekly* 2006-06-29) (apparently, there was a draft in 2006 as well, *Daily News Egypt* 2008-09-05), and ten months later, in April 2007, Jamāl Mubārak, the influential son of the President and Deputy General Secretary of the government party, presented the outlines of the new health insurance system to high ranking ministers and local party

members to start an internal discussion (*al-ahrām* 2007-04-04). A preliminary draft (No. 8) prepared by the ministry of health and population came to light in June 2007 (al-hayʾa al-ʿāmma 2007-06) and was ought to be finalized and introduced into parliament in November 2007, now envisioning full implementation in 2011 (*Al-Ahram Weekly* 2007-05-17; *al-ahrām* 2007-07-12; *Al-Ahram Weekly* 2007-07-19; *Al-Ahram Weekly* 2007-10-25). However, the law was postponed because of internal rifts within the government over financing. In particular, no agreement could be reached between the Ministry of Health, the Health Committee of the People's Chamber, and the Ministry of Finance, the latter doubting the reform's financial feasibility. But also there had been indications that government had withdrawn its support of the reform as a whole, at least temporarily; for instance the topic had not made it on the agenda of the NDP's annual conference in 2007 (*Egypt.com News* 2007-12-13; *al-maṣrī l-yawm* 2007-08-20; *al-fajr* 2007-08-20).

Attempts to finalize the draft were made in 2008 (*al-ahrām* 2008-09-13), when it was announced to be discussed during the following parliamentary session period that started in November 2008, and it figured prominently among the cabinet's legislative projects for that session period (*al-maṣrī l-yawm* 2008-10-14; *al-ahrām* 2008-12-01; *Daily News Egypt* 2008-09-05).[54] However, when Minister of Health Ḥātim al-Jabalī attempted to introduce the draft into parliament, the Ministry of Finance announced that it would delay stating its position towards the draft, thus not allowing it to get out of the cabinet. The MOF rejected the feasibility study prepared by the MOH and claimed that the necessary funding was not available at the time being (*al-maṣrī l-yawm* 2008-12-13).

The tale continued. As late as February 2009, the MOH publicly stated a timetable by which the draft would be made public during a conference at the end of March and then enter the legislation process before June 2009 (*majallat rūz al-yūsif* 2009-02-07; *Al-Ahram*

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[54] The annual parliamentary session usually starts on the second Thursday of November and lasts nine months. However, the President of State may call for the start of the annual session before that and terminate it after at least seven months have passed. The session that started in November 2008 will adjourn in June 2009 (*Al-Ahram Weekly* 2009-02-19).

Weekly 2009-02-19). The time-table changed once again in early March 2009 when the minister declared that the draft would not be ready before May but was to be presented to both houses of parliament in the current session period (i.e. until June 2009) in order to be voted on at the beginning of the next parliamentary session period, that is usually in November (*al-maṣrī l-yawm* 2009-03-04). Not even two weeks later the presentation of the draft was postponed to November 2009, allowing for its passing not before early 2010.

Another characteristic of the imminent reform is a profound confusion in the media over the timeline for its full implementation, i.e. the point in time when universal coverage of citizens in all governorates will be accomplished. In early 2009 for example, an informed follower of the Egyptian press could read about either 2012 (*al-maṣrī l-yawm* 2009-03-17a), 2017 (*al-maṣrī l-yawm* 2009-03-23), and 2026 (*majallat rūz al-yūsif* 2009-02-07) as the ultimate timeframe. While this may be partly due to confusion between the passing of the law, the implementation of the new functional division in all governorates, and the universal coverage of all citizens in all governorates, the MOH and the Ministry of Finance seem nevertheless to rely on very different prospects.

The background for the delays in 2009 was negotiations over financing between parliament's Health Committee and the Ministry of Health on one side and the Ministry of Finance on the other. The latter, in response to a feasibility study by the MOH that it had rejected in December 2008 (*al-maṣrī l-yawm* 2008-12-13), had been conducting a study on the eventual costs of the new health insurance system, cooperating with an international think tank and experts of the World Bank (*al-dustūr* 2009-02-02). The results of this study were supposed to be presented in May 2009 (*al-maṣrī l-yawm* 2009-03-04), first details leaked out in March (*majallat rūz al-yūsif* 2009-02-07), but it took until July for the results to be presented to the Prime Minister (al-hayʾa al-ʿāmma 2009-07-14a; al-hayʾa al-ʿāmma 2009-07-14b).

The Preliminary Draft

Before describing the nature of these negotiations, let's have a closer look at what regulations the new law is to entail. Since at the time of this writing — June 2009[55] — a finalized draft still does not exist, I'll draw from a preliminary draft that was made public and discussed in the summer of 2007 (al-hayʾa al-ʿāmma 2007-06; *al-maṣrī l-yawm* 2007-08-20).

This draft No. 8, prepared by the MOH, consists of six sections. The first section states the general domain of the law and the new system's major characteristics: insurance will be compulsory, it will cover sickness and work related injury but not the effects of natural disasters; the functional division of financing from service provision is mentioned here and that its implementation shall be gradual.

The second section deals with the administration of the new system, for the sake of which a new authority will be established under the control of the MOH. Until then, the HIO will substitute.

Section 3 expounds on the financing of the new insurance, that is on premiums, fees, additional payments, and support by the state. I will get back to this aspect later on.

The key feature of the new insurance system, i.e. the contracting of service providers, is spelled out in the following section No. 4. Regulations for contracting will be worked out by the new authority.

The title of the fifth section is "general provisions" and it details, among other things, the insurance authority's responsibilities towards beneficiaries. The extent to which those unable to pay premiums or fees will be covered falls into this section, as do the obligations of service providers to keep medical records and make them available to the authority and rules of how to deal with the new system's eventual debts and surpluses.

Finally, the sixth section defines penalties for obstructing the authority, not cooperating with it, and fraudulent behavior (al-hayʾa al-ʿāmma 2007-06).

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[55] See section "P.S.: October 2009", p. 61.

The Negotiations

The negotiations in early 2009 concerned the financial aspects of the draft. The relevant provisions are found in sections 3 and 5 of preliminary draft No. 8. Section 3 describes the system of premiums, fees, additional payments, and state support, or, in other words, the revenues of the system. In addition, in section 5, the stipulations of the authority's responsibilities determine the expenditure side.

In order to get at least a vague impression of what elements of the legislation are problematic and debated, I will compare the drafts of 2005 (by the *tajāmmuʿ*-party) and 2007 (No. 8 by the MOH) with the little information that is available on the feasibility study and the negotiations of 2009.

Revenues

Regarding the income side, there are two types of revenues, the premiums payed by the insured (and their employers) and state support generated from taxes. And both were up for negotiation. With premiums, the main issue is whether to opt for fixed rates or for an income related proportional system. The draft of 2007 for example lists income related premiums of 1.5%, the feasibility study calculating with a slightly lower rate of only 1%.[56] These payments by the employees are complemented by an employers' contribution of 4%. On the other hand, according to the draft, certain groups — children under school age, non-working women, professionals without a steady income, etc. — pay fixed rates (al-hayʾa al-ʿāmma 2007-06, mādda 6; *majallat rūz al-yūsif* 2009-02-07).

So in all likelihood and in accordance to Egypt's tradition to extend insurance and other services one social group or one corporatist entity at a time, the new system will combine both elements. The exact mixture however still has to be negotiated. In general the Health Committee, according to its head Dr. al-Sayyid, favors income related premiums while government and especially the Ministry of Finance tend toward fixed rates. Concerning students and pu-

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[56] The feasibility study talks of employees in the public and private sector while the draft speaks of workers by the laws of social insurance.

pils for example, 2007's draft had proposed a proportional premium of 5% of the annual tuition but at least 10 L.E. The feasibility study on the other hand figured with the current fixed rate of 5 L.E. per year. Apart from the social concern that may be involved in this example, fixed premiums are easier to calculate — many people, like small shop owners for instance, have an unsteady income so that proportional premiums may prove problematic, as the MOF argued in 2009. The Health Committee is less worried by such concerns and suggested to use tax declarations as a basis, its main interest lying in the appropriate funding of the health sector (al-hayʾa al-ʿāmma 2007-06 mādda 6; *majallat rūz al-yūsif* 2009-02-07; personal interview with Dr. Ḥamdī al-Sayyid).

Differences over this issue are quite central to the reform as a whole and an accommodation seems hard to reach. Negotiations between the MOH and the Health Committee in 2007 failed to reach an understanding in this regard when members of the committee harshly criticized the government's preliminary draft for not providing an adequate financing (*al-fajr* 2007-08-20). And government was equally adamant in its rejection of other proposals, so that in 2008, when Minister of Health Dr. Ḥātim al-Jabalī presented the revamped preliminary draft to Prime Minister Aḥmad Naẓīf, details on premiums were simply left out (*al-ahrām* 2008-09-13).

As to taxes, there seems to be little disagreement. Both the draft and the study propose a special tax on tobacco and cement, they merely differ in the selection of services for which extra fees should be raised, the draft opting for drivers' licenses, car licenses, and licenses given out to health centers, hospitals and pharmacies, while the study considers fees for harmful substances (al-hayʾa al-ʿāmma 2007-06; *majallat rūz al-yūsif* 2009-02-07).[57]

Expenditures

With regards to the funding of a system, expenditures matter just as much as the revenues. Tensions may arise in several fields: the

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[57] Yet it seems to have never been part of the discussion to move to a tax based system of funding health care in a larger extent, as is considered and compared to the premium-based model by Gericke 2006.

scope of services covered, the scope of people covered, and the additional payments and fees to be payed by patients.

However, only few of these are spelled out in the law itself, the bulk of issues to be detailed in bylaws and regulations. What the drafts do detail, concerning expenditures, are the domain of health insurance and inability. And here the MOH's draft of 2007 is somewhat limiting the responsibilities of health insurance compared to the draft law of Dr. Fayyāḍ of the *tajammuʿ*-party, adding, for example, the underlined phrase to the definition of the insurance's domain: "the treatment of the patient until he is cured, his state gets permanent, or his inability is verified" (al-hayʾa al-ʿāmma 2007-06, mādda 11; niqābat aṭibbāʾ miṣr 2008-03-16, mādda 25). And inability, in the MOHP's draft, is defined as inability "because of sickness or work-accidents", and, other than in Fayyād's version, does not implement a patient's right to have a decision by the HIO committees reviewed (al-hayʾa al-ʿāmma 2007-06, mādda 13; niqābat aṭibbāʾ miṣr 2008-03-16, mādda 30-32).

The content of bylaws — the regulation of additional payments and fees, the exact definition of who will be exempt from premiums and how fast the coverage shall be extended to include all citizens — and the negotiations about them are somewhat harder to grasp at this point in time, with the assumptions underlying the (not yet published) feasibility study as the only source. Judging from press coverage about the study, it was carried out on a basis that corresponds largely to the demands of the Health Committee and the Doctors' Syndicate. They propose that about 20% of the Egyptian population be exempt from all costs, that there be an upper limit for fees and additional payment and that those chronically ill be exempt from such payments (personal interview with Dr. Ḥamdī al-Sayyid; *majallat rūz al-yūsif* 2009-02-07). The study, on this basis, expects the new system to cost 85 billion L.E., with a potential of 150 billion L.E. if health care services are extended, compared to a current annual expenditure of 36 billion L.E. for health care. These costs would put enormous strains on Egyptian society and the state: until 2012, costs for health insurance would rise by an average of 9.19% and state contribution by 56.1% (*majallat rūz al-yūsif* 2009-02-07).

P.S.: October 2009

On October 15th, 2009, the Egyptian daily newspaper *al-maṣrī l-yawm* published three articles with lengthy quotes from the new draft law on health insurance that the President of State had submitted to the State Council — Egypt's administrative judiciary — to take its legal expertise. The next step will be to present the draft to both houses of the parliament (*al-maṣrī l-yawm* 2009-10-15a; *al-maṣrī l-yawm* 2009-10-15b; *al-maṣrī l-yawm* 2009-10-13).

The draft would establish three new institutions adhering to the MOH, first, the "general economic authority" (*hayʾa ʿāmma iqtiṣādiyya*) that will manage all MOH affiliated hospitals (and possibly more in accordance with future decrees by the Prime Minister), second, the "national health insurance fund" (*al-ṣandūq al-qawmī li-l-taʾmīn al-ṣiḥḥī*) that will be run by the HIO but have its independent budget and be responsible for the financing of health care services, and, third, the "national authority for the organization, control, and realization of quality in health services" (*hayʾa qawmiyya li-tanẓīm wa-murāqaba wa-taṭbīq jawdat al-khidamāt al-ṣiḥḥiyya*). The division of functions that had failed in 2007/08 would thus be accomplished.

All health care services covered by the national health insurance scheme will be delivered by either Family Health Units or private facilities contracted by the HIO and approved and licensed by the new authority for quality control. The public hospitals managed by the economic authority are to be transferred into its actual ownership over a period of two years.[58] The draft, at this point and to the

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[58] The wording of the summarizing article that went along with the excerpts can be misunderstood at this point: "the law aims at *turning* the public hospitals *into* economic authorit*ies*" (*kamā yahduf al-qānūn ilā taḥwīl al-mustashfayāt al-ʿāmma ilā hayʾāt iqtiṣādiyya*) (*al-maṣrī l-yawm* 2009-10-15b), whereas the text of the actual draft reads: "these hospitals are gradually registered and *transferred to* an economic authority" (*yatimm taʾhīl hādhihi l-mustashfayāt tadrījiyyan wa-naqluhā ilā hayʾa iqtiṣādiyya...*) (*al-maṣrī l-yawm* 2009-10-15a). The first article indicates that each public hospital would be turned into a profit-oriented entity that could be sold individually, which sounds much more like privatization than the actual plan of transferring them altogether to one authority — the selling of which would definitely not go down unnoticed or without protest.

extent quoted in *al-maṣrī l-yawm*, does not explicitly state a prohibition to sell the economic authority.

As to the financial aspects, the draft stays true to its predecessors' strategy to exclude natural disasters and plagues, emergency medicine, and preemptive care like vaccinations from its scope of coverage. Insurance will be mandatory but implemented gradually by decrees of the Prime Minister and in accordance with the financial abilities of the state. Premiums are dependent on the income categories introduced by the various laws on social insurance and vary between 1% and 4% of the monthly income with a minimum of 20 L.E. for lower incomes. Members of professional syndicates pay a premium of 5% not of their individual income but of the "average/mean of monthly social insurance income" (*mutawassaṭ al-ajr al-taʾmīnī al-ijtimāʿī al-shahrī*) that is determined as the average income of all insured persons.

Premiums for poorer citizens are to be covered by the state, although the law does not specify here who will qualify as such; school aged children and students are insured by a standard fee of 15 L.E. to be annually deducted from their registration fees, and children under school age as well as non-working wives and husbands are insured via the insured head of the household who has to pay a certain extra premium for each.

There are a number of fees and co-payments detailed in the draft. The patient pays for 30% of treatment costs in out-house clinics and 5% in hospitals. This is a steep increase to the 10% currently paid in public clinics. Co-payment for medication is 30% but with an upper limit of 40 L.E. and an exemption for those chronically ill. There is a fee of 5 L.E. for visiting a general doctor, 10 L.E. for a specialist, 20 L.E. for examinations at home and a co-payment of 5 L.E. for each day in a hospital (with a maximal 50 L.E.).

Part of the state transfers to the health insurance funds will be generated by a 15% tax on all tobacco items sold.

In short, the draft law at this point does certainly raise premiums, fees and co-payments and has implemented a mechanism that is likely to generate an even higher expenditure for health care. The combination of premiums proportional to one's income, fixed minimal premiums and the possibility to annually adjust the premi-

ums according to inflation are not to be found in previous draws and probably are the result of the last months' negotiations that centered on financial feasibility. Yet social concerns were not completely disregarded, as can be seen from the upper limits for co-payments and fees. Almost certainly, it will draw criticism from opponents of privatization.

P.P.S.: January 2010

As of January 2010, not much has happened with regard to the draft law. It was presented to the State Council (i.e. Egypt's administrative courts) which raised 12 legal concerns, some of them, according to the daily *al-maṣrī l-yawm*, constitutional (*al-maṣrī l-yawm* 2009-12-10). However, the MOH and HIO regard these concerns as suggestive comments and deny all doubts that the law could violate the constitution (*al-ahrām* 2010-01-13). Overall, the draft has not even instigated a public debate yet and is not commented on very often. Concerning the legislative procedure, President Mubārak named it as one of the chief projects for this legislative period (*al-maṣrī l-yawm* 2009-11-22) and a preliminary version has been presented to members of the People's Chamber to discuss while awaiting a final draft (*al-maṣrī l-yawm* 2010-01-13).

3 Some Context

Now, this paper is dealing with one topic only, trying to outline structural features of the Egyptian health sector and ongoing reforms. While this focus has certainly been necessary for pragmatic reasons, it has led to a somewhat skewed perspective as well. First, viewing health care issues in isolation may contribute to an all too easy overestimation of the topic's importance. That is because, although no doubt it does matter for the lives and well-being of millions, so do other urgent issues that would deserve equal attention. As a reminder of that, I'll briefly discuss Egypt's Five-Year-Plans For Development to put health care into a wider context. The discussion of the plans also serves to stress the general contingency of state policy on economic development.

Second, most of the material and sources used for the description of the health care sector actually deal with or were written before the background of the Health Sector Reform Program. And on that account, they are, just as is this paper based on these texts, likely to reinforce the reform plan's narrative by foregrounding the same issues the HSRP wants to deal with. By doing that, they implicitly outline the problem side of a situation in a way that makes the HSRP an almost natural solution because the situation is described in correspondence with the HSRP's aims. In other words, texts on the HSRP tend to deal with the same problems that the HSRP deals with and thus make it appear more convincing as a solution than it may actually be, because they leave out the predicaments that the HSRP provides no ailment for. To counter this bias somewhat, I'll sketch one internal factor in the health care sector — the situation of doctors — that is neglected in the HSRP's framework although it is highly problematic and linked to several key issues of reform.

3.1 The Five-Year-Plans

Egypt's Five-Year-Plans are prepared by the Ministry of Investment and seek to ensure continuity in the state's development policy. They promote a "vision of development" with a time horizon of

roughly 20 years, to which the actual Five-Year-Plans' projects accede. Accordingly, the plans considered here — the fifth plan for the years 2002–2007 presented in 2001, and the sixth Five-Year-Plan of 2007 for 2008–2010 — project their goals of development until 2022 and 2027 respectively: to counter overpopulation by the extension of the populated area, to limit the growth of the population, to accomplish a just distribution of wealth and resources, and to promote the development of human resources. Boosting economic growth is seen as a general prerequisite (*al-khiṭṭa* 5 2001a, p. 5–8; *al-khiṭṭa* 6 2007a, p. 12ff. 16f.).

Each of these goals is a response to a very concrete problem. Take for example the extension of the populated area. Egypt has a population of 75 million people (wizārat al-ṣiḥḥa wa-l-sukkān 2009c) and an area of over one million square kilometers, but actually only 2.5% of its territory is inhabited. The latter roughly coincides with the narrow Nile Valley, i.e. Egypt's fertile ground. While the density of population has reached intolerable levels already in some areas, the continuing growth destroys 12,500 ha (30,000 *faddān*) of fertile ground annually and ultimately endangers Egypt's ability to produce sufficient amounts of crop and vegetables. Also, the concentration in urban centers will grow and add to the existing 1,100 slum areas, which have devastating effects on all conceivable levels from social to environmental to political concerns, as well as put pressure on existing infrastructure from streets to canalization to the electric grid to the system of social services. Therefore, increasing the populated area and shifting urbanization towards desert land appears mandatory (*al-khiṭṭa* 5 2001a, p. 5).

In order to achieve this goal, new towns like New Asyut or New Suhag are to be built and extended along several geographical axes. State investment is to be redistributed towards these axes. In order to create job opportunities for the new towns' and villages' population, massive investments have to be made into irrigation systems to promote agricultural activity, either relying on the Nile or groundwater, and into industrial and touristic projects (*al-khiṭṭa* 5 2001a, p. 6f. 72).

It's easy to see how this is a vital yet enormous task that requires funding, expertise and staunch political support. The same can be

said with regard to the other main goals in the Five-Year-Plans. To attain these goals, five strategies are invoked: human development, reform of administration and democratic institutions, the development of Egypt's industrial and natural resources, the establishment and growth of a scientific and technological basis, and, lastly, cooperation on the regional and international level. The provision of health services and health insurance to all citizens is just one part of the strategy for human development, alongside education, wastewater management, and the provision of drinking water. In the plan of 2001, it is argued that experience in other countries has shown the beneficial effect of health care on national productivity. In 2007, this line of thought is taken for granted and the plan speaks of a reorientation of state investments towards human development, especially education and health care (*al-khiṭṭa* 5 2001a, p. 8; *al-khiṭṭa* 6 2007a, p. 16).

Before we take a closer look at how the health sector and its reform fit into the general theme of the Five-Year-Plans and how much resources are allotted to it, I would like to demonstrate how even such long term plans depend heavily on economic growth and performance.[59]

Both Five-Year-Plans' second chapters evaluate the progress made in the years preceding them. The fifth Five-Year-Plan (2002–2007) looks back at the years 1997–2002, the years 2002–2007 are evaluated by the sixth plan of 2007 (*al-khiṭṭa* 5 2001c, p. 79ff.; *al-khiṭṭa* 6 2007c).

Economic circumstances differed greatly during these two periods. Economic development in the first five years was disappointing. GDP-growth, the usual measure for economic development, was at an average of 4.5% during 1997–2002, instead of the projected 6.9%, and dropped to 3.1% towards the end. 2002–2007 on the other hand saw the GDP-growth rise from 3.1% in 2001/2002 to 6.9% in 2006/07, making for an average of 5.5%. This latter development was actually better than anticipated and instigated an adap-

[59] This point is rather obvious, I admit. Yet undermining it with some detail won't hurt either.

tion of the original Five-Year-Plan for these years (*al-khiṭṭa* 5 2001b, p. 18–24; *al-khiṭṭa* 6 2007c, p. 18–23).

And investments corresponded with the economical development. Overall investment for 1997–2002, understood as the amount of money spent for goods and services (excluding transfer payments and savings), were 320.3 billion L.E., and the ratio of investment to GDP decreased from 21.1% in 1997/98 to 16.9% in 2001/02. Government (together with economic authorities) carried the bulk (42.9%) of investment during this period. Almost none of the proclaimed aims for this period could be fully attained. In 2002–2007 on the other hand, investments were 503.4 billion L.E., and the ratio of investment to GDP had risen to 22.75% by the last year of the plan.[60] While investment by private and public sector boomed (70.4%), the share of government and economic authorities in investment decreased to 29.6% and private investment became the dominant factor with an increase from 45.9% in 2003/04 to 66% in 2006/07. This increase of private spending was reflected in the adjusted planning that cut back somewhat on government's investments and measured by this adjustment the fifth Five-Year-Plan was over-fulfilled.

So, these two different developments — economic growth falling back behind expectations in 1997–2002 and government having to shoulder almost one half of all investment versus unexpected economic growth in 2002–2007 with non-governmental and private sectors funding the larger share of investment — illustrate the extent to which long term plans depend on economic circumstances, a fact that should be kept in mind when discussing health insurance legislation.

Now, let us turn to the health sector's place in relation to other projects. The sixth Five-Year-Plan projects investments of 1,295 billion L.E. for the period 2007–2012. Of these overall investments (including public and private spending) 4.8% are dedicated for agri-

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[60] This last figure was inferred from the projected GDP by factor cost for 2007/08 (725 billion L.E.) and the projected sum of investments for the same time (165 billion L.E.). For 2006/07 the according figures are: GDP by factor cost (674.6 billion L.E.), investment (150 billion L.E.), and the ratio of investment to GDP 22.2% (*al-khiṭṭa* 6 2007f, m1).

culture, 11.2% are allotted for the extraction of natural resources like gas and oil and 22% flow into their refinement (*al-ṣināʿāt al-taḥwīliyya*). Another 21% of investments go to transportation and storage, electricity and its production takes up 5.7%, and 8.3% are invested into real estate, while construction and renovation attracts as little as 1.9% and so on. Everything that could be deemed social services[61] taken together takes up 15.6% with a respective 3.7% for education, 2.2% for health care, 6.3% for "other services", and 3.4% for waste water management (*al-khiṭṭa* 6 2007f, m7). So despite the importance to develop the health system that has hopefully been demonstrated in this paper, the perspective of investment demonstrates how health care is just one of many venues of national development, many of which are just as important and even require or attract much more funding.

As a last point in this sub-chapter, I want to take a glance at how investment in health care has developed over the last years and is planned to develop in the future. The original idea was to see in how far the HSRP and especially the new health insurance are included in long-term investment plans.[62] It turned out however, that the HSRP seems not to be factored in, as the ratio of health care investment to total investment remains about the same (2.2%) as does health care contribution to the GDP (1.19% in 2012 vs. 1.17% in 2007), thus showing no considerable dynamic in the sixth Five-Year-Plan's figures for 2008–2012 (*al-khiṭṭa* 6 2007d, p. 73–78; *al-khiṭṭa* 6 2007f, m6f.).[63]

Also, the development of spending for health care is not easy to judge based on the Five-Year-Plans, because subsequent plans use

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[61] "Services of education, health, and personal services" (*khidamāt al-taʿlīm wa-l-ṣiḥḥa wa-l-khidamāt al-shakhṣiyya, al-khiṭṭa* 6 2007f, m7).

[62] As part of the goals, they are included implicitly and explicitly, implicitly because the sixth Five-Year-Plan subscribes to President Mubārak's election program and to the Third Millennium Goals (*al-khiṭṭa* 6 2007c, p. 53–58), and explicitly as a goal to raise the number of health care beneficiaries to 80 million (100%) by 2012 in the sixth plan's section on social development (*al-khiṭṭa* 6 2007e, p. 156). For the HSRP and the FHM in the fifth Five-Year-Plan, see: *al-khiṭṭa* 5 2001c, p. 80.

[63] In absolute numbers, investment in 2008–2012 will increase by 157% compared to the previous five year period, but inflation is not factored in. Also, the share of government investment in health care will rise only slightly (5.9% > 6.5%) (*al-khiṭṭa* 5 2001b, p. 19ff. 21ff. 31ff.; *al-khiṭṭa* 6 2007f, m 6f.).

different figures and consequently make it hard to compare. To give just one of many examples, the fifth plan introduces the ratio of expenditure for health care to the GDP (4%, *al-khiṭṭa* 5 2001b, p. 31), yet for the sixth plan I was not able to find a corresponding figure (see *al-khiṭṭa* 6 2007d, p. 75–78; *al-khiṭṭa* 6 2007e, p. 155–157).[64] The only trend I could make out is that the role of health care within the category of "social services" (see above) has gained importance, as the ratio of investment increased in 1996/97–2001/02 (7.4% > 10.7%, *al-khiṭṭa* 5 2001b, p. 21f.) and remained at that higher level during the fifth Five-Year-Plan (10.38%) and continues to do so in the plans for 2008–2012 (10.5%) (*al-khiṭṭa* 5 2001b, p. 19ff. 21ff.; *al-khiṭṭa* 6 2007f, m6f.). However, taken by itself does not say much.

So, while the Five-Year-Plans would require a much deeper and informed inquiry to be of help in judging the development of investment in health care, they have at least been useful in providing some context in which to situate the ambitions for health sector reform.

3.2 Doctors

Now I'd like to introduce a factor internal to the health care system that has not been fully considered in the HSRP or this paper thus far. The close connection between quality problems and the situation of the very people delivering health care services has already been noted above (see subchapter "Quality", p. 40). Yet it's worth to take a closer look and heed the details.

First of all, there are many doctors in Egypt. In the last years (2000–2007), the ratio of doctors *per capita* ranged at 2.4 per 1,000 (*World Health Statistics* 2009, p. 95ff.; compare: *Al-Ahram Weekly* 2001-04-05),[65] and as of 2009 there was a total of 205,000 physi-

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[64] According to National Health Account Series 2009-03, the GDP ratio of health care expenditure has steadily increased from 3.9% in 1995 to 6.4% in 2003 and remained over 6% until 2007. However, (*Regional Health System Observatory* 2006, p. 29) gives quite different numbers for the same ratio for the years 2000, 2004, and 2005.

[65] That may be less than in Cuba, as Gericke points out (Gericke 2005), but then again Cuba, with a ratio of more than 6 doctors per 1,000, is among the world's

cians (*al-dustūr* 2009-07-22). The sheer mass of physicians exceeds the health system's capacity with regard to practical training on the job, proper employment and payment. Still, enrollment figures into the prestigious medical faculties are high and every year about 10,000 fresh physicians leave the universities, although only about a third of them receive quality training in university hospitals (*al-dustūr* 2009-07-22; *Al-Ahram Weekly* 2000-04-13). The Doctors' Syndicate[66] has been calling for a limitation for years, especially after the emergence of private universities allowed students to circumvent the top-grade requirements at regular state and Al-Azhar's universities (*Al-Ahram Weekly* 2000-04-13), which rendered the syndicate's definitions of actual demand for doctors useless (*al-wafd* 2007-06-08). However, in September 2007 an administrative court ruled in favor of the Doctors' Syndicate's head Dr. Ḥamdī al-Sayyid and obliged the High Council of Universities that oversees all universities in Egypt to gradually reduce the enrollments to 3,500 *per annum* over a period of four years (*al-maṣrī l-yawm* 2007-10-03). The implementation of the ruling is apparently not to be taken for granted and the syndicate has launched a campaign on that account, but 2009 saw a first reduction of accepted new students and the desired limitation of 3,500 enrollments per year is to be reached in 2014 (*al-dustūr* 2009-07-22).

The abundance of doctors however, is countered by an odd ratio of general practitioners vs. specialized doctors and a scarcity of

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leading nations right next to Italy and the USA, while the European average is 3.2 doctors. Thus, Egypt's ratio is well higher than the regional average of the Eastern Mediterranean Region (1.0) and still higher than that of Saudi Arabia (1.4) or England (2.3) (*World Health Statistics* 2009, p. 95ff.). The WHO's Health Systems Profile talks of an "excess of physicians" considering the country's income situation (*Regional Health System Observatory* 2006, p. 46).

[66] The Doctors' Syndicate (*al-niqāba al-ʿāmma li-aṭibbāʾ miṣr*) is the professional organization of physicians founded in 1940 and with a membership of about 170,000 doctors, 70,000 of them in state service. Internal elections have not been held since 1992, since when the responsible court has not granted the permission for holding elections yet. The board elected in 1992 is still in charge and displays a majority of members belonging to the Muslimbrothers, while its chairman is Dr. Ḥamdī al-Sayyid, a prominent NDP-MP and longstanding head of the People's Chamber's Health Committee, who seems to be respected both by government officials and his constituency (*al-wafd* 2007-06-08; *Al-Ahram Weekly* 2008-02-07). For the syndicate's role in bioethical decisions see also Bentlage 2007.

other trained medical personnel like nurses, midwives and assistants. This is highly inefficient, as doctors are forced to carry out functions they have no sufficient training for (Gericke 2005, p. 1080ff.; *Regional Health System Observatory* 2006, p. 46). In 2009, the MOH declared that it lacked 50,000 trained nurses (*al-maṣrī l-yawm* 2009-12-27).[67]

Also related to the high number of medical doctors is the inadequate payment of doctors, at least when in public service. The basic salaries they receive are very low because there is no system in place to raise wages paid by the government in accordance with the development of costs (*Al-Ahram Weekly* 2009-08-06). Especially young graduates are in a dire financial situation since the basic salary is estimated by seniority, graduates starting out with less than 300 L.E. per month while doctors close to retirement earn 500% more;[68] in 2009 there were protests of young doctors claiming to live below the poverty line and calling for a basic salary for graduates of 1000 L.E. (*al-maṣrī l-yawm* 2009-08-11). In addition to the basic salary, there are a number of compensations, bonuses, and incentives. For example, there is a monthly compensation of 25 L.E. for fighting infections and contagion (*badl al-ʿadwā*),[69] for night shifts (*badl al-sahar*), for transportation (to work) (*badl muwāṣalāt*), etc., plus one-time bonuses for achieving higher university degrees like the doctorate and the magister (*ḥāfiz al-diblūm, ḥāfiz al-mājistīr*),[70] a bonus for additional qualifications (*ḥāfiz al-zamāla*), a monthly local bonus (*ḥāfiz al-maḥalliyyāt*) of 75% of the basic salary,[71] as well as a "reward bonus" (*ḥāfiz al-ithāba*) (*al-*

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[67] Other anecdotal evidence of this scarcity is an article about 16 nurses with Hepatitis C, who cannot be transferred to desk jobs because there would be no one to take their place (*al-maṣrī l-yawm* 2009-12-19).

[68] The latter is based on the income situation in 2001, when graduates received a basic salary of 120 L.E. and senior doctors about 600 L.E. (*Al-Ahram Weekly* 2001-04-05). However, since the basic salary for graduates has since changed, it might well be that the increase by seniority has been adjusted as well.

[69] The ratio of doctors with Hepatitis C in Egypt is rather high and many need liver transplantations (*al-maṣrī l-yawm* 2008-10-26).

[70] This bonus is a compensation for the high expenditures that can easily reach 20,000 L.E. for a doctorate (*al-maṣrī l-yawm* 2008-10-26), since the admission fees have reached 3,650 L.E. (*al-maṣrī l-yawm* 2009-08-11).

[71] Supposedly for doctors working in rural areas.

maṣrī l-yawm 2009-08-11; *al-maṣrī l-yawm* 2008-10-26; *al-maṣrī l-yawm* 2009-04-01).

All in all, many doctors cannot make do with only one job but work in public clinics part time only. Since their salary does not depend on performance, motivation is low. Accordingly, former head of the HIO Nabīl al-Maḥayrī in 2001 named the reallocation of available sources as a key to reform, opting for a limited number of doctors working full time against an increased salary (*Al-Ahram Weekly* 2001-04-05). And the Doctors' Syndicate has been calling for a complete restructuring of the payment system since 1988, replacing the various ministerial decrees that regulate bonuses and incentives with a unified law, a so called cadre law (*kādir khāṣṣ*) (*al-wafd* 2007-06-08; *Al-Ahram Weekly* 2008-02-07; *Al-Ahram Weekly* 2008-03-27). In his election program of 2005, President Mubārak had included the promise to introduce a cadre for medical professionals (*al-wafd* 2007-06-08).

Apart from the fact that many see the necessity for a complete overhaul of payment structures, another reason for doctors to demand a cadre law is that bonuses based on ministerial decrees can not always be counted on. For example the MOH's decrees 318–320 of 2008, promised a monthly bonus of 150% of the basic salary for general practitioners (*al-ṭabīb al-mukallaf, al-mumāris al-ʿāmm*), 300% for local doctors (*al-ṭabīb al-muqīm, al-ṭabīb al-muʾahhal al-muqīm*), 30% for specialists and their assistants (*ṭabīb ikhṣāʾī*), and 400% for doctors working in emergency units (*al-mutafarraġūn li-l-ʿaml bi-aqsām al-ṭawāriʾ*) (*al-maṣrī l-yawm* 2008-10-23). This package, usually referred to as "doctor's bonus" (*ḥāfiz ṭabīb*, see *al-maṣrī l-yawm* 2008-10-27), was the first stage of a plan to alleviate doctors' financial problems over a period of three years, which the syndicate and the government had agreed on (*al-maṣrī l-yawm* 2009-04-01; *al-maṣrī l-yawm* 2009-05-20). The payments were due starting August 2008 but until September 18,000 doctors still had not received the promised bonuses as several organizations, including the HIO's teaching hospitals, did not responded to the decree (niqābat aṭibbāʾ miṣr 2008-09-14). In late October the Doctors' Syndicate held an assembly of the national board of administration with its local counterparts to discuss the matter and repeat its demand for a general cadre law (*al-maṣrī l-yawm*

2008-10-23) and decided to call for an urgent general assembly in November to decide on measures of protest (*al-maṣrī l-yawm* 2008-10-26).[72] Protests were then put off[73] to await a meeting with Prime Minister Aḥmad Naẓīf in March 2009 (*al-maṣrī l-yawm* 2009-02-22). The meeting, with the global financial crisis still unfolding, didn't resolve the situation and in April 2009 on several occasions doctors demonstrated in front of the Ministry of Finance, the People's Chamber, and the syndicate's headquarters, surrounded by hundreds of police and payed thugs (*al-maṣrī l-yawm* 2009-04-01; *al-maṣrī l-yawm* 2009-04-29). By this time, it had become clear that the second phase of the plan to improve doctors' income was not being implemented as expected either. And on April, 9 2009 several thousand private clinics were closed in strike (*al-maṣrī l-yawm* 2009-04-09).[74] Still, the second and third phase of the plan were suspended and new harsher rules for the implementation of the first stage decided, which caused much uproar and rage among doctors (*al-maṣrī l-yawm* 2009-05-20; *al-dustūr* 2009-05-26). In July 2009 the Ministry of Finance announced that the MOH's new budget included an additional 571 million L.E. to implement the delayed second stage (*al-maṣrī l-yawm* 2009-07-29) but in late August the Doctors' Syndicate reported that not even the first stage's bonuses had been payed everywhere and the administrative boards threatened to

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[72] This early threat to protest has to be seen against the backdrop that earlier that year, in March 2008, the syndicate's administrative board had, going against what a lot of its members demanded, called off a strike in virtue of mere demonstrations because of legal issues and maybe to avoid full scale confrontation with the regime (*al-ahrām* 2008-03-10). The reason for the discontent in spring 2008 was a proposal for a cadre law by the MOHP that doctors deemed "an arbitrary package of incentives that fails to address their demands for an overhaul of wages and conditions" (*Al-Ahram Weekly* 2008-02-07).

[73] In November 2008 doctors' attention was averted from financial issues for a while because two Egyptian doctors had been arrested in Saudi Arabia and sentenced to be flogged, which was cause for angry demonstrations and protests (see for example *al-maṣrī l-yawm* 2008-11-12b).

[74] Again, the syndicate's board had found a compromise to avoid the general strike that many doctors called for but that would have raised some legal issues and probably led to a gridlock in all attempts to reconcile with the government: public hospitals and clinics stayed open and private clinics didn't officially strike but took a day of vacation. However, the date of the vacation happened to be the same date a general strike had officially been planned for (*al-maṣrī l-yawm* 2009-04-10).

resign collectively throughout the republic because of the procrastinations and promises not kept (*al-maṣrī l-yawm* 2009-08-30).

So far, the syndicate's leadership has not stepped back nor did things escalate to a full strike (*al-maṣrī l-yawm* 2010-01-11). Rather, constrained outrage and protest continues to be a vital part of syndicate politics and negotiating with the government, and the syndicate in January 2010 has proposed a new compensation for doctors to help them overcome their financial problems at least until further legislation is passed (*al-maṣrī l-yawm* 2010-01-11). Just as the syndicate's board, the government itself is in a tough spot, because any quick solution to the doctors' financial dilemma (i.e. raising the salary or bringing down the number of doctors in public service) would either overburden the state budget or cause much hardship and unrest among those laid off. And because any solution will need be, first of all, long-termed, and secondly has to take a very broad and comprehensive approach, since the public health sector merely reflects general staffing and payment pattern in government service (*Al-Ahram Weekly* 2009-08-06). First improvements can be seen as plans were evoked to both bring down enrollment figures and raise the income of doctors, but as of now, the financial situation of doctors poses a possible obstacle to the success of Egypt's ambitious reform program for its health care system, and the Doctors' Syndicate's head Dr. al-Sayyid calls on students to enroll with faculties for nursing instead of medicine "if you want good job opportunities and excellent payment" (*al-maṣrī l-yawm* 2009-12-27).

4 Concluding Remarks

The previous three chapters have been very descriptive. They basically assembled information available in the sources. Now I'd like to add some observations and remarks, first regarding the plans for reform.

It has been stated at several points that the ongoing reform is "an overhaul" of the health care system in Egypt. In fact, the choice of words isn't inspired by the often-exaggerating language of mass media only. It's a quite accurate description of what the HSRP can be if it is eventually implemented, I think. It could profoundly change how patients interact with the health care system, because beyond changing some structures, it may in fact create a new dynamic.

Over the past two decades, several developments shaped the health sector in Egypt. First, out-of-pocket payments — i.e. the money people spend directly and by their own choice — went to private facilities mostly. The only segment where public facilities clearly dominate in terms of being frequented by patients is hospitals, due to high costs for patients as well as private investors. Public spending on the other hand largely passes into the complex system of public facilities, a lot of which have huge quality problems. Until now, the revenues of both sources are hardly ever combined. Even patients with health insurance pay fully for their treatment in private clinics, not making use of the revenues of their premiums, while public hospitals rely almost entirely on state funding.

The new health insurance law will change that. The "national authority for the organization, control, and realization of quality in health services" will be able to contract public and private facilities indiscriminately based on quality standards only. Under the condition that private facilities do participate and seek contracts, this would combine private and public spending to an unprecedented extent and possibly trigger a synergetic dynamic. The partial coverage of treatment costs by health insurance can bring down the price of private health care for many patients. If, for instance, private

hospitals were to receive anything close to the subsidy HIO and MOH hospitals receive per patient and hospital bed, this segment could be made profitable for private hospitals beyond the high-price strata to which it is currently refined. Also, because insured patients will have a wider choice of providers, health insurance funds will flow specifically to those facilities that are able to attract many patients. And for public clinics, the higher co-payments mean a larger share of out-of-pocket payments. In short, the separation of functions and the contracting of providers are very likely to introduce much more competition into the health care system, with all of the benefits that has for the successful and all of the disadvantages for those not managing to compete. For an underfunded system, a more targeted and synergetic use of revenues can lead to a dynamic that I think it is justified to talk of as a fundamental change, i.e. an "overhaul."

On the other hand, there are serious obstacles as well. First, there is the question of political commitment to a costly reform that will render tangible results not right away and that against the backdrop of a panorama of other pressing issues. Second, there is the unresolved problem of Egypt's doctors who are far too many and a lot of them poorly paid while enrollment figures are just starting to decline for medical faculties. The negative impact of this dilemma is and will be felt when it comes to raising the quality of health care, to make treatment more efficient, to implement stricter guidelines in an environment where many work part time and put most of their energy in coping financially.

There are many other doubts and hopes one may have for the further development of the Egyptian health care sector, but I'll leave it at that, since the situation is still very much unfolding.

Now, concerning the Egyptian health care system in general, I think that it's a topic deserving much more attention — that is both as a research object in its own right, and also as a site for research on other topics, be it bioethical issues (institutional loci of decision making like the Health Councils), cultural matters (changes in the concepts of public and personal benefit between medicalization and Islamic *fiqh*), the transformative role of international agencies (foreign and international funding), national politics (contestation and

representation through professional syndicates) or economics. I hope that this paper succeeds to provide information and facilitate access to existing sources that may be of use in these regards.

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[75] The "jihāz al-markazī ..." (Central Agency for Public Mobilization and Statistics) has a new website < http://www.capmas.gov.eg/d >. However, until February 2011 not all documents had been transferred from the old site.

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Erscheinungsweise und Bezugsmöglichkeiten:

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