

Technical Report No. 5  
Volume V

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**Analysis of the  
Political  
Environment for  
Health Policy  
Reform in Egypt**

*September 1996*

*Prepared by:*

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Partnerships  
for Health  
Reform



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# Abstract

Technical Report No. 5, Volume V analyzes Egypt's political environment in the context of health sector reforms proposed by the Ministry of Health and Population and the United States Agency for International Development by examining political trends as well as the perceptions, agendas, and priorities of key health sector players and their collective impact on the health policy environment. This analysis consists of four parts: a review of Egyptian political trends that have affected health sector policy, a description of key players and stakeholders and their organizational objectives, an assessment of the international donors' role in Egypt's health sector reform, and an analysis of public opinion about the reform. Information for the analysis was collected from public documents, research papers, and a few telephone interviews.



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# Acronyms

<b>CCO</b>	Curative Care Organization
<b>CME</b>	Continuing Medical Education
<b>CRHP</b>	Cost Recovery for Health Project
<b>DDM</b>	Data for Decision Making Project/Harvard University
<b>EC</b>	European Community
<b>EPI</b>	Expanded Program of Immunizations
<b>GATT</b>	General Agreement on Trade and Tariffs
<b>GIS</b>	Geographic Information System
<b>GOE</b>	Government of Egypt
<b>GNP</b>	Gross National Product
<b>HIO</b>	Health Insurance Organization
<b>HMIS</b>	Health Management Information Systems
<b>IMF</b>	International Monetary Fund
<b>MCH</b>	Maternal and Child Health Care
<b>MOE</b>	Ministry of Education/Universities
<b>MOF</b>	Ministry of Finance
<b>MOHP</b>	Ministry of Health and Population
<b>MOLA</b>	Ministry of Local Administration
<b>MOP</b>	Ministry of Planning
<b>NGOs</b>	Non-Governmental Organizations
<b>NODCAR</b>	National Organization for Drug Control and Research
<b>PHC</b>	Primary Health Care
<b>PM</b>	Preventive Medicine
<b>PVOs</b>	Private Voluntary Organizations
<b>QA</b>	Quality Assurance
<b>TA</b>	Technical Assistance
<b>THO</b>	Teaching Hospital Organization
<b>UN</b>	United Nations
<b>UNDP</b>	United Nations Development Program
<b>UNFPA</b>	United Nations Fund for Population Activities
<b>USAID</b>	United States Agency for International Development
<b>WB</b>	World Bank
<b>WHO</b>	World Health Organization

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# Preface

This report is one of a series of six analyses conducted by the Partnerships for Health Reforms (PHR) Project for the Health Office of the United States Agency for International Development/Cairo between June and September 1996. PHR was requested by the Mission to conduct these analyses to support and inform the design of its upcoming Health Sector Reform Program Assistance, which is intended to provide technical and financial assistance to the Government of Egypt in planning and implementing health sector reform. The analyses examine the feasibility and/or impact of a set of health sector reform strategies that were proposed jointly by the Ministry of Health and Population and the United States Agency for International Development. These proposed strategies are shown in the following table.

Technical Report No. 5 contains all six analyses. The analyses and their corresponding volume numbers are as follows:

Volume I	Suggested National Health Sector Reform Strategies, Benchmarks, and Indicators for Egypt
Volume II	Economic Analysis of the Health Sector Policy Reform Program Assistance in Egypt
Volume III	Social Vulnerability Analysis of the Health Sector Policy Reform Program Assistance in Egypt
Volume IV	Legal Analysis of the Health Sector Policy Reform Program Assistance in Egypt
Volume V	Analysis of the Political Environment for Health Policy Reform in Egypt
Volume VI	Analysis of the Institutional Capacity for Health Policy Reform in Egypt
Volume VII	Summary of Analyses

<b>Proposed Health Sector Policy Reforms</b>	
<b>Specific Strategy</b>	<b>Generic Strategy</b>
<b>1. ROLE OF THE MINISTRY OF HEALTH AND POPULATION (MOHP)</b>	
<b>1.1 Rationalize the Role of the MOHP in Financing Curative Care</b>	
1.1.1 Stop the construction of unnecessary hospitals and set strict guidelines for the completion of facilities under construction	Improve the allocation of the MOHP investment budget
1.1.2 Transfer existing hospitals to other parastatal organizations	Allow hospital autonomy
1.1.3 Expand cost recovery in government facilities	Expand cost recovery
1.1.4 Allow private practitioners to use the MOHP facilities	Allow private practitioners to use government facilities
1.1.5 Allow hospital autonomy	Allow hospital autonomy
1.1.6 Support hospitals based on efficiency indicators such as on a per capita, per bed basis, etc.	Use alternative budget allocation formula for MOHP hospitals
1.1.7 Examine the cost recovery of curative services at the primary health care (PHC) level	Expand cost recovery
<b>1.2 Strengthen the role of the MOHP in the provision and increased share of financing preventive medicine (PM) and primary health care (PHC)</b>	
1.2.1 Use cost effectiveness analysis to identify a package of PM and PHC services to be supported by MOHP to which every Egyptian is entitled	Increase the cost effectiveness of MOHP's program
1.2.2 Increase emphasis on Maternal and Child Health (MCH) programs	Increase emphasis on MCH programs
1.2.3 Provide incentives for the health care providers to specialize in PM, PHC, and family medicine	Increase the cost effectiveness of MOHP's program
1.2.4 Do not separate curative services at the PHC level	Continue to provide curative services in PHC facilities
1.2.5 Ensure adequate allocation of resources, e.g., personnel	Improve the allocation of the MOHP recurrent budget
<b>1.3 Reform the MOHP personnel policy</b>	
1.3.1 There should be no guaranteed employment	Reduce the overall number of MOHP personnel

<b>Proposed Health Sector Policy Reforms</b>	
<b>Specific Strategy</b>	<b>Generic Strategy</b>
1.3.2 Develop guidelines for MOHP personnel and apply them to redistribute personnel based on needs assessment	Improve the allocation of the MOHP recurrent budget
1.3.3 Reduce the overall number of MOHP personnel	Reduce the overall number of MOHP personnel
1.3.4 Provide incentives for the MOHP personnel to serve in underserved and remote areas	Improve the allocation of the MOHP recurrent budget
<b>1.4 Develop the MOHP capacity for national health needs assessment, sectoral strategic planning and policy development</b>	
1.4.1 Adapt the national health information systems, including Geographic Information Survey (GIS) for planning and policy decision making	Improve the allocation of the MOHP investment budget  Improve the allocation of the MOHP recurrent budget
1.4.2 Prioritize the allocation of MOHP resources based on needs using health status indicators	Improve the allocation of the MOHP investment budget  Improve the allocation of the MOHP recurrent budget
1.4.3 Create incentives for other health care providers to function in under served areas	Provide incentives to private health providers to function in under served areas
1.4.4 Target GOE subsidy to poor and indigent populations	Improve the equity of MOHP subsidies
1.4.5 Use cost effectiveness analyses in determining the essential health services	Increase the cost effectiveness of MOHP's program
<b>1.5 Develop the MOHP role in regulation, accreditation, and quality assurance of health services</b>	
1.5.1 Develop and adopt National Health Standards of Practice and health facility accreditation	Develop and adopt national health standards and accreditation
1.5.2 Establish a policy of continued physician licensing and continuing medical education (CME)	Establish CME and physician licensing
<b>2. NATIONAL SOCIAL HEALTH INSURANCE PROGRAM</b>	
<b>2.1 Ensure the viability of the Health Insurance Organization (HIO)</b>	
2.1.1 Do not add any new groups of beneficiaries to HIO	Eliminate HIO's deficit
2.1.2 Eliminate the current HIO deficit	Eliminate HIO's Deficit

<b>Proposed Health Sector Policy Reforms</b>	
<b>Specific Strategy</b>	<b>Generic Strategy</b>
2.1.3 Reduce the proportion of the pharmaceutical costs	Redefine HIO's benefits
2.1.4 Unify the existing health insurance laws into one law	Unify existing health insurance laws
2.1.5 Change the HIO legal and legislative framework to ensure its autonomy	Ensure HIO's autonomy
2.1.6 Develop premium based on actual costs using copayments and deductibles	Redefine HIO's benefits
2.1.7 Identify and adopt an affordable health benefit package(s)	Redefine HIO's benefits
<b>2.2 Transform the HIO into a financing organization</b>	
2.2.1 Stop constructing new HIO hospitals	Transform HIO into a financing organization
2.2.2 Develop a plan to sell or transfer to other private or parastatal organizations, in phases, the existing HIO hospitals, polyclinics, and general practitioner clinics	Transform HIO into a financing organization
2.2.3 Develop different mechanisms to subcontract all health service providers, including private and MOHP hospitals	Develop alternative reimbursement mechanisms for HIO contracted services
2.2.4 Allow beneficiaries to choose service providers	Transform HIO into a financing organization
<b>2.3 Expand social health insurance coverage coupled with adequate administrative and financing mechanisms</b>	
2.3.1 Design and develop a single national health insurance fund for universal coverage	Expand social insurance coverage
2.3.3 Develop a well-defined standard package of benefits that every citizen is entitled to receive	Redefine HIO's benefits
2.3.4 Separate financing from provision of services	Transform HIO into a financing organization
2.3.5 Ensure legal and financial autonomy of fund	Ensure HIO's autonomy



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# Acknowledgments

This work was based on the foundation laid by an earlier political analysis in the report *Egypt's Strategies for Health Sector Change* developed by the Data for Decision Making project of Harvard University. My participation in this earlier work was under the guidance of Professor Michael Reich of the Harvard School of Public Health, who taught me everything I know about the political economy of international health and to whom I remain an obliged student.

A large number of colleagues at the Egyptian Ministry of Health and Population, the Health Insurance Organization, and the United States Agency for International Development in Cairo were helpful in the development of this report. I am grateful to all of their valuable inputs.

Nihal Hafez



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# Executive Summary

This political analysis provides an assessment of the political environment for health sector policy reform in Egypt by examining the influences that (a) the broad political trends and (b) the perceptions, agendas, and priorities of key health sector players have on the health sector policy setting. *The main findings of the analysis are summarized as follows:*

- ▲ There is serious concern in Egypt about the nation's health care services. Although there is growing recognition at all levels of society of the need for significant changes, to date, health policy reform is not a topic of explicit public debate. The debate entails the deteriorating health sector conditions rather than specific health policy changes. Issues such as competing national health objectives and the associated trade-offs are not discussed in government agencies or academic and intellectual circles.
- ▲ During the last two decades, Egypt has moved from the concept of a centrally planned socialist model to a more liberalized and market-oriented economy. It is the government's intention to gradually allow the private sector to play a bigger role and to pursue and expand its structural and sectoral adjustment programs. The threat of serious resistance from many sections in the society including fundamentalist groups, political parties, labor unions, and entrenched bureaucracy coupled with the lack of institutional capacity, however, has caused reforms in health sector to lag behind.
- ▲ The public perception remains that it is the government's responsibility to provide free health care to all citizens. Even after it became evident that the growing health needs have outrun the government capacity to pay and provide for all, the expectation is for the government to come up with a solution. The discussions in the National Assembly, opposition parties, newspapers, and labor syndicates are more in rhetorical terms rather than addressing the real issues and are still dominated by a vision of the welfare state.
- ▲ The private and nongovernmental sectors are not represented in the policy dialogue. The nongovernmental organizations (NGOs), however, have the potential of becoming active and effective participants if invited to join the debate. The private and government sectors view each other as adversaries, and this reflects in government attitude towards matters of regulatory nature and in the private sector's lack of interest in public policy debates. While most of the Egyptians depend on health care through private providers because of the failure of government services, there is a perception in the public mind that the private sector is exploitative and profit-oriented. The consumers of health services in Egypt, however, are not organized and have no way of expressing their views.
- ▲ Physicians represent the most powerful professional group in the health sector. Those who are employed by the government, but run a private practice because of their low salaries, account for a large portion of private providers. They represent a major interest group and have a significant stake in any major reform. The Medical Syndicate is the physicians' professional association and presumably the official channel through which their views are expressed. To date, however, the syndicate's role in national policymaking has not been significant.

- ▲ The role of international agencies in initiating, facilitating, and sustaining public policy reforms in Egypt is significant. While there are many donors operating in health care, the United States Agency for International Development has been by far the most active in the policy area. The World Bank has recently been involved in initiating a dialogue with the Ministry of Health and Population (MOHP) regarding health sector reforms, as a part of the proposed European Union health sector investment project, with an estimated outlay of \$120 million.
- ▲ The Government of Egypt (GOE), as represented by the MOHP, is the agency most likely, but not necessarily most qualified, to lead any policy reform to be implemented in the Egyptian health sector.
- ▲ Though the distinction between the government sector (the MOHP and other ministries) and the parastatal sector (the Health Insurance Organization [HIO] and the Curative Care Organization [CCO]) is usually made when describing the Egyptian health sector, both sectors are, in practice, run by the state. From operational and financial perspectives, the parastatals are governed by their own set of rules and regulations, have separate budgets, and exercise more autonomy in daily operations. From a political perspective, however, the GOE/MOHP have a controlling share of decisionmaking in parastatal organizations and will accordingly determine their role in the reform process. It is the Minister of Health who appoints or discharges the chairman of the HIO and authorizes any change in the social health insurance policy.
- ▲ The two most significant policy questions confronting Egypt today revolve around the changing role of the GOE and the future of the social health insurance program. As previously mentioned, the GOE/MOHP has the most power to mobilize policy changes in either of these two domains. International donors propose reform packages and support them by funding and technical assistance. The National Assembly, as the representative of the Egyptian public, retains the ultimate authority of clearing the policy for execution. Depending on the reform package chosen, a variety of health institutions, e.g., HIO, CCO, GOE hospitals, the Medical Syndicate and/or NGOs, can become critical players during the policy implementation phase. The Supreme Health Council, Shura Council, universities, intellectual circles, and other advisory bodies are likely to provide input to policy design.
- ▲ The most critical ingredient of the political analysis is studying the true reform commitments of the GOE, i.e., how far it is willing to go with the change, how it intends to go about it, and at what pace. The incumbent Minister of Health and Population has expressed his views on health sectoral reform, both before and after his appointment. These views, coupled with the knowledge gained about past performance of health sector reform endeavors (e.g., the Cost Recovery for Health Project), and combined with an evaluation of the current political conditions in Egypt, can lead us to believe that the most politically feasible health sector reforms focus on the following:

**(1) Regarding the Role of the Government in Health Care**

- ▲ *Rationalization of the Role of the MOHP in Curative Care:* Promote GOE allocative efficiency by dedicating more resources to cost-effective health interventions, primary and preventive care, and underserved and rural areas. The actual termination of curative care provision by the MOHP, or the transfer of its hospitals to a parastatal or NGO, is not likely to be supported in the short run, however. Also, the government's true commitment to stop new hospital construction remains questionable.

- ▲ *Expansion of Health Sector Resources:* Increasing the health sector’s share in the gross national product, imposing health-earmarked taxes, enhancing partnership with private and nongovernmental sectors, and encouraging community health financing are likely options. Also, cost-containment policies, like rationalizing drug consumption, minimizing government waste, and limiting growth of the labor force, have high acceptance within the government. Though “economic treatment” schemes have been adopted in many MOHP facilities, however, nationwide expansion of cost-recovery systems is not the MOHP leadership’s preferred policy. Even in the event of supporting the use of fee-for-service systems on a large scale, the government will authorize charging only modest or “minimal” fees that will fail to recover full or partial service costs. Moreover, the government still pledges its commitment to support, at least in theory, the indigent populations, and is not likely to eliminate subsidies for this purpose until an alternative social protection mechanism is already in place.
  
- ▲ *Manpower Policy:* Plans to review and modify medical education and training programs and to promote health management and health economics expertise have wide support. Although the Minister of Health and Population is open to review of employment and compensation policies and supports taking measures to limit further growth of the governmental labor force, the termination of guaranteed government employment is not likely to be undertaken in the foreseeable future.
  
- ▲ *New Roles for the MOHP:* Development of the role of the MOHP in national policymaking and sectoral planning, and in regulation, accreditation, and quality assurance, has wide acceptance inside and outside GOE circles.
  
- ▲ *Health Systems Development and Management Improvements:* The development of health information systems, management training programs, cost controls, and effective referral systems as means to improve the technical efficiency of the health sector are all favored interventions in all spheres. Also, coordination and integration between health, population, and environmental agencies, between the MOHP and other involved ministries, and between the governmental and private sectors are some of the mandates of the incumbent Minister of Health and Population.

**(2) Regarding the Future of Social Health Insurance**

- ▲ Both the GOE/MOHP and the HIO support the (a) review of health insurance regulatory framework and unification of legislation, (b) review and subsequent modification of the current benefits package, (c) separation of financing and provision, (d) HIO institutional development, (e) quality of care improvements, (f) reduction of waste and control of drug consumption, and (g) promotion of a bigger role for private sector health insurance. The GOE, however, is likely to exert political pressure to further expand HIO beneficiaries and ultimately achieve universal coverage. The HIO itself, however, tends to be skeptical about expansions that are too accelerated, not carefully planned, or beyond the organization’s administrative or financial capabilities.

A summary of the findings of the political analysis of the proposed health policy sector reforms can be found in *Section 6.0*. Some of the above findings do raise concerns about the political feasibility of a tangible health care reform depending on the specific elements of a reform package, how the reform process is managed, and other factors in the broad political environment. The preliminary assessment of the political environment, however, illustrates that both opportunities and obstacles abound. The current political timing represents a window of opportunity for Egypt: Significant foreign aid is ready to be committed to support the reform, the political conditions have relatively stabilized, and other sectoral reforms have demonstrated their success. And

though the GOE is likely to continue to avoid controversial policies or hard decisions that are likely to provoke public resistance or political antagonism, there is room within the previously described “politically safe” health sector reform domain for developmental and redistributive policy changes that can improve the overall sectoral performance and alleviate its current distortions and inequities, thus preparing the groundwork for more aggressive structural changes.

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# 1. Introduction

Health policy reform in Egypt is challenged by growing economic burdens, rising public expectations, and political turbulence, thus representing a unique case where the political feasibility of a health policy is not only imperative for its implementation and sustainability, but also to the country's overall political stability.

The purpose of the analysis is to provide an initial assessment of the political environment for health sector policy reform in Egypt. The report examines the influences of broad political trends and the perceptions, political agendas, and priorities of key health sector players on health policy setting in Egypt, including the pattern of financing and provision of health services, role of the state in health care, and political feasibility of implementing significant reforms. The analysis is intended to provide input to the design of the health sector Program Assistance that United States Agency for International Development (USAID) plans to develop to assist the Government of Egypt (GOE) in undertaking necessary reforms.

The report comprises the following main parts:

1. A review of overall political trends that have shaped health sector policy and performance in contemporary Egypt.
2. A description of the key players and stakeholders in the health sector and an initial assessment of their organizational objectives and political agendas, including their perceptions of reform, and any past and present reform positions.
3. An assessment of the role of international donors in health sector policy reform in Egypt, with particular emphasis on the orientations and reform agendas of the two most influential donors: the USAID and the World Bank (WB).
4. An analysis of public opinion and perception of reform.

The report concludes with an overall evaluation of the political environment for health sector reform in Egypt, together with some recommendations to improve the political feasibility of any proposed reform.

A summary of anticipated stakeholder positions regarding the specific reform policies and strategies suggested by the USAID in its proposed agenda is found on page 32 of *Section 6.0*.

It should be noted that, so far, health policy reform has not been the subject of explicit public debate in Egypt. This report, therefore, provides only background information on the stakeholders and their possible policy positions but does not provide a full political analysis. As the policy dialogue evolves, and key decisionmakers mobilize and take explicit positions on specific policy options, a more complete political analysis can be carried out and used for designing strategies to practically manage the policy environment. Annex I introduces an example of such detailed political analyses by utilizing the political mapping methodology to assess the political feasibility of expanding cost recovery in government hospitals in Egypt.

The information contained in this report is mainly derived from public documents and research papers. Due to logistical and time limitations, only a few telephone interviews were conducted to collect data on the political environment and the key players in health policy. Additional interviews can be conducted to construct a more detailed report.

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## 2. Health Sector Policy Background: Main Political Trends in Egypt

In the four-decade period starting after the 1952 Revolution, Egypt underwent a transition from a centrally planned, or socialist, economy to a relatively laissez-faire or “open-door” economy. Along with this transition, the vision for the GOE as the main provider of social services, including health care, was significantly affected. Three broad periods of Egypt’s political economy are briefly described in Sections 2.1-2.3.

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### 2.1 The Centrally Planned Era (1952–1973)

This period was characterized by strong socialist vision, inspired by President Nasser and embodied by the “Socialist Arab Confederation.” A significant wave of nationalization of banks, insurance companies, and industrial enterprises occurred in June/July 1961, and the Egyptian Charter was issued stating that the country’s economic development must be based on socialism (United Arab Republic, The Charter, 1961). Land reform, rent control legislation, and taxation measures were institutionalized to prevent the exploitation aspects of private ownership. The main political emphasis during this period was to achieve an independent development model that relied mainly on the mobilization of domestic resources. In addition, two main policies that were specifically relevant to health care emerged from the socialist era:

- ▲ Price controls: An extensive system of price controls was established, aiming at equitable income redistribution. In the health sector, prices of drugs and medical supplies were controlled by the GOE. To a large extent, these prices remain under GOE control.
- ▲ Welfare orientation: A welfare-oriented social policy was designed in the health, education, employment, and social security sectors. The Constitution set the basic rights of all Egyptian citizens to include free medical care, free education, employment, minimum wages, and insurance benefits in old age and ill health. The objectives of social policy were to improve welfare distribution and raise the population’s health and education levels.

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### 2.2 The Open-Door Policy Era (1974–1984)

This period coincided with the leadership of President Sadat and was characterized by major changes in the international political environment and domestic socioeconomic policy.

#### 2.2.1 International Policy

- ▲ Western Orientation: Significant improvement in the diplomatic and economic relations with the West, especially with the United States, and severe weakening of special ties with the former Soviet Union.
- ▲ Peace with Israel: Negotiation and ultimately endorsement of a U.S.-facilitated peaceful settlement with Israel at Camp David, 1979. The peace treaty resulted in restoration of all

Egyptian territories occupied in the 1967 war, but simultaneously cost Egypt its diplomatic relations with the Arab countries. Foreign aid in general, and American aid in particular, served in substituting for the loss to the Egyptian economy caused by the Arabic boycott and in sustaining the peace process.

### **2.2.2 Domestic Policy**

On the domestic level, President Sadat, in his “October 1974 Paper,” announced the objectives of the “open-door policy” were to

- ▲ Encourage private, foreign, and Arab investment,
- ▲ Emphasize the role of foreign trade in the economy, and
- ▲ Limit the previously predominant roles of the state and the public sector.

In spite of the open door policy, however, the GOE continued to maintain its socialist welfare policy, including its commitment to provide free medical services to all citizens. This policy resulted in continuing strains on the health budget and declining quality of services.

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## **2.3 The Liberalization and Reform Era (1985–1996)**

Under Mubarak’s leadership, Egypt restored its position in the Arab world, while maintaining its special U.S. ties, normalizing relations with the former U.S.S.R., improving economic relations with China and the East, and intensifying its political status in Africa.

From 1985 to the present, the WB and the International Monetary Fund (IMF) started exerting strong pressure on the GOE for structural adjustment and exercised a growing role in resource allocation. Some observers have argued that all changes in economic policy in Egypt since 1985 have been driven by the WB, the IMF, and/or foreign aid institutions.

On domestic grounds, the most important features of Mubarak’s era were the move towards liberalization in the management of the economy and a further decline in the central role of the state. As part of the WB structural adjustment package, exchange rate systems were gradually unified and the pound was allowed to take on a market value, most subsidies were eliminated, agricultural production was reemphasized, foreign investment was encouraged, external trade was freed, and finally privatization and reforms ending public sector dominance of the economy were authorized, yet they proceeded haltingly.

In one of his speeches, President Mubarak encouraged a fundamental change in public attitudes regarding the role and responsibilities of central government in Egypt’s development and the social protection of its populations. “Local citizens who once argued that ‘government must provide’ now agree that ‘we must provide for ourselves’,” he said. Although the role of the state as the main provider of health services was finally questioned in recent years, health reform—a sensitive issue to most Egyptians—lingered behind reforms in other sectors of the economy.

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### **3. Stakeholder Analysis: Key Health Sector Players and Their Reform Positions/Priorities**

Policy reform represents the interaction of various stakeholders and their value-driven choices. Health care reform often involves a trade-off between competing national health objectives, with varying degrees of emphasis on equity, efficiency, health impact, and/or financial yield. Accordingly, a comprehensive policy analysis needs to extend beyond the technocratic or economic frameworks to study the policy stakeholders, their orientations, and their agendas. This is particularly important in Egypt today because of the lack of a generally accepted definition of reform.

Health services in Egypt are provided by agencies in all three sectors of the economy: government, public, and private. The distinction is made between the government sector, which represents activities of the Ministry of Health and Population (MOHP) and other ministries providing health services (e.g., Ministry of Education, Ministry of Defense, and Ministry of Interior); and the public sector, which is comprised of parastatal organizations in which government ministries have a controlling share of decisionmaking. These include the Health Insurance Organization (HIO), Curative Care Organization (CCO), and Teaching Hospitals Organization (THO). Private sector provision of services covers everything from traditional midwives, private pharmacies, private doctors, and private hospitals of all sizes. Also, in this sector is a large number of non-governmental organizations (NGOs) providing services, including religiously affiliated clinics and other charitable organizations, all of which are registered with the Ministry of Social Affairs.

These players are likely to affect any prospective health sector reform in Egypt in different manners and to varying degrees depending on their orientations and priorities, their power status, and the specific policies proposed in the reform package. The following section will first describe the key players and stakeholders in the health sector and then provide an initial assessment of their organizational objectives and political priorities, including their past, present, or anticipated reform positions (if any). The assessment will attempt to specifically address stakeholder positions toward the two most significant policy questions confronting Egypt today: the changing role of the GOE and the future of the Social Health Insurance Program (SHIP).

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## 3.1 The Government Sector

### 3.1.1 The Ministry of Health and Population

The Egyptian Ministry of Health and Population (MOHP) has classically stated its mission as improving the health status of the Egyptian people by enhancing the quality, affordability, and accessibility of health services to citizens of all socioeconomic levels.

Since the constitution pronounced free medical care as a basic right for all Egyptians, the MOHP has been the sole provider and financier of all primary and preventive care and of the majority of curative care in the country.

Since 1986, Egypt has embarked on a structural adjustment accompanied by shrinking central spending on health and a decrease in the MOHP proportion of the GOE budget. In short, the needs and demands of a rapidly growing Egyptian population have outrun the capacity of the GOE to pay for and provide all health services. Although this historic commitment of the MOHP has never been officially changed, the ministry in recent years was forced to start thinking about prioritization and rationalization.

#### 3.1.1.1 Reform Positions and Priorities

As previously mentioned, the two most significant policy questions confronting Egypt today revolve around the changing role of the MOHP and the future of the SHIP. The GOE/MOHP, with its control over HIO policy, has the most power to mobilize policy changes in either of these two domains. This renders the GOE, as represented by the MOHP, as the agency most likely—but not necessarily most qualified—to lead any policy reform to be implemented in the Egyptian health sector.

Though wide acknowledgment of the need for reform has been attained within the MOHP, commitment to actually pursue specific reform plans has not been made. As early as 1992, official ministry reports have emphasized the need for

- ▲ A shift of allocative priorities so that GOE funds are used for priority preventive and primary health care (PHC) programs, which cannot be financed privately.
- ▲ Continued commitment by the GOE to protect the poorest segment of the population who cannot afford to pay for their own medical care.
- ▲ More efficient and rational allocation of health resources and modification of MOHP investment policy, including new technology acquisition so as to be based on economically sound principles.
- ▲ Generation of new resources through an expansion of cost-sharing and fee-for-service schemes in the MOHP facilities.

Nevertheless, with the exception of continued support of its subsidized care policy, the MOHP has not fully implemented any of these intended reforms. Whether it was due to lack of political will, institutional capacity, or both, the fact does not change. Even in those instances where some policy change materialized, it was energized by external forces. One example is the expansion of fee-for-service schemes known as “economic treatment systems” in some GOE hospitals, which were mobilized by local governorates or as part of the USAID-funded Cost Recovery for Health Project (CRHP). Even then, the fees imposed were too modest to recover full or partial service costs, and the policy was far from being considered a structural reform.

In early 1996, a new Egyptian cabinet was appointed with a mandate to further the country’s economic reform process. The present Minister of Health and Population is a dynamic and aggressive politician, a leading surgeon, and a professor. He is an active member of the National Democratic Party and comes with a mandate of his own to restructure the health sector. Before his ministerial appointment, he was the chairman of the Health Committee of the Shura Council and he developed a “vision statement” in which he presented his views on the future of the Egyptian health sector. These views represent the MOHP’s current official reform position and are centered around

- ▲ Rationalizing the role of the MOHP in curative care provision and focusing on preventive/PHC, cost-effective health maximizing interventions, and improving the accessibility and quality of health services in Upper Egypt and rural areas. There is no indication, however, that the ministry is willing to completely give up its role as a curative care provider, transfer its existing facilities to some other organization, or completely stop new facility construction.
- ▲ Expanding health sector resources by increasing the health sector’s share in the gross national product (GNP), imposing health-earmarked taxes, enhancing partnership with private and nongovernmental sectors, encouraging cost sharing through “minimal” user fees, and containing health care costs by rationalizing drug consumption and minimizing government waste. Although “economic treatment” schemes have been adopted in many MOHP facilities, nationwide expansion of cost-recovery systems is not the preferred MOHP policy. Even in the event of supporting the use of fee-for-service systems on a large scale, the GOE will only authorize charging modest or minimal fees that fail to recover full or partial service costs. Moreover, the GOE still pledges its commitment to support—at least in theory—the indigent populations and is not likely to eliminate subsidies for this purpose until an alternative social protection mechanism is already in place.
- ▲ Reviewing health manpower policy, modifying medical education/training programs, and developing skills in health care management and economics. Although the minister is open to the review of employment and compensation policies and supports taking measures to limit further growth of governmental labor force, the termination of guaranteed government employment is not likely to be undertaken in the foreseeable future.
- ▲ Developing new MOHP roles in national policymaking and sectoral planning and in regulation, accreditation, and quality assurance (QA).
- ▲ Enhancing coordination and integration between health, population, and environmental agencies; between the MOHP and other involved ministries; and between the governmental and private sectors.

### **3.1.2 The Ministry of Education and Universities (MOE)**

Egypt has 13 medical schools (Faculties of Medicine) affiliated with the major universities and operates 31 university hospitals. These facilities operate under the General Authority for Hospitals and Educational Institutions, which is cochaired by the Minister of Education. University hospitals account for about 9 percent of total health spending and 14 percent of all hospital beds. They are financed largely through the MOE but also raise significant amounts of funds through user fees.

University hospitals are regarded as secondary and tertiary care facilities and tend to be much more advanced in terms of technology and medical expertise than the MOHP facilities. The per-bed expenditure at university hospitals is significantly above that in the MOHP or the HIO. Cairo University, with a new modern hospital, is considered the largest and most sophisticated hospital system in this sector.

#### **3.1.2.1 Reform Positions and Priorities**

With the university hospitals sector providing more than 14 percent of all hospital beds in Egypt, and given the elitism of academia in Egypt, the educational sector is likely to play a significant role in health policy reform, if not as a policy setter, at least in an advisory capacity. This is particularly true in relation to reforms addressing manpower policy and review of the medical education system. The specific reform priorities and policy positions of the universities, however, need further study.

### **3.1.3 Ministries of Planning, Finance, and Local Administration**

The ministries of planning, finance, and local administration are involved in decisionmaking related to budgeting and resource allocation to all ministries. The MOHP budget is based on the available total GOE resources and the five-year and annual plans. It is determined through negotiations between the MOHP Planning Department, the Ministry of Planning (MOP), and the Ministry of Finance (MOF). In addition to the centrally allocated funds, governmental health facilities receive decentralized budget allocations for operating expenses and capital investments from the Ministry of Local Administration (MOLA) through the health directorates.

#### **3.1.3.1 Reform Position and Priorities**

It is generally agreed that sound health sector financial planning and resource allocation in the health sector will require greater MOHP control over planning and budgetary discretion. Such a reform would be implicitly taking away power from the MOP and the MOF. These players could be expected to resist such changes, throwing doubt on the ease with which such reforms could be implemented.

Aside from their role in budget allocation, these ministries currently play no role in setting the national health policy. The MOP has a potential capability for providing analyses that can feed into health policy design process. The MOLA can become a key player if decentralization of governmental health services provision is considered. It is not envisioned, however, that these institutions will provide strong political or technical input to the reform, at least in the short run.

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## 3.2 The Public Sector (Quasi-Governmental Organizations)

Although the distinction between the government sector (including the MOHP and other ministries) and the parastatal or quasi-governmental sector (including the HIO, the CCO, and the THO) is usually made when describing the Egyptian health sector, both sectors are, in practice, run by the state. From an operational and a financial perspective, the parastatals are governed by their own set of rules and regulations, have separate budgets, and exercise more autonomy in daily operations. From a political perspective, however, the GOE/MOHP has a controlling share of decisionmaking in parastatal organizations and will accordingly determine their role in the reform process.

### 3.2.1 The Health Insurance Organization

The HIO was established in 1964, with the objective of covering the entire Egyptian population within 10 years. There are three broad classes of HIO beneficiaries: employees covered through Law 32 of the year 1975 (all employees working in the government sector), employees covered through Law 79 of 1975 (some public and private sector employees), and pensioners and widows. In February 1993, the HIO began to provide students with a medical insurance program, with over 14 million students currently eligible for coverage, thus pushing the total number of beneficiaries to more than 20 million Egyptians. This accelerated expansion of coverage, combined with the low premium structure, the extensive benefits package, and the poor institutional capacity has left the HIO with a cumulative deficit amounting to LE 300 million.

#### 3.2.1.1 Reform Position and Priorities

There seems to be general agreement—at least, in theory, amongst officials inside the HIO, the GOE, and donor community—that the HIO needs to undertake the following initiatives:

- ▲ Review of health insurance regulatory framework and unification of legislation (laws 32 and 79),
- ▲ Review and subsequent limiting of the current benefits package,
- ▲ Revision of premium structure and introduction of “modest” copayments,
- ▲ Reduction of waste and control of the HIO’s biggest expense item—drug costs,
- ▲ Institutional developments and quality of care improvements,
- ▲ Progressive separation of financing and provision, and
- ▲ Promoting a bigger role for the private sector in health insurance.

There seems to be disagreement, however, amongst health sector players regarding future expansion of HIO’s beneficiary coverage. (The HIO, which itself is supported by international donors, including the USAID and the WB, tends to be skeptical about expansions that are too accelerated, not carefully planned, or beyond the organization’s administrative or financial capabilities.) The GOE and the People’s Assembly, however, are likely to exert political pressure to further expand HIO beneficiaries and achieve universal coverage in the near future. The incumbent Minister of Health and Population advocates universal insurance coverage as the future vision for curative care in Egypt because

- ▲ The free health care system has failed to meet people’s expectations and cannot be sustained within the governmental budgetary constraints,

- ▲ A fee-for-service system reflecting actual costs of care cannot be afforded by a large portion of the population, and
- ▲ The economic treatment system (a system whereby governmental hospitals are allowed to run a percentage, usually 30 percent, of their beds on a fee-for-service basis) has only generated limited resources and failed to alleviate budgetary strains on GOE facilities.

A new chairman for the HIO was only recently appointed by the Minister of Health and Population. The previous chairman faced serious opposition from all quarters—People’s Assembly, labor syndicates, the media, and political parties—to some of his proposed reforms. These reforms included restricting the health insurance coverage to other beneficiaries until the HIO puts its financial house in order, halting new hospital construction, and raising salaries for doctors, as well as their accountability and work schedules. As he and the minister did not agree on many of these issues, conflicts arose and the HIO chairman was finally replaced in July 1996.

### **3.2.2 The Curative Care Organization (CCO)**

The CCO system was established in 1964, with branches in Cairo and Alexandria. There are currently an additional four CCOs in operation, in Port Said, Qalyoubia, Damietta, and Kafr El-Sheikh. There is no CCO presence, however, in Upper Egypt. Each CCO is run independently, although the ultimate decision-making authority resides with the Minister of Health. CCOs are run on a nonprofit basis, with surplus revenues returned to the service development.

#### **3.2.2.1 Reform Position and Priorities**

The location of CCO facilities tends to be highly concentrated (the six CCOs own and operate 20 hospitals, 12 of which are in Cairo alone), limiting its potential of growth into a nationwide system. This factor, coupled with the organization’s modest power status, suggests that the CCO is not likely to play a significant role in the politics of the health sector reform. The reform significance of CCO, however, lies in the fee-for-service parastatal model it represents—an institutional model that might be eligible for replication or application to governmental health facilities under the reform.

### **3.2.3 The Teaching Hospitals Organization (THO)**

The THO operates eight general teaching hospitals and eight research institutes, including the Institute for Tropical Medicine, Heart & Chest Surgery Institute, Hearing and Speech Institute, Poliomyelitis Institute, Entomology Research Institute, Memorial Ophthalmology Institute, Nutrition Institute, and Diabetes Institute.

#### **3.2.3.1 Reform Position and Priorities**

The THO is not perceived as a key player in the health sector. It stands quite low in terms of power status as compared to other parastatal or governmental players. Its role in reform is not likely to be significant.

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## 3.3 The Non-Governmental and Private Sector

The private sector in Egypt includes private practitioners running individual practices; private hospitals and polyclinics; non-governmental and charitable provider organizations; and private insurance firms.

### 3.3.1 Private Practitioners

Physicians represent the most powerful professional group in the health sector. Doctors are permitted to work simultaneously for the GOE and the private sector. Those who are employed by the GOE but run a private practice because of their low salaries account for a large portion of private providers. Many other physicians, however, cannot afford to open a private clinic. To earn a living, most of them presently work in more than one private or nongovernmental religious facility, in addition to their morning government jobs. This category of physician comprises more than three-quarters of licensed and practicing physicians in Egypt.

The remaining physicians include well-established and qualified senior physicians, who are usually faculty members in the major medical schools and/or shareholders in modern private hospitals. These physicians have the expertise, technology, resources, and visibility required to run very successful and profitable private practices. Demand for their services is very high, and they typically have long waiting lists.

#### 3.3.1.1 Reform Position and Priorities

Officially, private providers exercise little influence in setting national health policy, but they represent a major interest group and will have a significant stake in any major reform. The Medical Syndicate, discussed later in this document, is—at least in theory—the main charter through which physicians express their political agendas.

Junior physicians and physicians without an independent private practice are likely to support a reform that promises improved pay levels from GOE jobs or proposes to extend credit in support of private sector expansion. These physicians are likely, however, to oppose a reform of the GOE's guaranteed employment policy, because they tend to hold on to government and public sector jobs for security in spite of the very low pay levels.

Reforms tackling the current geographic and functional misallocation of physicians, in an attempt to favor rural over urban and public health over clinical specialties, are likely to be resisted by profit-driven private practitioners, unless provider payment and incentive systems are simultaneously modified.

The small proportion of prosperous physicians who have established themselves in the market and are currently acting as price and quality setters for the private sector are likely to have different reactions. Given that they are currently benefiting from the inefficiencies and distortions of the health care market, they will stand to lose from quality improvements and market restructuring.

### **3.3.2 Private and Non-Governmental Facilities**

After Sadat's declaration of an open economic policy in 1974, the private health sector began to grow. Between 1975 and 1990, the total number of beds in Egypt rose by 60 percent, whereas the number of private beds rose by 180 percent. Private care providers in Egypt range from large, modern, sophisticated hospitals (commonly known as "investment hospitals") to smaller hospitals, day care centers, and polyclinics.

In the private sector, there is also a number of nongovernmental and charitable organizations providing care through polyclinics and hospitals, which usually are affiliated with mosques or churches.

#### **3.3.2.1 Reform Position and Priorities**

The private and nongovernmental sectors are *not* represented in the policy dialogue. The NGOs, however, have the potential of becoming active and effective participants if invited to join the debate. The private and government sectors view each other as adversaries. This reflects in the GOE's attitude towards matters of regulatory nature and in the private sector's lack of interest in public policy debates.

Naturally, a reform movement attempting to expand the role of the private sector in the provision of care by improving the business environment is likely to be embraced by private providers. If the reforms are likely to improve the quality of services at the MOHP and from public sector providers and make them more competitive, however, the private sector will stand to lose or may react by altering prices, services, or quality. Whether the ultimate setting is a free market or managed competition will also determine to a great extent the impacts on and reactions of private providers.

In addition, most private providers are likely to react negatively to reforms that intensify the MOHP role in the regulation, accreditation, and quality control of private services.

### **3.3.3 Private Insurance Companies**

Under the current regulatory environment, private health insurance does not represent an attractive business opportunity for enterprises; in fact, it is quite difficult to make money on private health insurance in Egypt. Premiums are too low in comparison to the costs. Another constraint is that the law guarantees the employee the right to refuse to participate in a copayment mechanism.

#### **3.3.3.1 Reform Position and Priorities**

The future of private insurance in Egypt depends to a great extent on loosening legal constraints on companies interested in doing business in Egypt. A health care policy reform tackling the current regulatory environment for insurance, with the intent of making it a more attractive business opportunity, is likely to be embraced by interested private insurance firms. Such liberalization would also assist the whole industry through the introduction of more sophisticated information technology, better capitalized companies, and more actuarial experience. A new law is under study to allow the opening of private foreign insurance companies. Under the General

Agreement on Trade and Tariffs (GATT), the minimum capital needed to start an insurance company has been decreased.

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## 3.4 The Pharmaceutical Sector

As of mid-1987, the pharmaceutical sector in Egypt was organized as follows:

- ▲ *Research and Development:* Research and Development is undertaken by the National Organization for Drug Control and Research (NODCAR) and by private and multinational pharmaceutical production firms.
- ▲ *Production:* Almost 75 percent of drugs are produced locally by 16 pharmaceutical corporations, 8 of which are public, and the rest private or foreign.
- ▲ *Importation:* Only 25 percent of total drugs are imported in Egypt (almost all raw materials are imported, however). Drug imports are handled by one public sector and 13 private sector firms.
- ▲ *Distribution:* Wholesale distribution is carried by private and public producers, while retail distribution is handled by over 75,00 private pharmacies, some cooperative pharmacies, and a very few public pharmacies.
- ▲ *Monitoring and Control:* Pharmaceutical monitoring and control functions are performed by the NODCAR and the MOHP pharmaceutical department.

The majority of imported and domestically manufactured drugs are subsidized by the GOE, though the size of the subsidy has been shrinking gradually under the WB/IMF structural adjustment. In addition, prices of privately produced drugs tend to be controlled by the GOE, leading to the frustration of private manufacturers.

### 3.4.1 Reform Position and Priorities

The cost of pharmaceuticals is a central issue to health sector reform. An estimated 30–40 percent of total national health expenditures are on drugs, and as mentioned before, drugs are the HIO's biggest cost item. Public perceptions of the efficacy of drugs and public subsidies of drug prices both contribute to overprescription and self-medication, with many drugs sold without prescription. With a population afflicted by high prevalence of diabetes, renal failure, and cardiovascular and chronic diseases, affordability of drugs is a very sensitive political and moral issue in Egypt.

If liberalization of drug prices and elimination of government subsidies are part of health sector reform, they are likely to be supported by international donors, embraced by the pharmaceutical industry, resisted by the Egyptian public and the People's Assembly, and dreaded by

politicians. The question of whether free-market forces will operate in favor of the private or the public pharmaceutical industry still remains to be answered.

In recent years, MOHP policy plans have been emphasizing the expansion of domestic production of drugs in an attempt to contain high-cost imports. It is not clear, however, whether the expansion is intended through public sector or private pharmaceutical companies, or both.

The WB has recommended in its preliminary reform proposal to the GOE/MOHP the privatization of government-owned pharmaceutical companies. Although the policy has not been publicly debated, it is not unlikely to materialize, given the pace of privatization in other industrial sectors of the economy.

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## **3.5 Professional Associations: The Medical Syndicate**

The Medical Syndicate is the country's association of physicians and by far the most powerful professional association in the health sector. The Medical Syndicate is also the most likely professional association to become involved in and react to health reform.

Over the past several years, the syndicate's elections have been dominated by members of the "Moslem Groups," although Dr. Hamdy El Said, who was reelected several times as chairman of the syndicate, is not publicly perceived as a supporter of these groups.

The Medical Syndicate is the founder and administrator of what is perceived as a successful health insurance model in Egypt: the Medical Union, which includes the four medical syndicates (physicians, dentists, pharmacists, and veterinarians). The plan, established in 1988, serves members of the syndicates, spouses, children, retirees, and widows/ers of deceased members. The program is tightly run, with hospital accreditation and control on utilization and drug fraud. It also has a number of built-in cost containment measures, such as copayments and moderate coverage ceiling.

The Medical Syndicate could play a technical assistance (TA) role for other health insurance programs, as part of the reform.

### **3.5.1 Reform Position and Priorities**

There seems to be a perception that the composition of the syndicate suggests that it could be a considerable source of resistance for governmental reforms that are perceived as "anti-socialist" or West-driven.

In recent years, there has been a tendency inside the Medical Syndicate to put more emphasis on political rather than technical or health sector issues. For example, the syndicate has formulated committees and organized efforts to support humanitarian aid to Moslems in Bosnia, Afghanistan, and the Palestinian West Bank. In contrast, there has not been a single committee addressing the future of Egypt's health care industry or a national plan for health manpower development.

As the representative of the medical profession, the syndicate's interest in national health policy and its likely reform priorities tend to focus on promoting physicians' interests: higher pay levels, more fringe benefits, better work conditions, and guaranteed job security. The syndicate,

however, has taken less interest in provider accreditation, physician licensing, certification, and continuing medical education (CME).

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## **3.6 Committees and Advisory Bodies**

In Egypt, there are a number of independent committees that are likely to provide advisory input to health sector reform or are authorized to review and consequently approve its content policies. These include the Health Committee of the National Assembly, the Health Committee of the Shura Council, the Supreme Council for Health, and others. The exact relationship of these bodies to each other and to the MOHP and other health sector players is not well defined.

Policy discussions inside these committees tend to be more in rhetorical terms rather than addressing the real issues and are still dominated by a vision of the welfare state. The debate entails the deteriorating health sector conditions rather than specific health policy changes.

### **3.6.1 The Health Committee of the People's Assembly**

As the legislative body elected by the Egyptian people to represent them, the National (People's) Assembly holds a mandate to protect the rights and interests of the public. The Health Committee of the Assembly was developed to have oversight responsibility over the functioning and accountability of the MOHP, as the national agency with the prime responsibility for health care.

The committee has the authority to approve any new health sector legislation, bylaws, or decrees or to approve the modification of existing ones. It can also approve the endorsement or amendment of cooperative agreements with bilateral or international organizations in the health sector. In that sense, the Committee is a powerful legislative body with a strong likelihood of impacting health policy changes.

#### **3.6.1.1 Reform Position and Priorities**

As previously mentioned, any health policy change needs to be cleared by the National Assembly prior to implementation. The Minister of Health and Population will be required to defend any prospective health sector reform plan to the Health Committee of the Assembly. The committee reserves the right to call upon the minister, the chairman of the HIO, or any health official to question their policies or performances, as it deems appropriate.

The People's Assembly, in its majority, has traditionally supported government decisions. The main preoccupation of the Health Committee, however, seems to be with social protection issues, such as universal insurance coverage and PHC for all. Therefore, if some reform policies are perceived to have adverse effects on the social welfare of the poor (e.g., elimination of GOE subsidies), potential resistance of the People's Assembly should not be underestimated by policymakers and supporting donors.

## **3.6.2 The Health Committee of the Shura Council**

The Shura Council was developed to be a “think tank” for advising the GOE on national public policy matters. The Council’s Health Committee can recommend health policy changes but has no actual decision or policymaking authority.

### **3.6.2.1 Reform Position and Priorities**

As compared to the Health Committee of the National Assembly, the Shura Council’s committee is likely to be more open in considering health sector reforms. The mandate and composition of the committee give it more capacity to study the true merits of policy options and more flexibility to support those who are technically, and not just politically, feasible.

In November 1995, the committee, under the chairmanship of the incumbent Minister of Health and Population, conducted a health sector review. The recommendations set in this report represent the committee’s reform position and priorities. They were previously presented in Section 3.1.1.

## **3.6.3 The Supreme Council for Health**

The prime responsibility of the Supreme Council for Health is to set the direction for national health policy. The council was formulated by a presidential decree and presumably reports directly to the president. The council has a very complex structure with 18 working groups, each comprising 15–20 members. Each group is designated for a specific policy area, including PHC, family planning, maternal/child health (MCH), health insurance and private sector, training and human resource development, health promotion and education, research, legislation, management, pharmaceuticals, nutrition, foreign affairs, and coordination. Each working group is responsible for producing a policy, strategy, and reform plan for its specific policy area.

### **3.6.3.1 Reform Position and Priorities**

Though the council’s affiliation with the President could have given it political leverage, its complex structure hampered coordination and undermined its potential for effectively setting national priorities for health care.

The council produced its first and only health policy report back in 1995, in which it summarized its health reform priorities as follows:

- ▲ PHC should be prioritized
- ▲ National health plans should cover nutritional and environmental programs
- ▲ Maximum cost-effectiveness from the available resources should be achieved
- ▲ Rational drug use should be enforced
- ▲ Better coordination between public and private sectors should be attempted

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## 4. The Role of the International Donor Community

In Egypt, there is a large number of international and bilateral donors providing support in field of development. The orientations, scope of interest, size of operations, and political leverage of the various agencies vary to a great extent. Those who are active in the health sector and likely to impact policy reform are discussed in the following sections.

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### 4.1 The United States Agency for International Development

As compared to other international donors, the USAID has had one of the earliest and greatest involvements in the health sector in Egypt, with a history of fruitful collaboration with the GOE/ MOHP in the PHC, preventive health, family planning, child survival, and rural/urban health service delivery areas.

As early as 1989, the USAID started to become active in the health sector policy area through the CRHP and its various components and subprojects. The CRHP planned to broaden and diversify approaches for financing personal health services in Egypt through a three-tier approach:

- ▲ Pilot testing user fee systems in governmental health facilities, the introduction of which was coupled with systems development and quality improvement;
- ▲ Improving the efficiency, utilization, and management of existing parastatal cost-recovery organizations, especially the HIO and the CCO; and
- ▲ Promoting the expansion of private sector financing of individual, group, and prepaid care practices.

In addition, the CRHP, through its Data for Decision Making (DDM) component, worked on developing the institutional capacity of the MOHP for policy analysis and development by providing TA to the Department of Planning in conducting a burden of disease study, cost-effectiveness analysis, political mapping of health policies, and other policymaking tools.

The policy change dimension of the CRHP, however, failed to meet the targeted implementation rate and desired reform impact. This led the USAID to initiate discussions with the MOHP regarding the long-term vision for the health sector.

Against this background, the USAID started to plan a health sector Program Assistance, where it continues to support the basic reform measures embodied in the CRHP (e.g., cost recovery, diversification of financing, and public-private partnership). The Program Assistance draft agenda emphasizes rationalizing governmental curative care; attaining an appropriate balance between the MOHP's sometimes conflicting roles as regulator, financier, and provider of health services; expanding social insurance in a financially viable manner; promoting improvements in the quality of health care; and developing appropriate policies to meet the health sector's manpower needs.

The USAID, however, still needs to undertake considerable policy dialogue with the GOE to agree upon the target definition of health care policy reform and reach a consensus on the many and complex system changes that will be required to get there.

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## 4.2 The World Bank

In spite of its significant role in structural adjustment in Egypt, the WB showed no interest in health sectoral adjustment until recently. This disinterest was partly because the GOE did not want to utilize WB loan funds to support social sector services, especially since grants for health from other donors were available.

Recently, a WB mission was sent to Egypt to discuss with the MOHP a strategy for undertaking health sector policy review. Consequently, the WB might get involved in assisting the MOHP to institute a policy planning and development process supporting reforms, as a part of the proposed European Union health sector investment project, with an estimated outlay of \$120 million.

The WB's agenda and reform priorities for Egypt seem to be focused on five main areas:

- a. Health sector management, where the WB advocates revisiting the roles and accountabilities of main health sector players; differentiating and restructuring management, service delivery, and health care financing; developing the MOHP's role in policy development and sector planning; and establishing adequate regulatory framework.
- b. Health care financing, where the WB supports the pooling of financial resources through either a tax-based or insurance-based system, redefining the role of the MOHP in financing, ensuring HIO's financial viability (e.g., by stopping expansion of coverage, limiting the benefits package, reducing growing costs, phasing out service provision), and reallocating government funding in a cost-effective manner.
- c. Health services delivery, where the WB proposes limiting the role of the MOHP as a health services provider and exploring other alternatives to public facility management (e.g., contracting to the private sector, NGOs, and other providers; autonomous management of public hospitals).
- d. Human resource development, where the WB recommends reviewing physician employment and payment systems to create incentives for provider efficiency; improving the institutional capacity of the MOHP and HIO, reforming the medical education system, and reviewing the functions of professional syndicates.
- e. Pharmaceuticals, where the WB supports promoting rational drug consumption (e.g., through the essential drug list), reforming the drug pricing policy (e.g., reviewing subsidies), and privatizing government-owned pharmaceutical companies.

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## 4.3 Other Donors

The following United Nations (UN) agencies are active in the health sector in Egypt:

- ▲ World Health Organization (WHO) has been collaborating with the MOHP in areas of health systems research and strengthening management of district health systems and referral systems and in rural areas, human resource development, and disease prevention and control, including Expanded Program of Immunizations (EPI);
- ▲ UNICEF has been providing support to areas of child survival, nutrition, communicable disease control, environmental sanitation, health education, human resource development, and women's empowerment;
- ▲ United Nations Fund for population Activities (UNFPA) has been focusing in the family planning, population, and reproductive health fields; and
- ▲ United Nations Development Program (UNDP) has made some health-related contributions to management improvements and information systems development for the Egyptian cabinet.

In general, UN agencies have their program orientation focused on the grassroots (governorate and below) levels, with less emphasis on the central or policymaking level. Although most UN agencies have so far had a marginal role in the health policy area, they are likely to support, at least in theory, the notion of health sector reform. There is no clear indication of a commitment by any UN agency to actively participate in or provide significant funding for health policy reform in Egypt, however.

The European Community (EC) has not been previously active in the health sector in Egypt, but might collaborate with the WB on the previously mentioned health sector reform project. If it materializes, the project will be the largest investment made to date in reforming the health sector policy in Egypt.

In addition, there is a number of international not-for-profit foundations and private voluntary organizations (PVOs) active in health in Egypt. For example, Save the Children is working on MCH and women's empowerment issues in Upper Egypt, and the Ford Foundation is involved in reproductive health and family planning activities. The overall size of PVO operations is limited, however, and they have not demonstrated interest in programs involving partnership with the GOE.

Aside from the USAID, other bilateral donors operating in Egypt include the Canadian, German, Finnish, and Dutch development agencies. They mostly do not have significant health sector involvement, and certainly not in the policy area.



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## 5. Analysis of Public Opinion and Perception of Reform

There is serious official and public concern in Egypt about the nation's health care services. A senior official commenting on this issue stated that there was great dissatisfaction at all levels—consumers, media, politicians, government leaders, and private and public health providers—about the state of the country's health services, both in the public and private sectors.

After a 10-year pursuit of an economic reform program, the country's economy is better in macro terms, but still has many serious problems. Unemployment is high, incomes have not kept pace with escalating cost of living, and productivity is low in the governmental and public sectors. While the GOE struggles to maintain its level of spending on health, education, and other social services, consumers are not at all satisfied with the quantity and quality of the services they receive.

In the health sector, the deteriorating quality of care at GOE facilities has forced consumers to use private sector services at a very high cost to them or not to seek medical care at all when they need it. The worst affected were the rural and urban poor, as well low-income, salaried middle class. The decline in accessibility and affordability of health care to these groups is demonstrated by the decrease in their utilization of health services, and in the regional and socioeconomic inequities in health indicators in Egypt. There is serious discontent among these social groups. Their perception remains that it is the GOE's responsibility to provide adequate health care to all citizens, even though the country has moved away from the welfarist role of the state. Due to the nature of the power structure in the country, however, there is no formal channel for expression of public discontent.

While many Egyptians depend on health care through private providers because of the failure of GOE services, there is a public perception that the private sector is exploitative and profit oriented. Consumers of health services in Egypt, however, are not organized and they have no way of advocating their rights.

Public frustration expresses itself through the demoralization and low productivity of the labor force. In addition, a strong undercurrent of political reaction is expressed through the fundamentalist movement. The urban, low-income, educated middle classes are the supporters of this movement.

The GOE dreads the threat of serious resistance from many sections in the society—including fundamentalist groups—in its pursuit of structural and sectoral adjustment programs. This fear has hampered and can continue to impede reforms in the health sector.



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## 6. Conclusion and Recommendations

The Stakeholder Analysis Matrix shown on page 26 summarizes actual responses and likely reactions of major health sector players in Egypt to the Health Sector Policy Agenda drafted by the USAID/Cairo with input from the Egyptian MOHP, for the purposes of designing the prospective health sector Program Assistance. Each policy item of the health sector reform agenda and the suggested strategies for its implementation is examined in relation to the positions, orientations, and objectives of the various stakeholders. Stakeholders' positions were either elicited through interviews, drawn from reports and official statements, projected based on past policy positions, or predicted in view of respective priorities and interests. It is to be noted that not all aspects of the agenda were directly addressed in relation to all stakeholders, but overall, the matrix attempted to summarize the general policy environment and identify those policies/strategies that are not likely to be politically feasible due to intense or widespread opposition by stakeholders.

It should be noted that many of the issues included in the proposed health sector reform agenda and suggested strategies are not necessarily policy issues but are considered to be policy implementation issues mainly by the MOHP and the HIO. Policy is not the constraint, but rather, failure to act appears to be the main problem. The main consideration here will be institutional restructuring and reorganization.

The preliminary assessment of the political environment for health policy reform in Egypt provides both encouragement and caution. There seems to be a general recognition of serious shortcomings in the health sector. There also seems to be consensus that the role of the GOE/MOHP in financing and provision of health care must be re-envisioned for both the short and long-term future, and that the ministry must play a major role in defining priorities and setting the direction for reform. Opinion is divided, however, as to who should and could lead the effort.

This preliminary assessment also identified a number of important issues about the goals and mechanisms of health reform, which need further study:

- ▲ Is the current political timing for reform appropriate? Could reforms that are viewed as “anti-socialist” or abandoning the vision of the welfare state pose a serious threat to GOE stability?
- ▲ Does the MOH have the technical and analytic capabilities and the political leverage to propose, initiate, gain acceptance, and implement reform?
- ▲ Will support and commitment to the reform be sustained by Egyptian leadership and GOE officials, even if it is likely to threaten their positions?
- ▲ How will Egyptians react to reforms that might increase economic burdens on lower- and middle-class citizens through less affordable health care? Will Egyptians agree to change their perception of health care as a free and guaranteed right?
- ▲ How much resistance to reform will come from special interest groups that stand to lose power, income, or other benefits as a result of significant restructuring?
- ▲ Will it be possible to change the complex and control-oriented legislative environment governing health care in Egypt? Will the People’s Assembly be a significant source of

resistance? Given the multiplicity of parties involved in the legislative process, what would be required, for example, to change health sector regulations?

- ▲ In the current economic sluggishness and insecurity of the business environment, what measures are required to promote the expansion of private sector investment in health?
- ▲ With personnel expenditures as the largest cost item for the MOHP, can there be a significant health care reform without tackling the personnel policy? Can the GOE change its commitment to a full employment policy? With the GOE as the largest employer in the country, will a transfer of employment under reform be tolerated?
- ▲ Can the underpaid and highly demoralized governmental health sector employees be mobilized to construct and sustain a reform effort?

There is no doubt that these questions raise serious concerns about the political feasibility of health care reform, and the solutions depend on the specific elements of a reform package, how the reform process is managed, and other factors in the broad political environment. A critical challenge for health sector reform in Egypt is the need to arrive at a generally accepted definition of what needs to be done, who should do it, and how it should be accomplished.

Also, for the policy changes to be successful, the MOHP and the HIO will have to build a strong constituency and partnership by involving all the stakeholders in policymaking and the implementation process. These stakeholders include the People's Assembly and Shura Council membership, university professors, Medical Syndicate members, NGO representatives, governorates, leading private service providers, labor syndicate leaders and, most importantly, a representative cross-section of the MOHP and the HIO staff.

Also, lack of national "ownership" of the reform can be detrimental to its political acceptability, successful implementation, and sustainability. The emphasis on national ownership should be an important consideration in donor-driven programs seeking to promote health sector reform in Egypt.

In addition, the design of the reform package should be based on realistic GOE commitments. Policy changes that address technical and allocative efficiency of the health sector are generally more politically feasible and sustainable—especially in the early stages of reform—as compared to those reforms that attempt to significantly restructure the sector and change traditional provider and financier roles or jeopardize the image of the welfare state. Also, the implementation of the reform should be adequately phased. Incremental, gradual change was proven to be more politically feasible in the Egyptian context, as opposed to acute and accelerated reforms.

In addition to these factors, international experience has demonstrated that consideration of the following factors can significantly improve the political feasibility of health sector reform:

- ▲ *Political timing:* Developing country experience suggests that, while health is often a relatively low national priority compared to economic issues, at certain definable and perhaps predictable political moments, it is possible to launch health sector reform onto the national political agenda and change key elements of health policy in significant ways. Manipulation of political timing provides opportunities for policy entrepreneurs to introduce their ideas into public debate and control some of the political effects of the policy on the major stakeholders.

- ▲ *The role of physicians:* Experience suggests that some political patterns in health sector reform may be predictable, especially the role of physicians as an organized interest group. Any effort to reform the health sector must take into account the physicians' association, and must design strategies to co-opt, neutralize, or mobilize this group. Studies in developed countries have similarly emphasized the political role of physicians' associations and reached the general conclusion that a government can change the method of paying physicians only when the physicians agree. This finding suggests the possibility of future studies to examine the political conditions under which the Medical Syndicate is likely to promote or obstruct health sector reform.
  
- ▲ *Managing the politics of reform:* Political conditions for policy reform can be manipulated and perhaps created by skilled leaders, so that reforms can be both politically feasible and politically sustainable. In an effort to assist decisionmakers in managing the politics of health sector reform, several analytical tools having been developed, including the method of political mapping, which systematically assesses (1) the consequences of policy reform efforts, (2) the positions of support and opposition taken by key players, (3) the analysis of underlying stakeholders' objectives, (4) the relationship of players in a policy network map, (5) the transitions under way that create opportunities, and (6) the construction of strategies for change. Political mapping can improve various aspects of health policy reform, including problem identification, by providing rapid identification and definition of obstacles; policy formulation, by assisting in communication among different organizations; implementation strategies, by proposing new ideas and strategies that can improve the political feasibility of health policy; and overall enhanced impact of health policy, by improving the chances that a policy will achieve its intended effects. An illustration of the use of political mapping in assessing the policy environment is provided in Annex I.

In conclusion, it should be emphasized that the preliminary assessment of the political environment illustrates that both opportunities and obstacles abound. The current political timing represents a window of opportunity for Egypt: significant foreign aid is ready to be committed to support the reform, the political conditions have relatively stabilized, and other sectoral reforms have demonstrated their success. And though the GOE is likely to continue to shy off from controversial policies or hard decisions that may provoke public resistance or political antagonism, there is room within the "politically safe" health sector reform domain for developmental and redistributive policy changes that can improve the overall sectoral performance and alleviate its current distortions and inequities, thus preparing the groundwork for more aggressive structural changes.

Summary of Anticipated Stakeholder Policy Positions Regarding Suggested National Health Sector Reform Strategies		
National Health Sector Policy Reform Agenda	Suggested Health Sector Reform Strategies	Stakeholders and Their Probable Policy/Strategy Position
<b>1. Role of the MOHP</b>		
1.1 Rationalize the role of the MOHP in financing curative care	1.1.1 Stop the construction of unnecessary hospitals and set strict guidelines for completion of facilities under construction	Most stakeholders are aware of the need for—and, at least in theory, support—this strategy. In practice, however, the political commitment to enforce strict construction guidelines remains questionable. The GOE/MOHP has historically yielded to political pressures from governors, the People’s Assembly representatives, local politicians, and special interest groups, who try to gain public support, especially during election times, by opening a new hospital wherever there isn’t one, disregarding overall health budget priorities or the actual demand for the service.
	1.1.2 Transfer existing governmental hospitals to other parastatal organizations.	Opposition to this reform strategy will be due to either political reluctance on the part of the GOE or technical reservations in relation to the implementing parastatal agency. Though the MOHP is burdened by the responsibility to provide for and run its facilities, giving them away can be perceived by some within the ministry as undermining its national role and political leverage. The strategy, however, is harmonious with the economic reform and privatization policy that is being implemented in most other sectors of the economy.
		Also, transfer of employment of the masses of MOHP-employed personnel is a politically sensitive and procedurally complicated issue with implications for job security, tenure, benefits, and pay scales, and can be met with resistance from employees, syndicates and unions, and the new employer.
		Moreover, any existing parastatal organization will be reluctant to take over run-down, overstaffed hospitals requiring significant capital investments and operating budgets. When asked, the current chairman of the CCO has explicitly expressed the CCO’s disinterest. A more politically feasible option would be setting up CCO-type agencies at the governorate levels to run hospitals. Though unlikely to be met by an opposition from stakeholders, the technical feasibility and cost implications of the strategy need to be carefully studied, especially to define where funding will originate (the GOE and the MOHP, or the MOLA and local governorates ).

<b>Summary of Anticipated Stakeholder Policy Positions Regarding Suggested National Health Sector Reform Strategies</b>		
<b>National Health Sector Policy Reform Agenda</b>	<b>Suggested Health Sector Reform Strategies</b>	<b>Stakeholders and Their Probable Policy/Strategy Position</b>
	1.1.3 Expand cost recovery in government facilities	Though cost-recovery endeavors have been initiated and sustained in several Egyptian governorates without any significant political antagonism, to date, the strategy has been limited in its implementation base, and the user fees charged were too low to reflect actual service costs. Nationwide expansion of cost-based user fees can have accessibility and affordability implications for the lower-middle and lower-income population groups, and unless coupled with mechanisms to ensure access of the medically indigent, will be met by resistance from the public, the People’s Assembly, opposition parties and the press. In addition, cost recovery coupled with quality improvements can make government facilities more competitive, thus reducing the market share of private practices run by MOHP physicians, who will thus not support the change. Expansion of cost recovery, however, will only face low opposition – if any – from a few stakeholders and will be supported by many others, including the MOH, the MOF, and MOLA and major donor agencies, such as the USAID and the WB.
	1.1.4 Support hospitals based on efficiency and equity indicators	No stakeholder is likely to show any political opposition to this strategy. To be successfully implemented, however, there has to be an incentive for hospital staff to undertake such initiatives. Their commitment requires their mobilization to support the policy and their involvement in the policy dialogue.
1.2 Strengthen the role of the MOHP in the provision and increased share of financing preventive medicine (PM) and PHC	1.2.1 Use cost-effectiveness analysis to identify a package of PM/PHC services to be supported by the MOHP	Although the use of cost-effectiveness analysis to identify health-maximizing PHC services to be supported by the GOE is generally accepted as a feasible policy option by most health officials and highly supported by the current Minister of Health and chairman of the Medical Syndicate, the political will to implement the policy and limit the MOHP service package to only those interventions identified as cost effective is not certain, as it will imply elimination of GOE support of a number of cost-ineffective yet publicly demanded and life-saving services, including renal dialysis, chemotherapy and radiotherapy for cancer, and open-heart surgeries.

<b>Summary of Anticipated Stakeholder Policy Positions Regarding Suggested National Health Sector Reform Strategies</b>		
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	1.2.2 Increase funding to MCH programs	Increasing GOE funding to MCH programs is not a policy but rather a funding question. All players in governmental, public, and international domains support the strategy, but implementation continues to lag behind due to the limitation of MOHP resources and the diversity of competing health budget items.
	1.2.3 Provide incentives for providers to specialize in PM, PHC, and family medicine and to serve in remote and underserved areas	Most stakeholders are proponents of this strategy and will not express any resistance if it is pursued by the MOHP. As they struggle for survival in big cities with physician surpluses and escalating costs of living, more junior graduates are now willing to pursue nontraditional career tracks and relocate to remote areas, if financial rewards are worthwhile. Nevertheless, the public perception of PHC and PM specialities has never been very favorable in Egypt, so monetary incentives to these specialists need to be coupled by career development plans and raising public awareness of the significance of their role.
1.3 Reform the MOHP Personnel Policy	1.3.1 Eliminate guaranteed government employment	The elimination of guaranteed GOE employment is regarded by most stakeholders as one of the most politically problematic policies to the extent that many think it is not worth consideration. Although, in reality, complete reliance on GOE pay for subsistence is impossible, most employees hold on to GOE jobs for security. Those who are most likely to be affected by the change are the staff, particularly the medical staff in the MOHP and the HIO. They are large in number, have political support through the syndicate, and are a major vested interest group. Their response to changes may range from apathy, avoiding action, or noncooperation to severe resistance to the reform.
	1.3.2 Develop guidelines for MOHP manpower planning and apply them to redistribute personnel	The development and implementation of guidelines for MOHP manpower distribution is politically acceptable by most stakeholders. Health personnel are likely to resist unless the redistribution is coupled with provider incentives to serve rural and remote areas.

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<b>National Health Sector Policy Reform Agenda</b>	<b>Suggested Health Sector Reform Strategies</b>	<b>Stakeholders and Their Probable Policy/Strategy Position</b>
1.4 Develop the MOHP role in regulation and accreditation and its capacity for national strategic planning and policy analysis	1.4.1 Develop and adopt National Health Standards of Practice and health facility accreditation	The barriers to the development and utilization of standards for facility accreditation are likely to be more technical than political in nature. The necessary institutional and technical capacity is not currently available within the MOHP. There is general support for the policy amongst stakeholders, and the only likelihood of resistance is expected to come from providers who will be regulated by the accreditation process. Involvement of other health sector players, especially universities, public sector, private providers, and the Medical Syndicate, in the process can enhance both technical capacity and political acceptability of the policy.
	1.4.2 Establish a policy of continued physician certification and CME	There is general support for the policy and overall recognition of its value by most stakeholders. Again, the barriers are more technical than political and attributed to the lack of institutional capacity within the MOHP. Though the Medical Syndicate is not likely to be a source of resistance, its collaboration with the MOHP in relation to physician licensing and CME is required for policy implementation.
	1.4.3 Adapt the national health information systems including the Geographic Information System (GIS) for planning and policy decisionmaking	The policy is certainly politically feasible and well supported—in theory—by the majority of stakeholders. The feasibility of its implementation will require the provision of TA to the MOHP to help upgrade its capacity to both develop the Health Management Information Systems (HMIS) and utilize its outputs for policy and decision-making.
	1.4.4 Develop a nuclear MOHP unit for economic and policy analysis	The barriers to the policy implementation are not likely to be political. Stakeholders inside and outside the MOHP recognize the need for such a unit. Sustainability of this nucleus, however, will depend to a great extent on the political will and commitment of MOHP leadership to this new role. It is also worth mentioning that frequent leadership changes and lack of continuity in organizational development can impair institutionalization of new functions.

<b>Summary of Anticipated Stakeholder Policy Positions Regarding Suggested National Health Sector Reform Strategies</b>		
<b>National Health Sector Policy Reform Agenda</b>	<b>Suggested Health Sector Reform Strategies</b>	<b>Stakeholders and Their Probable Policy/Strategy Position</b>
<b>2. National SHIP</b>		
2.1 Ensure the financial viability of the HIO	2.1.1 Stop further expansion of HIO beneficiary coverage	The policy is likely to be supported by the HIO and international donors who fear the consequences of further expansion of the HIO's fiscal deficit. In view of HIO's constitutional commitment to universal coverage, pressure to expand is likely to come from the National Assembly, political parties, syndicates and unions, and GOE.
	2.1.2 Eliminate the current HIO deficit	There is general political consensus that the HIO should eliminate its deficit. There is no agreement, however, on the mechanisms through which the HIO could restore its financial viability amongst the various stakeholders.
	2.1.3 Reduce the proportion of pharmaceutical costs	(Containment of the HIO's biggest expenditure, drug costs, is supported by all stakeholders.) There seems to be an inclination on part of the GOE to contain drug costs through efficiency measures such as information systems and control of fraud, rather than policy measures such as implementation of essential drug policy or total exclusion of drugs from HIO's benefit package.
	2.1.4 Unify existing health insurance laws into one law	The unification of health insurance laws is perceived to improve the overall legislative environment and improve equality of health insurance rights amongst a large portion of the population. The incumbent Minister of Health and Population is strongly committed to this policy and is not likely to face significant resistance from other stakeholders.
	2.1.5 Change the HIO's legal and legislative framework to ensure its autonomy	The HIO, notionally a parastatal organization, functions as a government entity with no control over setting premiums, fixing benefits, contracting services, and setting up copayments. The Minister of Health and Population has technical oversight over the organization. Over the years, the HIO's autonomy was eroded due to its financial and management weaknesses. The chairman of the HIO, for all practical purposes, reports to the minister. Accordingly, it is not unlikely that policy change would be resisted by the MOHP, as it minimizes its power status.

**Summary of Anticipated Stakeholder Policy Positions Regarding Suggested National Health Sector Reform Strategies**

<b>National Health Sector Policy Reform Agenda</b>	<b>Suggested Health Sector Reform Strategies</b>	<b>Stakeholders and Their Probable Policy/Strategy Position</b>
2.2 Expand social health insurance coverage, coupled with adequate financial and administrative mechanisms	2.1.6 Develop premiums based on actual costs; implement co-payments and deductibles	These reforms are politically controversial and cannot be dealt with as a gun-shot matter. Resistance is likely from the public, labor unions, National Assembly, and political parties. The HIO will have to undertake a lengthy negotiation and awareness-building process so as to neutralize opposition to these policy measures.
	2.1.7 Identify and adopt an affordable benefits package	The policy is deemed necessary by the HIO, the USAID, and the WB to control the organization's fiscal deficit. It is also supported, at least in theory, by the present Minister of Health. Beneficiaries, employers, and labor unions, however, call for a broad and comprehensive benefits package and are likely to resist the policy change.
	2.2.1 Transform the HIO into a financing organization	The termination of the HIO's direct provision of services immediately poses the question of what to be done with its health facilities and raises many political concerns. First, the HIO facility staff will resist selling or contracting as a threat to their job security. Second, the private sector is not likely to be interested in buying or providing services through the deteriorated, overstaffed HIO facilities. And third, the HIO itself might not be inclined to give up its provider role and settle for being a financier.
	2.2.2 Develop a plan for expanding national insurance coverage	There is no resistance to this policy from any stakeholder. It is the implementation rate that is likely to be a subject of debate, with the GOE and the National Assembly pressuring the HIO to adopt an accelerated implementation schedule.

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# Annex I: Demonstration of the Use of the Political Mapping Methodology to Assess Reform Feasibility

Health sector reform is a profoundly political process. Thus, it makes sense for organizations that seek to promote or engage in reform to use some analytical tool to enhance their understanding of the political environment and their ability to manage it.

Political mapping is a formal, systematic methodology for analyzing and managing the politics of public policy reform. By informing policy analysts and decisionmakers about the political circumstances affecting the fate of a chosen policy, political mapping can determine the political feasibility of a potential policy or strategy before it is formally proposed. In addition, it can help decisionmakers manage the policy environment, identify opportunities affecting stakeholders, and choose effective political strategies, thus improving the policy's political feasibility after it gets on the agenda. In that sense, political mapping can be used as both a descriptive and a prescriptive tool.

A comprehensive political mapping process addresses (1) the content, goals and consequences of a policy reform; (2) the positions of support and opposition taken by key policy stakeholders; (3) analysis of underlying stakeholders' objectives and motivations; (4) policy consequences for the various stakeholders; (5) the political circumstances that can create opportunities; and (6) the construction of strategies to improve political feasibility.

The use of political mapping to conduct detailed analyses of the policy environment is demonstrated through an analysis of the political circumstances facing the expansion of cost recovery in financing governmental curative care in Egypt. Since health policy reform in Egypt is in its formulation stage, factual political mapping will not be possible until actual policies and strategies are chosen and stakeholders take explicit positions. The analysis is, therefore, not immune to some judgmental assessments by the analyst. Past and present political trends of the various stakeholders, however, will be the basis upon which their probable future positions will be predicted.

## **Analysis of the Political Environment for Expanding Cost Recovery Systems in Governmental Health Facilities in Egypt**

The expansion of user fees or cost-recovery systems in the financing of curative care in the GOE health facilities has several merits, including

- ▲ Reducing the burden on GOE spending by substituting private payment for curative care services, which are currently taking the lion's share of the MOHP budget.
- ▲ Improving the health sector's allocative efficiency through
  - △ Allocating public money to pay for programs that affect the health and well-being of the public and private funds to personal curative services.
  - △ Marketing hospital services and recovering costs, allowing the MOHP to reallocate funds to support the costs of primary and PHC programs.
- ▲ Improving technical efficiency and quality to generate user payments and recover costs.

The impact of cost-recovery on the socially vulnerable, however, makes one of the most politically controversial policy options. Studies indicate that governmental health facilities and services are used more heavily by the socially vulnerable than by other population groups. Under these circumstances, charging user fees for MOHP services would have a disproportionately negative effect on the socially vulnerable, either by disproportionately increasing the cost of their health care or lowering their utilization of health services (or some combination thereof). Studies show that if suitable mechanisms for identifying and exempting the poor from having to pay user fees (e.g., means testing, geographic targeting) are developed, implemented, and carefully evaluated, the potentially adverse effects of user fees can be minimized. In addition, if the revenue from user fees is used to improve the quality of care in facilities used by the socially vulnerable, the health status effects of cost recovery can be positive for the socially vulnerable.

Expansion of cost-recovery, therefore, represents a classic example of a policy decision that will involve a trade-off between financial yield, efficiency, equity, and health impact objectives, with different implications for different stakeholders. The policy, therefore, is one that calls for a thorough political analysis.

In what follows, the main steps involved in conducting a political mapping process will be described and applied to assess the political feasibility of expanding cost recovery in governmental health facilities in Egypt. The assumption here is that the GOE/MOHP is the policymaker, i.e., the expansion is proposed and supported by the ministry.

### **Step 1: Defining the Policy Question**

Broad strategic questions must be defined for the policy under consideration:

Policy Question
Is cost recovery feasible as a means of expanding nongovernmental financing of curative health care?

To further define the policy question, the following need to be specified:

- ▲ Health sector goals addressed by the policy and their priority order
- ▲ Strategies likely to be used to implement the policy and achieve each of its goals
- ▲ Indicators to be used to measure whether each policy goal has been achieved

As previously mentioned, expansion of user fee policy impacts many competing health sector goals, namely financial yield, efficiency, and equity. The goals, as envisioned by the policymaker, in this case the GOE, therefore need to be prioritized.

	<b>Health Policy Goal</b>	<b>Priority</b>	<b>Strategy for Implementation</b>	<b>Indicator</b>
1	Alleviate pressure on the GOE's central health budget.	High	Expanding and diversifying the current mechanisms for nongovernmental financing of health.	An increase in the sources of funds for health care. An increase in share of national health funds provided through nongovernment sources.
2	Improve allocative efficiency of GOE spending on health, and shift MOHP's spending priorities from curative care to the more cost-effective primary and preventive care.	High	Generating new resources for financing of curative care, so as to release MOHP funds, currently tied up in the hospital sector for other uses.	Leveling of the MOHP budget allocation between curative care and primary/ preventive care.
3	Expand the scope and level of costsharing currently adopted by MOHP hospitals to allow the GOE to recover a larger portion of curative care costs.	Medium	Spreading user fee systems in MOHP hospitals, and modifying current fee structures to allow better cost recovery.	Progressive increase in user fee revenues generated by MOHP hospitals. Progressive increase in percent of curative care costs recovered through user fees.
4	Maintain GOE commitment to protect the medically indigent and vulnerable populations, who cannot afford to pay for their own care.	Medium	Better targeting of the government subsidy to only the truly indigent groups. Implementation of cross-subsidy mechanisms in MOHP hospitals.	A mechanism for targeting GOE subsidy institutionalized in MOHP facilities. No decline in indicators for utilization of care by lowest socioeconomic groups.
5	Improve technical efficiency and quality of care in MOHP hospitals.	Low	Authorizing the retention and rechanneling of user fees revenues and their flexible use in service improvement at facility level.	Improvement in MOHP quality of care indicators. Improvement in public perception and utilization of governmental hospitals.

## Step 2: Analyzing Stakeholders' Objectives and Motivations

Motivations and objectives of stakeholders that are likely to be affected by the policy implementation can help explain why a specific player is expected to take a certain position (as shown in the Player Table and the Position Map). The analysis is thus important in exposing value systems of the stakeholders, which in turn influence their positions and policy choice. Three qualitative assessments about stakeholders' objectives need to be made:

- ▲ Description of the objective: A statement about what is believed to motivate the player to assume his position towards the policy
- ▲ Type of objective: Whether financial, political, or technical/organizational
- ▲ Priority of the objective: Importance of this objective to the player

Objectives need to be particularly analyzed for those stakeholders who are likely to depict high or medium support or opposition towards the policy. Since most “low support,” “low opposition,” and “nonmobilized” positions represent neutrality, it is assumed that the underlying objectives are insignificant.

Stakeholders mostly affected by expansion of user fees in Egypt include the MOHP, the MOLA, nongovernmental and private sector providers, Health Committee of the National Assembly, Supreme Council for Health, the USAID, the WB, and the Egyptian public. Their objectives are presented here, in order of the priority of the objective to the stakeholder.

<b>Stakeholder</b>	<b>Motivation(s)</b>	<b>Type</b>	<b>Priority</b>
<b>Egyptian Public – Lower Income Groups</b>	To have continued access to affordable (or free) health care as their only resort: governmental facilities	Financial	High
<b>MOHP</b>	To increase the system's financial yield, decrease burdens on the health budget, improve allocative efficiency, and yet continue to be a provider of curative health care	Financial	High
<b>Private hospitals and polyclinics</b>	To maintain current competitiveness in the health care market and ensure profitability	Financial	High
<b>USAID</b>	To promote health sector reform, strengthen ties with the GOE, and play a leadership role in international development	Political/ Technical	High
<b>WB and IMF</b>	To promote structural adjustment programs, and decrease government spending on social services	Financial	Medium
<b>Egyptian Public and Middle Income Groups</b>	To get the “best health care buy,” and pay as little as possible for acceptable quality services	Financial	Medium
<b>People's Assembly/ Health Committee</b>	To maintain political power and leverage as the representative of the people and the protector of the interests of the poor	Political	Medium
<b>Press and Media</b>	To actively influence the political scene; also, opposition press wants to demonstrate its independence from the GOE's political agendas	Political	Medium

<b>Stakeholder</b>	<b>Motivation(s)</b>	<b>Type</b>	<b>Priority</b>
<b>Supreme Council for Health</b>	To set direction for national health policy and contribute to improvement in accessibility, efficiency, equity, and quality of care	Technical/ organizational	Medium
<b>MOLA</b>	To promote decentralization and decreased reliance of governorates on central funding	Organizational Political	Low

### **Step 3: Positioning Stakeholders**

A stakeholder's analysis includes (a) identification of organizations, organizational subunits, and social and other groups that are likely to be affected by or affect the policy; (b) assessment of their power status; and (c) analysis of their position on the policy.

The objective is to provide organized information on who is likely to support the policy, who is likely to oppose it, and who is likely to be neutral or not to take a position. The ultimate significance of a specific stakeholder's policy position is calculated by combining his power status and the intensity of his position.

Since no formal policy proposal on user fees has been announced in Egypt to date, stakeholder positions are estimated based on projection from past trends depicted in related policy situations, on estimates regarding their interests and orientations, and on the personal judgement of the analyst.

## Player Report

<b>Player Name</b>	<b>Type</b>	<b>Policy Position</b>	<b>Power</b>	<b>Sector</b>
MOHP	Organization	High Support	High	Government
MOE	Organization	Low Support	Medium	Government
MOP	Organization	Neutral	High	Government
MOF	Organization	Neutral	Medium	Government
MOLA	Organization	Neutral	High	Government
HIO	Organization	Low Support	Medium	Public
CCO	Organization	Low Support	Low	Public
THO	Organization	Low Support	Low	Public
Private Practitioners	Profess. Group	Not clear	High	Private/Commercial
Private Hospitals and Polyclinics	Organization	Not clear	High	Private/Commercial
Private Insurance Companies	Organization	Not clear	Low	Private/Commercial
USAID	Organization	High Support	High	International
WB and IMF	Organization	High Support	High	International
People's Assembly Health Com.	Org. Sub-unit	High Opposition	High	Political
Supreme Council for Health	Org. Sub-unit	Medium Support	Medium	Political
Medical Syndicate	Social Group	Not clear	High	Professional/Unions
Press and Media	Social Group	Med. Opposition	High	Media
Egyptian Public/Higher Income	Social Group	Neutral	High	Social
Egyptian Public/Middle Income	Social Group	Med. Opposition	High	Social
Egyptian Public/Lower Income	Social Group	High Opposition	High	Social

### *Remarks*

- ▲ The MOP is responsible for interministry budget allocations. Since generation of user fees is expected to relieve pressure on the central health budget, the MOP's position is likely to be neutral or more supportive than opposing. The same argument is valid for the MOF.
- ▲ Position assessment regarding the MOLA is based on its previous support of implementation of user fees and cost-sharing systems in some local governorates.
- ▲ University hospitals run a significant portion of their operations on a cost-sharing basis and are, therefore, anticipated to be supportive—at least in ideology—to similar initiatives in the MOHP.
- ▲ Neither the HIO, the CCO, or the THO are likely to have good reasons to strongly oppose or support the user fee policy.
- ▲ Private practitioners and hospitals and the Medical Syndicate are not shown to have clear policy positions but are expected to either support or oppose the policy depending on the incentives and profit consequences it holds for them.

- ▲ The USAID, the WB, and most other donors are in general supportive of structural reforms and are therefore expected to be highly supportive of the policy. The strongest support, however, is anticipated to come from the USAID.

#### Step 4: Analyzing Policy Consequences

The effects a policy can have on its stakeholders must be assessed along four dimensions:

- ▲ Identity: Who is affected?
- ▲ Size: How much of an effect?
- ▲ Timing: When will the effect start?
- ▲ Importance: How important are the effects?

The following table presents the consequences of expansion of user fees in GOE hospitals on major stakeholders. The consequences are sorted in order of importance.

Stakeholder	Policy Effect	Potential Size of the Effect	Timing of the Effect	Importance of the Effect
<b>Egyptian Public/Lower-Income Groups</b>	Decreased affordability of GOE health services, increased denials of access to care, and worsening of socioeconomic inequities	Large, depending on size of medically indigent populations, price elasticity of demand for care, and combined social protection mechanisms	Few weeks to few months after implementation of new fees gradual recovery from the initial decline in MOHP service utilization might occur later	Very important, especially for the very poor who rely completely on the MOHP for affordable care and have no other resource
<b>MOHP</b>	Expansion of user fees will allow the generation of nongovernmental resources for funding of curative care, and accordingly alleviate the MOHP's financial burdens and allow release of funds for more allocatively efficient uses	Large, depending on financial yield of policy as affected by ability and willingness to pay	Few years, to allow experience in managing user fees operations to grow and funds to accumulate	Very important for the MOHP, as the central health budget is not expected to grow in real terms under current economic conditions

<b>Stakeholder</b>	<b>Policy Effect</b>	<b>Potential Size of the Effect</b>	<b>Timing of the Effect</b>	<b>Importance of the Effect</b>
<b>People's Assembly/ Health Committee</b>	If introduction of user fees is perceived by the public as a capitalist reform and abandonment by the GOE of its previous social protection commitments, public resistance is likely to be channeled through the People's Assembly, and the Health Committee will be put in a difficult position	Large to medium	After public announcement of policy	Important—an negatively affect GOE Assembly relations and determine the fate of whole policy
<b>USAID</b>	If successful, this USAID-sponsored policy can demonstrate the USAID's leadership role in promoting health care reform in developing countries and represent a major political and ideological accomplishment	Large, as the USAID has made a sizable investment in the CRHP	After success of the policy in creating a sound economic foundation for the Egyptian health sector is demonstrated	Important for USAID organizational success; also can affect future USAID funding for other health projects in Egypt
<b>Private Hospitals and Providers</b>	Introduction of user fees in the MOHP can result in a shift of consumers to cheaper or better quality private providers, thus increasing their profits; if user fees are coupled with quality improvements that make the MOHP hospitals more competitive, the private sector may lose	Medium to large	Few weeks to few months after implementation, depending on public reaction (i.e., demand elasticities)	Important for the private sector
<b>Egyptian Public/ Middle-Income Groups</b>	Shift by those who used the previously free MOHP services to cheaper or better quality providers	Medium to low	Few months to few weeks after new fee policy implementation at the hospital level	Not very important, as these income groups can afford to substitute services with ease

## Step 5: Drawing Conclusions

If the MOHP decides to adopt a policy of nationwide expansion of user fees in its curative care facilities, the policy is likely to be strongly supported by the USAID and the WB, and strongly opposed by low-income Egyptians and the People's Assembly and, to a lesser extent, by middle-income groups, the media, and political parties. The policy position of private physicians as represented by the Medical Syndicate and private hospitals will depend on how the policy will affect their financial viability. Other GOE ministries and public sector organizations (the HIO, the CCO, and the THO) will not be significantly affected by the policy and therefore are likely to be neutral.

The political feasibility of the policy will be significantly affected by:

- ▲ Coupling the introduction of user fees with social protection mechanisms (e.g., means testing, geographic targeting) to minimize its adverse effects on the poor and socially vulnerable,
- ▲ Public perception of the quality of health services at MOHP hospitals. This perception will determine users' willingness to pay and financial yield of the policy, and
- ▲ Supplementary policy ingredients (e.g., retention of revenues for service upgrades and provision of incentives for facility staff), which will determine both its outcome and likely positions by its stakeholders.

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