

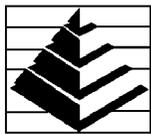
Technical Report No. 5
Volume IV

**Legal Analysis of the
Health Sector Policy
Reform Program
Assistance in Egypt**

August 1996

Prepared by:

Hassouna and Abou Ali
Attorneys at Law



**Partnerships
for Health
Reform**

PHR



Abt Associates Inc. # 4800 Montgomery Lane, Suite 600
Bethesda, Maryland 20814 # Tel: 301/913-0500 # Fax: 301/652-3916

In collaboration with:

Development Associates, Inc. # Harvard School of Public Health #
Howard University International Affairs Center # University Research Corporation



Partnerships
for Health
Reform

Mission

The Partnerships for Health Reform Project (PHR) seeks to improve people's health in low- and middle-income countries by supporting health sector reforms that ensure equitable access to efficient, sustainable, quality health care services. In partnership with local stakeholders, PHR promotes an integrated approach to health reform and builds capacity in the following key areas:

- ▲ *policy formulation and implementation*
- ▲ *health economics and financing*
- ▲ *organization and management of health systems*

PHR advances knowledge and methodologies to develop, implement, and monitor health reforms and their impact, and informs and guides the exchange of knowledge on critical health reform issues.

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Submitted to: Mellen Tanamly
USAID/Cairo

and: Robert Emrey, COTR
Health Policy and Sector Reform Division
Office of Health and Nutrition
Center for Population, Health and Nutrition
Bureau for Global Programs, Field Support and Research
United States Agency for International Development

Abstract

In cooperation with the Egyptian government and its Ministry of Health and Population, the United States Agency for International Development plans to develop health sector Program Assistance to facilitate needed health sector reform. Technical Report No. 5, volume iv, identifies possible legal constraints to Program Assistance policies that are likely to be undertaken during the implementation of this project. The report also assesses the feasibility of accomplishing legislative changes or amendments that may be necessary to enact the project in a timely manner.

In conducting the legal analysis, the report focused on three primary state and parastatal organizations that provide public health services: the Ministry of Health and Population, Health Insurance Organization, and the collective Curative Organizations. A brief analysis of the legal frameworks of university hospitals and educational hospitals and institutes was also included. The Information and Decision Support Center was frequently consulted during the scope of the study to verify the accuracy of amendments to laws, decrees, and regulations. Several specific strategies were analyzed to determine whether any could be implemented as part of the proposed health sector reform plan. Possible strategies included operating new Ministry of Health and Population hospitals as fee-for-service institutions, improving the autonomy of hospitals and curative units, subcontracting health services, and establishing a national health insurance fund.

The authors conclude that although there are no absolute legal constraints to the policy reforms, there may be a need for issuance of presidential and ministerial decrees or amendments to existing laws to achieve some of the proposed objectives.

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Acronyms

ACO	Alexandria Curative Organization
BS	Basic salary
CAOA	Central Agency for Organization and Administration
CCO	Cairo Curative Organization
CO	Curative Organization
EHI	Educational Hospitals and Institutes
GAEHI	General Authority for Educational Hospitals and Institutes
GIS	Geographic Information Survey
HIHC	Health Insurance Hospitals and Clinics
HIO	Health Insurance Organization
IDSC	Information and Decision Support Center
LAHME	Local Administration Hospitals and Medical Establishments
MCH	Maternal and Child Health Care
MOH	Ministry of Health
MOHH	Ministry of Health and Population Hospitals
MOHP	Ministry of Health and Population
MOLA	Ministry of Local Administration
MU	Medical Units (attached to curative organizations)
PHC	Primary Health Care
PM	Prime Minister
USAID	United States Agency for International Development

Preface

This report is one in a series of six analyses conducted by the Partnerships for Health Reform (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 United States Agency for International Development/Cairo 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

Proposed Health Sector Policy Reforms	
Specific Strategy	Generic Strategy
1. ROLE OF THE MINISTRY OF HEALTH AND POPULATION (MOHP)	
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 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
1.2 Strengthen the role of the MOHP in the provision and increased share of financing preventive medicine (PM) and primary health care	
1.2.1 Use cost-effectiveness analysis to identify a package of PM and PHC services to be supported by the MOHP to which every Egyptian is entitled	Increase the cost effectiveness of the 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
1.3 Reform the MOHP personnel policy	
1.3.1 There should be no guaranteed employment	Reduce the overall number of the MOHP personnel

Proposed Health Sector Policy Reforms	
Specific Strategy	Generic Strategy
1.3.2 Develop guidelines for the 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 the MOHP personnel	Reduce the overall number of the 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
1.4 Develop the MOHP capacity for national health needs assessment, sectoral strategic planning, and policy development	
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 the 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 underserved areas	Provide incentives to private health providers to function in underserved areas
1.4.4 Target government of Egypt (GOE) subsidy to poor and indigent populations	Improve the equity of the MOHP subsidies
1.4.5 Use cost-effectiveness analyses in determining the essential health services	Increase the cost effectiveness of the MOHP's program
1.5 Develop the MOHP role in regulation, accreditation, and quality assurance of health services	
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
2. NATIONAL SOCIAL HEALTH INSURANCE PROGRAM	
2.1 Ensure the viability of the Health Insurance Organization (HIO)	
2.1.1 Do not add any new groups of beneficiaries to the HIO	Eliminate the HIO's deficit

Proposed Health Sector Policy Reforms	
Specific Strategy	Generic Strategy
2.1.2 Eliminate the current HIO deficit	Eliminate the HIO's deficit
2.1.3 Reduce the proportion of the pharmaceutical costs	Redefine the 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's legal and legislative framework to ensure its autonomy	Ensure the HIO's autonomy
2.1.6 Develop premium based on actual costs using copayments and deductibles	Redefine the HIO's benefits
2.1.7 Identify and adopt an affordable health benefit package(s)	Redefine the HIO's benefits
2.2 Transform the HIO into a financing organization	
2.2.1 Stop constructing new HIO hospitals	Transform the 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 (GP) clinics	Transform the 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 the HIO's contracted services
2.2.4 Allow beneficiaries to choose service providers	Transform the HIO into a financing organization
2.3 Expand social health insurance coverage coupled with adequate administrative and financing mechanisms	
2.3.1 Design and develop a single national health insurance fund for universal coverage	Expand social insurance coverage
2.3.2 Develop a well defined standard package of benefits that every citizen is entitled to receive	Redefine the HIO's benefits
2.3.3 Separate financing from provision of services	Transform the HIO into a financing organization
2.3.4 Ensure legal and financial autonomy of fund	Ensure the HIO's autonomy

Acknowledgments

This legal analysis is prepared by the firm of Hassouna and Abou Ali, at the request of the University Research Corporation. Section I sets forth in detail the background, objectives, and mandate of the study.

The analysis is prepared in accordance with the terms of reference we have received from the University Research Corporation, dated June 3, 1996 (i.e., Terms of Reference) and the provisional list of specific policy reforms developed jointly by the Ministry of Health and Population and the United States Agency for International Development.

The analysis and findings of the study are made on the basis of legal research, the scholarly writings, and information obtained from certain persons related to the Ministry of Health and Population, Curative Organizations, and the Health Insurance Organization. We have examined and consulted more than 150 laws, regulations, and decrees to determine, to the best of our knowledge and to the extent of information available, the applicable legal framework.

The Terms of Reference indicated that staff of the legal departments of the Ministry of Health and Population and the Health Insurance Organization will be available as resource persons for the legal analysis. The team responsible for preparing this analysis faced many difficulties in its attempts to interview and meet with such staff, thus prolonging the time required to finalize the final draft. The team finally managed to conduct several interviews, a list of which is attached to the report. Unfortunately, by the time the team was afforded the opportunity to meet with certain staff of the Ministry of Health and Population and the Health Insurance Organization, major changes within the Health Insurance Organization were taking place, thus limiting the team's ability to obtain additional clarifications and meet with other Health Insurance Organization staff.

As Appendix A shows, a thorough and comprehensive legal analysis of all applicable laws and regulations pertaining to the provision of health services by state and parastatal organizations requires ample time and opportunity to conduct detailed interviews at different levels of each organization. In the absence of such time and opportunity (and in view of the mandated scope of work), the study attempted to scan the existing legal framework with a view to providing the Ministry of Health and Population and the United States Agency for International Development with a background on the basic structure of such a framework, with a particular focus on the proposed health reform strategies. For the Ministry of Health and Population and the United States Agency for International Development to accomplish their goals, further work may be recommended. Such work could focus on specific issues that the Ministry of Health and Population, after having reviewed this study, deems relevant and necessary.

Executive Summary

The origins of the legal framework of state and parastatal organizations that provide health services and social health insurance in Egypt go back to the 1950s, but the present structure was developed during the 1960s, when Egypt adopted socialism as a political and economic regime. This contrasts with Egypt's current policy of market economy. It is not, therefore, a surprise that the strategies that the Egyptian health care system adopted in the past are different from those suggested jointly by the Ministry of Health and Population (MOHP) and the United States Agency for International Development (USAID). The mandate of the team conducting this legal analysis was "to identify any legal constraints to the policy reforms which are likely to be undertaken during the course of USAID's proposed health policy reform Program Assistance and assess the feasibility of accomplishing any legislative changes which may be needed to enact the reforms in a timely manner."

In conducting the legal analysis, the study focused on three main state and parastatal organizations that provide health services to the public. These are the Ministry of Health and Population, the Health Insurance Organization (HIO), and the Curative Organizations (CO). To obtain a universal understanding of the system as a whole, the study also briefly visited the legal framework of university hospitals and educational hospitals and institutes. The MOHP no longer owns or acts (except in certain few cases) as direct provider of health services, but has relinquished this role to the local administration units (governorates and other municipalities). In examining the legal framework of these organizations and the structure pursuant to which they provide health services, the study considered whether the following set of strategies, among others, could be implemented:

- ▲ Freezing of construction of new Ministry of Health and Population hospitals (MOHs)
- ▲ Transferring existing MOHs to other organizations
- ▲ Operating new MOHs as "fee-for-service"
- ▲ Allowing private practitioners to use MOHs
- ▲ Improving MOH autonomy
- ▲ Allowing management to offer bonuses and incentives to MOH employees
- ▲ Improving the CCO's autonomy
- ▲ Unifying existing social health insurance laws
- ▲ Freezing expansion of General Authority for Health Insurance (HIO) benefits to new groups
- ▲ Freezing construction of new health insurance hospitals and clinics (HIHC)
- ▲ Enabling HIO to sell and transfer HIHC
- ▲ Subcontracting health services
- ▲ Establishing a national health insurance fund
- ▲ Abolishing guaranteed government employment
- ▲ Enabling MOHP to transfer and reduce its own personnel

The study has come to the conclusion that there are no absolute legal constraints to the policy reforms that are likely to be undertaken during the course of the Program Assistance. There would be need for issuance of presidential and ministerial decrees, and possibly certain amendments to existing laws, should other analyses determine that such changes are required to achieve the objectives after having reviewed this study.

These legislative changes vary from a change in a particular law, presidential decree, or ministerial decree. Changes in a law require a parliamentary act. A presidential decree is issued by the president after having consulted with the government. Presidential decrees are tools by which public authorities and organizations, such as the HIO, are established and regulated. Ministerial decrees are issued by the competent minister and are easier to obtain.

Section 5 of the study discusses each of the strategies suggested by the MOHP and the USAID and indicates where a change in a law, Presidential decree, or ministerial decree is or could be required. The required action for the proposed policy reforms is summarized in Table 2. The time needed to effect any of the legislative changes to implement the suggested strategies cannot be determined at the outset. This largely depends on the political will behind these changes.

1.0 Introduction

The United States Agency for International Development (USAID) plans to develop health sector Program Assistance to facilitate needed health sector reform in Egypt in participation with the government of Egypt (GOE) and the Ministry of Health and Population (MOHP). The USAID has identified five areas as most likely to be emphasized in its health sector Program Assistance:

- ▲ Rationalizing curative care (e.g., expand cost recovery, improve the cost effectiveness of government health services, improve access to care for the poor and those living in underserved areas);
- ▲ 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.

1.1 Legal Analysis: Objectives of the Study

As stated in the Scope of Work, the objectives of the study are to:

“Provide support to the design of health sector Program Assistance by preparing five special analyses and developing indicators to track health policy changes as a condition for cash disbursements under the Program Assistance.”

These analyses are (i) social vulnerability, (ii) institutional, (iii) political, (iv) legal, and (v) economic.

The legal analysis is mandated to identify any legal constraints to the policy reforms that are likely to be undertaken during the course of the Program Assistance. It will assess the feasibility of accomplishing any legislative changes that may be needed to enact the reforms in a timely manner.

1.2 Methodology

The legal analysis is mandated to include any administrative regulations of the government that may constrain health reform (e.g., civil service procedures that apply to all

ministries and are not under the control of the MOHP).¹ Since the exact nature of the policy reforms beyond the first year of the Program Assistance is unknown at this time, the legal analysis is required to focus on the legal and administrative framework surrounding each of the five anticipated broad reform areas referred to earlier.

Due to difficulties encountered by the team undertaking the legal analysis in conducting interviews with the legal adviser to the MOHP and other MOHP personnel, the analysis did not begin with interviews of key health sector legal specialists. Interviews that took place immediately prior to the completion of the final draft of this study, which included the MOHP's and the General Authority for Health Insurance's (HIO) legal and other staff, were used to test the findings concluded by the study on the basis of the legal analysis of the various instruments that form the present legal framework. Interviews also confirmed whether any of those laws and regulations could hinder the policy reforms likely to be undertaken in connection with the Program Assistance. The legal analysis examined legal and administrative documents and obtained the actual texts of such laws and regulations pertaining to the issues examined in this report. Section 5 indicates those laws and regulations that are likely to impede the reform process and identifies the legal instruments required to effect the change of such laws and regulations.

The laws and regulations examined by the study date back to the early 1950s, and since then numerous changes and amendments to such laws and regulations were adopted. The study, therefore, frequently employed the services of the Information and Decision Support Center (IDSC) to verify any amendments to those laws, decrees, and regulations published in Egypt's Official Gazette. A recent USAID-funded study has stated that:

“Lack of either a well indexed, hard copy law-finding system or a complete, integrated, full text computerized database for laws, regulations, and published court decisions makes it difficult for lawyers, judges, and legislators ...to know and predict the rules. ..”
(Egyptian Legal and Judicial Sector Assessment, February 1994).

Although the accuracy of information obtained could not be verified, the study is generally comfortable in reaching its conclusions assisted by the verifications obtained from the IDSC. The problem, however, relates to those ministerial and lower-level decrees that are not published at all (including decrees pertaining to the Cost Recovery Project).

1

¹The study uses the reference to the Ministry of Health (MOH) with respect to decrees and actions taken by the MOH prior to becoming the MOHP. The MOH was the predecessor to the MOHP.

2.0 Overview

2.1 Egypt's Legal and Law-Making System

2.1.1 General

Egypt has been a modern constitutional state since 1923, when the country adopted its first written constitution. The Constitution of 1971 (i.e., the Constitution), which remains in force today as amended in 1980, provides for a presidential system of government based on the principle of separation of the legislative, executive, and judicial powers.

The Constitution vests legislative power in the People's Assembly; the president, however, may also promulgate decrees, having the force of law in certain circumstances.

The Constitution divides the Republic into various administrative units, including governorates, cities, villages, and such other units as may be established. Executive authority is vested in governors, mayors, and village headmen. Legislative authority is vested in local People's Councils.

2.1.2 Sources of Law

Egyptian law is derived from a variety of sources. Article One of the Civil Code states that the sources of law are (i) applicable legislation, (ii) custom, (iii) principles of Islamic law, (iv) principles of natural justice, and (v) rules of equity.

The hierarchy of various forms of Egyptian legislation, in descending order, are as follows:

- The Constitution
- International treaties
- National laws
- Presidential decrees
- Council of Ministers' decrees
- Prime Ministerial decrees
- Ministerial decrees
- Governorate and local council resolutions, legislation, and decrees
- Decrees of governors and local officials

Forms of legislation that are lower in the hierarchy (e.g., governors' decrees) must agree with and be authorized by higher forms of legislation, or else they are not valid.

2.2 Role of the Ministry of Health and Population

Responsibilities and organization of the MOHP, with respect to the health sector, are regulated by Presidential Decree No. 268 of 1975 (i.e., Decree 268). Article 1 of Decree 268

provides that the MOHP's predecessor, the Ministry of Health (MOH), is responsible for the preservation of the health of Egyptians through the provision of preventive and curative services on a centralized level and locally in agreement with the competent local administration units. These services will include those related to the improvement of the health of individuals, improvement of the environment, immunization of the population against diseases, and the early diagnosis of such diseases.

In particular, Decree 268 provides that the MOH shall (i) evaluate health services quantitatively, qualitatively, and with respect to performance; (ii) provide centralized health services, including central laboratories, pharmaceutical services, medical councils, manpower training, governorates' health directorates, and medical licensing; (iii) manage health services and units throughout the country as may be determined by the minister of health in agreement with the competent authorities. In this regard, the minister shall determine the attachment of such units to the various departments within the MOH and issue necessary regulations for their organization and authority; and (iv) coordinate among the various local medical units (MU) within the governorates, and provide assistance in their organization and development of their services.

The following entities, among others, are units of and under supervision of the MOHP:

The Supreme Council for Health Services

- ▲ Egyptian General Authority for Pharmaceuticals and Medical Chemicals and Requirements
- ▲ HIO
- ▲ Egyptian Authority for Biological Products and Vaccines
- ▲ Curative Organizations (COs)
- ▲ General Authority for Educational Hospitals and Institutes (EHI)
- ▲ Nasser Institute for Research and Treatment

Implementation and execution of certain health legislative and regulatory mandates may be within the jurisdiction of the president of the republic or the prime minister (PM). In many such cases, however, enabling laws and decrees delegate these powers to the MOHP.

In carrying out its mandate, the MOHP offers preventive and curative services to the public through health units located all around Egypt. The organizational structure of the MOHP is divided into a central level represented by the MOHP in Cairo and a local level represented by health directorates in the governorates.

2.3 Constitutional Analysis

The following provisions of the Constitution are relevant to the health reform Program Assistance:

- ▲ **Article 7:** The society is based on social solidarity.
- ▲ **Article 8:** The state shall guarantee equality of opportunity for all citizens.

- ▲ **Article 10:** The state shall guarantee the protection of motherhood and childhood, take care of the children and youth, and provide suitable conditions for the development of their talents.
- ▲ **Article 14:** The state shall guarantee the protection of public employees and the performance of their duties in taking care of the people's interests. They may not be dismissed other than through disciplinary action, except as provided by law.
- ▲ **Article 16:** The state shall guarantee cultural, social, and health services and shall ensure their availability in villages in an easy and regular manner in order to raise their standard.
- ▲ **Article 17:** The state shall guarantee social and health insurance services, and all citizens shall have the right to pensions in cases of incapacity, unemployment, and old age, in accordance with the law.
- ▲ **Article 144:** The President of the Republic shall issue the executive regulations to enforce the laws without amending, freezing, or exempting from the application of such laws. He may delegate others to issue such executive regulations. It is possible for the law to determine who shall issue the executive regulations.
- ▲ **Article 146:** The President of the Republic shall issue the decrees necessary for the establishment and organization of public utilities and departments.

Nothing in the foregoing provisions limits the ability of the MOHP in making structural changes to the health sector in Egypt in the manner proposed under the Program Assistance. Hierarchical authority should be observed, however. Any proposed structural changes would not (so far as the study has assumed) eliminate the role of the government in ensuring the widespread availability of health services and health insurance at an affordable cost.

2.4 Role of Central Agency for Organization and Administration (CAOA)

The CAO is an independent authority currently attached to the Ministry of Administration Development. The chairman of the CAO enjoys the status of a member of the Cabinet of Ministers, with similar authorities over the CAO employees. The role of the CAO is largely consultative.

The CAO exercises jurisdiction with respect to the following entities:

- (i) The government and its subdivisions, and
- (ii) Public authorities, organizations, and companies attached thereto.

Article 3 of Law 118 of 1964, as amended, defines the role of the CAO in part as follows:

- ▲ Proposing employee laws and regulations and rendering opinions with respect to related drafts, prior to their enactment. It has interpretation authority with respect to existing laws and regulations. Accordingly, any entity subject to the CAO is under an obligation to submit any employee regulation to the CAO for its review. Strictly from a legal view, the CAO is consultative; in practice, however, public authorities, organizations, and public sector companies tend to support the remarks of the CAO. As a result, most such regulations are uniform and tend to emphasize the special nature and requirements of the various entities.
- ▲ Studying the need for employees of all professions and specialties, in cooperation with the respective departments, and selecting rules of their appointment and allocation on the basis of competence and equality.
- ▲ Developing civil service affairs to ensure uniformity in treatment and assisting authorities in determining methods of health and social care.
- ▲ Proposing policies with respect to salaries, bonuses, allowances, and incentives.
- ▲ Examining budget proposals with respect to employee allocations, to the number of jobs, and to the level and seniority of the employees. The CAO authority in this respect is not binding.

The CAO exercises these powers through, among other things (i) technical supervision over the execution of laws and regulations pertaining to employees; (ii) review of draft laws and regulations concerning the establishment of additional department or units and their reorganization or amendments to their powers prior to their approval by the appropriate authority; and (iii) review of budget proposals with respect to employees, number of jobs, and classification prior to their review by the Ministry of Finance.

The scope and binding nature of the authority of the CAO are not clear. Many powers of the CAO are not in fact found in its decree but are found within several laws and regulations. Of importance in this regard are the powers granted to the CAO in the Civil Service Employment Law, Law 47, discussed in Section 2.5. The CAO is given authority under Articles 6, 8(A), 21, and 55 (concerning the transfer of employees in certain situations) of Law 47. Other powers are granted through instructions of the Cabinet of Ministers, such as, for example, the authority granted to the CAO to issue uniform employee disciplinary regulations when authority is granted initially to the Competent Authority (as defined in Section 2.5) under Article 81 of Law 47.

2.5 Civil Service Employment Law

Employees of state and parastatal hospitals and MU are subject to the Civil Service Employment Law issued by Law 47 of 1978 (i.e., Law 47). Law 47 applies to state, government, and public authorities' employees and to internal regulations.

Employees are not bound by Law 137 of 1981 concerning private labor law (i.e., Law 137), except to the extent provided under Chapter 5 of Law 137 concerning employee safety and health regulations and as stipulated by Decree 94, which is silent in this respect.

2.5.1 Law of Executive Positions within Government

In addition to the internal employment regulations and Law 47, executive employees are also subject to Law 5 of 1991 concerning civil executive positions within the government and public sector (i.e., Law 5). Positions subject to Law 5 rank from general manager to higher level of executive. Law 5 provides that appointments to key executive positions within the government and public authorities shall be for a period of three years, renewable in accordance with the law. Employment in these positions will terminate upon the expiration of the stated period unless otherwise renewed. Executive regulations of Law 5 regulate methods of selecting and appointing employees to these key executive positions and conditions leading to renewal of the term of appointment. If not renewed, the employee is transferred to another position either within the same entity or another entity, the latter by a decision of the prime minister.

2.5.2 Appointment of New Graduates and Compulsory Service

Appointment of new graduates is generally a matter of government policy. We could not identify a particular instrument of law that regulates or directs this policy. In practice, should a policy determination be reached, implementation would be left to the various ministries and departments in accordance with the applicable rule regarding conditions of employment under Law 47 and other regulations.

Compulsory service by the medical profession and supporting staff is, however, regulated by Law 29 of 1974 (i.e., Law 29). Law 29 authorizes the minister of health to compel graduates to be employed by the various institutions and departments of the central or local governments for a period of two years, renewable for two additional years. Such renewal is made pursuant to the request of the entity where the graduate was appointed. The law further limits the ability of the minister in exercising these powers to one year from the date of graduation.

The law prohibits persons to employ the graduates and holds them accountable to Law 29 unless the graduates hold a release certificate from the MOHP. Any such violation is sanctioned by imprisonment, fine, or both.

2.5.3 Transfer of Public Service Employees

As employees subject to Law 47, medical personnel may be transferred, pursuant to Article 54 of Law 47, from one entity governed by Law 47 to another, to other public authorities and government departments that enjoy special budgets, or to public sector companies and vice

versa, as long as such a transfer will not prejudice any rights of the employee in terms of seniority or if he so requests.

Article 55 of Law 47 authorizes the minister of finance, after obtaining the consent of the CAO, to transfer an employee to another entity from among the entities previously described in either one of two situations: (i) if the employee does not meet the requirements of the position he/she occupies or some other vacant position in the same unit or (ii) if he/she can be classified as excess labor. Exercise of this authority is affected by (i) Presidential decree for high-ranking positions and the competent authority for other positions (Article 54) and (ii) the Ministry of Finance (Article 55).

2.5.4 Termination of Public Service Employees

Provisions of Law 47 regulate the termination of civil servant employees. Article 171 lists the following reasons for termination: (i) retirement age (60 years), (ii) health problems, (iii) resignation, (iv) dismissal, (v) loss of nationality or loss of reciprocity for nationals of other countries, (vi) dismissal by Presidential decree in circumstances provided by law, (vii) committing a crime, (viii) cancellation of the position offered (prior to commencing employment), and (ix) death.

Article 35 of Law 47 provides another reason for the termination of employment. It provides that any employee who receives two consecutive annual reports with a “poor” rating that will be reviewed by the employee affairs committee within the organization that employs him or her. This committee shall either transfer the employee to another position more suitable to his or her ability or recommend the termination of employment. Should the recommendation not be approved, the employee will be terminated if he/she receives another poor rating for a third year (preserving, however, the employee’s right to pension or bonus).

In carrying out the mandate of Article 14, public employees may not be dismissed other than through disciplinary action, except as provided by law. The Parliament issued Law 10 of 1972 to provide four situations where it is possible to dismiss a public employee other than through disciplinary action. These are (i) serious breach of duties causing considerable damage to production or economic interest of the state or public legal persons (such as public authorities), (ii) serious indications that the employee poses a threat to national security, (iii) if the employee is a high-ranking employee and loses eligibility for the position for reasons other than health reasons, and (iv) if the employee is a high-ranking employee and loses credibility.

2.6 The MOHP Role in Regulation, Accreditation, and Quality Assurance of Health Services

The role of the MOHP in regulation, accreditation, and quality assurance of health services is regulated by (i) Presidential Decree 268 of 1975, discussed in Section 2.2; (ii) laws regulating the various medical professions, including Law 49 of 1969 concerning the Physicians’ Association, Law 46 of 1969 concerning the Dentists’ Association, and Law 47 of 1969 concerning the Pharmacists’ Association; (iii) Law 51 of 1981 concerning medical establishments (limited to private sector); and (iv) laws regulating the practice of the various medical professions, including Law 415 of 1954 concerning the Practice of the Medicine,

Law 537 of 1954 concerning the Practice of the Dentistry, and Law 127 of 1955 concerning the Practice of Pharmacy.

2.6.1 Health Standards of Practice

Applicable laws are not specific as to the role of the MOHP in this respect. Presidential Decree 268 empowers the MOHP with supervisory powers. No specific regulations are available, however, that set health standards of practice. The major role in this respect appears to be vested with the various professional associations, whose boards of directors are empowered by their laws to issue internal regulations and codes of practice. The role of the MOHP appears to be limited in issuing these standards by an MOHP decree. It is not clear what role the MOHP plays in the formulation of these standards.

2.6.2 Health Facility Accreditation

The role of the MOHP in health facility accreditation is based on its role as the supervisor and licensor of such facilities. The establishment of a health facility is permitted if a construction license is procured that imposes the building specifications. These licenses are issued by the concerned governorate after being examined by the governorate's Health Department. In carrying out its supervisory powers and responsibilities assigned to the MOHP under Presidential Decree 268 referenced earlier, the MOHP conducts periodic inspection to determine the right of the health facility to maintain its license. Further research and additional interviews are required to comprehensively understand and determine the exact role of the MOHP in this respect, particularly with regard to state and parastatal hospitals and clinics.

2.6.3 Continued Physician Licensing and Continuing Medical Education

Licensing of physicians and other medical professions is regulated by the various laws referred to in Section 2.6. These laws generally follow a unified pattern where the practice of any of these professions is contingent on (i) registration with the MOHP in a special register that requires a relevant university degree and compulsory one-year training in an accredited hospital, and (ii) registration with the appropriate professional association. Generally, the registration requirements (except for the required training period) are not enforced.

None of the laws discussed earlier provides for a continuing medical education nor requires any additional training programs or qualifications that the applicant must satisfy to maintain his or her license. Certainly, it is recommended that amendments to these laws be adopted to require additional and periodic qualification for physicians and other medical practitioners.

3.0 Regulatory Structure and Organization of State and Parastatal Hospitals and Other Medical Facilities

The existing regulatory framework governing state hospitals and other medical establishments in Egypt is at least as old as 1936, when the MOH was established. In its present structure, it dates back to 1955 when Law 490 of 1955 was issued to regulate medical establishments. This law was later superseded by Law 51 of 1981, which concern medical establishments. Since 1955, hundreds of laws and presidential, prime ministerial, and ministerial decrees have been issued, some superseding others and some providing new regulation for certain aspects of the medical service sector.

A survey of these laws and regulations indicate that today there are at least five categories of state and parastatal hospitals and medical facilities. These are

- ▲ Local administration hospitals and medical establishments (LAHME) (also referred to as “Ministry of Health Hospitals”)
- ▲ CO
- ▲ Health insurance hospitals and clinics
- ▲ Educational hospitals and institutes
- ▲ University hospitals

The following is a brief discussion of the regulatory framework of each category. A list of the most important applicable laws, regulations, and decrees forming the regulatory framework is listed in Appendix A.

3.1 Local Administration Hospitals and Medical Establishments

LAHME and Ministries of Health Hospitals (MOHH)² refer to hospitals owned and managed financially and administratively by their local administration units. The MOHP’s role is limited to the technical aspects, the approval for construction of new hospitals, and the determining of financial needs of the MOHH with regard to the MOHP’s annual health plan.

²The study refers to the Cairo Curative Organization as “CCO.”

Each governorate has within its structure a health directorate reporting to the governor. The governor acts as the chief administrative officer. The MOHP, however, appoints the director and deputy director of each health directorate after consulting with the appropriate governor (Articles 2 and 26 of Local Administration Law 43 of 1979, i.e., Law 43, and Article 96 of Prime Ministerial Decree 707 of 1979 concerning the Executive Regulations of Law 43, i.e., Decree 707).

3.1.1 Scope and Organization

The MOHH governed by Presidential Decree 2444 of 1965, concerning the organization and management of hospitals and units attached to local councils, in addition to Law 43 and Decree 707.

Article 6 of Decree 707 provides that local units (municipalities), i.e., governorates, cities, and villages (as defined in Article 1 of Law 43), are authorized to establish, equip, and manage MUs within the general policy and plan of the MOHP. Under such a scheme, governorates have jurisdiction over, among other things, public hospitals and polyclinics, health insurance projects and hospitals, the licensing for establishment of private sector hospitals, and educational and CCO hospitals.

Decree 2444 stipulates that the LAHME, which are selected by a joint decree of the Ministry of Local Administration (MOLA) and the MOHP, enjoy financial and administrative independence in the manner provided by Decree 2444. Through the years, several joint ministerial decrees were issued to name certain hospitals to be subjected to Decree 2444. The MOH and MOLA's joint Decree 18 of 1967 delegated to the governors the authority to subject all remaining LAHME to Decree 2444 at the dates they deem appropriate. Although specific data is lacking, it would appear that all LAHME now have been subjected to Decree 2444.

3.1.2 Management and Financial Autonomy

According to Article 2 of Decree 2444, LAHME shall be regulated in accordance with the basic rules to be issued jointly by the MOLA and the MOHP, which cover management, technical, and financial matters irrespective of existing government regulations. The basic rules are incorporated today under Prime Ministerial decree, MOLA, and MOHP Decree 3 of 1988 (as amended) (i.e., Decree 3).

3.1.2.1 Management Autonomy

Article 3 of Decree 2444 provides that each LAHME will be managed by a board of directors in accordance with Decree 3. The board is established by a decision of the appropriate governor upon the recommendation of the director of the health directorate (who is appointed by the MOHP) . Decree 3 empowers the LAHME board of directors to

- ▲ Supervise LAHME services;
- ▲ Approve the internal regulations of each LAHME;
- ▲ Approve annual projections for needs of pharmaceuticals, medical supplies, food, and other equipment and supplies;
- ▲ Supervise the implementation of the budget;

- ▲ Regulate the provision of paid services in accordance with Decree 3;
- ▲ Disburse funds from the LAHME service fund maintained for the purposes of improving LAHME services (i.e., LAHME Fund);
- ▲ Contract, when necessary, with physicians and others who are not LAHME employees out of the share allocated for such purpose from the LAHME Fund;
- ▲ Contract with companies and other organizations for the provision of LAHME services against a fee in accordance with Decree 3; and
- ▲ Exercise powers granted by laws and regulations pertaining to warehouses, purchases, and accounts as detailed in Exhibit 1 to Decree 3.

Article 4 of Decree 3 further regulates the powers of the manager of the LAHME. It provides that the manager is responsible for the day-to-day operations and for all LAHME employees and is the legal representative of the LAHME vis-à-vis third parties. In particular, the manager is empowered to

- ▲ Implement the decisions of the board of directors;
- ▲ Appoint temporary employees when necessary out of the LAHME Fund;
- ▲ Submit an annual report to the LAHME board of directors;
- ▲ Prepare a quarterly report to the Department of Health of municipality on the activities of the LAHME; and
- ▲ Propose and enforce disciplinary actions within the limits of the law, and authorize regular annual vacations up to 15 days.

3.1.2.2 Financial Autonomy

Article 4 of Decree 2444 provides that each LAHME shall have a special budget and separate financial account. Such budget and account shall include, on the revenue side, the LAHME's share of contribution from its municipality. Such a contribution is determined on the basis of the level of service provided by the appropriate hospital and the number of beds. In addition to the annual budget, each LAHME shall have a fund whose revenues shall be used in improving the medical services. The resources of such a fund shall be composed of (i) special revenues of the LAHME derived from services and (ii) any other resources. Surpluses from the fund shall be carried forward from year to year. Expenditures out of the foregoing revenues shall be in accordance with Decree 3.

The contribution payable by the competent municipality referred to in the preceding paragraph is allocated to the municipality through the general budget of the state. Initially, the competent health directorate within each governorate (the head of which reports to the MOHP despite the fact that the department is part of the governorate) discusses the needs of each LAHME within the governorates with regard to the national plan of the MOHP. Once agreed upon, the LAHME proposed budget is referred by the MOHP to the Ministry of Planning which, with the Ministry of Finance, determine the funds allocated to each LAHME. Such allocation is then reported to the National Investment Bank, which disburses the allocated funds to each LAHME every three months.

3.1.2.3 Services Against Nominal Fees

Certain LAHME selected by the MOHP may charge nominal fees for medical services in accordance with specific rules provided in Appendix 3 of Decree 3.

3.2 Curative Organizations

3.2.1 Organization

Curative Organizations were founded in 1964 with the transfer of about 22 non-governmental hospitals, which were nationalized (among others pursuant to Law 135 of 1964) to two newly created health organizations, the Cairo Curative Organization (CCO) and Alexandria Curative Organization (ACO).³ COs are governed by Presidential Decree 1581 of 1967 concerning the reorganization of COs (which repealed Presidential Decree 1210 of 1964). Under this scheme, one CO may be established in each governorate by a presidential decree.

COs are established as “public authorities” governed by Law 61 of 1963 concerning public authorities. Each CO is located at the capital of each governorate and enjoys full legal capacity. Currently, there are six COs: (i) the CCO, established pursuant to Presidential Decree 1212 of 1964; (ii) the ACO, established pursuant to Presidential Decree 1213 of 1964; (iii) the Qalubiya CO, established pursuant to Presidential Decree 286 of 1988; (iv) the Kafr El- Sheikh CO, established pursuant to Presidential Decree 246 of 1989; (v) the Damietta CO, established pursuant to Presidential Decree 325 of 1990; and (vi) the Port Said CO (decree unavailable). Each of these COs manages and operates, through ownership or otherwise, a number of hospitals and MUs.

According to Article 6 of the Executive Regulations of the Local Administration Law, PM Decree 707, governorates have supervisory authority over the COs located in that governorate.

3.2.2 Purpose

The purpose of the CO is to execute the state’s general curative services in hospitals and MUs attached to COs. The COs have jurisdiction for planning, supervision, control, and follow-up for services rendered by the hospitals and medical units MUs. Among the CO’s powers are (i) the ability to establish hospitals and other MU whether by construction, purchase, lease, or otherwise; (ii) setting the general rules for the fees-for-services rendered by the hospitals and other MUs; and (iii) providing the general rules for the contracting by the hospitals and MUs with other organizations, establishments, companies, and other entities for the provision of medical services to their employees.

³The study refers to the Curative Organizations as “COs” and not CCOs. The Arabic name does not contain the word “Care.” For this reason, the study also does not use the reference “CHO.”

3.2.3 Main Features

The main features of a CO as provided by Decree 1581 and Law 61 are the following:

- ▲ It is a public authority in charge of operating a public service under the supervision of a responsible minister.
- ▲ It is managed by a board of directors that is empowered to take all necessary action toward the fulfillment of the objectives stated in its decree. In particular, the board is empowered to:
 - △ Issue rules and internal regulations concerning financial (including contracting and procurement arrangements), administrative (including employee regulations), and technical matters without being bound by governmental rules;
 - △ Establish staff employment regulations similar to those followed in private establishments;
 - △ Study the fee structure for medical services proposed by its hospitals and MUs within the framework set by the CO for which a ministerial decree shall be issued;
 - △ Approve its own annual budget prior to review by the competent authority;
 - △ Establish general rules for contracting by hospitals and MUs with other entities for the provision of medical services to their employees;
 - △ Review periodical reports concerning its own activities and financial situation; and
 - △ Examine all matters referred to the board by the competent minister.
 - △ The chairman is responsible for day-to-day operations and the implementation of the CO's general policy under the supervision of the minister of health.
 - △ Board resolutions are subject to the approval of the minister of health.
 - △ The CO's funds are considered public funds and are subject to the rules governing such funds, unless otherwise provided in its decree.

3.2.4 Financial Resources

According to Article 10 of Decree 1581, the capital of a CO is composed of (i) the combined capital of hospitals and MUs (ii) funds allocated to the CO from the state's budget, (iii) loans, and (iv) contributions and charities.

3.2.5 CO Hospitals and MUs

Decree 1581 regulates and provides a general framework for hospitals and MUs. The main features for such a framework are as follows:

- ▲ Each hospital and MU is administratively and financially independent.
- ▲ Each is managed on a basis identical to private projects, and each shall have a responsible manager appointed by the minister of health upon the recommendation of the CO's board of directors.
- ▲ Each hospital and MU has a separate budget prepared on a basis similar to commercial budgets. Surplus funds shall be carried forward to constitute statutory reserves for the next financial year, to be used in improvements of medical services. Such reserves may not be used for purposes other than those for which they were allocated for without the approval of the CO and the minister of health.
- ▲ Revenues include (i) hospital and MU charges for examinations, laboratory services, and accommodation payable by patients; (ii) income from contracts to provide medical services for other entities; (iii) percentage of profit allowed to COs with respect to pharmaceuticals; (iv) governmental support; and (v) contributions and charities approved by the CO's board of directors.
- ▲ A system of bonuses and incentives shall be set by the minister of health subject to the approval of the PM (Article 15 of Decree 1581).

3.3 Health Insurance Hospitals and Clinics (HIHC)

HIHC are governed by Law 79 of 1975 (i.e., Law 79), Presidential Decree 1209 of 1964 concerning the establishment of the HIO (i.e., Decree 1209), Law 32 of 1975 concerning Health Insurance for Government, Local Administration and Public Authorities Employees (i.e., Law 32). According to Article 6 of Decree 707, governorates shall have supervisory authority over the HIHC located in that governorate.

3.3.1 Establishment and Regulatory Framework

HIHC are entities established by the HIO, through which the HIO provides health care services to employees of the government, local governments, and public organizations and authorities (Article 2 of Decree 1209).

Specific information on the numbers and locations of the HIHC could not be verified. Some have estimated that there are about 27 hospitals, 138 polyclinics, and 56 specialized centers.

3.3.2 Management and Authority

Pursuant to Decree 113 of 1976 of the chairman of the board of the HIO, HIHC are managed by a board of directors appointed by the chairman of the board of the HIO. The HIHC board is the authority responsible for its management and medical services. The board of directors of the HIHC meets at least once each month, and its decisions are submitted to the director of the competent HIO branch for approval. Unless objected to within one month from the date of its submission, such decisions become effective.

The board of directors is empowered to:

- ▲ Determine the services to be provided by the HIHC;
- ▲ Prepare internal regulations within the limits decided by the HIO;
- ▲ Propose the HIHC budget for submission to the competent authority; and
- ▲ Use the powers of the “head of the department” referred to in the laws and financial regulations (the “head of the department” refers to the director of the HIO branch).

The board, however, has no authority in determining the pricing of HIHC services. The pricing of such services is either determined by the governing law, namely, Law 79 of 1975 and Law 32 of 1975 concerning social insurance and HIO decrees or by other regulations.

3.3.3 Procurement of Medical Equipment

Decree 55 of 1995 of the chairman of the board of the HIO establishes a central committee, called the Procurement of Medical Equipment Committee, with the task of receiving requests from various HIO branches and units for new or additional equipment. Whenever a need for such equipment arises, the appropriate HIHC physician submits a request to the director of the HIHC. The director then refers the request to the Medical Supplies Committee within the hospital. The committee reviews the request and refers it to the Procurement of Medical Equipment Committee through the competent HIO branch. If the request is approved, procurement is then processed pursuant to Law 9 of 1983 concerning tenders and offers.

We have learned that a new procurement decree to replace Decree 55 of 1995 is in the process of being issued. No further information was available as to the contents of the decree.

3.3.4 Financial Resources

HIHCs are not legally independent units. They are financed through the general budget of the HIO. Each HIHC proposes its own budget for each financial year. The proposed budget is then submitted to the competent HIO branch in an intermediary step before being reviewed by the board of directors. The HIO then proposes its own budget for

that same year, including the budgets for all HIHCs, to the ministry of finance for submission in accordance with the Constitution to the Parliament. Determination of each HIHC's budget ultimately is based on the general plan at the HIO level and pursuant to the general priorities set by the HIO.

3.4 Educational Hospitals and Institutions

EHI's are attached to the General Authority for Educational Hospitals and Institutes (GAEHI), whose authority is governed by Presidential Decree 1002 of 1975 (i.e., Decree 1002), which further regulates the EHI's attached thereto.

Since its establishment, at least two presidential decrees were issued transferring about 16 MOHP hospitals and institutes to the possession of the GAEHI. These are Decrees 223 and 652 of 1976.

3.4.1 Purpose

The GAEHI was established to undertake the following tasks:

- ▲ Staff hospitals and institutes with qualified physicians;
- ▲ Provide medical care on a regional and national level; and
- ▲ Assist in the teaching of undergraduates, physicians under training, and university faculty.

3.4.2 Main Features

The EHI's board of directors has authority to, among other things:

- ▲ Approve the GAEHI's budget;
- ▲ Determine the powers of the EHI's management committees and approve the internal regulations proposed by such committees; and
- ▲ Issue the financial and administrative regulations of the GAEHI without regard to the applicable government regulations.
- ▲ Each EHI shall constitute an independent unit financially, technically, and administratively.
- ▲ Each EHI shall be managed by a committee appointed by the GAEHI's board of directors in the manner specified by Decree 1002.

The GAEHI's financial resources shall be composed of

- ▲ Government allocations from the MOHP or university budgets;
- ▲ Amounts received against services rendered; and
- ▲ Contributions and charities.
- ▲ EHI's staff must meet the requirements of Law 49 of 1972 concerning the Organization of Universities, and any appointments shall be by a decision of the chairman of the board of the GAEHI.

3.5 University Hospitals

University hospitals are governed by Presidential Decree 3300 of 1965 concerning the organization of university hospitals. These are hospitals annexed to faculties of medicine and offer medical education, certain medical services to the public, and special services to the students. These hospitals are not included in the scope of work, for the legal analysis.

4.0 Health Insurance Organization

The HIO was established as a public authority under Law 61 pursuant to Presidential Decree 1209 of 1964. The purpose of the HIO is to provide health insurance for employees of the government, local governments, public authorities, and employees regulated by Law 137 of 1981 concerning the Labor Law, either by itself or through its branches.

4.1 Authority and Organization

In carrying out its mandate, the HIO may, among other things:

- ▲ Provide health services to all participating employees;
- ▲ Establish, operate, and manage hospitals and clinics and other medical establishments;
- ▲ Lease or contract services from other hospitals and medical establishments;
- ▲ Employ medical professionals; and
- ▲ Provide pharmaceutical products to insured employees.

The HIO is currently divided into seven branches: Cairo, Alexandria, and West Delta; Middle Delta (Tanta); East Delta (Shobra El Kheima); Canal region (Port Said); Giza and North Upper Egypt; Middle Upper Egypt; and South Upper Egypt.

4.2 Autonomy

Table 1 provides a summary concerning the legal status, authority, management, financial, and human resources autonomy given to the HIO.

In practice, there appears to be occasional tensions between the HIO and governorate concerning supervision and control. The HIO maintains the position that it is an independent public authority pursuant to its decree of establishment, Decree 1209. Governors, however, apparently on the grounds of Article 6 of Decree 707, sometimes attempt to exert supervision authority over the HIHCs located in their governorates.

Table 1: Summary of Legal Status and Autonomy of the HIO	
Area	Status
A. Legal Status and Authority	
Establishment	Presidential decree
Governing law	Decree + Law 61
Legal form	Public organization
Reporting	Ministry of Health and Population
i) Capital and ii) financial resources	i) N.A.; ii) revenues generated from payments pursuant to social insurance law, investments, grants
B. Management Autonomy	
Management Structure	Board of Directors
Board Appointment Authority	Chairman and General Manager: President; 3 members: Minister of Health; others: by position
Management Authority	Wide range of powers; free of government rules and regulations; freedom of pricing, but subject to the High Counsel for Health Insurance (except for borrowing)
Independence to Undertake Trading and Commercial Activities	None, except for establishing and operating hospitals and clinics
C. Financial Autonomy	
Budgeting and Planning Independence	Budget semi-independent from state and may follow commercial budgets; board has authority to approve proposal for budget, which is finalized by the Minister of Finance and approved by Parliament under a special law
Ownership and Control of Assets	Owens its assets, but disposal of assets must have approval of the prime minister after consulting with Ministry of Finance
Independence to Obtain Financing	See A. (Capital and Financial Resources)
Procurement and Contracting Independence	Freely sets its own rules; Law 9 is non-binding
Surplus or Profit Distribution/ Reinvestment Independence	Surpluses, if any, to state
Nature of Funds	Public Funds
D. Human Resources Management Autonomy	
Personnel Policies and Regulations	May have its own policies and regulations without restrictions of government rules
Independence to Set Salary and Benefit Levels Salary Scale	According to proposal of board, subject to approval by Presidential decree
Employee Regulation	Priority: 1) Decree; 2) Regulations by the board; 3) Law 47. Decree 94 is silent. Board has authority to appoint. Decree requires Presidential decree for salary scale and appointment regulations.

4.3 Beneficiaries of Social Health Insurance

Social health insurance is governed by Laws 79 and 32 of 1975 and Law 99 of 1992. These laws specifically enumerate the participants of the social health insurance system. Generally, those are (i) civil servants of the government, public authorities and organizations, economic persons or entities attached to other public sector economic organizations; (ii) employees governed by the Labor Law who are more than 18 years old and maintain a continuous employment relationship (as defined by the minister of social insurance, a relationship extending beyond six months or can be defined as such according to its nature); (iii) household servants who are not exempted; (iv) participants of prior social insurance laws; (v) pensioners who apply to participate in the health insurance system at the

time of their retirement; (vi) foreign employees subject to the Labor Law under certain conditions; (vii) school students; (viii) widows of former participants who elect to participate in the health insurance system; and (ix) families of participants and pensioners resident of Alexandria governorate in accordance with the numbers and criteria determined by the MOHP.

By elimination, certain categories of the society are not eligible to participate in the social health insurance system. Among these are (i) families of participants, excluding residents of the Alexandria governorate; (ii) employers and their families; (iii) employees less than 18 years old or those who do not maintain a continuous employment relationship; and (iv) employees not governed by the Labor Law, such as exempted household servants.

For determination of eligibility under the various health insurance schemes covered by Laws 32 and 79 of 1975, please also refer to “A Status Report on Health Insurance,” a draft report dated June 12, 1996, prepared by Dr. Hamdy El-Hinnawy and submitted to the Cost Recovery Health Project.

Appendix B summarizes the benefits, fees, and contributions provided under the existing social health insurance laws and regulations.

4.4 Right to Select Services and Providers

Procedures for receiving treatment and other services under the health insurance provided in accordance with Laws 79 and 32 are regulated in great detail by HIO Decree 614 of 1967 (i.e., Decree 614). Decree 614 covers services by the general practitioner and the polyclinics.

According to the rules set by the HIO, in particular Article 86 of Law 79, beneficiaries are limited in selecting both the practitioner and the clinic. This is organized pursuant to the geographical location of the employee’s workplace and is tied to the location of each HIO’s MU.

In the event an insured requires medical care while outside his/her place of work, he/she may, under stipulated rules, receive medical care at other HIO locations (HIO Decree 113 of 1983).

Article 48 of Law 79 further allows the insured to receive a treatment higher in quality than that provided conventionally, under the applicable rules, provided the insured pays for any difference in the cost of treatment. In addition, the law allows the insured to be treated by the employer if the latter is so authorized by the HIO pursuant to conditions specified by the minister of health in agreement with the minister of social insurance.

Minister of Health Decree 179 of 1985, which regulates certain aspects of health insurance under Laws 32 and 79, also provides for circumstances that require an insured to be treated outside of Egypt.

5.0 Legal Analysis of Suggested Reform Strategies

Below we describe the results of the legal analysis and required actions for each proposed reform strategy. These actions are summarized in Table 2.

5.1 Legal Analysis of MOHH-Related Strategies

5.1.1 Freezing of Construction of New MOHH

A decision to construct MOHH is a process that involves both the MOHP and the applicable governorate. The MOHP is responsible for preparing the general health plan and needs of the country. Proposals to construct new MOHH by the governorates or other municipalities would have to be included in the MOHP plan and budget. Accordingly, authority to construct MOHH is ultimately entrusted with the MOHP, subject to the availability of the necessary funding and consent of the Cabinet of Ministers. The decision, therefore, to freeze the construction of new MOHH is that of the MOHP, whose decision is a passive action by not including any construction of new facilities in the MOHP plan. There is no constitutional mandate or legal obligation that would compel the MOHP not to freeze the construction of new MOHH for a period of time.

5.1.2 Transfer of Existing MOHH to Other Organizations

State ownership is classified under Egyptian law in two categories: funds held in public ownership and funds held in private ownership. Articles 87 and 88 of the Civil Code define what constitutes funds held in public ownership and describes the limitations imposed on their disposition. Article 87 states that real and movable property of the state or public legal persons, which is allocated for public benefit whether in practice by a law or decree or decision of the competent minister, are considered as “public funds.” Article 87 further provides that such funds may not be disposed of, attached, or owned by way of prescription.

The MOHH are state assets held by the appropriate local administration in public ownership. Therefore, transfer of the MOHH and MU is legally permissible to the extent that transfers are made to other state or parastatal organizations, such as the COs or the HIO. Such transfers can be authorized only pursuant to a presidential decree. This is the manner by which most hospitals now attached to the existing COs were transferred from the MOHP. The scope of work does not specifically identify the other parastatal organizations to which the MOHH could be transferred.

Transfer to the private sector is a relatively complicated process due to the legal specification of the MOHH assets and funds as public. The funds have to be declared as public funds held in private ownership pursuant to Article 88 of the Civil Code. This requires in most cases either a law or decree of the competent minister, which has to be issued on the basis of a detailed report and legal review prior to any such transfer.

To transfer MOHH in governorates where no CO has been created, a CO must first be established pursuant to a presidential decree, which shall simultaneously mandate the transfer of the MOHH to the newly created CO. At present, there are only six COs.

5.1.3 Operation of New MOHH Under Cost Recovery

Decree 3, which governs the administration and financial management of MOHH (LAHME), already allows the adoption of the cost recovery system under certain rules. According to Decree 3, there are three cost recovery regimes:

- (i) Services provided for a nominal fee (Article 5) in the MOHH selected by an MOHP decree, provided that such a system does not apply to more than 30 percent of available bed capacity for inpatient services and that outpatient services should be limited to certain daily specific hours outside the normal business hours;
- (ii) Services provided for full fee (Article 7) in some of the MOHH selected in the manner specified in (i) and approved by the appropriate governor after receiving the opinion of the director of the health directorate as to selection and applicable fees. Selection of the MOHH for this type of service takes into consideration the social and environmental circumstances of the particular locality of the MOHH; and
- (iii) The cost recovery system provided under the Egypt-U.S. agreement issued by Presidential Decree 25 of 1989. This system, however, is limited to 40 MOHH and a duration that expired in September 1996 unless otherwise extended and its coverage is expanded.

Any change in the scope or nature of these cost recovery regimes or adoption of any new system would require an amendment to Decree 3 (MOHP and MOLA decree) or the Egypt-U.S. Agreement (Presidential decree). It is noted also in this regard that the MOHP and the MOLA have issued Decree 248 of 1991 according to which the governors, each in their governorate, are delegated the authority to amend the prices for services provided under the “fee-for-services” section of each MOHH.

5.1.4 Use by Private Practitioners of MOHH

Existing laws and regulations applicable to MOHH do not address the issue, except in Decree 3, Article 3(7), which sets the authority of the board of directors of the LAHME and authorizes the board to contract with physicians and other personnel not employed by the hospital in certain necessary circumstances. The cost incurred as fees to such outside personnel would be covered from the percentage allocated in the Improvement of Services Fund.

A regime by which private practitioners are allowed to use the MOHH would have to be issued by an MOHP decree determining the rules applicable in this regard.

5.1.5 MOHH Autonomy

Four basic regulations appear to affect the autonomy of MOHH: (i) Presidential Decree 2444 as to organization and regulatory framework, (ii) Ministerial Decree 3 as to management, (iii) local administration Law 43 of 1979, and (iv) Law 47 of 1978 and Law 118 of 1964 as to employee regulations. Improving existing autonomy would require an amendment to Decrees 2444 and 3, whose amendments could exempt MOHH from certain rules concerning government employment and other regulations if determined as necessary for the improvement of the MOHH’s autonomy.

A proposal worth examining in this regard is the grouping and transformation of all MOHH/LAHME within each governorate under one entity to be established under Law 61 of 1963 concerning public authorities. Although MOHH would remain public ownership, public authorities appear to have added independence and freedom in determining most of their internal regulations, including employment regulations. A Presidential decree would be required to create each public authority.

5.1.6 Bonuses and Incentives to MOHH Employees

MOHH employees are government employees governed by Law 47 of 1979, which regulates allowances, in-kind benefits, compensations, and bonuses to MOHH employees. In this respect, Law 47 provides as follows:

- ▲ Article 50 authorizes the “competent authority” (a term referring to the minister with respect to his ministry, to the governor with respect to the local government units, and to the chairman of the board with respect to public authorities) to set a system of bonuses for employees, which shall be detailed and related to the performance of the employee and his annual reports.
- ▲ Article 51 authorizes the competent authority to declare incentives to employees to improve performance and to work more efficient .
- ▲ Article 52 authorizes the competent authority to grant the employee an “encouragement incentive” equal to the periodic allowance under certain conditions, two of which are that no more than 10 percent of the employees of the same employment classification could receive this incentive in any one year, and no employee is granted such an incentive more than once each two years.

On May 30, 1996, the MOHP issued Decree 212 of 1996 by which the minister authorized the grant of incentives and reward for extraordinary efforts to certain employees and according to certain percentages provided in an appendix (i.e., Decree 212). Decree 212 grants general practitioners (between 50 percent and 250 percent of basic salary [BS]), specialists (250 percent of BS), and dentists (same as general practitioners) of primary health care units in the villages, directors of health departments (200 percent of BS), directors and deputy directors of general and central hospitals (200 percent of BS), physicians in the MOHH (40 percent of BS plus 50 percent of chargeable fees of fees-for-services, among others), and employees in emergency sections and nursing staff (fixed amounts per night and 40 percent of BS for nurses).

Any improvement or additional autonomy with respect to bonuses and incentives would require an amendment to Decree 2444, which did not except the employees of the MOHH/LAHME from the government employment regulations issued as Law 47 of 1979.

5.2 Legal Analysis of CO-Related Strategies

5.2.1 Establishment of New COs

Establishment of new or additional COs is legally permissible under the Constitution, Law 61 of 1963 and Presidential Decree 1581 of 1967. Establishment of a CO can only be authorized pursuant to a presidential decree. This is the manner by which the existing COs were created to establish new hospitals and other MUs in governorates where no CO has been created. A CO must first be established pursuant to a presidential decree.

5.2.2 Improving COs Autonomy

As public authorities, COs could have ample authority should their boards of directors fully utilize the powers granted to them under Law 61 and their decree of establishment. Autonomy of COs, however, is restricted to the extent that board resolutions would require approval of the MOH, being the competent minister, and constrained by the binding authority of the CAO in reviewing work regulations adopted by the board of directors. Lifting these limitations would require an amendment to Law 61. An added negative element is the fact that members of the boards of public

authorities often try to avoid a dispute with the MOHP by attempting to secure the MOHP consent in advance.

5.3 Legal Analysis of HIO-Related Strategies

5.3.1 Unification of Existing Social Health Insurance Laws

Unification of social health insurance laws could be made only pursuant to a legislative amendment to existing laws. HIO staff appear to support this proposal. This is an area where further work and extensive meetings with the HIO management is recommended to reach concrete conclusions.

5.3.2 Freezing Expansion of HIO Benefits

Any expansion of the coverage of the social health insurance system would require either a change in the current laws and regulations or an exercise by the competent minister of certain powers granted to such a minister, pursuant to the existing laws and regulations. Examples of such powers are found in Article 73 of Law 79 of 1975, which empowers the MOHP in determining the persons eligible for social health insurance. Pursuant to Article 73, the MOH issued Decree 858 of 1981, extending the coverage to entities employing between 5 and 499 employees, and Decree 553 of 1983 extending coverage to entities employing between 1 and 4 employees. Article 75 of Law 97 of 1975 provides a further example in that it empowers the prime minister to extend the coverage to families of the participants pursuant to conditions determined jointly by the MOHP and the minister of social insurance. As of the date of this study, Law 10 of 1981 enabled such an extension within the Alexandria governorate. It is also noted that Law 126 of 1981 establishes a Supreme Council for Health Insurance Care to extend health insurance coverage to all the people of Egypt.

5.3.3 Freezing of Construction of New Health Insurance and Hospital Clinics (HIHC)

Authority to freeze the construction of additional HIHC is entrusted to the HIO board of directors, subject to the availability of the necessary funding (refer to Section 4.1) and concurrence of the MOHP. Interviews conducted with the HIO chairman and other staff indicate that the HIO has no current plans for construction of new hospitals for the following reasons: (i) the lack of funds compared to the amount of investment required and (ii) the potential losses due to the pricing system over which the HIO has no control, as such system is regulated by law and takes into consideration social aspects over economic management. As a result, HIO has not expanded the coverage of the beneficiaries' families program, which started in Alexandria.

5.3.4 Sale and Transfer of HIHC

The HIHC are state assets owned by a public authority. As stated in Section 5.1.2, state ownership is classified under Egyptian law into two categories: funds held in public ownership and funds held in private ownership. Although Decree 1209 is silent as to the nature of HIO's funds, Law 61 provides a general rule that applies to all public authorities (unless otherwise stated in the decree of establishment) that funds of public authorities are "public funds." Accordingly, HIO may not sell any of its properties, and if it does, value will be given to the ministry of finance as a representative of the state (please refer to the discussion in Section 5.1.2).

For the HIO to dispose of its real or movable property to the private sector, such assets must be redefined as non-public funds (either by law, decree, or ministerial decision) or this fact must be established in reality (i.e., funds are no longer allocated or used for public benefit). The HIO may, however, enter into agreements with others whereby such others utilize the resources and properties allocated to the HIO by way of concession agreements and licenses to use such properties for public benefit.

Transfer of HIHC and MUs to other parastatal organizations is legally permissible but could only be authorized pursuant to a presidential decree. This is the manner by which many hospitals attached to the HIO today were transferred from the MOHP.

5.3.5 Subcontracting Health Services

According to HIO Decree 1209, HIO is authorized to contract with other medical establishments (private as well as public) to achieve its objectives. Article 86 of Law 79 stipulates the terms and conditions that the HIO has to observe in this regard. Generally, it provides that any contracting for medical services in specified situations will have to meet the requirements of the minimum standard of services required by Ministerial Decree 140 of 1986. Accordingly, there are in principle no constraints in subcontracting health services, although implementing HIO decrees could be necessary if a wider scheme is adopted.

5.3.6 Establishment of National Health Insurance Fund

Considering the existing regulatory framework of the social health insurance as described in the preceding sections, establishing a universal national health insurance fund by transforming the HIO into a national social insurer requires a major legislative amendment and overhauling of the existing system. Such an amendment should be possible under the existing laws and regulations and should not breach any constitutional mandates.

The HIO, as stated earlier, is mandated by its law to provide health services to all participant employees; establish, operate, and manage hospitals, clinics, and other medical establishments; lease or contract services from other hospitals and medical establishments; employ medical professionals; and provide pharmaceutical products to insured employees. Limiting its role to a national social insurer would violate its mandate. The limitation would also violate laws licensing the HIO to undertake the social health insurance under Law 79.

Law 126 of 1981 establishes a High Council for Health Insurance Care to extend the health insurance coverage to all the people of Egypt, and stipulates that any coordination among the various existing systems should not prejudice the independence of the Disease and Work Injuries Fund established pursuant to Law 79.

An element of economic concern, but not necessarily of legal impact, is the fact that the economic success of such national social insurer would require a proper economic calculation of premiums payable to the fund. As the existing system appears to have shown, social and political goals could prevent the application of a proper economic analysis. Accordingly, a complementary regime to compensate for the social and political deficiencies would probably be needed. At present, the HIO has a negative role in determining the premiums it receives. Such premiums are said to be below the margins required for a more efficient system. The ability of any social insurance fund to determine the appropriate premiums would need to be provided under legislative or regulatory amendments.

Limiting the role of the HIO to a national health insurance fund also means that HIO has to dispose of its existing inventory of hospitals and clinics. For transfer of such assets, please refer to the discussion in Sections 5.3.4 and 5.1.2.

5.4 Legal Analysis of Employment-Related Strategies

5.4.1 Guaranteed Government Employment

There is no legal obligation on the government of Egypt to employ new graduates. This is a matter of policy adopted by the government according to the political, social, and economic circumstances at the time. This type of decision is usually issued by the Cabinet of Ministers and the Ministry of Labor and Manpower, which would arrange for the distribution of the newly appointed graduates among the various ministries and departments in consultation with the various ministries which would have allocated appropriate funding in their budgets for such appointments. There is, therefore, no particular action required to be taken except a policy determination by the Cabinet of Ministers that, at least with respect to the MOHP and related services, no new positions are made available for a period of time.

5.4.2 Transfer of MOHP Personnel

Ability to transfer employees is regulated by Law 47 in the manner discussed earlier. If the required changes in the organization of employees within a particular unit does not fall within the limits of Law 47 (in the manner discussed in Section 2.5.3), a legislative amendment would be required. Alternately, examination of an early termination package scheme may be warranted.

5.4.3 Reduction of MOHP Personnel

Except as otherwise provided under the termination of employment provisions of Law 47 as discussed in Section 2.5.4, and as provided in Article 35 of Law 47 concerning termination of employees who receive “poor rating” in two consecutive annual reports, reduction of MOHP Personnel and Law 10 of 1972 would require the issuance of an amendment to Law 47. There are no constitutional constraints in this respect since Article 14 of the Constitution mandates that dismissal of employees, other than by disciplinary action, would be governed by the law. Any dismissal in violation of existing laws would result in filing a court case before the Administrative Court, which will force, in most cases, the employer to accept the employee back to his position and may even grant the employee monetary damages.

Table 2: Actions Required to Implement Reform Strategies	
Suggested Strategy	Legal or Regulatory Action Required
Freezing of construction of new Ministry of Health and Population Hospitals (MOHH)	Passive action, by not including any construction of new facilities in the Ministry of Health and Population (MOHP) annual (or any other relevant period) plan
Transfer of existing MOHH to other organizations	Transfers among state and parastatal organizations require a presidential decree. Transfers to private sector require re-classification of assets into private funds, which in most cases requires either a law or decree of the competent minister. Transfers to COs require first a CO to be established pursuant to a presidential decree.
Operation of new MOHH under cost recovery	To exceed existing cost recovery schemes, requires an amendment to Decree 3 (MOHP and Ministry of Local Administration (MOLA) decree), and/or the Egypt-U.S. agreement (presidential decree)
Use by private practitioners of MOHH	A MOHP decree determining the rules applicable in this regard
MOHH autonomy	Amending Presidential Decree 2444 and MOHP and MOLA Decree 3. Presidential decree would be required to create a public authority
Bonuses and incentives to MOHH employees	Improvement or additional autonomy requires an amendment to Decree 2444 to grant exemption from Law 47 of 1979
Establishment of new Curative Organizations (COs)	A presidential decree
Improving COs' autonomy	Lifting limitations would require an amendment to Law 61 of 1963
Unification of existing social health insurance laws	A major legislative amendment to existing laws
Freezing expansion of Health Insurance Organization (HIO) benefits	Passive action, by not issuing any laws to expand the coverage of the social health insurance systems, and refraining from exercising certain authorizations to ministers in some laws and regulations
Freezing of construction of new Health Insurance Hospitals and Clinics (HIHC)	Authority to freeze the construction of additional HIHC is entrusted with the board of directors of the HIO, subject to the availability of the necessary funding and concurrence of the MOHP

Table 2: Actions Required to Implement Reform Strategies	
Suggested Strategy	Legal or Regulatory Action Required
Sale and transfer of HIHC	The assets must be redefined as nonpublic funds, either by law, decree, or ministerial decision or such fact is established in reality, i.e., funds are no longer allocated or used for public benefit. Transfer of HIHC and MU to other parastatal organizations is legally permissible but could only be authorized pursuant to a Presidential decree.
Subcontracting health services	In principle, no constraints in subcontracting health services, although implementing HIO decrees could be needed if a wider scheme is adopted
Establishment of National Health Insurance Fund	Amendment and overhauling of the existing system. An amendment to HIO's Decree 1209, Law 79 of 1975 (particularly Articles 48 and 84) and Law 126 of 1981. Limiting the role of the HIO to a national health insurance fund means also that the HIO has to dispose of its existing inventory of hospitals and clinics. For transfer of such assets please refer to the discussion in Ser. 12
Guaranteed government employment	No action required except a policy determination by the Cabinet of Ministers, at least with respect to the MOHP and related services.
Transfer of MOHP personnel	A legislative amendment would be required. Alternatively examination of an early termination package scheme may be warranted
Reduction of MOHP personnel	If exceeding existing legal limits, requires the issuance of an amendment to Law 47

Appendix A: Pertinent Health Laws and Regulations

1. GENERAL

Ser.	Type	No.	Year	Subject
1	Constitution	—	1971	The Permanent Constitution of Egypt.
2	Law	131	1948	The Civil Code.
	Law	415	1954	Practice of the Profession of Medicine.
3	Law	453	1954	Industrial and Commercial Establishments.
4	Law	127	1955	Practice of Pharmacist Profession.
5	Law	1	1960	Jurisdiction of the MOH and Local Councils Concerning Health Matters (Repealed).
6	Law	61	1963	Public Authorities.
7	Law	71	1964	Grant of Pensions and Exceptional Bonuses.
8	Law	118	1964	Central Agency for Organization and Administration.
9	Law	42	1967	Delegation of Some Authorities.
10	Law	45	1969	Physicians Association.
11	Law	46	1969	Dentists Association.
12	Law	47	1969	Pharmacists Association.
13	Law	10	1972	Dismissal Other Than by Disciplinary Action.
14	Law	53	1973	State General Budget.
15	Law	69	1973	Scientific Researchers in Public Organization.
16	Law	29	1974	Compulsory Service for Physicians, Dentists, and Nurses.
17	Law	47	1978	Civil Service Employees.
18	Law	51	1981	Organization of Medical Establishments.
19	Law	127	1981	Governmental Accounting.
20	Presidential Decree	3300	1965	Regulating Employment in University Hospitals.
21	Presidential Decree	61	1966	The Supreme Council for Health Services in the MOH.
22	Presidential Decree	2420	1971	The Governmental Organization.
23	Presidential Decree	49	1972	Organization of Universities.
24	Presidential Decree	268	1975	Authorities and Organization of the MOH

Ser.	Type	No.	Year	Subject
25	Presidential Decree	223	1976	Attachment of Some MOHH to GAEHI
26	Presidential Decree	652	1976	Attachment of Some MOHH to GAEHI
27	Presidential Decree	81	1978	Establishment Of Health Council
28	Presidential Decree	25	1989	Agreement on a Grant for the Cost Recovery Health Project Between Egypt and U.S.A.
29	Presidential Decree	23	1996	Delegation of Certain Authorities to the PM
30	MOLA Decree	643	1956	General Conditions Required in Medical Establishments
31	MOH Decree	—	1952	Regulation of Nursing Profession
32	MOH Decree	17	1967	General Rules Regulating Cure against Nominal Fees in Hospitals and Clinics
33	MOH Decree	204	1967	General Rules Regulating Cure against Low Fees at Certain Beds at The Psychiatric Clinic in the Abbasyia Psychiatric Hospital
34	MOH Decree	84	1968	Alexandria Psychiatric Hospital
35	MOH Decree	374	1970	Executive Regulations for Burns Institute of El-Whylee Hospital in Cairo
36	MOH Decree	111	1982	The Maximum Monthly Bonuses to Employees in Projects under the Supervision of MOH
37	MOH Decree	216	1982	Executive Regulations Organizing the Medical Establishments
38	MOH Decree	320	1991	Financial Executive Regulation for Cost Recovery Project
39	MOH Decree	304	1994	Executive Regulation for Hospitals and Clinics Subject to the Cost Recovery Project
40	MOH Decree	84	1994	Amendments to the Ministerial Decree No. 3(H) of 1988 Concerning the Basic Bylaw for Hospitals and Health Units under the Local Administration
41	MOH and MOLA Decree	212	1996	Execution Regulation Organizing Incentives and Compensation for Extraordinary Efforts

2. CURATIVE ORGANIZATION

Ser.	Type	No.	Year	Subject
42	Law	490	1955	Organization of Curative Organizations (Superseded By Law 51/1981)
43	Law	42	1967	Delegation of Some Responsibilities
44	Law	135	1964	Organization of Curative Organization
45	Presidential Decree	1210	1964	Establishment (Curative Organization in Governorate Superseded By Decree 1581)
46	Presidential Decree	1212	1964	Establishment of a Curative Organization in Cairo Governorate
47	Presidential Decree	1213	1964	Establishment of a Curative Organization in Alexandria Governorate
48	Presidential Decree	1581	1967	Re-Organizing Curative Organization
49	Presidential Decree	394	1982	Transfer the Ownership of Nasser Institute for Research and Cure to CCO
50	Presidential Decree	286	1988	Establishment of Curative Organization in Kalyoubia Governorate
51	Presidential Decree	246	1989	Establishment of Curative Organization in Kafr El-Sheikh Governorate
52	Presidential Decree	325	1990	Establishment of Curative Organization in Damietta
53	CO Chairman's Decree	126	1995	Financial Regulation Concerning the Budgets and Accounts of CCO and Its Subsidiaries
54	CO Chairman's Decree	127	1995	Tenders and Auctions Regulation of CCO
55	CO Chairman's Decree	128	1995	Stores Regulations of CCO
56	CO Chairman's Decree	643	1956	General Conditions Required for Curative Organizations
57	MOH Decree	174	1989	Delegation to Kafr El-Sheikh Governor in Some of MOH Responsibilities Re: Governorate's Curative Organization

3. HEALTH INSURANCE

Ser.	Type	No.	Year	Subject
58	Law	75	1964	Health Insurance (Superseded by Law No. 79/75)
59	Law	10	1967	Dealing in Pharmaceuticals of HIO
60	Law	32	1975	Health Insurance Rules for Government, Local Administration Units, and Public Authority Employees
61	Law	79	1975	Social Insurance
62	Law	112	1975	Social Insurance for Employees Not Covered by Other Pensions and Social Insurance Laws
63	Law	10	1981	Insurance Supervision and Control
64	Law	126	1981	Establishment of Supreme Council for Curative Care Insurance
65	Law	99	1992	Health Insurance for Students.
66	HIO Chairman's Decree	55	1995	Central Committee for Medical Equipment
67	Presidential Decree	1209	1964	Establishment of HIO and Its Branches
68	Presidential Decree	3298	1964	Execution of Health Insurance by HIO
69	Presidential Decree	1585	1967	Authorizing the HIO to Undertake Medical Care for Employees of General Organization for Military Factories and Its Subsidiaries
70	Presidential Decree	2323	1967	Licensing HIO to Provide Medical and Pharmaceutical Services against Fees
71	Presidential Decree	30	1968	HIO Employee Regulations
72	Presidential Decree	3104	1971	Establishment of the Egyptian General Authority for Insurance and Medical Care
73	PM Decree	1	1981	Enjoyment of Widows of the Right to Cure and Medical Care
74	PM Decree	10	1981	Extending the Right to Cure and Medical Care to the Families of the Insured and Pensioners Who Are Citizens of the Alexandria Governorate
75	HIO Decree	488	1966	Establishment of Health Insurance Committees in Every Company and Establishment

Ser.	Type	No.	Year	Subject
76	HIO Decree	614	1967	Procedures for Medical Care for Beneficiaries of the Health Insurance Laws
77	HIO Decree	382	1970	Establishment of Three Branches of HIO and Determination of Their Duties and Responsibilities (Superseding Decrees 3 of 1964, 143 of 1967, and 172 of 1968)
78	HIO Decree	394	1971	Establishment of Health Insurance Committees
79	HIO Decree	113	1976	Formation of Boards of Directors for Hospitals and Determination of Their Duties
80	HIO Decree	113	1983	Enjoyment of the Insured of Treatment and Medical Care Privileges outside the Cities and Governorates Where the Insured Work
81	MOLA	2	1964	Executive Regulations of Presidential Decree 3298 of 1964 Implementing the Health Insurance Specified in Law 63 of 1964
82	MOSI	14	1981	Application of Cure and Care to Widows
83	MOH Decree	52	1965	Determining Establishments to Which the Health Insurance System Applies
84	MOH Decree	295	1966	Executive Regulations of Law 75 of 1964
85	MOH Decree	60	1967	Applicability of Health Insurance
86	MOH Decree	142	1967	Applicability of the Executive Regulations of Law 75 Of 1964
87	MOH Decree	84	1968	Alexandria Psychiatric Hospital
88	MOH Decree	249	1975	Nationalized Hospitals That Were Transferred to the HIO
89	MOH Decree	282	1975	Fees Payable by Beneficiaries of the Health Insurance System When Service Is Requested
90	MOH Decree	140	1976	Specifications of the Minimum Levels for Providing Insurance Medical Services
91	MOH Decree	285	1976	Lowering of Some Fees for Beneficiaries of the Insurance System

Ser.	Type	No.	Year	Subject
92	MOH Decree	613	1976	Imposition of Certain Fees on Beneficiaries of Health Insurance Pursuant to Law 32 of 1975
93	MOH Decree	804	1981	Executive Regulations for Applicability with Respect to Families of Insured
94	MOH Decree	858	1981	Applicability of Disease Insurance Rules in Public and Private Sector Establishments Having between 5499 Employees in All Governorates
95	MOH Decree	160	1982	Amendments to Certain Provisions of MOH Decree 858 of 1981
96	MOH Decree	532	1983	Applicability of Health Insurance on Officers and Individuals of the Police Authority in the Beheira Governorate
97	MOH Decree	553	1983	Applicability of Disease Insurance Rules in Public and Private Sector Establishments Having 1–4 Employees
98	MOH Decree	405	1984	Required Minimum Limits and Degrees of Services Provided by Employers
99	MOH Decree	179	1985	Rules for Implementation of Disease Insurance and Notification of Termination of Treatment and Disability Status
100	MOH Decree	10	1986	Applicability of Social Insurance Law to Employees of the Khatara Project in Sharkkyia Governorate
101	MOH Decree	125	1988	Applicability of Health Insurance Specified in Law 32 of 1975 to Government, Local Administration Units, and Public Authorities Employees Lacking a Private Cure System in the Red Sea Governorate
102	MOH Decree	162	1988	Applicability of Health Insurance to Staff of the Minyia Electricity Police
103	MOH Decree	1	1989	Applicability of Health Insurance to Staff of Station Prison Department in Certain Governorates
104	MOH Decree	4	1989	Applicability of Health Insurance to Employees of the Central School and University Books Agency

Ser.	Type	No.	Year	Subject
105	MOH Decree	125	1989	Applicability of Health Insurance to Employees at Assyout University and its Branches
106	MOH Decree	381	1991	Applicability of Health Insurance to Government, Local Administration Units, and Public Authorities Employees in North Sinai Lacking a Private Cure System
107	MOH Decree	300	1992	Basic Rules for the Application of Health Insurance to Primary and Secondary School Students
108	MOH Decree	320	1992	Applicability of Health Insurance to Students
109	MOH Decree	13	1993	Applicability of Health Insurance to Students
110	MOH Decree	15	1993	Collection of Insurance Premiums from School Students
111	MOH Decree	129	1993	Applicability of Health Insurance to Students in the Second Stage
112	MOH Decree	307	1995	Applicability of Disease Insurance Specified in Law 79 of 1975
113	MOH Decree	499	1995	Applicability of Disease Insurance Specified in Law 79 of 1975

4. MOHP AND LOCAL ADMINISTRATION HOSPITALS

Ser.	Type	No.	Year	Subject
114	Law	43	1979	Local Administration System
115	PM (MOLA) and MOH Decree	6	1989	Amendment to Article 9 of Decree 3(H) of 1988 Imposing a Charge for Pharmaceutical Packages
116	PM (MOLA) and MOH Decree	3 (H)	1988	Basic Rules for Hospitals and Health Units Affiliated with Local Administration Units
117	PM (MOLA) and MOH Decree	12(H)	1990	Amendment of Some Rules of the Basic Regulations of Hospitals and Medical Units Affiliated with Local Administration Units
118	Presidential Decree	2444	1965	Organization and Administration of Hospitals and Units Attached to Local Councils

Ser.	Type	No.	Year	Subject
119	Sohag Governor Decree	1008	1969	Application of Presidential Decree 2444 of 1965 and MOH and MOLA 689 Of 1965 to Certain Hospitals
120	Sohag Governor Decree	97	1970	Application of Presidential Decree 2444 of 1965 and Health Minister and State Ministers of Local Administration 689 of 1965 to Certain Hospitals
121	MOH Decree	140	1976	Specification of Minimum Levels for the Provision of Medical Insurance Services
122	MOH Decree	285	1976	Reduction of Certain Fees for the Beneficiaries of Health Insurance
123	MOH Decree	160	1982	Amendment of Certain Provisions of MOH Decree 858 of 1981
124	MOH Decree	405	1984	Minimum Limits and Degrees Required in Treatment Provided by Certain Entities to Their Employees
125	MOH Decree	217	1988	Delegation to the Governor of Qalyubiya of Certain Responsibilities of the MOH
126	MOH Decree	174	1989	Delegation to the Governor of Kafr El-Sheikh of Certain Responsibilities of the MOH with Regard to the CO of the Governorate
127	MOH Decree	200	1990	Delegation to the Governor of Damietta of Certain Responsibilities of the MOH
128	MOH and MOLA Decree	697	1965	Determination of Hospitals Governed by Presidential Decree 2444 of 1965 for the Organization of Hospitals and Units Attached to Local Councils
129	MOH and MOLA Decree	698	1965	Establishment of a Fund for Improving Services and Medical Units Attached to Local Councils and Their Budgets
130	MOH and MOLA Decree	399	1965	Determination of Hospitals Governed by Presidential Decree 2444 of 1965 for the Organization of Hospitals and Units Attached to Local Councils
131	MOH and MOLA Decree	18	1967	Application of Decree 2444 and Decree 689 to All Remaining Hospitals Subject to Decree 2444 by a Governmental Decree
132	MOH and MOLA Decree	132	1967	Application of Presidential Decree 2444 of 1965

Ser.	Type	No.	Year	Subject
133	MOH and MOLA Decree	214	1971	Establishment of a Health Fund for Improvement of Service at Each Health Department
134	MOH and MOLA Decree	447	1975	Basic Regulations of LAHME (Repealed)
135	MOH and MOLA Decree	454	1976	Application of Presidential Decree 2444 of 1965 with Respect to the Rheumatoid Center in Hamammat Helwan
136	MOH and MOLA Decree	248	1991	Delegation to the Governors Certain Responsibilities of the MOH and MOLA Specified in Annex 3 of Decree 3H of 1988
137	MOH and MOLA Decree	118	1992	Amendment of Basic Rules of Hospitals Medical Units Affiliated to Local Administration Units Decree 3H of 1988
138	MOH and MOLA Decree	103	1992	Exemption of Leprosy Patients from Fees Stipulated in Article 10 of Decree 3H of 1988

Appendix B: Regulations, Contributions, and Benefits of Existing Social Health Insurance Scheme

Regulations, Contributions and Benefits of Existing Social Health Insurance Scheme				
Law 79	Law 32	Law 99	PM Decree 1	PM Decree 10
Insurance Benefits:				
<p>1. Medical services by the GP 2. Medical services by specialists 3. Medical care at home, if needed 4. Treatment and accommodation at hospitals or specialized centers 5. Surgery 6. Laboratory tests and x-rays 7. Provision of pharmaceuticals 8. Disability medical services and equipment 9. Pregnancy and childbirth treatment</p> <p>The foregoing services are provided within Egypt and abroad (under certain rules and conditions).</p>	<p>Same as provided under Law 79.</p> <p>Services are provided within Egypt and abroad as provided under Law 79.</p>	<p>A. <u>Medical Treatment</u></p> <p>Same as provided under Law 79, except pregnancy and childbirth</p> <p>B. <u>Preventive Care</u></p> <ul style="list-style-type: none"> ▲ Complete examination upon joining at every educational stage ▲ Immunizations ▲ Periodical examination ▲ Submitting recommendations to the educational institute concerning health and environmental conditions ▲ Medical examination for participants in sport and other activities ▲ Supervised school meals, if available <p>Services are only provided within Egypt.</p>	<p>Same as under Law 79, except pregnancy and childbirth</p> <p>Services are only provided within Egypt.</p>	<p>Same as under Law 79.</p> <p>Services are only provided within Egypt.</p>

Regulations, Contributions and Benefits of Existing Social Health Insurance Scheme

Contributions:				
<p>A. <u>Work Injury</u></p> <p>Monthly contributions payable by employer:</p> <ul style="list-style-type: none"> ▲ 1% of salaries of employees of the government, public authorities, and organizations ▲ 2% of salaries of employees of public sector economic units ▲ 3% of all other insured <p>B. <u>Sickness</u></p> <p>1. Monthly contributions by employer:</p> <ul style="list-style-type: none"> ▲ 3% of salaries of employees of the government, public authorities, and organizations ▲ 4% of all other insured. These are distributed as follows: <ul style="list-style-type: none"> △ 3% for treatment and care △ 1% for salary compensation and transportation expenses <p>2. Monthly contributions by insured:</p> <ul style="list-style-type: none"> ▲ 1% of salary for all employees ▲ 1% of pension for pensioners and in cases where the HIO approves an “employer alternative health plan” 	<p><u>Employer’s Share</u></p> <p>Government, local administration, public authorities, and organizations:</p> <p>1 1/2% of BS</p> <p><u>Employee’s Share</u></p> <p>1/2% of basic salaries</p>	<p><u>Student’s Share</u></p> <p>LE 4.00 per year</p> <p><u>Government Share</u></p> <p>LE 12.00 for each student</p>	<p><u>Widow’s Share</u></p> <p>2% of pension</p>	<p><u>Insured’s Share</u></p> <p>1/2% of salary or pension on each family member</p> <p><u>Employer’s Share</u></p> <p>1/2% of salary on each family member</p> <p><u>Government’s Share</u></p> <p>1/2% for pensioners on each family member</p>

Regulations, Contributions and Benefits of Existing Social Health Insurance Scheme

Fees and Charges:				
<ul style="list-style-type: none"> ▲ LE 0.05 for GP ▲ LE 0.20 for house visits 	<ul style="list-style-type: none"> ▲ LE 0.05 for general practitioner ▲ LE 0.10 for specialist ▲ LE 050 per hospital day for employees of 2nd classification and above ▲ LE 0.25 per hospital day for employees of 3rd classification ▲ 25% of the medicine cost at the general practitioner and specialist stage with a max of LE 1 ▲ 25% of all lab tests with a max of LE 1 ▲ 50% of disability instruments, eyeglasses and dental replacements ▲ 25% of treatment cost at HIO with a max of LE 1 in cases treated at the outside clinics ▲ LE 0.20 house visits within the city 	<ul style="list-style-type: none"> ▲ Receipts from house visits of no less LE 3.00 and not more than LE 5.00 ▲ Student's 1/3 contribution for medicines outside hospitals, but free of charge with respect to chronic cases ▲ LE 0.10 as health insurance fee imposed on each 20 cigarettes in the Egyptian market 	<p>Same as under Law 79 pursuant to MOH decree 804 of 1981</p>	<ul style="list-style-type: none"> ▲ LE 0.15 for general practitioner ▲ LE 1.25 for house visits ▲ LE 0.30 for specialist; LE 1.50 for house visits ▲ LE 050 per hospital day for employees of 2nd classification and above 35% of medicines outside the hospital ▲ 50% of lab tests costing over LE 0.50 ▲ 50% of hospital stay with a max of LE 5.00 per day, including all medical services and care

Regulations, Contributions and Benefits of Existing Social Health Insurance Scheme

Conditions:

<p>1. Treatment provided by HIO until cured or disability is established 2. Gradual application by MOHP ministerial decrees. Pensioners must submit a request 3. Insurance is obligatory 4. Treatment is provided at facilities, determined by HIO. Treatment outside HIO facilities must be preceded by special agreements with such outside facilities ensuring minimum quality of services as required by MOH Decree 140 of 1976 5. Benefits are discontinued as follows: - While working abroad - While working for a noninsured entity - During compulsory military service - During special vacation time and scientific missions abroad</p>	<p>Same as under Law 79</p>	<p>With respect to items 1–4, basically same as under Law 79. Students have a right to select treating physician and medical facility from an HIO list. Student has an opportunity to change his selection one month prior to the end of the year</p> <p>5. Student must be registered with an educational institution; paid the required fees; and have program I.D.</p>	<p>With respect to items 1–4, same as under Law 79, but at the request of the widow, whose request cannot be withdrawn</p> <p>5. Benefits cease if widow is employed and receives benefits under Law 79, or if she remarries</p>	<p>With respect to items 1–4, same as under Law 79</p> <p>5. Benefits cease to any family member: if one of the conditions stipulated in Law 79 is met; in case of divorce; when a family member is employed under Law 79; and if the family member is covered under Law 79</p>
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Appendix C: List of Individuals Interviewed

The following individuals were interviewed before the final draft was completed. Although other persons were identified to be interviewed, circumstances discussed in Section 1.0 did not allow for additional interviews.

Individual	Position
Dr. Nabil Nassar	First Undersecretary, MOHP
Dr. Adly Said	Undersecretary for Medical Treatment, MOHP
Mr. Ismail Sedik	Legal Adviser, MOHP
Dr. Nabil El Mehairy	Chairman, HIO
Mr. Mohammed Abdel Hamid	Director, Legal Department, HIO
Dr. Hani Ashour	Director, Medical Services, HIO
Mrs. Fatma Shaker	Director, Office of HIO Chairman
Dr. Sanaa Mohammed Hassan	Committee of Medical Equipment, HIO
Mr. Hedayet El Turgoman	Legal Adviser, CCO