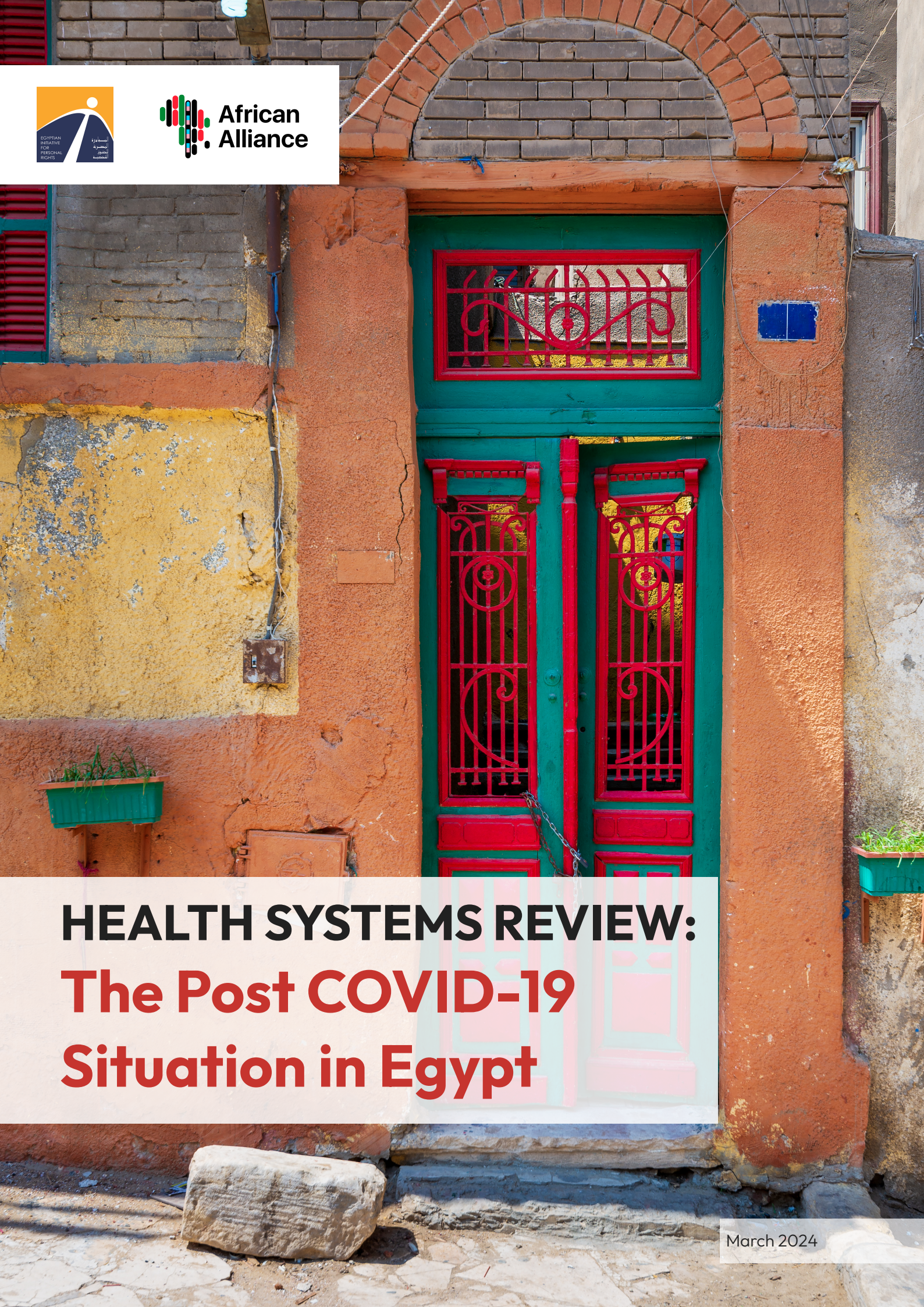

HEALTH SYSTEMS REVIEW:
The Post COVID-19 Situation in Egypt

March 2024

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The Post COVID-19 Situation in Egypt

First edition in March 2024

This study was prepared by the Right to Health program team of the Social and Economic Justice Unit at the Egyptian Initiative for Personal Rights (EIPR) in partnership with the African Alliance.

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ABOUT THE PROJECT

Why a "Post-COVID" review?

While the COVID-19 global pandemic burdened healthcare systems worldwide, it also helped to shed light on their deficiencies and weaknesses and, in some cases, it may have even accelerated a number of reform processes – not only in terms of pandemic preparedness but also with regard to the strength of the healthcare system as a whole.

This paper is part of comparative evaluation of the ramifications of the COVID-19 pandemic on the healthcare systems and the changes brought by it in three North African countries (Egypt, Tunisia and Morocco). The evaluation aims to provide an overview of the key changes and effects of the pandemic on the functioning of healthcare systems in each of these countries.

The ultimate objective of this evaluation is to help unmask interventions needed to improve the working conditions of healthcare workers, increase their retention and, naturally, build healthcare systems that are capable of addressing different health crises (pandemics included). The evaluations and interventions that will stem from it are also attuned to the short, medium and long-term objectives of closing the gap on the Sustainable Development Goal of securing Universal Healthcare Coverage to all. This should also provide decision-makers and civil society actors with the knowledge needed moving forward in health systems reform efforts.

The COVID pandemic shed light on a number of deficiencies and vulnerabilities in the global and national healthcare systems alike. On the other hand, attention to those vulnerabilities was accompanied by a sense of urgency to act quickly, with new challenges of social justice and equity surfacing particularly when it comes to access to vaccines. A quick reaction is still needed to handle the distribution of healthcare services and resources that may have been unjust in many cases. Conducting a post-pandemic assessment of the healthcare sector will provide our societies with a possible roadmap moving forward. Not only in terms of pandemic preparedness, but also the strength, effectiveness and state of governance of the healthcare system as a whole.

The assessment will take stock of effective measures and interventions that were rolled out and given the green light in the context of the pandemic, but that can also give us a multitude of lessons learnt. The aim is to make this pool of experiences, successes, and failures available to be shared on a regional level and then across the continent for mutual learning and collaboration.

To summarise, the objective of this series of papers is to understand the changes and effects of the pandemic on the healthcare systems and highlight needed interventions to strengthen them. The research partners of this project will use these insights in identifying specific policy recommendations in each of the papers and advocate for them.

Sources and Methods

In light of the general limitations in accessing reliable, up-to-date data about healthcare systems performances in the region, the research team opted for a research methodology that relies on two main sources of data:

1. Literature and official sources released by government data made public and data from international development agencies (namely the World Health Organization (WHO) and the World Bank).

2. Experts' and stakeholders' consultations, providing their reviews, observations, and analysis of this data in light of practical experiences, implemented policies and observed realities on the local grounds.

Study Tool

To carry out this exercise, a study tool was created detailing the different review questions to examine during the experts' consultations. This study tool is based on the framework of the Health Systems Building Blocks created by the WHO and its indicators and measurements for the monitoring of those building blocks[1]. It also includes components that are based on the Epidemic Preparedness Index published in 2019 in the BMJ Global Health journal[2]. Both of these frameworks have been used as a guide for the researchers who added details about each indicator and measure, its recommended sources and a brief explanation of their key characteristics. All these served as the basis for the expert review upon which the paper's conclusions are drawn.

A summarized version of this study tool is available **on this link** providing a succinct reference for readers interested in the methodology underpinning our investigation.

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[1] World Health Organization, Monitoring the Building Blocks of Health Systems, A handbook of indicators and their measurement strategies, 2010
https://apps.who.int/iris/bitstream/handle/10665/258734/9789241564052-eng.pdf

[2] Oppenheim B, Gallivan M, Madhav NK, et al. Assessing global preparedness for the next pandemic: development and application of an Epidemic Preparedness Index. BMJ Glob Health 2019;4:e001157.doi:10.1136/bmjgh-2018-001157
https://gh.bmj.com/content/bmjgh/4/1/e001157.full.pdf

Limitations

The study methodology was specifically designed to address the inherent difficulty of acquiring reliable data for forming objective opinions. The reviews and analysis provided strive to be based on nationally approved data whenever available. However, reaching a consensual conclusion for some of the review components was impossible. This was clearly highlighted in the studies with the underlying reasons.

All efforts were exerted to provide a systematic review that reflects objective opinions about the healthcare systems.

Yet, this paper presents the potentially subjective opinions, reviews and recommendations of its authors and consulted experts within the context of short consultations. Consultations that in turn were part of a series of overview papers that provide a bird's eye view of healthcare systems without digging into the details of each component.

In Egypt, to guide the experts and stakeholders consultation process, quantitative data reflecting the WHO health systems review framework were diligently sought to cover the three points in time covered in this study (2019 or before COVID-19, 2021 (during COVID-19) and 2022 (post COVID-19)), however the available official data were scarce and in all cases did not provide the capacity to make any comparisons. This makes the comparison increasingly difficult and justifies the challenge faced by the consulted stakeholders to deliver evidence-based inputs.

About the Peoples Vaccine Alliance Africa

PVA Africa is a regional movement of organisations and networks supported by Nobel Laureates, Heads of State, health experts, economists, world leaders, faith leaders and activists working together to ensure Africans everywhere have equitable access to vaccines. Housed in the African Alliance, PVA Africa, under the guidance of the Steering Committee, comprises leaders of five regional networks and never loses sight of our collective desire for the decolonisation of public health and rights-based access to products and science that saves lives, keeps us healthy and accelerates our right to dignity as Africans. PVA Africa's role is to ensure that the voices, priorities and work of African activists and communities, in all our diversity, are meaningfully reflected in the global work of PVA. PVA Africa also works to ensure that interventions, strategies and approaches to addressing the lack of access to COVID-19 vaccines, tests and treatments, as well as gender and economic inequalities in relation to vaccine equity and access, are addressed in our (African) terms.

THE PEOPLE'S VACCINE AFRICA

A Movement by Africans, in Africa, for Africa

THE EGYPTIAN HEALTHCARE SYSTEM REVIEW

ABSTRACT

As COVID-19 hit the world, the Egyptian Healthcare system had already initiated its first steps towards the roll-out of a Universal Healthcare Coverage scheme. Although several positive improvements took place within the context of the new healthcare coverage scheme, yet, its phased geographical application and the relatively limited scope of implementation it has reached so far, make these improvements difficult to consider as nation-wide developments, though some of them constitute promising lessons to learn from the future.

A review of the available literature, official data and experts consultations following the WHO's framework of the Health Systems Building Blocks, revealed an improvement in some aspects related to lessons learned from COVID-19 and the concurrent implementation of the new Universal Health Insurance Law. In other healthcare systems pillars, a clear deterioration was observed particularly in the healthcare workforce, healthcare spending, and the availability of reliable data. It was difficult to assess developments in a number of components due to lack of up-to-date, reliable data.

Finally, experts' consultations highlighted a call for a sustained inclusion of stakeholders in developing healthcare policies, continuing the efforts of rolling out the Universal healthcare Insurance scheme, and ensuring pandemic preparedness that focuses on human resources, access to data and efficient use of resources.

EXPERTS' AND STAKEHOLDERS' CONSULTATION WORKSHOP

The project's local research partners compiled a list of 10 local healthcare systems experts and stakeholders representatives for each of the study's respective countries. Each list included a diverse set of key experts representing the different stakeholders concerned with the healthcare system. Government representatives, service provider representatives, policy-makers, parliamentarians, members of civil society, academics and private healthcare service providers, were involved among others.

These experts were then invited to an immersive consultation in which they were asked to provide their expert's opinions about the situation of each of the components of the health systems pillars in the corresponding national context, by answering a standard question for each of the health systems components: "Comparing the situation now with that of 2019 (before COVID-19), did this component improve, regress or stay the same?"

For the Egypt study, a highly diverse and representative pool of experts participated in this exercise. These include:

1. The ex-head of the Health Insurance Organization
2. The head of a private sector health service provision group
3. A high elected officer at the Medical Syndicate
4. A high officer at the General Authority for Healthcare
5. A member at the health committee of the Parliament
6. An expert from a civil society organization working on the right to health
7. An expert from civil society researching economic and social rights
8. A high-leveled public officer on population issues
9. A high-leveled public officer at the Ministry of Health
10. A health systems consultant at the World Bank.

Facilitators asked the participants to start with an initial vote to detect if there is a consensual answer followed by a discussion to provide justification for each opinion. The outcomes of these discussions were compiled and a brief rationale was introduced in the paper for the collective answer to each question.

RESULTS

A. Health service delivery

There is significant difficulty to prove a cross-cutting review of the state of health service delivery in Egypt as the matter varies considerably between governorates, those where the new social health insurance law has been applied (3 governorates) and the rest of Egypt. Overall, a noticeable improvement in most health service delivery measures can be observed the first group, yet, it was noted that these governorates and their population are relatively small and not necessarily representative of the rest of the population. The scale and scope of implementation of this law are still limited and therefore cannot be generalized on the entirety of the population.

It has been agreed upon that in this study, the expert's opinion will focus on services provided outside those 3 pilot governorates. At the same time the commentary will acknowledge the current implementation status of the various components of the right to health where the social health insurance system has been rolled out. The commentary will also highlight successes and defects and give an insight on where things are headed in the future with the gradual roll-out of the new social health insurance system.

1. Comprehensiveness

"A comprehensive range of health services is provided, appropriate to the needs of the target population, including preventative, curative, palliative and rehabilitative services and health promotion activities."

Fragmentation of the healthcare system and its multitude of service points operating in silos has been the common denominator in the Egyptian healthcare system for decades. The COVID-19 pandemic and the stress it caused on the healthcare system only accentuated this fragmentation making it quite clear that without an integrated plan for service delivery, the comprehensiveness of services will remain highly unlikely.

The consulted experts outlined sporadic cases of provision of comprehensive services particularly in vertical campaigns and programs such as the hepatitis C program. However, a consensus was reached during the discussions that the comprehensive and continuous provision of critical service has been heavily compromised during the COVID-19 outbreak, with some experiencing that more than others. HIV/AIDS services which used to be provided through fever hospitals have been heavily compromised as they were attributed a new role for COVID-19. The delivery of services, such as

family planning services, antenatal care and child health services, has naturally been affected while management of chronic diseases began to organically and uncontrollably adopt new forms through online consultations offered by the private sector. Mental health services have also benefited from online platforms with some uptake of these tools from the government, though not compared with the private sector.

2. Accessibility

" Services are directly and permanently accessible with no undue barriers of cost, language, culture, or geography. Health services are close to people, with a routine point of entry to the service network at primary care level (not at the specialist or hospital level). Services may be provided at homes, the community, the workplace, or health facilities as appropriate."

There has been a consensus among consulted experts that, in the light of the high reliance on out-of-pocket and private healthcare service provision, the effects of the inflation and the economic challenges faced during those 3 years, caused an increasing difficulty to a number of communities to access some healthcare services. It has been observed that the public sector has done considerable efforts to mitigate these challenges particularly when it comes to COVID-19 related services. This however did not translate into sustained improvement in healthcare accessibility post COVID-19.

For governorates where the social health insurance system has been rolled-out, accessibility of services has seen a noticeable increase, at least, if measured by the number of services provided by the General Authority for Healthcare. However, it has been noted that access to services is still not satisfactory, as some co-payments present a barrier to access and some other services are still not provided.

3. Coverage

" Service delivery is designed so that all people in a defined target population are covered, i.e. the sick and the healthy, all income groups and all social groups."

The data occasionally disclosed by the government in press releases suggest a significant improvement in healthcare coverage concomitant with: 1) The gradual roll-out of the social health insurance scheme, 2) The addition of new demographic strata in the pool of citizens covered by the old (or current) health insurance system provided by the Health Insurance Organization (HIO) and 3)

The provision of a number of vertical programs focusing on specific healthcare services and public health concerns.

However, there was consensus that no reliable data have been published to reflect on the actual coverage of the population. Real coverage needs to be measured through census or accurately collected and publicly available data that include not only individuals or families registered in national healthcare coverage schemes, but most importantly, those who are actually utilizing or benefiting from it. Also, data are missing regarding the rates of mandatory vaccination coverage, utilization of antenatal and postnatal care. The latest data (preceding the time scope of the study) estimated that the rates of childhood vaccination were stable and an improvement in utilization rates of family planning methods. No recent update to these data has been published and no evidence is available regarding children's health. In addition, further data need to be available regarding healthcare coverage in general.

4. Continuity

"Service delivery is organized to provide an individual with continuity of care across the network of services, health conditions, levels of care, and over the life-cycle."

In the covered period, a number of presidential initiatives or vertical programs addressed and brought some gaps in healthcare service provision to light. The consulted experts acknowledged the value and effectiveness of some of these initiatives, all while presenting some criticism regarding them: It has been agreed upon that some of these programs were designed to offer a certain continuity of care, at least during their lifespans. Some of these programs dealt positively with a long-missing defect in the continuity of provision of care to their target citizens. Nevertheless, they need to be fully integrated and continued through the normal, day to day work of the ministry of health. After all, the objectives of these programs are directly and fully the responsibility of the established structures, departments, and divisions of the Ministry of Health.

The heaving consensus of "improvement" reached by the experts reflected the success story of the Hepatitis C program, which provided a story to tell when it comes to continuity of care. Starting with the goal of mass screening all Egyptians for Hepatitis C, the program offered a comprehensive set of services which included diagnostic services, provision of treatment, and follow-up.

However, it was noted that other programs failed to realize this continuity of care, particularly medical caravans which are often characterized by insufficient integration with the work of primary healthcare units and fail to provide the continuity of care patients need.

5. Quality

"Health services being of high quality means they are effective, safe, centered on the patient's needs and given in a timely fashion."

Multiple efforts have been exerted towards improving healthcare services quality at all levels. The consulted experts agreed that it has always been difficult to measure the extent to which these efforts practically translate into improvements in service quality. However, with the roll-out of new health insurance law, a new and specific metric can be used for the very first time, and allowed for a consensus on improvement on that front.

This new metric is linked to the role of the newly established General Authority for Healthcare Accreditation and Regulation (GAHAR). Law Number 2 for the year 2018, states that, to ensure the quality and safety of health services, "accreditation" of healthcare facilities is necessary for contracting them by the new health insurance scheme.

It is the responsibility of GAHAR to play this role of being the accrediting and regulating body, strongly rooted in its independence, which is stipulated by law. GAHAR is an independent authority under the direct supervision of the president and is the body responsible for issuing standards to ensure the provision of health care services in different health facilities in accordance with the highest quality and safety. These standards have been prepared by healthcare quality experts and are intended to be in line with the latest developments in quality and global safety. The standards are meant to be pillars that provide safe services to patients.[1]

According to the latest data from the GAHAR, a total of 114 healthcare facilities have achieved provisional accreditation and 142 have been fully accredited [2], While the General Authority for Healthcare reports a total of 57 facilities with provisional accreditation and 76 fully accredited in the governorates where the new health insurance law is being implemented [3].

However, there are some cautionary notes about these figures: They always need to be presented as a percentage of the total amount of operating healthcare facilities in the country. In the latest available statistic, it was estimated that there is at least 1809 registered hospitals in Egypt and 5388 primary healthcare units [4], giving a total of 7,222 healthcare facilities excluding labs, radiology centers, pharmacies and private clinics, which have been estimated at over 89,000 clinics in Cairo

1 GAHAR, Who we are, https://gahar.gov.eg/page/p/%D9%85%D9%86-%D9%86%D8%AD%D9%86

2 GAHAR, Statistics, as displayed on October 24th 2023, https://gahar.gov.eg/

3 The Egyptian Government Portal, August 2023

4 Number of healthcare facilities in Egypt according to CAPMAS, October 2022

alone in 2021 [5]. This practically means that the percentage of accredited facilities is an infinitely negligible fraction of the total.

The experts also pointed out that some other key metrics of quality of care are not available, data that relate to clinical outcomes of surgeries, length of stays in hospital, treatment compliance and comparison of data between public, private and health insurance facilities are all critical data that need to be available for the public.

Furthermore, data about perceived quality of care need to be collected following a clear, scientific, comparable and transparent methodology that serves beyond disclosing data for promotional purposes. The latest statistics made available about patient experience in the new health insurance facilities carried out by the GAHAR constitute a step in the right direction in that regard although the methodology for their collection and the results they show can be questioned. [6]

6. Person-centeredness

"Services are organized around the person, not the disease or the financing. Users perceive health services to be responsive and acceptable. There is participation from the target population in service delivery design and assessment. People are partners in their own health care."

The experts agreed that there is mild improvement in this characteristic, demonstrated firstly by the role played by the patient-centered care department at the General Authority of healthcare, secondly the creation of Patient Committees and their involvement in grievances redress as part of the new health insurance scheme and thirdly a number of efforts towards patient centered care as the core mandate of the GAHAR. However, these benefits may not extend to areas where the new health insurance law hasn't been underway.

7. Coordination

"Local area health service networks are actively coordinated, across types of provider, types of care, levels of service delivery, and for both routine and emergency preparedness. The patient's primary care provider facilitates the route through the needed services, and works in collaboration with other levels and types of provider. Coordination also takes place with other sectors (e.g. social services) and partners (e.g. community organizations)."

[5] El Mal News, 2021

[6] Monitoring Patient Experience In UHI, GAHAR, 2023

A significant improvement in coordination of efforts between the Ministry of Health and the rest of the government have been initiated during the COVID response. For the very first time we have seen health addressed during ministerial meetings with high levels of coordination that include all levels of decision-making. Some aspects of this coordination have continued afterwards particularly as the ministry of Social Solidarity carried out programs and projects in close collaboration between both ministries.

Coordination with the private and social sector however is still lagging behind and it has been stated by the consulted experts that defects in coordination do not reflect lack of political will but rather technical and logistical barriers. They have noted policies such as merger of databases between ministries, creation of integrated referral pathways that include health, legal, psychological and social services (as demonstrated by the gender-based violence management pathway), and collaborative work in determining individuals and families in critical need of services (through the Takafol and Karama programs for example). A number of technical and logistical barriers in ensuring their full and effective implementation were also acknowledged. The National Alliance for Civil Development Work has been launched with the aim of addressing these barriers.

8. Accountability and efficiency

"Health services are well managed so as to achieve the core elements described above with a minimum wastage of resources. Managers are allocated the necessary authority to achieve planned objectives and held accountable for overall performance and results. Assessment includes appropriate mechanisms for the participation of the target population and civil society."

Accountability is clearly in a worse state than before 2019 as concluded by the consulted stakeholders. Performance based incentives are not fully or effectively implemented. Mechanisms for rewards and punishments are highly subjective and rarely put into action and we still often see footage of the minister of health carrying out random checks to hospitals, which is revealing of major defects in any regular monitoring or accountability within the structures of the ministry. Corruption is still omnipresent, and any efforts previously carried out to promote transparency have been aborted. Documentation of available resources is also lagging behind providing fertile grounds of inefficiency, corruption and lack of accountability. A lot needs to be done on that front.

B. Health workforce

Data on healthcare workforce, its distribution, skills and capacities is significantly limited. The latest available data by CAPMAS for 2021 reveal an average of 12.8 doctors and 21.2 nurses. No reliable sources for later data have been found.

1. Strategic Planning and Medical Human Resources Management system

"The way the health authority manage and develop plans regarding human resources in health systems. Recruitment and deployment systems including incentive schemes to ensure that health-care facilities meet their nationally recommended staffing norms"

There have been some signs of initiated efforts to create a strategic plan for human resources management in healthcare. In fact, this is an imperative prerequisite for the proper implementation of the new health insurance law. Initial steps have also been noticed to align the work of the Ministry of Higher Education and the Ministry of Health to get reliable numbers and build a measurable plan to ensure the needed human resources are available and ready to deploy. Yet, these efforts have not yielded any visible results and have not been made available to the public.

2. Size

"The size of the national health workforce, include recruitment and training"

There is sufficient data to objectively reach a decision on the size of healthcare workers. However, the consensual opinion of the experts is that it has significantly decreased due to increasing brain drain.

3. Capacity

"The capacity of health professions educational institutions, including the quantity and quality of instructors and auxiliary staff"

Key stakeholders from the Medical Syndicate and the health insurance sectors stated that the increasing numbers of those trained by the Egyptian board (from 1500 to 10,000) without any particular change or improvement in the training resources, have directly caused a significant deterioration in health professionals' capacities.

Attempts of coordination between the Ministry of Health and the Ministry of Higher Education to ensure continuous medical education have yet to yield results.

The capacity of the country to produce highly qualified healthcare professionals (which are heavily needed for the implementation of the new health insurance law), requires a revisit of the model of medical and healthcare education altogether. Upon graduation, minutely trained healthcare professionals are assigned to remote healthcare facilities with little to no supervision or support. They learn by practice with limited access to continuous medical practical education, mentorship or support, especially in primary healthcare settings. The outcome is healthcare professionals with limited capacity to fulfill their role particularly, in primary healthcare settings, falling short of public expectations.

Recent positive developments like the new law for medical councils may help in attending to this degrading situation, nevertheless, it is unlikely that this alone will be sufficient to address the current needs of the healthcare sector in Egypt. Specific training is also required particularly on the referral system, management of chronic conditions and provision of patient-centered care.

4. Private Sector

"Interaction with or regulation of the private sector requiring accurate knowledge of the numbers, types and qualifications of private sector providers"

COVID-19 provided a golden opportunity for the regulatory bodies to impose a set of rules and regulations on the private sector, particularly regarding unified and regular reporting, pricing of services, availability of hospital beds, and clinical outcomes. This was unfortunately only mildly used.

No consensus could be reached regarding the degree to which COVID-19 related data accurately included data provided from private labs.

Attempts of the government to set standard pricing for specific COVID-19 related services were not fully implemented. It is also worth noting that laws and regulations regarding state-funding of emergency services for the first 48 hours were not enforced. Informal payments, even to the private sector, contribute substantially to the toll of out-of-pocket payments. Although official estimates show a relative decline in percentages, recent devaluation of the Egyptian pound weighed on the economic situation and prices of services and goods and most likely raised out-of-pocket payments to an unprecedented height, though no recent numbers are made available to this day.

The capacity of a regulated private sector to have a critical contribution to the new health insurance law is still a wasted opportunity to be seized, especially as the state budget has been investing heavily in infrastructure for primary healthcare services instead of contracting private providers in a regulated and systematic approach that reflects a unified plan.

5. Management of health workforce migration

"Managing health workforce market among countries that witness large numbers of health workers migration, efforts may be undertaken to manage the pressures of the international health workforce market on migration"

Migration of healthcare workforce is only a manifestation of unappealing working conditions, compensations and growth, at least in comparison with other countries.

Given the growing need of qualified healthcare workers in Egypt with little to no improvement in the provided benefit packages, the consulted experts consensually agreed on an exodus of healthcare workers, especially following the local currency devaluation.

Efforts to provide some additional incentives for healthcare workers have been acknowledged as well as the creation of committees to study doctors working conditions. However, these efforts radically fall short in facing the current situation which has been described as highly unplanned, with no vision, to the extent that they are merely individual sporadic efforts done in good faith.

6. Management of inefficiencies

"Inefficiencies may include identifying and reducing worker absenteeism that is known to be a significant problem in the public health system in many contexts"

Positive developments on this front may be shown through recruitment policies and human resources management in pilot governorates, taken for the implementation of the new health insurance law. Objective selection-based recruitment has been the rule since the beginning of implementation for all levels of new hires and attempts to address inefficiencies and absenteeism have been more successful within this context. However, beyond these governorates, absenteeism and major inefficiencies in human resources management is a growing concern, specially in the light of increasingly unsatisfactory working conditions for healthcare professionals particularly in the public sector.

7. Motivation and staff performance

"Health worker motivation and productivity, which may include strengthening of supervision. Potentially one of the most effective instruments to improve the competence of individual workers and effective management of performance of health workers."

Beyond symbolic and verbal acknowledgement of the sacrifices healthcare professionals had to endure during COVID-19, and compensation dispensed from the medical syndicate, no tangible improvement in the motivation and incentive system for healthcare professionals have been truly implemented.

Performance-based incentives, intended to play integral roles in service provision through the new health insurance scheme, are still not fully in place and indicators and measures that are supposed to be linked to these incentives mostly measure the process instead of outputs or clinical outcomes. Significant effort needs to take place on that front.

C. Health information systems

COVID-19 and international obligations regarding its management by states imposed a number of measures regarding the provision of regularly updated and standardized data about COVID-19 mortality, morbidity and vaccination. The question remains on whether these measures have continued or scaled-up post COVID and whether they were sufficiently accurate.

1. Data generation

"Data generation capacity using core sources and methods (health surveys, civil registration, census, facility reporting, health system resource tracking). These reflect country capacity to collect relevant data at appropriate intervals and uses the most appropriate data sources. Benchmarks include periodicity, timeliness, contents of data collection tools and availability of data on key indicators."

After a clear division in opinions regarding the status of data generation, there was agreement on having a relative and slight improvement in the data generation capacity following the practical experiences of the COVID-19 response. The need to generate impact data for the new social health insurance scheme has led to an enhanced capacity to collect data. However, this is still far from what is needed or what meets expectations in terms of data transparency and access and particularly with a most contested level of accuracy. The following shortcomings were observed:

a. Data collection and generation are still based on highly centralized requests or reflecting international commitments for different reporting needs. Regular data collection, that is part of the core function of executives, is still largely absent.

b. The capacity to generate accurate and reliable data requires tools to verify data from both government sources and the private sector. Data collection about COVID-19 infection rates has been highly criticized in terms of accuracy for many reasons including defects in the applied metrics (which considered PCR Positive cases only as COVID-19 cases, though PCR was only carried out to a limited number of cases according to the national protocols). Collection of data from the private sector is also debatable, not systemic and barely accurate.

c. Concerns about data security often hinders data collection and accessibility. More than often, these concerns are not justified and present significant obstacles to a reform process led by executives, supported and monitored by civil society.

2. Data analysis and validation

"Country capacities for synthesis, analysis and validation of data. These measure key dimensions of the institutional frameworks needed to ensure data quality, including independence, transparency and access. Benchmarks include the availability of independent coordination mechanisms and the availability of microdata and metadata

Although it has been agreed upon that data collection has slightly improved, the consulted experts stated that data analysis and accessibility is in decline. The following observations were noted:

a. The country still lacks an access to information act or law as stipulated by the 2014 constitution. Egypt is still lagging behind in this regard particularly if compared to Tunisia or Morocco.

b. Accurate, efficient and regular data collection requires a considerable synergy and communication between databases of different government departments and ministries. Efforts on this front have been ongoing with an increased pace in the last couple of years. A publicly shared plan for data collection needs to be put in place.

c. Access to regular and accurate data is an essential component for proper accountability. Parliament members struggle to access such data in order to properly and objectively evaluate government performance.

d. In August 2023, a national strategy for the reform of the data and statistical framework in Egypt has been launched with the goal of becoming a key reference for setting public policy agendas. This national strategy has yet to yield tangible results.[7]

e. Efforts carried out in data collection and the generated data need to be properly emphasized, communicated and disseminated.

7 Launch of the National Strategy for data and statistical data generation reform, August 2023, https://www.shorouknews.com/news/view.aspx?cdate=29082023&id=62e1c2e1-716e-408c-98b9-dd9c9659da42

3. Existence of Health surveys

"Country has a 10-year costed survey plan that covers all priority health topics and takes into account other relevant data sources."

COVID-19 presented a golden opportunity to account for a costed health survey plan for the country. The consulted experts were all not aware of any improvements taking place in this aspect.

4. Existence of birth and death registration

"The target goals are: Birth registration of at least 90% of all births, death registration of at least 90% of all deaths, ICD-10 used in district hospitals and causes of death reported to national level."

It has been agreed upon that considerable improvements have been noted in birth registration and its accuracy. However, experts observed that till now registration of births is still open till 2 weeks from birth, which is a challenge to accurate measurement of infant mortalities and needs of Neonatal Intensive Care Units and incubators.

Registration of deaths is still lagging behind in terms of causes of death. This has been made quite clear during COVID-19 resulting in highly questionable data about numbers of COVID-related deaths. Efforts are needed to ensure causes of death are properly and accurately documented following ICD-10 in all levels of care.

5. Existence of censuses

"Census completed within the past 10 years with population projections for districts and smaller administrative areas available for the next 10 years, in print and electronically, and well documented."

No improvements or declines have been noted regarding censuses.

6. Existence of Health facility reporting

"Special emphasis on system for reporting of notifiable diseases and how much it makes use of modern communication technology, and reporting of statistics from district to national levels."

The Ministry of Health has a slowly digitized health facility reporting system for notifiable diseases. However, considerable efforts are still in order regarding maternal mortalities and accurate reporting from facilities that do not fall under the Ministry of Health's jurisdiction (private sector, community facilities and other public facilities).

7. Existence of health system resource tracking

"This includes at least one national health accounts exercise completed in the past five years, a national database with public and private sector health facilities and geocoding, available and updated within the past three years"

A recent, yet, heavily outdated National Health Accounts have been released in late 2023, covering data from 2019-2020. No publicly available national database for public and private sector has been compiled and no disaggregated data for geocoding is available publicly.

D. Access to essential medicines

1. Access to essential medicines as a right

"Access to essential medicines/technologies as part of the fulfillment of the right to health, recognized in the constitution or national legislation as part of the progressive realization of the right to health and/or as a specific entitlement of all citizens."

No particular change on that front. The access to essential medicine has been enshrined in the 2014 constitution.

2. Published national medicines policy

"Existence and year of last update of a published national medicines policy (an official National Medicines Policy (NMP) and updated within the past five years)"

There are no published national medicines policies yet. The Egyptian Drug Authority has been created, constituting a considerable step forward in governance but the amount of data about drugs availability, consumption and needs is still very poor. Also, there is no agreement on policies to address challenges such as disposal of medications without prescriptions, the overuse and over-the-counter use of antibiotics, to name of a few. Detailed reports can be custom provided from private sector research entities with privileged access to government data, in return for considerable fees only affordable to private sector pharmaceutical companies or investors during their market research work.

3. Published national list of essential medicines

"Existence and year of last update of a published national list of essential medicines and updated within the past five years."

Consulted experts stated that there is a national list of essential medicines, but it is not published nor accessible. No information has been found on the year of last update of the list. The last listed

national list of essential medicines on the website of the World Health Organization dates from 2006 with a broken link[8]. Scanning the websites of the ministry of health, the Egyptian drug authority and Google search, using the terms "Egypt list of essential medicines", no official lists were found on any of these sources.

4. Practical availability of essential medicines

"In practice, are essential medicines available and accessible at all levels of care?"

Since no listing of essential medicines is available, it is impossible to accurately assess the practical availability of these drugs. However, the experts noted that, since many of these medicines were dispensed through public primary healthcare units and hospitals, and observing the restrictions on services and access to these facilities during COVID-19, it can be concluded that there has been deterioration on this front. This has been validated by a number of documented civil society and citizens reports during this period.

8 Essential medicines and pharmaceutical policies, World Health Organization, visited on October 29th 2023, https://www.emro.who.int/essential-medicines/publications/national-essential-medicines-list.html

E. Health systems financing

1. Government expenditure on health

"General government health expenditure as a proportion of general government expenditure"

Measuring government trends of health expenditure is important to determine whether there is a need to increase investment in order to realize the right to health. Article 18 of the Egyptian Constitution stipulates a government commitment to spending a minimum of 3% of the GNP on healthcare. Government spending on health contributes to reducing or eliminating financial barriers to access to health care, which is one of the Sustainable Development Goals, specifically Goals 3 and 8.

According to official budget documents, government spending on health decreased by 6% in the fiscal year 2022 / 2023, compared to previous fiscal year and is expected to increase by 15% in 2023 / 2024 [9]. However, this increase would still mean a decline in real terms as the inflation rate during the current fiscal year is estimated to be 16%. Also, government spending to gross domestic product GDP is expected to go down to 1.24 from 1.3 in 2023 / 2024, which is less than half of the constitutional commitment. This was confirmed by the Egyptian president's repeated statements that fulfilling the constitutional threshold is not possible because of lack of resources.[10] [11]

It is to be noted that statements by the ministry of finance tend to tell a different story, namely that is Egypt is currently fulfilling its constitutional commitments through government spending on health that reaches 3.72% of the GDP[12] in clear contradiction with the budget documents. This does not reflect an actual increase in spending as demonstrated earlier but rather a new approach for the calculation of these figures adopted which accounts not only for budget line items allocated to the ministry of health but also public companies and government agencies that include military and police hospitals and healthcare services, health insurance provided by other ministries in addition to the comprehensive health insurance program. It should also be noted that this government expenditure on health also includes expenditures on water, waste disposal or other services which

9 State General Budget 2023/2024, https://mof.gov.eg/ar/posts/stateGeneralBudget/63a95e67da80a50008d14783/%D9%85%D9%88%D8%A7%D8%B2%D9%86%D8%A9%20%D8%B9%D8%A7%D9%85%D8%A9%202023%2024

10 Statement by the President in the Parties Youth Conference, June 2023, Hour 1, Minute 16 https://www.facebook.com/watch/live/?ref=watch_permalink&v=824428972307666

11 Commentary on the president's statements on the constitutional commitments in government spending on health and education, EIPR, 2023, ttps://eipr.org/press/2023/06/-لأول-مرة-الرئيس-يعترف-بتجاهل-الحكومة-لنسب-التعليم-والصحة-الدستورية-تعليق المبادرة

12 Ministry of Finance, National Budget 2020/2021, http://www.mof.gov.eg/MOFGallerySource/Arabic/budget2020-2021/Financial-Statement2020-2021.pdf

the budget simply calls “public health services”. In addition, this figure also includes debt service related to loans not necessarily taken to finance healthcare.

2. Financial risk protection and coverage for vulnerable groups

“Population covered by health insurance. Mechanisms made available to ensure coverage of the most vulnerable populations”

The official data regarding health insurance coverage indicate an improvement in general financial risk protection and healthcare coverage. This is realized through inclusion of specific populations in the current health insurance organization (HIO) on one hand, and the implementation of the new universal health insurance scheme on the other.

However, the ongoing surge of inflation and significant rise in costs of life has also distended the costs of healthcare services, leading to a reduction of the services and coverage provided by the health insurance scheme and burdened the families with higher cost to receive services through the private sector. The consulted experts concluded that, in the light of absence of updated reliable data on out-of-pocket expenditure on health and the actual coverage of specific vulnerable groups, it is difficult to reach a consensus on this indicator.

3. Financial transparency

“Financial transparency at operational and managerial levels”

No improvement or regression have been observed on this front. Transparent access to financial data related to healthcare services have mostly been restricted to sporadic statements by high government officials. Operational and managerial levels data have been and remain highly absent from the public discourse.

4. Out-of-pocket payments

"The ratio of household out-of-pocket payments for health to total expenditure on health"

The latest published data regarding the ratio of out-of-pocket payment for health to total healthcare expenditure was estimated at 59.3% in 2020. This reflects an improvement if compared to the 2009 data of the National Health Accounts (72% of total expenditures were out-of-pocket). However, no recent data have been produced to reflect the ongoing inflation or the post-COVID new reality. Therefore, it was not possible to reach a consensus on the status of this indicator at the time of this study.

F. Leadership and governance

1. National health strategy

"How is it made? Is it publicly available? Is it regularly updated? Is it binding?"

Till early 2023, a national health strategy that is publicly discussed has been absent in Egypt. In Mid 2023, the World Health Organization country office initiated community consultation sessions, presenting drafts of a national health strategy for discussion with key stakeholders. This strategy was thoroughly presented and discussed in a recent Health and Population conference organized by the Ministry of Health and further updates and publishing are expected down the line. This is a positive development that can pave the way for considerable alignment of efforts along a nationally unified strategy for health.

2. Representation

"Are all relevant stakeholders regularly represented in decision-making? How participatory is the decision-making process? On service provision level, district level and national level?"

No improvement on that front. Attempts were unsuccessful to create a multi-disciplinary and representative high council for health mandated with the creation and follow-up of a national health strategy. Efforts by the World Health Organization country office to mobilize relevant stakeholders for feedback and ownership of the new national health strategy have been recognized and appreciated by the consulted experts, though still an exception, not the rule.

3. Transparency and 4. Accountability

"Is information made available in a transparent, precise and timely way? Are national health data accessible to all? On all levels? Are there mechanisms for local and national accountability towards service providers and regulators"

Although COVID-19 period witnessed a slight improvement in transparency of national health data related to COVID cases, with daily, followed by weekly reports about morbidity and mortality, yet, this was not expanded to cover other health data and did not continue past the pinnacle of COVID-19.

Local and national accountability mechanisms are still very limited. The General Healthcare Authority is currently operating initiatives to create local patient communities involved in the complaints management and the local level of service provision among the Universal health insurance first phase of implementation governorates, but the initiative is still too early to evaluate and did not expand beyond this scope. Existing decrees to establish patient rights committees in other public hospitals and healthcare districts have not yet been enforced.

5. Grievance redress mechanisms

"Are there complaints and grievances redress mechanisms in place?
Are they effective and timely in their results?"

Prior to COVID-19, the government has put in place a number of grievances redress mechanisms to attend to citizens' complaints from public services. Since then, the Cabinet Unified Complaints Hotline system has been operating with considerable effectiveness in managing these complaints. Funds dispensed by the World Bank through results-based financing models have also been focusing on the effectiveness of the grievance redress mechanisms used in healthcare service provision. Also, the implementation of the Universal Health Insurance scheme including the roll-out of a dedicated complaints management system pertaining to the beneficiaries of its services. At the peak of COVID-19, Egypt also witnessed the deployment of dedicated hotlines related to COVID services. Overall, there is a considerable improvement on that front, however, it is noted that most of the remedies are dedicated to attend to the specific issues of the person tabling the complaints but rarely induce systemic changes or improvements in the processes to avoid repetition of these grievances.

G. Epidemic preparedness

1. Public Health Infrastructure

Although additionally mobilized infrastructure was called to action during COVID-19, it was difficult to assess whether improvements in the stable public health infrastructure has taken place or not.

2. Surveillance

COVID-19 provided a sustained improvement on that front.

3. Immunization

The capacity to produce, roll-out, register and administer vaccinations has seen a dramatic improvement compared to pre-2019.

4. Hospital capacity and 5. Labs

It is difficult to have an objective assessment of the capacity of hospitals and labs to respond to pandemic needs without sound, accessible and reliable data. However, it has been observed that, in many fronts, Hospitals and Labs showed resilience in the face of the pandemic and the stress it created on the healthcare system and infrastructure.

6. Coordination

The government response to COVID-19, specially at the beginning of the global crisis, gave way to multi stakeholder coordination between the different circles of decision-making in the country. It was immensely positive to see meetings with all representatives of government discussing and contributing in attending to a health crisis and mobilizing their resources to alleviate the impact of the pandemic not only on health services but also on the social and living conditions of the population. The capacity of the government to mobilize this level of coordination when needed is not to be the norm nor the exception.

H. Public health communication

1. Public education and 2. Risk education

The mechanisms mobilized by the government for public education and risk aversion were relatively successful in reaching their target audiences and causing considerable positive changes in behavior. Some of these tools were still maintained and employed and possibly ready to deploy upon need.

3. Communication with healthcare workers

At the beginning of COVID-19, new mechanisms and technologies were mobilized to ensure communication of treatment guidelines and protocols for healthcare workers. Dedicated hotlines and support services for healthcare workers were put in place to ensure continuous communication and to attend to their mental health needs. These tools were rapidly deployed and put to action, though many of them were discontinued or not repeated afterwards.

I. COVID specific measures

1. COVID data available (incidence, mortality, morbidity)?

COVID data across the pandemic was generally available and accessible through the main communication channels and social media.

2. COVID data credible? 3. COVID data regular and 4. COVID data accessible?

The credibility of the published data was heavily questioned particularly regarding positive cases and COVID-related mortality rates. Their data collection mechanisms and produced data have been largely criticized for its severe underestimation of actual numbers.

5. Vaccine coverage ensured? 6. Vaccine equity realized?

The vaccine coverage was ensured across the country. Equity was one of the main principles of coverage when organizing the vaccination campaigns, and vaccines were accessible to all. Special programs and outreach efforts for at risk populations were limited but were organized to access hard-to-reach populations.

7. Vaccine outreach to high risk population and target groups achieved?

Although vaccines were quickly accessible to all, yet, special programs and outreach efforts for at risk populations were limited. Special access to healthcare providers was guaranteed but the general distribution of vaccines rarely considered the special needs or requirements of high-risk populations and target groups. At the beginning of provision of the vaccine, scenes of overcrowded vaccination sites with long waiting lines packed with elderly and chronic diseases patients were the norm with limited to no consideration of the impact this might make on the spread of the virus.

8. Boosters were available? 9. Boosters coverage achieved?

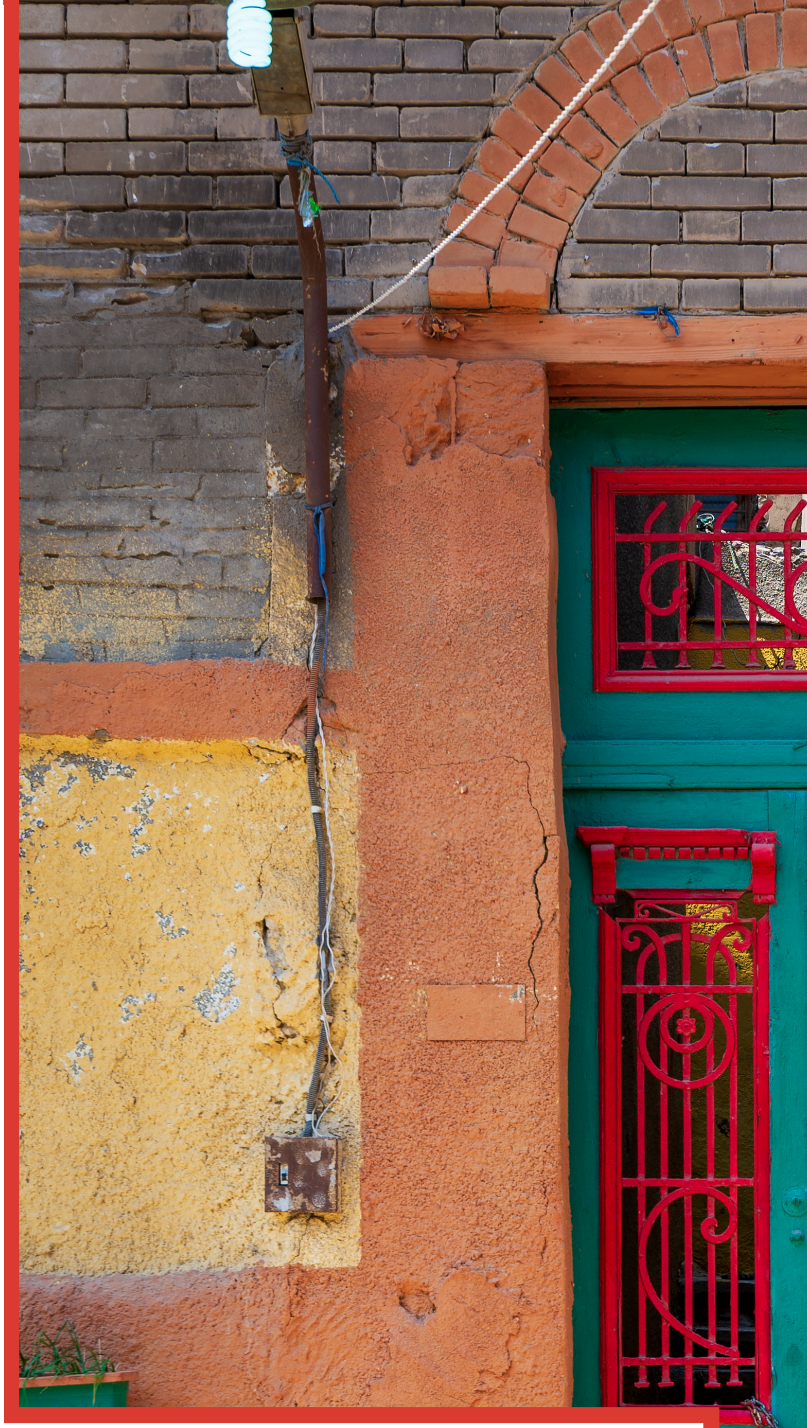
Booster doses of COVID-19 vaccines were readily available and distributed with great equity during the last phases of the pandemic, however, this has significantly slowed down since then, with little to no booster doses made available in the past year.

10. Access to testing guaranteed? 11. Affordability of testing ensured?

The work on COVID-19 testing was considerably lagging behind during the pandemic, between restrictions on accessing PCR testing in the public, delayed access to rapid tests and relatively high, uncontrolled pricing of testing in the private sector. This is an area which requires a significant amount of work for proper pandemic preparedness.

12. Access to treatment realized? 13. Affordability of treatment ensured?

Access to and affordability of treatment were largely covered by the public sector within the public sector. However, limitations of infrastructure and available beds made the role of private sector service providers critical in ensuring access to treatment. In the private sector, prices were heavily uncontrolled



CONCLUSION AND RECOMMENDATIONS

CONCLUSION AND RECOMMENDATIONS

Regular and objective evaluation of the healthcare system's performance (using frameworks like the WHO Health System Pillars) is essential. Reliable, up-to-date, and transparently available data are crucial for this purpose. Despite the positive impact of the international focus on COVID-19 public health data, precision and continuity of data about the healthcare system in Egypt are still questionable and require significant improvements.

The Universal Health Insurance scheme in Egypt has been paving the way to a number of considerable improvements in many aspects of the healthcare system, particularly regarding service quality, coverage, financial risk-protection and access to services. Although it is imperative to review many aspects of the implementation of this new scheme to ensure its scalability and coverage, what has been carried out in the pilot governorates already constitute a significant improvement, though limited in scale. Implementation of some of the solutions and adoption of some of the tools employed by the new Universal Health Insurance scheme, can be initiated and carried out around the country, in preparation for the roll-out of the new insurance scheme and to guarantee equitable distribution of quality services around the country.

Continuity of care requires a more systematic, patient-centered look at patient journeys and referrals, particularly within the scope of work of primary healthcare services, which still require significant revisiting, be it within the scope of the old health insurance scheme or the new Universal Health Insurance.

Efforts to standardize and promote quality of healthcare services spear-headed by GAHAR should not be an obstacle hindering the realization of the Universal health Insurance scheme or the improvement of services in the private or social sector. It is recommended to consider more acceptable and resource-aware regulations for accreditation and to ensure a one-stop-share for the accreditation process that does not require further audits by other authorities (such as safety permits).

Coordination of services between different government authorities has seen a significant improvement during the peak of COVID-19 with a “One health” approach clearly spanning access to different sectors. Some of these coordination efforts still prevail though not sufficiently.

Healthcare workforce and issues related to healthcare workers retention, migration and strategic planning of medical human resources constitute a grave area of concern. Attention to the working conditions of healthcare workers, their wages, continuous education and ensuring an attractive, truly performance-based set of incentives are an absolute must within the context of the new

Universal Health Insurance scheme and beyond. To this day, strategic planning regarding medical workforce is lagging behind and interventions to mobilize medical personnel are still carried out in a disruptive way that negatively affect the ecosystem and that is likely to constitute growing challenges as implementation of the health insurance schemes spans out to more governorates.

Although significant efforts have been put forth in ensuring equitable and continuous access to essential medicines, several policy efforts are necessary to promote national medication production, to ensure adequate patient compliance to treatment, and to promote availability of vaccines.

Recent efforts are commendable when it comes to the production of a consensual national health strategy that puts into account national strategies and priority areas. This exercise needs to be translated into workable national plans that involve different decision-makers and sectors including civil society and the private sector, and that promotes data transparency and social accountability.

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The Egyptian Initiative for Personal Rights has been working since 2002 to strengthen and protect basic rights and freedoms in Egypt, through research, advocacy and supporting litigation in the fields of civil liberties, economic and social rights, and criminal justice.

Founded in 2012, the Alliance seeks to strengthen and amplify civil society voices working on solutions to the current and future pandemics as well as those working in the health sector addressing access and quality of services, impacting inadequately served populations in one of the most unequal regions on earth.

To achieve this, the Alliance focuses on developing and implementing public education and engagement strategies, advocacy, policy reform and research translation to ensure that all people across the continent are informed about their rights and have the skills and access to platforms to hold others to account for violations.