EGYPT
Health sector reform

COUNTRY CASE STUDIES ON PRIMARY HEALTH CARE
Acknowledgements

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Background

At the time of the signing of the Declaration of Alma-Ata in 1978 (1), Egypt was a low-income country with high rates of preventable mortality, and infant mortality rates of 157/1000 live births (2). By 2018, Egypt has become a lower-middle-income country (3), with a population of about 92.1 million (3). Historically, Egypt had placed a disproportionate emphasis on specialized care, and the country had a fragmented payment system, with challenges related to quality of care and unacceptably high rates of maternal and child mortality. In response, a renewed focus on public primary health care (PHC) led to a pilot of the Health Sector Reform Program (HSRP) – a model for comprehensive, family-focused care – beginning in 1997 (4,5). The HSRP was designed to deliver the highest value care (defined as maximum health gains for amount of money spent) and to provide more accessible and high-quality care to Egyptians (6,7). Over time, this model has become central to the country’s goal to achieve universal coverage of basic health services for all Egyptians, in line with the tenets of the original Declaration of Alma-Ata.
Intervention

Five principles guided the design and implementation of the HSRP: universality, quality, equity, efficiency and sustainability (7). The HSRP was designed to change the care delivery approach for PHC facilities through the creation of the family health model, with the family classified as the basic unit of care (6,8,9). The objective was to meet the needs of the population through a responsive and comprehensive package of services that included maternal and child health services, family planning, immunizations and management of childhood illnesses (8,9). Family health units served rural catchment areas of fewer than 20,000 individuals, and family health centres were established in urban areas serving larger populations (8). Family doctors at each PHC unit acted as gatekeepers for specialty services, to decrease the burden on secondary care and better integrate service provision at the facility level (6,7). The programme also prioritized improving and ensuring quality of care. Improvements included formal, specialized family health training; implementation of standards for accreditation of PHC facilities using the family physician model; performance-based incentives for clinicians (5); improvements in facility infrastructure (7); and initial assurance that affordable quality drugs were available to all Egyptians. Staffing guidelines were implemented to ensure that facilities were efficient, and that 24-hour care was provided in both urban and rural settings (7).
The HRSP was piloted in three governorates (Alexandria, Menoufia and Sohag) from 1997 to 2006 (10), involving a range of facilities. The pilots started with the family health units and expanded to include higher level facilities such as family health centres; district, general, specialized and teaching hospitals; cancer centres; and special-purpose institutions. The aim was to provide a comprehensive continuum of care for families (7).

The HSRP programme also sought to increase financial access for the population served. The family health model was supported by the family health fund, a financing scheme that contracted PHC providers, and purchased services for both the insured and uninsured (7). The fund established contracting rules and eligibility criteria for facilities, including accreditation by the Ministry of Health (MoH). The accreditation involved an initial facility assessment and assessment of patient care and services, plus a broad range of requirements such as leadership, infection control training for staff, creation of staff performance improvement plans, safety standards, and a quality improvement programme (7). However, the family health fund has faced considerable challenges over time. The fund was intended to be similar to an independent insurance scheme, combining private and public funding. However, in reality it only supported provider functions and costs rather than reducing out-of-pocket expenses for families. Furthermore, the operations of the fund were often supported by time-limited international donor funds rather than by sustainable domestic resources (5).
Scale and impact

Since the start of the HSRP, Egypt has experienced incremental improvements in access to and quality of PHC services. Following the end of the pilot programme in 2006, the goal was to achieve national roll-out and full facility accreditation by 2020 (4). The number of PHC clinics that adopted the family health model increased from 66 in 2003 (5) to 3000 in 2011, with more than 2000 of these clinics being accredited (8). In 2017, there were more than 5300 PHC facilities with nearly 15 000 general practitioners and 256 certified family doctors (3). With the increase in PHC facilities, 95% of the population now lives less than 5 km from a facility (11). Despite this improved geographical access, there are still too few facilities to meet community needs; for example, there is less than one facility for every 10 000 individuals when the suggested goal is two for every 10 000, and facilities continue to be overburdened (3,11,12).

After the pilot and subsequent expansion of the HSRP, the family health model has resulted in better integration and improvement in the quality of PHC service delivery, and a more holistic view of care (5). The performance-based incentive system increased public provider accountability for assuring quality standards (5). Also, PHC vertical programmes and family health services were integrated, and there was some reduction of costs through provision of the Egyptian Essential Drug List and implementation of clinical guidelines. Associated with these changes, patient satisfaction increased together with use of public health facilities, with a rise in clinical visits from 3 to 16 per day (5).

Egypt’s maternal mortality rate decreased from 83/100 000 live births in 1995 to 33/100 000 live births in 2015 (13), and under-5 mortality decreased in the same period, dropping from 64.9/1000 live births to 22.8/1000 live births (13). Both rates have consistently been below those of its regional counterparts. Infant mortality had a similar trajectory, decreasing from 49.6/1000 live births in 1995 to 19.4/1000 live births in 2016; at the same time, life expectancy increased from 66.7 to 71.4 years (13). The country also saw a reduction in the burden of communicable diseases.
Barriers to sustained success

Many barriers remain to the sustained success of the HRSP. Although the pilot programme emphasized the importance of PHC in Egypt and targeted improvements in the public sector, many individuals still visit private facilities (50% as of 2010), which are poorly regulated and for which there is little performance data (11). The referral system is weak and there are insufficient management information systems at the facility level. Also, distribution of human resources in PHC centres continues to be inadequate. This situation is complicated by the rapid turnover of clinicians (who are unwilling to work in the public sector because of low remuneration), and by providers working in both public and private practices. Additionally, supply shortages continue, especially for essential drugs and health information software. Finally, there are inadequate data systems to measure quality of care within much of Egypt’s PHC.
The way forward

Quality PHC continues to be a priority for Egypt, to meet the changing needs of its growing population. As of 2015, the country planned to further strengthen its PHC public health network with a focus on noncommunicable diseases, which accounted for nearly 85% of all deaths in that year (11). Egypt is considering expanding the family health model to all governorates, with a distinct focus on more uniform measurement and improvement of the quality of service delivery (11). This focus on quality includes expanding national monitoring and evaluation systems, and focusing on training managers in supportive supervision. Another area of work is expanding clinician training through programmes and postgraduate degrees – to prepare qualified family doctors to lead family medicine programmes – and updating clinical guidelines for family practices. Reflecting that focus, the MoH, in collaboration with the World Health Organization (WHO), recognized that the current training for family health facilities was inadequate to ensure high-quality services. Hence, the MoH and WHO have piloted a 6-month training programme and are working towards a diploma programme in family practice.

Egypt also seeks to increase access to quality care through its universal health insurance law (14), which draws upon the family health model. The law states that PHC facilities act as the first level of contact, and that the family doctor should receive special training in family medicine (15).

Overall, the pilot HSRP paved the way for better integration of services and improvements in the quality of PHC service delivery. This model is a strategy for achieving one of the targets of the Sustainable Development Goals (SDGs) – SDG 3.8 –which relates to achieving universal health coverage. The model includes financial risk protection and access to quality essential health care services, medicines and vaccines for all Egyptians.


16. Soad, Abdel Megid, MD. Head of Primary Health Care Sector, Egypt Ministry of Health and Population. Email communication. 13 August 2018.