5 GOVERNANCE/OVERSIGHT

5.1 Process of Policy, Planning and management

National health policy, and trends in stated priorities

Ministry of Health and Population (MOHP) has published an analysis for health sector in Egypt with name of "Egypt Health Service Analysis and Future Strategy Report". The document was first published in 1998 and the Health Sector Reform Program has updated it on December 2003. The report has addressed the fragmentation of healthcare funding, low utilization rate and quality of health care. The following presents the proposed strategies at the document:

- Establishing an appropriate overall institutional and legal framework for the health sector is crucial for successful implementation and sustainability of the reform. It is, however, anticipated that this will take several years to complete.
- Undertake an analysis of the health sector legislative environment to identify which existing regulations are likely to hamper the intended reforms – then seek ways of removing them and replacing them with a legal framework supportive of the reform.
- Redefine the relationships between the various relevant institutions including Ministry of Finance, Ministry of Higher Education and the Central Agency for Organization and Administration to ensure that the MOHP takes the lead and has the necessary authority to determine overall priorities, plan and allocate all resources needed for its operations.

In order to achieve this, the following actions are in various steps of implementation:

a) Establish a multi-sector Legislative and Regulatory Review Committee led by the MOHP, with representation from other ministries, to recommend a legislative and institutional framework conducive to reform.
b) Redefine the relationship between the MOHP and the political bodies in order to enable the technical expertise within the MOHP to become available.

Ministry of Health and Population regulatory capacity to design and implement national standards has developed health sector regulatory bodies/functions. The following bodies/ roles / functions are in different stages of development for adequate regulation of the health sector:

- **Capital investment control and certification of need**: a new MOHP function that licenses capital and technological investment for the whole health sector (governmental and private).
- **Health Care Facility Accreditation**: an autonomous body that collaborates with the MOHP Quality Assurance Unit.
- **Physician certification**: re-certification on the basis of continued medical education – a collaborative function/body with MOHP, medical schools and medical syndicate representation.
- **Regulation of health insurance**: a new MOHP function to regulate social health insurance and private health insurance.

- **Standard Setting Unit:** as part of the MOHP, its role is to provide patients, health professionals and the public with authoritative, robust and reliable guidance on current best practice. The guidance would cover both individual health technologies (including medicines, medical devices, diagnostic techniques and procedures) and the clinical management of specific conditions. It started with the BBP for family-orientated primary health care.
- **Resource allocation**: in which Ministry of Health and Population develop methodologies and mechanisms for achieving the stated principle of "equity" through continued financing of priority public health programs, by applying an appropriately-weighted (i.e. addressing the country's health priorities and health needs assessment data) capitation formula.
- **Consumer awareness:** developing the capacity of consumers to make informed choices about providers and play a greater role in ensuring the accountability of providers for the quality of services. Developing regulations to require insurers (whether social or private) to provide written information to enrollees on their benefits, co-payments and choice of participating providers. Consumers should also be able to check on the credentials of a provider through the Licensing and accreditation agencies

5.2 Decentralization: Key characteristics of principal types

The Ministry of Health and Population (MOHP)

The MOHP operates through a functional structure, through an administrative and a technical workforce across four levels namely, Central, Health Directorates (at governorate level), Health Districts, and Health care Providers.

The central level organizational structure

The MOHP central organizational structure is an extensive structure headed by the Minister. It employs almost 5,000 personnel, including professional and supporting staff, who are in charge of main central functions such as planning, supervision, program management and maintenance. The MOHP is a merger of the Ministry of Health and the former Ministry of State for Population.

At the central level, the MOHP is divided into seven broad functional divisions including:

(i) The Minister's Office Affairs Sector
(ii) The Training and Research Sector
(iii) The Integrated Care and Nursing Sector
(iv) The Preventive Affairs and Endemic Diseases Sector
(v) The Curative Health Sector
(vi) The Health Regions Sector
(vii) Sector for Technical Support and Projects
(viii) Sector for Population and Family Planning

In addition to the above eight sectors, the central organizational structure of the MOHP includes a central department directly accountable to the Minister:

(ix) Central Department for General Secretariat

The MOHP overall structure is therefore made up of seven functional divisions embracing 23 central departments and 73 general departments at the central level. Each of departments is in charge of various functions. The eight sectoral heads, however, report

directly to the Minister. In addition to this, some of the central departmental heads also report directly to the Minister. These include the heads of:

- Research and Development
- Pharmaceuticals
- Dentistry

This central structure includes 103 sectoral, central and general departmental units, integrated under the Minister who, constitutionally, is the key policy formulator and decision-maker. The key role of the Minister is traditionally undertaken according to the practice and past experience of the previous 36 Ministers who have occupied this position since 1936 when the Ministry was established.

In addition to these functional units, the central organization structure includes certain policy-making, planning, and advisory bodies such as councils, executive committees and advisory committees.

The district level organizational structure

The district health organizational structure is simply a replication of the governorate structure, where the basic functions are implemented on a smaller scale. Reporting to the governorate health directorates are 255 health districts. Each district has a director The health districts (and to some extent the health directorate) work, in theory, according to the organizational structure and staffing patterns authorized by the CAOA. However, in reality, there is a great degree of variability in these structures and patterns.

Each district organizational structure is headed by a health director, supervising a team of physicians, nurse supervisor and administrators. Both health directorate and district level structures need to be restructured so that their organizational structure and capacity meet the demands of their new roles and functions.

The governorate level organizational structure

The above central organizational structure is replicated at each governorate level. The governorate level health directorates are responsible to the MOHP for technical functions, but report to the Governorate Executive Council (headed by the Governor) for day-to-day management of activities.

Egypt is formed of 26 governorates. There are, however, 27 health directorates in operation because Luxor City has a separate health directorate, despite being administratively part of Qena Governorate.

Each governorate health directorate is headed by an Undersecretary or a Director General, the “Director of Health Affairs”, whose functional grade differs according to the governorate size. The Director of Health Affairs supervises the Health District Directors.

Private Service providers, through contracts

The public sector in Egypt cannot provide all health care services because of the continuous increase of health services cost. The intention is to provide a hybrid model of both public and private sector provision. The aim is to encourage private sector investment where the local market conditions make it sustainable.

The Health Sector Reform Program, through the Governorate’s plans, is preparing to cover 35 - 40% of the urban population through MOHP health services, while the rest will be covered by private/NGO. Partnership with private/NGO will give the opportunity for HSRP to enable the coverage of underserved areas with family health model and basic benefits package.

Having a contract with the private sector will maintain the implementation of the national quality standards among different types of health service providers. On the other side, this will provide an equity dimension for both of public and private sectors patients.

Main problems and benefits to date

- The overall institutional framework of the health sector is complex. The MOHP has relations with more than 29 ministries and public sector agencies. MOHP lacks adequate control over its budgets, investment planning, human-resource planning and staff allocation. This has not changed since the last situation analysis five years ago.
- The organizational structure of the MOHP headquarters is complex including various sectors, departments and units vertically organized with little communication and interaction across boundaries. Organizational roles and responsibilities are sometimes redundant and lack clarity. Authority levels are ill defined and tend to be over-centralized.
- MOHP operations do not utilize modern management systems or well-defined policies and procedures. The MOHP decision-making process is mostly subjective and rarely information-based. Management information systems are under-developed.
- There is imbalance between the MOHP strategic and operational functions. Moreover, the MOHP operations demonstrate micro-management and over-emphasis on its health care delivery function at the expense of sectoral and national roles. This has not changed since the last situation analysis five years ago.
- The MOHP is currently undertaking the roles of planning, budgeting, financing, resource allocation, regulation, monitoring and evaluation as well as health care service delivery. This lack of differentiation of roles between levels, so that each level from the center to the periphery replicate and overlap, is leading to inefficient and poor quality of delivery of health services in general, and curative services in particular. (Proposals later in the document differentiate roles at different levels.)
- Highly centralized administrative structures, resource management and flow of funds has lead to a considerable degree of lack of responsiveness between the local needs and related policies, strategies and allocation of resources.
- The system of delivery of services is fragmented across a large number of providers. The service delivery system is not designed to integrate services and provide community orientation.
- There is uneven and insensitive allocation of resources and investments between primary, secondary and higher levels of care, mainly in favor of secondary and higher care levels not matching with the actual needs. This, added to the lack of efficient management systems and trained personnel, is leading to compromised quality of care provision at all levels and is evidenced by the poor utilization at the secondary and higher care levels.
- Information management and systems are fragmented across the different HOHP organizations, with lack of integration and lack of systems to avoid redundancy and ensure reliability of data and quality of information. The ministry does not have an clear strategy for information management across its organizations. There is poor utilization of information for health care planning, management and decision support.
- Pharmaceuticals and medical supplies suffer a lack of efficient and informed management based on local needs, leading to deficiencies and surplus of supplies,

with slow and ineffective ordering, stock replacement and inefficient drug dispensing control systems.

Integration of Services

The MOHP is the major provider of primary, preventive and curative care throughout Egypt, utilizing 4,300 health facilities and 66,440 beds nationwide. The MOHP services delivery units are organized along differing lines. These lines may be geographical (i.e. rural and urban), structural (i.e. health units, health centers, hospitals), functional (i.e. maternal child health centers), or programmatic (i.e. immunization, diarrheal disease centers).

The MOHP has attempted to target a number of health priorities in Egypt, mainly family planning and maternal child health, through a number of vertical programs that rely heavily on donor assistance. These programs are provided at the priamry health facilities:

- Population and Family Planning Program
- Control of Diarrheal Diseases (CDD)
- Acute Respiratory Infections (ARI)
- Expanded Program on Immunization (EPI)
- Maternal Health: Maternal Health is part of the Maternal Child Health program, which provides priority medical care during pregnancy and delivery.

5.3 Health Information Systems

In 2000, the Epidemiology and Disease Surveillance Unit (ESU) was established by ministerial decree, under the First Undersecretary of Preventive Affairs in the organizational structure of MOHP.

Activities

- Assessment of the available resources at governorate and district level, and selection of surveillance staff.
- Training of the selected staff.
- Training workshops for private sector staff.
- Field investigations.
- Cruise Boats Inspection Program.
- Release of version 1 of the National Egyptian Disease Surveillance System (NEDSS).
- Publishing the Disease Surveillance Bulletin of Egypt (in process).
- Monitoring and evaluation.

Objectives of the surveillance system

- Identification of disease pattern
- Follow temporal (mid and long- term) trends and patterns of disease
- Detection of sudden changes in disease occurrence and distribution
- Detection of changes in health care practice

Specific objectives

- Strengthening all surveillance components by:
  - Data collection, management and analysis
  - Interpretation, dissemination and feedback
  - Provide the decision-makers with data in time for action.
- Strengthening the link between all levels (units, districts, governorates and central).

- Standardization and computerization of data in all levels.
- Advanced epidemiological and biostatistics training for health staff.
- Increase the role of health unit staff in the surveillance system and the reporting of diseases.

Achievements

- Epidemic management and fieldwork:
  - Epidemic preparedness
  - Outbreak investigation.
- Field Epidemiology Training Program (FETP)
  - To train MOHP physicians to apply the principals of epidemiology and biostatistics to important public health issues.
- Private sector initiative:
  - To encourage the reporting of diseases under surveillance
  - To develop knowledge and skills in disease surveillance
  - To develop and strengthen the cooperation between the private sector and ESU.
- National Egyptian Disease Surveillance System (NEDSS)
- Upgrading laboratory capacity for surveillance:
  - Training of common governorate laboratories
  - Upgrading fever hospital laboratories.
- Non-communicable disease (NCD) surveillance:
  - Establishing a nationwide standardized surveillance system and database
  - Using simplified reporting forms and data management
  - Monitoring patterns and trends in NCD occurrence and risk factors
  - Supporting NCD prevention and planning priorities.
- Vessel sanitation program

5.4 Health Systems Research

The ministry of health and population regulate the process of research through the ministerial decree No 95 issued in May 2005. The scientific health researches are forbidden to be carried out before being submitted to the central administration for research and health development e.g operational researches , whether carried out by deferent sectors of MOHP, hospitals ,organizations or association belonging to MOHP or in partnership with others. The policy applies also for clinical researches with therapeutics.

The Central Administration for Research and Health Development is responsible for submitting the protocols of these researches to scientific and ethical committees

Improving the research capabilities of researchers in different sectors of MOHP , and establishing a research data base are some of our goals.

5.5 Accountability Mechanisms

Data is not available.