ELECTIVE (SSC5c) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

My elective placement in Cairo, Egypt was an amazing experience. The hospital that I was initially associated with was el-Nada hospital in Mohandiseen. However my supervisor is a professor at Cairo University and when he understood that I wanted to learn as much as I could about the health care system in Egypt he arranged for me to spend time at the University of Cairo (Qasr al-Ainy) hospital and then at various public and private hospitals in Cairo as well as a primary care facility. While spending time in the clinical environment, observing and assisting, I talked to scores of doctors, medical students about the health care system, its problems and their understanding of the health care reform process. I was also able to speak to officials at the World Bank and Ministry of Health about health care reform.

The Egyptian health care system is extremely fragmented compared to the UK system. It consists of a number of sectors – the Ministry of Health facilities, the Health Insurance Organisation facilities, the university hospitals run by the Council of Higher Education, hospitals run by (and for) the military, police and Ministry of Interior, and the private and charity/PVO sector.

Since the 1970s with infitah (liberalisation of the economy) there has been a shift in health care provision being provided by the state to it being provided by the private sector. The public sector (health insurance and Ministry of health sectors) has been comparatively starved of funds and only about 3% of GDP is spent on health care. Conditions in the public sector are poor and many patients also use the private sector to access health care where the standards of treatment in terms of hygiene, organisation, and respect for the patient are considered higher. The very poor however are forced to rely on the Ministry of Health and university sector where service is usually cheaper although even here user fees apply. Primary care is run by recently graduated doctors and the family health units are often poorly equipped. The doctors at these units are open about the fact they feel ill prepared and unskilled, unable to do more than treat symptoms or refer. Thus many patients prefer to go straight to the secondary or even the tertiary sector even for minor ailments, especially as user fees apply at all levels of care. Another important issue is regional disparities. The facilities in Upper Egypt for example are said to be far worse than they are around Cairo.

Most of my time in Cairo was spent in obstetrics and gynaecology (primarily obstetrics) although I was also able to spend time in other specialties such as emergency medicine, cardiology and paediatrics. In obstetrics the main problems seemed to be late presentations for common problems in pregnancy such as preeclampsia. This seems to have improved in the last ten years due to the Millennium Development Goals' emphasis on maternal and infant mortality. Thus pregnant women are now encouraged to come for scans on a regular basis and antenatal care appears to have improved. However late presentations are not uncommon amongst the very poor who prefer not to pay the user

fees for antenatal care. For example, it is not uncommon for pregnant women with mitral valve replacements due to rheumatic fever to turn up in labour having never seen a health care professional in pregnancy. Another major problem is birth defects and genetic and chromosomal problems due to consanguinity. In gynaecology, the main problem is late presentation. Unlike in the UK there is no screening for cervical cancer for example. In addition the problem of FGM is endemic, affecting 90% of women. While it is now illegal in Egypt, this is not enforced.

Giving birth in a public hospital is very cheap if not free. According to recent demographic data, women in Egypt are much more likely to give birth in hospital than ever before with about 90% of Egyptian women giving birth in hospital with trained health care professional. However the problem now is that c-section rates are extremely high among both the rich and poor. This seems to be both patient and doctor driven.

A major health issue that affects all the specialties is hepatitis C. Some sources state that 20% of the population carries the virus. The disease has such a high prevalence due to mass parenteral schistosomiasis treatment in Egypt during the 1960s-1980s with inadequately sterilised needles. While the government has entered into an agreement with the international pharmaceutical company (Gilead) to purchase a recently manufactured revolutionary drug Sofosbuvir more cheaply, unlike India the Egyptian government has not been able to negotiate to buy the ingredients to make the drug locally. Since Egypt has a well-established pharmaceutical industry, the reason for this is uncertain. In addition the government has neglected to introduce screening programmes which would help prevent some of the complications of hepatitis C such as liver cirrhosis. Doctors I spoke to said that the government did not want to screen because they did not want to pay to treat such a large number of patients. It seemed to me that antenatal care would be an ideal setting to screen women.

The nature and extent of health care reform in Egypt is unclear as the notion of reform means different things to different people and there are a number of projects underway. Plans have also been in flux due to the political upheavals of the last few years. The World Bank/EU/USAID-sponsored programme to transform primary care by making primary care more accessible, separating provision from financing and improving quality through incentives to doctors is currently on hold while the World Bank negotiates with the Ministry of Finance over plans to restructure health care financing. The primary care project which began in 1996 was successful for a while but once the donors pulled back to allow the Ministry of Health to continue the programme the Ministry of Health did not sustain it. A World Bank official suggested to me that the government lacked commitment to the reform. There are other projects underway such as a Ministry of Health programme targeting a section of the poor in Upper Egypt using Smart Cards. There are also NGOs trying to lobby the government through a Committee on Health Care for an expansion of health insurance. The government of Egypt has been committed to expanding health insurance to the poor for many years but this has not happened.

In terms of my own professional development goals, although I still have a great deal to learn, I have achieved my goal which was to better understand the role of health in the Egyptian political life prior

to the 2011 revolution and in subsequent time. I am planning to return to Egypt to carry out a year of fieldwork for my PhD. In terms of health care, most social scientific research on Egypt has focused on 'religious' clinics and hopsitals and how these have resulted in the shoring up of support for political parties such as the Muslim Brotherhood. Scholars are now suggesting that this case was somewhat overstated. There has been very little work on the health care system as a whole which is where I believe I can make a contribution. I am particularly interested in how the development of particular relationships between the private and the public sectors since the 1980s as a result of neoliberal reforms has created a dysfunctional system which does not deliver good health outcomes. More significantly this particular configuration of public/private relationships is hindering the reform process. I believe that focusing on patterns of institutional arrangment can help us to learn a great deal about health care reform in the developing world.