

30. Health and social justice in Egypt: towards a health equity perspective

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This contribution highlights Egypt's striking health inequities. They intersect with other inequities related to gender, socio-economic status, education levels, employment status and geographical location. It argues that efforts to improve the health sector in Egypt need to embrace health equity as an ideal and as a guiding principle for all attempted reforms.

Egypt's health sector has been in a state of crisis for decades. Run-down public hospitals, rampant corruption, lack of accountability, inadequate health insurance, poor-quality public health care and unaffordable and sometimes unreliable private health care have resulted in hardship and even death for many Egyptians (Rafeh et al., 2011).

A look at a number of health indicators is telling. In 2013, Egypt ranked 118th among the 193 member states of the World Health Organization (WHO), and 15th among Arab countries, in life expectancy at birth (WHO, 2013). It is 117th in hospital beds per capita and faces a severe shortage of intensive care units (Kaiser Family Foundation, 2013). Families cover 72 per cent of health-care costs in Egypt (Rafeh et al., 2011). In 2015, the health sector accounted for 5.4 per cent of the total government budget, compared with 12 per cent for education, one of the lowest rates in the Middle East and North Africa region (Ministry of Finance, 2014).

The state of health care in Egypt has in the past become a major cause of social and political discontent among Egyptians, leading up to the political uprising in January 2011 that called for 'bread, freedom, social justice and human dignity'. From January to February 2011, chants lamenting the deplorable health conditions of the Egyptian population echoed in Tahrir Square.¹

Intersecting inequalities, intersecting causes

There have been some improvements in aggregate health indicators over the past few decades. However, they mask striking inequalities among Egyptians by gender, income level, education and geographic location.

For instance, child mortality is twice as high in rural upper Egypt (thirty-eight deaths per 1,000 births) as in lower urban Egypt (twenty deaths per 1,000 births) (El-Zanaty and Associates, 2014).

Stunting among children aged 0–4 varies tremendously by governorate, from around 12 per cent in Suez to nearly 85 per cent in the Red Sea governorate (El-Kogali and Krafft, 2015). A recent study estimated that 96 per cent of women from the most advantaged group (MAG) (defined as urban, educated and belonging to the highest wealth quintile) receive prenatal care, compared with only 60 per cent from the least advantaged group (LAG) (defined as rural, uneducated and belonging to the lowest wealth quintile). Similarly, births attended by a skilled professional range between 97 per cent for the MAG to 54 per cent for the LAG. Infants born to the LAG are more than twice as likely to die in their first month of life than are those born to the MAG (1.9 and 0.8 per cent respectively: El-Kogali and Krafft, 2015). Health-care financing is also inequitable. Families in the lowest income quintile spend 21 per cent of their income on health-care-related costs, versus 13.5 per cent for those in the highest income quintile (Rafeh et al., 2011).

These examples highlight the fact that health inequities intersect with inequities among income groups and those related to gender, education and geographical location. The deterioration of the health system in Egypt, and its accompanying health inequities, is the outcome of a complex web of authoritarian politics, crony capitalism and corruption, which among other results has led to a brain drain of health-care workers.

The struggle for reform

Efforts have been made to reform the situation in Egypt. The most prominent voices in the fight to overhaul the health system have been medical doctors, who have coupled their professional demands for better wages, working conditions and training opportunities with social and political demands to improve the health-care system and increase public spending on health. Among various other efforts, doctors staged two long strikes, in 2012 and 2014, which lasted for nearly three months each.

These mobilizations have been largely unsuccessful, leading, even by the most optimistic accounts, to only modest increases in doctors' salaries. The deterioration of the public health system and the limited success of protest efforts cannot be understood outside the context of the state of Egyptian politics over the past several decades, characterized by authoritarian leadership, a downtrodden public sphere, a stifled civil society, a neutered opposition and a widespread crackdown on any anti-government social activism or popular mobilization.

It is also relevant to note that doctors in Egypt have historically been shaped by a modernizing project in a colonial and postcolonial setting that is articulated around 'the rule of experts' – including natural scientists, social scientists, economists, engineers, and physicians – who not only make sense of the world, but also shape it. Egyptian doctors historically have been shaped to play that role. Today theirs are the only audible voices in the contested space of health politics in Egypt, where, as Timothy Mitchell puts it, 'nobody listens to a poor man', and where experts have the most leverage to redirect the conversation (Mitchell, 2002). Health system reform has turned into what Matthieu Fintz calls 'a reform for the poor without them' (Fintz, 2006).

These political and historical realities are combined with political and economic factors that have allowed successive Egyptian regimes to maintain the status quo. Corruption, favouritism and crony capitalism are rampant in the health system. Private health-care industry moguls stand to benefit from maintaining the status quo of dilapidated public hospitals, which patients of means do their best to avoid, and of underpaid public-sector doctors who often end up taking second or third jobs at pitiful rates in private hospitals (Berman and Cuizon, 2004).

A brain drain of health workers has exacerbated the crisis. According to some estimates, more than 60 per cent of Egyptian doctors now work outside of the country, mostly in Gulf countries. Here they represent a significant percentage of the health workforce, despite being paid far less than local nationals or colleagues from other countries, and only slightly more than they would earn in Egypt (Fathi, 2012).²

While it is true that the crisis in the health sector is representative of a general crisis in the public sector (Shukrallah and Khalil, 2012), each sector has its own specific issues. For instance, despite the equally dismal state of the educational sector in Egypt, teachers' strikes in recent years have been more successful than doctors' strikes. This can be explained by structural factors in the two sectors. In the Egyptian education sector, as in the health sector, there is a two-tiered system of an expensive, relatively high-quality private sector operating in parallel to a nominally free, low-quality public sector. However, in the education sector the two tiers are almost mutually independent, because the private sector, which recruits highly skilled professionals, does not compete with or rely upon the public sector for teachers. In the health sector, the two tiers are much more interconnected, as the private sector exploits public-sector doctors who have to supplement their work with private-sector moonlighting to make ends meet.

The same can be said of demand from the Gulf countries. While they increasingly rely on teachers with higher qualifications than those currently possessed by most public school teachers in Egypt, they still rely on Egyptian doctors as a relatively cheap source of staff for health facilities. We might expect that this situation would enabled medical doctors to be more effective in their demands against the government. However, the government's interest in keeping doctors' salaries low coincides with that of the private-sector magnates and of the foreign employers.

It is not only the government, but also the private sector and oil-rich Gulf neighbours, which stand to benefit from maintaining the status quo.

Ways forward

Through the fieldwork I have conducted in Egypt since 2013 among health-care professionals, especially those who fight to reform the health system, I have noticed that the themes motivating their struggle revolve around resisting corruption, inefficiency, misguided spending priorities and exploitation, while health inequities were not as prominently or consciously cited. As has been shown above, health inequities exist in Egypt. However, a lack of epidemiological studies documenting inequitable health outcomes across geographic, gender and class lines has perhaps prevented the struggle for reforming the health system from being conceived of, first and foremost, as a fight against health inequities.

As Dr Hoda Rashad, director of the Social Research Center of the American University in Cairo, observes, Egypt still follows a ‘health systems approach’ which ‘allows you to see the big picture, but not the inequities in different social groups or the structural determinants beyond the health system’, such as poverty, unemployment and lack of education. As a result, we lack knowledge ‘about the cumulative effect of deprivation’. A health equity approach, in that view, would prioritize the most vulnerable groups and those who are most in need, and would shed light on the suffering of some social groups that are completely invisible today (WHO, 2011).

Interest in this health-equity approach is slowly burgeoning in Egypt. This makes it incumbent upon the advocates of health-care reform there to adopt a more expansive concept of health, one that incorporates an account of the social determinants of health and which explicitly aims to reduce health inequalities. This would allow us to gauge the multifarious effects of all policy – and not just ‘health policy’ strictly defined – on different segments of the population. The problem of health in Egypt is not simply a technical issue that requires technical solutions, but rather a social and political one that requires social and political solutions. This understanding warrants an opening-up of the reform movement to engage the efforts of citizens, stakeholders, patient groups, civil society organizations and political parties.

A perhaps promising recent push in that direction is the effort of a group of doctors, in collaboration with civil society organizations, political parties and a patient advocacy group, and engaged ordinary citizens, to produce an Egyptian ‘Patient Bill of Rights’. The current discussions about a new health insurance law that aims to guarantee universal coverage should also be inclusive of citizens and other stakeholders. Such efforts are indispensable if the mobilization to reform the health system in Egypt is to make strides on the path towards health equity, social justice and human dignity.

Notes

1. Examples of such chants were ‘**bā’ū dimānā wi bā’ū kalāwīnā wi binishḥat ihnā wi ahālīnā**’ (They sold our blood, and sold our kidneys, and we beg, we and our families) and ‘**is-saraṭān fī kull makān wi-l-ghāz mitbā’ bil-maggān**’ (cancer is everywhere, and the [natural] gas is sold for free), in reference to the deals that Egypt had with Israel to export natural gas to it at lower-than-market prices. For slogans, see <http://angryarab.blogspot.com/2011/01/egyptian-slogans.html> (Accessed 31 August 2014).
2. The Egyptian Medical Syndicate laments the fact that Egypt is losing its health-care workforce in that brain drain. Despite the lack of exact figures, it estimates that around 100,000 Egyptian doctors work outside the country, almost as many as the total of Egyptian doctors working in Egypt (Egyptian Medical Syndicate, 2014). Sylvia Chiffolleau (2005) sheds light on other global factors and international dynamics that shape and hamper the reform of the Egyptian health system.

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