Welfare in the Mediterranean Countries

Arab Republic of Egypt

Luciano Loffredo
C.A.I.MED.
Centre for Administrative Innovation in the Euro-Mediterranean Region
c/o Formez - Centro Formazione Studi
Viale Campi Flegrei, 34
80072 Arco Felice (NA)
Italy
Tel +39 081 525 0211
Fax +39 081 525 0312
e-mail gpennella@formez.it
nvolpe@formez.it

The views expressed do not imply the expression of any opinion whatsoever on the part of the United Nations and of Italian Department for Public Administration, Formez and the Campania Region Administration
Introduction

The alleviation of poverty is one of the most important economic and social challenges for the Egyptian Government. One of the six critical objectives of the fifth Five-Year Plan for Egypt is in fact to reduce poverty and to improve equity in the distribution of income.

In Egypt there is a strong legal and societal foundation for social protection which is recognised in the Constitution, and the social security system is one of the most comprehensive in Africa and in the Arab region. In spite of this, there is, somewhere between the legislative intention and its implementation, a loss of real impact in meeting social protection needs, the main problem being the imperfect targeting which channels most of the government transfers to the non-poor.

The existing government-provided safety net is targeted to various groups who are unable to obtain sufficient incomes through the labour market - including the poor, the unemployed, and the elderly.

In addition to these groups special attention is given to children. The National Council for Childhood and Motherhood in particular plays an important role in sustaining children’s welfare, in policy making, monitoring and co-ordinating actions in the best interests of children, especially improving child legislation in the fields of education and health. It represents the government commitment, on the highest political level, to the survival, protection and development of children.

On the other hand to protect and promote the role of the women in Egyptian society, a National Council for Women was established in 2000. It is a major step towards ensuring that gender concerns are systematically addressed during the formulation of national policies, its goal is to foster social, economic and political empowerment for women.

\[\text{Egypt Human Development Report 2003}^1\]

<table>
<thead>
<tr>
<th>Poor (as % of total households)</th>
<th>20.1</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ultra poor (as % of total households)</td>
<td>5.8</td>
<td>2000</td>
</tr>
<tr>
<td>% of total public expenditure spent on:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>19.7</td>
<td>2000/2001</td>
</tr>
<tr>
<td>Health</td>
<td>7.2</td>
<td>2000/2001</td>
</tr>
<tr>
<td>Social security</td>
<td>6.1</td>
<td>2000/2001</td>
</tr>
<tr>
<td>Public expenditure on education (as % of GDP)</td>
<td>6.7</td>
<td>2000/2001</td>
</tr>
<tr>
<td>Public expenditure on health (as % of GDP)</td>
<td>2.4</td>
<td>2000/2001</td>
</tr>
<tr>
<td>GDP per capita LE</td>
<td>5537.6</td>
<td>2000</td>
</tr>
<tr>
<td>Unemployment rate %</td>
<td>9.0</td>
<td>2001</td>
</tr>
</tbody>
</table>

\[^1\text{www.undp.org}\]
1- Social protection

The safety net is a key element of a poverty reduction strategy for Egypt. There are three main social safety net programs:\n\begin{itemize}
\item the consumer food subsidy program,
\item the cash transfers from the Ministry of Insurance and Social Affairs (MISA)
\item the Social Fund for Development
\end{itemize}

In addition, there are others interventions and programs aimed at alleviating poverty that are administered by or under the supervision of the MISA (Productive Families Program and Nasser Social Bank) and in the end there is the Social Insurance System, which is the Government's program to help combat poverty among the elderly.

The Government Actors that play an active role in combating poverty are:\n\begin{itemize}
\item The Ministry of Planning - draws the overall economic and social development plans for short, medium and long term;
\item The Ministry of Insurance and Social Affairs (MISA), provides several safety net programs;
\item Free education and literacy programs through the Ministry of Education;
\item Free health care through the local health units and large public hospitals of the Ministry of Health and Population;
\item Subsidies for bread, sugar and oil through Ministry of Trade and Supply;
\end{itemize}

1.1 - The social safety net programs

The safety net programs can be categorized into two groups: welfare and developmental programs. The food subsidy programs and the cash transfer programs fall under the welfare category, representing cash and in kind assistance to the population. The Social Fund (and micro credit programs) are supported by the Government primarily for their development impact, including their contribution to employment generation and thus fall under the developmental category.


\textsuperscript{3} Poverty Reduction Strategies in Egypt, 2002, \url{www.uneca.org};
a) The food subsidy program
The food subsidy program is by far the largest safety net programme spending 1.5% of GDP in 1999. It is one of the oldest in terms of continuity of assistance delivered to the population. It provides all the Egyptians regardless of their poverty status with a subsidy on:

- **baladi** (or indigenous) bread and **wheat flour**, which are provided at about one-third the cost of production and are sold to consumers without quantity restrictions by private sector bakeries.

- **sugar and cooking oil** that are more restricted, and are given out through a two-tier system of ration cards that are based on incomes and need and are sold at fixed monthly quotas by private groceries. In principle, higher-income households should get low-subsidy red ration cards and lower-income households should get high-subsidy green cards.

The bread subsidy lifted 730,000 people out of poverty in 1999/2000, On the other hand the subsidy on cooking oil was much less effective only easing poverty for 170,000 people.

b) The Ministry of Insurance and Social Affairs
As mentioned above, the Ministry of Social Affairs is engaged in a variety of interventions aimed at alleviating poverty either directly, through its social assistance and pensions programmes, or indirectly through the large number of NGOs it supervises and supports.

- Cash transfers by MISA to specific categories of the disadvantaged include social security payments, Sadat pensions and Mubarak pensions, They are made to poor families who do not have recourse to the labour market for income whether due to old age, disability, or because the family is headed by a woman with limited employment opportunities. These transfers are effective in reducing poverty, but suffer from being under funded; funding was only 0.04 percent of GDP in 1999.

- The Ministry also supervises the Nasser Social Bank (NSB). It is a financial institution in charge of a special social function, characterized by remarkable

---


7 Arab Republic of Egypt Poverty Reduction in Egypt….
performance and quick response to social needs and requirements with a total number of 90 branches all over the country.

- Finally there is a scheme for social assistance called the Productive Families Programme (PFP) established by MISA in 1964. It is a mixed training/loan/contract production and marketing system.

c) The Social Fund for Development

The Social Fund For Development (SFD) is a semi-autonomous governmental agency under the direct supervision of the Prime Minister. Financed by the Government of Egypt in cooperation with the World Bank, the European Union and other donors 8.

The objectives of the SFD are primarily achieved through promoting income and employment generating activities, providing basic social services, and enhancing local participation and awareness 9. The targets groups are: women, new graduates, unemployed youth and start-up entrepreneurs.

Two of SFD’s programs are closely related to poverty: the Community Development Programme (CDP) and the Public Works Programme (PWP) which target poor communities and provide employment opportunities to the poor 10. They spent 0.23 % of GDP in 1999.

2 - The social insurance system

The current social security system in Egypt was established by the Law 79 of 1975 which covers civil servants and employees in public and private sector enterprises. The system was subsequently extended to the self-employed (Law 108 of 1976), Egyptian workers abroad (Law 50 of 1978) and casual workers (Law 112 of 1980) 11.

The system is administered by two separate Funds, the Government Fund relating to Government workers and the Public and Private Sector Fund relating to workers in the public and private enterprises, the self-employed, casual workers and Egyptians working abroad.

There are six different social insurance schemes for different groups of the employed.

---

8 Poverty, Employment and Policy-Making in Egypt…op. cit.

9 See www.sfdegypt.org;


11”At present, a unified draft law of social insurance systems is being prepared by Ministry of Insurance and Social Affairs. Moreover, the Ministry seeks to amend some provision on unemployment and early retirement system”, Book Year 2002, State Information Service, www.sis.gov.eg;
Most of them are administered by the National Social Insurance Organisation (NSIO), but the coverage of risks insured and the generosity of the benefits granted varies greatly:

<table>
<thead>
<tr>
<th>Eligible categories</th>
<th>Insurance Scheme</th>
<th>Financing mechanism</th>
<th>Coverage of risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Permanent employees of the State, public and private sectors.</td>
<td>Enrol with the GSIS.</td>
<td>Financed by contributions from the employee and the employer.</td>
<td>Free health care, HIO, sickness and maternity pay, pension insurance, unemployment benefits.</td>
</tr>
<tr>
<td>2) Members of some of the professional associations and employees of foreign and some large Egyptian companies, who may opt out of the GSIS.</td>
<td>Preferential group insurance contracts with private insurers.</td>
<td>Contribution rates no higher than those of the general social insurance system.</td>
<td>Higher pension, better medical treatment.</td>
</tr>
<tr>
<td>3) Egyptian migrant workers abroad, employers and the formal sector self-employed.</td>
<td>Two separate contributory pension insurance schemes have been built up for these groups.</td>
<td>Slightly better pension/contribution ratio than the general scheme.</td>
<td>These schemes neither provide health, maternity or unemployment benefits.</td>
</tr>
<tr>
<td>4) Some employers and high-ranking employees.</td>
<td>Conclude individual insurance contracts with private companies.</td>
<td>Very expansive premium.</td>
<td>Higher pension entitlements and better medical treatment.</td>
</tr>
<tr>
<td>5) The entire working population not covered by any other social insurance scheme including (casual and informal sector workers).</td>
<td>Has to enrol with the Comprehensive Social Security System.</td>
<td>Contributions are deducted by the purchase of an LE one stamp each month from one of the NSIO’s local offices.</td>
<td>The system provides for LE 63 per month flat rate old-age, invalidity and survivors pensions only.</td>
</tr>
<tr>
<td>6) Army and the top bureaucracy.</td>
<td>Collective Social Security Systems, administered by some of the ministries and financed through general taxes.</td>
<td>Non-contributory scheme, outside the NSIO’s responsibility.</td>
<td>It is protected against all kinds of social risks.</td>
</tr>
</tbody>
</table>

---

3 - The Egyptian health system

The Egyptian health system is one of the world’s most complex. It has virtually all of the problems characterizing health systems in former socialist countries, while at the same time possessing few of the virtues and most of the problems of open-ended, US type systems. In order to overcome these problems, the GOE, with the assistance from three principal donors: the United States Agency for International Development (USAID), the World Bank, and the European Community, initiated in 1997 an ambitious 10-15 year reform process that aims to provide high quality, cost-effective solutions for Egypt’s health care needs. This reform process has so far covered only three pilot Governorates (Alexandria, Menoufia and Suhag,) with the aim of developing sufficient experience and knowledge to introduce the reform nation-wide, it is now being extended to other two Governorates (Quena and Suez).

In light of the above currently in Egypt we have two different health care delivery systems operating at once depending on the Governorate one refers to. It is worth thus analyzing the health system prior to the reform and its main problems before starting to illustrate the new health system that is being introduced.

3.1 - Institutional setting

The health care delivery system in Egypt is highly pluralistic and diverse. According to the Egyptian constitution, every individual is entitled to free health care services at government facilities.

The institutional framework for the health care system is represented by the government, public sector, and private sector.

a) Government Providers
- Ministry of Health and Population
The MoHP is responsible for overall health policy formulation in the country. It is also the executing or implementing agency of all health policies and legislation.
The MoPH has a large central administrative body and local offices at each governorate and district level.

14 Ibidem
At the central level, the MoHP is responsible for policy-making, planning and monitoring its activities. The same functions for each governorate are done under the General Health Directorate. Again, within each governorate the functions are further decentralized to the district level. Policy-making and planning capacities are limited, particularly at governorate and district levels. Although there is a potential for decentralization of MoHP role at the governorate level or even further at the district level, the system remains highly centralized.

The MoPH is responsible for drug policies and licensing, and all health related activities.

The MoHP has the largest network of primary, secondary and tertiary services in Egypt.

At all levels of administration, the MoHP has three main sectors, namely preventive, curative and population.

- Preventive provides public health services, individual preventative care, communicable disease control, and primary health care.
- The curative sector is responsible for all curative services provided at all levels of care (primary, secondary and tertiary). It runs the most extensive network of inpatient services in the country.
- The population sector is responsible for overall population policies and co-ordination of activities of other government ministries and institutions working in population related issues including, for example, environment, population distribution, etc.

The MoHP also runs rural hospitals, district hospitals, general hospitals and a number of specialized hospitals such as the fever hospitals. These hospitals provide the bulk of inpatient treatment to the Egyptian population.

- Ministry of Higher Education
The Ministry of Higher Education (MoHE) is responsible for the under and post-graduate university education. Currently there are sixteen medical schools and university hospitals in the country. They charge a fee for service or for a small margin of profit to maintain the running of their hospitals, all of them are in urban areas. University hospitals provide tertiary level of curative services.

- Ministry of Insurance and Social Affairs
The Ministry of Insurance and Social Affairs is responsible for supervising NGOs, based on Law 32 for Non Government Organizations (NGO). Hence, any NGO providing health care is under the supervision of MISA. However, MoHP is responsible for ensuring that they provide the services within acceptable technical standards. NGO development has been closely regulated in Egypt.
b) Public Sector Providers
Public sector providers include those organizations that are financed and monitored by a governmental ministry e.g. MoHP or Ministry of Finance but they exercise autonomy in their management and structure and their financing is from extra-budgetary sources. Public sector services include the Health Insurance Organization (HIO) and the Curative Care Organization (CCO), teaching hospitals and hospitals affiliated to other ministries or public sector firms. The HIO is the Egypt social health insurance organization. CCO is an autonomous public sector provider of health care. The CCOs are government-owned entities run like privately owned not-for-profit firms. Each of the three CCOs (Cairo, Alexandria, Port Said) is autonomous. They provide only curative services including both inpatient and outpatient services.

c) Private Health Care Providers
The private sector includes both the private-for-profit or private not-for-profit providers such as NGO clinics. Private providers offer mainly curative services and some preventive services such as childhood immunizations, family planning, and antenatal care.
NGO clinics are not very widespread in Egypt. They include clinics associated with mosques and religious institutions.

3.2 – Sources of health care financing

The Ministry of Finance is the government’s financing agency that provides financial resources to MoHP, MoE (university hospitals), other ministries, and extra budgetary funds to the Health Insurance Organization (HIO) and the Curative Care Organization (CCO).
But the greatest share of financial resource comes from direct private household spending, as is shown below.

<table>
<thead>
<tr>
<th>Source of Finance</th>
<th>Percent of Total Health Revenues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Households</td>
<td>51</td>
</tr>
<tr>
<td>Ministry of Finance</td>
<td>35</td>
</tr>
<tr>
<td>Social insurance contributions</td>
<td>6</td>
</tr>
<tr>
<td>Firms</td>
<td>5</td>
</tr>
<tr>
<td>Foreign donors</td>
<td>3</td>
</tr>
</tbody>
</table>

It should be also noted that MoPH receives only 19% of total health expenditures, which influence its power in decision-making. On the other hand, expenditure on pharmaceuticals represents the single largest item on health spending. It is worth noting that nearly all of the pharmaceutical spending is accounted for by direct household out-of-pocket expenditure.

<table>
<thead>
<tr>
<th>User of Funds</th>
<th>Percent of Total Health Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacies</td>
<td>36</td>
</tr>
<tr>
<td>Ministry of Health services</td>
<td>19</td>
</tr>
<tr>
<td>Private providers</td>
<td>18</td>
</tr>
<tr>
<td>University and teaching hospitals</td>
<td>10</td>
</tr>
<tr>
<td>Health Insurance Organisation sevices</td>
<td>8</td>
</tr>
<tr>
<td>Other private</td>
<td>5</td>
</tr>
<tr>
<td>Other public</td>
<td>3</td>
</tr>
<tr>
<td>Non-governmental organisation</td>
<td>1</td>
</tr>
</tbody>
</table>

4 - The major structural problems of the Egyptian health system

The system described above suffers from several structural problems and deficits17:

- **Health outcomes** are problematic and worse than the lower middle income (LMI) average this is illustrated by high national rates for child and maternal mortality (see conclusions pag…);
- There are significant equity problems in access to services, by both income and geographic grouping.
- Sector organization and management are fragmented, resulting in uncoordinated decision-making and pervasive inefficiencies which preclude effective risk pooling and efficiency in service delivery.
- Sector financing is also fragmented, with responsibilities shared but not coordinated among the HIO, the MoHP, the MISA, other Government Agencies and private services. There is inequity of financing: the 56% of spending which is private is mainly out-of-pocket expenses disproportionately made by lower income individuals.
- The delivery system is characterized by substantial excess capacity, under-use of sub-par quality facilities, and substantial inefficiency. Egypt has more beds per capita than other comparable income countries and a hospital occupancy rate under 50%. Unlike physical capacity, quality needs to

---

16 ibidem
be increased. Lack of basic equipment, supplies and drugs in MoHP primary facilities means that, despite impressive physical access, effective access is limited.

- Spending and consumption of pharmaceuticals are as much as 50% higher than in other LMI countries, and use is frequently excessive and inappropriate. While Egypt has 1.6 physicians per thousand population, 3-4 times the number in other comparable income countries, there is a shortage of primary care physicians relative to the number of specialists.

5 - The health sector reform program

The overall reform is thus designed to deal with the system's major underlying structural problems. The reform strategy encompasses change in many aspects of Egypt's health care system, including expansion and reform of health insurance, new strategies for health care delivery, and organizational reform. In general, the reforms propose the shifting of the role of the MoHP and HIO away from direct service provision towards a role of financier and regulator. The reforms attempt to define a vision for the shape of Egypt's health sector as well as a path through which health services delivery and financing becomes a much broader and richer partnership that involves not only the MoHP, but also private and social insurance institutions, and private and parastatal health care providers.

The reform falls into six main categories as follows18:

- Reform the MoHP that will be responsible for the delivery of preventive and primary care services and that will finance a package of secondary and tertiary services delivered by either private or parastatal health care delivery institutions.
- Rationalize the role of the MoHP in financing curative care by decreasing the proportion of the government’s budget going to curative care and increasing the resources available for preventive and primary health care.
- Reform the MoPH personnel policy including ending guaranteed employment for all medical school graduates, reducing the overall number of personnel, redistributing personnel based on needs, and

providing incentives to MoHP personnel to practice underserved and remote areas.

- Develop the MoHP capacity for national health needs assessment, sectoral strategic planning, and policy development. This includes upgrading the national health information system to allow for improved planning and policy decision making and prioritizing allocation of MoHP resources based on needs using health status indicators.
- Develop the MoHP role in regulation; accreditation; quality assurance, including developing national health standards of practice and health facility accreditation; and establishing policies of licensing and continued medical education for physicians.
- Reform the HIO, creating a new health insurance purchasing agency (the Family Health Fund) that will be no longer be involved in the direct provision of services but will act as a single national health insurance fund with universal coverage that will administer funds through contracts with service delivery sites.

5.1 The Family Health Model

Given the longer-term nature of many of these changes and pressing health problems of today, the strategy proposes phasing in universal coverage through a basic package of primary care services as a sensible first step. Thus the first phase of the reform begins with a new primary health care strategy.

The reform aims to introduce a new system of family based primary health care, named Family Health Model, the first level of care people receive when they have a health problem.

Meanwhile the bulk of curative care services will continue to be provided through MoHP, HIO, and CCO.

a) Universal Access to Basic Benefits Package (primary care level)

A basic benefits package was designed, placing special emphasis on services for vulnerable and underserved groups, especially women and children. The basic benefits package includes three groups of services selected on the basis of priority problems and cost-effectiveness of interventions: Maternal health care services, Child health services, Adult and all age group services.

b) Organization of Providers

To achieve the above goals, the Egyptian health system is being restructured according to a “Family health model.”. The purpose of reform is to provide all the basic care interventions at the primary care level, and to improve referral care. Accordingly, as part of the
“family health model,” the MoHP and other public primary care facilities up through the district level were reorganized and consolidated into Family Health Units (FHUs), Family Health Centers (FHCs), and District Hospitals. FHUs provide basic preventive and curative outpatient services, including family planning services and health education services. The Family health team, includes social workers, laboratory technicians, pharmacists, nurses, and doctors and in addition a new category of medical specialist, the “Family Practitioner”. This medical specialist has been created to lead the service of the future. It will become the gatekeeper for the system and will be responsible for a roster of patients.

Family Health Centers (FHCs) provide 24-hour service on referral from the doctors at the FHUs. FHCs provide basic preventive and curative outpatient services, as well as basic inpatient services.

District hospitals provide specialist care, including basic outpatient curative services as well as basic inpatient services. Staffing at district hospitals includes specialists and an anaesthetist.

Families rather than individuals will be registered with specific doctors and facilities in their home neighbourhood. Families may choose their general practitioner. In time, it is expected that that at least 80% of care will be provided by the general practitioner, with no necessity for referral.

Under this system, the population will be receiving far more primary and preventive care than they had been previously. Furthermore, integration at the point of service delivery will greatly enhance the efficiency of the delivery of essential services.

c) The Family Health Fund
The basic package of priority services will be financed through a single insurance purchasing agency (the Family Health Fund). The FHF will combine government resources that already exist but will be redirected from curative into primary care, and individual contributions. Out-of-pocket payments previously made in a haphazard way will now be diverted into a more formal structure, namely a standard co-payment, and very likely an annual enrolment fee. There will be a safety net provision that will qualify a family for a subsidy via a means test, to be developed. Thus, the Family Health Fund blends three streams of financing: MoHP funds, HIO funds, and individual co-pays and other out-of-pocket payments for private care and for pharmaceuticals.

The Family Health Fund will be constituted as a separate fund within the MoPH. The principle of fund management for this pilot period is to keep fiduciary and operational responsibility for the Fund specific to the Governorates, and policy oversight at the national level.

The FHF will act as a “purchaser” of services from the MoPH, HIO, private clinics and NGOs providing they meet the strict service quality standards laid down by the programme. Quality standards include the condition of clinic
buildings, and the knowledge, skills and attitudes of the staff. A Facility Accreditation System will be developed to monitor quality of services and influence the behaviour and functions of health care providers in a way to ensure compliance with quality standards. The idea is to use accreditation as the basis for contracting with the FHF. Thus only facilities that achieve an optimum level of quality will be allowed to contract with the FHF. This is a key factor in initiating competition across facilities/sectors including the private and NGO sectors in a competitive provider market accreditation mechanisms.

Physicians in FHUs are exclusively contracted to the Family Health Fund, and are paid directly by the Fund. The group as a whole is paid incentive payments for quality and a user fee retention; the practice is disciplined with penalties for over-referrals and over-prescription of drugs. In addition, care is monitored against basic indicators of quality, and efficiency, such as referral rates, patient wait times, number of patients served, and number of prescriptions. These new provider payment mechanisms will encourage providers to contain costs, improve quality, treat low-income patients and work in under-served areas.

6 – The state of on-going reform

The Health Sector Reform Programme has successfully piloted and implemented a new, family oriented model of primary care in Alexandria, Menoufia and Suhag. To date, 104 Family Health Units have been accredited by the Quality Improvement Department. These include units belonging to the MoPH, the HIO, NGOs and universities. The Health Sector Reform Programme is now preparing units for accreditation in Qena and Suez, and will soon expand to Menoufia and Kafr El Sheikh. Family Health Funds are operating successfully, purchasing defined services for the non-insured from the 104 accredited units in Alexandria, Menoufia and Suhag. The Family Health Funds have adopted a strategic institutional development plan and will expand its operations to the new Health Sector Reform Programme governorates, and to purchasing hospital services in 2004.

19 For an analytical description of the first phase of the reform see: Health Reform in Egypt: Reproductive Health and Health Sector Reform, Susan Harmeling, 1999, www.hsph.harvard.edu
Conclusions

Even with an overall decrease in the incidence of poverty (the percentage of poor households has decreased from 35% to 20.1% from 1990 to 2000), the situation in Egypt still reflects uneven development. According to the Egypt HDR 2003, 13,153,000 people still live below the poverty line, there are serious rural-urban disparities as well as a worrying poverty situation faced by Upper Egypt in both rural and urban areas. Thus, despite the considerable progress made, there is more to be done to ease poverty in the country.

The government safety net programs could indeed be more efficient in combating poverty; to do so they should improve targeting. Targeting problems affects the Subsidy on bread that is provided to all the Egyptians regardless of their poverty status but also the cash transfers from the MISA since the poor received only 13.9% of all Sadat pensions and 16.1% of all social security benefits21.

With regard to the Social Insurance System, one should note that the pensions are extremely unequally distributed, with the non-poor representing 83% of the population receiving almost 97% of government pensions. This is not surprising as most of the poor do not work in the regulated sector hence are not covered by any type of social insurance schemes. Only 40% of the working population (the permanent employees) are insured against work-related injuries and diseases, and no more than 16% are entitled to unemployment benefits22. It is hoped that the unified draft law of social insurance systems that is being prepared by MISA will bring about some positive changes in this respect.

As far as the Health System is concerned, the ambitious reform that is being implemented has the potential to tackle the serious problems that still affect Egypt, specifically the high infant mortality (39.1 deaths per 1,000 live births) and the high maternal mortality (60.7 per 100,000 live births)23, but it is too early to assess the effects of this reform that represents a real revolution in the way primary health care is delivered in Egypt.

21 Arab Republic of Egypt Poverty Reduction.....op.cit
22 Ibidem
REFERENCES: