

American University in Cairo

## AUC Knowledge Fountain

---

Archived Theses and Dissertations

---

November 2021

### The right to health: a case study on Hepatitis C in Egypt

Dina Iskander  
AUC

Follow this and additional works at: [https://fount.aucegypt.edu/retro\\_etds](https://fount.aucegypt.edu/retro_etds)



Part of the [Human Rights Law Commons](#)

---

#### Recommended Citation

##### APA Citation

Iskander, D. (2021). *The right to health: a case study on Hepatitis C in Egypt* [Thesis, the American University in Cairo]. AUC Knowledge Fountain.

[https://fount.aucegypt.edu/retro\\_etds/2492](https://fount.aucegypt.edu/retro_etds/2492)

##### MLA Citation

Iskander, Dina. *The right to health: a case study on Hepatitis C in Egypt*. 2021. American University in Cairo, Thesis. *AUC Knowledge Fountain*.

[https://fount.aucegypt.edu/retro\\_etds/2492](https://fount.aucegypt.edu/retro_etds/2492)

This Thesis is brought to you for free and open access by AUC Knowledge Fountain. It has been accepted for inclusion in Archived Theses and Dissertations by an authorized administrator of AUC Knowledge Fountain. For more information, please contact [fountadmin@aucegypt.edu](mailto:fountadmin@aucegypt.edu).

**The American University in Cairo**

**School of Global Affairs and Public Policy**

**THE RIGHT TO HEALTH:  
A CASE STUDY ON HEPATITIS C IN EGYPT**

**A Thesis Submitted to the**

**Department of Law**

**In partial fulfillment of the requirements for the degree of  
Master of Arts in International Human Rights Law**

**By**

**Dina Iskander**

**December 2013**

The American University in Cairo  
School of Global Affairs and Public Policy

THE RIGHT TO HEALTH: CASE STUDY ON HEPATITIS C IN EGYPT

A Thesis Submitted by

*Dina Magdi Ramzi Iskander*

To the Department of Law

December 2013

In partial fulfillment of the requirements for the degree of  
Master of Arts in International Human Rights Law  
Has been approved by the committee composed of

Professor Hani Sayed  
Thesis Supervisor  
American University in Cairo  
Date \_\_\_\_\_

Professor Alaa Ghannam  
Thesis First Reader  
American University in Cairo  
Date \_\_\_\_\_

Professor Thomas Skouteris  
Thesis Second Reader  
American University in Cairo  
Date \_\_\_\_\_

Professor Thomas Skouteris  
Law Department Chair  
American University in Cairo  
Date \_\_\_\_\_

Professor Laila El Baradei  
Acting Dean of GAPP  
Date \_\_\_\_\_

## DEDICATION

I dedicate this thesis to you, my beloved life companion, Amir.

I, also, dedicate this thesis to you, our soon expected daughter, praying for your healthiness and wellbeing; and aspiring that you grow up in an Egypt where your rights are respected, protected and fulfilled.

## ACKNOWLEDGMENTS

I would like to attribute a special Thank You to the National Liver Institute in Cairo for giving me permission to conduct my research within its facilities; and for giving me access to interview management staff, health practitioners and patients.

I would also like to acknowledge the work of the Right to Health Program at the Egyptian Initiative for Personal Rights, on which I have heavily depended in writing my thesis.

The American University in Cairo  
School of Global Affairs and Public Policy  
Department of Law

## THE RIGHT TO HEALTH: CASE STUDY ON HEPATITIS C IN EGYPT

Dina Iskander

Supervised by Professor Hani El Sayed

### ABSTRACT

Egypt ranks number one worldwide in terms of Hepatitis C (HCV) prevalence; 14 percent of its 80 million large population is infected by the disease. This research examines state actions and inactions with regards to the right to health of already infected patients; and other people, living in Egypt, at risk of getting infected. In doing so, the researcher analyzed relevant state policies; conducted interviews with patients, medical practitioners associated with HCV and leading health policy experts.

The research finds efforts of the state to be beneficial to a few at the expense of the many; and establishes its failure to decrease HCV prevalence and to protect non-infected Egyptians. Adopting a rights' based approach, the research ascertains Egypt's violation of its constitutional as well as international obligations with regards to infected as well as non-infected people living in Egypt.

The paper establishes that HCV is but a reflection of a broader dysfunction of the Egyptian health system; and proposes the adoption of a holistic approach of universal health coverage in addressing the right to health in Egypt. It goes further to suggest the instigation of a court proceeding, as an advocacy tool to trigger advancements towards the direction of universal health coverage.

## TABLE OF CONTENT

I.	Introduction .....	1
II.	HCV within the Egyptian health system .....	3
	A. HCV and the role of the state.....	3
	1. Historical background: How HCV was transmitted.....	3
	2. Current Status quo.....	4
	B. Background on the Egyptian Health System .....	6
	1. Health Expenditure in Egypt.....	6
	2. Key Players in the Area of HCV Care and Treatment .....	8
	a) Health Insurance Organization.....	9
	b) Program for Treatment at the Expense of the State.....	11
	c) Pharmaceutical Sector .....	13
III.	HCV in Egypt and the Right to Health.....	19
	A. What the State did about HCV: National Strategy to Combat Viral Hepatitis 19	
	1. Comparing HIO and PTES treatment packages.....	20
	2. Implementation of the Strategy 2008-2012.....	21
	B. What Constitutes a Violation of the Right to Health .....	23
	C. If the State Violated the Right to Health.....	24
	1. Right to Health of Patients already Infected by HCV <b>Error! Bookmark not defined.</b>	
	a) Nondiscrimination Principle.....	25
	i. Policy discrimination.....	25
	ii. Practice discrimination.....	28
	b) Use of Resources: Full Realization of the Right to Health .....	30
	c) Obligation to Protect: Egyptians at Risk of Getting Infected.....	32
IV.	Way forward .....	37
	A. HCV-specific Intervention Strategies .....	37
	1. Prioritization of Prevention .....	37
	a) Treatment as Prevention .....	<b>Error! Bookmark not defined.</b>
	b) Expanding Prevention Schemes .....	40
	2. Combating HCV: Global Concern .....	41
	B. Health Sector Reform .....	44
	1. Universal Health Coverage .....	46
	a) Adjudication of the Right to Health .....	47
	b) Supreme Constitutional Court on the Right to Health.....	51
V.	Conclusion .....	54

## I. Introduction

While poverty causes disease, disease causes poverty. According to Thomas Jefferson, “if people let governments decide what foods they eat and what medicines they take; their bodies will soon be in as sorry a state as the souls who live under tyranny.”<sup>1</sup> At a time where the decision-making structures, particularly in developing countries, favor essentially the richer at the price of the poorer, the rights’ based approach offers a slim way out to break the brutal cycle of poverty and disease. The International Covenant on Economic and Social Rights (ICESCR),<sup>2</sup> General Comment 14 on the right to health, together with the recognition of the right to health in the Egyptian constitutions (1971 and 2012) lay a solid ground for the principle of state responsibility towards people’s health in Egypt, which it needs to be accountable for.

While the right to health was already recognized in 1966, there still needs to be a mind shift for governments and people to see health as a right for everyone, rather than a mere service that the government provides at its discretion. Despite international legal recognition of the right to health, former United Nations Secretary General, Kofi Anan indicates “it is my aspiration that health finally will be seen not as a blessing to be wished for, but as a human right to be fought for.”<sup>3</sup>

With at least 14.7% of its population infected by Hepatitis C (HCV),<sup>4</sup> Egypt ranks number one in terms of prevalence, internationally. While there are numerous epidemiological researches on HCV in Egypt, very few researches have been conducted from a social science perspective to scrutinize what HCV infection actually means to people’s lives. Also, while the government is said to have taken particular steps in the area of HCV, little research has been done to assess its efficacy from public health or health policy perspective; and even less so, from a rights’ based perspective.

---

<sup>1</sup>Thomas Jefferson, former President of the United States of America (1743-1826), President of the United States of America between 1801 and 1809.

<sup>2</sup>International Covenant on Economic, Social and Cultural Rights [*hereinafter*: ICESCR], G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, *entered into force* Jan. 3, 1976, *available at* [http://www.unhchr.ch/html/menu3/b/a\\_cescr.htm](http://www.unhchr.ch/html/menu3/b/a_cescr.htm)

<sup>3</sup>Kofi Annan (1938-) Ghanian Diplomat, 7th UN Secretary-General.

<sup>4</sup>FATIMA EL-ZANATY & ANN WAY, DEMOGRAPHIC AND HEALTH SURVEY OF EGYPT 2008, 255, Cairo, Egypt: Ministry of Health, El-Zanaty and Associates, and Macro International(2009), *available at* <http://www.measuredhs.com/pubs/pdf/FR220/FR220.pdf>

Civil society, including academics, has a responsibility to promote a rights' based perspective to the right to health, which at this stage, requires much more research and advocacy work, in Egypt.

The thesis at hand aims at looking at the health sector in Egypt from a right to health perspective. Acknowledging the challenge to judge a state's general compliance with the right to health; and seeing targeted governmental efforts taken in reaction to the gravity of the disease, HCV was chosen as the lens, through which Egypt's health sector will be examined. Besides examination of Egypt's compliance with its obligations with regards to the right to health, this research aspires at coming up with suggestions for the purpose of enhancing the enjoyment of the right to health in Egypt.

First chapter looks at HCV within the Egyptian health system. The chapter covers efforts taken by the Egyptian state in its approach to the problematic of HCV, shedding the light on the most important players within the health system that shape state policy towards HCV. Second chapter focuses on the issue of the right to health; and what it means in the Egyptian context; and examines the extent to which the Egyptian state is in compliance with its international obligations with regards to the right to health. In doing so, the chapter proposes an understanding to the right to health, relying on scholarly and judicial interpretation of the right to health. The final chapter proposes steps to be taken by the state as well as by health activists for the purpose of fulfilling the right to health of people in Egypt. The chapter recommends HCV-particular steps to be taken; these would involve a role for the international community. Also, seeing HCV problematic as a reflection of the downsides of the Egyptian health system, the chapter recommends a more holistic approach for the way forward.

## II. HCV within the Egyptian Health System

### A. HCV and the Role of the State

#### 1. Historical Background: How HCV was Transmitted

Egypt's health system strived to combat schistosomiasis, which has been historically considered the biggest public health problem in Egypt; and which has been considered the biggest contributor to liver diseases in Egypt.<sup>5</sup> It is only in 1918 that treatment for the disease was discovered. Having the world greatest schistosomiasis problem, Egypt started using the newly discovered treatment extensively in its health facilities; and in the beginning of the 1950s up until the 1980s, the Egyptian Ministry of Health and Population (MOHP) conducted huge community-wide therapy campaigns to treat the country's biggest health threat.

Numerous studies confirm a causal relation between this treatment campaign and the unprecedented spread of HCV, on the basis of poor sterilization techniques.<sup>6</sup> According to a Lancet published research study, Egypt's mass campaigns of parenteral anti-schistosomal therapy (PAT) may represent “the world's largest” clinical transmission of blood-borne infection.<sup>7</sup>

Between 1964 and 1982, averages of 250,000 patients were injected with a standard regimen of 12 to 16 injections per patient; amounting to over 2 million injections per year. Between 1966 and 1969, when the treatment campaign was at its peak, annual doses given reached over 3 million. The procedure was happening as follows, according to a report by the World Health Organization (WHO) in 1964:

The skilful doctor began injecting at 9:20 am and completed 504 injections of men, women and children by 10:10 am. Allowing for a 10-min rest, the time taken for each injection was thus just under 5 seconds ... This remarkable performance is being repeated at various tempos all over Egypt... The used syringe is placed in an ‘out’ tray, from which it is taken by the nurse, washed thoroughly and boiled for a minute or two.<sup>8</sup>

---

<sup>5</sup> A Struthers PhD. *From Schistosomiasis to Hepatitis C: the Spread of HCV in Egypt*, 3 MED J THERAPEUT AFRICA 213, 213(2007), available at <http://mjota.org/images/SpreadofHCVEgypt.pdf>

<sup>6</sup> Frank et al., *The role of parenteral antischistosomal therapy in the spread of hepatitis C virus in Egypt*, 355 THE LANCET 887, 887 (2000), available at <http://www.ncbi.nlm.nih.gov/pubmed/10752705>

<sup>7</sup>*Id.* 6, at 1.

<sup>8</sup>BRIAN G. MAEGRAIGHT, TREATMENT OF BILHARZIASIS IN EGYPT, World Health Organization(1964), as quoted in WAHID DOSS ET AL, EGYPTIAN NATIONAL CONTROL STRATEGY FOR VIRAL HEPATITIS 2008-2012, 6, Ministry

It is worth noting that the recommended regimen of treatment for a patient of 12 to 16 injections was initially prescribed over the course of 2 to 3 weeks; in the 1960s for patients' convenience, this schedule was modified to a weekly injection spread out over 9 to 16 weeks. This change of schedule has, according to the Medical Journal of Therapeutics, permitted an even greater transmission of HCV, since it expanded the HCV infection pool within the health facilities. In the absence of efficient sterilization techniques, schistosomiasis patients already co-infected with HCV were transmitters of the infection to other schistosomiasis patients. In addition, those who got infected within their early weeks of PAT; soon became transmitters of HCV themselves. Therefore, at some point, and over a period of nearly thirty years, whereby millions of people were subject to PAT injections, both previously infected and newly infected patients were capable of passing the disease to others who happened to be treated with the same glass syringes or needles. Since the clinical symptoms of HCV are not detectable in 80% of the HCV infection cases, it is understandable that the spread of HCV was not detected at the early stages. It is only in the early 1980s that these cycles of infections stopped, when an oral treatment of schistosomiasis replaced the parenteral one.<sup>9</sup>

## 2. Current Status quo

Today, with at least 14.7% of its population infected by HCV,<sup>10</sup> Egypt ranks number one in terms of prevalence, internationally. HCV, according to the WHO “can lead to chronic liver disease, liver cirrhosis, and liver cancer, and thus also causes a significant rise in mortality rates.”<sup>11</sup>

In 2006, estimates of HCV prevalence ranged from 11% to 14% (an average of 12.6% of the 74.2 million population), with 8 to 10 million people having HCV antibodies and 5 to 7 million (of the 72.8 million population)<sup>12</sup> having chronic infections.<sup>13</sup> It is worth noting,

---

of Health and Population (2008), available at <http://www.pasteur.fr/ip/resource/filecenter/document/01s-00002i-03t/nsp-10-april-2008-final.pdf>

<sup>9</sup>A Struthers PhD, *supra* note 5, at 213.

<sup>10</sup>FATIMA AL-ZINATI& ANN WAY, *supra* note 4, at 255.

<sup>11</sup>World Health Organization [*hereinafter*: WHO]. *Global alert and response (GAR): Hepatitis C*, available at <http://www.who.int/csr/disease/hepatitis/whocdscsrlyo2003/en/index4.html>

<sup>12</sup> Central Agency for Public Mobilization and Statistics (CAPMAS). *Population in Censuses By Sex & Sex Ratio ( 1882-2006)*, available at <http://www.capmas.gov.eg/pdf/egypt/pop/6.pdf>

though, that persons infected with HCV may not necessarily develop liver cirrhosis, liver cancer or other serious health problems. According to a study quoted in the National Strategy to Combat Viral Hepatitis (National Strategy), approximately 10% of chronically infected HCV patients will need to be treated by a 48-week regimen of a combination of *peg-interferon* and *ribivirin*. On the other hand, at least 5-10% of HCV patients suffer decompensated liver cirrhosis. In addition, around 12% of HCV patients (900,000 in the year 2008) suffer advanced liver disease; 10% of those are eligible for liver transplant.<sup>14</sup>

As per 2006 figures, on average, 600,000 people were in need of treatment. This figure is expected to have reached at least 666,000 by 2011, considering population growth (which had reached 81.12 million in 2011, according to the Central Agency for Public Mobilization and Statistics, CAPMAS).<sup>15</sup> "This figure [...] will rise in the future as more chronically infected patients move towards advanced stages of the disease and necessitate treatment as well", according to the same study.<sup>16</sup>

Incidence rates are estimated at 2.4 per 1,000, an average of 165,000 new incidents per year, according to the Centers for Disease Control and Prevention (CDC);<sup>17</sup> transmissions are mainly associated with "inadequate infection control in medical and dental care procedures."<sup>18</sup> This figure suggests 16,500 new patients in need of the 48-week regimen treatment every year. According to a presentation by Wahid Doss, director of the National Liver Institute, new infections continue to occur as a result of "unscreened blood transfusions, unsafe injections, exposed health care workers, [dialysis for renal patients],

---

<sup>13</sup>WAHID DOSS ET AL, EGYPTIAN NATIONAL CONTROL STRATEGY FOR VIRAL HEPATITIS 2008-2012, 6, Ministry of Health and Population (2008), available at <http://www.pasteur.fr/ip/resource/filecenter/document/01s-00002i-03t/nsp-10-april-2008-final.pdf>

<sup>14</sup>*Id.* 13 at 36.

<sup>15</sup> Hussein A Sayed, *Egypt's Population Policies And Organizational Framework*, 1, available at [http://www.aucegypt.edu/research/src/Documents/population\\_conf/Studies\\_new/Paper%20Hussein%20Egypt%20s%20Population%20Policies%20And%20Organizational%20Framework.pdf](http://www.aucegypt.edu/research/src/Documents/population_conf/Studies_new/Paper%20Hussein%20Egypt%20s%20Population%20Policies%20And%20Organizational%20Framework.pdf)

<sup>16</sup>WAHID DOSS ET AL, *supra* note 13, at 33.

<sup>17</sup>Centers for Disease Control and Prevention [*hereinafter*: CDC], *Progress toward Prevention and Control of Hepatitis C Virus Infection — Egypt, 2001–2012*, 61 (29) MMWR, 545, 546 (2012).

<sup>18</sup>*Id.*

failure to sterilize medical equipment, dental and ‘traditional medicine’ and injection drug users.”<sup>19</sup>

## **B. Background on the Egyptian Health System**

Since HCV is essentially a part of the Egyptian health system, it is important to get a good overview of the sector, in general. The section below will shed the light on the issue of health expenditure; key players in the health sector, particularly the Health Insurance Organization (HIO) and the Program for the Treatment on the Expense of the State (PTES); and finally, the pharmaceutical sector.

### **1. Health Expenditure in Egypt**

Public spending on health is a small proportion of total health expenditure (THE); it has been declining from 33% in 1994-1995 to 24.8% in 2008-2009, denoting an under-spending by the government of Egypt.<sup>20</sup> Health allocations from government's spending constitute 4.75% of Egypt's public budget. In 2008-2009, Egypt's total expenditure on health constituted nearly 6% of its gross domestic product (GDP). In that regards, it is important to note that household spending constituted 71.8% of THE; while the Ministry of Finance share was 24.8%. The rest was covered by public and private firms, as well as donor assistance.<sup>21</sup>

While the share of the public budget of the THE is already small, “most of it is spent on salaries”, despite very low scales for health professionals, according to Abdel Fattah El Gebaly, director of Economic Studies at the Ahram Institute for Strategic and Political Studies.<sup>22</sup>

---

<sup>19</sup>WAHID DOSS, THE EGYPTIAN HCV NATIONAL CONTROL PROGRAM: OUTCOMES AND CHALLENGES, 7, (May 2011) *available at* [http://www.egfrhep.com/data/Eg\\_National\\_HCV\\_WDoss\\_Cairo\\_2011.pdf](http://www.egfrhep.com/data/Eg_National_HCV_WDoss_Cairo_2011.pdf)

<sup>20</sup>EGYPTIAN HEALTH SYSTEM PROFILE 2011 [*hereinafter*: EHSP], 65, EGYPT MINISTRY OF HEALTH AND POPULATION (MOHP) and REGIONAL HEALTH SYSTEM OBSERVATORY – EMRO (2011), *available at* <http://hinfo.humaninfo.ro/gsd/healthtechdocs/documents/s17293e/s17293e.pdf>

<sup>21</sup>*Id.*, at 63.

<sup>22</sup>EGYPTIAN INITIATIVE FOR PERSONAL RIGHTS (*hereinafter*: EIPR). INTRODUCTION TO HEALTH EXPENDITURE IN EGYPT 14 (Egyptian Initiative for Personal Rights) (Dec 2009), *available at* <http://eipr.org/en/report/2009/12/12/305/309>

The remaining public funds are spent on a fragmented fashion. While the MOHP is mandated with ensuring appropriate health care and services to people in Egypt; and to craft the necessary policies as appropriate; according to the latest figures of 2008-2009, it only manages 16.5% of the total health expenditure (THE).<sup>23</sup> This figure is a significant decline from nearly 23%, its share in expenditure in 2007-2008. On the other hand, the Health Insurance Organization (HIO), the Ministry of Higher Education (MoHE) and the Ministry of Defense (MoD) play a significant role in the Egyptian health system managing 8%, 6% and 1% respectively.

The most alarming factor is the high household spending that has actually been increasing from 51% to nearly 72% over the past 16 years.<sup>24</sup> Furthermore, the share of spending on pharmaceuticals is excessively high, constituting 33.1% of THE; private clinics absorb 38.4%; and private hospitals 8.2% of the THE. This is in contrast to 3.5% share of the THE for the MOHP hospitals, 2.9% share for the MOHP health centers and 1.9% share for the HIO hospitals.

Since 72% of THE is catered for by households, it is important to zoom-in into which entities actually benefit of such huge out-of-pocket expenditure. Households spend 42.6% of their expenditure on pharmaceuticals in private pharmacies, 29.3% in private clinics and 14.3% on private and NGO hospitals and clinics.

While spending of MOHP hospitals and health spending is only that little, it is important to remember that it is these institutions that have the biggest network and the best reach to the Egyptian rural and urban population. MOHP owns alone more than 70,000 hospital beds all over the country, which constitute 57% of the national hospital bed capacity, according to the MOHP in 1997.<sup>25</sup> In contrast, the HIO owns and manages 5%, the MoHE 14%;<sup>26</sup> and the private sector owns and manages around 11% of the national hospital bed capacity.<sup>27</sup>

---

<sup>23</sup>EHSP, *supra note* 20, at 63.

<sup>24</sup>*Id.*, at 64.

<sup>25</sup>SAMIR FAYYAD.*AL-SIHA FI MISR: AL WAD' AL HAALI WASINARIOHAT AL MUSTAQBALHATTA 'AM 2020*(Health in Egypt: Current Status and Future Scenarios till the Year 2020) Cairo: Al-Maktaba Al-Akadimiya, (2002).

<sup>26</sup>*Id.*, at 284.

<sup>27</sup>*Id.*, at 307.

Figures mentioned above illustrate a number of challenges facing the health sector in Egypt, which negatively influence the health service provision; and ultimately, the right to health. First, out-of-pocket spending is unreasonably high. This is a multidimensional problem. While out-of-pocket spending impoverishes an already poor population, it is often irrational, which is reflected, for example, on the excessive spending on pharmaceuticals. Ultimately, and particularly since the primary beneficiaries are members of the private sector rather than the public sector, such spending does not feed into any possible reform or development on the macro level. Second, the health sector is very fragmented, and many players are involved and often they would have conflicting interests, making any planning or reform even harder to undertake. Third, the health sector is unjust, showing clear indicators of inequity in the health service provision. In an already inefficient system, having the Egyptian government contributing with only one quarter of the THE, it comes as no surprise that health facilities (MOHP hospitals and health centers) which shall cover nearly two-thirds of the population (57% of hospital bed capacity) end up with less than 7% (2.9% and 3.5%) of the total health expenditure.

## **2.Key Players in the Area of HCV Care and Treatment**

Faced by the world highest prevalence of HCV; and cognizant of the fragmentation of the system and – to say the least – the difficulties patients will find to work through the system to get any kind of care and treatment, the MOHP mandated a Committee in 2006 to draw a national strategy with the purpose of combating viral hepatitis. In 2008, the committee drew a strategy that was seen to be implemented over a period of 4 years; and to be renewed thereafter.

Prior to looking further into the strategy and its implementation, it is important to zoom-in into two main public instruments that have and still are playing a major role in providing care and treatment to patients of HCV; the Health Insurance Organization (HIO); and the Program for Treatment at the Expense of the State (PTES).

### a) Health Insurance Organization

The Health Insurance Organization (HIO) was established by presidential decree 1209 for the year 1964; and is known for Law 79 for the year 1975 for the workers of the formal sector.<sup>28</sup> It aimed at covering Egyptian workers of the public sector and the private sector; as well as retired and widows within a period of 10 years. Employees of the private sector however, "may choose to opt out of the HIO insurance scheme by paying a fee", according to the National Control Strategy for Viral Hepatitis (National Strategy).<sup>29</sup> In 1992, health insurance scheme started to cover school students, by virtue of law 99 for the year 1992. Finally, in 1997, ministerial decree 380 was passed to give optional coverage for children below the age of school. While the inclusion of school students is seen as a good model that that has enriched the HIO while expanding coverage to an additional 5 million of the population, coverage of children below the age of school proved particularly costly on the HIO; particularly, since no additional budget allocation was allocated thereto.<sup>30</sup> According to leading health policy expert, Samir Fayyad, "speedy expansion in the coverage of a wide package of health services, weak funding caused by little beneficiaries' contribution and weak financial support to the HIO; together with a weak management of the HIO have led to an accumulated deficit over the years."<sup>31</sup> It is worth noting that coverage of children under the age of school became mandatory in 2012 as per law 86 for the year 2012. This step has been applauded by health policy experts, who consider that a non-voluntary insurance mechanism is more sustainable and does more justice to the poor.<sup>32</sup>

Despite the sought goal of covering all Egyptians, since the passing of Law 79 for the year 1975, to date, insurance coverage remains incomplete and fragmented in terms of span of coverage and services provided.<sup>33</sup> According to an MOHP spokesperson, "sixty per cent of

---

<sup>28</sup>EIPR. PROGRAM FOR THE TREATMENT AT THE EXPENSE OF THE STATE: ITS INCEPTION AND ITS OUTGROWTH, 5, Egyptian Initiative for Personal Rights, (Dec 2010), *available (only in Arabic) at* <http://www.eipr.org/report/2010/12/16/1035>

<sup>29</sup>WAHID DOSS ET AL, *supra* note 13 at 11.

<sup>30</sup>Alaa Ghannam, Right to health program director, Egyptian Initiative for Personal Rights, interview, 21 November 2013.

<sup>31</sup>SAMIR FAYYAD, *supra* note 25 at 278.

<sup>32</sup>Alaa Ghannam, *supra* note 30.

<sup>33</sup>Hossam Bahgat and Rebecca Wright, *Access to Medicines in Egypt: A Human Rights Approach to IP, Trade and Health*, in ACCESS TO KNOWLEDGE IN EGYPT: NEW RESEARCH ON INTELLECTUAL PROPERTY, INNOVATION AND DEVELOPMENT 56, 91 (N. Rizk and L. Shaver eds., 2009).

those who are insured are not satisfied with current healthcare services”. He further describes the HIO system as “inefficient” and “in dire need for a new and more competent alternative system.”<sup>34</sup> According to the Egypt National Health Accounts (2008-09), public health insurance, as managed by the HIO covers 57% of the Egyptian people;<sup>35</sup> and overall, 77% are covered by some form of insurance.<sup>36</sup>

Over the past few years, drafts for a new health insurance law have been and are still being presented to the different Houses of Parliament, however, to date, no law has passed. Failure of moving forward has always been attributed to the absence of major conditions that shall precede the passing of the law, such as a vision for the sources of funding to support wider strata of beneficiaries.

Considering the importance and the critical nature of a health insurance law, it is not expected that the law will be passed soon, midst an instable political context, like the one Egypt is undergoing since 25 January 2011. Yet, it is still important to get an idea on the possible law in the pipeline that is seeking to introduce improvements in the health insurance system in Egypt.

Last draft presented to the people's assembly in 2012 proposes mandatory coverage of all Egyptians, which was applauded by the rights' groups as a good step in the direction of social solidarity. According to Alaa Ghannam, director of the right to health program at the Egyptian Initiative for Personal Rights (EIPR) on the mentioned draft law, financing of the health insurance system will follow a so-called cross-subsidy system that would enable the rich to cover for the poor's expenses. Also the draft law has been applauded for attributing all emergency service provision, including epidemics, natural disasters and ambulance services to the MOHP, with a view of ensuring an equitable system.<sup>37</sup>

Yet, rights' groups were critical of other aspects of the law, too. The proposed draft does not clarify what health services it covers. Rights groups are wary that such ambiguity on the

---

<sup>34</sup>Reem Leila, *Ensuring Health Insurance*, Al Ahram Weekly Online, (19-25 July 2007), available at <http://weekly.ahram.org.eg/2007/854/eg8.htm>

<sup>35</sup>SHARON NAKHIMOVSKY ET AL., EGYPT NATIONAL HEALTH ACCOUNTS: 2008-2009, 20, United States Agency for International Development and Egypt Ministry of Health and Population (Nov 2011).

<sup>36</sup>FATIMA EL-ZANATY & ANN WAY, *supra* note 4, at 62.

<sup>37</sup>Alaa Ghannam, *Pro's and Con's on the Health Insurance Draft Law*, blog, Egyptian Initiative for Personal Rights (EIPR), (May 2012).

services may result in a reduction of the services package that was guaranteed under Law 79 for the year 1975. Furthermore, the draft law imposes excessively high co-payments that are viewed as impeding access to the health services; hence, violating Egyptian people right to health.<sup>38</sup>

#### **b) Program for Treatment at the Expense of the State**

In 1975, recognizing that the health insurance law does not cover all Egyptians who may not be able to cover for their treatment cost, the President issued decree number 691, with the effect of law. This law is still valid today, though some amendments have been introduced to it in 1986. According to the law, patients unable to cover for their treatment costs could apply to the relevant authorities, requesting that the Program for Treatment at the Expense of the State (PTES) would cover their treatment costs. Patients must meet certain criteria to qualify for such service; their health condition shall fit into the priorities set by the relevant authorities and it shall be proved that they are incapable of meeting the costs of treatment.<sup>39</sup>

Following the presidential decree, the Minister of Health issued a decree, establishing the Specialized Medical Councils (SMCs) which are mandated to look into the requests of patients. The following diseases have been prioritized by the PTES; heart diseases, cancers, renal failure, accidents and critical cases. In 1998, Ministerial Decree 4248 further added HCV as one of the priority diseases for the PTES.<sup>40</sup> Decisions on cases to be covered by the PTES are made in Cairo. Patients generally have to go to Cairo apply for the PTES, which naturally tends to be costly and time-consuming. Though some governorates have SMCs, these councils have to send patients' papers to the center for a decision to be made there.<sup>41</sup>

While the PTES gets its budget from the MOHP, it is important to bear in mind that it has a separate budget-line; and that hence, it cannot be utilized by the MOHP for other

---

<sup>38</sup>*Id.*

<sup>39</sup>EIPR, *supra* note 28, at 6.

<sup>40</sup>*Id.*, at 10.

<sup>41</sup>*Id.*, at 9.

purposes.<sup>42</sup> PTES enjoys a considerable share of the health budget. In 2009, it was allocated 2.2 billion out of a total of 12.1 billion Egyptian Pounds.<sup>43</sup> In 2013, the PTES budget has reached 3 billion.<sup>44</sup>

Yet, while the PTES started off as an exceptional outlet to the most vulnerable, “(b)y the mid-1990s, (P)TES had evolved [...] into a full-grown institutional fixture that allowed the government to cheaply fund individual treatments instead of meeting the full financial demands of comprehensive health care for what are now 80 million Egyptians.”<sup>45</sup> In her thesis in public policy, evaluating the PTES, Rasha Radwan indicates that “(t)he officials admit that the funds are not sufficient to fully cover all the cases. The patients on the other hand complain that having to supplement the allocated amount in order to cover the expenses is a financial burden they cannot bear.”<sup>46</sup>

Paradoxically, however, while the law's *raison d'être* is primarily to provide health care and treatment for the most vulnerable Egyptians who are unable to cover their treatment costs, law 691 does not exclude insured patients from the PTES service scheme, which has naturally led to cases of system abuse. According to EIPR, particularly in cases of treatment abroad, beneficiaries of the HIO would get their treatment covered by the HIO, while applying in parallel to the PTES to get financial coverage for the patient's accompanying travel costs.<sup>47</sup> Fortunately, however, the National Strategy has been attentive to this loophole; and indicated in its strategy that patients need to be uninsured to qualify for the PTES.<sup>48</sup>

By 2010, for a multitude of reasons, the PTES started to face enormous problems, mainly because of its accumulated debts and its inability to reimburse, which had ultimately driven particularly the university hospitals to refuse treating patients with decisions from the PTES. The media started reporting about alleged cases of corruption in the PTES and legal

---

<sup>42</sup>RASHA SADEK RADWAN, AN ASSESSMENT OF THE EGYPTIAN GOVERNMENT ALTERNATIVE HEALTHCARE COVERAGE SYSTEM: TREATMENT AT THE EXPENSE OF STATE, 55, American University in Cairo, Dept. of Public Policy and Administration, thesis, (2013), available at <https://dar.aucegypt.edu/handle/10526/3566>

<sup>43</sup>EIPR, *supra* note 28, at 14.

<sup>44</sup>RASHA SADEK RADWAN, *supra* note 42.

<sup>45</sup> Matt Bradley. *Egyptian medical system is mired in patronage*, The National, 17 May 2010, available at <http://www.thenational.ae/news/world/africa/egyptian-medical-system-is-mired-in-patronage>

<sup>46</sup>RASHA SADEK RADWAN, *supra* note 42, at 61.

<sup>47</sup>EIPR, *supra* note 28, at 12.

<sup>48</sup> WAHID DOSS ET AL, *supra* note 13, at 18.

proceedings implicating members of the Parliament and of the Cabinet were initiated. For example, according to Egypt's Central Auditing Organization, investigations have revealed decisions granted by the relevant authorities for operations that included facelift, weight-loss and tooth-whitening.<sup>49</sup>

Besides administrative corruption; according to the Egyptian Initiative for Personal Rights, near bankruptcy of the PTES was also attributed to low budgetary allocations to health and inefficient use of funds. In a project appraisal by the World Bank in 2009, the PTES was criticized for its unclear mandate and its ineffective use of funds.

The PTES fund is meant to protect Egyptians from the financial impact of illnesses requiring particularly costly treatment. Currently, however, the PTES is primarily reimbursing for routine care, as there are no clear criteria for awarding coverage and financing. Less than 30 % of funding is utilized for truly catastrophic coverage according to an MOHP-funded study in late 2006. Instead, it is often used to access far better quality facilities by those who can gain access through political or other means. In 2005, the PTES overspent its budget by 100 % and to date, it has accumulated a US\$0.5 billion deficit. Furthermore, the PTES program spends 40 % more per year than the HIO while only covering around 1.7 million people compared with the 38 million covered by the HIO.<sup>50</sup>

Ultimately, funds allocated to the PTES are not dispensed – at least – efficiently. A cost-benefit-analysis for the spending of these funds is required. It is quite possible that putting the investment in the mainstream HIO could be more useful to the people and more cost-effective to the health service sector than continuing to invest in a system that is more or less a parallel structure to the HIO, yet steered primarily by discretionary decision-making.

### **c) Pharmaceutical Sector**

Pharmaceutical manufacturing in Egypt dates back to 1939 when the firm Misr for Pharmaceutical Industries was first established. The sector has been developing slowly till the year 1962, when the Egyptian government created an independent institution mandated to

---

<sup>49</sup>EIPR, *supra* note 28, at 16.

<sup>50</sup>WORLD BANK, PROJECT APPRAISAL DOCUMENT ON A PROPOSED LOAN IN THE AMOUNT OF \$75 MILLION TO THE ARAB REPUBLIC OF EGYPT FOR A HEALTH INSURANCE SYSTEMS DEVELOPMENT PROJECT, 3, World Bank, Human Development Program, Middle East and North Africa, 23 November 2009, *available at* [http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2009/12/02/000334955\\_20091202012207/Rendered/PDF/509220PAD0P080101Official0Use0Only1.pdf](http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2009/12/02/000334955_20091202012207/Rendered/PDF/509220PAD0P080101Official0Use0Only1.pdf)

reorganize the sector and merge small- and medium-sized companies. While during the early 1960s domestic production covered only 10% of local consumption,<sup>51</sup> by the year 1975, domestic production covered nearly 85% of the local needs.<sup>52</sup> Such speedy expansion of the sector was made possible thanks to a strong political will to ensure accessible prices of medicines. The government controlled as well as encouraged domestic production, while domestic manufacturers entered into joint ventures between significant foreign companies such as Hoechst, Pfizer and Swiss Pharma.<sup>53</sup>

Yet, already by the year 1974, with the introduction of the “open-door-policy” under President Anwar El Sadat, local production became under threat. The government started to approve fully-foreign companies which mainly relied on importation rather than domestic production.<sup>54</sup> On the other hand, domestic producers started to produce under-license drugs of multinational cooperations (MNCs,) rather than manufacturing their own generic drugs. In the absence of a strategic vision for the pharmaceutical sector, according to Ahmed Dessouki, specialist in the pharmaceutical policies in Egypt, state control of the industry “disappeared.”<sup>55</sup>

Today, domestic pharmaceutical market continues to be heavily reliant on MNCs. While 70% of domestic needs are manufactured within public sector facilities or manufacturing facilities owned by local companies, much of the drugs produced therein are sublicensed from MNCs.<sup>56</sup> According to the Business Monitor International (BMI), MNCs are responsible for the production of 65% of Egyptian pharmaceutical domestic needs.<sup>57</sup>

---

<sup>51</sup> AHMED DESSOUKI, ANALYZING THE PUBLIC PHARMACEUTICAL POLICIES IN EGYPT, 66, Cairo University Department of Economics and Political Science, 2008.

<sup>52</sup> RAOUF HAMED, MUSTAKBALSENA'ET EL DAWA'A FI MISR (Future of the Pharmaceutical Sector in Egypt), 10, Academic Bookshop, 1997.

<sup>53</sup> *Id.*

<sup>54</sup> *Id.*

<sup>55</sup> AHMED DESSOUKI, *supra* note 51, at 68-69.

<sup>56</sup> AHMED DESSOUKI, *supra* note 51, at 278.

<sup>57</sup> BUSINESS MONITOR INTERNATIONAL, EGYPT PHARMACEUTICALS AND HEALTHCARE REPORT: Q4 QUARTERLY REPORT, 29, Business Monitor International, (2009).

While in theory 86 per cent of the domestic needs are produced locally whether by local firms or by international plants operated by MNCs,<sup>58</sup> the local value added, in drugs manufactured by either multinationals or local private–public producers, does not exceed 35%.<sup>59</sup> With at least 85% of the raw material imported, including the active pharmaceutical ingredients (API), many experts in the field would agree that Egypt does not have ‘a real pharmaceutical industry’, but rather an industry of assemblage of imported chemical compounds.<sup>60</sup> MNCs, on the other hand, specialize in the provision of newly introduced drugs—usually the top-of-the-line, most expensive drugs, which are also likely to be patented.<sup>61</sup>

MNCs in Egypt claim R&D expenditure of around 15 per cent of sales value; yet, according to Mahfouz Kassem, Research and Development Consultant for the Medical Union pharmaceuticals, in reality, they undertake very little research in Egypt.<sup>62</sup> This obstructs opportunities for the transfer of technology and exchange of know-how that the local pharmaceutical sector relied on in earlier periods, exposing it to threats of becoming out-dated and ultimately unimportant.

Today, despite substantial influence of MNCs, retail prices in Egypt are considered among the lowest in the Middle East.<sup>63</sup> This is mainly due to the ‘cost-plus’ compulsory pricing that the MOHP is imposing on all drugs registered in Egypt.<sup>64</sup> This level of low prices may not be sustainable due to immense pressure by the MNCs to increase prices either through excessive

---

<sup>58</sup>MOHAMED ABDEL FADIL, *EL AZMA EL RAHINA LE SOUQ EL DAWAA FI MISR* (The Current Crisis of the Pharmaceutical Market in Egypt) 34, Information and Decision Making Support Centre (IDSC), Council of Ministers Egypt, (Sep 2003).

<sup>59</sup>SAMIR FAYYAD, *supra* note 25 at 242.

<sup>60</sup>AHMED DESSOUKI, *supra* note 51, at 73.

<sup>61</sup>ADE AND DEVELOPMENT OPTIONS UNLIMITED, *EGYPT’S PHARMACEUTICAL SECTOR SURVIVAL AND DEVELOPMENT STRATEGY REPORT INCORPORATING RESULTS AND CONCLUSIONS OF REVIEW ACTIVITY*, 102, Egypt: Industrial Modernization Centre and Industrial Modernization Programme (Dec 2004), *available at* [http://www.imc-egypt.org/studies/FullReport/Pharmaceutical%20Development%20Strategy\\_EN.pdf](http://www.imc-egypt.org/studies/FullReport/Pharmaceutical%20Development%20Strategy_EN.pdf).

<sup>62</sup>Mahfouz Kassem, Research and Development Consultant, Medical Union Pharmaceuticals, interview, January 2011.

<sup>63</sup>AMERICAN CHAMBER OF COMMERCE, *PHARMACEUTICAL SECTOR DEVELOPMENTS IN EGYPT*, 23, AmCham Egypt Business Studies and Analysis Centre, 2006.

<sup>64</sup>Cost-plus system is a system "in which the Pricing Committee fixes the retail price of the drugs based largely on manufacturing expenses, which vary according to the drug in question. Other inputs, such as taxes and profit mark-ups, are often calculated as a fixed percentage mark-up on all drugs within a given category" according to Bahgat and Wright 2010, 97.

IPR enforcement<sup>65</sup> or through the removal of the ‘cost-plus’ compulsory pricing system. With the quick technological developments in the pharmaceutical sector, particularly in the area of biotechnology; and, considering government's heavy dependence on the MNCs, such pressures may be all the more effective.

While the state had seen pharmaceuticals as a strategic sector that requires a national plan in the early 1960s, over time, the state had deviated from such vision and moved to see its role as narrow as ensuring relative affordability of medicines. The case of HCV medicines is of particular interest in that regard.

MNCs Roche and Scherring-Plough had monopoly over the production of the recommended HCV medicine interferon and later on the more advanced version thereof the long lasting interferon "peg-interferon" for years. Approximately, according to WHO estimates in 2003, 170 million patients with chronic HCV infection all over the world were reliant on these medicines.<sup>66</sup> Egypt, having the biggest world population of HCV-positive patient was therefore an important client to these Pharma MNCs.

In the year 2004, Mina Pharm, a local private producer in Egypt, registered its product Reiferon Retard (RR), which is the *biosimilar* version of the biologic product peg-interferon. Unlike common pharmaceuticals that are essentially developed using chemical compounds, biologic products are developed within living cells. Since no two living organisms are essentially identical, the methods of producing biologic products are complex and require advanced technology. It is therefore that the imitation of biologic drugs is particularly complicated. Experts in the field are hence keen to call imitations of biologic drugs ‘biosimilar’ while calling imitations of chemical compounds ‘generic’, implying identicalness.<sup>67</sup>

While RR was the result of a joint-project with a German scientific research office, namely, Rhein-Biotech; upon its registration, RR has endured a huge media anti-campaign, doubting

---

<sup>65</sup>Hossam Bahgat and Rebecca Wright, *supra* note 33, at 88.

<sup>66</sup>WHO, *supra* note 11.

<sup>67</sup>Filiz Hincal, *An Introduction To Safety Issues In Biosimilars/Follow-On Biopharmaceuticals*, 7 J Med CBR 1, 1 (Sep 2009), available at [http://www.jmedcbr.org/issue0701/Hincal/Hincal\\_09\\_09.html](http://www.jmedcbr.org/issue0701/Hincal/Hincal_09_09.html)

its quality, safety and efficacy (QSE), compared to its multinational-produced counterpart.<sup>68</sup> The MOHP, despite being the responsible regulatory authority of pharmaceuticals in Egypt has remained silent. In September 2010, however, due to strong media pressure, the MOHP finally commissioned an independent committee to decide on the QSE of RR over the period of 18 months.<sup>69</sup> Conversely, while it did not freeze its registration authorization, it excluded RR from its National Treatment Reference Centers (NTRCs), which in due course solely depends on the products of the MNCs. Interestingly however; RR was and still is solely dispensed to the HIO patients. To date, findings of the committee have not been published and the situation remains as is.

While Roche's and Scherring-Plough's products were priced at 1400 Egyptian Pounds per ampoule in 2002 and 2003 respectively, when they were first registered, Mina Pharm's product, registered in 2004 was priced at only 370 Egyptian Pounds per ampoule.<sup>70</sup> Thanks to competition, as well as excessive bargaining by the National Committee, by the year 2011, MNCs agreed to provide their product at the price of 250 Egyptian Pounds to the NTRCs, operating under the National Strategy, while Mina Pharm agreed to provide its product at a price of 220 Egyptian Pounds to the HIO.<sup>71</sup>

It is obvious that competition pushes prices down. Public health research proves a positive relationship between the production of generic and biosimilar production on the one hand and increased access to medicines, on the other hand. For example, according to a WHO report, "80% of all donor-funded annual purchase volumes of antiretroviral medicines (ARVs) in 2008 were supplied by Indian [generic] manufacturers."<sup>72</sup> While it remains to be unclear whether the level of QSE of RR is identical to that of the MNCs, it is regrettable that the state

---

<sup>68</sup>Tariq Amin, Mohamed Talat al-Hiwari and Darin Ferghali, *Interferon: a new war between Egyptian drug companies...in health it is survival of the cheapest*, Al-Masry al-Youm newspaper, 19 October 2009, available at <http://www.almasry-alyoum.com/article2.aspx?ArticleID=229849&IssueID=1563>

<sup>69</sup>Khaled Abu Bakr, *Ministry of Health forms an impartial Committee to end the Interferon War*, Al-Shorouk newspaper, 22 September 2010, available at <http://www.shorouknews.com/ContentData.aspx?id=299886>

<sup>70</sup>EGYPTIAN INITIATIVE FOR PERSONAL RIGHTS, *THE EGYPTIAN INTERFERON: A SCIENTIFIC DEBATE AND NECESSARY REGULATIONS THAT NEED TO BE ISSUED*, briefing note, blog (Aug 2011), available at <http://eipr.org/en/report/2011/08/21/1258>

<sup>71</sup>*Id.*

<sup>72</sup>PADMASHREE GEHL SAMPATH ET AL., *LOCAL PRODUCTION FOR ACCESS TO MEDICAL PRODUCTS: DEVELOPING A FRAMEWORK TO IMPROVE PUBLIC HEALTH*, 5, World Health Organization, United Nations Conference on Trade and Development (UNCTAD) and the International Centre for Trade and Sustainable Development, Geneva (2011), available at [http://www.who.int/phi/publications/Local\\_Production\\_Policy\\_Framework.pdf](http://www.who.int/phi/publications/Local_Production_Policy_Framework.pdf)

which has initially supported the registration of the RR has then refrained from advocating its QSE; and more so, has sent an implicit message that MNC products are naturally more reliable than local ones. It is even more regrettable that the issue of QSE of the RR has not been resolved yet, leaving patients of HIO feeling unsure about the medicines they are provided with. In the absence of coordinated government vision and plan of action for the pharmaceutical sector, the generic medicines industry would soon be under threat; and so would the health of Egyptians.

While Egyptian generic producers have not felt yet the impact of the implementation of the TRIPS Agreement, they tend to agree that this is likely to change in the near future.<sup>73</sup> According to a report commissioned by the Industrial Modernization Center (IMC) in Egypt, incapability of the local generic industry to keep up with the international technological developments, particularly in the area of biotechnology subjects it to long-term threat. The IMC report further condemns the "defensive economic policies" adopted by the Egyptian government for such threat.<sup>74</sup>

---

<sup>73</sup>Osama Rostom, Vice President of the Egyptian International Pharmaceutical Industries Company (EIPICO), interview, November 2010. And, Hala Adly, Public Relations Manager of Amoun, interview, December 2010.

<sup>74</sup>ADE AND DEVELOPMENT OPTIONS UNLIMITED, *supra* note 61, at 29.

### III. HCV in Egypt and the Right to Health

#### A. What the State did about HCV: National Strategy to Combat Viral Hepatitis

In 2006, considering the gravity of the HCV prevalence issue in Egypt, the MOHP established the National Committee for the Control of Viral Hepatitis (The Committee). The Committee included leading liver experts from inside as well as outside of Egypt, members of the MoHE, the WHO, a few UN agencies as well as other local and international stakeholders, with expertise on the issue. By April 2008, The Committee had developed a National Control Strategy for Viral Hepatitis covering the period of 2008-2012.

The strategy calls for effective surveillance of incidents and prevalence of HCV and HBV, prioritizes infection control in medical settings and sets guidelines for access to care and treatment for patients of HCV and HBV.<sup>75</sup> Only those patients who have relatively high likelihood to be cured can have access to treatment by *peg-interferon* and *ribivirin*, under the National Strategy NTRCs screen each patient, using “uniform inclusion and exclusion criteria” for eligibility for subsidized treatment. Only patients who do meet these criteria are admitted to the treatment course; and have the option to be treated under the Program for the Treatment on the Expense of the State (PTES).

Patients suffering from decompensated liver cirrhosis must receive a range of expensive treatment. On the other hand, patients suffering advanced liver diseases are sometimes eligible for liver transplants, which cost between 220,000 and 400,000 Egyptian Pounds, notwithstanding the difficulties of finding liver donors seeing that cadaveric transplants are not available in Egypt, yet. While these two categories make up an ample percentage of patients of HCV, their treatment is prioritized in the National Strategy. Yet, “fully meeting the needs of the Egyptian population with regards to advanced liver care is, unfortunately, not a financially feasible proposition, at least at the present date,” according to the National Strategy.<sup>76</sup> The strategy further sets concrete objectives to be achieved within the 4-year period. These objectives include, among others;

Track[ing] prevalence and incidence of HBV and HCV from year to year according to WHO-approved surveillance standards; reduc[tion of] the prevalence of chronic HBV

---

<sup>75</sup>WAHID DOSS ET AL, *supra* note 13, at ii.

<sup>76</sup>*Id.*, at 36.

and HCV infection in the 15-30 age group by 20% of 2008 levels by 2012; treat[ment of] 20% of persons needing treatment by 2012 under subsidized schemes (currently: 2% of the estimated 600,000 people needing treatment).<sup>77</sup>

In order to achieve these objectives, the strategy identifies four intervention mechanisms; namely, “1) surveillance & monitoring, 2) prevention, 3) patient management, and 4) research.”<sup>78</sup>

The current recommended regimen for the treatment of HCV is a combination of *pegylated interferon* and *ribavirin*. This regimen is now available to all patients treated in the NTRCs. Thanks to the committee's negotiations with the international drug companies; and to the entry of the local Mina Pharm-produced *pegylated interferon*, the 48-week HCV treatment regimen, purchased from Scherring-Plough and Roche costs the state approximately 25,000 LE (\$3580).

### **1. Comparing HIO and PTES Treatment Packages**

While non-insured patients are provided with nearly free treatment options under the PTES, HIO beneficiaries enjoy a larger package of health services. Similar to patients of the PTES, the HIO covers the treatment of patients eligible for the 48-week treatment regimen by *interferon* and *ribivirin*. According to the National Strategy, 41% of this category of patients in Egypt is covered by the HIO. Like other services it contracts, the HIO contracts the MOHP liver centers for the treatment of its HCV patients.<sup>79</sup>

Unlike the PTES, the HIO covers the costs of expensive treatment needed for patients with decompensated liver cirrhosis, entirely. This patient category varies between 5% and 10% of patients with HCV. Furthermore, patients in need of liver transplant receive a partial, yet insufficient, cost coverage from the HIO. While a liver transplant operation would cost 220,000 to 400,000 Egyptian Pounds, the HIO contributes with only 75,000. From time to

---

<sup>77</sup>WAHID DOSS ET AL, *supra* note 13, at ii and iii.

<sup>78</sup>*Id.*

<sup>79</sup>*Id.*, at 17.

time, uninsured patients pleading to the PTES could get a similar amount for a liver transplant operation.<sup>80</sup>

Patients shall undergo a series of tests, including a liver biopsy, to know whether they qualify for the 48-week treatment regimen, or not. Whether under the PTES or under the HIO, however, in general patients have to pay out-of-pocket costs related to the required monitoring and testing facilities.<sup>81</sup> In exceptional cases, when patients are not able to cover costs for their tests, they may apply for PTES to cover 50% of the tests' costs. However, such permissions may be delayed, due to the centralized nature of the decision-making, causing treatment delays. Since patient E,<sup>82</sup> 45 years old, was not able to pay for his liver biopsy himself, he applied for a permission from the PTES to get his biopsy partially covered. According to him, after the lapse of a whole year upon his request submission, he never heard back from the PTES. Patient F,<sup>83</sup> on the other hand, complained that despite the PTES' partial contribution to the tests' costs, he still has to borrow money from acquaintances to pay for the required weekly tests of 47 Egyptian pounds. Patient F is 44 years old and has three daughters; he does not have a full-time job, he is a day-laborer. Since the course of treatment is tiresome, patient F often cannot work and hence is neither able to cover for the rest of his treatment cost, nor to sustain his family. Patients indicate however, that they often get financial assistance from non-governmental charity organizations.

Despite imperfection, patients used to benefit from the partial coverage of the tests costs by the PTES. Recently, however, the national committee has decided against such subsidizations, meaning that patients have to pay such costs out of their own pockets.<sup>84</sup>

## **2. Implementation of the Strategy 2008-2012**

In an interview taken with Dr Khaled Kabil, director of the National Project in 2012, a maximum of 2000 new patients are admitted to the treatment scheme each month; i.e. 24,000

---

<sup>80</sup>*Id.*, at 43.

<sup>81</sup>*Id.*, at 12.

<sup>82</sup>Patient E, interview, November 2011, Transcript on file with the author.

<sup>83</sup>Patient F, interview, November 2011, Transcript on file with the author.

<sup>84</sup>Mohamed El Kassas, Assistant Director of Egypt National Program for Viral Hepatitis, interview, March 2012.

per year.<sup>85</sup> According to the Centers for Disease Control and Prevention (CDC), 190,000 patients have been provided with health service and treatment by the end of 2011.<sup>86</sup> This figure is said to have reached 240,000 in 2012, according to local newspaper, Al Ahram.<sup>87</sup>

This figure is remarkable, particularly since it exceeded the 20% treatment coverage the national strategy had aimed for. Furthermore, it is obvious that the national committee and its centers are efficiently delivering on their strategy, managing to keep a waiting list of the patients relatively short.<sup>88</sup> Yet, it is important to underscore that admittance to treatment does not mean cure of the disease; on average, only 60% of patients with genotype 4 admitted to treatment achieve sustained virologic response (SVR), which means that HCV antibodies become undetectable in the body. Genotype 4 is the predominant HCV type in Egypt.

Judging these figures from a public health perspective, the achievements are less impressive, though. Ultimately, over a period of 4 years, only 190,000 of an average of 10.2 million (12.6% of the 81.12 million, 2011) with HCV antibodies; and 6.8 million (8.4% of 81.12 million, 2011) patients with chronic HCV infections got admitted to the treatment scheme, bearing in mind that only 60% thereof would have achieved SVR, namely around 114,000. This is at a time where an estimate of 165,000 new incidents of HCV infection occurs every year.<sup>89</sup> This data suggests that the spread of the disease is more rapid than the state's response to it, subjecting an even bigger population to HCV infection on the long-run, rather than controlling its spread. According to the CDC, “the primary focus for hepatitis control in Egypt has been on care and treatment; these activities consume up to 20% of the entire MOHP budget.”<sup>90</sup> Furthermore, while the National Strategy was set to prioritize infection control, the CDC reiterates that the Egyptian government has increased its allocation to

---

<sup>85</sup>Khaled Kabil, Director of Egypt National Program for Viral Hepatitis, interview, March 2012.

<sup>86</sup>CDC, *supra* note 17, at 547.

<sup>87</sup>Ingy Deif, *Egypt launches world's largest Hepatitis C patient registry*, 22 Oct 2012, available at <http://english.ahram.org.eg/NewsContent/7/48/56134/Life--Style/Health/Egypt-launches-world%E2%80%99s-largest-Hepatitis-C-patient.aspx>

<sup>88</sup>Mohamed El Kassas, *supra* note 84.

<sup>89</sup>CDC, *supra* note 17, at 546.

<sup>90</sup>*Id.*, at 548.

infection control to reach \$800,000 in 2011; which amounts “only to 1% of government's expenditure” on HCV care and treatment.<sup>91</sup>

## **B. What Constitutes a Violation of the Right to Health**

The right to health is respectively recognized in article 25.1 of the Universal Declaration of Human Rights,<sup>92</sup> in article 12 of the International Covenant on Economic, Social and Cultural Rights and ultimately in national constitutions, including the 1971 and 2012 Egyptian Constitutions.

It is of particular interest to zoom-in into article 12 of the ICESCR. States parties to the ICESCR recognize “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”, requiring “steps to be taken by the States parties ... to achieve the full realization of this right.”<sup>93</sup> As per article 151 of the 1972 Constitution, the ICESCR became part of the domestic legal system when Egypt ratified the treaty in 1982.<sup>94</sup>

Like all human rights, the ICESCR imposes on states parties the “obligations to *respect*, *protect* and *fulfill*” the right to health. The United Nations General Comment 14 defines article 12 of the ICESCR and elaborates on states’ obligation in that regard. While it is not legally binding, it provides an insightful explanation of the right to health. States are required under paragraph 33 of General Comment 14 to refrain from obstructing the enjoyment of the right to health (*respect*) in any possible way, they are demanded to protect against any form of third parties interferences with the rights granted under article 12 (*protect*); and finally, to fulfill the right to health. States parties are under an obligation “to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health” (*fulfill*).<sup>95</sup>

---

<sup>91</sup>*Id.*

<sup>92</sup>Universal Declaration of Human Rights, G.A. res. 217A (III), U.N. Doc A/810 at 71 (1948).

<sup>93</sup>ICESCR, *supra* note 2, at art. 12.

<sup>94</sup>EGYPTIAN INITIATIVE FOR PERSONAL RIGHTS. RIGHT TO HEALTH: WHAT IT MEANS FOR PEOPLE LIVING IN EGYPT, Egyptian Initiative for Personal Rights (Apr 2010), *available at* <http://eipr.org/en/report/2010/05/09/848/868>

<sup>95</sup>Committee on Economic, Social and Cultural Rights [*hereinafter*: CESCR], General Comment No. 14: The Right to the Highest Attainable Standard of Health, E/C.12/2000/4, 11 August 2000.

Mindful of limitations of resources, unlike civil and political rights, economic and social rights do not have immediate effect; they are subject to the principle of “progressive realization”. States parties are required to fulfill the right to health, however within the limits of “the maximum of its available resources, with a view to *achieving progressively the full realization of the rights*”.<sup>96</sup> As a result of this principle, violations of economic and social rights are more difficult to adjudicate. Entitlements related to the right to health would differ from one country to the other, depending on its available resources; and hence, deprivation of access to healthcare for example may not always qualify as violation of the right to health.

Yet, besides recognizing limitation of resources, the ICESCR did indeed identify obligations with regards to the right to health that have “immediate effect”; General Comment 14 calls such obligations “core obligations”. The right to health shall be guaranteed without discrimination<sup>97</sup>. State parties need to take deliberate, concrete and targeted steps leading to the full realization to the right to health; and, it has “a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of article 12.”<sup>98</sup> Finally, states parties are required to ensure the satisfaction of a minimum set of requirements in relation to health-service provision, including reproductive health care, immunization and prevention, treatment and control of essential diseases.<sup>99</sup>

The section below looks into these core obligations and analyzes actions or inactions of the state, with a view of assessing whether Egypt is in violation of the right to health in the case of HCV.

### **C. If the State Violated the Right to Health**

Having been the main perpetrator of the massive HCV infection during the undertaking of the mass campaign of parenteral anti-schistosomal therapy (PAT) between 1964 and 1982, the state of Egypt has clearly violated its obligations to protect and to respect the right to health, then. This section, however, aims at examining whether the state continues to be in

---

<sup>96</sup>ICESCR, *supra* note 2, at art. 2.

<sup>97</sup>ICESCR, *supra* note 95, at para. 43(a).

<sup>98</sup>*Id.*, at 31.

<sup>99</sup>*Id.*, at 33-34.

violation to these obligations today. In that regard, this research not only seeks to examine the state's responsibility vis-à-vis the already infected; but rather, extends its examination to those Egyptians at risk of being infected.

## **1. Right to Health of Patients already Infected by HCV**

### **a) Nondiscrimination Principle**

Article 2 of the ICESCR stipulates that all economic and social rights “will be exercised without discrimination of any kind as to race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.”<sup>100</sup> General Comment 14 puts non-discrimination in accessibility of health related facilities, goods and services as the first core obligation that a state is mandated to immediately comply with.<sup>101</sup>

#### **i. Policy Discrimination**

States are under an obligation to refrain from undertaking policies that would enforce discriminatory practices.<sup>102</sup> Furthermore, they are also obligated to be aware of inherent social structures that essentially put segments of society in more vulnerable positions. Just as discrimination could be the cause for poverty, poverty could equally be the cause for discrimination. It is therefore necessary that a human rights approach to health takes “both nondiscrimination and affirmative action to eliminate historical inequities and patterns of discrimination in access to health services.”<sup>103</sup> States should be aware of such structures that essentially discriminate against the poor and should hence take the necessary measures to ensure they are provided with “equal and effective protection against discrimination.”<sup>104</sup> According to General Comment 14, “states have a special obligation to provide

---

<sup>100</sup> ICESCR, *supra* note 2, at art. 2.

<sup>101</sup> *Id.*, at 43(a).

<sup>102</sup> *Id.*, at 34.

<sup>103</sup> Audrey R. Chapman, *Conceptualizing the Right to Health: A Violations Approach*, 65 *Tenn. L. Rev.* 87, 102 (1997-1998).

<sup>104</sup> University of Minnesota, *Draft Guidelines: A Human Rights Approach to Poverty Reduction Strategies*, para. 57, 10 September 2002, available at <http://www1.umn.edu/humanrts/instreet/povertyreductionguidelines.html#preface>

those who do not have sufficient means with the necessary health insurance and health-care facilities.”<sup>105</sup>

According to the strategy, only those patients with a higher likelihood of being cured are entitled to treatment. From a human rights perspective, this approach violates the principle of nondiscrimination. According to General Comment 14, among others, the Covenant prohibits “any discrimination in access to health care on the grounds of (...) health status, (...) which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health.”<sup>106</sup>

In that regard, it is interesting to evoke the judgment of the Court of Appeal in New Zealand in the case of *Shortland v Northland Health Ltd*, 1 NZLR 433 (1998), where the Court had to assess a clinical decision to withdraw dialysis treatment. According to a paper presented at the Inter-Regional Conference on Human Rights and Judiciary Systems on the adjudication of the right to health,

The Court held that extent of the duty to provide the necessities of life must be assessed in the context of the intensive appraisal of the patient’s condition by the clinical team which had knowledge of his condition and his ability to benefit from dialysis. In so doing it recognized that judges were concerned with the lawfulness of the decision to discontinue dialysis and not with the likelihood of the effectiveness of the treatment.<sup>107</sup>

While the Court had finally decided in favor of the relevant health facility, considering its satisfaction with the clinical team's opinion that “cessation of the treatment was in [the patient's] best interest”<sup>108</sup>, its judgment rested upon the right to health of such patient.

This approach is not evident in the strategy of the National Committee; and it violates states' core obligation with regards to the right to health, as per Article 2(2) of the ICESCR.<sup>109</sup> In an interview conducted by the researcher in Aswan in 2011, patient A indicates that she had started the 48-week HCV regimen treatment, covered by the PTES. After 12 weeks of regular

---

<sup>105</sup>CESCR, *supra* note 95, at 19.

<sup>106</sup>*Id.*, at 18.

<sup>107</sup>Iain Byrne, *Inter-regional Conference on Human Rights and Judiciary Systems: Working Group VI on the Right to Health*, 20, (Sep 2006), available at <http://www.pijip-impact.org/wp-content/uploads/2012/03/TheRighttoHealth-IainByrne.pdf>

<sup>108</sup>*Id.*

<sup>109</sup>CESCR, *supra* note 95, at para. 30.

injections, Patient A was advised that her body is not responding positively to the treatment; and would hence not be granted the rest of the 48 injections. Yet, conversely, Patient A was advised “to continue the treatment on her own expense, if she wished.”<sup>110</sup> While it could well be that it was in Patient A's best interest to stop the treatment; this was not the reason that the medical facility was resorting to in deciding that the treatment needs to stop. On the contrary, benchmarks set by the National Strategy are determined by financial considerations related to likelihood of treatment, as opposed to rights considerations for everyone.

The implementation of the strategy is discriminatory on another level, too. Patients with the same health conditions have a bigger treatment package under the HIO than their fellow patients who may only qualify for the PTES. This is all the more worrisome considering the already discriminatory coverage of the HIO, which excludes workers of the informal sector, self-employed, farmers or rural residents.<sup>111</sup> With 40% of Egyptian labor-force working in the agricultural sector;<sup>112</sup> the HIO clearly discriminates against this category of Egyptians; and so does the National Strategy. While a government employee is entitled for a comprehensive course of treatment of liver cirrhosis under the HIO, a farmer is not.

Having the strategy reinforcing an already discriminatory in the health provision services would go against the principle of equality and non-discrimination. According to the Supreme Court of Canada, the equality provision “does require that the government should not be a further source of inequality”. In *Eldridge v British Columbia* 3 SCR 624 (1997), where deaf patients challenged the executive authority for failing to provide sign-language interpreters in the publicly funded health care services, the Court decided against the executive authority. The Court held that in providing general benefits, the government “should guarantee that disadvantaged members of society have the resources to take full advantage of these benefits”<sup>113</sup>.

---

<sup>110</sup>Patient A, interview, November 2011, Transcript on file with the author.

<sup>111</sup>EGYPTIAN INITIATIVE FOR PERSONAL RIGHTS (EIPR), RIGHT TO HEALTH: WHAT IT MEANS FOR PEOPLE LIVING IN EGYPT, Egyptian Initiative for Personal Rights (Apr 2010), available at <http://eipr.org/en/report/2010/05/05/813/814>

<sup>112</sup>Egypt Independent. February 2012, available at <http://www.egyptindependent.com/news/informal-economy-presents-challenges-also-opportunities>

<sup>113</sup>Iaine Byrne, *supra* note 107, at 19.

The strategy clearly discriminates against patients of worse health conditions; as well, it reinforces an already discriminatory system that excludes a selective population segment from health insurance, ultimately, leading to inequality in the provision of health services to patients of HCV. This goes against article 2 of the ICESCR, which has the effect of law under the Egyptian legal system, requires that rights shall be exercised “without discrimination”.

## **ii. Practice discrimination**

One of the typical forms of discrimination in the context of the right to health is discrimination on the basis of health status. Aware of this reality, General Comment 14 explicitly explains that denying particular individuals or groups of health services as a result of overt or implicit discrimination is a violation of respect of the right to health. Due to the contagious nature of HCV and owing to the weak infection control in medical settings, HCV positive patients are sometimes subjected to discrimination on the basis of their health condition.

In an interview with the author, Patient D, 54 years old described her subjection to discrimination. She was advised that she needs to undergo a gall bladder operation; so she went to the hospital accordingly on the set day; however, without getting operated on. Every day she would go back to the hospital while fasting, prepared for the operation with no progress. Finally she was told that she was HCV positive. The anesthetist asked her for some tests to make sure that her body would endure the drugs. She did; and was informed by the anesthetist that she had no problem in that respect. With the delay of the operation, Patient D started suffering blockage in the ureter and had to stay in hospital for four days, as a result. Yet, she was still not operated on; and finally, she was given medication by the doctor and was advised that she needs the operation no more. Patient D was worried about her health and was not sure about her health condition; whether it was true or not that she needed the operation no more.

Patient G,<sup>114</sup> 51 years old, on the other hand, had a similar experience with the health sector. Patient G had to get an operation in her finger. According to her, she was dismissed from the hospital and was told by the doctor that if she is HCV positive, she cannot do the operation. Ultimately, Patient G had to pay 100 Egyptian pounds to get the necessary equipment to make sure that other patients will not get infected; and was admitted to another public hospital where she was allowed to be operated on.

Denial on health care on the basis of health condition is an explicit violation of the right to health. In a landmark case *Bragdon v. Abbott*, U.S. LEXIS 4212 (1998), the Supreme Court of the United States of America decided that denial of dental treatment of an HIV positive woman constitutes a violation of the Americans with Disabilities Act (ADA).<sup>115</sup> The ADA is meant to protect disabled Americans from possible discrimination in public settings, including health facilities.<sup>116</sup> The Court refused the dentist argument, Mr Bragdon, who argued that treating an HIV-positive patient would constitute a ‘direct threat’ on his health and safety of the treating dentist;<sup>117</sup> it further elaborated that denying treatment of HIV positive patients would by no means limit the threat of infection on other individuals. In its decision the Court indicated that

The risk of HIV transmission is not avoided by discriminatory treatment of those who disclose their illness. Such policies are not only discriminatory, but also irrational because they do little to protect the dentist or other patients from infection. In fact (...) refusing to treat those with AIDS is dangerous because it may create a false sense of security, [causing dentists to not be as stringent in their use of universal precautions].<sup>118</sup>

Denying treatment of patients of HCV cannot be justified. The MOHP, having the mandate of supervision and oversight of all health facilities in Egypt is liable for such mistreatment of HCV patients. Besides stronger infection control that is urgently needed, medical personnel shall be better educated into medical ethics and rights-based approach to patients’ health.

---

<sup>114</sup>Patient G, interview, November 2011, Transcript on file with the author.

<sup>115</sup>Laura F. Rothstein, *Bragdon v. Abbott -- Supreme Court Decision Addresses Application of Americans with Disabilities Act to Individuals with HIV* (1998), available at <http://www.law.uh.edu/healthlaw/perspectives/Disabilities/980626Bragdon.html>

<sup>116</sup>*Id.*

<sup>117</sup>*Bragdon v. Abbott*, 1998 U.S. LEXIS 4212, 1-32 (1998), available at

[http://www.justice.gov/crt/foia/readingroom/frequent\\_requests/ada\\_settlements/ma/me1.txt](http://www.justice.gov/crt/foia/readingroom/frequent_requests/ada_settlements/ma/me1.txt)

<sup>118</sup>*Id.*, at 32.

### **b) Use of Resources: Full Realization of the Right to Health**

The ICESCR imposes on states parties the obligations to take necessary steps for the full realization of the right to health. A Tennessee Law Review article, adapted from a paper presented at the 1997 Maastricht Guidelines Workshop on Violations of Economic, Social and Cultural Rights, identifies the development of a detailed plan with specific goals on the progressive realization of the right to health care as a core obligation on states' parties. Absence of such a detailed plan would constitute a violation of the right to health.<sup>119</sup> While the ICESCR recognizes that states may differ significantly in the route that they pursue to achieve such full realization, depending on economic ability and disease prevention,<sup>120</sup> states parties need to move as expeditiously and effectively as possible in order to achieve such full realization.<sup>121</sup>

Since full realization of the right to health is subject to steps to be taken by states parties, subject to their available resources; it is necessary that resource allocation decisions are not taken on random bases but rather contribute to the “full realization of the right to health”. Interestingly, General Comment underscores that “insufficient expenditure or misallocation of public resources which results in the non-enjoyment of the right to health by individuals or groups” would qualify as violations of the obligation to fulfill the right to health.<sup>122</sup> Inappropriate allocation of funding, according to General Comment 14, may even amount to discriminatory measure taken by the state, favoring a few on the expense of the majority. For example, it clarifies that a state is applying the right to health on a discriminatory basis if it disproportionately invests in an expensive curative area which is naturally only accessible to a small fraction of the population, rather than investing in preventive and curative care that would benefit a bigger part of the population.<sup>123</sup>

In that regard, it is interesting to look into the judgment of the Constitutional Court of South Africa in the case of *Soobramoney v. Minister of Health*, 1 SA 765 CC (1997) [hereinafter *Soobramoney*] who suffered from chronic renal failure; and who was in need of renal dialysis

---

<sup>119</sup> Audrey R. Chapman, *supra* note 103, at 99.

<sup>120</sup> Benjamin Mason Meier and Larisa M. Mori, *The Highest Attainable Standard: Advancing a Collective Right to Public Health*, 37 Colum. Hum. Rts. L. Rev. 101, 116 (2005).

<sup>121</sup> CESCR, *supra* note 95, at para. 31.

<sup>122</sup> *Id.*, at 52.

<sup>123</sup> *Id.*, at 19.

to survive death. On appeal, the Court “accepted that rationing of resources is integral to health service delivery in the public sector;”<sup>124</sup> and found that the hospital’s standards were within “the bounds of reason;” and thus, failure to provide Soobramoney with renal dialysis did not violate his right to health.<sup>125</sup> In that regard, it is interesting to take a deeper look into the standard of “bounds of reason” that the Court has introduced as a justification for limiting the right to health.

In that regard, paragraph 19 of General Comment 14 elaborates on the principle of nondiscrimination in resource-allocation,

Inappropriate health resource allocation can lead to discrimination that may not be overt. For example, investments should not disproportionately favor expensive curative health services which are often accessible only to a small, privileged fraction of the population, rather than primary and preventive health care benefiting a far larger part of the population.<sup>126</sup>

The strategy of the National Committee and the evaluation of its enforcement till 2011 by CDC indicate that the level of HCV is not in decrease in Egypt. By the end of 2011, with 10.2 million people (12.6% of the 81.12 million, 2011) having HCV antibodies; and 6.8 million (8.4% of 81.12 million, 2011) patients having chronic HCV infections, only 190,000 patients were provided with health service and treatment by the end of 2011; and an average of 114,000 patients achieved negative SVR. Ultimately, only 2.8% of patients infected by chronic HCV were admitted to treatment; and only 1.67% of the patients infected by chronic HCV got treated; ultimately, benefiting of the National Strategy within a period of four years. On average, between 2008 and 2011, yearly, 47,500 patients were admitted to the treatment. Such treatment cost \$170,050,000 per annum (47,500 x \$3580 regimen cost per patient). According to the CDC, the Egyptian government's annual budget for HCV disease control and treatment is \$80 million; this figure covers 40% of the total costs of the program. Insurance companies together with patients paying out of their own pockets cover the remaining 60%. This means that the Egyptian government pays \$68,020,000 out of a total of

---

<sup>124</sup> International Network for Economic, Social and Cultural Rights [*hereinafter*: INESCR], *Soobramoney v. Minister of Health (Kwazulu-Natal): Case Summary* (27 Nov 1997), available at <http://www.escr-net.org/docs/i/673074>

<sup>125</sup> *Id.*

<sup>126</sup> CESCR, *supra* note 95, at para. 19.

an \$80,000,000 budget; namely 85% of its annual total budget for the admission of 2.8% of HCV patients in the treatment scheme; and the actual treatment of 1.67% thereof. This figure is to be compared to the 1% it allocates to infection control (\$800,000 in 2011), according to the CDC, “bearing in mind that 165,000 new infections occur annually;” and that “the most common exposure to HCV infection in Egypt is from formal and informal medical and dental care.”<sup>127</sup>

On the other hand, experience with investing in infection control has proved successful in decreasing HCV infection levels. Possible inspiration could be derived from Egypt's experience with infection control in the renal dialysis units. According to the CDC, “among facilities with dialysis units, the annual incidence of HCV infection among previously uninfected recipients of renal dialysis decreased from 28% (before program implementation) to 6% (3 years after implementation).”<sup>128</sup>

It could be interesting in this case to apply to the benchmark of “bounds of reason” set by the Constitutional Court of South Africa. In its judgment, according to the analysis of the International Network for Economic, Social and Cultural Rights, “the Court implied that there might be grounds for the challenge of executive policies if such policies were unreasonable or if they were not applied fairly and reasonably.”<sup>129</sup> Having established that state's strategy would not decrease the spread of HCV, on the one hand; and would practically neglect at least 97% of patients infected by HCV, the reasonableness of the strategy and its relevant budgetary allocation could well be in question; and so, the question of the right to health of the vast majority of patients infected by HCV in Egypt.

### **c) Obligation to Protect: Egyptians at Risk of Getting Infected**

It is important to remember that core obligations for the right to health go beyond the right to medical care. States parties are under an obligation to take measures to “prevent (...) and control epidemic and endemic diseases,” under paragraph 44 of General Comment 14. On the other hand, it identifies prevention of diseases as one of the core obligations for the

---

<sup>127</sup>CDC, *supra* note 17, at 548.

<sup>128</sup>*Id.*, at 547.

<sup>129</sup> INESCR, *supra* note 124.

fulfillment of the right to health. Article 12 of the ICESCR, General Comment 14 as well as right to health related literature give a lot of attention to measure states parties are required to take to prevent unnecessary infections and diseases; among these are childhood vaccines, transmission of major diseases such as HIV, malaria and TB.

Following the same rationale; and seeing that the right to health shall naturally be adapted to each state's needs, states are under an obligation to prioritize prevention and infection control of those diseases that are most common to them. Failing to do so would constitute violation of the right to health. General Comment 14 clarifies that that state's actions or inactions that result in preventable mortality are to be considered as explicit violations of the state's obligation to respect the right to health.<sup>130</sup>

Patients know by coincidence about their infection. For example, Patient B,<sup>131</sup> 39 years old, indicates that he was traveling to the United Arab Emirates; and had to undertake HCV test; when he learned for the first time that he was HCV positive. Similarly, Patient C,<sup>132</sup> 45 years old, notes that he needed to donate blood to his brother, when he learned that he was infected by HCV. Patient D, 54 years old, was admitted to the hospital for a trivial operation, when she was informed that she was infected by HCV.<sup>133</sup>

This is particularly dangerous, considering the silent nature of the disease. A clinical study conducted by Dr Alaa Awad showed that "SVR was significantly higher in patients with a low degree of liver fibrosis (67.57%) compared with those with a high degree of liver fibrosis (45.45%)."<sup>134</sup> The earlier the detection the more chance there is for the patient to respond positively to treatment. If left untreated, hepatitis C may develop into liver cirrhosis, liver failure, and liver cancer.

Failure to detect HCV infections infringes on the right to health two-folds. On the one hand it nearly reduces the possibility of the success of the 48-week treatment regimen. On the other hand, within the given strategy, it excludes people from having access to treatment, as a

---

<sup>130</sup>CESCR, *supra* note 95, at para. 50.

<sup>131</sup>Patient B, interview, November 2011, Transcript on file with the author.

<sup>132</sup>Patient C, interview, November 2011, Transcript on file with the author.

<sup>133</sup>Patient D, interview, November 2011, Transcript on file with the author.

<sup>134</sup>Alaa Awad et Al., *Efficacy and Safety of a novel pegylated interferon alpha-2a in Egyptian Patients with Genotype 4 Chronic Hepatitis C*, 24(10) Can J Gastroenterol 597, 597 (Oct 2010).

whole. This is due to the fact that the National strategy determined that only such treatment could be covered by the PTES, excluding advanced liver diseases including liver transplants from the strategy, with very few exceptions.

It is paradoxical that the strategy relies on the prerogative of early detection, while taking no action for such detection. The strategy is silent on any early detection initiatives or screening campaigns for particular groups. Early detection of HCV would qualify patients for free treatment, will ensure the enjoyment of a higher attainable standard of health for the patient; and would decrease the risk of infection on other people; hence, protecting their right to health. Inaction of the state in relation to early detection, given the strategy in place would clearly violate the right to health of individuals who only learn about their health status when it was too late to qualify for the 48-week regimen; particularly since other treatment possibilities such treatments of advanced liver failure or of liver transplants are financially inaccessible to the vast majority of the Egyptian population.

Some inspiration could be derived from the decision of the Constitutional Court of South Africa in the case of *Minister of Health v. Treatment Action Campaign* 5 SA 721 CC (2002) in 2002. In its decision, the Court prioritized prevention of mother-child HIV infection over training and conclusion of medical research; and ordered the government provides the relevant drug to HIV-positive mothers in its facilities.<sup>135</sup> The Court further ordered the government “to take reasonable measures to extend the testing and counseling facilities throughout the public health sector;” thus, rejecting the government's arguments of core obligation and progressive realization.<sup>136</sup>

Parallels could be drawn between the knowledge of the government of South Africa of Mother-To-Child-Transmission (MTCT) and Egypt's knowledge of HCV transmission in medical and paramedical settings. While the former happens in a specific population; namely, pregnant women; same could be argued to apply to specific populations, either more vulnerable to HCV (children living with HCV-positive parents, particular male age groups in rural areas); or better positioned to reduce future HCV-prevalence.

---

<sup>135</sup>Iaine Byrne, *supra* note 107, at 9.

<sup>136</sup>INESCR, *Minister of Health v. Treatment Action Campaign: Case Summary* (05 July 2002), available at <http://www.escri-net.org/docs/i/403050>

Similarly, in Argentina, the Court issued its decision, ordering the multiple governmental actors to clean up the river basin. In its ruling set benchmarks and timelines for the undertaking of such cleanup work. Having established that the pollution of Riachuelo River Basin has affected the health of more than 3.5 million people over the period of 200 years, the Court decided to go beyond granting remedies to the litigants; but rather ordered that coordinated actions be taken by the relevant governmental entities “to protect the entire affected populations.”<sup>137</sup> The Supreme Court further rejected the individual requests for remedies, underscoring its “power to protect the 'general interest.’”<sup>138</sup>

This case sets a very good interpretation of paragraph 2(c) of Article 12 of the ICESCR, which states that “(t)he prevention, treatment and control of epidemic, endemic, occupational and other diseases”<sup>139</sup> are among the key steps that states shall take to achieve the full realization of the right to health. The Court rightfully pinpointed that the right to health goes beyond people already affected by the health hazards caused by the polluted river; but rather, saw that the state, in complying with its right to health obligations is mandated to protect the rest of the community of possible health issues. In the case of Egypt, where the government is cognizant of the fact that “the most common exposure to HCV infection in Egypt is from formal and informal medical and dental care,”<sup>140</sup> failure to control infection transmission in health settings is a clear violation the protection component that the space is responsible for in meeting its right to health obligations. This is particularly the case, since it is the state – represented by the MOHP - is itself responsible for the monitoring of formal as well as informal health providers.

It is not clear what rationale the Committee had adopted in writing the strategy. The committee identified several objectives and strived to make interventions on a number of

---

<sup>137</sup> KRISTI INVAER STAVELAND-SÆTER, LITIGATING THE RIGHT TO A HEALTHY ENVIRONMENT: ASSESSING THE POLICY IMPACT OF ‘THE MENDOZA CASE’, 25, (Dept. of Comparative Politics of University of Bergen, Chi. Michelson Institute Jun 2010) (2011), available at <http://www.cmi.no/publications/file/4258-litigating-the-right-to-a-healthy-environment.pdf>

<sup>138</sup> *Id.*, at 37.

<sup>139</sup> ICESCR, *supra* note 2, at art. 2(c).

<sup>140</sup> CDC, *supra* note 17, at 548.

fronts. However, as shown above, the committee did not necessarily go strategic about its choice of interventions.

The committee's set objectives were not consistent – in the sense that they do not feed into a larger goal; and they were too moderate that they failed to have an impact on the disease's trend in Egypt. Infection rates did not cease to increase; indicating that the problem continues to be amplified, despite huge investments, from the state and other players. On the other hand, the committee identified a 20% reduction in the age-group of 15-30 as a key priority, suggesting a tendency to prioritize reduction of infection rates in the near future. Yet, with a rapidly growing population, such goal is too modest to have any impact; besides, the committee did not put mechanisms in place to achieve this reduction of 20%, so it remains unclear to what extent this objective has actually been achieved. Possibly, should the committee have prioritized reduction of infection rates on the long-run, priority should have been given to preventive measures; and screening campaigns for particular age-groups/ vulnerable groups should have been prioritized.

Yet, in terms of budget allocation, the committee prioritized treatment on the expense of prevention and disease control. While the committee was successful in delivering the 48-week treatment regimen to 20% of those needing it, it completely ignored the vast majority of the infected, who are not qualified to take such treatment; and even worse, ignored an ample faction of the population who is at risk of becoming infected, too. Ultimately, with an annual investment of \$80 million, slightly more than 2% of current patients have benefited; while more than 97% have been ignored, in addition to other non-accounted for persons who have been infected by HCV, anew.

#### **IV. Way forward**

While Egypt is faced with a huge burden of HCV chronic infection, HCV remains to be a symptom of the failure of the health system rather than the problem itself. In order to treat the problem from its roots, it is imperative to intervene in the health system on the macro level. While this would not be feasible on the short-run, the section below features components of a short- as well as a longer-term scenario. While the short-term scenario will focus on the restructuring of the National Strategy; the longer-term scenario will conversely focus on the macro-level health reform.

##### **A. HCV-specific Intervention Strategies**

###### **1. Prioritization of Prevention**

Having analyzed the National Strategy and its implementation, the sections above concluded that the strategy only benefits a small portion of patients with HCV antibodies. Furthermore, as demonstrated in the sections above; while the strategy seeks to provide treatment to those who are most likely to have a successful treatment, over the period of four years, only 20% of those with high likelihood of successful treatment have actually had access to such treatment. By the time the remaining 80% know about their infection and get admitted to the system, they would have lost their comparative advantage of chances for a successful treatment. It is quite possible that by that time, they would have developed liver cirrhosis or other advanced liver disease. The strategy is discriminatory against patients with worse health conditions, as shown above, since, for resource-constraint purposes, it fails to provide them with the treatment necessary for patients with liver cirrhosis or other advanced liver diseases. Finally, the strategy does not offer a sustainable solution to the spread of HCV, as it fails to prioritize infection-control. Despite the yearly investment of an ample amount of Egypt's health budget, more patients develop HCV yearly than those who get treated, ultimately inflating the problematic of HCV rather than reducing it.

## 2. Treatment as Prevention

As demonstrated in the sections above, pursuing a rationale that prioritizes treatment, within the given budgetary constraints, renders discrimination against segments of HCV patients inevitable. Should the national committee nonetheless see it necessary to continue investing in treatment, it is crucial that such investments are allocated in a way that would ultimately reduce HCV prevalence rather than increase it. While due to budgetary constraints the state could argue that provision of HCV-related treatment to all is not feasible, on the basis of “progressive realization”, it is interesting to summon how Alicia Yamin, one of the leading right to health scholars, approaches such principle:

[P]rogressive realization does not mean that a State is free to adopt any measures that are broadly going in the right direction'; (o)n the contrary, in order to be appropriate, measures have to be deliberately calculated to bring about the fulfillment of a given aspect of the right to health.<sup>141</sup>

A lot of lessons could be learnt from countries with high prevalence of HIV that could be useful for Egypt in preventing, controlling and treating HCV. While recognizing the essential epidemiological differences between HIV and HCV, the concept of treatment as a form of prevention is a concept that HCV combating strategies could learn from.

According to the WHO in its policy framework on HIV, “[t]he ultimate goal is not simply to increase access to and uptake of HTC (HIV testing and counseling), but to support HIV prevention and provide treatment (including ART), care and support to all who need it.”<sup>142</sup>

One of the tools of prevention that the framework suggests is a directed provider-initiated testing (PITC) and treatment to certain groups that could be prone to be transmitters of the disease. The framework therefore suggests that in specific cases and among particular populations, provider-initiated testing and counseling (PITC) is recommended. For example, the framework prioritizes PITC to children presenting at health facilities with possible signs of underlying HIV infection, including possible natal exposure to HIV. Furthermore, the

---

<sup>141</sup>Alicia Yamin, *Beyond Compassion: The Central Role of Accountability in Applying a Human Rights Framework to Health*, 10(2) Health Hum Rights 1, 8 (2008).

<sup>142</sup>WORLD HEALTH ORGANIZATION, SCALING UP HIV TESTING AND COUNSELING IN THE WHO EUROPEAN REGION AS AN ESSENTIAL COMPONENT OF EFFORTS TO ACHIEVE UNIVERSAL ACCESS TO HIV PREVENTION, TREATMENT, CARE AND SUPPORT, 15 (World Health Organization, Europe) (2010).

framework recommends PITC to be undertaken in those health facilities that are receptive to patients with high probability of HIV-co-infection; such as TB or STIs patients. Finally, it recommends PITC for most vulnerable populations.

In the case of HCV in Egypt, where the main infection source is the health facility, it is more difficult to identify such populations. However, present data suggests that males of certain age groups, in certain geographical areas, with certain professions are more likely to be infected by HCV than others. According to the National Strategy, infection is over 50% in age-groups 35 to 49 in the Nile Delta, Lower Egypt.<sup>143</sup> Furthermore, a study issued by the Eastern Mediterranean Health Journal in 2011, which looked into prevalence of HBV and HCV in blood samples in Alexandria over a period of 6 months between 2007 and 2008 showed some interesting findings on HCV-positive populations. According to the findings of the study, HCV prevalence was highest among males with a ratio of 93.3%, among people living in urban areas with a ratio of 66.4% and among manual workers, with a ratio of 64.7%.<sup>144</sup>

On the other hand, it might be useful to undertake necessary studies to identify what groups are most prone to transmit the infection; and actually target possible provider-initiated testing and treatment towards them. For instance, while the health facility is the main source of infection spread, there is nearly no information about the HCV or HBV prevalence among Egyptian healthcare workers. It could naturally be expected that these particular population is at high risk of carrying such infections.<sup>145</sup>

Arguably, should a national strategy be designed to target the testing and the treatment of certain populations; it is essential that necessary studies be undertaken to ensure that sufficient budget is available to cover treatment costs of all persons who would turn out HCV positive; irrespective of their infection levels.

---

<sup>143</sup>WAHID DOSS ET AL, *supra note 13* at Fig. 3.

<sup>144</sup> OA Wasfi and NA Sadek, *Prevalence of hepatitis B surface antigen and hepatitis C virus antibodies among blood donors in Alexandria, Egypt*, 17(3) East Mediterr Health J. 238, 238-239 (2011), available at [http://applications.emro.who.int/emhj/v17/03/17\\_3\\_2011\\_0238\\_0242.pdf](http://applications.emro.who.int/emhj/v17/03/17_3_2011_0238_0242.pdf)

<sup>145</sup>Sayed Abdel Wahad et AL., *Risk Factors for Hepatitis C Virus Infection among Egyptian Healthcare Workers in a National Liver Diseases Referral Centre*, 106 Trans R Soc Trop Med Hyg 98, 98-99 (2012), available at <http://trstmh.oxfordjournals.org/content/106/2/98.full?sid=89132810-d893-4444-b517-83156be8e15e#ref-10>

### a) Expanding Prevention Schemes

While the state has a responsibility to respect, protect and fulfill the right to health as per the International Covenant for Economic, Social and Cultural Rights, meeting these obligations is subject to ‘progressive realization’. As a first step, for such progressive realization, this section argues that the spread of the disease needs to be firstly controlled. In the absence of such control, measures taken by the government are on the one hand discriminatory against a certain category of patients; on the other hand, it does not work for the general good for the population, from a public health perspective.

Ultimately, the state needs to find the right balance between public health priorities without infringing on individual’s right to health. It is therefore that the state needs to prioritize infection control and invest in stopping the spread of the disease, accordingly. According to Alaa Ghannam, priority measures need to be taken first; “the tap of disease needs to be switched off.”<sup>146</sup> In that regard, more attention needs to be paid to infection control measures.

According to the National Strategy, infection control measures to be taken on the national level include

[T]raining of health care workers (HCW); the establishments of infection control committees at the levels of the governorate, the directorate, and the hospital; and regular monitoring by local and national teams. As of January 2008, the plan has been implemented in 283 hospitals, representing all MOHP hospitals with more than 50 beds in 21 governorates (...). In 2009, MOHP will add the remaining 70 hospitals with more than 50 beds, to cover all 27 governorates, and vaccinate all healthcare workers in these facilities nationwide.<sup>147</sup>

While MOHP hospitals constitute a considerable amount of hospitals in Egypt, health care provided by university hospitals as well as HIO hospitals cover nonetheless an ample portion of healthcare nationwide, too. Furthermore, focusing on hospitals while ignoring dental clinics, which are equally responsible for the infection transmissions can be counterproductive<sup>148</sup>. With infection control measures showing favorable results in reducing prevalence of HCV, as discussed earlier in the paper, it is imperative to expand infection

---

<sup>146</sup>EIPR, Roundtable Discussion, *HCV and Health System in Egypt* (Jun 2013).

<sup>147</sup>WAHID DOSS ET AL., *supra* note 13, at 15.

<sup>148</sup>WAHID DOSS, *supra* note 19, at 25.

control measures and ensure that these cover all medical and paramedical facilities in Egypt. According to the CDC,

Decreasing the incidence and transmission of HCV infection in Egypt necessitates wider application of infection control standards to all providers of health and dental care. Best practices and guidelines should be disseminated to health-care and dental-care institutions and providers throughout Egypt, with an emphasis on expanding the number of trained experts capable of supporting and overseeing this effort.<sup>149</sup>

As demonstrated earlier; while the 85% of the budget allocated to HCV is spent on treatment of a few HCV patients, only 1% is allocated to infection control. It is therefore not surprising that the rate of yearly infection remains on the rise. While the prioritization of prevention by the National Strategy as one of its four intervention tools is to be praised, the fact that HCV infection is still on the rise suggests that more effort and investment need to be put in this area of intervention. According to the CDC, “increasing investments in health-care–facility infection control are necessary to limit the spread of hepatitis C and other health-care–associated infections in the country.”<sup>150</sup>

### **3. Combating HCV: Global Concern**

The right to health, like other human rights protected under the ICESCR, is subject to international assistance and co-operation<sup>151</sup>. States parties are obligated individually, and through international cooperation, to take necessary steps to the full realization of the right to health both technically and economically. General Comment 14 further clarifies that states parties are committed "to take joint and separate action to achieve the full realization of the right to health"<sup>152</sup>. It is in this under this obligation that rights' activists have managed to advocate for the adoption of the Millennium Development Goals, invoking actual states commitments to global health in several areas including reduction of mother and mortality, as well as prevention of HIV infection<sup>153</sup>. The recognition of such international obligation made

---

<sup>149</sup>CDC, *supra* note 17, at 548

<sup>150</sup>*Id.*

<sup>151</sup> ICESCR, *supra* note 2, at art. 2.

<sup>152</sup> CESCR, *supra* note 95, at para. 38.

<sup>153</sup> Benjamin Mason Meier and Ashley M. Fox. *International Obligations through Collective Rights: Moving from Foreign Health Assistance to Global Health Governance*, 12(1) Health Hum Rights, 61, 61-65 (Jun 2013),

the creation of the Global Fund to Fight HIV/AIDS, TB and Malaria (Global Fund) possible. The Global Fund supports the financing of health services related to the combat of HIV/AIDS, TB and Malaria all over the globe, through contributions from states and International Financial Institutions. Since its creation in 2002, the Global Fund supported programs which delivered HIV and TB related services to 5.2 million people all around the globe. Notwithstanding its shortcomings, the Global Fund conceptually, is a great example that the right to health movement shall capitalize on to advocate for further reassertion of states international obligation in relation to the right to health.

Following this rationale, HCV in Egypt shall not be dealt with as a domestic issue, per se. Rights activists in Egypt shall work together with the government to internationalize to the fight against HCV. It is important to bear in mind that though Egypt has the highest prevalence of HCV, others parts of the world are suffering high prevalence. Furthermore, it is important to recall that HCV treatment regimen can only promise cure to a small %age of HCV positive patients, all over the world. In that regard, it is important for right to health consideration that attention is given to technical advancement in the portfolio of HCV. According to *Epidemiology Health Journal*,

HCV represents a major health problem with approximately 3% of the world population—that is, more than 170 million people—infected. While only 20–30% of individuals exposed to HCV recover spontaneously, the remaining 70–80% develop chronic HCV infection (CHC). Moreover, 3–11% of those people will develop liver cirrhosis (LC) within 20 years, with associated risks of liver failure and hepatocellular carcinoma (HCC) which are the leading indications of liver transplantation in industrialized countries. The socioeconomic impact of HCV infection is therefore tremendous and the burden of the disease is expected to increase around the world as the disease progresses in patients who contracted HCV years ago.<sup>154</sup>

With 170 million people already infected, and expectations that this figure will continue to rise, HCV needs to be put more solidly on the international health agenda. Combating HCV

---

available at <http://www.hhrjournal.org/2013/08/27/international-obligations-through-collective-rights-moving-from-foreign-health-assistance-to-global-health-governance/>

<sup>154</sup>JulietaTrinks and Adrian Gadano and Pablo Argibay, *Evolving Trends in the Hepatitis C Virus Molecular Epidemiology Studies: From Sequences to the Human Genome*, 2012 *Epidemiology Research International*, 1, 1-5 (Jan 2012), available at <http://www.hindawi.com/journals/eri/2012/856810/>

worldwide still requires investment with regards to research as well as economic investments; just as HIV/AIDS, malaria and TB have previously been.

Combating HCV in Egypt, as well as worldwide, necessitates a lot of further research and development. Treatments currently available only benefit a small portion of HCV patients; and, the costs of such treatments are far from being affordable; ultimately, sustaining treatment for all HCV patients with the current level of R&D is economically impossible in Egypt and probably in other parts of the world, too. The international community has a responsibility towards combating HCV worldwide. Article 2 of the ICESCR underlines states obligations with regards to economic as well as technical cooperation. Health activists and policy makers in affected countries shall work together on urging the international community to support prevention and treatment of HCV positive patients worldwide. While this could be through financial assistance, attention should also be given to their obligation with regards to technical support.

In 2001, with more than 36 million people living with HIV/AIDS worldwide, the General Assembly recognized that this disease was a global concern; and accordingly passed a resolution under the title “Global Concern – Global Action.”<sup>155</sup> The resolution set out time-bound goals, urging particular sets of actions to be taken on national, regional and international levels to combat the spread HIV/AIDS. Intervention strategies set out by the General Assembly resolution included global action on prevention, care and treatment; and research and development, among others. The resolution indicates that the international community needs to ensure that prevention programs are implemented in all countries by 2005.<sup>156</sup> It called for collective action by governments, intergovernmental organizations, the business sector and civil society to ensure that strategies are developed “to strengthen health-care systems and [to] address factors affecting the provision of HIV-related drugs, including anti-retroviral drugs, *inter alia*, affordability and pricing, including differential pricing, and technical and health-care system capacity.”<sup>157</sup> Furthermore, the resolution urged member

---

<sup>155</sup>United Nations General Assembly. *Declaration of commitment on HIV/AIDS: Global crisis – Global action*. New York, Special Session on HIV/AIDS, Jun 21–27 (2001), available at <http://www.un.org/ga/aids/coverage/FinalDeclarationHIVAIDS.html>

<sup>156</sup>*Id.*, at para. 52.

<sup>157</sup>*Id.*, at para. 55.

states to increase investments in HIV/AIDS related research and development, including building of national capacities to undertake such research.<sup>158</sup>

Combating HCV worldwide merits similar actions. Investment on R&D for early prevention mechanisms and for the treatment of the different levels of infection is highly needed. Furthermore, developing countries, such as Egypt, could benefit of other countries' expertise on infection control in medical settings. Such efforts would require bilateral as well as multilateral engagement with countries with high prevalence rate. Furthermore, it is important to remember that six genotypes of HCV exist worldwide; Egyptian HCV patients suffer mostly from genotype 4. While the current treatment regimen promises an 80% curing rate for patients of genotype 1,<sup>159</sup> this rate is only 60% for patients infected by genotype 4 in Egypt. It is therefore eminent that R&D activities be conducted in those countries where the treatment will be dispersed.

Furthermore, given the current treatment regimen available, efforts should be exerted by the international community to bring the prices further down, ensuring that business gains would not override people's right to health. In that regard, it is important to give a closer look at the South African experience, where international pressures, coupled with evolving local generic manufacturing capacities, have pushed MNCs to reduce prices for first-line anti-retroviral treatment (ART) from \$10,000 per person per year in 2000 to \$100 per person per year in 2013, according to MSF.<sup>160</sup>

## **B. Health Sector Reform**

While HCV is in itself a big challenge for the Egyptian health system, it is merely a reflection of the futile health system in Egypt. In order to address the problematic of HCV in Egypt from its roots, it is imperative to tackle the main problems within the health system; arguably, even if HCV problems were to be resolved, the futile health system will necessitate the evolvement of another catastrophic health hazard.

---

<sup>158</sup>*Id.*, at para. 70.

<sup>159</sup>WAHID DOSS ET AL, *supra note* 13 at 5.

<sup>160</sup>MEDICINES SANS FRONTIERS: TREATMENT CAMPAIGN, UNTANGLING THE WEB OF ANTIRETROVIRAL PRICE REDUCTIONS 2 (Medicines Sans Frontiers) (2013), *available at* [http://www.msf.org/sites/msf.org/files/msf\\_access\\_utw\\_16th\\_edition\\_2013.pdf](http://www.msf.org/sites/msf.org/files/msf_access_utw_16th_edition_2013.pdf)

While it can indeed be argued that the National Committee to combat HCV has done a good job with regards to reducing the price of the HCV treatment regimen, opened specialized clinics all around the country and given treatment to hundreds of HCV patients, being a parallel structure to the health system, its level of remains limited, compared to the size of the problem it seeks to solve. Dealing with the HCV case could be an entry point for a large-scale reform to the health sector in Egypt. Violations of the right to health of HCV positive patients demonstrate shortcomings in the health sector in Egypt.

As demonstrated in the chapters above, Egyptian health sector is facing three key interrelated challenges; unjust provision of health care services, high and increasing out-of-pocket expenditure; and most importantly fragmentation of the health sector.

Besides the obvious downside of a fragmented health sector in terms of inequity in service provision, which ultimately violates state's obligation of non-discrimination, fragmentation also affects the efficiency of the system as well as the affordability of the services provided.<sup>161</sup> Furthermore, it is worth recalling that the MOHP manages only 16.5% of the THE, while it is expected to ensure appropriate health care and services to all, craft the necessary policies; and monitor facilities, as needed. Eventually, other stakeholders such as the Ministry of Higher Education and the Ministry of Defense and most importantly the patients who pay more than 70% of THE out of their own pockets steer decision-making in the health sector, in parallel to the MOHP, which ultimately affect the system's efficiency and affordability. Out of pocket payment essentially cause overuse of the health sector services by the wealthier, and underuse by the poorer,<sup>162</sup> finally causing prices to increase all the more.

---

<sup>161</sup>Diane McIntyre et al., *Beyond Fragmentation and towards Universal Coverage: Insights from Ghana, South Africa and the United Republic of Tanzania*, WHO BULLETIN, Nov 2008, available at <http://www.who.int/bulletin/volumes/86/11/08-053413.pdf>

<sup>162</sup>The Lancet, *Striving for universal health coverage*, 376 Lancet 1799, 1799 (27 Nov 2010), available at <http://download.thelancet.com/pdfs/journals/lancet/PIIS0140673610621484.pdf>

## 1. Universal Health Coverage

Egypt is not alone in facing these challenges and there are lessons to be learnt from the global trends and from experiences of health reform in other low- to middle-income countries. In that regard, it is important to zoom-in on the resolution of the World Health Assembly in May, 2005, where member countries were urged to work “towards sustainable health financing, defining universal health coverage as access for all to appropriate health services at an affordable cost.”<sup>163</sup> Universal health coverage (UHC) rests upon the premises of reducing out-of-pocket payments, maximizing pre-payments, and adopting a single national risk pool, where insured people and government would contribute to cover also those who are not able to contribute.<sup>164</sup> Details of UHC would obviously change from one country to the other depending on a variety of factors. Yet, in essence, examples of countries who have taken steps towards the adoption of UHC, like Chile, Moldova, Columbia, Ghana, Thailand, Rwanda and Kyrgyzstan,<sup>165</sup> have shown prominent results in terms of reduction of inequity and improvement of health outcomes.<sup>166</sup> To look into but a few examples, a policy paper published by Oxfam in 2013 reports,

The reforms in Kyrgyzstan have radically reduced fragmentation and inequity, revitalized primary care, and improved health outcomes (the infant mortality rate reduced by almost 50 per cent between 1997 and 2006). In Moldova the pooled health budget [...] has enhanced equity and reduced the burden of out-of-pocket payments for all income groups. [...] South Africa’s proposals to redress significant health inequities by introducing National Health Insurance (NHI) indicate that all citizens and legal long-term residents will be provided with essential health care through a defined set of comprehensive health service entitlements, regardless of employment status or ability to make a direct monetary contribution to the NHI fund.<sup>167</sup>

Despite valid concerns about efficacy and quality of the service provided to the insured by the HIO, which certainly need to be addressed, a universal health coverage scheme would

---

<sup>163</sup>Laurie Garrett and A. Mushtaque R Chowdhury and Ariel Pablos-Méndez, *All for Universal Health Coverage*, 374 *Lancet*, 1294, 1294–1295 (10 Oct 2009), available at

<http://www.rockefellerfoundation.org/uploads/files/d86af08f-0ccc-4739-ab2f-ce625450572d-lancet.pdf>

<sup>164</sup>OXFAM, UNIVERSAL HEALTH COVERAGE: WHY HEALTH INSURANCE SCHEMES ARE LEAVING THE POOR BEHIND,3 (Oxfam) (9 Oct 2013), available at [http://www.oxfam.org/sites/www.oxfam.org/files/bp176-universal-health-coverage-091013-en\\_.pdf](http://www.oxfam.org/sites/www.oxfam.org/files/bp176-universal-health-coverage-091013-en_.pdf)

<sup>165</sup>*Lancet*, *supra* note 140.

<sup>166</sup>OXFAM, *supra* note 142, at 5.

<sup>167</sup>*Id.*

help the health sector in Egypt overcome much of its grave challenges. In line with the global trend, Egypt's government has been discussing the option of a universal health insurance law since many years, already; yet, as shown above, such discussions have never materialized, causing continuing violation of the right to health of a large portion of Egyptians.

Notwithstanding economic considerations, achieving UHC whether in the form of universal health insurance or not, necessitate a political will. Such a will needs to be created.

While the right to health is recognized in Egypt and is legally binding as per the Egyptian constitution as well as the international conventions that Egypt is party to, a lot of steps still need to be taken to transform economic and social rights from legal principles to actual legal obligations that the state is accountable for. One way of doing that is pushing for the adoption of laws which will give flesh to the economic and social rights that have – to date – remained rather theoretical, or even idealistic. In the current political vacuum in Egypt; and owing to the fact that there have nearly been no houses of representatives over the past three years, the judiciary could play a leading role in making the right to health more tangible and in holding the executive to account, on such bases. Furthermore, Egyptian courts have passed decisions that were favorable to economic and social rights in recent years; such decisions have pushed these rights on top of the political agenda. Such push is indeed needed for health; and particularly for universal health coverage in Egypt.

The section below suggests an idea for strategic litigation, which, in combination with advocacy efforts from the different pressure groups could push for such a political will.

#### **a) Adjudication of the right to health**

The Egyptian constitutions (of the year 1971 and 2012) recognize the right to health; and recognize the state's responsibility to provide health insurance. While the provisions on the right to health differ in the two constitutions, both could set sufficiently good grounds for a case where uninsured citizens could claim their right to health.

According to article 17 of the 1971 constitution, “[T]he State- shall guarantee social and health insurance services; (...) all citizens have the right (as per) the law to pension in cases

of incapacity, unemployment and old age.”<sup>168</sup> Article 62 of the 2012 constitution is even more explicit, and goes further stating that

Every citizen has the right to health care, and the state assigns a sufficient share of the national budget to its provision. The state commits itself to providing health care services and health insurance through a system that is both just and of high quality. These services will be free of charge to those unable to pay.<sup>169</sup>

While the constitution protects the right to health to all citizens and accords the government the responsibility to provide social and health insurance, Law 79 for the year 1975 only grants this right to workers working in the formal sector, both in the public and the private sector. In the suggested case, a group of Egyptians working in the informal sector, such as farmers, street vendors and domestic workers, for example, would submit a case to the Court of Administrative Justice (CAJ), challenging the Minister of Health and the head of the Health Insurance Organization for violating their right to health by depriving them of their right to health insurance. In the absence of a law regulating health insurance for workers of the informal sector, such category does not have access to health insurance; since, among other reasons, employer’s contributions as identified in the law are not relevant for workers of the informal sector. During the proceeding in front of the CAJ, the litigants (the workers of the informal sector) would challenge the constitutionality of Law 79 for the year 1975, which regulates health insurance; and which is the founding law of the HIO; and which by its nature violates their rights to health insurance. According to paragraph 29(a) of Law 48 for the year 1979, which regulates the work of the Supreme Constitutional Court in Egypt,

During the consideration of a proceeding, if one of the opponents before a court or a body of jurisdiction challenges the constitutionality of a provision in the law or regulation, and the Court or the body of jurisdiction was satisfied about the seriousness of the claim, the Court or the body of jurisdiction would postpone consideration of the case and would set a date not exceeding three months for the relevant opponent to file a case in front of the Supreme Constitutional Court.

---

<sup>168</sup>A.R.E. CONST. 1971, art. 17 (Egypt), *available at* <http://www.sis.gov.eg/En/Templates/Articles/tmpArticles.aspx?CatID=208>

<sup>169</sup>A.R.E CONST. 2012, art. 62 (Egypt), *available at* <http://niviensaleh.info/constitution-egypt-2012-translation/>

Should the CAJ be satisfied that a constitutional issue is at stake, the CAJ would permit the litigants to raise the case in front of the Constitutional Court, which would then decide on whether the law at dispute conflates the relevant constitutional article, or not.

In that regard, it is important to look into previous decisions of the CAJ and check to what extent this sought decision is possible. Over the past years, Egyptian civil society has taken key important cases to the CAJ, which have shown quite progressive interpretation of economic and social rights in its rationale of the decisions delivered. Remarkably, in cases touching on the right to health and the right to minimum wage, the CAJ went beyond adopting a strict application of the law into interpreting the rationales upon which such laws were established, referring consistently to the constitution and to jurisdiction of the constitutional courts which interpret such constitutional provisions.

Most remarkably is the decision of the CAJ in the case of *Sharkawi et al. v. Prime Minister et al.* on 4 September 2008, in which the Court ordered the suspension of a Prime Minister decree on the establishment of the Health Care Holding Company.<sup>170</sup> According to the decree, the company will assume control over hospitals and clinics owned by the HIO. Rights groups have challenged the decree, arguing that a for-profit company will charge services with profit margin; hence, threatening the affordability of health services under the HIO.<sup>171</sup> In essence, the CAJ could have resolved the case solely quoting Law 79 for the year 1975 which clearly indicates that the HIO is responsible for the financing as well as service delivery; and that hence a decision to establish a holding company that would manage the service delivery would be a violation of the law.<sup>172</sup> However, the Court chose to look deeper into the rationale of law and referred to the fact that Law 79 for the year 1975 exempts the HIO of paying taxes to underscore that the services provided by the HIO cannot be managed by a for-profit holding company. According to the decision of the CAJ,

The rules of social health insurance are related to public interests which are important to society and to the protection of its vulnerable segments. These were set with the intention of achieving justice in the distribution of resources, as affirmed by the Constitution, health insurance laws and international conventions. It is therefore that the legislator attributed special protection to health insurance funds [...] (It) exempted (the HIO) from taxes, royalties and fees of all kinds. The executive branch possible embarking on the HIO, its

---

<sup>170</sup>Sharkawi et al. v. Prime Minister et. al, 21550 Egy 61 CAJ, 1-13 (4 Sep 2008).

<sup>171</sup> EIPR, *A Landmark Decision Sets New Basis for the Legal Protection of the Right to Health in Egypt*, EIPR, 15 Sep 2008, available at <http://eipr.org/node/709>

<sup>172</sup>Sharkawi et al. v. Prime Minister et al., *supra* note 148, at 11.

money or property would go against the responsibility that the HIO was mandated with as per the law.<sup>173</sup>

Furthermore, in laying its rationale for the decision, the Court elaborated on the state's responsibility, indicating that “[the right to health] is the State’s constitutional obligation and it cannot rescind from it...using justifications such as improvement [of the HIO], a budget deficit or any other justification put forward by the administration to achieve goals that would diminish the meaning of that obligation.”<sup>174</sup>

Similarly, in the case *Abdel-Salam et al. v. President of the Republic et al.* on minimum wage, the CAJ chose to elaborate on constitutional and the legal provisions that dictated the need for setting a minimum wage, rather than just sticking to the legal provision that required the executive to set a minimum wage; and that it ultimately failed to meet.<sup>175</sup>

Rights’ groups bringing the case to the CAJ, requested a decision “to stop the implementation of the negative decision to abstain from setting a minimum wage at the national level, which should take into account the cost of living and which should find the means to ensure a balance between wages and prices.”<sup>176</sup>

Labor Law 12 of the year 2003 necessitates the establishment of a High Council for Wages, as per paragraph 34. Such council is mandated to set a national minimum wage and to follow up on its implementation. While such Council was indeed established in 2003 by a ministerial decree and was directed to set the minimum wage within a maximum of three years, up until 2010, the council had not announced its findings and its decision on the minimum wage<sup>177</sup>. In that regard, the case is quite straight forward; and in essence, the CAJ did not have to get into elaborative interpretation of the law and the rationale behind it. However, in laying the ground to its decision, the Court indicated the following:

The Egyptian constitution adopted the principle of the minimum wage for workers [...] to ensure the fairness of wages. This constitutional protection of workers' wages is not just slogans or directives devoid of legal value, but being contained in a

---

<sup>173</sup>*Id.*

<sup>174</sup>*Id.*, at 9.

<sup>175</sup>*Abdel-Salam et al. v. President of the Republic et al.*, 21606 Egy 63 CAJ, 1-16 (30 Mar 2010).

<sup>176</sup>*Id.*, at 2.

<sup>177</sup>*Id.*, at 13.

constitutional framework ranks it at the top legal rules of the Egyptian legal system. The Constitution did not leave the decision of whether to set a minimum wage for workers or not to the will of the legislator, but the text of the Constitution ensures the workers' right to a minimum wage. [...] (and) [...] mandates the executive authority (the) duty to implement the provisions of the Constitution and the law to ensure minimum wage for workers.<sup>178</sup>

In reflection on the rationale delivered by the CAJ on the two cases demonstrated above, it comes to one's attention that the CAJ sees a role for itself beyond a strict application to the administrative law. In the two cases discussed above, the Court decided in favor of economic and social rights, relying on the one hand on administrative matters but also on its interpretation of the rationale upon which the legal provisions at dispute was configured. It went even further in its decisions by quoting the relevant constitutional reference, the relevant international provision and often, jurisprudence of the constitutional court, in making its case which ultimately upheld citizens' economic and social rights. Particularly, in the case of the Holding Company, in delivering its rationale, the CAJ quoted progressive jurisprudence from the constitutional court, that merits rights groups to capitalize on; both in front of the CAJ and also, when possible in front of the constitutional court. These two cases, among others, suggest that there could be a good chance to get a favorable decision from the CAJ to refer the health insurance law to constitutional court, for consideration.

#### **b) Supreme Constitutional Court on the Right to Health**

Giving a closer look at the Constitutional Court's jurisprudence on the right to health, one could forecast that it is possible that the Court would decide in favor of the workers of the informal sector. Should the Court decide that the law in dispute is unconstitutional, it will demand the executive and the legislative authorities to amend the law, accordingly. While not explicitly stated by the Supreme Constitutional Court that all citizens have the right to health insurance, aspects of some of its decisions, mainly in relation to social insurance, could be built on to support such a case; this, in combination with the principle of non-discrimination that the workers of the informal sector could rely on in their plea.

---

<sup>178</sup>*Id.*, at 11.

In its decision in *Sharkawi et al. v. Prime Minister et al.*, the CAJ cited a 1995 decision (16 for the judicial year 5) delivered by the SCC elaborated on the rationale behind protecting the rights to social and health insurance in the constitution. The SCC underscored the principle of solidarity and the responsibility of the state to ensure minimum levels of humane treatment for all citizens. According to the SCC,

The Constitution has taken a further step in the direction of supporting social insurance, when it called on the state to ensure services for its citizens, including social and health insurance..... Because the umbrella of social insurance should ensure that every person covered by it has a minimum of humane treatment [...], and which provides an appropriate climate for respect of his/her personal liberty, and which ensures the most important aspects related to his/her right to life; and those rights dictated by the principle of solidarity among the members of the group/ society [...]; those are the fundamentals that society is built on.<sup>179</sup>

The importance of this part of the rationale lies in the fact that the SCC laid out the rationale of the constitution's protection of social and health insurance. Such rationale could be built on in more particular cases touching on the right to health insurance. If the goal is to ensure a minimum humane treatment, then this should be attainable for all citizens, particularly those incapable of paying for their own health care. In September 2000, the SCC gave another decision (1 for the judicial year 18) that elaborated on the concept of "insurance" in article 17 of the constitution, as cited by the CAJ cited in *Sharkawi et al. v. Prime Minister et al.* In its decision, the SCC underlined that insurance is a "social necessity" that has the purpose of protecting citizens during illness, among others. According to the SCC,

Article 17 of the constitution supported the right to social insurance by calling on the state to extend its services in this area to all citizens of all strata, in the framework that the law would regulate, for the purpose of enabling them to face unemployment, inability to work and ageing. [...] Insurance care is a social necessity, which has the purpose of covering its beneficiaries in their future days throughout retirement, disability or illness.<sup>180</sup>

While article 17 of the 1971 constitution demands that the state provides for health and social insurance, it singles out a certain category of citizens that have "the right to pension";

---

<sup>179</sup>Sharkawi et al. v. Prime Minister et al., *supra* note 148, at 9.

<sup>180</sup>*Id.*, at 9-10.

namely, those citizens that are subjected to incapacity, unemployment and old age. In its decision quoted above, the SCC went a step further by underscoring that the right to social insurance extends “to all citizens of all strata”, which is actually not that clearly defined in the constitution. Such extension could be sought in another decision on the right to health insurance, too, owing to the fact that both rights are covered under the one and the same article and that both types of insurances would follow the same rationale of “social necessity” that the “fundamentals” of society should be built on. Both decisions quoted above by the SCC put health and social insurance on the same footing.

In reality, it takes years before the constitutional court delivers a decision. However, should the CAJ indeed refer the case to the Constitutional Court, it would already be a huge success to the right to health movement, even before a decision is passed. The political weight of a possible decision by the CAJ to refer such a case to the constitutional court could be an excellent step forward, laying the grounds for pressure groups and newly formed independent trade unions of the informal sector to make a strong case towards policy-makers, requesting their right to health insurance. For example, the decision of the minimum wage – though it suggested nothing new than what was actually clearly indicated in the law and in the ministerial decree that followed it – gave the issue that workers’ groups were fighting for a long time the necessary political weight and political momentum for further lobby work. The CAJ’s decision stopped before identifying how much this minimum wage should be; making sure not to take up the role of the executive. The CAJ clearly did not see itself in a position to decide on technical matters; however, it paved the way for societal discussion on the issue, which ultimately culminated in the High Council for Wages setting the minimum wage at 1200 Egyptian pounds.

## **V. Conclusion**

With an annual budget of \$80 million, expenditure on HCV treatment and care consumes around 20% of the MOHP's annual budget. These huge funds only benefit a few; and HCV prevalence is still on the rise. Egypt is violating its right to health obligations, with regards to HCV, on multiple grounds. The research found that government's resource allocation would not lead to the progressive realization of the right to health, which is violation of core principles of the right to health. The strategy favors groups of patients over others, ultimately discriminates against a large proportion of patients already infected by HCV, making treatment only accessible to a marginal segment of HCV-positive patients; and discriminates against an even a larger portion of society which gets newly infected on a yearly basis, in the absence of a effective program of infection control within health facilities. It is therefore that the research found the government of Egypt is in violation of its obligation to protect the right to health.

While HCV constitutes a huge burden of disease in Egypt, this thesis argued that it is just a symptom of the bigger set of challenges that the Egyptian health sector is facing. A sustainable method of combating HCV needs to go hand-in-hand with a larger scale reform to the health sector in Egypt.

HCV-specific interventions need to prioritize infection control and resource allocation should be prioritized in this area accordingly. Policy-makers shall give priority to stopping the spread of the disease and resource allocation on treatment and care need to follow equality benchmarks. Furthermore, in seeking access to treatment for all patients, Egypt shall seek international support, similar to that cried out for by countries suffering of high HIV/ AIDS prevalence in the 1990s, in line with states' international obligations as per the ICESCR.

The thesis proposed to follow WHA recommendations and global trends in the adoption of serious steps towards universal health coverage, as the key entry point for a progressive health sector reform. While draft laws on universal health insurance were recurrently proposed by the government; such propositions never materialized, mainly, on the grounds of lack of funding. In the absence of a political will; and considering that health insurance law only covers workers of the formal sector, workers of the informal sector, which are

ultimately the poorest of the poor, continue being denied of their rights to health, as protected by the Egyptian constitution. The thesis finally recommends that workers of the informal sector would bring a case to the CAJ, requesting it to refer their case to the constitutional court for review of the health insurance law. On the one hand the CAJ's referral of such a case to the constitutional court would achieve the momentum needed to push the government to move ahead with the law. On the other hand, should the constitutional court give a verdict in the favor of the workers of the informal sector; that would lay the grounds for health sector reform; and would ensure adherence to principles of equality and non-discrimination during such reform.