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HEALTH COVERAGE FOR WORKERS IN EGYPT

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Figure 1: "During the seven years of abundance the land produced plentifully" (Gn 41:47). Egyptian workers harvesting grain and carrying it away to be threshed. Tomb of Mena, Thebes, ca. 1420 B.C. ABR File photo.

Abstract:

This study aims at discussing the extent of covering the Egyptian employees with the basic/ essential occupational healthcare services. The paper detailed the legislative, institutional and technical aspects relevant to various OCH services, emphasizing the central role of Primary Healthcare (PHC) services and the Health Insurance Organization (HIO). The natural history of developing the public healthcare system in Egypt is revealed, in details, showing its objectives, procedures and categories/ leveling. The study illustrates the overall picture of healthcare services pertinent to Egyptian workers at present; the strengths, weaknesses and recommendations aiming at comprehensive and integrated coverage in order to comply with the international conventions and the national legislative framework.

The study concluded that OCH services are essentially necessary for the Egyptian labor force that constitutes about 31.7% of the whole population and about 48.84% of those aged 15 yrs. or more. There is an urgent need of expanding the OCH services, which currently cover about one-quarter of the working population, to provide every employee with the basic OCH services as indicated by the international recommendations and the Egyptian Constitution, legislation and community necessity.

Key words: occupational healthcare services, universal coverage, working population, Egypt

Introduction

More than 200 years elapsed since the first legislation had been issued to protect young workers against a defined workplace risk. Since then a number of acts including sections dealing with health and welfare of factory workers followed. Employment of workers, employment conditions and agencies competent with occupational safety and health as well as penalty clauses were covered by Act No. 91, the first comprehensive Labour Law, adopted on 5 April 1959.

Regulations developed and expanded gradually in order to cover all hazards and economic sectors. It should be noted that the Egyptian legislation related to Occupational Safety and Health (OSH) was extensively up-dated in July 2003, as described in chapter II. It now covers a great part of the requirements and provisions entailed in major ILO Conventions related to occupational safety and health.

Implementation bodies are thoroughly dealt with in chapter III. Their strengthening should be analyzed in the light of the best possible use

of already existing structures and of feasible ways to improve their functions on a sustainable basis.

Education, training and information mechanisms and institutions play a vital role in the progressive construction of a national Occupational Health (OCH) system. These are essential tools in the process of awareness-raising on hazards and preventive action at all levels and, considering the needs of the country in this respect, they should be given top priority.

The active involvement and participation of employers and workers in the development of a strong health and safety culture should never be forgotten. Special activities aimed at these target groups could be envisaged. In Egypt, a country where micro and small and medium sized enterprises, together with agriculture, employ a very large percentage of the working population, identifying priorities for the development of a national OCH action program is crucial.

This paper aims at discussing the extent of covering the Egyptian working population with the basic/ essential occupational healthcare services. It illustrates the overall picture of healthcare services pertinent to Egyptian workers at present; the strengths, weaknesses and a plan of action aiming at comprehensive and integrated coverage in order to comply with the international conventions and the national legislative framework.

Historic perspective

The earliest legislation pertaining to occupational health in Egypt dated back to July 1809. It dealt with employment of children in cotton ginning factories. Eighteen years later, the first medical school was launched at the Abu-Zaabal suburbs, about 20 Km to the north-east of Cairo, which was moved, 10 years later, to its location, till now, in the center of Cairo, at Kasr El-Aini Palace that was built at the 15th century by Amir (= Prince) Ahmed Ben El-Aini, one of the famous Mamlouks, during the medieval period. Seventeen years later, the first 'bylaws' organizing the healthcare services had been issued by the same Governor of Egypt: Mohamed Ali Pacha, who was behind issuance of the earlier decrees. The first constitutional rights to healthcare were declared in the 1923 constitution. Thirteen years later, re-organization of the healthcare services necessitated launching, for the first time, 'the Ministry of Public

Health' which started an ambitious plan to build hundreds of healthcare units and polyclinics that constitute the corner stone of the 'Primary healthcare services' few years later. Establishing a 'Multi- level healthcare system' got a powerful drive after the 1952 revolution, through building hundreds of primary healthcare units, hundreds of hospitals in the villages, districts, as well as public, specialized and university hospitals. A year ago, the government of Egypt agreed on adding 17 new occupational diseases to be covered under Egypt's social health insurance law 79/ 1975. This came in response to demands made by the ministers of Manpower and Immigration, and Health and Population, after the decision was ratified by the Board of Directors of the National Authority for Social Insurance. (Abo El-Ata and Nahmias, 2005, Amendment to Table 1 annexed to Law 79/ 1975). Box1 illustrates the main marks along the healthcare development in Egypt.

Box 1: The main marks along the healthcare development in Egypt

1809 .. Decree on prohibition of child work at cotton ginneries
1827 .. Establishing Kasr Al-Aini medical school;
1844 .. Bylaws organizing healthcare services;
1923 .. Constitutional rights to healthcare in the 1923 constitution;
1936 .. Launching the Ministry of Public Health;
1948 .. UN Declaration on Human Rights including Right to healthcare;
1956 .. Establish the High Institute of Public Health in Alexandria, with academic and applied functions,
1956 .. Establish the National Research Center in Giza, with academic and applied functions, emphasizing basic and advanced studies,
1959 .. Issuance of Labour Law 91/ 1959 with a Chapter on 'Industrial safety' issues and another Chapter on Social and cultural benefits for employees,
1959 .. Issuance of Social Insurance Law 92/ 1959 with Chapters on 'Health Insurance' benefits for employees,
1964 .. Establish the "Health Insurance Organization" to provide a wide-based Basic Benefit Package for various employees,
1969 .. Establish the National institute of Occupational safety and Health- NIOSH, for executing research, training, and technical consultancy,
1981 .. Issuance of Labour Law 137/ 1981 with a more comprehensive Chapter on 'Occupational safety and Health' issues,
1993 .. Establish supreme committee to control infectious dis.
2003 .. Issuance of the Unified Labour Law 12/ 2003 with a more advanced and comprehensive Book on 'Occupational safety and Health' issues,
2013 .. Modification of the national Schedule of Occupational Diseases to comply with the 2010-modified ILO list of Occupational Diseases,
2014 .. Draft amendments on Labour Law No. 12/ 2003 to include provisions in the ILO Conventions and Recommendations.

Egypt Population and Labor-force

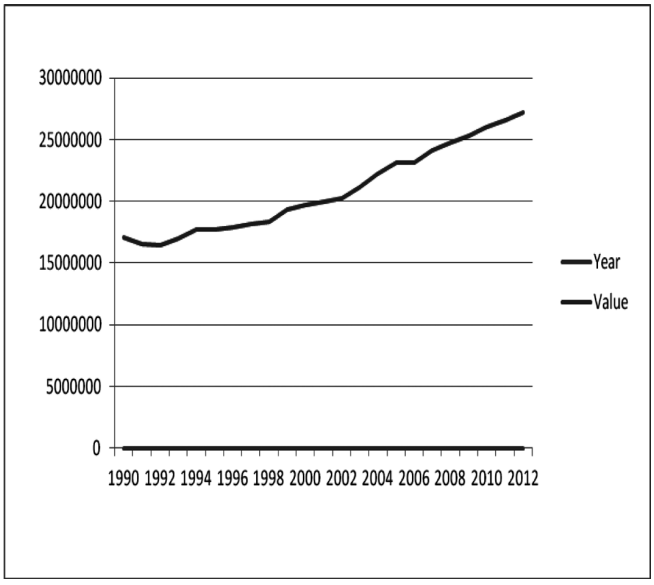
The population estimate at January 2014 is 85,783 thousand, of whom 43,796 thousand males (51.1%) and 41,987 thousand females (48.9%). About 42.8% of the population is currently living in urban areas, while 57.2% are living in rural areas. About 31.1% aged 0-14 years, 64.5% aged 15-64 years and 4.4% aged 65 years and above (CAPMAS, 2014).

The total Labor force in Egypt is last measured at 27.193.916, according to the Central Agency for Public Mobilization and statistics (CAPMAS, 2014). It comprises people ages 15 and older who meet the International Labour Organization definition of the economically active population: all people who supply labor for the production of goods and services during a specified period. It includes both the employed and the unemployed. While national practices vary in the treatment of such groups as the armed forces and seasonal or part-time workers, in general the labor force includes the armed forces, the unemployed and first-time job-seekers, but excludes households and other unpaid caregivers and workers in the informal sector.

The present estimate of the Egyptian labor force, developed along the last quarter of this century from nearly 16 million to the present figure: ≈ 27.2 million (Table 1 and figure 2).

Table 1 and figure 2: 25 years' development of Egypt labor force

Year	Value
2012	27.193.916
2011	26.585.338
2010	25.986.819
2009	25.348.543
2008	24.773.710
2007	24.149.082
2006	23.118.796
2005	23.105.750
2004	22.191.651
2003	21.182.263
2002	20.234.194
2001	19.976.065
2000	19.687.527
1999	19.377.289
1998	18.354.014
1997	18.136.300
1996	17.926.634
1995	17.720.373
1994	17.740.922
1993	17.029.122
1992	16.484.237
1991	16.545.813
1990	17.035.841



Source: CAPMAS (2014). Egypt in Figures 2014.

The following **Box 2** illustrates some important figures on the employment structure in Egypt.

Box 2: Some important figures on the employment structure in Egypt (CAPMAS, 2014)

Labor force at January 2014:

- 27. 2 million (≈31.7% of Egypt population, and 48.84% of those aged 15 years+);
  - Labor-force participation: females 22.7%, males 77.3% aged 15 yrs +
  - Urban 41.8%, Rural 58.2%

- Employed (87.3%): 23,596 million; females 19.8%, males 80.2% aged 15 yrs +
  - Unemployed (12.7%): 3,425 million; 1,483 females and 1,942 males
- Employment to population ratio:
  - Ages 25+ yrs. 51.3%,
  - ages 15-24 yrs. 54.1%,
  - ages 05-14 yrs. 07.0%.
- Employed 42.8% in formal activities, while 58.2% in informal activities.
- Employed according to major economic activities (International Youth Foundation, 2013)
  - 27.1% in agriculture and fishing,
  - 24.9% in manufacturing industry, metallurgical and construction
  - 48.0% in services and trade.
- Employed in the Government: 5,219 million (22.1%), in the Public sector and Public Business sector: 0.871 million (3.7%), and in Private sector: 17,506 million (74.2%).
- Total dependency ratio= 52.9 (in 100 people ages 15-64)

Economic facilities:

- > 40,000 large and medium- scale enterprises,
  - 2.9 – 4.4 million small and ultra-small enterprises- registered and unregistered.

Table 2: Figures on population and labor force and world rank

Comparison	Rank - world	Value	Date	Source
Population, total	16	85,783,117	2014	CAPMAS
Area (sq. km)	29	1.001.450,0	2011	Worldbank
Gross domestic product in exchange rates (US $)	41	262.000.000.000	2013	World Factbook
Gross domestic product per capita (US$)	135	3,256	2012	Worldbank
Labor force	20	27.021.512	2014	CAPMAS
Labor force, female (% of total labor force)	168	24,2	2012	Worldbank
Labor force with primary education (% of total)	117	10,4	2011	Worldbank
Labor force with primary education, female (% of female labor force)	124	3,7	2011	Worldbank
Labor force with primary education, male (% of male labor force)	112	12,3	2011	Worldbank
Labor force with secondary education, female (% of female labor force)	74	35,4	2011	Worldbank
Labor force with secondary education, male (% of male labor force)	72	37,7	2011	Worldbank
Labor force with tertiary education (% of total)	74	19,2	2011	Worldbank
Labor force with tertiary education, female (% of female labor force)	48	29,1	2011	Worldbank
Labor force with tertiary education, male (% of male labor force)	70	16,3	2011	World bank

Source: Central Agency for Public Mobilization and Statistics- CAPMAS (2014). Egypt in Figures 2014. Issued in March 2014, CAPMAS at Cairo- Egypt; and World Bank (2013): Labor force - total in Egypt - Trading Economics.

In: www.tradingeconomics.com/egypt/labor-force-total-wb-data.html.

Table 2 illustrates few figures on population and labor force in respect to the world rank.

Legislative framework

Article 13 of the new Constitution, issued in January 18th, 2014 stated on the state responsibility on providing the labor force with security, safety and health requirements in their workplaces. In addition, the Constitution tackled the following basic elements:

- The central role of the healthcare authorities (especially for poor),
- The "therapeutic" and "preventive" health services,
- Health of special groups: Children; Women; Workers, those with special needs.

The Labor Law No. 12/ 2003 stipulates that the employer takes all necessary measures to ensure safety and health at the workplace in particular with regard to mechanical, physical, chemical and biological hazards (article 208). The law also requires the medical examination of the worker before employment, i.e. pre-placement (article 216), first aid measures, medical attention and treatment depending on the number of workers employed (art. 220), and also periodic medical examination of those workers who are exposed to the risk of any occupational diseases (art.219) annexed to the Social Insurance Law No. 79/ 1975 and amendments (see table 3 below). Employers shall inform workers of the dangers they are exposed to in case of non-observance of protective measures and shall provide them with personal protective equipment (art. 208 - 215) (Abo El-Ata and Nahmias, 2005).

Table 3: The List of Occupational Diseases annexed to the Law No. 79/ 1975 and its amendments.

1. Lead poisoning and sequels	21. Anthrax	37. Pharmaceutical substances.
2. Mercury poisoning and sequels	22. Glanders	38. Copper and sequelae
3. Arsenic poisoning and sequels	23. Tuberculosis	39. Tin and sequelae
4. Antimony poisoning and sequels	24. Infectious disease in hospitals and HCFs, as well as in other sites	40. Zinc and sequelae
5. Phosphorus poisoning and sequels	25. Beryllium poisoning and sequels	41. Ammonia
6. Benzol (benzene) poisoning and sequels	26. Selenium poisoning and sequels	42. Organic solvents incl. Hexane
7. Manganese poisoning and sequels	27. Diseases and manifestations due to abnormal barometric pressure	43. Occupational Asthma, due to: o isocyanates, o antibiotics o formaldehyde o detergents with enzymes in their composition o flour and grain dust
8. Sulphur poisoning and sequels	28. Diseases and manifestations due to exposure to hormones	44. Extrinsic allergic alveolitis
9. Chromium ulcers and sequels	29. Occupational noise-induced hearing loss (deafness)	45. Aluminium and sequelae
10. Nickel ulcers and sequels	30. Segmental body Vibrations affecting upper limbs' hands and wrists	46. Carpal Tunnel Syndrome
11. Noxious gases' poisoning	31. Poisoning by nitrates, nitrites, and nitro-glycerine and salts of nitric acid	47. Post-traumatic stress disorder
12. Cyanide poisoning and sequels	32. Cadmium poisoning and sequels	48. Occupational cancer due to: o asbestos o benzidine o benzene and homologues o b-naphthan-amyl o vinyl chloride o tar of coal, petroleum, etc. o beryllium o certain wood dust o other definite human carcinogens.
13. Poisoning by Halogens and sequels	33. Poisoning by alcohols, glycols, ketons and their different types and sequels	
14. Poisoning by Petroleum and gases	34. Diseases resulting from non-ionizing radiations, e.g. ultraviolet and infra-red	
15. Poisoning by Chloroform and carbon tetrachloride	35. Poisoning by pesticides	
16. Poisoning by Aliphatic hydrocarbons and other halides	36. Acrylamide and acrylonitrile	
17. Pathological effects of Radium and other ionizing radiation.		
18. Primary skin cancer and chronic inflammation and ulcers to skin and eyes		
19. Effects due to heat and cold		
20. Pulmonary Dust Diseases (Pneumoconiosis) due to silica (silicosis), asbestos (asbestosis), talc (talcosis), cotton dust (Byssinosis)		

Source: Extracted from: Annex1 to the Law No. 79/ 1975 on Social Insurance and amendments (Table 1 annexed to Law 79/ 1975)

Law No. 27/1981 concerning "Employment of Workers in Mining and Quarrying Activities": Title 4 of part II (Work Organization and Regulation) requires pre-placement examination and periodic medical examinations every 6 months for workers exposed to dust, including a chest X ray. Part II deals with working hours, sick leave, safety measures, health & social care, retirement, inspection and others. Moreover the Minister of Health issued 3 Decrees (59/ 1997, 283/ 1997 & 215/1998) and designated a committee of 5 members for reading, and diagnosing radiographs of workers exposed to dust & fibrous minerals in mines, quarries and specific remote areas. Out of more than 12.000 radiographs, 5.000 cases of pneumoconiosis were diagnosed and workers were accordingly compensated for disability.

Law No. 59/1960 on protection against ionizing radiation regulates licensing and use of radiation sources. Open sources are the responsibility of the Atomic Energy Organization (AEO). The Ministry of Health and Population (MOHP) is responsible for closed sources and X-ray machines and specifies qualifications and training of personnel using them. Both bodies (AEO and MOHP) inspect places with radiation sources and keep absorbed radiation doses and medical records of all exposed workers.

Law 79/1975, the Social (and Health) Insurance Law as amended by Law No. 25 (1977) is implemented by the Ministry of Insurance and Social Affairs. Its objective is to provide benefits for old age (including disability and death), illness, unemployment, work-related injuries (victims of occupational accidents and diseases or overexertion at the workplace) and social care (covering maternity). The social insurance scheme, Law 79, applies to all civil servants in government and public sector services, with no age limit; workers in public institutions and public sector units, regardless of age; and workers with regular employment in the private sector, who are over 18 years of age. Its coverage was extended in 1976 to small employers and the self-employed (Law 108/1976); to Egyptian workers abroad (Law 50/1978); and to temporary workers (Law 112/1980). Employees in the Government and public sectors aged 16 and over, and in the private sector, aged 18 and over, are insured against the consequences of employment-related injuries or

occupational diseases. Domestic servants are not covered; in addition, agricultural workers and artisans in practice fall outside the scope of the law. Compensation occurs for diseases listed in the schedule of occupational diseases, in case of injury resulting from accident at work, or because of work, or due to a commuting accident.

Institutional/ organizational Framework

Primary Health Care (PHC) services are essentially aiming at the following:

- Prevention of epidemics and the spread of disease,
- Protection against environmental hazards,
- Prevention of injuries,
- Promotion and encouragement of healthy behaviors,
- Response to disasters and assists communities in recovery, and
- Assuring the quality and accessibility of health services.

Much of these objectives are coinciding with those of basic OCH services and even the procedures and accessibility of target personnel are similar.

The "Essential Services of Primary Healthcare" include:

1. Monitor health status to identify and solve community health problems
2. Diagnose and investigate health problems and health hazards in the community
3. Inform, educate, and empower people about health issues
4. Mobilize community partnerships to identify and solve health problems
5. Develop policies and plans that support individual and community health efforts
6. Enforce laws and regulations that protect health and ensure safety
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable
8. Assure a competent public and personal health care workforce
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services
10. Research for new insights and innovative solutions to health problems

Basically, any public health activity, including OCH activities, can fit into one of these ten categories. So for example, Essential Service #1 includes activities such as data collection, community health assessments and the maintenance of employee's health registries. As another example, Essential Service #7 includes personal health care services as well as transportation and other enabling services and assuring the availability of culturally appropriate personnel and materials (Arnaout, 2006).

Primary Healthcare Services (Not including: health offices, child and mother care centers, district clinics, or comprehensive clinics), are accessible in 253 administrations in 27 governorates (1 – 26 admin/ gov.), through 4490 primary healthcare units, centers, clinics, etc. The units are distributed in rural areas (3936 in number, representing 87.7% of all primary healthcare units), and in urban areas (554 in number, representing 12.3%). Table 4, illustrates various categories of Primary Healthcare Services.

Table 4: Various categories of Primary Healthcare Services

1ry HC services	No.	%
Family health units	1,694	37.7
Family health centers	250	5.6
Rural health units	2,242	49.9
Medical centers	304	7.6
Total	**4,490**	**≈100.0**

Source: The National Information Center for Health and Population (2014)

Primary Healthcare Services are the frontline of healthcare services all over the country. Their mandate could be summarized as follows:

Manage the vast majority of cases, those need simple investigations and treatment,

Refer difficult cases to district, public, specialized and university hospitals,

Refer cases with suspected occupational etiology to HIO Centers and Hospitals

Primary Healthcare units and centers provide their services by a workforce of about 104,817 healthcare personnel, categorized as follows:

- 12,853 Physicians 12.3%
- 7,344 Dentists 07.0%
- 8874 Pharmacists 08.5%
- 46,359 Nurses 44.2%
- 10,889 Technicians 10.4%
- 18,498 others 17.6%

Secondary and Tertiary Healthcare Services are accessible through district, public, specialized and university hospitals, as well as the 'Health Insurance Organization's Centers and Hospitals'. The number and capacity of these hospitals are illustrated in table 5, below.

Table 5: The number and capacity of government- related secondary and tertiary healthcare services in Egypt

Category	Hospitals		Beds	
	number	%	number	%
General hospitals	256	23.6	29429	27.6
Specialty hospitals and branches	586	53.9	21578	20.3
Specialized Medical Centers› Amana hospitals	42	3.9	5105	4.8
Health Insurance Organization hospitals*	**38**	**3.5**	**6919**	**6.5**
Educational hospitals and institutes	19	1.7	4484	4.2
Curative Establishment hospitals	11	1.0	1922	1.8
University hospitals	83	7.6	33168	31.2
Other hospitals**	52	4.8	3860	3.6
Total	**1087**	**100.0**	**106465**	**100.0**

Source: The National Information Center for Health and Population (2014).

* Cover about 59% of the population, of whom 7.5 million employees (current and retired), 15 million newborns (and below school age), 20 million pupils and students at various educational levels (see figure 3 below).

** Belonging to police, public and public business establishments.

Figure 3: Percentage of beneficiaries of HIO services according to Law 79/1975 and amendments

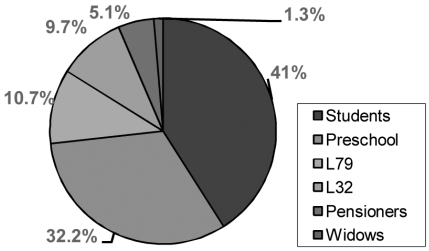
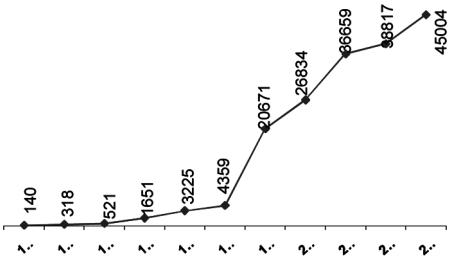


Figure 4: Development of number of population covered with HIO services along 45 years



L79= Law No. 79/1975 which standardizes benefits for insured workers; L32= Law No. 32/1977 which regulates benefits for government employees as well as their colleagues in public facilities and local municipalities.

Coverage of the insured population, through the Health Insurance Organization- HIO, rose gradually from 0.5% at 1965 to 59% at the end of 2013 (Figure 4). HIO provide healthcare services through:38 hospitals, 600 clinics,78 work related injury centers,34 general medical committees, thousands of school clinics, as well as outsourced hospitals (640) and outpatients' clinics (1,141) (Schwark and George, 2011).

According to the social insurance scheme promulgated by the Social (and Health) Insurance Law No. 79/1975 and amendments, the occupational health surveillance is provided by the Health Insurance Organization Centers, through:

- Pre-placement medical examination ⟶ fit to work
- Periodic medical check-ups ⟶ early diagnosis of occupational disease/s à treatment, follow up and rehabilitation
- Evaluation of impairment/ disability ⟶ compensation benefits.

Workers can apply personally or through the facility/enterprise physician to the nearest Health

Insurance Organization Centre/ office to claim for compensation on their occupational injury /illness. The HIO center/office will then investigate the case; analyze its relation to occupation; decide and define the rating for physical and/or functional impairment; and determine the degree of disability giving right to compensation according to table (2) appended to Law 79 of 1975. The Health Insurance Organization (HIO) also starts treatment of such health impairments.

In case of death due to a work-related accident (at work + commuting) the compensation provided to the victim's family is equal to his/her salary/wages for 6000 days (≈25 working years).

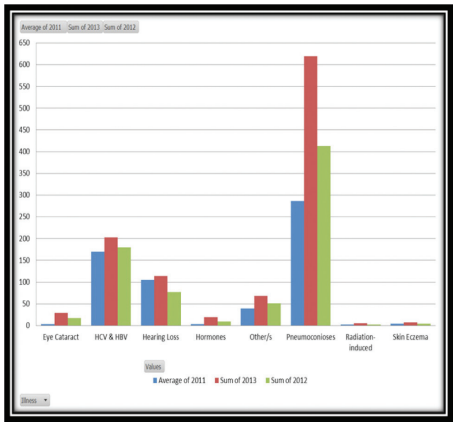
Decisions regarding diagnosis of an occupational disease or injury and matters related to compensation of benefits can be appealed to a special committee of referees, the decisions of which are final but can be brought to the general court. The committee membership and procedures are organized according to the Ministerial Decree 215/1997.

In addition to evaluation of disability, the HIO is also responsible, according to Law 79/ 1975 and Law 12/ 2003 (art. 216), to carry out both pre-placement and periodic medical examinations. The HIO usually perform 125-150 thousand pre-placement medical examinations and 400-450 thousand periodic medical check-ups, annually. Both types of medical examinations are regulated by the ministerial decree no. 133/ 1983 (for pre-placement medical examination) and no. 218/ 1977 (for the periodic medical checkups).

The number of cases being compensated for their proved 'occupational illnesses' during the last 3 years, are illustrated in table 6 and figure 5, below.

Table 6 and figure 5: Number of cases compensated for occupational illnesses during the last 3 years.

Illness	Years		
	2011	**2012**	**2013**
HCV & HBV	170	180	203
Pneumoconioses	286	413	619
Hearing Loss	105	77	114
Hormones	3	9	19
Skin Eczema	4	4	7
Eye Cataract	3	17	29
Radiation- induced	2	2	5
Other/s	39	51	68
Total	**612**	**753**	**1064**



Source: The Annual Report on HIO activities- 2014 "Fifty Years of Progress".

Table 7 and figure 6, below, illustrate the number of outpatient- employees' in various HIO injury centers and clinics as well as those referred to specialists in selected years along the past 30 years.

Table 7 and figure 6: The number of outpatient- employees' in various HIO injury clinics as well as those referred to specialists in selected years along the past 30 years

Year	Outpatient employees	Patient employees referred to specialists
1985	5,845,870	2,806,834
1990	9,459,987	5,787,569
1995	13,131,758	10.862,370
2000	10,719,744	12,767,116
2005	9,043,749	13,516,428
2010	5,870,895	11,896,018
2013	6,477,847	12,377,451

Source: The Annual Report on HIO activities- 2014 "Fifty Years of Progress"

Table 8, below, illustrates 33 years series of injured employees benefited from the HIO- injury centers.

Table 8: Injured employees benefited from the HIO- injury centers

Years Parameters		1980	1985	1990	1995	2000	2005	2010	2013
No. of centers		30	32	36	48	62	61	72	73
No. of cases	New	100,333	95,123	92,954	106,129	67,615	42,672	34,324	37,341
	Old	215,845	186,648	232,080	296,145	177,691	13,351	114,093	115,247
	Total	316,178	281,771	325,034	402,274	245,306	156,023	148,417	152,588
Refer to specialist		32,250	38,487	37,452	48,950	34,950	25,060	22,804	20,877
Refer to hospital		2,637	3,0006	4,872	5,817	4,970	4,086	4,234	4,586
Cured cases		96,845	90,689	93,363	99.859	63,472	38,179	51,770	31,404
Lost days		1,714,272	1,166,153	1,976,447	2,400,002	1,112,524	987,082	1,050,579	1,050,579

Source: The Annual Report on HIO activities- 2014 "Fifty Years of Progress"

Shortcomings

Based on the findings detailed above as well as previous diagnostic studies (Massoud et al., 1982, Said, 2014, Assaad and Krafft, 2013, and Sabbour, 2012) and the long experience with occupational health practices in Egypt, there are many difficulties and shortcomings preclude the comprehensive coverage with basic occupational health services. These could be summarized as follows:

- Uncovered population and labor force
  - About 40% of the population are still uncovered with the HIO umbrella,
  - Still, a majority of the Egyptian working population (≈20 million- 75%) are not insured for their health, mostly among temporary and informal laborers.
- Less budget allocated for health than it deserve
  - Public expenditure on health represents 3-5% of the total

public expenditure, compared to more than 10% in many countries with decent healthcare systems.

- Insufficient public, employers and employees' awareness;
  - Deficient communication with employees on OCH services.
- Deficient practice 'Guidelines' and 'codes of practice';
  - Pre-placement and periodic medical exams not well standardized.
- Weak 'voluntary compliance' versus inadequate 'obligatory enforcement';
  - Inadequate policy and procedures enabling Basic OCH services.
- Scarce OCH physicians and nurses;
  - General Practitioners (GPs) and Family physicians are not yet ready to provide Basic OCH services.
  - Limited number and capacity of professional units;
  - Deficient records and statistical reports;

Conclusion

Occupational healthcare services are essentially necessary for the Egyptian labor force that constitutes about 31.7% of the whole population and about 48.84% of those aged 15 yrs. or more. There is an urgent need of expanding the OCH services, which currently cover about one-quarter of the working population, to provide every employee with the basic OCH services as indicated by the international recommendations and the Egyptian Constitution, legislation and community necessity.

Recommendations- the way forwards

Supporting the current occupational healthcare services, aiming to cover all the employees with quality basic/ essential requirements should be the target of Egypt healthcare future policy and procedures. Collaborating efforts of the various categories of primary, secondary and tertiary healthcare services is necessary towards a real improvement in extending the coverage to the uncovered Egyptian employees. Supporting the primary healthcare services, especially in rural areas is quite important in providing frontline OCH services to millions of farmers and employees.

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