Healthcare Governance and Transparency Association
www.hegta.org

Health Finance & Investment Forum
Investing for a healthy future
HFIF Partner
www.hfif.org

GOVERNANCE AND TRANSPARENCY TO EMPOWER THE HEALTHCARE INDUSTRY

THE CASE OF EGYPT

Dr. Mostafa Hunter
Elvira Häusler

I. INTRODUCTION

Health represents the real wealth of any community and is a definite measure for social and economic development. Healthcare faces major challenges arising from the complexity of the provision process and its extreme sensitivity to adverse outcomes. In Egypt health has never been seen as a priority and this fact led to severe deteriorations during the last decades. Today, Egypt is facing a scattered healthcare sector in terms of service provision with a very high burden on out of pocket spending and deeply prone to corruption.

This paper will give an overview of the current state within Egypt by analyzing and comparing relevant indicators as well as the challenges and difficulties arising from them. Next, the concepts of governance and transparency within the healthcare sector will be explained, followed by an overview of the current governing structures of the healthcare sector in Egypt. The results of the analysis will be explained more detailed and addressed with recommendations.

Since Egypt is a country where it is not easy to find reliable timely and adequate information, all data and numbers have been researched very carefully. The authors tried as much as possible to get credible data. The tools and matrix analysis forms used in this study, as well as the recommendations are based on the personal experiences of the authors with healthcare system analysis and design.

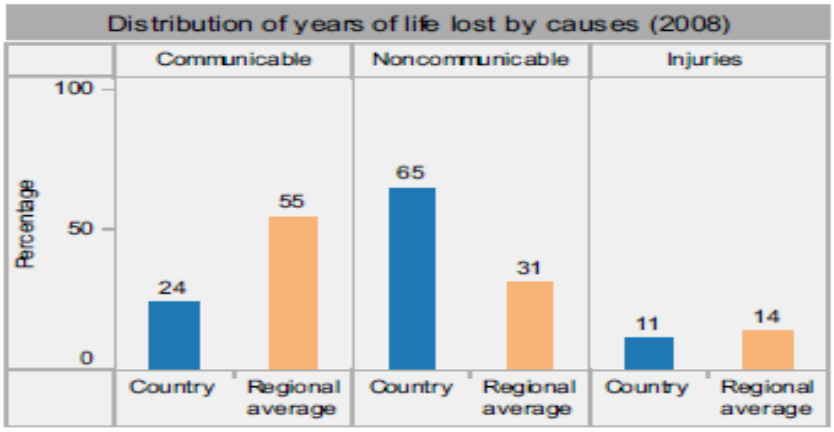
II. EGYPT COUNTRY PROFILE

In 2009, Egypt has spend a total of 5-6% of the GDP on health and the health expenditure per capita was about 282 Int. $. Overall, Egypt has a rather low physician density (2.83 / 1000 population) while physicians are basically localized in Cairo and Alexandria. Other parts of the country are underserved, while in Cairo clinics, centers and hospitals are very numerous. The hospital bed density is rather low, with 1.7 / 1000 population, again concentrated in Cairo, under serving the rest of Egypt. Huge improvement in the immunization rate as well as water and sanitation solved many primary health care issues.

	Egypt	Turkey	Germany
Total expenditure on health per capita (Intl $*)	282	965	4,129
Total expenditure on health as % of GDP	~5	6.7	11.3
Out of pocket expenditure as percentage of total health expenditure	72	35	25
Physician density / 1000 population	2.83	3.8	5.1
Hospital bed density / 1000 population	1.7	2.41	8.17
Age structure **0-14 Years: Male:** **Female:**	**32.7%** 13,725,282 13,112,157	**26.6%** 10,707,793 10,226,999	**13.3%** 5,569,390 5,282,245
15-64 Years: **Male:** **Female:**	**62.8%** 26,187,921 25,353,947	**67.1%** 26,741,33 26,162,757	**66.1%** 27,227,487 26,617,915
>65 Years: **Male:** **Female:**	**4.5%** 1,669,313 2,031,016	**6.3%** 2,259,422 2,687,245	**20.6%** 7,217,163 9,557,634

Source: WHO 2008, 2011

A comparison of economic and demographic indicators with other countries that have about the same number of population, Germany and Turkey, shows that Egypt is lagging behind in every aspect. The indicators show that the total expenditure in terms of GDP and per capita spending is generally low. The demographic situation shows that Egypt has a young population at the moment, nevertheless, it will transform into an aging population eventually. The US and many European countries are facing this problem at the moment and find it hard to address it in a right way. There will be a demand for different types of care and long term care (e.g. nursing homes). An aging population will have different disease patterns (as shift from infectious diseases to so called non-communicable diseases, NCDs). Primary care will no longer be in the focus, even more since most of the issues have been tackled successfully. The shift from communicable to NCDs is already recognizable (compare graph below). A growing and aging population will alter the need in healthcare services which will result in a cost explosion.



Source: WHO 2008

NCDs are the diseases that need most infrastructure, since they require long-term care patterns. Not only will non-communicable diseases change the demand for healthcare

service, but the market too, when it comes to the medical device industry and construction (Infrastructure). In addition to that, the fast-growing developments in technologies, are putting a vast pressure for upgrading of healthcare services. All this will put an economic burden on Egypt in terms of productivity and lives, as well as expenditure in healthcare.

Moreover, the lack of quality within the Egyptian healthcare sector is a big issue. Most public institutions have very bad reputation when it comes to quality of service. The little number of private hospitals that have a good reputation are only accessible to the very wealthy part of the population due to high costs of services without ceilings. Generally, the quality issue had resulted in a loss of trust in the (especially the public) sector. Basically, hospitals are not keeping records that document quality. There is no data available on hospital infection rates, complications, etc. The patient has no choice in treatment unless he is really wealthy. The average Egyptian patient has to take whatever service is being offered to him and is often facing corruption and unforeseeable costs. The treatment of a family member ruins families economically on a regular basis. In short, Egypt is facing:

- Burden of massive growth in total healthcare expenditure
- Massive demand for infrastructure and quality
- Massive needs for investments within the sector
- Growing pressure for social responsibility towards the population

The current governing structures of the healthcare sector are blocking the whole industry and hampering investment. This is resulting in duplication of resources, mismanagement and inefficiency and increasing the vulnerability to corruption. Hence, the implementation of governance and transparency may provide a complex but effective solution.

III. GOVERNANCE AND TRANSPARENCY AND THEIR ROLE IN THE HEALTHCARE INDUSTRY

Worldwide, the absence or inadequacy of governance and transparency has not only hindered the overall performance of the healthcare industry but also deprived the sector from valuable investment opportunities deemed critical for its sustainability and growth. Hence, it is crucial to introduce the concepts of governance and transparency for development to be enabled.

In a healthcare system, it is fundamental that the roles and responsibilities of the key players and stakeholders are classified and defined in order for it to be successful and efficient. The position of each organization has to be clearly defined according to its function and ownership structure and this has to be disclosed. Accountability should be created through segregation of duties as well as securing transparency and free flow of information.

Free flow of information is crucial for:

- enforcing accountability
- mitigating vulnerability to corruption
- eliminating resource duplication
- reducing waste
- achieving maximum utilization of core competencies
- fostering timely evidence-based decision making

Transparent and properly governed healthcare organizations with clearly defined roles, responsibilities and segregated duties should achieve high levels of efficiency and performance that can meet the demands of today's consumers and other stakeholders. Such organizations will also boost their ability to attract potential investments, so will a more transparent market. Transparency will raise the quality and the competition within a healthcare sector by disclosing information. At the same time, transparency will give patients the chance to chose and compare services and prices. Finally, corruption will be diminished to a great extend.

The governing structures of a healthcare system can be classified according to their function or ownership.

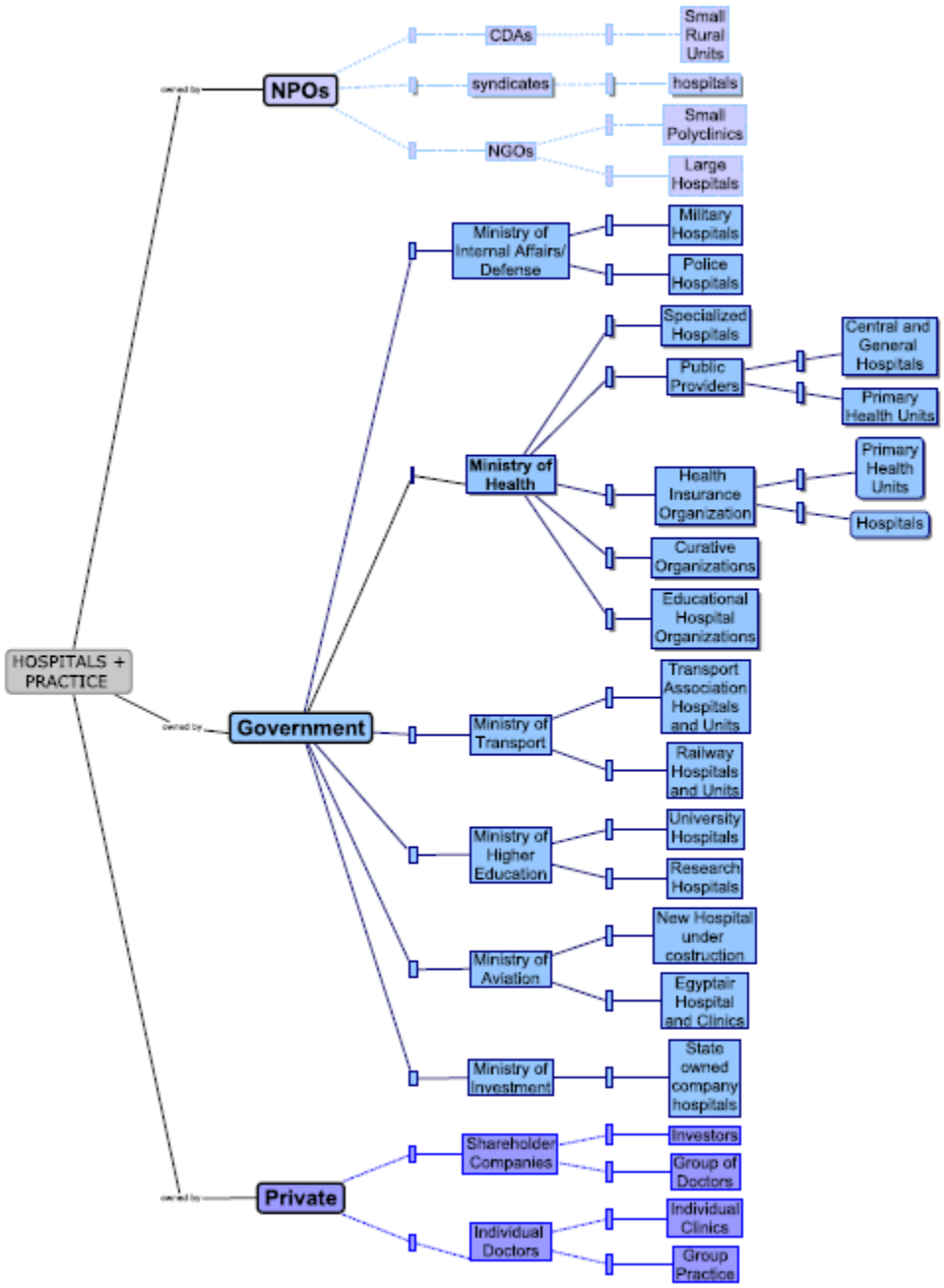
according to function	according to ownership
• service providers (treatment, research, education and training) • production industries (pharmaceuticals, consumables, machines and technology) • buyers of services (payer) • regulators (according to function or service) • representative bodies (Syndicates, Unions, Chambers) • intermediary bodies (TPA)	• governmental (governmental body/ authority/ government owned company) • private for-profit business • non-governmental not-for-profit organizations • mixed ownership

IV. EGYPT'S CURRENT GOVERNING HEALTHCARE STRUCTURE

i. Providers

Egypt is facing a co-existence of a multitude of healthcare providers that has historically developed and is enormously complex. It emerged from a strictly state controlled, socialist orientation to a mixed model (public and private). The strengths and weaknesses the industry is facing today arose from both: socialist and market-based influenced models. Hospitals and Practices can be owned by the government (public), Not for Profit Organizations (NPOs) or the private business sector. The public sector is divided into the MOH and other ministries, such as Ministry of Transport, Aviation, Investment, Internal Affairs/ Defense and Higher Education. The MOH runs public providers through five different entities, Central and General Hospitals as well as Primary Health Care Units (with the respective governorate), Health Insurance Organization hospitals and primary care units, Specialized Hospital Secretariat, Curative Organization Hospitals and Educational Hospital Association. The non for profit sector comprises NGOs (large hospitals and small policlinics) and Community Development Associations CDAs (small rural units). In addition to that there are hospitals and health units owned by syndicates. The private for-profit businesses are usually

shareholder companies (owned by a group of doctors or investors) or owned by individual doctors (individual clinics or group practice).



The graph shows that public healthcare service provision is not necessarily only duty of the MOH, but a multitude of other stakeholders that is hard to overlook.

ii. Buyers

Health Insurance Organization

The HIO has 4 laws in place that regulate the insurance. People employed in the public sector, pupils, students or widows are covered by insurance, privately employed have the option to opt out and usually do so. The HIO has its own network of hospitals and clinics and has only few contractual agreements with hospitals outside the HIO network. According to the HIO 44 million Egyptians are subscribed, which is more than half the population.

However, the HIO only contributes 6% to total health expenditure of Egypt. The insurance is usually only used by those who are not able to afford private care and usually in complex tertiary care services, which the patients cannot afford otherwise. There is no separation between the funding and service provision within the HIO.

Program for treatment at the expense of the state

This program included an account for financing uninsured patients, who cannot afford treatment. This program suffered a lot in the year 2010, where the expenditure was more than double the budget (around EGP 1.5.bn), which went unnoticed till the end of the fiscal year. There were related corruption scandals of using the fund for cosmetic surgeries, rich VIP treatments, treatment of insured patients, overpricing in private hospitals and political briberies.

Private for-profit insurance

Private insurance is only present to a certain extent. Most Third Party Administration companies, TPAs, in Egypt have not only functioned as management and processing intermediaries, but many of them also worked as brokerage companies and some of them started to take premiums, without being regulated by the governing law of the insurance. There are some national and international insurance companies operating in Egypt. Private insurance is only about 1% of the total health expenditure. Many of the private companies offer self-managed programs for their employees.

Not-for-profit NGOs and Syndicates

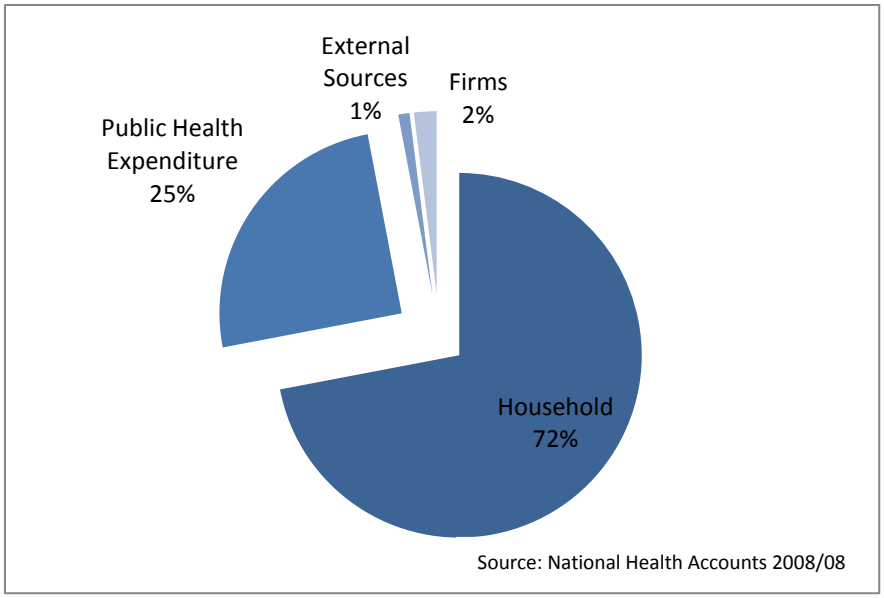
Besides insurance, there are several other payers including direct donations, syndicate programs for members, foreign aid funds and for-free services offered by private hospitals.

Out-of-Pocket Direct Household Expenditure:

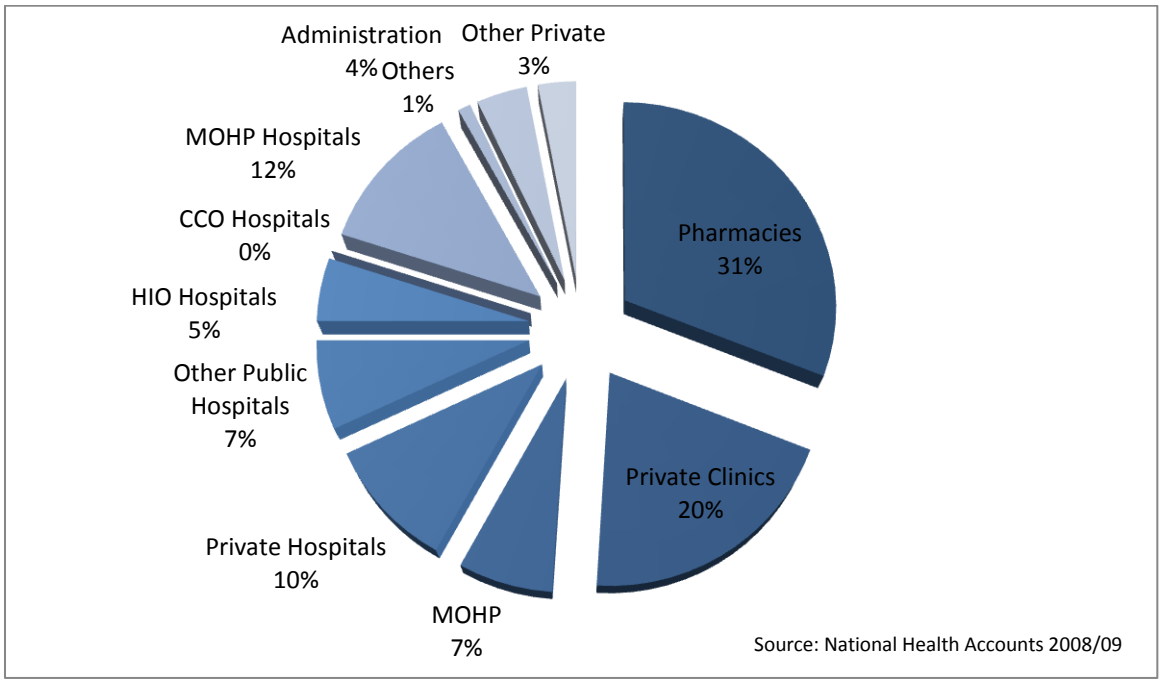
Despite the different financial systems explained above, the biggest part of the total healthcare expenditure is out of pocket payments (72%), which is one of the highest in the region, other countries range between 15% (Algeria) to 56% (Morocco) and in similar countries. This proves the inefficiency of the current funding system, which forced the population to move outside the healthcare structures.

iii. Flow of funds

Egypt is approximately spending 5-6% of its GDP on health, which is in the lower range compared to other countries in the region and worldwide. The total health expenditure consists of a big proportion of out of pocket payment (72%) and only to a little extent from public expenditure. The graph shows the fiscal year 2008/2009, tendencies are a further decrease in public and further increase in household expenditures.



There is an evident mixing between funding and service provision at all levels of the healthcare system. There is also no clear distinction between capital investment and operational investments. Most of the public funding is based on solid budgeting systems, rather than flexible result-based financing, which again counts for the inefficiencies in the system.



The graph shows that private facility spending for the fiscal years 2008/09 was about 64% of the total healthcare spending. Pharmaceuticals accounted for 31%. In contrary to that, spending on MOHP facilities accounted for 19% of the total spending and HIO hospitals 5%. Compared to the years before, clearly, private spending is increasing while public spending is decreasing. This concludes that most of the funding in the Egyptian healthcare system comes from and is spent in private-based systems.

iv. Regulatory bodies

Government-Based Regulation:

Some of regulatory bodies are installed but not or too little used, others still need to be created. There is no clear distinction between the role of MOH as a regulator, facilitator and a service provider. There is also no clear distinction between the roles of the MOH as a regulator of the technical parts of the service and the role of other ministries as a regulator of the organizations themselves.

For example, the MOH is responsible for the licensing of medical facilities, together with the relevant syndicates. However, all issues related to the governance and financing of such organizations fall under other parties that gives the license to the firm itself, which are the General Authority for Investment (GAFI) for private hospitals, the Ministry of Social Affairs for NGOs, and the MOF and Central Authority for Accounting for public hospitals. A substantial part of public hospitals belong administratively to the governorate. The MOH remains the main party for registering and even pricing of pharmaceutical and non-pharmaceutical medical products, however, the whole industry falls under the Ministry of Trade and Industries (MPTE). The MOH being a major purchaser of these products creates a clear conflict of interest and pressure on the producers, who are not able to negotiate legislative frameworks with the 'regulator', while fearing to lose an important 'client'. There is no clear definition and access to information for the flow of funds between the MOF and the MOH. There is mixing of roles between the MOH and MOHE regarding regulation and service provision of the 3 main services related to health, which are treatment, education and professional development, and research. Although the Egyptian Financial Supervisory Authority is the main party responsible for regulating the insurance market, a substantial part of the health insurance activities in Egypt are not regulated by it. These overlaps, vagueness and lack of coordination violate the whole accountability framework of the industry and hamper its growth. Information asymmetry, selective disclosure and abuse of confidentiality are major happenings within such a framework.

Market-based regulation

As the healthcare industry is not fostering competition, there are very few systems for market-based regulations. There are also very few civil society organizations like reputational agencies, whistle-blowers, customer and patient rights organizations functioning in Egypt.

v. Representative-bodies

Syndicates

Syndicates like the physicians, nurses and pharmacists, represent the working forces in the healthcare sector. However, they are again mixed in their roles by being involved in licensing procedures of organizations and service provisions for training and insurance services.

Chambers of Industries and Commerce

In general, the chambers of industries in Egypt like the Chamber of Private Healthcare Providers, the Medical Devices Division within the Chamber of Engineering industries, and the Chamber for Pharmaceutical Industries and Cosmetics are not very effective in playing

their ultimate role. Due to structural problems related to their mixed structure with the government and the mixing between the roles of the MOH and MOTI, they are still not strong. Another structural problem is the coexistence of two chambers, one for industry and one for commerce. There is also a cultural barrier in the Egyptian healthcare market, as the Egyptian industries are still not advanced in collective actions, lobbying and pressure-grouping.

V. NEW PARADIGM: GOVERNANCE AND TRANSPARENCY AS THE PROPOSED SOLUTION TO ADDRESS TO SHORTCOMINGS IN THE EGYPTIAN HEALTHCARE SECTOR

The chapter on the current governing structures has shown the present shortcomings in Egypt in a detailed way. A very effective yet complex solution is the introduction of governance and transparency into the sector. The advantages to the industry have been outlined in the previous chapter on governance and transparency.

The fact that there is no distinction between ownership and function as well as the high fragmentation within the providers leads to inefficiencies and duplications. These are very expensive. The structure of the system that mixes between provider and regulatory roles of the government as well as between providers and funders is an enormous problem. There is no distinction between capital and operational investment. On a macro level, the lack of a clear definition of who is responsible for the provision of different services such as treatment, research, education etc. is very questionable and leading to a waste of resources in terms of finances and manpower. The long-term planned law on social health insurance is still lacking a clear vision on funding. Generally, funding has no clear distinction between the Ministry of Finance on one side and the public providers of healthcare on the other side. This flow of funds is not very transparent and there are no efficient tools to give access to information about public spending on healthcare. Within the Ministries of Health and Higher Education, there is mix between funding and service provision and there is no distinction between the flow of funds allocated for treatment and education. There is a very minimal funding allocated for research. Moreover, although the Ministry of Health is the right authority for regulating services and securing the constitutional rights of all patients to access service, rather than providing services by itself, most of the funding is allocated to service provision. Moreover, there is a huge vulnerability for corruption in any level and layer of the industry. Additionally, the lack of accountability is producing another type of inefficiency and vulnerability to corruption. The absence of credible and timely information hampers evidence-based decision-making. This also increases the risk of investment in the country and hampers Egypt from competing as a medical tourism destination, depriving the country from a growing industry.

VI. RECOMMENDATIONS

The healthcare sector has to be analyzed in terms of institutions, bodies and governing structures, rather than only according to the quality of services.

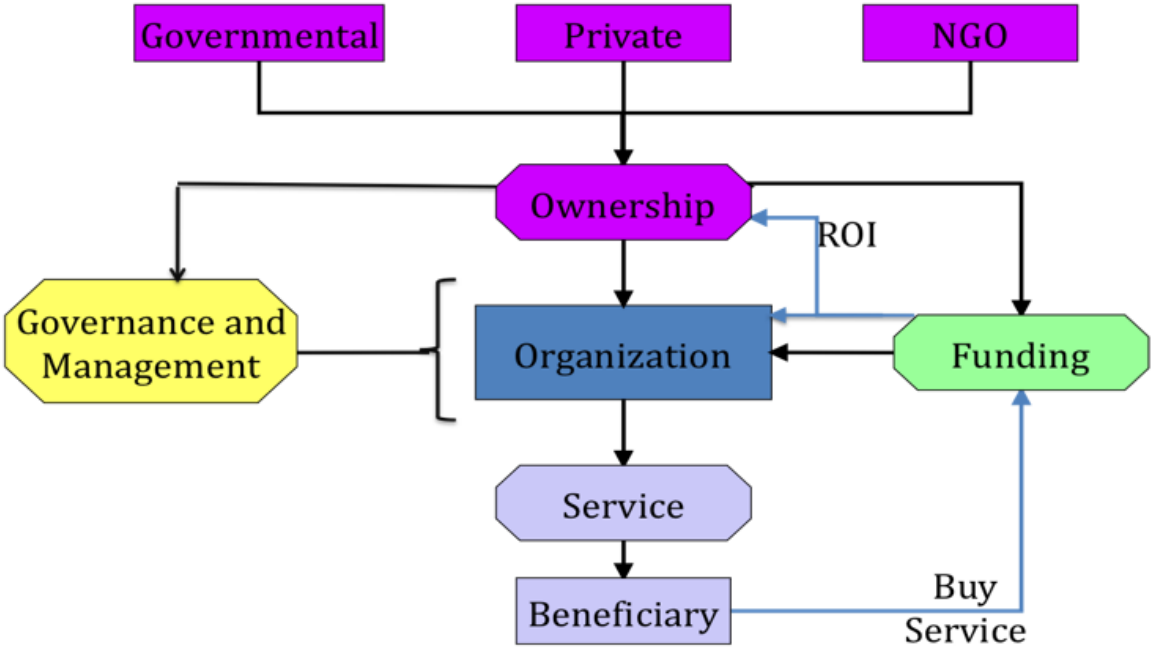
This analysis should be made in a universal way, including the key-players of the industry, such as providers, production industries, buyers, regulators, representative bodies and intermediary bodies. The structure of a healthcare system should balance the power of the

different stakeholders, distribute roles, responsibilities and authorities between them, foster accountability and secure free flow of information.

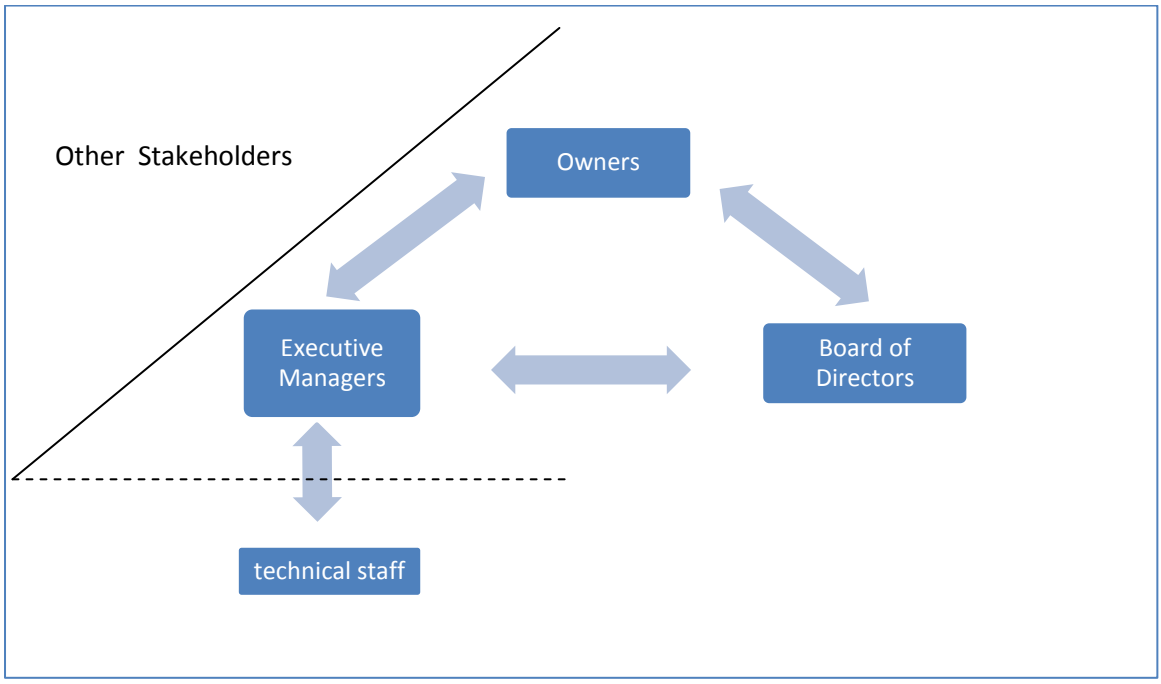
This can be summarized under the following principles that the authors recommend to be the pillars for the governing structure of the healthcare system in Egypt.

i. Split ownership from management and define a corporate governance structure for every organization:

In order to make this approach in an understandable way, we need first to define that any organization has owners either from the governmental sector, private business sector or non-governmental organizations. These owners invest capital into this organization. The source of this capital is taxpayers' money, donations and aid funds, private investments from shareholders or other financial tools like credit financing or leasing. The organization uses this capital to provide services / products to beneficiaries. These beneficiaries pay money to purchase these services / products. This money comes back into the financing of the organization. Finally, a certain return on investment (ROI) should come back to the owners, which can be financial or non-financial (in the case of public and not for profit sectors). This structure should be the same irrespective to the type of owners.



To achieve this, the owners assign a board of directors, which in turn assigns an executive management to run the organization in the best benefits of the owners and other stakeholders. There should be a clear governing structure that ensures accountability between these 3 different players. The role of physicians as technical staff within a healthcare organization should be distinct from their role as managers or board directors. Organizations need to split between the Board of Directors and the executive management. This creates accountability between them and helps the board scrutinize the management, which fosters efficiency, ensures long-term sustainability and decreases vulnerability to corruption. Other stakeholders should be put into consideration as well.



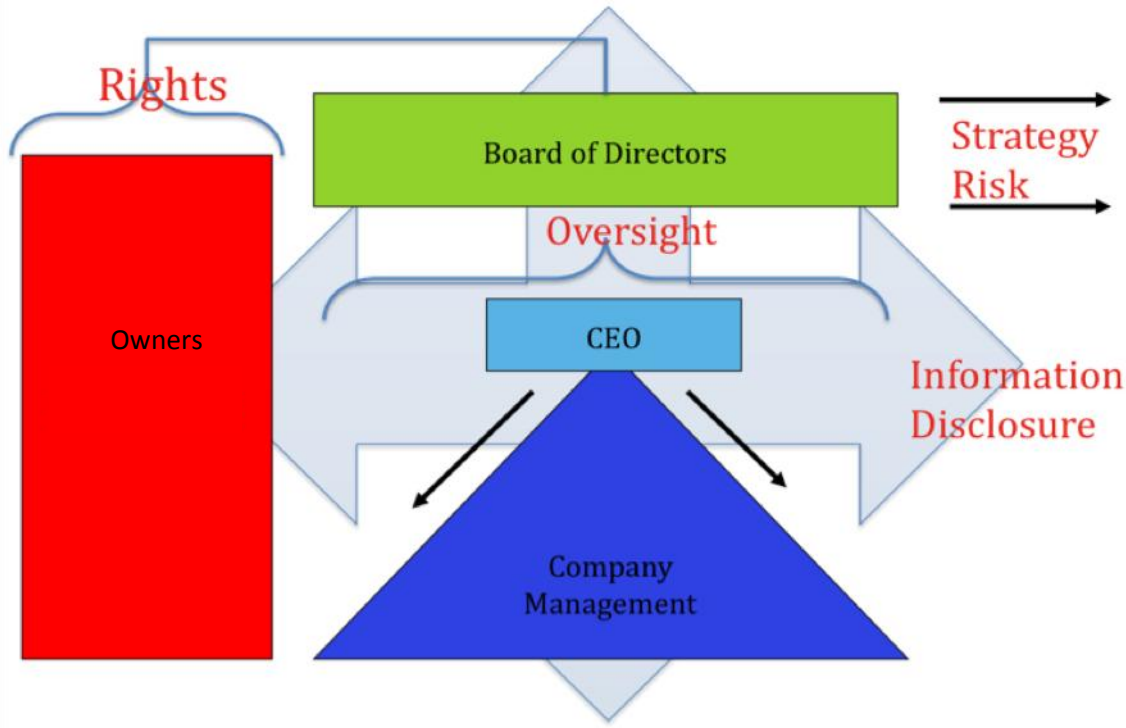
Board of Directors:

The major roles of the board are:

- Provision of long-term strategy
- Ensuring sustainability
- Risk management
- Overseeing the performance of the executive management
- Protecting the rights of the owners and other relevant stakeholders
- Ensuring the right policies for transparency and disclosure

The composition should look as the following:

- Right mix of skills/ qualifications (medical and non-medical; financial and legal experts etc.)
- Substantial number of independent directors
- Engaged members with authorization to take decisions



ii. Define services/ products and create distinction between the provider and its regulatory framework

<u>The service and its regulatory frameworks</u>

Services in the healthcare sector can be defined as

- Treatment
- Human Resources development
  - Academic Education and Degrees
  - Professional Development
- Research
  - Medical and Pharmaceutical
  - Health researches like epidemiology, economic etc.

Every service constitutes of:

- Facility where the service delivery takes place
- Human resources who deliver the service
- The output represented in the service itself

For each of the mentioned services and mentioned items above, we need to have a regulatory framework to ensure quality standards as follows:

- License to operate regulator
- Accreditation body/bodies to ensure the implementation of certain quality standards
- Organization producing standards and guidelines, doing field research, giving technical support and training on quality standards

The following matrices define the proposed regulatory frameworks for each of the services.

Treatment Services

	Facility	Human Resource	Product
License	MOH*	MOH + Syndicates**	MOH
Accreditation	Independent authorities for quality assurance	Independent authorities for quality assurance	Independent authorities for quality assurance
Guidelines and Standards	Authorized/Independent company or body (NGO, scientific society, etc.)	Authorized/Independent company or body (NGO, scientific society, etc.)	Authorized/Independent company or body (NGO, scientific society, etc.)

Professional Development Services (CME, CPD, Fellowship)

	Facility	Human Resource	Product
License	MOH*	MOH* + Syndicates**	MOH*
Accreditation	Independent accreditation body for CME + CPD	Independent accreditation body for CME + CPD	Independent accreditation body for CME + CPD
Guidelines and Standards	Authorized/Independent company or body (NGO, scientific society, etc.)	Authorized/Independent company or body (NGO, scientific society, etc.)	Authorized/Independent company or body (NGOs, scientific organizations)*

Academic Education Services (Bachelor, Master, MD, PhD)

	Facility	*Human Resource*	*Product*
License	MOHE***	MOHE***	MOHE***
Accreditation	National Association for Accreditation and Quality Assurance	National Association for Accreditation and Quality Assurance	National Association for Accreditation and Quality Assurance
Guidelines and Standards	Authorized/Independent company or body (NGO, scientific society etc.)	Authorized/Independent company or body (NGO, scientific society etc.)	Authorized/Independent company or body (NGO, scientific society etc.)

Research and Development Services

	Facility	Human Resource	Product
License	MOH* + MOHE***	MOH* + MOHE***	MOH* + MOHE*** Intellectual property regulations
Accreditation	Independent set of accreditation body + scientific commission + ethical commission	Independent set of accreditation body + scientific commission + ethical commission	Independent set of accreditation body + scientific commission + ethical commission
Guidelines	Authorized/Independent company or body (NGO, scientific society, etc.)	Authorized/Independent company or body (NGO, scientific society, etc.)	Authorized/Independent company or body (NGO, scientific society, etc.)

*Regulatory body: needs to be independent from service division of the MOH
**Regulatory body: needs to be independent from the representative role of the syndicate to avoid conflict of interest
***Regulatory body: needs to be independent from service division of the MOHE

Products and their regulatory frameworks

The products in the healthcare industry include:

- Pharmaceutical and cosmetic products
- Non-pharmaceutical products and devices including
  - Supplies and consumables
  - Instruments and implants
  - Devices and equipment
  - Furniture

	Facility	Human Resource	Product
License	MOTI	MOTI	MOH + MOTE Independent regulatory authority Intellectual property regulations
Accreditation	Independent set of accreditation body + scientific commission + ethical commission	Independent set of accreditation body + scientific commission + ethical commission	Independent set of accreditation body + scientific commission + ethical commission
Guidelines	Authorized/Independent company or body (NGO, scientific society, etc.)	Authorized/Independent company or body (NGO, scientific society, etc.)	Authorized/Independent company or body (NGO, scientific society, etc.)

iii. Split between buyers of services and service providers (irrespective of type of owner)

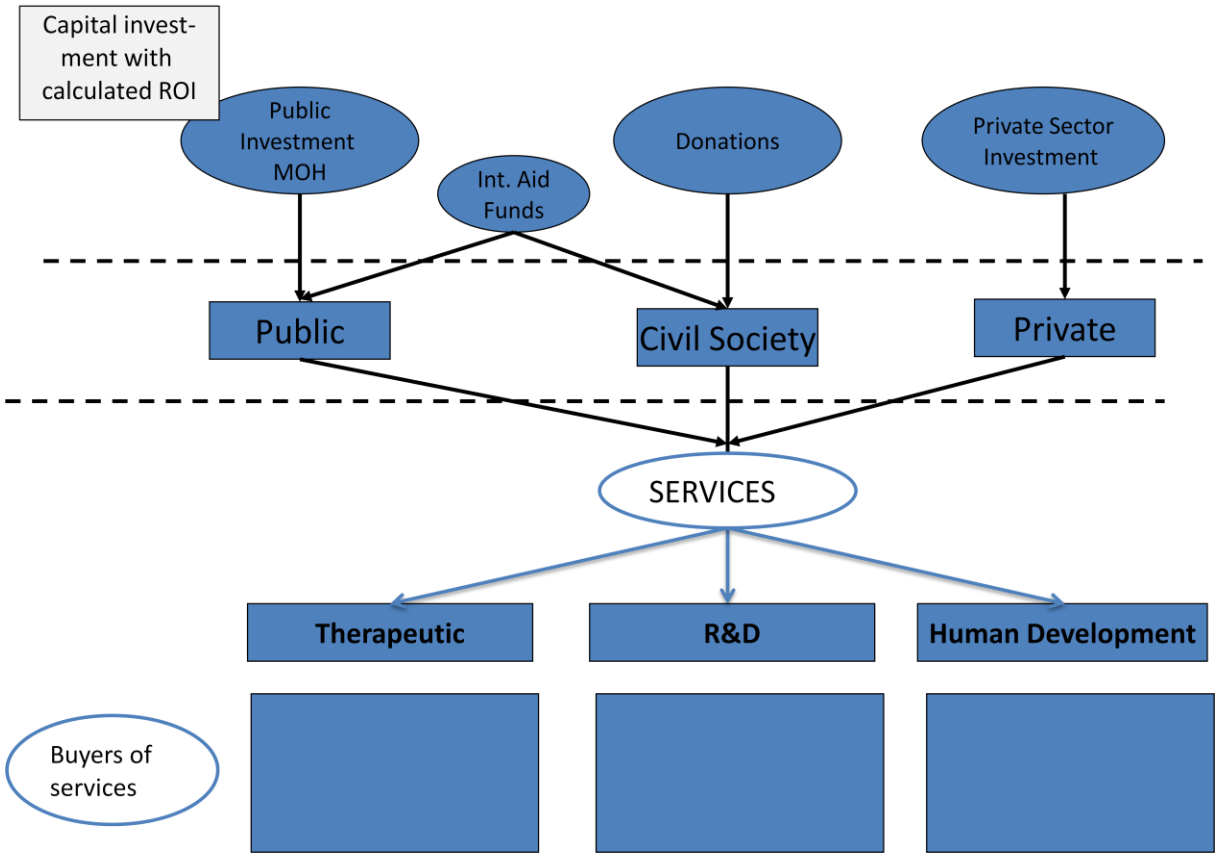
The money should follow the service in a competitive environment based on the quality of service and the price, irrespective of the owner whether it is public or private, for-profit or not-for-profit. The competition should be fair to avoid both governmental and private sector

monopoly and prevent usage of public money and donations to mask inefficiencies. All this should be done through transparent procurement processes.

	Provider	Buyer
Treatment	Hospitals Clinics Diagnostic centers Healthcare units Home care organizations Pharmacies	Insurance (through beneficiary contributions, government subsidy and donations). This can be public, private or NPO. Direct donations and aid funds Direct out-of-pocket for certain services
Research and Development	University hospitals Other hospitals licensed as a research facility Research and Development Centers Contractual research organization	Research funding organizations similar to Science and Technology Developing Fund (STDF) Corporate donations and research investment Donations, foreign aid funds, research grants Subsidy + governmental support similar to Industrial Modernization Center (IMC) Individual donations
Human Resources Development	University Hospitals Educational Hospitals Other hospitals licensed as training and/or academic institutes Training centers HR firms Management institutes	Professional development funding organizations and scholarship organizations Corporate donations and grants Donations, foreign aid funds, educational grants Subsidy + governmental support similar to Industrial Training Council Individual Donations

iv. Split between capital investment to create infrastructure and operational costs to run the facility

All money used in the healthcare infrastructure should be dealt with as capital investment money, irrespective of its source and irrespective of the organization receiving it. This money should be used to create the service in an efficient way that secures the highest quality possible at the lowest cost and secures a return on investment for the investors. These services should be then purchased by buyers as explained earlier.



v. Introduce the concept of governance and transparency within the healthcare industry

This can be achieved through various tools such as guidelines for disclosure and governance in hospitals, introduction of professional independent directors in hospital boards or the incorporation of classes on these subjects within the medical education as well as certification programs for health care managers and officials. Technical support for healthcare organizations is also needed.

vi. Independence of representative bodies

Representative bodies like unions, chambers, syndicates and business associations should not be involved in service provision. They should also have limited involvement in the licensing procedures to avoid conflicts of interests. Representative bodies should be independent from governmental influence. This would strengthen the role of these organizations in representing the interests of the individuals and/or organizations they represent.

vii. Integration of other regulatory frameworks and organizations

This should be through integration of healthcare services under other laws and entities that regulate the corporate level of any industry, for example

- Antitrust and competition protection authority
- Consumer protection authority

- Egyptian Financial Supervisory Authority
- General Authority for Free-zones and Investment
- Reputational and rating agencies
- Information right protection agencies and disclosure tools
- Pricing regulatory authorities

viii. Clear strategy for Corporate Social Responsibility and Sustainability

As this approach entails lots of involvements of the private sector, there should be a clear strategy to ensure these investments are socially responsible. Base of the pyramid inclusive business models and innovative social entrepreneurial solutions should be supported and encouraged to solve problems of the poor Egyptian population.

ix. Clear Strategy for Public Private Partnerships

This clear governing structure should be associated with clear models of PPPs. The roles of the MOF and other ministries should be clarified. Private sector involvement should be used to foster efficiency and not to only to use PPPs in building new hospitals.

VII. REFERENCES

www.who.int
www.healthsystems2020.org
http://hioegypt.org/english.aspx

About the Authors

Dr. Mostafa Hunter, Founder & President

Dr. Mostafa Hunter is the Treasurer of the European Health Management Association (EHMA), Belgium. He is also a Visiting Professor of International Healthcare Management and Corporate Governance and Strategic Corporate Social Responsibility Expert at the Management Center Innsbruck (MCI), Austria. He is also the Lead Founder and Chairman of the Healthcare Governance and Transparency Association (HeGTA) and the Egyptian Directors and Governance Association. Moreover, Dr. Hunter is also lead Founder and President of the Health Finance and Investment Forum. He is Deputy Chair of the Healthcare Committee and member of the Anticorruption Task Force at the Egyptian Junior Business Association (EJB). Dr. Hunter was awarded the "2011 Rising Star of Corporate Governance" from Yale School of Management in collaboration with its partners; the Open Compliance and Ethics Group (OCEG), the International Corporate Governance Network (ICGN), and Weil, Gotshal & Manges. He is certified director in corporate governance through the program conducted by the Egyptian Institute of Directors (EIoD) and the International Finance Corporation (IFC), accredited from the Egyptian Financial Supervisory Authority, RiskMetrics Group and the National Association of Corporate Directors (USA). Dr. Hunter worked between 2008 and 2010 as Advisor and Lead Expert for the Healthcare Sector at the EIoD, Ministry of Investment of Egypt to develop programs to strengthen corporate governance of private hospitals in Egypt to improve their access to outside capital. He also worked from 2010 till mid 2011 as a consultant to the UNDP Center for Transparency in Egypt to conduct a program for Financial Transparency in Healthcare Organizations. Dr. Hunter's special fields of experience are corporate governance, corporate social responsibility, international healthcare management and complex multi-stakeholder management. He is originally an ophthalmologist, which gave him in-the-depth knowledge of the dynamics of the healthcare industry from the physician, managerial as well as the investor perspectives. Living and working between Europe and Egypt gave him experience in both high and low-middle income countries as well as transitional economies and strengthened his international cross-cultural competence.

Elvira Häusler, Vice President

Elvira Häusler holds a Bachelor Degree in Political Science from the University of Innsbruck, Austria, with focus on European Union development policy in Africa and Reform Politics in the Middle East, as well a Master Degree in International Health Care Management from the Management Center Innsbruck, Austria. Elvira has gained broad experience within different policy levels in the healthcare sector in various countries. She spent 3 months in Sanaa, Yemen, working with GIZ on various projects within governance and health care. She spent also 6 months in Tanzania conducting the research for her Master thesis in the field of Priority Setting in Policy Implementation, where she gained deep insights in the Tanzanian Health Care System and its various institutions. She worked at the Austrian Ministry of Health, where she was involved in various projects on prevention, in particular in women health. Elvira Häusler is also part of the Healthcare Governance and Transparency Association (HeGTA) team, supporting the Chairman in various projects. Elvira is also the Vice-President of the Health Finance and Investment Forum, responsible mainly for the stakeholder management division.