

U N C L A S S

AGENCY FOR INTERNATIONAL DEVELOPMENT

Washington, D. C. 20523

PROJECT PAPER

EGYPT: Cost Recovery Programs for Health
(263-0170)

October 20, 1988

U N C L A S S I F I E D

UNCLASSIFIED

AGENCY FOR INTERNATIONAL DEVELOPMENT

Washington, D.C. 20523

PROJECT PAPER

EGYPT: COST RECOVERY PROGRAMS FOR HEALTH

Project No. 263-0170

UNCLASSIFIED

PROJECT DATA SHEET

1. TRANSACTION CODE

A = Add
C = Change
D = Delete

Amendment Number

DOCUMENT CODE

3

2. COUNTRY/ENTITY

EGYPT

3. PROJECT NUMBER

263-0170

4. BUREAU/OFFICE

Asia/Near East

5. PROJECT TITLE (maximum 40 characters)

Cost Recovery Programs for Health

6. PROJECT ASSISTANCE COMPLETION DATE (PACD)

MM DD YY
09 30 96

7. ESTIMATED DATE OF OBLIGATION

(Under "D" below, enter 1, 2, 3, or 4)

A. Initial FY 88 B. Quarter 3

C. Final FY 94

8. COSTS (\$000 OR EQUIVALENT \$1 =)

A. FUNDING SOURCE	FIRST FY 88			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total	10,000		10,000	75,000	20,000	95,000
(Grant)	(10,000)	()	(10,000)	(75,000)	(20,000)	(95,000)
(Loan)	()	()	()	()	()	()
Other U.S.						
1.						
2.						
Host Country						
Other Donor(s)						
TOTALS	10,000		10,000	75,000	20,000	95,000

9. SCHEDULE OF AID FUNDING (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) FSE	583	530				10,000		95,000	
(2)									
(3)									
(4)									
TOTALS						10,000		95,000	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)

920

910

11. SECONDARY PURPOSE

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code

DEL

B. Amount

13. PROJECT PURPOSE (maximum 430 characters)

To establish a sound financial basis for the health sector through cost recovery systems.

14. SCHEDULED EVALUATIONS

Interim MM YY MM YY Final MM YY
04 92 02 96

15. SOURCE/ORIGIN OF GOODS AND SERVICES

000 041 Local Other (Specify)

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a page PP Amendment.)

USAID Egypt controller concurs with the proposed methods of implementation and financing. Approval of advances to the Host Country implementing Agencies will be subject to assessment of accounting, internal controls, contracting and procurement capabilities of such agencies. Under MFAR methods, all specifications and cost estimates must be reviewed and approved in advance by the Mission's project support engineers.

WILLIAM A. MILLER, CONTROLLER

17. APPROVED BY

Signature
Marshall D. Brown
Title
Mission Director

Date Signed MM DD YY

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W COMMENTS, DATE OF DISTRIBUTION

MM DD YY

COST RECOVERY PROGRAMS FOR HEALTH

Project 263-0170

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- A. Logical Framework
- B. PID Approval Cable
- C. Statutory Checklist
- D. GOE Request for Assistance
- E. FAA 611 (e) Certification
- F. Gray Amendment Certification
- G. Technical Analysis
- H. Financial Analysis
- I. Economic Analysis
- J. Administrative Analysis
- K. Social Soundness Analysis
- L. Environmental Clearance
- M. Draft PPRGS Specifications Handbook
- N. Performance Disbursement Criteria
- O. Detailed Implementation Schedule

ACRONYMS AND ABBREVIATIONS

A&E	Architect & Engineer
CBD	Commercial Business Daily
CCO	Curative Care Organization
CDSS	Country Development Strategy Statement
RFTP	Request for Technical Proposals
CGC	Credit Guarantee Corporation
CPA	Certified Public Accountant
FAR	Fixed Amount Reimbursement
GOE	Government of Egypt
HIO	Health Insurance Organization
IFB	Invitation for Bids
IQC	Indefinite Quantity Contracts
LOP	Life of Project
MFAR	Modified Fixed Amount Reimbursement
MIC	Ministry of International Cooperation
MIS	Management Information Systems
MOH	Ministry of Health
M/TA	Management/Technical Assistance
PACD	Project Assistance Completion Date
PC	Personal Computer
PD	Project Directorate
PIO/Cs	Project Implementation Order/Commodities
PIO/Ps	Project Implementation Order/Participants
PM	Person Month
PPRGS	Policies, Procedures, Rules, Regulations, Guidelines and Standards
PSA	Procurement Supply Agent
RFTP	Request For Technical Proposals
ROI	Return On Investment
S&T/H	Science and Technology/Health
TA	Technical Assistance
UHDSP	Urban Health Delivery System Project
USAID	United States Agency for International Development

SUMMARY AND RECOMMENDATIONS

Cost Recovery Programs for Health

Project No. 263-0170

A. Project Summary

1. Introduction

Egyptians are guaranteed free health care under Ministry of Health (MOH) policy. The MOH administers a system of over 2,000 rural health clinics and 225 hospitals to implement this commitment. However, the cost of providing free health care is a heavy burden on the government development budget. Rapid population growth exerts heavy pressure on existing facilities, and funds are not available to expand the system. The MOH health care system can only provide rudimentary services of poor quality, since the budget is limited and they cannot charge fees. The free health care policy was intended to protect the poor, but it is not providing health care of acceptable quality to any social group.

Private health care services are a small proportion of the total in Egypt, comprising only 11.2 percent of all health care expenditures and 8 percent of all hospital beds. Large private group practices, with their more efficient allocation of skilled staff resources, are relatively rare. Prepaid health care systems, with their greater interest in preventive health care and cost control, are virtually unknown. Both individual and group private practitioners are heavily concentrated in metropolitan areas.

A comprehensive approach is required to address the complex problems of the Egyptian health sector. Building more hospitals is a problem rather than a solution, because they only add to the current heavy recurrent cost burden. What is required is a structural transformation of the health sector to put MOH facilities on a firm financial foundation through fee-for-service operation, and support the growth of private health care in order to relieve the government of its excessive burden.

2. Project Strategy and Feasibility

It is clear that Egyptians are willing to pay for quality health care. For example, two semi-autonomous government health care systems with dozens of hospitals and clinics between them, the Health Insurance Organization (HIO) and the Curative Care Organization (CCO), are currently charging fees for quality service and operating on a cost recovery basis. However, most of the existing MOH facilities will require considerable institutional development, renovation of facilities, and new equipment in order to provide the necessary efficiency of operation and the required quality of service. Existing HIO/CCO management systems, health care service quality, and fee schedules will provide model systems for cost recovery operation of converted facilities. Technical design studies indicate that MOH facilities can be

converted without major construction to provide improved health care service, and collect fees sufficient to cover their operational costs. Financial analysis estimated a financial internal rate of return of approximately 48 percent in real terms, indicating the very high efficiency of investing in conversion of facilities to cost recovery operation.

Even the health care providers currently operating on firm financial basis can be considerably improved. Technical studies indicate that improving the management and operations of the HIO and CCO will allow them to increase their efficiency and expand health care services to additional clients without adding new staff or facilities. Management improvements for these respected organizations also have considerable potential for "spread effect," and it can be anticipated that other health care providers will be motivated to adopt similar improvements.

Technical design studies of the needs of the private health care sector have concluded that lack of access to credit is a key constraint to the expansion of private practices. This is particularly the case in non-metropolitan areas, where MOH facilities carry the entire burden of health care. Access to credit is the key for setting up a practice in these areas, either for new graduates or for doctors presently working in government hospitals and clinics. In metropolitan areas credit availability is a lesser problem. Here the key constraint is lack of management expertise in individual and group practices. Particularly in group practices, which have the potential to utilize skilled manpower and allocate resources more efficiently, support for improved management techniques is a useful approach to fostering expansion of the private health sector.

3. Project Description

The purpose of this project is to establish a sound financial basis for the health sector through cost recovery systems. To achieve its purpose, the Project will fund an integrated program directed toward expanding and improving health care and cost recovery services. The program focuses on (1) enacting and implementing policy changes and institutional systems to introduce user fees and cost recovery throughout the GOE/MOH health care system; (2) introducing cost recovery management improvements to existing health insurance and fee-for-service health care providers; and (3) expanding private sector financing of individual, group, prepaid health care practices. These activities are packaged in the following three inter-related components:

(a) Component One - Implementing Cost Recovery Systems in GOE/MOH Facilities

Forty-five million U.S. dollars will be provided to the MOH by means of a performance-based disbursement system to finance the accelerated adoption and implementation of cost recovery systems throughout GOE/MOH health care facilities. A MOH Project Directorate will be given the mandate and assigned the required technical and managerial personnel to convert designated hospitals and clinics to fee-for-service operation. A technical assistance

contractor will supply all necessary technical support. The Project Directorate will develop an estimated 6-8 Cost Recovery Reform Plans (discussed below) over the life of project for converting approximately 40 MOH hospitals and 10 polyclinics to cost recovery institutions providing improved service and employing improved systems and user fees. Each facility undergoing conversion will be provided with adequate technical assistance and training for institutional development, as well as shelf item equipment. Renovation of facilities and offshore procurement of major equipment will be funded under "modified: Fixed Amount Reimbursement arrangements, i.e., funds will be disbursed to MOH based on implementation and payment schedules as approved by both MOH and USAID. As a condition precedent to disbursement of funds for facility renovation and equipment it is required that the GOE implement procedures to assess renovation and equipment needs, and formulate regulations governing the administration of funds.

A typical Reform Plan will consist of:

- selecting and identifying a specific number of MOH facilities for conversion;
- plans, cost estimates and schedules for cost-effective renovation, including equipment and technologies;
- specifications on level and quality of health services to be provided;
- plans for staff training and development;
- plans for new management systems, including information, maintenance and inventory control, and financial control;
- time-phased plans for converting the facilities into functioning cost recovery units;
- analyses of costs to be charged and projections of costs and revenues, demonstrating financial feasibility of conversion.

The management of each facility will develop and implement their cost recovery systems by improving staff, management, facilities, maintenance and services through appropriate contracting, training or other inputs. Completed hospitals and clinics will have more attractive and functional facilities, new medical equipment catering to the needs of patients, better organization and management, more efficient application of staff and other resources, resulting in significantly improved health care service. User fee payment systems, stratified according to the economic status of patients, will be established by each institution to generate local revenues. Each cost recovery facility will use the generated user fees to advance institutional self-sufficiency and improved quality of services. By the end of the project the facilities should be generating approximately 60% of operating revenues, and approximately 80% of the facilities will achieve self-sufficiency through user fees and third party payments.

Funds will be approved for one reform plan at a time, each encompassing 5 to 10 facilities. By the time the third reform plan is approved, the first one should be completed and the second well under way. Beginning with the third reform plan and all subsequent plans, approval of funds will be contingent not only upon the factors cited above, but also upon progress among completed facilities in implementing user fees. All completed facilities must achieve cost recovery from at least 60 percent of their patients, and 80 percent of facilities must be recovering 100 percent of their costs. In this way the project can insure that existing reform plans are working before approving funds for successive plans. In addition, this procedure builds in an incentive for the MOH to achieve its cost recovery objectives as quickly as possible.

(b) Component Two - Management Improvements for Current Cost Recovery Providers

The Project will provide \$10 million to improve the operational effectiveness and efficiency of current operating cost recovery systems, emphasizing management improvements and operations research activities. Major activities will focus on the Health Insurance Organization (HIO) and the Curative Care Organization (CCO). Smaller scale activities to improve management practices and fund operations research will involve medical school teaching hospitals, professional medical organizations, and other health care institutions.

Both the HIO and CCO have outgrown their rudimentary management procedures as they expanded from single care organizations to larger systems of facilities. Their monitoring and control procedures have become a patchwork of arrangements which were developed to deal with problems which faced these organizations at earlier points in their evolution. These procedures offer neither timely information or effective control. Modernization of management practices for these two large health care systems will increase their efficiency and enhance cost recovery. Since they are among the most respected health care institutions in Egypt, a considerable spread effect of this technology to other organizations can be anticipated.

The HIO already has a computerized MIS for beneficiary registration and drug usage at its Alexandria branch, developed under the Urban Health Delivery System Project (No. 263-0065). It has an experienced staff which is currently conducting design studies for expansion of the MIS in Alexandria to encompass cost accounting, patient records, and quality assessment modules. The project will provide the necessary technical assistance, training, and computer equipment for design and implementation of an expanded and improved MIS for the HIO Alexandria branch.

Since the CCO has little experience in MIS design and installation, they will require more substantial assistance. The project provides approximately twice the support for these activities in CCO as it does for HIO. The design of the MIS for CCO will draw heavily on the HIO systems and staff experience, adapted to the particular needs of the CCO. A U.S. technical assistance contractor will provide support for implementation of the system. Initial activities

will focus on developing a comprehensive system to encompass the current COO manual practices for financial and accounting systems and inventory control. Once the manual procedures have been developed and integrated into a system, computerization will be undertaken.

The project will also support somewhat smaller initiatives for improvement of management practices in university health care facilities and professional health organizations. The basic contours of these sub-projects will be negotiated between the Project Directorate and the participating organizations. Currently it is anticipated that support will be provided for two manual or computerized MISs for university health care providers, and for development of a model computerized MIS for group and individual health practices.

c. Component Three: Expansion of Private Health Care Practice

Private health care practitioners comprise a very small proportion of the total in Egypt, and are highly concentrated in metropolitan areas. Expansion of the private health sector will diminish the burden of the MOH system and help absorb surplus skilled labor from facilities converted to cost recovery operation. Expansion of the private health sector can also be fostered by supporting the development of group practices, which are inherently more efficient in their utilization of skilled manpower. Growth of the private health sector can also be assisted by supporting the development of prepaid group health care systems, an approach which emphasizes preventive health care, but which is currently uncommon in Egypt.

The major emphasis of Component Three is the expansion of credit accessibility for individual and group practitioners. The project will provide \$33 million (LE equivalent) for capitalization of a credit guarantee fund for loans to private health practitioners, with high priority given to new or expanded practices in non-metropolitan areas. Loans by participating banks will have repayment of principal 100 percent guaranteed by the program initially, decreasing to 50 percent or less toward the end of project as the superior repayment record expected of health care practitioners is proven. The resulting leverage will allow the AID funding to provide credit guarantees for \$70 million (LE equivalent) or more in loans.

The credit guarantee program will be administered by the Small Scale Credit Guarantee Corporation (CGC) which is currently being developed with technical assistance and training under the Private Enterprise Credit Project (No. 263-0201), and will be fully operational in 12 to 18 months. Component Three will provide technical assistance and training to the CGC in the specialized requirements of private health care practitioners. After the CGC is fully operational, funds will be obligated for capitalization of the credit guarantee fund.

The contractor will assist the CGC in establishing an accreditation and rating system for participating banks. Ceilings for loans under the guarantee program will be established for each bank, and criteria for loans will be

specified. Any loan within the guarantee ceiling and meeting CGC criteria will be virtually automatic. This will allow participating banks to operate more quickly and minimize their loan origination costs, and also eliminate the need for micro-management by CGC. Technical assistance and training also will be devoted to developing a support capability within the CGC to assist participating banks in improving their efficiency for servicing loans to private practitioners. This will include financial analysis, loan evaluation, access to and exchange of credit information, insurance claims settlement and guarantee recovery, and marketing of credit to the health community. These techniques will decrease loan origination and processing costs and increase collections, making loan activity to the private health sector more attractive.

Component Three also provides support for the development of individual and group practices by improving management procedures and upgrading service quality. This program will include publications, training courses and model management systems, with little or no direct assistance to any health care organization. A U.S. technical assistance contractor and appropriate local subcontractors will prepare guidebooks and training curricula and conduct training courses in health care management for individual and group practices. The project will also support the development of prepaid group health care systems. The major proportion of technical assistance under Component Three is devoted to this activity. The contractor will develop a model encompassing the complex empirical variables and estimates which must be considered in the design of a prepaid system. It will also develop a model management information system for monitoring and control of the resource inputs, financial operations, and service outputs characteristic of prepaid health care systems. These models will be adapted to the particular objectives and circumstances of each prepaid group health care system to facilitate the design process.

The contractor and local subcontractors will support interested groups in developing some 30 prepaid group health care systems. Assistance will include the preparation of detailed operational plans and projections which will enable each group to forecast initial revenue and expenses. This will form the basis for credit applications to the CGC under the credit guarantee program. The project also provides appropriate local and overseas training in the managerial and technical skills required for operation of prepaid systems. In addition, it will support approximately 20 operations research activities for design and implementation of the prepaid systems.

Project deliverables for all three project components are listed in Table S-1 on page ix.

4. Project Implementation

a. Organization and Management

An Executive Steering Committee will be appointed by the Minister of Health to provide policy, advisory and coordinating assistance to project activities and

participants. Membership will be representatives of MOH, MIC, the Egyptian Credit Guarantee Corporation, the Health Insurance Organization, the Curative Care Organization, the Medical Syndicate, a private health care provider, and the USAID Project Officer.

Component One will be managed by a Project Directorate reporting to the Minister of Health. The Directorate will be semi-autonomous, with administrative, personnel, financial and operational responsibility, including; planning, implementing and monitoring the component.

Component Two activities will be managed through existing staff organizations receiving grants. For example, activities for the Health Insurance Organization will be supervised by their Data Processing Center. Component activities will be coordinated with other implementing agencies through the Executive Steering Committee.

Component Three will be managed by the CGC under Law 159 as an independent, private sector joint stock corporation with a Board of Directors. The Board will be responsible for approving policy decisions, monitoring CGC performance and providing general guidance to the corporation's management.

b. Technical Support Services

To facilitate timely implementation, the AID/W centrally funded ST/H REACH Project will provide technical assistance for the project's first twelve months. Activities include developing and putting into operation basic policies, procedures, rules, regulations and guidelines and assisting in initiating project activities. IQC's or 8A contracts will be used for audits and evaluations.

Component One : Through an AID direct contract, a U.S. management system/technical assistance (MTA) contractor with Egyptian subcontractors will assist the Project Directorate in managing and monitoring the project. The MTA contractor will provide initial TA to each cost recovery facility in developing implementation plans and requests for technical proposals for contractors. Each health care facility converting to a cost recovery system may enter into local contracts, including A&E, management, fiscal accounting and maintenance.

Component Two :The U.S. M/TA contractor will assist each funded health care agency/provider in developing/adapting management improvements and management information systems. The systems will be specific to each unit's needs.

Component Three : The CGC, with assistance from M/TA contractor, will provide technical assistance to improve the capability of lending institutions in providing financial and credit services to health care providers. A U.S. consulting firm and local subcontractors will provide technical assistance to prepaid health care providers and private/group practices for management and quality care improvements.

c. Project Activity Completion Date

It is anticipated that implementation of the project will require 8 years, so the PACD has been established at September 30, 1996.

5. Cost Estimates

USAID will provide a total of \$95 million in funding for the project. The Government of Egypt contribution is LE39.85 million (equivalent to \$17.3 million*) in-kind over the life of project. An illustrative budget by component and activity is presented in Table S-2 on page x.

B. Project Committee

James Sarn, HRDC/H, Co-Chairman
Bill Duncan, PDS/PS, Co-Chairman
Kevin O'Donnell, AD/LEG
John Wiles, HRDC/H
Mohamed Mounir, FM/FA
Nishkam Agarwal, PDS/E
Sidney Anderson, PDS/P
Daniel Rathbun, IS/IR

Other Contributors

Lawrence Ervin, HRDC/ST
James Brody, FM/FA
Basharat Ali, PDS/PS

C. Recommendation

That the Mission Director authorize a grant of \$95 million for the Cost Recovery Programs for Health Project in accordance with the terms and conditions set forth in the Project Authorization which follows this summary. It is presently anticipated that funds will be obligated on the following schedule: FY88, \$10 million; FY89, \$15 million; FY90, \$30 million; FY91, \$20 million; FY92, \$20 million.

* The conversion rate of U.S. dollars at \$1 = LE2.30 is only made for presentation purposes and does not imply "maintenance of value" if the exchange rate changes during the life of project.

Table S-1
Project Deliverables
(in Dollars 000)
(Page 1 of 2)

I. Conversion of MOH Facilities		
1. TA and training for 50 sites		
a. MGT/Administration Staff Development	2,542	
b. Maintenance/Inventory control Systems	1,436	
c. Financial Control Systems	1,890	
d. Management Information Systems	3,332	
e. Procurement Agent Services	300	
f. Inspection Services for FAR Construction	<u>2,400</u>	11,900
2. Renovation of Facilities		
a. Equipment Procured Off-shore	10,000	
b. FAR Reimbursements		
(1) Construction/Renovation	16,500	
(2) Equipment Procured Locally	<u>4,500</u>	31,000
3. Training		
a. approximately 60 person-months of short-term academic training	370	
b. approximately 60 person-months of short-term on the job training	430	
c. approximately 5200 hours of on-site training	<u>800</u>	1,600
4. Operational Support to Project Directorat		<u>500</u>
Sub-total Component I		<u>45,000</u>
II. Management Improvements, Existing Organisations		
1. Equipment, four Management Information Systems		3,800
2. Training		
a. approximately 40 person-months of short-term academic training	200	
b. approximately 80 person-months of short-term on the job training	520	
c. approximately 5000 hours of on-site training	<u>780</u>	1,500
3. Technical Assistance		
a. to HIO	1,100	
b. to COO	<u>2,100</u>	3,200
4. IC Operations Research Studies		<u>1,500</u>
Sub-total Component II		<u>10,000</u>
III. Financing of Health Care Practices		
1. Technical Assistance for Feasibility/Design Studies		1,500
2. Training and Related Equipment		1,700
3. Project Support Services		2,300
4. Guarantee Fund		33,000
Sub-total Component III		<u>38,500</u>
IV. Audits, Assessments, and Evaluations		<u>1,500</u>
Project Total		<u>95,000</u>

Table S-2
Illustrative Budget by Component and Activity
\$(000)
AID Life-of-Project

	<u>Component</u> A	<u>Component</u> B	<u>Component</u> C		<u>LOP</u> <u>TOTAL</u>
	Cost Recovery MOH Facilities	Manage- ment Improve- ment	Health Care Practice Finance*	Eval- uation & Audit	
Guarantee Fund			33,000		33,000
Equipment/Commodities ¹	10,000	3,800	200	-	14,000
Renovation/Facilities ²	21,000	-	-	-	21,000
Training	1,600	1,500	1,500	-	4,600
Support Services	12,400	4,700	3,800	1,500	22,400
TOTAL	45,000	10,000	38,500	1,500	95,000

¹Offshore Procurement

²Including Shelf Item Procurement

*USAID authorized LOP level is \$38.5 million for Component C. Current obligation includes \$1.5 million for technical assistance for this component. Future year obligations will depend on review of progress under Component C.

Note: these cost estimates are illustrative only, and funds may be shifted between line items by mutual agreement between GOE and USAID.

PROJECT AUTHORIZATION

Name of Country: Arab Republic of Name of Project : Cost Recovery for Health
Egypt

Number of Project: 263-0170

1. Pursuant to Section 531 of the Foreign Assistance Act of 1961, as amended (the "Act"), I hereby authorize the Cost Recovery for Health Project (the "Project") for the Arab Republic of Egypt ("Cooperating Country") involving planned obligations not to exceed Ninety Five Million United States Dollars (\$95,000,000) in grant funds over six years from the date of authorization, subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to help in financing the foreign-exchange and local-currency costs of goods and services required for the Project. The estimated Life of Project is eight years from the date of initial obligation.

2. The Project will assist the Cooperating Country in expanding and improving health care and cost recovery services. The Project is intended to have three main components: (a) planning for and implementing cost recovery systems in Ministry of Health facilities; (b) management improvements for current cost recovery providers; and (c) expanded financing of private health care practices. The funding level and other details concerning component (c), with exception of start-up technical assistance, will be reconfirmed prior to obligation of funds for that component.

3. The Project Agreement, which may be negotiated and executed by the officer to whom such authority is delegated in accordance with A.I.D. regulations and delegations of authority, shall be subject to the following essential terms and covenants and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate.

a. Source and Origin of Goods; Nationality of Services:

Goods and services, except for ocean shipping, financed by A.I.D. under the Project shall have (as applicable) their source, origin and nationality in the Cooperating Country or in the United States, except as A.I.D. may otherwise agree in writing. Ocean shipping financed by A.I.D. under the Project shall, except as A.I.D. may otherwise agree in writing, be financed on flag vessels of the United States.

b. Conditions Precedent to Disbursement

(1) First Disbursement

Prior to any disbursement or to the issuance of any commitment documents under the Grant, the Cooperating Country shall, except as the

Parties may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D.:

(a) A statement of the names and titles of the persons who will act as the representatives of the Cooperating Country, together with a specimen signature of each person specified in such statement.

(b) Evidence of establishment of a Project Directorate, including delegation of authority for components (a) and (b) as referenced above, under the Project Steering Committee, and including assignment of required managerial and technical staff.

(c) Evidence of restructuring of the Cost Recovery Project Steering Committee, including delegation of authority for policy decisions, planning, and implementing of component (a), referenced above, of the Project.

(2) Additional Disbursements: Renovation of Facilities

Prior to any disbursement or to the issuance of any commitment documents under the Grant for the purpose of financing renovation of facilities or related equipment, the Cooperating Country shall, except as the parties may otherwise agree in writing, furnish A.I.D., in form and substance satisfactory to A.I.D., evidence that:

(a) Appropriate authorities of the Cooperating Country have approved the conversion of such facilities for operation on a fee-for-service basis.

(b) Appropriate cost estimates are in hand for carrying out such renovation work and procurement and plans exist to obtain necessary equipment and commodities.

(c) Appropriate plans exist for operation of such facilities, once renovated and equipped, on a fee-for-services basis.

(3) Additional Disbursements: Credit for Private Health Providers

Conditions precedent and covenants relevant to this component will be confirmed prior to obligation of A.I.D. funds therefor.

c. Covenants

The Cooperating Country shall covenant substantially as follows:

(1) The Cooperating Country will provide, on a timely basis, all local logistic support as may be required to ensure effective use of Grant-financed goods and services.

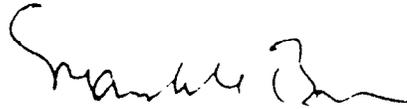
(2) The Steering Committee and the Project Directorate will meet formally with the A.I.D. Project Officer, at least semi-annually, to discuss major elements of Project progress.

(3) The Project Directorate shall furnish A.I.D. annual implementation and financial plans.

(4) The Grantee shall maintain appropriate records, and provide to A.I.D. on request the details of its counterpart contribution to the Project.

(5) Neither Grant proceeds nor funds derived from the Special Account may be used to pay salary supplements or incentives except in accordance with mutually agreed guidelines.

(6) Any taxes on expatriates arising under Grant-financed work will be paid directly or reimbursed by the Cooperating Country from its own resources.



Marshall D. Brown
Director, USAID/Egypt

Oct 24, 1968

Date

I. BACKGROUND AND RATIONALE

Egypt was a pioneer in the establishment of rural health services in 1942. Since that time, a variety of innovative steps have been taken, including the integration in 1952 of separate community health programs within rural health units. The Government made a commitment in its 1962 Constitution to provide free health care to all citizens, and it has made a valiant effort by developing over 2,000 rural health units and over 225 hospitals. However, rapid population growth has exerted tremendous pressure on existing facilities, and competing budget priorities have prevented the expansion of financial support. Lacking significant fees for health services, these facilities cannot provide quality services or expand to serve the increasing patient load. It has become apparent that the good intentions manifested in the Constitution cannot support an adequate system of quality health care.

A. Government Health Care Facilities

The Ministry of Health provides the following health care facilities:

- Basic or Primary Health Care: Approximately 2100 rural health units and 55 small rural hospitals providing integrated clinic services for maternal child health, school hygiene, communicable disease control and general therapeutic care. These clinics and hospitals service 20 million out-patients and 16,000 in-patients per year.
- Central and General Hospitals: Located in the Markaz and governorate capitals, these major curative care referral units include 190 central and general hospitals, providing health services to more than 21 million out-patients and 1.1 million in-patients annually.
- University and Specialty Hospitals: There are 25 University hospitals. Specialty hospitals include pediatric/obstetrics, mental facilities, TB and chest disease, ophthalmic hospitals, leprosy facilities, student hospitals, fever and communicable disease hospitals, and assorted specialty and educational hospitals. They serve approximately 5.4 million out-patients and 216,000 inpatients per year.
- Semi-autonomous MOH Health Care Systems: There are two government health care systems which operate with considerable autonomy. Both charge fees for quality health services, and have considerable control over staff and other resources. The Health Insurance Organization (HIO) provides health insurance for 3.5 million workers nationwide, and labor accident and occupational health insurance for 6 million workers. Facilities include 66 polyclinics and medical centers and 25 hospitals. The Curative Care Organization (CCO), encompasses 15 hospitals in Cairo and Alexandria.

The health care facilities directly administered by the MOH provide only rudimentary services of relatively meagre quality, since their budgets are limited and they cannot charge fees. The MOH budget of LE 35 million for its basic or primary health care system provides less than LE 1 per person per

year for health care service. These low expenditure levels cannot support adequate service levels, maintenance of facilities and equipment, or the retention of quality personnel.

The semi-autonomous health care systems, on the other hand, provide satisfactory service levels on a fee-for-service basis. Both the HIO and CCO have relatively high degrees of client satisfaction, indicating a willingness to pay for quality health care even when free health services of a lower caliber are available. Both services are in sound financial condition, with net incomes of 8 to 12 percent on gross revenues.

B. Private Health Care Services

Private health care services are a relatively small proportion of the total in Egypt, comprising 11.2 percent of all health care expenditures and 8 percent of all hospital beds. Currently there are no private health maintenance organizations, preferred providers, independent provider associations or other prepaid health care systems. As in most countries, private health care practitioners are heavily concentrated in metropolitan areas.

The small size of the private health sector is to some extent a function of the pervasiveness of public health facilities. However, the government now welcomes an expansion of the private health sector, since it cannot divert its budget from critical development priorities to expand MOH health facilities. The relative lack of private practitioners in provincial cities and rural areas was previously thought to be a function of market forces, but recent analysis indicates that lack of access to credit has been a stronger impediment. Technical experience, along with inaccessibility of capital, has impeded the development of prepaid group health care systems. The private health sector has tremendous potential to increase its share of the health care burden in Egypt.

C. Constraints to Developing the Health Care Sector

Population growth and rising expectations are exerting pressure to expand present health care facilities and improve services. However, development of the sector faces a variety of basic constraints.

- The free health care policy prevents generating revenues to finance the expansion of facilities or improvement of services. This policy was intended to protect the poor, but it is not providing health care of acceptable quality to any social group.
- Because of competing developmental priorities, funds are not available for expanding government health care facilities. Even if GOE or AID funds were available to expand the system, without basic policy changes their provision would create a heavy recurrent cost burden rather than provide a lasting solution.

- Government health care facilities lack control over staffing and other resources, and are the employer of last resort for medical school graduates. These facilities must be allowed to coordinate and control their inputs in order to provide quality health service and attain efficient operation.
- The government has ordered that the HIO and CCO services be expanded to provide wider coverage, but sufficient investment funds are not available for developing new facilities. It is believed that services could be increased significantly by incorporating modern management systems to replace present outdated and unsystematic practices.
- The private health sector is neither substantial nor dynamic, particularly in the provinces and rural areas. Vigorous expansion of private health practices and prepaid health care systems would relieve government health care facilities of a considerable burden.

D. A Strategy for Sectoral Transformation

A permanent solution to these problems requires a complete transformation of the policy framework, institutional structure, and financial operation of the health care sector. The Ministry of Health is fully aware of this, and is prepared to make the necessary policy changes, convert its facilities to fee-for-service operation, and transform its health care system to a cost recovery basis. The first requirement of this transformation is the improvement of health care services. The Cost Recovery Programs for Health Project will provide funding and technical assistance for this purpose.

The HIO and CCO clearly demonstrate that health care systems can operate on a cost recovery basis in Egypt. They provide a paradigm for the level of service, organization and operation of financially viable health care facilities. This Project will assist the MOH in converting 40 selected hospitals and 10 clinics of varying type and condition. Conversions include institutional development and upgrading facilities and equipment. A performance disbursement mechanism will provide funding for packages of 5 to 10 facilities after AID has approved detailed, integrated plans and schedules for conversion to a cost recovery basis.

In changing its policy from free health care to fee-for-service, the GOE has no intention of abandoning those who cannot pay. Rather, it is undertaking a transition from a system which clearly does not offer satisfactory service to anyone, to one providing improved health service to all social groups. The CCO uses a stratified fee schedule which provides low-cost health service to a quota of indigent patients. A similar approach will be used in the converted facilities, thus supporting higher quality service for all patients.

Although the HIO and CCO are currently operating on a sound financial basis, they can be significantly improved. Both organizations use outdated management practices, and could expand their caseload by using modern management systems to coordinate and control their resources. This Project will design and install management information systems for the HIO and CCO.

This will improve their efficiency, and encourage the spread of modern management systems to other health care facilities.

Expansion of the private health sector must be part of any comprehensive strategy for improving Egyptian health services. This project will develop a credit program to private practitioners, emphasizing loans for establishing practices in peri-urban and provincial areas. It will also provide technical assistance and encourage credit accessibility for developing group and prepaid health care systems. This will stimulate an expansion of the private health sector and diminish the burden on government facilities.

E. Project Rationale

AID policy supports efforts to establish a sound financial basis for health care systems. The AID Policy Paper on Health Assistance notes that "Health financing activities should address development of private services, fees-for-service, efficient resource allocation and use equitable distribution of resources, cost containment, and the overall organization of the health system." This is virtually a recipe for the Cost Recovery Programs for Health Project, which responds to all these guidelines.

The USAID FY 1989 CDSS repeatedly stresses two themes: the need to control recurrent costs, and the value of encouraging private sector expansion to diminish reliance on government institutions. One of the three areas identified for health and nutrition programs is expanding cost-effective investments for health services, emphasizing cost recovery for a more rational health financing system. The Project focuses on these themes by assisting the government to convert health facilities to a fee-for-service cost recovery system, and providing credit and technical assistance for expansion of the private health sector.

The GOE's funding constraints do not allow for expanding health care facilities and services. This constraint has stimulated the MOH to consider sweeping reforms in order to expand facilities and increase the quality of services. They are prepared to convert existing facilities to a sound financial basis by changing to fee-for-service operations. They are also encouraging an expanding role for the private sector in carrying the burden of health care in Egypt. Both of these are important elements of the Cost Recovery Programs for Health Project. USAID/MOH committees have been developing the project since 1984, and are in agreement on its strategy and basic approach.

F. Relationship to Other Projects and Lessons Learned

USAID has gained considerable experience with the Egyptian health sector and health care delivery through four Mission health projects: Strengthening Rural Health Delivery, Urban Health Delivery Systems, Suez Medical Education, and Control of Diarrheal Diseases. These experiences have yielded lessons on what works in project design, project management and implementation. These lessons are reflected throughout the Project.

II. PROJECT DESCRIPTION

A. Project Goal and Purpose

The goal of the Cost Recovery Programs in Health Project is to improve the health of the Egyptian people by enhancing the quality, availability, sustainability, and accessibility of health services.

The Project purpose is to establish a sound financial basis for the health sector through cost recovery systems.

To achieve its goal and purpose the Project includes a comprehensive approach involving three components. Component One will assist the GOE in implementing policy changes and institutional development for converting selected MOH hospitals and clinics to fee-for-service facilities providing improved health services and operating on a cost recovery basis. Component Two promotes the modernization of management practices in two leading health care systems currently operating on a cost recovery basis, to improve their efficiency and spread these improvements to other institutions. Component Three focuses on the private health sector to encourage its expansion, and diminish the MOH burden accordingly, by providing funding and technical assistance for the expansion of credit to private practitioners and the development of prepaid group practices. Detailed descriptions of the three components follow.

B. Component One: Conversion of MOH Hospitals and Clinics to Cost Recovery Basis

The HIO and CCO have clearly shown that health facilities in Egypt can operate successfully on a fee for service basis and recover their operational costs. It is equally clear that substantial fees cannot be charged without providing improved medical service, which calls for considerable investment in institutional development, improved facilities and equipment, and financial systems development. The HIO/CCO examples demonstrate that a viable cost recovery health facility is much more than good doctors in an adequate building. It must have effective management to allocate personnel and physical resources efficiently, and it requires concise and timely information to monitor financial and other operations.

The MOH is prepared to make the policy changes and structural modifications required for cost recovery operation of its facilities. As a basis for the project it will issue a decree designating selected hospitals as Cost Recovery facilities, with regulatory status similar to the HIO and CCO. This means that fees can be charged to cover the cost of operations, and revenues can be retained in the facility for its operation, maintenance, and improvement. It also means that skilled personnel can be hired via annual contracts which provide more adequate pay in return for specified higher level performance.

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A Project Steering Committee which participated in development of the project will be revised to direct its implementation. A Project Directorate will be created within the MOH to undertake implementation of Component Three, with U.S. and local technical assistance contractors to provide necessary support for conversion of facilities to cost recovery systems. This mechanism has been utilized previously on USAID/MOH projects, and provided satisfactory implementation arrangements. Appropriate managerial and technical personnel will be assigned to the Directorate by MOH as a condition precedent to initial disbursement. No new personnel will be hired for the Directorate, which will be a temporary organization to be absorbed into the MOH before project completion. No AID funds are provided for salary supplements.

Component One will provide \$45 million to support the conversion of 40 hospitals and 10 clinics into cost recovery facilities. This includes improving management systems, upgrading service delivery systems, enhancing personnel effectiveness and productivity, and rehabilitating facilities and equipment. Each health facility is unique, and thus the mix of inputs will differ in each case.

Detailed plans for institutional development, upgrading facilities and equipment, and financial monitoring and control systems must be prepared and approved as a basis for proceeding. These plans will include:

- Assessment of baseline institutional, physical, and financial conditions.
- Specification of scope and quality of planned services and anticipated patient load.
- Detailed plans, cost estimates and schedules for cost effective rehabilitation and conversion of facilities to support improved services.
- Specifications, cost estimates and rationale for new equipment.
- Plans for staff training and development.
- Plans for design and installation of management systems, including information systems, maintenance and inventory controls, and financial management systems.
- Integrated system plan and schedule for completing conversion of the facility.
- Specification of fee structure and projection of revenue and expenses, demonstrating financial feasibility of conversion to cost recovery.

These conversion plans will be certified by the MOH and reviewed and approved by USAID in blocks of 5 to 10 facilities. A rigorous performance disbursement plan will provide funding for each package, in order to control both the design and implementation process. The initial disbursement will require the

MOH to issue a decree specifying the conversion of selected facilities to cost recovery status, assign staff to the Project Directorate, and prepare plans for developing its management capabilities. A second disbursement will fund project startup, including technical assistance for developing specifications and general plans, and securing a long term technical assistance contractor to provide support for the conversion of facilities to cost recovery operation. A third disbursement will provide funding for an initial block of 3 or 4 facility conversions, after the above plans, specifications and procedures have been developed and approved. Subsequent performance disbursements will be made for each consecutive Conversion Package, based on the feasibility of the plan and the implementation of previous conversions. The performance disbursement plan is described in greater detail in Section III, and presented in Annex N.

Component One involves three basic activities: (1) Institutional development, (2) Technological Improvement, and (3) Financial Systems Development.

1. Institutional Development

Institutional development activities will focus on achieving improved management systems stressing flexible and responsive approaches such as those pioneered by the CCO and HIO systems. They will also emphasize staff development to improve capabilities to manage improved health care services and cost recovery systems. Specific areas for systems development will be (a) designing and applying policies, procedures, regulations, guidelines and standards (PPRGS); (b) administrative, staff development/productivity systems; (c) management information systems to monitor and control the operations of each cost recovery facility; and (d) logistical management systems to maintain quality services, facilities, and equipment.

a. PPRGS Development and Institutionalization

Development of management policies, procedures, rules, regulations guidelines and standards (PPRGS) will be critical to implementing and coordinating the cost recovery system. PPRGS development will be a key output of second disbursement funding and a prerequisite deliverable prior to Disbursement Three. The PPRGS will be used by the Directorate and USAID project management as a matrix or "cookbook" for guiding the development and evaluation of cost recovery services in the targeted facilities and for other future cost recovery activities.

The PPRGS will be developed by the Project Directorate in collaboration with national and governorate health professionals and private sector experts, assisted by expatriate and local technical assistance. Approximately, 110 pm of TA will be available throughout the life of project for design and evaluation activities related to PPRGS development. Successful components of the CCO, HIO and other exemplary GOE/private sector health systems will be used as a basis for PPRGS development. Very detailed guidelines for developing the PPRGS system have already been prepared, and are included in Annex M.

b. Management, Personnel and Staff Development Systems

Management, administrative and personnel systems will be developed by adapting and applying the general systems outlined in the PPRGS to each of the cost recovery facilities by the Project Directorate, the cost recovery facility management team and technical assistance contractors. The project will provide 56.5 pm of expatriate TA for design/evaluation and 96 pm of local TA for project development assistance to each facility. Cost recovery facilities can access approximately 12pm of TA each (600 pm total) for institutional development of appropriate PPRGS and administrative/personnel systems.

- Personnel efficiency and productivity will be improved by adopting new personnel practices including contract hiring, concise definitions of responsibilities, and performance evaluations.
- Staff development will be introduced through on-site training for management personnel which will include at least 130 hours of formal training per facility in relevant aspects of management and administration. The Project Directorate will work with the Director of each facility to prepare a training plan and administer all training.
- Special training workshops and seminars will be prepared to present new approaches for implementing cost recovery methods and improving the quality of health care services. These will be conducted by local contractors, and will include 6 person months of staff training per facility and 40 person months for the Project Directorate staff and other MOH/GOE officials.
- Approximately 60 months of short term training and 60 months of on-the-job training will expose MOH/GOE health care personnel to state of the art managerial and quality care practices associated with cost recovery activities.

Procurement and contracting are important administrative skills when converting to cost recovery operations. The Project provides approximately 14 pm of assistance to the Directorate and 4 pm to each facility (total of 200 pm) to improve these skills.

c. Management Information Systems

Management information systems will be designed and implemented to provide timely monitoring, evaluation and feedback for each of the 50 cost recovery facilities. PPRGS will outline basic requirements for initiating an adequate management information system in each cost recovery facility. Directorate consultants in collaboration with the facility management will develop a MIS plan with electronic and manual components. Key areas will be management data (service unit use analysis, financial management/cost accounting and basic management controls), maintenance management, logistics/inventory control and basic patient registration information. The project will provide

approximately four microcomputers per facility and appropriate software for financial spreadsheets, inventory control, word processing, data storage/retrieval and basic statistical analysis.

To facilitate MIS development, Component One will assist the MOH with 26 pm of design/evaluation expatriate TA, 132 pm of Directorate TA and 12 pm of TA for each facility (600 pm total). Contractors will work with project and facility staff to develop and install an integrated system for facility management and improved patient care.

d. Logistics/Maintenance Management Control System

Currently, few MOH/GOE health facilities have adequate management control systems for maintenance or logistic/inventory control. The project will introduce preventive/operational maintenance programs for equipment users; monitoring facilities and equipment through graded indicators (red/amber/green operational status); and minimum downtime for inoperable equipment. Appropriate shelving and storage facilities will be provided. Maintenance and logistics/inventory management practices will be outlined in the PPRGS.

Developing the PPRGS for maintenance and logistic/inventory management will be aided by 26 pm of expatriate TA. The Project Directorate will insure that the PPRGS are appropriately adapted to the cost recovery facilities through some 192 pm of local TA which will be the largest single TA component available from the Directorate. Component One will provide each facility with approximately 12 person months of maintenance and logistic/inventory management TA, a 600 pm total.

Approximately six person months of on-site training will be available to each facility and 40 person months for Directorate and other MOH/GOE officials (total of 340 person months of local training). The major focus of the training will be workshops to identify optimum preventive maintenance, operational maintenance and equipment repair procedures.

2. Improvement of Technology and Facilities

This activity involves upgrading diagnostic and therapeutic services in cost recovery facilities through appropriate equipment, facility renovation, and equipment use training. Diagnostic and therapeutic services in most MOH/GOE facilities are seriously underfunded and deficient, particularly quality laboratory services. A major focus of equipment purchases and renovations is to improve the diagnostic and therapeutic capability and operational efficiency of cost recovery facilities.

Outpatient, pediatric, ob-gyn and surgical services are usually high demand/volume services critical to quality patient care and the success of cost recovery programs. The project will focus on improving these services through better equipment and appropriate facility renovations, including basic sanitation and utilities upgrading.

Laboratory services are essential to providing quality health services and are a major source of revenues. Appropriate level laboratory services, including hematology, microbiology and biochemistry, will receive high priority. With improved equipment capability, significant improvements can be realized in accurately diagnosing many infectious, metabolic and hematological diseases.

The project will provide substantial technical assistance for A&E and commodity procurement. The Project Directorate will use some 180 pm of local TA for initial planning and monitoring of renovations, and the cost recovery facilities will use a total of some 960 pm of A&E TA for assistance in designing and supervising renovations. It is estimated that clinic renovations will require approximately 12 pm each, small hospitals 18 pm each and larger hospitals some 24 pm each. Some 200 pm of purchasing/contracting TA will be provided to assist with medical equipment specifications, preparing and evaluating RFTPs and contract negotiations. Significant portions of the 132 pm of Directorate and 600 pm of facility TA for maintenance and logistic control can be used to insure the appropriate use and maintenance of laboratory and other patient care equipment and renovations.

3. Financial Systems Development

This activity will provide (a) macroeconomic analysis and policy development for the health care sector; and (b) financial management, analysis and accounting procedures to manage cost recovery facilities and utilization of locally generated revenues.

a. Macroeconomic Health Sector Policy Analysis and Development

Component One will provide approximately 52 person months of technical assistance to facilitate analysis of the determinants of cost effectiveness, efficiency and benefit measurements for the health care delivery system. The Project Directorate will prepare the economic analysis data in coordination with appropriate MOH operational units. The MOH will use this information to facilitate developing the cost recovery system and for budgeting health delivery services. Particularly important deliverables for the macroeconomic health sector management plan will be the design, implementation, and evaluation of the following systems:

- Management control system to compare the operation of various facilities within the MOH/GOE health system, particularly cost recovery facilities. Key management control areas of interest include cost effectiveness; efficiency and benefit indicators for facility performance; financial programming methods; budgeting methods; reporting methods; and fiscal and operational analysis methods.
- Budgeting/Fee Setting/Capitation systems to determine the overall extent to which cost recovery can augment current GOE budgetary requirements for health care services in various socioeconomic settings.

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- Economic Failure Avoidance Review systems to facilitate understanding of the characteristics of successful and unsuccessful efforts of cost recovery facilities to achieve financial self sufficiency.
- Financial performance profiles to include paid patients versus subsidized patients per unit and per facility; payroll expenses, staffing patterns and employees per average hospital census per day; payroll expenses per employee; and total expenses per bed per unit per day, including commodity and pharmaceutical expenditures.

b. Financial Management Systems

The financial systems of the GOF/MOH health care system will be improved by developing and adapting the financial management PPRGS to cost recovery facilities. The Project Directorate will develop the financial management PPRGS in collaboration with national and governorate level health professionals and subsequently provide technical assistance to each cost recovery facility to adapt the PPRGS to local settings. The project will provide the Directorate 12pm of expatriate TA for design/evaluation and 132pm of local TA for design/evaluation and assistance to facilities. Each cost recovery facility will be provided with approximately 12 person months of CPA technical assistance (600 pm total) to implement appropriate cost recovery financial management systems/accounting practices and staff training.

Increasing the capacity of the system to provide standardized periodic reporting data will be the focus of design and evaluation efforts. Financial management systems will include:

- Accounting systems, compatible with GOF standards, designed and implemented for revenue centers, expense centers, mission centers, key service centers, program centers and opportunity costs.
- Standard accounting formats evaluated and defined for cost recovery facilities which outline balance sheet revenues/expenses; changes in fund balances; working capital; changes in financial position; activity revenues; costs and income.
- Formatted audit guides for facilities.
- Budget development procedures outlined; data development (historical and forecasting); and unit budgets.

All plans for facility performance disbursements will include sub-plans for developing financial management, control and accounting systems for each facility. Evaluation of previously funded financial systems should be completed prior to submission of new disbursement plans to insure appropriate modifications for the cost recovery system.

4. End of Project Status for Component One Activities

- Cost recovery management systems and provider services in 40 hospitals and 10 clinics.
- Cost recovery facilities recovering operating costs from at least 60 percent of patients.
- Locally generated funds being appropriately managed and used to improve preventive and curative care services in the facility and community.
- 80 percent of the cost recovery facilities achieving operational self-sufficiency.
- Cost recovery facilities using cost effective contracting mechanisms for hiring staff and providing essential services.
- Appropriate PPRGS system developed and frequently modified for use by the Project Directorate and cost recovery facilities.
- Improved quality of services for patients/clients of targeted cost recovery facilities.

B. Component Two: Management Improvements for Existing Cost Recovery Facilities

There are two health care systems currently operating in Egypt on a fee-for-service basis and recovering most or all of their costs. They are the Health Insurance Organization (HIO) and the Curative Care Organization (CCO). Both serve as a paradigm for the conversion of other MOH hospitals and clinics to a cost recovery basis. Component Two will provide funding and technical assistance for improving the management information and control systems of these and other health care systems.

The HIO and CCO have both outgrown their rudimentary management procedures as they expanded from single care institutions to larger systems of facilities. Their management practices and performance monitoring procedures have become a patchwork of arrangements which mostly are designed to deal with problems which faced these organizations at earlier points in their evolution. Medical service operations and financial controls are monitored using outmoded systems and procedures which cannot offer timely information or effective control. Inefficient cost recovery is the result. Modernization of the CCO management systems will not only increase its internal operating efficiency, but will spread these benefits throughout the Egyptian health care system.

1. Proposed Component Two Activities

Component Two will provide effective programs to modernize the HIO and CCO management systems; investigate and apply other management ideas through

operations research; and introduce these innovative systems to other health care programs. The HIO and CCO will each prepare proposals for developing and installing Management Information Systems (MIS) and submit them to the Project Directorate. These proposals will include at a minimum the following:

- General description of planned activities including schedule, costing, equipment (including hardware) requirements.
- Anticipated relationships and benefits to the other Project components.
- Training and technical requirements including software needs; staffing implications to the organizations.
- Other specifications and details as determined necessary by the Steering Committee.

Project funds will be available to both organizations for preparation of their proposals. It is anticipated that in addition to Egyptian expertise, some outside technical experts in MIS will be required to assist with proposal preparations. Approximately three person months (Management Specialist, Systems Design Expert, Information Specialist) over a 30 day period for the HIO and six person months (same specialists) over a 60 day period for the CCO will be required for preparing proposals. As noted below, HIO already has considerable experience with MIS development.

The proposals will also form the basis for Requests for Technical Proposals (RFTPs) for both organizations for contracting the required technical assistance, training and equipment needs to implement the HIO and CCO management information systems activities. Project funds will assist both organizations with this step once their proposals have been accepted by the Steering Committee.

Requests for assistance from university facilities and professional health organizations will go through the same approval process. Funds for preparing proposals to the Steering Committee will be available as needed. However, it is anticipated that funding levels for these operations research activities will be small (not expected to exceed \$500,000 per activity). Therefore, the need for outside assistance to prepare proposals will be limited.

2. Sub-activity Descriptions

a. Health Insurance Organization

The HIO established a successful and innovative computerized management information system for beneficiary registration and drug usage control at its branch in Alexandria. Financial support for technical assistance, software development, training and hardware (mini and PCs) was provided through the Urban Health Delivery System Project (UHDSP) No. 263-0065. The HIO made a very significant contribution to the activity with its support of staff salaries, new positions and construction.

The HIO now has a trained staff with considerable experience in computer operations, and is satisfied with its results and confident in its sustainability. The HIO will now expand the system in Alexandria by upgrading the patient records system, cost accounting procedures and the patient care quality assessment program. HIO also plans to expand the MIS to the National Headquarters in Cairo and to at least one of the other remaining branches (most likely Cairo Governorate) using experiences and systems developed in Alexandria.

Currently, the HIO is conducting a feasibility study for expansion of its MIS system in Alexandria. The expansion will provide management at all levels with timely and accurate information so that plans and objectives can be achieved or, as needed, changed to accommodate new circumstances. The feasibility study will be completed by the time this Project is funded. The results of the feasibility study, which will also examine appropriateness of the remaining MIS modules (cost accounting, patient records, quality assessment), will form the basis for the HIO proposal to the Project Directorate for funding support.

The trained staff of the HIO Alexandria Branch can play a significant role in expansion of the MIS to its other branches and perhaps to other organizations. Training facilities in Alexandria and elsewhere can be used to run focused skills upgrading sessions in data management, data processing and service delivery. Where computerization is not practical, the lessons learned from creating and handling mechanical data bases can be passed on to those responsible for manual data handling. The idea will be to cultivate a systemic and organized approach to data handling and interpretation. Project funds can be used to refine and further develop these training modules.

b. Curative Care Organization

The CCOs are currently operating at close to a break-even point. However, improved management information systems will greatly improve their efficiency and effectiveness of operation and provide experiences and lessons that can be applied to other facilities as cost recovery programs expand around the country. Component Two will provide assistance to the CCO in setting up such a MIS. The first step will be to develop a comprehensive system based on the CCOs' current manual system. This will include financial and accounting systems and inventory control. Where necessary, the manual system should be filled out and completed. Once a good manual system is in place, computerization can proceed.

Another activity will be improvement of the patient record system. This system will be set up along established hospital and clinic record-keeping systems that exist in the U.S. and Egypt, particularly the system that will be developed by the HIO. The patient record system will also be set up so that other medical statistical data can be easily obtained for performance reporting and program/services planning.

Experiences in developing HIO's MIS will be used by the CCO to develop their own management information systems. For example, HIO has Arabized its software. They understand the MIS needs of a health care provider organization in Egypt, and they have trained staff that can transfer knowledge to the CCO. In effect, HIO has already completed much of the research and development required to get MISs up and running. The availability of this knowledge will shorten the period required for the CCO to develop its management information system.

c. Innovative Management Improvement and Policy Dialogue Activities

Proposals put forward by university health care facilities and other health care providers such as professional organizations will also be supported by the Project. Individual funding levels for such activities are expected to be between \$25,000 and \$250,000. The Project Steering Committee will decide on the merits of individual proposals and will set funding levels as appropriate. There must be a clear benefit to the overall project purpose for a proposal to be accepted. Specific activities that might be funded from this innovative activities fund include:

- Development of small computerized MISs for group and individual medical practices. Funds will be used to test the technology and develop a prototype only. Funds required by health care providers to set up a MIS in their practices will come from other sources (such as bank loans).
- Development of MISs for university health care providers, either manual or computerized or both.
- Development and distribution (e.g. printing costs) of information packages for improved management techniques for small-size health care providers.
- Policy dialogue conferences and training sessions in Egypt to explore cost recovery practices and progress.
- Policy dialogue studies.

3. End of Project Status for Component Two Activities

- Utilization by HIO and CCO of modern integrated management systems for monitoring and control of staff, commodities and resources, general operations and provision of health services, and financial operations.
- Service delivery expanded in HIO and CCO without developing new facilities or addition of new staff.
- HIO and CCO capable of providing technical assistance to other interested health organizations for designing and implementing management information systems.

- Innovative management improvements in place and contributing to more efficient operations at selected university health care facilities and other health care providers such as professional organizations.

C. Component Three: Expansion of Private Health Care Practice

Private sector practitioners and institutions have great potential for expansion, which would relieve government health care facilities of some of their excessive burden. However, their growth has been impeded by a variety of factors. Component Three will address some basic constraints and foster the expansion of private sector health care.

Private practitioners are highly concentrated in large metropolitan centers such as Cairo and Alexandria, and have a much smaller presence in provincial cities and virtually none in villages. MOH hospitals and clinics must fill this void, but have been unable to provide quality health services. The distribution of private practitioners is to some extent a function of the market, but recent studies have clearly indicated that provincial and village clients can and will pay for quality health services.

Health finance experts have identified inadequate access to commercial credit for startup and expansion of private practices as a critical constraint to the expansion of private sector health care outside the major metropolitan centers. In particular, it has been found that many doctors who work at MOH facilities and "moonlight" after hours would prefer to leave government service and set up full time private practice if they could secure credit for the considerable investment required. Thus credit availability would not only stimulate expansion of the private sector in non-metropolitan areas, but also would draw surplus labor which may be displaced by the conversion of MOH facilities to cost recovery operation.

Another basic constraint is a relative lack of modern management capabilities. Individual, group and prepaid health care practices use rudimentary systems for monitoring and controlling personnel and physical resources, for managing costs and billing clients. Component Three will provide technical assistance and training to enhance the managerial capabilities of these private practices, improving the quality of health care and facilitating greater efficiency and profitability. This should encourage expansion of private health care practices and diminish the burden of government facilities.

The major activities proposed under this component are (1) augmenting the institutional capacity and financial motivation of private sector commercial lending institutions to provide loans to private health care practitioners; (2) improving the technical capability of commercial banks for financial analysis and services; and (3) improving the capacity of private health care providers to develop cost effective private, group, and prepaid health care practices. These activities are described in detail below.

1. Expansion of Credit for Private Sector Health Care Practitioners

Egyptian commercial banks have traditionally had little involvement with private sector health practitioners. The small size of the average loan to an individual medical practice, and the complexity of financial analysis and credit requirements for prepaid health care services, has made the health sector less attractive for loan activity than other private enterprises. Other obstacles are the high collateral requirements (fixed assets at least 100 percent of loan value), and lengthy loan processing time.

The project will utilize an organization developed by another AID project to address similar problems of credit for small scale enterprises. It is the Small Enterprise Credit Guarantee Corporation (CGC), an element of the Private Enterprise Credit Project (No. 263-0201). Component Three will provide additional capitalization to CGC for guaranteeing loans to private health care practitioners, and technical assistance and training in the special characteristics and requirements of the health sector to the CGC and private commercial banks.

The project will provide \$33 million for additional capitalization of a credit guarantee fund in the CGC specifically designated for loans to private health care practitioners. The design contractor for credit and banking estimated these credit needs at \$118 million (LE equivalent) during the life of project. Credit guarantee programs usually start out with 100 percent coverage of each loan, but after participating banks become accustomed to the new client group and realize their credit worthiness, coverage can be decreased to 50 percent or less. Leveraged in this fashion, project funds can provide credit guarantees for well over \$70 million in loans by the end of project.

Loan criteria will emphasize credit for health care practitioners in provincial cities and the rural service areas of MOH hospitals and clinics. In metropolitan areas, loans to group practices and prepaid health care organizations will be encouraged. Loan portfolios of participating banks will be reviewed annually by the CGC to assess the targeting of loans as well as default rates, guarantee claims, and other loan servicing criteria.

The CGC has been under design for two years, and is scheduled to have staff and facilities by the end of calendar 1988. Since it will require initial institutional development and training, it is not planned to be fully operational for another 12 to 18 months. During that interim, until the technical assistance contractor has been selected and mobilized, a PSC consultant will monitor the development of CGC and make preliminary plans and initial preparations for the contractor's activities. AID will obligate funds for credit guarantees after the CGC has developed the institutional capability to respond to the special requirements of the private health care sector.

The technical contractor will assist the CGC in establishing an accreditation and rating system for banks wishing to participate in the guarantee program.

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The system will assess each bank's qualifications for participating, and establish a ceiling for health loan guarantees. This eliminates the need for micro-management of loan applications by the CGC, since any loan meeting CGC criteria and within the guarantee ceiling will be virtually automatic. To date, about 25 percent of banks permitted to conduct business in local currency have expressed interest in the program, and it is anticipated that more banks will become interested as the program gets underway. Accreditation will be carried out by a panel of senior banking experts, and reviewed periodically.

Component Three will also provide technical assistance and training to the CGC to improve its capacity for servicing loans to private health care practitioners. This will include financial analysis, loan evaluation, access to and exchange of credit information, insurance, claims settlement and guarantee recovery, and marketing the loan guarantee program in the health community. These activities are aimed not only at creating these capabilities in the CGC, but at developing the institutional capacity for CGC to provide technical assistance and training to participating commercial banks. The CGC will assist these banks in developing flexible systems responsive to the needs of private practitioners, simplifying and streamlining documentation for loan processing and monitoring, and developing effective and efficient management procedures for decreasing transaction costs.

2. Technical Capability of Participating Commercial Banks

The project will provide technical assistance to improve the loan processing and monitoring capabilities of participating banks. Streamlining and simplifying their procedures will decrease the cost of originating and managing loans to private health care practitioners, making such loans more attractive to commercial banks. Assistance will include developing appropriate management information systems and health sector market assessment skills.

Component Three will assist the CGC and its member banks to develop compatible management information systems for health sector financial data, market information on health sector providers, practices and other health sector information needs. The Project will provide 84 person months of systems analyst assistance over the first five years of the project to develop and implement appropriate management information systems, to include designing, testing and installing software in the CGC and participating banks. User-friendly software will be developed for simple and rapid processing of standard health care practice loans. The package will provide standard questions and data processing capabilities to facilitate rapid eligibility assessment for health care financing.

The Project will also provide technical assistance for CGC to conduct an initial series of market profiles on health sector practitioners and institutions. The Project will provide 12 person months of market analyst

technical assistance, and survey expenses including 36 months of survey time, per diem, travel, and data processing.

3. Management Capabilities of Individual/Group and Prepaid Group Practices

The project will provide technical assistance, training, and operations research activities to individual, group or prepaid health care practices through a direct AID contract with a U.S. contractor and appropriate Egyptian subcontractors. Approximately 132 person months of expatriate and 551 person months of Egyptian technical assistance will be provided. Training will include 980 person months of formal in-country training, 70 person months of U.S. on-the-job training, and 12 person months of U.S. or third country short-term training. Selected operations research activities will be devoted to developing improved management approaches and procedures. Detailed plans for technical assistance and training will be included in technical proposals submitted by potential contractors. All contractor technical assistance and training activities will be coordinated with the relevant CGC assistance to participating commercial banks.

a. Individual and Group Practices

Component Three will provide technical assistance and training to individual and group practices to improve management practices and upgrade the quality of service. Some 120 person months of local and 33 person months of expatriate technical assistance will be devoted to the preparation of publications, workshops, seminars and on-the-job training, as well as specific assistance to a limited number of practices. Some 4,800 private health care practitioners will develop improved management skills as a result of these activities.

The contractor will produce a management guideline booklet in Arabic and a training curriculum for developing management skills for individual/group practitioners. The guidelines and curriculum will include key areas for management and service quality improvements such as office management, filing procedures, and management information systems; staffing requirements, workplans and practices; financial accounting and billing practices; use of commercial banking system and credit services; patient registration and record systems; office care practices; and clinical laboratory operations and contracting.

Subcontracts may be developed with the Medical Syndicate, the Junior Medical Doctors Association, or local consulting firms to provide approximately 800 person months of management training for health care practitioners. Software packages to assist in managing private practices will be developed with some 24 person months of systems analyst and programming skills.

b. Prepaid Group Systems and Practices

Prepaid systems are an attractive alternative to fee-for-service private health care, because they focus on preventive health measures and motivate

physicians to control health care costs. Private health care practitioners in Egypt have had limited experience with designing and implementing prepaid health care systems. Component Three will devote the major portion of its technical assistance to developing new prepaid health systems. Approximately 176 person months of local and 153 person months of expatriate technical assistance will be used to develop some 30 prepaid health care practices. Approximately 180 person months of local training and 70 person months of on-the-job training in the U.S. or third countries will also be provided. Approximately 20 operations research activities will also be conducted in support of designing and implementing the prepaid health care systems.

The Project will focus its technical assistance and training on key management and service delivery issues for designing, implementing, developing, monitoring, and evaluating effective and efficient prepaid systems. Detailed operational plans and projections will enable the organization to estimate initial revenue and expenses and to apply for credit. Within the first year the technical assistance team will develop a financial planning model including appropriate procedures, methods, guidelines, and standards for developing prepaid health care systems.

The model will encompass all important variables for designing prepaid systems. These include expected annual use of medical and health care services, alternative organizational structures for providing various health services, and alternative staffing patterns and levels for service and patient load designs. It will also include methods for making estimates under various design assumptions of critical planning variables such as: costs and revenues, external funding needs, patient loads, system size, premium levels and capitations on annual cash flow; physical resources, equipment and expendibles requirements for given services and patient loads; and annual cost projections and revenue schedules for system management. The model will also assess key organizational and operational policies which could result in low initial operating costs, low indebtedness, and early profits.

The technical assistance team will also develop a model management information system and software package to monitor indicators of the financial planning model outlined above and other sensitivity indicators which measure service quality and cost data associated with systems operations. These indicators might include service use by enrollees; days of hospital care per enrollee; premium levels and payments; health provider productivity indices; use and cost inflation rates for various services, contracts, facilities or supplies.

The contractor will use these financial plans and management information systems to assist with developing and implementing all training and technical assistance. The contractor will revise these procedures based on the experience of other prepaid health care providers in developing their systems.

4. End of Project Status for Component Three Activities

Component Three activities will lead to the following accomplishments by the end of the Project:

- Approximately 14,000 physicians adequately capitalized in private, group, or prepaid practices.
- 90 percent of project supported private medical practices operating at a profit and providing quality services.
- Approximately 45,000 patients receiving services in prepaid health care practices.
- At least 10 commercial banks providing appropriate financial credit services.
- At least 4,800 health care providers trained in improved management and financial practices to operate cost effective private health care practices.
- Thirty prepaid health care systems developed.

III. COST ESTIMATES AND FINANCIAL PLAN

A. Cost Estimates

1. AID Contribution

The Cost Recovery Programs for Health Project will provide up to \$95.0 million in AID grant funding, of which an estimated \$20.0 million will be in local currency costs. The USAID Mission Accounting and Control System (MACS) will utilize six major project elements for financial reporting: (1) Support Services including technical assistance and operational support for the Project Directorate, \$20.9 million; (2) Equipment/Commodities, \$14.0 million; (3) Facility renovations, \$21.0 million; (4) Training, \$4.6 million; (5) Guarantee Fund, \$33.0 million; and (6) Evaluation and Audit, \$1.5 million. Table III-A presents details on proposed AID funding by component and sub-activity.

Cost estimates were prepared by technical design contractors in concert with the MOH and reviewed by USAID. For Component One the institutional development estimates were prepared by design contractor and reviewed by the USAID Health Office. The cost of facility renovations and new equipment was estimated by MOH and USAID. USAID has considerable experience with the rehabilitation and upgrading of hospitals in Egypt, having completed 51 hospitals and clinics under the LAD Programs and Urban Health Project. Variation in the cost of upgrading each of the 50 hospitals and clinics proposed by this project will be considerable, but in general the cost estimates are in accord with previous experience. The USAID engineers and project officers familiar with these activities have been consulted, and the Project Design Committee has concluded that the requirements of FAA 611(a) for engineering plans and reasonably firm cost estimates have been fulfilled.

Cost estimates for Component Two are based on the considerable experience of the Urban Health Project with design and installation of a management information system in the Health Insurance Organization. The requirements for upgrading the present system in the HIO and expanding it throughout its branches can be accurately specified. Estimates for designing a new MIS for the Curative Care Organization are adjusted to allow for their lesser experience. Additional funds for management improvements in other organizations will support small unsolicited proposals until they are exhausted.

The Component Three cost estimates were prepared by technical design contractors and reviewed by USAID. They provide for institutional development and capitalization of a loan guarantee fund. This activity will be initiated when the implementing agency is fully operational and the amount and phasing of capital requirements have been finalized.

Cost Recovery in Health
Estimated Expenditures
(in \$ 000)

<u>Component</u>	<u>Before Inflation/ and Contingency</u>	<u>Inflation/ Contingency</u>	<u>Including Inflation/ Contingency</u>
I. Conversion of MOH Facilities			
1. Equipment/Commodities (Off-shore Procurement)	6,423		
2. FARs for Renovation and Shelf Item Procurement	13,730		
3. Training			
a. short term academic	259		
b. on-the-job, U.S./third countries	302		
c. in-country	561	1,122	
4. Technical Assistance			
a. to Project Directorate and Health Facilities	6,117		
b. for Procurement Agent Services	197		
c. to AID for inspection under FAR	1,584	7,898	
5. Operational Support to Directorate		354	
total	<u>29,527</u>	<u>15,473</u>	<u>45,000</u>
II. Management Improvements			
1. Equipment/Commodities	2,702		
2. Training			
a. short term academic	143		
b. on-the-job, U.S./third countries	365		
c. in-country	552	1,060	
3. Technical Assistance			
a. to HIO	784		
b. to CCO	1,496	2,280	
4. Operations Research and Special Studies		1,061	
total	<u>7,103</u>	<u>2,897</u>	<u>10,000</u>
III. Credit			
1. Technical Assistance for Design of Credit Program/Project Support	2,705		
2. Training and Related Equipment	1,212		
3. Guarantee Fund	22,975		
total	<u>26,892</u>	<u>11,608</u>	<u>38,500</u>
Audit, Assessment and Evaluation	979	521	1,500
Project Total	<u>64,501</u>	<u>30,499</u>	<u>95,000</u>

2. GOE Contribution

The GOE counterpart contribution of \$17.3 million (LE equivalent) is made up of project related operations, support staff, facilities and office and secretarial support for the technical assistance and advisory teams. Table III-B "Illustrative Budget" provides a summary of these contributions. The project design has not devised a method for tracking GOE contributions. This will be a concern of the Project Officer. Details of AID requirements for tracking of GOE counterpart contributions will be included in PIL #1, and reference to the tracking of these contributions will be made as a covenant in the Project Agreement.

B. Estimated Expenditure Schedule

The estimated expenditure of AID funds by year is presented in Table III-C. The life of project is 6 years from date of initial disbursement.

C. Recurrent Costs

The GOE currently provides the annual budgetary support required for the operation and maintenance of its health facilities. The conversion of the existing facilities to a cost recovery basis and the management improvements to existing fee-for-services health care providers will help reduce the current heavy recurrent cost burden on the GOE budget resources and provide a quality health services and efficient operation at no additional costs to the GOE.

D. Methods of Implementation and Financing

Table III-D illustrates the methods of implementation and financing covering AID contribution to the project. The following are justifications for departing from the use of AID preferred methods of financing, namely FAR or MFAR, FRLC, Direct reimbursement and Direct payment:

1. Direct L/Comm

Because of severe shortage in foreign exchange, the Host Country does not have the financial resources to make dollar payments to contractors and seek daily reimbursement from AID.

2. Bank L/Comm

The project budget includes \$10.0 million for purchase of medical equipment, supplies and commodities for 50 hospitals and clinics. Equipment specifications are not standard for all facilities and will be purchased from multiple vendors. Therefore, use of a Procurement Supply agent (PSA) is contemplated. The Bank L/Comm method is proposed to control payments to Suppliers under various letters of credit where proliferation of invoices are anticipated.

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TABLE III-B: GOE CONTRIBUTION
LIFE-OF-PROJECT

	<u>GOE Contribution</u>	
	LE (000)	
	In-kind	Total
Equipment Commodities	6,000	6,000
Renovation/Construction	6,250	6,250
Training	2,000	2,000
Project Support Services	25,000	25,000
Evaluation/Audit Monitoring	600	600
TOTAL	39,850	39,850

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Cost Recovery in Health
Estimated Expenditures
(in \$000)

Component	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96	Total
I. Conversion of MOH Facilities									
1. Equipment/Commodities (Off-shore Procurement)	246	420	710	913	1,278	1,066	1,007	783	6,423
2. FARs for Renovation and Shelf Item Procurement	549	1,098	1,648	2,197	2,746	2,197	1,922	1,173	13,730
3. Training									
a. short term academic	25	25	38	51	45	42	33	0	259
b. on-the-job, U.S./third countries	29	30	43	61	52	49	38	0	302
c. in-country	54	57	81	111	97	91	70	0	561
4. Technical Assistance									
a. to Project Directorate and Health Facilities	397	612	746	973	1,164	850	771	604	6,117
b. for Procurement Agent Services	4	13	20	28	41	33	33	25	197
c. to AID for inspection under FAR	49	97	160	232	315	274	259	198	1,584
5. Operational Support to Directorate	150	102	68	34	0	0	0	0	354
component sub-total	1,503	2,454	3,514	4,600	5,738	4,602	4,133	2,983	29,527
inflation @ 10 % per year	0	245	738	1,523	2,663	2,810	3,189	2,830	13,997
contingency @ 5 %	75	123	176	230	287	230	207	148	1,475
component total	1,578	2,822	4,428	6,353	8,688	7,642	7,529	5,961	45,000
II. Management Improvements									
1. Equipment/Commodities	0	0	647	1,423	632	0	0	0	2,702
2. Training									
a. short term academic	0	29	50	43	14	7	0	0	143
b. on-the-job, U.S./third countries	0	43	65	64	63	63	54	13	365
c. in-country	40	73	86	85	84	83	68	33	552
3. Technical Assistance									
a. to HIO	56	102	194	178	105	69	47	33	784
b. to COO	103	196	367	349	197	131	88	65	1,496
4. Operations Research and Special Studies	40	145	180	178	176	173	136	33	1,061
component sub-total	239	588	1,589	2,320	1,271	526	393	177	7,103
inflation @ 10 % per year	0	59	334	768	590	321	302	168	2,542
contingency @ 5 %	12	29	79	116	64	26	20	9	356
component total	251	676	2,002	3,204	1,925	873	715	354	10,000
III. Credit									
1. Guarantee Fund			5,570	10,443		6,962			22,975
2. Equipment/Commodities		17	34	36	30	26			143
3. Technical Assistance/Support Services		321	640	676	570	498			2,705
4. Training		127	253	267	225	197			1,069
component sub-total	0	465	6,497	11,422	825	7,683	0	0	26,892
inflation @ 10 % per year	0	47	1,363	3,781	383	4,691	0	0	10,264
contingency @ 5 %	0	23	325	570	41	384	0	0	1,344
component total	0	535	8,185	15,773	1,249	12,758	0	0	38,500
IV. Audit, Assessment, and Evaluation									
inflation @ 10 % per year	37	47	335	47	46	45	379	43	979
contingency @ 5 %	0	5	70	16	21	27	292	41	472
component total	2	2	17	2	2	2	19	2	49
component total	39	54	422	65	69	74	690	86	1,500
TOTAL PROJECT	1,868	4,087	15,037	25,395	11,931	21,347	8,933	6,401	95,000

TABLE III-D: METHODS OF IMPLEMENTATION AND FINANCING

ACTIVITY	METHOD OF IMPLEMENTATION	METHOD OF FINANCING	APPROX. COST \$(000)	HOST COUNTRY OR AID CONTRACT	GOE IMPLEMENTING UNIT
II. CONVERSION OF MOH FACILITIES					
1. Equip./commod. (off-shore)	PSA	Bank L/Com for commod.	10,000	HC	MOH
2. Renov. & shelf items proc.	MFAR	Fixed amount reimb.	21,000	HC	MOH
3. Training	AID DIRECT	Direct pay	1,600	AID	-
Short term acad.			370		
D.J.T. US/third countries			430		
In country			800		
4. Technical assistance	AID DIRECT	Direct pay	11,900	AID	-
Proj. direct./health facilities			9,200		
Procur. agent svcs.			300		
AID (IFAR inspec.)			2,400		
5. Operational Supp. to directorate	PIL	Direct Reimb. (with advance)	500	HC	MOH
III. MANAGEMENT IMPROVEMENTS					
1. Equip./commodities	Host Country Cont.	Direct L/Com	3,800	HC	MOH
2. Training	AID DIRECT	Direct pay	1,500	AID	-
Short term acad.			200		
D.J.T. US/third countries			520		
In country			780		
3. Technical assistance	AID DIRECT	Direct pay	3,200	AID	-
HIO			1,100		
CCD			2,100		
4. Oper. research/studies	Host Country Cont. & PIL's	Direct L/Com & Direct Reimb. (with advance)	1,500	HC	MOH
IV. PRIVATE SECTOR CREDIT STUDIES					
	AID DIRECT	Direct pay	5,500	AID	-
V. AUDIT, ASSESSMENT & EVALUATION					
	AID DIRECT	Direct pay	1,500	AID	-

NOTE: Method of implementation and finance for \$33 million loan guarantee portion to be determined.

3. Periodic Advance

Because of the GOE budgetary limitations, AID will advance local currency to the Project Directorate on a 90 days requirement, based on a yearly workplan and budget approved by AID. Before processing the initial advance to the Directorate, AID will assess the Directorate's readiness to disburse the funds for the purpose approved in the Project Implementation Letter (PIL) and within the time frame requested by the advance. In this respect, AID will perform a preliminary assessment of the procedures, rules and financial controls established for the Directorate's contracting, procurement and accounting activities. AID will periodically conduct financial reviews of the Directorate's disbursements, procurement and financial reporting under the PIL(s) authorizing the Directorate to perform these functions. The financial review will be performed by either RIG, USAID or non Federal auditors.

4. Audit Coverage

Under the Audit, Assessments and Evaluation element, a total of \$60,000 is budgeted for audit of project activities. This amount includes \$20,000 for audit, assessments and financial review of the Directorate's operations. All USAID fund disbursements will be subject to U.S. Government audit. Each implementing agency will be responsible for maintaining a complete set of records for up to three years after PACD. These records will be made available to USAID and GOE auditors on request.

E. Performance Disbursement Mechanisms

The Cost Recovery Programs for Health Project utilizes a performance disbursement system to control expenditures. Essentially, a baseline assessment specifies precise needs; then an integrated plan and schedule is prepared with the objective of fulfilling those needs; and finally the appropriate disbursement is made to fund implementation of those plans. This basic funding mechanism is utilized by all three components, but it differs in some respects for each.

1. Component 1: Conversion of MOH Hospitals and Clinics

Disbursement 1 is contingent on the development and approval of plans for improvement of the Project Directorate's management capability. These will include (a) an RFTIP for initial technical assistance to the Directorate for the design and development of management, operational, administrative, and fiscal procedures for project implementation; (b) a work plan for development of the Project Handbook/PPRGS to include a draft outline of the Project Handbook; (c) a work plan for developing the operational capacity of the Directorate to plan, budget and implement the project; and (d) a review and update of the project implementation schedule contained in Annex O. Prior to disbursement, the MOH will issue a letter to AID specifying its intention to undertake the conversion of 50 facilities to a cost recovery basis and a preliminary listing of those facilities.

Disbursement 2 involves improvement of the operational and implementation capability of the Project Directorate. It requires presentation and approval of a plan and budget to USAID which includes (a) an RFTP for technical assistance and training from the Directorate to the facilities undergoing conversion to cost recovery systems; (b) a completed Project Handbook outlining management, operational, administrative and other procedures; (c) specifications and criteria for implementing cost recovery systems in hospitals and clinics; (d) prioritization of facilities to be converted; (e) general technical assistance requirements for facility conversion; and (f) updating of the project implementation schedule.

Disbursement 3 will involve the estimated funding required to convert the initial block of 3 to 5 facilities. Prior to disbursement, detailed plans and schedules will be presented to USAID for approval. The plans will include GOE authorization to convert the specified facilities; on-site assessment of each facility; selection and contract employment and training of required staff; comprehensive cost recovery conversion plans following Project Handbook guidelines and other specifications and criteria; plans for deployment of all resources to implement the conversion; RFTPs for renovation of facilities and procurement of equipment, supplies, and maintenance services; and assessment and revision of Component 1 implementation schedule.

Disbursement 4 comprises the estimated funding required to convert the next block of 5 to 7 facilities. Prior to disbursement the same detailed plans, schedules and other preparations required for disbursement 3 will be presented to USAID for approval. In addition, an evaluation of implementation progress on the conversion of the first block of facilities will be included.

Disbursement 5 and all subsequent disbursements will consist of funding for the next block of 5 to 10 facilities. Prior to disbursement the same criteria as Disbursement 4 must be fulfilled, with the addition of an evaluation of the cost recovery status of previously converted units to date. All completed facilities must be achieving cost recovery from at least 60 percent of their patients, and 80 percent of the converted facilities must be operating on a cost recovery basis.

The above performance disbursement criteria have been elaborated in considerably greater detail in Annex N. These criteria will be reviewed and finalized prior to first disbursement. The finalized performance disbursement criteria will be included in the Project Handbook for the use of all Project personnel.

2. Component 2: Management Improvements

Disbursements for the development of management information systems and other management improvements will be made on the basis of proposals to the Project Steering Committee. The project will make funds and technical assistance available for the preparation of proposals and RFTPs. When a proposal is approved, funding for the proposed activity will be disbursed.

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Disbursement 1 will include funding for technical assistance in MIS design for preparation of proposals and RFTPs. Up to 3 months of technical assistance will be funded for HIO, and 6 person months for the less experienced CCO. Sub-project proposals for improvement of management practices in University hospitals and professional groups will be supported as needed. Disbursement will be made after satisfactory negotiation of the parameters of the proposed activity and the format of the proposal.

Disbursement 2 includes funding for the preparation of RFTPs which will be based on the approved proposals. Once the sub-project activity has been approved, the health care organization will negotiate the funding required and format of the RFTP with the Project Steering Committee, and disbursement will be made.

Disbursement 3 will provide funding for implementation of the proposed sub-project activity. Disbursement will be made after the Project Steering Committee approves the RFTP.

3. Component 3: Expansion of Credit for Private Health Sector

The performance disbursement mechanism for Component 3 involves USAID approval of plans for institutional development of the implementing organization, implementation of those plans, operationalization of technical assistance capability, and capitalization of a credit guarantee fund. USAID will disburse funds to the Ministry for International Cooperation (MIC) when performance disbursement criteria are fulfilled, and MIC will disburse local currency to the implementing organization for developing its capability to encourage the expansion of credit availability to the private health sector.

The present obligation provides funding for initial technical assistance but not for capitalization, training, or technical assistance to group and prepaid group plans. These funds will be obligated by amending the grant agreement when funding is required and when USAID is satisfied that the implementing organization is fully operational and prepared to assist the private health sector.

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IV. IMPLEMENTATION PLAN

A. Administrative arrangements

1. Government of the Arab Republic of Egypt (GOE)

The Minister of International Cooperation (MIC) will be the signatory to the Project Agreement (ProAg) and to all subsequent ProAg amendments.

2. GOE Implementing Agencies

The Ministry of Health (MOH) will be the lead GOE agency responsible for implementing this Project. The Minister of Health will issue a decree for reorganizing the Cost Recovery for Health Program Project Steering Committee and establishing the Project Directorate as semi-autonomous units under the administrative umbrella of the MOH.

B. Project Management

The organizational structure of the Project requires management at both the implementing agency (MOH) and the service delivery agency for each component.

1. GOE Management

Component One; the MOH Project Directorate will be the lead agency for planning, implementing and evaluating this component's activities. The MOH will be responsible for delegating authority to the Project Directorate and the individual facilities for project implementation and host country contracts for technical assistance, facility renovation, commodity purchases and training.

Component Two: the Project Directorate will be the lead agency for evaluating proposals and coordinating program implementation. The MOH will delegate authority to the Health Insurance Organization, the Curative Care Organization, and other key cost recovery institutions for project implementation and host country contracting for technical assistance, training, equipment and other essential activities.

Component Three: the Ministry of International Cooperation will be the lead agency for planning, implementing and evaluating this component's activities. The MIC will be responsible for delegating authority to the Egyptian Small Business Credit Guarantee Corporation for project implementation and host country contracting for technical assistance, training commodity purchases, and loan guarantee activities. USAID will issue a direct contract, in coordination with MIC, to provide TA and training for management improvements for individual, group and prepaid health care providers.

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a. Project Steering Committee

The Project Steering Committee (SC) will provide policy, advisory and coordinating assistance for project implementation. The SC was first organized in 1984 to participate in developing and designing the Project. Membership was exclusively from the Ministry of Health. Because of the diversity of activities, the SC will be restructured as a requirement precedent for the Project. The major duties of the SC will be:

- Establishing project policy;
- Recommending and following up on law changes, decrees and regulations for implementing cost recovery in government facilities;
- Reviewing and approving plans for converting GOE health care facilities to fee for services operation;
- Promoting policy dialogue in the public and private sectors;
- Reviewing and approving initial guidelines for providing CGC guaranteed credit to individual and group physicians through the Egyptian banking system; reviewing procedures on a biannual basis;
- Reviewing and approving Project funding proposals for the HIO, CCO and Innovative Activities.

Steering Committee members will be appointed by the Minister of Health, in collaboration with the Minister of International Cooperation. Members will be recommended by the involved Ministries and Corporations, in consultation with USAID.

b. Project Directorate

A Project Directorate (PD) will manage and implement Component One under the supervision of the Minister of Health. The PD Director will have undersecretary rank and authority to contract at levels appropriate for an undersecretary.

The PD will consist of the Director, a Deputy Director, Management Specialist, Hospital Administrator, Financial Advisor and other support staff to be determined. At a minimum, the first two positions will be filled by government employees whose full-time job will be managing and implementing Component One. Contract experts (both U.S. and Egyptian) will be obtained as needed to assist with implementation.

The PD will be a temporary organization. Once policies are established, firm guidelines written and tested and cost recovery in government facilities a reality, the PD can cease to exist as a separate office. Its functions will be transferred to an existing undersecretariat in the MOH, such as Hospitals/Curative Care. This transfer of authority could occur as early as year three of the Project and as late as the PACD. The Project staff will make this conversion at the earliest possible time.

c. Health Insurance Organization and Curative Care Organization

Activities planned under Component Two will be primarily implemented within the existing administrative structure of the HIO and CCO. The Steering Committee will be responsible for reviewing and approving funding applications from the HIO, CCO and other organizations. Once approved, the organization will be responsible for appointing a person or persons to implement the activities within the organization's overall structure. For example, the HIO will use the existing Data Processing Center staff for implementing expansion activities.

Persons appointed as principals by organizations must have authority to contract for activity support and act on behalf of the organizations. Contracting will be in accordance with AID Handbook 11, Host Country contracting procedures.

d. The Small Scale Enterprise Credit Guarantee Corporation (CGC)

The CGC will be established under Law 159 as an independent, private sector joint-stock corporation. The activity is being funded under the Private Enterprise Credit Project (No. 263-0201). While promoting credit for physicians was not part of the original concept, it has been accepted in principle by the CGC and the Ministry of International Cooperation (MIC), the implementing ministry for the CGC.

Funds for Component Three will be channelled through MIC to the CGC which will guarantee loans made by participating banks to individual and groups of physicians. Oversight of CGC activities will be through the MIC with the Project Steering Committee advising on guidelines for use by CGC guaranteed credit facilities. The CGC will contract directly for the services of a team of advisors to assist providers with such things as market analyses and credit applications.

2. USAID Management

USAID/Cairo's Office of Health will be responsible for managing, coordinating and monitoring the Project. The USAID Project Officer will maintain contact with the Project Directorate's staff, have access to all Project associated documentation, and serve as an ex-officio member of the Steering Committee. The Project Officer will make on-site inspections and review Project progress. He/she will be responsible for processing any amendments and allocations of Project funds and monitoring the work of TA and A&E contractors. The Office Director will lead in policy dialogue.

C. Procurement Plan

Project goods and services will be provided through both direct and host country contracts. AID will not be directly involved with procurement actions carried out by the Government of Egypt.

1. Technical Assistance

a. AID Contracting Arrangements -- Technical Support Services

1) Interim Contractor: During the first twelve months of Project implementation, and until a long-term management/technical assistance (M/TA) contractor is mobilized, USAID will use the AID/W funded S & T/Health REACH project under a buy-in arrangement. Contractor activities include developing and putting into operation basic policies, procedures, rules, regulations and guidelines, and assisting in initiating project activities, including the first Reform Plan and RFTPs for other project contract services.

2) Management/Technical Assistance (M/TA) Contractor: During the first year of project implementation, USAID will contract the services of a US. consulting firm to assist the Project Directorate in implementing this project. The contractor will be openly competed and will last for approximately eight years. The M/TA contractor's responsibilities are summarized as follows:

- Component One: assisting the Directorate in all aspects of converting health care facilities, including refining policies, procedures and regulations as lessons are learned, developing and implementing the conversion Reform Plans, staff training and monitoring progress. Services will be required through the life of this component.
- Component Two: assisting in implementing management improvements/management information systems at the Health Insurance Organization and Curative Care Organization. The contractors' responsibilities include designing, procuring and installing the systems, staff training, and actual systems implementation. Services will be required for approximately the first four years of this component.
- Component Three: assisting physicians and other health practitioners in establishing and maintaining private and group practices, insurance schemes and health maintenance organizations. The contractor will also be responsible for advising the Steering Committee on establishing credit mechanisms for the Project.

The M/TA contractors' first responsibilities will be to assist USAID in evaluating the progress of CGC, and assessing its ability to implement this component, assuming Component approval. Services will be required for approximately five years.

3) Local A&E Contractor: USAID will also contract the services of an U.S./Egyptian architect/engineering (A&E)

firm for monitoring the progress and quality of work performed in Component One renovations. The A&E contractor will assist USAID in assessing acceptable performance for liquidating advances and evaluating proposed Reform Plans. The services will be required for the life of Component One.

The interim contractor, the M/TA contractor and the A & E contractor will be under the guidance and supervision of the Office of Health Project Officer.

4) Support Services: The contract services of two IQCs or 8(a) firms will be used by USAID to conduct external evaluations and audits.

b. Project Directorate Contracting Arrangements

The Project Directorate will be responsible for the following contracting arrangements:

1) Procurement Services Agent (PSA): The Project Directorate will contract the services of a U.S./Egyptian PSA firm to procure medical/health equipment required in renovating health care facilities in Component One. U.S. procurements will be in accordance with Handbook 1. Procurement of local materials and supplies will follow AID policies and procedures for shelf items set forth in Handbook 1 B, section 18.4.6.

2) Architect/Engineer (A&E) Contractor: The Project Directorate will contract the services of an Egyptian A&E firm to assist the Directorate in preparing renovation designs, cost estimates, selecting local contractors and supervising local construction.

3) Component Two Operations Research and Special Studies: The Project Directorate will encourage unsolicited proposals from health care providers, universities and consulting firms for operations research and special studies, as well as proposals solicited through the media. Since contract awards are expected to be under \$100,000, advertising will be conducted only in Egypt. Host country contracting rules will be followed.

The host country contracts will be competitively procured, and the contractors will be directly supervised by the Project Directorate.

2. Commodities

Ten million dollars worth of hospital and medical supplies and equipment will be procured through a Procurement Services Agent (PSA) using Handbook 11 procedures. U.S. advertising for the PSA will be through the CED. Both U.S. and Egyptian firms will be invited to participate in the PSA selection process. Commodity procurement through the PSA will use IFBs and in a few cases, small value procurement procedures outlined in Handbook 11.

Five and one-half million dollars is set aside for procuring computer hardware, software and peripherals. Since the TA contractors will play a

major role in selecting, installing and training in using the computer systems, equipment specifications will be required of bidders in proposals submitted for the HIO and CCO activities.

There may be limited requirement to procure commodities through PIO/Cs. This is not expected to exceed \$250,000 over the life of the Project. This equipment will be used to support TA contractors performing under direct contracts with AID.

3. Training

Training procurement will be part of the plans developed for Components One and Three, and for the proposal development contractors in Component Two. Contractors providing technical assistance will be responsible for all participant and in-country training activities in coordination with the host country officials. Zero funded PIO/Ps will be filed to account for participants. Participants will be similarly accounted for as a part of the AID direct TA contractors in support of Component Three activities.

Host country contractors in Component One will arrange for approximately \$364,000 of short-term and \$432,000 of on-the-job training in the U.S./third countries and \$739,000 of local training. Host country contractors for Component Two will manage \$500,000 of short-term and \$300,000 of local training activities. The direct USAID contractor for Component Three will implement \$784,000 of local workshop training, \$210,000 of short-term and \$540,000 of on-the-job training.

4. Gray Amendment

Careful consideration will be given to Early Alert identification of opportunities for minority, Small Business, 8 (a), and women-owned firms, minority-controlled Private Voluntary Organizations, and Historically Black Colleges and Universities. In particular, the RFP for the M/TA contractor will require that all M/TA proposals include a plan for minorities participating in Project Implementation. A Gray Amendment certification is included in Annex F.

D. Training Plan

Detailed training plans will be required within the Performance Disbursement Plans of Components One and Three. A detailed Training Plan will also be a required deliverable of the design contractors for Component Two activities. The Directorate TA contractors for design and evaluation will schedule and arrange for appropriate training activities for Component One. An illustrative training plan consists of the following major activities:

1. Component One

- On-site training conducted by contractors; 26 hours per site in each of the following disciplines: financial management/accounting, health

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administration/management, procurement, contracting, maintenance/logistics, management information and records control (5,200 total on-site hours).

- Local training organized by the Project Directorate to improve cost recovery delivery; 40 person months of training Directorate staff, and 340 person months of local staff training.
- Short-term training, primarily U.S.; 60 months of on-the-job training in hospital management/financing and 60 months of short-term training (approximately 15 participants for 3 months each).

Component One training will take place in the U.S. and Egypt. Participants traveling to the U.S. will collaborate with appropriate level U.S. health care managers as provided by the Directorate's TA contractor. The contractor will be responsible for contracting with appropriate institutions and monitoring the training. On-site training will be the responsibility of facility level TA contractors in collaboration with Directorate guidelines for on-site training protocol. MOH facility officials and TA will be responsible for maintaining on-site training records to be reviewed regularly by Directorate staff/consultants.

2. Component Two

- Short-term Participant Training, primarily U.S., for some 30 management and management information skill areas for 6 months each.

Component Two will provide approximately 30 management/management information, 6 month short-term participant training opportunities. The host country contractor will be responsible for arranging and monitoring the activities. The HIO system will probably need fewer training courses than CCO because of the strength of management information personnel as a result of the systems training under the Urban Health Services program.

3. Component Three

- Local training for 4,800 individual, group and prepaid Component participants who will receive approximately 4 day classes in administrative and fiscal management of private practices.
- Local training for 90 prepaid health care managers/practitioners who will receive an approximately 12 day course in developing and implementing prepaid practices.
- Short-term training, primarily U.S., consisting of 70 person months of on-the-job training and 42 months of short-term training (approximately 14 participants for 3 months each).

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Component Three training will also take place in the U.S. and Egypt. The U.S. short-term training program will focus on developing prepaid health care systems. The USAID direct contractors will be responsible for contracting with appropriate institutions and monitoring. The USAID direct contractor will also be responsible for developing 980 person months of local training for some 4,300 physicians and 90 prepaid managers.

The quality of the training program will be ultimately reflected in the ability of Egyptian health care managers to plan and implement the cost recovery activities outlined in this Project. Periodic evaluations that may be used to determine training progress and effectiveness are:

- Number of personnel trained;
- Effectiveness of trained personnel in establishing cost recovery activities;
- Familiarity of health managers with principles of cost recovery activities;
- Monitoring the quality of the formal training sessions.

Training program quality and progress will be monitored by Directorate TA contractors and the USAID direct contractor.

E. Implementation Schedule

Table IV-A summarizes the Project implementation schedule.

Table IV-A

Project Implementation Schedule

<u>ACTIVITY</u>	<u>MONTHS</u>	
1. Project Paper approved	September	1988
2. Project Agreement signed	September	1988
3. Project Directorate (P.D) established	November	1988
4. PIL # 1 issued & Requirements Precedent satisfied	November	1988
5. Interim Contractor mobilized	November	1988
6. RFP for Technical Service Contractors issued	February	1989
7. PD starts institutional development	May	1989
8. MTA Contracts awarded & Contractors mobilized	July	1989
9. First Reform Plan Approved (3-4 Units)	August	1989
10. Evaluation of CGC begins	September	1989
11. Component Two activities begin	September	1989
12. Component Three approved	December	1989
13. First disbursement for capitalization approved	July	1990
14. Second Reform Plan approved (6-8 Units)	August	1990
15. Third Reform Plan approved (10 Units)	August	1991
16. Mid-Term Project Evaluation	April	1992
a. First Reform Plan implemented		
b. Second Reform Plan approaching completion		
c. Component Two activities - 30 months underway		
d. Component Three activities - 27 months underway.		
17. Fourth Reform Plan approved (10 Units)	August	1992
18. Fifth Reform Plan approved (10 Units)	August	1993
19. Six Reform Plan approved (10 Units)	August	1994
20. Final Evaluation	February	1996
21. PACD	May	1996

V. MONITORING AND EVALUATION

A. Monitoring Plan

1. Project Directorate Monitoring System

The primary responsibility for managing Project activities is vested in the Director of the Project Directorate. Overall monitoring will be performed by the Steering Committee semi-annually. Committee members will review Project progress to date, problems encountered, and detailed renovation and equipment plans for the coming year. The review will emphasize Project performance in relation to the Project goal and purposes, the record of the Directorate in implementing and facilitating all the necessary activities, and Project expenditures. The reports submitted to the Steering Committee for review, plus any comments offered by the Steering Committee, will be forwarded to USAID.

Renovation and management improvement monitoring will be conducted by the activity coordinators of the Project Directorate, assisted by independent monitors, as needed. Monitoring site visits by members of the Directorate will be an important aspect of Reform Plan consideration, award and continuation.

2. USAID

USAID monitoring activities will focus on:

- Operating procedures including financial, procurement, contracting, project policies and other issues as appropriate;
- Annual renovation Reform Plans;
- Long-term training plans; and
- Selecting specialized contractors or consultants to assist the Directorate.

USAID's monitoring responsibility will focus on the Steering Committee's and Project Directorate's compliance with policies and procedures as stated in annual reform plans, and financial and progress reports. In addition to reports, progress will be monitored by periodic consultations with Steering Committee and GOE officials, site visits, baseline data and evaluation. USAID's primary role will be ascertaining the effectiveness of the overall implementation process.

A checklist detailing monitoring responsibilities within USAID will be developed by the Project Officer.

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B. Evaluation Plan

Two types of evaluation mechanisms will be used to ensure the Project continues making progress toward its goal and objectives, responds to changing priorities, is managed efficiently, and results in effective cost recovery programs.

1. Continuing Internal Evaluation

The Directorate will be responsible for annual assessment of progress in renovating facilities, improving management systems and achieving policy reform. The Directorate will also evaluate other activities within its area of responsibility to ensure that appropriate attention is given to all Project components.

2. Formal External Evaluation

Formal external evaluations of the Project will be conducted in years four and eight. They will follow standard AID guidelines for project evaluation and will be conducted by a joint team of AID, Egyptian and U.S. consultants. An IQC will be used to provide the services of the U.S. team members. The skills needed for the evaluation include: cost recovery program design and implementation, health delivery management and administration, project management, and loan guarantee program management. The evaluation teams will use the Project's logical framework and baseline data as a reference point to measure progress.

The evaluation team will assess the following:

- Verification of the inputs, outputs and assumptions;
- The extent to which policy reform, facility renovation and cost recovery have been effectively incorporated into the MOH health delivery system;
- The performance of the Steering Committee, Project Directorate, the contractors; and
- The progress and effect of expanded private sector medical care in rural and periurban areas.

3. Special Evaluation

During the Project's second year a special external evaluation will be conducted to determine the success and effectiveness of the CGC. Upon completion, a decision will be made to proceed with the Component Three loan guarantee program using CGC as the implementing agency. If a negative finding occurs, the Project will have to identify a new organization for implementing this Component.

VI. CONDITIONS PRECEDENT AND NEGOTIATING STATUS

The Grantee shall agree to cooperate fully with USAID to accomplish the purposes of the Grant. To this end, it accepts the following conditions precedent and covenants

A. Conditions Precedent

1. Initial Disbursement

Prior to any disbursement for this Project, or the issuance by USAID of documentation pursuant to which disbursement will be made, the GOE will, except as the parties may otherwise agree in writing, furnish to USAID, in form and substance satisfactory to USAID:

- a. Evidence of GOE approval of the fee-for-service operation of designated hospitals and clinics converting to a cost recovery basis.
- b. Evidence of restructuring the Cost Recovery Project Steering Committee, including delegation of authority for policy decisions, planning, and implementing Components One and Two of the project.
- c. Evidence of establishing a Project Directorate, including delegation of authority for Components One and Three under the Project Steering Committee, and assigning required managerial and technical staff.
- d. A statement of the name of the person(s) designated as authorized representatives(s) on behalf of the GOE and of any additional representatives, together with specimen signatures of each person specified in such statement.
- e. Such other documentation as USAID may reasonably require.*

2. Disbursement for Facility Renovation and Equipment

Prior to release of funds for Component One facility renovation and equipment, the GOE will, except as the parties may otherwise agree in writing, furnish USAID, in form and substance satisfactory to USAID, evidence that:

- a. All necessary procedures for assessing renovation and equipment needs and costs are in place, and all appropriate sets of regulations governing the administration of funds have been formulated by the Project Directorate to facilitate implementation.
- b. Such other documentation as USAID may reasonably require.*

* Not to be included in the Project Authorization.

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3. Disbursement for Financing Private Health Care Practices

Prior to release of Component Three funds for financing private health care practices, the GOE will, except as the parties may otherwise agree in writing, furnish USAID, in form and substance satisfactory to USAID, evidence that:

- a. A private sector organization with potential for successfully operating a loan guarantee program for purposes of this Component has been identified and will be acceptable to AID.
- b. Such other documentation as USAID may reasonably require.

B. Covenants

The GOE agrees that:

1. It will provide, on a timely basis, all local logistic support as may be required to ensure effective use of Grant financed goods and services.
2. The Steering Committee and the Project Directorate will meet formally with the USAID Project Officer, at least semi-annually, to discuss major elements of Project progress.
3. The Project Directorate shall furnish complete Reform Plans for facility renovation to USAID for funding approval.
4. The Project Directorate shall furnish USAID annual implementation and financial plans.
5. The Grantee shall provide to USAID the details of its counterpart contribution on request.

C. Negotiation Status

There has been a continuous dialogue with the MOH in preparing the Project Paper. The MOH is in agreement with the Project description and implementation as presented herein.

* Not to be included in the Project Authorization.

VII. SUMMARY OF ANALYSES

A. Summary of Technical Analysis

The Cost Recovery Programs for Health Project is being proposed at the right time. The GOE is prepared to introduce policy and program reforms; a cadre of administrative and management talent exists to start implementing the programs; because of prior USAID assistance the MOH has considerable experience and talent in managing hospital and clinic renovation and equipment purchasing activities; and successful organizations exist to serve as role models and implementors of an expanded health cost recovery program.

Component One employs the successful aspects of the model fee-for-service system of the Curative Care Organization to expand revenue generating services. The MOH has impressive staff capabilities and experience in earlier USAID health facility projects for carrying out the Component's renovation and re-equipping efforts. Additionally, phased performance disbursements will assure that implementation proceeds at a level which the system can absorb.

Component Two activities will be carried out by two groups that have proven themselves quite capable at cost recovery program management. The approach to introducing management improvements in this Project was successfully tested in the Urban Health Delivery Systems Project. The implementing organizations are completing their third year of demonstrating the technical feasibility of this approach.

Component Three focuses on introducing the standard loan/credit guarantee program approach through accredited banks. After an extensive examination of Egypt's financing systems, the design team concluded this is the most effective and efficient way of expanding private sector financing to individuals and groups. The first year-and-one-half of component activities will concentrate on designing the loan program; both the mechanics and loan criteria.

Given the expert technical planning in selecting project activities, and the safeguards for supervision and collaboration built into the project design, this project is considered technically feasible and highly relevant. Where constraints were noted, such as gaps in technical knowledge and logistics, technical assistance and staff training are included to overcome them.

Annex G provides a full technical feasibility analysis.

B. Summary of Financial Analysis

The aim of the financial analysis is to show that the proposed project is 'financially viable', i.e., the expected stream of revenues exceeds the costs when suitably discounted and summed. Alternatively, the rate of discount which produces a zero net present value should be higher than the minimum

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threshold acceptable to project planners. At this stage of the proposed project, component one is amenable to more quantitative financial assessment than the other components. The purpose of this assessment is to ascertain the financial internal rate of return from marginal investments through the project in a "representative" medical facility with approximately 200 beds. Technical assistance was received from officials of the Ministry of Health and the International Science and Technology Institute (ISTI) in putting together a hypothetical spreadsheet of costs and revenues for such a facility. Under certain baseline conditions and assumptions appropriate in the Egyptian context, the project to "convert" a representative medical facility into a "cost recovery mode" was found to have a financial internal rate of return (FIRR) of approximately 48 percent in real terms.

Sensitivity tests on the FIRR confirmed the robustness of the above result. These tests were conducted to monitor the impact on the FIRR of varying assumptions about (i) the price elasticity of demand for medical services and (ii) wages. Under extreme cases of high price elasticity, the FIRR was still above 15 percent in real terms. The results of the wage tests were also favorable. With real annual wage increases in the 10 to 50 percent range, the FIRR rose to between 90 and 70 percent, from its base value of close to 50 percent (reflecting the assumption of much higher wage rate changes in the base case).

Turning to component two, section II.D of this paper mentions the Health Insurance Organization (HIO) and Curative Care Organization (CCO) as two health care systems currently operating in Egypt on a fee-for-service basis and recovering most or all of their costs. Another source (Phase I design report prepared by ISTI, June 1987) indicates that CCO, in particular, achieved a 9.7 percent return on Investment (ROI) in FY1986, where ROI measures the return to the shareholders from current operations; investment in this instance equals the original capital invested in the operation and the refined surplus plowed back into operations. These organizations, however, are restricted in their ability to generate working and investment capital from internal resources. On the other hand, ISTI (and others) strongly recommend providing financial assistance for such purposes to these organizations. If past performance is a good indicator for the future, one can be reasonably confident of a net positive payoff from such investments into these and similar institutions. More concrete evidence should clearly be gathered as the project moves along.

Finally we consider briefly component 3. According to conventional wisdom, the basic constraints to the development of private health care come from the supply side and not the demand side. "Recent studies have clearly indicated that provincial and village clients can and will pay for quality health services." (Source: Section II of this paper). The absence of a serious demand constraint will be demonstrated by the high loan repayment rates expected in component three.

In view of the above, we conclude that, overall, the financial analysis points to a potentially viable investment in the Egyptian health sector, through the medium of the proposed project. The Financial Analysis is in Annex H.

C. Summary of Economic Analysis

In evaluating the Cost Recovery Programs for Health Project, we recognize that this project is a package of interdependent components. For example, if government hospitals are to operate user-fee/cost-recovery schemes successfully, major improvements in the quality of the services provided by these facilities will be necessary. Pursuant to this, the project will assist government hospitals to improve efficiency, particularly as this is reflected in the quality of the services provided by them. This will entail changes in hospital organization structure and procedures to produce an organization environment in which success in producing a high quality product which satisfies consumers will be rewarded and in which hospital management will have a realistic opportunity to succeed in this way.

The organization changes required for enhanced efficiency will themselves be greatly facilitated where, as planned under one component of the project, the hospitals have established user fees, market services and in this way earn revenue. Thus, there is a simultaneous relationship — improved efficiency/quality is necessary for a successful user-fee/cost-recovery program and, in turn, revenue earned from fees is necessary to establish organization procedures necessary to enhance efficiency/quality.

There are further interdependencies among the project components. For example, to the extent that there can be social financing (insurance, prepay) of the demand for services marketed by government hospitals, the prospects for successful operation of cost-recovery programs will be enhanced. By supplying technical assistance and in other ways, the project will assist government hospitals to participate in social financing schemes. (It will also assist other parties, on the demand side of the market and on the supply side of the market, to implement health insurance programs).

Given such relationships among the project components, it should be clear that any attempt to evaluate the project by looking at the components seriatim, would not be in accord with the logic which has informed the design of the project. Collectively, the project components comprise a package which we shall characterize as a "structural" intervention. This kind of intervention calls for a different kind of economic evaluation than that suitable for the "performance" interventions represented by what have been historically the typical health-sector projects.

Expenditures to implement the project may best be regarded as an investment in "system" change — i.e., it seeks to change Egypt's health-care financing system in important ways. Generally speaking, the benefits to be yielded by the project are the kinds of benefits usually associated with "privatization."

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As has been noted, the project will assist MOH hospitals to establish systems of user fees such that they will in this way achieve significant cost recovery. The GOE has proposed the Curative Care Organization (CCO) as the initial model for user-fee/cost-recovery programs in the MOH general hospital system. Annex I addresses some aspects of the issue of the feasibility of reliance on the (CCO) model for cost recovery generally throughout the MOH general hospital system, e.g., the question of the burden on household budgets that would be entailed by household purchases of such services at prevailing CCO charge rates. A comparison of household income levels and distributions with the burden of medical-services costs implied by CCO charge rates, suggests that there is indeed scope for significant cost recovery by converting some MOH facilities to the CCO model. At the same time that this component begins to implement such conversions, research should begin to inform judgments about what modifications in the CCO model may be in order as cost recovery generalizes across the MOH hospital system.

One of the components, namely, loans to physicians to establish practices in rural areas, is very much a part of the overall "privatization" thrust of the project. Nevertheless, this component is not as interdependent with other project components as are the other components. For the economic analysis, it can be regarded as standing on its own feet, and therefore this component is addressed separately in the annex, following an analysis for the feasibility of the CCO as a cost-recovery model. We find that, within a wide range of assumptions about demand-related contingencies, the cost per beneficiary household is modest in light of the opportunity for access to health services afforded to these households. Moreover, this component should be regarded as responsive to problems in the health-services sector owing to underfinancing of MOH health services.

Finally, the annex analyses the project as a whole regarded as a structural intervention. This section is in four parts:

- (i) Benefits of privatization
- (ii) Rationalizing health financing
- (iii) Service to equity objectives
- (iv) Evaluating structural interventions generally and in the Health Sector

The overall conclusion reached is that the expected present value of this future time-stream of benefits is such that expenditures for the project must be regarded as cost worthy.

D. Summary of Administrative Analysis

The Administrative Analysis, Annex J, assessed the Ministry of Health, noting it is a large organization designed for ongoing coordination, day-to-day operations, and repetitive activities on a nationwide basis. It was concluded that a new Project Directorate should be created to implement components 1 and 2, specially

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designed to focus its attention on unique activities, make quick decisions, and assess the complex options and innovative approaches involved in this project.

The Project Directorate, which will conduct on-going operations, is specifically tailored to accomplishing project objectives. It will have precisely the staff and technical resources required, and its small size and clear focus will allow consistent attention to problems and rapid decision-making. A technical assistance contractor will provide full technical support for the Directorate to carry out its responsibilities. The USAID Health Office has used similar specialized implementing organizations on most of its MOH projects, and they have proven to be effective mechanisms for project implementation. A policy-making body, the Project Steering Committee, will meet at least quarterly, and will include representatives from USAID, MOH, and other ministries involved in the project.

In Component One the Directorate is directly responsible for converting selected hospitals and clinics to operate on a cost recovery basis.

Component Two involves preparing technical proposals and implementing management improvements by the HIO, CCO and interested university hospitals and professional organizations. The Project Directorate will be the implementing agency, with considerable responsibility taken by the HIO and CCO for implementing their proposed management improvements. Both groups are well organized and effective, and HIO has considerable expertise in management information systems. Technical assistance is provided for preparing technical proposals. These management improvement subprojects can be carried out by consultants with minimal technical support from the Project Directorate.

The host government counterpart for Component Three is the Ministry of International Cooperation, serving as a conduit for channeling credit guarantee funds to a private sector implementing organization. MIC has extensive experience in this capacity.

The Credit Guarantee Corporation is being considered as the implementing organization of Component Three. If the CGC is chosen, additional financial support and technical assistance will be provided to develop the expertise required for assisting the private health sector. The CGC will be fully operational in 12 to 18 months, and at that time a decision will be made whether to use CGC or create a specialized organization to implement Component Three activities.

The detailed administrative analysis in Annex IV-C, concludes that the implementing organizations have the experience and capability to carry out all the proposed activities. The use of a specialized project directorate has been demonstrated by previous experience to be an effective mechanism for implementing projects. The HIO and CCO are well organized and experienced organizations, capable of taking most of the responsibility for implementing improved management systems and practices. The CGC or a specialized

organization can be tailored for effective implementation of Component Three activities.

In all cases, technical needs or institutional shortcomings have been identified, and appropriate technical assistance and institutional support will be provided. The Project design team concluded that adequate administrative arrangements have been made or are in process to assure effective project implementation.

E. Summary of Social Soundness Analysis

Scientific health care practices are not an innovation in Egypt. Even in rural areas traditional or folk medicine is rare, and all social groups seek modern health care. Annex K presents a full Social Soundness Analysis and concludes there are no social or cultural barriers to project acceptance and success.

1. Project Replicability and Spread Effect:

The project is specifically designed to maximize the potential for replicability and spread effect. Component One will convert approximately 50 government health care facilities to a cost recovery basis, with a clear MOH intent that with success in this project and valuable lessons learned, the entire system of 350 hospitals and clinics will be similarly converted. In Component Two, installing improved management information systems at the HIO and CCO will have a powerful demonstration effect, and the institutions' improved competence will provide a capable and experienced source of technical assistance for other organizations. Component Three will stimulate expansion of credit for private practitioners, with the idea that once underway the process will continue without outside intervention.

2. Social Consequence and Incidence of Benefits:

The project is designed to improve the quality of health services for all socio-economic groups. Converting selected facilities to a cost recovery basis will provide improved services for those unable to pay. Providing management improvements for selected health care systems will expand the service capacity of these organizations, supporting a larger client base without additional staff or facilities. Supporting the expansion of credit to private health practitioners in provincial cities and rural areas will increase the quality and availability of health care for middle class patients, and diminish the budgetary burden of providing public health care services in these areas.

3. Conclusion:

The Cost Recovery Programs for Health Project is carefully tailored to the Egyptian social environment. Its objective is to put the Egyptian health care system on a firm financial basis which will assure its continued viability

after the project is completed. The project improves the quality of health care in general while protecting those who are unable to pay. With replication throughout the government health care system and the private health sector, its benefits will continue after the project is completed. The project is socially and culturally feasible, provides considerable spread effect, and is beneficial to a wide variety of social groups with benefits widely distributed throughout Egyptian society.

F. Summary of Environmental Analysis

The Project's planned activities will not have an effect on the natural of physical environment. A categorical exclusion has been granted under AID's environmental procedures, Section 216.2(c) (VIII); programs involving health care or population and family planning services.

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PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Project Title & Number: COST RECOVERY PROGRAMS FOR HEALTH No. 263-0170

<u>NARRATIVE SUMMARY</u>	<u>OBJECTIVELY VERIFIABLE INDICATORS</u>	<u>MEANS OF VERIFICATION</u>	<u>IMPORTANT ASSUMPTIONS</u>
<u>PROGRAM OR SECTOR GOAL TO WHICH PROJECT CONTRIBUTES</u>	<u>MEASURES OF GOAL ACHIEVEMENTS</u>		<u>ASSUMPTIONS FOR ACHIEVING GOAL TARGETS</u>
To improve the health of the Egyptian people.	Progressive increase in life expectancy. Decrease in infant & under 5 mortality.	GOE Statistics	Disease specific technologies remain effective. Cost recovery will remain top GOE strategy. Current economic growth and income distribution maintained. Role of the private sector in the Egyptian economy will continue to expand. Population programs will receive top level support. National political and health sector stability maintained.

<u>PROJECT PURPOSE:</u>	<u>CONDITIONS THAT WILL INDICATE PURPOSE HAS BEEN ACHIEVED: END OF PROJECT STATUS</u>	<u>MEANS OF VERIFICATION</u>	<u>ASSUMPTIONS FOR ACHIEVING PURPOSE</u>
To establish a rational financial basis for the health sector through cost recovery systems.	80% of 50 cost recovery facilities achieve operating self-sufficiency. 90% of project supported, private medical practices operating at a profit.	GOE financial records, facility reports. Bank loan repayment records.	Egyptians will continue to utilize cost recovery GOE facilities for quality curative/health care. Private sector health care providers can not fully meet health care needs

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<u>PROJECT PURPOSE (continued)</u>	<u>CONDITIONS THAT WILL INDICATE PURPOSE HAS BEEN ACHIEVED: END OF PROJECT STATUS</u>	<u>MEANS OF VERIFICATION</u>	<u>ASSUMPTIONS FOR ACHIEVING PURPOSE</u>
	Improved, cost-effective services provided to 2.5 million people in HIO and COO facilities.	Financial records, ratios and MIS reports.	Egyptians will progressively use private health sector as source of quality care.
	45,000 people using new prepaid health care services.	GOE records, clinic reports, bank loan distributions and records.	Reasonable profit possibilities exist for private health care providers within the economy.

<u>OUTPUTS</u>	<u>MAGNITUDE OF OUTPUTS:</u>	<u>MEANS OF VERIFICATION</u>	<u>ASSUMPTIONS FOR ACHIEVING OUTPUTS.</u>
GOE facilities converted to cost recovery operations.	40 hospitals, 3,500 beds 10 polyclinics	GOE records.	GOE continues to support cost recovery.
Improved commercial banking system to provide financial services to health care providers.	10 banks participating	Bank records	Commercial banking sector continues interest in serving small scale lenders.
Expanded number of private, prepaid health delivery mechanisms.	5 private insurance schemes 25 HMO or HMO-like facilities	Bank records, clinic reports, GOE files.	GOE continues support of private sector.
Improved administrative and financial capabilities at COOs and HIO thru MIS improvements.	4 complete MISs to include cost accounting, registration, patient information, inventory control, quality assessment	Records, site reports.	HIO and COO can retain trained personnel.
Increased number of private medical practices particularly in rural areas and secondary cities.	14,000 individual practices 25 group practices	Bank loan records; GOE reports	Private physicians continue to be good credit risks.

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INPUTS	IMPLEMENTATION TARGET (Type & Quantity - \$000)	MEANS OF VERIFICATION	ASSUMPTIONS FOR PROVIDING INPUTS
1. Cost recovery conversions:	\$45,000		
Technical Assistance: (\$10,000) Performance Disbursements: (35,000) (Equipment: (17,000) (Renovations: (18,000))			GOE continues to support public and private health sector development.
2. Management Improvements to HIO and COOs	10,000		
Technical Assistance: (3,639) Training: (1,500) Commodities/Equipment (3,800) Operations Research (1,061)			Designed technology training, equipment and resources levels can improve effectiveness of the health sector.
3. Private Sector Credit	38,500		
Credit Fund (33,000) Technical Assistance: (3,800) Training: (1,500) Commodities: (200)			
4. Evaluation and Audit	1,500		
TOTAL:	<u>\$95,000</u>	Financial disbursement records	

(DCC: LOGICAL)