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**COST RECOVERY FOR HEALTH PROGRAMS
IN EGYPT
PHASE I DESIGN REPORT**

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EXECUTIVE SUMMARY

Introduction

Article 16 of the Egyptian Constitution states that all its citizens shall have the right to free health care. Since the promulgation of this right, the Government of Egypt (GOE) through the Ministry of Health (MOH) has attempted, in vain, to implement it. This failure is mainly for economic reasons. The diversion of GOE resources to defense, reduction in oil revenues, reduction in remittances from Egyptians working abroad, and the low priority given to the MOH have resulted in that Ministry's share of the national budget declining from five percent in 1976 to less than two percent in 1986. The MOH is faced with providing health care to a larger population with a smaller revenue base. In addition, a tandem policy of free education and guaranteed jobs has resulted in a glut of doctors in Egypt most of whom are employed by the MOH. Thus, on the cost side also the MOH has to apportion a major portion of its budget (as high as 78 percent) for the fixed costs of maintaining personnel and facilities. The portion of the budget left for provision of health care is unrealistic in relation to the demand.

The MOH has tried to co-opt partners in the delivery of health care. Public sector organizations, such as the Health Insurance Organization (HIO) and the Cairo Curative Organization (CCO), provide prepaid health insurance to parts of the wage-based population and fee-for-service health care to other citizens. However, the total number of beneficiaries covered by these organizations is very small (no more than eight percent of Egypt's estimated 50 million citizens). Government schemes aimed at the private sector such as special concessions for privately financed hospitals with special tax and custom duty exemptions ("investment hospitals") and tax holidays for rural practitioners have also not provided large-scale health coverage. Health coverage is unequal in that the two large centers of population, Cairo and Alexandria, are well-covered while rural areas and secondary towns in the 26 governorates are not adequately covered.

At the same time that the MOH is attempting to increase quality health care coverage for all of Egypt's citizens, there is a large population willing and able to pay for health care.

There is a growing awareness, therefore, within the MOH and among health planners and professional bodies that the health delivery system in Egypt needs to be realigned so that:

- o the burden of providing curative care is shifted from the MOH to the private sector;
- o the focus of the MOH is shifted to preventive health care thereby making it more like a ministry of public health;

- o the financing of curative services comes mainly from the beneficiaries; and
- o the truly indigent continue to be assured access to quality health care free of charge.

In addition, there is a growing consensus that the changes can only be accomplished if certain laws are modified and the managerial role of the MOH redefined.

Cost Recovery Project

In order to alleviate these concerns and find a solution for them, USAID and the MOH agreed to design a project that would address these issues. The Cost Recovery of Health Programs project (CRHP) should be designed and implemented by capable organizations.

The design phase has been divided into two parts: Phase I which is concerned with data collection, information gathering, and analysis and Phase II in which the project will be fully defined and a Project Paper (PP) completed.

Phase I

During Phase I of the project in April 1987 a team of four consultants from the International Science and Technology Institute (ISTI) visited Cairo, Alexandria, Ismailiya, Suez, Damanhur, and Fayum for four weeks. The team was led by Ajit S. Dutta, a Health Management Specialist, and consisted of Emma Hooper (Health Economist), Stephen Wahmann (Banking Specialist), and Pamela Edison (Public Policy Specialist).

The objectives of the visit were to assess: (1) the management and operational needs of HIO and CCO; (2) the extent and popularity, of prepaid insurance schemes; (3) the current laws and regulations under which health care delivery takes place in Egypt; (4) the supply and distribution of practitioners and beneficiaries; (5) the attitudes of both practitioners and beneficiaries concerning health care; (6) the feasibility of credit and/or grant programs under which financial inducements could be made for practitioners to relocate to secondary towns and rural areas; and (7) to define the activities to be undertaken under Phase II of the design phase.

Recommendations for Phase II Actions

The Phase I team recommends that Phase II focus on five clusters of options. The recommended course of action perceives of CRPH as a catalyst, helping to realign the health delivery system in directions that have already been recognized and accepted by the market, i.e., private financing. These options are discussed below, briefly.

o Collaborative Community Clinics

Phase II should examine the feasibility of setting up a group of experimental Collaborative Community Clinics (CCCs) in rural areas and secondary towns. These clinics will provide curative outpatient care at affordable fees that will ensure fiscal sustainability. The CCCs will be corporate entities with participation from the community in which they are located, private practitioners, the MOH, USAID, and the private sector. The CCCs will be managed autonomously by an executive director under the policy direction of a board of directors made up of community representatives, the private practitioners, and the local Director of Health. Patients will come from the community and the community will help shape the types of services offered to it by stating its health needs to the clinic practitioners. Premises for the CCCs, for the clinic, and for the practitioners' housing will come from the community, private landlords, or the MOH (if legally possible). The CCC will pay rent for these premises. The practitioners will provide working capital for the clinic and will thus "buy in" to the corporate entity. Their ownership of the CCC will ensure that they can transfer their interest when they want to leave the clinic practice. Financing for the equipment will be provided on a co-financing basis by USAID and Egyptian banks. USAID will act as the catalyst for the project and through its participation, will encourage the private sector and the MOH to cooperate and thus produce a multiplier effect.

Phase II will also identify the numbers of CCCs that could be opened up on an experimental basis and set procedural guidelines for project implementation. In addition, Phase II assistance will include guidance on site selection (centrally planned/market driven/expanding existing centers, etc.).

o Expanding Prepaid Insurance Coverage

Prepaid insurance schemes are currently offered by the public sector (HIO and CCO) to about four million beneficiaries and, to a much smaller extent, by the private sector. Almost all schemes are job-linked fringe benefits and cover the wage earner alone, providing no dependent coverage.

HIO and CCO expansion is intricately linked and constrained by the predetermined fees (either deductions-at-source or co-payments at the time of service delivery) that these organizations can charge. Rate setting is done with MOH approval and the rates are generally seen as uneconomic. The two Laws that govern public sector health insurance, Laws 79 and 32, are slightly different in that Law 32 (for government employees) allows for co-payments while Law 79 (for other employees) does not. This has led to higher per patient costs under Law 79 since patients can abuse the system and demand service at no additional cost to them. The low fees means that very little capital is internally generated by the two organizations and expansion

monies have to be sought through the MOH or foreign donors/investors. HIO is eager to use its operational surpluses for renovation and upgrading of existing facilities so that quality of care is improved. On its side, MOH, while pressuring to expand the insurance umbrella, cannot underwrite the additional cost of new facilities nor its share of contributions made on behalf of new beneficiaries. A possible source of financing exists providing the Laws can be changed. Phase II should examine the feasibility of consolidating Laws 79 and 32 so that initial deductions-at-source are reduced and co-payments are actuarially determined at more economic levels.

A second constraint to HIO and CCO is management and systems related. HIO has, with USAID help, established a partial Management Information System (MIS) in one of its branches. The MIS is, however, focussed on policing aberrational actions and punishing those responsible. It should be, instead, a tool for improving managerial performance and rewarding excellence. While, therefore, Phase II should consider the possibility of completing the MIS effort and perhaps extending some aspects to other branches through training, the MIS should be reevaluated for its potential to provide incentives rather than disincentives. CCO has limited management systems by way of patient records, inventory control, etc. Phase II should examine the possibility of providing management strengthening help to CCO by way of control systems.

Private sector prepaid schemes are very limited and are virtually non-existent outside Cairo and Alexandria. During Phase II parameters should be set up to allow interested groups to conduct feasibility studies and implement these schemes outside the two major urban areas.

o Banking Options

Credit mechanisms, for private sector practitioners willing to set up group CCCs and prepaid insurance schemes as discussed above will have to come from the Egyptian banking system. At present very few loans are given for medical practice. Most of these are fully collateralized and therefore difficult to obtain by other than well established practitioners. However, USAID and the banking system have established a precedent in co-financing schemes for small enterprises.

Phase II should examine the feasibility of setting up similar schemes for medical practices.

o Strengthen the coordinating role of MOH

The health system in Egypt is decentralized among private, public, and governmental systems. These systems need to be coordinated and managed by a central body. The MOH carries that responsibility but is currently unable to fulfill the role

because of budgetary and organizational constraints. In addition, certain Laws affecting its role (such as Laws 79 and 32) need to be amended.

Phase II can examine the areas in which the project can assist the MOH in improving its managerial capacity and its ability to efficiently focus its service delivery and to make optimum use of the resources under its jurisdiction. Phase II can also examine the feasibility of regulatory amendments. It can investigate the possibility of increased budgetary allocations for the MOH because of its acceptance of a new role in preventive health and in taking over some of the teaching responsibilities that currently reside with the Ministry of Education.

o Phase II Logistics

The major problems encountered during Phase I were (1) lack of time for field work and (2) lack of accurate data and information. If the CRPH is to succeed, sufficient time needs to be spent in the design stages to lay a strong foundation. It is therefore strongly recommended that (1) Phase II not begin until all necessary data, enumerated in the report, have been collected; and (2) that sufficient budgetary and time allocations be made to allow for its success.

Phase II personnel, both US and Egyptian, are also listed in the report.

I. INTRODUCTION

A. THE PROBLEM

The Government of Egypt (GOE) has explicitly stated that it would undertake to provide health care services free of charge to all of its citizens. Included in this definition of health care were both curative and preventive services. Included, too, were services ranging from primary care to tertiary care and specialized services where necessary.

However, since that official policy was promulgated, economic and political circumstances have made the realization of that policy impossible. The Ministry of Health (MOH) has a budget now of approximately 2.6 percent of the total GOE budget. It runs a vast network of rural health clinics and rural health units, supplemented by polyclinics and hospitals in both rural and urban settings. It employs the majority of Egypt's 85,000 registered doctors. The drain on its budget of these fixed expenses (salaries for personnel and running costs for facilities) means that a very small percentage is available for the medical treatment and medications for its beneficiaries, i.e., the Egyptian citizenry.

The paucity of its budget is reflected in its ability to provide quality health care services, which in turn has influenced the attitude of the beneficiaries. They, the beneficiaries, perceive that the free health services provided by the MOH are not of high quality and, therefore, have increasingly turned to other fee charging providers of health care.

These providers range from the traditional, i.e., dayas, health barbers, and pharmacists to the physicians and specialists employed by the public and private sectors. All of them charge fees. Some, because of their affiliations with mosques, churches, and other community-based clinics, charge moderate fees. Others in the public sector, i.e., under the control and purview of the MOH but considered outside the Government, such as the Health Insurance Organization (HIO) and the Cairo Curative Organization (CCO), charge moderate fees that are regulated by the MOH. Still others, employed in private practices, charge market-determined fees.

Indeed the correlation in the beneficiaries' minds of fees and better quality health care has led the MOH to experiment with "economic clinics" or "economic treatment centers." Where, nominal fees are charged. Unfortunately this has further reduced the stature of the free MOH clinics.

What has clearly been established, however, is the willingness and ability of a large proportion of Egyptians to pay fees for health care.

Concurrently with this phenomenon, the MOH has also begun to realize the need to devote more of its budget and resources to preventive, rather than curative, care.

There are, thus, several factors that have emerged clearly in recent years concerning health delivery in Egypt. These are:

- o the constraints placed on ability of the MOH because of its budget, to provide high quality curative services in its facilities;
- o the ability and willingness of a large number of Egypt's estimated 50 million people to pay fees for health services;
- o the ability and interest of the public and private sectors to provide curative and perhaps preventive services to a fee-paying public and their interest in doing so; and
- o the realization on the part of the MOH that it should concentrate on providing preventive care.

Given this broad analysis, the GOE has increasingly become aware that the solution to these problems could be found in initiating and expanding cost recovery programs and private sector initiatives.

B. COST RECOVERY PROGRAMS FOR HEALTH

One way out of the health conundrum stated above would be to take advantage of the beneficiaries' interest in obtaining services from the private and the public sectors for a fee. This would relieve the MOH from some of the burden of providing free health care to a large part of the population and would resolve two current ills: first, it would allow the MOH to improve the quality of its continuing curative services by shifting the financial burden to the private and public sectors; and, second, it would allow the MOH to take on the role of a Ministry of Public Health by focussing on preventive care. It would offer a larger share of the curative pie to the private and public sectors. The privatization of health financing could also be structured in such a way that a more equitable distribution of doctors could be achieved--away from the two large urban centers of Cairo and Alexandria and towards the secondary towns and rural areas. In this way, the de facto condition would be recognized, and a realignment of GOE health delivery services realized. The Cost Recovery for Health Program (CRHP) was proposed to achieve some of the above objectives.

C. DESIGN OF COST RECOVERY PROGRAMS

The use of cost recovery programs to realign health delivery systems needs careful planning. Many individuals and organizations are involved: the MOH, the Ministry of Education (MOE) which is responsible for the education of doctors, the Ministry of Plan (Minplan), the Ministry of Social Affairs (MOSA), public sector organizations (HIO and CCO), medical associations (such as the Medical Syndicate, the Egyptian Junior Medical Doctors Association, the Pharmacists Association, and others), private sector hospitals and clinics, and, of course, the beneficiaries themselves.

It was agreed that prior to the undertaking of the project a design effort would be initiated that would plan the project implementation based on current data and attitudes.

The design effort was divided into two phases. During Phase I data and information would be gathered and analyzed to (1) assess the capabilities and developmental potential of key organizations; (2) fine-tune the direction and purpose of the CRPH project; and (3) lay the foundation for Phase II of the design effort. During Phase II a Project Paper (PP) would be developed and the final design of the project would be developed.

D. PHASE I DESIGN

Phase I of the design effort, with its objectives stated above, was undertaken in April 1987. A four-person team spent the month of April in gathering and analyzing data and information.

The team members, and their respective tasks, were as follows.

Ajit S. Dutta, the Team Leader and Health Management Specialist. His specific tasks, in addition to the coordination of the team effort, was to assess the capabilities of HIO and CCO in implementing parts of the project and in improving their managerial effectiveness and operational productivity. In addition, he was responsible for an analysis of prepaid insurance schemes offered by the private sector and an assessment of their expansion plans and capability.

Emma Hooper, as the Health Economist on the team, was responsible for establishing the patterns of and reasons for the supply and geographical distribution of doctors and beneficiaries. She was also responsible for investigating applicable GOE laws and regulations affecting the health care sector and for investigating the objectives and plans of the MOH.

Pamela Edison, the Public Policy Analyst/Health Planner on the team, assisted in policy analysis concerning the GOE and the MOH and in assessing the extent of services offered by private sector organizations under prepaid health insurance schemes.

Stephen Wahmann, as the Banking Specialist, investigated the possibilities of setting up credit mechanisms that would induce doctors to relocate in secondary towns and rural areas.

Members of the team visited MOH, private sector, public sector, and PVO-run practices, clinics, and hospitals. They also met with other key health care organizations, professional associations, and banks. Since one of the objectives of the project was to extend services outside of Cairo and Alexandria, their visits included sites in Ismailiya, Fayum, Damanhur, and Suez as well as Cairo and Alexandria.

It was also decided to initiate a survey in four governorates to assess the attitudes of doctors and beneficiaries as to the provision and quality of health care services.

It is important to note here that much of the team's time and effort was spent in trying to obtain accurate and hard statistical, legislative, and financial data. In all areas and in all sectors it was quite clear that very few tabulated and easily retrievable data exist quite contrary to the claims made.

E. TEAM REPORT

Part I of the team report is the Introduction. Part II covers the major findings of the team and provides recommendations and options to be followed up by Phase II of the project. Several of these options are clustered in global issues, i.e., they do not fall easily into one segment of the team effort or another but, rather, are interconnected and "macro" in their approach. Chapters III, IV, V, and VI consist of the reports of the individual team members, detailing the data they have gathered and the analysis they have performed thereon. Each of these chapters also contains recommendations included in Part II. Chapter VII consists of Scopes of Work for the Phase II team. Lists of persons contacted, a bibliography and other exhibits are included as appendices.

F. ACKNOWLEDGMENTS

Finally, it is important to note that much of the team's efforts would not have been fruitful had it not been for the help and support provided by a number of people. Dr. Helmy, the MOH liaison for this project, was especially helpful in setting up appointments, arranging field visits, and putting us in touch with key personnel both within and outside the MOH. John Wiles,

the USAID Health Development Officer in charge of this project, was extraordinarily helpful in arranging meetings, providing logistical support, and in being a technical sounding board. The team owes them, and many others too numerous to mention here, a debt of gratitude.

II. ISSUES, OPTIONS, AND RECOMMENDATIONS FOR PHASE II OF THE COST RECOVERY PROJECT

The health delivery system in Egypt as it now exists, presents a confused and inefficient picture. The confusion and inefficiency exist on both sides of the system, i.e., on the supply (practitioners') side and on the demand (beneficiaries') side. The inefficiency is exacerbated by the way that doctors are trained and educated as well as by the numbers in which they are trained, by the manner in which the majority of the facilities are sited and utilized, and by the way that these resources are managed. Finally, one of the major expenses of medical treatment in Egypt, drugs and medications, are not adequately controlled. These factors are discussed, briefly, below.

A. ISSUES

1. Health Services, Supply and Demand

There are, on the supply side, approximately 85,000 registered physicians, GPs, specialists, and other practitioners. This number does not take into account the providers of traditional medicine, i.e., the dayas (midwives), health barbers, pharmacists, and others who also provide health care services. The majority of the formally trained providers, i.e., the approximately 85,000 practitioners who are registered with the Medical Syndicate, are employed by the MOH. They are required to serve in the MOH facilities after completing their formal education and training. Salaries of these MOH practitioners are very low and are considered uneconomic by them. Because of this, the MOH practitioners take on second and third jobs in public and private sector facilities. They are also encouraged by the MOH to establish and practice in the MOH-run "economic treatment" clinics. These clinics are based in the MOH facilities and are usually held in the afternoon. Patients pay a nominal fee and the revenues thus generated are shared in a predetermined fashion by the provider, the clinic staff (including clinic expenses), and by MOH. Most of the MOH doctors, therefore, work during the morning in MOH facilities, in the afternoon in the MOH economic treatment clinics, and in the evening in private practices. The fact that the MOH service is obligatory and provides the lowest compensation means that practitioners often do not provide their best services and skills at those outlets. The MOH free clinics have become in many cases and for many practitioners feeder and referral points to the more lucrative afternoon and evening sessions.

The glut of practitioners is thus accommodated in the limited number of facilities where health care is provided. These facilities include:

- o the private sector:
 - investment hospitals (privately financed hospitals exempt from tax and customs duties)
 - group and individual practices
 - PVO run clinics often linked to mosques and churches
- o the public sector:
 - physicians inside factories or other places of work (implants), clinics, and hospitals run by HIO
 - clinics and hospitals run by CCO
- o the governmental sector run by the MOH:
 - rural health units and centers
 - polyclinics
 - economic treatment clinics, and
 - hospitals

There is, thus, a confused and inefficient pattern of service provision, albeit determined by the market.

On the demand side of the equation, the beneficiaries also obtain services in an inefficient manner. This is caused by certain attitudinal factors. First, the beneficiaries' demand for medical treatment from traditional and modern sources is great. Second, they are willing to pay for the treatment. Third, there is a strong correlation in their minds between fees and quality of services. Fourth, they are willing to go to more than one provider and take more than one type of medication to ensure that treatment is effective. Given these attitudes, it is easy to see how their use of the present system is inefficient.

Beneficiaries will tend to go to the free MOH clinics as a first measure. They do not expect good services from this source, but since it is free and is a source of free medications, they feel they have nothing to lose. Often beneficiaries will go to MOH clinics on a "social" visit, i.e., to pass the time of day. There are, thus, a great number of unnecessary visits clogging up the MOH clinics. The MOH doctors are unable to cope with the numbers and provide cursory examinations and routine medications from their limited supplies. This superficial treatment further enforces the view that MOH facilities are incapable of providing quality services.

Once the beneficiaries have exhausted the free services, they will go to a fee-for-service practitioner. Sometimes the practitioners they visit are the same doctors they saw in the MOH

clinics but who are now providing services in private or group practices for fees. The beneficiaries will pay the fees levied and will get prescriptions for drugs which they will take to a pharmacist for filling. Consumers of health care under the present system thus "triplicate" their use of the system by consecutively using free treatment, economic treatment, and private practices in conjunction with pharmacies in search of treatment for a single condition.

Thus, both practitioners and beneficiaries are engaged in multiple and duplicative activities which is extremely costly and inefficient.

2. Manpower

The personnel related problems in Egypt's health delivery system are as follows:

- o a glut of doctors,
- o not enough nurses,
- o no procedure for relicensure and continuing education,
- o inadequate training in hospital administration and the management of medical practice, and
- o no training schemes for personnel.

These factors combine to dilute compensation levels and produce personnel ill-equipped to provide uniformly high standards of health care.

Egypt has approximately 85,000 registered physicians plus an almost equal number of nurses and an undetermined number of technicians and other medical personnel. No accurate count of these personnel exists, nor is there any definitive knowledge of their distribution and areas of work. There is, thus, no accurate data base of health service personnel classified by type (doctors, nurses, technicians, administrative, clerical, and skilled workers), geographic area, type of facility where they provide their services, and training levels. (The team was unable to obtain lists of registered doctors from the MOH or from the Medical Syndicate. A summary of sorts was provided but added up to only 36,000 physicians--a number which is vastly below the estimates of 85,000 used in official reports.)

Many of these doctors wish to practice and/or work in the large urban areas of Cairo and Alexandria. Very few venture to the rural areas on their own. Most put in their required stint with the MOH and then seek ways of returning to urban clusters. However, wherever they practice the major drawbacks to establishing a practice is finding premises for the clinic and for housing. Key money is not affordable in many cases.

The educational system is producing medical graduates at a rate of between 5,000 to 7,000 doctors a year at 13 medical colleges. There is a heavy demand for entrance into the medical colleges. The medical profession is highly sought after, mainly for the economic status it brings. In addition, high school grades automatically qualify students for medical colleges. These medical graduates add to the present glut of doctors. There is not a matching outflow of providers, through retirement and other factors, and, therefore, the numbers of doctors to be accommodated in the health sector are constantly increasing.

The universities do not provide enough focus on hospital administration. This is so because administrators are seen as "failed doctors" and administration is seen as a second-class activity. In addition, administrators are legally precluded from private practice. Thus, there is no incentive for the development of managers. Consequently, medical facilities are, on the whole, poorly managed and maintained.

Similarly, there are very few training courses that provide ongoing training to improve skills, nor is there a system of continuing education. Relicensure does not exist, and even the initial licensing is a rubber-stamping process with no continuing professional requirements. The poorly educated doctors are not required to keep their skills current unless, of course, it happens to be a requirement of the organization in which they are practicing.

For the above reasons, manpower in Egypt's health delivery system is poorly educated, inadequately trained, and poorly compensated.

3. Facilities

Phase I information indicated that private, public, and governmental sector facilities are unevenly located throughout Egypt: the patient/bed ratio is very poor in Upper Egypt and the desert governorates of Sinai and Red Sea, while Cairo and Alexandria have much better than average patient/bed ratios.

4. Management

Some of the causes (educational, legislative, and attitudinal) for poor resource management have been discussed above. All these causes result in inadequate preparation of managers. Further, managers and administrators have very few analytical data on which to make informed decisions. Phase I analysis indicates that a great deal of statistical information is collected and is available to managers. However, very little of this is tabulated and presented in such a manner that can help managers act. The plethora of information is too unwieldy, and there is a natural tendency to discard it. Because of the perceived unimportance of administrative skills, there is no cadre of trained hospital

administrators in Egypt. Nor is there any professional body which encourages entry into these ranks or nurtures its members and carves a niche for them in the health delivery system.

One area where there is widespread need is that of patient records and patient information. Most systems are inadequate in terms of information collected and tabulation of historical data. Data collection in this area is left to individual incentive and, therefore, even within the same organization data quality is uneven and inconsistent.

5. Drugs

Phase I information revealed that there are several problems connected with the supply and prescription of drugs. Drugs constitute an alarmingly high proportion of treatment costs reaching as high as 50 percent in the case of HIO managed insurance schemes. This is because of the ease with which drugs are prescribed and obtained and because of their low cost.

Many beneficiaries go to pharmacists who prescribe drugs over the counter: almost all drugs can be prescribed in this way. The pharmacists are not licensed by any professional body nor is there any oversight of their activities.

Concerning supply, it was clear that inventory management is not practiced by all organizations. Several rural clinics reported extreme volatility in drug usage which centered around those days when drugs were delivered. After the run on drugs when supply trucks made deliveries, clinics were left with minimal or no stocks. This has been identified as a major cause of unsatisfactory diagnostic procedures by physicians who feel that in the absence of an adequate range of drugs to prescribe there is little point in spending time on diagnosing precise causes of illness.

B. OPTIONS

The cost recovery project is seen as a catalyst that will help to make optimal use of health delivery resources in Egypt. There are already several precedents for this realignment. First, the concept of fee-for-service is widely accepted and practiced, i.e., financing of curative health services can be shifted from the MOH budget. This is not to say that the right to free service has been given up, but to comment on the current acceptable norm. Second, most parties concerned--the MOH, the private and public sectors, and the professional associations--agree that the MOH should move towards preventive care and should turn curative care over to the private and public sectors. Third, there is a growing movement in the private sector to establish group practices and prepaid health insurance schemes forming a bond between providers and beneficiaries, either through economic or social and community networks. Fourth, private sector

practitioners have expressed an interest in providing emergency and preventive care services, where such services are economically sustainable.

Phase I of the CRPH was engaged primarily in data collection and analysis with a view to fine-tuning the Project's objectives and providing a foundation for the Project Paper to be done in Phase II. Several areas requiring further attention therefore emerged from Phase I work. These are:

1. Provision of curative health care services through collaborative clinics;
2. Expanding the prepaid insurance umbrella;
3. Institutionalizing banking and credit mechanisms for health delivery;
4. Strengthening the role of a central policy coordinating and information unit;
5. Recommendations for Phase II.

1. Option One: Provision of Curative Health Services in Collaborative Clinics

The cost recovery project can be used to catalyze the change sought for. At the heart of this issue, and recommendation, is the setting up of experimental Collaborative Community Clinics (CCC).

Under the project, perhaps six CCCs (depending on available funding) will be set up with the joint participation of the local community, private practitioners, the local Governorates, the private sector banks and landlords, MOH, and USAID. (A Phase II objective would be to decide the number of sites to be selected.) The characteristics of these CCCs will be as follows.

1. They will be a joint effort between at least four independent parties--the GOE (through MOH and local governorates), the community, the private sector (practitioners, banks, landlords), and USAID.
2. The CCCs will be independent corporate structures with shares held by the community and the practitioners.

3. They will be autonomously managed on a day-to-day basis by an executive director under the policy control of a tripartite board made up of community representatives, local MOH representatives, and the participating private practitioners.
4. The Executive Director will operate the clinic under the medical standards promulgated by the MOH and by the Medical Syndicate. The facilities and the practitioners will be licensed by the MOH.
5. The CCCs will be responsive to the health demands of the local communities in which they are located.
6. The CCCs will provide curative care services in an outpatient clinic setting at affordable fees. They will act as feeder points for the MOH's regional tertiary care centers.
7. The CCCs will assure continuity of services to the community because they will be operated for profit and because they will be group practices.
8. The CCCs will help in the efficient redistribution of practitioners away from Cairo and Alexandria to rural areas and secondary towns. Practitioners will "own" the practices with the possibility of building equity. The CCCs will also provide a secure and steady source of income for the practitioners emanating from the pool of patients from the community. (In addition to these economic inducements, there will be other non-economic inducements discussed below).
9. The CCCs will provide a real choice for the beneficiaries in that they could then choose between the CCC, the MOH clinic, or other private sector clinics. However, it is envisaged that because of the community participation, a bonding will emerge between the CCC and the community.
10. The CCCs, if successful, can be replicated in other communities in other parts of Egypt.

An examination of the roles of the various participants and benefits accruing to them will clarify the operations of the CCCs.

a. The Community

Roles

The communities will have the primary role of providing a pool of patients to the CCCs. They will help to manage the CCCs through community representatives and will determine the services to be provided by the clinics based on need. The communities will pay the clinics for these services. Finally, in some cases the communities will provide premises or land for the practitioners and for the clinic itself.

Benefits

The benefits to the community are that it will receive appropriate and good quality health care at affordable prices. Indigent community members can be identified and where possible free care provided for them by the CCC. (Naturally, these will always have the option of going to the MOH facilities for free care.) And, where the community has provided premises or land for the clinic or practitioners it will receive rent at the fair market rate.

b. The Ministry of Health

Role

The primary role for the MOH will be that of setting standards for health services delivery regarding qualifications of the manpower, the physical features of the facilities, and the services themselves. Where possible, and after the MOH has identified surplus facilities, it can vacate such surplus facilities and rent them out to the CCC. (There is a possibility that the MOH could not constitutionally do this. The legality of such a move needs to be ascertained in Phase II.)

Benefits

The benefits to the MOH are financial. It will be relieved of the fixed expenses of running under-used facilities and can save all the fixed personnel and operational costs. In addition, were it able to turn over the facility to the CCC it would receive some income. Thus, its economic gain will be from cost savings and income generation. The MOH can use these to bolster preventive services. Through the setting up of CCCs and the divesting of surplus facilities, the MOH will also aid in streamlining the health delivery system in Egypt with the attendant benefits of making best use of resources as discussed above. The MOH will also benefit because the setting of strategically placed CCCs and tertiary care centers will improve geographic equity in placement of facilities.

c. Practitioners

Roles

The primary roles for the practitioners will be to provide quality care at affordable fees and to help manage the CCCs under the guidance of the Board of Directors and the Executive Director. The Executive Director will be chosen from among the practitioners and will be a trained administrator, not just a medical doctor. The practitioners will help to define the medical needs of the community and will respond, through their services, to these needs. They will also be responsible for providing the working capital for the CCC, either through loans or their own resources.

Benefits

The benefits to the practitioners will be economic. They will be part owners of their own business and will have a stake in it. When and if they wish to relocate, their good will and stake in the CCC can be sold to other practitioners. They will enjoy autonomous working conditions with job security. They will have premises for the clinic and for housing and good, controlled working conditions. Thus, the two major deterrents for relocation will have been resolved: availability of premises and the assurance of clients. The third, availability of loan funds, will also be resolved through loans from banks (see Chapter VI below). All in all, these benefits will add to professional satisfaction for the practitioners and will make relocation easier.

d. USAID

Role

USAID's primary role will be the provision of seed money for the purchase of office and medical equipment. These monies will be provided on a co-financing basis through participating Egyptian banks. Money will only be needed for six or so CCCs. USAID will thus act as the catalyst for this model and will energize the other parties to participate. USAID will also help in developing prototypes for the CCC model and for developing training modules for CCC personnel in management, administration, and health delivery matters.

Benefits

The benefits to USAID are enormous. It will create a multiplier effect from its seed monies. It will help develop private sector participation in the CCCs and quality health care for CCC beneficiaries.

e. Local Governorates

Role

The local governorates will have the primary role of providing rental premises for clinics and housing if these are not forthcoming from the community or from the MOH. It will also use local development funds as matching seed monies where necessary. (A precedent for this exists in Ismailiya where seed monies were made available for the mosque clinic.)

Benefits

The benefits to the governorate are the rents earned on premises and the fulfillment of local development objectives and missions.

f. Private Sector

Role

The private sector, here represented by banks and landlords, will aid in providing premises for housing and for clinics not available from MOH. The banks will participate by providing loans and banking facilities for the CCCs.

Benefits

In addition to the rents earned from premises, banks will earn economic returns on the loans they give out.

g. Recommendation for Phase II Work

It is recommended, therefore, that Phase II investigate the possibility of setting up CCCs and develop process for identifying sites. Care should be taken that CCCs, once established be replicable.

2. Option Two: Expanding Prepaid Insurance Coverage

The issues under this generic title include the expansion of HIO and its insurance umbrella, the expansion of private sector insurance schemes, financing the expansion of HIO through regulatory amendments concerning co-payments and deductions-at-source, replication of managerial skills, and the expansion of preventive care. The reader is referred to the Health Management Specialist's Report on HIO and Private Sector Insurance in Chapter III below. Many of the problems of expansion are more fully discussed there. CRPH Phase II issues and options are discussed briefly below.

HIO Expansion: The GOE has a stated policy of expanding the health insurance umbrella to a significant portion of the citizenry. When the insurance plan under Law 79 was first announced in 1964 the plan was to cover all the citizens within ten years. However, economic reality has made the implementation of this ambitious plan unfeasible, and the time table has been changed materially. The plans now are to cover at least 10 million citizens by the year 2000. That means insurance coverage will extend to about a sixth of the projected population at that time. Currently, HIO insurance coverage extends to 3.5 million people, or seven percent of the population. HIO expansion of coverage can come about by bringing in new beneficiaries in existing areas of operations, adding new beneficiaries in new areas of operations, adding new services, and by franchising its operations to other organizations under strict medical and administrative guidelines. The issue of HIO expansion cannot be addressed without focussing on the financing of such expansion. This is discussed below.

Private Insurance Schemes: A tandem, and perhaps related, growth can come about in insurance offered by private sector groups. (The relatedness of this growth to HIO expansion would be through franchise operations made available by HIO.) There are a number of nascent plans concerning group practices which are seeking to expand their patient base by offering health insurance schemes to employers and other groups of beneficiaries. The schemes will be underwritten through private insurance companies, several of whom have shown marked interest in this work. For instance, Misr Insurance and El Sharq Insurance are already implementing health insurance schemes through contracts with clinics and practitioners. However, these are centered around Cairo and/or Alexandria and aimed at the middle classes. Thus, if the project were to encourage growth in this sector, it would have to set up stringent parameters for project support.

Financing HIO Expansion: The issue of HIO's expansion of the insurance umbrella is closely related to financing. The MOH is interested in getting HIO to increase its coverage so that its stated public policy can be fulfilled. HIO is also interested in achieving this result. However, neither party has the investment capacity to underwrite the cost of new facilities and other operational costs. While the MOH is interested in HIO expanding its services, it is unable to guarantee that it will be able to provide its share of contributions (under Law 32) for new beneficiaries. Thus, the issue of expansion is one that cannot be discussed without establishing the financial underpinnings. This means that the insurance laws, Laws 79 and 32 especially, will have to be reviewed and perhaps amended. Once amended or consolidated the rates for deductions-at-source and for co-payments will need to be examined for economic viability and adjusted where possible.

Improving Management Skills: An issue to consider is the possibility of replicating the management techniques and experience of HIO/Alexandria within HIO and in other organizations. HIO/Alexandria has, through its recent experience in computerizing and the creation of a data base, acquired new skills in management. These skills can be transferred to other branches of HIO and to other organizations in such a way that both parties benefit. HIO can charge fees for this training and the recipients will acquire new skills. HIO personnel and management have expressed an interest in this training expansion.

Preventive Care: A final issue in this area concerns the provision of preventive care by HIO and other private insurance groups. HIO is mainly in the curative sector but could take over some preventive work especially in the areas of immunization and family planning.

Recommendations and Phase II Options

HIO: The project can be used to accomplish several objectives focussed on HIO. Phase II can examine the following project options and decide which of these should be recommended. First, Phase II can identify the amount of funds that will be needed for technical assistance and equipment so that the already existing computerization process is completed. However, it must be made clear that the focus of the MIS should be changed so that it is conceived of as a tool for managers to improve their effectiveness and performance, and not as a policing mechanism. (See Chapter III, below for further details on this subject.)

Second, Phase II can identify areas of technical assistance to HIO in developing intra-organization training modules to develop the management skills and computer literacy of personnel from other branches. Phase II can examine the possibility of project funds to be used to develop training curricula, training materials, and an overall scheme for progressive training at set intervals. The project can also help HIO to determine the feasibility of offering these training courses as well as other in-house training aimed at medical personnel to personnel from other organizations.

Third, Phase II can further assess HIO's expansion options and determine whether this can be most efficiently achieved through the addition of new services, new beneficiaries, new areas, or a combination of these three factors. Phase II should consider the possibility of doing a feasibility study for this expansion. The feasibility study should have a strong financial analysis required of such an expansion in terms of facilities, equipment, personnel, and ancillary administrative and maintenance services. The financial analysis should highlight the investment required to underwrite such expansion schemes and the sources of financing for such investments. A possible source of self-financing would be the Laws (79 and 32) themselves. The study should assess the possibility of amending the laws and consolidating them.

Consideration should be given, based on actuarial and demand elasticity studies, of the feasibility of reducing deductions-at-source amounts and of raising co-payment amounts to economic or near economic levels. Naturally, such an assessment must take into account the attitudes of the beneficiaries, their ability and willingness to pay increased fees, and the political determination of the MOH to amend the Laws. Phase II should finalize whether the project can assist in researching these areas.

CCO: Phase II should examine the ways in which CCO can be helped to improve managerial efficiency. Phase I indicates that CCO can use help in the following:

- o Designing and implementing a management information system, a patient records system, and an inventory management system. These can begin as manual systems and be computerized later,
- o Developing a medical secretariate
- o Developing training modules for their personnel.

Private Insurance Expansion: Private insurance coverage schemes, i.e., those that are managed by insurance companies with services provided through contracted out personnel and clinics, are few in number. The data collected point to two such organizations--Misr Insurance and El Sharq--who are important in this field. There are three or four more minor insurance companies who offer health insurance coverage, but they are insignificant and cover only one or two employer groups each. It is important to note that total coverage provided by this sector probably does not exceed 15,000 to 20,000 beneficiaries. The benefits offered are duplications of those offered through HIO. Thus, this sector, in order to expand, has to demonstrate its ability to match or better HIO benefits at equal cost to the employers and employees. The revenues of these insurance schemes are taxed by the GOE and provide some credits to the MOH budget.

Several groups of medical practitioners and the Egyptian Junior Medical Doctors Association have indicated their interest in providing such insurance coverage with seed monies from AID. Some of these are aimed at middle class beneficiaries in Cairo while others are still in a more nascent stage.

Phase II should assess how the project can provide assistance in this area. There are two ways in which Phase II can examine this question. One option would be to consider whether a global feasibility study, financed under the project, can be used to help accelerate private sector movements. The study should be

global, i.e., not linked to any specific proposal from a group of practitioners. It should provide a framework for other feasibility studies that would answer the following questions:

- o What is the overall market for such schemes in secondary towns and rural areas?
- o What types of groups can they cover? And are such groups organized? Or able to organize themselves (e.g., such as farmers)?
- o What types of benefits should be offered? Should these match HIO's benefits, or be better? Should they be comprehensive, i.e., curative and preventive?
- o What types of financing would be needed to set up a typical scheme?
- o What premiums would need to be charged to make the scheme economically viable? Are these rates actually sound? What is the demand elasticity?

A second option, to be assessed by Phase II, would be to provide grant monies to pre-qualified groups (i.e., to those groups whose plans fall within overall project objectives) to conduct their own feasibility studies, perhaps using identified Egyptian professional firms.

Phase II should also consider the viability, and need, for an "open season" among insurance schemes, i.e., HIO and private schemes.

3. Option Three: Expand Access to Bank Credit for Medical Practices

There are two major banking issues for consideration under Phase II:

1. Who will finance the possible credit packages under this project? and
2. What is the structure of the financing package? i.e., what is to be financed, and what is the basis of financing?

The possible options to these issues are discussed in detail below. Briefly, as per Phase I information, the Egyptian banking system is composed of joint-venture banks, so-called "private" banks, the four public sector banks, Islamic banks, and development or "specialized" banks. These banks have local currency financing capabilities and they can and do make stand-alone loans for financing these types of projects--lending to medical practices. That is, they can accept entirely the credit risk/loan exposure.

In addition, for added support in this private sector area, AID can co-finance projects with the Egyptian banks. Phase II should assess whether this co-financing could also be established specifically for lending to the health sector in conjunction with local institutions. The terms and conditions could be similar to the USAID Egypt credit program of "Private Sector Credit & Term Finance Scheme" (see Chapter VI) or could build on these terms and conditions. Phase II should assess the possibilities of a revolving loan fund which could be established for health sector financing of medical practices. The banks would accept applications for potential projects and make an independent credit analysis of the acceptability of the project by their credit standards. Then, if co-financing were required, the banks would apply through the GOE (or an agency/ministry) to USAID Egypt for additional credit/funding.

Phase II should also seek to answer what the bank financing should cover, i.e., should it be available for working capital, current assets (such as inventory and drug stocks), purchase of medical equipment, or for fixed assets (such as land and buildings and "key money" for apartments). Phase I indicated that financing is needed most for land and building, key money, and medical equipment, in that order. Phase II should consider where USAID monies will be most effective: in foreign exchange for medical equipment or local currency for bricks and mortar. It should also consider the magnitude of project funding: land and buildings alone can eat up the entire project budget.

Phase I indicates that the basis of financing would be under normal traditional Egyptian banking methods, i.e., generally the credit would be secured by some form of collateral and/or guarantee. This credit, either short-term or long-term, would attract fees and commissions as dictated by the Central Bank of Egypt.

Phase II should see if other options are available.

4. Option Four: Strengthen Role of the MOH in Managing and Coordinating Health Care Provision

Management needs in the health sector have become more complex with (1) the policy of decentralization and local government control, (2) increasing emphasis on expansion of preventive and promotive health programs, (3) a continuing need for investment in curative care facilities, and (4) a rapidly growing network of private practitioners, clinics, and investment hospitals. Management systems to monitor progress in meeting health care goals have not kept pace with these increasingly diverse needs. Phase I information indicated that a centralized policy planning and coordinating unit within the health delivery system was needed to manage effective growth of the system and its eventual efficiency. The coordinating unit would also be responsible for

promulgating medical standards and protocols to be followed by health personnel and facilities. The MOH is currently designated as that coordinating unit.

However, because of certain problems, the MOH is not fulfilling that role effectively. In order to improve health care services the Ministry of Health must strengthen its capabilities to manage and coordinate health care services. The preliminary Five Year Health Plan 1987-1982 also identifies this need and gives priority to raising the efficiency of free medical services provided by the government, improving the efficiency of all medical service delivery whether MOH, university hospital, or the private sector, and enforcing compliance of standards in the private sector hospitals. The following sections review issues and strategies for strengthening the role of the Ministry of Health.

a. Generation, Centralization, Availability, and Use of Accurate Data.

The efficiency and effectiveness of the public health care system depends on the capacity for management, supervision, and financial discipline. While routine service statistics are maintained manually at all levels of health care facilities, there is no uniformity in record keeping, little effort to maintain accuracy, and no feedback from central authorities. Thus, consolidation of information at the central level is reported to be both inaccurate and incomplete. Furthermore, there is no national authority to compile service statistics across all points of service delivery, e.g. government, public, and private sectors.

A thorough review of existing management information systems should be undertaken during Phase II project design. The objective will be to specify precise data needs and to make recommendations for a routine data analysis system covering governorate level operating expenditures, patterns of health service use, assessment of excess and under-capacity, and manpower/capital investment needs relative to changing population-based needs.

b. Regulatory Controls

The Ministry of Health is charged with establishing standards for all health services in the country. Existing laws permit the MOH to license private practice clinics and hospitals, review fee schedules, and supervise standards of performance. However, enforcement of these laws is reported to be weak. Clinics routinely begin offering services prior to actual inspection and licensing, while private practice physicians maintain clinics with fewer than three beds to circumscribe the required standards. The policy issue of how to efficiently use private sector resources becomes moot without stronger controls over

market entry. Clearly, the MOH must be able to work with professional associations in establishing reasonable standards of care with adequate provision for enforcement.

The need for regulatory control in the private sector corresponds to a similar need to upgrade the standards of care in government facilities which continue to provide the bulk of all health care services. In addition to basic guidelines for construction, equipment, and staffing, general hygiene and infection rates can be used to gauge standards of care, medical records can provide useful check on diagnostic and prescribing patterns, and spot checks of pharmacy packaging and labelling compliance can contribute to improved health care delivery.

Activities to strengthen the management role of the MOH and institutionalize regulatory control of standards will be detailed in the next design phase. A separate project component is planned to address these institutional development issues.

c. Increase MOH Resources.

Over the past ten years, the health sector budget as a proportion of overall government expenditures has declined from five percent to an estimated two percent. Government expenditures are highly sensitive to price changes and inflation with revenues highly price inelastic. Infrastructure investments in the health sector have been adequate at the expense of recurrent budget support for both labor and suppliers resulting in an underfunded public health system.

Two feasible strategies to increase government allocations, were discussed with the MOH project steering committee:

- o An additional funding request for Primary Health Care. The Five Year Plan gives priority to primary and preventive health care services. Without additional resources, the MOH will not be able to develop adequate service coverage. If the MOH is to take on the full responsibility for these services, a case could be made to increase the overall health sector budget to the previous level of five percent.
- o Merge Ministry of Education (MOE) university hospitals into the MOH medical care system.

The Ministry of Education manages 21 university hospitals which provide tertiary care and training residencies for young doctors. Typically, the hospitals are well-equipped with a full range of intensive care and critical care units, laboratories, and diagnostic facilities. These institutions are not subject to direct control by the MOH, though clearly the services provided are an important adjunct to the MOH medical care system.

Additional revenues could be realized from a merging of MOE university hospitals into the MOH medical care system. More importantly it may be more efficient to use existing tertiary care facilities in the MOE system than to construct new tertiary care facilities for the MOH. This strategy is consistent with the Five Year Plan goal of improving of medical care service delivery. While this strategy clearly requires considerable political support, the idea is conceptually palatable to a wide range of high-level policy makers.

d. Ensure Continuity of Consistent Policy.

There is a growing professional awareness of the need to establish medium to longer term policies for health sector development. Optimal use of the health care resources with a shift in MOH priority to preventive health services is a case in point. Regardless of changing political leadership, the civil service professionals represent an important asset to continuity of government policy. This role can be further encouraged by the development of a civil service secretariat to enable consistent implementation of bottom-up plans and policies.

e. Amend and Streamline Legislation.

- o As discussed in the insurance option section above, Laws 79 and 32 should be consolidated.
- o Greater flexibility in local planning, budgeting, and expenditure will be important to the future of cost recovery efforts.

f. Additional Recommendations

AID project assistance through the Cost Recovery Project should include:

- o Activities to enhance the managerial role of the MOH.
- o Strategies to improve the governments' ability to focus service delivery on the indigent, high risk/high need groups, particularly through the use of a health card, Medicaid-type system within the context of a fiscal policy dialogue.
- o Policy dialogue coordinating and streamlining health services across ministries and organizational entities through institutionalization of computerized management information system and clearer delineation of management responsibilities.

C. RECOMMENDED PHASE II ACTIVITIES AND TEAM SPECIALTIES

Phase II's objectives are (1) to analyze the options for implementation presented in the Phase I report, (2) to design the proposed Cost Recovery Programs for the Health Sector, and (3) to gather other information as necessary to produce the project paper. An outline for the PP is attached.

The Phase I Report has outlined four major Options for Phase II and Project work (see above). There were not many options available to the Phase I team. This was partially due to inadequate and inaccurate data, as well as lack of time to conduct extensive field work, such as a survey. However, a field survey instrument was prepared and interested parties were contacted. The survey has to commence after Ramadan (June 1) and be finalized by mid-July. There is a general lack of accurate data in Egypt, not just in the health sector. However, with these four Issues and Options, choices can be made by the Phase II team for the design of the project.

1. Phase II Personnel

The personnel envisioned for the Phase II Team are as follows:

- 1) Institutional Development Specialist/National Health Planner: this individual would also be qualified to follow-up on the Health Economist's work from Phase I;
- 2) Health Management Consultant;
- 3) Banking Specialist;
- 4) Social Scientist: this person would write the social soundness analysis for the PP, including the analyses described in their Phase II Scope of Work;
- 5) Facilitator: this team member will conduct discussion groups.

In addition, these local hire personnel are recommended:

- 1) An Administrative Assistant to gather required data and laws before arrival of Phase II team members described above. This individual would also work during parts of Phase II;
- 2) A Lawyer/Financial Consultant to guide administrative assistant in extracting appropriate laws prior to commencement of Phase II. During Phase II to provide expertise to team members as required. An example would be to assist the Banking Specialist in

establishing a framework for a credit criteria, studying the legal entity issue, and an AID co-financing credit scheme;

- 3) A Translator to translate pertinent documents prior and during Phase II as required;
- 4) A Marketing Consultant to assist in field work and advise, as required, the Institutional Development Specialist/National Health Planner.

2. Activities and Timing of Phase II

Phase II should begin as soon as possible after the submission of the Phase I Report and after approval by AID/W and the Mission. The local personnel (i.e., Administrative Assistant, etc.) should commence work by July 1 to gather data and obtain copies of laws and have them translated where required. The field survey should be completed by mid-July, and Phase II Team members can begin work in Egypt on design and the PP by August 15, 1987.

Phase I team members found that not sufficient time was allotted to gathering information, analyzing it, and writing the reports in the field. It is strongly recommended that the Phase II scopes of work allow sufficient time for a complete analysis of options and writing the PP.

The CRHP funding is tentatively projected at \$50 million. Design costs for Phase I and Phase II are projected at under \$200,000 including local currency costs of LE 40,000. This means that a major project is going to be designed at a cost of less than 0.4 percent of projected capital investment. Even banks charge more than that percentage, as loan origination fees, to cover administrative expenses on routine loans. It is strongly recommended that this budget be increased to realistically reflect the importance and true cost of a full design effort.

The length of assignments for team members would be as follows:

- 1) Health Management Consultant - 10 weeks;
- 2) Institutional Development Specialist/National Health Planner - 10 weeks;
- 3) Banking Specialist - 4 weeks;
- 4) Social Scientist - 8 weeks;
- 5) Facilitator - 1 week.
- 6) Administrative Assistant - 12 weeks;
- 7) Lawyer/Financial Consultant - 3 weeks;

- 8) Translator - 3 weeks;
- 9) Marketing Consultant - 3 weeks.

3. Data Collection

Certain data should be collected prior to Phase II team arrival so that their work flows smoothly. It is strongly recommended that work on Phase II not begin until all statistical data and laws have been collected and assembled as suggested in the Phase I Report. This would include translations where required. This will enhance the Phase II design team's productivity and efficiency.

Data requirements and laws which should be gathered before commencement of the Phase II are:

- 1) HIO: all missing data referred to in the body of the Phase I Report;
- 2) CCO: consolidated financial statement for Fiscal Years 1984/1985;
- 3) HIO & CCO: detailed information from each organization on what specific management assistance is required;
- 4) Laws:
 - a. Social Insurance legislation;
 - b. all other laws applicable to the health sector;
- 5) Statistics required:
 - a. Details on physicians:
 - i. by income levels;
 - ii. by demographics;
 - iii. by exact locations (as detailed by village location);
 - iv. by sector - MOH, private, public;
 - b. Details on MOH facility locations;

4. Sample Project Paper Outline

I. Project Setting

- A. Background
- B. Sector Challenges and Constraints
- C. Other Donors
- D. Strategy/Relationship to AID Policy Initiatives
 - 1. Institutional Development
 - 2. Policy Dialogue
 - 3. Private Sector

II. Project Description

- A. Goals & Purpose
- B. Project Components
- C. Preliminary Budget
- D. Expected Impact/Project Specific Analyses
 - 1. Technical
 - 2. Economic
 - 3. Administrative

III. Project Administration

- A. Implementing Agencies
- B. Agency Arrangements/Co-ordination
- C. Design Schedule and Implementation Plan
- D. Contracting Services
- E. Gray Amendment Alert
- F. Evaluation Plan
- G. Procurement Plan

IV. Policy Issues

III. PUBLIC AND PRIVATE HEALTH INSURANCE IN EGYPT

A. HEALTH INSURANCE ORGANIZATION

The Government Health Insurance Organization (HIO) is a Cairo based organization providing health care services (almost entirely curative in nature) to beneficiaries under two Laws promulgated by the GOE. Repeated requests were made of HIO for data covering financial, statistical, operational, and management matters (see Appendix C for list of requested information). However, only very general information and partial data on the Alexandria branch operations were available for security reasons. Therefore, much of the basic information in this section was generated by Dr. James Jeffers' 1982 Health Sector Assessment and papers written by Carl Stevens before that. Because of the lack of data, hard quantitative analysis could not be done. However, some areas of needed project assistance were clearly indicated from discussions with HIO and MOH officials. Data provided in discussions did not materially differ from those in Jeffers' paper, and thus it is believed that findings as reported are valid.

1. Charter and Organizational Details of HIO

HIO was established by Law 79 in 1964 and began operations that year in Alexandria in some MOH facilities. It is a public sector "Economic Authority" (or Economic Organization). Law 79 has been amended several times since, and in 1975, more beneficiaries were added to the HIO umbrella under Law 32. Currently, HIO has about 3.5 million beneficiaries serviced equally under the two Laws. The following table shows the growth of beneficiaries since inception.

HIO is monitored by the MOH and must follow directives concerning beneficiary coverage, fees, and staff levels. The MOH also ensures HIO operational financing through government-sponsored social security deduction-at-source schemes. However, HIO is largely autonomous within these MOH parameters. It is able to set salary and contract rates for its employees and consultants at significantly higher rates than those allowed in the governmental or public sectors and is also able to use its surplus for financing investments. Nevertheless, there are areas where HIO's future plans and MOH's expectations of HIO are in conflict. This is especially true in the case of expansion of insurance coverage to new clients.

TABLE 1

Growth of HIO Coverage 1965-1985

<u>Year</u>	<u>Coverage_in_Thousands</u>
1965	140
1966	145
1967	171
1968	257
1969	296
1970	318
1971	368
1972	379
1973	415
1974	436
1975	602
1976	922
1977	1,081
1978	1,255
1979	1,427
1980	1,651
1981	2,516
1982	2,720
1983	2,950
1984	3,073
1985	3,225
Beneficiaries under Law 79	1,513,000
Beneficiaries under Law 32	1,573,000
Pensioners and Widows	139,000

HIO is headquartered in Heliopolis, Cairo, and is under the Chairmanship of Dr. Samir Diaey. It has six branch operations, as follows:

- o Cairo Branch covering the Cairo Governorate;
- o Northwest Delta Branch covering Alexandria, Buhera, and Matruh Governorates;
- o Middle Delta Branch covering Gharbea, Kafer El Sheikh, Menufea, Dakhalea, and Damyetta Governorates;
- o Canal and East Delta Branch covering Ismailiya, Kalubea, Port Said, Suez, and Sharkea Governorates;
- o Giza and North Upper Egypt Branch covering Giza, El Fayum, Beni Suef, and Elmenia Governorates;
- o Assiut and South Upper Egypt Branch covering Assiut, Suhag, Kena, Aswan, Elbahr El Ahmar, and Elwadi El Gedid Governorates.

Of these, the largest by far is the Northwest Delta Branch, headquartered in Alexandria, which services some 850,000 beneficiaries.

Table 2 below shows the facilities operated by these six branches.

Table 2
Facilities Operated by Branches

Branch	Polyclinics and Medical Centers	Hospitals	
		No.	Beds
Cairo	8	4	652
Northwest Delta	20	3	1,081
Middle Delta	8	3	441
Canal & East Delta	10	6	722
Giza & North Upper Egypt	7	5	682
Assiut & South Upper Egypt	13	4	256
Total	66	25	3,834

Table 3 below shows the number of patients seen in 1985 by HIO personnel.

Table 3

Number of Visits in 1985 (in '000s)

GPs	5,866
Specialists	3,267
Radiography & Lab	1,523
Hospitalization	98
Surgical Operations	58
Home Visits	58
Rehabilitation Services	40

Total	10,910
	=====
Number of Prescriptions	6,547

2. Laws Covering HIO

The operations of HIO, and especially its financing, are mainly covered by two Laws, as mentioned earlier: Law 79 of 1964, as amended, and Law 32 of 1975. In addition, the Social Insurance Organization Act obliged HIO to cover industrial accidents for employees and also regular health coverage for pensioners and widows. The salient features of these Laws are shown in Appendix D.

a. Law 79

Under Law 79 private and public sector employers with over 300 employees are required to participate in the health insurance scheme provided by HIO. (In Alexandria the Law was changed to cover all non-agricultural employees. Thus, a one-employee firm is also required to participate in the scheme.) According to HIO estimates, there are now 1.75 million beneficiaries under this Law. (Note that estimates of numbers may be materially inaccurate: HIO estimates that the Northwest Delta Branch covers 850,000 beneficiaries, as reported above; however, indications arising from their recent effort to computerize all beneficiaries served by that Branch show that the number may be as low as 650,000. This is mainly due to duplicate counts of beneficiaries who have lost cards and those who have left one employer for another.)

On a case-by-case basis exceptions are granted to employers to opt out of the coverage provided by HIO. However, they must provide health coverage to their employees, either through in-house direct coverage or through contracts with outside providers. In addition, those employers that opt out of the HIO system need to contribute one percent of wages to HIO in the interests of "national solidarity." Under Law 79 the employer makes a contribution of three percent of base wages for HIO coverage and the employee makes a one percent contribution. Once these deductions at source are made, HIO is obliged to provide

any and all curative health services to the employees at no further cost to them, except a nominal three piasters for the first visit. Because of this lack of payment at the time service is provided, many at HIO and the MOH feel that the system under Law 79 is open to abuse by the patients. Employees use this free service for social purposes and/or as excuses to be absent from work. Table 4 shows the average cost, per patient visit, per year for the two Laws.

Table 4

Average Cost in Egyptian Pounds Per Patient in 1986

	Law 79	Law 32
Out patient treatment	3.973	2.116
Drug costs	11.848	6.469
Inpatient treatment	5.999	2.788
Treatment abroad	.474	.474
Rehabilitation expenses	.596	.484
Administrative expenses	1.157	1.060
	-----	-----
Total Cost	LE 24.047	13.441
	=====	=====

In almost all categories, and especially in drug costs, treatment under Law 79 is higher than under Law 32. Indeed, the average cost is almost double under Law 79.

b. Law 32

Law 32 covers government employees at both the central and governorate levels. Employees pay 0.5 percent of their base wages, and the Government pays 1.5 percent as its contribution. However, patients are required to supplement these lower contributions at source through co-payments made at the time of service delivery. These co-payments are as follows:

- o 25 percent of all drugs, outpatient procedures and appliances with a cap of LE 1 per prescription, procedure, or appliance;
- o 5 piasters per visit to a GP;
- o 10 piasters per visit to a specialist; and
- o LE 0.5 per day of hospitalization (lowered to 25 piasters per day after two weeks) with free drugs during the stay in the hospital.

It is felt the co-payments help to limit misuse and abuse of the system.

The Social Insurance Organization Act (SIO) provides coverage for all industrial accidents (trauma and occupationally-caused disease and disability). Employers contribute three percent of base wages to the SIO of which one percent is sent on to HIO to provide services. In addition, HIO also provides the preemployment and obligatory periodical health examinations for employees. It does, however, receive a 50 piaster payment per examination. There are approximately 6.6 million beneficiaries under this scheme. Note that some of these may also be covered under Laws 79 or 32.

The SIO Act was modified in 1980 to provide coverage to those pensioners and widows who wanted such health insurance. Pensioners contribute one percent of their pensions for coverage and widows contribute two percent of their pensions. These services are provided free of co-payments. Current enrollees number approximately 165,000 with a projected annual growth of 11 percent in their numbers.

In 1982 a trial program was started in Alexandria to expand the insurance by adding dependents of covered employees. An employee could cover a maximum of four dependents with a contribution of 0.5 percent of base wages for each dependent. In addition, co-payments at the time of service delivery were to be made as follows:

- o 35 percent of drugs with no limits;
- o 50 percent of the cost of hospitalization with a cap of LE 5 per day;
- o 50 percent of the cost of X-ray and lab costs with no limit;
- o 15 piasters per visit to a GP;
- o 30 piasters per visit to a specialist; and
- o LE 1.25 and LE 1.50 for home visits by a GP or specialist respectively.

Approximately 30,000 beneficiaries were enrolled in this collaborative effort sponsored by HIO and the High Institute of Public Health in Alexandria. However, currently only 11,000 beneficiaries remain. This attempt to increase coverage to other groups, albeit in this case a "captive" group, is seen as a failure by HIO and the MOH. There are several reasons ascribed for its failure. First, the Ministerial decree establishing the experiment was seen to be vague in its wording and implied a choice on the part of the employee, i.e., it should have been worded such that the mandatory nature of the deductions and the coverage was explicit. Because of this element of choice, only the high risk beneficiaries came forward to be enrolled. Second,

the co-payments, especially the fact of no capping for drugs and examinations and the high cap for the daily hospital stay cost, were seen as prohibitive at that time.

3. Financial Status

As stated in the introductory passage, no financial and statistical information was made available by HIO except for the financial statements of the Northwest Delta branch in Alexandria.

Based on prior written material, and current discussions with Dr. Diaey and other HIO officials, it is apparent that HIO is generating some surpluses and that it has a retained surplus (by some accounts as high as LE 150 million). However, it is also clear that not all of HIO's services are profitable. For instance, the services under Laws 79 and 32 are breaking even, the high-risk group of pensioners is generating large deficits, and the industrial accident coverage pool is generating sufficient surpluses to cover all other deficits and, in effect, produce HIO's net income.

The Northwest Delta Branch results are presented as Tables 5 and 6. (The reader is referred to the section on Cairo Curative Organization for an explanation of the financial ratio analysis that follows.) The analysis of these results shows that the Branch is in good financial condition, and that it produces a healthy return on investment (13.28 percent). Net income for the year 1986 was 12 percent of gross revenues and is markedly up, both in percentage terms and in absolute values, from 1985. Operational revenues increased by 18 percent from 1985 to 1986 (by about LE 3.3 million). Costs, in percentage terms, were contained over 1985 and this has resulted in the significant profit increase.

The Balance Sheet analysis shows the branch to be in a good and financially strong condition. The current ratio is 3.24:1 (which is very high). The acid test ratio shows that the Branch has sufficient cash (by U.S. standards a very high degree of liquidity) to cover its short term liabilities. However, a significant portion of HIO/Alexandria's balance sheet (26 percent) is tied up in inventories and accounts receivable. Better use could be made of cash released by reducing these numbers. Further, the system of managing cash flow, especially those related to receipts from HIO headquarters (from where HIO/Alexandria receives quarterly tranches of budgeted expenses) needs to be looked at so that the whole organization's cash flow is smoothed out. The Branch has also done a remarkable job in controlling debt collection and the analysis shows that accounts receivable are collected within an average of 19 days. However, the number of days outstanding was six in 1985--about one-third of the 1986 number--and the Branch should investigate this sharp increase even though the current number is excellent by all standards.

Table 5

HEALTH INSURANCE ORGANIZATION: NORTHWEST DELTA BRANCH
ANALYSIS OF FINANCIAL STATEMENTS

Balance Sheet	1986	1985	1984
Assets			
Fixed Assets	9,252,054	7,016,269	5,988,018
Less Depreciation Provision	(1,626,630)	(1,307,963)	(1,411,135)
Work in Process	4,867,925	3,846,661	3,875,290

Sub Fixed Assets	12,493,349	9,554,967	8,452,173
Inventory	4,642,136	3,182,244	2,552,852
Accounts Receivable	1,136,947	291,871	105,419
Miscellaneous Debtors	784,518	244,751	1,467,810
Cash in Bank	3,519,853	4,217,360	4,112,164

TOTAL ASSETS	22,576,803	17,491,193	16,690,418
	=====		
Liabilities			
Capital	2,521,598	2,521,598	2,521,598
Retained Surplus	16,944,304	12,810,631	11,089,621

Sub Capital and Retained Surplus	19,465,902	15,332,229	13,611,219
Reclassified Credits	(265,917)	(214,108)	
Short term liabilities	707,455	378,541	204,778
Accounts Payable	2,669,363	1,994,531	2,874,421

TOTAL LIABILITIES	22,576,803	17,491,193	16,690,418
	=====		
Notes			
1. Current assets	10,083,454	7,936,226	8,238,245
2. Current liabilities	3,110,901	2,158,964	3,079,199
3. Working capital	6,972,553	5,777,262	5,159,046
4. Current Ratio	3.24	3.68	2.68
5. Acid Test Ratio	1.13	1.93	1.34
6. Days in Accounts Receivable	18.58	5.61	
7. Expense days in Working Capital	129	118	

Table 6

HEALTH INSURANCE ORGANIZATION: NORTHWEST DELTA BRANCH
ANALYSIS OF PROFIT AND LOSS STATEMENT

	1986	1986	1985	1985	86/85	CHANGE
	LE	%	LE	%	%	%
REVENUES						
Sale of Goods						
Operations	22,329,542	100%	18,986,353	100%		18%
	<u>22,329,542</u>		<u>18,986,353</u>			
Sub Operational Revenue	22,329,542	100%	18,986,353	100%		18%
OPERATING EXPENSES						
Wages and Fringe Benefits	4,589,830	21%	4,401,870	23%		4%
Operational Expenses	14,634,999	66%	13,105,459	69%		12%
Operating Profit	3,104,713	14%	1,479,024	8%		110%
PROVISIONS AND OTHER RESERVES						
Provisions	638,381	3%	436,357	2%		46%
Reserves and Other Charges	59,315	0%	20,919	0%		184%
Net Surplus	2,407,017	11%	1,021,748	5%		136%
NON-OPERATIONAL REVENUES						
	178,565	1%	92,653	0%		93%
	<u>178,565</u>		<u>92,653</u>			
Transferred to Retained Surplus	2,585,582	12%	1,114,401	6%		132%
	<u>2,585,582</u>		<u>1,114,401</u>			

Notes

1. Revenue expense percentages are indicated above.
2. Return on Investment: Net Revenue/Shareholders' Equity = 13.28% in 1986 (7.26% in 1985).

When complete financial information on HIO activities is available, analysis needs to be done concerning the real profitability of the service sectors covered by HIO. This would indicate to HIO management and the MOH what the real needs are to change either the deductions-at-source or the co-payments to economic levels. Any actuarial and/or price elasticity analyses can only be done after these data have been collected.

4. Expansion Plans and Constraints

HIO's expansion plans and constraints can be examined under two groupings: first, those concerning the provision of services to new beneficiary groups, new geographical areas, or the introduction of new services themselves; and, second, those concerning HIO's MIS and computerization plans.

Concerning the expansion of HIO services to new beneficiary groups, new geographical areas, and the addition of new services, it is clear that HIO's views of expansion and those held by the MOH are divergent. The MOH is under political pressure to accelerate the pace of beneficiary coverage. Its stated objective in 1964 was to provide insurance coverage to "include all Egyptian citizens within the next ten years." This overly optimistic target was changed to cover ten million citizens in ten years. Recently it has changed further so that now the hope is to cover ten million citizens by the year 2000. As of now, the coverage is 3.5 million beneficiaries, or roughly seven percent of the population. The goals have not been met because of the economic situation in Egypt and the inability of the MOH to secure a higher percentage of the governmental budget. Thus, the MOH has not been able to provide funding for new facilities, nor has it the capacity to provide its matching share for new beneficiaries' coverage by HIO under Law 32. In a similar vein, HIO's capacity to expand to new areas, to take on new beneficiaries, and to add new services is hampered by its lack of a sound funding base and its inability to generate capital from its operations. HIO's facilities are overcrowded, sometimes to the extent of three times the ideal number of patients. Polyclinics that are meant to serve 40,000 patients are serving 120,000. HIO has set itself high standards of management and of health service delivery. Its view is that, until its present facilities are of sufficiently high quality and serving a more ideal number of patients, it should not attempt to expand to new areas or take on new beneficiaries.

This then is the stalemate: MOH wants HIO to expand but is unable to provide financing for this expansion; HIO wishes to expand but sees as its first priority the quality servicing of existing beneficiaries and, given its limited financial resources, would rather accomplish this before taking on expansion. The dilemma, of course, is compounded by the fact that when they are ready to expand the number of beneficiaries and the concomitant demand from them, will be much more difficult to fulfill. The only solution to this predicament is the introduction of new funds.

These funds can come from the MOH (extremely improbable), from a sounder system of fee setting (probable, but only in the long run), or from external donors (tenuous and uncertain as to amounts and timing). Thus, attention must be turned to rate setting, i.e., revising the governing laws (79 and 32) and attempting to increase co-payments. This can be done by reducing the deduction-at-source to, perhaps, one percent for both employer (or the government) and employee and by basing co-payments on actuarial and elasticity studies. (Deductions-at-source, once made by the employee do not influence use or non-use of HIO facilities, since they are seen as "lost". Thus, co-payments need to be established on an economic basis.)

Since 1979 HIO (more specifically in its Northwest Delta Branch headquartered in Alexandria) has been engaged in an effort to upgrade its monitoring by introducing computers. A pilot study of a fairly comprehensive management information system was done in 1979. AID was contacted in 1981 for funds to implement the computerization. An RFP for partial computerization was issued in March 1984 based on a feasibility study, and Price Waterhouse, with NCR as its subcontractor, was awarded the \$2.3 million contract in April 1985. The envisaged MIS encompassed the following interlinking modules:

- o Drug Control
- o Beneficiary Registration
- o Patient Information Tracking
- o Cost Accounting and
- o Quality Assessment

The first two of these modules have been completed and HIO/Alexandria is now in the process of starting the system. It has a cadre of trained managers, data base administrators, programmers, training personnel, data entry clerks, and computer operators that will ensure the efficient running of the system. The personnel, highly sought after in Egyptian business ventures, are bonded to HIO through their past training and present compensation levels. Most of them are physicians who have chosen to alter their career paths. HIO is especially lucky in this because they have a team of qualified computer personnel who also understand and know HIO's main service. Their compensation levels have been set at very high standards according to MOH pay scales and they are thus assured recognition of their skills by HIO's management. A status summary of the project is attached as Appendix E.

With the introduction of this MIS, HIO/Alexandria's monitoring capacity has been greatly increased. However, a closer examination of the objectives of the MIS modules, both those that have

been implemented and those that remain, shows that the major thrust is that of policing the activities of beneficiaries, personnel, and drug suppliers. This policing activity can only have punishment as an end result. The system outputs clearly indicate this. For instance, some of the objectives of the Patient Information System are as follows:

- o prevent abuse or misuse of service;
- o follow up and investigate patients who utilize services beyond certain limits over a period of time;
- o follow up the performance and outcomes of different units, services, and doctors.

Certainly these objectives can be by-products of an MIS protocol, but to work towards them as main objectives is to lose the point of management information systems.

5. Conclusion and Recommendations

HIO, through its Alexandria branch, has gone a long way in establishing a good data base of information and in training manpower to run the systems. The computer team is enthusiastic about its work and confident of its abilities to run the systems and to train others to do so as well. What is needed now is for the completion of the MIS project.

However, some points need to be made about this. First, the remaining modules must be re-evaluated as to pertinence. For instance, there is disagreement within the organization as to the feasibility of implementing a quality assessment module. The objectives of this module are to measure and evaluate technical performance of doctors in the provision of medical care, and to quantify the impact of this care on beneficiaries thereby giving management the opportunity to intervene in critical areas with training, resources, etc. While the overall objectives of such a system are commendable, the practical implementation of such a system, dependent as it will be on subjective indicators, is not feasible at this moment. The opportunity cost of the money that would be used for this purpose far outweighs the benefits. Part of this is that HIO is not ready at the moment to go into this and needs to strengthen other areas first.

Second, the focus of the remaining modules should be shifted from policing to a management tool for improving performance. The concept of MIS is to provide management with timely and accurate information so that plans and objectives can be achieved or, if need be, changed to accommodate new circumstances. MIS in this context is a tool which will help managers attain their objectives and, therefore, enhance their performance and their rewards.

A point concerning this needs to be made here. When HIO/Alexandria was requested for information regarding the total number of patients treated the previous year, the response was to supply a vast amount of data covering patients seen by categories of physicians and by location. A simple request for one global number resulted in a large mass of unnecessary data. There was no summary or overview of the data. Missing, too is the ability to produce and use "exception" reports, i.e., to highlight significant deviations alone (in trends, averages, ratios, and other indicators). For instance, indicators could be developed concerning capacity ratios, utilization ratios, service cost ratios, financial ratios, first vs. repeat visit ratios, etc. Parameters could be set to highlight deviations in these indicators on either side and this should set off detailed investigations, follow-up, and corrective action. The MIS in HIO/Alexandria and the remaining modules should, therefore, be examined from this point of view and incorporated in future work. This concept of reducing data flow progressively with higher levels of management would help managers perform their tasks more efficiently and will also mean that the output from the MIS will actually get read and acted upon.

Third, the cost accounting module should be re-examined with a view to producing financial information rather than detailed cost accounting information. This recommendation is in keeping with the previous recommendation and will enable HIO to develop a financial overview of its operations, linked to pertinent indicators. Naturally, the cost accounting information will continue to be produced but only as a by-product of the system and will not be its focus. Financial indicators would include the following, inter alia:

- o revenue/cost percentages;
- o net return percentages;
- o return on investment;
- o day's sales in receivables;
- o current and quick assets ratios;
- o asset percentages to total assets;
- o service cost, by component, per patient;
- o service cost by stay and by bed;
- o and others.

These financial indicators, linked to statistical indicators, and trend analyses will help management to take corrective action when needed and to develop a steadily increasing data base concerning operations.

HIO now has a valuable asset in HIO/Alexandria: trained computer personnel and management techniques that are seen to be effective. A second recommendation, therefore, is for the exportation of this asset from HIO/Alexandria to other HIO branches. Training facilities in Alexandria and elsewhere should be used to run focussed skills upgrading sessions in both management, data processing, and service delivery. Where computerization is not possible, the lessons learned from the creation and handling of mechanical data bases should be passed on to those responsible for manual handling of such data. The idea would be to cultivate a systemic and organized approach to data handling and interpretation. HIO/Alexandria personnel are keen to perform this task for other HIO branches. They foresee a drop in their work load once the implementation is complete, and this would certainly be a challenging direction for them to take and a profitable one for HIO to encourage. Project funds could be made available to develop training modules and also to study the feasibility of exporting such organizational talent to other organizations for a fee.

No other project funds are recommended for HIO, i.e., for equipment, facilities, renovations, construction, etc.

B. CAIRO CURATIVE ORGANIZATION

The Cairo Curative Organization (CCO), sometimes also called the Cairo Health Organization and the Cairo Center for Medical Care, is an economic service authority monitored and regulated by the Minister of Health.

CCO operates ten hospitals in the Greater Cairo area with a current total of 2,300 beds. Current patient visits total 67,000 annually. Additional facilities are being built and put into service. These include the Nasser Institute Hospital (NIH) with a total capacity of 930 beds (of which 100 beds will be allocated for short term stays including intensive care), the Red Crescent hospital with a total of 220 beds, and the New Pyramids hospital which has a capacity of 353 beds under Phase one of its construction. The Red Crescent Hospital will replace an existing facility. In all, therefore, CCO will have a capacity of 3,803 beds in 12 facilities by the time expansion is completed.

CCO provides its service on a fee-for-service basis. Fees are levied on four levels depending on accommodation, i.e., from single patient suites down to four patient rooms. Approximately one-third of its service revenues comes from public sector employer groups. Patients (employees of these public sector employers) are treated directly by CCO, according to their regular fee schedule, and the billing is sent to the company for reimbursement. CCO receives some monies from employers as advances against estimates for treatment. CCO's revenue for the year ended June 30, 1986 was LE 18.5 million from all patients.

1. Financial Analysis

CCO's Balance Sheet and Profit and Loss statements for the year ended June 30, 1986 are presented in Tables 7 and 8. (Dr. Samir Fayad, Chairman of CCO, reported that the consolidated statements for all CCO facilities had been done for the first time in 1986. The quality and depth of reporting included in the consolidated statements--not included here in toto because they are in Arabic--are excellent and could serve as model statements for other multi-facility organizations. Thus, while comparative statements in similar detail for the previous years were not available, certain financial indicators could be extracted. However, trend analysis and source/use statements could not be produced.)

The financial statement analysis indicates that CCO is in a sound and stable fiscal condition. Note that comparative indicators for the Egyptian health industry are not available, and, therefore, while the CCO indicators, per se, show that the organization is in good financial condition, no external validation can be done. These indicators are discussed below.

Return of Investment: This measure, ROI, indicates the return to the shareholders from current operations. Investment in this instance equals the original capital invested in the operations and the retained surplus plowed back into operations. CCO achieved a 9.7 percent Return on Investment in FY 1986 based on revenues of LE 18.5 million. CCO uses its surpluses to renovate old equipment and facilities and in new capital projects.

Net Income: CCO's net income, i.e., profit after expenses and provisions, was eight percent of total revenues. A further analysis of CCO's ten hospitals shows that net revenues for each of them range from a high of 11.3 percent (Dar El Shefa) to a loss of four percent (El Helal El Ahmar). The median net return is about 6.5 percent. Thus, clearly, while CCO is producing reasonable returns overall, attention should be focussed on certain hospital units to ascertain reasons for poor returns and appropriate action taken. Net income has declined in 1986 from 1985 by 40 percent--almost LE 1 million. This has been because of increased expenses: revenues have increased by LE 1.8 million but operational expenses and reserve provisions have increased by LE 2.8 million.

Revenue Ratios: CCO's four sources of revenues are sales of goods, service fees, accommodation income, and miscellaneous operations. Of these, the major source of revenues is from services--at 55 percent of total revenues for both 1986 and 1985. Total revenues have increased by 11 percent over 1985--by LE 1.9 million to LE 18.5 million. The major percentage increase has been in accommodation income--up by 23 percent.

Expense Ratios: Expenses for 1986 as stated above have increased significantly over 1985--by LE 2.8 million or 19.5 percent. Major increases have been in operational expenses, i.e., other than

Table 7

**CAIRO CURATIVE ORGANIZATION
ANALYSIS OF BALANCE SHEET**

Balance Sheet	1986	1986
	LE	%
Assets		
Fixed Assets	18,171,466	87%
Less Depreciation Provision	(5,452,285)	-26%
Work in Process	525,624	3%

Sub Fixed Assets	13,244,805	63%
Inventory	2,003,331	10%
Accounts Receivable	2,842,397	14%
Miscellaneous Debtors	290,799	1%
Investments	178,260	1%
Cash in Bank	2,288,212	11%
Miscellaneous	23,376	0%

TOTAL ASSETS	20,871,730	100%
	=====	
Liabilities		
Capital	4,678,274	22%
Retained Surplus	10,315,068	49%

Sub Capital and Retained Surplus	14,993,342	72%
Provisions	628,329	3%
Long-term loans	2,492,944	12%

Sub Long-term liabilities	3,121,273	15%

Accounts Payable	1,609,151	8%
Miscellaneous payables	1,147,964	6%

TOTAL LIABILITIES	20,871,730	100%
	=====	

Notes

1. Current Assets :	7,626,925	4. Number of days in Accounts
Current Liabilities :	2,757,115	Receivable: 49 days
Working Capital :	4,869,810	5. Working Capital to
Liquid Assets :	2,466,472	Sales Ratio: 96 days
2. Current Ratio :	2.77	6. Working Capital to
3. Quick Assets Ratio:	0.89	Expenses Ratio: 104 days

Table 8

CAIRO CURATIVE ORGANIZATION

ANALYSIS OF PROFIT AND LOSS STATEMENT

	1986 LE	1986 %	1985 LE	1985 %	86/85 CHANGE %
REVENUES					
Sale of Goods	5,555,312	30%	4,770,950	29%	17%
Services Revenue	10,154,998	55%	9,337,290	56%	9%
Accommodation	1,643,000	9%	1,340,000	8%	23%
Other operations	1,104,971	6%	1,187,104	7%	-7%
Sub Operational Revenue	18,462,281	100%	16,635,344	100%	11%
OPERATING EXPENSES					
Wages and Fringe Benefits	4,807,538	26%	4,513,957	27%	7%
Operational Expenses	10,150,351	55%	8,376,795	50%	21%
Operating Profit	3,504,392	19%	3,744,592	23%	-6%
PROVISIONS AND OTHER RESERVES					
Provisions	1,284,730	7%	813,312	5%	58%
Reserves and Other Charges	772,768	4%	530,575	3%	46%
Net Surplus	1,446,894	8%	2,400,705	14%	-40%
NON-OPERATIONAL REVENUES					
Transferred to Retained Surplus	1,446,894	8%	2,400,705	14%	-40%

Notes

1. Revenue to expense ratios are indicated above.
2. Return on investment: 1986 -- 5.7%

wages and fringe benefits and in provisions for depreciation and other reserves. Operational expenses went up by LE 1.8 million (or 21 percent), provisions for depreciation, etc., by LE 0.5 million (or 58 percent), and reserves by LE 0.2 million (or 46 percent). Operational expense details are available for 1986. However, since similar details are not available for 1985, no reasons can be attributed to these increases based on material from CCO. Similarly, no breakdowns are available for provisions and reserves. Further work needs to be done in this area in Phase II of the design effort.

Current Ratio: The current ratio is one of the basic measures of an organization's fiscal stability. It compares current assets, i.e., everything other than land, buildings, and fixed assets, with current liabilities (all liabilities excluding shareholders' equity). It indicates an organization's ability to meet current obligations (liabilities) from its short-term assets without having to dip into equity or reserves. CCO has a healthy current ratio (2.77:1) showing that short term liabilities can adequately be met out of short-term assets.

Acid Test Ratio: This ratio indicates the availability of cash and assets (investments) that can be liquidated in seven days over short-term liabilities. Again, this is a test of the organization's ability to satisfy short-term creditors with ready assets. CCO's acid test ratio is 0.89. While the ratio is higher or better than those prevalent in the U.S., it reflects the cash orientation of the Egyptian economy.

Days in Accounts Receivable: This measure indicates the amount of time debtors take to pay their obligations to CCO. It is an indicator of the organization's control of the credit it has extended. The greater the average collection time, the higher will be the need for the organization to have sufficient working capital, i.e., cash flow to meet obligations to its creditors out of its own resources. Thus, the lower the number of collection days, the better it is for the organization. CCO's average collection period is 49 days, or 1.7 months. This figure seems to be high, especially given the cash orientation of the society. It may be high because of the arrangements CCO has with employer groups and the fact that it has to wait for reimbursement of billings. CCO may need to strengthen this side of its operations and come to some agreements with clients as to term discounts for early payment or require higher advance payments.

Expense Days in Working Capital: This measure of the total expenses divided by working capital indicates the coverage the organization has, i.e., how long it could operate at current expenditure levels on available working capital. CCO could continue to operate for 104 days at current expenditure levels without having to substantially increase its working capital through debt financing. Again, this points to CCO's healthy working capital situation.

2. Expansion Plans

CCO is in the process of adding three new hospitals, which will bring its total facility to 13 and total beds to 3,803. These hospitals include the Nasser Institute Hospital, the Red Crescent Hospital, and the New Pyramids Hospital.

The Nasser Institute Hospital (NIH) is a 930 bed facility, and 830 beds are currently available of which 100 are earmarked for short-stay patients, intensive care patients, and other time limited stays. Funding for the NIH came from French/Belgian sources as well as from certain sources in the Ministry of Planning. CCO has also obtained funding from Kuwaiti sources to add 100 beds in 48 rooms. In addition, the NIH has existing structural foundations and skeletal forms for an additional 400 rooms. No decision has been taken as yet as to the usage of the skeletal structure, but Dr. Fayad hopes that this can be used for conference/training facilities and/or for developing a high class hospital facility for tourists. The other two expansions are in the Red Crescent Hospital, which will replace an existing facility, and the New Pyramids Hospital.

CCO has no plans, in the short- or long-term to expand outside of Cairo, nor to offer prepaid insurance plans.

3. Constraints to Expansion and Efficient Growth

The constraints faced by CCO can be reviewed under those that affect current operations and those that affect new projects. While CCO is constrained by several factors, none of these is major, but some which are outside CCO's sphere of influence can hinder efficient growth. These constraints are discussed below.

Current operational constraints are linked to rate-setting, development of meaningful management information and inventory control systems, developing a patient records data base and a medical secretariat, and instituting training schemes for all levels of personnel.

Rate setting is done every three years. CCO's fee schedule is approved by the Minister of Health after it has been determined by an in-house committee within overall MOH guidelines. The process is lengthy, is open to politicization, and generally viewed as being non-responsive to CCO needs and reality. CCO's fees are on four tiers for inpatients, ranging from a high of LE 16 per day for Level 1 patients, i.e., accommodation in single rooms, to LE 1 per day for Level 4 patients, i.e., four per room accommodation. These fees have remained steady since July 1983.

In addition, outpatients are charged LE 1 per visit plus the cost of special examinations. The fee structure is seen as being too low. CCO is currently working on a new rate structure that will increase fees by some 30 percent. Dr. Fayad states that fees for the new Nasser Institute Hospital will be double the new fee

structure and will range from LE 45 to LE 6 per day for inpatients and LE 3 for outpatients. CCO is generating surpluses on the current fee schedule, as is seen from the above financial analysis. The surplus is used to improve services, to replace obsolete equipment, and to repair old equipment. However, the low fee schedule restricts its ability to generate working and investment capital from internal resources. If, therefore, CCO wished to increase productivity through better management systems (MIS, inventory, patient records) and improved training facilities, it could not because of lack of funds. However, such items are vitally needed.

CCO's information and patient record systems are currently based on a manual system. It must be noted here that the financial statements produced by CCO in 1986 were excellent in terms of detail and quality. However, most of the information systems are developed on the basis of individual initiative. Because of this, organizational memory concerning patients and their treatment and fiscal and statistical data is sparse and inconsistent. This is a real impediment to improving CCO's productivity and quality of care.

Another area which constrains CCO's development is the lack of trained personnel. This problem, however, is not CCO's alone but is endemic in the Egyptian health services field. While there is a surplus of qualified doctors in Egypt, there is a lack of trained nurses, technicians, lab assistants, and skilled and unskilled workers. Certainly one way in which organizations have circumvented this shortage is to match market compensation and to train personnel in-house to their own requirements (much like the HIO situation). CCO's does have training programs but needs to do this in a larger and more sustained way.

CCO also faces obstacles to projects under construction. Most of these, however, are external and may be out of CCO's immediate sphere of influence.

The most important of these concerns the availability of foreign exchange for construction and the lengthy process involved in obtaining it and in contracting. The approvals required for construction include consultations with and sign-offs by various authority levels ranging from the in-house CCO and local committees all the way up to the Cabinet and the Assembly. All amendments need to go through this process as well. The processing cycle for foreign exchange is equally lengthy and involves the Ministries of Planning and Health, the Investment and Central Banks of Egypt, and CCO's own bankers.

Another constraint is fiscal in nature. The GOE has given tax abatement and custom duty exemptions to private sector "investment hospitals" while denying these to CCO, a public sector organization. In doing this it is felt that the investment hospitals have been given a competitive edge through lower costs.

In addition, private sector hospitals can charge higher fees with no ceilings (except those dictated by the market) whereas CCO's fees are capped.

4. Recommendations

Certainly, CCO as a major health provider in the public sector needs to continue its valuable service. It is in good fiscal condition but is in need of developmental help in certain areas. Help can be provided in the following ways.

First, the CRHP project can provide help in setting up management information systems for use by CCO. The first step would be to develop a good and comprehensive system based on the current manual system. Where necessary, the manual system should be filled out and completed. Once a good manual system is in place, plans can be made to computerize it. However, it is important that manual systemization be implemented first. Care should be given to developing an MIS that allows improvement of management performance, especially management by exception. Phase II design efforts can be helped by obtaining complete information as listed in Appendix F.

Second, CCO's patient record systems should be set up along established hospital and clinic record-keeping systems that exist in the U.S. and in Egypt. Again, patient record systems need to be established on a manual basis prior to computerization attempts.

Third, CCO needs help in establishing a medical secretariat, i.e., one which will be responsible for the upkeep of the patient records and which will keep track of other medical statistical data.

Fourth, CCO needs help in setting up training schemes for all levels and types of personnel. These would include, inter alia, doctors, nurses, X-ray technicians, laboratory assistants, maintenance and engineering staff, financial and management staff, patient record staff, and certain levels of semi-skilled workers. What is needed is a comprehensive schema for training such personnel and help in course/seminar design such that training is an ongoing effort which upgrades skills continuously.

C. PRIVATE SECTOR HEALTH INSURANCE

Private health sector insurance plans currently cover a small proportion of the working population. The existing market for insurance is restricted to those employers who have obtained exemptions from HIO contributions. Approximately 7.2 million people are employed in the wage-based sector and they constitute the primary target for private sector, market-driven expansion of prepaid insurance plans.

1. Laws Covering Private Health Insurance Companies

Under Law 79, employer and employee contributions to HIO are compulsory. On a case-by-case basis employers can receive exemptions from the HIO contribution provided they offer similar or more comprehensive health coverage to their employees. In addition, these employers are required to contribute one percent of wages to HIO as a token of national solidarity. The three percent of base wages, that would have been contributed to HIO had the employer participated in HIO coverage, as well as the one percent employee share can then be applied towards a self-insured plan or for contracts with insurance companies.

Law 10 is the prevailing insurance law that sets guidelines for establishment of insurance companies. The law restricts entry of any new companies into the market. Only nationalized companies established prior to 1962 are permitted to sell insurance plans in the country. The term "private" health insurance is more precisely defined as government-owned companies, i.e., public sector companies.

The law also extended the standard of coverage to include first day coverage of all pre-existing conditions. Thus, pre-employment health exams are not routine practice. Liability coverage is available only to HIO. Other companies must reinsure policies abroad usually in UK. A later amendment to Law 10 requires that all premium collections be deposited in Egypt for three months at a fixed interest rate of five percent. All payments to providers must be made out of the account, thus restricting investment capital to residual balance.

Insurance benefits are exempt from taxes as are social insurance funds established as legal entities.

2. The Market

During the consultancy mission, interviews were conducted with representatives from the two largest insurance companies, Misr Insurance and Al-Sharq, as well as three self-insured companies (Arab Contractors, Suez Canal Authority, and Esso-American Express) to obtain information on the non-HIO insurance schemes in operation.

All of the plans operate through contracts with specified hospitals, specialists, and pharmacies. Fees established by these contracts are generally 10 to 30 percent lower than usual charges. With referral from a consulting physician, usually hired by the employing company, employees can obtain specialist and hospital care.

The perceived advantages of these health insurance plans are :

- o Reduced absenteeism. Employees can receive needed care without waiting in long queues. Furthermore, control over sick leave is maintained.
- o Access to better quality facilities. The so-called first-class investment hospitals in Cairo are not affordable to most of the estimated three to four million middle income families.
- o In some cases, more comprehensive benefits, including cancer treatment abroad, prosthetic devices, hearing aids, dentures, and corrective lenses, are available.

Table 9

Benefit Coverage of Private Insurers

Name	Total Cov'd	Contrib. or Non-contrib.	Premium Cap	Liab'y Served	Area
Arab Contractors	50,000	N/C	None	Unltd.	Cairo+
Suez Canal Authority	18,000	N/C	None	Unltd.	Cairo+
Esso/Amex	700	N/C	None	Unltd.	Cairo
Al-Sharq Insurance	11,000	C	LE 250	15,000	Cairo
Misr Insurance	7,000	C	LE 150	10,000	Cairo

3. Analysis

Employer-sponsored health plans such as those sponsored by Arab contractors and Suez Canal Authority are not strictly health insurance schemes in that they are part of a social insurance package of benefits and restricted to company employees. None of the employers or insurance companies interviewed were interested in expanding benefits to non-employees or dependents. However, widows and pensioners are included under Arab Contractors' social insurance scheme.

Al-Sharq and Misr Insurance offer a range of plans tailored to the demand from companies that chose to opt out of HIO coverage. The set of benefits offered is essentially the same as those offered through HIO, with the exception of non-government providers. Heavy reliance is placed on the HIO fee structure in negotiating contracts with providers. As dependents are not

covered by HIO, there is little demand from employers to include dependents in company policies. Both Al-Sharq and Misr, however, claim that dependents could easily be accommodated, for the same premium fee entitles the employee to care. If actual data were available, Al-Sharq would be able to use existing use and cost records to determine a more varied fee structure.

A policy to promote health insurance plans, either employer-sponsored or through private health insurance companies, will encourage government competition with itself in the form of HIO. Market forces may encourage these companies to grow without government intervention. Accordingly a more global investigation of the potential for health insurance to reach new beneficiaries should be undertaken.

Several Egyptian institutions have expressed interest in developing health insurance plans. Two such proposals have been presented to USAID/Cairo from Agouza Medical Centre and Egyptian Junior Medical Doctors Association (EJMDA).

The Agouza Medical Centre in Cairo is committed to offering comprehensive services in a clinic and hospital setting to middle class beneficiaries. In addition to facility construction, they propose to establish a private health insurance system for shareholders and other groups.

Pricing and feasibility studies will be conducted during the initial phase of activity.

EJMDA proposes to establish a similar health insurance plan to complement new group practice polyclinics in Cairo. The plan is seen as a mechanism to assure patient flow as well as provide more comprehensive, higher quality care.

These proposals reflect a growing interest in the potential of shared risk plans. Benefits will accrue to both the providers as assured income and to consumers as increasing choice of providers.

The feasibility of these plans cannot be determined in the absence of sufficient data. A broader question remains whether to support individual groups proposing to work in the densely populated cities of Cairo and Alexandria or to approach the issue more globally by expanding health insurance coverage to rural towns and secondary cities.

IV. HEALTH CARE SERVICES IN SECONDARY TOWNS AND
RURAL AREAS AND
NATIONAL LAWS AND POLICIES

A. HEALTH CARE IN SECONDARY TOWNS AND RURAL AREAS

Health care services in secondary towns and rural areas in Egypt are provided by:

- o government (MOH);
- o private sector;
- o public (semi-private semi-public insurance facilities);
- o university facilities (under the Ministry of Education);
- o special employee insurance provided by, e.g., the military, the police, the Ministry of Transport, etc.

Government: This represents the largest service provider primarily to non-paying patients, though with an economic treatment (fee-paying) section for private/semi-private accommodation with special attendants and more personalized care.

Private: A typical private practitioner will spend a limited number of hours per day or per week in his or her own practice and the rest of the time working in government, university, or other health facilities. This sector serves the better-off sections of society, but is increasingly used by low and middle income groups who feel that free health care is inferior in quality.

Insurance: Facilities linked to insurance schemes e.g., HIO provide health care for government and other employees, as part of their employment contract (see Chapter III above). Unlike other health service sectors, insurance organizations usually have their own distinct clients and physicians some of whom may have limited private practices on the side who teach.

Medical_Care_Organizations: These organizations such as the Cairo Curative Organization have their own hospitals but employ doctors from other health sectors particularly government facilities. They cater to paying patients who come directly to the facility or are referred there. They have two different fee schedules according to whether patients report directly to the facility or are government-referred. Patients who are unable to pay fees are treated free of charge but costs are billed to the MOH.

Universities: These facilities are under the supervision of the Ministry of Education (MOE). They cater to both non-paying and paying patients referred from the private sector, medical care organizations, and MOH facilities.

Special Organizations: The organizations have their own facilities for their own members/employees, which are sometimes open to non-members in return for premium fee payments. Access for non-members depends on the regulations of the individual organizations.

1. Estimates of Supply.

During the mission, repeated attempts were made to obtain lists of the distribution of physicians by location and of PVO's offering health services. It was said that these data were available, yet neither the MOH nor the Medical Syndicate could provide the lists.

Precise estimates of the number of medical practitioners are difficult since many work simultaneously in several capacities (e.g., in the MOH as a government employee from 8:00-12:00 in the same facility but in a private capacity in an "economic" clinic from 12:00-2:00, and in his or her own purely private practice from 6:00-9:00 pm). Only a few hundred physicians are in completely private practice. However, estimates are possible from figures for MOH employees, which are inequitably distributed among five governorates as well as the inadequate number of nursing staff in relation to numbers of physicians (see table below.)

Table 1

Ministry of Health Employees (1985)

	<u>Governorate</u>				
<u>Staff</u>	<u>Cairo</u>	<u>Alexandria</u>	<u>Giza</u>	<u>Souhag</u>	<u>Qena</u>
Doctors	4,776	2,913	2,095	1,177	720
Nurses	3,823	2,208	1,573	696	737

For the number of registered Medical Practitioners by governorate, see Table 2 below. An indication of distribution of facilities among governorates is that of the numbers of hospital beds, first aid centers and pharmacies in relation to population in Table 3. The distribution is clearly skewed towards Cairo and Alexandria, with Qena having the lowest ratio of beds per one thousand population. Table 4 provides a comparison of numbers of beds by sector and by governorates which further reflects this inequitable distribution.

Table 2

Registered Medical Practitioners (MOH) by Governorate
1/1/1987*

<u>Governorate</u>	<u>No</u>
Cairo	5,809
Alexandria	3,814
Port Said	320
Suez	292
Ismailiya	462
Damietta	674
Dakahliya	2,855
Sharkiya	2,166
Kaliubia	1,208
Kafr al Sheikh	1,108
Gharbiya	1,975
Menufiya	1,100
Baheira	1,465
Giza	2,672
Beni Suef	1,167
Fayyum	774
Minya	1,053
Assyut	1,380
Sohag	1,638
Qena	1,028
Aswan	1,231
Matrouh	332
Wadi el Gedid	213
Red Sea	254
North Sinai	346
South Sinai	215
TOTAL	----- 35,651

* Source : Ministry of Health Information Center. Figures seem low unless they represent MOH employed physicians only.

Table 3

Comparative Distribution of Curative Beds,
First Aid Centers and Pharmacies (1985)

	Pop. (000)	Total beds	Beds per 000 pop.	1st aid ctrs.	Pop. per ctr.	Total phrms.	Pop. per phrm.
Egypt	48,575	92,700	1.9	264	183,996	7,530	6,451
Cairo	5,673	24,367	4.3	44	128,932	1,519	3,593
Alexandria	2,723	8,126	2.9	15	181,533	870	3,130
Giza	2,951	7,624	2.5	13	227,000	722	4,081
Souhag	2,319	2,873	1.2	11	210,818	229	10,127
Qena	2,049	2,338	1.1	11	186,273	221	9,271
Aswan	740	1,757	2.3	4	185,000	571	2,982

A more detailed picture of the private sector practitioners will be obtained from the survey to be done prior to the start of Phase II. It will indicate the characteristics of individual and group practices and the voluntary sector in at least one secondary town and surrounding rural area, in four locations in Egypt (the Delta, Ismailiya Governorate, Sinai, and Upper Egypt). An overview will be provided of the services each type of facility offers; the way in which they are financed; the groups they serve, and physicians' estimates of utilization of facilities. Appendix G provides details of the structure of the survey and questions to be answered from its results.

Additional source of information on numbers of practitioners was obtained during the Phase I mission on field visits to Ismailiya, Abu Sultan, Suez, Fayum, Alexandria, and Damanshour. A full account of the facilities visited is presented in Appendix H.

Table No. 4

Number of Beds in the Public and Private Sector
January 1985

Governorates	Health Ministry	Other Ministries	Educational Hospitals & Institutes	Public Sector	Private Sector	TOTAL
Cairo	9,033	7,289	1,318	2,990	3,737	24,397
Alexandria	3,389	2,570	-	1,926	241	8,126
Port Said	1,186	20	-	136	67	1,410
Suez	695	-	-	47	60	802
Ismailiya	664	-	-	130	58	852
Damietta	1,335	-	-	60	60	1,455
Dakahlia	3,644	1,512	-	180	221	5,557
Sharqia	3,300	805	-	168	14	4,287
Kaloubia	5,778	153	368	613	25	6,939
Kafr El-Sheikh	1,851	-	-	-	14	1,865
Gharbia	3,786	973	-	446	363	5,568
Monofia	2,116	40	505	112	124	2,897
Beheira	2,651	-	613	112	7	3,383
Giza	4,074	311	356	951	1,932	7,624
Bani Suef	1,867	40	-	80	22	2,009
El Fayum	1,698	-	-	42	25	1,765
El Minia	2,691	40	-	160	4	2,895
Assiout	2,356	570	-	155	94	3,175
Souhag	2,335	-	428	60	50	2,873
Qena	2,178	40	-	-	120	2,338
Aswan	1,460	-	-	40	50	1,557
Marsa Matrouh	240	-	-	-	4	244
El Wadi El-Gidid	261	-	-	-	-	261
Red Sea	144	-	-	83	3	230
North Sinai	121	-	-	-	-	121
South Sinai	100	-	-	-	-	100
Grand Total	58,961	14,363	3,588	8,491	7,297	92,700

a. Ismailiya

An MOH urban health unit in El Shohada (one of four in the city), a general practitioner in solely private practice, a community clinic located on the same premises as a mosque, and the Suez Canal University Group Practice were visited.

Urban Health Unit

Preventive and curative services are offered at a nominal charge of five piasters per patient from 8:00-12:00 in the mornings by 14 doctors with varying specializations. The clinic has requested the local Directorate of Health to raise this fee to 25 piasters to try to reduce the number of unnecessary visits by patients who regard visits to clinics as social events. In the view of doctors there the majority of the target group which they serve (low and middle income groups within a 13 km radius of the clinic) can definitely afford this price increase. The clinic is trying to keep patient records for four years even though this is not an MOH requirement. One other urban clinic in Ismailiya was said to keep records also.

The range of drugs available to physicians was very limited and inhibited their making proper diagnoses because they cannot prescribe appropriate drugs. Patients were said to make multiple visits to different types of health facilities making payments of various amounts in attempts to receive adequate health services. A common pattern was described as a patient first visiting the urban health clinic, paying five piasters and receiving (unsuitable) drugs at his own insistence, then going to a private physician (likely to be also working for the MOH in the mornings) and paying LE 5 for a visit, receiving a prescription and going to a pharmacist and paying LE 10 for drugs for a total expenditure of LE 15.05. Clinic doctors were paid an average of LE 70 per month and nurses 30 per month. The urban clinic was reported to operate at a loss of LE 5,000/month.

Private Practitioner

One of the four solely private sector physicians in Ismailiya is a family practitioner with two clinics, one in a middle-income area (clinic I) and one in a low-income area (clinic II). He has individual patients and contracts with firms (particularly foreign employers) to provide services to them at specified times. He also provides a 24-hour emergency service. Clinic I is extremely clean, well equipped, and well maintained and costs him LE 62 a month because he has been there since 1978. It is reported to be difficult to find suitable premises because of both a building shortage and increasingly high rents.

The doctor sees about 30 patients a day in his two clinics and charges LE 7 a visit in clinic I with free follow-ups. He is particularly aware of the need for continuing education for general practitioners and makes strenuous efforts in this regard

himself on a self-help basis through subscriptions to journals, etc. He has financed his clinics himself buying his equipment from abroad over the years as and when he had money to spare.

Mosque clinic

Jointly staffed by doctors from the Suez Canal University and MOH practitioners, the clinic was started on the premises of a mosque with a loan from the Governorate of LE 15,000 to buy equipment. It pays no rent. It has ten beds and undertakes many operations (500-600/year). It has 14 doctors with a range of specializations and is open twice a day, from 1:00-4:00 pm and 6:00-10:00 pm. The physicians are united by a common desire to provide good quality services at affordable prices, to provide themselves with a good working atmosphere in terms of equipment availability and maintenance, and to work as equals. Visits cost LE 5 whether to see a specialist or a general practitioner. Operations costs from LE 5 to LE 20. The average cost for a colistectomy operation, for instance, with a four or five-day hospital stay, is LE 80. The clinic receives 16,000 to 18,000 initial visits a year, with two or three free follow-up visits per patient. Estimated revenue is LE 8,000-9,000/month. Doctors receive 75 to 80 percent of the clinic income after expenses and support staff salaries are deducted. There is a full-time accountant on the premises. The clinic would like to expand its services and sees the only obstacle as the high cost of specialized diagnostic equipment. Lack of physical space is not a problem in this regard. Most of the clinics patients have low incomes, and many come from rural areas outside Ismailiya even from Suez and Port Said.

Group Practice

One group practice is run by 40 doctors attached to the Faculty of Medicine of Suez Canal University. The practice offers outpatient and inpatient services for a fee and has a facility with 22 beds. Patients are mostly from the middle income group. The premises are used on a part-time basis as a private facility by physicians working in the university. The practice sees some 36,000 patients a year and does about 100 operations a month. The gross monthly income of the practice is LE 35,000-40,000. Mortgage payments are made on the premises. About five percent of the gross income is set aside for contingencies, five percent for taxes, and ten percent for support staff salaries. The remainder is distributed between the physicians. Roughly 75 to 80 percent of the revenue generated by physician returns to him as a fee. No money is as yet being allocated for replacement of equipment. A full-time administrator is employed for the practice. A ceiling of LE 280 has been set for operations. Visits cost LE 5-7 for most physicians and LE 15 for senior specialists from the University. If patients feel unable or unwilling to pay the higher fees they can choose to see a different physician whose fees are lower.

b. Abu Sultan Rural Health Center, Ismailiya Governorate

Built in 1964, this MOH facility offers both outpatient and inpatient services and both preventive and curative care. It has a training center for the preservice training of rural physicians. The Center has ten doctors (five in training and five on duty), ten nurses, three radiologists, one lab technician, and a pharmacy. It is open to outpatients from 8:00 to 2:00 with a 24 hours emergency facility. It serves 50 to 60 patients a day, who pay five piasters each per initial visit. The doctors would like to have a clinic after regular hours where services would be offered for nominal fees feeling that patients will receive better treatment, and it was understood that the idea has received general acceptance from the Directorate of Health in Ismailiya. Some of the physicians who work there also have private practices in Ismailiya. Doctors in the center usually stay for the required year, then return to practice in the areas where their families are.

c. Economic Clinic, Alexandria

This urban polyclinic in Alexandria was built three years ago and currently has only outpatient services. However, a 400-bed inpatient facility is also planned. The clinic offers three types of service: free, economic, and "al Shifa" or a higher scale of fees. Fee structuring is regulated by the municipality with 30 percent going to doctors and ten percent to nurses and support staff, 25 percent to the institution for operation and maintenance, and the balance to the municipality itself. Numbers of patients seen in each category for 1985 and 1986 are shown in the table below.

Table 5
Number of Patients by Category of Payment,
Alexandria Urban Clinic

	1985 No./Patients	1986 No./Patients	Payment/visit
Free of charge	464,750	498,153	-
Economic treatment	37,868	42,832	25 piasters
"Al Shifa" system	56,556	62,033	LE 1

This system exists in most MOH hospital facilities in Alexandria. Patients at the economic clinic sessions do not have to wait as long for services as those in the free clinics, and many people chose this form of treatment for convenience. The Al Shifa system offers the opportunity to see specialists, and preference is given to employing those who do not already run private clinics.

The distribution of fees from the al Shifa sessions is as follows: 40 percent to doctors, 20 percent to nurses and support staff, 20 percent to the polyclinic itself, and 20 percent to the MOH. In the view of doctors at the polyclinic most patients can afford to pay more than they do under the present fee structure and would be willing to do so since they receive a good level of care at considerably less cost than at private clinics. The table below shows staffing patterns of service by type.

Table 6
Staffing patterns at an MOH Urban Polyclinic

	Total	Economic clinic	Al shifa System
Doctors	183	37	37
Nurses	47	27	27
Clerks & support staff	163	(unavailable)	(unavailable)
Service personnel	66	(unavailable)	(unavailable)

2. Vocational Decisions by Physicians

It was learned from discussions in Cairo with such groups as the Medical Syndicate and the Egyptian Junior Medical Doctors Association and with individual private and public sector physicians outside Cairo that, once physicians complete their mandatory one-year period of rural service and are free to practice privately, increasing numbers of young physicians are choosing to remain outside primary cities. In the absence of empirical data as to the reasons for this, the analysis presented here is based on substantive discussions held during the mission which will be supplemented by information from the survey to be undertaken before the start of Phase II.

The survey will ascertain from private and public sector physicians in secondary towns and rural areas the reasons why they do or do not decide to establish or maintain practices in those locations. From the survey it should be learned whether the reasons are financial or logistical (lack of competition leading to opportunities for good earnings; access to housing and practice premises at a cheaper rent than in primary cities), a philanthropic desire to provide care for those with least access to health care, lifestyle (a preference for small town/rural living), family ties (the opportunity to work in the same location in which a spouse is posted; proximity to family home or relatives), or medical practice style (autonomy; provision of quality care; professional satisfaction).

3. Mission and Field Trip Analysis

Two main bottlenecks to the establishment of private practices have been identified during the course of the mission:

- o a lack of premises for setting up practices and adequate housing, high rents, and particularly the need for key money in primary cities.
- o lack of access to credit for young physicians due to lack of collateral).

A third obstacle to providing good quality care is the lack of opportunities for continuing education both for private sector family practitioners (an increasing area of interest together with preventive care for many newly qualified doctors, particularly outside primary cities) and for young doctors within the MOH system who have finished their qualification requirements. To some extent attempts have been made to overcome this both by the private sector and the MOH, but for doctors living and working outside Cairo and Alexandria self-teaching would appear to be the only alternative and few doctors have access to relevant materials unless they have contacts with foreign associations such as the American Association of Family Practitioners which supplies its members with materials for continuous learning. Attempts to rectify this are being made in the Ismailiya area by a recently formed Association of General Practitioners which sees itself as playing a role in the dissemination of information to its members. In primary cities, the medical syndicates sponsor seminars and exhibitions for interested members, and in secondary towns with active faculties of medicine there are also of course better opportunities for continuing education.

a. Incentives to Practice Medicine in Rural Areas

Despite these difficulties, there is anecdotal evidence that physicians are becoming increasingly interested in living and working in secondary towns and rural areas which is likely to be further supported by survey data. Among the possible range of incentives that could be offered to physicians are:

- o allowances for housing or meals for those in rural areas in addition to base salary;
- o benefits in the form of grants for housing or training services;
- o bonuses based on the number of patients seen or the type of tasks performed;
- o medical, disability, or life assurance;
- o profit sharing in group practices;

- o annual bonuses;
- o access to skill upgrading and continuous education;
- o access to credit for working capital or for housing and practice premises,
- o tax exemptions for rural physicians;
- o professional satisfaction from a congenial work environment.

Four of these incentive--profit sharing, congenial working environment, access to credit, and access to premises for living and working--are addressed further in the project recommendations in Chapter II above. The issue of tax exemptions is discussed below.

b. Public Sector Disincentive.

Physicians working in the public sector are attracted to private practice because of the low pay scales, lack of management, lack of discipline and supervision which characterize working conditions in many MOH facilities. Salaries are related to education and years of service and there is little economic motivation for physicians to work harder or better. Performance incentives are lacking, and indeed the co-existence of a public system in which physicians are also allowed to charge fees for services in the course of their public sector work acts as a further disincentive to providing good quality service.

MOH based private practices run by doctors in rural areas, however, provide incentives for them to stay in these areas once their obligatory service is finished, since their initial provision of public service generates a pool of patients who would seek their services privately thereafter.

B. STATUS OF GOE POLICIES, LAWS, AND REGULATIONS AFFECTING THE HEALTH CARE SECTOR

1. Existing Policies

The Preliminary Framework for the Five year Plan (1987/8 - 1991/2) states that increased attention is to be paid to preventive medical care in all forms and at all levels. Regarding curative care, it stresses increased efficiency of free medical services by increasing the number of beds and better service provision and charging reasonable fees for medical treatment in public, district, educational and rural hospitals, for those with average incomes.* It also gives increased attention to those medical organizations which offer treatment at reasonable prices

* The average income in Egypt was LE 1,200 a year in 1986

and the expansion of their services geographically. And finally the plan calls for expansion of medical insurance to new beneficiaries.

Until relatively recently health has been viewed as a consumer activity and accorded low priority in national budgetary allocations. The national budget for health is currently 1.9 percent of GNP and represents a continuing decrease over the years. The latter, together with the burden of inflation--and low elasticity of revenues and high elasticity of expenditures in relation to prices--has meant that the public sector health care has been severely under-funded. As a result, GOE policies and practices to bring about improved access to health services for the indigent have been considerably limited.

From discussions with relevant officials within and outside the MOH it is clear that there is a growing recognition that:

- o the MOH's main responsibility should shift towards preventive and away from curative care,
- o the cost of curative care should be shared further with the private sector while simultaneously providing free preventive and curative care for the indigent and/or those at great risk or with great need,
- o given limited government resources, GOE cannot continue to provide free care for the entire population; and
- o cost recovery schemes should be initiated for certain health care services.

2. Existing Laws

Some of the existing laws which affect the health sector are reviewed below. Despite repeated attempts, it has proved impossible to get the full range of health-related legislation. This problem is addressed in the recommendations in Chapter II of this report regarding data management. Such legislation is in theory readily accessible either within MOH or elsewhere, but in practice it is not.

The following laws, policies, and regulations have a major influence on the delivery of health care in terms of its organization and administration, financing (setting fees, regulating health insurance), and local level (versus national level) development possibilities.

Law 122/1980 assigns and defines a specific role for agricultural cooperatives in rural economic and social development. It covers health insurance, including the possibility of providing financing for it. Under this law, five percent of the "surplus" of

such cooperatives is to be deposited in a special account to be invested for the welfare of the agricultural laborers and persons working in agricultural cooperative societies.

Law 112/1975 (somewhat modified by its successor Law 112/1980) provides survivor and disability allowances for the agricultural labor force among others. It includes provisions for financing, including a fee based on sales of agricultural products and sets a precedent for indirect contributions to rural social insurance programs from the profits of public sector agencies and enterprises.

Law 52/1975 stipulates that local People's Councils at village, district and governorate levels may establish accounts for "local services and development." These accounts are separate from the government's central budget, and their monies do not revert to the central treasury in Cairo if not spent, but can accumulate and be invested. Sources of revenue for such local accounts are special local duties to finance the account, profits which may come from development activities financed by this fund, and donations, contributions, and loans or grants from local, national, and international agencies.

For a discussion of Law 79/1979 and Law 32 see Chapter III above.

Law 43/1974 concerns investing Arab and foreign capital and free zones. It was amended by 32/1977.

Law 32/1977 states that investments should lead to the realization of economic and social development goals within Egypt's public policy and national plans. The law applies to development projects or those that require foreign capital. Certain capital advantages are also cited in the law, in particular an tax exemption commercial profit and income for five years from the year following the start of business. In addition, equipment and construction materials are exempt from customs duties. This type of investment is not bound by labor laws and regulations and can be transferred abroad in hard currency.

Decree 242/1983 specifies the rates which could be charged for services provided in hospitals and health care institutions.

Decree 501 allows the following distribution of fees, after funds for drugs and drug containers have been deducted:

- 40 percent to doctors and specialists
- 20 percent to nurses and service personnel
- 10 percent to the health services in Cairo governorate
- 30 percent for the maintenance of facilities and service provision in health centers where fee-for-service programs are offered.

The fees of private doctors are controlled by Ministerial Decree in agreement with the Medical Syndicate. Administrators are not allowed by law to maintain practices as private physicians, and former promotion opportunities for administrators now no longer exist, which accounts for their low status within the medical progression.

Law 137/1981 particularly articles 50, 121, 154, and 155, addresses personnel incentives.

3. Implications of the Laws for Health Care

All physicians are obliged to register with the Medical Syndicate. No re-licensing requirements currently exist. If the GOE wishes to implement a new policy in this regard, it does so in consultation with the Syndicate. One member of the Higher Council for Health is also a member of the Syndicate.

As a result of legislation physicians in rural private practices are exempt from tax for three years after graduation and are not obliged to report their private income.

The existence of Local Development Funds within the governorates can and does allow a certain degree of local autonomy and administrative decentralization of health care. For example, the initial capital investment for the community clinic in Ismailiya was locally funded.

The country has 26 governorates, each with a semi-autonomous Directorate of Health as the regional arm of the MOH. Sub-divisions of the governorates for health care purposes are divided into centers (markaz), with a small town as the focus. Under local laws and procedures rural communities themselves are supposed to participate in the operation of the primary health care system through village organizational structures.

In addition, individual efforts can be made by Directorates of Health in the Governorates to solicit local councils to increase the percentage of beds within MOH facilities for patients who are charged a fee or to raise the fees for treatment (the team was informed that it was hoped that these fees could be tripled by 1989).

4. Required Changes

Some changes in existing legislation and regulations are likely to be required under the proposed project. These requirements are described in more detail in Chapter II but are summarized here:

- o Medical educational facilities would be transferred from MOE responsibility to MOH responsibility;

- o underused MOH premises would be used for private medical practices and the MOH would receive rent at the market value;
- o there needs to be more rigorous licensing and re-licensing procedures for physicians;
- o there needs to be greater regulation of (or enforcement of existing regulations on) prescription of drugs restricting it to physicians;
- o eventual higher levels of remuneration for fewer MOH physicians;
- o Laws 32 and 79 need to be amended regarding health insurance to make such insurance available to segment population.

5. Objectives and Plans of the Ministry of Health

MOH policy has undergone a shift in emphasis toward the provision of preventive care, without entirely abandoning responsibility for curative care (linked to the right of the individual to health care under Article 16 of the Constitution). The MOH is clearly aware that it cannot continue to bear all the costs of curative care.

a. MOH Facilities

The increase of nominal fee-for-service or "economic" treatment clinics is a further indication of this recognition, in practical form, as is the move to increase payments in such clinics to 30 piasters (instead of 25 piaster) starting May 1, 1987. However, in terms of cost recovery, it is stressed that these so-called "economic" clinics merely represent a step in the right direction in terms of covering real costs and do not constitute true cost recovery by any means. It is rather in their symbolic (vs. practical) value in support of the principal of recovering costs that these measures are of use. Individual physicians within MOH facilities unquestioningly welcomed their fees and fee increases not only because greater financial benefits accrued to them but also because they were enabled thereby to provide better service because of the provision and maintenance of equipment, etc. It is also recognized within the MOH that beneficiaries believe services which are paid for are better than free services and make better and more efficient use of services for which they pay.

Senior MOH officials said that the Ministry would encourage the development of the private sector, in order to reduce the burden on the MOH of curative care. The existing increased emphasis on primary health care by the MOH is also a positive step in this direction, given current budgetary limitations. A possible increase in the percentage of beds within MOH facilities for

paying patients from 20 percent to 30 percent of all beds is being talked about. Some local councils reportedly want 40 percent of the beds to be free. It is also a recognized that fees need to be increased.

b. Expansion of Health Insurance

MOH Officials said they would encourage the expansion of coverage by health insurance schemes (an attitude reflected in the forthcoming Five-year Plan), particularly to rural populations such as agricultural or farmer cooperatives. However, given the restricted MOH budget, such support would be reflected in policy rather than funding.

c. Issues in Cost Recovery

In determining what costs should be recovered, a distinction has to be made between costs to the beneficiary and costs to the nation. In setting the level of costs to be recovered and determining beneficiary ability and willingness to pay for health care in the light of other expenditures, policy decisions will have to be made as to what cost elements are to be recovered from beneficiaries and what costs will be recovered from other sources.

Cost elements can be separated into at least four categories :

- o capital costs
- o operation and maintenance costs
- o service development and delivery
- o administrative costs

In the government sector even capital costs should not be entirely recovered from beneficiaries, since provision of health care contains an element of public good which can be taken to imply a reduction in the cost to the community. Service development and delivery costs as well as start-up and administrative costs are similarly not usually passed on to beneficiaries. In Egypt, given that many rural inhabitants by-pass local-level facilities and go straight to urban hospitals or clinics and that average rural incomes are about 50 percent of those in urban areas it is not equitable to require rural people to pay the full cost of services provided for them nor will they be able to.

The question is raised whether the health service should itself take on a financing role or whether it should use, for example, a bank as an intermediary for processing cost recovery. To maximize both recovery levels and efficiency, the recovery of costs is probably best left to a financial institution.

The optimal proportional relationship between loan and grant (if any) components should be determined. Large external grants can lessen the urgency of the need for cost recovery.

Good managerial ability leads to good cost recovery and therefore the management ability of a delivery system is very important. Any existing examples of successful cost recovery initiatives (e.g. HIO, CCO or even in sectors other than health) should be used as a basis upon which to promote effective cost recovery.

In the context of the proposed project, cost recovery is regarded as a catalyst for the upgrading of service provision in both the private and the public sectors and for the provision of a range of choices for beneficiaries rather than as a finite end in itself. As things stand currently under the existing health care conditions, people of all socio-economic groups in Egypt except the indigent pay something for their health care and frequently pay several times and various amounts to multiple service providers "free" treatment, economic clinics, pharmacies, and private physician as well as traditional practitioners who are readily available, cheap, and well integrated into the community). The question remains as to the extent of disposable income and the ability to pay, i.e., for what level and type of treatment are beneficiaries willing and able to pay how much money. This is intrinsically linked to user perceptions of value for money. This question will be addressed in the survey prior to Phase II. Existing statistics are inadequate to track cost recovery. What is already apparent however is that :

- o 80 percent of the beneficiary population are able to pay for health services and
- o they are probably paying too much for services and to too many different sources of care in relation to treatment received (a "triplication" of service and thus of payments by patients).

Cost recovery can be used as a catalyst to streamline service provision and provide better quality care than is being received at present for the same or less money through avoiding triplication of use of facilities. This will be achieved through the provision of health care facilities under the project which are:

- o affordable to all but the indigent and
- o self-sustaining in terms of capital and maintenance.

Patient costs influencing service use involve both direct and indirect:

Direct costs:

- o payment for treatment
- o payment for drugs
- o fees
- o "access payments" (to ensure a place in the queue or to see a particular physician) transportation to a health facility

Indirect costs:

- o waiting time
- o wages lost during visit to health facility
- o costs incurred by a patient's family members accompanying him or her to the health facility
- o food (separate provision for inpatients and those who accompany them, over and above household provision)

User perception of services is heavily linked to cost. "Free" is equated with second best. For example, inexpensive generic drugs are regarded as inferior to expensive brand names. Utilization of services is affected by pricing. High cost can be both positive and negative (good because it is paid for; bad because it may not be affordable). MOH price setting emphasizes equity, which is promoted through price subsidizing, and the government health system is under capitalized in terms of health professionals and complementary resources, resulting in poor services to the beneficiary. The pricing of services has to cover baseline expenditures and maintenance plus an incentive to suppliers in the form of an adequate salary level to ensure good quality care to beneficiaries. For example, the Embaba Teaching Hospital in Cairo has a strategy of intense use of facilities which enables it to price its care at 50 to 70 percent of that of either medical insurance or other teaching hospitals.

6. Options and Responsibilities for the Organization and Administration of the Proposed Project (Institutional Counterparts).

It is recommended that the Phase II Project Design Team Identify organizations to implement and be responsible for the various project components once their details have been designed. The following institutions might be considered. Their level of interest in or ability to organize and administer the Project is

regarded as more appropriately a Phase II activity, when project design (and thus allocation of responsibility) will have advanced a step further.

a. Medical Syndicate

Membership in the Syndicate is a requirement for all physicians. The Syndicate plays a strong policy-making role in national health policy and decision-making, and its members sit on all the major health advisory boards which guide the Ministry of Health. The Syndicate has indicated that the private sector is capable of playing a greater role in the provision of health services, and individual senior members have indicated a concern with cost containment in both private and public sector facilities. Drug wastage due to inadequate diagnosis, lengthy investigations leading to over-long hospital-stays, and simultaneous under use of beds in MOH facilities due to inadequate budgets were cited as major problems.

The Syndicate has decentralized branches in the governorates and sub-branches in rural areas (preferably linked to licensure and hence membership affiliations of rural physicians). The Syndicate's affiliates are legally incorporated and recognized by the MOH. Local-level syndicates have their own elected board and can initiate their own project though information on them is also sent to the Syndicate's Central body in Cairo. The main activities of Syndicate affiliates in the governorates are the provision of opportunities for in-service training (via seminars and conferences) and the organization of social welfare and recreational opportunities for members and assisting with their professional problems.

At the Center the Syndicate also holds equipment exhibitions where members can purchase equipment at discounts with repayments staggered over a period of time. The Syndicate has also formed a Medical Professions Corporation for Investment (MCPI). Its original capitalization was LE 10 million, with the Syndicate paying LE 2 million and the rest coming from contributions from the National Bank of Egypt; Al Mohandess Bank, the Egyptian Company for Medical Requisites (all public sector companies) as well as individual contributions by physicians, dentists, and veterinarians. The corporation provides more than 50 percent of the capital of the companies which it establishes. The object of the MCPI is to augment public sector efforts to expand the delivery of health services by establishing a chain of combined hospitals/polyclinics in close proximity to university hospitals. They offer both preventive and curative care, with basic care being provided at nominal cost in morning shifts (including free immunization and first aid), specialized services (for all branches of medicine, laboratory analyses, and radiology) in afternoons and evenings, and continuous coverage for first aid and pharmacy services. The Medical Professions Corporation for Investment (MPCI) was reported by Jeffers (April 1982) as an effort to organize private group practices in Egypt and thus

support the public sector's effort to expand health services delivery. Interestingly, this is also being promoted by the Egyptian Junior Medical Doctors Association.

However, the Vice-President reported that the Medical Professions Corporation for Investment is now more interested in investing in private companies that produce veterinary and feed additive products, human pharmaceutical products (due to begin distribution in 1988), and food supplements for special dietary needs such as diabetics.

The Syndicate expressed interest in acting as a coordinating body for loans to private practitioners under the proposed project.

The Medical Syndicate has relationships with two other professional associations, the Egyptian Medical Association described as "the scientific wing" of the profession and the Union of Medical Syndicates which acts as a trade union for physicians, pharmacists, dentists, etc. as well as undertaking social and welfare activities on behalf of its members.

b. Egyptian Junior Medical Doctors Association (EJMDA)

EJMDA was started in December 1981 and currently has an estimated 8,000 members. The Association assists junior doctors (defined as those graduating within the past 20 years) in solving problems and provides health services in the country as a whole. It started out as an administrative body, but currently has expanded into three areas: administration, finance, and the development of "action centers" (a computer center, a center for continuing medical education, a conference center, and a publishing/information center). In these centers EJMDA also initiates and implements projects including a housing and clinic scheme for members--selling items of equipment on credit provided by various local banks, a village development project, and the publication of a journal.

EJMDA's view is that young doctors have particular needs which are not being met by other professional bodies. The large numbers of graduates from medical schools (some 50,000 over the past ten years) means an increasing shortage of job opportunities, while their economic situation has severely limited young doctors' access to housing and practice premises, and even in some instances, to basic equipment and even clothing, given low MOH salaries. Through an initiative with Bank Misr and Nasser Bank a credit fund of LE 8.5 million has been used in Cairo (Nasser City) to renovate existing clinics or lease or buy new ones (equipped according to the specialization of the physician). Credit is provided to individual doctors with a 15 year repayment period and a LE 5,000 down payment. EJMDA wishes to extend this type of project to other governorates.

The Continuing Education Center provides in-service training for EJMDA members under the supervision of Cairo University professors and has video equipment. EJMDA feels it is necessary to reorient prevailing attitudes among physicians towards the provision of health care by means of organizing the providers of care. Its computer center provides services such as thesis or manuscript typing/word processing by typists familiar with technical and scientific terminology and with graphics capabilities and statistical analysis. Private practitioners approach EJMDA for assistance in setting up their practices. The services regarded by EJMDA as most needed are the creation of a patients' data base and medical diagnosis packages for minor diseases, together with the raising of physician awareness of how computers could help them. The Center offers computer training courses to doctors. Its Medical Information and Publishing Center provides a forum for young doctors to publish their papers and abstracts of MD thesis and will shortly start to publish books.

Members of its executive board are experienced in health systems management, with 10 percent of EJMDA's employees in the Association's headquarters having received training from the Faculty of Commerce and Administration. The Board emphasized the importance of and their commitment to the private sector and its leading role in health care in Egypt.

c. Union of Medical Syndicates

The Union of Medical Syndicates is a professional membership association open to medical doctors, dentists, veterinarians, and pharmacists. With a total membership of 120,000 virtually all of the country's professionals in these fields are members. Medical doctors represent nearly 60 percent of the total membership, and thus the current president of the Medical Syndicate is designated head of the Union of Medical Syndicates. The same individual sits on the National Health Council and is a member of the People's Assembly.

On behalf of its members, the Union manages a pension fund with contributions from stamp taxes on prescription drugs a low cost medical care insurance plan that covers 50 percent of inpatient care for members and their families (annual fees are LE 10/year) and a holding company formed in accordance with Law 43 for private development investments in the medical profession.

The Union of Medical Syndicates, like the Medical Syndicate, is profit-oriented, suggesting that both services and products are intended for a higher-income population. However, they may be useful for disseminating information on rural opportunities, group practices, continuing education, and new guidelines and standards.

V. HEALTH PLANNING AND POLICY ANALYSIS FOR COST RECOVERY

The issues and problems of health policy and health care delivery are a reflection of Government of Egypt general policies and strategies for economic development. These strategies emphasize a leading role for direct public sector investment and allocation of national resources ostensibly to benefit the majority. The GOE has not allocated significant resources to social welfare services such as health. Health sector expenditures as a proportion of overall government expenditures have declined to two percent from over five percent in 1976. New strategies for reducing dependency on general revenue financing of social and industrial services are needed because of continuing declines in overall government expenditures, growing deficits, and inflation. The current Five Year Plan 1987-1992 sets a new policy of improving productivity in existing investments across all sectors. Cost recovery efforts in the health sector are recognized as a catalyst to promote efficient use of health resources and to reduce the budgetary burden. The following sections outline GOE policies that have a significant impact on health sector development, specifically financing, local autonomy and accountability, and health insurance coverage.

A. SOURCES OF INFORMATION

The available sources of new information used in this report were the preliminary draft Five Year Plan 1987-92 and interviews with MOH officials. Detailed financial data were not available for analysis. Consequently, the data collected for health sector assessments in 1980-1982 are used here as the most reliable information available. Other sections of this report review opportunities for project assistance to strengthen data collection and analysis.

B. GENERAL REVENUE FINANCING

Factors that significantly influence the degree of health care sector dependence on general revenue financing include (1) the overall scope of direct health care provision commitments, (2) delineation of public and private sector roles, (3) the actual cost of delivering services as a function of labor, equipment, and supply minus service generated revenues. To the extent that GOE policies can encourage both greater efficient and productivity, recurrent costs can be reduced.

C. SCOPE OF DIRECT HEALTH CARE COMMITMENTS

Universal access to health care is a commitment bound by the National Charter of 1962 which states that:

"The right to health welfare is foremost among the rights of every citizen. To ensure this right, medical treatment and pharmaceuticals, should not be reduced to mere commodities

subject to sale and purchase, but should be guaranteed to be available free of charge to every citizen."

Notably, the government is not defined as the sole provider of health services. Furthermore, the guarantee of health welfare is only partially met by medical treatment. Preventive and promotive care is arguably of equal or higher priority in assuring right to health.

Egypt has followed a policy of directly providing services through public health facilities. The MOH has developed, promotive, and family planning services in addition to curative care. This policy has provided employment for an increasingly large number of health professionals and thus expanded access to care in the rural areas. However, this achievement has not occurred without cost. According to the report Public and Private Health Care Expenditures in Egypt, (Grosse, Pleassas, Berwamy 1982), combined Title I (wages and salaries) and Title II (operating/running costs) expenditures were equal to 78 percent of all public funds in the health sector. The magnitude of these fixed recurrent costs reduces the funds available for expansion or upgrading of health facilities which cater to higher income patients who are able and willing to pay for such care. HIO legislation in 1979 (Laws 79 and 32) established mandatory paycheck deductions from more middle-income wage earners to support medical and accident insurance coverage. Most recently, decrees 501 and 242 (1983) legislated the existence of so-called economic clinics--a token fee for service system within the GOE/MOH facilities. This progressive acceptance of payment for medical services has occurred without concurrent development of clear policies and procedures to restrict free public medical care to the indigent and other needy groups and the development of procedural or organizational innovations to significantly reduce dependence on general revenue financing.

The current Five Year Health Sector Plan gives priority to further development of preventive and emergency care services, as part of governmental free health care obligations. This basic needs principle is used to justify a no-cost provision regardless of income. However, the GOE has not yet specified which services constitute the "basic needs" due to all. While the health sector plan proposes to shift the provision of health care services to the private sector, neither the specific public/private sector roles nor identification of the groups which require access to which free care are articulated. To the extent that the government is willing to pursue strategies to improve the identification of beneficiaries, funding under the cost recovery project has merit. A viable safety net system will ultimately support more focussed service commitments and potentially reduce dependency on government funds in the medium to long term.

The GOE needs to determine whether to pursue policies that focus on the indigent, high risk, high need populations. These policies could be pursued through any number of mechanisms--

health cards, vouchers, organizing demand for care through community-based groups, agricultural cooperatives, women's groups, etc. In the absence of reliable service cost data, service use statistics, and morbidity information by income group, however, a selection of mechanism(s) will be based on little more than "guesstimates." Thus, if the GOE is interested in developing new polices along these lines, an initial project activity should clearly be an increased capacity for gathering and analyzing information as a basis for developing and adequately funding feasible strategies. Any recommendation on mechanisms to focus services one way or another would be premature. Other country experience suggests that health cards, theoretically:

- o influence and structure rural demand for health services;
- o increase use of government health services, particularly for primary health care;
- o institute a more rational referral system and thus reduce congestion and waiting time at hospitals; and
- o encourage improved manpower distribution to areas outside Cairo and Alexandria.

Regardless of the strategy selected, a system for managing the provision of services must be developed, coverage benefits need to be controls instituted. Demonstration projects and operational research studies may be useful activities to include for mid-project design and implementation.

D. DELINEATION OF PUBLIC AND PRIVATE SECTOR ROLES

Current GOE and MOH policies lend support to an expansion of the HIO and private sector responsibility in bearing the cost of curative care services. If the costs of financing public service delivery with resources owned and managed by the government are shifted to either the quasi government (including HIO, Cairo Curative Organization (CCO), teaching/education hospitals and institutes, and public hospitals that offer fee for service) providers who have some means of levying service fees or to the network of private hospitals, clinics, pharmacies, group practices, and solo practitioners which draw exclusively on patient fees then overall dependence on general revenue financing will be reduced.

On closer examination, the distinction between government, quasi-government, and private sectors is misleading. They can be viewed as overlapping and parallel activities with major difference in the method of patient payment. To a large extent, public and private sector services are offered by the same

individuals. An expansion of non-government providers may not increase the choice of practitioners, but rather spur further duplication of service facilities.

The policy to shift the burden of services delivery may also have a direct and deleterious influence on the kind of health services offered as government free care. Physicians as well as nurses, pharmacists, and laboratory technicians have great incentives to provide minimally adequate services in government health units and to use the facility to refer patients to their clinics. Incentives to expand so-called private sector provision of services are already significant. The key public policy issue remains whether government employees can serve both in the public system and concurrently practice fee-for-service medicine. As pointed out by Dr. James Jeffers in his 1982 Health Policy Review, "the growth of private sector health service delivery ... is 'gutting' the capacity of government to manage and supervise its own system." Without a reappraisal of government control of its medical practitioners, a rapid private capability to provide services to those who truly can not afford to pay. What is needed therefore is a clear delineation of public responsibilities and private sector capabilities to provide health care.

E. OPTIONS FOR PROJECT ASSISTANCE

Many options are open to the GOE. If there is strong political support to encourage development of a separate and independent private sector, GOE/MOH policy could (1) restrict government physicians from private practice, at least for the initial ten years of employment, (2) rent out underused government facilities to non-government providers; (3) develop fee-for-service schedules for payment of non-government providers serving indigent, high risk, high need populations, and (4) contract out needed ancillary, diagnostic services to non-government providers, reducing the recurrent cost of maintaining facilities, personnel, etc. While these efforts may require legislative approval and ministerial decrees to implement, the potential impact on general revenues will be both immediate and profound.

If there is only moderate support for public-private sector coordination, GOE/MOH policy could (1) examine strategies for expanding government and private health insurance coverage; (2) improve regulatory guidelines for all facilities, including construction, staffing, equipment, and hygiene; (3) develop competency-based standards for licensure and recertification of physicians; (4) expand GOE authority to collect/analyze service delivery and expenditure statistics from government, quasi-government, and private sector providers. This effort is consistent with the Five Year Health Sector Plan objective to improve supervision of all medical services as a means to fully use existing capacities.

USAID project assistance can serve to support the GOE in developing policies, guidelines, improving collaboration with professional associations, improving management information system, developing continuing education/training curricula, and preparing licensure and relicensure examinations.

F. COST CONTROL AND MANAGEMENT

The magnitude of financing requirements in government services delivery is largely determined by two primary cost factors--health manpower and subsidized pharmaceutical. To the extent that MOH management can reduce these costs and increase cost recovery, the overall need for general revenue financing will decline. Several GOE policies have diminished the management flexibility of the MOH to respond to changing demand and reduced incentives to improve performance efficiency. Accordingly, a reappraisal of these policies is recommended, along with specific activities outlined below.

1. Health Manpower Development

Free education as part of the GOE policy has encouraged a rapid increase in the number of trained health professionals, particularly physicians. In compliance with government full employment initiatives, the MOH has created jobs in both government and quasi-government facilities. Professionals are absorbed into the existing system by subdividing job responsibilities into small tasks. Medical technicians appear to become specialized in performing a single diagnostic test.

While pay scales and incentives are low (LE 70-120 per month), the additional numbers of personnel drain a substantial portion of the recurrent budget, reducing funds available for maintenance and supplies.

Insofar as nurses contribute directly to both quality of patient care and efficient use of physician time, the lack of nurses is a significant manpower problem. MOH officials report difficulty in recruiting and retaining skilled nurses. The low pay and job status associated with the nursing profession result in unfilled slots in training schools. Overall, the number of nursing graduates has not kept pace with the increasing number of physicians.

Health facility managers are another class of workers in critically short supply. Low pay, legal restrictions on pursuit of private practice, and a perception that physician managers are "failed" physicians result in fewer skilled managers. Lack of professional certification and limited career opportunities also contribute to lower status for the health managers in the system.

In order to more closely match health manpower development to manpower needs, the MOH must develop the capacity to make informed assessments of critical shortages and excesses. An

accurate data base of existing manpower resources is essential. Enrollments and graduating class sizes should be monitored closely for each job classification. Where excess capacity exists, educational facilities could be productively used to train manpower in critical need areas. Furthermore, population-based statistics and service patterns should also be used to project future manpower configuration needs in governorates farther from the main city centers of Cairo and Alexandria.

Personnel costs are not likely to decline in the near term, short of unprecedented mass lay offs. Rather, the objective is to more efficiently use existing manpower resources and slow the process of creating additional jobs within the government health service delivery system. Should there be a real decline in the numbers of health personnel, and upward revision of salary levels is likely.

2. Subsidized Pharmaceuticals

The GOE policy of subsidizing pharmaceuticals is part of an economic strategy of industrialization through import substitution. Currently, 82 percent of the drugs consumed are locally produced. Production of all pharmaceutical is tightly controlled with import quotas and a 30 percent restriction on total budget outlay for foreign exchange transactions. Detailed expenditure information was not available for the past six years. In 1980/81, the drug industry accounted for almost 70 percent of the government health budget. Private sector outlays on drugs in 1978 were estimated to consume 54 percent of all recurrent health sector expenditures.

While inflation has steeply increased prices with one insurance company reporting a 300 percent increase in 1986 drug expenditures, the government maintains that the problem is one of over consumption. With subsidized drug prices, production capacity cannot match increasing demand. As other health studies have shown (i.e. J. Newhouse, et al, the Rand Study; Popkin, Akin, et al, Bicol Philippines, Health Study; H. Luft, on Health Maintenance Organizations; PRICOR, W. Stinson, Community Financing of Health Services, etc.) health care services offered without cost to the patient, result in significantly higher rates of use and when matched against a need index, show high levels of unnecessary usage.

Thus, the demand for free or low cost pharmaceuticals in Egypt appears to be approaching infinity. Local MOH units have resorted to single-dose distribution of drugs as a method to ration supplies. However, a more comprehensive drug policy is needed to reduce both unnecessary use of pharmaceutical and the level of subsidies from manufacture to distribution. GOE policies to promote the drug industry do not appear to be under reappraisal. However, the MOH can undertake to establish an essential drug policy and restrict government procurement to

essential drugs. Enforcement of existing prescription requirements for drug purchases can further reduce the overuse of common medications such as antibiotics.

3. Service_Generated_Revenues

The economic clinics established through Decrees 242 and 501 deliberately set symbolic fee levels at 25 piasters per consultation visit and LE 1-3 for in-patient stays. The current Five Year Plan 1987-92 supports expansion of economic treatment in public, district, educational, and rural hospitals for those with middle incomes. Middle income patients are by definition those who are willing to pay.

The policy precedent for user fees in health centers is encouraging. However, the return is not yet sufficient to be deemed cost recovery. The absence of cost accounting constrains the potential for service generated revenues to replace government allocation financing. Service generated revenues also provide incentives for increasing productivity. Thus, the GOE must determine whether to pursue higher rates of cost recovery as a means to improve the quality of services. In addition, the collection and analysis of service delivery cost accounting should be institutionalized within the local and national levels of the MOH. The cost recovery project assistance package should support GOE efforts to implement cost recovery policies. Development of a management information system, including cost accounting is important for future sustainability of improvements in the sector.

G. GOE DECENTRALIZATION AND GOVERNORATE AUTONOMY

Decentralization laws over the past 22 years have sought to strengthen local infrastructure in the 26 governorates. While responsibilities for implementation of line functions and services have increased, there remains an unclear delineation of management functions. More importantly, there is a lack of autonomy over fiscal resources within governorate jurisdiction, including private resources for local development activities. As a result, there are strong disincentives to develop technical and managerial staff at local levels or to identify and obtain additional resources for operations or expansion of facilities.

1. Functional_Divisions

According to MOH officials, the role of the MOH at the national level is to serve as a planning and support management unit, coordinating inter- and intra-ministerial health sector activities (e.g. emergency programs, research, drug manufacture, legal resolutions), and external funding. The role of the governorate level General Directorate or Directorate for Health is to implement the Ministry's service delivery programs and coordinate with the Governors and Local Councils in districts and villages for community-based development activities. The

simplicity of the organization scheme does not fully reflect the level of overlapping activities or constraints on local level autonomy as listed below.

National

1. Consolidate and modify health plans; determine, with the Ministry of Finance and Planning, fixed allocations based on facility coverage formula.
2. Collect service statistics (Note: There is no uniform reporting format or feedback to local level or no check on quality control or performance efficiency).
3. Plan National Health Programs (vertical programs, e.g. family planning, malaria, etc.).
4. Supplies/manufacture and distribution of drugs/laboratory reagents.
5. In consultation with Central Agency for Organization and Management, determine career promotions, personnel policies, number and type of positions. Selects advanced training scholarship recipients.
6. Develop health laws and decrees.
7. Determine policies, e.g. 1987-1992 goal to increase productivity in medical care services, strategies to expand cost recovery insurance.

Governorate

1. Annual health plan and budget request.
2. Collect service statistics (no requirement to maintain medical records or to monitor quality control).
3. Implement programs per decree.
4. Dispense supplies as available and repackage bulk drugs.
5. Provide on-the-job training.
6. Assure compliance with law/decrees.
7. Registration of 2nd care facilities, monitor performance in private and government clinics.

8. Coordinates donor and development assistance projects, overseas training opportunities.

8. Coordinates with Governate and Local Councils.

2. GOE_Budget_Planning

Governate authorities initiate plans but do not retain control over resource generation or allocation. The budget planning process focuses on investment (Title III) resources, specifying the numbers and types of facilities to be renovated, upgraded, constructed. Beds and facilities are the basis for fixed formula allocations to wages/salaries (Title I) and running/operating expenses (Title II) including drugs, food, fuel, supplies, etc. Consequently, the budget process confines health sector planning to a facility coverage strategy.

There is no authority at either national or governorate levels to shift budgets between categories to meet increasing operating expenses. In 1982 governorates were given the flexibility to reapportion investment funds (Title III) among approved projects, as long as the aggregate total was not exceeded and priority was given to projects already underway. However, strict separation of budget funds for Titles I and II must be maintained. Thus, governorates and health unit managers have no authority or incentive to allocate resources according to output performance or to respond to changing demand for services.

3. Local_Development_Resources

The decentralization legislation of 1975 (Law 52) allowed for special local development funds separate from central government allocations. These funds do not return to the treasury if unspent; they can accumulate, be invested, and even used to established profit-making enterprises. Sources of revenue include local duties, loans/grants and donations, as well as half of any local revenue surplus over estimated collections.

Cost recovery for some hospital outpatient and inpatient services are permitted by Decrees 242/501. Municipalities determine the guidelines for cost recovery by setting fee structures. Typically, fees are token payments to help "share" the cost of service provision. Up to 20 percent of inpatient beds in secondary care facilities can be set aside for paying patients. Outpatient services may be available for a fee on the premises of government clinics with government doctors after regular 8:00 to 2:00 o'clock free clinic hours.

Revenues from these cost recovery projects do not contribute significantly to the cost of providing curative care. No precise data were available at any of the sites visited, though fees are minimal and 10 to 20 percent of the revenues are not kept at source but rather are returned to the governorate and to the governorate of Cairo.

Recent comparison data on central grants in aid to locally raised revenues was not available at the time of its report. In 1979 the Central Government provided approximately three fourths of cumulative governorates' budget. (From Private and Public Sector Health Services Delivery Systems in Egypt, Dalton, Benjamin, Fabricant, Reyes, 1982).

Site visits provided observation of two examples of small scale local investments in the health sector: initial capitalization of a mosque clinic in Ismailiya and the expansion of endoscopy services in the District Hospital, El Fayum. However, these appear to be exceptional cases. There seems to be little direct effort to mobilize private resources for governorate development activities.

Governorates remain fiscally dependent on the central government. Capacity building is needed to strengthen existing local institutions that meet locally defined needs. The assumption is that some continuity with the past will improve the chances that improved systems will be sustainable into the future.

4. Options

Two key issues emerge from analysis of decentralization and governorate authority in the health sector: the lack of management capacity at the governorate level to efficiently use health sector resources and lack of authority to use government allocations most effectively for local conditions and to draw on private sector resources.

Development of a management capacity is contingent on knowledge of existing levels of service provision at the local level. Governorates will only be able to established performance standards and identify management efficiencies when they have an accurate data base of service and cost information. A functioning management information system will also provide feedback to facility managers for continuing program and budget planning. Capacity building at the local level could be achieved either through the central MOH or directly with several governorates to pilot test management systems and promote future collaboration.

Project assistance modes should be consistent with GOE and USAID local development initiatives. Direct support for technical and managerial skill development at the governorate level is a preferred strategy to strengthen the role of the MOH in managing health care provision. Improved budget and planning skills at the local level may contribute to higher overall funding levels, generating increased fiscal flexibility.

Local control over resources could be achieved in several ways. The central government could issues new budget guidelines, permitting local governorates to adjust categorical budget allocations up to 10 percent between accounts. Another option,

developed for local control over irrigation systems in another, is to use a cost recovery as a basis for annual subsidy levels from the central government. Higher returns in the way of service fee revenues is rewarded with higher budget allocations to the governate or to special projects in the next fiscal year.

However, the private sector resources are most likely to reduce dependency on general revenue financing and thus offer increasing autonomy and authority over local health infrastructure. Further attention should be directed to mechanisms that will allow revenues from service fees or facility rental to be retained at source. Improved cost recovery efforts are a proven strategy to promote efficient use of health resources. Additional benefits include, hospital capital formation for better quality health services, purchase of diagnostic equipment, and upgrading skills of health workers. If the MOH is to shift priority to preventive health care, other sources of operating funds for curative care services will have to be found at the local level.

The MOH can further assist in the progress of decentralization efforts with a review of respective responsibilities. Special regard should be made to address mechanisms for focussing on beneficiaries at the local level and developing new curative care services through technology assessment. In addition, the MOH can assist in the recognition of management excellence in the field.

VI. BANKING RESOURCES AVAILABLE FOR MEDICAL PRACTICES

The banking specialist as "to investigate ways in which the proposed project can work with Egyptian banks to make loans available to the private sector to establish medical practices ... in secondary towns and rural areas." Before, however, discussing those terms of reference, some background information will be useful on the present economic environment that prevails in Egypt.

A. ECONOMIC BACKGROUND:

In 1986 Egypt faced a difficult economic situation. Falling oil prices, declining tourism earnings, and reduced worker remittances through official channels have decreased the GOE official foreign currency reserves and revenues which in turn have precipitated a major review of economic policies. One of the major issues being addressed by the Government is reaching a standby agreement with the International Monetary Fund (IMF) which will allow rescheduling of Egypt's external debt (estimated at US\$44.4 billion, with US\$12 billion GOE guaranteed.). At present, only a Letter of Intent has been signed with the IMF. When a final agreement is signed, this should provide a temporary balance of payments relief. Also, reaching sectoral agreements with the World Bank (IBRD) will result in a resumption of IBRD lending.

IMF guidelines for the GOE are as follows:

1. budget deficit/subsidies to be reduced;
2. interest rates (at present in a range of 11-15 percent a year) to be increased to reflect "real interest", that is, not "negative" interest rates when taking into account inflation (estimated at between 20-25 percent);
3. additional money supply controls outside of the interest rate mechanism (e.g. a credit/lending ceiling recently imposed on Egyptian banks by the Central Bank of Egypt--CBE);
4. unification of foreign exchange rates based on market conditions, i.e. narrowing the gap between the CBE-set official commercial exchange rate versus free market exchange rate (LE 1.35/US\$1.00 vs. for example LE 2.20/US\$1.00);

B. THE EGYPTIAN BANKING SYSTEM:

The banking sector in Egypt is regulated by the Central Bank of Egypt. It consists of:

Type 1: Representative Offices of Foreign Banks

Banco Do Brazil
 Bank of Handeland Effekten
 The Bank of Tokyo Ltd.
 Bankers Trust Co.
 Banque de l'Union Europeene
 Banque Francaise Du Commerce Exterieur
 Banque Indosuez
 Banque National Du Paris
 Byblos Bank
 Chase Manhattan Overseas Corp.
 Chemical Bank
 Commerzbank
 IT Commerciale De France
 Creditor Italiano
 Den Norske Credit Bank
 Deutsche Bank AG
 Dresdener Bank AG
 European Arab Bank
 Habib Bank Ltd.
 Midland Bank Ltd.
 Monte Dei Paschi Banking Group
 Morgan Grenfell and Co. Ltd.
 The Royal Bank of Canada
 Societe General
 State Bank of India
 Sumitomo Bank Ltd.
 Swiss Bank Corporation
 Union De Banque Arabes et Francaises (UBAF).

Type 2: Off-shore Free-zone Bank

Manufacturers Hanover Trust Company

Type 3: Foreign Bank Branches

American Express International Banking Corp.
 Arab Bank Ltd.
 Arab International Bank
 Banca Commerciale Italiana
 Bank Melliran
 Bank of America
 Bank of Credit & Commerce Int'l O/S
 Bank of Nova Scotia
 Bank of Oman Ltd.
 Banque Parisbas
 Citibank

Credit Lyonnais
 Credit Suisse
 Lloyds Bank PLC.
 National Bank of Abu Dhabi
 National Bank of Greece
 National Bank of Oman Ltd.
 National Bank of Pakistan

Type 4: Joint-venture Banks (established under Law 43/1974)

Bank of Credit and Commerce (Misr)
 Banque du Caire Barclays International
 Banque du Caire et de Paris
 Cairo Far East Bank
 Chase National Bank Egypt
 Credit Foncier Egyptien
 Credit International d'Egypte
 Egyptian American Bank
 Hong Kong Egyptian Bank
 Misr America International Bank
 Misr Exterior Bank
 Misr International Bank
 Misr Romanian Bank
 National Societe General Bank

Type 5: So-called 'Private' Banks

Alexandria Kuwait international Bank
 Alwatany Bank of Egypt
 Bank of Commerce and Development (Al Tegaryoon)
 Middle East Bank Ltd.
 Mohandes Bank
 Nile Bank
 Pyramids Bank
 Suez Canal Bank

Type 6: The Four Public Sector Banks

Bank of Alexandria
 Banque du Caire
 Banque Misr
 Banque Parisbas
 National Bank of Egypt

Type 7: Islamic Banks

Faisal Islamic Bank of Egypt
 Islamic International Bank for Investment and
 Development
 Nasser Social Bank

Type 8: 'Specialized' or development-type Banks

Arab African International Bank
 Arab Investment Bank
 Arab Land Bank
 Development Industrial Bank
 Egyptian Gulf Bank
 Housing and Development Bank
 Misr Iran Development Bank
 National Bank for Development
 National Investment Bank
 Suez Canal Bank

For the purpose of this report, the survey concentrated on those banks which have local and foreign currency lending capabilities. Because of the IMF negotiations and their proposed guidelines for the GOE, the CBE in April 1987 issued a Circular which limits the loan growth of the Egyptian banks to 2/2.5 percent of the outstanding loans on their books as of December 31, 1986. This will in the short run curtail the money supply, but it is not perceived as a long-term solution. Naturally, the banks are presented from aggressively seeking new business, financing any new projects, or even increasing loans to existing good customers. This Circular is to be reviewed by CBE as of June 30, 1987.

C. SUMMARY OF INTERVIEWS:

A full spectrum of Egyptian financial institutions were surveyed. One should bear in mind, though, that because of the recent CBE Circular referenced above, a less than optimistic attitude prevailed among the bankers, especially involving new projects. In addition, most banks have not had much exposure, if any, to the health sector. Therefore, they have had little experience in evaluating any peculiarities that may occur in the health sector environment. Also, they don't have a experience with delinquency factors in these type of start-up projects.

Joint-venture banks who had dealt with AID in the past, in general, had no appetite for Cost Recovery Programs for the Health Sector (CRPH). They were not involved in the past with these types of projects, nor do they foresee in the short or medium term any lending to this sector. Without an extensive branch network in Egypt and the high administration costs that could be associated with the CRPH, the cost/benefit for these joint-venture institutions would not merit involvement.

As for the so-called "private" banks, i.e., those banks with individuals or small institutional shareholders, in general, their policy has been even more conservative in their review/analysis/approval process of new projects. Their philosophy is basically to provide a "safe" reasonable return to their shareholders. Also, their profit margins between cost of

funds and interest charged for borrowings are traditionally thinner than most other financial institutions in Egypt as they lack a large branch network and hence a smaller deposit base.

Islamic banks work as financial institutions under the Koranic concept of "el riba" or economic return versus traditional occidental banking methods using interest. They would most likely be involved on a case-by-case basis in financing such medical practices as proposed by this project. A good example might be the "mosque" clinics. In addition, they are historically flush with local currency and lend their Egyptian pound excesses to other local Egyptian banks in return for foreign currency deposits. This source of local currency could be effectively tapped for banks participating in the project with a local currency requirement i.e., banks with smaller deposit bases, such as the Principal Bank of Development and Agricultural Credit (PBDAC), which will be discussed later. This analysis could not be readily verified first hand, but was reinforced by other reliable sources. A brief example of the Islamic type financing appears in Appendix I.

The four Public Sector banks (National Bank of Egypt, Banque Misr, Banque du Caire and Bank of Alexandria) are at present involved in the health sector on a case-by-case basis. A brief example of this is the Arab Contractors Medical Center whereby most of the four Public Sector banks have participated in term loans for construction and financing medical equipment.

Another example of such financing is for the Medical Professions Corporation for Investment. The MPCCI is sponsored by the Medical Syndicate of Doctors and was structured with an initial share capital of LE 10 million. The original shareholders were diverse and consisted of 28 individual physicians and pharmacists, the National Bank of Egypt, Mohandess Bank, and four Public Sector pharmaceutical manufacturing companies. Presumably, the two banks are also involved in any financing requirements. MPCCI's main objective is to establish subsidiaries that will be involved in producing specialty drugs (e.g., veterinary medicines), while secondarily it will finance medical practices.

The assessment of the four public sector banks as regards financing to CRPH is neutral. One chairman of a joint-venture bank, who was previously a long standing director of a public sector bank, stated emphatically that these four banks are "drowned by social responsibility lending."

"Specialized" or development-type banks which do deal more in long term projects, however, see some merit and potential for the CRPH. This is not only to assist "the Nation", but also from a practical business point of view. They have more experience in analyzing longer term projects where the payback to the financing institution and shareholders may take longer than commercial banks are willing to accept. This type of financial institution

also lends to the health sector on a case-by-case basis (refer to Appendix J). That is, they analyze the credit risks of each individual project on its own merits.

It is worth commenting that for long term projects, the time from initial introduction to the potential client until the money is actually disbursed can in most cases be lengthy. After much detailed analyses of the feasibility study, the bank enters into timely negotiations with the customer in structuring the loan. That would entail such details as specific collateral, interest rates, tenure of the loan, and structure of the legal entity to which the financial institution will ultimately make the loan. In registering the collateral and possibly establishing a new corporate or partnership entity, more time is involved before that bank is satisfied that it is fully secured before disbursement.

Taking collateral for any overdrafts or loans, be they short or long term commitments, is the traditional method of financing. For long term projects, the highest interest rates allowable by the CBE are charged, as well as all fees and commissions involved in the transaction, such as commitment fee and management and/or administration fees. It is worth emphasizing that the CBE publishes a tariff schedule which not only pertains to interest rate charges by sectoral lending (i.e., manufacturing industries, service industries, etc.) but also dictates the fee and commission schedule. No deviation from these charges is officially allowable.

The Development Industrial Bank (DIB) and the National Bank for Development (NBD) were interested in the CRPH scheme, particularly if there is any element of co-financing with AID. From the borrower's and the bank's perspective, the possibility of any foreign currency requirements for financing the import of a limited quantity of medical equipment would be attractive, that is providing seed money for these fixed assets. Local currency requirements for working capital, procurement of medical equipment on the local market, and inventory financing (pharmaceuticals) should be provided (funded) by local banks, while land and building or "key money" for clinics should be out of the capital invested by the doctors. The Arab Investment Bank (AIB), having dealt with AID on other co-financing transactions, was also positive towards assisting CRPH. They initially saw their role (along with, say, the Islamic banks) as providing additional local currency funds.

PBDAC with over 5,000 branches would be a high priority vehicle to channel money to agricultural co-ops and/or credit unions. They are knowledgeable about the populace (farmers) in the secondary towns and rural areas. They are also administratively capable of handling small loans (say LE 5,000); that is they have experience in handling the processing of small loans such as analysis, disbursement, monitoring, and collection. Their loan portfolio has numerous types and sizes of lending activities,

albeit to the agricultural sector. They do admit, though, that they have a small deposit base in relation to their balance sheet footings and are a traditional taker of LE funds. If hypothetically they were to finance polyclinics at say the district or village agricultural co-operative level, this would ensure some community commitment and involvement and thus produce the desired stability for a medical practice.

A possible scenario can be drawn from the above. DIB has been involved with long term projects since their incorporation. The National Bank for Development, in that it owns 51 percent equity of 18 governorate level banks, is comfortable with projects in the secondary towns and rural areas. Also it has the capability of effectively and productively channelling money to these areas. PBDAC with its extensive branch network and small loan analysis history would be one of the additional conduits for financing the project. In addition, they might be able to administer and monitor the project. The Arab Investment Bank et al could provide the local currency financing through the "conduit" banks or those actually making the credit risk assessments. If required for foreign currency funding requirements, AID co-financing could be available in terms of a revolving loan that would be used as required and replenished by repayments to the banks. Naturally, AID could make this revolving fund available in local currency, translated at the CBE official commercial exchange rate.

As to the question of the size of each loan, i.e. minimum or maximum amount, it was too premature in discussions with the banks to review the exact procedures. LE 50,000 should be a minimum target figure for a loan, except, perhaps for PBDAC which has had experience in smaller lines of credit.

Another major issue that was apparent from the interviews of financial institutions was what legal entity should be the recipient of the money. It appears that traditionally medical practices (especially polyclinics) are sole proprietorships or associations. It was evident from discussions with experienced Egyptian bankers that this legal structure should be modified if more of this lending were encouraged under the CRHP. Associations are not legal entities, and sole proprietorships are difficult to collect bad debts from in case of default or bankruptcy. A majority of the banks feel that lending to an incorporated legal entity (share capital company under, say, Law 43/1974 and Law 159/1981) or, alternatively, to a limited partnership set up under Egyptian laws is the best method. As a side issue, Law 43/1974 and Law 159/1981 do provide for some tax holidays. The primary function of these entities would be to establish medical practices or groups of medical practices, polyclinics, hospitals, etc. This would be the most practical and efficient legal structure to lend money. The taking of collateral as security is a well-established Egyptian bank method for lending, particularly for the worst-case scenario of default by the borrower. If term loans were established under AID

co-financing and/or by the banks, this would certainly be the case. In addition, assignment of shareholders' (partners') individual life insurance policies is a standard technique utilized in Egypt.

An example of equity structure for a prototype medical practice could be as follows:

XYZ Medical Practice
Sample Equity Breakdown

<u>Shareholders</u>	<u>%Equity</u>
- doctors working in practice	60%
- individuals of community	30%
- specialized banks, e.g., NBD	10%

Total Equity	100%
	=====

In that it appears likely that some medical equipment would have to be imported to establish these new medical polyclinics and/or secondary or rural located hospitals, a foreign currency element is required for the financial package. Foreign currency loans can be made by local banks to the private or public sector. However, it is officially prohibited by CBE regulations for the private sector to have direct access through banks to convert local currency into foreign currency at the official commercial bank exchange rate (i.e., LE 1.35/US\$1.00) in order to repay their foreign currency obligations. The bank may, though, act as a conduit between its private sector customers who have an excess supply of foreign currency and its clients who are required to buy foreign currency to repay loans or cover obligations for imports under letters of credit. An example of this system is that Chase National Bank Egypt acts as an intermediary for its customers who purchase US dollars from employees and dependents of the USAID or the US Embassy in Egypt. In turn, those employees/dependents are receiving Egyptian pounds from CBNE's customers, not the bank. In most cases, though, the private sector utilizes the free market or "gray" market to exchange Egyptian pounds for foreign currency.

A foreign currency revolving fund could be established with the banks who participate in the project. This loan, not envisioned as a grant, could be set up by AID, and should be either an additional monetary allocation under existing AID programs (e.g. Private Sector Credit & Term Finance - see Appendix K), whereby the new money would be specifically earmarked for the health sector. Or a new AID facility could be established under basically the same terms and conditions that exist with the other AID programs. As a matter of funding policy, grants or US

government guarantees should not be extended to the Egyptian banks who would in turn lend to medical practices. However, one should consider grants to establish the credit process, administrative procedures, etc.

It must be taken into consideration, however, that the costs of financing these projects will be increasing over the long run if the GOE follows the policy guidelines recommended by the IMF, IBRD, and US government. Because of Egypt's current economic situation, this will occur, certainly, over the next few years. Specifically, interest rates will rise, and a more unified foreign exchange rate (increased LE against the US\$) will occur. These additional costs will have to be borne by the borrower. It is, therefore, essential that the legal entities established be well capitalized, thus decreasing the burden of increased debt servicing and having a cushion for any cost overruns. Simply stated, more personal capital and fewer loans, or a ratio of at least one Egyptian pound from the investors to one pound of loans from the banks, is considered a prudent financial structure.

A hypothetical balance sheet appears below:

XYZ Medical Practice
Sample Balance Sheet

Current Assets

Cash	LE10,000	
Inventory*	<u> 5,000</u>	

15,000

Fixed Assets*

Equipment		
Imported	LE10,000	
Local	30,000	

Land & Building	45,000	<u> 85,000</u>
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TOTAL ASSETS		LE100,000
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Current Liabilities

Overdraft	LE10,000	
Term loan	40,000	

TOTAL LIABILITY		50,000
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Shareholder Equity		<u> 50,000</u>
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TOTAL LIABILITY & SHAREHOLDER EQUITY		100,000
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* Fixed Assets and possibly inventory are assumed to be collateral for the short term facility (overdraft) and term loan.

It can be ascertained from the above example, that from a banker's policy point of view, the investors have contributed 50 percent of their own funds to the project to demonstrate their long-term commitment to keep the medical practice as an "on-going concern".

If the practices do not require foreign currency loans and/or foreign currency becomes more readily available through the official banking system, those Egyptian banks participating in the project should be encouraged to evaluate medical practice cost/recovery projects on a stand-alone basis, i.e., without AID co-financing.

In conclusion, this report has covered the Phase I banking specialist's scope of work. More detailed investigations and discussions should be carried out by a banking specialist if Phase II of the project materializes, since it appears that some banks in Egypt have an interest in participating in Cost Recovery Programs for Health.

VII. PHASE II SCOPES OF WORK

A Phase I recommendation is that Phase II personnel consist of the following:

1. A Health Management Specialist
2. A National Health Planner/Institutional Developer
3. A Banking Specialist
4. A Social Scientist
5. A Facilitator

In addition, the following Egyptian personnel will be needed:

6. A Lawyer
7. A Marketing Consultant
8. An Administrative Assistant
9. A translator

The facilitator will be responsible for planning, directing, and conducting an informal brainstorming session, in Egypt, for two days. About 15 visitors from the public, private, and governmental sectors will attend, including Phase II team members. They will discuss the various aspects of the CRPH and will aid in project design bringing to it specific knowledge of what is to be expected.

The Scopes of Work for the Egyptian personnel are described in Chapter II of this report.

The Scopes of Work for numbers 1 to 4 are as follows.

A. HEALTH MANAGEMENT CONSULTANT

The objectives of the health management consultant in Phase II are (1) to specify the amount and type of project assistance to the HIO and CCO to improve their operations and managerial effectiveness, (2) to design the grant portion of the project in conjunction with the banking specialist, (3) to design a feasibility study for the expansion of private prepaid health insurance schemes in secondary towns and rural areas, (4) to coordinate the work with the other team members and the design committee to establish the overall organization and administration of the proposed project, and (5) to act as the Team Leader.

1. Scope of Work

- a. Identify the types and amounts of assistance which the proposed project will make available to HIO and CCO to alleviate the major constraints to improved productivity and effectiveness. This analysis will cover management information systems, pricing and rate setting issues, and training and continuing education for managers and service personnel. HIO and CCO will be requested initially to identify areas of management needs, and the management specialist will take these into consideration in preparing his recommendations. He/she will also specify how the project resources made available to these organizations will be organized and administered.
- b. Recommend organizational (including staffing and budget) and operational arrangements for a grants program to operate separately from but in conjunction with the loan program for the purpose of assisting and thereby encouraging applications for loans to establish general medical practices and adopt risk-sharing and/or social financing schemes. Grants would be available, for example, to apply for loans, to conduct feasibility and market studies, and to establish fee structures and sound accounting/bookkeeping practices.
- c. Work with and coordinate the contributions of the other team members and the design committee to establish the organizational, administrative, and operational basis (including staffing and budget) of the proposed project, i.e., the Health Care Financing and Investment Board, its staff, and the financial intermediary/agent.
- d. The management specialist will act as the team leader and ensure coordination between the team members and outside parties. He/she will be responsible for report production and delivery.

2. Required Report

The health management consultant will produce a written report of the information and analyses called for in the above scope of work (documenting all sources) which will be incorporated into the PP. Therefore, the organization and formatting of this report will adhere to official PP guidelines and be coordinated with the reports of the other team members.

3. Qualifications

The health management consultant will be professionally trained at the MBA, MHA (or equivalent) level, with expertise in financial management and pricing of health services. A minimum of ten years working experience in the health sector in hospital management and management of health care systems including

patient records is required, with the largest part of this time spent in an operational (as opposed to a consultant) position. Total familiarity with US health care financing and delivery systems (inpatient and outpatient) is necessary, as is international work (preferably in North Africa and the Middle East) and project design experience with AID. There is no foreign language requirement, but Arabic is desirable.

B. NATIONAL HEALTH PLANNER/INSTITUTIONAL DEVELOPMENT SPECIALIST

The National Health Planning/Institutional Development Specialist will work on the Phase II Cost Recovery Project design team to further detail project activities and to help prepare a Project Paper. She/he is expected to review available information, conduct interviews, and develop collaborative working relationships with Egyptian counterparts as well as other design team colleagues.

The major objectives are to (i) develop a framework for a policy analysis of the project, (ii) detail activities to strengthen the MOH role in managing and coordinating health services, and (iii) in conjunction with the Health Management Consultant, design an investigation to better define actuarial issues, elasticity of demand for health care services, and the potential impact of project-assisted cost recovery policies.

1. Scope of Work

- a. Review an extensive body of information on the Egypt Health Sector, including but not confined to:
 - Health Sector of Egypt, edited by D. Storms, 1982
 - Health Policy Review (Health Sector Assessment, 1982) by Dr. James Jeffers
 - Preliminary Five Year Plan 1987-1992
 - Shoura Council Report (released 1987)
 - Phase I Cost Recovery Project Report
 - Analysis of 1987 Survey on the Supply of and Demand for Health Services

The following are to be collected prior to initiation of Phase II design work:

- (i) Data on the estimated 86,000 practicing physicians in Egypt, by location, by age, by urban-rural practice, and by work sites (public, private, MOH)
- (ii) Complete the list of licensed health facilities by geographic distribution and by type (classification)

- (iii) MOH budget by Governorate, by budget category, and for pharmaceuticals
 - (iv) Population-based Statistics including age/sex Distribution, income stratification, and morbidity/mortality patterns
 - (v) Comprehensive lists of laws/decrees guiding health care delivery, insurance, local development functions, standards of health facility performance and construction, registration and licensure of non-government facilities and provision for transfer of government properties and facilities.
- b. Participate in the design and implementation of a cost recovery policy workshop for leaders of educational institutions, health service delivery, and health insurance organizations. Expected output will be a source of information to guide in project design.
 - c. Develop a flexible framework for the policy analysis component of the project recommending types of data, identifying institutions/organizations to be involved in implementation, and specifying staffing, organizational arrangements, and budgets.
 - d. Design project activities with incremental benchmarks to assess progress towards capacity building objectives. Specify studies, data generation, technical assistance, training, and collaborative efforts required to strengthen MOH's institutional and regulatory roles in managing health services delivery, e.g. formalize plans and procedures to assure care to the indigent, improve standards of licensure, institute relicensure and mandatory continuing education, improve enforcement of prescription requirements for drug purchase, adoption of essential drug lists, upgrade professional role and status of administrative managers, increase MOH control over development of health manpower, and encourage greater flexibility in local planning and budgeting.
 - e. Specify the types of institutional agreements and organizational arrangements necessary for cost recovery and retention of revenues at service delivery sites, e.g. among MOH, HIO, CCO, governorates, group practices, etc.
 - f. Set reasonable quantifiable indicators of cost recovery effectiveness to stimulate productivity and efficiency, e.g., proportion of government health facilities with economic clinics, cost recovery revenues as proportion of actual cost, expansion of health insurance enrollees, number of private and group practices outside Cairo and Alexandria, local government dependence on general revenue financing.

- g. In conjunction with the health management consultant, develop a method for investigating actuarial issues, elasticity of demand for health services, and potential impact of project-assisted cost recovery policies.
- h. Conduct an inventory of existing management training and education programs. Include the High Institute of Public Health, medical schools, professional associations, etc., and MOH training facilities.
- i. Conduct an inventory of other official donor assistance in the health sector.
- j. Tasks g. and h. above may be subcontracted to a local person or firm or an additional team member.
- k. Participate in the MOH Project Steering Committee review of the Project Paper.

2. Final Report

The National Health Planning/Institutional Development Specialist will coordinate with other design team members to produce a final PP report in the following format:

I. Project Setting

- A. Background
- B. Sector Challenges and Constraints
- C. Other Donors
- D. Strategy/Relationship to Agency Policies
 - 1. Institutional Development
 - 2. Policy Dialogue
 - 3. Private Sector
 - 4. Women in Development

II. Project Description

- A. Goal and Purpose
- B. Project Components
 - 1. Policy Analysis
 - 2. HIO Expansion
 - 3. Strengthening Management Capacities (National and Local)
 - 4. Private Sector (Finance, Cost Recovery)
- C. Preliminary Budget
- D. Expected Impact/Project Specific Analyses
 - 1. Technical Analysis
 - 2. Economic Analysis
 - 3. Administrative Analysis

III. Project Administration

- A. Implementing Agencies
- B. Agency Arrangements/Coordination
- C. Design Schedule and Implementation Plan (Phase in some components, contracting, etc.)
- D. Contracting Services
- E. Gray Amendment Alert
- F. Evaluation Plan
- G. Procurement Plan

IV. Policy Issues

3. Qualifications

National Health Planning/Institutional Development Specialist will have professional training in economics, preferably with an MD, a minimum of ten years of practical experience in national health planning/institutional development. He/she should have a minimum of five years experience in international programs, preferably with some of it in Egypt, and AID project design experience. The specialist should be a recognized health policy expert, familiar with national level expenditure and use of data bases. There is no foreign language requirement, but Arabic is desirable.

C. BANKING SPECIALIST

The banking specialist in Phase II will specify the administrative and operational arrangements through which a small private sector loan program can function and the amount of funding which should be made available for this activity by the proposed projects and will work with other team members and the design committee to establish the overall organization and administration of the proposed project.

1. Scope of Work

The banking specialist will recommend:

- a. Specific banks to function as the financial intermediary/agent for the small loan component of the proposed project and the size and type of staffing, organization, and functions within the loan component of the proposed project. The specialist should only concentrate on those institutions in the Egyptian banking system that have local currency capabilities and have an appetite for credit exposure in this area, e.g., joint-venture banks, the four public sector banks, Islamic banks, "specialized" or development-type banks and, to a limited extent, so-called "private" banks;

- b. Specific terms and conditions which applicants for loans must satisfy, both to make application for loans, (e.g., feasibility studies, fees, etc.) and to successfully qualify for a loan (e.g., collateral requirements). The assistance of a foreign consultant may be required to create credit criteria packages. This consultant should be familiar with Egyptian banking practices and its legal system particularly in regard to the legal aspects of using collateral for securing bank lines of credit. The time of this consultant in Phase II is anticipated to be two weeks;
- c. Specific terms and conditions of financial risk-sharing among the banks in question and the proposed project (i.e., the AID project grant). Study should be made of the mechanics, terms, conditions, and administration of an AID co-financing credit scheme similar to the existing "Private Sector Credit & Term Finance";
- d. Guidelines and operational procedures to be issued by the "Health Care Financing and Investment Board" to the banks to implement the loan component of the proposed project and criteria and procedures to be used by the Board's staff to monitor loan disbursements. The specialist, in conjunction with the team, may decide that for these specific credit guidelines and procedures they defer to an existing agency of the GOE such as the Investment Authority which also assists in some other USAID credit schemes. This issue should be investigated thoroughly during Phase II. The same expert or consultant who would be contracted to develop credit criteria, above, might assist here.
- e. Maximum and minimum available loan amounts (in US dollars and Egyptian pounds) and procedures for linking approved medical equipment purchases to foreign and domestic suppliers;
- f. The total amount of funding from the proposed project to budget for the loan component. This amount should be broken down in terms of grants for participating banks to establish credit criteria packages as well as to cover design and administrative procedures in addition to aggregate loan amounts required to establish any AID co-financing revolving fund;
- g. The proper types of legal entities that medical practices should establish (e.g., limited partnerships or share capital companies). These studies and investigations should be in consultation with the prospective banks that might wish to participate in health sector lending. A legal consultant should be engaged to assist. He could feasibly be the same consultant as the one recommended for b. and d. above. The time required for a financial/banking/legal consultant for all three tasks is not expected to exceed two weeks.

2. Required Reports

The banking specialist will produce a written report containing the information and analyses called for in the above scope of work (documenting all sources) which will be incorporated into the Project Paper (PP). Therefore, the organization and formatting of this report will adhere to official PP guidelines and be co-ordinated with the reports of the other team members.

3. Qualifications

The banking specialist will be a professionally-trained banker at the MBA level with at least ten years of operational experience including working with disadvantaged businesses and small entrepreneurs. International banking experience, preferably in the Middle East and North Africa, and previous project design work with AID are also required. There is no foreign language requirement, but Arabic is desirable.

D. SOCIAL SCIENTIST

The social scientist in Phase II will write the social soundness analysis of the PP, including the analyses described in the following scope of work, and work with the other team members and the design committee to establish the overall organization and administration of the proposed project.

1. Scope of Work

- a. Analyze the degree and extent of which people in the proposed project areas are familiar with the generic concepts of the health insurance and social financing (e.g., risk-sharing, prepayment). Identify insurance plans that may exist for other commercial or social transactions, particularly in the private sector. Identify and explain social and economic factors which may be associated with levels of receptivity to these concepts, for example, income and educational levels.
- b. Describe and analyze, to the extent possible, patterns of health services use by class of health care provider in the proposed project areas, by private and public sector and including non-physicians and traditional healers.
- c. Suggest specific project interventions and/or analyses which could be done to enhance the prospects of success with private sector delivery of health services and health insurance financing methods in the proposed project areas.

2. Required Reports

The social scientist will be professionally trained at least at a master's level in the social sciences, particularly in medical anthropology or public health. Some training in macroeconomics

is highly desirable. A minimum of ten years professional working experience is required; five years of which should have been spent working in villages in the Middle East and North Africa. There is no foreign language requirement, but Arabic is highly desirable.

Persons Contacted

NAME	ORGANIZATION	TITLE
ABDEL QUAYYUM	Price Waterhouse KHATTAB	Manager
BAROUDI Elie	Egyptian American Bank	Managing Director
BARSOUM Rashad S.	Al Salam Hospital	Director
BENTLEY John	Kamel Law Office	Int'l Legal Consultant
CARR, David	AID/CAIRO	Economist
COLLINS Connie	AID/CAIRO	Project Officer
CONLY Shanti	AID/CAIRO	
CROWE Paul	AID/CAIRO	Economist (Member Credit Committee)
Dr. ABDEL HAMID Mohamed	Directorat of Health, Fayoum	Director
Dr. ABDEL SALAM A. Hamad	Directorate of Health/Ismailia Govern.	Director
Dr. Ahead	Fayoum General Hospital	
Dr. ASFOUR Amany	Egyptian Junior Med. Assoc.	
Dr. ASKAR H. Abdul Salam	Ismailia Governorate	Director of Health
Dr. AZIZ Mohamed	Abu Sultan Clinic	
Dr. BARSOUM Rashid	Al-Salaam Hospital	Private Clinician
Dr. BASSILY S.	Advanced Biochemical Indust.	Chairman
Dr. BAKER Ibrahim	Fayoum General Hospital	Director
Dr. David	General Hospital, Damanhur	Director
Dr. DIAEY Samir	HIO	Chairman
Dr. EL AKHRAS Atef	FOM Group Practice	Medical Director
Dr. EL DEEB Hassan	MOH	Undersecretary of State
Dr. EL GAYAR Sameh E.	Egyptian Junior Medical Doctors Associat.	Computer Manager
Dr. EL HAKIM A. Mohssen	HIO, Alex Branch	DIRECTOR
Dr. EL KHATTAB Hind	Delta Consultants	
Dr. EL KHATTAB Sawsan	Directorate of Health, Alexandria	
Dr. EL SHARIF Sohair	Middle East Advisory Group	
Dr. EL TABBAKH Sawsan	Alexandria	Dir. Health Dept./H. Affairs Directorate
Dr. EL TAHER Fouad	Middle East Advisory Group	
Dr. EL TATAWI Nawal A.	Arab Investment Bank	General Manager, Investment Sector
Dr. Eng. EL GHOROURY M.S.	Development Industrial Bank	Chairman
Dr. EZZAT Esmat	Faculty of Medicine, S.C.U., Ismailia	Dean
Dr. FAYYAD Samir	Cairo Curative Health Organization	Chairman
Dr. SALAL Mahoud	MOH	Und. Sect./Currat. Serv.
Dr. GIPSON Reginald	AID/DRT Project	Chief of Party
Dr. HAKIM Abdel Mohsen	H.I.O., Alexandria	Director
Dr. HANDY Hassan	Ismailia	
Dr. HAMMAMY Mustafa T.	US/MOH	
Dr. Hassan	El Shohada Urban Health Unit, Ismailia	
Dr. HELMY Helmy Syed	MOH	Director General, External Relations
Dr. HUSSEN Fouad Taha	Central Administration of Pharmacy, MOH	Undersecretary of State
Dr. ISRAHIM Afaf	Sabbah Center, Suez	
Dr. ISMAIL Ashraf A.	Egyptian Junior Medical Doctors Associat.	Executive Director
Dr. ISMAIL Ayman Anwar	Egyptian Junior Medical Doctors Assoc.	President
Dr. Khalifa	HIO, Alexandria	Database Manager
Dr. KHALIFA Ismail	Ismailia Mosque Clinic	
Dr. Khalil		
Dr. KHATAB Mohey	Price Waterhouse Khatab	
Dr. LOZA Sarah	S. P. A. A. C.	
Dr. Maqdy	Mubarra, Hospital, Damanhour	Director
Dr. Mahoud	Bahiera Governorate, Damanhur	Chief Pharmacist
Dr. MAHMOUD Galal	MOH	Under Secy. Curative & Emergency Sector
Dr. MAHMOUD S.	Suez Canal Authority Hosp., Ismailia	Head of Surgery Department
Dr. MATTA Nahed	AID/CAIRO	Program Specialist
Dr. MEKAWY Said	Director of Health, Damanhour Mubarra Hosp.	Director

Dr. MOHAMED, Galal	MOH	Undersec./Curative & Emerg. Sector
Dr. MOKKTAR Samir	Misr Insurance Co.	Medical Director
Dr. Nabil	HIO, Alexandria	Manager, Computer Operations
Dr. NASR, Mounir	US Embassy - Liaison	Doctor
Dr. NEMATALLAH Mounir	Environmental Quality International	
Dr. Noor	HIO, Alexandria	Manager, Computer Operations
Dr. NUFMAN Zohair	SCU/FOM	Vice Dean
Dr. Osama	Fayoum General Hospital	
Dr. Randa	Abu Sultan Clinic	New President
Dr. RIAD Ramzy	HIO	Under Secretary
Dr. SAFTY Madiha	American University/Cairo	
Dr. SHAWKY, Abdel Tattah M.		
Dr. SHEHATA Hosni	General Organisation	Director
Dr. SHEHATA Mohamed I.	FOM Management	Consultant
Dr. TAWFIK A.	HIO, Alex	
Dr. TERRY, Julia	Suez Canal University	Project Manager
Dr. TOMQUM Yehya	HIO, Cairo	Director, Cairo Branch (Under Secretary)
Dr. UMLAND Bert		
Dr. Yehia	El Shohada Urban Health Unit/Ismailia	
Dr. Youssef	Abu Sultan Rural Health Center	
Dr. YOUSSEF Mohamed	TEAM MISR	Vice-President
Dr. ZAWAHRY	Egyptian Medical Syndicate, Cairo	Secretary General
EL MANADILU A.	TWK/	
EL ORABI Mohamed Zaki	National Bank for Development	Chairman
FLORES George	AID/CAIRO	Office of Finance & Investment
GAJEK Marion	Arthur Andersen & Co., Cairo	Partner
GAYNOR Fred	Commercial Section US Emb	Commercial Officer
GRANT Stephen	AID/CAIRO	Office of Education
HAFEZ Mohamed	Banque Misr	Director & General Manager
HARDIMAN Mark	GM Egypt SAE	Comptroller
HARRIS Gene R.	Commercial Section US Emb	Commercial Attache
HUSSEIN Fouad K.	Egypt Investment Finance Corp.	Chairman
JACOBINI Chas.	US Embassy, Cairo	1st. Sec./Econ.
KEAVENY Mike	AID/CAIRO	Office of Urban Develop. Support
LANDE Peter	US Embassy, Cairo	Economic Counselor
LEWIS Jim	Chase National Bank, Egypt	Managing Director
MAHMOUD M. M.	MIBANK	Chairman
MOLDREM Vivika	AID/CAIRO	
Ms. EL KHOLY Heba	Environmental Qua. Inter.	
Ms. FAHMY Randa	Environmental Qua. Inter.	
NASSER Kamal	Principal Bank for Development	Managing Director
PETRICH Ernie	Sevin Group	Vice President
RATHBURN Dan	AID/CAIRO	Of. of Industrial Relations
RIAD, Nelly	Misr Insurance Representative, @ US. Emb.	
SHARAWI Osama Z.	Arab Investment Bank	Manager, Loan Department
SHIHATA Alphonse	Arab Contractors Co.	Social Insurance Advisor
SINGER El Sayed M.	Central Bank of Egypt (CBE)	Deputy Governor/Foreign Dept.
TADROS Fawzia	AID/CAIRO	Program Specialist
VOKRAL Charles J.	MIBANK, Cairo	Dep Ser. Gen. Mgr
WATSON Jim	AID/CAIRO	Of. of Finance & Investment
WILDER, Bernie	AID/CAIRO	AD/HRDC
WILES JOHN	AID/CAIRO	Project Officer

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4. Local Financing of Primary Health Care in Rural Areas of Developing Countries. James A. Morrissey, Trinity University, San Antonio, Texas. October 1980.
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doc. no. 0236H

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Preliminary General Framework of the 5 year plan (1987/8 - 1991/2) Ministry of Planning and International Cooperation.

ARE/MOH Health Profile of Egypt. Study on Health Financing and Expenditures in Egypt Publication No. 10, April 1980. Principal Researcher Dr. Ramsis Abael Alim Gomaa.

ARE/National Council for Population. ... Principal Work Plan for the Population Strategy, ARE until 2000.

C. Stevens, some financing and organization considerations in extending Health Insurance to Rural Areas in Egypt 10/80.

doc. no. 0236H

INFORMATION REQUIREMENTS FROM HIOA. ORGANIZATION

1. Organization chart
2. Bio-Data of top management
3. History of HIO
 - brochures
 - general literature
4. Location of Hospitals/Offices
 - addresses
 - organization chart of each hospital
 - number of beds
 - services offered
5. Growth Plan
 - by services
 - by geographical area
 - by revenue source
 - how will they be financed
6. Patient Records/Appointments/Tracking systems.
7. Plans for computerization
8. Plans for insurance coverage

B. FINANCIAL

1. For HIO, i.e. Whole Organization
 - Revenues & Expenditures for 3 years
 - Audited Financial Statements
 - Profit and Loss Statement
 - Balance Sheet for 3 years
 - Statement of sources and uses of funds for 3 years.
 - Inventory levels
 - drugs
 - others
 - Fixed assets levels and financing methods
 - loans, credit, leases or lease/back
 - Revenue source analysis
 - Net income source analysis
 - Management Ratios
 - Cash Management Systems
2. For each Location
 - Revenue & Expenditures by location for 3 years
 - Patient Statistics
 - no. of visits
 - no. of repeats
 - by income
 - by demography
 - Revenue by source
 - Net revenue by source
 - Management Ratios
 - Monthly MIS reports for 2 years.

C. PROCEDURES

- Financial accounting manual
- Cost accounting manual
- Management manual
- Inventory control procedures
- Fixed Asset Control procedures
- Depreciation methodology
- Budgeting procedures
- Rate-setting procedures
 - government rules on fees
 - Plans on fee growth
 - Information on fees charges by the hospitals/groups
- Management information systems
- Medical practice standards
- Contracted-out services
 - What else can be contracted-out

- 
- o All basic training for HIO EDP professionals has been completed. This includes:
 - Training of trainees,
 - Training of Programmers,
 - Training of data base and system administrators,
 - Training of Unit test and system test personnel,
 - Training & Micro & Mainframe Computer Operator (Main site only),
 - Training of data entry operators (main site only),
 - Training on maintenance of data entry system and mainframe program,
 - Training on processing transactions,
 - Training on verifying and validating data,
 - Training of data encoding draft (main site only),
 - Training of users in the use of forms, system etc. (pilot sites only),
 - Training on procedures for data control.

EDP professionals managerial training and user's training at the satellites' sites have started with the start up of the implementation phase and will continue till end of February 1987.

- o EDP organizational structure and associated job descriptions have been prepared. Staffing of the structure will be completed by the end of November.
- o Pilot test has been completed successfully. All daily, weekly and monthly functions were tested successfully. Following is the test of functions tested during pilot:
 - Physical drug Inventory,
 - Drug transfer,
 - Prescription issuance and processing,
 - Prescription book inventory and transfer,
 - Beneficiary conversion,
 - I.D. card issuance (paper)

HEALTH INSURANCE ORGANIZATION
STATUS OF PROJECT
NOVEMBER 10, 1986



STATUS OF SYSTEMS

- o All reports have been tested and finalized with the user. This includes the drug code and drug quality changes requested by HIO.
- o All input forms have been reviewed and approved by the user. They are currently waiting to be printed.
- o All basic data for HIO has been reviewed and entered into the system.
- o All documentation has been prepared and delivered to HIO. This includes:
 - System documentation,
 - Program documentation,
 - Operating procedures documentation,
 - User documentation, and
 - Management documentation.

These documentations explains the current HIO MIS system.

Some of these documentations are currently being updated for changes and will be complete by November 20.

- o All required training materials have been prepared and delivered to HIO. This includes:
 - User training agenda and training materials,
 - Data entry operator training agenda and training materials,
 - Management training agenda and training,
 - Materials,
 - Computer operator training agenda and training materials.

SALIENT FEATURES OF HIO ELIGIBILITY CATEGORIES

CATEGORY	SERVICE PROVIDED	PREMIUM (BASED ON WAGES OR PENSION)	COPAYMENTS/FEEES	CONDITIONS OF ELIGIBILITY
<u>Law 79</u> Private and public sector workers Government workers (in Alexandria)** Pensioners Widows Dependants	Disease cover- age (comprehensive medical, surgi- cal, dental... services)	1% by Beneficiary 3% by Employer 1% by Pensioner 2% by Widow 0.5% by Benefi- ciary, for each Dependent	Piast. 3 stamp for new visit Copayment* on receiving ser- vices for depen- dants	In Alexandria Compulsory for all worke Optional for pensioners widows and dependants, but once enrolled they cannot disenroll
<u>Law 32</u> Government workers (mainly outside Alexandria)	Disease coverage	0.5% by Beneficia- ry 1.5% by Employer	Copayment* on receiving services	Optional to governmental departments but once enrolled they disenroll
<u>Labor Accident Coverage</u> (For all workers)	Periodic Med- ical examination for workers ex- posed to occu- pational haz- ards HIO certifies the percentage of disability Medical services	1% by employer	None	All workers in Egypt who are covered by Social Insurance Organization (SIO) whether they are medically insured or not

* Copayments are changeable. They differ according to the Laws. They are paid at service delivery sites or at HIO headquarters

** Or workers outside Alexandria having 3% in their budget for HIO services

BEST AVAILABLE COPY

- Periodic medical examinations (PME),
- Drug and beneficiary inquiry,
- Maintenance of basic HIO data (Physician, Clinic, Assignment, Zone, Disease, Drug, etc.)

Sites which participated in the pilot test included the following:

- Central store,
- Alexandria polyclinic & pharmacy,
- 20 contract pharmacies,
- PME/Medical service department,
- Gamal Adel Naser hospital & pharmacies,
- El Hadra Clinic,
- Medical Zone 2 central office,
- In-company clinics for selected employers,
- Central HIO data center (central site).

o Highlights of implementation phase includes the following:

- Implementation activity started on October 22,
- Beneficiaries for Alexandria and Hadra clinic have already been posted,
- Training activity for users in Zone 2 has already started,
- All training and beneficiary pasting by Zone 2 will be completed by November 20th,
- Implementation of Zone 1 will start on November 22,
- Drug balance loading for Zone 2 will start as soon as computers are installed at the satellite sites. Currently they are not ready,
- I.D. card printing for beneficiary posted is expected to start next week (November 22),
- Data validation and verification has already started for posted beneficiaries,



- All employers have been converted and posted from SAKRCO type to the data base,
- UPS is installed and the computer is now working for 24 hours.

A. ORGANIZATION

1. Organization chart
2. Bio-Data of top management
3. History of CHO
 - brochures
 - general Literature
4. Location of Hospitals/Offices
 - addresses
 - organization chart of each hospital
 - number of beds
 - services offered
5. Growth Plan
 - by services
 - by geographical area
 - by revenue source
 - how will they be financed
6. Patient Records/Appointments/Tracking systems.
7. Plans for computerization
8. Plans for insurance coverage

B. FINANCIAL

1. For CHO, i.e. Whole Organization

- Revenues & Expenditures for 3 years
- Audited Financial Statements
 - Profit and Loss Statement
 - Balance Sheet for 3 years
- Statement of sources and uses of funds for 3 years.
- Inventory levels
 - drugs
 - others
- Fixed assets levels and financing methods
 - loans, credit, leases or lease/back
- Revenue source analysis
- Net income source analysis
- Management Ratios
- Cash Management Systems

2. For each Location

- Revenue & Expenditures by location for 3 years
- Patient Statistics
 - no. of visits
 - no. of repeats
 - by income
 - by demography
- Revenue by source
- Net revenue by source
- Management Ratios
- Monthly MIS reports for 2 years.

C. PROCEDURES

- Financial accounting manual
- Cost accounting manual
- Management manual
- Inventory control procedures
- Fixed Asset Control procedures
- Depreciation methodology
- Budgeting procedures
- Rate-setting procedures
 - government rules on fees
 - Plans on fee growth
 - Information on fees charges by the hospitals/groups
- Management information systems
- Medical practice standards
- Contracted-out services
 - What else can be contracted-out

NOTES FOR THE SCOPE OF WORK FOR SURVEY CONSULTANTS
PHASE I COST RECOVERY FOR HEALTH PROJECT.

FOCUS: Data collection and analysis

AIM: To investigate the supply of and demand for health care provision in 3-4 locations.

LOCATIONS: 1 secondary town and 1 rural area (minimum) in each of the following areas:

1. - Ismailia Governorate
2. - Assyut
3. - The Delta (any representative town)
4. - Red Sea/Sinai *

STRUCTURE: Three sets of questionnaires will be implemented

- a) Suppliers of health care
- b) Consumers of health care
- c) Social Groups or organisations with the potential to purchase groups health care provision.

TIMING: Issuing of contracts; initial administration and questionnaire development: May 1 - June 1, 1987.
 Field Work Start Date: Immediately after Eid (early June)
 Analysis: End June
 Results Available: End June/early July.

SCOPE: The survey is a tool for project design and guidance in this regard. It should not aim to provide in-depth, statistically accurate information, but rather is a qualitative (vs. quantitative) undertaking which will fulfil that overall aim by providing broadly indicative/representative answers to specific issues. It will be limited by the constraints of

- a) time (it must be completed and results available before the start of Phase II Design);
- b) cost (in the region of US \$ 5,000 for fees, per diems, travel and report production).

For all these reasons, an attitudinal, qualitative approach to information gathering is preferred.

* If four locations are decided upon. Time and/or budget constraints may limit field work to 3 locations

CONTROLS TO BE BUILT

IN THE SURVEY SCOPE OF WORK FOR CONSULTANTS.

1. The final draft form of the questionnaire should be submitted to John Wiles and discussed with him before finalisation (prior to the pilot). It should contain questions likely to elicit answers to the key questions outlined in the scope of work.
2. A small, brief pilot study, should be undertaken
 - i) in Cairo (to avoid delays) simply to test the questionnaires on one or two of interviewees.
 - ii) in the field, for say 1-2 interviews in category 2 (beneficiaries/consumers), at a minimum. It may not be necessary to pre-test the other categories in the field, as this will have been done adequately in Cairo. This should be carried out at the start of the survey period in each location.
3. The consultants should check back with John Wiles after 2 (i) above.
4. The consultants should make contact with, and debrief John Wiles after each location has been surveyed, to discuss progress, problems, brief account of findings (verbally) before proceeding to the next location for field work. This is seen as an informal briefing, but administrative necessary to field minor problems before they become major ones.
5. A similar "clocking-in" should be done at the end of the field work period to ensure field work's timely completion.
6. The consultants' analysis and report should be made available to AID/John Wiles within a specified number of days following completion of field work (10 days-2weeks).
7. The report should contain:
 - a) an analysis of the answers to the questions as phased in the questionnaires (interview schedules);
 - b) a specific response to each of the points outlined in the (draft) key questions (attached) given to the consultants as part of their scope of work.

Location checked with JW

8. Before the start of the field work (... days ahead of start date), the consultants should familiarise John Wiles with their intentions as to:
 - a) selection of a sample frame/sample selection/sample size;
 - b) administrative procedures/logistics of carrying out the survey prior to the submission of the draft trial questionnaire;
 - c) provide him with a work plan within days of signing the contract;
 - d) indicate their understanding of who they will be interviewing in each of the 3 categories of respondents.
9. AID/John Wiles should, if feasible, obtain information from M.O.H. in advance of field work re: numbers of doctors, and numbers of MOH facilities by type, in each of the survey locations, to facilitate survey implementation.
10. Lists of physicians by location obtained from the Medical Syndicate and/or the Egyptian Junior Medical Doctors Association should similarly be made available to or obtained by the survey consultants for the same purpose.
11. Lists of PVO's plus location should should be made available (present within the Ministry of Social Affairs) to the survey consultants to facilitate the identification of community-based clinics.
12. The size of sample in each of the 3 groups to be surveyed should also be discussed with John Wiles in conjunction with (8) above.

SURVEY QUESTIONS

- I. Suppliers of Health Care: (i.e. Doctors, Pharmacies, community based health care providers, NGO's).

Purpose of Questions:

- (a) To investigate the supply of health care providers in (i) secondary towns; (ii) rural areas.
- (b) To investigate incentives/disincentives to where physicians locate/remain.

The following points should be covered in the survey: they may or may not form specific questions in the content of the questionnaire, but the survey should provide answers to each of them.

- 1. a) What are the supply characteristics of (i) individual; (ii) group practices in the private sector; the voluntary sector. Questions to individuals should identify multiple service (i.e. (i) private practice physician who also works 8-2 at MOH.)
- b) What services are offered by each of the above types of facility (an overview).
- c) What financing arrangements do they have ? (i) who funds them/how; (ii) do they accept health insurance contracts from e.g. firms/groups; (iii) do they have any prepayment/capitation schemes? What government contributions are made; are Local Development Funds being used for this purpose; can they estimate the value of subsidies; salaries & wages? Do they have schemes for cost recovery (details of schemes)?
- d) What are the characteristics of the target groups they serve (e.g. social status; income group; level of education; occupation; ...)
- e) In respondent's opinion, is the facility in which they work underused/overused/adequate to meet existing need?
- f) In respondent's view, what improvements in efficiency would be needed?

2. a) Why the different types of providers of medical care decide to establish/maintain practices in secondary towns and rural areas:

e.g.:

- financial: (lack of competition; opportunities exist to earn good money; MOH provision of free housing)
- philanthropic: (provide care to those with least access (eg rural inhabitants))
- lifestyle: (prefers rural/small town lifestyles)
- family ties: (has relatives here; posting of spouse in that location)
- medical practice style: (opportunity to work in a particular way).

b) are financial incentives alone enough to make physicians move to another location ? (eg access to credit; earning potential,)

3. Why they do not wish to establish or maintain practices in

(i) secondary towns, (ii) rural areas

- financial,
- lifestyle,
- family ties,
- medical specialisation,
- other.

4. Financial/budget information:

a) What do they charge for (a range of) different types of services (to include deliveries, lab and diagnostic work; minor/major operations; outpatient visits; inpatient stays);

b) what are they paid;

c) what are support staff paid (nurses; service personnel);

d) what are out patient charges; inpatient charges.

5. What is the point at which physicians can be induced to provide "good" service:
- a) physician is to define "good"
 - b) physician should describe (i) the working conditions which would/ do enable him or her to give good service to patients; (ii) his or her needs as a professional practitioner.
6. a) What is the physician's awareness of or receptivity to the need for management/administrative capabilities (either on the part of an individual physician or a manager/administrator who may not additionally be a physician) in running a medical practice.
- b) Has the physician received any management/administrative/business training; of what type and where.
 - c) Why was/was not he or she interested in that (eg. lack of training of this sort in medical school curricula; low status of administrators; low pay; lack of opportunities for physician/administrators in M.O.H. facilities to engage in private practice.)
 - d) What would attract physicians to a management/administrative position within health care service (eg. good pay/status; possibility of earnings in a private sector; possibility of practising medicine and administration/administration only...);
 - e) What pay incentive would be sufficient to make up for lost earnings in private practice?
7. Has the physician ever thought of joining or forming a group practice with other physicians ? (need for working definition of "group practice" to be included in question, to avoid different interpretations by individual physicians).

8. What is the physician's attitude to health insurance schemes, from:
 - a) his or her point of view,
 - b) his or her perception of the beneficiary's (consumer's) view.

9. a) Does he/she prefer to practice (i) preventive, (ii) curative medicine, or both: this question will apply most to MOH practitioners.
 - b) What would induce him/her to practice mainly or exclusively preventive medicine ?

10. What if any are the obstacles or impediments which physicians would like to see removed, that would attract them to (i) secondary towns, (ii) rural areas; or retain them in those locations.

11. Who do they see as being unable to pay for health care: (income range/employment/description or profile of those patients who in his/her view are unable to pay (i)for treatment, (ii)for drugs).

12. How many people use their services
 - a) as individual physicians,
 - b) for the facility within which they work (i) daily, (ii) yearly/seasonal fluctuations.

SURVEY QUESTIONS

II. Consumers of Health Care:

Purpose of Questions:

- (a) To determine the nature of consumer demand for health care;
- (b) To estimate willingness and ability to pay for health services;
- (c) To obtain an overview of the consumer market for medical care;
- (d) To identify target beneficiaries under the project;
- (e) To identify patterns of health care of low-income households.

A. The following points may or may not form specific questions included in the interview schedule; however, the survey should provide answers to each point, in one form or another. This should be reflected in the presentation of the survey results, which should cover each of the points below.

B. Beneficiaries/consumers of health care to be interviewed will be of two types:

- (a) Those actually using (i) an urban MOH facility, (ii) a rural MOH facility, (iii) a private clinic or private practitioner;
- (b) Low-income households who are not in the process of using a facility; to be interviewed in their place of residence.

1. a) What types of health facilities does the consumer use - MOH x type of facility; community based facility (eg attached to mosque or church); private clinic, private hospital; traditional medicine: (daya/barber/bone setter/eye healer/dogbite healer/herbalist/child healer/magico-religious healer....); pharmacy: when need arises, which facility is used (i) ever, (ii) as main source of health care.
- b) What is the pattern of usage: (eg MOH then private/local then MOH or private/regional center; or bypasses MOH altogether).

2. What is the cost x type of facility, both:
 - direct costs: (eg payment for treatment; hospital bed; for drugs, for any payments to get priority in queue for service or access to a particular physician, drug, or information from support personnel on e.g. illness or use of drugs, etc.);
 - indirect costs: (eg lost income; waiting time to get access to care; travel cost);
 - a) to patient;
 - b) to family:(eg those who accompany/stay overnight with patients may also give up (i) time, (ii) income, (iii) have to buy food for self plus patient, etc.)

3. Why does consumer use the particular or facilities he/she does:
 - a) Is the availability of free drugs an incentive to use MOH facilities,
 - b) Cost factor,
 - c) Level of care provided by e.g. private doctor or traditional practitioner (may be regarded as qualitatively better for reasons such as cost; community involvement; availability in time of need; etc).
 - d) Hours of service; convenience of location; trust.

4. What is the point at which the consumer:
 - a) is prepared to pay and for what services: acute illness (e.g. child with high fever; accident); chronic illness (arthritis); other (toothache; eye obstruction);
 - b) assumes care received is worth paying for (vs "free" MOH care).
 - c) what illness did they actually pay to have treated when a member of household last become ill?

5. a) If the consumer needs advice on e.g. how to use a particular drug, or which drug to take/what to do in case of illness, who does he/she consult ? (e.g. self-prescribed remedy bought from pharmacy; advice from pharmacist/doctor/traditional practitioner/nurse/social welfare worker/relative (who)/other/media.
b) which is seen as the "best" (and how is this defined) by the consumer?
6. What would be the consumer's "ideal" health facility/practitioner: e.g. someone who spent more time examining them; talked more and gave more information re. illness or treatment; cleaner surroundings; more/less drugs prescribed, etc....)
7. If consumers do not use a particular type of facility, why not: (cannot afford it/do not believe it to be useful/other).
8. a) Do consumers perceive some types of facility as better sources of preventive care than others; of curative care ?
b) What role do they see the different types of providers as playing: i.e. for what illness/treatment do they go where/why.
9. What amounts of money (payment) do they regard as acceptable amounts to pay for:
 - a) a visit to a general physician/a specialist.
 - b) drugs.
 - c) a minor operation (define....)
 - d) a major operation (define....)
 - e) a bed (inpatient/day)

f) follow up visits (generally free even in private sector).

Differentiation would need to be made by type of care: i.e. public - MOH; community; private.

10. If consumers do not use a particular service, is it because they cannot afford it, or because they do not see it as useful (x service, x reason).

11. a) Request respondent to self-assess his/her level of health (excellent, good, fair) then ask about the following:
 - b) Frequency of use (times per year?) of types of facilities.
 - c) (i) where consumers go if they fall ill, (MOH; economic clinic within MOH facility; private; community clinic; within MOH facilities: specify type of facility, e.g. rural unit/regional hospital, etc.)
(ii) why (it is in the same district/town/area where consumer lives; quality of care is better; cost is less, etc...)

12. What is the level of care/evaluation of service received by consumers in e.g. the past (year) good/fair/poor (x reason x facility).
 - a) Does the consumer know about the existence of health insurance?

13. a) Does the consumer's household have anyone in it with health insurance ? Who/where from; attitude to it/cost; does it cover dependents; would they like it to ?
 - b) would they like to have it?

14. a) Priority ranking allocated to health services by consumer, in relation to paying for/access to :
 - water
 - food
 - shelter
 - employment
 - health
- b) How strong a felt need is health care provision ?
15. Total amount spent on health care in the past year/per household; if possible, broken into government (MOH)/private sector health facility expenditure: (a ratio would do if respondent is unable to give precise amount.)
16. Household's' monthly income (total - all sources).
17. Household's total monthly expenditure.
18. Number of income earners and size of households.
19. Regularity of flow of income; regularity of employment/job security of earners.
20. Tenure status of dwelling; amount paid per month for housing/food/water (where applicable), type of dwelling (building materials, land size, finish of buildings as measure of income level).
21. Occupation of head of household.

SURVEY QUESTIONS

III. Social Groups:

A. To include:

- Farmers Groups/Rural Cooperatives
- University students (via unions?)
- Formal or Informal Womens' Association
- Teachers' Associatioins
- Any other associations (ethnic/religious/occupation-based....)
present in survey location.

Purpose:

To determine the groups' ability to form or use existing social groupings or associations to request (solicit) or buy into health care on a joint basis, or a level which would not be available at a similar cost/quality of care, to them in their individual capacity.

1. What is their:

- a) interest
- b) ability to form or use existing social organisational structures to commission health care from e.g. (i) a group practice with a contract to provide the members of the group with health services, (ii) a health insurance organisation (a) existing, e.g. HIO, (b) future e.g. the new interest in health insurance being shown by some private sector insurance companies such as Al Shark?

2. a) What is the extent/nature of members knowledge about health insurance schemes ?

- b) How do they feel about whether it should cover e.g. the insured only or his/her dependents also ?

3. a) Do they have (i) any knowledge or understanding or; (ii) interest in pre-paid health care?
b) What are their attitude to (i) risk-sharing, (ii) pre-payment.
c) Have they (as an organisation) any previous experience with the management of collective funds, informal loans, etc. If so, what.
4. Have they or their organisation any knowledge of financing any activities e.g. a social security/widows & orphans type fund which could serve as a basis for learning how to finance health care provision for members ?
- 5 a) Would they be receptive to one or more of their representatives receiving managerial/financial training towards this end ?
b) How/what;
c) What do they see as constraints/advantages of this.
- 6 What is the extent/nature of their perceived need for health care provision
a) for themselves,
b) for their members,
c) for their dependents.
i.e., is it a "felt need" of a type or to an extent that would lead them to act in some way to obtain it?
7. What do they regard as an affordable "due" or subscription from their members (i.e. the amount of money contributed by each) towards a health care fund of some sort ?
8. In their capacity as a group, have they ever thought of initiating a request for health care provision ?

Appendix H

Field Trip Details

Ismailia:

- El Shohada - MOH Urban Unit serving one quadrant of the Ismailia city district located in a residential area on quiet street. Coverage includes 120-150,000 people in a geographic area 13 x 5 kms. Hours are 8:00 - 1:00. The unit offers MCH services (including immunizations, ORT, FP, Antenatal care), occupational Medicine consultation, Dental care twice a week, Hypertension clinics, and serves as the official morgue for the governorate. Facilities include: 1 Designated MCH room with ORS chairs, 1 Pharmacy/Chemistry room, 1 locked, unused OR, 4 Consultation rooms, 1 Dentists Office with chair, some Medical Instruments, and broken drill, 1 Accounting/Birth/Death Registration Room, 1 Forensic/Autopsy Room. (Physicians report that a significant proportion of their time is to devote to procurement of supplies. Use is reported to include 8-10 birth/month and almost 300 death autopsies per month. No medical records or service statistics were readily available.
- GP Private Practice - is the first solely private practitioner in the city providing 24 hour service in two clinics and at the business sites of contracted companies. The downtown clinic is located in an apartment building with waiting room, 2 consultation rooms ... X-ray room, Office, 1 room with 2 beds, a WC.

Equipment includes: Sphygmometer, Ent kit, Resuscitator (with additional build for children), blood analyzer kit, fibrolator, microscope, cautery, urine/stool analyzer kit, plastic disposal syringes, band dressing, suture supplies, sterilizer, voltage regulator, refrigerator for vaccines, X-ray machine.

Staffing is provided by one receptionist (non-med ...), one part-time X-ray technician, and the doctor. No RN is employed due to shortage expense, difficulties in assuming job satisfaction. The MD sees approximately 30 patients/day.

- Mosque clinic established with a LE 20,000 loan from the governate and staffed by Suez Canal University, MOH, and Suez Canal Authority physicians. It is the only mosque clinic in Ismailia. Staff include (2) Pediatricians, (1) Obgyn. (1) Dermatologist/STD/VD specialist; (1) GP, (1) cardiology, (1) Pathologist, (1) Anesthesiologist, (1) Army MD, Several Surgeons, (4) Lab and Medical Technicians, (1) Partime Rehabilitation Physiotherapist and (1) X-Ray technician. Facilities include: a large waiting room area with snack bar. Several offices for administration, a lab room, pharmacy well-stocked, all labelled, and organized on shelves by type of medication with reirigerator, (8) consultation rooms shared by physicians on rotating basis, (1) physiotherapy room with exercise equipment, changing rooms, (1) X-Ray room, (10) beds in 3 rooms, available for brief post-op stays, (1) operating room, immaculately clean, stocked with "essentials", sterilizer, refrigerated blood bank for transfusion, IV hooks, back up generatin centrifuge, overhead lamp, 2 operating tables, crub sink, two sessions/day 1:00-4:00 and 6:00-9:00 p.m. daily. Over 500 operations performed in the clinic every year. The clinic's OR facilities are higher standard than those available in many private clinics a well as MOH.

the clinic shares half the cost of additional capital equipment with the physician in the form of a loan. Equity ownership remains with the physician. Among the planned investments are (i) ultrasound equipment for radiologist, (ii) endoscopy for OR. surgeons.

Group Practice located in a multi-story apartment building near residential area. Bright neon lights announce evening working hours 5:00 - 9:00 p.m. The facility is staffed by 40 physicians who are also members of the Suez Canal Faculty of medicine. Specialists include inter....., dermatologists, general surgeons, neurologist, OB/GYN, Physiotherapist/Rehab. Two to three physicians share each apartment office. Once c..... is designated reception/medical records area. waiting space is limited, forcing patients to crowd the narrow hallways star..... There is an operating room and 22 in-patient beds. The group plans to expand into a larger building with sufficient space for dental and pharmacy services.

Abu Sultan Rural Health Center occupies a large complex in a rural area near Suez. Clinic is open 8:00 - 2:00 for outpatient care, and 24 hour availability for in-patient/emergency care. Staff includes (5) resident doctors, (5) licensed doctors with consulting GP specialists from Ismailia. Nurses X-Ray technicians, (1) pharmacist, and (1) part time accountant, Services offered include immunizations on Mondays, MCH, pharmacy, lab/diagnostic work for parasitic and infectious diseases. Some outreach and extension work is undertaken through mothers classes, and school health program routine urine/stool testing. Facilities include (6) consultation rooms, several offices, (1) special training center equipped for TV and video recorder, space, separate kitchen. The operating room is not yet finished.

Sabban Center, Suez is located in a two-storey structure in a residential complex. The upper floor was recently renovated with AID project assistance to Suez Canal University, as an economic clinic downstairs the MOH unit offers a free clinic 8:00 - 1:00 p.m. daily seeing almost 200 patients on outpatient basis staffed by MOH, Pediatrician, Nutritionists OB/GYN, part time dentist, and General Practitioners. The clinic is one of the training sites for 20 - 25 Suez Canal University/Faculty of Medicine students. Facilities include large central waiting area, (8) consultation rooms, (1) clinical pathology lab - upgraded for student practice... work, (1) Pharmacy area.

The upstairs facility opened one month ago, to serve the lower middle and middle income population in Suez. A collaborative effort between the MOH and the Faculty of Medicine in Ismailia was complicated by strong resistance from the Director of General Hospital who is also the President of the local Medical Syndicate, competition. Consequently, the clinic is maintaining a low profile and continuing to offer practice opportunities to experienced MOH physicians. The new economic clinic will have 7 to 8 specialists with lab facilities. Hours are 1:00 - 5:00 p.m. with MOH personnel on duty Wednesdays

and Thursdays and the Faculty on Sunday, Monday, Tuesday, Wednesday staffing includes (6) physicians and (1) managing director. The GP practitioner who work in the morning clinic downstairs are also seeing patients later in the afternoon economic clinic upstairs. Some fees are set according to technical GP LE LE/3.00 is for consultation visit, specialists LE 5.00 and Masters LE 7.00. The plan is to return 65% of collected fees to the physician and 35% to the health Center. It is too preventive to estimate revenues from economic clinic.

Damanhur :

Damannur Teaching Hospital is both the district's general hospital and a teaching facility, receiving funds from the general organization of teaching and educational Hospitals and Institutes. It was established in 1965, with additional annexes constructed in 1975 for pediatrics, neurology, and kidney dialysis, training and education center in 1980, and a new casualties/emergency medicine ward in 1986. Most major specialist care is available, including Orthopedics, neurology, kidney dialysis (11 units), ENF, OB) ..., Pediatrics, Burn Unit, ICU, Plastic Surgery, Cardiology. An economic clinic for outpatient services is open 8:00 - 12:00 for 25 p, and a LE 2 fee for services 12:00 - 3:00. Governate approved Out-patient laboratory fees are X-Ray LE 3 Urinalysis 50 p. Blood Analysis LE 1. These fees are recognized as symbolic sharing of cost burden. Half the revenues are returned to hospital as a means to improve services, and the other half to physicians, ancillary staff as small incentive payments primarily middle income people are the economic treatment services, despite summer time waiting lists. The over income people are also served in free care wards by the same physicians.

The facility maintains 650 in-patient beds, setting aside 90 or 20% of the beds for paying patients as permitted by law -, occupancy rates for paying beds is close to 100%. On a contract basis, (i) the local syndicate pays LE 550/ year for each of 3 first class beds designated for MC use; and (ii) HIO pays LE 750/year for each of 55 beds, including full treatment and physician fees.

Fees for operations depend on the severity of the illness and the class of preferred accommodation as listed below

	<u>Minor</u>			<u>Moderate</u>			<u>Major</u>			<u>Specialist</u>		
	<u>Surg.</u>	<u>Anes.</u>	<u>Opening OR</u>	<u>Surg.</u>	<u>Anes</u>	<u>OR</u>	<u>Surg.</u>	<u>Anes</u>	<u>OR</u>	<u>Surg.</u>	<u>Anes</u>	<u>OR</u>
1st	15	4	3	25	7	4	40	12	6	120	12	6
2nd	10	3	3	20	4	4	30	10	6	80	10	6
modified												
2nd	8	2	3	15	3	4	20	8	6	60	8	6

though fees do bring in additional revenues, the overall operating budget is strained. Exact figures are not available. Officials support the idea of cost recovery and are waiting for government approval to raise fees to a more economic level. Parallel with that development, they recognize a need for continued of fee structures affordable to the people.

Christian clinic was established six years ago as a charity clinic for the poor in an upstairs church apartment. It is operated by a nun/RN sent from Franciscan Missionary order with support from (2) semi-skilled assistants. She provides first aid and PHC consultation services between 7:00 - 12:00 daily, asking for \$0.50 fee. Medications available are begged, borrowed and bought. A referral network of private physicians willing to accept low or no fees is established. Occasionally, the nurse refers patients to the MOH for further care. The clinic provides care primarily to the indigent, regardless of religious denomination.

Mubara Hospital is a 40 bed private hospital established in 1983 to provide high quality surgical services to the residents of Beheira/Damanhur. The hospital is built on land donated by 3 physicians in return for shares in the hospital. Initial equity included the LE 40,000 value of land, and LE 80,000 cash purchase of shares in the corporation: A LE 700,000 loan from the National Bank for Industry and Development was secured in 1980 to build and equip the facility Market feasibility studies were conducted to demonstrate adequate ... flow prior to release of loan funds. The hospital is staffed by (4) full-time resident physicians, (2) full-time, RNs, (1) Pharmacist, several medical technicians spot inspections, imposes strict hygiene standards, encourages continuing education particularly for RNs and insists that all patients be treated kindly.

Salaries for staff are relatively high. RNs are paid LE 120/no on average, with incentive pay increments for the evening shift. All the nurses are Damanhur residents. Medical residents earn LE 120/no, in addition to free room and board, as well as LE 10 per patient from the attending private physician.

Facilities include two fully-equipped operating rooms, out-patient consulting rooms, pharmacy, kitchen (immaculately clean), (1) delivery room, (1) X-Ray room, (1) endoscopy and laboratory, and dormitory quarters for (4) residents. Admitting privileges are currently restricted to surgical specialists medical specialty services are not offered at the facility. The shareholders want to retain a reputation for sustaining good health.

Fees for hospital services were approved by the governate Health Office Syndicate representative after low-cost (ordinary) beds were set-aside for more middle-income patients. Neither the hospitals nor the governate reviews physician fees.

A table of fees is listed below:

Table 1:
OR Fees

	Minor Surg.	OR RM	Moderate Surg.	OR RM	Major Surg.	OR RM	Complex Surg.	OR RM
1st	35	10	100	15	120	25	200	30
2nd	25	8	70	10	100	15	150	20
high 3rd	15		50		80		120	

Half of the beds are "ordinary" class, with 3 patients in a non and accommodation for an accompanying person. These beds have the highest occupancy rates 60-75%.

Table 2:
Daily Room Rates

1st	2nd	High	3rd	Ordinary
LE 30	25	20		7.5

The hospital does not maintain contracts with employer groups for prepaid services. The Director reports that these groups generally prefer the lower-cost teaching hospitals as referral providers.

El Fayyum - General Hospital part of the MOH system, serves the district of Fayyum (PPP. 1.5 million) with specialists in-patient and outpatient care services. Detailed information on hospital operations was readily available from the Director, who is committed to managing the hospital well. The 465 bed facility is staffed by (275) physicians, (228) registered nurses, (190) support staff. Specialists include (38) general/Gastroenterologist, (25) Internal Medicine, (18) Urogoloy, (13) Ent, (12) laboratory, bactendo... Hemotologist, clinical pathologist, (8) pharmacist, and (8) chemist/water sanitation.

New speciality services have been added with a view to competency based training, equipment maintenance, and sustainability. Within the facility neonatal and intensive care units, endoscopy equipment, and a new kidney dialysis unit are operating examples of excellence in management. This extends to financial decisions as well. Some services that receive high patient flow, charge nominal fees to cover costs and subsidize the free-care porivions. Other services, such as endoscopy are heavily subsidized to improve access to the care needed by lower income people.

Other financial detail for 1986 is listed below.

Source of funds:

1. MOH

Per/Bed Subsidy (395) LE	180,000
wages & Salaries	1,017,000
out-patient Lab/Diagn	252,000

2. Paying Beds (70) 145,000

Occupancy rates are reported by month, though some figures may include out-patient/day use of beds:

Jan.	74%	July	120
Feb.	73	August	84
March	89	Sept.	86
April	89	Oct.	81
May	78	Nov.	77
June	70	Dec.	72

Fees for economic beds are LE. 1.8/night for first class, LE 1.20/night for second, LE 180/night for notified second. The physicians are instructed to rely on the integrity of patient when determining ability to pay. If a patient says she cannot afford to pay, they are not turned away. The MOH officials estimate that 30-40% of the patients can afford a pay. Generally, medicines are in short supply, so patients purchase their medications at nearby pharmacies.

Admissions to the free charge beds for 1986 were 21,856 and accounted for 127,74% bed days.

Fieldtrips - Checklist

Clinics

What's provided/services

What PP go there for

How many PP

Hours open

Number and type of staff

Payment or

" for what

How Finance: Land

Building

... ..

Other

Drugs

Maintenance

Support Services

Capital equipment

Doctors/Physicians.

Why they do not located in sec. cities and rural areas

- financial (capital)
- lifestyle (culture/education)
- familyties
- medical specialization

rural: - Less competition/rural areas

generally prefers rural
family
practice style

- Private Clinics/MD's - Trends & Magnitudes.
- Governate Policies re: Economic Clinics.

Appendix I

Case Study Example of El Riba (Islamic) Financing

An association of doctors which has about 11,000 members has arranged lines of credit with two banks - Nasser Social Bank and a branch of Banque Misr that practices the el riba (i.e., non-interest charges). From Nasser Social Bank their line is LE 3.7 million, while from Banque Misr the line is for LE 5.0 million. The two lines are ten year revolving credits which are guaranteed by Mohandes Insurance who are counter-guaranteed by this association. The association has their member doctor participants in turn guarantee them. The premiums charged by Mohandes are seven percent per mile. The premiums are passed onto the participants who also pay the association a one percent flat administrative fee.

Under the scheme participants can purchase medical equipment on the local market, either through distributors and agents or through trade fairs sponsored by the association. With the purchase order in hand the participant makes a ten percent down payment and pays 30 monthly installments of the entire invoice value of the equipment purchased. Bad debts of the association have been few with a ratio of three doctor in one thousand being defaulters. As of the date of the interview, the association had utilized approximately LE 3.9 million out of the LE 8.7 million revolving loan facility.

APPENDIX J

Summary of Feasibility Study:
Estimated Financial Analysis
Of ABC National Hospital*

A. NAME

ABC National Hospital

B. Location and Area

ABC Governorate on an area of one feddan. Buildings shall occupy 2,000 square meters. It is estimated that the land shall be provided by the governorate at a complementary price.

C. Objective

Providing outstanding and advanced medical services similar to those provided by General Hospital in the capital. The cost for such services should be adequate and less than those of Private Hospitals in Cairo and Alexandria. This National Project shall accordingly be a stereotype for recurrent similar projects in the different governorates.

The main aim is, hence, to satisfy the need for more hospitals and raise the standard of medical services in Egyptian governorates.

D. Proposed main divisions

- External clinic
- X-Ray and Ultrasonic
- Laboratory
- Morgue
- Intensive Care
- 60 beds
- Maternity
- Major Operating Room
- Secondary Operation Room
- Kidney Dialysis Unit
- Probing Unit
- Other Non Medical Services

*This is an actual Feasibility Study presented to an Egyptian Bank in 1986. For banking confidentiality, the source and client cannot be revealed.

E. Estimated Investment Cost and Financing

1. The total investment cost is estimated for LE 3,225,000 broken down as follows:

Operating Capital	LE	60,000
Foundation Fees	LE	40,000
Contingency for increase in prices upon implementation (20%)	LE	350,000
Fixed Assets	LE	<u>2,775,000</u>
Total Investment Cost	LE	3,225,000

Financing is proposed to be distributed as follows:

Founding Doctors	LE	1,300,000	40%
Shareholder Banks' Loans	LE	1,130,000	35%
General Loans	LE	795,000	*25%

*For example, this component of the financial package could be AID co-financing for any imported Medical Equipment.

2. Establishment and Equipment

Land	LE	40,000
Infrastructure	LE	160,000
Buildings	LE	800,000
Medical Equipment	LE	1,285,000
Other Equipment	LE	344,000
Furniture	LE	81,000
Transportation	LE	25,000
Generator	LE	<u>40,000</u>
Total Fixed Assets	LE	2,775,000

Assumption:

1. Depreciation and Amortization

Annual amortization during the first five years is estimated for LE 200,000; decreasing to LE 142,000 as of the sixth year.

2. Operational Capacity

The Operational capacity for the first year and second year is estimated to be 50% and 75% Consecutively. Full capacity shall be achieved as of the third year.

F. Estimated Annual Revenues

First Year	LE	675,000
Second Year	LE	1,012,000
Third & following years	LE	1,350,000

G. Estimated Annual Operational Cost (Before Amortization)

First Year	LE	390,000
Second Year	LE	533,000
Third & Following Years	LE	652,000

H. Estimated Net Annual Profit

First Year	LE	65,000
Second Year	LE	259,000
Third Year	LE	478,000
Fourth Year	LE	478,000
Fifth Year	LE	478,000
Sixth & Following Years	LE	334,000

Appendix K

PRIVATE SECTOR CREDIT AND TERM FINANCE

Private Enterprise Credit (No. 263-0201) is a project which combines commodity import credit and term financing. One component of this project, a credit guarantee fund, is currently under development and will provide guarantees to banks for loans to small-scale firms. The project's two existing components include:

- Private Sector Commodity Import (0201.1) (previously Production Credit Project)
- Project Finance Facility (0201.2) (previously Private Investment Encouragement Fund)

These two project components are described on the following pages. As other credit and finance needs are determined, additional components will be added under the Private Enterprise Credit umbrella project.

PRIVATE ENTERPRISE CREDIT
PRIVATE SECTOR COMMODITY IMPORT PROGRAM*
AID PROJECT NO. 263-0201.1

Summary and Purpose

The Commodity Import Program - Private Sector is designed to expand investment in Egyptian private sector enterprises. The project provides short and medium-term credit to the private sector to finance the importation of goods and equipment from the United States. This program is governed by Circular No. 1 of 1986, as from time to time amended, which is issued by the Ministry of Planning and International Cooperation (MPIC).

Who is Eligible?

Those eligible for assistance include individual Egyptian entrepreneurs and private sector firms, including those that are organized under Law 43 of 1974 and its amendments and those importing for their own use. Intermediaries or traders are not eligible to participate in the program.

What Commodities May be Imported?

Importers who are purchasing U.S. source and origin commodities for their own use may import any item which is eligible as shown in the AID Commodity Eligibility Listing.

What are the Transaction Limits?

The minimum transaction size is \$10,000. The maximum transaction size is \$750,000 for capital equipment and \$350,000 for other types of goods. A single client may use up to \$1.1 million in a 12-month period (i.e., the maximum limit for capital and non-capital goods combined).

*Note: This project is a continuation and expansion of USAID's previous Production Credit Project.

What are the Credit Terms?

- All repayments are in Egyptian pounds calculated at the Commercial Bank Rate declared by the Central Bank of Egypt (CBE), currently in the range of 1.35 L.E. = U.S. \$ 1.00.
- The down payment amount is 25 percent of the Letter of Credit Value.
- Repayment schedule for the balance of the Letter of Credit value is as follows:

Up to five years for capital goods;
Up to 18 months for non-capital goods.

Actual credit terms are set by the participating bank.

- Interest is charged in accordance with the Central Bank of Egypt schedule of rates, currently:

13 percent maximum for industrial sector
13 percent to 15 percent for services sector

Where Can I Apply for Funding under the Commodity Import Program - Private Sector?

At any one of the Participating Banks listed below:

- Arab Investment Bank
Banque du Caire
- Bank Misr
Bank of Alexandria
- Chase National Bank
Development Industrial Bank
- Egyptian American Bank
Export Development Bank
- Misr Iran Development Bank
National Bank of Egypt
- Misr International Bank
National Bank for Development

What are the Procedures?

- The Egyptian importer submits an application to any of the twelve participating banks.

The application must include a reasonable number of proforma invoices from U.S. suppliers, normally three.
- The proforma invoices should refer to appropriate U.S. Department of Commerce Schedule B Numbers, to be provided by the supplier.
- The participating bank reviews the application for conformance with Circular No. 1 of 1986 and applicable AID regulations and also examines the credit worthiness of the client.
- The participating bank forwards the approved application to USAID/Cairo for review and concurrence.

- Within 60 days of receipt of the USAID concurrence letter, importer pays down payment amount to the participating bank which in turn opens a Letter of Credit through the U.S. Correspondent Bank in favor of the selected U.S. supplier.
- The U.S. supplier ships the commodities and submits the documents specified in the Letter of Credit to the U.S. correspondent bank for payment. Required documents include AID Form 282 and Form 11, the latter must be approved by AID in Washington, D.C. prior to shipment of commodities.
- Upon arrival of the goods in Egypt, the importer arranges for customs clearance and inland transportation.
- The importer makes subsequent payments of principal and interest to the participating bank in accordance with agreed upon credit terms.

PRIVATE ENTERPRISE CREDIT
PROJECT FINANCE FACILITY
AID PROJECT NO. 263-0201.2

Purpose: To stimulate the growth and modernization of the Egyptian private sector by providing medium and long-term foreign exchange credit to new or significantly expanding private sector enterprises.

Available to: Egyptian and joint venture companies operating in Egypt. (See Terms and Conditions below).

Description: The Fund offers medium to long-term credit to finance the importation of U.S. equipment and essential services for new private sector productive enterprises and for the expansion and modernization of existing productive facilities. Financing is provided on a co-financing basis through authorized participating banks. Banks are obliged to share in the risk of the loan on an equal basis with the Fund.

Procedures: Potential borrowers contact one of the authorized participating banks (listed below) to discuss financing requirements and eligibility based on criteria (presented below).

Borrower prepares and submits feasibility studies and other required supporting documents.

Participating bank reviews the technical, financial and economic feasibility of the project and, if satisfactory, presents its recommendations to the Fund's Advisory Board at the Investment Authority.

- Potential borrowers contacts one of the authorized participating banks (listed below) to discuss financing requirements and eligibility based on criteria (presented below).
- Participating bank reviews the technical, financial, and economic feasibility of the project and, if satisfactory, presents its recommendations to the Fund's Advisory Board at the Investment Authority.
- Advisory Board reviews and approves the proposed loan and presents documentation to USAID for concurrence.
- A Letter of Commitment is opened by USAID with a U.S. bank at the Egyptian participating bank's request.
- The participating bank then opens Letters of Credit with U.S. equipment suppliers chosen by the borrower.

Note: This project is the revised Private Investment Encouragement Fund (PIE Fund). The terms "PIE Fund" and Project Finance Facility ("PFF") are used interchangeably here.

Terms and Conditions (Criteria):

1. Eligible Activities: All productive enterprises contributing to the economic development of Egypt.
2. Ineligible Activities: Projects involving the production, processing or marketing of sugar, palm oil or citrus for export; Projects which establish or expand the production of any commodity for export if the commodity is likely to cause substantial injury to U.S. producers; Projects involving the importation of the following commodities or related services (as defined in the AID Commodity Eligibility Listing): military equipment, surveillance, policy and law enforcement equipment, abortion equipment, luxury goods, gambling equipment or weather modification equipment.
3. All procurements financed by AID under this project shall be done in accordance with good commercial practices. Solicitations by the importer for quotations and offers shall be made uniformly to a reasonable number of prospective suppliers and all quotations and offers received, whether or not specifically solicited, shall be given consideration before making an award.
4. Egyptian Ownership Not less than 30%
5. Government or Public Sector Ownership Not to exceed 30%
6. Minimum PFF Loan Amount Not less than \$300,000
7. Maximum PFF Loan Amount Normally, not to exceed 20% of total project investment or \$5 million, whichever is less. Exceptions may be granted on a case by case basis.

(Total project investment is calculated utilizing current market rate between Egyptian pounds and the U.S. dollar).

8. Bank Co-Financing Loan Amount Bank must share in the risk of the loan on an equal basis with the Fund through provision of equal bank term loans or combination of equity shares and guarantees. (Short-term, working capital loans not included in calculation.)
9. Maximum Debt/Equity Ratio 3/1.

10. Interest Rate Based on Central Bank interest rate schedule (currently 11-13 percent for industrial loans and 13-15 percent for service loans).
11. Currency Conversion for Calculated at the Commercial Bank Disbursement and Repayment Premium Rate currently at 1 \$U.S. = 1.35 L.E. Rate of exchange for the term of the credit is fixed upon execution of loan agreement.
12. Currency Conversion for Generally, market rate. Calculations in Feasibility Studies.
13. Internal Rate of Return (IRR) must exceed the effective interest rate on all loans.
14. Economic Rate of Return (ERR) must be positive.
15. Environmental Review Form to be completed and each question answered. An answer of "not applicable" is insufficient without an explanation. Details for environmental review, as well as necessary forms, available at the bank.
16. PFF Repayment Period Generally, same as bank's loan, but not to exceed 36 months.
17. PFF Grace Period Generally, same as bank's loan, but not to exceed 36 months.
18. FPP Fees: Commitment fee of one percent per annum on undisbursed loan amounts; management fee of one percent of the amount of the loan, paid one time only; and other fees negotiated by bank.



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