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Volume VI

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**Analysis of the  
Institutional  
Capacity for Health  
Policy Reform in  
Egypt**

*September 1996*

*Prepared by:*

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Partnerships  
for Health  
Reform



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# Abstract

Technical Report 5, Volume VI is an institutional analysis of the health sector players most critical to Egypt. The report assesses the competence of each organization in performing its current role, and its potential capability to readily undertake its proposed new role, under the reform. The analysis also identifies some of the changes needed to enhance the reform's feasibility, prosperity, and sustainability.

Internal reports and external audits were used to complete the analysis. Due to the scarcity of information available from these documents, however, a framework for institutional assessment was also developed, which provides methodologies and a comprehensive set of organizational indicators that can be used to produce a more detailed analysis.

Both the United States Agency for International Development and the World Bank encourage restructuring the roles of major health sector players; separating finance, management, and service delivery; improving the sector's allocative and technical efficiency; developing the Ministry of Health and Population's and the Health Insurance Organization's institutional capacities; and reforming health manpower policy. In addition, the following changes were recommended: (1) the Ministry of Health and Population should determine the reform agenda and create an in-house, institutional framework to coordinate policy development and implementation; (2) planning and policy development roles of all key health sector players must be strengthened and more clearly defined; (3) the Ministry of Health and Population and the Health Insurance Organizations must undertake organizational analysis and restructuring; and (4) the ministry should have more control over health care financing and budget allocation, while the Health Insurance Program should be granted more autonomy to pursue the expansion of population coverage and other initiatives.

Although there are tremendous institutional problems confronting Egyptian health care organizations, the future of health sector reform appears positive, and its implementation should be encouraged. In fact, the diversity and intensity of the existing problems are ideal for a sector-level approach to reform. In addition, a reform will likely redefine the roles of health sector organizations, and this redefinition may, in itself, solve many of the institutional deficiencies with little need for further intervention.

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# Acronyms

<b>CCO</b>	Curative Care Organization
<b>CME</b>	Continuing Medical Education
<b>CRHP</b>	Cost Recovery for Health Project
<b>DDM</b>	Data for Decision Making Project
<b>GIS</b>	Geographic Information System
<b>GOE</b>	Government of Egypt
<b>HIO</b>	Health Insurance Organization
<b>HMIS</b>	Health Management Information System
<b>HMO</b>	Health Maintenance Organization
<b>IMF</b>	International Monetary Fund
<b>MCH</b>	Maternal and Child Health Care
<b>MIS</b>	Management Information Systems
<b>MOF</b>	Ministry of Finance
<b>MOHP</b>	Ministry of Health and Population
<b>MOLA</b>	Ministry of Local Administration
<b>MOP</b>	Ministry of Planning
<b>NGOs</b>	Non-governmental Organizations
<b>NHA</b>	National Health Accounts
<b>PHC</b>	Primary Health Care
<b>PIO</b>	Pensioner's Insurance Organization
<b>PM</b>	Preventive Medicine
<b>PVOs</b>	Private Voluntary Organizations
<b>SIO</b>	Social Insurance Organization
<b>TA</b>	Technical Assistance
<b>THO</b>	Teaching Hospital Organization
<b>UN</b>	United Nations
<b>UNFPA</b>	United Nations Fund for Population Activities
<b>USAID</b>	United States Agency for International Development
<b>WB</b>	World Bank
<b>WHO</b>	World Health Organization



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## Preface

This report is one in a series of six analyses conducted by the Partnerships for Health Reform Project for the Health Office of the United States Agency for International Development/Cairo between June and September 1996. The Partnerships for Health Reform was requested by the United States Agency for International Development/Cairo Mission to conduct these analyses to support and inform the design of its upcoming Health Sector Reform Program Assistance, which is intended to provide technical and financial assistance to the government of Egypt in planning and implementing health sector reform. The analyses examine the feasibility and/or impact of a set of health sector reform strategies that were proposed jointly by the Ministry of Health and Population and the United States Agency for International Development. These proposed strategies are shown in the following table.

Technical Report No. 5 contains all six analyses plus a summary. The analyses and their corresponding volume numbers are as follows:

Volume I	Suggested National Health Sector Reform Strategies, Benchmarks, and Indicators for Egypt
Volume II	Economic Analysis of the Health Sector Policy Reform Program Assistance in Egypt
Volume III	Social Vulnerability Analysis of the Health Sector Policy Reform Program Assistance in Egypt
Volume IV	Legal Analysis of the Health Sector Policy Reform Program Assistance in Egypt
Volume V	Analysis of the Political Environment for Health Policy Reform in Egypt
Volume VI	Analysis of the Institutional Capacity for Health Policy Reform in Egypt
Volume VII	Summary of Analyses

<b>Proposed Health Sector Policy Reforms</b>	
<b>Specific Strategy</b>	<b>Generic Strategy</b>
<b>1. ROLE OF THE MINISTRY OF HEALTH AND POPULATION (MOHP)</b>	
<b>1.1 Rationalize the role of the MOHP in financing curative care</b>	
1.1.1 Stop the construction of unnecessary hospitals and set strict guidelines for the completion of facilities under construction	Improve the allocation of the MOHP investment budget
1.1.2 Transfer existing hospitals to other parastatal organizations	Allow hospital autonomy
1.1.3 Expand cost recovery in government facilities	Expand cost recovery
1.1.4 Allow private practitioners to use the MOHP facilities	Allow private practitioners to use government facilities
1.1.5 Allow hospital autonomy	Allow hospital autonomy
1.1.6 Support hospitals based on efficiency indicators such as on a per capita, per bed basis, etc.	Use alternative budget allocation formula for MOHP hospitals
1.1.7 Examine the cost recovery of curative services at the primary health care (PHC) level	Expand cost recovery
<b>1.2 Strengthen the role of the MOHP in the provision and increased share of financing preventive medicine (PM) and primary health care</b>	
1.2.1 Use cost-effectiveness analysis to identify a package of PM and PHC services to be supported by the MOHP to which every Egyptian is entitled	Increase the cost effectiveness of the MOHP's program
1.2.2 Increase emphasis on Maternal and Child Health Care (MCH) programs	Increase emphasis on MCH programs
1.2.3 Provide incentives for the health care providers to specialize in PM, PHC, and family medicine	Increase the cost effectiveness of the MOHP's program
1.2.4 Do not separate curative services at the PHC level	Continue to provide curative services in PHC facilities
1.2.5 Ensure adequate allocation of resources, e.g., personnel	Improve the allocation of the MOHP recurrent budget

<b>Proposed Health Sector Policy Reforms</b>	
<b>Specific Strategy</b>	<b>Generic Strategy</b>
<b>1.3 Reform the MOHP personnel policy</b>	
1.3.1 There should be no guaranteed employment	Reduce the overall number of the MOHP personnel
1.3.2 Develop guidelines for the MOHP personnel, and apply them to redistribute personnel based on needs assessment	Improve the allocation of the MOHP recurrent budget
1.3.3 Reduce the overall number of the MOHP personnel	Reduce the overall number of the MOHP personnel
1.3.4 Provide incentives for the MOHP personnel to serve in underserved and remote areas	Improve the allocation of the MOHP recurrent budget
<b>1.4 Develop the MOHP capacity for national health needs assessment, sectoral strategic planning, and policy development</b>	
1.4.1 Adapt the national health information systems, including Geographic Information Survey (GIS) for planning and policy decision making	Improve the allocation of the MOHP investment budget  Improve the allocation of the MOHP recurrent budget
1.4.2 Prioritize the allocation of the MOHP resources based on needs using health status indicators	Improve the allocation of the MOHP investment budget  Improve the allocation of the MOHP recurrent budget
1.4.3 Create incentives for other health care providers to function in underserved areas	Provide incentives to private health providers to function in underserved areas
1.4.4 Target government of Egypt (GOE) subsidy to poor and indigent populations	Improve the equity of the MOHP subsidies
1.4.5 Use cost-effectiveness analyses in determining the essential health services	Increase the cost effectiveness of the MOHP's program
<b>1.5 Develop the MOHP role in regulation, accreditation, and quality assurance of health services</b>	
1.5.1 Develop and adopt National Health Standards of Practice and health facility accreditation	Develop and adopt national health standards and accreditation
1.5.2 Establish a policy of continued physician licensing and continuing medical education (CME)	Establish CME and physician licensing

<b>Proposed Health Sector Policy Reforms</b>	
<b>Specific Strategy</b>	<b>Generic Strategy</b>
<b>2. NATIONAL SOCIAL HEALTH INSURANCE PROGRAM</b>	
<b>2.1 Ensure the viability of the Health Insurance Organization</b>	
2.1.1 Do not add any new groups of beneficiaries to HIO	Eliminate the HIO's deficit
2.1.2 Eliminate the current HIO deficit	Eliminate the HIO's deficit
2.1.3 Reduce the proportion of the pharmaceutical costs	Redefine HIO's benefits
2.1.4 Unify the existing health insurance laws into one law	Unify existing health insurance laws
2.1.5 Change the HIO's legal and legislative framework to ensure its autonomy	Ensure the HIO's autonomy
2.1.6 Develop premium based on actual costs using copayments and deductibles	Redefine the HIO's benefits
2.1.7 Identify and adopt an affordable health benefit package(s)	Redefine the HIO's benefits
<b>2.2 Transform the HIO into a financing organization</b>	
2.2.1 Stop constructing new HIO hospitals	Transform the HIO into a financing organization
2.2.2 Develop a plan to sell or transfer to other private or parastatal organizations, in phases, the existing HIO hospitals, polyclinics, and general practitioner (GP) clinics	Transform the HIO into a financing organization
2.2.3 Develop different mechanisms to subcontract all health service providers, including private and MOHP hospitals	Develop alternative reimbursement mechanisms for the HIO's contracted services
2.2.4 Allow beneficiaries to choose service providers	Transform the HIO into a financing organization
<b>2.3 Expand social health insurance coverage coupled with adequate administrative and financing mechanisms</b>	
2.3.1 Design and develop a single national health insurance fund for universal coverage	Expand social insurance coverage
2.3.2 Develop a well defined standard package of benefits that every citizen is entitled to receive	Redefine the HIO's benefits
2.3.3 Separate financing from provision of services	Transform the HIO into a financing organization
2.3.4 Ensure legal and financial autonomy of fund	Ensure the HIO's autonomy

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# Acknowledgments

This work was made possible due to the wealth of information provided by a large number of colleagues at the Egyptian Ministry of Health and Population, the Health Insurance Organization, and the United States Agency for International Development in Cairo. I am especially indebted to Mrs. Mellen Tanamly and Dr. Sameh El Saharty of the United States Agency for International Development/Cairo, who provided valuable input to the design of the report and made available a lot of useful documentation.

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# Executive Summary

Health sector reform is likely to revisit traditional roles assumed by major health sector players in Egypt. An institutional analysis is needed to assess (1) the competence of the specific institution in performing its current roles to determine whether these roles should be expanded, sustained, or limited under the reform and (2) the potential capability of the institution to undertake new roles envisioned under the reform.

Nowadays, the two most significant health policy questions facing Egypt revolve around restructuring (1) the current role of the government in health care and (2) the future role of the national Social Health Insurance Program. The institutional capacity of the Ministry of Health and Population (MOHP) and the Health Insurance Organization (HIO) will thus be critical success factors for any health sector reform likely in Egypt. Other institutions that can affect the reform, but to a lesser extent, include related government ministries, other parastatal organizations, advisory councils and committees, professional syndicates, and international donors organizations.

A summary of the results of the institutional analysis is found in Table 3. The analysis, which assessed strengths and weaknesses in the structure, functioning, and culture of these organizations, indicated the following:

- ▲ The MOHP has many institutional deficiencies, including a fragmented structure that lacks the institutional framework for performing strategic roles in sectoral analysis, policymaking, regulation, and accreditation; underdeveloped management and information systems; and a highly centralized authority structure. The MOHP and its affiliated facilities are overstaffed, with geographical and functional misallocation of human and other resources. There is a strong recognition of the need for reform, yet a seemingly weak political will to undertake it. The MOHP's strengths, however, include some successful programs and an eager and well trained staff who, if targeted, mobilized, and effectively led, can become catalysts for change.
- ▲ The HIO suffers from the lack of an institutionalized structure to undertake policy development and strategic planning; absence of the middle management tier; and lack of autonomy to set premium rates, define benefits package, contract services and set up copayments for services. The HIO has no institutional capacity to implement cost controls or set standards for managing and monitoring its many branches. The nascent managed care structure of the HIO and its growing mandate to provide health care to a large portion of the population, however, can clearly play an important role in health sector reform. Compared to Curative Care Organization (CCO) or MOHP facilities, which do not finance health care, the financing features of HIO give the organization potentially great economic power to act as a vehicle for reform.
- ▲ The CCO is not run as an integrated provider organization but operates as a loose confederation of hospitals without a centralized corporate management structure or any centrally administrated efforts to manage utilization and control costs and improve quality throughout all member hospitals. The location of CCO facilities tends to be highly concentrated, limiting its potential for growth into a nationwide system. If a transfer of ownership of the MOHP hospitals is proposed as part of the reform, the CCO does not have the institutional capability to run these hospitals.

- ▲ Other government ministries playing a role in health sector policymaking in Egypt include the Ministry of Planning, the Ministry of Finance, and the Ministry of Local Administration, which are involved in planning, budgeting, and resource allocation. The MOHP, though notionally the national health policymaking agency, has little control over health care financing and budgetary discretion. The ministries of Planning and Finance do not have the technical expertise to determine health sector priorities and needs, and their interministerial budget allocation process allocates funds to government units based on the claims made by each of these agencies separately, without consideration of health sector priorities in totality.
- ▲ Health sector advisory bodies including the Health Committees of the National Assembly, the Shura Council, and the Supreme Council for Health, lack either the technical capacity to analyze policy options or the legislative power to authorize them, or both. Their roles, accountabilities, and relationships to each other and to other health sector players are not well defined. Their structure and composition undermine their potential for effectively setting national priorities for health care.

The role of international donors in initiating and promoting health sector reform in Egypt is significant. The United States Agency for International Development (USAID) has been by far the most active in the policy area. USAID has previously supported the Egyptian government through projects complimentary to the health sector reform process and is currently assessing the feasibility of a health sector Program Assistance. The World Bank (WB), which, to date, did not have significant health sector activity in Egypt, recently initiated health policy discussions with the minister and may get involved in a proposed European Union health sector investment project. The reform priorities of both the USAID and the WB are similar. Both emphasize revisiting roles and accountabilities of major health sector players; separating financing, management, and service delivery; improving the allocative and technical efficiency of the sector; developing the institutional capacity of the MOHP and the HIO; and reforming health manpower policy.

In addition, the analysis identified the following institutional changes that are needed to enhance the feasibility, prosperity, and sustainability of health sector reform in Egypt:

- a. The minister and senior MOHP staff should state the reform agenda themselves, commit to it, and set up an institutional framework (e.g., a Health Policy Unit) within the MOHP to coordinate policy development and implementation tasks. It is also important that the reforms be prioritized and that agreement on the common minimum agenda, rather than a whole menu of broad range reforms, be reached.
- b. The policy analysis/development and sectoral planning roles of the key health sector institutions, especially the MOHP and the HIO, must be strengthened through organizational development, capacity building, and technical assistance.
- c. The MOHP must define its roles vis-à-vis a national health policy and development agency, regulatory agency, and service delivery agency. The HIO must define its roles as a financing, management, and/or provider organization.
- d. Both the MOHP and the HIO must undertake organizational analysis and restructuring to set up their design along decentralized lines, promote middle management responsibility, and clearly delineate the strategic and operational organizational levels.
- e. The MOHP should have more control over health care financing and budget allocation. The role of other ministries should be one of coordination and integration.

- f. The HIO should be granted more autonomy to expand population coverage, set premium rates, define benefits packages, contract services, and set up copayments in a manner consistent with its financial viability.
- g. The HIO could benefit from improvements in its provider operations, especially in utilization management/review, quality control, and contracts monitoring.
- h. The roles of the various agencies, committees, task forces, and advisory bodies involved in health sector policymaking and their interrelationships must be clearly defined to avoid overlaps and conflicting reform priorities. International donor efforts should be similarly coordinated.
- i. The design of donor health policy support programs should be sensitive to the key factor that constrains the sector's ability to move forward in policy reform, specifically, the current absence of an institutional capacity to analyze alternative policies.

The analysis concludes by emphasizing that the magnitude of institutional problems facing Egyptian health care organizations should not discourage health sector reform initiatives. In fact, it is the very diversity and intensity of the problems that make the "sectoral-level" approach to reform mandatory. An attempt to correct all structural, functional, and cultural deficiencies identified by this analysis through "organizational-level" interventions, approaching each individual institution in isolation, is not likely to be feasible or affordable in an Egyptian context. A sectoral reform is likely to redefine the roles and accountabilities of the various health sector players and then modify health policies and organizational conditions accordingly. Often, the redefinition can in itself treat many of the underlying institutional deficiencies, with no or little need for further intervention.

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# 1. Introduction

The objective of the institutional analysis is to assess the organizational structure, functioning, and culture of institutions and parties that have (or are likely to assume) a role in (a) financing, organizing, and providing health services (e.g., the Ministry of Health and Population [MOHP], the Health Insurance Organization [HIO], and the Curative Care Organization [CCO]) and/or (b) proposing, analyzing, or evaluating health policies (e.g., the MOHP, health committees, and donors) under the prospective sectoral reform, so as to assess the capability of the Egyptian health sector to effectively formulate, implement, and sustain policy reform. In addition, the analysis will identify those institutional changes that are viewed as prerequisites for feasibility and sustainability of the reform.

The report comprises five main sections:

1. An overview of the Egyptian health sector structure and a description of the organizations that are involved, their functions, and their interrelationships.
2. A description of past patterns and future trends in the role of the government in health care.
3. The core institutional analysis of the main organizations involved in the reform. The discussion addresses both organizational strengths and weaknesses in relation to each of the following dimensions: (a) institutional structure (e.g., organizational design, human resources); (b) institutional functioning (e.g., management systems, program/service delivery); and (c) institutional culture (e.g., leadership style, political will). In addition, the required organizational changes are identified. The MOHP and the HIO are discussed in detail, due to their significance to any prospective reform.
4. A description of the role of international donors in initiating and promoting health sector reform in Egypt, with special emphasis on the prospective United States Agency for International Development (USAID) and World Bank (WB) programs.
5. Conclusions and recommendations regarding overall institutional considerations for feasibility, successful implementation, and sustainability of a health sector reform in Egypt.

The Institutional Feasibility Matrix, shown in Table 3, summarizes the institutional requirements necessary for the implementation of the specific policies and strategies presented under the national health sector reform agenda proposed by the USAID for its health sector Program Assistance.

Since the scope and depth of this analysis have been limited by the scarcity of internal reports and external audits of the structural and operational deficiencies of pertinent organizations, a more thorough instrument, *Framework for Institutional Assessment*, is presented in Annex II. The instrument relies on documented institutional analysis methodologies and utilizes a comprehensive set of organizational indicators. It is recommended as a tool to conduct more detailed institutional analyses that are deemed necessary before the actual reforms begin.



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## 2. Overview of the Egyptian Health Care Sector

Although the nation's constitution promotes a major role for the state in ensuring medical care for all Egyptians, nonetheless, as in many other countries and despite sizable public investment in health care provision, a pluralistic health sector has developed in response to an increasing gap between what the state can provide and popular demands.

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### 2.1 Health Sector Structure

As shown in Figure 1, there are three main “sectors” in Egypt’s health care system:

- ▲ The government sector comprises the MOHP and other ministries that provide health services (e.g., Ministry of Education, Ministry of Defense, and Ministry of Interior).
- ▲ The public sector includes a variety of government-owned parastatal institutions including the HIO, the CCO, and the Teaching Hospital Organization (THO), in which government ministries have a controlling share of decisionmaking.
- ▲ Private sector provision of services covers everything from traditional midwives, private pharmacies, and private doctors, to private hospitals of all sizes. Also in the private sector is a large number of non-governmental organizations (NGOs) that provide services, including religiously affiliated clinics and other charitable organizations.

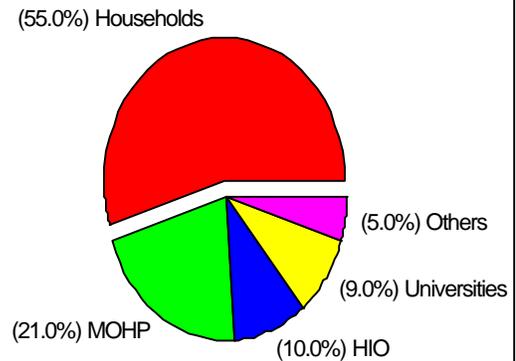
**Figure 1. Structure of the Egyptian Health Sector**



## 2.2 Health Sector Financing

Egypt spends 4.7 percent of its national income on health care. Government spending on health is low, and private spending is relatively high. Figure 2 shows the sources of funds for health as estimated by the MOHP Department of Planning and the Data for Decision Making (DDM) project for the 1990/91 fiscal year. The MOHP accounted for 2 percent of total health spending (down from an estimated 31 percent in 1978) and, in stark contrast, household out-of-pocket expenditures accounted for 55 percent. Ninety percent of this amount goes for ambulatory treatment of illness and only 10 percent for expenditures on inpatient treatment. In ambulatory spending, two-thirds goes for the purchase of pharmaceuticals.

Figure 2: Sources of Health Care Spending in Egypt, 1990/91



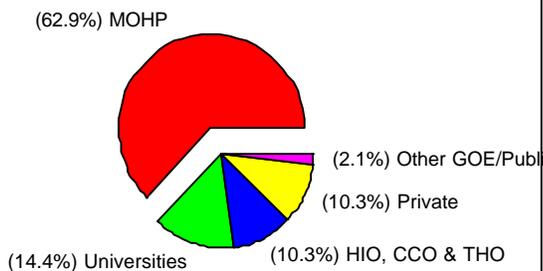
Source: MOHP-DDM (Berman et al, 1995)

## 2.3 Health Sector Investment

The government is a major investor in the health sector. Over the past decade, government and public investment has comprised an average 83 percent of total investment in health (MOHP: Five Year Plan 92/93–96/97). The private sector, however, has been growing rapidly, and at a much higher rate than that of the overall health sector growth.

## 2.4 Health Services Provision

Figure 3: Distribution of Hospital Beds, Egypt 1992



Source: MOH-IDC, Kemprecos, 1992

Overall, the government and public sector institutions finance and provide most of Egypt's hospital-based curative health care and all its public health services. In contrast, the private sector provides most ambulatory care. Of the total hospital beds in the country in 1992, more than 60 percent were under the MOHP and just over 10 percent in the private sector. The distribution of hospital beds by provider is shown in Figure 3.

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## 2.5 Health Services Utilization

As with provision, the utilization of Egypt's health care services is sharply dichotomized. Inpatient treatments in government and public sector institutions account for almost 85 percent of all hospital admissions. In stark contrast, almost 61 percent of ambulatory visits are in the private sector.

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## 2.6 Health Manpower

The MOHP employs more than 170,000 medical, paramedical, and technical personnel, almost 58 percent of the total registered medical manpower in the country (MOHP: Basic Health Statistical Data, June 1995). If all support personnel were added to this number, the MOHP is likely to be the employer of more than 500,000 persons. This does not include personnel employed in the other government-owned establishments, such as the HIO, the CCO, university hospitals, and military and other organizations. When these personnel are added, the government emerges as the largest employer in the health sector.



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### 3. The Role of the Government in Health Care

Since the constitution pronounced *free medical care* as a basic right for all Egyptians, the government of Egypt (GOE)<sup>1</sup> has been the sole provider and financier of all primary/preventive and most inpatient curative care in Egypt.

The MOHP's share of the total GOE budget is estimated at 2.4 percent, whereas its share of total national expenditure on health is estimated at 21 percent. A major part of the MOHP budget maintains and runs hospitals and curative services, and a small part is allocated to preventive and primary care and maternal child health (MCH) services meant for rural and urban poor populations.

Both the MOHP's budget allocation and its overall role in financing health care have declined significantly over the past two decades. The MOHP leverage to bargain for additional resource allocations has steadily decreased, compared with other ministries. The structural adjustment program has reduced the GOE's resource position vis-à-vis allocation for social service sectors in general, and health services in particular. The MOHP efforts over the last few years to raise funds through user fees have not yet contributed much in terms of funding.

The rise in average life expectancy and literacy rates, however, has put pressure on the GOE MOHP to meet the demands of the Egyptian people for more and better quality health care. Although portions of Egypt's population suffer from diseases largely attributable to poor public health, it is mainly the growing demands for curative services from higher income, better educated, and aging groups of the population that are responsible for the strains on the system. The demands of these individuals stem primarily from chronic diseases, and from the expectations of this population for secondary and tertiary inpatient care and for outpatient care delivered by physician specialists.

Accordingly, the MOHP ran a downward course of increasing responsibilities and decreasing resources, resulting in deterioration of government services, growth of private sector provision, and loss of potential health gains.

Although the rhetoric of the vision of the welfare state continued to dominate many political and social circles in Egypt, a fundamental change in public perception of the GOE's role in social protection was initiated. The sustainability of its current role in funding and providing all types of health care is already being questioned by many officials. Gradually, a new long-term vision for the role of the GOE surfaced and was included in MOHP plans and reports. This vision is centered around:

- ▲ A shift of GOE allocative priorities so that public funds are used for (i) the highest priority preventive health programs that cannot be financed privately and (ii) the poorest segment of the population that cannot afford to pay for its own medical care.

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<sup>1</sup>Although the government sector includes health-related activities of several ministries, the terms "Government of Egypt" and "Ministry of Health and Population" are used interchangeably, since the MOHP represents the largest constituent of the government sector.

- ▲ Generation of new resources and vehicles for health care provision through implementation of user fee systems, enlargement of the role of private sector in the care of those who can afford to pay, and expansion of health insurance schemes.
- ▲ Upgrading the MOHP's technical efficiency through management improvements, human resource development, and control of GOE waste.

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## 4. Institutional Analysis of Major Health Sector Organizations

Health sector reform is likely to involve changes in traditional roles assumed by major health sector players. The capability of those institutions to effectively assume their reformed roles is requisite to the feasibility, successful implementation, and sustainability of any reform. Accordingly, assessing the institutional capacity of those organizations with a significant role as health policy analysts, makers, or implementers and also health services financiers, organizers, or providers is of paramount importance.

In Egypt, the two most significant health policy questions revolve around restructuring (i) the current role of the GOE in health care and (ii) the future role of the social health insurance program. The institutional capacity of the MOHP and the HIO will thus be critical success factors for any health sector reform in Egypt. Other institutions, that can affect the reform but to a lesser extent, include related GOE ministries (e.g., Ministry of Planning [MOP], Ministry of Finance [MOF], Ministry of Local Administration [MOLA]), other parastatal organizations (e.g., the CCO), advisory councils and committees e.g., Supreme Health Council, Health Committees of the National Assembly, and Shura Council), and international donor organizations (e.g., the USAID and the WB).

A comprehensive framework that tends to capture multiple facets of institutional measurement is outlined in Annex II. The framework addresses institutional capacity as having three broad dimensions: (1) institutional structure, which captures organizational resources, design, and components; (2) institutional functioning, which captures organizational systems, policies, and procedures, and impact as defined by program/service delivery; and (3) institutional culture, which captures additional elements, such as organizational values, political will, and leadership style.

Full application of this institutional assessment framework for the purposes of this analysis has been constrained by the lack of information and documentation on many of the aspects of institutional capacity of Egyptian health sector players. The analysis will, however, attempt to utilize as many aspects of the framework as possible to assess the major health sector players. Both the organizational strengths and weaknesses in relation to each of the institutional dimensions will be discussed, together with an identification of the required organizational changes. The MOHP and the HIO will be discussed in greater detail, due to their significance to any prospective reform.

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## 4.1 The Ministry of Health and Population

### 4.1.1 Institutional Structure

The organization of the MOHP comprises the central headquarters and governorate-level health directorates.

The headquarters' organization is extensive and headed by the minister. Headquarters functions include planning, supervision, and program management. The population portfolio, which was formerly an independent ministry, was recently added to the MOH. Approximately 13 undersecretaries in charge of various departments report to the minister. All functions are divided into five broad sectoral divisions, which include central administration for the minister's office; curative health services, population, and family planning; basic and preventive health services; and administration and finance. On average, about 30 to 35 functional areas and specialized units, headed by the director generals and directors, are grouped under each sectoral area headed by an undersecretary.

The sectoral level model is replicated at each governorate level. The governorate-level health directorates are responsible to the MOHP for technical functions, but administrative and day-to-day activities are functions of the governorate administration, supervised by an undersecretary.

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#### 4.1.1.1 Structural Weaknesses

- ▲ The organization structure at the MOHP headquarters is complex, including various sectors, departments, and units vertically organized with little communication and interaction across the boundaries.
- ▲ Organizational roles and responsibilities lack clarity. Authority levels are not well defined and tend to be centralized at the minister's level.
- ▲ The middle management level is weak.
- ▲ The health directorates, who are principal actors at the governorate level, have little policy or decisionmaking authority. They administer services based on the decisions made at the headquarters level and have very little autonomy to mobilize local resources or set local priorities.
- ▲ The human resources management function suffers from the classical ailments of the Egyptian governmental sector: surplus employment, geographical and functional maldistribution, meager pay scales, inadequate incentive schemes, lack of output-based performance evaluations, and inadequate personnel training at all levels. In addition, there is no institutional capacity to undertake manpower planning, job design, or career planning.

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#### **4.1.1.2 Structural Strengths**

Structurally, the MOHP is the agency with primary responsibility for the nation's health, a sectoral position that qualifies it to play a leading role in health sector reform.

While the middle management level in the MOHP is weak, there are a few eager and well-trained staff at various levels in different departments who, if mobilized and given a meaningful role and responsibility, can serve as effective change agents.

#### **4.1.2 Institutional Functioning**

The MOHP operations reflect its many complex and conflicting roles and responsibilities as policymaker, regulator of public and private providers, and financier and direct provider of preventive and curative health services.

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#### **4.1.2.1 Functional Weaknesses**

- ▲ There is no clear delineation between the MOHP's strategic and operational functions. Moreover, the MOHP demonstrates overindulgence in micromanagement and bureaucratic functions at the expense of sectoral and national roles.
- ▲ While the MOHP places much emphasis on its health care delivery function, it also has a minor role in critical functions, such as health care financing, provider regulation, and accreditation.
- ▲ The MOHP has no institutional capacity to undertake policy analysis and development functions.
- ▲ The strategic planning, investment management, cost accounting, and budgeting functions of the MOHP are weak or nonexistent.
- ▲ MOHP operations do not utilize modern management systems or well-defined policies and procedures.
- ▲ The MOHP decision-making process is mostly subjective and rarely information-based. Management information systems (MIS) are underdeveloped.
- ▲ Delivery of health services in general, and curative services in particular, is inefficient and of poor quality.

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#### **4.1.2.2 Functional Strengths**

- ▲ In spite of its many problems, the MOHP has delivered some successful programs, such as those in the area of child survival and family planning. These programs, being relevant to the local needs, have established some level of accountability at the governorate level.
- ▲ The MOHP has succeeded in setting up one the most extensive primary health care (PHC) networks in the developing world. The chain starts at the grassroots level with a network of rural health units that links to rural health centers or hospitals. The network allows for 99 percent of the population to live within a four-kilometer radius of any given health facility. The current minister is committed to upgrading these facilities and involving local communities and NGOs in delivering their services and programs.

#### **4.1.3 Institutional Culture**

The key policy and decisionmaker in the MOHP has always been the minister of health himself. Since 1936, when the MOH came into existence (the predecessor to the MOHP), there have been between 36 to 40 ministers. The strength of the minister depends upon the constituency he represents. The present incumbent is a dynamic and aggressive political leader, a leading surgeon, and professor. He was chairman of the Health Committee of the Shura Council and has credibility within the political party. He comes with a mandate of his own to focus on PHC and extend the scope of health insurance and reform it.

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#### **4.1.3.1 Cultural Weaknesses**

- ▲ The decision-making process and leadership function are highly centralized at the minister's level. Participatory decisionmaking is the exception rather than the rule.
- ▲ There is lack of continuity due to frequent leadership changes. No effort is taken to establish an MOHP structure to sustain reforms and build institutional capacity.
- ▲ Although there is strong recognition of the need for reform, the political will to undertake it appears weak.
- ▲ There is reluctance by managers to take full advantage of even the limited autonomy they are allowed within the system.

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### 4.1.3.2 Cultural Strengths

- ▲ The MOHP has some senior and junior staff at various levels who are eager to make a difference. If targeted, mobilized, and effectively led, they can become catalysts for reform.
- ▲ There is a considerable awareness of the need for reform in the MOHP that was generated by the Cost Recovery for Health Project (CRHP) interventions and other similar efforts. This awareness sets the groundwork for the next step, which is the systematic identification of reform priorities and policy options.

### 4.1.4 Institutional Requirements for Reform Feasibility

- ▲ For health policy reform to be feasible, the minister and senior MOHP staff should state the reform agenda themselves, commit to it, select few areas for execution, and set up an institutional framework within the MOHP to undertake policy planning, development, and implementation tasks. The MOHP will need technical assistance (TA) for this and will rely on this USAID and other donors to provide this support.
- ▲ It is essential that the MOHP undertake an analysis of its role vis-à-vis a national health policy and development agency, regulatory agency, and service delivery agency.
- ▲ A sustainable capacity to direct health sector reform and analyze health policy issues (e.g., financing alternatives, managed care, capitated payments and insurance, governmental subsidies, the role of the private sector) should be built into the MOHP and institutionalized in a Policy Analysis Unit.
- ▲ The MOHP should undertake organizational analysis and restructuring to modify its set up and leadership function along decentralized lines, promote middle management responsibility, and clearly delineate the strategic and operational, organizational levels. These modifications are needed to internalize changes, provide initiative, and meet the requirements of an institution expected to initiate a sectoral reform.
- ▲ The MOHP should review policies concerning guaranteed employment of physicians and other health personnel and base job stability on accredited credentials and job performance.
- ▲ The MOHP should capitalize on the growing awareness and support for health reform within its organization and at the highest levels of government.

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## 4.2 The Health Insurance Organization

The Egyptian Health Insurance Organization was created after the enactment of the Health Insurance Law in 1964, with the mission of covering the entire Egyptian population within 10 years. Coverage was provided to government, private, and public sector employees, pensioners, and widows. In 1993, the Student Health Insurance Program was introduced to cover more than 14 million students, thus increasing the total beneficiary population from 6 to 20 million. Recently, the People's Assembly began discussions to extend coverage to children less than 5 years old—an action that would increase the beneficiary population by some 9 million, roughly to include 55 percent of the Egyptian population. There is considerable speculation that the HIO will be asked to extend its coverage to the entire population of Egypt in the near future.

The HIO is a parastatal, government-owned entity under the Egyptian MOH. As such, the final decision on major policy, structural, and managerial changes rests within the ministry. As a government-owned entity, the HIO is governed by governmental decrees and laws.

The HIO acts as both a payer and provider of health care. The HIO's revenues come from four primary sources: the Social Insurance Organization (SIO), as a proportion of employee's salaries; the Pensioners' Insurance Organization (PIO), as a proportion of pensioners' allowance; a fixed amount of school registration fees, as a contribution to the Student Health Insurance Program, and the GOE subsidy. The HIO also receives some revenues in the form of co-payments, primarily from the GOE employees.

### 4.2.1 Institutional Structure

Organizationally, the HIO is divided into eight branches, distributed throughout the country, which contain a number of hospitals, polyclinics, and clinics. The headquarters' organization has departments for statistics/registration, finance, medical services, and medical supplies/drug control. In addition, it has a number of medical zones. Each zone is responsible for supervising clinics and polyclinics, but not hospitals in its geographical area.

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#### 4.2.1.1 Structural Weaknesses

- ▲ As with many organizations in Egypt, the HIO has grown over the years, but its organizational structure failed to cope with its complex management tasks.
- ▲ The headquarters' organization structure shows lack of a middle management tier, ill-defined accountability lines, unmanageable span of control, and lack of skills required for carrying out its diverse mission.
- ▲ The HIO does not have an institutionalized structure to undertake strategic planning and policy development. Its cost-accounting and containment functions are undeveloped, and its MIS is rudimentary.
- ▲ The health care structure of HIO is fragmented with no continuity between direct and indirect care. The scope of benefits and standards of care must be clearly defined.

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#### 4.2.1.2 Structural Strengths

- ▲ The large number of beneficiaries enrolled under this single insurance organization and its growing mandate to provide health care to a larger portion of the population renders the HIO a significant role in shaping the future health care delivery system of Egypt.
- ▲ Compared to the CCO or the MOHP facilities, which do not finance health care, the financing features of the HIO and its nascent managed care structure give the organization potentially great strategic and economic powers as a vehicle for health sector reform.
- ▲ The USAID is currently providing TA to the HIO for organizational reengineering at the headquarters level. These efforts will help create an institutional framework for undertaking strategic planning and policy development activities.

#### 4.2.2 Institutional Functioning

The HIO functions as both a payer and provider of health care. As a payer of health care, the HIO functions as a staff model health maintenance organization (HMO), running a prepaid managed care plan, whereby it provides comprehensive curative and preventive benefits to its beneficiaries through its hospitals, clinics, and physicians. With the addition of the students to HIO beneficiaries, however, the organization has found it necessary to contract services from other provider organizations, using a variety of payment mechanisms ranging from fee-for-service to time-based reimbursement. As a provider of health care, the HIO manages 119 polyclinics and 29 hospitals. Its outpatient care structure has gatekeepers to promote more efficient use of resources, with general practitioners referring patients to more resource-intensive specialists or hospital care as needed.

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#### 4.2.2.1 Functional Weaknesses

- ▲ As a large organization spread throughout the country, the HIO lacks standard policies and procedures for managing and monitoring its branches and their affiliated facilities, which has impaired the quality and cost of HIO services.
- ▲ At present, all major decisions regarding services, purchasing, finances, and the direct operation of health care facilities emanate from the HIO headquarters. The centralized operational style allows the headquarters very little time for its strategic and policymaking roles and allows the branches no autonomy or incentive to run efficient operations.
- ▲ The HIO costs are high, its benefits are, in theory, very comprehensive, and its premiums, which are set by the GOE, are low and not adjustable to inflation. As a result, the HIO is running in deficit, and its cumulative deficits to date are estimated at LE 300 million. In addition, the HIO is reimbursed through a capitated system, whereby the premiums it receives are fixed for each beneficiary and not based on the individual's likelihood of using health care.

- ▲ As a provider, the HIO has no effective mechanisms to manage and control the utilization and costs of its services, thus contributing further to its financial losses. Failure to control drug consumption in particular is causing the HIO significant financial losses.
- ▲ A large portion of HIO beneficiaries consider its services to be of inferior quality and refuse to use the facilities.

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#### **4.2.2.2 Functional Strengths**

- ▲ The HIO is unique in Egypt as a large staff model HMO, with capitated financing, gate-keeping, and referral functions already in place. This gatekeeping/referral function, whereby general practitioners in ambulatory care are used to provide access to specialists through referrals, is important in reducing unnecessary specialty and inpatient care.
- ▲ Although HIO contracts with other providers lack the utilization management features of service delivery under managed care arrangements, the organization has the potential to improve its contracting capabilities, use its economic power in the health care marketplace, and shape its contracts so that contractors act as group model HMOs in providing services.
- ▲ Effective MIS are being developed for the HIO through USAID TA under the CRHP. In addition to their value to the HIO, the systems have potential applications throughout the Egyptian health care system.

#### **4.2.3 Institutional Culture**

The HIO is now, more than ever, under pressure from within its own organization and from outside entities (the MOHP, the GOE, the National Assembly, etc.) to expand its beneficiary coverage, balance its deficit, and contain the rising costs and diminishing quality of its care. These pressures have reflected upon the organization's environment.

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##### **4.2.3.1 Cultural Weaknesses**

The HIO, notionally a parastatal organization, functions as a GOE entity with no control over setting premiums, fixing benefits, contracting services, and setting up copayments.

The minister for Health and Population has technical oversight over the organization. Over the years, however, the HIO completely lost its autonomy due to its financial and management weaknesses. The chairman of the HIO, for all practical purposes, reports to the minister. This has frequently caused considerable friction and tension and affected the working of the organization.

The recent, frequent leadership changes caused confusion and uncertainty about the future in the HIO. In addition, there is lack of clarity regarding the organization's changing mission and its growing mandate.

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### 4.2.3.2 Cultural Strengths

- ▲ The HIO staff have higher morale, stronger organizational commitment, and more political will for reform than the MOHP staff. Personnel believe that, with changes, the HIO can become the most important health sector player in the country.

### 4.2.4 Institutional Requirements for Reform Feasibility

- ▲ While the HIO has been seen as a major vehicle for financing medical care in Egypt, its current condition suggests that the GOE should be cautious about its expansion, unless major improvements in revenue generation, financial control, management, and quality can be achieved.
- ▲ The HIO needs to define its roles as a financing, management, and/or service provision organization.
- ▲ The HIO should be given autonomy to decide on premium structure, fix benefits packages, impose co-payments, and contract services in a manner consistent with its financial viability.
- ▲ The more than 30-year-old regulatory framework under which the HIO operates must be carefully reviewed and modified, or new laws, and/or decrees, must be enacted because of the large additional beneficiary base now under the HIO.
- ▲ The structure within the HIO headquarters, especially that dealing with the cost factors and the generation of revenue, must be reviewed and changed to meet the new challenges. These changes will require complete and unqualified support from the MOHP.
- ▲ The HIO's institutional capacity for policy analysis and development and sectoral planning must be strengthened through management development, staff training, and TA. The HIO also needs TA in undertaking public relations and social marketing activities.
- ▲ The HIO must develop standards for policies, procedures, and normal operations of its branches and facilities. With standards in place, HIO headquarters can decentralize facility management and have more time to deal with more strategic tasks.
- ▲ Improvements in provider operations, especially utilization management, utilization review, quality control, and contracts monitoring, are needed to control costs and improve quality of services.
- ▲ The implementation of MIS can provide a solid foundation to improve the HIO's ability to fund and provide services. Automated systems are needed, both to isolate potential cost-containment methods and to identify practices that lead to improved, long-term health outcomes.

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## 4.3 Other Parastatal Organizations: The Curative Care Organization

The CCO was established in 1964, with branches in Cairo and Alexandria. There are currently an additional four CCOs in operation, in Port Said, Qalyoubia, Damietta, and Kafr El-Sheikh. There is no CCO presence, however, in Upper Egypt. Each CCO is run independently, although the ultimate decisionmaking authority resides with the minister of health and population. (CCOs are run on a non-profit basis, with surplus revenues put back into the operation of hospital services.)

### 4.3.1 Institutional Weaknesses

- ▲ The location of CCO facilities tends to be highly concentrated (the four CCOs own and operate 20 hospitals, 12 of which are in Cairo alone), limiting its potential of growth into a nationwide system and its strategic importance in achieving health sector reform.
- ▲ The CCO is not operated as an integrated provider organization, but as a loose confederation of hospitals without a centralized corporate management structure.
- ▲ Each hospital in the CCO functions independently. There are no centrally administrated efforts to collectively manage utilization, control costs, and improve quality throughout all member hospitals.
- ▲ The CCO has management weaknesses, a few which include inadequate staffing patterns, inefficient resource and bed allocation, and the lack of a social marketing function.
- ▲ Many CCO hospitals have had operating deficits for years, due to low occupancy rates and failure of the set fees to recover costs.
- ▲ It is unlikely that the CCO would become a critical player in achieving health sector reform. If a transfer of ownership of MOHP hospitals is proposed as part of the reform, the CCO does not have the institutional capability to run these hospitals.

### 4.3.2 Institutional Strengths

The CCO is an important provider of inpatient care, and its hospitals have charged patients user fees since the mid-1960s. The significance of the CCO lies in the parastatal cost-recovery model it represents.

The economic incentives for physicians and staff to maintain quality are greater in the CCO than in the HIO or the MOHP. The CCO is regarded as the premier governmental health care organization in Egypt.

The CCO is a fee-for-service provider, serving mostly private patients, and is therefore less vulnerable to the political process when compared to the HIO, which is charged with providing health care to groups determined by the GOE and the People's Assembly.

### 4.3.3 Institutional Requirements for Reform Feasibility

- ▲ The present and future role of the CCO in Egypt's health care system must be clarified.
- ▲ The potential of the CCO as a major multi-institutional provider and its possible role in a managed care environment must be fully explored.
- ▲ The organizational and managerial capacity of the CCO to apply system improvements must be developed.

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## 4.4 Other Related Government Ministries

Health sector planning, budgeting, and resource allocation in Egypt is a multiparty decisionmaking process that involves, in addition to the MOHP, the ministries of Planning, Finance, and Local Administration. The process includes the following steps:

1. Interministry allocation of central government funds: The MOP is the key agency concerned with allocation of the health budget. The allocation process is affected by other ministries' bargaining power and national priority status, and is based on the available overall GOE budget and the five-year and annual plans of each ministry.
  - ▲ The five-year plan for the health sector comprises investment (capital account) budgets and is basically determined through negotiations between the MOHP Planning Department and the MOP.
  - ▲ The annual plan includes both capital account budget (investment or Chapter III) and current account budgets (salaries or Chapter I and operating expenses or Chapter II). The budgeting process starts at the local government level by submitting proposals to the MOHP Planning Department. There follows a first round of negotiations between representatives of the local governorates and the Planning Department, where some trimming is done. A second round of negotiations then follows, where the MOHP, along with other ministries, takes its budget proposal to a conference with the MOP. It is at this stage that the economy-wide interministry allocations are made and the share of the health sector in the central budget is set, primarily by the MOP, and secondarily by the MOF. Finally, the third phase of the process takes place throughout the year where all ministries, including the MOHP, have to present adequate documentation and implementation schedules for their programs to release funds earmarked for them from the MOF.
2. Intraministry allocation of central government funds: This process is primarily handled by the MOF. The MOHP has budgetary discretion only in relation to allocating the investment budget (Chapter III) among its sectors. The process occurs as follows:
  - ▲ The capital budget (Chapter III) is allocated through negotiations between the various MOHP undersecretaries representing all sectors and the MOHP Planning Department.
  - ▲ Chapter I (salaries) and Chapter II (operating expenses) are allocated on a cost-reimbursement basis from the MOF directly to the local governorates and the facilities with very little MOHP influence. The MOF, in its allocation and disbursement process, tends to follow guidelines set by the annual budgets and the historical performance of health facilities and programs.

3. Allocation of local government funds: In addition to the centrally allocated funds, governmental health facilities receive decentralized budget allocations for operating expenses and capital investments from the MOLA through the governorate-level health directorates.
4. Manpower planning: The Central Agency for Organization and Administration plays an important role in determining staffing levels and manpower allocations under each planning period for all ministries, including the MOHP. The agency thus subsequently shapes the salaries budget to a great extent. Based on the five-year plan, the MOHP presents its position vacancies and manpower requirements to the agency, which has the authority to sanction positions. If positions are authorized, the MOHP can then include them in its plan and obtain funding for them from the MOF.

It is evident from this MOF description that the formulation and allocation of the health budget is a complicated, multiparty process, with the following deficiencies:

- ▲ The decision-making process involves formal as well as informal relationships, and although the official organizational format can be identified, it is difficult to analyze how the process works in practice.
- ▲ The budgeting process lacks integration. The financial allocation priorities by the MOF, and the MOP are based on the claims made by the GOE agencies separately, without consideration of health sector priorities in totality.
- ▲ The MOF and the MOP do not have the technical expertise to determine health sector priorities and needs.
- ▲ There is no coordination among the GOE agencies at the policymaking and strategic planning level; instead, they compete with each other for GOE financial allocations.
- ▲ The MOHP, notionally the national health policymaker, has little control over national planning, manpower policy, and budgetary discretion.
- ▲ Most of the budget allocation for health facilities is for staff salaries and other overhead expenses, and only 20 percent is available for operations, allowing very little flexibility to the field staff.

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## **4.5 Advisory Committees and Councils**

### **4.5.1 The Health Committee of the National Assembly**

- ▲ The committee oversees the functioning of the MOHP and its accountability. Its main preoccupation, however, is with social protection issues, such as universal insurance coverage and PHC for all.
- ▲ The committee must approve any new health sector legislation or modification of existing ones. It must also approve the endorsement or amendment of cooperative agreements with bilateral or international organizations.
- ▲ Although it is a powerful legislative body, the committee does not have the technical expertise to adequately analyze, evaluate, and, accordingly, approve or reject health policy changes.

## **4.5.2 The Health Committee of the Shura Council**

- ▲ The committee has the role of advising the GOE on national public policy matters.
- ▲ The committee tends to have more health-specific expertise than the People's Assembly. Yet, it has no actual decision or policymaking authority.
- ▲ The committee has in the past generated substantive sectoral analysis reports, including the report produced under the chairmanship of the incumbent minister of health and population.

## **4.5.3 The Supreme Council for Health**

- ▲ The council was formulated by presidential decree to set the direction for national health policy.
- ▲ The structure of the council is very complex, with 18 working groups, each comprising 15 to 20 members. Each group is designated for a specific policy area, including PHC, family planning, MCH, health insurance and private sector, training and human resource development, pharmaceuticals, and others.
- ▲ There is ambiguity regarding the council's organizational relationship with the MOHP and its role vis-à-vis other advisory bodies.
- ▲ Although the council's affiliation with the president could give it political leverage, its complex structure has hampered coordination and undermined its potential for effectively setting national priorities for health care.



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## 5. The Role of International Donors in Health Sector Reform

The role of international donor agencies in development has always been significant in Egypt.

- ▲ The United Nations (UN) agencies World Health Organization (WHO), UNICEF, and United Nations Fund for Population Activity (UNFPA) have been involved in child survival, family planning, communicable disease prevention, health education, and health systems development activities. The UN agencies have had a tendency to focus their efforts on the grassroots level, with less emphasis on central-level policymaking.
- ▲ The WB and the European Community have not previously been active in the health sector in Egypt but are currently studying the feasibility of a major health sector reform project with a significant outlay. If it materializes, the project will be the largest investment made to date in reforming the health sector policy in Egypt.
- ▲ The USAID has been one of the most active in the health field. The USAID has worked on both central and peripheral levels, supporting programs in MCH, family planning, rural and urban health care development, health systems, and human resources development. In addition, as early as 1989, USAID was directly involved in health sector policy through the CRHP.
- ▲ Other bilateral donors operating in Egypt include Canadian, German, Finnish, and Dutch development agencies. They mostly do not have significant health sector involvement, however, and certainly not in the policy area.
- ▲ In addition, there are a number of international not-for-profit foundations and private voluntary organizations (PVOs) active in health in Egypt. For example, Save the Children is working on MCH and women's empowerment issues in Upper Egypt, and the Ford Foundation is involved in reproductive health and family planning activities. The overall size of PVO operations, however, is limited, and they have not demonstrated interest in programs involving partnership with the GOE.

Considering the size of operations and political leverage of the various donors, the USAID and the WB are the two donors most likely to significantly impact health sector reform in Egypt. They will, therefore, be discussed in more detail in the following sections.

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### 5.1 The United States Agency for International Development

The USAID has traditionally included policy reform conditionality within health sector projects or program grants. Early USAID conditionality reflected economists' concerns regarding the sustainability of health sector interventions at the end of donor support. For example, the release of funds for the Control of Childhood Communicable Diseases Projects was, in many cases, conditional on the development and implementation of efforts to generate sufficient local funds to make the activities self-financing. In some countries, the USAID programs required policy or institutional reforms and/or studies in areas such as cost containment (e.g., implementation and use of the essential drugs list), cost recovery, (e.g., implementation of

new hospital fee systems and accounting procedures), and decentralization (e.g., transfer of PHC facilities and personnel from central to local government control).

In Egypt, the USAID has at least partially adopted its policy change conditionality in some of its health projects. In addition, as early as 1989 the USAID started supporting health sector projects that are complementary to the health sector reforms process. These include cost recovery in MOHP hospitals, MIS development in the CCO, and MIS and organizational re-engineering in the HIO and the DDM in the MOHP's Department of Planning. These projects have generated considerable awareness of the need for change and paved the road for launching a sectoral reform.

Against this background, the USAID plans to develop health sector Program Assistance to facilitate needed health sector reform. Although discussions are ongoing between the USAID and the GOE, the preliminary USAID agenda identified the role of the MOHP and the future of the Social Health Insurance Program as the two main domains for reform. Under each of these two areas, the following policies and implementation strategies are likely to be emphasized in USAID's Program Assistance.

### **5.1.1 The Role of the Ministry of Health and Population**

In relation to the role of the MOHP in health care, the USAID is proposing the following:

- ▲ Rationalizing the role of the MOHP in the financing and provision of curative care by
  - △ Stopping construction of unnecessary hospitals and setting strict guidelines for completion of facilities under construction,
  - △ Transferring existing governmental hospitals to other parastatal organizations, and
  - △ Expanding cost recovery in GOE facilities.
- ▲ Strengthening the role of the MOHP in financing and provision of preventive medicine (PM)/primary care by
  - △ Using cost-effectiveness analysis to identify a PM/PHC package of services to be supported by the MOHP,
  - △ Increasing funding to MCH programs, and
  - △ Providing incentives for providers to specialize in PM/PHC and to serve in remote and underserved areas.
- ▲ Developing the role of the MOHP in regulation and accreditation and its capacity for national strategic planning and policy analysis:
  - △ Developing and adopting national health standards of practice and facility accreditation,
  - △ Establishing a policy of continued physician certification and continuing medical education (CME),

- △ Adapting national health information systems for planning and policy decisionmaking, and
- △ Developing a nuclear MOHP unit for economic and policy analysis.
- ▲ Reforming the MOHP personnel policy by:
  - △ Eliminating guaranteed government employment and
  - △ Developing guidelines for manpower planning and applying them to redistribute personnel.

### **5.1.2 Recommendations for the Social Health Insurance Program**

In relation to the future of the Social Health Insurance Program, the USAID is recommending the following:

- ▲ Restoring and securing the financial viability of the HIO by
  - △ Stopping further expansion of HIO beneficiary coverage until its fiscal deficit is eliminated;
  - △ Containing the costs of pharmaceuticals;
  - △ Setting premiums based on actual costs, implementing co-payments and deductibles, and defining a minimum benefits package; and
  - △ Modifying the HIO's legal/legislative framework to ensure its autonomy in making financial decisions.
- ▲ Expanding social health insurance coverage on sound financial and administrative grounds by
  - △ Decoupling HIO financing and service delivery functions; and
  - △ Developing a phased, financially sound plan for expanding national health insurance coverage.

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## **5.2 The World Bank**

Publicly available materials suggest that the World Bank has undertaken health sector reform primarily as part of its overall economic reform efforts in a country. Social policy reforms have been included either as conditions or actions in the WB's structural and sectoral adjustment loans.

To date, the WB has not had a significant role in the health sector in Egypt. It is likely, however, that the WB would get involved in assisting the MOHP in instituting a policy planning and development process to support health sector reforms, as a part of the proposed European Union health sector investment project, with an estimated outlay of \$120 million.

Representatives of the WB's mission to Egypt discussed with the minister a strategy for undertaking health sector policy reform. The WB's domains and policies for reform were identified under five main areas:

1. Health sector management, where the WB is proposing
  - ▲ Revisiting the roles and accountabilities of main health sector players,
  - ▲ Differentiating and restructuring management, service delivery, and health care financing,
  - ▲ Developing the MOHP's role in and capacity for policy development and sector planning,
  - ▲ Establishing adequate regulatory framework, and
  - ▲ Correcting overlaps between governmental and private agencies.
  
2. Health care financing where the WB is proposing
  - ▲ Pooling of financial resources through either a tax-based or insurance-based system, with consideration to issues such as size and growth of tax base, size and growth of formal labor force, and health care demand;
  - ▲ Redefining the role of the MOHP in financing;
  - ▲ Ensuring the HIO's financial viability by stopping expansion of coverage, limiting the benefits package, reducing growing costs, phasing-out service provision, and developing institutional capacity; and
  - ▲ Reallocating GOE funding in a cost-effective manner.
  
3. Health services delivery, where the WB is proposing
  - ▲ Limiting the role of the MOHP as a health service provider and
  - ▲ Exploring alternatives to public facility management (e.g., contracting to private sector, NGOs, and other providers; autonomous management of public hospitals).
  
4. Human resource development, where the WB is proposing
  - ▲ Reviewing physician employment and payment systems to create incentives for provider efficiency,
  - ▲ Improving the institutional capacity of the MOHP,
  - ▲ Reforming the medical education system and modifying training curricula, and
  - ▲ Reviewing the accountabilities of providers and the functions of professional syndicates.
  
5. Pharmaceuticals, where the WB is proposing
  - ▲ Improving rational use and consumption of drugs (e.g., through essential drug policy),
  - ▲ Reforming drug pricing policy (e.g., subsidies), and
  - ▲ Privatizing government-owned pharmaceutical companies.

Following discussions with the WB, the minister set up five task forces to work on each of these areas. Each task force has 10 to 15 members, with not more than one-third of the members from the MOHP and the rest from universities, the private sector, and other ministries. The WB will provide TA through international consultants and, after reviewing the task forces' reports, will make a decision regarding the feasibility of supporting a sectoral reform in Egypt.

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## 6. Conclusions

The review of the experience of international donors and developing countries in the design and implementation of programs to reform health sector policy, structure, and financing suggests that the completion of health sector reforms is more difficult than that of reform in other sectors. Reasons for these specific difficulties have not been delineated, but they likely relate to the facts that health programs affect many or most interest groups in the society and that access to free health services is often regarded as a right. In addition, many reforms require more than merely a statement or restatement of policy; they often require the alteration or creation of administrative practices and institutional structures. Experience shows, however, that within a favorable external political and economic environment, and in conjunction with reasonably capable and stable institutions, programs that concentrate on reform in two or three areas and link counterpart fund awards to reform are likely to succeed.

The results of an evaluation of USAID efforts to promote agricultural policy reform in developing countries show that programs with the right environmental and institutional factors have an 82 percent likelihood of success.

The following table provides a simulations of policy reform success:

<i>Table 1</i>		
<b>Simulations of Policy Reform Success</b>		
<b>Scenario</b>	<b>Probability of Success</b>	<b>Confidence Interval</b>
Good institutional and environmental factors	.82	(.64,1.0)
Poor institutional and good environmental factors	.44	(.21,.68)
Good institutional and poor environmental factors	.15	(0,.32)
Poor institutional and environmental factors	.03	(0,.11)

Source: Tilney and Block (1991), p. 14.

The same study identified specific institutional and program management factors that, when present, were believed to have contributed significantly to the success of the USAID's agricultural reform projects. These factors are shown in Table 2.

In addition to these factors, there are institutional requirements for reform feasibility presented throughout Section 4 of this report. The following overall institutional considerations can also support successful implementation and sustainability of health sector reform in Egypt:

- ▲ Continuity in the senior management of the major health sector organizations (especially the MOHP and the HIO) contributes to the success of the reform. Frequent leadership changes slow down or interrupt policy reform and result in a considerable waste of time and effort that should instead be spent reintroducing the reform package and developing support for its implementation.

Committees responsible for wider coordination of reform activities can act as safeguards against disruption due to leadership changes.

<i>Table 2</i>			
<b>Institutional and Program Management Factors Contributing to Success of the USAID's Agricultural Reform Projects</b>			
<b>MOHP</b>	<b>USAID</b>	<b>Technical Assistance</b>	<b>Donor Coordination</b>
<p>Continuity at ministerial and secretarial level.</p> <p>Creation and financing of project committees.</p> <p>Appointment of personnel to new divisions and units.</p>	<p>Technical and administrative requirements were not underestimated.</p> <p>High USAID staff involvement has catalyzed policy and institutional reforms.</p> <p>Prolonged absence of USAID staff was avoided.</p>	<p>Placement of TA teams high within the MOHP.</p> <p>Recruitment of senior long-term technical advisers.</p> <p>Policy experience provided in the chief-of-party.</p> <p>Short-term TA not best suited to bring about administrative or institutional reforms.</p>	<p>Coordination is vital where:</p> <p>Program linked to progress in other donor projects</p> <p>Several donors active in a policy area</p> <p>Donor coordination can take the form of:</p> <p>A donor takes the lead role for a policy area or MOHP and donors form a coordinating committee</p>
Source: Tilney and Block (1991), p. 14.			

- ▲ Better understanding of health policy issues and reforms by official and public circles and at national, regional, and institutional levels can significantly decrease resistance to the policy changes involved and can be facilitated by
  - △ Sponsoring informative seminars on health policy issues, where the alternative models for health care finance and service delivery available for Egypt could be presented and their pros and cons weighed.
  - △ Enhancing official policy dialogue by creating a forum, where representatives of the MOHP, the HIO, the CCO, the private sector, academia, and other government ministries can meet to study and debate issues of health policy.
  
- ▲ Policy studies can play a role in the identification and assessment of policy options, as well as in the development of consensus and ownership of a decision regarding which option to implement. To the extent that the MOH and donors are accountable for the impact of any reform implemented, the conduct of a study during design or implementation of a program helps to facilitate the development of consensus over the option to be implemented and the understanding of the consequences of its implementation. Egypt has a need for sector-wide analyses of health care financing, provision of personal health services, manufacture and distribution of pharmaceuticals, and other related health care industries. The analyses should be forward-looking and need to model

likely scenarios of future reliance on managed care organizations to provide the majority of medical care in Egypt.

- ▲ Careful consideration should be given to the design of donor TA provision:
  - △ TA, which is more junior in experience, was found to be generally less successful in promoting policy or institutional change, a process which requires more than technical skill.
  - △ The appropriateness of using short-term TA should be carefully weighed. Unless it is provided on a consistent basis, the consultants are unlikely to develop the necessary understanding of technical issues and political processes to know what to recommend and may not develop the necessary personal relationships through which to influence policymakers. Furthermore, it is unclear whether short-term TA is adequate to bring about institutional changes, especially when the number of national staff with advanced training and experience is limited.
  - △ Donor coordination is important in sectoral adjustment programs when more than one donor is attempting to influence a given policy. Scopes and relationships must be clearly defined to avoid overlaps and contradicting reform priorities. The sometimes conflicting efforts of different donors can lead to confusion and inaction in terms of policy on part of the GOE. Donor coordination can be facilitated through the formulation of a coordination committee or designation of one donor to have a lead role in a given policy area.
  
- ▲ Sustaining the capacity of policy formulation, development, and analysis that will be built in the sector will require certain considerations on part of both the GOE and donor agencies:
  - △ Donor agencies supporting the reform should commit a significant portion of program assistance resources and TA to local capacity building and institutionalization.
  - △ The GOE must ensure that all staff posts in the Planning and Policy Analysis departments are adequately filled, so as to make the transfer of knowledge and skills possible.
  - △ All foreign experts, especially contracted staff, should have the capability to effectively serve as teachers, mentors, and advisors for the local Egyptian staff.
  - △ Donor TA should be provided only if necessary from a technical point of view, not as a mere substitute for effort required on part of the local counterpart. Lack of GOE involvement reduces the opportunities for transfer of skills and institutionalization.
  - △ The GOE should, after donor assistance termination, continue to provide the institutionalized Policy Analysis Unit(s) with political support and adequate staff and operating funds.

Finally, it should be emphasized that the interpretation of the findings of the previous institutional assessment must be bound to the policy reform context. The vision for Egypt's health sector after the reform will dictate the set of institutional requirements needed to make this reform feasible and sustainable. A vision, for example, in which the MOHP and other GOE organs continue to play a major role in the direct provision of curative health care may imply a different set of institutional requirements from a vision in which the GOE's role in the health sector would be limited to correcting market failures and ensuring efficiency and

equity. If pursuing the former vision, hospital systems development may receive the highest priority among alternative institutional requirements; whereas if, pursuing the latter vision, bolstering the MOHP's institutional capacity as a regulator of health markets may receive the highest priority. Although the USAID and the WB have identified main areas of emphasis in their prospective health sector programs, the specific policy reforms and institutional developments needed in each area will depend critically on Egypt's vision of its future health sector. A summary of the findings of the institutional analysis can be found in Table 3.

In conclusion, it should be noted that the magnitude of institutional problems facing Egyptian health care organizations should not discourage health sector reform initiatives. In fact, it is the very diversity and intensity of the problems that make the sectoral-level approach to reform mandatory. An attempt to correct all structural, functional, and cultural deficiencies identified by this analysis through a series of organizational-level interventions, tackling each individual institution in isolation, is not likely to be feasible or affordable in an Egyptian context. Past experiences with microlevel or bottom-up health reform programs show that, in addition to their very high costs, they ultimately fall short of inducing the intended macrolevel policy changes. Moreover, if these programs are implemented in the absence of a vision for the overall health sector, failure to implement their policy change dimension is very likely. A sectoral or top-bottom approach to reform, however, initially redefines the roles and accountabilities of the various health sector players and then modifies health policies and organizational conditions accordingly. Often, the redefinition can in itself treat many of the underlying institutional deficiencies, with no or little need for further intervention.

*Table 3: Institutional Feasibility Matrix*  
**Institutional Requirements for the Feasibility and Sustainability  
of Health Sector Policy Reform in Egypt**

National Health Sector Policy Reform Agenda	Suggested National Health Sector Reform Strategies	Conditions/Requirements for Policy Implementation
<b>1. Role of the Ministry of Health and Population (MOHP)</b>		
1.1 Rationalize the role of the MOHP in financing curative care	1.1.1 Stop construction of unnecessary hospitals and set strict guidelines for completion of facilities under construction.	<ul style="list-style-type: none"> <li>• Formulating an institutional entity in the MOHP (e.g., facility standards unit or committee) to be responsible for setting and implementing guidelines and standards for new construction, and providing it with the necessary TA .</li> <li>• Ensuring the entity's autonomy and its authority to clear any construction plans (e.g., by making it directly accountable to the minister or a higher authority, such as the prime minister).</li> <li>• Granting the entity the political leverage needed to allow it to oppose politically popular yet economically harmful decisions.</li> </ul>
	1.1.2 Transfer existing government hospitals to other parastatal organizations.	<ul style="list-style-type: none"> <li>• Conducting a thorough institutional analysis of the proposed parastatal organization (both headquarters and affiliated health facilities) to assess its capability to run the MOHP hospitals.</li> <li>• Exploring other alternatives to public facility management (e.g., formulation of a new parastatal body, autonomous management of public hospitals, contracting NGOs and private sector providers) in the likely event of failure of any existing parastatals to meet the necessary institutional requirements.</li> <li>• Establishing adequate legislative and regulatory frameworks.</li> </ul>
	1.1.3 Expand cost recovery in the GOE facilities.	<ul style="list-style-type: none"> <li>• Granting GOE facilities management autonomy to set user fees and run efficient operations.</li> <li>• Developing financial management and cost-accounting systems to support fee-for-service operations in the cost recovery facilities.</li> <li>• Introducing management developments and quality improvements to upgrade operations and allow the facilities to market their services.</li> <li>• Establishing a marketing function to help facilities promote their services.</li> </ul>

Table 3: Institutional Feasibility Matrix

Institutional Requirements for the Feasibility and Sustainability of Health Sector Policy Reform in Egypt		
National Health Sector Policy Reform Agenda	Suggested National Health Sector Reform Strategies	Conditions/Requirements for Policy Implementation
	1.1.4 Support hospitals based on efficiency and equity indicators.	<ul style="list-style-type: none"> <li>• Providing TA to the MOHP in conducting studies necessary for identifying efficiency and equity indicators.</li> <li>• Building the MOHP institutional capacity to develop, update, implement, and interpret the indicators.</li> <li>• Gaining political support and establishing the required regulations.</li> </ul>
1.2 Strengthen the role of the MOHP in the provision and increased share of financing PM and PHC.	1.2.1 Use cost-effectiveness analysis to identify a package of PM/PHC services to be supported by the MOHP.	<ul style="list-style-type: none"> <li>• Providing TA to the MOHP in conducting cost-effectiveness studies.</li> <li>• Institutionalizing the technical capacity to conduct and utilize cost-effectiveness analysis in the MOHP.</li> <li>• Gaining political support and establishing the required regulations.</li> </ul>
	1.2.2 Increase funding to MCH programs.	<ul style="list-style-type: none"> <li>• Freeing MOHP funds currently committed to financing curative care by creating alternative financing mechanisms and limiting the MOPH's role in direct provision of curative care.</li> </ul>
	1.2.3. Provide incentives for providers to specialize in PM, PHC, and family medicine and to serve in remote and underserved areas.	<ul style="list-style-type: none"> <li>• Developing the MOHP capacity to conduct manpower planning and project health sector needs by specialty and geographic zone.</li> <li>• Redistributing providers to correct the poor geographical and functional allocation.</li> <li>• Creating provider payment mechanisms and other incentives to promote providers' interest in PM/PHC and underserved areas.</li> </ul>
1.3 Reform the MOHP Personnel Policy.	1.3.1 Eliminate guaranteed GOE employment.	<ul style="list-style-type: none"> <li>• Enhancing public-private sector partnership to create more jobs for those who will be denied GOE employment.</li> <li>• Neutralizing likely antagonism from labor unions and professional associations through discussions and negotiations.</li> <li>• Establishing the necessary legislative (e.g., labor law) modifications.</li> </ul>

Table 3: Institutional Feasibility Matrix

Institutional Requirements for the Feasibility and Sustainability of Health Sector Policy Reform in Egypt		
National Health Sector Policy Reform Agenda	Suggested National Health Sector Reform Strategies	Conditions/Requirements for Policy Implementation
1.3 Reform the MOHP Personnel Policy.	1.3.2 Develop guidelines for MOHP manpower planning and apply them to redistribute personnel.	<ul style="list-style-type: none"> <li>Developing a national database for health manpower by education/ training, professional specialty, geographic location, and years of experience.</li> <li>Conducting a national health manpower needs assessment survey.</li> <li>Reallocating and retraining surplus governmental manpower in a manner consistent with actual health sector needs.</li> <li>Enhancing the institutional and management capability of the MOHP's personnel department to develop it into a human resource management function capable of undertaking needs assessment, skills inventory, and manpower planning.</li> </ul>
1.4 Develop the role of the MOHP in regulation and accreditation and its capacity for national strategic planning and policy analysis.	1.4.1 Develop and adopt national health standards of practice and health facility accreditation.	<ul style="list-style-type: none"> <li>Creating in the MOHP an institutional body to undertake regulation and accreditation roles (e.g., a unit or committee similar in structure and function to the United States Joint Commission on Accreditation of Hospitals).</li> <li>Utilizing international TA and local expertise to develop "facility standards" that are feasible in an Egyptian context.</li> <li>Building on the knowledge and experience gained through the CRHP in this respect.</li> </ul>
	2.1.2 Eliminate the current HIO deficit.	<ul style="list-style-type: none"> <li>Redefining the HIO's comprehensive benefits package to make it more affordable.</li> <li>Reviewing premium rates and authorizing their periodic adjustment to inflation.</li> <li>Expanding the use of copayments and deductibles.</li> <li>Controlling drug costs and wasteful service utilization.</li> <li>Developing the HIO's cost-accounting and containment systems.</li> <li>Ensuring the HIO's autonomy in making policy choices consistent with its financial viability.</li> </ul>

*Table 3: Institutional Feasibility Matrix*

**Institutional Requirements for the Feasibility and Sustainability of Health Sector Policy Reform in Egypt**

National Health Sector Policy Reform Agenda	Suggested National Health Sector Reform Strategies	Conditions/Requirements for Policy Implementation
	2.1.3 Reduce the proportion of pharmaceutical costs.	<ul style="list-style-type: none"> <li>• Developing an essential drug list.</li> <li>• Including only essential drugs in the benefits package.</li> <li>• Implementing internal controls to minimize waste and corruption.</li> <li>• Modifying provider prescription habits through training and supervision.</li> <li>• Rationalizing drug consumption patterns through health education.</li> </ul>
	2.1.4 Unify existing health insurance laws into one law and change the HIO's legal/legislative framework to ensure its autonomy.	<ul style="list-style-type: none"> <li>• Conducting a comprehensive, analytic review of all laws and legislations governing health insurance in Egypt.</li> <li>• Engaging the appropriate legislative bodies (e.g., National Assembly, Ministry of Justice) in the review process, raising their awareness of the need for change, and obtaining their support.</li> <li>• Guaranteeing unqualified MOHP support of the changes.</li> </ul>
	1.4.2 Establish a policy of continued physician certification and CME.	<ul style="list-style-type: none"> <li>• Creating the MOHP's institutional capacity to undertake or oversee provider certification and CME.</li> <li>• Involving the Medical Syndicate as a lead agency or major participant in physician certification and CME</li> </ul>
	1.4.3 Adapt the national health information systems, including the Geographic Information System (GIS) for planning and policy decision-making.	<ul style="list-style-type: none"> <li>• Identifying the main indicators required for national health planning and policymaking, and incorporating them as part of the HMIS and GIS.</li> <li>• Disseminating information outputs and reports of the HMIS/GIS to health sector planners, managers, and policymakers at all levels.</li> <li>• Enhancing the practice of information-based policy and decision-making amongst GOE and MOHP officials through training and awareness building.</li> </ul>

*Table 3: Institutional Feasibility Matrix*

**Institutional Requirements for the Feasibility and Sustainability of Health Sector Policy Reform in Egypt**

National Health Sector Policy Reform Agenda	Suggested National Health Sector Reform Strategies	Conditions/Requirements for Policy Implementation
	1.4.4 Develop a nuclear MOHP unit for economic and policy analysis.	<ul style="list-style-type: none"> <li>• Creating an institutional unit for policy analysis in the MOHP headquarters organization reporting to the Minister.</li> <li>• Providing the unit with skilled staff, TA, and modern technology necessary to support its operations.</li> <li>• Capacity building and developing the health policy and economics expertise of a carefully selected group of MOHP staff through long-term training.</li> </ul>
<b>2. National Social Health Insurance Program</b>		
2.1 Ensure the financial viability of HIO.	2.1.1 Stop further expansion of HIO beneficiary coverage.	<ul style="list-style-type: none"> <li>• Granting HIO the autonomy to plan its expansion in a manner consistent with its financial viability and administrative capacity.</li> <li>• Raising the awareness of politicians, GOE officials, and National Assembly representatives regarding the risks of accelerated expansion of insurance coverage.</li> </ul>
	2.1.5 Develop premiums based on actual costs; implement copayments/deductibles; identify and adopt an affordable benefits package.	<ul style="list-style-type: none"> <li>• Granting the HIO the autonomy to decide on premium structure, specify the benefits package, and impose copayments in a manner consistent with its financial viability.</li> <li>• Developing the HIO's institutional and technical capability to analyze options and project the effect of changes in benefits, premiums, and copayments on its costs and revenues through systems development and staff training.</li> <li>• Providing the HIO with TA to support the necessary economic studies and analyses.</li> <li>• Developing Egyptian expertise in actuarial sciences.</li> </ul>

*Table 3: Institutional Feasibility Matrix*

**Institutional Requirements for the Feasibility and Sustainability of Health Sector Policy Reform in Egypt**

National Health Sector Policy Reform Agenda	Suggested National Health Sector Reform Strategies	Conditions/Requirements for Policy Implementation
2.2 Expand social health insurance coverage, coupled with adequate financial and administrative mechanisms.	2.2.1 Transform the HIO into a financing organization.	<ul style="list-style-type: none"> <li>• Expanding the contracting of HIO services to other providers, whether private, NGOs, or other public providers.</li> <li>• Enhancing HIO's contract management and monitoring capabilities.</li> <li>• Developing standards for monitoring contractors' service quality and costs.</li> <li>• Exploring options for transferring the management and/or ownership of HIO hospitals to other organization(s).</li> </ul>
	2.2.2 Design and develop a plan for expanding national health insurance coverage.	<ul style="list-style-type: none"> <li>• Granting HIO the autonomy to expand coverage in a manner consistent with its financial viability, without being vulnerable to political pressures.</li> <li>• Developing HIO's capability to develop a technically sound plan and budget for expansion of coverage.</li> <li>• Developing a parallel plan for upgrading HIO's institutional and administrative capabilities to enable it to support the expansion.</li> </ul>
	2.2.3 Develop a well-defined minimum package of benefits under the national health insurance	<ul style="list-style-type: none"> <li>• Granting the HIO the autonomy to redefine its benefit package in a manner consistent with its financial viability, given the expansion of its beneficiary coverage.</li> <li>• Developing the HIO's technical capability to develop a minimum benefits package through TA.</li> <li>• Researching and identifying a list of cost-effective interventions to be included in the benefits package.</li> </ul>

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# Annex 1: A Framework for Institutional Analysis and Assessment

Institutional analysis is not an exact science. Based on its experience, the WB affirms that institutional assessment and development are extremely complex activities due to vagaries of human behavior and the influence of cultural and political factors. The complexity is even greater for public sector agencies that lack market-driven valuation of their services and have few “bottom-line” indicators to measure institutional capacity.

From a measurement perspective, the challenge is to reduce the elements of institutional capacity to a meaningful yet workable set of indicators. It is difficult to ensure that one is measuring the appropriate aspects of capacity. A comprehensive framework that attempts to capture the multiple facets of institutional measurement will be presented in this annex.

Although in many instances (including the preceding preliminary institutional assessment of the Egyptian health sector) limitations regarding availability of information impede the full utilization of such comprehensive models, it is included in this report due to its potential relevance to more detailed analyses that will be required in the future, before actual policymaking and implementation begin.

## 1. The Design of the Assessment Instrument

### 1.1 Conceptual Framework

(A framework that tends to capture the multiple facets of institutional measurement is to address institutional capacity as having three broad dimensions.<sup>3</sup>) The first dimension is institutional structure, which captures organizational resources (e.g., financial resources, human resources), internal design, and components. The second is institutional functioning, which captures organizational systems, work policies and procedures, and organizational impacts as defined by program/service delivery. The third is institutional culture, which captures additional elements, such as organizational values and leadership style.

### 1.2 Setting Indicators

In addition to the conceptual framework, a set of indicators to use in measuring capacity in relation to each of the three institutional dimensions, is listed in Table 1.

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<sup>3</sup>This framework draws on a study by Olson et al. (1985) that measured the institutional development of host country organizations assisted by United States PVOs.

*Table 1*  
**Indicators for Assessment of Institutional Capacity**

Dimension	Category	Indicators
Institutional Structure	Infrastructure	<ul style="list-style-type: none"> <li>• Appropriate facilities and equipment are available to support operations.</li> <li>• The institution has access to logistical and communications needs.</li> <li>• The institution possesses needed technological resources.</li> </ul>
	Human Resources	<ul style="list-style-type: none"> <li>• The institution has adequate staff in all key positions.</li> <li>• Compensation is adequate and equitable.</li> <li>• Monetary and nonmonetary incentives support targeted behavior.</li> <li>• Staffing levels, patterns, and turnover are adequate.</li> <li>• Opportunities exist for staff professional development and on-the-job training.</li> <li>• Staff are held accountable for getting work done according to clear performance standards.</li> <li>• Staff levels and patterns are determined through manpower planning process, and allocated according to assessed needs.</li> <li>• Recruitment and promotion policies provide for staff development.</li> </ul>
	Financial Resources	<ul style="list-style-type: none"> <li>• Fiscal data are up-to-date and accurate.</li> <li>• The institution has access to resources in line with planning budgets (including subsidies or grants, where appropriate).</li> <li>• The institution has control over its own budget.</li> <li>• The institution has awareness of its future resource needs.</li> <li>• Effective financial management and accounting procedures are in place.</li> <li>• Budgets are used as planning and monitoring tools.</li> </ul>
	Design	<ul style="list-style-type: none"> <li>• The institution's legal framework, policies, rules, and procedures provide a consistent baseline for operations.</li> <li>• The organizational structure meets needs of efficiency and control.</li> <li>• Lines of reporting and authority are clear.</li> <li>• Span of control and supervision is reasonable.</li> <li>• Staff can clearly describe their roles and responsibilities.</li> </ul>

*Table 1*  
**Indicators for Assessment of Institutional Capacity**

Dimension	Category	Indicators
Institutional Functioning	Management	<ul style="list-style-type: none"> <li>• Organizational subsystems for administration, financial management, personnel management, and other operations operate efficiently.</li> <li>• MIS are functioning and management decisionmaking is information-based.</li> <li>• There is effective delegation of management responsibility to second-level managers.</li> <li>• Management skills are adequate.</li> <li>• Managers have a clear sense of realistic goals and priorities.</li> <li>• Managers have a high level of fiscal and operational awareness.</li> </ul>
	Environmental Mastery	<ul style="list-style-type: none"> <li>• The institution has a high degree of autonomy.</li> <li>• Appropriate links exist with other institutions.</li> <li>• Bureaucratic support is evident for the institution's activities.</li> <li>• Major environmental influences are identified and assessed for relative degree of influence.</li> <li>• The institution has controlled access to essential resources and other inputs.</li> <li>• The institution has access to needed technologies.</li> </ul>
	Program/Service Delivery	<ul style="list-style-type: none"> <li>• The institution's scope of programs, services, or other activities is appropriate to its financial and management capabilities.</li> <li>• Program outcomes are measured, documented, and widely known to institutional managers.</li> <li>• The institution's programs and policies contribute to the achievement of its objectives.</li> <li>• The institution has measurable "bottom-line" performance benchmarks.</li> <li>• The institution possesses appropriate economic, sector, or market analysis capability.</li> <li>• The institution maintains reliable evidence of the degree of client and constituent satisfaction.</li> <li>• The institution has structures of accountability to clients and constituents.</li> </ul>

<i>Table 1</i> <b>Indicators for Assessment of Institutional Capacity</b>		
Dimension	Category	Indicators
Institutional Culture	Character	<ul style="list-style-type: none"> <li>• The institution has a documented mission that is clear and understood by staff and members.</li> <li>• Institutional activities mesh with institutional mission and priorities.</li> <li>• Staff attitude and performance are clearly aligned with institutional goals.</li> <li>• The institution’s management style is participatory and enabling.</li> <li>• “Critical events” analysis indicates that the institution is effective in defining and acting on significant development opportunities.</li> <li>• Staff morale and job satisfaction are high at all levels, and regularly evaluated by the institution.</li> <li>• Information is shared openly within the organization.</li> </ul>
	Leadership	<ul style="list-style-type: none"> <li>• Management effectively represents the institution to external interests.</li> <li>• The institution’s leadership philosophy is clear, and its vision is clear and affirmed at all levels in shared values.</li> <li>• There is evidence of institutional innovation.</li> <li>• Leadership employs effective staff involvement and teamwork in planning and work.</li> <li>• The external institution image is consistent with its goals and objectives.</li> </ul>

**2. The Application of the Assessment Instrument**

While this framework tends to be generic— that is, applicable to institutions across spectrums of size, locale, level, and function—institutional analysis always must be linked to context. There are several ways to address this reality. First, the choice of indicators should be sensitive to variations in structures, processes, activities, and outcomes between the various institutions and in the same institution over time. Second, varying weights among the assessment categories might be tailored to a given institution’s role and purpose. Third, for limited-purpose assessments, application might be made of only some of the indicators of institutional capacity.

In addition, any system of measurement must consider the needs of various constituents with a stake in the results. These may be policymakers, institution managers, members, and clients or intervening donors. Each may have a unique perspective that will be reflected both in how the assessment is conducted and how the results are interpreted and used. Organizations seldom, if ever, satisfy all strategic constituencies. What appears to be substandard performance from the standpoint of one constituency may be acceptable performance when multiple perspectives are assessed and, of course, the reverse is also true. Institutions are often caught in the crossfire between differing interpretations of their capacities or performance.

**2.1 Defining the Assessment Context**

Given the importance of context for applying and interpreting an institutional assessment tool, it is necessary to start the assessment by determining

- ▲ On what role(s) should the assessment focus? Institutions may operate in several roles with different degrees of success (e.g., the roles of the MOHP as provider, policymaker, and regulator). Over time, emphasis among roles may shift.
- ▲ What level of analysis should be used? Possibilities include the total institution or specified subunits. Achieving effectiveness at one level may or may not correlate with effectiveness at a broader or narrower level. In loosely coupled organizations (e.g. the MOH's headquarters, governorate-level health directorates, and the MOHP health facilities), for example, subunit analysis may be most appropriate.
- ▲ What time frame should be employed? Long-term effectiveness may be incompatible with short-term effectiveness (e.g., effectiveness of the MOHP as a direct provider of curative care in the short run could be incompatible with its long-term financial viability and effectiveness in its public health roles).
- ▲ What type of information should be used? Documented information and the perceptions of members or constituents may differ. The availability and credibility of each kind of information will differ from case to case. The balance struck is context-bound, but should be made known to users of the assessment.
- ▲ What referent should be employed? In the absence of established norms, the assessment may be comparative (to other similar organizations), normative (to a theoretical ideal), goal-centered (in relation to a stated target), or trend-centered (keyed to improvement over time).
- ▲ How will the assessment results be used and by whom? Results of the assessment should be provided in a form that is timely, relevant, and usable. Regard for the needs of users may affect the length and detail of the analytical presentation, if not the analysis itself.

## **2.2 Applying the Indicators**

The indicators from Table 1 should be applied within the assessment context to be further defined by the reform agenda. The indicators should be used to assess:

- ▲ The competence of the specific institution in performing its current roles to determine whether these roles should be expanded, sustained, or limited; and/or
- ▲ The potential capability of the institution to undertake new roles.

While weights may be adjusted to suit individual circumstances, a recommended general scoring framework is shown in Table 2. Using this table, an institutional capacity score can be determined by dividing the actual score by 100. For an assessment using fewer or more indicators, the denominator will change accordingly. Weights can also be changed to suit a particular context. Measurement will of necessity be, in part, impressionistic. This accents the importance of the “context questions,” which help define biases and perspective.

<i>Table 2.</i> <b>Assessment Scoring</b>		
Dimension/Category	Maximum Score	Actual Score
I. Institutional Structure: 1. Institutional Infrastructure 2. Human Resources 3. Financial Resoucs 4. Organizational Design Dimension I Score	10 10 10 10 40	
II. Institutional Function: 1. Management Systems 2. Environmental Mastery 3. Program Delivery Dimension II Score	15 10 15 40	
III. Institutional Culture: 1. Organizational Character 2. Leadership Style Dimension III Score	10 10 20	
Total Institutional Capacity Score	100	
Defining what is satisfactory should be a joint effort involving the institution’s management and the assessor. It does not simply mean a numerical score but depending on the referent employed, determining a target that is appropriate and feasible.		

### 2.3 Measurement

A range of information-gathering methods, selectively based on local circumstances, is necessary to address the analytical questions suggested by the indicators in Table 2. The major strategies appropriate for institutional assessment include the following:

- ▲ Review of documentation: Internal institution reports, correspondence, organization and staffing charts, personnel records, administrative reports, contracts and agreements, transaction records, information system outputs, and other files are a major source of information. Documented information is especially important for assessing Dimension I (structure) factors. Planning documents, budgets, and financial and accounting records are particularly useful. Information heavily represented in institutional record-keeping is likely to emphatically shape decisionmaking.

Information not collected suggests issues of lower perceived importance to the institution. Documents are relatively easily reviewed and a valuable source prior to interviews with key persons in the institution. Documentation is less useful for analysis of priorities or predicted behavior.

**Key informant interviews:** Questioning knowledgeable persons (for example, institutional managers, key representatives of client or constituent groups, and leaders of related or linked, external organizations or groups) is an important information gathering step. Interviews provide an opportunity for open-ended inquiry and probing issues of particular importance. The abilities to identify and gain access to key informants and to extract accurate information from them are intuitive processes that require sensitivity on the part of the investigator. It usually is necessary to build rapport with informants and perceive complex factors, patterns, and relationships. Interviews are particularly important for assessment of Dimensions II (functioning) and III (culture).

**Group interviews, seminars and workshops:** Talking to groups of staff or other stakeholders of an institution provides a uniquely valuable opportunity to elicit new information or check impressions gained by other means. A good interviewer can be less obtrusive or intimidating in a group setting than in one-on-one interviews. Group processes can take advantage of interactions within the group to stimulate participants and generate new material. Sometimes a series of meetings can break down communications barriers. In many respects, group interviews are similar to the common “focus group” method of research.

**Observation:** Observation can expose information not otherwise obtained by the investigator or validate information gained by other means. For example, observation of the behavior of institution members is much more difficult, especially if the time available is short, but can provide important insights, especially for Dimension III (culture).

An institutional assessment will need to blend each of these techniques, combining and balancing the findings to derive a score for each measurement category.

## **2.4 Interpretation**

The final application step, after addressing the context questions and applying the indicators for measurement, is to determine response to findings regarding the institutional capacity score. For donors, potential furnishers of TA and/or funding to support institutional development, this step entails cooperation with local counterparts/institution managers to determine the following:

- ▲ Reasons for gaps between the actual score and maximum score, for each category (these will be illuminated by the assessment itself, but further analysis may be needed for some categories);
- ▲ Resources required for each category to bring the institution from its existing level to a satisfactory level;
- ▲ Resources available from the institution and its constituents and from the local government; and
- ▲ Quantity and form of supplementary resources required from the donor or other sources to bridge the gap from the existing status to the desired condition.

This, of course, constitutes a major series of actions, which are beyond the scope of this discussion. Without an effective and usable measurement framework, however, any subsequent assistance process will be a much more uncertain endeavor.

This framework can contribute to interest in institutional assessment as a component of health sector policy analysis and institutional capacity building. It can be used by donor staff, host country researchers and consultants, and institutional managers themselves.

The instrument provides a basis for comparative assessment by different investigators, but does not negate the need for competent experts to do the analysis. Users should have training and experience in institutional management, organizational development, or a related field.

There are no blueprints for institutional analysis. The framework herein is not proposed as a definitive or final answer, it is only a guide.

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