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Partners for Health Reformplus

# Strengthening Egypt's Health Sector Reform Program: Pilot Activities in Suez

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*October 2005*

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### **Mission**

*Partners for Health Reformplus is USAID's flagship project for health policy and health system strengthening in developing and transitional countries. The five-year project (2000-2005) builds on the predecessor Partnerships for Health Reform Project, continuing PHR's focus on health policy, financing, and organization, with new emphasis on community participation, infectious disease surveillance, and information systems that support the management and delivery of appropriate health services. PHRplus will focus on the following results:*

- ▲ *Implementation of appropriate health system reform.*
- ▲ *Generation of new financing for health care, as well as more effective use of existing funds.*
- ▲ *Design and implementation of health information systems for disease surveillance.*
- ▲ *Delivery of quality services by health workers.*
- ▲ *Availability and appropriate use of health commodities.*

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# Abstract

This report summarizes the work of the United States Agency for International Development-funded Partners for Health Reform*plus* (PHR*plus*) in the Suez governorate of Egypt from 2002 through 2005 to strengthen the Egyptian Health Sector Reform Program (HSRP). Egypt's Ministry of Health and Population and the donor community established the HSRP in the 1990s to shift the focus of care from heavy reliance on vertical programs and inpatient care to a more integrated and less costly primary care model. As of 2002, the HSRP had been implemented in three governorates but was confronting a number of weaknesses to further expansion. PHR*plus* proposed a new framework for the program, and conducted a market analysis in Suez to tailor modifications to the needs of Suez residents. PHR*plus* piloted the modified HSRP to achieve tangible results for Suez and also strengthen the HSRP by operationalizing many of the innovations needed to scale up and expand it more rapidly into new governorates across Egypt. These innovative results included a new open enrollment system, improved access and coverage for low-income groups, expansion of the benefits package to include secondary care, and building capacity at the local levels to sustain reforms.

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# Acronyms

<b>BBP</b>	Basic Benefits Package
<b>DPO</b>	District Provider Organization
<b>ECTAT</b>	European Commission Technical Assistance Team
<b>FACT</b>	Feedback Analytical and Comparison Tool
<b>FHF</b>	Family Health Fund
<b>FHU</b>	Family Health Unit
<b>GPO</b>	Governorate Provider Organization
<b>HIO</b>	Health Insurance Organization
<b>HSRP</b>	Health Sector Reform Program
<b>LE</b>	Egyptian Pound (Exchange rate LE1 Egyptian pound = \$US 0.17)
<b>MD</b>	Ministerial Decree
<b>MOHP</b>	Ministry of Health and Population
<b>NGO</b>	Nongovernmental Organization
<b>PHR</b>	Partnerships for Health Reform
<b>PHR<i>plus</i></b>	Partners for Health Reform <i>plus</i>
<b>TSO</b>	Technical Support Office
<b>USAID</b>	United States Agency for International Development

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# Executive Summary

This report summarizes the work of the United States Agency for International Development (USAID)-funded Partners for Health Reform*plus* (PHR*plus*) in the Suez governorate of Egypt from 2002 through 2005 to strengthen the Egyptian Health Sector Reform Program (HSRP). These technical activities renewed many of the intentions of Egypt's original health sector reform program, adapting them to the needs of the Suez governorate and thereby demonstrating the feasibility of several innovations that were needed for expansion of the HSRP to new governorates.

In the 1990s, Egypt's Ministry of Health and Population (MOHP) and the donor community recognized that fundamental reforms in the organization of the health sector were needed to further progress toward health indicators and to address new health challenges. In response, the MOHP established the HSRP, a 10- to 15-year program to shift the focus of care from heavy reliance on vertical programs and inpatient care to a more integrated and less costly primary care model. By 2002, the MOHP, with donor assistance, had implemented the HSRP through the establishment of 26 family health units (FHUs) in the governorates of Alexandria, Souhag, and Menoufia. Local stakeholders and an analysis of the HSRP in 2002 identified program strengths, as well as a number of weaknesses:

- ▲ The Family Care Model represents an impressive potential for reform of the primary care delivery system in Egypt, but it is slow to implement.
- ▲ Different population groups have different needs and expectations regarding reform.
- ▲ As structured, the program does not attract participation by private providers.
- ▲ The basic benefits package (BBP) does not address the need to rationalize secondary-level care.
- ▲ The financial aspects of the HSRP – separation of delivery and financing of health care, and a public health insurance organization (the Family Health Fund, or FHF) that contracts a broad set of providers – have not yet been fully implemented.
- ▲ There are important gaps in the Ministerial Decree 147, which codifies the HSRP.

USAID/Egypt requested PHR*plus* assistance to reinvigorate the health sector reform program by testing modifications to the HSRP in a pilot site. PHR*plus* began its program in late 2002 by proposing a new framework for the HSRP that had six main principles:

1. Expanded BBP that includes primary care, specialist, and secondary inpatient care, with an effective referral system.
2. Consumer choice of provider.

3. Provider networks including the concept of a public sector network consisting of FHUs, family health centers, and a district hospital; and a parallel network organization for private for-profit or nongovernmental organization (NGO) providers.
4. Single-payer organization serving as the insurance administrator that would separate financing from provision of care. The single payer would pool health care funds, contract with provider networks, pay providers, administer consumer enrollment, and perform other insurance functions. It would be financed by premium sharing and co-payments from beneficiaries, and contributions from government (currently paid to facilities via budgets and worker salaries) and employers.
5. Insurance portability, which allows insurance coverage to “follow” the patients to their providers of choice, because the single-payer organization pools all sources of financing and pays the provider based on utilization.
6. Consumer participation in financing.

Suez was selected as a site for testing enhancements to the HSRP. *PHRplus* undertook a market analysis to analyze the demographic, health, and economic profile of Suez in order to tailor the reforms to meet the needs of the governorate and its people. The market analysis included secondary data analysis, a household survey (1,047 households with 4,734 individual respondents, representing about 1 percent of the Suez population), nine focus group discussions (seven of health care professionals and two of business leaders), and interviews with 41 key decision makers. Key findings of the market analysis were that:

1. Suez is adequately endowed with human and physical resources for health care. It does not require construction of facilities, but there is an inequitable distribution of health facilities.
2. Suez is small geographically and by population (about 500,000), obviating the need for separate district-level administration of HSRP implementation.
3. About 50 percent of residents has some form of health insurance coverage, but they do not use more services or spend less out of pocket on health care than do persons without health insurance.
4. 6.2 percent of the population (32,111 people out of a total population of 500,000) are very poor and cannot afford to pay for health care.
5. Health leaders, community leaders, and citizens are concerned about the quality of health care services offered in public facilities.
6. Economic development of the region, which otherwise seems promising in Suez due to the industrial base, is likely to be limited by the lack of high quality providers in the area.
7. There is widespread support for initiating a health reform program in the governorate.
8. Suez citizens want to be allowed to choose their providers freely.

The market analysis findings supported the principles proposed in the new strategic framework for the HSRP, and the general idea that the health reform program and implementation need not be uniform but rather should adapt to local circumstances.

Based on the evidence from the market analysis, local stakeholders determined a number of specific implications for the implementation of a HSRP pilot in Suez. PHR*plus* piloted the new framework to effect tangible and positive results for the Suez population:

1. **A new open enrollment system was made operational**, allowing people to choose their preferred health facility irrespective of district boundaries. The open enrollment system was made possible by installation of the facility-based information system (Feedback Analytical and Comparison Tool, or FACT) in all participating health care facilities; FACT enables open enrollment by registering patients across traditional district catchment area boundaries. By June 2005, 36,000 families (128,000 individuals) were registered in the FACT system; of these, 18,000 families (30 percent of the catchment area population) were enrolled in the facilities.
2. **Access and coverage were improved for low-income groups** by identifying the lowest-income groups, refining the exemption policy and procedures, and training social workers in their use; mobilizing local resources to cover the poor; and implementing outreach campaigns to market participating facilities and create awareness among the poor about their rights to free services.
3. **Benefits were expanded to include secondary care**, including work with local hospitals to establish a referral system to ensure continuity of care between primary and secondary health care.
4. **Capacity was built at the governorate and district levels to implement and sustain reforms.** Extensive capacity building relating to the HSRP objectives and principles, particularly insurance concepts and functions, was done with FHF staff at the governorate level; FHU staff were trained to enroll families and open family folders, social workers were trained to apply the new exemption system; and the MOHP Quality Improvement Directorate was trained to identify, screen, and accredit providers. The newly designed FACT was installed in 14 FHUs, and provided feedback to clinicians concerning practice patterns to improve the quality of primary health care. As noted above, by June 2005, 36,000 families (128,000 individuals) were registered in the system; 36,000 patient visits were documented; and 28 doctors, 14 pharmacists, and 28 registration staff were trained to use FACT.

These results strengthened the HSRP by operationalizing many of the innovations needed to scale up and expand the HSRP more rapidly into new governorates across Egypt. While these results are important innovations, there are a few reform principles that remained unrealized:

- ▲ Full pooled financing of the FHF from the MOHP, Health Insurance Organization, and private sources,
- ▲ FHF contracts with private sector providers, and
- ▲ FHF contracts with hospitals.

# 1. Introduction

This report summarizes the work of the United States Agency for International Development (USAID)-funded Partners for Health Reform*plus* (PHR*plus*) in the Suez governorate of Egypt from 2002 through 2005 to strengthen the Egyptian Health Sector Reform Program (HSRP). These technical activities renewed many of the intentions of Egypt's original health sector reform program, adapting them to the needs of the Suez governorate while still maintaining consistency with the ongoing HSRP implementation activities in other governorates.

The rest of this report is organized into four major sections: Section 2 provides a brief history of Egypt's health sector reform program over 1998 to 2002, and its status as of 2002 under PHR*plus* with an analysis of the strengths and weaknesses of the program that set the stage for PHR*plus* assistance. Section 3 presents the new framework for Egypt's HSRP. Section 4 presents the findings of the Suez market analysis and the implications for piloting the new HSRP framework in Suez. Both these efforts laid the foundation for implementation of extensive technical assistance to implement reforms and capacity building in Suez. Section 5 presents the results of the Suez pilot, which strengthened the HSRP by demonstrating the feasibility of several needed innovations.

## 2. Background: Egypt's Health Sector Reform Program

Egypt has made significant advances in improving the health status of its population over the past few decades. In the 1990s, Egypt's Ministry of Health and Population (MOHP) and the donor community recognized that additional progress and addressing new health challenges would be increasingly difficult without fundamental reforms in the organization of the health sector and the ways in which it has historically allocated and spent its resources.

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### 2.1 Development of the Health Sector Reform Program

In the late 1990s, the MOHP established the HSRP, a 10- to 15-year program with the overall goal of shifting the focus of care in Egypt from heavy reliance on vertical programs and inpatient care to a more integrated and less costly primary care model. Quality of primary care services in government clinics would be improved and access expanded, especially for poor people. The model included features such as the adoption of family medicine and a family health care model of service delivery, an explicit package of basic benefits, cost sharing by families, accreditation of health facilities based on quality standards, and financing reforms to separate health financing from provision of services by channeling government financing<sup>1</sup> through a Family Health Fund (FHF) that would contract with and pay providers. Implementation was overseen by the MOHP's Technical Support Office (TSO).<sup>2</sup>

The USAID-funded Partnerships for Health Reform project (1995-2000) supported the MOHP/TSO from 1998 to 2000 to demonstrate the various components of an effective system for primary health care in the governorate of Alexandria. During this phase, the HSRP established pilot health facilities called family health units (FHUs) for the Family Care Model of service delivery; the FHF, a contracting entity that executes performance-based contracts with primary health care providers; a Quality Improvement program that is linked to the performance-based contracts<sup>3</sup>; and tools for the MOHP to make resource allocation decisions and policies based on evidence (e.g., in manpower and hospital beds). Since 2000, the European Commission Technical Assistance Team (ECTAT) has been providing technical assistance to the MOHP/TSO to train physicians in family medicine, roll out additional FHUs (26 sites as of 2002) in the governorates of Alexandria, Souhag, and Menoufia.

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<sup>1</sup> Government financing of health comprises MOHP funds and the Health Insurance Organization (HIO). The HIO is an autonomous government organization under the supervision of the MOHP that finances health care services through a combination of payroll and cigarette taxes, and delivers health care services through its own network of hospitals, clinics, and pharmacies as well as through contracting private sector providers. The HIO manages several separate social health insurance programs for formal sector workers, pensioners, widows, and school children.

<sup>2</sup> In 2002, the TSO was renamed the Central Administration for Technical Support and Projects.

<sup>3</sup> The MOHP Quality Improvement Directorate, responsible for quality improvement in service delivery, developed a system and tools for accrediting service delivery sites to ensure that they meet minimum quality standards for contracting with the FHF.

In the Family Care Model, an entire family chooses a primary provider team in a FHU in their catchment area and then is enrolled with that team for one year.<sup>4</sup> FHUs have been renovated and accredited according to a set of national quality standards. Provider teams are carefully screened before being allowed to participate. The teams generally comprise a family practice doctor and a community nurse, both of whom have received special training including prescribed guidelines for treatment. The provider team serves as both a primary source of care and as a “gatekeeper” to referral services in order to promote better continuity of care. Family medical records (family folders) are maintained in the FHU.

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## 2.2 Status of the Health Sector Reform Program

Egypt’s HSRP has made significant progress, for example, in the piloting of the Family Care Model and a Quality Assurance system to accredit primary care facilities. In 2002, PHR*plus* consulted local stakeholders in an analysis of HSRP operations; the analysis identified strengths, as well as a number of weaknesses that needed to be addressed.

**The Family Care Model represents an impressive potential for reform of the primary care delivery system in Egypt, but it is slow to implement.** The intervention includes building necessary management systems, setting accreditation standards, and developing a training curriculum with a family medicine orientation. The shortage of doctors trained in family medicine and the shortage of qualified nurses are important challenges to the wide replication of the model. In 2002, after nearly three years of implementation, fewer than 30 family health units had been established, and only about 75,000 persons in Egypt were enrolled to receive care in these facilities.

**Different population groups have different needs and expectations regarding reform.** The current Family Care Model has been tried on limited basis, and seems to work in heavily populated areas, among the urban poor and low middle-income groups. However, the model has not yet included rural or higher-income populations. Several different reform models may be needed to meet the needs of the different population segments and different providers. Studies have shown that the private sector is the provider of choice for outpatient care across all income levels (from 44 percent of outpatient visits in the lowest quintile to 64 percent in the highest); 56 percent of all outpatient visits in Egypt are made to private providers (Berman et al. 1998). Egyptian consumers are accustomed to having choice of their providers, and enrolling with a single provider team may not appeal to many, thus limiting the potential for universal adoption. Finally, there is anecdotal evidence that Egyptian consumers consider specialists as having a higher status than general practitioners or family medicine doctors. The Family Care Model faces the challenge of these consumer perceptions and the shortage of family medicine physicians.

**As structured, the Family Care Model does not attract participation by private providers.** The reform model requires private and nongovernmental organization (NGO) providers to convert their facilities into the Family Care Model in order to be accredited and thus able to participate. This is not only costly, but also has stringent renovation requirements, often imposing significant investment costs on the provider organization. The model also does not seem to be well suited to private providers, who usually do not want to give up their patient base in order to dedicate their practice to enrolled patients only. It is important to include the private sector in the reform process for several reasons: (1) Specific interventions intended to improve the quality of care in the MOHP sector

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<sup>4</sup> A typical FHU serves basic primary care needs for a catchment area of from 5,000 to 20,000 inhabitants (Carl Bro and Associates 2001: 56).

would also enhance care in the private sector. (2) Principles that guide the reform vision include universal coverage with portable insurance benefits. These objectives will eventually require private sector participation. (3) The reform process needs to move beyond the MOHP, broadening support for health sector strengthening from stakeholders within and outside the public health sector. Participation and support from private providers will be important if reform is to achieve its objectives.

**The basic benefits package (BBP) has become a limiting factor in the HSRP.** The BBP is narrow. It does not address the need to rationalize secondary-level care, which continues to dominate spending on health care in Egypt. The BBP is also not being used to define the limits of services in reformed facilities; the services that FHUs actually deliver exceed BBP limits. For example, FHUs perform many routine primary care services associated with monitoring chronic diseases, though the BBP does not comprise those services. The BBP should be expanded to cover other outpatient, specialty, and possibly even secondary hospital care. Without a broader, integrated package, it will be difficult to rationalize resources allocated to secondary care. These savings are a critical source of financing for expanding primary care.

**The financial aspects of the planned HSRP should be implemented.** The defining principles of health reform in Egypt – separation of delivery and financing of health care, and a public health insurance organization (the Family Health Fund) that contracts a broad set of providers – have not yet been implemented. Implementation of the FHF that pays providers based on performance measures to serve as an incentive for high-quality care has not been realized. Government financing continues to be centrally controlled, with salaries, operating expenses, and facility upkeep paid directly by the national structure (MOHP and the Health Insurance Organization [HIO]). The FHF, thus far funded largely by donors, has been established in each reform governorate, but it pays only supplemental salaries to the providers. The FHF has no sustainable source of financing, even to continue these limited payments. Subsidizing the FHF with donor funds may only postpone the need to seriously address the financing of primary care. The Family Care Model cannot be sustained without reformed financing. It is very unlikely that the public health system will receive any significant increase in funding from the Ministry of Finance in the foreseeable future. Therefore, financing reforms must be implemented that increase and improve public health system outputs using existing resources.

**Gaps in the Ministerial Decree should be addressed.** By 2002, Ministerial Decree (MD) 147 was formulated to formalize and re-establish several aspects of the HSRP. Firstly, it codified a significant program of cost sharing for families. Each family would register with a FHU for family services, receive a family folder for documenting services rendered, and pay 30 LE (Egyptian pounds) per year per family (renewal of 15 LE). Single enrollees would pay a third of these amounts. Patients would also pay a co-payment of 3 LE per visit. Secondly, it re-established the FHF as the payer and fundholder. FHUs would send to the FHF the monies they collected in enrollment fees and co-payments. The FHF would return 40 percent to the FHU to pay for supplies, special equipment, and incentives. The remaining 60 percent would be retained by the FHF for provider payments. Thirdly, the decree provided for the FHF to contract with private and NGO facilities, and it established community governance requirements for FHUs. However, MD 147 did not address several important issues, including how to deal with exemptions from payments for the poor. Also, it did not provide specifics about financing of the FHF, particularly about the way monies from the MOHP budget or HIO would (or would not) be contributed toward the cost of care.

Based on the *PHRplus* review of the status of the HSRP in 2002, USAID/Egypt requested *PHRplus* assistance to reinvigorate the health sector reform program by testing some refinements to the HSRP in a pilot site. *PHRplus* began its program in late 2002 by proposing a new framework for the HSRP based on a new district reform concept.

## 3. Developing a New Strategic Framework for the HSRP

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### 3.1 Conceptualizing Modifications to the HSRP

The analysis of the status of Egypt's Health Sector Reform Program in 2002 led to recognition that a new conceptual approach was needed for the HSRP. The first step in this process was to prepare a concept paper (see Annex A) that set out a strategic framework for implementation of a modified HSRP in Suez, including ideas about the financing of service delivery. The paper was developed in late 2002 in consultation with the TSO Finance Technical Team.

PHR*plus* proposed a new framework, discussed in detail below, with elements such as an expanded basic benefits package, a single-payer organization that contracts with providers, and consumer choice of government or nongovernment providers. The proposed framework addressed distinct objectives of the Egyptian health sector:

- ▲ Improved access and coverage of low-income groups
- ▲ Improved allocation and management of health sector resources
- ▲ Expanded and strengthened public health insurance

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### 3.2 Principles for the New Strategic Framework

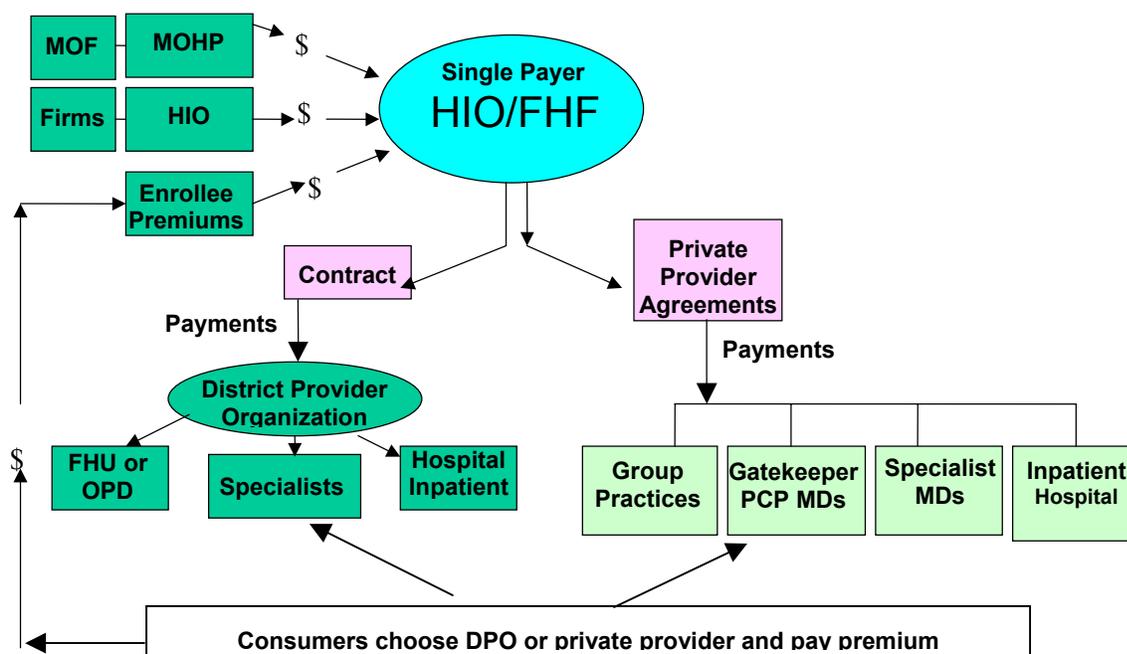
The new strategic framework had six main principles:

1. **Expanded BBP** that includes primary care, specialist, and secondary inpatient care, with an effective referral system to ensure appropriate utilization of specialist and hospital services.
2. **Consumer choice of provider.** Families or individuals could enroll in either a network of public facilities or enroll in a network of private providers. Consumers could choose a doctor within the network. This is also referred to as “open enrollment.”
3. **Provider networks.** The concept of a public sector network consisting of FHUs, family health centers, and a district hospital was previewed in Egypt's original HSRP (MOHP 1997: 169, Carl Bro Associates and MOHP 2001: 5-57) and was more recently discussed in the MOHP as a “district provider organization” (DPO). A parallel network organization for private for-profit or NGO providers could be established. In both cases, the new strategic framework proposed that Egypt's Quality Improvement Directorate accredit any provider, public or private, in order to contact with the single payer organization.

4. **Single-payer organization serving as the insurance administrator.** Unlike the traditional system, where the government (MOHP and HIO) both pays for and provides care, this payer organization will be separate from providers of care. The single payer will pool health care funds, contract with provider networks, pay providers, administer consumer enrollment, and perform other insurance functions. Such a single-payer organization would blend the provider contracting and payment functions of the FHF and HIO. It would be financed by premium sharing and co-payments from beneficiaries, and contributions from government (currently paid to facilities via budgets and worker salaries) and employers (currently paid via the HIO). The single-payer organization's mandate would be to improve the allocation and management of health sector resources. The organization's focus on insurance tasks would strengthen public health insurance.
5. **Insurance portability,** which allows insurance coverage to “follow” the patients to their providers of choice, because the single-payer organization pools all sources of financing and pays the provider based on utilization. No longer would funds flow to providers who may not be sought out by consumers. This is a critical complement to consumer choice of provider.
6. **Consumer participation in financing.** Consumers would pay part of the premium and a co-payment. The size of these payments would be proportional to income, based upon a means test at enrollment. The premiums and user fees for a private provider would be higher than for a public provider in the DPO. Ideally, the poor would be eligible to enroll in the private network, but this would require a considerable subsidy.

Thus, the new strategic framework re-introduced the original reform concepts of (1) separation of payer and providers (see Annex B), and (2) creation of a provider organization as the entity with which the payer would contract. Figure 1, based on the concept paper, illustrates the relationships of consumers, providers, and payer(s), with the DPO as the contracting agent of the public sector.

**Figure 1: New Strategic Framework for HSRP Separation of Payer-Provider and Consumer Choice**



This new strategic framework was shared and discussed with Egyptian stakeholders leading to agreement to pilot the principles in the governorate of Suez. Suez was selected as a site for testing enhancements to the reform program for a number of reasons:

- ▲ It is a small governorate in terms of both geography and, with not quite 474,000 residents, population. The fairly concentrated population around the city of Suez allows for full implementation of the reform program in all districts and clinics of the governorate.
- ▲ Suez provides a good model of a small urban governorate in Egypt, similar to neighboring Port Said and Ismailia governorates. Implementation in Suez will facilitate roll-out in those governorates.
- ▲ Suez demonstrated leadership commitment to and support for reform, especially on the part of its governor, undersecretary for health, local officials, and local business leaders, making it easier to implement program and expedite its implementation.

## 4. Suez Market Analysis: Customizing the HSRP to Build Stakeholder Support

The purpose of the market analysis was to analyze the demographic, health, and economic profile of Suez in order to better understand how its health sector was serving the governorate's residents and how to tailor the reforms to meet the needs of the governorate and its people.

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### 4.1 Market Analysis Components

Data collection began in 2003 and used four approaches: secondary data analysis, a household survey, focus group discussions, and interviews with key decision makers.

The **secondary data analysis** gathered and examined existing data relating to the Suez's demographics, health care resources, health status indicators, vital events, prior household surveys, and socioeconomic status. The many sources of data included the MOHP, the Central Agency for Population Mobilization and Statistics, the National Information Center for Health and Population, and district and governorate information centers (Health Care International 2004a).

A **household survey** was conducted in 2004 to measure utilization, provider choice, satisfaction with care, and other topics. The survey covered a total of 1,047 households with 4,734 individual respondents, representing about 1 percent of the Suez population (PHR*plus* 2004). **Focus group discussions** were conducted with different segments of the Suez population (nine groups), different cadres of health care professionals (seven), and business leaders (two). Each group consisted of 6-12 persons, and most discussions were recorded by a notetaker and video camera. The purpose of the focus groups was to better understand the priority health problems, quality of and satisfaction with health services and working conditions, the health insurance situation in the governorate, and residents' rationale for seeking care outside Suez. Each group was also questioned about willingness to participate in a new health reform model (Health Care International 2004b).

**In-depth interviews** to identify strengths and weaknesses of the health care system in Suez were conducted with key informants – 41 government officials (including Suez's governor and undersecretary for health), health care organizations, businesses, community leaders, syndicates, and others (Health Care International 2004c).

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### 4.2 Market Analysis Findings

Key findings of the market analysis were that:

1. Suez is adequately endowed with human and physical resources for health care. It does not require construction of facilities, but there is an inequitable distribution of health facilities (see next point below).

2. Suez is geographically small and without rural or otherwise isolated populations. Its population is small, about 500,000. There is an overlap of administrative divisions due to the geographical proximity of its districts and health care facilities. For example, the Al-Haweas Clinic, on the border of Al-Arbaeen district, serves a near-by catchment area of Al-Ganayen district. Other outlying Al-Arbaeen clinics serve an adjacent catchment area of Ataqa district. In addition, health care facilities are inequitably distributed among the districts. Whereas the densely populated Al-Arbaeen district is home to at least 46 percent of Suez's population, it has only four health care centers and five health care units and clinics. Meanwhile, Ataqa district, with the lowest population density (approximately 15 percent of the governorate's population), has 12 government health care centers, and five health care units and clinics. Suez's size and the geographical proximity of its four districts obviate the need for separate district-level administration of HSRP implementation.
3. Health insurance is prevalent; about 50 percent of residents have some form of coverage – direct care provided by their employer, private insurance through their employer, or HIO coverage. Firms and eligible workers often prefer to pay extra to the HIO to have access to private primary care and hospital providers rather than deal with the administrative bottlenecks of the HIO provider network.
4. While a large percentage of Suez residents have access to health care or insurance coverage through their employers (see point above), the survey estimated that 32,111 people (6.2 percent of the total population of 500,000) are very poor and cannot afford to pay for health care. Table 1 presents the different categories of low-income groups.
5. Suez residents covered by health insurance do not use more services or spend less out of pocket on health care than do persons without health insurance. HIO coverage in particular, is not working as intended; that is, to protect its beneficiaries from health expenditures by lowering patients' point-of-service payments in its HIO-provider network.
6. Health leaders, community leaders, and citizens are concerned with the quality of health care services offered in MOHP and HIO facilities. Utilization is low, particularly given the extent of covered costs of care. Much of the care for persons with ability to pay is delivered in Cairo, a two-hour drive from Suez.
7. Economic development of the region, which otherwise seems promising in Suez due to the industrial base, is likely to be limited by the lack of high-quality providers in the area.
8. There is widespread support for initiating a health reform program in the governorate. Formal sector employment is substantial, with many large and prosperous employers – many of which seem willing to help finance care for the poor and actively support health system strengthening in order to attract economic development and well-educated professionals to the governorate.
9. Suez citizens want to be allowed to choose their providers freely.

**Table 1: Categories and Number of Low-Income Citizens in Suez Governorate**

Serial no.	Category	Distribution by district			Total
		Ataqa	Arbaeen	Other	
1	Irregular labor (agriculture; raising livestock, poultry; apiaries)	✓	✓	Al-Ganyaen	672 workers
2	Transferable laborers	✓	✓	Faisal	4,864 workers
3	Widows	178	501		679 widows
4	Divorcées	202	382		584 divorcées
5	Elderly	240	645		885 old women
6	Disabled persons	✓	✓	✓	333 cases
7	Orphans	16	31		47 orphans
8	Unemployed	✓	✓	✓	15,800 persons
9	Fishermen				2,537 fishermen
10	Young self-employed workers	✓	✓	✓	710 workers
11	Sadat pension				1,000 beneficiaries
Total					32,111 citizens

#### 4.3 Impact of the Market Analysis on the HSRP and Suez Pilot

The market analysis findings were shared widely with stakeholders in Suez and policymakers in Cairo in 2004. First, PHR*plus* shared the findings individually with key stakeholders for their review and acceptance. They in turn presented the data at a dissemination workshop in Suez governorate in October 2004. This approach engendered ownership of the evidence and political and financial support among the leadership of Suez to implement new reforms. The undersecretary of health for Suez supported inclusion of private providers in the reforms. They also contributed the identification of gaps in the Ministerial Decree 147 (Annex C) and work toward tailoring the decree to the needs of Suez.

The market analysis findings supported the principles proposed in the new strategic framework for the HSRP, and the general idea that the health reform program and implementation need not be uniform, but rather should adapt to local circumstances. Based on the evidence from the market analysis, local stakeholders determined a number of specific implications for the implementation of a HSRP pilot in Suez:

**Free choice of provider, including private providers.** Residents of Suez traditionally have sought health care from the provider – government, private, or NGO – of their choice and they wish to continue doing so. A HSRP that includes only government providers would capture very few enrollees, and restrict reforms to only the poor and the uninsured with modest means. Including private and NGO providers is needed to effect broad impact.

**Exempting the poor.** The poor need special attention and should be exempted from the government-mandated annual family enrollment fee of 30 LE (US\$ 5.23) and co-payment fee of 3 LE per visit (US\$ 0.52).

**Adapting the District Provider Organization model.** Because of the small size of the Suez governorate, the district-level structure that was used in Alexandria was found to be administratively redundant. A governorate-wide structure (governorate provider organization) was proposed to cover all of Suez's four districts. This could serve as an example of how to organize decentralization efforts in smaller governorates.

**Improving quality.** Existing clinics and hospitals were perceived to have longstanding and significant problems in both technical and service quality. Reform would only be meaningful if significant and visible improvements could be made in both outpatient and inpatient care. A substantial program of facility accreditation was implemented, supported by central-level institutional development and capacity building (Rafeh and Schwark 2006, *PHRplus* 2005).

**Participation of well-off segments of the population.** Persons able to pay were not initially interested in enrolling in FHUs. To create solidarity across the population, a special campaign was needed to inform all citizens, particularly those who can afford to pay, to encourage them to enroll in the reformed facilities.

**Expanded benefits package.** Persons were concerned about having insurance coverage for hospital care as well as good primary care. The HSRP, while intended ultimately to reform the entire health system, initially focused on primary care, with its Family Care Model to integrate care across various vertical service programs. Clearly, this approach was not sufficient to gain support for the reforms in Suez. Access to and insurance coverage of quality hospital care was needed. As a result, the HSRP developed a broader program of coverage and guidance on referral procedures.

## 5. Impact of the Suez Pilot on Egypt's HSRP

In response to the characteristics and needs found by the market analysis to differentiate Suez from other governorates, PHR*plus* piloted the new framework for the Health Sector Reform Program to effect tangible and positive results for the Suez population. These five results strengthened the HSRP by operationalizing many of the innovations needed by governorates in order to scale up and expand more rapidly.

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### 1. New open enrollment system made operational

In response to the uneven distribution of facilities and the health care-seeking behavior of Suez residents, catchment areas were redefined beyond district boundaries in accordance with the availability and distribution of health facilities and distribution of the population. As a result, open enrollment was implemented in Suez, allowing people to choose their preferred health facility irrespective of district boundaries. The open enrollment policy was made possible by installation of the facility-based information system designed by the PHR*plus* Project (Gaumer 2005) in all participating clinics. FACT established a central database of enrolled families so clinics avoided duplicate enrollments. By June 2005, 36,000 families (128,000 individuals) from the catchment areas were registered in the FACT system of which 18,000 families, or 30 percent of catchment area population, were enrolled in pilot facilities.

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### 2. Access and coverage improved for low-income groups

One of the most important goals of health reform is to provide equitable and quality health care to all citizens, especially low-income groups. To do this, PHR*plus* assisted Suez to implement four measures to target the poor:

- ▲ Identify the lowest-income groups
- ▲ Refine exemption policy and procedures and train social workers to use them
- ▲ Mobilize local resources to cover the poor
- ▲ Organize outreach campaigns to market participating facilities and create awareness among the poor about their rights to free services

#### **Identify lowest-income groups**

The market analysis showed that 6.2 percent of the population in Suez is poor and cannot afford to pay for health care. This is especially true in Al-Ganayen and Al-Arbaeen districts. Government records show that certain categories of the population, approximately 32,111 individuals, are below the poverty level (see Table 1 in previous section).

## **Refine exemption policy and procedures**

Suez officials found that current policy did not adequately protect poor families from paying fees that were beyond their ability to pay. For example, under current policy, clinics were allowed to exempt up to 15 percent of their enrolled families. However, the market analysis showed that some areas in Suez have higher concentrations of poor people than others. The poor in the community of Arab El-Mamal likely exceed 15 percent of the population; in contrast, Suez district has a small percentage of poor.

Suez adopted a pro-poor exemption policy that exempted entire families and not just individual members in the above-stated categories. Exemption coverage was made comprehensive, i.e., the poor were exempted from the 30 LE annual premium, the 3 LE visit co-payment, and the one-third of drug costs. The exemption limit of 15 percent per clinic was expanded to 15 percent per governorate. This provided more flexibility in exempting more families in poorer districts.

Suez adopted a new assessment procedure and form used by social workers that defined objective criteria rather than subjective. The form included more information about individual or family income level and identified specific categories, such as the disabled, the beneficiaries of Al-Sadat pensions, orphans, the aged, or patients suffering from epidemic diseases. All categories listed in Table 1 are identified as poor and eligible for exemption after a social worker verifies the status of the family.

## **Mobilize local resources**

PHR*plus* assisted Suez to mobilize new resources in order to sustain access to care by poor and other vulnerable populations and ensure financial solvency of the Family Health Fund. While comprehensive financing reforms still lagged behind the service delivery reforms, PHR*plus* assisted the Suez reform team to initiate two efforts to mobilize local resources.

First, the reform team in Suez built awareness and support for reform among key leaders and committees such as the Governorate Health Committee and the Committee of Private Businesses in Suez. The team used messages based on social solidarity and social responsibility to reach out to the large number of private and public companies that provide health coverage to employees and their families, and who support local social and development projects. An initial success was the governor's donation of 500,000 LE from the Governorate Improvement Fund to cover the cost of exempting a first group of poor from enrollment fees in the participating clinics. Further efforts are planned and will be needed to leverage corporate support of reform.

Second, the Suez reform team seeks to increase enrollment of higher-income families in participating facilities. The market analysis indicated that Suez residents in middle- and higher-income brackets – the people who can afford to pay premiums and visit fees – are reluctant to enroll in government facilities due to past dissatisfaction with the quality of public sector services. They are instead likely to continue seeking care in the private sector. Getting them to enroll in public facilities has required a special strategy that will (1) improve the quality of care in public facilities and markets those facilities based on that quality, and (2) expand the network of providers to include private sector facilities and clinics within private companies. Officially, the FHF can contract with the private sector, and initial steps were taken to identify a few successful private and NGO clinics to participate in the reform and drafted initial plans for contracting with them, but this had not yet been completed by the time the PHR*plus* presence in Egypt ended in December 2005.

### **Conduct community outreach campaign**

After an initial phase of implementing the measures described above, it became apparent that the poor still were not utilizing FHUs as expected, thus falling short of the objective of improving access and coverage of low-income groups. In investigating why utilization remained low, it became apparent that low-income communities were unaware of the program and/or had misperceptions about the cost of services. Also, the household survey showed that 60 percent of women's primary care visits take place in the private sector, whereas a majority of child health visits occur in public facilities. These findings highlighted the need to reach out to women.

In response, PHR*plus* assisted the reform team to organize an outreach campaign through the Social Services in Suez. Local social workers were tapped to implement the campaign targeting people by socioeconomic category and geographical area. Messages were tailored to each group. In low-income communities, messages emphasized easy access to service at the lowest cost possible. In middle-income communities, messages emphasized improvements in the quality of services. The campaign also targeted groups such as women to educate them about the availability of free family planning and maternal/child health services and encouraging them to enroll their families in participating public clinics.

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### **3. Benefits expanded to include secondary care**

In response to the market analysis finding that Suez residents are more concerned about having coverage for hospital services than for primary care services, the benefits package was expanded to include secondary care. Several steps were taken in Suez to select hospitals for participation. PHR*plus* assisted the Suez team to establish criteria for the selection of hospitals: quality of care, geographical location, type of services provided, etc. A hospital could be contracted to provide specific specialty services, not necessarily all hospital services. The FHF negotiated a contract with a relatively new HIO hospital in Suez (see sample contract in Annex D) however; other steps were needed to receive approvals from the central HIO authorities and were in process as of the end of the PHR*plus* project. Once approved, this will allow enrolled families to benefit from the relatively new HIO facilities and make it easier for the HIO beneficiaries and others to receive services there. The Suez team also worked with local hospitals to establish a referral system to ensure continuity of care between primary and secondary health care (see Annex E, Referral Approval and Payment Form). Further efforts are needed in Suez to implement the referral strategy and expand beyond public hospitals, to add private hospitals.

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### **4. Capacity built at the governorate and district levels to implement and sustain reforms**

PHR*plus* provided extensive capacity building at the governorate/district levels in conjunction with pilot-testing the new strategic framework for the HSRP in Suez:

- ▲ Extensive capacity building and training of FHF staff at the governorate level relating to the HSRP objectives and principles, particularly insurance concepts and functions.
- ▲ Training in certain operational functions that need to be performed at the governorate/district level as an actual part of the pilot. This includes training FHU staff to enroll families and open family folders, training social workers to apply new exemption system, and training Quality Improvement Directorate staff to identify, screen and accredit providers.

- ▲ Training and capacity building of governorate and district health authorities in functions that are useful to, though not specific to the pilot, for example, resource rationalization, budgeting, and monitoring.
- ▲ Design and implementation of the facility-based information system, FACT. FACT is an easy-to-use computer system that collects utilization and monitoring data on patient visits and provides feedback to clinicians concerning practice patterns, as part of the overall goal to improve the quality of primary health care. FACT was installed in 14 primary health care facilities that participated in the Suez pilot. As of June 2005, a total of 36,000 families (128,000 individuals) were registered in the system and 36,000 patient visits have been documented. *PHRplus* had trained 28 doctors, 14 pharmacists, and 28 registration staff to use FACT.

While these results are important innovations that strengthen Egypt's HSRP, several principles remain unrealized:

- ▲ Full pooled financing of the FHF from the MOHP, HIO, and private sources,
- ▲ FHF contracts with private sector providers, and
- ▲ FHF contracts with hospitals.

# Annex A: Concept Paper: A New District Reform Concept For Egypt

November 21, 2002

by

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Nadwa Rafeh

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AK Nandakumar

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## Introduction

Between 1996 and 2000, the USAID-funded Partnerships for Health Reform (PHR) project supported the Ministry of Health and Population (MOHP) in Egypt to develop and pilot test a Family Care Model. PHR*plus*, a new program of USAID support, has discussed the status of the Family Care Model and the ongoing health reforms with the TSO and their advisors, as well as others in the MOHP. From these discussions it seems evident that there is a need to broaden the reform concept and begin to examine mechanisms for financing.

This paper outlines a research approach for introducing an enhanced model of delivering and financing care in the reforms that would include new insurance mechanisms with a wider range of providers. The aim of this model is to build upon the successes of the current reform Family Care Model without limiting the speed of reform to the availability of family doctors and high institute nurses. The proposed model is not intended as a substitute for the current reform model being implemented in the three pilot governorates, but is an expansion or refinement that expands the choices available to families in the district. The concepts and ideas presented here are preliminary and are intended to support discussions about, and refinements to, the proposed model.

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## 1.0 Why the Pilot Study Approach?

The reform activity in Egypt is still young and limited in scope. Information about important issues remains unavailable and many aspect of the reform are still not tested or implemented. Furthermore, compelling evidence of success is still needed to create a broad constituency of support for reform outside of the MOHP. Without evidence of success, prospects for wide political support needed to facilitate the roll out and expansion of the model at a national level are less likely.

This paper proposes a model of service provision and insurance that would be tested in one district as part of a research activity. The aim of the pilot study will be to answer key questions about the reform strategy without making fundamental organizational changes, and before moving ahead with a universal program in Egypt. The study approach also avoids the need for major and lengthy

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<sup>1</sup> Authors are from Abt Associates Inc.

legislative changes since reforms are just being piloted and tested. The study questions are posed in section 5.0 below.

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## 2.0 The Current Reform Model

Egypt has been implementing a reform model aimed at improving the quality of and access to primary care services in three pilot governorates. In this model, entire families choose a primary provider team in a Family Health Unit (FHU) and are rostered (enrolled) with that team for one year. A typical FHU serves basic primary care needs for a catchment area of 5,000 to 20,000 inhabitants<sup>2</sup>. Such facilities have been renovated and accredited according to a set of national quality standards. The provider teams are carefully screened before being selected, and are generally composed of a family practice doctor and a high institute nurse, both having received special training including prescribed guidelines for treatment. The family provider team serves as both a primary source of care, and as a “gatekeeper” to referral services in order to promote better continuity of care. Family medical records (family folders) and an information system to collect and report data on patient encounters are installed in these sites. Salaries, operating expenses and facility upkeep continue to be paid directly by the parent organization (MOHP, HIO, NGO). Therefore, facility managers have little financial autonomy. Supplemental salaries for doctors and small performance bonuses are paid by a Family Health Fund in each Governorate, largely funded by donors. Patients pay modest user fees that provide facility improvement funds in each unit.

A number of important issues raise questions about the adequacy of the current reform model to provide a universal approach to delivering and financing primary health care to all Egyptians. These issues are:

- ▲ **The current model represents an impressive reform of the primary care delivery system in Egypt, but it is slow to implement.** After nearly three years of implementation, less than 30 of the Family Health clinics have been established, and only about 75,000 persons in Egypt are now rostered to receive care in these reform units. The pace of implementation is slow because of the intensity of the interventions needed to implement this new model of care. The intervention include building necessary management systems, setting standards and accreditation, and building a family medicine orientation training. The shortage of doctors trained in family medicine and the shortage of qualified nurses are important obstacles to the wide replication of the model.
- ▲ **The current reform model may not permit universal coverage of the population because all Egyptians may not be interested in changing the way they seek and provide health care services.** The current reform model has been tried on a very limited basis, and seems to work in heavily populated areas, among the urban poor and low middle income groups. However, the model has not yet successfully included rural or higher level income populations. Several different models may be needed to meet the needs of the different population segments and different providers. Studies have shown that 56 percent of all outpatient visits in Egypt are made to private providers, and the private sector is the provider of choice for outpatient care across all income levels (from 44% of outpatient visits in the lowest quintile to 64% in the highest).<sup>3</sup> Egyptian consumers are accustomed to having choice of their providers, and rostering to a single provider team may not appeal to many, thus

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<sup>2</sup> Carl Bro and Associates. Master Plan Alexandria Governorate. May 2001. page 56.

<sup>3</sup> Berman, Nandakumar and Yip. 1998. Health Care Utilization and Expenditures in the Arab Republic of Egypt. Technical Report No. 25. Bethesda, MD: Partnerships for Health Reform

limiting the potential for universal adoption. Finally, there is anecdotal evidence that Egyptian consumers consider specialists as having a higher status than General Practitioners or Family Medicine doctors. The Family Care Model faces the challenge of these consumer perceptions and the shortage of Family Medicine physicians.

- ▲ **The current reform model is more successful with MOHP and HIO facilities, and less attractive to private and NGO providers.** Participation in the reform model requires private and NGO providers to invest in converting their clinics into the family practice model in order to receive accreditation. This model is not only costly, but also has stringent renovation requirements, often imposing significant investment costs on the organization. The family care model also does not seem to be well suited to private providers, who usually do not want to give up their patient base in order to dedicate their practice to rostered patients only.

There are several good reasons for believing that the private sector would be a good partner in the reforms, which, to date, have been largely restricted to strengthening of the MOHP primary care delivery system; (1) there are aspects of the quality of care in the private sector that can be enhanced by applying specific interventions that are part of the reform improvements in the MOHP sector. (2) the principles that still guide the reform vision include the ideas of universal coverage of portable insurance benefits for all. These objectives will eventually require private sector participation in many forms, including primary care delivery. And, (3) the reform process needs to move beyond the MOHP, bringing support for health sector strengthening more broadly representing the stakeholders from within, and outside the health sector. Participation and support from private providers will be important if reform is to achieve its objectives.

The current reform model covers a narrow set of primary health care services. It has not been expanded to cover other outpatient care including specialty care nor does it attempt to rationalize hospital care. The basic benefit package (BBP) of preventative and basic acute services is narrow. The services actually being delivered in the FHU sites at present go well beyond the limited BBP coverage. For example, many routine primary care services associated with monitoring chronic diseases are being performed, though not officially part of the BBP, as currently designed. Work needs to be done to extend the benefits package to cover other outpatient, specialty and possibly even secondary hospital care. Without a broader, integrated package, it will be difficult to rationalize resources allocated to secondary care. Savings from rationalization can be a critical source of resources for increasing support for primary care in Egypt.

The financial aspects of the planned reforms have not yet been implemented. The vast majority of government resources continue to be disbursed through the line item budgets to MOHP and HIO facilities. Similarly, the core principle of the health reform, separation of the delivery from the financing of health care and having a public health insurance organization contract with a broad set of providers, has not yet been implemented, even on a pilot basis. Other concepts such as decentralization, single payer financing, and right-sizing the supply of physicians and hospital beds were envisioned in the original health sector reform documents, but there has been no material progress on these fronts, leaving incentives for providers and organizations essentially unchanged.

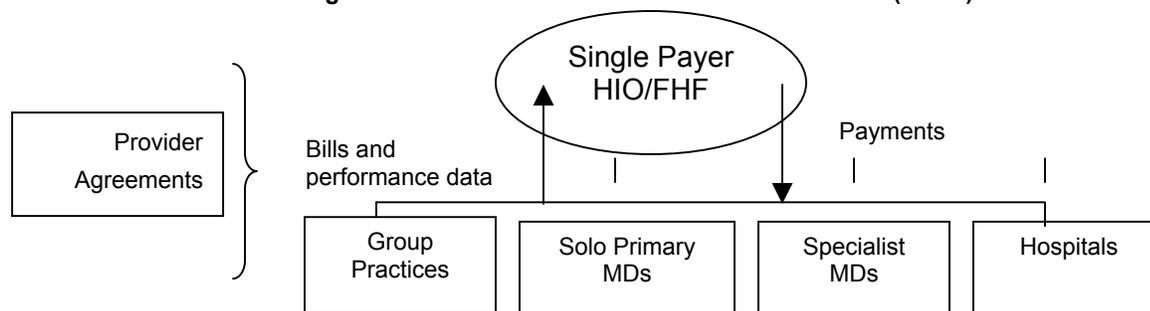
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### 3.0 New Concept for a District Model

The proposed model has six main principles:

- ▲ **Comprehensive benefits** including primary care, specialist and secondary inpatient care.
- ▲ **Single payer organization serving as the insurance administrator.** This organization will be separate from the organizations delivering care and will contract and pay providers. The single payer would pool funds and administer the contracts with provider networks, administer consumer enrollment, and other insurance functions.
- ▲ **Introduce networks of private and/or public providers.** Families or individuals could enroll in a network of providers and choose a doctor within the network. A network of private (private or NGO) providers could be established which would allow enrollees to choose which ones to use. A possible structure for a Network of Pre-selected Private Providers (NPPP) is illustrated in Figure 1. The concept of a public sector network was previewed in Egypt’s original HSR Program<sup>4,5</sup> and has more recently been discussed in the MOHP as a “District Provider Organization”. This network concept is illustrated in Figure 2.
- ▲ **Consumer Choice.** All families in a district would be offered a **choice** to roster with one of several Family Health Units, in a network of public facilities (a District Provider Organization) consisting of one of several Family Health Units, a Family Health Center, and a district hospital; or in a Network of Private Pre-approved Providers (NPPP)<sup>6</sup>.
- ▲ **Insurance portability,** where consumers are allowed to receive care from any of the pre-selected providers in the network, thus allowing money to move with the patients to the provider they choose.
- ▲ **Family Financial Participation.** Consumers would pay part of the premium and user fees. The size of these payments would be proportional to income, based up on a means test at enrollment. **The premiums and user fees for the free choice NPPP would be higher than for the FHU enrollees.** Ideally, the poor would be eligible to enroll in the NPPP, but this would require a considerable subsidy.

**Figure 1: Network of Pre-selected Private Providers (NPPP)**



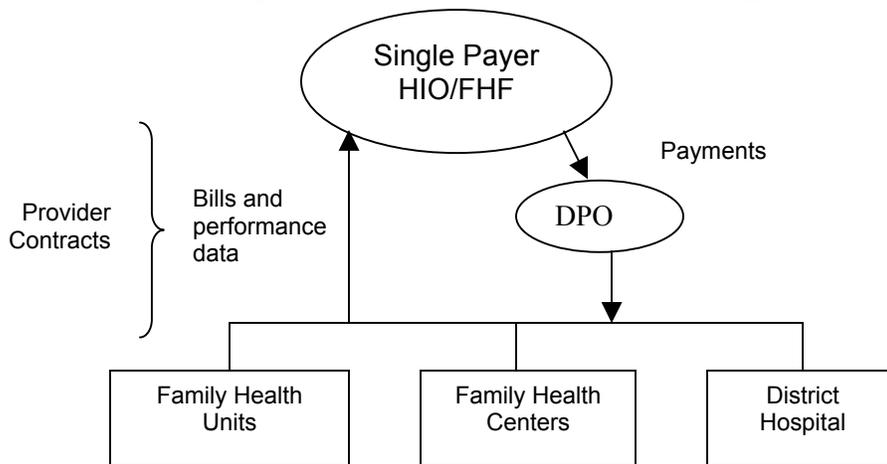
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<sup>4</sup> “Egypt Health Sector Reform Program” MOHP. December 1997. page 169.

<sup>5</sup> “Master Plan Alexandria Governorate” Carl Bro Associates and MOHP. May 2001. page 56-57.

<sup>6</sup> The new insurance model being proposed here is aimed primarily at urban markets, where multiple providers are available to create a network, and where choice may be possible between the NPPP and FHUs. This is not a model intended to deal with the peculiarities of the rural population in Egypt.

**Figure 2: Network of Public Providers (e.g., DPO)**



The enhanced financing and care model being proposed here can be implemented in one of several ways in the pilot district:

- ▲ **Implementation Approach 1 – Allowing families to choose to enroll in the NPPP, or not.** This approach to implementation would be simplest, and involve establishment of a NPPP and a payer organization to support it. There would be no conversion of MOHP clinics into FHUs or development of a public sector network (DPO). Consumers who did not choose to enroll in the NPPP would use the same public or private providers that they have been using in the past. Figure 3 describes this option.
- ▲ **Implementation Approach 2 – Allowing families to choose between FHUs and the NPPP.** MOHP and/or HIO clinics would be converted to Family Health Units or Centers. The FHUs and centers would contract with the single payer to be paid. A NPPP would be established. The single payer would contract with FHUs and centers, and administer the NPPP. This approach to implementation is the most difficult, since it requires establishing FHUs and centers as well as the NPPP. High levels of coordination with the technical assistance and funding sources pertaining to FHU development would be required. Figure 4 describes this alternative.
- ▲ **Implementation Approach 3 – Allowing families to choose between a District Provider Organization and the NPPP.** A DPO would be established that would organize MOHP facilities to deliver services of coordinated primary, specialty, and hospital care within the district. This is essentially a form of decentralization of MOHP resources to the district level. Also, a network of private providers (NPPP) would be established. Figure 5 describes this alternative.

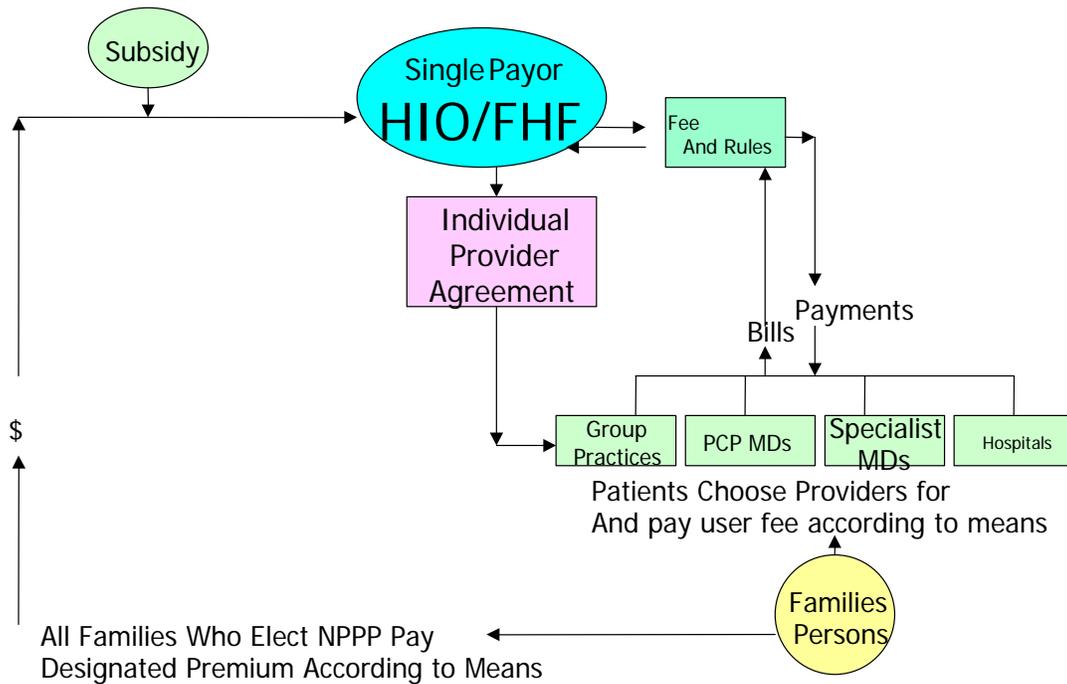
These proposed models all include the development of the NPPP and a single payer, quality, coverage and other issues. It is also important to remember that implementation approaches 2 and 3 require prior decision action by the MOHP to set up FHUs and/or DPO. The primary implementation issues are described in the next few sections.

### 3.1 Creating a Single Payer Function and the Roles of HIO/FHF/TST

It is essential at this stage of the reform to have a single payer entity to hold pooled funds, and to administer the payments to provider organizations.

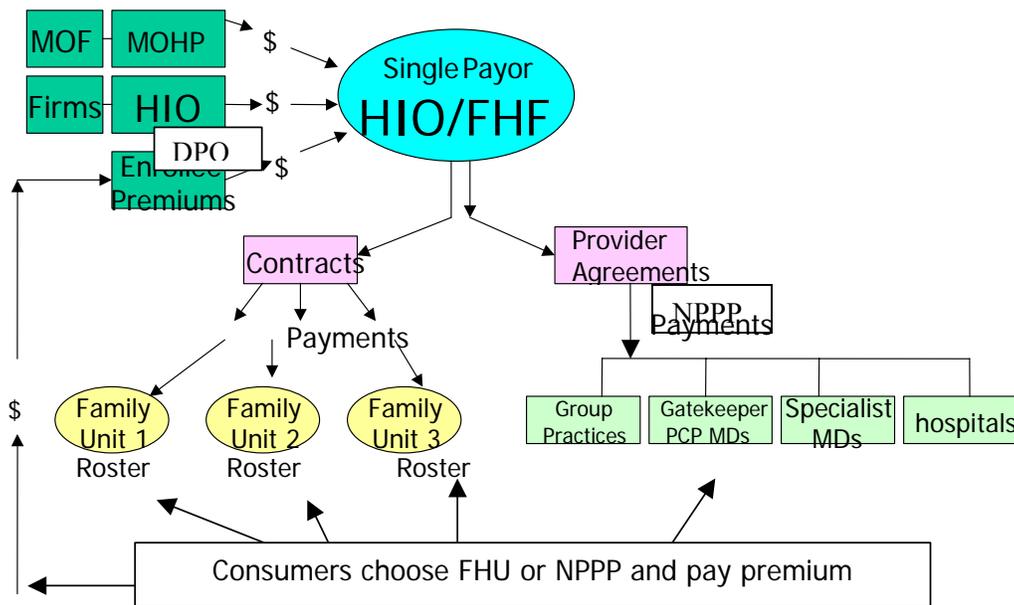
The insurance entity needs to perform a number of functions including fund pooling, enrollment, premium setting, benefit plan maintenance, claims adjudication, provider contracting, systems development and maintenance and other functions. The organization could be the Family Health Fund (FHF), the National Organization for Health Insurance

**Figure 3: 1st Implementation Approach of NPPP**



(NOHI), or the Health Insurance Organization (HIO)<sup>7</sup>. As the largest payer of insured health services in Egypt, the HIO has existing capacity to conduct contracting, rate setting, performance monitoring, transactions, and claim adjudications, as well as other insurance and payer functions. Development of the HIO to prepare it to assume the role of the public health insurance organization in health sector reform would avoid duplication by extending existing capacity within Egypt’s public sector. Capacity development would need to be carried out at both the central and regional levels within the HIO. Payment mechanisms and private sector contracting would be used to control costs/prices and gain efficiencies by taking advantage of natural forces in the health sector market.

**Figure 4: Second Implementation Approach Choice of NPPP or Family Health Units**

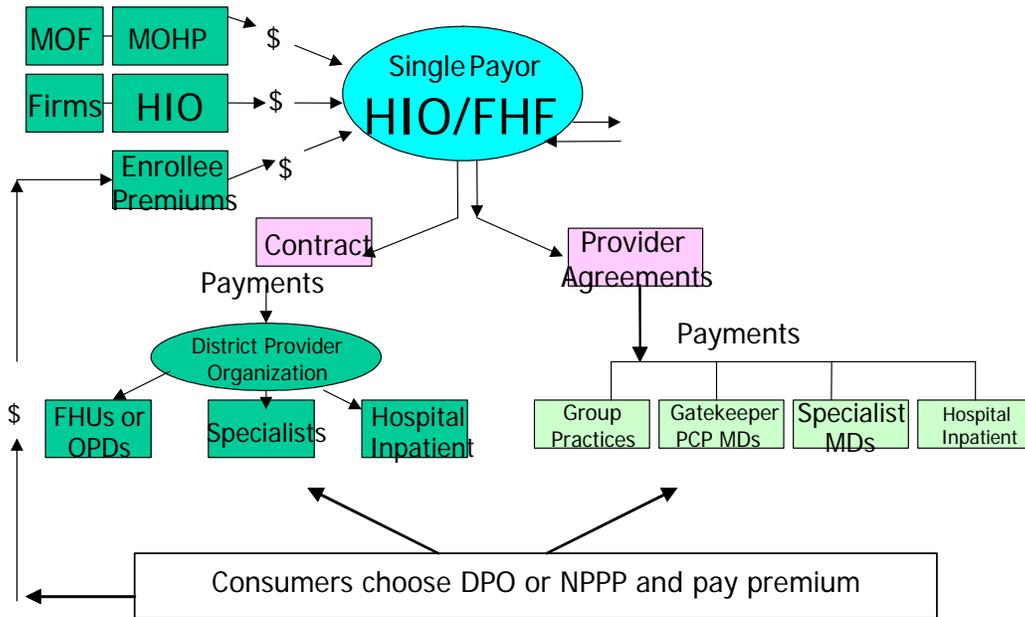


It would be possible to extend HIO regional offices to create enhanced local level administrative units that would perform the necessary local duties (screening providers, facilitating enrollment, conducting ongoing provider performance monitoring relations, conducting appeal processes, etc). These organizations could be built around the regional HIO offices<sup>8</sup>, the FHF units and the TSTs.

<sup>7</sup> Ideally, the single payer functions would be performed by a single, national organization. There are significant economies of scale arguing for a national organization as the single payer, as well as the possibility for the broadest possible pooling of funds.

<sup>8</sup> The regional HIO offices already have capacity to perform many of the necessary local functions of a single payer. They now hold and distribute funds to providers. They also perform provider contracting services, and monitor performance.

**Figure 5: Third Implementation Approach Choice of Private (NPPP) or Public (DPO) Network**



The new unit would be integrated within the HIO/Single Payer organization. However, these units would not manage funds, nor make policy. Considerable capacity has been built within these units in the past two years, and this capacity needs to be mobilized to support the enhanced concept for the Districts.

Several important stages would need to occur to integrate the single payer HIO and FHF activities. These might include conducting a baseline assessment of the capacities of the HIO and FHF and TST units in insurance functions and determining training and technical assistance requirements. This could be followed by implementation of a program of training and technical assistance in priority need areas. And, of course, the HIO will need support to enable it to separate provision of services from payment inside the organization.

### 3.2. Consumers' Selection of a Plan:

All families in a district would be required to choose between three insurance and delivery plan options:

1. Roster in one of several Family Care Models (FHUs),
2. Enroll in a Network of Private Pre-approved Providers (NPPP)
3. Enroll in a network of public providers like a district provider organization (DPO).

In the Family Care Model the families would roster in a FHU and receive specialty care and hospital care from public sources, as now done in the pilot governorates. On the other hand, families could enroll in the provider network NPPP, composed of private sector and NGO doctors and hospitals. Families would (eventually) pay premium contributions and user fees in both options. However, the family financial contribution would be significantly more in the NPPP option, and for all but the poorest families, would need to be sufficient to fully finance the plan.

### **3.3 Selecting and Pre-Approving Providers for the NPPP**

NPPP is form of insurance scheme where individual physicians, or group practices, participate with the fund and agree to become part of a network of providers delivering services to enrolled population and be paid according to a pre-set fee schedule. These could include private or NGO providers.

These providers could be individual doctors or group/outpatient clinic practices, hospitals and independent labs. The model would **not** require their practice to be dedicated to enrollees. This would allow providers to continue to be able to serve non-enrolled patients. By not restricting providers to dedicate their entire facility to attend only enrolled patients, private providers are more likely to participate.

Group practice needs to be encouraged in the provider selection process. Not all types of providers should be equally preferred. There is good reason to believe that providers who operate in group situations (in a clinic, or in an outpatient department) have more peer pressure and more organizational pressure to adhere to rules and practice wisely. It is also probably easier to administer and work with a group of providers than individual providers, since these organizations often have administrative support staff and better systems for billing and payment.

Encouragement of this form of “group practice” can be done in several ways. One way is to set higher payment rates for such organizations. Another way to encourage this form of organization is to set lower user fees (and pay larger subsidies). Either way, the idea is for the fund to pay more for better quality providers. These forms of encouragement would tend to promote formation of such organizations in Egypt. Other providers, not in such groups, with demonstrably better quality could also be paid more based upon experience in the plan.

#### *How are NPPP Providers Selected?*

Selecting high quality providers is the key to the success of the NPPP. Providers in the NPPP would be selected according to quality screening criteria. This would be done using a competitive process. The process would begin with broad notification or solicitation wherein candidate providers would be able to review two key policy documents:

- ▲ “Conditions of Network Participation” – a form of streamlined contract that establishes policy about what is to be expected from providers, and
- ▲ “Payment policy and fee schedule”

Interested applicants would then be screened according to streamlined quality standards according to type of services to be provided (all basic primary care services, just obstetrics, just pediatrics, other specialized services, etc). These quality screens would be derived from, but less intensive and less thorough than the accreditation standards that are now used for FHU facilities.

*How many providers are needed in the NPPP?*

For start up, the best approach may be to allow all who qualify be included. This allows families to select from the broadest possible list. The continuing process of monitoring and profiling of provider practice patterns (see section on Quality below) would be used to exclude providers who fail to practice according to the provider agreement.

*How will the quality of care of NPPP providers be monitored?*

Quality objectives need to be met by two means; (1) initial provider screening criteria, and (2) profiling provider behaviors through the use of claims data. Both of these objectives can be met by drawing upon the quality improvement activities and tools previously developed for the Family Model. The network providers need to be monitored continuously, a process largely based on examination of the administrative data from the bill and payment process (e.g. the claims process). This process is often called “provider profiling”, and should include feedback on the basic measures and comparisons against other providers and/or external standards (as was the design of the FHF provider monitoring system).

This profiling activity, as well as more in depth retrospective review of records, are the principal means for monitoring quality of provider services and appropriateness for continued participation in the network. These functions (administering provider screening criteria, provider profiling) would be performed by the single payer organization. The policies regarding such activities would require participation and/or advice from some widely respected quality oversight committee or body.

*How will over-utilization be controlled?*

A risk of the NPPP model of service delivery and financing is over-utilization. There are several ways to discourage over-utilization:

- ▲ Require designation of primary doctor (gatekeeper)
- ▲ Referrals by gatekeeper to other providers have lower user fee than unauthorized (self) referrals
- ▲ Claim review process based on rules and criteria for limiting overuse
- ▲ Continued provider participation is determined based on profiling and retrospective utilization review activities
- ▲ Pre-authorization of special procedures and hospital admissions (when available)
- ▲ Enrollee counseling for exceptional situations of over-use
- ▲ User fees

Some of these are common single payer functions and requirement of insurance plans. The development of utilization controls appropriate to Egypt is something that will evolve over time. No particular design is failsafe, and vigilant monitoring of performance and costs (at the policy level) and development of capacity within the single payer for analyzing data and conducting related research on the benefits and costs of new policy in this area will be very important.

### *How will continuity of care be promoted?*

Though the NPPP is built around the concept of self-referral, it is possible to encourage continuity of care. One way to do this is to designate a primary care doctor as a “gatekeeper” so patients would have to see this doctor first in order to be referred for secondary care (specialists, diagnostics, or inpatient care). Indeed, one of the most critical early pilot design decision will relate to whether to have a gatekeeper in the NPPP plan. A gatekeeper, in theory, will make referrals according to medical need. Building capacity for this function in Egypt is not unlike training doctors in family practice. It may not be possible to begin the research implementation work with such a model, but could be planned for a later stage.

### **3.4 Financing of the Single Payer Fund**

Financing for the fund for the District pilot would come from three sources:

1. Insurance Funds: Employers and others insured by the HIO;
2. MOF funds: and MOHP for the uninsured; and
3. Enrollee premium sharing (based on a means test).

Financial resources to pay providers would come from these resources, and the pooled funds would be used to pay providers according to payment rules. The nature of the fund, and the contributions, would depend on the role of the MOHP in the research project and the ability to get new law (or an exemption) for families to contribute premiums.

There are two ways for the MOHP facilities to participate in the research project in the pilot district. If FHUs exist, then MOF/MOHP will need to contribute operating funds (in the form of a premium) to the single payer fund so that the single payer can pay the FHUs a capitation fee. An alternative to this is for the fund to make capitation arrangements to a District Provider Organization, which would manage resources for all MOHP facilities in the district.

The HIO would also need to contribute operating funds (in the form of the premium) to the Fund for insured persons who elect to join the NPPP.

#### *What is included in the Premium?*

The premium will include the full, expected cost of providing the coverage package plus the costs of administering the single payer function. The premium should be made to include three elements:

- ▲ Expected payments to providers according to anticipated utilization, the fee schedule, and the user fee amounts (typically about 80–85% of premium)
- ▲ Administrative costs of the NPPP plan – including all costs associated with administration of the single payer function, network creation and maintenance, and claims processing (around 12–16%)
- ▲ Risk premium – for building a modest reserve for the Fund (around 2–3%)

All three sources of financing will be pooled in a single district/governorate pool and paid out by the single payer organization. However, many steps are needed to determine the premium level and how much each financing source will contribute to the fund. Some of these steps are:

- ▲ Specifying the benefit plan or coverage,
- ▲ Estimating provider costs for these services,
- ▲ Estimating willingness to pay by families (both premium sharing and co-payments)
- ▲ Estimating the required premium and its components.
- ▲ Estimating the required subsidies for the plan for including the poor (including the estimated demand for this NPPP by the poor)
- ▲ Identifying the source of such subsidies

Important Note: The model we propose here for including private sector providers in a network will not be successful unless full funding is made available. It is important to understand that the FHU model was never able to operate under a situation of fully funded financing; recurring costs for the FHUs were provided directly by the parent organization (HIO, MOHP, NGO). This fact made it nearly impossible to get participation of private providers.

### **3.5 Provider Payment**

#### *Paying Public Providers*

As described above, the payment of public FHU providers by the Fund could be done in two ways. One way would be for the Single Payer to contract directly with FHUs and centers. This would provide the most autonomy and strongest incentives for productivity improvement at the point of service, but put the greatest management burden on the individual facility. Another approach would be to have the fund pay a District Provider Organization. This organization would be responsible for budgeting and paying for the resources required by the FHU, center, and inpatient facilities now operated by the MOHP.

#### *Paying NPPP Providers and User Fees*

Providers that deliver services to NPPP enrollees would be paid for the services they provide based on a pre-set national price schedule(s)<sup>9</sup>. The price schedule would be set according to the list of covered services, and would be done to encourage consumption of basic and preventative services.

Enrollees in the plan would be given a card certifying eligibility in the NPPP. Using this card, enrollees seek care from participating providers. Bills will be submitted by the provider to the single payer for payment. These bills would be forms that would be designed by the single payer and would

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<sup>9</sup> The price schedule is a pre-set amount per procedure or service. Possibly more than one price schedule will be required. Urban–rural differences in costs may indicate the need for more than one national schedule. Also, if higher prices are to be paid for certain types of providers (group practice, high quality) then multiple schedules will be needed. However, the point is to not negotiate separate price schedules with each provider. They should be shown the price schedule, and make a determination as to their willingness to sign the provider agreement, or not. They will certainly have a choice.

contain data about the presenting condition, the services provided, the recommended follow-up care (including Rx and referrals) and billed amount. If the single payer determines that other information is required to determine coverage or medical necessity of the services, then the payer will specify it in the payment policy, or suspend payment until the data is made available by the provider (i.e. data demonstrating the necessity for a C-section).

The fee or price to be collected by the NPPP provider will be of two parts.

- ▲ User fee from the patient
- ▲ Insurance amount paid to the provider

Patients would be responsible for paying a user fee at the point of service, with the amount (or percentage) determined by their economic status. The means test would be determined at the point of enrollment (and noted on the card). It is likely that the best way of administering this system is to have the patient pay a fixed percent of the authorized national fee, where the percentage is higher for wealthier enrollees<sup>10</sup>.

For the NPPP providers the price they are paid, in total, needs to be high enough to attract a sufficient number of them to participate in the plan<sup>11</sup>.

### 3.6 Covered Benefits

Both the public and private providers would cover a basic package of ambulatory services. This would be an ambulatory care package, broader than the BBP, representing all ambulatory (non-hospital) care needed by Egyptians. It is also possible and advisable that a more comprehensive package could be constructed (including secondary hospital care). Indeed several “levels” of coverage could be established, with richer packages being available for higher premiums.

To illustrate how the program choices facing the enrollee might work we prepared the following table. We assume here that three options would be available for mandatory enrollment in a district. Plan X is a basic plan (the Basic Family Health Benefit) including primary care in a rostered facility and basic specialty and inpatient care. Plan Y would include the NPPP, which provides flexibility of using providers in a network. Plan Z would have an expanded benefit package including expanded specialty coverage and other benefits. The presumed cost (excluding the contributions of the co-payments) are 80 le, 125 le, and 180 le respectively. Everyone, including the poor, would pay more for better coverage. We assume a pattern of enrollment in the table for purposes of showing the patterns of subsidy required by the government. The medium and high income persons will prefer the Y and Z plans, and not Plan X. The poor will likely prefer the Plan X. Assumptions about enrollment percentages for each population segment are shown in the cells of the table.

Under the assumptions on the table, Plan Y is nearly breakeven (with the middle and high income enrollees subsidizing the 10% of the poor who enroll in this plan). In Plan Y, the 23% of the

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<sup>10</sup> Possibly three groups would be constructed (poor, medium, upper) with the percentages of the national fee for the user component being on the order of 10%, 20%, 30%.

<sup>11</sup> It is not necessary, or even advisable, for the provider fee schedule to cover the full historical costs of care. The fees should have incentives in them for providers to be more economical than they have historically been. And, more important, because these providers are not dedicated to serving only reform patients (they have other business), they do not require a full cost payment in order to benefit financially from serving plan patients. They must have fees high enough to cover their added, or incremental, costs of seeing the patient.

population who enroll here more than pays for itself by an amount of 12.90 le per citizen. This amount covers about half the cost of the basic Plan X, which is dominated by poor enrollees, resulting in a required public subsidy of 27.60 le per citizen<sup>12</sup> in the district. This would change under differing assumptions about plan cost, distribution of population across the three income categories, enrollment in the plans, and the premium levels by plan by population segment.

**Table 1. Health Plan Coverage Options and Cost Sharing by Families**

	<b>Family Income High 20% of pop</b>	<b>Family Income Medium 30% of pop</b>	<b>Family Income Low 50% of pop</b>	<b>Est. Cost of Package per Capita</b>	<b>Public Subsidy Required</b>
Plan X: Basic Plan without NPPP	Premium: 125 Copay: 10 5%	Premium: 100 Copay: 5 20%	Premium: 15 Copay: 2 90%	LE80	- 27.60 per cap 52% of pop
Plan Y: Basic Plan with NPPP	Premium: 170 Copay: 10 10%	Premium: 145 Copay: 5 60%	Premium: 30 Copay: 2 10%	LE125	-00.25 per cap 25% of pop
Plan Z: Added benefits including NPPP	Premium: 250 Copay Basic:10 Copay extras 20 85%	Premium: 200 Copay Basic: 5 Copay extras 10 20%	Premium: 60 Copay Basic2 Copay extras5 0%	LE180	12.90 per cap 23% of pop
	100%	100%	100%		-14.75 per cap

#### 4.0 The Need For Quality Monitoring and Regulation

This concept of NPPP will not succeed unless it is supported by a strong monitoring and regulatory process, much of which will need to be developed during the implementation phase and based upon the procedures developed for the Family Model. Standards and enforcement approaches (some by the central authority and some by the single payer) need to be developed for ensuring:

- ▲ Quality of participating providers
- ▲ Quality of services provided
- ▲ Avoid fraud
- ▲ Avoid over-utilization of unnecessary services
- ▲ Avoid under-utilization of needed services, such as PHC services, prevention services, counseling and patient education, etc.
- ▲ Access to the poor and those who need the services the most
- ▲ Equity in resource distribution: rich subsidizing the poor through higher premiums

<sup>12</sup> The subsidies (both plus and minus) are expressed per citizen, not per enrollee. For example, the basic Plan X has a total subsidy of 27.60 per citizen, or about 54 le per enrollee in that plan. For poor enrollees only, the subsidy would be 65 le in that plan.

Some regulatory activities and policies that could be designed and implemented are:

- ▲ Provider participation agreement
- ▲ Utilization review procedures
- ▲ Provider profiling procedures
- ▲ Continuous provider and beneficiary education
- ▲ Dissemination of Clinical Guidelines and Standards
- ▲ Developing different forms of monitoring/accreditation.
- ▲ Accreditation of participating PHC Units and hospitals.
- ▲ Guidelines for “gatekeepers”
- ▲ Mechanisms to ensure continuity of care (e.g. profiling of patients)
- ▲ Appropriate referral standards

These activities are likely to require regulatory leadership and policy formulation at the central level, and implementation in many cases by the single-payer organization.

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## 5.0 Key Pilot Study Questions

There are several critical study questions that this proposal aims to address:

- ▲ How broad will enrollment be in a district being offered these choices? Is participation of providers and families big enough to consider this mixed choice model as having potential for achieving universality throughout Egypt (or at least the urban areas)?
- ▲ What kind of primary care model is preferred by different groups of Egyptians? Are Egyptians willing to pay more for choice of preferred provider? By offering choice of plan, we will be able to observe this directly in the district site, and it will be possible to better understand the requirements for universality of reform.
- ▲ Will the NPPP model attract more participation of the private and NGO sectors?
- ▲ Does the NPPP model of insurance achieve high levels of quality and economy? Are there any important differences between the FHU model and the NPPP with respect to practice patterns, ability to meet quality standards, and other outcomes?
- ▲ Is utilization of services too high in the NPPP model? Is it going to be necessary to have persons choose a “gatekeeper doctor” in the NPPP model (a primary provider who controls access to specialists and other referral services)?
- ▲ What are the actuarial costs of the benefit and the premium requirements? What levels of premiums, premium sharing, and co-payments seem necessary for financing the benefit package?

- ▲ Is the single-payer organization able to effectively perform insurance administrative functions in a professional fashion and at low levels of administrative cost? Can this function be performed for all of Egypt by a centralized organization, supported by small district offices? Is the NTL system able to support all NPPP and FHU models of reform and the open enrollment activity?
- ▲ By separating the provider and payer functions for the FHU organizations in the district, we can discover the effects of this separation (and the autonomy afforded to the unit managers) on the effectiveness of FHU operations. This can be done by comparing unit costs and patient satisfaction in this site with other FHUs in the pilot governorates (where there has been no separation of provider and payer functions).

The research activities necessary to answer these questions would be conducted in parallel to the implementation work. A research plan would need to be designed as soon as the specific details of the implementation are settled.

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## 6.0 Summary of Essential Next Steps

The previous sections have described a new Model to be implemented using a research approach and have mentioned a number of preparatory activities.

Preparatory activities are summarized here:

1. Develop a more comprehensive set of covered benefits (broader than the BBP) that reflects actual utilization in the FHUs that could be used to develop the benefits package for the District Model
2. Select pilot site(s)
3. Develop actuarial estimates of the costs of this benefit package and required premium
4. Assess the capabilities of the HIO for performing single payer functions, and build capacity where needed
5. Assess willingness to pay premiums and user fees for different groups of Egyptians in the pilot site and establish cost sharing policies?
6. Assess private provider, NGO provider, syndicate and other stakeholder interest in the network approach
7. Coordinate with TSO/TST/other donors to establish a public sector network in the pilot site
8. Determine how the subsidies will be financed
9. Assess adequacy of computer systems for single-payer functions

Work also remains to be done to determine the demand for NPPP by private doctors and other non-governmental health care organizations. A systematic understanding of the demand for private sector participation in the reform process is not available in Egypt. Assessing this demand would be required to better design models of participation. This knowledge could be gained by designing a set

of plausible options for interventions (as above, but in more detail) and testing them using focus groups of private providers in the pilot Governorate/district, or more broadly.

A second area of uncertainty is the reality of cost and quality differences between private and public sector provider organizations. It is not known if private sector organizations are less or more costly than service delivery in the public sector. Certainly, there are wide ranges of quality in both sectors, but the extent is not known. An assessment of these differences would lend a basis to the thinking about what gains might come from different candidate interventions.

# Annex B: Benefits of Separating Payer from Providers

Separating the provision of care from financing is valued in health system strengthening for several reasons. The separation itself provides little direct benefit, other than more specialized focus of management attention. The benefits of “separation” arise primarily because of three main activities that are permitted by the “separation”. These are:

- ▲ *Pooling funds.* If financing is pooled (across programs, across delivery organizations, across covered populations) in a single fund, administered by a single payer, the **opportunity is created to distribute the funds to the care of the people in a more equitable way** because the funding base is broadened. Without pooling, then the generosity of care in one program or one group of individuals can persist.
- ▲ *Methods used by the Payer to compensate Providers.* By creating separate “payer” and provider organizations, then we must **replace management controls** (that might have linked provision and payment within an organization) – **with contracts or payment provisions** between the payer and the provider organizations. Essentially, this means promoting operational and financial autonomy of providers (or provider organizations) who will then deal directly with the single payer for funding, subject to whatever performance standards are established in the contract. This is generally perceived as a ‘good’ thing, because it creates much sharper incentives for providers or provider organizations to eliminate waste and improve productivity.
- ▲ *Separating Health Finance from Government Budgeting.* A third reason for separating payment from provision that is sometimes mentioned when government organizations are involved is that by creating a separate “fund” for the payer to administer, **the integrity of the fund is separated from the annual verities and politics of government agency budgeting.** This is seen as a ‘good’ thing because the fund manager is left to worry about the longer term financial stability of the of the fund (relationship between the inflow of funds and the related flow of coverage requirements) rather than be preoccupied with annual government budget issues. The benefit here would be that the single payer/fund manager would tend to be preoccupied with creating a situation where benefits, payment rates, coverage controls and administrative costs are balanced against the fund’s expected inflows. This imperative of ‘balancing’ as a fund manager is notably different than the administrative department manager who often has less flexibility to control outflows, and is responsible for running a department rather than balancing funds and spending.

Pooling more broadly is to be preferred to maintain equity across regions, and across population groups. In the US, where there is not a national fund, the fund established (nationally) for the elderly (Medicare) is sometimes more or less generous than funds established for military families, for veterans, for poor people, or the privately insured persons. Here, worries continue about equity across groups, and separate ‘classes’ of providers who often tend to specialize (some refuse to treat the poor, because these funds tend to be less generous in payment rates). In Canada, there is no national fund

either, with separate funds (and single payers) for each province. While there are rigid national standards for coverage and payment, there is always a worry that the more wealthy provinces may be able to offer more and better benefits than the poorer places.

Currently most of the resources in the Egyptian health care system are owned, operated and financially controlled by two organizations; the MOHP and the HIO. Creating a single payer in Egypt would essentially require that both organizations relinquish financial controls on providers in one way or another. Presumably the result would be that HIO might become a single payer organization, contracting for all the care required to deliver services to the currently “insured populations”, including the poor others who might be “covered” by reform provisions and financed by the MOF and premium contributions of households. The MOHP, in such a single payer model, might specialize in policy, special programs and regulatory activities much as the MOH does in most developed countries. In such a model, the single payer not only looks after the “fund” but specializes in performing all of the necessary administrative functions such as benefit package maintenance, enrollment, premium and cost sharing calculations, contracting with providers, payment policy, claims adjudication, provider certification, utilization review and control, and appeals from provider and citizens. All of the matters of medical coding and administrative data requirements are included as single payer functions too.

What would happen to the MOHP or HIO providers in such a world? Several models could be imagined:

- ▲ **Divest** the facilities and workers from MOHP/HIO. This would create complete autonomy for providers, and remove all delivery system involvement from the MOHP. It is an extreme approach given the history of public provision and public employment in Egypt’s health system.
- ▲ Create **District Provider Organizations (DPO)**. These could be government (MOHP or HIO) provider organizations that contract with the single payer for delivering services. The DPO might be set up to include **only FHUs and Centers, or it could be broader**. The idea would be that there would be competition for the DPO (in the form of a NPPP, or other kinds of delivery systems that are available and encouraged by the single payer). The DPOs could be organizationally attached to the MOHP, for example, but they would be financially autonomous and would be paid according to contracts with the single payer, who would be financed by the MOF/Employers for all the resources needed to deliver covered services (e.g. all service delivery monies would be re-directed by MOF to the fund rather than to the MOHP). Here, the ultimate decision about whether to contract with such organizations at all, and how much to pay would need to be made by the payer organization. The link between provider and payer would be broken, though the district officials might retain certain administrative and management functions.
- ▲ **Decentralize Budget Authority to Districts (DBA)**. A possible first step toward a DPO would not require re-directing funding from the MOHP to the single payer (as would be the case for the DPO). The MOHP (or the HIO too) could achieve many of the same benefits by simply financing the resource needs of the District, by giving them a Global Budget (which would be set based on expected service volumes) and the flexibility to move monies between lines as they see fit. This would mean that the fund would not have the ability to pool these funds. Instead they (the payer) could perform the role of determining the financial requirements for the DBA, and working with the MOHP to determine the likely volume levels and the associated level of funding required in the DBA. While funds would not be “pooled” nor diverted from the MOHP, the DBA would be able to contract with the single

payer, and would presumably be contracting with other providers in the district (such as a NPPP).

- ▲ **Decentralize Budgets to Certain Providers (DBAP).** Under the DBA or DPO models, there would be an incentive for the District to contract with the providers in a way that creates powerful incentives for the providers to be economical and successful in recruiting clients.

In summary, this is possibly the most difficult aspect of financing reforms. The separation of provider and payer functions means more than splitting the HIO to create a single payer agent. Doing this alone would mean very little and would have no real impact on the health system. The single payer needs to be able to set payment arrangements with autonomous provider organizations, who have both the incentive to perform within financial limits, and the authority to do so. Clearly, this is an area where stages of reform need to be considered. At the first stage, there must be an assessment of the capacity to operate autonomously at the provider and district levels. Second, there will likely need to be strengthening of the capacities of these organizations to become more autonomous---both management capacity and accounting capacity.

# Annex C. Ministerial Decree Chapter 147

The following is an English translation of MD 147.

## **Organizational Regulations (financial and administrative) of Distinguished Family Health Centers and Units**

### **First Chapter**

#### **Scope of the Regulations and the Aims of Distinguished Family Health Units and Centers**

**Article No. (1):** These regulations are applied on the family health centers and units, enjoying the following conditions:

1. being distinguished units,
2. approved technically,
3. working in the framework of the Health Sector Reform Program (HSRP),
4. contracted with the family health fund.

**Article No. (2):** These centers and units aim at implementing the policies of the HSRP through delivering a package of comprehensive health services governed by family health system. They work with a system of comprehensive quality according to specified and agreed upon criteria leading to the satisfaction of the service beneficiaries.

**Article No. (3):** Following are definitions of terms:

*Family health unit:*

It is the first model of health facilities working in the field of family health. It has one or more staff to deliver services. Every staff consists of a family doctor and his assistants. Every staff is responsible for taking care of 600-700 families. They may work two periods, one in the morning and another in the afternoon.

*Family health center*

It is the second model of the health facilities working in this field. It may include a family health unit. The centers include three specialties, namely, pediatrics, internal medicine and gynecology, to examine the cases transferred from the family health units connected to them. The center has an equipped room for delivery, an operation room, an advanced lab to do medical analysis, and X-ray as well as TV equipment.

*Family health fund*

It is a financial and ensuring fund, working as an agent to contract on purchasing the health services for the benefit of family in order to separate the funding of health services from delivering them, and to assure its quality and sustainability.

#### *Service improvement fund*

It is a financial fund to organize the paid treatment at hospitals and the health units of the local department according to the ministerial decree no. 239 for the year 1997.

#### *Referral hospital*

It is the general or central hospital located in the health department or medical area where the distinguished family health centers and units work, and to which the cases needing a higher level of service are transferred.

**Article No. (4):** The staff of such units and centers are selected through assignment by the Ministry of Health and Population (MOHP), or contracting with persons from outside the ministry on condition that they get suitable training in the field of family health and application of HSRP concepts.

**Article No. (5):** It is possible to ask the help of private and nongovernmental sectors in delivering the service according to the contract with the family health fund and following its policies and regulations.

### **Second Chapter**

**Article No. (6):** Each unit or center forms an administrative board after a decree from the concerned governor according to the suggestion of the health affairs director at the governorate. It consists of seven members, two of whom are from the public personalities who are concerned with the health affairs. It is headed by the unit or center director. The board members choose a permanent secretary.

The head as well as the members of the administrative board are given sessions attendance allowance from the unit financial allocations in the family health fund. The allowance is fifty pounds for every sessions and maximum twelve sessions in the year.

The board holds a meeting monthly according to an invitation from the board head. The invitation is sent at least three days prior to the date attached with the agenda and the memos of the subjects presented to the board. The board head could, when necessary, invite the board members for meeting without being restricted to the mentioned dates and measures.

The head could also invite the board members to a meeting if most of them ask for one, on the condition that the request is attached with the reasons lying behind it, the meeting tackles only the specified subjects. The meeting becomes right if most of the members attend. If the legal number does not attend, the board head or his deputy, in case of his absence, schedules another meeting within one week. The meeting becomes right if the attendees are not less than four members including the board head or his deputy.

The minutes of the sessions are recorded in a special register. The session minutes demonstrate the date of the meeting, the time of the meeting beginning and conclusion, names of attendees as well as the absent members, the subjects tackled and the decisions taken in this concern. The member who has a contradicted opinion has the right to mention it in the minutes. The minutes are signed by the board head and the permanent secretary.

The board could invite anyone working in the health directorate or medical area, or anyone having wide experience to attend the sessions in order to benefit from his opinion in a certain subject presented to the board without being a counted voice in the discussions.

The board head or his deputy, when absent, is responsible for managing the sessions. The board decisions are issued according to the majority of the attendees voices. If the voices are equal, the side including the head voice is recommended.

- Article No. (7):** The administrative board carries out the responsibilities and authorities necessary for the supervision on the managing of the unit or center in the framework of the policy and general plan of the MOHP. To attain this, it could:
- a. Set the annual implementation plans of the unit or the center and supervising its implementation.
  - b. Supervise the services delivered in the unit or the center.
  - c. Set the policies leading to the sources development, costs restrictions, make sure that work is going well, and accreditate the means helping in increasing the efficiency of services.
  - d. Follow up the implementation of quality program requests at the unit or center.
  - e. Follow up the implementation of the accreditation conditions of the unit or center.
  - f. Make contract with the family health fund to deliver the service.
  - g. Approve the evaluation of the professional performance of the employees at the unit or center.
  - h. Organize the expenditures from the special account of the unit or center according to the approved annual plans.
  - i. Accept the presents, donations and gifts in order to attain the activities of the unit or center aims, taking in consideration the regulations and laws followed and what is mentioned in the these regulations.

### **Third Chapter**

#### **The regulating rules of treatment at the distinguished family health units and centers**

**Article No. (8):** These units and centers are managed by the system of paid treatment to serve the local society surrounding them.

**Article No. (9):** The working hours of the medical staff teams are 6 hours, divided into two shifts (morning and night shifts) according to the number or registered families and the available medical staff teams.

**Article No. (10):** Each beneficiary who has no health insurance will pay three pounds as a fee for the examination, at any time except the following:

- a. Emergency cases,
- b. Check up cases.

**Article No. (11):** Each beneficiary registered in the unit or the center and who has no medical insurance will pay 1/3 of the price of the prescribed medicine.

- Article No. (12):** Each beneficiary member will pay 10 pounds and each beneficiary family will pay 30 pounds for opening a family folder at the beginning of registering the family at the unit or center. Each beneficiary member who has no health insurance will pay 5 pounds and or the family will pay 15 pounds for renewing the file annually.
- Article No. (13):** The beneficiaries who have no health insurance pay the fees of the lab services, radiology lab, dentists and minor surgeries according to the attached price list.
- Article No. (14):** Each unit or center will be contracted with the family health fund to deliver services directly or through the different health departments or the groups responsible for delivering the services, compromising the private and nongovernmental sectors.
- Article No. (15):** The total income of each unit or center, according to these regulations, will be collected and transferred to the family health fund on weekly basis. The price of medicine is set to complete the purchase of the essential drugs for the unit or the center.
- Article No. (16):** 40% of the money transferred to the family health fund from the unit or the center, after keeping away the price of the medicine, will be allocated to actions aiming at improving the service at the unite or the center, such as:
- Purchasing emergency medicine,
  - Purchasing the medical supplies, x-ray films and dentist supplies,
  - Purchasing the non-medical supplies,
  - Purchasing and maintaining equipments,
  - Building's maintenance,
  - Attendance allowance for the sessions of the administrative board.
- Article No. (17):** The family health fund will carry out the expenditure of incentives for the supervision team at the health directorates, health districts, specialists at the referral hospitals, ambulance staff that cooperate with the HSRP, according to Article no. 11, third paragraph, in the organizational regulations of the family health fund, issued by a ministerial decree no. 190 for the year 2003.

#### **Fourth Chapter General Rules**

- Article No. (18):** The name of the health service fund account is to be changed to family health unit or center – HSRP.
- Article No. (19):** Laws of health insurance and rules of the basic regulations for hospital and the medical units related to the local departments, issued by a ministerial decree no. 239 for the year 1997, of Minister of Local Administration and Minister of Health and Population, will be applied in matters not tackled in these regulations.

# Annex D. Contract between Family Health Fund and Provider

## Agreement to Provide Health Services to the Inhabitants of \_\_\_\_ Municipality and City in \_\_\_\_ Governorate

On.....corresponding to.....this agreement has been made between:

1. Family Health Fund at.....as a purchaser for the health services, represented by Dr.....in his capacity as Manager of the Fund. (First Party)
2. Facility .....in Governorate..... Represented by Dr. \_\_\_\_\_ director of \_\_\_\_\_ facility (Second Party).

In order to conclude this Agreement according to the following articles:

### **Article 1** **(Responsibilities and Obligations of the Second Party)**

The Second Party shall be committed to undertake the following:

1. Rendering specialty and/or secondary health care services covered under or attendant to the package of the primary services (Annex BBP\_\_\_\_).
2. Second Party facility agrees to provide the following specialty and technical service services to enrollees in the health sector reform program (list of services to be provided by Second Party annex \_\_\_\_).
3. The only services covered under this agreement are those requested by family doctors in FHUs, as described on a valid referral request form (Annex 1) and presented to the Second Party by the patient.
4. Second party agrees to deliver only those services called for in the request for referral (annex 1), and to do nothing to cause patients to fail to return to their family doctor. If the family doctor agrees to extensive follow up care by the Second Party, then a referral request of this sort must be made by the family doctor using the form in Annex 1.
5. Second Party agrees to submit required forms (annex 1) and clinical findings, test results, procedures and findings to the First Party on completion of services called for in the referral request.
6. Agreeing to be reviewed by appropriate accreditation authorities using a suitable protocol (clinic or hospital) and to bring the facility in compliance for the contracted services within one year of notification of deficiencies.
7. Being committed to the exemptions policies specified by the Technical Assistance Sectors and the projects of the Ministry of Health and Population (Annex No. 12).

8. Second Party will receive payment for referral services from patients according to a negotiated schedule of fees. These fees will be negotiated between the Parties prior to the agreement becoming effective. These fees are shown in Annex \_\_\_\_).
9. In the case of patients who are determined by the First Party to be exempt from fees because of poverty the referral form will make note of this (annex 1) and the Second Party will agree to provide the referral services according to the referral ticket and not seek payment from the patient. The First Party will make payment of the negotiated fees for these services.
10. Periodic (quarterly) assessment of the Second Party's performance under the contract and may make Incentive Payments at levels ranging from \_\_\_ le per referral to \_\_\_ le per referral.
11. Second Party agrees to permit First Party to collect information, review clinical records, and otherwise audit the performance of the Second Party under the terms of this contract.

**Article (2)**  
**(Responsibilities and Obligations of the First Party)**

The First Party Shall be committed to undertake the following:

1. Unilaterally determine what the scope of services to be referred to the Second Party will be.
2. Negotiate in good faith (with the Second Party) to arrive at a fee schedule for services to be paid under this contract.
3. Notify the Second Party in writing and in a timely fashion, of any concerns regarding contract compliance.
4. Pay the Second Party for the services referred by family doctors in Family Health Units to persons who are exempt because of poverty.
5. Facilitate disputes and concerns of the FHUs and the Second Party regarding provision and recommending of referral services.
6. Conduct periodic studies to determine what incentive payments might be due to the Second Party, and making such payments, as appropriate.
7. Investigating the complaints that were referred to him by the beneficiaries of health services units and centers, and notifying the Second Party of the results of the investigation in order to adopt the necessary procedures as soon as possible.
8. Conducting periodical evaluation concerning the beneficiaries' acceptance and the health services providers.

**Second: Methods of payment to hospitals and they shall be according to Annex No. (17)**

**Article (6)**  
**Duration of the Agreement**

The duration of this Agreement shall be effective from date of signing it by the two parties.

In case one of the two parties does not desire to renew the Agreement, the Second Party shall be notified by a written letter at least three months before termination of the Agreement.

The First Party has the right to terminate this Agreement before its termination date in the following cases:

- If the Second Party breached the implementation of any article of this Agreement without a reasonable excuse accepted by the First Party.
- If the Second Party breached the regulations applied by the PHR*plus* Project.

**Article (7)**  
**Arbitration**

In case any dispute took place between the two parties relevant to the enforcement of this Agreement, arbitration shall be effected pursuant to the arbitration principles stated in Law No. 27 for the year 1994 relevant to Arbitration.

**Article (8)**

This Agreement is made in four copies, two copies handed to each party, the third copy shall be filed at the Health Affairs Directorate in the Governorate and the fourth copy shall be filed at the Technical Support and Projects Sector in the Ministry of Health and Population.

<b><u>First Party</u></b>	<b><u>Second Party</u></b>
Name:	Name:
Title:	Title:
Signature:	Signature:

**Annex: List of Contracted Services and Negotiated Fees**

Referral Service

Negotiated Fee

# Annex E. Referral Approval and Payment Form

## SADAT Family Health Unit (FHU)

Patient Name

Date

Patient Age

Exemption Status

FHU ID #

\_\_\_yes \_\_\_no

Name of facility to which the referral is being made

Services being referred

- 1.
- 2.
- 3.

Family Doctor Name

Family Doctor Signature

**Billing portion of the Form**  
to be completed by the referral facility

Service	Service Date	Facility Negotiated Rate	Patient Paid Amount
1.			
2.			
3.			
4.			
5.			
<b>Total</b>		_____	_____

Name of Doctor  
Name of Facility

Signature of Doctor

**Instructions.** Please submit this form in its original to \_\_\_\_\_ at the FHF offices at \_\_\_\_\_ and attach medical documentation pertaining to above services (test results), medical findings, prescriptions or drugs provided, description of procedures and results.

## Annex F: References

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