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Suggested National Health Sector Reform Strategies, Benchmarks, and Indicators for Egypt

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The Partnerships for Health Reform Project (PHR) seeks to improve people's health in low- and middle-income countries by supporting health sector reforms that ensure equitable access to efficient, sustainable, quality health care services. In partnership with local stakeholders, PHR promotes an integrated approach to health reform and builds capacity in the following key areas:

- *policy formulation and implementation*
- *health economics and financing*
- *organization and management of health systems*

PHR advances knowledge and methodologies to develop, implement, and monitor health reforms and their impact, and informs and guides the exchange of knowledge on critical health reform issues.

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Abstract

This document proposes appropriate, verifiable benchmarks that can be used by the United States Agency for International Development (USAID) and the Egyptian Ministry of Health and Population to track the ministry's progress toward the completion of a mutually agreed-upon health sector reform agenda. The agenda was developed by the USAID and has the ministry's approval. The USAID provided the agenda in draft form to be used as the basis for this document. The agenda contains a mixture of legal and legislative changes, government policy reforms, and administrative and management procedural changes. It is anticipated that a subset of this reform agenda will form the basis of a Sector Program Assistance agreement between the USAID and the government of Egypt. These benchmarks will be included in the program agreement as conditions precedent to the release of program funds. Program funds are intended primarily to assist the Egyptian Ministry of Health and Population and the government of Egypt to meet (or offset) short-term costs associated with the agreed-on reforms.

This report was drafted by the Partnerships for Health Reform Project, a USAID-funded project, and it links suggested national health sector reform strategies to verifiable benchmarks and indicators. Assumptions are clearly stated. Benchmarks are delineated on an annual basis. The report concludes with a detailed table that links each indicator to specific strategies, definitions, data sources, and baseline values.

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Acronyms

CCO	Curative Care Organization
CHO	Curative Health Organization
CME	Continuing Medical Education
CRHP	Cost Recovery for Health Project
DALY	Daily Adjusted Life Year
DDM	Data for Decision Making
GOE	Government of Egypt
HIO	Health Insurance Organization
HIS	Health Information System
MCH	Maternal and Child Health
MOHP	Ministry of Health and Population
MOU	Memorandum of Understanding
PHC	Primary Health Care
PHR	Partnerships for Health Reform
SO	Strategic Objective
SPA	Sector Program Assistance
USAID	United States Agency for International Development

Preface

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

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

Volume I Suggested National Health Sector Reform Strategies, Benchmarks, and Indicators for Egypt

Volume II Economic Analysis of the Health Sector Policy Reform Program Assistance in Egypt

Volume III Social Vulnerability Analysis of the Health Sector Policy Reform Program Assistance in Egypt

Volume IV Legal Analysis of the Health Sector Policy Reform Program Assistance in Egypt

Volume V Analysis of the Political Environment for Health Policy Reform in Egypt

Volume VI Analysis of the Institutional Capacity for Health Policy Reform in Egypt

Volume VII Summary of Analyses

Proposed Health Sector Policy Reforms		
	Specific Strategy	**Generic Strategy**
1.	**ROLE OF THE MINISTRY OF HEALTH AND POPULATION (MOHP)**	
1.1	**Rationalize the role of the MOHP in financing curative care**	
1.1.1	Stop the construction of unnecessary hospitals and set strict guidelines for the completion of facilities under construction	Improve the allocation of the MOHP investment budget
1.1.2	Transfer existing hospitals to other parastatal organizations	Allow hospital autonomy
1.1.3	Expand cost recovery in government facilities	Expand cost recovery
1.1.4	Allow private practitioners to use the MOHP facilities	Allow private practitioners to use government facilities
1.1.5	Allow hospital autonomy	Allow hospital autonomy
1.1.6	Support hospitals based on efficiency indicators such as on a per capita, per bed basis, etc.	Use alternative budget allocation formula for MOHP hospitals
1.1.7	Examine the cost recovery of curative services at the primary health care (PHC) level	Expand cost recovery
1.2	**Strengthen the role of the MOHP in the provision and increased share of financing preventive medicine and PHC**	
1.2.1	Use cost-effectiveness analysis to identify a package of preventive medicine and PHC services to be supported by the MOHP to which every Egyptian is entitled	Increase the cost effectiveness of the MOHP's program
1.2.2	Increase emphasis on maternal and child (MCH) programs	Increase emphasis on MCH programs
1.2.3	Provide incentives for the health care providers to specialize in preventive medicine, PHC, and family medicine	Increase the cost effectiveness of the MOHP's program
1.2.4	Do not separate curative services at the PHC level	Continue to provide curative services in PHC facilities
1.2.5	Ensure adequate allocation of resources, e.g., personnel	Improve the allocation of the MOHP recurrent budget
1.3	**Reform the MOHP personnel policy**	
1.3.1	There should be no guaranteed employment	Reduce the overall number of the MOHP personnel
1.3.2	Develop guidelines for the MOHP personnel, and apply them to redistribute personnel based on needs assessment	Improve the allocation of the MOHP recurrent budget
1.3.3	Reduce the overall number of the MOHP personnel	Reduce the overall number of the MOHP personnel
1.3.4	Provide incentives for the MOHP personnel to serve in underserved and remote areas	Improve the allocation of the MOHP recurrent budget

Proposed Health Sector Policy Reforms		
	Specific Strategy	**Generic Strategy**
1.4	**Develop the MOHP capacity for national health needs assessment, sectoral strategic planning, and policy development**	
1.4.1	Adapt the national health information systems, including the Geographic Information System for planning and policy decision making	Improve the allocation of the MOHP investment budget Improve the allocation of the MOHP recurrent budget
1.4.2	Prioritize the allocation of the MOHP resources based on needs using health status indicators	Improve the allocation of the MOHP investment budget Improve the allocation of the MOHP recurrent budget
1.4.3	Create incentives for other health care providers to function in underserved areas	Provide incentives to private health providers to function in underserved areas
1.4.4	Target government of Egypt subsidy to poor and indigent populations	Improve the equity of the MOHP subsidies
1.4.5	Use cost-effectiveness analyses in determining the essential health services	Increase the cost effectiveness of the MOHP's program
1.5	**Develop the MOHP role in regulation, accreditation, and quality assurance of health services**	
1.5.1	Develop and adopt National Health Standards of Practice and health facility accreditation	Develop and adopt national health standards and accreditation
1.5.2	Establish a policy of continued physician licensing and continuing medical education (CME)	Establish CME and physician licensing
2.	**NATIONAL SOCIAL HEALTH INSURANCE PROGRAM**	
2.1	**Ensure the viability of the Health Insurance Organization (HIO)**	
2.1.1	Do not add any new groups of beneficiaries to the HIO	Eliminate the HIO's deficit
2.1.2	Eliminate the current HIO deficit	Eliminate the HIO's deficit
2.1.3	Reduce the proportion of the pharmaceutical costs	Redefine HIO's benefits
2.1.4	Unify the existing health insurance laws into one law	Unify existing health insurance laws
2.1.5	Change the HIO's legal and legislative framework to ensure its autonomy	Ensure the HIO's autonomy
2.1.6	Develop premium based on actual costs using copayments and deductibles	Redefine the HIO's benefits
2.1.7	Identify and adopt an affordable health benefit package(s)	Redefine the HIO's benefits

Proposed Health Sector Policy Reforms		
	Specific Strategy	**Generic Strategy**
2.2	**Transform the HIO into a financing organization**	
2.2.1	Stop constructing new HIO hospitals	Transform the HIO into a financing organization
2.2.2	Develop a plan to sell or transfer to other private or parastatal organizations, in phases, the existing HIO hospitals, polyclinics, and general practitioner clinics	Transform the HIO into a financing organization
2.2.3	Develop different mechanisms to subcontract all health service providers, including private and MOHP hospitals	Develop alternative reimbursement mechanisms for the HIO's contracted services
2.2.4	Allow beneficiaries to choose service providers	Transform the HIO into a financing organization
2.3	**Expand social health insurance coverage coupled with adequate administrative and financing mechanisms**	
2.3.1	Design and develop a single national health insurance fund for universal coverage	Expand social insurance coverage
2.3.2	Develop a well defined standard package of benefits that every citizen is entitled to receive	Redefine the HIO's benefits
2.3.3	Separate financing from provision of services	Transform the HIO into a financing organization
2.3.4	Ensure legal and financial autonomy of fund	Ensure the HIO's autonomy

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Executive Summary

The purpose of this document is to propose appropriate, verifiable benchmarks that can be used by the United States Agency for International Development (USAID) and the Egyptian Ministry of Health and Population to track the ministry's progress toward the completion of a mutually agreed-upon health sector reform agenda. The agenda was developed by the USAID and has the ministry's approval. The USAID provided the agenda in draft form as the basis for this document. The agenda contains a mixture of legal and legislative changes, government policy reforms, and administrative and management procedural changes. It is anticipated that a (yet-to-be-determined) subset of this reform agenda will form the basis of a Sector Program Assistance agreement between the USAID and the government of Egypt. These benchmarks will be included in the program agreement as conditions precedent to the release of program funds. Program funds are intended primarily to help the ministry and the Egyptian government meet (or offset) short-term costs associated with the agreed-on reforms.

Experience has shown (see the Evaluation and Documentation of Health Sector Non-Project Assistance in Niger and Kenya) that using conditionality to support reform requires significant levels of effort and oversight by the Mission to track progress against the established benchmarks and to assess their effect on the delivery of services and eventually the population's health and well-being. The reform agenda examined here is ambitious. It seeks to influence policy and operations in a wide range of areas. The suggested benchmarks (and indicators) contained in this document may be useful to the Mission in further refining and focusing the reforms to be contained in the final Sector Program Assistance program.

This document also suggests outcome indicators that will allow the USAID to assess the impact of the reforms completed. Some of these indicators are drawn without modification from the USAID/Cairo's Strategic Plan for Sustainable Improvements in the Health of Women and Children: Strategic Objective No. 7. In doing so, this document draws a direct link between the suggested reform agenda and Mission objectives and results for the health sector. It is assumed that the data necessary to track the Strategic Objective No. 7 indicators are available from the ministry sources. In some cases, relevant outcome indicators beyond those contained in the Strategic Objective No. 7 plan are also suggested.

1. Introduction and Background

The proposed reform agenda centers around two domains:

- The role of the Ministry of Health and Population (MOHP)
- The National Health Insurance Program

These domains provide the anchors for the health reform program to be initiated. The policy reform agenda and the sector reform strategies that the Mission chose under these domains are important in that they attempt, mosaic-like, to define a future vision for the shape of Egypt's health sector. The health sector reform strategies proposed and discussed here attempt to define a path through which health services delivery and financing become a much broader and richer partnership that involves not just the MOHP, but also private and social insurance institutions and private and parastatal health care providers. Within this framework, each partner will play a specific and defined role. Many of the current roles of the key players are unclear and in certain cases redundant. The new partnership that is implied by the proposed reform agenda can be characterized by the following:

- An MOHP that is responsible for the delivery of preventive and primary care services but that finances a package of secondary and tertiary services delivered by either private or parastatal health care delivery institutions.
- An expanded role for the Curative Care Organizations (CCOs) and newly created Curative Health Organizations (CHOs) in the management of all secondary and tertiary care facilities currently operated by the MOHP.
- A Health Insurance Organization (HIO) that is no longer involved in the direct provision of services but acts as a single national health insurance fund with universal coverage.

It must be remembered that the reform agenda supported by the Sector Program Assistance (SPA) alone will be insufficient to bring about such a transformation. The elements of the agenda supported by the United States Agency for International Development (USAID) should be developed in concert with other donors (most notably the World Bank) that are actively involved in health sector reform.

Several strategies in the preliminary reform agenda and discussed in this document may be redundant depending on their planned implementation and timing. For example, several strategies discussed with regard to the MOHP hospitals (i.e., increased cost recovery, granting of autonomy) would appear to be redundant if reforms designed to transfer all secondary and tertiary level facilities to the managerial responsibility of the CCO, the CHO, or other parastatal institutions are implemented fully. Such a transfer would imply both autonomy and cost recovery. The Mission should examine the reform agenda closely as part of the design process for the anticipated SPA program.

2. Suggested Benchmarks and Indicators

2.1 The MOHP's Role

2.1.1 Stop the Construction of Unnecessary Hospitals and Set Strict Guidelines to the Completion of Facilities Under Construction

Assumptions

This strategy is intended to redirect the MOHP capital budget away from the construction of unnecessary hospital facilities. Many facilities under construction are, presumably, secondary and tertiary level facilities or in geographic areas that already have access to sufficient levels of service. There appears to be no clear coverage targets, and/or the MOHP capital budget does not appear to be developed according to those targets. The ability to identify necessary or unnecessary construction projects implies a rational and needs-based approach to capital resource allocation. The MOHP must develop and apply criteria based on geographic distribution and estimated need for types of services in order to assess current construction projects and guide future decisions.

Suggested Benchmarks

Year One:

- The MOHP will submit to the USAID evidence of a one-year freeze on initiating facilities construction for all types of hospitals.
- The MOHP will conduct and submit to the USAID a comprehensive review of the current distribution of MOHP and CCO facilities and types and levels of services offered. The review will also set population-based targets reflecting the demand for hospital services for coverage by level and type of facility.
- The MOHP will submit to the USAID a plan for the completion of current construction projects that are justified by the comprehensive assessment described above. The plan will include steps necessary to terminate construction of unnecessary projects.

Years Two to Five:

- The MOHP will renew its moratorium on initiation of new construction projects pending completion and adoption of the facilities development plan described above.

- The MOHP will submit to the USAID evidence that expenditures under the previous year's capital budget and the next year's capital budget correspond to the plan developed in year one.

Indicators

The suggested benchmarks correspond (or contribute) directly to the following result indicators defined by the USAID/Cairo's Strategic Plan for Sustainable Improvements in the Health of Women and Children: Strategic Objective No. 7 (SO7):

- Percentage of the MOHP funding (recurrent budget) allocated for primary and preventive services
- Policy measures and benchmarks established and agreed to with the MOHP

In addition, the following indicator may be valuable in assessing the strategy's ability to improve the MOHP's capital spending:

- Percentage of governorate meeting (but not exceeding by more than 10 percent) population-based targets for all levels of the health facility

2.1.2 Transfer Existing Hospitals to Other Parastatal Organizations

Assumptions

This strategy assumes agreement by both the USAID and the government of Egypt (GOE) (not simply the MOHP) that the MOHP should not be responsible for the direct delivery of all secondary and/or tertiary level services. This would allow the MOHP to concentrate a greater percentage of its efforts and resources on preventive and primary care service delivery. This strategy assumes that CCOs or CHOs are the appropriate mechanism to manage secondary and tertiary care facilities rather than simple or individual autonomy or private ownership and operation for those facilities. In either case (CHO or autonomy), a key issue remains personnel and the ability of the managing body to hire, fire, and/or transfer personnel based on need. Currently, redundant personnel remain employed by the MOHP and constitute a financial drag on the MOHP budget.

Suggested Benchmarks

Year One:

- The MOHP will develop and submit to the USAID the legal and administrative elements needed for the creation of CHO in governorate(s) where they do not exist.
- The MOHP will create new CHOs in a number of additional governorates agreed on mutually by the MOHP and the USAID.

- The MOHP will submit to the USAID a detailed plan and timeline for the progressive transfer of secondary and tertiary level care facilities in chosen governorate(s).

Years Two to Five:

- The MOHP will create CHOs in remaining governorate(s) according to the agreed-on timeline.
- The MOHP will submit to the USAID evidence of the transfer of all facilities to CHO control in an agreed-on number of governorates, according to the timeline proposed in the detailed plan, on an annual basis.
- The MOHP will transfer at least one facility in all governorates with CHOs according to the mutually agreed-on timeline.

Indicators

The suggested benchmarks correspond (or contribute) to the following SO7 result indicators:

- Percentage of the MOHP funding allocated to primary and preventive services
- Policy measures and benchmarks established and agreed to with the MOHP
- Inpatient care provided in private facilities

In addition, the following indicators may be helpful in assessing the MOHP's progress in transferring direct service delivery responsibility for secondary and tertiary services:

- Percentage of hospitals remaining under direct MOHP management
- Percentage of governorate(s) with functioning CHOs

2.1.3 Expand Cost Recovery in Government Facilities

Assumptions

This strategy applies to hospital-level facilities only (cost recovery in primary care facilities is addressed in strategy 2.1.7). Targets for cost recovery initiation in hospitals should be developed in conjunction with the timeline for the transfer of facilities to the CCO/CHO authority (see 2.1.2 above). Cost recovery expansion for curative services may also be explored at primary care facilities (see 2.1.7 below). It must be assumed that a simplified model for hospital cost recovery, based on the Cost Recovery for Health Project's (CRHP) experience, will be adopted by the MOHP and be available for broader implementation. The criteria for identifying facilities to implement cost recovery under this strategy must be developed and clearly stated.

Suggested Benchmarks

Year One:

- The MOHP will refine and adopt a standard cost recovery model in the MOHP's hospital facilities (as recommended by the CRHP mid-term evaluation). The model should set specific, escalating annual targets for cost recovery revenues as a percentage of facility recurrent budget.

- The MOHP will develop and submit to the USAID a detailed plan containing agreed-on numeric targets and a timeline for the conversion of MOHP hospital facilities to the cost recovery model.

Years Two to Five:

- The MOHP will submit to the USAID evidence of conversion of hospital facilities to cost recovery status according to detailed conversion plan (benchmark to be repeated yearly for duration of conversion plan).

Indicators

The activities defined by this reform strategy correspond directly to the following SO7 result indicators:

- Percentage of MOHP recurrent budget allocated for primary and preventive services

- Number of MOHP hospitals/polyclinics operating as cost recovery facilities

In addition, the following indicator may be helpful in assessing the MOHP's ability to generate financial resources through cost recovery:

- Cost recovery revenues as a percentage of the total MOHP non-personnel recurrent budget

2.1.4 Allow Private Practitioners to Use MOHP Facilities

Assumptions

This strategy assumes that the financial burden of its currently underused infrastructure may be reduced by allowing private practitioners to use facilities on a rental or contract basis. Many MOHP practitioners with outside private practices currently use MOHP facilities at no charge (by admitting private, paying patients into MOHP facilities under their MOHP hat).

The mechanisms for implementing this strategy may be tested and refined under CRHP efforts to further develop and refine a standard cost recovery package/model for MOHP hospital facilities. Under this strategy, the use of MOHP facilities need not be confined to the hospital level alone and

could conceivably include polyclinics and other outpatient and diagnostic facilities as well, depending on demand.

Suggested Benchmarks

Year One:

- The MOHP will develop and submit to the USAID appropriate legal and administrative texts, decrees, etc., authorizing the use of MOHP facilities by private practitioners. These texts should specify that revenues generated through this cost recovery mechanism should be retained and managed by the facility itself.

- The MOHP will develop and submit to the USAID a detailed plan (including criteria for the choice of facilities in which the strategy will be implemented) and timeline for the implementation of the agreed-on mechanisms to permit use of MOHP facilities by private practitioners.

Years Two to Five:

- The MOHP will submit evidence that measures have been implemented to permit the use of MOHP facilities by private practitioners according to the agreed-on detailed plan and timeline (benchmark to be renewed and updated annually based on the plan).

Indicators

The activities included under this strategy will contribute directly to changes in the following SO7 result indicators:

- Percentage of MOHP funding (recurrent budget) allocated to primary and preventive services

- Number of MOHP hospitals/polyclinics operating as cost recovery facilities

In addition, several other indicators may be suggested to allow the USAID (and the MOHP) to track this strategy's implementation and its effect on the financial health of facilities:

- Cost recovery revenues as a percentage of total MOHP non-personnel recurrent budget

- Percentage of hospitals allowing private practitioner use of facilities

2.1.5 Allow Hospital Autonomy

Assumptions

The limits of autonomy must be defined and agreed on in advance. The critical element of these discussions will be the autonomous facility's ability to hire, fire, and transfer personnel.

Suggested Benchmarks

Year One:

- The MOHP will develop and submit to the USAID a documentation package that clearly defines the limits of autonomy and proof of adoption of all legal and administrative elements required to grant autonomy.
- The MOHP will submit to the USAID a detailed plan, including criteria for the selection of facilities to be granted autonomy, a timeline, and annual numeric targets for granting autonomy to MOHP hospitals.

Years Two to Five:

- The MOHP will develop and provide evidence of implementation on a yearly basis of the detailed plan and timeline to grant autonomy to the agreed-on number of facilities.
- The MOHP will write and submit to the USAID a report evaluating the effects of autonomy versus transfer to the CCO/CHO operation on the performance and financial status of hospital facilities.

Indicators

The activities undertaken under this reform strategy will correspond (or contribute) directly to the following SO7 result indicators:

- Percentage of MOHP (recurrent) budget allocated to primary and preventive services
- Policy measures and benchmarks established and agreed to with the MOHP
- Number of MOHP hospitals/polyclinics operating as cost recovery facilities

2.1.6 Support Hospitals Based on Efficiency Indicators Such as Per Capita, Per Bed, etc.

Assumptions

This strategy implies a change in the process of budget resource allocation in use at the MOHP. It is closely linked to other strategies designed to accord increased autonomy of management to MOHP hospitals (either through autonomy or transfer to the CCO/CHO's responsibility).

Suggested Benchmarks

Year One:

- The MOHP will prepare and submit to the USAID a report assessing various options for allocating budget resources to hospital facilities.

Year Two:

- The MOHP will provide documentation indicating the adoption of one or more of the studied options for determining budget allocations to hospital facilities in one or more governorate(s) on a pilot basis.
- The MOHP budget for the following year will reflect the options in its allocations of resources to hospital facilities.

Years Three to Five:

- The MOHP will submit to the USAID a report evaluating the impact on performance and financial status of the facilities in the pilot test.
- Each successive year's budget allocations for hospitals will reflect the results (or the need to test additional options) of the pilot tests and the application of adopted options on a wider basis.
- The MOHP will submit reports on actual expenditures that indicate that the budget resource allocation option has been applied and implemented.

Indicators

The activities associated with the implementation of this reform strategy will contribute to the achievement of the following SO7 result indicators:

- Percentage of MOHP funding (recurrent budget) allocated for primary and preventive services
- Policy measures and benchmarks established and agreed to with the MOHP

In addition, the following indicators are suggested to assess the impact of reforms on the method of allocation of budget resources to hospital facilities:

- Average length of stay (adjusted for facility case-mix)
- Occupancy rate for MOHP hospital beds
- Inpatient mortality rate

2.1.7 Examine the Cost Recovery of Curative Services at the Primary Health Care Level

Assumptions

The MOHP wishes to expand the financial resources available to finance primary level services by exploring the potential for direct fee-for-services payments by patients for curative services. Many other African and Asian countries have successfully implemented similar cost recovery mechanisms for primary care services.

Suggested Benchmarks

Year One:

- The MOHP will submit a plan to pilot-test options to recover costs of primary curative services. The test will be designed to assess the cost recovery's impact on use and quality of services and on the poor. A scientifically rigorous experimental design should be used for the pilot test.

Years Two to Three:

- The MOHP will provide documentation to the USAID of the pilot test results.
- The MOHP will adopt a national cost recovery policy for primary curative services in MOHP facilities based on the pilot test results.
- The MOHP will submit to the USAID a plan and timeline for the progressive implementation of cost recovery for primary curative services in MOHP facilities.

Years Four to Five:

- The MOHP will submit evidence to the USAID that the plan to introduce cost recovery for primary curative services at MOHP facilities is being implemented successfully and according to the timeline contained in the implementation plan.

Indicators

The activities proposed to implement this reform strategy will contribute directly to meeting the following SO7 result indicators:

- Percentage of MOHP hospitals/polyclinics/primary health centers operating as cost recovery facilities (SO7 result indicator is modified to include primary care facilities)
- Percentage of MOHP funding (recurrent budget) allocated for primary and preventive services

- Policy measures and benchmarks established and agreed to with the MOHP

In addition, the following indicator is suggested to assess the reform's impact on the availability of resources to finance MOHP-delivered services:

- Cost recovery revenue as a percentage of MOHP non-personnel recurrent budget

2.1.8 Use Cost-Effectiveness Analysis to Identify a Package of Preventive Medicine and Primary Health Care Services to Be Supported by the MOHP to Which Every Egyptian Is Entitled

Assumptions

This strategy implies that there is not a comprehensive statement of the actual services that are implied by preventive and primary services. The delivery of this level of service is not uniform throughout the country, and the financing of these services is not assured and/or insufficient. The MOHP should articulate its vision of this level of services by defining the partners involved and the financial resources available and by choosing those services and activities that offer the greatest return in terms of the reduction of the burden of disease and/or the daily adjusted life years (DALY) gained. The results of an analysis performed by the Data for Decision Making (DDM) project will be available. This analysis will cover resources available and possible preventive and primary level interventions that define the most cost-effective package of services in terms of DALYs and burden of disease.

Suggested Benchmarks

Year One:

- The MOHP will review, adopt, and identify mechanisms to support delivery of a list of services based on the recommendations of the DDM report described above.

Indicators

This strategy will contribute to the following result level indicators contained in SO7:

- Percentage of MOHP funding (recurrent budget) allocated for primary and preventive services

- Policy measures and benchmarks established and agreed to with the MOHP

In addition, the following indicators are suggested to assess the availability and impact of primary and preventive services contained in the adopted package:

- Percentage of MOHP recurrent budget allocated to support of the chosen cost-effective package

- Rates of incidence and/or prevalence of diseases targeted by the services contained in the package

2.1.9 Increase Emphasis on Maternal and Child Health Care Programs

Assumptions

This strategy assumes that the maternal and child health (MCH) care programs will be included in the basic package of preventive and primary services that will be chosen as the core health package to be guaranteed to all Egyptians. It also assumes that budget resources devoted to the MCH programs are insufficient and that resources can be reallocated from secondary and tertiary level services in favor of primary and MCH services. It is not assumed that the MOHP budget will increase significantly in the near to medium term, making resource reallocation and the introduction of cost recovery mechanisms the MOHP's primary avenues for increasing available resources. Reliance on donor support for the MCH program needs is not considered financially sustainable. It assumes that the MOHP and the USAID can agree on appropriate measures of and targets for emphasis.

Suggested Benchmarks

Year One:

- The MOHP will submit to the USAID a proposal for targets of indicators of emphasis and appropriate methods of their measurement for the MCH programs.

Years Two to Five:

- The MOHP will submit documentation to USAID stating that mutually agreed-on annual targets for emphasis of the MCH programs have been met.

Indicators

The activities proposed under this strategy correspond directly to the following SO7 result indicator:

- Percentage of MOHP funding (recurrent budget) allocated for primary and preventive services

In addition, the following indicators are suggested as relevant in assessing this strategy's effect on the health of women and children:

- Rates of coverage and service delivery statistics by governorate for the priority MCH programs identified
- Incidence rates of childhood preventable diseases
- Maternal mortality rate
- Infant mortality rate

2.1.10 Provide Incentives for Health Care Providers to Specialize in Preventive Medicine, Primary Health Care, and Family Medicine

Assumptions

This strategy assumes that there is a shortage of practitioners in preventive medicine, primary care, and family medicine practices. It is assumed that this shortage exists within the public sector and that it is unlikely incentives can be created to draw additional private practitioners with these skills into the public services. Therefore, the MOHP must find incentives for a greater number of medical students to choose these specialties and/or current practitioners to change specialities through retraining. It is assumed that this strategy is intended to increase the supply of practitioners with these skills within the public sector only and not in private or HIO practice. It is assumed that the training capacity exists to accommodate the numbers of trainees choosing these specialities. This strategy appears designed to address the absolute lack of specialists in these fields and not their distribution within the country (perhaps to be addressed in strategy 2.1.16).

Suggested Benchmarks

Year One:

- The MOHP will submit to USAID the results of a study of the current number and distribution patterns of preventive, primary, and family medicine specialists and set population-based targets for the optimal number and distribution of these specialists. The report will set yearly targets for the production and employment of these specialists. Targets will necessarily be based on a clear definition of the preventive and primary care service package to be delivered throughout Egypt by the MOHP.
- The MOHP will submit to the USAID the results of a study of medical students and current practicing specialists. The study report will include recommendations for incentives for current students to choose preventive, primary, and family medicine specialities and for current practitioners to undergo additional training to become specialized in these areas. The report will estimate the cost of the recommended incentive packages.

Years Two to Five:

- The MOHP will submit documentation to the USAID that the incentive plans have been progressively introduced for medical students/residents and current practitioners.

Indicators

As several of the incentive packages to be implemented under this strategy will require funding, they will contribute to meeting the following SO7 objective:

- Percentage of MOHP funding (recurrent budget) allocated for primary and preventive services

The effect of these incentives on the availability of preventive and primary services may also be assessed through the following indicators:

- Number of targeted specialists/100,000 population
- Rates of coverage and service delivery statistics by governorate for the priority MCH programs identified
- Incidence rates of childhood preventable diseases
- Maternal mortality rate
- Infant mortality rate

2.1.11 Do Not Separate Curative Services at the Primary Health Care Level

Assumptions

It is assumed that this strategy intends to ensure the MOHP's role as the provider of preventive and primary curative services throughout the country.

Suggested Benchmarks

Years One to Five:

- The MOHP will submit annual reports to the USAID that document the number of primary facilities delivering curative care and the types and numbers of services delivered using population-based denominators by governorate.

Indicators

This strategy does not appear to link directly to any of the SO7 result indicators developed and adopted. The availability of primary curative services at MOHP facilities may be assessed through the following indicator:

- Percentage of MOHP recurrent budget allocated to primary health care (PHC) facilities

2.1.12 Ensure Adequate Allocation of Resources, e.g., Personnel

Assumptions

The amount of the central government's budget allocated to the health sector is inadequate to finance all services and programs. The resource-allocation method does not protect certain priority services and programs. The MOHP's wage bill consumes an unacceptably high percentage of all resources, leaving few resources for other recurrent costs such as drugs. The geographic distribution of resources may not be equitable. The personnel allocation among levels of services (i.e., primary vs. secondary and tertiary) does not indicate an emphasis on primary services.

Suggested Guidelines

Year One:

- The GOE will provide the USAID with documentation stating that the MOHP budget as a percentage of total GOE spending has not dropped below current levels.
- The MOHP will provide the USAID with a plan that establishes norms and quotas for staffing and equipping all levels of facility. The plan will establish allocation mechanisms and a timeline to implement the norms at all levels of facility.

Years Two to Five:

- The GOE budget will provide evidence that MOHP funding does not drop below 1996–1997 levels as agreed on.
- The GOE will provide the USAID with documentation stating that the plan implementation described above has proceeded according to the agreed-on timeline.

Indicators

This strategy corresponds and/or contributes to the following SO7 result indicators:

- Percentage of MOHP funding (recurrent budget) allocated for primary and preventive services
- Policy measures and benchmarks established and agreed to with the MOHP

In addition, the following indicator is suggested to assess changes in MOHP resource levels and allocation formulas:

- Percentage of MOHP primary level facilities that are staffed and equipped according to established norms

2.1.13 There Should Be No Guaranteed Employment

Assumptions

Employment by the state is guaranteed by the Egyptian constitution. It is unlikely to anticipate constitutional reform under the proposed SPA. This strategy is designed to stop the growth of the MOHP wage bill from hiring medical personnel who are not needed by the public-sector delivery system. It is assumed that this oversupply of personnel applies to all levels of health care providers and allied health professionals, not just physicians.

Suggested Benchmarks

Year One:

- The MOHP will issue a decree freezing new employment by the MOHP for five years.

Years Two to Five:

- The MOHP will provide the USAID with documentation that the MOHP has hired no new employees during the preceding year.

Indicators

This strategy will contribute to meeting the following SO7 result indicator:

- Policy measures and benchmarks established and agreed to with the MOHP

In addition, the following indicator is suggested to assess this strategy's impact on limiting the size and cost of the MOHP workforce:

- MOHP personnel costs as a percentage of total MOHP recurrent budget

2.1.14 Develop Guidelines for MOHP Personnel Needed and Apply These to Redistribute the Personnel Based Upon Needs Assessment

Assumptions

The lack of agreed-on staffing norms and guidelines has led to an overall surplus and a non-optimal personnel distribution.

Suggested Benchmarks

Year One:

- The MOHP will submit a report to the USAID analyzing personnel needs based on programmatic needs and the types of services to be delivered by type and level of facility. The report will set staffing norms for each type of facility. The report will use those norms to calculate personnel needs by type of personnel and by governorate.

- The MOHP will submit to the USAID a plan and timeline for personnel redistribution according to the needs indicated by staffing norms adopted for all levels and types of facilities.

Years Two to Five:

- The MOHP will provide documentation to the USAID that its plan to redistribute personnel according to adopted staffing norms is being implemented successfully and according to the mutually agreed-on timeline.

Indicators

The development of staffing norms will contribute to the following SO7 result indicator:

- Policy measures and benchmarks established and agreed to with the MOHP

In addition, the following indicator is suggested to assess the MOHP's progress toward more rational and equitable utilization of human resources:

- Percentage of facilities that are staffed according to adopted norms by governorate

2.1.15 Reduce the Overall Number of MOHP Personnel

Assumptions

There is an absolute surplus of personnel on the MOHP payroll. This creates an unacceptable wage burden on MOHP financial resources. Large scale layoffs of MOHP employees would appear to be politically and socially difficult or unacceptable. Activities planned under this strategy should be combined with those under strategy 2.1.13 (freeze on new hiring by the MOHP). Major reform of civil service law is beyond the scope of the anticipated SPA. Reductions in personnel imply consensus on the optimal or necessary number of personnel required by the MOHP. Estimates of this need should be based on agreed-on norms for the optimal staff numbers and mix required to deliver services at all types of facilities.

Suggested Benchmarks

Year One:

- The MOHP will develop and adopt necessary legal/administrative measures to ensure that employees of facilities transferred to the authority of the CCO/CHO or other parastatal authority become employees of the new managing institution.

- The MOHP will submit to the USAID a report that will estimate the direct financial cost of selected personnel reduction options, including selected layoffs, voluntary severance, and early retirement.

- The MOHP and the USAID will agree on a plan for personnel reduction that includes numeric targets and a timeline based on adopted staffing norms and patterns for MOHP facilities.

Years Two to Five:

- The MOHP will submit yearly documentation detailing the successful implementation of the agreed-on personnel reduction plan within the agreed-on time frame.

Indicators

By reducing the MOHP wage bill, this strategy will allow the MOHP to allocate more of its budget toward priority programs and services. As a result, this strategy will contribute to the following SO7 result indicators:

- Percentage of MOHP funding (recurrent budget) allocated for primary and preventive services

- Policy measures and benchmarks established and agreed to with the MOHP

Several other indicators may be suggested in assessing this strategy's impact on reducing personnel numbers and cost for the MOHP, including the following:

- MOHP personnel costs as a percentage of total the MOHP's recurrent budget

2.1.16 Provide Incentives for the MOHP Personnel to Serve in Underserved and Remote Areas

Assumptions

Despite an assumed overall personnel surplus (principally characterized as a physician surplus), underserved areas remain in the country. The development of incentives to encourage personnel to relocate to these underserved areas must be developed in conjunction with staffing norms and guidelines developed under 2.1.13 above. This strategy assumes that civil service reform is beyond

the scope and intent of the anticipated SPA. Therefore, only incentives that are feasible under current civil service law will be considered.

Suggested Benchmarks

Year One:

- The MOHP will submit to the USAID a study exploring the feasibility and cost of various options for incentive packages to encourage MOHP personnel to voluntarily relocate to provide services in currently underserved areas. The report will identify areas that are considered underserved based on population-based targets for service delivery, demand, and personnel. The report will analyze the feasibility of providing incentives under current law and regulations and identify the resources available to implement a chosen incentive package.

- The MOHP will provide the USAID with documentation of the adoption of an incentives package to promote the voluntary transfer of personnel to underserved areas. The documentation will include indication of the amount and source(s) of resources that will be available to finance implementation of the package.

Years Two to Five:

- The MOHP will submit to the USAID annual reports documenting the implementation of the chosen incentives. The report will show the number of personnel who have accepted transfers and the effect in achieving population-based targets for services and providers by governorate.

Indicators

The implementation of incentive packages to encourage personnel to provide services in underserved areas will contribute to the following SO7 result indicator:

- Policy measures and benchmarks established and agreed to with the MOHP

In addition, the following indicator is suggested to assess the MOHP's progress toward more rational and equitable use of human resources:

- Percentage of facilities that are staffed according to adopted norms by governorate

2.1.17 Adapt the National Health Information Systems Including Geographic Information Survey for Planning and Policy Implementation

Assumptions

This strategy assumes that the basic components necessary for a national health information system (HIS) have been developed and await implementation to become operational and provide defined outputs for the entire country. The system should provide information to local, provincial, and national authorities with information on the health status of the population, the utilization of services, service delivery costs, and resource allocation. The strategy assumes that the planning and resource-allocation mechanisms used by the MOHP are capable of using the HIS products for improved planning. The strategy assumes that the application of the Geographic Information Survey technology will improve the MOHP's ability to use information for planning and resource allocation decisions. The introduction of HIS elements implies a planning and resource allocation process that is both analytical and transparent. Lacking such a process will make the evaluation of utilization and impact of any HIS virtually impossible. The strategy assumes that the participants in the MOHP planning and policy process can be identified.

Suggested Benchmarks

Year One:

- The MOHP will submit a report to the USAID of the final review of the HIS system components, recommendations for their modification (if any), detailed plans, and a timeline for their implementation and operationalization in all governorates. The report will clearly indicate the users of HIS products at all levels and will suggest analyses and utilization of HIS products relevant to the planning and policy decision-making process at all levels of the health system. The report will indicate the resource level and sources required to implement the plan according to the specified timeline.

Years Two to Five:

- The MOHP will submit to the USAID annual reports and evidence of the national HIS implementation and operation. The reports will include recommendations for policy reform as indicated by the data.

Indicators

The review and adoption of the HIS components will contribute to the following SO7 result indicator:

- Facilities submitting required reports and data

2.1.18 Prioritize the Allocation of MOHP Resources Based on Needs Using Health Status Indicators

Assumptions

This strategy assumes a resource allocation process that is adequately documented and transparent. Without a high degree of transparency, it will be virtually impossible to assess the effect of information-system products on resource-allocation decisions. Resource-allocation decisions are,

in general, highly political, and introducing health status indicators to the evaluation of allocations may prove difficult. The strategy assumes that health status information is available to decision-makers in a timely fashion and in a useful format (i.e., geographic disaggregation, population based).

Suggested Benchmarks

Year One:

- The MOHP will submit to the USAID a plan for the introduction of health status indicators into the resource-allocation and planning process. The report will indicate the information required and the process by which it will be made available to decision-makers. The plan will indicate the means by which the MOHP will monitor future resource allocation decisions with respect to health status indicators.

Years Two to Five:

- The MOHP will provide the USAID with annual reports that will document the link between resource allocation decisions and appropriate health status indicators. The report will document trends in resource allocation by program and geographic area.

Indicators

The introduction of health status indicators into the MOHP resource-allocation process will contribute to the following SO7 result indicator:

- Percentage of MOHP funding allocated to primary and preventive services

In addition, the following indicator is suggested in assessing the strategy's impact on MOHP resource-allocation decisions:

- Rates of coverage and service delivery statistics by governorate for the priority MCH programs

2.1.19 Create Incentives for Other Health Care Providers to Function in Underserved Areas

Assumptions

Other health care providers are assumed to refer to non-MOHP private practitioners. It is assumed that the geographic distribution of these personnel suffers from the same lack of rational linkage to service delivery concerns as currently exists with respect to MOHP personnel. This strategy assumes that there are incentives that can be developed and provided to these individuals to encourage their voluntary relocation according to need. The strategy's benchmarks and indicators closely parallel those developed under strategy 2.1.16.

Suggested Benchmarks

Year One:

- The MOHP will submit to the USAID a study exploring the feasibility and cost of various options for incentive packages to encourage non-MOHP personnel to voluntarily relocate to provide services in underserved areas. The report will identify which areas are considered underserved based on population-based targets for service delivery, demand, and personnel. The report will analyze the feasibility of providing incentives under current law and regulations. The report will identify the resources available to implement a chosen package of incentives.

- The MOHP will provide the USAID with documentation on the adoption of an incentives package to be made available to promote the voluntary relocation of non-MOHP personnel to underserved areas. The documentation will include an indication of the amount and source(s) of resources that will be available to finance implementation of the package.

Years Two to Five:

- The MOHP will submit to the USAID annual reports documenting the implementation of the chosen incentive packages. The report will indicate the number of personnel who have accepted the incentives and relocated and the effect in achieving overall population-based targets for services and providers by governorate.

Indicators

The implementation of incentive packages to encourage personnel to provide services in underserved areas will contribute to the following SO7 result indicator:

- Policy measures and benchmarks established and agreed to with the MOHP

2.1.20 Target GOE Subsidy to Poor and Indigent Populations

Assumptions

This strategy assumes that current GOE subsidies do not adequately target the poor and indigent. The reasons for this unclear. The redistribution of resources in favor of rural population may be one effective way to retarget subsidies based on the assumption that rural populations are poorer than urban ones. Geographic targeting may be more feasible than targeting individuals requiring subsidized services, which, pending the implementation of cost recovery measures on a much broader scale, means all public services. Another potential strategy for better targeting is instituting cost recovery with mechanisms to exempt the poor from payments. The costs of alternative targeting methods must be considered. In addition, the incidence and cost of leakage (i.e., subsidies that go to people who do not deserve them) should be estimated for the targeting options to be considered.

Suggested Benchmarks

Year One:

- The MOHP will submit a report to the USAID analyzing options for improving the ability of the MOHP to target its subsidies toward the poor and indigent. The report will assess each option's cost. The report will also provide a plan and timeline for the adoption and implementation of one or more of the options studied.

Years Two to Five:

- The MOHP will submit reports of its budget tracking system to the USAID to document the implementation of chosen actions to improve the targeting of MOHP subsidies to the poor. The reports will monitor implementation efforts against the timeline developed in year one.

Indicators

The following SO7 result indicators are relevant to the assessment of the strategy's ability to improve targeting of MOHP subsidies to the poor:

- Percentage of MOHP funding (recurrent budget) allocated for primary and preventive services
- Policy measures and benchmarks established and agreed to with the MOHP
- Number of MOHP hospitals/polyclinics/PHC operating as cost recovery facilities

The following outcome indicator is also suggested to assess the strategy's effect on MOHP subsidies:

- Percentage of patients receiving exemptions, waivers, or reduced fees

2.1.21 Use Cost-Effectiveness Analyses in Determining the Essential Health Services

Assumptions

This strategy represents an expansion of strategy 2.1.8 above and is intended to introduce cost-effectiveness analysis in the determination of basic primary and preventive services to be offered to the population. Therefore, the benchmarks and indicators developed for strategy 2.1.21 represent an expansion or broadening of the benchmarks and indicators developed for strategy 2.1.8. The MOHP should articulate its choice of those services and activities that offer the greatest return in terms of the reduction of the burden of disease and/or DALYs gained. The results of an analysis performed by the DDM will be available. It will document the resources available and possible preventive and primary

level interventions that define the most cost-effective package of services in terms of DALYs and burden of disease.

Suggested Benchmarks

Year One:

- The MOHP will review and adopt a list of services based on the recommendations of the DDM report described above.

Indicators

This strategy will contribute to the following result level indicators contained in SO7:

- Percentage of MOHP funding (recurrent budget) allocated for primary and preventive services
- Policy measures and benchmarks established and agreed to with the MOHP

In addition, the following indicators are suggested to assess the availability and impact of primary and preventive services contained in the adopted package:

- Rates of coverage and service delivery statistics by governorate for the priority MCH programs identified
- Incidence rates of childhood preventable diseases
- Maternal mortality rate
- Infant mortality rate

2.1.22 Develop and Adopt National Health Standards of Practice and Health Facility Accreditation

Assumptions

Many technical templates exist (from the World Health Organization and elsewhere) that can be adapted to create the national health standards of practice. It will be necessary to define a strategy that emphasizes consensus among all interested parties and stakeholders for the adoption of the standards. It is assumed that the legal basis for accreditation and regulations developed under this strategy will be applied to both private and public facilities of all types and levels (including outpatient).

Suggested Benchmarks

Years One to Two:

- The MOHP will submit to the USAID evidence that expert working groups have been created and charged with the responsibility of developing recommendations for national standards of practices.
- The MOHP will submit to the USAID proof that, based on the results of the working groups, it has adopted a comprehensive package of standards of practice to be implemented in all public facilities.
- The MOHP will submit to the USAID proof that it has adopted a comprehensive plan describing detailed criteria for the accreditation of all levels and types of private and public health service facilities.

Years Two to Five:

- The MOHP will submit to the USAID annual reports of activities related to the implementation and enforcement of the national health standards of practice and health facility accreditation according to the agreed-on plan.

Indicators

The establishment and adoption of standards of practice and accreditation criteria will contribute to changes in the following SO7 result indicator:

- Policy measures and benchmarks established and agreed to with the MOHP

The following additional outcome indicator is suggested to assess the strategy's impact on the improvement of the quality of services in health facilities:

- Hospital mortality rate

2.1.23 Establish a Policy of Continued Physician Licensing and Continuing Medical Education

Assumptions

The strategy promotes the establishment of a policy requiring periodic renewal of physician licenses based on (at least) participation in a program of Continuing Medical Education (CME). The strategy implies the establishment of a CME program. Such a program does not exist at the scope and level that would be required to meet the needs of the current Egyptian physician population. The policy established under this strategy will apply to all (public and private) physicians. This strategy may require changes in the body of law governing medical practice. The strategy assumes that the

MOHP has the administrative and/or technical capacities necessary to fully implement the policies implied by the strategy.

Suggested Benchmarks

Years One to Two:

The MOHP will submit to the USAID an adopted plan for the institution of a program for continued physician licensing that includes requirements and guidelines for CME as part of the licensing process. The plan will estimate the resources necessary to implement the plan. The plan will include provisions for enforcement of appropriate sanctions against individuals practicing without a license. The plan will include a realistic time frame for its institution (and perhaps appropriate grandfathering provisions) and extension to all practicing physicians.

Years Three to Five:

- The MOHP will submit to the USAID annual reports as evidence that the plan for institution of physician-licensing regulations and a program of CME is being implemented according to the established and agreed-on timeline.

Indicators

This strategy will contribute to changes in the following SO7 result indicators:

- Policy measures and benchmarks established and agreed to with the MOHP

The process of licensing physicians and improvements in the quality of services may be assessed using the following additional outcome indicators:

- Hospital mortality rate
- Number of CME courses and participants

2.2 HIO's Role and Service Provider Issues

2.2.1 Do Not Add Any New Groups of Beneficiaries to HIO

Assumptions

The HIO has a significant deficit. Until the deficit is eliminated and premiums analyzed and adjusted, it is assumed to be imprudent for the HIO to assume coverage for additional beneficiary groups. The total number of individuals covered by the HIO may rise despite a freeze on the addition of new beneficiary groups due to fluctuations in the memberships of the groups.

Suggested Benchmarks

Years One to Five:

- The MOHP will submit to the USAID annual reports analyzing the HIO beneficiary pool and demonstrating that no new beneficiary groups have been added.

Indicators

This strategy corresponds to the following SO7 result indicator:

- Percentage of Egyptians covered under social insurance

2.2.2 Eliminate the Current HIO Deficit

Assumptions

This strategy assumes that the HIO deficit can be eliminated through an acceptable package of premium adjustments, management improvements, and control of benefits.

Suggested Benchmarks

Year One:

- The HIO will submit to the USAID a report that analyzes its deficit and its causes. The report will include a plan of action to be implemented by the HIO to progressively eliminate the deficit within a mutually agreed-on time frame.

Years Two to Five:

- The MOHP will submit annual reports to the USAID that document actions to reduce the deficit and the current size of the deficit.

Indicators

This strategy corresponds to the following SO7 result indicator:

- Percentage of Egyptians covered under social insurance

To assess the effectiveness of the HIO's actions in reducing the deficit, the following outcome indicator is suggested:

- Current HIO deficit or surplus as a percentage of total expenditures

2.2.3 Reduce the Proportion of Pharmaceutical Costs

Assumptions

Pharmaceutical expenditures constitute an unacceptably high percentage of the total HIO expenditures (estimated to be as high as 60 percent).

Suggested Benchmarks

Year One:

- The HIO will provide evidence to the USAID of adoption of a revised benefits package that will reduce the percentage of expenditures currently spent on pharmaceuticals to mutually agreed-on levels.

Years Two to Five:

- The HIO will submit to the USAID annual reports that monitor progress against the mutually agreed-on targets for the percentage of HIO expenditures going to pharmaceutical costs.

Indicators

This strategy corresponds to the following SO7 result indicator:

- Percentage of Egyptians covered under social insurance

To assess HIO progress in implementing this strategy, the following outcome indicator is suggested:

- HIO expenditures for pharmaceuticals as a percentage of total expenditures

2.2.4 Unify the Existing Health Insurance Laws into One Law

Assumptions

The current legal framework covering insurance in Egypt is fragmented. This leaves gaps and may not provide the desired environment for the development and expansion of insurance coverage.

It is assumed that by unifying these fragmented laws into a single comprehensive insurance law, these gaps will be closed and the environment for health insurance improved.

Suggested Benchmarks

Years One to Two:

- The HIO and the MOHP will submit to the USAID a study of the legal framework for the insurance industry. This will include recommendations for consolidating laws into a single health insurance law.
- The MOHP will submit evidence to the USAID that legislation incorporating the recommendations of the report described above has been passed by the appropriate legal/legislative/administrative body.

Indicators

This strategy will contribute to the following SO7 result indicator:

- Percentage of Egyptians covered under social insurance

2.2.5 Change the HIO Legal and Legislative Framework to Ensure Its Autonomy

Assumptions

HIO autonomy is desirable and not ensured by the existing legal and legislative environment.

Suggested Benchmarks

Years One to Two:

- The MOHP will submit evidence to the USAID that agreed-on legal and legislative changes to ensure the autonomy of the HIO have been adopted by the appropriate legal/legislative/administrative body.

Indicators

This strategy corresponds to the following SO7 result indicator:

- Percentage of Egyptians covered under social insurance

2.2.6 Develop Premiums Based on Actual Costs Using Copayments and Deductibles

Assumptions

This strategy assumes that current HIO premiums are outdated and no longer linked to actual costs. The strategy also assumes that co-payments and deductibles by beneficiaries are a desirable way to share and/or reduce costs and moderate utilization of services.

Suggested Benchmarks

Year One:

- The HIO will submit to the USAID a report that examines options for the revision of the current premiums. The report will recommend changes in premiums in order to have them correspond more closely to actual costs. The report will recommend mechanisms for the periodic review of premiums. The new premium structure recommended will include provisions for co-payments and deductibles.

Years Two to Five:

- The HIO will submit to the USAID documentation that recommendations for the revision of premiums, including co-payments and deductibles, have been adopted and enacted.
- The HIO will submit to the USAID reports of periodic reviews of premiums and their relationship with costs.

Indicators

This strategy corresponds to the following SO7 result indicator:

- Percentage of Egyptians covered under social insurance

2.2.7 Identify and Adopt an Affordable Health Benefits Package(s)

Assumptions

This strategy assumes that the current benefits package offered by the HIO is not financially sustainable and must be redefined to improve its affordability and the HIO financial situation. The redefinition of the HIO benefits package should be undertaken in conjunction with the review of premiums and payment strategies (co-payments, deductibles) to be conducted under strategy 2.2.6 above. It should also coincide with the MOHP determination of a basic package of priority, cost-effective services to be guaranteed to all Egyptians (2.1.8, 2.1.21).

Suggested Benchmarks

Year One:

- The HIO will prepare and submit to the USAID an analysis of revenue and costs that will identify a benefits package that it will finance for beneficiaries. The package will be developed in conjunction with a review of HIO revenues (2.2.6) and the definition of a cost-effective package of services to be offered to all Egyptians at MOHP facilities (2.1.8, 2.1.21).

- The HIO will submit to the USAID evidence that an affordable modified benefits package has been adopted.

Years Two to Five:

- The HIO will submit to the USAID annual reports detailing the benefits package offered, the numbers and type of services financed and delivered, and recommended modifications in the benefits package.

Indicators

This strategy will contribute to the following SO7 result indicator:

- Percentage of Egyptians covered under social insurance

2.2.8 Stop Constructing HIO Hospitals

Assumptions

If the HIO ceases to be a direct provider of services, then construction of new facilities is unnecessary. Facility construction is an unnecessary drain on HIO finances.

Suggested Benchmarks

Year One:

- The HIO will submit to the USAID evidence that no new facility construction has been initiated.

- The HIO will submit to the USAID a plan to terminate contracts for facilities under construction.

Years Two to Five:

- The HIO will submit annual evidence to the USAID that no new facility construction has been initiated.

Indicators

This strategy does not appear to be linked to any of the SO7 result indicators. The following indicator is suggested to assess this strategy's effect in terminating HIO facility construction:

- Number of HIO facilities

2.2.9 Develop a Phased-Out Plan to Sell or Transfer to Other Private or Parastatal Organizations the Existing HIO Hospitals, Polyclinics, and then General Practitioner Clinics

Assumptions

As the HIO moves from a provider of services to a financier of services, it will no longer want to operate service delivery facilities. There will be a market for these facilities among private and parastatal health service providers. This strategy calls for only the development of a plan to sell off facilities; it does not call for a phased or progressive plan implementation. This strategy assumes that there is a market among private and/or parastatal health care providers for HIO facilities.

Suggested Benchmarks

Year One:

- The HIO will submit to the USAID a detailed plan and timeline for the sell-off of all service delivery facilities to private and/or parastatal health service providers. The plan will include an analysis of the market for HIO facilities and estimates of their potential market value.

Indicators

This strategy does not appear to be linked to any of the SO7 result indicators. The following indicator is suggested to assess this strategy's effect in terminating HIO facility ownership and operation:

- Number of HIO facilities

2.2.10 Develop Different Mechanisms to Subcontract All Health Service Providers Including Private and MOHP Hospitals

Assumptions

As HIO sells off facilities, it will need to identify direct service providers who will provide services to HIO beneficiaries. The HIO will finance those services. The HIO should experiment with development of contracting mechanisms with all types (private and public) service providers. The coverage of HIO beneficiaries through these contracts should be expanded in conjunction with plans to sell off HIO service delivery facilities.

Suggested Benchmarks

Year One:

- The HIO will submit to the USAID a report assessing options for contracting mechanisms with service providers (public, parastatal, and private) for services to be provided to HIO beneficiaries. The report will contain a plan and timeline to test feasible contracting mechanisms and progressively expand their coverage.

Years Two to Five:

- The HIO will submit evidence to the USAID that it is expanding its use of contracting mechanisms to finance beneficiary services according to the plan and timeline developed in year one.

Indicators

This strategy does not appear to be linked to any of the SO7 result indicators. The following indicator is suggested to assess this strategy's effect in reducing the direct delivery of services by the HIO and expanding the use of contracts to finance services for members:

- Number and cost of services provided by contractors as a percentage of total services delivered and costs

2.2.11 Allow Beneficiaries to Choose Service Providers

Assumptions

As the extent of HIO contracts with direct service providers expands, it will be desirable to allow beneficiaries to choose their own service providers.

Suggested Benchmarks

Year One:

- The HIO will submit to the USAID evidence that its operations procedures have been amended to permit beneficiaries to choose their own service providers from the list of providers under contract.

Indicators

This strategy does not appear to be linked to any of the SO7 result indicators. The following indicator is suggested to assess this strategy's effect in reducing the direct delivery of services by the HIO and expanding the HIO's role as a financier and not provider of services for members:

- Number and cost of services provided by contractors as a percentage of total services delivered and costs

2.3 Long-Term Strategies

2.3.1 Design and Develop a Single National Health Fund for Universal Coverage

Assumptions

This strategy assumes that the long-term future for health services financing in Egypt rests with the development of a national, universal social insurance system. It is assumed that with the development of adequate and necessary administrative capacities and proper definition of financing mechanisms, the HIO can grow into the role of the national social insurer.

Suggested Benchmarks

Years One to Two:

- The MOHP and the HIO will submit to the USAID a comprehensive plan for the transformation of the HIO into a social insurance fund. The report will provide a timeline for the development of the fund. Revenue sources will be defined. The report will integrate the products developed under strategies 2.3.2, 2.3.3, and 2.3.4 below.

Years Three to Five:

- The MOHP and the HIO will submit annual reports as evidence that the implementation of the adopted plan to transform the HIO into a national social insurance fund is proceeding according to the agreed-on timeline.

Indicators

This strategy will contribute to the following SO7 result indicator:

- Percentage of Egyptians covered under social insurance

2.3.2 Develop a Well Defined Standard Package of Benefits That Every Citizen Is Entitled to Receive

Assumptions

The definition of a standard benefits package to be covered by a social insurance fund is an essential part of the plan to create a fund to be developed under strategy 2.3.1. The development of the benefits package must be conducted in conjunction with the definition of the fund's revenue sources and estimates of revenue and cost including individual services in the package.

Suggested Benchmarks

Year One:

- The MOHP and the HIO will submit to the USAID a report that examines options for a basic services package to be covered by the national social insurance fund. The report will include cost estimates for the services package. These cost estimates will be compared to revenue projections for the fund based on chosen strategies for the fund's creation.
- The MOHP will provide evidence to the USAID that it has adopted a basic health services package that will constitute the benefits package to be financed by the social insurance fund once it becomes operational.

Indicators

This strategy will contribute to the following SO7 result indicator:

- Percentage of Egyptians covered under social insurance

2.3.3 Separate Financing and Provision of Services

Assumptions

It is assumed that the social insurance fund will finance health services for beneficiaries but will not be a direct provider of services. This is consistent with the SPA strategy 2.2 intended to transform the HIO from a provider of services to a financier of services.

Suggested Benchmarks

Year One:

- The MOHP will submit to the USAID evidence (in the form of the legal and legislative documents creating a national social insurance fund) that the fund will be legally restricted from participation in the direct delivery of health services of any type. It will be restricted from participating in the operation of health facilities and prohibited from ownership of health facilities.

Indicators

This strategy will contribute to the following SO7 result indicator:

- Percentage of Egyptians covered under social insurance

2.3.4 Ensure Legal and Financial Autonomy of Fund

Assumptions

The national social insurance fund must be legally and financially separate from both the HIO and the MOHP. It is important to note that autonomy should extend to the fund's ability to hire and fire its own personnel.

Suggested Benchmarks

Year One:

- The MOHP will submit to the USAID evidence that the legal and legislative framework adopted creating the national social insurance fund includes elements that define and guarantee the fund's legal, financial, and administrative autonomy.

Indicators

This strategy will contribute to the following SO7 result indicator:

- Percentage of Egyptians covered under social insurance

Annex: Indicators, Strategies, Definitions, Data Sources, and Baseline Values

Indicator	Strategy(s)	Definition	Data Sources	Baseline Value
Percentage of MOHP funding allocated to primary and preventive services	1.1.1, 1.1.2, 1.1.3, 1.1.4, 1.1.5, 1.1.6, 1.1.7, 1.2.1, 1.2.2, 1.2.3, 1.2.5, 1.3.3, 1.4.2, 1.4.4, 1.4.5	Funds allocated to primary and preventive services as a percentage of total MOHP recurrent budget	MOHP budget tracking system	40% (1994)
Policy measures and benchmarks established and agreed to with MOHP	1.1.1, 1.1.2, 1.1.5, 1.1.6, 1.1.7, 1.2.1, 1.2.5, 1.3.1, 1.3.2, 1.3.3, 1.3.4, 1.4.3, 1.4.4, 1.4.5, 1.5.1, 1.5.2	Yes or no	Joint MOHP - USAID MOU	no (1995)
Number of MOHP hospitals/polyclinics/ primary care facilities operating as cost recovery facilities	1.1.3, 1.1.4, 1.1.5, 1.1.7, 1.4.4	Number of facilities implementing cost recovery model as a percentage of total number of facilities of each level	MOHP budget tracking system	0 (1995)
Social insurance	2.1.1, 2.1.2, 2.1.3, 2.1.4, 2.1.5, 2.1.6, 2.1.7, 2.3.1, 2.3.2, 2.3.3, 2.3.4	Percentage of Egyptians covered under social insurance	HIO beneficiary registration reports	30% (1994)
Quality assurance committees	1.5.1, 1.5.2	Number of hospitals with functioning quality assurance committees and submitting regular reports	MOHP management reports	1 (1995)
Facilities submitting required reports and data	1.4.1	Number of governorates with operational Management Information Systems and submitting required reports and data	MOHP management reports - MOHP Management Information Systems reports	0 (1994)
Inpatient care provided in private and parastatal facilities	1.1.2, 1.1.4	Number of inpatient bed days provided in private and parastatal facilities as a percentage of total inpatient bed days	MOHP management reports	10% (1991)

Indicator	Strategy(s)	Definition	Data Sources	Baseline Value
Percentage of governorates meeting (but not exceeding by >10%) population-based targets for numbers of health facilities at all levels	1.1.1	Number of governorates who meet population-based targets for numbers of facilities of all levels	MOHP management reports	Targets not available
Percentage of hospitals remaining under direct MOHP management	1.1.2	Number of MOHP-managed hospitals as percentage of all hospital facilities	MOHP management reports	64.1% (1995)
Percentage of governorates with functioning CHOs	1.1.2	Number of governorates with functioning CHOs as percentage of total governorates (27)	MOHP management reports	19.2% (1992)
Cost recovery revenues as a percentage of total MOHP nonpersonnel recurrent budget	1.1.3, 1.1.4, 1.1.7	Total cost recovery revenues at MOHP facilities as a percentage of total MOHP non-personnel recurrent budget	MOHP budget tracking system	1.3% (1992)
Percentage of hospitals allowing private practitioner use of facilities	1.1.4	Number of hospitals allowing private practitioners to use facilities as percentage of all hospitals	MOHP management reports	Data not currently collected
Average length of hospital stay	1.1.6	Average length of stay for all hospital inpatients	Facility records and reports	4.8 (1991)
Occupancy rate for MOHP hospital beds	1.1.6	Number of bed days occupied as percentage of total bed days	Facility records and reports	49% (1991)
Inpatient mortality rate	1.1.6, 1.5.1, 1.5.2	Mortality rate for inpatients in MOHP hospitals	Facility records and reports	1.1 (1991)
Percentage of MOHP recurrent budget allocated to support chosen cost-effective package	1.2.1	Budget resources allocated to adopted package as a percentage of total recurrent budget	MOHP budget tracking system	Package not identified
Rates of incidence and prevalence of diseases targeted by chosen cost effective package	1.2.1	Number of new cases/population for time period	MOHP HIS	Data available-diseases not identified
Coverage rates and service-delivery statistics for priority MCH programs identified	1.2.2, 1.2.3, 1.4.2, 1.4.5	Number of services delivered/target population	MOHP HIS	Data available-MCH programs not identified
Incidence rates for childhood preventable diseases	1.2.2, 1.2.3, 1.4.5	Number of new cases/population for time period	MOHP HIS	Data available

Indicator	Strategy(s)	Definition	Data Sources	Baseline Value
Maternal mortality rate	1.2.2, 1.2.3, 1.4.5	Number of maternal deaths/100,000	MOHP HIS	184 (1990)
Infant mortality rate	1.2.2, 1.2.3, 1.4.5	Deaths age 0–1 year/1,000 live births	MOHP HIS	33 (1989)
Coverage with targeted specialties	1.2.3	Number of specialists in identified specialties/100,000 population	MOHP management reports	Data available-indicator not calculated
Percentage of MOHP recurrent budget allocated to PHC facilities	1.2.4	Total recurrent budget allocation to PHC facilities as percentage of total MOHP recurrent budget	MOHP budget tracking system	Data available-indicator not calculated
Percentage of MOHP primary level facilities staffed and equipped according to established norms	1.2.5, 1.3.2, 1.3.4	Number of facilities staffed or equipped according to norms as percentage of total primary facilities	MOHP management reports	Norms not established
MOHP personnel costs as percentage of total MOHP recurrent budget	1.3.1, 1.3.3	Total MOHP wage costs as percentage of total MOHP recurrent budget	MOHP budget tracking system	70.4% (1993)
Percentage of patients receiving exemptions, waivers, or reduced fees	1.4.4	Number of patients receiving exemptions, waivers, or reduced fees as percentage of total number of patients	Facility management reports	Data not currently available
Number of CME courses and participants	1.5.2	Number of CME courses given and total number of course participants	MOHP-CME management reports	CME program does not currently exist
Percentage HIO surplus or deficit	2.1.2	HIO surplus or deficit as percentage of total revenue	HIO management and financial report	Data available
Percentage HIO expenditures for pharmaceuticals	2.1.3	Total HIO expenditures for pharmaceuticals as percentage of total HIO expenditures	HIO management and financial reports	53% (1992)
Number of HIO facilities	2.2.1, 2.2.2	Total number of facilities operated and managed by HIO	HIO management and financial reports	24 (1992)
Number and cost of services provided by contractors as percentage of total services and costs	2.2.3, 2.2.4	Total number and value of services provided by contract providers as percentage of total services and costs delivered directly by HIO	HIO management and financial reports	Not applicable—contracts not established