

## 9 HEALTH SYSTEM REFORMS

### 9.1 Summary of Recent and planned reforms

Egypt's system displays some structural characteristics, such as centralized control, extensive infrastructure, state responsibility for health care for all individuals, and extensive state involvement in the pharmaceutical sector. At the same time, the system has many of the characteristics (e.g. multiple public and private sources of finance and delivery, limited government oversight of the private sector) of more open-ended market-based systems. This complex system has significant strengths and weaknesses resulting from its continuing evolution.

The basic goals of a health care system reform are as follows.

- Improving population health status and social well-being.
- Ensuring equity and access to care.
- Ensuring microeconomic and macroeconomic efficiency in the use of resources.
- Enhancing clinical effectiveness.
- Improving quality of care and consumer satisfaction.
- Assuring the system's long-term financial sustainability.

In early 1996, the MOHP initiated a re-assessment of the health sector situation and recognized a need to explore alternatives for a comprehensive reform. As a result of these discussions, the Government adopted the HSRP for Egypt, which lays out a framework for undertaking a comprehensive reform of the health sector over the medium- and long-term.

One of the key objectives of the HSRP is to achieve universal insurance coverage for all Egyptians.

In addition to the reform and expansion of the social health insurance functions, the HSRP includes the following elements:

- Redefine the role of the MOHP to develop its regulatory functions, notably to establish quality norms and standards and to establish a mechanism of accreditation and licensure to enforce those standards, and to consolidate the multiple vertical public health programs.
- Strengthen the program for training and retraining of family health care doctors, nurses and allied health professionals, with greater emphasis on preventive health care.
- Decentralize management of the government health delivery system to the governorate and district level, and introduce greater managerial autonomy at the facilities level.
- Rationalization of the public investment in health infrastructure and health manpower based on Governorate and District Health Plans that identify the actual needs and availability of resources to sustain the investments.

## **Chronology and main features of key reforms**

The Government of Egypt has embarked on a major restructuring of the health sector. This reform was deemed necessary because the MOHP and its main partners had identified fragmentation in the delivery of health services, excessive reliance specialist care and low primary care service quality as the main constraints to achieving universal coverage.

The Egyptian Health Sector Reform Program (HSRP) was officially launched in 1997. The World Bank (WB) started its contribution by designing the Master Plan for Montazah Health District in Alexandria Governorate, in May 1998. By the following year, in 1999, United States Agency for International Development (USAID) was the first donor to begin field-level operations, while the European Commission (EC) joined the HSRP in November 1999. The African Development Bank (ADB) initiated its work through designing Master Plans for three health districts in June 2003. The most recent partner at HSRP is the Austrian Government, which directs its participation to improving the district hospitals as part of health district approach.

The overall aim of the HSRP is twofold. Firstly to introduce a quality basic package of primary health care services, contribute to the establishment of a decentralised (district) service system and improve the availability and use of health services. Secondly to introduce institutional structural reform based on the concept of splitting purchasing/providing and the regulatory functions of the Ministry of Health and Population. Coverage would be provided by a National Social Insurance System. The ultimate goal of health sector reform initiatives is to improve the health status of the population, including reductions in infant, under-five, maternal mortality rates and population growth rates and the burden of infectious disease.

The HSRP has meanwhile initiated a new primary care strategy in accredited facilities, known as Family Health Units (FHU's). Facilities are being contracted by a purchasing agency -the Family Health Fund (FHF) - to provide services to the population. It is envisaged that the HSRP will gradually extend its scope to the secondary level by establishing "District Provider Organizations". The FHF will consequently develop in the direction of a full purchasing agency of services from the public and private sector. The newly introduced Family Health Model (FHM) constitutes one of the cornerstones of the reform program. It brings high quality services to the patient and will integrate most of the vertical programs into the Basic Benefit Package of services. To date the FHM has been introduced in over 400 health facilities, which present 10% of the total public primary health care facilities. HSRP has an ambitious five years plan, by the end of year 2009, to cover the entire public primary health care facilities with the Family Health Model.

The Health Sector Reform Program is made up of Egyptian experts from within the Ministry of Health and Population, individuals across the Egyptian health care system and international advisors.

The Egyptian Health Sector Reform Program went through several stages, including the preparatory stage from 1994 to 1996. During this stage, several valuable studies were conducted and used later to develop the "Strategies for Health Sector Change" study. This was an analytical report on the Egyptian health sector. This was followed by designing the health Master Plans stage for the five pilot governorates. Experimenting stage of the Family Health Model took place in one of the primary health care facilities, which took about two years to implement. This was followed by piloting stage of the Model in five governorates and included activities such as: Building staff pattern, designing the contents of the Basic Benefits Package and Essential Drug List, and other

components of the Family Health Model. The Program has shifted its strategy in March 2003 from health facility oriented approach to the district approach, which was called the District Provider Organization. As of 2005, the HSRP has gradually expanded its operations to ten additional governorates, pushing the total number of involved governorates to 15, which presents more than 50% of the country coverage.

### **Process of implementation: approaches, issues, concerns**

It has been seven years since the Government of Egypt (GOE) initiated the pilot phase of the HSRP: the Family Health Project. The service delivery component of the Project has been implemented with success, where a large number of PHC facilities were upgraded, new management systems were implemented and family health staff was trained. By September 2005, 500 family health facilities have been accredited, around two third of them entered into contractual agreements directly with the Family Health Fund or through the District Provider Organization. It is envisaged that in the course of year 2006, 500 additional family health facilities will be accredited. This will add a total of 1,000 by mid 2006 presenting 25% of the total public primary health care facilities.

However, while the original project design emphasized involvement of health care providers from all sectors (government, public, non-governmental and private) to ensure consumer choice and provider competition, most FH centers and units are MOHP, with only 15 Health Insurance Organization, and very limited number of private and NGO facilities.

Three major innovations in service delivery were introduced:

- The Family Health Model was adopted for the first time in Egypt, where integrated services were provided under the same roof for the entire family requiring less time and transportation and offering better quality. Both physicians and patients valued the concept of continuity of care and the unified medical record.
- Performance-based incentive systems were also adopted for the first time in Egypt and succeeded in increasing provider accountability for quality standards and reform goals. The Family Health Pilot Project thus demonstrated that health provider behavior can be favorably modified to serve national health sector goals. While this experiment has been limited to mostly public providers, it can also be used to harness private provider participation in the health sector reform in Egypt.
- Rationalization of health infrastructure investment was introduced based on Master Plans in the three pilot governorates, where rehabilitation, extension and construction of health facilities were undertaken based on the health needs of the poor population in the catchment areas, thus improving access, efficiency and equity in service provision.

The successful implementation of the service delivery component of the Family Health Pilot Project resulted in:

- Increased provider satisfaction and productivity, as demonstrated by the rise of physician encounters from 3 to 16 per day.
- Increased patient satisfaction and demand for FH services, as demonstrated by the long waiting lists at FH facilities that were previously under-utilized.

The development of the FHF's, the financial component of the Family Health Pilot Project, has been constrained by the legislative environment governing the health sector in Egypt, which prohibits any agency outside the HIO from collecting premiums or capitated payments from individuals or families. The FHF's were thus established in the five pilot governorates with the legal status of bank accounts under the respective HIO

branches (Ministerial Decree 294 of the year 1999). From an institutional perspective, the five FHF are managed by the MOHP, with the central FHF being fully integrated into the Ministry's Sector for Technical Support and Projects. As such the FHF ended with an awkward legal and institutional status. Currently, the only flow of funds through the FHF is the disbursement of incentives to contracted providers based on performance criteria. The costs of the FHF's administration and incentive disbursement are primarily covered by HSRP funds from the European Commission (EC) and the Ministry of Finance (MOF). The costs of providing BBP services go directly from the MOHP and the HIO to their FH facilities. Also, nominal collections from patients (visit fees) go directly from providers to the MOHP or the HIO without passing through the FHF. As such, the Family Health Pilot Project failed to model the separation of financing from provision.

Ministerial decree 147 of the year 2003 was issued to increase the revenue -generating ability of the FHF by authorizing FH units and centers to collect user fees and drug copayments from beneficiaries. While the decree has not been yet operationalized, its implementation is not anticipated to yield substantial revenues since the proposed fee structure covers only a small portion of the actual cost of providing BBP services. Drug copayments are also set at one-third of the market price of the drug. Moreover, only a portion of collections from patients will be retained at the FHF to assist in covering their administrative costs. The other limitation of the decree is the fact that it does not provide any risk pooling mechanism as fees are collected at the time of service provision. Thus, while the decree represents some improvement, its potential to make the FH program financially sustainable is very limited.

### **Progress with implementation**

On July 6<sup>th</sup>, 2005 President Mubarak has announced the six dimensions of the National Plan for Improvement of the Health Sector. The Presidential announcement reflects the Health Sector Reform Program (HSRP) objectives. The six dimensions of the National Plan for Improvement of the Health Sector is aiming to universal converge of the Egyptians with health insurance by the year 2010 through:

1. First dimension: "Improving the managerial and administrative capacity of Health Insurance Organization through separation between financing and providing of health services".
2. Second dimension: "Establishing of Family Health Fund at each Governorate".
3. Third dimension: "Include the uninsured population, with the health insurance system".
4. Fourth dimension: "Rolling Out of Family Health Model on the nation wide with participation from the private and NGO".
5. Fifth dimension: "Improving the health services for the secondary care".
6. Sixth dimension: "Integrating all the current health care providers under one entity to provide universal health insurance by the year 2010".

The Minister of Health and Population has announced, on several occasions, the MOHP plan for Rolling out the model. On August 10 of last year, HE has presented the five-year plan to the Prime Minister. The estimated plan cost is 2.9 billion L.E. for the next five years. Forty eight percent of this number represents the annual recurrent cost to maintain the quality of PHC services.

The Prime Minister has followed up and presented the new Government Plan to the People's Assembly on December 12, 2004. For the national health services, The Prime Minister affirmed Rollin Out the Family Health Model and stated the number of

PHC's in Phase One with a five-year plan to improve PHC services on the national level.

During an official interview in October 2004, the Prime Minister stated the following "there is this great program that we all should stand behind and support, which is primary health care for all Egyptians. In previous phases, many investments were directed towards what is called advanced health care and the establishment of hospitals for performing surgeries or specialized hospitals such as Cancer and Heart Institutes. That's why most of our investments were consumed into this course of direction; including both private and public sectors, while investments for primary health care had less investment. Nowadays, MOHP is conducting a pioneer project to extend and expand these services all over the Egyptian rural villages through a new model called the integrated health unit, which is working economically and autonomously, and providing a complete record for each family in Egypt. The cost of improving the services per primary health care unit is LE 2 million on average including the annual operational expenses. In fact it is a great national project that we should all stand behind and support".

### **Process of monitoring and evaluation of reforms**

Measuring of HSRP impact, through assess its five main objectives on the district level, is mandatory in this stage. In mean time, establishing a causal relation between HSRP and activities and a change in health status is risky. There are logistical problems in measuring impact (large sample sizes, costly and time consuming). On the other side, HSRP does not have yet complete district population coverage to evaluate the effect on population health status (morbidity and mortality) as result of HSRP implement on district. HSRP is developing a quarterly measure for HSRP five objectives' achievements on the district level. This will be accomplished through modifying the developed list of indicators by the program (with technical support from KIT in the year 2003).

The Family Health Model review has been a jointly-led exercise between Sector of Technical Support and Projects Sector, and the different sectors within the Ministry of Health and Population. The reviewing Steering Committee has been composed of representatives from European Commission (EC), Ministry of Health and Population (MOHP), World Health Organization (WHO), United Nations Population Fund (UNFPA) and United States Agency for International Development (USAID). The review process went through a rigorous evaluation procedure for several documents produced by the program as well as having interviewed several officials at the MOHP central and peripheral levels. The reviewers have visited all pilots Governorates to assess the implementation of the Model at the family health facilities level.

Reviewing of the Family Health Model concluded that there is no alternative option to this strategy followed by the family health program in Egypt to improve access to health, make effective disease control programs and strengthen the health system.

- The project represents a successful initial step of a complex program aiming at reforming the entire health system. To be successful, it is pivotal that there be stability with the (CDTSP, other MOHP structures and technical assistance) teams in charge of the project.
- In the future, all administrative levels will need to be involved in the process. The creation of a small national team endowed with the responsibility of bringing technical support to DPO officers is both a priority and a challenge.
- The continuous political support of the Government will be pivotal for the success of this enterprise.

The Health Sector reform Program has started in the mid 90's focusing on primary health care on its first phase. The Program will continue for 15 – 20 more years, to be concluded, as forecasted, by the year 2015.