Document of

# The World Bank

Report No. 17214-EGT

**PROJECT APPRAISAL DOCUMENT**

**FOR A**

**PROPOSED CREDIT**

**IN THE AMOUNT OF SDR 66.8 MILLION (US$90.0 MILLION EQUIVALENT)**

**TO THE**

**ARAB REPUBLIC OF EGYPT**

**FOR A**

**HEALTH SECTOR REFORM PROGRAM**

**April 24, 1998**

Human Development Sector
Middle East and North Africa Region

## CURRENCY EQUIVALENTS

(Exchange Rate Effective 03/24/98)
Currency Unit = Egyptian Pound (EGP)
EGP 1 = US$0.29
US$1.00 = EGP 3.4

## FISCAL YEAR

July 1 - June 30

## ABBREVIATIONS AND ACRONYMS

| | |
|---|---|
| AFDB | African Development Bank |
| AWP | Annual Work Plans |
| CAS | Country Assistance Strategy |
| CCO | Curative Care Organization |
| DANIDA | Danish International Development Assistance |
| EMP | Environmental Management Plan |
| EU | European Union |
| FMS | Financial Management System |
| GDP | Gross Domestic Product |
| GOE | Government of Egypt |
| GPCC | Governorate Program Coordination Committee |
| HPF | Health Policy Forum |
| HIO | Health Insurance Organization |
| HSRP | Health Sector Reform Program |
| ICR | Implementation Completion Report |
| IA | Implementing Agency |
| IDA | International Development Association |
| LMI | Lower Middle Income |
| M&E | Monitoring and Evaluation |
| MIS | Management Information System |
| MOHE | Ministry of Higher Education |
| MOHP | Ministry of Health and Population |
| MOPIC | Ministry of Planning and International Cooperation |
| MOSA | Ministry of Social Affairs |
| NHIF | National Health Insurance Fund |
| OECD | The Organization for Economic Cooperation and Development |
| OM | Operations Manual |
| NGO | Non-governmental Organization |
| PPMC | Program Planning and Monitoring Committee |
| SA | Special Account |
| SFD | Social Fund for Development |
| TOR | Terms of Reference |
| TSO | Technical Support Office |
| TST | Technical Support Team |
| USAID | United States Agency for International Development |

| | |
|---|---|
| Vice President: | Kemal Derviş |
| Country Director: | Khalid Ikram |
| Sector Director: | Jacques Baudouy |
| Task Team Leader: | George Schieber |

**Arab Republic of Egypt**
**Health Sector Reform Program**

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INTERNATIONAL DEVELOPMENT ASSOCIATION

Middle East and North Africa Regional Office
Human Development Sector

# Project Appraisal Document

**Arab Republic of Egypt**
Health Sector Reform Program

| | | | |
|---|---|---|---|
| Date: April 24, 1998 | | Task Team Leader: George Schieber | |
| Country Director: Khalid Ikram | | Sector Director: Jacques Baudouy | |
| Project ID: 45175 | Sector: Pop. Health & Nutrition | Program Objective Category: Poverty Reduction | |
| Lending Instrument: Sector Investment and Maintenance | | Program of Targeted Intervention: [X] Yes [ ] No | |

| | | | | |
|---|---|---|---|---|
| **Project Financing Data** | [ ] **Loan** | [X] **Credit** | [ ] **Guarantee** | [ ] **Other [Specify]** |

**For Credits:**
Amount (US$/SDR): US$90.0 million equivalent/SDR 66.8 million

| | | | | | | |
|---|---|---|---|---|---|---|
| Proposed terms: | | [ ] | Multicurrency | [ ] | Single currency | |
| Grace period (years): | 10 | [ X] | Standard IDA | [ ] | Fixed | [ ] LIBOR-based |
| Years to maturity: | 35 | | | | | |
| Commitment fee: | .50% (less any waiver) | | | | | |
| Service charge: | .75% | | | | | |

Financing plan (US$m):

| Source | Local | Foreign | Total |
|---|---|---|---|
| Government | 86.6 | 10.4 | 97.0 |
| Cofinanciers | | | |
| *European Union (EU)* | | 120.0 | 120.0 |
| *United States Agency for International Development (USAID)* | | 80.0 | 80.0 |
| IDA | 48.0 | 42.0 | 90.0 |
| Total | 134.6 | 252.4 | 387.0 |

Borrower: Arab Republic of Egypt
Guarantor: N/A
Responsible agency(ies): Ministry of Health and Population

| Estimated disbursements (Bank FY/US$M): | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|---|
| Annual | 6.0 | 10.0 | 20.0 | 25.0 | 20.0 | 9.0 |
| Cumulative | 6.0 | 16.0 | 36.0 | 61.0 | 81.0 | 90.0 |

Project implementation period: 1999-2003 Expected effectiveness date: 01/31/99 Expected closing date: 06/30/04

## A: Project Development Objective

*1. Project development objective and key performance indicators (see Annex 1):*

The Government's long-term Health Sector Reform Program (HSRP) is intended to improve the population's health status, ensure equity (physical and financial accessibility for all population groups), improve the efficiency and quality of services, and promote the system's long-run financial sustainability. The Bank *project* will assist the GOE in implementing the first five-year phase of its comprehensive Health Sector Reform Program (HSRP).

The specific *project development objectives* are:

- Improve population health status and well being in three pilot Governorates through universal coverage to a basic package of primary health care and public health services.
- Improve access to, efficiency, and quality of primary health care services in three pilot Governorates.

The *key performance indicators* for this project relate to measuring: improvements in population health status; improved access to, quality of, use, and efficiency of primary health care services. With respect to health status, the project will contribute to Egypt's medium-term plan to reduce: (i) infant mortality rate from 38/1000 to 29/1000; (ii) under-five mortality from 84/1000 to 64/1000; and (iii) deaths of women due to pregnancy and delivery from 160/100,000 to 90/100,000.

The project will contribute to the achievement of these goals, but other factors outside both the project and the health sector will also affect these indicators. Thus, for purposes of monitoring the effects on health status of universal coverage to primary health care and public health services in the three Governorates, it is proposed to monitor levels and trends in these measures before, during and after the project, and compare these indicators to other comparable Governorates where there is no Bank project intervention.

With respect to measuring the effects of the project on access to, quality of, equity, and efficiency of primary health care services, use of a needs-based masterplan, retraining physicians to practice family medicine, and operationalizing the insurance entities in the pilot areas are used as process measures for these indicators. Increased use rates for primary care services can also be expected, monitored, compared pre- and post-project implementation, and compared to other Governorates.

## B: Strategic Context

*2. Sector-related Country Assistance Strategy (CAS) goal supported by the project (see Annex 1):*

CAS document number: 16533-EGT Date of latest CAS discussion: May 5, 1997

The Country Assistance Strategy for Egypt places high priority on reinforcing the social agenda to address poverty and the transitional costs of adjustment while maintaining the record of sound macroeconomic management that has contributed to the resumption of strong economic growth in recent years. The incidence of poverty in relative terms has declined significantly over the past 50 years, but high population growth rates as well as regional disparities in access to essential social services and income-earning opportunities have meant that the absolute number of households living in poverty has continued to rise. The Government recognizes that rapid economic growth is essential to achieve a sustained reduction in the level of poverty, but this needs to be complemented by improvements in the quality and coverage of key social services, including universal access to a minimum critical package of health care services, in a fiscally sustainable manner.

***3. Main sector issues and Government strategy:***

The HSRP was developed by the Government with the assistance of the Bank and other donors to address *underlying structural problems* in the various sector domains which collectively determine *national health outcomes as well as the equity, efficiency, quality, and long-run financial sustainability of the health sector.* The reform program proposes a complete overhaul of all aspects of the health system. Both the costs and implementation realities require a phased approach. The overall reform is designed to deal with the system's major underlying structural problems.

That *health outcomes* are problematic and worse than the lower middle income (LMI) average is illustrated by high national rates for child and maternal mortality (8.5% of children die before age 5; 1.7% of births result in the mother's death) and wide disparities between rural and urban areas (infant and child mortality is 3 times higher in rural areas; maternal mortality is 5 times higher).

There are significant *equity problems in access to services*, by both income and geographic grouping. Public spending is regressive, with only 16% of health allocations benefiting the lowest income quintile and 24% going to the highest. In line with this skewed allocation, per capita public spending is 67% higher in richer urban than in poorer rural Governorates.

*Sector organization and management are fragmented*, resulting in uncoordinated decision-making and pervasive inefficiencies which preclude effective risk pooling and efficiency in service delivery. Twenty-nine separate and uncoordinated Government and public entities are responsible for decision-making. This impedes rational policy making, equitable and efficient financing, efficient provision, and effective coordination both among public sector programs and between public and private actors.

Sector *financing is also fragmented*, with responsibilities shared but not coordinated among the Health Insurance Organization (HIO), The Ministry of Health and Population (MOHP), the Ministry of Social Affairs (MOSA), other Government Agencies and private services. This prevents risk pooling and encourages strategic behavior among providers. Overall spending is low: with just 3.7% of GDP (US$38 per capita) spent on health care, Egypt spends less than other LMI countries. Low total and public spending also reflects the inequity of financing: the 56% of spending which is private is mainly out-of-pocket expenses disproportionately made by lower income individuals.

The delivery system is characterized by *substantial excess capacity, under-use of sub–par quality facilities, and substantial inefficiency.* Egypt has more beds per capita than other comparable income countries and a hospital occupancy rate under 50%. Unlike physical capacity, quality needs to be increased. Nosocomial infection rates are at least 5 times as high as in OECD countries and lack of basic equipment, supplies and drugs in MOHP primary facilities means that, despite impressive physical access (e.g., 95% of the population being within 5 kilometers of a facility), effective access is limited. Finally, efficiency varies widely, with costs per hospital day and per admission varying by 3 and 4 to 1, respectively, in MOHP and HIO hospitals.

Spending and consumption of *pharmaceuticals* are as much as 50% higher than in other LMI countries, and use is frequently excessive and inappropriate. Generics are infrequently used, and price controls effectuate poorly targeted subsidies while inefficient state owned enterprises are inappropriately subsidized at import, production, and distribution levels.

As with physical capacity, there are both surpluses and imbalances of medical personnel. While Egypt has 1.6 physicians per thousand population, 3-4 times the number in other comparable income countries, there is a shortage of primary care physicians relative to the number of specialists, and an absolute shortage of skilled nurses. Quality also needs to be improved as evidenced by as many as 50% of deaths in emergency situations being due to improper treatment by physicians.

***4. Sector issues to be addressed by the project and strategic choices:***

While in the long term the HSRP will address all of the issues raised above, the *Bank's focus in this project* will be on the Government's chosen priorities for the first five-year phase of the reform: universal coverage to a basic package of primary health care, including rationalization of the primary health care delivery system, and reform of the HIO.

This project assists the GOE in the phased implementation of universal coverage and primary care delivery system rationalization, beginning in three Governorates. *Criteria for selection of Governorates include*: level and depth of poverty; income; health status; concentration of women, children and other vulnerable groups; commitment to reform; administrative capacity; existing delivery capacity; presence of the HIO in the Governorate; presence of other donor primary care activities; and, representativeness and replicability. The Governorates chosen by the GOE are: Alexandria, Minoufia, and Sohag, and represent one Governorate from each of Egypt's major subdivisions (i.e., Urban Governorates, Lower Egypt, and Upper Egypt) excluding the sparsely populated Frontier Governorates.

Similarly, the HIO, which currently covers one-third of the population will be reformed to improve its efficiency of administration and service delivery. It is currently running a 40% deficit and is not financially sustainable in the long-term. It will also be transformed to become the future single national health insurance entity by enhancing its role to function through new Governorate level subsidiaries as the insurance entity administering the basic primary health care benefit package in the three pilot Governorates.

These are the appropriate *strategic choices* for a number of reasons. First, by focusing on primary care and public health, the project's *most significant impacts would benefit underserved and vulnerable populations*, women and children. Second, focusing on these areas is the *most cost effective means of reducing the burden of illness.* Third, this allocation of resources will significantly *reduce some of the most egregious urban–rural differentials* in health outcomes, access, and spending. Fourth, it would *lay the base for universal coverage* of a comprehensive benefit package in the future. Fifth, it would *begin to rationalize the service delivery system*, starting with ambulatory care up through district hospitals. Rationalizing secondary and tertiary facilities will be much more costly and more volatile politically, will require more fundamental changes in the medical education and planning systems, and will yield lower benefits in terms of health outcomes. Starting with the introduction of family physicians, a specialty new to Egypt, and retraining other primary care personnel in the three Governorates are sensible first steps in improving primary care quality and efficiency. Sixth, the primary care initiative can be undertaken while MOHP and HIO continue to insure curative care and begin the long process of changing their functions and divesting their delivery systems.

## C: Project Description Summary

*5. **Project components** (see Annex 2 for a detailed description and Annex 3 for a detailed cost breakdown):*

| Component | Category | Cost Incl. Contingencies (US$M) | % of Total | Bank-financing (US$M) | % of Bank-financing |
|---|---|---|---|---|---|
| **1. Provide Universal Access to a Basic Package of Primary Health Care (PHC) Services:** | Physical; Institutional Building | **347.3** | **90%** | **79.7** | **23%** |
| *a. Implement Governorate PHC Insurance System* | | *22.8* | *7%* | *16.3* | *72%* |
| *b. Improve Quality and Efficiency of PHC Delivery System* | | *299.0* | *86%* | *60.3* | *20%* |
| *c. Improve Public Health Programs* | | *25.5* | *7%* | *3.1* | *12%* |
| **2. Reform of the HIO** | Physical; Institutional Building | **39.7** | **10%** | **10.3** | **26%** |
| | **Total** | **387.0** | **100%** | **90.0** | **100%** |

Taken together, these two project components begin the process of introducing universal coverage of a comprehensive package of services to be administered by a single national health insurance entity. During *Phase I, universal coverage for a basic primary health care package* will be implemented in the three pilot Governorates. Phase I will also address reforming the organization and management of broad-based MOHP public health programs, which either are included in the PHC benefit package or provide the requisite complementary services to the basic primary health care benefit package. In the *long run* a restructured HIO will become the National Health Insurance Fund (NHIF), a national insurance entity administering the country's social health insurance system. To administer introduction and operation of the basic primary health care package in pilot Governorates during Phase I of the reform (which includes HIO restructuring at the national level), Governorate level HIO subsidiaries will be used. To ensure efficient and effective delivery of quality services, the delivery system will also be rationalized. As with reform of the insurance system, this process will entail testing and adjustment of primary health care system reforms in Phase I pilot Governorates, followed by extension of those reforms to the entire nation in later phases.

***6. Key policy and institutional reforms supported by the project:***

The project will support a shift in investment policy away from its current urban and tertiary emphasis by focusing major physical investments on primary care facilities largely in underserved areas. Establishment of needs-based masterplans as the framework for facility rehabilitation and human resource development supported by the project will serve as the mechanisms to effectuate this shift. At the same time, by improving HIO's operational efficiency, the project will support extension of access to a basic primary health care package through the insurance system.

*7. Benefits and target population:*

By supporting the Government's long-term comprehensive reform program, the project will ultimately benefit the entire population. Project design will ensure that *in the medium term the poor will benefit more* than those who already enjoy adequate access to basic primary care. *First*, the initial stage of phasing in universal coverage to a basic package of primary health care services will largely benefit the poor, children, women and other underserved vulnerable groups. *Second*, project activities in facility rehabilitation will be predicated on a needs-based masterplan emphasizing poor, underserved areas. *Third*, the types of primary care and basic public health programs to be supported disproportionately benefit poor groups. *Finally*, because the poor are less able to substitute private for public services, project activities which help to improve quality and availability of services and rationalize the payment system in public delivery will therefore have an immediate impact on the poor.

*8. Institutional and implementation arrangements (for a detailed discussion, see Annex 6 and the Operations Manual) :*

*Project Oversight*: The Ministry of Health and Population (MOHP) has the overall responsibility for management and implementation of the HSRP. To ensure continuity, technical quality, and effective coordination between the many organizations involved in planning and implementing the reforms, the Minister of Health and Population will be assisted by several entities at the central and local levels: a Health Policy Forum (HPF), a Program Planning and Monitoring Committee (PPMC), a Technical Support Office (TSO), as well as Governorate Program Coordination Committees (GPCCs) and Technical Support Teams (TSTs) in the three pilot Governorates.

*Health Policy Forum (HPF):* The HPF will be established as an ad-hoc advisory committee by the Minister of Health and Population. It will promote policy dialogue among concerned GOE officials and stakeholders, encourage transparency in policy making, ensure continued Government commitment to the reform program and facilitate intersectoral coordination. It will include private sector representatives, public figures who the Minister may wish to invite, and members from concerned Government ministries and agencies including the Ministries of Higher Education, Planning, and Finance and the Health Insurance Organization. The HPF will provide a forum for full participation of all stakeholders in the reform.

*Program Planning and Monitoring Committee (PPMC):* The PPMC, chaired by a senior designate of the Minister and including MOHP undersecretaries, TSO Director, in addition to senior representatives from HIO, the Curative Care Organization (CCO) and the Medical Syndicate, will be located at the MOHP and will be responsible for strategic planning for the reform program. The main role of the PPMC is policy formulation, planning and monitoring of the reform outcome. With responsibility for translating policies into activity plans and for overseeing implementation of the health reform program, the PPMC will ensure that all reform initiatives are consistent with the agreed strategic plan. It will update the strategic plan, decide on overall program strategy and organization, and review and monitor Annual Work Plans (AWPs) in accordance with agreed performance indicators. The PPMC will be responsible for evaluating the impact of the project in terms of health outcomes, access, efficiency, and quality.

*Technical Support Office (TSO):* The Minister has formally established a Technical Support Office (TSO) as part of his central administration and has issued a decree appointing the TSO Director who reports directly to him. The TSO is in charge of coordinating the HSRP implementation and is finally accountable to the Minister. The TSO will be composed of full-time operational and technical staff recruited on a competitive basis and retained for the life of the project. The capacity of the TSO to coordinate program implementation will be strengthened by assigning adequate financial and administrative powers corresponding to its complex and varied tasks, comprising: planning, facilitation, capacity building, appraisal, coordination, disbursement, procurement and overall direction of the program. An Operations Manual outlining procedures for all areas of its work and including criteria for

AWP design and implementation, is being developed for use by the TSO staff during project implementation. The TSO staff will undertake a series of training activities during the preparatory phase of the project to improve their readiness for implementation. The TSO staff will perform all their functions according to the highest standards of efficiency, productivity and transparency. They will work with all concerned, within and outside the MOHP, to ensure that program activities are undertaken properly and in the most cost-effective manner.

*Technical Support Teams (TSTs):* The TSO will help establish small Technical Support Teams (TST) in each of the three pilot Governorates to include initially a team coordinator, a financial specialist and a procurement/engineer. These teams will mirror the TSO at the Governorate level, though on a much smaller scale, and will serve as liaison between the Health Mudiriyyas (where they will be located) and the TSO in coordinating all implementation activities at that level. The TSTs will be assigned smaller procurement and financial responsibilities which they will undertake according to the guidelines and procedures outlined in the program's Operations Manual. While the TSTs will report on a day-to-day basis to the Mudiriyyas' Health Directors, they will undertake only functions agreed between the TSO and the Governorate Program Coordination Committee (see below) and which are outlined in the Governorate's annual work plan.

*Governorate Program Coordination Committees (GPCCs):* To oversee program planning and to monitor implementation at the Governorate level, the Minister of Health and Population will establish a Program Coordination Committee in each pilot Governorate. Counterparts from the main program components (PHC, HIO, etc.) will serve on these Committees, which will be headed by the Director of the Health Mudiriyya in each pilot Governorate. The Committees will play a technical advisory role to the TSTs at the Governorate level and will have neither management nor financial responsibilities for program implementation. The main function of these Committees will be to help prepare the annual work plans and to ensure that health needs and priorities are properly reflected in the various reform interventions at the Governorate level. The Director of the Health Mudiriyya in each pilot Governorate will become a member of the PPMC and will attend all regular PPMC meetings, and contribute to all major strategy and policy decisions that will be taken as part of the PPMC's planning and monitoring activities. The TSTs will facilitate the functions and operations of these Committees.

*Implementation:* The TSO is ultimately responsible for programming, coordination and implementation of the reform. It will work through the MOHP with Governorates, donors, and other stakeholders to coordinate the implementation of a comprehensive program of activities to be defined each year in the AWPs. The AWPs would incorporate priority activities needed to achieve interventions identified in the Strategic Framework. The AWPs would be developed in collaboration with the TSO and TSTs on the basis of priorities and development objectives identified jointly with the PPMC and GPCCs and agreed with the donors. IDA and other donors would assist in preparing AWPs as needed and upon Government request. While formal IDA approval of AWPs would not be required, review and discussion of draft AWPs by IDA would take place each year and would constitute a key area of IDA assistance to the GOE. IDA review of AWPs would focus on three factors: (a) consistency with the overall Strategic Framework; (b) overall internal coherence of the plan and complementarity among its various interventions; and (c) feasibility, in terms of managerial and operational capacity and adequacy of funding. Due to the extent and depth of the reforms, the TSO is expected to establish and support several cross-sectoral ad-hoc advisory committees, expert panels, task forces, and work teams that would assist in the detailed analysis, programming and implementation of the various program components and activities at all levels.

The MOHP will implement program activities through various agencies within and outside the Government. The TSO would establish linkages with all concerned parties and stakeholders, liaise between central and local authorities, provide technical assistance to Implementing Agencies (IAs), and

provide feedback and report regularly on program implementation to the Minister and the donors. The IAs could include, but are not limited to: departments of the MOHP, the HIO, CCOs, universities and medical institutes, training centers, NGOs, consulting firms as well as qualified individual consultants. During the development of the AWPs, IAs would be identified for each activity or group of tasks. The IAs would operate under contract (in the case of NGOs, medical institutes and private firms) or under inter-agency agreement (in the case of public entities) with the TSO. These contracts or agreements would include detailed Terms of Reference (TORs), budgets, implementation schedules, performance indicators and requirements for progress reporting. The TSO/TSTs would ensure that these contracts and agreements are selected and executed in accordance with the procurement and contracting procedures of funding agencies, and based on sound business practices that assure competitiveness and transparency. The TSO/TSTs may, as needed, extend technical support to IAs, especially public entities, in developing proposals or in carrying out their activities. The TSO/TSTs would be supported, as needed, by technical experts (local and foreign), to help it carry out its various assignments and responsibilities.

*Accounts and Audits:* The GOE is in compliance with IDA audit reporting covenants. The TSO will establish and maintain separate program-related accounts for each donor and for all program expenditures. These accounts will be maintained in accordance with internationally sound recognized accounting practices and in an accounting system acceptable to IDA. The TSO will prepare interim and annual financial statements and submit them to IDA. These statements shall reflect the financial performance of the program. The Special Account, all project accounts, and SOEs will be audited in accordance with international standards at the end of each GOE fiscal year, beginning with fiscal year 2000, by independent auditors acceptable to IDA. These reports will be submitted to IDA within six-months from the end of each fiscal year and will be made available to the Minister of Health and the other donors. All accounts, financial reports and audits should provide adequate and timely information to IDA for supervision of the program.

*Reporting:* The TSO will maintain continuity in project management, and will ensure that all project documentation is well prepared and on schedule and that procedural problems are reduced to the minimum. The TSO/TSTs will prepare the AWPs in consultation with expert panels and the IAs, and forward these to IDA for discussion by no later than October 30 of each year. The TSO will prepare semi-annual progress reports against AWP indicators. These reports would discuss problems encountered, solutions adopted, and adjustments to the AWPs. The TSO will develop and maintain a computerized management information system (MIS) which will give financial and operational data on a continual basis and track program implementation progress. In addition, the TSO will develop a uniform (standard) reporting system for the evaluation by all concerned donors. All reports will be submitted concurrently to the Minister of Health, IDA and the concerned donors. The TSO will prepare a detailed Mid-Term report and submit it to all participating donors by end 2000 to serve as the basis for the Mid-Term review, which donors and the GOE will conduct by early 2001. The TSO will also prepare an Implementation Completion Report (ICR) for review by IDA and other concerned donors within six-months of the closing date of the Credit.

*Monitoring and Evaluation (M&E):* The TSO will be responsible for monitoring progress against agreed performance indicators (specified in Annex 1). It will also be responsible for undertaking an extensive (independent) evaluation of the reform and the project interventions. The TSO's main M&E functions include: (i) develop and undertake baseline and subsequent surveys to measure the process and performance indicators for HSRP objectives and activities; (ii) monitor implementation progress and performance of the various IAs; (iii) develop and maintain a database of program status for the generation of *annual progress reports* for the Government and participating donors; (iv) conduct continuous evaluation on the impact of the initiatives/interventions and provide feedback for modification or improvement as necessary; (v) prepare *summary reports* for the Minister and the donors highlighting problems, issues, and recommended actions. The TSO will contract independent technical

auditors to undertake a full analysis of all program activities which will form the basis of the annual progress reports. In addition, the IAs will provide the TSO with quarterly progress reports summarizing: (i) the current status of project implementation and reasons for deviation from agreed implementation plans; (ii) financial records; (iii) constraints faced and corrective actions to be taken; (iv) a work plan for the subsequent six months; and, (v) an update on agreed upon monitoring indicators. These reports will be consolidated by the TSO and forwarded to the Minister, IDA and the other donors semi-annually.

## D: Project Rationale

***9. Project alternatives considered and reasons for rejection:***

Although the Government's HSRP is a broad reform strategy covering all aspects of health sector reform, project support for design and implementation of Phase I will focus on universal insurance coverage, primary care, and delivery system reforms. These areas were selected by the Government as the major components of the reform's Phase I because they would have the greatest impact on health status, equity, and efficiency and are necessary prerequisites for later reform phases. Focusing on primary care and public health programs while at the same time undertaking major reform of their delivery and insurance systems in three selected Governorates provides a sensible balance on policy, implementation, and financial sustainability grounds.

Areas not covered by the project include: the curative care delivery system (above the District Hospital level), which will require civil service reform and prior institutional and management reform of the multiple public financing and delivery programs; pharmaceuticals, a very politically sensitive area requiring further study before implementing major reforms; and, total system manpower (beyond primary care), which will require addressing employment policies, civil service reform, and sensitive inter-ministerial issues, and where technical training programs aimed at alleviating unemployment produce excess manpower supply.

***10. Major related projects financed by the Bank and/or other development agencies** (completed, ongoing and planned):*

| Sector issue | Project | Latest Supervision (Form 590) Ratings (Bank-financed projects only) | |
|---|---|---|---|
| Bank-financed | | Implementation Progress (IP) | Development Objective (DO) |
| National Schistosomiasis Control Project (Cr. 2403-EG); US$26.8 million. | Support the development of a sustainable national program to control schistosomiasis. | S | S |
| USAID: Cost-Recovery in Health; Ongoing (US$85.0 million) | Introduce cost-recovery in public hospitals managed by the MOHP, HIO and CCO. | N/A | N/A |
| NETHERLANDS: Tuberculosis Control; Ongoing (DFL 13.0 million) | Upgrade tuberculosis units and increase the effectiveness of tuberculosis prevention and control programs. | N/A | N/A |
| GTZ: Improvement of Family Planning Services; Preparation (DM 3.0 million) | Improve family planning service delivery | N/A | N/A |

| | | | |
|---|---|---|---|
| DANIDA: Primary Health Care; Ongoing (DKK 39.2 million) | Improve health conditions in selected communities particularly of mothers and children. | N/A | N/A |
| ADB: Schistosomiasis Control; Completed (US$10.0 million) | Reduce bilharzia infestation among the rural population in the Delta area. | N/A | N/A |
| UNICEF: Primary Health Care Revitalization; Ongoing (US$2.0 million) | Induce greater use of primary care facilities and revitalize the PHC system. | N/A | N/A |
| UNICEF: Health Information Systems and Operational Research; Ongoing (US$0.1 million) | Improve health sector management at all levels. | N/A | N/A |
| UNICEF: Expand Program of Immunization (EPI); Ongoing (US$12.4 million) | Eradicate polio and control tetanus and measles. | N/A | N/A |
| UNICEF: Control of Diarrheal Disease (CDD); Ongoing (US$2.7 million) | Support ORS production and diarrhea prevention. | N/A | N/A |
| UNICEF: Control of Acute Respiratory Infection (ARI); Ongoing (US$0.8 million) | Reduce deaths due to ARI in children under five and improve surveillance system for ARI. | N/A | N/A |
| UNICEF: Safe Motherhood; Ongoing (US$0.9 million) | Training TBA's and to increase utilization of MCH services. | N/A | N/A |
| UNICEF: Nutrition; Ongoing (US$1.0 million) | Support studies and interventions on micronutrient deficiencies. | N/A | N/A |
| UNICEF: Control of HIV/AIDS; Ongoing (US$0.4 million) | Support health education among high school ages. | N/A | N/A |
| WHO: Health Planning; Ongoing (US$0.2 million) | Strengthen planning and development of national health care quality system. | N/A | N/A |
| WHO: Health Systems and Services Development; Ongoing | Strengthen District Health System Development. | N/A | N/A |

IP/DO Ratings: HS (Highly Satisfactory), S (Satisfactory), U (Unsatisfactory), HU (Highly Unsatisfactory)

***11. Lessons learned and reflected in the project design:***

*Global experience with Health:* Much of the Bank's past experience in the health, nutrition, and population (HNP) sectors has been in basic public health, including reproductive health, infrastructure development, and pharmaceuticals purchasing. There is less experience in comprehensive health sector reform programs focusing on insurance reform and universal coverage. The Quality Assurance Group (QAG) reviews have documented that simple, well designed projects tend to perform better, and that projects based on good sector work have better development impacts. Unfortunately, risk pooling, insurance expansion, and provider payment reforms are by their very nature complex undertakings even

for developed countries; these however are needed areas of reform and are appropriate for Bank assistance, as the Bank's HNP Sector Strategy Paper concluded. Bank projects have only recently begun to focus on these areas.

*Egypt Project Implementation Experience:* Project implementation in Egypt has improved steadily in the last two years. A major problem in the past – long delays in achieving loan/credit effectiveness – has been nearly eliminated through high level attention to obtaining parliamentary ratification. Finally, recent projects are being designed with simplified management, procurement and disbursement systems.

*Egypt Health Projects Implementation Experience:* The Bank has only had two health projects in Egypt and the implementation experience has been mixed. The Bank's Schistosomiasis project took a long time to become effective although it is now performing satisfactorily, and the Population Project has still not been approved by the Government despite several extensions. MOHP capacity will need significant technical assistance to enable the Ministry to develop, implement and monitor a broad and long-term reform such as is envisioned under the HSRP. Coordination with other donors through sharing of relevant experiences will help to address these issues and to provide the coordination needed for a broad sector reform effort.

***12. Indications of borrower commitment and ownership:***

There is high level ownership of the strategy by the GOE since the HSRP was developed by the GOE with technical assistance from the Bank, USAID, EU, and DANIDA. It reflects the perspective and priorities of the Government and is the Government's first attempt to develop a comprehensive and analytically based health reform program. The Minister of Health and Population and his principal deputies have all been deeply involved with the development of the strategy.

***13. Value added of Bank support in this project:***

The value added by the Bank is its economic focus and experience in areas such as health care financing, insurance issues, provider payment issues, and general system reform issues. The Bank brings experience in macroeconomic and public finance issues as well as in the complex issues regarding financial and economic incentives inherent in a comprehensive reform. The Bank has also done an extensive analysis as part of project preparation on the costs and affordability of both the Phase I and overall health reform program. The Bank's comparative advantage resides in its ability to apply the experiences of developed as well as developing countries in other regions to the process of addressing these very difficult health finance and delivery issues.

## E: Summary Project Analysis (Detailed assessments are in the project file, see Annex 4)

***14. Economic** (supported by Annex 4):*

[ ] Cost-Benefit Analysis : NPV=US$ million; ERR= % [ ] Cost Effectiveness Analysis:
[X] Other (Specify)

Support for policy changes in the public financing and provision of Egyptian health services is justified on a number of grounds. Chief among these are *first,* distributional arguments addressed to the current regressive financing system whereby the poor bear a heavier relative burden in out-of-pocket payments and yet do not enjoy effective access to basic care; *second,* efficiency and distributional arguments addressed to risk pooling and insurance market failures manifest in "cream skimming" (*i.e.* limited enrollments and adverse selection in schemes covering formal sector employees), unfunded mandates (*e.g.* expansion of HIO to cover all infants and school children), and poor use of the combined resources of the multiple public and private health delivery systems, and; *third,* traditional public good arguments

based on the positive externalities which accrue from public health activities and which are manifest in a healthy labor force and lower burden of disease.

The Government's program will specifically address the issues impeding efficiency and effectiveness of public health and primary care activities. In so doing, it will also lay the groundwork for a gradual introduction of formal universal coverage of a basic benefit package, starting with the most vulnerable groups and geographic areas. Public health and primary care interventions will target the major health problems and promote cost-effective interventions. The basic benefit package is also established with cost-effectiveness as the chief criteria to ensure the maximum gain in health status per pound spent. By extending coverage to pregnant women (who are not now covered) and maternal health services through the basic services package, both maternal and infant mortality should be substantially reduced. The Government will seek to improve technical efficiency in a number of ways. First, it will restructure the primary care delivery system by creating family health units and family health centers and by rehabilitating and re-equipping district hospitals. Second, incentive based provider payment mechanisms will be used by the insurance entities to ensure efficient delivery of services. Third, cost-sharing for pharmaceuticals will be implemented through HIO as part of reforming the national benefit package it currently administers. Fourth, the primary care delivery system will be restructured through retraining physicians and nurses and reorienting the medical education system towards production of manpower needed for primary care. This will increase both efficiency and quality.

Bank assistance in this project will support the primary care, public health, and financing aspects of the Government's program. Quantification of savings due to these reforms is not feasible. Payoffs to enhanced micro-efficiency stemming from improved contracting procedures, drug copayments, and phased movement to a single source financing system for the basic package will be seen in the expansion and extension of services through the basic services package. Moreover, improved service quality and health status, and reduced out-of-pocket payments for private services engendered by the reform are not readily measurable *ex-ante* and may not be entirely quantifiable *ex-post*.

In terms of the Phase I reform, it is possible to estimate the investment costs to restructure the primary health care delivery systems in the three pilot Governorates, the investments needed to set up the insurance entities, and recurrent costs of providing universal insurance coverage to the 5.9 million uninsured in the three pilot Governorates. It is estimated that restructuring of the primary health care delivery systems in the three pilot Governorates, both human and physical, would maximally require investments of US$300 million. These figures assume replacement of most facilities and limited gains from efficiency. With efficiency gains (i.e., eliminating unneeded facilities) and renovation instead of replacement, the primary care infrastructure investments are likely to be about half this maximal figure. Future recurrent costs from these investments would be on the order of 20% of the overall investment costs. It is estimated that some US$23 million is needed to establish the insurance entities in the three pilot Governorates.

The cumulative total five year recurrent costs of phasing-in insurance coverage to the 5.9 million uninsured for the basic primary health care benefit package (cost of EGP 60 per capita) is estimated at some EGP one billion or almost US$300 million. These costs would need to be financed through some combination of individual payments (premiums and cost-sharing) and public expenditures. Individuals on average are currently spending some EGP 98 per capita out-of-pocket for health services, 95% of which goes for ambulatory care and drugs.

Thus, the real challenge for the GOE is to develop financing mechanisms which recycle these currently largely private out-of-pocket payments into the public primary care insurance system. On the investment side, in addition to the Bank project, grant support from USAID and the EU are likely to be available to assist with the investment costs of restructuring the delivery system. In short, Phase I of the reform is sustainable and affordable, but will require GOE commitment and action to institutionalize an equitable and transparent financing source. It must also face the potential costs of the overall reform in terms of

affordability and long-run financial sustainability. It will need to develop transparent mechanisms to finance the investment and recurrent costs of universal coverage, delivery system restructuring, etc. This will need to be reconciled with current spending levels, the public-private mix in financing and the future growth prospects for the Egyptian economy. Efficiency gains from the current inefficient system are an additional source of finance. These issues are analyzed in Annex 4.

***15. Financial:*** *NPV* N/A *FRR* N/A

Project funds will be provided by the Government, IDA, the EU, USAID. Other donor funds may be made available at later stages of the project. Once implementation is complete, the technical ministry, agency or private sector organization responsible for a particular component will be responsible for its continued management and operation. As discussed above, the project is not expected to produce a significant short-term financial burden, but the fully phased-in system of universal coverage and facility rationalization will, and it will be necessary for the GOE to address these issues as it proceeds with implementation.

*Fiscal impact:* Egypt spends about US$2.3 billion (or 3.7% of GDP – about 1% less than comparable income countries) per year on health care, some US$1.0 billion of which is public. The share of health in total public expenditures (including the parastatal HIO) is only about 4%. Spending is thus relatively low in both total and budgetary share terms in comparison to other LMI countries. The Bank credit of US$90.0 million over 5 years amounts to a 1.8% annual increase in public health spending, and less than 1% of overall spending. Even if recurrent costs are generated at a rate of 25% of investment per year, annual increases in public spending for each year of the project would be on the order of 2%.

On the other hand, as discussed above, the recurrent costs generated by universal coverage and the other elements of the comprehensive reform package will be significant. While the Phase I reform in the three pilot Governorates was analyzed above, the overall longer-term reform costs of a fully phased in system will be much higher. It is estimated that universal coverage to a comprehensive package of benefits would increase health spending in Egypt from its current level of 3.7% of GDP to 4.8%. However, the public share would increase from its current level of 1.7% to 3.0%, while the private share would drop from its current level of 2.0% to 1.8%. Rationalization of the entire delivery system would add some additional recurrent costs to these figures, bringing Egypt's health spending to something on the order of 5% of GDP. A detailed revenue analysis conducted as part of the appraisal mission (and available in the project document file) indicates that under reasonable assumptions of projected economic growth, the long-term reform is affordable and sustainable. The major issue for the GOE will be the significant fiscal implications for the public budget as opposed to the overall level of spending. As the reform will be phased in over a period of 15 years, the GOE will have the experiences gained from the pilot Governorates as well as a long period of time to make this transition.

***16. Technical:***

The project is based on extensive analysis in the HSRP completed as part of project preparation, as well as on many studies performed by the Bank and other donors. The highest priorities for Phase I of the reform, identified by the Government and determined by it to be politically realistic, are incorporated in the project design. Preparation of the project involved participation and involvement of senior level technical consultants and top level Government officials.

***17. Institutional:***

*Executing agencies*: Except for the Schistosomiasis Control Project, the MOHP has limited experience implementing IDA financed projects. The HIO, universities, medical institutes, training centers and NGOs likely to be involved in project implementation, also have limited experience in working with the

Bank. However, the MOHP has extensive experience implementing a series of large USAID financed projects and numerous other small donor financed projects, and has embarked on several reform initiatives over the last two years. As a result, MOHP senior management and staff have become more familiar with donor requirements and are qualified to handle technical aspects of the reforms. Procurement and financial management systems related to project implementation at MOHP and HIO were reviewed at appraisal and found to be largely consistent with Bank policies and guidelines, though lacking in capacity and relevant international experience. However, MOHP, HIO and other relevant agencies would be supported with resident consultants and other technical assistance to strengthen initial implementation capacity, transfer know-how and ensure compliance with the procurement and disbursement guidelines of the Bank and other donors. Achieving and sustaining timely implementation will be a constant challenge. Detailed Annual Work Programs (AWP) with performance and monitoring indicators will ensure a clear definition of tasks, deliverables, timetables and responsibilities, including terms of reference for key staff and implementation units.

*Project management*: The HSRP is a unique operation in its scale of coverage and comprehensiveness. The effective management of the multiplicity of interventions envisaged at national and Governorate levels requires an organizational structure that combines the need for central coordination with operational flexibility at the local level. Accordingly, the responsibilities and membership of the HPF, PPMC, TSO, GPCCs and TSTs have been designed to provide cross-sectoral support and to facilitate the coordination and collaboration required for timely project completion.

*Financial Management Capacity:* A review of the financial management system at the MOHP has found that it is largely consistent with Bank policies and guidelines. However, the review concluded while internal controls seemed adequate, the accounting process was slow and the accounting department was lacking in qualified computer-literate staff who could handle Bank accounting requirements. Therefore, it was agreed that the MOHP would establish a separate computerized financial management system (FMS) at the TSO and that it would promptly seek the technical assistance of the Social Fund for Development (SFD) to put it in place under similar arrangements to the Bank supported project at the Ministry of Education. It should be noted that the FMS at SFD was set up according to Bank's requirements and has been in successful operation since 1993.

***18. Social:***

The project is expected to have a positive social impact by targeting vulnerable population groups in terms of both universal coverage as well as the services covered in the primary health care benefit package. Components will support improved access to and quality of health services. In particular, the population will benefit from receiving care from better trained physicians with incentives to provide quality care in facilities which conform to norms and standards and are functionally efficient. Drugs used for patient treatment will be better targeted to actual needs, and patients will likely spend less on drug purchases. Any resistance to the project would likely arise from those who have a vested interest in private health sector growth, in particular the private pharmaceutical sector. The Government's goal of strengthening the national health insurance system will have significant social benefits. The project would support this goal by improving resource use and the quality of service delivery, both necessary prerequisites to expanding coverage. Surveys conducted by USAID indicate that individuals, including the poor, are willing to pay increased out-of-pocket costs for quality services and drugs delivered by public facilities. This indicates that a contributory social health insurance system which provides real access to services will enhance consumer well-being.

***19. Environmental assessment:*** Environmental Category [ ] A [x] B [ ] C

The only project input with a potential environmental impact is public health facility rehabilitation, for which an Environmental Management Plan (EMP) would be required. The capacity to handle medical and non-medical waste will be incorporated into the sector norms and standards being developed. Consideration will be given to the waste treatment and disposal capacity at health facilities during preparation of the investment masterplan and during preparation of facility rehabilitation plans.

***20. Participatory approach:***

The HSRP and project are based on both extensive collaboration with the GOE and numerous providers, stakeholder analyses performed by USAID and other donors, and consumer surveys conducted as part of USAID's cost-recovery project. The project design comports to the underlying needs, GOE and population demands, and political realities in the country. Local participation will be an important factor in Governorate implementation, especially in terms of enrollment of individuals not part of the formal sector. The implementation arrangements have been designed to assure participation by all stockholders in the implementation of the project and overall reform. In particular, the HPF provides just this forum. Moreover, we have discussed with the GOE launching the reform and building consensus through a national town-hall meeting type symposium, and USAID has expressed interest in funding such an endeavor. Furthermore, stakeholder reactions to the reform will be part of the project evaluation.

a. Primary beneficiaries and other affected groups:

The primary beneficiaries of the HSRP are the entire population of Egypt. However, specific groups are targeted under this project. The public health, primary care and universal coverage initiatives will substantially benefit women, children and other disadvantaged population groups. Under the project, the primary beneficiaries of the project will be underserved populations in the three pilot Governorates.

b. Other key stockholders:

Key stockholders are personnel in the health sector, local governments, NGOs, and the pharmaceutical industry. As discussed above, participation of all these groups will be institutionalized during implementation through the HPF, the PPMC and the GPCCs. Other donors have been fully briefed and will receive copies of the HSRP when it is finalized by the Government.

## F: Sustainability and Risks

***21. Sustainability:***

Over the next twenty years Egypt will need to enhance its social programs to handle its dual disease burden and to facilitate its integration in the global economy. Over the same period, the health sector will face increasing financial pressure from the growing non-communicable disease burden and new and higher cost medical technologies. Phase I of the HSRP will promote long run financial sustainability of the health care financing system by cost effectively improving the delivery network's clinical effectiveness and increasing its economic efficiency. It will increase coverage to achieve both equity and the most cost effective health gains. Coverage expansions will be balanced against efficiency gains. The primary care and public health focus of Phase I will reduce curative care spending over the short- and long-term. Developing an actuarially sound financing base for the HIO and rationalizing its benefit structure (*e.g.*, drug copayments) will also assure financial sustainability.

The costs of both Phase I and the overall reform have been analyzed along with the long-run growth potential of the Egyptian economy. As indicated above, the reform is affordable and sustainable both in

the short- and long-term, although there will be significant shifts in financing from private to public sources. For Phase I the Bank project will meet a substantial part of the investment costs for establishing the insurance entities and rationalizing the delivery system. Costs not covered through the Bank project will be met partially by current MOHP and HIO spending as well as increased GOE support, along with assistance from other donors. In particular, *first*, donor assistance will be available in the short run. USAID has US$80.0 million in grant assistance allocated to Egypt, with disbursement based on broad policy conditionalities effectively met through adoption of the HSRP and implementation of Phase I, and other donors will base funding decisions on release of the HSRP. The EU has tentatively (subject to approval of its member countries) committed US$120.0 million in grant support to the reforms. *Second*, reallocating private spending to the public sector will be important in both the short- and long-term. Sustainable financing will require mobilization of private spending (over 60% of primary care is privately financed) through some combination of premiums, user charges, and taxes.

*Finally*, increasing the level and efficiency of public spending on health could be an important source of funds. Given the currently low proportion of spending allocated to the sector, reallocation favoring health at the expense of other programs would be reasonable. Improvements in efficiency are the focus of various project supported reforms, including rationalization of resource allocation and investment in the delivery network through the needs-based masterplan. Manpower and facility rationalization under the first component, and use of incentive-based contracting to deliver the primary health care package and by the HIO should result in further efficiency gains to finance recurrent costs. Moreover, as the effectiveness of primary care and public health programs increases as a result of the reform, the rate of increase in spending on curative care should decline, providing further savings to finance reform measures. In the longer-term, savings should occur in curative care spending as a result of the primary care focus, and these funds should be available to help support the system.

***22. Critical Risks for the Project:***

| Risk | Risk Rating | Risk Minimization Measure |
|---|---|---|
| Services may not improve in public sector. | S | Pilot introduction for improving services in three Governorates/districts; provide training for health providers in pilot Governorates (and through ongoing pilot in universities). |
| Political or institutional opposition to decentralization of control of the primary care delivery system precludes implementation. | M | Ensure smooth transition from central to local level by participatory involvement in project design and implementation plans. |
| Government does not have the fiscal resources to finance the reform. | S | Detailed actuarial analyses of the reform costs and revenue availability undertaken as part of the finalization of the HSRP . |
| Governorate level insurance entities encounter difficulties collecting premiums and enrolling individuals not in the formal sector. | H | Provide sufficient TA and community based involvement to assure enrollment of these groups. |
| Family physician training programs not established on a timely basis; coordination between MOHP and MOHE to revise training programs is lacking. | M | Close coordination/cooperation instilled through the HSRP program to the development of curricula by MOHP and MOHE. |

| | | |
|---|---|---|
| Opposition to HIO reforms by government agencies now responsible for financing and delivering care. | S | Long-term promotion of both social and financial benefits through integrated services focusing on equity and efficiency. |
| Government may not make primary care rationalization decisions based on the masterplan. | S | Government in-depth involvement in the preparation of the masterplan and TA available from donors (EU, USAID). |
| MOHP and HIO not able to divest themselves or grant autonomy to facilities, close facilities, or reconfigure personnel. | S | Provide technical assistance to carry out rationalization studies, quality/efficiency studies and develop internal frameworks which would carry out recommended implementation measures. |
| Private sector may resist increased government role in financing care. | M | Ensure popular and private sector stakeholder support through wide-ranging publicity campaigns. |
| Relevant government agencies unable to coordinate activities both at the national policy and local service delivery level. | S | Reinforce implementing agencies and monitoring committees with needed expert technical assistance, and institute open dialogue between all partners. |
| Overall Risk Rating | S | |

Risk Rating - H (High Risk), S (Substantial Risk), M (Modest Risk), N (Negligible or Low Risk)

***23. Possible Controversial Aspects:***

As a major and far reaching reform affecting both opportunities for rent seeking behavior and numerous goods perceived by society as social entitlements, the HSRP may encounter various and serious instances of opposition. Popular opposition to reform measures to implement actuarially sound funding for insurance expansion as well as to cover recurrent costs generated by the reform and donor assistance may be strong. Strong resistance to specific changes may also be mobilized by the affected vested interest groups (*e.g.*, physician and nursing associations, the pharmaceutical industry). Likewise, as copayments on drugs are increased, HIO covered individuals may mobilize opposition. Middle- and upper-class segments of society may resist restrictions to medical school enrollment opportunities. Local communities may object to facility closings as the delivery system is rationalized. Because facilities in better off areas containing excess capacity would likely be some of the first facilities targeted for closure, this opposition may be disproportionately influential. The phased implementation in three pilot Governorates may be controversial as various interest groups raise questions about the choice of the three pilot sites. Finally, various Government institutions may resist change as their functions change in major ways (*e.g.*, HIO and MOHP divestiture of their facility networks and potential MOHP assumption of MOHE's medical education functions).

## G: Main Credit Conditions

*24. Agreements Reached at Negotiations:*

- GOE would address the major health policy reform issues contained in the Letter of Policy Statement signed by the Minister of Health and Population;
- GOE would maintain the HPF, the PPMC and the GPCCs for the life of the project with composition and terms-of reference satisfactory to IDA;
- GOE would maintain the TSO and the TSTs for the life of the project with staffing, qualifications and resources satisfactory to IDA;
- GOE would undertake all procurement, financial and disbursement responsibilities under the Credit according to the applicable Bank guidelines and procedures specified in the Operations Manual;
- GOE would use the Bank's Standard Bidding Documents or, where applicable, simplified bidding documents acceptable to the Bank, as further specified in the Operations Manual;
- GOE would submit to IDA annual financial reports audited by independent auditors acceptable to IDA covering all project accounts, SOEs, and the Special Account;
- GOE would maintain adequate policies and procedures to enable it to monitor and evaluate the implementation of the HSRP and achievement of its objectives on an ongoing basis, in accordance with agreed performance indicators;
- GOE would prepare a mid-term report integrating the results of monitoring and evaluation activities, including progress achieved and recommended measures for improvement, under terms of reference satisfactory to IDA, and would carry out the mid-term review of the project by early 2001, and to implement all actions agreed with IDA as a result of the review.

## H. Compliance with Bank Policies

[X] This project complies with all applicable Bank policies.

G. Schieber 4/24/98
Task Team Leader: George Schieber

Baudouy 04/24/98
Sector Director: Jacques Baudouy

for Khalid Ikram
04/24/98
Country Director: Khalid Ikram

## ANNEX 1

## Egypt: Health Sector Reform Program

| Narrative Summary | Key Performance Indicators | Monitoring and Evaluation | Critical Assumptions |
|---|---|---|---|
| **CAS Objectives Supported:** | | | |
| Reinforce the social agenda by implementing a comprehensive Health Sector Reform Program (HSRP) | -Population health status is improved<br>-All Egyptians are provided with formal insurance coverage<br>-Urban–rural differentials in utilization and expenditure are reduced | -Census data<br>-Household, provider, and consumer surveys<br>-Government and industry statistics<br>-Insurance data | -Political will and sustained economic growth allows GOE to undertake the reform and finance the system |
| **Project Development Objectives:**<br>Implement Phase I objectives of the HSRP by: | | | |
| a) Improving population health status and well being in three pilot Governorates through universal coverage to a basic package of primary health care and public health services | -IMR, Under-Five Mortality, MMR in pilot Governorates reduced in absolute terms and relative to comparable Governorates with no project intervention | -Use of surveys and other baseline data<br>-Comparisons pre- and post-Bank intervention in pilot Governorates and comparisons to control groups | -Population is provided with insurance coverage<br>-MOHP undertakes necessary measures to define and implement the reform |
| b) Improving access to, efficiency and quality of primary care services in the three pilot Governorates | -Increased use rates of primary care services in the pilot Governorates | -Consumer and provider surveys<br>-Public and private insurance records<br>-Government and industry health statistics | -Lack of capacity to develop masterplans and stakeholder controversy overwhelm GOE commitment to rationalize the delivery system |

| Narrative Summary | Key Performance Indicators | Monitoring and Evaluation | Critical Assumptions |
|---|---|---|---|
| **Project Components/Outputs** | | | |
| **I. Provide Universal Access to a Basic Package of Primary Health Care (PHC)** | | | |
| a) Implement Governorate PHC Insurance System | -Universal coverage for a basic package of primary and public services phased in for eligible populations in three pilot Governorates | -Consensus reached between MOHP and other relevant parties on the definition of basic package<br>-Insurance funds are established in each pilot Governorate<br>-Insurance funds begin operation<br>-Experiments with provider payment mechanisms undertaken<br>-Beneficiary registration and claims processing system established<br>-Insurance quality monitoring and control system established | -Funding for the primary health care packages in pilot Governorates is identified<br>-Adequate local capacity to implement the system can be developed<br>-The various relevant Government agencies can coordinate both at the national policy and local service delivery level<br>-USAID provider mechanism is implemented in timely fashion<br>-Coordination achieved with the development of the PHC delivery system |
| b) Improve Quality and Efficiency of PHC Delivery System | -A needs based masterplan for the pilot Governorates is developed and implemented<br>-Facilities rehabilitated and re-equipped<br>-Family practice physicians and nurses are trained | -Government completes masterplan by the end of the first year of the project<br>-Standards for FHU and FHC developed<br>-Family practice training curriculums are established | -Underlying population needs can be assessed<br>-Private sector practices can be identified, allowing timely completion of the masterplan<br>-Insurance entities establish incentive based payment system |
| c) Improve Public Health Programs | -National communicable diseases surveillance system is designed, tested, and implemented | -Surveillance system is operational | -Adequate local capacity to implement the system can be developed |

| **II. Reform of the Health Insurance Organization** | | | |
|---|---|---|---|
| Reform the current social insurance organization (health Insurance Organization—HIO) to transition it into the future single national health insurance entity providing universal coverage for a primary and eventually a comprehensive benefits package | -Establish the Health Insurance Department<br>-Establish operational insurance system and guidelines<br>-Review premium and copayment schedule, develop and implement selective contracting approaches and modern reimbursement methods<br>-Development of MIS modules to support the insurance functions | -Staff identified and recruited<br>-HIO's legal and regulatory framework and organizational structure and operation reviewed and recommendations proposed<br>-HIO's financial system analyzed<br>-MIS modules developed, tested, and implemented | -Unification of Laws 79, 32 and revision of copayment and premium rates<br>-Political commitment to place HIO on a financially sustainable basis<br>-Political consensus to adopt a standardized benefits package<br>-Legal and political framework to enforce contracts between the insurer and the providers |

# ANNEX 2

## Egypt: Health Sector Reform Program

## Project Description

The project will assist the GOE in implementing Phase I of Egypt's Comprehensive Health Sector Reform Program (HSRP). Under Phase I of the HSRP, universal coverage for a basic package of primary health care and public health services will be phased in. The package is defined in the HSRP and consists largely of cost-effective primary health care services as well as necessary emergency and basic curative care services. Concomitantly, organization and management of broad-based MOHP public health programs, which are either included in the primary care benefit package or provide the requisite complementary services to the basic primary health care benefit package, will also be reformed. The project will assist the GOE to refine the basic package, establish the public insurance entity to finance it, ensure access to, and contracting mechanisms to pay for delivery of the package, and undertake needed reforms in the organization and management of complementary public health services in the pilot Governorates as well as nationally. It will also assist in the reorganization, restructuring, and rationalization of the primary care delivery systems in the pilot Governorates so that both the financing and delivery of primary health care are assured (Component 1). The second component will reform the HIO so that it can be transformed into the National Health Insurance Fund (NHIF) (Component 2).

The bulk of curative care services will continue to be provided through MOHP, HIO, CCO and Teaching Hospital facilities outside the basic package and new insurance mechanism. Most curative care financing and delivery reforms, as well as major changes in the overall medical education system and pharmaceutical sector, are likely to take place in the reform's second phase.

**PROJECT COMPONENT 1 - PROVIDE UNIVERSAL ACCESS TO A BASIC PACKAGE OF PRIMARY HEALTH CARE (PHC) SERVICES**
**- US$79.7 million IDA contribution**

The first component consists of three subcomponents that will assure implementation of the insurance mechanisms for and service delivery of the PHC benefit package to the populations in the three pilot Governorates. The three activities and their project costs are:

- Implementing the PHC Insurance Systems in the Three Pilot Governorates ----------US$16.3 million
- Improving Quality and Efficiency of PHC Delivery Systems in the Three Pilot Governorates----------US$60.3 million
- Reforming Public Health Programs----------US$3.1 million

The Bank project will provide technical assistance, training, equipment and facilities needed to begin phasing in universal insurance coverage for the basic package of primary health care services in the three pilot Governorates of Alexandria, Minoufia, and Sohag. Under this component, the Governorate level insurance entity will be established, operationalized, and evaluated. This will include training staff, setting up all insurance functions (e.g., revenue collection, enrollment, distributing health cards, contracting with medical care providers, claims processing, monitoring quality, etc.), purchasing

necessary equipment, and constructing or renovating appropriate office facilities. Branches or new subsidiaries of the HIO will serve as the insuring entities for the primary health care benefit package. Concomitantly, assistance will be provided to improve the management, organization, efficiency, effectiveness and quality of the MOHP public health programs which are either in or complementary to the PHC benefit package both nationally and in the pilot Governorates. Particular areas of focus include development of surveillance and disease coding systems.

The primary health care delivery system in the three pilot Governorates will be restructured and rationalized on the basis of a needs-based masterplan. The Bank project will support consolidation, rehabilitation and re-equipping of the poorly functioning MOHP primary health care facilities up to the district hospital level so that the current facilities can transition to become family health units, family health centers, and district hospitals. Retraining will be provided to physicians in family medicine, nurses and other primary care personnel. Imbalances in human resources thus will also be addressed. Essential drug lists will be developed and implemented. All rationalization activities will be based on a masterplan reflecting underlying health needs and existing public (e.g., MOHP, HIO) *and* private sector capacity. Contracting procedures developed for the insurance entities to promote efficient delivery will focus on facility autonomy, decentralization, separation of finance and provision, money–following–patients, and use of incentive-based contracting and payment mechanisms. Basing investment decisions on a needs-based masterplan will ensure that only appropriate rehabilitation and investment in equipment takes place.

**PROJECT COMPONENT 2 - REFORM OF HIO**
**- US$10.3 million IDA contribution**

The second component will finance the costs of reforming the HIO to adapt its existing institutional structure to provide the primary care benefit package in the three pilot Governorates as well as to prepare it for its transition to the National Health Insurance Fund (NHIF) in the later phases of the reform. The component will support enhancing management capacity, implementation of MIS, development of incentive-based contracting mechanisms, putting HIO's currently insured population on a sound actuarial basis, development of automated claims processing and enrollment systems, and other measures. The component will support TA, training, equipment, and construction needed to achieve the actuarial and functional reforms at HIO which will enable it to administer nationwide implementation of the primary health care package (as the NHIF) as well as its future role as the country's national social health insurance fund.

# ANNEX 3

## Egypt: Health Sector Reform Program

## Estimated Project Costs

| Project Component | Local | Foreign | Total |
|---|---|---|---|
| | ---------- | US$ million | ---------- |
| **Universal Coverage to a Basic Package of PHC Benefits** | **190.5** | **78.5** | **269.0** |
| *a. Governorate PHC Insurance System* | *14.0* | *6.5* | *20.5* |
| *b. Improve Quality & Efficiency of the PHC Delivery System* | *160.1* | *67.1* | *227.2* |
| *c. Public Health* | *16.4* | *4.9* | *21.3* |
| **Reform of the Health Insurance Organization** | **7.3** | **30.8** | **38.1** |
| **Total** | **197.8** | **109.3** | **307.1** |
| **Total Baseline Cost** | | | |
| Physical Contingencies | 14.9 | 7.4 | 22.3 |
| Price Contingencies | 48.1 | 9.5 | 57.6 |
| **Total Project Cost** | **260.8** | **126.2** | **387.0** |

# ANNEX 4

## Egypt: Health Sector Reform Program

### Economic Analysis

Public financing or provision of services can be justified when Government interventions aim at achieving allocation, distribution, and economic stabilization goals. Government intervention to achieve these goals is frequently important when market failures, externalities, and public or merit goods are prominent in an economic or social sector. This is the case in the health sector, where many of the basic conditions necessary for achieving efficient outcomes (in terms of either private or social welfare) in competitive markets do not hold. The conceptual arguments for public finance and a public–private mix of provision in the health sector are relatively straightforward (World Bank, *Innovations in Health Care Financing Discussion Paper 365* and *Public and Private Roles in Health Discussion Paper 339*). Market failures which impede efficient outcomes and lead to socially undesirable distributional effects provide strong justifications for public intervention on both the financing and provision sides of the health services market (*e.g.*, assuming a particular function, or regulating private activity). These commonly include risk pooling difficulties and instability in the insurance market, information asymmetries, and interdependence between supply and demand. Significant positive externalities which the private sector frequently cannot internalize devolve from the prominence of public and merit goods and from potential economies of scale and scope in the sector. Finally, the distributional and equity effects of market operation without public intervention in the health sector may not be consistent with maximizing social welfare in that individuals in such a context neither pay according to ability nor consume services on the basis of need, basic social principles endorsed by most countries.

Governments need to be involved in financing *public health services, as well as personal health services for the poor and other vulnerable groups.* Without public financing or subsidization of public health services, consumption of these services will be less than optimal from the standpoint of maximizing social utility or health status. Governments in virtually all countries are involved directly or indirectly in assuring physical access to personal health services in rural areas. To *assure equitable risk pooling,* all OECD countries except the US have concluded that the most effective mechanism is publicly financed insurance covering most personal health services for the entire population. Governments also need to regulate private insurance, as well as private sector provision, to ensure *acceptable balances of quality, cost containment and operational efficiency.* All countries regulate quality, and virtually all OECD countries also regulate provider payment rates.

While the arguments concerning public versus private provision are clear on conceptual grounds, empirical evidence indicating appropriate policy directions is often less straightforward. The decision on whether to use public rather than private provision of health services should in theory be based on whether it is cheaper for the government to produce and provide or to purchase the service in question. The important issue is not whether a given service is publicly or privately provided, but whether the basic incentives faced by the organization or entity providing the service facilitate or impede efficient delivery and an equitable distribution of quality health care. In Egypt and other lower middle income countries, conceptual justifications for public intervention and actual policies are constrained by limits on available public resources and on the administrative capacity needed to implement conceptually correct policies. The following evaluation of the Egyptian system, and the proposed project, are predicated on these basic premises.

Externalities in the Egyptian health market arise from underproduction and underconsumption of public health and health promotion interventions, from information asymmetries and underproduction of information, and from limited effective access to basic care. Microefficiency is hampered by the existence of multiple uncoordinated financing and delivery programs and by uncoordinated and often perverse provider incentives. The system's overall effectiveness – in terms of health status achieved for the level of financial, physical and human resource inputs committed – is hampered by poor quality, limited effective access and micro inefficiency. The impact of the financing system on distributional equity is regressive: while those covered by the HIO and therefore the recipients of substantial public subsidies for health care are typically male, urban, and employed in the formal sector; the poorest households spend the largest proportion of family income in out-of-pocket payments due to ineffective actual access to basic services.

The HSRP is designed to build on existing strengths in the system while reforming its basic weaknesses in order to achieve the basic goals defined for the reform. These goals address the broad problems identified above in basic incentives and externalities, micro- and total system efficiency, and the tradeoffs inherent in achieving a balance between quality, efficiency and access needed to assure an adequate health status for the entire population.

*HSRP long-term goals are to*:

- improve the health status of the Egyptian population.
- provide universal access to formal insurance coverage.
- promote equity in both the financing and delivery of care.
- enhance the allocative and technical efficiency of the service delivery system.
- improve the quality of both public and private services.
- enhance the efficiency and effectiveness of the pharmaceutical sector.
- assure long-run financial sustainability of the system.

*Strengths of the current system are*:

- Nominally, all Egyptians are "insured" by the State for their health needs either through formal HIO coverage or the MOHP.
- Physical access to care is widespread, as 95% of the population is within 5 kilometers of a medical facility.
- Health infrastructure of physicians, clinics and hospitals is extensive.
- State of the art technology is readily available.
- Pharmaceuticals are generally available.
- Immunization levels are high.
- Population growth has been reduced significantly.
- Over 80% of the population has access to safe water and sanitation.
- Health reform is a high priority for the Government.

*Major system problems include*:

- Health outcomes are poor relative to other comparable income countries.
- Maternal mortality is 174 on average and exceeds 500 in some areas.
- One in 12 children die before reaching age 5, one in seven in Rural Upper Egypt.
- Public health programs are poorly targeted to NCDs, while over 50% of adult males smoke.
- Less than 40% of the population has formal insurance coverage.

- Equity needs to be improved as the poor pay relatively more (both out-of-pocket and through the tax system) and receive relatively less in benefits than the non-poor.
- The fragmentation of financing does not lead to effective or equitable risk pooling.
- Spending at 3.7% of GDP is low relative to other comparable income countries.
- There are large urban rural disparities in health spending.
- Management and financing of the system is completely fragmented with 29 public agencies involved, which precludes a consistent policy focus and consistent incentives from impacting on both public and private sector institutions.
- Public programs combine both financing and provision which together with rigid civil service rules precludes incentives for efficient public provision of services.
- Egypt has too many low quality inputs (i.e., beds and physicians) and there are serious geographic maldistributions.
- There is substantial inefficiency as evidenced by a hospital occupancy rate below 50%.
- There are too many specialists relative to primary care physicians.
- Quality is poor as evidenced by hospital nosocomial infection rates on the order of 30-40%
- Pharmaceutical consumption and spending is 50% higher than that in other comparable countries, and there are serious inefficiencies in production, distribution, management, procurement, financing, and consumption.

*A Conceptual Systemic Evaluation of the HSRP*

The HSRP is a comprehensive program designed to address all these issues over the next 15 to 20 years. In Phase I, which will be supported by the Bank project and the efforts of other donors, the HSRP will address areas that provide the greatest returns in improving health status in a cost-effective manner while laying the basis for later phases of the reform effort. Given the serious political constraints and practical difficulties inherent in achieving all of the HSRP's goals in the context of the system's present problems (such as resistance against large reductions in the public workforce, difficulties in closing large numbers of facilities, political sensitivities surrounding domestic pharmaceutical production and pricing, fiscal inability of the Government to immediately provide universal coverage of a comprehensive package of primary and curative care services to the entire population, etc.), Phase I of the reform will focus on interventions likely to engender rather than reduce support and which are essential to further reform stages. The first five year phase of the reform focuses on implementing universal coverage to a basic package of primary care services in three pilot Governorates, restructuring the human and physical delivery infrastructures in those Governorates, reforming basic public health services that are either included in or are complementary to the basic primary care package, and reforming the national HIO to transition it to the future single social insurer for the country.

By supporting cost-effective interventions in public health and primary care, including improving the efficiency and quality of service delivery, Phase I of the reform should yield maximum value in terms of health gains for the resources invested. Effective risk pooling will be pursued through phasing in universal coverage for a basic package of primary care and basic curative services. The most vulnerable groups and geographic areas will be given initial priority in the process of introducing universal coverage, thereby achieving the largest marginal impact early in the process. Focusing on family medicine and retraining physicians and nurses will improve quality. Basing all facility rehabilitation (from primary care centers to district hospitals) on a needs-based masterplan which takes account of both public and private sector capacity will increase allocative efficiency in the sector and assure the efficiency of Bank supported investments. The project will create further efficiency gains by providing the HIO with assistance to improve its capacity to contract with providers for delivery of the basic health package and by assisting it to divest itself of its delivery network.

These steps will also lay the basis for further stages of the reform focusing on financing and delivery of curative care. To prepare for latter stages, Phase I of the Government's program will initiate studies on the pharmaceutical sector as well as general human resource and curative care delivery. Experiences gained in Phase I will provide critical input for the design and implementation of the subsequent phases.

Empirical assessment of the impacts of all aspects of the Phase I reform or the Bank project are not feasible, although a fiscal analysis of the basic insurance and system restructuring reform is undertaken below. While directional changes can be evaluated, accurate assessment of these changes is confounded by the multitude of interactions within the health sector as well as by the effects on health status and the performance of sector institutions and actors of trends and policies external to the sector. A general equilibrium quantitative assessment is impossible because the costs of service expansion (which are justified by the low base level of spending and formal coverage) will be offset to an indeterminable degree by micro efficiency gains from better contracting procedures, copayments on drugs, and eventual adoption of a single source financing system for the basic package. The yield from efficiency gains will in turn be somewhat offset by measures to enhance quality. Quantitative assessment would also require a numerical accounting of improved quality, better health outcomes, and reductions engendered by the reform in out-of-pocket payments for private services. While the last of these could be determined through extensive surveys, quantification of the first two would simply reflect the assumptions used in the assessment methodology.

Some conclusions can however be drawn in regard to the HSRP Phase I and project impact. Given Egypt's demographic and epidemiological profile and poor health outcomes, allocative efficiency will be improved by focusing on cost-effective interventions via both national public health initiatives and universal access to the basic primary health care package of services. Ensuring that project renovation and equipment expenditures are targeted according to a needs-based masterplan and changing the economic incentives faced by medical care providers will provide the appropriate context for achieving technical efficiency improvements.

*Phase I Fiscal Analysis*

While the detailed impacts of offsetting quality and efficiency gains are not readily measurable, the costs of the Phase I reform can be evaluated as well as the costs of providing universal coverage in the long-term. The detailed analyses underlying this analysis are contained in the project document file, which also contains a detailed analysis and future projections of Egypt's revenue structure undertaken specifically for this project.

In terms of the costs of Phase I, it is possible to estimate the investment costs to restructure the primary care delivery systems in the three pilot Governorates, the investments needed to set up the insurance entities, and recurrent costs of phasing-in universal insurance coverage to the 5.9 million uninsured in the three pilot Governorates. It is estimated that restructuring of the primary care delivery systems in the three pilot Governorates, both human and physical, would maximally require investments of US$300.0 million. These figures assume replacement of most facilities and limited gains from efficiency. With efficiency gains (i.e., eliminating unneeded facilities) and renovation instead of replacement, the primary care infrastructure investments are likely to be about half this maximal figure. Future recurrent costs from these investments would be on the order of 20% of the overall investment costs. It is estimated that some US$23.0 million is needed to establish the insurance entities in the three pilot Governorates.

In terms of the large investments needed to rationalize the delivery systems, other donor funding is likely to be available. The USAID had allocated US$80.0 million for support of the health sector reform, and

the EU has tentatively, subject to approval by its member countries committed US$120.0 million for the reform afford. The African Development Bank is likely to commit US$15.0 million as well. These funds plus relatively minimal GOE contributions should suffice for meeting the investment costs of implementing the Phase I reform.

Meeting the recurrent insurance costs is a different matter. The cumulative total five year recurrent costs of providing insurance coverage to the 5.9 million uninsured for the basic primary health care benefit package (cost of EGP 60 per capita) in the three pilot Governorates is estimated at some EGP one billion or almost US$300.0 million. These costs would need to be financed through some combination of individual payments (premiums and cost-sharing) and public expenditures. Individuals on average are currently spending some EGP 98 per capita out-of-pocket for health services, 95% of which goes for ambulatory care and drugs. Funds currently spent by MOHP and HIO to maintain their networks and for curative care can also be reallocated to meet these new recurrent costs.

Thus, the real challenge for the GOE is to develop financing mechanisms which recycle these currently largely private out-of-pocket payments into the public primary care insurance system. On the investment side, as discussed above, in addition to the Bank project, grant support from USAID, AFDB, and the EU are likely to be available to assist with the investment costs of restructuring the delivery system. In short, Phase I of the reform is sustainable and affordable, but will require GOE commitment and action to institutionalize an equitable and transparent financing source.

In terms of the recurrent costs of the Bank project itself in the short-term, Egypt spends about US$2.3 billion (or 3.7% of GDP – about 1% less than comparable income countries) per year on health care, some US$1.0 billion of which is public. The share of health in total public expenditures (including the parastatal HIO) is only about 4%. Spending is thus relatively low in both total and budgetary share terms in comparison to other LMI countries. The Bank credit of US$90.0 million over 5 years amounts to a 1.8% annual increase in public health spending, and less than 1% of overall spending. Even if recurrent costs are generated at a rate of 25% of investment per year, annual increases in public spending for each year of the project would be on the order of 2%.

*Fiscal Analysis of Long-Term Comprehensive Reform*

On the other hand, as discussed above, the recurrent costs generated by universal coverage and the other elements of the comprehensive reform package will be significant. While the Phase I reform in the three pilot Governorates for a primary health care benefit package is affordable with some significant recycling of private funds, the overall longer-term reform costs of a fully phased in system for a comprehensive benefit package will be much higher. It is estimated that universal coverage to a comprehensive package of benefits would increase health spending in Egypt from its current level of 3.7% of GDP to 4.8%. However, the public share would increase from its current level of 1.7% to 3.0%, while the private share would drop from its current level of 2.0% to 1.8%. Rationalization of the entire delivery system would add some additional recurrent costs to these figures, bringing Egypt's health spending to something on the order of 5% of GDP. A detailed revenue analysis conducted as part of the appraisal mission (and available in the project document file) indicates that under reasonable assumptions of projected economic growth, the long-term reform is affordable and sustainable. The major issue for the GOE will be the significant fiscal implications for the public budget as opposed to the overall level of spending. As the reform will be phased in over a 15 year period, the GOE will have the experiences gained from the pilot Governorates as well as a long period of time to make this transition.
In summary, both the cost of the Phase I and overall reform will need to be met through a variety of mechanisms. These include reallocating private health spending to the public financing mechanisms,

increasing GOE contributions to the health sector, reallocating current MOHP, HIO, MOF, and MOPIC expenditures, and increasing the level and efficiency of public (and private) spending on health.

The Egyptian health system is one of the world's most complex. It has virtually all of the problems characterizing health systems in former socialist countries, while at the same time possessing few of the virtues and most of the problems of open-ended, US type systems. Given rigid bureaucratic structures, limited administrative capacity, and limited fiscal capacity, reforming the system is an immense challenge. The GOE has committed itself to undertake such a reform. This project will provide the GOE with the support for development and implementation of systemic changes needed in Phase I of a 15 to 20 year undertaking.

In view of the obstacles to improving system performance and outcomes, the HSRP provides a rational basis for reform by clearly relating GOE reform policies to system problems and real world constraints. The HSRP provides the reform blueprint for the Government and the donor community. Because the project supports a reform program both endorsed by the Government and founded in a comprehensive analysis of the sector, it represents a substantial improvement over past piecemeal donor supported reform efforts. Present favorable economic and political conditions provide the Government with a window of opportunity to initiate such a comprehensive reform. Use of a specific investment instrument approach will assure that Bank resources used to support the reform are targeted to specific interventions known to yield maximum results on the margin. Conditionalities – such as determining capital investments on a needs-based masterplan – can further assure appropriate targeting and favorable outcomes.

# ANNEX 5

## Egypt: Health Sector Reform Program

## Financial Summary

Years Ending June 30
(US$ Million, 1998/99 base year)

| | Implementation Period | | | | | Operational Period | | |
|---|---|---|---|---|---|---|---|---|
| | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 |
| Project Costs | | | | | | | | |
| Investment Costs | 35.6 | 54.5 | 77.1 | 63.3 | 106.0 | | | |
| Recurrent Costs | 1.6 | 7.1 | 7.5 | 13.7 | 20.6 | 20.6 | 20.6 | 20.6 |
| **Total** | **37.2** | **61.6** | **84.6** | **77.0** | **126.6** | **20.6** | **20.6** | **20.6** |
| Financing Sources (% of total project costs) | | | | | | | | |
| IDA (amount) | 8.36 | 13.62 | 18.51 | 16.72 | 27.43 | | | |
| IDA (%) | 22% | 22% | 22% | 22% | 22% | | | |
| Co-financiers (amount) | 25.08 | 40.85 | 55.54 | 50.16 | 82.28 | | | |
| Co-financiers (%) | 67% | 66% | 66% | 65% | 65% | | | |
| Central Gov. (amount) | 3.80 | 7.12 | 10.52 | 10.12 | 16.89 | 16.89 | 16.89 | 16.89 |
| Central Gov. (%) | 10% | 12% | 12% | 13% | 13% | 100% | 100% | 100% |
| **Total (%)** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** |

# ANNEX 6

# Egypt: Health Sector Reform Program

## Procurement and Disbursement Arrangements

### Procurement

The Credit would finance selected pilot activities requiring the procurement of : (a) works, i.e., major and minor renovations and possibly reconstruction of family health units, family health centers and district hospitals; (b) goods, including medical equipment, supplies, furniture and vehicles; and (c) services for (i) the preparation of drawings and specifications for the required works and equipment acquisitions, and subsequent field supervision of construction, (ii) technical assistance consisting initially of needs assessments and rationalizations of existing health care facilities within the program, and the undertaking of various studies for PHC and HIO; and (iii) training of PHC and HIO staff in technical areas and other program staff in implementation, procurement, financial control and facilities maintenance for sustainability. Procurement under the Credit would be carried out in accordance with the Bank's Guidelines for "*Procurement under IBRD Loans and Credits*" - January 1995, revised January and August 1996 and September 1997 and for "*Selection and Employment of Consultants by World Bank Borrowers*" - January 1997 and revised September 1997. Program components not financed by the Bank would be procured in accordance with national regulations or the guidelines of cofinancing institutions. The Bank's standard bidding documents would be used for all procurement under International Competitive Bidding (ICB) and, with modifications acceptable to the Bank and in Arabic language, also for National Competitive Bidding (NCB). Simplified documents would be prepared for use under the Program and apply to National and International Shopping (NS/IS) and small-value consulting contracts.

**Works:** Following the rationalization of existing health care facilities under the Program and prioritization according to the criteria of the pilot activities, the requirement for works would range from minor renovations to address maintenance deficiencies to major rehabilitation and possibly reconstruction of facilities whose condition has fallen below minimum functionality. Most of the targeted facilities in each of the Governorates would be small in size (500 - 2,000 square meters), at scattered locations (up to 200 per Governorate), and therefore suitable mainly for competitive bidding or quotations from local contractors. No ICB procurement of works would be feasible, since the estimated contract values and conditions would be unattractive for international contractors, even as packages. Contracts exceeding an estimated value of US$300,000 equivalent would be procured using NCB procedures and documents and advertisements in at least two national newspapers. Contracts below an estimated value of US$300,000 equivalent, up to an aggregate amount of US$15.2 million equivalent, would be procured using (i) advertisements in a local newspaper (if available) or announcements posted in a public place, (ii) solicitation of competitive quotations from at least three capable local contractors and (iii) simplified documentation and evaluation procedures agreed with the Bank.

**Goods:** To the maximum possible extent, the procurement of medical equipment and other goods would be through packages and lots of similar items. Each package would have an estimated contract value above US$500,000 equivalent and be procured using ICB procedures and documents and advertisements in the "UN Development Business" and at least two national newspapers. Bidders would be subject to post-qualification in accordance with the Bank's

standard bidding document for "*Procurement of Goods*" - January 1995. Bid evaluations would be submitted on the Bank's standard bid evaluation form "*Procurement of Goods and Works*" - April 1996. Goods, including supplies, at estimated contract values between US$100,000 and US$500,000 per procurement, up to an aggregate amount of US$8.0 million equivalent, would be procured using NCB procedures and documents and advertisements in at least two national newspapers. The procurement of goods below an estimated contract value of US$100,000 equivalent per procurement, up to an aggregate amount of US$2.5 million equivalent, would follow NS/IS procedures, using simplified documents and procedures for soliciting, receiving and evaluating competitive quotations from a minimum of three capable national or international suppliers. Incidental goods and supplies below a cost of US$5,000 per purchase, up to an aggregate amount of US$500,000 would be purchased directly from the nearest available source.

Goods required as part of the rehabilitation of large health care facilities in some Governorates may be procured more cost-effectively through appropriate arrangements with construction contractor of the same facility, e.g., through turnkey contracting. The estimated value of such goods would be below the aforementioned threshold for ICB procurement. The bidding documents for the turnkey procurement of works and goods would follow the Bank's standard bidding document for "*Supply and Installation of Plant Equipment - November 1997*" and be subject to the Bank's prior review.

**Services:** The needs assessment and rationalization of facilities would require site inspections by architects and engineers to measure the works, evaluate the state of disrepair and estimate renovation or replacement costs, as appropriate. A parallel assessment would cover medical equipment and supplies. Following the setting of priorities for the pilot activities in the three Governorates, architects and engineers would be retained to provide comprehensive services covering drawings, specifications and administration of the construction contract on behalf of Government. Initially, an invitation for expressions of interest in these consultancies would be advertised in at least two national newspapers. Using transparent criteria, responses would be evaluated by an evaluation committee and qualified consultants would be short-listed for selections as opportunities materialize; the Governorates would share this short list of qualified architectural/ engineering consultants. For architectural/engineering consultancies above an estimated contract value of US$50,000 equivalent, the selection method would be Quality and Cost-Based (QCBS). For other architectural/engineering consultancies, other specialized consulting assignments and short-term, low-cost contracts with consultants, the selection would follow the Quality-Based (QBS), Consultants' Qualifications-Based (CQ) & Single-Source Selection (SS) methods, depending on the nature of the terms of reference which would precede all selections. A special category of service contracts to be financed under this Credit will involve the maintenance and repair of medical equipment after the expiration of the supplier's normal warranty period. A unit-cost contract with an annual ceiling will be used for this purpose, following a competitive selection based on Least-Cost Selection (LCS).

**Training:** Institutional capacity building at the central and Governorate levels would entail a staff training masterplan aimed at achieving proficiency in all technical skills required for the proper operation of all rehabilitated health facilities under the project. The project would also strengthen necessary skills required for the management of the reform program through supporting training in implementation, including procurement, contract administration, financial control, maintenance planning and similar subjects, in the shortest possible time. The substance of this plan would be a skills assessment followed by staff enrollments in appropriate courses, workshops, temporary secondments and the like, combined with on-the-job coaching by more experienced staff. While the Bank and the cofinancing institutions may be able to provide some

of this training, national and international training centers, as well as individuals, would have to be contracted directly to satisfy all other requirements of the staff training plan. TA and training would be contracted in accordance with TOR, budget and implementation schedule agreed with the Bank during review of the Annual Work Plans (AWP).

**Prior Review:** The first three contracts in each category (works, goods and services), irrespective of the estimated contract value, would be subject to the Bank's prior review, in accordance with the applicable guidelines. Thereafter, all procurement of goods subject to ICB procedures and all procurement of works, through NCB, with estimated contract values above US$300,000 equivalent, and of goods with estimated contract values above US$500,000 equivalent would be subject to prior review. Contracts with individual consultants in excess of US$50,000 and with consulting firms in excess of US$100,000, as well as all single-source contracts, would be subject to prior review. The prior review process would cover about 70% of the total works and goods contract values procured under ICB and NCB. All other contracts would be subject to post-review on a random basis, during supervision missions and procurement audits.

**Procurement Responsibilities:** The Ministry of Health and Population (MOHP) would have primary responsibility for procurement under the HSRP. In particular, MOHP would prepare and update the Consolidated Procurement Plan, as part of the AWP. MOHP would also oversee and guide procurement at all levels based on the Program's Operations Manual. This Manual would have to be approved and agreed among MOHP, the three selected Governorates, the Bank and the cofinanciers, and should form the cornerstone of the Program Launch Workshop and subsequent training activities. Among other guidance, this Manual would provide consistent procurement procedures for all Program beneficiaries. It would also provide illustrations and outline specifications for the Program's preferred models of health care facilities and related equipment. In addition to these managerial and advisory functions, MOHP would undertake all procurement activities that require ICB and NCB procedures, and all selections for consultancies.

A central Technical Support Office (TSO) has been established at MOHP Headquarters. Its core staff must include a program coordinator, a financial specialist, a procurement/engineer, an MIS specialist, and several technical staff. The Minister of Health and Population will have executive authority and accountability for all TSO's operations. These organizational arrangements would be mirrored in the three Governorates in the form of Technical Support Teams (TSTs) which would initially include a team coordinator, a financial specialist and a procurement/engineer. The executive oversight function for the TSTs would be vested in each Governorate's Program Coordination Committee (GPCC), chaired by the Undersecretary for Health in the Governorate. The TSTs would only be responsible for the procurement of works and goods involving national shopping and direct contracting procedures, in conformance with the Program's Operations Manual. TSTs would not undertake any procurement that may involve NCB or ICB, or consultants' selection. Architects and engineers selected competitively by the TSO would be given assignments at the Governorate level, e.g. to provide comprehensive services covering drawings, specifications, bills of quantity and administration of the construction contract, under the direction of the benefiting Governorate. The TSTs will provide monthly reports to the TSO for its consolidated reports and the updated Procurement Plan. To expedite procurement, the TSO would establish special tender committees for goods and works. An independent procurement audit would be undertaken every 12 months following Credit Effectiveness Date to confirm compliance with Bank procedures.

The Bank will arrange for training of relevant TSO staff to become familiar with Bank procurement guidelines and procedures. However, these procedures tend to be complex, especially for new borrowing entities that have limited experience in international procurement and in the Bank procedures in particular. Until the TSO staff become fully conversant with the Bank's procedures, the TSO may wish to consult with other national entities which have had experience implementing Bank credits, and arrange for transfer of relevant know-how and on-the-job training of TSO staff. In addition to building procurement capacity at the TSO, the Bank will support the central procurement unit at MOHP to ensure that its staff are properly trained and equipped.

## Disbursement

The proposed Credit, which constitutes Phase I of the reform program, would be disbursed over a period of five years beginning in January 1999. The completion date would be December 31, 2003, and the closing date June 30, 2004. This is shorter than the country disbursement profile of eight years. This period is deemed feasible due to the following reasons: (a) while the reform program is long-term and comprehensive, Phase I represents priority interventions that are within the capacity of MOHP to implement; (b) program definition and policy dialogue are at an advanced level; and (c) some activities have already been initiated with donor financing.

The proceeds of the IDA credit will be disbursed against:

(a) 100% of foreign expenditures and 90% of local expenditures for civil works.
(b) 100% of foreign expenditures and 90% of local expenditures for goods.
(c) 100% of expenditures for consultants' services, technical assistance, training and studies.

***Use of Statements of Expenditures (SOEs):*** Disbursements against civil works contracts exceeding US$300,000, goods exceeding US$500,000, and consultants' contracts exceeding US$100,000 for firms and US$50,000 for individuals, will be fully documented. The first three contracts in each category (works, goods and services), irrespective of the estimated contract value, would be subject to the Bank's prior review, in accordance with the applicable guidelines. For all expenditures below the thresholds, disbursement will be made against Statements of Expenditures (SOEs). Supporting documents for SOEs will not be submitted to the Bank, but will be retained by the TSO/TSTs and made available for review by IDA supervision missions. The TSO/TSTs will record the contracts as agreed with IDA, so that IDA can monitor them for prior or ex-post review as needed.

***Special Account:*** To ensure that funds are readily available for program implementation and to facilitate disbursements from the Credit proceeds, a Special Account (SA) in US Dollars will be established by the Government at the Central Bank under TSO responsibility. The authorized allocation of the SA is US$9.0 million, but the initial deposit will be limited to US$6.0 million until US$18.0 million has been disbursed. The SA will be operated by the TSO under terms and conditions satisfactory to IDA. The TSO Director along with another senior MOHP representative will be designated by the Ministry of International Cooperation as authorized signatories of the SA. Separate identifiable accounts would be maintained for each donor and for all program expenditures, and supporting documentation would be retained for subsequent review by World Bank Egypt Country Department Staff and visiting IDA supervision missions. Disbursement applications will be prepared and submitted to IDA by the TSO with copies of such applications provided to the Ministry of Planning & International Cooperation for information. Replenishment of the SA by IDA will require the submission of full documentation

or certified SOEs showing that payments were made exclusively for eligible expenditures against contracts that are below the prior review threshold. The SA will be replenished monthly, or after one-third of the initial deposit amount has been disbursed, whichever is sooner. Applications for direct payment or Special Commitment will be subject to a minimum value of 20% of the authorized allocation to the Special Account.

***Accounts and Audits***: The GOE is in compliance with IDA audit reporting covenants. The TSO will establish and maintain separate program-related accounts for each donor and for all program expenditures. These accounts will be maintained in accordance with internationally sound recognized accounting practices and in an accounting system acceptable to IDA. The TSO will prepare interim and annual financial statements and submit them to IDA. These statements shall reflect the financial performance of the program. The SA, all project accounts, and SOEs will be audited in accordance with international standards at the end of each GOE fiscal year, beginning with fiscal year 2000, by independent auditors acceptable to IDA. These reports will be submitted to IDA within six-months from the end of each fiscal year and will be made available to the Minister of Health and Population. All accounts, financial reports and audits should provide adequate and timely information to IDA for supervision of the program.

***Reporting***: The TSO will maintain continuity in project management, and will ensure that all project documentation is well prepared and on schedule and that procedural problems are reduced to the minimum. The TSO will prepare AWPs in consultation with expert panels and IAs, and forward these to IDA for discussion by no later than October 30 of each year. The TSO will prepare semi-annual progress reports against AWP indicators. These reports would discuss problems encountered, solutions adopted, and adjustments to the AWP. The TSO will develop and maintain a computerized management information system (MIS) which will give financial and operational data on a continual basis and track program implementation progress. In addition, the TSO will develop a uniform (standard) reporting system for the evaluation by all concerned donors. All reports will be submitted concurrently to the Minister of Health and Population, IDA and the concerned donors. The TSO will prepare a detailed mid-term report and submit it to all participating donors by the end of December 2000 to serve as the basis for the mid-term review, which donors and the GOE will conduct by February 2001. The TSO will also prepare an Implementation Completion Report (ICR) for review by IDA and other concerned donors within six-months of the closing date of the Credit.

***Monitoring and Evaluation (M&E)***: The TSO will be responsible for monitoring progress against agreed performance indicators (specified in Annex 1). It will also be responsible for undertaking an extensive (independent) evaluation of the reform and the project interventions. TSO's main M&E functions include: (a) develop process and performance indicators for HSRP objectives and activities; (b) monitor implementation progress and performance of the various IAs; (c) develop and maintain a database of program status for the generation of *annual progress reports* for the government and participating donors; (d) conduct continuous evaluation on the impact of the initiatives/interventions and provide feedback for modification or improvement as necessary; (e) prepare *summary reports* for the Minister and donors highlighting problems, issues, and recommended actions. The TSO will contract independent technical auditors to undertake a full analysis of all program activities which will form the basis of the annual progress reports. In addition, the IAs will provide the TSO with quarterly progress reports summarizing: (a) the current status of project implementation and reasons for deviation from agreed implementation plans; (b) financial records; (c) constraints faced and corrective actions to be taken; (d) a work plan for the subsequent six months; and (e) an update on agreed upon monitoring indicators. These reports will be consolidated by the TSO

and forwarded to the Minister of Health and Population, IDA and the other donors semi-annually.

***Program Launch Workshop*:** Program activities will be launched at a workshop shortly after Credit effectiveness. The workshop will introduce the program activities to all designated counterparts and discuss major technical and operational details. The TSO will design and organize the workshop. Participants will include key counterparts and major stakeholders and representatives of relevant MOHP departments, HIO, CCOs, and the pilot Governorates.

**Annex 6, Table A: Project Costs by Procurement Arrangements[1]**

(in US$ million equivalent)

| Expenditure Category | Procurement Method | | | | Total Cost (including contingencies) |
|---|---|---|---|---|---|
| | ICB | NCB | Other | N.B.F | |
| | | | | | |
| 1. Works | | 42.3 | 131.1 | 41.8 | 215.2 |
| | | (29.2) | (15.2) | | (44.4) |
| | | | | | |
| 2. Goods | 35.5 | 43.8 | 6.9 | 2.5 | 88.7 |
| | (21.3) | (8.0) | (3.0) | | (32.3) |
| | | | | | |
| 3. Services | | | 16.2 | 66.9 | 83.1 |
| | | | (13.3) | | (13.3) |
| | | | | | |
| | | | | | |
| Total | 35.5 | 86.1 | 154.2 | 111.2 | 387.0 |
| | (21.3) | (37.2) | (31.5) | (0.0) | (90.0) |

Note: N.B.F. = Not Bank-financed (includes elements procured under parallel cofinancing procedures, consultancies under trust funds, any reserved procurement, and any other miscellaneous items). The procurement arrangements for the items listed under "Other" and details of the items listed as "N.B.F." are explained in the text.

Figures in parentheses are the amounts to be financed by the IDA credit.

[1] For details on presentation of Procurement Methods refer to OD11.02, "Procurement Arrangements for Investment Operations." Details on Consultant Services can be shown more easily in the Table A1 format (additional to Table A, where applicable).

**Annex 6, Table A1: Consultants and Training Selection Arrangements (optional)**

(in US$ million equivalent)

| Consultants and Training Services Expenditure Category | Selection Method | | | | | | | Total Cost (including contingencies) |
|---|---|---|---|---|---|---|---|---|
| | QCBS | QBS | SFB | LCS | CQ | SS | N.B.F. | |
| Firms/Individuals | 75% | 10% | 0% | 5% | 5% | 5% | 0% | US$13.3 |

Note: QCBS = Quality- and Cost-Based Selection
QBS = Quality-Based Selection
SFB = Selection under a Fixed Budget
LCS = Least-Cost Selection
CQ = Selection Based on Consultants' Qualifications
SS = Single-Source Selection

N.B.F. = Not Bank-financed.

**Annex 6, Table B: Thresholds for Procurement Methods and Prior Review[2]**

| Expenditure Category | Contract Value (Threshold) US$ thousands | Procurement Method | Contracts Subject to Prior Review |
|---|---|---|---|
| 1. Works | | | |
| | > US$300,000 | NCB, advertisement in two national newspapers | First 3 contracts<br>All contracts above US$300,000 |
| | < US$300,000 | NS | First 3 contracts |
| 2. Goods | | | |
| | > US$500,000 | ICB, advertisement in UN Development Business | First 3 contracts<br>All ICB Contracts |
| | US$100,000-500,000 | NCB | First 3 contracts |
| | < US$100,000 | NS/IS | First 3 contracts |
| | < US$5,000 | Direct Purchase | First 3 contracts |
| 3. Services | | | |
| | > US$50,000<br><br>< US$50,000 | QCBS<br><br>QBS, LCS, CQ, SS | First 3 contracts<br>All contracts for firms above US$100,000<br>All contracts for individuals above US$50,000<br>All Single-Source contracts |

[2] Thresholds generally differ by country and project. Consult OD 11.04 "Review of Procurement Documentation" and contact the Regional Procurement Adviser for guidance.

**Annex 6, Table C: Allocation of Credit Proceeds (in SDR equivalent)**

| Expenditure Category | Amount of the Credit (expressed in SDR million equivalent) | Financing Percentage |
|---|---|---|
| 1. Civil Works | 30.1 | 100% of foreign expenditures and 90% of local expenditures |
| 2. Goods/Equipment | 22.1 | 100% of foreign expenditures; 100% of local expenditures (ex-factory cost) and 90% of local expenditures for other items procured locally |
| 3. Services | | |
| Training | 7.0 | 100% |
| Consultants | 3.0 | 100% |
| 4. Unallocated | 4.6 | |
| TOTAL | 66.8 | |

**Allocation of Credit Proceeds (in US$ equivalent)**

| Expenditure Category | Amount of the Credit (expressed in US$ million equivalent) | Financing Percentage |
|---|---|---|
| 1. Civil Works | 40.5 | 100% of foreign expenditures and 90% of local expenditures |
| 2. Goods/Equipment | 30.0 | 100% of foreign expenditures; 100% of local expenditures (ex-factory cost) and 90% of local expenditures for other items procured locally |
| 3. Services | | |
| Training | 9.3 | 100% |
| Consultants | 4.0 | 100% |
| 4. Unallocated | 6.2 | |
| TOTAL | 90.0 | |

# ANNEX 7

## Egypt: Health Sector Reform Program

## Project Processing Budget and Schedule

| A. Project Budget (US$'000) | Planned (At final PCD stage) US$433.9 | Actual US$387.6 |
|---|---|---|
| B. Project Schedule | Planned (At final PCD stage) | Actual |
| Time taken to prepare the project (months) | 13 | |
| First Bank mission (identification) | 03/20/1997 | 03/20/1997 |
| Appraisal mission departure | 02/06/1998 | 02/06/1998 |
| Negotiations | 04/20/1998 | 04/23/1998 |
| Planned Date of Effectiveness | 01/31/1999 | / /19 |
| Prepared by: Ministry of Health and Population | | |
| Preparation assistance: PHRD Grant TF027142 (Country executed) and TF27166 (Bank executed); Cofinanciers (USAID, EU) | | |
| Bank staff who worked on the project included: | | |
| George Schieber | Health Sector Leader | |
| Bassam Ramadan | Senior Economist | |
| Albert Sales | Health Specialist | |
| Egbe Osifo | Health Specialist | |
| Rekha Menon | Health Economist | |
| Atsuko Aoyama | Health Specialist | |
| Eileen Sullivan | Program Assistant | |
| Mariam Claeson | Senior Public Health Specialist | |
| Ramesh Govindaraj | Lead Pharmaceutical Specialist | |
| Akiko Maeda | Health Finance Specialist | |
| Nicole Klingen | Economist | |
| Sahar Ahmed Nasr | Economist | |
| Mahmoud Gamel El Din | Senior Procurement Specialist | |
| Luca Frontini | Economist | |
| Micheline Faucompré | Senior Language Task Assistant | |

# ANNEX 8

## Egypt: Health Sector Reform Program
## Documents in the Project File*

### A. Project Implementation Plan

* Operational Manual: Managing the Reform Process, Draft April, 1998 (World Bank/MOHP).
* Conceptual Framework for a Health Sector Reform Strategy, April 1997.
* Ministry of Health and Population Health Policy Change: An Agenda for Action.

### B. Bank Staff Assessments

* Egypt Health Sector Reform: Universal Access to Basic Primary Care and Public Health Services, February 1998 (Mariam Claeson)
* Egypt: Fiscal Situation and Medium-Term Outlook: Health Care Sector Reform Fiscal Sustainability, February 1998 (Luca Frontini)
* Expanding Social Health Insurance Coverage; Financial Projections 1995-2001, February 1998 (Akiko Maeda)
* Facility Rationalization: Cost Tables, February 1998 (Nicole Klingen)
* Egypt Health Sector Reform Program (developed at the request and under the guidance of His Excellency Prof. Ismail Sallam, Minister of Health and Population), December 1997
* The Situation of Human Resource Development and Management in the Health Sector, July 1997 (Atsuko Aoyama with contribution from Paulo Ferrinho).
* Health Care Financing in Egypt: The Role of the Health Insurance Organization, September 1997 (Rekha Menon).
* Work Group on Primary Health Care (Scope of Work), 1997 (Dr. El-Khoby, Dr. Shamma, Dr. Hamoud, Dr. Tamman, Dr. Mansour, Dr. Gipson, Dr. Ahmed (MOH)).
* A Reform Strategy for Primary Care in Egypt, Draft May 1997 (USAID).
* Egypt: Reconnaissance Mission, Health Insurance Organization, February 1997 (V. Turbat).
* The Human Resources Situation in Health Care Services in Egypt: Preliminary Assessment, March 1996 (G. Dussault, Univ. of Montréal).
* World Bank Reconnaissance Mission: The Egyptian Pharmaceutical Sector Analysis, February 1996 (P. Lalvani, VCF Inc.).
* World Bank's Health Sector Reconnaissance Mission - Health Care Financing, March 1996 (Gilles des Rochers, Consultant, Québec, Canada).
* Health Situation in Egypt, February 1996 (Claude Letarte, MD, DTPH, Consultant).
* World Bank's Health Sector Reconnaissance Mission - The Egyptian Hospital Sector at the Crossroads, February 1996 (Daniel Letouzé, PhD, Health Sciences, Dakar, Sénégal).

### C. Other

* List of Health Projects in Egypt supported by the following members of the HRD Donor Sub-Group Members.
* Partnerships for Health Reform: TA to Egypt Health Sector Policy Support - Draft Year One Country Activities Plan, March 1997 (USAID/GOE).
* Health Services Provider Survey (Dr. Hala Abou-Taleb).
* DDM: Provider Survey Preliminary Results - The Role of Independent Pharmacists in Health Services Provision (Dr. F. Kader, Dr. M. El-Adawy, M. M. Hamdy).

*Including electronic files

# Annex 9

## Egypt: Health Sector Reform Program
## Statement of Loans and Credits
### Status of Bank Group Operations in Egypt, Arab Republic of
### IBRD Loans and IDA Credits in the Operations Portfolio

| Project ID | Loan or Credit No. | Fiscal Year | Borrower | Purpose | Original Amount in US$ Millions | | | | Difference Between expected and actual disbursements a/ | | Last ARPP Supervision Rating b/ | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | IBRD | IDA | Cancellations | Undisbursed | Orig | Frm Rev'd | Dev Obj | Imp Prog |
| Number of Closed Loans/credits: 88 | | | | | | | | | | | | |
| Active Loans | | | | | | | | | | | | |
| EG-PE-5149 | IBRD 31980 | 1990 | GOVERNMENT OF EGYPT | IRRIG./PUMPING | 31.00 | 0.00 | 0.00 | 4.74 | 4.28 | 0.00 | HS | S |
| EG-PE-5140 | IBRD 31370 | 1990 | GOVERNMENT | ENGINEERING & TECHNI | 30.50 | 0.00 | 0.00 | 8.96 | 9.73 | 0.00 | HS | S |
| EG-PE-5111 | IBRD 33540 | 1991 | EGPC | GAS INVESTMENT PROJE | 84.00 | 0.00 | 0.00 | 11.96 | 11.97 | 0.00 | S | S |
| EG-PE-5146 | IBRD 34170 | 1992 | GOVERNMENT OF EGYPT | NATIONAL DRAINAGE | 45.00 | 0.00 | 0.00 | 45.00 | 3.64 | 0.00 | HS | HS |
| EG-PE-5152 | IDA 24030 | 1992 | GOVERNMENT | SCHISTOSOMIASIS CONT | 0.00 | 26.84 | 0.00 | 20.26 | 13.22 | 0.00 | S | S |
| EG-PE-5146 | IDA 23130 | 1992 | GOVERNMENT OF EGYPT | NATIONAL DRAINAGE | 0.00 | 75.00 | 0.00 | 9.84 | 3.64 | 0.00 | HS | HS |
| EG-PE-5168 | IBRD 36050 | 1993 | GOVERNMENT | PVT SEC TOURISM INF & ENV | 130.00 | 0.00 | 0.00 | 94.85 | 58.48 | 0.00 | S | S |
| EG-PE-5153 | IDA 25040 | 1993 | GOVERNMENT OF EGYPT | MATRUH RESOURCE MANAGEMENT | 0.00 | 22.00 | 0.00 | 17.64 | 6.35 | -.19 | S | S |
| EG-PE-5161 | IDA 24760 | 1993 | GOE | BASIC EDUCATION PROJ | 0.00 | 55.50 | 0.00 | 26.35 | 10.64 | 0.00 | S | S |
| EG-PE-5157 | IBRD 37190 | 1994 | GOE/PBDAC | AGRICULTURAL MODERNI | 54.00 | 0.00 | 0.00 | 11.01 | -36.47 | 0.00 | S | S |
| EG-PE-5157 | IDA 25850 | 1994 | GOE/PBDAC | AGRICULTURAL MODERNI | 0.00 | 67.00 | 0.00 | 24.04 | -36.47 | 0.00 | S | S |
| EG-PE-5173 | IBRD 38320 | 1995 | MPWR | EGYPT IRRIGATION IMP | 26.70 | 0.00 | 0.00 | 26.70 | 8.72 | 0.00 | S | S |
| EG-PE-5173 | IDA 26720 | 1995 | MPWR | EGYPT IRRIGATION IMP | 0.00 | 53.30 | 0.00 | 47.29 | 8.72 | 0.00 | S | S |
| EG-PE-40507 | IBRD 40180 | 1996 | GOVERNMENT OF EGYPT | POLLUTION ABATEMENT | 20.00 | 0.00 | 0.00 | 20.00 | 4.64 | 0.00 | S | U |
| EG-PE-40507 | IDA 28660 | 1996 | GOVERNMENT OF EGYPT | POLLUTION ABATEMENT | 0.00 | 15.00 | 0.00 | 14.20 | 4.64 | 0.00 | S | U |
| EG-PE-43102 | IDA 28650 | 1996 | GOVERNMENT | SOCIAL FUND II | 0.00 | 120.00 | 0.00 | 101.32 | 24.36 | 0.00 | HS | HS |
| EG-PE-5163 | IDA 28300 | 1996 | GOE | POPULATION | 0.00 | 17.20 | 0.00 | 16.40 | 2.83 | 0.00 | S | U |
| EG-PE-5169 | IDA N0080 | 1997 | GOE | ED.ENHANCEMENT PROG. | 0.00 | 75.00 | 0.00 | 67.96 | 8.10 | 0.00 | S | S |
| EG-PE-49166 | IDA 30020 | 1998 | | EAST DELTA AG.SERV. | 0.00 | 15.00 | 0.00 | 15.00 | 0.00 | 0.00 | | |
| Total | | | | | 421.20 | 541.84 | 0.00 | 583.52 | 111.02 | -.19 | | |

| | Active Loans | Closed Loans | Total |
|---|---|---|---|
| Total Disbursed (IBRD and IDA): | 370.65 | 3,561.87 | 3,932.52 |
| of which has been repaid: | 10.14 | 1,909.19 | 1,919.33 |
| Total now held by IBRD and IDA: | 952.90 | 1,656.20 | 2,609.10 |
| Amount sold : | 0.00 | 7.48 | 7.48 |
| Of which repaid : | 0.00 | 7.48 | 7.48 |
| Total Undisbursed : | 583.52 | 0.00 | 583.52 |

a. Intended disbursements to date minus actual disbursements to date as projected at appraisal.

b. Following the FY94 Annual Review of Portfolio performance (ARPP), a letter based system was introduced (HS = highly Satisfactory, S = satisfactory, U = unsatisfactory, HU = highly unsatisfactory): see proposed Improvements in Project and Portfolio Performance Rating Methodology (SecM94-901), August 23, 1994.

Note: Disbursement data is updated at the end of the first week of the month.

**Egypt, Arab Republic of**

**STATEMENT OF IFC's**

**Committed and Disbursed Portfolio**
As of 30-Sep-97
(In US Dollar Millions)

| | | Committed | | | | Disbursed | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | IFC | | | | IFC | | | |
| FY Approval | Company | Loan | Equity | Quasi | Partic | Loan | Equity | Quasi | Partic |
| 1982/88 | Luxor Hotel | 0.00 | 1.37 | 0.00 | 0.00 | 0.00 | 1.37 | 0.00 | 0.00 |
| 1983/91/94/92/96 | ANSDK | 18.57 | 11.44 | 0.00 | 0.00 | 18.57 | 11.44 | 0.00 | 0.00 |
| 1985 | MFIC | 0.00 | .12 | 0.00 | 0.00 | 0.00 | .12 | 0.00 | 0.00 |
| 1986/88/92 | Meleiha Oil | 0.00 | 30.82 | 0.00 | 0.00 | 0.00 | .24 | 0.00 | 0.00 |
| 1991 | Al Bardi | 1.55 | 0.00 | 0.00 | 0.00 | 1.55 | 0.00 | 0.00 | 0.00 |
| 1991 | ETIC | 0.00 | 1.95 | 0.00 | 0.00 | 0.00 | 1.95 | 0.00 | 0.00 |
| 1992 | Misr Compressor | 9.70 | 3.77 | 0.00 | 0.00 | 9.70 | 3.77 | 0.00 | 0.00 |
| 1992 | Serena Beach | 5.00 | 1.20 | 0.00 | 0.00 | 5.00 | 1.19 | 0.00 | 0.00 |
| 1992/97 | Carbon Black-EGT | 10.25 | 2.96 | 0.00 | 0.00 | 6.25 | 2.96 | 0.00 | 0.00 |
| 1993 | Cmrcl Intl Bank | 0.00 | 15.59 | 0.00 | 0.00 | 0.00 | 15.59 | 0.00 | 0.00 |
| 1994 | Club Ras Soma | 4.84 | 2.40 | 0.00 | 0.00 | 4.84 | 1.93 | 0.00 | 0.00 |
| 1994/96 | Abu Soma Develop | 0.00 | 1.20 | 0.00 | 0.00 | 0.00 | .91 | 0.00 | 0.00 |
| 1996 | Apache Corp. | 0.00 | 10.00 | 0.00 | 0.00 | 0.00 | 10.00 | 0.00 | 0.00 |
| 1996 | Apache Qarun | 10.00 | 0.00 | 0.00 | 15.00 | 7.54 | 0.00 | 0.00 | 11.31 |
| 1996 | Orix Leasing EGT | 0.00 | .89 | 0.00 | 0.00 | 0.00 | .89 | 0.00 | 0.00 |
| 1996 | Phoenix Qarun | 20.00 | 0.00 | 0.00 | 30.00 | 14.36 | 0.00 | 0.00 | 21.54 |
| 1997 | Egypt Trust | 0.00 | 5.00 | 0.00 | 0.00 | 0.00 | 5.00 | 0.00 | 0.00 |
| 1997 | MGDK | 0.00 | 1.50 | 0.00 | 0.00 | 0.00 | .37 | 0.00 | 0.00 |
| 1997 | Orascom | 20.00 | 5.00 | 0.00 | 0.00 | 12.00 | 5.00 | 0.00 | 0.00 |
| | | | | | | | | | |
| Total Portfolio: | | 99.91 | 95.21 | 0.00 | 45.00 | 79.81 | 62.73 | 0.00 | 32.85 |
| | | | | | | | | | |
| Approvals Pending Commitment | | | | | | | | | |
| | | Loan | Equity | Quasi | Partic | | | | |
| 1997 | ANSDK GDR | 0.00 | 0.00 | 0.00 | 30.00 | | | | |
| 1997 | ECC | 35.00 | 0.00 | 0.00 | 0.00 | | | | |
| 1997 | MGDK | 4.00 | 0.00 | 0.00 | 0.00 | | | | |
| 1995 | MISR COMP-CAP IN | 1.60 | 0.00 | 0.00 | 0.00 | | | | |
| 1996 | ORIX LEASING EGT | 5.00 | 0.00 | 0.00 | 0.00 | | | | |
| 1997 | UNIPAK-NILE | 5.00 | 0.00 | 0.00 | 5.00 | | | | |
| | | | | | | | | | |
| Total Pending Commitment: | | 50.60 | 0.00 | 0.00 | 35.00 | | | | |

Minister of Health and Population
Egypt

جمهورية مصر العربية
وزارة الصحة والسكان

الوزيـــــر



**ARAB REPUBLIC OF EGYPT**
**MINISTRY OF HEALTH AND POPULATION**

Kemal Dervis
Vice President
Middle East & North Africa Region
The World Bank

Dear Mr. Dervis:

In the context of the continuing collaboration between the Arab Republic of Egypt and the World Bank, I would like to restate the policy of the Government of Egypt (GOE) regarding the content and phasing of our comprehensive health sector reform program.

Improvements in the health status of the Egyptian population through universal access to high quality and cost-effective services in the context of a fiscally sustainable and efficient system are the goals of our comprehensive reform program. This program is described in detail in the attached Egypt *Health Sector Reform Program* (HSRP) document developed by the Ministry of Health and Population under my guidance and in collaboration with the World Bank, USAID, EU, and DANIDA. The basic reform approach builds on the strengths of the current system, while dealing with its weaknesses.

The HSRP over the long-term will:

- improve health outcomes and reduce regional disparities
- reform system organization and management
- increase health spending
- improve the equity, allocative efficiency and technical efficiency of health spending
- enhance the fairness of the current financing arrangements
- rationalize the extensive human and physical infrastructure and eliminate regional disparities
- improve the quality of care in both public and private sectors
- implement economic incentives to improve operational efficiency
- improve the efficiency of the pharmaceutical sector and quality of its products

The HSRP provides a 10-15 year reform framework to achieve these objectives. As you know, health reform is a difficult and complex process. Reform must be dealt with in an incremental, yet substantive manner. The GOE is embarking on the first five-year phase of the reform. During this phase, we plan to lay the basis for future stages of the reform, while addressing our most serious health status, efficiency, and quality problems.

٣شارع مجلس الشعب - القاهرة -جمهورية مصر العربية تليفون : ٣٥٥٧٠٤٦ - ٣٥٤٠٥٢٦ - ٣٥٤١٥٠٧ فاكس :٣٥٥٣٩٦٦ - ٣٥٥٩٤٢٢
3 Magles El Shaab St., Cairo . Tel.:3557046 - 3540526 - 3541507 Fax: 3553966 - 3559422

During the first phase of the reform, universal coverage to a basic package of primary care benefits will be introduced in three pilot Governorates: Alexandria, Minoufia, and Sohag. The insurance entities will be local subsidiaries of the Health Insurance Organization specifically oriented to providing coverage for the primary care benefit package. The service delivery systems, both human and physical, in the pilot Governorates will be rationalized according to needs-based masterplans. These masterplans will be based on existing human and physical infrastructures, underlying health needs, and norms developed by the Government concerning appropriate capacity, efficiency, and quality needed for effective and efficient delivery of the primary care benefit package. Complementary vertical national public health programs will also be reformed to reinforce the basic primary care package. The National Health Insurance Organization will be eventually restructured so that it can serve as the national social health insurance system for the entire population in the future. Major studies and analyses will be undertaken in the areas of curative care, pharmaceuticals, and human resource development to serve as the base for future phases of the reform.

Based on our experiences with the first phase, we plan to expand coverage to other Governorates and ultimately to the entire population. In the longer term, consonant with improved systems efficiency and availability of financing, we plan to expand the basic primary care package to a comprehensive benefit package. Learning from our experiences and the results from the masterplans, we will initiate steps to deal effectively with general over-capacity of personnel and facilities, while resolving problems of appropriate mix and geographic distribution. The human resource and facility planning will also result in improved quality and accessibility. The incentive-based payment arrangements employed by the primary care insurance entities will reinforce both quality and efficiency objectives.

While much of the phase one effort focuses on primary care, we are also taking a serious look at the issues of overall health manpower and system capacity. We will develop policies on medical school enrollments as Egypt has too many physicians, yet has serious geographic and specialty mal-distributions. In addition, medical school enrollments are far in excess of our needs. We are also focusing broadly on overall systems capacity in terms of beds and the low occupancy rates. While the phase one reforms per se will address these issues for primary care, we will address these critical issues and develop policies that we will implement during phase one or later phases of the reform as appropriate and feasible.

Phase one of the reform will be costly. While the proposed Bank project and other donor assistance will assist the government in meeting the underlying investment costs, the government is committed to meeting the significant annual costs of providing health insurance to a basic package of primary care benefits for the 5.7 million uninsured in the three pilot governorates, and ultimately to all Egyptians. As part of our policy planning, we will develop transparent financing mechanisms to meet these primary care insurance costs through premiums, co-payments, and additional government revenue contributions. Some of these costs can be met through efficiency gains achieved through the planning process. Financing social health insurance is a difficult economic and policy issue that we will resolve during the phase one implementation process.

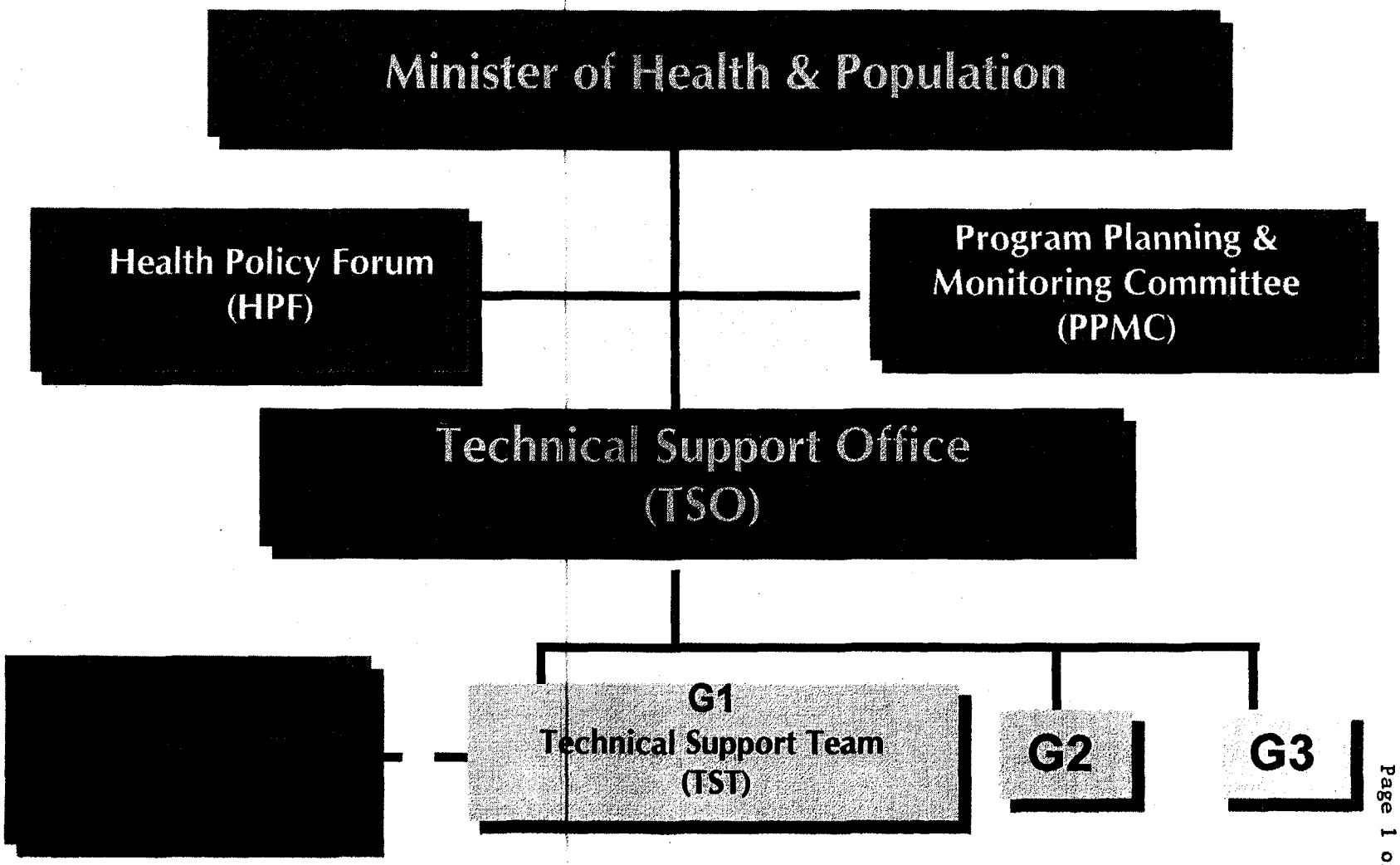
**Prof. Dr. Ismail Sallam**
**Minister of Health and Population**
**Arab republic of Egypt**

٣شارع مجلس الشعب - القاهرة -جمهورية مصر العربية تليفون : ٣٥٥٧٠٤٦ - ٣٥٤٠٥٢٦ - ٣٥٤١٥٠٧ فاكس :٣٥٥٣٩٦٦ - ٣٥٥٩٤٢٢
3 Magles El Shaab St., Cairo . Tel.:3557046 - 3540526 - 3541507 Fax: 3553966 - 3559422

Annex 11

# Egypt Health Sector Reform Program (HSRP)

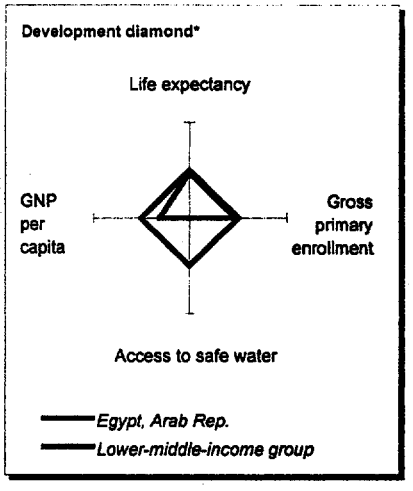
*Proposed Management Structure*



# ANNEX 12
## Egypt Health Sector Reform Program
# Arab Republic of Egypt at a Glance

1/13/98

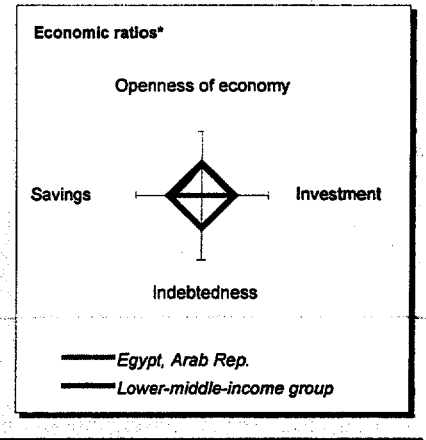
| POVERTY and SOCIAL | Egypt | M. East & North Africa | Lower-middle-income |
|---|---|---|---|
| Population mid-1996 *(millions)* | 59.3 | 279 | 1,125 |
| GNP per capita 1996 *(US$)* | 1,090 | 2,090 | 1,750 |
| GNP 1996 *(billions US$)* | 64.6 | 582 | 1,967 |
| **Average annual growth, 1990-96** | | | |
| Population *(%)* | 2.0 | 2.6 | 1.4 |
| Labor force *(%)* | 2.8 | 3.3 | 1.8 |
| **Most recent estimate** *(latest year available since 1989)* | | | |
| Poverty: headcount index *(% of population)* | .. | .. | .. |
| Urban population *(% of total population)* | 45 | 57 | 56 |
| Life expectancy at birth *(years)* | 63 | 66 | 67 |
| Infant mortality *(per 1,000 live births)* | 56 | 54 | 41 |
| Child malnutrition *(% of children under 5)* | 9 | .. | .. |
| Access to safe water *(% of population)* | 64 | 85 | .. |
| Illiteracy *(% of population age 15+)* | 49 | 39 | .. |
| Gross primary enrollment *(% of school-age population)* | 98 | 97 | 104 |
| Male | 105 | 104 | 105 |
| Female | 91 | 91 | 101 |




**KEY ECONOMIC RATIOS and LONG-TERM TRENDS**

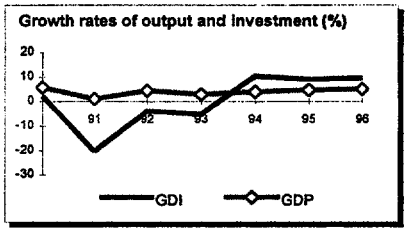
| | 1975 | 1985 | 1995 | 1996 |
|---|---|---|---|---|
| GDP *(billions US$)* | 11.4 | 34.7 | 59.0 | 67.6 |
| Gross domestic investment/GDP | 33.4 | 26.7 | 16.7 | 16.6 |
| Exports of goods and services/GDP | 20.2 | 19.9 | 24.2 | 20.6 |
| Gross domestic savings/GDP | 12.3 | 14.5 | 12.1 | 12.1 |
| Gross national savings/GDP | .. | .. | 14.1 | 13.9 |
| Current account balance/GDP | -21.2 | -9.3 | 0.8 | 0.7 |
| Interest payments/GDP | 0.7 | 2.1 | 2.1 | 1.8 |
| Total debt/GDP | 42.3 | 80.6 | 58.2 | 46.8 |
| Total debt service/exports | 10.3 | 9.6 | 11.6 | 11.8 |
| Present value of debt/GDP | .. | .. | .. | .. |
| Present value of debt/exports | .. | .. | .. | .. |

| | 1975-85 | 1986-96 | 1995 | 1996 | 1997-05 |
|---|---|---|---|---|---|
| *(average annual growth)* | | | | | |
| GDP | 7.8 | 4.0 | 4.7 | 5.0 | 6.9 |
| GNP per capita | 4.4 | 2.7 | 2.9 | 3.6 | 5.3 |
| Exports of goods and services | 3.8 | 6.9 | 1.5 | 8.4 | 9.0 |

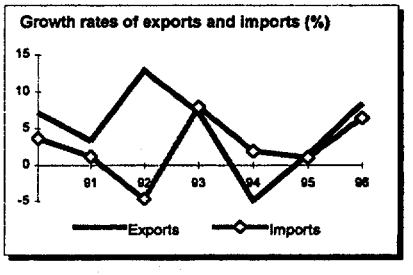



**STRUCTURE of the ECONOMY**

| | 1975 | 1985 | 1995 | 1996 |
|---|---|---|---|---|
| *(% of GDP)* | | | | |
| Agriculture | 29.0 | 20.0 | 17.2 | 17.3 |
| Industry | 26.9 | 28.6 | 33.1 | 31.6 |
| Manufacturing | 17.4 | 13.5 | 25.0 | 24.3 |
| Services | 44.1 | 51.5 | 49.7 | 51.1 |
| Private consumption | 62.9 | 68.2 | 77.1 | 77.5 |
| General government consumption | 24.9 | 17.2 | 10.8 | 10.4 |
| Imports of goods and services | 41.3 | 32.0 | 28.8 | 25.1 |




| | 1975-85 | 1986-96 | 1995 | 1996 |
|---|---|---|---|---|
| *(average annual growth)* | | | | |
| Agriculture | 2.8 | 2.8 | 2.9 | 3.1 |
| Industry | 9.8 | 4.3 | 5.0 | 4.9 |
| Manufacturing | .. | 4.8 | 7.1 | 6.9 |
| Services | 10.6 | 3.7 | 5.0 | 5.6 |
| Private consumption | 6.8 | 4.6 | 3.1 | 3.6 |
| General government consumption | 4.4 | -0.2 | 5.7 | 2.4 |
| Gross domestic investment | 7.8 | -2.8 | 9.1 | 9.7 |
| Imports of goods and services | 3.9 | 1.2 | 1.0 | 6.4 |
| Gross national product | 7.0 | 4.9 | 5.0 | 5.5 |



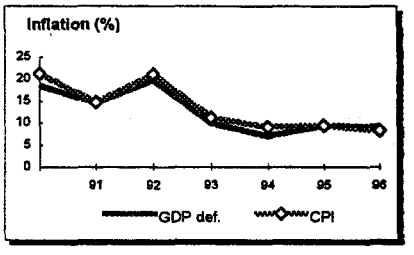

Note: 1996 data are preliminary estimates.

* The diamonds show four key indicators in the country (in bold) compared with its income-group average. If data are missing, the diamond will be incomplete.

*Egypt, Arab Rep.*

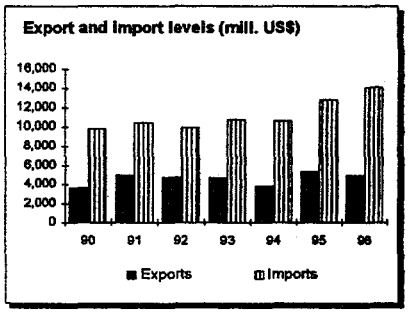
**PRICES and GOVERNMENT FINANCE**

| | 1975 | 1985 | 1995 | 1996 |
|---|---|---|---|---|
| ***Domestic prices*** | | | | |
| *(% change)* | | | | |
| Consumer prices | .. | .. | 9.3 | 8.3 |
| Implicit GDP deflator | 10.4 | 9.0 | 9.4 | 9.0 |
| ***Government finance*** | | | | |
| *(% of GDP)* | | | | |
| Current revenue | .. | 22.2 | 26.4 | 25.1 |
| Current budget balance | .. | -13.7 | 2.6 | 2.5 |
| Overall surplus/deficit | .. | -21.6 | -1.3 | -1.3 |



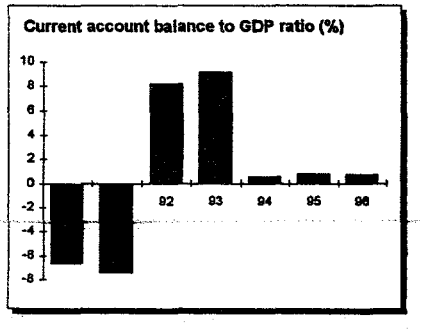

**TRADE**

| | 1975 | 1985 | 1995 | 1996 |
|---|---|---|---|---|
| *(millions US$)* | | | | |
| Total exports (fob) | .. | .. | 5,366 | 4,964 |
| Cottom | .. | .. | 306 | 91 |
| Other Agriculture | .. | .. | 309 | 230 |
| Manufactures | .. | .. | 2,202 | 1,314 |
| Total imports (cif) | .. | .. | 12,811 | 14,107 |
| Food | .. | .. | 2,760 | 2,887 |
| Fuel and energy | .. | .. | .. | .. |
| Capital goods | .. | .. | 3,108 | 4,100 |
| Export price index *(1987=100)* | .. | .. | 118 | 127 |
| Import price index *(1987=100)* | .. | .. | 140 | 145 |
| Terms of trade *(1987=100)* | .. | .. | 84 | 87 |



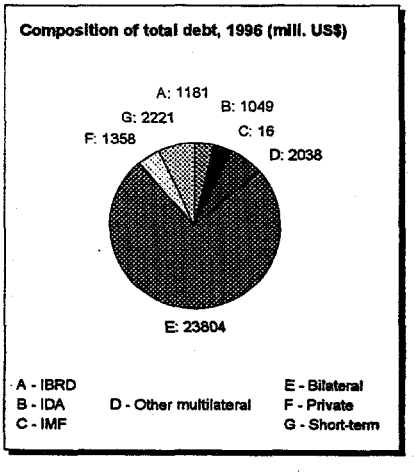

**BALANCE of PAYMENTS**

| | 1975 | 1985 | 1995 | 1996 |
|---|---|---|---|---|
| *(millions US$)* | | | | |
| Exports of goods and services | 2,503 | 6,866 | 13,470 | 15,245 |
| Imports of goods and services | 5,141 | 12,606 | 16,894 | 18,951 |
| Resource balance | -2,638 | -5,740 | -3,423 | -3,706 |
| Net income | -244 | -990 | -454 | 539 |
| Net current transfers | .. | .. | 5,276 | 4,390 |
| Current account balance, before official capital transfers | -2,426 | -3,209 | 480 | 499 |
| Financing items (net) | 1,878 | 3,022 | 274 | 72 |
| Changes in net reserves | 548 | 187 | -754 | -570 |
| ***Memo:*** | | | | |
| Reserves including gold *(mill. US$)* | .. | 1,587 | 16,949 | 18,811 |
| Conversion rate *(local/US$)* | 0.5 | 1.0 | 3.4 | 3.4 |




**EXTERNAL DEBT and RESOURCE FLOWS**

| | 1975 | 1985 | 1995 | 1996 |
|---|---|---|---|---|
| *(millions US$)* | | | | |
| Total debt outstanding and disbursed | 4,835 | 27,950 | 34,369 | 31,667 |
| IBRD | 14 | 720 | 1,494 | 1,181 |
| IDA | 84 | 745 | 999 | 1,049 |
| Total debt service | 305 | 1,044 | 2,134 | 2,345 |
| IBRD | 1 | 109 | 318 | 290 |
| IDA | 1 | 6 | 20 | 22 |
| Composition of net resource flows | | | | |
| Official grants | .. | 0 | 0 | 0 |
| Official creditors | 2,169 | 1,354 | 289 | 10 |
| Private creditors | 49 | 175 | -187 | -376 |
| Foreign direct investment | .. | 0 | 0 | 0 |
| Portfolio equity | .. | 0 | 0 | 0 |
| World Bank program | | | | |
| Commitments | 132 | 4 | 124 | 79 |
| Disbursements | 62 | 306 | 140 | 131 |
| Principal repayments | 0 | 44 | 215 | 198 |
| Net flows | 62 | 262 | -75 | -67 |
| Interest payments | 1 | 71 | 123 | 113 |
| Net transfers | 61 | 191 | -198 | -180 |



Approved by: for Ikram
Khalid Ikram Khalid
Country Director
MNCEG

Date: April 24, 1998

FROM: The Vice President and Secretary

## STATUS OF NEGOTIATIONS

## ARAB REPUBLIC OF EGYPT

## HEALTH SECTOR REFORM PROGRAM

Negotiations have been completed and the Credit documents will be submitted to the Executive Directors for consideration on a date to be determined.

The following is a description of the proposed Credit:

| | |
|---|---|
| Borrower: | Arab Republic of Egypt |
| Beneficiary: | Health Sector Reform Program |
| Amount: | SDR 66.8 million |
| Terms: | Payable in 35 years, including 10 years of grace. |
| Commitment Fee: | 0.50% on undisbursed credit balances, beginning 60 days after signing, less any waiver. |
| Service Charge | 0.75% on disbursed amount. |
| Purpose: | This project will improve population health status as well as access to care, equity, and the efficiency and quality of Egypt's health care financing and delivery by assisting the Government in the implementation of the first phase of its comprehensive Health Sector Reform Program (HSRP). During the first five-year phase of the reform, universal access to a basic package of primary care services will be implemented in three pilot Governorates--Alexandria, Minoufia, and Sohag. The national social Health Insurance Organization (HIO) will be reformed so that in the future it will serve as the single national health insurance entity. In later phases of the reform, universal coverage will be expanded to other Governorates and, ultimately, the entire population. |
| Co-financier: | United states Agency for International Development (USAID)<br>European Union (EU) |

Distribution:

Executive Directors and Alternates
President
Bank Group Senior Management
Vice Presidents, Bank, IFC and MIGA Executive Committee
Directors and Department Heads, Bank, IFC and MIGA

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Contact person: George Schieber
Task Manager, ext. 87319

**MAP SECTION**

# ARAB REPUBLIC OF EGYPT