



Project Information Document (PID)

Appraisal Stage | Date Prepared/Updated: 30-Mar-2020 | Report No: PIDA28239



BASIC INFORMATION

A. Basic Project Data

Country Egypt, Arab Republic of	Project ID P172426	Project Name Supporting Egypt's Universal Health Insurance System	Parent Project ID (if any)
Region MIDDLE EAST AND NORTH AFRICA	Estimated Appraisal Date 10-Mar-2020	Estimated Board Date 14-May-2020	Practice Area (Lead) Health, Nutrition & Population
Financing Instrument Investment Project Financing	Borrower(s) Ministry of Finance	Implementing Agency Ministry of Finance	

Proposed Development Objective(s)

To increase the coverage of Egypt's Universal Health Insurance System in Phase I Governorates and to strengthen UHIS-related governance and institutions.

Components

- Component 1: Enrollment and empanelment of the population into UHIS
- Component 2: Strengthening UHIS governance, systems and facilitating environment
- Component 3: Institutional Capacity Building, Technical assistance and Project Management

PROJECT FINANCING DATA (US\$, Millions)

SUMMARY

Total Project Cost	2,787.00
Total Financing	2,787.00
of which IBRD/IDA	250.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Bank for Reconstruction and Development (IBRD)	250.00
--	--------



Non-World Bank Group Financing

Counterpart Funding	2,537.00
Borrower/Recipient	2,537.00

Environmental and Social Risk Classification

Substantial

Decision

The review did authorize the team to appraise and negotiate

Other Decision (as needed)

B. Introduction and Context

Country Context

1. **Egypt has adopted a bold reform program to address long-standing economic challenges.** Egypt’s macroeconomic conditions are improving, following several years of slowing economic activity, and large external and fiscal imbalances further exacerbated by the economic downturn in 2011. The economy’s turn-around started when Egypt implemented key reform measures in July 2014, including: (i) a fiscal consolidation program, which introduced value added tax, helped contain the civil servants’ wage bill, and gradually reduced energy subsidies; (ii) the liberalization of the exchange rate in November 2016; and (iii) legislative reforms to ameliorate the business environment. These reforms were widely endorsed, including by the World Bank Group’s (WBG) programmatic Development Policy Financing (DPF) and the International Monetary Fund’s (IMF) 3-year Extended Fund Facility. As a result, Egypt’s sovereign credit outlook was upgraded to ‘positive’ by rating agencies. While the IMF assesses Egypt’s macroeconomic outlook as favorable, the IMF sees two priorities moving forward. Firstly, to cement the hard-won gains in stabilizing the economy, and secondly, to accelerate reforms to unleash the economy’s potential, making the private sector the engine of growth.

2. **The overall deficit and the primary balance continue to improve on the back of prudent fiscal policies which have underpinned macroeconomic stabilization.** The overall budget deficit narrowed to 8.1 percent of Gross Domestic Product (GDP) in the fiscal year 2019, compared with 9.7 percent a year earlier. The primary balance, excluding debt servicing costs, reached a surplus of 1.9 percent of GDP up from 0.1 percent a year earlier. Reform measures on both the expenditures side (energy subsidy reforms) and the revenues side (particularly the VAT regime) have helped achieve the turn-around in fiscal aggregates. Over the three-year period FY17-19 Egypt has achieved a fiscal consolidation of about 5.5 percent of GDP in the primary balance, however the concentration of the fiscal consolidation efforts is on the expenditures side as tax ratio to GDP has declined to reach 13.8 percent of GDP in FY19 down from 14.2 percent during FY18; signaling difficulty to mobilize revenues and poor performance of sovereign taxes.

3. **Economic activity is picking up and macroeconomic imbalances are narrowing.** Real GDP) growth increased to 5.6 percent in fiscal year 2019, up from 5.3 percent in FY18, and compared to an average of 4.6 percent over the previous



three years.¹ Meanwhile, inflation declined to 7.2 percent in January 2020, down from a three-decade high of 33 percent in July 2017.² Government debt is declining as a ratio of GDP but remained high at 90.2 percent of GDP at the end of FY19 compared to 97.3 percent of GDP at the end of FY18. External accounts improved significantly after the floatation of the Egyptian pound, supported by a narrowing current account deficit and a surge in capital inflows in the form of sovereign bond issuances and external borrowing. However, FY19 reflects a slightly expanding current account deficit as percent of GDP (despite narrowing of the non-oil trade deficit and achieving oil trade surplus for the first time since FY13), accompanied with a significant drop in the capital and financial accounts surplus. Net international reserves reached 45.5 billion by the end of February 2020, covering around 8 months of merchandise imports.

4. **Fiscal consolidation measures have helped reduce inefficient and unsustainable public spending.** However, the education and health sectors have yet to see the benefits. Despite a constitutional mandate to increase spending on education and health to 6 percent and 3 percent of GDP, respectively. The spending on health was limited to 1.4 percent of GDP in FY18, down from 1.6 percent in FY17, while on education, it was 2.5 percent of GDP in FY18 down from 3.6 percent in FY16.

5. **The Government has introduced new and scaled-up existing social assistance mechanisms to improve social conditions.** The erosion of real incomes (following the 2017 and 2018 inflation shocks) continues to adversely affect households. In FY18, at least 32.5 percent of the population lived below the poverty line up from 27.8 percent in FY15. The deterioration in the standards of living is mainly in urban governorates in which poverty rates increased from 15.1 percent in FY 15 to 26.7 percent in FY18. To mitigate the social costs of reforms and their disproportionate effect on those in poverty, the government has scaled up available social assistance mechanisms. Through three consecutive social packages the government introduced exceptional wage and pension bonuses, revised tax exemption thresholds and raised the minimum wage to 2000 LE/Month up from 1200 LE/month. The budget allocation for the Takaful and Karama cash transfer program grew by more than 400 percent between FY15 and FY19, expanding the program to reach 2.2 million households in October 2019. Similarly, the government has doubled the semi-cash allowance on the food subsidy ration cards. Finally, the government has introduced a Universal Health Insurance program to mitigate against out-of-pocket (OOP) and catastrophic healthcare expenditures, as well as boost accessibility to quality health services.

6. **There is a greater need for reforms for better private sector participation.** With improvement in macroeconomic conditions, further efforts are needed to foster the development of a private sector-led economy and to alleviate key binding constraints to inclusive and sustained growth. Access to finance and land as well as the lack of a level-playing field remain key impediments to private sector activity. Thus, the implementation and proper enforcement of legislative reforms are imperative to enhance the business environment and ensure fair competition and equal-opportunity for all market players.

¹ The pickup in FY19 growth was mainly driven by positive contributions from net exports, followed by investments, and private and public consumption, while unemployment declined to pre-2011 revolution levels (7.5 percent in FY19 Q4).

² Egypt's fiscal accounts and primary balances improved to an estimated -8.1 percent and 1.9 percent of GDP, respectively in FY19, from -9.7 percent and 0.1 percent of GDP a year earlier.

B. Sectoral and Institutional Context

7. **Egypt has significantly improved health outcomes, but disparities remain.** Between 1990 and 2017, Egypt's maternal mortality ratio declined from 106 to 37 deaths per 100,000 live births and infant mortality rate fell from 60 to 18 deaths per 1,000 births. Life expectancy increased from 66 to 72 years over the last two decades but remains below the Middle East and North Africa (MENA) average of 74 years. The life expectancy at birth for Egyptian females was estimated at 73.6 years in 2015, which is 4.4 years higher than that of males. Egypt achieved the Millennium Development Goals 3 and 4, related to improving gender equality and maternal health, respectively.

Table 1: Selected Health Outcomes and Health Financing Indicators for some Low Middle-Income Countries (2016-2017)³

	Egypt	Indonesia	Pakistan	Tunisia	Ukraine	Nigeria	Morocco
Life Expectancy at Birth (years)	72	71	67	76	72	54	76
Infant Mortality Rate (/1000 birth)	18	21	57	15	8	76	19
Maternal Mortality Ratio (/100,000 live birth)	37	177	140	43	19	917	70
Immunization DPT rate (%)	95	79	75	97	50	57	99
Human Capital Index (2018)	0.49	0.53	0.39	0.51	0.65	0.34	0.50
Out of Pocket Expenditures (%)	61	37.3	65.2	39.9	54.3	75.2	48.6
Government Health Expenditure (% of GDP)	1.4	1.4	0.8	3.9	2.9	0.5	2.7
Government Health Expenditure (% of Total Government Expenditure)	4.2	8.3	3.9	13.7	7.0	5.0	9.1
Health Expenditure per Capita (US\$)	131	111.6	39.6	256.5	141.2	79.3	171.5

8. **Despite overall improvements, disparities in health outcomes persist, with populations in remote rural areas and urban slums, as well as women being significantly worse off.** Upper Egypt and the border governorates are the worst performers. For instance, under-five mortality is highest in Upper Egypt (38 deaths per 1,000 births) which is almost twice the level of the urban governorates (20 deaths per 1,000 births).⁴ Access to and use of health services especially preventive care services and risk of morbidity and mortality are also different for women and men due to their roles and



to unequal power relations, with poor health outcomes for women. Possible causes are cultural norms regarding the typical female being the main health care-taker in the family as well as supply issues related to unfavorable working hours of health facilities to working men.

9. **Egypt is also facing a growing burden of non-communicable diseases (NCDs), mainly due to poor prevention and control of NCD risk factors such as hypertension, obesity, high cholesterol levels, diabetes and smoking.** NCDs now account for 82 percent of all deaths and 67 percent of premature deaths in the country. The recent national screening campaign under the “100 million healthy lives” program funded by the Bank-Supported Transforming Egypt’s Healthcare System Project (TEHSP) showed that out of the 53 million adults above the age of 18 years who were screened, 6 percent were diabetic, 26 percent hypertensive and 70 percent overweight. Egypt has the highest obesity rate among the world’s 20 most populous countries.⁵ Around 22.8 percent of Egyptian adults are smokers. As a result of the high prevalence of such risk factors, NCDs such as ischemic heart disease and cerebrovascular disease are now the leading causes of death.⁶ According to the latest 2015 Egypt Health Issues Survey (EHIS), half of women aged between 15 and 59 are obese and an additional 26 percent are overweight. Being obese and overweight are consequences of poor nutrition, representing key risk factors associated with non-communicable diseases, particularly cardiovascular disease and diabetes. The prevalence of obesity and overweight was lower among males (26 percent and 34 percent, respectively).

10. **An unexpected uptick in fertility is driving the new population dynamics in Egypt.** Between 2000-2006, Egypt’s Total Fertility Rate (TFR) slowed down from 3.4 to 3 births per woman respectively in line with global good practice. However, this trend unexpectedly reversed with fertility rates steadily increasing and reaching 3.37⁷ births per woman in 2017. Consequently, between 2012-2015 alone, Egypt registered the highest absolute increase in population growth of 9.5 million people. A few Middle East and North Africa Region (MENA) countries are experiencing similar reversed trend in fertility, while most countries (higher, similar or lower income than Egypt) have a steady decline in fertility⁸. It is expected to reach 128 million by 2030 and 150 million by 2050.⁹

11. **Egypt’s health system faces multiple challenges that impact its ability to meet the rising demands of the population.** While a combination of rising NCDs, high population growth and a longer life expectancy is increasing demand for health services, the service delivery system is seriously underfunded, highly fragmented with sub-optimal provider payment mechanisms and offers low quality of care.

12. **Egypt has one of the lowest levels of total health expenditures in the MENA region at 1.4 percent of GDP with out of pocket payments being the largest source of financing.** Only 5.6 percent of total government budget is spent on health, with public spending accounting for 38 percent of the total health expenditure (THE). More than half of THE (61 percent) is private, of which 90 percent is out of pocket (OOP) payments by households and 10 percent in the form of prepaid private voluntary health insurance.¹⁰ The rest is expenditure by the government (29 percent) and employers (10 percent). Families in the lowest income quintile spend 21 percent of their income on health versus 13.5 percent for those in the highest income quintile.¹¹ Health financing is further compounded by constrained public finances.

³ World Bank Open Data.

⁴ Egypt Demographic & Health Survey 2015.

⁵ Global Burden of Disease, (2017).

⁶ IHME, (2014).

⁷ World Bank Data Bank (2019), https://data.worldbank.org/indicator/SP.DYN.TFRT.IN?locations=EG&most_recent_year_desc=false

⁸ World Bank Data Bank (2019), https://data.worldbank.org/indicator/SP.DYN.TFRT.IN?most_recent_year_desc=false

⁹ UN population projections.

¹⁰ CAPMAS 2018.

¹¹ Rafeh N, Williams J, and N Hassan. (2011). Egypt Household Health Expenditure and Utilization Survey 2010. Bethesda, MD: Health Systems 20/20 project, Abt Associates Inc.



13. **Egypt's health service delivery system is highly fragmented.** There are three key players in health services: government, parastatals and the private sector. The government sector consists of different parallel delivery systems maintained by various line ministries in which there is no separation between financing and service provision functions. The parastatals include (i) the Health Insurance Organization (HIO) which provides not only health insurance coverage but also health services for civil servants, preschool and school children (around 58 percent of the population), (ii) the Curative Care Organization (CCO) which provides secondary hospital services to both public and private health insurance beneficiaries and (iii) the Teaching Hospitals and Institutes Organization (THIO) which provides tertiary care and treats non HIO insured individuals. The Ministry of Health and Population (MOHP) has significant decision-making authority over the parastatals despite their autonomous status. There is a growing private-for-profit sector mostly in tertiary care and for specialized health services in large urban areas. The presence of private sector in primary care as well as in poor rural areas remains negligible. Many non-governmental organizations (NGOs) including religiously affiliated clinics and other charitable organizations also provide private-not-for-profit services.

14. **The Egyptian health system is not well placed to deliver quality health services.** Although more than 95 percent of the population lives within 5 kilometers of a health facility, facilities are often ill-equipped to respond to the people's health needs. Dilapidated state-run facilities, regular drug stock-outs and lack of adequate personnel have been widely reported.¹² While Primary Health Care (PHC) is mostly provided by MOHP, the shortage of PHC physicians is a concern, especially in Upper Egypt and border governorates where around 50 percent of public PHC facilities lack a full-time on-duty doctor. Most healthcare jobs are low-paid and provide little incentive to improve performance. Health professionals receive life-long licenses with no continuing medical education requirements. Dual practice is allowed with no legal restrictions and therefore rampant. As a consequence, quality of care is often poor, leading to low utilization and reduced health benefits.¹³

15. **The current health system presents two important gender gaps in health service utilization.** The first gap relates to utilization rate among men and women, with men having lower utilization rates. While this is similar to global trends, the lower utilization rates for men in Egypt are mainly influenced by cultural and socioeconomic factors as well supply side barriers e.g. unfavorable working hours of PHC facilities to men. The second gap relates to women being less likely to be insured, although women use more healthcare services than men where (61 percent of all utilization was done by women in 2018¹⁴). In a recent study 80 percent of women reported not having any health insurance coverage compared with 63 percent of men, respectively in 2018.¹⁵ Women also often use private providers and, consequently, spend more on all types of healthcare¹². Further, healthcare benefits are not tailored to gender specific health needs e.g.) persistent very high levels of cesarean sections (52 percent in Egypt compared to the WHO recommended rate of 15 percent) and the lack of well-structured breast and cervical cancer screening programs.

16. **In response to the above challenges, Egypt has selected universal health insurance as the pathway towards achieving universal health coverage (UHC).** In December 2017, the Government passed the Universal Health Insurance Law (UHIL) to accelerate progress towards UHC in line with the health pillar of Egypt's 2030 Sustainable Development Vision and the Egyptian Constitution (Article 18 "Every citizen is entitled to health and to comprehensive health care with quality criteria"). The UHIL envisions mandatory coverage for all citizens in the country, including vulnerable groups (approximately 30 percent of the population) who will be subsidized by the government. In addition, the UHIL allows (i) optional coverage for Egyptians living abroad and (ii) coverage for all foreign residents, subject to reciprocal agreements

12 World Bank 2010, 2015.

13 El-Zanaty and Associates. (2014). Egypt Demographic and Health Survey 2014. Cairo, Egypt: Ministry of Health, El-Zanaty and Associates, and Macro International.

14 MOHP Data, 2018.

15 Social Protection and Vulnerability in Egypt, A gendered analysis, Economic Research Forum, 2018.



with their respective countries.

17. **UHS will be progressively rolled-out in phases.** Starting as a pilot in Port Said in 2018, it will be rolled out nationwide in six phases over a 15-year period (see Table 2).

Table 2: Phases of UHS roll-out

Phase	Period	Governorates
1	2019 – 2021	Port Said, Ismailia, Suez, South Sinai, Luxor and Aswan,
2	2022 – 2024	N. Sinai, Matrouh, Qena and Red Sea
3	2025 – 2027	Alexandria, Beheira, Damietta, Kafr Elsheikh and Sohag
4	2028 – 2029	Assiut, Beni Suef, Fayoum, Minya and New Valley
5	2030 – 2031	Dakahlia, Gharbia, Menoufia and Sharqia
6	2032 - 2033	Greater Cairo (Cairo, Giza & Qalyubia)

18. **UHS implementation will entail a provider-purchaser split and the formation of four agencies.** The Universal Health Insurance Agency (UHIA) serves as the “purchaser” and the Healthcare Organization (HCO) as the “provider” of services. In addition, the General Authority for Healthcare Accreditation and Regulation (GAHAR) will be the “accreditor” (responsible for quality assurance and accreditation) and the Egyptian Authority for Standard Procurement and Medical Technology Management (EASPMTM) the “public procurer” (responsible for the procurement drugs, medical equipment and other supplies for the public sector).

- **UHIA:** Reporting to the Prime Minister and under close supervision by the MOF, UHIA is responsible for pooling, provider payments, management and investment of UHS funds. As UHS single payer, UHIA contracts qualified public and private providers who are accredited by GAHAR. UHIA can also purchase health services for private insurance beneficiaries under special arrangements with private insurers.
- **HCO:** Reporting to the Minister of Health, HCO will provide primary, secondary and tertiary care. When each governorate enters the UHS, the HCO will acquire the ownership of all public health facilities within that governorate to achieve: (i) economies of scale; (ii) efficiency; and (iii) integration of care (including referrals). HCO facilities will be contracted by UHIA only after being rehabilitated and accredited by GAHAR.
- **GAHAR:** Reporting directly to the Office of the President and having the highest level of independence under Egyptian law, GAHAR has the mandate to develop quality standards and accredit service providers. The accreditation process includes two steps: (i) registration on the condition that the provider meets the basic safety, regulatory and licensure requirements; and (ii) accreditation that will certify achievements of standards related to structural quality, clinical processes, and patient outcomes.
- **EASPMTM.** Reporting to the Prime Minister, EASPMTM will procure and manage the supply of pharmaceuticals, medical equipment and other medical supplies for all public entities.

19. **The four new UHS related agencies are in the early stages of development.** While there is some variation among the new UHS agencies, overall, they are not adequately staffed with some not functioning beyond board meetings. The GOE plans to fully staff the most critical positions at central and governorate levels within the agencies in the first year of operation of the UHS. Substantial capacity building will be needed to ensure proper functioning of these agencies.

20. **UHS revenues will be collected from various sources.** UHS aims to help Egypt achieve long-term stability in health financing with less dependence on state budget and less exposure to economic fluctuations. UHS revenues will

come from three main sources: (i) contributions/premiums (Table 3); (ii) earmarked fees and taxes including, inter alia, contributions from toll road fees, car licensing fees and tobacco taxes; and (iii) copayments paid by beneficiaries at the point of service (Table 5). Various entities will be involved in revenue collection, including MOHP, MOF, Ministry of Transportation, Ministry of the Interior, Tax Authority, Social Insurance Fund, UHIA, and service providers. Revenue collection is therefore a complex tax and requires a robust IT system and continuous data exchange among different entities. The UHIA can also enter into agreements with private entities to collect, for a marginal fee, the contributions by the third parties. Per global experience, the collection of contributions from the non-poor informal sector has been identified as a major challenge.

 Table 3: UHIS Contributions/Premiums¹⁶

Category	Contribution	Dependents
Formal employees (civil servants, private sector and other non-Government)	1% of subscription wage	3% for a non-working spouse or one without steady income, 1% for each child or dependent
Self-employed.	5% of insured wage or wage according to tax declaration or the maximum insured wage, whichever is greater	
People with total disability and non-formal employment pensioners.	5% of the insured wage, and the total amounts paid by the person for all the family members shall not exceed 7% and the Public Treasury shall pay the cost differential	
Pensioners	2% of the monthly pension value	
Single mothers and beneficiaries of pensions	2% of the monthly pension value	
Employer's share covering their employees	4% (3% for illness + 1% for occupational injuries) of insured wage	
Subscription covered by the Public Treasury for the vulnerable groups	5% of the national minimum wage for each vulnerable person	

Table 4: Earmarked Fees & Taxation

EGP 0.75 of the price of each pack of cigarettes sold in the local market, whether of local or foreign production, and this amount shall be increased every three years by the amount of EGP 0.25 and capped at EGP 1.5. 10% of the value of any sold tobacco item, other than cigarettes EGP 1 for each vehicle on a toll road EGP 20 per year when issuing or renewing a driving license EGP 50 when issuing or renewing a car license whose engine capacity is less than 1.6 liters EGP 150 when issuing or renewing a car license whose engine capacity exceeds 1.6 liters and is less than 2 liters EGP 300 when issuing or renewing a car license whose engine capacity is 2 liters and more. EGP 1,000 to 1,500.00 when clinics, treatment centers, pharmacies, and pharmaceutical companies enter into contract with the UHIS. EGP 1,000 for each bed when issuing licenses for hospitals and medical centers. A solidarity contribution tax of 2/1000 out of the total of the sole proprietorships and companies, regardless their nature, line of business or the legal system they are subject to, as well as the economic public authorities

¹⁶ The lump sum values shall increase by 7% annually, including the national minimum wage declared by the Government.

50% of the revenues collected in the self-revenue funds in public health facilities.

EGP 5 stamp tax on the applications submitted to the UHIA, HCO and GAHAR.

Returns of the UHIA Investments

Fees for other services provided by the UHIA other than those provided for under the UHIL

Foreign and domestic grants and loans concluded by the government for the UHIA

Gifts, aid, donations and bequests accepted by the UHIA's Board of Directors

Table 5: Fees and co-payments paid by insured persons

Medical Service	Co-payment Value ¹⁷
Home visit by a doctor	EGP 100
Medication	10% with a maximum of EGP 1000 to reach 15% in the tenth year of Law implementation. No copayment for chronic diseases as identified by UHIA and all cancer treatment
Radiology scans and other medical imaging; medical and laboratory tests (except for chronic diseases and tumors)	10% of the total value, with a maximum of EGP 750 for each case
Internal Medicine Departments (except for chronic diseases and cancers)	5% of the total value, with a maximum of EGP 300 per visit

21. **The public treasury will cover UHIS contributions for vulnerable groups.** Eligibility criteria includes any of the following conditions¹⁸: (i) the person or family is entitled to cash support provided by the Takaful and Karama Cash Transfer Program and the older Social Security Program; (ii) the unemployed person or family head is ineligible to or has exhausted his/her eligibility period to unemployment benefits including every dependent person in the same family; (iii) the person or family head with no income, who lacks family support and resides in a social or health care facility; (iv) the disabled person or family head who cannot earn money or who do not have any source of income, without prejudice to the Law on the Rights of Persons with Disabilities; (v) persons and families who reside in specific geographic areas and are temporarily experiencing a natural or man-made disaster; and (vi) the person or family head whose average income does not satisfy his/her own needs or his/her family members' essential needs determined after appealing to a dedicated board. Eligibility criteria will be amended at periodic intervals of not more than three years.

22. **UHIS will provide a benefits package for all beneficiaries.** The UHIL outlines an implicit benefit package which includes primary; secondary and tertiary care services as well as in-patient and out-patient drug benefits. The insured persons will also have the right to be treated abroad subject to the approval of a special board. Only services included in the defined benefit package will be covered. There will be no self-referrals allowed, except in the case of an emergency. Balance payments are prohibited for covered services, except for add-on services of a non-medical nature.

23. **Public health and preventive services will continue to be funded by government revenues and provided by the MOHP.** These include vaccinations, ambulance services, family planning services, health services in disaster and outbreak

¹⁷ The lump sum values will increase by 7% annually, including the national minimum wage announced by the GOE.

¹⁸ Prime-Ministerial Decree No.1948/2019



situations. Mechanisms for MOHP to deliver and/or contract such services are yet to be developed.

24. **New provider payment mechanisms will be introduced to increase quality and efficiency.** Under UHIS, there will be a shift from input to output-based reimbursement. PHC services will be reimbursed on a capitation basis, with 15 percent of the capitation payment contingent on the achievement of certain key performance indicators (e.g. patient utilization and referral rates). A set of priority PHC services (to be determined) and specialized outpatient services will however be paid on a fee-for-service (FFS) basis. For in-patient services, simple case-based payment will be made for surgical interventions and FFS/per-diem for non-surgical interventions. Payment rates were approved by the UHIA Board in late 2019 and will be adjusted on a quarterly basis in the first year of UHIS implementation, bi-annually for another two years, and yearly thereafter. How provider payment will influence behavior of providers remains to be seen because UHIA has an umbrella contract with the HCO for services by all qualified public facilities. Level of provider autonomy for public facilities under the HCO remains unclear. However, there is an understanding of the importance of granting some managerial autonomy to health facilities in combination with adequate capacity, appropriate accountability mechanisms and effective incentives to enable them to provide services more efficiently and with better quality.

25. **An integrated Information Technology IT system will be the backbone of the UHIS.** Such an IT architecture is envisioned to consist beneficiary portal, health care portal, provider portal, accreditation portal, access management and contact center. It will have the following required components: (i) Payer System; (ii) Health information Exchange (HIE); (iii) Enterprise Resources Planning (ERP) which include financial, human resources, asset management, investment management modules; (iv) Accreditation System; (v) Pharmacy Information System (vi) Clinical Order Management System/ Provider Portal; (vii) Standards; and (viii) Analytics and Enterprise Risk Management. A consortium led by an international vendor has been chosen to undertake this work.

26. **The International Bank for Reconstruction and Development (IBRD) has a long engagement in Egypt's health sector to support UHIS roll-out in Egypt.** This includes support to MOHP through technical assistance (TA) and five projects, including the TEHSP, which was launched in September 2018 to help improve health service delivery in Egypt. In addition to screening 52 million citizens for Hepatitis C (Hep C) and NCDs and providing ongoing treatment for 2.2 million Hep C patients, the project is supporting the MOHP to improve the quality of care in 600 PHC facilities and 30 tertiary hospitals (many of which are in UHIS Phase I governorates); train and contract 2,800 community health workers; boost demand- and supply-side interventions for family planning programs; and provide advanced nucleic acid testing for the public blood supply.

27. **IBRD and the International Finance Corporation (IFC) will partner together to support the UHIS under the proposed operation.** With the aim of boosting the WBG's 'Maximizing Finance for Development' Initiative and realizing IFC's 3.0 Strategy. The WBG will collaborate in the following areas: (i) improving quality accreditation standards that are conducive to private sector providers; (ii) providing an enabling environment for greater private sector participation. IFC will provide input to the Bank to inform the technical support to the new health insurance agencies for better engagement with private sector players. Joint missions will be conducted, and opportunities for joint analyses and dialogue with the government will be pursued. IFC plans to invest in Egypt \$325 million on its own account and mobilize an additional \$150 million by 2025.



I. PROJECT DESCRIPTION

A. Project Development Objective

PDO Statement

28. To increase the coverage of Egypt’s Universal Health Insurance System in Phase I Governorates and to strengthen UHIS-related governance and institutions.

B. Proposed Development Objective(s)

Development Objective(s) (From PAD)

To increase the coverage of Egypt’s Universal Health Insurance System in Phase I Governorates and to strengthen UHIS-related governance and institutions.

Key Results

PDO Level Indicators

PDO	PDO Indicators
To increase coverage of Egypt’s UHIS in Phase I Governorates	<ol style="list-style-type: none"> 1. Number of target population enrolled in UHIS and empaneled with a GP in Phase I Governorates 2. Per capita annual PHC visits by UHIS enrollees in Phase I Governorates
To strengthen UHIS-related institutions	<ol style="list-style-type: none"> 1. Percentage of UHIA’s overhead cost of in UHIA’s annual expenditure 2. Annual percentage of payments by UHIA that are made to contracted providers in Phase I Governorates within 60 days from the date of claim submission



C. Project Description

29. **The proposed project will assist the GOE in rolling out the new UHIS in Phase 1 governorates.** The project will support the MOF and the four newly formed UHIS organizations (UHIA, HCO, GAHAR and EASPMTM) to roll out UHIS in Phase I Governorates over a four-year period, using the Investment Project Financing (IPF) with Disbursement-linked Indicators (DLIs) instrument. With the use of DLIs, the government will be reimbursed for Eligible Expenditures (EEs) after verification of DLI achievements. Input-based financing will be provided for technical assistance and institutional capacity building for the four UHIS-related institutions. The project will support three components, each focusing on a distinct results area.

30. **Component 1: Enrollment and empanelment of the population into UHIS (US\$123 million).** This component will support the enrollment of the entire population (including the vulnerable groups who are eligible for premium subsidies as per the UHIL) in Phase I Governorates into UHIS as well as the empanelment of enrollees with General Practitioners (GPs). Data show that there is a gap, to the disadvantage of males, in terms of utilization of health services especially at the PHC level in comparison to females - utilization rate for females is 60 percent compared to 40 percent for males). The project will address this gender gap by increasing service utilization for both men and women with expected outcomes favorable to men given that the UHIS intends to target the head of households who are largely male. By lowering financial barriers to use of health services and the potential decrease of OOP, especially for the poor, the project is expected to encourage males to utilize health services more often and to bring male utilization rates to at least 45 percent, in line with global trends. This component will disburse based on verified achievement of two DLIs, which constitute Result Area 1.

Result Area 1: Increasing population coverage and empanelment for UHIS (US\$123 million)

- **DLI 1: Number of target population enrolled in UHIS and empaneled with a GP in Phase I Governorates (US\$20 million).** This DLI will support various processes and systems to ensure that all population subgroups are enrolled and empaneled. This will include the support for active mechanisms to target some difficult to reach population subgroups e.g. informal non-poor and nomadic/tribal concentrations in remote areas. Given the geographical scope of Phase I Governorates, DLI 1 will include populations that are particularly vulnerable to climate change including people who reside in specific geographic areas that temporarily experience a natural or man-made disaster. This DLI will help increase their resilience to climate change, especially through improving access to care for climate-sensitive diseases.
- **DLI 2: Number of vulnerable populations enrolled in UHIS and empaneled with a GP in Phase I Governorates (US\$103 million).** This DLI will support results in identifying, enrolling, empaneling and subsidizing of contributory premiums and/or copayments of designated vulnerable groups in Phase I Governorates as stipulated in the UHIL.

The six under-privileged groups that meet the Public Treasury criteria¹⁹ to have their contributions covered by the UHIS live in the same geographical areas prone to climate change as those under DLI 1. Given their disadvantaged status, they are more vulnerable to natural hazards (such as extreme precipitation and flooding, and sea level



rise), resulting price changes and have less access to support to cope and adapt to extreme climate events, fluctuations in heat and are at higher risk of vector-borne diseases. They are particularly vulnerable to health impacts of climate change and the safety net in health provided by the project is all the more critical.

Component 2: Strengthening UHIS governance, systems and facilitating environment (US\$120 million). This component will: (i) foster UHIS governance and institutional arrangements, including UHIS oversight and coordination platform; and (ii) create an enabling environment for UHIS, including the policy environment for private sector participation, citizen engagement mechanisms at both the central and Governorate levels; and (iii) introduce novel mechanisms to ensure UHIS positive environmental, climate and social outcomes. This will be achieved by supporting, inter alia : (i) build the capacity of agencies; (ii) clearly define the benefits package and cost it; (iii) define and institute contracting providers; (iv) establish provider payment mechanisms; (v) support the rollout of a modular IT system in terms of enrollment, provider management and claims management; (vi) strengthen governance and private sector participation; and (vi) adopt mitigation and adaptation measures to make UHIS more environment- and climate-friendly.

Result Area 2.1. Strengthening UHIA (US\$83 million)

- **DLI 3: Development and adoption of an explicit benefit package for the continuum of care (primary care, secondary and tertiary hospital care) (US\$10 million).** This DLI will support the process of development and adoption of an explicit benefit package for all levels of care as well as related rules such as referrals, co-payments, and waiting lists. The process will consider factors such as cost-effectiveness, financial protection and equity. The benefit package will include interventions to (i) build climate resilience in health; and (ii) promote the use of care at the lower levels which has a smaller carbon footprint. The benefit package provided under the UHIS will be tailored to the needs of women including screening for chronic diseases and cancer and will strengthen some of the maternal health packages. According to DHS 2014, Caesarean deliveries make up about 52 percent of all deliveries in Egypt, one of the highest rates globally. Given that cesarean deliveries involve greater risks of morbidity and mortality for both the mother and her baby, the new benefit package will price normal deliveries similarly to caesarean deliveries. Therefore, helping to reduce the increased risk of morbidity and mortality resulting from caesarean deliveries. This component will disburse based on verified achievements of six DLIs, which constitute Result Areas 2 and 3.
- **DLI 4: Supporting modular UHIS information system roll-out (US\$35 million).** This DLI will support capacity building for the roll-out of different essential IT modules required for the UHIS operations in terms of enrollment, provider management and claims management. The modules will be integrated within a currently under-developed backbone IT infrastructure that would link different modules as the system matures. Support will also

19 The Public Treasury will cover contributions for financially under-privileged persons who meet any of the following conditions: (1) The person or family entitled to cash support provided by Takaful and Karama Program and the Social Security Program; (2) The unemployed person or family head who is ineligible to or has exhausted his/her eligibility period to unemployment benefits and every dependent person in the family; (3) The person or family head with no bread-winner or income, who lacks family care and resides in a social or health care facility; (4) The disabled person or family head who cannot earn money or have any source of income, without prejudice to the Law on the Rights of Persons with Disabilities hereinabove; (5) Persons and families who reside in specific geographic areas and temporarily experiencing a natural or man-made disaster; (6) The person or family head whose average income does not satisfy his/her own needs or his/her family members' essential needs.



be extended to the procurement module managed by EASPMTM to ensure effective value-based supply chains for pharmaceuticals, medical equipment and technology for quality services by public UHIS providers. The new data infrastructure will be energy efficient. The following DLRs are proposed:

- DLR 4.1: Capacity building for roll-out of beneficiary enrollment and empanelment module within UHIA. (US\$10 million)
 - DLR 4.2: Capacity building for roll-out of provider empanelment module within UHIA. (US\$10 million)
 - DLR 4.3: Capacity building for roll-out of claim management module within UHIA. (US\$10 million)
 - DLR 4.4: Capacity building for roll-out of the medical procurement module within EASPMTM. (US\$5 million)
- **DLI 5: Strengthening accreditation and provider contracting (US\$18 million).** This DLI will support the achievement of results in UHIA contracts with a set of accredited service providers (by types of services including public versus private). This will ensure the realization of key UHIL principles, specifically: (i) provision of quality services by UHIS providers, (ii) freedom of choice for beneficiaries; (iii) private sector inclusion and a level playing field that is conducive to market competition. The DLR (also supports contracting of individual provider entities, regardless of their affiliation with bigger holding/ownership arrangements to boost their responsiveness and autonomy).
 - DLR 5.1: Number of hospitals accredited by GAHAR and contracted by UHIA in phase I Governorates. (US\$10 million) - (at least 20 of which are 5 non-governmental)
 - DLR 5.2: Number of individual pharmacies accredited by GAHAR and contracted by UHIA in phase I Governorates. (US\$2 million) - (at least 30 of which are 20 non-governmental)
 - DLR 5.3: Number of radiology services providers accredited by GAHAR and contracted by UHIA in phase I Governorates. (US\$2 million)- (at least 8 of which are 4 non-governmental)
 - DLR 5.4: Number of laboratory services providers accredited by GAHAR and contracted by UHIA in phase I Governorates. (US\$2 million) - (at least 15 of which are 10 non-governmental)
 - DLR 5.5: Number of ambulatory services providers accredited by GAHAR and contracted by UHIA in phase I Governorates. (US\$2 million) - (at least 15 of which are 5 non-governmental)
 - **DLI6: Strengthening provider payment (US\$20 million).** This DLI will enhance both UHIS and providers' financial sustainability through: (i) strengthening provider payment mechanisms to achieve an optimal payment mechanism mix (capitation, fee for service, per diems, lump-sum) to help improve efficiency and quality of contracted services; and (ii) strengthening UHIA's capacity to process payment for providers in a timely manner.
 - DLR 6.1: *Development and adoption of a provider payment mechanisms regulation by UHIA* (US\$5 million)
 - DLR 6.2: *Annual percentage of payments by UHIA that are paid in less than 60 days from the date of claim submission to UHIA by contracted providers in Phase I Governorates* (US\$15 million)

Result Area 3. Strengthening governance and creating a facilitating environment for UHIS (US\$ 37 million). This Result Area will support UHIS governance, promote social inclusion measures, boost climate mitigation and adaptation measures under UHIS, as well as monitor and evaluate the short to medium term effects of the roll-out of UHIS.

- **DLI 7: Social inclusion and governance (US\$22 million).**



- DLR 7.1: *Creation of coordination bodies for UHIS at the national level and in all Phase I Governorates* (US\$10 million). This DLR will support the creation of a suitable body that would act as a dialogue platform for the various public ministries, agencies, institutions, stakeholders, etc. that are involved in the policy, decision and implementation spheres of UHIS. It will also ensure equal representation for women and men.
 - DLR 7.2: *Dissemination of annual reports on patient satisfaction, grievances and utilization*. (US\$5 million). This DLR will support such reports as a means to take stock of client experience and feedback for UHIS to improve its people-centeredness and boost accountability of the system including issues pertaining to gender and vulnerable groups. It will present gender-disaggregated data including a gender analysis.
 - DLR 7.3: *Establishment of a one-stop shop for licensing of private primary care services* (US\$3 million). To facilitate private investments in primary healthcare services, this DLR will support the establishment of a one-stop shop within a suitable government agency for the licensing of private primary health care services.
 - DLR 7.4: *Development and adoption of a process guide for hospital accreditation standards by GAHAR* (US\$2 million). This DLR will strengthen the uptake, understanding and implementation of hospital accreditation tools by providers through the development and adoption of a process guide.
 - DLR 7.5: *Operationalization of a Big Data Analytics unit within UHIA* (US\$2 million). This DLR will support the creation and operationalization of such a unit which includes, inter alia, development of TORs, standard operating protocols, staffing, and capacity building of such a unit within UHIA. The unit will provide timely and in-depth analytics to inform UHIA decision making.
- **DLI 8. Development and adoption of a set of complementary regulations and strategies for UHIS (US\$ 15 million)**
 - DLR 8.1: *Revision of the strategy to target the vulnerable groups for UHIS subsidies in Year 3* (US\$7 million). The revision will be based on an assessment of the impact of subsidizing the vulnerable groups under UHIS as per the prime-ministerial decree (1948/2019) after 3 years of implementation. The assessment will report on differentiated impacts on women and men.
 - DLR 8.2: *Completion of a Strategic Environmental and Social Assessment (SESA) study to examine the environmental and social risks associated with the roll-out of the UHIS in Year 2* (US\$1 million). Such a study will inform the finetuning of safeguards measures for UHIS in general and project activities in particular. The assessment will follow the WBG guidelines for safeguards assessments based on the newly adopted WBG Environmental and Social Framework (ESF).
 - DLR 8.3: *Development and Adoption of a Green Health Insurance System Strategy by Year 3*. (US\$2 million). This DLR will support the development and adoption of a new 'Green Health Insurance System' strategy. The new strategy should be aligned with the 'Go Greener' initiative adopted by the GOE and will include mandatory measures over time including, but not limited to: (i) improved energy efficiency in health facilities; (ii) of a Climate and Health Vulnerability Assessment (CHVA); (iii) use of digital health records; (iv) promoting the use of Telemedicine; (v) use of local food sources; (vi) waste reduction; (vii) energy conscious sourcing and construction; and (viii) reduced usage of non-recyclables. DLR 8.3 will include climate adaptation measures, particularly through the promotion of telemedicine which can reduce the carbon footprint related to travel to health facilities.
 - DLR 8.4: *Satisfactory Adoption & Implementation of 3 hospitals (2 public and 1 non-public) of the Green Health Insurance System Strategy in target Phase I Governorates*. (US\$5 million). Disbursement will be made against



the verification that three hospitals have met the requirements under the adopted Green Health Insurance System Strategy.

31. **Component 3: Institutional Capacity Building, Technical assistance and Project Management (US\$7 million).** This component will support TA including capacity building and analytical activities for the establishment of the new UHIS. It will include support for UHIA, HCO, GAHAR, EASPMTM and the Economic Justice Unit (EJU) of the MOF. Project management and project monitoring and evaluation (M&E) will also be supported through this component.

I. **Project Management and Monitoring and Evaluation (US\$2 million).** This will include support for the Project Management Unit (PMU), training for MOHP staff, contracting Internal Verification Agency (IVA), Financial auditors. The support to the PMU will involve supervision activities, contracting of additional required staff to the PMU and costs of holding supplemental working groups.

II. **Institutional Capacity Building of the UHIS agencies to provide selected TA to strengthen the institutional capacity of the key relevant public-sector agencies involved in the delivering the different functions of UHIS (US\$5 million).** It will also provide technical assistance and research support for the roll-out of the Universal Health Insurance System, its pertinent financial and actuarial sustainability and various project activities. Specifically, the component will support the following activities by agency:

Economic Justice Unit at MOF (US\$1.5 million): Within its capacity to monitor, evaluate and follow-up on the financial sustainability and results of the major MOF supported programs, the project will support EJU to:

- Revise and update the actuarial model of the UHIS by year 4 of the project and as stipulated by the UHIL.
- Conduct yearly studies to evaluate the efficiency of the existing financial revenues and for UHIS to ensure the financial sustainability of the system. This will include exploring the possible new financial sources for UHIS with their expected social and financial impact, as well as, their impact on the efficiency of other existing general budget resources, when they materialize.
- Train staff on gender-sensitive data management (collection of sex-disaggregated data, development of gender analysis, etc.).
- Build capacity of designated staff who will be tasked with the M&E functions for UHIS.

UHIA (US\$1.5 million): Within its role as a national payer for UHIS, the project will support institutional capacity building for UHIA to strengthen and enhance designated staff ability on:

- Pre-authorization functions to service providers.
- Claims processing and fraud control management using automated tools.
- Business process definitions, design and production of the business processes manual.
- Training for staff on: i) the usage, interpretation, analytics of the electronic dashboards of the UHIS information system and ii) healthcare financing tools and analytics.

HCO (US\$500,000): Within its mandate for operating all public primary care facilities and secondary and tertiary hospitals, the following will be conducted:



- Institutional capacity building on building the internal financial systems and capacity within the costing, claims and internal audit departments.
- Strengthen the capacity of the Human Resources (HR) department through staff training and developing staffing and staff compensation plans for the organization including relevant Key Performance Indicators (KPIs).
- Develop and finalize internal clinical protocols to be streamlined across affiliated facilities.
- Conduct a study to how to institutionalize a homecare-based model of care of nursing and physiotherapy.

GAHAR (US\$1 million): Within its role as the accreditor, quality auditor and regulator of the UHIS, the project will support GAHAR realize and achieve certain elements of its strategic plan. The plan calls for a set of programs that will enable GAHAR to perform its main core functions under the UHIS. The following programs will be supported:

- Healthcare accreditation and registration program: Complementing the project results-based support under Subcomponent 2.1 through DLI5 for finalization, adoption and field implementation of the accreditation tools, the project will also support the surveying capacity of GAHAR for accreditation purposes by training 30 surveyors and financing nearly 100 surveying visits to different types of provider facilities.
- Clinical governance program: Aiming at building a clinical governance audit program, the project will support: (i) phased development of clinical standards, guidelines and protocols for clinical services; (ii) Training and continuous development of nearly 100 clinical auditors; (iii) develop a clinical audit process design; and (iv) development of clinical measures, data collection and reporting mechanisms.
- Egypt Certified Auditor Program (EGYCAP): Aiming at training staff affiliated with different healthcare providers on developing internal quality auditing skills, the project will support the curricula setting, trainer readiness if the EGYCAP program, as well as the selection of, training and certification of 50 graduates in the early phases of the program.
- Self-Assessment Program: The project will finance the development of the required tools for the technical skills of 10 GAHAR staff on the institutional self-assessment mechanisms with the purpose to create an internal audit and anti-corruption functions.

EASPMTM (US\$500,000): This agency will be responsible for procuring pharmaceuticals, consumables and medical equipment as well as managing the efficient use of medical technology within all publicly owned healthcare facilities and hospitals including those which are funded by development partner organizations. The organization will also carry out the functions of Health Technology Assessments (HTA) on behalf of all public healthcare facilities. In this context, with the scope of this project, support will be provided for the following:

- Development and institutionalization of an International Medical Procurement Department (IMPD) within the organizational structure of EASPMTM. The support will enable IMPD to handle procurement operations based on international best procurement practices including those which are funded by international development partners. Specifically, the project support will encompass the following activities: (i) setting procedures and regulations; (ii) selection and training of staff on national and international procurement regulations; (iii) provision of the required IT tools and software packages for smooth operations of the unit; and (iv) on-the-job training during actual procurement activities. It is to be noted that the WBG procurement department will heavily be engaged in providing the needed support to this institutional capacity building activity.



- Institutional capacity building of the Health Technology Assessment Unit (HTA unit): The support will enable the HTA unit to progressively handle advanced evaluations of all health technologies (pharmaceuticals, equipment, etc.). Specifically, the project support will include: (i) selection and technical capacity building of staff; (ii) partnering with a world renowned HTA academic institution to provide technical and skill transfer training to designated staff; and, (iii) financing of required IT software packages and office computers.

Legal Operational Policies

	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Areas OP 7.60	No

Summary of Assessment of Environmental and Social Risks and Impacts

32. **Based on identified potential risks and impacts and in accordance with the MOF prepared key documents, including the Social Impact Assessment (SIA), Stakeholder Engagement Plan (SEP), and Environmental and Social Commitment Plan (ESCP).** The SIA has identified and analyzed the potential risks and impacts of the project, and proposed mitigation measures to maximize social benefits and minimize potentially negative impacts.

33. **Environmental risk is moderate.** As the project will not support any healthcare supply-side activities or physical interventions including construction, rehabilitation or provision of medical services, no major direct environmental risks are expected. The relevant ESSs were determined to be: ESS1, ESS2, ESS3, ESS4 & ESS10.

34. **Under DLR 8, a Green health insurance system strategy will be developed in year three, to channel environmental benefits into better healthcare service provision, through developing performance standards.** Those standards will incentivize healthcare facilities to adapt energy and resource efficiency measures. Healthcare service providers will be enrolled and accredited in the new health insurance system by meeting several performance standards developed by GAHAR including GAHAR’s Environment and Health and Safety Standards (EHSS). The WBG conducted a gap analysis between GAHAR’s EHSS and the WBG Environment and Health and Safety guideline (WBGEHS) for health care facilities. The gap analysis concluded that the GAHAR EHSS and the national standards are aligned to a great extent with WBGEHS for healthcare facilities in terms of management of environmental risks associated with health care services, including air emissions, hazardous materials and waste, occupational health and safety, infection control and wastewater effluent.

35. **The main indirect environmental risk during the roll-out in Phase I is an increase in the generation of health care waste streams at the national level due to potential increases in health care service utilization.** The project design has therefore integrated the preparation of a SESA in year two to assess and examine the potential impacts of the rolling out of the UHIS at the national level. The development and implementation of the SESA is committed to in the project ESCP. Additionally, at the project governorate level, monitoring of different waste streams will be carried out and



documented in the enrolled health care service providers and aggregated at the project management unit level to be reported quarterly.

36. **The project is expected to contribute to considerable positive results, including extending coverage to an estimated six million individuals in Phase I Governorates.** The UHIS is expected to reduce the burden of OOP expenditures and achieve financial protection to virtually all citizens in Phase 1 Governorates during the project period. It will also offer non-contributory coverage for disadvantaged groups²⁰, who are estimated to be more than two million people in the Phase I Governorates. Exemption of these groups from paying both premiums and copayments is expected to encourage them to utilize healthcare, whenever necessary, and protect them from getting trapped in poverty due to OOP expenses and loss of livelihood due to illness. The UHIS expands financial coverage to non-working women, unlike the out-phasing system, which excludes such vulnerable categories. It is also anticipated to contribute to delivery of good quality services, through provision of TA and capacity building to GAHAR. Adopting a “people-centered” approach in the standards for healthcare facility registration and accreditation is a real shift in paradigm in the delivery of healthcare services in Egypt and is well aligned with the stakeholder engagement requirements of the project. The project is expected to secure more citizen engagement through establishment and/or support of platforms necessary for the citizens to be able to provide their feedback, concerns, and complaints on any aspects pertaining to the new system.

37. **The draft SIA demonstrated that the project may encounter several potential social risks and impacts.** These include: (i) some lack of public acceptance due to cultural challenges and lack of trust in the general practitioners' capacity (gate-keeping system), which is a core shift that the UHIS is introducing; (ii) in the quality and even coverage of services; (iii) exclusion of vulnerable populations due to targeting errors; (iv) financial burdens on the near-poor; (v) limited institutional capacity and inability to deal with social risks; f) inability of small private clinics to be part of the new system, due to registration and accreditation requirements, which could be challenging for them; and g) double insurance payments, for example by private sector employees, who already have private insurance coverage. Mitigation measures have been proposed in the SIA to ensure that potential risks and impacts can be managed.

38. **The SEP identified and analyzed the project's key stakeholders and interested parties; outlined a strategy for engagement; and assessed existing grievance redress mechanisms and information disclosure channels, as well as provision of the necessary measures for addressing identified gaps.** The SEP has set a systematic and inclusive approach for communication and information sharing that will be followed by the different groups of stakeholders. This is in turn expected to contribute to minimizing the potential social risks and impacts of the project and proactive addressal of grievances and concerns. The ESCP, which forms part of the legal agreement of the project, sets out time-framed measures and actions that the GOE shall commit to, in order to ensure that potential adverse project risks and impacts are avoided, reduced, or mitigated. While the ESCP will be part of the project legal agreement, the GOE commits to follow an adaptive management approach, which provides a room for proper handling of risks and impacts that may emerge, throughout the project lifecycle, due to any unforeseen circumstances.

39. **Identified project benefits and risks went through different rounds of consultations with stakeholders.** Following the SEP, the consultation, information disclosure and engagement with different groups of stakeholders should

²⁰ Prime Minister's decree 1948/2019 has defined six groups as disadvantaged: 1) beneficiaries of the cash transfer programs (Takaful and Karama, as well as the social security pension); 2) the unemployed person or family head who is ineligible to or has exhausted his/her eligibility period to unemployment benefits and every dependent person in the family; 3) the person or family head with no breadwinner or income, who lacks family care and resides in a social or health care facility; 4) the disabled person or family head who cannot earn money or have any source of income; 5) Persons and families who reside in specific geographic areas and temporarily experiencing a natural or man-made disaster; 6) The person or family head whose average income does not satisfy his/her own needs or his/her family members' essential needs.



continue as a process during the project's lifecycle. The project's involved entities, namely UHIA, GAHAR, MOF, HCO, and MOHP have conducted several rounds of consultation and outreach. For instance, GAHAR has been very proactive in reaching out to and consulting with the different groups of service providers including public and private hospitals, clinics and NGOs. GAHAR also ensures to update the registration and accreditation standards to reflect the different needs of beneficiaries in different geographic locations. For example, they are currently finalizing a set of standards that further accommodate office-based practice (rather than larger facilities) in areas where the population is widely-dispersed, such as in South Sinai.

40. **The MOHP and the HCO have led several consultation and awareness raising events** with different groups of beneficiaries in the targeted governorates with a focus on Port Said, Luxor and South Sinai, in light of the gradual expansion of the system. The primary target of the HCO is the citizens/project beneficiaries. Outreach to local tribes in different districts in South Sinai has been done to share information about the project, get feedback and also to get the beneficiaries registered to the new system using locally appropriate modalities (e.g. mobile campaigns in difficult-to-reach areas) that make it easy and less costly for citizens. The same approach has been followed in Luxor districts. In addition to field (face-to-face) campaigns, different stakeholders disseminate UHIS-related information on their social media platforms on a regular basis. Such platforms include, for example, the Facebook pages run by the MOHP (about 800,000 followers) and UHIA (about 10,000 followers). Moreover, senior respective officials appear very often on TV, radio, and newspapers to disseminate information on the new system and respond to concerns of the people.

D. Implementation

Institutional and Implementation Arrangements

41. **The project will be implemented by the MOF through a Project Management Unit (PMU) that will include government and contracted staff.** The PMU, under the supervision of the MOF EJU, will be responsible for day-to-day project implementation, overall fiduciary activities, documentation, contracting of consulting and non-consulting services, M&E and reporting to the MOF and the Bank on all aspects of the project. The PMU will prepare a Project Operational Manual (POM), expected to be completed prior to project effectiveness, detailing the operational procedures to be followed and the roles and responsibilities of PMU staff, which may be adjusted to reflect any changes made to project design, implementation arrangements, or fiduciary oversight. The PMU will have dedicated M&E staff who will be responsible for regular data collection and analysis, regular reporting on the status of the Results Framework Indicators including reporting on DLIs and disseminating lessons from the project. In addition, an annual external audit, combining both technical and financial audit components, will be conducted to ensure the appropriate use of funds and to monitor physical progress in the targeted activities and governorates. Achievement of DLIs will be verified by an independent verification agency.

42. **A Steering Committee (SC) will be established not later than three months after effectiveness.** The SC will be responsible for overall project stewardship, oversight and monitoring of implementation progress. It will include heads of the main agencies involved in the UHIS (UHIA, HCO, GAHAR and EASPMTM) and representatives from relevant ministries (MOF, MOHP and Ministry of Planning, Monitoring and Administrative Reform). It will be chaired by the Minister of Finance and with the PMU coordinator serving as the Secretary. The SC will meet at least every six months, and its main tasks will be to: (i) review policy issues relevant to the achievement of project objectives; (ii) approve annual work-plans and budgets; and (iii) review project progress reports and take appropriate actions to support project implementation.



CONTACT POINT

World Bank

Amr Elshalakani
Senior Health Specialist

Elizabeth Mziray
Senior Operations Officer

Borrower/Client/Recipient

Ministry of Finance

Implementing Agencies

Ministry of Finance
Mohamed Maait
Minister
mamaait@mof.gov.eg

FOR MORE INFORMATION CONTACT

The World Bank
1818 H Street, NW
Washington, D.C. 20433
Telephone: (202) 473-1000
Web: <http://www.worldbank.org/projects>



APPROVAL

Task Team Leader(s):	Amr Elshalakani Elizabeth Mziray
----------------------	-------------------------------------

Approved By

Environmental and Social Standards Advisor:		
Practice Manager/Manager:		
Country Director:	Robert Bou Jaoude	31-Mar-2020