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

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*Executive Summary; October 2005*

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# Abstract

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

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# Executive Summary

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

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

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

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

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

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

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

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

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

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

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

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

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