ANNEXES

Annex 1
Action Fiche : Health Sector Policy Support Programme - II

1. IDENTIFICATION

Title/Number	Health Sector Policy Support Programme - II ENPI/2009/020-494		
Total cost	110,000,000 €		
Aid method / Method of implementation	Sector Policy Support Programme Sector budget support (centralised management)		
DAC-code	12110	Sector	Health sector policy

2. RATIONALE AND COUNTRY CONTEXT

2.1. Country context and rationale for SPSP

2.1.1. Economic and social situation, poverty analysis

Egypt's economy experienced another year of sound macroeconomic performance in 2008, although growth slowed down in the second half of 2008 on the back of the global financial crisis. As in other emerging economies, the crisis in Egypt is mainly affecting the real economy. As reported in the latest IMF Article IV consultation report[1] the Egyptian economy may experience a decline in its growth rate to 5.5%-4.5% in the next two years compared to the 7% average of the 2005-2008 period. On the other hand the inflationary pressures seem to have come to a halt, and the outlook for the 2009-2010 period sees inflation decline to 8-12% (compared to 20% of December 2008). Unemployment will be affected by slower economic growth in the near to medium term and poverty reduction targets may be challenged. The current subsidy system (food aid and cash transfers) benefits close to 50 million people out of a population of 75 million, making a significant impact on public expenditure and fiscal policy options. The Egyptian government will have to balance the prerogatives of economic and social reform (e.g. removing costly subsidies) and its response to the international economic slowdown while maintaining social protection for lower income groups.

2.1.2. National development policy

Egypt's long-term development programme is set out in its National Plan 1997-2017. This has been accompanied by a series of five-year socioeconomic plans, the latest of which for 2007-2011 focuses on: (1) improvement of living standards and social security, (2) economic growth and job creation, (3) strengthening of state institutions and political reform. Key targets of the plan are the reduction of poverty from the 20-18% rate of 2006-2007 to 10% by 2011/12 and the decrease in unemployment to 5.5 % by 2012. 43% of the population are living on less than $2 per day. In view of the projected economic slowdown, these targets may not be met by the projected deadline, but they are expected to remain feasible in the longer-term. The MDG Mid-

[1] Article IV Consultations – IMF Staff Report December 2008

term Report (2008) shows that the Egyptian government's progress towards MDG targets is slow but consistent.

2.2. Sector context: policies and challenges

The Government's health reform plan for achieving universal health coverage embraces: (1) the establishment of a purchaser body in each governorate in order to separate the purchaser from the provider functions, (2) the building of a single payer financing system covering the primary health care services with the Basic Benefits Package, (3) the development of a partnership with the private sector invited and encouraged to provide services, (4) the roll-out of the Family Health Model (FHM) for reforming the Primary Health Care (PHC) level.

In Suez[2], a well designed pilot project, which merges Health Insurance Organisation (HIO) and the Family Health Fund (FHF) is being implemented. Furthermore, experience is being accumulated in the four other governorates where FHF has been developed. An actuarial study has been conducted by the Ministry of Finance, and a draft health insurance law was prepared for reading by parliament. During the entire period of the reform, the EC Delegation will remain attentive to the financial mechanism put in place to cover the expenses of the poor.

The roll-out of the FHM includes the physical upgrading, a redefinition of the staff pattern, an intensive training programme, an accreditation of health facilities, and a census of community households including poor families. The FHM ensures access to efficient and good health quality services in accordance with the epidemiological profile of the population. The target is 330 additional accredited units per year during the period 2010-2012.

Since salaries are low, incentives are a crucial element of the structure of the Family Health Model to ensure its sustainability: human resources stability (attraction) and financial balance. The application of the new incentive policy introduced by the generalisation of the decree 075 will be followed by the EC Delegation. In particular, the EC Delegation will monitor the legal provisions relating to staff incentives and the contracts between the FHF and FHU with respect to their ability to balance conflicting requirements of financing, financial sustainability and of ensuring a satisfactory level of staff motivation)

In terms of budget, the sector accounts for 6.1% of GDP, with a total of 10.6 billion LE for 2007-2008 distributed as follows: employees' salaries and compensations (45%), goods and services (29%), subsidies, grants and social benefits (13%), and investments (10%). The health sector expenditure framework is established annually and on incremental basis. Multi-year projections are presented in the first phase of the National Investment Plan (2007-2010) that supports the expansion of the FHM for a total of 2,180 billion LE (corresponding to the development and/or the establishment and the equipment of a total of 2,214 FHUS). However, based upon progress made so far with broadly 1300 FHUs refurbished, it would suggest that the MoH is capable of developing or establishing 330 FHUs per year. While this is nearly one-per-day, it does imply that it will take broadly three more years to achieve the plans objectives. An extension of the investment plan (2010-2011) is foreseen and will be submitted for the approval of the cabinet of the Minster of Health.

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[2] The EC Delegation considers the monitoring of the Suez project as an essential part of the ongoing Policy Dialogue maintained with the GoE and international partners.

The reform process is coordinated by the Ministry of Health and Population (MoH), with the Ministry of International Cooperation managing donor relations. Within the MoH, the Technical Support Office (TSO) plays an important role in the reform process by planning, monitoring and coordinating the actions of the different departments. The institutional capacity of the MoH, has indeed improved in the past years thanks to the adoption of a new internal organization which prioritizes Primary Health Care (PHC) and medical quality, and the integration of all PHC programmes under a single authority. Donors' capacity building activities and the Government's own training programmes have also contributed to this achievement. A new computerized network (on-line system), the Clinical Information System (CIS), recently replaced the Health Information System (HIS), and covers 249 Family Health Units (FHU). Demographic Health Surveys (DHS) are carried out every three years and provide reliable information for monitoring purposes.

2.3. Eligibility for budget support

Sector policy: A health sector strategy is in place and its component for the roll-out of the Family Health Model on a national scale is clearly defined. An investment plan and an accreditation programme are already ongoing, supplemented by a plan for primary health care programmes output. In a situation where the overall reform of the health care system and the introduction of mandatory social health insurance are still in their infancy, the choice of supporting the sub-sector of primary care is a judicious decision

Macroeconomic stability: Egypt's overall macroeconomic context remains relatively stable although it is inevitably affected by the negative impact of the international crisis on the real economy. A set of measures to support growth – including a fiscal stimulus to public infrastructure expenditure, acceleration of public-private partnerships, cuts in policy interest rates and other revenue boosting measures are expected to balance expenditure and keep the budgeted fiscal of 6.9% for 2009 on target. These measures to sustain the pace of reform in the face of the international economic slowdown appear reasonable and adequate to support the medium-term fiscal consolidation plan and boost investment. The impact on trade, investment and the rest of the real economy is being monitored closely.

PFM: Progress has been made since mid-2004 toward improving PFM systems in Egypt, as confirmed by latest CFAA report and the ongoing PEFA exercise. Achievements include better budget performance, greater accountability of the budget authorities and more budget transparency. The Government is committed to continue its reform plans and as long as the government continues to implement and consolidate its ongoing PFM reform programme the fiduciary risks will continue to decline. The EC will build upon the PEFA exercise to strengthen dialogue on PFM reform issues with the Egyptian government and other donors.

2.4. Lessons learned

The final evaluation report of the Health Sector Reform Programme (HSRP, 1998-2008) stated: the reform of the public primary health care services centred on Family Health Practice is in place, the rolling out of the model can no longer be delayed too long. Regarding the ongoing HSPSP, the MEDA evaluation reported that its Policy matrix does not reflect current EC sector policy guidelines. The Result Oriented Monitoring (ROM) report underlined that the SPSP approach is appropriate as it accompanies the sector reform initiative of the government, but it also highlighted that the HSPSP is very ambitious and complex, imposing fairly high transaction costs

for the GoE. The EC Delegation, however, has been able to develop a Policy Dialogue of good quality and to work with the national authorities for the implementation of an effective SBS. The design of the HSPSP-II takes into account the conclusions of these reports and the lessons learned through implementation of the ongoing HSPSP.

2.5. Complementary actions

Major donors in the health sector include the World Bank, the African Development Bank, Saudi Arabia, USAID, DANIDA and the Italian Cooperation. The World Bank will provide Egypt with a new loan of 75 M$ for the implementation of the insurance component of the reform. USAID has been implementing a large Reproductive Health Integrated Project which covered 192 Family Health Units. Other donors are active on a smaller scale.

2.6. Donor coordination

The DPG Health Sector Sub-Groups provides an effective platform for sector policy coordination and for information exchange among donors. The EC Delegation will take the opportunity of the HSPSP-II to enhance donor coordination and the Policy Dialogue already in place, on health issues, in particular on the primary health care provider network and Family Health Model.

3. DESCRIPTION

Given the complexity and the long term timeframe for the introduction of the mandatory social health insurance, the priority has been given to the development of the well-defined Family Health Model programme. Therefore, this intervention will focus on the improvement of the Primary Health Care provider network which, by being the backbone of the Health Sector Reform, will better provide the whole population and especially the poor, with access to affordable basic quality health care.

The EC Delegation will propose a TA to support: (1) the supervision of the surveys that will be conducted, (2) the monitoring of the financial sustainability versus incentives and coverage of the poor, (3) to address questions related to the PHC management.

3.1. Objectives

Overall objective: To support the Health Sector Reform Programme in Egypt by improving access to and quality of Public Primary Health Care. This overall objective will be sustained by three specifics objectives:

Specific objective 1: The quality of the services provided by the Public Primary Health Care network is improved.

Specific objective 2: The utilization and satisfaction rates of the upgraded Public Primary Health Care network facilities are improved.

Specific objective 3: The systemic, social and financial sustainability of the Family Health Model is strengthened.

3.2. Expected results and main activities

Each specific objective is sustained by expected results:

1. Expected results sustaining the specific objective 1:

Around one thousand Health Care Units will be physically reconditioned and the personal will be trained to reach Family Health Units standard requirements, in order to be accredited according to internationally approved Standards.

2. Expected results sustaining the specific objective 2:

Within the catchment area, the utilization rate of the upgraded Health Facilities by the population and especially by the poor will be increased (including for the reproductive health services and family planning). The rate of satisfaction for the population using these facilities will increase.

3. Expected results sustaining the specific objective 3:

The proportion of the catchment area's population enrolled in the Family Health Fund will increase and the number of FHU/Cs establishing a contractual relation with the Family Health Fund (or a similar health public purchaser) will increase. As a consequence, the out-of pocket money (paid by visit) earmarked to health will decrease.

These specific objectives and the expected results entail not only a quantitative and qualitative improvement of the primary health care services (through the roll-out of the Family Health Model), but also address the utilisation rate of these services, and the financial access of the beneficiaries by reducing the amount of out-of-pocket money earmarked to health.

4. Monitoring:

In agreement with the Egyptian authorities, indicators related to access, utilisation, equity, quality and sustainability have been added in the matrix, since the programme looks into the effects of the rolling-out of the FHM model on the population’s access to and satisfaction of services provided there. The use of household surveys for the monitoring of the programme has been discussed with the Deputy Minister for PHC and his team.

3.3. Assumptions and risks

It is assumed that the health sector reform process will keep up its political momentum and that the national investment plan covering the PHC and the expansion of the Family Health Model will be concluded before the start of the SBS and the first tranche release. There are some uncertainties related to the financial sustainability of the reform objectives. The EC Delegation will monitor the development of the reform in order to suggest appropriate measures to reduce the risks and offer technical assistance when appropriate and necessary.

3.4. Stakeholders

The main stakeholder is the MoH. Other stakeholders include the Ministry of Finance responsible for health financing and the Ministry of Social Solidarity (MoSS) mandated to cover the insurance for the poor. The physicians and nurses working at the FHU/C level are also important stakeholders. Civil society is represented at FHU/C governance board level. The success of the reform will also depend on the public debate organised with Non State Actors and on the quality of the social dialogue. Therefore, the EC Delegation will address these topics through Policy Dialogue while remaining attentive to the legislation and the regulatory activities developed by the GoE to set the parameters for the new system.

3.5. Cross-cutting Issues

Poverty reduction is the overarching objective of Egypt's National Development Plan which this programme will support by focusing, among others, on increasing access to health care for the poor. Access to, and quality of, health care also has a strong basic human rights dimension.

4. IMPLEMENTATION ISSUES

4.1. Method of implementation

Direct centralised management.

4.2. Procurement and grant award procedures

Service contracts related to the technical assistance and monitoring, audit and evaluation of the programme will be awarded and implemented directly by the Commission in accordance with the procedures and standard documents laid down and published for the implementation of external operations, in force at the time of the launch of the procedure in question.

4.3. Budget and calendar

The total amount of the programme is €110 million. €107.7 million will be earmarked for budget support: the first, second and third tranches will indicatively be €30 million each, the last tranche will indicatively be €17.7 million. The four annual fixed tranches will be released after the Commission services ascertain that the conditions for each instalment are met. The programme will allocate €2 million for Technical Assistance and €300,000 for monitoring, audit, visibility and evaluation purposes. The operational implementation phase will last 36 months.

4.4. Performance monitoring and criteria for disbursement

A Steering Committee (SC) shall be in charge of the follow up of the programme activities as well as the general progress of the reform of the sector. The SC will periodically review progress against the matrix of conditions and it may invite anytime to representatives from any other Government body or private sector organization considered relevant for the programme in order to facilitate the follow up of the reform measures.

The National Coordinator will prepare, under the supervision of the Minister of Health, an plan for activities foreseen under the technical assistance component.

Implementation of the programme will be monitored regularly by the European Commission's services in close cooperation with the Steering Committee and the National Coordinator. Continuous dialogue will take place between the European Commission and key stakeholders. Monitoring missions will take place at least once a year and will be arranged with reference to: (i) Fulfilment of the conditions for disbursement of instalments and (ii) The general progress of the programme.

In order to prepare the disbursement of the different tranches, a dialogue with the Steering Committee will be organised annually at the end of each semester and before each annual disbursement, in order to discuss progress of the programme on the basis of the indicators chosen.

Standard Indicators (SI) for a project or sector financed by the EC are designed to measure the effect of aid and to be better accountable for aid operations. SIs are also part of the dialogue with the partner country.

4.5. Evaluation and audit

An external evaluation, contracted by the Commission, will be carried out at the end of programme. If needed, monitoring mission will be carried-out by the EC Delegation or external monitors under the ROM system.

4.6. Communication and visibility

The entire action will follow the "Communication and Visibility Manual for EU External Actions" issued by EuropeAid. Proper communication and visibility of the action will be achieved via regular joint communication events on the occasion of tranche release.