Project Information Document (PID)

Concept Stage | Date Prepared/Updated: 13-Dec-2019 | Report No: PIDISDSC27978

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Parent Project ID (if any)	Project Name
Egypt, Arab Republic of	P172426		Supporting Egypt's Universal Health Insurance System (P172426)
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
MIDDLE EAST AND NORTH AFRICA	Jan 12, 2020	Mar 31, 2020	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Ministry of Finance	Ministry of Finance	

Proposed Development Objective(s)

To increase the coverage of Egypt's Universal Health Insurance System (UHIS) in Phase 1 Governorates and to strengthen UHIS-related governance and institutions

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	511.28
Total Financing	510.00
of which IBRD/IDA	510.00
Financing Gap	1.28

DETAILS

World Bank Group Financing

International Bank for Reconstruction and Development (IBRD)	510.00

Environmental and Social Risk Classification	Concept Review Decision
Substantial	Track II-The review did authorize the preparation to continue

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's programmatic Development Policy Financing (DPF) and the International Monetary Fund's 3-year Extended Fund Facility. As a result, Egypt's sovereign credit outlook was upgraded to 'positive' by rating agencies.

2. Economic activity is picking up and macroeconomic imbalances are narrowing. Real Gross Domestic Product (GDP) growth increased to 5.6 percent in fiscal year 2019, up from 5.3 percent in FY18, and compared to an average of 4.3 percent over the previous three years.1 Meanwhile, inflation declined to 4.8 percent in September 2019, 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 97.3 percent of GDP at the end of FY18. External accounts are improving, supported by a narrowing current account deficit and a surge in capital inflows in the form of sovereign bond issuances and external borrowing. Net international reserves reached US$45.1 billion by the end of September 2019, covering around 8 months of merchandise imports.

3. Fiscal consolidation measures have helped reduced inefficient and unsustainable public spending. However, the health and education sectors have yet to see benefits. Despite a constitutional mandate to increase spending on education and health to 6 percent and 3 percent of GDP (respectively), 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 - well below their constitutional targets.3

4. Socioeconomic conditions remain difficult, as high inflation over the course of FY17 and FY18 has resulted in the erosion of real incomes. The national poverty rate increased to 32.5 percent in FY18 – compared to 28.5 percent in 2015 - with higher rates concentrated in rural Upper Egypt. Regional disparities are an enduring characteristic, with Upper Rural Egypt continuing to lag behind other regions, and poverty rates reaching as high as 60 percent in some governorates. The Government of Egypt (GOE) has scaled up social protection measures through higher allocations for food subsidies through smart cards and targeted cash transfer programs to mitigate the adverse effects of the economic reforms. Yet, these

[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 -8.3 percent and 1.9 percent of GDP, respectively in FY19, from -9.7 percent and 0.1 percent of GDP a year earlier.

[3] The share of public spending on health and education includes debt servicing for both sectors and the provision of drinking water and sanitation for the health sector.

efforts need to be complemented with efforts to improve targeting, widen coverage, and enhance service delivery, and to transit into a wider concept of safety nets.

5. 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.

Sectoral and Institutional Context

6. Egypt has made significant health progress since 1990. Its maternal mortality ratio declined from 106 to 37 deaths per 100,000 live births and infant mortality rate fallen from 60 to 18 deaths per 1,000 births between 1990 and 2017. Egypt was able to achieve the Millennium Development Goals (MDGs) 3 and 4, focused on promoting gender equality and empowering women and improving maternal health, respectively. However, following rapid improvements in the 1990s and early 2000s, health progress has been considerably slowing down. s 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.

7. Disparities persists with rural, remote and slum areas having the poorest health outcomes and inadequate medical services, especially basic health services such as maternal and child health. Upper Egypt and the border governorates as 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]

8. Egypt is also facing a growing burden of non-communicable diseases (NCD), mainly due to poorly controlled risk factors. NCDs now account for an estimated 82% of all deaths and 67% of premature deaths in the country . Ischemic heart disease and cerebrovascular disease are the leading causes of death[5]. Egypt has the highest obesity rate among the world's 20 most populous countries.[6] The recent national screening campaign under the '100 healthy lives' program funded by the World Bank showed that out of the 53 million screened adults (>18 years), 6% were diabetic, 26% hypertensive and 70% overweight.

Table 1: Selected Health Outcomes Indicators for some Low Middle-Income Countries (2017)[7]

	Egypt	**Indonesia**	**Pakistan**	**Tunisia**	**Ukraine**	**Nigeria**	**Morocco**
Life Expectancy at Birth (years)	72	71	67	76	72	54	76

[4] Egypt Demographic & Health Survey 2015
[5] IHME, (2014)
[6] Global Burden of Disease, (2017)
[7] World Bank Open Data

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

9. Egypt's demographic transition has not been consistent. Between 2000 and 2006, its Total Fertility Rate (TFR) declined from 3.4 to 3. However, over the next decade, this quickly reversed with a steady increase in fertility rate reaching 3.87 in 2017. Between 2012-2015 alone, Egypt registered the highest absolute increase in population in its history with 9.5 million people8. Egypt's population surpassed 100 million in 2019 and is expected to reach 128 million by 2030 and 150 million by 2050 (UN Population Projections).

10. The Egyptian healthcare system faces multiple challenges to improve and protect the health and well-being of a fast-growing population. The rise in non-communicable diseases (NCDs) and a high birth rate combined with a longer life expectancy is putting additional pressure on the system and expected to increase health care costs. against the context of limited government resources and constrained public finances.

11. Furthermore, Egypt's health system is fragmented, vertically organized and highly centralized with little communication and interaction between institutions and different levels, resulting in considerable disconnects between health policies and local needs.910 The health care system is highly pluralistic, with many different public and private providers and financing agents. Health services in Egypt are currently managed, financed, and provided by different agencies in all three sectors of the economy: government, parastatal, and private. The government sector consists of integrated delivery systems maintained by various line ministries in which there is no separation between financing and service provision functions.

12. The parastatal sector is composed of three quasi-governmental organizations: the Health Insurance Organization (HIO), the Curative Care Organization (CCO), and the Teaching Hospitals and Institutes Organization (THIO). From an operational and a financial perspective, the parastatal sector is governed by its own set of rules and regulations, has separate budgets, and exercises more autonomy in their daily operations. However, from a political perspective, the Ministry of Health and Population (MOHP) has a controlling share of decision making in parastatal organizations. The HIO is financed through premiums and government budget to provide health insurance for civil servants and children (around 58% of the population). The CCO which covers a myriad of secondary hospital servies is financed through the government and private contracts to provide services for…. The THIO, tasked with running tertiary hospitals that provide training to MOHP employed health professionalsis financed by the government with the objective to…while the Program of Treatment on the Expense of the State (PTES) is financed by the government and HIO referrals.

13. The private sector includes for-profit and non-profit organizations, which include traditional private pharmacies, private doctor clinics, and private hospitals of all sizes. Private sector participation in primary care services remains

[8] CAPMAS, Annual Report, (2018_

[9] World Bank, 2016

[10] Pande A, Abdel-Hamid A and A Elshalakani, Amr. (2015). A roadmap to achieve social justice in health care in Egypt. Washington, D.C. : World Bank Group. http://documents.worldbank.org/curated/en/508181468000283284/A-roadmap-to-achieve-social-justice-in-health-care-in-Egypt

negligible. Notably, major providers of tertiary and specialized health services are concentrated in large urban cities due to a substantial lack of regulatory incentives to attract private providers into regions such as Upper Egypt and Delta Governorates which typically demonstrate higher rates of poverty and modest human development indicators. Further, owing to a business model relying on out-of-pocket (OOP) payments, major private service providers shy away from investing in the typically poorer regions of the country. Furthermore, there are many non-governmental organizations (NGOs) providing services, including religiously affiliated clinics and other charitable organizations, all of which are registered with the Ministry of Social Solidarity.

14. The Egyptian health system is not positioned to deliver high-quality health services to meet the most pressing needs of its population. Although more than 95% of the population lives within 5 kilometers of a health facility, facilities are often ill-equipped to respond to the real needs of the population in their catchment areas Grim conditions at dilapidated state-run facilities, regular medication stock-outs due to outdated and inefficient supply chains, lack of updated and enforced clinical guidelines for managing chronic diseases and limited numbers of specialists have been widely reported.11. As such, quality of care is often poor, leading to low utilization and reduced health benefits.12

15. Most healthcare jobs are low-paid and provide no incentive for performance. Medical providers receive life-time licensing with no continuous medical education requirements. Dual practice is allowed with no restrictions by law and therefore rampant.

16. Egypt is one of the lowest healthcare spenders in the Middle East and North Africa (MENA) region with heath expenditure at 1.4 percent of Egypt's GDP. Only 5.6 percent of total government budget is spent on health, accounting for 38% of the total health expenditure (THE) . Thus, more than half of THE (61%) is out-of-pocket payment (OOP).13 In addition to low health spending, systemic inefficiencies and inequities in health financing limit the effectiveness of the healthcare system. There are three major financing flows: (i) from MOF to MOHP facilities through the MOHP budget; (ii) from the Social Insurance Organization and MOF to HIO; and (iii) from households (OOP expenses) directly to private providers and pharmacies. Families in the lowest income quintile spend 21 percent of their income on healthcare-related costs, versus 13.5 percent for those in the highest income quintile.14

17. Approximately 90% of private expenditures are considered OOP, directly paid to healthcare providers by households. These expenditures are either prepaid to voluntary health insurance (10% of THE) or paid directly to healthcare providers by households.

18. Egypt has a small but growing market for private health insurance. Syndicates offer forms of coverage to their members, and some public and private organizations and corporates offer financial protection schemes to their employees. In addition, some NGOs also offer financial coverage schemes for the poor, and some government programs offer additional protection. All of these add to the fragmentation in financing .

19. As part of the effort to respond to health challenges, in December 2017, the government passed the universal health insurance law (UHIL) to accelerate progress toward universal health coverage (UHC) which is in line with the health pillar of Egypt's 2030 sustainable development vision and the Egyptian constitution (Article 18 - "Every citizen is entitled

[11] World Bank 2010, 2015

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

[13] CAPMAS 2018

[14] 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

to health and to comprehensive health care with quality criteria''). The UHIL envisions coverage for all citizens, including vulnerable groups (approximately 30% of the population) who will be subsidized by the government

20. Management and application of the UHIS will entail the formation of three agencies separating the health service provision from the pooling and purchasing and quality supervision: the Universal Health Insurance Agency (UHIA) (i.e., the 'purchaser'), the Healthcare Organization (HCO) (i.e., the 'provider'), and the General Authority for Healthcare Accreditation and Regulation (GAHAR) which will be responsible for quality assurance and accreditation. The new system will have an integrated IT system that is anticipated to be gradually built up through sequential yet integrated modules that would address the different needs of the system.

21. (a) Universal Health Insurance Agency (UHIA). The UHIA, reporting to the Prime Minister with close supervision from the MOF, is responsible for the overall management, collection, and pooling of funds for the UHIS. The UHIA is responsible for paying for healthcare services for its beneficiaries as well as investing the accumulated surpluses pursuant to an investment strategy. The UHIA will contract with providers, public and private, to render insurance services to citizens. Such contracts will be valid and operative for a maximum period of three years, and subject to renewal only in the case of meeting the comprehensive quality standards as accredited by GAHAR. The UHIA is also permitted to purchase health services for those who have private insurance systems or health programs pursuant to a special agreement with those private insurers whether such services are provided by public providers or others accredited by GAHAR. Some of the UHIA's employees will have judicial control capacity and have the right to access and physically inspect providers to review registers, books, documents and all other materials in addition to electronic databases and data registries to validate and investigate financial, administrative and/or clinical malpractices.

22. (b) General Authority for Healthcare Accreditation and Regulation (GAHAR). With the greatest independence permissible under Egyptian law (reporting directly to the President), GAHAR aims to ensure the provision and continued improvement of high-quality health services, and entrenched confidence in the quality of health service outputs in Egypt at the local, regional and international levels. It will control and regulate the delivery of health insurance services in accordance with specific standards of quality and accreditation. It will be responsible for regulating, developing and improving the quality of the health sector and balancing the rights of participants. GAHAR will issue a detailed guidebook, describing the standard quality healthcare services, after having been approved by the International Society for Quality in Healthcare, which will be updated every four years. Assessment and accreditation processes are designed to be conducted in an objective and transparent manner, ensuring that all participants are prohibited from providing consultancy or training to the facility subject to assessment or being part of its management structure. The Accreditation process is a two-tier process: (i) registration: ensuring that the provider meets the basic safety, regulatory and licensure procedures; and (ii) accreditation: certifying higher quality of administrative and clinical processes, care and health outcomes. GAHAR will accredit all facilities affiliated with the Healthcare Organization (HCO) which reports to the Minister of Health and is tasked with operating and regulating the provision of medical services through acquiring, upgrading and operating all public health facilities. HCO will not be included in the project, given that it focuses on provision of health services which is under the purview of the MOHP and is being currently supported by the, Bank's funded, Transforming Egypt's Project.

23. (c) Healthcare Organization (HCO), reporting to the minister of health, shall render health and therapeutic care services, at all three levels of service. It should gradually acquire the ownership and responsibility for operations of all owned public health facilities (irrespective of their previous affiliation) within a specific governorate whenever that respective governorate is admitted to the UHIS. The HCO was perceived to control and operate all public health facilities to achieve: (i) economies of scale for the main public provider arm of the UHIS; (ii) streamline operations among its facilities; and (iii) enhance and institutionalize internal referral mechanisms. UHIS related health services may be rendered at HCO owned facilities only after being rehabilitated and having been registered, accredited by standards set by GAHAR.

The HCO shall also issue decisions as required to organize the procedures of medical care with respect to occupational health and work injury related incidents. Further, HCO will conduct a preliminary medical examination for all work candidates to verify physical and psychological fitness for work, before starting their work in accordance with the Occupational Safety and Health Rules.

24. Egyptian Authority for Standard Procurement (EASPMTM). Reporting to the Prime-Minister, EASPMTM was recently created through a subsequent, yet interrelated, law to the UHIL to conduct procurement transactions of human medical equipment and pharmaceuticals for all public authorities and entities. EASPMTM prepares plans and arranges for standard procurement from internal and/or external markets. It is tasked with holding a strategic medical stock for the state and help public health facilities/hospitals conduct proper needs assessment exercises Moreover, EASPMTM will implement a national system to conduct Health Technology Assessment. Under the law, a mandate has been set for the creation of an electronic system that, among others, sets an integrated medical technology database for healthcare providers, warehouses, pharmacies to follow up on their needs, uses, maintenance and training, manage warehousing, transportation and distribution of all related medical equipment and pharmaceuticals. The EASPMTM is expected to attain efficiency in procuring high quality products through utilizing economies of scale and value-based purchasing mechanisms.

25. The new health insurance system will be managed by a myriad of central governmental agencies. These include, but are not limited to (i) MOF which oversees UHIA and has a central role in the financing of the system and ensuring financial protection for the poor; (ii) MOHP which oversees the HCO through upgrading and adequately operationalizing public health facilities; (iii) the office of the President which oversees GAHAR including in building GAHAR's capacity as an independent regulator of quality services within the public and private providers spheres; and (iv) Prime-Ministers office overseeing the Egyptian Authority for Standardized Procurement and Medical Technology Management (EASPMTM) . The Universal Health Insurance System (UHIS) started in 2018 in Port Said and will be progressively rolled-out in six phases over a 15-year period. The first phase of implementation includes Port Said, Ismailia, Suez, South Saini, Luxor and Aswan

C. Proposed Development Objective(s)

26. The Project Development Objective is to increase the coverage of Egypt's Universal Health Insurance System (UHIS) in Phase 1 Governorates and to strengthen UHIS-related governance and institutions.

Key Results (From PCN)

27. The PDO results indicators may include:

- Annual percentage of the population being empaneled with a general practitioner (GP) in Phase I governorates (coverage)
- Annual referral rate by GPs in Phase I governorates (coverage)
- Annual average time from claim submission to reimbursement for hospitals in Phase I governorates (UHIA capacity)
- Annual percentage of UHIS providers due for accreditation undergoing assessment in Phase 1 Governorates (GAHAR capacity)
- Annual Local and National Health Assemblies (UHIS governance)

D. Concept Description

28. The proposed US$510 million project will assist the MOF to roll out UHIS, using the Investment Project Financing (IPF) instrument, with a Disbursement-Linked Indicators (DLIs) approach over a 4-year implementation period.

Project Components

29. The project will support the GOE to implement UHIS as envisioned in the newly passed UHIL in Phase I governorates. Specifically, the project will support the MOF, UHIA, and GAHAR and EASPMTM to carry out their mandates, which does not include the provision of medical services that is covered by the HCO and supported through TEHS. With the use of DLIs, the government will be reimbursed for eligible expenditures after achievements of the DLIs have been verified. The project will support three components.

Component 1: Enrollment and empanelment of the population into UHIS (US$300 million). This component will support the enrollment of the population in UHIS as well as the empanelment of enrollees with General Practitioners (GPs). This will be achieved by supporting, inter alia (i) the enrollment and empanelment for the entire population in Phase I governorates, (ii) IEC campaigns to raise awareness about UHIS among the population, (iii) identification of the vulnerable who are eligible for premium subsidies, (iv) premium subsidies for the vulnerable, and (v) government contribution to UHIS for civil servants. This component will disburse on the basis of verified achievement of one DLI, which constitutes Result Area 1.

Result Area 1:

- DLI 1: Annual number of civil servants and annual number of the vulnerable population enrolled in UHIS and empaneled with a GP in Phase I governorates.

Component 2: Strengthening capacity of UHIS-related agencies, UHIS governance and creating an enabling environment (US$200 million). This component will support:

- ***Capacity building for UHIS-related agencies***, with a focus on the UHIA and GAHAR to better help them carry out their mandates. For each agency, the project will support institutional strengthening including the development and implementation of a comprehensive set of complementary regulations, strategies and work plans, which are required for UHIS roll-out.
  - UHIA: development of benefit package, development and roll-out of a modular information system, actuarial functions, provider payment mechanisms/strategic purchasing, contract management, fraud prevention and detection, health technology assessment, and private sector engagement.
  - GAHAR: strengthening governance and technical management of GAHAR and capacity building in development and implementation of accreditation standards.
- ***Institutional arrangements and governance for UHIS***: this includes support for UHIS oversight and coordination platform.
- ***Creating an enabling environment for UHIS***, including the policy environment for private sector participation, citizen engagement mechanisms at both the central and Governorate level such as 24X7 Call Center, and Local and National Health Assemblies/Forums.

This component will disburse on the basis of verified achievement of various DLIs under three Results Areas:

Result Area 2.1. Strengthening UHIA

- DLI 2: Development and adoption of an explicit benefit package for the continuum of care (primary care, secondary and tertiary hospital care)
- DLI 3: Development and roll-out of a modular UHIS information system (beneficiary enrollment, provider management and claim management)
- DLI 4: Establishment of the HTA and Big Data Analytics Units within UHIA
- DLI 5: Development and implementation of the Quality Framework and Quality indicators for Strategic Purchasing of services from:
  - Pharmacies
  - Laboratories
  - Radiology services
  - Physiotherapy
  - Ambulatory Services
  - Hospitals

Result Area 2.2. Strengthening GAHAR

- DLI 6: Number of providers contracted by UHIA, who are accredited in Phase I governorates (annual)
  - Family medicine
  - Hospitals
  - Community pharmacies

Result Area 2.3 Strengthening governance and creating a facilitating environment for UHIS

- DLI 7: Governance
  - DLR 7.1. Creation of an oversight body for UHIS
  - DLR 7.2. Production of annual reports of patient experience and grievances
  - DLR 7.3. Implementation of Local and National Health Forums/Assemblies (Annual)

- DLI 8. Development and adoption of a set of complementary regulations and strategies for UHIS
  - DLR 8.1. Development and adoption of a Public Private Engagement Framework for UHIS
  - DLR 8.2. Development and adoption of a Provider Payment Mechanisms Regulations
  - DLR 8.3. Development and adoption of Provider Autonomy Regulations
  - DLR 8.4. Revision of the strategy to target the vulnerable for UHIS subsidies in Year 2

Component 3: Technical assistance, project management and monitoring and evaluation (US$10 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, GAHAR, and the Social Justice Unit of the MOF. In addition, TA will be provided to EASPMTM including on the development of procurement guidelines. Project management and project monitoring and evaluation (M&E) will also be supported through this component.

Eligible Expenditure Categories (EEC). Eligible expenditure categories to be supported by the project will include:

- Salary and non-salary operating cost of
  - Relevant MOF departments involved in UHIS
  - UHIA
  - GAHAR
- Premium subsidies for the vulnerable and employer premium contribution for civil servants in Phase I governorates
- UHIS-related consultancies and training

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

Summary of Screening of Environmental and Social Risks and Impacts

A. Environmental and Social Risk Classification (ESRC) Substantial

Environmental Risk Rating Moderate

At this stage, the proposed project will not be supporting any construction works, rehabilitation, procurement of medical equipment or healthcare services provision. Also, the project may introduce "green healthcare facility" principles' to take advantage of the roll-out of the UHIS in channeling environmental benefits into better service provision, such as improving energy efficiency in hospitals. Consequently, no direct significant negative environmental impacts are anticipated. The project entails supporting the UHIS's two, out of three, main agencies (UHAI and GAHAR) to carry out their mandates which does not include provision of medical services. Currently the technical assistance activities are not finally identified, however it is anticipated to be limited to strengthening the institutional setup of the two agencies to support the rolling out of the UHIS. Therefore, the direct environmental impacts of the project can be considered minimal. However, at the national level, investigating the effects of expanding the health insurance coverage on health care services utilization is necessary to determine if the rolling out of the UHIS will lead to increase in different health care waste streams. The associated indirect environmental impacts are considered linked to the project interventions from an environmental perspective. Therefore, due to uncertainty on the nature of the associated indirect environmental risks and the capacity of the implementing agency, the environmental risk rating of the project is currently considered moderate.

Social Risk Rating Substantial

The project will not involve construction works, land acquisition, or recruitment of a large number of workers. However, the main social risks related to this project are stemming from the transformative very ambitious nature of its approach. Below are the main anticipated social risks:

Cultural Aspects: While the universal health insurance Program of the Government involves immense opportunity to improve access to the poor, increase utilization of health services, and reduce the burden of out-of-pocket expenditure on healthcare, the Program's gatekeeping mechanism may challenge the deeply rooted culture of Egyptians who tend to have more trust in the specialized doctors rather than the general practitioners or the family doctors. Because this is a very widely dominating practice, it is expected that building trust in the system to reach the anticipated utilization will take time and will likely need a gradual process of testing, trial and learning.
Exclusion of the intended beneficiaries if eligibility screening system does not work well: The support of the Bank is directed under Component 1 on enrollment of the population in the UHIS in the Phase I Governorates. Under this component, eligible disadvantaged population will be covered for free. There are always risks of exclusion errors that typically come with poverty targeting programs.

Potential exclusion of the marginalized groups: The unified set of criteria under the afore-mentioned Prime Minister's

Decree suggests a potential risk of excluding certain groups in the cases where the Governorate context has some special characteristics (demographic, socioeconomic and cultural) such as the tribal groups in South Sinai and Ismailia. That may suggest that neither the unified criteria nor the unified style of service provision will benefit them. Financial Burden on the Non-Exempted Poor: The project also entails collection of contributions from the wider Egyptian population, in a progressive manner (well off groups with higher income will pay more) to ensure equity and solidarity. For the lowest stratum of the near-poor, there could be some negative economic impacts that need to be further assessed to avoid exposing those groups to risk of impoverishment because they will still be paying premiums and copayments.

Potential Economic Risk on Groups of Stakeholders: Due to the complexity of the health sector stakeholders landscape and interests, there are also some uncertainties related to how the project will affect certain groups. For instance, the risk on the local private clinics which are employing large number of doctors and support staff needs to be assessed further. During the first 2-3 years of the Project, it is unlikely that the private clinics will be enrolled into the system. Yet, this is not necessarily seen as risk of crowding out for them because the assumption is that patients, because of the cultural consideration, will remain at early stages inclined to follow the service model of the specialized private doctors that they are accustomed to. The assumption is that private doctors' enrolment will come gradually as well as increased level of utilization for the system by citizens. Similarly, the net effect on the pharmaceutical business (which is a huge business in Egypt with 90% of Egypt medicine locally manufactured) is still uncertain. There is an assumption that the volume agreements will be profitable for the companies, yet this is still to be tested. On the level of the health insurance companies, the assumption is that the Government will be reaching agreement with them to help in better utilization as well as offering complementarities and supplementary packages. In light of these potential risks, coupled with limited institutional capacity of implementing agency particularly at the preparatory stage, the social risk is assessed as substantial. The risk could be revisited at following stages based on the more careful assessment of impacts.

CONTACT POINT

World Bank

Amr Elshalakani, Elizabeth Mziray
Senior Health Specialist

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

Practice Manager/Manager:		
Country Director:		