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Evaluation of the Demonstration Project for the Financing of Primary Health Care in Egypt

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Partnerships
for Health
Reform



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- > *more equitable and sustainable health financing systems;*
- > *improved incentives within health systems to encourage agents to use and deliver efficient and quality health services; and*
- > *enhanced organization and management of health care systems and institutions to support specific health sector reforms.*

PHR advances knowledge and methodologies to develop, implement, and monitor health reforms and their impact, and promotes the exchange of information on critical health reform issues.

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Abstract

This report uses a change management conceptual framework to analyze the Family Health Fund demonstration project that was implemented in Egypt from 1998-2001. The Family Health Fund was a new organization established to finance primary care under the first phase of the health reform program in Egypt. Technical assistance was provided by the Partnerships for Health Reform Project (PHR) through the United States Agency for International Development Health Policy Support Project. This project provided early assistance to the government of Egypt and the Ministry of Health and Population to establish the capacity to regulate reform and to test the feasibility of key reform components through a demonstration project in Alexandria. This report is the last in a series of technical reports that provide information on various aspects of the demonstration project and its impact on reform development. The series provides an important resource for understanding the key aspects of the Alexandria demonstration project. A complete list of PHR technical report titles included in the series is provided at the end of this document.

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Acronyms

BBP	Basic Benefits Package
BOT	Board of Trustees
FHC	Family Health Center
FHF	Family Health Fund
FHU	Family Health Unit
GOE	Government of Egypt
HIO	Health Insurance Organization
HPSP	Health Policy Support Program (USAID)
HSRP	Health Sector Reform Project
MIS	Management Information Systems
MOHP	Ministry of Health and Population
NICHP	National Information Center for Health and Population
PHR	Partnerships for Health Reform Project (USAID)
TSO	Technical Support Office
TST	Technical Support Team
USAID	United States Agency for International Development

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Executive Summary

The Government of Egypt (GOE) has begun an extensive, long-term program of health sector reform. The priorities for the first five-year phase of the reform are: universal coverage for a basic package of primary health care services, including rationalization of the primary health care delivery system and reform of the Health Insurance Organization (HIO). Three major donors support the reform program: the World Bank, the European Commission, and the United States Agency for International Development (USAID). The USAID Health Policy Support Program (HPSP) was the first program designed to provide technical assistance supportive of Phase I health reform objectives. One of the most important components of the HPSP program was a demonstration project undertaken in the Alexandria governorate. The purpose of this demonstration project was to fully implement and test the feasibility of the major reform objectives in phase I: implementation of the basic benefits package, coverage for all family members through an integrated primary care model, and major changes in the way primary care was financed. This demonstration project proved highly successful in introducing the major components of the reform to all stakeholders. Perhaps one of the most important achievements of the demonstration project was the learning opportunity it provided for the Ministry of Health and Population, the HIO, and the technical teams assigned to support the reform. The demonstration project provided concrete examples to all stakeholders of the scope, depth, and breadth of the change that reform would bring to the Egyptian health care system. One of the lasting legacies of the demonstration project is the awareness of the revolution in Egyptian health care that reform implementation would initiate. Reform means change and response to change is always turbulent and unpredictable.

The purpose of this report is to highlight the reform as an example of major change in the way health care is organized and delivered in Egypt, and to provide a focused discussion of the demonstration project as a managed change process. The organizing framework for the report is Walt and Gilson's model for health policy analysis. This model proposes three major components that are interrelated and affect change: content, process, and context. The demonstration project in Egypt is discussed as an example of the interrelated actions of technical content and group process within the context of the existing Egyptian health care system. These components are not separable, and the effect of each component is examined in the context of the change management process.

The analysis presented here provides some important insights that can enhance future demonstration project in health reform. Some of them are:

- > **Implementing reform requires both political will and technical knowledge.** Frequently those charged with reform implementation have political will, but lack necessary technical skill. Wherever possible implementation should be done with existing line managers and staff rather than those charged with reform oversight.
- > **Profound change engenders fear and insecurity on the part of all stakeholders.** Role clarification, reorientation to proposed changes, and technical and process support for change agents are vital components of successful reform implementation.
- > **Reform implementation is a complex, multifaceted activity that requires a well coordinated team.** Delays in technical implementation of reform are often due to lack of team preparation, training, or rather than flaws in design.

- > **A change management plan with clear goals and objectives is vital to successful reform implementation.** Change management is often assumed rather than made an explicit part of the reform process. In fact, change management planning can enhance implementation and decrease the risk of delay.
- > **Readiness to implement change is a prerequisite for effective reform.** In complex reform designs, flexibility in planning is essential since many factors may impact readiness to implement. Reform implementation planning should include frequent assessment of readiness to implement change together with activities that will achieve readiness.
- > **Technical experts that support reform activities should be briefed in change management strategies.** Wherever possible, a small group of consistent technical experts is preferable.
- > **Those regularly engaged in care delivery should implement changes at the delivery level.** Reform is not sustainable if those regularly engaged in a task are not the implementers of the change. Alternative strategies of replacing regular staff with special staff who do not expect to remain in the organization threaten sustainability.
- > **Set clear expectations for change and define milestones that signal achievement.** Breaking a complex implementation plan into a set of achievable stages increases reform momentum, and provides a mechanism to identify barriers to change.
- > **Assessment of reform progress should consider technical feasibility, process, and context.** Technically feasible reform may not progress because there was insufficient attention to progress or context, however these aspects of reform implementation are frequently overlooked in assessment or evaluation activities.
- > **The need for frequent communication with all stakeholders cannot be overemphasized.** Communication need not always be formal, in fact, informal mechanisms are often more effective in early stages of reform when clear policies have not emerged.

This report provides expanded discussion and analysis that supports and expands these recommendations.

1. Introduction

The Government of Egypt (GOE) is implementing an extensive, long-term program of health sector reform, that emphasizes primary care in its first phase. The Health Sector Reform Project is a 10-15-year reform process initiated by the GOE with the assistance from three principal donors: the United States Agency for International Development (USAID), the World Bank, and the European Community.

At the outset, the minister of health selected, as the strategy for the reform, an emphasis on the development of a strong mechanism for primary health care. The minister's strategy is described in a Ministry of Health and Population (MOHP) publication: *A New Egyptian Health Care Model for the 21st Century*:

“The first phase of the reform towards the ultimate goal of universal coverage begins with a new primary health care strategy...Primary care has the greatest potential to improve the well being of the majority of the Egyptian people. Primary care plays a crucial role in meeting the new health challenges and in helping to reduce the financial burden of future health needs and demands of a growing population.

Primary care reform lays the foundation for universal coverage of a more comprehensive package of benefits in the future. Reorganizing the delivery of primary care services begins the vital process of strengthening and improving the organization and management of services at all levels of the health care system in subsequent phases”

Early in the process, USAID determined that its contribution to health sector reform in Egypt would be a health policy support project (HPSP) to provide technical support in five areas of national health sector policy reforms:

- > strengthen the role of the MOHP in providing and financing preventive medicine and primary health care;
- > rationalize the role of the MOHP in providing and financing curative care;
- > reform the MOHP personnel policy;
- > develop the MOHP role in regulation and accreditation and its capacity for national health strategic planning, policy analysis, and management;
- > ensure the viability of the Health Insurance Organization (HIO) as the instrument for social insurance expansion; and
- > expand social health insurance coverage coupled with adequate administrative and financing mechanisms.

The Partnerships for Health Reform Project (PHR) provided technical assistance to the MOHP with the activities of the HPSP project. It was decided that the HPSP project would demonstrate the various components of an effective system for primary health care. The MOHP, with the assistance of PHR, was tasked with the development of a demonstration model that would support necessary regulatory change, improve service delivery, and test financing mechanisms in a pilot district. The pilot project for primary health care set out to implement and demonstrate a reform model to build on three vital and interdependent components: service delivery (i.e., the care model), policy/regulation, and the creation of a health insurance purchasing agency (the Family Health Fund) that would administer funds through contracts with service delivery sites.

The demonstration project had two main components: 1) redesign of the primary care delivery strategies to accommodate integrated primary care delivered by a family physician to a roster of families; and 2) establishment of the Family Health Fund, a contracting entity that would execute performance-based contracts with primary health care providers.

The MOHP, with PHR assistance, decided to begin with redesign of primary care delivery strategies for a number of reasons:

- > Care delivery was the activity most familiar to counterparts in the Ministry of Health and Population.
- > The establishment of high quality service delivery sites was a prerequisite for contracting by the Family Health Fund (FHF), as contracting for quality could not be successful if facilities were run down, inadequately equipped, poorly managed, or not focused on clinical outcomes or patient satisfaction.
- > Creation of service delivery pilot sites could be done within existing MOHP policies and regulations and could show early results that would be an impetus for further development of the pilot project.
- > Service delivery improvements could provide a forum for expanded participation in the reform effort, particularly for affected consumers and local stakeholders.
- > Preparation of new service delivery sites was part of the Ministry of Health and Population's Master Plan for ensuring that a network of adequate facilities was available to meet the needs of the population, first in the three pilot governorates (Alexandria, Menoufia, and Sohag), and later in other governorates.

PHR's effort to support improvements in service delivery was, by necessity, limited to those activities that would create an adequate level of quality for insurance contracting purposes in a small group of primary care facilities. The supporting system redesign components including medical and nursing education, continuing education for primary care delivery staff, redeployment of health workforce, and curative health sector redesign were not part of the demonstration project. The HPSP project did address these issues, in collaboration with other donors, at the MOHP strategic planning and policy level.

The MOHP decided to establish a new service delivery model at one site in each of the four sectors that currently deliver primary care: MOHP, HIO, private, and NGO. The activities required to establish the sites were undertaken with the full participation of staff from the Technical Support Office of the MOHP and the Technical Support Team in the Alexandria governorate. By the end of

the HPSP project all four demonstration sites were open, and the MOHP had independently established several additional sites in the Montazah District of Alexandria.

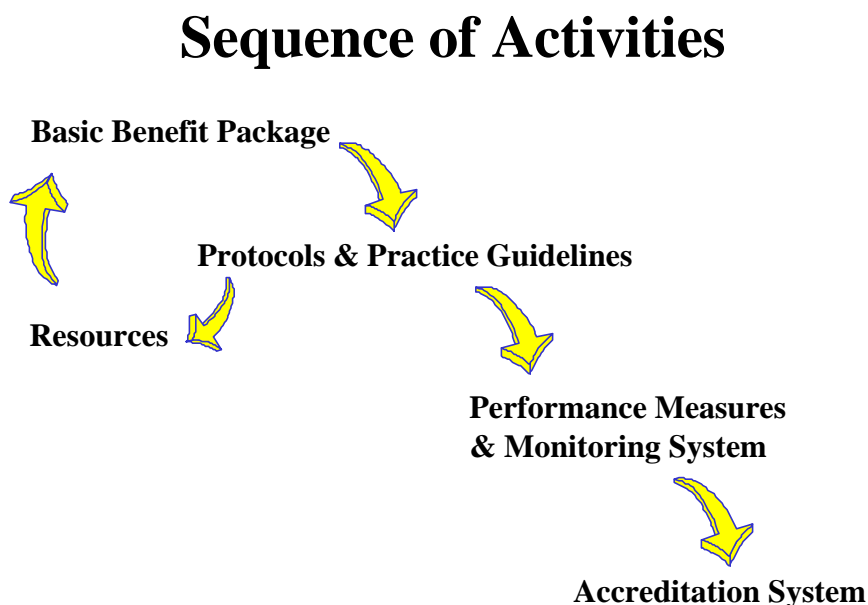
The policy and regulation component had many different aspects. It included the early focus of PHR on capacity building in the MOHP in the National Information Center for Health and Population (NICHP) and in creating an organization within the MOHP, the Quality Directorate, responsible for quality improvement in service delivery. It also involved development of the mechanisms for accrediting service delivery sites to ensure that they meet minimum quality standards for contracting with the FHF. A computerized accreditation instrument was designed to impartially rate facilities for high quality service delivery. In addition, training of counterpart staff was provided in the use of the instrument and the Quality Directorate became the organizational “home” for the accreditation function. Early work in defining a basic benefits package for primary health care, and subsequent work in developing treatment protocols and practice guidelines for the basic benefits package was also part of building the capacity of the MOHP to regulate the new system as illustrated in Figure 1 on the following page.

Financing, the last of the three components of the demonstration site, required extensive technical support from the PHR team. The second phase of the demonstration model was the establishment of the Family Health Fund as the agency that would contract with the service delivery sites for quality health care services. Even though preliminary work on this component was concurrent with development of the care model, implementation of the Family Health Fund occurred after the care model was established in two large facilities. Initially, the decision to delay action on this component was a deliberate strategy because this component was conceptually complex and required time for orientation of counterparts. As events unfolded, however, there was an unplanned delay in the process of setting up the Family Health Fund because of the complex process of obtaining a Ministerial decree for its establishment and obtaining initial GOE funding for FHF operations.

In addition to the establishment of the FHF, management information systems development was undertaken at two levels. At the first level, the existing HIO system was modified to include clinic data systems capable of recording and processing encounter data at HIO sites. At the second level, software was also developed for the FHF to apply performance standards to encounter data received from the pilot sites.

Since there was a lack of utilization and cost data on which to base financing calculations, a financing analysis conducted by PHR provided a preliminary analysis of the cost of primary health care (PHR Technical Report # 36). This approach was taken with the understanding that the pilot project itself would provide richer data for refining the financing estimates. The demonstration project would be able to confirm these estimates after a few months of operational experience using the performance-based incentive payment methodology.

Figure 1. Sequence of Activities



Once the FHF was established, a proposal was made for the amount and sources of funds to be obtained and placed in a bank account. Funds would initially be used for performance-based incentive payments, replacing the previous system of incentives in use in the MOHP and HIO. Data collection during the demonstration project would permit the cost analysis that would enable the GOE to refine their estimates of the cost of universal health insurance for primary health care.

At the outset of PHR's involvement in the health sector reform, it was clear that the pilot project would need to be designed, disseminated, and implemented as a fully functioning demonstration of the new model. No number of workshops and seminars could illustrate how this complex model would function. The demonstration project would demonstrate, among other things, the separation of provider and purchaser roles, inclusion of the private and NGO sectors in a competitive provider market, accreditation mechanisms, patient satisfaction, patient choice, universality of coverage, affordability, cost effective services, reduced emphasis on prescription drugs, monitoring of quality, and a data collection system for performance monitoring. It would raise issues of provider and patient education, training, methods of staff selection, costing, sources of required funds, development of management teams, etc. These were some of the very complex inter-related components that were demonstrated and tested. Only by experiencing the model and its results would counterparts be able to appreciate the true nature of the changes proposed.

In fact, the results were so dramatic that those working closely with its development came to realize that this model represented a revolution in the way primary health care is delivered in Egypt. However, in designing the demonstration project, PHR had to focus on achievable outcomes within the context of available resources and the comparatively short time frame in which to show results.

This evaluation report reviews the activities undertaken by the MOPH with technical assistance from PHR under the USAID HPSP contract to implement the primary health care demonstration model in Egypt, assesses the results, and extract lessons for future demonstration projects of a similar nature.

2. Managing the Change Process

Very early in the implementation stages of the demonstration project, it was recognized that certain dynamics of change are inherent and predictable and can, therefore, be managed. The primary emphasis of the change management strategy was to reduce resistance through the introduction of a number of activities specifically designed to increase understanding, communication, and involvement of various key individuals and direct stakeholder groups. The activities, an assortment of change management devices such as: information seminars, focus groups, policy discussion papers, consensus-building workshops, stakeholder analysis, and team building, were effective to varying degrees. One reason for the variability is the tendency in most reform projects to implement any or all of these tools as independent technical activities, rather than *related elements of a change process*. This chapter presents a basic change management schema and principles as well as a model of group development, as a way to better understand the extent to which the demonstration project activities achieved their objectives. It also suggests more effective methods to build change management understanding and capability into the planning and implementation phases of future reform demonstration projects.

2.1 A Change Management Schema

In most reform projects, planning and implementation are focused mainly on the *technical content* of the change, neglecting the *context* within which the reform will take place, the *local* individuals and groups who will implement and sustain the change, and the *change processes* themselves. It has been observed that that this focus on content "diverts attention from understanding the processes, which explain why, desired policy outcomes fail to emerge."¹ Their logic applies equally well to explain the problems encountered in many reform implementation efforts.

Figure 2 (on p. 27) is adapted from Walt and Gilson's model for health policy analysis and is presented in this chapter for use as a basic change management schema, a backdrop to inform reform project planning and resulting implementation activities. The authors caution that the model "is a highly simplified model of an extremely complex set of interrelationships" and should not give the impression that each can be considered separately.

The cultural, political, economic and religious aspects of their country context affect local individuals as well as the groups and organizations of which they are a part. These cultural, political, economic and religious aspects, in turn, can be affected by factors such as war, environmental issues, the state of public health, the global economy, and historical experience. The process of planning and implementing reform is affected by all elements of the country context as well as by the individual and group change agents within it.

Against the background of Figure 2, the following principles for managing change and the model depicting phases of group development, provide a powerful framework for increasing the likely success of future reform projects by building context, content, process and agents of change into the

¹ Walt, Gill and Lucy Gilson. 1994. "Reforming the health sector in developing countries: the central role of policy analysis" *Health Policy and Planning*, 9(4), Oxford University Press.

planning and implementation phases. Examples from the Egypt HPSP demonstration project illustrate the powerful effect that change management can have on project results.

2.2 Change Management Principles

Change management principles have been developed primarily in western society, often in the context of planned interventions implemented inside formal organizations. They inevitably assume somewhat ideal situations in which those with control are willing champions of change, able to set the agenda and lead the way, even if it means giving up some or all of their control.

How can these principles be understood and applied within the context of reform in developing countries, when it is often a mistake to assume that all major stakeholders in the target system are interested in change, let alone in the change the project has defined? In most complex systems, the reality is that the ability and willingness of those in control to share their power cooperatively and without resistance, is limited at best.

Perhaps the goal of change must be simply to move the system more and more towards readiness—to provide real experience of a different way of doing things, to raise doubts about the status quo, to build competence and commitment to a vision of new possibilities—so that in the next change effort the ground is more fertile. In complex reform environments, even the method of implementing some of the principles of managing change may have to be revised.

2.2.1 Principle 1: Examine existing centers of control

The first principle of effective change management is to examine existing centers of control in the reform environment: where it resides, how it has been exercised within each of its spheres, and what forms it takes. The aim of the principle is to use existing centers of control to help convert resistance, conflict, and struggles for power into cooperation and synergistic productivity.

Implementing this first principle is critical even in an environment where formal control resides solely in the hands of the government where political realities often subsume readiness to effect change. Examination of control centers provides the opportunity to learn about the realities of the political and cultural context, and to use official centers of control to bring potential change agents together to paint a broad picture of the reform direction.

Within the boundaries of even a limited degree of willingness to support involvement, cooperation, and change, the groundwork often can be prepared for rapid implementation of a demonstration project that will be supported by the government to the extent that it provides quick and visible activity and improvement.

Often paving the way for further reform, a demonstration project can also:

- > focus energy and resources on a broad, common goal;
- > begin to make real a language and concepts that may be almost impossible for some to visualize;
- > build commitment and ownership through involvement in implementation;

- > provide opportunities for local and expatriate change agents alike to learn by doing;
- > raise doubts about "the way we've always done things" by demonstrating another way; and
- > discover or create new sources and forms of informal control or influence, willingness to change, and competence.

HPSP Demonstration Results

In the autumn of 1997, the minister of health and population, with the assistance of the major donors, formed several working groups composed of Ministry staff and technical advisors and headed by senior ministry officials. The groups focused on such issues as health financing, primary care, health and human resources, and curative care, among others. The mandate was to examine, within each specified area, the strengths and weaknesses of the current situation in Egypt, and identify the potential for reform.

Based on the recommendations from this participatory process, the minister made the decision to focus the first phase of reform efforts on a basic package of primary care and public health services as well as restructuring of the primary health care delivery system.

About mid-1998, USAID began to design the Health Policy Support Project (HPSP) to support the reform and to demonstrate the various components of an effective system for family health care, including the concept of separation of health insurance payer functions from service provider roles.

The first phase of the pilot project, development of service delivery sites according to a new family practice model, received active support of MOHP through its reform teams: the Technical Support Office (TSO) at the ministry level and the Technical Support Team (TST) within the governorates. These teams became so involved with development of the care model and delivery system that it was difficult for them to redefine their roles when the momentum shifted to establishment of the Family Health Fund, which required active involvement of the Health Insurance Organization. The Family Health Fund's role as purchaser of services from the newly developed primary health care delivery sites represented a new dimension in the demonstration project, and one that was not easily understood or accepted by stakeholders unfamiliar with health care financing and insurance.

Additionally, as the demonstration project moved toward the next phase, it became apparent that the work that had been done with the line management of MOHP in Alexandria to prepare them to assume responsibility for the established MOHP demonstration sites had not provided adequate preparation. In fact, TST seemed reluctant to transfer learning and ownership, failing to realize that they could not manage implementation of the master plan for expansion of the model to other MOHP sites, if they would not let go of those sites that were already contracting with the FHF.

The HIO proved itself to be an especially valuable center of support and influence. As early as mid-1998, the chairman of HIO appointed an advisory committee to work with PHR to identify and solve problems affecting successful preparation of the HIO Abu Qir Family Health Unit. With the establishment of the FHF, the Advisory Committee has become a supportive group working to help the FHF director resolve HIO policy issues that spanned the care delivery and financing challenges in the demonstration. Many of these solutions provided templates for discussion and later action by the Alexandria TST.

The Director of the HIO West Delta Branch appointed HIO members to become the FHF management team, choosing individuals who were experienced, capable and willing to step into a situation of which they had absolutely no previous understanding. He guaranteed continuation of their HIO salaries and benefits and assured them that they could return to HIO after a period of one year, if they were not content to remain in the FHF. In addition, he supported their coaching/training by providing space in HIO offices for this to occur and releasing them from their HIO positions for up to three days a week over the six-month training period until they would fill their FHF roles full time.

HIO also provided the physical location for the temporary FHF office in the Northwest Delta Branch at Stanley, and HIO Cairo provided computers, desks, chairs and other necessary office equipment for the FHF from that was originally slated for development of the World Bank funded National Technical Laboratory.

Without HIO determination and cooperation, the FHF could not have been established. The HIO leadership in supporting the Family Health Fund and linking it to the HIO clinical site at Abu Qir provided an essential step in the development of the fully functional demonstration project.

Lessons for the Future

Implementing demonstrations requires both political will and technical knowledge. Frequently those charged with reform implementation have political will, but lack necessary technical skill. Wherever possible, implementation should be done with existing line managers and staff rather than those charged with reform oversight. Specific recommendations are:

- > Identify and build on existing centers of competence as well as centers of control. Centers of competence that emerge as a project progresses offer the opportunity to shape and expand reform efforts in the future. They also indicate the potential for a more functional form of control based on capability rather than mere political power.
- > Use centers of control that are already politically powerful wherever possible to work with senior line management and technical advisors to set the broad direction for reform, give legitimacy to implementation activities, and negotiate necessary policy and legislative changes.
- > Do *not* set up a central body responsible for reform implementation that is separate from existing line management structures. Rather, build a strong insider/outsider implementation team in which the "insiders" are line staff permanently assigned to work on the reform with "outsider" technical advisors.

2.2.2 Principle 2: Understand the Potential Reactions and Impact of Individuals, Groups, Organizations, and their Cultural Context

The second change management principle focuses on understanding the potential reactions and impact of individuals, groups, organizations, and their cultural context. Certain dynamics of change are predictable in each of these systems:

- > a sense of loss as things begin to change;
- > a sense of ambiguity and feelings of confusion;

- > deterioration of trust as a result of the loss and confusion;
- > the impulse toward self-protection;
- > deterioration of communications;
- > struggles for power and control;
- > loss of morale and commitment;
- > loss of team cooperation;
- > reduced productivity;
- > loss of good people; and
- > attempts at sabotage.

Awareness and understanding of control and change dynamics are not enough. That knowledge must be put to use in the design of the *process* of change. And because the process of change inevitably depends on people, whether as individuals or within groups or organizations, it must take into account the potential impact of the behavioral dynamics of change. It is also important to remember that this principal of change is as true for expatriate change agents and their short-term technical advisors as it is for local change agents and implementers.

HPSP Demonstration Results

The impulse toward self protection is a prime example of the "me" behavior indicated in phase I of the Phases of Group Development (Figure 3 on p. 28) and described in the discussion of principle four. This behavior is normal and predictable in situations where individuals start to feel threatened, uncertain about the terrain they are navigating, and their competence to navigate it.

When the focus of the Alexandria demonstration project shifted from development of the pilot service delivery sites to establishment of the Family Health Fund, the role of the TST had to be redefined. The TST had been actively engaged in supporting the care model implementation, and in managing the MOHP demonstration sites. As the Family Health Fund was established and provider contracts were completed, the role of the TST as supervisor of the demonstration sites became redundant. The TST was very unsure of their future role, and tried to retain management control over both demonstration sites and the Fund. Since the TST was established solely to support reform. As the demonstration sites moved to routine functioning, new activities were indicated for the TST.

PHR organized and facilitated a workshop with the TST and FHF in order to discuss their different purposes and contributions to the reform (PHR Trip Report: *Exploring the Need for a Changing Role for the Technical Support Team in the Operational Phase of the Alexandria Family Health Care Pilot Project*, March 22, 2000). The hope was that this discussion would help to reduce the feelings of uncertainty and competition and begin to rebuild a sense of team in the project.

Unfortunately, without the visible support of the TSO in this effort, it came to be seen as an indication that PHR favored the FHF over the TST. The PHR technical advisory team has recognized in this competitive behavior a long-standing pattern heightened by the predictable dynamics of change. The one possibility to break the pattern seems to lie with the ability of the FHF to establish its

credibility by making performance incentive payments to the service delivery facilities, and establishing routine policies and procedures for all contracted facilities.

Lessons for the Future

Plan sessions for key individuals, change agents, and direct stakeholder groups focused on project reorientation, role clarification, and understanding change dynamics periodically throughout the reform project, particularly prior to movement from one phase to the next. This will help to minimize the negative impact of the predictable dynamics of change. The successful development of a strong insider/outsider team as described above, will lay the groundwork for open, trusting relationships in which coaching conversations held in the context of performance management, can focus on observed behaviors, their impact, and appropriate ways to deal with them.

2.2.3 Principle 3: Identify, Advise, and Support Appropriate Champions of Change

The third principle of managing change is to identify, advise, and support appropriate champions of change—individuals with formal control and authority as well as those who, because of the informal networks they have established and the respect they command, exert their own form of control. The role of champions of change is to lead, defend, support, and back the broad direction of the reform as well as the change agents who will implement it.

Effective champions of change are willing to take the risk of visibility, publicly articulating the vision and defending its various associated activities, particularly when understanding of the reform is limited and/or resistance is strong. Because they are an essential part of the systems, which they will help to reform, their understanding of the political and cultural terrain is invaluable in designing and implementing the change process.

The reform's technical advisors must remember that champions of change are also people. They will, as the reform progresses, experience many of the change dynamics described previously. They will need help to understand that their feelings are normal and predictable *and* that how they handle them will become a model for all those they influence. Their challenge will be to continue to communicate the vision when the path of progress seems unclear and people, including themselves, begin to lose motivation.

It is important also that reform donors and their technical advisors recognize themselves as change agents with considerable power to be influential. They need to discover how to "lead from behind" so as not to be seen as the champions or owners of the reform.

HPSP Demonstration Results

Certainly the Minister of health and population and Population is a champion of change. He has signaled the direction for this first phase of health sector reform. He has spoken publicly about the key concepts in the Alexandria pilot project for family health care. He and his media entourage have paid visits to the Seuf, Mohsen, Gon, Khorshed, and Abu Qir Family Health Units as well as the Family Health Fund. He has also taken the risk of introducing draft legislation to raise revenue that would make the financing of universal health insurance feasible.

The Ministry of Health and Population assumed the responsibility to align the multi-donor resources and programs to realize the vision of reform. The magnitude of the task and the challenges

of coordinating so large a project created many mandates for a comparatively small group of ministry change agents whom were themselves learning about reform implementation. Integrating the technical teams and aligning the technical work with the general reform direction required resources that were not always immediately available.

The PHR technical assistance team was able to focus both resources and time to one aspect of the reform. They emerged as advocates for the demonstration project in Alexandria as well as for the Alexandria Family Health Fund, and were often misidentified as the main architects of the change strategy.

Lessons for the Future

Spend time with change agents permanent and short-term alike, to clarify and explain the role, particularly in the context of competing responsibilities and time constraints. Include milestones and measurable indicators of success for the individuals and groups in filling change agent roles (e.g., increasing understanding and consensus about the direction and scope of proposed changes as well as increasing support for them).

2.2.4 Principle 4: Establish a Strong Sense of Teamwork

Principle four for effective management of the change process is to establish, in the hearts and minds of the key individuals and direct stakeholders, a strong sense of teamwork to achieve the common mission or purpose. Both aspects of this principle, the common mission or purpose *and* the strong sense of teamwork are critical to success.

Figure 2, Phases of Group Development, has been adapted from B.W. Tuckman's well known "forming, storming, norming, performing" model to explain group development (1965, *Psychological Bulletin*, 63, 384-399). These phases provide an invaluable tool to assess motivation and commitment to the reform and guide team-building processes. It is applicable to the entire project system of multiple players with varying interests and stakes in the reform as well as to smaller, focused groups which might be existing organizations, special project committees, newly formed organizations, or even subgroups within them.

An explanation of Figure 3 will help to clarify its use. Task performance, which may also be viewed as content or "*the what*," is shown along the horizontal axis and involvement, or process, or "*the how*," along the vertical.

Phase I, the "me" phase, describes the early formation of a group. Individuals enter with a focus on themselves. They are not sure they want to be part of the group or the changes ahead. They do not fully understand the purpose or what the benefit will be to them. They are not sure they want to work closely and cooperatively with the others. The main challenge for the change agents during this early phase is that of helping people to feel the need for change, encouraging the champions of change to communicate the broad direction so those who will be involved begin to understand, honoring the fears and the hopes, and helping them to feel that they are valuable players in the process of change that is just beginning.

Phase II occurs after some period of orientation and inclusion, when members feel they will become involved but start to fear that they will be lost in the process, forced to give up their individuality or their past associations with and loyalties to, certain organizations or individuals. A

sense of loss as things begin to change, the impulse for self-preservation, and struggles for power and control are typical Phase II dynamics.

Phase II is as necessary to group development as crawling is before walking. However, it is important to note that many groups and reform projects become stuck in this phase, with underlying fights for control taking the energy and focus away from productive work. The task of the change agents is to help groups define their unique purpose within the reform and to help the individuals within groups identify the skills, experience, and ideas they bring to the work ahead. In addition, when change agents are able to help those involved in the reform develop their own ground rules for working effectively together, they will already have begun the cooperation they need for effective teamwork.

In phase III the group is demonstrating effective teamwork in achieving its goals and completing its tasks. This does *not* mean that there is never disagreement. It *does* mean that the level of trust is high so that open discussion about different viewpoints and ideas can occur. The common goal remains clear and in focus despite disagreements and the established ground rules for working together in the change project are used effectively to make decisions that are most likely to lead to success. In this phase everyone feels ownership for his or her part of the project and is actively working to solve problems and move the project forward.

The phases of group development are very real, even though the progress from one phase to another is often confused. In every reform project, unexpected events such as a change in direction, the replacement or resignation of a key player, or the move from one phase of the project to the next, may cause change agents and direct stakeholders alike to worry about their continued involvement. Behaviors may begin to look and sound much like those of phase I. This is natural and predictable. The challenge is to take the time once again to acknowledge hopes and concerns, revisit the need for reform, restate the common goal, redefine purpose, roles and responsibilities, and the contributions each player can make, in order to re-establish a sense of commitment and ownership.

HPSP Demonstration Results

The TSO and TST were established as reform implementation organizations at the suggestion of the major donors. However, no one donor assumed clear responsibility for capacity building and team development for the TSO and TST. As a result, the groups were often unclear about their purpose as well as how to work together to accomplish it effectively. At the same time both groups were responding to significant support requests from ministry counterparts, donor technical teams, and other government officials. They did not control sufficient resources, of time or personnel, to allow in-depth participation in extensive capacity building activities.

The HIO Advisory Committee, on the other hand, worked for a period of more than two and a half years with PHR on a clear and consistent aspect of the project. During this time they developed a good understanding of their role in the reform as well as precise meeting procedures and processes for solving problems. The Advisory Committee functioned effectively even when the composition of the committee changed.

The Family Health Fund was designed with a well-defined mandate and the management team had clear responsibilities (*Alexandria Governorate Family Health Fund: Organization Design Recommendations and Methodology*, May-June 1999). They worked for more than five months with the PHR organization development consultant to:

- > learn how to function effectively as a team;

- > develop ground rules for working together;
- > understand the key pilot project players and their responsibilities;
- > understand an overview of the Family Health Fund;
- > visit Seuf FHU to see the family practice model in action;
- > analyze how the family practice model is different from that currently in use;
- > examine the unique responsibilities of the managers in the Family Health Fund;
- > understand the concept of accountability;
- > learn a group problem solving model;
- > learn about giving and receiving feedback;
- > understand the importance of motivation;
- > develop behavior principles for all FHF staff;
- > learn about effective meeting process;
- > understand and begin to apply a performance management system; and
- > understand the inputs, throughputs and outputs for the Family Health Fund as a whole as well as for each of its departments.

As a result of this degree of technical support and emphasis on both “what” they do and “how” they do it, the FHF has become a cohesive team, with a clear sense of mission and responsibilities and a strong determination to be successful. They have assumed ownership for their piece of the pilot project and are forging relationships with their board of trustees, the TST, the management teams at Seuf and Abu Qir, as well as the HIO Advisory Committee.

Lessons for the Future

Plan for and spend the time to build a strong project team as an essential component of the reform project. This will entail working with the large team composed of the various sub-groups and individuals necessary to plan for, implement, and assess the project, as well as with each smaller group within the reform implementation team.

Do not assume that teambuilding is completed after a one- or two-day session. Allocate resources that allow reform implementation teams to meet regularly, discuss openly, re-orient periodically, build understanding of the reform and specific roles within it, resolve conflicts, share ideas, solve problems, build commitment and trust, and continually assess team effectiveness.

2.2.5 Principle 5: Involve People in Defining the Changes that Will Effect Them

The more input people have in defining the changes that will affect them, the more they will take ownership for the results. Champions of change serve a very important "up front" role in managing change. However, it is also very important to recruit local "hands on" change agents, help them to understand the need for and direction of the reform, and involve them as much as possible in defining the specifics of the changes that they will help to implement. Figure 2 reminds us that these individuals need to understand not only the content of what they will do, but also the significance of *how* they accomplish what they do in order to enhance understanding and build involvement, motivation, and commitment.

Successful implementation of this principle in country reform projects must differ quite substantially from implementation inside western organizations. When change agents are working within the context of their own culture, it is a safe assumption that everyone involved in the change is starting with a common understanding and interpretation of the major issues and a common language for expressing and visualizing the future direction. If that initial assumption is true, it is only a small step further to assume common understanding of the reasons for and ability to picture, the desired outcomes of action steps in the project implementation plan.

It is very misleading and potentially dangerous to start with the same assumptions in developing countries. When experience inside the reform environment is all that is known, it is likely that the definition of the need for reform will be quite different from that of donor agencies and their technical advisors. If the need is not understood and accepted, then defining a shared vision for the future is almost impossible.

When the need is defined in such a way as to generate understanding and acceptance, the next steps—painting the broad picture of the future, developing a detailed action plan and implementing it—must be taken with full involvement of those who will, without doubt, only partially understand the real implication of the words and the desired outcomes. The challenge for everyone is to learn by doing: to develop enough understanding, commitment, and competence to involve everyone in establishing a demonstration model that will start to make the concepts real and then to explicitly assess learning as the process moves forward, to generate feelings of accomplishment and local ownership.

HPSP Demonstration Results

Every one of the planned activities to establish the Family Health Fund (Technical Report 42, *Establishing a Family Health fund in Alexandria Egypt: The Quality Contracting Component of the Family Health Care Pilot Project*, Chapter 2) were intended to fulfill the objectives of this fifth principle. Yet the results and impact of these activities often had unexpected results.

Information seminars and consensus building workshops included all direct stakeholders and change agents involved in the pilot project. Most were facilitated so that discussion was focused, lively, and highly participatory. Furthermore they were designed as a progressive package, including:

- > a broad overview of the pilot project within the context of longer-term health reform;
- > principles of the family practice model;
- > specifics of the focus on service delivery site development;

- > policy issues surrounding the accreditation function in the pilot project;
- > the meaning, implications, and mechanism for performance-based contracting;
- > the institutional location of and long-term vision for, the Family Fund; and
- > policy issues surrounding financing for the work of the Family Health Fund.

Despite the intent, these seminars and workshops were viewed as stand alone events by participants, who failed to realize that each one built upon those that had gone previously, and that it was their input that was helping to shape the project design.

Policy/discussion papers were an effective vehicle to disseminate ideas and generate discussion. An informal system was used to distribute such papers widely to direct stakeholders and local change agents on an informal basis. The content of several of the papers generated interest, demand for wider discussion, and the above-mentioned workshops. Several strategies were tried to communicate policy issues and generate discussion, the informal distribution of short policy papers followed by discussions with key stakeholders proved to be the most effective way to begin policy dialogue. Likewise, focus groups and the structured staff selection process— while they involved direct stakeholders and change agents, and established a degree of understanding and commitment— were effective in establishing a sense of shared purpose and ownership. However no single activity could stand alone, and it was the composite of information policy papers, and other activities that slowly built a shared understanding of reform. One of the most serious threats to the development of this understanding was the rapid turnover of staff in the ministry TSO during the first two years of the project.

The method of implementing all these activities shared one thing in common: the emphasis was on the technical content of the specific activity, to the exclusion of the change process itself. Most of the Egyptian stakeholders and change agents in the pilot project had never before been given the opportunity or the skills to take ownership and responsibility for even a small piece of a large, complex, cooperative effort. Ownership was for them as vague a concept as family practice. Perhaps if the various activities had explicitly been framed as elements of a process to build understanding, involvement, commitment, and ownership, they might have been more successful at doing so.

Lessons for the Future

Develop, assess, revise, implement and reassess, a change management plan. Ensure that the technical advisors, who lead the various activities that make up the elements of the plan, are aware of it and how their piece contributes. Schedule the various change management activities appropriately to achieve the goals of the plan, and maintain sufficient flexibility in scheduling, content, and process to reflect necessary changes. Ensure that participants understand how each activity builds upon the others to achieve the overall change management goal.

2.2.6 Principle 6: Readiness

Readiness is the sixth principle of effective change management. An effective change process begins where those who will be affected by the change currently are, and helps them to move steadily in their degree of understanding, involvement, and commitment toward where they need to be.

The reality facing donors and their technical advisors in country reform is that "where they need to be" may turn out to be quite different from what was initially planned. This is especially true if a good job has been done of involving local champions of change and change agents in defining the direction and shape of the reform, as principle five encourages. Furthermore, "where they need to be" may change as the reform progresses and everyone involved develops a better understanding of what will work and what won't in the reform environment.

Donors, technical advisors, local champions of change, and change agents also need to keep in mind that their understanding of the need for and direction of reform will become much greater than that of the rest of the system as the project moves forward. "Readiness," therefore, will come to have different meanings for different segments of the reform environment population. As new stakeholder groups and individuals become part of the implementation team and/or will be potentially affected by the reform, a concerted effort needs to be made to start where *they* are and help to bring them to where they need to be. Furthermore, it is important for change agents to remember that newly involved individuals will demonstrate the behaviors associated with the dynamics of change described in principle two, just as they did earlier in the process.

HPSP Demonstration Results

In mid-September 1999, PHR held a participatory work-planning meeting using a strategic management approach and tools to focus on implementation of the Family Health Fund. The first MOHP pilot service delivery site had been operating only since May. The HIO site was preparing to open. The Family Health Fund was a much-discussed concept only, with decisions still outstanding as to its institutional location, the sources of its financing, and even its official establishment by ministerial decree.

Participants included the usual TSO and TST members as well as the MOHP under secretary of health for the governorate of Alexandria, the HIO Advisory Committee, others members of HIO, the interim FHF director, and members of PHR. The meeting was facilitated by a strategic planning consultant as per an earlier plan for short-term technical assistance in the pilot project.

PHR advisors based in Egypt felt that September was too early a date to facilitate a strategic workshop. Now that the MOHP was functioning fairly effectively, direct stakeholders and change agents had a real understanding of some of the reform concepts that had remained elusive for them until they could see them in operation. They were just beginning to comprehend that the next phase of the pilot project would introduce the Family Health Fund, but the notion of sustaining quality health care and recognizing the work of health providers through performance-based incentive payments was still vague in their minds. They were starting to learn the language of this aspect of the reform, but had no real way to understand its meaning.

The workshop helped to prepare all stakeholders to think strategically about the next phases of reform, however, most of the counterparts were not ready to engage these new concepts. At a certain point in the workshop, when the frustration of participants could no longer be contained, a senior member of TSO quietly and firmly took control of the meeting. The TSO member recognized that many counterparts were not ready to engage the strategic planning material, and started a discussion at a much more basic level. Together the counterparts worked from where they were to where *they* decided they needed to be, and were able to work together to present both options concerning the location of the Family Health Fund to the minister of health for a decision. This document became the catalyst for the December decree establishing the FHF inside HIO.

Lessons for the Future

Ensure flexibility of the schedule, content, and process, to adapt to necessary changes, and be ready to accept sudden changes in direction despite previously scheduled technical activities. Technical assistance for complex reforms should be provided by a consistent group of dedicated consultants who establish their credibility and understanding of the project and return many times, as necessary, to assist with the development. All technical consultants should be prepared to understand the process of change in addition to their content expertise.

2.2.7 Principle 7: Find the Balance Between Respect for the Past and Present, and the Need to Invent the Future

This change management principle has to do with "the way we've always done things." It involves finding the balance between respect for the political reality and cultural traditions of the target system and the need to toss out the rulebook to re-invent as the change process moves forward. From time to time everyone involved in reform needs to be reminded of this delicate balancing act. It is easiest for the donor agencies and their technical advisors to see what rules should be changed. The local champions of change and change agents are in the best position to know how far and how fast changes can occur. When the vision is shared, trust is high, teamwork is effective, and local ownership is strong, the right balance will be found.

The reality is that all these conditions are rarely in place. Because, as described above, it is often the case that many individuals cannot visualize specific desired reform outcomes, or even the new structures within which these outcomes would be achieved, it is difficult to convince them of the need to sometimes change existing rules.

This is an additional argument for demonstration projects that make the stages of reform real and permit firsthand experience of the problems that arise if "things" around the project remain as they always have. Resistance to required changes in the rules is less likely to occur when need for change is locally inspired and the change can be framed as a "demonstration project" itself.

HPSP Demonstration Results

One aspect of the family health model established in the pilot service delivery sites, is 12-hour service, from 8 a.m. to 8 p.m., six days a week. Seuf, an MOHP facility, began its operations within the traditional framework of MOHP regulations, including the provision of free drugs to patients who pay a small visit fee in the clinic before 11 a.m.

It soon became apparent to everyone working at Seuf, that this regulation was a perverse incentive for patients to crowd into the facility before 11 a.m., and it prevented an even distribution of patient visits during the twelve-hour operating period. Physician/nurse family practice teams were swamped for the first three hours of the day, and sat around with virtually nothing to do for the remaining nine hours. Furthermore, the crowds of patients jostling for position duplicated those seen at other MOHP clinics, and made redundant the attractive seating areas outside each family practice room, which had been designed, for patient comfort.

What was needed was a quick and creative idea that would be consistent with the pilot project design and, for the time being, continue to protect MOHP's objective of constraining drug costs. The director of the Seuf facility found the solution. She proposed that patients who arrive at the FHU prior to 11 a.m. and pay the visit fee, be eligible for free drugs as usual, but be given an appointment to be

examined later the same day or on another, as was convenient for them. Her idea was approved and implemented almost immediately. The objective of constraining drug costs would eventually be met after the FHF was established and included low prescription drug costs as a performance indicator for family doctors.

The outcome of the appointment system was surprising, especially to Egyptians who said that such a system would never work in this country. In addition to achieving the goal of spreading patient visits more evenly throughout the day, patients commented that they felt very special: "We never thought we were so important that the doctor would wait for us."

The appointment system worked so well in Seuf that it was immediately adopted in Abu Qir when it opened several months later.

Lessons for the Future

Work regularly with grass roots staff to tailor the pilot project to the needs of the reform. Make design compromises to adjust to the reality of existing conditions *and insist on* changes when the pressure to retain the status quo is unreasonable. Use grass roots experience and competence to influence involvement from the top only when it is necessary, as in the case of policy or legislative change.

Conduct reform implementation from the grass roots up rather than top down. Solutions formulated by counterpart staff who understand the reform model are particularly successful, while resistance to change is frequently voiced by counterpart staff who are not directly involved in the reform implementation.

2.2.8 Principle 8: Set Priorities and Milestones

Setting priorities and milestones is the eighth change management principle. Often the vision for reform, the common goal toward which everyone is working, is years and many small steps away. While it is critical to keep the big picture in mind, particularly when confusion and disagreements abound or motivation and momentum flag, it is the intermediate priorities and milestones that provide focus for the varied work of the many individuals and groups necessary for project implementation.

Achievements along the path to the larger goal provide hard data for assessment of what is working and what is not, so that problems are continually being identified and solved. It is for this reason that priorities and milestones need to be set for implementation of the change process as well as for the traditional project content elements.

It is important that the process of setting priorities and milestones receives input from local champions and change agents so that they feel a real sense of ownership for the targets as well as for their achievement. It is equally important that those leading priority/milestone setting activities ensure that everyone understand not only the words agreed to, but also the implications and actions necessary to make the desired outcomes real.

Furthermore, donors, technical advisors, local champions of change, and change agents should remain open to the need to change priorities and re-define milestones as the project moves forward. Of course, such alterations should occur only as a result of new learning and/or changes in reform direction and never to hide failure to successfully implement action steps or achieve desired outcomes.

HPSP Demonstration Results

This project was designed to achieve several benchmarks, which reflect the framework of USAID commitment to reform in Egypt. Within the scope of these benchmarks, a number of broad outcomes have been identified and discussed with PHR, and within those, some specific measurable indicators that the Ministry of Health and Population needs to accomplish over time to receive its donor allocations from USAID. The minister of health has reviewed these and he has given his signature to indicate agreement.

PHR's responsibility is to provide the ministry with the necessary technical support. At the end of each of several identified time periods, an independent verification contractor employed by USAID visits the country to evaluate the completion of the appropriate indicators, and to give some input into the setting of those to be achieved next.

It is clear that priorities and milestones are necessary to motivate change agents and direct reform efforts appropriately for effective results. However, the process for setting, communicating, and achieving the benchmarks was essentially a top-down activity. As such local champions of change and change agents felt little or no ownership for their accomplishment. Discussions between the minister and USAID did not involve local change agent groups and there was no formal process in place for the minister, as the champion of change, to communicate his commitment to achievement of the benchmark indicators to these important local change agents. The resultant resistance to the Benchmarks was unavoidable since there was no ownership of this process by local change agents who actually did the work of the reform implementation.

Lessons for the Future

Include the minister of health and population, the technical contractor, *and* the local change agents who work to implement reform, with USAID in discussions of the broad outcomes and measurable indicators to be achieved. Ensure that everyone understands the meaning and implications before commitment is given. Give each Ministry official the opportunity to assume responsibility for an appropriate element of the reform, and the associated indicators of success.

Ensure ministry officials understand the role of champion of change. This role includes communicating to their "insider" line members of implementation teams, committing to the reform and benchmarking achievement, as well as being a supporter and defender of the reform.

Build in regular and ongoing communication and assessment of progress (content and process) with each ministry official and with the larger project team, including all ministry officials involved.

2.2.9 Principle 9: Maintain flexibility

Especially in the case of complex, long-term reform projects, the individual, group, organizational, and cultural systems may be changing even as the first phases of reform are being implemented. Particularly in situations where planning has not been a part of the way things were done, anything presented in writing may be viewed as definite and final. It is important that everyone understand that a change in direction, timing, or detail is not necessarily a signal of failure, but could be an effective strategy for managing change and applying new learning.

Flexibility is also an important personal characteristic for donors, technical advisors, champions of change and change agents. They need to be aware of and adapt to changes inside and outside the

reform project, demonstrate an ability and willingness to change their own viewpoints and behavior on occasion, and accept that an important aspect of successful reform implementation is learning about what works and what does not, and adapting accordingly.

HPSP Demonstration Results:

The original schedule was for the FHF to be established by July 1, 1999 and the first performance-based payment by the Family Health Fund to contracted Family Health Units was planned for October 1, 1999. The reality on that date was that Seuf was the only operational FHU, it was still far from being accredited, Abu Qir was not ready to open its doors to patients, and the Family Health Fund had not yet been established.

If the project had ended at that time, there would have been many reasons to call it a failure, since priorities and milestones had clearly not been achieved—unless the accepted goal of change were to move the system more and more towards readiness. In that case, it would have been quite valid to point to Seuf and declare success. Seuf provided real experience of a different way of doing things. It raised doubts about the status quo and it built competence and commitment to a vision of new possibilities. The proof of that is that the next aspect of the project, development of the Family Health Unit at Abu Qir, moved more quickly, avoided many of the initial problems facing Seuf, and made improvements to the model even before it was implemented onsite.

The target date for the first payment from the Family Health Fund was moved to July 1, 2000. The reality at that time was that both Seuf and Abu Qir had been given conditional accreditation and were ready to contract with the FHF. The people and the systems at the FHF were in place and able to be fully operational, and the management teams at the pilot service delivery sites had been trained to solve problems indicated by the performance reports they would receive from the FHF. However, a board of trustees had just been appointed and not yet met, and the money for the FHF was not yet available.

If the project had ended on July 1, 2000, it could have been deemed a failure. In fact, there were some individuals who believed just that. Those working in MOHP's Seuf site who had not regularly received their ministry incentive payments were concerned that the FHF would follow the pattern of unreliability. They were wrong. The pilot project had successfully implemented an accreditation procedure. Seuf and Abu Qir were fully operational. Physicians were submitting completed encounter forms to the FHF, and the FHF staff were processing and examining them to ensure completion and to set performance standards. Concepts that had been only words were now a reality.

The target date was moved to August 1 then to October 1. The board of trustees has met and made a recommendation to the minister of health for the financing of the FHF. FHF staff are working closely with the Advisory Committee to make necessary HIO policy changes. They have visited FHU management teams to ensure understanding of the FHF performance reports and standards. They are writing policy papers in preparation for discussions with the Board of Trustees about additional policy changes to support the project. TST is actively working with the managers of an NGO and private sector site to bring them into the project. They are also continuing to prepare the MOHP sites at Gon, Khorshed, and Mohsen, for accreditation. The first performance-based incentive payment was made by the fund in February 2001.

Lessons for the Future

Ensure that everyone involved in the reform project understands, from the beginning, the need both to plan *and* be flexible. A plan is a roadmap, with markers along the way that should be

consulted regularly to ensure that the destination is growing nearer even though the route taken to reach it may have changed during the course of the journey.

Assessments of progress should focus on the technical content of the reform project as well as on the implementation of the change process itself. Acquaint everyone with a continuous improvement model for assessment early on, so that part of the competence that is built into the project is recognizing what is working, what is not, and what is being learned. Feedback is an important element that should be included, so that identification of problems or the need to change strategies is seen as an opportunity to learn rather than a reason to condemn.

Do not wait for formal outsider verification of benchmarks to assess, evaluate, and improve. Encourage each reform sub-team to take responsibility for monitoring its own progress toward identified performance indicators on a regular basis and to share learning with others. Plan large team workshops to share lessons learned, celebrate success, and acknowledge hard work, on a periodic basis throughout.

2.2.10 Principle 10: Communicate

Effective change management cannot occur without application of the tenth principle: communicate, communicate, communicate! Communication needs to happen often and widely. It needs to be well planned, so that the necessary messages reach the right people at the right times. It needs to be open and honest, even when the news that must be communicated is "bad" news. It needs to be disseminated in a variety of ways by a variety of sources for a variety of reasons. Some of the reasons for communication include:

- > building broad understanding, gaining trust ,and getting input from potential champions of change and change agents early on in the planning phases of a project;
- > educating about the importance and principles of managing change as well as the responsibilities of champions of change and change agents;
- > identifying the need for the reform;
- > painting a picture of the long-term vision;
- > ensuring that direct stakeholders understand their mission, roles, and responsibilities and know how what they do fits into the big picture;
- > developing ground rules for how various groups and individuals will work together;
- > gaining input to shorter term priorities and milestones;
- > evaluating progress against milestones;
- > sharing what is working and what is not;
- > gaining input and explaining strategy and policy decisions necessary for the transition from one phase to another;
- > communicating necessary changes to or problems with, the overall direction or detail of the

reform;

- > quashing or confirming rumors;
- > re-orienting when the process gets off track or slows;
- > widening the direct stakeholder base; and
- > celebrating success.

Who communicates is almost as important as the message itself. As a reform project moves forward and more people become involved in its implementation or are impacted by its results, it is increasingly important that the messengers be local champions of change and change agents. When this does not happen, either because of unwillingness or inability, donors and their technical advisors must resist the impulse to step in and do it themselves for several reasons.

One reason is that unwillingness of local change agents to communicate could signal lack of commitment or feelings of ownership for the reform, a significant problem that must be addressed. Another possibility is that local change agents may not understand what is happening well enough to be able to communicate and that, too, is a significant problem, which cannot be ignored. Final reasons for technical advisors to refrain from taking on the direct communication role include the danger of promoting dependence and lack of initiative in local change agents as well as sending the unintended message that outsiders own the reform and are imposing it on the system.

HPSP Demonstration Results

PHR developed a marketing and communications strategy for the primary care reform and the FHF. The aims of the strategy were:

- > "Phase 1...to foster consensus-building and understanding of proposed policies for the establishment of the FHF; and
- > Phase 2:...to enhance understanding of the FHF's role and objectives among implementers and policymakers...to promote provider participation in the FHF and patient enrolment in a pilot project service delivery site." (Technical Report 42, Chapter 7)

The ministry did not emphasize the communication strategy for the process of change. The products and processes developed by PHR were largely determined by a collaborative plan developed with TSO counterparts. Since they were unfamiliar with the change process, they did not focus on strategies to explain the principles of change or the predictable dynamics that would occur. There was one exception. The coaching of the Family Health Fund management team included a discussion of the phases of group development. Like so much in this reform project, it was initially just a theoretical concept, with little to make it real except the "me" feelings the members of the team were experiencing in that early stage of their development. However, those same dynamics of change provided the opportunity for the theory to become very genuine.

The FHF team had gone through five intensive months of training together. They understood thoroughly their organizational mandate and their individual responsibilities. They had worked together to develop ground rules for their team, and behavior principles for the FHF. They understood performance management and had learned how to use a group problem-solving model. They were a team in every sense of the word.

Suddenly the Interim Director of the Fund was reassigned. The remaining team members reacted as one might expect - one decided to resign in protest. The others were angry, worried, confused, guilty, and sad. They discussed whether they would also quit, but decided to hold off making a decision. Quickly a new Director, well qualified and known to all, was appointed. Despite his efforts to bring the team back together, their commitment and determination had gone.

At the first opportunity, the team spent time with the PHR Organization Development consultant who had trained them, re-visiting the phases of group development. Suddenly the theory became real. They saw how their feelings and behaviors were normal and predictable. They discussed what they felt, their concerns and the hopes that still remained for the success of the FHF. They were able quickly to re-commit to the mission of the FHF and to the team, and have regained feelings of ownership for the work they were trained to do.

Lessons for the Future

There cannot be too much communication during a major reform project, only too little. Develop a formal communication plan as part of the change management plan, but add communication on an ongoing basis as necessary.

Communicate what is working well as well as what is not, what is being learned, what has happened, what will happen next, what is on track, and what is changing. Ensure that communication is bottom up and horizontal as well as top down. Support counterparts and ensure all understand that communication of ineffective strategies is as important as communication of effective strategies. Try to design approaches that allay fears that early failures will threaten the entire reform.

Whenever possible use face-to-face communication techniques, bringing together different sub-groups and constituents to hear progress, share experiences, and solve problems. Ensure that sub-groups are responsible for their own communications so that the project system does not become dependent upon the reform consultants. Model openness.

2.3 Learning for Future Reform Projects

PHR examined centers of official control in the reform environment from June until September 1996. In Technical Report No. 5, Volume V, *Analysis of the Political Environment for Health Policy Reform in Egypt*, Dr. Nihal Hafez notes, "This renders the GOE, as represented by the MOHP, as the agency most likely—but not necessarily most qualified—to lead any policy reform to be implemented in the Egyptian health sector." She delves more deeply into the issue of capability in the companion Volume VI, *Analysis of the Institutional Capacity for Health Policy Reform in Egypt*.

As a result of her analyses, Dr. Hafez emphasized several major challenges for successful health sector reform in Egypt, including:

- > the need to develop a generally accepted definition of the focus of the reform—*what* needs to be done, *who* should do it, and *how* it should be accomplished;
- > the need for MOHP and HIO to build "a strong constituency and partnership by involving all the stakeholders in policymaking and the implementation process;"
- > the need for development of national ownership for the reform;

- > the need for adequate phasing of the reform to take into account realistic commitments for policy changes; and
- > the need to manage the politics of reform.

In her report conclusions, Dr. Hafez asked several pointed questions, some of which focus on:

- > the technical and analytical capability and political power of the MOHP to propose, initiate, gain acceptance for, and implement reform;
- > the likelihood of senior government officials to support and commitment to sustaining the reform if it is perceived to threaten their positions;
- > the ability and willingness of underpaid, demoralized employees of the government health sector to implement and sustain a major reform effort; and
- > the difficulty of changing the complex, control-oriented legislative environment governing health care in Egypt.

The pilot project in Alexandria has demonstrated much more than the primary care model, the FHF quality contracting agency to model separation of provider and payer, and the regulatory requirements that were anticipated. It has confirmed the validity of much of Dr. Hafez' analysis by demonstrating the necessity to devote as much planning, implementation, and learning assessment effort to the *process of change* as is currently given to the content.

Our learning about the change management process in this project suggests a number of important points for future country reform efforts:

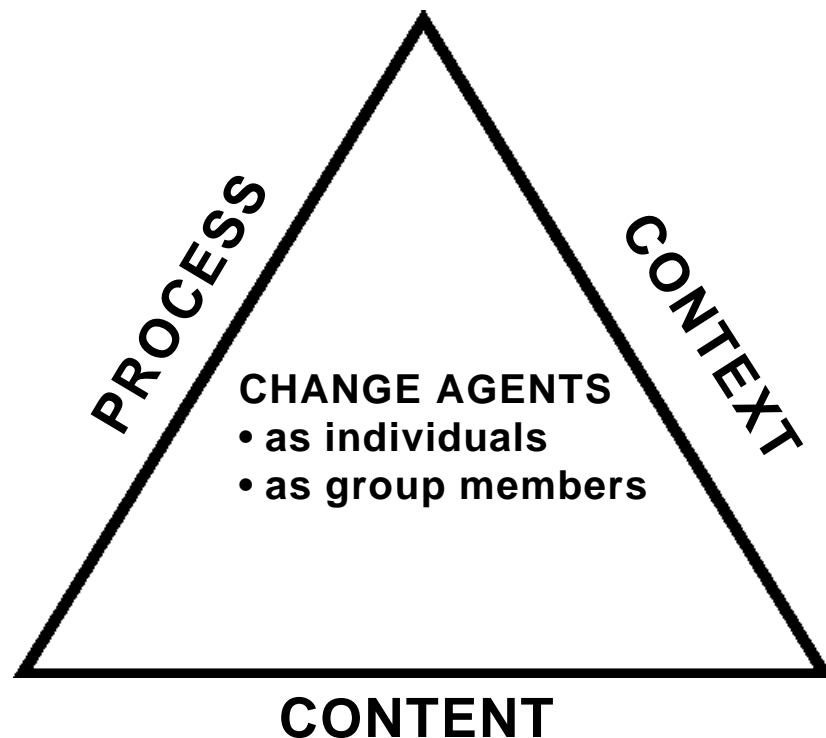
- > Explicitly include the change management schema and the ten change management principles when planning and implementing all project activities, *including* planning itself.
- > Everyone—including consultants who do pre-project assessments, and long- and short-term technical advisors to the local champions of change and change agents—is an agent of change and should understand the basic schema and principles of change management.
- > Build a strong and effective insider/outsider implementation team in which the "insiders" are line staff permanently assigned to work on the reform with "outsider" technical advisors.
- > Prepare the team to understand the context, content, *and* process of change.
- > Learning by doing (action learning) in quick, contained demonstration projects is the best way to make the concepts being tested (content concepts *and* change management concepts) real for local and expatriate change agents alike.
- > Include specific priorities and milestones related to the change management principles along with those for the content of the reform project, involve line management as much as possible in their development and ensure they understand the country commitment to achieve them.
- > Plan for continuous assessment of what went well and what needs improvement for both the change process and the technical content as the demonstration project progresses. Involve

local change agents in the assessment and communicate the results widely.

- > Ensure that the scheduling and content focus of short-term technical advisors is well suited to the current needs of the reform project; use a team of advisors who will visit repeatedly as needed and develop an understanding of and relationship with the reform environment and its change agents
- > Build on centers of competence as well as centers of control
- > Do not foster dependence. Know when readiness and competence signal the time for technical consultants, long- and short-term, to leave.

We speak about change as a process, not an event. Yet our approach to country reform has been to think about, plan, and implement a number of technical activities as though they were distinct events rather than related content elements in a process of change. In any context, as long as it is people who are implementing reform and people who are affected by the reform being implemented, there will be a need to know as much about the process as the content. Intellectual knowledge of the change process is not the same as the wisdom that comes from actually producing change and learning from the experience. To truly be successful, reform must be, above all, a process of learning.

Figure 2. Change Management Schema



Adapted from: Walt, Gill and Lucy Gilson. 1994. "Reforming the health sector in developing countries: the central role of policy analysis" in *Health Policy and Planning*, 9(4). Oxford University Press, pp. 353-370.

Figure 3. Phases of Group Development

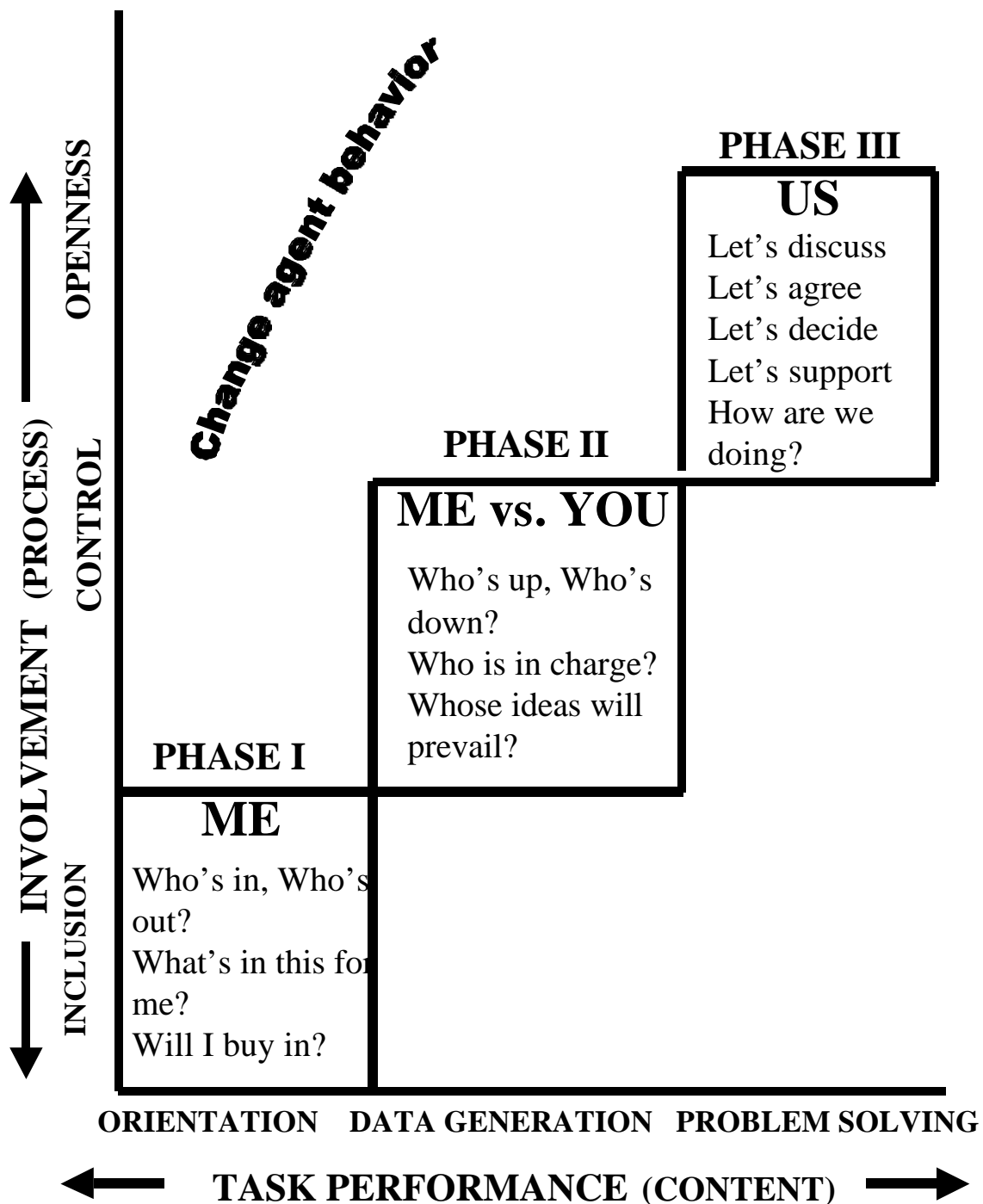


Table 1. Learning for Future Reform Project Organization and Technical Support

Planning for Technical Support	Preparing Technical Assistants	Implementing Technical Support	Evaluating Technical Support
<p>Use the change management schema as a planning framework, to focus attention on the reform context, the change process, and the agents of change, as well as the content.</p> <p>View separate technical support activities as related elements to support the process of change, rather than distinct events; how does each move the process along and contribute to both process and content goals?</p> <p>Schedule the timing and content of short-term technical assistance to meet needs of the client and the project. Obtain the active input of the insider/outsider team to the timing and content of technical support activities.</p> <p>Ensure flexibility of the schedule, content, and process, to adapt to necessary changes as the project progresses.</p> <p>Technical assistance should be provided by a group of dedicated consultants who establish their credibility and understanding of the project and return as many times as necessary.</p>	<p>Prepare technical assistants to understand the process of change in addition to their content expertise.</p> <p>Spend time with change agents long and short-term alike, to explain what it means to be a change agent. Ensure they understand that they fulfill a change agent role in addition to providing support in their particular area of expertise.</p> <p>Involve the project's technical support staff in early teambuilding activities so that a strong insider/outsider team is developed.</p> <p>Ensure that every technical assistant has an understanding of the broad purpose of the project, the various content and process elements, the mission of the various groups and how they depend on one another, what technical support activities have already occurred, what is planned for the future, and how his or her activities fit in.</p>	<p>Make certain that objectives, participating individuals/groups, content and process elements, desired outcomes, output, and measures of success are clearly articulated for each technical support activity and everyone involved.</p> <p>Ensure also that everyone is clear about how any one technical support activity contributes to the whole.</p> <p>Short-term technical assistants, whenever possible, should work in partnership with an "insider" member of the core insider/outsider team or another appropriate counterpart.</p> <p>Whenever possible, counterparts should learn about the process(es) used by the technical assistants so that their skills are developed in various areas of expertise even as they benefit from the content provided.</p>	<p>Involve the participating individuals/groups in giving feedback about the achievement of objectives of the technical support activities.</p> <p>Ensure that short-term technical assistants prepare a report and presentation to the insider/outsider team, so that everyone stays informed.</p> <p>Build process measures into the evaluation of technical support, in addition to the more traditional content indicators.</p> <p>Remember to evaluate the package of technical support activities as the project moves forward. Is the package fulfilling both content and process goals? Do changes need to be made to the timing of visits? The content? The processes used? How are technical support activities contributing to the implementation of the change process and the development of necessary capabilities?</p>

3. Family Health Fund Organization Design and Management Team Development

The financing component of the Egypt family health care model is the Family Health Fund. Initially it was conceived as the new financing agency within a full-functioning health insurance system. As such it would have collected and held all health insurance funds from the Health Insurance Organization on behalf of its beneficiaries, as well as those from the Ministry of Health and Population for individuals covered by its service delivery program.

However, consistent with the intent of a demonstration project, this initial concept was adapted to suit the complex realities associated with developing and implementing new health insurance legislation to replace that which currently exists in Egypt. A discussion of the specific issues and options considered prior to the minister of health's decision to establish the FHF as a sub-account within HIO, can be found in PHR Technical Report No. 42, *Establishing a Family Health Fund in Alexandria, Egypt: The Quality Contracting Component of the Family Health Care Pilot Project*, Chapter 3, December 1999.

The Alexandria governorate Family Health Fund was officially established by ministerial decree on December 29, 1999, and the organization was staffed two months later. Its mission is to ensure that high quality health care services are provided to the population of Alexandria, by means of:

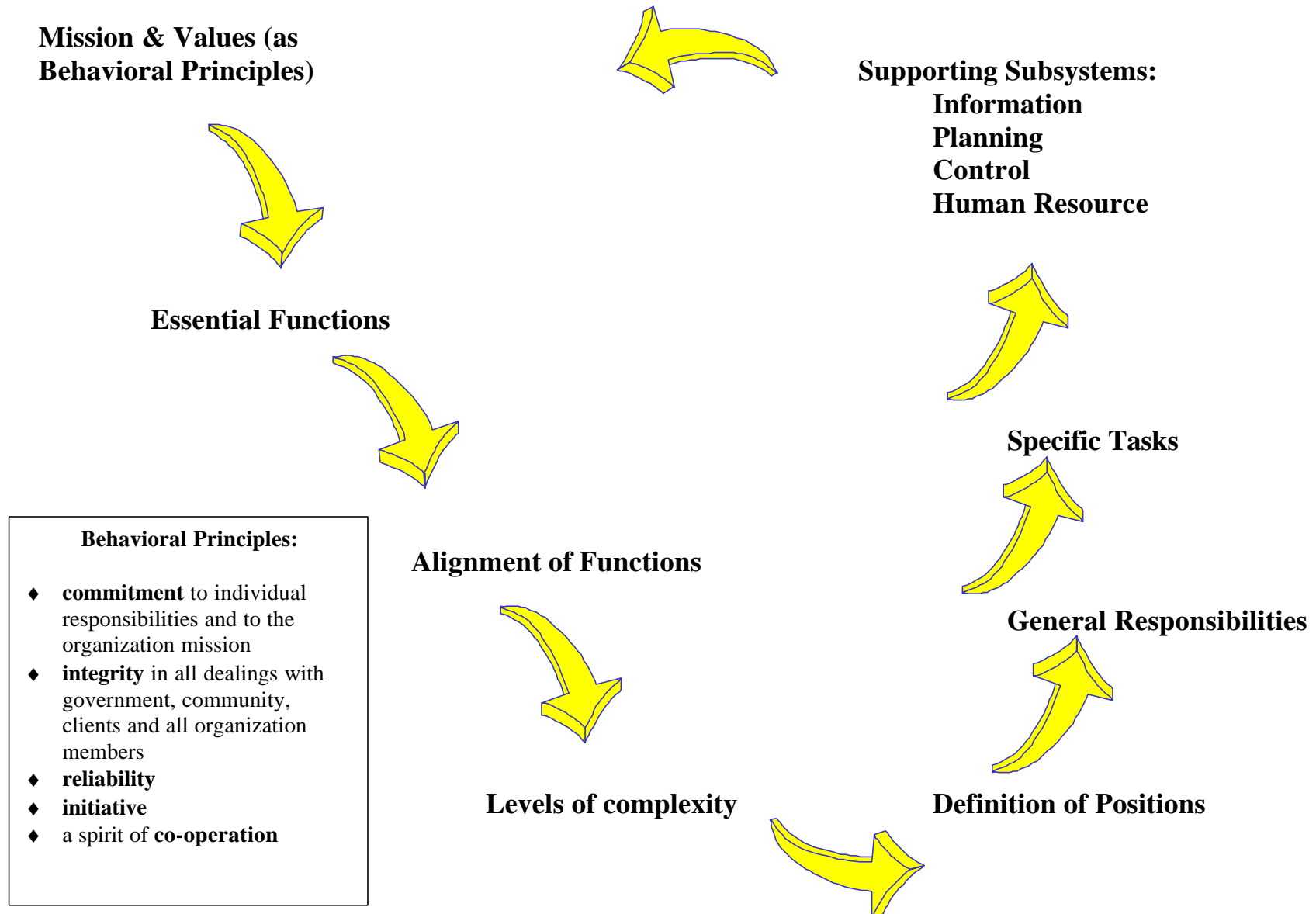
- > a pay-for-performance system of contracting with health professionals that motivates them to contribute their very best; *and*
- > the cost-effective purchase of health services.

This chapter examines both the content and the process of the organization design and management team development of the FHF component of the demonstration project. It also indicates what was learned as the project progressed and offers suggestions for the development of organizations/working groups in future reform projects.

3.1 The FHF Organization Design

The purpose of organization design is to align roles and responsibilities of people to best fulfil the mission of the organization, within the bounds of a set of accountability and behavioral principles. The organization design process yields boxes on an organization chart. But even properly aligned boxes will not ensure the long-term success of an organization. What goes on *inside and between* the boxes is equally significant. That, too, is part of organization design. From the very beginning, the focus was on the task content of the FHF, which determined the necessary functions to be performed within roles, as well as the process elements, which define how FHF staff will work to accomplish their goals. (See Figure 4.)

Figure 4. The Organizational Design Process



The original structure of the FHF emanated from a clearly articulated mission and identification of critical functions. For specific details of the design methodology and recommendations, see PHR Trip Report, *Alexandria Governorate Family Fund: Organization Design Recommendations and Methodology*, May 9-June 9, 1999 and PHR Technical Report No. 42, Chapter 3. The design recommendations included a staff selection process to provide the organization with the best-qualified people available for each of its vacant positions. In keeping with the Egyptian custom of appointment to positions, however, an interim director for the FHF was named in July 1999.

The initial staffing strategy was to fill only the senior FHF management positions and to expand as the workload required it. Although the new director was fully prepared by the end of August to use the formal selection process to choose his management team, he could not move ahead until complex issues relating to the issuance of the ministerial decree were solved. The ministerial decree that formally established the FHF was issued in December 1999. By that time, the development of the financial component of the pilot project was almost one year behind schedule.

In order to proceed as quickly as possible, the director of the Northwest Delta Branch of HIO was asked to choose individuals to form the FHF management team. On February 29, 2000, five experienced HIO employees were appointed to the Family Health Fund on a part-time basis, and on March 1, their coaching/training began. The individuals were assigned to the positions most closely approximating their HIO work experience giving the FHF a director of support services, a management information systems (MIS) manager, a director of insurance operations, and a director of monitoring and evaluation.

Strategic planning is a function lacking in most Egyptian organizations, including HIO, and an experienced individual was impossible to find. In addition, experience in the development of financial strategy, policy, and systems does not exist within HIO. However, the need for a policy development function was well understood, and within the boundaries of available experience, the position of director of strategy and policy was also filled. See Figure 5 for the original FHF organization structure.

During the five-month organization development process it became increasingly apparent that the MIS function was essential to achievement of the FHF mission. The MIS experience provided within HIO had been limited to operation of dumb terminals connected to mainframe computers, rather than working with personal computers. The development of the understanding and competence necessary to use the sophisticated software system being created for the FHF required pulling MIS out from the support services group to function as a department on its own. The individual who had been appointed as director of support services had the most experience, and became director of MIS. The manager of MIS, while willing and able to support the function, was more experienced in accounting procedures, and took on the role of collecting cost data from the Family Health Units and training newly appointed FHU business managers to continue that function. Figure 6 shows the FHF organization as it evolved during this time.

As the project progressed, the need to add several new positions was identified. These include a director of marketing and communications, a financial officer or director of finance, a manager of human resources, and an accounting manager (see Figure 7). Without the time pressures that accompanied the initial management team formation, it is expected that the FHF Director will use the formal selection process to choose the best qualified individuals to assume these new positions. It is likely that the search will need to go beyond the boundaries of HIO.

Figure 5. Original Design of the Family Health Fund Organization Structure

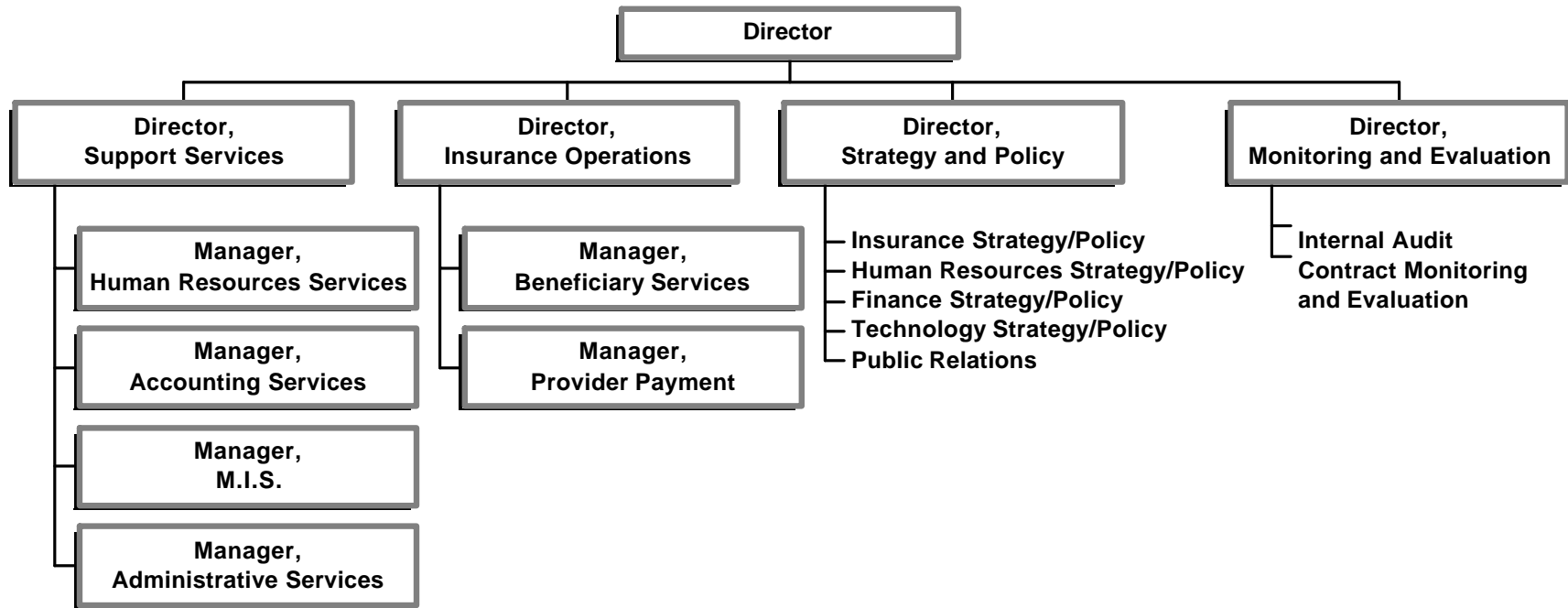
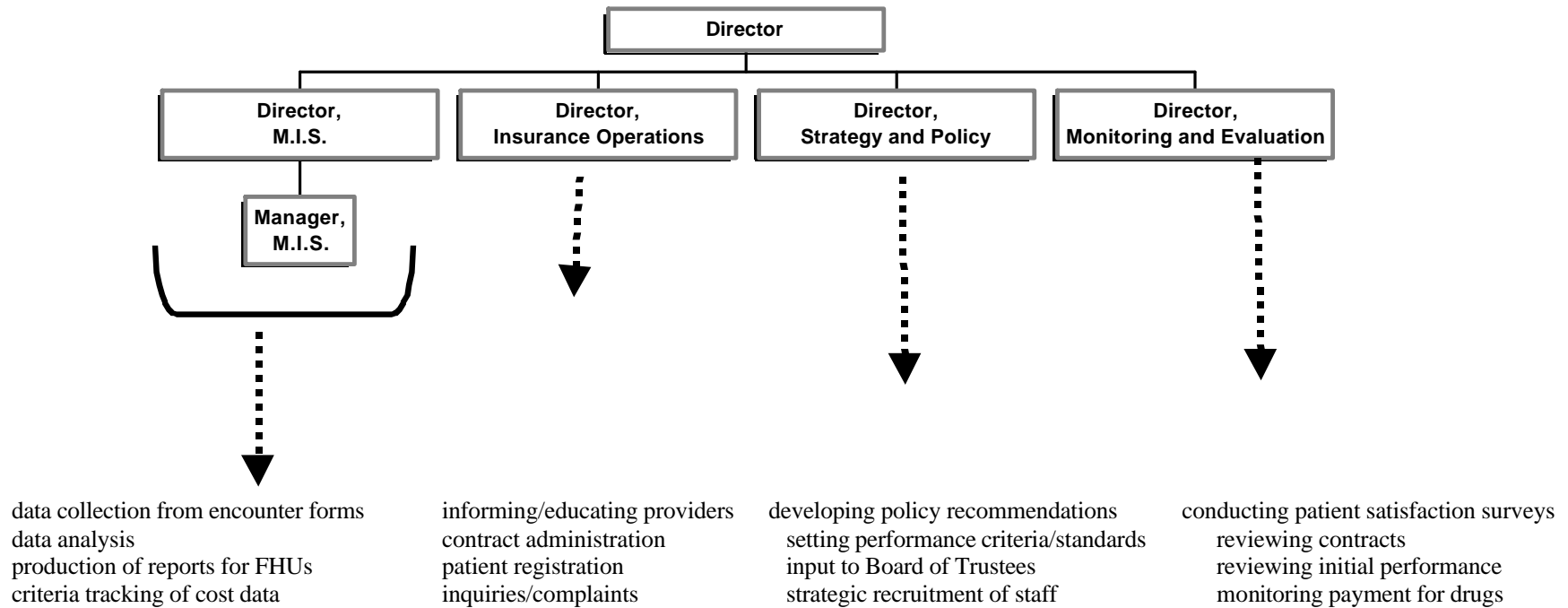


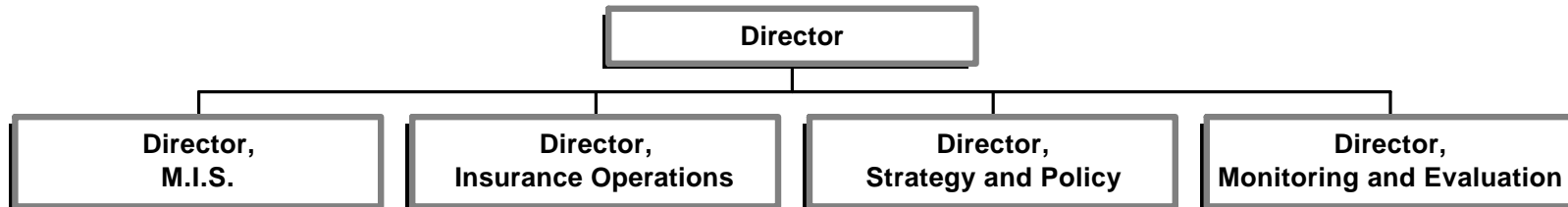
Figure 6. Initial Implementation of the Family Health Fund Organization Structure



Behavioral Principles

- ◆ **commitment** to individual responsibilities and to the organization mission
- ◆ **integrity** in all dealings with government, community, clients and all organization members
- ◆ **reliability**
- ◆ **initiative**
- ◆ **flexibility**
- ◆ a spirit of **co-operation**

Figure 7. Planned Expansion of the Family Health Fund Organization Structure



Planning to select:

- > Director, Marketing and Communications (reporting to director—responsible for media presentations on the Family Health Program), a spokesperson on behalf of the FHF within the community;
- > Finance Officer (or director of finance; reporting to director—responsible for financial strategy, policy and systems);
- > Accounting Manager (temporarily reporting to finance officer, later to new director of support services—preparation of budgets, reports); and
- > Manager, Human Resources (temporarily reports to director; eventually to new director of support services—payroll, administer performance management system, employee records).

Note: Individual formerly in the role of MIS manager now functions as a cost accountant and will report to the new accounting manager.

Behavioral Principles

- ◆ **commitment** to individual responsibilities and to the organization mission
- ◆ **integrity** in all dealings with government, community, clients and all organization members
- ◆ **reliability**
- ◆ **initiative**
- ◆ **flexibility**
- ◆ a spirit of **co-operation**

Just as the service delivery sites need the mechanism of a quality contracting agency to sustain and improve the level their performance over the long term, the Family Health Fund needs a performance management system to sustain and improve effectiveness in the achievement of its mission and associated responsibilities. The development of the performance management system for the Alexandria Family Health Fund began with the design of its organization structure, roles, and responsibilities. For details of the system, see PHR Trip Report, *Performance Management in the Alexandria Governorate Family Health Fund*, March 1-June 18, 2000.

Implementing and sustaining an effective performance system inside the FHF is an especially difficult challenge. There is an absence of role models for effective management of performance in Egypt and the FHF management team members lacked experience with the philosophy, process, and tools of such a system. While the team members now understand the *concept* of performance management, *implementing and sustaining* it requires a paradigm shift from management by control to management by motivation. This shift would be easier if the contextual environment surrounding the FHF operated from a similar paradigm or was, at least, supportive. The reality is, however, that management approaches in Egypt reflect a command and control strategy, and the MOHP and HIO, organizations most likely to dominate the future operations of the FHF, typify this management approach.

The ministerial decree, which established the Family Health Fund, also defined the formula for membership of a FHF Board of Trustees (BOT). It was hoped that this board would provide the strategic vision and support for the new approach to management in the Family Health Fund. Plans were in place to help BOT members understand and be supportive of the FHF mission and performance management system. However, the first BOT meeting did not take place until September 25, 2000, just as PHR was decreasing its on-the-ground implementation efforts and moving to the final documentation stage of the project. Therefore, coaching of the board consisted merely of discussing its role and responsibilities and helping the members to develop a preliminary set of operating procedures. For more information on the establishment of the FHF Board of Trustees, see PHR Trip Report, *Establishing the Alexandria Family Health Fund Board of Trustees*, July-September 2000.

Lessons for the Future

For organizations being created within reform projects, organizations which are being restructured or refocused, and all project committees, working groups, and teams, clarify mission, values (in the form of visible behaviors), roles, and responsibilities, to help reduce conflict and confusion and increase effectiveness of the contribution. Key change agents should be involved as early as possible in discussions regarding organizational structure.

Wherever possible use a formal selection process to staff reform project organizations, committees, and groups so that the best qualified individuals are chosen for the identified positions. Even in situations where use of a formal selection process is not possible, ensure clarity of job requirements and use a "best fit" process to match the individual to the position.

Maintain flexibility. As a project progresses, it may require new or additional functions to be performed. Involve change agents and major stakeholders in a regular and ongoing process of assessing progress, learning to identify needed changes, and incorporating them into the project design in an effective manner.

Keep communication current. It is easy for technical advisors and change agents to become so involved in the details of implementing the project, assessing its progress, and making required

changes that they forget to inform and involve others. This is especially critical in a demonstration project, where all concepts are being tested and counterparts may have no idea of their real meaning or implications until they see them in action. Many conflicts and misunderstandings have at their root different sets of information about project direction or specific project details and that could have been eliminated by regular communication updates.

3.2 FHF Management Team Development

From the beginning the hope was to create a Family Health Fund organization that was without precedent in Egypt, in terms of the way it is structured as well as the manner in which it accomplishes its operational mandate.

Since the purpose of the FHF is to encourage quality performance from service delivery providers by means of performance-based incentives, its internal operations must also emphasize effective management of performance. However, as is the case in many developing countries, managers in Egypt learn primarily by the example of others, and, as has been described, that example often models management by control, fear, and compliance, resulting in less than effective performance and achievement of goals.

Furthermore, individuals working together often do not have a sense of how what they do contributes to a larger whole; activities are compartmentalized and become meaningless. The notion of the need for quality output is irrelevant. Work becomes a matter of looking busy and competent, protecting one's reputation and job security by creating an illusion of merit.

Clearly the development of the FHF management team required a unique approach that could model a different way of interacting and provide the content members needed to be able to fulfill their responsibilities. The development activities were designed to:

- > build a sense of ownership and confidence;
- > increase capability;
- > influence effective leadership;
- > promote a culture of continuous improvement and learning; and
- > give every FHF staff member a thorough understanding of:
 - ↑ the mission of the organization,
 - ↑ the mandate of his/her department,
 - ↑ the specific responsibilities in his/her position,
 - ↑ the tasks and outputs assigned by the manager,
 - ↑ how the work that has been assigned contributes to the purpose of the organization as a whole, and
 - ↑ how to function as a member of an effective team.

The process used was a combination of training and coaching dependent upon the active participation of the members in shaping the nature of their teamwork and defining the framework within which they would function as staff of the Family Health Fund. The foundation of the process was the development of openness and trust through ongoing communication and critical feedback. The FHF members learned as they connected theories and concepts to their personal experience, reflected on the connections, shared and discussed them, and planned for their integration into the emerging reality of their FHF work life.

The decision to fill only the senior FHF positions initially and expand as the workload required, was supported by another to coach everyone together so that each person would have a clear picture of the role of the FHF within the pilot project as well as a thorough understanding of how each segment of the organization contributed to the achievement of its mission—*what* it was to accomplish. Equally essential was the building of a strong and effective team—*how* the staff would work together.

When the FHF management team members were appointed, they had absolutely no knowledge about the direction and goals of health reform in Egypt or the objectives and details of the Alexandria pilot project. They had been asked to become part of an organization, which they had never heard of, to leave their familiar HIO positions and colleagues, and to commit time and effort to learning whatever was necessary to assume responsibilities, which had not yet been explained.

This was definitely a phase I group (see Figure 3) and the development process they would experience was designed with that in mind. It began with an acknowledgement that they were stepping into something they knew nothing about, and continued with a fun exercise designed to encourage an open discussion of their serious and very real feelings about involvement in the project. This discussion was used as the basis for crafting the content of the next immediate segments of the coaching process, that served to orient the participants and reduce their feelings of uncertainty and fear.

Throughout, an attempt was made to balance the content and the process, so that the management team members became quite comfortable discussing what they were learning and how they were learning it, as well as what they would be responsible for and how they would fulfill those responsibilities. They were introduced to the Phases of Group Development early on in the process, and periodically reviewed where they believed the group was in its development and what it needed to do to continue to move toward the goal of phase III.

They developed a set of operational ground rules, that included how they would make decisions as a team and how they would solve problems. They also took the behavioral principles that had been built into the FHF organization design, and defined them in measurable terms that had meaning for them, reflecting how they felt members of an effective team should work together. They insisted on the need for an additional principle—flexibility—reflecting their awareness that they were involved in a demonstration project that was continually changing as implementation progressed.

Annex A provides a description of the major management team development activities implemented from March 1 through mid October 2000. More detailed descriptions of the MIS training can be found in chapter 5 of this report. Details of some of the other activities is described in the PHR Trip Report, Performance Management in The Alexandria Governorate Family Health Fund, March 1-June 18, 2000.

One of the biggest challenges during the management team development process was the fact that the content, though very specific, remained conceptual. Until late June the Family Health Fund

had no designated office space, furniture, computers, or management information system. They understood the big picture, the FHF role within it, their individual responsibilities as well as those of their team members, all the bits and pieces of the input, throughput and output information they had been given. However, they had no opportunity to practice what they had learned. With the installation of the MIS that had been developed for them in Bethesda and the associated training, everything suddenly became real.

At about the same time, the team members were given the opportunity to test their ability to live the flexibility behaviors they had defined, and to learn first-hand about the impact that outside influences can have on the phases of group development. The reassignment of the first fund direction was an initial shock to the Family Health Fund organization. After a relatively short period characterized by feelings of shock, anger, sadness, and confusion as well as the resignation of one of the team members, the group refocused its energy and efforts to support the new director and move forward with its work.

At the present time the management team has prepared six different contracts for use between the FHF and each sector, including HIO and the MOHP. Criteria are in place for performance incentive payments, most of which are based on data collected from encounter forms submitted by the FHUs. One measure of performance not based on encounter form data is a customer service survey that has been completed at the Seuf and Abu Qir sites. Another, yet to be implemented, is an audit of adherence to treatment protocols focusing on antenatal care, hypertension, and family planning. Criteria are also being developed using recommendations in the recent report of a short-term technical expert, for audit of medical records at pilot sites.

Lessons for the Future

Whenever possible, schedule management and organization development coaching/training activities to coincide with the availability of an appropriate place and equipment/systems to do the work which will be required. This will increase the opportunity for practice, which will make the unfamiliar and often complex concepts, real.

Ensure that management and organization development activities start where the participants are and take them to where they need to be. Where they are, more often than not, is confused, anxious, uninformed, and unprepared. Process at this point in time is much more important than content. Development of trust and confidence in the technical advisor(s) is essential.

Tailor development activities to the needs of the target audience as much as to the needs of the project. Develop a learning partnership with the participants, using their work experience and wisdom to define how they will work together, how they will assess performance, what is possible in their country and culture, what real-life problems or issues they face which can be used to practice new learning together, what content needs more explanation and what, less.

Model the processes participants need to learn. Meetings, for example, should have explicit objectives, an agenda, a given time frame, a means of recording important points and decisions made, and an opportunity for assessment of the session. Often participants will have no idea how to plan or use formal problem-solving procedures, because it is not a part of their cultural experience. Plan with them so they will learn how to do it, then let them plan while being observed. Solve problems in an organized step-by-step manner, so they will learn the process, then let them solve their own problems with support when needed.

At least in the initial stages of management team development, technical advisor support should be full-time in order to build trust and assess the validity of assumptions about what learning is needed and what is not.

Use the real need to develop organizational or group procedures, prepare reports or presentations, and organize meetings, as opportunities for participants to implement what they have learned, develop skills, and gain confidence. Lead from behind.

3.3 Learning for Future Reform Projects

In a *Journal of Management in Medicine* article, "Participatory system development: A case study from Urban Health Lahore component DFID second family health project," (Vol. 13, No. 2, 1999, pp. 114-121), Simon Azariah comments that "while the 'content' of reform, which refers to the kind of changes that have to be brought into the system, is important, the 'process' of reform is equally, and at times perhaps more, important. The process of reform means the way the planned changes are brought into the system." He goes on to say "the ability of human resources and their preparedness to carry out the functions that become necessary in the reformed state of affairs is mostly inadequate. Lack of ownership and indifference to change may also manifest themselves."

Capacity building is a significant element of most reform projects, designed specifically to address this issue of human resource capability. However, capacity building is most often defined in the most narrow of ways to include only the development of the skills most obviously essential to implement the content of the reform project. Management and team skills are rarely developed, even though they are characteristically absent in most developing countries.

Several change agent and major stakeholder groups and organizations have been actively involved in the Egypt Family Health Care pilot project. None has received the same level of explicit attention to structure and management team development as the Family Health Fund. And none has developed the same clarity of purpose, feeling of ownership or sense of teamwork.

Our learning from this experience suggests a number of important points for "capacity building" in future reform efforts:

- > Plan for the necessary time, funds, and technical expertise to structure and develop major organizations, teams, and work groups within the reform project to best achieve their mandates.
- > Ensure that development is not just a content-focused series of training sessions or programs to build needed skills, but also stresses the process of involvement and teambuilding and the essentials of good management.
- > Context, mission, necessary functions, roles and responsibilities, performance expectations, and a process for regular review of what and how the work is being done, should be basic for every group and individual in the project, including visiting technical advisors.
- > Give the various organizations and stakeholder groups in the reform project the opportunity to meet together to understand how each contributes to the project's overall goals and to assess how they can function most effectively together.
- > Use every interaction as a learning opportunity, not only for the participants, but also for the

technical advisor(s). What is working? What is not understood, and why? Is there a better way to do what was intended, given the reality of life in the reform environment? Are some procedures just not appropriate or necessary?

Organization design and management team development are components essential to the early stages of any project. They require planning, funding, technical expertise, time, indicators of success, milestones, and ongoing assessment. Together they can contribute to the formation of the solid foundation of understanding, commitment, and capability necessary to successfully implement and sustain major reform efforts.

4. FHF Financing and Incentive Payment System

An extensive study of cost and utilization data was conducted in mid-1999 to prepare for the pilot project. PHR Technical Report No. 36, *Options for Financing Health Services in the Pilot Facilities in Alexandria*, documents the findings and financing options. The report presented a financing scenario containing the following:

- > Households would pay a 10 LE roster fee per year for each uninsured family member.
- > Uninsured patients would pay a user fee of 3 LE per visit for an estimated two visits per year, for a revenue of 6 LE per year per person.
- > Of the visit fee revenue, 3 LE would be used for the FHF and the remaining 3 LE would be retained at the FHU to cover operating expenses.
- > There would be no fees for visits for the purpose of immunizations, family planning and antenatal visits.
- > There would be no fee for lab investigations at the FHU level consisting of blood, stool and urine tests.
- > Uninsured patients would pay 5 LE co-payment for other referred lab investigations.
- > Uninsured patients would pay 1 LE co-payment per drug prescription.
- > Insured patients would pay none of the above charges, but HIO would pay an annual capitation fee on their behalf, using the above methodology for calculating the amount.
- > The MOHP would provide a similar subsidy for poor families unable to pay the above fees.

PHR Technical Report No. 36 was an attempt to estimate costs through a “top down” approach, based on whatever data were available from various sources at the time. It was recognized that better cost projections could only be determined through “bottom up” collection of data in the pilot project, and that those projections would be used to provide information to the minister for a decision on the expansion of the project and the related financing required.

HPSP Results

The original concept of the pilot project was that the Family Health Fund would provide full cost health insurance for primary health care through a capitation payment system for members of families registered for continuous care at the pilot sites. It soon became apparent, however, that this ideal model would require major structural support, including new legislation and mechanisms for collection of roster fees from families, that could not be achieved within the timeframe of PHR’s involvement. It was therefore decided to take an incremental approach to implementation, with the first phase consisting of FHF payment of incentive payments to FHU staff only, based on performance criteria to be established. Measurement of performance would be through data submitted

by family doctors on an encounter form, the key document for gathering of operational data by the FHF. In phase I, the owner of the facility, whether the MOHP, HIO, a private enterprise or an NGO, would continue to pay all expenses of the facility, including base salaries to the staff.

Financing was the most difficult aspect to implement in the pilot project. Counterparts had difficulty understanding that financing decisions should be based on data collected and that “seed money” would be required until such data were available to confirm previous cost estimates. Even when money was made available from the Ministry of Finance as GOE counterpart funding, there was a total reluctance to use any portion of that money. Technical staff were frequently asked why donors did not provide the seed money for experimentation.

In discussing the incentive payment system with FHUs, staff at MOHP sites had difficulty appreciating the concept of performance based payments, particularly because incentives had hitherto been based on subjective and administrative criteria rather than on measured performance. MOHP physicians wanted to have concrete amounts: exactly how much would they get paid?

In the other sectors, physicians better understood and even welcomed the concept of a bonus payment related to measurable performance. The reason for this could be that at HIO physicians were used to receiving incentive payments based on some form of measured outcomes. In the private and NGO sectors, payments by the FHF were welcomed as additional revenue, and the logic of payments based on performance was easy to grasp.

One significant policy issue that is causing an imbalance in the workload between Abu Qir FHU and Seuf FHU is that Abu Qir is seeing the entire family while Seuf is seeing mainly women and children. The reason for this is that the male head of the family is usually covered under HIO and receives services at HIO factory or workplace clinics. The solution is for HIO to take some action to insist that members of families that are rostered at Seuf are “shut out” of receiving primary health care services at any place but Seuf. This issue was discussed many times by the HIO Advisory Committee and was raised as an urgent issue to be resolved in September 2000. As coverage increases and the significant coordination of benefits issues between the Ministry of Health and Population clinics, and the HIO are solved, this issue may be expected to be resolved.

Another complicating factor is that because this is a pilot project, the performance standards will change as the project proceeds. As providers become used to performance expectations, it is logical that such expectations will increase. Providers will need to participate in the discussion of performance and understand and support increased performance expectations.

4.1 Financing Scenarios

A number of financing scenarios for the pilot project were discussed with the Technical Support Office. Following the initial findings of the financing study, it was suggested that the sum of LE 13 should be provided to the FHF for every patient enrolled in the pilot project. For insured patients, this should be provided by HIO out of premium revenue collected. For uninsured patients, this could be collected as an annual fee, whether considered a roster fee, a membership fee, or an insurance premium for primary health care. For patients unable to pay, the MOHP should pay LE 13 for each patient assessed as needy through a standard means testing procedure. In the longer term, consideration could be given to other sources of revenue such as GOE contributions through the Ministry of Finance, a new health tax to be applied to industries contributing to environmental health risks (such as the cement industry), or a targeted progressive tax such as an assessment on electricity bills (people pay in accordance with their income, as measured by their consumption of electricity).

There is a precedent for a targeted tax, as a tax on cigarettes is already used to finance the HIO student health insurance program.

HPSP Results

At the time of the writing of this report, the Ministry of Finance had provided the sum of LE 7.5 million for the pilot project. While this sum is sufficient for the pilot project to be conducted, clearly more stable and sustainable sources of financing are required if the pilot project is to be extended to more pilot sites and aimed at universal coverage in a district or governorate. Attention to the question of reform financing will be a key issue in the next phase of reform.

4.2 The Encounter Form as the Mechanism for Data Collection by the Family Health Fund

As soon as the first pilot site was established, an early version of an encounter form was implemented. There were a number of objectives:

1. to familiarize the family doctors and nurses with the concept of data completion for every patient encounter;
2. to start the process of communication between the Family Health Fund and the pilot sites;
3. to ensure that complete medical records were maintained at the pilot sites and to provide a vehicle for audit of medical records;
4. to provide preliminary data to the FHF for analysis;
5. to assist the FHF with the determination of measurable performance standards for the application of performance based incentive payments; and
6. to provide experience on which to design a more permanent encounter form as the pilot project proceeded.

A prototype referral form was also designed to collect referral data.

Some control mechanisms had to be implemented for the use of the encounter form. These were:

1. The encounter form had to originate in the reception area of the pilot site, when the patient arrived for an appointment.
2. The encounter form could not originate with the family doctor, as this would provide the opportunity for unchecked fraud.
3. The encounter form number had to be assigned when the encounter form was initiated.
4. Every encounter form number had to be accounted for. This meant that the encounter form could not be given to the patient, to avoid the situation where the patient walked off with the form.

5. Data entry of the encounter form had to be completed on a daily basis at the pilot site to avoid development of backlogs.
6. Diskettes containing encounter form data for the entire calendar month had to be sent to the FHF within 3 days after the end of each month.

HPSP Results

The initial encounter form proved to be a valuable learning tool for both the pilot sites and for the FHF. Once feedback reports were received from the technological systems developed for clinical information systems and from the FHF systems, staff at the pilot sites came to understand the true nature of the pilot model. They saw, for the first time, how their encounter form data generated performance reports, and how they could improve overall performance and thereby maximize incentive payments.

There were some initial problems. At one site, family doctors were given supplies of the encounter form to complete and numbers were assigned at the end of the day, opening the system to fraud. Another problem arose when a system of appointments was implemented. The encounter form was generated at the time the appointment was made and sometimes the patient did not come back for the appointment, resulting in a blank form. These minor problems were soon resolved by changes in operational procedures.

Another issue arose because the TST ordered the printing of equal numbers of encounter forms and referral forms, when in fact referrals were made in the ratio of 1 referral for every 10 encounters. When both of these forms were subsequently revised, large numbers of supplies of the previous versions were still in stock. It was decided that these old supplies would be used (for practice purposes) in new primary health care facilities being prepared for accreditation, but that once such sites were accredited, they would have to use the latest versions of these forms.

It should be noted that in the first phase of payments by the FHF, incentive payments were to be based only on services provided by the family health unit, by family doctors and nurses. In preparation for the expansion of incentive payments to include the services of the family health center, in phase II of the FHF payment system, the referral form was redesigned as the vehicle for data capture for the work of the FHC, using the same consultative process as used for the redesign of the encounter form.

4.3 The Concept of Performance-Based Incentives

Seven categories of criteria for initial performance based incentives were suggested in PHR Policy Paper # 8:

- > Productivity related indicators. These are incentives paid for number of patients seen. The purpose of this category is to ensure that physicians have a fair share of the workload within the FHU practice.
- > Customer service indicators. These are incentive payments based on a measurement of customer satisfaction, as determined through the administration of a standard scientific instrument for such measurement, such as a survey. The survey will determine patient views on how they were treated by the staff at the FHU, how they view the cleanliness of facilities, and how long they waited for treatment, etc.

- > Quality indicators for vertical programs. Vertical programs are those MOHP and donor supported programs that relate to a single medical objective, such as immunizations for children to protect them from childhood diseases, or family planning to deal with the issue of uncontrolled population growth.

Indicators in this category will be determined through consultation with vertical program staff with the involvement of the Quality Directorate, and would include such standards as rate of family planning among rostered women of childbearing age and rate of immunization in rostered children 0-10 years of age. Emphasis in this category will initially be on established MOHP vertical programs.

- > Drug volume/cost indicators. The intent of this category is to reverse an established trend in Egypt towards over medication or self medication of patients. Initially the indicator would be defined as the number of drugs prescribed per visit. Later, as drug codes and costs are developed in look-up tables, a more sophisticated drug cost-per-visit indicator would be applied.
- > Referral volume indicators. This category is designed to encourage physician and nurse teams to treat patients themselves, within their area of competence, rather than simply refer them to specialists for treatment. Trainers from Exeter University estimated that fully competent family doctors should be able to treat 90 percent of cases presenting for primary health care. This would certainly be the aim of the project, but would depend on the training provided and the competence of the family doctors as primary health care physicians, particularly given the lag in family medicine training.
- > Health outcomes for rostered patients. The ultimate aim of all health care systems is to improve the health of patients seen. Monitoring health outcomes requires a degree of sophistication to compare the health of the rostered population, using techniques such as control group comparisons or outcome evaluations to meet internationally recognized standards.
- > Indicators for maintaining facility accreditation. Incentive payments must encourage facilities to maintain certain operating standards on an ongoing basis, such as cleanliness, hours of operation, and staff attendance, etc. It is very important not to let facilities compromise on such standards, since that would ruin the image and positive outcome of the pilot project, reduce the competitiveness of the facility, and lose patient loyalty and support.

HPSP Results

The FHF recognized that the structure of the incentive payments required careful thought following an analysis of encounter form data. Incentive payments should not be an easy way for family doctors and nurses to increase their income. The payment should be meaningful and earned rather than simply routine. The detailed structure of the incentive payments should be determined following discussions with the staff of the Family Health Fund, as well as with the service providers who are included in the pilot sites. The important of data collection, data accuracy and data analysis for monitoring by the FHF cannot be overemphasized.

The director and staff of the Family Health Fund have decided to apply the following standards for the first incentive payment using October 2000 data, planned for payment in December 2000:

- > number of patients seen per day: 20-48 interim standard (target 32-48);

- > number of drug prescriptions per visit: less than two;
- > number of referrals as a percentage of patients seen: 1-8 percent interim standard (target 2-4 percent);
- > customer satisfaction: standard above 90 percent in a standard instrument;
- > protocols review: initially of patient visits for hypertension, diabetes, antenatal care, family planning;
- > medical records review: 90 percent complete standard (as recommended in PHR Technical Report, Medical Records Study).

The FHF is preparing to add new standards for incentive payments in the future as operational data are collected and more sophisticated processing systems are developed. These are:

- > patient wait time from time of entering the facility for an appointment to time seen by the primary health care team
- > cost of drugs, replacing the interim standard of number of drugs per visit
- > health indicators for achieving vertical program targets;
- > health outcomes for rostered patients; and
- > efficiency indicators (such as administrative overhead cost, cost per patient, cost per service, etc.) based on cost analysis.

4.4 Cost Analysis

An important part of the pilot project is to collect and analyze cost data from the various sites and the various components of the primary health care system. This has many purposes:

- > to permit cost comparisons between sectors (MOHP, HIO, private, NGO);
- > to permit cost comparisons between individual sites providing primary health care;
- > to allow for the application of overall cost as a performance indicator for future FHF payments;
- > to target administrative costs at primary health care sites at 10 percent of total cost;
- > to allow for the expansion of FHF payments from an incentive system to a full cost insurance system;
- > to introduce a further element of competition between sectors;
- > to provide data for determination of financing required for full cost health insurance by the FHF; and
- > to provide health facility managers with information on the cost of care that will prepare

them to manage under capitation.

HPSP Results

Collection of cost data was tied to the appointment of business managers at the pilot sites. Each site appointed a person from among the administrative staff as a nominal business manager and this person was trained in the costing methodology.

A significant issue was the development of the technological systems for data capture and reporting to the FHF. The MOHP used the National Information Center for Health and Population as the organization that would collect and report encounter data as well as cost data on behalf of MOHP sites. HIO, on the other hand, required a system consistent with its Oracle-based information system. A local software development firm, Guide made a front-end adjustment to HIO's system, as part of the PHR development. This means that the FHF has to work with two different software programs, adding some complexity to its operations. A decision has not yet been made about the nature of the software to be used by the private and NGO sectors.

5. The Primary Health Care Model in Egypt

5.1 Background

This chapter describes the situation of primary health care in Egypt prior to the reform. It also describes the initial design of the service delivery model as agreed upon by the ministry and the donors and as documented in the Egypt Health Sector Reform Document (D4 Report). The primary care delivery model was one aspect of the three components of the pilot project besides the financing and regulation. It certainly evolved significantly from the phase of initial planning to the implementation phase. This evolution is expected in a demonstration project designed to test policy options and operational alternatives in order to provide a model that best suits the Egyptian system.

The health care system in Egypt is very fragmented, where multiple public entities are responsible for the management, financing and delivery of care, in addition to the private and NGO providers. The Ministry of Health organizational structure is one example, with various departments, vertical programs and functions, that are difficult to coordinate. Thus, service delivery is divided along different lines: geographic and structural units (urban and rural units and centers), functional (e.g., maternal and child health), and vertical programs (e.g., immunization, family planning).

Every citizen is by the constitution, eligible to obtain health services from MOH; however due to the very poor quality of the services delivered, only the poor who have no access to other services use it. Less than 40 percent of the population are insured and have access to HIO polyclinics. These have their own problems (general practitioners [GPs] who are the gate keepers, are overloaded, and spend no time with the patients, over prescribe ,and refer frequently to specialists). The private sector gets a big share of service delivery as it is regarded as better quality, 60 percent of the out of pocket payments are allocated to the private sector.

Physicians and nurses in the public sector in general, and the Ministry of Health and Population, in particular, receive very low basic salaries, and supplement their income by having one or more private practices outside their public job. Lack of appropriate incentives to establish efficiency and quality in the system had serious negative effects on the quality of health care received by the patients.

5.2 Egyptian Health System Facts

- > On average, 174 mothers die for every 100,000 live births.
- > One in every 12 children die before reaching the age of 5 years.
- > Fewer than 40 percent have social or private insurance coverage.
- > Poor individuals pay a greater proportion of their personal income for health care than the wealthy.
- > An estimated 60 percent of all primary care visits take place in the private sector facilities.

- > Public facilities lack supplies and drugs, and physicians training is insufficient; there is a vast shortage of skilled nurses.
- > Some 50 percent of the deaths in emergency cases are due to improper case management.
- > Drugs spending and consumption are high with weak cost and quality controls.

Thus, health reform had to be addressed by the MOHP. In order to improve the health outcomes of the population in the long term, immediate improvements in the quality, delivery, organization and financing of health services had to be made. Primary care has the greatest potential to improve the well being of the population. For these reasons health reform started with reorganizing the delivery of primary health care services, leading to the vital process of strengthening and improving the organization and management of services at all levels of the health system in the subsequent phases.

5.3 Design of the Service Delivery Model

The new health service delivery system agreed upon by the MOHP and all the donors was designed to engage both public and private facilities with a family health approach. Health facilities infrastructure would be consolidated at the district level into three types of facilities, family health unit, family health centers and district hospitals. The services at the units level are integrated through provision of a specific basic benefits package to an identified population by means of family doctors who are the gatekeepers of the health system. The family physician is assisted by a team of community nurse and a social worker and is responsible for providing health services to specific family roster. An organized referral system would be developed, from the unit level where family doctors refer patients for investigations or specialists at the center, and to the tertiary level of care and specialized hospitals. To ensure quality and patient satisfaction, only accredited facilities would be contracted by the Family Health Fund, to deliver the services and would receive performance-based incentives.

The Master Plan developed by the MOHP with assistance from the World Bank, has set standards for staffing of the units and centers as regards to population size. Table 2 shows the staffing pattern of a reformed unit and center and the responsibilities of each.

PHR's role was to assist the MOHP to feasibility test this new service delivery model to discover what works and what doesn't before replication. In addition, a demonstration model was the best way to involve stakeholders and produce evidence of improvement in the delivery system before moving into the financial aspects of the reform including incentive payments, creation of the insurance fund, and transfer payments among sectors. Below is a discussion of the different aspects of the care model design and the practical implementation issues discovered during the demonstration project.

Table 2. Staffing Patterns and Responsibilities of Reformed Health Care Facilities

Facility Type	Family Physician	High Institute Nurses	Other Trained Nurses	Other Physicians	Services
Units (p=10,000)	1FP/ 2,500 p	4/ 10,000 p	2/ 10,000 p	None	BBP
Centers (p=75,000)	None	4/ 75,000 p	16/ 75,000 p	6/ 75,000 p	Clinical and procedural diagnosis of referred cases
District Hospitals (p=150,000)	None	6/ 150,000 p	75/ 150,000 p	41/ 150,000 p	Referral of complicated cases
Other Hospitals	None	1/ 25 beds	1/ 2 beds	0.28/1,000 p	Specialized care

5.4 Basic Benefits Package

In early 1998, the World Bank developed a restricted list of services for primary health care, the following table shows the preliminary basic benefits package (BBP) developed. Several discussions took place from this point forward involving USAID, PHR, World Bank officials, MOHP counterparts and vertical program directors to develop this preliminary package into a benefits package of services that best suit the Egyptian system and the population's need. The package placed special emphasis on services for vulnerable and underserved groups, especially women and children. Services provided under the vertical programs were also included in the package to provide an integrated model of care. However, funding and management of those programs were so complex and isolated that resistance to change was created. There was a constant pressure from the MOHP counterparts to add more services to the package without a consideration of the resource and cost implications. One example is dentistry. It would not have been possible to include this service at the onset of the pilot and ensure the same quality being demanded of family doctors and nurses since resources were not sufficient, appropriate funding was not available, and there was no time to train and upgrade dentistry services. Thus, the agreement was to start with an essential, but limited package of priority services and then expand it as the new system starts, people enroll, and more funds are available.

5.4.1 Costing the Basic Benefits Package

Subsequently, a study was undertaken with the assistance of a team of experts from the MOHP and PHR to estimate the costs and resources required for the basic benefits package. PHR (Technical Report 32) describes the methodology for costing of the basic benefits package. Costing of the basic benefits package was based on estimates of the number of contacts (visits) to the facilities and not the actual cost of the service. It was clearly stated that the results were to be viewed as only an estimate, to be confirmed by collecting actual cost data during the pilot test in Alexandria. In addition, issues like referral, overhead, and services outside the package (public health services, sanitation and inspection) that were still provided at the facilities, were not included in the estimates.

Table 3. Preliminary Basic Benefits Package of Services

Category	Preventive and Curative Outpatient Services	Curative Inpatient Services
Children	Immunization, IMCI, breast Feeding, safe weaning, vitamin A and growth monitoring	Referral of severely ill children
Women	Family planning, antenatal care, postpartum care, reproductive tract Infection	Safe delivery, emergency obstetric neonatal care
Adults	Screening and management of uncomplicated DM, Hypertension, cardiovascular diseases, treatment of TB, STDs management, counselling on diet, substance abuse and stress	
All	First aid management and dental care	Minor/common surgery, emergency management of accidents, trauma and burn

Source: Egypt Health Sector Reform Program, Table 3.2.2.1.1.

5.4.2 Medical Guidelines and Treatment Protocol

In the design of the pilot project, careful consideration was given to the quality of health care delivered. This was the heart of the reform and an essential factor to attract the public to the health plan. The quality directorate, inside the Ministry of Health and Population was responsible for working with the PHR team to set quality standards and develop practice guidelines for the new delivery system. After the basic benefits package had been decided, treatment protocols and medical guidelines were developed with participation of many stakeholders in the MOHP and medical schools. This was also the basis of estimating required resources, equipment, furniture, and supplies to deliver the services. An essential drug list was finalized for the package of services, and planning began to ensure availability of medicines at pilot facilities within a stipulated time frame.

However, the quality directorate was a new MOHP department and was not a fully functioning entity. Organizational issues delayed the progress of work greatly. Had those delays not happened, the newly assigned physicians and nurses would have benefited from clinical training on medical guidelines and treatment protocols before the facilities opened their doors. Pharmacy, medical, and clinical nursing staff had to be trained in the principles and options of the essential drug list system as well.

5.4.3 Selection and Preparation of the Pilot Sites

Early in 1998, preliminary assessment of prospective pilot sites in Alexandria first took place at MOHP and HIO facilities then later at NGO and private facilities. A primary health care facilities survey was carried out for all MOHP units and centers in the Montazah and Shark districts to assess the available infrastructure. Because most facilities were in such bad condition and the pilot could only start with facilities fulfilling a level of quality, the selection was restricted to the facilities that were undergoing renovations according to the master plan. To date four MOHP family health units,

one MOHP family health center, one HIO FHU, and one HIO FHC are operating with the new system. One private FHU and one NGO FHU have recently been involved in the demonstration.

PHR was responsible for initiating the model in one clinic from each sector. However, due to the extended time required to familiarize the NGO and private sector with the complex reform program, only MOHP and HIO clinics were functioning for the first year and a half of reform. Seuf Health Center (the units and center were physically in the same location) was selected to be the first pilot site, primarily because it was newly built and so the process of hiring staff and equipping it was thought to be advantageous. Also, the location of the facility in a very rural area surrounded by schools and an uninsured population was a perfect test of how beneficial this model would be to such demographic groups.

A unit consists of the family practice clinic, lab for performing blood, urine and stool tests and a pharmacy for dispensation of drugs and functions 12 hours daily on two shifts basis.

A center consists of specialists offices (the three main specialties under the BBP are gynecology and obstetrics, pediatrics, and internal medicine), radiology unit, laboratory for other investigations under the BBP, emergency room, and small operation theatre for deliveries and minor operations. It functions 24 hours through the emergency unit.

Equipment and Staffing: Despite, the Ministry's pressure to open the facility as quickly as possible, the process of site preparation was complex with many delays. Many bureaucratic steps stood in the way of a rapid start (providing equipment, furniture, and introducing services such as electricity and water to the facility). To date the facility does not have access to a telephone. During the start-up phase an extensive series of interviews were held to select family doctors and nurses based on structured selection criteria. The selected groups were well-trained physicians and nurses, many of whom had received short courses and training abroad in family medicine. Most of the physicians had requested hands-on and clinical training as they were not comfortable with some of the services, for example IUD insertion. Training was provided during the early months of clinic operations.

Opening: It was decided from the beginning that it would be best for a small pilot project to start without publicity in order not to exhaust the system with demand that it can not fulfil. The facility opened its doors to the public on May 1999 when the first patient walked into Seuf and got registered. However, the word of mouth was sufficient to have patients cluster in front of the doors of the facility and the rosters were soon built up. Seuf completed its roster of families in three months. There is currently a waiting list of families.

Registration: When a patient walked into the facility, registration for all family members occurred. Registration meant, opening of a family folder with a unique family and individual identification numbers. Inside the folder, a file for each member of the family was opened, the family was assigned to a clinic/family physician, which initially occurred randomly in sequence. Information about the household social and economic status was gathered by a social worker and kept in the folder. The assignment of patients to teams was decided to be in sequence in the initial registration to ensure a fair distribution of patients among teams so that the mix of patients, old young, sick/ healthy would be about the same. Patients could change their physicians after the first year and then once yearly thereafter.

In preparing of the HIO pilot site, Abu Qir, many of the technical and operational obstacles that had faced the MOHP site, were overcome because they were aware of the problems and prepared themselves for alternatives, illustrating the value of a demonstration project. Abu Qir facility had

started its operation in September 1999, and since this was formerly an HIO facility serving the insured only, they had an active role in orientation of the population in the catchment area about the new system and about eligibility of the uninsured to register. So Abu Qir completed its roster in February 2000, 20 percent of the enrollees were previously uninsured.

5.5 Patient Flow System

Initiation of patient flow systems in out patient facilities was a breakthrough in the organization of the patients' visit to the clinic to ensure quality and efficient service delivery. Although the flow varied from one site to the other due to the structural difference in the facilities, the basic concept was similar. Registered patient flow was as follows:

- > Issue a visit ticket, for which patient paid a user fee.
- > Generate the encounter form that the physician fills out providing details of the visit.
- > Retrieve the family folder delivered to the clinic by a clerk.
- > Family clinic visit, preliminary examination by the nurse, then examination and diagnosis by the physician.
- > Record results of the visit on the encounter form, which basically summarizes the findings of practitioner, the recommendations, and is the claim form for the FHF.
- > Outcome of the visit is lab or pharmacy or referral (either internal to a specialist or external to the hospital). If a referral is recommended, a referral form is issued.

First encounter. During the first visit of the patient to the family clinic, the family physician and nurse do a thorough family history and clinical examination which is included in the individual patient file in the family folder. This is particularly important, as patients never had such an examination in a public facility. For recurrent visits, the same family team attended to the patient and basic diagnostic and curative services were delivered to the patients in the clinic.

Patient referral system. Basically, all services outside the scope of family practitioner's work as stated in the BBP was to be referred to the FHC. These included services needing specialists care (obstetrics and gynecology, pediatrics, internal medicine) in addition to x-ray and laboratory investigations other than blood, stool and urine analysis, which were done at the unit. Direct referral of the patient could occur from the FHU to the district hospital in a case of emergency, otherwise if the patient needed more services that the FHC could not provide, a referral would be made. For the continuity of care and maintenance of the patient medical record, the interventions done to the patient had to be tracked. A referral form had to be filled out in case any referral was requested, which was returned and maintained in the patient's medical record. In addition, to ensure quality and necessity of the referral, the referral form is the document by which FHF can monitor referral patterns of contracted physicians.

Medical records. The patient care documentation in the family folders was initiated by the Social Fund Project and was implemented in some MOHP rural health facilities. Both MOHP and HIO pilot facilities adopted the family folder concept with an addition of two forms, the encounter and referral forms. The automated information systems developed were different, MOHP acquired a patient based system and HIO upgraded its existing system to accommodate patient encounter

reporting. Both systems contained information on the registered enrollees as well as medical records generated from the encounter and referral forms. The FHF requires each facility to send monthly downloads of the system to do the performance management and evaluation which is the basis for incentives payment and monitoring of quality.

Training of staff. The MOHP provided basic training in family medicine in two ways: an off-shore 12-week courses offered by cooperating universities in the U.K. and U.S. to interested Egyptian physicians and nurses; and an in-country 12 week program offered by an Egyptian University. The MOHP also sponsored or arranged short training sessions in family planning, IMCI, women health, quality and clinical practice guidelines.

5.6 Development of a Facility Accreditation System

The aim of the accreditation program developed under the reform was to improve the quality of care and to use accreditation as the basis for contracting with the family health fund. Thus only facilities that achieve an optimum level of quality would be allowed to contract with the family health fund. This is a key factor in initiating competition across facilities/sectors and in ensuring maintenance of a channel for continuous quality improvement. The accreditation system, standards policies, and procedures were developed and tested in the pilot facilities taking into consideration the following indicators:

- > productivity related indicators;
- > customer service indicators;
- > quality indicators for vertical programs;
- > drug volume /cost indicators;
- > referral volume indicators;
- > health outcomes for rostered patients; and
- > indicators for maintaining facility accreditation.

5.7 Pilot Experience and Recommendations

Basic benefits package. It soon became apparent in the design of the Family Health Fund primary health care model that the concept of a restricted basic benefits package was not practical. Patients could not be turned away by the family physician because their condition did not match the package list. Table 4 shows the top 10 diagnosis in four family health facilities for six months. The most frequent diagnosis, arthritis, was not included in the BBP. In addition, the BBP was not clearly laid out and there were no boundaries between the level at which service should be provided and when it should be referred. The terminology “refer complicated cases” was not clear because the level of complication is wide and can vary according to the judgement of the treating physician. This meant that every patient condition, acute, chronic, or preventive care, required an intervention by the family doctor. Referrals were made to a specialist or hospital only when the condition was outside the physician’s area of expertise. The basic benefits package costing methodology had no basis for estimating such demands on the family doctor’s time. It was abundantly clear that the pilot project

would have to depend on a budget approach from actual experience to determine the true cost of providing the primary health care services in the new model.

Table 4. Top Ten Diagnosis for Four Family Health Facilities for Six Months

S. #	ICD 10	Diagnosis	Number of Visits	%
1	M13	Other arthritis	2,518	8.90
2	J02	Acute pharyngitis	2,125	7.51
3	I10	Essential (primary) hypertension	1,509	5.33
4	J00	Acute nasopharyngitis (common cold)	1,501	5.31
5	J03	Acute tonsillitis	1,434	5.07
6	R05	Cough	1,173	4.15
7	K02	Dental caries	1,128	3.99
8	J06	Acute upper respiratory infection of multiple and unspecified sites	1,054	3.73
9	E11	Non insulin dependent diabetes mellitus	1,038	3.67
10	D50	Iron deficiency anemia	971	3.08

Referral system. The first demonstration sites Abu Qir and Seuf had units and centers in one facility. One finding of the pilot is that family physicians referral rate to specialists in the center was as low as 3.4 percent and hospitals was as low as 10-15 percent. This was very different from the rate of general practitioners' referral to specialists at HIO traditional polyclinics (60 percent). The internal referral to specialists was predictable for two reasons. First, family physicians were not necessarily filling out a referral form when requesting a referral internally. The second reason was that most of those family physicians were essentially specialists and they used each other's expertise through informal consultation. The complexity of the referral system was more in tracking external referrals to the hospital, as the hospital staff was not oriented enough about all the forms and the requirements of the system. Therefore when a referral was made to the hospital, the referral form would not usually be filled out and returned at the hospital end. Additionally, patients often refused to go to the hospital because they were not willing to pay out of pocket and not getting the same quality of service received from their own physicians at the demonstration sites.

Medical records. The medical record was a major innovation for MOHP clinics. In HIO, the medical record supporting the payment system. However, it was solely for that purpose and had very little to do with keeping track of the beneficiaries' health status, with the exception of some chronic diseases. The family folder was too small in comparison to the number of forms and documents that it held. The encounter and referral forms were initially kept in the folder, creating a bigger problem if documents were lost. Later automation of the medical records could essentially alleviate the need for storing those forms in the folder. In addition, physicians had to fill out forms. Then in another stage, the data was entered. This accounted for data errors and delayed the availability of computerized data for the FHF. An additional problem was the number of forms and registers that the family practice teams were requested to fill out for the existing vertical programs. Although those programs were supposed to be integrated in the new care model, they still requested their own registers to be filled out. This created a significant load on the family practice team considering the time they have to spend with each patient.

Quality and accreditation. The newly established quality directorate inside the MOHP has the primary responsibility of developing the standards and testing the program. However, for sustainability, the accreditation program had to be institutionalized. Additionally, no effective way existed to accredit providers and regulate their practice. The MOHP, with assistance from the EC teams established the Family Practice Board as a professional group charged with regulating practice. Additionally, the MOHP is currently considering the idea of establishing a national accreditation body that will set the criteria for accreditation of providers. Training issues are also emerging as a top priority for the next phase of reform.

Incentives. Physicians and nurses were required to work longer hours (eight hours shift) to serve a roster of 600 families. They were thus obliged to leave their private practices and be devoted for the program. The MOHP has agreed to pay them 200 percent incentives of their basic salaries until the FHF is completely established and will pay performance-based incentives. However, the incentives were not dispersed on regular basis which resulted in demotivation and a very low moral. HIO staff did not experience the same problem as MOHP in allocating incentives, as incentives were part of the HIO system and were maintained in the new pilot site until performance-based incentive payments started.

Transfer payments. The health reform project intended to unify the sectors and defragment the care delivered to the patients. Prior to reform each of the sectors ran their own facilities and had separate budgets and financing systems. In the design of the new care model, the facilities from different sectors were required to serve populations in the catchment area regardless of their insurance status. Since the cost of the basic benefits package estimated small premiums to be paid out of pocket the remaining amount was to be financed by each of the sectors, MOHP for the uninsured and HIO for the insured. Simply, the money follows the patient. If an insured patient receives care at an MOHP facility then HIO would owe MOHP the expenses that would have to be paid to the FHF and vice versa. However, the MOHP was slow to deal with financing issues and therefore the patients have not yet paid their contributions to the FHF. In the future, revenue sources must be rationalized if reform momentum is to be maintained.

The family practice model and value. The family practice model introduced benefits to the patients and the providers that were not known before. The providers were satisfied with the quality of the facilities and work environment as well as with the improved relations with and the satisfaction of the patients. The patients valued the concept of continuity of care (being seen by the same physician and having an organized medical record). The patients received integrated services under the same roof for the entire family with less costs, transportation, and time when compared to the previous system of travelling to receive various services at different facilities. For example, although the vertical programs had achieved a lot of success under the ministry, they led to a highly fragmented system represented in the multiple infrastructures (MCH centers, immunization in health offices, family planning units, etc.). Separate funding and management systems led to having patients deal with programs not with providers.

Need for adaptation of family doctor model to multi-specialty model. As the pilot project enters an expansion phase, it is apparent that the pool of adequately trained family physicians is rapidly declining and the need for providing trained family doctors and nurses is becoming urgent. The number of family physicians required to cover the population in Alexandria is 2,000 physicians and 33, 000 physicians for all Egypt. The current supply of primary care doctors is very small in comparison to curative care. General practitioners who are not always adequately trained are also a smaller fraction in comparison to specialists. The current training programs available are for new family physicians cannot possibly satisfy the requirements of the reform.

From the pilot facilities, especially Seuf, it was obvious that the low referral rate to specialists was not purely due to the good training of the selected family practitioners. Actually, internal referral occurred among the different teams, as most of the physicians were essentially specialists who decided to take family practice as a career. They worked as a bigger team inside the facility to substitute for the lack of knowledge among certain aspects of the services such as family planning. This is a demonstration of how a multi-specialty practice can substitute for lack of family physicians. The group practice of specialists in the main three specialties (obstetrics and gynecology obstetrics and gynecology, pediatrics and internal medicine) can cover the services under the basic benefits package. A group practice would be as a clustered family practitioner serving one roster of families. This would also allow freedom of choice among family members on primary physician, since internal referral between the three specialties is allowed, while referral outside the group practice is counted as a referral. However, the multi-specialty model requires trained practice managers. This training is not currently available in Egypt.

Data evidence. The data shown is from 5,938 patient encounters over the period of three months from January 1, 2000-March 31, 2000 at Seuf Family Health Center.

- > Visits from females: 73 percent of total visits.
- > Visits from Women age 15-45 and children under age 5 years constituted 45 percent of the total.
- > Average number of drugs prescribed per visit was 1.69.
- > Average length of visit was 10 minutes.
- > Family doctor practice productivity is 18.3 patients per day. Specialists saw less than one patient per day.
- > Referral to specialists is 3.4 percent in comparison to 65 percent at the HIO general practitioner clinic and 32 percent at the HIO school clinics. At university hospital clinics the referral rate was 10.6 percent for pediatrics and 11.7 percent for internal medicine.
- > Antenatal care visits accounted for 4 percent of all visits.

6. Strategic Policy Development and Planning

In Chapter 8 of PHR Technical Report No. 42, *Establishing a Family Health Fund in Alexandria, Egypt: The Quality Contracting Component of the Family Health Care Pilot Project*, a policy process developed by Brinkerhoff and Scribner (1999) was introduced as a framework to discuss many of the short- and long-term policy issues affecting the development of the Family Health Fund and the proposed expansion of the pilot model to other governorates in the country. See Figures 8 and 9.

In a manner consistent with the traditional approach to strategic health policy planning and development, the chapter emphasized the technical elements of policy content. However, the context in which reform policy would be developed and implemented, the individual and group change agents who would influence it, as well as the processes by which issues would be identified, discussed, analyzed, formulated as policy, legitimized, and implemented emerged as equally important. In a *Health Policy and Planning* article entitled "Reforming the health sector in developing countries: the central role of policy analysis," Walt and Gilson argue that "focus on policy content diverts attention from understanding the processes which explain why desired policy outcomes fail to emerge."

This chapter uses the change management schema and some of the principles presented in chapter two to review the outcomes and progress of the policy process within the pilot project, and to highlight lessons learned. It also suggests more effective ways to influence strategic policy planning and development in the future.

6.1 The Context, the Change Agents, the Process, and the Content

Walt and Gilson comment, "Given that policy reforms often depend on political compromise and not on rational debate, a particular influence on their impact is the power structure within which they operate...In many low income countries there are large gaps between top and lower level bureaucrats, between nurses and doctors, between policy elites and managers. In such countries power is further complicated because it rests not only on internal relationships, but significantly, on external relationships with advisers, experts, aid donors and financial institutions."

In fact, as indicated in Table 1, policy outcomes of FHF-related issues identified by December 1999, the only movement by MOHP to implement policy-related changes in health financing was the ministerial decree which established the Family Health Fund and its board of trustees.

There are two ways to look at these results. One is that there was significant delay in achieving the project's policy-related goals in health financing. Another is that, by providing real experience of a different way of doing things, as well as increased competence and commitment to a vision of new possibilities, the Egypt family health care demonstration project has moved the system closer to readiness for major policy reform. This latter viewpoint is consistent with Figure 8, which indicates that implementation of the five technically led stages of the policy process can serve to reshape the social, economic, and political context within which policy is defined and changes implemented.

It is also supported by the assessment found in PHR Technical Report No. 5, Volume V, *Analysis of the Political Environment for Health Policy Reform in Egypt*, (p.6) Dr. Nihal Hafez points to several major indicators of the likelihood of influencing major policy changes in Egypt. Among them:

- > senior government officials whose commitment to supporting and sustaining reform is determined primarily by the extent to which they believe it will threaten their positions;
- > limited technical and analytical capability within MOHP for strategic health policy planning, development, and implementation;
- > questionable political power and credibility of the MOHP to develop, build consensus for, and implement major health policy reform;
- > a complex legislative environment governing health care in Egypt, sustained by control-oriented management processes, lack of data-based decision making, and a strong instinct for self-preservation; and
- > limited capability and willingness of underpaid, demoralized employees of the government health sector to implement and sustain a major reform effort.

With this background in mind, what can the policy process model and change management principles teach us about implementing health policy reform?

6.2 The Policy Process Model

The policy process model implies a natural progression from stage one through five, with each stage influencing the nature of the others. In fact, the process is much more iterative, moving forward and cycling back again as the reform project progresses, experience and learning grow, new issues and responsibilities arise, and the specific objectives of the stages themselves are required to change.

The early stages of the Alexandria pilot project, involved translating the decision of the minister of health to focus the first phase of Egypt health reform on a basic package of primary care and public health services as well as restructuring of the primary health care delivery system, into a statement of the broad direction of reform together with associated principles and long-term goals, and using these as a framework for the development of the various components of the family health care model.

Initially, stage two (constituency building) was specifically designed to build understanding and active support among those groups and individuals who would be responsible for implementing the service delivery phase of the demonstration project. In fact, as discussed in chapter two, it is likely that at this point, understanding of policy implications was almost nonexistent, because there was no foundation of experience with the new terms, concepts, tools, or processes being promoted. Nevertheless, many did understand the need for change and saw an opportunity to be involved in shaping and benefiting from it.

Stage three (resource mobilization), goes right to the heart of the issue of capacity building discussed in chapter 3. Because this was a demonstration project, the emphasis was on mobilization of resources to train, staff, and equip the pilot service delivery sites and, later in the project, the Family Health Fund. The Chairman of HIO in Cairo approved the formation of an advisory committee to work closely with PHR to ensure successful preparation of the HIO pilot service

delivery site at Abu Qir and support the later establishment of the Family Health Fund. The degree of competence and willingness of the members of TSO and TST proved to be a stumbling block. Yet, the MOHP, TSO, and TST were not targeted for technical content and process capacity building., nor did project milestones and benchmarks support such a focus.

Brinkerhoff and Scribner comment that those involved in health sector reform "need to determine at which stage in the policy process they are." In many ways, stage four (implementation design and organization structuring) is really the essence of the Alexandria pilot project, and each of the other steps has had as its main objective, the successful implementation of stage four.

Stage five (progress/impact monitoring), began as the Seuf service delivery site was being developed and it is partly because of those lessons learned that Abu Qir took less time to become operational and received a higher score on its initial accreditation survey. This stage also focused on assessment of the process of building understanding of the other components of the pilot project, and revealed that many change agents and major stakeholders had forgotten that service delivery was only one element. There was a definite need to recycle back to stage two in order to develop understanding and support for the Family Health Fund.

During this second iteration of stage two, change agents and major stakeholders were involved in a process to define their vision for the Family Health Fund and identify some of the strategic issues which could affect its implementation. Foremost among these was the issue of financing. However, it has remained unresolved despite the articulation of goals, data collection, the recommendations of technical experts, policy/discussion papers, stakeholder workshops, proposals by the management of the Family Health Fund, and recommendations from its board of trustees to the minister of health and population.

The next iteration of stage three (resource mobilization for the FHF) followed and, as mentioned above, the major stumbling block was the TSO. It was only through the determination and commitment of the leadership of HIO, both in Cairo and Alexandria West Delta Branch, that the human resources and office equipment for the FHF were provided. These, together with technical assistance for coaching/training and computer equipment through USAID, enabled the FHF to develop to the point of readiness to achieve its operational mandate.

Unfortunately, mobilization of the policy development components of the project (the FHF Board of Trustees and the High Committee for Health Insurance) was heavily dependent upon the director of TSO to make the necessary recommendations to the Minister of health and then to implement his decisions. The committee was never convened and the board was appointed so late in the project that it was impossible to spend sufficient time building members' understanding and capacity to achieve their mandate effectively.

The HIO Advisory Committee has redefined its mandate to focus on identification of policy issues and recommendations to support the operation of the FHF and provide a strategic focus for HIO in order to ensure the expansion of the Family Health Care model throughout its service delivery clinics. Unfortunately, because of the culture of management by control dominated by the Ministry of Health and Population, its influence is likely to be limited to HIO policy planning and development. Nevertheless, changes in HIO policy will inevitably change the political and social environment which may, in turn, influence MOHP to re-examine its own approach to the process of health policy planning and development.

This report is part of the output from the second major iteration of stage five (progress/impact monitoring). Hopefully its contents will inform the planning, design, and implementation of future

reform projects. Unfortunately, the TSO has not developed a mechanism for formal assessment of progress and impact, or implemented an approach to bring together MOHP change agents to openly discuss lessons learned. In fact, the MOHP culture encourages the presentation of a veneer of achievement and success; honesty is not only discouraged, it is often punished. It is likely, therefore, that the pilot projects in the early stages of development in other governorates will unfold without benefit of many content and process insights from the Alexandria family health care project.

Lessons for the Future

The policy process is not an independent technical activity. Rather, it must be seen as one element in the process of change. As such, it must be planned and implemented within the framework of the change management schema described in chapter two. Implementation of the policy process is cyclical and iterative, with changing objectives for each stage of the process as the environment changes and the cycles progress closer to the ultimate goal of policy reform.

Set realistic policy objectives for demonstration projects which are, by definition, relatively focused and short-term. Their primary efforts are directed at implementation of activities described in Stage 4 of the policy process. As a result, while they will inevitably cycle through all stages of the policy process, their major impact is likely to be measured in terms of increased competence of local change agents and major stakeholders to identify and make recommendations to resolve policy issues, rather than implement the necessary reform.

6.3 Change Management Principles

Use of the change management principles introduced in chapter two of this report can supplement the framework for implementation of the policy process provided by the change management schema, increasing the chances of achieving the goal of moving the system closer to readiness for policy reform. Some specific principles have particular application to the situation surrounding the family health care demonstration project in Alexandria.

Principle one for effective management of the change process, is to examine existing centers of control in order to understand how they can best be used to help convert resistance, conflict, and struggles for power into cooperation and synergistic productivity. During the early phases of Egyptian reform, those in power were willing to cooperate and supportive of the reform implementation. However, they lacked the necessary capability for policy planning, development, and implementation that were to develop later, through experience with early implementation efforts.

One of the lessons learned during the Alexandria pilot project is the importance of identifying and building on existing centers of willingness and competence. Chapter two describes several examples where HIO used its resources to assist the MOHP and, as indicated in Table 1. HIO has made some policy changes, within the scope of its authority, in order to support the concepts being tested in the project. Furthermore, it has already begun the process of expanding the family health care model to its other clinics.

Principle four is to establish, in the hearts and minds of the key individuals and direct stakeholders, a strong sense of teamwork to achieve the common mission or purpose. Teambuilding activities were not an explicit part of the Alexandria pilot project plan, which is not unusual since early reform implementation focus more on the *how* of project implementation than on the *what*. Also, the capacity of reform implementers to spend sufficient time on team-building activities was compromised by the absolute need to coordinate three major donors, their technical teams, and begin

support for a large procurement program that would support reform rollout. The dilemma reflected here is typical of large reform efforts, and deserves serious strategic consideration at the outset of major reform planning. Reform is, by definition, a significant change in the status quo. Building the understanding and commitment to that change in all stakeholders is a critical element in major reform processes.

Principle five, involve people in defining the changes that will affect them, builds on principle four to increase feelings of ownership for the change process and its results. The TSO of the MOHP is the linchpin for all Egypt health reform activities. TSO members may be seconded from regular Ministry of Health and Population positions, or they may be expert local consultants providing much needed skills specific to the reform as for example procurement or financial expertise. All proposals and recommendations must pass through TSO to reach the minister. Procurement of all supplies, equipment, and technical assistance must be approved by TSO. In the early stages of the reform, it was also important to include the regular MOHP employees as well as the district and governorate in discussions and reform planning. However, the pressure to implement activities, build the procurement unit, and move ahead rapidly with implementation often conflicted with the need to carefully build consensus.

Principle eight is to set priorities and milestones. As discussed in chapter two, USAID benchmarks tied to its donor tranche payments were the primary set of priorities and milestones. These benchmarks emphasized content and neglected process gains. Thus, evidence of a strong, focused, and committed insider/outsider project team was not a benchmark. Increased TSO and/or MOHP capacity to understand policy issues and/or prepare policy workshops and recommendation documents, was not a benchmark. The benchmarks related to activities and outcomes highly supportive of stage four in the policy process, quite appropriate to a demonstration project, rather than one whose goals include broader major policy reform.

Principle ten, stresses the importance of communication, whether face-to-face, written, verbal, computer-based, formal or informal. Communication is an essential learning device, and policy reform, like change itself, begins with learning. The learning must be content and process focused. It must be iterative. It must be broad—directed at decision-makers and implementers, as well as those whose lives are and will be affected.

Inevitably in a short-term demonstration project, the focus of policy communication is identification and suggestions for resolution of issues that immediately impact project implementation. While larger and more strategic policy issues may be recognized, development of a common vision for the future, and learning about the complex interactions and influences that various decisions (including the decision to make no policy change) can have upon that vision, are unlikely. The most that reasonably can be expected is that the awareness and competence of local change agents and stakeholders (including those with legitimate power to make change as well as the population at large) may be increased, moving the reform environment to a place of greater readiness for open discussion and advocacy for policy change.

Lessons for the Future

Identify and build on centers of willingness and competence in order to move the reform system forward. At the same time, be aware of and work with existing focal points of control to increase understanding and competence because, without legitimate sponsors, no policy change will be made.

Plan for teambuilding activities, which include those with legitimate authority, willingness and competence to further the policy reform process. Ensure that they understand the iterative nature of

the strategic policy planning and development process as well as their unique role within it. Emphasize to all stakeholders that teambuilding to develop a shared vision of the reform deserves both time and resources.

Make certain that those responsible for policy development and implementation understand the process and their role in it. Ensure that they have the necessary capability, and are actively involved at all stages, including the setting of policy-related priorities and milestones.

Set realistic policy-related goals, priorities, and milestones, stressing both content and process, and develop a project plan to support the activities necessary to further the policy development process.

6.4 Learning for Future Reform Projects

In a 1994 article, "Knowledge Utilization and the Process of Policy Formation: Towards a Framework for Africa", Robert Porter and Irvin Hicks conclude, "policy learning tends to be open ended and, perhaps, never ending. The context continually changes, policy actors come and go, information that was crucial and topical at one time may not be at another, new information needs to be generated." Policy planning and development is not linear. It is iterative, cyclical, and long-term, much like change itself. Yet, often, policy goals focus only on the making of a decision, excluding necessary intermediate priorities and periodic milestones throughout the complex process.

The Alexandria Family Health Care pilot project has yielded some valuable learning for policy development and implementation goals in future reform projects:

- > In the case of short-term demonstration projects, limit policy-related priorities, milestones, and activities to issues related directly to project implementation. At the same time, ensure that there *are* appropriate policy-related milestones, to encourage those with power to use results of the demonstration to shape policies that will support future reform.
- > Include process measures in project milestones such as development of a strong project team focus, increased awareness of policy issues, development of critical thinking capabilities, strategic planning ability, policy discussion facility, preparation of policy recommendations, development of policy advocacy ability and focus.
- > Identify and build on centers of capability and willingness. These groups and individuals will begin to understand new concepts as they become readily visible and operational. And the operational new concepts will begin to change the context within which policy issues will be identified and discussed.
- > Do not underestimate the impact of political will on the policy process.

Implementation of the various stages of the policy process will serve, among other things, to influence change agents' and major stakeholders' viewpoints and understanding of policy issues, discussion, and actions. However, it is a mistake to assume that it is a straightforward path through the stages of the process or that information, research data, stakeholder discussions, and expert recommendations are sufficient to move governments to risk changes that they do not fully trust, or that force risky political positions. Furthermore, just as the principles of change need to be re-examined when applied in developing countries, so the stages of the policy process may need to be

reframed to more adequately reflect the context, process, content, and change agents of the reform environment.

Figure 8. The Strategic Policy Planning and Development Process

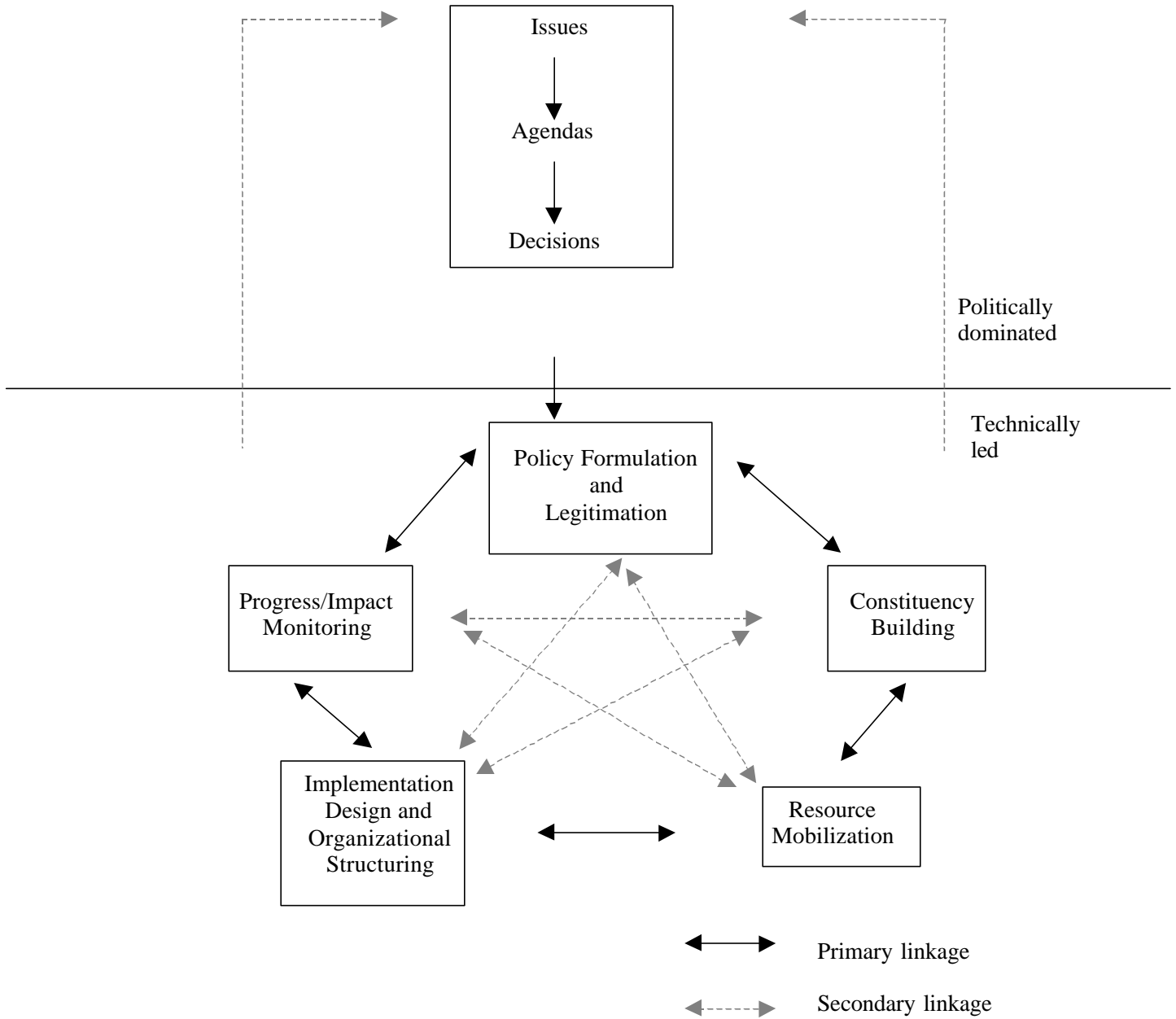


Figure 9. Elements of Strategic Management

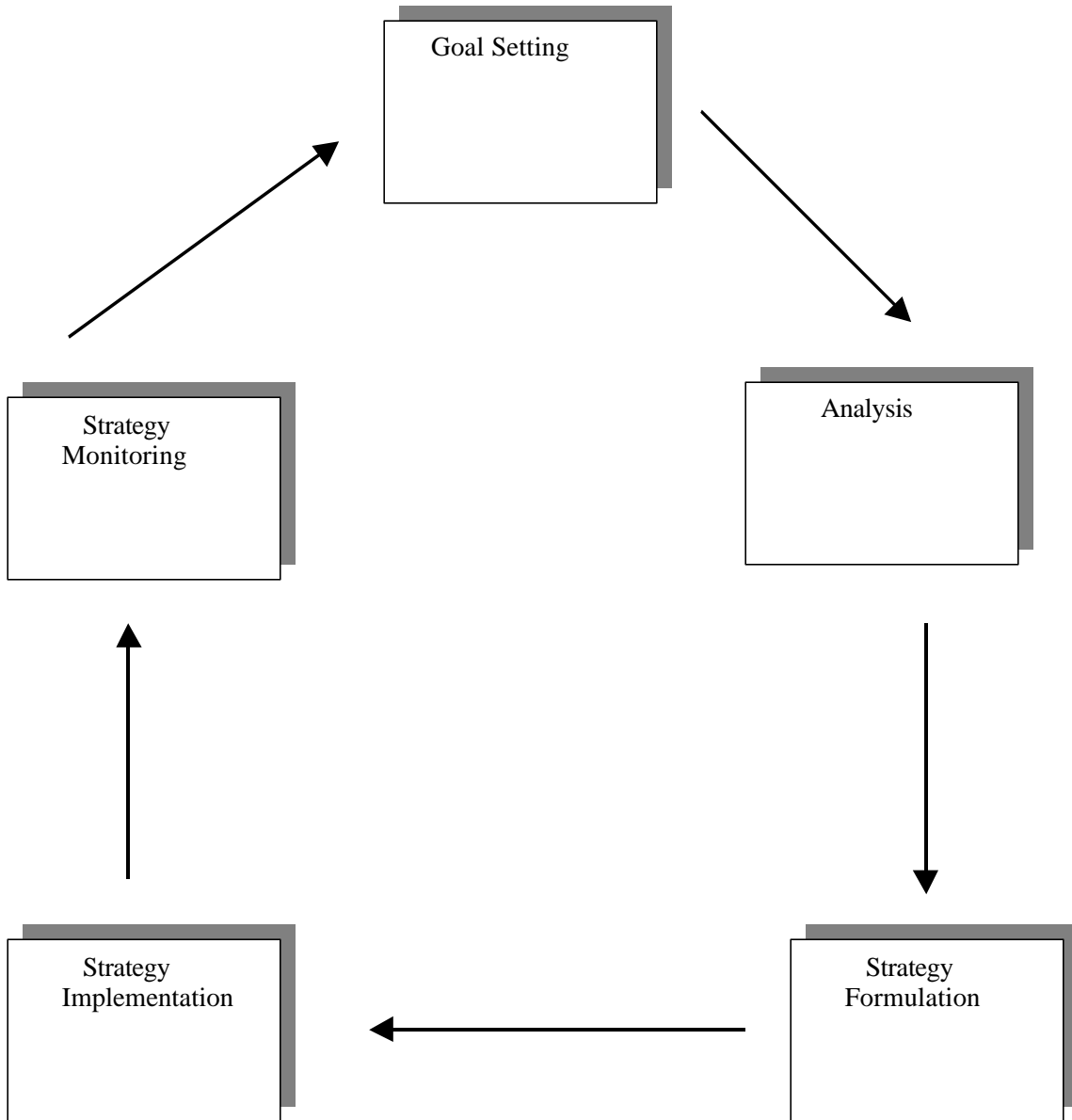


Table 5. Policy Outcomes of FHF-Related Issued Identified by December 1999

Short Term	Outcome	Long-term	Outcome
<p>Legitimize through ministerial decree the FHF quality contracting agency and a fiduciary Board of Trustees(BOT).</p> <p>Devise approaches to collect patient/beneficiary roster fees for registration with a service provider, as well as regulations governing distribution of collected fees for FHF operations and provider payment incentives.</p> <p>Develop and implement policies concerning collection of user fees and copayments during the period of the pilot project.</p> <p>Determine how to assess and make decisions based upon health-related measures tied to the current basic benefit package.</p>	<p>Decree issued December 29, 1999.</p> <p>Technical advisor recommendations; major stakeholder discussions; FHF Management Team policy/discussion paper presented to FHF Board of Trustees; BOT recommendation to minister of health; no policy development or decision implemented by MOHP.</p> <p>HIO policy decision to charge 2 LE all day for uninsured patients (the amount was usually 3 LE); HIO policy decision to charge uninsured patients discounted price for drugs.</p> <p>Data to be collected by FHF as initial input to National Technical Lab which will be developed by the World Bank.</p>	<p>Determine whether FHF role continues as a quality contracting agency or evolves into a full health insurance fundholder.</p> <p>Formulate and implement legislation to permit full health insurance fundholding by an institutionally autonomous FHF governed by an independent, stakeholder represented fiduciary BOT.</p> <p>Define and implement new roles and associated responsibilities for MOHP and HIO.</p> <p>Identify sources of funding to sustain FHF operations after the term of the pilot project.</p> <p>Develop and implement policies concerning collection of user fees and copayments after the end of the pilot project.</p> <p>Determine how to expand the basic benefit package while sustaining high quality care and managing cost to the health system.</p>	<p>First incentive payment made February 2001.</p> <p>HIO Advisory Committee redefining its mission and responsibilities to ensure existing HIO clinics and health providers learn about the health care model and the FHF, and are prepared to be accredited and become part of the reformed system.</p> <p>Sufficient cost and usage data not yet available for any policy recommendations or decisions.</p>

7. Counterparts

There were three categories of counterparts for PHR activities:

1. The Technical Support Office of the MOHP

This was the group responsible for the implementation of the entire reform effort in Egypt. TSO had its offices in the Ministry of Health and Population complex in Cairo. The mandate of the TSO included coordination of all donor activities relating to the reform, all procurement activities relating to donor and World Bank loan funds, and liaison with the minister. It was also the group in the MOHP responsible for the achievement of USAID benchmarks. The special advisor headed the TSO to the minister of health and population.

2. The Technical Support Office in the Alexandria Governorate

This was the governorate-level group responsible for the implementation of the reform in Alexandria. It was situated in the Samoha Training Center in Alexandria. The mandate of the TST included the coordination of all donor activities aimed at the implementation of the reform at the governorate level in Alexandria, under the direction of the TST. The TST was headed by a senior official in the office of the undersecretary of health in Alexandria.

Similar TSTs were established in the other pilot governorates, Menoufia and Sohag.

3. Staff at the North West Delta Branch of the Health Insurance Organization

This was the Governorate level group responsible for implementing the reform as it related to the health insurance infrastructure in Alexandria, including the service delivery sites and the new health insurance contracting agency, the Family Health Fund. The North West Delta Branch is headed by a director who took an active interest in the reform, but the ongoing PHR counterparts were the senior members of his staff who formed the HIO Advisory Committee. The chairman of HIO appointed the members of the advisory committee.

PHR had very different experiences with the three sets of counterparts.

The TSO started as a small group of MOHP staff seconded full time to work on the reform. In the early years of the reform, in 1997 and 1998, PHR was the only donor involved in the health reform that had a full time presence in Egypt, and TSO worked effectively with PHR staff. As the other ex-patriot participants came to Egypt to join the reform effort, TSO grew to accommodate the counterpart need, and tried to respond to many requests from the technical teams. As a result the TSO tried to serve many groups simultaneously. TSO turnover increased and coordination of the team became a major challenge. By then, however, PHR's effort had moved from the planning stage to the implementation stage and the focus of its work had shifted to Alexandria, where the TST was the group responsible for implementing the reform. Since much of the reform effort was also centered on the Health Insurance Organization, the HIO Advisory Committee and the TST became the key counterpart teams. The support of the Alexandria Governorate Undersecretary of Health, as well as the West Delta HIO Director were vital to the success of the demonstration project in Alexandria.

The deputy director of the North West Delta Branch of HIO chaired the Advisory Committee and some of his senior staff were members. These were all employees of HIO who had full time operational responsibilities, but nevertheless gave generously of their time. They all took their membership responsibilities very seriously and made every attempt not to miss the meetings despite their considerable other workloads. The advisory committee met weekly over a period of 30 months, excluding holidays and prime vacation periods. Minutes were kept of all the meetings and action items were assigned to members for follow up. The branch director was briefed by his staff after every meeting and made required decisions as the pilot project progressed. Periodically, meetings were held with the chairman of HIO in Cairo to inform him of progress and obtain his direction or decisions, as required.

As with any committee that has a long tenure, membership of the Committee changed over time as members were promoted or moved to assume other responsibilities. Some of the more significant changes were:

- > When the director of the North West Delta Branch was promoted to be Assistant to the Chairman of HIO and moved to Cairo to assume his new responsibilities, the deputy director, a member of the Advisory Committee, took his place.
- > The new deputy director at the branch became the chair of the advisory committee, but because of his close ties with the committee, the branch director continued to take an active interest in the work of the advisory committee and asked his staff to brief him after every meeting.
- > When the time came to appoint an interim director of the Family Health Fund, a member of the advisory committee was nominated to that position. His involvement with the committee proved to be a valuable impetus for the successful launch of the FHF.
- > The second, (permanent) director of the FHF was a member of the advisory committee.

Thus, despite changes in membership, the body of knowledge built up over the life of the advisory committee provided continuity within the reform at HIO.

As counterparts, the TST were extremely important to the development of the care model and support of the first MOHP pilot sites at Seuf, Mohen, Khorshed and Gon. The TST supported the many changes necessary in MOHP supervisory procedures and practices to allow the new care model to be implemented. They were less familiar with the insurance aspect of the reform, and as the implementation plan shifted to the development of the Family Health Fund, the HIO Advisory Committee assumed an important role in implementation of the reform.

7.1 The Importance of the Advisory Committee as a Counterpart

Of the three sets of counterparts, the Advisory Committee had the most impact on the development of the Family Health Fund and on the participation of HIO in the pilot project. Its contribution to the reform was unique in a number of ways:

- > The committee acted as a catalyst for decisions and implementation.
- > The members were knowledgeable about health insurance principles and procedures

- > They shaped the health insurance component of the model by contributing their expertise to make it practical in the Egyptian setting.
- > They came to understand the details of the model, from principles to policies to practical implementation issues.
- > The early emphasis of the advisory committee was on the development of the HIO sector Family Health Unit at Abu Qir.
- > The experience gained from that activity will assist it in preparing future HIO sites for contracting with the Family Health Fund.
- > The later emphasis was on the establishment of the Alexandria Family Health Fund.
- > The members understood the principle of the separation of purchaser and provider roles and were useful advocates in explaining the role to others.,

7.2 The Role of the Advisory Committee in Preparing the First HIO Family Health Unit for Participation in the Pilot Project

The advisory committee played a very significant role in the selection of the first HIO clinic to participate in the pilot project and subsequently in preparing that clinic for contracting with the FHF. The committee visited potential HIO sites, assessed site preparation needs and catchment areas, analyzed patient characteristics and workload. It then made a recommendation that the site at Abu Qir should be the first HIO Family Health Unit in the pilot project. The branch director and chairman of HIO approved that recommendation. The committee then ensured that site preparation activities proceeded in a timely way to meet the October 1, 1999 deadline for the opening of the clinic. The following were some of its activities:

- > It participated in the development of patient flow systems and floor plans and reviewed and approved the renovation plans for the Abu Qir site.
- > It arranged for a seminar on the pilot project to be conducted for HIO staff to generate interest in participation.
- > It became a selection board for recruitment, through a competitive process, of staff for the FHU, including physicians, nurses, technicians, and administrative staff.
- > It arranged for acquisition of supplies and equipment for the FHU
- > It participated in the preparing of training programs and in scheduling staff training.
- > It worked with the FHU director to resolve procedural and policy issues to encourage patients to roster their families at the FHU.

When the emphasis shifted to the establishment of the Family Health Fund, once again the committee had a pivotal role in ensuring that the fund was set up as an effective organization to fulfill its mandate. Since there had been a substantial delay in setting up the FHF, the advisory committee decided that there would not be sufficient time to recruit staff through a competitive selection process. The members worked with the branch director to ensure that the most successful and competent HIO

staff were nominated to senior positions in the fund and agreed that subsequent recruitment of other staff would be through a competitive process. The contribution of the advisory committee to the establishment of the FHF included:

- > support for the idea that the Family Health Fund should be a unique organization in Egypt and that there was a need for investment in FHF management development as well as technical training;
- > assistance in obtaining interim accommodation for the FHF in the offices of the HIO North West Delta Branch;
- > assistance in preparing draft contracts between the FHF and the different provider sectors;
- > reviewing and contributing to the development of performance standards for incentive payments by the Fund;
- > assistance in developing management information systems for the FHF;
- > input to the design of the encounter form and referral form and systems for their use;
- > resolving issues of coordination of benefits between insured and uninsured family members; and
- > assisting the FHF in resolving issues arising from contracting with different sectors.

7.3 Chronological Summary of Key Activities/Decisions Made by the HIO Advisory Committee, July 1998 to October 2000

July 1998

- > HIO procedures, contracting mechanisms, auditing and control mechanisms, provider payment mechanisms reviewed.

October 1998

- > Key features of the pilot project discussed.
- > Target date set for opening of HIO pilot site: October 1, 1999.

November 1998

- > Potential HIO pilot sites discussed.
- > Financing Options for HIO sites discussed.
- > Co-payments for the pilot project discussed.

February 1999

- > Critical success factors: reviewed PHR Policy Paper # 3.
- > PHR annual plan: reviewed HIO portion and benchmark requirements.
- > HIO pilot sites: began selection process.
- > Contracting: reviewed HIO existing strategies.

April 1999

- > HIO pilot sites: field visits for evaluation/selection, narrowed search to four sites, recommended Abu Qir as first pilot site and obtained approval.
- > HIO doctors and nurses: discussed process for selection.
- > Orientation seminar for HIO doctors and nurses planned.
- > Payment of salary incentives: reviewed PHR Policy Paper # 5.
- > Set up interview board for selection of family doctors, nurses, and administration staff.

May 1999

- > Orientation seminar for family doctors and nurses conducted.
- > Interviews for family doctors and nurses held, selections made.

July 1999

- > Interim director of FHF (a member of the HIO Advisory Committee) appointed by director of HIO.
- > Abu Qir implementation issues discussed.
- > Development and organization of the Family Health Fund discussed.

August 1999

- > Follow-up to Policy Paper # 5 on incentives. HIO agreed that family doctors and nurses at Abu Qir should continue to receive incentives at their previous level until the FHF is in place.
- > Working hours: agreed that HIO pilot site will be open 8 a.m. to 8 p.m.
- > Accommodation for the FHF: Agreed to raise this issue with Dr. Hassan Abdel Fatah, Chairman HIO
- > Sub-account for FHF in HIO discussed.
- > Potential space for the FHF office at North West Delta Branch offices at Stanley discussed.

September 1999

- > Abu Qir MIS issues discussed with director of HIO MIS.

December 1999

- > Roster at Abu Qir FHU as of December 20: 1,482 families out of target 6,000.
- > Expanded catchment area for registration from Abu Qir and Marmora to Marmora Beach, Tossou and Marmora Village to assist with roster build-up.
- > Factory workers: recommended ways to encourage transfer to Abu Qir FHU.
- > Sick Leaves: recommended and implemented policy change to allow Family Doctors at Abu Qir FHU to issue sick leave certificates.
- > Family planning services started at Abu Qir FHU.
- > Draft of PHR's FHF Technical Report reviewed for comments.
- > Measure: Advisory Committee informed of visit by benchmark verification contractor.
- > Drug list for primary health care at HIO sites: recommended additions to conform with treatment protocols.
- > Distributed PHR Policy Paper # 9, User Fees and Co-payments.

January 2000

- > Roster at Abu Qir FHU: 1650 families on January 3, 3350 families by January 31.
- > FHF decree distributed for information.
- > Seminar on accreditation and contracting held.
- > Business manager: recruitment discussed.
- > FHF Incentive payment: target payment date of June 2000 established.
- > Equipment and supplies for Abu Qir: problem of no computers discussed, as well as lack of forms for registration and for family folders, TST approached.
- > Family Club: decision made to start as soon as possible.

February 2000

- > Roster at Abu Qir FHU as of February 22: 4,300 families.
- > Family Club started at Abu Qir.
- > FHF members appointed by West Delta Branch director.

- > Space for FHF: allocated space at Stanley Offices of HIO.
- > FHF space renovations discussed: funding to be sought.
- > Study of medical records implemented.
- > Supplies and equipment for Abu Qir: encounter forms and referral forms required, issue referred to TST.

March 2000

- > Roster at Abu Qir FHU: 4,900 families on March 4, 5,200 families on March 29.
- > Full-time availability of FHF staff: discussed issue of conflict of interest if they work for the provider, even on a part-time basis .
- > FHF space renovations: funding for site preparation approved by USAID.
- > FHF Management Development started.
- > Obtained approval for family doctors to prescribe all drugs related to the basic benefits package.

April 2000

- > Roster at Abu Qir FHU: 5,400 families on April 3, 5,850 families on April 26.
- > Workload review: apparent that workload at Abu Qir exceeds that at Seuf: “shut out” policy discussed to prevent members of families rostered at Seuf from obtaining primary health care services at other HIO facilities.
- > Integration of vertical programs at Abu Qir discussed.
- > HIO lack of awareness of Master Plan discussed.
- > Questions for provider survey discussed.
- > Performance based contracting discussed.

May 2000

- > Roster at Abu Qir FHU as of May 3: 6,040 families, target achieved.
- > Waiting list for new families discussed.
- > Possibility of expanding to more rooms discussed: agreed not to expand until pilot project evaluated.
- > Revisions to encounter form discussed.
- > Seminars held to inform non pilot HIO staff about the pilot project to prepare for expansion to new HIO sites.

- > Interviews for directors of future HIO FHUs planned.
- > ECTAT team introduced to the advisory committee.
- > Cost Study: committee informed about methodology for collection of data.

June 2000

- > Encounter form revision discussed, input received for additions.
- > Contract with private sector discussed.
- > Training in immunization procedures discussed.
- > Accreditation visit to Abu Qir arranged.
- > Training for FHF and Abu Qir staff arranged: technology and management training.

July 2000

- > Meeting held to discuss and finalize revision of the encounter form.
- > Full time FHF staff: issue of conflict of interest raised again.
- > Medical Records Study: presentation by Mike Forte.
- > Contract with private sector finalized by HIO Legal Department.

September 2000

- > Changes to the membership of the advisory committee made by Dr. Hazim Helmy.
- > 14 urgent policy issues raised for resolution by HIO.
- > End of PHR project and technical support discussed.
- > Decision to hold a special meeting of the advisory committee to discuss its future role.

October 2000

- > Advisory Committee Workshop held to discuss its role and recommend strategies for its future to Chairman of HIO.

7.4 Why Was the Advisory Committee So Successful at Supporting the Family Health Fund Implementation?

The advisory committee's success as a counterpart may be attributed to many factors:

- > The HIO chairman established the committee and he gave it his full support.
- > The members were senior employees of HIO at the Branch level who, though they had full-

time responsibilities, contributed their time to weekly meetings.

- > They had the knowledge and seniority to make informed decisions or, where appropriate, recommendations.
- > They maintained a clear focus on the HIO role in the reform and insisted on being involved in the development of their own sites for contracting with the FHF.
- > They did not have overall responsibility for reform implementation, and could focus and concentrate their efforts on implementation of reform concepts in the HIO context.
- > As insurance specialists, they understood the concept of separation of purchaser and provider roles and recognized that some of the problems of HIO resulted from mixing these two roles.

7.5 What Are the Lessons for Establishment of Effective Counterparts in Future Projects?

- > Counterparts at the decentralized level are more focused on operations. Due to this operational focus they can often be more successful at implementation issues than those at the central level.
- > Contractors and consultants should work closely and intensively with a small group of dedicated change agents.
- > Informed counterparts at the local level can promote and sustain the reform.
- > The support of the head of the organization in appointing competent staff contributes to the success of the counterpart relationship.
- > Give the counterparts a role in ensuring that the entire chain of command is kept informed of progress within their organization.

Annex A: FHF Management Team Development Activities, March 1–October 18, 2000

The following activities comprise the major content elements of the FHF management team development process. These intensive coaching/training sessions took place an average of three days a week. At the same time, the team members were continuing to fulfill the responsibilities of their HIO positions, during the remaining three days a week.

1. Orientation to the Pilot Project

- > The objectives of the 10-15 year reform
- > Donor contributions
- > Objectives of the pilot project
- > The pilot project system
- > Progress to date in the pilot project
- > Concepts and principles being tested in the FHUs
- > Concepts and principles being tested in the FHF
- > Link between them

2. Teambuilding

- > Underlying philosophy of team effectiveness
- > Phases of group development
- > Link with personal feelings about involvement in the pilot
- > Group process, effective meeting management
- > Assessment of team effectiveness

3. Overview of the Family Health Fund

- > The FHF in the pilot project system
- > Mission/purpose of the FHF
- > Link between mission and organization structure of the FHF

- > Necessary functions within the FHF to achieve the mission
- > Main responsibilities of each department within the FHF

4. Visit to Seuf FHU

- > First-hand opportunity to see the FHU model in action
- > What is different in this primary care family practice model?
- > What are the principles being tested, which cannot be unilaterally changed?
- > What is the role of the FHF in maintaining and improving the quality of care at the FHUs?
- > How will the management teams at the FHUs improve quality?
- > What does it mean for the FHF to be a payer in this pilot project, and not a provider?

5. Management and Accountability in the FHF

- > What are the unique responsibilities of managers in the Family Health Fund?
- > Why have the concept of accountability?
- > Why are managers accountable for all the outputs of their subordinates?
- > How does a manager ensure quality outputs produced by subordinates?
- > Motivation by commitment versus control
- > The purpose of a performance management system

6. Inside the Family Health Fund

- > Necessary inputs, throughputs, and outputs to achieve its mission?
- > From where do the inputs come?
- > To whom do the outputs go?
- > For each department within the Family Health Fund:
 - ⌆ What are the necessary inputs?
 - ⌆ From where do they come?
 - ⌆ What are the throughputs (responsibilities of the department)?
 - ⌆ What are the outputs?
 - ⌆ To whom do they go?

7. Introduction to the Encounter Form as a Tool for Performance-Based Incentive Payments

- > Purpose of the encounter form
- > Design of the encounter form
- > Process for submission and collection of data from the encounter form
- > Opportunity to use the encounter form
- > Opportunity to use simulated input data to determine performance based incentive payments
- > Understanding of significance and complexities of setting performance standards and incentive payment criteria
- > Understanding the differences between medical record data collection and performance standards data collection

8. Introduction to Accreditation

- > Accreditation as a quality improvement tool
- > The accreditation survey
- > The measures and standards
- > Process to date in FHUs
- > Opportunity to experience quality improvement challenges as FHU teams will face them
- > Similarities and differences between accreditation and performance standards data from encounter form
- > Linkage between accreditation and performance-based contracting of FHF

9. Development of FHF Behavioral Principles

- > Their purpose
- > Their rationale
- > What they really mean
- > How to use them everyday

10. The FHF Performance Management System:

- > Its purpose
- > Its rationale
- > Its process
- > Link to previous work in segment 6

- > Preparation of performance contracts for each member of the FHF team
- > Performance effectiveness appraisal:
 - Ĥ Purpose
 - Ĥ Process and tools

11. Basic Computer Training

- > Windows
- > Microsoft Word
- > Microsoft Excel
- > Microsoft PowerPoint

12. Group Problem-Solving

- > Purpose
- > Issues
- > Process, including action planning
- > Practice

13. The Policy Development Process

- > Purpose
- > Process
- > Issues
- > Practice

14. Contracting

- > Purpose and principles of contracting with FHUs
- > Development of legal contracting framework
- > Examination of issues
- > "Testing"
- > Revision

15. Setting Performance Standards

- > Purpose
- > Principles
- > Issues
- > Process
- > Implementation and Communication

16. Using the Actual Encounter Form Data

- > Beginning the process of data collection, input, report production, assessment
- > Practice
- > Communication and feedback from FHUs
- > Revision

17. Understanding and Using the FHF MIS

- > Purpose, overview
- > Link with encounter form input
- > Practice
- > Custom reports
- > Practice
- > Manipulating data
- > Practice
- > Planning module
- > Cost data module
- > Input to changes/improvements

Note: A module on basic financial management for non-financial managers was planned, but not delivered. This training module was replaced by in-depth short-term technical assistance from a financial expert, whose work for the FHF included provision of a budget preparation framework, cost analysis framework, explanation of real cost to budget variance, and help in understanding and preparing business plans.

Annex B: PHR Technical Report Series

This report is the last in a series of technical reports that provide information on various aspects of the demonstration project and its impact on reform development. The series provides an important resource for understanding the key aspects of the Alexandria demonstration project. Other reports in this series are:

- > Edmond, Alan, H., Mary A. Paterson, Ahsan J. Sadiq, Linda M. Sadiq, Susan Scribner, and Nena Terrell. December 1999. *Establishing a Family Health Fund in Alexandria, Egypt: The Quality Contracting Component of the Family Health Care Project*. Technical Report 42. Bethesda, MD: Partnerships for Health Reform Project, Abt Associates Inc.
- > Forte, Michael A. May 2000. *Medical Records Systems Assessment of Family Health Facilities in Egypt*. Technical Report 51. Bethesda, MD: Partnerships for Health Reform Project, Abt Associates Inc.
- > Nandakumar, A.K., Khaled Nada, Ahmed Ibrahim, Marwa Ezzat, Mamoud Abdel-Latif, and Ahsan Sadiq. May 1999. *Health Expenditure Review: Alexandria, Egypt*. Technical Report 35. Bethesda, MD: Partnerships for Health Reform Project, Abt Associates Inc.
- > Nandakumar, A.K., Mamoud Abdel-Latif, and Wessam El-Beih. August 1999. *Options for Financing Health Services in the Pilot Facilities in Alexandria*. Technical Report 36. Bethesda, MD: Partnerships for Health Reform Project, Abt Associates Inc.
- > Terrell, Nena. May 2000. *Focus Group Results: Family Health Pilot Test in Alexandria, Egypt*. Technical Report 55. Bethesda, MD: Partnerships for Health Reform Project, Abt Associates Inc.
- > Villaume, Mary Lyn, Marwa Ezzat, and Gary Gaumer. October 2000. *Study of Hospital Referrals in the Pilot Program in Alexandria, Egypt*. Technical Report 56. Bethesda, MD: Partnerships for Health Reform Project, Abt Associates Inc.