



Scaling health system reform through Universal Health Insurance

Egypt



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Egypt's exemplar focuses on the institutional restructuring introduced under the Universal Health Insurance Law, especially the separation of purchaser, provider, and regulator roles. It assesses how that model is supporting national scale-up and what it suggests for other large systems pursuing universal coverage.

Core exemplar

Institutionalizing provider-purchaser-regulator restructuring for a 110-million-person system through the Universal Health Insurance Law.

Why it matters for ALM: It shows how institutional separation, diversified domestic revenue, and phased rollout can strengthen purchasing, regulation, and service accountability at scale.

Primary ALM contribution: More health for the money, more money for health, and governance and accountability, with strong implications for equity and financial protection.

Replicability potential: High for larger countries pursuing UHI through phased implementation, legal reform, and clear purchaser-provider-regulator roles.

1. Context: High Out-of-Pocket Spending and Fragmented Health Governance

Egypt is the most populous Arab country and the third most populous in Africa, with nearly 110 million people. Before reform, its health-financing system faced three persistent weaknesses: household out-of-pocket payments accounted for about 62% of current health expenditure, government health spending was only about 1.5% of GDP, and financing, regulation, and service delivery were spread across multiple fragmented institutions. Several earlier reform attempts had failed to resolve those structural problems.

The new Egyptian Constitution created the opening for change by recognizing health as a fundamental right and requiring comprehensive coverage. Universal Health Insurance Law No. 2 of 2018 became the main instrument for turning that mandate into an operational system. Later presidential directives in 2024 and 2025 then accelerated the timetable, bringing the national target forward from 2032 to 2027 and linking the reform more directly to domestic resource mobilization and health-product sovereignty.

2. Mechanism: Universal Health Insurance and Institutional Separation

The UHI Law created three independent regulatory authorities, fundamentally restructuring Egypt's health governance:

- UHIA (Universal Health Insurance Authority): The single-payer institution, under Prime Minister supervision, responsible for collecting premiums, pooling funds, investing reserves, and purchasing services.
- EHA (Egypt Healthcare Authority): Regroups most public healthcare facilities under one governance structure, providing three tiers of care (health units, general hospitals, specialized centres) with eight core services.
- GAHAR (General Authority for Healthcare Accreditation and Regulation): Under Presidential supervision, sets quality standards and accredits providers eligible for UHIA contracts. Only accredited facilities can deliver UHI-covered services.

The financing model draws on several sources: payroll contributions, corporate levies, and earmarked taxes on products and transactions such as tobacco, alcohol, car licensing, civil certificates, and polluting industries. The state covers premiums for indigent groups through budget transfers, creating cross-subsidies from the formal sector to poorer and more informal populations. Egypt also introduced an upfront payment arrangement for private providers, with 75% of costs paid before final paperwork clearance, to reduce cash-flow risk and encourage participation in the system.

Egypt: UHIS Phased Rollout — Accelerated to 2027 from 2032 target

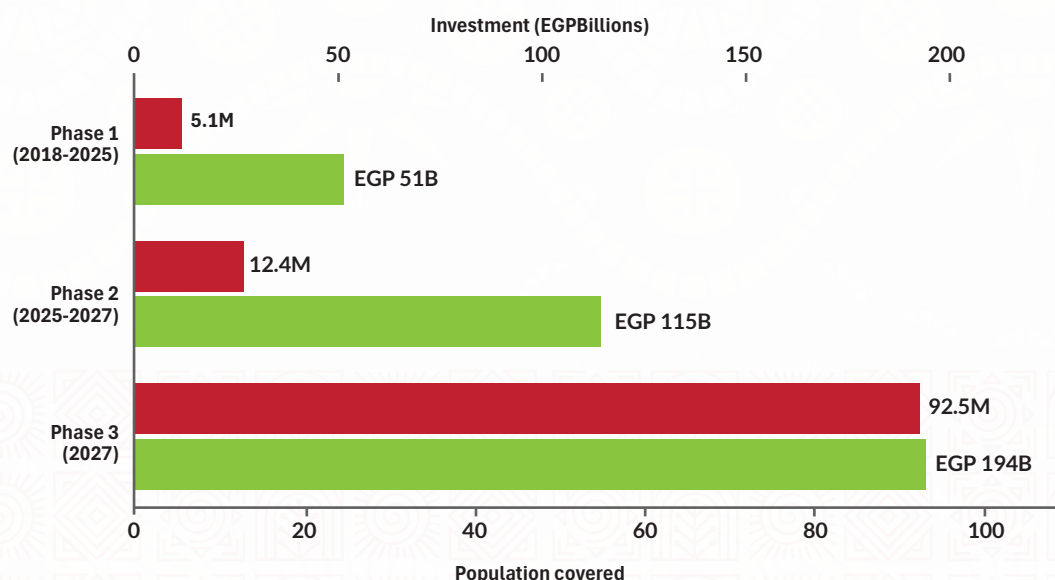


Figure E-1. Egypt: UHIS Phased Rollout (2018–2027). Phase 1 complete (6 governorates, 5.1M people, EGP 51B); Phase 2 launched (12.4M people, EGP 115B); nationwide rollout accelerated by presidential directive from the original 2032 target to 2027.

3. Outcomes: Phased UHI Expansion and Accelerated National Rollout

Implementation began in July 2019 in Port Said. By July 2025, Phase 1 had been completed across six governorates—Port Said, Luxor, Ismailia, South Sinai, Suez, and Aswan—covering 5.1 million citizens through 406 contracted facilities and 3,451 approved health services. Total Phase 1 investment reached EGP 51 billion between 2018 and 2025. Aswan alone absorbed more than EGP 12 billion for infrastructure, equipment, and digital transformation, and delivered 2.8 million services during its trial phase, including more than one million diagnostic tests and 20,000 surgeries.

Phase 2, covering Damietta, Marsa Matrouh, Kafr El-Sheikh, North Sinai, and Minya, is being launched for 12.4 million people through 69 hospitals and 669 primary health care units at an estimated cost of EGP 115 billion. Total projected rollout costs now exceed EGP 360 billion. At the same time, Egypt's 100 Million Health Initiative demonstrated the system's capacity for large-scale public health delivery when the country became the first to receive WHO Gold Tier validation on the path to hepatitis C elimination. The UHC service index rose from 50 in 2000 to 70 in 2021, and the National Digital Health Strategy for 2025–2029 aims to connect health data and electronic medical records across the country.

Key Vulnerability

- **What is at risk:** Smooth national scale-up of UHI—especially when the rollout reaches the highest-population governorates.
- **Why it matters (evidence):** While the UHI Law established strong institutional separation, several purchasing details were left insufficiently specified—particularly benefit design, provider payment methods, and rate-setting. Workforce shortages, the long-run financial sustainability of the UHIA fund, and enrolling Egypt's large informal sector remain binding challenges. Public awareness is still limited outside Phase 1 governorates. Cairo and Giza—the largest population centres—are not yet in the rollout, so the hardest operational test is still ahead. The acceleration of the national target from 2032 to 2027 is politically welcome but operationally ambitious.
- **What would reduce the risk:** Clearer purchasing rules (benefits, payment methods, tariffs), an aggressive enrolment strategy for informal workers, sustained workforce planning, and a public communication push ahead of Cairo/Giza onboarding—so acceleration does not outpace operational readiness.

4. Egypt on the ALM Scorecard

Egypt's ALM scorecard is one of the strongest in the report, with nine commitments rated On Track and one rated Partial. The Partial rating applies to hosting-role recognition, reflecting visibility rather than capability. The strongest performance is anchored in a constitutional mandate for UHC, the 2018 Health Insurance Law, and the institutional separation of purchaser, provider, and regulator functions through UHIA, EHA, and GAHAR. Overall, the scorecard is consistent with a system that has built a strong reform architecture and is now being tested through accelerated national scale-up.

ALM Scorecard Heat-Map	
Country	Egypt
Political Agenda	On Track
Leverage Partners	On Track
Domestic Mobilization	On Track
Private Sector	On Track
PMPA Harmonization	On Track
Operational Undertakings	On Track
Monitoring & Reporting	On Track
Accountability Framework	On Track
Hosting Role	Partial
Leveraging AU Support	On Track

Legend:

- Green = On Track
- Amber = Partial
- Red = Off Track

5. Key Lessons and Policy Implications

- A constitutional mandate can give reform unusual durability. In Egypt, embedding health as a right created a stronger foundation than an ordinary policy commitment.
- Institutional separation matters when systems are large and fragmented. Egypt's purchaser-provider-regulator model reduces conflicts of interest and creates clearer lines of accountability.
- Diversified revenue sources make UHI more resilient. Egypt's mix of payroll contributions, levies, and earmarked taxes offers a practical template for other large middle-income economies.
- Phased geographic rollout gave the reform room to learn before expanding into the country's most complex governorates. The later decision to accelerate the timetable shows how political leadership can build on early implementation proof points.
- The upfront payment arrangement for private providers addressed a common bottleneck: cash-flow risk. That design choice helped bring private capacity into the system without abandoning public oversight.

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Key words: More money for health; More health for the money; Governance & accountability; Equity & financial protection; health insurance; private provider regulation; digital health; Domestic resource mobilization; earmarked taxes; legal reform; institutional reform; Egypt; Northern Africa

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ALM score card sources: Egypt (9/10 On Track, 1 Partial)

C1: Political agenda — On Track Indicators: Constitutional mandate Art.18; UHI Law 2/2018; presidential directive 2032→2027; Tokyo Compact Sources: UHI Law 2/2018 (Egyptian Gazette); WB Tokyo Compact Dec 2025

C2: Leverage partners — On Track Indicators: WB P172426 \$530M; IFC \$325M for Phase 2; AfDB; AFD Sources: WB P172426 (projects.worldbank.org); IFC 2025 press release

C3: Domestic mobilisation — On Track Indicators: UHIS payroll 4%+1%; corporate levies; tobacco/alcohol/civil-certificate levies; ~\$85 per capita Sources: UHI Law 2/2018 Art.30-36; MoF Budget Statements; WHO GHED

C4: Private sector — On Track Indicators: GAHAR accredits 1,500+ facilities; UHIS contracts private providers Sources: GAHAR (gahar.gov.eg); EHA reports

C5: PMPA — On Track Indicators: EDA reference authority; Vacsera manufacturer; Unified Procurement Authority = continental template Sources: EDA (edaegypt.gov.eg); AU AVATT documentation

C6: Operational — On Track Indicators: UHIS levies active; PPPs; Unified Procurement; inter-ministerial Steering Committee; Phase 2: 12.4M Sources: UHI Law 2/2018; EHA quarterly reports

C7: Monitoring — On Track Indicators: EHA digital infrastructure; GAHAR tracking; SIS Egypt publications Sources: EHA (eha.gov.eg); SIS Egypt UHIS Phase 1 July 2025

C8: Accountability — On Track Indicators: Three-authority architecture (UHIA/EHA/GAHAR) = built-in checks; Cabinet oversight Sources: UHI Law 2/2018 institutional architecture

C9: Hosting role — Partial Indicators: Continental health-financing events via Africa CDC; strong candidate for North/Francophone Africa Sources: Africa CDC regional office; Cairo Health Investment Forum 2024-25

C10: Leveraging AU — On Track Indicators: Active in AU AMA; AVMA eligibility; AU Vision 2040 60% local production aligned Sources: AU AMA Treaty; Gavi AVMA; AU PAVM Framework

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