

Egypt National Health Accounts

Establishing an expenditure baseline to support
Egypt's health care reform



World Health
Organization

Egypt



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Foreword by the Minister of Health and Population

Health is a vital pillar of a strong society and an inherent human right, as affirmed by Egypt's Constitution. The Ministry of Health and Population (MoHP), in collaboration with the Ministry of Finance (MoF), is working to implement the country's health sector reform goals and to implement the new Universal Health Insurance (UHI) system, in line with the national sustainable development strategy, Egypt Vision 2030.

With this goal in mind, MoHP and MoF, in collaboration with the World Health Organization, have produced this edition of the National Health Accounts (NHA) report for 2019/2020. The NHA report tracks and analyses the flows of funds across Egypt's health care sector, providing invaluable data on health expenditure in the country. This edition of the NHA also provides granular data that was not available in previous editions, including breaking down expenditure by disease type. By providing detailed information on health financing flows, the NHA study can be used to establish benchmarks and track progress, and thus to guide future

decision-making. In particular, this edition of the NHA provides data that can be considered a baseline for expenditure prior to the rollout of the UHI system. These valuable efforts represent an excellent beginning to the institutionalization of the NHA tool in Egypt, and we look forward to implementing further NHA studies in the future in order to provide the data needed to measure progress and to alert decision-makers to areas that need intervention.

I would like to offer my sincere thanks for the commendable efforts of the MoHP team, and for the efforts of all those involved in generating this important study, including the teams from MoF and CAPMAS. I would also like to gratefully acknowledge the valuable support of the World Health Organization. We look forward to a continued close partnership working on achieving the goals of Egypt Vision 2030 and ultimately securing a better quality of life for all Egyptians.

Dr Khaled Abdel-Ghaffar
Minister of Health and Population

Foreword by the Minister of Finance

The Egyptian Ministry of Finance (MoF), along with the Ministry of Health and Population (MoHP), is paving the way to achieve health sector reform goals, implementing the Universal Health Insurance (UHI) system, and promoting the welfare and financial protection of all Egyptians. To that end, MoF and MoHP, in collaboration with the World Health Organization, have produced this edition of the National Health Accounts (NHA) report for 2019/2020, “establishing an expenditure baseline to support Egypt’s health care reform.”

This NHA serves as an evidence-based report to guide and inform our health financing policy and monitor the health care system’s performance. The report follows WHO’s approved framework to gather, organize, and estimate the flow of funds in the health care sector. It provides an overview of the health sector expenditure and gives a financial pulse to decision-makers. The current edition of NHA is critical to monitor and inform the UHI rollout launched in 2019 by providing a baseline for tracking the ongoing UHI rollout from a health expenditure perspective. It enables us to compare the expenditures in UHI and non-UHI governorates and highlight the vital areas that require immediate interventions to achieve universal health coverage and Egypt’s 2030 vision. Moreover, this version went beyond the areas covered by the previous reports, providing details about the disease-specific expenditures and the levels of care that would inform the evidence-based design of the UHI benefit package.

Furthermore, this evaluation comes at a significant time in our health system reform strategy. Despite not providing extensive conclusions for the UHI implementation, the NHA report serves as a vital resource to update our actuarial study for the UHI. The UHI actuarial study is a cornerstone in the strategic planning of the reform rollout. This NHA report is a valuable resource that provides baseline information for monitoring the impact of the UHI reform as the system continues to be rolled out nationwide.

The financial risk protection of the population is the centre of our UHI decision-making. Stemming from this commitment, I am happy to see the recent reductions in out-of-pocket expenditure reported in this study. Despite this good news, there is still a lot for us to do and crucial interventions for the success of the UHI reform and leaving no one behind.

Finally, I would like to extend our gratitude for the outstanding efforts of the MoHP, MoF, CAPMAS and UHI teams in developing this report. I would also like to acknowledge the continuous support of the World Health Organization as a key partner in our path to universal health coverage. I look forward to continuing this productive collaboration and institutionalizing the NHA in Egypt as a periodic tool for monitoring health care system performance on our road to achieving universal health coverage for all Egyptian citizens.

Dr Mohamed Maait
Minister of Finance and Chairman of
Universal Health Insurance Authority

Foreword by the Head of the National Health Accounts Unit

Egypt's new republic has adopted a bold health system transformation, grounded in stringent political will and determination, to push universal health coverage (UHC) for all Egyptians.

The new 2014 constitution has placed "health" at the heart of Egypt's political priorities and has defined UHC as Egypt's vision for its 2023 Sustainable Development Strategy. This has materialized with the issuance of the new Universal Health Insurance (UHI) law as the framework for coverage of the entire population with health services, based on principles of universality, accessibility, equity, solidarity, quality and beneficiary satisfaction.

Financial viability is in the lead among the principal means of achieving sustainability of the insurance system, which should be based on scientific evidence to inform sound planning and rollout strategies. Health accounts provide essential information to guide this process, informing policy makers on the way forward to pursue health financing strategies to achieve the system's financial viability.

The current round of health accounts has been carried out over the past two years with the leadership of MOHP, MOF, and CAPMAS, and with participation of other key national stakeholders – and in partnership with, and with the guidance of, WHO. This particular NHA is a landmark study, being the first one to be conducted after starting the rollout of the new UHI, with its major transformation of the system constituents, financial flows and expenditure pathways.

It provides, for the first time over the past six NHA rounds taking place in Egypt since

2008, essential information to track expenditure on diseases, as well as expenditure disaggregated by Egypt's 27 governorates, with a clear view of health expenditure on pharmaceuticals; and according to hospital types, including private hospitals. It also provides detailed health expenditure specific to data sources, such as voluntary private health insurance and nongovernmental organizations.

I would like to express my sincere thanks and appreciation to HE Minister of Health and Population, HE Minister of Finance, and HE Head of the Central Administration for Public Mobilization and Statistics, for their unlimited and sincere efforts and collaboration that made this study possible. I would also like to extend my sincere appreciation to all technical teams from these ministries and organizations which have participated in the work. A special gratitude and acknowledgement go to WHO, particularly the Office of the WHO Representative in Egypt, for their strenuous efforts, leadership and continued collaboration and support throughout this work.

I trust that such collaboration and partnership spirit will continue to be the driving force to support Egypt's striving towards achieving UHC for all Egyptians in dignity and welfare, leaving no one behind.

Dr Ahmed El Sobky
Head of National Health Accounts
Unit, Ministry of Health and
Population, and Chairman of
Egypt Healthcare Authority

Foreword by the World Health Organization Representative in Egypt

It is heart-filling to witness the work of the Egypt National Health Accounts (NHA) 2019/2020 report reach the world. The current study comes at a crucial time, with Egypt having embarked on the rollout of the Universal Health Insurance (UHI) system, a major health financing reform. This ambitious reform aims to make universal health coverage (UHC) a reality in Egypt, serving all with a lens of equity. The objective of UHC is at the core of World Health Organization's (WHO) collaboration with the Government of Egypt, and WHO's support for the NHA 2019/20 study is an important piece of this collaboration.

NHA is an important monitoring tool which provides evidence to measure progress determining if the health financing system is heading in the right direction. The NHA 2019/20 report discusses both the impressive areas of progress in health financing in Egypt and the challenges that still remain. These crucial data points will ensure that Egypt can build on its recent advances in implementing the UHI reform and can achieve an efficient, equitable and sustainable health financing system, supporting the goal of UHC.

The NHA 2019/20 exercise has been a major undertaking, and the scope of the work has been expanded since previous NHA studies in Egypt. For example, the new study for the first time tracks health expenditure by disease, by provider type (including the private and charity sectors) and by geographic area. This provides important data that enrich the resulting analysis of health care financing in Egypt.

A key factor in ensuring that NHA remains a relevant policy-making tool is to see that NHA studies are produced regularly. I am confident that the extensive work behind the NHA 2019/20 study has generated positive

momentum to institutionalize the NHA process in a way that ensures the quality and comprehensiveness of future studies, and a consistent approach to implementing them. WHO is committed to providing all necessary support to this process of institutionalizing NHA in Egypt.

The new study was conducted during a time when Egypt, alongside the rest of the world, was dealing with the COVID-19 pandemic. I want to applaud the NHA study team for their hard work while facing difficult circumstances that made both data collection and teamwork more difficult than usual. The pandemic was also a timely reminder of the complexities and unknowns which can arise in public health and which require ongoing adaptation of health financing policies. WHO will be collaborating with the Ministry of Health and Population, the Ministry of Finance and all key Egyptian stakeholders to ensure that the evidence from the NHA 2019/20 report is effectively utilized as Egypt moves forward with its health financing reform.

On a final note, I would like to offer my gratitude for their leadership and support throughout the study process to His Excellency Dr Khaled Abdel Ghafaar, Minister of Health and Population; His Excellency Dr Mohamed Maait, Minister of Finance; and Major General Khayrat Mohamed Barakat, CAPMAS Chairman. I would also like to thank Dr Ahmed El Sobky, Head of the NHA unit at the Ministry of Health and Population and Chairman of Egypt Healthcare Authority, for his support and for overseeing NHA completion.

Dr Naeema Al Gasseer
WHO Representative in Egypt and
Head of Mission

Acknowledgements

The study team gratefully acknowledges the many experts and agencies who contributed to the planning, development and review of this report.

Institutional partnership

The National Health Accounts (NHA) report is the result of collaborative efforts from the Ministry of Health and Population, the Ministry of Finance, the Central Agency for Public Mobilization and Statistics, the Egypt Healthcare Authority, the Universal Health Insurance Authority and the World Health Organization.

The NHA team would like to thank Dr Ahmed El Sobky, Chairman of the Egyptian Healthcare Authority and Assistant Minister of Health and Population for Monitoring and Follow-Up, for leading and overseeing the NHA development process. The team would also like to acknowledge the full partnership of the Ministry of Finance team under the management of Ms Mai Farid, Assistant Minister of Finance, Executive Director of the Economic Justice Unit, and Acting CEO of the Universal Health Insurance Authority. Thanks are due to the full engagement in the study development from the Central Agency for Public Mobilization and Statistics.

Technical writers

This report was developed under the technical lead of Ahmed Yehia Khalifa, Health Economist, WHO Representative's Office in Egypt, who was responsible for writing, coordinating the development and production of the report. Mahmoud Farag, WHO NHA consultant, was responsible for building the capacities of the national team and handling the data management and production, and he also contributed to the review of the final report. Riku Elovainio, WHO consultant, provided valuable insights and extensive contributions to the writing of the report.

WHO contributors and reviewers

The team would like to express their gratitude to Julien Dupuy, Technical Officer (Health Expenditure Tracking), WHO HQ, for his review and comments on the report, and to Xu Ke, Senior Health Financing and Expenditure Analyst, WHO HQ, for support and advice received at different stages. The team also thanks Awad Mataria, Director, Universal Health Coverage/Health Systems, WHO EMRO; Gasser Gad Elkareem, Health Systems Coordinator WHO Egypt; and Magdy Bakr, Health Systems Consultant, WHO Egypt, for their valuable input and feedback.

The National Health Accounts team

The successful completion of the report was dependent on the dedicated efforts of the NHA team members involved. Mohsen Saad Eldin led the data collection process and analysis of disease-specific expenditure, Mahmoud El Sarawy worked on the household health expenditure analysis, Miral Shehata worked on the financial accounts of the health sector and economic entities under the Ministry of Finance, Mohamed Adly worked on the financial accounts of the Ministry of Health and Population and related entities, and Ahmed Seyam worked on health insurance organizations. The NHA team also included Gamal Rataba, Mohamed Nouh, Amr el Sheikh, Yara el Nagar, Yousef Temraz, Heba Korayem, Tarek el Geneedy, Sherif Abdel Gaber, Nour Abdelbaki, and Ebshoy Magdy. Haitham Ibrahim El Dahshan made a major contribution, managing and leading the NHA unit.

External contributions

The NHA team gratefully acknowledges the contributions of a number of entities in sharing relevant data, including IQVIA for sharing pharmaceutical expenditure data, the Financial Regulatory Authority for sharing private

insurance data, the Ministry of Social Solidarity for sharing the data of NGOs working in health, the Central Agency for Public Mobilization and Statistics for providing the analysis of the economic census and household survey data, and the Magdy Yacoub Heart Foundation and Mersal Foundation for sharing their expenditure data.

The team would like to thank Hazel Haddon for copy-editing the report, Communications Development Incorporated in Washington, DC, for the design and layout, and the Health Emergency Information and Risk Assessment in the Eastern Mediterranean Regional Office for map production.

Leadership

Finally, the NHA team would like to acknowledge with gratitude Dr Naeema Al Gasseer, WHO Representative in Egypt, for her overall guidance and for sparing no effort in deploying all needed resources to the national authorities throughout the NHA process. Without her leadership, this project would not have been completed successfully. The team also expresses gratitude for the leadership of H.E. Minister of Health and Population, H.E. Minister of Finance and the Chairman of the Central Agency for Public Mobilization and Statistics.

Abbreviations

AMR	antimicrobial resistance	HIECS	Household Income, Expenditure and Consumption Survey
ATC	Anatomical Therapeutic Chemical	HIO	Health Insurance Organization
CAPMAS	Central Agency for Public Mobilization and Statistics	IMF	International Monetary Fund
CHE	current health expenditure	LMICs	lower-middle income countries
COVID-19	coronavirus disease 2019	MoF	Ministry of Finance
EGP	Egyptian pound	MoHP	Ministry of Health and Population
EHA	Egypt Healthcare Authority	NGOs	nongovernmental organizations
EMR	Eastern Mediterranean Region	NHA	national health accounts
FRA	Financial Regulatory Authority	NPISH	nonprofit institutions serving households
GAHAR	General Authority for Healthcare Accreditation and Regulation	OOPs	out-of-pocket payments
GDP	gross domestic product	OECD	Organisation for Economic Co-operation and Development
GGE	general government expenditure	PHC	primary health care
GGHE	general government health expenditure	SDGs	Sustainable Development Goals
GGHE-D	general government health expenditure from domestic sources	SHA	System of Health Accounts
GOTHI	General Organization for Teaching Hospitals and Institutes	THE	total health expenditure
HAPT	Health Accounts Production Tool	UHI	Universal Health Insurance
		UHIA	Universal Health Insurance Authority
		WHO	World Health Organization





Executive summary

The Egypt National Health Accounts 2019/2020 study provides an up-to-date overview of health expenditure in the country. It tracks health expenditure across the Egyptian health system and provides in-depth analysis of the quantities and flows of funds through standard health expenditure classifications and key indicators.

The study uses the methodology outlined in *A System of Health Accounts 2011* (SHA 2011), which is based on the main classifications of health care consumption, service delivery and health financing.

The 2019/20 study fills many gaps found in previous Egypt national health accounts (NHA) studies. For example, it tracks detailed health expenditure specific to data sources, such as voluntary private health insurance and nongovernmental organizations. Moreover, for the first time, it tracks expenditure on diseases, as well as expenditure disaggregated by governorate. Furthermore, it provides a more granular view of health expenditure on pharmaceuticals and according to hospital typologies.

The context of the NHA 2019/20 exercise was unique in many ways. First, the data collection period partially coincided with the coronavirus disease 2019 (COVID-19) pandemic. However, the overlap in timing was minimal, and the main implications of COVID-19 for health expenditure will not be visible until subsequent health accounts studies are carried out. Second, the NHA 2019/20 study coincided with implementation

of the Universal Health Insurance (UHI) system reform. However, the implementation of the new UHI system was still in the earliest stages during the NHA study, and there are therefore limited conclusions that can be drawn about the impact of the reform. Nevertheless, the NHA study is expected to inform the update of the UHI actuarial study and will provide important baseline information for monitoring the impact of the UHI reform in the future, as the system is rolled out across further governorates and eventually nationwide.

Key findings

The 2019/20 NHA study's findings for a set of key indicators are summarized in Table 1.

Current health expenditure (CHE): CHE reached EGP 255.6 billion in 2019/20, equating to EGP 2,560 per capita, and representing 4.6% of gross domestic product (GDP). In real terms, CHE has been fairly stable in recent years, but in the few years prior to the NHA study, growth in CHE did not match economic growth, with the share of CHE as a percentage of GDP having declined since 2017, when it was around 5.6%.

Total health expenditure (THE): THE includes both CHE and capital formation, with the latter estimated at EGP 15.5 billion for the public sector in 2019/20. THE is estimated at EGP 271.4 billion, equating to EGP 2,720 per capita and representing 4.9% of GDP.

TABLE 1 Key indicators from the NHA 2019/20

Indicator	Health accounts 2019/20
Current health expenditure (CHE) per capita	EGP 2,560
Total health expenditure per capita	EGP 2,720
CHE % gross domestic product (GDP)	4.6%
Out-of-pocket expenditure % CHE	59%
General government health expenditure from domestic sources (GGHE-D) % CHE	33%
GGHE-D % GDP	1.5%
GGHE-D % general government expenditure (GGE)	5.2%
CHE % to retailers of medical goods	33%
CHE % to hospitals	29%
CHE % to ambulatory service providers	17%
CHE % on noncommunicable diseases	55%
Primary health care % CHE	55.3%

Out-of-pocket expenditure: The level of out-of-pocket payments has historically been higher in Egypt than in most peer countries in the region or in other lower-middle income countries. However, a decrease in out-of-pocket payments compared with previous years was recorded in 2019/20, with payments as a percentage of CHE estimated at 59.3%.

General government health expenditure from domestic sources (GGHE-D): GGHE-D in 2019/20 amounted to EGP 81.5 billion, or EGP 817 per capita, growing by 8% year to year in real terms and 13% in nominal terms for the last two reported years.

GGHE-D represents 33% of CHE. As a share of GDP, GGHE-D represents 1.5%, which is lower than the average in lower-middle income countries (2.3%) or in countries of the World Health Organization's (WHO) Eastern Mediterranean Region (EMR) (2.6%). As a share of general government expenditure (GGE), GGHE-D represents 5.2%.

Expenditure by health service provider: In 2019/20, most CHE flows went to retailers of medical goods (33%), hospitals (29%) and ambulatory care (i.e., outpatient care) providers (17%). The majority of out-of-pocket payment flows were directed to retailers of medical goods (54%), with hospitals and ambulatory care providers capturing 18%, while the majority, or 51%, of government schemes' spending was directed to hospitals.

Factors of health care provision: For expenditure by government schemes, the two main spending items were wages and salaries, at 49%, followed by materials and services used, at 36%.

Health care functions: The main expenditure item in terms of health care functions was curative care, with 45% of CHE, followed by medical goods, with 33%. Preventive care as defined by the NHA classification represents only 1.5% of CHE.

Pharmaceutical expenditure: Total pharmaceutical expenditure in retail and inside facilities is estimated at EGP 96 billion, or 38% of CHE and 1.7% of Egypt's GDP. The majority of pharmaceutical expenditure is privately financed (85% by out-of-pocket payments, 2% by prepaid voluntary health insurance).

Disease and health conditions: The largest share of CHE goes to noncommunicable diseases, with at least 55%. The second largest share goes to infectious diseases, with at least 6.9% of CHE. Around 30% of CHE could not be attributed to any diseases or health conditions.

Expenditure on primary health care (PHC): Using the standard NHA formula for defining PHC expenditure, it is estimated that EGP 141.3 billion, or 55.3% of CHE, goes to PHC. This indicates that PHC expenditure has grown by almost 20% since 2018, when it was estimated at 46.2%.

Key policy messages

- 1. The Egypt National Health Accounts study is an essential health system performance monitoring tool.** The 2019/20 exercise has an important purpose: to establish a much-needed baseline for tracking the ongoing UHI system rollout to all governorates from a health expenditure perspective.
- 2. There has been a recent decrease in out-of-pocket expenditure, but further reductions will be crucial for the success of the UHI reform.** This will require increases in pooled funding (key policy message 3) and effective coverage through a benefit package that covers key drivers of out-of-pocket payments (key policy message 4) and disease burden priorities (key policy message 5).
- 3. Budget allocations to health can increase in the future primarily through a combination of general government revenues and revenues from UHI contributions, but what matters is the net effect of these revenue streams.** The 5.2% share of general government health expenditure from domestic sources (GGHE-D) over general government expenditure and the 1.5% share of GGHE-D over gross domestic product indicate that there could be room to increase government funding allocations to health. Future NHA exercises should track GGHE-D components and report on how their shares evolve. This will give an indication of how the revenue streams are shifting and what the net effect is in terms of pooled funding for health.
- 4. Household expenditure on pharmaceuticals is an important driver of out-of-pocket spending, and the UHI reform will need to address this in its current implementation plan** by ensuring coverage of pharmaceuticals in the benefit package and by expanding contracting with private pharmacies.
- 5. The 2019/20 NHA study provides expenditure details by disease and level of care, which is important evidence for developing and revising the UHI benefit package and for strategic purchasing.** As the UHI system matures, the benefit package will be periodically adjusted. NHA studies will be able to track in which ways the benefit package adjustments impact health expenditure flows, particularly to primary health care, according to classification of diseases or the levels of care. This in turn provides evidence for further rounds of benefit package revision and further emphasis on primary health care from the purchasing perspective.
- 6. Relatively little expenditure is allocated to preventive care services (1.5% of current health expenditure), and there is a need to ensure adequate funding for essential public health functions.** This is especially critical in the context of the UHI rollout, which might create pressure to further emphasize funding of personal and curative health services. Future NHA studies will need to closely monitor the evolution of expenditure on preventive care.



Introduction

This report presents Egypt's national health accounts (NHA) for fiscal year 2019/20, aiming to provide systematic data and evidence on the quantity of funds and financial flows related to the consumption, provision and financing of health care goods and services in Egypt. This requires an update to the core health account indicators of health care financing, service provision and health care consumption according to the methodology laid out in *A System of Health Accounts 2011 (1)*.

This edition's main highlight is that it addresses data gaps that previous health accounts did not. This has been achieved by integrating data on disease-specific expenditure and subaccounts disaggregated by geographic area (i.e., the 27 Egyptian governorates). Egypt is currently rolling out its new Universal Health Insurance (UHI) system in certain governorates ahead of future nationwide deployment, and it is therefore important to disaggregate health expenditure data beyond national averages in order to meet decision-makers' needs. Additionally, the results from this edition are expected to inform the update of the UHI's actuarial study. For this reason, the NHA team worked to refine and update data sources that were not available in previous NHA studies, such as data on voluntary (private/commercial) insurance schemes, nongovernmental schemes, private hospitals and expenditure on pharmaceuticals.

The institutionalization of the NHA and its findings is expected to lead to a performance review of the country's health sector and will be used to guide priority-setting and resource allocation. With these findings, the Government of Egypt will be able to address the key health care financing issues related to revenue-raising, pooling and purchasing. They will also help ensure that the impact of the UHI reform process is monitored in terms of health system revenues and expenditures from the government, provider and household perspectives. It will monitor revenue sources, especially the level of out-of-pocket expenditure, to ensure better financial risk protection, which is one of the key objectives of the introduction of the UHI system.

This report presents the key findings of the NHA study for fiscal year 2019/20. It starts with background on Egypt's health sector, including the socioeconomic context, an epidemiological profile and the structure of the health system. The report then presents the main findings and responses to the key questions that the NHA study aims to address, namely, where does the money come from? Where does it go, and to which goods and services? This is followed by a separate section on capital formation in the public sector. Finally, the report concludes with the main policy implications for decision-makers. A brief separate section on the essential methodological considerations of the study is included in the annex.

Socioeconomic context

Egypt is a lower-middle income country with a population of 102 million and a gross domestic product (GDP) per capita of around US\$ 3,880 (2, 3). Egypt's economy has been on a steady growth path, with an average 3.7% increase in GDP annually between 2010 and 2021. The coronavirus disease 2019 (COVID-19) pandemic has had a negative effect on Egypt's economy, particularly through decreased activity in the tourism sector. Egypt's economy has also faced a steady decline in exports over the past few decades, while private domestic consumption drives growth. According to the latest International Monetary Fund (IMF) analysis at the time of writing, Egypt's economy is still on a steady growth path, helped by government policies that have improved fiscal sustainability, the business climate and public financial management (4).

Egypt's state budget has been expanding amid economic growth and an improved government revenue-to-GDP ratio, which currently stands at 20.4% of GDP (4). Egypt's general government budget expenditure stands at 24.6% of GDP. The difference in revenues and expenditure reveals a budget deficit. Egypt has accumulated an increasing debt burden in recent years, with the debt-to-GDP ratio reaching 92%. However, in the latest IMF projections, the debt-to-GDP ratio is projected to slowly decline.

Underlying the consumption-driven growth lies the demographic dynamic of Egypt, with an annual population growth of 2.0% between 2010 and 2021. The population is projected to reach 225 million by 2100 (5). Rapid population growth is putting pressure on the Government of Egypt to secure access to jobs and basic services, including health services. Furthermore, while Egypt's population remains relatively young (34% of the population is under 15 years old), the population over 65 years old grew from 3.97 million in 2010 to 5.66 million in 2021, adding further pressure on health and pension systems.

The poverty rate according to the nationally defined poverty line increased from 27.8% in fiscal year 2015/16 to 32.5% in 2017/18 but fell again in 2019/20 to 29.7%. Extreme poverty, according to the Central Agency for Public Mobilization and Statistics (CAPMAS), stood at 4.5% of the population in fiscal year 2019/20 (6). The Government of Egypt has scaled up available social assistance mechanisms, notably the cash transfer programmes Takaful and Karama, which currently reach

more than 2 million households. In addition, in 2021 the minimum wage was raised from EGP 1,200 to EGP 2,000 per month and then to EGP 2,400 in 2022.

Egypt has expressed strong, high-level political support for progress towards the 2030 Agenda for Sustainable Development and its 17 Sustainable Development Goals (SDGs). This has been translated into a dynamic process of setting SDG targets and policies through the national Sustainable Development Strategy, Egypt Vision 2030, which responds both to the 2030 Agenda and Africa's Agenda 2063. The highlights of Egyptian SDG policies include the National Strategy for Empowerment of Egyptian Women 2030, the Integrated Sustainable Energy Strategy 2035, the National Project for Family Development and the rolling out of the UHI system.

Disease burden and epidemiological profile

Life expectancy at birth in Egypt stands at 74 years (7), which is similar to Jordan (74 years) but lower than regional peers such as Morocco and Tunisia (both 76 years).

The disease burden in Egypt is a combination of communicable diseases and noncommunicable diseases, with the latter growing in terms of their share of morbidity and mortality. Currently, about 84% of total mortality in Egypt is attributed to noncommunicable diseases (Fig. 1) (8). The main risk factors for death and disability in Egypt are, in descending order, high blood pressure, high body mass index, tobacco use, air pollution, and high fasting plasma glucose (9).

There has been a marked decrease in communicable diseases, especially viral hepatitis C, which is notable given that Egypt previously had one of the highest prevalence rates of the disease in the world (10). In recent years, Egypt has implemented many successful programmes targeting hepatitis C, most recently the mass screening intervention programme "100 Million Seha," which aims to eliminate the disease.

Egypt is faced with a double burden regarding nutrition, with stunting coexisting alongside high obesity rates. The latest figures show that 21% of children under five are considered to have stunted growth, while 16% are overweight or obese.

There have been important improvements in maternal and child health in Egypt in recent years. The maternal mortality ratio

declined by 42% between 2000 and 2017 (from 64 deaths per 100,000 live births to 37) (11), and the under-five mortality rate decreased from 46.6 deaths per 1,000 live births in 2000 to 19.5 in 2020. These downward trends in Egypt follow global trends of improvements in maternal and child health outcomes, except in countries in active conflict or post-conflict situations. Nevertheless, despite the improved situation in maternal and child health outcomes, there are still important regional disparities within Egypt. Child mortality is highly concentrated in some regions, such as Upper Egypt and to some extent North Sinai, and there are also wealth-based health disparities within governorates (12).

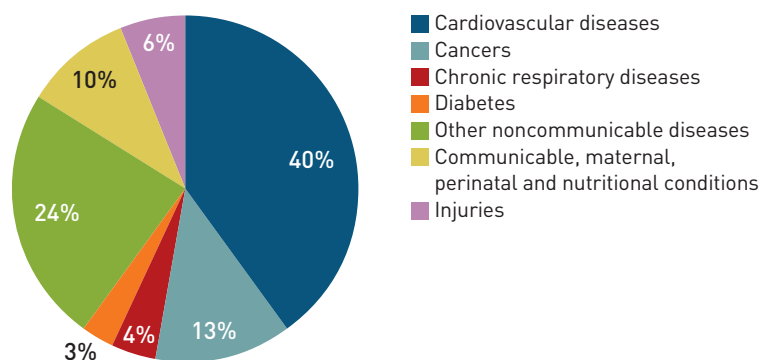
As has been the case all around the world, the experience of the COVID-19 pandemic in Egypt showed that health systems and the economy are intertwined. With stronger health systems, countries are in a better position to respond to pandemics and health threats like COVID-19. Egypt's recent focus on health system improvement already paid dividends during the pandemic, as from an overall perspective, the health system was able to respond effectively to the situation. However, as with many countries around the world, the COVID-19 pandemic is expected to have derailed some of the gains on population health outcomes, especially in relation to vulnerable subpopulation groups.

Health system context

Sustainable Development Goal 3 calls on countries to ensure health for all by 2030, including achieving universal health coverage. The 2014 Constitution of Egypt strongly addresses health as a fundamental human right and affirms a commitment to providing the whole population with quality health services.

Egypt's health system is moving through an intense phase of reforms. These reforms are encapsulated in the UHI law of 2018 and its bylaws, which have set the objective of revitalizing the country's health system. This reform, which is currently in the early stages of implementation, is set to bring about deep systemic change, by consolidating the previously fragmented health system under a new overarching organizational setup. This new system configuration relies on new health financing and service delivery arrangements that aim to ensure sustainable funding and financial protection, as well as to establish clear roles for public and private providers.

FIGURE 1 Proportional mortality, by disease category



Under the new organizational setup, three new bodies form the backbone of the health system:

- The Universal Health Insurance Authority (UHIA), which is the payer in the UHI system. The UHIA is a new structure, but it has been able to draw from the experience and staff of the Health Insurance Organization (HIO), which was the main national health insurer prior to the full implementation of the UHI system.
- The Egypt Healthcare Authority (EHA), which regroups health facilities previously under the Ministry of Health and Population (MoHP) and other previously semi-autonomous public facilities. The EHA is the main contractual partner with the UHIA for service purchasing arrangements.
- The General Authority for Healthcare Accreditation and Regulation (GAHAR), which is the body in charge of setting accreditation standards and registering and accrediting health care providers to be eligible for contracting with the UHIA. The GAHAR also has a general mandate to improve the quality of health services.

Each of the three UHI authorities has a board with considerable autonomy in decision-making. The UHIA board is nominated by the prime minister (the current board chair is the finance minister), the EHA board is nominated by the MoHP and confirmed by the prime minister (the current EHA board chair is the deputy minister of health) and the GAHAR board is nominated by the cabinet and confirmed by the president.

Under this setup, the MoHP is the overall steward of the health sector and continues to ensure provision of public health functions. These functions consist of public health services such as health promotion and prevention, epidemic surveillance, and pandemic

preparedness and response; key health system supporting functions such as information systems and health workforce training; and overall governance of the health sector and representation of Egypt internationally in health matters. In addition, the MoHP will continue to undertake its role in health financing and providing curative services in non-UHI governorates until the complete UHI rollout, which is expected to be finalized in the coming decade.

In 2019, a major piece of legislation established the Egyptian Authority for Unified Procurement, Medical Supply and the Management of Medical Technology and the Egyptian Drug Authority. The two agencies are responsible for the regulation and procurement of pharmaceuticals and the medical goods market.

The new setup also profoundly changes resource mobilization and funding flows in the health system. The UHI system is funded by contributions collected from formal sector workers, informal sector workers and self-employed workers. For those categorized as poor or vulnerable, the contributions are fully subsidized through general budget transfers by the Ministry of Finance. Other revenue sources for the UHI system include earmarked tobacco taxes, road tolls, fees on car licensing and copayments.

The reform restructures other health financing functions by merging and replacing current pools/schemes (e.g., the programme for the treatment at the expense of the state, the programme for treatment of poor people, the HIO) into a single pool for the UHI system. This allows for better risk subsidization among population groups, increasing the fund's purchasing power and reducing administrative burdens (13, 14). In addition, new purchasing arrangements are introduced with redesigned payment mechanisms and redefined cost-sharing arrangements (e.g., relatively low ceilings and exemptions for poor people or those with chronic conditions or cancers) in order to ensure financial protection for the population.

The new UHIA is the sole purchaser under the UHI system, contracting with public and private providers. The providers, once

registered and accredited by the General Authority for Healthcare Accreditation and Regulation, are paid by the UHIA based on a contractual relationship, with both public and private providers contracted and paid in the same manner.

In essence, the UHI system shifts health financing from the supply side to the demand side, with provider payments shifting from input-based to output-based mechanisms. As mentioned above, the MoHP retains a crucial role in the new structure of the Egyptian health sector, responsible for overall governance authority and ensuring key public health functions—for example, health security and pandemic preparedness and response. This means that funding for and through the MoHP will not disappear, even if funding for public curative facilities will not flow through it anymore once the UHI system is fully rolled out.

The UHI system is being rolled out in six phases over 10 years. Implementation started in September 2019 in the governorate of Port Said and was extended to Luxor governorate in July 2021 and to Ismailia governorate in August 2022.

Implementation of the new reform is expected to raise demand for higher quality health services. It requires public and private facilities to meet international accreditation standards, with PHC and family health physicians at the centre of the system. By full implementation, the objective of the new set of reforms is to improve access to quality health services for everyone while ensuring a high level of financial protection by reducing out-of-pocket expenditure. This is expected to reduce impoverishment and improve labour force productivity, thus linking health system reform to wider development goals.

There are still challenges facing the implementation of the UHI system, and these challenges are likely to be similar to those faced by countries that have implemented similar reforms (e.g., Indonesia, Morocco and Thailand). The challenges include sustaining funding for the system, engaging private providers through contracting with the UHIA and defining an equity- and efficiency-driven benefit package.





Key findings and interpretations

Financing the health system

For fiscal year 2019/20, current health expenditure (CHE) in Egypt is estimated at EGP 255.6 billion, equating to EGP 2,560 per capita and representing 4.6% of GDP. Total health expenditure (THE), meaning CHE and capital formation, is estimated at EGP 271.4 billion, equating to EGP 2,718 per capita and representing 4.9% of GDP.

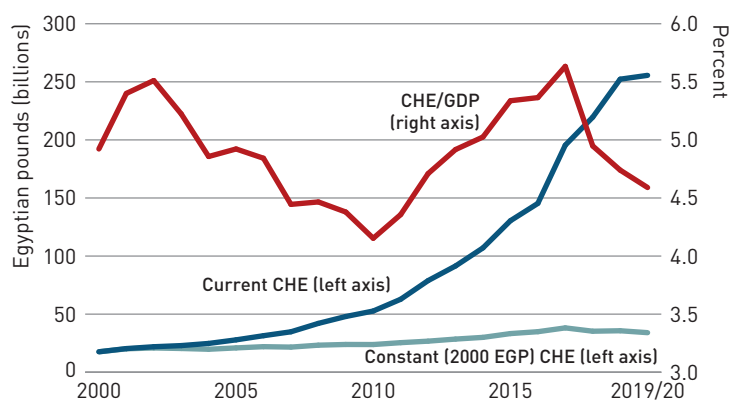
From 2000 to 2020, CHE increased by an average of 4.1% per year in real terms (i.e., taking into account inflation).¹ From 2000 to 2010, CHE grew slower than the economy on average: in 2000, CHE represented 4.9% of GDP, whereas in 2010 it had decreased to 4.2%. From 2010 to 2017, CHE growth outpaced economic growth, with CHE rising to 5.6% of GDP. From 2017 onwards, CHE growth has again lagged behind economic growth, resulting in a decline in CHE as a proportion of GDP (Fig. 2).

CHE per capita (in real terms) grew on average by 1.4% per year between 2000 and 2020. Nevertheless, population growth has outpaced CHE growth, resulting in negative growth in CHE per capita since 2017 (Fig. 3).

Financing sources: where does the money come from?

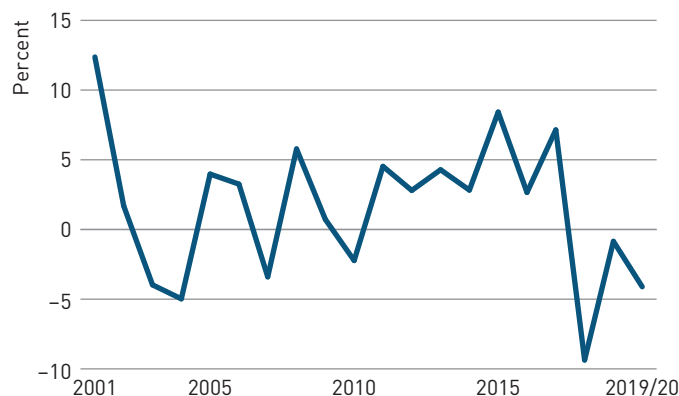
The aim of the SHA 2011 accounting framework is to provide a clear and transparent picture of Egypt's health financing flows and the structure of its health financing system. The

FIGURE 2 Current health expenditure, 2000–2020



Note: EGP is Egyptian pounds. GDP is gross domestic product. CHE is current health expenditure.

FIGURE 3 Current health expenditure per capita, year-to-year real growth, 2000–2020



1. Inflation adjustment for CHE is done using consumer price index figures from the Central Bank of Egypt (<https://www.cbe.org.eg/en/EconomicResearch/Statistics/Pages/Inflationhistorical.aspx>).

framework includes financing flows (transactions) of key functions of revenue raising and resource allocation, as well as the institutional units involved. This section identifies, classifies and measures the mix of revenue sources within the financing system.

Direct revenues from households' out-of-pocket payments remain the largest source of financing in the health system, making up an estimated EGP 151.6 billion, or 59.3% of CHE and 55.9% of THE. Out-of-pocket payments depend mainly on households' capacity to pay and show the direct burden of medical costs that households bear at the time of service use.

General government health expenditure (GGHE), which consists of government domestic revenue allocated to health, transfers

distributed by government from foreign origins and social contributions, is the second largest source, at around EGP 84 billion, or 33% of CHE (Fig. 4).

Out-of-pocket payments as a share of CHE have remained at approximately 60% over the past 20 years, with fluctuations above and below that point. From fiscal year 2018/19 to 2019/20 there was a marked decrease in the share of out-of-pocket payments over CHE, from 62.7% to 59.3%. This evolution coincides with a slight increase in government spending and with the first steps in the implementation of the Universal Health Insurance (UHI) system. While it would be difficult to attribute this decrease to the UHI reforms, it could still be regarded as an important signal of improved financial protection in Egypt. As the UHI reform gathers pace, it will be important to closely monitor the development of out-of-pocket payments and GGHE as a share of CHE (Fig. 5).

General government health expenditure from domestic sources (GGHE-D)² in 2019/20 amounted to EGP 81.5 billion. There has been a steady growth of GGHE-D in recent years, but when adjusted for inflation (i.e., in real terms), growth has been more modest.³ In real terms, there was an uptick of GGHE-D between 2014 and 2015, but since 2015, the level has plateaued (Fig. 6).

In per capita terms, GGHE-D represented EGP 817 in 2019/20. In real terms, per capita growth in GGHE-D has been rather slow, and since 2017, there has been a small decline, although this was reversed between 2018/19 and 2019/20, with GGHE-D per capita increasing by 8% year to year in real terms and 13% in nominal terms (Fig. 7).

Finally, as a share of GDP, Egypt's current GGHE-D constitutes 1.5%. The share of GGHE-D over GDP is somewhat lower in Egypt than in many comparable countries and in peer country groups, such as other lower-middle income countries, or other countries in the World Health Organization's (WHO) Eastern Mediterranean Region (Fig. 8).

The share of public funding allocated to health (i.e., GGHE-D as share of GGE) stands at 5.2%. This share was higher in the early 2000s and has since fluctuated between around 4% and 5%, indicating that the priority given to health in public expenditure has not changed

FIGURE 4 Revenue sources of the Egyptian health care system

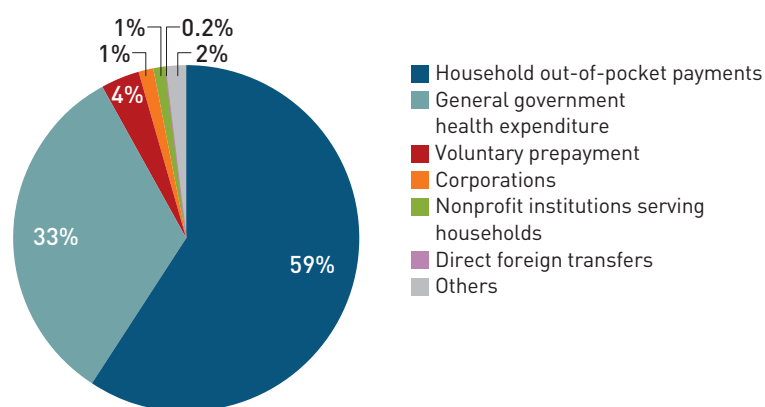
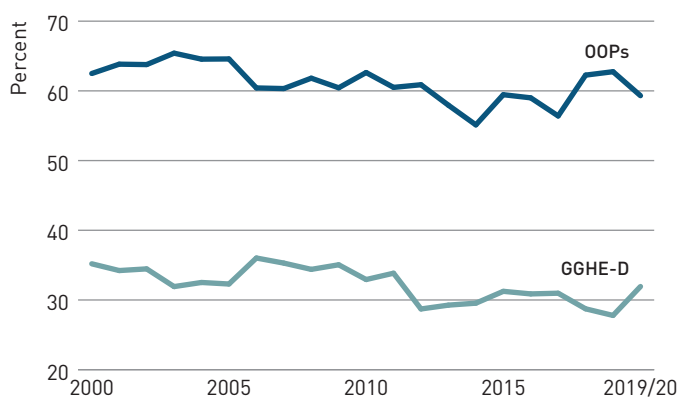


FIGURE 5 Household out-of-pocket payments and general government health expenditure from domestic sources (GGHE-D) as a share of current health expenditure, 2000–2020



Note: OOPs are out-of-pocket payments.

2. GGHE-D differs from GGHE in that funding from external (i.e., international) sources flowing through the government budget is excluded. As external funding for health in Egypt is very low, GGHE and GGHE-D can be considered broadly similar in the current context.

3. Constant values for government expenditure are estimated based on the World Bank's GDP deflator (<https://data.worldbank.org/indicator/NY.GDP.DEFL.KD.ZG?locations=EG>).

significantly in recent years. Nevertheless, from 2019 to fiscal year 2019/20, there was an uptick from 4.7% to 5.2%. Even with this recent increase in GGHE-D as a share of GGE, Egypt still allocates a lower share of government expenditure to health than its peer country groups (Fig. 9–10).

Household out-of-pocket payments and GGHE-D can be seen as two sides of the same coin, with high out-of-pocket payments resulting from low government health expenditure. In general, Egypt's out-of-pocket payments as a share of CHE are higher than in many peer countries, such as other lower-middle income countries, or other countries of the WHO's Eastern Mediterranean Region. Conversely, GGHE-D is lower in Egypt than in these comparison countries (Fig. 11).

Following revenues from out-of-pocket payments and GGHE-D, the other financing sources in terms of size are voluntary prepayments, public corporations, nongovernmental organizations (NGOs) and direct foreign transfers.

The category of public corporations includes the resources of corporations that are devoted to health purposes other than those included in social insurance contributions and/or other forms of compulsory or voluntary prepayment. In addition, since all corporations considered in this study are either fully public or quasi-public entities (i.e., public sector, public business sector or economic entities affiliated with the government), they are included under the GGHE by the Ministry of Finance (MoF). When added to other government spending, the value of GGHE increases to EGP 87.7 billion, or 34.3% of CHE. It is also assumed that most of the health expenditure from private corporations has already been included in the category of voluntary (private) prepayment insurance from employers.

The voluntary prepayment category includes voluntary private insurance premiums, whether received from individuals/households or from employers. Of the EGP 9 billion in revenues received from voluntary prepayments, 92% is from employers and 8% is from individuals. This represents 3.5% of CHE. Data in this section were obtained mainly from the Financial Regulatory Authority (FRA), to which all commercial insurance companies are obliged to report. Revenue sources from other entities that fall under the voluntary prepayment category but are not mandated by law to report to the FRA (such as health maintenance organizations and

FIGURE 6 General government health expenditure from domestic sources (GGHE-D), 2000–2020

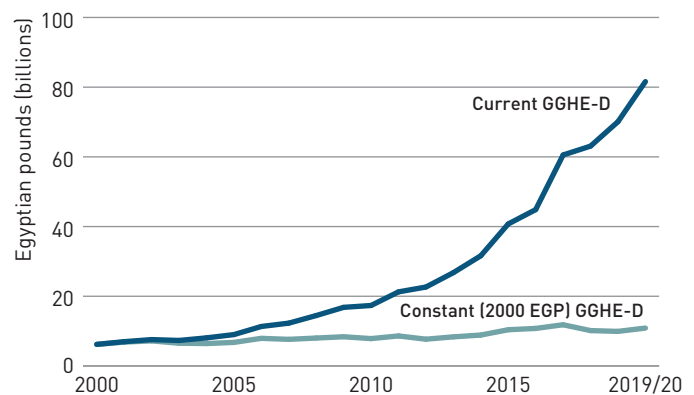


FIGURE 7 General government health expenditure from domestic sources (GGHE-D) per capita, 2000–2020

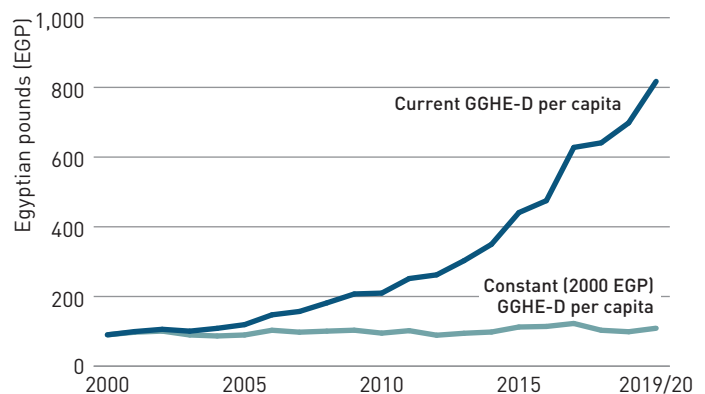
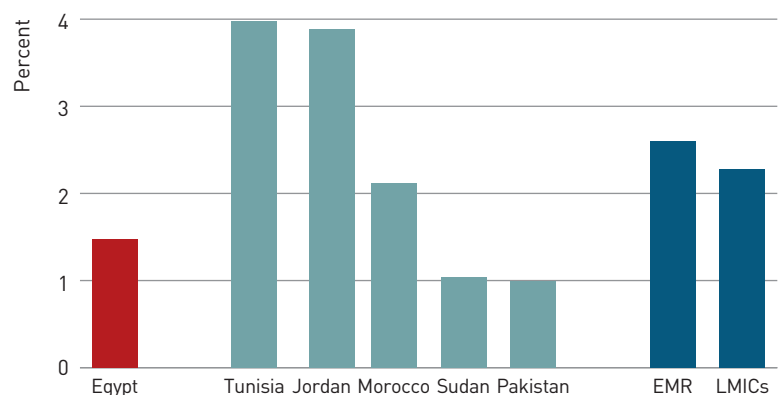


FIGURE 8 General government health expenditure from domestic sources as share of GDP in Egypt and peer country groups



Note: For Egypt, data are from 2019/20; for all other countries, data are from 2019. EMR is the World Health Organization's Eastern Mediterranean Region. LMICs is lower-middle income countries.

syndicates) were estimated by the NHA team based on evidence received from a panel of subject matter experts.

FIGURE 9 Share of public funding allocated to health (GGHE/GGE), 2000–2020

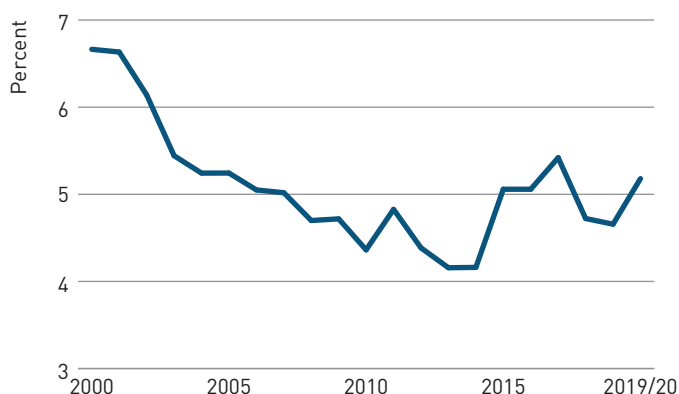
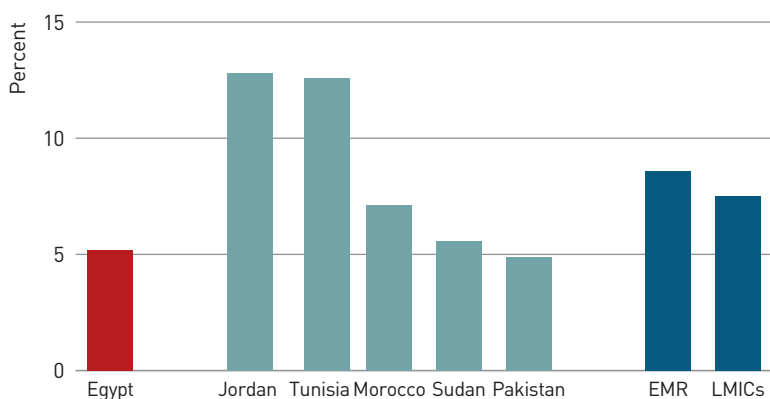
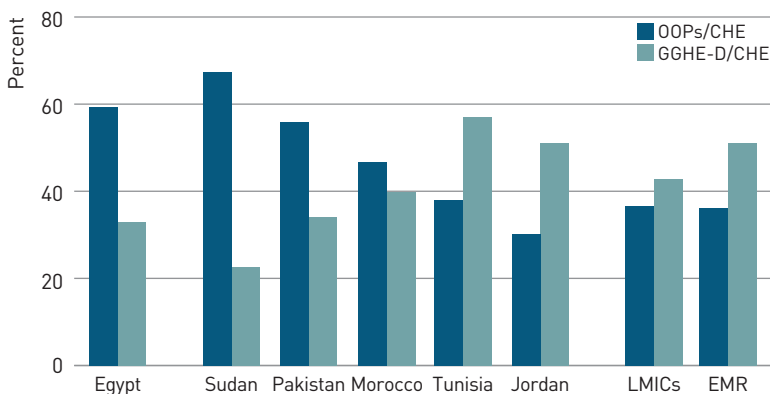


FIGURE 10 Share of public funding allocated to health (GGHE/GGE) in Egypt and peer country groups



Note: For Egypt, data are from 2019/20; for all other countries, data are from 2019. EMR is the World Health Organization’s Eastern Mediterranean Region. LMICs are lower-middle income countries.

FIGURE 11 Household out-of-pocket payments and general government health expenditure from domestic sources (GGHE-D) as share of current health expenditure in Egypt and peer country groups



Note: For Egypt, data are from 2019/20; for all other countries, data are from 2019. EMR is the World Health Organization’s Eastern Mediterranean Region. LMICs are lower-middle income countries. OOPs are out-of-pocket payments. CHE is current health expenditure.

Direct foreign transfers represented only EGP 443.8 million, or 0.2% of CHE. However, this category represents only direct foreign financial revenues earmarked for health that contribute directly to the funding of domestic health financing schemes. Nevertheless, another EGP 2.4 billion came from transfers originating abroad (bilateral, multilateral or other types of foreign funding) and distributed through the general government. That is, the provider of the fund is the government, but the fund itself has a foreign origin. Therefore, when estimating all revenues received of foreign origin,⁴ the overall total is EGP 2.8 billion, or 1.1% of CHE.

Data on nonprofit institutions serving households, primarily referring to NGOs, were retrieved from the Ministry of Social Solidarity for the top 11 NGOs working in the health sector, as explained in the methodology section in the annex. Contrary to prevailing perceptions that NGOs contribute significantly to financing the health system, revenues from NGOs are estimated at EGP 2.4 billion, or only 1% of CHE. The NHA team relied on the data provided by the ministry and did not estimate for residuals due to the lack of strong evidence on which to base valid assumptions. The EGP 2.4 billion represents only sources of funds from NGOs. However, other nongovernmental health care providers may receive funds from multiple sources and increase the overall expenditure at the provider level. Funds for charitable purposes are also paid directly to public and private institutions but are included within the overall financial envelope without being disaggregated, due to lack of data.

Financing schemes: the building blocks of the health financing system

Health care financing schemes are considered the main building blocks that structure the health financing system, as they are the main types of arrangements that can guarantee access to needed health services. In Egypt, CHE is distributed primarily from government schemes and compulsory contributory health financing schemes, voluntary health care payment schemes and household out-of-pocket payment schemes.

The health expenditure of government schemes and compulsory contributory schemes is estimated at EGP 88.4 billion. This includes all current expenditure allocated for health purposes from the central government scheme and the new national health insurance

4. SHA code FS.RI.1.5: Rest of the world.

BOX 1

Key reflections on Egypt's health financing sources

Analysing sources of revenues is important, as it gives clear indication of how the health system is funded and how the burden of revenue raising for health is distributed within a society. It is widely recognized that health financing systems that rely on out-of-pocket payments as a primary or substantial way of collecting revenues are problematic from an equity point of view, as this means that those who have little or no capacity to pay are excluded from health services and/or have access to health services that are limited in volume and quality. Furthermore, out-of-pocket payments are highly correlated with catastrophic health expenditure, meaning that those who end up paying directly out of pocket for health services at the point of service are at risk of financial hardship.¹

Levels of out-of-pocket payments in Egypt have historically been relatively high, as is the case in many lower-middle income countries and in countries of the Eastern Mediterranean Region. Historically, Egypt's out-of-pocket payments as a share of current health expenditure (CHE) have been slightly higher than in these peer countries. Egypt's level of out-of-pocket payments increased between 2017 and 2019 and then fell from 2018/19 to 2019/20, which is an encouraging sign.

The only effective policy path to reduce out-of-pocket payments is to increase resource mobilization through any type of prepayment mechanism (15). These include compulsory prepayment mechanisms by individuals or firms, in principle either through taxes or social contributions. In some countries, external funding can also be a substantial way to reduce reliance on out-of-pocket payments, but external funding represents only 1.1% of CHE in Egypt. Similarly, voluntary prepayments are not an important source of health expenditure in Egypt, representing approximately 3.5% of CHE.

In practice, the main source of health funding that can lower out-of-pocket payments is general government health expenditure from domestic sources (GGHE-D). As outlined above, the level of GGHE-D has grown steadily in Egypt, but once adjusted for inflation and once the country's demographic growth is taken into account, the level of government funding for health

per capita has not risen substantially in the last 10 years. GGHE-D as a share of GDP is still at the relatively low level of 1.5%. As in any country, the level of GGHE-D over GDP is a reflection of two components. The first is the share of government expenditure in the total economy—i.e., the level of general government expenditure (GGE) over GDP, which in Egypt stood at 24.6% in 2020 (4). The second is how large a share of GGE health receives. As seen above, this share (GGHE-D over GGE) currently stands at 5.2% (Fig. 9–10).

The question regarding the level of GGE over GDP lies largely outside of the immediate influence of the health sector and has to do with issues such as formalization of the economy and efficiency of tax collection. This determines the overall fiscal envelope of the government. The question of the share of GGE spent on health captures the “piece of the pie” going to health—i.e., the priority of health. In Egypt, the current level of GGHE-D over GGE is 5.2%, which seems to indicate that Egypt is allocating less funding from government revenues for health than most of its peer countries.

In sum, the current 1.5% level of GGHE-D over GDP is a result of low levels of both GGE over GDP and GGHE-D over GGE. Structural economic and fiscal reforms are needed and are already being implemented (4) to increase the level of GGE over GDP, while the level of GGHE-D over GGE requires further prioritization of health in government expenditure. The recent reform plans, including the presidential public health campaigns and the implementation of the Universal Health Insurance system are expected to positively contribute to increasing the priority of health within government spending and therefore increasing government health spending as a share of GGE and of GDP.

Note

1. In the Sustainable Development Goals, this financial hardship from direct health payments is defined by Target 3.8.2 as health payments that take up more than 10% and 25% of household budgets. The monitoring of this target requires household survey analysis, which the World Health Organization has produced for Egypt in collaboration with the Central Agency for Public Mobilization and Statistics.

system (the HIO and UHI). This is higher than GGHE, as it includes other domestic revenues.

Further details of the management of central government schemes are discussed in the following section on financing agents.

This section focuses on the main social health insurance schemes that currently exist in Egypt, namely the HIO and the UHI system that has begun to be rolled out. CHE in the HIO scheme is estimated at EGP 16 billion, while

FIGURE 12 Revenue sources of the Health Insurance Organization scheme

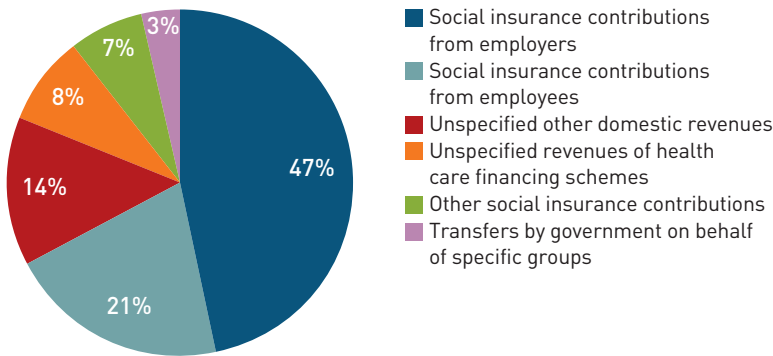


FIGURE 13 Revenue sources of the Universal Health Insurance scheme

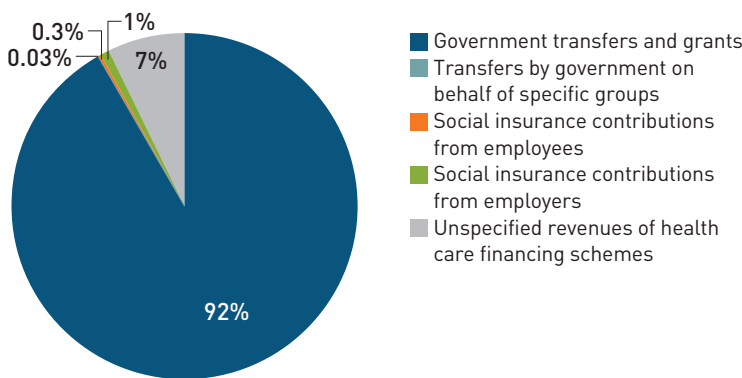
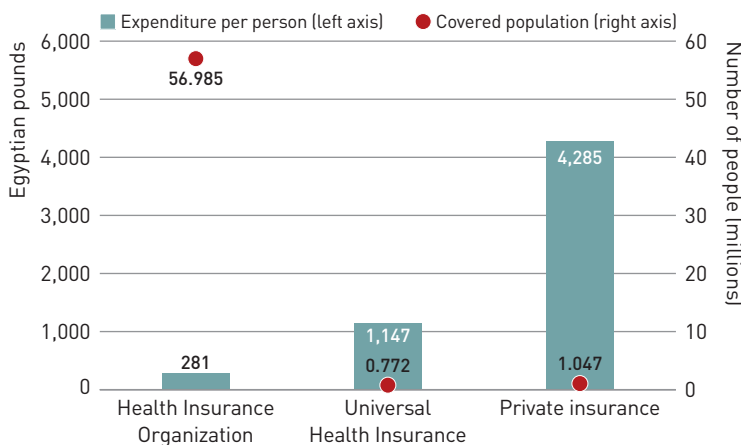


FIGURE 14 Expenditure per person, by financing scheme



that in the UHI system is estimated at EGP 886 million. The value of the UHI system in the current account does not consider accumulated savings, which can be reported as a memorandum item in the capital account.

Cross-classification of the values of financing sources with health insurance schemes

would be of particular interest in the case of Egypt, as this could inform the periodic revisions of the actuarial study, which estimates future projections of the financial space of the system (Fig. 12–13). As shown in the figures, both insurance schemes rely on diverse sources of revenues to finance their systems. The HIO relies mainly on social insurance contributions from employers (47%) and employees (21%), with relatively small amounts of funding in the form of transfers from government finances on behalf of specific groups (3.6%). By contrast, the UHI system relies mainly on general transfers from government finances (91.7%), of which 51% goes to the Universal Health Insurance Authority (UHIA) and around 41% goes directly to the Egypt Healthcare Authority (EHA). Social insurance contributions from employers or employees—which are supposed to be the main source of financing for the new system, according to the UHI actuarial study—represent around 1.2% in total. Transfers by government on behalf of specific groups, such as poor and vulnerable populations who are exempt from UHI contributions, represent only 0.03%.

These figures are extremely important, as they highlight early challenges that could jeopardize the fiscal position of the new UHI system in the near future, as it is rolled out across more governorates. Such challenges include the difficulty of identifying poor and vulnerable populations, which could mean less funding in the form of government transfers than is required by the size of these groups. These figures could also indicate a potential lack of compliance by the formal sector in terms of contributing to the system, an additional challenge on top of the existing issue of how to seek contributions from the informal sector. To put this in context, however, this study tracks expenditure for fiscal year 2019/20, which was year one of the UHI’s system implementation, and as a result, the full set of processes for revenue collection were not yet in place.

Voluntary prepayment schemes include voluntary insurance schemes managed by commercial insurance companies, health maintenance organizations and professional syndicates or trade unions. It also includes NGOs’ charitable financing schemes and enterprise financing schemes managed by corporations.

One of the key indicative measures in countries with multiple financing schemes such as Egypt is to estimate the expenditure per person of each scheme. This will inform

decision-makers about aspects of equity in resource allocation and potential access to health services. Fig. 14 shows the expenditure per person under the HIO scheme, the UHI scheme and voluntary private (commercial) insurance schemes, highlighting the major differences between the three. For example, expenditure per person by private insurance schemes is almost 15 times higher than under the HIO scheme and four times higher than under the UHI scheme. This wide variation suggests that equity and efficiency gains are possible through improved resource allocation. It is therefore recommended to monitor how the UHI scheme evolves in terms of revenues and expenditure over time and how it may be able to help to bridge existing equity gaps.

Financing agents: who manages the funds?

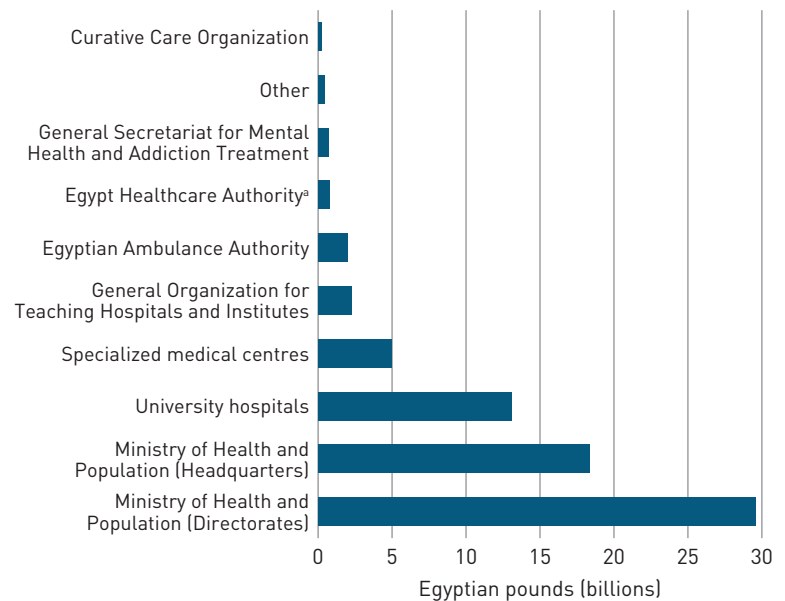
The fragmented nature of the Egyptian health system is best illustrated through an analysis of the financing agents, or the institutional units that administer health financing schemes. This section provides a particular focus on the institutional entities that are affiliated with the general government schemes. These are entities financed, at least partly, through budget transfers, excluding the social health insurance schemes. Of the public and quasi-public financing agents, CHE in Ministry of Health and Population (MoHP) directorates is the highest, at around EGP 29.6 billion, followed by MoHP headquarters (at EGP 18.3 billion), university hospitals (at EGP 13 billion) and specialized medical centres (at EGP 4.9 billion) (Fig. 15). The financing agent that has the lowest CHE is in the Curative Care Organization. Most of the listed entities also operate an integrated provider side, and it is for this reason that their funding is highlighted in this section, as it is hard to disentangle expenditure at the provider level with the required accuracy, given the available data.

Fig. 16 summarizes the flow of funds across the health financing system, from the revenue sources to financing schemes and financing agents.

Current health expenditure by governorate

To better inform the UHI rollout plan, particular focus is given to the disaggregation of health expenditure data beyond national averages and into subaccounts disaggregated by the country's 27 governorates. This will provide much needed baseline information that can further inform health sector reform planning, monitoring and evaluation.

FIGURE 15 Financing agents of the public and quasi-public sector, excluding insurance organizations



a. EHA funds here are the sum of those received directly from Ministry of Finance budget transfers and those paid by the Universal Health Insurance Authority for purchased services.

The governorate with the highest proportion of CHE is Cairo, at EGP 37.6 billion, followed by Giza. The lowest is South Sinai, at EGP 712.9 million (Fig. 17). However, it is also useful to analyse CHE adjusted for population size. Fig. 18 shows CHE per capita by governorates and financing schemes. By contrast with the previous figure, the highest CHE per capita is in South Sinai, at EGP 6,607 per capita. This figure might be artificially inflated due to the governorate's small population size (107,916). The touristic nature of this governorate might also be a factor, as many people visit for short-term trips and potentially use health care services locally while being registered in other governorates. Aside from this outlier, Cairo is at the top of the list of governorates, at EGP 3,792 per capita, followed by Port Said, at EGP 3,787 per capita. The relatively high CHE per capita in Port Said can be seen as an indication of increased investment by the Government of Egypt in the UHI scheme in this governorate, the location for the pilot UHI scheme. It is also noteworthy that household out-of-pocket payments in Port Said are above the national average in absolute terms, at EGP 1,814 per capita, compared with the national average of EGP 1,518, but below the national average in relative terms (i.e., out-of-pocket payments as a share of CHE), at 47.9% in Port Said, compared with 59.3% at the national level (Fig. 19). This is an

FIGURE 16 Fund flow across the health financing system

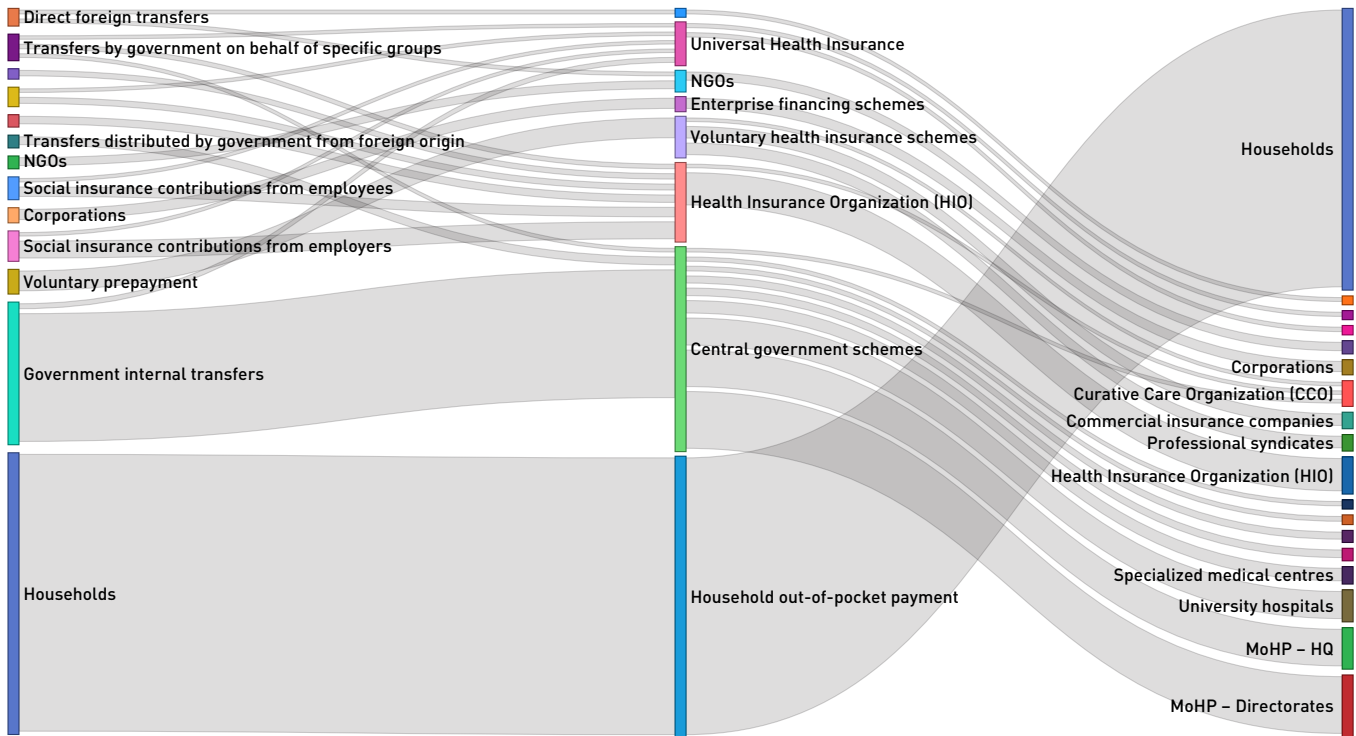
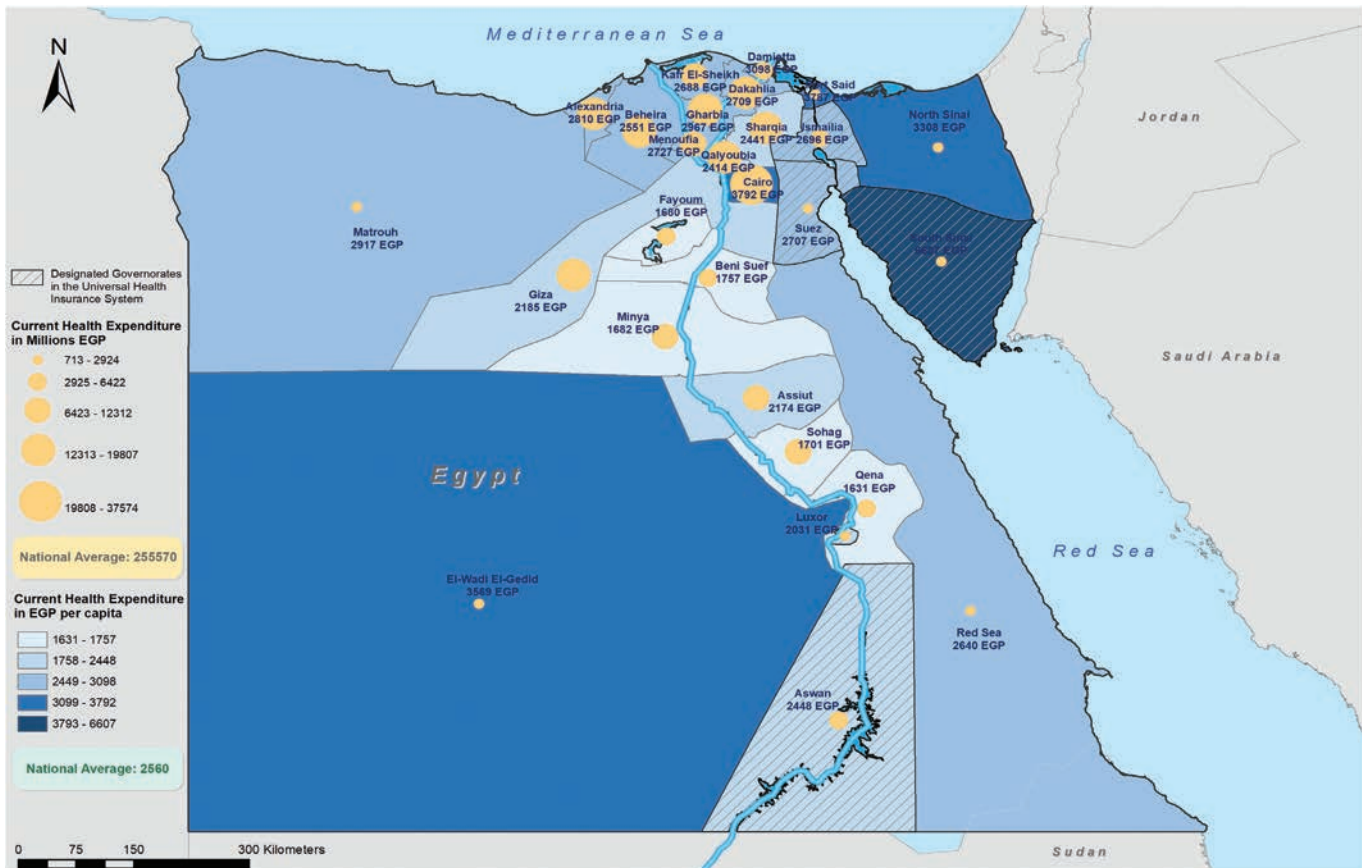


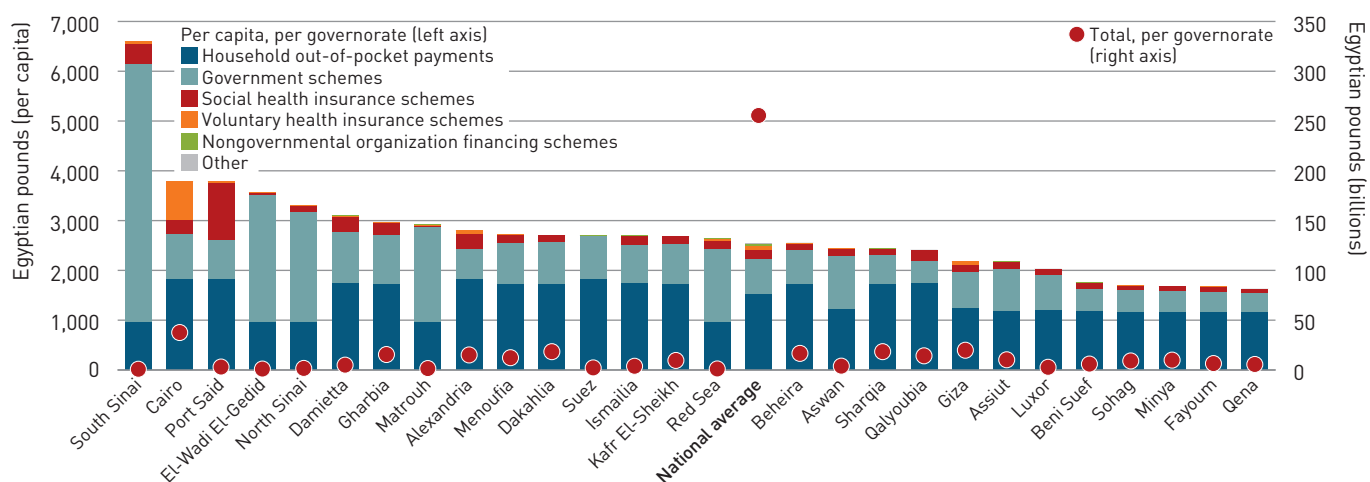
FIGURE 17 Map of current health expenditure per governorate



The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

Map production: Health Emergency Information and Risk Assessment (HEIR) Eastern Mediterranean Regional Office (EMRO) World Health Organization - emroghim@who.int

FIGURE 18 Current health expenditure, total and per capita, by governorate and financing scheme



Note: CHE is current health expenditure.

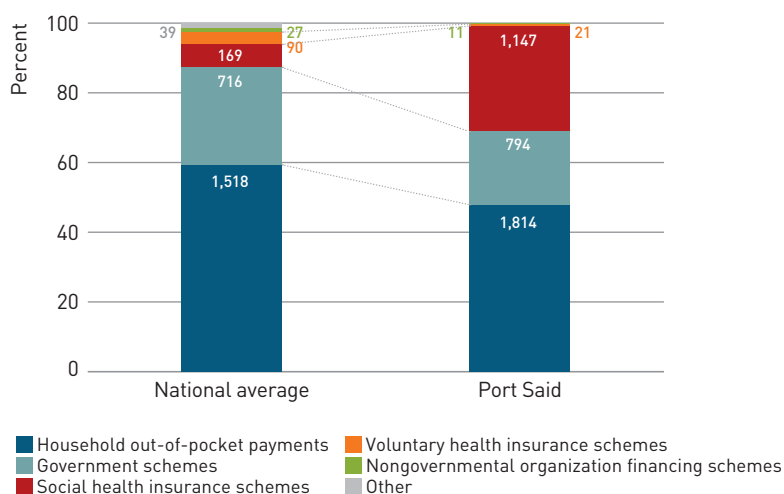
important baseline figure to track over time to ensure that the UHI system is delivering on its objectives of reducing out-of-pocket payments.

Health service providers: who receives the money?

Health care providers are considered the end recipient of health care funds. In Egypt, health care is provided through all levels of service delivery, including hospitals, providers of ambulatory (i.e., outpatient) services, providers of ancillary services (e.g., ambulance services, diagnostic radiology and laboratories), retailers of medical goods (mainly pharmacies), providers of preventive care and providers of health system governance and administration. Analysing health expenditure by provider type, alongside the financing and consumption dimensions of the health accounts, gives a more comprehensive picture of health resource allocation and consumption.

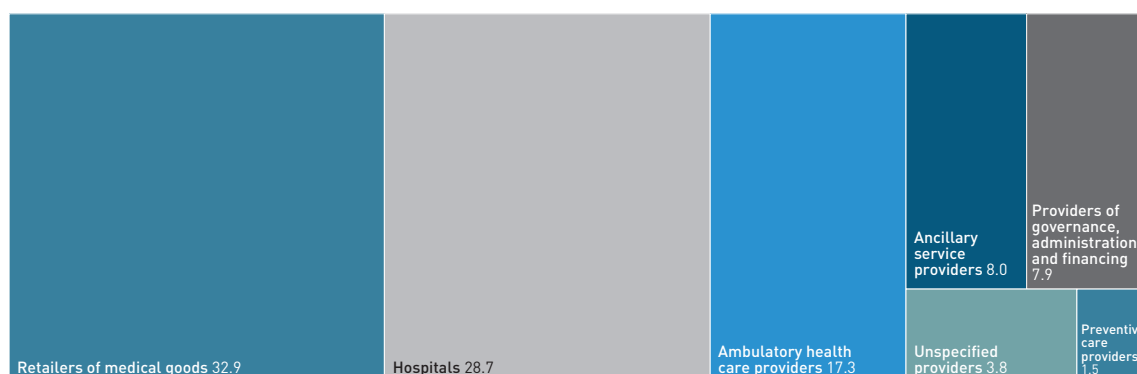
Funds flowing to retailers of medical goods (mainly pharmacies) account for the largest proportion of CHE in Egypt. In fiscal year 2019/20, retailers received EGP 84 billion, or 33% of CHE. The second largest category of health care providers are hospitals, with EGP 73 billion, or 29% of CHE. The hospital category represents public, semi-public and private hospitals and includes expenditure on all activities undertaken inside a hospital setting, such as inpatient services, outpatient services, day care, and radiology and imaging. It is relevant to note that the CHE of mental health hospitals is estimated at EGP

FIGURE 19 Share of current health expenditure per capita, by financing scheme, national average and Port Said



713 million, or almost 1% of overall hospital expenditure. Other main provider categories include ambulatory health care providers, at 17%, and providers of ancillary services, at 8% (Fig. 20, Table 2).

There is wide variation in the distribution of health care spending by different sources of financing or financing schemes (Fig. 21). For example, 54% of household out-of-pocket spending goes to pharmacies and other retailers of medical goods. This is followed by spending on hospitals and ambulatory providers (18% each). On the other hand, 51% of government scheme spending is directed to hospitals. These figures underline the findings of previous expenditure and utilization studies—namely, that households rely on their own out-of-pocket spending for services from

FIGURE 20 Current health expenditure, by provider**TABLE 2** Current health expenditure, by provider

Provider	CHE (in million EGP)	Share of CHE (%)
Retailers of medical goods	84,017	32.9
Hospitals	73,248	28.7
Ambulatory health care providers	44,112	17.3
Ancillary service providers	20,434	8.0
Providers of governance, administration and financing	20,258	7.9
Preventive care providers	3,893	1.5
Unspecified providers	9,607	3.8

Note: CHE is current health expenditure. EGP is Egyptian pounds.

pharmacies and outpatient clinics but understandably rely more on government schemes for hospital (inpatient) services.

Of particular interest is the distribution of spending by the UHI financing scheme to its contracted providers. As shown in Fig. 21, activities delivered in ambulatory provider settings received the largest share of the UHI's current expenditure (49%), followed by spending on hospitals (39%). Although it is early to evaluate the organizational priorities of the UHI system, these figures indicate a potential shift in service delivery from hospital settings towards ambulatory care and primary health care (PHC). No spending from the UHI system flows to retailers of medical goods, such as pharmacies. This is because no contracts had been made between the UHIA and pharmacies in the fiscal year looked at by the study. However, if population needs are not sufficiently met by pharmacies operating in the UHIA-contracted hospitals and in PHC facilities owned mainly by the EHA, households may continue their existing tendency of relying on retailers to satisfy their needs, which may therefore create a financial

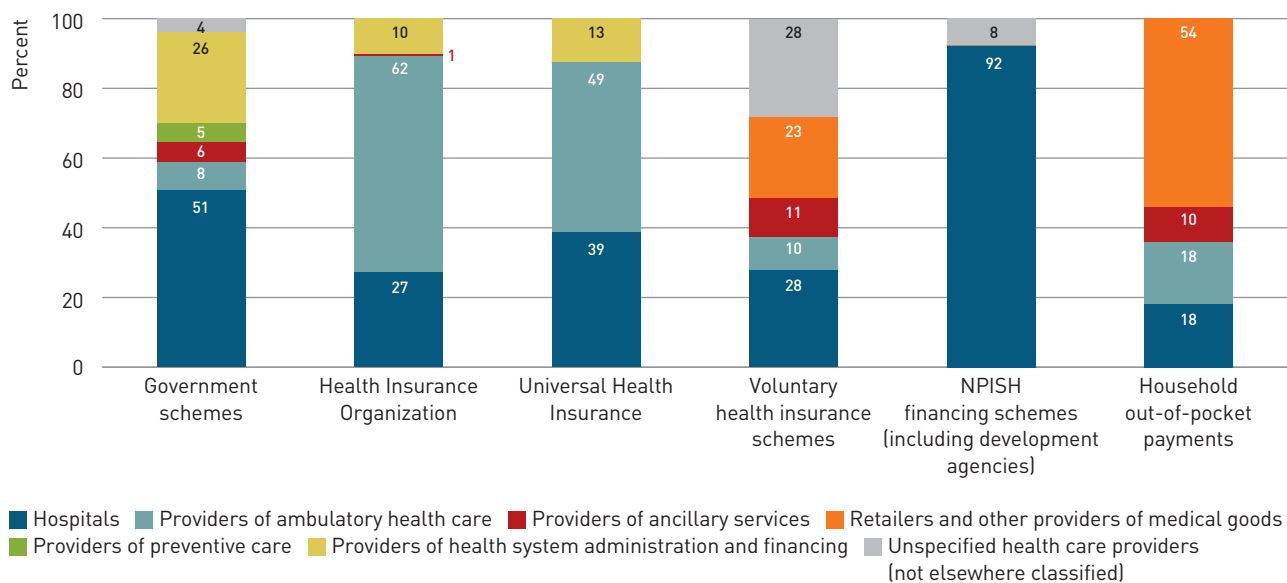
burden for households that already have insurance coverage.

Factors of health care provision: the cost of resources used to produce health services

Factors of provision are all the inputs used in producing health care goods and services. Classification of factors of provision can illustrate the shares of CHE allocated to resources such as labour, health goods such as pharmaceuticals, health services and nonhealth goods and services and can therefore show the difference across production patterns by provider. When combined with data on utilization and/or number of beneficiaries, classification of the factors of provision can provide useful information on the productive efficiency of different provider institutions.

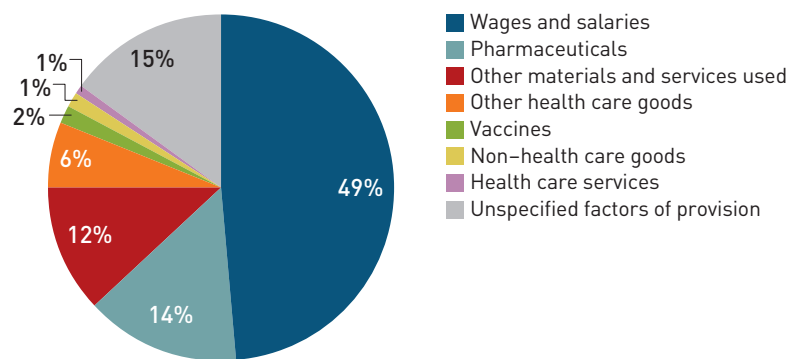
Expenditure by factors of provision was tracked for all government sector agents, with budget line items coded and mapped according to the SHA 2011 methodology. For the government sector, wages and salaries constituted the largest spending item, at 49% of the total, followed by materials and services, at 36%. The materials and services

FIGURE 21 Share of current health expenditure, by health care providers and financing schemes



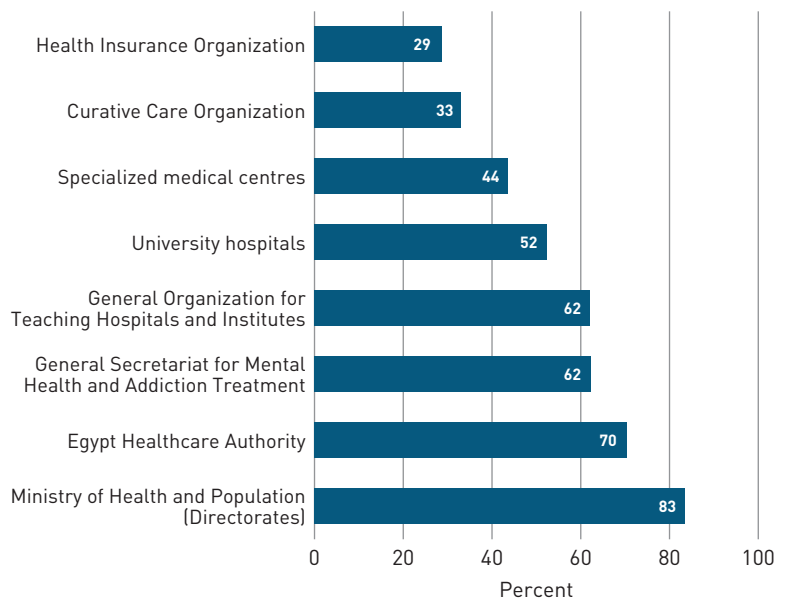
category consists of health and nonhealth goods and services that are bought from other providers—i.e., those not produced in-house. In particular, spending on pharmaceuticals⁵ accounts for EGP 12.6 billion, or 14%, of governmental expenditure, while spending on vaccines accounts for EGP 1.4 billion, or 2%, of government health expenditure (Fig. 22).

FIGURE 22 Current health expenditure, by factor of provision in the government sector



Generally, human resources, along with medicines and medical goods, represent around two thirds of current spending in most health systems (1). Nevertheless, this report refrains from making any comparisons to inform decisions based merely on this fact due to the contextual difference between the production patterns across different health systems. An alternative approach to drive efficiency gains is to use national-level data as a benchmark for governmental provider agencies in terms of their pattern of inputs in relation to outputs. Comprehensive efficiency studies will require output-level data to combine with NHA expenditure data.

FIGURE 23 Wages and salaries as a share of current health expenditure in government entities



This report focuses on salaries and wages, as these represent the most important driver of government expenditure. As shown in Fig. 23, MoHP hospitals have the highest share of salaries to overall current expenditure, at 83%, followed by the EHA, at around 70%. The HIO has the lowest share, at 29%. This kind of information can give valuable insights into production patterns, but it is important to interpret such information carefully, considering

5. A dedicated section on pharmaceuticals follows later in this report.

BOX 2

The hospital sector’s financial landscape

The different categories of health care providers are defined in this report per the classification in the manual *A System of Health Accounts 2011 (1)*. The manual distinguishes among general hospitals, mental health hospitals and specialized hospitals (excluding mental health hospitals) based on both the scope of medical treatments provided and the specificity of diseases or medical conditions of inpatients. However, the classification does not take into account hospital expenditure based on ownership—i.e., public (governmental), quasi-public, private, nongovernmental and so on.

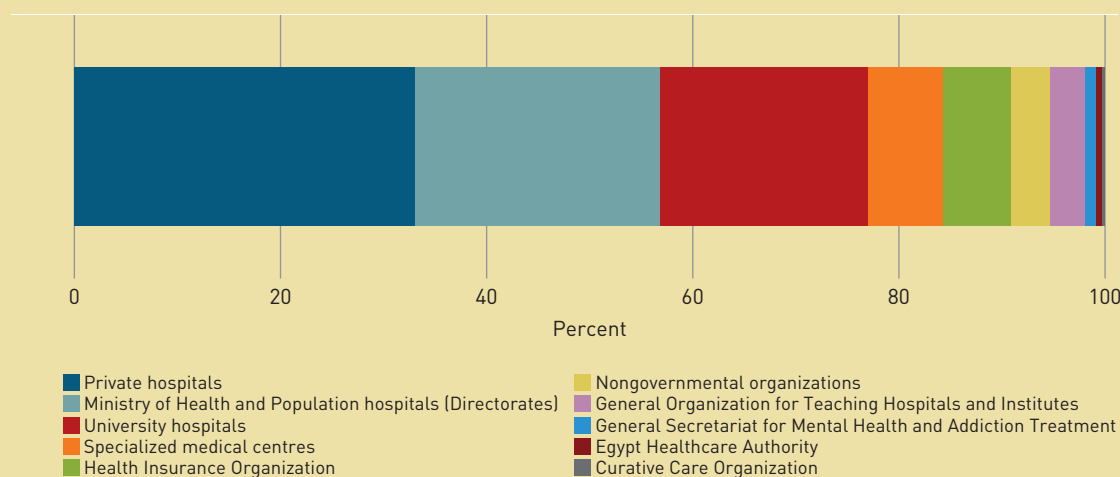
Given the relevance of, and growing interest in, the status of private hospitals in Egypt, the NHA team made a preliminary effort to estimate the total current expenditure on private hospitals based on available raw data. Two main data sources were used as a basis for the estimation of private hospital expenditure, namely the Household Income, Expenditure and Consumption Survey by the Central Agency for Public Mobilization and Statistics (CAPMAS) and private health insurance expenditure data from the Financial Regulatory Authority. The data were then triangulated using additional data from CAPMAS’s economic census on the health care sector, after adjustment for the same fiscal year.

Activities delivered in private hospitals account for approximately EGP 24 billion, or 33% of total current hospital expenditure.¹ As expected, most of this expenditure, approximately one third, is concentrated in Greater Cairo (Cairo, Giza and Qalyoubia). The top six governorates that follow in terms of private hospital expenditure are Sharqia (8%), Dakahlia (7%), Beheira (6.8%), Alexandria (6%), Gharbia (5.4%) and Menoufia (4.7%). The NHA team acknowledges that this figure is likely to be a slight underestimate, as it does not take into account government transactions that can take place in private facilities for some outsourced services. However, this fund stream from government schemes or the Health Insurance Organization is extremely minor relative to overall private hospital expenditure. Current health expenditure on public (governmental) and semi-public hospitals represents 63%, whereas nongovernmental organization hospitals account for approximately 4% of hospital expenditure (box figure).

Note

1. Expenditure by subnational level (i.e., governorates) follows the residency principle; refer to the methodology section in the annex for details.

BOX FIGURE Distribution of current hospital expenditure, by hospital ownership



its corresponding context—for example, by combining patterns of inputs with the level of output, the structure of public administration, the payment system or the nature of each institution (i.e., teaching hospital, general hospital, specialized hospital, etc.).

Health care functions: what is the purpose of health care spending?

Consumption of health care refers to the types of goods and services provided and the activities performed within the health system.

Classification of health care functions aims to identify the purpose of service provision. As such, health care functions are classified in categories such as curative care, rehabilitative care, preventive care, medical goods, ancillary services, and governance and health system administration and financing.

In fiscal year 2019/20, the largest share of CHE was directed to curative care services (45%). The share of curative care can be broken down further, according to the service delivery setting, into outpatient curative care (receiving 22% of CHE), inpatient curative care (receiving 21%) and day curative care (receiving 2%). Curative care is followed by expenditure on medical goods (mainly pharmaceuticals), at 33%, and ancillary services, at 8%. Expenditure on governance functions, administration and financing accounts for 8%, while preventive care remains relatively low at approximately 1.5% (Table 3, Fig. 24).

The distribution of CHE by function reflects the areas considered priorities for allocating health care resources. In this regard, two important categories are worth further attention, as they are considered important markers of health system reform—namely, expenditure on preventive care and expenditure on health system governance, administration and finance.

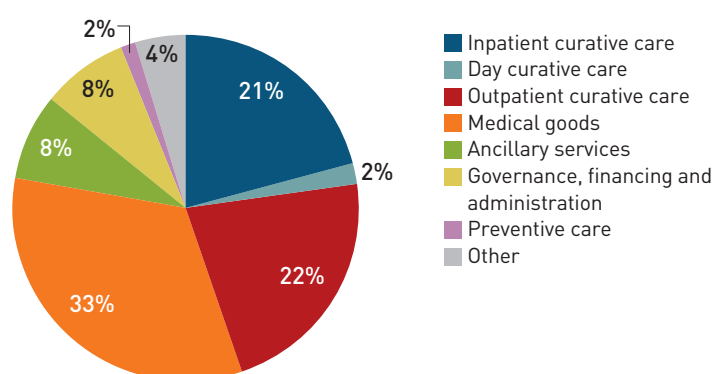
Expenditure on preventive care includes any measure that aims to avoid injuries and diseases or reduce their number or severity. This includes immunization programmes, epidemiological surveillance, early detection and disease control programmes, among others. Within Egypt's health care reform, special attention should be given to the quantity and quality of preventive services provided to the population. One of the suggested ways of monitoring progress in the reform process is to monitor the quantity and flow of funds to the preventive functions by governorate, especially those under UHI implementation.⁶ In this study, the NHA team estimated both relative and absolute values of preventive care expenditure by governorate to establish a baseline that can facilitate future impact assessments. The national average for expenditure on preventive functions as a share of CHE is around 1.5%, or EGP 39 per capita. In Port Said, the UHI pilot governorate, the share of CHE on preventive functions is 1.3%, or EGP 51 per capita. These figures should be of special interest for decision-makers over the next

TABLE 3 Current health expenditure, by health care function

Health care function	CHE (in million EGP)	Share of CHE (%)
Curative care	115,878	45.3
Medical goods	84,017	32.9
Ancillary services	20,332	8.0
Governance, financing and administration	20,075	7.9
Preventive care	3,893	1.5
Other	11,374	4.5

Note: CHE is current health expenditure. EGP is Egyptian pounds.

FIGURE 24 Current health expenditure, by health care function



few years in order to assess the progress of health system reforms, particularly when complemented by a measure of outputs.

Of equal importance is the share of expenditure on health system governance, administration and finance functions. With the ongoing reform and the establishment of at least five new authorities in the recent years, namely the UHIA, the EHA, the General Authority for Healthcare Accreditation and Regulation, the Egyptian Drug Authority, and the Egyptian Authority for Unified Procurement, Medical Supply and the Management of Medical Technology, it is important to closely monitor the quantity and flow of funds to governance, administration and financing functions to avoid inflated and inefficient spending that grows rapidly and unnoticed. For fiscal year 2019/20, the share of governance spending is estimated at approximately 8% of CHE. To put this in context, the average expenditure on both preventive and governance functions in the countries of the Organisation for Economic Co-operation and Development (OECD) is around 5%. While it may be inadvisable

6. Refer to the introduction for background on the separation of functions between the MoHP and the UHI scheme for preventive and curative services.

to draw conclusions from simple comparisons between Egypt and high-income member countries of the OECD, it is nevertheless worth highlighting the relative difference between the two figures.

For more in-depth analysis, Fig. 25 provides greater focus on the expenditure of the governance, administration and finance functions in the three major government financing schemes: central government schemes, including the MoHP and all its affiliates; the HIO scheme; and the UHI scheme. This figure, however, is not intended to make specific judgments on the efficiency of these organizations, but rather to establish a baseline for future monitoring and impact assessments. It worth mentioning, however, that the governance expenditure per capita for the HIO scheme (the total Egypt population less the population of Port Said) is EGP 16, whereas for the UHI scheme it is EGP 144 (Port Said population only for fiscal year 2019/20). This variation between the two schemes can help in establishing a medium- to long-term benchmark and in monitoring the reduction in governance spending per capita as the UHI is rolled out and more of the population is included.

Pharmaceutical expenditure landscape

Retail pharmaceutical expenditure has always been one of the largest expenditure categories in the Egyptian health system and a key driver for increased out-of-pocket spending. In fiscal year 2019/20, retail pharmaceuticals accounted for approximately EGP 79 billion, or 31% of CHE. This is clearly higher than the average expenditure on medical goods in OECD countries, which is around 21%. Furthermore, this EGP 79 billion is financed almost exclusively through private spending. To be precise, out-of-pocket payments finance approximately 98% of retail pharmaceuticals,

while the remaining 2% is covered by voluntary health insurance.

Retail pharmaceutical expenditure averaged EGP 791 per capita. Cairo and Port Said are the highest governorates in terms of retail pharmaceutical expenditure per capita, at EGP 1,179 and EGP 1,020, respectively, while North Sinai and EL-Wadi El-Gedid are the lowest, both at EGP 440 (Fig. 26–27).

The retail pharmaceutical sector, however, tells only part of the story of overall pharmaceutical expenditure in Egypt, since considerable pharmaceutical spending takes place inside health facilities. This NHA study for the first time includes pharmaceutical spending inside public and private health facilities. Pharmaceutical spending inside MoHP and other government facilities accounts for around EGP 12.6 billion. The MoHP is also the sole provider of vaccines, which accounts for around EGP 1.38 billion of spending in fiscal year 2019/20. Private hospitals account for approximately EGP 4.5 billion of pharmaceutical expenditure, 95% of which is financed through out-of-pocket payments.

Overall, the total market for pharmaceuticals in retail and inside facilities amounted to an estimated EGP 96 billion, or 38% of CHE in fiscal year 2019/20. Fig. 28 illustrates the distribution of pharmaceutical expenditure and its flow from financing schemes to health care providers, although it does not capture out-of-pocket payments for purchasing pharmaceuticals in government facilities, as this is not currently tracked at the provider level.

This relatively high pharmaceutical expenditure, which alone accounts for almost 1.7% of Egypt's GDP, could be viewed positively as a considerable driver for Egypt's economy, but it also raises concerns about the equity and future sustainability of the health system. With around 87% of pharmaceutical expenditure privately financed (85% by out-of-pocket payments and 2% by prepaid voluntary health insurance; see Fig. 28), access to pharmaceutical services is constrained by the population's capacity to pay and is not necessarily based on need. This could in turn prevent large population groups from seeking care and/or result in financial hardships for those who could obtain care. If left uncontrolled, this would create financial risk for Egypt's health reform in the medium to long term, since these expenditures should be covered by the new UHI system on behalf of the population.

These high levels of pharmaceutical expenditure can be attributed to a myriad of factors,

FIGURE 25 Expenditure on governance, administration and finance functions as a share of current health expenditure in main government schemes

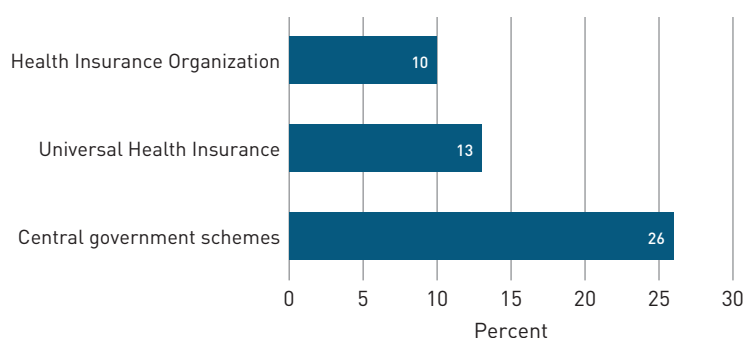


FIGURE 26 Map of retail pharmaceutical expenditure per capita

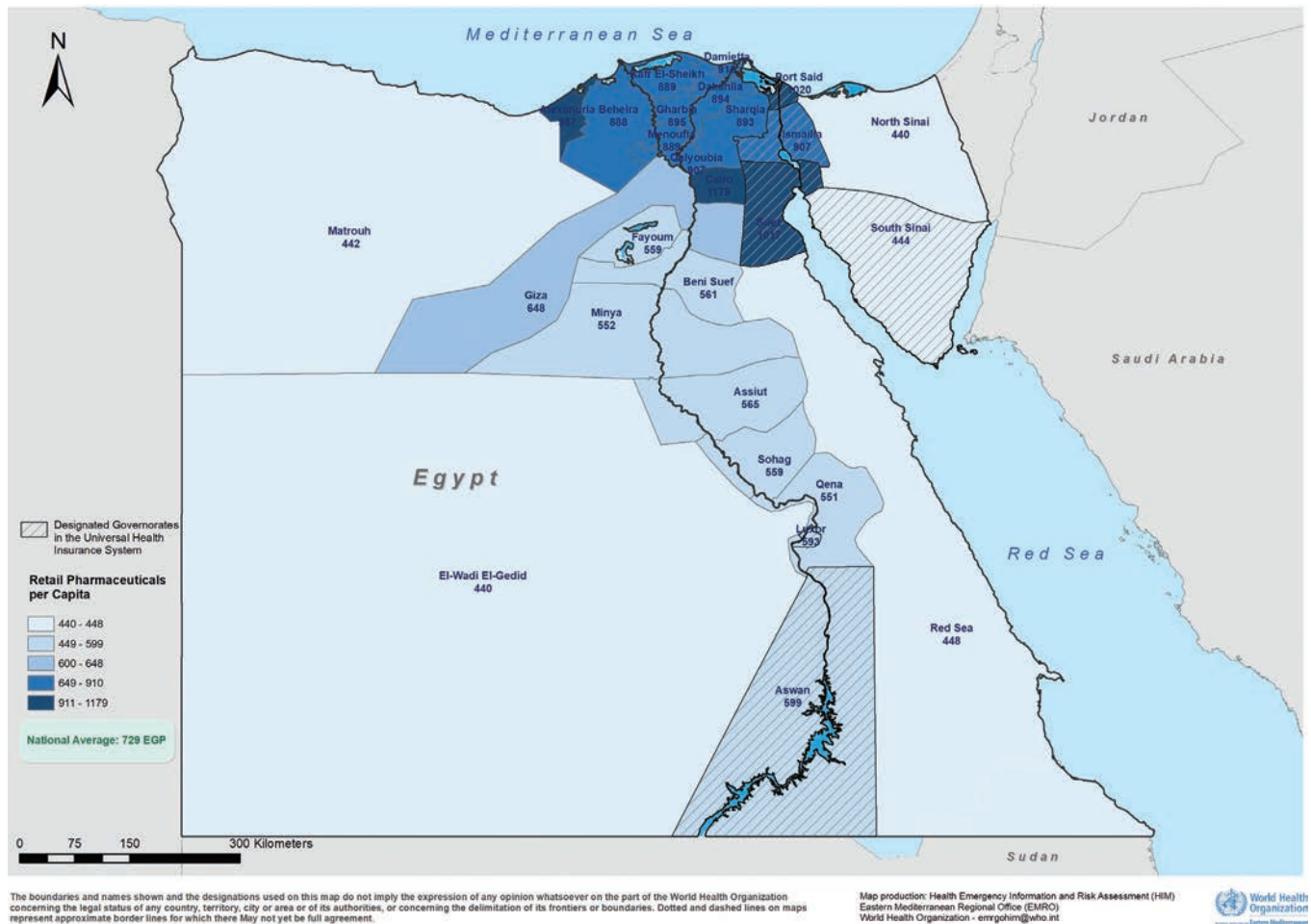
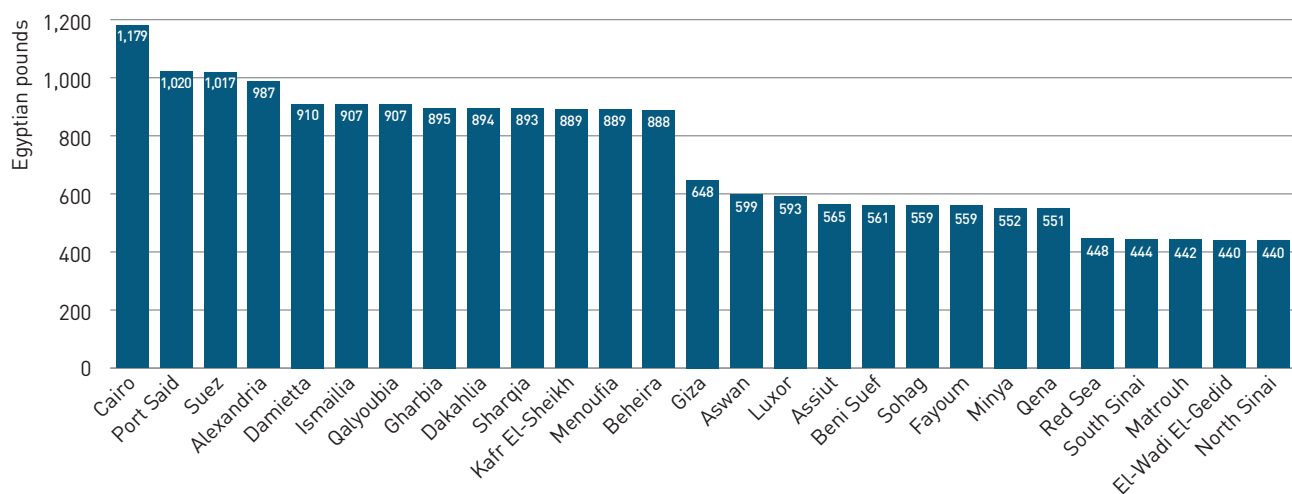
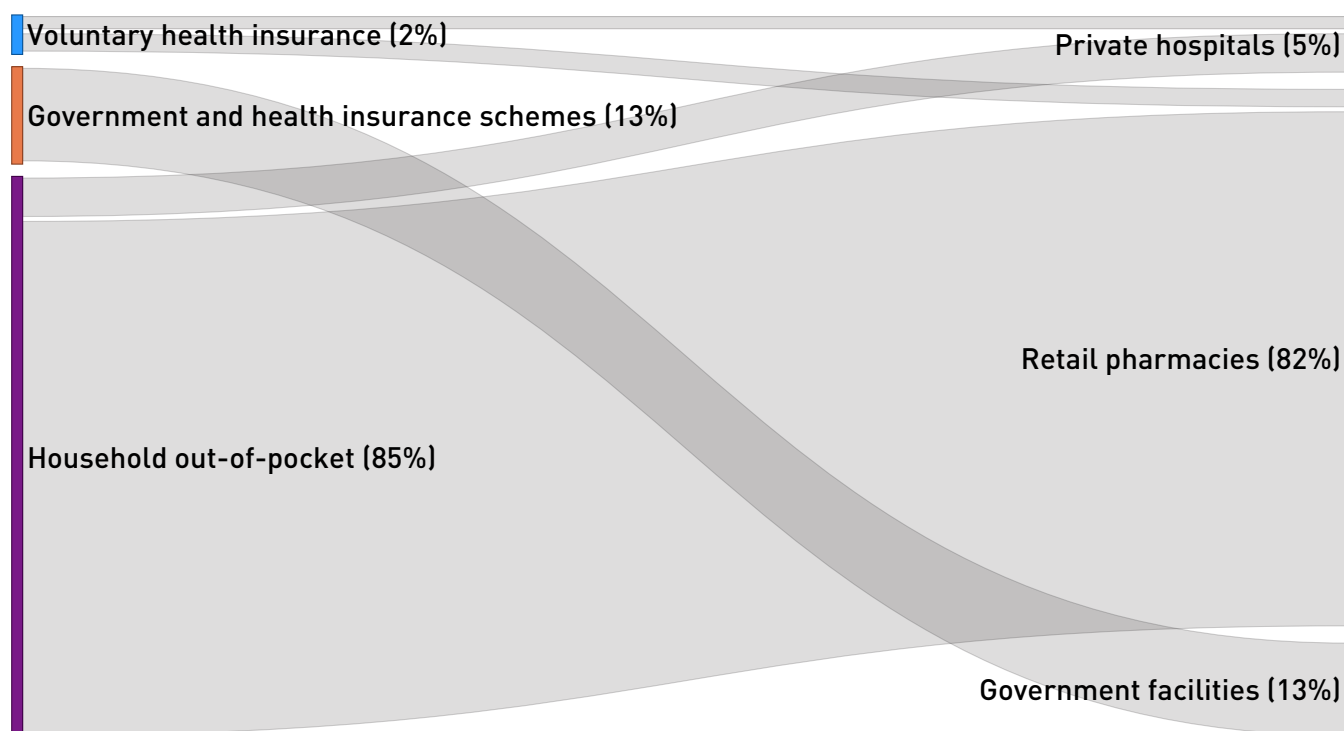


FIGURE 27 Retail pharmaceutical expenditure per capita, by governorate



including unenforced regulatory policies on pharmaceutical prescription and dispensing, the health-seeking behaviour of patients with respect to self-medication, the prevalence and

perception of generic medications, and supplier-induced demand that is aggravated by pharmaceutical companies' promotion efforts. Part of the increased expenditure at the retail

FIGURE 28 Pharmaceutical expenditure flows from financing schemes to health care providers

level can also be attributed to the lack of availability of medicines in some hospitals, leading patients or their relatives to purchase stock-out items to cover their inpatient stays.

In general terms, pharmaceutical expenditure is a function of pharmaceutical prices and volume consumed. With Egypt's pharmaceutical prices presumably rather below regional peers, particular focus needs to be given to addressing consumption levels from both the demand and the supply side. Close monitoring and tracking of pharmaceutical expenditure trends at all levels of service delivery over time can inform decision-makers, particularly the newly established Egyptian Authority for Unified Procurement, Medical Supply and the Management of Medical Technology and the Egyptian Drug Authority, in addition to the UHI authorities, of more efficient and equitable allocation of resources.

Primary health care expenditure

PHC is widely recognized as the most cost-effective way to reach universal health coverage. PHC emphasizes a comprehensive package of essential services, including disease prevention and health promotion, and ensures equity of access to most essential interventions.

The new UHI system in Egypt emphasizes the role of PHC as the cornerstone of the new

structure of service delivery. Tracking PHC expenditure is thus critical to establishing baselines and assessing progress over time.

The SHA 2011 manual does not include a ready-made classification for PHC spending. Therefore, for cross-country comparability, the NHA team estimated PHC expenditure according to the available spending categories in the latest global operational definition of PHC expenditure aggregates (16). As such, the following spending categories are considered part of PHC spending:

- General outpatient curative care
- Dental outpatient curative care
- Curative outpatient care not elsewhere classified (excluding specialized outpatient care)
- Outpatient and home-based long-term health care
- Preventive care
- Part of (80%) medical goods provided outside health care service packages
- Part of (80%) health system administration and governance expenditure.

Following the global operational formula above, current PHC expenditure is estimated at EGP 141.3 billion, or 55.3% of CHE. This category of expenditure has grown by almost 20% since 2018, when it was estimated at 46.2%.

Government financing of PHC is critical to its sustainability and to improving the quality of care provided. For fiscal year 2019/20,

BOX 3**Antimicrobial resistance and antimicrobial expenditure**

The World Health Organization has declared antimicrobial resistance (AMR) one of the top 10 global public health threats facing humanity. It is estimated that there were 1.27 million deaths globally in 2019 directly attributable to drug-resistant infections, and this death rate is rising. The cost of AMR to the economy is also significant. In addition to death and disability, prolonged illness can result in longer hospital stays, the need for more expensive medicines and financial challenges for those impacted. The World Bank estimates that total health care costs could increase by 30% in low- and middle-income countries because of AMR, if no action is taken at scale to contain it.

The use of antimicrobials drives the development of resistant pathogens. In many countries around the world, at least half of all antibiotics consumed are used inappropriately. Available data on consumption suggest that Egypt is in the mid-range globally of antimicrobial consumption, although it is likely that consumption rose during the COVID-19 pandemic.

Egypt has made addressing AMR a priority, as shown in the endorsement of a national action plan in March 2019 that lays out a roadmap to tackling this public health

challenge. The roadmap includes four main pillars: optimizing antibiotic use, AMR surveillance, infection prevention and control, and education and public awareness.

To complement the country's efforts, the NHA team extracted antimicrobial expenditure based on available data. For fiscal year 2019/20, expenditure for antibiotics in retail pharmacies and private hospitals accounted for approximately EGP 11.2 billion, or just 12% of total pharmaceutical expenditure. This figure is likely an underestimate, as it restricts consumption to the Anatomical Therapeutic Chemical (ATC) codes of J01 and J02 only.¹ Moreover, the estimated figure does not include antibiotic use in government facilities due to lack of data. These preliminary data can be used as a baseline for further analysis of antimicrobial use over time, especially when combined with data on volume and complemented with data from government-owned facilities.

Note

1. The ATC classification system assigns unique codes to medicines according to the organ or system they work on and how they work. The classification system is maintained by WHO.

government funds made up an estimated 32.7% of all PHC spending. Government spending on PHC represents around 51.5% of current general government health expenditure, which is up from 48.7% in 2018.

As in other sections of this report, attention is given to analysing PHC spending by governorate to establish a baseline for system reform. Accordingly, Fig. 29 and Fig. 30 show PHC spending per capita in each governorate. Port Said has the second-highest level of spending, at EGP 2,222 per capita, compared with the national average of EGP 1,558 per capita.

However, there are a few drawbacks to the global operational formula for PHC spending stated above. The assumption that 80% of medical goods should be allocated to PHC will presumably lead to an overestimate, since the retail pharmaceutical market is less regulated, where specialized and prescription medicine can be easily dispensed at the retail market level. Likewise, 80% of governance cost might be an overestimate given the relative hospital orientation of the Egyptian health system. The NHA team is exploring and evaluating other options to estimate a PHC spending

allocation that is more appropriate for the Egyptian health care market and will consider updating PHC values in future NHA reports.

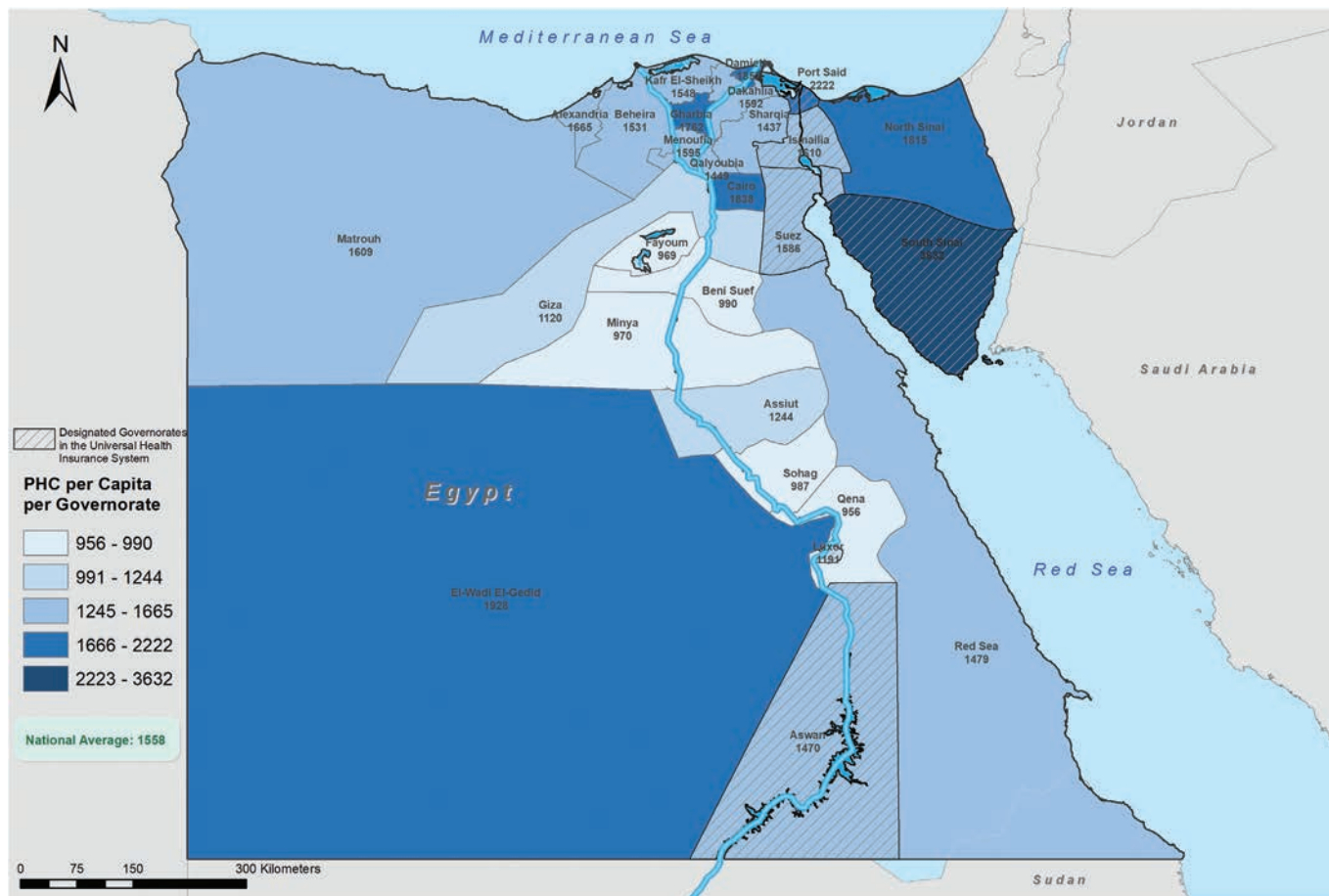
As for the new UHI, PHC expenditure can be directly estimated by the cross-classification of financing agents (FA) with functions (HC) or providers (HP). For fiscal year 2019/20, PHC expenditure under the new UHI system can be preliminarily estimated at EGP 521 million, or 59% of total current health spending on UHI, showing an early positive sign of the tendency towards a PHC-oriented health system.

Disease-specific health expenditure

One of the main gaps in previous health accounts studies is the lack of expenditure data by disease group. Tracking health expenditure by disease classification answers questions that were left open in previous rounds, such as:

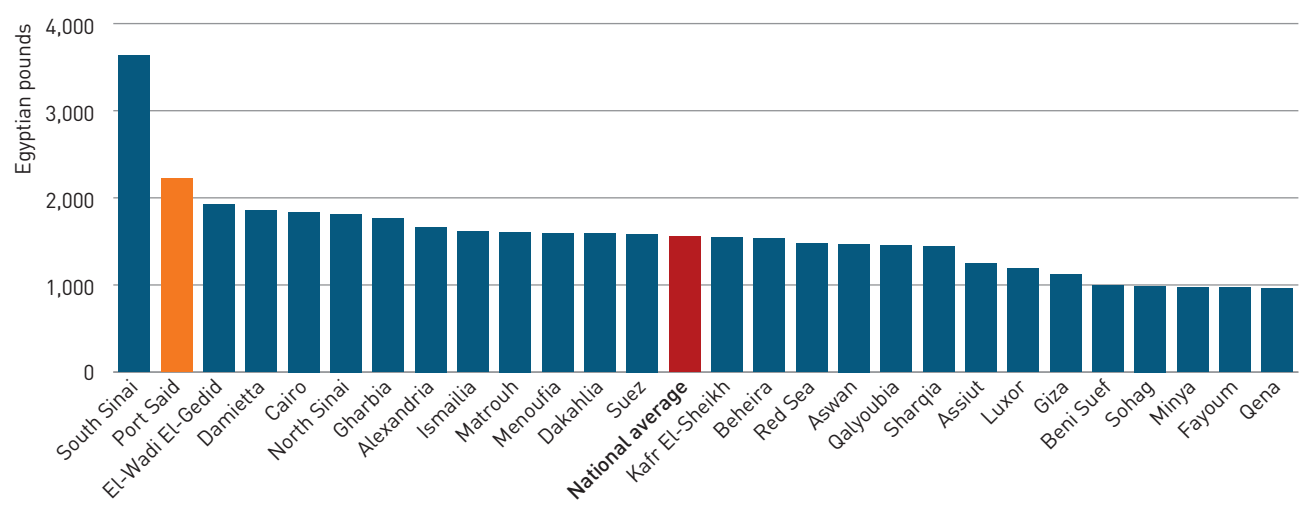
- How much was spent on different disease categories?
- What are the most expensive diseases, and where do the financial resources spent on them come from?
- What is the estimated out-of-pocket spending on priority diseases?

FIGURE 29 Map of current primary health care expenditure per capita per governorate



The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement. Map production: Health Emergency Information and Risk Assessment (HIM) Eastern Mediterranean Regional Office (EMRO) World Health Organization - emroghim@who.int

FIGURE 30 Current primary health care expenditure per capita, by governorate



The disease-specific evidence on expenditure is important for the UHI system in Egypt, particularly for the revision of the UHI benefit package, which needs to be sensitive to the way treatment and prevention of different diseases are currently funded and which would help guide pricing policies and choices concerning methods of payment.

The NHA team was able to allocate around 70% of CHE on diseases for the first time in this edition. The largest share of CHE was allocated to noncommunicable diseases, with at least 55.1%, while the second largest was allocated to infectious and parasitic diseases, with at least 6.9%. Since around 30% of CHE cannot be allocated to diseases, all disease group figures may be considered underestimates, as the true figures may contain portions of the unallocated component (Fig. 31, Table 4).

Noncommunicable diseases constitute the largest portion of expenditure, which may be expected given Egypt's epidemiological profile. Further analysis presented in Fig. 32 shows the distribution of expenditure on different types of noncommunicable diseases.

Among this group, diseases of the genitourinary system (including kidney diseases and haemodialysis) received the largest share of CHE, followed by cardiovascular diseases (hypertension, ischaemic heart diseases, pulmonary heart diseases, blood diseases, etc.) and then by diseases of the digestive system (including liver cirrhosis due to hepatitis). Current spending on diabetes is estimated at minimum of EGP 10.6 billion, which is less than that spent on mental health conditions, sense organ disorders, neoplasms (cancers) or musculoskeletal system diseases.

Data on disease expenditure are most useful when compared with disease burden data, especially after the cost per case per disease area are adjusted for using details on beneficiaries. Preliminary data for Egypt on the disease burden in terms of disability-adjusted life-years can be sought from WHO (17) based on global projections. This approach can inform disease areas where economic evaluations need to be conducted and can be used to project future disease costs based on changes in demographics, epidemiology, etc.

Mapping diseases with financing schemes is critically important since it informs policy-making, especially around financial protection and benefit package design. Fig. 33 illustrates disease expenditure by financing scheme and shows that expenditure on injuries and reproductive health is financed mainly by both government schemes and social health insurance schemes. Expenditure on infectious diseases is split almost evenly between government schemes and out-of-pocket payments, whereas nutritional deficiencies are covered largely via out-of-pocket payments (80%).

FIGURE 31 Current health expenditure, by disease group

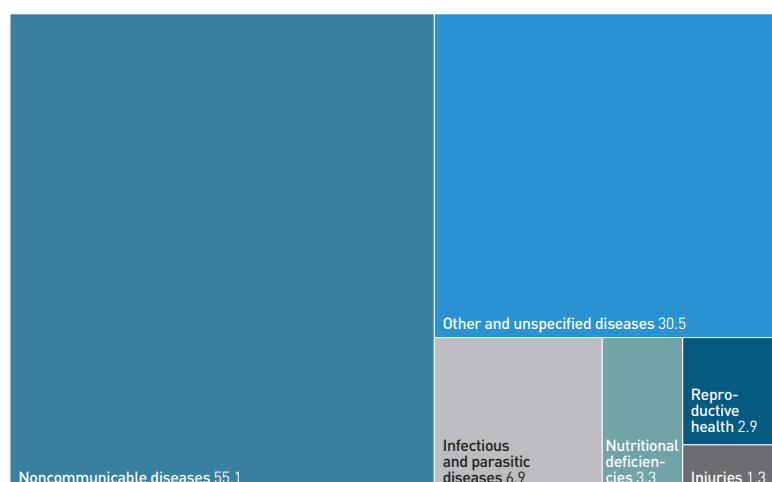
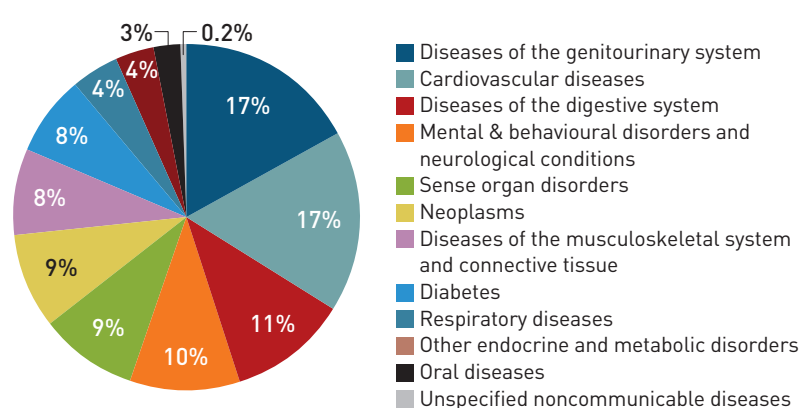


TABLE 4 Current health expenditure, by disease group

Disease group	CHE (in million EGP)	Share of CHE (%)
Noncommunicable diseases	140,924	55.1
Infectious and parasitic diseases	17,558	6.9
Nutritional deficiencies	8,485	3.3
Reproductive health	7,413	2.9
Injuries	3,210	1.3
Other and unspecified diseases	77,980	30.5

Note: CHE is current health expenditure. EGP is Egyptian pounds.

FIGURE 32 Distribution of noncommunicable disease expenditure



Overall spending on noncommunicable diseases is distributed across different schemes in a relatively similar pattern as overall CHE: 60% from out-of-pocket payments, 29% from government schemes, 6% from social health insurance, 2% from voluntary health insurance and 1% from

both NGOs and enterprise schemes. Nevertheless, there is quite wide variation with regard to the different disease groups under noncommunicable diseases (Fig. 34).

FIGURE 33 Current health expenditure, by disease group and financing scheme

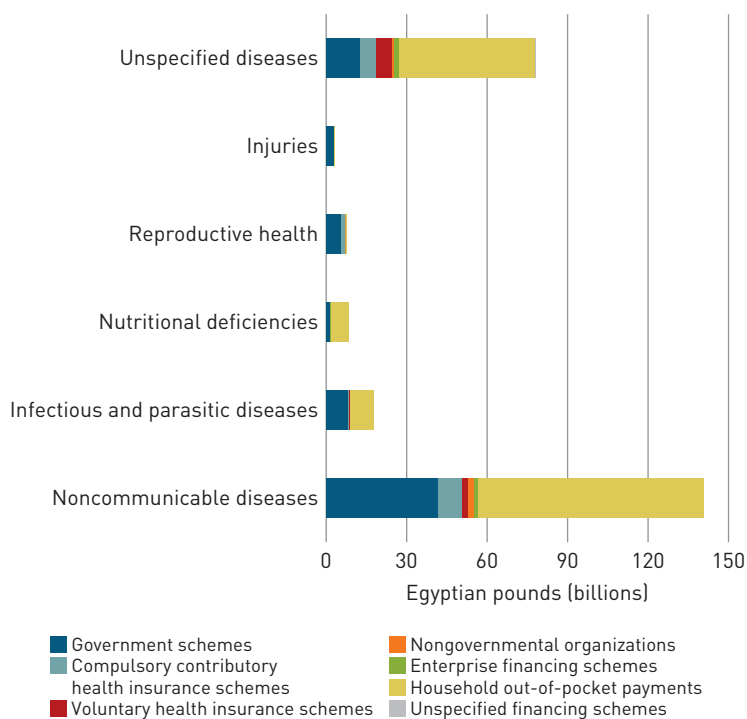
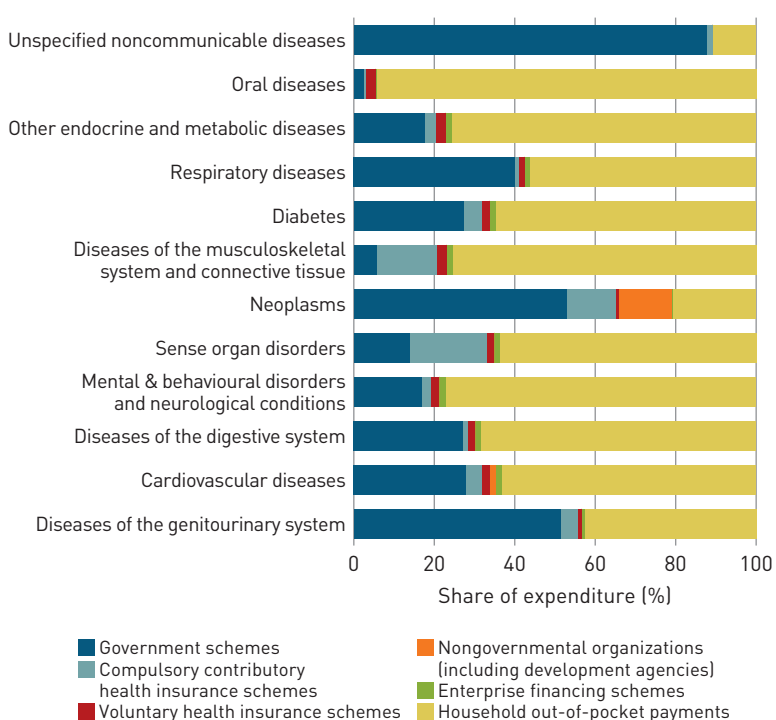


FIGURE 34 Share of noncommunicable disease expenditure, by financing scheme



Neoplasms (cancers) and diseases of the genitourinary system (including haemodialysis sessions) are two disease areas that are financed predominantly by government schemes and social health insurance schemes, 65% for neoplasms and 56% for genitourinary system diseases. By contrast, oral diseases, mental health conditions, endocrine diseases and musculoskeletal diseases are financed predominantly through out-of-pocket payments, at 94%, 77%, 76% and 75%, respectively. This finding can contribute directly to the discussions and prerequisite evidence related to benefit package design within the UHI rollout.

Capital formation

Investment in health care facilities and equipment, creating assets that are typically used over a long period of time, is classified under the capital account. As discussed in the methodology section in the annex, the SHA 2011 manual separates the current and capital accounts, since they correspond to health spending over different time horizons.

Tracking expenditure in capital allows for the analysis of future supply patterns in relation to expected demand for services. The Government of Egypt is currently investing in the health care sector, upgrading existing health facilities and planning for future expansion in health service delivery. In fiscal year 2019/20, the capital expenditure of the government/public sector was estimated at EGP 15.8 billion. To the extent possible, the value of gross capital formation is subclassified by infrastructure, medical equipment, transport equipment, and other machinery and equipment not elsewhere classified and then mapped by health care provider and subnational level.

The distribution of capital investments across governorates can indicate government priorities and potential investment opportunities at the geographic level. The highest share of government capital formation flows to Cairo, at EGP 1.2 billion. Most of the UHI's phase 1 governorates are at the top of the list of governorates in terms of share of capital formation. When population size is adjusted for, the six governorates in phase 1 have the highest shares of capital formation per capita, with Aswan, Luxor, Ismailia, Suez and Port Said taking the top five positions nationwide and South Sinai in the seventh position (Fig. 35–36). This reflects government willingness to invest in equipping health facilities

FIGURE 35 Map of capital formation per governorate

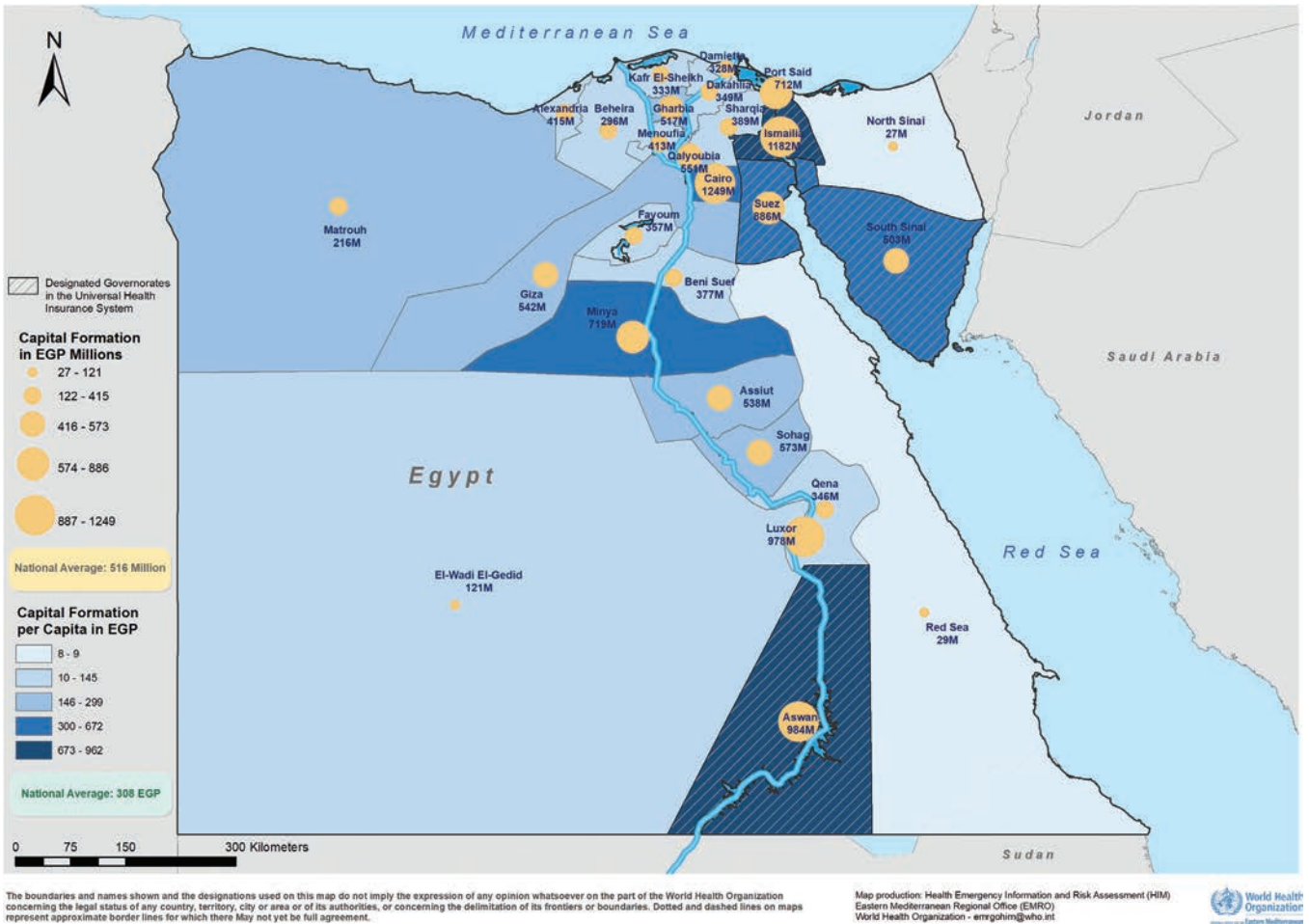
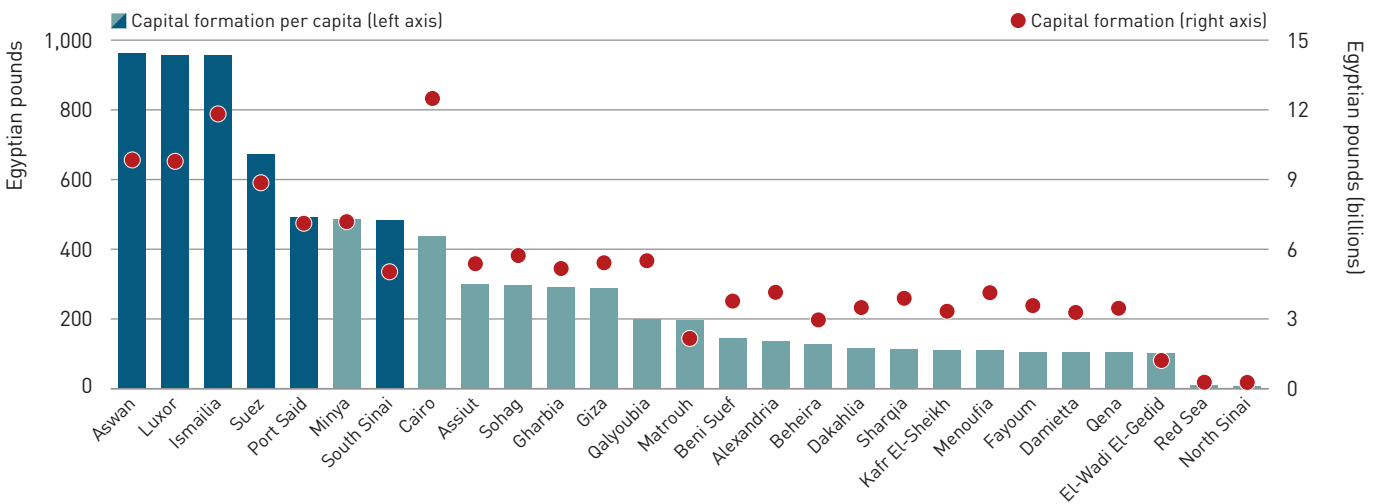


FIGURE 36 Expenditure on capital formation and capital formation per capita, by governorate



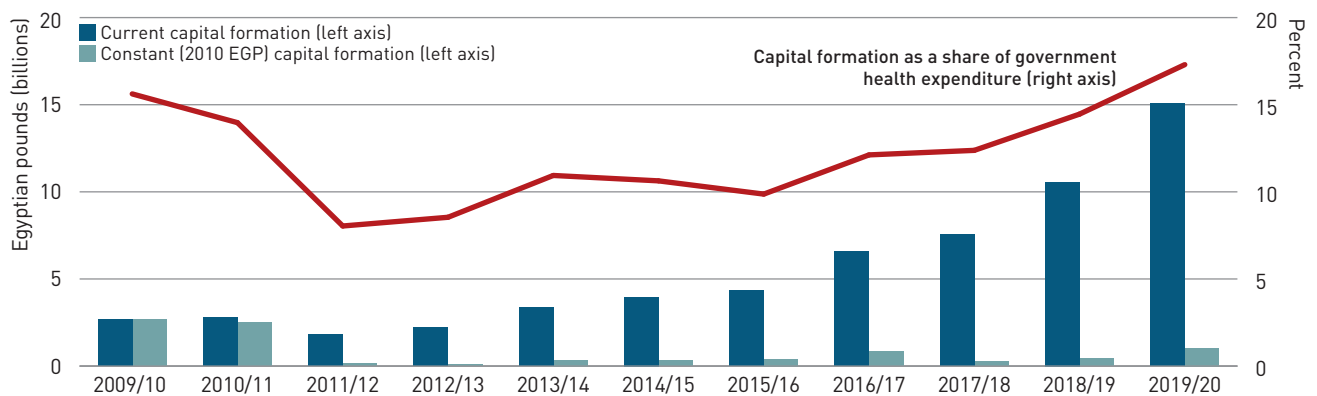
in UHI governorates and accelerating UHI implementation. Tracking capital formation by governorates can also serve as a guiding manual for better planning, coordination and alignment in investments between the public and

private sectors, particularly when combined with other metrics that indicate health facilities' productivity and population health needs. Further analysis of the trend of capital formation shows the steady growth over the

past decade in current EGP, constant EGP and as a share of total government health expenditure, reaching 17% in 2019/20 (Fig. 37). The consistent growth of capital investment still holds for fiscal year 2020/21, when it reached almost 21%. This steady growth translates the government commitment to invest in health system. It is equally

important to link future investment decisions with output measures to assess productive efficiency and expected returns, population needs and existing capacities from other health sector stakeholders, such as the for-profit and not-for-profit private sector, to better inform and coordinate future investment planning.

FIGURE 37 Capital formation trend, 2010–2020



Note: Figures in constant 2010 EGP have been adjusted using the GDP deflator.



Development Goals



Policy implications

1. The Egypt National Health Accounts study is an essential health system performance monitoring tool. In addition, the 2019/20 exercise has a specific purpose: to establish a much-needed baseline for tracking the ongoing UHI system rollout to all governorates from a health expenditure perspective.

The ongoing health system reform process taking place under the UHI umbrella requires effective monitoring, especially from the point of view of health expenditure, as the reform's key elements relate to health financing arrangements. NHA exercises are a key strategy and tool for monitoring and tracking in this context. Health accounts generate evidence about different levels and aspects of health expenditure, many of which are crucial for monitoring UHI implementation, as they are linked to the reform's key policy questions of financial protection, efficiency, equity and improved access to quality services.

The NHA exercise was carried out for fiscal year 2019/20, meaning it took place during the first stages of the UHI reform, with implementation under way in Port Said and ongoing preparations in Luxor and Ismailia. In the other 24 governorates, the UHI reforms were not yet operational. This variation provides a valuable opportunity to generate a baseline measure on health expenditure before the UHI has been substantially implemented. It also puts further emphasis on the need to repeat the

NHA exercise at regular intervals in order to measure UHI reform results against key health expenditure parameters.

As the UHI reform is rolled out to more governorates, it will be important to do more in-depth analytical work at the governorate level to monitor how UHI implementation affects health revenues and expenditure patterns. For example, it will be important to monitor the level of contributions to the Universal Health Insurance Authority (UHIA) and the level of subsidized enrolment with the authority, as well as other revenue sources at the governorate level, to further understand the dynamics of revenue mobilization for the UHI system. Similarly, it will be important to track out-of-pocket payments at the governorate level to monitor if and how the UHI system is able to lower this type of spending in each governorate.

Additionally, it will be important to track the UHIA's level of expenditure by governorate, as this will be an important measure of how equitable the distribution of funding through the authority is. For example, if UHIA funding starts flowing in larger proportion (in per capita terms) to the richest governorates compared with the poorer ones, this could indicate an equity issue, which would need to be addressed. Expenditure tracking for this purpose needs to include both current expenditure as well as capital formation, as the latter is a better measure for long-term investment and

thus can reveal longer-lasting imbalances between governorates. The current figures show a sharp increase in government capital investment in governorates in the first phase of UHI implementation. It is important therefore to monitor whether similar investments are made for governorates in subsequent phases of the UHI rollout.

2. There has been a recent decrease in out-of-pocket expenditure, but further reductions will be crucial for the success of the UHI reform.

A key objective of the UHI reform is to lower financial barriers to accessing health services and reduce catastrophic health expenditure. The level of out-of-pocket payments as measured in the NHA is a proxy indicator for these objectives (18). In fiscal year 2019/20, the study found a reduction in out-of-pocket payments from the previous year. Although this reduction cannot be attributed to the UHI reform because of the limited rollout of the reform by that date, it is still an encouraging sign. If the UHI reform continues its current trajectory of implementation, it is expected that out-of-pocket payments will continue to gradually decline. However, this is in no way an automatic process, and much will depend on how the UHI is implemented and the increases in pooled funding. The overall level of out-of-pocket payments is therefore a good measure for monitoring the success of the UHI reform in future years.

The majority of out-of-pocket payments flow to private providers, including private pharmacies and private providers of ambulatory and ancillary care. In order for the UHI system to reduce such payments in the future, it needs to effectively contract with private providers, cover utilization at these providers through its benefit package from pooled funds and respond to disease burden priorities. Producing NHA will help monitor these expected changes in out-of-pocket payments at the provider level.

3. Budget allocations to health can increase in the future primarily through a combination of general government revenues and revenues from UHI contributions, but what matters is the net effect of these revenue streams.

The NHA figures indicate that government health expenditure, measured through general government health expenditure from domestic sources (GGHE-D) per capita

or as a share of GDP (1.5%), has in recent years stagnated in real terms. This can be explained by many factors, including the general fiscal position of the Government of Egypt or the priority given to health in government spending. For the latter, the 5.2% of GGHE-D over general government expenditure (GGE) seems to indicate that there could be room to further increase allocations to health from the government budget. Increasing the level of government funding for health is especially crucial for the success of the UHI reform, which will require substantial funding to reach its coverage targets and its objective of improving quality of health services.

As the UHI system is rolled out, the contributions paid by its members will be counted under GGHE-D, as these are compulsory prepayments. It will be important to follow how the increasing contributions affect total GGHE-D—for example, if there is a reduction in government health funding from other sources (namely budget transfers) that matches the increase in funding through UHI contributions, total government health expenditure will remain at the same level. This would likely be reflected in GGHE-D over GGE as further stagnation. However, if the net effect of increased contributions and changes in other government funding is positive, this would likely be indicated by an increase in GGHE-D over GGE.

At a more detailed level, what will be important to monitor are the sources of funding for UHI as a scheme. The UHIA as the purchaser of the UHI system receives, among other sources, funds from UHI contributions and from government transfers, the latter covering vulnerable population groups. In the publicly available actuarial study estimates for UHI, it has been projected that approximately 50% of total UHI revenues will be covered by UHI contributions, 22% by general government transfers/subsidies on behalf of poor and vulnerable populations and 21% by earmarked taxation such as tobacco taxes and others. It is thus critical to track these sources and their shares in future NHA exercises in order to verify the extent to which the actuarial study hypothesis on the UHIA funding sources holds.

While current government health expenditure has seen relatively modest growth in real terms, this is not the case for capital formation, which has recorded

regular increases in government investment over the past few years. This is a positive signal regarding the Government of Egypt's willingness to upgrade infrastructure (e.g., buildings, equipment) for improved health service quality.

4. Household expenditure on pharmaceuticals is an important driver of out-of-pocket spending, and the UHI reform will need to address this in its current implementation plan by ensuring coverage of pharmaceuticals in the benefit package and by expanding contracting with private pharmacies.

The results of this health accounts exercise show that a large proportion of current health expenditure (CHE), and especially of out-of-pocket payments, currently flow to pharmaceuticals. This makes it especially important to continue efforts to cover pharmaceuticals from pooled funds. The UHI reform is designed to increase financial coverage for pharmaceuticals through the contracting of retail pharmacies. However, in the first phase of the UHI rollout, contracting with pharmacies was still limited.

At the same time, the UHI reform is also an opportunity to focus on prescription practices through promoting rational use of medicines and expanding the use of generic drugs. In the future, the UHIA as the purchaser of the system will need to establish strong incentives and controls regarding medicine prescription for all contracted providers. This will not only have an effect on coverage and on efficiency but may also help in the response to other challenges, such as antimicrobial resistance.

It is also important to improve monitoring and tracking of pharmaceutical expenditure at all levels of service delivery, particularly through the newly established Egyptian Authority for Unified Procurement, Medical Supply and the Management of Medical Technology, in addition to the UHI authorities. Tracking of user fees for medicines in public facilities also needs to be strengthened, as at present, it is difficult to estimate the amount of out-of-pocket payments from households made to public facilities for pharmaceuticals.

5. The 2019/20 NHA study provides expenditure details by disease and level of care, which is important evidence for

developing and revising the UHI benefit package and for strategic purchasing.

Tracking health expenditure can give important evidence on how effectively and efficiently funding is allocated. In the 2019/20 NHA, particular attention was given to tracking spending on diseases and on PHC, with the aim of providing evidence to support UHI benefit package design.

The findings on expenditure by disease classification indicate that health expenditure is fairly well aligned with the disease burden. It could also be argued that government expenditure per disease reflects an objective to focus on high-cost diseases and conditions, such as cancers, or interventions such as haemodialysis, thus providing needed financial coverage to ensure access to these services. Some gaps in coverage can be identified, however, such as the relative low level of mental health services covered by pooled funds (although the large proportion of mental health services paid for by out-of-pocket payments could also reflect patient choice and/or service delivery options). The results of the health accounts study can help further develop the UHI benefit package in order to ensure that it reflects the disease burden and that it promotes equity and efficiency, as well as providing effective financial risk protection.

The level of expenditure on PHC in Egypt has increased from 46.2% of CHE in 2018 to 55.3% in 2019/20. Interpreting PHC expenditure in Egypt according to the global formula is difficult because it includes 80% of expenditure on pharmaceuticals, which, as discussed above, is at a very high level in Egypt and could be more of a reflection of a PHC inefficiency and because it includes assumptions that could be further refined to reflect the Egyptian context. Nonetheless, it is particularly encouraging that UHI expenditure seems to be strongly focused on PHC. Again, this result needs to be interpreted with caution, as the UHI rollout was in its early stages during the NHA exercise and contracting of hospitals by the UHIA was lagging. Nevertheless, these results show that the UHIA can be a strategic purchaser with the ability to refocus expenditure on PHC. The share of UHIA funding for PHC will be an important indicator to monitor from the purchasing perspective.

6. Relatively little expenditure is allocated to preventive services (1.5% of current health expenditure), and there is a need

to ensure adequate funding for essential public health functions.

In the future, even when the UHI system is fully rolled out, there will still be government health expenditure flowing through channels other than UHI, notably to the Ministry of Health and Population in areas such as health promotion, health security, governance, health workforce development and general governance of the system. These essential public health functions will need to be ensured through budget funding, as they relate to public goods for which private funding is not a realistic option. In addition, they are population-based services and therefore cannot be funded directly through UHI, which covers individualized services.

The NHA results show that 1.5% of CHE, or EGP 32 per capita, is attributable to preventive services, a category that includes many essential public health functions, such as vaccination campaigns and pandemic preparedness and response.⁷ It will be important to monitor how these different government funding flows evolve in the coming period. It is particularly important to monitor the level of funding flows to essential public health functions in order to ensure that these functions are funded at an adequate level and that there is a strategic division on what comes under funding for UHI and what comes under other government funding.

7. While the data period for the NHA 2019/20 exercise overlapped by a few months with the COVID-19 pandemic, the vast majority of COVID-19-related expenditure happened during the following fiscal year (2020/21), and it is therefore expected that very little COVID-19-related expenditure is captured in this NHA exercise.





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Annex

Methodological considerations

The Egypt National Health Accounts 2019/2020 report tracks health expenditure according to the methodology of the SHA 2011 manual, which was codeveloped by the Organisation for Economic Co-operation and Development (OECD), Eurostat and the World Health Organization (WHO) (1). SHA 2011 is a statistical reference manual that gives a comprehensive description of the financial flows in health care and provides a set of revised classifications of health care functions, providers of health care goods and services, and financing schemes. The SHA classifications build on common concepts, boundaries, definitions and accounting rules for measuring consumption of health care goods and services.

The Egypt NHA study includes health care expenditure only when it serves the resident population in Egypt and when it falls within the SHA 2011 boundaries. These boundaries are characterized by four main criteria:

- The primary intent of the activity is to improve, maintain or prevent the deterioration of the health status of individuals, groups of the population or the population as a whole as well as to mitigate the consequences of ill health.
- Qualified medical or health care knowledge and skills are needed in carrying out this function, it can be executed under the supervision of those with such knowledge or the function is governance and health system administration and its financing.

- The consumption is for the final use of health care goods and services of residents
- There is a transaction of health care services or goods.

Health care expenditure is tracked according to the main SHA 2011 classifications. In this report, the NHA team expanded classifications (Table A1).

NHA development process

The process for developing the Egypt NHA study included several steps, starting with sensitization and capacity-building, then proceeding to data collection, data verification, data mapping and coding, data analysis, data validation and report writing. The NHA team has witnessed major changes to ensure wider representation from all relevant stakeholders. The current NHA team includes active participation from the Ministry of Health and Population (MoHP), the Ministry of Finance (MoF), the Central Agency for Public Mobilization and Statistics (CAPMAS), the Egypt Healthcare Authority (EHA) and the Universal Health Insurance Authority (UHIA).

Data sources

Primary and secondary data sets were retrieved from the main actors, as per the SHA 2011 and the Health Accounts Production Tool (HAPT). All data sources are mapped and coded and further disaggregated to diseases and subnational level (i.e., the governorate level) to the extent possible. In total, around 3 million records were mapped, as per

TABLE A1 A System of Health Accounts 2011 classifications used in Egypt National Health Accounts 2019/2020

Description	SHA code	Details
Institutional units providing revenues	FS.RI	Current health expenditure by institutional units providing revenues to financing schemes.
Financing sources	FS	The revenues of the health financing schemes received or collected through specific contribution mechanisms.
Financing schemes	HF	Components of a country's health financial system that channel revenues received and use those funds to pay for, or purchase, the activities inside the health accounts boundary.
Financing agent	FA	Institutional units that manage health financing schemes.
Health care providers	HP	Entities that receive money in exchange for or in anticipation of producing the activities inside the health accounts boundary.
Factors of provision	FP	The types of inputs used in producing the goods and services or activities conducted inside the health accounts boundary.
Health care functions	HC	The types of goods and services provided and activities performed within the health accounts boundary.
Diseases	DIS	Current health expenditure by classification of diseases/conditions.
Subnational level	SNL	Current health expenditure by subnational level (in Egypt's case, by governorate)
Capital formation	HK	The types of the assets that health care providers have acquired during the accounting period and that are used repeatedly or continuously for more than one year in the production of health services.

the data sources, using HAPT. The reporting currency for the NHA study is the Egyptian pound (EGP). An additional currency used is the US dollar (US\$), with the exchange rate derived from the yearly average for fiscal year 2019/20, retrieved from the Central Bank of Egypt database at US\$ 1 = EGP 16.08.

Government health expenditure

All institutional units under government and compulsory contributory schemes were identified and coded. Data on expenditure and use were sought from each institutional unit separately. The main institutional units are MoHP–Headquarters, MoHP directorates, the EHA, specialized medical centres, the General Secretariat for Mental Health and Addiction Treatment, the General Organization for Teaching Hospitals and Institutes, the Curative Care Organization, the Egyptian Ambulance Authority, university hospitals, the Health Insurance Organization, the UHIA and unspecified central government agents. In parallel, financial data from the government final account was retrieved by the MoF and the MoHP finance team per institution after remapping to conform to SHA classifications. All government expenditure is therefore mapped to factors of provision. In cases of discrepancies between different sources of data, the MoF final account data are used. Expenditure data for the UHI scheme include both the EHA and the UHIA after reconciliation for potential double counting.

Voluntary insurance expenditure

Voluntary insurance expenditure includes expenditure from commercial private insurance companies, health maintenance organizations and syndicates. Data on private insurance companies were retrieved from the Financial Regulatory Authority (FRA), as these companies are legally obliged to submit annual reports to this body. The data include revenues and expenditures of the insurance companies mapped by health care function and distributed by governorate. Other categories under voluntary health insurance that are not obliged to report to the FRA, such as health maintenance organizations and professional syndicates, were prorated with similar expenditure patterns, based on broad expert consultations.

NGOs' expenditure

The Ministry of Social Solidarity provided health expenditure and revenue data for the top 11 NGOs working in the health sector in Egypt. These NGOs are Misr el Kheir, Baheya foundation, Magdi Yacoub Heart Foundation, Shefaa Al Orman, Children's Cancer Hospital 57357, Al Nas foundation, Mersal foundation, Egypt With No Diseases foundation, Ayady Al Mostakbal foundation, Resala foundation and Moustafa Mahmoud foundation. Data on health care functions, providers and governorates were received only for certain NGOs; the rest were left unclassified. Due to insufficient evidence, the NHA did not make

projections for the remaining health expenditure from other NGOs working on health. It is assumed that the received expenditure represents the main bulk of NGOs expenditure, and it is supposed that data will be available on a larger scale from the Ministry of Social Solidarity for future NHA updates.

Corporations' expenditure

The category of corporations includes the resources of corporations that are devoted to health purposes, other than those included in social insurance contributions and/or other forms of compulsory or voluntary prepayment. All corporations considered in this study are either fully public or quasi-public entities (i.e., public sector or public business sector economic entities that are affiliated with the government). Data for this category were provided by the MoF as a lumpsum figure with no classification of functions or providers and were left unclassified in this study.

Households' expenditure

Household expenditure in this NHA study is estimated based on the Household Income, Expenditure and Consumption Survey (HIECS). CAPMAS provided HIECS results for the same fiscal year as the NHA study. HIECS data followed the UN Classification of Individual Consumption by Purpose and were mapped with SHA functional classifications. HIECS data were available at the regional level and were allocated based on relative weights for population size and rural/urban settings per each governorate.

Donors' expenditure

Donor health expenditure is retrieved from the OECD Creditor Reporting System database for the relevant fiscal years of the study. Data were mapped and classified either as transfers distributed by government from foreign origin or as direct foreign transfers, based on the available data in the OECD database. Mapping by type of service and provider is made only for certain donors, where data

exist. However, no data were distributed by governorate in this category.

The Health Accounts Production Tool

The NHA team used the latest version available of the software application HAPT. The software facilitates the production of the health accounts by mapping national health expenditure according to SHA 2011 classification. Moreover, HAPT allows the input of defined country-specific classifications and simplifies estimation processes, quality checks and reconciliation for potential double counting.

Disease-specific classification

The starting point in disease distribution is the classifications of health care providers. For each provider, detailed data are retrieved on diseases treated. Data on utilization are combined with data on expenditure (or cost) for each disease. The use of costs and utilization by type of services and type of providers are used as "allocation keys." In the case of vertical programmes, resources are assigned (earmarked) directly to the associated disease.

Three main types of providers are subject to disease distribution, namely hospital inpatient, ambulatory (outpatient) and retail pharmacies. For inpatient hospital services, data on resource use (e.g., utilization by number of cases) and resource intensity, (e.g., expenditures by diseases or cost by disease) are available for certain providers and financing agents. The NHA team estimated the base rate (i.e., average expenditure of all cases and all diseases) and average expenditure per case per disease. Relative case weights are then derived by dividing average expenditure per disease by the base rate. To generalize expenditure by diseases in providers with no cost or expenditure data, relative case weights from providers with comparable case mix were used as a proxy and multiplied by the base rate of these providers. Pharmaceutical data were received in ATC codes. The NHA team created a model mapping ATC code to SHA disease classification.

Main cross tables

Financing schemes	Revenues of health care financing schemes <i>Egyptian Pound (EGP), Million</i>	HF.1 Government schemes and compulsory contributory health care financing schemes	HF.1.1					
			Government schemes	Central government schemes	Compulsory contributory health insurance schemes	Social health insurance schemes	Health Insurance Organization (HIO)	Universal Health Insurance Authority (UHIA)
FS.1	Transfers from government domestic revenue (allocated to health purposes)	70,901.95	69,062.91	69,062.91	1,839.04	1,839.04	1,351.79	487.25
FS.1.1	Internal transfers and grants	68,973.49	68,938.69	68,938.69	34.80	34.80		34.80
FS.1.2	Transfers by government on behalf of specific groups	1,476.29	124.22	124.22	1,352.07	1,352.07	1,351.79	0.28
FS.1.4	Other transfers from government domestic revenue	452.17			452.17	452.17		452.17
FS.2	Transfers distributed by government from foreign origin	2,421.65	2,421.65	2,421.65				
FS.3	Social insurance contributions	10,692.04			10,692.04	10,692.04	10,641.15	50.89
FS.3.1	Social insurance contributions from employees	3,380.17			3,380.17	3,380.17	3,372.48	7.69
FS.3.2	Social insurance contributions from employers	5,562.56			5,562.56	5,562.56	5,519.36	43.20
FS.3.4	Other social insurance contributions	1,749.31			1,749.31	1,749.31	1,749.31	
FS.5	Voluntary prepayment							
FS.5.1	Voluntary prepayment from individuals/ households							
FS.5.2	Voluntary prepayment from employers							
FS.6	Other domestic revenues n.e.c.	3,538.62			3,538.62	3,538.62	3,256.41	282.21
FS.6.1	Other revenues from households n.e.c.							
FS.6.2	Other revenues from corporations n.e.c.							
FS.6.3	Other revenues from NPISH n.e.c.							
FS.6.nec	Unspecified other domestic revenues (n.e.c.)	3,538.62			3,538.62	3,538.62	3,256.41	282.21
FS.7	Direct foreign transfers							
FS.7.3	Other direct foreign transfers (n.e.c.)							
FS.nec	Unspecified revenues of health care financing schemes (n.e.c.)	818.27			818.27	818.27	752.62	65.64
All FS		88,372.52	71,484.55	71,484.55	16,887.97	16,887.97	16,001.97	886.00
Share of HF		34.58	27.97	27.97	6.61	6.61	6.26	0.35

HF.2	HF.2.1	HF.2.1.2	HF.2.1.2.2	HF.2.1.nec	HF.2.2	HF.2.2.1	HF.2.2.2.nec	HF.2.3	HF.2.3.nec	HF.3	HF.3.nec	HF.nec	All HF	Share of FS
Voluntary health care payment schemes	Voluntary health insurance schemes	Complementary/supplementary insurance schemes	Other complementary/supplementary insurance	Unspecified voluntary health insurance schemes (n.e.c.)	NPISH financing schemes (including development agencies)	NPISH financing schemes (excluding HF.2.2.2)	Unspecified NPISH financing schemes (n.e.c.)	Enterprise financing schemes	Unspecified enterprise financing schemes (n.e.c.)	Household out-of-pocket payment	Unspecified household out-of-pocket payment (n.e.c.)	Unspecified financing schemes (n.e.c.)		
													70,901.95	27.74
													68,973.49	26.99
													1,476.29	0.58
													452.17	0.18
													2,421.65	0.95
													10,692.04	4.18
													3,380.17	1.32
													5,562.56	2.18
													1,749.31	0.68
9,015.00	9,015.00	4,488.59	4,488.59	4,526.41									9,015.00	3.53
717.57	717.57	358.78	358.78	358.78									717.57	0.28
8,297.43	8,297.43	4,129.80	4,129.80	4,167.63									8,297.43	3.25
6,150.90					2,445.32	2,445.32		3,705.57	3,705.57	151,587.32	151,587.32		161,276.84	63.10
										151,587.32	151,587.32		151,587.32	59.31
3,705.57								3,705.57	3,705.57				3,705.57	1.45
2,445.32					2,445.32	2,445.32							2,445.32	0.96
													3,538.62	1.38
206.47					206.47		206.47					237.34	443.81	0.17
206.47					206.47		206.47					237.34	443.81	0.17
													818.27	0.32
15,372.36	9,015.00	4,488.59	4,488.59	4,526.41	2,651.79	2,445.32	206.47	3,705.57	3,705.57	151,587.32	151,587.32	237.34	255,569.55	
6.01	3.53	1.76	1.76	1.77	1.04	0.96	0.08	1.45	1.45	59.31	59.31	0.09		

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Health care providers		HP.1	HP.1.1	HP.1.2	HP.1.3	HP.1.nec	HP.3	HP.3.1	HP.3.1.nec	HP.3.2	HP.3.4	HP.3.4.5
Financing schemes		Hospitals	General hospitals	Mental health hospitals	Specialised hospitals (Other than mental health hospitals)	Unspecified hospitals (n.e.c.)	Providers of ambulatory health care	Medical practices	Unspecified medical practices (n.e.c.)	Dental practice	Ambulatory health care centres	Non-specialised ambulatory health care centres
Egyptian Pound (EGP), Million												
HF.1	Government schemes and compulsory contributory health care financing schemes	40,877.28	21,027.23	712.67	3,421.31	15,716.07	16,256.48				16,256.48	5,913.07
HF.1.1	Government schemes	36,180.49	16,672.52	712.67	3,421.31	15,373.99	5,913.07				5,913.07	5,913.07
HF.1.1.1	Central government schemes	36,180.49	16,672.52	712.67	3,421.31	15,373.99	5,913.07				5,913.07	5,913.07
HF.1.2	Compulsory contributory health insurance schemes	4,696.80	4,354.72			342.08	10,343.40				10,343.40	
HF.1.2.1	Social health insurance schemes	4,696.80	4,354.72			342.08	10,343.40				10,343.40	
HF.1.2.1.1	Health Insurance Organization (HIO)	4,354.72	4,354.72				9,910.33				9,910.33	
HF.1.2.1.2	Universal Health Insurance Authority (UHIA)	342.08				342.08	433.07				433.07	
HF.2	Voluntary health care payment schemes	4,944.57	516.71		1,966.44	2,461.42	874.54	874.54	874.54			
HF.2.1	Voluntary health insurance schemes	2,499.25	37.82			2,461.42	874.54	874.54	874.54			
HF.2.1.2	Complementary/supplementary insurance schemes	1,230.71				1,230.71	437.27	437.27	437.27			
HF.2.1.2.2	Other complementary/supplementary insurance	1,230.71				1,230.71	437.27	437.27	437.27			
HF.2.1.nec	Unspecified voluntary health insurance schemes (n.e.c.)	1,268.54	37.82			1,230.71	437.27	437.27	437.27			
HF.2.2	NPISH financing schemes (including development agencies)	2,445.32	478.89		1,966.44							
HF.2.2.1	NPISH financing schemes (excluding HF.2.2.2)	2,445.32	478.89		1,966.44							
HF.2.2.nec	Unspecified NPISH financing schemes (n.e.c.)											
HF.2.3	Enterprise financing schemes											
HF.2.3.nec	Unspecified enterprise financing schemes (n.e.c.)											
HF.3	Household out-of-pocket payment	27,426.24				27,426.24	26,980.96	21,818.40	21,818.40	3,052.32		
HF.3.nec	Unspecified household out-of-pocket payment (n.e.c.)	27,426.24				27,426.24	26,980.96	21,818.40	21,818.40	3,052.32		
HF.nec	Unspecified financing schemes (n.e.c.)											
All HF		73,248.10	21,543.95	712.67	5,387.74	45,603.74	44,111.98	22,692.94	22,692.94	3,052.32	16,256.48	5,913.07
Share of HP		28.66	8.43	0.28	2.11	17.84	17.26	8.88	8.88	1.19	6.36	2.31

HP.3.4.9	HP.3.nec	HP.4	HP.4.1	HP.4.2	HP.4.9	HP.5	HP.5.1	HP.5.9	HP.6	HP.7	HP.7.1	HP.7.2	HP.nec	All HP	Share of HF
All Other ambulatory centres	Unspecified providers of ambulatory health care (n.e.c.)	Providers of ancillary services	Providers of patient transportation and emergency rescue	Medical and diagnostic laboratories	Other providers of ancillary services	Retailers and Other providers of medical goods	Pharmacies	All Other miscellaneous sellers and Other suppliers of pharmaceuticals and medical goods	Providers of preventive care	Providers of health care system administration and financing	Government health administration agencies	Social health insurance agencies	Unspecified health care providers (n.e.c.)		
10,343.40		4,188.80	2,016.94		2,171.87				3,892.96	20,257.86	18,623.22	1,634.63	2,899.14	88,372.52	34.58
		4,086.51	2,016.94		2,069.58				3,892.96	18,512.38	18,512.38		2,899.14	71,484.55	27.97
		4,086.51	2,016.94		2,069.58				3,892.96	18,512.38	18,512.38		2,899.14	71,484.55	27.97
10,343.40		102.29			102.29					1,745.48	110.84	1,634.63		16,887.97	6.61
10,343.40		102.29			102.29					1,745.48	110.84	1,634.63		16,887.97	6.61
9,910.33		102.29			102.29					1,634.63		1,634.63		16,001.97	6.26
433.07										110.84	110.84			886.00	0.35
		984.01		984.01		2,098.93	2,098.93						6,470.30	15,372.36	6.01
		984.01		984.01		2,098.93	2,098.93						2,558.26	9,015.00	3.53
		492.01		492.01		1,049.47	1,049.47						1,279.13	4,488.59	1.76
		492.01		492.01		1,049.47	1,049.47						1,279.13	4,488.59	1.76
		492.01		492.01		1,049.47	1,049.47						1,279.13	4,526.41	1.77
													206.47	2,651.79	1.04
														2,445.32	0.96
													206.47	206.47	0.08
													3,705.57	3,705.57	1.45
													3,705.57	3,705.57	1.45
	2,110.24	15,261.58		10,596.76	4,664.81	81,918.55	77,966.65	3,951.89						151,587.32	59.31
	2,110.24	15,261.58		10,596.76	4,664.81	81,918.55	77,966.65	3,951.89						151,587.32	59.31
													237.34	237.34	0.09
10,343.40	2,110.24	20,434.39	2,016.94	11,580.77	6,836.68	84,017.48	80,065.59	3,951.89	3,892.96	20,257.86	18,623.22	1,634.63	9,606.78	255,569.55	
4.05	0.83	8.00	0.79	4.53	2.68	32.87	31.33	1.55	1.52	7.93	7.29	0.64	3.76		

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Financing schemes	Health care functions	HC.1	HC.1												HC.2	HC.2.nec	HC.3	HC.3.nec	HC.4		
			Curative care	HC.1.1	HC.1.1.1	HC.1.1.2	HC.1.1.nec	HC.1.2	HC.1.2.1	HC.1.2.2	HC.1.2.nec	HC.1.3	HC.1.3.1	HC.1.3.2						HC.1.3.3	HC.1.3.nec
HF.1	Government schemes and compulsory contributory health care financing schemes	55,659.19	23,115.80	9,781.17	1,625.56	11,709.07	4,642.44	1,538.43	414.51	2,689.50	27,900.96	3,387.19	38.23	1,559.72	22,915.81	3.71	3.71	35.22	35.22	4,086.51	
HF.1.1	Government schemes	40,519.88	18,815.85	9,781.17	1,625.56	7,409.12	4,265.77	1,538.43	414.51	2,312.83	17,438.26	3,383.97	35.02	1,559.72	12,459.56	2.48	2.48	23.60	23.60	4,086.51	
HF.1.1.1	Central government schemes	40,519.88	18,815.85	9,781.17	1,625.56	7,409.12	4,265.77	1,538.43	414.51	2,312.83	17,438.26	3,383.97	35.02	1,559.72	12,459.56	2.48	2.48	23.60	23.60	4,086.51	
HF.1.2	Compulsory contributory health insurance schemes	15,139.31	4,299.95			4,299.95	376.67			376.67	10,462.70	3.22	3.22	10,456.26	1.22	1.22	11.62	11.62			
HF.1.2.1	Social health insurance schemes	15,139.31	4,299.95			4,299.95	376.67			376.67	10,462.70	3.22	3.22	10,456.26	1.22	1.22	11.62	11.62			
HF.1.2.1.1	Health Insurance Organization (HIO)	14,364.16	3,957.87			3,957.87	376.67			376.67	10,029.62	3.22	3.22	10,023.18	1.22	1.22	11.62	11.62			
HF.1.2.1.2	Universal Health Insurance Authority (UHIA)	775.15	342.08			342.08				433.07				433.07							
HF.2	Voluntary health care payment schemes	5,811.17	2,484.87			2,484.87	1.89			1.89	879.08			879.08	2,445.32	0.76	0.76	7.19	7.19	984.01	
HF.2.1	Voluntary health insurance schemes	3,365.84	2,484.87			2,484.87	1.89			1.89	879.08			879.08	0.76	0.76	7.19	7.19	984.01		
HF.2.1.2	Complementary/supplementary insurance schemes	1,667.98	1,230.71			1,230.71				437.27				437.27						492.01	
HF.2.1.2.2	Other complementary/supplementary insurance	1,667.98	1,230.71			1,230.71				437.27				437.27						492.01	
HF.2.1.nec	Unspecified voluntary health insurance schemes (n.e.c.)	1,697.86	1,254.16			1,254.16	1.89			1.89	441.81			441.81	0.76	0.76	7.19	7.19	492.01		
HF.2.2	NPISH financing schemes (including development agencies)	2,445.32													2,445.32						
HF.2.2.1	NPISH financing schemes (excluding HF.2.2.2)	2,445.32													2,445.32						
HF.2.2.nec	Unspecified NPISH financing schemes (n.e.c.)																				
HF.2.3	Enterprise financing schemes																				
HF.2.3.nec	Unspecified enterprise financing schemes (n.e.c.)																				
HF.3	Household out-of-pocket payment	54,407.20	27,426.24			27,426.24				26,980.96			3,052.32	23,928.64						15,261.58	
HF.3.nec	Unspecified household out-of-pocket payment (n.e.c.)	54,407.20	27,426.24			27,426.24				26,980.96			3,052.32	23,928.64						15,261.58	
HF.nec	Unspecified financing schemes (n.e.c.)																				
All HF		115,877.56	53,026.91	9,781.17	1,625.56	41,620.19	4,644.33	1,538.43	414.51	2,691.39	55,761.00	3,387.19	3,090.55	1,559.72	47,723.54	2,445.32	4.46	4.46	42.41	42.41	20,332.10
Share of HC		45.34	20.75	3.83	0.64	16.29	1.82	0.60	0.16	1.05	21.82	1.33	1.21	0.61	18.67	0.96	0.00	0.00	0.02	0.02	7.96

HC.4.1	HC.4.2	HC.4.3	HC.4.nec	HC.5	HC.5.1	HC.5.1.3	HC.5.1.4	HC.5.2	HC.5.2.9	HC.6	HC.6.2	HC.6.5	HC.6.5.nec	HC.6.nec	HC.7	HC.7.1	HC.7.1.2	HC.7.1.nec	HC.7.2	HC.7.nec	HC.9	All HC	Share of HF
Laboratory services	Imaging services	Patient transportation	Unspecified ancillary services (n.e.c.)	Medical goods (non-specified by function)	Pharmaceuticals and Other medical non-durable goods	Other medical non-durable goods	Medicines (Prescribed & OTC)	Therapeutic appliances and Other medical goods	All Other medical durables, including medical technical devices	Preventive care	Immunisation programmes	Epidemiological surveillance and risk and disease control programmes	Unspecified epidemiological surveillance and risk and disease control programmes (n.e.c.)	Unspecified preventive care (n.e.c.)	Governance, and health system and financing administration	Governance and Health system administration	Monitoring & Evaluation (M&E)	Other governance and health system administration (n.e.c.)	Administration of health financing	Unspecified governance, and health system and financing administration (n.e.c.)	Other health care services not elsewhere classified (n.e.c.)		
	2,016.94	2,069.58								3,892.96	1,375.00	1,323.61	1,323.61	1,194.35	20,075.46	18,450.48	17.72	18,432.76	1,411.06	213.91	4,619.47	88,372.52	34.58
	2,016.94	2,069.58								3,892.96	1,375.00	1,323.61	1,323.61	1,194.35	18,339.64	18,339.64	17.72	18,321.92			4,619.47	71,484.55	27.97
	2,016.94	2,069.58								3,892.96	1,375.00	1,323.61	1,323.61	1,194.35	18,339.64	18,339.64	17.72	18,321.92			4,619.47	71,484.55	27.97
															1,735.82	110.84		110.84	1,411.06	213.91		16,887.97	6.61
															1,735.82	110.84		110.84	1,411.06	213.91		16,887.97	6.61
															1,624.97			1,411.06	213.91			16,001.97	6.26
															110.84	110.84		110.84				886.00	0.35
		984.01	2,098.93	2,098.93		2,098.93															6,470.30	15,372.36	6.01
		984.01	2,098.93	2,098.93		2,098.93															2,558.26	9,015.00	3.53
		492.01	1,049.47	1,049.47		1,049.47															1,279.13	4,488.59	1.76
		492.01	1,049.47	1,049.47		1,049.47															1,279.13	4,488.59	1.76
		492.01	1,049.47	1,049.47		1,049.47															1,279.13	4,526.41	1.77
																					206.47	2,651.79	1.04
																						2,445.32	0.96
																					206.47	206.47	0.08
																					3,705.57	3,705.57	1.45
																					3,705.57	3,705.57	1.45
5,934.19	4,662.58		4,664.81	81,918.55	79,547.41	1,580.76	77,966.65	2,371.14	2,371.14													151,587.32	59.31
5,934.19	4,662.58		4,664.81	81,918.55	79,547.41	1,580.76	77,966.65	2,371.14	2,371.14													151,587.32	59.31
																					237.34	237.34	0.09
5,934.19	4,662.58	2,016.94	7,718.40	84,017.48	81,646.35	1,580.76	80,065.59	2,371.14	2,371.14	3,892.96	1,375.00	1,323.61	1,323.61	1,194.35	20,075.46	18,450.48	17.72	18,432.76	1,411.06	213.91	11,327.12	255,569.55	
2.32	1.82	0.79	3.02	32.87	31.95	0.62	31.33	0.93	0.93	1.52	0.54	0.52	0.52	0.47	7.86	7.22	0.01	7.21	0.55	0.08	4.43		

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Sub-National Level		SNL.1	SNL.2	SNL.3	SNL.4	SNL.5	SNL.6	SNL.7	SNL.8	SNL.9	SNL.10	SNL.11	SNL.12
Financing schemes	Egyptian Pound (EGP), Million	Cairo	Alexandria	Port Said	Suez	Damietta	Dakahlia	Sharqia	Qalyoubia	Kafr El-Sheikh	Gharbia	Menoufia	Beheira
	HF.1	Government schemes and compulsory contributory health care financing schemes	11,848.40	4,854.28	1,499.52	662.59	2,097.50	6,608.53	5,269.93	3,896.47	3,403.32	6,424.77	4,487.59
HF.1.1	Government schemes	9,142.07	3,196.81	613.53	659.33	1,603.39	5,726.86	4,394.93	2,699.94	2,868.88	5,115.94	3,735.18	4,571.51
HF.1.1.1	Central government schemes	9,142.07	3,196.81	613.53	659.33	1,603.39	5,726.86	4,394.93	2,699.94	2,868.88	5,115.94	3,735.18	4,571.51
HF.1.2	Compulsory contributory health insurance schemes	2,706.34	1,657.47	886.00	3.26	494.11	881.67	875.00	1,196.53	534.44	1,308.83	752.42	782.53
HF.1.2.1	Social health insurance schemes	2,706.34	1,657.47	886.00	3.26	494.11	881.67	875.00	1,196.53	534.44	1,308.83	752.42	782.53
HF.1.2.1.1	Health Insurance Organization (HIO)	2,706.34	1,657.47		3.26	494.11	881.67	875.00	1,196.53	534.44	1,308.83	752.42	782.53
HF.1.2.1.2	Universal Health Insurance Authority (UHIA)			886.00									
HF.2	Voluntary health care payment schemes	7,754.00	431.93	24.24	16.94	35.38	72.90	163.64	105.51	37.71	71.62	77.24	103.17
HF.2.1	Voluntary health insurance schemes	7,652.34	376.54	16.04	8.74	18.97	3.18	86.75	45.00	0.80	18.31	31.10	36.53
HF.2.1.2	Complementary/supplementary insurance schemes	3,808.11	187.42	8.02	4.37	9.49	1.59	43.37	22.50	0.40	9.15	15.55	18.26
HF.2.1.2.2	Other complementary/supplementary insurance	3,808.11	187.42	8.02	4.37	9.49	1.59	43.37	22.50	0.40	9.15	15.55	18.26
HF.2.1.nec	Unspecified voluntary health insurance schemes (n.e.c.)	3,844.23	189.12	8.02	4.37	9.49	1.59	43.37	22.50	0.40	9.15	15.55	18.26
HF.2.2	NPISH financing schemes (including development agencies)	101.66	55.39	8.20	8.20	16.41	69.72	76.90	60.51	36.91	53.31	46.14	66.64
HF.2.2.1	NPISH financing schemes (excluding HF.2.2.2)	101.66	55.39	8.20	8.20	16.41	69.72	76.90	60.51	36.91	53.31	46.14	66.64
HF.2.2.nec	Unspecified NPISH financing schemes (n.e.c.)												
HF.2.3	Enterprise financing schemes												
HF.2.3.nec	Unspecified enterprise financing schemes (n.e.c.)												
HF.3	Household out-of-pocket payment	17,971.66	9,793.42	1,400.73	1,379.49	2,701.44	11,675.94	12,942.19	10,188.68	6,099.26	8,995.81	7,747.02	11,191.02
HF.3.nec	Unspecified household out-of-pocket payment (n.e.c.)	17,971.66	9,793.42	1,400.73	1,379.49	2,701.44	11,675.94	12,942.19	10,188.68	6,099.26	8,995.81	7,747.02	11,191.02
HF.nec	Unspecified financing schemes (n.e.c.)												
All HF		37,574.07	15,079.63	2,924.49	2,059.02	4,834.32	18,357.37	18,375.76	14,190.67	9,540.29	15,492.19	12,311.85	16,648.23
Share of SNL		14.70	5.90	1.14	0.81	1.89	7.18	7.19	5.55	3.73	6.06	4.82	6.51

SNL.13	SNL.14	SNL.15	SNL.16	SNL.17	SNL.18	SNL.19	SNL.20	SNL.21	SNL.22	SNL.23	SNL.24	SNL.25	SNL.26	SNL.27	SNL.28	All SNL	Share of HF
Ismailia	Giza	Beni Suef	Fayoum	Minya	Assiut	Sohag	Qena	Aswan	Luxor	Red Sea	EL-Wadi El-Gedid	Matrouh	North Sinai	South Sinai	nec		
1,302.92	7,818.41	1,944.79	1,929.88	3,030.31	4,658.21	2,795.69	1,571.35	1,916.13	1,078.53	617.65	658.89	936.97	1,102.39	603.48		88,372.52	34.58
1,073.47	6,554.90	1,522.78	1,509.82	2,533.87	4,012.11	2,298.77	1,320.17	1,671.25	933.63	558.53	648.43	917.80	1,041.40	559.29		71,484.55	27.97
1,073.47	6,554.90	1,522.78	1,509.82	2,533.87	4,012.11	2,298.77	1,320.17	1,671.25	933.63	558.53	648.43	917.80	1,041.40	559.29		71,484.55	27.97
229.45	1,263.51	422.01	420.06	496.44	646.10	496.92	251.18	244.88	144.90	59.12	10.46	19.16	60.99	44.19		16,887.97	6.61
229.45	1,263.51	422.01	420.06	496.44	646.10	496.92	251.18	244.88	144.90	59.12	10.46	19.16	60.99	44.19		16,887.97	6.61
229.45	1,263.51	422.01	420.06	496.44	646.10	496.92	251.18	244.88	144.90	59.12	10.46	19.16	60.99	44.19		16,001.97	6.26
																886.00	0.35
20.77	704.18	42.65	42.09	77.19	52.13	80.35	41.92	21.50	17.10	22.95	3.88	8.08	5.13	6.39	5,331.78	15,372.36	6.01
6.42	610.77	7.79	3.13	17.72	4.97	26.01	7.06	5.09	3.78	18.85	0.80	2.96	0.01	5.36		9,015.00	3.53
3.21	305.38	3.89	1.57	8.86	2.48	13.01	3.53	2.55	1.89	9.42	0.40	1.48	0.00	2.68		4,488.59	1.76
3.21	305.38	3.89	1.57	8.86	2.48	13.01	3.53	2.55	1.89	9.42	0.40	1.48	0.00	2.68		4,488.59	1.76
3.21	305.38	3.89	1.57	8.86	2.48	13.01	3.53	2.55	1.89	9.42	0.40	1.48	0.00	2.68		4,526.41	1.77
14.35	93.42	34.86	38.96	59.47	47.16	54.34	34.86	16.41	13.33	4.10	3.08	5.13	5.13	1.03	1,626.21	2,651.79	1.04
14.35	93.42	34.86	38.96	59.47	47.16	54.34	34.86	16.41	13.33	4.10	3.08	5.13	5.13	1.03	1,419.74	2,445.32	0.96
															206.47	206.47	0.08
															3,705.57	3,705.57	1.45
															3,705.57	3,705.57	1.45
2,390.72	11,284.64	3,917.08	4,450.37	6,785.11	5,504.20	6,171.20	3,900.31	1,888.08	1,590.49	363.21	242.27	460.21	449.69	103.10		151,587.32	59.31
2,390.72	11,284.64	3,917.08	4,450.37	6,785.11	5,504.20	6,171.20	3,900.31	1,888.08	1,590.49	363.21	242.27	460.21	449.69	103.10		151,587.32	59.31
															237.34	237.34	0.09
3,714.40	19,807.23	5,904.52	6,422.35	9,892.61	10,214.55	9,047.24	5,513.57	3,825.71	2,686.13	1,003.80	905.03	1,405.26	1,557.21	712.96	5,569.12	255,569.55	
1.45	7.75	2.31	2.51	3.87	4.00	3.54	2.16	1.50	1.05	0.39	0.35	0.55	0.61	0.28	2.18		

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Classification of diseases/conditions		DIS.1	DIS.1.2	DIS.1.2.1	DIS.1.2.nec	DIS.1.3	DIS.1.4	DIS.1.5	DIS.1.7	DIS.1.8	DIS.1.9	
Financing schemes	Egyptian Pound (EGP), Million	Infectious and parasitic diseases	Tuberculosis (TB)	Pulmonary TB	Unspecified Pulmonary Tuberculosis (n.e.c.)	Unspecified tuberculosis (n.e.c.)	Malaria	Respiratory infections	Diarrheal diseases	Vaccine preventable diseases	Viral Hepatitis	Public Health Emergencies of International Concern (PHEICs)
HF.1	Government schemes and compulsory contributory health care financing schemes	8,414.76	10.23	9.33	9.33	0.90	0.38	464.47	64.75	2,513.51	1,480.98	89.48
HF.1.1	Government schemes	8,127.36	10.01	9.11	9.11	0.90	0.38	390.66	64.74	2,513.46	1,368.94	
HF.1.1.1	Central government schemes	8,127.36	10.01	9.11	9.11	0.90	0.38	390.66	64.74	2,513.46	1,368.94	
HF.1.2	Compulsory contributory health insurance schemes	287.40	0.22	0.22	0.22	0.00		73.81	0.01	0.05	112.04	89.48
HF.1.2.1	Social health insurance schemes	287.40	0.22	0.22	0.22	0.00		73.81	0.01	0.05	112.04	89.48
HF.1.2.1.1	Health Insurance Organization (HIO)	276.83	0.00	0.00	0.00	0.00		73.81	0.01	0.05	104.62	89.48
HF.1.2.1.2	Universal Health Insurance Authority (UHIA)	10.57	0.21	0.21	0.21						7.42	
HF.2	Voluntary health care payment schemes	384.08	0.20	0.00	0.00	0.20		258.53	32.78	16.42	29.64	
HF.2.1	Voluntary health insurance schemes	217.22	0.09	0.00	0.00	0.09		143.65	17.96	9.01	18.52	
HF.2.1.2	Complementary/supplementary insurance schemes	107.77	0.04			0.04		71.82	8.98	4.49	8.98	
HF.2.1.2.2	Other complementary/supplementary insurance	107.77	0.04			0.04		71.82	8.98	4.49	8.98	
HF.2.1.nec	Unspecified voluntary health insurance schemes (n.e.c.)	109.45	0.05	0.00	0.00	0.04		71.84	8.98	4.52	9.55	
HF.2.2	NPISH financing schemes (including development agencies)											
HF.2.2.1	NPISH financing schemes (excluding HF.2.2.2)											
HF.2.2.nec	Unspecified NPISH financing schemes (n.e.c.)											
HF.2.3	Enterprise financing schemes	166.86	0.11			0.11		114.87	14.82	7.41	11.12	
HF.2.3.nec	Unspecified enterprise financing schemes (n.e.c.)	166.86	0.11			0.11		114.87	14.82	7.41	11.12	
HF.3	Household out-of-pocket payment	8,759.26	5.19	0.39	0.39	4.80		5,069.36	878.58	439.36	1,191.99	3.12
HF.3.nec	Unspecified household out-of-pocket payment (n.e.c.)	8,759.26	5.19	0.39	0.39	4.80		5,069.36	878.58	439.36	1,191.99	3.12
HF.nec	Unspecified financing schemes (n.e.c.)											
All HF		17,558.11	15.62	9.72	9.72	5.90	0.38	5,792.35	976.12	2,969.29	2,702.61	92.60
Share of DIS		6.87	0.01	0.00	0.00	0.00	0.00	2.27	0.38	1.16	1.06	0.04

DIS.1.9.2	DIS.1.nec		DIS.2					DIS.2.nec	DIS.3	DIS.3.nec		DIS.4	DIS.4.1				
	Disease from coronavirus SARS-CoV-2 (COVID-19)	Other and unspecified infectious and parasitic diseases (n.e.c.)	Reproductive health	Maternal conditions	Perinatal conditions	Congenital Malformation	Other Perinatal conditions			Unspecified reproductive health conditions (n.e.c.)	Nutritional deficiencies		Anaemia due to nutrition deficiencies	Other Nutritional deficiencies	Noncommunicable diseases	Neoplasms	Malignant neoplasms
89.48	3,790.97	7,012.22	4,664.95	1,804.70	127.97	1,676.73	542.56	1,316.56	491.45	825.11	50,412.97	7,944.50	4,506.07	4,506.07	328.45	3,109.98	
	3,779.17	5,321.55	4,660.49	125.80	125.80		535.26	1,301.00	490.79	810.21	41,434.04	6,461.88	4,474.32	4,474.32	324.89	1,662.67	
	3,779.17	5,321.55	4,660.49	125.80	125.80		535.26	1,301.00	490.79	810.21	41,434.04	6,461.88	4,474.32	4,474.32	324.89	1,662.67	
89.48	11.79	1,690.66	4.46	1,678.90	2.17	1,676.73	7.30	15.56	0.66	14.90	8,978.92	1,482.62	31.75	31.75	3.55	1,447.31	
89.48	11.79	1,690.66	4.46	1,678.90	2.17	1,676.73	7.30	15.56	0.66	14.90	8,978.92	1,482.62	31.75	31.75	3.55	1,447.31	
89.48	8.86	1,684.71	0.19	1,677.21	0.48	1,676.73	7.30	15.53	0.63	14.90	8,152.51	1,442.79	0.24	0.24	0.47	1,442.08	
	2.93	5.95	4.27	1.68	1.68			0.04	0.04		826.41	39.83	31.51	31.51	3.08	5.23	
	46.51	0.49	0.11	0.30	0.30		0.08	338.82	91.31	247.51	6,028.87	1,719.07	183.64	183.64	0.29	1,535.13	
	27.98	0.49	0.11	0.30	0.30		0.08	175.77	54.25	121.52	2,420.87	90.42	89.92	89.92	0.29	0.22	
	13.47							85.28	26.93	58.35	1,202.94	44.89	44.89	44.89			
	13.47							85.28	26.93	58.35	1,202.94	44.89	44.89	44.89			
	14.51	0.49	0.11	0.30	0.30		0.08	90.49	27.32	63.17	1,217.93	45.54	45.03	45.03	0.29	0.22	
											1,966.44	1,624.94	90.02	90.02		1,534.92	
											1,966.44	1,624.94	90.02	90.02		1,534.92	
	18.53							163.05	37.06	125.99	1,641.57	3.71	3.71	3.71			
	18.53							163.05	37.06	125.99	1,641.57	3.71	3.71	3.71			
3.12	1,171.67	400.30	229.38	115.93	11.65	104.27	55.00	6,829.31	1,973.91	4,855.40	84,481.80	2,545.03	2,090.45	2,090.45	14.92	439.66	
3.12	1,171.67	400.30	229.38	115.93	11.65	104.27	55.00	6,829.31	1,973.91	4,855.40	84,481.80	2,545.03	2,090.45	2,090.45	14.92	439.66	
92.60	5,009.15	7,413.01	4,894.44	1,920.93	139.92	1,781.00	597.64	8,484.69	2,556.67	5,928.02	140,923.64	12,208.60	6,780.17	6,780.17	343.66	5,084.77	
0.04	1.96	2.90	1.92	0.75	0.05	0.70	0.23	3.32	1.00	2.32	55.14	4.78	2.65	2.65	0.13	1.99	

(continued)

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Classification of diseases/conditions		DIS.4.2					DIS.4.3						
		DIS.4.2.1		DIS.4.2.2	DIS.4.2.3	DIS.4.2.nec		DIS.4.3.1		DIS.4.3.2	DIS.4.3.3	DIS.4.3.4	DIS.4.3.nec
		Endocrine and metabolic disorders	Diabetes	Disorders of thyroid gland	Diseases of the immune system	Other and unspecified endocrine and metabolic disorders (n.e.c.)	Cardiovascular diseases	Hypertensive diseases	Ischaemic heart diseases	Pulmonary heart disease and diseases of pulmonary circulation	Other blood diseases	Other and unspecified cardiovascular diseases (n.e.c.)	
Financing schemes	Egyptian Pound (EGP), Million												
HF.1	Government schemes and compulsory contributory health care financing schemes	4,421.35	3,365.93	75.97	383.51	595.94	7,552.17	2,473.36	1,465.73	33.24	734.48	2,845.38	
HF.1.1	Government schemes	3,811.43	2,905.74	70.67	379.97	455.05	6,619.44	2,310.69	1,422.22	33.11	501.31	2,352.11	
HF.1.1.1	Central government schemes	3,811.43	2,905.74	70.67	379.97	455.05	6,619.44	2,310.69	1,422.22	33.11	501.31	2,352.11	
HF.1.2	Compulsory contributory health insurance schemes	609.92	460.18	5.30	3.54	140.89	932.73	162.67	43.51	0.13	233.16	493.27	
HF.1.2.1	Social health insurance schemes	609.92	460.18	5.30	3.54	140.89	932.73	162.67	43.51	0.13	233.16	493.27	
HF.1.2.1.1	Health Insurance Organization (HIO)	429.33	288.67	0.05	0.36	140.24	713.18	1.03	5.52	0.00	226.73	479.90	
HF.1.2.1.2	Universal Health Insurance Authority (UHIA)	180.59	171.51	5.25	3.18	0.65	219.55	161.63	37.99	0.12	6.43	13.37	
HF.2	Voluntary health care payment schemes	583.24	383.11	0.03	34.57	165.53	1,156.25	0.64	3.44	0.00	205.73	946.44	
HF.2.1	Voluntary health insurance schemes	342.38	216.36	0.03	27.16	98.83	481.25	0.64	3.44	0.00	116.80	360.37	
HF.2.1.2	Complementary/supplementary insurance schemes	170.57	107.73		13.47	49.37	237.90				58.35	179.54	
HF.2.1.2.2	Other complementary/supplementary insurance	170.57	107.73		13.47	49.37	237.90				58.35	179.54	
HF.2.1.nec	Unspecified voluntary health insurance schemes (n.e.c.)	171.81	108.63	0.03	13.69	49.45	243.35	0.64	3.44	0.00	58.45	180.83	
HF.2.2	NPISH financing schemes (including development agencies)						341.50					341.50	
HF.2.2.1	NPISH financing schemes (excluding HF.2.2.2)						341.50					341.50	
HF.2.2.nec	Unspecified NPISH financing schemes (n.e.c.)												
HF.2.3	Enterprise financing schemes	240.86	166.75		7.41	66.70	333.50				88.93	244.57	
HF.2.3.nec	Unspecified enterprise financing schemes (n.e.c.)	240.86	166.75		7.41	66.70	333.50				88.93	244.57	
HF.3	Household out-of-pocket payment	10,784.16	6,879.36	8.86	462.65	3,433.29	15,038.13	568.86	394.79	1.07	3,528.46	10,544.95	
HF.3.nec	Unspecified household out-of-pocket payment (n.e.c.)	10,784.16	6,879.36	8.86	462.65	3,433.29	15,038.13	568.86	394.79	1.07	3,528.46	10,544.95	
HF.nec	Unspecified financing schemes (n.e.c.)												
All HF		15,788.75	10,628.40	84.86	880.73	4,194.76	23,746.55	3,042.85	1,863.95	34.31	4,468.67	14,336.76	
Share of DIS		6.18	4.16	0.03	0.34	1.64	9.29	1.19	0.73	0.01	1.75	5.61	

DIS.4.4	DIS.4.4.2 DIS.4.4.3 DIS.4.4.nec			DIS.4.5	DIS.4.6		DIS.4.7		DIS.4.8	DIS.4.9	DIS.4.10	DIS.4.nec	DIS.5	DIS.nec	All DIS	Share of HF
Mental & behavioural disorders, and Neurological conditions	Behavioural disorders	Neurological conditions	Unspecified mental & behavioural disorders and neurological conditions (n.e.c.)	Respiratory diseases	Diseases of the digestive	Hepatology	Other Diseases of the digestive	Diseases of the genito-urinary system	Sense organ disorders	Oral diseases	Diseases of the musculoskeletal system and connective tissue	Other and unspecified noncommunicable diseases (n.e.c.)	Injuries	Other and unspecified diseases/ conditions (n.e.c.)		
2,717.69	3.93	688.16	2,025.59	2,478.50	4,440.25	1,074.07	3,366.18	13,523.44	4,367.31	109.84	2,412.34	445.57	2,829.71	18,386.30	88,372.52	34.58
2,397.92	3.78	499.90	1,894.24	2,420.28	4,268.14	960.88	3,307.25	12,449.74	1,819.80	83.93	663.09	438.40	2,678.45	12,622.14	71,484.55	27.97
2,397.92	3.78	499.90	1,894.24	2,420.28	4,268.14	960.88	3,307.25	12,449.74	1,819.80	83.93	663.09	438.40	2,678.45	12,622.14	71,484.55	27.97
319.77	0.15	188.26	131.35	58.23	172.11	113.18	58.93	1,073.71	2,547.51	25.91	1,749.25	7.17	151.26	5,764.16	16,887.97	6.61
319.77	0.15	188.26	131.35	58.23	172.11	113.18	58.93	1,073.71	2,547.51	25.91	1,749.25	7.17	151.26	5,764.16	16,887.97	6.61
289.97	0.00	160.04	129.93	56.04	160.35	106.72	53.62	745.72	2,533.37	25.34	1,749.25	7.17	145.49	5,726.91	16,001.97	6.26
29.80	0.15	28.22	1.43	2.19	11.77	6.46	5.31	327.99	14.14	0.57			5.77	37.26	886.00	0.35
535.47	0.00	0.28	535.20	157.02	497.86	29.70	468.16	417.42	410.43	95.65	456.16	0.32	1.80	8,618.30	15,372.36	6.01
305.73	0.00	0.28	305.45	90.32	297.76	18.59	279.17	228.43	225.15	80.82	278.29	0.32	1.80	6,198.85	9,015.00	3.53
152.61			152.61	44.89	148.12	8.98	139.15	112.21	112.21	40.40	139.15			3,092.59	4,488.59	1.76
152.61			152.61	44.89	148.12	8.98	139.15	112.21	112.21	40.40	139.15			3,092.59	4,488.59	1.76
153.12	0.00	0.28	152.84	45.43	149.64	9.61	140.03	116.22	112.94	40.43	139.15	0.32	1.80	3,106.26	4,526.41	1.77
														685.36	2,651.79	1.04
														478.89	2,445.32	0.96
														206.47	206.47	0.08
229.75			229.75	66.70	200.10	11.12	188.98	188.98	185.28	14.82	177.87			1,734.10	3,705.57	1.45
229.75			229.75	66.70	200.10	11.12	188.98	188.98	185.28	14.82	177.87			1,734.10	3,705.57	1.45
11,028.94	0.45	235.70	10,792.79	3,404.36	10,782.26	783.94	9,998.32	10,319.66	8,369.09	3,386.82	8,769.45	53.89	378.89	50,737.76	151,587.32	59.31
11,028.94	0.45	235.70	10,792.79	3,404.36	10,782.26	783.94	9,998.32	10,319.66	8,369.09	3,386.82	8,769.45	53.89	378.89	50,737.76	151,587.32	59.31
														237.34	237.34	0.09
14,282.10	4.38	924.13	13,353.58	6,039.88	15,720.37	1,887.71	13,832.66	24,260.52	13,146.82	3,592.31	11,637.95	499.77	3,210.40	77,979.70	255,569.55	
5.59	0.00	0.36	5.23	2.36	6.15	0.74	5.41	9.49	5.14	1.41	4.55	0.20	1.26	30.51		

The Egypt National Health Accounts 2019/2020 study provides an up-to-date overview of health expenditure in the country. It tracks health expenditure across the Egyptian health system and provides in-depth analysis of the quantities and flows of funds through standard health expenditure classifications and key indicators. The 2019/20 study fills many gaps found in previous Egypt national health accounts studies. For example, it tracks detailed health expenditure specific to data sources, such as voluntary private health insurance and nongovernmental organizations. Moreover, for the first time, it tracks expenditure on diseases, as well as expenditure disaggregated by the 27 governorates. Furthermore, it provides a more granular view of health expenditure on pharmaceuticals and according to hospital typologies, including private hospitals.

