Economic Challenges for Enhancing PPPs in UHI in Egypt

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Abstract

Public-Private Partnerships (PPPs) play a critical role in improving healthcare quality, efficiency, and financial sustainability. In Egypt, the Egyptian Universal Health Insurance (UHI) program, launched in 2018, aims to achieve Universal Health Coverage (UHC). However, Public-Private Partnerships (PPPs) successful implementation faces economic and governance challenges, particularly regarding private sector engagement, strategic purchasing, and service integration.

This study aims to enhance the role of the (PPPs) in the (UHI) system in Egypt by identifying the economic challenges facing (PPPs). The study employs an inductive approach using qualitative methods, incorporating a descriptive approach through a literature review of published research and official data alongside semi-structured interviews with seven purposefully selected public and private sector stakeholders. Data collection focused on economic implications, market conditions, monitoring mechanisms, and implementation challenges.

The findings emphasize that the private sector's major role in enhancing service provision within PPPs, while its contribution to infrastructure

development remains limited. The main economic challenges include strict pricing processes, delays in payment mechanisms, inflation rates, and the high cost of accreditation.

Enhancing the role of PPPs within the UHI system requires a well-defined governance framework, value-based pricing, and strategic service integration to strengthen Egypt's Universal Health Insurance (UHI) system. To boost private sector participation while ensuring financial sustainability, the study recommends adopting well-suited PPP models, such as BOO for specialized services and DBFO for integrated clinical and non-clinical services. Clear regulations, financing strategies, and competitive procurement mechanisms are essential for maintaining cost Effectiveness, service quality, and equitable healthcare access within the UHI framework.

Key words: Public-Private Partnerships (PPPs), Universal Health Insurance (UHI), Private sector, Universal Health Coverage (UHC), Egypt.

Introduction

Over the last few decades, the private sector has played an increasingly vital role in healthcare service provision, particularly in urban areas. Its ability to rapidly develop infrastructure, implement efficient processes, and enhance technical and managerial capacities makes it a key player in improving healthcare delivery, especially in developing countries (IQVIA, 2022).

Public-Private Partnerships (PPPs) enhance both the quality and accessibility of healthcare services by improving key performance indicators such as diagnostic and curative services, waiting times, referral efficiency, and overall patient outcomes (Basabih et al., 2022). They also contribute to healthcare financing and system reforms by leveraging private sector resources to enhance allocative and technical efficiency, ultimately maximizing value for money. Importantly, PPPs help ensure access to essential health services for all income groups, with a particular focus on low-income populations. Additionally, they facilitate the construction and maintenance of healthcare facilities by utilizing private sector expertise (HSF, 2023).

The implementation of Public-Private Partnerships (PPPs) in healthcare varies across regions, reflecting differences in economic conditions and healthcare priorities. In high-income countries, particularly in Europe, PPPs primarily focus on healthcare financing, infrastructure development, and optimizing resource allocation to enhance cost-efficiency (HSF, 2023). In low- and middle-income countries, they play a crucial role in expanding healthcare services and improving accessibility, especially in underserved areas (Siddiqi et al., 2023). In Asia, as demonstrated by India, PPPs facilitate equitable access to healthcare across all income levels, ensuring broader service coverage (Phua, 2017). Meanwhile, in the Eastern Mediterranean Region, PPPs are instrumental in delivering essential health services, aligning with national efforts to achieve Universal Health Coverage (WHO-EMRO, 2022).

Given the increasing demand for healthcare services, many governments have recognized the importance of engaging with the private sector to address systemic challenges. The 2018 Ministerial Meeting, The Road to Universal Health Coverage (UHC) in the Eastern Mediterranean Region, organized by the World Health Organization (WHO), reinforced this approach. Following the adoption of the UHC 2030 Global Compact and the Salalah Declaration, most countries in the region have prioritized UHC, with a regional roadmap emphasizing primary healthcare development to achieve this goal by 2030.

Further, PPPs in the health sector involve long-term agreements between private entities and government agencies to finance, develop, and manage healthcare infrastructure and services. According to the World Bank, a PPP is "a long-term contract between a private party and a government agency for providing a public asset or service, where the private party assumes significant risk and management responsibility" (World Bank, 2012). In the healthcare sector, this framework enables the provision of health facilities, equipment, and essential services (HSF, 2023).

The participation of both for-profit and non-profit private entities in health system reforms can help countries address key challenges in achieving UHC, including economic instability, fiscal constraints, demographic shifts, and gaps in healthcare infrastructure. Through PPPs, governments can expand high-quality healthcare services, strengthen human resource capacities, promote digitalization, support research and development (R&D), and enhance healthcare infrastructure. Additionally, PPPs contribute to cost containment and help bridge resource gaps, making them a vital component of health system sustainability. In this context, cost-effective PPPs are essential for efficient implementation, and their success depends on adopting suitable models - such as the Infrastructure-Based Model, Discrete Clinical Services Model, and Integrated PPP Model -according to the circumstances of each country (WHO-EMRO, 2022; Clarke et al., 2019; Phua, 2017).

In Egypt, the Universal Health Insurance (UHI) law, enacted in 2018, aims to achieve Universal Health Coverage (UHC) within 12 to 15 years by ensuring financial sustainability, high-quality services, and protection from financial hardship (Khalifa et al., 2022; Mathauer, 2019). The law aligns with Sustainable Development Goal 3 (SDG 3), specifically target 3.8, which emphasizes universal health coverage, financial risk protection, and access to quality healthcare services and essential medicines (UN, 2015). Additionally, Egypt's Vision 2030 reinforces the importance of achieving UHC.

Most importantly, the implementation of the UHI program faces challenges related to strategic purchasing, governance, information management, and fiscal space constraints (Khalifa et al., 2022; Mathauer, 2019). Given that the private sector accounts for 63.4% of inpatient facilities (CAPMAS, 2022), effective regulation of covered services and payment methods is essential to mitigate potential negative impacts on the health system (Mathauer, 2019). In this context, analyzing the role of Public-Private Partnerships (PPPs) in achieving the UHI system is crucial, considering the various challenges hindering its implementation. To the best of the authors' knowledge, since the implementation of UHI began in Port Said governorate in 2019—while still in its early stages in many other governorates very few studies have explored the challenges of enhancing the role of Public-Private Partnerships (PPPs) in the UHI system, particularly from an economic perspective.

The aim of this study is to enhance the role of the (PPPs) in the (UHI) system in Egypt by identifying the economic challenges facing (PPPs). The finding of this study can support policymakers and researchers in addressing the challenges hindering the private sector's role in the effective system's implementation.

The main hypothesis of this study is that the economic challenges significantly limit the effective role of PPPs in the implementation (UHI).

Due to the limited availability of data and related research at this critical stage of implementing the UHI, this study employs an inductive approach using qualitative methods within a descriptive framework to examine the role of PPPs in Egypt's Universal Health Insurance (UHI) program. Data were collected from reports and published research on PPP and UHI development, followed by semi-structured interviews with seven purposefully selected stakeholders from the public and private sectors. The questionnaire, formulated based on previous literature and revised by two PPP experts, covered economic implications, market conditions, monitoring mechanisms, and implementation challenges. The selection of interviewees ensures a diverse group is represented, allowing for a range of perspectives. The stakeholder group includes participants from the public sector, private sector, financial public administration, and the Egypt Healthcare Authority. Ethical guidelines were strictly followed, with informed consent obtained before interviews, which lasted between 60 and 100 minutes. Participants had the option to skip questions or withdraw at any point. Data collection was supported by two research team members who took notes and transcribed interviews immediately after each session. The analysis followed principles of clarity, integration, and reliability, employing content analysis to identify key themes. Interview transcripts were reviewed multiple times, coded, and categorized according to study objectives.

The study is divided into the following sections: The first section reviews recent literature. The second section discusses the current situation of Public-Private Partnerships in Egypt's health sector. Finally, the third section outlines the conclusion and policy recommendations.

Literature review

1.1 An Overview of Public Private Partnership (PPP):

Public-Private Partnerships (PPPs) provide a viable framework for regulating private sector engagement, with model selection depending on national priorities and implementation capacity (Kang et al., 2019; HSF, 2023; Tombari, 2017; WHO-EMRO, 2022; Basabih et al., 2022; Siddiqi et al., 2023; Clarke et al., 2019; Phua, 2017). Ensuring financial sustainability and strong managerial capacity in long-term PPP agreements is essential for program success (HSF, 2023).

Empirical studies indicate that PPPs are increasingly adopted across high-, middle-, and low-income countries. In high-income nations, particularly in Europe, PPPs have played a key role in fundraising and implementing health system reforms, leading to improved system performance and cost efficiency (HSF, 2023).

Siddiqi et al. (2023) demonstrated that in low and lower-middle-income countries such as Pakistan, Sudan, Zanzibar, Somalia, and Afghanistan, various aspects of PPP policies have been developed to enhance service delivery. Phua (2017) and Razvi & Khan (2015) confirmed that PPPs are steadily expanding in the health systems of Asian countries, such as India, benefiting not only middle- and high-income groups but also low-income populations.

Tombari (2017) revealed that in Nigeria, the government employs PPPs to alleviate pressure on the public sector in delivering services such as laboratory testing, imaging, and referral hospital care. Additionally, strategic purchasing through performance-based funding has encouraged PPP initiatives in the country, as resources are managed through contractual agreements between partners with proper monitoring mechanisms in place to minimize the risk of failure.

In addition, PPP models can alleviate the pressure on the public capital budget by mobilizing private financing, thus easing the constraints on the public budget. The impact on future public budgets will depend on how

the contract is terminated. Therefore, PPPs must be carefully planned to maximize value for money and ensure the sustainability of financing. As a result, it is recommended to maximize the use of PPP models. In this context, the main effects of implementation of PPP models include lowering operating and maintenance costs, as the private partner is motivated by incentives to ensure maintenance compliance and meet quality standards. This is especially crucial, as maintenance is usually given low importance in the public sector due to budget limitations (HSF, 2023).

Moreover, according to World Health Organization, PPPs are applied in Eastern Mediterranean countries(1) to deliver essential health services, including programs for communicable diseases (CD), non-communicable diseases (NCDs), reproductive, maternal, newborn, child, and adolescent health, nutrition, mental health, and emergency care. In Bahrain, the United Arab Emirates, Oman, and Qatar, PPPs have been applied to obesity-targeting programs, adopting measures such as banning trans fatty acid products, reducing salt consumption, and enforcing stricter regulations on the marketing of unhealthy foods to school-age children. In Pakistan, PPPs are employed to improve family planning services. In Egypt, PPP models have been used for media awareness campaigns and NCDs service delivery . Additionally, food fortification through PPP models has been implemented in some countries in the Eastern Mediterranean Region (EMR) (World Health Organization, Regional Office for the Eastern Mediterranean, 2022b).

1.2 Public-Private Partnership (PPP) Models:

Although there are many different models of PPPs, which vary in the extent of private sector involvement, all these models aim to achieve one or more of the following six functions:

1. **Finance** – providing financing or co-financing for the project.

(1) According to the World Health Organization, Eastern Mediterranean Region consists of 21 Member States and occupied Palestinian territory (including East Jerusalem), with a population of nearly 745 million people (WHO, 2024).

2. **Design** – designing the project, including both the infrastructure and care delivery model.
3. **Build** – constructing or renovating the facilities involved in the project.
4. **Maintain** – maintaining the infrastructure, including facilities and relevant equipment.
5. **Operate** – supplying necessary equipment, IT, and managing non-clinical services.
6. **Deliver –** providing and managing specified clinical and clinical support services (Abuzaineh et al., 2018).

1.2.1 PPPs Basic Models:

The majority of facility-based PPPs consolidate these functions into three basic models:

1. **Infrastructure-based Model** – focused on constructing or renovating public healthcare infrastructure. On the one hand, the model gained widespread use in healthcare in the 1990s when the UK launched a major initiative to modernize outdated facilities and increase capacity within its National Health Service (NHS). Since then, the Infrastructure-based model has become the most widely adopted form of healthcare PPP, implemented globally in countries such as Australia, Canada, Egypt, Italy, Japan, South Africa, and throughout Latin America. On the other hand, the Infrastructure-based model is particularly suited for situations where the public sector either faces budgetary limitations preventing upfront investment in infrastructure or lacks the expertise and experience to oversee large-scale capital projects.
2. **Discrete Clinical Services Model** – designed to increase or enhance service delivery capacity. This model is widely used in India because the availability of advanced diagnostic services is limited,

particularly for high-end equipment like CT and MRI machines, while the government's capacity to manage more complex projects is also constrained. In this respect, Discrete Clinical Services PPPs, when structured with clear performance indicators, provide a lower-risk option for the public sector to engage in PPPs and for private providers to participate in public service delivery. This approach could, therefore, serve as a stepping stone toward more complex Integrated PPP models in the future.

3. **Integrated PPP Model** – delivering a complete package that includes both infrastructure and service delivery. This model is applied in Lesotho, Spain, Peru and Australia. The Integrated PPP model, though the least common, offers substantial potential for health reform by focusing on clinical service management, cost, and quality. While it can significantly enhance clinical performance, its complexity necessitates that governments assess their capacity and secure political support before implementation (Abuzaineh et al., 2018).

1.2.2 PPP Models in Hospital Provision:

Moreover, countries adopt various PPP models in hospital provision, addressing key issues such as cost, risks, quality, and complexity. These models include:

1. **Franchising:** In this model, a private partner is contracted to manage an already existing hospital.
2. **BOO (Build, Own, Operate):** In this model, the public partner purchases services from the private partner for a fixed period.
3. **DBFO (Design, Build, Finance, Operate):** This involves the private partner designing, constructing, financing the capital costs, and operating facilities based on specified public sector requirements.
4. **BOLB (Buy, Own, Lease Back):** In this arrangement, the private partner purchases and owns the facilities, then leases them back to the public sector, which manages and operates them.

5. **BOOT (Build, Own, Operate, Transfer):** The private partner finances, builds, owns, and operates the facilities or services for a fixed period. After this period, ownership is transferred back to the public sector.

6. **Alzira Model:** Under this model, private partners build and operate facilities to deliver specific services to a defined group of people (McKee et al., 2006).

1.2.3 Commonly Used PPP Models in Middle-Income European Countries (MICs):

In addition, there are three PPP models commonly utilized in middle-income European countries (MICs). It is worth mentioning that there are key similarities between these models and the ones mentioned above; all of these models aim to improve healthcare delivery through PPPs, but the degree of private sector participation varies depending on the scope of services and infrastructure involved. However, the models used in European countries vary in terms of costs, benefits, risks, and payment methods, as explained below:

1. **Specialized Clinical/Diagnostic Services Model:** The private partner delivers specialized services specified by the public partner, such as dialysis, radiology, and imaging, under the BOO framework.

2. **Health Facilities Model:** The private partner oversees all non-clinical services, such as facility management, while clinical services remain under public partner management, utilizing the DBFO model.

3. **Integrated Model:** The private partner manages both clinical and non-clinical services comprehensively under the DBFO framework (HSF, 2023).

However, each of the above-mentioned models comes with its own set of benefits, costs, and risks, which are illustrated in Table 1.

Table 1: Benefits, Costs, and Risks Associated with Each PPP Model:

PPP model	Economic features	Opportunities	Challenges
Specialized clinical / diagnostic services	-The public sector determines the specialist services (such as dialysis, radiotherapy, and day surgery) or diagnostic services (like laboratory services, imaging, and nuclear medicine) to be provided by a private operator. -The private operator covers the initial capital costs. - Payment to the operator is made by the government based on an annual per capita or per treatment model (or a combination), and in some cases, users are required to make co-payments.	- The model can improve the availability of medical facilities, equipment, and services for the targeted population(s), while also enhancing the quality of clinical services and/or the efficiency of their delivery.	- High transaction costs and/or per capita/per session prices are likely to be higher compared to other delivery modes, including alternative private sector contracting methods. - This model may impact, and potentially distort, resource allocation priorities unless projects are specifically chosen to address identified gaps in the availability of prioritized services (such as those defined in the essential health service package).

Health facilities	- The private sector partner is responsible for the design, construction, financing, and operation of health facilities, including hospitals, ambulatory care facilities, polyclinics, primary care centers, and maternal and pediatric clinics. However, the management of clinical services remains within the public sector. - Contracts typically span over 30 years and may involve outsourcing certain aspects of facilities management, such as catering, cleaning, and laundry. - The government makes payments to the private operator, usually based on a performance-adjusted availability charge. - Users may be required to make co-payments for certain costs, such as parking fees.	- The model allows access to private funding for capital expenditure, bypassing public budget limitations and facilitating additional investments in healthcare infrastructure and equipment. -The model improves the efficiency of capital procurement, focusing on ensuring predictable public sector costs throughout the asset lifecycle.	- A competitive procurement process is essential to ensure and maintain value for money throughout the contract's duration. - In practice, forecasting and budgeting for costs in advance can be challenging. The ability to defer and spread out the costs of capital investments through private financing may result in an overcommitment of future public sector funds. - Consequently, there are risks to affordability later on, which could undermine the financial sustainability of health systems.

Integrated model	- The private operator is responsible for managing the design, construction, financing, and operation of healthcare facilities (including hospitals, ambulatory care centers, polyclinics, primary care centers, and maternal and pediatric clinics) as well as the full spectrum of associated clinical services, typically for a long-term period ranging from 10 to 30 years. - Payments to the private operator are made by the government, typically based on a forward-looking global budget that covers the operator's capital costs, along with co-payments from users.	- The model can attract private financing for both capital and recurrent expenditures (if user fees are applicable), improve the efficiency of government procurement by focusing on lifecycle costs, and expand both the range and quality of medical equipment and clinical services for individuals in the targeted populations.	- A strong government capacity, along with a market environment that supports competitive bidding, is essential to ensure and maintain value for money throughout the contract's duration. - Contracting authorities must clearly define clinical service requirements and ensure their delivery. - Failing to do so could jeopardize both the quantity and quality of clinical services. - Market prices may be high due to a shortage of qualified bidders and elevated transaction costs, making it difficult to predict and budget for associated expenses. - The risks to affordability—and thus to the financial sustainability of health systems—can be significant and challenging to manage in practice. If user fees constitute a major part of the private operator's revenue, it could undermine equity of access and financial protection.

Source: Authors' analysis, based on HSF (2023).

1.2.4 Commonly Utilized PPPs Models in Eastern Mediterranean Region (EMR):

Further, in Eastern Mediterranean Region (EMR) the most commonly used PPPs Models are:

1. Build-Finance-Maintain Model: Some PPP projects are structured to include the design, construction, financing, and maintenance of facilities, while core medical services remain under the jurisdiction of the Ministry of Health. For instance, the Turkish government partnered with a private infrastructure management firm, supported by multilateral development banks like the European Bank for Reconstruction and Development (EBRD), to design, finance, build, and operate a €360 million hospital campus with 1,000 beds. Similarly, Egypt sought the assistance of the IFC[(1)] to collaborate with the private sector in designing, constructing, and operating two new specialty teaching hospitals for Alexandria University.

2. Public-Private Insurance Partnerships: This model leverages the capabilities and resources of private insurers to develop insurance schemes for populations previously excluded from conventional systems. A successful example from the UAE demonstrates how PPPs can address the needs of marginalized communities. Specifically, Roche partnered with AXA to explore innovative ways of providing affordable cancer funding. Through this collaboration, Roche provided medical education and disease management guidance to AXA and the Dubai Health Authority (DHA), enabling them to develop supplementary insurance coverage for expatriates. The initiative offers comprehensive access to all expatriates in Dubai, including those from low-income groups. As a result, 4.4 million expatriates, from diverse income levels, now have access to cancer treatment funding. Furthermore, a system has been designed to accommodate future population growth, ensuring that all Dubai residents benefit from improved screening and diagnosis, regardless of their insurance policy.

(1) IFC refers to the International Finance Corporation, a member of the World Bank Group.

3. Value-Based Partnerships – Some countries are adopting the payment by results (PbR) model. In these contracts, the focus shifts from simply delivering a set of services to incentivizing improvements in patient and public health outcomes and experiences. Providers have the flexibility to implement these improvements in whatever way they see fit (IQVIA, 2022).

In fact, each government's decision on which model to adopt is primarily influenced by local health needs and other factors (e.g., political, social). Additionally, the level of risk and responsibility that the government intends to allocate, as well as the extent to which the private partner is willing to accept, are key factors in this decision-making process. In addition, before initiating a PPP, governments must evaluate the project in the context of the broader health system's needs. Comprehensive data on current and future healthcare demands and costs are essential to inform sound policy decisions, guide PPP design, and select an appropriate cost model (Abuzaineh et al., 2018).

To sum up, the literature emphasizes the vital role of Public-Private Partnerships (PPPs) in enhancing healthcare efficiency across different economic contexts. High-income countries focus on infrastructure development and cost control, while middle- and low-income nations use PPPs to expand healthcare access and optimize resources. Empirical evidence shows that well-structured PPPs can ease financial pressures on governments, improve service quality, and support long-term sustainability if managed effectively. Examples include strategic purchasing in Nigeria, reproductive health programs in Pakistan, and disease prevention efforts in the Eastern Mediterranean. However, financial sustainability, governance, and risk management remain key challenges, requiring strong regulatory oversight.

PPP models vary in private sector involvement and risk-sharing, ranging from infrastructure-based and clinical service agreements to integrated service models. Countries also employ hospital provision models like BOOT and the Alzira Model, each with distinct benefits and risks.

Additionally, middle-income European and Eastern Mediterranean nations implement specialized frameworks, such as value-based partnerships and public-private insurance collaborations, to improve efficiency and equity. Further, the literature underscores the importance of selecting a PPP model that aligns with a country's healthcare needs and governance capacity.

The next section will assess Egypt's PPP experience, evaluate its effectiveness, and examine the challenges facing the expansion of the private sector's role in Egypt's Universal Health Insurance.

2- Current situation of Public-Private Partnerships in the Health Sector in Egypt

2.1 Health Expenditure Trends and the Role of the Private Sector in Egypt:

Since 1980, Egypt has encouraged private sector involvement in healthcare to promote health by optimizing infrastructure and workforce use. The government supports private investment across sectors, including health, and has gradually reduced public health spending to expand the private sector's role as illustrated earlier (World Health Organization, 2014). In 2020, private health expenditure accounted for 61% of current health expenditures, with a high percentage coming from out-of-pocket payments, which represented 54% of current health expenditures. This section highlights various issues related to enhancing the role of public-private partnerships in Egypt's health sector.

Moreover, analyzing Egypt's health expenditures over the period 2018–2020, as shown in Table 2, reveals that:

1. There is a growing focus on public policy priorities for health; however, the Abuja target - set as a goal for mobilizing at least 15% of public resources to health in African countries - has not yet been reached.

2. The fiscal capacity of a country to be able to mobilize its public revenue is medium (25-35%), indicating fiscal constraints[1].

3. The share of economy for spending on health from public revenues tends to be decreased with constant ratio.

4. The highest proportion of health expenditures come from the private sector with the highest percentage of out-of-pocket payments as mentioned above.

Table 2: Health expenditure in Egypt from 2018 until 2022:

Indicators		2018	2019	2020	2021	2022
1	Current Health Expenditure (CHE) as % Gross Domestic Product (GDP)	5.0	4.8	4.4	5	5
2	Domestic General Government Health Expenditure (GGHE-D) as % General government expenditure (GGE)	4.7	4.8	5.2	2	2
3	General Government Expenditure (GGE) as % Gross Domestic Product (GDP)	30.1	28.3	27.0	26	25
4	Domestic General Government Health Expenditure (GGHE-D) as % Gross domestic product (GDP)	1.4	1.4	1.4	2	2
5	Domestic General Government Health Expenditure (GGHE-D) as% Current health expenditure (CHE)	28.5	28.2	31.9	38	38

(1) The "fiscal envelope," or the overall level of government spending, is typically measured by the government spending-to-GDP ratio, which reflects the size of the public sector within the economy. As a general guideline, a government spending-to-GDP ratio of less than 15% indicates very low fiscal capacity, 15%-20% is considered low, 20%-25% is low to medium, 25%-35% is medium, 35%-45% is medium to high, and above 45% reflects very high fiscal capacity (World Health Organization, 2016).

6	Domestic Private Health Expenditure (PVT-D) as % Current Health Expenditure (CHE)	70.9	70.8	67.0	38	38
7	Out-of-pocket (OOPS) as % of Current Health Expenditure (CHE)	62.6	62.5	59.3	55	54
8	Voluntary Prepayments as % of Current Health Expenditure (CHE)	6.9	6.9	3.5	3	3
9	External Health Expenditure (EXT) as % of Current Health Expenditure (CHE)	0.7	1.0	1.1	1	2

Source: Authors' based on World Health Organization (2024).

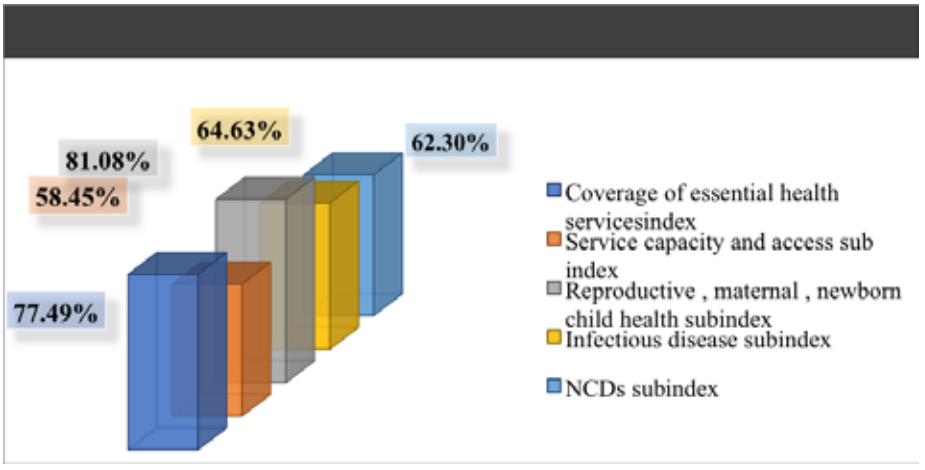
In light of previous analysis, it is crucial to focus on providing essential health services of good quality to all, without causing financial hardship, which is the goal of the UHI program.

2.2 Coverage of essential health services in Egypt:

In general, the Essential Health Services Coverage Index serves as an indicator of a country's health system performance in delivering necessary services without causing financial hardship. It reflects the system's ability to provide essential healthcare with good quality while ensuring financial protection (Boerma et al., 2014).

In Egypt, the coverage of the Essential Health Services Index was 77.49% in 2019. Its sub-indexes were as follows: service capacity and access at 58.45%, reproductive, maternal, and newborn child health at 81.08%, infectious diseases at 64.63%, and non-communicable diseases at 62.3%, as illustrated in Figure 1 (World Health Organization, 2023).

Figure 1: Coverage of essential health services in Egypt in 2019:



Source: Drawn by authors, based on World Health Organization (2023).

The private sector accounts for approximately 63% of total health facilities and 27% of total inpatient beds in Egypt, as shown in Table 3 (CAPMAS, 2022).

Table 3: The structure of healthcare infrastructure in Egypt by its mixed private and public providers (2010-2019).

	2010	2019
Total number of health facilities with beds	1587	1782
Public sector number of health facilities with beds	660	652
Public sector share of health facilities as %	41.5%	36.5%
Private sector number of health facilities with beds	927	1130
Private sector share of health facilities as %	58.4%	63.4%
Total bed number	125123	128344
Public sector total bed number	99270	92599
Public sector % from total bed number	79.3%	72.1%
Private sector total bed number	25853	35745
Private sector % from total bed number	20.6%	27.8%

Source: CAPMAS (2022).

The Public-Private Partnership (PPP) program, launched in 1990, aims to provide healthcare services and is estimated to account for 50% to 70% of the services provided, with its diverse offerings. These classifications highlight the complexity of the private health sector in Egypt. However, the Ministry of Health faces challenges in regulating the private sector and managing activities within the mixed public-private system (World Health Organization, 2014). In this respect, the regulations are aimed solely at official healthcare providers, with no mention of extensively used informal healthcare services. The formal healthcare sector market access is controlled by licensing, registration, and contracting. Furthermore, the policies developed to standardize pricing and ensure affordability are inadequate. While the government's activities encourage the commercialization of healthcare, it lacks control over this practice, leaving institutions to determine service pricing and charges. As a result, patients are often redirected to the private sector or privatized public services (World Health Organization, 2014).

Moreover, the Egyptian healthcare market is highly fragmented, with services provided by public, semi-public, and private providers, each operating under its own set of regulations and organizational structures. The referral system is poorly functioning, and the purchase of an unstandardized Health Benefit Package (HBP) is passive. This fragmented system is marked by multiple revenue pools, poor quality, inefficiency, inequity, and significant financial hardships.

In 2019, the enactment of the New Universal Health Insurance (UHI) law aimed to achieve Universal Health Coverage (UHC) for all Egyptians. Its implementation is planned gradually over a 12 to 15-year period across all governorates, starting in July 2019 with Port Said. Under this scheme, the Health Benefit Package (HBP) must ensure high-quality health services and financial protection. A key component of the law addresses health financing, detailing how health services will be purchased through the Universal Health Insurance Authority (UHIA), which will pool revenues primarily from public sources.

The HBP will be delivered through public health facilities owned and managed by the Egyptian Health Authority (EHA) and private health facilities contracted by the UHIA. Beneficiaries will have the freedom to choose their providers, particularly for secondary and tertiary care. Strategic purchasing will play a crucial role in advancing progress towards UHC, with primary goals including improving health service quality, enhancing efficiency, promoting equity, and ensuring financial protection (Khalifa et al., 2022; Mathauer, 2019).

Moreover, the concept of implementing PPP in the UHI program is steadily growing, with considerable efforts being made to achieve this goal (Universal Health Insurance Authority, 2022; Egyptian Taxation Authority, 2022). For example, in Port Said governorate, PPP agreements have been announced between El Tadamon Hospital, El Nasar Hospital, and El Nessa Hospital representing the public sector, and Cleopatra Group Hospitals representing the private sector. Additionally, El Zohour Hospital (public) and Dar El Fouad Hospital (private) have also entered into a similar PPP agreement (Shorouk News, 2019).

In this respect, regulating the role of the private sector under the UHI program is crucial. If the private sector in healthcare continues to operate under its current regulations without addressing both payment methods and the Health Benefit Package (HBP), it could lead to negative consequences such as cost escalation and the creation of a dual healthcare system. Therefore, the role of the private sector should be carefully evaluated to ensure it provides a complementary function, such as covering user fees or offering services not included in the HBP, as well as a supplementary role, such as hospitality services, under the UHI program. One concern is that private providers may focus primarily on governorates during the initial phases of implementation, potentially resulting in inadequate availability in the later phases (Mathauer et al., 2019).

2.3 Legal Framework of Public Private Partnership (PPP) in Egypt:

The legal and institutional framework for PPPs in Egypt is established through the Egyptian Public Private Partnership Law and its executive regulations (No. 67 of 2010), the Ministerial Decree No. 2735 of 2018 regarding the structure and responsibilities of the PPP Supreme Committee, and the Public Procurement Law (No. 182 of 2018) for the legal framework. On the institutional side, the Egyptian Public-Private Partnership Central Unit (PPPCU) was created within the Ministry of Finance (MOF).

According to the law, a PPP is defined as a "partnership contract with the private sector, along with related advisory contracts, concluded between the administrative authorities and the private sector to execute infrastructure projects, services, and public utilities, while ensuring the availability of related services". This framework is characterized by its emphasis on transparency, free competition, and fairness. The selection of PPP projects and the related steps leading up to contract signing between partners are managed by the PPPCU, which also oversees public and/or private obligations. Furthermore, a dispute resolution mechanism is in place to support project monitoring.

2.4 Financial Challenges and Proposed Solutions for Implementing the UHI Program:

According to the UHI program, entry will primarily occur through the public sector, given its growing role in the Egyptian healthcare market. Therefore, the challenges related to the private sector's involvement should be addressed, including the following:

1. The referral system should be clearly defined from lower to higher levels, starting from public primary healthcare facilities (PHFs) to private physicians' clinics, to enhance service quality by fostering competition. It is also essential to integrate the referral system with health information system management across all three levels of healthcare.

2. The coverage of bypass costs by private health insurance entities to higher levels of healthcare should not undermine the rules of the referral system.

3. A limit for private health insurance premiums should be added to protect people against financial hardship.

4. Avoidance of escalating costs by setting methods and rates of payment should be developed to restrict the presence of two systems, one for poor and other for rich.

5. Complementary and supplementary healthcare services should be clarified with its payment rates to achieve equity and financial protection.

6. The multiple and fragmented regulations governing the private health sector need to be updated to promote an integrated delivery system between the public and private sectors.

7. Mechanisms for quality monitoring for the private sector should be developed (Khalifa et al., 2022; Mathauer, 2019).

8. There are significant challenges in fostering infrastructure projects, especially in Public-Private Partnerships (PPP), in Egypt. In general, these challenges can be categorized into five main areas: funding capacity, the legal framework, the institutional structure within the framework, the bidding and contracting process, and risk-sharing (Public-Private Partnership Legal Resource Center, 2023b; 2015c).

On the one side, as a result of UHI law there are many financial challenges related to the implementation of UHI program which are:

1. Funding capacity: The local Egyptian banking sector's financial capacity to fund small to medium-sized PPP projects is limited, as it is impacted by exchange rate risks related to foreign currencies. In addition, payment mechanisms face challenges, particularly in the absence of long-term financial projections that account for macroeconomic risks such as inflation and exchange rate fluctuations. Furthermore, project affordability is impacted by shorter loan

repayment periods, leading to higher annual debt payments relative to repayment terms, making project costs relatively high (European Investment Bank, 2011 ; World Bank, 2023).

2. Strategic purchasing is essential for advancing progress toward the UHC goal. Its main objectives are to promote the quality of health services, enhance efficiency, and improve equitable access and financial protection (European Investment Bank, 2011 ; World Bank ,2023).

3. The optimal distribution of health facilities and workforce should be determined based on healthcare needs and disease burden to enhance efficiency (Khalifa et al., 2022; Mathauer, 2019). This is particularly important given the limited current capacity of PHFs, as previously mentioned, and the need to strengthen the role of family physicians (Radwan & Adawy, 2019).

4. Primary healthcare facilities will provide both curative and preventive services under two separate funds, requiring strong coordination to ensure continuity between them. The Ministry of Health and Population (MOHP) remains responsible for prevention and early detection, which are not covered under the UHI package. This arrangement may unintentionally shift resources toward curative care services.

5. The Health Benefits Package (HBP) needs to be more focused and prioritized to address issues such as long waiting times and shortages of essential services. Clear and explicit criteria should be established to align the package with identified needs.

6. Cost-sharing mechanisms, including rate adjustments and ceilings, need to be clarified, as the permitted quantity of medicines remains uncertain and is not restricted to a specific period. Additionally, a defined list of chronic diseases should be developed for full or partial coverage, as there are no clear prerequisites for including chronic conditions and related medications. Ceilings should be income-based to ensure equity and financial protection.

7. Payment methods need to be clarified, particularly regarding cost limits and pricing mechanisms, especially given the discrepancies in the quality of clinical and non-clinical services provided (Khalifa et al., 2022; Mathauer, 2019).

8. Improving and strengthening the health information system, and linking it with payment methods across all involved organizations and ministries, is highly recommended (Khalifa et al., 2022; Mathauer, 2019). This is essential to overcome existing obstacles related to networking infrastructure, aligned policies, and the adaptation of system users, especially in the context of financial constraints and proper supply chain management (Uluc, 2016).

9. The constrained fiscal space[1] of the Universal Health Insurance Authority UHIA during the implementation period will be a challenge, necessitating the achievement of balance through forecasted and stable expenditures. This can be accomplished by contracting with providers on a performance basis to ensure transparency and accountability (Khalifa et al., 2022; Mathauer, 2019).

2.5 The main findings from in-depth Interviews :

There were seven stakeholders interviewed, including top and middle managers from Egypt's health care authority and private sectors. The interviewees were selected to ensure representation of diverse groups, allowing for a variety of perspectives. The stakeholders group comprises strategic, operational, and financial administration. All participants have experience in PPP within UHI.

2.5.1 The role of PPP in UHI for service provision and infrastructure development:

Most of the interviewees agreed that the PPP are established between the strategic purchaser of services within the UHI and the providers for

(1) Fiscal space refers to the available capacity within a government's budget to allocate resources for a specific purpose without compromising its financial sustainability or economic stability (International Monetary Fund [IMF], 2024).

a specialized healthcare service, frequently: laboratory investigations, radiological examinations, some diagnostic &follow-up visits, private pharmacies, critical care services, inpatient services, and hemodialysis services.

Most of participants emphasized the significant role of PPP in strengthening service provision, especially in improving service accessibility, reducing waiting lists and enhancing medication availability for the UHI. Additionally, capacity building of the healthcare staff, especially in highly technical skills. However, the private sector's role in infrastructure development remains limited. They noted the experience of the automation of inventories through partners in private sector as Vodafone (communication company) Egyptian chapter.

Few of stakeholders mentioned the role of PPPs in outsourcing high-cost treatments, such as some chemotherapy in cases of rare malignant diseases and chronic disease management, ensures that patients receive timely and effective care without overextending public resources.

Success stories from PPPs:

The obvious success story example is the collaborating protocol with Magdy Yacoub center in the provision of highly specific cardiological services for beneficiaries and building capacities of the medical staff, especially physicians. Another collaborative partnership in Port-Said example was Maghraby clinics for ophthalmic services. Additionally, the waiting list initiative in Egypt which was one of the most influential initiatives to solve the problems of waiting lists provides a good model for pricing.

The interviewees also emphasized the role of private entities to enhance follow-up care for complex medical conditions. Specially, the use of advanced technologies, for instance, using gamma knives in brain tumors, genetic studies, hematological services like acute leukemia and bone marrow transplantation. This collaboration aims for a mass provision of services and reducing patient waiting time.

2.5.3. Services suggested to be included or excluded from the current benefit package:

Most interviewees recommended the inclusion of additional services in the health care benefit package, such as telemedicine services, therapeutic plastic surgery, homecare services, flexible cystoscopy, and organ transplant. A few participants suggested adding advanced dental care like dental crown installation, dental implants, and morbid obesity management to be included. Half of the interviewees emphasized the need for services that require external referral outside the public entities but included in the package as not present in their public entities. For instance, advanced lab investigations, quantitative HCV/PCR test, anti-DNA test, anti-thyroid peroxide Thyroid Peroxide Ab test, Calprotectin in Stool test, anti-lupus test, anti-cardiolipin test. Additional services suggested were Visual Evoked Potential (VEP), cardiology MRI, Electro-Encephalogram (EEG), full assessment of hearing and equilibrium functions, X-ray spine all positions, different endoscopic surgeries such as knee endoscopy, and Thermocoagulation. Advanced treatment like Gamma knife therapy, cataract surgery, cornea transplantation and radiotherapy were also proposed. The mental health services only recommended by one interviewee.

However, only one participant suggested excluding certain services from the package, including medications for specific chronic diseases such as ketostril in chronic kidney diseases and some immune therapy, Lasik in eye treatment, treatment of some genetic diseases, cosmetic procedures, and addiction management services.

2.5.4 Monitoring of the private sector's role in the UHI:

The interviewees mentioned that the private sector's role can be governed through the application of pay-for-performance and fee-for-service models for contracted services when purchasing the services. Most of the stakeholders also suggested developing a standardized value-based price list for both public and private partners. They recommended that the private sector would contract with UHI to provide both profitable and

non-profitable healthcare services. Additionally, they emphasized the necessity of developing a strong governance system to prevent the risk of fraud especially in the claims. Furthermore, they suggested the indicators to monitor the role of private sector as the number of cases that referred and followed by private sector, waiting time, facilities accreditation rates, feedback of patient satisfaction, reported adverse events and geographical distribution.

2.5.6 The economic risk associated with PPPs in UHI:

Among the remarked economic risks is the possibility of termination of the contract. For example, a termination of an agreement with a specific health facility has been done while maintaining to provide a particular type of service. Additionally, rejection of certain cases from some providers may lead to adverse selection[1] problems. Furthermore, the referral time of beneficiaries may be elongated, especially if the needed services are not available in their government, which leads to suffering and pain and is reflected in beneficiary satisfaction.

2.5.7 External economic factors that affect PPP agreements:

All the interviews agreed upon factors several factors that affect PPP in UHI. These factors include inflation rate, exchange rate, pricing mechanisms, increasing the cost of inputs used in services production and fiscal constrains in Egypt.

Most of participants highlighted the effect of local market situation on the success of PPPs. They added Investing in healthcare services can help reduce costs and stimulate competition among providers, ultimately improving the quality of care. However, outdated infrastructure may hinder the potential for Public-Private Partnerships (PPPs). To overcome this challenge, developing new infrastructure that includes specialized services, and advanced technology will not only promote PPPs but also ensure the long-term sustainability of healthcare services.

(1) Adverse selection occurs when individuals or groups with higher-than-average risk actively seek insurance coverage, placing financial pressure on the insurance system (Shapiro & Greenlaw, 2016).

2.5.8 Key economic challenges /barriers in implementing PPPs in UHI as mentioned by participants:

1- Health information system: for instance, the coding system which manifested in different codes used for contracted services.

2-Financing and Pricing system:

- Deficiency of a clear costing process for the inputs consumed in service provision, which leads to financial loss
- If beneficiaries concerned about certain services as the most suitable but they must request them from private providers. They ought to pay the difference in prices at the private provider which may lead to an increase in the OOPS problem.
- The representation of the private sector in the pricing committee of UHI is low, limiting their ability to influence the price list and considering the continuous increase in service input costs.
- The delay in payment mechanisms for the claims and the discounting rates on claims are not well-defined.

3- Accreditation and contracting:

- High cost required for accreditation of healthcare facilities by GAHAR, and there are no guarantees from UHI to complete the contraction process after the accreditation.
- Civil protection certificate license is a big challenge as the cost required to adjust the infrastructure is very expensive.
- Regarding private pharmacies, the risk of high cost of medication in case of contract termination, the risk of no or low number of referred beneficiaries to dispend their medication, objection of some pharmacies on the discount rate used in UHI contract and commitment to the least five generic prices.

4- Service provision and beneficiary awareness:

- Pre-service payment requirements by some private entities.
- Some contracted services are provided for the patient outside the governorate of the beneficiary.
- It is obligatory for beneficiaries to get a referral document before accessing services from a private provider, following the patient's selection of the provider.
- Raising beneficiaries' awareness about their rights and responsibilities is required.
- Interviewees highlighted the importance of examining the PPPs announced between public and private hospitals in Port-Said governorate. Lesson learned from Port-said PPP agreements could provide sustainable models on the future to help in achieving the goal of the UHI program in Egypt.

2.5.9 Adjusting PPP Models for Specialized and Integrated Health Services

The discussion with participants revealed that, the private sector plays an outstanding role in providing specialized care and integrated services. Therefore, the **Build, Own, operate (BOO)** model appears suitable for high-cost specialized services, such as homecare, flexible cystoscopy, and organ transplants. This model ensures service quality while effectively managing financial risks.

On the other side, for integrated clinical services, the **Design, Build, Finance, operate (DBFO)** model is believed appropriate for services such as morbid obesity treatment, therapeutic plastic surgery, and dermatological procedures. The DBFO model can be utilized for the digitalization and health facilities development, including the improvement of health information systems and telemedicine. Involving private sector through external referrals for specialized diagnostic and

therapeutic services —such as advanced laboratory tests, endoscopic surgeries, and radiotherapy. This approach effectively shifts both recurrent and capital expenditures to private partners. Nevertheless, its success relies on well-defined contractual terms, including the specification of service fees and payment mechanisms, to ensure cost-effectiveness and maintain accessibility.

About the Participants' recommendations for improving PPPs in UHI, all stressed on developing the equitable unified value-based healthcare price list to achieve equity. Some interviewees focused on improving transparency in the contracting process. Improving the current health information system such as developing the coding system for all provided services and linking them with all entities of the UHI. Developing tight flexible payment mechanism for private entities with short time frame. They proposed that 50% of GAHAR accreditation costs be covered through future payment. Additionally, offering free consulting visits by GAHAR before the accreditation procedures to access & provide recommendation for missed or incomplete standards. Furthermore, enhancing the awareness of beneficiaries about their rights and responsibilities.

3 - Conclusion and Recommendations

The literature of the study highlights the crucial role of PPPs in enhancing healthcare efficiency, with high-income countries focusing on infrastructure and cost control, while lower-income nations use PPPs to expand access and optimize resources. Effective PPPs can alleviate financial burdens, improve service quality, and ensure sustainability, though challenges like governance and risk management persist. Various models exist, including infrastructure-based and integrated service arrangements, alongside specialized frameworks like value-based partnerships. The choice of PPP model depends on a country's healthcare priorities and regulatory capacity.

Egypt's Vision 2030 aims to achieve UHC. (PPPs) play a pivotal role in strengthening the current healthcare system. Addressing the challenges

faced by PPPs within the (UHI) framework is essential. Particularly as Stakeholder interviews emphasized that many of these challenges arise from economic constraints. This perspective, align with evidence from the literature review.

However, Egypt has increasingly relied on private sector involvement in healthcare, yet the system remains fragmented, with inefficiencies and financial burdens on patients. The implementation of the Universal Health Insurance (UHI) law in 2019 was a significant step toward integrating private providers into a structured health financing system.

In this respect, without clear regulations on private sector participation and service pricing, there is a risk of escalating costs and unequal access. Stronger regulation is needed to address pricing, affordability, and oversight challenges, ensuring cost-effectiveness, service quality, and equitable healthcare access under PPP arrangements. Expanding PPP engagement within the Universal Health Insurance (UHI) program is necessary to enhance service delivery and alleviate pressure on public providers.

While PPPs have facilitated service coverage and capacity building, infrastructure-focused models remain underutilized, and several essential services have yet to be fully integrated. Addressing these gaps through well-defined PPP frameworks will be critical to achieving the program's objectives and ensuring sustainable, high-quality healthcare for all. Certain diagnostic and therapeutic procedures are only accessible through external referrals to private providers due to gaps in public sector capacity. These include specialized lab tests—such as quantitative HCV/PCR, QuantiFERON-TB Gold (IGRA), ANA, anti-DNA, anti-thyroid peroxidase, calprotectin in stool, anti-lupus, and anti-cardiolipin tests—as well as procedures like Visual Evoked Potential (VEP), cardiology MRI, EEG, full hearing and equilibrium assessments, spine X-rays, various endoscopic surgeries, radiofrequency thermocoagulation, Gamma Knife

therapy, chronic total occlusion (CTO) procedures, cataract surgery, corneal transplantation, and radiotherapy.

To manage risks and ensure the effectiveness of PPPs—such as service disruptions, adverse selection, and delays in beneficiary referrals—several measures are needed. A unified value-based pricing system, incorporating copayments where appropriate, can promote equitable healthcare costs while discouraging unnecessary utilization. Pay-for-performance mechanisms can enhance service quality in private sector partnerships, while improved transparency in contracting processes will build trust among stakeholders. Strengthening the health information system, including the development of a standardized coding system and its integration across all UHI entities is also essential. A robust monitoring system should track referrals and service utilization to prevent fraud and ensure accountability. Strategic Public-Private Partnership (PPP) models should be adopted to enhance service provision within the Universal Health Insurance (UHI) program. The BOO (Build, Own, Operate) model is particularly suitable for high-cost specialized services such as homecare, flexible cystoscopy, and organ transplants, ensuring quality while managing financial risks.

However, clear criteria must be established for including these services in the UHI program, along with sustainable management mechanisms to prevent excessive cost burdens. For integrated clinical services, the DBFO (Design, Build, Finance, Operate) model can be applied to services such as morbid obesity treatment, therapeutic plastic surgery, and dermatological procedures, effectively shifting both recurrent and capital expenditures to private partners. However, its success depends on well-defined contractual terms that specify service fees and payment mechanisms to ensure cost-effectiveness and accessibility. Additionally, the DBFO model can be leveraged for health facilities and digital services, including telemedicine expansion and enhancements to the health information system. Engaging private providers through external referrals for specialized diagnostic and therapeutic procedures—such as advanced lab tests, endoscopic surgeries, and radiotherapy—can

alleviate public sector capacity constraints and shift capital costs to private entities. Nevertheless, careful financial planning is necessary to ensure the sustainability of these partnerships beyond contract periods. Furthermore, fostering procurement competition will be essential to optimizing cost efficiency and maintaining service quality within the UHI framework. For successful implementation of PPP models, the following key actions are recommended:

1. Separate Investment and Procurement Decisions: Initial investments should focus on identifying actual needs before procurement.
2. Establish Clear Procurement Objectives: This ensures cost-effectiveness and strategic allocation of resources.
3. Incorporate Financing Capacity into Strategic Planning: Investments should enhance technical efficiency and financial sustainability.
4. Strengthen Capacity Building: Developing institutional capacity is crucial for delivering strategic reforms effectively.

To address challenges in PPP implementation, governance strategies should be tailored to ensure effective stewardship. This includes defining partner roles, fostering collaboration, aligning structures with objectives, and maintaining transparency to build trust among stakeholders.

The governance framework should also regulate private sector participation to prevent unintended consequences, such as excessive patient migration to private providers due to inadequate public sector benefits. Egypt's private healthcare sector plays an increasingly important role in service provision. However, its regulatory framework remains fragmented, requiring updates to facilitate mixed public-private service delivery.

Effective PPP models can help structure private sector involvement in the UHI system, ensuring equitable service provision. Addressing key challenges—including accreditation barriers, unclear private sector market share, and entry transparency—is essential.

Additionally, healthcare utilization surveys and healthcare mapping should guide private sector investment decisions. To maximize PPP effectiveness, the government must refine payment mechanisms and fee structures to safeguard citizens from financial hardship while ensuring service quality, equity, and provider competition.

A well-regulated private sector role within the UHI framework will enhance healthcare accessibility and financial sustainability, ultimately supporting Egypt's broader health system reform goals.

Future Research:

This study addresses the key challenges To enhance PPP in UHI. This serves as initial exploratory step in the first-stage implementation of the UHI program across six governorates. The study uses qualitative methods, including in-depth interviews. It acknowledges potential bias and highlights the need for further quantitative research. Additionally, the study calls for a deeper investigation into the benefits, risks, and costs of PPP models post-implementation, emphasizing the importance of an action plan to optimize value for money. Assessing the health benefits package is also crucial for evidence-based PPP model selection.

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List of Abbreviations

BOLB	Buy, Own, Lease back
BOO	Build, Own, Operate
BOOT	Build, Own, Operate, Transfer
CD	Communicable Diseases
CHE	Current Health Expenditure
GGHE-D	Domestic General Government Health Expenditure
DBFO	Design, Build, Finance, Operate
EMR	Eastern Mediterranean Region
EXT	External Health Expenditure
EHA	Egypt Healthcare Authority
EMOF	Egyptian Ministry of Finance
GAHAR	General Authority for Healthcare Accreditation and Regulation
GDP	Gross Domestic Product
GGE	General Government Expenditure
HBP	Health Benefit Package
HCV	Hepatitis C Virus
ICU	Intensive Care Unit
MOHP	Ministry of Health and Population
NCDs	Non-Communicable Diseases
UHI	New Egyptian Universal Health Insurance
OOPS	Out of Pocket Spending
PCR	Polymerze Chain Reaction
PPPs	Public Private Partnerships
PPPCU	Public Private Partnership Central Unit
PVT-D	Domestic Private Health Expenditure
SCCT	Suez Canal Container Terminal
SDG	Sustainable Development Goal
UHC	Universal Health Coverage
UHI	Universal Health Insurance
UHIA	Universal Health Insurance Authority

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التحديات الاقتصادية لتعزيز الشراكات بين القطاعين العام والخاص في نظام التأمين الصحي الشامل في مصر

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مستخلص

تلعب الشراكات بين القطاعين العام والخاص (PPPs) دورًا حيويًا في تحسين جودة الرعاية الصحية وكفاءتها واستدامتها المالية. في مصر، يهدف برنامج التأمين الصحي الشامل(UHI)، الذي أُطلق في عام ٢٠١٨، إلى تحقيق التغطية الصحية الشاملة (UHC) ومع ذلك، تواجه عملية تنفيذه تحديات اقتصادية وإدارية، لا سيما فيما يتعلق بمشاركة القطاع الخاص، والشراء الاستراتيجي، ودمج الخدمات.

تهدف هذه الدراسة إلى تعزيز دور الشراكات بين القطاعين العام والخاص فى نظام التامين الصحى الشامل فى مصر UHI، وذلك من خلال تحديد التحديات الاقتصادية التى تواجه الشراكات بين القطاعين العام والخاص . تعتمد هذه الدراسة على المنهج الاستقرائي باستخدام الأسلوب الوصفي التحليلي من خلال مراجعة الأدبيات البحثية المنشورة والبيانات الرسمية، إلى جانب إجراء مقابلات semi-structured مع سبعة من أصحاب المصلحة من القطاعين العام والخاص. ركزت عملية جمع البيانات على التداعيات الاقتصادية، وظروف السوق، وآليات المراقبة، والتحديات التي تواجه التنفيذ.

وتؤكد النتائج أن القطاع الخاص يلعب دورا هاما في تعزيز تقديم الخدمات فى اطار الشراكات بين القطاعين العام والخاص، في حين أن مساهمته في تطوير البنية التحتية لا تزال محدودة. وتشمل التحديات الاقتصادية الرئيسية عمليات

التسعير الصارمة، والتأخير في آليات الدفع، ومعدلات التضخم، وارتفاع تكلفة الاعتماد.

تؤكد نتائج الدراسة أن تعزيز دور الشراكات بين القطاعين العام والخاص (PPPs) داخل نظام التأمين الصحي الشامل (UHI) يتطلب وجود إطار واضح للحوكمة ، وآليات تسعير قائمة على القيمة، ودمجًا استراتيجيًا للخدمات. وتوصي الدراسة باعتماد نماذج شراكة مناسبة، مثل نموذج BOO للخدمات المتخصصة ونموذج DBFO للرعاية السريرية وغير السريرية المتكاملة لضمان تعزيز مشاركة القطاع الخاص مع ضمان الاستدامة المالية . كما يعد التشريعات، واستراتيجيات التمويل الملائمة، وآليات الشراء التنافسي ضرورة للحفاظ على الكفاءة المالية وجودة الخدمات وضمان وصول الرعاية الصحية العادل في إطار نظام التأمين الصحي الشامل.

الكلمات الدالة: الشراكة بين القطاعين العام والخاص (PPPs)، نظام التأمين الصحي الشامل (UHI)، القطاع الخاص، التغطية الصحية الشاملة (UHC) ، مصر.