



Republic of Zambia

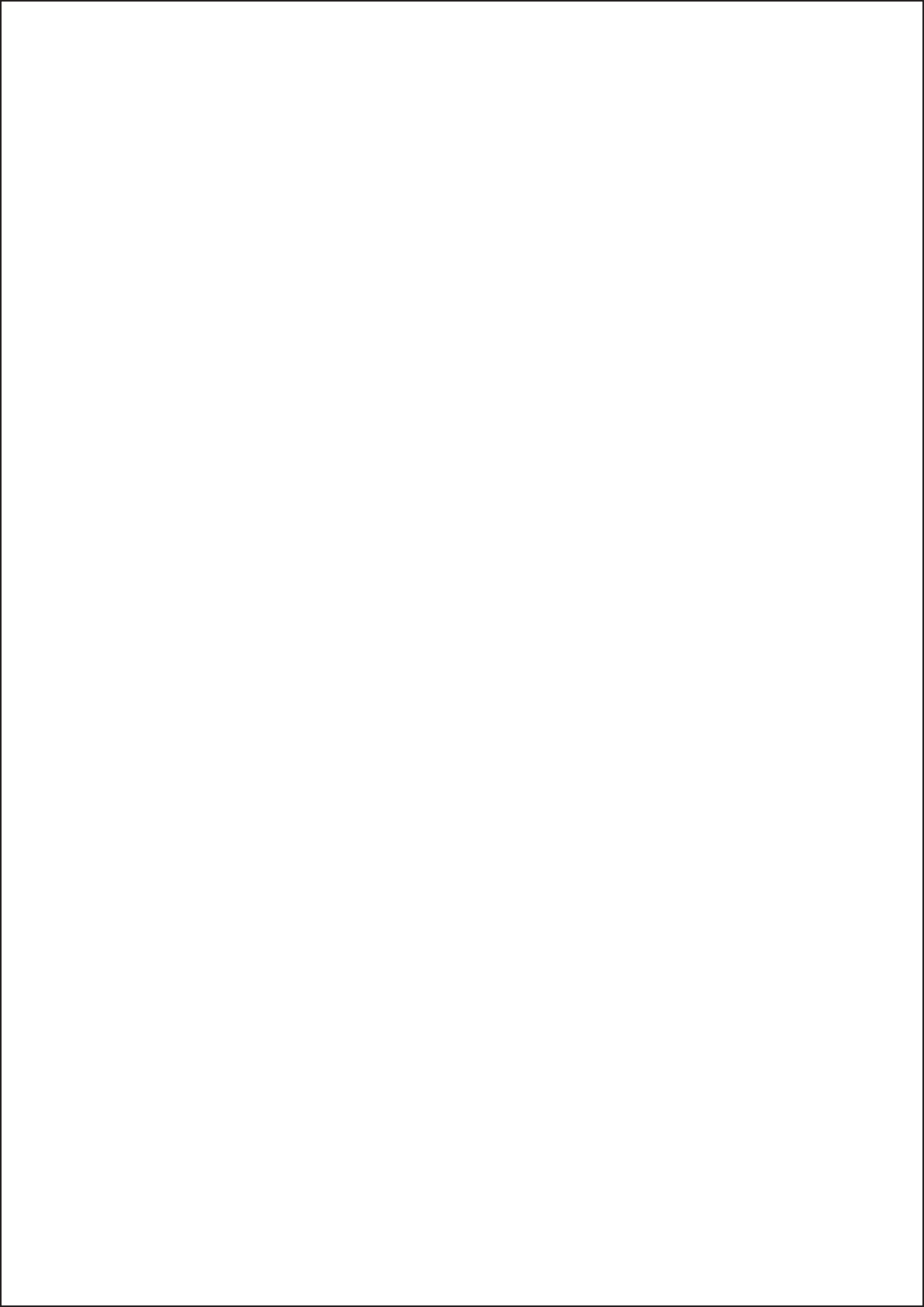
Ministry of Health



Zambia National Health Accounts

2013 - 2016

December 2018





Republic of Zambia

Ministry of Health

Zambia National Health Accounts 2013 - 2016 ESTIMATES



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Abbreviations and Acronyms

| | |
|--------|--|
| AIDS | Acquired Immune Deficiency Syndrome |
| CHE | Current Health Expenditure |
| GDP | Gross Domestic Product |
| GHE | Government Health Expenditure |
| HAPT | Health Accounts Production Tool |
| HIV | Human Immunodeficiency Virus |
| ICT | Information, Communication and Technology |
| IMF | International Monetary Fund |
| IMR | Infant Mortality Ratio |
| LCMS | Living Conditions Monitoring Survey |
| LMICs | Lower Middle Income Countries |
| MCDMCH | Ministry of Community Development, Mother and Child Health |
| MMR | Maternal Mortality Ratio |
| MoH | Ministry of Health |
| NCD | Non-communicable disease |
| N.E.C | Not elsewhere classified |
| NGOs | Non-governmental organizations |
| NHA | National Health Accounts |
| NPISH | Non-Profit Institutions Serving Households |
| OOP | Out of Pocket |
| PHC | Primary Health Care |
| R&D | Research and Development |
| RH | Reproductive Health |
| SBH | Systems for Better Health |
| SDSN | Sustainable Development Solutions Network |
| SHA | Systems of Health Accounts |
| TB | Tuberculosis |
| U5MR | Under-5 Mortality Rate |
| UHC | Universal Health Coverage |
| USAID | United States Agency for International Development |
| WHO | World Health Organization |
| ZMW | Zambian Kwacha |

Forward

This National Health Accounts (NHA) survey report presents an insight in the healthcare financing system in Zambia over the period 2013–2016. The study uses the Systems of Health Accounts (2011) methodology to measure the level and flow of funds through the health system from the various institutional units providing the revenues of financing schemes all the way to goods and services on which these resources are spent. The analysis is split between current and capital expenditures on health.

The results of this NHA indicate that nominal expenditure on health for the whole sector increased from ZMW 7.4 billion in 2013 to ZMW 10.2 billion in 2016. The majority of the expenditure (95 percent) was on Current Health Expenditures (CHE) while the difference of 5 percent was on capital goods. In nominal terms, total CHE increased by 36 percent from ZMW 7.1 billion in 2013 to ZMW 9.7 billion in 2016. This report estimates per capita total CHE for Zambia at US\$59 in 2016. The Zambian Government and donors were the two main sources of total CHE, averaging about 41 percent and 42 percent, respectively, during the study period. Government's health sector spending increased by 87 percent from ZMW 1.98 billion in 2013 to ZMW 3.7 billion in 2016. As a share of total CHE, current government expenditure on health increased from 28 percent in 2013 to 38 percent in 2016, having attained a peak of 50 percent in 2014.

Donors expenditure on health at ZMW 4.1 billion in 2013 remained at the same level in 2016 but the level of spending in 2014 and 2015 were lower. Nonetheless, donor spending at 42 percent of total CHE per annum over the period 2013–2016 was the largest source of financing. On the other hand, households contributed an average of 12 percent of total CHE through out-of-pocket payments during the period under review. Meanwhile, employers' contribution to the total CHE increased from 3 percent in 2013 to 7 percent in 2016. On average, internal government transfers and direct foreign transfers constituted the largest share for revenues of financing schemes at 41 percent and 32 percent of total CHE, respectively, during the review period. The proportion of expenditures allocated to curative care was the largest during the study period while an examination of expenditures by diseases shows that HIV and AIDS, Malaria and Reproductive Health accounted for 34 percent, 13 percent and 9 percent of total CHE, respectively, in 2016. The other diseases and conditions consumed about 44 percent of total CHE in the same year.

It is hoped that all the stakeholders operating in the health sector will find time to read the full report and use it to strategize on how best the health sector can be financed in Zambia. Furthermore, it is hoped that this NHA report will be used for planning and budgeting purposes at all levels of health care, and that it will help to shape the way resources are allocated to the various programmes in the health care system in Zambia.



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Executive Summary

This study measures the level, composition, and flow of funds from all sources (public, private employers and individuals, and external) in the health sector in Zambia over the period 2013—2016. The flow of funds through the health system was tracked from the various institutional units providing the revenues to financing schemes, from financing schemes to financing agents, and all the way to functions or services and goods on which these resources are spent. In other words, the study looks at how much was spent in the health sector, the payers, and how much they paid. In so doing, the main sources and agents in health financing and how the expenditures were spread across different levels of the entire health system were identified. The analysis is split between current expenditures on health and gross capital formation.

GENERAL FINDINGS

In nominal terms, total current health expenditure (CHE) in Zambia increased by 36 percent from ZMW 7.1 billion in 2013 to ZMW 9.7 billion in 2016. On the other hand, gross capital formation increased by 76 percent from ZMW 297 million in 2013 to ZMW 521 million in 2016. The nominal increase in total CHE was mainly due to consistent annual increases in government spending in the health sector during the period under review; and high expenditures by donors in 2013 and 2016. In per capita terms, Zambia's total CHE per capita increased from ZMW487 in 2013 to ZMW607 in 2016. However, in US\$ terms, there is a declining trend in total CHE per capita from US\$90 in 2013 to US\$59 in 2016. Zambia's total CHE per capita in 2016 was below the average for lower-middle income countries (LMICs) which was estimated at US\$82 in 2016.

In terms of sources of health expenditure, the Zambian Government and the rest of the world (donors) are the two main sources of CHE, averaging about 41 percent and 42 percent per annum, respectively, of the total CHE over the period 2013 to 2016. Government's CHE increased by 87 percent from ZMW 1.98 billion in 2013 to ZMW 3.7 billion in 2016. As a percentage of general government expenditure, CHE by government stood at 6.1 percent in 2013, peaked at 8.2 percent in 2014 before declining to 7.1 percent in 2016. This level of expenditure falls short of the Abuja target of 15 percent to which Zambia is a signatory. Interestingly, the government increased capital expenditure in the health sector by 121 percent from ZMW 165 million in 2013 to ZMW 365 million in 2016. This level of investment signifies government's commitment to increasing physical access to healthcare, especially in rural areas.

Donor funding to the health sector decreased from 57.1 percent of the total CHE in 2013 to 32.5 percent of the total CHE in 2014 after which it increased steadily to 36.6 percent and 42.5 percent in 2015 and 2016, respectively. In nominal terms, donors contributed an average of ZMW 3.3 billion per annum over the period 2013–2016 of which the highest contributions of ZMW 4.1 billion were made in 2013 and 2016. Henceforth, the health sector in Zambia is still donor dependent; and it will be difficult to sustain funding and program implementation in the absence of donor funding. The other key challenge is that 70 percent of the total donor expenditure in the health sector in Zambia in 2015 and 2016 were earmarked and spent on HIV/AIDS and STIs. Earmarking reduces efficiency in resource allocation and capability of the government to optimize total funding in the health sector across all programs. On the other hand, household out-of-pocket spending on health as a share of total CHE was estimated at around 12 percent per annum over the period 2013–2016. This is lower than several countries in Africa. However, most of these funds are spent out-of-pocket due to lack of/insufficient prepayment and risk pooling mechanisms.

In case of financing agents or entities that manage funds from financing schemes, government institutions managed over half (average of 54 percent per annum) of the total CHE over the period 2013–2016 while aid agencies and NGOs managed an average of 30 percent of the total CHE in Zambia annually during the same period. In particular, HIV/AIDS programs receive a lot of financial support from donors but most of it was off-budget. This trend could be attributed to low confidence in the existing public financial management system in the health sector in Zambia. However, provision of financial support through vertical programs undermines the stewardship role of the government and its ability to allocate funds strategically. Going

forward, it will be important for donors to make greater use of government systems in order to enhance the stewardship role of government, ownership, and aid effectiveness.

A review of expenditure on primary health care programs and activities over the period 2013–2016 shows that the share of health expenditures going to providers of ambulatory healthcare has doubled from 9 percent of the total CHE in 2013 to 18 percent in 2016. Meanwhile, there has also been an upward trend in proportions allocated to hospitals from 23 percent of the total CHE in 2013 to 33 percent in 2016. Therefore, hospitals receive the bulk of the total CHE, and this calls for a realignment to primary health care. Further, the proportion of expenditures allocated to curative care is the largest and has progressively increased from 31 percent (ZMW 1.4 billion) in 2013 to 53 percent (ZMW 3.6 billion) in 2016. The share allocated to preventive care was estimated at 17 percent in 2013 and 24 percent in 2016.

DISEASE ACCOUNTS

This study also reviewed the distribution of total CHE by diseases and conditions over the period 2013–2016. The results show that HIV/AIDS, malaria, tuberculosis (TB), nutritional deficiencies, and reproductive health (RH) consumed an average of 60 percent of the total CHE per annum over the period 2013–2016. However, a further breakdown of the expenditures show that 34 percent of the total CHE was spent on HIV/AIDS and STIs on average per annum, followed by malaria at 16 percent, RH at 9 percent, and maternal conditions at 5 percent. Expenditure on respiratory infections was about 3 percent, nutritional deficiencies 1 percent, and TB was less than 1 percent of the total CHE.

Concentration of total CHE on a few diseases and conditions could be attributed to earmarking of resources by donors. As alluded to earlier, about 70 percent of the total donor CHE in the health sector in Zambia in 2015 and 2016 was earmarked and spent on HIV/AIDS and STIs. While this is probably in line with the high disease burden due to HIV/AIDS in Zambia; donor spending on malaria, nutritional deficiencies, and RH is substantively lower despite the fact that malaria, nutritional deficiencies, and poor maternal health are the highest causes of morbidity and mortality in Zambia.

HIV/AIDS subaccount

In nominal terms, there was a decline in total expenditure on HIV/AIDS (CHE on HIV/AIDS) from ZMW 3.05 billion in 2013 to ZMW 1.76 billion in 2014 and then an increase to ZMW 2.59 billion in 2015 and ZMW 3.32 billion in 2016. Expressed in US\$ terms, there was a decline in total expenditure on HIV/AIDS from US\$ 565 million in 2013 to US\$ 322 million in 2016. Most of the funding for HIV/AIDS was from donors who contributed an average of 85 percent of the total expenditure on HIV/AIDS per year in 2015 and 2016 while the government was the second largest contributor at an average of 14 percent per year in 2015 and 2016. Households and corporations played a minimal role in HIV/AIDS financing. Voluntary non-profit institutions serving households (NPISH) were the main channel through which HIV/AIDS programs were financed in Zambia in 2015 and 2016. On average, they managed about 63 percent of the total HIV/AIDS expenditures per annum in 2015 and 2016 while government institutions managed 34 percent of the total HIV/AIDS expenditures per annum over the same period.

At the provider level, an annual average of 40 percent of the total HIV/AIDS funding was managed by providers of preventive care in 2015 and 2016. These were followed by hospitals and health centres where an average of 21 percent and 13 percent of the total HIV/AIDS expenditure were utilised per year in 2015 and 2016. In terms of functions, the largest share of HIV/AIDS health expenditures were on outpatient curative care estimated at 38 percent on average per year over the period 2015–2016.

Malaria subaccounts

During the period 2013–2016, there was a minimal nominal increase in total expenditure on malaria (CHE on malaria) from ZMW 1.09 billion in 2013 to ZMW 1.27 billion in 2016. In US\$ terms, there was a decline in total expenditure on malaria from US\$ 201 million in 2013 to US\$ 123 million in 2016. Government accounted for the largest share of total expenditure on malaria at an annual average of 63 percent between 2015 and 2016 followed by donors who contributed an annual average of 26 percent during the same

period. Households also contributed a significant share averaging 9.5 percent of the total expenditure on malaria in 2015 and 2016.

The government was the largest financing agent for malaria goods and services accounting for 35 percent and 76 percent of the total expenditure on malaria in 2015 and 2016, respectively. Meanwhile, the main providers of malaria services were hospitals and providers of ambulatory care. In 2015 and 2016, providers of ambulatory care services consumed 37 percent and 40 percent of the total funding for malaria, respectively; followed by hospitals who accounted for an average of 34 percent of the total expenditure on malaria per year in 2015 and 2016. The next largest expenditure category was providers of preventive services who accounted for 27 percent of the total expenditure on malaria in 2015 and 11 percent in 2016. The drop from 27 percent in 2015 to 11 percent in 2016 calls for reprioritization of funding to preventive care services. The decline in expenditure on preventive care malaria services explains why expenditure on outpatient curative care for malaria in Zambia has been high. Between 2015 and 2016, outpatient curative care for malaria absorbed the largest share of the total expenditure on malaria at 56 percent on average per annum followed by inpatient care services at an average of 17 percent per annum during the same period.

RH subaccount

During the period 2013–2016, there was a nominal increase in total expenditure on RH (CHE on RH) from ZMW 641 million in 2013 to ZMW 892 million in 2016. In US\$ terms, there was a decline in total expenditure on RH from US\$ 119 million in 2013 to US\$ 87 million in 2016. Government was the major financier of RH services, accounting for 76 percent of total expenditure on RH in 2015 and 50 percent in 2016. The decline in government funding in 2016 was compensated for by donors who increased their contribution from 13 percent in 2015 to 36 percent in 2016. Households contributed 15 percent of the total expenditure on RH in 2015 and 12 percent in 2016.

Government institutions were the major channel through which RH resources were distributed. Between 2015 and 2016, government schemes accounted for an average of 64 percent per year, which was followed by NPISH which accounted for an average of 20 percent. Government entities remained the largest financing agents, controlling an average of 64 percent of the total expenditure on RH between 2015 and 2016 followed by NPISH at 19 percent, and households at 13 percent. RH services were mainly provided by public hospitals and health centres. Public hospital accounted for 52 percent in 2015 and 38 percent in 2016 while ambulatory services represented 22 percent and 18 percent per year in 2015 and 2016, respectively. Providers of preventive care were the third largest at 8 percent in 2015 rising to 18 percent in 2016. Inpatient curative care absorbed the largest share of total expenditure on RH at an annual average of 49 percent between 2015 and 2016 followed by providers of preventive care at 40 percent over the same period.

1.0 Background

1.1 Introduction

Zambia has been compiling National Health Accounts (NHA) since 1998. With the addition of this survey, Zambia has undertaken seven rounds of National Health Accounts (NHA) covering the period 1995 to 2016. The first five rounds of the NHA in Zambia (1995-2010) used the System of Health Accounts (SHA) 1.0 methodology while the last two rounds covering the period 2011-2016 were compiled using the SHA 2011 methodology—the revised international standard framework for producing health accounts (OECD et al., 2017). Unlike the previous framework (SHA 1.0), estimates derived from the SHA 2011 framework are more coherent, comprehensive, and consistent; and facilitates international comparability. The 2011 framework also accommodates changes in healthcare financing over the past two decades.

Specifically, the SHA 2011 framework provides a streamlined approach to understanding issues in the healthcare financing system such as: financial sustainability, effectiveness, efficiency and equity in the allocation and use of health resources. This is because the health expenditures are disaggregated by current and capital spending, and are organised around four elements consisting of: a) revenues of health financing schemes or where resources are mobilised, b) health financing schemes or entities that receive and manage funds, c) healthcare providers, and d) health functions or services on which the funds are spent. In a nutshell, the SHA 2011 framework provides a comprehensive description of sources of healthcare finances and managers of these finances, providers of healthcare, and functions on which these funds are utilized. Results that are generated from this exercise can be used for immediate and future decision-making.

1.2 Objectives of the Study

This study builds on previous NHA studies that have been undertaken in Zambia, and seeks to answer questions on core issues on healthcare financing such as:

- How are healthcare goods and services financed?
- Where does the population consume them?
- What goods and services are financed?

In particular, this study sought to achieve the following healthcare policy goals:

- Estimate total health expenditure by financing sources and where resources are mobilised;
- Document the flow of health resources within the health system through various institutional units providing revenues of financing schemes to financing agents and to its end-use;
- Describe the use of healthcare expenditures across various levels of healthcare, service areas, providers, functions, and end-users;
- Reveal healthcare expenditures by factors of provision; and
- Provide an aggregated estimate of financial flows and expenditure by disease areas specifically HIV/AIDS, Malaria, and RH.

In the pursuit of the above objectives, this report segments capital expenditures from current expenditures in line with the SHA 2011 requirements.

1.3 Country Context

1.3.1 Macro-economic Profile

Zambia is a lower middle-income country with an estimated gross domestic product of US\$21.9 billion in 2016. Between 2013 and 2016, Zambia's real GDP growth was estimated at about 4.1 percent per annum representing a slowed growth rate compared to the annual average of 6 percent between 2010 and 2013. Specifically, annual economic growth dipped from 5.1 percent in 2013 to 2.9 percent in 2015 after which it rose to 3.8 percent in 2016. The decline in economic growth was attributed to falling copper prices, depreciation of the Zambian Kwacha against the US dollar by 62 percent between the start of 2015 and end-May 2016, increasing power outages (due to reduced hydro-electric power generation), and a decline of 7.7 percent in agricultural output in 2015 as compared to 2014 due to late, low and poorly distributed rains during the 2014/15 agricultural season (World Bank, 2016). In the domestic market, the electricity supply crisis affected all economic activities. This was compounded by the consecutive fiscal deficits that averaged at about 7 percent of GDP between 2013 and 2016 and were mainly debt-financed (ibid). As a result, government's total debt rose from 27.1 percent of GDP in 2013 to 60.5 percent in 2016 due to issuance of Eurobonds. Most of this debt (36.5 percent of GDP in 2016) is external and the country has been assessed to be at high risk of external debt distress (International Monetary Fund, 2017). The prevailing macro and fiscal challenges have a negative effect on fiscal space for health.

Table 1: Selected Macro-Fiscal Indicators: 2013–2016

| | 2013 | 2014 | 2015 | 2016 |
|---------------------------------------|-------------|-------|-------|-------|
| GDP growth (annual %) | 5.1 | 4.7 | 2.9 | 3.8 |
| GDP per capita (current US\$) | 1,851 | 1,738 | 1,314 | 1,263 |
| Inflation, consumer prices (annual %) | 7.0 | 7.8 | 10.1 | 17.9 |
| Exchange rate | 5.40 | 6.15 | 8.63 | 10.31 |
| Fiscal deficit (cash basis) (% GDP)^ | 6.7 | 5.4 | 9.4 | 5.7 |
| Total Public debt (% GDP)* | 27.1 | 35.6 | 61.4 | 60.5 |
| <i>Domestic debt (% GDP)</i> | 13.2 | 15.5 | 18.3 | 24 |
| <i>External debt</i> | 13.8 | 20.1 | 43.1 | 36.5 |
| Poverty** | 60.5 (2010) | - | 54.4 | - |
| Gini Coefficient (Income based)** | 0.65 (2010) | - | 0.69 | - |

Sources: All indicators World Development Indicators¹ except for ^World Bank (2016); (World Bank, 2017); *IMF (2017); ** Central Statistics Office (2016)

Equitable distribution of wealth by geographical areas and income-status has historically been challenging in Zambia even when the economy was registering high annual GDP growth rates averaging 7.4 percent between 2004 and 2014, and 6 percent between 2010 and 2013. The 2015 Living Conditions Monitoring Survey (LCMS) reveals that 54 percent of the population were poor in 2015, with 41 percent experiencing extreme poverty as per the national poverty line (Central Statistical Office, 2016). Poverty is largely a rural phenomenon with 77 percent of the households residing in rural areas being poor as compared to 23 percent of the households in urban areas. The 2015 LCMS further showed that 56 percent of the total household incomes in Zambia were earned by the top 10 percent of households while the bottom 50 percent of households only earned seven percent of the total household incomes (ibid). With a Gini Coefficient of 0.69 (0.60 for rural areas and 0.61 for urban areas), Zambia is one of the countries in sub-Saharan Africa (SSA) with the most unequally distributed income (ibid).

1 Downloaded on 1st January 2019 from <http://datatopics.worldbank.org/world-development-indicators/>

1.3.2 Demographic and Health Profile

Most of the country's demographic and health indicators improved significantly over the 2006–2016 decade (table 2). For instance, total fertility rate (births per woman) improved by 12 percent while the percentage of children aged 12-23 months immunized against measles, and the percentage of births attended by skilled health personnel increased by 9 percent and 40 percent, respectively. These improvements contributed to substantial reductions in maternal and child mortality, and an increase in life expectancy as outlined in table 2. Despite this progress, infant and under-5 mortality rates and other key indicators in Zambia are higher than the averages for lower-middle income countries (LMICs) (table 2). This could be attributed to a high prevalence of HIV among the 15-49 age group and stunting in under-five children. The total fertility rate is also high, and this has a huge impact on population growth which increased by 34 percent between 2006 and 2016. Given the high fertility levels and large youth population, Zambia is expected to continue experiencing significant population growth as more children enter the reproductive age. High population growth would increase the demand for jobs, health and other social services which the economy is currently not able to provide—and undermine Zambia's growth prospects.

Table 2: Selected Demographic and Health Indicators: Zambia (2006-2016)

| Indicator | 2006 | 2016 | Change | LMIC |
|---|------|------|--------|------|
| Population, total (millions) | 12.4 | 16.6 | 34% | |
| Total fertility rate (births per woman) | 5.7 | 5.0 | -12% | 2.8 |
| Children 12-23 months immunized against Measles (%) | 85 | 93 | 9% | 81 |
| Births Attended by Skilled Health Personnel (%) | 45 | 63 | 40% | 75 |
| Prevalence of HIV (population 15-49 years) (%) | 12.7 | 11.8 | -7% | 0.6 |
| Prevalence of Stunting in children under-five (%) | 46 | 40 | -13% | 32 |
| Infant Mortality Rate (deaths per 1,000 live births) | 63 | 43 | -32% | 38 |
| Under-five Mortality Rate (deaths per 1,000 live births) | 103 | 62 | -40% | 50 |
| Maternal Mortality Ratio (deaths per 100,000 live births) | 338 | 224 | -34% | 257 |
| Life Expectancy at Birth | 51 | 62 | 22% | 69 |

Source: All indicators from World Development Indicators² LMIC = Lower-Middle Income Country

It is also worth noting that communicable diseases and conditions such as malaria, HIV/AIDS, TB, respiratory infections, diarrhoeal disease and traumas continue to be the main contributors to the country's burden of disease. Recently, non-communicable diseases such as neoplasms, diabetes and hypertension have become common due to changing lifestyles. The changing epidemiological profile has a negative impact on the health system, and how healthcare is financed.

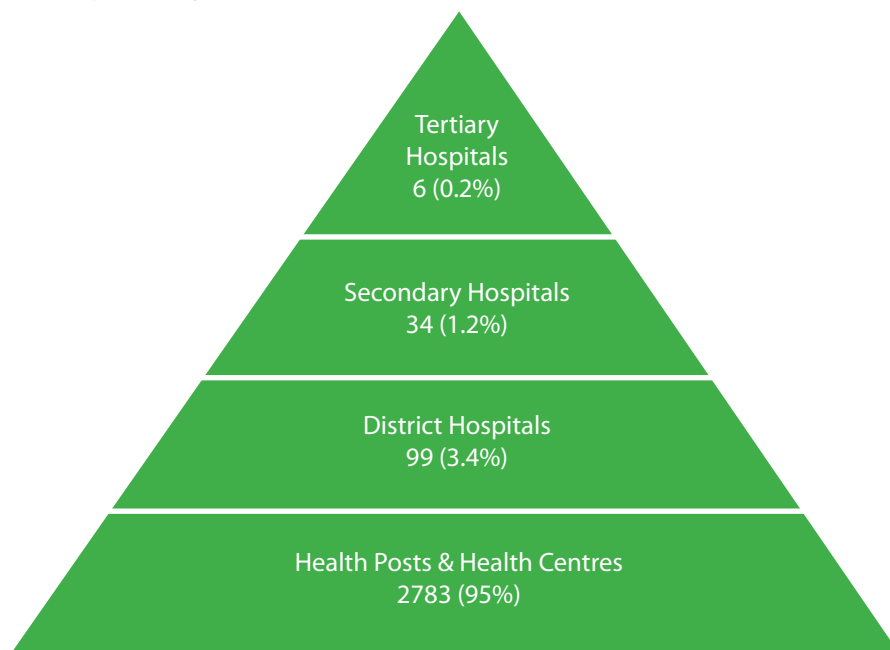
1.4 Organization of the Health System in Zambia

Zambia has a pyramid-structured healthcare delivery system which comprises both public and private healthcare providers (figure 1). Private facilities are divided into private for-profit and private not-for-profit health providers. Most of the private not-for-profit health providers are faith-based and deliver health services in close collaboration with the Ministry of Health (MoH). The health system consists of three levels namely: (i) the district level where Primary Health Care (PHC) services are provided through health posts, health centers, and district hospitals; (ii) the secondary level that consists of general/secondary level referral hospitals which provide curative care in internal medicine, pediatrics, obstetrics and gynecology, and general surgery; and (iii) the tertiary level where specialized care is provided. By the end of 2017, Zambia had a total of 2,922 public and private health facilities (figure 1). The government owned about 80 percent of the total number of health facilities in the country in 2017, and about 80 percent of all health care was delivered through the public sector.

² Downloaded on 1st January 2019 from <http://datatopics.worldbank.org/world-development-indicators/>

Zambia aspires to attain universal health coverage (UHC) as stipulated in the National Health Policy which underscores government’s commitment to “providing equitable access to cost effective and quality health services as close to the family as possible in a caring, competent and clean environment” (Ministry of Health, 2012). Among the measures to facilitate the attainment of UHC, medical user fees were abolished in rural areas, peri-urban areas, and all primary health care facilities countrywide in 2006, 2007, and 2012, respectively. In addition, the country has been using a needs-based resource allocation formula to allocate operational funding from the MoH headquarters to the districts since 2004. With regards to implementation, the MoH has historically been the main implementing agency in the health sector but briefly shared the mandate with the Ministry of Community Development Mother and Child Health (MCDMCH) during the period 2011–2015.

Figure 1: Pyramid of Health Facilities (Public & Private) in Zambia, 2017



Source: Author’s construction from Ministry of Health (2018)

1.5 Organization of the Report

The next section of this report (Chapter 2) provides the methodology and entities surveyed in the study. Chapter 3 presents general findings on current expenditures from financing sources to financing schemes and agents, level of health care, health providers and functions. In Chapter 4, an analysis of gross capital formation is provided, and this is broken down by financing sources, health providers, and functions is presented. Lastly, in Chapter 5, total CHE is broken down by diseases and conditions by financing sources, financing schemes and agents, health care providers and functions.

2.0 Methodology

This study uses the SHA 2011 framework (OECD et al., 2017) to derive the health expenditures over the period 2013–2016. The framework describes the health expenditure estimates according to a global standard framework, which provides a standardized approach to classifying health expenditures according to consumption, provision, and financing. It also provides a structure for collecting, cataloguing, and estimating all monetary flows related to healthcare and healthcare-related expenditures allowing for international comparisons. The SHA 2011 framework builds on the previous methodology (SHA 1.0) by providing more clear distinctions of classifications at different levels of the health system. The major classifications used in this report are provided in Table 3:

Table 3: Health Accounts Classifications and Definitions

| Classification | Definitions and Examples |
|--------------------------------------|---|
| Revenues of Financing schemes (FS) | Types of transactions through which funding schemes mobilize their income. Examples include internal transfers (from the ministry of finance to governmental agencies); direct foreign financial transfers (e.g. External donors providing funds to non-governmental organizations (NGOs); and voluntary prepayment from employers. |
| Financing schemes (HF) | This refers to the main funding mechanisms by which people obtain health services, answering the question “how are health resources managed and organized and how the healthcare goods and services are financed or paid for”. Spending is categorized according to criteria such as: the mode of participation in the scheme (compulsory vs. voluntary), the basis for entitlements (contributory vs. non-contributory). |
| Revenues of Financing schemes (FSRI) | The institutional units that provide revenues for the various schemes. Examples are government, corporations, households, rest of world (such international foundations), and NPISH. |
| Financing agents (FA): | These are institutional units that manage one or more health financing schemes. Examples include MoH, commercial insurance companies, NGOs and international organizations. |
| Healthcare providers (HP): | These are entities or organizations and actors who provide medical goods and services as their main activity, as well as those for whom the provision of healthcare is only one activity among many others. Examples include hospitals, clinics, health centres, pharmacies and traditional healers. |
| Healthcare functions (HC): | The goods and services consumed by health end-users. Examples include: curative care; information, education, and counselling programs; medical goods such as supplies and pharmaceuticals; and governance and health system administration. |
| Factors of provision (FP): | These are inputs to the production of healthcare goods and services by healthcare providers. Examples include: compensation of employees, healthcare goods and services. |
| Healthcare-Related (HCR) | These are activities that may overlap with other fields of study, such as education, overall “social” expenditure, and R&D, and sometimes may be closely linked to healthcare in terms of operations, institutions, and personnel. |
| Capital formation (HK) | These are assets which once acquired can be used for a period longer than one year such as infrastructure or machinery investment, as well as education and training of health personnel. |
| Disease (DIS) | These are ailments, conditions or intervention areas by which health expenditure is analyzed. Examples are malaria, Dengue, RH, trauma, and NCDs. |

Source: OECD et al. (2017) *A System of Health Accounts 2011: Revised edition*

2.1 Definition of Health Expenditure and Boundaries

The boundary of “health” in the health accounts is “functional” in that it refers to activities whose primary purpose is disease prevention, health promotion, treatment, rehabilitation, and long-term care. Thus, this report considers expenditures for all activities whose primary purpose is to restore, improve, and maintain health from all institutions (such as government, traditional healers and non-governmental) involved in healthcare delivery. The health expenditures constituted those incurred on:

- Health promotion and prevention
- Diagnosis, treatment, cure and rehabilitation of illness
- Caring for persons affected by chronic illness
- Caring for persons with health-related impairment and disability
- Palliative care
- Governance and administration of the health system
- Providing community health programs

The previous NHA studies that have been conducted in Zambia aggregated all the health expenditures to come up with the total health expenditure (THE). However, in the SHA 2011 methodology, expenditures are reflected as CHE and gross capital formation for health. CHE constitutes of all economic resources spent on health functions, and represents the final consumption of health goods and services by residents of the country within the year of estimation (OECD et al., 2017). On the other hand, gross capital formation for health is measured by the total value of assets that providers of health services have acquired during the accounting period and that are used repeatedly for more than one year in the provision of health services (ibid).

2.2 Data Collection

Information was collected from primary and secondary sources over the period August–October 2017. Primary data was collected from donors and aid agencies, NGOs, employers and private medical schemes, while secondary data was collected from the Zambian Government using financial (expenditure) reports, and estimates of household expenditures through the 2014 Zambia household expenditure and utilization survey (Ministry of Health, 2014). Data was collected by trained research assistants who visited all sampled institutions under the supervision of the technical team. The research team vetted all the questionnaires used in primary data collection to ensure compliance with SHA 2011 methodology. The institutions from which data was collected are discussed below.

2.2.1 Government

Government expenditure data was obtained from audited financial reports (blue books). The major government ministries that provided curative health services during this period were the MoH, the MCDMCH and the Ministries of Defence and Home Affairs. The data from all other ministries that predominantly provide workplace programs especially for HIV/AIDS were also included in this report. The data was triangulated with information from the integrated financial management system and budget status reports. This triangulation aimed to ensure that the data reflects the actual expenditures for each year and minimises the risk of double-counting the development assistance for health. A number of government statutory bodies and parastatals also provide healthcare services, and regulation. These were also surveyed to capture all expenditures, especially from donor sources that provide support directly to these institutions and may not be captured by the central government or MoH.

2.2.2 Households

Household expenditure on health was obtained from the nationally representative 2014 Zambia household health expenditure and utilisation survey (Ministry of Health, 2014). The survey generated information on household expenditures on health including out-of-pocket payments, and its distribution. It also highlighted the factors that influence the use of various health services and providers. The total estimate by source, provider and function was extrapolated using the consumer price index over the years period under review.

2.2.3 Donors

All the bilateral and multilateral donors working in the health sectors were captured. The data was collected using tailor-made questionnaires that included comprehensive questions on the flow of resources through the health sector. The donors provide aid through the central government at the Ministry of Finance (on-budget), directly to the MoH through basket funding or sector support at the headquarters, and through vertical programs or projects at provincial, districts and facility level. In addition, some donors provide funding through aid agencies and NGOs while other donors implement programs themselves. A total of 18 key donors were identified through this process and all except one completed the survey. The data was triangulated for accuracy using the NGO survey and government donor data.

2.2.4 Employers and Insurance Providers

Employers tend to have workplace programs aimed at improving employees' health. During this round of the NHA, a complete list of formal sector employers was obtained from the economic census database. Since a large number of the firms indicated that they did not incur health expenditures, only firms that reported to have some health expenditure and employed at least 250 people were listed for sampling. The process yielded a sample of 93 firms cutting across different economic sectors such as agriculture, manufacturing, transport education, telecommunication, and financial institutions. This allowed the team to assess the financial role of these entities within the Zambian health system. A total of 48 firms responded to the survey questionnaire and the information was used to estimate the total expenditures by firms. In addition, insurance firms were also surveyed as agents. Only four of the 21 insurance firms indicated that they provide health insurance.

2.2.5 Non-Governmental Organizations

A number of NGOs are involved in healthcare delivery in Zambia. They often operate using financial resources received from donors. A complete list of NGOs involved in the health sector was compiled based on the previous NHA studies and consultations with the MoH and other stakeholders. Through this approach 53 NGOs were identified and deemed eligible for inclusion in the survey sample. The expenditure collected from NGOs was triangulated with the donor and government reports to avoid double counting.

2.3 Data Analysis

At the questionnaires design stage, a number of adjustments were made to the classifications and coding rules to customize the SHA 2011 framework to the country-specific context. Once data was collected, the technical review team undertook validation and consistency checks. Thereafter, the data was entered into Excel and uploaded into the Health Accounts Production Tool (HAPT), which was used to analyze the results. The HAPT is a standardized tool developed by the WHO and USAID and helps to estimate resource flows with a well-defined procedure and methodology that enhances the data quality by checking for double-counting and errors in the allocation of classification codes.

2.3.1 Analysis of non-targeted Expenditures

The NHA reports data from the source to the level of care and functions, such as diseases, or inpatient and outpatient spending. However, most institutions are unable to disaggregate actual expenditures by these categories. In order to fill this gap, the research team developed the distribution keys for the disease,

and inpatient and outpatient breakdowns using utilisation data from the health management information system. The number of inpatient admissions was converted to average bed days for each level of care. Unit costs were applied to these average bed days as well as the number of outpatient visits to determine the total costs by the type of service used. The unit costs were provided by the MoH based on historical costs of service provision as reflected in the Basic Healthcare Package, and expenditure patterns from the 2014 household expenditure and utilisation survey (Ministry of Health, 2014). Each type of service was categorised according to the function and disease classifications. The relative proportions of the total costs were then used to determine the allocations by level of care, function and disease.

2.4 Limitations of the Study

The study managed to collect data from a number of institutions that provide health services. However, a number of challenges can be observed.

- a) During the study period, government health services were provided through the MoH and the MCDMCH. The splitting of the two ministries made it difficult to accurately track government expenditure for several reasons. The MCDMCH, which was charged with the responsibility of managing primary healthcare, also provided other services such as social welfare services, cash transfers etc. While health expenditures at district level were earmarked, expenditures at the headquarters were mainly in aggregate form. Thus, non-health expenditures may have been included in this report, which may have resulted in the over-estimation of health expenditures in some years.
- b) The response rate for employers and insurance companies was less than expected. This could lead to under-estimation of expenditures from these sources.
- c) Most of the expenditures in Zambia's health system are recorded in a manner that does not exactly conform to the existing SHA 2011 classifications and codes for health financing schemes. Thus, there is a possibility of mismatching expenditures across the reporting systems. However, the team took due diligence to minimize such errors.

3.0 General Health Accounts

This section presents the estimated health expenditures for Zambia at various levels of disaggregation. The structure follows the prescribed format for writing health accounts reports (OECD et al., 2017). It begins by describing resource flows through the health care system from financing sources and types of revenues to financing schemes, from financing schemes to providers, and from providers to the health care goods and services. A number of tables and figures are presented taking into consideration the Zambian context and usefulness for policy and planning in Zambia, international comparability, and feasibility of their construction.

3.1 Level and Composition of Health Financing in Zambia

Zambia's nominal CHE estimates from all sources, including government, donors, household and NPISH for the period from 2011 to 2016 are presented in Table 4. Total CHE increased in nominal terms by 36 percent from ZMW 7.1 billion in 2013 to ZMW 9.7 billion in 2016. This increase was mainly from government which increased its current expenditure to the health sector in absolute terms by 87 percent from ZMW 1.98 billion in 2013 to ZMW 3.7 billion in 2016; and high expenditures by donors amounting to ZMW 4.1 billion in 2013 as well as 2016. However, the real value was eroded by the deterioration in the macroeconomic indicators, particularly the inflation and exchange rate in 2014 and 2015. For example, in US dollar terms, the total CHE declined from a peak of US\$1.3 billion in 2013 to US\$938.34 million in 2016. Similarly, total CHE per capita fell from US\$90.33 in 2013 to US\$58.87 in 2016 (table 4). Zambia's total CHE per capita in 2016 was below the average for lower-middle income countries (LMICs) which is estimated at US\$82.

Total CHE accounted for only 4.7 percent and 4.5 percent of GDP in 2013 and 2016, respectively. This is relatively in line with the recommendation by the Sustainable Development Solutions Network (SDSN) for all countries to allocate at least 5 percent of their national GDP as public financing for health to achieve health and wellbeing at all ages (SDSN, 2014). However, government CHE was only 1.8 percent of GDP on average over the period 2013–2016. Moreover, government CHE as a percentage of general government expenditure was about 7.2 on average per year over the period under review. This shows that government did not meet the Abuja target of spending at least 15 percent of its domestic revenue on health. In per capita terms, government CHE was about US\$28 per annum over the study period, having dropped from US\$34.24 in 2014 to US\$22.54 in 2016.

Table 4: Level and Composition of Health Financing in Zambia: 2013–2016

| | 2013 | 2014 | 2015 | 2016 |
|--|----------|----------|----------|-----------|
| Nominal total CHE (ZMW millions) | 7,098.90 | 6,396.78 | 8,134.79 | 9,674.31 |
| Nominal total capital spending (ZMW millions) | 296.92 | 500.09 | 304.48 | 521.30 |
| Nominal Total Health Expenditure (current plus capital spending) (ZMW millions) ³ | 7,395.82 | 6,896.87 | 8,439.27 | 10,195.61 |
| Nominal total CHE (US\$ millions) | 1,317.05 | 1,040.13 | 942.62 | 938.34 |
| Government CHE (ZMW millions) | 1,982.20 | 3,163.70 | 3,833.80 | 3,704.60 |
| Donor CHE (ZMW millions) | 4,056.80 | 2,082.07 | 2,977.06 | 4,115.03 |
| Households - Out of Pocket (OOP) Expenditure (ZMW millions) | 810.00 | 884.00 | 996.00 | 1,177.00 |
| Employers CHE (ZMW millions) | 235.60 | 265.90 | 321.00 | 673.80 |
| NPISH CHE (ZMW millions) | 11.60 | 0.40 | 3.90 | 4.30 |
| Other institutions CHE (ZMW millions) | 2.30 | 0.90 | 0.90 | 1.00 |
| Total CHE per capita (US\$) | 90.33 | 69.23 | 60.92 | 58.87 |
| Government CHE per capita (US\$) | 25.22 | 34.24 | 28.71 | 22.54 |
| Donor CHE per capita (US\$) | 51.62 | 22.53 | 22.29 | 25.04 |
| Government CHE % total CHE | 27.9 | 49.5 | 47.1 | 38.3 |
| Donor CHE % total CHE | 57.1 | 32.5 | 36.6 | 42.5 |
| Total CHE % GDP | 4.7 | 3.8 | 4.4 | 4.5 |
| Government CHE % GDP | 1.3 | 1.9 | 2.1 | 1.7 |
| Government CHE % General Government Expenditure (GGE) | 6.1 | 8.2 | 7.4 | 7.1 |
| OOP Expenditure % total CHE | 11.4 | 13.8 | 12.3 | 12.2 |
| OOP Expenditure % GDP | 0.5 | 0.5 | 0.5 | 0.5 |
| Corporations CHE % total CHE | 3.3 | 4.2 | 4.0 | 7.0 |

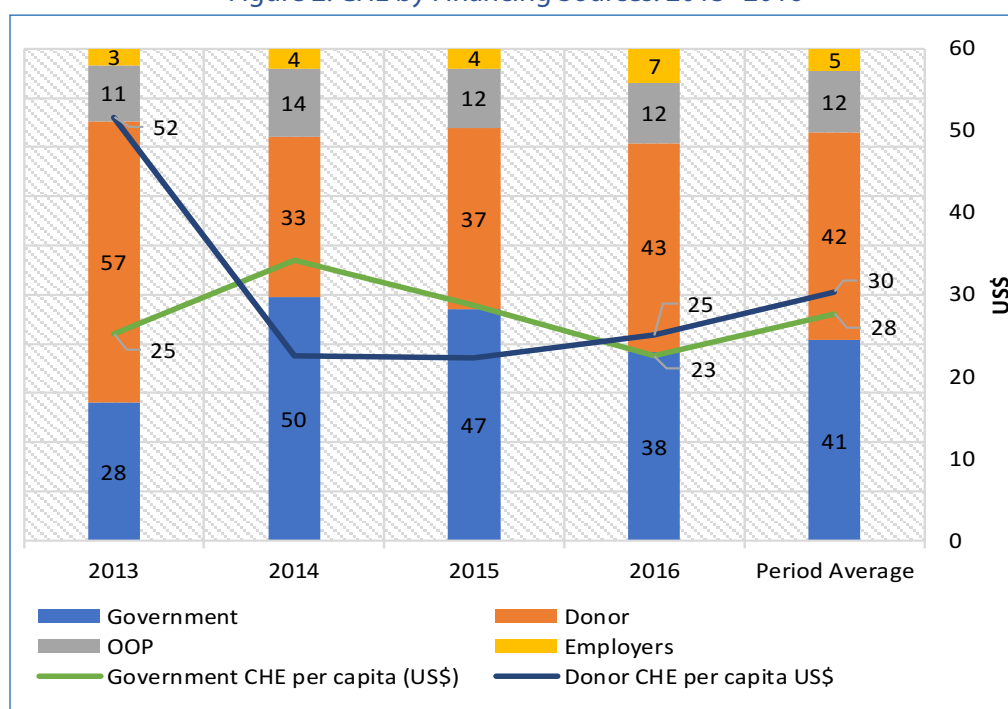
Source: Author's compilation from survey data

Trends in the composition of total CHE are shown in Figure 2. Government CHE as a share of total CHE rose from 28 percent in 2013 to 50 percent in 2014 before declining to 38 percent in 2016. In absolute terms, the government increased its current expenditure in the health sector by 87 percent between 2013 and 2016 which is equivalent to 22 percent per annum. This increase was driven by government's commitment to investing in health sector to close the resource gap in the face of stagnant donor support to the health sector during the period under review. The share of total CHE contributed by donors has remained at the same levels. It reduced from 57 percent in 2013 (when there was almost twice as much donor funding compared to other years), to a low of 33 percent in 2014 and then increased steadily to 43 percent 2016 (figure 2). In nominal terms, donor CHE was basically static having increased marginally from ZMW 4.06 billion in 2013 to ZMW 4.12 million in 2016 (table 4).

Households were the third largest institutional unit providing resources for health services with a annual average of 12.4 percent of total CHE over the period under review (figure 2). These contributions were in form of out-of-pocket (OOP) expenditure for travelling expenses to health facilities, drugs and other services not available at public health facilities. Household OOP expenditure increased by 45 percent over the period under review from ZMW 810 million in 2013 to ZMW 1.18 billion in 2016 (table 4). At 12 percent of total CHE, OOP spending on health in Zambia is lower than several countries in Africa. Meanwhile, contributions from employers increased from 3 percent in 2013 to 7 percent of total CHE in 2016 (figure 2). In nominal terms, employers' contribution more than doubled from ZMW 236 million in 2013 to ZMW 674 million in 2016 (table 4). Employer contributions are primarily through their own health facilities and insurance schemes for their employees. This level of contribution by private employers relative to the size of the private sector remains low. However, the contribution by employers is likely to increase once the recently introduced compulsory national health insurance scheme becomes operational.

3 Total health expenditure is no longer allowed in SHA 2011. However, this indicator is included for continuity reasons with respect to SHA 1.0. See page 347 of the SHA 2011 Manual: OECD, Eurostat & World Health Organization. (2017). A System of Health Accounts 2011: Revised edition. Paris: OECD Publishing

Figure 2: CHE by Financing Sources: 2013–2016



Source: Author's compilation from survey data

In a nutshell, results from this subsection show that the health sector is dependent on external assistance (donors) with an annual average of 42 percent (US\$30 per capita) of the total CHE coming from donors during the period 2013–2016, and 41 percent (US\$28 per capita) from government (figure 2). Since the country attained the lower-middle income country status in 2011, many donors are likely to reduce their support to the country. Thus, policy makers have to devise strategies of improving the fiscal space for health to cover for the expected shortfalls in the sector.

3.2 Flow of Revenues of Financing Schemes

In line with the definitions outlined in the SHA 2011 Manual (OECD et al., 2017), financing schemes are defined as “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” (p. 341). Since financing schemes are involved in revenue mobilisation, health accounts have to highlight where the funding came from, how the funding flows, and the nature of the funding flows. Analysing revenues of financing schemes is important in tracking the revenue collection mechanisms in a health financing framework; and to inform policy makers on the existing mechanisms for financing the healthcare system. Therefore, this section presents the financing path to funding the various financing schemes in the country.

The results show that the main channels of disbursing funds from financing sources to financing schemes in Zambia was through direct foreign financial transfers, internal transfers and grants, transfers distributed by government from foreign origin, voluntary prepayments from households, voluntary prepayments from employers, and other unclassified domestic revenues (Table 5 and Figure 3). Transfers from government domestic revenue (internal transfers and grants) increased by 25.8 percent on average per year over the period under review while transfers by government from foreign origin increased by 67.6 percent per annum, and voluntary prepayments from employers by an annual average of 50.7 percent (table 5).⁴ Meanwhile, direct foreign transfers declined marginally by an annual average of 1.2 percent during the period under review.

⁴ This was done by calculating the relative percentage change in the current year against the previous year, and then averaging.

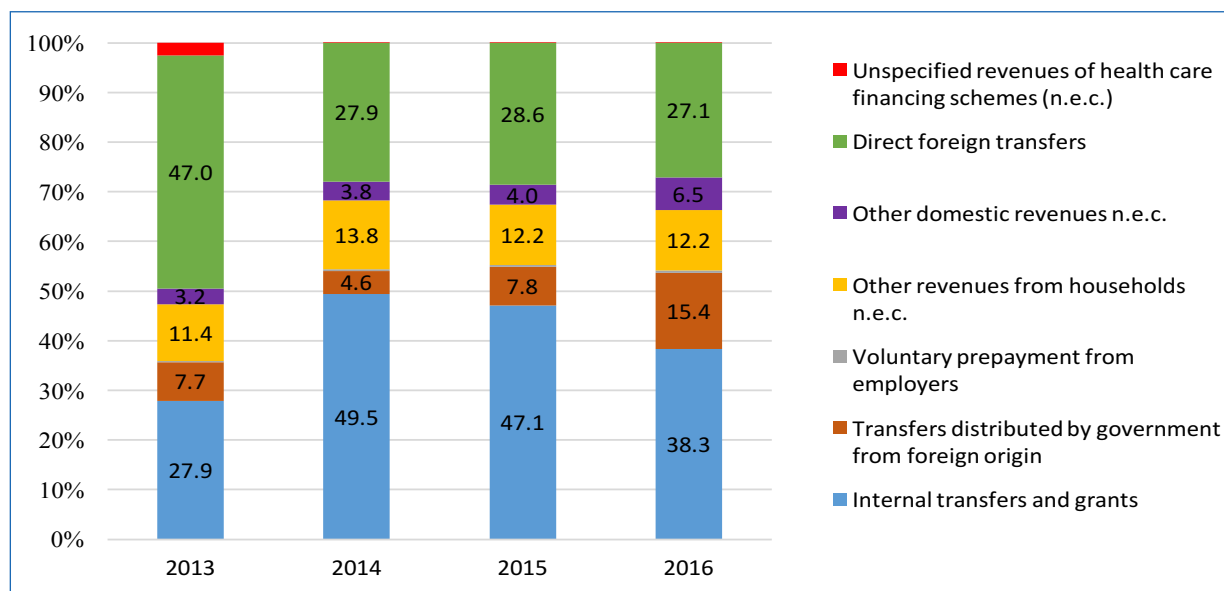
Table 5: Funding Mechanisms for Financing Schemes: 2013–2016

| | 2013 | 2014 | 2015 | 2016 | Annual average growth (%) |
|--|-----------------|-----------------|-----------------|-----------------|---------------------------|
| Internal transfers and grants | 1,982.20 | 3,163.69 | 3,833.66 | 3,704.58 | 25.8 |
| Transfers distributed by govt from foreign origin | 549.77 | 295.49 | 633.94 | 1,487.39 | 67.6 |
| Voluntary prepayment from employers | 18.60 | 20.67 | 21.55 | 51.03 | 50.7 |
| Other revenues from households. | 810.48 | 884.03 | 996.22 | 1,176.57 | 13.3 |
| Other domestic revenues n.e.c. | 224.08 | 245.84 | 323.86 | 631.49 | 45.5 |
| Direct foreign transfers | 3,336.47 | 1,786.58 | 2,323.29 | 2,624.09 | -1.2 |
| Unspecified revenues of healthcare financing schemes | 177.16 | 0.57 | 0.63 | 0.12 | -56.7 |
| Total | 7,098.80 | 6,396.86 | 8,133.13 | 9,675.27 | 12.1 |

Source: Author's compilation from survey data

Figure 3 further shows that transfers from government domestic revenue (internal transfers and grants) were the main channel for disbursing funding to financing schemes accounting for 27 percent (ZMW 1.98 billion) of the total CHE in 2013, and this increased to 49.5 percent in 2014 (ZMW 3.16 billion) and then declined to 38.3 percent (ZMW 3.70 billion) in 2016. Direct foreign transfers dropped from 47 percent in 2013 to 27.1 percent in 2016. The decline in direct foreign transfers has been associated with an increase in the transfers distributed by government from foreign origin. These transfers accounted for 7.7 percent in 2013, declined to 4 percent in 2014 before rising to 15.4 percent in 2016. The relative increase in transfers by government from foreign sources reflects the increasing donor confidence in the use of government disbursement mechanisms in 2015 and 2016. OOP remained the main channel by which households made their contributions to the health sector and this was estimated at an annual average of 12 percent of total CHE during the period under review. Flow of funds through voluntary funded prepayment schemes (mainly through private insurance schemes) remained insignificant as they only accounted for an average of 0.3 percent of the total CHE per annum during the period under review.

Figure 3: Shares of Funding Mechanisms for Financing Schemes: 2013–2016

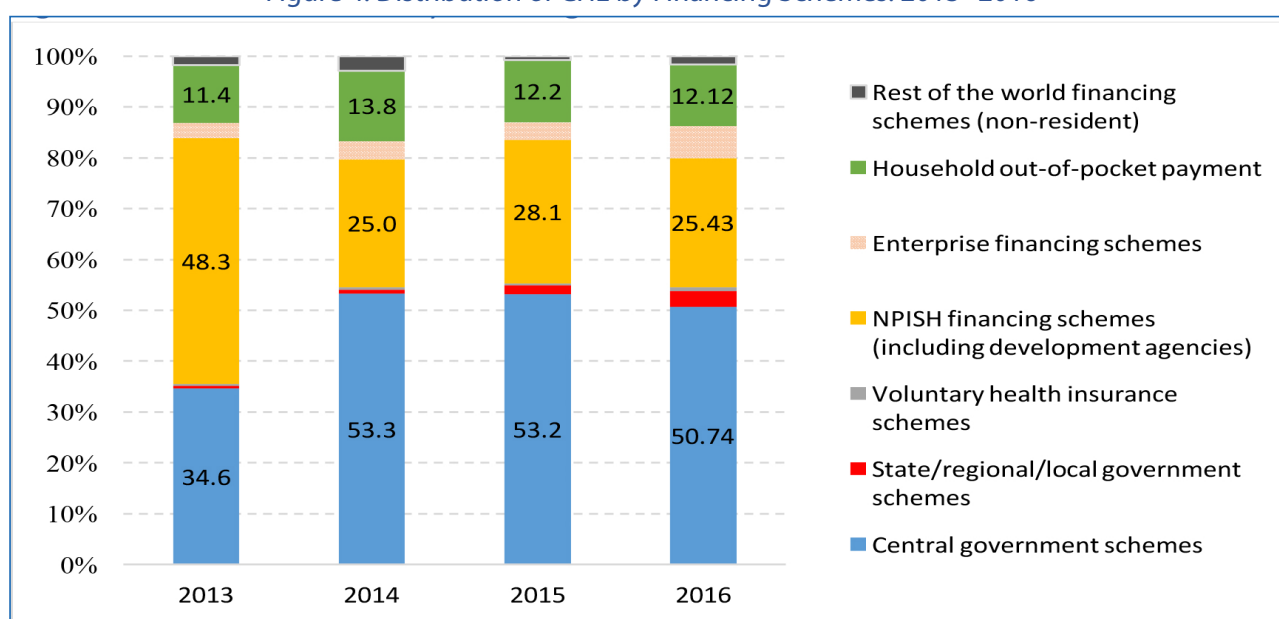


Source: Author's compilation from survey data

3.3 Distribution of CHE by Financing Schemes

As earlier stated, financing schemes are structural components of the health financing system through which revenues are received and used to fund payments for good and services. By so doing, financing schemes define how healthcare resources are pooled in a healthcare system. In line with the SHA 2011 framework, the main financing schemes in Zambia are: central government schemes, local government schemes, voluntary health insurance schemes, NPISH schemes, enterprise financing schemes, Household OOP payment, and rest of the world (donor) financing schemes. The key channels through which the healthcare goods and services were paid for and how they have changed during the period under review are presented in Figure 4. Over the study period, central government schemes became an increasingly important channel for financing the health sector. Over half of the healthcare funding was provided through central government schemes. Their share increased from 34.6 percent in 2013 to 53 percent in 2014 and 2015 before declining marginally to 50.7 percent in 2016. NPISH financing scheme (including aid agencies by donors), were the second largest financing scheme despite a decline from 48.3 percent in 2013 to 25.4 percent in 2016.

Figure 4: Distribution of CHE by Financing Schemes: 2013–2016



Source: Author's compilation from survey data

The nominal values of CHE channelled through the various financing schemes are presented in Table 6. The results show that all the financing schemes registered growth during the period under review except for NPISH. Local government schemes registered the fastest annual average growth rate at 105.7 percent, albeit starting from a very low base of ZMW 37.7 million in 2013 rising to ZMW 292 million in 2016.

Table 6: Distribution of CHE by Financing Schemes: 2013–2016 (ZMW million)

| | 2013 | 2014 | 2015 | 2016 | Annual growth (%) ⁵ |
|--|-----------------|-----------------|-----------------|-----------------|--------------------------------|
| Central government schemes | 2,459.70 | 3,407.80 | 4,329.10 | 4,909.60 | 26.3 |
| State/regional/local government schemes | 37.70 | 51.30 | 138.50 | 292.30 | 105.7 |
| Voluntary health insurance schemes | 27.80 | 31.10 | 32.30 | 69.30 | 43.4 |
| NPISH schemes (including aid agencies by donors) | 3,429.00 | 1,601.10 | 2,286.80 | 2,460.50 | -1.0 |
| Enterprise financing schemes | 209.10 | 236.30 | 290.70 | 609.50 | 48.6 |
| Household out-of-pocket payment | 809.70 | 883.40 | 995.50 | 1,172.40 | 13.2 |
| Rest of the world financing schemes (non-resident) | 125.70 | 185.90 | 60.20 | 161.60 | 49.6 |
| Total | 7,098.80 | 6,396.90 | 8,133.10 | 9,675.30 | 12.1 |

Source: Author's compilation from survey data

⁵ This was done by calculating the relative percentage change in the current year against the previous year, and then averaging.

3.4 Financing Agents for CHE

Financing agents are institutional units that manage healthcare financing in the health system. Table 7 shows the level of CHE resources managed by each institutional unit and how their contributions have changed over time. The share of resources managed by government entities increased from 35.8 percent (ZMW 2.5 billion) in 2013 to 53.8 percent (ZMW 5.2 billion) in 2016. The MoH managed and controlled the largest share of CHE resources over the period 2013 to 2016. The share stood at 49.7 percent (ZMW 4.8 billion) in 2016 having risen from 27.8 percent (ZMW 1.98 billion) in 2013. The amount managed by other ministries increased in 2014 and 2015 and then dropped in 2016 due to changes in the responsibility of managing primary healthcare from the MoH to MCDMCH and vice versa during the period under review.

NPISH implement a number of donor programs off-budget. They managed a significant share of total CHE at 47 percent (ZMW 3.4 billion) of total CHE in 2013, which declined sharply to 26.7 percent (ZMW 1.7 billion) in 2014 and to 25.4 percent in 2016. On the other hand, households continued to manage their own resources through OOP spending and this was estimated at about 12.8 percent of total CHE over the period under review. Resources managed by corporations trebled from ZMW 209 million (3 percent) in 2013 to ZMW 610 million (6 percent) in 2016 (table 7). Resources managed through the private health insurance sector increased from ZMW 27.85 million (0.4 percent of total CHE) in 2013 to ZMW 69.31 million (0.7 percent of total CHE) in 2016. This increase signifies a growing interest in health insurance in the country.

Table 7: Distribution of CHE by Financing Agents: 2013–2016

| Financing agent | 2013 | % | 2014 | % | 2015 | % | 2016 | % |
|-------------------------------------|----------------|------------|-----------------|------------|----------------|------------|---------------|------------|
| Central government | 2,542.6 | 35.8 | 3,459.2 | 54.1 | 4,467.6 | 54.9 | 5201.9 | 53.8 |
| <i>Ministry of Health</i> | 1,976.8 | 27.8 | 2,259.0 | 35.3 | 2,694.3 | 33.1 | 4804.2 | 49.7 |
| <i>Other Ministries</i> | 565.7 | 8.0 | 1,200.2 | 18.8 | 1,773.3 | 21.8 | 397.7 | 4.1 |
| Insurance corporations | 27.8 | 0.4 | 31.1 | 0.5 | 32.3 | 0.4 | 69.3 | 0.7 |
| Corporations (Other than insurance) | 209.1 | 2.9 | 236.3 | 3.7 | 290.7 | 3.6 | 609.5 | 6.3 |
| NPISH | 3,384.0 | 47.7 | 1,705.3 | 26.7 | 2,287.0 | 28.1 | 2460.5 | 25.4 |
| Households | 809.7 | 11.4 | 883.4 | 13.8 | 995.5 | 12.2 | 1172.4 | 12.1 |
| Rest of the world | 125.5 | 1.8 | 81.6 | 1.3 | 60.1 | 0.7 | 161.6 | 1.7 |
| Total | 7,098.8 | 100 | 6,396.86 | 100 | 8,133.1 | 100 | 9675.3 | 100 |

Source: Author's compilation from survey data

3.5 Expenditure by Healthcare Providers and Functions

In the SHA 2011 context, healthcare providers include organisations and actors committed to delivering healthcare goods and services to the population. Health providers exist at different levels within the healthcare system. Functions are categories of health goods and services consumed by final users to attain a specific health outcome. These are discussed in more detail below.

3.5.1 Total CHE by Healthcare Provider

There are many providers of health services and products in Zambia including hospitals, nursing and residential care facility providers, ambulatory healthcare providers, retail sale and medical goods providers, and public health program providers. Table 8 and Figure 5 shows the distribution of health expenditures accounted for by each of these providers for the period 2013–2016. Hospitals remain the main recipient of total CHE. On average, about 30 percent of the total CHE was spent on hospitals during the period under review. There has been an upward trend in proportions from 24.2 percent in 2013 to 33.8 percent in 2016. The amount spent on ambulatory healthcare providers nearly trebled from ZMW 739 million in 2013 to ZMW 1.9 billion in 2016. As a percentage of total CHE, providers of ambulatory healthcare accounted for 10.4 percent in 2013 and 19 percent in 2016. The increase in proportion of expenditure on providers of ambulatory health is in line with government's primary healthcare approach.

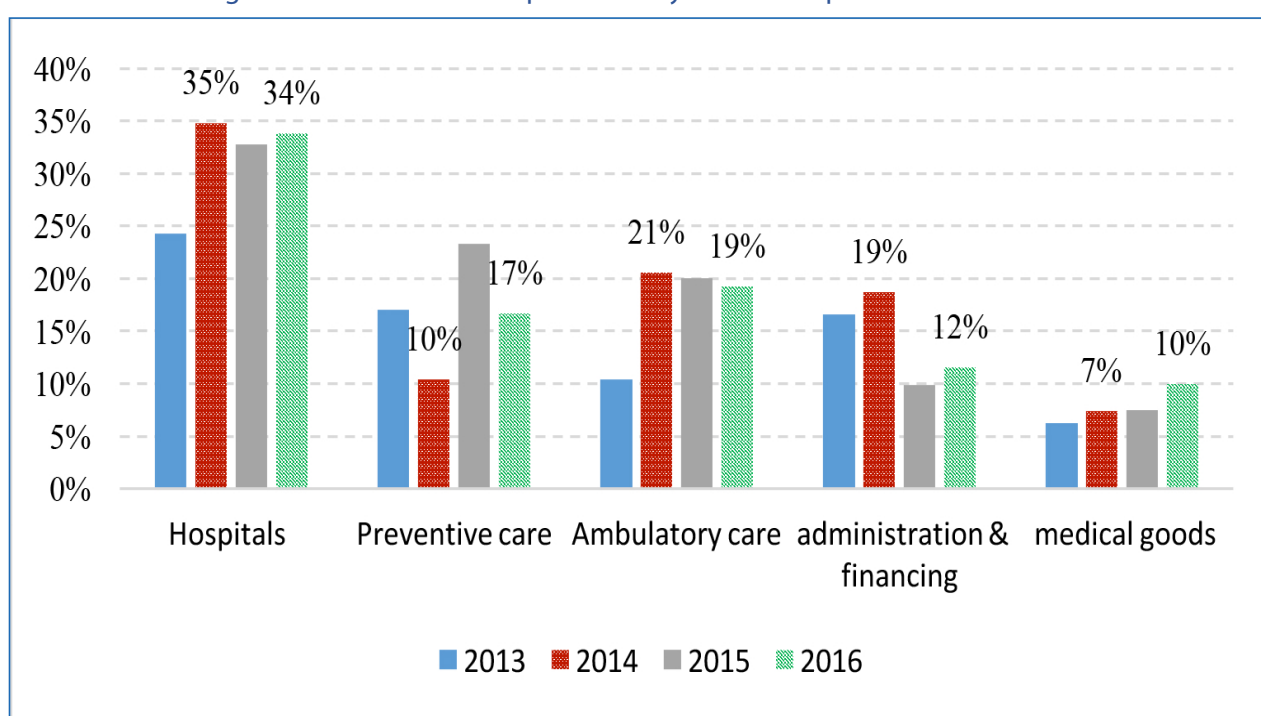
Table 8: Distribution of CHE by Healthcare Providers: 2013–2016

| Provider | 2013 | % | 2014 | % | 2015 | % | 2016 | % |
|---|----------------|------------|----------------|------------|----------------|------------|----------------|------------|
| Hospitals | 1,721.0 | 24.2 | 2,226.6 | 34.8 | 2,664.8 | 32.8 | 3,271.9 | 33.8 |
| Residential long-term care facilities | | | 1.1 | 0.0 | 1.2 | 0.0 | 1.0 | 0.0 |
| Providers of ambulatory healthcare | 739.1 | 10.4 | 1,317.5 | 20.6 | 1,629.4 | 20.0 | 1,862.0 | 19.2 |
| Providers of ancillary services | 86.0 | 1.2 | 66.1 | 1.0 | 90.6 | 1.1 | 115.3 | 1.2 |
| Retailers and other providers of medical goods | 442.9 | 6.2 | 473.3 | 7.4 | 608.8 | 7.5 | 967.0 | 10.0 |
| Providers of preventive care | 1,209.5 | 17.0 | 667.2 | 10.4 | 1,895.0 | 23.3 | 1,610.8 | 16.6 |
| Providers of healthcare system administration and financing | 1,178.9 | 16.6 | 1,198.4 | 18.7 | 803.2 | 9.9 | 1,115.3 | 11.5 |
| Rest of economy | 16.0 | 0.2 | 1.1 | 0.0 | 1.9 | 0.0 | 554.6 | 5.7 |
| Rest of the world | 117.5 | 1.7 | 0.1 | 0.0 | 0.1 | 0.0 | 0.2 | 0.0 |
| Unspecified healthcare providers | 1,587.9 | 22.4 | 445.4 | 7.0 | 438.3 | 5.4 | 177.1 | 1.8 |
| TOTAL | 7,098.8 | 100 | 6,396.9 | 100 | 8,133.1 | 100 | 9,675.3 | 100 |

Source: Author's compilation from survey data

CHE by providers of healthcare system administration and financing declined from ZMW 1.2 billion (16 percent of total CHE) in 2013 to ZMW 1.1 billion in 2016 (12 percent of total CHE). Meanwhile, there were some fluctuations in the absolute amounts and share of total CHE utilized by providers of preventive care. The share of total CHE utilized by providers of preventive care decreased from ZMW 1.2 billion (17 percent of total CHE) in 2013 to ZMW 667 million (10.4 percent of total CHE) in 2014 rising to ZMW 1.9 billion (23 percent of total CHE) in 2015 and then dropping to ZMW 1.6 billion (17 percent of total CHE) in 2016. Retailers and providers of other medical goods comprises pharmacies and other specialised establishments whose primary activity is the manufacturing or retail sale of medical goods to the general public for individual or household consumption. The proportion of total CHE spent on medical goods increased consistently from 6.2 percent in 2013 to 10 percent in 2016. In nominal terms, the amount doubled from ZMW 443 million in 2013 to ZMW 967 million in 2016.

Figure 5: Distribution of expenditure by healthcare provider: 2013–2016



Source: Author's compilation from survey data

3.5.2 Distribution of total CHE by Facility Type

Table 9 presents a breakdown of the nominal value of CHE utilized by health facilities. Figure 6 shows the proportions. Most of the CHE for health facilities was spent at public health centres and health posts (ambulatory healthcare providers) which accounted for 30 percent (ZMW 739 million) of the total health facility expenditure. The level of spending increased to ZMW 1.9 billion by 2016 which represents 36 percent of the total health facility expenditure. Third level hospitals were second and accounted for 23 percent (ZMW 565 million) of the total health facility expenditure in 2013. The amount increased in absolute terms to ZMW 1.2 billion in 2016 but the percentage share of the total health facility expenditure remained at 23 percent in 2016 after some declines in 2014 and 2015. Expenditure at first level hospitals as a share of total health facility expenditure increased from 13 percent in 2013 to 19 percent in 2016, while the proportion of resources expended at second level hospitals declined from 17 percent in 2013 to 13 percent in 2016 (figure 6). These results are consistent with government’s policy of prioritising the provision of primary healthcare services.

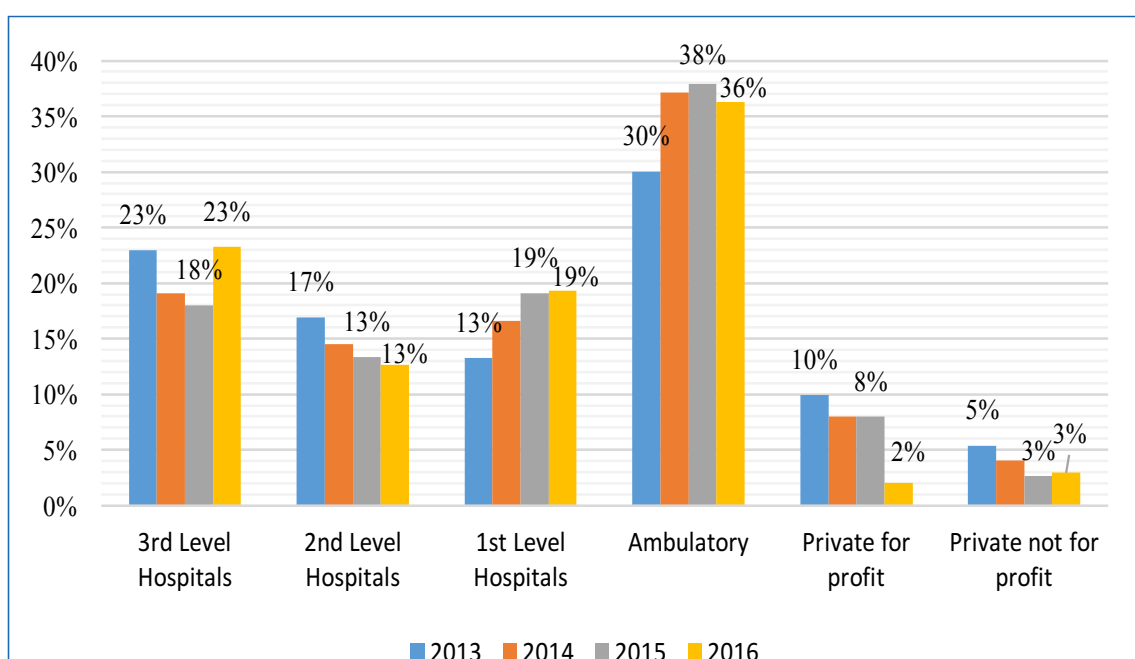
Table 9: Distribution of CHE at level of health facility: 2013–2016

| Provider | 2013 | 2014 | 2015 | 2016 |
|------------------------------|-----------------|-----------------|-----------------|-----------------|
| Third-Level Public Hospital | 565.16 | 677.48 | 774.03 | 1,195.04 |
| Second-Level Public Hospital | 416.12 | 513.49 | 571.61 | 650.18 |
| First-Level Public Hospital | 326.45 | 588.49 | 819.19 | 990.04 |
| Ambulatory | 739.08 | 1,317.51 | 1,629.43 | 1,862.04 |
| Other Public Hospitals | 35.86 | 22.33 | 44.09 | 181.96 |
| Private for profit | 244.84 | 282.24 | 342.08 | 102.82 |
| Private not for profit | 132.60 | 142.55 | 113.81 | 151.89 |
| Total | 2,460.11 | 3,544.08 | 4,294.25 | 5,133.98 |

Source: Author’s compilation from survey data

We observe a significant reduction in the share of the total health facility expenditure accounted for by private-for-profit health facilities. The proportion decreased from 10 percent (ZMW 244 million) in 2013 to 2 percent (ZMW 102 million) in 2016. Private-not-for profit facilities accounted for 5 percent of the total health facility expenditure in 2013 and 3 percent in 2016.

Figure 6: Breakdown of Facility Level CHE: 2013–2016



Source: Author’s compilation from survey data

3.5.3 CHE by Financing Agents and by Healthcare Provider

This subsection presents an analysis of how total CHE that is managed by the financing agents is distributed to the healthcare providers (Table 10). The table is helpful in identifying where resources are concentrated and the funding paths. The results show that in both 2015 and 2016, household OOP spending was mainly on retailers and other providers of medical goods estimated at 54 percent in both 2015 and 2016 (Table 10). This was mainly on medicines, and this could be attributed to stock out of essential drugs at public health facilities. Households also spent a substantial amount of their resources at ambulatory health services providers (health centres and health posts) estimated at 23 percent in both years; while the remainder of the household OOP expenditure (23 percent) was spent at public and private hospitals. This suggests that despite the free public healthcare policy having been operational at the entire primary health care level in Zambia since 2012, patients still incur costs when accessing healthcare.

CHE by the MoH is concentrated at the primary healthcare level, followed by first and third level hospitals, and then healthcare administration. On the other hand, expenditures by NGOs is mainly concentrated on preventive care despite a huge reduction in the absolute amounts and percentage share in 2016 as compared to 2015 (Table 10). The reduced expenditure on preventive care by NGOs corresponds to significant increases in expenditure on ambulatory care and at public hospitals.

Table 10: Distribution of CHE by Financing Agents and Healthcare Providers: 2015–2016

| | Household OOP | | | | MoH | | | | Others (NGOS donors) | | | |
|--|---------------|-------|--------|-------|--------|-------|--------|-------|----------------------|-------|--------|-------|
| | 2015 | % | 2016 | % | 2015 | % | 2016 | % | 2015 | % | 2016 | % |
| Third-Level Public Hospital | 78.7 | 7.9 | 92.7 | 7.9 | 694.1 | 15.5 | 932.2 | 17.9 | 1.2 | 0.0 | 170.2 | 5.2 |
| Second-Level Public Hospital | 29.8 | 3.0 | 35.1 | 3.0 | 541.2 | 12.1 | 491.1 | 9.4 | 0.6 | 0.0 | 123.9 | 3.8 |
| First-Level Public Hospital | 17.3 | 1.7 | 20.3 | 1.7 | 801.9 | 18.0 | 798.5 | 15.4 | 0.0 | 0.0 | 171.2 | 5.2 |
| Private HC | 43.3 | 4.3 | 51.0 | 4.3 | 0.0 | 0.0 | | 0.0 | | 0.0 | 0.1 | 0.0 |
| Other Ambulatory | 228.4 | 22.9 | 268.9 | 22.9 | 1215.8 | 27.2 | 1182.4 | 22.7 | 135.5 | 5.1 | 336.2 | 10.2 |
| Other Public Hospitals | 0.0 | 0.0 | 0.0 | 0.0 | 1.5 | 0.0 | 112.3 | 2.2 | 53.8 | 2.0 | 69.7 | 2.1 |
| Private for profit | 57.0 | 5.7 | 67.1 | 5.7 | 1.1 | 0.0 | 1.0 | 0.0 | 286.9 | 10.7 | 34.7 | 1.1 |
| Private not for profit | 6.8 | 0.7 | 8.0 | 0.7 | 105.2 | 2.4 | 107.1 | 2.1 | | 0.0 | 48.9 | 1.5 |
| Residential long-term care facilities | 0.0 | 0.0 | | 0.0 | 1.2 | 0.0 | 1.0 | 0.0 | | 0.0 | | 0.0 |
| Providers of ancillary services | 0.0 | 0.0 | 0.0 | 0.0 | 43.2 | 1.0 | 44.4 | 0.9 | 42.4 | 1.6 | 70.9 | 2.1 |
| Retailers and Other providers of medical goods | 533.4 | 53.6 | 628.2 | 53.6 | 75.4 | 1.7 | 334.5 | 6.4 | 0.0 | 0.0 | 15.6 | 0.5 |
| Providers of preventive care | 0.0 | 0.0 | | 0.0 | 263.3 | 5.9 | 349.8 | 6.7 | 1631.7 | 61.1 | 1261.0 | 38.2 |
| Providers of health care adminis | 0.0 | 0.0 | | 0.0 | 619.3 | 13.9 | 847.0 | 16.3 | 183.8 | 6.9 | 268.3 | 8.1 |
| Rest of economy | 0.9 | 0.1 | 1.1 | 0.1 | 0.1 | 0.0 | 0.5 | 0.0 | 0.2 | 0.0 | 553.0 | 16.8 |
| Rest of the world | 0.0 | 0.0 | | 0.0 | | 0.0 | 0.0 | 0.0 | | 0.0 | 0.2 | 0.0 |
| Unspecified health care providers (n.e.c.) | 0.0 | 0.0 | | 0.0 | 103.6 | 2.3 | | 0.0 | 334.7 | 12.5 | 177.1 | 5.4 |
| Total | 995.5 | 100.0 | 1172.4 | 100.0 | 4466.8 | 100.0 | 5201.9 | 100.0 | 2670.8 | 100.0 | 3301.0 | 100.0 |

Source: Author's compilation from survey data

3.5.4 Total CHE by Healthcare Functions

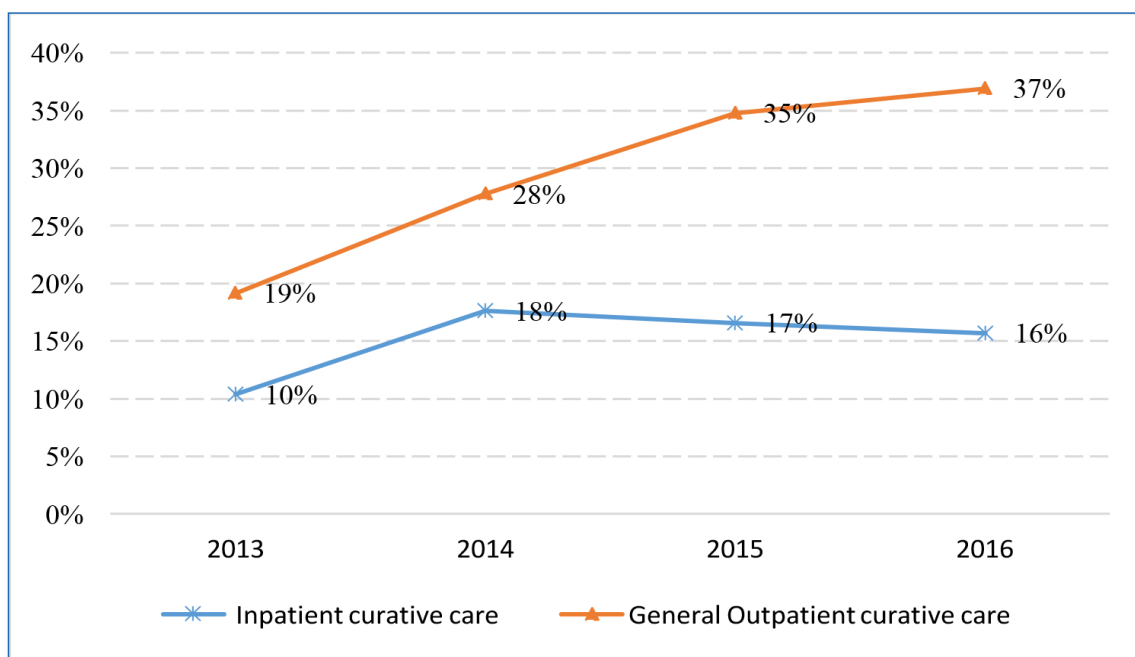
Healthcare functions refer to the categories of health goods and services consumed by final users to attain a specific health purpose (OECD et al., 2017). Table 11 shows that most of the CHE is dedicated to curative care, preventive, purchasing medical goods, and governance, health system and financing administration. The proportion of expenditures allocated to curative care is the largest and has progressively increased from 30 percent (ZMW 2.1 billion) in 2013 to 53 percent (ZMW 5.1 billion) in 2016. A larger amount of CHE was spent on outpatient care, which accounted for 19 percent (ZMW 1.4 billion) in 2013, 28 percent in 2014 and peaked at 37 percent (ZMW 3.6 billion) in 2016. In 2015 and 2016, the share of total CHE on outpatient care was more than twice the amount spent on inpatient care (Table 11). Trends in inpatient and outpatient expenditures are presented in Figure 7. The share of total CHE on preventive care declined from 30 percent in 2013 to 26 percent in 2016. Despite the reduction in the proportion allocated to preventive care, there was an increase in nominal terms from ZMW 2.1 billion in 2013 to ZMW 2.5 billion in 2016. The share allocated to administration activities has largely been stable over the four-year period averaging around 10 percent of total CHE.

Table 11: Distribution of CHE by Functions: 2013–2016

| | 2013 (%) | 2014 (%) | 2015 (%) | 2016 (%) |
|--|--------------|--------------|--------------|--------------|
| Curative care | 30.2 | 47.6 | 51.9 | 52.6 |
| Inpatient care | 10.4 | 17.6 | 16.6 | 15.7 |
| Outpatient care | 19.2 | 27.8 | 34.8 | 36.9 |
| Unspecified Curative | 0.7 | 2.2 | 0.5 | 0.0 |
| Rehabilitative care | 0.0 | 0.0 | 0.0 | 0.0 |
| Long-term care (health) | 1.6 | 0.6 | 0.0 | 0.4 |
| Ancillary services (non-specified by function) | 1.2 | 1.1 | 1.1 | 1.2 |
| Medical goods (non-specified by function) | 6.1 | 5.4 | 5.6 | 8.4 |
| Preventive care | 30.2 | 27.0 | 31.3 | 25.9 |
| Governance, health system and financing administration | 9.9 | 12.6 | 9.9 | 11.2 |
| Other healthcare services not elsewhere classified | 20.8 | 5.7 | 0.1 | 0.3 |
| Total (ZMW Millions) | 7,099 | 6,397 | 8,133 | 9,675 |

Source: Author's compilation from survey data

Figure 7: Trends in CHE by Inpatient and Outpatient: 2013–2016



Source: Author's compilation from survey data

4.0 Capital Expenditure

Capital Expenditure is an important component of health expenditure in the SHA 2011 methodology due to its contribution in the production of health services. The classification includes the construction of new health facilities or upgrading/expansion of existing ones, training and investment into health equipment or information systems. Information on capital expenditure facilitates the assessment of the appropriateness, deficiency or excessiveness of health system production. In the analysis, the team only included actual amounts spent on capital items.

4.1 Capital Expenditure by Source

During the period 2013–2016, the amount of money spent on capital items increased by 76 percent from ZMW 297 million in 2013 to ZMW 521 million in 2016. The government was the main contributor to capital expenditure during the period under review contributing about 73 percent of the total on average annually. The government contribution increased from 56 percent of total capital expenditure (ZMW 165 million) in 2013 to 70 percent in 2016 (ZMW 365 million), having peaked in 2015 at 90 percent (ZMW 273 million) as indicated in Table 12. The increase in capital expenditure was largely due to upgrading of health centres into district hospitals and district hospitals into second level hospitals; and construction of new district hospitals and health posts throughout of the country. Donor capital contribution fluctuated during the review period, reducing from 44 percent (ZMW 130 million) in 2013 to 30 percent (ZMW 156 million) in 2016, having reached a low of 9 percent in 2015. Contributions by NPISH were minimal, averaging less than 1 percent throughout the review period.

Table 12: Capital Expenditure by Source: 2013–2016 (ZMW million)

| | 2013 | % | 2014 | % | 2015 | % | 2016 | % |
|-------------------|---------------|------------|---------------|------------|---------------|------------|--------------|------------|
| Government | 165.17 | 56 | 389.24 | 78 | 273.28 | 90 | 364.95 | 70 |
| NPISH | 2.14 | 1 | 0.75 | 0 | 2.57 | 1 | 0.03 | 0 |
| Rest of the world | 129.61 | 44 | 110.11 | 22 | 28.62 | 9 | 156.32 | 30 |
| Total | 296.92 | 100 | 500.09 | 100 | 304.48 | 100 | 521.3 | 100 |

Source: Author's compilation from survey data

4.2 Capital Expenditure by Function

The largest two components of capital expenditure have been investments in machinery and equipment, and infrastructure. Expenditure on machinery and equipment relates to the purchase and repair of medical equipment, transport equipment, and ICT equipment among others. In 2013 and 2015, expenditure on machinery and equipment accounted for more than half the total capital expenditure but there was a decline to 29 percent (ZMW150.31 million) in 2016 (Table 13). Conversely, expenditure on infrastructure accounted for more than half of the total capital expenditure in 2014 and 2016, estimated at 54 percent (ZMW 272 million) and 71 percent (ZMW 371 million), respectively. In nominal terms, expenditure on infrastructure development has more than doubled from ZMW 131 million in 2013 to ZMW 371 million in 2016 representing a 184 percent increase over the four years (Table 13).

Minimal amounts of capital expenditures went towards the development of intellectual property and products. Such kind of expenditures include investments in research, development, investigation or innovation leading to knowledge that the developers can market or use to their own benefit in production. Over the period 2013–2016, less than one (1) percent of the total expenditure on capital was on intellectual property development on average each year.

Table 13: Capital Expenditure by Function: 2013–2016 (ZMW million)

| | 2013 | % | 2014 | % | 2015 | % | 2016 | % |
|--|---------------|--------------|---------------|---------------|---------------|---------------|----------------|--------------|
| Infrastructure | 130.47 | 44 | 271.86 | 54 | 140.59 | 46 | 370.78 | 71 |
| Machinery and equipment | 158.62 | 53 | 211.83 | 42 | 154.47 | 51 | 150.31 | 29 |
| Intellectual property products | 2.29 | 0.8 | 3.37 | 0.7 | 3.88 | 1.3 | 0.0 | 0.0 |
| Unspecified gross capital formation (n.e.c.) | 5.40 | 2 | 13.04 | 3 | 5.54 | 2 | 0.21 | 0.0 |
| Total | 296.77 | 100.0 | 500.09 | 100.00 | 304.48 | 100.00 | 521.302 | 100.0 |

Source: Author's compilation from survey data

4.2.1 Breakdown of government capital expenditure by function

Table 14 shows that more than half of the government capital expenditure was spent on infrastructure during the period 2013–2016, except in 2015 when expenditure was highest on machinery and equipment (52 percent). In nominal terms, government capital expenditure on infrastructure increased by 267 percent from ZMW 84 million in 2013 to ZMW 307 million in 2016. On the other hand, expenditure on machinery and equipment reduced by approximately 21 percent from ZMW 74 million in 2013 to ZMW 58 million in 2016.

Table 14: Capital expenditure by government: 2013–2016 (ZMW million)

| | 2013 | % | 2014 | % | 2015 | % | 2016 | % |
|----------------------------------|---------------|------------|---------------|------------|---------------|------------|---------------|------------|
| Infrastructure | 83.65 | 51 | 198.58 | 51 | 122.62 | 45 | 306.9 | 84 |
| Residential and non-residential | 83.65 | | 198.58 | | 122.62 | | 318.54 | |
| Machinery and Equipment | 73.83 | 45 | 174.26 | 45 | 141.78 | 52 | 58.04 | 16 |
| Medical Equipment | 71.67 | | 162.72 | | 130.79 | | 46.97 | |
| Transport equipment | 0.46 | | 11.13 | | 9.52 | | 0 | |
| ICT equipment | 0.42 | | 0.4 | | 0.18 | | 0 | |
| Machinery and Equipment | 1.29 | | 0 | | 1.29 | | 11.07 | |
| Intellectual Property Products | 2.29 | 1 | 3.37 | 1 | 3.879 | 1 | 0 | 0 |
| Other capital | 5.4 | 3 | 13.03 | 3 | 5 | 2 | 0.03 | 0 |
| Total Capital Expenditure | 165.17 | 100 | 389.24 | 100 | 273.28 | 100 | 364.97 | 100 |

Source: Author's compilation from survey data

4.3 Capital Expenditure by Healthcare Provider

Table 15 shows the distribution of capital expenditure by provider. Most of the capital expenditure incurred was at hospitals with an allocation of 47 percent (ZMW 141 million) in 2013 rising to 68 percent (ZMW 353 million) in 2016. Other significant consumers of capital expenditures were providers of ambulatory healthcare and providers of healthcare system administration and financing with expenditures of approximately 10 percent for each category in 2016. A comparison of nominal amounts for the years 2013 and 2016 shows that capital expenditures on providers of ambulatory care doubled from ZMW 27 million to ZMW 53 million, while a slight increase is observed for providers of healthcare system administration and financing rising from ZMW 46 million to ZMW 50 million. Capital expenditures on providers of preventive care remained low at less than 1 percent in 2015 and 2016.

Table 15: Capital Expenditure by Provider: 2013–2016 (ZMW million)

| | 2013 | % | 2014 | % | 2015 | % | 2016 | % |
|---|---------------|------------|---------------|------------|---------------|------------|---------------|------------|
| Hospitals | 140.68 | 47.4 | 410.78 | 82.1 | 266.58 | 87.6 | 353.12 | 67.7 |
| Providers of ambulatory healthcare | 26.81 | 9.0 | 14.42 | 2.9 | 19.31 | 6.3 | 53.14 | 10.2 |
| Providers of ancillary services | 2.22 | 0.7 | 1.06 | 0.2 | 6.53 | 2.1 | 18.00 | 3.5 |
| Providers of preventive care | – | – | 8.69 | 1.7 | 0.23 | 0.1 | 0.07 | 0.0 |
| Providers of healthcare system administration & finance | 45.51 | 15.3 | 20.09 | 4.0 | 6.62 | 2.2 | 49.96 | 9.6 |
| Rest of economy | 0.59 | 0.2 | 9.28 | 1.9 | – | 0.0 | 15.27 | 2.9 |
| Unspecified healthcare providers (n.e.c.) | 81.10 | 27.3 | 35.78 | 7.2 | 5.22 | 1.7 | 31.73 | 6.1 |
| Total | 296.92 | 100 | 500.09 | 100 | 304.48 | 100 | 521.30 | 100 |

Source: Author's compilation from survey data

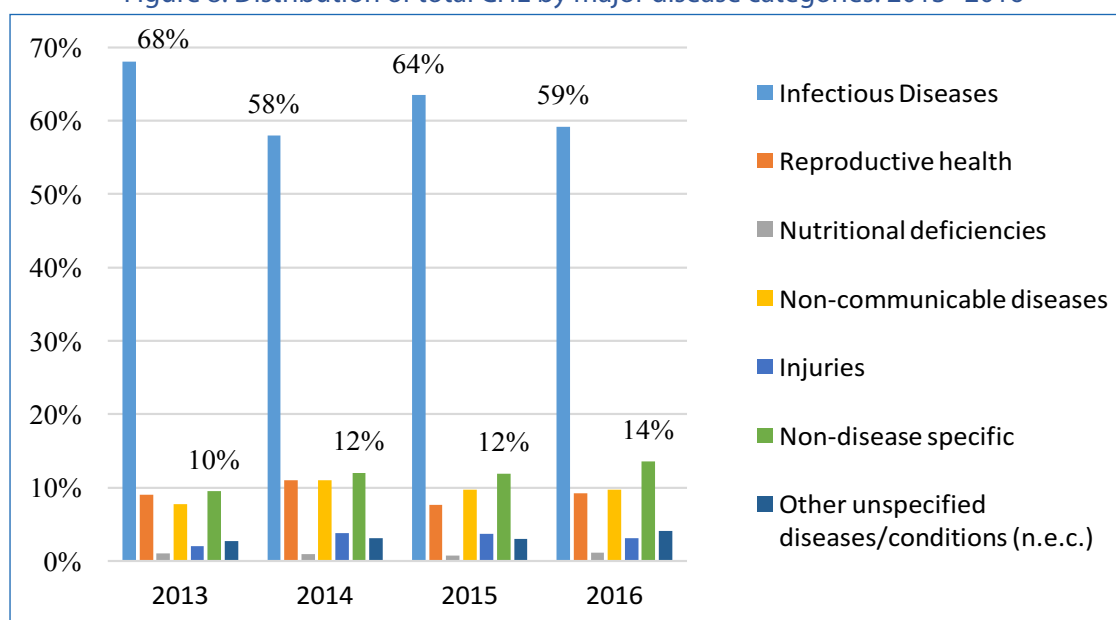
5.0 Disease-specific Accounts

This study also reviewed the distribution of total CHE by diseases and conditions over the period 2013–2016. Detailed analysis is provided for HIV/AIDS, Malaria, and RH focusing on the years 2015 and 2016 and for CHE alone.

5.1 CHE by Major Disease Categories

Figure 8 presents a breakdown of total CHE by major disease categories. Infectious and parasitic diseases account for more than half of total CHE. The share of expenditure on infectious diseases declined from 68 percent in 2013 to 59 percent in 2016. However, in nominal terms the amount increased from ZMW 4.8 billion in 2013 to ZMW 5.7 billion in 2016 (Table 16). Other major disease categories and conditions include RH and non-communicable diseases with each accounting for about 9 percent of CHE in 2016. The proportion of expenditure on non-communicable diseases increased between 2013 and 2016, from 8 percent (ZMW 552 million) to 9.8 percent (ZMW 943 million). The proportion spent on RH remained constant over the same period even though there was a growth in nominal terms from ZMW 641 million in 2013 to ZMW 892 million in 2016.

Figure 8: Distribution of total CHE by major disease categories: 2013–2016



Source: Author's compilation from survey data

5.2 Breakdown of CHE by Diseases and Conditions

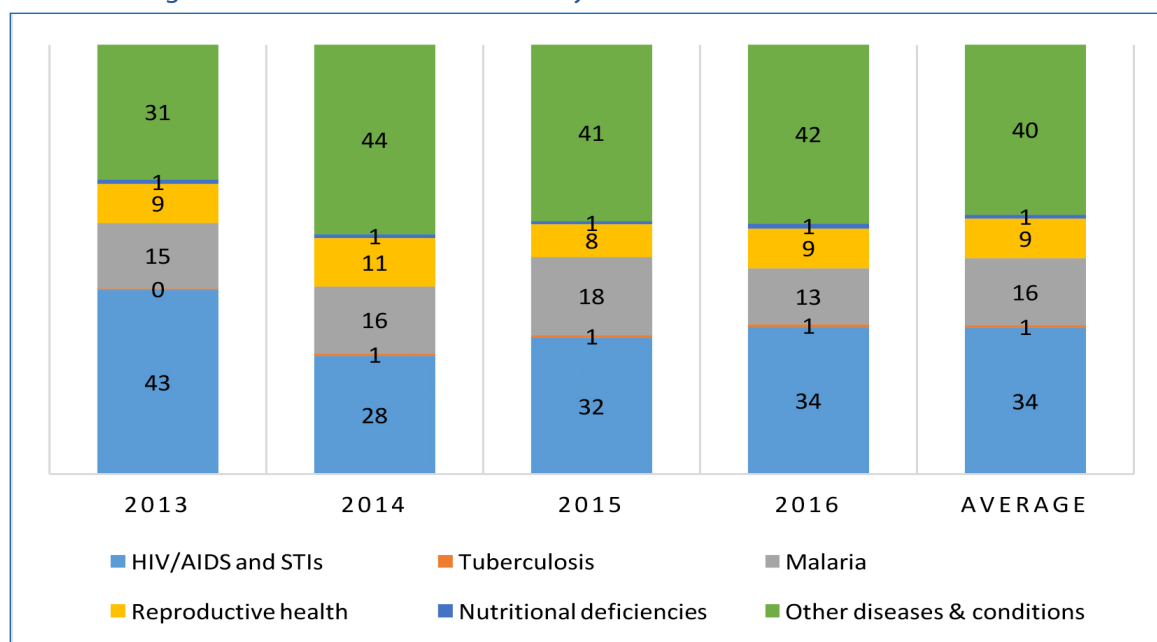
Detailed analysis on the disease and conditions is presented in Table 16 and Figure 9. The table shows that HIV/AIDS accounted for the largest proportion of CHE. The percentage of the total CHE that was utilized for HIV/AIDS was 43 percent (ZMW 3.05 billion) in 2013, which reduced to 28 percent (ZMW 1.76 billion) in 2014 and then increased to 34 percent (ZMW 3.32 billion) in 2016 (Table 16). Malaria accounted for the second largest share after HIV/AIDS, at 15 percent of the total CHE in 2013 but the proportion reduced to 13 percent in 2016. The other major diseases and conditions on which significant amounts were spent in 2016 include: maternal conditions which constituted approximately 5 percent of the total CHE; vaccine preventable diseases (4 percent); oral diseases (4 percent); injuries (3 percent); and respiratory infections (3 percent) (Table 16). And during the entire period 2013–2016, expenditure on TB accounted for less than 1 percent of total CHE while expenditure on nutritional deficiencies was about 1 percent. Given that the burden of disease due to maternal conditions, TB and nutritional deficiencies is very high in the country, low levels of spending in these areas is concerning.

Table 16: Current Health Expenditure by disease and conditions: 2013–2016

| | 2013 | % | 2014 | % | 2015 | % | 2016 | % |
|--|-------------|-------------|--------------|------------|--------------|-------------|----------------|-------------|
| Infectious Diseases | 4824 | 68 | 3685 | 58 | 5161 | 63.5 | 5725 | 59.2 |
| HIV/AIDS and Other STDs | 3047 | 42.9 | 1762 | 27.5 | 2585 | 31.8 | 3324 | 34.4 |
| Tuberculosis (TB) | 27.6 | 0.39 | 39.75 | 0.62 | 50.09 | 0.62 | 53.98 | 0.55 |
| Malaria | 1085 | 15.3 | 997 | 15.6 | 1482 | 18.2 | 1268 | 13.1 |
| Respiratory infections | 137 | 1.93 | 216.9 | 3.39 | 290.4 | 3.57 | 292.42 | 3.02 |
| Diarrheal diseases | 57.8 | 0.81 | 75.51 | 1.18 | 100.5 | 1.24 | 101.62 | 1.04 |
| Neglected tropical diseases | 1.16 | 0.02 | 8.03 | 0.13 | 5.18 | 0.06 | 2.86 | 0.03 |
| Vaccine preventable diseases | 225 | 3.16 | 225.9 | 3.53 | 293 | 3.6 | 364.85 | 3.77 |
| Others & unspecified | 244 | 3.44 | 359.9 | 5.63 | 354.4 | 4.36 | 318.41 | 3.29 |
| Reproductive health (RH) | 641 | 9.02 | 720 | 11 | 622 | 7.64 | 892.0 | 9.22 |
| Maternal conditions | 405 | 5.71 | 436 | 6.8 | 412 | 5.06 | 498.73 | 5.15 |
| Perinatal conditions | 0.01 | 0 | | 0 | | 0 | 6.6 | 0.07 |
| Contraceptive management | 154 | 2.17 | 181.9 | 2.84 | 161.6 | 1.99 | 250.55 | 2.59 |
| Others & Unspecified | 81.5 | 1.15 | 101.5 | 1.59 | 48.19 | 0.59 | 136.16 | 1.41 |
| Nutritional deficiencies | 74.5 | 1.05 | 56.5 | 0.9 | 57.7 | 0.71 | 105.67 | 1.09 |
| Non-communicable diseases | 552 | 7.77 | 708 | 11 | 787 | 9.67 | 942.93 | 9.75 |
| Neoplasms | 24.2 | 0.34 | 57.66 | 0.9 | 64.35 | 0.79 | 98.84 | 1.02 |
| Endocrine and metabolic disorders | 11.7 | 0.16 | 15.67 | 0.25 | 18.77 | 0.23 | 20.36 | 0.21 |
| Cardiovascular diseases | 81.1 | 1.14 | 101.1 | 1.58 | 118.3 | 1.45 | 132.03 | 1.36 |
| Mental & behavioral disorders | 25.5 | 0.36 | 35.64 | 0.56 | 41.34 | 0.51 | 94.59 | 0.98 |
| Respiratory diseases | 13.6 | 0.19 | 22.41 | 0.35 | 28.47 | 0.35 | 29.57 | 0.31 |
| Diseases of the digestive | 18.9 | 0.27 | 32.87 | 0.51 | 43.01 | 0.53 | 43.3 | 0.45 |
| Diseases of the urinary system | 9.13 | 0.13 | 15.3 | 0.24 | 19.02 | 0.23 | 19.70 | 0.2 |
| Sense organ disorders | 30.4 | 0.43 | 44.64 | 0.7 | 53.15 | 0.65 | 57.08 | 0.59 |
| Oral diseases | 247 | 3.49 | 278.9 | 4.36 | 318.3 | 3.91 | 369.71 | 3.82 |
| Others and unspecified | 89.7 | 1.26 | 104.1 | 1.63 | 82 | 1.01 | 77.71 | 0.8 |
| Injuries | 141 | 1.98 | 241 | 3.8 | 301 | 3.7 | 300.28 | 3.1 |
| Non-disease specific | 675 | 9.5 | 787 | 12 | 964.1 | 11.9 | 1311.16 | 13.6 |
| Other and unspecified diseases/conditions | 193 | 2.72 | 199.8 | 3.1 | 241.3 | 2.97 | 398.45 | 4.12 |
| Total | 7099 | 100 | 6397 | 100 | 8133 | 100 | 9675 | 100 |
| Percentage of total donor CHE on HIV/AIDS | | | | | | 72 | | 70 |

Source: Author's compilation from survey data

Figure 9: Distribution of total CHE by Diseases and conditions: 2013–2016



Source: Author's compilation from survey data

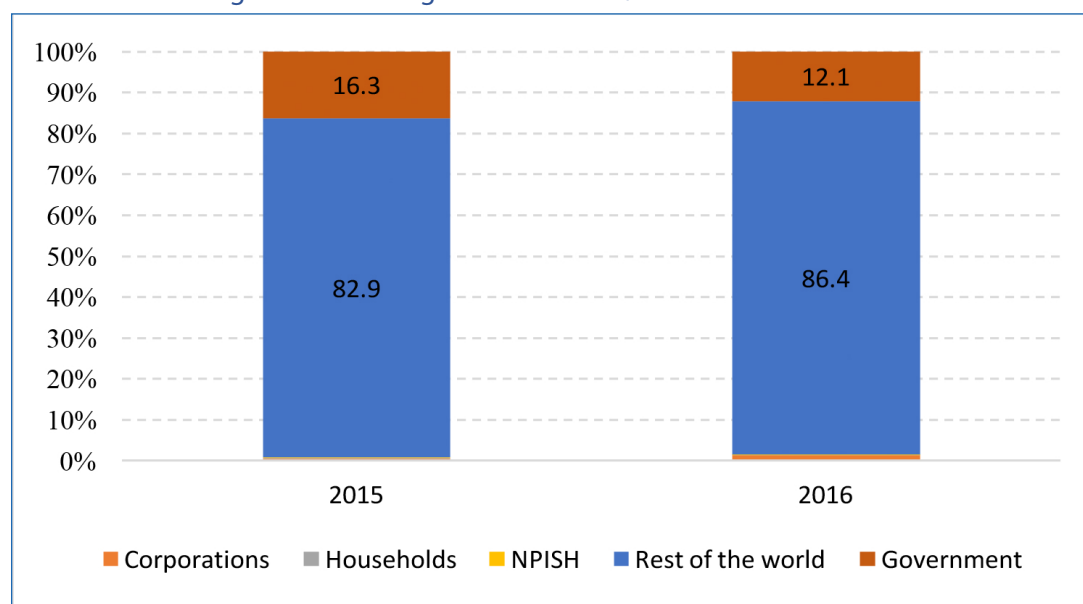
5.3 HIV/AIDS Subaccount

During the period Zambia's nominal CHE on HIV/AIDS and opportunistic infections increased by 28.6 percent. The expenditure increased from ZMW 2.6 billion (US\$294 million) in 2015 to ZMW 3.3 billion (US\$316 million) in 2016.

5.3.1 Funding Sources for HIV/AIDS in Zambia

The main institutional units which provided funding for HIV/AIDS and STIs in Zambia in 2015 and 2016 were government and donors. Figure 10 shows that donors were the main financiers of HIV/AIDS programs in 2015 and 2016. Donors contributed 83 percent of the total HIV/AIDS CHE in 2015 and 86 percent in 2016 while government's contribution declined from 16 percent in 2015 to 12 percent in 2016. The decline in the share of government expenditure on HIV/AIDS could be explained by the overall reduction in government expenditure in the health sector which fell from ZMW 3.8 billion in 2015 to ZMW 3.7 billion in 2016. The results further show that 72 percent and 70 percent of the total donor CHE in the health sector in Zambia in 2015 and 2016, respectively, was spent on HIV/AIDS and STIs (Table 16). Meanwhile, the role of households, employers, and NPISH in financing HIV/AIDS in Zambia was very minimal during the period under review. These institutions combined accounted for 0.8 percent in 2015 and 1.4 percent in 2016 of the total HIV/AIDS CHE.

Figure 10: Funding Sources for HIV/AIDS CHE: 2015–2016



Source: Author's compilation from survey data

5.3.2 Distribution of HIV/AIDS CHE by Financing Schemes

Table 17 shows the major channels through which HIV/AIDS spending was channelled by the key financiers. Most of the funding for HIV/AIDS was channelled through NPISH which accounted for 70 percent of the total HIV/AIDS CHE in 2015 and 56 percent in 2016. The government was the second largest channel and accounted for 28 percent in 2015 and 40 percent of the total HIV/AIDS CHE in 2016. Donors played a minimal role as financing scheme, handling 1.3 percent and 3.3 percent in 2015 and 2016, respectively. Households and private enterprises also accounted for an insignificant share of total HIV/AIDS CHE during this period.

Table 17: Distribution of HIV/AIDS CHE by financing schemes: 2015–2016

| | 2015 | % | 2016 | % |
|---|-----------------|------------|-----------------|------------|
| Government schemes & compulsory contributory healthcare | 705.24 | 27.78 | 1291.86 | 39.6 |
| Voluntary healthcare payment schemes | 1797.23 | 70.80 | 1863.56 | 57.1 |
| NPISH financing schemes | 1,784.72 | 70.30 | 1,820.99 | 55.8 |
| Enterprises financing schemes | 12.52 | 0.49 | 42.57 | 1.3 |
| Household out-of-pocket payment | 3.85 | 0.15 | 4.53 | 0.1 |
| Rest of the world (non-resident) | 32.27 | 1.27 | 106.22 | 3.3 |
| Total | 2,538.59 | 100 | 3,266.17 | 100 |

Source: Author's compilation from survey data

5.3.3 Financing Agents for HIV/AIDS

The results in Table 18 show that NPISH managed a significant share corresponding to 70.3 percent in 2015 and 55.8 percent in 2016. Government (MoH and other ministries) accounted for 27.8 percent in 2015 and this share increased to 39.5 percent in 2016. The role of private insurance corporations, households and donors in the management of HIV/AIDS resources is minimal. These agents, together managed less than 3 percent of the total HIV/AIDS spending in the country.

Table 18: Financing Agents for HIV/AIDS CHE: 2015–2016

| | 2015 | (%) | 2016 | % |
|--|-----------------|------------|-----------------|--------------|
| Ministry of Health | 428.53 | 16.9 | 925.57 | 28.3 |
| Other government line ministries & departments | 276.71 | 10.9 | 366.29 | 11.2 |
| Corporations (other than insurance corporations) | 12.53 | 0.5 | 42.57 | 1.3 |
| NPISH | 1,784.88 | 70.3 | 1,820.99 | 55.8 |
| Households | 3.85 | 0.2 | 4.53 | 0.1 |
| Rest of the world | 32.27 | 1.3 | 106.22 | 3.3 |
| Total | 2,538.76 | 100 | 3,266.17 | 100.0 |

Source: Author's compilation from survey data

5.3.4 Who uses HIV/AIDS Funds to Deliver Healthcare?

Table 19 shows CHE for HIV/AIDS by providers in 2015 and 2016. The major providers of HIV/AIDS services during the period under review were providers of preventive care (40 percent on average), hospitals (21 percent on average), and ambulatory care (13 percent).

Table 19: Distribution of HIV/AIDS spending by healthcare providers

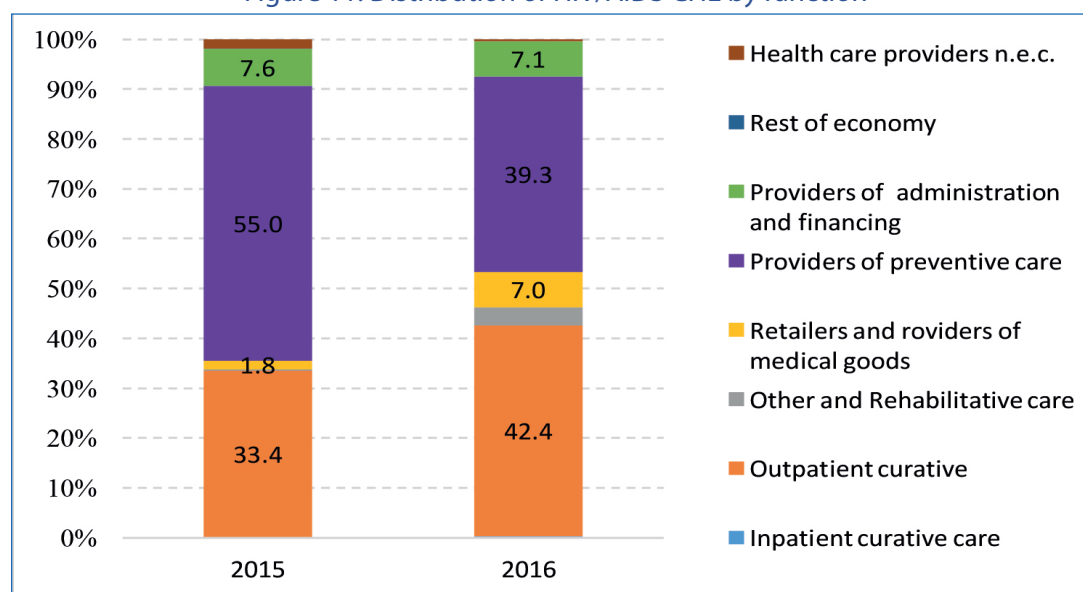
| Provider | 2015 | % | 2016 | % |
|---|-----------------|------------|-----------------|------------|
| Hospitals | 316.27 | 12.46 | 996.312 | 30.50 |
| 1st Level Public Hospital | 164.52 | 6.48 | 375.30 | 11.49 |
| 2nd Level Public Hospital | 56.83 | 2.24 | 243.56 | 7.46 |
| 3rd-Level Public Hospital | 77.49 | 3.05 | 377.00 | 11.54 |
| Private For-Profit Hospitals | 12.85 | 0.51 | 0.45 | 0.01 |
| Private Not for Profit Hospitals | 4.58 | 0.18 | 39.77 | 1.22 |
| Ambulatory Care | 267.18 | 10.52 | 503.79 | 15.42 |
| Residential long-term care facilities | 0.10 | 0.00 | | 0.00 |
| Providers of ancillary services | 46.17 | 1.82 | 85.55 | 2.62 |
| Retailers and Other providers of medical goods | 46.63 | 1.84 | 200.85 | 6.15 |
| Providers of preventive care | 1,255.30 | 49.45 | 1,025.78 | 31.41 |
| Providers of healthcare system administration and financing | 189.70 | 7.47 | 241.84 | 7.40 |
| Rest of economy | 0.16 | 0.01 | 59.41 | 1.82 |
| Unspecified healthcare providers (n.e.c.) | 417.26 | 16.44 | 152.66 | 4.67 |
| Total | 2,538.76 | 100 | 3,266.18 | 100 |

Source: Author's compilation from survey data

5.3.5 HIV/AIDS Expenditure by Functions

Figure 11 shows the actual spending on goods and services with the intention of preventing or treating HIV/AIDS illnesses. Most of the total HIV/AIDS CHE was used to purchase outpatient curative services accounting for 33 percent in 2015 and 42 percent in 2016; with expenditure on preventive care declining from 55 percent in 2015 to 39 percent in 2016 (Figure 11). Inpatient care accounted for a negligible 0.1 percent of the total HIV/AIDS CHE during the period under review.

Figure 11: Distribution of HIV/AIDS CHE by function



Source: Author's compilation from survey data

5.4 Malaria Subaccount

Malaria is the leading cause of morbidity and mortality in Zambia, and is among the priority public health programmes in the National Health Policy (Ministry of Health, 2012); and the Zambian government seeks to eliminate the disease by 2030. In 2015, total current expenditure on malaria (total CHE on malaria) accounted for 18 percent of the total CHE but declined to 13 percent in 2016. This decline was about by 13 percent in absolute values from ZMW 1.5 billion in 2015 to ZMW 1.3 billion in 2016.

5.4.1 Financing Sources for CHE on Malaria

The main providers of revenues to financing schemes for malaria programs in Zambia are government, donors and households. The contribution by each of these institutional units in 2015 and 2016 is presented in Table 20. Government was the main contributor to the financing of the malaria programs accounting for 63 percent and 63 percent of the total CHE on malaria in 2015 and 2016, respectively. The donors were the second largest source of expenditure on malaria contributing 29 percent of the total CHE on malaria in 2015. However, this share declined to 24 percent in 2016. In nominal terms, donor expenditure on malaria decreased from ZMW 423 million in 2015 to ZMW 299 million in 2016. Households were the third largest contributors accounting for 8 percent in 2015 and 11 percent in 2016.

Table 20: Distribution of CHE on malaria by Financing Sources: 2015–2016

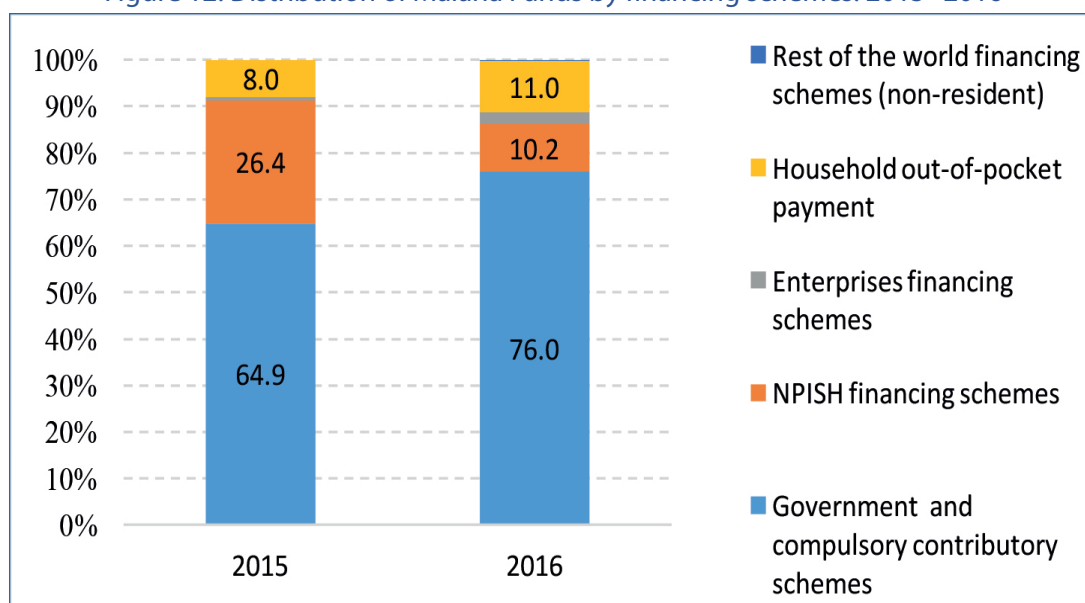
| | 2015 | % | 2016 | % |
|-------------------|-----------------|------------|-----------------|------------|
| Government | 926.06 | 62.5 | 797.19 | 62.9 |
| Corporations | 10.78 | 0.7 | 32.27 | 2.5 |
| Households | 118.76 | 8.0 | 139.86 | 11.0 |
| Rest of the world | 426.67 | 28.8 | 298.89 | 23.6 |
| Total | 1,482.27 | 100 | 1,268.22 | 100 |

Source: Author's compilation from survey data

5.4.2 Distribution of Malaria Funding by Financing Schemes

The main channels of financing malaria in Zambia are displayed in Figure 12. Government financing schemes were the major channels through which malaria healthcare goods and services were financed. Government schemes accounted for 65 percent of the total CHE on malaria in 2015 and this increased to 76 percent in 2016. On the other hand, NPISH financing schemes were the second major financing channels but there was a decline from 26 percent to 10 percent of the total CHE on malaria between 2015 and 2016.

Figure 12: Distribution of Malaria Funds by financing schemes: 2015–2016

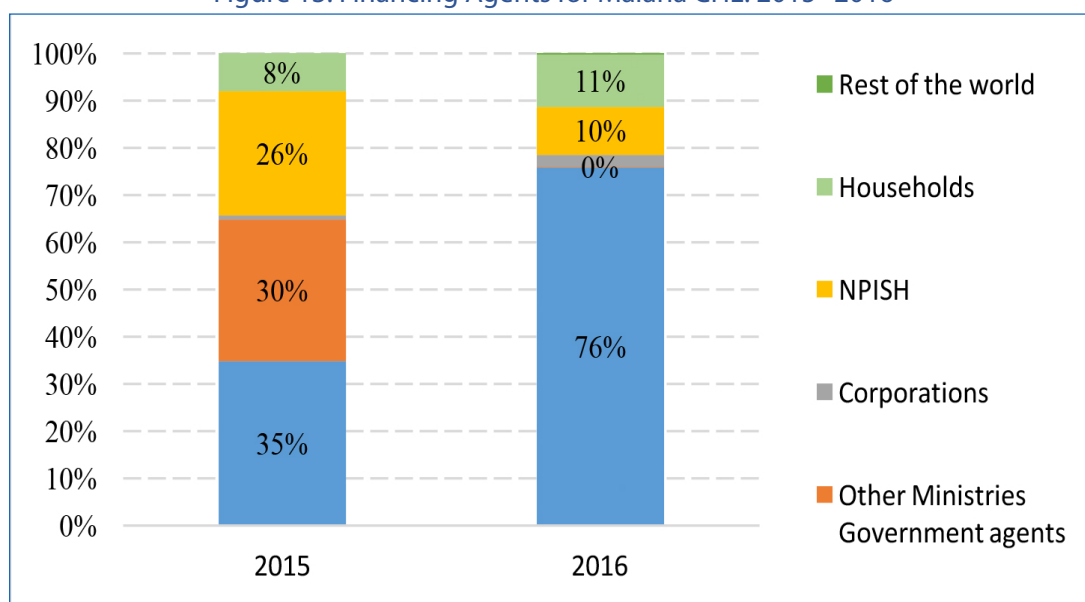


Source: Author's compilation from survey data

5.4.3 Financing Agents for Malaria

The distribution of malaria expenditure by financing agents is presented in Figure 13. The distribution shows that government (MoH and other government ministries/agents) managed most of the resources (65 percent in 2015 and 76 percent in 2016). This is followed by NPISH financing schemes who managed 26 percent of the total CHE on malaria in 2015, and 10 percent in 2016. Meanwhile, households through OOP spending managed 8 percent of the total CHE on malaria in 2015, and 11 percent in 2016 (Figure 13).

Figure 13: Financing Agents for Malaria CHE: 2015–2016



Source: Author's compilation from survey data

5.4.4 Distribution of Malaria Funds by Healthcare Providers

Table 21 presents the major providers of malaria goods and services to the population. The largest provider are ambulatory care facilities (37 percent in 2015 and 40 percent in 2016) followed by hospitals which accounted for approximately 34 percent of the total CHE on malaria in 2015 and 2016. The third largest were providers of preventive care who accounted for 27 percent of the total CHE on malaria in 2015 and 11 percent in 2016.

Table 21: Distribution of Malaria CHE by healthcare providers: 2015–2016

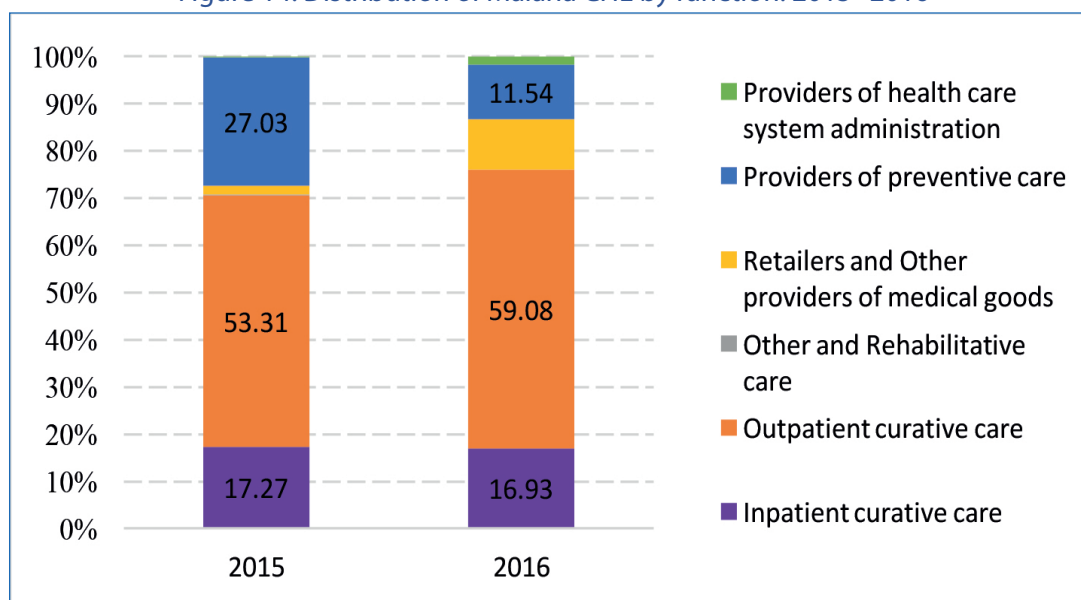
| | 2015 | % | 2016 | % |
|---|-----------------|------------|-----------------|------------|
| Hospitals | 499.9 | 33.7 | 433.4 | 34.2 |
| 1st Level Public Hospital | 143.1 | 9.7 | 110.3 | 8.7 |
| 2nd Level Public Hospital | 142.2 | 9.6 | 106.8 | 8.4 |
| 3rd Level Public Hospital | 169.5 | 11.4 | 177.6 | 14.0 |
| Private For-Profit Hospitals | 17.2 | 1.2 | 10.3 | 0.8 |
| Private Not for Profit Hospitals | 27.8 | 1.9 | 28.5 | 2.3 |
| Ambulatory Care | 546.1 | 36.8 | 502.6 | 39.6 |
| Providers of ancillary services | 2.6 | 0.2 | | 0.0 |
| Retailers and Other providers of medical goods | 31.8 | 2.1 | 138.7 | 10.9 |
| Providers of preventive care | 397.6 | 26.8 | 141.8 | 11.2 |
| Providers of healthcare system administration and financing | 4.2 | 0.3 | 22.8 | 1.8 |
| Rest of economy | 0.2 | 0.0 | 29.0 | 2.3 |
| Total | 1,482.27 | 100 | 1,268.22 | 100 |

Source: Author's compilation from survey data

5.4.5 CHE on Malaria by Function

Distribution of total CHE on malaria by function is shown in Figure 14. The majority of the expenditure was on curative care (inpatient and outpatient) services which accounted for about three-quarters of the total CHE on malaria during the period under review. In particular, outpatient curative services comprised 53 percent of the total CHE on malaria in 2015 and 60 percent in 2016. Expenditure on inpatient curative care accounted for 17 percent in 2015 and 16 percent in 2016, respectively. The second largest expenditures were incurred on preventive care (27 percent in 2015 and 12 percent in 2016).

Figure 14: Distribution of Malaria CHE by function: 2015–2016



Source: Author's compilation from survey data

5.5 RH Subaccount

Nominal expenditure on RH increased by 43 percent from ZMW 622 million in 2015 to ZMW 892 million in 2016. The flow of these resources in the health system is described below.

5.5.1 Financing Sources for CHE on RH

The main financiers of financing schemes for RH programs are government, donors and households (Table 22). Most of the resources for RH were provided by government, which accounted for 72 percent of the total CHE on RH in 2015 and 50 percent in 2016. The decline in the share of government financing for RH is explained by the rise in donor spending on RH, which increased from ZMW 78 million (13 percent of the total CHE on RH) in 2015 to ZMW 322 million (36 percent of the total CHE on RH) in 2016. Households were the second largest source of financing and contributed 15 percent and 12 percent in 2015 and 2016, respectively.

Table 22: Distribution of RH funds by Financing Sources: 2015–2016

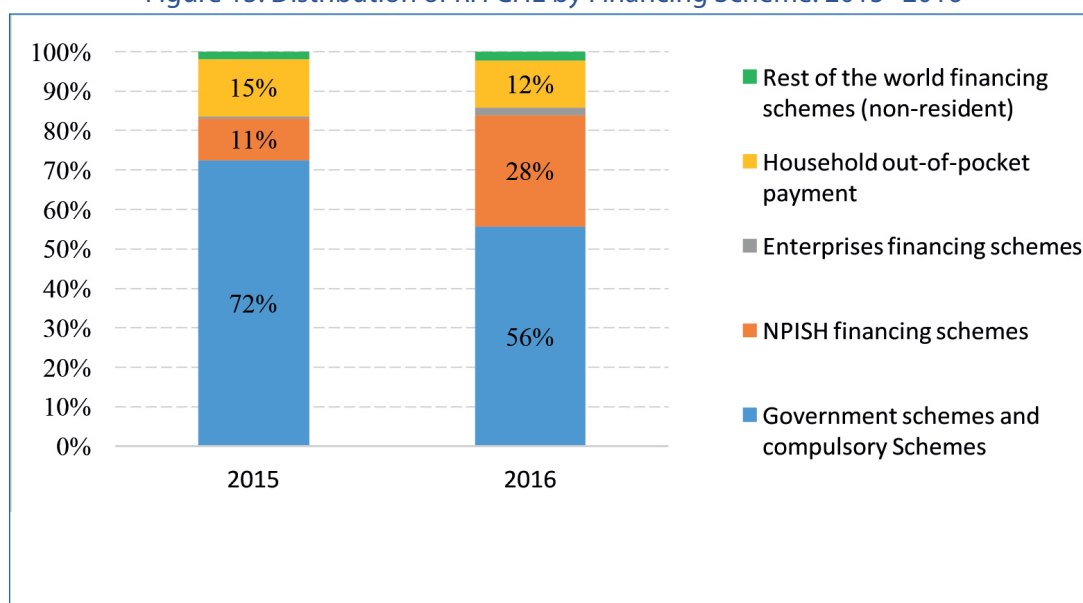
| | 2015 | % | 2016 | % |
|-------------------|--------------|------------|--------------|------------|
| Government | 449.8 | 72.4 | 446.8 | 50.1 |
| Corporations | 3.8 | 0.6 | 16.8 | 1.9 |
| Households | 90.1 | 14.5 | 106.2 | 11.9 |
| NPISH | | 0.0 | 0.2 | 0.0 |
| Rest of the world | 77.8 | 12.5 | 322.1 | 36.1 |
| Total | 621.5 | 100 | 892.1 | 100 |

Source: Author's compilation from survey data

5.5.2 CHE for RH by Financing Schemes

Figure 15 shows the main financing schemes through which revenues for RH services are channelled. The flow of these resources through these schemes closely mimics the institutional units providing revenues to the schemes. The main financing scheme for RH funds in Zambia in 2015 and 2016 was government which handled 72 percent and 56 percent of the total CHE on RH, respectively. These were followed by the NPISH schemes that managed about 11 percent in 2015 and 28 percent in 2016.

Figure 15: Distribution of RH CHE by Financing Scheme: 2015–2016

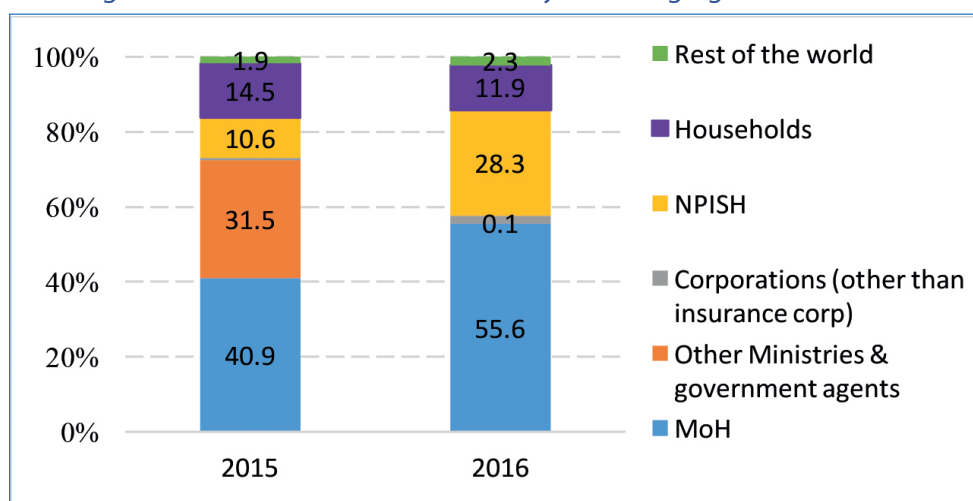


Source: Author's compilation from survey data

5.5.3 Financing Agents for CHE on RH

Several institutional units manage funds for RH (Figure 16). Government institutions (MoH and other government line ministries) managed the largest share of RH expenditures at 72 percent in 2015 and 57 percent in 2016. The share of RH expenditures managed by NPISH rose from 11 percent in 2015 to 28 percent in 2016. The increase was driven by a rise in the flow of resources from donors at the expense of government institutions. Households were the third largest financing agent for RH at 15 percent of the total CHE on RH in 2015 and 12 percent in 2016.

Figure 16: Distribution of CHE on RH by Financing Agent: 2015–2016



Source: Author's compilation from survey data

5.5.4 Distribution of RH Funds by Healthcare Provider

RH services are provided at various tiers of the health sector that include hospitals, ambulatory care providers, administration and preventive healthcare providers (Table 23). The hospitals were the major providers of RH services accounting for 52 percent in 2015 and 37 percent of total CHE on RH in 2016. Ambulatory healthcare providers accounted for 22 percent and 18 percent of total CHE on RH in 2015 and 2016, respectively. Retailers and other providers of medical goods accounted for 13 percent and 11 percent of the total CHE on RH in 2015 and 2016.

Table 23: Distribution of RH funds by healthcare providers: 2015–2016

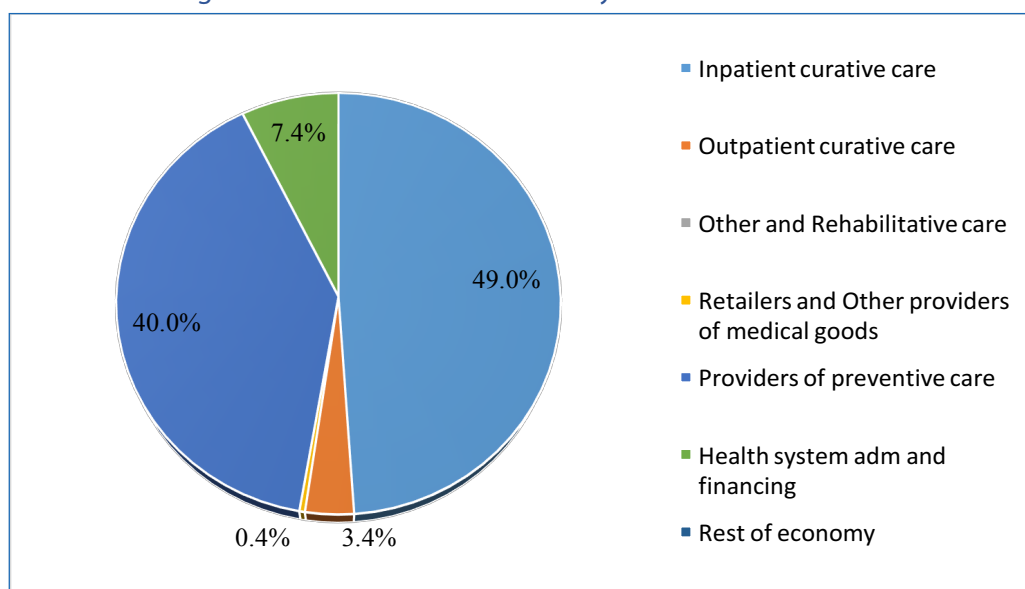
| | 2015 | % | 2016 | % |
|---|---------------|------------|---------------|------------|
| Hospitals | 326.0 | 52.4 | 335.0 | 37.6 |
| 1st Level Public Hospital | 97.9 | 15.8 | 95.3 | 10.7 |
| 2nd Level Public Hospital | 90.3 | 14.5 | 74.7 | 8.4 |
| 3rd Level Public Hospital | 107.0 | 17.2 | 135.8 | 15.2 |
| Private For-Profit Hospitals | 10.3 | 1.7 | 8.9 | 1.0 |
| Private Not for Profit Hospitals | 20.5 | 3.3 | 20.3 | 2.3 |
| Ambulatory Care | 136.7 | 22.0 | 155.7 | 17.5 |
| Providers of ancillary services | 4.6 | 0.7 | 0.2 | 0.0 |
| Retailers and other providers of medical goods | 80.4 | 12.9 | 94.7 | 10.6 |
| Providers of preventive care | 52.4 | 8.4 | 160.5 | 18.0 |
| Providers of healthcare system administration and financing | 0.7 | 0.1 | 130.3 | 14.6 |
| Rest of economy | 0.0 | 0.0 | 15.0 | 1.7 |
| Unspecified healthcare providers (n.e.c.) | 20.8 | 3.3 | 0.7 | 0.1 |
| Total | 621.53 | 100 | 892.08 | 100 |

Source: Author's compilation from survey data

5.5.5 CHE on RH by Function

Between 2015 and 2016, an average of 49 percent of the total CHE on RH was incurred on inpatient care while 40 percent was on preventive care. Further, an average of 3 percent of the total CHE on RH was incurred on outpatient curative during the period under review.

Figure 17: Distribution of RH CHE by function: 2015–2016



Source: Author's compilation from survey data

6.0 Conclusion

This report uses the SHA 2011 framework to describe the level, composition, and flow of health expenditures from all sources (public, private employers and individuals, and external) in the health sector in Zambia over the period 2013—2016. Some of the key findings of the survey are:

- i. In nominal terms, total CHE in Zambia increased by 36 percent from ZMW 7.1 billion in 2013 to ZMW 9.7 billion in 2016. On the other hand, gross capital formation increased by 76 percent from ZMW 297 million in 2013 to ZMW 521 million in 2016 mainly due to increased government expenditure in infrastructure development.
- ii. In per capita terms, total CHE in Zambia increased from ZMW 487 in 2013 to ZMW 607 in 2016. If expressed in US\$ terms, there is a declining trend in total CHE per capita from US\$90 in 2013 to US\$59 in 2016. Zambia's total CHE per capita in 2016 was below the average for LMICs which was estimated at US\$82 in 2016.
- iii. The donors and the government were the major financiers of Health Services in Zambia with about 42 percent (US\$30 per capita) of the total CHE coming from donors and 41 percent (US\$28 per capita) from government during the period 2013–2016.
- iv. At about 12 percent of total CHE, household spending on health in Zambia is lower than several countries in Africa. However, most of these funds are spent out-of-pocket (OOP) as the country does not have compulsory prepayment and risk pooling mechanisms.
- v. Government institutions managed over half (average of 54 percent per annum) of the total CHE over the period 2013–2016 while NPISH managed an average of 30 percent of the total CHE per annum over the same period.
- vi. Allocation of funds by different levels of the health system shows that hospitals account for 34 percent of total CHE, followed by ambulatory care (19 percent) and preventive care (17 percent).
- vii. An analysis of the distribution of total CHE by diseases and conditions shows that most of the monies were spent on the following diseases and conditions: about 34 percent of the total CHE was spent on HIV/AIDS and STIs, followed by malaria at 16 percent, RH at 9 percent, and maternal health conditions at 5 percent.
- viii. While the high expenditure on HIV/AIDS and STIs is probably in line with the high disease burden due to HIV/AIDS in Zambia; there is need to also increase expenditure on malaria, nutritional deficiencies, and RH given that they also contribute to the high morbidity and mortality in Zambia.
- ix. Concentration of total CHE on a few diseases and conditions could be attributed to earmarking of resources by donors. About 70 percent of the total donor expenditure in the health sector in Zambia in 2015 and 2016 was earmarked and spent on HIV/AIDS and STIs.
- x. Most of the funding for HIV/AIDS were provided by donors while the Zambian Government was the second largest financier for HIV/AIDS. Further, NPISH were the main channel through which HIV/AIDS programs were managed during the period under review. This further highlights the off-budget nature of HIV/AIDS financing in Zambia.
- xi. Unlike HIV/AIDS, the Zambian Government was the largest financier for malaria and RH goods and services. Further, the Zambian Government was also the largest financing agent for malaria and RH goods and services during the period under review.
- xi. Unlike HIV/AIDS, the Zambian Government was the largest financier for malaria and RH goods and services. Further, the Zambian Government was also the largest financing agent for malaria and RH goods and services during the period under review.

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Annexes A: Selected NHA Matrices

Table A1: Current health expenditures (2016) by healthcare financing schemes and revenues

| Institutional units providing revenues to financing schemes | | FS.RI.1 | FS.RI.1 | FS.RI.1 | FS.RI.1 | FS.RI.1 | FS.RI.1.n | All FS.RI | Share of HF |
|---|---|-----------------|---------------|-----------------|-------------|-------------------|---|-----------------|--------------|
| <i>Kwacha (ZMK), Million</i> | | Government | Corporations | Households | NPISH | Rest of the world | Unspecified institutional units providing revenues to financing schemes | | |
| Government schemes and compulsory contributory health care financing | | 3,750.05 | | | | 1,341.63 | | 5,091.68 | 53.29 |
| Government schemes | | 3,750.05 | | | | 1,341.63 | | 5,091.68 | 53.29 |
| HF.1.1.1 | Central government schemes | 3,749.21 | | | | 1,049.33 | | 4,798.53 | 50.22 |
| HF.1.1.2 | State/regional/local government schemes | | | | | 290.76 | | 290.76 | 3.04 |
| HF.1.1.nec | Unspecified government schemes (n.e.c.) | 0.84 | | | | 1.54 | | 2.38 | 0.02 |
| Voluntary health care payment schemes | | | 673.77 | 4.14 | 4.30 | 2,445.32 | 1.01 | 3,128.55 | 32.75 |
| Voluntary health insurance schemes | | | 64.24 | 4.12 | | | 0.95 | 69.31 | 0.73 |
| HF.2.1.1 | Primary/substitutory health insurance schemes | | 64.24 | 4.12 | | | 0.95 | 69.31 | 0.73 |
| HF.2.1.1.1 | Employer-based insurance (Other than enterprises schemes) | | 64.24 | 4.12 | | | 0.95 | 69.31 | 0.73 |
| | NPISH financing schemes (including development agencies) | | | 0.02 | 4.30 | 2,445.32 | 0.06 | 2,449.71 | 25.64 |
| HF.2.2.1 | NPISH financing schemes (excluding HF.2.2.2) | | | 0.02 | 4.20 | 2,378.66 | 0.06 | 2,382.95 | 24.94 |
| HF.2.2.2 | Resident foreign agencies schemes | | | | | 64.32 | | 64.32 | 0.67 |
| HF.2.2.nec | Unspecified NPISH financing schemes (n.e.c.) | | | | 0.10 | 2.35 | | 2.44 | 0.03 |
| HF.2.3.1 | Enterprise financing schemes | | 609.53 | | | | | 609.53 | 6.38 |
| | Enterprises (except health care providers) financing schemes | | 76.89 | | | | | 76.89 | 0.80 |
| HF.2.3.2 | Health care providers financing schemes | | 499.76 | | | | | 499.76 | 5.23 |
| HF.2.3.nec | Unspecified enterprise financing schemes (n.e.c.) | | 32.89 | | | | | 32.89 | 0.34 |
| Household out-of-pocket payment | | | | 1,172.43 | | | | 1,172.43 | 12.27 |
| Out-of-pocket excluding cost-sharing | | | | 1,172.43 | | | | 1,172.43 | 12.27 |
| Rest of the world financing schemes (non-resident) | | | | | | 161.59 | | 161.59 | 1.69 |
| Voluntary schemes (non-resident) | | | | | | 92.03 | | 92.03 | 0.96 |
| HF.4.2.2 | Other schemes (non-resident) | | | | | 92.03 | | 92.03 | 0.96 |
| HF.4.2.2.1 | Philanthropy/international NGOs schemes | | | | | 64.70 | | 64.70 | 0.68 |
| HF.4.2.2.2 | Foreign development agencies schemes | | | | | 16.19 | | 16.19 | 0.17 |
| HF.4.2.2.3 | Schemes of enclaves (e.g. international organisations or embassies) | | | | | 11.13 | | 11.13 | 0.12 |
| | Unspecified rest of the world financing schemes (n.e.c.) | | | | | 69.56 | | 69.56 | 0.73 |
| Unspecified financing schemes (n.e.c.) | | | | | | 0.01 | | 0.01 | 0.00 |
| | | 3,750.05 | 673.77 | 1,176.57 | 4.30 | 3,948.55 | 1.01 | 9,554.25 | |

Table A2: Current health expenditures (2016) revenues of healthcare financing schemes by agents

Currency: Kwacha (ZMK)

| Revenues of health care financing schemes | | | FS.1 | FS.2 | FS.5 | FS.5.2 | FS.6 | FS.7 | All FS | Share of FA. |
|---|---|--|--|---|----------------------|-------------------------------------|--------------------------------|--------------------------|----------------|---------------|
| <i>Kwacha (ZMK), Million</i> | | | Transfers from government domestic revenue (allocated to | Transfers distributed by government from foreign origin | Voluntary prepayment | Voluntary prepayment from employers | Other domestic revenues n.e.c. | Direct foreign transfers | | |
| Financing agents | | | | | | | | | | |
| FA.1 | General | | 3,750 | 1,321 | | | | 20.72 | 5,091.7 | 53.29 |
| FA.1.1 | Central government | | 3,750 | 1,095 | | | | 20.72 | 4,865.2 | 50.92 |
| FA.1.1.1 | Ministry of Health | | 3,687 | 930 | | | | 20.72 | 4,637.7 | 48.54 |
| FA.1.1.2 | Ministry of Defense | | 5.42 | | | | | | 5.42 | 0.06 |
| FA.1.1.3 | Ministry of Home Affairs | | 0.96 | 15.60 | | | | | 16.55 | 0.17 |
| FA.1.1.4 | Statutory Bodies | | 56.25 | 21.17 | | | | | 77.42 | 0.81 |
| | FA.1.1.4.1 National AIDS Council | | | 6.18 | | | | | 6.18 | 0.06 |
| | FA.1.1.4.nec Other Statutory Bodies | | 56.25 | 14.99 | | | | | 71.24 | 0.75 |
| FA.1.1.5 | Ministry of Higher Education | | | 104.06 | | | | | 104.06 | 1.09 |
| FA.1.1.nec | Unspecified central government agents (n.e.c.) | | | 24.01 | | | | | 24.01 | 0.25 |
| FA.1.2 | State/Regional/Local government | | | 226.09 | | | | | 226.09 | 2.37 |
| FA.1.9 | All other general government units | | 0.41 | | | | | | 0.41 | 0.00 |
| FA.2 | Insurance corporations | | | | 51.03 | 51.03 | 18.24 | | 69.31 | 0.73 |
| FA.2.1 | Commercial insurance companies | | | | 51.03 | 51.03 | 18.24 | | 69.31 | 0.73 |
| FA.3 | Corporations (Other than insurance corporations) | | | | | | 609.53 | | 609.53 | 6.38 |
| FA.3.2 | Corporations (Other than providers of health services) | | | | | | 609.53 | | 609.53 | 6.38 |
| FA.4 | Non-profit institutions serving | | | | | | 7.9 | 2,441.8 | 2,449.7 | 25.64 |
| FA.5 | Households | | | | | | 1,172.4 | | 1,172.4 | 12.27 |
| FA.6 | Rest of the world | | | | | | | 161.58 | 161.60 | 1.69 |
| FA.6.1 | International organisations | | | | | | | 99.92 | 99.93 | 1.05 |
| FA.6.2 | Foreign governments | | | | | | | 7.63 | 7.63 | 0.08 |
| FA.6.3 | Other foreign entities | | | | | | | 54.04 | 54.04 | 0.57 |
| All FA | | | 3,750 | 1,321 | 51 | 51 | 1,808 | 2,624 | 9,554 | 100.00 |
| Share of FS | | | 39.25 | 13.83 | 0.53 | 0.53 | 18.92 | 27.47 | | |

Table A3: Current health expenditures (2016) by healthcare providers and healthcare financing schemes

Currency: Kwacha (ZMK)

| Institutional units providing revenues to financing | | | FS.RI.1. | FS.RI.1. | FS.RI.1. | FS.RI.1. | FS.RI.1. | FS.RI.1.ne | All FS.RI | Share of HP |
|---|--|---|-----------------|---------------|-----------------|-------------|-------------------|---|-----------------|--------------|
| <i>Kwacha (ZMK), Million</i> | | | Government | Corporations | Households | NPISH | Rest of the world | Unspecified institutional units providing revenues to financing schemes | | |
| Health care providers | | | | | | | | | | |
| HP.1 | Hospitals | | 2,082.07 | 115.55 | 225.52 | 1.07 | 751.41 | 0.79 | 3,176.41 | 33.25 |
| HP.1.1 | Non-Specialized Hospitals | | 1,974.25 | 114.28 | 225.52 | 1.07 | 751.41 | 0.79 | 3,067.32 | 32.10 |
| | HP.1.1.1 | Public Hospitals | 1,866.13 | 49.15 | 149.51 | 0.02 | 714.28 | 0.32 | 2,779.43 | 29.09 |
| | | HP.1.1.1.1 First-Level Public Hospital | 689.26 | | 20.35 | | 242.14 | | 951.75 | 9.96 |
| | | HP.1.1.1.2 Second-Level Public Hospital | 423.92 | 18.67 | 35.13 | | 148.92 | | 626.64 | 6.56 |
| | | HP.1.1.1.3 Third-Level Public Hospital | 748.53 | 12.88 | 92.66 | | 307.28 | | 1,161.35 | 12.16 |
| | | HP.1.1.1.nec Other Public Hospitals | 4.43 | 17.61 | 1.37 | 0.02 | 15.94 | 0.32 | 39.69 | 0.42 |
| | HP.1.1.2 | Private For-Profit Hospitals | 1.02 | 34.37 | 67.08 | | 0.35 | | 102.82 | 1.08 |
| | HP.1.1.3 | Private Not for Profit Hospitals | 107.10 | 0.13 | 6.84 | 1.05 | 36.77 | | 151.89 | 1.59 |
| | HP.1.1.nec | Other General hospitals | | 30.62 | 2.09 | | | 0.47 | 33.18 | 0.35 |
| | HP.1.2 | Mental health hospitals | 49.08 | | | | | | 49.08 | 0.51 |
| | HP.1.3 | Specialised hospitals (Other than mental health hospitals) | 58.74 | | | | | | 58.74 | 0.61 |
| | HP.1.nec | Unspecified hospitals (n.e.c.) | | 1.27 | | | | | 1.27 | 0.01 |
| HP.2 | Residential long-term care facilities | | 1.01 | | 0.04 | | | | 1.04 | 0.01 |
| HP.2.1 | Long-term nursing care facilities | | 1.01 | | 0.04 | | | | 1.04 | 0.01 |
| HP.3 | Providers of ambulatory health care | | 1,006.75 | 5.65 | 321.45 | | 458.32 | 0.11 | 1,792.28 | 18.76 |
| HP.3.4 | Ambulatory health care centres | | 1,006.75 | 5.65 | 321.45 | | 458.17 | 0.11 | 1,792.13 | 18.76 |
| | HP.3.4.1 | Family planning centres | | | | | 22.40 | | 22.40 | 0.23 |
| | HP.3.4.5 | Non-specialised ambulatory health care centres and Clinics | 1,006.75 | 5.65 | 321.45 | | 435.77 | 0.11 | 1,769.72 | 18.52 |
| | | HP.3.4.5.1 Public Health Centre | 1,006.75 | | 268.93 | | 435.64 | | 1,711.32 | 17.91 |
| | | HP.3.4.5.2 Private Not for Profit Health Centre | | | 1.17 | | 0.13 | | 1.30 | 0.01 |
| | | HP.3.4.5.3 Private For Profit Clinics | | 0.13 | 50.98 | | | | 51.10 | 0.53 |
| | | HP.3.4.5.nec Other Non-specialised ambulatory health care centres | | 5.52 | 0.37 | | | 0.11 | 6.00 | 0.06 |
| HP.3.5 | Providers of home health care services | | | | | | 0.15 | | 0.15 | 0.00 |
| HP.4 | Providers of ancillary | | 46.89 | | | 0.16 | 87.24 | | 134.30 | 1.41 |
| HP.4.1 | Providers of patient transportation and emergency rescue | | 41.74 | | | | 1.84 | | 43.59 | 0.46 |
| HP.4.2 | Medical and diagnostic laboratories | | 5.15 | | | 0.16 | 71.47 | | 76.78 | 0.80 |
| HP.4.9 | Other providers of ancillary services | | | | | | 13.93 | | 13.93 | 0.15 |
| HP.5 | Retailers and Other providers of medical goods | | | 2.56 | 628.32 | 1.50 | 334.53 | 0.05 | 966.96 | 10.12 |
| HP.5.1 | Pharmacies | | | 2.56 | 628.32 | 1.50 | | 0.05 | 632.43 | 6.62 |
| HP.5.9 | All Other miscellaneous sellers and Other suppliers of pharmaceuticals and medical goods | | | | | | 334.53 | | 334.53 | 3.50 |
| HP.6 | Providers of preventive | | 11.65 | | | | 1,587.19 | | 1,598.84 | 16.73 |
| HP.7 | Providers of health care system administration and financing | | 601.15 | 13.21 | | 0.10 | 538.00 | 0.06 | 1,152.52 | 12.06 |
| HP.7.1 | Government health administration agencies | | 601.15 | | | | 471.40 | | 1,072.56 | 11.23 |
| HP.7.3 | Private health insurance administration agencies | | | 13.21 | | | | | 13.21 | 0.14 |
| HP.7.9 | Other administration agencies | | | | | 0.10 | 66.60 | 0.06 | 66.76 | 0.70 |
| HP.8 | Rest of economy | | 0.49 | 536.17 | 1.08 | | 16.85 | | 554.58 | 5.80 |
| HP.8.2 | All Other industries as secondary providers of health care | | 0.49 | 536.17 | 1.08 | | | | 537.73 | 5.63 |
| HP.8.3 | Community health workers (or village health worker, community health aide, etc.) | | | | | | 16.85 | | 16.85 | 0.18 |
| HP.9 | Rest of the world | | 0.03 | | | | 0.20 | | 0.24 | 0.00 |
| HP.nec | Unspecified health care providers (n.e.c.) | | | 0.63 | 0.18 | 1.47 | 174.80 | | 177.08 | 1.85 |
| All HP | | | 3,750.05 | 673.77 | 1,176.57 | 4.30 | 3,948.55 | 1.01 | 9,554.25 | |
| Share of FS.RI | | | 39.25 | 7.05 | 12.31 | 0.05 | 41.33 | 0.01 | | |

Table A4: Current health expenditures (2016) by healthcare functions and healthcare financing schemes

| Institutional units providing revenues to financing | | | FS.RI.1. | FS.RI.1. | FS.RI.1. | FS.RI.1. | FS.RI.1. | All FS.RI. | Share of HC |
|---|---|---|-----------------|---------------|-----------------|-------------|-------------------|-----------------|--------------|
| <i>Kwacha (ZMK), Million</i> | | | Government | Corporations | Households | NPISH | Rest of the world | | |
| Health care functions | | | | | | | | | |
| HC.1 | Curative care | | 2,790.08 | 653.44 | 555.70 | | 1,099.64 | 5,099.81 | 53.38 |
| HC.1.1 | Inpatient curative care | | 1,271.49 | 181.02 | 56.74 | | 8.58 | 1,518.21 | 15.89 |
| | HC.1.1.1 | General inpatient curative care | 1,271.49 | 160.65 | 55.11 | | 1.56 | 1,488.81 | 15.58 |
| | HC.1.1.2 | Specialised inpatient curative care | | 0.08 | | | 6.63 | 6.71 | 0.07 |
| | HC.1.1.nec | Unspecified inpatient curative care (n.e.c.) | | 20.30 | 1.63 | | 0.39 | 22.70 | 0.24 |
| | HC.1.3 | Outpatient curative care | 1,518.59 | 472.39 | 498.96 | | 1,090.62 | 3,581.13 | 37.48 |
| | HC.1.3.1 | General outpatient curative care | 1,518.59 | 442.48 | 489.13 | | 1,073.97 | 3,524.17 | 36.89 |
| | HC.1.3.2 | Dental outpatient curative care | | | 7.54 | | | 7.54 | 0.08 |
| | HC.1.3.nec | Unspecified outpatient curative care (n.e.c.) | | 29.91 | 2.29 | | 16.64 | 49.42 | 0.52 |
| | HC.1.4 | Home-based curative care | | | | | 0.15 | 0.15 | 0.00 |
| | HC.1.nec | Unspecified curative care (n.e.c.) | | 0.02 | 0.00 | | 0.29 | 0.31 | 0.00 |
| HC.2 | Rehabilitative care | | 0.00 | | | | 0.58 | 0.58 | 0.01 |
| | HC.2.nec | Unspecified rehabilitative care (n.e.c.) | 0.00 | | | | 0.58 | 0.58 | 0.01 |
| HC.3 | Long-term care (health) | | 1.01 | | | 0.36 | 34.84 | 36.20 | 0.38 |
| | HC.3.nec | Unspecified long-term care (n.e.c.) | 1.01 | | | 0.36 | 34.84 | 36.20 | 0.38 |
| HC.4 | Ancillary services (non-specified by function) | | 27.90 | | | 0.16 | 84.27 | 112.33 | 1.18 |
| | HC.4.1 | Laboratory services | 3.84 | | | | 84.20 | 88.04 | 0.92 |
| | HC.4.2 | Imaging services | 2.32 | | | 0.16 | 0.07 | 2.56 | 0.03 |
| | HC.4.3 | Patient transportation | 21.74 | | | | | 21.74 | 0.23 |
| HC.5 | Medical goods (non-specified by function) | | | | 449.10 | 1.50 | 363.76 | 814.35 | 8.52 |
| | HC.5.1 | Pharmaceuticals and Other medical non-durable goods | | | 449.09 | | 25.94 | 475.03 | 4.97 |
| | | Prescribed medicines | | | 449.09 | | | 449.09 | 4.70 |
| | HC.5.1.1 | | | | 449.09 | | | 449.09 | 4.70 |
| | HC.5.1.3 | Other medical non-durable goods | | | | | 25.94 | 25.94 | 0.27 |
| | HC.5.nec | Unspecified medical goods (n.e.c.) | | | 0.00 | 1.50 | 337.82 | 339.32 | 3.55 |
| HC.6 | Preventive care | | 329.90 | 6.33 | 171.55 | 1.75 | 1,830.57 | 2,340.11 | 24.49 |
| | HC.6.1 | Information, education and counseling (IEC) programmes | 1.32 | | | 1.61 | 44.12 | 47.06 | 0.49 |
| | | Nutrition IEC programmes | | | | | 1.33 | 1.33 | 0.01 |
| | HC.6.1.2 | | | | | | 1.33 | 1.33 | 0.01 |
| | HC.6.1.3 | Safe sex IEC programmes | | | | | 0.08 | 0.08 | 0.00 |
| | HC.6.1.nec | Other and unspecified IEC programmes (n.e.c.) | 1.32 | | | 1.61 | 42.71 | 45.65 | 0.48 |
| | HC.6.2 | Immunisation programmes | 100.27 | | 8.00 | | 71.72 | 179.99 | 1.88 |
| | | Routine immunisation | 100.21 | | 8.00 | | | 108.21 | 1.13 |
| | HC.6.2.1 | | 100.21 | | 8.00 | | | 108.21 | 1.13 |
| | HC.6.2.2 | Supplemental immunisation | | | | | 40.60 | 40.60 | 0.42 |
| | HC.6.2.2.nec | Other immunisation programmes | 0.07 | | | | 31.13 | 31.19 | 0.33 |
| | HC.6.3 | Early disease detection programmes | 116.39 | | | 0.02 | 11.44 | 127.86 | 1.34 |
| | HC.6.4 | Healthy condition monitoring programmes | 61.00 | | | | 3.34 | 64.34 | 0.67 |
| | HC.6.5 | Epidemiological surveillance and risk and disease control programmes | 5.96 | 0.00 | 0.00 | 0.11 | 1,194.09 | 1,200.16 | 12.56 |
| | | Planning & Management | 5.15 | | 0.00 | 0.08 | 194.51 | 199.75 | 2.09 |
| | HC.6.5.1 | | 5.15 | | 0.00 | 0.08 | 194.51 | 199.75 | 2.09 |
| | HC.6.5.2 | Monitoring & Evaluation (M&E) | 0.01 | | | 0.04 | 12.32 | 12.37 | 0.13 |
| | HC.6.5.3 | Procurement & supply management | | | | | 901.65 | 901.65 | 9.44 |
| | HC.6.5.4 | Interventions | 0.79 | 0.00 | | | 13.52 | 14.31 | 0.15 |
| | | Male circumcision | 0.06 | | | | 7.72 | 7.78 | 0.08 |
| | HC.6.5.4.1 | | 0.06 | | | | 7.72 | 7.78 | 0.08 |
| | HC.6.5.4.nec | Other and unspecified interventions (n.e.c.) | 0.73 | 0.00 | | | 5.80 | 6.53 | 0.07 |
| | HC.6.5.nec | Unspecified epidemiological surveillance and risk and disease control programmes (n.e.c.) | | | | | 72.09 | 72.09 | 0.75 |
| | HC.6.nec | Unspecified preventive care (n.e.c.) | 44.96 | 6.33 | 163.55 | | 505.85 | 720.70 | 7.54 |
| HC.7 | Governance, and health system and financing administration | | 601.15 | 13.21 | 0.02 | 0.53 | 504.54 | 1,119.51 | 11.72 |
| | HC.7.1 | Governance and Health system administration | 554.35 | 10.47 | | 0.17 | 249.53 | 814.58 | 8.53 |
| | | Planning & Management | 554.35 | | | | 16.53 | 570.94 | 5.98 |
| | HC.7.1.1 | | 554.35 | | | | 16.53 | 570.94 | 5.98 |
| | HC.7.1.3 | Procurement & supply management | | | | | 3.64 | 3.64 | 0.04 |
| | HC.7.1.nec | Other governance and Health system administration (n.e.c.) | | 10.47 | | 0.17 | 229.36 | 240.00 | 2.51 |
| | HC.7.2 | Administration of health financing | 44.05 | | | 0.36 | 18.29 | 62.70 | 0.66 |
| | HC.7.nec | Unspecified governance, and health system and financing administration (n.e.c.) | 2.75 | 2.73 | 0.02 | | 236.72 | 242.22 | 2.54 |
| HC.9 | Other health care services not elsewhere classified | | 0.01 | 0.80 | 0.19 | | 30.35 | 31.35 | 0.33 |
| All HC | | | 3,750.05 | 673.77 | 1,176.57 | 4.30 | 3,948.55 | 9,554.25 | |
| Share of FS.RI | | | 39.25 | 7.05 | 12.31 | 0.05 | 41.33 | | |

Table A5: Current health expenditures (2016) by healthcare financing schemes and revenues

Currency: Kwacha (ZMK)

| Institutional units providing revenues to financing | | FS.RI.1. | FS.RI.1. | FS.RI.1. | FS.RI.1. | FS.RI.1. | All FS.RI. | Share of HF |
|---|---|-----------------|---------------|---------------|-------------|-------------------|-----------------|--------------|
| <i>Kwacha (ZMK), Million</i> | | Government | Corporations | Households | NPISH | Rest of the world | | |
| Financing schemes | | | | | | | | |
| HF.1 | Government schemes and compulsory contributory health care financing | 3,233.00 | | | | 479.71 | 3,712.71 | 50.33 |
| HF.1.1 | Government schemes | 3,233.00 | | | | 479.71 | 3,712.71 | 50.33 |
| HF.1.1.1 | Central government schemes | 3,233.00 | | | | 341.21 | 3,574.21 | 48.45 |
| HF.1.1.2 | State/regional/local government schemes | | | | | 138.50 | 138.50 | 1.88 |
| HF.2 | Voluntary health care payment schemes | 0.14 | 321.05 | 0.85 | 3.92 | 2,279.92 | 2,606.80 | 35.34 |
| HF.2.1 | Voluntary health insurance schemes | | 30.70 | 0.68 | | | 32.26 | 0.44 |
| HF.2.1.1 | Primary/substitutory health insurance schemes | | 30.70 | 0.68 | | | 32.26 | 0.44 |
| HF.2.1.1.1 | Employer-based insurance (Other than enterprises schemes) | | 30.70 | 0.68 | | | 32.26 | 0.44 |
| HF.2.2 | NPISH financing schemes (including development agencies) | | | | 3.92 | 2,279.92 | 2,283.87 | 30.96 |
| HF.2.2.1 | NPISH financing schemes (excluding HF.2.2.2) | | | | 3.82 | 2,279.84 | 2,283.70 | 30.96 |
| HF.2.2.nec | Unspecified NPISH financing schemes (n.e.c.) | | | | 0.10 | 0.07 | 0.17 | 0.00 |
| HF.2.3 | Enterprise financing schemes | 0.14 | 290.35 | 0.18 | | | 290.67 | 3.94 |
| HF.2.3.1 | Enterprises (except health care providers) financing schemes | 0.14 | 71.40 | 0.18 | | | 71.71 | 0.97 |
| HF.2.3.2 | Health care providers financing schemes | | 218.45 | | | | 218.45 | 2.96 |
| HF.2.3.nec | Unspecified enterprise financing schemes (n.e.c.) | | 0.50 | | | | 0.50 | 0.01 |
| HF.3 | Household out-of-pocket payment | | | 995.54 | | | 995.54 | 13.49 |
| HF.3.1 | Out-of-pocket excluding cost-sharing | | | 995.54 | | | 995.54 | 13.49 |
| HF.4 | Rest of the world financing schemes (non-resident) | | | | | 62.29 | 62.29 | 0.84 |
| HF.4.2 | Voluntary schemes (non-resident) | | | | | 62.29 | 62.29 | 0.84 |
| HF.4.2.2 | Other schemes (non-resident) | | | | | 62.29 | 62.29 | 0.84 |
| HF.4.2.2.1 | Philanthropy/international NGOs schemes | | | | | 39.85 | 39.85 | 0.54 |
| HF.4.2.2.2 | Foreign development agencies schemes | | | | | 1.30 | 1.30 | 0.02 |
| HF.4.2.2.3 | Schemes of enclaves (e.g. international organisations or embassies) | | | | | 21.13 | 21.13 | 0.29 |
| All HF | | 3,233.14 | 321.05 | 996.39 | 3.92 | 2,821.91 | 7,377.33 | |
| Share of FS.RI | | 43.83 | 4.35 | 13.51 | 0.05 | 38.25 | | |

Table A6: Current health expenditures (2016) by healthcare financing schemes and revenues

Currency: Kwacha (ZMK)

| Revenues of health care financing schemes | | | FS.1 | FS.1.1 | FS.2 | FS.5 | FS.5.2 | FS.6 | FS.7 | FS.nec | All FS | Share of FA |
|---|---|---|--|-------------------------------|---|----------------------|-------------------------------------|--------------------------------|--------------------------|--|----------------|---------------|
| Kwacha (ZMK), Million | | | Transfers from government domestic revenue (allocated to | Internal transfers and grants | Transfers distributed by government from foreign origin | Voluntary prepayment | Voluntary prepayment from employers | Other domestic revenues n.e.c. | Direct foreign transfers | Unspecified revenues of health care financing schemes (n.e.c.) | | |
| Financing agents | | | | | | | | | | | | |
| FA.1 | General | | 3,233.0 | 3,233.0 | 479.71 | | | | | | 3,712.7 | 50.33 |
| | FA.1.1 | Central government | 3,233.0 | 3,233.0 | 393.95 | | | | | | 3,626.9 | 49.16 |
| | FA.1.1.1 | Ministry of Health | 2,217.8 | 2,217.8 | 322.28 | | | | | | 2,540.1 | 34.43 |
| | FA.1.1.2 | Other ministries and public units (belonging to central government) | 1,015.2 | 1,015.2 | 47.02 | | | | | | 1,062.2 | 14.40 |
| | FA.1.1.4 | National Health Insurance Agency | | | 7.48 | | | | | | 7.5 | 0.10 |
| | FA.1.1.4.1 | National AIDS Council | | | 5.07 | | | | | | 5.07 | 0.07 |
| | FA.1.1.4.nec | Other Statutory Bodies | | | 2.41 | | | | | | 2.41 | 0.03 |
| | FA.1.1.5 | Ministry of Higher Education | | | 17.16 | | | | | | 17.16 | 0.23 |
| | FA.1.2 | State/Regional/Local government | | | 85.76 | | | | | | 85.76 | 1.16 |
| FA.2 | Insurance corporations | | | | | 21.55 | 21.55 | 10.12 | | 0.59 | 32.26 | 0.44 |
| | FA.2.1 | Commercial insurance companies | | | | 21.55 | 21.55 | 10.12 | | 0.59 | 32.26 | 0.44 |
| FA.3 | Corporations (Other than insurance corporations) | | | | | | | 290.67 | | | 290.67 | 3.94 |
| | FA.3.1 | Health management and provider corporations | | | | | | 168.35 | | | 168.35 | 2.28 |
| | FA.3.2 | Corporations (Other than providers of health services) | | | | | | 122.32 | | | 122 | 1.66 |
| FA.4 | Non-profit institutions serving | | | | | | | 23.80 | 2,262 | 0 | 2,286 | 30.99 |
| FA.5 | Households | | | | | | | 995.54 | | | 996 | 13.49 |
| FA.6 | Rest of the world | | | | | | | | 60 | | 60 | 0.81 |
| | FA.6.1 | International organisations | | | | | | | 59 | | 59 | 0.80 |
| | FA.6.2 | Foreign governments | | | | | | | 1.30 | | 1.30 | 0.02 |
| All FA | | | 3,233.0 | 3,233.0 | 479.7 | 21.5 | 21.5 | 1,320.1 | 2,322.3 | 0.6 | 7,377.3 | 100.00 |
| Share of FS | | | 43.82 | 43.82 | 6.50 | 0.29 | 0.29 | 17.89 | 31.48 | 0.01 | | |

Table A7: Current health expenditures (2016) by healthcare financing schemes and health providers

| Financing schemes | | | HF.1 | HF.2 | HF.3 | HF.3.1 | HF.4 | All HF | Share of HP |
|-----------------------|--|--|--|---------------------------------------|---------------------------------|--------------------------------------|--|----------------|--------------|
| Health care providers | | | Government schemes and compulsory contributory health care financing schemes | Voluntary health care payment schemes | Household out-of-pocket payment | Out-of-pocket excluding cost-sharing | Rest of the world financing schemes (non-) | | |
| Kwacha (ZMK), Million | | | | | | | | | |
| HP.1 | Hospitals | | 1,842.59 | 331.15 | 188.56 | 188.56 | | 2,362.3 | 32.02 |
| HP.1.1 | General hospitals | | 1,842.59 | 331.15 | 188.56 | 188.56 | | 2,362.2 | 32.02 |
| HP.1.1.1 | Public Hospitals | | 1,736.25 | 30.92 | 125.79 | 125.79 | | 1,893.0 | 25.66 |
| HP.1.1.1.1 | First-Level Public Hospital | | 554.92 | | 17.28 | 17.28 | | 572.2 | 7.76 |
| HP.1.1.1.2 | Second-Level Public Hospital | | 518.42 | 0.55 | 29.83 | 29.83 | | 548.81 | 7.44 |
| HP.1.1.1.3 | Third-Level Public Hospital | | 661.47 | 1.24 | 78.68 | 78.68 | | 741.39 | 10.05 |
| HP.1.1.1.nec | Other Public Hospitals | | 1.44 | 29.13 | | | | 30.57 | 0.41 |
| HP.1.1.2 | Private For-Profit Hospitals | | 1.11 | 283.93 | 56.96 | 56.96 | | 341.99 | 4.64 |
| HP.1.1.3 | Private Not for Profit Hospitals | | 105.15 | 2.85 | 5.81 | 5.81 | | 113.81 | 1.54 |
| HP.1.1.nec | Other General hospitals | | | 13.45 | | | | 13.45 | 0.18 |
| HP.1.2 | Mental health hospitals | | 0.07 | | | | | 0.07 | 0.00 |
| HP.2 | Residential long-term care facilities | | 1.20 | | 0.03 | 0.03 | | 1.23 | 0.02 |
| HP.2.1 | Long-term nursing care facilities | | 1.10 | | 0.03 | 0.03 | | 1.13 | 0.02 |
| HP.2.9 | Other residential long-term care facilities | | 0.10 | | | | | 0.10 | 0.00 |
| HP.3 | Providers of ambulatory health care | | 829.8 | 129.2 | 272.6 | 272.6 | 6.5 | 1,238.1 | 16.78 |
| HP.3.4 | Ambulatory health care centres | | 829.8 | 129.2 | 272.6 | 272.6 | 6.5 | 1,238.1 | 16.78 |
| HP.3.4.1 | Family planning centres | | | | | | 0.2 | 0.2 | 0.00 |
| HP.3.4.5 | Non-specialised ambulatory health care centres | | 829.8 | 129.2 | 272.6 | 272.6 | 6.3 | 1,237.9 | 16.78 |
| HP.3.4.5.1 | Public Health Centre | | 817.7 | 22.7 | 228.4 | 228.4 | 4.3 | 1,073.0 | 14.54 |
| HP.3.4.5.2 | Private Not for Profit Health Centre | | 12.2 | 81.8 | 1.0 | 1.0 | 2.0 | 97.0 | 1.31 |
| HP.3.4.5.3 | Private For Profit Clinics | | | | 43.28 | 43.28 | | 43.28 | 0.59 |
| HP.3.4.5.nec | Other Non-specialised ambulatory health care centres | | | 24.67 | | | | 24.67 | 0.33 |
| HP.3.5 | Providers of home health care services | | | 0.00 | | | | 0.00 | 0.00 |
| HP.4 | Providers of ancillary services | | 43.19 | 40.12 | | | 0.44 | 83.74 | 1.14 |
| HP.4.1 | Providers of patient transportation and emergency rescue | | 36.63 | | | | 0.44 | 37.07 | 0.50 |
| HP.4.2 | Medical and diagnostic laboratories | | 6.55 | 40.12 | | | | 46.67 | 0.63 |
| HP.5 | Retailers and Other providers of medical goods | | 75.36 | | 533.41 | 533.41 | | 608.76 | 8.25 |
| HP.5.1 | Pharmacies | | | | 533.41 | 533.41 | | 533.41 | 7.23 |
| HP.5.9 | All Other miscellaneous sellers and Other suppliers of pharmaceuticals and medical goods | | 75.36 | | | | | 75.36 | 1.02 |
| HP.6 | Providers of preventive | | 258.54 | 1,602.1 | | | 7.5 | 1,868.2 | 25.32 |
| HP.7 | Providers of health care system administration and financing | | 557.32 | 170.62 | | | 13.25 | 741.19 | 10.05 |
| HP.7.1 | Government health administration agencies | | 553.15 | 0.14 | | | | 553.28 | 7.50 |
| HP.7.3 | Private health insurance administration agencies | | | 9.15 | | | | 9.15 | 0.12 |
| HP.7.9 | Other administration agencies | | 4.17 | 161.34 | | | 13.25 | 178.76 | 2.42 |
| HP.8 | Rest of economy | | 1.07 | 0.14 | 0.91 | 0.91 | | 2.11 | 0.03 |
| HP.8.2 | All Other industries as secondary providers of health care | | 0.01 | 0.05 | 0.91 | 0.91 | | 0.97 | 0.01 |
| HP.8.3 | Community health workers (or village health worker, community health aide, etc.) | | 0.05 | 0.09 | | | | 0.13 | 0.00 |
| HP.8.9 | Other industries n.e.c. | | 1.01 | | | | | 1.01 | 0.01 |
| HP.9 | Rest of the world | | 0.05 | | | | | 0.05 | 0.00 |
| HP.nec | Unspecified health care providers (n.e.c.) | | 103.59 | 333.52 | | | 34.54 | 471.65 | 6.39 |
| All HP | | | 3,712.71 | 2,606.8 | 995.5 | 995.5 | 62.3 | 7,377.3 | |
| Share of HF | | | 50.33 | 35.34 | 13.49 | 13.49 | 0.84 | | |

