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Government of Zambia

Ministry of Health

Policy Brief

Zambia National Health Accounts 2013-2016

Key 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 mainly due to increased government expenditure in infrastructure development.
- In per capita terms, total CHE in Zambia increased from ZMW 487 in 2013 to ZMW 607 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.
- The health sector remains dependent on external assistance (donors) with an 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. In the absence of donor funds, it will be difficult to sustain funding and program implementation.
- At 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) due to lack of/insufficient prepayment and risk pooling mechanisms.
- Allocation of funds by different levels of the health system is sub-optimal. Hospitals account for 34 percent of total CHE, followed by ambulatory care (19 percent) and preventive care (17 percent). This calls for a realignment to primary health care.
- 70 percent of the total funding from donors in the health sector is earmarked to HIV/AIDS and STIs. Earmarking reduces efficiency in resources allocation and capability of the government to optimize total funding across all programs.

1. Introduction

This policy brief presents findings and policy implications of Zambia's National Health Accounts study for the period 2013 to 2016. By design, the National Health Accounts (NHA) survey framework estimates all expenditure and financial flows through the health system from sources to final uses and beneficiaries. The evidence that is generated allows decision-makers to gain a better understanding of the existing health financing landscape, which is critical for making policy decisions and planning.

2. Methods

The 2013–2016 NHA survey uses the 2011 system for health accounts (SHA) analytical framework, which is an internationally standardized tool to collect, analyze, and describe health financing systems.

3. Data Sources

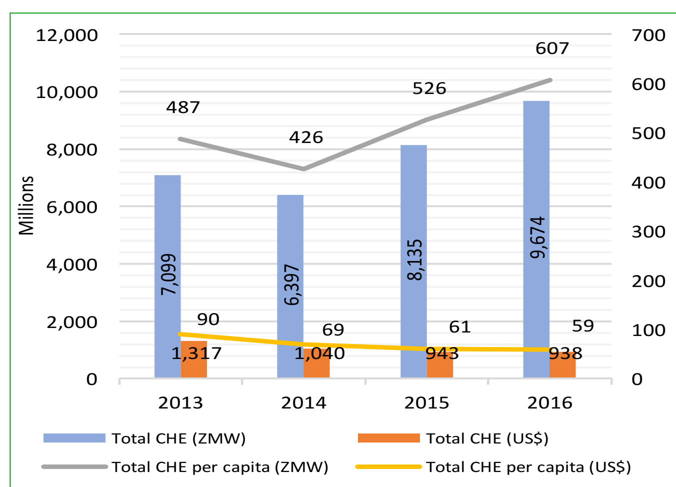
The study used primary and secondary data sources. Primary data was collected from government ministries and departments, cooperating partners, NGOs, private employers, and insurance companies involved in health delivery. In addition, health expenditure from households was estimated using data from the 2014 Zambia household health expenditure and utilization survey.

4. General Findings

4.1. *How much does Zambia spend on health?*

Over the period 2013-2016, Zambia's total nominal CHE increased by 36 percent from ZMW 7.099 billion in 2013 to ZMW 9.674 billion in 2016. In per capita terms, total CHE increased from ZMW487 per capita in 2013 to ZMW607 in 2016. However, if expressed in US$, total CHE declined from US$ 1.317 billion in 2013 to US$ 938 million in 2016. Similarly, total CHE per capita expenditure declined from US$90 in 2013 to US$59 in 2016. This can be attributed to a decline in the value of the Zambian Kwacha during the period under review. Zambia's total health sector spending in 2016 was below the average for LMICs which is estimated at US$82

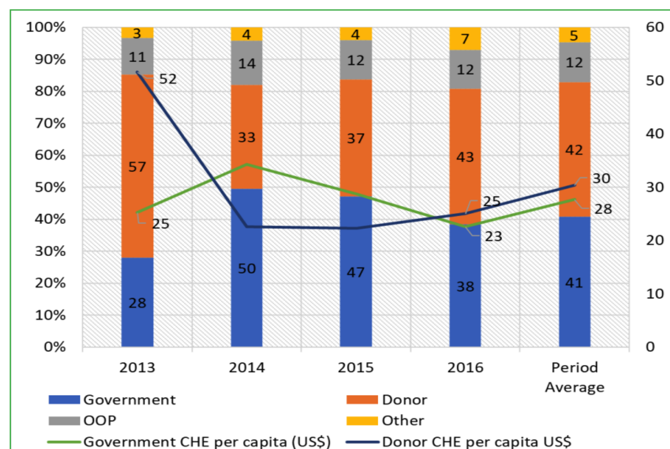
Figure 1: Trends in total CHE (nominal terms)



4.2. *Who funds health spending?*

The donors, government and households are the three biggest contributors to health spending in Zambia. Over the period 2013–2016, donors contributed an average of 42 percent of total CHE while the government contributed 41 percent, and households contributed 12 percent (Figure 2). Employers and non-profit institutions serving households (NPISH) contributed 5 percent of total CHE on average over the same period.

Figure 2: Sources of total CHE in Zambia



The large share of external funding suggests a huge dependency on external assistance to implement key programs and activities in the health sector. This could be unsustainable in the medium-to-long term given that Zambia is now a LMIC. Given its income status, the country has to find alternative ways of financing the health sector in view of the fact that external assistance will likely reduce in the near future.

Another cause for concern is the low contribution from private firms and corporations towards the funding of the health sector. If harnessed properly, these organizations can be an additional source of financing for the health sector in the medium-to-long term as the economy grows.

4.3. *Risk Pooling*

Households are protected from the burden of catastrophic health costs through risk pooling. Risk pooling highlights the level of equity in paying for health and the extent to which households are burdened when they require healthcare.

Table 1: Total CHE by financing schemes (%)

	2013	2014	2015	2016
Central government	34.6	53.3	53.2	50.7
Regional/local government	0.5	0.8	1.7	3
Voluntary health insurance	0.4	0.5	0.4	0.7
NPISH	48.3	25	28.1	25.4
Enterprise	2.9	3.7	3.6	6.3
Household Out of Pocket	11.4	13.8	12.2	12.1
Rest of the World	1.8	2.9	0.7	1.7

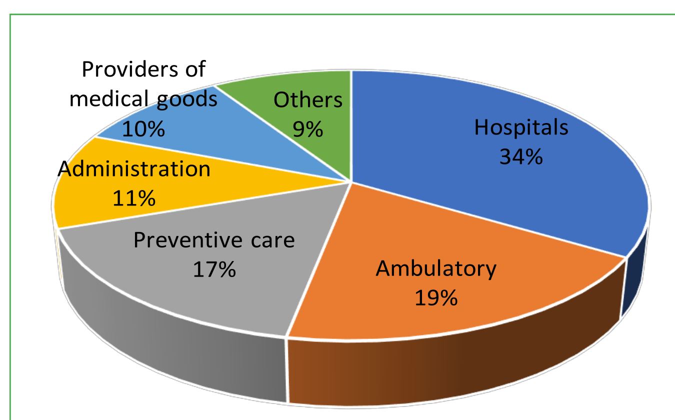
In 2016, about 51 percent of the total CHE was channelled through public institutions, NPISH accounted for 25 percent, and households accounted for 12 percent through out-of-pocket (OOP) spending. NPISH financing schemes are an important channel for disbursing earmarked HIV/AIDS expenditures by donors. And in comparison to other countries in the region, OOP spending on health in Zambia

is very low. However, the study also shows low levels of voluntary prepayment, which could be attributed to a lack and/or insufficient prepayment and risk pooling mechanisms in the country. Currently, participation in the private health insurance market is very low and doesn't promote risk pooling.

4.4. *Resource Allocation*

Allocation of funds to the different levels of care within the health system is sub-optimal. Hospitals account for 34 percent of total CHE in Zambia, followed by ambulatory care (19 percent) and preventive service providers (17 percent). Henceforth, even though more resources are expected to go to primary health care in line with government's vision, this is not the case. This could be explained by the fact that district, secondary and tertiary hospitals have a high number of health workers as compared to the health centres, high concentration of doctors (who are paid 6-times more than the other health workers), high consumption of drugs and medical supplies, and provision of in-patient requisites including food, linen, and ambulance services. Most importantly, there has been a huge increase in expenditure on salaries and wages in the health sector in Zambia; the bulk of which has been at hospital level.

Figure 3: Distribution of CHE by Healthcare Providers, 2016



Inefficient allocation does not only end at provider level, but also extends to functional level, especially diseases. Table 2 shows that more than half (59 percent) of the total CHE in 2016 was spent on the treatment of infectious diseases. Further, spending on HIV/AIDS and STIs accounted for 34 percent of the total CHE in 2016, while Malaria accounted for 13 percent. This kind of spending can be explained by the large portions of external funding that is earmarked to HIV/AIDS and STIs. As a share of the total donor spending in the health sector (total donor CHE), about 70 percent was spent on HIV/AIDS and STIs in 2015 and 2016 (table 2).

Table 2: Percentage share of CHE by disease and conditions (%)

	2013	2014	2015	2016
Infectious Diseases	68	58	63	59
HIV/AIDS and STIs	*43*	*28*	*32*	*34*
Tuberculosis	*0*	*1*	*1*	*1*
Malaria	*15*	*16*	*18*	*13*
Reproductive health	9	11	8	9
Nutritional deficiencies	1	1	1	1
Non-communicable diseases	8	11	10	10
Injuries	2	4	4	3
Percentage of total donor CHE spent on HIV/AIDS			72	70

Earmarking external resources to HIV/AIDS and other diseases reduces the resource allocation capabilities of the government, and policy space to optimise funding across all programs.

5. Policy Implications and recommendations

a) The government increased its nominal spending on the health sector during the period 2013—2016. However, the health sector is still heavily dependent on external funding, which is not sustainable. Therefore, the government should:

- Raise additional resources from alternative domestic sources. Among the options, there should also be increased focus on improving efficiency in the allocation and use of the available resources.
- In the short-to-medium term, the government should ensure that a greater portion of funding from external sources is provided in a flexible manner in order to increase efficiency in resource allocation and use.
- Government should strengthen the role of the private sector in healthcare financing and service provision. This could be achieved through micro-financing and workplace programs.

b) The analysis shows that resource and risk pooling mechanisms in Zambia are still in their infancy. The government should:

- Strengthen existing pooling mechanisms through the public and private sectors.

c) The results show that the bulk of the resources in the health sector are spent at hospital level rather than on ambulatory and prevention services. Further, spending is skewed towards infectious diseases, particularly HIV/AIDS and STIs. The government should:

- Put in place an effective resource allocation formula to optimize the allocation of resources by level of healthcare, and disease burden.

The 2013–2016 NHA survey was conducted by the University of Zambia with financial and technical support from the World Bank Group (Health, Nutrition and Population Global Practice), the Department for International Development (UK Government), and the United States Agency for International Development (Systems for Better Health project). For more information please contact the Permanent Secretary, Ministry of Health, Ndeke House, Lusaka or visit http://www.moh.gov.zm/