HEALTH FINANCING PROFILE

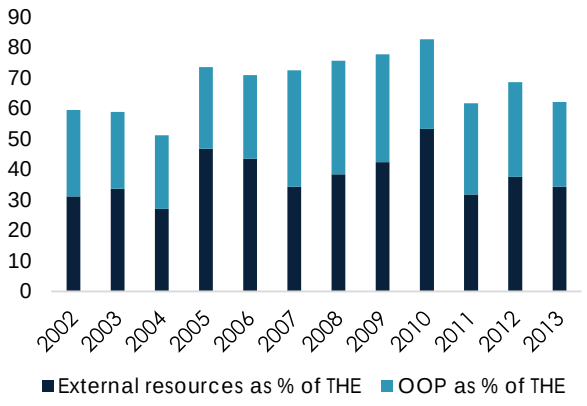
ZAMBIA

May 2016

Key Indicators	
Population (2014)	15.7 million
GDP per capita (current USD, 2014)	$1,722
Income classification	Lower-middle
Health Financing (2013)	
THE per capita (USD)	$93
THE as % of GDP	5.0%
GHE as % of THE	58.3%
GHE as % of GGE	12.6%
OOP as % of THE	27.8%
DAH as % of THE	34.2%
HIV Financing (2015)	
HIV/AIDS prevalence (ages 15–49)	12.4%
DAH for HIV/AIDS as % of TAE	75%
TAE per PLHIV (USD)	$347
GAE as % of GGE	2.1%
GAE as % of TAE	22%

Source: WHO, 2015; Fagan and Zeng, 2015.
THE = total health expenditure, GDP = gross domestic product, GHE = government health expenditure, GGE = general government expenditure, OOP = out-of-pocket, DAH = development assistance for health, TAE = total AIDS expenditure, PLHIV = people living with HIV, GAE = government AIDS expenditure.

Figure 1: Shares of Total Health Expenditure (THE)



Source: WHO, 2015.

Overview

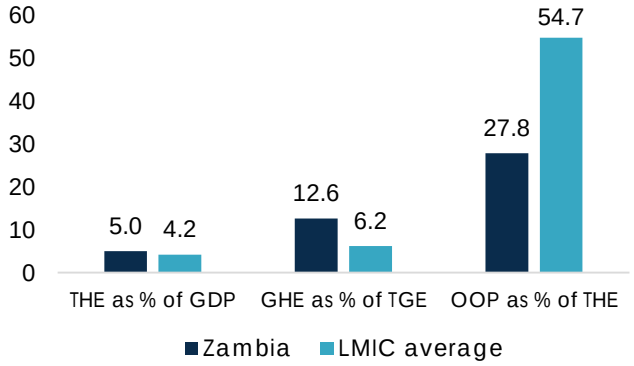
In recent years, Zambia has aimed to expand provision of health services through the public sector. Between 2006 and 2013, government health expenditure as a percentage of total health expenditure (THE) increased from 38% to 58%. External resources contributed heavily and have remained relatively stable, accounting for 34% of THE in 2013. The abolishment of user fees at the primary level of care—first in rural districts and later nationally—between 2006 and 2012 has led to a steady decline in the share of out-of-pocket (OOP) expenditure, from 38% in 2007 to 28% in 2013 (Figure 1). However, many higher-level public facilities retain "fee-for-service" wings, providing a higher quality of care and shorter wait times for patients who can afford them.

In 2015, the Government of Zambia (GRZ) proposed a social health insurance (SHI) scheme with the aim of covering all Zambians. If enacted, this scheme will mark rapid progress toward universal health coverage. Despite the absence of user fees at the primary level of care in the public sector, inadequate funding for the health sector has limited access to and equity of health service provision. The private sector remains a significant contributor to healthcare provision. Two-thirds of private expenditure on health is OOP. Employer-operated clinics are a significant provider of health services, particularly in mining areas.

Per capita government expenditure on health is US$54, compared to US$93 from all sources. Zambia has achieved expenditure on health of 5% of GDP (Figure 2), compared to an average of 4.2% in other lower middle-income countries (LMICs). With 12.6% of general government expenditure spent on health, Zambia is more than double the LMIC average (6.2%) and is nearing the Abuja target of 15% for the share of government budget allocated to health. Continued growth of expenditure for health and improvement of equity and access to services face a number of challenges and will have to rely on new, innovative sources of financing.

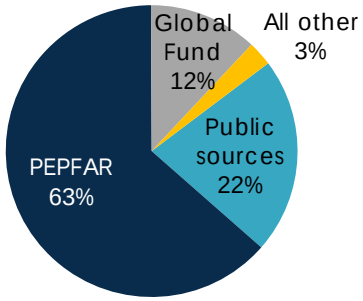
- The GRZ has proposed a national SHI scheme supported by a 5% payroll tax, to be rolled out in two phases—beginning with public and formal sector employees—after the presidential election scheduled for November 2016.
- Inflation in health worker salaries, which has roughly doubled for lower cadres in 2013, poses a significant financial challenge to the sustainability of health service provision in the public sector.
- Private health insurance (PHI) coverage in Zambia is extremely low, with estimates ranging from 0.5% to 3%.

Figure 2: Comparative Health Expenditure (2013)



Source: WHO, 2015.

Figure 3: Total HIV Expenditure 2015 (est.): US$415,731,349



Source: Fagan and Zeng, 2015.

- Corporate contributions to direct provision of health services (excluding PHI), although difficult to measure, are considered significant. The mining sector is the largest such contributor, although recent dips in the price of copper, Zambia's primary export, may have adverse effects on the provision of these services.

Health Financing Functions

Revenue contribution and collection

Financing for the health sector flows primarily through the GRZ, with external donors providing significant on- and off-budget support. External resources provide 34% of total resources for health. GRZ financing for the health sector is provided by general tax and budget support, with no designated revenue stream.

Pooling

The proposed SHI scheme aims to cover all Zambians under a single designated funding pool. The first phase of implementation will reach an estimated 4.5 million Zambians, focusing on formal sector employees and their dependents, and vulnerable populations. The second phase will extend coverage to the general population, bringing more than 11 million people in the informal sector under the scheme. Of the small portion of the population (including dependents) covered by PHI, almost all receive coverage through their employers. Hospital-based insurance schemes provide an additional source of risk pooling. These unregulated schemes operate much like third-party insurance with individuals or families paying a premium for coverage for a defined package of services; however, hospitals themselves, rather than a third-party insurer, assume the risk. It is estimated that these schemes may cover as many as 500,000 Zambians.

Purchasing

Health services in the public sector are provided by the Ministry of Health (MOH) and Ministry of Community Development, Mother and Child Health (MCDMCH), with the latter managing level one and two facilities (health posts and rural and urban health centers), and MOH managing level three, four, and five facilities (district, provincial, and tertiary hospitals). In 2015, MOH received 57% of the GRZ health budget, compared to 42% for MCDMCH. Other line ministries received less than 1% of the total health budget, primarily for infrastructure development and HIV and AIDS mainstreaming.

HIV Financing

Funding for HIV totaled an estimated US$532 million in 2015, with external sources contributing more than 75% of available funds (Figure 3). However, estimated total HIV and AIDS expenditure (TAE) was just US$409 million, highlighting the low execution and utilization of available HIV and health sector funds. With an estimated 1,177,614 people living with HIV (PLHIV), TAE in Zambia per PLHIV was US$347, of which an estimated US$79 came from domestic sources.

GRZ budget allocation for HIV increased from US$95 million in 2012 to US$152 million in 2014, but declined sharply in 2015 to US$129 million due to currency depreciation. Nonetheless, funding for HIV accounts for a full 20% of the GRZ health budget, closely aligned with the HIV and AIDS share of the burden of disease—25% of deaths and 20% of years of life lost.

References and Works Consulted

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