HEALTH FINANCING PROFILE

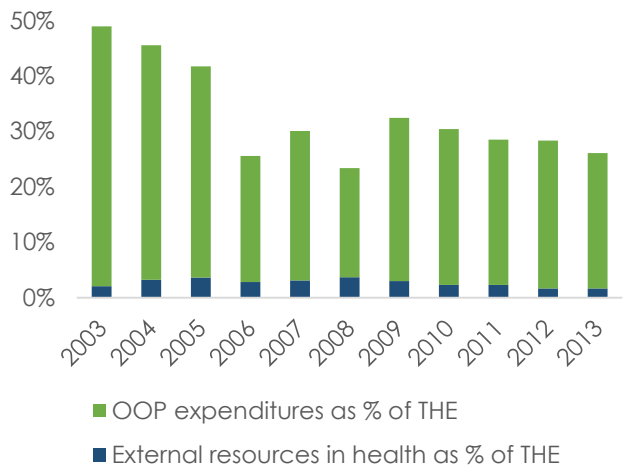
ANGOLA

May 2016

Key Indicators	
Population (2014)	24.2 million
GDP per capita (2013, current USD)	$5,901
Income classification	Upper-middle
Health Financing (2014)	
THE per capita (USD)	$267
THE as % of GDP	3.8%
GHE as % of THE	66.6%
GHE as % of GGE	7.7%
OOP as % of THE	24.4%
DAH as % of THE	3.4%
Pooled private as % of THE	33.3%
HIV Financing	
Adult HIV/AIDS prevalence (2015)	2.4%
DAH for HIV as % of TAE (2014)	36.6%
TAE per PLHIV (USD) (2014)	$14.5
GAE as % of GGE (2014)	0.03%
GAE as % of TAE (2014)	63.3%

Source: WHO, 2016b; World Bank, 2015; MOH, 2014a; MOH, 2014b; WHO, 2016a; UNAIDS, 2015; author's estimates. THE = total health expenditure, GDP = gross domestic product, GHE = government health expenditure, GGE = general government expenditure, OOP = out-of-pocket payment, DAH= development assistance for health, TAE = total AIDS expenditure, GAE= government AIDS expenditure, PLHIV = people living with HIV.

Figure 1: Shares of Total Health Expenditures (THE)



Source: WHO, 2016b.

Overview

Angola is less dependent on donor funding for health than other sub-Saharan African countries, with external resources comprising only 3.4% of total health expenditure (THE) compared to the regional average of 22%. Out-of-pocket (OOP) expenditures as a percentage of THE have gradually decreased (Figure 1). In 2013, THE per capita reached US$267. Although public financing for primary care faced a growth rate of 415% from 2000 to 2005, government health spending as a percentage of general government expenditure remains relatively low, at 7.7%—below the average of 11.4% for upper middle-income countries (UMICs) (Figure 2).

Since 2008, public primary care facilities have not charged user fees, but funding to replace this revenue has been uneven. The public payroll system functions reliably; however, one of the major challenges remaining is to finance non-salary recurrent costs (drugs, water, fuel, and supplies); such financing remains inconsistent and often inadequate due to poor funding for health from the central level and insufficient allocation, planning, and spending at subnational levels.

Negative health indicators remain high despite improvements in those such as maternal mortality (per 100,000 live births), which went from 1,400 in 2001 to 477 in 2015, and neonatal mortality (per 1,000 live births), which went from 98 in 2001 to 48.7 in 2015. The 2010 constitution's Article 21 (f), titled "State Duties," describes "a responsibility of the government to promote universal and free primary healthcare" (National Assembly, 2010). However, the goal of universal health coverage may be challenging for Angola, given decreasing oil prices, inherent social issues, lack of proper infrastructure, and famine. The *National Health Development Plan 2012–2025* (NHDP) envisioned the health system transitioning from a model largely financed by the government to one that emphasizes diversified revenue streams, although primary healthcare will continue to rely on domestic public and external resources. An estimated US$31.2 billion is required to execute the NHDP from 2016 to 2020.

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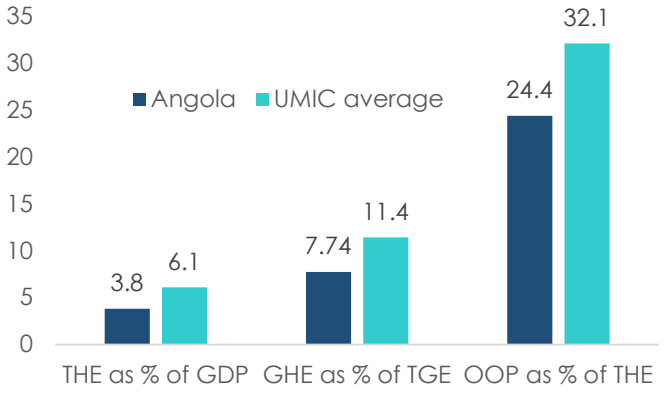
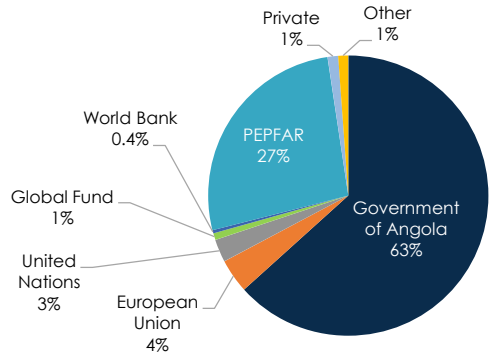
Figure 2: Comparative Health Expenditure (2013)



Source: WHO. 2016a; WHO. 2016b.

Figure 3: HIV Financing by Source (2011)



Source: MOH, 2014a; MOH, 2014b

Health Financing Functions

Revenue contribution and collection

Government expenditures account for two-thirds of THE. The remaining financing for healthcare services comes from private sources, such as companies, insurance, and OOP expenditures; the majority of these private contributions (73%) are OOP. Revenue generation for the government has centered on trade in natural resources, with a weak value-added tax and income tax system in place. The fiscal space for health may be limited in future years due to anticipated declines in revenue from oil exports—currently, 53% of government revenue is generated by the export of crude petroleum.

Pooling

Private health insurance companies emerged in Angola in 2009 and have been concentrated mainly in Luanda. Private and public organizations provide health coverage for their employees and dependents; however, these schemes constitute small, fragmented risk pools, and most preventive health services and HIV and AIDS services are excluded. In the long term, private insurers could develop a solid foundation in actuarial analysis, risk and claims management, and provider contracting; these skills that could benefit future national or social health insurance.

Purchasing

About 60% of the government's health budget is used to cover hospital services. In the private sector and secondary/tertiary levels of the public sector, contracting is on the basis of fee-for-service (FFS). Insurance companies pay on an FFS basis through their contracted hospitals. Angola has poor oversight systems, and many unregulated private providers that deploy poorly skilled human resources and quality of care have emerged.

HIV Financing

Angola has a generalized HIV epidemic, with an estimated prevalence of 2.4% (ages 15–49). HIV accounts for 8.6% of all deaths in the country, whereas the total AIDS expenditure (TAE) accounts for just 0.88% of THE in Angola.

The government is the largest financial contributor to the national response. In 2011, it contributed US$21.5 million, or 63.3% of all funds (Figure 3). In the same year, all other partners contributed US$12.4 million. The TAE per capita in 2011 was US$14.51, or 0.03% of GDP.

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Contact Us
Health Policy Project
1331 Pennsylvania Ave NW, Suite 600
Washington, DC 20004
www.healthpolicyproject.com
policyinfo@futuresgroup.com

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