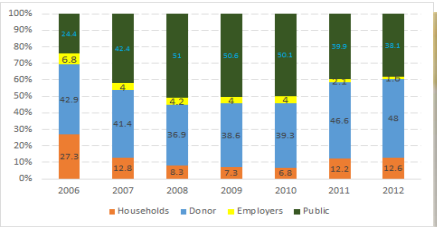
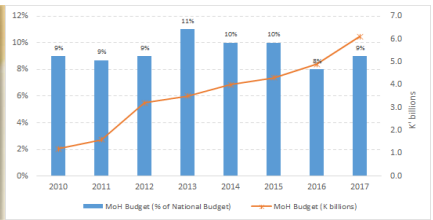
**Republic of Zambia**

**Ministry of Health**

# HEALTH FINANCING STRATEGY: 2017 – 2027

*Towards Universal Health Coverage for Zambia*

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# HEALTH FINANCING STRATEGY: 2017 – 2027

*Towards Universal Health Coverage for Zambia*

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# Foreword

Universal Health Coverage (UHC), is top of the global health policy agenda and has been adopted as part of the Sustainable Development Goals (SDGs). Zambia's transformative agenda acknowledges that a healthy nation is key to our socio-economic development agenda. The transformative agenda has been aligned towards attainment of UHC for all. Pivotal to attaining UHC is the design and implementation of innovative, predictable and sustainable mechanisms to finance health care in a challenging and changing environment.

Given the importance of sustainable financing for healthcare in Zambia, the Ministry of Health has developed the first ever Healthcare Financing Strategy to run from 2017 to 2027. The Healthcare Financing Strategy supports the sector's National Health Strategic Plan (NHSP) and the National Vision 2030 which expresses the Zambian people's aspiration to become a prosperous middle-income nation by 2030. The Healthcare Financing Strategy is premised on the guiding principles of equity, efficiency, transparency, accountability, effective partnerships and evidence based decision making.

This plan envisions a country where all Zambians have access to sustainably financed quality healthcare without facing the risks of catastrophic health expenditure or impoverishment as a result of paying for healthcare services.

It is my considered view that with sustained and predictable levels of financing for health service delivery the Country will achieve the health sector's legacy goals of reduction in maternal and child mortality, malaria elimination, epidemic control of HIV and TB, as well as help build a strong foundation for combatting non-communicable diseases. I therefore urge all people involved in the implementation of this plan to fully dedicate themselves to this cardinal national assignment.

Honourable Dr Chitalu Chilfuya MP, MCC

MINISTER OF HEALTH

# Acknowledgment

This strategy was prepared by the Ministry of Health through a consultative and multi-stakeholder participatory process. The Department of Health Policy and Planning coordinated the process and supervised two local consultants engaged to facilitate the process. In this regard, the Ministry expresses gratitude to the core team at the MoH Headquarters for their leadership and commitment in the process of formulating this strategy. They include the following staff in the Health Policy and Planning Directorate; the Director Dr. Maximillian Bweupe; the Deputy Director, Mr. Henry Chewe Kansembe; the SHI Coordinator Dr. Mpuma Kamanga, the Chief Planners, Mr. Patrick Banda and Mr. Amadeus Mukobe; the Principal Planners, Mr. Terence Siansalama, Mr. Wesley Mwambazi and Ms. Maudy Kaoma; the Senior Planners, Ms. Namwinga Choobe, Mr. Melvin Sikazwe, Mr. Mannix Ngabwe and Mr. Alex Kaba; the Planners, Ms. Fridah Nguni, Ms. Doreen Bwalya, Ms. Rita Banda and Ms. Yolanda Lumpuma. The other key contributors include Ms Namasiku Chime from the Directorate of Mobile health Services, Dr. Anita Kaluba the Director Health Care Financing, Mr, Lazorous Mwelwa the Principal Budget Analyst from the Ministry of Finance and Mr Palale Munda an Independent expert.

Furthermore, special gratitude goes to Mr. Davis Chimfwembe and Dr. Christopher Simoonga the former Directors, Policy and Planning and Mr. Mubita Luwabelwa, the former Deputy Director, Planning and Budgeting who were part of the initial processes of developing this strategy.

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The Ministry expresses gratitude to the members of Heath Financing Technical Working Group and cooperating partners that provided critical comments at various stages. Special tribute to our cooperating partners in particular USAID/Systems for Better Health (SBH) and the World Bank for providing technical support and co-financing the entire process of developing this strategy.

Dr. Kennedy Malama

Permanent Secretary – Administration

MINISTRY OF HEALTH

# Executive Summary

The Health Financing Strategy (HFS) 2017-2027 provides a framework for improving and developing health financing in Zambia to contribute to overall health system goals and objectives. The strategy aligns with the country's vision of having a healthy nation by 2030, the National Health Strategic Plan 2017-2021, the seventh National Development Plan, and the National Health Policy (NHP) 2012. The NHP emphasises the need to mobilise health resources through equitable and sustainable means for the provision of cost-effective quality health care as close to the family as possible. This HFS provides an integrated approach that complements various national policies in addressing present and future health financing challenges.

The Ministry of Health (MOH) and the Health Financing Technical Working Group led the development of the HFS and employed a participatory process over a one-year period. They undertook a comprehensive Health Financing System Assessment. The key findings from the assessment formed the basis for developing the strategy. Local organisations, international experts, and other key stakeholders in the health sector reviewed the draft HFS.

The challenges health financing faces stem from bottlenecks within and outside the health sector. At the macro-fiscal level, the increase in domestic and external debt limits the ability to increase the fiscal space for health through government funding. The high debt-service ratio will make it difficult for government to reprioritise its expenditures to health and other social sectors. Further, the high levels of informality, unemployment, and widespread poverty limit the prospects to generate additional revenue through taxes and the Social Health Insurance (SHI). Further, the country's attainment of the lower-middle-income country status will result in most donors reducing their support to the health sector and government as a whole. As a result, the sector needs a comprehensive HFS to provide an action-oriented agenda on how to mobilise additional resources in the midst of the macro-fiscal challenges.

The table below presents the gaps and weakness in Zambia's health system's three core pillars: resource mobilisation, pooling or revenue, and purchasing.

Broadly, the proposed 10-year HFS is aimed at addressing these challenges through increasing private sector participation. Methods include public-private partnerships, capturing household payments and channelling them efficiently in prepayment and pooling arrangements, and continued engagement with cooperating partners (CPs) in financing the health sector. The key focus is to advocate for increases in the share of government funds allocated to the health sector and to ensure that households are not exposed to financial hardships in seeking health services. The strategy also aims to reduce inefficiencies in the system and improve the system for purchasing. The following is a summary of challenges in the three health financing functions.

| Resource Mobilisation |
| --- |
| - Low and erratic funding to the health sector in relation to needs, particularly for primary care at the district level<br>- Low contribution of domestic revenue to health sector with limited prospects for growth in the short to medium term in light of the large domestic and foreign debt burden<br>- Heavy dependence on external sources of financing, which are unpredictable<br>- Delayed implementation of the SHI Scheme, which is aimed at raising additional revenue for the health sector and promoting household financial protection |

| |
|---|
| - High out-of-pocket (OOP) spending, particularly for secondary level of care |
| - Inefficiencies in resource allocation and use |
| - Outdated resource allocation formula for districts and training institutions |
| - Few public-private partnerships and limited private sector participation in health financing |
| Pooling of revenue |
| - Low level of voluntary prepayment mechanisms |
| - Lack of mechanisms for pooling of risk and cross subsidisation between the different sources of revenue |
| - High level of fragmentation of resources for health services |
| - Lack of harmonisation of donor funding in the health sector, leading to duplication and inefficiency |
| - Lack of a mechanism to track and coordinate donor-funded projects in the health sector |
| Purchasing |
| - Passive and poor purchasing mechanism that does not incentivise improved performance |
| - Lack of purchaser-provider split in the public sector, which does not create the necessary incentives for efficiency and quality of services |
| - Weak mechanism for paying providers that exacerbates health services supply inequities across the tiers of the health system and between rural and urban areas |
| - Lack of strategic purchasing of specialised health services, especially from the private sector abroad, which increases the cost of service delivery |

The overall goal of the HFS is to attain adequate, sustainable, equitable, and predictable financing through existing and new sources for improved health outcomes. HFS will achieve the goal through the following objectives:

1) Provide viable options for increased resource mobilisation and strengthen revenue collection
2) Enhance efficiency in resource allocation and utilisation
3) Improve the risk pooling and redistributive capacity of funds
4) Strengthen the strategic purchasing mechanism
5) Strengthen overall public financial management (PFM) and information systems within the health sector.

The proposed strategic interventions to achieve the stated objectives are as follows:

*Revenue Collection:* To address the challenge of inadequate resources in the health sector in relation to need, the strategies include: 1) advocating for increased government domestic budget allocation to the health sector. MOH will generate evidence to show the existing resource gaps in relation to needs for the health sector to justify the need for additional resources from the government budget; 2) emphasising joint planning and budgeting of resources to ensure that all health sector programmes and activities are aligned to sector priorities; 3) lobby for introduction of 'sin taxes' as a measure to generate additional revenue for the health sector and to deter risky behaviours that are likely to contribute to an increased disease burden with significant financial implications; 4) broadening private sector participation and encouraging strategic public-private partnerships in provision of specialised health services and non-clinical care, human resource training, and health infrastructure development; 5) designing and implementing the SHI scheme to generate additional resources for the health sector and to ensure financial protection to all citizens; and 6) increasing efficiency in the

allocation and use of resources by revising the allocation formulae for district, intra-district, tertiary hospital, training, and statutory boards resources.

*Pooling:* The strategic interventions aimed at reducing fragmentation in resources and risk pooling will target domestic government resources; external resources; and resources generated from households through prepayment mechanisms. The aim is to harmonise and align external financing, enhance complementarity of revenue sources, and avoid duplication of efforts. An immediate goal is to set up an internal tracking mechanism of external resources, which includes tracking of commitments/budget, annual resource/budget mapping, and spending. In addition to designing and implementing the SHI, MOH will facilitate the set-up of voluntary community-based health insurance schemes, which will be linked to the SHI. Emphasis will be on sensitising and empowering households to participate in the insurance schemes to enhance financial protection.

*Purchasing:* The main elements of purchasing mechanism are determining what services or benefits to purchase and determining how to purchase the services. The HFS proposes to develop and cost an essential health care package with primary health services offered free of charge in primary health facilities. The services defined for secondary and tertiary levels of care will be fee based and will be purchased through the insurance coverage via the referral system. The actions to undertake include: 1) Designing and establishing a comprehensive framework for new provider payment mechanisms; 2) Accreditation of health facilities to ensure that only facilities that meet the basic quality requirement are engaged to provide services under the SHI scheme; and 3) Continuous review and revisions of the essential health package in response to changes in drugs and treatment procedures. This requires establishing a health technology assessment unit responsible for economic evaluation of the cost effectiveness of any changes.

Another key strategy is to use a combination of different provider payment mechanisms to stimulate quality improvements in health service delivery. This strategy is proposed because current health worker purchasing and payment mechanisms in Zambia are passive and do not motivate or incentivise staff, encourage productivity and efficiency in the use of resources, or promote service quality. The proposed strategic interventions involve rationalising the various payment systems and aligning them with incentives as follows: 1) Strengthen the case-based payment system, in particular the Diagnostic Related Group (DRG) as a preferred reimbursement model at hospital level. As a fee-based model, DRGs will incentivise hospitals to improve performance since DRGs include some form of active purchasing and are linked to outcomes; 2) Develop capacity among MOH staff and providers to scale-up or reinforce results-based financing (RBF) as a major tool to pay for ambulatory care services for all Zambians. The scaling up process must incorporate the feedback from the monitoring and evaluation process of the current RBF; 3) Continue use of capitation as a mode of provider payments for tax-financed health services in the short to medium term and gradually blend incentive and performance-based financing strategies; 4) Revise input-based payment system by introducing strategic purchasing mechanisms that stimulate accountability and promote quality health services delivery by shifting to a more out-put based provider payment system; and 5) As an efficiency and equity generation measure, pay for key investments in public health facilities from general taxes using an input-based budgeting system. This approach will ensure equity in the distribution of infrastructure and capital equipment among different types of health providers and regions.

The implementation of the HFS will depend on the mechanisms and processes developed to fulfil the vision and achieve the goals and objectives of the health sector. MOH will develop an independent and flexible implementation plan for this strategy that will include implementation plans, prioritisation and sequencing, institutional structures, roles and responsibilities, and processes to develop human and institutional capacity.

# 1. Introduction

## 1.1 Background

This HFS is responding to a number of developments in the country and health sector since the early 1990s. Government initiated major health sector reforms through the National Health Policies and Strategies (NHPS) in 1992 with a vision of attaining "*equity of access to cost-effective quality health services, as close to the family as possible*". This strategy committed government to attaining universal health coverage (UHC). The 1992 NHPS provided the overall national health policy framework for implementation of wide-ranging health sector reforms. Further policy changes came in five successive National Health Strategic Plans (NHSPs) in 1995-1998, 1998-2000, 2001-2005, 2006-2010, 2011-2016 and this will continue in the six NHSP 2017-2021. In line with Zambia's Vision 2030, the NHSP 2017-2021 aims to improve health service delivery and health outcomes. The NHSP 2017-2021 provides a framework for evaluating health sector performance in line with the national health priorities in National Development Plans (NDPs) such as the Fifth, Sixth and Seventh NDP. These documents prioritise and endeavour to make health services available to the population to achieve the country's vision of a nation of healthy and productive people by 2030. The NDPs align with Government's commitment to the Millennium Development Goals (MDGs, 2000-2015) and the subsequent Sustainable Development Goals (SDGs, 2016-2030).

The ultimate goal of the plan as outlined in Vision 2030 is to achieve *"A Nation of Healthy and Productive People."* Government recognises that investing in people's health and well-being is important to achieving its long-term goal. Moreover, achieving this goal requires the strengthening of health systems, including an adequately financed and well-functioning health financing system. However, Zambia's health financing system faces several challenges observed in the Mid-term Review of the Health Sector Strategic Plan (2011-2016) MOH (2015a) and the National Health Accounts (NHA) report (2015). First, the health financing schemes are fragmented. This brings inefficiencies in service provision and investments. Second, health system faces administrative and allocative inefficiencies compounded by ineffective legal, governance, and accountability mechanisms. Third, public expenditure on health has remained low, inefficient, and unable to achieve maximum impact on health outcomes (NHA, 2016). Further, Zambia failed to meet a number of targets set in the MDGs related to health, partially because of underspending in health, inequitable health financing and input allocations, inappropriate incentive mechanisms for providers, and barriers to accessing health services (Zambia Household Expenditure and Utilisation Survey (ZHHEUS, 2016).

Zambia has previously implemented policies to deal with some aspects of health financing to improve health outcomes. However, the country does not have an integrated HFS to complement the various national policies and plans. The objective of this HFS is to consolidate the health financing issues fragmented in various plans into an integrated strategy. The strategy will serve as an instrument for a health financing system that is sustainable, equitable, accountable, and efficient to accelerate the achievement of its stated health goals. The strategy takes a holistic approach to health financing by addressing the current inefficiencies in the sector within the context of existing national strategies and plans such as the NHSP 2017- 2021 and 7 NDP 2017- 2021.

## 1.2 Methodology and Process of Developing the HFS

This HFS was largely developed on the basis of an extensive literature review and consultations with key stakeholders that began in 2016. Based on the WHO's Health Financing Diagnostics and Guidance, the process provided for a diagnostic assessment of the health sector in terms of health financing, efficiency of resource use, resource mobilization, risk pooling, and purchasing. The purpose of this assessment was to inform the development of the HFS. The study reviewed a number of national documents, including the NHA, the Service Availability and Readiness Assessment report, and the Mid-Term Review (MTR) of the Implementation and Performance of the revised NHSP. The study also reviewed international documents from multilateral and bilateral partners such as the World Health Organisation (WHO) and the World Bank on best practices in health financing. Evidence from other commissioned studies such as the benefit-incidence analysis and the Zambia Household Expenditure and Utilisation Survey (ZHHEUS) informed the situation analysis.

MOH developed this HFS using the key findings from the situation analysis. The development process was consultative, involving workshops with a technical team of health financing specialists and planners drawn from MOH, academia, other government ministries, and CPs. MOH supported by consultants presented the preliminary draft reports of the situation analysis and resultant strategy to the Health Care Financing Technical Working Group, which provided additional comments. MOH and the consultants incorporated those comments into the HFS. In addition, a number of local and international experts reviewed the draft strategy and provided useful inputs. In its whole approach, the methodology took into account best practices from WHO reference documents and protocols on designing and developing national health strategies.

## 1.3 Organisation of the strategy document

The rest of this report is organised as follows. Section 2 outlines Zambia's macroeconomic, fiscal, and social context and presents an overview of the current state of the country's health financing profile. The health policy strategic interventions and reforms are in Section 3 and are organised around the core health financing functions. They include resource mobilisation, efficiency enhancement, risk pooling, and strategic purchasing. The governance, legal, and institutional reforms are also in this section. The last section highlights the implementation plan and suggests further work to operationalise the HFS.

# 2. Country Context of Health Care Financing

This section presents the macro and socio-economic context that informed the development of the HFS. It relies on a comprehensive Health Financing System Assessment undertaken in the first phase of the development process of this strategy and published as a separate document.

## 2.1 Macroeconomic Context

Zambia experienced impressive growth in the past decade. Real gross domestic product (GDP) grew at an average 6.2% between 2007 and 2014 and remained resilient during the global economic crisis of 2008. The strong GDP growth rates resulted in per capita gross national income (GNI) trebling from US$550 in 2006 to US$1740 in 2014, and the country moved to a lower-middle-income country (LMIC) in 2011. The key factors in this GDP growth were the copper mining sector (which accounts for more than 70% of foreign exchange earnings) and the good performance of services (transport, communication, and construction subsectors), which account for 73% of GDP, agriculture (8% of GDP), and some manufacturing subsectors (8.1% GDP).

However, GDP growth slowed from a high of 7.2% in 2014 to 3.2% in 2015 and 3.4% in 2016 due to external shocks in commodity prices, inconsistent policies in key sectors, and power shortages. The growth prospects for 2017 remain subdued at 4%, but the economy is likely to recover in the medium-term. The year-on-year inflation rate trebled from an average of 7.2% between 2012 and 2014 to a high of 21.6% in December 2015 partly because of rapid depreciation of the Kwacha against the major currencies. The exchange rate depreciated from an annual average of ZMK5 to ZMK8.63 per dollar. The GNI per capita slumped from US$1740 in 2014 to US$1500 in 2015.

Despite the positive GDP growth rates, high poverty levels persist. In 2015, 54.4% of the estimated 15 million people were defined as poor, and 40.8% lived in extreme poverty. This is above the MDG target of 29% for extreme poverty by 2015 from 58% in 1990 (Central Statistical Office [CSO], 2015). The majority of the poor (77% in 2015) reside in rural areas. The lack of inclusiveness in growth results in income inequality (Gini coefficient), which rose from 0.60 in 2006 to 0.69 in 2015. The richest decile owned 53% of the income share compared with 0.5% for the poorest decile (Living Conditions and Monitoring Survey [LCMS], 2015).

The high poverty and persistent income inequality reflect the jobless growth of the economy. The national level unemployment rate is estimated at 7.5%. However, this rate masks the number of people who are disguised in underemployment and poor quality jobs. Only 13% of the labour force is employed in the formal sector. The majority are engaged in low quality and less productive informal employment, especially subsistence agriculture and petty trading (CSO, 2015). These workers remain susceptible to domestic and external shocks and can easily fall back into poverty. The unemployment problem is compounded by the current demographic trends indicating a larger and growing youthful population that lacks adequate and quality education. As estimated 66% of the population of Zambia in 2015 was below the age of 25. In 2015, youth unemployment stood at 16% compared with the national average of 7.5%.

The prospects of increasing formal youth employment in the medium-term are low due to the rapid population growth rate, estimated at 3.1% per annum. That reflects the high fertility rate, estimated at 5.3 in 2014. Government's policy aims at improving sexual and reproductive health, including family planning. However, assessments show a big gap of unmet family planning needs, estimated at 21% in 2013 (MOH, MTR, 2015a). As a result of the high Total Fertility Rate and unmet family planning needs, Zambia is expected to continue experiencing rapid population growth as more youths enter reproductive age, which will further weaken economic prospects. To mitigate this

prospect, government has to invest heavily in and prioritise the health sector. The assessment of the demographic dividends suggests that the large youthful population can earn the country an additional per capita income of US$611 in 2030 and US$7,393 in 2053 if it invests in the social sectors such as health services, particularly family planning, and education in addition to economic reforms (Government of the Republic of Zambia [GRZ], 2015).

## 2.2 Fiscal Context

Zambia's tax revenue averaged 19% of GDP between 2007 and 2015. Prior to 2011, government maintained a moderate fiscal policy anchored on debt management and stability. However fiscal policy since 2012 has been expansionary, with real government expenditure growing at an average of 13.8% a year. It rose from 22.6% of GDP in 2010 to 28.9% in 2015. This resulted in budget deficits of about 10.6% of GDP in 2015, up from 6.5% in 2012. The deficit swelled as government made heavy investments in road infrastructure and unbudgeted spending on fuel and agricultural subsidies.

The public debt burden has risen to finance the deficit, mainly from non-concessional loans. At the end of 2015, public debt was estimated at 52.7% of GDP. External debt rose from 27% of GDP in 2010 (US$1.2 billion) to 38.7% of GDP in 2015 (US$7.2 billion). That represents 54.4% and 66% of total exports respectively (Ministry of Finance (MOF), 2015, World Bank, 2016). Domestic debt has grown from 5.8% of GDP in 2008 to about 10% of GDP in 2016. The elevated exchange rate and escalating interest rates have increased the cost of debt service. Consequently, the global rating agencies have downgraded the country's economic outlook.

In the short to medium term, huge debt service is likely to limit the country's fiscal outlook for health spending. Interest payments averaged 2.3 % of total government expenditure between 2012 and 2015. In 2017, interest payments are expected to reach an estimated K11.5 billion, twice the health budget. This is likely to rise as interest payments on recently acquired Eurobonds fall due and become unsustainable after 2021, when principal payments fall due. In addition, fiscal consolidation efforts to put public finances on a sustainable path have remained elusive. The International Monetary Fund (IMF) Mission of March 2017 found that expenditures in the first two months of the year substantially outpaced revenue, with an elevated fiscal deficit of 9.3% of GDP. These indicators point to high risk of debt distress. Cursory debt sustainability analyses suggest that the debt ratio will rise to 54% of GDP by end of 2017, two points below the sustainability threshold of 56%.

Public health care providers are financed through the national budget. The country's budgeting process is highly centralised, with the Ministry of Finance (MOF) and the executive playing a leading role in priority setting and resource allocation. The budgetary process is transparent and allows for inputs from other stakeholders, although MOF is not legally obliged to take these inputs into account. In any particular year, MOF provides budget ceilings under the Medium Term Expenditure Framework (MTEF) to ministries, provinces and other spending agencies (MPSAs) based on the priorities outlined in the NDPs. The MPSAs use the budget ceiling to allocate funds across various activities, usually with the active participation of sectoral advisory groups. However, allocations are inadequate, making it difficult for MOH to budget for all the needs in the sector. Once MOF makes and approves budgets, the line expenditure allocations may not be varied without prior permission.

Zambia's public finance management is fairly strong. The 2016 Public Expenditure and Financial Accountability (PEFA) assessment indicates great improvement in areas related to tax administration and transparency in the budgetary process. However, the 2016 PEFA showed that budget certainty through ceilings is eroded by variations during the year, with over and underspending of allocations in some departments. The system suffers from inadequacies in internal control systems and financial reporting. These weaknesses raise fiscal risks and the possibility of wastage and leakage of funds, resulting in operational inefficiencies in the use of resources (World Bank, 2016). The 2017 PEFA assessment found significant improvements in Zambia's budgetary process. The health and education sectors generally spend close to the allocated budget.

The use of Integrated Financial Management Information System (IFMIS) was recently rolled out to ministries, including MOH and Provincial Administration. Within MOH, the rolling out of IFMIS to all

provinces has been delayed, and this denies the districts the opportunity to strengthen financial management (MTR, 2015a).

Other weaknesses include overreliance by the executive on the use of supplementary appropriations and in-year budget amendments, which reduce the credibility and efficiency of the process. There also were significant financial management challenges and difficulties in getting resources to health centres and health posts that form the lower levels of health system. The monitoring of the budget is weak, mainly due to systemic and procedural problems and capacity shortcomings in fundamental elements of PFM.

Overall, the prospects to increase Zambia's fiscal space for health through SHI, donor, and public financing are constrained by the complex social and macro-fiscal environment. First, the country's graduation to LMIC will result in most donors reducing their support to the country and the health sector. Second, the country is operating under large fiscal deficits and huge external and domestic debt, which is largely commercial. The high debt-service ratio will make it difficult for government to reprioritise its expenditures to health and other social sectors. Further, the prospects to generate additional revenue through taxes and SHI are limited by the high levels of informality, unemployment, and widespread poverty. The informal sector is hard to reach and tax, while the dependency ratios have remained high at more than 92% due to high poverty. Since SHI is contributory through payrolls, it will be difficult to grow the SHI beyond the small formal sector, with limited prospects for expansion to the unemployed and the informal sector.

These recent fiscal developments have a negative impact on resource mobilisation in the short and medium term. The attainment of LMIC status will result in most donors reducing their support to the health sector and government as a whole. With the unpredictability of donor aid and increasing debt unsustainability, government will need to mobilise more internal resources, broaden its revenue base, and stabilise the resultant macroeconomic indicators.

## 2.3 Health System Organisation, Delivery, and Health Outcomes

Zambia's health sector comprises public, private-for-profit, and private-not-for-profit providers. The public sector has a dominant role in providing health services in both rural and urban sectors. Health services are provided in the 10 provinces, with some of them having a vast geographical area. That makes health service delivery costly. New districts were created between 2011 and 2016, raising the number from 72 in 2011 to 103 in 2016. This undermines proper allocation and flow of resources to districts and health facilities.

The public health system in Zambia consists of three levels and 1,956 health facilities. This includes: (i) the district level, where 1,926 health posts, health centres, and district hospitals provide Primary Health Care (PHC) services; (ii) the secondary level, which consists of 24 general/second-level referral hospitals providing curative care in internal medicine, paediatrics, obstetrics, gynaecology, and general surgery; and (iii) the tertiary level, which consists of six central hospitals providing specialised and sub-specialised care. The provision of health services in the public sector is organised around a referral system, which coordinates patient flows from lower levels of care at health posts to higher levels of care.

Although the supply of Human Resources for Health (HRH) in Zambia has increased over the past five years, the expansion is not adequate to meet the country's HRH requirements. In 2015, only 68% of the positions provided on the approved establishment list were filled, mainly due to inadequate funding from Treasury for new staff recruitments. The money in the annual budget for recruitment, which is subject to the IMF recommendation of Personal Emoluments to GDP ratio, is below what is required to meet the planned national target for recruitment. As a result, the current mix of personnel does not correspond to the establishment because so many positions are not funded (MOH, MTR, 201a). There are also regional and geographical inequalities in the distribution of core health workers, compounded by the poor retention of health workers, particularly in rural,

remote, and hard-to-reach areas. Although government has incorporated incentives within its salary structure to attract skilled health workers to rural areas, they are not sufficient to attract the correct mix or a suitable number of health workers. The disparities suggest that other factors are important in attracting health workers to the rural and remote areas.

Inadequate access to drugs and medical supplies remains one of the leading causes of poor health outcomes in many developing countries, including Zambia. MOH's buys essential medicines and medical supplies through framework contracting, with the goal of ensuring a guaranteed and uninterrupted supply of the commodities. Through a competitive bidding process, suppliers receive two-year procurement contracts. During this period, contracts lock in prices of essential drugs and medicines. Adjustments can occur only after an extension of the initial contract. Under the provisions of the framework contract, MOH orders essential medicines and medical supplies as need arises. This system allows for an uninterrupted supply of essential medicines and supplies, in contrast to the traditional tendering processes, which did not guarantee a smooth supply. However, the effectiveness of the framework contracts could be improved by ensuring that funding for essential drugs and medicines is frontloaded on time to guarantee efficient and smooth delivery of the orders. The contracts stipulate an advance payment of up to 50%, with the balance paid upon full delivery. But MOH has faced challenges in meeting these obligations, partly due to inadequate and untimely funding from MOF.

Delays and under-funding of pharmaceutical procurements results in stock outs of essential drugs and medical supplies. Zambia needs measures to encourage importation of raw materials for essential drugs with the view of boosting the local pharmaceutical manufacturing industry.

Although nominal budgetary allocations for essential drugs have increased from an average of 8% between 2010-2012 to an average of 14% between 2013 and 2015, the depreciation of the Kwacha against the US dollar by more than 40% has reduced the real value of the allocation. This decrease in real value reduces the quantity of imported drugs and medical supplies from a given budget allocation while the debt service on purchased products increases.

In general, Zambia inadequately funds infrastructure development, procurement of medical equipment, and equipment maintenance. For instance, the allocation of ZMW 245million on infrastructure development in 2015 fell far below the required ZMW 500 million needed to carry out the planned infrastructure development for that year in the MOH Annual Action Plan, 2015b. The routine maintenance of existing infrastructure and equipment is almost non-existent at all levels of health facilities due to low budget allocation. The lack of routine maintenance leads to deterioration of critical equipment with high replacement costs. Other challenges include lack of maintenance contracts for some equipment and dysfunctional transport services, which increase service and maintenance costs due to outsourcing of vehicle service and repair (MOH MTR, 2015a). However, some measures to improve efficiency have been undertaken. For instance, government is replacing cold chain equipment that is older than 10 years with newer equipment that requires less maintenance.

Despite the financial obstacles, Zambia has made significant progress in improving such health outcomes as key maternal, infant, and under-five mortality. Communicable diseases (HIV, AIDS, malaria, lower respiratory infections, diarrheal diseases, and tuberculosis) are likely to remain as the major sources (67%) of morbidity and pre-mature mortality in the medium to long term. However, the increase in non-communicable diseases (NCDs) arising from the epidemiological transition is likely to put more pressure on health sector resources in both the short and long term. This requires concerted efforts to mobilise resources for enhanced prevention activities to tackle both NCDs and communicable diseases, especially among the youth.

With the adoption of the test and treat (90-90-90) strategy for HIV/AIDS, the number of people on antiretroviral therapy (ART) services will double. This requires further resource allocation to HIV/AIDS, which stood at 30% of total health expenditures in 2012. Given government financial constraints, the expected increase in ART utilisation and moves into high cost treatment regimens inevitably will put strains on the treasury and health system.

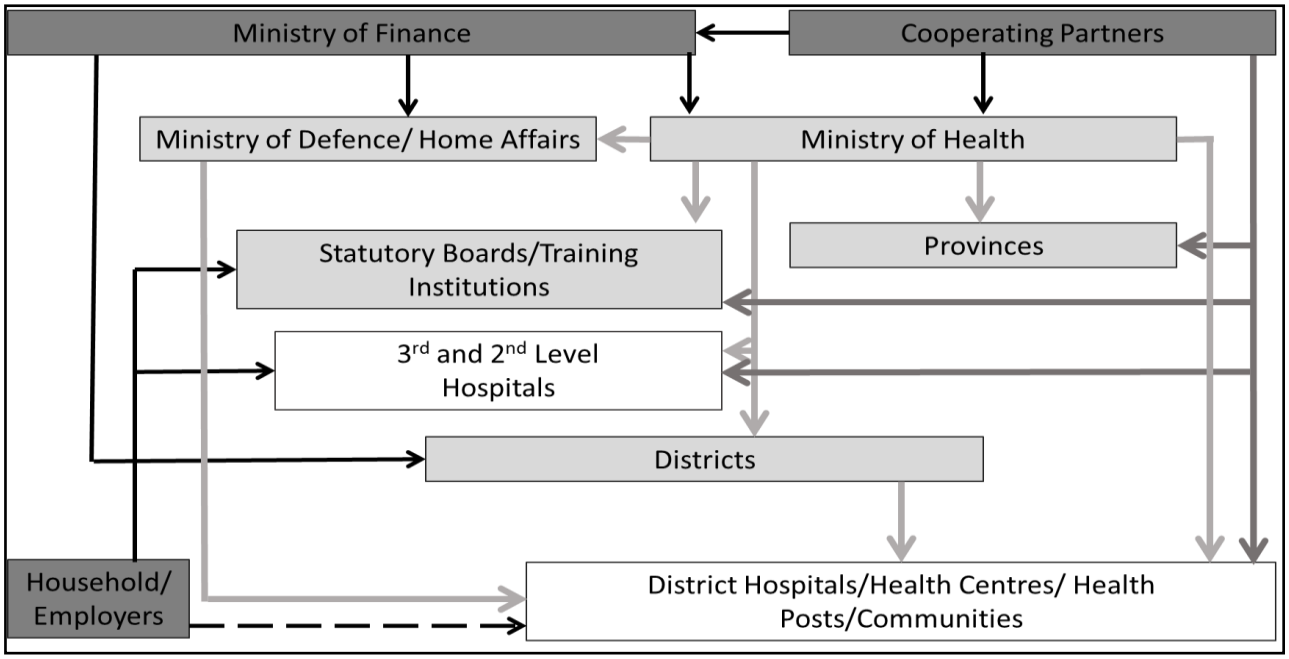
## 2.4 Health Financing System Overview

Progress toward UHC requires sustainable and robust financing solutions that function in challenging economic and institutional environments and promote equitable mobilisation and distribution of resources. This section examines the current health financing arrangements in Zambia in terms of organisation, resource mobilisation, pooling, and purchasing.

Figure 1 summarises the flows of funds from financiers to various levels of the public service delivery system. The main financing sources are Ministry of Finance (MOF), CPs, and households/employers. MOF acts as a fund holder for government-generated funds while it receives grants and loans from CPs. Part of the money from MOF is disbursed directly to government line ministries such as MOH, Ministry of Defence (MOD), and Ministry of Home Affairs (MOHA). On the other hand, MOF disburses salaries and wages directly into individual bank accounts for all health workers on the Payroll Management and Establishment Control system and directly disburses the monthly operations grant allocation for health facilities to the districts.

In addition to the on-budget support, the CPs disburse funds directly to different institutions at all levels of the health system through vertical projects and disease-specific programmes. Households and employers are key financiers in the Zambian health system through direct payments for hospital-managed medical schemes, laboratory and other diagnostic tests, bypass fees, patient books, purchase of drugs, and secondary levels of care (secondary and tertiary hospitals). Although primary health services are free at public health facilities, households still pay for diagnostic tests such as x-rays (Figure 1).

**Figure 1: Flow of funds in the public health sector in Zambia**




Source: Ministry of Health (2016)

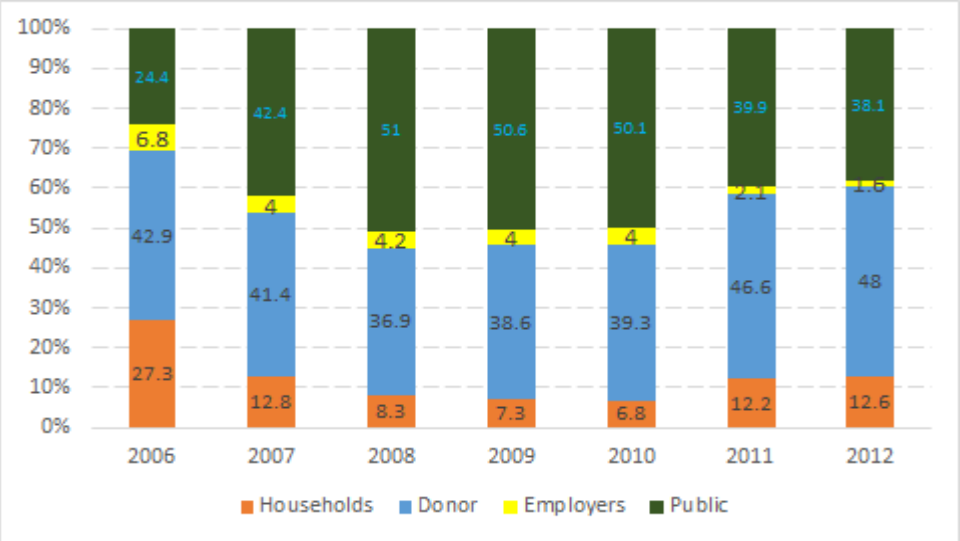
## 2.5 Revenue Collection

### 2.5.1 Sources of Health Financing

The main sources of health financing are government, CPs and OOP payments by households. Other sources include employer-financed schemes through health insurance companies. Zambia's NHA

shows that government contribution to health increased steadily from 2006 to 2010, averaging about 42.4% of health spending from 2006 to 2012. The trend as displayed in Figure 2 shows a heavy reliance on external sources of financing, which contributed on average 41.9% from 2006 to 2012. Private sector contributions increased from 10.8% in 2010 to 14.3 % in 2012, largely from households. The upward trend of households' contribution is troubling given that a large share of this contribution is in the form of OOP payments.

**Figure 2: Sources of Health Financing 2006–2012**



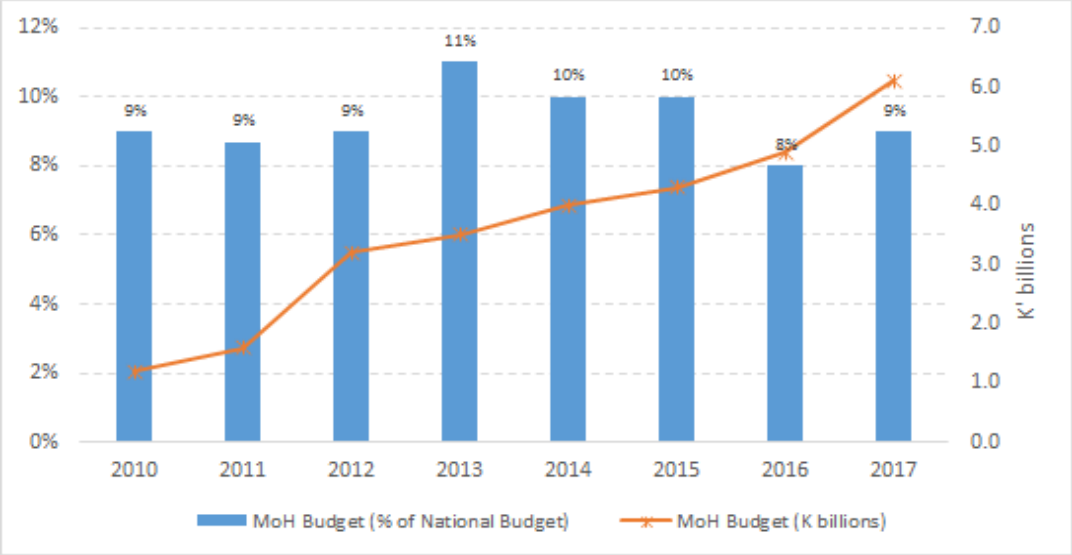

Source: 2011 – 2012 NHA Report, MOH (2016)

Real total health expenditure increased by 11% from ZMW4,226 million in 2011 to ZMW4,683 million in 2012. In per capita terms, it rose from US$ 66.9 to US$73.6, with government contributing US$28.1. This level of per capita expenditure compares well with other LMICs. However, this total per capita expenditure falls short of the minimum target of US$86 recommended by Chatham House (2014) to ensure UHC for priority services for everyone. In addition, Zambia's current health expenditure relies heavily on external sources. This is unsustainable in the medium to long term since the country faces prospects of limited eligibility for donor assistance with its graduation to LMIC status.

## 2.5.2 Government health expenditure

Figure 3 shows the trend in government budgetary allocations to the health sector from 2010 to 2017. Projections from the MTEF 2016-2018 suggest a decline in the proposed allocation to health from 9.3% in 2017 to 8.8% in 2018. While budgetary allocations are an indication of government's commitment to the health sector, the actual amount and predictability of funds disbursed determine the outputs and outcomes generated. The mid-term review of the NHSP 2011-2016 revealed significant weaknesses in budget execution both in terms of amounts and predictability. This was especially true at district level, with government disbursements ranging from 66% to 93% of the budget commitments. Since 2013, MOF directly disburses operational grants to the districts, a measure undertaken to improve the predictability of funding.

**Figure 3: Trends in budgetary allocations to the health sector, 2010-2017**

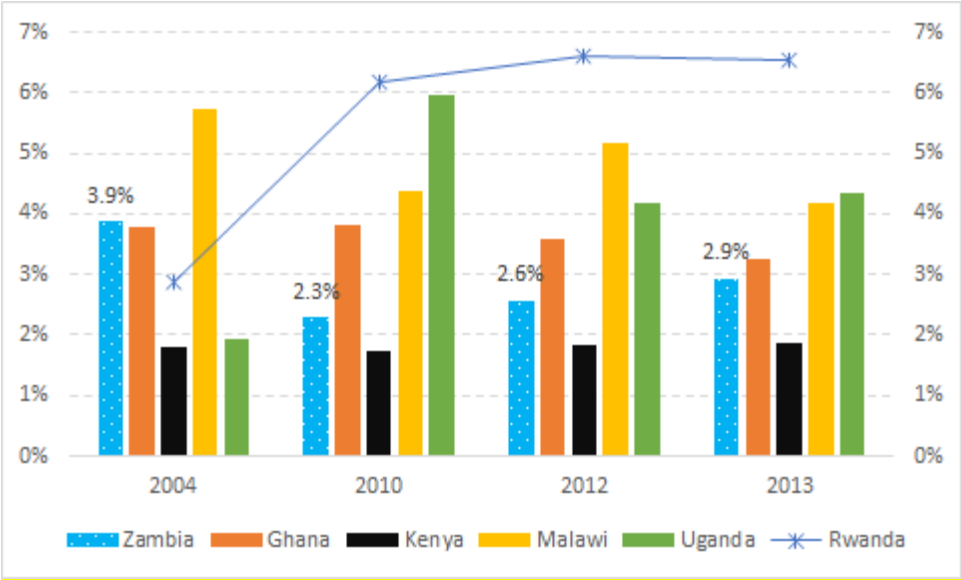



Source: MOH database

The extent to which government prioritises the health sector, measured by total government health expenditure as a share of total government expenditure, was 11.5% in 2010 and fell to 8% in 2011 and 7.7% in 2012 (NHA report 2016). This level of budgetary allocation to the sector has consistently fallen short of the 15% target set by the Abuja Declaration and the NHSP 2011-2016 target of 13%. As a percentage of GDP, government expenditure on health increased from 2.3% in 2010 to 2.9% in 2013. This also falls short of the 5% of GDP recommended for the minimum health services in the Chatham House Report (McIntyre and Meheus, 2014).

The 2.9% share is minimal compared with some lower income countries such as Malawi, Uganda, and Rwanda (Figure 4). The evidence suggests that allocations to the health sector have not kept pace with overall economic growth rates. Consequently, Government's health sector expenditure falls short of the basic health care requirement. Figure 5 compares the GRZ health budget with the financing need as outlined in the costing for the NHSP 2011-16 under Scenario 3.

**Figure 4: Government health expenditure as a share of GDP**

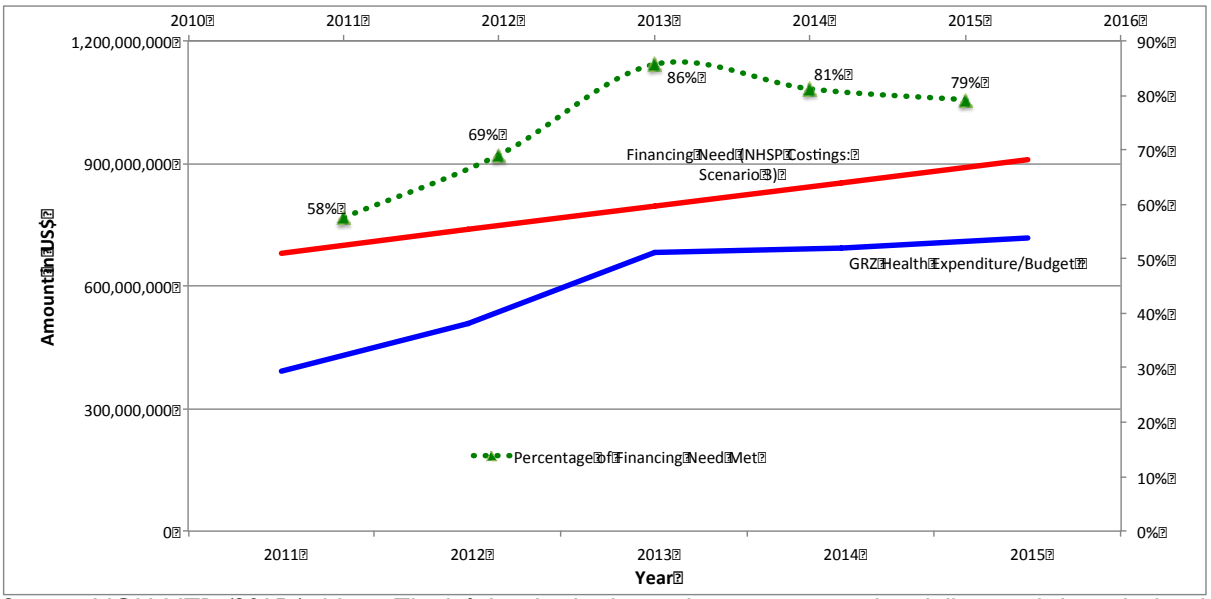



Source: WHO NHA (2004-2013)

Figure 5 shows that only 58% of the financing need was met in 2011, 69% in 2012, 86% in 2013, 81% in 2014, and 79% in 2015. While it has improved since 2011, the health budget remains insufficient to

meet the priority needs of the sector. Government must mobilise more resources to improve health outcomes.

**Figure 5: Percentage of financing need met**




Source: MOH MTR (2015a): Note: The left hand side shows the resource need in dollars, and the right hand side shows the percentage of the needs met.

In addition to inadequate financing that falls below local and international commitments, government uses the resources available inefficiently. The majority of funds are allocated to wages and salaries, which absorb between 55% and 60% of the health budget (MOH MTR, 2015a). From 2011 to 2014, the disbursement rate for salaries and wages was 100% compared with operational budget disbursements ranging from 66% to 93% (MTR: MOH, 2015a). This level of personnel emoluments is much higher than known averages in Sub-Saharan Africa, where the share of labour cost falls around 50% or less. For example, Vujicic et al. (2009) found the average share of wages in government health spending around 40% in Sub-Saharan Africa and around 45% in high-income countries. Evidence suggests that wages in the health sector are among the highest in the Southern Africa region, and Zambia's wage bill is expected to continue growing as more health workers are recruited. Executing a higher wage budget at 100% constrains the ability of government to fund the operational budget.

### 2.5.3 OOP expenditure on health

OOP spending, which is considered an inequitable source of health spending, remains a significant source of health expenditure in Zambia. Evidence shows that 20% of households using public health services pay OOP (Masiye and Kaonga, 2016). The majority of Zambians (80%) seeking primary health services do not pay OOP, so user fees do not impede access to healthcare for most of the population. However, the burden of paying OOP is still large for secondary services, mostly at hospital level. The ZHEUS survey shows that the largest expenditure items for OOP spending are drugs at 42%, consultations at 26%, other costs at 17%, and transport/food at 7%. In addition, OOP payments are significantly higher for individuals in urban areas, who spend twice the amount spent in the rural areas. Nearly 70% of OOP spending is on NCDs. This calls for measures to address OOP spending for secondary level of care and promotion of preventative measures to mitigate the rising prevalence of NCDs.

### 2.5.4. External Funding

Mobilised resources necessary to advance the goals of UHC need to be adequate and sustainable. Reliance on domestic sources of revenue thus is a key determinant of sustainability. However, the health sector in Zambia relies heavily on external sources of financing, averaging 39% from 2007 to 2011 and 47% in 2011 and 2012. With the breakdown of the Sector-Wide Approach (SWAp) mechanism, donor support is often channeled through non-governmental organisations' (NGOs') vertical programmes. In the absence of coordination or collaboration, this presents a challenge to ensuring aid effectiveness and harmonisation of resources (MTR, MOH, 2015). Furthermore, almost 70% of donor funding is earmarked for specified disease programs. In Zambia, external financing covers more than one-third of expenditure for tuberculosis and malaria and nearly two-thirds of HIV and vaccination-preventable diseases. While these communicable diseases represent some of the largest sources of the burden of disease in Zambia, there is need to coordinate efforts and to focus on other government priority areas.

Similarly, external support for pharmaceuticals is mainly linked to the procurement of antiretroviral (ARV) and malaria and tuberculosis drugs. During the period 2011-2012, CPs provided 64% of the financing for HIV/AIDS (NHA 2011-2012, MOH, 2016). Furthermore, about half of the total health expenditure for drugs is spent on malaria and HIV/AIDS, and this is largely externally financed. This raises a question of whether the disproportionate allocation of the drug budget toward these selected disease burdens is an optimal allocation of resources across the disease profile in Zambia. With the re-classification of Zambia as an LMIC, external support for funding of pharmaceuticals is likely to decrease. So Zambia must find alternative sources of financing to guarantee availability of pharmaceuticals such as ARVs.

## 2.6 Efficiency in health financing and delivery of health services

The extent to which a country improves its health outcomes depends on the available resources and how the collected funds are allocated and spent across tiers of the health system and geographic regions. Typically, efficiency can be attained through the appropriate input mix to achieve maximum output or when the health system maximises outputs and outcomes for a given level of inputs such as staff, drugs, and equipment.

Zambia's health service delivery system is characterised by a range of inefficiencies that are a significant drain on public resources. In terms of resources mix, the highest amount of the resources is allocated to the centre and provinces (38% in 2014) (Table 1). A proportion of the allocations to the centre and provinces is used to purchase supplies for lower level health providers. But the allocation for district health services remains low (averaging 27.5% between 2014 and 2015) given government's policy of delivering PHC as close to the family as possible. Between 2011 and 2014, the health sector continued to be characterised by delays in disbursements and underfunding, with operational budget execution rates of 66% to 93%. Challenges related to supply and logistics for medicines and medical supplies at PHC facilities affect the quality of services (MTR, MOH, 2015). That is why the population tend to bypass PHC services in favour of hospital services, leading to congestion at higher levels of care. Increasing resource allocation to PHC could lead to significant efficiency gains.

**Table 1: Expenditure by level of care**

| Level of care | 2008 | 2010 | 2012 | 2014 | 2015 |
|---|---|---|---|---|---|
| Statutory Boards | 8% | 12% | 10% | 12% | 11% |
| Health training institutions | 2% | 5% | 3% | 5% | 5% |
| District health services | 23% | 37% | 26% | 28% | 27% |

| | | | | | |
|---|---|---|---|---|---|
| General Hospitals | 9% | 9% | 9% | 9% | 10% |
| Tertiary Hospitals | 9% | 12% | 6% | 8% | 9% |
| Central & Provincial level | 49% | 25% | 46% | 38% | 38% |

Source: MOH (2015) MTR

In addition, the allocation for tertiary hospitals remains disproportionally large compared with district health services care (Table 1). This is contrary to the country's policy to emphasise delivery of PHC. Literature suggests that Zambian hospitals operate at a 67% level of efficiency, which implies significant wasting of resources (Masiye, 2007). The unsuitable hospital scale of operation and low productivity of some inputs reinforce each other to make Zambian hospitals technically inefficient at producing and delivering services. These substantial inefficiencies undermine Zambia's prospects of achieving its health goals.

In addition, some services at secondary and tertiary hospitals are provided on a cost-sharing basis. The user fees collected constitute a significant amount of revenue. The fees are in the form of laboratory tests, by-pass fees for those not following the referral system, and in-patient care through various medical schemes. With the dwindling resource envelope for the health sector, hospitals and other training institutions collecting user fees need to improve efficiency in revenue collection and report all revenue generated to MOH to alleviate distortions in resource allocation. To ensure flexibility of use for internally generated resources, however, all revenue collected may continue to be retained and used at the point of collection.

Another source of inefficiency is that the provision of services under the premium cost schemes (previously referred to as "high-cost schemes") is not based on full cost recovery. To enhance equity in use of resources, it is important to ensure that price levels for premium services are set at appropriate levels to ensure that they generate a net surplus, which institutions can use to cross-subsidise health services for standard services. In the current set up, specialist services provided under the premium cost schemes are not based on full cost recovery. It can be argued that patients who seek specialist services using the premium cost schemes are therefore subsidised. They otherwise would have sought care from the private sector. Setting competitive prices requires that the quality of health services for premium cost schemes improves to ensure that public hospitals can compete with private-for-profit providers. In addition, hospitals need clear guidance on how to use the surplus to enhance equity.

Further, expenditures on services that boost health outcomes for all patients should be prioritised. With no strict guidance, surpluses maybe used to enhance the quality of premium cost services, which would further increase quality differential between the premium and standard cost services and undermine equity. Evidence suggests that the possibility of bias toward premium private wards can be mitigated by deliberate policies such as explicitly prohibiting additional remuneration for health staff attending to patients in private wards. However, in some cases, these benefits tend to act as incentives to keep health professionals, particularly specialists, in the public health system.

Another source of inefficiency is the time lag in the procurement and appropriate mix of medicines. The current stock-outs of drugs and supplies indicate a weak purchase and distribution arrangement. The supply chain requires strengthening by advance releases of funds for drug procurement to minimise importation delays. Delays in payment for the drug contracts have led to accumulation of debt, exacerbated by the depreciation of the exchange rate and interest rates charges for delayed payment.

To allocate financial resources to districts, MOH uses a needs-based resource allocation formula (RAF) developed in 2004 and revised in 2009. The formula takes into account material deprivation (including poverty levels), disease burden, and population size, among other parameters. With the creation of new districts, the district RAF is outdated and needs revision. Moreover, there is no robust formula for allocating resources within the districts. The hospital RAF is not fully implemented, given the limited resources to match the needs.

The overall health system performance in Zambia faces inefficiencies in the mix of inputs within facilities and across regions. While government has an established skills mix such as nurses, midwives, and environmental health technologists at various levels of health care, the mix is rarely met and the problem is greater in rural than urban areas (MOH MTR, 2015a). The problem has been exacerbated by the lack of equipment and human resource development and deployment that lag behind the recent expansion in infrastructure. Further, the input mix is inefficient as it does not integrate planning and construction of new health facilities with the availability of other critical inputs, such as human resources and medical equipment.

The problem of inadequate capacity is more evident in specialised services such as heart surgery and renal treatments at the country level in both public and private health facilities. As a result, most of the associated services requiring specialised treatment cannot be provided locally and patients have to seek alternative sources of care abroad. Government has continued to spend substantial amount of resources in referring and sending people for treatment abroad. For instance, in 2014, spending on treatment abroad was three times more than the budget allocation (expenditure of ZMW21million against a budget of ZMW6 million). This calls for measures to promote the establishment of specialised health services locally through public-private partnerships (PPPs) to reduce the cost of sending patients abroad.

Increasing public spending on health may not lead to improved health outcomes without addressing inefficiencies in health care delivery, management, medical and supplies disbursements, and financial flows. The country will make efficiency gains in resource use through strategic planning and reorganisation of the input mix and resource disbursements to contribute to increased health coverage, improved quality of services, and health outcomes.

## 2.7 Pooling of Revenues

The key principle that guides pooling of funds is that the different funding sources need to be complementary in financing health sector priorities to address existing needs. Pooling revenue entails putting resources in one or more baskets of funding, which creates the opportunity for better dialogue and negotiation on scope of services, quality and accessibility. Pooled resources can be used in a way that promotes cross-subsidisation among different income groups and risk-sharing in order to enhance equity. In essence, the goal is to simplify the overall financial system by reducing fragmentation, duplication and overlap and to promote the redistributive capacity of funds.

In the Zambian context, pooling of revenues is limited as funds from CPs, employers and households are predominantly being channelled in fragmented and parallel systems. Currently, the types of pools include: Treasury (which includes on-budget support from CPs), vertical programmes by donors, private/voluntary health insurance/prepayment schemes and the almost non-existent donor basket funding managed by MOH. The multiple fragmented pools create inefficiencies in managing resources and duplication in use.

Although the country has strong policy documents and agreements with major CPs, most of the external resources are channelled outside of the government system. Funding from CPs is fragmented and predominantly channelled through NGOs, their implementing partners and directly by the respective donors. In addition to the funds the CPs provide to the government for on-budget support, the CPs also disburse funds directly to different institutions at all levels of the Zambian health system through earmarked vertical projects and health condition programmes such tuberculosis, HIV/AIDS, and immunisation. Current evidence shows that substantial amounts of the donor funds continue to flow in project modes. The NHA 2011-2012 report shows that 83% of funding from CPs in 2011 was channelled through NGOs and this proportion only reduced to 57% in 2012. Donor funding to the health sector has increased. However, MOH has little or no control over the use of these additional resources. This brings into question the issue of aid effectiveness in strengthening the entire health system in line with government priorities.

In terms of policy and coordination of external resources, the Aid Policy and Strategy, and the Joint Assistance Strategy for Zambia (JASZ [II]) that was signed in 2011 provided the overarching

framework for Official Development Assistance (ODA) to Zambia. In addition, 23 external partners, NGOs and civil society organisations signed the revised Memorandum of Understanding and Mutual Accountability Framework (MOU/MAF) in 2013 and in the process made a commitment to provide financial and technical support to the previous NHSP (2011-2016). The SWAp MOU/MAF are aligned to the JASZ [II]. Zambia is also a signatory to the International Health Partnership (IHP+) global compact and ascribes to principles of aid effectiveness (MOH, MTR Report, 2015a). Despite these broad agreements on ODA assistance between the CPs and government, the pooling mechanism for donor funding remains weak.

### 2.7.1 Risk Pooling and Equity in Paying for and Accessing Health Services

Households can be protected from the burden of catastrophic health costs through risk pooling, which is a system where contributions from those who are healthy subsidise care of those who are ill to avoid the double burden of illness and financial costs of care. With no SHI and only 3.9% of the population with private insurance and other prepayment mechanisms, risk pooling is almost non-existent in Zambia. The uptake of private health insurance is low partly due to the small formal sector and relatively undeveloped insurance markets. Currently, there are no laws or acts governing the operation of medical aid schemes or medical insurers. The few private health insurance firms that offer insurance to individuals and companies on voluntary basis are fragmented, diverse and favouring those in the formal sector and urban settings, and those already better off. Only a negligible (less than 1%) portion of the health sector is channelled through insurance markets. This limits the income and risk cross subsidisation across the insurance schemes.

Evidence shows that the effect of OOP on financial well-being is not severe, but it is concentrated among the poor (Masiye and Kaonga, 2016; Maisye et al., 2016). The majority of patients using PHC do not incur OOP expenses at the time of seeking health services, but one in five patients still make health payments in the form of OOP payments and 10% of these patients suffer financial catastrophe. Moreover, the incidence of catastrophic health expenditure is proportionately higher among the poorer households.

Plans are underway to introduce a SHI scheme that will contribute to the UHC goals of providing access to quality health services, while ensuring that people do not suffer financial hardship when paying for these services, particularly at the secondary level of care. The proposed SHI fund will provide financial risk protection and help to generate additional resources to the health sector. However, implementing a comprehensive SHI scheme in the short-term is not feasible given the delay in the enactment of the SHI bill and the need to set up the institutional framework. Measures to encourage participation by the informal sector, such as the promotion of voluntary community health insurance schemes, could be promoted. In addition, legal frameworks, strengthening of institutional capacity to manage the SHI and a package of services that will be available to the insured will have to be designed and defined prior to the implementation of the SHI.

The health sector can make efficiency gains in resource use through improved pooling of resources, by operationalising the SHI to cover the poor, promoting prepayment mechanisms to cover the rural and informal community, and promoting private health insurance.

During the implementation of the HFS, households and external resources will continue to be major sources of health financing for the Zambian health sector. As such, mechanisms to ensure that all health sector resources are used effectively in funding government priorities are needed. Improving pooling of external resources requires addressing the previous challenges of managing and coordinating external resources through the single basket. Other options include setting up mechanisms to effectively track donor resources at the central, provincial and district level to establish internal tracking mechanisms of external resources. Reducing fragmentation can be successful if government is able to direct resources previously paid as OOP through insurance prepayment schemes and use these resources to finance key health sector priorities.

## 2.8 Paying providers: Health Care Purchasing

The purchasing of health care has two dimensions. The first is determining what services should be purchased. The WHO 2010 World Health Report unpacks this into three components comprising share of the total population to be covered, the range of services to be provided and the cost-sharing mechanisms. The range of services covered is often specified in the benefit package. In the public sector, MOH has previously developed the basic health care package at different levels of the health care system.

The delivery of these services is premised on the effective implementation of the packages, which cover health conditions to be attended to at different tiers of the health sector. The current MOH package emphasises primary and preventive health care and is available to the entire population with exceptions of the defence forces that have their own health facilities. The hospital-level packages focus on specialised services – which, despite being comprehensive, are not fully implemented due to lack of resources. Often, the basic health care package is used for strategic planning rather than purchasing services.

The second dimension of health care purchasing focuses on provider payment mechanism. In Zambia, the private sector provision has until recently remained relatively minor. The insurance industry has remained rudimentary. Several provider payment mechanisms are currently used to purchase health services across providers. Public sector services are purchased through MOH and there is no provider-purchaser split. The primary health services providers are purchased using a combination of capitation and input-based budgeting. The second and third level hospitals are reimbursed based on their workloads, using the concept of Diagnosis-Related Groups to compute shares for different hospitals. MOH also purchases health services through NGOs, organised under the Churches Health Association of Zambia, with which it has a memorandum of understanding that stipulates the services to be provided. Individuals purchase services directly through OOP and insurers.

Traditionally the public sector funds public health services, and there is currently no single provider payment system for various services and across tiers. The input-based, line-item budget payment system is used to pay for health worker salaries, capital (equipment and infrastructure) and procurement of drugs and medical supplies. MOH allocates resources for operation using the capitation systems to fund the district's facilities. MOH also purchases services from faith-based NGOs through the provision of grants for specified services based on service agreements. Under the service agreements, contracted faith-based NGOs that receive funding from MOH offer prescribed services free of charge. Further, most of the donor funds channelled through the public health services are earmarked to specific health conditions, mainly HIV and AIDs, malaria and tuberculosis.

Recently, MOH initiated a RBF system under the initial sponsorship by the World Bank and CORDAID. The payment method aims to increase the quantity and quality of health services by providing incentives to service providers based on measurable outputs or outcomes. Government will need to scale-up RBF to other districts as a way of shifting from the inflexible and difficult to incentivise input-based financing to output-based for primary level services. This is in line with government's goal to shift to an output-based budgeting system as a way of incentivising health care providers.

The current relationship among the different purchasing payment systems creates inefficiencies and conflicting incentives. These purchasing methods will require harmonising to ensure that only incentive compatible ones are retained.

# 3. Health Care Financing and Policy Objectives

The design of the national health strategy has to take into account the existing policies in the sector. The current design of the national health care financing strategy is guided by the National Health Policy (MOH, 2012). The policy aims at mobilising resources through equitable and sustainable means for the provision of cost-effective quality health care as close to the family as possible. This policy design espouses a right-based approach to health care provision in the context of UHC, assuming the existence of a well-defined and systematically implemented Basic Health Care Package. The policy recognises the failure of the cost-sharing schemes implemented during the health policy reforms of 1991. The cost sharing schemes became prohibitive to accessing health care and had a catastrophic impact among the majority of the poor. Cognisant of these negative consequences, national health financing policy design aims to enhance resource mobilisation while protecting the poor against catastrophic expenditures.

First, the policy measures oblige government to ensure that PHC services at all levels are funded from general tax revenue and provided at no cost to all citizens. This resonates well with government's key priority of attaining UHC since primary health services are the most widely available services and mostly used by the poor. Second, the policy supports the provision of health services that are partially funded from tax revenue and partially from a mandatory SHI fund and other medical aid schemes. However, the extent to which SHI will generate additional resources depends on the size of the formal sector, which provides most of the resources for health through general taxes.

The third strategy to improve health services entails creating a strong and viable PPP for health and strengthening private sector participation in financing and delivery of health services. Fourth, many donor projects – bilateral, multilateral and global initiatives − are still implemented as vertical projects. In light of high donor dependence, the health policy advocates for the full integration of these funds into official strategic and operational planning and budgeting process. Finally, the policy encourages creation of schemes in hospitals to generate additional resources for their use.

Table 2 presents the summary of the gaps and weaknesses identified in Zambia's health financing system. The weaknesses range from the outdated legal system to inefficiencies and fragmentation in resource allocation and use to weak public finance management.

**Table 2: Priority areas to be addressed in Zambia's Health Financing System**

| |
|---|
| Policy and Institutional Framework |
| - Inadequate and outdated National Health Services Act requiring amendments |
| - Lack of a legal and regulatory framework for the health insurance market in general<br>- Lack of a legal, regulatory and institutional framework for the proposed SHI scheme |
| Resource Mobilisation |
| - Low and erratic funding to the health sector in relation to needs, particularly for primary level of care at district level |
| - Low contribution of domestic revenue to health sector with limited prospects for growth in the short to medium term, considering the high domestic and foreign debt burden |

| |
|---|
| - Heavy dependence on external sources of financing, which are unpredictable and unsustainable |
| - Delayed implementation of the SHI scheme, which is aimed at raising additional revenue for the health sector and promoting household financial protection |
| - High OOP, particularly for secondary level of care |
| - Inefficiencies in resource allocation and use |
| - Outdated resource allocation formula for districts and training institutions |
| - Low PPPs and private sector participation in health financing |
| Pooling of revenue |
| - Very low level of voluntary prepayment mechanisms |
| - Lack of mechanisms for pooling of risk and cross subsidisation between the different sources of revenue and population groups |
| - High level of fragmentation of health resources |
| - Lack of harmonisation of donor funding in the health sector leading to duplications, inefficiency and inequity |
| - Lack of mechanism to track and coordinate donor funded projects in the health sector |
| Purchasing |
| - Passive and poor purchasing mechanism that does not incentivise improved performance |
| - Lack of purchaser-provider split in the public sector, which does not create the necessary incentives and does not promote efficiency and quality of services |
| - Weak mechanism of paying providers that exacerbates health services supply inequities across the tiers of the health system and between rural and urban areas |
| - Lack of strategic purchasing of specialised health services, especially from the private sector abroad that increases the cost of service delivery |

## 3.1 Vision, Goals, and Objectives

**Vision**

To attain adequate and sustainable financing for quality health services

**Mission**

To provide equitable access to cost-effective, quality health services as close to the family as possible

**Goal**

To attain adequate, sustainable and predictable financing through existing and new sources for improved health outcomes

**Objectives**

Based on the identified challenges in the health sector, the objectives of the health financing strategy are to:

1) Develop health financing legal, regulatory and institutional frameworks;

2) Provide viable options for increased resource mobilisation and strengthen revenue collection;
3) Enhance efficiency in resource allocation and utilisation;
4) Improve the risk pooling and redistributive capacity of funds;
5) Strengthen the strategic purchasing mechanism; and
6) Strengthen the overall PFM and information systems within the health sector.

## 3.2 Guiding Principles

The core guiding principles considered in the development of the Health Care Financing Strategy are:

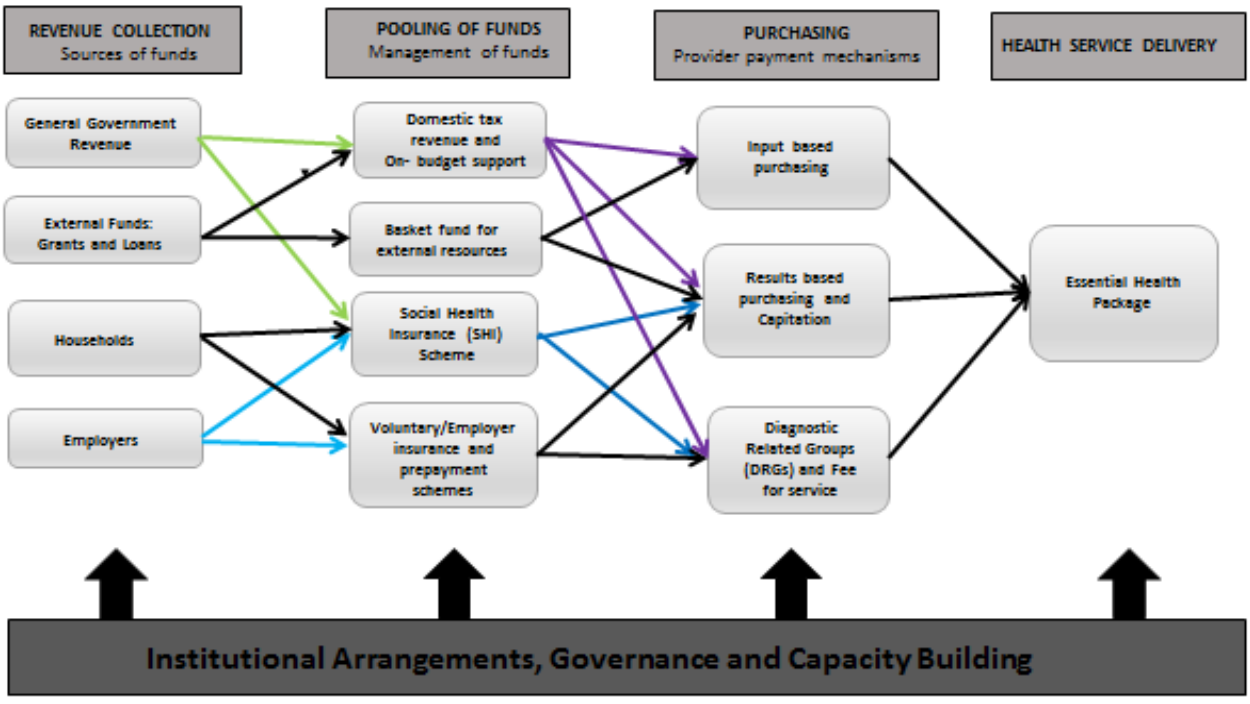
1) **Equitable access** to health care for all Zambians, regardless of geographical location, demographic characteristics, socio-economic and political status;
2) **Affordable** health care services to all, taking into account the socio-economic status of the citizens;
3) **Efficient and cost-effective** delivery of healthcare services;
4) **Transparency and accountability** in the management and use of resources;
5) **Effective partnerships** with all key stakeholders through stronger coordination and harmonisation;
6) **Evidence-based** decision-making to ensure the provision of high quality health services; and
7) **Sustainable and predictable** financing of health care.

# 4. Strategic Interventions

This section presents the proposed strategic direction, which needs to be operationalised through the development of an independent implementation plan. The plan will include detailed guidelines for the resources and level of effort needed to implement each of the proposed strategies. Estimating the resources to implement the HFS and revenues to be generated from the proposed strategies and final costing will be undertaken as a separate activity.

The strategic interventions presented in this section are necessary to address the existing bottlenecks in Zambia's health financing system. These interventions are organized around revenue collection, pooling of funds, strategic purchasing and public finance management. Figure 6 shows how the health financing functions are interlinked to achieve the goal of health service delivery. MOH, in collaboration with other health sector partners, will have to intervene in each of the financing functions.

**Figure 6: Linkages of the strategic interventions**




## 4.1 Strategic intervention 1: Revenue collection

The goal of the priority interventions under revenue collection is to deal with the following existing challenges: low contribution of domestic revenue to the health sector in relation to need, high dependence on external sources, low private sector participation in health financing and high OOP spending, particularly at secondary level of care. The key principles for revenue collection are to increase reliance on public funding generated through a progressive tax system and to increase predictability and budget execution in the flow of public and external funds. However, given the

current fiscal constraints in Zambia, interventions to be implemented in the next 10 years need to focus not only on mobilising additional resources for health but also enhancing efficiency in the use of existing resources. Specific interventions for improving revenue mobilisation are presented in the next section and summarised in Table 3 below.

### 4.1.1 Objective: To provide viable options for increased resource mobilisation and strengthen revenue collection

#### Strategy 1: Advocate for increased government domestic budget allocation to the Health Sector

To address the challenge of inadequate resources in relation to need, the health sector will engage in evidence-based advocacy with MOF and Parliament to lobby for a gradual increase in total government domestic revenue allocated to health. As part of the interventions, MOH will develop analyses and evidence to show the existing resource gaps in relation to need for the health sector. The analyses will include a detailed estimation of costs for providing primary and secondary level health services for an increasing population and disease burden.

#### Strategy 2: Improve predictability of external resources

To address the issue of predictability of external health resources, the Memorandum of Understanding between MOH and the CPs will require the CPs to make firm financial commitments in the short and medium term (at least three years). However, this will be undertaken with the understanding that some partners may not be able to commit to multi-year funding plans as their budgets are approved on an annual basis. The main emphasis will be on joint planning and budgeting of resources from key CPs for both on- and off-budget funds to ensure that programmes and activities are aligned with sector priorities. MOH will use evidence-based advocacy and continue to improve stewardship and governance to mobilise additional external resources. Intervention to improve coordination and management of external resources, such as resource mapping, are addressed in detail in the next section.

#### Strategy 3: Innovative financing options

To mobilise additional resources for the health sector, MOH will explore innovative financing that has been shown to be effective in other developing countries. Evidence suggests that targeting risky behaviours that affect health and pose a huge financial burden to the health system is an effective public policy measure. MOH will lobby MOF to introduce 'sin taxes' on cigarette and alcohol in the short to medium term as a means to mitigate the health impacts of these products' use and to raise additional revenue. The measure will also lead to efficiency gains in health as it would promote preventive rather than curative care, particularly for NCDs. One concern is that to mitigate the health impact, the tax should be high enough to reduce use, and this in turn can work against the revenue generation objective. Detailed considerations for the specific modalities on the introduction of the sin taxes will be undertaken and the most desired option will be adopted.

#### Strategy 4: Promote Private Sector Participation and PPPs

MOH will undertake innovative and creative measures to broaden partnerships with the private sector and mobilise additional resources for health. Some interventions include:

- Encouraging strategic PPP in sharing diagnostic equipment and contracting of clinical and non-clinical services
- Encouraging private sector involvement in training Human Resource for Health (HRH)
- Stimulate greater participation of the banking sector in health through the provision of credit for 1) providers of services looking to establish or expand services 2) financing in order to establish new or expand existing pre-service training institutions for HRH
- Facilitate and lobby for increased private sector participation in local pharmaceutical production

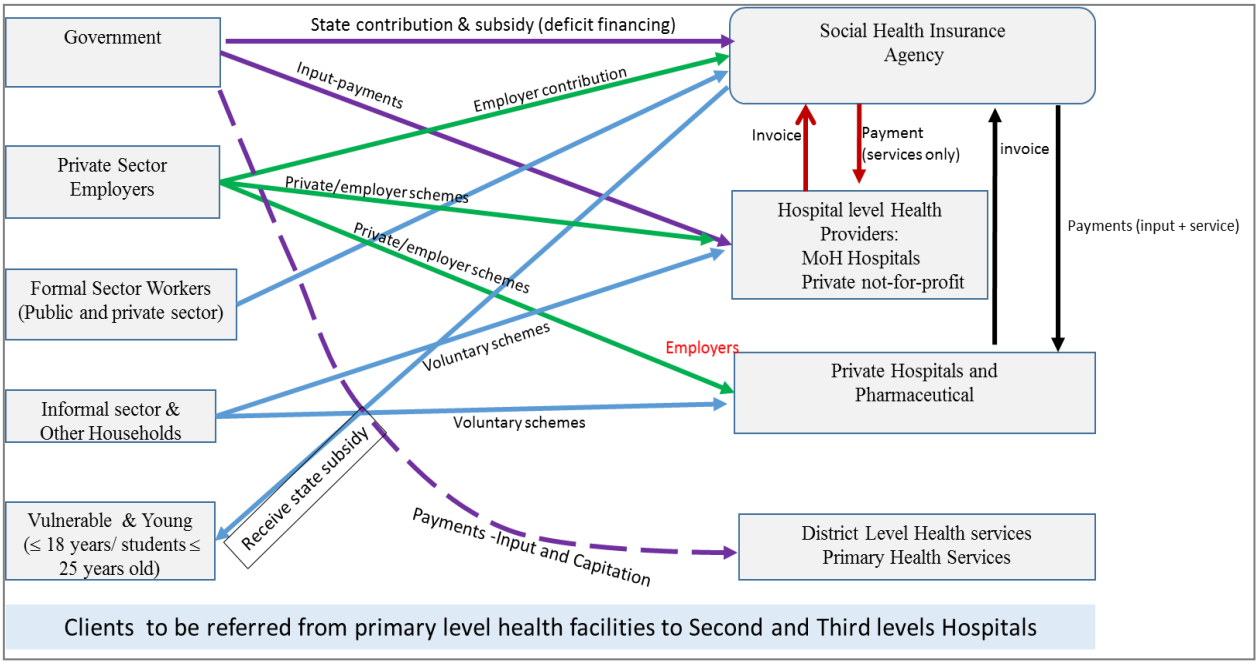
- Encourage the use of technology in supporting e-Health, by collaborating with mobile telecommunication companies to provide facilities for communication to support health service delivery
- Encourage pension schemes to invest in infrastructure for health
- Establish partnerships with the private sector and investors to provide specialised treatment within Zambia in form of a PPP
- Facilitate for the provision of hospital hotel services by the private sector including cleaning, laundry, catering for premium services offered under the prepayment schemes. Subcontracting of such services to the private sector will enable MOH to concentrate on the core function of providing health services. Hospital hotel services have an influence on customer satisfaction and can affect hospital selection more than clinical services

## Strategy 5: Design and implement a SHI Scheme

The current challenge of low levels of funding in the health sector can be addressed through designing innovative financing options, increasing the level and efficiency of government allocation and increasing private sector involvement. Another mechanism is through designing and implementing a SHI scheme. In order to reach a significant share of total health spending, resources generated through the SHI scheme need to grow at a sustained rate.

The immediate intervention is to finalise the SHI bill to be submitted to parliament and to lobby for the enactment of the SHI bill. The bill will provide a legal framework for the establishment of the SHI scheme. The next step will involve the establishment of the SHI scheme, which will be compulsory for all workers in the formal sector. Contributions to the SHI scheme for these individuals will be directly deducted from the payroll, and will consist of contributions from the employer and employee. In addition, MOH will encourage and facilitate the formation of voluntary community-based health insurance (CBHI) schemes for individuals in the informal sector that will be linked to the national SHI scheme. Individuals in the informal sector and other households not affiliated to any voluntary CBHI scheme will contribute directly to the SHI scheme. Vulnerable groups, children under 18 years, and youths aged 25 and below who are still in college/university will be exempted from contributing to the SHI scheme, and will be covered using government subsidy. Voluntary employer-based insurance schemes and other voluntary prepayment schemes will co-exist with the SHI scheme.

**Figure 7: Illustration of proposed resource flows in the context of SHI**



With the implementation of the SHI scheme, primary health services will continue to be provided free of charge. Insured individuals will access second and third level health services and will pay a prescribed co-payment. Second and third level hospital services included in the essential health package will be funded from the SHI scheme and government revenue (Figure 7). The SHI scheme will be an additional funding mechanism for the health sector and is not intended to replace government funding to health. MOH will engage in advocacy with MOF to mitigate reduction in the level of funding commitments by central government. Specific actions include:

- Facilitate the finalisation of the SHI bill for submission to parliament
- Lobby for the enactment of the SHI bill
- Set up a system to build capacities for implementation and monitor SHI
- Sensitising and empowering households to participate in the SHI scheme and the voluntary community-based health insurance schemes

### 4.1.2 Objective: Enhance efficiency in resource allocation and utilisation

#### Strategy 1: Improve efficiency in the use of available resources

While mobilising additional resources for the health sector is key, efforts to improve efficiency in allocation of resources within the health sector and to different factors of production need to be strengthened. Specific actions include periodic assessments of the efficiency bottlenecks in the health sector. The results of the assessments will determine the actions to take to achieve efficiency gains. Overall, the health sector could reap some gains by strengthening governance and accountability across the whole system and building capacity in financial management at all levels. Specific emphasis will be provided to reduce inefficiencies arising from human resource management; limit growth in health infrastructure that is not matched to need and not in coordination with other health inputs; reduce the lack of maintenance of expensive equipment, which shortens its lifespan; reducewaste and leakage in the pharmaceutical sector due to pilferage of drugs, poor procurement and supply management, and poor prescription practices, which pose a significant financial burden on the health system.

Other measures include strengthening the collection of revenue from hospital income-generating activities. The loss in revenue from leakages in revenue collection from diagnostic charges, by-pass fees, fees charged for in-patient care services, etc. needs to be assessed and quantified. Appropriate measures should be put forward to avoid such leakages. A system for reporting revenues generated from user fees at hospitals needs to be devised to enable MOH to fully account for all of the available resources. All user fees collected will continue to be retained for use at the point of collection.

#### Strategy 2: Review and strengthen resource allocation

*District RAF:* With the creation of new districts, the district RAF is outdated and will be revised. The revised formula will take into account the high cost of provision of health services in remote districts and areas with bad terrain. To accommodate other parameters that affect the cost of delivering health services in devising the RAF, such as the number of facilities in a district, population density, expansiveness of the district etc., existing datasets apart from LCMS, such as the Census, ZDHS, and HMIS may be used.

*Intra-district RAF:* Intra-district RAF will also be developed. Although guidelines on the proportions to be spent at the various levels of service provision exist, evidence suggests that in practice, districts have been deviating away from the guidelines, with increased allocation towards administrative costs (Chileshe, 2013).

*Second and Third Level RAF:* The second and third level hospital RAF was revised in 2012 and includes the cost of procedures and treatment therapy. The hospital RAF was derived using an activity-based case mix guided by the concept of DRGs. However, its full implementation is hindered partly by inadequate resources. MOH will lobby for additional finances from MOF to fill this funding gap.

*RAF for training institutions and statutory boards:* The current RAF for training institutions allocates a flat rate per student enrolled by course across all the schools in the country. The RAF for training institutions will be revised to ensure that the allocation reflects the full cost of providing training and the variations in costs across the country. A RAF to allocate resources to regulatory and statutory Boards will be developed. Although some statutory boards generate additional revenue by charging fees (e.g. registration, inspections and licenses), other statutory boards are solely dependent on the government grant, which makes it difficult for these boards to regularly conduct core statutory functions.

**Table 3: Key strategic interventions for revenue collection**

| Focus Area | Strategic Intervention | Time-frame | Milestone | Institution Responsible |
|---|---|---|---|---|
| Advocate for increased government budget allocation to the health sector | Evidence-based advocacy with MOF to lobby for a gradual increase in total and/or share of government domestic revenue allocated to health | Short term | - Relevant technical studies conducted<br>- Increase in domestic government revenue allocated to health | MOH, CPs, University of Zambia (UNZA), MOF, Parliament |
| Improve predictability of external resources | Memorandum of Understanding between MOH and CPs on firm financial commitments in the short and medium term.<br>Emphasis on 3-year commitment done on a case-to-case basis with each of the partners, considering that some partners will not be able to commit to multi-year funding, as their budgets are approved on an annual basis by their parliaments. | Short term | - Functional MOU in place adhered to by all parties<br>- CPs three year firm financial commitments | MOH, CPs |
| Innovative financing options | Lobby for the introduction of 'sin tax' for cigarettes and alcohol | Short term | - Amount of funds generated from sin taxes<br>- Costs averted due to reduction in risky behavior that contributes to NCD burden | MOH, MOF, Zambia Revenue Authority |
| Design and establish the SHI scheme | Facilitate and lobby for finalising the SHI bill for submission to parliament | Short term | SHI bill approved | MOH, Parliament, Cabinet |
| | Sensitising and empowering households to participate in the SHI scheme | Medium to Long term | Increase in percentage of the population covered by the SHI scheme and voluntary community-based insurance schemes | MOH, Pensions and Insurance Authority(PIA), Informal sector associations |
| | Set up a system to monitor SHI and build capacities for implementation | Medium to Long term | MOH, district and health facility managers trained on health insurance | MOH, MOF, PIA |

| | | | | |
|---|---|---|---|---|
| Promote Private Sector Participation and PPPs | - Strategic PPP in sharing diagnostic equipment and contracting of non-clinical and clinical services<br>- Encouraging and facilitating private sector involvement in training HRH<br>- Stimulate participation of the banking sector in health through the provision of credit and financing to establish new or expand existing pre-service training institutions for HRH<br>- Facilitate and lobby for increased private sector participation in local pharmaceutical production<br>- Promote the use of e-Health service delivery, by collaborating with mobile telecommunication companies<br>- Encourage pension schemes to invest in infrastructure for health.<br>- Establish partnerships with the private sector and investors to provide specialised treatment within Zambia in form of a PPP.<br>- Facilitate for the provision of hospital hotel services by the private sector. | Short to Medium term | - Increased private sector participation<br>- Increased investment in human resource and infrastructure by private sector<br>- Increased local production of pharmaceuticals<br>- Improved hotel services in public hospitals<br>- Specialist treatment service available locally at a relatively lower cost | MOH, MOF, Various Private Sector Associations, Pension funds |
| Improve efficiency in the use of available resources | Periodic reviews of inefficiencies in the health sector | Short to long term | - Efficiency assessments conducted and corrective measures undertaken | MOH, UNZA, CPs, MOF |
| | Avoid waste and theft by using a system to track expiration and stock of drugs | Short to medium term | - Reduced drugs leakages and theft<br>- Waste of commodities avoided | MOH, Zambia Medicines Regulatory Authority, Medical Stores Limited |
| | Strengthen planning for procurement and maintenance of infrastructure and equipment | Short to medium term | Effective implementation of plans for infrastructure development and equipment | MOH, CPs |
| | Strengthening the collection of revenue from hospital income generating activities and financial management. | Short to medium term | Improve revenue collection mechanisms and financial management | MOH, second and third level hospitals |
| Review and strengthen resource allocation | Revise outdated district RAF<br>Develop intra district RAF, training institution and statutory board RAF | Short to medium term | Revised district RAF<br>Intra district RAF developed<br>Training institution and Statutory body RAF developed | MOH, UNZA, CPs |

## 4.1 Strategic Intervention 2: Pooling of funds

The strategic interventions aimed at reducing fragmentation in resources and risk pooling will target government resources, external resources and resources generated from households through prepayment mechanisms. The goal is to create resource pools that are coordinated and allow for income and risk cross-subsidisation between the rich and the poor, and between the sick and the healthy. The pooled resources will help deliver the services covered under the essential health package. Risk pooling facilitates efficiency gains in management and strategic purchasing and enhances equity during revenue generation and use of health care. The next section describes the specific interventions for pooling of funds. The priority interventions are summarised in Table 4.

### 4.2.1 Objective 4: Improve risk pooling and redistributive capacity of funds

#### Strategy 1: Harmonise and align external financing in line with government priorities

Currently, external resources in the health sector are not adequately coordinated and managed. Harmonising and aligning external resources with government priorities is necessary to improve the complementarity of the different revenue sources. In the short-term, MOH will explore mechanisms to revive the basket fund, which will be managed and governed by the IHP+ Compact principles. The process of reviving the basket fund will take into account all the factors that led to the collapse of the fund. These factors will be identified through a consultative and participatory process involving all key stakeholders, with a view to developing the checks and balances that should support the governance and management of the basket funds. The actions to be taken will be guided by the lessons learnt from the earlier implementation of the basket fund. The main goal of this intervention is to create a single pool for all external resources, which will allow for planning and budgeting of external resources to ensure effective resource use and alignment with sector priorities.

An immediate goal is to set up an internal tracking mechanism of external resources, which include tracking of commitments/budget, annual resource/budget mapping and spending. MOH will collaborate with the Ministry of Development and National Planning (MDNP) to strengthen the internal tracking mechanisms of external financial flows. This will involve improving the joint planning and use of a single monitoring and evaluation system. The joint planning and implementation will enhance alignment of public and external resources to the health sector priorities and reduce inefficiencies due to duplication of effort.

#### Strategy 2: Develop new and promote existing prepayment mechanisms in the health sector to promote financial protection

MOH will facilitate the set-up of voluntary community-based health insurance schemes. Specifically, emphasis will be on sensitising and empowering households to participate in the schemes to enhance financial protection and reduce the risk of facing catastrophic health payments at the time of illness. The voluntary community-based insurance schemes will be managed by organised entities such as associations and linked to the national SHI scheme. Relevant legislation and institutions to support the operation of the community-based health insurance schemes will be set up. In the long term (post 10 years), it will be important to reduce fragmentation of these pools. MOH will establish a SHI fund that will bring together resources from the different community and private health insurance schemes to facilitate income and risk cross-subsidisation.

**Table 4: Key strategic interventions for pooling of funds**

| Focus Area | Strategic Intervention | Timeframe | Milestone | Institution Responsible |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| Harmonise and align external financing with government priorities | Establish internal tracking mechanisms of external resources, which include tracking of commitments/budget, annual resource/budget mapping, and spending | Short term | System for tracking external flows set up | MOH, CPs, Ministry of Planning and National Development |
| | Revive the single basket fund for external resources | Medium term | Operational basket fund for external resources | MOH, CPs, MOF |
| Develop new and promote existing prepayment mechanisms in the health sector to promote financial protection | Strengthen institutional capacities to ensure income cross subsidisation and risk pooling among the different risk pools and schemes | Medium - Long term | Legal framework for the different health insurance schemes | MOH, PIA, Insurance schemes, CPs |
| | Facilitate and encourage the growth of voluntary community-based health insurance schemes | Medium - Long term | Increase in percentage of the population covered by the voluntary community-based insurance schemes | |
| | Sensitising and empowering households to participate in the voluntary community-based health insurance schemes | Medium to Long term | Increase in percentage of the population covered by the voluntary community-based insurance schemes | MOH, PIA, Informal sector associations |
| | Set up a system to monitor voluntary community-based health insurance schemes and build capacities for implementation | Medium to Long term | MOH, district and health facility managers trained on health insurance | MOH, MOF, PIA |

## 4.2 Strategic Intervention 3: Strategic Purchasing Mechanism

The current major sources of MOH's health budget funding are government through MOF and donors. This strategy also envisions the establishment of a SHI scheme to be administered by an autonomous agency under MOH. These streams of income require devising new purchasing mechanisms without enhancing efficiency in provision of health care services. The main elements of purchasing mechanisms are determining what to purchase in terms of services or benefits. The second is to design the provider payment mechanisms or determining how to purchase the services.

### 4.3.1 Objective: Adapt and shape the purchasing structure in the health system for improved service delivery

#### Strategy 1: Establish the Essential Health Care Package

Zambia's health services are currently provided free of charge in government-owned primary level health facilities through the referral system to all, regardless of their ability to pay. This strategy seeks to facilitate the process of determining the health services that can be provided free to all and benefits that will be purchased. The objective of MOH's health financing policy is to have a free-of-charge package accessible by all people at primary level and a fee-based benefit based package at higher tiers of the health sector to cater to those in the formal sector who will be contributing to SHI. To promote efficiency in the use of SHI and MOH facilities, access to secondary and tertiary level facilities will be based on the referral system for both insured and uninsured clients. Facilities will continue charging bypass fees to non-referred clients. To achieve these objectives, the strategy proposes that MOH explore the introduction of a categorised benefit and service package. The strategic interventions are:

- Design and cost an essential health care package that defines services for both primary and higher levels of health care. The package for primary health services will be provided free of charge to all people. This package should also be a priority setting tool financed using tax revenue and will strictly be through the PHC providers, which will also serve as initial point of contact in the MOH referral system. The services in the essential health package defined for secondary and tertiary levels of care will be fee based, purchased through the insurance coverage via the referral system. Clients will be required to co-pay depending on the type of services received.
- The strategy envisions that in the short- to medium-term, SHI will cater to people employed in the formal sector and subsequently apply to those in the informal sector when they join SHI. In terms of implementation design, general tax revenue shall be used to provide subsidised secondary care services targeted to the vulnerable (identified through official institutions), the poor, children under 18 years of age and students without income that go through the referral system. This subsidised package for the poor could provide restricted sub-services such as essential clinical services, critical surgeries and the treatment of chronic diseases and can gradually be expanded as more people join the insurance system and more investment funds or resources are generated. Additional services will be funded through cross subsidisation.
- To encourage efficiency in resource use, insured individuals and their families will access the benefit package through the referral system − from PHC providers. This could prevent trivial use of health services and encourage financial sustainability. To further assure the sustainability of SHI, a limit will be placed on the number of specific high-cost laboratory tests and interventions that providers will be reimbursed from SHI.

In preparation for the implementation of this strategic objective, MOH has to undertake the major activities that include:

- Design and establish a comprehensive framework for the new provider payment mechanism. Currently, MOH is the purchaser and provider of health services. A split of the provider and purchaser roles is essential to ensure effective delivery of health services. This split will create an autonomous agency for handling strategic purchasing (with a board comprising representation from the private and public sector). This is even more critical as the decentralisation policy is implemented. This policy change will require MOH to purchase services from local authorities. These new roles will require building new and strengthening existing skills to effectively implement this strategy.
- Accredit health facilities: Zambia's health sector is a mixture of public and private providers. These providers will have to be accredited to ensure that only facilities that meet the basic quality requirement are engaged to provide services.
- Establish a health technology assessment unit: The essential health care package will undergo continuous review and revisions in response to changes in drugs and treatment procedures on the package. This requires establishing a health technology assessment unit responsible for economic evaluation of the cost effectiveness of any changes.

## Strategy 2: Design different payment mechanisms to stimulate quality improvements

There are currently many purchasing arrangements focused on workers compensation, goods and services and capital purchasing. First, government uses line-item budget payment system for health worker salaries and procurement of drugs and medical supplies. Second, the capitation systems are used to fund the districts while funding for hospitals is based on the workload in line with the concept of DRGs to compute shares for different hospitals. Donor funds also enter the health system under a variety of payment systems such as the RBF at primary level. The current health worker purchasing mechanisms in Zambia are inactive and do not motivate or incentivise staff or encourage productivity, equity in service delivery, efficiency in use of resources and promote service

quality. This HFS proposes that in the short to medium term, MOH continues to use a combination of purchasing mechanisms comprising capitation systems for districts or primary level services, DRGs for tax funded hospital services and fee-for-service for SHI-funded hospital services. The proposed strategic interventions involve rationalising the various payment systems and aligning them with incentives as follows:

- **Strategy 2.1:** Strengthen the case-based payment system, in particular the DRGs as a preferred reimbursement model at the hospital level. As a fee-based model, DRGs will incentivise hospitals to improve performance since it presents some form of active purchasing and is linked to output, a shift from the current mode of inactive purchasing. Since 2008, t MOH has been implementing the RBF strategy as its long-term preferred reimbursement model for primary health services. With the implementation of decentralisation in the medium term, MOH designs frameworks where primary service providers are remunerated based on the quantity and quality of services offered within the RBF framework. This method will help to achieve the strategic objectives of achieving equity and efficiency through by incentivising both the supply and demand side of critical services such as maternal and child health services. MOH will develop capacity among its staff and providers to scale-up or reinforce RBF as a major tool to pay for ambulatory care services for all Zambians. The scaling up process must incorporate the feedback from the monitoring and evaluation process of the current RBF. This method should be cognisant of the catchment population and social and economic factors.
- **Strategy 2.2:** Capitation is currently used for paying providers at the district or primary-care level. The method involves paying health-care providers a predetermined fee to cover prescribed health services using the deprivation index and catchment population. In the short to medium term, capitation has to continue for tax financed health services and gradually blend incentive and performance based financing strategies. This shift to new contracting methods results in administrative efficiency through the pooling of tax and SHI resources under one agency. Similarly, training institutions will be reimbursed based on the number of sponsored students and type of training.
- **Strategy 2.3.** MOH currently uses the input-based line item budget payment systems for critical inputs such as human resources, drugs and medical supplies and infrastructure. However, an input-based payment system for health services provision lacks flexibility for prioritisation. It also doesn't provide incentives to health providers to improve efficiency and performance. This provider payment method fails to match key inputs, such as infrastructure and capital investment, within the essential package. This approach will need to be revised by introducing strategic purchasing mechanisms that stimulate accountability and promote quality health services delivery by shifting to a more output based provider payment system.

To encourage efficiency, resource use, pharmaceuticals will be centrally procured and will be allocated using the paper-based budget while capital projects will be based on strategy 2.3.

## Strategy 3: Improve capital purchasing

The design of this strategy is premised on a decentralised system of health service delivery where councils manage primary health services. However, by policy, MOH, in consultation with local authorities, will retain the role of planning for major infrastructure and capital investments since health facilities are not likely to fund bigger projects. As an efficiency and equity generation measure, key investments in public health facilities should be paid from general taxes using an input-based budgeting system. This approach will ensure equity in the distribution of infrastructure and capital equipment among different types of health providers and regions. Investment planning for infrastructure should be informed by the essential health care packages and not at random. Capital maintenance costs are currently neither well planned nor incorporated into payment systems, which fuels less-than-optimal return on capital investments and maintenance.

However, hospitals and health facilities should be allowed to use their savings to invest in small capital and infrastructure investment up to some threshold. In this regard, MOH will provide policy mapping where necessary and put up infrastructure.

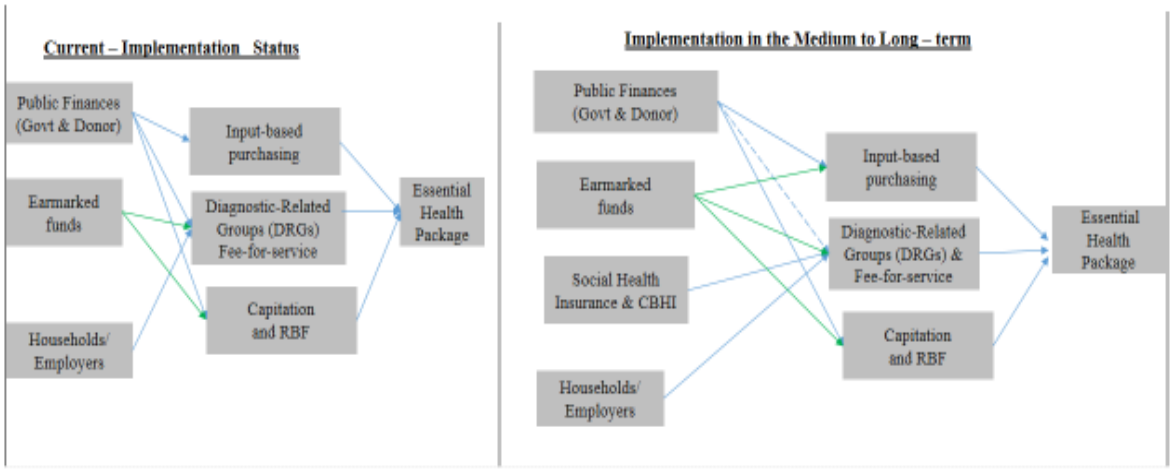
**Table 5 : Key strategic interventions for purchasing**

| Focus Area | Strategic Intervention | Timeframe | Indicator | Institution Responsible |
|---|---|---|---|---|
| Identify the actual capacity needs to implement the facility accreditation and strategic purchasing | Undertake an institutional needs assessment | Short term | Identified capacity gaps and training needs | MOH<br>MOF<br>Private health care associations |
| Build capacity for purchasing in the sector | Train specialists in purchasing and build capacity in MOH<br>for successful implementation of the new interventions | Short-term | Train enough staff to manage purchasing | MOH |
| Establish an accreditation and purchasing agency/unit | Establish a strategic purchasing/contracting and accrediting agency | Medium term | Established and functional agency | MOH<br>HPCZ |
| Capitation for tax funded services | Review the allocation formula at all levels of health care, including resource allocation within districts and local levels | Short-term | Revise the allocation formula to make more need and workload based | MOH<br>MOF |
| | Train health facility managers, especially at district level in the light of the proposed decentralisation | | Health care quality improvements | MOH Ministry of Local Government<br>MOF |
| Fee-for-service and DRGs for hospital level care | Standardise the cost of health care at higher levels of care to make it competitive | | Improved quality of services | |
| | Train hospital facilities managers/administrators on financial management emphasising accountability for quality of services | Short term | Number of trained managers and improving quality of services | MOH<br>MOF<br>Private not-for-profit-providers |
| Results-based financing | Strengthen the purchasing/contracting and accrediting agency towards results-based financing mode | Medium tern | Increased use of RBF than capitation at lower levels of health care | MOH |
| Provide an essential health care package | Design and develop the essential health care package for universal access | Medium term | Operational benefit package | MOH<br>MOF<br>Private not-for-profit-providers |

| | | | | |
|---|---|---|---|---|
| | Enhance collaboration between public and private sector to enable contracting, especially for specialist treatment | Medium term | More local private provision of specialist services and operating in government underserved areas | MOH<br>Private for-profit- providers<br>Private not-for-profit-providers |
| | Establish a health technology assessment unit | Medium term | Establish a unit responsible for technological assessments within MOH structure | MOH |
| Strengthen the referral systems | Strengthen PHC system by availing adequate resources to meet the basic package | Short to medium term | Availability of quality services | MOH<br>MOF |
| Secure fiscal autonomy of facilities | Capacity building in hospital management | Short to medium term | Hospitals with independent boards<br>Share of facilities with fee retention | MOH<br>MOF |

Figure 8 illustrates how the pooling and purchasing mechanism in Zambia is expected to evolve from the current passive purchasing arrangement to an active purchasing mechanism to incentivise providers in the post SHI implementation period. The process envisions the maintenance of the current reimbursement system but with increased flow of resources through the health insurance mechanism. In the medium- to long-term, government and employer purchases of hospital level services will be through the mandatory SHI. However, voluntary schemes will be allowed to co-exist with the SHI as additional covers for employers.

**Figure 8: Current and Expected Implementation Arrangements of Pooling and Purchasing**




## Strategy 4: Provide fiscal autonomy for secondary and tertiary health care providers.

Government's policy objective is to decentralise the provision of services to local levels. For the reimbursement mechanism to stimulate providers to improve their quality of service delivery, the ownership and management of facilities should become more autonomous. This requires defining separate financing and management arrangements that allow managers to retain any savings from management efficiencies as an incentive for improved performance and cost effectiveness. Similarly, government must allow secondary and tertiary hospitals to retain internally-generated revenues

from user-fees to improve efficiency and quality of care. Failure to deepen health facility autonomy may frustrate the positive incentives envisioned in the decentralisation of health services and this strategy.

## 4.3 Strategic Intervention: Strengthen PFM

### 4.4.1 Objective: Strengthen PFM and information systems

#### Strategy 1: To strengthen PFM and information systems to support health purchasing

The PFM system, which includes the budgeting process, accounting, financial reporting and internal controls, plays an important role in the effective delivery of quality and timely health services for UHC. The PFM and information systems are critical to effective purchasing of services. To encourage efficiency in resource use in Zambia, the PFM in the health sector must emphasise the ability of the system to direct sufficient funds to where interventions and services are needed in a timely and cost-effective manner. To strengthen the PFM, government and MOH should in the medium to long-term move towards extending the information system−IFMIS from Headquarters and a few province centres to districts. However, in the short-term, MOH will roll-out Navision to lower tiers of the health sector to improve control over preparation, release and accounting for budgeted expenditure, as well as strengthening of internal and external audit and other external financing arrangements.

In the long-term, both information systems−Navision and IFMIS− should be unified, enhanced and adapted to the health sector and new provider payments to increase efficiency, and ensure effective operations, such as claims management and standard information availability for effective planning. A strong and accountable PFM is an important foundation of health purchasing that can contribute to improving the quality of health care services. This process will involve strengthening PFM at all levels of the system and linking the financial management systems to the health information system and other supporting systems.

**Table 6: Key strategic interventions for PFM**

| Focus Area | Strategic Intervention | Timeframe | Milestone | Institution Responsible |
|---|---|---|---|---|
| Strengthen PFM at all levels of the health sector | Update the PFM guidelines and manuals<br><br>Build capacity in PFM across levels of the health sector | Short-medium term | | MOH<br>MOF<br>Private not-for-profit- providers<br>CPs |
| Enhance mechanisms for financial transparency and accountability | Roll out Navision to facility level | Short term | Number of facilities connected to functioning system | MOH<br>MOF<br>Private not-for-profit- providers |
| | Integrate information systems (Navision and IFMIS)<br><br>Strengthen internal control systems auditing | Short to medium term | Functioning and increased use of IFMIS at local levels | MOH<br>MOF<br>Private not-for-profit- providers<br>Private for-profit- providers |

# 5. Legislative and Regulatory Frameworks

The implementation of this strategy is premised on the existence of an elaborate institutional, legal and regulatory framework guiding the operations of the health sector. However, these are largely missing and in some cases require strengthening to make them consistent with the evolving institutional, health policy and operational experience. To address these inadequacies, MOH has to undertake crosscutting activities to create a conducive environment for increased stakeholder participation. The activities include the implementation of new institutional, governance and regulatory frameworks to accommodate the aspirations of the health financing policy.

The immediate legal and institutional reforms and strategies that the MOH must implement include:

- The amendment and enactment of the new National Health Services Bill to replace the National Health Services Act of 1995, which was repealed in 2005. This reform is essential to bridge the legislation gap left by the repealed Act of 1995 and clarify the vision, values, objectives and guiding principles for the proper functioning of the health system as a whole. The Bill will also provide a legal framework to enhance private sector participation through progressive incentives and an elaborate legal and institutional framework for engaging with the private sector in a decentralised system.
- The second strategy for the MOH is to advocate to the Pensions and Insurance Authority to amend and pass the National Health Insurance Act to strengthen the legal regulatory framework for a health insurance market in the country. A well-regulated public and private health insurance industry through a National Health Insurance Act can foster pooling of resources into the health sector. Despite the proposed SHI, the legal framework should not prevent the participation of private health insurance firms to serve as agents of resource mobilisation and risk pooling and should ensure fair competition and quality of services.
- Third, the MOH needs to pass the SHI Act for the implementation of the proposed SHI scheme as an additional resource mobilisation and risk-pooling mechanism. The Act will provide the requisite legal and institutional framework, such as the provider-purchaser split and lobby for its passing by parliamentarians.

# 6. Institutional, Governance, Capacity Building and Implementation plan

The successful implementation of this HFS depends on revising the legal framework, establishing appropriate institutional arrangements, and improving efficiency in service delivery to generate additional resources for health care. In this regard, MOH will develop an independent and flexible implementation plan for this strategy. Flexibility is essential to allow for their continuous review and revisions to ensure that they respond to any changes that could affect the implementation of the strategy.

To be successful, the implementation process will require the engagement and support of stakeholders, such as providers and financiers. In this regard, MOH should create and lead a special health financing committee comprised of various stakeholders to provide oversight with the support of the Technical Working Group. The rest of the implementation strategy should involve setting priorities in a progressive manner that allows for implementation without delayed activities acting as bottlenecks.

The proposed plan must first deal with the legislative requirements by amending the existing laws or passing new legal provisions to accommodate the proposed changes. Priority may be given to the review of the National Health Services Act to allow for the proposed decentralisation of services and participation of other providers. Also key to the implementation of the HFS is the establishment of SHI. Among the activities that can be implemented are:

- Revise the health insurance law and pass new legislation to enhance the role of insurance and foster the establishment of the proposed SHI.
- Undertake capacity mapping in order to assess the human resources and technical requirements for human capacity development and setting up a new institutional framework.
- Build the required capacity and essential systems for the operationalisation of the strategies highlighted in the strategy.
- Shift to new provider payment mechanisms that incentivise the delivery of health services such as RBF to drivers of SHI and the decentralised health care system. This will require accrediting providers that could be paid on a per case or DRG payment plan.
- Improve the general functioning of MOH in terms of resource allocation across regions and tiers to enhance efficiency.
- Engage in lobbying for more public resources from MOF and advocate for facility level income retention.

**Table 7: Proposed Action Plan (timeframe to be determined)**

| Priority interventions |
|---|
| Initiate the amendment of existing laws such as the NHS act, insurance act or passing new legal provisions (such as SHI bill) to accommodate the proposed changes |
| Train relevant departments of MOH to create and strengthen the competencies required for successful implementation and monitoring of the HFS |
| Train relevant stakeholders who will be involved in the implementation of HFS interventions |

| Priority interventions |
| --- |
| Initiate the amendment of existing laws such as the NHS act, insurance act or passing new legal provisions (such as SHI bill) to accommodate the proposed changes |
| Improve health financing and expenditure information to guide policy and decision making |
| Establish new and strengthen existing institutions to undertake proposed changes |
| Rationalise use of medicines and pharmaceutical supplies (e.g. regulation of medicines pricing) |
| Evidence based advocacy for increased government prioritisation of the health sector |
| Engagement and mobilisation for the finalisation and approval of the SHI bill by cabinet and government |
| Strengthen mechanisms for financial transparency and accountability to encourage trust among all partners |
| Put in place a system for effective implementation and monitoring of the SHI (for the formal sector), including building relevant capacities required for its implementation |
| Establish a single basket for all donor funding |
| Establish a unit to implement strategic purchasing |
| Sensitise households in informal sector to participation in the voluntary health insurance schemes |
| Initiate legal and institutional reforms |
| Build capacity and strengthen existing capacity in MOH to implement strategic purchasing |
| Develop institutional capacity of MOH and providers to implement performance based financing |
| Establish results-based payment mechanisms for the different providers |
| Revise allocation formula district, intra district, training institutions and statutory boards |
| Build the management capacity of facility managers and to emphasise accountability for quality of services |
| Establish institutionalised contracting mechanisms for reimbursement of activities best suited to this mode of payment |
| Articulate the essential benefit package that will be accessed by the population |
| Setting eligibility and qualification standards for accreditation of providers |
| Build partnership arrangements between public and private sector to ensure availability of specialised care and quality care for all |
| Strengthen institutional capacities for relevant actors to ensure income cross subsidisation and risk equalisation across the different risk pools |

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