Republic of Zambia

MINISTRY OF HEALTH

NATIONAL HEALTH ACCOUNTS ESTIMATES FOR ZAMBIA: 2017 -2021

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2017 - 2021




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NATIONAL HEALTH ACCOUNTS ESTIMATES FOR ZAMBIA:

Foreword

Minister Photo

The 2017-2021 National Health Accounts (NHA) is the eighth in a series of reports produced by the Ministry of Health. The NHA exercise provides a detailed analysis of health expenditure data encompassing government spending, households' expenditure on health, development assistance to the health sector as well as private employer's expenditure on health. The study was conducted in accordance with the World Health Organization's System of Health Accounts (SHA 2011) methodology to estimate the level and flow of funds through the health system. This report provides necessary evidence for the formulation of strategies aimed at mobilizing resource for strategic health investments. The report also contributes to evidence-based decision making and enhances transparency and efficiency in health expenditure management.

The findings of this National Health Accounts (NHA) report show that nominal public health sector expenditure rose from ZMW K6.4 billion in 2017 to 10.75 billion in 2021. The bulk of this spending (over 95 percent) was directed towards Current Health Expenditures (CHE), with the Capital expenditure accounting for below 5 percent over the period. Total nominal CHE rose from K11.8 billion in 2017 to K29.6 billion in 2021.In percapita terms, the total CHE for Zambia was estimated at US$73.4 in 2021. The Zambian Government and donors were the primary sources of total CHE, each contributing approximately 44 percent and 43 percent, respectively, during the study period. In absolute terms, the government increased its current expenditure in the health sector by 73.7 percent between 2017 and 2021 which is equivalent to 14.7 percent per annum.

The contributions by CPs increased from 31.5 percent in 2017 to 49.4 percent in 2021. The share of households' out-of-Pocket expenditures declined from 10.7 percent in 2017 to 7.3 percent in 2021, partially due to the introduction of the compulsory insurance scheme for the employed during this period. The corporations had the least share of 4.1 percent in 2021. On average, internal government transfers and direct foreign transfers constituted the largest share for revenues of financing schemes. Transfers through government stood at 44 percent in 2018 and declined to 38 percent in 2021 while direct foreign transfers increased from 44 percent in 2018 to 58 percent in 2021. Expenditure by the major diseases categories show that Zambia spent most (over 70 percent) of the health resources on infectious and parasitic communicable diseases such as Malaria, HIV/AIDs, Malaria, TB and emerging diseases like Covid-19 in 2021. This bias in health spending towards communicable diseases is could be attributed to earmarked expenditure by cooperating partners.

This NHA report along with the previous editions will assist the Ministry of Health and other stakeholders to ascertain sources of funds and utilization trends in the health sector over the years. The MOH is hopeful that the findings from this exercise will be effectively utilized by all the stakeholders to accelerate progress towards achievement of Universal Health Coverage.

Dr. Elijah Muchima
Honorable Minister of Health

Photo of PS, Admin

This health accounts 2024 study is a product of contributions from many organisations under the guidance of the directorate of Planning and Directorate of Policy and Planning of the Ministry of Health. The Ministry is thankful to the Directorate of Policy and Planning for the steward of this NHA study. The study is a result of a strong collaborative effort, with inputs from many stakeholders including cooperating partners such as the World Health Organization and World Bank, and the academia.

The study was co-financed by the Ministry of Health, the World Bank and the United States of America International Development Agency through the Revenue for Growth Project. The Ministry would therefore like to thank the World Bank and all the partners for their continued financial support and technical support without which this study would not have been possible. The Ministry also grateful to the WHO team who reviewed the report and provided input that improved this report.

Special thanks also go to the University of Zambia, Department of Economics for their technical support in the production of this report. In particular, we many thanks should go to Dr. Dale Mudenda, Mr Abson Chompolola and Dr. Kaonga for their dedication. We also extend our thanks also to Dr. Bupe Simuchimba, Dr. Bona Chita, Dr. Chitalu Chiliba and Mr. Henry Kansembe for their inputs during the study process.
Many MoH staff also deserve thanks for their respective contributions.

Prof Christopher Simoonga

Permanent Secretary, Administration

Contents

List of Tables

List of Figures

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
CHE	Current Health Expenditure
CSO	Central Statistical Office
GDP	Gross Domestic Product
GHE	Government Health Expenditure
HAPT	Health Accounts Production Tool
HIV	Human Immunodeficiency Virus
IMR	Infant Mortality Ratio
MMR	Maternal Mortality Ratio
MoH	Ministry of Health
NGOs	Non-governmental organizations
NHA	National Health Accounts
NPISH	Non-Profit Institutions Serving Households
OOP	Out of Pocket Expenditures
SHA	Systems of Health Accounts
TB	Tuberculosis
THE	Total Health Expenditure
U5MR	Under 5 Mortality Ratio
USAID	United States Agency for International Development
WHO	World Health Organization
ZHHEUS	Zambia Household Health Expenditure and Utilization Survey
ZMW	Zambian Kwacha

Executive Summary

In the period 2017 to 2021, Government of Zambia (GRZ) nominal expenditure (CHE) and capital expenditure increased from ZMW6.4 billion to ZMW610.75 billion in 2021. Capital expenditure accounted for 4.1 percent in 2017 and rose to 7 percent in 2018 and due to fiscal constraint triggered by the debt crisis reduced to 1 percent in 2021.

The total nominal CHE, comprising private sector and households spending, government and cooperating partners (CPs) rose from ZMW611.8 billion in 2017 to ZMW629.4 billion in 2021. This increase was mainly driven by increases in both government and CPs spending on the health sector in general and as a response to the Corona Virus (Covid-19) pandemic. The largest increase in CHE was from the CPs that rose from ZMW3.7 billion to ZMW14.5 billion between 2017 and 2021. This increase is partially driven by the rapid depreciation of the Kwacha from as low as ZMW9.5/US$ to about ZMW20.1/US$, respectively in 2017 and 2021. In dollar terms, the total CHE rose from US$1, 239.2 million in 2017 to US$1, 572.9 in 2019 and declined from this peak to US$1,461.8 in 2021. Similarly, the CHE per capita rose from US$71.7 in 2017 to US$85.6 in 2019 before declining to US$75.1 in 2021.

The other indicators show that the government's share in total CHE oscillated from 52.5 percent in 2017 to 33.4 in 2019 and 53.5 percent in 2020 and 36.6 percent in 2021. The contributions by CPs increased from 31.6 percent in 2017 to 49.4 percent in 2021. The share of households' out-of-Pocket expenditures declined from 10.7 percent in 2017 to 7.7 percent in 2021, partially due to the introduction of the compulsory insurance scheme for the employed during this period. The corporations had the least share of 6.8 percent in 2021.

In terms of transfers, transfers through the government (domestic and foreign origin), which stood at 51.2 percent in 2018, declined to 45.9 percent in 2021. This is attributable to the increase in the share of direct foreign transfers from 36.7 in 2018 to 40.1 percent and 2021. The Non-Profit Institutions Saving Households (NPISH) managed a significant share of total CHE that rose from 22.7 percent of total CHE in 2017, to 45.2 percent in 2019, but dropped to 28.3 percent in 2021 as most CPs channeled their funds through government to mitigate the impact of Covid-19.

Health services in Zambia are provided through hospitals, residential care facility providers, ambulatory healthcare providers, retail sale and medical goods providers, and public health program providers. The study shows that on average 44.18 percent of the total CHE was spent on hospitals during the period under review. As a percentage of total CHE, providers of ambulatory healthcare accounted for 37.1 percent in 2017 and 25.5 percent in 2021, averaging 26.9 percent over the study period. Spending on health administration and management averaged 14.3 percent over the 5 year period covered in the study.

Finally, the expenditure by the major diseases categories show that Zambia spends most (over 70 percent) of the health resources on infectious and parasitic communicable diseases such as Malaria, HIV/AIDs, Malaria, TB and emerging diseases like Covid-19 in 2021. This bias in health spending towards communicable diseases is mainly due to earmarked expenditure by cooperating partners.

1: Introduction

1.1. Background

The Ministry of Health in Zambia has conducted nine rounds of the National Health Accounts (NHA) studies covering the period 1995 to 2016. The exercise is carried out to determine the country's health expenditure to meet the health care needs of residents and to describe the various dimensions of those expenditures in terms of financial sources, financing mechanisms, provider and functions. The analysis captures both capital and current expenditures.

This study updates the NHA estimates to the period 2016 to 2021 using the System of Health Accounts (SHA) 2011 of the World Health Organization (WHO). This is the third round of estimates for Zambia presented according to the SHA 2011. The SHA 2011 is an internationally adopted standard framework for producing health accounts. The framework allows for coherency, comprehensiveness, consistency and international comparability of the measurements and reporting of expenditures. The framework makes health accounts more adaptable to changes in healthcare financing systems.

The SHA 2011 data design contributes to understanding issues that pertain to financing sustainability, effectiveness, efficiency and equity in the allocation and use of health resources. The health expenditures are disaggregated in form of current and capital expenditure and are organized around four elements consisting of:

a) revenues of health financing schemes or where resources can be mobilised.
b) health financing schemes or funding arrangements,
c) health care providers and
d) health care functions or services on which the funds are spent.

Taken together, the NHA gives a comprehensive description of sources of health care finances, managers of these finances, the various providers of health care, and the various functions on which these funds are utilised. The results are important for immediate and future decision-making, planning and implementation of the health system goals such as health policy and financing strategy.

In Zambia, government envisaged to institutionalize the National health accounts in the early 2000's. However, efforts to form the National Health Accounts Cell (NHA Cell) at MoH supported by the academia has not taken shape to date. The objective of this effort was to ensure a continuous and timely annual reporting of health expenditures in Zambia through robust, systematic, and institutionalized health accounts system.

1.2. NHA Policy Objectives

In the context of SHA 2011, this report builds on previous studies with a focus on the core issues of health care financing and seeks to answer questions such as how are health care goods and services financed? Where does the population consume them? What goods and services are financed? This study sought to achieve the following healthcare policy goals:

- Estimate total health expenditure by financing sources or where resources are mobilized.
- Document the flow of health resources within the health system through various institutional units providing revenues of financing schemes to financing agents.
- Describe the use of healthcare expenditures across various levels of health care, service areas, providers and end use or functions.
- Provide an aggregated estimate of financial flows by disease areas.
- Provide a disaggregated estimate of expenditure on HIV/AIDs

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

1.3. Country Context

1.3.1. Socio-Economic Profile

The country's selected socio-economic indicators for the period 2017 to 2021 are presented in **Table 1**. After impressive economic growth that averaged at 6 percent between 2010 and 2013, real GDP growth rate slowed down to an average of 1.6 percent between 2017 and 2021. The GDP per capita collapsed from US1, 567 in 2017 to US$1,157 in 2021 leading to the World Bank reclassifying the country as a low-income country.

The decline in growth resulted from the dampened copper prices on the international market, reduced electricity supply that affected all economic activities. The situation was exacerbated by the impact of Corona Virus (COVID-19) that affected the global economy and debt financed fiscal deficits that averaged at 10.3 percent of GDP between 2017 and 2021. Zambia slipped into a sovereign debt crisis. External debt rose from 38.2 percent of GDP in 2017 to 95.8 percent in 2020 mainly comprising commercial debt from the issuance of Eurobonds. At the same time, domestic debt ballooned from 27.3 percent of GDP in 2017 to 61.3 percent in 2021. The country's debt service accounted for over 43 percent of its domestic revenue and has since 2020 defaulted on its Eurobonds while also accumulating arrears to other creditors. This debt distress affected the country's fiscal space for health.

The high external debt service amidst the reduced inflow of foreign exchange resulted in the continuous depreciation of the kwacha against the dollar. The exchange rate rose from an annual average of K9.5/ US$ in 2017 to K20.05/US$ in 2021. Inflation remained elevated reaching 22 percent in 2021, eroding the real value of national expenditures and output. In the health sector, the depreciation of the Kwacha affected the value of imported goods and supplies (such as drugs and equipment).

Table 1 Selected socio-economic Indicators for Financial Years 2017 - 2021

Indicators	2017	2018	2019	2020	2021
Population (Million)	17.3	17.84	18.38	18.93	19.47
GDP Growth rate	3.4	4	1.4	-2.8	3.6
GDP per capita (US$)	1,567.30	1,616.50	1,596.20	1,083.80	1,157.50
Inflation	6.6	7.5	9.2	15.7	22.0
Exchange rate	9.54	10.45	12.91	18.28	20.05
Budget deficits (% GDP)	-7.7	-9.2	-9.4	-13.3	-11.9
Government debt (% GDP)	**65.5**	**77.8**	**103.3**	**150.3**	**126**
Domestic debt (% GDP)	27.3	29.7	41.2	54.5	61.3
External debt	38.2	48.1	62.1	95.8	64.7
Poverty *	62.8	-	-	-	60* (LCMS-2022)
Gini Coefficient (Income based)*	0.65	-	-	-	0.507 (LCMS 2022)

** estimates are for 2015, Source: Bank of Zambia and World development indicators*

The country's growth has not been inclusive, and this has exacerbated income inequality. In 2020, an estimated 61 percent of the population lived below the poverty line while the gini stood at 0.507 putting the country among the most unequal societies in the world.

1.3.2. Epidemiological profile

Zambia has made improvements in population health outcomes over the past 5 years as shown in **Table 2**. The country's life expectancy increased from 62.1 in 2017 to 62.4 while the fertility rate reduced from 4.7 to 4.4 over the same period. The modelled maternal mortality ratio has reduced from 222 deaths per 100 000 live births in 2016 to 213 in 2017. Similarly, the under-five, neonatal and infant mortality rates declined over the period under review. The infant mortality rate dropped from 45.6 per 1000 live births in 2016 40.2 in 2021 while the under-five mortality rate fell to 57.7 in 2021 from 63.5 per 1000 live births in 2016.

Table 2: Selected Health Indicators for Zambia

Health Indicators	2016	2017	2018	2019	2020	2021
Life expectancy	61.8	62.1	62.3	62.8	62.4	..
Fertility rate	4.7	4.6	4.5	4.5	4.4	..
Mortality rate, infant (per 1,000 live births)	45.6	44.2	43.6	42.4	41.1	40.2
Mortality rate, neonatal (per 1,000 live births)	26.1	25.9	25.7	25.4	25.0	24.6
Mortality rate, under-5 (per 1,000 live births)	65.3	64.2	64.2	62.6	59.7	57.7
Maternal mortality ratio (modeled estimate, per 100,000 live births)	222.0	213.0	..	..	..	..
Immunization, DPT (% of children ages 12-23 months)	95.0	94.0	90.0	88.0	84.0	91.0
Prevalence of stunting, height for age (% of children under 5)	..	..	34.6	..	..	..

Source: World Development Indicators

Despite this progress made in improving the life expectancy, MMR, IMR and U5MR, the rates remain higher than its comparable peer countries. The country has one of the highest stunting levels in the world.

The country's disease profile has not significantly changed over the study period. The major sources of morbidity and mortality are mainly communicable diseases and conditions including malaria, HIV and AIDS, tuberculosis, respiratory infections, diarrhoeal disease and trauma . Recently, non-communicable diseases such as neoplasms, diabetes and hypertension have become common due to changing lifestyles. These have implications for the health system and health care financing that needs to mirror the changing epidemiological profile.

1.4. Organization and reforms of the Zambia's Health Sector

Zambia has a three-tier pyramidal health services delivery system Zambia's health delivery system. It comprises tertiary and specialized hospitals at the top which service the entire country on specialized health conditions. The secondary level health services are provided at provincial level while health posts and health centres offer primary health services managed by districts health teams at the bottom. Districts also provide first level referral hospitals.

The health system comprises both public and private health care providers. The public health facilities account for 79% (2317) while the private sector make up 22% of the total health care facilities. Private health care providers are divided into private for profit (19% or 544) and private-not-for-profit (PNP) that account for 2% (68) of the total facilities. Most of the PNPs are faith-based and are administratively coordinated nationally by the Churches Health Association of Zambia (CHAZ). They receive operational grants and health staff from government and jointly provide health services with the Ministry of Health.

The MoH is charged with the responsibility of designing policies, mobilizing resources, implementing and monitoring the implementation of these policies. While this has remained the role of MoH, government is making strides to decentralize the delivery of health services. Under this reform, the districts and local governments will be responsible for managing all health care providers under their jurisdiction. This suggest that districts will be responsible for leadership in the planning and management of health services, supervision and quality assurance and capacity development support. One of the core aims of decentralization was to ensure that districts are able to direct resources to funding health services in line with local priorities.

1.5. Organization of the report

The rest of this report is structured as follows. The next section provides the methods employed and entities surveyed in this health accounts study. Section 3 presents the estimation of the national health expenditures based on the sample. Section 4 provided details of expenditure and organized around the core SHA 2011 elements, identify the revenues of financing schemes followed by the financing schemes and agents, the health provision and health functions. Capital expenditure is also presented in this section. Section 5 provide disease specific accounts with a focus on HIV, Malaria and reproductive health.

2: Methodology

This NHA exercise was carried out using the System of Health Accounts 2011 (SHA 2011) guidelines. The framework describes the health expenditure estimates according to a global standard framework. The approach unpacks expenditures into Current Health Expenditures (CHE) and Capital Formation for health (HK). Current health expenditures (CHE) constitute all economic resources spent on health functions and represents final consumption of health goods and services by residents of the country within the year of estimation. Capital expenditures (HK) for health is measured by the total value of assets that providers of health services have acquired during the accounting period and that are used repeatedly for more than one's year in the provision of health services.

The analysis is based on major classification used in this report are based on the SHA 2011 framework that focus on revenues of financing schemes (FS), financing scheme (HF), institutional units providing revenues of financing schemes (FSRI), financing agents (FA), health care providers (HP), health care functions (HC) and factors of provision (FP). This categorization of expenditures allows the NHA to accommodate in more pluralistic systems that obtain in most developing countries that has multiple sources of income such as Zambia. The description of these terms are elaborated in appendix 1.

2.1. Surveys and Data Collection

The data for this report was sourced from various audited primary and secondary sources. Primary data was collected using the standard questionnaire from donors, NGOs employers and private insurance schemes. Secondary data sources were used for Government and Household expenditures. The data collection was conducted by trained research assistants who visited all sampled institutions under the supervision of the technical team. The technical team vetted all the questionnaires used for the collection of primary data to ensure compliance with SHA 2011 methodology. The key the institutions from which data used in this HA report were collected are discussed below.

2.1.1. Government Data Sources

The government expenditure data used in this study was obtained from audited reports (Blue Books) of various ministries that provide health services. The major government ministries that provided curative health services during this period were the Ministry of Health, ministries of Defence and Home Affairs. The data from all other ministries that predominantly provide workplace programmes especially for HIV and Aids were also included in this report. The data were triangulated with the Ministry of Finance sources, the integrated financial management system unit and in some cases the budget status reports to ensure that the data reflect the actual expenditures for each year and minimizes double counting the development assistance for health.

During the period under review, government changed its data reporting from activity-based budgeting to output based budgeting. Thus, some government Health Expenditure that included both recurrent and capital expenditures had to be recategorized to ensure comparability across years.

Furthermore, a number of statutory bodies and parastatals providing health care auxiliary services such as regulatory entities were surveyed to capture all expenditures especially from donor sources that provide support to these institutions.

2.1.2. Households Expenditure

The out-of-pocket (OOP) expenditure was obtained from the nationally representative 2014 Zambia household health expenditure and utilisation survey (ZHHEUS). The survey generated information about the total out-of-pocket expenditure on health and its distribution on health care. It also highlighted the factors that influence the use of various health services and providers. The total estimate by source, provider and function was extrapolated using the consumer price index over the years 2017 to 2021. However, the estimates for 2020 were adjusted for the introduction of the National Health Insurance Scheme. The scheme is compulsory for the formally employed workers. In particular, the share of OOPs for employed health seekers was netted off the total OOPs assuming that they all resorted to using the scheme.

2.1.3. Donors

A survey of donors- both bilateral and multilateral- captured the total amount of development assistance for health (DAH) for each of the years included in this study (2017 to 2021). The survey captured all the key donors that are active in the health sector based on the expert knowledge from MoH and MoF and donors themselves. A total of 18 key donors were identified through this process and all except one completed the health accounts survey. The data was triangulated with those from the NGO survey and government donor data. Traditionally cooperating partners support the health sector in four ways: i) direct budget support at the MoF, ii) health sector support at the MoH HQ, (ii) direct support to provinces and districts, and (iv) ring-fenced or earmarked support for certain programs and/or diseases.

2.1.4. Employers and Insurance Providers

Employers pay for the health services of their employees. During this round of the Health Account survey, a complete list of formal sector employers was obtained from the CSO's economic census database. Since a large number of the firms indicated that they did not incur health expenditures, only firms that reported having some health expenditure and employed at least 100 people were listed for sampling. The process yielded a sample of 93 firms cutting across different economic sectors such as agriculture, manufacturing, transport education, telecommunication, and financial institutions which allowed the team to assess the financial role that these entities have within the country's health systems. A total of 43 firms responded to the survey questionnaire and the information was used to estimate the total expenditures by firms. In addition, the insurance firms were also surveyed as agents as well as employers. Only four of the 20 insurance firms indicated that they provide health insurance.

In addition to the voluntary private insurance schemes, Government in 2019 introduced a compulsory social health insurance scheme. The scheme is managed by the National Health Insurance Authority (NHIMA) and became effective in 2019. During the period under review, the employers and employees were required to each, contribute 1% of the basic salary of the employee. In addition, NHIMA also registers self-employed workers.

2.1.5. Non-Governmental Organisations

A number of NGOs are involved in health care delivery in Zambia. They operate often using financial resources received from the development partners. A complete list of NGOs involved in the health sector was compiled based on the previous HA studies in consultation with the Ministry of Health and other stakeholders. The survey collected data from 46 NGOs that were deemed eligible. The expenditure collected from NGOs was triangulated with the donor and government reports to exclude potential double counting.

2.1.6. Non-Targeted Expenditures

The health accounts report data from the source to the level of care and functions such as diseases, inpatient and outpatient spending. However, most institutions are unable to disaggregate actual expenditures by these categories. To fill this gap, the research team developed the diseases, inpatient and outpatient distribution key using the utilisation data from the health management information system (HMIS). The number of inpatient admissions was converted to the average bed days for each level of care. The unit costs were thereafter assigned to each type of service used, based on the specific disease classification. The unit cost was provided by the Ministry of Health.

In cases where the provided data could not show the expenditure by level of care, policy planning rules were used to disaggregate these expenditures. However, the out-of- pocket expenditures by level of care were obtained from the ZHHEUS dataset. This was adjusted for the potential impact of the creation of the National Health Insurance Scheme which was first rolled out to the formal sector in 2020.

2.2. Analysis

At the questionnaires design stage, a number of adjustments were made to the classifications and coding rules to customized them to the SHA 2011 framework. Once questionnaires were collected, the Health Accounts technical team undertook validation and consistency checks. The data was analysed using the excel-based combo, which like the HAPT is standardized and helps to estimate resource flows.

2.3. Study Limitations

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

a) During the study period, Government changed the budgeting system from the activity based to the output-based approach. The output-based approach does not provide much detail on the expenditures compared to the activity based. The team worked closely with Ministry level budgeting staff to isolate expenditures and code them in line with the SHA 2011 system. Given this change that occurred at different stages in

various ministries, some health expenditures may have been underestimated or overestimated in some years.

b) The response rate for employers and insurance companies was less than expected. This could have resulted in underestimation of expenditure from these sources.

c) Most health expenditure in Zambia's health system is recorded in a manner that does not exactly conform to the existing SHA 2011 classifications and codes for health financing schemes. Therefore, there is a possibility of mismatching expenditures across the reporting systems. However, the team took due diligence to minimize such errors.

d) The use of vertical programs and direct provincial and districts funding implemented by donors through their aid agencies or nongovernmental organizations (NGOs) are often outside government budgeting and accounting system. The flow of resources through various tiers of the health sector could also compromise the actual amounts and use for these resources.

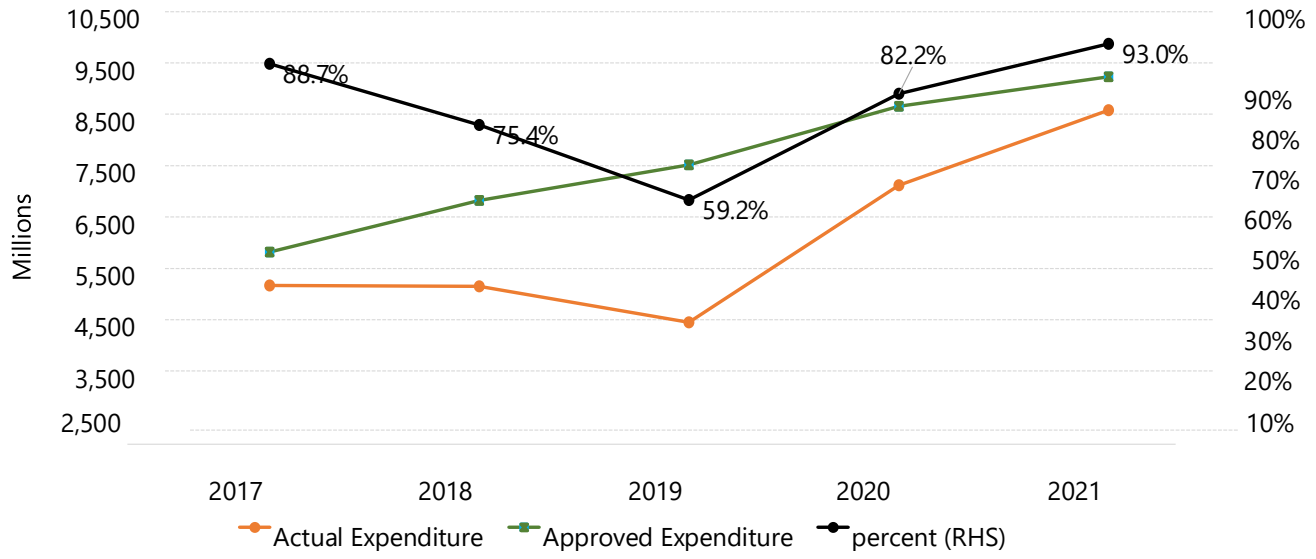
3: General Health Accounts Key Findings

This section presents the estimated health expenditures for Zambia at various levels of disaggregation. The section begins by describing the structure of government health expenditure by key categories of health spending in Zambia. The next subsection 3.2 presents the key health indicators based on current health expenditure. In subsection 3.3 presents the various expenditure classifications, starting from sources of health expenditure to functions and diseases the money is spent on based on current expenditures within the general account's framework. Section 3.4 looks at capital flows.

3.1. Government Expenditure on Health

The period 2017 to 2021 the budgetary execution rates were constrained by a shrinking discretionary spending caused by increased debt service costs and declining economic growth. Figure 1 shows the trend in the disbursement to health against the approved health budget. The results show that government disbursed approximately 80 percent of the approved budget during the period under review. The disbursement that stood at 88 percent in 2017 dipped to 59.2 percent in 2019. This was mainly due to the allocations to constitutional expenditures especially debt service costs and the wage bill that exceeded the domestic revenues leaving less resources for social spending. However, due to the suspension of the debt service in 2020 the budget releases increased to 82.2 percent. The reduced disbursement in some years may have affected service delivery in the health sector.

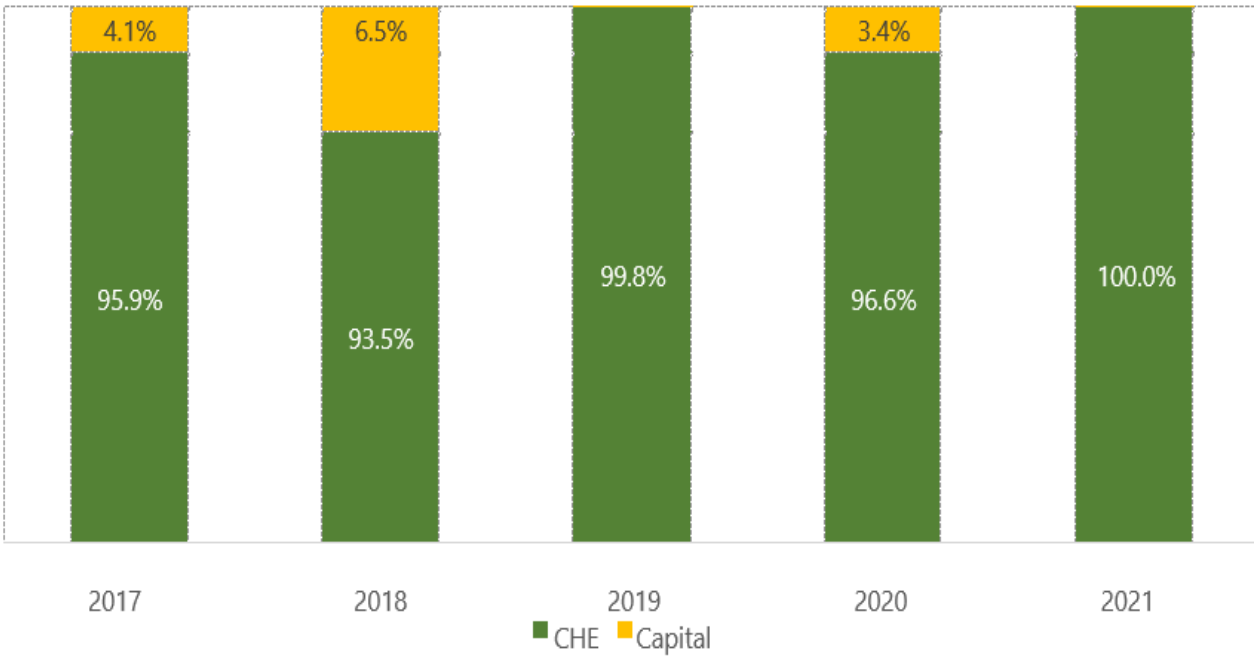
Figure 1: Government approved budget vs disbursements



Source: Constructed from MoH budget database

Government expenditure is often categorized into recurrent health expenditure (CHE) and capital. The government expenditure on capital and CHE rose from K6.1 billion in 2017 to K11.2 billion in 2020 before declining to K10.8 billion in 2021. The share of expenditure on capital projects increased from 4.1 percent in 2017 to 6.5 percent in 2018 and, as the fiscal constraint due to the debt crisis increased, government reduced its capital expenditure to less than 1 percent in 2021.

Figure 2: Health expenditure allocation by capital and CHE



Source: Constructed from MoH budget database

3.2. Key Health Financing Indicators for Zambia

Table 3 presents Zambia's key current health expenditure indicators for the period 2017 to 2021 by the system of Health Accounts 2011 classification categories. The nominal CHE more than doubled over the five-year period to K29.38 billion in 2021 from K11.77 billion in 2017. The increase in the nominal expenditure is driven by the increase in both government and donor expenditure. Government nominal health expenditure rose by almost 74 percent from K6.18 billion in 2017 to K10.75 billion in 2021 while donor spending more than quadrupled from K3.71 billion to in 2017 to K14.53 in 2021. The rise in government spending over the period can be explained by the need to replace the displaced donor funding between 2017 and 2018 and subsequently the need to mitigate the COVID-19 pandemic in 2020 and 2021. The kwacha value expenditure by donors rapidly increased due to the depreciation of the currency over the study period. However, the real value was eroded by the deterioration in the macroeconomic indicators, particularly the exchange rate depreciation and rising inflation between 2017 and 2021. For example, in dollar terms, the total CHE rose from US$1,239 million in 2017 to US$1,573 million in 2019 and declined from this peak to US$1,462 million in 2021. Similarly, the CHE per capita rose from US$71.7 in 2017

to US$85.6 in 2019 and fell to US$75.1 in 2021. The sharp rise in expenditure in 2020 and 2021 can be attributed to additional expenditure by government and CPs to mitigate the impact of COVID-19.

The key health financing indicators have followed a similar pattern. Current health expenditure accounted for only 4.8 percent and 6.7 percent of GDP in 2017 and 2021 respectively. Government CHE accounted for an average of 2.5 percent which falls short of 5 percent GDP recommended by the WHO macroeconomics working group. Moreover, the share of CHE in general government expenditure fluctuated around 8.5 percent average throughout the study period. This is below the 15% Abuja Declaration to which Zambia is a signatory. The per capita government CHE averaged at US$31.50 throughout the study period, having dropped from US$37.6 in 2017 to US$27.50 in 2021, averaging US$31.4 over the study period.

Table 3: Selected Health Financing Indicators for Zambia NHA Estimates Financial Years 2017-2021

Indicator	2017	2018	2019	2020	2021
Nominal CHE (ZMW millions)	11,774.7	13,125.8	20,290.3	20,983.9	29,383.0
Nominal CHE (US$ millions)	1,239.4	1,250.1	1,572.9	1,146.7	1,461.8
Government Health Expenditure (CHE) (ZMW Mns)	6,181.9	5,745.7	6,785.1	11,216.4	10,745.9
Donor Current (ZMW millions)	3,718.7	5,789.6	11,765.9	6,925.4	14,526.5
Out of Pocket Expenditure (ZMW Millions)	1,255.1	1,348.8	1,471.5	1,702.6	2,078.8
Corporations	619.0	241.7	267.8	1,139.5	2,031.9
Government CHE % Nominal CHE	52.5	43.8	33.4	53.5	36.6
Donor CHE % Nominal CHE	31.6	44.1	58.0	33.0	49.4
Per capita CHE (US$)	71.7	70.1	85.6	60.6	75.1
Government CHE per capita (US$)	37.6	30.7	28.6	32.4	27.5
Donor CHE per capita US$	22.6	30.9	49.6	20.0	37.1
CHE % GDP	4.8	4.8	6.8	6.4	6.8
Government CHE % GDP	2.5	2.1	2.3	3.4	2.5
Government CHE/ GGE %	9.6	7.5	7.6	9.9	8
Out of Pocket Expenditures (OOPE) % CHE	10.7	10.3	7.3	8.1	7.7
Corporations' expenditure % CHE	5.3	1.8	1.3	5.4	6.8

Source: NHA Survey data 2022

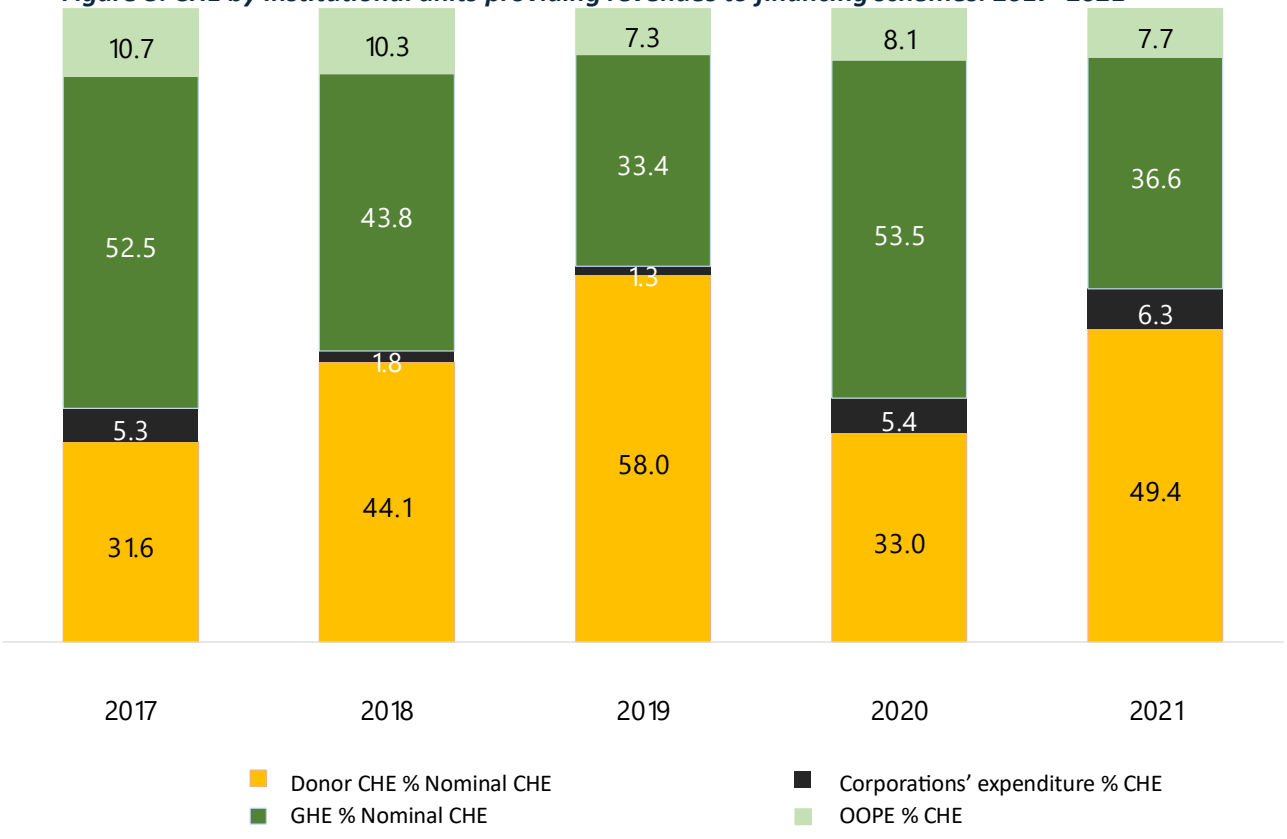
4: General Health Accounts

This chapter presents the estimated health expenditures for Zambia at various levels of disaggregation. It begins by describing resource flows through the health care system from financing sources and types of revenues to financing schemes, from financing schemes to providers, and from providers to the health care goods and services. The tables and figures are presented taking into consideration the Zambian context and usefulness for policy and planning in Zambia, international comparability, and feasibility of their construction.

4.1. Level and Composition of Health Financing in Zambia

The pattern of percentage contribution to CHE by source is presented in Figure 3. The figure shows that the government and cooperating partners are the largest sources of health care financing in Zambia, with the two sources accounting for, on average 87 percent of the total CHE. Their contribution to the sector has been mixed over the year. The government health expenditure (GHE) as a share of total CHE has been fluctuating over the study period. It declined from 52.5 percent in 2017 to 33.4 percent in 2019 and rose to 53.5 percent in 2020 before declining to 36.6 percent in 2021. However, in nominal terms, the government increased its current expenditure in the health sector by 73.7 percent between 2017 and 2021, which represents annual increases of 14.7 percent.

Figure 3: CHE by Institutional units providing revenues to financing schemes: 2017–2021



Source: 2017 to 2021 SHA survey data

During the periods 2018 to 2021, donor support increased from 44,4% to 58% of CHE, this likely closed the resource gap created by the decline in government expenditure. The contribution by cooperating partners comprising donors and non-profit organizations serving households contributed an average of 44 percent of total CHE. Specifically, the CPs' CHE rose from 31.6 percent (US$563 million) in 2017 to a peak of 58 percent (US$1.2 billion) in 2019 before declining to 33.0 percent in 2020 and rising again to 49.4 percent (US$657 million) in 2021. The share of OOP expenditure by households has consistently declined over the years. It fell from about 11 percent in 2017 to 7.7 percent in 2021. The decline in the share of OOP expenditure is expected to accelerate as NHIMA gets more entrenched among contributors.

4.2. Flow of Revenues of Financing Schemes

In line with the definitions outlined in the SHA 2011 Manual (OECD et al., 2017), financing schemes are defined as "components of a country's health financial system that channel revenues received and use those funds to pay for, or purchase, the activities inside the health accounts boundary". Since financing schemes are involved in revenue mobilisation, health accounts have to highlight where the funding came from, how the funding flows, and the nature of the funding flows. Analyzing revenues of financing schemes is important in tracking the revenue collection mechanisms in a health financing framework; and to inform policy makers on the existing mechanisms for financing the healthcare system. Therefore, this section presents the financing path to funding the various financing schemes in the country.

The results show that the main channels of disbursing funds from financing sources to financing schemes in Zambia was through direct foreign financial transfers, internal transfers and grants, voluntary prepayments from households, compulsory prepayments from households/individuals and employers and other unclassified domestic revenues (Table 4 and Figure 4). Social Health Insurance contributions from employers were initiated in 2020. While the voluntary prepayments experienced a decline of 71.5 percent from ZMW186.9 million in 2017 to ZMW 53 million in 2021, the Social Health Insurance contributions increased from ZMW740 million in 2020 to ZMW 1,741.60 million in 2021. This is due to the introduction of social health insurance in the country. Direct foreign transfers increased by an annual average of 337.6 percent while other domestic revenues increased by an annual average of 35.8 percent. Overall, annual average disbursed funds increased by 26 percent. The transfers distributed by government from foreign origin increased from ZWM 1,020.10 million in 2017 to ZWM 2,766.46 million in 2021, this showed an average growth of 171.2 percent.

Table 4: Funding Mechanisms for Financing Schemes (ZMW million)

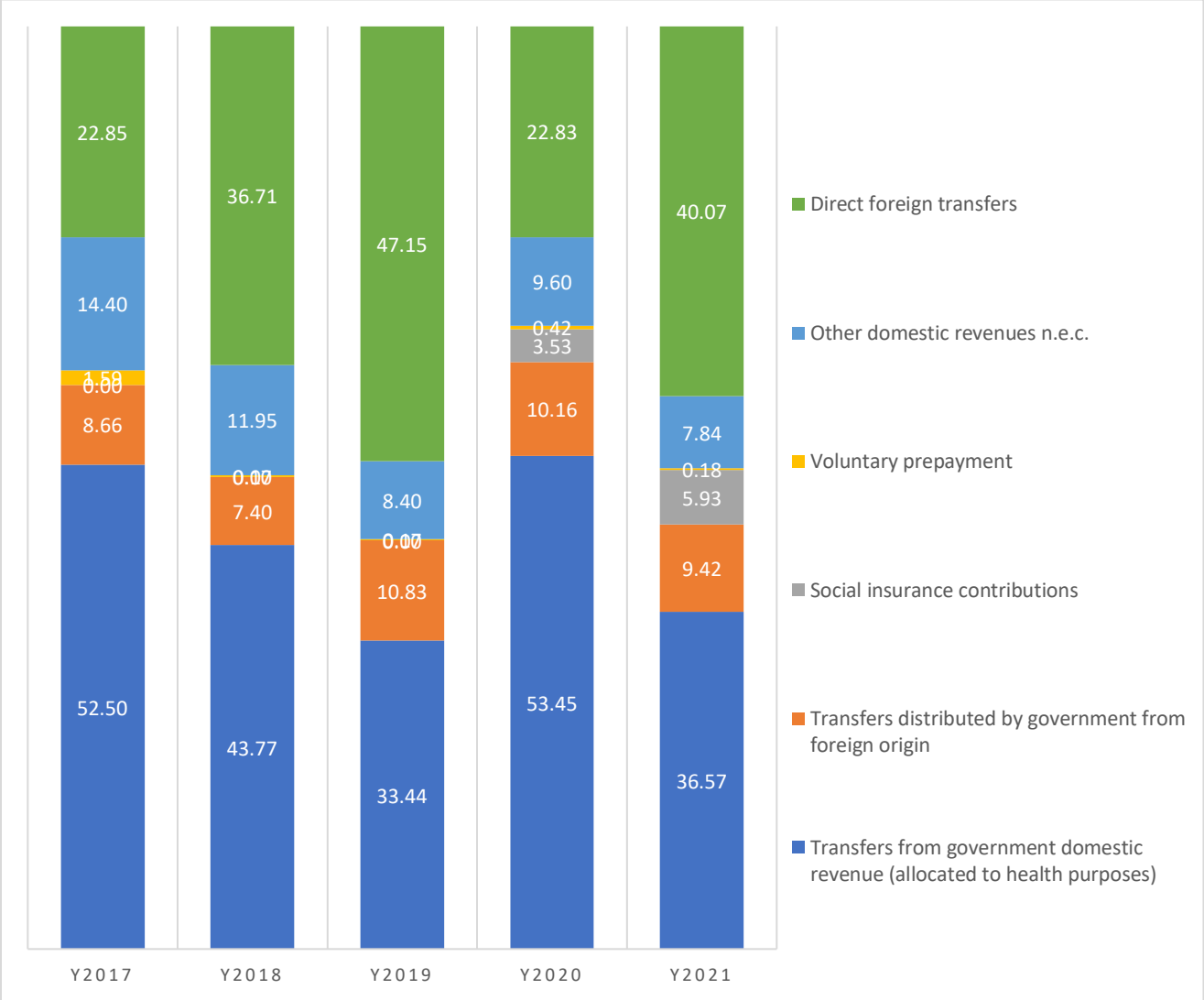
Funding Mechanism	Financial year				
	2017	2018	2019	2020	2021
Transfers from government domestic revenue (allocated to health purposes)	6,181.89	5,745.70	6,785.09	11,216.37	10,745.87
Transfers distributed by government from foreign origin	1,020.10	971.19	2,197.79	2,132.85	2,766.46
Social insurance contributions	0.00	0.00	0.00	740.46	1,741.60
Voluntary prepayment	186.94	22.85	34.86	89.00	53.22
Other domestic revenues n.e.c.	1,695.52	1,567.88	1,705.25	2,014.48	2,302.84
Direct foreign transfers	2,690.24	4,818.16	9,567.31	4,790.70	11,773.03
Total	11,774.69	13,125.77	20,290.30	20,983.86	29,383.02

Source: 2017 to 2021 SHA survey data

Figure 4 further shows that transfers from government domestic revenue were the main channel for disbursing funding to financing schemes accounting for about 52.5 percent (ZMW 6.18 billion) of the total CHE in 2017. In subsequent periods, transfers from government as proportion of CHE reduced to 43.8 percent (ZMW 5.75 billion) in 2018, 33.4 percent (ZMW 6.79 billion) in 2019 before rising to 53.5 percent in 2020 (ZMW 11.23 billion) and declining to 36.6 percent (ZMW 10.75 billion) in 2021. The gap created by reduction in government transfers in some of the years was covered for by an increase in external transfers. The share of direct foreign transfers of CHE, for example, increased in 2018 and 2019 to 36.7 percent and 47.2 percent respectively.

OOP remained the main channel through which households made their contributions to the health sector and this was estimated at an annual average of 1.2 percent of total CHE during the period under review. Flow of funds through voluntary funded prepayment schemes (mainly through private insurance schemes) remained insignificant as it only accounted for an average of 0.4 percent of the total CHE per annum during the period under review. Other domestic revenues accounted for an average of 10 percent of CHE during the five years (ranging from 8 percent to 14 percent).

Figure 4: Shares of Funding Mechanisms for Financing Schemes: 2017–2021



Source: Author's compilation from survey data

4.3. Financing Agents for CHE

Financing agents are institutional units that manage healthcare financing in the health system. Table 5 shows the level of CHE resources managed by each institutional unit and how their contributions have changed over time. The share of resources managed by government entities reduced from 61.0 percent in 2017 to 45.7 percent in 2021. The MoH managed and controlled the largest share of CHE resources over the period 2017 to 2021. The share stood at 45.7 percent in 2021 having dropped from 61.0 percent in 2017. The amount managed by other ministries increased from less than 1 percent in 2017 to 7.4 percent in 2019 but remained less than 1.0 percent during the rest of the years.

NPISH implement a number of donor programs off-budget. They managed a significant share of total CHE at 22.7 percent of total CHE in 2017, which increased in subsequent periods with the largest share in 2019 of 45.2 percent. On the other hand, households' share of total CHE fluctuated, but recorded a general decline from 10.7 percent in 2017 to 7.1 percent in 2021.

Resources managed by corporations declined from 3.7 percent in 2017 to 0.8 percent in 2021 while resources managed through health insurance companies increased from 1.6 percent in 2017 to 6.1 in 2021. This is on account of the introduction of social health insurance by government.

Table 5: Distribution of CHE by Financing Agents: 2017–2021

Financing agent	Financial year and percentage (%)									
	2017	%	2018	%	2019	%	2020	%	2021	%
Ministry of Health	7,186.0	61.0	6,701.0	51.1	7,475.0	36.8	13,315.0	63.5	13,436.0	45.7
Other Government Ministries	16.0	0.1	15.0	0.1	1,506.6	7.4	26.0	0.1	68.0	0.2
Insurance corporations	187.0	1.6	23.0	0.2	34.0	0.2	829.0	4.0	1,795.0	6.1
Corporations	432.0	3.7	219.0	1.7	233.0	1.1	310.0	1.5	223.0	0.8
NPISH	2,672.0	22.7	4,756.0	36.2	9,176.0	45.2	4,315.9	20.6	8,327.0	28.3
Households	1,255.0	10.7	1,349.0	10.3	1,472.0	7.3	1,703.0	8.1	2,078.0	7.1
Rest of the World	27.0	0.2	62.1	0.5	394.0	1.9	485.0	2.3	3,456.0	11.8
Total	**11,775.0**	**100**	**13,125.1**	**100**	**20,290.6**	**100**	**20,983.9**	**100**	**29383.0**	**100**

Source: Author's compilation from survey data

4.4. Expenditure by Healthcare Providers and Functions

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

4.4.1. Total CHE by Healthcare Provider

There are many providers of health services and products in Zambia including hospitals, residential care facility providers, ambulatory healthcare providers, retail sale and medical goods providers, and public health program providers. Table 6 and Figure 5 show the distribution of health expenditures accounted for by each of these providers for the period 2017–2021. On average, 44.2 percent of the total CHE was spent on hospitals during the period under review. This share of expenditure which increased from 37.1 percent in 2017 to 41.1 percent in 2018, peaked at 58.3 percent at the height of Covid-19 in 2020 before declining back to 41.7 percent in 2021. The amount spent on ambulatory healthcare providers increased from ZMW 4.4 billion in 2017 to ZMW 7.5 billion in 2021. As a percentage of total CHE, providers of ambulatory healthcare accounted for 37.7 percent in 2017 and 25.5 percent in 2021.

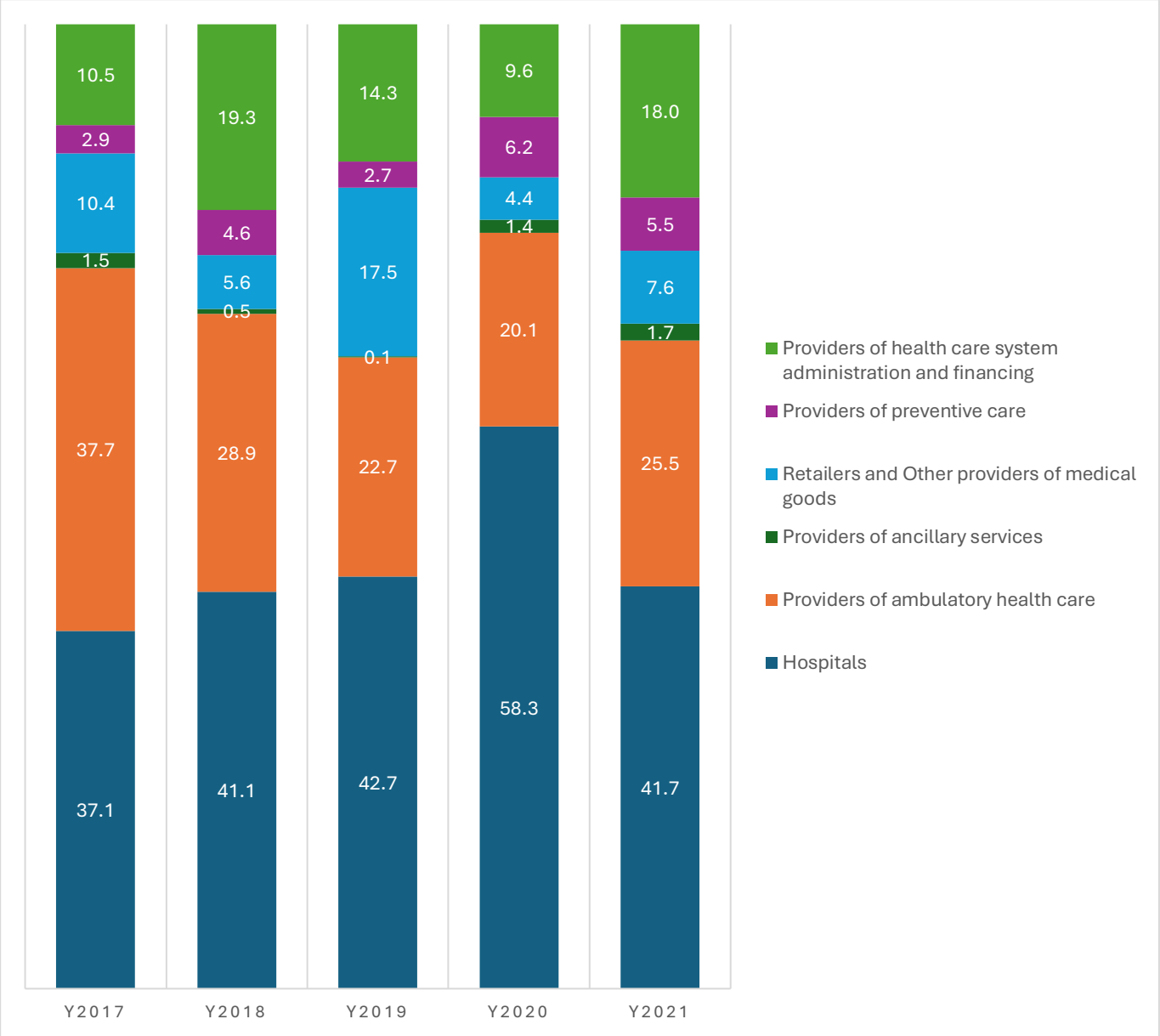
Table 6: Distribution of CHE by major Healthcare Providers: 2017–2021 (ZMW million)

Healthcare provider	Financial year and percentage (%)									
	2017	**%**	**2018**	**%**	**2019**	**%**	**2020**	**%**	**2021**	**%**
Hospitals	4,366.6	37.1	5,399.4	41.1	8,668.9	42.7	12,231.8	58.3	12,259.5	41.7
Providers of ambulatory health care	4,433.6	37.7	3,786.9	28.9	4,613.9	22.7	4,210.8	20.1	7,494.6	25.5
Providers of ancillary services	182.0	1.5	62.8	0.5	17.9	0.1	289.5	1.4	501.6	1.7
Retailers and Other providers of medical goods	1,219.5	10.4	737.5	5.6	3,550.5	17.5	923.1	4.4	2,229.8	7.6
Providers of preventive care	340.0	2.9	609.2	4.6	546.6	2.7	1,311.3	6.2	1,615.0	5.5
Providers of health care system administration and financing	1,232.9	10.5	2,530.1	19.3	2,892.5	14.3	2,017.5	9.6	5,282.4	18.0
Total	**11,774.7**	**100.0**	**13,125.8**	**100.0**	**20,290.3**	**100.0**	**20,983.9**	**100.0**	**29,383.0**	**100.0**

Source: Author's compilation from survey data

The CHE by providers of government healthcare system administration as a proportion of total CHE remained modest most of the period under review. It rose from 10.5 percent in 2017 (ZMW 1.23 billion) to 18.0 percent (ZMW 5.28 billion) in 2021, albeit, with large fluctuations. Meanwhile, the share of total CHE utilized by providers of preventive care increased from ZMW 340 million (2.9 percent of total CHE) in 2017 to 1.6 billion (5.5 percent of total CHE) in 2021. This was during the COVID 19 pandemic. Retailers and providers of other medical goods comprises pharmacies and other specialised establishments whose primary activity is the sale of medical goods to the general public for individual or household consumption. The proportion of total CHE spent on medical goods reduced consistently from 10.4 percent in 2017 to 7.6 percent in 2021. In nominal terms, the amount increased from ZMW 1.2 billion in 2017 to ZMW 2.2 billion in 2021.

Figure 5: Distribution of Expenditure by Healthcare Provider: 2017–2021



Author's compilation from survey data

4.4.2. Distribution of total CHE by Level of Care or Facility Type

Table 7 presents a breakdown of the nominal value of CHE utilized by health facilities. The pattern shows that expenditure increasingly shifted from ambulatory health care to hospitals at the outbreak of Covid-2019. In 2017, most of the CHE for health facilities was spent at public health centres and health posts (ambulatory healthcare providers). It accounted for 37.3 percent (ZMW 4.43 billion) of the CHE. In 2020, the proportion of health facility expenditure that was spent in ambulatory healthcare facilities reduced to 20.1 percent. In 2021, the proportion of expenditure by providers of ambulatory care was 25.5%, however in nominal term it represented a noticeable increase to ZMW 7.5 billion from ZMW 4.2 billion in 2020.

Table 7: Distribution of CHE at level of health facility: 2017-2021 (ZMW million)

Level of Care	Financial year and percentage (%)									
	2017	***%***	**2018**	***%***	**2019**	***%***	**2020**	***%***	**2021**	***%***
First-Level Public Hospital	1,276.34	*10.8*	1,605.83	*12.2*	3,366.28	*16.6*	4,022.96	*19.2*	4,227.52	*14.4*
Second-Level Public Hospital	948.36	*8.1*	789.44	*6.0*	2,366.03	*11.7*	3,489.78	*16.6*	1,633.83	*5.6*
Third-Level Public Hospital	946.03	*8.0*	901.89	*6.9*	1,970.15	*9.7*	1,489.90	*7.1*	1,297.07	*4.4*
Private For-Profit Hospitals	53.31	*0.5*	38.32	*0.3*	3.99	*0.0*	166.68	*0.8*	194.06	*0.7*
Private Not for Profit Hospitals	1,101.56	*9.4*	2,018.20	*15.4*	911.42	*4.5*	2,994.47	*14.3*	4,884.10	*16.6*
Unspecified hospitals (n.e.c.)	41.00	*0.3*	45.68	*0.3*	51.01	*0.3*	67.96	*0.3*	22.94	*0.1*
Providers of ambulatory health care	4,433.62	*37.7*	3,786.88	*28.9*	4,613.90	*22.7*	4,210.77	*20.1*	7,494.60	*25.5*
Providers of ancillary services	182.05	*1.5*	62.77	*0.5*	17.88	*0.1*	289.46	*1.4*	501.63	*1.7*
Retailers and Other providers of medical goods	1,219.50	*10.4*	737.48	*5.6*	3,550.49	*17.5*	923.06	*4.4*	2,229.83	*7.6*
Providers of preventive care	340.04	*2.9*	609.15	*4.6*	546.63	*2.7*	1,311.30	*6.2*	1,615.04	*5.5*
Providers of health care system administration and financing	1,232.89	*10.5*	2,530.11	*19.3*	2,892.51	*14.3*	2,017.51	*9.6*	5,282.39	*18.0*
Total	**11,774.69**	***100***	**13,125.77**	***100***	**20,290.30**	***100.0***	**20,983.86**	***100***	**29,383.02**	***100***

Source: Author's compilation from survey data

Expenditure at first level hospitals as a share of total health facility expenditure increased from 10.8 percent in 2017 to 19.2 percent at the outbreak of Covid-19 in 2020 before declining to 14.4 percent in 2021. The proportion of resources expended at second level hospitals declined slightly from 8.1 percent in 2017 to 6.0 percent and raising to 11.7 and 16.6 percent in 2029 and 2020 respectively, it then declined 5.6 in 2021 (Table 7). The level of spending in third level hospitals increased from ZMW 946.0 million in 2017 to a peak of ZMW 1, 970.2 million in 2019 before declining to ZMW 1, 297.1 million in 2021 (Table 7).

Figure 6: Breakdown of facility level CHE

Source: Author's compilation from survey data

4.4.3. Total CHE by Healthcare Functions

Healthcare functions encompass various goods and services final users use to achieve specific health objectives (OECD et al., 2017). The period under review, there was a notable shift in total CHE from curative care to preventative care. Specifically, the share of total CHE allocated to curative care declined from 50.3 percent in 2017 to 37.7 percent in 2021 as more resources were most likely spent on COVID-19 prevention activities. However, there was a general increase in nominal values in the same period, i.e. ZMW 5,922.5 million in 2017 to ZMW 11,063.3 million in 2021. Most curative CHE was dedicated to outpatient care, accounting for 34.2 per cent in 2017 and decreasing to 14.1 percent in 2020 before rising to 21.7 percent in 2021.

Table 8: Distribution of CHE by Functions: 2017–2021

Health care function	Financial year and percentage (%)									
	2017	**%**	**2018**	**%**	**2019**	**%**	**2020**	**%**	**2021**	**%**
Curative care	5,922.5	*50.3*	6,182.1	*47.1*	9,087.6	*44.8*	10,018.6	*47.7*	11,063.3	37.7
a) Inpatient curative care	*1,256.9*	*10.7*	*1,023.6*	*7.8*	*3,063.7*	*15.1*	*4,468.3*	*21.3*	*2,392.2*	*8.1*
b) Outpatient curative care	*4,028.9*	*34.2*	*2,700.9*	*20.6*	*5,031.6*	*24.8*	*2,949.0*	*14.1*	*6,361.8*	*21.7*
c) Home-based curative care	*56.5*	*0.5*	*49.3*	*0.4*	*19.2*	*0.1*	*33.5*	*0.2*	*0.4*	*0.0*
d) Unspecified curative care (n.e.c.)	580.1	*4.9*	2,408.3	*18.3*	973.2	*4.8*	2,567.7	*12.2*	2,308.9	7.9
Rehabilitative care	0.0	*0.0*	12.8	*0.1*	9.8	*0.0*	0.0	*0.0*	4.7	0.0
Long-term care (health)	425.1	*3.6*	244.9	*1.9*	465.4	*2.3*	112.5	*0.5*	1,303.3	4.4
Ancillary services (non-specified by function)	182.0	*1.5*	62.8	*0.5*	17.9	*0.1*	289.5	*1.4*	501.6	1.7
Medical goods (non-specified by function)	1,219.5	*10.4*	737.5	*5.6*	3,550.5	*17.5*	923.1	*4.4*	2,229.8	7.6
Preventive care	2,509.5	*21.3*	2,971.4	*22.6*	3,505.2	*17.3*	7,430.0	*35.4*	8,868.8	30.2
Governance, and health system and financing administration	1,232.9	*10.5*	2,530.1	*19.3*	2,892.5	*14.3*	2,017.5	*9.6*	5,282.4	18.0
Other health care services not elsewhere classified (n.e.c.)	283.3	*2.4*	384.2	*2.9*	761.4	*3.8*	192.7	*0.9*	129.2	0.4
Total	**11,774.7**	***100***	**13,125.8**	***100***	**20,290.3**	***100***	**20,983.9**	***100***	**29,383.0**	**100**

Source: Author's compilation from survey data

In contrast, the share of total CHE allocated to preventive care increased progressively from 21.3 percent (ZMW 2,509.5 million) in 2017, 35.4 percent (ZMW 7, 430.0 million) in 2020 and 30.2 percent (ZMW 8,868.8 million) in 2021 (Table 8). The main expenditure categories under preventative care were information, education and counselling programmes and early disease detection programmes. This rise was driven by large-scale public health campaigns, including vaccination, testing, and awareness efforts. The sustained emphasis in 2021 (30.2%) highlights the prioritization of prevention as a cornerstone of the health system. On average, administrative activities accounted for 15.1 percent of the total CHE over the five-year period, fluctuating from 10.5 percent in 2017 to 9.6 percent in 2020 and rising to 18.0 percent in 2021.

4.5. Capital Expenditure

Capital expenditure plays a crucial role in health expenditure under the SHA 2011 methodology due to its significant contribution towards the production of health services. This class of expenditure encompasses construction of new health facilities, upgrading and expanding existing ones, investing in health equipment or information systems, research and training. Providing information on capital expenditure helps evaluate the appropriateness, adequacy, or surplus of health system production. Only the actual amounts spent on capital items in the year under review are included in the analysis for that year.

4.5.1. Capital Expenditure by Source

As seen in table 9, there is a mixed pattern over the years in terms of source of fund spent on infrastructure. However, government and the ROW were the main sources on expenditure on capital, with the ROW contribution over 75% in the last three financial years under this review period.

Table 9: Institutional unites providing revenue for capital expenditures

Institutions	Financial year and percentage (%)									
	2017	%	2018	%	2019	%	2020	%	2021	%
Government	313.6	42.8	363.1	31.9	35.2	2.9	172.8	7.0	168.6	9.5
Corporations	3.0	0.4	3.0	0.3	3.0	0.2	35.2	1.4	259.0	14.6
NPISH	3.0	0.4	3.0	0.3	0.2	0.0	75.7	3.1	0.0	0.0
ROW	413.3	56.4	770.6	67.6	1,169.6	96.8	2,186.3	88.5	1,347.4	75.9
Total	**732.9**	**100**	**1,139.7**	**100**	**1,208.0**	**100**	**2,470.0**	**100**	**1,775.0**	**100**

4.5.2. Capital Expenditure by Function

During the period 2017 to 2021, investments in infrastructure, research and development in health and education and training of health personnel were the largest three components of capital expenditure (Table 10). In 2017, infrastructure expenditure accounted for the larger share of total capital expenditure, 46.1 percent (ZMW 337.9 million), while research and development had the largest share in 2018 and 2020, accounting for 40.4 percent (ZMW 460.5 million) of capital expenditure in 2018 and 49.4 percent (ZMW 1, 221.2 million) in 2020. Infrastructure expenditure relates to the construction of residential and non-residential buildings and other structures. The expenditure on education and training of health personnel fluctuated from ZMW 156.3 million (21.3 percent of capital expenditure) in 2017 to ZMW80.6 million (7.1 percent) in 2018. It thereafter increased to ZMW597.5 million (49.5 percent) in 2019 and stood at ZMW 694.9 million (39.1 percent) in 2021. Spending on the development of intellectual property and products was minimal, averaging less than one percent (ZMW 5 million) during the period under review.

Table 10: Capital Expenditure by Function: 2017-2021 (ZMW million)

Function	Financial year and percentage (%)									
	2017	%	2018	%	2019	%	2020	%	2021	%
Infrastructure	337.9	46.1	420.7	36.9	266.0	22.0	563.1	22.8	578.5	32.6
Machinery and equipment	43.1	5.9	177.2	15.5	115.5	9.6	94.2	3.8	102.8	5.8
Intellectual property products	0.4	0.1	0.8	0.1	3.5	0.3	2.3	0.1	32.1	1.8
Research and development in health	195.2	26.6	460.5	40.4	225.5	18.7	1,221.2	49.4	366.7	20.7
Education and training of health personnel	156.3	21.3	80.6	7.1	597.5	49.5	589.3	23.9	694.9	39.1
Total	**732.9**	**100**	**1,139.7**	**100**	**1,208.0**	**100**	**2,470.0**	**100**	**1,775.0**	**100**

Source: Author's compilation from survey data

4.5.3. Breakdown of government capital expenditure by function

Table 11 shows the allocation of government capital expenditure between 2017 and 2021. The allocation declined from ZMW313.6 million in 2017 to 168.6 million in 2021. Infrastructure accounted for an average of 38.7 percent of government capital expenditure over this period, except for 2021, when most resources were directed to education and machinery and equipment. Education and training was the second largest capital expenditure by government, averaging 28 percent during the five years. Expenditure on machinery and research and development each averaged 17 percent.

Table 11: Breakdown of Government capital expenditure: 2017-2021 (%)

Function	Financial year and percentage (%)									
	2017	**%**	**2018**	**%**	**2019**	**%**	**2020**	**%**	**2021**	**%**
Infrastructure	255.9	81.6	168.5	46.4	5.1	14.5	88.1	51.0	0.2	0.1
Machinery and equipment	8.5	2.7	152.5	42.0	2.5	7.2	0.2	0.1	54.6	32.4
Intellectual property products	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Research and development in health	17.9	5.7	14.9	4.1	14.9	42.4	22.3	12.9	29.3	17.4
Education and training of health personnel	31.4	10.0	27.2	7.5	12.6	35.9	62.2	36.0	84.5	50.1
Total	**313.6**	**100**	**363.1**	**100**	**35.2**	**100**	**172.8**	**100**	**168.6**	**100**

Source: Author's compilation from survey data

4.5.4. Breakdown of Cooperating Partners capital expenditure by function

Cooperating partners significantly increased their capital expenditure on various sectors during the same period. Table 12 shows that donor capital expenditure on infrastructure increased steadily from ZMW 81.4 million in 2017 to ZMW 485.1 million in 2021. Similarly, donor expenditure on research and development surged from ZMW 176.1 million in 2017 to ZMW 1,158.7 million in 2020. Expenditure on education and training of health personnel by donors also significantly increased from ZMW124.0 million in 2017 to ZMW 512.0 million in 2021. Donor capital expenditure on machinery and equipment remained low compared to the other items.

Table 12: Breakdown of capital expenditure by Cooperating Partners: 2017-2021 (ZMW Million)

Function	Financial year and percentage (%)									
	2017	**%**	**2018**	**%**	**2019**	**%**	**2020**	**%**	**2021**	**%**
Infrastructure	81.4	19.7	251.2	32.6	260.8	22.3	459.1	21.0	485.1	36.0
Machinery and equipment	31.4	7.6	21.6	2.8	109.9	9.4	56.8	2.6	40.4	3.0
Intellectual property products	0.4	0.1	0.8	0.1	3.5	0.3	2.2	0.1	26.9	2.0
Research and development in health	176.1	42.6	443.9	57.6	210.5	18.0	1,158.7	53.0	283.0	21.0
Education and training of health personnel	124.0	30.0	53.2	6.9	584.8	50.0	509.4	23.3	512.0	38.0
Total	**413.3**	**100**	**770.6**	**100**	**1,169.6**	**100**	**2,186.3**	**100**	**1,347.4**	**100**

Source: Author's compilation from survey data

4.5.5. Capital Expenditure by Healthcare Provider

Table 13 shows the distribution of capital expenditure by healthcare providers. Most of the capital expenditure was provided at ambulatory health care level and healthcare system administration and finance providers. Providers of health care system administration and financing were the largest provider, with an average of 37.9 percent, followed by providers of ambulatory health care, with an average of 32 percent, and first level public hospitals, with an average of 9 percent. The category of unspecified healthcare providers was relatively significant, averaging 9 percent, for the period 2017-2021.

Table 13: Capital Expenditure by Provider: 2017–2021 (ZMW million)

Provider	Financial year and percentage (%)									
	2017	**%**	**2018**	**%**	**2019**	**%**	**2020**	**%**	**2021**	**%**
First Level Public Hospitals	79.3	10.8	50.9	4.5	204.3	16.9	126.2	5.1	160.6	9.0
Second level Public Hospitals	40.6	5.5	25.9	2.3	102.1	8.5	63.1	2.6	80.3	4.5
Third Level Public Hospitals	51.6	7.0	34.2	3.0	102.1	8.5	63.1	2.6	80.3	4.5
Mental health hospitals	0.5	0.1	0.3	0.03	-	-	-	-	-	-
Specialised hospitals	0.2	0.0	0.9	0.1	-	-	-	-	-	-
Providers of ambulatory health care	173.1	23.6	156.0	13.7	418.7	34.7	1,368.1	55.4	569.8	32.1
Retailers and Other providers of medical goods	-	-	71.4	6.3	6.0	0.5	2.4	0.1	5.3	0.3
Providers of health care system administration and financing	341.7	46.6	520.0	45.6	290.6	24.1	712.7	28.9	820.1	46.2
Unspecified health care providers (n.e.c.)	45.8	6.2	280.0	24.6	84.3	7.0	134.5	5.4	58.6	3.3
Total	**732.9**	**100.0**	**1,139.7**	**100.0**	**1,208.0**	**100.0**	**2,470.0**	**100.0**	**1,775.0**	**100.0**

Source: Author's compilation from survey data

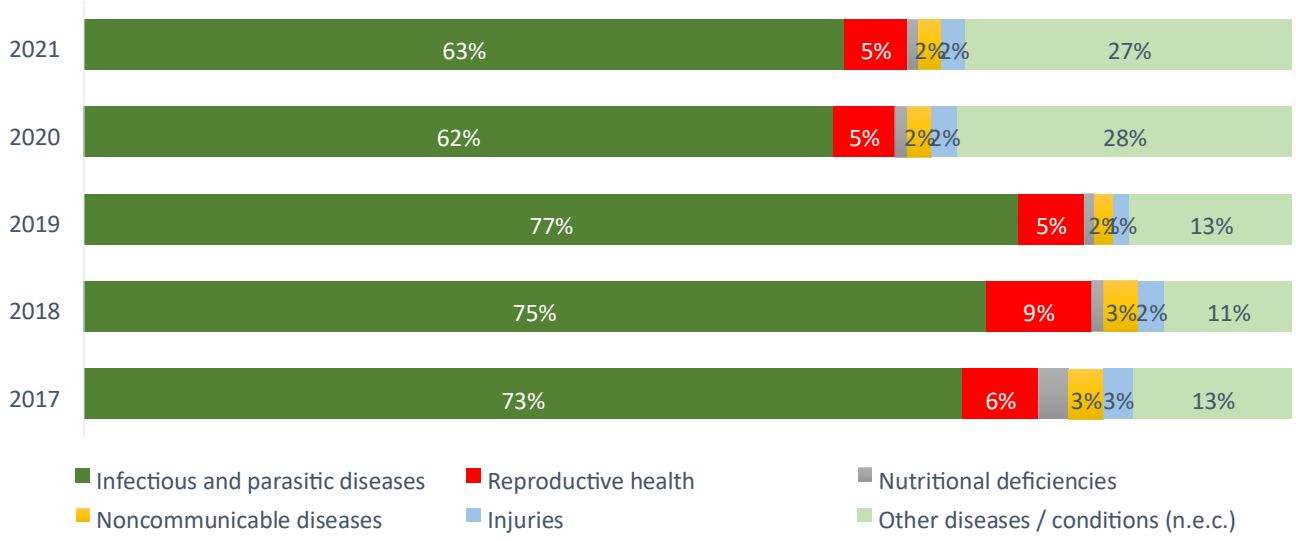
5: Disease-Specific Accounts

This chapter describes expenditure on a selected set of major disease for the period 2017-2021. The focus of analysis in this chapter are major diseases including HIV/AIDS, Malaria, and RH. All expenditures in this section relate to CHE.

5.1. CHE by Major Disease Categories

Figure 6 presents a breakdown of total CHE by major disease categories. Infectious and parasitic diseases accounted for between 62 and 77 percent of the disease-specific CHE. In nominal terms, expenditure on infectious and parasitic diseases increased from ZMW 8,563 million in 2017 to ZMW 15, 693 million in 2019, and ZMW 18, 497 million in 2021. The third largest diseases specific expenditure was on reproductive health and related conditions. These accounted for between 5 and 9 percent of disease specific CHE. In nominal terms, expenditure on reproductive health was ZMW 738.9 million in 2017, increased to ZMW 1,103.5 million in 2019 and ZMW 1,528.6 million in 2021. The proportion of CHE on non-communicable diseases, nutritional deficiencies, injuries and other conditions was collectively about 5 percent of total CHE.

Figure 6: Distribution of total CHE by major disease categories: 2017–2021



Source: Author's compilation from survey data

5.2. Breakdown of CHE by Diseases and Conditions

Table 14 gives a detailed breakdown of CHE for specific diseases and conditions. Expenditure (CHE) on HIV/AIDS was the largest expenditure on a single disease condition. The proportion of CHE attributed to HIV/AIDS increased from 47.4 percent in 2017 to a high of 61.3 percent in 2019, but slide down to 46.9 percent in 2021. In nominal terms, CHE attributed to HIV/AIDS interventions increased from ZMW 5,585.6 million in 2017 to ZMW 13, 777.98 million in 2021, with some fluctuations in the intermediate years. Expenditure on Malaria interventions was the

second largest expenditure on a specific condition/disease and accounted for between 10.1 and 17.5 percent of total disease specific CHE, and a nominal amount ranging between a low of ZMW 1,782.5 million in 2017 and a high of ZMW 4,532.2 million in 2021.

Table 14: Breakdown of CHE by disease and conditions (% of total), 2017–2021

Disease/Condition	Financial year				
	2017	2018	2019	2020	2021
HIV/AIDS	47.4	49.8	63.1	43.6	46.9
Tuberculosis	2.9	3.9	2.6	3.5	3.5
Malaria	15.1	14.2	10.1	17.5	15.4
Respiratory infections	14.0	12.9	9.6	16.0	15.2
Diarrheal diseases	2.5	2.4	2.9	2.8	2.7
Vaccine Preventable Diseases	1.0	1.6	1.2	0.9	1.0
Other infectious diseases	1.5	2.4	0.9	1.3	1.0
Maternal conditions	4.2	4.1	2.6	3.7	4.4
Perinatal conditions	0.0	0.0	0.0	0.0	0.0
Contraceptive management (family planning)	0.1	1.7	0.3	0.3	0.3
Nutritional deficiencies	2.4	1.1	0.9	1.0	0.9
Neoplasms	0.2	0.1	0.1	0.1	0.1
Endocrine disorders	0.2	0.2	0.1	0.2	0.2
Cardiovascular diseases	0.4	0.3	0.3	0.4	0.4
Mental disorders	0.1	0.5	0.1	0.2	0.2
Other non-communicable diseases (n.e.c.)	2.7	2.4	1.7	2.4	2.3
Injuries	3.3	3.0	2.2	3.7	3.5
Other diseases / conditions (n.e.c.)	2.1	2.0	1.4	2.4	2.2

Source: Author's compilation from survey data

5.3. HIV/AIDS Subaccount

This sub-section focuses on CHE specific to HIV and AIDS. A discussion of various aspects of CHE on HIV/ AIDS is provided including sources of financing, financing agents, health care functions and healthcare providers attributed all expenditures on HIV/AIDS.

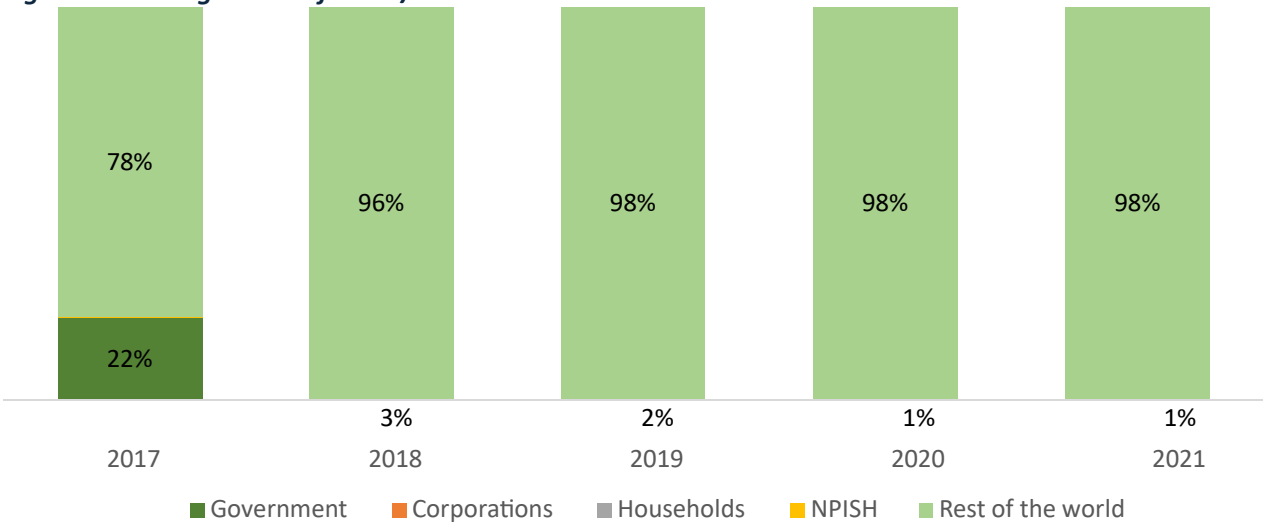
5.3.1. Financing sources for HIV/AIDS CHE

Figure 7 gives a summary of financing schemes attributed to CHE on HIV/AIDS. The Rest of the World was the dominant institutional unit providing financing to financing scheme spending on HIV/AIDS CHE for all the five years. Except for 2017 when 22 percent of the financing was sourced from the government, the rest of the world contributed more than 90 percent of the financing to CHE on HIV/AIDS interventions.

In nominal terms, government provided ZMW 1,221.1 million to CHE on HIV/AIDS in 2017, but the amount reduced in subsequent years to ZMW 229 million in 2019 and ZMW 71.1 million in 2021. On the other hand, spending by the Rest of the World fluctuated over the five years, increasing from ZMW 4,336 million in 2017 to ZMW 12,543.9 million in 2019, and declined to ZMW 13, 567.4 million in 2021. The role of households, and

employers in the financing of HIV/AIDS interventions was negligible throughout the five years. This is on account of the fact that most HIV/AIDS interventions are funding by donors and households are able to access these services free at point of service.

Figure 7: Funding Sources for HIV/AIDS CHE: 2017–2021



Source: Author's compilation from survey data

5.3.2. Distribution of HIV/AIDS CHE by Financing Schemes

The distribution of HIV/AIDS CHE by financing schemes is summarised in Table 15, which shows two major financing schemes for HIV/AIDS CHE. These were the NPISH and government. In 2017, 61 percent of the HIV/AIDS CHE were attributed to the NPISH financing scheme. The proportion increased to 90 percent and 83 percent in 2018 and 2019 respectively but declined to 37 percent and 55 percent in 2020 and 2021 respectively. The government scheme was attributed to between 9 percent and 39 percent of HIV/AIDS CHE during the five years. Households, enterprises, social insurance and the rest of the world schemes had a limited role to play in channeling HIV/AIDS CHE.

Table 15: Distribution of HIV/AIDS CHE by financing schemes: 2017–2021 (ZMW million)

Financing scheme	Financial year and percentage (%)									
	2017	**%**	**2018**	**%**	**2019**	**%**	**2020**	**%**	**2021**	**%**
Central government	2,176	39	618	9	0.0	17	0.0	20	2,239	16
Social health insurance	-	0	-	0	-	0	60.5	1	122.5	1
Voluntary insurance	-	0	-	0	-	0	-	0	-	0
NPISH	3,381	61	5,896	90	10,609	83	3,384	37	7,533	55
Enterprise	3.7	0	12.5	0	12.7	0	28.9	0	0.8	0
OOPs	9.3	0	9.0	0	7.5	0	15.4	0	16.2	0
RoW	15.4	0	1.0	0	-	0	3,848	42	3,867	28
Total	**5,586**	**100**	**6,537**	**100**	**12,793**	**100**	**9,148**	**100**	**13,778**	**100**

Source: Author's compilation from survey data

5.3.3. Financing agents for HIV/AIDS CHE

The main financing agents for HIV/AIDS CHE were NPISH and the government. The government is represented by three ministries which are the Ministry of Health (MoH), Ministry of Defence (MoD), and Ministry of Home Affairs (MoHA). Table 16 shows that the majority of HIV/AIDS CHE was managed by NPISH with a share of 60.6 percent in 2017, 82.4 percent in 2019 and 8.6 percent in 2021 with some fluctuations in the other years. On the other hand, the government through MoH was managing 38.9 percent in 2017, but the proportion kept fluctuating and was estimated at 16.3 percent in 2021. The role of households, donors and insurance companies remained subdued throughout the five years.

Table 16: Financing Agents for HIV/AIDS CHE: 2017–2021 (ZMW' 000)

Financing Agent	Financial year and percentage (%)									
	2017	**%**	**2018**	**%**	**2019**	**%**	**2020**	**%**	**2021**	**%**
Government agents (n.e.c)	3	0.1	2	0.0	1	0.0	1	0.0	-	0
MoH	2,172	38.9	615	9.4	2,163	16.9	1,810	19.8	2,239	16.3
MoD	0	0.0	0	0.0	0	0.0	-	0.0	-	0.0
MoHA	1	0.0	1	0.0	0	0.0	0	0.0	-	0.0
Insurance	-	0.0	-	0.0	-	0.0	60	0.7	122	0.9
Employers	4	0.1	12	0.2	13	0.1	29	0.3	1	0.0
NPISH	3,387	60.6	5,887	90.1	10,537	82.4	7,214	78.9	11,379	82.6
Households	9	0.2	9	0.1	8	0.1	15	0.2	16	0.1
RoW	10	0.2	10	0.2	73	0.6	18	0.2	21	0.2
Total	**5,586**	**100**	**6,537**	**100**	**12,793**	**100**	**9,148.**	**100**	**13,778**	**100**

Source: Author's compilation from survey data

5.3.4. Users of HIV/AIDS finances

During the five years under consideration, HIV/AIDS CHE was made mainly by rest of the economy followed by retailers and providers of medical goods, and providers of health care system administration and financing. The proportion of HIV/AIDs CHE spent by the rest of the world ranged between 24 and 81 percent, while expenditure by retailers and providers of medical goods ranged between 0 and 28 percent. Expenditures made by providers of health systems administration and financing ranged from 4 to 35 percent. Generally, there was a lot of variation in the proportion of expenditure by the various health care providers (Table 17).

Table 17: Distribution of HIV spending (CHE) by provider: 2017-2021 (ZMW million)

Healthcare providers	Financial year and percentage (%)									
	2017	%	2018	%	2019	%	2020	%	2021	%
Unspecified Hospitals (n.e.c)	2	0	2	0	2	0	5	0	-	0
First Level Public Hospitals	0	0	0	0	0	0	0	0	0	0
Second level Public Hospitals	1	0	1	0	1	0	1	0	1	0
Third Level Public Hospitals	1	0	1	0	1	0	1	0	1	0
Unspecified providers (n.e.c)	370	7	0	0	559	4	1,652	18	1,530	11
Residential long-term care facilities	-	0	2	0	288	2	0	0	124	1
Ambulatory health centres & clinics	777	14	543	8	445	3	687	8	1,081	8
Providers of home healthcare services	35	1	14	0	20	0	-	0	-	0
Providers of ancillary services	55	1	5	0	5	0	181	2	583	4
Retailers of medical goods	536	10	7	0	3,634	28	18	0	52	0
Providers of preventive care	308	6	236	4	209	2	1,049	11	1,087	8
Providers of health admin	1,391	25	417	6	4,531	35	671	7	588	4
Rest of economy	2,108	38	5,308	81	3,099	24	4,882	53	8,730	63
Total	5,586	100	6,537	100	12,793	100	9148	100	13778	100

Source: Author's compilation from survey data

5.3.5. What were the HIV/AIDS CHE spent on

Table 18 Provides a summary of the uses to which HIV/AIDS funds were put to. Three major uses of these funds were preventive measures, curative measures as well as the purchase of medical goods. However, the proportions were characterized by significant fluctuations over the five years period. For example, 40 percent was spent on curative care in 2017, but this reduced to 32 percent in 2018 and 3 percent in 2019 before rising to 54 percent and 70 percent in 2020 and 2021 respectively. Generally, expenditures on all functions doubled in 2019 except for curative care and preventive care. Procurement of medical goods had the largest proportion of expenditure on a single function in 2019.

Table 18: HIV CHE by function: 2017-2021 (ZMW million)

Function	Financial year and percentage (%)									
	2017	%	2018	%	2019	%	2020	%	2021	%
Curative care	586	10	3,580	55	716	6	2,421	26	2,005	15
Long-term care	448	8	334	5	612	5	157	2	494	4
Ancillary services	309	6	21	0	23	0	655	7	888	6
Medical goods	1,627	29	175	3	5,859	46	57	1	46	0
Preventive care	2,215	40	2,092	32	339	3	4,959	54	9,694	70
Governance	397	7	331	5	4,403	34	880	10	633	5
Others (n.e.c.)	3	0	5	0	841	7	19	0	19	0
Total	**5,586**	**100**	**6,537**	**100**	**12,793**	**100**	**9,148**	**100**	**13,778**	**100**

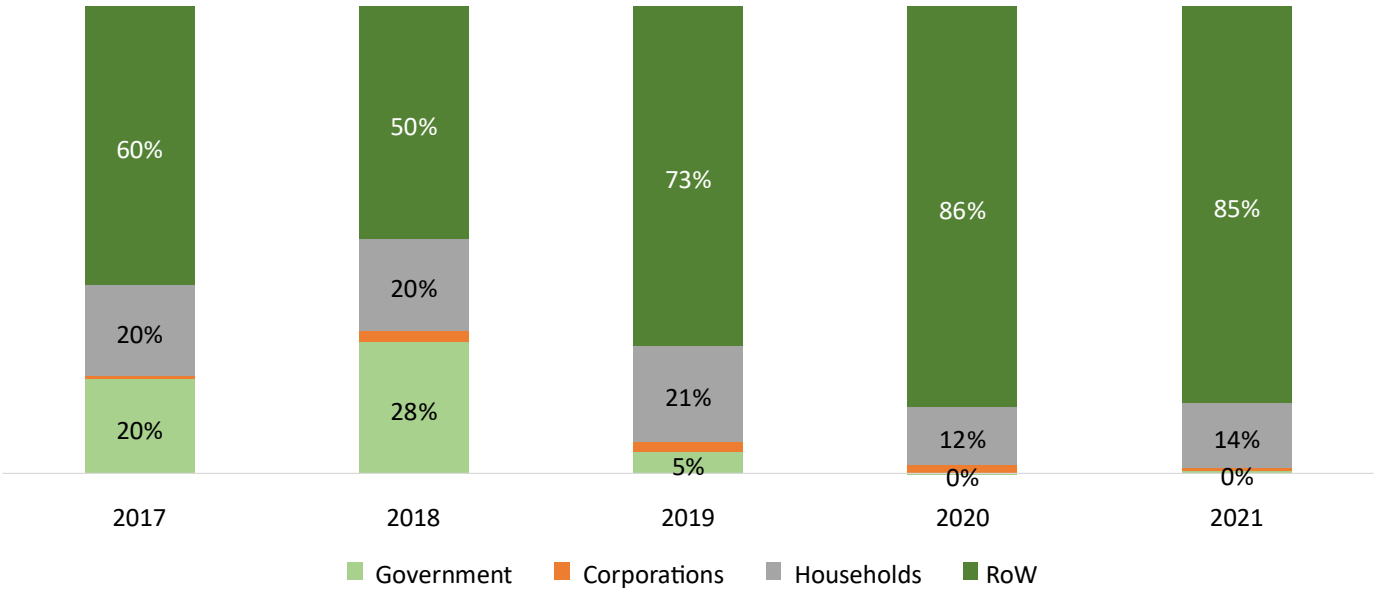
Source: Author's compilation from survey data

5.4. Malaria Sub Accounts

Malaria continues to be a major public health concern, leading to significant illness and death in Zambia. In 2021, the country recorded about 6 million cases (equivalent of 340 cases per 1000 population) and 1,480 deaths due to malaria (NHSP 2022-2026). Reducing malaria cases is among the national health priorities with the target to lower incidence to by a third in 2026. There were three main sources of financing for Malaria interventions during the five year under review. These are the Rest of the World (RoW), households, and the government.

Figure 8 shows that the main sources of revenue for Malaria during the five years were donors (RoW), contributing between 50 and 86 percent of total CHE during the five years. In nominal terms, donor expenditure on malaria more than doubled from ZMW 1,860 million in 2017 to ZMW 4,532 million in 2021. Households' contribution to Malaria CHE has been declining but remains a significant proportion contributing 20 percent in 2017 and 14 percent in 2021. Generally, total CHE for Malaria doubled during the five years, rising from ZMW 1, 782 million in 2017 to ZMW 4, 532 in 2021.

Figure 8: Funding sources for Malaria, 2017-2023



Source: Author's compilation from survey data

5.4.1. Distribution of Malaria CHE by financing schemes:

The main channels of financing malaria programs in Zambia are shown in Table 19. Over the same period under review, Government financing schemes were the major channels through which malaria healthcare goods and services were financed. Government schemes accounted for 58 percent of the total CHE on malaria in 2017, but this reduced to 40 percent in 2021. NPISH was the second major financing scheme accounting 22 percent of malaria funds in 2017, rising to 35 percent in 2021. Households also had a significant proportion ranging between 12 percent and 21 percent, with a decline 13 percent in 2021.

Table 19: Distribution of Malaria CHE by financing schemes: 2017–2021 (ZMW million)

Financing scheme	Financial year and percentage (%)									
	2017	%	2018	%	2019	%	2020	%	2021	%
Central government	1,026	58	870	47	686	33	1,515	41	1,829	40
Social health insurance	-	0	-	0	-	0	22	1	57	1
NPISH	399	22	579	31	900	44	1,367	37	1,570	35
Enterprise	8	0	42	2	46	2	53	1	6	0
OOPs	350	20	369	20	422	21	449	12	603	13
RoW	-	0	-	0	-	0	275	7	467	10
Total	**1,782**	**100**	**1,860**	**100**	**2,054**	**100**	**3,681**	**100**	**4,532**	**100**

Source: Author's compilation from survey data

5.4.2. Financing agents for Malaria CHE

The distribution of malaria expenditure by financing agents is presented in Table 20. The distribution shows that government through the MoH managed most of the resources (58 percent in 2017 and 40 percent in 2021). This is followed by NPISH who managed 22 percent of the total CHE on malaria in 2017, and 44 percent in 2021. Households (through OOP spending) managed 20 percent of the total CHE on malaria in 2017, and 13 percent in 2021.

Table 20: Financing agents for Malaria CHE: 2017-2021 (ZMW million)

Financing Agent	Financial year and percentage (%)									
	2017	%	2018	%	2019	%	2020	%	2021	%
Ministry of Health	1,026	58	870	47	686	33	1,515	41	1,829	40
Insurance corporations	-	0	-	0	-	0	22	1	57	1
Employers	8	0	42	2	46	2	53	1	6	0
NPISH	399	22	578	31	900	44	1,642	45	1,992	44
Households	350	20	369	20	422	21	449	12	603	13
RoW	-	0	1	0	-	0	-	0	45	1
Total	**1,782**	**100**	**1,860**	**100**	**2,054**	**100**	**3,681**	**100**	**4,532**	**100**

Source: Author's compilation from survey data

5.4.3. Distribution of Malaria Funds by Healthcare Providers

Table 21 presents levels of expenditure categorized according to the main providers of malaria goods and services to the population. For the year 2017, the largest expenditure is on retailers and other providers of medical goods which accounted for approximately 44 percent of the total CHE on malaria. In 2021 the provider with the largest was the rest of the economy (35 percent) followed by providers of preventive care (30 percent).

Table 21 Expenditure on Malaria (CHE) by health care provider: 2017-2021 (ZMW million)

Health care Provider	Financial year and percentage (%)									
	2017	%	2018	%	2019	%	2020	%	2021	%
Unspecified Hospitals	3	0	3	0	5	0	6	0	-	0
First Level Public Hospitals	9	1	10	1	11	1	11	0	15	0
Second level Public Hospitals	32	2	35	2	38	2	42	1	55	1
Third Level Public Hospitals	29	2	32	2	35	2	38	1	50	1
Unspecified providers (n.e.c)	180	10	399	21	65	3	515	14	528	12
Ambulatory centres/clinics	117	7	126	7	358	17	239	6	373	8
Providers of ancillary services	38	2	4	0	0	0	19	1	129	3
Retailers of medical goods	787	44	247	13	236	12	256	7	338	7
Providers of preventive care	1	0	224	12	43	2	1162	32	1,379	30
Providers of health admin	584	33	666	36	541	26	27	1	92	2
Rest of economy	2	0	113	6	722	35	1367	37	1,573	35
Total	**1,782**	**100**	**1,860**	**100**	**2,054**	**100**	**3,681**	**100**	**4,532**	**100**

Source: Author's compilation from survey data

5.4.4. Malaria CHE by function

Table 22 shows the distribution of total CHE on malaria by function. In 2021, the larger share of expenditure was spent on preventive care which accounted for 64 percent of the total CHE on malaria. In the same year, curative services accounted for 30 percent of CHE.

Table 22: Malaria CHE by function: 2017-2021 (ZMW million)

Functions	Financial year and percentage (%)									
	2017	%	2018	%	2019	%	2020	%	2021	%
Curative care	532	30	400	21	530	26	974	26	1,338	30
Ancillary services	35	2	4	0	-	0	18	0	134	3
Medical goods	914	51	549	29	330	16	75	2	-	0
Preventive care	65	4	446	24	753	37	2,556	69	2,903	64
Governance & admin	232	13	98	5	431	21	47	1	154	3
Others (n.e.c.)	5	0	364	20	10	0	12	0	3	0
Total	**1,782**	**100**	**1,860**	**100**	**2,054**	**100**	**3,681**	**100**	**4,532**	**100**

Source: Author's compilation from survey data

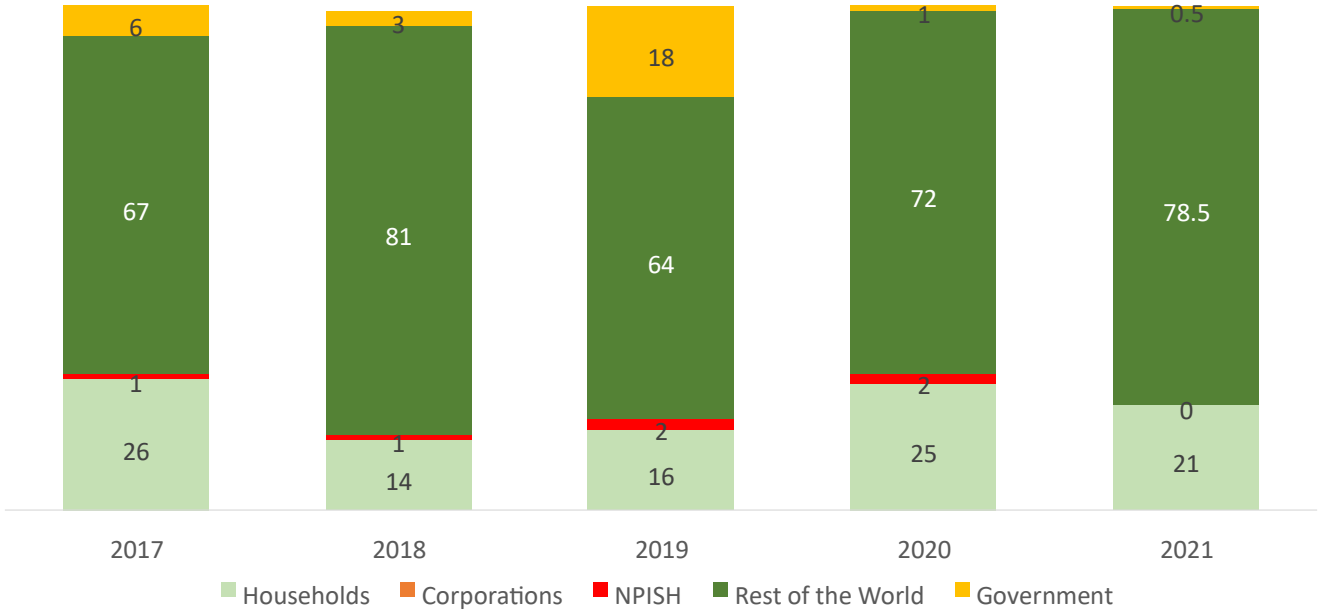
5.5. Reproductive Health Sub-account

Between 2017 and 2021, nominal expenditure on RH doubled, increasing from ZMW 738.9 million in 2017 to ZMW 1,528.6 million in 2021. This section describes the sources and flow of these resources in the health system.

Figure 9 show that the main sources of funds for reproductive health programs were the rest of the world (donors) and households. The donors contributed the largest share of resources ranging between 64 and 82 percent of

total RH CHE. Households were the second largest source of financing and contributed 26 percent and 21 percent in 2017 and 2021, respectively, representing a 5 percent decrease over the 5-year period.

Figure 9: Funding sources for Reproductive Health, 2017-2023



Source: Author's compilation from survey data

5.5.1. Distribution of Reproductive Health CHE by financing schemes:

From the financing sources, the revenues for RH services are channeled through the financing schemes. Table 23 shows three main financing schemes that includes the Government, the NPISH financing schemes and Households (OOPs). Most of the RH resources were handled by government which accounted for between 39 percent and 80 percent of the total CHE on RH over the 5 years. These were followed by the NPISH schemes that managed about 38 percent in 2017 and 2019, and 20 percent in 2021.

Table 23: Distribution of Reproductive CHE by financing schemes: 2017–2021 (ZMW million)

Financing scheme	Financial year and percentage (%)									
	2017	**%**	**2018**	**%**	**2019**	**%**	**2020**	**%**	**2021**	**%**
Central government	251	34	575	50	490	44	275	25	288	19
Social health insurance	-	0	-	0	-	0	7	1	15	1
NPISH	284	38	392	34	414	38	339	31	307	20
Corporations	10	1	14	1	18	2	37	3	4	0
OOPs	193	26	164	14	181	16	265	24	308	20
RoW	-	0	2	0	1	0	163	15	606	40
Total	**739**	**100**	**1,147**	**100**	**1,103**	**100**	**1,085**	**100**	**1,529**	**100**

Source: Author's compilation from survey data

5.5.2. Financing Agents for reproductive health CHE

Table 24 show the institutional units that manage funds for RH. The Government through the Ministry of Health managed 34 percent of RH expenditures in 2017 and 19 percent in 2021. The share of RH expenditures managed by NPISH rose from 38 percent in 2017 to 43 percent in 2021. The increase was driven by a rise in the flow of resources from donors at the expense of government institutions. Households were also a significant financing agent for RH managing 26 percent of the total CHE on RH in 2017 and 20 percent in 2021.

Table 24: Financing agents for Reproductive Health CHE- 2017-2021 (ZMW million)

Financing Agent	Financial year and percentage (%)									
	2017	%	2018	%	2019	%	2020	%	2021	%
Ministry of Health	251	34	575	50	490	44	275	25	288	19
Insurance corporations	-	0	-	0	-	0	7	1	15	1
Employers	10	1	14	1	18	2	37	3	4	0
NPISH	284	38	386	34	135	12	232	21	652	43
Households	193	26	164	14	181	16	265	24	308	20
Rest of the world	-	0	8	1	281	25	270	25	261	17
Total	**739**	**100**	**1,147**	**100**	**1,103**	**100**	**1,085**	**100**	**1,529**	**100**

Source: Author's compilation from survey data

5.5.3. Distribution of RH Funds by Healthcare Provider

Table 25 shows the various tiers of the health sector that provided RH services. Generally, providers of preventive care were the major providers of RH services except for the year 2021 when Non-specialised Ambulatory health care centres and clinics accounted for 34 percent of total CHE on RH. Health administration agencies were another significant provider in terms of the size of RH CHE over the five years.

Table 25: Expenditure on Reproductive Health (CHE) by providers: 2017-2023 (ZMW million)

Health care Provider	Financial year and percentage (%)									
	2017	**%**	**2018**	**%**	**2019**	**%**	**2020**	**%**	**2021**	**%**
Unspecified Hospitals	5	1	3	0	6	1	9	1	0	0
First Level Public Hospitals	5	1	4	0	4	0	6	1	7	0
Second level Public Hospitals	17	2	13	1	16	1	23	2	27	2
Third Level Public Hospitals	15	2	12	1	14	1	21	2	25	2
Unspecified Health care providers	126	17	9	1	5	0	9	1	8	1
Family planning centres	0	0	2	0	14	1	12	1	16	1
Non specialised Ambulatory centres	62	8	48	4	68	6	165	15	520	34
Retailers/providers of medical goods	111	15	83	7	100	9	150	14	174	11
Providers of preventive care	226	31	420	37	340	31	350	32	403	26
Government health administrators	21	3	14	1	197	18	0	0	0	0
Other administration agencies	33	5	151	13	313	28	248	23	300	20
Other industries	1	0	6	1	8	1	22	2	1	0
Community Health workers	33	5	10	1	0	0	0	0	1	0
Rest of the world	57	8	84	7	19	2	62	6	42	3
Rest of economy	26	4	287	25	0	0	7	1	5	0
Total	**739**	**100**	**1147**	**100**	**1103**	**100**	**1085**	**100**	**1529**	**100**

Source: Author's compilation from survey data

5.5.4. Expenditure (CHE) of reproductive health by function

Curative and preventive care are the two largest functions that RH revenue was spent on. In 2017 46 percent of the total CHE on RH was spent on curative care and this proportion remained almost the same in 2021, but fluctuated in the intermediate years (table 26). Preventive care accounted for 38 and 32 percent in 2017 and 2021 respectively. The absolute nominal amount spent on various RH functions doubled from K739 million in 2017 to K1, 529 million in 2021.

Table 26: Expenditure (CHE) of reproductive health by function: 2017-2021 (ZMW million)

Function	Financial year and percentage (%)									
	2017	**%**	**2018**	**%**	**2019**	**%**	**2020**	**%**	**2021**	**%**
Curative care	338	46	165	14	181	16	259	24	723	47
Long-term care	43	6	-	0	-	0	75	7	-	0
Medical goods	45	6	31	3	12	1	16	1	15	1
Preventive care	281	38	795	69	395	36	475	44	489	32
Governance & admin	18	2	148	13	505	46	246	23	297	19
Others (n.e.c.)	14	2	7	1	10	1	15	1	4	0
Total	**739**	**100**	**1,147**	**100**	**1,103**	**100**	**1,085**	**100**	**1,529**	**100**

Source: Author's compilation from survey data

Conclusion

This report has presented the flow of health expenditure in Zambia for the period 2017 to 2021 using the SHA 2011 framework. The analysis has covered the flow of funds in both government and private sector that includes private employers, parastatals, out of pocket expenditures, NGOs and donor expenditures. The survey has revealed that:

- In the period 2017 to 2021, nominal health expenditure more than doubled from K11.8 billion in 2017 to K29.38 billion in 2021. However, in United States dollar terms, this expenditure represented US$1.2 billion in 2017 and US$1.46 billion in 2021. The increase in nominal income is partially explained by the rapid depreciation of the kwacha that increased kwacha value of the dollar denominated donor funding.

- Similarly, the per capita expenditure for Zambia was estimated at US$ 71.4 in 2017 before and increased to US$84 in 2019 and declined to US$75.1 in 2021 on account of the deterioration in inflation and the exchange rate.

- The central government and donors remained the major sources of health care financing. The period contribution of the donors and government stood at 43 percent and 44.3 percent respectively. The central government was the major source in 2017 accounting for 52 percent before declining to 33.4 percent in 2019 and rose to US$37. The contribution by donors remained symmetrical to that of government. Households ranked third as sources of health expenditure and contributed 10.7 percent in 2011 before declining to 7.26 percent in 2021.

- The share of the resources managed by government fluctuated over the review period. In 2021, government managed almost half (47 percent) of CHE resources while the NPISH managed about a third (30 percent) of CHE. The households have continued to manage their own healthcare spending.

- Zambia's CHE expenditure is concentrated on HIV and AIDs accounted for 49.2 percent of CHE in 2021 while malaria absorbed about 14. 5% during the same years.

- The findings also suggest that donors finance over 95 percent of HIV and AIDS over the period 2017 to 2021. Government's contribution declined to less than 2 percent of total expenditure on HIV/ AIDS in 2021.

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Appendices

Appendix 1: Selected Health Accounts Classifications terminologies and Definitions

Classification	Definitions and Examples
Revenues of Financing schemes (FS)	Types of transactions through which funding schemes mobilize their income. Examples include internal transfers (from the ministry of finance to governmental agencies); direct foreign financial transfers (e.g. External donors providing funds to nongovernmental organizations (NGOs); and voluntary prepayment from employers
Financing schemes (HF)	This refers to funding arrangements by which people obtain health services. These financing schemes categorize spending according to criteria such as: the mode of participation in the scheme (compulsory vs. voluntary), the basis for entitlements (contributory vs. noncontributory) OOP
Revenues of Financing schemes (FSRI)	The institutional units that provide revenues for the various schemes. Examples are government, corporations, households, rest of world (such international foundations, NPISH
Financing agents (FA):	These are institutional units that manage one or more health financing schemes. Examples include Ministry of Health, commercial insurance companies, NGOs and international organizations
Health care providers (HP):	These are entities or organizations and actors who provide medical goods and services as their main activity, as well as those for whom the provision of health care is only one activity among many others. Examples include hospitals, clinics, health centres, pharmacies and traditional healers
Health care functions (HC):	The goods and services consumed by health end-users. Examples include: curative care; information, education, and counselling programs; medical goods such as supplies and pharmaceuticals; and governance and health system administration
Factors of provision (FP):	These are inputs to the production of health care goods and services by health care providers. Examples include: compensation of employees, health care goods and services
Health Care-Related (HCR)	These are activities that may overlap with other fields of study, such as education, overall "social" expenditure, and R&D, and sometimes may be closely linked to health care in terms of operations, institutions, and personnel
Capital formation (HK)	These are assets which once acquired can be used for a period longer than one year such as infrastructure or machinery investment, as well as education and training of health person
Disease (DIS)	These are ailments or condition or intervention area by which health expenditure is analysed or is expected to address. Examples are malaria, Dengue, Trauma, NCDs
Providers of ambulatory health care (HP.3)	This comprises establishments that are primarily engaged in providing health care services directly to outpatients who do not require inpatient services.
Providers of ancillary services (HP.4)	This category comprises establishments that provide specific ancillary type of services directly to outpatients under the supervision of health professionals and not covered within the episode of treatment by hospitals, nursing care facilities, ambulatory care providers or other providers. Included are providers of patient transportation and emergency rescue, medical and diagnostic laboratories, dental laboratories and other providers of ancillary services
Retailers and Other providers of medical goods (HP.5)	This item comprises specialised establishments whose primary activity is the retail sale of medical goods to the general public for individual or household consumption or utilisation. Establishments whose primary activity is the manufacture of medical goods, such as making lenses, orthopaedic or prosthetic appliances for direct sale to the general public for individual or household use, are also included, as is fitting and repair done in combination with sale.
Providers of preventive care (HP.6)	This category comprises organisations that primarily provide collective preventive programmes and campaigns/public health programmes for specific groups of individuals or the population-at-large, such

	as health promotion and protection agencies or public health institutes as well as specialised establishments providing primary preventive care as their principal activity, e.g Public health institutes, institute of occupational medicines, health promotion agencies
Providers of health care system administration and financing (HP7)	This item comprises establishments that are primarily engaged in the regulation of the activities of agencies that provide health care and in the overall administration of the health care sector, including the administration of health financing.
	Source: Compiled from the SHA 2011 Manual

Appendix 2: Selected Preliminary Matrices from the HAPT

TABLE HF x FS FOR THE YEAR 2017									
	Revenues of health care financing schemes	**FS.1**	**FS.2**	**FS.3**	**FS.5**	**FS.6**	**FS.7**	**All FS**	
Financing schemes	*Kwacha (ZMW), Million*	**Transfers from government domestic revenue (allocated to health purposes)**	**Transfers distributed by government from foreign origin**	**Social insurance contributions**	**Voluntary prepayment**	**Other domestic revenues n.e.c.**	**Direct foreign transfers**		**Share of HF**
HF.1	**Government schemes and compulsory contributory health care financing schemes**	**6,182**	**1,020**					**7,202**	**61**
HF.1.1	Government schemes	**6,182**	**1,020**					**7,202**	**61**
HF.2	**Voluntary health care payment schemes**				**187**	**433**	**2,690**	**3,310**	**28**
HF.2.1	Voluntary health insurance schemes				**187**			**187**	**2**
HF.2.2	NPISH financing schemes (including development agencies)					**0**	**2,690**	**2,691**	**23**
HF.2.3	Enterprise financing schemes					**432**		**432**	**4**
HF.3	**Household out-of-pocket payment**					**1,255**		**1,255**	**11**
HF.4	**Rest of the world financing schemes (non-resident)**					**8**		**8**	**0**
All HF		**6,182**	**1,020**		**187**	**1,696**	**2,690**	**11,775**	**100**
Share of FS		**53**	**9**		**2**	**14**	**23**	**100**	

TABLE HF x FS FOR THE YEAR 2018									
	Revenues of health care financing schemes	**FS.1**	**FS.2**	**FS.3**	**FS.5**	**FS.6**	**FS.7**	**All FS**	
Financing schemes	*Kwacha (ZMW), Million*	**Transfers from government domestic revenue (allocated to health purposes)**	**Transfers distributed by government from foreign origin**	**Social insurance contributions**	**Voluntary prepayment**	**Other domestic revenues n.e.c.**	**Direct foreign transfers**		**Share of HF**
HF.1	**Government schemes and compulsory contributory health care financing schemes**	**5,745**	**971**					**6,716**	**51**
HF.1.1	**Government schemes**	**5,745**	**971**					**6,716**	**51**
HF.2	**Voluntary health care payment schemes**	**1**			**23**	**219**	**4,816**	**5,059**	**39**
HF.2.1	**Voluntary health insurance schemes**				**23**			**23**	**0**
HF.2.2	**NPISH financing schemes (including development agencies)**	**1**				**0**	**4,816**	**4,817**	**37**

TABLE HF x FS FOR THE YEAR 2018									
	Revenues of health care financing schemes	**FS.1**	**FS.2**	**FS.3**	**FS.5**	**FS.6**	**FS.7**	**All FS**	
Financing schemes	*Kwacha (ZMW), Million*	**Transfers from government domestic revenue (allocated to health purposes)**	**Transfers distributed by government from foreign origin**	**Social insurance contributions**	**Voluntary prepayment**	**Other domestic revenues n.e.c.**	**Direct foreign transfers**		**Share of HF**
HF.2.3	**Enterprise financing schemes**					**219**		**219**	**2**
HF.3	**Household out-of-pocket payment**					**1,349**		**1,349**	**10**
HF.4	**Rest of the world financing schemes (non-resident)**						**2**	**2**	**0**
All HF		**5,746**	**971**		**23**	**1,568**	**4,818**	**13,126**	**100**
Share of FS		**44**	**7**		**0**	**12**	**37**	**100**	

TABLE HF x FS FOR THE YEAR 2019									
	Revenues of health care financing schemes	**FS.1**	**FS.2**	**FS.3**	**FS.5**	**FS.6**	**FS.7**	**All FS**	
Financing schemes	*Kwacha (ZMW), Million*	**Transfers from government domestic revenue (allocated to health purposes)**	**Transfers distributed by government from foreign origin**	**Social insurance contributions**	**Voluntary prepayment**	**Other domestic revenues n.e.c.**	**Direct foreign transfers**		**Share of HF**
HF.1	**Government schemes and compulsory contributory health care financing schemes**	**6,784**	**2,198**					**8,982**	**44**
HF.1.1	Government schemes	**6,784**	**2,198**					**8,982**	**44**
HF.2	**Voluntary health care payment schemes**	**1**			**35**	**234**	**9,559**	**9,829**	**48**
HF.2.1	Voluntary health insurance schemes				**35**			**35**	**0**
HF.2.2	NPISH financing schemes (including development agencies)	**1**				**1**	**9,559**	**9,561**	**47**
HF.2.3	Enterprise financing schemes					**233**		**233**	**1**
HF.3	**Household out-of-pocket payment**					**1,472**		**1,472**	**7**
HF.4	**Rest of the world financing schemes (non-resident)**						**9**	**9**	**0**
All HF		**6,785**	**2,198**		**35**	**1,705**	**9,567**	**20,290**	**100**
Share of FS		**33**	**11**		**0**	**8**	**47**	**100**	

TABLE HF x FS FOR THE YEAR 2020									
	Revenues of health care financing schemes	**FS.1**	**FS.2**	**FS.3**	**FS.5**	**FS.6**	**FS.7**	**All FS**	
Financing schemes	*Kwacha (ZMK), Million*	**Transfers from government domestic revenue (allocated to health purposes)**	**Transfers distributed by government from foreign origin**	**Social insurance contributions**	**Voluntary prepayment**	**Other domestic revenues n.e.c.**	**Direct foreign transfers**		**Share of HF**
HF.1	**Government schemes and compulsory contributory health care financing schemes**	**11,208**	**2,133**	**740**				**14,082**	**67**
HF.1.1	Government schemes	**11,208**	**2,133**					**13,341**	**64**
HF.1.2	Compulsory contributory health insurance schemes			**740**				**740**	**4**
HF.2	**Voluntary health care payment schemes**	**8**			**89**	**312**	**2,597**	**3,006**	**14**
HF.2.1	Voluntary health insurance schemes				**89**			**89**	**0**
HF.2.2	NPISH financing schemes (including development agencies)	**8**				**2**	**2,597**	**2,607**	**12**
HF.2.3	Enterprise financing schemes					**310**		**310**	**1**
HF.3	**Household out-of-pocket payment**					**1,703**		**1,703**	**8**
HF.4	**Rest of the world financing schemes (non-resident)**						**2,194**	**2,194**	**10**
All HF		**11,216**	**2,133**	**740**	**89**	**2,014**	**4,791**	**20,984**	**100**
Share of FS		**53**	**10**	**4**	**0**	**10**	**23**	**100**	

TABLE HF x FS FOR THE YEAR 2021									
	Revenues of health care financing schemes	**FS.1**	**FS.2**	**FS.3**	**FS.5**	**FS.6**	**FS.7**	**All FS**	
Financing schemes	*Kwacha (ZMW), Million*	**Transfers from government domestic revenue (allocated to health purposes)**	**Transfers distributed by government from foreign origin**	**Social insurance contributions**	**Voluntary prepayment**	**Other domestic revenues n.e.c.**	**Direct foreign transfers**		**Share of HF**
HF.1	**Government schemes and compulsory contributory health care financing schemes**	**10,738**	**2,766**	**1,742**				**15,246**	**52**
HF.1.1	Government schemes	**10,738**	**2,766**					**13,504**	**46**
HF.1.2	Compulsory contributory health insurance schemes			**1,742**				**1,742**	**6**
HF.2	**Voluntary health care payment schemes**	**8**			**53**	**224**	**7,917**	**8,203**	**28**
HF.2.1	Voluntary health insurance schemes				**53**			**53**	**0**
HF.2.2	NPISH financing schemes (including development agencies)	**8**				**1**	**7,917**	**7,926**	**27**
HF.2.3	Enterprise financing schemes					**223**		**223**	**1**
HF.3	**Household out-of-pocket payment**					**2,079**		**2,079**	**7**
HF.4	**Rest of the world financing schemes (non-resident)**						**3,856**	**3,856**	**13**
All HF		**10,746**	**2,766**	**1,742**	**53**	**2,303**	**11,773**	**29,383**	**100**
Share of FS		**37**	**9**	**6**	**0**	**8**	**40**	**100**	

TABLE HC x HP FOR THE YEAR 2017														
	Health care providers	HP.1.1.1.1	HP.1.1.1.2	HP.1.1.1.3	HP.1.1.2	HP.1.1.3	HP.1.nec	**HP.3**	**HP.4**	**HP.5**	**HP.6**	**HP.7**		
Health care functions	*Kwacha (ZMW), Million*	First-Level Public Hospital	Second-Level Public Hospital	Third-Level Public Hospital	Private For-Profit Hospitals	Private Not for Profit Hospitals	Unspecified hospitals (n.e.c.)	**Providers of ambulatory health care**	**Providers of ancillary services**	**Retailers and Other providers of medical goods**	**Providers of preventive care**	**Providers of health care system administration and financing**	**TOTAL of HC**	**Share of HC**
HC.1	**Curative care**	**1,064**	**835**	**827**	**53**	**308**	**14**	**2,821**					**5,922**	**50**
HC.1.1	Inpatient curative care	614	283	336	6	12	6						**1,257**	**11**
HC.1.3	Outpatient curative care	373	521	461	9	15	6	**2,645**					**4,029**	**34**
HC.1.4	Home-based curative care							**57**					**57**	**0**
HC.1.nec	Unspecified curative care (n.e.c.)	77	31	31	39	282	2	**119**					**580**	**5**
HC.3	**Long-term care (health)**	**45**	**23**	**23**		**118**		**217**					**425**	**4**
HC.4	**Ancillary services (non-specified by function)**								**182**				**182**	**2**
HC.5	**Medical goods (non-specified by function)**									**1,219**			**1,219**	**10**
HC.6	**Preventive care**	**163**	**90**	**95**	**0**	**642**	**1**	**1,178**			**340**		**2,509**	**21**
HC.7	**Governance, and health system and financing administration**											**1,233**	**1,233**	**10**
HC.9	**Other health care services not elsewhere classified (n.e.c.)**	**4**	**1**	**1**		**33**	**26**	**218**					**283**	**2**
TOTAL of HP		**1,276**	**948**	**946**	**53**	**1,102**	**41**	**4,434**	**182**	**1,219**	**340**	**1,233**	**11,775**	
Share of HP		**11**	**8**	**8**	**0**	**9**	**0**	**38**	**2**	**10**	**3**	**10**		

TABLE HC x HP FOR THE YEAR 2018														
	Health care providers	HP.1.1 .1.1	HP.1.1. 1.2	HP.1.1. 1.3	HP.1.1.2	HP.1.1.3	HP.1 .nec	**HP.3**	**HP.4**	**HP.5**	**HP.6**	**HP.7**		
Health care functions	*Kwacha (ZMW), Million*	First-Level Public Hospital	Second-Level Public Hospital	Third-Level Public Hospital	Private For-Profit Hospitals	Private Not for Profit Hospitals	Unspecified hospitals (n.e.c.)	**Providers of ambulatory health care**	**Providers of ancillary services**	**Retailers and Other providers of medical goods**	**Providers of preventive care**	**Providers of health care system administration and financing**	**TOTAL of HC**	**Share of HC**
HC.1	**Curative care**	**843**	**658**	**771**	**29**	**1,684**	**15**	**2,183**					**6,182**	**47**
HC.1.1	Inpatient curative care	404	278	305	17	13	6						**1,024**	**8**
HC.1.3	Outpatient curative care	303	312	399	11	17	9	**1,650**					**2,701**	**21**
HC.1.4	Home-based curative care							**49**					**49**	**0**
HC.1.nec	Unspecified curative care (n.e.c.)	135	67	67	0	1,654		**483**					**2,408**	**18**
HC.2	**Rehabilitative care**	**4**	**2**	**2**				**5**					**13**	**0**
HC.3	**Long-term care (health)**	**16**	**8**	**8**		**37**		**175**					**245**	**2**
HC.4	**Ancillary services (non-specified by function)**								**63**				**63**	**0**
HC.5	**Medical goods (non-specified by function)**									**737**			**737**	**6**
HC.6	**Preventive care**	**740**	**120**	**119**	**9**		**0**	**1,372**			**609**		**2,971**	**23**
HC.7	**Governance, and health system and financing administration**											**2,530**	**2,530**	**19**
HC.9	**Other health care services not elsewhere classified (n.e.c.)**	**3**	**1**	**1**		**297**	**30**	**51**					**384**	**3**
All HC		**1,606**	**789**	**902**	**38**	**2,018**	**46**	**3,787**	**63**	**737**	**609**	**2,530**	**13,126**	
Share of HP		**12**	**6**	**7**	**0**	**15**	**0**	**29**	**0**	**6**	**5**	**19**		

TABLE HC x HP FOR THE YEAR 2019														
	Health care providers	HP.1.1 .1.1	HP.1.1. 1.2	HP.1.1. 1.3	HP.1.1.2	HP.1.1.3	HP.1 .nec	**HP.3**	**HP.4**	**HP.5**	**HP.6**	**HP.7**		
Health care functions	*Kwacha (ZMW), Million*	First-Level Public Hospital	Second-Level Public Hospital	Third-Level Public Hospital	Private For-Profit Hospitals	Private Not for Profit Hospitals	Unspecified hospitals (n.e.c.)	**Providers of ambulatory health care**	**Providers of ancillary services**	**Retailers and Other providers of medical goods**	**Providers of preventive care**	**Providers of health care system administration and financing**	**TOTAL of HC**	**Share of HC**
HC.1	**Curative care**	**2,110**	**2,165**	**1,240**	**4**	**506**	**17**	**3,045**					**9,088**	**45**
HC.1.1	Inpatient curative care	1,175	1,294	556	1	29	8						**3,064**	**15**
HC.1.3	Outpatient curative care	824	818	630	1	26	8	**2,725**					**5,032**	**25**
HC.1.4	Home-based curative care							**19**					**19**	**0**
HC.1.nec	Unspecified curative care (n.e.c.)	111	54	54	2	451	1	**301**					**973**	**5**
HC.2	**Rehabilitative care**	**3**	**1**	**1**				**4**					**10**	**0**
HC.3	**Long-term care (health)**	**65**	**33**	**33**		**53**		**282**					**465**	**2**
HC.4	**Ancillary services (non-specified by function)**								**18**				**18**	**0**
HC.5	**Medical goods (non-specified by function)**									**3,550**			**3,550**	**17**
HC.6	**Preventive care**	**1,092**	**119**	**648**	**0**		**1**	**1,099**			**547**		**3,505**	**17**
HC.7	**Governance, and health system and financing administration**											**2,893**	**2,893**	**14**
HC.9	**Other health care services not elsewhere classified (n.e.c.)**	**96**	**48**	**48**		**352**	**33**	**184**					**761**	**4**
All HC		**3,366**	**2,366**	**1,970**	**4**	**911**	**51**	**4,614**	**18**	**3,550**	**547**	**2,893**	**20,290**	
Share of HP		**17**	**12**	**10**	**0**	**4**	**0**	**23**	**0**	**17**	**3**	**14**		

TABLE HC x HP FOR THE YEAR 2020														
	Health care providers	HP.1.1.1.1	HP.1.1.1.2	HP.1.1.1.3	HP.1.1.2	HP.1.1.3	HP.1.nec	**HP.3**	**HP.4**	**HP.5**	**HP.6**	**HP.7**		
Health care functions	*Kwacha (ZMK), Million*	First-Level Public Hospital	Second-Level Public Hospital	Third-Level Public Hospital	Private For-Profit Hospitals	Private Not for Profit Hospitals	Unspecified hospitals (n.e.c.)	**Providers of ambulatory health care**	**Providers of ancillary services**	**Retailers and Other providers of medical goods**	**Providers of preventive care**	**Providers of health care system administration and financing**	**TOTAL of HC**	**Share of HC**
HC.1	**Curative care**	**2,119**	**3,215**	**1,306**	**130**	**917**	**25**	**2,306**					**10,019**	**48**
HC.1.1	Inpatient curative care	1,256	2,495	642	35	33	8						**4,468**	**21**
HC.1.3	Outpatient curative care	724	720	664	30	37	14	**759**					**2,949**	**14**
HC.1.4	Home-based curative care							**34**					**34**	**0**
HC.1.nec	Unspecified curative care (n.e.c.)	139	0	0	65	848	3	**1,513**					**2,568**	**12**
HC.3	**Long-term care (health)**	**3**	**0**	**0**	**1**	**61**		**47**					**112**	**1**
HC.4	**Ancillary services (non-specified by function)**								**289**				**289**	**1**
HC.5	**Medical goods (non-specified by function)**									**923**			**923**	**4**
HC.6	**Preventive care**	**1,881**	**270**	**180**	**35**	**1,966**	**1**	**1,785**			**1,311**		**7,430**	**35**
HC.7	**Governance, and health system and financing administration**											**2,018**	**2,018**	**10**
HC.9	**Other health care services not elsewhere classified (n.e.c.)**	**20**	**5**	**4**		**50**	**42**	**72**					**193**	**1**
All HC		**4,023**	**3,490**	**1,490**	**167**	**2,994**	**68**	**4,211**	**289**	**923**	**1,311**	**2,018**	**20,984**	
Share of HP		**19**	**17**	**7**	**1**	**14**	**0**	**20**	**1**	**4**	**6**	**10**		

TABLE HC x HP FOR THE YEAR 2021														
	Health care providers	HP.1.1.1.1	HP.1.1.1.2	HP.1.1.1.3	HP.1.1.2	HP.1.1.3	HP.1.nec	**HP.3**	**HP.4**	**HP.5**	**HP.6**	**HP.7**		
Health care functions	*Kwacha (ZMK), Million*	First-Level Public Hospital	Second-Level Public Hospital	Third-Level Public Hospital	Private For-Profit Hospitals	Private Not for Profit Hospitals	Unspecified hospitals (n.e.c.)	**Providers of ambulatory health care**	**Providers of ancillary services**	**Retailers and Other providers of medical goods**	**Providers of preventive care**	**Providers of health care system administration and financing**	**TOTAL of HC**	**Share of HC**
HC.1	**Curative care**	**3,095**	**1,318**	**988**	**194**	**1,276**	**23**	**4,169**					**11,063**	**38**
HC.1.1	Inpatient curative care	1,257	512	471	94	59							**2,392**	**8**
HC.1.3	Outpatient curative care	1,804	805	511	90	62		**3,090**					**6,362**	**22**
HC.1.4	Home-based curative care							**0**					**0**	**0**
HC.1.nec	Unspecified curative care (n.e.c.)	34	1	7	10	1,155	23	**1,079**					**2,309**	**8**
HC.2	**Rehabilitative care**	**5**											**5**	**0**
HC.3	**Long-term care (health)**	**20**	**10**	**10**				**1,263**					**1,303**	**4**
HC.4	**Ancillary services (non-specified by function)**								**502**				**502**	**2**
HC.5	**Medical goods (non-specified by function)**									**2,230**			**2,230**	**8**
HC.6	**Preventive care**	**1,107**	**305**	**298**	**0**	**3,536**		**2,006**			**1,615**		**8,869**	**30**
HC.7	**Governance, and health system and financing administration**											**5,282**	**5,282**	**18**
HC.9	**Other health care services not elsewhere classified (n.e.c.)**	**1**	**0**	**0**		**72**		**56**					**129**	**0**
All HC		**4,228**	**1,634**	**1,297**	**194**	**4,884**	**23**	**7,495**	**502**	**2,230**	**1,615**	**5,282**	**29,383**	
Share of HP		**14**	**6**	**4**	**1**	**17**	**0**	**26**	**2**	**8**	**5**	**18**		

Republic of Zambia

MINISTRY OF HEALTH

NATIONAL HEALTH ACCOUNTS ESTIMATES FOR ZAMBIA: 2017 -2021

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