Universal Health Coverage Assessment

Zambia

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Global Network for Health Equity (GNHE)

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Universal Health Coverage Assessment:
Zambia

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Introduction

This document provides a preliminary assessment of the Zambian health system relative to the goal of universal health coverage, with a particular focus on the financing system and related aspects of provision.

In the 2010 World Health Report, universal health coverage is defined as providing everyone in a country with financial protection from the costs of using health care and ensuring access to the health services they need (World Health Organisation 2010). These services should be of sufficient quality to be effective.

This document presents data that provide insights into the extent of financial protection and access to needed health services in Zambia.

Key health care expenditure indicators

This section examines overall levels of health expenditure in Zambia and identifies the main sources of health financing (Table 1). In 2012, total health expenditure accounted for 6.5% of the country’s GDP, an amount that was considerably higher than the average of 4.5% for other lower-middle-income countries but below the global average of 9.2%.

Public allocations to fund the health sector (including donor funds flowing through government accounts) stood at about 16% of total government expenditure, almost double the average of 8.4% for other lower-middle-income countries. Zambia therefore exceeded the 15% target set by the Organisation for African Unity’s 2001 Abuja Declaration, as well as the global 2012 average of 15%.

Table 1: National Health Accounts indicators of health care expenditure and sources of finance in Zambia, 2012

<table>
<thead>
<tr>
<th>Indicators of the level of health care expenditure</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Total expenditure on health as % of GDP</td>
<td>6.5%</td>
</tr>
<tr>
<td>2. General government expenditure on health as % of GDP</td>
<td>4.2%</td>
</tr>
<tr>
<td>3. General government expenditure on health as % of total government expenditure</td>
<td>16.4%</td>
</tr>
<tr>
<td>4a. Per capita government expenditure on health at average exchange rate (US$)</td>
<td>62</td>
</tr>
<tr>
<td>4b. Per capita government expenditure on health (PPP $)</td>
<td>72</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicators of the source of funds for health care</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>5. General government expenditure on health as % of total expenditure on health*</td>
<td>64.1%</td>
</tr>
<tr>
<td>6. Private expenditure on health as % of total expenditure on health**</td>
<td>35.9%</td>
</tr>
<tr>
<td>7. External resources for health as % of total expenditure on health#</td>
<td>32.3%</td>
</tr>
<tr>
<td>8. Out-of-pocket expenditure on health as % of total expenditure on health</td>
<td>23.9%</td>
</tr>
<tr>
<td>9. Out-of-pocket expenditure on health as % of GDP</td>
<td>1.6%</td>
</tr>
<tr>
<td>10. Private prepaid plans on health as % of total expenditure on health</td>
<td>1.3%</td>
</tr>
</tbody>
</table>

Notes: * This includes government tax-funded health spending and external revenues (loans and grants) flowing through government accounts in the category of general government expenditure on health.

**This includes external resources that flow through NGOs.

#Some external resources flow through government and some through NGOs. Indicators 5 and 6 therefore add up to 100% whereas indicator 7 in this Table is a separate indicator altogether. This is different from Figure 1 where donor funds are distinguished from tax-based financing.

Source: Data drawn from World Health Organisation’s Global Health Expenditure Database (http://apps.who.int/nha/database/Key_Indicators/Index/en).

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The data quoted in this section all derive from the 2012 data in the World Health Organisation’s Global Health Expenditure Database (http://apps.who.int/nha/database/Home/Index/en). Comparisons with other countries are based on figures expressed in terms of purchasing power parity. The country’s income category is determined from the World Bank’s classification for the same year (http://data.worldbank.org/about/country-and-lending-groups).
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Government health expenditure (including donor funding flowing through government accounts) translated into 4.2% of GDP. This amount was much higher than the lower-middle-income country average for that year of 1.7% (and even the upper-middle-income country average of 3.4%), demonstrating the Zambian government’s commitment to the public health sector.

Nonetheless, the level of government health expenditure was somewhat lower than the global average of 5.3% of GDP. In addition, per capita government expenditure on health was around $72 (in terms of purchasing power parity), not very much higher than the lower-middle-income country average of $67 and nine times less than the global average of $652.

External sources have grown in Zambia over the past two decades, accounting for around one third (32%) of total health sector expenditure in 2012. This is very high for a lower-middle-income country (where the average for that year was 2%) and even for a low-income country (where the average was 28%). The high level of donor support is one explanation for why the Zambia government has been able to achieve relatively high levels of health spending.

As would have been expected from the high levels of government expenditure, out-of-pocket payments were relatively low at just under a quarter (24%) of total health financing. This was almost half the lower-middle-income country average of 54% and close to the global average of 21%. It was also getting close to the 20% limit suggested by the 2010 World Health Report to ensure that financial catastrophe and impoverishment as a result of accessing health care become negligible (World Health Organisation 2010). This would lead one to expect that Zambian citizens experience relatively good financial protection against the risk of high health care costs.

Lastly, in 2012 private health insurance played an insignificant role in Zambia, at only 1.3% of total health sector financing.

**Structure of the health system according to health financing functions**

Figure 1 provides a summary of the structure of the Zambian health system, depicted according to the health care financing functions of revenue collection, pooling and purchasing, as well as health service provision. Each block represents the percentage share of overall health care expenditure accounted for by each category of revenue source, pooling organisation, purchasing organisation and health care provider.3

**Revenue collection**

There are three key financing sources in the Zambian health care system. Donor funding is the most important financing source, accounting for as much as 42% of total funds in 2006. Given this heavy reliance, Zambia is vulnerable to fluctuations in donor financing.

According to Figure 1, out-of-pocket payments are the second most important financing source in Zambia at 29% of total health financing in 2006. This estimate, which is from a different source and for a different year, is higher than the figure quoted in Table 1, suggesting that financial protection had not been as good as described in the previous section, at least for that year.

In the public sector, user fees are paid at secondary and tertiary health facilities. User fees are also charged by non-profit health facilities (which mainly belong to faith-based organisations). Although these facilities receive government subsidies, fees are required to help them cover their costs. For-profit providers charge user fees but their rates are limited by government regulations.

Tax-based government financing is the third most important source (at 24% of total financing in 2006). It is comprised of direct and indirect taxes, which made up 48% and 52% of total taxes respectively in 2007 (see Table 4). There are no alternative public financing models, such as social health insurance.

As already mentioned, private insurance remains limited and is an urban-based model to which only employers and a few independent individuals subscribe.

**Pooling**

The donor community is comprised of bilateral and multi-lateral agencies as well as non-governmental organisations, both domestic and international. Donor funds are channelled through the Ministry of Finance in the form of general budget support and through the Ministry of Health for health sector-specific support and certain vertical programmes. Donors work with the Ministry of Health through strategic planning and monitoring and

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3 The data quoted in this section are somewhat different to the previous section because they are from six years earlier and based on more detailed disaggregation by the authors of The Zambian National Health Accounts (Ministry of Health and University of Zambia 2006).
Figure 1: A function summary chart for Zambia (2006)

<table>
<thead>
<tr>
<th>Revenue collection</th>
<th>General taxation</th>
<th>Donors</th>
<th>Private insurance</th>
<th>Out-of-pocket</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pooling</td>
<td>Ministry of Health</td>
<td>NGOs</td>
<td>No pooling</td>
<td></td>
</tr>
<tr>
<td>Purchasing</td>
<td>Ministry of Health</td>
<td>Other government</td>
<td>NGOs</td>
<td>Private insurance</td>
</tr>
<tr>
<td>Provision</td>
<td>Public providers</td>
<td>NGOs</td>
<td>Private for profit providers</td>
<td></td>
</tr>
</tbody>
</table>

Notes:
- In 2012, and as noted in the main text, health care functions were split between the Ministry of Health and Ministry of Community Development, Maternal and Child Health. This is not reflected in the chart as the data pre-date this development.
- In the case of this Zambian chart, some donor funds (in the revenue collection row) have been allocated to “no pooling” (in the pooling row) and “individual purchasing” (in the purchasing row) where they were not pooled with the general government budget but made conditional on specific programmes. This reflects the principles of the sector-wide approach. Nonetheless, the case could be made that conditional (and often vertical) donor-funded programmes do achieve some degree of risk pooling.

Source: Authors’ calculations based on the Zambian National Health Accounts (Ministry of Health and University of Zambia 2006)

Evaluation processes to minimise the distortion of priorities and unnecessary expenditures sometimes associated with vertical programmes. However, some inefficiencies, and problems with the breadth and depth of coverage offered by donor-funded programmes, remain.

Pooling of government and donor resources had some positive effects on financial protection and access to services. Most notably, it allowed for the removal of user fees at the primary health care level in rural areas in 2006. This lessened exposure to the risk of household impoverishment due to catastrophic expenditures (Chitah et al. 2010). Furthermore, it led to a marked increase in health services utilisation (Masiye et al. 2010).

In 2005, the Zambian health sector went through a major structural reform, reversing an earlier decentralised health system and reverting to a centrally controlled governance structure. Resource allocation by the Ministry of Health was not impacted by these changes. As was the case before, funds are allocated to geographic areas on the basis of a deprivation formula adjusted for population size and infrastructure or capital investment needs. The purpose of the resource allocation process is, through improving access to health services and addressing inequity, to reduce the substantial health care differences that exist in the population as well as militate against poverty (especially that related to ill-health).

During 2012, primary health care functions were transferred from the Ministry of Health to the Ministry of Community Development (which was renamed the Ministry of Community Development, Maternal and Child Health). This left the Ministry of Health with matters relating to policy, human resources and clinical care at the level of secondary and tertiary services only. This split resource pools between the two Ministries, and resulted in some fragmentation of decision-making around curative versus preventive care, and between different levels of care.

The pooling of resources through private insurance schemes is limited as these accounted for only a small fraction of total health care expenditures. Out-of-pocket payments are not pooled at all.

**Purchasing**

Donors have had three key channels for disbursement of funds. As already described, two channels are general
budget support through the Ministry of Finance and sector support through the Ministry of Health. A third channel is through direct payments to programme areas such as immunisation, infrastructure, procurement of medicines and other vertical programmes such as maternal, newborn and child health, HIV, Malaria and TB.

There is direct financing of public providers in Zambia but purchasing arrangements have been affected over the years by changes in legislation. Prior to the re-centralisation reforms in 2005, autonomous District Health Boards were fund-holding agents and purchasers of services for primary care at the district level. A Central Board of Health was the fund-holding agent and purchaser for secondary and tertiary services. A system of performance-based contracting was designed to ensure an accountable and transparent financial and service provision system. It included clearly identified performance indicators that were the basis for purchasing services, monitoring and reimbursing funds, as well as a clearly defined performance structure for management that was used as an accountability framework for health system governance.

Thus, prior to 2005, public health providers were reimbursed on the basis of the completion and acceptance of global budgets. This was part of a negotiated process in which progress towards performance targets was reviewed. The current process, though, is based on activities but relies more heavily on historical (inflationary) adjustments. This exacerbates the risk of developing inequities in resource distribution.

The reversal of the decentralised system also led to the loss of capacity in community mobilisation and engagement in service delivery planning and implementation, because community structures and their autonomous functions were curtailed (Ministry of Health 2010 and 2012). This may well have lessened pressure on health services to meet the needs of disadvantaged communities in some instances.

With respect to the services supposed to be purchased in the public sector, these were defined during the 1990s as an essential package of priority conditions, procedures and interventions, called the Zambian Basic Health Package. The principle of the package was to provide a minimum set of services using public funding. Conditions that could not be afforded with public resources would either not be provided in the public sector, or be provided on a cost-sharing or cost-recovery basis. However, the package has never been recognised officially or adopted as policy by Cabinet. Although this is the case, treatment guidelines for frontline workers have been based on the package since the mid-1990s.

Private health insurance schemes reimburse providers on a fee-for-service basis. Individual patients paying out of pocket also reimburse providers on a fee-for-service basis.

**Provision**

Generally the public sector dominates the delivery of health services in Zambia. Public health facilities are organised under the Ministry of Health, the Ministry of Defence, the Ministry of Home Affairs and, more recently, the Ministry of Community Development, Maternal and Child Health. According to the Ministry of Health (2008) facility survey report, government owned about 86% of the health facilities in the country. It owned all the tertiary facilities, two-thirds of secondary level facilities and 80% of health centres.

Zambia has a shortage of human resources and their distribution is characterised by rural and urban inequities, as well as local-level differences in distribution based on facility types and geographic location.

Private health care providers include faith-based providers or mission–owned facilities under the coordination of the Churches Health Association of Zambia. These accounted for around 15 per cent of secondary and primary health services (which includes first level hospitals) and are mainly located in rural areas (Churches Health Association of Zambia 2006). The distribution of these facilities reflects the historical orientation of the various missionary organisations active in Zambia. In general, individual denominations tend to take responsibility for different regions and have had a tendency to favour the provinces least served by Ministry of Health facilities. The government provides them with some subsidies while the management rights are retained by the individual denominations.

The private for-profit sector, which had been relatively nascent in earlier years, appears to have begun to grow, not only in terms of expenditure, but also in terms of investments and coverage. Government does not contract with for-profit providers as these are situated in the urban areas and are utilised mainly by the wealthy. The Household Utilisation and Expenditure Survey, for instance, shows that the main users of these services are from the fourth and fifth quintiles (Ministry of Health, Central Statistics Office and University of Zambia 2014).

In terms of the relative shares of expenditures on different functions, more than 55 % of total health expenditure was on provision of curative care services. Expenditure
on inpatient care accounted for more than 55% of the allocations to curative care. The proportions spent on preventive and rehabilitative health services were around 15% and 30% respectively (Ministry of Health and University of Zambia 2006).

Government resources are spent on curative care and to a lesser extent preventive care. The expenditure by donors is mainly on prevention while most of their expenditure on curative care has increasingly been associated with HIV/AIDS antiretroviral programmes and malaria treatment (Ministry of Health National Health Accounts 1998, 2002 and 2006). Households, on the other hand, have maintained high expenditures on curative care and were responsible for close to half of all curative care spending in 2006 (Ministry of Health and University of Zambia 2006).

Figure 1 shows that there is a relatively large share of expenditure (10%) on the private sector. This is despite the fact that public primary health care services are free.

### Financial protection and equity in financing

A key objective of universal health coverage is to provide financial protection for everyone in the country. Insights into the existing extent of financial protection are provided through indicators such as the extent of catastrophic payments and the level of impoverishment due to paying for health services. This section analyses these indicators for Zambia and then moves on to assess the overall equity of the health financing system.

### Catastrophic payment indicators

Table 2 uses a range of percentage thresholds of household expenditure (including and excluding food expenditure) for assessing catastrophic payments. It shows that, when using the threshold of 40% of non-food household expenditure, 5% of the Zambian population incurred...
catastrophic spending in 2010 as a result of accessing health care. This is substantially higher than the median of 3% for 17 lower-middle-income countries studied by World Health Organisation and World Bank (2015). In addition, it is agreed in the literature that catastrophic payment indicators understate the actual problem because it does not capture the reality that there are people who do not utilize health services when needed because they are unable to afford out-of-pocket payments at all (Wagstaff and van Doorslaer 2003).

These results are somewhat unexpected, given that out-of-pocket payments are progressive (see Table 4) and relatively low as a proportion of total health expenditure (see Table 1). In addition, primary health care is free at rural public facilities. Possible explanations might be that the estimated proportion of out-of-pockets payments is higher than recorded (see, for example, the discrepancy between the estimates in Table 1 and Figure 1), the fact that fees are charged by public hospitals and urban primary health care facilities, as well as private for-profit and non-profit facilities (which the poor might need to use where they have poor access to good quality public care) and the high level of poverty in Zambia (see Table 3 below) (which means that even small payments place large burdens on poor households).

**Impoverishment indicators**

While the extent of catastrophic payments indicates the relative impact of out-of-pocket payments on household welfare, the absolute impact is shown by the impoverishment effect. In Zambia, a large percentage of the population (70%) lived below $1.08 per day in 2010 (see Table 3). An extra 1.3% dropped into poverty as a result of paying out of pocket when accessing health services. This translated into approximately 156,000 people or approximately 26,000 households per year falling into poverty because of out-of-pocket expenditure on health care. The normalised poverty gap (also shown in Table 3) measures the percentage of the poverty line necessary to raise an individual who is below the poverty line to that line. The difference between the pre-payment and the post-payment poverty gaps was 1.3 per cent in 2010. This proportion might be lower than the situation in reality because of the fact that the methodology only captures those who access health care services, excluding those already very poor individuals who cannot afford to pay for health care.

**Equity in financing**

Equity in financing is strongly related to financial protection (as described by the indicators above) but is a distinct issue and health system goal. It is generally accepted that financing of health care should be according to the ability to pay.

A ‘progressive’ health financing mechanism is one in which the amount richer households pay for health care represents a larger proportion of their income. Progressivity is measured by the Kakwani index: a positive value for the index means that the mechanism is progressive; a negative value means that poorer households pay a larger proportion of their income and that the financing mechanism is therefore regressive. Table 4 provides an overview of the distribution of the burden of financing the Zambian health system across different socio-economic groups (i.e. the financing incidence) as well as the Kakwani index for each financing mechanism.

Table 4 shows that the Zambian health financing system was marginally progressive in 2010. With respect to specific sources, value-added tax (VAT) was progressive although it is an indirect consumption tax. The key reason is that there are VAT exemptions on commodities that are consumed by the poor while products that are consumed by the wealthy attract tax.

### Table 3: Impoverishment indicators for Zambia in 2010 (using $1.25 poverty line (in terms of 2005 purchasing power parity))

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-payment poverty headcount</td>
<td>70.1 %</td>
</tr>
<tr>
<td>Post-payment poverty headcount</td>
<td>71.4 %</td>
</tr>
<tr>
<td>Percentage point change in poverty headcount (pre- to post-payment)</td>
<td>1.3 %</td>
</tr>
<tr>
<td>Pre-payment normalised poverty gap</td>
<td>36.8 %</td>
</tr>
<tr>
<td>Post-payment normalised poverty gap</td>
<td>38.1 %</td>
</tr>
<tr>
<td>Percentage point change in poverty gap (pre- to post-payment)</td>
<td>1.3 %</td>
</tr>
</tbody>
</table>

Source: Chitah, Mphuka and Masiye (2013b)
The progressivity of overall health financing was reduced by the regressivity of excise tax, largely due to the tax on cigarettes, which are consumed by rich and poor alike. Excise tax on alcohol is progressive largely because the tax on spirits and wines is higher than that on opaque and clear beers, which are mostly consumed by poor households.

Corporate profit tax, personal income tax, the fuel levy (an added tax on fuel purchases), the health levy (a tax on all savings accounts in banking and other financial institutions) and the ‘withholding’ tax are all progressive.

Although globally out-of-pocket payments are often found to be regressive, in Zambia they are marginally progressive. This is certainly a counter-intuitive finding and should be investigated further once data that capture out-of-pocket payments better are collected.

**Equitable use of health services and access to needed care**

This section considers how benefits from using different types of health services are distributed across socio-economic groups. Figures 2 and 3 show utilisation by quintile in 2010. The poorest quintile utilised just over a fifth (23%) of district-level care (including primary health care and district hospital care), but only 14% of referral hospital care. The latter figure is very low.

When one examines the distribution of government spending, while it is fairly equally distributed between the bottom four quintiles with respect to public district-level services, it is higher for the richer two quintiles relative to the distribution of utilisation. The distribution of government spending for those services delivered through the faith-based sector does not seem to reflect relative utilisation at

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**Table 4: Incidence of different domestic financing mechanisms in Ghana (2007)**

<table>
<thead>
<tr>
<th>Financing mechanism</th>
<th>Percentage share</th>
<th>Kakwani index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct taxes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal income taxes</td>
<td>29%</td>
<td>0.01</td>
</tr>
<tr>
<td>Corporate profit taxes</td>
<td>12%</td>
<td>0.2</td>
</tr>
<tr>
<td>Total direct taxes</td>
<td>41%</td>
<td>-</td>
</tr>
<tr>
<td>Indirect taxes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VAT</td>
<td>22%</td>
<td>0.24</td>
</tr>
<tr>
<td>BEER</td>
<td>-</td>
<td>0.21</td>
</tr>
<tr>
<td>Cigarette tax</td>
<td>-</td>
<td>-0.16</td>
</tr>
<tr>
<td>Excise tax</td>
<td>12%</td>
<td>-0.02</td>
</tr>
<tr>
<td>Corporate Income Tax for non-residents</td>
<td>-</td>
<td>0.20</td>
</tr>
<tr>
<td>Fuel tax</td>
<td>-</td>
<td>0.25</td>
</tr>
<tr>
<td>Withholding tax (for non-residents)</td>
<td>-</td>
<td>0.1</td>
</tr>
<tr>
<td>Health tax</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Import tax</td>
<td>14%</td>
<td>-</td>
</tr>
<tr>
<td>Total indirect taxes</td>
<td>44%</td>
<td>-</td>
</tr>
<tr>
<td>Total public financing sources</td>
<td>85%</td>
<td>0.18</td>
</tr>
<tr>
<td>Prepaid plans</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Out-of-pocket payments</td>
<td>-</td>
<td>0.06</td>
</tr>
<tr>
<td>Total private financing sources</td>
<td>15%</td>
<td>-</td>
</tr>
<tr>
<td>Total financing sources</td>
<td>100%</td>
<td>0.18</td>
</tr>
</tbody>
</table>

Notes:
- This analysis by the authors was based on data from the 2010 Living Conditions and Monitoring Survey, using various tax amounts paid by each household based on the type of income earned and the commodities consumed, and using the tax rate as provided by the Ministry of Finance and National Planning. For consistency, the amounts were also adjusted to tally with national amounts of taxes raised. This was done by using appropriate tax rates. Kakwani estimates were based on per adult equivalent expenditures.
- * = insufficient data to perform calculation

Source: Chitah and Mphuka (2010)
Figure 2: Relative utilisation and government funding for district-level services* by quintile in Zambia (2010)

*District hospitals and primary health care services
Source: Adapted from Ministry of Health (2010)

Figure 3: Relative utilisation and government funding for referral hospital services by quintile in Zambia (2010)

Source: Adapted from Ministry of Health (2010)
all. Relative spending by government on referral hospitals for the poorest quintile is very low, reflected by a negative Kakwani index of -0.9 (Chitah, Mphuka and Masiye 2013a).

Figure 4 shows the distribution of benefits (subsidies) across the different regions in Zambia. Lusaka is the capital city of Zambia while the Copperbelt, the most urbanised region in the country, is the copper mining region. The Figure shows that the allocation of health centre funds is not always in line with the size of the population in a region.

It is generally agreed that individuals’ use of health services should be in line with their need for care. The universal coverage goal of promoting access to needed health care can be interpreted as reducing the gap between the need for care and actual use of services, particularly differences in use relative to need across socio-economic groups. The utilisation and financing incidence results discussed above do not allow one to draw a categorical conclusion about whether the distribution is equitable or not: the distribution of benefits first needs to be compared to the distribution of need for health care.

Figure 5 uses a proxy, self-reported assessment of health, to represent the distribution of need across different income quintiles. It shows that the shares of self-reported illness did not differ substantially across the different quintiles, except that the richest quintile had slightly lower need. Despite this, the poorest quintile (which accounted for 21% of self-reported illness) only accounted for 14% of referral hospital visits.

Figure 4: The proportion of government funding spent on health centres relative to population size, by province (2010)

Source: Chitah, Mphuka and Masiye (2010)
Conclusion

Zambia is making continuous progress in all the key areas of its health system. However, while this may be the case, there are gaps that exist which need to be resolved for the country to be able to realise the goal of universal coverage, including universal financial protection and access to care.

First, a more equitable distribution of resources between urban and rural areas is required. Currently there is an urban bias in resource distribution. This is evidenced not only in the allocation of public health sector resources, but also in expenditures by the wealthy on private health care.

Second, resources need to be allocated to promote access to, and utilisation of, health care by the poorer socio-economic groups. The higher consumption of public inpatient health care services by wealthier groups is a striking example of inequitable utilisation, as is the relatively greater levels of government subsidy received by wealthier groups, even for primary health care.

Third, the impoverishing effect of out-of-pocket payments exposes poorer households to financial risk, driving households into poverty or further into poverty. This requires reconsideration of public hospital user fees, both in terms of the level of fees and the application of bypass fees (which are charged when patients bypass primary health care facilities, including because of the severity of their conditions and their proximity to higher-level health facilities).

Finally, Zambia’s ambition to introduce social health insurance as a mechanism for improving the pooling and purchasing of services needs to be scrutinised for its possible impacts on equity. The proposed social health insurance scheme would require co-payments and perhaps other contributions, which would increase the financial burden on households. This means that the proposed scheme could effectively run counter to the ambition of attaining universal health coverage. There should be a critical evaluation of the alternative option of simply continuing – and strengthening - the current tax-based financing system.
References


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More about GNHE …

GNHE is a partnership formed by three regional health equity networks – SHIELD (Strategies for Health Insurance for Equity in Less Developed Countries Network in Africa), EQUITAP (Equity in Asia-Pacific Health Systems Network in the Asia-Pacific, and LANET (Latin American Research Network on Financial Protection in the Americas). The three networks encompass more than 100 researchers working in at least 35 research institutions across the globe.

GNHE is coordinated by three institutions collaborating in this project, namely: the Mexican Health Foundation (FUNSALUD); the Health Economics Unit of the University of Cape Town in South Africa; and the Institute for Health Policy based in Sri Lanka.

More information on GNHE, its partners and its work can be found at http://gnhe.org