Health Financing Progress Matrix assessment

Zambia 2024

Summary of findings and recommendations

Republic of Zambia
Ministry of Health

World Health Organization

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Foreword

Zambia is committed to improving the health on its Citizens to ensure a Nation of Healthy and Productive People by providing equitable access to cost-effective, quality health services as mandated by the constitution. The constitution requires the State to guarantee the right to life and right to health. Therefore, the national health policy and the strategic plan align to the constitution, the national development plan as well as regional and global commitment on health including the need to move towards Universal Health Coverage (UHC); one of the United Nations (UN) Sustainable Development Goals (SDGs) targets.

Achieving UHC require a resilient health system including a robust health financing system. Therefore, Zambia continues to reform its health system including financing as means of accelerating progress towards UHC. To guide health financing reforms towards UHC, the Ministry of Health developed and is implementing a national health financing strategy (2017-2027). The Ministry uses various approaches to gather and analyze data to track health financing strategy implementation, identify gaps and institute appropriate corrective actions. These include amongst others household health expenditure surveys, public expenditure review, national health account studies and more recently the health financing progress matrix (HFPM). The HFPM adds qualitative dimensions to assessing progress on UHC.

The World Health Organization (WHO) HFPM tool guides assessment of a country's health financing system against a set of evidence-based benchmarks that have been noted as key in making progress towards UHC. This report adopted the WHO HFPM method to assess our health financing system performance. It is the second assessment the country has conducted using the HFPM tool. It updates the previous assessment using a revised version of the HFPM tool, the HFPM 2.0.

The present report, explores Zambia's health financing landscape, providing a comprehensive analysis of the country's health financing and makes critical recommendations on strategic changes needed to improve our country's health system financing. The report points out the need to sustain improvement in public funding for health, progressively reducing reliance on external funding, reducing fragmentation and moving towards strategic purchasing. It also calls for improvement in public financial management system including incorporating flexibility to enhance decision making space for frontline health workers. The report emphasizes the need to enhance allocative and technical efficacies in the health sector, to ensure more health for the funds channeled to the health sector. Therefore, the Ministry of Health through the relevant departments and other stakeholders shall develop and implement action plans addressing the reports' recommendations in the spirit of improving our health system financing and accelerating progress towards UHC.

The Ministry of Health is grateful to the staff, cooperating partners and other health stakeholders, who contributed variously to the development of this report.

Prof. Christopher Simoonga
Permanent Secretary – Administration
MINISTER OF HEALTH

About the Health Financing Progress Matrix

The Health Financing Progress Matrix (HFPM) is WHO's standardized qualitative assessment of a country's health financing system. The assessment builds on an extensive body of conceptual and empirical work and summarizes "what matters in health financing for Universal Health Coverage (UHC)" into nineteen desirable attributes, which form the basis of this assessment.

The report identifies areas of strength and weakness in Zambia's current health financing system, in relation to the desirable attributes, and based on this recommends where relevant shifts in health financing policy directions, specific to the context of Zambia, which can help to accelerate progress to UHC.

The qualitative nature of the analysis, but with supporting quantitative metrics, allows close-to-real time performance information to be provided to policy-makers. In addition, the structured nature of the HFPM lends itself to the systematic monitoring of progress in the development and implementation of health financing policies. Country assessments are implemented in four phases as outlined in Fig. 1; given that no primary research is required, assessments can be implemented within a relatively short time-period.

Fig. 1: Four phases of HFPM implementation

Phase 2 of the HFPM consists of two stages of analysis:

- Stage 1: a mapping of the health financing landscape consisting of a description of the key health coverage schemes in a country. For each, the key design elements are mapped, such as the basis for entitlement, benefits, and provider payment mechanisms, providing an initial picture of the extent of fragmentation in the health system.

- Stage 2: a detailed assessment based on thirty-three questions of health financing policy. Each question builds on one or more desirable attribute of health financing and is linked to relevant intermediate objectives and the final goals of UHC.

Countries are using HFPM findings and recommendations to feed into policy processes including the development of new health financing strategies, the review of existing strategies, and for routine monitoring of policy development and implementation over time. HFPM assessments also support technical alignment across stakeholders, both domestic and international.

Further details about the HFPM are available online: https://www.who.int/teams/health-systems-governance-and-financing/health-financing/diagnostics/health-financing-progress-matrix

About this report

This report provides a concise summary of the Health Financing Progress Matrix assessment in Zambia, identifying strengths and weaknesses in the health financing system and, extending from this, priority issues which need to be addressed to accelerate progress towards UHC. Findings are presented in several different summary tables, with each providing varying levels of detail.

The first section providers an overarching summary of the assessment, highlighting the substantial progress over the past twenty years, and highlight four areas of policy which can support continued progress on a positive trajectory. Table 1 provides a high-level summary for each of the seven assessment areas, based on the core health financing functions, directed toward senior officials interested in the broader picture of health financing. Table 2 then provides a more detailed summary using by each of the nineteen desirable attributes of health financing, which signal what a high performing health financing system looks like and will be of interest to those working on the details of policy design and implementation.

By focusing both on the current situation, as well as priority directions for future reforms, this report provides an agenda for priority analytical work and related technical support for the coming years. The latest information on Zambia's performance in terms of Universal Health Coverage (UHC) and key health expenditure indicators, are also presented. Detailed responses to individual questions are available on the WHO HFPM database or alternatively upon request.

This assessment is a living document and is published with a view to receiving further feedback and comments from those engaged in health financing policy development and implementation in Zambia, to further improve it over time.

Acknowledgements

The World Health Organization (WHO) and the Ministry of Health, Zambia, would like to thank all those who contributed to the completion of this assessment. WHO is especially thankful to the Ministry of Health for commissioning this study and for their support throughout the process and would in particular like to thank the Department of Policy and Planning for coordinating the implementation of the assessment.

Special thanks go to the three technical staff in the Department of Policy and Planning, Ms. Maudy Kaoma (Chief Planner), Ms. Mwango Ng'uni (Senior Planner) and Mr Oliver Kaonga (USAID Revenue for Growth, Health Financing Advisor), for their commitment in providing the necessary reference documents, for critically reviewing the initial drafts of this work, and for providing comments which helped to improve the document. The feedback provided by the technical team at the Ministry of Health during their busy schedule is greatly appreciated.

Special thanks also go to the Principal Investigator, Mr Gemini Mtei, two external peer reviewers Professor Sophie Witter and Dr Solomon Kagulura, former Technical Officer, WHO Country Office in Zambia, Lusaka, and now Senior Health Specialist, World Bank country office in Zambia, for allocating their time to review earlier drafts of the Health Financing Progress Matrix (HFPM). Their independent review input helped to significantly improve the analysis and come to consensus in scoring the different attributes of this HFPM analysis.

Gemini Mtei (independent consultant), Justine Hsu (WHO headquarters, Geneva) and Joe Kutzin (independent consultant) developed this report. Dr Matthew Jowett (WHO headquarters) provided guidance and oversight. Mr Juan Gregorio Solano, WHO headquarters, Geneva, Switzerland, compiled and analysed data from official sources to generate all charts and diagrams used in the report.

This work was prepared in the context of the Country Cooperation Strategy between the Ministry of Health, Zambia, and the WHO Country Office in Zambia, Lusaka, and was made possible thanks to the funding from WHO's core funders, with additional support from the United Kingdom of Great Britain and Northern Ireland and the Universal Health Coverage Partnership funded by the European Union.

Abbreviations

AFRO	WHO Regional Office for Africa
CHE	Current Health Expenditure
DHO	District Health Office
DRGs	Diagnosis Related Groups
DTP3	Diphtheria, Tetanus Toxoid and Pertussis Vaccine
EPHS	Essential Package of Health Services
EXT	External
GDP	Gross Domestic Product
GFF	Global Financing Facility
GGHE-D	Domestic general government health expenditure
GHO	Global Health Observatory
HDU	High Dependency Unit
HFPM	Health Financing Progress Matrix
HIV	Human Immunodeficiency Virus
ICU	Intensive Care Unit
IMF	International Monetary Fund
LMI	Lower middle income
MRI	magnetic resonance imaging
NCD	Noncommunicable diseases
NGO	Nongovernmental organization
NHA	National Health Account
NHIMA	National Health Insurance Management Authority
NHIS	National Health Insurance Scheme
OOPs	out-of-pocket payments
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PHC	primary health care
PI	Principal Investigator
RAF	Resource Allocation Formula
RMNCH	Reproductive, Maternal, Newborn, and Child Health
SDG	Strategic Deliverable Goals
SHI	Social Health Insurance
NHIS	National Health Insurance Scheme
TB	Tuberculosis
UHC	universal health coverage
USD	United States Dollar
WHO	World Health Organization
ZAMMSA	Zambia Medicines and Medical Supplies Agency

Executive Summary

The Ministry of Health in collaboration with the World Health Organization (WHO) conducted assessment on the Zambia health financing system using the WHO Health Financing Progress matrix (HFPM) tool. The assessment was conducted to identify strengths and weaknesses in the health financing system and, priority issues which need to be addressed to accelerate progress towards UHC.

The assessment findings indicate a remarkable progress towards UHC as reflected in the UHC Service coverage index (UCI) steady increase from 27 percent in 2000 to 56 percent 2021. However, these remained below the average score for lower-middle income countries.

The country is implementing Health Financing Strategy 2017-2027 which was developed though a transparent and consultative process. The government allocation to the health sector fluctuated between 5.5% and 9.4% on the national budget between 2009 – 2021, translating into a per capita government spending ranging from US$19 in 2009 to US$32 in 2021.

The revenue sources are generally progressive, with the proportion of total current health expenditures coming from out-of-pocket spending declining from 45% in 2000 to 7% in 2021. Domestic public expenditures represented 43%, however external financing continues to constitute a large proportion of current health expenditure; 49% in 2021.

Government health budget is the primary mechanism for pooling and redistribution of resources, supporting free primary care for all citizens. More generally there are multiple fragmented pools that includes Central Treasury, National Health Insurance Scheme (NHIS), health basket fund, vertical programmes, and private health insurance companies. The NHIS established to reduce fragmentation and improved the health system capacity to redistributive risks still has limited capacity. Purchasing of health services is largely passive and provider payment mechanisms do not adequately incentivize improvements in the quality of care.

There are likely duplications in covered services between the budget funded EPHS, the benefits package of the NHIS, and some services provided through vertical disease programmes. For example, the EPHS provides free primary care services for all, and both the NHIS and the vertical programmes have no co-payments for their services, which include some of the EPHS.

In Conclusion, this assessment indicate that the country has made significant progress in moving towards UHC. Several desirable attributes for UHC such as good governance, transparency and accountability for public funds, well defined benefits package, and reduction in OOP were palpable. However, there are areas that needs further work, especially increasing the proportion of public health expenditure so that there is decreasing reliance on external sources of funding and circumvent associated potential predictability and fragmentation issues. There is also a need to improve health system capacity for risk redistribution, moving towards strategic purchasing and reduction in duplications in activity funding through better coordination of the various pools. Alignment of the external funding to the annual plans and sharing records of donor funding to be captured through the PFM system is also critical.

Methodology and timeline

Zambia was part of the first wave of countries which worked with a prototype of the Health Financing Progress Matrix instrument (version 1.0) in 2019. Following the revision and launch of version 2.0 in December 2020, Zambian officials attended several webinars to discuss and debate the value-add of the instrument and discuss a number of implementation issues.

In early 2022, the Ministry of Health requested a further briefing to the Health Care Financing Technical Working Group (HCF TWG), leading to a formal request to WHO Zambia Country Office to support the implementation of the HFPM. Two senior staff together with the WHO Zambia counterpart subsequently attended a one-week training event convened by WHO in Victoria Falls, Zimbabwe in June 2022 for fifteen countries from east and southern Africa.

A Tanzanian health financing expert, with experience of the HFPM, was hired to act as the Principal Investigator for the assessment late in 2022, working closely with the Zambian technical team which included technical staff from the Ministry of Health, the World Health Organization representative in the WHO Country office in Zambia, and from other stakeholders in the HCF TWG through the first half of 2023.

The Principal Investigator conducted a first analysis of the literature provided by the Zambian team, populating Stage 1 and Stage 2 of the HFPM. Preliminary drafts were shared with the technical staff in the Ministry of Health, Zambia, for review and input. Necessary refinements were made to accommodate comments, with the report submitted for external review in late summer 2023.

External review was conducted independently by two health financing experts not closely involved with assessment, who then met to consolidate feedback. As a result of subsequent discussion with the Principal Investigator, changes were made to the scores for two questions, although refinements were made to the analysis on a number of other questions as a result of a robust discussion.

The report summarizing key findings was then developed jointly by the Principal Investigator, and input from Justine Hsu, WHO Geneva, with high level messages drafted for discussion by Joseph Kutzin, (former Head WHO Health Financing Unit, WHO Geneva).

The Principal Investigator was an external consultant hired through a WHO procurement contract; declaration of conflict of interest was managed in the processes related to this contract.

High level findings and recommendations

Zambia has shown remarkable progress on UHC from 2000 – 2019, and health financing policies should focus on reinforcing and sustaining this improvement. Average levels of service coverage steadily increased over the period, and income-related inequalities for selected RMNCH indicators reduced, especially since 2013. Coinciding with this, there appears[1] to have been a reduction in dependence on out-of-pocket (OOP) spending, both in real per capita terms and as a proportion of total health spending. While the most recent data point for catastrophic expenditure is from 2010 (and showed a sharp decline since 1996), the relatively low level of OOP spending is consistent with at least the maintenance of the low levels of financial hardship arising from out-of-pocket health spending. While the reasons for this are not known with certainty, health financing decision-makers are advised to reinforce the aspects of the system that have a plausible link to these results while concurrently addressing emerging as well as long-standing barriers to sustained progress.

1. Protect levels of public spending on health. During the period 2009 to 2021, Zambia's overall government spending as a share of GDP has nearly doubled from 17.8% to 30.4%. During that same period the share of this spending allocated to the health sector initially decreased from 9.4% in 2009 to 5.5% in 2013, after which the share fluctuated but showed a general increase to 9.3% in 2021. These effects combined to yield an increase in public spending on health in GDP to 2.8% in 2021, compared to the 2009 figure of 1.7%. In per capita terms (constant 2021 dollars), there has been a general increase since 2009 from US$19 per capita to US$32 in 2021, albeit with some fluctuations. Going forward, maintaining, or even increasing the prioritization for health will be important, particularly if high levels of budget execution continue. However, the overall fiscal situation may not enable continued increases in overall public spending, especially given increased debt service obligations and other concerns arising from the fallout from Covid-19 for economic growth, poverty, inequality, and fiscal capacity. More positively, the debt restructuring agreement reached in mid-2023 may limit the immediate threat of budget cuts, and indeed, protection of social spending is supported by the IMF and other partners. Health policy-makers and advocates should build on this by incorporating Zambia's relatively good performance to date, as well as performance challenges, into budget dialogue – which may already be happening given that the planned allocations for 2023 and 2024 show increases in health's share of the government budget. Even with this supportive climate, however, the magnitude of any increase in the level of public spending on health is likely to be small. Thus, the bulk of our recommendations focus on spending better rather than spending more.

1 The more recent OOPS estimates are extrapolations from past trends, as there have been no household surveys in the last several years. Thus, caution is warranted with respect to the precision of these figures, though the broad patterns are likely to be accurate.

2. Reinforce policies and actions, including prioritization of public resources, to ensure effective access to primary care services.

a) There has been a convergence of the service benefits that are funded by the government health budget for all Zambians through the Essential Package of Health Services (EPHS) with the availability of free services in primary care facilities, and the structure of the budget reinforces this. Infrastructure investments to extend facilities to previously underserved areas and a large increase in the recruitment of health workers since 2017 have likely also contributed, reducing the burden of transport costs for remote populations. Reinforcing the provision of free services in primary care facilities, which the population appears to understand and has come to expect (though this understanding should be monitored in future quantitative and qualitative research), remains the priority for any potential incremental increases in public spending on health.

b) Despite progress with output-based budgeting and overall public financial management (PFM), there remain challenges in getting operational funds to frontline service providers. Addressing this demands urgent attention in order to achieve greater efficiency and productivity in service delivery. Although frontline staff in larger facilities have some authority to make spending decisions, the current imprest system does not deliver adequate results compared with possible alternatives to *enable greater flexibility* in resource use by softening line-item constraints, approval thresholds for virement, and other PFM reforms such as bank accounts for those primary care facilities that have sufficient staffing to cope with the managerial requirements. With adequate support in terms of both skills and management systems, this can be implemented in a phased manner that is sensitive to the different capacities that exist across the country currently. Such measures will increase the potential to bring greater efficiency and accountability by empowering facilities to directly manage and account for their funds from all sources.

3. Sustain progress by incorporating external flows to vertical programmes within the overall health financing policy framework. The heavily donor-funded disease control programs have contributed to progress on HIV, TB and malaria, and these have driven improvement in the overall service coverage index. However, the fiscal outlook and unclear situation for the future of flows from global health initiatives means that the sustainability of past positive trends is in question. This elevates the importance of addressing the system-wide (cross-programmatic) costs of maintaining the vertical programs in their current structure, because parallel arrangements for financial flows and underlying systems such as for health information implying large costs to government going forward. The governance issues for these programs raise concerns, and in line with government's intention to incorporate external funding as budget support, they need to be brought on-budget and more explicitly into the Ministry of Health policy framework, to enable enhanced continuity of care for persons with multiple conditions or risk factors (e.g., delivering mothers), address potentially costly duplications, and identify synergies that offer the potential to improve the efficiency and coverage of the overall health system.

4. Establish a unified benefits framework across schemes and programs to enable more explicit complementarity in health spending. There appear to be duplications in covered services between the budget funded EPHS, the benefits package of the NHIS, and some services provided through vertical disease programmes. For example, the EPHS provides free primary care services for all, and both the NHIS and the vertical programmes have no co-payments for their services, which include some of those in primary care. In a context of (at best) slow growth in public spending on health and the risks inherent in dependence on external funding, moving towards explicit complementarity in the detailed design and funding arrangements for these schemes and programmes

is needed to enable progress on both levels and inequalities of service coverage and financial protection to be sustained. This will require defining more precisely the roles and responsibilities between these three groups of coverage programs and the agencies that manage them. While low levels of NHIS enrolment are indeed a concern, there is a need for clarity on its role in the system, relative to the other players, so that policies to expand affiliation to the scheme can be more coherent with overall system objectives and the flow of funds to providers. Some priorities for attention and action:

a) *Make "explicit complementarity" between the budget funded EPHS, the NHIS, and the vertical disease programmes a policy priority* by establishing a unified benefits framework for the entire population across all of these coverage programs rather than in parallel for each one. This must go beyond "what is declared on paper" to get at the actual flow of funds, the specific services that are covered or not covered, and the funding sources for the inputs of the health delivery system. Deeper research is needed to establish more precisely where the overlaps are, as is engagement with all key stakeholders involved in the governance of these programs and schemes, though the overall process should be led by the Ministry of Health to ensure coherence in overall design.

b) Explore specific design features across the schemes and programmes that can either be merged or for which compensating measures can be established. In particular, *unpack the roles and responsibilities for implementing the purchasing function to identify potential opportunities for consolidation*. For example, move now towards a unified patient information system, with the concrete aim of establishing unified or inter-operable national databases (e.g. inpatient, outpatient, enrolment) that can serve multiple purposes, rather than a separate database for each purpose.

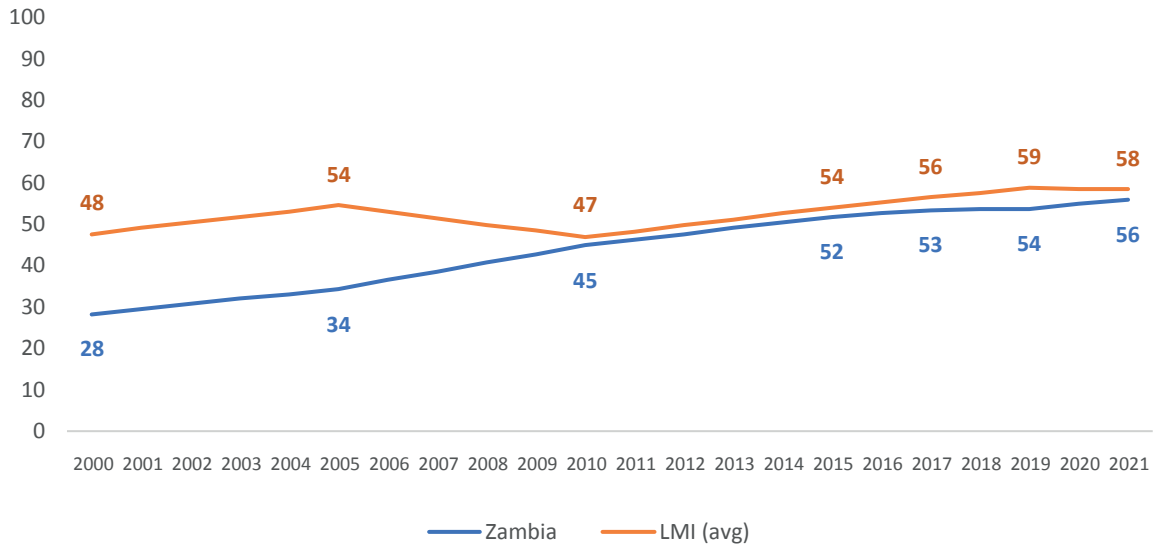
c) In turn, *identify specific objectives for such unifying actions*. These could be in terms of improving efficiency given the higher cost of running multiple systems rather than one integrated system, the potential gains of consolidation all citizens in one database by allowing for more robust simulation of various reform scenarios, and improved quality as a result, for example, of better care coordination for delivering mothers also at risk of HIV infection. Ultimately, it will be harder to drive systemic improvements in a context of multiple, uncoordinated financial flows and purchasing agencies under separate governance, so strengthening coherence in this respect is especially important.

d) Because any shift to merge or coordinate currently separate programmes and schemes will likely be challenged by those who currently control resources (e.g. vertical programme managers, Ministry of Labour), *integrate political economy analysis as an ongoing part of health financing reforms*. There are multiple ways to improve complementarity, and it is important to explore politically feasible options rather than those which are only technically sound. Power and influence will matter. It will be essential, however, to keep the complementarity objective in mind as a guiding factor so that any options that are developed (which inevitably will involve some compromises) are still aligned with this vision.

Universal health coverage (UHC) performance in Zambia

SDG indicator 3.8.1 relates to the coverage of essential services and is defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, noncommunicable diseases and service capacity and access (World Health Organization, 2021). The service coverage index is a score between 0 and 100, which in Zambia has increased steadily since 2000 (see Fig. 2).

Fig. 2: Service coverage has steadily increased in Zambia since 2000



Source: Global Health Observatory 2023 (https://www.who.int/data/gho/data/themes/topics/service-coverage), accessed 1 August 2023)

For some service components of the index, it is possible to obtain disaggregated information, as shown in Fig. 3, which provides a picture of inequalities in access, although latest data are for 2018. For antenatal care, there was a dramatic improvement in equitable access since 1996, although worryingly this took place within an overall decrease in household coverage, notably amongst the two wealthiest income quintiles. In contrast, improvements in equitable DTP3 coverage have taken place within absolute improvements in coverage across the entire population.

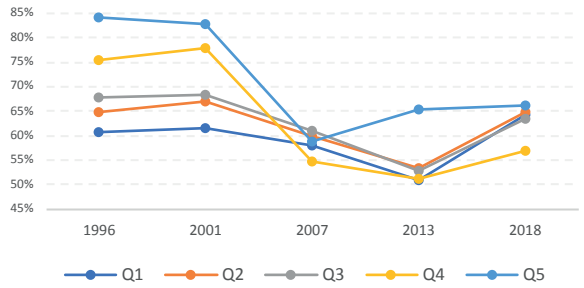
Fig. 3: Antenatal care and DPT3 coverage by quintile in 2018

Antenatal care +4 visits

National average (2018): 63.1%

Value by quintile – 2018

Q1 (poorest)	Q2	Q3	Q4	Q5 (richest)
64.3%	64.9%	63.4%	56.8%	66.2%

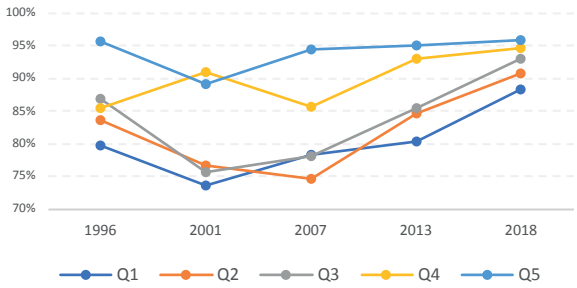


DTP3 coverage 1 year

National average (2018): 92.3%

Value by quintile – 2018

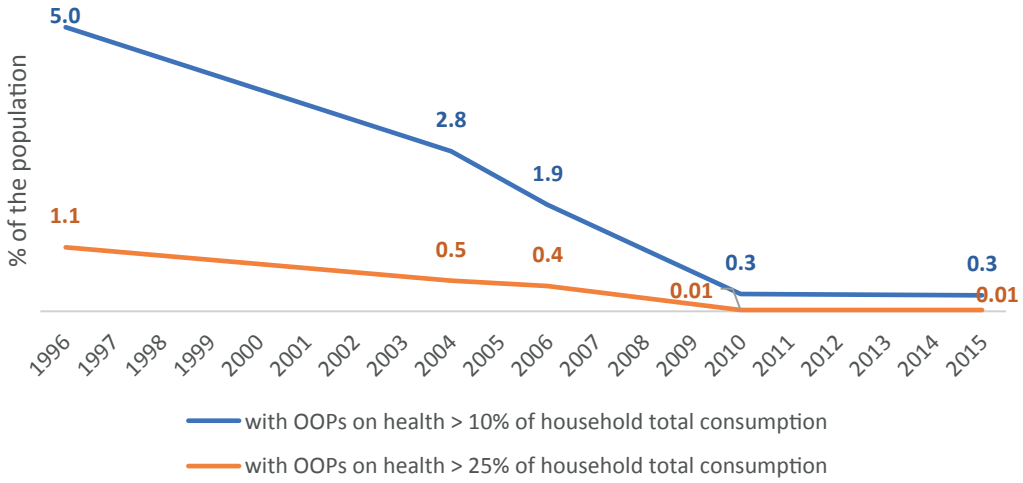
Q1 (poorest)	Q2	Q3	Q4	Q5 (richest)
88.4%	90.8%	93.0%	94.6%	96.0%



Sources: Antenatal care +4 visits – https://apps.who.int/gho/data/view.main.94030, accessed 1 August 2023; DPT3 coverage 1 year – https://apps.who.int/gho/data/view.main.94200, accessed 1 August 2023

SDG indicator 3.8.2 relates to financial protection, measured in terms of catastrophic spending, and defined as the "Proportion of the population with large household expenditure on health as a share of total household expenditure or income". Large is defined using two thresholds first greater than 10% of the household budget and secondly greater than 25% of the household budget. Both indicators have been declining, and thus financial protection has been improving in Zambia, although data only run up to 2015 (see Fig. 4).

Fig. 4: Trend in catastrophic health spending in Zambia 1996–2015



Source: https://www.who.int/data/gho/data/indicators/indicator-details/GHO/population-with-household-expenditures-on-health-greater-than-10-of-total-household-expenditure-or-income-(sdg-3-8-2)-(-), accessed 1 August 2023

Summary of findings and recommendations by assessment area

Using the guidance provided in the Health Financing Progress Matrix Country Assessment Guide, the next section summarizes the key findings and recommendations for Zambia to consider in order make further progress towards UHC.

For each of sections below, recommendations are drawn directly from the extensive review of evidence conducted by WHO and documented in the Health Financing Progress Matrix data collection template. WHO has summarized what has worked in other countries with regards to health financing reform in the different areas of health financing in order to make progress towards UHC. Hence the recommendations in this report are rooted in global evidence of what works in health financing but specifically adapted to the current situation in Zambia.

Table 1: Summary of findings and recommendations

Assessment area	Summary findings	Status
Health Financing Policy Process & Governance	The Government of Zambia has a well-established health financing policy environment. There is a health policy and financing strategy that clearly stipulates the ambition to achieve UHC, and policy arrangements prioritize delivery of PHC services to address the needs of the majority of the population. Nevertheless, challenges remain in monitoring effective implementation of these policies, including the monitoring of the implementation of the free PHC policy, which needs improved coordination. There is also a need to establish accountability systems to strengthen the monitoring of vertical health programmes.	Progressing ●●○○
Revenue raising	Despite some fluctuations in domestic public expenditures on health, there has been a slight increase since 2009, both as a proportion of GDP and in absolute terms (see Fig. A1.5). Overall, revenue sources are progressive with the proportion of total current health expenditures coming from out-of-pocket spending which have declined significantly over the past two decades from 45% in 2000 to 7% in 2021. However, there continues to be a high dependency on external financing, which represented 49% of total current health expenditure in 2021; thus, external financing was of slightly greater importance than domestic public expenditures which comprised 43% of the total that same year. It is critical to improve coordination with external partners, advocating for greater on budget support. An initial mapping of external funds to budget lines would help to identify duplications and gaps and aid in a transition towards greater reliance on public spending.	Established ●●●○
Pooling revenues	The government health budget is the primary mechanism for the pooling and redistribution of resources, supporting free primary care for all citizens. The NHIS was recently launched but plans to subsidize premiums for the poor are still under development and yet to be implemented. Similarly, further efforts to enrol informal sector workers into the NHIS, drawing on the experience of other countries, should be developed. Further scale-up of the NHIS through the expansion of coverage, in particular to vulnerable populations such as people with disabilities, HIV/AIDS, tuberculosis and malaria, requires financial resources to be identified, which harmonize rather than further fragment health financing flows.	Progressing ●●○○

Table 1: Summary of findings and recommendations

Assessment area	Summary findings	Status
Purchasing and Provider Payment	Zambia uses a resource allocation formula to distribute funds to district health offices (DHOs), which helps to align resource flows with population health needs across districts. Funds are disbursed according to budget line items. Hospitals receive funds directly from the central Ministry of Health, with DHOs responsible for the disbursement of funds to individual health facilities, conducted through an imprest mechanism. However, not all funds earmarked for health facilities are fully disbursed, with some held by the DHO who uses it to pay for utilities and to procure inputs, which are then 'disbursed' to facilities in-kind. Purchasing of health services remain passive and provider payment mechanisms (e.g. fee-for-service, case-based, DRGs) do not adequately incentivize improvements in the quality of care. For example, while the NHIS enters into contractual arrangements with providers, specific quality-related requirements that are more process-oriented versus structural are lacking and should be built in as requirements. In addition, budget control can be further improved by shifting to capitation for PHC services and away from too much reliance on FFS at higher levels of care.	Established
Benefits and conditions of access	Zambia has a benefit package of PHC services, which is a universal entitlement, i.e. for the entire population, however the package is outdated and most of the population is not aware of their entitlements. Packages of health services are, however, well defined according to levels of health services and workforce categories. Additionally, even though user charges were abolished at the primary health care level, patients still are requested to pay when they go to the hospital. There is a lack of clarity regarding the design of the NHIS benefit package in terms of the process for selecting interventions to ensure they meet population health needs, are cost–effectiveness, provide financial protection, etc. There is a need to invest in building capacity to generate such evidence and to define a regular process which engages the population in revisions of the package. Alignment with the budget is also of concern as the proportion of the government budget allocated for primary care services has been declining in recent years and should be re-prioritized.	Progressing
Public financial management	The budget formulation process in Zambia is highly consultative. The Ministry of Health is engaged in budget negotiations through dedicated hearing sessions with the Ministry of Finance. However, there is limited flexibility in the use of budget funds due to line-item control rigidities. Consideration of more flexible modalities that would allow for mid-year reallocation of the budget would better support priorities. In terms of the ability of providers to receive, manage and report on funds, only district hospitals and above can receive directly funds and manage spending according to their priorities. Funds earmarked for PHC facilities are managed by DHOs and where not all funds allocated for health facilities are disbursed. A review of how facility funds are managed, requests for DHOs to provide expenditure reports, and/or formal recognition of PHC facilities as fund managers and spending entities (alongside both building capacity and developing parallel mechanisms of accountability) would be beneficial.	Established
Public Health Functions and Programmes	Disease and public health programmes are implemented in parallel to central budget funded services, creating fragmentation and a risk of inefficient duplication in fund flows. In turn, this can lead to inefficiency in resource use and service provision. Positively, sub-national levels are engaged when budgets and plans are prepared at the national level for health programmes such as Malaria. Efforts to integrate or at least align funder support to disease programmes is a key priority issues. At the moment, there are consultative meetings with funders to align support in line with key priority areas. However, more effort is also needed to address programme coordination especially by having partners align to the PFM system, specifically by moving to on-budget support (as outlined in the PFM Act 2018 and the National Planning and Budgeting Act 2020). The Government of Zambia also need to make efforts to improve, monitor, and adhere to implementation of IHR to address capacities for emergency preparedness.	Emerging

Summary of findings and recommendations by desirable attributes of health financing

Policy process and governance

Desirable attribute GV1	Health financing policies are guided by UHC goals, take a system-wide perspective and prioritize and sequence strategies for both individual- and population-based services
Key areas of strength and weakness in Zambia	**Zambia is currently implementing its Health Financing Strategy 2017-2027, which was developed after a comprehensive review across all functions of the health financing system.** The main goal is to ensure adequate, sustainable and predictable financing through existing and new sources for improved health outcomes. The specific objectives for the strategy include: 1. Provide viable options for increased resource mobilization and strengthen revenue collection; 2. Enhance efficiency in resource allocation and utilization; 3. Improve the risk pooling and redistributive capacity of funds; 4. Strengthen the strategic purchasing mechanism; and 5. Strengthen the overall PFM and information systems within the health sector. The Government of Zambia is also guided by the National Health Policy (NHP) 2012 (currently being updated), which similarly gives clear priorities to move towards the goals of UHC, including the **priority of financing essential health services from general tax revenues in a free PHC policy.** The provision of PHC to the entire population creates an effective platform to fast-track progress towards UHC goals and is complemented by the creation of the SHI.
Recommended priority actions	• Complete the update to the NHP 2012, within which identification of priorities for the short, medium and long-term are identified. • Establish monitoring mechanisms for more effective implementation of the free PHC policy. For example, by linking incremental changes with key performance indicators.
Desirable attribute GV2	**There is transparent, financial and non-financial accountability in relation to public spending on health**
Key areas of strength and weakness in Zambia	The National Planning and Budget Acts 2020 and the Public Financial Management (PFM) Act 2018 are the two instruments that guide and manage the use of public resources. **The budget formulation process is transparent and inclusive.** The PFM Act provides for required accountability for the use of public resources, including stipulation of necessary reports that need to be produced and appropriate controls. The Ministry of Health introduced the use of NAVISION systems at lower levels to improve transparency and accountability in the use of funds. **However, there are no policies to ensure accountability in the use of off budget resources such as vertical funds** across different disease programmes. About 70% of donor funding is flowing off budget and is not accounted in the public financial management system.
Recommended priority actions	• Enhance donor coordination in regards to the financing of vertical disease programmes to improve efficiency and equity. This could be done by stronger advocacy to development partners to move towards on budget support and to use the country PFM system. • Improve tracking of donor spending across different interventions and strengthen such monitoring mechanisms (e.g. by linking resources to results) to ensure effective use of donor spending on health.
Desirable attribute GV3	**International evidence and system-wide data and evaluations are actively used to inform implementation and policy adjustments**
Key areas of strength and weakness in Zambia	The country **regularly produces data through the national health accounts, public expenditure reviews and household health expenditure and utilization surveys.** These are often disseminated to stakeholders through the technical working groups. **However, the evidence produced is not always up-to date**, which may limit the extent of its relevance for informing policy adjustments. Further there is limited evidence on the performance of some aspects of health financing, such as the purchasing of health services through the prepayment scheme (NHIS).
Recommended priority actions	• Build local capacity to enable production of NHA and other technical reports on a more regular and timelier basis. • Disseminate evidence more broadly (e.g. published on ministerial web sites, presented in various policy fora) in order to ensure policies are informed by the data.

Revenue raising

Desirable attribute RR1	Health expenditure is based predominantly on public/compulsory funding sources
Key areas of strength and weakness in Zambia	**Although there have been fluctuations over time, the general trend shows a slight increase in domestic public expenditures on health** since 2009, both as a proportion of GDP and in absolute terms. General tax plays an important role in financing health care in Zambia with an increase in the health sector allocation as a share of the national budget in the last three years. Budget allocation to the health sector for 2023 was 10.4% of total budget (Ministry of Finance, 2022). **Out of pocket payments were relatively low, representing 7% of total current health expenditure in 2021.** However, the health sector remains heavily donor-dependent with **external financing representing 49% of total current health expenditure in 2021** and thus was even of a slightly greater importance than domestic public expenditures which comprised 43% of the total that same year. In addition, 70% of donor funding is earmarked for specific programmes, often through off budget arrangements, posing concerns over efficiency and effectiveness in financing.
Recommended priority actions	• The Government of Zambia should continue to maintain positive trends showing a decline in reliance on out-of-pocket spending with parallel increases in public funding. • During budget negotiations, cite evidence to more effectively advocate for increases in the general budget priority to health. • Improve alignment of external funds by starting with a review of how donor supported initiatives are organized within the overall health (financing) system. For example, an initial mapping of external funds to budget lines would help to identify duplications and gaps.
Desirable attribute RR2	**The level of public (and external) funding is predictable over a period of years**
Key areas of strength and weakness in Zambia	Data on domestic general government health expenditure remained predictable over recent years (i.e. $30 per capita in constant (2021) US$ in 2017, $27 in 2019 and $32 in 2021). On the other hand, external funding has been unpredictable over recent years (i.e. $18 per capita in constant (2021) US$ in 2017, $46 in 2019 and $37 in 2021). The Government of Zambia does have a Medium-Term Budget Plan (MTBP), which is a three-year rolling macroeconomic framework, meant to enhance predictability; however, the extent to which this enhances predictability in the health sector specifically is unknown.
Recommended priority actions	• There is also a need to improve coordination with external partners to improve predictability of external financing, as well as advocate for greater on budget support. • A sector-specific medium-term expenditure framework would further aid enhancing predictability.
Desirable attribute RR3	**The flow of public (and external) funds is stable and budget execution is high**
Key areas of strength and weakness in Zambia	Budget execution has not been steady over the last decade. From a very high execution rate of 98% in 2015, execution has been declining over time to 70% in 2021. Thus, recent trends suggest that the government is not disbursing funds according to budget commitments.
Recommended priority actions	• Consider an updated analysis of PFM in the health sector in order to identify country-specific bottlenecks in budget execution, more specifically this could map major funds and related rules regarding their disbursement.
Desirable attribute RR4	**Fiscal measures are in place that create incentives for healthier behaviour by individuals and firms**
Key areas of strength and weakness in Zambia	**In September 2018, the Government of Zambia introduced a 3% excise tax on soft drinks.** The main objective for this tax is clearly stated **as a means to control prevalence of NCDs** in Zambia by reducing consumption of sugar sweetened beverages. **However, the rate imposed of 3% is considered low**, and hence may not have a significant effect in changing consumption patterns. In addition, Zambia also imposes a tax on tobacco and alcohol, although it is not clearly stated whether an objective was to incentive healthier behaviour. Moreover, rates are considered low (i.e. the excise tax share was 21.5% in 2022, which is similar to the average rate for the WHO African region and for its income group but much below the WHO recommended tax share of 70%).
Recommended priority actions	• Ministry of Health to review rates based on global good practice and advocate for increasing the rates of sin taxes on both tobacco, alcohol, and sugary drinks in order to more effectively stem the consumption of products linked to NCDs. • The Government of Zambia should strengthen the administration and enforcement of taxes and impose stronger penalties to curb illicit tobacco and alcohol trade and consumption, which are harmful to health. This might help to improve population health behaviour.

Pooling revenues

Desirable attribute PR1	Pooling structure and mechanisms across the health system enhance the potential to redistribute available prepaid funds
Key areas of strength and weakness in Zambia	The public budget pools resources for the population, notably to provide the Essential Package of Health Services (EPHS). In 2019, the Government of Zambia introduced the National Health Insurance Scheme (NHIS), collecting premiums from both the formal and informal sectors. The aim of introducing the NHIS was to reduce fragmentation due to community health insurance pools across the country. It thus an important risk pool meant to guarantee access and financial protection. However, at this early stage, there is currently limited capacity to redistribute risks within it as the poor are not yet effectively enrolled and no sustainable sources have been identified nor committed to finance the poor through the NHIS. Possible avenues to address this are to revise taxation from net to gross pay as well as to introduce earmarked taxes specifically to fund the scheme to cover the poor and vulnerable populations.
Recommended priority actions	• As there are currently no committed financial resources to finance the poor through the NHIS, review options to subsidize their enrolment, e.g. earmarking sin tax.
Desirable attribute PR2	**Health system and financing functions are integrated or coordinated across schemes and programmes**
Key areas of strength and weakness in Zambia	Currently, there are multiple fragmented pools in the Zambia health financing system, including general budget at Central Treasury, NHIS, health basket fund, vertical programmes, and private health insurance companies. The NHIS is an important mechanism to harmonize benefits, entitlements, purchasing and provider payments and information systems but is still in very early stages of implementation.
Recommended priority actions	• Further scale-up of the NHIS is a promising means that could contribute towards greater harmonization of health financing functions including improved coordination of resource flows, benefit provision, and provider payment mechanisms.

Purchasing health services

Desirable attribute PS1	Resource allocation to providers reflects population health needs, provider performance or a combination
Key areas of strength and weakness in Zambia	Ministry of Health uses a needs-based resource allocation formula, which was last updated in 2012 for subnational allocations. The formula accounts for material deprivation including poverty levels, disease burden, population size and other such parameters, to allocate funds to DHOs. This formula does not extend to facilities. Distribution of funds within districts is based on guidelines which outline the proportion of resources to be spent at various levels. A 2019 Public Expenditure Tracking Survey (PETS) found that resource allocation favoured higher levels of care compared to the provision of primary health care. This was perpetuated by an inadequate number of health centres and posts within districts. Moreover, despite the allocation formula, provincial receipt of resources is reported as inequitable as the poorest and most remote or least urbanized provinces receive the lowest per capita Ministry of Health releases.
Recommended priority actions	• As there is a high reliance on donor funds, this can overshadow the importance of public funds, such that the application of needs-based resource allocation formula has limited impact. Further integration of financing flows (i.e. bringing donor funds on budget) would help to realize the gains anticipated from needs-based allocation. • To improve alignment between the flow of resources and priority population needs, the Ministry of Health may consider adopting capitation payment arrangement for PHC facilities and case-based payments for hospitals.
Desirable attribute PS2	**Purchasing arrangements are tailored in support of service delivery objectives**
Key areas of strength and weakness in Zambia	The Ministry of Health is mandated to monitor the quality of care; it conducts performance assessments of its facilities and provides technical support and capacity building where needed. In addition, all health facilities are to be accredited by the health professions council of Zambia before they can provide any services to the population. However, general government budget is disbursed to health facilities on a line-item basis, a method that is considered to be passive purchasing and does not adequately incentivize improvements in the quality of care. While the NHIS usually enters into contractual arrangements with providers prior to their provision of services to its members and where these include standards that facilities need to meet, the NHIS pays providers using a mix of fee-for-service, case-based and DRGs, which do not create an incentive to improve quality.
Recommended priority actions	• Adopt changes to provider payment mechanisms which specifically create an incentive for quality improvement, e.g. beyond simple accreditation where contracting is more selective with specific quality-related requirements that are more process-oriented versus structural.

Purchasing health services

Desirable attribute PS3	Purchasing arrangements incorporate mechanisms to ensure budgetary control
Key areas of strength and weakness in Zambia	A transition from input-based controls and line-item based payments towards more strategic purchasing arrangements with output-based budgets provides an opportunity for increased efficiencies. Further, the NHIS uses a mix of provider payment systems to counter incentives for overprovision and thus provide some budgetary control. The NHIS uses fee-for-service to pay pharmacies and diagnostic centres; in comparison, hospitals receive a flat rate payment, with different rates for inpatient and outpatient services, while diagnosis related groups (DRGs) and fee-for-service is used for high-cost interventions such as dialysis and some cardiac interventions. There is also a need to strengthen the monitoring of claims to improve cost control and detection of over-provision of services and fraudulent reporting. Regarding medicines, budgetary control is reflected through centralized and bulk procurement through the Zambia Medicines and Medical Supplies Agency (ZAMMSA) (previously the Medical Stores Limited), which is expected to bring some efficiency gains. It is important to ensure that the ZAMMSA is efficient in supplying medicine and medical supplies across all levels.
Recommended priority actions	• Consider adopting capitation payment arrangement for PHC facilities as well as greater reliance on bundled payment methods to hospitals as a means to further improve efficiency in purchasing arrangements. • Analyse other potential sources of inefficiencies linked to referrals across levels of care and use of the private sector.

Benefits and entitlements

Desirable attribute BR1	Entitlements and obligations are clearly understood by the population
Key areas of strength and weakness in Zambia	PHC services are a universal entitlement provided freely across all public PHC facilities for the entire population. This entitlement is clearly articulated in various policy documents such as the National Health Strategic Plan, which is publicly available. In addition, the list of PHC services as well as the benefit package for the NHIS is published on a public web site, however the actual level of population awareness and understanding is unknown.
Recommended priority actions	• It is important for the government to put in place an effective mechanism to ensure understanding both by providers and by the population of the free PHC policy. This would help to guarantee access to primary services as well as to referral services, especially through the NHIS. • Effort should also be put in place to increase population engagement in reviewing essential health package and NHIS benefit packages.
Desirable attribute BR2	**A set of priority health service benefits within a unified framework is implemented for the entire population**
Key areas of strength and weakness in Zambia	Under the free PHC policy, all citizens have the right to access a uniform set of services provided at PHC facilities without a fee. These include the following: 1. Primary health care services 2. Reproductive, maternal, neonatal, child and adolescent health and nutrition 3. Communicable diseases (Malaria, HIV and AIDS, STIs and TB control) 4. Noncommunicable diseases 5. Other areas of public health including Viral Hepatitis, Neglected Tropical Diseases, Ear, Nose and Throat, eye health The policy is working well in rural PHCs, however there is evidence that some users of services at urban health centres and district hospitals are paying user fees to access these services.
Recommended priority actions	• Strengthen monitoring mechanisms to ensure effective implementation of free PHC policy across facilities, especially those in urban areas. • Consider penalties in cases where the population are being charged for such services.
Desirable attribute BR3	**Prior to adoption, service benefit changes are subject to cost–effectiveness and budgetary impact assessments**
Key areas of strength and weakness in Zambia	Free health services were determined based on existing primary health care services, burden of disease, and the goal of improving financial protection. However, no cost–effectiveness or budget impact analyses were conducted.
Recommended priority actions	• Invest in building capacity to ensure that relevant cost–effectiveness studies, health technology assessments, and budget impact analyses are conducted and used to inform future revisions to benefit packages. • Build in regular revision processes to update packages as trends in epidemiological patterns evolve. • Improve engagement of the population in reviewing packages.

Benefits and entitlements

Desirable attribute BR4	Defined benefits are aligned with available revenues, health services, and mechanisms to allocate funds to providers
Key areas of strength and weakness in Zambia	While Zambia has mandated a free PHC policy, data trends show that priority in the allocation of budgets to PHC has been decreasing over time from 53.4% in 2020 to 34.3% in 2022. In contrast, the budget allocation for hospitals has increased from 30.8% in 2020 to 47.5% in 2022. In addition, as noted earlier, there is an inadequate number of health centres and posts within districts. Funds are also not flowing directly to service providers, and they often receive less than what was allocated.
Recommended priority actions	• Advocate for reprioritizing the health sector budget to fully finance the committed PHC package, better allocate resources to areas of greater need and address bottlenecks in flows to providers – doing so would also help stem informal charges being levied on the population for PHC services meant to be provided freely to all.
Desirable attribute BR5	**Benefit design includes explicit limits on user charges and protects access for vulnerable groups**
Key areas of strength and weakness in Zambia	Free PHC is a major step towards guaranteeing access and financial protection. However, there are variations in how much PHC facilities abide by the free PHC policy. For example, there had been reports that some urban health centres were charging user fees for laboratory tests and medical examinations. In regard to higher level facilities accessed via referrals user fees are charged. There are no co-payments for services covered by the NHIS and no user fees charged in targeted disease programmes.
Recommended priority actions	• Strengthen monitoring mechanisms to ensure effective implementation of free PHC policy across all facilities, especially in urban areas. • Strengthen the mechanism for referral services and review the design of related user fees with consideration of government subsidies to support exemptions for vulnerable populations. • Ensure funding is sufficient to meet provision of free PHC services and reaches facilities in order to help mitigate providers charging patients because of a gap.

Public financial management

Desirable attribute PF1	Health budget formulation and structure support flexible spending and are aligned with sector priorities
Key areas of strength and weakness in Zambia	The budget formulation process in Zambia is highly consultative and participatory. It starts with a call circular by the Ministry of Finance to provide indicative sector and programme budget ceilings and a budgetary framework outlining priorities. This is followed by a ministerial-level national launch of the planning cycle where programmatic technical updates are provided as additional guidance in setting priorities for the sector, alongside priorities already identified in the national health strategic plan. This sets the direction for the planning process in the coming year, subsequently taken forward by provincial launches of the planning and budgeting cycle. Outputs from this planning cycle are then used to develop the Ministry of Health budget which is later submitted to Ministry of Finance. Hearing sessions allow the Ministry of Health to engage in budget negotiations as ministers are able to further justify funding of priorities in their sectoral budgets. Following these budget hearings, the budget is presented to the National Assembly for debates by parliamentarians and final approval. In terms of flexibility, while a mid-term budget review is conducted to provide checks and balances and ensure that the budget is on course, there is limited flexibility in reallocations across priorities due to line-item control rigidities. While regulations allow re-allocation of funds across inputs, this can only be done after approval by the Ministry of Finance (i.e. the 2018 Public Finance Management Act No. 1 stipulates that additional expenditure requirements for one item can be met by savings from another item within their appropriation, but this adjustment has to be initiated by the controlling officer and approved by Ministry of Finance).
Recommended priority actions	Consider more flexible modalities that would allow for mid-year reallocation of the budget to better support priorities.
Desirable attribute PF2	**Providers can directly receive revenues, flexibly manage them, and report on spending and outputs**
Key areas of strength and weakness in Zambia	There is limited autonomy held by health facilities to manage funds in Zambia. Only district hospitals and above can receive funds directly and subsequently manage spending according to their priorities. For PHC facilities, funds earmarked under the central government budget flow through DHOs, who are then responsible for disbursing the funds to facilities. However, experience shows not all funds allocated for health facilities are actually disbursed to facilities and there are variations across facilities whereby some facilities received less than 60% of their allocated funds. On average, 30% remains with DHOs and are spent on behalf of facilities to pay for utilities and procurement of inputs, e.g. funds are 'disbursed' to facilities as in-kind. In terms of accessing funds, facilities do so through an imprest system, however, this has proved to be a challenge for many PHC facilities as evidenced by delays in making withdrawals. In addition, facilities are unable to receive additional funds unless they have retired the previous imprest. This largely affects rural facilities who could not always retire their imprest in time.
Recommended priority actions	• Consider formula-based capitation (refer also to related purchasing attribute) as a means to disburse budgeted operational funds to PHC facilities and to contribute to their financial autonomy. • Review accountability mechanisms in the management of facility grants, e.g. requesting DHOs to provide expenditure reports for funds earmarked for frontline service providers. • Extend formal recognition of PHC facilities as fund managers and spending entities, alongside both building of capacity and introducing parallel mechanisms of accountability.

Stage 1 assessment

The health coverage schemes included in Stage 1 were selected according to the criteria outlined in the HFPM Country Assessment Guide. The aim is not to conduct an inventory, but rather to describe the main health schemes and programmes which make up the health system, around which health financing and other policies are made, and through which money flows to health facilities. The objective is to provide a detailed description of the policies within each scheme, highlight the relative financial weight of each (see Fig. 6), and to identify the extent of any structural fragmentation within the health system.

Health coverage schemes in Zambia: health financing arrangement

Key design feature	Government Health Budget	National Health Insurance Scheme	Vertical Disease Programmes
A) Focus of the scheme	General budget includes domestic revenue and donor funds that goes through the ministry of finance for the purpose of supporting the general budget and not earmarked for specific sector or disease. General budget support is allocated to the health sector to provide Essential Package of Health Services to All Citizens. The government has specified Essential Package of Health Services (EPHS) which is an entitlement to all Citizens. This includes the following services; 1. Child health and nutrition (MNCH) 2. Integrated reproductive health 3. HIV and AIDS, TB and STIs 4. Malaria 5. Epidemics 6. Hygiene, sanitation and safer water 7. Human resources 8. Essential drugs and medical supplies 9. Infrastructure and equipment 10. Systems strengthening The general budget also covers the costs of free health care provision in primary health facilities. General budget is used to pay salaries of staff in public facilities, procurement of medicine and medical supplies and equipment.	The National Health Insurance Scheme is established under the National Health Insurance Act of 2018. The scheme aims to provide health insurance cover for the entire population of Zambia. The Scheme started effective registration of members on 1 February 2020	Focus on specific Disease/health programme financing. Vertical programmes operate outside the Treasury system (Off-budget) and allocate funds to finance disease specific interventions. Almost 70% of donor funding is earmarked for specified disease programs. More than one-third of donor expenditure is for tuberculosis and malaria and about two-thirds is earmarked for HIV and vaccination of preventable diseases. Hence, a substantial proportion of vertical programmes is prioritized for HIV services. The main disease programmes are 1. Contraception 2. MNCH 3. Immunization 4. TB 5. Malaria 6. HIV
B) Target population	All Citizens. According to the Zambia Statistics Agency, in 2022 Zambia had a population of about 19,610,769. General budget targets to provide EPHS to this population	All Zambians, who are above 18 years, are expected to enrol with NHIS. In addition, foreigners who enter Zambia are supposed to have a valid health insurance that can be used in Zambia, otherwise they are supposed to enrol with NHIS for the entire period of stay in Zambia. Employers are required to register their employees including temporal staff within 30 days of issuance of a contract. Managers of pension schemes are also supposed to ensure that a retiree is registered with the authority. Population above 65 years and below 18 years, and the indigents (the unable to pay) are exempted from contributing to NHIS. The premium for these groups is financed by the government. The National Health Insurance Management Authority (NHIMA) is supposed to explore alternative sources to pay premium for these exempted groups. The NHIS contributions allows up to 7 members of the household including the principal contributor, spouse 5 dependants below 18 years	Vertical programmes do target the entire population but with special focus in a geographic location (districts & provinces) based on donor priority informed by disease burden and other criteria. There is also a special attention to a segment of the people affected by the targeted disease condition such as HIV. Priority is usually given to disease prevention interventions.

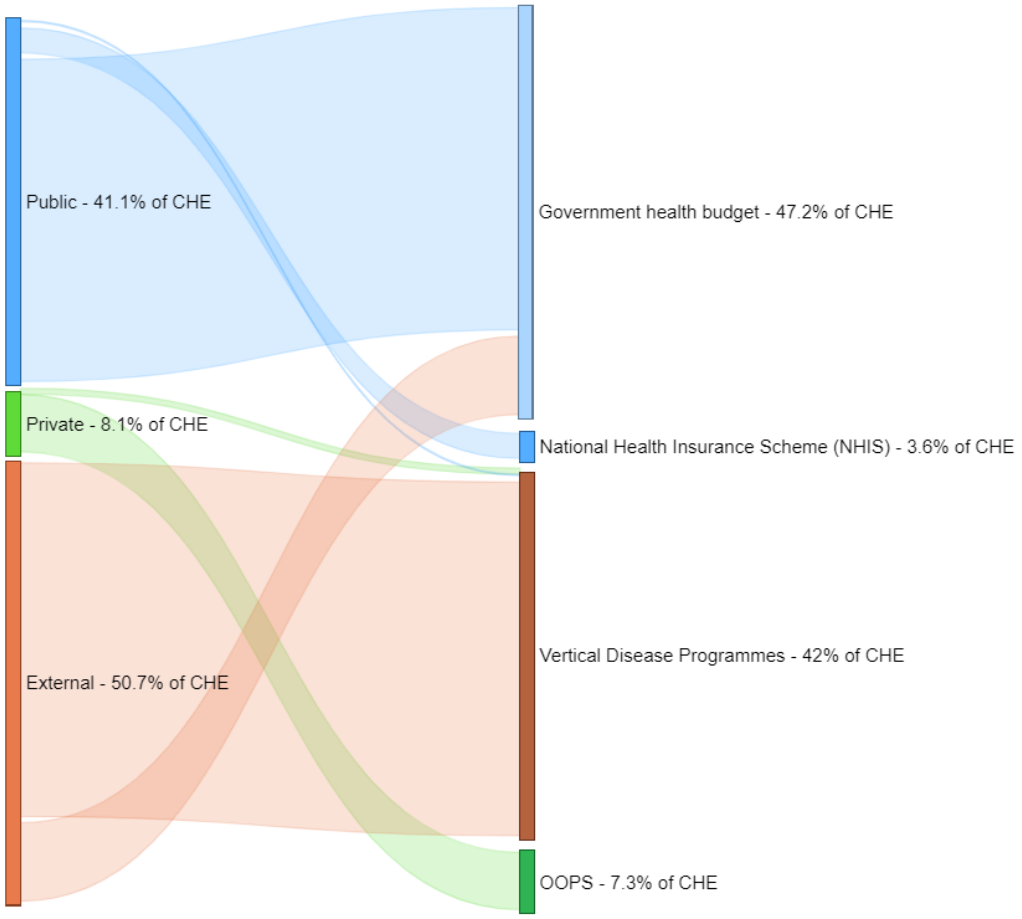
Key design feature	Government Health Budget	National Health Insurance Scheme	Vertical Disease Programmes
C) Population covered	While general budget targeted to provided EPHS to 19,610,769 in practice only those who seek care get covered. Statistics shows that out of those who were seek in 2016 (about 22%) 59.4% sought formal care while 29.9% opted for self-medication while 10% didn't seek care. This is despite the fact that health care was made free at the point of service in 2016.	About 1,350,000 principal members were covered by NHIS as of 1 February 2022. This translated to an estimate of about 7,000,000 eligible beneficiaries, equivalent to 35% of the total population. This figure includes public and private formal employees, retirees, indigenous/vulnerable, and informal sector employees. However, information from the NHIMA indicates that only 500,000 beneficiaries of the principal members are registered with the system meaning that there are still a lot of eligible members who are not using NHIS to access health services. About 70,000 beneficiaries are estimated to be accessing health care through NHIS each month.	Prevalence of priority vertical programme diseases is as follows; 1. TB (72,295 in 2018; Source: Lungu, et al. 2021) 2. Malaria (9% among under 5 children in 2018; Source: Malaria indicator survey 2018) 3. HIV (12% among adults aged 15-59 in 2016 corresponding to approximately 960,000 people living with HIV; Source: Zambia Population-based HIV Impact Assessment (ZAMPHIA))
D) Basis for entitlement/ coverage	Every citizen in Zambia is entitled to EPHS in Zambia.	Membership to NHIS is mandatory to all adults above 18 years. Formal sector employees (public and private) enrol through a payroll deduction of 1% of monthly salary paid by employer and employee. The self-employed enrol through a deduction of 1% of declared salary. Contributions for exempted groups (The poor, mentally ill, adults above 65 years and children below 18 years and other groups as identified by the Minister for Health) are paid by the government, hence their membership is automatic.	All citizens dwelling in targeted geographic location as prioritized by specific donor for a specific programme
E) Benefit entitlements	The EPHS in Zambia include the following services; 1. Child health and nutrition (MNCH) 2. Integrated reproductive health 3. HIV and AIDS, TB and STIs 4. Malaria 5. Epidemics 6. Hygiene, sanitation and safer water 7. Human resources 8. Essential drugs and medical supplies 9. Infrastructure and equipment 10. Systems strengthening	The following services are included in NHIS benefit package 1. OPD Registration and Consultation 2. Pharmaceuticals and blood products (as per the National Essential Medicines list) 3. Investigations 4. Surgical Services 5. Maternal, New-born and Paediatric Services 6. Inpatient Care 7. Physiotherapy and rehabilitation services 8. Vision care and Spectacles 9. Dental and Oral health Services 10. Cancer/Oncology services (Limited number of investigations and interventions for cervical, prostate, breast and colon cancer) 11. Mental health 12. Medical/Orthopaedic Appliances and Prosthesis The following services require Pre-authorization 1. CT – Scan (with or without contrast), 2. MRI, 3. Dialysis services, 4. CATHLAB services- angiogram, balloon & Stenting, 5. Pacemaker placement, 6. Orthopaedic Implants & Prosthesis, 7. Spectacles, 8. HDU and 9. ICU beyond stipulated period in the schedule The following services are excluded from NHIS benefit package 1. Cosmetic surgery and aesthetic treatments and associated 2. Medicines not registered with the Zambia Medicines Regulatory Authority (ZAMRA) 3. Trans-sexual surgery 4. Spectacles and artificial lenses (except if medically required) 5. Experimental Treatment 6. Treatment of occupational accidents and illness 7. Overseas health care services 8. Fertility treatment according to set criteria 9. Illegal abortion and illicit drug use	No info

Key design feature	Government Health Budget	National Health Insurance Scheme	Vertical Disease Programmes
F) Co-payments (user fees)	Essential health package that is funded by the government. These services are mainly provided at public primary health care facilities where all services are fee. However, user fees are charged for services that are outside the essential benefit provided at secondary and Tertiary level hospitals.	There are no co-payments for services covered by the NHIS	No co-payments or user fees are implemented in targeted disease programmes
G) Other conditions of access	Government budget is used to finance only public health facilities	A member is required to make 4 contributions, for four consecutive months before accessing the health services under the scheme. Issuance of prescription for spectacles is restricted to public and private hospitals and clinics only. Accredited Opticians will not be allowed to prescribe but rather provide spectacles based on prescription and after receiving pre-authorization from NHIMA. Only medicines that are stipulated in the National Essential Drug list are covered under NHIS	No info
H) Revenue sources	The general government health budget is financed by; 1. Domestic taxes and fees 2. Grants and loans from external funders	Sources of revenue for the NHIS as identified in the National Health Insurance Act 2018 are as follows; 1. Member contributions 2. Monies as may be appropriated by Parliament for the purpose of the Scheme 3. Monies as may be paid to the Fund byway of loans, grants or donations 4. Such monies as may, by or under any other law, be payable to the Fund 5. Interest arising out of any investment of the Fund 6. Such other monies as may vest or accrue to the Fund	Mainly 1. PEPFAR 2. Global Fund 3. GFF
I) Pooling	Funds for general government budgets are pooled at the Ministry of Finance at the national level. The Ministry of Finance then allocates a budget for the Ministry of Health. The Ministry of Health at the central level then allocates funds to Provinces and Districts. The District Health Office is responsible for managing funds for primary health facilities. All Consolidated Funds i.e. funds for budget support, are pooled under the Treasury Single Account.	Revenues are collected into a single central pool. All revenues to the scheme are s kept in bank account designated for the scheme.	Vertical programmes are highly fragmented with different donors coming up with different funding modality. NGOs are the main Schemes for vertical programme funds.
J) Governance of health financing	Funds disbursed by the Ministry of Finance to different levels of the government are supposed to be audited by the Internal Auditors to make sure that the process of use of funds abide to rules and regulations stipulated by the Public Finance Act (Public Finance Act 2018). All funds are also Audited by the External Auditor (The Auditor General) District Health Offices receives funds for primary health facilities (i.e. communities, health posts, health centres) in their localities but analysis shows that it is not clear how funds earmarked for facilities are accounted for (Source: PETS-QSDS 2019).	The NHIS is managed by the National Health Insurance Management Authority (NHIMA) which is responsible to oversee the day-to-day operation of the scheme. Financial statements of the scheme are supposed to be audited by the Auditor General. The NHIMA is supposed to prepare an annual statement of the income and expenditure of the Authority which is presented to the National Assembly	Vertical programme funds do not have oversight from the government and the oversight in most case relies on specific donor requirements and implementing partner arrangements. These funds are normally off-budget, making it difficult for the government to track its use.

Key design feature	Government Health Budget	National Health Insurance Scheme	Vertical Disease Programmes
K) Provider payment	Ideally, the EPHS is expected to be provided at PHC facilities which is the level of care that serve a significant proportion of the population. Funds for primary health facilities are disbursed from Ministry of Health to DHOs. Facilities are supposed to get in-kind supplies from DHO.	Accredited health care providers are paid on a Fee-for-service basis. Providers are supposed to submit claims to NHIMA for the services rendered to NHIS members. The NHIMA is supposed to negotiate with accredited health care providers, a schedule of fees and charges for insured health care services that are fair and optimal. About ZMW 300 million (About $19 million) was paid as claims reimbursements by February 2022	Vertical programme funds are mainly allocated to NGOs that are directly implementing the disease programmes. There are no direct transfers of funds to frontline service providers. Funds are mainly used to finance labour costs for staff who are involved in providing technical support for example during HIV public awareness and testing campaigns. The analysis from NHA 2016 shows that about 38.1% of NGO/donor funding was allocated to providers of prevention services, 8.1 to providers of health care administration, 16.8 percent to rest of the economy and 10.2 percent to providers of ambulatory services and 14.2 was spent at hospitals.
L) Service delivery & contracting	Statistics also shows that about 85% of those who sought care in 2015 did so from a public PHC facility (i.e. district hospital, public health centre or public health post). (Source: Masiye and Kaonga, 2016).	By June 2022 a total of about 495 health service providers were accredited by the scheme of which 235 are private health care providers, including Hospitals, Opticians, Dental Hospitals, Diagnostic Laboratories, Pharmacies and Hospices.	The analysis from NHA 2016 shows that about 38.1% of NGO/donor funding was allocated to providers of prevention services, 8.1 to providers of health care administration, 16.8 percent to rest of the economy and 10.2 percent to providers of ambulatory services and 14.2 was spent at hospitals.

Health expenditure by Stage 1 coverage schemes

Fig. 6: Expenditure flows by scheme (Sankey diagram)



WHERE DO SCHEMES/PROGRAMMES REVENUES COME FROM?

Stage 1 Schemes	Public	Private	External	TOTAL
Government health budget	79.5%	-	20.5%	100%
National Health Insurance Scheme (NHIS)	100%	-	-	100%
Vertical Disease Programmes	0.1%	2.1%	97.8%	100%
OOPS	-	100%	-	100%

HOW ARE REVENUE SOURCES DISTRIBUTED ACROS SCHEMES/PROGRAMMES?

Stage 1 Schemes	Public	Private	External
Government health budget	91.2%	-	19.0%
National Health Insurance Scheme (NHIS)	8.7%	-	-
Vertical Disease Programmes	0.1%	10.8%	81.0%
OOPS	-	89.2%	-
TOTAL	100%	100%	100%

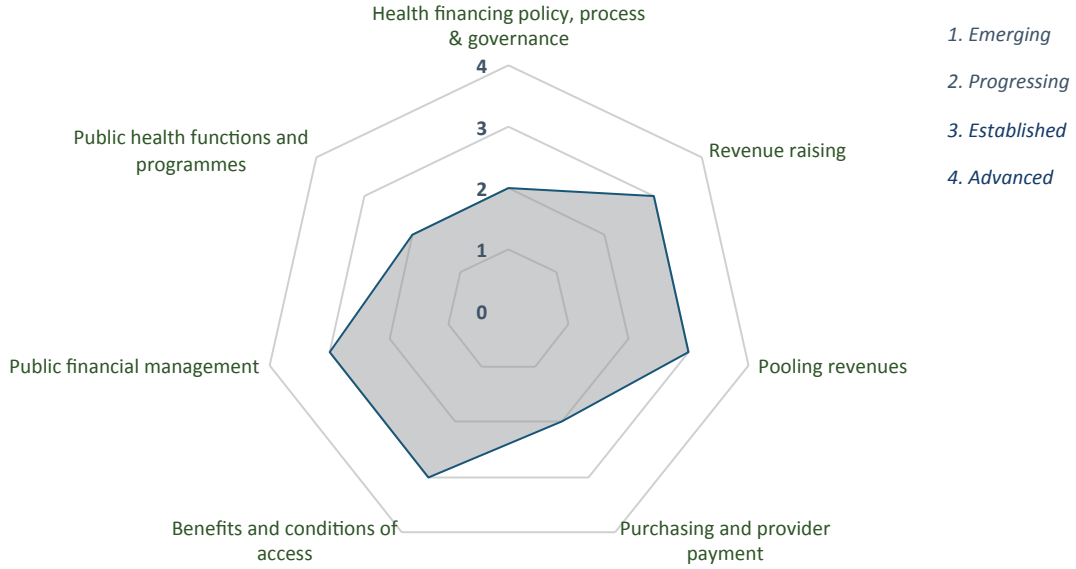
Source: Author estimates based on the HF x FS breakdown available using Health Accounts 2021 (Ministry of Health, Zambia), supplemented by the most recent expenditure estimates for the schemes/programmes identified in Stage 1. (6).
Note: CHE: current health expenditure.

Stage 2 assessment

Summary of ratings by assessment area

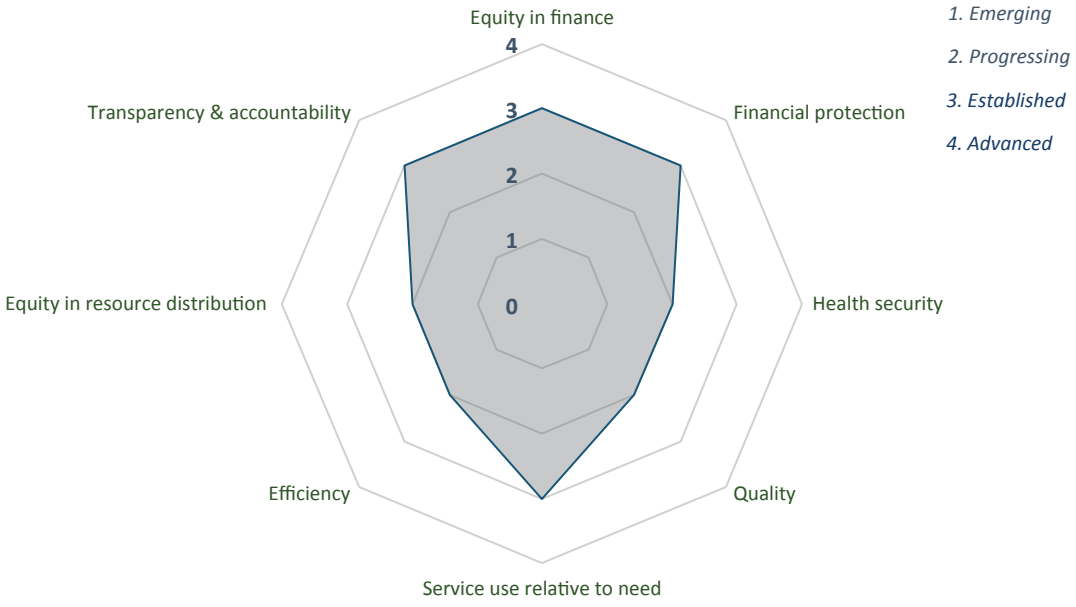
Figs. 7 to 10 summarize the assessment scores according to the different functions, questions, goals and objectives of health financing. For further details see Annexes 2, 3 and 4.

Fig. 7: Average rating by assessment area (spider diagram)



Source: Based on HFPM data collection template v2.0, Zambia 2023

Fig. 8: Average rating by goals and objectives (spider diagram)

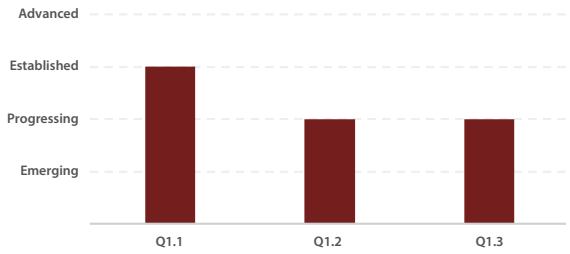


Source: Based on HFPM data collection template v2.0, Zambia 2023

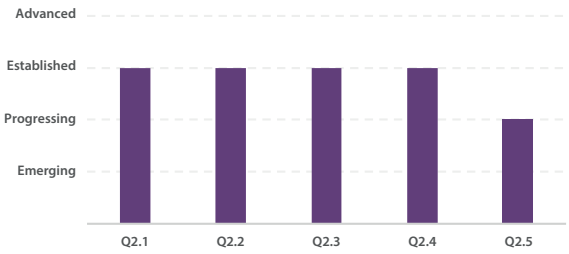
Assessment rating by individual question

Fig. 9: Assessment rating by intermediate objective and final coverage goals

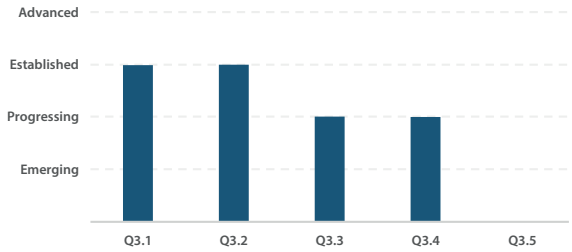
1. Health financing policy, process & governance



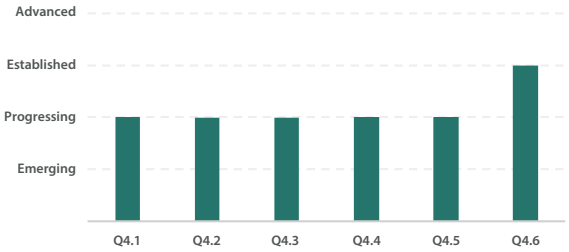
2. Revenue raising



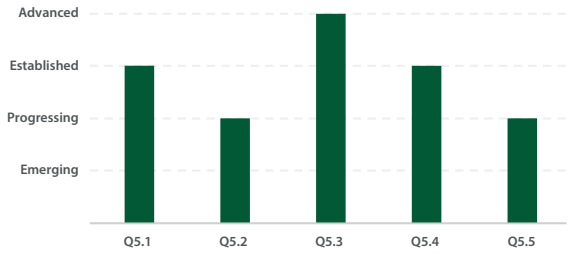
3. Pooling revenues



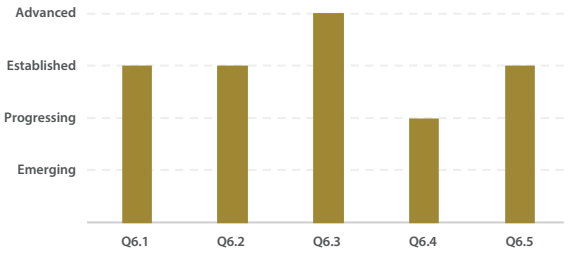
4. Purchasing and provider payment



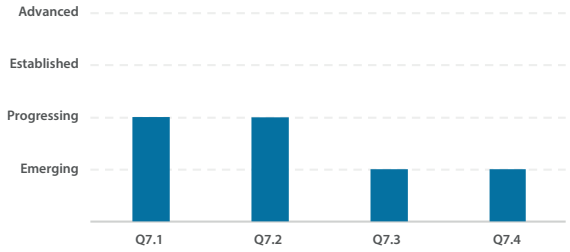
5. Benefit and conditions of access



6. Public financial management



7. Public health functions and programmes

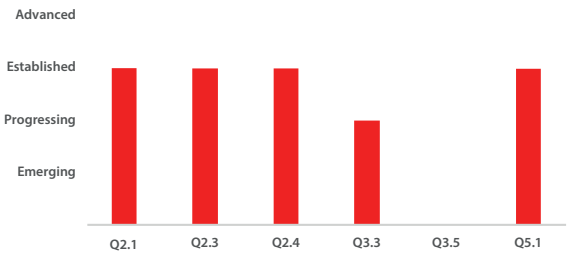


See Annex 3 for question details

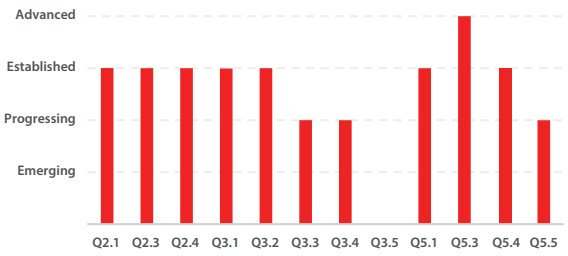
Assessment rating by UHC goals

Fig. 10: Assessment rating by intermediate objective and final coverage goals

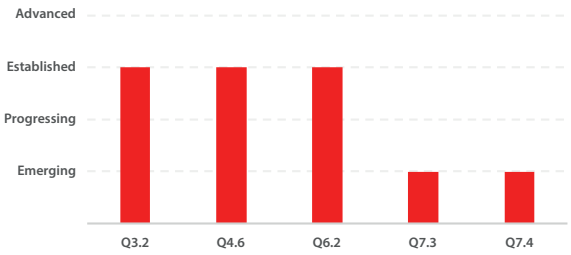
Equity in finance



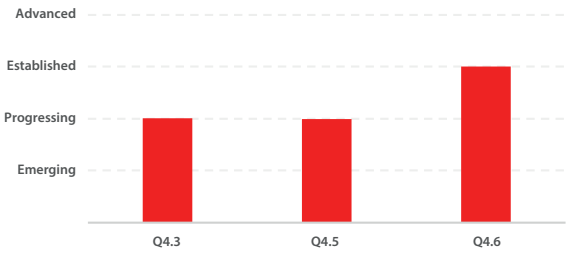
Financial protection



Health security



Quality



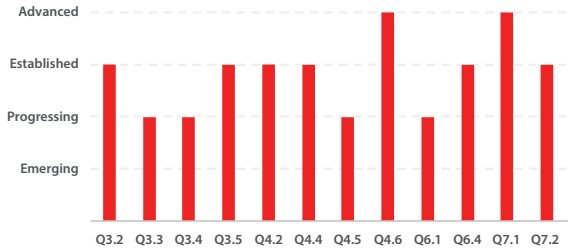
Service use relative to need

See Annex 3 for question details

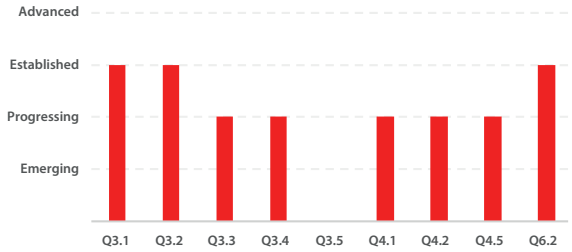
Assessment rating by intermediate objective

Fig. 10 (continued): Assessment rating by intermediate objective and final coverage goals

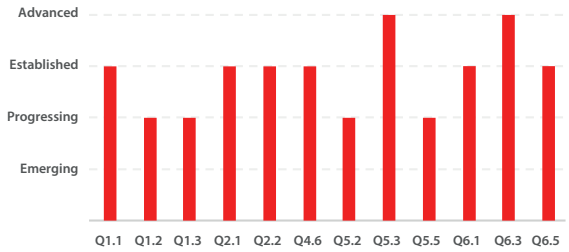
Efficiency



Equity in resource distribution



Transparency & accountability



See Annex 3 for question details

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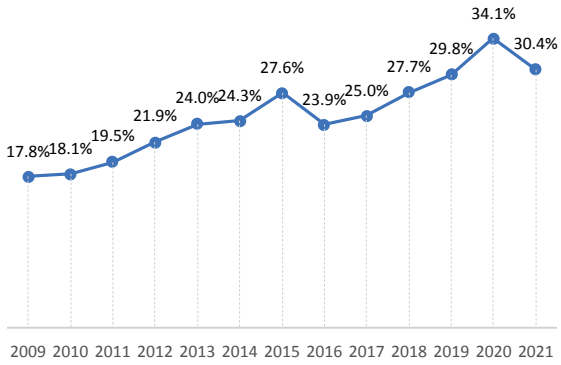
Annexes

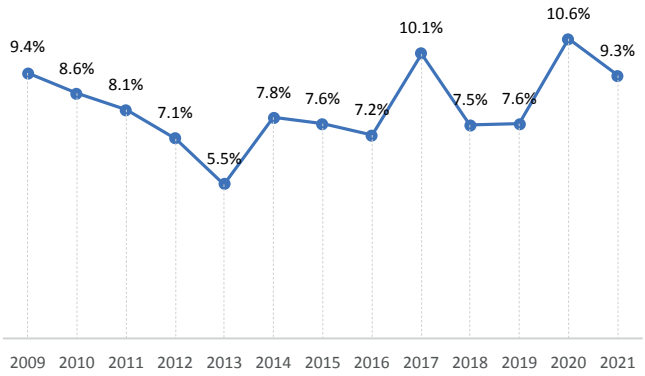
Annex 1: Selected contextual indicators

Fig. A1.1. Health expenditure indicators for Zambia

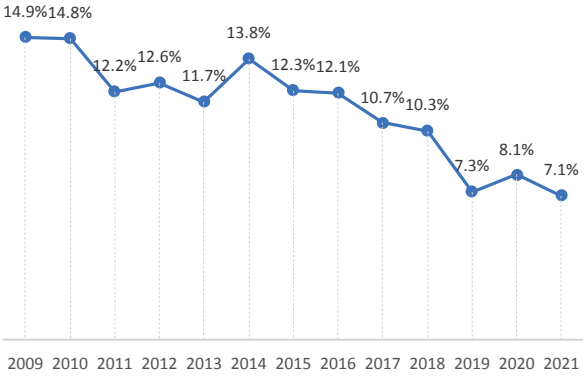
General Government Expenditure (GGE) as % Gross Domestic Product (GDP)



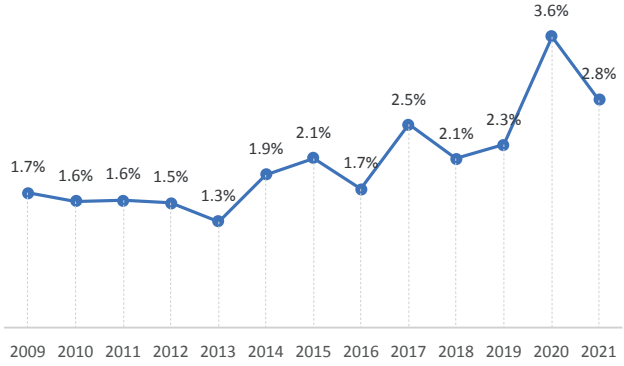
Domestic General goverment health expenditure (GGHE-D) as % General Government Expenditure (GGE)



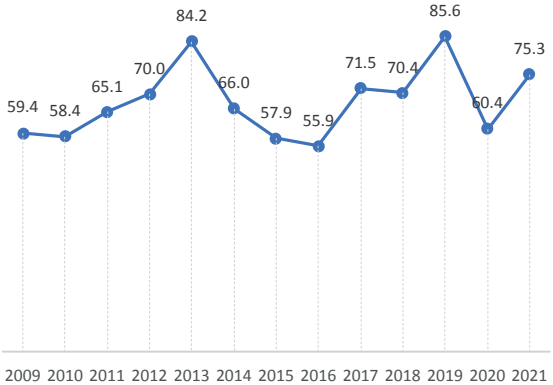
Out-of-pocket spending as % Current health expenditure (OOPS % CHE)



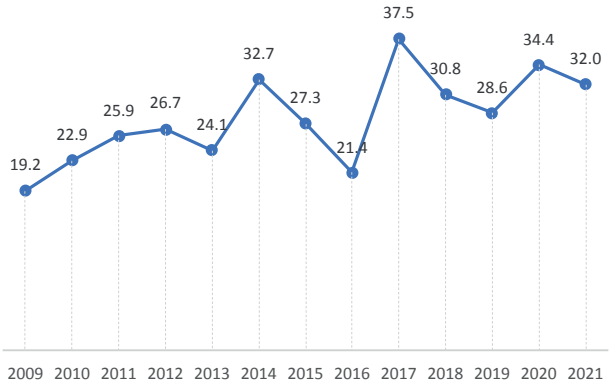
Domestic General goverment health expenditure (GGHE-D) as % Gross Domestic Product (GDP)



Current Health Expenditure (CHE) per Capita in US$

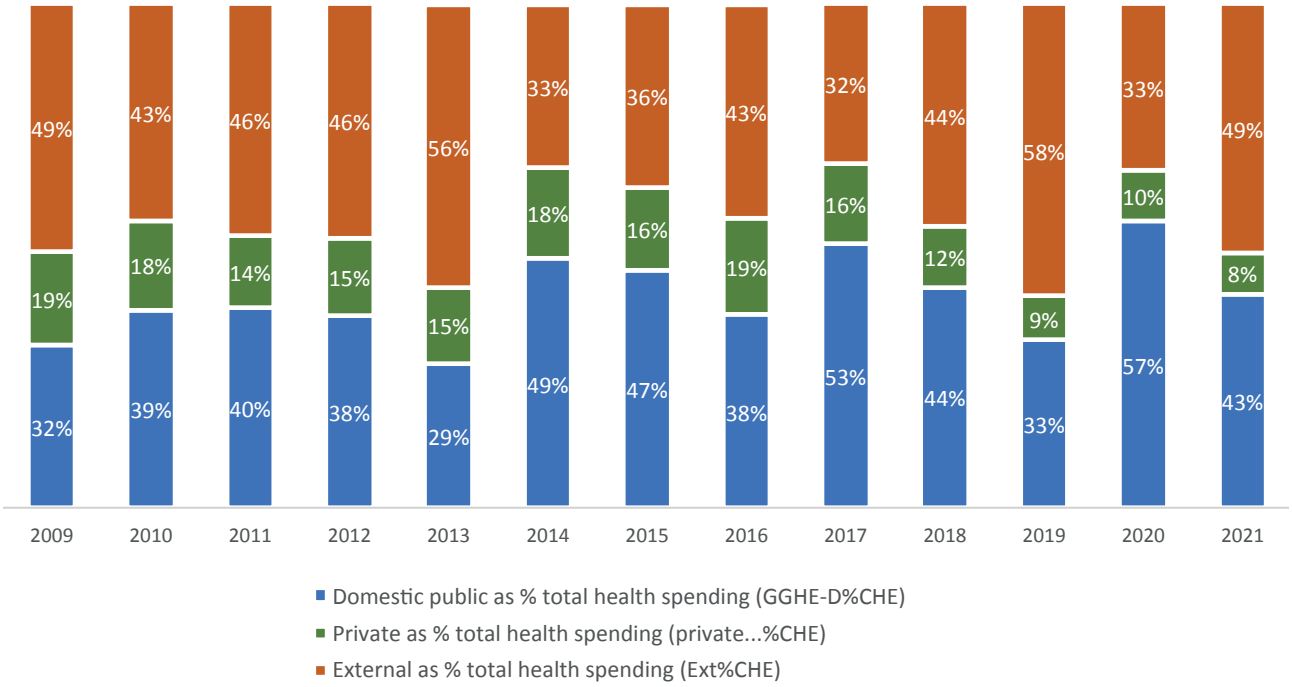


Domestic General Government Health Expenditure (GGHE-D) per Capita in US$



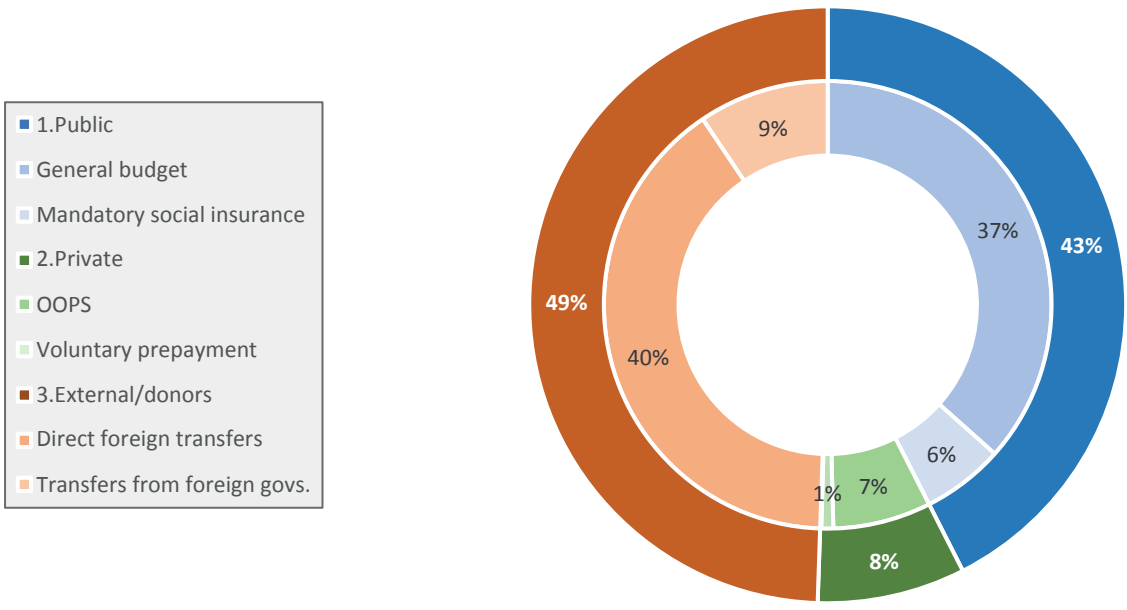
Source: WHO Global Health Expenditure Database, 2023 (https://apps.who.int/nha/database/Home/Index/en, accessed 1 August 2023)

Fig. A1.2. Revenue sources for health in Zambia



Source: WHO Global Health Expenditure Database, 2023 (https://apps.who.int/nha/database/Home/Index/en, accessed 1 August 2023)

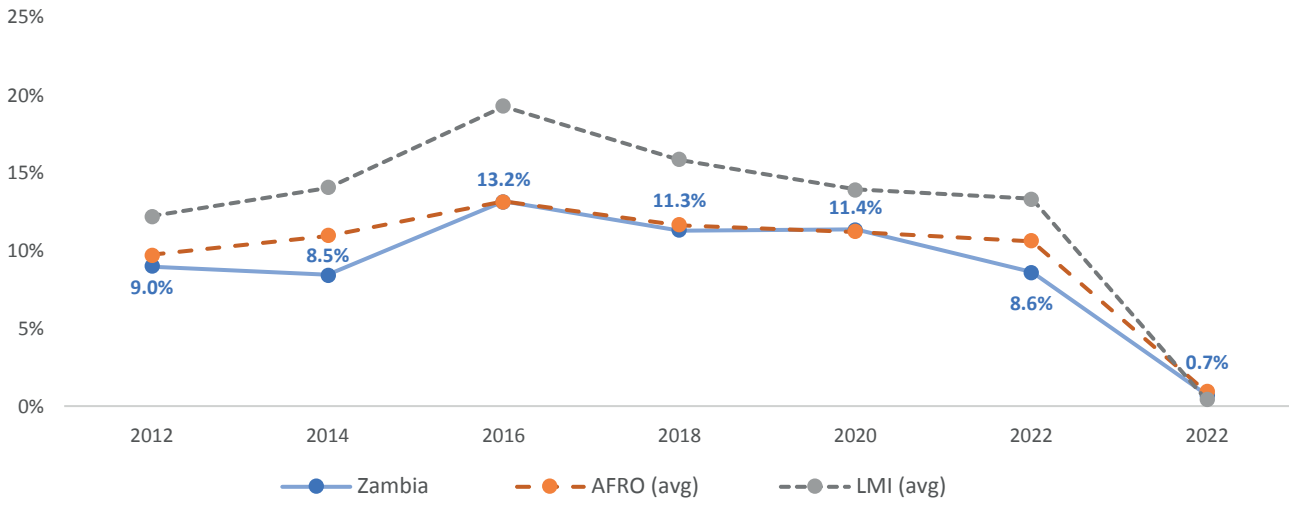
Fig. A1.3. Revenue sources disaggregated 2021



Source: WHO Global Health Expenditure Database, 2023 (https://apps.who.int/nha/database/Home/Index/en, accessed 1 August 2023)

Fig. A1.4. Cigarette affordability in Zambia

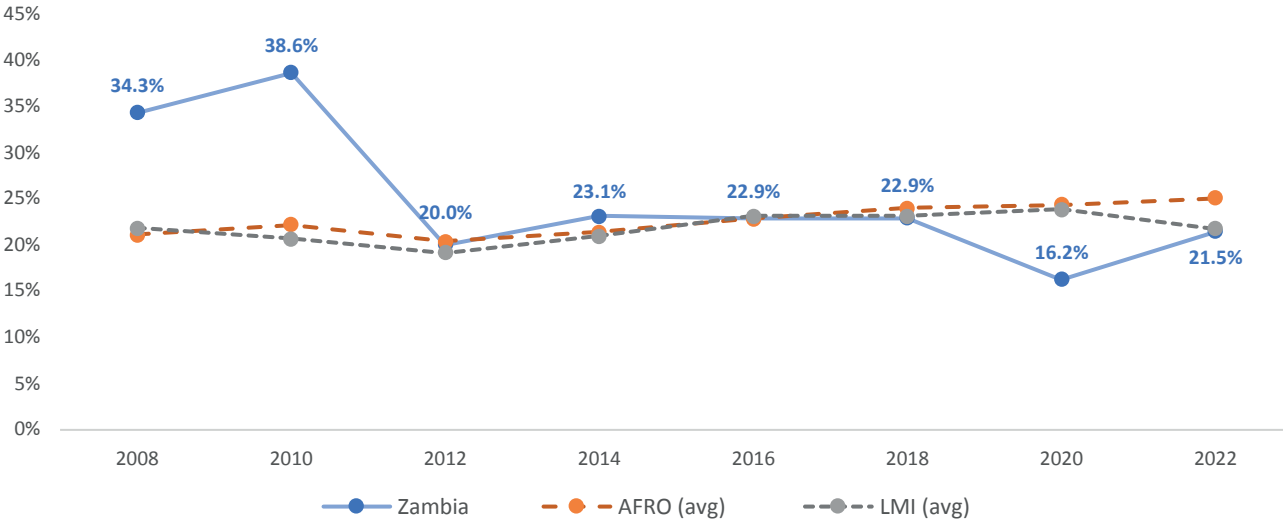
Reducing affordability is an important measure of the success of tobacco tax policy. In the longer term, a positive, higher measure means cigarettes are becoming less affordable. Short term changes in affordability are also presented.



WHO report on the global tobacco epidemic 2023
(https://www.who.int/teams/health-promotion/tobacco-control/global-tobacco-report-2023)

Fig. A1.5. Excise tax share for cigarettes in Zambia

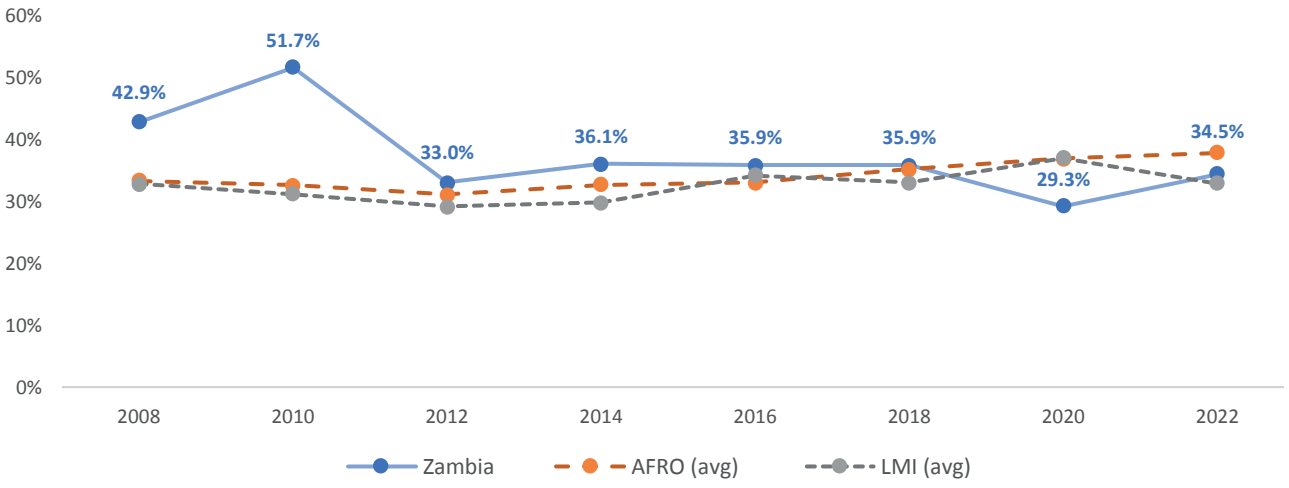
WHO recommends an excise tax share of 70%. Total tax share includes import duties and levies.



WHO report on the global tobacco epidemic 2023
(https://www.who.int/teams/health-promotion/tobacco-control/global-tobacco-report-2023)

Fig. A1.6. Total tax share of cigarettes in Zambia

This indicator represents the best comparable measure of the magnitude of total tobacco taxes relative to the price of a pack of the most widely sold brand of cigarettes in the country. Total taxes include excise taxes, VAT/sales taxes and, where relevant, import duties and/or any other indirect tax applied in a country.



WHO report on the global tobacco epidemic 2023
(https://www.who.int/teams/health-promotion/tobacco-control/global-tobacco-report-2023)

Annex 2: Desirable attribute of health financing

Policies which help to drive progress to UHC are summarized n terms of nineteen desirable attributes of health financing policy. For further information see: https://www.who.int /publications/i/item/9789240017405

Desirable attributes of health financing systems		
Health financing policy, process & governance	GV1	Health financing policies are guided by UHC goals, take a system-wide perspective and prioritize and sequence strategies for both individual and population-based services
	GV2	There is transparent, financial and non-financial accountability, in relation to public spending on health
	GV3	International evidence and system-wide data and evaluations are actively used to inform implementation and policy adjustments
Revenue raising	RR1	Health expenditure is based predominantly on public/compulsory funding sources
	RR2	The level of public (and external) funding is predictable over a period of years
	RR3	The flow of public (and external) funds is stable and budget execution is high
	RR4	Fiscal measures are in place that create incentives for healthier behaviour by individuals and firms
Pooling revenues	PR1	Pooling structure and mechanisms across the health system enhance the potential to redistribute available prepaid funds
	PR2	Health system and financing functions are integrated or coordinated across schemes and programmes
Purchasing & provider payment	PS1	Resource allocation to providers reflects population health needs, provider performance or a combination
	PS2	Purchasing arrangements are tailored in support of service delivery objectives
	PS3	Purchasing arrangements incorporate mechanisms to ensure budgetary control
Benefits & conditions of access	BR1	Entitlements and obligations are clearly understood by the population
	BR2	A set of priority health service benefits within a unified framework is implemented for the entire population
	BR3	Prior to adoption, service benefit changes are subject to cost–effectiveness and budgetary impact assessments
	BR4	Defined benefits are aligned with available revenues, health services and mechanisms to allocate funds to providers
	BR5	Benefit design includes explicit limits on user charges and protects access for vulnerable groups
Public financial management	PF1	Health budget formulation and structure support flexible spending and are aligned with sector priorities
	PF2	Providers can directly receive revenues, flexibly manage them and report on spending and output

Desirable attributes of health financing systems		
Public health functions & programmes[3]	GV1	Health financing policies are guided by UHC goals, take a system-wide perspective and prioritize and sequence strategies
	PR1	Pooling structure and mechanisms across the health system enhance the potential to redistribute available prepaid funds
	PR2	Health system and financing functions are integrated or coordinated across schemes and programmes
	PS2	Purchasing arrangements are tailored in support of service delivery objectives
	PF1	Health budget formulation and structure supports flexible spending and is aligned with sector priorities

Annex 3. HFPM assessment questions

Assessment	Question number code	Question text
1) Health financing policy, process & governance	Q1.1	Is there an up-to-date health financing policy statement guided by goals and based on evidence?
	Q1.2	Are health financing agencies held accountable through appropriate governance arrangements and processes?
	Q1.3	Is health financing information systemically used to monitor, evaluate and improve policy development and implementation?
2) Revenue raising	Q2.1	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?
	Q2.2	How predictable is public funding for health in your country over a number of years?
	Q2.3	How stable is the flow of public funds to health providers?
	Q2.4	To what extent are the different revenue sources raised in a progressive way?
	Q2.5	To what extent does government use taxes and subsidies as instruments to affect health behaviours?
3) Pooling revenues	Q3.1	Does your country's strategy for pooling revenues reflect international experience and evidence?
	Q3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
4) Purchasing & provider payment	Q4.1	To what extent is the payment of providers driven by information on the health needs of the population they serve?
	Q4.2	Are provider payments harmonized within and across purchasers to ensure coherent incentives for providers?
	Q4.3	Do purchasing arrangements promote quality of care?
	Q4.4	Do provider payment methods and complementary administrative mechanisms address potential over- or under-provision of services?
	Q4.5	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?
	Q4.6	To what extent do providers have financial autonomy and are held accountable?

Assessment area	Question number code	Question text
5) Benefits & conditions of access	Q5.1	Is there a set of explicitly defined benefits for the entire population?
	Q5.2	Are decisions on those services to be publicly funded made transparently using explicit processes and criteria?
	Q5.3	To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?
	Q5.4	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?
	Q5.5	Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?
6) Public financial management	Q6.1	Is there an up-to-date assessment of key public financial management bottlenecks in health?
	Q6.2	Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?
	Q6.3	Are processes in place for health authorities to engage in overall budget planning and multi-year budgeting?
	Q6.4	Are there measures to address problems arising from both under- and over-budget spending in health?
	Q6.5	Is health expenditure reporting comprehensive, timely, and publicly available?
7) Public health functions & programmes	Q7.1	Are specific health programmes aligned with, or integrated into, overall health financing strategies and policies?
	Q7.2	Do pooling arrangements promote coordination and integration across health programmes and with the broader health system?
	Q7.3	Do financing arrangements support the implementation of IHR capacities to enable emergency preparedness?
	Q7.4	Are public financial management systems in place to enable a timely response to public health emergencies?

Annex 4: Questions mapped to objectives and goals

Each question represents an area of health financing policy, selected given its influence on UHC intermediate objectives and goals, as explicitly defined below.

Objective / goal	Question number code	Question text
Equity in resource distribution	Q3.1	Does your country's strategy for pooling revenues reflect international experience and evidence?
	Q3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
	Q4.1	To what extent is the payment of providers driven by information on the health needs of the population they serve?
	Q4.2	Are provider payments harmonized within and across purchasers to ensure coherent incentives for providers?
	Q4.5	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?
	Q6.2	Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?
Efficiency	Q3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
	Q4.2	Are provider payments harmonized within and across purchasers to ensure coherent incentives for providers?
	Q4.4	Do provider payment methods and complementary administrative mechanisms address potential over- or under-provision of services?
	Q4.5	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?
	Q4.6	To what extent do providers have financial autonomy and are held accountable?
	Q6.1	Is there an up-to-date assessment of key public financial management bottlenecks in health?
	Q6.4	Are there measures to address problems arising from both under- and over- budget spending in health?
	Q7.1	Are specific health programmes aligned with, or integrated into, overall health financing strategies and policies?
	Q7.2	Do pooling arrangements promote coordination and integration across health programmes and with the broader health system?

Objective / goal	Question number code	Question text
Transparency & accountability	Q1.1	Is there an up-to-date health financing policy statement guided by goals and based on evidence?
	Q1.2	Are health financing agencies held accountable through appropriate governance arrangements and processes?
	Q1.3	Is health financing information systemically used to monitor, evaluate and improve policy development and implementation?
	Q2.1	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?
	Q2.2	How predictable is public funding for health in your country over a number of years?
	Q4.6	To what extent do providers have financial autonomy and are held accountable?
	Q5.2	Are decisions on those services to be publicly funded made transparently using explicit processes and criteria?
	Q5.3	To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?
	Q5.5	Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?
	Q6.1	Is there an up-to-date assessment of key public financial management bottlenecks in health?
	Q6.3	Are processes in place for health authorities to engage in overall budget planning and multi-year budgeting?
	Q6.5	Is health expenditure reporting comprehensive, timely, and publicly available?
Service use relative to need	Q2.2	How predictable is public funding for health in your country over a number of years?
	Q2.3	How stable is the flow of public funds to health providers?
	Q3.1	Does your country's strategy for pooling revenues reflect international experience and evidence?
	Q3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
	Q4.1	To what extent is the payment of providers driven by information on the health needs of the population they serve?
	Q5.1	Is there a set of explicitly defined benefits for the entire population?
	Q5.3	To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?
	Q5.4	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?
	Q5.5	Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?
	Q6.2	Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?

Objective / goal	Question number code	Question text
Financial protection	Q2.1	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?
	Q2.3	How stable is the flow of public funds to health providers?
	Q2.4	To what extent are the different revenue sources raised in a progressive way?
	Q3.1	Does your country's strategy for pooling revenues reflect international experience and evidence?
	Q3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
	Q5.1	Is there a set of explicitly defined benefits for the entire population?
	Q5.3	To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?
	Q5.4	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?
	Q5.5	Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?
Equity in finance	Q2.1	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?
	Q2.3	How stable is the flow of public funds to health providers?
	Q2.4	To what extent are the different revenue sources raised in a progressive way?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
	Q5.1	Is there a set of explicitly defined benefits for the entire population?
	Q5.4	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?
Quality	Q4.3	Do purchasing arrangements promote quality of care?
	Q4.5	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?
	Q4.6	To what extent do providers have financial autonomy and are held accountable?
Health security	Q3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q4.6	To what extent do providers have financial autonomy and are held accountable?
	Q6.2	Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?
	Q7.3	Do financing arrangements support the implementation of IHR capacities to enable emergency preparedness?
	Q7.4	Are public financial management systems in place to enable a timely response to public health emergencies?

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