

## Inequalities in Healthcare Spending on Curative Services: Evidence from Zambia

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### MAIN MESSAGE

Both public spending and overall spending on curative services have become more egalitarian in Zambia with the rollout of Universal Health Coverage policies across the country. New research finds that the distribution of benefits from public spending remains consistently poor, except at public hospitals. But while the distribution of benefits from overall spending has become more equitable across levels and types of healthcare, equality has not yet been achieved.

Differences between provinces in the distribution of public and overall benefits have become smaller over time, with only two provinces displaying a pro-least-poor distribution of health spending. Further policy action is needed to consolidate current equity gains by tackling the remaining sources of inequality.

### CONTEXT & MOTIVATION

In 2013, total healthcare spending in Zambia was nearly 5% of GDP, with the government contributing 38%, out-of-

pocket expenditures by households 28%, and the rest covered by development partners.

Over 90% of health service provision takes place within the public sector. Since 1992, this has focused mainly on provision of primary care services delivered in a decentralized way. Between 2006 and 2012, user charges initially introduced in 1992 were progressively removed for all primary care services: first in rural areas; then in semi-urban areas; and finally nationwide.

But many higher-level public facilities retain 'fee-for-service' wings, providing higher quality care and shorter waiting times for patients who can afford them. Despite the removal of user fees for primary care in the public sector, inadequate funding continues to hamper equitable access to services.

In 2015, the government proposed the introduction of a social health insurance scheme to cover all citizens progressively, but no concrete steps have yet been taken towards its implementation. Between 2011 and 2014, the government piloted the

introduction of 'performance-based financing' in a total of 30 districts across 8 provinces. The program introduced supply-side incentives tied to provision of a wide range of primary health services, including both maternal and curative care.

### METHODS

This study uses Benefit Incidence Analysis to analyze the distribution of healthcare spending for curative services over time. The objective is to understand the extent to which spending on curative services has been distributed so as to reach people across different socio-economic groups in light of recent reforms.

To compute utilization rates for curative services, the study uses data from the 2006 and 2010 rounds of the Living Conditions Monitoring Survey, and the 2014 Zambia Household Health Utilization and Expenditure Survey. The study looks at spending by type of provider (public, mission) and/or by level of care (health center, hospital) and, by aggregating utilization rates across types of provider and levels of care.

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**Geography** Zambia

**Find out more about this project:** [afd.fr/en/carte-des-projets/assessing-equity-health-spending-sub-saharan-africa](https://afd.fr/en/carte-des-projets/assessing-equity-health-spending-sub-saharan-africa)

**Key words** Health, Curative, Spending, Inequality, Distribution

**Themes** Health Financing, Health Inequality, Health Spending, Curative Healthcare

The unit costs are based on data from National Health Accounts on: recurrent public spending on curative services; donor spending on curative services; and household out-of-pocket expenditures on curative services. The study also uses descriptive geo-spatial analysis to visualize disparities in both public and overall spending on curative services across regions.

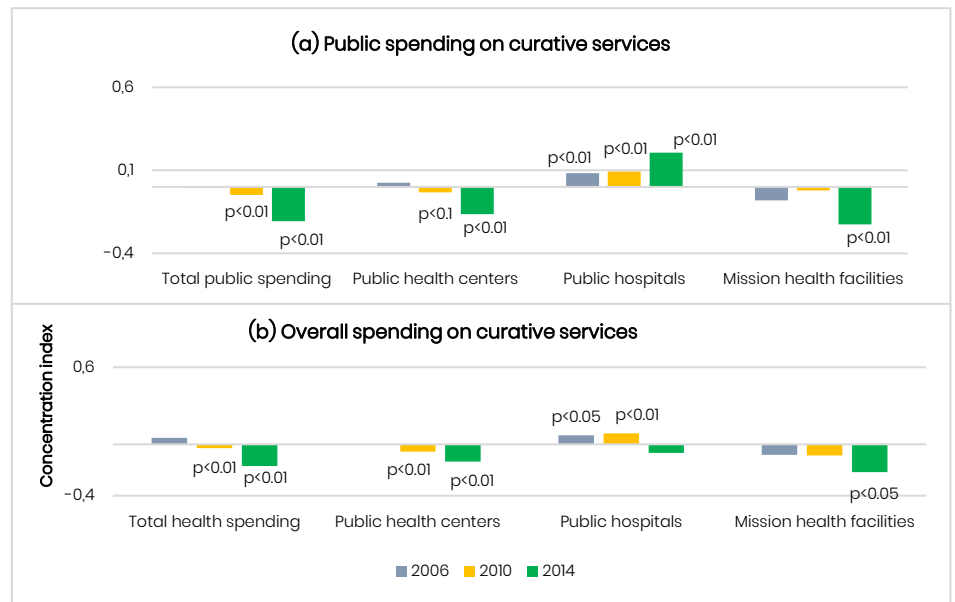
## RESULTS

### The distribution of public spending on curative services remains consistently pro-poor over time, except at public hospitals

Total public spending displays an increasingly pro-poor distribution over time. Looking at distributional incidence by type of provider and level of care, it becomes evident that the pattern for total public spending is largely driven by the distributional incidence at the level of public health centers and mission health facilities. In contrast, public hospitals have consistently displayed a pro-least-poor distribution (see Figure 1). This may be due to public hospitals that continue to impose user fees for certain services and therefore end up attracting wealthier patients.

### There is increased equality in overall spending, with spending at public health centers and mission health facilities becoming more pro-poor

## Distributional incidence of public and overall spending on curative services by level of care and over time



The distributional incidence of overall spending on curative services has been increasingly pro-poor across all types of provider and levels of care (see Figure 1). This may be an indication that both donor and private resources are allocated to compensate for the inequalities in the distributional incidence of public spending at higher levels of care. Explaining this somewhat counter-intuitive finding may require further qualitative investigation.

### Geographical disparities in distributional incidence have been decreasing substantially for both public and overall spending

Provincial disparities in the distributional incidence of both

public and overall spending on curative services have decreased substantially over time, largely reflecting the overall increase in equality at the national level. While in 2006, provinces display a diverse set of pro-poor, least-pro-poor and egalitarian patterns, by 2014, almost all provinces display a pro-poor pattern in the distributional incidence of both public and overall spending.

Only two provinces (Muchinga and Northwestern) display values indicating a distributional incidence of both public and overall spending that favors the least poor. But the magnitude of the value is negligible as it approaches the line of equality.

## RECOMMENDATIONS

- ▶ Continued investment in reforms is essential to sustain an egalitarian or pro-poor distribution of health benefits in the healthcare sector.
- ▶ It is advisable to investigate the source of decreasing geographical disparities over time to identify what lessons can be learned and adapted to other contexts.
- ▶ It is essential to investigate the source of persisting inequities in the distribution of public spending at the level of public hospitals and to design measures to counteract observed inequality.