

**Health sector financing and COVID-19:
East and Southern Africa trends and a
Zambia case study**

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Executive Summary

The Regional Network for Equity in Health in East and Southern Africa (EQUINET) commissioned this study from the University of Zambia to explore trends in equity-related healthcare expenditures in East and southern Africa (ESA) countries *prior to* the pandemic (2000–2019), and, through a deeper case study of expenditures in Zambia, how financing changed during the COVID-19 pandemic in 2020/21.

The regional analysis reviewed selected indicators available from the WHO Global Health Expenditure database for 2000–2019 of the:

- extent to which governments prioritise health in domestic budget spending;
- level of financial protection;
- level of government pro-poor spending on primary health care; and
- the share of public versus private financing in total health expenditure.

It is recognised that these selected indicators do not represent the full spectrum of measures of equity in health financing, but they do show trends in key dimensions that can be used to signal significant issues. The Zambia case study used a desk-based review of data for 2020–2021 and projections for 2023 collected from the Ministry of Health (MoH) in Zambia, supported by local National Health Accounts (NHA) publications. The financing trends for 2000–2019 in ESA countries raise issues around health system preparedness for the pandemic, while the Zambia case study demonstrates the consequent impact of the responses to COVID-19 on health system financing.

The findings indicate that between 2000 and 2019, less than half of ESA countries included progressively increased their share of health spending in the budget and by 2019, only two met the Abuja Declaration commitment of 15% of government budget spending on the health sector. By 2019, ten ESA countries were spending over 5% of their gross domestic product (GDP) on health from all sources, much of which came from household spending. By 2019, seven ESA countries had out-of-pocket spending (OOPS) above the upper limit of 20% suggested by WHO to avoid catastrophic expenditures and impoverishment, four of them considerably so. For nine of the 16 ESA countries (including Zambia) in 2019, less than 50% of spending on primary health care (PHC) came from government spending, suggesting a high degree of reliance on external funding for this key area of pro-poor spending. Reliance on external funder priorities leaves countries more susceptible to unpredictable and short term inflows. For seven ESA countries, 40% or more of current health spending came from private sector sources. This share has been falling in many countries in the region, although not always in direct proportion to increases in public spending and, drawing from the findings, possibly more due to falling OOPS.

Countries that gave less priority to health spending or reduced their share of health spending in 2019, are argued to have been in a weaker position at the onset of the COVID-19 pandemic in relation to their public health sectors. Providing high levels of financial protection is noted to be important for protecting households during the pandemic. Ensuring adequate domestic spending on PHC is observed to be necessary to resource the public and community health and primary care levels of health systems that are key in pandemic responses. The pandemic is thus likely to have created an immediate demand for significant levels of new domestic resources, particularly for the public sector, given that its strength is critical in ensuring a co-ordinated, equitable and comprehensive response to the pandemic across all sectors.

Within the ESA data, Zambia's spending on health from all sources was about 5% of GDP and falling, with low OOPS, indicating reasonable levels of spending from all sources and increasing levels of financial protection. These are important positive features in pandemic preparedness. However, Zambia's share of government spending on health has also been falling, along with a low share of government spending in total PHC expenditures. This suggests dependency on external funds for PHC, potentially limiting the available resources for domestic public sector leadership to co-ordinate and implement pandemic responses.

The Zambia case study shows some evidence of the pandemic's impact on health financing. The country had a period of positive economic growth, which was lower in the years immediately before the pandemic. The pandemic's impact and responses are reported to have led to economic disruption, recession and increased domestic and external debt, intensifying household poverty and inequality and implying resource scarcity, including for health sector spending. Rising indebtedness reduces the fiscal space for social spending, as has been evident in rising debt and falling health sector and education spending in real terms in the last three years. Increasing reliance on external sources of health financing left the country relatively exposed to external influence in policy priorities and design for the COVID-19 response. For instance, in Zambia, over 50% of malaria, antiretroviral therapy (ART) support and TB drug procurement are traditionally met by external funds, as was Overall health spending fell in real terms and the budget increasingly focused on curative care, with a falling share of spending on health promotion and prevention. .

Hence, while Zambia implemented features of a robust preventive, health promotion and care response, the data on the financing needs versus resources mobilised points to a likelihood of shortfall in the coverage and achievements intended in policy. The financial planning for the health sector response showed that, contrary to prior spending patterns, the greater share of resource needs was allocated for prevention-related activities including testing, infection prevention and control, including for the health workforce, and for health product and waste management systems. These are also areas where the funding gap was noted to be highest. In part, this appears to be due to the dependence on external funds to meet resource gaps, with the data indicating relatively greater levels of external funder support for treatment and care, rather than for the range of prevention services.

The Zambian health ministry COVID-19 budget showed a sudden, urgent and costly increase imposed by the need to mitigate COVID. The shock induced by the negative impacts and demands of the pandemic has affected the provision and uptake of other healthcare services, with some reports of reversals in gains made in areas such as maternal and child health programmes as resources were redirected to address emergent pandemic needs and health workers were over-stretched.

Leaving significant areas of the pandemic response critically underfunded, by over 90% in some areas, raises questions of what this means for the overall efficiency, effectiveness and equity of the response. Further, a funding need for the pandemic that is nearly 60 times higher than the last recorded government health spending in the 2016 national health accounts, raises a question of how far this is a consequence of sustained under-financing of critical prevention infrastructure, supplies and services over many years. Conversely, the benefit of such previous investments is apparent in the ability to make use of existing HIV, malaria and TB related laboratory services to rapidly decentralise laboratory capacity for COVID-19

The evidence suggests that pandemic preparedness is not an acute event, but rather a sustained process of investment in key areas of: diagnostic testing; surveillance; infection prevention and control; health product and waste management systems; and health promotion interventions for the wider range of priority public health conditions. This may be more likely to enable rapid repurposing and switching to address pandemic needs. Pandemic preparedness implies ensuring adequate investment in the organisation and capacities of care services and personnel, so that other health services do not suffer during a pandemic. Beyond provision of specific services, the evidence also suggests that pandemic preparedness is likely to be greater where the public sector share of financing does not fall to levels that undermine domestic public sector leadership of the multiple actors in the response, including aligning the priorities and resources of private and external actors. This too is not an event, and the evidence suggests that in a number of countries in the ESA region, it demands a more consistent prioritisation of public health sector financing and performance and a reversal of financing trends that undermine this.

1. Introduction

The nature and level of healthcare financing is a critical element of health systems development including in how resources are mobilised, pooled and spent, and services purchased. While there are many measures and features of health financing in each of these dimensions, African countries have identified the following as key issues for equity in health financing:

- a. The extent to which government prioritises health in its domestic budget spending, both as a share of overall government spending and as a share of gross domestic product (GDP). In 2001, heads of state committed to the 'Abuja Declaration' which committed them to allocating 15% of domestic government spending to health (Africa Union, 2001). Countries that have performed better in advancing towards universal coverage spend above 5% of their GDP on health (McIntyre 2012).
- b. The level of financial protection provided to ensure that health costs at point of care do not present as catastrophic or impoverishing expenditures as assessed by the extent to which mandatory prepayment options reduce out-of-pocket spending (OOPS) as a share of total health spending.
- c. The extent of government spending on primary healthcare as encompassing pro-poor local level health systems and more pro-poor population health interventions.
- d. The share of public versus private financing in total health expenditure, given the key role of public services in delivering services used by most lower income households, and
- e. The extent to which different sources of financing are pooled to enable income and risk cross-subsidies (Mills 2012, Kutzin 2013, Bennett and Gilson, 2001).

Beyond pooling, further features supporting equity relate to resource allocation in relation to health need and strategic purchasing, contracting and reimbursement of health care providers for services, quality and features of health service functioning that have greatest impact on population health equity.

East and southern Africa (ESA) countries face a range of challenges in fulfilling these features, including challenges that result from historical inequalities and reduced public funding under structural adjustment policies. More recent challenges also include those arising from economic performance, socio-economic inequality and a triple burden of non-communicable diseases, infectious diseases and health emergencies due to climate and pandemics. Many of these are outside the control of the health sector and relate to broader sectoral policies and trends within countries and at global level (Kutzin, 2000, McIntyre et al., 2005, McIntyre and Thiede, 2021).

While these issues were pertinent to equity in health systems in ESA countries before the COVID-19 pandemic, the pandemic and the responses to it have impacted on population health and household socio-economic status, including through a rise in precarious employment, income and food insecurity (TARSC/EQUINET and SATUCC, 2021). The pandemic has also led to stagnant or declining national economic performance, demands for spending on health and social protection and imported technologies that have raised debt levels (World Bank, 2021a). Public sector social and health systems that were already underfunded, poorly prepared and overstretched, faced challenges in meeting both the demands of the pandemic and regular service needs, worsening many dimensions of family, women's, child and adolescent health and well-being that already faced deficits and generating a rising health and social debt in communities (Loewenson et al., 2021).

The WHO (2020) noted that rising demand for health spending at a time of falling household and national income due to supply disruptions and economic losses resulting from lockdown responses led to health care financing constraints in low and middle income countries. This affected both their response to the pandemic, generating demand for external and private contributions, and had the potential of undermining equity in and progress towards universal health systems.

The Regional Network for Equity in Health in East and Southern Africa (EQUINET) commissioned this study from the University of Zambia to explore trends *prior to* the pandemic (2000–2019) in equity-related health care expenditures in ESA countries, and, through a deeper case study of expenditures in Zambia, to look at how financing changed during the pandemic in 2020.

2. Methods

The ESA regional analysis covers selected indicators of the four areas of health system financing indicated in (a) to (d) and outlined in Section 1 available from the WHO Global Health Expenditure database for 2000–2019 (WHO, 2021), with 2019 the most recent year available. The indicators selected for the analysis of trends in ESA countries are those shown below:

- a. For the extent to which government prioritises health in its domestic budget spending,
 - a. Domestic general government health expenditure (GGHE-D) as % general government expenditure (GGE) – the Abuja Declaration.
 - b. Current health expenditure (CHE) as % GDP ;
- b. For the level of financial protection, OOPS as % of current health expenditure (CHE);
- c. For the level of government pro-poor spending on primary health care (PHC), domestic general government expenditure on PHC as % PHC, albeit only for 2019, based on data availability; and
- d. For the share of public versus private financing in total health expenditure, domestic private health expenditure (PVT-D) as % current health expenditure (CHE).

It is recognised that these are selected indicators and do not represent the full spectrum of measures of equity in health financing, but they do show trends in key dimensions that can be used to signal significant issues. Trends were captured in five-year intervals. Supplementary data was obtained from the World Development Indicators database (World Bank, 2021b).

The Zambia case study used a desk-based review of data for 2020–2021 and projections for 2023 collected from the Ministry of Health (MoH) in Zambia, supported by local National Health Accounts (NHA) publications.

The data was captured in Excel spreadsheets, from which charts and tables were generated.

While the data sets used derive from government and intergovernmental agency sources, various limitations need to be noted. There are gaps in key evidence data sets. For the ESA data 2019 (pre COVID-19) is the most recent year available in the WHO cross country database and it is difficult to relate the ESA data to the Zambia case study data as the time periods differ. However, the paper uses the ESA data to explore trends in health financing for what this may imply for pandemic preparedness, while the Zambia case study data provides an insight into the financing implications during the first year of the pandemic. Together, the two datasets address the questions indicated in *Section 1*: what were the consequences of financing trends 2000-2019 for health system preparedness in ESA countries, and what does the Zambia case study indicate about the consequent financing of health system responses to COVID-19.

3. Health financing in the ESA region post-2000

3.1 Socio-economic context

As a context for the health financing data, *Table 1* provides selected indicators of the economic status of ESA countries in terms of aggregate GDP, Inflation, inequality measures by the Gini coefficient (0–100%, higher = greater inequality) and external debt. The paper shows the diversity of GDP measured in US\$ per capita for 2020, from lowest levels in Mozambique (US\$449) and the DRC (US\$557); to highest levels in Botswana (US\$6,711) and South Africa (US\$5,091) – more than ten times that of those with the lowest GDP per capita.

Aggregate income, however, poorly indicates who accesses this income. Despite being among the highest in GDP/capita, South Africa also has the highest Gini coefficient (63%), suggesting significant income inequality, while many of the countries with lower GDP/capita have Gini coefficients of less than 45%. Three countries – Eswatini, Tanzania and Mozambique have become more inequitable with increasing Gini coefficients between 2015 and 2020. Inflation appears to be relatively stable in all the countries, as does the total external and domestic debt, noting that data for the latter is available only to 2019 and thus does not reflect the impacts of the pandemic. The level of current health expenditure as a share of total government expenditure was lower than the Abuja Declaration’s recommended 15% throughout the period for most countries. Botswana (with a growing share to 14%) and South Africa (consistently at 13%) had the highest shares. Other ESA countries averaged between 5–10% over the period.

Table 1: Socio-economic context, ESA countries 2015–2020

Country	Variable Name	2015	2016	2017	2018	2019	2020
Angola	External debt stocks, total US\$ million	56 269	56 815	50 917	51 685	51 998	.na
	GDP per capita US\$	4167	3 506	4 096	3 290	2 810	1 896
	Gini coefficient (%)	43	Na	na	na	Na	51
	Inflation	9	31	30	20	17	Na
	CHE % Government expenditure	5	5	5	5	Na	Na
Botswana	External debt stocks, total US\$ million	2 237	2 126	1 741	1 782	1 565	Na
	GDP per capita US\$	6 800	7 244	7 893	8 280	7 971	6 711
	Gini coefficient (%)	61	Na	na	na	na	53
	Inflation	3	3	3	3	3	2
	CHE % Government expenditure	10	11	14	14		Na
Kenya	External debt stocks, total US\$ million	19 777	21 061	26 197.8	30 688.1	34 217.1	..na
	GDP per capita US\$	1337	1411	1 572	1 708	1 817	1 838
	Gini coefficient (%)	48	Na	na	na	Na	41
	Inflation	7	6	8	5	5	5
	CHE % Government expenditure	Na	Na	na	na	Na	Na
Lesotho	External debt stocks, total US\$ million	921	922	936.0	903.6	935.9	..na
	GDP per capita US\$	1 146	1 019	1103	1 192	1 113	861
	Gini coefficient (%)	54	Na	na	na	na	45
	Inflation	3	7	4	5	5	5
	CHE % Government expenditure	11	11	12	12		Na
Malawi	External debt stocks, total US\$ million	1 721	1 847	2 162.4	2 265.8	2 433.9	..na
	GDP per capita US\$	381	316	497	535	583	625
	Gini coefficient (%)	46					45
	Inflation	22	22	12	12	9	9
	CHE % Government expenditure	10	10	10	10		Na
Congo, Dem. Rep. (DRC)	External debt stocks, total US\$ million	5 328	5 022	5 083.9	4 955.7	5 437.5	..na
	GDP per capita US\$	497	471	467	557	581	557
	Gini coefficient (%)	44	na	na	na	Na	42
	Inflation	1	3	..na	na.	..na	na
	CHE % Government expenditure	3	3	3	3	Na	Na

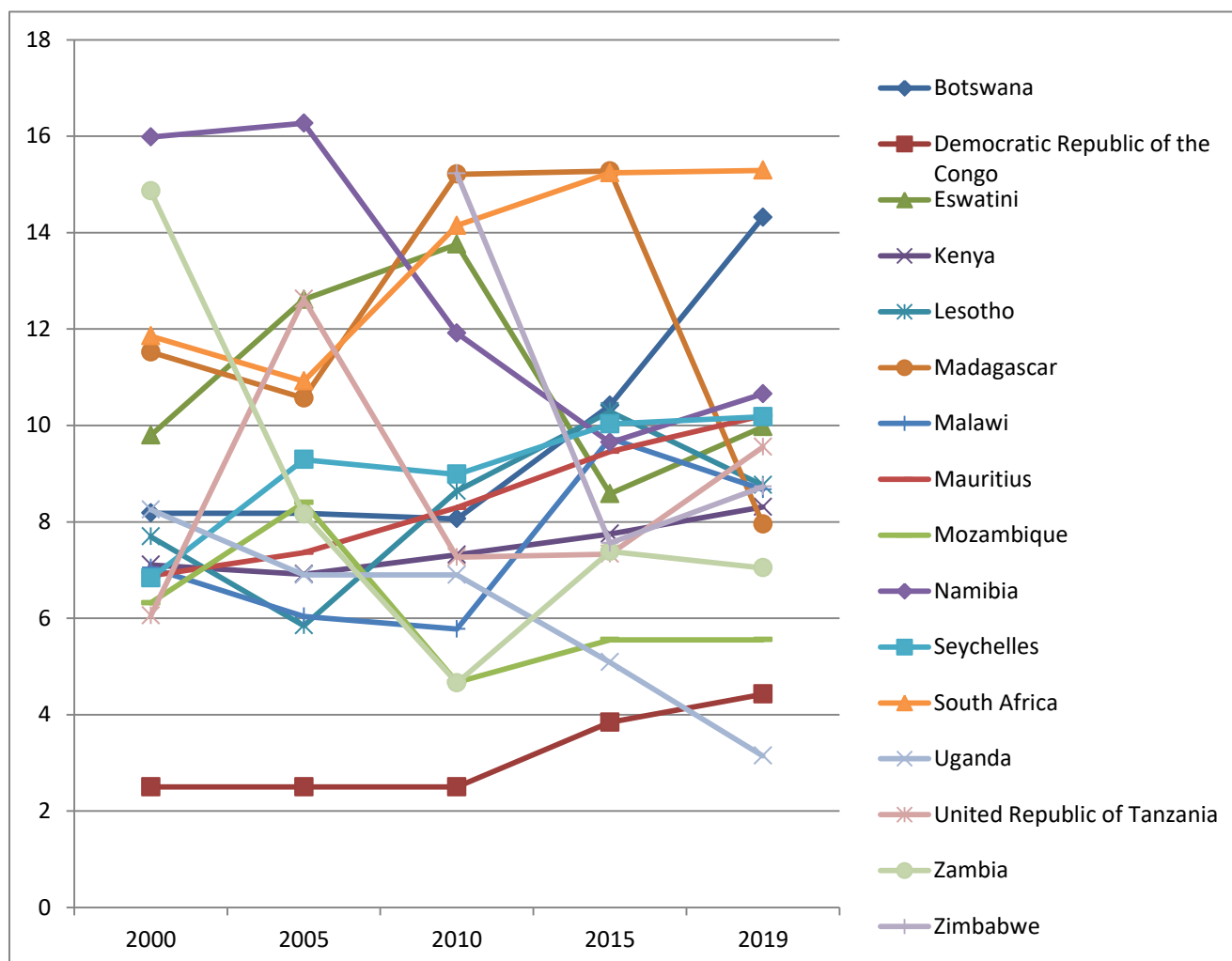
Country	Variable Name	2015	2016	2017	2018	2019	2020
Mozambique	External debt stocks, total US\$ million	14 382	14 428	16 019	18 814	20 354	..na
	GDP per capita US\$	590	429	461	503	504	449
	Gini coefficient (%)	47					54
	Inflation	4	17	15	4	3	..na
	CHE % Government expenditure	6	6	6	6		Na
Namibia	External debt stocks, total US\$ million	Na	na	na	na	na	Na
	GDP per capita US\$	4 897	4 547	5 367	5 588	5 037	4 211
	Gini coefficient (%)	61	na	na	na	Na	59
	Inflation	3	7	6	4	4	2
	CHE % Government expenditure	10	10	11	11	na	Na
South Africa	External debt stocks, total US\$ million	124 405	142 305	177 126	171 908	187 667	Na
	GDP per capita US\$	5 735	5 273	6 131	6 373	6 001	5 091
	Gini coefficient (%)	65	na	na	Na	na	63
	Inflation	5	7	5	5	4	3
	CHE % Government expenditure	13	13	13	13	Na	na
Tanzania	External debt stocks, total US\$ million	15 412	16 381	18 301	18 490	19 584	na..
	GDP per capita US\$	948	967	1 005	1 043	1 086	1 076
	Gini coefficient (%)	38	na	na	na	Na	41
	Inflation	6	5	5	3	3	3
	CHE % Government expenditure	7	10	10	9	Na	na
Uganda	External debt stocks, total US\$ million	9 571	10 086	11 673	12 315	13 971	na
	GDP per capita US\$	844	733	747	770	794	817
	Gini coefficient (%)	45	na	na	na	Na	43
	Inflation	5	5	6	3	3	4
	CHE % Government expenditure	5	5	5	5	Na	na
Zimbabwe	External debt stocks, total US\$ million	9 679	11 496	12 541	12 646	12 270	na
	GDP per capita US\$	1 445	1 465	1 336	1 352	1 156	1 128
	Gini coefficient (%)	Na	na	na	Na	44	na
	Inflation	2	2	1	11	Na	na
	CHE % Government expenditure	8	8	8	8	Na	na
Zambia	External debt stocks, total US\$ million	11 779	15 221	17 381	19 005	27 342	na.
	GDP per capita US\$	1 338	1 281	1 535	1 516	1 305	1 051
	Gini coefficient (%)	58	na	na	na	na	57
	Inflation	10	18	7	7	9	16
	CHE % Government expenditure	7	7	7	7	na	na

Source: Author from World Bank, 2021b, WHO, 2021 CHE= Current health expenditure na=not available

3.2 Government priority to health in its spending

Figure 1 shows the 2000–2019 trend of domestic general government health expenditure (GGHE-D) for ESA countries as a percentage of general government expenditure (GGE). As noted in the previous section, by 2019, only Botswana and South Africa were spending above 14% of their domestic budgets on the health sector. However, Figure 1 also shows that a number of countries have progressively increased their share of health spending in their budgets, these being DRC, Seychelles, South Africa, Botswana, and Mauritius, while others have shown declines; Uganda, and Kenya. For other ESA countries, notably including Zambia (given the case study discussed later), the levels have fluctuated. Significantly some countries that were allocating improved shares post 2000, had a fall in 2019 (Madagascar, Malawi, Zimbabwe), putting them in a weaker position at the onset of the COVID-19 pandemic, while inversely, others (Tanzania, Eswatini) had boosted their share of budget spending on health in 2019. The share of budget spending does not indicate the adequacy of funds allocated. However, the data does suggest that, while some countries have been consistently prioritising health spending, for others prioritisation of health in the budget has fluctuated or fallen, putting the health sector in a more resource-constrained situation by the time of the pandemic.

Figure 1: Domestic general government health expenditure (GGHE-D) as % general government expenditure (GGE), ESA countries, 2000–2019

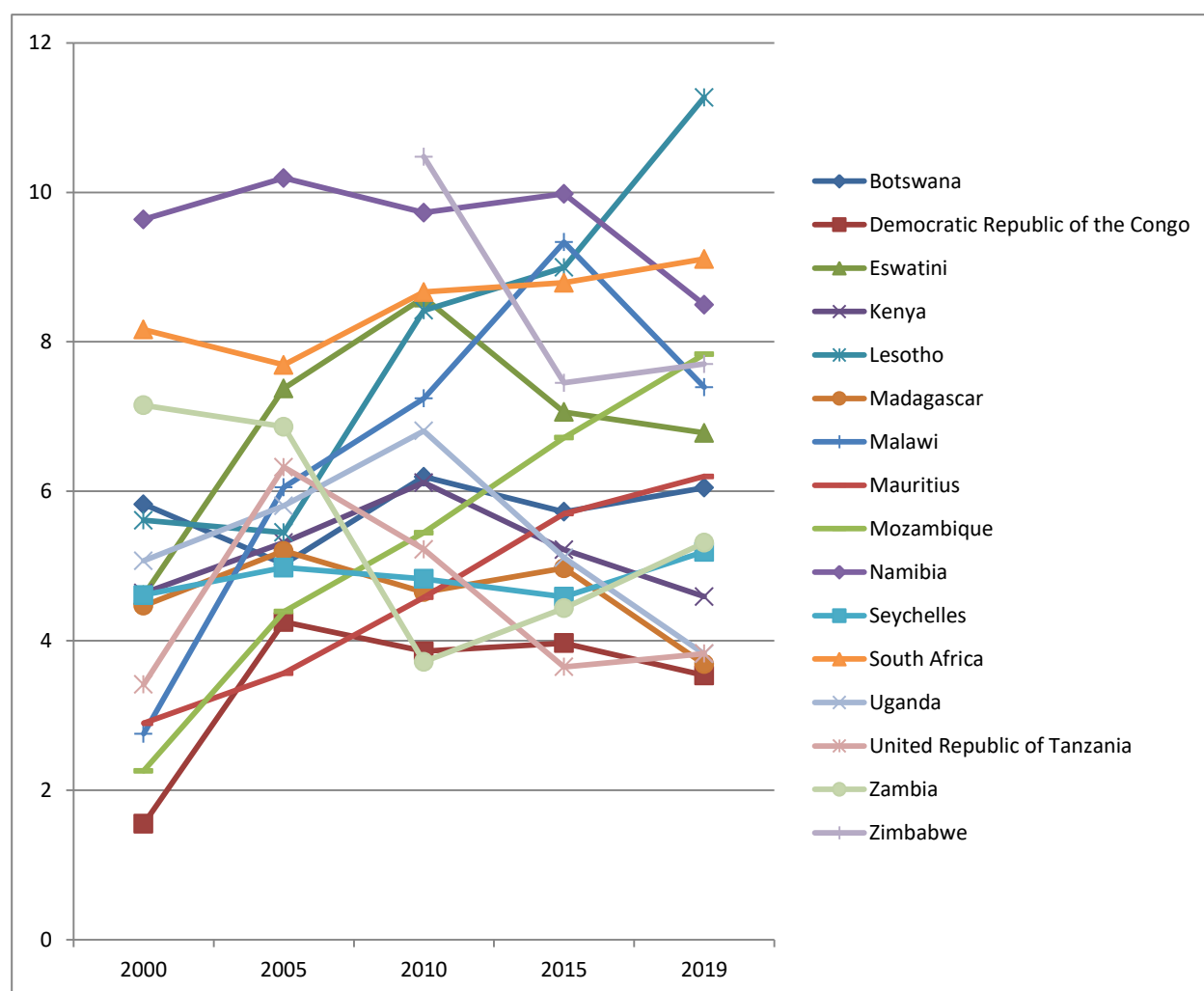


Source: WHO, 2021

Figure 2 shows the trend 2000–2019 for ESA countries of current health expenditure (CHE) as a percentage of GDP. For a number of ESA countries, namely: Lesotho, Namibia, South Africa, Malawi, Eswatini and Botswana, the share of current health spending in GDP from all sources exceeded 5% across the whole period. Over the period 2000–2019, it has only consistently increased in Lesotho, Mauritius, Mozambique and South Africa. While this suggests widening mobilisation of health sector resources in these countries, it is noted that this combines resources from public, private and household sources. The evidence of rising public spending in the health budget shown in Figure 1, suggests that public sector leadership of this rising spending on health may have been greater in Mauritius and South Africa, and may have enabled these countries to maintain greater public sector leadership in co-ordinating and aligning contributions towards the pandemic.

In contrast, some countries, including Madagascar and Uganda, showed lower and falling shares of health spending vis a vis their GDP, which, with falling shares of public budget spending on health in 2019, could have weakened health sector resources in these countries and their ability to manage both COVID-19 and other ongoing health needs. The implications of these trends for health system preparedness would need to be explored through follow up country reviews. However, the evidence suggests significant variability in the extent to which governments in the region were prioritising resource support to their health sectors.

Figure 2: Current health expenditure (CHE) as % GDP, ESA countries, 2000–2019

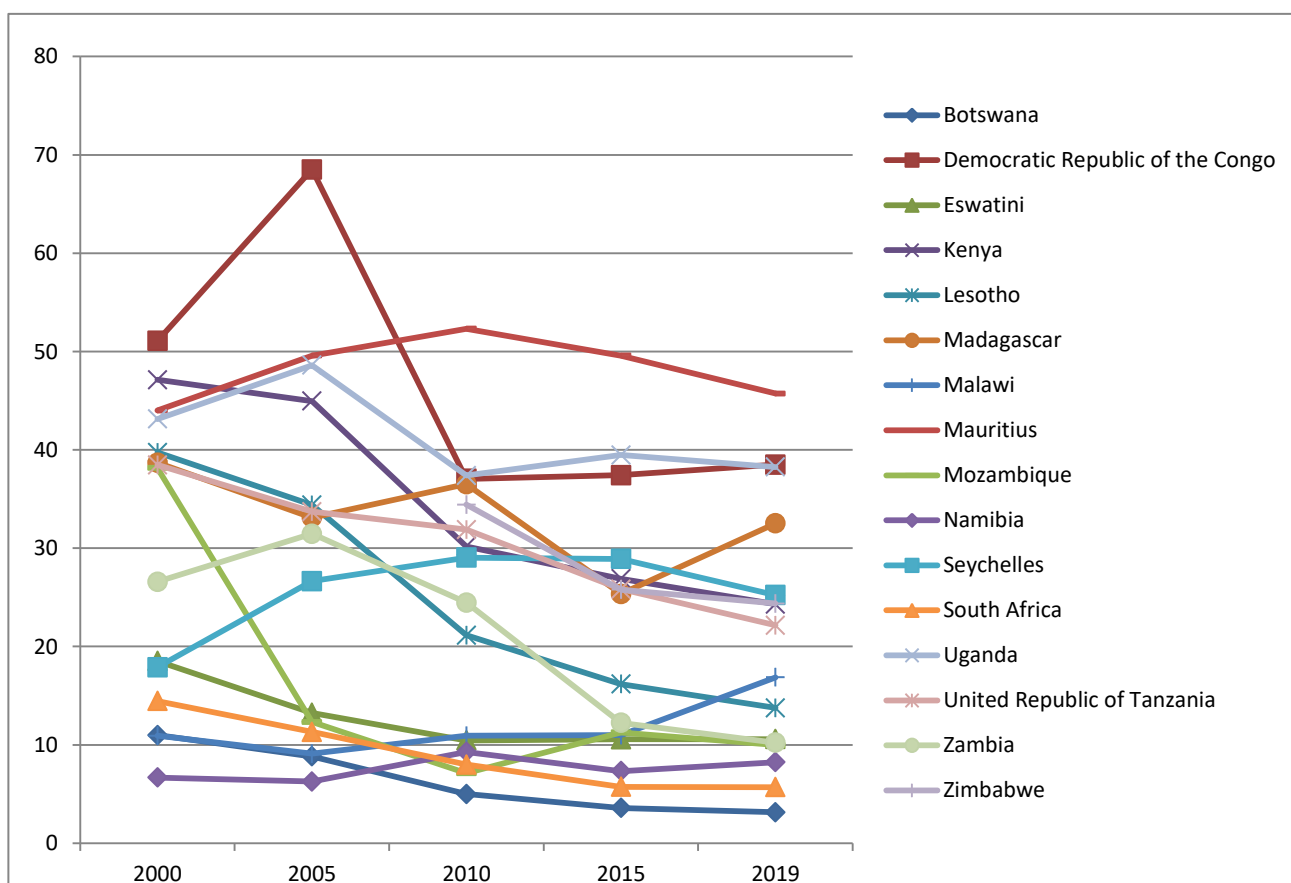


Source: WHO, 2021

3.3 Financial protection in health spending

Figure 3 shows the trends between 2000 and 2019 in the level of OOPS on health as a share of current health spending in ESA countries. Higher OOPS indicates poorer financial protection, with potentially catastrophic and impoverishing spending on health at the point of care, as opposed to more equitable pre-paid spending. OOPS is the most regressive source of health care financing and generally declines in ESA countries, as government spending increases (Doherty, 2019). Overall, Figure 3 suggests that OOPS was lowest and thus financial protection greater across the period 2000–2019 in Botswana, Namibia, South Africa, Malawi and Mozambique, and that financial protection improved in Zambia, Lesotho, Tanzania, Kenya and Zimbabwe. In contrast, OOPS rose or remained relatively high in Uganda, Mauritius, DRC and Madagascar over the period. In these latter countries, OOPS was above 30% of CHE, including in 2019, suggesting that households facing difficulties with rising food prices and falling incomes during the pandemic may have been more likely to fall out of health services. This was more so in lower income countries (Uganda, DRC, Madagascar) than in Mauritius. By 2019, seven ESA countries had OOPS spending above the WHO’s suggested upper limit of 20% to avoid catastrophic expenditures and impoverishment, four of these substantially so.

Figure 3: Out-of-pocket spending (OOPS) as % of current health expenditure (CHE), ESA countries, 2000–2019



Source: WHO, 2021

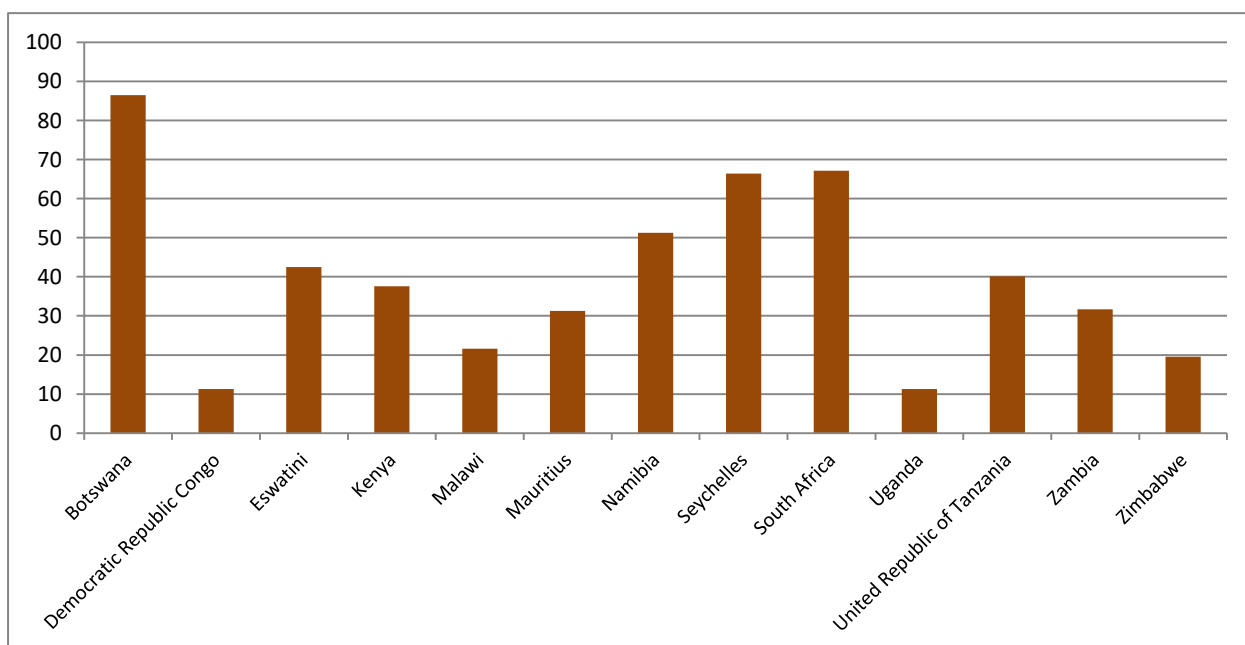
3.4 Pro-poor spending on primary health care

Figure 4 shows the trends in the share of government spending on PHC as a share of all spending on PHC as an indication of domestic pro-poor spending on local level health systems and pro-poor population health interventions. The data was only available for selected ESA countries and only for 2019. The data indicates that domestic spending on PHC as a share of

total PHC spending in that year was higher in Botswana, Seychelles and South Africa, and lowest in DRC, Uganda and Zimbabwe.

This is not an indication of *total* expenditure on PHC, as countries with low domestic spending may have higher levels of external financing on PHC. This is likely to be the case when countries with lower domestic spending are also lower income countries, and thus more likely to receive external funding. However, lower shares of domestic spending on these pro-poor levels and functions of health systems makes these countries more reliant on external funder priorities and therefore more susceptible to unpredictable and short term flows. Given the importance of public and community health and primary care levels of health systems for pandemic responses, particularly for detecting and preventing transmission, countries with lower levels of domestic spending on PHC may have had fewer resources under domestic control to quickly pivot to local level responses. This would imply a need for mobilisation of significant new domestic resources for effective responses, an issue further explored in the later section on the Zambia case study.

Figure 4: Domestic general government expenditure on PHC as % expenditure, ESA countries, 2019



Source: WHO, 2021

3.5 Public-private mix in health spending

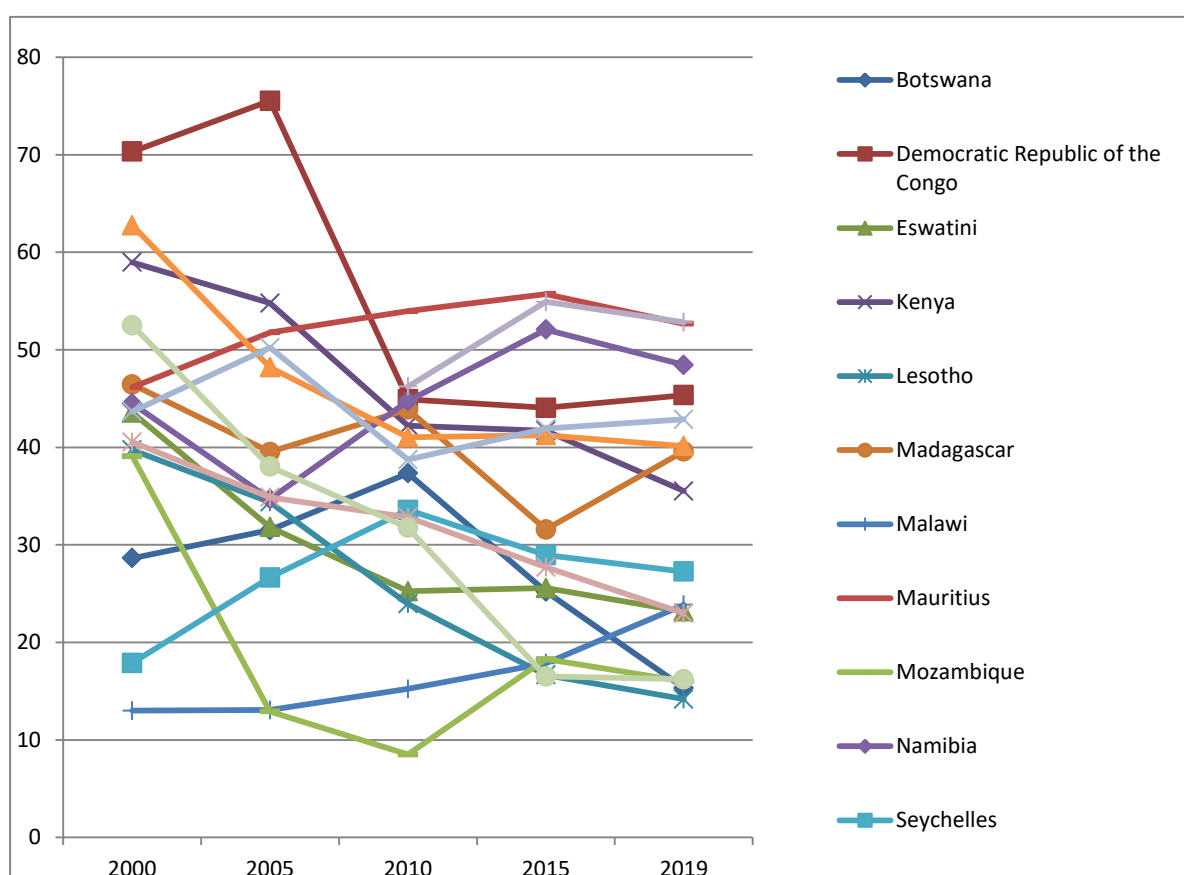
Figure 5 shows the trends between 2000 and 2019 in the share of domestic private health expenditure (PVT-D) in current health expenditure (CHE) in ESA countries. Lower income communities may have more difficulty in affording private services in countries with high shares of private spending, unless private spending is pooled with public funds in national health insurance funding. Private spending may be in the form of voluntary health insurance. In ESA countries, this extends cover for elites with limited pro-poor benefit, especially in the context of a weakly regulated for-profit private sector (Doherty, 2019).

Many ESA countries are seeking to create or expand social and national health insurance schemes, albeit with varying degrees of pooling funds from different sources and varying proportions of the population covered. South Africa's proposed national health insurance is observed to be the only option being considered or implemented that meets the definition of a

true national health insurance, under which all members of the population would be enrolled through pooling tax/non-contributory and contributory financing (Doherty, 2019).

Figure 5 indicates high shares of domestic private spending on CHE in Mauritius, Zimbabwe, Namibia, the DRC, Uganda, Madagascar and South Africa, with lowest shares by 2019 in Zambia, Malawi, and Mozambique. In the period 2000–2019, the private share in CHE fell markedly in the DRC, South Africa, Zambia and Tanzania, rose consistently in Malawi and fluctuated in the other ESA countries. In South Africa and the DRC, Figure 1 suggests that the falling private share may be related to rising public funding. This is less clear in Zambia and Tanzania. South Africa and Zambia, where falling OOPS may be better controlling the equity implications of private spending (See Figure 3) compared to Malawi, where both private shares and OOPS have been rising from 2000–2019.

Figure 5: Domestic private health expenditure (PVT-D) as % current health expenditure (CHE), ESA countries, 2000–2019



Source: WHO (2021)

The specific implications of a rising share of private spending in CHE for health sector preparedness for COVID-19 would need to be explored at country level. However, in a context where the pandemic further strained already stretched health systems, a review of public and private sector responses to COVID-19 in the region found that the public sector role was ‘critical and responsible in ensuring a co-ordinated, equitable and comprehensive response across all sectors, and for regulating and accrediting private sector activities’ (Chanda-Kapata, 2021:2). The review found many areas of private sector contribution, while noting that the extent to which these contributions were aligned to wider population needs was affected by public sector leadership and its engagement with the private sector (Chanda-Kapata, 2021).

4. Health financing in Zambia

This section presents a case study of health financing in Zambia, providing data on the trends in health financing post 2000 based on available national data and a particular focus on financing of the health system response to the COVID-19 pandemic in 2020.

As shown in *Table 2*, Zambia's positive economic growth in the 2010s led to the country being reclassified from a low-income to a lower middle-income country. Higher growth rates up to 2013 were however followed by declines post-2013. The COVID-19 pandemic, lockdown responses and trade and economic disruptions had a deep impact on Zambia's economy. The African Development Bank reported in 2021 that the country 'fell into a deep recession due to the adverse impact of the COVID-19 pandemic. Real GDP contracted by an estimated 4.9% in 2020, after growing by 4% in 2018 and 1.9% in 2019.' (ADB, 2021:online). While the exchange rate, inflation and budget positions in the early 2010s (see *Table 2*) suggested a relatively stable economy, from these indicators the economy appears to have become more unstable in the latter part of the decade. Domestic and external debt both rose consistently after 2010, and the economic costs of the pandemic significantly added to this. Zambia's stock of public debt was reported to have increased to an 'unsustainable 104% of GDP on 30 September 2020' (ADB, 2021:online). *Table 2* indicates that while poverty fell from 2010 to 2015, inequality rose. The pandemic is reported to have generated negative impacts, especially for lower income households, with estimates of rising poverty and inequality, notwithstanding the emergency cash transfer scheme put in place during the pandemic (UNU-Wider, 2021).

Table 2: Selected socio-economic indicators, Zambia 2010–2019

	2010	2013	2015	2016	2019
Population ('000s)	13 046	14 580	15 474	15 938	17 861
GDP Growth rate (%)	7.6	6.3	2.9	3.4	1.45
GDP per capita (US\$)	1 547.74	1 924.84	1 377.26	1 330.99	1 305
Inflation rate	6.5	7.1	21.1	7.5	9.2
Exchange rate (ZMW per US\$)*	4.8	5.39	8.63	10.31	14
Budget deficits (% GDP)	2.66	6.5	9.4	5.8	21
Government debt (% GDP)	21.8	25.5	61.4	60.5	77.5
Domestic debt (% GDP)	na	12	18.3	24	52
External debt (% GDP)	na	13.5	43.1	36.5	33
Poverty rate/ incidence	62.8	na	54.5	na	n.a
Gini Coefficient (%)	65	na	69	na	n.a

Sources: ZSA, 2013; BoZ, 2019, 2020

*The exchange rate is shown as a simple annual nominal rate of the Zambian kwacha (ZMW) to the US\$.

This economic situation provides a context for the demand for and allocation of health sector resources before and during the pandemic, as discussed in the following sub-sections.

4.1 Pre-pandemic health financing in Zambia

The health financing data for Zambia is drawn from National Health Accounts data covering the period 2002 – 2016. This data used specific classifications of financing measures in the system of health accounts (SHA) as shown in *Table 3*. Rather than undertake annual SHA surveys, Zambia SHA surveys have consistently been undertaken over a two to three-year interval in which the preceding years are covered retrospectively.

Government's overall expenditure on health increased in nominal terms between 2013 and 2016, with over 89% of this on current health spending and only 9–13% on capital spending (See *Table 4*).

Table 3. Definitions of financing classifications for SHA data

Classification	Definitions and Examples
Revenues of Financing schemes	Types of transactions through which funding schemes mobilize their income. Examples include internal transfers (from the ministry of finance to governmental agencies); direct foreign financial transfers (e.g. External donors providing funds to nongovernmental organizations (NGOs); and voluntary prepayment from employers
Financing schemes	The main funding mechanisms by which people obtain health services, answering the question “how are health resources managed and organized and how the health care goods and services are financed or paid for. These categorize spending according to criteria such as: the mode of participation in the scheme (compulsory vs. voluntary), the basis for entitlements (contributory vs. non-contributory) OOP
Revenues of financing schemes	Institutional units that provide revenues for the various schemes. Examples are government, corporations, households, rest of world (such as international foundations)
Financing agents	Institutional units that manage one or more health financing schemes. Examples include Ministry of Health, commercial insurance companies, NGOs and international organizations
Health care providers	Entities/organizations/actors that provide medical goods and services as their main activity, and those for whom health care provision is only one activity among many others. Examples include hospitals, clinics, health centres, pharmacies and traditional healers
Health care functions	Goods and services consumed by health end-users. Examples include: curative care; information, education, and counselling programs; medical goods such as supplies and pharmaceuticals; and governance and health system administration
Factors of provision	Inputs to the production of health care goods and services by health care providers. Examples include: compensation of employees, health care goods and services
Health Care-Related	Activities that may overlap with other fields of study, such as education, overall “social” expenditure, research and development (R&D), that may be closely linked to health care in terms of operations, institutions, and personnel
Capital formation	Assets which once acquired can be used for a period longer than one year such as infrastructure or machinery investment, as well as education and training of health person
Disease	Ailments or condition or intervention area by which health expenditure is analysed or is expected to address. Examples are malaria, reproductive health, trauma, non communicable diseases (NCDs)

Source: OECD et al., 2017

Table 4: Government Health Expenditure 2013 to 2016 (ZMW Million)

Expenditure Type	2013	%	2014	%	2015	%	2016	%
Current Health	1 982.2	87.0	3 163.7	87.0	3 833.8	90.7	3 704.6	89.2
Capital Expenditure	169.3	7.4	394.9	10.9	275.0	6.5	364.9	8.8
Capital -Related	120.0	5.3	72.1	2.0	113.3	2.7	77.0	1.9
Health Related	5.6	0.2	6.2	0.2	2.8	0.1	4.4	0.1
Total	2 277.2	100.0	3 637.0	100.0	4 224.8	100.0	4 150.9	100.0
Exchange rate (ZMW per US\$)*	5.39				8.63		10.31	

Source: MoH, UNZA, 2019. * The exchange rate is a simple annual nominal rate of the ZMW to the US\$.

As shown in *Table 5*, health expenditure was largely from government funding (41%) and external funders (42%), albeit with rising levels of government spending between 2011 and 2016. Current health expenditure (CHE) rose as a share of general government expenditure up to 2014, but fell thereafter to 2016. External funds to the sector decreased from 57% of CHE in 2013 to 41% in 2016. OOPS from households averaged 13% of total health expenditure in 2011–2016, and fell marginally after 2014.

There was an annual average increase in CHE of 8.3% in this period in nominal terms, but in US\$ terms, total CHE declined from US\$1,317.05 million in 2014, to US\$938.34 million in 2016 (See *Table 5*). Per capita CHE fell from US\$73 in 2012 to US\$58 in 2016. Public expenditure, at 2% of CHE, is below the WHO recommended minimum of 5%, and CHE at 6–8% of general government expenditure was below the Abuja target of expending at least 15% of the domestic budget on health. In 2014, the per capita spending by government rose to US\$34.2, but fell thereafter to US\$22.5 by 2016.

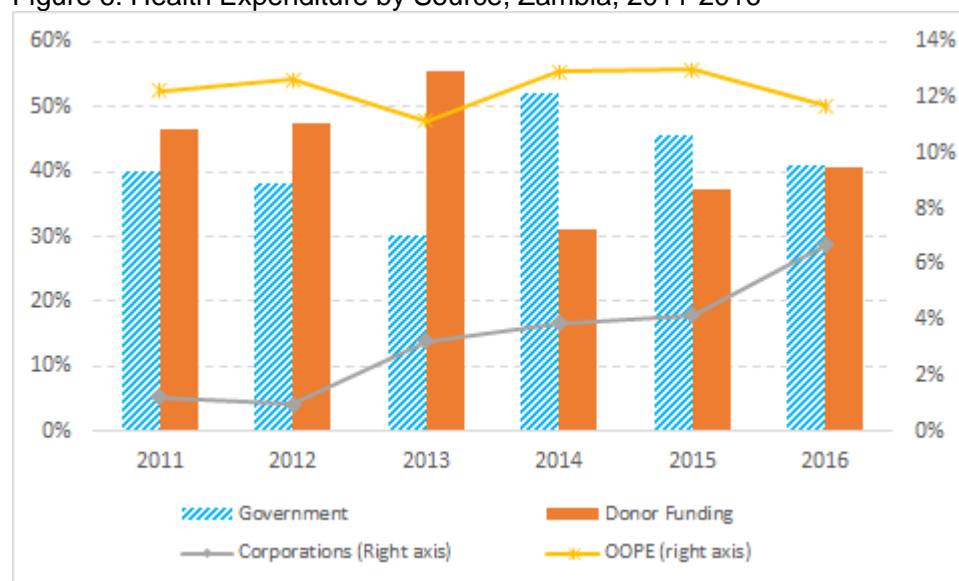
Table 5: Selected Health Financing Indicators for Zambia, NHA Estimates, 2011-2016

	2011	2012	2013	2014	2015	2016
Nominal CHE (ZMW millions)	4016.6	4732.8	7098.9	6396.8	8134.8	9674.3
Nominal CHE (US\$ millions)	826.5	851.2	1317.1	1040.1	942.6	938.3
Government Health Expenditure (GHE) (ZMW M'000)	1637.3	1888.8	1982.2	3163.7	3833.8	3704.6
External Current (ZMW millions)	1771.6	2076.9	4056.8	2082.1	2977.1	4115.0
OOPS (ZMW Millions)	550	671	810	884	996	1 177
External CHE % Nominal CHE	44.1	43.9	57.1	32.5	36.6	42.5
Government CHE% Nominal CHE	40.8	39.9	27.9	49.5	47.1	38.3
Per capita CHE (US\$)	60.24	60.18	90.33	69.23	60.92	58.87
Government per capita CHE(US\$)	24.56	24.02	25.22	34.24	28.71	22.54
External per capita CHE (US\$)	26.57	26.41	51.62	22.53	22.29	25.04
CHE % GDP	4.08	3.61	4.69	3.83	4.43	4.47
Government CHE % GDP	1.67	1.44	1.31	1.89	2.09	1.71
Government CHE % GGE	7.31	7.17	6.13	8.21	7.42	7.14
OOPS % THE	13.70	14.17	11.41	13.82	12.25	12.16
OOPS % GDP	0.56	0.51	0.54	0.53	0.54	0.54

Source: Adapted from the MoH, UNZA, 2019

Funding came from government, external funders ('donors'), households (OOPS) and private (corporations) as shown in *Figure 6*. The figure shows a fall in the share of government health expenditure after 2014 and a corresponding rise in the share of external financing, although at lower levels than pre-2014 averages. While OOPS remained relatively constant, private financing rose in the period. The increased reliance on external sources of health financing leaves the country relatively exposed to external influence in policy priorities and design.

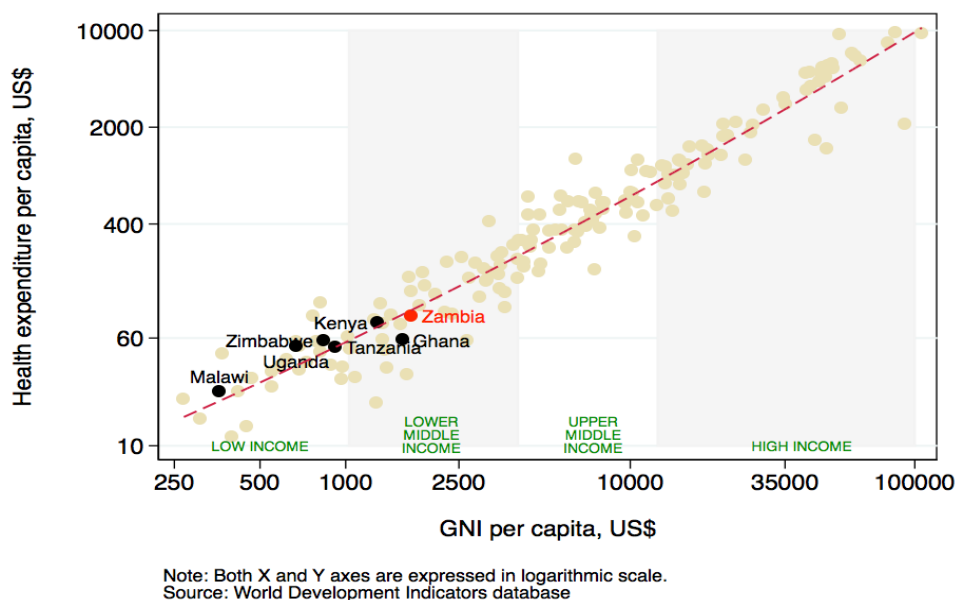
Figure 6: Health Expenditure by Source, Zambia, 2011-2016



Source: MoH, UNZA, 2019

While health financing has fluctuated and public financing has fallen in recent years, as indicated, Zambia's per capita expenditures are comparable with other countries in the region and with the relationship between its per capita gross national income, as shown in *Figure 7*.

Figure 7: Zambia's per capita health expenditure vis a vis comparator 2014



Source: MoH, UNZA, 2019

4.2 Pre-pandemic distribution of health financing

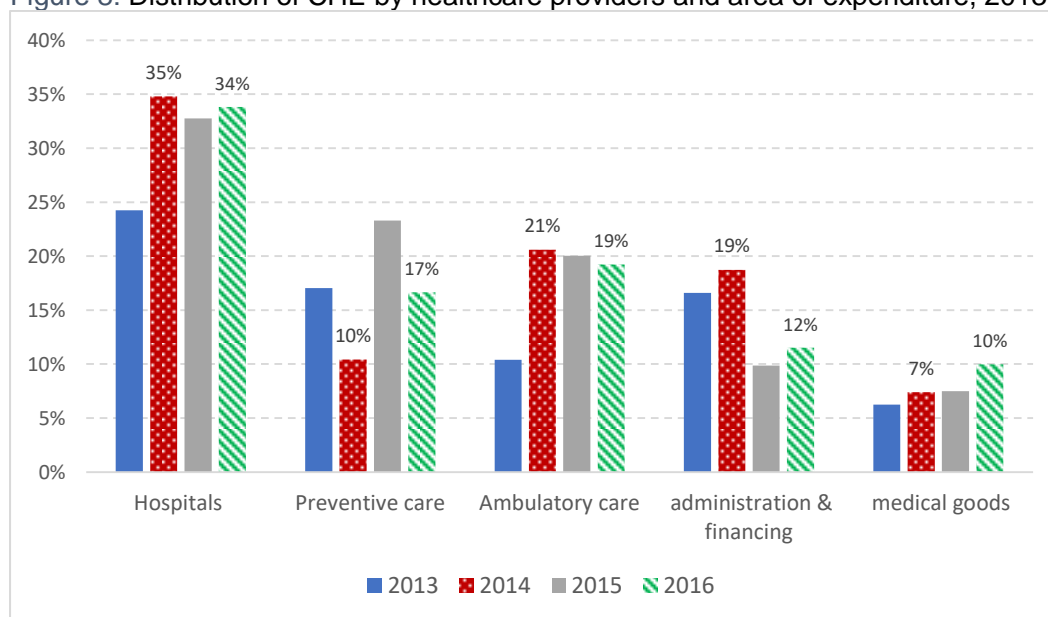
As shown in *Table 6 and Figure 8*, hospitals were the major recipient of health spending, averaging over 30% in 2013–2016. Ambulatory care services include community health worker services, health posts, health centre services, and district hospitals as health centre referral services. Ambulatory services continued to receive lower shares in relation to hospitals, although this increased from 9% in 2013 to 18% in 2016. Expenditures on preventive services and health promotion were consistently lower than for curative care over the period. This is not unusual but what is noticeable is that while the share of spending on curative functions rose from 31% in 2013, to 53% in 2016, the share for preventive services and health promotion rose only from 17% to 25% over this time; HIV/AIDS, malaria and reproductive health consumed an average of 56% of total CHE annually, with HIV/AIDS alone accounting for 34% (MoH and UNZA, 2019).

Table 6: Distribution of CHE (percent) by provider and area of expenditure, 2013–2016

Provider	2013	2014	2015	2016
Hospitals	24	35	33	34
Residential long-term care facilities	0	0	0	0
Providers of ambulatory health care	10	21	20	19
Providers of ancillary services	1	1	1	1
Retailers and other providers of medical goods	6	7	8	10
Providers of preventive care	17	10	23	17
Providers of health care system administration and financing	17	19	10	12
Unspecified health care providers	22	7	5	2
Total	100	100	100	100

Source: MoH and UNZA, 2019

Figure 8: Distribution of CHE by healthcare providers and area of expenditure, 2013–2016



Source: MoH and UNZA, 2019

Falling overall budget spending by government (as indicated in *Table 5*) has been associated with a relative decline in the prevention and health promotion budget as compared to the curative budget. This is important in considering preparedness for prevention of disease outbreaks.

4.3 Financing the response to COVID–19 in Zambia

In response to the pandemic, Zambia set up a Public Health Emergency Operations Centre (PHEOC) and activated a multi-sectoral incident management system. Various forms of communication outreach were used on radio, TV, social media and in daily press briefings, to inform the public and a dedicated call centre was set up for the public to report concerns and receive information.

A COVID-19 Contingency Plan and Contingency Fund was set up under the Office of The Vice President Disaster Management and Mitigation Unit, to finance procurement of medical supplies and equipment associated with the response. Donations were centralised to ensure accountability, with systems for targeted audit of COVID resources and a publicised list of donated items and targets (Chanda-Kapata, 2021).

Mandatory reporting, quarantine, isolation, testing and contact tracing were put in place and, as cases increased, there were restrictions on public gatherings, social distancing, school closures, travel restrictions and encouragement of remote work. Active surveillance and mandatory screening was implemented at ports of entry at various periods around pandemic peaks, with mandatory quarantine for international travellers and restrictions on non-essential foreign travel.

Facility preparedness and staff training was implemented in all districts to manage COVID-19 cases free of charge and efforts were made to minimise interruptions to child, maternal and reproductive health and to key services for surgical cases, cancer treatment and others. Protective equipment and related commodities were secured for frontline health workers and resources mobilised to expand or rehabilitate medical oxygen plants. Laboratory testing capacities were expanded to all provinces, including the repurposing of existing testing facilities for TB and HIV to include COVID-19. Genomic analysis and epidemiological assessment and forensic pathology were scaled up to track pandemic developments (Chanda-Kapata, 2021). These actions raised significant new resource needs that demanded rapid attention.

Table 7 summarises the external pledges made for the national response to the pandemic, while *Table 8* indicates the overall budget projections and allocations for COVID-19 interventions. *Table 8* also shows the gap between available funding versus total costs for successful management of the response, covering prevention and health promotion interventions, case management, and treatment and care. The funding gap indicated in *Table 8* is significant, notwithstanding the level of funds expected to be raised from external resources.

The budgeted external funds shown in *Table 8* significantly exceed those committed, as shown in *Table 7*, while external funds in *Table 8* are much greater than the domestic resource allocation. At the same time, the domestic budget allocation for the COVID-19 health sector response in 2021 (US\$447,727), is 12% of the total health budget allocated in 2016, and the total funding need is six times the 2016 health budget, even without vaccine costs, which are not reflected in *Table 8*. The table does, however, indicate that 77% of funding needs are for prevention and health promotion-related functions, as opposed to curative and administration functions, which is notably inverse to the routine allocation of the health budget.

Table 7 Pledged and Committed Funds for the COVID-19 National Response 2021-2022

Co-operating Partner	Amount Pledged (000s)	US\$ Equivalent (000s)	ZMW Equivalent (000s)
African Development Bank (ADB)	USd 67 500	67 500	1 215 000
World Bank	USd 79 900	79 900	1 438 200
European Union	EUR 89 300	97 100	1 747 800
Global Fund to Fight HIV/AIDS, TB and Malaria	USd 6 700	6 700	120 600
Germany	EUR18 500	20 116	362 086
United States of America	USd 14 500	14 500	261 000
United Kingdom (DFID)	GBP 46 400	57 300	1 031 400
Sweden	USd 12 400	12 400	223 200
Total		355 516	6 399 286

Source: GoZ, 2021b

The total funding need for the pandemic, of 220 million ZMW shown in *Table 8*, dwarfs the 2016 government health budget of 3.7 million. The greater share of prevention-related budgets was for diagnostic testing, infection prevention and control, including for the health workforce and health product and waste management systems. These are also the areas where the funding gap was noted to be highest (See *Table 8*).

For example, in 2021, the funding gap for health products and waste management is 91% of need; for infection prevention and control, 90% of need; and for diagnostics and testing, 92% of need. For therapeutics and case management, the funding gap is much lower, at 45% of need. While the funding gap for surveillance and contract tracing is also low, imbalances in resource availability for the full chain of prevention responses indicated by these high funding gaps, is suggestive of weaknesses in the public health response chain.

Table 8 suggests that external funding has a preference for, or more easily directs resources to treatment, leaving some critical areas of the pandemic response significantly underfunded.

Further to these features of the funding for the pandemic, the 2020 report of the Zambian Auditor-General noted limitations in both the capacity and accountability. This may affect the effectively management of resources when faced with the significant rise in demand from a major public health challenge. The report pointed to the necessity of building strong information systems including routine health system data collection and reporting (GoZ, 2021b).

Table 8 Zambia: Country COVID-19 funding allocations (ZMW*), 2020-2023

		Country-level coordination and planning	Risk communication	Surveillance-Epidemiological investigation and contact tracing	Surveillance systems	COVID Diagnostics and testing	Laboratory systems	Infection prevention and control and protection of the health workforce	Health products and waste management systems	Case management, clinical operations and therapeutics	Total
Funding Need	2021	1 179 573	1 529 545	2 877 555	679 545	35 500 000		50 516 127	77 413 636	50 516 127	220 212 110
	2022	1 474 467	1 911 932	3 596 943	849 432	44 375 000	0	63 145 159	96 767 045	63 145 159	275 265 138
	2023	1 769 360	2 294 318	4 316 332	1 019 318	53 250 000	0	75 774 191	116 120 455	75 774 191	330 318 165
Domestic	2020										0
	2021	20 455	22 727	18 182	45 455	90 909		9 0909	68 182	90 909	447 727
	2022										0
	2023										0
Non-Global Fund External	2020										0
	2021	710 615	1 247 706	2 684 168	180 030	2 690 980		5 265 197	6 842 915	27 337 422	46 959 033
	2022	45 000	70 000	175 000	250 000	1 500 000		1 000 000		75 000	3 115 000
	2023	30 000	40 000	150 000	250 000	1 500 000		750 000		75 000	2 795 000
Funding Gap	2021	448 504	259 112	175 205	454 061	32 718 111	0	45 160 021	70 502 540	23 087 796	172 805 350
	2022	1 429 467	1 841 932	3 421 943	599 432	42 875 000	0	62 145 159	96 767 045	63 070 159	272 150 138
	2023	1 739 360	2 254 318	4 166 332	769 318	51 750 000	0	75 024 191	116 120 455	75 699 191	327 523 165

*Exchange rates: “ 2019 14.05 ZMW = 1US\$; 2020 ZMW 20.02 =1US\$.

Source: MoH, 2021

5. Discussion

The regional analysis reviewed selected indicators of the:

- extent to which governments prioritise health in domestic budget spending;
- level of financial protection;
- level of government pro-poor spending on primary healthcare; and
- share of public versus private financing in total health expenditure.

The findings indicate that between 2000 and 2019:

- While five ESA countries progressively increased their share of health spending in the budget, two showed declines, and the levels have fluctuated in the others. Countries that gave weaker priority to health spending or reduced their share of health spending in 2019, are argued to have been in a weaker position at the onset of the COVID-19 pandemic in relation to their public health sectors. Zambia's share of health spending in the budget fell markedly to 2010 and then rose in the later part of the decade, though at 8%, still well below the target of 15%.
- As a wider indication of the priority given to health, across the whole period, the share of current health spending from all sources in GDP exceeded 5% for six ESA countries, increased in four and fell in two. By 2019, ten ESA countries were spending over 5% of their GDP on health from all sources, much of it from household spending.
- By 2019, seven ESA countries had OOPS above the WHO's suggested upper limit of 20% to avoid catastrophic expenditures and impoverishment, four of them significantly so. In the four countries where OOPS was above 30% of CHE, including in 2019, households facing difficulties with rising food prices and falling incomes in the pandemic may have been more likely to fall out of health services. Zambia had a falling level of OOPS post 2010 and was one of five ESA countries providing a higher level of financial protection by 2019, important in protecting households during the pandemic.
- In nine of the 16 ESA countries (including Zambia) less than 50% of PHC spending is allocated from government sources, suggesting a high degree of reliance on external funding for this key area of pro-poor spending. These countries are therefore more reliant on external funder priorities and more susceptible to unpredictable and short term flows, particularly for the public and community health and PHC levels of health systems that are key in pandemic responses. The pandemic is thus likely to have created an immediate demand for significant levels of new domestic resources.
- For seven ESA countries, 40% or more of current health spending is from private sector sources. Drawing on the findings, this share has been falling in many ESA countries, although not always in direct proportion to increases in public spending, possibly due more to falling OOPS. High shares of private financing, together with low shares of public financing, suggest fragmented health financing and fragmentation of the health system, with implications for equity and quality. The strength of the public sector has been found to be critical for ensuring a co-ordinated, equitable and comprehensive response to the pandemic across all sectors. However, this in turn depends, not only on the share of public spending of total health spending, but also on the adequacy of domestic public sector resources for the response.

Within the ESA data, Zambia's spending on health from all sources is about 5% of GDP spending, with low and falling OOPS, indicating reasonable levels of spending from all sources and falling OOPS suggesting increasing levels of financial protection. These are important positive features in pandemic preparedness. However Zambia has also had a falling share of government spending on health, a low share of government spending in total PHC expenditures, suggesting dependency on external funds for this level and potentially limiting the resources for domestic public sector leadership in co-ordinating and implementing pandemic responses.

Botswana and South Africa both demonstrate multiple positive features: rising government share of spending on health; reasonable health expenditure as a share of GDP; low and falling OOPS; and a high share of domestic government spending in total PHC expenditure. The implications of this for pandemic preparedness would need to be explored through more focused country studies.

While the regional data indicating the pre-pandemic preparedness situation was only available up to 2019, from 2020, health care financing has faced the added weight of COVID-19. The pandemic has created both health and economic burdens, as well as the interactions between them. In the health sector there are new demands for a range of health promotion and prevention interventions building on past investment, yet these are hampered by deficits in these areas. It has also raised demand for curative services at a time when services for other conditions are still needed. The pandemic has exerted a heavy toll on households and communities. This makes the health sector response a critical element for household wellbeing both during and after the pandemic. With fragmented systems and dependence on external funding for PHC services, public health sectors must have the capacity to align the various actors to achieve a co-ordinated pandemic response.

In the Zambia case study, there is some evidence of the pandemic's impact on health financing. The country experienced a period of positive economic growth, but with lower growth in the years immediately prior to the pandemic. The pandemic impact and responses are reported to have led to economic disruption, recession, increased domestic and external debt, intensified household poverty and inequality, with resource scarcities for health sector and other spending. Rising indebtedness reduces the fiscal space for social spending, as has been evident in the fall in real health sector and education spending over the last three years. Increasing reliance on external sources of health financing left the country relatively exposed to external influence in policy priorities and design for the COVID-19 response. So too, however, was the falling share of spending on health promotion and prevention, particularly as overall health spending fell in real terms, and an increasing focus on curative care in the budget.

While Zambia implemented features of a robust preventive, health promotion and care response, the data on financing need versus resources mobilised, points to a shortfall in the coverage intended in policy. Financial planning for the health sector response showed that, in contrast to prior spending patterns, the greater share of resource needs was for prevention-related activities including: testing; infection prevention and control, including for the health workforce; and health product and waste management systems. These areas are also where the funding gap was noted to be highest. In part this appears to be due to the dependence on external funds to meet resource gaps. The data indicates relatively greater levels of external funder resource support for treatment and care rather than for prevention services.

The health ministry's COVID-19 budget showed a sudden, urgent and costly increase demanded by the need to mitigate COVID. This shock and COVID's impacts and demands have affected the provision of and uptake of other health care services, with some reports of reversal of previous gains in areas such as maternal and child health, as resources were redirected to address emergent pandemic needs and health workers were over-stretched.

Leaving significant areas of the pandemic response critically underfunded, by over 90% in some areas, raises questions of what this means for the overall efficiency, effectiveness and equity of the response. Further, a funding need nearly 60 times higher than the last recorded government health spending in the 2016 national health accounts, raises the question of the extent to which this is a result of sustained under-financing of critical prevention infrastructure, supplies and services over many years. Conversely, the benefit of such previous investments is apparent in the ability to make use of existing HIV, malaria and TB related laboratory services to rapidly decentralise laboratory capacity for COVID-19.

The evidence suggests that pandemic preparedness is not an acute event, but rather a sustained process of investment in key areas of: testing; surveillance; infection prevention and control, including for the health workforce, and in health product and waste management systems and health promotion interventions for the wider range of priority public health conditions. This may be more likely to enable rapid repurposing and switching to address pandemic needs. Pandemic preparedness implies ensuring adequate investment in the organisation and capacities of care services and personnel so that other health services do not suffer during a pandemic.

Beyond provision of specific services, the evidence also suggests that pandemic preparedness is likely to be greater where the public sector share of financing does not fall to levels that undermine domestic public sector leadership of the multiple actors in the response, including their ability to align the priorities and resources of private and external actors. This too is not an event, and this study indicates a demand for a more consistent prioritisation of public health sector financing and performance, and a reversal of financing trends in a number of countries in the ESA region that undermine this.

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Acronyms

ART	Antiretroviral Therapy
EQUINET	Regional Network for Equity in Health in East and Southern Africa
ESA	Eastern and Southern African countries
CHE	Current Health Expenditure
COVID-19	Coronavirus-Related Disease
HIV/AIDS	Human Immunodeficiency Syndrome/Acquired Immune Deficiency Syndrome
GDP	Gross Domestic Product
GGHE	Government Health Expenditure as Share of Government Expenditure
GHE	Government Health Expenditure
MoH	Ministry of Health
NGO	Non-Governmental Organisations
NHA	National Health Accounts
OOPS	Out-Of-Pocket Spending
PHC	Primary Health Care
PHE	Private Health Expenditure
PHEOC	Public Health Emergency Operations Centre
PVT-D	Domestic Private Health Expenditure
SHA	System of Health Accounts
TB	Tuberculosis
WHO	World Health Organization
WB	World Bank

Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity-oriented interventions. EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

EQUINET implements work in a number of areas identified as central to health equity in east and southern Africa

- Protecting health in economic and trade policy
- Building universal, primary health care oriented health systems
- Equitable, health systems strengthening responses to HIV and AIDS
- Fair Financing of health systems
- Valuing and retaining health workers
- Organising participatory, people centred health systems
- Promoting public health law and health rights
- Social empowerment and action for health
- Monitoring progress through country and regional equity watches

EQUINET is governed by a steering committee involving institutions and individuals co-ordinating theme, country or process work in EQUINET from the following institutions:
TARSC, Zimbabwe; CWGH, Zimbabwe; University of Cape Town (UCT), South Africa;
CEHURD Uganda; University of Limpopo, South Africa; SEATINI, Zimbabwe; REACH Trust Malawi; Ministry of Health Mozambique; Ifakara Health Institute, Tanzania; Kenya Health Equity Network; Malawi Health Equity Network, SATUCC and NEAPACOH

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