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POLICY BRIEF



Advancing Strategic Health Purchasing in Zambia's Decentralized Health System: Progress, Gaps and Opportunities

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Abstract

In pursuit of Universal Health Coverage (UHC), Zambia has been implementing decentralization reforms alongside strategic health purchasing reforms, including the establishment of the National Health Insurance Scheme (NHIS) in 2019. While these reforms mark important progress, decentralization continues to face challenges. This policy brief is based on a qualitative study that utilized the Strategic Health Purchasing Progress Tracking Framework to assess strategic health purchasing progress and gaps in Zambia's decentralized health system. Findings reveal persistent barriers, including limited resources, fragmented governance, weak coordination, outdated benefit packages, passive provider payment, and fragmented data systems. To strengthen strategic health purchasing within decentralization, this brief outlines key policy opportunities, including stronger governance arrangements, improved data management, the use of Health Technology Assessment (HTA) in benefit design, and capacity building at the district level.

Background

Over the past 10–15 years, Zambia has implemented significant health sector reforms, including health financing and strategic health purchasing (SHP) reforms, as part of its progress towards Universal Health Coverage (UHC). Key milestones include revising the basic health care package (2011), introducing of Result Based Financing (RBF) in selected districts (2012), abolishing user fees at Primary Health Care (PHC) level (2006, 2011), developing the Health Financing Strategy (2017-2027) and establishing of the National Health Insurance Scheme (NHIS) (2019).

In parallel, Zambia has been implementing decentralization reforms since the 1980s, gradually shifting from a centralized model to an increasingly devolved structure, as shown in Figure 1. The ongoing health sector devolution aims to enhance Primary Health Care (PHC) by shifting purchasing authority from the central government to Local Authorities (LAs). District Councils (DCs) are being positioned as the principal purchasers of PHC services, with strengthened mandates for decision making and resource management at the sub-national level. This reform is designed to empower local governance structures, increase efficiency and improve their response to community health needs.

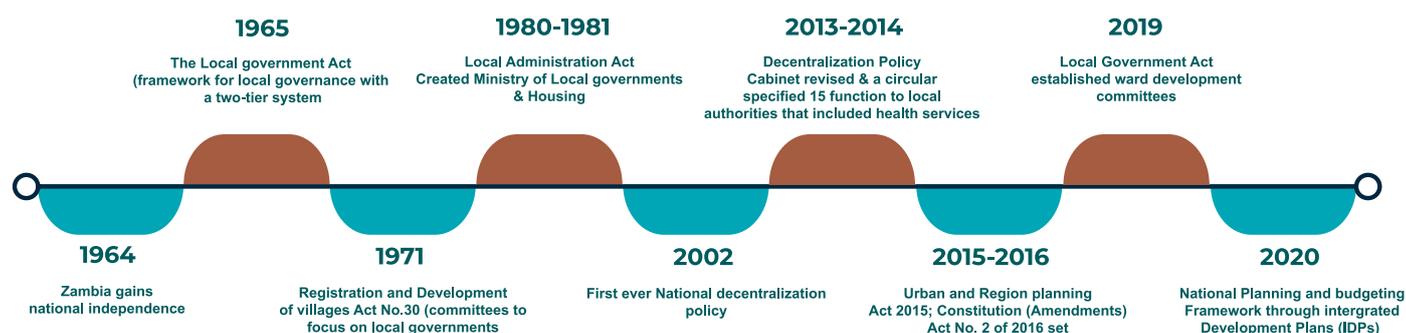
Under the devolved structure, implementation of Strategic Health Purchasing (SHP) reforms and progress towards UHC is significantly dependent on the political, policy, and technical capacity of the DCs. These transitions have encountered implementation challenges in governance, legal framework, and institutional capacity. This policy brief examines SHP reforms within the context of decentralization, highlighting key challenges and identifying policy opportunities.

Zambia at a Glance

- ▶ Population (2022): **19,693,423**
- ▶ Gross Domestic Product (GDP) per capita (2023): **\$1,330.7**
- ▶ Current Health Expenditure (CHE) as % of GDP (2021): **6.64%**
- ▶ Current Health Expenditure (CHE) per Capita in US\$ (2021): **74.84%**
- ▶ Domestic General Government Health Expenditure (GGHE-D) as % of CHE (2021): **42.52%**
- ▶ Domestic Private Health Expenditure (PVT-D) as % of CHE (2021): **8.02%**
- ▶ Out-of-Pocket (OOPS) as % of CHE (2021): **7.08%**
- ▶ External Health Expenditure (EXT) as % of CHE: **49.46%**
- ▶ National Health Insurance Scheme (NHIS) as % of CHE: **5.93%**

Source: WHO Global Health Expenditure Database, Zambia Statistics Agency (ZamStats), Revised 2022 Census of Population and Housing Summary Report Volume II, World Bank, World Development Indicators – GDP per Capita (NY.GDP.PCAP.CD)

Figure 1: The Journey of Devolution in Zambia: A Timeline



Source: Authors

Methodology

The findings reported in this brief are based on a qualitative study that applied the Strategic Health Purchasing Progress Tracking Framework to assess SHP progress and gaps in the context of ongoing decentralization reforms in Zambia. Data were collected through document reviews of gray and published literature, and 14 semi-structured key informant interviews (KIIs). A stakeholder validation workshop was held in February 2025, with representatives from the Ministry of Health (MoH), Ministry of Finance (MoF), Ministry of Local Government (MoLG), National Health Insurance Management Authority (NHIMA), Development Partners, and District Health Offices (DHOs) to validate the findings.

Purchasing Arrangements in Zambia

In Zambia’s decentralized state, there are three main purchasers: The Ministry of Health (MoH), District Councils (DCs) and National Health Insurance Management Authority (NHIMA). The MoH is mandated to develop policies to oversee parastatals and training institutions, and purchase health services from tertiary and secondary hospitals. Secondly, the DCs are mandated as key purchasers of PHC services, utilizing funds allocated through the Government Health Budget. These funds are transferred to districts through grants, which then allocate these resources to primary health facilities for the provision of the Basic Health Care Package (BHCP). Thirdly, NHIMA was established in 2019 to govern the National Health Insurance Scheme (NHIS), which provides health insurance for formal and informal sector workers, funded through payroll taxes and member contributions.

Table 1: Purchasing arrangements in Zambia’s decentralized health system

SHP arrangements	Ministry of Health	District Councils	National Health Insurance Management Authority
% of Current Health Expenditure	43%= Government funded budget 49.4%= External funding	(not explicitly stated – inferred to be part of MoH’s 43%)	5.93%
Population covered	All population [100%] App. 20 m (2022)	All population [100%]	25% of the population
Governance arrangements	MoH is mandated to develop policies to oversight parastatals and training institutions, purchase health services from tertiary and secondary hospitals, and oversee vertical disease programs (HIV, Malaria, NCDs, NTD).	District Councils are mandated to plan, budget and implement the PHC policy under decentralization. Semi-autonomous; limited authority to allocate funds to meet local health needs; reliance on central procurement resulting in reduced flexibility.	NHIMA oversees the day-to-day activities of the NHIS. NHIMA Board provides oversight, but limited independence affects decision-making.
Public Financial management	The MoH receives direct grants from the Ministry of Finance (MoF), with internal audits conducted under parliamentary oversight and annual external audits to enhance transparency. Additionally, hospitals have been granted financial autonomy, though they must report financial data through Navision, a financial oversight system.	DCs receive PHC funding through the Government Health Budget, which integrates domestic revenue (79.5%) and donor contributions (20.5%). Full council financial meetings provide mechanisms of accountability for resources entrusted to the district council including PHC funds.	NHIMA’s financial management is guided by the public financial management act and public procurement act. However, NHIMA’s financial management system is not fully integrated within Integrated Financial Management Information System (IFMIS).

Benefit specification	The MoH defines the national health benefit package Basic Healthcare Package (BHCP) which has undergone multiple revisions with the last revision being in 2012. This guides the MoH to purchase health services. There is an element of co-payment through user fees at district, provincial and referral hospitals especially for patients who do not have any form of health insurance.	The BHCP guides District Councils purchase services from the Primary Health Care (PHC) level. The User Fee Removal Policy (2006) mandates that the benefit package is provided free of charge at the point of access for all Zambian citizens at PHC level, however, patients incur informal payments.	NHIMA has an explicit benefit package that outlines the included and exempted services. It provides services beyond level 1 hospitals - district hospitals, as user fee is abolished at the PHC Level. This package was last revised in 2024 guided by an actuarial review reflecting Zambia's health needs. A 50% co-payment in private healthcare facilities was introduced. Exclusions made include high-cost, low-impact services like spectacles and private-sector dental crowns.
Contracting & provider selection arrangements	Automated selection of public facilities without formal agreements. There are no provisions to engage private health providers. The Churches Health Association of Zambia (CHAZ) has a Memorandum of Understanding (MoU) with the Government of Zambia.	Contracts with PHC providers are implicit, relying on historical allocations rather than formal agreements. There are no provisions to engage private health providers. However, there exists a Memorandum of Understanding between the government and faith based PHC providers.	NHIMA offers formal contracts to both public and private providers. Contracts specify service quality standards; however, they tend to be limited to input indicators and there is limited use of output/ outcome data. Contracts are standardized, specifying service scope, pricing (based on MoH guidelines), and penalties for fraud (e.g., clawbacks, de-accreditation).
Provider payment methods	Mainly passive purchasing mechanisms e.g. allocation of global budgets to public hospitals and faith-based facilities under CHAZ based on a predefined allocation formula.	Mainly passive provider payment methods such as line-item budgets for inputs such as salaries, medicines and medical supplies, and cash imprest for minor operational expenses.	NHIMA uses a mix of input-based methods. Fee for service is used to reimburse accredited pharmacies and diagnostic centers, as well as high-cost interventions like cardiac procedures. Flat-rate payments apply to inpatient and outpatient services at Level 1 hospitals and outpatient services at Level 2 and 3 hospitals. Diagnosis-Related Groups (DRGs) were introduced to reimburse inpatient services at level 2 and 3 hospitals.
Performance monitoring	The MoH rely on the District Health Information System (DHIS2) to track service outputs and Navision for financial oversight. The data collected is not consistently used to inform purchasing decisions.	Each district council undertakes quarterly performance assessments of every facility. The DCs also rely on DHIS2 to track service outputs and Navision for financial oversight. The data collected is not consistently used to inform purchasing decisions.	NHIMA has advanced its automation efforts by incorporating eNHIMA for membership and contributions, ASPACE for claims processing, HIP (Holistic Insurance Platform) for comprehensive claims management, and DHIS2 for data reporting.

Barriers to Effective Strategic Health Purchasing under Health Sector Decentralization in Zambia

Zambia is in its first steps of institutionalizing SHP in a decentralized state guided by key policies such as the National Decentralization Policy (2013), Local Government Act of 2019 and the Constitution of Zambia (Amendment) Act No. 2 of 2016. These policies mandate the transfer of PHC oversight and implementation to DCs. While progress has been made in governance and institutional strengthening, challenges in advancing SHP at the district level still persist.

Weak governance structures

Overlapping mandates between the Ministry of Health (MoH) and District Councils (DCs) create weak accountability structures and slow decision-making. While DCs are responsible for PHC, MoH retains control over key decisions, including human resource management. This slows down the decision-making process. Weak collaboration between the MoH and DCs limits priority alignment, resource coordination, and SHP reform implementation. Dual reporting structures between District Health Departments and Provincial Health Offices (PHO), for DCs, further complicate governance. Lastly, weak technical capacity at the DCs limits the effective implementation of SHP reforms.

Financial management limitations and inefficiencies

The implementation of the Basic Health Care Package (BHCP) is hindered by funding shortages, leading to informal charges despite the User Fee Removal Policy (2006). Late disbursements of these limited funds to DCs, limited financial autonomy and weak budget enforcement result in rationing of supplies, and limited responsiveness to health needs affecting service delivery. Additionally, financial allocation is based on historical patterns rather than current needs.

Donor-funded programs operate separate financial structures, with 70% of donor funds bypassing national systems, weakening government oversight. Additionally, there is a lack of integration between financial and service data systems. Systems like Navision that track financial and DHIS2 that monitor services operate independently, making it difficult to align expenditures with health outcomes.



Outdated BHCP and non-participatory benefit design

The BHCP has not been updated since 2012, making it misaligned with Zambia's evolving health needs. Additionally, DCs have minimal input in benefit package revisions, relying on MoH directives, which limit their ability to adjust services based on real-time priorities. The multiple HBPs limit alignment with the overall health system's goals.



Weak contracting processes

The absence of stringent contracting and quality enforcement mechanisms for public health facilities results in inconsistent service delivery and a lack of accountability.



Lack of performance-linked payments

Provider payments are not tied to performance, reducing incentives to improve service quality and efficiency, leading to disparities in care standards.



Limited use of data for purchasing decisions

While data collection systems exist, MoH and DCs do not consistently use them to guide purchasing decisions. Many DCs still use manual financial tracking (paper – based systems), which undermines transparency, accountability, and real-time financial oversight.

Policy Opportunities

- ▶ **Strengthen governance integration** - To enhance policy coherence, Zambia should establish a multi-stakeholder coordination body that brings together DCs, NHIMA, the Ministry of Health (MoH), and donor agencies. This platform would facilitate joint planning, harmonize priorities and fund allocation for strategic health purchasing (SHP) reforms. Clearly defining roles and responsibilities will help address governance ambiguities and overlapping mandates, ensuring that decision-making at the district level is more efficient.
- ▶ **Evidence based benefit packages** - To ensure that the package meets current health needs, the revision process should be expedited, incorporating non-communicable diseases (NCDs) and mental health services. The inclusion of Health Technology Assessment (HTA) in benefit package design will help prioritize cost-effective interventions and ensure that limited resources are allocated where they have the greatest impact.
- ▶ **Performance based payments** - Provider payment mechanisms should be restructured to incentivize quality service delivery. Lessons from Zambia's 2012-2015 Results-Based Financing (RBF) pilot should be mainstreamed, ensuring that financial incentives drive improvements in essential services.
- ▶ **Operationalize and strengthen decentralization** - Finalize legislative reforms to clarify council mandates, decentralize procurement, and build local capacity through sustained training partnerships.
- ▶ **Data for decision making** - Integrate DHIS2 with NHIMA's claims data and donor reporting systems, creating a real-time health information system that improves financial tracking and enhances strategic purchasing efficiency. Additionally, enhance data-driven decision-making by institutionalizing routine performance reviews at the district level, where SHP purchasing decisions are informed by service utilization trends and financial sustainability analyses.

Conclusion

Decentralization offers an opportunity to advance strategic health purchasing in Zambia, but progress is constrained by weak governance, financial inefficiencies, outdated benefit packages, limited performance-based payment and limited use of data in decision making. Strengthening local capacity, enhancing intergovernmental collaboration, engaging district councils and communities in regular benefit package reviews, linking payment to facility performance, and integrating data systems are key to unlocking the full potential of strategic health purchasing within Zambia's decentralized health system.