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Health Care in Zambia: Reforming the System

Health care systems across the developing world are going through a process of reform. Although situations differ greatly, the motivation for health reform consistently centers around efforts to improve the effectiveness, efficiency, and equity of health care services. The World Bank's *World Development Report 1993: Investing in Health* and *Better Health in Africa* both assert that even countries with severe resource constraints can achieve substantial improvements in the health status of their populations through improving coverage with a basic set of health care services. Over the past three years, the government of Zambia has attracted attention for the way in which it has anticipated, and responded, to this message.

The Reform Environment

Zambia was once one of the wealthiest countries in Sub-Saharan Africa. With deteriorating economic conditions, the inefficient, publicly-financed health care system floundered. Infrastructure was not maintained so that many health centers in rural areas were without water or sanitation facilities. Incentives for personnel were insufficient. Consequently, almost half of Zambia's physicians have been working abroad, while the Ministry purchases the services of expatriate physicians. Most medical equipment became obsolete, and working vehicles became scarce except in those districts which received direct donor support. Infant mortality rates and the prevalence of malnutrition increased significantly. As the population continued to grow at a rate of 3.2%, and the incidence rates of malaria, tuberculosis and AIDS increased, the deteriorating system could no longer meet demand. Clients more and more frequently by-passed the first level of care, seeking basic drugs and services at hospitals. Health centers could not compete with higher levels of care for rehabilitation, staff and supplies.

In 1991, a new government emphasized health care reform which would *manage limited resources in order to maximize quality care* and *provide cost-effective, quality health care as close to the household as possible.*

Planning for Reform

By early 1993, the initial process of reform was well under way. In July 1993, a visiting World Bank mission expressed concern that the planning of reform was focused on repairing the existing health system which had been developed when Zambia was a wealthier country, less concerned with cost-effectiveness. The team argued that Zambia had sufficient resources to maintain a more efficient system which could provide essential health care services for all, but in order to achieve this, the system would have to be re-designed. It subsequently noted that no clear picture existed of the reformed health care system, only plans for reformed components of the system, inputs and outputs which were disassociated from one another: family planning, infrastructure, nutrition, human resources, quality assurance.

The core group of ministry staff charged with planning reform, the Health Reform Implementation Team (HRIT) and Planning and Management Unit of the Ministry, agreed on an approach which would :

- Define the health needs of the country;
- Determine how they could most cost-effectively be addressed;
- Quantify the most efficient combination of inputs which would be necessary to ensure the effective delivery of these services; and
- Estimate how much they would cost.

If an assessment of the resources available (public and private) implied that they would be able to afford the *recurrent* costs of the proposed system, then the "gap" between the existing system and the more cost-effective, financially sustainable system proposed would represent the bulk of the need for external donor support.

The Ministry, together with donors and other stakeholders, invested extensive staff time into identifying input requirements, determining which services should be delivered at each level of care, defining appropriate catchment areas, and determining what package of cost-effective services it could afford to ensure to the entire population. The result was a national prototype package of essential health services comprising immunization, family planning, perinatal care, HIV/AIDS prevention, treatment of tuberculosis, malaria, diarrhea, respiratory and sexually transmitted diseases, and some basic surgical care. These services are all capable of being delivered at the levels of the health center and district hospital. This prototype is subject to modification by districts. To ensure district health boards employ appropriate criteria when locally adapting the national package, provincial advisors have received training in assessing the burden of disease and performing cost-effectiveness analysis.

The core group has also spent time considering what centralized support would be necessary to maintain quality, oversee logistics systems, coordinate essential national health research, formulate national plans and budgets, and ensure accountability. They have subsequently begun to define new terms of reference for the central Ministry departments and parastatals. The vision for the reformed system is summarized within a Strategic Plan for Health Reform to be updated annually together with donors and other stakeholders.

From Vision to Reality

The Ministry of Health was determined that the extensive planning process should not delay the initiation of reforms. This sense of urgency occasionally pushed implementation too quickly, as with the rapid initiation of user fees and pre-payment schemes, but it also facilitated some initiatives such as decentralization. Many of the system's problems had been linked to excessive centralization, and health care reforms quickly became associated with an effort to decentralize decision-making and financial responsibility. In January 1993, the government decided to try providing a sample group of districts with grants from which they would finance all of their own recurrent costs (excluding salaries and drugs). The Bank, together with UNICEF, WHO and DANIDA persuaded the Ministry to go ahead with all of Zambia's 61 districts, and DANIDA agreed to finance the initial grants. The legislation necessary to institutionalize decentralization was drafted with the support of WHO and is expected to be passed by July 1995.

The disbursement of funds directly to the district level necessitated the rapid establishment of accounting systems to ensure that decentralization would not be undermined by financial abuse. Building capacity for financial management at the district level became one of the responsibilities of the HRIT, formed to provide full-time support to the process of planning and implementing reform. The terms of reference for the HRIT also focused on quality assurance, human resource development, district level capacity for planning and policy development/legislation.

Efforts to mobilize private sector resources have been more challenging. The Ministry has recommended that its own budget be utilized to ensure coverage with the defined essential package of care. Yet it simultaneously recognizes that

- If those who could afford to pay for services were encouraged to do so, the amount of public financing available for an essential package would be greater;
- Contributions can be used to instill a sense of community ownership;
- Fees may be necessary to encourage cost-effective patterns of utilization, and in particular discourage by-passing the primary level; and
- Pre-payment and insurance schemes might target demands for those services which are not included in the essential package, or those individuals who are willing to pay for "amenities."

Initially, districts and provincial and central hospitals were authorized to charge for services and utilize any revenues generated without adequate guidelines. Pre-payment schemes were instituted at central hospitals and copied by provincial hospitals without consideration of the costs of administration and the increased demand for care (there were no disincentives for overutilization). In many hospitals, the increase in costs exceeded the increase in revenues. Recognizing the problems, the Ministry has begun to develop guidelines and to critically assess the schemes which are underway.

National support to reform has proved essential. Between 1993 and 1994, the government increased the proportion of the budget allocated to health from 8% to 13%. The Ministry evidenced its commitment by reducing its allocations for the central teaching hospital from 25% to 17% . Although the recurrent costs of the new system are intended to be fully financed through local resources, external support will be necessary to support the transition. There are significant costs associated with the redistribution and retraining of staff, renovation of infrastructure, and the reallocation of physical resources between and within districts. The proposed changes have been particularly daring in a country which had a precedent of publicly financed and provided care, and which had been allocating increasing proportions of its public resources towards inequitably- accessible, high-technology care.

Bilateral and multilateral donors to the health sector determined that this innovative approach taken by the Zambian government deserved an equal response on the part of the donor community. At the time of project appraisal, donors signed a joint statement committing themselves to supporting the comprehensive process of health reform and not financing inputs outside of the agreed upon plan. An increasing proportion of donors have agreed to finance the overall plan rather than specified inputs or discrete projects. A consulting firm has been working with the Ministry and donors to develop a single accounting, reporting and disbursement system which would meet the requirements of all donors. IDA, in its position of "donor of last resort" has committed $56 million to supporting those elements of the plan for which no other source of financing is identified.

A Different Approach to Reform

A common approach to reform has been to identify problems in the system which cause inefficiencies, ineffectiveness, and insufficient coverage, and then define solutions. The approach applied in Zambia has rather been to define standards for a cost-effective system which would be financially sustainable, and then to determine how to move from the existing system to the more cost-effective one envisioned. This has resulted in an approach notable for its comprehensiveness, the extent to which every aspect of the system has been open to consideration, and the unique partnership formed with the donor community. Zambia's health care system offers tangible evidence that national commitment can spur the transition from rhetoric to actual reform.

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