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TOWARDS AN EQUITY-ORIENTED POLICY OF DECENTRALIZATION IN HEALTH SYSTEMS UNDER CONDITIONS OF TURBULENCE: THE CASE OF ZAMBIA

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ABOUT THE FORUM ON HEALTH SECTOR REFORM

The *Forum on Health Sector Reform* is a group of experienced senior technical people with a common interest in health policy and health sector reform who meet regularly. Members are currently drawn from bilateral and international agencies, regional development banks, ministries of health and selected resource institutions.

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A brief acknowledgement

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Katele Kalumba

INTRODUCTION

In recent years, there has been a widespread critical reappraisal of the determinants of health, patterns of ill health, the nature and performance of existing health services, and the appropriate role of the state in health care. This paper looks at the issues from the perspective of Zambia. It is organised in three sections. First, it reviews the influence of international trends and the local environment on the direction of health policy in Zambia. The second section discusses the design and implementation of Zambia's 1991 health sector reforms. The final section sets out intentions for future developments in Zambia's health system.

1 IDEOLOGICAL TRENDS AND OPERATIONAL REALITIES: The international and national background to reform

This section reviews the areas in which there are common international trends, and some convergence of opinion, and also highlights where there are differences of opinion and direction amongst international actors. The importance of recognising that changing ideologies about the role of the State, in general, have important effects on the trends in reforms within the health sector in particular, is discussed. This is followed by an examination of the influences these international trends are having on health sector reform in Africa, and then considers the internal influences that affect the organisation and operation of Ministries of Health. Experience in Zambia is used to illustrate the point that, as elsewhere, political and administrative structures and cultures have a strong influence on the design and performance of apparently 'technical' ministries such as the Ministry of Health. What may appear to be incoherent policies are in fact a logical response to diverse and conflicting social pressures.

1.1 The impetus for health sector reform

There are trends the world over that suggest convergence in paradigms about health and health government. Ecological failures such as drought, increased use of technology, increased demands for human rights, re-privatisation and/or decentralization of health care services, payments and the re-emergence of private clinics side by side with public health infrastructure, growing numbers of urban and rural poor, and dwindling investments by external agencies, among other trends, all suggest that more sophisticated analyses of governmental interventions in a health sector in any country are needed.

Analyses that attempt to explain the global trend towards health reforms suggest a variety of reasons why reforms are being undertaken in developing as well as developed countries (Cassels, 1995; WDR, 1993):

The health transition

The current spectrum of ill-health in countries is usefully examined by using the concept of the health transition (Terris 1983, Caldwell 1989). Populations in transition gradually move, as they become more 'developed', from a situation in which ill health and high premature mortality is caused primarily by infections and malnutrition, to a situation where there is a predominance of chronic, non-communicable diseases with high morbidity, concentrated particularly in the elderly. However, in many developing countries today both stages of the transition commonly exist at the same time. This diversity complicates the setting of priorities for financing and providing health services.

Persisting problems with existing services

The following problems continue in many health services: the efficiency with which resources are used (the scarcity thesis); access constraints (the equity problem); the unsatisfactory nature of services themselves (the quality issue); the financing difficulties both for the government and people (the cost dimension).

A recognition of the economic benefits of better health

Other analyses stress new or re-emerging conditions, such as AIDS, as giving impetus to health sector reform, and emphasize the relationship between health and productivity. As Dean Jamison, one of the editors of the World Development Report (WDR) 1993, puts it: 'For developing countries, the main reason [for health reforms] is a better understanding of the importance of health for improving the productivity of workers and of the potential for enormous gains in health at very low cost'. The WDR has given us the new concept of 'Disability Adjusted Life Years' (DALYs), as well as stressing that the *quality* of government health policies really matters in terms of better levels of health.

Changing policies of international agencies

The WDR told governments that there are three ingredients of quality health policies:

- fostering an environment that enables households to improve health
- improving government spending on health
- promoting diversity and competition

Other multilateral agencies are also reformulating their guidance on health policies. The four main ingredients of the new WHO Global Health Policy recommends that governments initiate political action for health, focus on health protection and promotion, concentrate on health system development, reform and management, and combat ill-health. UNICEF (1995) recommends that country reforms must focus on increasing political will,

build multi-sectoral partnership, and mobilise communities in addressing child and maternal health.

Cassels (1995) stresses that redefining policy objectives alone is not enough. He points out that health sector reforms are concerned with changing health policies *and* the institutions through which policies are implemented. Institutional reform is a priority because existing institutions, organizational structures and management systems generally fail to deal adequately with empirical problems of health sector performance.

Bilateral donors have aid policies for health that reflect broad aid concerns, particular health issues, and also the experience of health reforms in their own countries. Experience of health reform in Northern countries, which introduced new ways of addressing health problems, and created considerable debate about health services, has had a profound influence on policies in developing countries. For example, in Sweden major reforms were introduced in the 1990's to address structural problems in the way in which county councils provided services (Anell 1995). The new reforms emphasized patient choice, purchaser/provider split, performance-based provider payments, and increased competition in service provision.

Changing political ideologies

It can be less evident that current global trends in health reforms have as much to do with the reconfiguration of the structure of state governance, as with a concern to promote good health. A criticism of analyses such as the WDR is that they fail to address the political imperatives of health reform implementation (Reich, 1993). However, whilst implementation does require an investment of political will, the fact that health reforms also explicitly or implicitly seek to transform the state means that analyses must examine whose interests are served by any given proposals. For example, one of the key objectives of health sector reform proposed for El Salvador (ANSAL, 1994) is to 'redefine the role of the state in the health sector, transforming it from a direct provider of health services to a facilitator for services provided by private organizations'.

1.2 Policy reforms, and their implications for the distribution of power

The nature of public policies

Policy strategies are forms of symbolic power. What is critical is that we know what changes in the balance of power are taking place when structures for regulating the distribution and access to social entitlements are re-organized. We must ask the social purpose of doing so. The question of who gains and who loses in terms of resource allocation by a new technique of health system management can be answered by analysing the way institutional reforms reflect the influences of different interest groups. Previous relevant studies (Parmelee, 1985; Csaszi, 1985; Diderichsen, 1995) have helped to illuminate the managerial (controlling) as well as the political (legitimizing) function of public health

policy. The focus of their analysis shifts from the search for guarantee that the state administration and its policy functions are determined in all aspects by macroeconomic factors, to a recognition of the partial and provisional nature of state policies. In this instance it may be the case that, however partial and sometimes incoherent public health policy may appear, there are specific social interests to which it is a deliberate response. Because there are real stakes and stakeholders involved, rational explanations of the process of health reforms can appear inconsistent with real observed experience.

Any search for a coincidence of public interests between health care specialists, and those who emphasize the need for overall social development in order to achieve better health, is bound to lose sight of the fact that technological innovation is a *'salesman's package'*, which has to be pushed on to the consumer, even though it was produced in his name. Hence the crisis in implementation. The politics of building consensus is complex, and few have succeeded in describing why it succeeds or fails. It is the tension between needing popular legitimacy as a basis for authority, and having to make choices between groups when allocating resources, that makes debate on health reforms necessary. What appears to be a 'rational' basis for allocating resources is actually a way of meeting the state's need to make administrative structures for resource allocation coincide with the social balance of power. Moreover, although the existing bureaucratic hierarchy may be officially used as the basis for allocating resources, public sector discipline does not wholly regulate demand, and public authority is questioned in practice. Therefore policy struggles are also conducted outside public institutional spheres, and non-bureaucratic principles of division, sometimes referred to as 'market forces', begin to emerge.

A European example

Public policies are part of the instruments governments use to gain public acceptance to political rule. The example from Sweden, quoted above, reveals some important lessons about political incentives in public health services. Anell comments 'It is more important for county council politicians that activities are *perceived as efficient*. They can talk about decentralization, more choices for patients, purchaser-provider split and competition, as long as these concepts are associated with high efficiency. In this way critics and the larger public are given the impression that changes for the better are well on their way'.

Policy reform and its social and political implications in Zambia

The ruling MMD party in Zambia, like governments elsewhere, wants to stay in power. The structures it recommends for health service improvement have social consequences. For this reason, among others, they can only be realised if they correspond with the current political practice in the country. Under existing conditions of macroeconomic turbulence, the crucial role of social interests in influencing the pattern of state intervention must be fully understood if health policies are to lead to an acceptable quality of life.

Past attempts at institutional reforms of health systems in countries like Zambia have led to increased bureaucracy and centralization of health care, associated with a crisis of health policy, and bureaucratic incompetence (Kalumba & Freund, 1989). Equity has been a desired principle in many reform efforts in the African region. However, the organization of the public sector medical systems has been built on the logic of hierarchical state administration, which is not designed in a way that promotes achievement of equity. Through the definition of levels of care and resource requirements, it sets up a structure of high and low areas of resource input. Rural areas are 'less' complex, and require lower investment, whilst capital cities are 'more' complex. In other words, the logic of state administration has provided the 'technical' rationale for the medical care system's administration of allocation. Although this is politically convenient, it is by no means a rational approach. The irony is that in practice users have challenged this hierarchy by bypassing or ignoring low level services.

1.3 Zambia during the 1970's and 80's: A pattern of macroeconomic turbulence and decline

Factors contributing to the economic decline

From being one of the most prosperous countries in sub-Saharan Africa in the early 1970's, Zambia had by 1990 become a country with low levels of economic development, declining incomes and deteriorating social indicators. With a per capita GNP estimated at US$250 in 1991, Zambia is classified among the least developed countries. The economic situation deteriorated quite rapidly from the early 1970's, with the first oil shock, and the collapse of world prices for copper, Zambia's main export. Thus the poverty crisis in Zambia is not a recent phenomenon, but a result of inappropriate policies compounded by severe external economic shocks and an unwillingness to adjust to them.

The development strategy followed by Zambia after independence in 1964 was biased against agriculture and rural development, and failed to generate significant employment and income growth. The country's potential for smallholder agriculture was neglected and the agricultural sector was never able to play a major role in poverty reduction. The economic situation deteriorated as reforms were neither systematic nor sustained. Unemployment increased in urban areas and rural terms of trade worsened. Government tried to cushion the impact of external shocks by keeping prices of the staple food maize low, and by paying for the subsidy through foreign borrowing. The education and health status of the population worsened, and the Government was unable to meet the increased demand for free social services. Vulnerability increased as the economy declined and the basis for urban employment shrank (Evlo and Mwabu, 1992).

The scope and scale of rising poverty

Poverty increased in urban and rural areas. A Poverty Assessment study in 1991 (World Bank, 1994) showed that overall, 69% of all Zambians were living under the Poverty

Datum line. Rural poverty was reported to be more prevalent, deeper and more severe than urban poverty, and was worse in the more remote areas, and in female headed households (30% of the total). In urban areas prevalence increased from 4% in 1975 to 51% by 1991. Most urban poor were found in unplanned squatter settlements on the periphery of urban centres, many without legal status and without service provision. The World Bank study points out that poor people's human capital was negatively affected by high degrees of malnutrition, poor health status and low levels of education. The hungry season before the harvest followed closely after the season of highest morbidity and highest need for labour inputs into agriculture, thereby creating a vicious cycle where disease and malnutrition reduce productivity, thus lowering production, and forcing family members to do piecework on their families farms during the peak labour demand months (Freund, 1986).

1.4 Zambia's health sector before 1991

The decline in health and health services during the 1970's and 80's

As in many African nations, with the decrease in economic indicators Zambia's health indicators worsened. With diminishing resources, the expensive, publicly-financed health care system floundered. Infrastructure was not maintained so that many health centres in rural areas were without water or sanitation facilities. Financial and other incentives for personnel had been insufficient, and subsequently about one third of senior Zambian physicians left the country to work abroad, while the Ministry continued to purchase the services of expatriate physicians. Chronic housing shortages contributed to many areas being understaffed, or required the Ministry to pay for expensive hotel accommodation. Most medical equipment had been deemed obsolete, and working vehicles were scarce except in those districts which had received direct donor support as a result of special vertical programmes.

As early as 1982, a WHO\UNICEF report decried the impact of government policies in health in this manner 'There are no Zambian doctors among the 53 district medical officers and only 2 out of the 9 provincial medical officers are Zambian.' The same report describes the appalling state of district hospitals in Northern Zambia, which resembled 'museum specimens of Dr David Livingstone's bush hospitals' (Kalumba, 1988).

Early attempts at reform

Some measures at health care reform had been initiated, but mainly to improve the technical performance of many vertical programmes as well as to streamline their management. Evidence of these efforts can be seen as early as 1985 when a new Medical Services Act was enacted. The UNIP government realized that direct management of Zambia's major hospitals by the Ministry of Health was inefficient, and that these institutions had to be given enough capacity to raise revenue from users, including prescription charges. This was a reversal of the free medical care policy. However, the Government did not have the political capacity to implement its own policies and legislation. Attempts to effect the

institutional imperatives of the 1985 Act were at best half-hearted. A Hospital Management Board was set up at the country's University Teaching Hospital in Lusaka, but Boards were not established at other major hospitals. Medical fees were introduced on and off. The only places where they were consistently implemented in a modest fashion were in some Mission medical facilities.

The Government's policy dilemma neither improved the quality of health services nor access to them by the poor in Zambia. In fact, while major urban hospitals began to decline in quality in the early 1980's and worsened by the end of the decade, rural health care had already started to deteriorate by the middle of the 1970s (Freund and Kalumba, 1986).

Persistent health policy dilemmas in the early 1990's

By 1990, it had become increasingly difficult for government health policy makers to maintain the ideological dissimulation that free health services were going to be sustainable. But politicians were explicitly forbidden to raise publicly cost-sharing as a viable policy option in arresting the two empirical problems of health care. The problems were, first, the real decline in public finance of health services. Annual MOH expenditures, at constant 1984 Kwacha, declined from K 159.1 million in 1982 to K 64.5 million in 1989 -- a reduction of 59%. This affected most acutely those services needed by the poor. During this period, primary health care services designed to meet the bulk of health care needs were being wholly financed through donor support, until 1987 when Zambia broke off from the IMF structural adjustment programme. The second problem was that central government revenues were being swallowed up by investments in services provided by the three major hospitals, which collectively accounted for 52 % of total government recurrent budget by 1990.

There has always been a lack of co-ordination between health, finance and social services at the policy and programme levels in Zambia, leading to lofty Ten-Year Health Plans in the last three decades that were poorly financed, and their gains unsustained. Furthermore, the health implications of government decisions in various ministries were never assessed with respect to their impacts on community health.

Experience with Zambia's past attempts at reform suggests that reformers found it difficult to secure broader and consistent ownership of the reform idea within the Ministry of Health (Kasonde & Martin, 1982). Emphasis on structural transformation in national health policies and priorities have been undermined by professional and vertical programme pressures to satisfy both the special status of local experts with the external donors who fund their programmes, and the requirements of the donor accountability systems. Past neglect in building consumer responsibility for health, and the lack of conceptual clarity and initiative among medical professionals in management leadership, have led to deficiencies in key decision-making. This has been compounded by the absence of other relevant, non medical disciplines at top-management and other professional levels including health economists and health policy analysts.

Weak legislative capacity of the Ministry of Health in times of major reform plans has always weakened its public legitimation. Until 1991, the most comprehensive health reform legislation which fundamentally defined the health field was the 1930 Public Health Ordinance. No comprehensive reform of legislation had been carried out since then to make it consistent with a clear vision of a healthy future. In the absence of such legitimating legislation on reform, public decision-making and programmes were being developed on the basis of institutional aspirations or professional demands, rather than on the needs of the community (Kalumba, 1995).

While the 1985 Medical Services Act empowered health institutions to raise revenue outside allocated budgets from the Ministry of Finance, there were difficulties in addressing the political conditions of cost-containment and cost-recovery issues which were essential for achieving quality assured health care. Further, the institutional prerequisites for cost-recovery, such as collection and retention mechanisms, had never been seriously addressed (World Bank, 1993).

2 ZAMBIA'S 1991 HEALTH SECTOR REFORMS

This section sets out the new philosophy of health care introduced by the MMD Government, and discusses how the policy had to be translated into practice in an unpredictable environment, where factors beyond the control of the health sector had a direct effect on it. It is suggested that the recent trend towards more explicit competition for very limited State resources has created unique tensions (and thus greater turbulence than previously), because groups are increasingly expected to both collaborate and compete with each other. The principles underpinning the reforms, which were designed to address some of the problems created by an uncertain environment, are set out. This is followed by a description of the main policy features, and discussion of the process of policy development and implementation.

2.1 The new political and economic context

By 1992, Zambia's new Government, voted into power on 31 October 1991 as a result of a major political transformation from one-party rule to plural democracy, announced bold macroeconomic policy measures in its budget. Learning from past mistakes, it has since then been pursuing a more aggressive and comprehensive adjustment programme. Key measures have included liberalizing foreign trade and exchange rates, lowering fiscal deficit through expenditure cuts, controlling liquidity through strict cash budgeting and government securities, and privatizing maize and agricultural input marketing.

2.2 The new health sector reform policy: direction and underlying principles

The overall framework

The new MMD (Movement for Multi-Party Democracy) Government's Health Policy Framework Paper, *Managing For Quality in Health Care* (Kalumba, 1991) provided a vision and reform paradigm for a programme of comprehensive reform. It stated that 'Zambians must commit themselves to building a health care system that guarantees equity of access to cost-effective, quality health care as close to the family as possible'.

In this process of development, Zambia needed a government

- whose role will be both to lead and manage the process
- that will collaborate with consumers and health providers to determine how best to improve the system
- that will encourage partnerships among all those concerned with health and health care
- that will encourage accountability in the health system for consumers, providers, and the Government to work together to provide the most effective and efficient treatments and programmes.

The Health Policy Framework Paper specified some core values upon which health system reform would be built. Within the basic commitment to creating a health care system which seeks to achieve equity of access to cost-effective, quality assured health care as close to the family as possible, Zambia's policy package comprised a number of important features. These are set out below.

ZAMBIA'S HEALTH REFORM POLICY PACKAGE

- A goal-oriented, financially sound management system for health care
- Clear accountability and responsibilities at every level
- A mechanism for regular review of progress
- Enhancing the role and responsibilities of consumers
- Strengthening health-centre supported community-based health care
- Maintaining the role of public hospitals, including psychiatric hospitals and the University Teaching Hospital
- Integrating private sector strengths and resources
- Improving quality assurance and treatment effectiveness
- Broadening the range of professionally regulated health providers, improving their conditions and strengthening team work among them both in clinical and public health settings

(Source: National Health Policies and Strategies, Zambia, 1992).

Three management concepts

The MMD Health Policy Framework Paper's proposed strategy was to improve the health sector by restructuring the managerial systems of *leadership, accountability* and *partnership*. These three management principles, which are spelt out in more detail in the following paragraphs, are an integral part of a health reform process deliberately designed to address the objective of reconstructing the state system of health governance. They are based on continued national analysis and debate, and aim to identify solutions rather than scapegoats. The outcomes of this process are expected to be better quality care and better use of existing resources in infrastructure, personnel, equipment, drugs and information. This has frequently involved diverging from entrenched governmental practices. Health sector reform is more than just a bureaucratic process of fixing parts together. Our approach has therefore often been at variance with established government civil service procedures, but it has been justified by the results obtained.

Leadership: The MOH has recognized the problems resulting from dependence on donors to provide support for primary health care services during the past 15 years. Numerous national programmes, created with donor assistance, have led to fragmented management and delivery of basic health services, without a coherent national health strategy. Under the reform process, the central Ministry is undertaking the leadership role in the health sector, by coordinating work with donors and national programmes, and by delegating programme implementation, for which they have little capacity, through decentralization. District Health Management Teams are being trained and supported to organize and provide local health services that are of good quality and responsive to real needs of the surrounding communities.

Accountability: The previous Ministry of Health's pattern of financial and staffing allocations reflects years of giving preference to high-tech curative care, in response to political and popular pressure. This was in spite of the official (but rhetorical) priority given to primary health care. It is therefore not surprising that most illnesses treated at Zambian hospitals could have been treated at health centres, at lower cost and with more continuity and personal attention. The emphasis is now on a client focus, by making health care providers accountable to local Health Boards, which represent a spectrum of the community. The new patterns of accountability are more transparent. They have created a spirit of openness that is conducive to discussion of successes and problems between staff, managers and the community, and between the MOH and donor partners.

Partnership: Health status in Zambia could be dramatically improved within current resources, both national and international. New partnerships are being developed between the centre, provinces, districts and donors. Health care providers are now being encouraged to organize their skills and services to work as a team providing comprehensive health services. One of the first steps in the process has been the training of district health staff to act as partners in defining appropriate standards for

health care services and the use of resources. New relationships are being explored with private non-profit providers of care to serve households better by drawing upon private sector strengths and resources. This spirit of partnership is also shared with donors, encouraging them to discuss new ways of providing assistance in the health sector. Decentralization is not a top-down, unilateral exercise, but a process in which *all* actors are expected to contribute to the strengthening and sustainability of the new health system. A further challenge for reform will be the establishment of this spirit of partnership between the health system and communities.

A belief in the need for fresh approaches to management in an unpredictable environment...

A description of Zambia's health sector reforms which does not reflect the contemporary policy-makers' commitment to translate a set of simple management concepts into principles of action, would miss the ideological basis of the reforms. It has been a central feature that policy decision-making must support an ideological commitment to reform the health sector. Application of the management principles of leadership, accountability and partnership has to be undertaken within a turbulent policy environment. This environment is characterised as a situation where events beyond the control of a particular sector of government directly affect its operations. The consequences which flow from the actions of individual sectors lead off in ways that become increasingly unpredictable. Government ministries, like other organisations including non governmental organisations (NGO's), are being pressed to become highly interdependent yet adversarial in their inter relations as they struggle to influence resource allocation. This modern, turbulent environment is complex, uncertain, rapidly changing, and beyond the comprehension or control of any one element. Much has been accommodated as a result of the leadership's conviction that specific approaches are called for in managing a turbulent policy environment.

.. combined with a clear sense of the preferred future for the health sector

Within Zambia's policy-making team there has been a consistent commitment to the view that, to achieve anything, there must be a shared vision, a preferred future that serves a known social purpose, and that is not simply stumbled into but deliberately chosen. A scenario of a healthy future cannot be calculated from how many hospitals a country is going to have, how much to spend on drugs, or indeed how many doctors Zambia can train or attract back from outside its borders. Nor is it enough to simply say we need 'Health For All'. This is just more of the same thing. Instead, Zambia's approach to reform has translated into a consistent effort to address the following methodological issues in health planning in a turbulent environment:

A commitment to increase choices: Instead of increasing bureaucratization of health care, Zambia's reform promotes more diversity in policy responses to health concerns. A pluralist approach may increase uncertainty, and therefore turbulence, at individual, household, and health partner/provider levels. However, it also

encourages innovation and broadens the adaptive response repertoire. Greater tolerance for differing possibilities, status and mechanisms to regulate conflict is necessary. The decision to diversify the choices in the health sector was made against a stifling background of a socialist tradition of aspiring towards a health system which assumes a classless society.

Negotiated health order: A more effective basis for adaptation to a turbulent policy environment is a process of reform that stresses cooperation rather than competition. The new mode of health system management assumes that there will be a multiplicity of nodes of power and only a measure of cooperation between them will produce a change in the desired direction. The failure in the past to harness the potential of the private and the mission health sectors is evidence of the inherent dynamic of competitive behaviour among health providers. The issue is not to proscribe these sectors, but rather to provide proper structures of negotiation, freer exchange of information, opportunity for dialogue, formation of shared values and ideals and joint solutions to shared problems.

A futurist vision of health: In turbulent conditions, where unpredictability exists and it seems as though man lacks complete control over the consequences of his actions, it is important to guide plans towards a desired future. The use of present and past trends to plan for the future is particularly maladaptive in a turbulent environment because the situation is changing so rapidly. Health reforms which are driven by a vision of a desirable health future help counter the practice of disjointed and incremental health planning.

Influence instead of control: Being in control is basic to the responses modern societies have so far developed to cope with a changing environment. Different views exist on the ways 'control' is achieved in a turbulent environment. A useful approach is based on the following assumptions: the consequences of our actions are unpredictable; society can only be *influenced* in the direction of a desired future; competence is measured by the ability to learn, experiment and embrace error; there is a need for more fluid organizational structures with more decision-making power at the base. Increasing regulations and bureaucracy tend to make our social and political institutions more rigid and reduce their ability to change. Instead of regulations, our focus was to propose that self-guiding mechanisms governed by values be established, so that events would be 'controlled' by influence. This required that more power would rest with localized units, allowing for greater public participation and greater local 'control' over health development. Such units are also more flexible and easier to disassemble and reorganize as change becomes necessary. In the new scenario of reform, competence was to be measured in terms of ability to learn, experiment and embrace error.

Use interactive learning processes: The need for society to adopt an attitude of being in a state of continuous learning is critical to our three tier health vision. Because one cannot be sure that one's data are correct in a country like Zambia, there is a need to test continuously new ideas and hypotheses in real life situations and learn from them to guide the future planning processes. As policy leaders of the health sector, we had to be ready to learn from our mistakes. Authoritarian and non-participative bureaucracies do not encourage creative and mutual learning at and between all levels. We had to think of ways of fusing the technical know-how of our staff, the pressures from our people for quality health care, the structure of our donor partners and the emerging collective vision, in an on-going bold experiment of health reform, based on mutual respect for all social agents.

Greater respect for individual and local autonomy: Respect for persons as responsible individuals helps not only to adapt to turbulence but also to plan for individual and community health and well-being. It leads to democratization of decision-making and encourages citizen participation at all levels. Health institutions have to begin to treat clients as responsible people who appreciate the value of their own health. This leads to greater participation in decision-making processes, and to a real partnership in building a healthy society. Although greater individual and local autonomy may appear to increase turbulence, we in Zambia believe it is a more adaptive response. Decisions are more likely to be in keeping with individual and local differences. The manner of our managing change towards our health vision continues to be driven by these principles. The use of think-tanks, consultants, local workshops, national consensus building meetings and careful analytical thinking at the policy leadership level are part of the broad mix of factors currently being put to work towards the attainment of Zambia's future vision. This is the process of social learning which, like a rider on a bicycle, we must continue to pedal, otherwise the reform will collapse.

2.3 The main features of reform

The bulk of managerial reform in the health sector has focused on **decentralization.** The government argued in the Policy Document

> 'The main core of the health strategy shall be managing for quality through a District Health Management System. The district shall be the basic unit of management where bottom-up planning and implementation initiatives meet the thrust of national policies. Therefore, it forms the basic point of reference for the articulation of people's power in health care. Through Area-specific Health Management Boards, popular representation and technical\professional interests can combine to give Zambia a health care system that is responsive to local and national interests and needs'
> (MOH, National Health Policies..., 1992:ii-iii).

Arising from this commitment were multiple needs

- The need for capacity building to overcome the constraints of human resources (technical, managerial and support staff) to implement health reforms
- Management had to be decentralized fully to the district, not merely as a political imperative but as a practical health necessity
- The need to provide integrated services to respond cost-effectively to health problems, by enabling multiple needs to be treated on a single visit
- The need to incorporate in all projected programmes, community participation, gender issues and the role of the private sector
- Defining the most cost-effective package of care which the nation can support

Key authorities transferred

The major thrust of health reforms has been in the devolution to the districts and autonomous hospital management boards of key Ministry of Health functions -- planning, management, service delivery, funding/resource allocation, and revenue generation. These have been complemented by key strategic reforms which build strong commitment from the central government -- involvement of key stakeholders, clear goals and objectives, definition of roles and responsibilities, all backed by a legislative reform agenda and a master corporate plan.

The effort has been complemented by the enactment in Parliament of a new National Health Services Act (1995). This Act has in effect registered the policy initiatives that were being implemented as 'pilots' for the past three years.

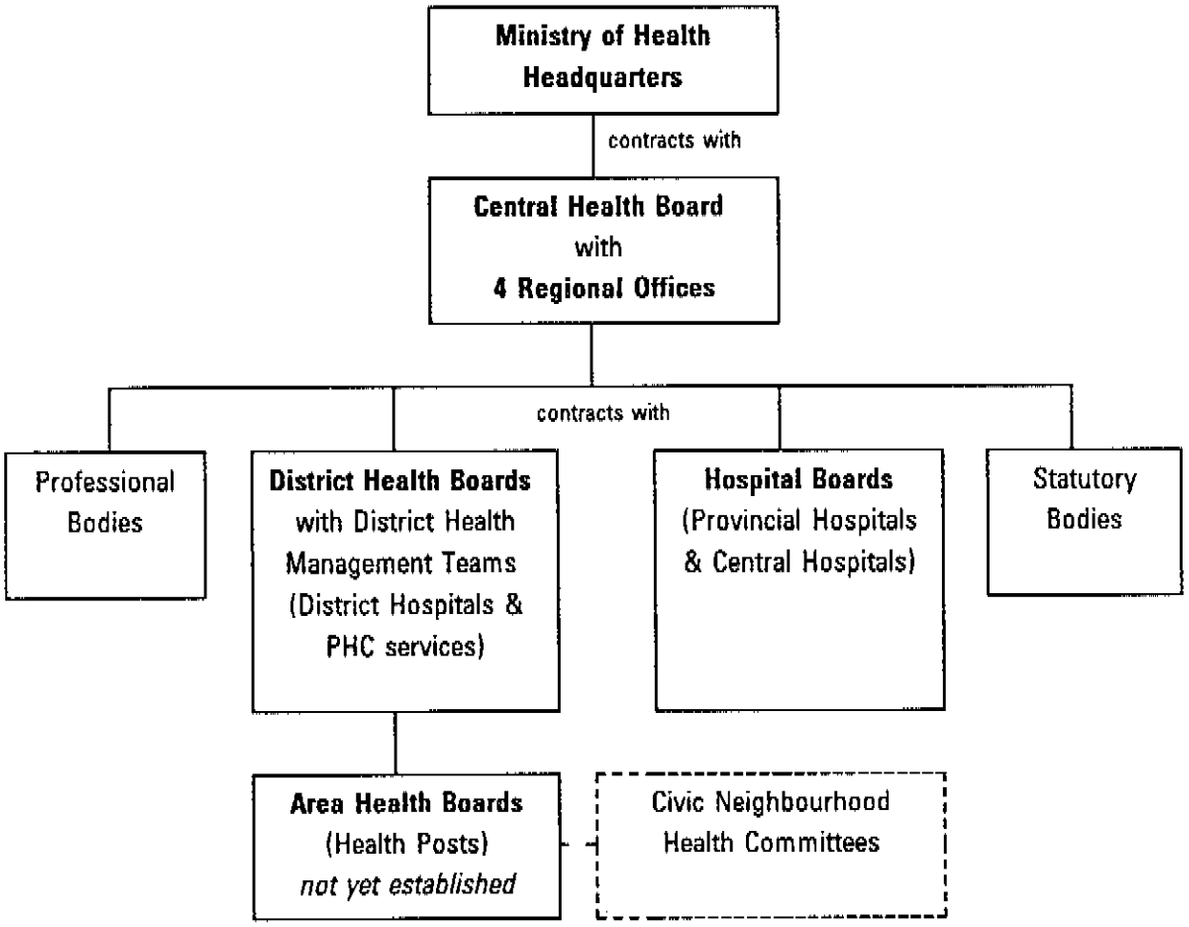
The reformed health care system has management and support needs and responsibilities at each level from the household to the central Ministry of Health. The linkages between the levels of the system are interwoven. The district and national levels are intended to respond directly to support needs at the household and community level, as well as through the hierarchy of the formal system. Defined responsibility for performing management and support functions have been allocated to the various levels of the system to ensure that real needs are addressed in the most cost-effective manner.

New functions and structures

The diagram overleaf illustrates the new structure. The traditional role of the Ministry of Health -- planning, management, service delivery, resource allocation and generation of revenue -- is being progressively devolved to a hierarchy of Health Boards. As a result, the MOH headquarters has been much reduced (from 315 to 66 members of staff). It retains overall political responsibility for the health sector, its principal functions being those of policy formulation, legislation, monitoring the performance of the Central Board of Health, consultation and donor coordination. Overall responsibility for technical management of the health sector is contracted to the *Central Board of Health,* which is now operational. It contracts with, supervises and monitors the performance of the peripheral structures on

behalf of the MOH, as well as acting as adviser to the Minister. Resources are now transferred from MOH to CBH in a 'commissioning procedure'. The resulting contract includes the directives and priorities of the MOH, reflected in restrictions on inputs, anticipated outputs, outcomes, and in guidelines. In a move to make best use of scarce

THE STRUCTURE OF THE NEW HEALTH SYSTEM (1997)



technical expertise, the 9 Provincial Medical Offices, which previously had an administrative function, have been replaced by 4 *Regional Offices*, which constitute the operational arm of the Central Board, and provide technical support to the districts. At this latter level, which is the principal focus of the Act, authority rests with *District Health Boards*, each with a trained District Health Management Team. These Boards, which are in charge of district hospitals as well as primary care services, are responsible for formulating and costing intervention strategies, according to district priorities and needs, and submitting them to the Central Board for approval, and eventually for incorporation into the national health plan. The District Boards are also expected to set up *Area Health Boards* which create the essential link with health service users, thus encouraging quality control and community involvement. At the community level, *Civic Neighbourhood Health Committees* have emerged spontaneously,

and are spreading throughout the country, ensuring a voice for the consumer in the health system.

Hospital administration and management, including budget, drug supply and revenue recovery, is the responsibility of *Hospital Management Boards*, which have been set up in all central and provincial hospitals. These Boards have the same legal status and relationship to the Ministry of Health as the District Health Boards. A continuous monitoring of the progress of health reform is carried out by the *Health Reform Implementation Teams*, which operate at all levels in the country. One of their functions has been the establishment of a management training programme for all district team staff to help them discharge more effectively their new and extended role.

Although the central Ministry of Health has been much reduced as a result of devolution, the Minister retains the right to nominate a number of members on each of the Health Boards, the remaining members being locally appointed. This ensures some measure of central control, as well as responding to the priorities and requirements of health service users.

Annex 1 describes in more detail the roles and functions of each structure in the new hierarchy as prescribed in the 1995 Act, and clarified in subsequent workshops. It should be understood that structures below the level of the district are at this time still in the process of development.

The implications of the reformed role of the Ministry of Health

As part of Zambia's Public Sector Reform Programme, MOH reforms have provided a model for other Ministries. However, the debates in Cabinet, Parliament and the media have suggested a need to clarify the functions of the Ministry HQ, which, with its Central Health Board, now faces a number of major challenges. These are discussed in the following paragraphs.

Policy advocacy: The Ministry staff must be able to support the Minister and Deputy Minister in policy advocacy. This responsibility places a considerable burden of both strategic and routine work on the Ministry, involving such duties as briefing on policy matters, support on the enactment of health legislation, replies to Parliamentary Questions, and travel within the country and abroad.

Planning: The Ministry has the key responsibility for formulating and seeking agreement to overall health goals, policies and plans. This is not just a matter of reviewing the present status of health and health services, formulating the new goals and drawing up realistic plans. It involves gaining the commitment of other Ministries, such as the Cabinet Office and Finance, and various political parties, and developing links with those who determine what is politically, economically and socially

acceptable, so that the MOH gets as favourable a hearing as any other Ministry in the competition for resources.

Mobilising resources: A major responsibility of the Ministry is to obtain sufficient resources for the development and delivery of health services. The Government, despite the very difficult economic situation, provided the health services in 1994 with 13% of total Government expenditure, which is comparable to that provided in 1976. The Ministry must ensure that this proportion is at least maintained, and it must further seek additional resources from consumer contributions and increased donor aid. The Government and the donors must therefore be convinced that existing resources are being utilised effectively and efficiently. MMD's policy on cost sharing must be translated into practical revenue and service quality, and the working relations with the donors must be positive, open and based on mutual trust.

Resource allocation and management: The Ministry is expected to support good management practices, especially in the distribution of available resources. This, in a period of austerity, requires both political courage and considerable management skills. It requires the co-operation of professional and management staff right through the system.

Standard setting: The CBH should *set standards for accountability,* particularly for Health Boards and Hospital Management Boards, and other health sector managements (whether public, private or non-profit NGO's). Without agreement on accountability, norms and minimum standards of provision and practice, it is not possible to develop without losing coordination and system regulation. The work involved needs considerable judgement, sensitivity and top management skills, requiring very close co-operation between professional and administrative staff at the points at which the service is delivered, in training bodies and institutions and among groups representing the health professions. Linkages and lines of accountability will be defined by the contractual arrangements.

Performance assessment: The Ministry must evaluate the output of the health system. People are raising fundamental questions about the contribution which the health system is making to the reduction of morbidity and mortality, and to the improvement of health status. Zambia's health system could be greatly improved at no extra cost if its best practices could be extended country-wide. It is therefore essential that the Ministry develops the competence to formulate contracts and measure the outputs of comparable services, and take steps to bring the general level up to that of the best performers. The measurement of impact is more difficult, but should be borne in mind as a longer term aim in the design of information systems and the construction of research programmes. Responsibility for monitoring is divided between the MOH and CBH. The MOH will assess the overall performance of the CBH, who will in

turn need to monitor the performance of the health boards with whom they have contracts.

Responsibility for financial management: The Ministry has to assume responsibility for financial systems management, and the Permanent Secretary has a statutory role in this as Accounting Officer. There is an urgent need for a full review of MOH accounting policies in liaison with the Ministry of Finance, and for the reform of the Central Accounts Unit as a matter of priority.

Purchasing role: The Ministry must now create conditions conducive to service delivery at all levels. With the new Act, the MOH HQ has become a purchaser of services provided by independent and semi-independent providers, through the CBH. This management responsibility is complicated by the extent to which the MOH is still dependent on other Ministries for authorization in certain specific areas, and on the Ministry of Works and Supply for vital operational and building services. The District Health Boards must assume primary responsibility in these areas, and will be allowed to contract out to private markets under clear Central Ministry policy guidelines.

This statement of the Central Ministry's role represents the goal towards which the Ministry must strive if it is to do all that District Based Health System Reform demands. Its role is mixed and complex. Its day-to-day management responsibilities are potentially in conflict with its overseeing, supervisory functions. At its top, it is at the interface between the political and administrative systems. It must possess and deploy a great range of political, negotiating, analytical and managerial skills, in the knowledge that it is critically short of the minimal resources required.

Even if resources were not an overriding problem, the Ministry's task would be difficult. Like Ministries of Health all over the world, it is faced with operating a supply-determined service in a period of growing political scepticism about the value of health services expenditure. It will be judged by the results it achieves with the resources made available to it. It must ensure that existing legislation and procedures are enforced, and that the existing legislative, organisational and procedural framework is appropriate to the job it now has to do. It will often find itself having to take the lead in seeking changes which impact on the wider civil and public service. There are no short cuts to successful reform, which calls for support at Cabinet level and for building a broad-based national consensus for change.

Decentralisation so that Districts and major Hospital authorities can have discretionary authority for personnel recruitment, task assignment, and resource allocation, has been a central focus of our reform. It requires the creation of suitable structures for community participation in decision-making, quality control, and financial accountability.

The new social forces promoted at the District level have led to a demand for the centre to intensify its monitoring and consultative capacity.

Whilst the initial policy priorities have of necessity been formulated by the centre, it is the eventual aim of reform that the districts will provide plans conceived by the district management teams, and approved by the District Health Boards, for incorporation annually into national plans. New projects and programmes which fall within the context of the reform process are designed in such a way that their implementation and absorptive capacity are realistically assessed. To ensure the feasibility of these projects and programmes, information gathering is undertaken by the planners through pilot studies, and empirical data collected and analysed by the Health Reform Implementation Teams (HRIT).

2.4 The process of reform

Building a partnership with donors from the start

There were observers who pointed out that Zambia's reforms stood the danger of being 'high-jacked' by donors such as the World Bank. We have been aware of the need to manage this relationship in very strategic terms. There has been a progressively closer partnership between the MOH and donors in our annual joint review meetings since 1991, which indicate the seriousness with which this relationship has been managed and its consequences for the planning approach we have taken.

The initial strategy employed by the Ministry at the end of 1991 was code-named 'Operation Quench Fire'. This initiative required that work should continue to deal with emergencies (e.g. cholera and dysentery epidemics) which attacked the country, and represented a test for the new government's capacity to deal with public health security problems. 'Operation Quench Fire' was a confidence building phase while the development work of health systems reform was being undertaken. However, it became evident to our co-operating partners that too much time was being spent on this operation, while the real work of reform was receiving limited attention. This might have been because the Zambian policy makers found it difficult at the beginning to make the hard decisions needed to translate their policy commitment into real reforms. The following example shows the concern felt by a major donor, the World Bank, in 1992, expressed in the form of a metaphor.

THE METAPHOR OF THE CADILLAC

In July 1992, a World Bank project planning team reviewed the progress made in health reforms. The Bank Team was concerned that health reforms were focused on repairing the existing health system which had been developed when Zambia was a wealthier country, less concerned with cost-effectiveness. The Bank mission suggested that the Zambian health system could be likened to a Cadillac which was maintained by a relatively wealthy family for years. But as the family's economic situation has changed, it could no longer

afford to maintain this gas-guzzling vehicle without seeking assistance from cousins and relatives, to help fuel, repair and maintain it. The team argued that Zambia had sufficient resources to maintain a more efficient system which could provide essential health care services for all, but the "Cadillac" system would have to be retooled. The Ministry agreed with the analogy. Unfortunately, a subsequent Bank mission in October found 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 mission suggested that the Ministry was designing car parts rather than considering what the new Zambian vehicle as a whole would look like.

This was a turning point. The Ministry agreed that rather than taking a problem solving approach, they would consider employing a method which had been previously used by the Bank in Laos. This approach asked that they define the type and quantity of health care services required to meet the health needs of the country, determine how they could most cost-effectively be delivered, quantify the 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 implied that they would be able to afford the recurrent costs of the proposed system, the guided process directed them to then consider the "gap" between the existing system and the financially sustainable one, and the cost of this gap. If sufficient local and external financing was available to invest in the cost of transforming the system, then the design of the new Zambian car would be acceptable.

As a result, instead of taking a traditional approach of defining the problems with the existing system (repairing the broken Cadillac), the Ministry of Health undertook to draft the designs for a new system capable of meeting needs for health care, given the limited resources available (the design of the new, more efficient car). The iterative process of designing an affordable system has involved medical and health staff, sociologists, logistical experts, accountants, economists and managers.

Steps in the planning process

Zambia's vision of the new health care system had to address several questions. What do we want? what do we have? what do we need? what can we afford? A step-by step process has guided planners.

- Undertake a *critical self-assessment* of health needs and available resources, and of stakeholders in the process of reform.
- *Propose a set of standards* for the new health system -- on the basis of the agreed-upon principles of equity and affordability -- in terms of what the respective levels of health care from the household up could reasonably be expected to provide. Identifying requisite inputs and management support has been a critical part of this process.
- *Estimate costs*, based on level of institution and its anticipated workload, of the recurrent and investment costs, and of the first year's operational cost.

- *Define a health financing strategy* to cover these costs - from the Ministry's budget, from what would be willingly paid by clients or private expenditure, and from the support of external donors.
- *Reassess needs and draft plan* until one was developed for which the financing would be sustainable,
- *Determine how to implement the plan* within the reformed system.
- *Monitor the impact* of this plan's implementation on the beneficiaries.

Taking a system-wide perspective

A combination of cost-effective interventions will not necessarily result in a cost-effective system, nor will new approaches to financing automatically produce a more efficient system. The health care system comprises households, communities, and public and private health care institutions. Even in countries where the public sector is the primary provider of health care services, health care reform must consider the potential role of other providers, whether family members, indigenous healers, or private allopathic practitioners. Coverage of the entire population with even a minimum package of care is unlikely to be achieved with only public sector support.

To maximize the efficiency of the system, our planners have had to programme the use of limited public sector resources in a way which will complement other sources of financing. Consideration of the entire system is necessary for planners to anticipate how the different components can complement one another to ensure the development of an effective and affordable system. This is such a daunting exercise that few will attempt it, preferring instead to address specific components of the system (e.g., primary health care) or specific issues (e.g., the public/private mix).

Involving other stakeholders

The decisions made during the planning of health care reform have been examined by the many stakeholders in the existing system of care: clients, public and private providers, government leaders and donors. This has been necessary for several reasons. Changing the system of health care delivery has quality of life consequences, including whether one lives or dies. The decision by Zambia to adopt a new, less tested approach to planning health sector reforms had to be carefully negotiated. Moreover the process must be transparent. If the decision-making process in the new system is not appreciated by all involved, the plan will not receive the support critical for its implementation. The commitment to comprehensive planning of change has required the mobilisation of stakeholders with real material and intellectual interest in the objectives of reform, who also have a moral obligation to commit real resources to the exercise. Co-operating partners were therefore asked to make a collective commitment to the support of the strategy. The case for Zambia was presented using an analogy, as shown below.

HEALTH REFORMS: A ZULU HEALER'S TRAGEDY

An anthropologist documented the Zulu healer's method of proving success with cases of epilepsy: to have the patient dive into a river known to be infested with crocodiles and lethal snakes completely nude, early on a morning during the coldest part of the year, and hold his breath as long as possible. If he came up alive, he would be cured of epilepsy. There are no records to show how many survived the ritual to tell the story!

We in Zambia are trying to avoid a Zulu healer's tragedy of the past. We all need a real success story in Health Reform, consistent with a vision of health that moves away from orthodoxy... or more of the same thing. Work with us to provide environments that are conducive to health; help our people learn the art of being well; and provide a basic package of health care for all. We want to be able to spend less on drugs, less on expensive technology; less on super-specialists with long credentials whose value is only acknowledged by editors of professional journals. We want cost-effective, quality-assured health, centred around the needs and resource possibilities of the family. This vision we have defined. This vision we share with you. This vision, we learn, is now being shared by many the world over. Somewhere, it must succeed. That place is here...

You cannot walk away from Zambia's reform effort saying, 'We helped Zambia dive into the river of comprehensive Health Reforms...and those chaps were courageous, but Zambia's infant mortality rate has become worse; its infrastructure remains unfixed; its drug supplies still inadequate; its epidemics uncontrolled, etc'. There is no taxpayer in Europe, Japan, America or member country of multilateral agencies who wants to hear that kind of 'success' story. Our fate is your fate too; we are in this boat together. We have gone too far together not to share in the common cause for real success - and not one measured by the volume of documents we collectively produce.
(Dr Katele Kalumba. Speech at MOH "Appraisal Workshop", April 1994).

The series of dialogues with partners between 1991 and 1995 has created powerful insights and allowed difficult questions to be handled in a non-threatening way. The meaning of 'partnership' in the reform process was recently agreed upon in October 1995 at a joint review between the MOH and donors, as follows:

'The Ministry of Health and all its collaborating partners will share commitment to health reforms and attain a common vision which will be reflected in the investment of the required effort to achieve a mutually beneficial outcome while maintaining the integrity of partners.'

A number of principles of partnership were agreed upon. These were: recognition of the comparative strengths and limitations of partners leading to clearly defined roles and responsibilities; mutual transparency and the need for effective communication among all partners; acceptance of the diversity of choices and options; building consensus through regular consultation; respect for local initiatives and autonomy; and shared ownership.

Ownership of the process of reform by health workers

Any analysis of the process of reform must include an assessment of *how* stakeholders, especially health workers, begin to own the reforms. This cannot be done by examining trends in conventional health indicators. Instead, more qualitative approaches are needed.

International experience of reform suggests that in order to engage the support of different stakeholders, strategies must be specifically tailored to the concerns of each group. Let us consider only two categories in this context.

From the point of view of the health worker There are very specific interests that touch upon each health worker's experience of health reforms. What effects are health reforms having on the technologies health workers use to produce health services (budgets, ward procedures, internal supervisory relations)? How are they forcing changes between provider and "users" or "consumers" of health services, and how do health workers react to the changed relations? What is the impact of health reform on the "social welfare" of health workers - salaries, accommodation, transport, etc?

From the point of view of the user How do consumers of health services react not only to the technologies of health care (more drugs, better facilities), but also to charges and increased fees? How do they react to the demands for increased community responsibility for ensuring quality care and equity of access?

Apart from these two groups, there are politicians and parties, unions, managers of health care service institutions, Ministry of Health programme leaders and other change agents. Health workers must be encouraged to realize that health reform is not what the Ministry of Health alone is doing, but rather what various categories of authorities and providers at all levels are doing.

Ownership is not achieved by reciting an impressive list of accomplishments and success stories, but rather on careful management of relations between health workers and health authorities at different levels. Educating health workers about health reforms is a delicate process as they are both the object and subject of health sector reforms. The political processes needed to win health workers over need to be managed in a way which attends to their welfare and professional satisfaction.

We have learned, despite criticism, that by using extensive capacity building workshops in which health workers have an opportunity to discuss policy proposals and produce a 'product' which they can own, significant advances can be made. For example, health workers who have developed the Reproductive Health Policy guidelines or the national health financing policies are the most effective communicators of the reform processes to other health workers. Discussions with health workers' unions must equally take

different forms consistent with the substantive issues to be discussed, and styles of communicating in these relations.

2.5 Essential Health Care Packages

Defining the package

In order to save more lives with the same resources, the Government has committed itself to financing an essential package of cost effective services, provided through primary care and district hospital levels. This will require a redistribution of resources from higher levels of care. Care outside this package will require private rather than government sources of funding.

In order to set priorities for the health care package, the burden of disease or the loss of productivity due to various diseases in Zambia has been identified, using the method of Disability Adjusted Life Years (DALYs) (Annex 2). The burden of disease has been calculated using data from health centres and hospitals, as well as population-based data from other Southern African countries. Malaria, ARI, diarrhoea, AIDS, perinatal problems and TB account for most DALYs lost in Zambia - a typical pattern for most countries in Southern Africa.

The Zambian package is being developed on the basis of the cost-effectiveness of different interventions for the various diseases. The possible interventions for each disease have been identified and their cost-effectiveness (or the cost per DALY saved) calculated. Other support costs (e.g. administration, transport, maintenance, training, IEC, etc) are being estimated, as well as other interventions that are not specifically disease-oriented (e.g. family planning and normal deliveries), and areas for intersectoral collaboration such as water and sanitation.

In developing a national package of care, it was important that health care workers at all levels, as well as key people representing different areas of interest and knowledge participated in the process of identifying the package, as they will be its implementors. The package is therefore being defined through a consultative process, including health care workers and administrative staff at all levels of the health care system. An important part of cost-effectiveness is quality of interventions. If quality can be increased, cost-effectiveness of the interventions is also increased. Quality assurance and quality strengthening are therefore vital inputs to the package. The method of DALYs and cost-effectiveness is a useful tool for introducing *cost-effectiveness thinking* into health care institutions at all levels. It also serves to guide the reallocation of resources from central to lower levels of the health care system.

Although much work has been done, some issues remain to be solved. There is for example need to agree on 'non-negotiable' services that need to be included in the package, not on cost-effectiveness grounds but rather due to moral issues and/or demand, such as care

for AIDS patients. We also need to further define the costs for identified support functions; define the roles for statutory boards, Public Health Laboratories etc; define costs and needs for capital investments at each level and for new posts and training of staff to support the package; and identify real costs for providing the package at each level. Information from the costing study should be fed into the cost-estimates during 1996.

The package will be introduced as far as possible in 1996. Those health centres that are being rehabilitated in 1996 will start providing most of the health centre package, and these could serve as pilot health centres to verify the costs and effectiveness of the package. Monitoring should be extended to include health posts and communities in order to verify what activities are being carried out at this level supported by a well-functioning, upgraded health centre in the district. The community health workers (CHW's) and traditional birth attendants (TBA's) will be crucial in delivering health care within the communities. The communities are therefore being encouraged to support the CHW'S and TBA'S in order to improve access to health care services.

Monitoring its implementation

There are two main objectives in monitoring the implementation of the package:

- To compare the assumptions made when calculating the cost-effectiveness in the packages with reality (focusing on inputs needed, cost estimates, demand, etc)
- To look at the cost-effectiveness and rationale for upgrading some health centres and downgrading others (focusing on indicators such as health outcomes and coverage)

Revising its content

Based on the outcomes, necessary alterations to the assumptions in the cost-effectiveness calculations and in the content identification of the package will be made before the package is further implemented in 1997. The package will be subject to a yearly revision of assumptions because disease patterns, costs, inputs, etc, change over time, and because the reliability of the data will improve. The 1997 revision of the package will include actual costs at hospital level in 1996 as an input. District staff will receive further training in DALY and cost-effectiveness calculations to facilitate the development of specific district packages that reflect local disease patterns and costs. Districts will then base their plans for 1997 on their defined packages.

2.6 Financing the reforms

The limited availability of funds

In addition to the problems of managing the essential partnership between health providers and consumers of health care, there are very real problems to be faced in financing equitable health provision for all sections of the population, including the poorest members of the community. As Abel-Smith and Rawal (1992) point out, many patients incur

substantial costs when they use apparently 'free' services, so simply exempting the poor from charges at the point of delivery does not necessarily make financing more equitable.

Financial resources for health are in jeopardy in many African countries. Frequently cited symptoms include budgetary overruns in ministries of health, lack of funds to cover salaries, pharmaceuticals and equipment in public facilities, cut-backs in capital development programmes, inability of the poor to pay for services, and limited risk-sharing or health insurance schemes. Binding financial constraints have been attributed to poor economic performance, cuts in government expenditures to meet the health demands of rapidly growing populations, and a variety of exacerbating factors, such as emergency conditions associated with famine, refugees and the outbreaks of epidemics.

Better management of existing funds

In the public sector, more revenue is clearly needed for public health goods and services. Equally important is to make better use of available public funds by reallocating them from expensive curative care to preventive and primary health care. Zambia's Health Policy document directs the Planning and Management Unit to identify specific initiatives in the area of cost-containment and sourcing of additional revenues for the health sector. This has given rise to a radical budget reform process within the MOH which has preceded and informed ongoing changes to budgetary practice within the Ministry of Finance. Through an experimental pilot project in three districts during 1991-1992, the MOH demonstrated that effective management of health services was possible at much lower levels of government, i.e., at the district level. As a result of external evaluation of this project, *District Health Budgeting* throughout the country became a reality from January 1994.

Approaches to more equitable financing

Financing the curative aspects of the Zambian health system has always been difficult. Our principle of building partnership for health has led us to reformulate the concept of equity. All able-bodied Zambians with capacity to earn an income are in principle expected to contribute to the cost of health care, whilst everyone is entitled to some minimum package of essential services. Such a scheme does not provide total equity but neither does any other affordable system of health care. In access terms, a basic level health package for all that is optimally costed for users minimises the equity constraints for society, while allowing for those who can afford higher cost services to have that choice as part of their individual responsibility for health. The main options for supplementary resource mobilization highlighted in these health reforms include: compulsory/private health insurance, user charges (cost-sharing), and community financing.

The primary reason for this intensive discussion within the Ministry and public debates is that Zambia finds itself no longer able to raise the additional revenue required to finance health services through taxation.

2.7 Establishing regular monitoring and evaluation of the reforms

The goal within the reformed system is to establish a self-sustaining monitoring and evaluation system to improve decision making at all levels of the system, with timely, valid and appropriate information as required to increase the effective utilization of quality health services. The intention is to monitor and evaluate implementation of the plan through a continuous process of assessing whether standards are being met and maintained, and to review the appropriateness of these standards.

This process will require an assessment of:

- the ability of the system to achieve standards - producing the anticipated outputs, functioning according to prescribed processes, and utilizing inputs as intended
- the accuracy of the assumptions made regarding the linkages between the use of inputs, processes (or system organization and structure), and outputs
- the accuracy of the assumptions made about the linkages between outputs and outcomes.

The major parameters to be monitored and evaluated include:

- Coverage with the essential package of health services
- Provider and client perceptions on quality of health services
- Management and development of human resources
- Status of infrastructure, equipment and logistics
- Morbidity and mortality rates
- Equity (including gender issues)
- Financial (costs and expenditures)
- Health reform process

Standards have been designed for formal institutions as well as for households and community. These standards (adapted at district level, and approved by the MOH) will be mandatory for institutions receiving government funding. However, the effective implementation of the system also depends on the maintenance of standards by individuals in the community. Certain preventive and curative health care actions are expected to be performed in the home or community. Use of the first level of the system, without by-passing it to other levels, is expected when conditions present which require care from the formal sector.

2.8 An assessment of the progress so far in implementing the 1991 reforms

In the following paragraphs, we share the experiences we have realised in Zambia, with comments on some outstanding difficulties ahead.

- *Definition of new functions, and the creation of Boards* In the process of decentralization which began in June 1992, the Ministry has defined new roles and responsibilities for the central, regional and district levels, and produced guidelines. The major thrust of health reforms has been the devolution of the key MOH functions of planning, management, service delivery, funding and resource allocation, and revenue generation. In 1994, eight more Hospital Management Boards and 58 District Health Boards were created. Boards were established in the remaining three districts in 1995. Districts now have discretionary authority for personnel recruitment, for task assignment and for resource allocation.

- *The Health Reform Implementation Teams* (HRIT's) have been established. They are operating as project teams. So far, they have exceeded expectations in their ability to create capacity for reform implementation. The HRIT'S, in conjunction with the Planning Unit, have developed a successful strategy for integrating vertical programme activities into district health plans.

- *Training programmes* were organized for district health personnel to prepare them for the added responsibilities they will handle. District Health Management Teams received training in planning, management and financing, and specialized training was provided for accountants and health information officers. Diploma level training for District Health Managers, (Core District Management), is planned to begin in 1996. Negotiations with other training institutions are under way to cater for hospital managers, accountants and technical staff. The first workshop for planning the role and functions of the Polyvalent Health Worker, a kind of community health practitioner with multiple health skills, has been conducted with the stakeholders. Resistance has been observed among the clinical officer category and further negotiations are under way.

- *Human resource issues* The basic employment conditions of the civil service for health staff cannot be improved in isolation from the rest of the civil service. However, where health institutions have generated sufficient medical fees, incentive bonuses have been awarded periodically to hospital staff. Transport as well as housing has been made available to staff in addition to improving the physical environment in which they work. More important, the establishment of autonomous Health Boards under the new Act has set in motion the de-linkage of public health services from direct provision by the Government. A time-table for de-linkage of Health Boards personnel is envisaged to start in 1997 and will be completed in 1999. This provides new opportunities to consider better conditions for health workers. In order to address the issue of staff imbalances, a national human resource survey has been conducted.

- *Shifts in resource allocation* The Ministry has received an increase in the share of the total central budget allocation for health from an annual average of 8% in 1991 to

13% in 1994, 14.2% in 1995, and 14.3% in 1996. The MOH has allocated nearly 18% of its budget as grants to District Health Management Boards, and 10% for drugs under recurrent departmental charges. Disbursement of funds within the Ministry of Health is in line with the new policy of decentralization. Thus, in 1993, the District Health Boards submitted plans for their activities to the Ministry of Health for review. Using a method based on a weighted per capita formula which takes into account Zambia's demographic parameters (Annex 3), districts were allocated grants for implementing their plans. The shift in resource allocation is indicated in Annex 4, and by 1999 it is projected that 62% of MOH resources will go to Districts.

- *Legislation* There is a National Health Services Act in place as of 6th September, 1995. This Act empowered communities to assume greater control over health services, by participation of public trustees chosen from the communities on Health Boards. It is now a legal requirement that health plans have to be cleared by Health Boards before they are submitted to the Central Ministries of Health and Finance for Parliamentary action.

- *A uniform financial administrative management system* (FAMS) has been developed through a participatory process with all the key stake-holders involved. The development of FAMS is part of the preparatory phase in the implementation of 'basket funding' strategy proposed by the MOH and recently agreed upon in October 1995 by donors. This involves donor support being channelled to the districts using a single set of planning, budgeting, disbursement, accounting and auditing mechanisms.

- *Rigorous financial monitoring* Releases from Ministry of Finance to Ministry of Health, as well as actual expenditures and releases from MOH to lower levels of the health care system, are now being monitored on a monthly basis by Headquarters. The monitoring includes comparisons between actual payments/expenditures and budgeted expenditures for each item under the budget for each grant-receiving institution.

- *A health care financing policy framework* (community co-financing) has been completed. Cost-sharing medical fees have been introduced across the board in the country. Further research on cost-sharing is necessary, but meanwhile, communities have been introduced to the idea that health care services cannot be provided at no cost. And further, communities are encouraged to use their involvement in financing the health services to make demands for improved quality in health care.

- *Essential packages* of cost-effective health services to be funded by GRZ have been successfully defined for all levels of care, to correspond to the burden of disease as indicated by DALYs (see Annex 2). Workshops were conducted for participants from all levels to introduce the concept. Information from the workshops will enable the

finalisation of the packages. Draft packages for Household and Community will be shared with other stakeholders.

- A study to determine the unit costs of health service provision in the existing system was undertaken in seven districts during July and August 1995, to provide baseline information on service costs, and also to feed into the central resource allocation process. The aims were to test assumptions made on the shares of district budgets to be allocated to hospital, health centre and district administration; to gather cost information to be fed into the packaging process; and to train district and provincial health staff in the methodology. The study identified resources used, quantified and costed them, then combined the information with utilisation data to determine the unit cost of an outpatient visit, under-five visit, antenatal, delivery, and postnatal and family planning. Major problems were experienced due to the poor quality of both health and management information at health facility and district level.

- *Rehabilitation of urban clinics and rural health centres* has started, in accordance with the new health package standards. Critical rehabilitation of central and regional hospitals will continue in 1996.

- *Laboratory services* A task force was appointed in May 1995 to formulate a comprehensive policy on laboratory services. A policy has been drafted on equipment specifications and distribution of laboratory supplies, and a situation analysis across the country has been completed.

- *Community neighbourhood health committees* The symbiotic relations being promoted among social forces at the district level, and between this level and higher levels, are releasing a considerable amount of implementation capacity in the reform programme. As a result, the centre is being pressed to intensify its monitoring and consultative capacity. The spontaneous emergence of community neighbourhood health committees is an important innovation, and they complement the lowest official structures, the Area Health Boards (see Figure on p15).

- *Inter departmental linkages* A pilot scheme has been established in 9 districts to formalise the linkage between the Department of Social Welfare and the Ministry of Health in ensuring access to health care by the destitute.

- *An urban health development strategy* has been defined in Lusaka as a pilot activity. As a result, a number of projects have been identified and funded. Lessons from Lusaka are being shared with other urban districts.

3 1996: THE SECOND AGENDA

Zambia can afford and achieve better health care. A national consensus for better health for all emerged during the first five years of MMD governance. The programme of health reform introduced during government by the MMD, which has significantly reconstructed the health sector, ranks as one of its major achievements. Now in its second term, MMD has had to review and revise policies, in the light of progress so far.

Recognizing that health security is a consequence of *Healthy Public Policy*, and not merely the effect of medical services, the Government's second agenda of health reforms address four key policy areas:

- Integrated Community Health Development under a reformed District Health System
- National Essential Health Packages of Care for sustainable health
- The quality of life and health security of specific population groups
- Accountability for health in public policy

Within these policy parameters, the government proposes to reinforce and promote the following policy developments:

- Further strengthen the newly mandated *District Health System* under the National Health Services Act (1995) as the focus of national health policy

- Build on popular democratization of public health services, by fully implementing the concept of *civic neighbourhood health committees* in each District, as part of an integrated community health development strategy

- Rationalize *target led financing*, whereby finance follows the explicit identification of health care needs and not the existing pattern of health facilities

- Strengthen the Ministry of Health as a *policy body*: setting policies, agreeing on strategies and targets with District and Hospital Boards, and allocating finance on the basis of contract for services of a specified quantity and quality

- Introduce a *district-level, quality-assured, Basic Package of Essential Health Care Services* to be fully financed from national tax revenue by 1999 as a minimum entitlement of all Zambians

- Rationalize the system of drugs procurement and distribution through a comprehensive *National Essential Drugs Policy*

- Upgrade 400 prototype *Accountable Health Centres* to 12-bed and 30-bed capacity in rural and urban areas respectively, to improve both quality and coverage

- Limit hospital expansion, but *fully modernize diagnostic and theatre capacity* in existing national referral and regional hospitals

- Transform, in collaboration with the private sector, the existing Flying Doctor Service into a *self-financing air and land-based ambulatory referral service*, capable of serving each district

- In addition to current emphasis on reducing infant and maternal mortality, begin to focus on developing services to *improve the quality of life of the elderly*, on whom the burden of AIDS orphans now falls, and to *prevent sexually transmissible diseases among adolescents* as part of a national HIV/AIDS prevention and care strategy

- Work with multiple stake-holders, including the private sector, to design an *incentive system for health workers* to further improve the quality of health care

- Implement an improved financing policy, based on a *pre-payment complementary community financing strategy*, and establish a *District Health Innovation Fund.* This will be consistent with Zambia's macro-economic realities, its commitment to popular democracy in managing health services, and to the principle of equity of costs and benefits in public goods

- Intensify strategic management of donor, mission and overall NGO partnership in health, by fully implementing the *basket funding and health package strategy*

- Increase *advocacy for health* in the public policy agenda, as a necessary dimension in human development

CONCLUSION

'Changes taking place in the health sector in Zambia are far reaching and radical enough to facilitate manoeuvre for PHC innovations' (Nangawe, 1993). A systems approach being employed to determine future ministerial functions is emphasizing the need to reduce the size of MOH headquarters, limiting its functions to policy guidance, reviews, monitoring, logistics support and resource mobilisation. When the autonomous Health Boards have mastered their new roles, the functions of resource mobilisation, personnel hire and fire and smaller scale logistics will be shed from the centre. This process will require time and systematic planning if the transition period is to be well managed.

There are a number of attractive attributes in Zambia's reform efforts: the emphasis on practical workable options; a demand for comprehensive quality assured health care; stress on autonomous health authorities and freedom for local innovation.

As Kalumba *et al* (1995) point out, there are many opportunities for success, such as:

- Favourable political climate
- Very dedicated leadership in the sector
- Decentralisation of decision making power to the periphery
- "Home grown" initiatives
- Fairly well articulated policy and strategies framework
- Strong donor support and coordination

However, there are a number of factors which threaten progress. These are among the conditions of turbulence:

- Diminished purchasing power of families
- Natural resistance to change
- 'Hasty' implementation, in the absence of a critical mass of people who fully understand and share the policy and strategic direction of the reform process
- The difficult task of persuading many cooperating partners to accept and work within a government-directed change process
- Human resource development policy lagging behind the rest of the reform programme.

A continuing challenge to reform is the building of a commitment among MOH staff and key health policy communities to the spirit of the Government's vision and strategies for health in Zambia. The Ministry calls for far-reaching reforms in the national health system. A plan for managing the changes needed to improve performance and quality of district health care is now in place. Because the reform programme calls for fundamental changes in the way health services are produced and delivered, there is bound to be resistance by vested interests within the health and related sectors. Efforts must continue to build a broader consensus within the MOH and among key actors for a systematic, staged implementation of the reform programme.

Health development is about the pursuit of a higher quality of life for oneself and for others. Such a concept must start with individual and family self-care and self-improvement. Accepting this definition, the achievement of a healthy society is less a medical than a socio-political problem. There is therefore need to build consensus within and outside the health sector for this new vision of health and for the infrastructure it requires. Whether this consensus succeeds or not will be judged by the response of the social agents affected by the changes. The tensions of any system of service provision and service regulation lies in the opposition between the interests of those whom the system serves, and of those whom it excludes or serves poorly, relative to their perceived 'needs'.

The struggle over quality health care for our people is at once a struggle over political rule and about democratic empowerment. If the social consequences of our current reforms

serve to downclass the real health needs of the majority through technologies of packaging that do not reflect their needs, they have the capacity and the opportunity to respond. This response constitutes an important factor in the transformation of social structures such as health systems (Kalumba, 1988). If the current district-based strategy fails, the impact on tertiary level care, which has in the past attracted policy emphasis, will begin to show in terms of lowered quality of care and possibly eventual collapse. This is the most likely consequence because demands that fail to be met at lower levels would begin to express themselves at higher levels and the unit cost of treating primary health care problems at these levels are higher. Worse still, the political legitimation of government in our democratic system of rule may be at peril. To reiterate, the Government in Zambia, like governments the world over, will do only that which improves its chances of staying in power.

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ANNEX 1

ROLES AND RESPONSIBILITIES OF THE NEW MINISTRY OF HEALTH HIERARCHY

A District Health Board

The new focus on the district means different roles that engender the investment of new management technical and political capacities hitherto unavailable. The Health Services Act of 1995 describes the responsibilities of the District Health Board. It represents the primary management unit in the decentralized health system, and as such is responsible for:

- Administering the affairs of the district health service
- The planning of all the district health activities
- Coordinating with other sectors, such as agriculture, local government
- Monitoring performance of health centres and the district level hospital against established standards
- Providing training for district staff.

The new Act distributes some substantive authorities to Hospital Boards, but remains cautious about District Boards. Because of turbulence in general District government, the minister of Health has been allowed to hold a relatively strong interventionist role; most members are public trustees appointed by the minister except those that are statutorily defined. This shields the Health Boards from local politics, but also undermines local representation. However Health Boards and their District Health Management Teams still do have to submit reports to the full District Council before they are submitted to Ministry of Health Headquarters and Finance Ministry. The Act gives the District Board more powers of raising revenue outside central budget grants, as well as responsibility for staff recruitment, and public health authority over any other health provider within its catchment area.

B Regional Health Office

A new role for the Regional Health Office (originally the Provincial Medical Office) has shifted the old emphasis on health administration to technical support of Districts. These Offices now represent the operational arms of the Central Health Board, and provide it with a direct link to the Districts. The following roles have been defined in support to the District Health Boards and Teams:

Technical Support Function

- Development of action plans and budgets
- Advise on implementation of action plans
- Provide consultancy on specific identified needs, such as financial management and epidemic preparedness - human resources development and training

Monitoring and Evaluation

- Action plan implementation
- Quality assurance
- Performance of district general and financial management

Health Management Information System and Health Systems Research

- Training of district health staff in gathering required information data
- In relation to the national information system, feed-back to districts, and to national data base

Logistical Support

- Ensure regular supply to districts of equipment, drugs, vaccines, from national sources
- Economy of scale functions, such as maintenance of cold chain

Communication

- Translate national policies into practical instructions for District Health Boards

Mediation

- Clarify roles of District Directors, Boards, etc
- Strengthen relationships among different actors (public/private sectors, Missions, etc)
- Provide guidance in restructuring numbers of health centres and hospitals, in line with the national strategic plan

C Central Board of Health

The Central Board of Health is a national administrative agency for overall technical management of the health sector. It is responsible for overall production of quality health care service, and for servicing the Ministry in its policy and advocacy roles. Responsibilities are:

Commissioning

- Developing and intermittently revise a Commissioning Strategy, including addressing particular needs of geographical regions and risk groups.
- Working out yearly Commissioning Plans, *i.e.* operationalising the National Health Strategy including targets and mensurable progress indicators.
- Negotiating and contracting services from DHB's and HMB's, as well as from other providers, such as the private sector, ensuring that plans are translated into services.
- Performing financing, costing and auditing of health services.
- Devising and implementing health advocacy and health education programmes.

- Commissioning and regulating food quality control.
- Devising and operating/commissioning an efficient system for procurement, handling and distribution of pharmaceutical and other supplies.
- Commissioning research.

Regulation

- Ensuring implementation of health laws.
- Monitoring compliance with laws and regulations and enforcing them by devised means, if necessary.
- Regulating all boards and institutions falling under MOH.

Running of Failing Boards

- Performing, with the approval of the Minister, the functions of a failing board.

Performance Support

- Defining and successively revising quality standards.
- Developing and operating a Health Management Information System (HMIS) that provides DHB's and HMB's with useful and timely information and decision-making support.
- Developing and operating systems for quality assessment and assurance.
- Developing and disseminating guidelines and best practices in various fields, including *inter alia* clinical guidelines and public health guidelines.
- Advocating professional values.
- Defining performance indicators that in themselves are positive end-results or have a very clear link to such.
- Developing and operating systems to follow-up and compare performances of different providers.
- Providing technical assistance FAMS to boards.
- Providing general technical assistance to boards.

Human Resource Management and Development

- Working out and yearly revising a human resource plan, assessing needs for personnel, skills and training.
- Developing and commissioning/performing technical, professional and managerial training, both pre-service and in-service.
- Developing and implementing an industrial relations policy.
- Designing and putting into force an appropriate personnel policy, including remuneration.
- Implementing a comprehensive management strategy, including management training.
- Developing, and among employees and boards, promoting and instilling a set of core values in themselves promoting decentralization and the provision of cost-effective care close to the family.

Planning and Decision-Making Support

- Developing systems for gathering and processing data.
- Providing information for planning and decision making at CBH and MOH.
- Monitoring and evaluating health services results in terms of costs (input), services (outputs), health status (outcomes) and user perceptions.
- Facilitating research (mainly through commissioning).
- Documenting.

Health Care Facilities

- Coordinating and regulating different providers regarding planning of institutions to ensure that number, distribution and locations of hospitals and health centres are appropriate.
- Advising DHB's and HMB's on matters of physical planning and engineering.
- Setting standards regarding physical facilities, buildings and equipment.

Management and Administration

- Handle the internal administration (accounting, personnel administration, transports *et al*) of a decentralized CBH.
- Preparing accounts, balances and financial reports for submission to MOH and donors on a regular basis.
- Fostering good public relations.

D Ministry of Health

The restructured Ministry of Health is currently accountable for the following functions:

Health Policy and Strategy

- Publishing intermittently reports on the health situation based on information provided by the CBH or special surveys.
- Developing every five years, with yearly progressive reports, a National Health Strategy, in which health situation and needs, as well as efficiency and effectiveness of different policies in improving the general health status are considered.
- The National Health Strategy shall also include priorities and objectives, deliberation of resource allocation between different sectors, intra-sectoral programmes, guidelines for resource allocation between different levels and forms of care, as well at other means of improving the health status, including health advocacy.
- Submitting yearly a five-year rolling investment plan.
- Working out (liaising with Financing and Budgeting) contract with CBH.

Financing and Budgeting

Resource Mobilisation

- Developing, and when needed, revising a health financing policy and strategy.
- Participating in the Government's national budget process.
- Liaising win cooperative partners and presenting yearly demands for contribution from them to fill-out gap between financing requirements and budget allotment.
- Co-ordinating funding from different sources as the basis for a comprehensive resource allocation.

Resource Allocation

- Based on the National Health Strategy and available funds developing yearly guidelines for resource allocation to enter into contracts with the CBH about the provision of services (see above).

Legislation

- Assessing needs for legislation and change of legislation.
- Preparing legislation and amendments.

Advocacy and Public Relations

- Developing a national health advocacy policy.
- Liaising with, and co-ordinating other sectors, including NGO'S, around this policy.

International Cooperation

- Coordinating cooperative partners and international organisations active in the health sector based on strategies and plans mentioned above (National Health Strategy, the Financing Strategy and the Health Advocacy Policy).
- Negotiating with international partners.
- Representing Zambia in international organizations and in general bilateral and multilateral contacts.

Evaluation

- Assessing in a yearly 'Contract Follow-up Report' efficiency and effectiveness of the health care system and the CBH's management of it, based on information provided by the CBH.

Administration

- Handling the internal administration (accounting, personnel administration, transports) of MOH.

ANNEX 2

BURDEN OF DISEASE IN ZAMBIA (CALCULATED IN DALYs)

DISEASE	DALYs LOST
Malaria*	6,777,962
ARI*	5,451,037
AIDS*	3,205,208
Diarrhoea*	2,146,002
Perinatal*	1,320,444
TB*	266,799
Malnutrition	125,955
Other Gastro-intestinal diseases	106,150
Maternal	91,887
Anaemia	65,624
All other diseases in the nervous system	44,620
Heart diseases	38,924
Injuries and poisoning	36,171
Measles	34,315
Other Bacterial diseases	24,990
UTI/PID	15,254
Mental illness	9,728
Diabetes	8,657
Worms	5,504
STDs	3,809
Hypertension	3,438
Eye diseases	1,937
Bilharzia (tot national figures)	1,248
Ear diseases	783

* These 6 conditions account for most DALY's lost in Zambia

ANNEX 3

POPULATION PARAMETERS

PARAMETER		PROPORTION	1995
Total population		100%	9,233,258
Rural population		58%	5,355,290
Urban population		42%	3,877,968
Population growth rate		3.28%	3.2
Births per annum		4.95%	457,046
Population distribution	0-12 months	3.99%	368,407
	0-59 months	20.26%	1,870,658
	0-14 years	48.76%	4,502,137
	15+ Years	51.24%	4,731,121
	Women child bearing age	22.1%	1,903,542
Number of provinces			9
Number of districts			61

ANNEX 4

REDISTRIBUTION OF RESOURCE ALLOCATION FROM THE CENTRAL LEVEL TO DISTRICTS, 1994-1996

LEVEL	1994	1995	1996
MOH HQ & Regions	10.04%	7.25%	7.55%
Hospitals (2nd & 3rd Refer.)	42.35%	42.64%	36.86%
District Health Services	41.84%	44.47%	51.76%
Other	5.77%	5.64%	3.83%
Total	100%	100%	100%

Source: MOH, 1995.