Towards universal health coverage in Zambia: impediments and opportunities.

Abstract

Universal health coverage is expected to take a prominent place in the post-2015 global development agenda, but there are concerns over its feasibility in low- and middle income countries. This paper assesses successive Zambian governments’ efforts to achieve this agenda. We discuss the recent restructuring of health governance to support policies that re-emphasise the social determinants of health and health equity. This includes a new Ministry of Community Development and Mother and Child Health alongside the Ministry of Health. We argue that recent innovations in policy and practice need to be extended to include ministries which focus on economic development.
Introduction

The concept of universal health coverage (UHC) is expected to take a prominent place in the post-2015 global development agenda as the United Nations facilitates a revision of the Millennium Development Goals (MDGs) (UN, 2012). The concept combines both a technical agenda - the provision of all necessary services to serve health care demands in a national population, and a rights agenda - equity in the provision of health services amongst that population. Central to the concept of UHC are the access to health services and financial risk protection. The goal of UHC is “to ensure that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship” (WHO, 2010). In 2005, World Health Organisation (WHO) member states committed to this goal via adoption of the World Health Assembly resolution 58.33. (WHA, 2005). The inclusion of UHC in the post-2015 global development agenda will be a reiteration of health as a fundamental human right, intending to renew the global commitment to closing the pervasive gaps in access to health care between the poor and the rich.

UHC is not a new concept. It has existed under various guises since the late 1970s and, most recently, as ‘universal coverage’ summarising the goals of national anti-retroviral treatment programmes. The significance of the concept is that it represents a globally agreed goal, which also underpins health system strengthening in many African countries, and yet it has been elusive in those countries (Travis et al., 2004; Waage et al., 2010). This article considers the major impediments and opportunities for moving towards UHC, by means of a country case study. We analyse past and current efforts in Zambia in providing equitable health care since the country gained political independence in the 1960s and whose government, in 2013, implemented substantive changes in policy and health governance to help achieve this goal.

Methodology

In our analysis, we understand a country’s health sector as being one in a range of factors influencing progress toward UHC. We refer to the analytical framework by Solar and Irwin (2010) in which contextual factors, such as governance, societal values, macroeconomic and public policies are given substantial weight in determining health equity outcomes in any country (Solar and Irwin, 2010). There is a body of literature which support this perspective (Baker and van der Gaag, 1993; Coburn, 2000; Foley, 2008; Gilson, 1998; Labonté et al., 2007; Loewenson, 1993; London and Schneider, 2012; Makinen et al., 2000; McIntyre and Gilson, 2002; McKee et al., 2013; Missoni, 2013; Muntaner et al., 2011; Navarro et al., 2006; Savedoff et al., 2012; Stuckler et al., 2010).
Towards universal health coverage in Zambia

This article is based on results from a qualitative study we conducted in Zambia between September 2012 and September 2014, which examined the development of public policy and strategy for the provision of chronic care services in the country. Methods included desk reviews, interviews, focus group discussions and service observations. Our informants were officials from the Ministry of Health (e.g. policy makers, senior programme- and tertiary level facility staff), the Ministry of Community Development, Mother and Child Health, the National AIDS Council and in-country technical assistance, funding, and United Nations agencies (n=18), health care professionals operating at district and primary and community level, such as physicians, nurses, counsellors and programme staff of community based care programmes (n=17), specialists involved with the country’s health management information system (n=19) and community caregivers (n=36). Interim results revealed substantive changes in policy and governance structures in 2013 which reflected both the government’s commitment to providing ‘equitable access to health care for all’ alongside awareness of the threats to its health agenda, such as the emergence of chronic conditions. This led us to extend our study with an exploration of past and current reforms in the Zambian health sector. We undertook a desk review and conducted further interviews with directors and senior managers in Zambia’s health services and with health system researchers and advisors (n=7), in relation to the goal of equitable health care. Our selection included both local and international informants and was based on the informants’ experiential knowledge on recent developments and changes to the national health policy and on past periods of health sector reforms.

The study was approved by the bio-medical research ethics committee of the University of Zambia (reference 013/02/11) and the medical ethics review committee of the VU University Medical Centre in Amsterdam, the Netherlands (reference 2011/180).

Findings

It should be noted that we discuss ‘findings’ rather than ‘results’ because, as is indicated above, this article is the product of additional primary and secondary research to the core study, to investigate a particular set of issues and put them in historical context. The results of the core study have been published elsewhere (Aantjes et al 2014a, c).
Results

A history of aspiration, directed efforts and profound challenges to equitable health care

From the 1960s to date, consecutive governments have aspired to “equitable health care for all Zambians”. Here, we set the scene for our analysis by outlining the efforts and challenges associated with achieving this goal during the past five decades.

Inheriting a very inequitable, colonial health system in 1964 provided the impetus for that aspiration, not as an overt expression of human rights to health but from a conviction that all Zambians should be treated equally. There was no separate public policy on health at the time; health was included in the national development plan (GRZ, 1966). The health sector was initially centrally governed by a Ministry of Health (MoH) with headquarters in the capital, with some allocation of administrative responsibilities to the provincial level and the larger hospitals. The sector’s focus was on undoing the inequitable divisions in health service delivery along racial and geographical lines and involved a significant, and necessary, expansion in health infrastructure. The emphasis was on provision of basic health services, disease prevention and health education. Hospital and out-patient services were provided free of charge. The success of these efforts, evidenced by improvements in health indicators (Garenne & Gakusi, 2006), was founded upon fast growth of Zambia’s market economy during the 1960s (Maddison, 2001). However, that momentum stalled by 1974 as the country experienced economic stagnation (Maddison, 2001). Declining revenues from its main economic resource, copper minerals, and the effects of a global economic crisis, pushed Zambia from its middle-income country classification to a low-income country (Ferguson, 1999). By 1978, the country was heavily indebted and underwent a series of World Bank-led structural adjustment programmes (SAPs). A dramatic decline in the health expenditure per capita, and a ‘SAP ideology’ in which health was regarded a consumer good and not a right, were the deathblow to the provision of equitable health care in Zambia. The net results were plummeting health indicators in a context of steeply rising poverty amongst the populace (Bequelle & van der Hoeven, 1980; Blas & Limbambala, 2001a).

In 1991, a new government was elected. It criticised the former government for not having been able to address the unequal distribution of health care services, particularly between urban and rural areas (Kalumba, 1997). This government developed Zambia’s first national health policy, and committed to reducing this disparity (MoH, 1991). The new ruling party’s vision for the health sector was to provide equity of access to cost-effective, quality health care as close to the family as possible. It emphasized the need to return to the delivery of comprehensive primary health care (PHC) services, and acknowledged the significance of the social determinants of health (MoH, 1991). According to informants, this included efforts to integrate disease programmes in primary health services and environmental health (water and sanitation activities)
Towards universal health coverage in Zambia

was built into the definition of the basic health care package. Health care equity was sought via the delivery of PHC and the decentralisation of authority and finance to district health management teams. These teams as well as district health boards were established in 1993-1994, with the objective to match planning and budgeting processes with the realities on the ground (Bossert & Beauvais, 2002). Provisions were made, by earmarking 75% of the total budget, to secure sufficient budget for district health care. This was a conscious attempt to ‘right-size’ the budget which, after independence, had disproportionally been consumed by the larger hospitals. The governance of the health sector was restructured via the establishment of a semi-autonomous body, the Central Board of Health, which monitored the performance of the districts. The role of the MoH was confined to policy-making and sector regulation. The restructuring was based on a Swedish model (MoH, 1991). The country was initially a frontrunner in the region (Cassels & Janovsky, 1996) but the conditionalities attached to the SAPs and the deterioration in socio-economic circumstances for many Zambians proved major obstacles in the implementation of the health sector reforms.

Via the adjustment programme- and other donor aid conditionalities, neo-liberal political influences percolated into public policy in Zambia. To illustrate, the national health policy stated that “every abled bodied Zambian with an income should contribute to the cost of his or her health” (MoH, 1991). The reality was that only a small proportion of Zambians at the time were able to make such contributions. In 1991, 68.9% of the population fell below the poverty line (Thurlow & Wobst, 2004; World Bank, 1994). Poverty was particularly rampant in rural areas (88%) as a result of urban-biased government policies; in urban areas 46% of the population was below the poverty line (Thurlow & Wobst, 2004). In pursuit of cost-recovery, user fees for health services were introduced in 1993. This intervention had a detrimental effect on the utilisation of health care by the poor (Atkinson et al., 1999; Blas & Limbambala, 2001b); a trend which was also witnessed elsewhere in the region (Baker & van der Gaag, 1993; Makinen et al., 2000). Two years later, these fees were exempted for certain users and conditions (e.g. children under five and chronic conditions) but this had little effect as the public welfare assistance scheme which had to facilitate this policy decision failed to do so (Masiye et al., 2010). The human development index, a composite measure for human development, consistently ranked Zambia in the lowest group globally (and Zambia has not been able to migrate from there since (UNDP, 2013).

These developments occurred as Zambians experienced the devastating effects of an HIV/AIDS epidemic. In the context of a severely constrained and underfunded health sector, civil society organisations led the response to the epidemic through pragmatic, community-oriented palliative care services and through invocation of existing, cultural values that emphasised mutual social support among community members (Aantjes et al., 2014a). In the provision of services use was made of trained lay-persons, who
lived in the villages and towns visited by mobile medical teams, to assist medical staff. It was a means to mitigate the costs of providing care and the limited human resources and infrastructure of Zambia’s health system. The government’s health decentralisation programme of the 1990s promoted the use of community-based networks. Neighbourhood health and health centre committees were formed as a means to institutionalise the link between local communities and the health system (Jeppsson & Okuonzi, 2000). In effect, this policy provided the space for civil society to emerge as key agents in the provision of community-based health care and close part of the gap left by the State’s inability to protect the most vulnerable in society.

It took well into the 2000s for substantive actions to redress the negative effects of the structural adjustment programmes on the health sector. The enablers for these actions were a recovery in national economic growth (Kragelund, 2011), debt relief to the country (Rakner, 2004), and large scale increases in donor aid for health, specifically for HIV/AIDS programmes (Ainsworth & Over, 1997; Cuesta et al., 2010; Ndubani, 2009; Oomman et al., 2007). Ideologically, the government was influenced by the HIV strategies of international agencies such as UNAIDS and the WHO, which advocated for people-centred services (WHO, 2008e). In other words, the government could re-emphasize its commitment to equitable health care because of the exceptional foreign investment in health care and global political support for this aspiration. To illustrate, donor funding constituted 11% of the country’s health budget in 1995 and 38% in 2004 (MoH, 2008). Foreign aid outweighed the domestic allocation for health, which averaged 9% during the period 2006-2009 (Cuesta et al., 2010).

There were substantive changes in Zambian health strategies within a very short time period. For example, in 2004, the government introduced free anti-retroviral treatment (ART) for HIV patients in selected hospitals (Schumaker & Bond, 2008). In the same year, the Central Board of Health was disbanded and MoH regained authority to direct the country’s health agenda. The MoH began to decentralise the ART programme across the country. In 2006, user service fees at rural health facilities were abolished and, in 2007, at peri-urban health facilities. The MoH also increased the wages of medical professionals in an attempt to halt their exodus out of the country, which had started in the early 1990s and had a profound effect on service capacity (Sousa et al., 2014). The government formulated a long-term development plan with the vision to become a middle-income country by 2030 (GRZ, 2006). In this plan, equitable health care provision was once more affirmed. The policy and programmatic emphasis was on development of community-level services which by then were founded largely upon CSO-led community programmes. Around 2007-2008, the MoH was exploring avenues to engage with these (mostly HIV-focussed) programmes and commenced with preparations for a national community health worker strategy and a community-based health management information system. In 2008, the MoH signed the Ouagadougou
declaration, together with other African countries, which committed it to the ‘revitalisation of PHC’ (WHO, 2008d). The goal of the declaration was to re-entrench the principles to achieving health for all from the 1978 Conference in Alma Ata. Actions by the government included plans to construct an additional 650 health centres, to recruit more nurses to staff these centres, and a training programme to establish cadres of state-paid CHWs, called ‘community health assistants’ (CHAs). These efforts provided the basis for a strategy to integrate CSO-led community programmes into the ambit of MoH PHC facilities. In 2012, the MoH deployed its first cadre of CHAs into rural communities and in that same year, Zambia reached universal coverage for ART (covering 450,000 of the 520,000 of people in need of treatment (UNAIDS, 2013) after having successfully decentralised this treatment to PHC clinics. Practical innovations in the ART programme have included experiments with introducing electronic patient files, establishing mobile treatment clinics in rural areas, and delegation of treatment-related tasks to nurses and counsellors.

During this time, in 2011, a new government came to power and it quickly emphasised its commitment to the aspiration of equitable health care. It abolished the user fees for PHC in urban health facilities and promulgated a new national health policy (GRZ, 2012b). The explicit vision in the policy is to “provide equitable access to cost effective quality health services, as close to the family as possible”, with an explicit commitment to address the social as well as bio-medical determinants of health by aligning future health strategies with the country’s socio-economic development plans. In brief, the government prioritised health and wellbeing from the perspective that investments in public health are necessary for sustainable development. The vision was supported by the necessary financial injections as well as a restructuring process in social sector Ministries. In 2011, Zambia was one of six African countries which was spending 15% of the national budget on health care, a goal agreed upon by all members of the African Union in 2001. The government has maintained this level of spending; for example, in 2014 it increased the 2013 domestic allocation to the health budget by 16% (KPMG, 2014). Similar increases are witnessed in the social welfare budget. One director in this Ministry explained that for 2014,

“the social welfare programme budget line has increased to 199 million [Kwacha; local currency]. They have been given an extra 150 million. Before they used to be as low as 30 or 40 something. So the government allocation is very high, it is the highest I think has happened.”

The government made substantive changes to the governance of health and social welfare services by creating a new Ministry: the Ministry of Community Development, Mother and Child Health (MCDMCH). This Ministry was given the responsibility to manage the delivery of PHC services, as part of its mission “to effectively and efficiently
facilitate the provision of equitable social protection and quality PHC services to communities in order to contribute to sustainable human development” (MCDMCH, 2013). The MoH retained authority to manage implementation of the health policy, research and delivery of ‘curative care’ (i.e. the management of secondary and tertiary level health care). The expectation is that the alignment of PHC with the departments of social welfare and community development under one Ministry will create greater opportunities for addressing the social determinants of health, via a pool of civil servants who actively liaise with each other and with existing groups of volunteers in the delivery of services at community level.

In summary, in the past five decades, a multitude of factors have influenced the provision of equitable health care. Many of these, such as macroeconomic policies, fell outside the jurisdiction of the sector but had a profound impact on the aspired outcome. In the last six years, better economic prospects as well as a range of innovative policies and strategies have brought the country closer to the longstanding ideal of equitable health care. Now, as Zambia continues this quest under the guise of achieving UHC, new impediments arise. We discuss these in the next section.

**Current impediments and opportunities**

The economic foundation for Zambia to sustain its commitment to equitable health care is the country’s successive, substantive annual economic growth rates during the last 15 years (World Bank, 2013a). The pursuit of equitable health care is underpinned by an explicit attention on the social determinants of health in the current government’s agenda: expressed in the promotion of ‘intersectoral’ interventions and epitomised in the creation of the MCDMCH. This is not a new agenda in Zambia, as we showed in the previous section; the difference today is the evidence that the trickle-down effect of economic growth to the poor population – as once promoted by the ‘Washington consensus’ (Williamson, 1990) – has unfortunately been negligible in the country. In 2010, 60.5% of the Zambian population still lived below the poverty line, with a continuation of the strong rural-urban disparity (77.9% versus 27.5%) (GRZ, 2012a). Furthermore, income inequality has risen consistently since 2003: in 2010 the Gini coefficient for Zambia was worse than it was in 1993 and the latter was a time when SAPs were in place (World Bank, 2010). This situation is not unique to Zambia. For example, the African Development Bank has reported that during the last decade, six out of the world’s ten fastest growing economies were in Africa but there was insignificant redistribution of wealth within these economies (ADB, 2012).

Economic growth coupled with widespread poverty has also generated new demands on the country’s health system. Notably, changes in the composition and concentrations of the national population have led to the increase in chronic non-communicable diseases
Towards universal health coverage in Zambia

(Aantjes et al., 2014a). The manager of one of the largest hospitals in the country made the point aptly:

“you see the costs for health care, for sure, has gone up. Because mainly the dynamics in the community, there has been a shift in health dynamics that will require more money on certain disease conditions. The demographics also you see, Lusaka is rapidly expanding, lots of poor shifting to the city, so impact on health services is much more.”

Furthermore, even though recent consecutive Zambian governments have increased, and continue to increase domestic funding for the country’s health services, the health system as a whole is subsidized by foreign donor funds and that funding has been decreasing since 2010 following the global financial crisis (Dang et al., 2009). Precise figures on the funding reductions for Zambia’s health sector do not yet exist in the public domain but World Bank data (World Bank, 2013b) indicate a decrease during the period 2010-2012 and less financial support than was received during the previous decade. There is some indication that Zambia is managing to maintain the momentum of its broad ‘health system strengthening’ agenda partly by securing loans and investments from India and the People’s Republic of China (Kragelund, 2011). Senior Zambian government officials also reported that social health insurance and further taxation are being considered as options; these being mechanisms which have previously been advocated by the WHO as means to achieve UHC (WHO, 2005b, 2010c). However, it should be noted that there is a body of research which shows that these measures do not necessarily work in contexts of widespread poverty (Basaza et al., 2008; Ekman, 2004; Jütting, 2004).

This leaves Zambian policy-makers, for now, with the option to either spread the available resources thinly or to prioritise a number of diseases. Both options affect the equity agenda. If resources are spread to thinly, the quality and quantity of services are inevitably affected. As one advisor to the MoH stated:

“equity to services does not mean equity to poor services.”

As a result, those who can afford better services opt for the private health sector. This point was made succinctly by a director of health programmes in a large umbrella organisation representing the private-not for profit health sector in Zambia:

“you have equipment, even state of the art equipment, you have a specialist but it is congested, and nobody would like to wait for six months to be seen by a doctor. But if I go into the private sector, the same doctor will see me within a day.”

If certain services are prioritised over others, inequity also creeps into the system. The strain of decision-making is already evident as voiced by a MoH director:
“the difficulty I have is .... I can buy a CAT-lab at such an amount of money and then drive just 15 km from here, what is confronting a child is just malaria and diarrhoea.”

In sum, health officials are grappling with the challenges associated with sustaining improvements to the country’s PHC services and developing the capacity of secondary and tertiary level health care services, in the face of changing burden of disease and health care demands in the country. In practice, at present, the programmatic focus at the level of primary health facilities is on maternal and child health, the integration of CSO-managed community and home-based care (CHBC) programmes with MoH PHC facility operations and on the provision of health care for communicable diseases at these facilities. MoH officials highlighted plans to address the rise of NCDs in the country; for example, via establishment of specialist clinics at each provincial hospital, expansion of the cancer hospital, purchase of necessary technologies such as MRI, CT and CAT scan machines, building a heart catheterisation laboratory, and the investment in overseas medical specialisation training for Zambian doctors. However, there was little evidence of development of NCD care services at primary level facilities despite comments from doctors that secondary and tertiary level facilities were overburdened with treating complications in NCD cases that could have been prevented through appropriate patient monitoring and treatment in PHC facilities. For instance, at present, NCD care skills are not part of the training curriculum for community health workers; there are no NCD care ‘refresher’ courses for nurses and doctors; and there are no standardised protocols for simple screening activities such as blood pressure measurement in health centres. This is the context behind the frustrations voiced by an MoH director:

“If you do not fix things at PHC, you will change the secondary level hospitals into first level hospitals and then you will have the whole system again bending towards, responding to where there is a challenge. That is what we are seeing, that is what we were discussing now...”

These challenges reiterate challenges that Zambia has experienced since the 1960s; and which have been well described in the literature (Marquez & Farrington, 2012; Rice, 1966; Shiffman et al., 2009; WHO, 2007), namely how to balance investment between curative and preventive care services, whether to opt for comprehensive or selective health care, and how to prevent inequities that inevitably arise with the growth of private health services. Currently, Zambia seems to be trying to gradually expand from a narrow set of services to comprehensive services which focus on maternal and child health, communicable and non-communicable diseases, as also suggested in the literature on UHC (Knaul et al., 2012; O’Connell et al., 2014; Sachs, 2012; WHO, 2014). This is complemented by an acceleration in the delivery of social welfare services. Notably, according to two informants, one director in the MoH and another in the MCDMCH, the intention in 2015 is to use conditional social cash transfers to reach
the very poor with basic social services. For example, pregnant women enrolled into
the cash transfer programme will need to use ante-natal and post-natal services. A
related planned intervention, informed currently by strong advocacy amongst women
parliamentarians to reduce the practice of ‘child marriages’ (girls married at a young age
according to customary norms and values), is to provide the cash transfers on condition
that parents ensure their daughters attend secondary schools.

The alignment between Zambia’s health, community development and social welfare
departments is a significant step as it re-emphasizes commitment to the social
determinants of health. However, as our historical analysis shows, this collaboration may
still fall short of overcoming the structural impediment of poverty. The observation is
supported by the work of other scholars who argue that health and social protection
programmes are not sufficient to address ill health in contexts of poverty (de Janvry
& Sadoulet, 2009; Marmot et al., 2008). This infers that inter-sectoral action needs
to be extended further in Zambia. There are precedents; for example, promotion
of agricultural production in China has helped to improve the economic and social
conditions of the rural poor (de Janvry & Sadoulet, 2009; Montalvo & Ravallion, 2010).
It should be noted that there are limited references in literature on how to design and
implement effective inter-sectoral policies (Shankardass et al., 2012). In the case of
Zambia, efforts to achieve UHC need to be accompanied by investigation of what
combination of policies and actions could effectively reduce economic inequities and
contribute to improving the health status of the poor.

Conclusion

UHC, under different guises, is a long standing aspiration in Zambia. It is an aspiration
which made important strides in the last 6-8 years via innovative strategies in the health
sector. Notably, substantive changes in health policy and governance in the last 2-3 years
re-emphasize the social determinants of health. This is an important but, of itself, not
sufficient step to address the underlying inequities in the Zambian society which help
aggravate the burden of disease. The crux of the matter is that the MCDMCH and the
MoH may be seen to be driving innovative, effective interventions but these confront
only the symptoms of inequitable economic development in the country. Consequently,
it is predictable that the goal of UHC, which has seemed achievable in the last 5-6 years,
will once again elude Zambian policy makers. The caveat to this conclusion is that much
depends on whether the alignment between the MCDMCH and MoH will be followed
by a further elaboration of Zambia’s inter-sectoral policies and which include ministries
that focus on economic development.