MAKING FREE HEALTH CARE WORK FOR ALL ZAMBIANS: WILL THIS ELECTION DELIVER?

VOTE HEALTH FOR ALL

In 2006 – the year of the last regular presidential and parliamentary election – health care was made free for all patients in rural districts in Zambia. This decision –was warmly welcomed by many Zambians and was internationally acclaimed. It was envisaged as a first step in an effort to roll out free care to all citizens and achieve universal access to health care.

The immediate impact of the reform was dramatic – an average 40% increase in use of health services. The policy was right – user fees did block access to health care for Zambians and should have been removed. Unfortunately the positive impact has been patchy and not sustained. Waning political commitment, poor and uneven implementation including the neglect of health workers and medicines, a drop in investment and serious problems of corruption and lack of transparency are to blame. As a result, direct payments continue to exist in many rural and all urban health facilities and Zambians continue to be denied the decent quality health care they need to live healthy and productive lives. Only about half of all births are attended by a skilled birth attendance; in rural areas the proportion is as low as 31%. The country still has one of the highest maternal mortality rates in the world.[1]

As Zambia approaches parliamentary and presidential elections in September 2011, it is time to take stock and tackle the challenges facing the health sector. Which candidates will demonstrate the commitment necessary to make free health care work for all Zambians?

USER FEES BLOCK ACCESS TO HEALTH CARE

After a long period of free health care provision, user fees were introduced in Zambia in the early 1990s. Their introduction, combined with severe spending cuts for health, was devastating. Providing only 4% of total health expenditure, fees failed in their objective to raise needed additional revenue.[2, 3] More importantly, utilisation of health services dropped significantly.[4, 5, 6] Household surveys in 2002 showed that across the country about one quarter of patients were turned away from health facilities because they could not afford even modest fees. Almost one in four patients given a prescription could not afford to buy the medicines.[7] Rural dwellers in particular find it difficult to raise even modest cash resources to pay for health care, as Sheba Siakanzaba Silumesi from Chanyanya explains:

"People in the rural areas have little options in terms of income generating activities since most of us are involved in farming which gives us meaningful income only once a year"

Other studies showed that exemptions, which should have protected the poorest from being charged, were not working.[8] As seen in many other countries, user fees were highly inequitable, limiting access to health to those who could afford to pay.

FROM FEES TO FREE IN 2006

Within government a consensus formed that the financial barriers to health care had to be overcome. Pressure from local civil society, growing international sentiment supporting fee removal [9] as well as positive domestic developments including an increase in donor aid, the introduction of free ARVs in 2005, and debt relief, all combined to further promote the case for a policy change.[10]

In January 2006 the late President Levy Mwanawasa announced the removal of user fees in rural areas "as a first step" to increase access to health care. As the official policy would state, the government had "taken the position in view of the overwhelming poverty levels in the country and the high cost of accessing health care services".[11] The policy aimed at promoting the principle of accessing health services by Zambians as a human right.

The situation in many rural health facilities changed dramatically. One study reported an immediate jump in utilization of 40% after implementation of the policy.[12] Another found an average increase of 50% compared to virtually no increase over the same period in urban areas where fees were still charged.[13] Yet another measured an increase of 55% at 15 months into the new policy.[14] Evidence suggests the poorer districts with the greatest deprivation recorded the greatest increase in utilisation after fees were abolished.[15]

The evidence was clear that user fees had blocked access to those needing health care. Many insist that free care was the only way to go given the widespread poverty, as one village headmen puts it:

"*We appreciate the fact that government honoured their promise to remove user fees, we will not accept anyone who will try to re-introduce the fees."* Kerby Nkhotami – Bonanza Village in Chinyanya-Kafue

CHALLENGES AND DISAPPOINTMENT

Unfortunately, few of the now well understood, steps necessary to make user fee removal a success were taken in Zambia.[16] As a result the immediate positive uptake in health care utilisation has not been sustained. Despite hard work by all involved, a number of failings helped to undermine the success of the policy.

Funding Cuts: At the very time when income from fees stopped and more patients used the health facilities, the resources for those facilities were actually cut - in 2006 the district grant from central government declined by a staggering 40%.[17] This was a result of poor decision-making rather than scarcity of funds – in 2006 overall resources available for Zambia's health sector actually increased by 11%.[18]

To make matters worse, the biggest cuts were experienced in the non-wage districts grants including for drugs, community activities, and flexible emergency cash; precisely those inputs – in addition to human resources – that were required to cope with the increasing number of patients at the facilities.

The situation for the districts was further aggravated by the fact that the UK DFID's sponsored replacement grant – meant to substitute the loss of income due to fee removal – reached many facilities late, not in full, or not at all.[19]

While both challenges were addressed and modest improvement could be seen in the subsequent years, a new and unprecedented blow hit the cash-strapped districts. Following a massive corruption scandal exposed in the Ministry of Health in 2009, nearly all major donors froze their aid for the health system almost immediately. Many have cut funds substantially since. UK DFID's replacement funding for the policy change also ended in 2010.

It remains unclear how the Government of Zambia plans to increase and improve the allocation of its own domestic resources for health or how it will work to win back the confidence of development partners to scale up urgently needed aid for health. This leaves health workers and patients in a dire situation:

"We used those fees to buy kerosene for the vaccine fridge and petrol for the motorbike, but now we have to rely on the District Health Office in Mumbwa for those things. They tell us their grants have been reduced since the Global Fund withdrew its money and now they don't have enough money to run the whole district." Jacob Kaneya - Environmental health technologist, Lungobe Rural Health Centre

A health worker emergency: Prior to the user fee policy change the health worker gap was already severe – the health sector operates with half the expected number of staff.[20] Many of the more remote rural health centres do not have any qualified personnel at all. Despite these shortages the user fee removal policy came with no plan or budget to recruit and deploy the urgently needed additional health workers. No measures have been taken to mitigate the impact of the policy change on existing health workers, for instance through additional incentive payments, or to make up for the loss of income from bonuses. Alarmingly, some studies actually report a decrease in health workers in rural areas during the years after the policy change.[21, 22]

Several strategies have since been set up to address this shortage of health workers including the Zambia Health Workers Retention Scheme, which offers salary top-ups to selected individuals in order to attract doctors and nurses to the most remote parts of the country.[23] While the initiatives are welcome, overall health worker shortages remain critical and government action is urgently required.

Drug stock-outs: During the first year of the new policy the supply of essential medicines to districts was irregular and inadequate. The Joint Annual Review of the Ministry of Health stated that 60% of essential drugs and medical supplies were out of stock in 2006.[24] Poor supplies can in large part be blamed on pre-existing problems and the fact that no measures had been taken to procure and distribute the additional medicines needed for the increase in demand that came with user fee removal.

Drug availability has improved slightly since 2006, partly due to the creation of a new Unit in the Ministry of Health to manage medicine procurement and supply.[25] However, shortages of medicines continue. It is commonplace for patients to leave facilities with prescriptions instead of medicines, directly undermining the free care policy. In a setting where cash is hard to come by and mostly seasonal, this can have dire consequences as Headman Kerby Nkhotami explains: *"Many people in rural areas cannot afford to buy drugs for themselves hence they resort to using traditional health remedies which are not very effective".* Kerby Nkhotami – Bonanza Village in Chinyanya-Kafue.

Poor communication and implementation: The user fee removal guidelines agreed by the government only vaguely specified services which should be provided free of charge as *'consultation, admission and diagnostic services' in 'rural areas'.* Charges for non-Zambians as well as 'by-pass fees' for those coming directly to the hospital without a referral letter were to continue. What exact services were free and where were frequently questioned and then re-defined. The lack of clarity caused significant confusion amongst both staff and patients and led to different interpretations of the policy in different facilities. In many cases fees continued to be charged.

A large part of reason for uneven and incomplete implementation of the policy was down to insufficient planning time. This contributed to poor consultation especially with the very staff responsible for implementing the reform at provincial, district and facility level.

Patients let down and continue to pay: Due to poor planning and implementation, what was a good and welcome policy for free care turned into a missed opportunity for the nation. Quality of health care at times suffered and patients often faced longer waiting times, fewer drugs, and overworked staff.

While health care utilisation more than doubled in some districts, it actually reduced in others. Changes in utilization per district ranged from -39% to +108% (see Figure 1).

Lack of government action meant the most vulnerable suffered most. The evidence suggests the free care policy may have had a crowding out effect on the utilization of services by children under five years of age.[26] The facilities were simply not able to cope with the increased utilisation.

Overall and despite the commitment of individual civil servants, the government of Zambia has failed to ensure fees were abolished as the policy intended. While rural residents now pay less than their urban countrymen, they do continue to pay when services should be free. Household survey data shows that on average rural patients paid ZK 3, 334 in hospitals, ZK 1,440 in health posts, and as much as ZK 8,803 for accessing care in a mission facility.[27] Even where health facilities have stopped charging patients directly, in-kind payments often continue to be asked from patients, such as operating material or simply stationary:

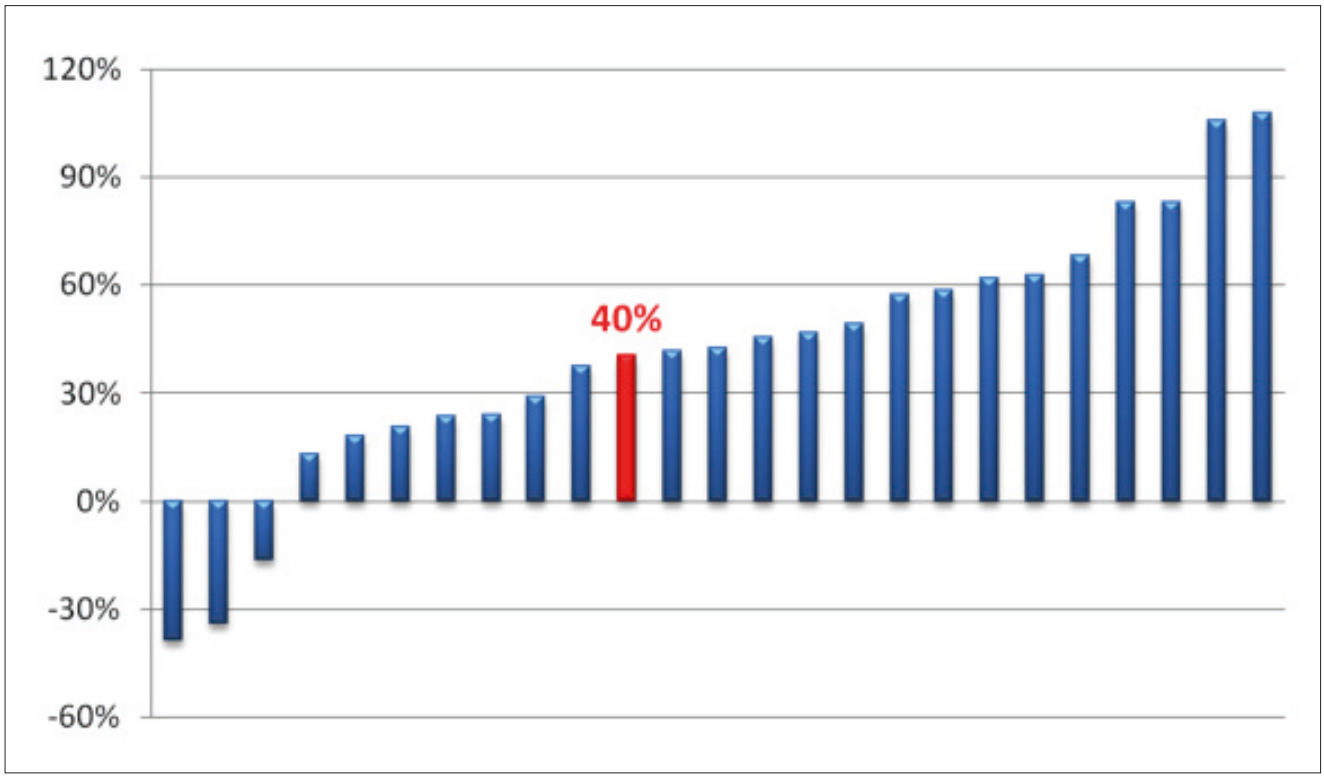

Figure 1: Heterogeneity in changes in the number of outpatient visits of >5s immediately after the policy change in 27 districts (average 40% increase) *Source: Lagarde 2010*

"Even though there are no user fees that are charged at the rural health centres, we still have to buy an exercise book which is used for record keeping at a cost of ZMK 500" Kerby Nkhotami – Bonanza Village in Chinyanya- Kafue

Of course for poor people in urban areas fees remain high and constitute a huge burden and barrier to access, as market trader Maxwell Mvula (pictured right) from Kafue Town explains:

"We are made to pay for all the tests, for example a blood slide is K5000, mobile Ante Natal Clinics are K5000 per child. We want free health care services which includes medicines and free diagnosis"

According to the WHO, out-of-pocket-payments constitute "by far the greatest obstacle to progress towards universal coverage".[28] In Zambia out-of-pocket payments continue to rise almost unabatedly (see Figure 2). This apparent contradiction to the free health care policy in Zambia can be explained by two facts: firstly the reform has not fully been implemented in rural areas, and secondly user fees still exist in urban areas.

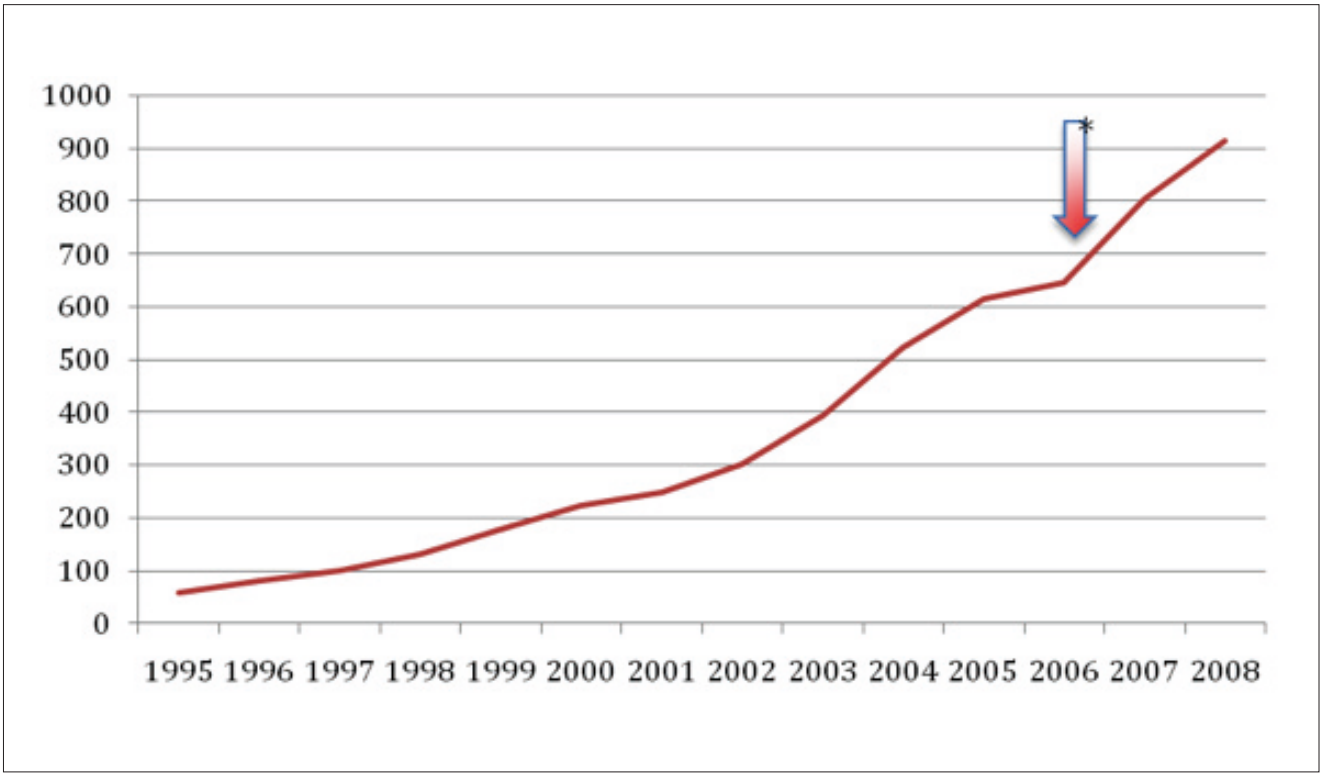

Figure 2: Trend in out-of-pocket expenditure 1995-2008 (in 1,000 million ZK, the red arrow showing the policy change)
Source: adapted fromhttp://www.who.int/nha/country/zmb/en/ (last updated March 2010; accessed March 2011)

THE ELECTION: AN OPPORTUNITY TO DELIVER

The evidence shows that user fees block access to healthcare in Zambia and their removal can dramatically improve utilisation, especially for the poorest people. However, good policy announcements are not enough and poor implementation and failure to address ongoing health system weaknesses, as well as wider determinants of health, lead to disappointing results.

The forthcoming elections constitute an important moment to turn past performance around and deliver health care for the nation. Change is possible if the essential ingredients to make free health care a success are put in place, including: strong political commitment; increased funding for health especially for districts and rural facilities; action to address health worker shortages and poor medicines supplies; improved transparency and accountability as well as timely, comprehensive and participatory planning and implementation.

AN ELECTION PROMISE?

Zambian citizens have the right to decent quality health care accessible to all. It is the responsibility of the government of Zambians, as the primary duty bearer, to deliver it.

We look for strong commitment from election candidates to prioritise equitable and improved free health care for all Zambian by promising to:

- Increase the health budget to at least 15% in accordance with the Abuja Declaration
- Ensure access to medicines and eliminate drug shortages at all levels of the health care system
- Ensure adequate numbers of qualified health workers allocated to the areas where they are needed most
- Ensure an increase in health facilities to reduce pressure and waiting times and ensure citizens have access within reach of their homes
- Make free health care really free in rural areas and ensure there is no place for user fees or direct payments in Zambia's health care financing strategy going forward
- Ensure that the government of Zambia entrenches the practice of transparency and accountability in planning and spending of the health budget
- Ensure that health is included in the Constitution's Bill of Rights as one of the fundamental human rights
- Ensure generation of and access to appropriate information on health to assist evidence based decision making and accountability

Endnotes

1 WHO data, http://www.who.int/making_pregnancy_safer/countries/zam.pdf (accessed August 4, 2011).

2 However, fees were found to comprise 13% and 66% of the recurrent budget in rural and urban health centres, respectively (Government of the Republic of Zambia, *Zambia Public Expenditure Tracking and Quality of Service Delivery Survey in the Health Sector - findings and implications,* G.o.t.R.o.Z. Swedish International Development Agency, World Bank, University of Zambia, Editor. 2007)

3 Masiye, F., *Estimating anticipated revenue loss in public health facilities due to removal of user fees in Zambia,* Department of Economics, Editor. Dec 2005, University of Zambia: Lusaka.

4 Daura, M., et al., A*n evaluation of district-level cost sharing schemes. Draft report prepared for Central Board of Health meeting on cost sharing, Lusaka, 13–14 March 1998.* 1998..

5 Kahenya, G. and S. Lake, *User fees and their impact on utilization of key health services,* Ministry of Health/UNICEF, Editor. 1994: Lusaka.

6 UNZA, et al., *Health Care Financing in Zambia: a study of the possible policy options for implementation,* Aug 2005: Lusaka.

7 Central Statistics Office, *Zambian Demographic Health Survey ZDHS 2001-2002.* 2002: Lusaka.

8 PHRplus, *Zambia Community Health Waiver Scheme: Final Evaluation, K.D.C. Team, Editor. 2006, Partners for Health Reform Plus; GEGA, Coordinator's Report: GEGA visit to the Zambia Gauge.* 2002, Global Equity Gauge Alliance.

9 For example the World Health Organisation's Commission for Macroeconomics & Health in 2001 and four years later the G8 endorsed Commission for Africa made the case for access to free care. Even the World Bank – a long time promoter of user fees – started altering its pro-fee stance.

10 Carasso, B., Palmer N., and Gilson L., *A policy analysis of the removal of user fees in Zambia.* Oct 2010, LSHTM & UCT.

11 Government of the Republic of Zambia, *Revised Guidelines on the Removal of User Fees in Government and Mission Health Facilities in Zambia,* M.o.H. Zambia, Editor. May 2007: Lusaka.

12 Lagarde, M. and Palmer N., *Removal of user fees in Zambia: was the impact sustained over time?*. 2010, LSHTM.

13 Masiye F, Chitah B.M., Chanda P. and Simeo F., *Removal of user fees at Primary Health Care facilities in Zambia: A study of the effects on utilisation and quality of care,* Department of Economics, University of Zambia, Equinet Discussion Paper 2008.

14 Masiye, F., Chitah B.M., and McIntyre D., *From targeted exemptions to user fee abolition in health care: experience from rural Zambia.* Soc Sci Med, 2010. 71(4): p. 743-50.

15 Masiye F., Chitah B.M, Chanda P. and Simeo F. 2008 op.cit.

16 For example, in the original terms of reference for the User Fee Removal Committee, budget proposals were to be prepared to meet the costs of an anticipated increase in demand for free services, including the procurement of additional drugs and recruitment and deployment of more health workers to rural areas. However, these proposals were never finalised. For a fuller discussion of the necessary steps for successful fee removal see Save the Children UK (2008) 'Freeing Up Health Care: A guide to removing user fees' accessible at http://www.savethechildren.org.uk/en/docs/Freeing_up_Healthcare.pdf. (accessed July 15, 2011).

17 MoH Zambia, *Health Sector Joint Annual Review Report 2006,* M.o.H. Zambia, Editor. 2007, Government of the Republic of Zambia: Lusaka.

18 Government of the Republic of Zambia, *Zambia Public Expenditure Tracking and Quality of Service Delivery Survey in the Health Sector* - findings and implications, G.o.t.R.o.Z. Swedish International Development Agency, World Bank, University of Zambia, Editor. 2007.

19 The replacement grant was agreed to be US-$ 25 Million over five years based on a calculation of the anticipated loss of income through the removal of fees.

20 MoH Zambia, *Human Resources for Health Strategic Plan 2006-2010,* M.o.H. Zambia, Editor. 2006, Government of the Republic of Zambia.

21 Carasso, B., et al., *The impact of user fee removal on measures of staff motivation and satisfaction in five districts of Zambia* Feb 2010, UNZA, LSHTM, MoH.

22 Walsh, A., et al., *Task sharing in Zambia: HIV service scale-up compounds the human resource crisis.* BMC health services research, 2010. 10: 272.

23 Government of the Republic of Zambia, *Scale up Plan for the Zambian health Workers Retention Scheme* M.o.H. Zambia, Editor. 2009, Government of the Republic of Zambia.

24 MoH Zambia, *Health Sector Joint Annual Review Report 2006,* op.cit.

25 NHSP IV MTR Team, Mid-Term Review of the Zambia National Health Strategic Plan NHSP IV, 2006-2010. 2008.

26 Lagarde, M., *Analysis of the impact of user fee removal on health seeking behaviours using a difference-in-differences approach.* 2010, LSHTM.

27 Ibid.

28 WHO, The World Health Report: Health Systems Financing – The Path to Universal Coverage. Geneva 2010.

This paper is published by the Civil Society Health Forum, Fair Play for Africa, Women in Law Southern Africa, 2410 and Media Life, with technical support provided by Oxfam.

Front Cover : Patients waiting at Lungobe Rural Health Centre, Lusaka, August 2011. Photo: Nicole Johnson/Oxfam