CHAPTER FOURTEEN

HEALTH

Health and Poverty

The wealth of poor people is in their capabilities and their "assets". Of these, health is the most important. Health allows poor people work. A sick, weak and disabled body is a liability, both to the persons affected and to those who must support them. Thus if health is an asset and ill-health a liability, for poor people, protecting and promoting health care is central to the entire process of poverty reduction and human development.

In the recognition that the link between poverty and ill health, It is important to note that "ill health is more likely to lead to further impoverishment amongst the poor than among the wealthy and that meeting the health needs of the poor is an important means to preventing the increase of poverty in any society.

Linkages between Health and Poverty

Meeting the health needs of the poor is important for preventing the increase in poverty. However, because often the lost income as result of seeking care or caring for the sick can amount to approximately 70 percent of total costs, utilisation rates for the poor are lower because of the opportunity cost of time spent on seeking care. For the poor taking time off on medical grounds may jeopardise the future economic situation.

Poverty can also be linked to poor health in that the poor lack basic needs such as health services. The poor have worse health outcomes than other economic and social groups. Infant, child and maternal mortality rate and malnutrition are higher in poor communities and countries.

Given the relationships explained above, it is clear that health care is an investment good, i.e. improving human capital results into higher productivity. In the least developed and poor countries such as Zambia, economic growth has not been sufficient to allow for significant allocations to social programmes such as health, education and measures to alleviate mass poverty.

Situation Analysis:
Strengths, Weakness, Opportunities and Threats SWOT)

Few if any of the general health indicators have improved in Zambia over the last ten years and some have moved in the opposite direction. For instance, life expectancy at birth had come down to 41 years; the infant mortality rate had increased to 109 per 1000; and, the under-five mortality rate had gone up to 197 per 1000. (DHS, 1996). The maternal mortality ratio was officially recorded as 649 per 100,000 live births, but figures even higher than 1,000 are reported in surveys. Nationally, HIV zero-prevalence seems to have stabilized over the past 3-4 years at 29 percent in urban and 14 percent in rural settings, with a national average of 20 percent in the 15-45 age

group (MoH/ CBoH, 1999). There are some indications that the HIV infection rate for young adults is decreasing. With an official annual growth of 2.7 percent (DHS, 1996) Zambia's population increase is well within the average rate of 2.9 percent for most of sub-Saharan Africa though with HIV/AIDS this rate may now be overestimated.

AIDS and AIDS – related diseases have become prominent with the number of households experiencing chronic illness and death is rising. In 1998, 17 percent of rural and 12 percent of urban households had experienced an HIV/AIDS related death (CSO, 1998). TB related cases, as mentioned earlier, have risen. Other diseases also continue to have a negative impact on the health system in. At the same time malaria, diarrhoea and respiratory tract infections remain heavy burdens. Equally, malnutrition remains a serious problem. For example, according to the 2001 UNICEF State of the World's Children, 42 percent of under-five Zambian children are stunting. Moreover, in recent years, the country has been suffering from epidemics of both cholera and measles. (HMIS, 1999).

Access to basic services also shows a wide spatial variation. Provinces closer to the 'line of rail' have closer access to services. In urban areas, 99 percent of households are within 5km of a health facility while it is only 50 percent in rural areas (CSO, 1998). Further, household expenditures on health vary according to location, though most poor households spend the highest proportion of their income on health – up to 10 percent of total expenditure when 'in kind' costs are included.

As shown above the Health Sector is facing numerous problems principally caused by the double burden of declining resources in real terms in the face of an escalating disease burden. Management of resources is also of concern. The sector however has some strengths and in-built opportunities, which can be utilised to make it more efficient and equitable

Firstly the country has a basic health package of service being implemented put together after a Government assessment in 1995. It aims at streamlining interventions in the sector. The information provided in this assessment was an essential tool for planning and implementing strategic and cost effective health interventions for all especially the poor. An assessment of the burden of disease resulted in the ranking of priority of disease.

Following the decentralization of Planning and Budgeting in the public health sector, an objective and transparent resource allocation criteria has been developed for allocating funds to districts and hospitals and further improvements to the criteria are underway. In addition to that, a mechanism for pooling financial resources has been developed beginning with district funds (district basket) and later to extend to the wider sector. The main levels for financial allocation are the following:

- District level: An allocation of resources on a per capita basis and weighted for, population density, price of fuel, proness to epidemics and the presence of a bank is used. This mechanism allows for management of funds at district level to meet specific districts needs. It is suggested, however, that social indicators such as poverty be also included in the criteria.

- Hospital services: Allocation to hospitals is based on cost per bed day. Standard bed/population ratios are used to determine the number of beds per given population for 1st, 2nd and 3rd level hospitals.
- Other levels: Allocations to other institutions and levels below are based on estimates presented subject to availability of resources. The institutions include The Ministry of Health Headquarters, The Central Board of Health and Statutory Boards and Bodies

Structures for community participation in decision-making have been established at neighbourhood, Health Centre and District levels. The neighbourhood Health Committees (NHCs) are composed of about 5 to 15 members, of which at least half should be women. The NHC's activities include collecting and maintaining community based health management information system data, providing a link between the community and the health centre and other development agents. They also mobilize communities and are responsible for selection of CHWs. Because of the importance of resources to good service delivery, the NHCs are also involved in mobilizing resources and maintaining a health fund. They are also charged with the responsibility of contributing to strategic plans and representing the NHC on Health Centre Committee (HCCs) meetings. The HCCs comprise representatives from the Neighbourhood health Committees and representatives from the Health Centre. The tasks of the HCC include drawing up annual plans, providing financial support to neighbourhood initiatives and reviewing progress of community-based programs. With regard to participation guidelines have been developed to strengthen partnerships at different levels.

Despite having the above-mentioned strengths the Zambian health sector has several weaknesses that for the purpose of the PRSP have to be addressed. These include lack of Hospital Policy, outdated and obsolete legislation, cost sharing and fees, distance to health facilities and lack of transport, problems of access for under-served groups, poor physical Infrastructure and equipment, participation and empowerment, resource allocation and the performance of the health system in general.

At the start of the implementation of the Health Reforms in 1992, it was erroneously assumed that the hospital sub-sector with high-level management personnel did not require re-orientation and capacity building. In addition, there has been the assumption that the hospitals are high consumption areas without discernable impact on the health of the people hence the prior reluctance to invest in the hospitals.

The introduction of user fees in 1993 coincided with a significant decrease in the utilization of health services. Several studies in the mid-1990s concluded that user fees play a big role in this. Antenatal attendance dropped, as did Family Planning (FP). Under-five clinic reductions showed a more marked drop in new attenders than re-attenders. Most alarming was that attendances for Sexually Transmitted Diseases (STD) treatment dropped by 76 percent.

With regard to legislation a number of acts are not current with the needs of today especially with the developments that have taken place in the sector. There is therefore an urgent need to review legislation so as to improve service delivery.

Long distances and lack of transport in a large but sparsely populated country is a key determinant of health seeking behaviours in Zambia. The distance to the nearest health facility rather than user fees is the most significant variable determining access to health services as well as to exemption schemes. In relation to this currently, there is no definitive analysis on specific groups who are not served well by health services. However, from available data on Maternal Mortality Rate (MMR), there seems to be a significant problem in meeting the needs of pregnant women and safe motherhood.

Another identified group is adolescents, especially for sexual and reproductive health services. Adolescents may not access services for a number of reasons, but privacy and confidentiality are primary concerns. Cost as well as the attitude of staff is also major deterrents. Orphans are a group that is also under-serviced.

The majority of people especially poor and vulnerable groups do not participate in the health system apart from seeking treatment when needed. In response to this NHCs have been established, but Area Health Boards have not. These aim to get stakeholders participate in health care. At the District level of services, the current resource allocation criterion is not based on need for health care by the population but only considers cost factors. The criteria are being revised to take into consideration socio-economic factors and other proxies for need.

The Performance of the sector is measured in terms of output in the production function. The variables in this function are responsiveness, fairness in financial contribution and Health Expenditure. Usual considerations taken and their levels are below:

- Total expenditure on health as percent of GDP: 5.9
- Public expenditure as percent total expenditure on health: 38.2.
- Private expenditure as percent total expenditure: 61.8.
- Out of pocket expenditure as percent total expenditure on health: 42.4.
- Tax-funded and other public expenditure as percent of public expenditure on health: 100.
- Public expenditure on health as percent total public expenditure: 9.7.

Health Services Outcomes are also used to assess the performance of the sector and with these too the picture is still bad especially for the poor. While the Basic Health Care Package, which guarantees access of Health Services to the poor has been identified and costed at US$11.5 per capita, the health sector has available only US$10.5 per capita. From above the sector performance has not been adequate and needs to achieve better efficiency and equity.

In light of the weaknesses there is need to identify existing opportunities and to use them to improve health. With regard to cost sharing the overall health policy, which affect the poor is that, “Every able-bodied Zambian with an income shall contribute towards his or her health”. To make the cost-sharing scheme more equitable, a system has been put in place. This system focuses on two mechanisms:

Exemptions: There are two types of exemptions demographic exemptions; for children under 5 and adults over 65 years old and disease based exemptions; for

treatment of chronic illnesses such as TB, HIV/AIDS; treatment of STDS, treatment of epidemics such as cholera and dysentery; safe motherhood and family planning services; immunization; treatment of chronic hypertension; and treatment of diabetes.

The Safety Net: Health Care Cost Scheme: The Public Welfare Assistance Scheme (PWAS) introduced in 1995, was intended to address inequalities in access. Chronic patients who cannot pay are supposed to be referred to the District Social Welfare Office for assessment; and approved fees are paid to the District Health Management board by PWAS. However the referral system has not functioned well.

Physical infrastructure has been given some attention but more needs to be done. Apart from the three hospital levels and health centres, the Ministry of Health has introduced health posts as a level of services below the health centres and bring the service closer to people. For every 3,000 people in the rural areas and for a population of between 10, 000 to 50,000 in urban areas a health post is to be established. This, however, has raised issues of affordability, human resource requirements, and the redefinition of clinical and posts' roles and responsibility

The Government has also been promoting community-based health care. This is an alternative or a complement to extending physical infrastructure and it strengthens partnerships. Among the principles of the Health Reforms is partnership at various levels i.e. community participation, inter-sectoral collaboration and international cooperation. In this regard community involvement is fostered through the creation of a board. Recent initiative spurs communities to be involved in health matters through community-initiated programs beyond those implemented by the health workers. This activity is funded through a Central Community Health Innovation Fund (CHIF). The objective of the fund is to catalyse innovative health activities, which are not part of the Basic Health Package. Most activities funded so far are water and sanitation related and construction of infrastructure, particularly mothers' shelters.

Zambia has been implementing health reforms since 1992 under the framework of Sector Wide Approach (SWAP), which takes a holistic/comprehensive development to sector development. In the SWAP resources are pooled from Government and other stakeholders so as to utilize resources efficiently.

The health sector has several threats that have to be taken into consideration especially when planning and programming. Firstly there is a growing recognition in Zambia of the two-way link between HIV/AIDS and poverty. HIV/AIDS is inexorably consuming more resources, which means that less is available for other important diseases such as malaria and cholera.

Another threat in some districts is refugee arrivals from neighbouring countries. It is estimated that around 127, 000 refugees from Angola have spontaneously settled in districts neighbouring the country (UNHCR, 2000). Where the base populations are quite small, such an influx can have a significant impact on the resources available and the demands articulated.

Programme Priorities

Basic Health Package

As a priority financing of the basic health care package would drastically reduce both the morbidity and mortality rates in the country and contribute to poverty reduction.

Cost Sharing and Fees

The policy of "Every able-bodied Zambian with income should contribute to his or her health" should be upheld. However, mechanisms to protect the poor must be further developed to prevent user fees being a barrier to the poor accessing public health services. Improvements in the current exemption schemes should be all embracing. Specific improvements should be as follows: -

- Demographic Exemptions: People over 65 years with means but currently exempted should be made to contribute to the cost sharing schemes.
- Disease based exemptions: The list should include malaria and should also include product exemptions.
- The Safety Net: The implementation of this policy through Public Welfare Assistance should be continued. However, the management of this initiative requires improvement through enhanced funding and better management.

Resource Allocation:

The Ministry of Health/Central Board of Health should expedite the working out of new approaches to allocation of financial and human resources to Districts to give more weight to poverty issues than is currently done.

Community Health Innovation Fund

Has a tremendous opportunity to strongly impact on economic growth in the long-term if it would be adequately funded. "Grassroots" can be an effective way of poverty reduction.

Sector Wide Approach (SWAP)

Sector Wide Approach takes a wide and holistic view to health sector. This policy should be supported and retained.

Governance Issues (Procurement Systems)

There is an immediate need to restructure the procurement system so as to ensure that purchasing of drags is done more efficiently and on a needs basis.