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Title: DECENTRALISATION AND DELINKAGE OF PERSONNEL IN THE ZAMBIAN HEALTH CARE SYSTEM

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A research report submitted to the Faculty of Management, University of the Witwatersrand, in partial fulfilment of the requirements for the degree of Master of Management (in the field of Public and Development Management).

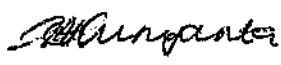
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Abstract

This thesis attempts to look at delinkage and decentralisation in health care reforms taking place in Zambia. While an attempt has been made to look at the international context, the main focus is on Zambia with its donor issues, manpower constraints and liquidity problems. The issues are looked at through the actors in the reform process. The findings are interpreted in light of organisational and administrative factors, behavioural factors, political circumstances and the financial and human resource situation. Zambia's reform efforts are viewed in the light of current worldwide trends is health care reform.

Declaration

I declare that this report is my own unaided work. It is submitted in partial fulfilment of the requirements of the degree of Master of Management (in the field of Public and Development Management) in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination in any other University.



Helen M. Chinyanta
13 February 1999.

Dedication

I wish to dedicate this work to my husband, Justin, who was a source of constant practical encouragement and support. Mwanga, Chantal and Ngwashi had to put up with endless hours without their mother and yet always celebrated my successes and encouraged my efforts.

Mum and dad – for always pushing us to do more and being the greatest example.

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Auntie D without whom all this would have been academic!

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List of Abbreviations

CBOH	Central Board of Health
CMAZ	Churches Medical Association of Zambia
DANIDA	Danish International Development Agency
DFID	Department for International Development
DHA	District Health Authority
DHB	District Health Board
DHS	District Health Systems
FAMS	Financial and Administrative Management Systems
GRZ	Government of the Republic of Zambia
HFB	Health Facility Board
HQ	Head Quarters
HRIT	Health Reforms Implementation Team
MOH	Ministry Of Health
MMD	Movement for Multiparty Democracy
NGO	Non Governmental Organisation
NHPS	National Health Policies and Strategies
OECD	Organisation for Economic Co-operation and Development
PHC	Primary Health Care
SIDA	Swedish International Development Agency
SHP	Strategic Health Plan
SSA	Sub-Saharan Africa
SWAP	Sector-Wide approach
UNICEF	United Nations International Children's Education Fund
UNIP	United National Independence Party
USAID	United States Agency for International Development
UTH	University Teaching Hospital
WB	World Bank
WHO	World Health Organisation
ZHR	Zambia Health Reforms
ZCCM	Zambia Consolidated Copper Mines

CHAPTER 1: Introduction

1.1 Introduction

The study undertaken by the researcher aims to look at the issues of delinkage and decentralisation in the Zambian health care system. Both are key to the approach being taken in Zambian health care reform as they form part of the background context. The background and context against which decisions are taken largely influence the actual shape that reforms take in health care. Thus in Zambia, where health care reforms are premised on primary health care provision at the lowest level possible, certain prerequisites are essential for success.

A decentralised structure to ensure authority and responsibilities are assumed at the lowest point of contact with health personnel and the community was deemed imperative. Delinkage became one of the mechanisms used to 'hive' off staff from the civil service so they could fall under the various boards created to give greater autonomy in decision-making.

It is necessary to define the two key terms used above as they are employed in Zambian health care reforms. The term delinkage has been used before to define the relationship of linkages within the economies of developed and developing nations. In the Zambian context and specifically in the health sector, delinkage is defined differently by the Ministry of Health (MOH) as is shown below. Similarly decentralisation is a problematic term as it takes many forms and is not always a clear-cut process. The researcher has opted for a loose definition below and chosen instead to go into details about the various forms of decentralisation in the literature review.

1.2 Definition of terms

It is important to have a clear definition of the key terms being used in this research paper, as similar terms are sometimes understood slightly differently.

Decentralisation

The extent to which authority and decision-making are spread throughout all levels of an organisation rather than being reserved for top management.

Delinkage

"Delinkage is the process whereby the Ministry of Health continues its decentralisation focus by delinking all civil servants from the Public Services Commission (except for the few MOH HQ staff). The rationale for delinkage is to enable staff to be more accountable, to improve ownership and therefore encourage innovation (the driving force of change) to occur. Delinkage is not an end in itself but is required to allow the legal framework of autonomous health boards to function effectively and efficiently. Delinkage will finish once all eligible civil servants within the Ministry of Health have made choices, and either left the civil service and where possible, joined an autonomous institution. The exercise will not be continued indefinitely and the MOH HQ will negotiate with the Public Services Reform Programme (PSRP) on the implementation process and programme". (National Health Policies and Strategies: 1998, p. 66)

1.3 Historical background and international context

Zambia's health reforms are firmly rooted in the transformation that took part internationally over the past two and a half decades. A desire to see worldwide improvements in health permitted the setting of targets and objectives to achieve this goal in the late seventies, as did a worldwide financial crisis where the budget governments were able to allocate to the health sector shrunk. In the third world and in Africa particularly, governments began to borrow money to pay back debts and a cycle of poverty ensued. This led to the imposition, over the next two decades, of structural adjustment programmes by the International Monetary Fund (IMF), the World Bank (WB) and the donor communities through mechanisms such as the Paris Club.

Internal political pressures also influenced the general reforms that began to take place in Zambia. Prior to 1990 there had been a single party government under the United National Independence Party (UNIP) that had an avowed socialist/humanist agenda in the way it dealt with the distribution of resources, whether in the education or health sector. All of these services were delivered from the proceeds of the country's copper earnings. The quality of health and education, two crucial sectors of government concentration in the wake of independence from Britain, had improved birth rates and brought a substantial number of graduates into the system. At the time of Zambia's independence in 1964 there were only 100 graduates.

By 1990 the country was reeling under the impact of debt caused by several factors, amongst these the oil crisis and the heavy burden of the liberation wars being fought simultaneously on four of Zambia's borders. The result was a drop in the delivery of quality service in the health and education sectors as well as reduced living standards. This led the government to begin to look at new ways of delivering a service that people would now have to pay for, except for the very poor.

In 1991 the Government of the Republic of Zambia (GRZ) embarked upon a programme of economic and political reforms. The primary objective of the reform programme was to open up the economy to greater competition and the political process to greater public participation. The poor resource picture also dictated a painstaking review by the GRZ of its public expenditure programmes with an eye to reducing waste and improving efficiency in the use of resources and the delivery of publicly provided services. The new economic realities and political climate have created an environment in which policy makers are willing to explore alternatives to traditional methods of organising, delivering and financing health care (Shilalukey-Ngoma, 1997)

In order to improve and sustain the delivery of health services to the Zambian people, in 1991 the Ministry of Health (MOH) embarked on a wide-ranging assessment of the future of the health sector. The assessment included a review of the role of the government as a provider and financier of health care, the role of the private sector and the Ministry

of Health and the resources required to arrest the decline in Zambia's health indicators. The review culminated in the adoption of an innovative package of reforms aimed at mobilising additional resources for health and improving efficiency in the delivery of health services. The objective of these reforms is to provide Zambians with "equity of access to a cost-effective, quality assured health care as close to the home as possible". (National Health Policies and Strategies: 1991, p. ii)

Influences behind the health reforms in Zambia

There are many influences on Zambian health care reforms However, three key reasons that helped determine the direction and scope can be identified and elaborated on for the purposes of this document:

1. The Zambian economy began to experience difficulties to do with both internal and external factors, not least of which was the structural adjustment program imposed by the World Bank in exchange for funding.
2. The Alma Ata Conference of 1978 provided a basis for the shape of the reforms, including the decentralised form that Primary Health Care (PHC) requires in order to deliver the health care service to the individual within his community.
3. The political mandate that the Movement for Multi-Party Democracy (MMD) had upon entering office, facilitated the moves made in the health care sector due to the window of opportunity this offered.

1. The Zambian economy

Before independence Zambia's s[illegible]al indicators of income and wealth were highly uneven. "In 1991 about 68% of all Zambians were living in households with expenditures per adult equivalent below a level sufficient to provide basic needs" (World Bank Report, 1996, p. 8). Their welfare and productivity were negatively affected by malnutrition, poor health and low levels of education and Zambia was one of the few countries to experience an increase in infant mortality during the 1980's (from 97 per thousand in 1980 to 107 in 1990). (World Bank Report, 1996, p 9)

Current economic reforms are divided into two eras: pre- and post-1991. The first phase began in 1989 with the decontrol and market determination of all consumer prices and ended in September 1991, when donor support to the UNIP government was delayed due to lack of adherence to the policy reforms in the run-up to the multi-party elections of October 1991.

A review of the public sector role was started with a view to narrowing its scope and strengthening its capacity to perform its legitimate functions more effectively (World Bank Report, 1996, p. 11). Consequently the Zambian government initiated a Public Sector Reform Programme "to recast the role of the Government's administrative machinery to deliver public goods more effectively and create a conducive atmosphere for the private sector" (World Bank Report, 1996, p. 12). This programme involves a three pronged strategy:

- restructuring of Ministries and provinces to streamline the structure and make them more consistent with current policy priorities;
- improving human resource management by developing and instituting performance management systems and individual performance appraisals, training, encouraging optimum human resource utilisation, building a culture of accountability and instituting measures which motivate workers; and
- decentralising and strengthening local government, addressing the performance management system and financing functions of provincial and local government, and facilitating the decentralisation of functions to provinces and local authorities in support of participatory governance". (World Bank Report, 1996, p. 12)

The 1996 report acknowledges that while preparatory work has proceeded well, in most components of the programme implementation has lagged far behind the original schedule. In their view a key component – "a comprehensive and affordable plan for reducing public employment to facilitate competitive salaries to remaining workers" - is still missing. (World Bank Report: 1996, p 12)

With the Zambian economy going through a period of deep structural

change and far-reaching policy reform the transition has not been as successful as hoped for in increasing growth and reducing poverty (World Bank Report, 1996, p. 44). "Disappointment with the results of this effort has touched many parts of Zambian society - urban and rural, public and private sectors etc. - as well as the international community" (World Bank Report, 1996, p. 44). The report questions why this should be so in the economy as a whole and attributes this to several factors, key amongst them being:

(i) the elusiveness of stabilisation;
(ii) the credit crunch;
(iii) the fact that positive results and building investor confidence take time;
(iv) recurrent external shocks - decline in copper production and the severe drought of 1992.

These have had an impact on the poor. Criticism of the economic reform programme varies from it being "too market-oriented and too fast, too soft and too gradual, insensitive to the needs of the poor" and as having "given inadequate attention to social services in general, and safety nets in particular". (World Bank Report, 1996, p. 49)

2. Alma Ata Conference, 1978

Why did reforms come about in the health sector in Zambia? Partly for the reasons enumerated above regarding general changes in the economic sector as a whole in conjunction with changing trends in health care worldwide in particular. In 1978 an international conference on Primary Health Care (PHC) was held at Alma Ata in the then Soviet Union. The need was expressed for urgent action "to protect and promote the health of all the people of the world" (WHO European Policy for Health For All, 1998, p. 1). The ten point Declaration addressed the disparities in health between developed and developing countries and the right and duty of people to participate individually and collectively in planning and implementing of their health care. There was also a basic recognition that the highest possible level of health is dependent upon the action of other social and economic sectors in addition to the health sector.

PHC was seen as the key to attaining the target of acceptable levels of health for all by the year 2000. "It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where the people live and work, and constitutes the first element of a continuing health care process". (WHO European Policy for Health for All, 1998, Item VI)

3. The political equation

The MMD government on coming into power had a window of opportunity that permitted it to implement fairly radical sector-wide reforms. The reform of the public service had a direct impact on the reforms in the health sector, although paradoxically the latter has moved far ahead of any of the other sectors with the delinkage exercise and contraction of health personnel at the MOH. The health sector has been negatively impacted in its delinkage exercise by the lack of funding to ensure that packages for those leaving the health service can be given.

Other issues impacting the reforms are instantly visible. They will not succeed without the requisite manpower to staff the clinics. Zambia suffers from a brain drain in vital areas such as health and education. Doctors, nurses and other medical staff are trained and soon leave to find greener pastures outside the country. The net result is that only a few are left to build on and a constant haemorrhage of manpower is experienced. One wonders whether the government has found a way of stemming the flow, as any reforms undertaken under these conditions would be meaningless if they are to be sustained over the long term. The cost of hiring foreign doctors is high and there is the question of externalisation of scarce foreign exchange resources. Greater development would be promoted if local staff were to utilise their resources within the country.

Conditions need to be improved to encourage doctors to go to the rural areas and take up permanent positions there. The reforms need to go hand in hand with the drive for rural development to improve conditions for

the poor. This also implies infrastructure. It is evident that the government will have to appeal to the Zambians to unite in the task of nation building. This will have to be backed up with incentives which mean that personnel are not obsessed with the mundane problems of existence (having to keep down two jobs) and can devote themselves instead to the task of looking after patients' welfare. There is a need for a return to professionalism.

All this is easier said than done and would involve putting in place institutional mechanisms to encourage these tendencies. What are the forces that have helped to neutralise the professionalism of the medical corps? The harsh economic climate, the clampdown by the previous government on private medical practices which would have allowed for the freeing up of state resources spent on individuals for health and permitted the medical practitioners to open up practices wherever they chose instead of being tied to the hospital system. Once openings became scarce, medical staff opted to take up jobs outside the country resulting in a shortage of qualified personnel.

Vision for health: the emphasis on decentralisation

The reform process involved a major reorientation in the thinking of everyone in the country. Every health worker was expected to think like a manager, to think of others and for others, in order to salvage a health service that seemed unsalvageable. This entailed understanding a vision for health where the government was committed to providing quality health care as close to the family as possible. It meant every individual feeling responsible for ensuring his or her health. It meant some basic rules and principles being laid down and shared by key people throughout the country including the principles of leadership, accountability and partnership. Translated into reality this meant three things. (Shilalukey-Ngoma, 1997)

The first was decentralisation, the devolution of power from the central Ministry of Health headquarters to the districts. This was a clean, clear process. Accountants were trained to handle district finances and managers to lead district health teams. The district was to become the 'implementer' of health, making its own decisions and managing its own

affairs (Shilalukey-Ngoma: 1997). Through funding provided primarily by DANIDA (Danish International Development Agency), training took place nation-wide for two years to equip health workers with skills in planning, budgeting and district capacity building. The Health Reforms Implementation Team, a national secretariat, provided overall leadership of the decentralisation process. The mechanism through which the government anticipated that these reforms would be carried out is the Central Board of Health (CBOH).

The Central Board of Health

The CBOH was established in September 1996 with the appointment of the board members. By June 1997, it was anticipated that all health staff would be completely delinked from government. Civil servants previously employed by the Ministry of Health would now fall under various health boards and only 67- 69 staff would remain under the Ministry of Health. Central and district health boards would appoint board members from the community except for the following, who by virtue of the positions they hold, would be on the board:

Traditional Healers Association of Zambia (THAZ)
General Nursing Council
Churches Medical Association of Zambia (CMAZ)
The Attorney General
Zambia Chamber of Commerce and Industry (ZACCI)
Zambia Medical Association
Dean of the School of Medicine
Seven ordinary community members

Zambia is divided into four regions for CBOH administrative convenience. They are:

i) Luapula, Copperbelt and North Western Provinces - HQ at Kitwe
ii) Northern and Central Provinces - HQ at Kabwe
iii) Lusaka and Eastern Provinces - HQ at Lusaka
iv) Western and Southern Provinces - HQ at Livingstone (See Appendix 1 for map of Zambia)

Seven directorates would be created – three of which would be at the

CBOH headquarters and these are:

i) Systems Development,
ii) Monitoring and Evaluation, and
iii) Health Communication Services.

The main role of the Ministry of Health or government would be advocacy, mobilisation of funds from parliament and internationally, dealing with health policy matters - should children under five pay for medical care or should people over 60 pay etc. The day-to-day running of health services would be the responsibility of the CBOH. (See Appendix 2 for CBOH structure)

Everyone was to have three-year contracts and performance indicators needed to be determined. It was expected that this would promote efficiency, as anyone not performing would not have his or her contract renewed. Staff would be motivated to work hard through the improvement of service conditions that in turn would ensure good performance and accountability. Boards would have some uniformity on salaries, but there would be some differences, for example in a Level 3 hospital such as the University Teaching Hospital (UTH), staff are doing more advanced work and would therefore be paid slightly more than those in a Level 1 or 2 hospital. Examples of Level 2 hospitals are Chipata, Kasama or Solwezi. (See map of Zambia in Appendix 1)

In terms of standards, it was expected that a Level 2 hospital, e.g. Kasama, should have the following minimum staff:

Consultant surgeon
Consultant paediatrician
Consultant obstetrician/gynaecologist
Radiologist
Eye specialist

The role of experts is essentially at two levels: the hospitals and the CBOH. Local experts are expected to fulfil roles such as those outlined above. It is expected that conditions of service would make it attractive for such people to take up rural postings. Experts at the CBOH will supervise

these boards and provide technical support. In certain cases outside agencies may be used - if a research project is required, outside consultants may be hired to undertake the research.

Major funders of the health reform programme are: Ministry of Health, Swedish International Development Agency (SIDA), Danish International Development Agency (DANIDA), Overseas Development Agency (ODA, now under the new acronym of DFID - Department for International Development), Japanese International Co-operation Agency (JICA), United States Agency for International Development (USAID), Netherlands Embassy including international organisations such as the World Health Organisation (WHO), United Nations International Children's Education Fund (UNICEF) and United Nations International Development Organisation (UNIDO).

The government adopted a basket concept for funding so that they sold the concept of health reforms as a whole and not in pieces. The big advantage to this approach is that the piecemeal activities of the past where donors had 'pet' projects that they funded to the exclusion of other important sectors is being substituted for a sector-wide approach that allows for more coherence in tackling the problems of health. Funders who approved the concept were asked to put money into a central basket and CBOH will decide on the allocation of resources to each sector, for example Immunisation, Malnutrition, HIV/AIDS, Malaria, Maternal morbidity and mortality and Diarrhoeal Disease (DD) which are the main areas of health concern. Some donors are still grappling with the structure that is to be adopted and with internal financing accountability constraints vis-à-vis their own governments.

The effectiveness of the CBOH will be established through a monitoring and evaluation unit that will be set up shortly. The stated aims of the government are that there should be a radical change in the health care system and participation in the form of public/private partnerships. The objective will be to see how far these expressed aims have been carried out and whether there is still room for improvement and adjustment within the set-up of health reforms.

Delin[illegible]e

The Zambian health reforms are considered to be the most radical undertaken in sub-Saharan Africa. The Ministry of Health is often called upon to provide lessons and experiences for other countries in Africa that are attempting to reform their health sector.

"...the Zambia Health Reforms of 1992 ... caught the attention of WHO and other partners that were willing to collaborate with the Ministry of Health in bringing the vision of the new health order into reality. The vision, courage and leadership of the officials of the Ministry of Health have made this experience a global example of health care delivery system reform. The process is dynamic and pragmatic. There exists, among the Zambian health care providers, the courage to learn by doing... Zambia serves as an [illegible]ample for some countries that are at different stages of developing their own health sector reforms." (Boayue, 1997)

The structure being incorporated in Zambian reforms is taken from the one introduced in the United Kingdom and New Zealand and is dealt with in the literature review. Autonomous provider units which are organisational units with a high degree of autonomy as to how income is spent can take the form of quasi-public authorities, statutory authorities, NGOs or private providers and they have the following in common:

- they all earn their income by being paid for results
- they all directly employ their staff so that they can work free of external constraints.

This paper will explore the nature of the structure adopted in Zambia. This structure will no doubt be shaped by the conditions existing on the ground.

Current thinking around health reforms

During a meeting of co-operating partners held in Lusaka in April 1998, it became clear that there are many and varied problems that have arisen during the implementation of health reforms and this conference was an attempt to address them. The CBOH has been legally constituted and now has the task of delivering health services within the context of severe

financial and human resource constraints. This is being done in an increasingly hostile political environment for the Ministry of Health where the issue has now become one of striving to obtain short-term gains to give the appearance of positive movement on the reform front, perhaps at the expense of long term gains. There is conflict between the donors and the Ministry over several issues such as the procurement of a drug policy, and as long as these remain unresolved they compromise the performance at the national, regional and district level.

1.4 Challenges of the Zambian health reforms

Gilson and Mills (1995, p 293) identify four common objectives of reforms in Sub-Saharan Africa (SSA).

1. Improve planning and management through decision-making that is more responsive to local needs.
2. Improve service organisation.
3. Increase accountability upwards and downwards through Health Facility Boards (HFBs) and District Health Authorities (DHAs).
4. Promote popular participation to encourage self-reliance and plural decision-making processes.

These four objectives could be held up against the Zambian health care reform process and indeed, the NHPS does indicate that these are some of the objectives of reform in Zambia.

Rondinelli *et al* (Gilson and Mills, 1995 p. 297) identify four main groups of factors affecting the implementation of decentralisation programmes in Tanzania and Papua New Guinea:

1. Organisational and administrative factors
2. Behavioural factors
3. Political circumstances
4. Financial and human resource situation

1.5 Conclusion:

It is clear that the Zambian health reforms owed much to a combination of prevailing circumstances, some of which were beyond the control of the government. It is clear from the situation described that incremental reforms would have been doomed to failure as were the attempts at establishing boards under the Health Act of 1985. The UNIP government realised that something had to be done and actually began the process but proved incapable of turning its back on its independence promises of free health and education if the cost to be paid was political unpopularity - even within a one-party state. The MMD, riding on the crest of popular support, and carrying with it some of the frustrated reformers of the previous era, was in a position to 'shock treat' the health system to get it moving in a different direction. Whether this momentum is destined to last remains to be seen.

CHAPTER 2: Literature review

2.1 Introduction

This chapter reviews the literature of health reforms in an international context in an attempt to place the Zambian health reform process. We see that the health sector has been evolving through the primary health care revolution and the attendant problems of attempting to achieve this in Sub-Saharan Africa.

2.2 Health reforms: the international context

Primary Health Care

Segall (Segall, 1983) reviews the principles of Primary Health Care (PHC) and says they embody three main ideas: that the promotion of health depends fundamentally on improving socio-economic conditions and on the alleviation of poverty and underdevelopment; that in this process the mas[illegible] people should be both major activists and the main beneficiaries; ar[illegible]e health care system should be restructured to support priority [illegible]at the primary level because these respond to the most urgent [illegible] needs of the people. In the co[illegible]text of Zambian health reforms, [illegible]se are driven by economic reforms that the country is undergoing that [illegible]ecessitate the restructuring of the organisational mechanisms of service delivery and a capacity-building exercise to reinforce the decentralisation that is being undertaken simultaneously.

The environmental context in which the health reforms are being undertaken has to be studied for an accurate assessment of the implications. Zambia has moved from a social welfare state where health was free for everybody and where the government bore the costs of medicines and health personnel. With the economic crisis of the 1980s an attempt was m[illegible]de to phase in some form of medical fees and user charges. However the previous government was mindful of the social and political implications of the decision and did not enforce the measure strictly and no one was turned away as long as they brought their National Registration Cards (identity documents) with them.

There are several problems that present themselves: people are having to make the mental leap from a culture of receiving health care 'for free' to one of having to pay for it before a service could be dispensed. There was no need for health insurance mechanisms in a set-up where health was free and so very little existed for the health sector to fall back on to create options for those who were employed and able to afford the monthly instalments.

Segall goes on to say that while community participation has become one of the shibboleths of PHC there are some issues that should be considered with reference to it. There should be equity in the distribution of resources, i.e. not specialists for the urban areas and village health workers for the rural areas, and an imbalance in resource allocation only in favour of those in greatest need. The question of power is central to community participation in that an assumption is made th. 'here is homogeneity within the community. The fact that deprivation creates its own obstacles to participation, as does lack of commonality in the values of the members of the community, is not take into account.

"In official mythologies of community participation, communities are portrayed as harmonious homogenous entities, existing in an unproblematic relationship with governments and even sometimes with the wider economy. But communities are divided and stratified socially, and they exist within the social class structure of the national society". (Segall, 1983a)

The entire attempt at health reforms spans a wide spectrum of sectors: economic, political and social and therefore cannot be undertaken in any narrow context but instead has to be inter-sectoral. Finance is involved in the allocation and scrutiny of resources, training is involved so the education sector also becomes involved. Another crucial point is that health reforms cannot be successful without a critical look at poverty alleviation. It is acknowledged that in the context of a developing country, the people targeted for the health reforms are those that are in want. This sector of society is usually unable to pay fees for health needs and medication.

The Zambian Health Reforms

As the Zambian health reforms are premised on the PHC approach, the importance of an examination of what PHC entails will become evident. The focus in Zambia is on the district as the lowest unit of government administration and of health service management. Service integration is important for a cost-effective response to health problems and joint planning for common activities carried out in different programmes.

The National Health Policies and Strategies document of 1991 prepared by the Ministry of Health states the following: "Health Vision: The Government is committed to the fundamental and humane principle in the development of the health care system to provide Zambians with equity of access to effective quality health care as close to the family as possible. This means provision of better management for quality health care for the individual, the family and the community. In order to facilitate the attainment of this vision, the Government has adopted the Primary Health Care strategy as the most appropriate vehicle to achieve it". The document further states that the PHC approach was adopted by the Government as the "most appropriate ... for meeting the urgent needs of the people in Zambia". (National Health Policies and Strategies, 1991, p. viii)

In their analysis of the existing situation at the time the reforms were being considered, it was stated that, "The definition of PHC in Zambia is action-oriented, focused on promotive, preventive, curative and rehabilitative efforts within and outside the health sector. In a Zambian context Primary Health Care would not merely mean accessibility to health services but peoples' participation in improving their quality of life and gaining power to master their affairs for health improvements" (National Health Policies and Strategies, 1991, p. ix). As a consequence some of the operational principles underpinning the concept of PHC strategy in Zambia are:

i) individuals, family and community self reliance and participation
ii) equity
iii) intersectoral collaboration
iv) decentralisation

v) appropriate technology
vi) emphasis on promotive and preventive health services (National Health Policies and Strategies, 1991, p. x)

A comprehensive review of Zambian health reforms (ZHRs) was conducted in 1997 by a review team led by Dr Mahler, a WHO director. They observed that the strategy for achieving the vision for the Zambian health reforms was through "restructuring [of] the managerial system according to three management principles of leadership, accountability and partnership as an integral part of the reform process deliberately designed to address the objective of reconstructing the state system of health governance". (Comprehensive Review of the Zambian Health Reforms 1997, p. 5)

The Mahler report attempts to get to the root of the orientation of the health reforms, particularly the emphasis on decentralisation. It found that this stemmed from the earlier experience of a few key reformers during the 1970s and 1980s in Zambia while working in the districts and dealing with the frustrations of a "stifling and autocratic centralised health system" (Mahler *et al*, 1997, p. 5). Then during the 1980s, following the Alma Ata Declaration, the emerging PHC movement allowed for the emergence of a new conceptual framework for health care provision emphasising de-medicalisation and the importance of preventive medicine. An example is given of a Dutch-supported PHC project in the Western Province of Zambia that 'laid the foundation for the technical/conceptual PHC framework in which the dismantling of the vertical programmes was rooted'. (Mahler *et al*, 1997, p. 5)

In 1985 the Medical Services Act was passed providing for management boards in hospitals and permitting them to raise revenues. In 1987/88 management capacity was identified as a key concern and with the key reformers now at the central Ministry of Health, moves were made to modify health policies in light of comparative insights and experiences derived from international contacts and debates. "In 1989, at the prompting of a small group of health officials, the Ministry organised a meeting to discuss policy issues. This initiative proved to be highly controversial however, as it did not meet with party approval. The policy

area was considered to be the ruling party's exclusive preserve". (Mahler *et al*, 1997, p. 6)

With the issue shelved until the political changes that occurred in 1990 that lead to the MMD's electoral victory in 1991, it was only at this point that a task force was created to fuse the MMD's political manifesto and policy paper with the Ministry of Health's health policy framework (the key reformers had joined the MMD in the run up to the elections). (See Appendix 3 for details of the reform process).

The review team found that health sector reform under the present political leadership is indistinguishable from the encompassing political project of decentralisation and democratisation taking place in the country. This in itself poses problems for health reforms in that the reforms taking place in the wider context in the Civil Service lag behind the creation of the CBOH, which requires health personnel to delink to the new structure. "With regard to the process of decentralisation and democratisation underway in the country, the health sector is ahead of other sectors and the public service reform. The mechanisms and processes through which the health reforms are attempting to empower localities is consistent with what is happening in the wider context". (Mahler *et al*, 1997, p. 6)

The Mahler Report acknowledges in the main conclusions and recommendations that "the MOH opted for an incremental reform process and principles which held that the process itself was as significant as the end. The reformers were opportunists who seized on occasions, such as the funding to get district financing started, even though all the elements were not fully in place. This decision made sense for a ministry working in an environment where parallel reforms were not occurring in the general administrative sector. Even the internal MOH environment was not always favourable to the reforms, so reform advocates have continually seized opportunities when they saw openings that would permit a part of the reforms to pass through". (Mahler *et al*, 1997, p. 13)

When the ZHRs were born in 1992 they caught the attention of WHO and other partners that were willing to collaborate with the Ministry of Health in bringing the vision of the new health order into reality. "The vision, courage

and leadership of the officials of the Ministry of Health have made this experience a global example of health care delivery system reform. The process is dynamic and pragmatic. There exists, among the Zambian health care providers, the courage to learn by doing. ... The new structure of health care delivery system is designed to be flexible in order to meet the challenges of changing priorities in a dynamic setting. Zambia serves as an example for some countries that are at different stages of developing their own health sector reforms". (Boayue, 1997)

International experience

Literature exists that details the shape health reforms take in a given situation. Gilson and Mills (1995) review health sector reforms in sub-Saharan Africa over the last ten years and they scrutinise two specific types of strategy that are used by governments: reforms of financing strategies and reforms of public sector organisation and procedures. They pay particular attention to the experience of introducing user fees, community financing and decentralisation as they observe that these have been some of the more popular strategies utilised.

They conclude after a look at the nature, objectives and extent of reforms and an attempt to apply an evaluative framework to the criteria of efficiency and equity that this exercise is hindered by the limited duration of reforms and the limited nature of existing evaluations. They infer that "a policy package is required rather than isolated reform strategies, and that in order to design an effective policy package, more needs to be known about the implementation and operation of reforms - particularly with respect to the influence of context, actors, and processes". (Gilson and Mills, 1995, p. 277)

Schieber reviews the preconditions for health reforms through the experiences of Organisation for Economic Co-operation and Development (OECD) countries. While these countries do not have the excessive economic constraints that developing countries like Zambia, Uganda and Zimbabwe face in trying to make inroads into education, health care and poverty alleviation, some of the lessons drawn are important for the developing countries in an effort to help them to maximise their efforts.

While acknowledging that it is often difficult to find precise specifications of the goals of different countries' health systems, Schieber says these are often found "in the arcane legislative language and/or in the speeches of politicians and high level government health officials. Such pronouncements generally refer to improving the health status of the population, health being a right, and government guaranteeing access to all needed services for all individuals. Concepts such as universality, portability, choice, quality and security abound". (Schieber, 1995, p. 364)

Schieber points out that it is extremely difficult to evaluate the performance of the different health systems and reform efforts in the OECD countries for several important reasons. Some of the terms used such as cost effectiveness, and the problems associated with measuring access and medical effectiveness require the measurement of health outcomes which he believes is an area of 'limited understanding at best'. For this reason it is also difficult to evaluate the effects of even narrowly targeted health sector reforms. These problems are further compounded by what he terms a lack of detailed descriptive information on the health systems of different countries and lack of comparable micro-level information both within and across countries.

Schieber points out that over the past ten years OECD countries have come a long way towards basing their reforms on analysis and evaluating their impacts. While this level of analysis and evaluation of reform policies is far from ideal, more and more of the OECD countries are using multi-disciplinary approaches and technically sophisticated public health, economic, sociological statistical and medical professionals to analyse and evaluate policy choices. There are important lessons for developing countries to draw from these experiences.

In terms of the institutional, governance and information infrastructures, most of the OECD countries have well-developed governance structures, legal and regulatory systems regarding taxation, inter-governmental fiscal relations, property rights, anti-trust and financial sectors etc., and information systems that permit stakeholders to perform their functions relatively effectively.

In developing countries, and in Zambia in particular, public governance structures, private institutions and information availability are all in a far less developed state than those in developed countries. Schieber's viewpoint is that this is a precondition for reform if the countries are to be in a position to develop, implement and evaluate health sector reform policies. "For reforms to succeed, governments must have coherent organisational structures, technically competent multi-disciplinary staff, and an effective inter-governmental structure which allows efficient information flow and implementation at national, regional and local levels. Organisation charts displaying the functions of different offices and their interconnections are important first steps. If these functions and responsibilities cannot be enumerated, then there is no responsibility and accountability, and reforms will not succeed. Policy planning, implementation, and evaluation must also be given a high priority, and there must be a high level of co-operation with the Ministry of Finance and other governmental agencies". (Schieber, 1995, p. 367)

In terms of information for decision-making, Schieber points out that appropriate epidemiological, socio-economic, medical and financial information is a sine qua non for policy design, implementation and evaluation. Data on manpower and facilities provide information for delivery system design, manpower training policies, facility and equipment acquisition and health planning. Such information is needed at national, regional and local levels. However, developing countries will have to make judgements on the costs of obtaining information and its utility in decision-making. Basic information on health system infrastructure and costs are required to assist in planning for rational health system development.

With regard to the structure of the delivery system, Schieber sees public health activities, manpower, facilities, equipment, health planning, quality assurance activities and the interaction of health with other social systems as being critical components of any reform activity. The OECD countries have mostly been attempting to ensure appropriate types and distributions of health manpower through medical education and regulatory policies affecting the geographic location of practice and the restriction of medical school enrolments and limiting provider participation in public financing

programmes to under-served areas.

He identifies monitoring and assuring quality of care as another important feature of health delivery systems, especially in the context of tight budgetary constraints. The OECD countries have increased their efforts in the area of quality of care. The establishment of structure, process and outcome standards is essential for the monitoring of health sector performance as well as the impact of specific reform policies. The OECD countries mainly rely on structural standards such as educational requirements for practitioners and specific conditions of participation for hospitals, nurse to patient ratios and infection control barriers. For developing countries, in addition to these requirements, he adds quality assurance measures such as conditions of participation for hospitals, licensing policies and manpower training standards as being the most relevant given the current infrastructures in an attempt to upgrade and monitor quality of care. "In addition to the activities previously mentioned, having access to lists of essential drugs, proper training of physicians, nurse midwives and other health care workers, proper location of clinics and other facilities, outreach programmes, clean drinking water and proper nutrition, are essential first steps in reform". (Schieber, 1995, p. 377)

Schieber concludes that in both the OECD countries and developing countries the health sector cannot be viewed in isolation from other social sectors as they impact on it. Areas such as income support, nutrition, housing and social services for the elderly and disadvantaged have consequences for the health status of individuals and health sector costs and performance. He recommends that these are analysed and clearly understood in the design of health sector reform policies. He cautions that success for developing countries will depend on stability of leadership, technically competent staff and support from top government leadership and the Ministry of Finance as well as the sensible application of relevant lessons drawn from other countries. However, without this basic political commitment and support, reformers have to be prepared to handle all these relevant parts of the reform equation to make it work.

2.3 Decentralisation

The term decentralisation is used to mean various things. To show the difficulties of defining the term Mills *et al* quote Furniss (1974, pp 958 - 982):" decentralisation may mean the transfer of authority over public enterprises from political officials to a relatively autonomous board; the development of regional economic inputs into national planning efforts; the transfer of administrative functions either downwards in the hierarchy, spatially or by problem; the establishment of legislative units of smaller size; or the transfer of responsibility to subnational legislative bodies, the assumption of control by more people within an economically productive enterprise, the hope for a better world to be achieved by more individual participation". (Mills *et al*, 1990, p. 15)

Some of the factors influencing the form of decentralisation taken, other than the legal framework, include the control over resources, the ability of local bodies to mobilise political support, the perceived legitimacy of their position and the general climate of rules, regulations and expectations within which they operate. (Lee and Mills, 1982)

Collins provides the following definition of decentralisation (Collins, 1994, p. 68) as "... basically a transfer of authority to make policies and decisions, carry out management functions, and use resources. It involves the passing of these from central government authorities to such bodies as local government, field administration, semi-autonomous public corporations, area-wide or regional development organisations, functional authorities, subordinate units of government and specialised functional authorities" (Cheema and Rondinelli 1983). Collins takes six organisational options for decentralisation experienced in the health sector as follows:

1. Decentralisation as deconcentration: considered one of the milder forms of decentralisation involving the transfer of functions within the central government hierarchy by shifting the workload from central ministries to field officers and through the creation of field agencies or the shifting of local administrative units that are part of the central government structure.

2. Decentralisation as devolution: this involves the transfer of functions or decision-making authority to legally incorporated local governments implying greater autonomy for the decentralised unit.

3. Decentralisation to local bodies with mixed central and local/regional representation: decentralisation here is to local and regional bodies that are made up of locally elected representatives, central government appointees and sometimes party officials. The bodies are semi-autonomous with their own legal status using central government personnel and highly dependent on central financial resources.

4. Decentralisation through delegation to semi-independent agencies: Rondinelli (1983, p. 188) quoted in Collins (1994, p. 77) sees this as 'the transfer of functions to regions or functional development authorities, parastatal organisations, or special project implementation units that often operate free of central government regulations concerning personnel, recruitment, contracting, budgeting, procurement and other matters, and that act as an agent for the state in performing prescribed functions with the ultimate responsibility for them remaining with the central government."

5. Federalism: in this version the main area governments receive their powers from the national government and the constitution that vests federal powers in these governments.

6. Decentralisation through public sector markets: in this case the attempt is to partially replace public sector planning decisions regarding the allocation of resources with market mechanisms and the form these public sector markets take varies depending on the nature and extent of competition desired. There are various approaches that can be followed under this form of decentralisation.

Mills *et al* (1990, p. 24) point out that countries may make use of different types of decentralisation at the time for different functions. "The distinction between the four types of decentralisation is based essentially on their legal status. In reality, however, other factors (e.g. financial authority,

means of representation of the local community) are also important in determining the type of decentralisation. Moreover, decentralisation in a particular country may have features from more than one type". (Mills *et al*, 1990, p. 24)

Mills *et al* say that decentralisation "can be defined in general terms as the transfer of authority, or dispersal of power, in public planning, management and decision-making from the national level to subnational levels, or more generally from higher to lower levels of government" (Mills *et al* 1990, p. 11). They make the point that while decentralisation and delegation have long been discussed in the field of public administration this has not been the case so much in the health sector. Mills *et al* identify four forms of decentralisation: deconcentration, devolution, delegation and privatisation. Distinction between the four types is based essentially on their legal status, however other factors also help determine the type of decentralisation undertaken. These factors include financial authority, means of representation of the local community, the size of the country, the choice of the level to which authority is to be decentralised, civil service attitudes and issues of interagency collaboration.

They state that the four should not necessarily be seen as clearly distinct from each other, but may have characteristics of one or the other overlapping in the reform process of a particular country. "In particular, forms of local government with a high degree of autonomy tend to be rare in developing countries; instead, local institutions have been created that provide some local discretion while retaining substantial central influence, particularly over policies and resources". (Mills et al, 1990 p 24)

Which of these models best describes the Zambian experience? Perhaps it is a combination of aspects of these models that creates the basis for it and this will be explored in this paper. The government has constituted a legal body, the CBOH, a process that has gradually seen the "transfer" of staff from the Ministry of Health. Gilson and Mills (1995, p. 293) review the experiences of past decentralisation in Anglophone sub-Saharan Africa and say it was often the result of post-independence steps to improve broader development planning. "It has mostly taken the fairly limited form of deconcentration within the sector though some countries (e.g.

Botswana, Ghana, Nigeria and Tanzania) have developed to different degrees, a role for local government structures. In practice, whilst sometimes having the stated goal of promoting popular participation, decentralisation was more often a guise for the extension of centralised decision-making by ruling political parties".

The recent impetus for health system decentralisation comes from several sources including the fact that within the sector, decentralisation has been seen as an important factor in the success of PHC policies with the WHO espousing strengthening of district health systems (Gilson and Mills 1995, p. 294). Outside of the health sector they see support for decentralisation as coming from policies of political and economic liberalisation, which result in a re-emphasis on popular participation. However the authors point out that despite the relatively long history of decentralisation "there has been only limited critical appraisal of decentralisation within the health sector". (Gilson & Mills 1995, p 294)

Janovsky and Cassels (1996) look at commonalities and contrasts of health sector reform in Ghana and Zambia. In reviewing decentralisation and the role of local government they emphasise that the transfer of power to local government is an important component of public policy. "In both countries, decentralisation *within* the health sector is equally important and has actually proceeded more rapidly. In Zambia, these two *streams* of decentralisation are not incompatible as an explicit *twin-track* approach has been adopted."

Under the 1980 Local Government Act in Zambia and prior to 1991, district councils were given the power to prepare their own budgets and control most government staff. "In reality, however, financial power was retained by Provincial Permanent Secretaries and the Provincial Accounting and Control Units. Funds for health were disbursed to the Provincial Medical Officer and thence (usually with some reluctance) to health staff in the districts. Current decentralisation policy in Zambia explicitly recognises that local government does not have the capacity to take on the management of health care (with the exception of environmental sanitation). Under the heal reforms, the work of District Health Management Teams is now governed by autonomous health boards,

which have a contractual relationship with the Central Board of Health to provide a specified range of services". (Janovsky and Cassels, 1996, p. 3)

Problems of decentralisation

One of the objectives of decentralisation is to make decision-making more responsive to public needs, increase accountability, improve the quality of service, and promote popular participation. (WHO, 1991). All of these objectives have figured prominently in Uganda, where decentralisation has been promoted and supported by the donor community. The problem is that decentralisation is not the panacea for structural problems that it is often assumed to be (Gilson, 1995). In Uganda, district-level authorities often have political priorities that are different from those of central government. Moreover, political decentralisation has proceeded in advance of the development of proper structures for establishing political and financial accountability.

Heaver (1995) looks at the implications of health transition in the context of PHC from the novel standpoint of strategic management principles and attempts to provide a conceptual framework that can be applied to specific countries. He is quick to acknowledge that this framework has yet to be applied to specific countries and therefore to be tested, but this is "a first attempt to apply strategic management thinking to the challenge of the health transition" with the hope that it "stimulates and encourages policy-makers to think proactively about managing institutions to meet new needs". (Foreword, 1995) (See Appendix 4)

According to Heaver there are several reasons why management questions are not receiving the attention they should and he provides four key reasons:

1. The first is simply due to the newness of the concern with health transition.
2. The second is the continuing preoccupation among policy-makers in many quarters with economic and technical issues at the expense of implementation strategy issues.
3. The third is due, he says, to a tendency among health managers to

'firefight' day to day operational management issues at the expense of dealing with broader strategic management issues. PHC managers are not encouraged to think strategically - companies that can't think strategically go bankrupt but public health systems don't.

4. The fourth in his view is that there is a lack of an accepted conceptual framework that addresses the management implications of rapid change.

In the context of the Zam. , ealth reforms it appears that there is not enough emphasis on strategic management of the health reform transition. What seems to obtain is a situation where there are some clear visionaries who remain committed to the reform agenda and in spite of the 'turbulence' of the environment doggedly push onwards. They are fought by those who for various reasons do not wish to see the reforms succeed, either because they feel threatened by the changes involved or because they do not see the vision for health as espoused by the reformers. They have not bought into the vision. Given the harsh environment that the reforms were always destined to be pursued in there should have been more thought given to the perspective that Heaver puts forward - strategic management of the health reform transition.

Maddock and Morgan in assessing the barriers to transformation argue that "neither the planned centralised administrations nor the market-driven agencies have delivered forms of organisation which bring users and staff closer together - and future agencies not only require strategic development but also are managed and organised in a manner which does not allow a greater coalition between user and workers ... in Britain and in other countries this form of agency transformation is proving as difficult - if not more difficult - within the contracting environment". (Maddock and Morgan, 1998, p. 235)

In transforming, managers and professionals have to overc e organisational problems as well as drive managerialism and other systems. "There is a tendency to underestimate the psychological and cultural barriers to organisational transformation and to overlook why employees behave and interrelate in the way in which they do.... there is

frequently a mismatch between corporate message and internal systems and cultures - consequently the real innovation in organisational transformation is to ground social principles in a broad organisation strategic framework which is flexible enough to encourage learning amongst all staff and give greater voice to the most junior staff, in order to compensate for the power imbalance in organisations which acts as a megaphone for those at the top". (Maddock and Morgan, 1998, p. 235)

Agenda for Decentralisation

An agenda for effective decentralisation is proposed by Collins (1994, p. 95). It lays out ten key questions to be posed by planners before embarking on decentralisation in order to achieve a greater compatibility with PHC.

1. Why is decentralisation being introduced?
2. What form will decentralisation take and how will relations of authority be set out?
3. To what level in the governmental system should decentralisation of resources and functions be made?
4. Has adequate attention been paid to the role of the centre in the decentralisation system?
5. What resources, functions and authority will be decentralised?
6. Has a programme for strengthening district health management been agreed upon?
7. Does decentralisation facilitate the democratisation of health management and planning?
8. Does decentralisation contribute to the development of national planning?
9. How does decentralisation fit into the development of national planning?
10. What provisions have been made to ensure the compatibility of decentralisation with the principle of equity?

While Collins' guidelines are useful for a planned form of decentralisation, in the case of Zambia change was forced upon the new government for the health sector if they were to survive their mandate of five years. Their

election promises were premised on change and there was a lot of hope generated amongst the professionals.

2.4 Delinkage

Delinkage was described by the MOH as "the process whereby the Ministry of Health continues its decentralisation focus by delinking all civil servants from the Public Services Commission (except for the few MOH HQ staff). The rationale for delinkage is to enable staff to be more accountable, to improve ownership and therefore encourage innovation (the driving force of change) to occur. Delinkage is not an end in itself but is required to allow the legal framework of autonomous health boards to function effectively and efficiently. Delinkage will finish once all legible civil servants within the Ministry of Health have made choices, and either left the civil service and where possible, joined an autonomous institution" (GRZ/MOH National Health Strategic Plan 1998 - 2000 From vision to reality, 1998). Delinkage is only considered to be one aspect of the staff employment exercise and is not an indefinite exercise.

As indicated elsewhere in this paper delinkage takes place within a certain context. There should be clarity regarding funding to finance the costs of transferring staff to autonomous organisations and funding of redundancy costs for those opting for retirement or retrenchment. In the case of Zambia there is employment uncertainty through the loss of 'jobs for life'.

2.5 Difficulties of reform

Why is reform so difficult? Roger England (1997, p. 17) says that attempts to introduce autonomous provider units, agencies and the use of contracting between purchaser and provider require a combination of factors:

- legislation to create autonomous provider agencies and purchasing agencies able to spend public finance
- legislation to facilitate the transfer of staff from public service employment
- legislative change to national employment and disciplinary bodies
- funds for investment in redundancy costs and achieving more cost-

effective skill mixes
- revision or creation of alternative pension arrangements where health workers are to leave public service employment
- communication efforts to gain support for reform initiatives.

When an attempt is made to introduce the above elements, England argues that there may be a perceived threat on the part of various stakeholders and this may result in a combination of fear and resistance. He lists the sources of this uncertainty as:
- employment uncertainty - loss of the civil service 'job for life' attitude
- reduction in the strength of the public service unions
- doctors fear of losing power to managers
- threats to "informal incomes (the hospital is my farm and the patients are my cattle)"
- loss of personal fiefdoms by senior consultants and academics
- threats to civil service power bases
- threats to nepotism (England, 1997, p. 18).

Given the complex nature of concepts underlying the need for reforms England says it is not surprising that it is difficult to get this message across to the target audience of politicians and the general public. In the case of the Zambian health reforms, at the beginning of the year parliamentarians took issue with the Ministry of Health over the reforms. This pressure on the Ministry was manifested by the pressure it in turn put on the CBOH for 'visibles' within the health reform process. (Co-operating Partners Conference, April 28-29 1998)

England says this requires sustained political effort linked to broader public service reforms through legislation. He says much of the investment that is spent on improving infrastructure would be better spent on:
- financing the costs of transferring the employment of public service health workers to autonomous organisations and funding redundancy costs
- the reform of public sector pensions, where necessary, so that mobility is increased and staff transfers and reductions can be achieved
- transforming ministries of health into streamlined policy and regulatory bodies able to direct public finance for health to the more cost-effective

autonomous providers

- large-scale communications efforts to promote the need and opportunities for change (England, 1997).

2.6 Conclusion

Relevance of the literature to the problem

What model of decentralisation is being pursued in the delinkage process in Zambia? England (1997) provides us with the various forms that may be taken with examples from the United Kingdom (UK) and New Zealand: autonomous provider agencies, a mix of private-public partnerships and the transfer of staff from public service employment to the agencies. This literature will help in part to address this question as will literature focusing more specifically on the UK and New Zealand, two countries where examples of this model are best typified. Mahler (1997) also points out that the mechanisms and processes through which the health reforms are attempting to empower the local level is consistent with what is happening in the wider context.

Schieber gives us insight into what the trends of health care reform in the OECD countries are: reforms are based more and more on analysis and the evaluation of their impacts. Several countries are beginning to follow the example of the US in conducting small-scale demonstration projects of proposed reforms prior to full-scale implementation. Mahler's review of the Zambian health care reforms shows us that there are pressing considerations that necessitate the 'rush' to implement reforms in Zambia and a look at these considerations may provide some answers to the questions posed in the study. Schieber also gives us important first steps for the success of reforms: coherent organisational structures, technically competent multi-disciplinary staff, effective inter-governmental structures for efficient flow of information and implementation at national, regional and local levels, organisation charts displaying the functions of different offices and their inter-connections for effective responsibility and accountability.

Schieber and Gilson both argue that information, micro-level data, is key to the evaluation of reforms with a view to maximising the effects to reap greater benefits. However, Gilson and Mills in addition perceive that a policy package rather than isolated reforms is required with information focusing particularly on the influence of context, actors and processes.

In exploring the question as to what delinkage is designed to achieve and its strengths and weaknesses, Gilson and Mills shed some light on the experiences of decentralisation in some African countries and say that decentralisation was often a guise for the extension of centralised decision-making by ruling political parties. This question, in addition to viewing the organisational structures in place, will be key to shedding light on the reality of the reforming Zambian health care system.

The grouping of the factors influencing the success of implementation of decentralisation programmes is comprehensively summarised by Rondinelli and Cheema (Gilson and Mills, 1995, p. 297): organisational and administrative factors, behavioural factors, political circumstances and the financial and human resource situation. Schieber more or less covers these aspects in his literature. England pays particular focus to the behavioural aspects and how these negatively impact reforms and points to some of the ways in which this can be avoided. Gilson and Mills refer to at least three of these factors but lay more emphasis on political circumstances.

CHAPTER 3: Research methodology

3.1 Propositions

In looking at the reactions to the health reforms from medical personnel, the targeted population and the primary actors such as the MOH and the CBOH, it has become apparent that there is a gap between what the health reforms were intended to achieve and the reality to date. In speaking to doctors affected by the reforms for instance, they point out that they have no idea what the MOH is doing and what the doctors' roles are in the process. The question that arises is not so much as whether the MOH held workshops with medical personnel but as to whether enough emphasis has been put on the methods of communicating information. Obviously the representatives of the hospitals are present and tasked with the job of reporting the results of the various workshops to their hospitals. However I believe that the way in which this information is being imparted is responsible for the gap being experienced and the sense of alienation from the process.

Another issue is the Central Board of Health. In the meeting held with the co-operating partners, accusations flew around the room. The Minister thought that CBOH was being defensive in protecting its position and refusing to accept criticism for being ineffective since its inception in 1995. The MOH was perceived as being autocratic and as flexing its muscles when the idea to create a CBOH was precisely to give the latter autonomy. The MOH responded by saying that autonomy did not mean independence and that the CBOH was still ultimately accountable to the Ministry and would continue to do so since it was the arm that the Ministry was using to deliver the goods to the people. The co-operating partners indicated for their part that it was too soon to tell whether the CBOH was effective or not as several issues had hindered their performance: a court injunction had forced delays on them while they were still in the setting up stage as had a lack of resources, both human and financial. Most of the assistance given by the donors to the reforms to date under the reform process has fallen into the category of technical assistance while the concept of basket funding is being refined and thus the co-operating partners were accused by the Ministry of wanting to protect their 'baby'.

From the contributions of the various participants I was able to glean that there is still a lack of clarity around the role that the CBOH is to play and that of the MOH. The concern of the CBOH was that they had inadequate funding an ' this tended to compromise the pace of the reform process. The government position as represented through the MOH was that it had no further funding to offer and that they would have to 'cut their dress to fit the size of the cloth they were given'. This is almost a self-fulfilling prophecy of defeat for the CBOH as they are staffed at up to 60% capacity and having to undertake all the various functions of the reform process by stretching their staff and resources very thinly.

The constraints that all the parties have to operate under are clear and worrying as anyone of them could ultimately compromise the reform process. The MOH stressed the political equation by insisting that the Zambian people are the ultimate judge of whether the reform process has failed or not and they measure results in the tangibles that they are able to have around them. Behind this aggressive attack of the MOH on CBOH and the field operators was a parliamentary tongue-lashing that was given to the Minister in February on the inadequacy of the health reform process to date. How can the MOH better manage this perception better on the part of the Members of Parliament and the Zambian people? How can information be shared with everyone effectively so that the achievements and the prospects of health reforms can be experienced and understood by everyone?

The health reform process in Zambia is taking place in an environment of dynamic change in health, economic, political and social conditions (poverty level figures are currently up to 80% in Zambia).

3.2 Research questions

Some of the questions that this study will seek to address are as follows: What model is being utilised in the Zambian delinkage process? Why is delinkage being pursued by the Ministry of Health? What is it designed to achieve? What are the strengths and weaknesses of the delinkage process? Should the process of delinkage be discontinued? Since reform of the civil service is affecting other ministries and not just the health

sector, the lessons drawn from the process of delinkage may prove useful for other ministries attempting to do a similar exercise.

3.3 Nature of the research

Data Collection

The general approach to the research undertaken is one of qualitative analysis. I consulted primary and secondary data for the research and conducted in-depth interviews with 15 - 20 key stakeholders at the level of the Ministry of Health, the Central Board of Health, the Lusaka Urban District Health Team partners such as the Churches Medical Association of Zambia, the unions (Civil Servants Union of Zambia) and the donors. One of the immediate problems encountered was with the movement of staff involved with the reforms. Within the past year there has been a high turnover of staff including the replacement of the Minister of Health by his Deputy. While the new people are willing in some instances to talk about the reforms, I was obliged to follow the previous holders of positions within the various organisations to get first hand information surrounding the health reforms. They kindly obliged to give me some time to interview them but since they were in different ministries in some instances with heavy workloads time for interviews was at a premium.

The sources of secondary data were newspapers and magazines, textbooks, reports of the MOH and other co-operating partners in the reform process and conference papers. Organisations such as the World Health Organisation (WHO), Department for International Development (DFID) and USAID were useful sources of additional information. Comparative analysis will be employed to examine international experience of decentralisation within the health sector.

Interviews:

The intention was to conduct 15 - 20 interviews with key actors and partners in the reform process. The questions asked are detailed in this section. It was anticipated that these interviewees would be drawn from the Ministry of Health, the HRIT, the CBOH, the Churches Medical

Association of Zambia, Non Governmental Organisations (NGOs) such as CARE International, BASICS (A Zambia Child Health Project), USAID, SIDA, DANIDA, DFID and the World Bank. (See Appendix 5). However, due to time constraints once in Zambia and the pressurised timetable of interviewees, it proved impossible to interview the NGOs such as CARE, BASICS and the mission hospitals involved in partnerships with MOH and CBOH.

In teasing out the factors influencing decentralisation the researcher expects to draw conclusions as to the status of the process of decentralisation in Zambian health reforms and to see whether this process can succeed. Given that the government is committed to the reforms through the legislation enacted and the strategy documents drawn up, it is obligated to ensure that decentralisation is achieved if the whole reform process is not to be compromised.

3.4 Analysis of the data

Sample questions posed to interviewees:

1. What do you understand by the term delinkage?
2. How would you describe what is going on?
3. How does this problem impact on you?
4. Why, in your opinion, is this happening?
5. What is delinkage designed to achieve?
6. Is delinkage designed to achieve equitable and appropriate distribution of staff?
7. If the answer is no, what in your opinion is delinkage designed to achieve?
8. Was there consultation with the medical personnel about the process of delinkage?
9. Do they in your opinion understand what the intention of the Ministry of Health is in delinking the staff from the civil service?
10. What is hampering the process of delinkage?
11. What needs to be done to achieve the goal of delinkage?
12. What are the strengths and weaknesses of the current strategy?
13. How can the current strategy be improved upon?

14. Should delinkage be postponed or not? What are your reasons for saying this?
15. Is there a lack of clarity between the roles of the CBOH and Ministry of Health? If yes, to what do you ascribe this situation?

The effective agenda for decentralisation given by Collins will also be used, suitably blended in to complement the questions above, to provide a basis for analysing the process of delinkage taking place in Zambia (refer to p. 30 of this paper). Where possible attempts will be made to compare the theory with the reality found in exploring delinkage and decentralisation taking place in Zambia.

CHAPTER 4: Description of findings

4.1 Introduction

Two trips were undertaken by the researcher [illegible]a to interview key role players in the reform proces[illegible] [illegible]icipate[illegible] that the people seen would be from the MOH, the [illegible] community, the CMAZ, the academics at the Unive[illegible]nk and the Civil Servants Union of Zambia (CSUZ). Witn[illegible] the World Bank and the academics, I was able to meet with indi[illegible] representing all the other groups listed above. In the case of the academics I was able to obtain documents produced by them to provide some insight into their position on the reform process in general and in som[illegible] instances on decentralisation in particular.

The categories of people seen reflected not only different perspectives on the reform process but also different linkages in the reforms. The guideline by Collins that I used presented some valid questions to be posed to the MOH for instance. However different q[illegible]estions had to be prepared for the individual donors involved in the reform process so that the interviews, by and large, took the form of structured interviews and in some instances were unstructured.

The researcher found that depending on the institution visited people being interviewed were either very open and volunteered information and documentation easily or they were cagey and reluctant, in the opinion of the researcher to be seen to be out of step with the official line and thus perhaps court the wrath of the MOH. This circumstance is sure to have shaped the nature of the findings of the report.

This chapter makes a first attempt to look at the actors in the reform process in brief in section 4.2 before combining their specific responses to questions posed in section 4.3 when the research questions are answered but not interpreted.

4.2 Actors in the reform process

The actors in the reform process range from the Minister of Health, to the health planners, district management teams, donors, NGOs, staff, receivers of the services, parliamentarians, insurance agencies and unions to name but a few. Not all of these actors were relevant to the debate of decentralisation and delinkage and so were not interviewed.

4.2.1 MOH

In this instance I was fortunate to access the individual who wrote the concept paper that was the cornerstone of the reform process. He was in a position to give me insights as to how the present reforms were able to arise. This is key in my opinion to understanding the reforms even under their current state. The background to the coming to power of the MMD has been elaborated on in the introduction – the desire for change, politically, socially and economically – and the resultant window of opportunity that was afforded to the incoming government. There was a coincidence of resolve to change and a preparedness for change on the part of the reformers that meant that once the new government was in place, they were in a position to seize the opportunity for a radical push to reform the health sector.

Present day reformers are quick to point out that the reform process in health did not begin with the 'revolution' of 1991. Reforms had been instituted in the 1980's but by and large these had failed because of a lack of political will on the part of the government. Reasons cited for the reforms of today stem from system failures and include:

- the crisis of access (geographic, economic and social)
- the crisis of capacity (unable to run services due to incompetences of skills and lack of numbers)
- the crisis of quality
- the crisis of confidence (free hospitals but they were empty)
- the crisis of low morale (low salaries with poor working conditions)
- the crisis of the shortage of drugs (epidemics were prevalent).

Service delivery was an issue too and these frustrations led the

professionals to take a risk, in an era where the setting of policy was the preserve of the ruling party in an authoritarian state, of daring to organise a meeting where issues were discussed. In 1990 the MMD government was preparing itself for contesting the elections of 1991 and with their successful election in November of that year the rest is history. For the first time there was a fusion of the health vision with that of the ruling party and this led to the breakthrough.

This in part accounts for the radical nature of the reforms but the other reason was an attempt to short circuit the possible dissenters to the reform process. The reforms anticipated that a decentralised structure would be the optimal way of attaining the goals of the ministry – equitable access to cost effective health care as close to the family as possible. The decentralised form that was to be taken was tied into reducing the role of the MOH to that of policy making, provision of the regulatory frameworks and oversight of health through the new structure of the CBOH.

The argument for decentralisation was to improve access and enhance equity considerations:

- accountability would be enhanced (value for money issue). An attempt to move away from policing to supervision through the introduction of a private sector culture
- partnership - taking the services to the people to encourage them to be proactive, to empower them.

A cornerstone of this was and still is delinkage. Through delinkage of health personnel from the civil service to the CBOH performance will be enhanced for the following reasons:

- personnel would be subject to contracts of service with performance criteria
- discretion to hire and fire would rest with the districts and would result in more appropriate usage of staff. Disciplinary decisions are more immediate
- accountability is more immediate to the community.

4.2.2 CBOH

The CBOH is staffed largely from the MOH. In 1993 the Health Reform Implementation Team (HRIT) was set up to pursue the objectives of the reforms and was placed outside the MOH deliberately so that it could perform independently while issues were still being resolved internally at the Ministry. This was an attempt to circumvent the elements within the Ministry that would have proved stumbling blocks to the process of reform. The HRIT was tasked with the preparation of districts for reforms, the building of capacity and the preparation of infrastructure. Once the CBOH had been legally constituted the HRIT ceased to exist and was folded into the former to continue the reforms.

A fundamental question that was addressed prior to the set up of the CBOH was the structure it would have. It was felt that the appointment to the position of Director General should be a constitutional one effected by the President and not by the Ministry of Health in a clear attempt to have an autonomous institution that was free to carry out the mandate of health service delivery that it had been given. The reason for this was to negate attempts by the Ministry to reverse the process that had been started should they feel the temptation to do so at some point in the future in such a way as to compromise the reforms under the existing structure.

This concern has proven to be a valid one. One of the Minister's in the chain altered the initial intent of the reforms and the Health Act of 1995 reflects the fact that the appointment of the Director General of the CBOH will be effected by the MOH. The net impact of this single action, so vital to the success of the reforms under the decentralised structure, was to confuse the roles of the CBOH and the MOH.

This tension is still apparent and in some instances disciplinary action has been taken directly by the Ministry leading to confusion with regard to whom the districts are accountable to. This perception of the confused roles of the MOH and CBOH has led to the reinforcement of the idea on the part of medical personnel that the CBOH will not be in a position to make good on its obligations in terms of pensions and benefits, as the Ministry will still continue to 'control' it as the MOH will still be policing

rather than supervising.

The relationship between the CBOH and MOH is seen as a challenge - the challenge to make people more accountable for day to day, quarterly and yearly tasks. Systems are in place to review the districts but for the moment the principal mechanism being used to ensure results is the funding penalty. The districts are required to produce budgets for their operations and are judged on the basis of their quarterly performance. If they are unable to adequately account for funding then their budget for the next quarter is suspended. Assistance is rendered to the districts but the quality and frequency of visits is not covered in this paper.

The CBOH is 90% staffed at present but the main concern is that there is inadequate capacity to cope with the present tasks and insufficient funding. The argument of the Ministry is that there will never be adequate funding as long as the present economic climate prevails so the CBOH has to work within these constraints and try to ensure efficient delivery of a cost-effective service.

4.2.3 Lusaka Urban District Health Management Team (LUDHMT)

The view of the people interviewed was that the reforms as a concept were good, however the expectations created were not realised by the MOH and the perception now is that the reforms are failing. Staff in the clinics are demoralised due to lack of clarity and movement on the reforms and the following are the positive and negative elements elicited:

Positive elements:

- 24 clinics within the Lusaka Urban District and they have been upgraded - upgrading has meant a nurse is now required instead of only a clinical officer
- Clinics are now open 24 hours a day
- UTH has been decongested and is only dealing with cases referred from the clinics
- Health workers can now properly plan for themselves when adequately funded

Negative elements:

- Due to clinics being upgraded and UTH being decongested, staffing in the clinics is inadequate to cope with the increased workload
- Maintenance of the existing system plus the new system creates pressures
- Morale is low due to inadequate salaries
- Conditions of service are still not known because the Cabinet still has not approved these
- Retrenchments are still unsure

Some problems are being experienced with drug supplies in that the MOH gives funds to the districts to purchase drugs but when the drugs are requested through the centralised Essential Drugs and Medical Supplies Store (EDMSS) invariably there are none. Funding itself is an issue as the government through the MOH fails to meet its targets and this leaves the districts with no power to act. The sentiment expressed is that the reforms are presently in limbo.

4.2.4 The Churches Medical Association of Zambia (CMAZ)

The CMAZ was in accord with the expressed aims of the MOH as laid out in the reform agenda. Some issues however were of concern to them and these were, amongst others, the drug procurement exercise and the financial management aspects of the decentralised structure. For further responses under the specific questions posed look to section 4.3.

4.2.5 The Civil Servants Union of Zambia

The CSUZ representative felt that the concept of reforms was good in general but that not enough thought had gone into the mechanics of the exercise. The unions abruptly halted the process of delinkage through the court injunction they took out preventing the MOH from continuing with the process. The reasons for this action on the part of CSUZ are explored in further detail in the responses to the questions posed to interviewees that follow in section 4.3.

4.2.6 The Donors

The donors are not always unanimous in their opinions, especially when one looks at the traditional role they have played in funding different sectors in Zambia. Prior to 1991 they tended to have projects that they supported in isolation from each other. The health and agricultural sectors, priority areas for the MMD government if economic growth is to be achieved, have for the first time seen a shift in this pattern. The MMD brought about the notion of looking at the health sector as a whole and not as separate programmes. A concept of basket funding for health was initiated which took a while to begin functioning. This is because the donor countries have their own accounting procedures to follow and it takes time to initiate and approve these kinds of procedures.

The donors now have an informal liaison group amongst themselves to discuss issues and the views expressed by them in interviews reflected a common thread. Donors were deeply concerned by certain aspects of the reforms. They see themselves as investors. The concern of someone who invests his funds in a project is to see that those funds are used as optimally as possible to ensure that the benefits are reaped in terms of health improvement and so as not to compromise future investment in health. The donors are willing to make funds available with two objectives: to improve the health of the poor and to improve economic growth since the donors believe that improved health leads to economic growth which in turn leads to economic stability. Governments need to carry out policies so as to support this. The belief is that the government is not generating investor confidence at present.

The donors support the direction that the reforms have taken. The initial intent was true and radical decentralisation of the health system with districts being given the authority to manage resources and personnel. They believe that decentralisation is the way to go because it was proven that the government had failed to manage from the centre. Even with high rates of urbanisation there is still a need to penetrate the rural sector. Delays came about for various reasons:

- One of the key ministers who pushed the reforms through the establishment of boards did not take adequate note of the reactions of

people (pension rights, jobs for life) and as a result was removed too soon with the result that the reform process has suffered badly Simplistic and unrealistic decisions were made with a lack of thought to information channels

- The CBOH hasn't tackled the question of roles within and without the organisation
- There is no organisational development in CBOH – no clarity of roles, job descriptions, etc.
- CBOH is stretched too thin – there are resource and staff problems and too much being taken on; there are no positive signals
  here is not enough depth at national level to deal with the issues and the district level is working better in this regard
- Credit is given for the vision shown in doing things differently with high marks given for taking advantage of opportunities; however the operationalising of the vision shows glaring shortcomings and perhaps different skills are required here
- The vision at present is not clear
- The Drug policy and issues around the old Medical Stores (Essential Drugs and Medical Supplies Stores (EDMSS)) are unresolved and funds will not be disbursed until this is done
- There is an issue of a lack of transparency in awarding the management contract for EDMSS

4.3 Research questions answered

The questions the paper sought to have answered were the following:

1. Why were the reforms in Zambia carried out in a seemingly haphazard fashion?

The points made in the introduction to health reforms in Zambia are appropriate to responding to this sector (refer p. 15). The reformers within the Ministry were responding to the environment around them and seizing opportunities to implement parts of the reforms either when funding became available or when a Minister was amenable to certain changes. One example of this was the funding needed to start district financing even though all the requisite elements were not yet in place. Hence the choice

was between waiting for the climate to be 'right' and doing nothing or seizing the opportunity presented and dealing with the consequences. They opted for the latter.

2. What is the structure of the reforms in Zambia?

An emphasis is placed on the PHC approach and a desire to take health services to the lowest level while stressing equity and access. These are to be achieved through the decentralisation of health services to the districts.

3. What model is being utilised in the Zambian delinkage process?

No specific model is being used. Delinkage is merely a response to the knotty problem of responsiveness of the health services to the needs of the community they are supposed to be serving.

4. Why is delinkage being pursued by the Ministry of Health?

The researcher was informed that delinkage needed to be implemented in order to change the traditional way of doing things and in order to support the decentralised set up in the districts. The districts needed to be empowered to have authority to discipline their workers without having to wait for the central authority to respond - a practice that usually entailed waiting for several months if not years to receive disciplinary decisions. This led to workers acting with impunity as they were still employed in the interim and in some cases might have moved on by the time the decision was made.

5. What is delinkage designed to achieve?

The primary consideration is accountability - the personnel are given contracts with performance criteria and this allows the districts to enforce standards in terms of the work ethic, job performance, rewards and sanctions. Accountability works in two ways - for the employer and the consumer. Another important consideration was the equitable recruitment of staff. The reasoning on the government's part was that with three-year

contracts, the area where staff were assigned would receive the benefits for a three-year period. The capping of this period to three years was to reassure staff members that they would not be assigned to a post and be forgotten, as there would always be the possibility of renewal or reassignment if performance was good. However, this does not seem to have been effectively communicated to the staff with the result that they have only focused on the negative aspect of job insecurity.

6. Was the process of delinkage rushed?

The general response to this question was that the process was rushed with not enough care having been given to for instance the financial aspect, conditions of service, job descriptions and performance criteria amongst others. For the unions and their membership the conditions of service and a frank and candid discussion of what was to become of the pension packages was a fundamental question. The unions claimed that staff were asked to reapply for positions without them knowing what and where those positions would be. There was a lack of clarity and information and this created a climate that was ripe for misunderstanding to occur.

7. What are the strengths and weaknesses of the delinkage process?

The strengths of the delinkage process will:

i. bring about a discussion of real issues and the staff have been
ii. proactive in dealing with their concerns - including taking out an injunction against the Ministry and derailing the process for almost a year
iii. promote better job performance through rewards and sanctions
iv. promote equitable recruitment of staff
v. promote accountability

The weaknesses were that:

i. the process was rushed
ii. the ministry underestimated the size of the task
iii. the Government was not adequat' 'y prepared financially to pension off the staff that would leave and to ensure a transfer of the pension

funds of those remaining within the new structure

iv. conditions of service had not been worked out and this led to postponement of the delinkage exercise while the issue was being addressed

v. the CBOH was perceived as being ill equipped to deal with the issue of staff conditions because the Ministry is 'not letting go' and so it had no substantive power to promise delivery. The civil service staff would rather stay with an erratic employer (government's obligations regarding the pension fund have been unpaid for the last five years) that nevertheless has the authority to resolve the issue in the future. The CBOH is seen as a 'toothless bulldog'

vi. issues of change management were inadequately addressed. Issues of resistance, financing and information hampered the process from day one.

8. Should the delinkage process be discontinued?

This question is now invalid. By the time I was able to go to Lusaka to conduct my interviews, I discovered that the delinkage exercise had been indefinitely postponed until such time as the conditions of service have been clarified. The unions have since suspended their court case pending discussions with the ministry regarding the same issue. The request to handle the case out of court came from the ministry itself and the union is standing by ready to reinstate the case before the courts, should these discussions fail.

9. Is delinkage designed to achieve equitable and appropriate distribution of staff?

The belief is that delinkage can bring about equitable recruitment of staff but the validity of this can only be tested once the exercise is underway after the obstacles have been removed. One of the aims is to redistribute the staffing structure that is heavily biased in favour of the urban areas. However those districts that are better off and the larger hospitals may still end up attracting the best staff to the detriment of poorer ones and the problem of inequitable distribution will not be resolved. This is an area that

will have to be monitored with emphasis placed on conditions of service to assist the poorer districts to match the urban areas (housing and schooling for staff and their families).

10. Was there consultation with the medical personnel about the process of delinkage?

The position of those involved in instituting the reform process is that personnel were consulted and are fully aware of what is intended by the Ministry of Health in its pursuit of delinkage. One view expressed was that the ministry cannot be held accountable if doctors in Lusaka for example are too busy with private practice agendas and unwilling or unable to attend meetings that were called to inform everyone.

The view of the unions is that at the peripheral levels information did not filter down and staff were unaware of what was happening. Consultations took place at the central level with certain individuals but these individuals did not adequately disseminate the information to their colleagues in the rural areas once they returned. In addition their position is that a person has to consent before a transfer can be effected to a new job. Applications for positions can only be effected after the conditions of service have been given and not before. This being the case then the delinkage exercise was premature as the conditions of service were not laid down. The Civil Servants Union of Zambia wished to be consulted before the statutory instrument was passed creating the CBOH, before the stage of drafting it. They claim that if there had been consultation then the problems being experienced now would have been negated.

11. What is hampering the process of delinkage?

Resistance from the health workers has been a major factor with the resultant injunction being taken out. The perpetual problem of a lack of funding is another important factor. The unions raised the issue of job security. The staff are supposed to transfer to their new jobs with the assurance that pensions will be carried forward, but the staff have no assurance that the Boards will continue to remit the seven and a quarter percent contribution to fulfil their part of their obligation to their employees.

For the past five to six years the union claims that the government has not been remitting its portion with the result that they have an outstanding bill of K46 billion with interest that remains unpaid (equivalent to USD 23 million in October 1998).

Under the new structure the feeling is that the government is still not in a position to pay but the latter is preferable as an employer to the boards that still have to prove themselves. The boards are perceived as not being self-sustaining, so how can the staff entrust their issues to them? The three-year contracts create uncertainty for the employees. What happens to them after three years if their contracts are not renewed?

A constraint expressed by the Churches Medical Association of Zambia (CMAZ) was the lack of guidelines to districts on funding and delinkage of staff. This resulted in a lot of time being spent on resolving resulting problems, particularly in the first and second quarters of 1997. Another constraint is the capacity as district levels - there are leaders but no human resources. There needs to be consistency in terms of interpretation of policies and communication needs to be improved - "information seems to reach church-run institutions faster from CMAZ Secretariat than from CBOH to district health management teams. This has been causing problems as church-run institutions find that the district health teams do not have any information to support the circulars which church-run institutions have received. Furthermore, there are frequent changes in information about the on-going reforms. This was causing confusion." (The Balm: Vol. 2 No. 1, 1998)

12. What needs to be done to achieve the goal of delinkage?

Clarity on the conditions of service with a strong emphasis on information feeding the reform and delinkage processes. Without this the exercise is seriously compromised and quality personnel that the MOH can ill afford to lose are opting to leave to pursue other avenues usually outside the country. On the conditions of service it was promised by the MOH that they would be tabled before Cabinet last October. To date the present promise is that by the end of October 1998 they will be ready. This kind of action leads to a lack of credibility and the MOH should be urged to bear

this in mind and act with decisiveness before the reform process is sunk.

13. Why is decentralisation being introduced?

When this question was put to one of the interviewees their response was that there was no choice if reforms were the way to go. There had to be a change in the way of doing things - a change from central decision making to decisions being made at the place where the impact needed to be felt. They contend this was the main justification for decentralisation. The old way of doing things had proven a failure as government had failed to manage from the centre. Even with high rates of urbanisation there is still a need to penetrate the rural sector and the belief was that if one improves the health of the poor this leads to economic growth which in turn leads to economic stability.

The first attempt at autonomous boards in 1985 failed. It was suggested that this was because the UNIP government was attempting cost recovery through user fees and the fear of the government was that the promises of independence were being compromised. Fear of alienating the UNIP constituency therefore was the motivating factor for not following through with these incremental reforms. In the MMD era there is now a different fear - fear of losing power and control on the part of the politicians if the decentralisation exercise in health is carried through to the letter of the original reforms. What we see now is a conflict between the aims of decentralisation and the aims of the health reforms as presented today after subsequent tinkering with the original reform agenda.

14. Has decentralisation made decision-making more responsive to public needs, increased accountability, improved the quality of service and promoted popular participation?

There have been some notable successes with the decentralisation of health reforms. Decentralisation as a notion has been accepted across the board as the most effective means for the achievement of equitable and accessible health services. The unions accept the theory although their concern is with avoiding the council fiasco where as they put it the quality of leadership was of a low calibre. Mechanisms should be put in

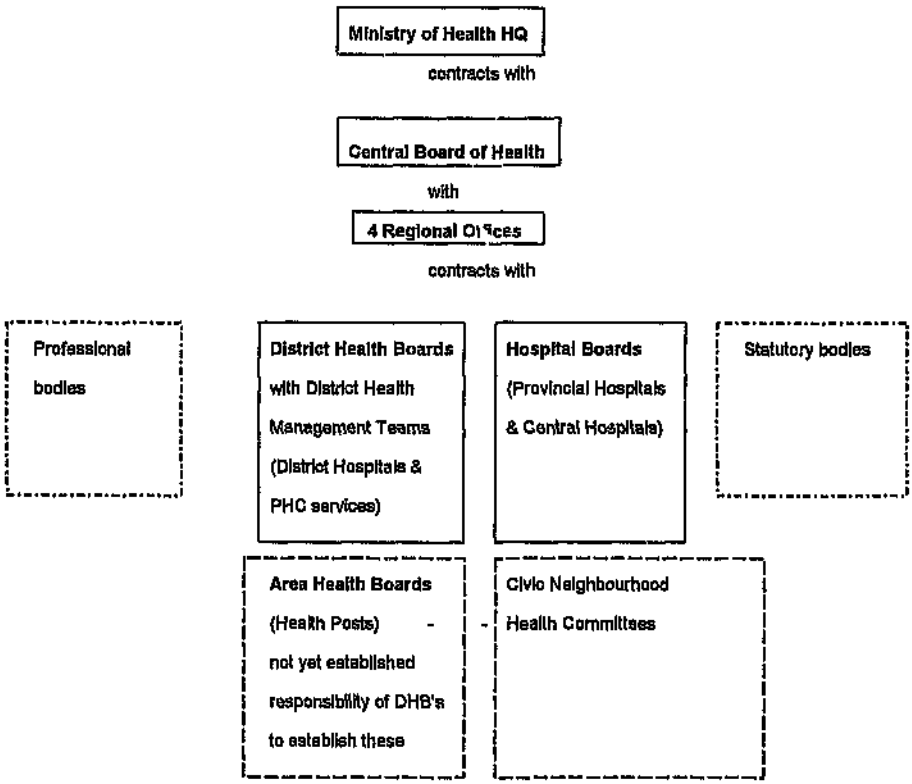
place to ensure that leadership on the community's part is of a sufficient quality so as to ensure that the decentralisation exercise is not compromised.

In terms of infrastructure, there has been a steady improvement in some of the health centres as a first step where levels of cleanliness and hygiene are being improved and the health centres as a first level of contact are adequately playing their role. Community participation is being experienced although there has been a drop in use of facilities and various studies and reviews have been conducted to get to the root of this problem. For some people there is the perception that they already pay taxes and should not be required to pay the clinics more money. Others appreciate the improved facilities and impute this to the cost recovery mechanisms in place.

15. What form has decentralisation taken and how are the relations of authority set out?

Decentralisation was effected to the district level. "The District Health Boards are the prime management unit in the decentralised system, responsible for administrating the affairs of the district health services, for planning and co-ordination with other sectors in the district etc" (Kalumba, 1997). The diagram on the next page shows the structure of the new decentralised health system.

THE STRUCTURE OF THE NEW HEALTH SYSTEM (1997)



Taken from Katele Kalumba (1997)

16. Was adequate attention paid to the role of the centre in the decentralised system?

The initial reformers had a clear idea of how they anticipated the reform process should go. However since the only constant is change, and change was happening at a very fast rate in both the internal and external environments to the reforms, this change or 'turbulence' as it is referred to by insiders made for a very bumpy ride. It was anticipated that the restructured ministry with 66 staff members would be responsible for the following functions: policy advocacy, planning, mobilising resources, resource allocation and management, standard setting, performance assessment, responsibility for financial management and a purchasing role. There is recognition of the potential conflict between the day-to-day

management responsibilities of the MOH with its overseeing, supervisory functions.

The key authorities being transferred through devolution of functions to districts and autonomous hospital management boards are planning, management, service delivery, funding or resource allocation and revenue generation. All of these are made possible by passing appropriate legislation, the setting of clear goals and objectives and the definition of new roles and responsibilities.

17. Is there a lack of clarity between the roles of the CBOH and MOH?

The view of observers from the outside is that the CBOH hasn't tackled the question of roles within and without the organisation. There is no organisational development and no clarity of roles and job descriptions. A criticism is the lack of communication channels. Insiders are more sensitive to the politics of the situation they find themselves in and are not so candid in their comments on this question.

18. What resources, functions and authority have been decentralised?

The resources to pay personnel, purchase drugs and materials (subject to approval from the CBOH in the quarterly budget and to satisfactory accounting procedures) have been delegated to the districts.

The authority to discipline staff at the district level has been delegated. The authority to enter into contracts with partners in health e.g. church hospitals and health centres since the latter do not fall under the jurisdiction of the DHB. "The DHB is the fund-holder for all primary health care services within the essential health care package. It is the obligation of the DHB to ensure that the entire population of the district has equity of access to quality health care services as close to the family as possible. This includes access to first level referral hospital care. If the district does not itself have a hospital which is equipped and staffed to provide this service, or if the geography of the district is such that it is more convenient for part of the population to use a church institution or a hospital in a neighbouring district contracts should be made to ensure equity of

access". (MOH/CBOH Annual Health Report, 1997)

The DHB has also been tasked with delegating authority to health centres to enable the latter to set priorities and manage their own resources.

19. Was a programme for district health management strengthening agreed upon?

A programme for district health management strengthening was agreed upon. In the Zambian health reform process the first component to be delegated was the management of resources. Money was going out to the districts in tandem with training. Systems followed, then planning. All these activities and support to the DHMTs was being given via the HRIT which was composed of less than 15 people. The creation of the CBOH was the last item and then staff from the HRIT and MOH were collapsed into the CBOH to continue the reform process.

20. What has the impact been of the various ministers on reforms?

In summary, the single biggest factor influencing the shape of reforms is political and the various ministers that have held the portfolio have shown this in one way or another. When the MMD came into power it was in the enviable position of having a well thought out document detailing the reform agenda which meant that the MOH was able to hit the deck running in a sense. Notwithstanding the enormous problems faced, they were able to encourage the donors back to a sector from which they had all but withdrawn prior to 1991. Since the MMD instituted these reforms there have been four ministers appointed to date in health over a seven-year period.

1. Honourable Boniface Kawimbe: He was the first Minister for Health under the MMD and was responsible for getting the reforms underway as quickly and as effectively as possible. The MMD was at this stage benefiting from a period of popularity following the ousting of Kaunda in the 1991 elections and was quickly able to seize this window of opportunity to push through as many of the reforms as they could. Kawimbe was one of the original reformers pre-1991 and therefore was

keen to see the reforms translated into reality. He was summarily dropped from the Cabinet and an 'outsider' was brought in to see the reforms through.

2. Honourable Michael Sata: He had been Minister for Local Government in the UNIP days and it is widely acknowledged that local government had collapsed by the time the MMD came into power. An interview yielded the observation that he was clearly against the devolution of power and wanted at a' osts to retain control which would be lost under the decentralised structure. Anecdotal reference is made to a remark he made saying that he was not a minister of a few people but the whole of the Ministry of Health (a reference to the reduced numbers at MOH HQ and the loss of employees to the autonomous boards).

It is important to review his role in the reform process because it was under him that crucial legislation was to be debated and enacted that would set out the structure of the CBOH and the Medical Services Act. The initial draft was 'fiddled' with drastically as it had been intended to entrench the policy of decentralisation and reduce the involvement of the minister in day to day management of health care delivery. We see here the beginnings of an anti-reform drive and those within the ministry who were for reform were forced to make compromises. In order to keep the reforms moving they opted to seek amendment of the Act at a future date (the donors had made it a precondition that the Act should be passed before funds could be released). The feeling of the stakeholders is that there was inadequate discussion and debate around the Act and that at the end the Bill that was passed was different from that envisioned in the initial draft. Minister Sata also resolved not to initiate the CBOH under his term of office because he perceived it as a loss of power.

3. Honourable Katele Kalumba: this was the most active period of the reforms according to observers and actors. He was the one most keen to decentralise and to translate the Act into reality. He initiated the appointment of the boards and the setting up of the CBOH. Various factors were responsible for his removal from office and these are mostly to do with the results of the reforms:

- delinkage should have been effected in 1997 and the exercise

provoked anxiety amongst health workers. Appointments were to be made under different conditions in line with staff assignments of autonomous boards. There was resistance from the unions because general workers would be lost - the largest proportion of membership came from health personnel.

- there was a lot of misinformation occurring on the part of the unions and the MOH did an inadequate job to counter this. The unions implied that terminal benefits would be lost and urged the workers to insist on payment of these upfront before transfers would be effected. The government would effectively have to come up with the money for this and they were broke.
- there was the perceived insecurity surrounding the boards - short-term contracts would now be effected and there was no security of tenure (jobs for life).
- the basis for allocation of funds to health institutions changed from looking at the size of the institution and what they did, to looking at the size of the population served (per capita allocation as defined by the CBOH). This posed problems for hospitals with a reputation for service in a particular field where the catchment area is less but the population served is far more (people coming from all over the country). For instance patients would bypass the referral hospital Kasama General in the north of the country in order to go to Chilonga Mission Hospital in the same region because the infrastructure at the former is run down and the system cannot cope. This led to the perception by the local people that the government was 'killing' the mission hospitals that had served them. The view was that there should have been a transition phase to stabilise demand through the 'beefing up' of the general hospitals instead of referring patients to the mission hospitals who ethically could not turn patients away.

These factors combined to create perceptions of chaos and this spilled over to the parliamentarians who last February asked for an account of the reforms to date. The CBOH was perceived as overzealously pursuing its objectives and this created problems for the minister. However it is felt that this was just an excuse to get rid of him but perhaps these are signs again of the anti-reform agenda at play

4.4 Conclusion

The questions posed yielded insights into the decentralisation and delinkage exercise taking place in Zambia. There are difficulties and tensions being experienced in the relationship between the MOH and the CBOH that are yet to be resolved. The structure that was adopted leading to the appointment of The Director General (DG) of the CBOH by the minister and the direct involvement of the MOH in resolving problems leaves the CBOH in a quandary and promotes the notion that they are not in charge. Relationships with the districts and other partners in service delivery are compromised as a result.

The poor resource situation and the lack of prompt action in dealing with the restructuring of the old Medical Stores have hindered the operations of the LUDHMT. The donors have seized on these issues and made them preconditions for the release of further funding to the health sector. The political situation has a profound impact on health reform in Zambia. The role of actors is highlighted through the impact of the individual minister's on the reforms and the effect of strong political support in the initial stages of reform. Towards 1997 we begin to see waning support to the health sector in terms of political support and more criticism and pressure brought to bear on the minister's for 'successes' failure to which support will be withdrawn. An anti-reform agenda is underway and the reformers are having to fight for every gain they make and show their commitment to their ideals.

CHAPTER 5: Interpretation of the findings

5.1 Introduction

When we look at the research findings and compare them with the theory we find that there are inadequacies that come to light. The researcher will view these through the four factors identified by Rondinelli *et al* (refer to page 14 of this document). These are organisational and administrative factors, behavioural factors, political circumstances and the financial and human resource situation. Although Rondinelli *et al* separate these factors the reality is that they overlap and can affect each other. The issues refused to remain confined to the structure laid out by the authors.

5.2 Research findings versus the theory

In terms of the conditions that the various pieces of international and national literature give us as preconditions for successful reforms, Zambia has recorded some pluses. Cassels and Janovsky (1996) note that the plan of the MMD government on coming to power was well thought out and was impressive enough to encourage the donors to come on board in terms of financial and technical assistance to the MOH. The vision was clear and well articulated but the lack of a critical mass of people committed to this vision is noticeable and "'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" is a threat to the successful accomplishment of the reforms. (Kalumba 1997, p. 33)

The reformers acknowledge that there was a huge amount of firefighting taking place even while the reforms were being instituted. This meant that not only did health workers have to contend with the enormous changes taking place in their working environment and methods, but they also had to deal with the continuing outbreaks of epidemics that were occurring in tandem.

5.2.1. Organisational and administrative factors

The Zambian health reforms ran ahead of themselves. For reasons given earlier regarding the poor economic and resource climate, decline in infrastructure and contraction of the civil service under the structural adjustment reform policies, the reforms were implemented by and large as windows of opportunity presented themselves. The implication of this was to lead for example to the implementation of district funding while district staff in some areas were inadequately equipped to carry out these functions. In the meanwhile legislation creating the districts was not yet in place. Funding was provided by DANIDA for training and was made available immediately so implementation moved forward to begin funding the districts.

This kind of piecemeal approach, while defended by the government and while it can be understood in the light of financial constraints experienced by the government, nevertheless led to the problems being experienced today. The decision to delink was taken but not enough thought was put into determining the factors critical to its success. England (1997, p. 17) tells us that a certain combination of factors is required to reduce the difficulties of reform. While it is understood that reform will prove difficult due to resistance, resource constraints and other factors, various forms of legislation are required to ensure the transition under the type of reform structure chosen by the MOH.

Legislation was required to create autonomous provider agencies and purchasing agencies able to spend public finance; legislation was required to facilitate the transfer of staff from public service employment (finalised in 1997) and legislative change was required for national employment and disciplinary bodies. Funds were required to invest in redundancy costs in order to achieve more cost-effective skill mixes and revision or creation of alternative pension arrangements for health workers were required for those leaving public service employment. England also stresses the need for communication efforts to gain support for reform initiatives and the MOH recognised this issue and is presently taking steps through the CBOH to address the poor information situation around the reform process in Zambia.

While reformers within the ministry seemed to have a keen understanding of the scope of the organisational change required to bring about health reforms, judging from interviews and conversations with players in the reform process, the reality far superseded expectations in terms of how problematic the changes would prove to be. The implications of organisational change, through decentralisation, were on several levels:

- change in the structure of the MOH from it being responsible for hiring and disciplinary procedures relating to staff, to a reduced centre with responsibilities for policy, supervisory and regulatory overview of health through newly constituted boards and a new Health Act.
- change in responsibilities and accountability at the district level with appropriate guidelines being drafted showing procedures to be followed. Responsibilities for hiring and firing of staff are passed down and responsibilities for budgeting and accounting for funds are given to districts
- movement of staff from the Public Services Commission to autonomous management boards
- strengthening of private sector and NGO links to provide health services at the lowest level possible
- change in the structure of Medical Stores - the provider of essential drugs to the entire country. This also entailed the establishment of a new drugs policy which is still not ready and the translation of Medical Stores into the EDMSS, although discussion of this was denied at the meeting in April 1998.

The reality now is that change has occurred although in some instances it has done so in fits and starts and with resistance of some kind at all levels. An aspect of change management was the holding of workshops which were extremely vital not only for communication of the changes being made so that ownership of the reforms was ensured, but vital also as a feedback mechanism for the MOH so that it could continue to adjust its policies accordingly as problems were encountered with implementation in the field. One of the first actions of the new minister appointed in March/April last year was to ban workshops. Information flow may not have been ideal before but with this one action the sense of participants in the reform process is that reforms are in limbo.

5.2.2 Behavioural factors

It is acknowledged that Zambian health reforms were taking place in a turbulent environment and that therefore the reformers would have to manage great change within a chaotic situation[1]. Some of the key issues here include the perceptions and reactions of the staff to the bold new vision of the MMD and MOH central planners. It must be acknowledged that it is unusual for a system in power to devolve powers from itself and effectively the central planners were working themselves out of jobs in the near future. It is not surprising therefore that there was some resistance at this level and literature covered in this paper confirms this.

There are certain key issues that needed to be tackled boldly if the government was not to lose the momentum and let resistance to reforms build up. The majority of the people spoken to confirmed that the reforms as a concept were commendable. Given this scenario and given that there was bound to be resistance on the part of the unions who were stirring the pot to suit their own interests, the government should have been more proactive in managing the kind of information that seeped out. The lack of leadership in this led to the perception by the people and the parliamentarians that chaos was prevailing at the MOH and there was no direction.

The reaction of the mission organisations was predictable. The newly introduced system of per capita allocations for funding based on the catchment area of the institution meant that the missions were being crippled in their operations. They did not sit back and wait to negotiate but went directly to State House. President Chiluba declared Zambia a Christian nation on entering office so the missions were confident their problems would receive immediate attention, which they did, and the allocations were reinstated. The net impact of this reversal of a decision by the President himself was to promote the perception that the MOH was taking decisions arbitrarily and yet this was the approved reform agenda. In order to limit the impact of behavioural factors the health workers need

[1]Chaos theory has it that even within a turbulent environment there is an order to things. It is however acknowledged that information fed through such a system does much to negate the impact of this perceived chaos, permitting the organisation to continue to function.

to be part of the system, to take ownership of the reform process that is unfolding. One of the key ways in which this was successfully done for certain programmes under the reforms was through workshops. One of the first actions of the present minister was to immediately ban workshops in order to focus on the 'deliverables'.

5.2.3 Political circumstances

The selection of Ministers to lead the reform agenda is political in so far as the person selected is a choice of the President and the ruling party. In the past seven years there have been four ministers appointed to head the Health Ministry. Elsewhere in this paper I have dealt with the impact of each Minister on the reform process. What was clearly shown was that those who had been the visionaries had no trouble identifying where they wanted to take the reforms on assuming office Note is taken of the incredible achievements of the reforms to date but even this is not enough to ensure that a minister survives when votes are threatened. The government reacts swiftly to safeguard its constituency.

Cassels and Janovsky conclude after contrasting Ghana and Zambia that "the political nature of the reform process and the importance of political leadership to the success of reform initiatives are quite clear. A sound understanding of the issues, clarity of purpose and robust backing from higher levels of government are essential to success." (Cassels and Janovsky, 1996, p. 15)

5.2.4 Financial and human resource situation

In Zambia, with its strong dependence on donor support to supplement the government budget, there is the realisation that the political circumstances strongly affect the economic situation. Currently there has been a cessation of donor funding that has impacted the health sector because the privatisation exercise under the structural adjustment programme was supposed to entail the sale of the copper mines. The donors criticised the pace and circumstances of the process of the sale through Zambia Consolidated Copper Mines (ZCCM) of the major mines. For their part the government insist that a sale of this magnitude cannot be concluded in a

short space of time. The mines to date remain unsold with the result that the donors finally premised any future aid on the successful sale of the mines. These factors are seriously compromising the performance of the health sector and the morale of the workers as redundancies are the order of the day.

The Independent review of the Zambian health reforms (1997, p. 24) acknowledges that staffing of the health services is perhaps the most difficult and complex of all the components associated with the reforms. Emphasis to date has been more with creating the legal structural and financial frameworks for the reforms to the detriment of this sector. As the process moves towards implementation now the pressures of appointing staff to the new structures while continuing to build necessary capacities have begun to make themselves felt. The review found that while the MOH had given a lot of thought to these questions, "the ideas have shot far ahead of the capacity to analyse and document the implications in the form of clear plans for implementation". (1997, p. 24)

5.3 Implications of findings

The role of the leaders of the reform process, be they titular as in the case of ministers or real as is the case of the career personnel in the MOH, is extremely important for the unfolding of the reforms. The impact of four 'leaders' on the reforms is shown in terms of the direction that the Zambian reforms have taken or failed to take to date. Even with the commitment of the visionaries within the ministry, there is still a tendency to look to the minister to provide leadership in the process and when this is perceived to be missing the health workers feel that the reforms are in limbo.

T various roles of the different structures set up and their interrelationships is fundamental to progress in the reforms. A key sentiment that was expressed is that the MOH ceases to be a micro-manager and leaves that task to the different boards that have been constituted to perform the various functions. It is not anticipated that the Minister should be the one to go to the provinces to fire non performers when that is the task of the constituted boards. The result is that mixed signals are sent out and the boards are reluctant to act as the central

authority still seems to be in charge.

One of the key reformers I interviewed grappled with these issues in posing the question as to whom any system is beneficial? In the view of this reformer different people will always have differing reasons why they push for reforms or stifle them. He contended that the health reforms are taking place under conditions of turbulence and that there is a butterfly effect in play. A small seemingly unconnected action somewhere may have unforeseen repercussions for the reform movement. He accepts that a system will have different nodes of power with multiple goals but there needs to be a clear idea of a future state (a common vision) through the definition in this case of the future state of health reforms. There also needs to be a negotiated order for the competing visions and this implies that channels of communication are open between parties. However he cautioned that even a collective decision can be flawed (the common vision) and the only way to test if the hypothesis is correct is through the use of pilot tests to ascertain whether the idea is wrong and possibly adjust it if it is.

In the case of Zambia, pilots are an idea that still has merit for certain components of the reforms as they advance through the implementation stage. However the circumstances sometimes were such that in order for the reforms not to slow down decisions to go ahead had to be taken even if not all the aspects had been worked through ideally, which created an environment that the reformers in Zambia refer to as 'learning by doing'. Innovation was encouraged in order to move the process and it was hoped that efforts would be made to allow for the innovators to inform others of how they achieved results within the turbulent environment through workshops and another means of information exchange.

Gallops in the Ministry's reform efforts were put down to the visionaries. The latter did not last because in some instances the pace of reform far outstripped the capacity to cope and as a result the visionaries were seen as being too zealous and as not carrying everyone with them. Some observers acknowledge that the reforms would not be where they are today if it were not for this push that was made. If the minister had been able to survive the year (1997 through 1998) - a critical period for the

reforms - the result would have meant this sector would have been a beacon for other sectors such as education and defence amongst others that are also undergoing reforms.

The health workers watch the actions of the government (from the appointment of ministers to the actions taken to resolve contentious issues) and respond either negatively or positively. It is thus incumbent on the government to look at each of its actions taken and try to anticipate the problems or resistance to come or to try to manage the change better through information flow and advocacy for the government's position.

The example of the OECD countries (Schieber, 1995) serves as a good basis for determining where the developing countries need to place themselves in the future in terms of basing reforms on analysis and evaluation of their impacts. The truth of the matter is that developing countries are still in an embryonic form of development regarding the institutional, governance and information infrastructures that are required to push reforms of the magnitude that Zambia has undertaken. A simple example is the 1995 Health Act that was passed in circumstances that were less than ideal for implementation of reforms as the visionaries saw them. Compromises were made in order not to hinder the reforms - the donors were putting pressure on the government to pass the legislation so the framework could be in place; the minister had his own view of the kind of legislation he wished to see his name put to; the reformers realised this was a battle they could not hope to win without losing the war. The net result was that the reformers compromised their stand on the shape of the legislation (the stakeholders contend that the consultation around the final draft adopted was inadequate) in order to ensure that the reforms continued, even if on a slightly altered path. There is little sense of ownership of this part of the reform process.

For successful reforms Schieber says that coherent organisational structures, technically competent multi-disciplinary staff and an effective intergovernmental structure allowing for efficient information flow and implementation at national, regional and local levels. The reality in Zambia is that most of the organisational structures are in their infancy and there is a recognition that multi skilling is necessary if the reforms are to succeed.

This creates setbacks for the immediate moment as the reformers struggle to forge ahead. Access to interviewees was made much harder by the fact that there are many work pressures being brought to bear on the competent individuals running the reforms. They are required in the country and without, to present papers on the Zambian experience and the result is that while they are absent their workload is left unattended and when they return there are other imperatives, including making representation to cabinet on the status of health reforms.

Schieber points out the success criteria for reforms in developing countries as being dependent on stability of leadership, technically competent staff, support from top government leadership and the Ministry of Finance (MOF) as well as sensible application of lessons drawn from other countries. Zambia has all of the above even if there is inadequate critical mass in terms of technically competent staff. The Zambians are learning from the lessons of other countries as well as taking the bold step of 'learning by doing'. The political commitment may begin to waver the longer the reforms progress without enough of the 'visibles' being seen that will persuade the MMD electorate that their government is looking after their health interests.

Gilson and Mills (1995) observe that decentralisation is sometimes used as a guise for strengthening control from the centre. While this is acknowledged as being one of the paradoxes of attempts at decentralisation, in the case of Zambian health reforms there is a clear intent to devolve power and support this move with appropriate legislation and support from the MOH. The reality is that the government is not in a position to deliver health services through the traditionally weakened local government without making attempts to involve the communities and the districts in the resolution of their health problems. Decentralisation is real and working in health reforms but the government must guard against losing momentum and resolve in pressing ahead with the reforms. Should they lose ground and the districts fail to have the requisite support from the MOH, for various reasons such as funding and technical support rather than a lack of will, then they run the risk of seeing their reform agenda overturned should they fail to secure a mandate in the 2001 elections.
In terms of what I will call the 'stepping stones' for reforms, England (1997,

p. 17) provides us with some clear criteria for successful implementation of health reforms. He provides us with the things we can look out for and prepare for in order to ensure that interference is kept to a minimum. Amongst the factors listed are revision or creation of alternative pension arrangements where health workers are to leave public service employment and funds for investment in redundancy costs and achieving more cost-effective skill mixes. In the case of Zambia these two aspects were underestimated or not given enough consideration and they were the two most critical factors for a smooth delinkage of staff under the reform programme. Because funds were not readily available to government to fund redundancies a climate of uncertainty was created that was capitalised upon by the civil servants union, half of whose membership was composed of health staff.

The entire delinkage exercise had been made twice as hard for the government to achieve because control of the process was not seized from the beginning in terms of communication efforts. This would have gained support for reform initiatives and countered the negative publicity being put about by the misrepresentation of facts by the union. England argues that the money spent on infrastructure improvement would be better spent in financing the costs of transferring the employment of public service health workers to autonomous organisations and funding redundancy costs. I disagree with this as the rationale for the reform process was to begin to make people accountable for their own health and to ensure that if a quality service was delivered, then payment for it should be made in one form or another. The reality was that the government could not ask people to pay for poor quality service and one of the most basic things required was to upgrade the clinics and health facilities throughout the country. Once this was done, then even if people argued about the issue of payment the government could point to the improved facilities and services as justification for the charge.

CHAPTER 6: Conclusion

6.1 The significance of this research

It is clear that there are many factors to be taken into account when analysing health reforms and attempting to see what are the critical success factors for implementation. The health reforms in Zambia are taking place in the broader context of public service reform and this has sometimes been a factor in hindering the process of health reform. When we look at the health sector it is by far the most advanced in terms of the progress made to reform, whereas other sectors such as education are lagging far behind. The delays with delinkage in health and the strikes that resulted have not been a good omen for the education staff and they are learning from this and resisting reforms. The government knows it does not have the money to pay redundancy packages and pensions so it also benefits from a slowdown in this area. However the delay in delinking is to the detriment of the health reform process.

The theory can be very useful in pointing out the potential trouble spots to look and prepare for, but in conclusion it is clear that not all aspects can be anticipated and there are situations where reform is the only option even if it has to be conducted in a hostile environment with limited resources. The Zambian example shows us that even with a strong theory base motivating the reform movement in health, and with various actors having competing visions for the reform process, it is not easy to focus on the factors that are critical to successful implementation of the reforms.

Operationalisation of Zambian health care reforms was seen as the weak spot in achievement of the vision that was so clearly elucidated in all the documentation. Operationalisation of the reforms can only be achieved if enough critical attention is paid to potential trouble spots and the research has confirmed Gilson's view that actors in the process are crucial to successful accomplishment of objectives. This is borne out by a look at the effect the various ministers have had for example on the actual reform structure that is in place today and the impact of union resistance to delinkage.

This research is significant to the Zambian context for several reasons. As stated earlier public service reforms through a process of contracting and the creation of autonomous bodies is the preferred option of the MMD government to bring the country out of its crisis in various sectors of society. Health is seen as the basis for the anticipated economic growth in tandem with agriculture and education. The way in which the health sector delinkage exercise is carried out has a 'knock on' effect to the other sectors such as education, as pointed out earlier, with the potential to frustrate the genuine efforts of the government in its search for meaningful solutions to the health problems of the population. The momentum and drive that have so far helped propel the health reforms to the stage they are at must not be lost at all costs as everyone, from donors to health workers, acknowledges that they are commendable ideas and the willingness to support efforts is there.

It was made clear to the researcher that at present the vision for the reforms has been lost or is not clear to those who are expected to follow the reformers. Initially communication of this vision was effective with attempts being made to provide workshops at which people could exchange experiences and ideas that fed directly into the health sector. The health personnel are worried that the momentum has been lost and a look at the problems that are being experienced in the wider economy does not give one hope for progress in the health sector.

The donors to the Zambian economy have premised future aid on the successful sale of the mines that are costing Zambia millions of dollars for every day that they remain unsold. While some money is going directly to the health sector through the basket funding mechanism, the latter concept is premised on the Zambian government also putting up counterpart funds that it obviously does not have. The net result is that the health sector is constrained in terms of funding, drugs and the situation with the personnel and the delinkage exercise cannot be successfully concluded, as funding is unavailable for packages and pensions.

The research is also significant for other developing countries that are contemplating health reforms. Zambia's reforms are influenced by ten years of research and the country is at the cutting edge of reforms and has

taken leadership in this area.

6.2 Suggestions for future research

Future research should be concentrated on the strategic management of health sector reform in developing countries. Most reforms in these countries do not take place in ideal conditions for policy making and implementation. There is resistance from various critical players, funding is often short, the critical mass of staff required to achieve the reforms is often missing and community participation is not a given. Often the reformers are operating in conditions where they have to firefight - cope with the day to day issues as well as attempt to have a broader overview of the direction the reforms are taking. Heaver (1995) in looking at this aspect within the context of health transition, says that companies may be expected to think strategically or go bankrupt but public health systems do not and therefore do not feel the urgency to do so.

Zambia's example shows that even basic strategies that look at strengths, weaknesses, opportunities and threats are useful as anticipatory tools for looking at problem areas. Should a situation arise that is critical to the reform process, there might already have been attempts made to gather information that might prove key in resolving the issue. Factors such as the sale of the mines, the strikes by the workers, the action by the civil servants union and the funding of redundancy and pension packages might all have been anticipated and fought more vigorously with good public relation campaigns.

6.3 Concluding comments

In looking at the Zambian health reforms from the perspective of delinkage and decentralisation it is clear that one of the lessons to be learnt is that even with the best will in the world one cannot run before one is able to walk. By this I mean that the reforms, in spite of the windows of opportunity afforded and seized by the reformers, still needed to build up the support of the health workers, users of the services and the government in terms of continued and committed support for reform initiatives in order to have any hope of sustaining the gains made. The

view was expressed that a politician with a vision will not sacrifice short-term gains for long-term gains yet we know that the imperatives of the electorate and an election year will often sway even the most committed of politicians away from his long term agenda in the perhaps mistaken belief that he or she might live to fight another day.

We have seen examples of these compromises over legislation where the hope was expressed that at some time in the future amendments would be made to the present Health Act but that is for a future date. To revisit the issue so soon would lead the parliamentarians to question the seriousness and capability of the reformers. It has been argued that too much was taken on at once and with hindsight issues such as financing might not have been taken on so early. Other issues such as the drug policy might and should have been tackled earlier to ensure a rational system for drug use was in place as financing mechanisms came into effect.

The research has attempted to view the health reform process in Zambia through the windows of delinkage and decentralisation. The observations have been set out principally under the four factors that Cheema and Rondinelli (1983) give us, namely organisational and administrative factors, behavioural factors, political circumstances and the financial and human resource situation. Using these four factors the researcher has attempted to relate the theory base provided in the context of reforms in sub-Saharan Africa and the OECD countries to the Zambian experience and drawn relevant lessons.

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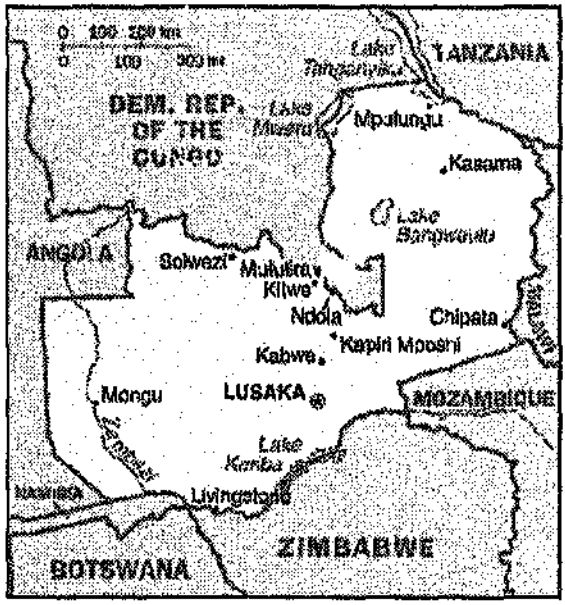
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Appendix 1

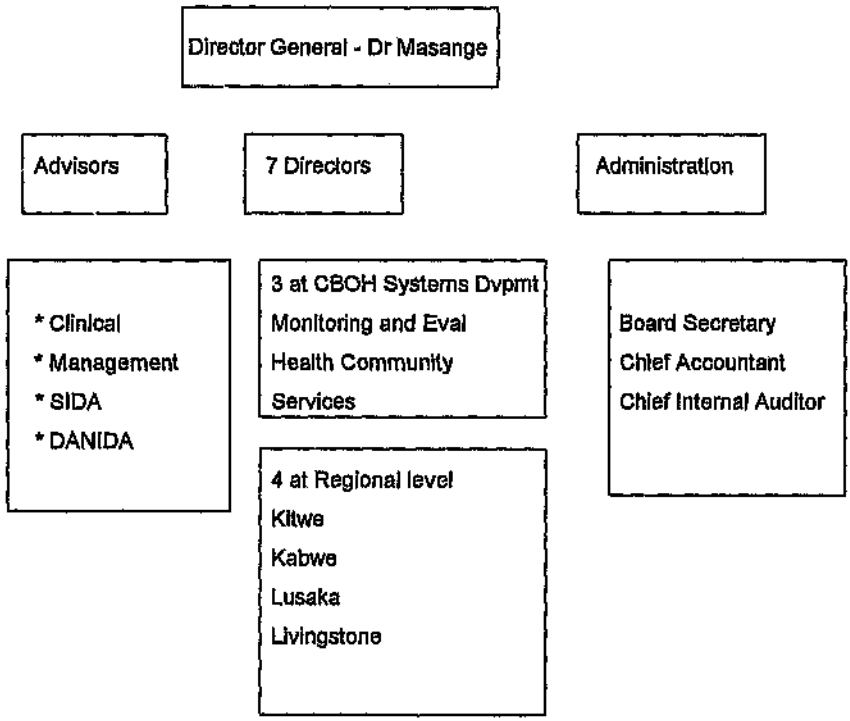


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Map of Zambia
Source: *The World Factbook 1998*

Appendix 2

Structure of the Central Board of Health



CBOH structure as envisaged in May 1997

Appendix 3

Milestones of the Zambian health reforms

Jan 91	Health sector policy review meeting in Livingstone
Nov/Dec 91	Landmark: translation of MMD manifesto into National Health Policies & Strategies document
Mar 92	Blueprint corporate plan framework
Nov 93	Strategic Health Plan (SHP) (vision to reality - costing)
Jan 94	HR Policy and Strategies document
Apr 94	First MOH/Co-operating Partners meeting (Sector-wide approach (SWAP)
May 94-Oct 95	Second edition of SHP refined Development of monitoring and evaluation indicators begun
Dec 95	Work on personnel management handbook

Capacity building

Dec 92	Creation of Health Reforms Implementation Team (HRIT)
Jan/Mar 92	Consultations with districts for needs assessment
1992	Decision to decentralise to districts – short-term strategies for long-term gains
Mar-Jul 93	District capacity management training, problem-solving planning in context of reforms
May 95	Development of Financial & Administrative Management Systems (FAMS)
Jan 94	GRZ increases health budget allocation (8 to 13%); district GRZ grants take effect; criteria for equitable allocation worked out; negotiations with stakeholders

Partnerships

Health care cost scheme for the poor

Apr 93	Statutory instrument establishing District Health Boards (DHBs) - interim boards; wrong law used to create boards therefore interim until 1995 when Act was passed
Jan 95	Scheme initiated as collaborative work began between MOH and Community Development and Social Services
May 96	CMAZ Memorandum of Understanding signed
Jun 96	Public/private mix conference held in Siavonga

Restructuring

Dec 91	First transfers and adjustment of roles (DDMS at MOH HQ)
Sep 96	Establishment of CBOH through appointment of board members
Oct 96	Appointment of first Director General (DG) of CBOH and later seven Directors

Policies

Oct 92	Cabinet adoption of national Health Policy Document
1996	Second Health agenda based on MMD Manifesto
1996	Medical Laboratories Policy completed
Jun 96	National Drug Policy completed
1997	National Health Care Financing policy complete
1998	National Health Policy - incomplete

Legislation

Apr 93	Statutory instrument establishing District Health Boards (interim)
Sep 95	National Health Services bill passed
Jul 97	Statutory instrument No. 76 passed transferring civil service to Public Service Commissioning
Nov 97	Private Members motion requesting review of National Health Policy (1992). Motion defeated

Feb 98	Budget address: Ministry criticised for certain aspects of reforms

Reviews

Aug 96	External review of reforms
Apr 98	Annual MOH/Co-operating Partners review
May 98	Public Service Reform Programme - institutional review of MOH/Ministry of Education and Ministry of Home Affairs (e.g. affordability of staffing)

Appendix 4

TABLE

TABLE 1: Strategic Management: Concepts and Vocabulary

Strategic Management:	The set of top management interventions which provides the framework for day to day operational management
Fit:	The degree to which management strategies, structures and processes together make sense in terms of the organisation's goals and environment
Environment:	The forces outside the organisation which present opportunities and constraints to the organisation. Examples are political conditions, the external policy framework, local institutional arrangements, clients' priorities and cultural beliefs
Structure:	The durable arrangements in an organisation which define reporting relationships, and the distribution of authority and responsibility
Processes:	The instruments open to managers to influence the behaviour of workers and clients. Examples are processes for training, monitoring and rewarding workers, or for understanding and attracting clients

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Appendix 5

List of potential interviewees

The actors in the Zambian Health Reforms

*Hon. Dr. Katele Kalumba	Former Minister of Health
Dr Kawaye Kamanga	Former Permanent Secretary, MOH
*Mr Vincent Musowe	Senior Health Planner, MOH
Dr. Sam L. Nyaywa	Team Leader, HRIT
Dr. Eddie Limbambala	Quality Assurance Unit, HRIT
*Mrs Jennifer Nyoni	Human Resource Development, HRIT
Mr A. Mulungo	Capacity Building, HRIT
Mr S. Mtonga	FAMS/HRIT
Mr. Charles Mundale	HMIS Co-ordinator, HRIT
Mrs G.A. Mundia	Donor Co-ordination, HRIT
Dr Ely Nangawe	PHC Advisor, MOH
*Dr J.J. Banda	Director, Health Services Commissioning
Mr Davis Chimfwembe	HRIT (Budgeting), HRIT
Dr Eric Blas	DANIDA/HRIT
Mr Jan H. Olsson	Financial Advisor/HRIT
Dr Moses Sichone	Programme Manager, AIDS/TB/STD Leprosy, MOH
Mr Edgar Chani	Senior Medical Statistician, MOH
Ms. Violet Kabwe	Managing Director, Medical Stores Limited
Mr Oliver Hazemba	Senior Pharmacist
Dr G.D.M. Katema	Former Executive Director, UTH, Lusaka
Dr E. Chomba	Executive Director, UTH, Lusaka
Dr R. Kumwenda Phiri	Director of Health, Lusaka Urban
Hon. B. Kawimbe	Former Minister of Health, Director Private Clinic
Hon. Michael Sata	Former Minister of Health, Minister without portfolio, State House
Ms. Olive Munjanja	Chairperson, Gender and Health Advisory Committee
Ms. Monique Calon	First Secretary, Royal Netherlands Embassy (Women and Development)

Dr Anders Nordstom	Senior Programme Officer (Health) Swedish Embassy
Mr Walter Slunge Embassy	Central Board of Health/Swedish
*Dr O'Dwyer	Health and Population Field Manager ODA (UK)
Dr A. O'Connell	Urban Health Advisor, ODA, (UK)
Mr N. Sorensen	Counsellor, Danish Embassy
*Dr Paul Zeitz	Health and Population, USAID
Dr Elizabeth Burleigh	Advisor (Community Mobilisation), USAID
Mr M Stirling	UNICEF Representative
Dr T. Moeti	Programme Officer (Health), UNICEF
Dr Boayue	WHO Representative, Lusaka
Dr Shilalukey-Ngoma	Programme Officer, WHO, Lusaka
Dr Peggy Chibuye	Programme Officer, World Bank Resident Mission
Dr Ngila Mwase	Senior Economist, UNDP, Lusaka
Dr Remi Sogunro	Zambia Child Health Project, BASICS, Lusaka
*Lucy Gilson	Centre for Health Policy, Johannesburg

Donors funding the health sector such as JICA*, ODA, SIDA*, DANIDA*, USAID*, the World Bank etc. will be interviewed as well as NGOs and partners in health service delivery such as the Churches Medical Association of Zambia*, the Mission hospital representatives, etc.

* Interviews obtained with the individuals or with the organisation

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