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The Health Care System in Zambia

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Content

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1. Country overview (latest data available)

Source: (https://ontheworldmap.com/zambia/ (Acessed June 15, 2023)

- Sub-Region: Sub-Saharan Africa
- Capital: Lusaka
- Official Language: English
- Population size: 19,610,769 (CSO 2022)
- Share of rural population: 55 % (World Bank 2021)
- GDP: $22 billion (World Bank 2021)
- Income group: Low-income country (World Bank 2021)
- Gini Index: 57.1 (World Bank 2015)
- Colonial period: In the 1890s the British South Africa Company invaded the regions that in 1911 were unified to form Northern Rhodesia, which became a British protectorate in 1924 until its independence on October 24 1964 as Zambia (Encyclopaedia Britannica 2023).

2. Selected health indicators

Indicator	Country	Global Average
Male life expectancy (World Bank, 2021)	58	69
Female life expectancy (World Bank, 2021)	64	74
Under-5 mortality rate (per 1000 live births) (World Bank, 2021)	58	38
Maternal mortality rate (World Bank, 2021)	213	159
HIV prevalence (% of population ages 15-49) (World Bank 2021)	10.8%	0.7%
Tuberculosis prevalence cases per 100,000 people) (World Bank 2021)	307	134

Source: The World Bank (2021)

3. Health care in Zambia before and after independence

Zambia, a former British colony, gained independence in 1964 and has remained politically stable since then. There is not much literature on the healthcare sector on Zambia prior to political independence. Nevertheless, accessibility to health care and other social services such as education for the Zambians who were the indigenous was a challenge. There was segregation in accessibility, for instance, there were schools and hospitals that were designated for Zambians and White immigrants respectively. There was little investment in the health-care system. For example, rural areas, which had a larger population than urban areas, had to access health care services through mission hospitals. At the time of independence, there were only 19 government hospitals in urban areas (WHO, 1994).

At the time of independence, the Zambian government inherited a very inequitable colonial health system with no specific policy on health; health was included in national development plans (Aantjes, et al, 2016). In order to address the inequity, the government had set an objective to improve and expand health services to cover all areas of the country by ensuring that that the health services are efficient and available to all Zambians free of cost (Simson, 1985).

Beginning in 1975, the country went through two decades of devastating economic deterioration, which eventually led to the fall of the one-party regime. This was following a decline in copper prices on the international market which was the major source of revenue financing health care including other sectors such as education. This had a significant impact on the health-care sector. As a result of two decades of economic downturn, Zambia was among the six countries that fell from middle-income to least-developed status in 1991. This had also resulted in shortages on vital commodities in health facilities, as well as excessive living costs, resulting in a number of riots (Kamwanga et al, 1999; Rakner, 2003).

In 1991, there was the introduction of democracy that supports capitalism; the State and non-state entities, including non-governmental organizations (NGOs) and faith-based organizations (FBO) came on board to supplement government efforts towards health care. This was in response to a decline in the state's provision of public services, which was caused by the poor socio-economic situation (de Montfort Shepherd et al, 2021).

The Zambian government has implemented policies to address some of the country's most serious concerns, such as human resource shortages and disease burden reduction including reducing the disparity in the accessibility of services. These measures primarily address HIV/AIDS and malaria, which are prevalent in the population. Although the government is in charge of policy and service delivery, cooperating partners, non-governmental and faith-based organizations play an important role in healthcare delivery in Zambia. Despite progressive policies, challenges such as limited healthcare funding, a high disease burden, and staff shortages, as well as poverty, inequality, and poor resource distribution in rural areas, have an impact on the healthcare system because these are inextricably linked to economic policies and infrastructure development.

4. Legal beginning of the system prior independence

Name and type of legal act	Public Health Act
Date the law was passed	1930
Date of *de jure* implementation	11th April 1930
Brief summary of content	This strategy's principal purpose was to oversee all elements of public health in Zambia. The policy includes disease prevention and control, protection of water and food supplies, mosquito prevention and eradication, and cemetery identification. Most critically, the Act addresses sanitation and housing (Public Health Act, 1930).
Socio-political context of introduction	Political power was held by the federal and territorial administrations, which were governed by the federal and colonial legislatures, respectively, from 1889 and 1964. Northern Rhodesia, now Zambia, established its economy on the exploitation of mineral reserves, mostly copper. The copper mines attracted immigrants of European descent from Southern Rhodesia (now Zimbabwe) and South Africa. Similarly, funding for healthcare largely relied on revenue from the copper industry which produced a political economy of health based on ensuring a plentiful supply of black labour (WHO, 1994). The British colony had replicated English common and statutory law to its acquired territories in America, Asia, Africa including Northern Rhodesia now Zambia. Among statutory laws, the Public Act of 1930 was in effect

Socio-political context of introduction (Continued)	up to the time Zambia got its independence (Public Health Act, 1930). It is worth noting that this act actually transitioned into the new government of 1964 coupled with the successive National Development Plans as major policy instruments to guide the provision of health care services in the country.

5. Characteristics of the system prior independence

a. Organisational structure

Aantjes, et al (2016), maintains that the health sector prior to independence was managed centrally by the Ministry of Health with headquarters in the capital city headed by a Minister who is appointed by the head of state, with some administrative tasks delegated to the provincial level and major hospitals. The core responsibility of Ministry of Health Headquarters was to oversee the entire health system while the provincial level offices and bigger hospitals were assigned administrative functions such as supervision. There were massive discrepancies in health care that existed from the pre-colonial and colonial periods to the time of political independence (Kamwanga et al, 1999). There was little investment in the health-care system. For example, rural areas, which had a larger population than urban areas, had to access health care services through mission hospitals which were introduced during the 19th century by the advert of the missionaries. At the time of independence, there were only 19 government hospitals in urban areas (WHO, 1994).

b. Coverage

According to Mwansa (1989) Zambia's population was divided into Europeans, Asians (who came into the country as traders and shop-owners) and coloureds (off-spring of black and white unions), and Africans, in that order of importance. There was discrimination in terms of accessibility; for instance, indigenous Zambians had designated health facilities that were different from the settlers. All this segregation was being done in line with the colonial policies and practices which were strictly colour-segregated (Mwansa, 1989). The colonists had a same approach when it came to accessibility of other social services. Indigenous (Zambians) were not entitled to access the same services with that of the settlers. For instance, settlers had designated shops, hospitals and schools et cetera. Most of the health facilities were concentrated in urban areas with a few mission hospitals in rural areas (WHO, 1994).

c. Provision

There is little literature that specifically indicates the amount of physicians and nurses who were available prior to independence. Nonetheless, it is obvious that there was a disparity in the supply of health care services between urban and rural areas, with rural areas having insufficient health personnel in comparison to urban areas. This imbalance was necessitated by the colonial government's objective of providing health to create a safer environment for the white expatriate population, and to maintain a healthy labour force for the industrial and commercial activities in die Colony (Aantjes, et al 2016; Mwansa, 1989). As previously stated, the majority of health-care facilities, such as hospitals, were concentrated in urban areas. The Copperbelt province (mining province) had the highest number because it produced more economic benefits from the copper industry. There were 48 hospitals and 306 health centers in 1964, with a total bed capacity of 7,710 (Mwansa, 1986). Government hospitals, mine hospitals, and a few mission hospitals were among the facilities. There was no equity in the provision of health care services; rural populations had insufficient health facilities simply because they had little to offer in terms of economic benefits to investors and the colonial government.

d. Financing

All Social services including the health sector were financed by the government through the mining industry; these included government and mining hospitals. The mission hospitals were funded through their respective charitable organisations both locally and externally (outside the country).

e. Regulation

The health sector was governed centrally by a Ministry of Health (MoH) with headquarters in the capital, with some administrative responsibilities delegated to the provincial level and larger hospitals (Aantjes et al, 2016).

6. Subsequent historical development of public policy on health care

a. Major reform I

Name and type of legal act	National Health Services Act
Date the law was passed	September, 1995
Date of *de jure* implementation	2nd March, 1996
Brief summary of content	This is an act to "establish [the] Central Board of Health; provide for the procedures for establishing management boards for hospitals and health services; to define functions and powers of such boards and their relationship and to provide for matters connected to or incidental to the foregoing" (National Health Services Act, 1995:2). In addition, the act was enacted in order to support the implementation of the health sector changes in Zambia (ACCA, 2013). It called for a significant shift in the Ministry of Health's mission and structure, as well as the formation of an autonomous health-care delivery system. The Act also aimed to "provide the people of Zambia with equity of access to cost-effective, high-quality healthcare as close to family as possible." (Kamwanga et al, 1999: 45). Access to health facilities, the availability of medications and other medical supplies, adequate human resources, and so on were the key indicators for quality healthcare services (Kamwanga et al, 1999). This commitment was in response to the health sector's challenges which included inadequate funds, a high disease burden, and staff shortages.
Population coverage	60.5 per cent were residing in rural areas while 39.5 per cent were residing in urban areas, accessing public hospitals, mission hospitals and a few through private hospitals mainly using the out-of-pocket system (World Bank, 2021). This was the case because there was no form of health insurance that could cater for the larger population. There were however a few employers or private health insurance systems, but the majority of the people needed to pay for their health care through out-of-pocket system.
Type of benefits	These included both primary care services and curative services. Primary services included, public health services, clinical services while the curative services included surgery, obstetrics, gynecology, medicine, pediatrics and laboratory or other specialised or supportive services (National Health Services Act, 1995).
Socio-political context of introduction	The Act was enacted while the country was still recovering from economic downturn in the 1970s and 1980s, which had resulted in a reduction of funding for the health-care services. Along with that, there was a shift in government systems, from socialism to capitalism. With the change of government came policy changes in health care. The majority of the population, largely rural, took time to embrace capitalism since it introduced cost-sharing for health-care services. People were required to contribute to health-care services, which had a ripple effect on their social well-being and eventually reduced accessibility to healthcare services (Seshamani, 2003).

b. Major reform II

Name and type of legal act	National Health Insurance Act No. 61
Date the law was passed	April, 2018
Date of *de jure* implementation	11th April, 2018

Brief summary of content	This Act accounts for the following: » Proper financing for the national health system. » Providing a universal access to quality insured health care services. » Establishing the National Health Insurance Management Authority (NHIMA), indicating its functions and powers. » Establishing the National Health Insurance Scheme (NHIS) and provide for its systems, procedures and operation. » Establishing the National Health Insurance Fund and provide for contributions to and payments from the Fund. » Establishing for accreditation criteria and conditions in respect of insured health care services. » Providing for complaints and appeals processes; provide for the progressive establishment of provincial and district health offices of the authority. » Providing formatters connected with, or incidental to, the foregoing.
Population coverage	The scheme covers employees of the formal sector (central government, local government, parastatal organizations, and the private sector and includes their spouse and up to four dependents). The informal sector, in which the majority of the population works, is also covered under the scheme. The government has continued to provide assistance to the poor and disadvantaged. According to a UNICEF report (2022), NHIMA had 68,000 informal sector principal members out of the 1.2 million currently registered, representing approximately 6% of the 7 million beneficiaries who could access services from a network of more than 200 accredited Health Care Providers.
Available benefits	Out-patient care, consultation, pharmaceuticals and other crucial medical products like blood plasma, surgical services. The scheme covers for the cost of minor, major, orthopedic, ENT and diagnostic surgical procedures, maternal, new-born and inpatient care services. Physiotherapy, vision care and spectacles; dental services, mental health and cancer and oncology services (NHIMA,2021).
Socio-political context of introduction	The development of the National Health Insurance program was necessary in order to provide all citizens with access to high-quality health-care services. This followed the repeal of the user fees policy, which was mostly favorable to the rural population, and the out-of-pocket system, which was relevant to the urban population. The government experienced challenges with health-care financing as a result of fiscal uncertainty, the health sector has been unable to function properly. For example, insufficient medical supplies have been coupled with insufficient human resources to meet the country's health-care demands.

7. Description of current health care system

a. Organisational structure

- The abolishment of the Health Services Act of 1995 in 2005 which had resulted in the dissolution of the Central Board of Health, gave birth to a current four-tier structure; Ministry of Health with responsibility for policy, regulation and standard setting, Provincial Health Offices, with responsibility for performance management at the provincial level, District Health Offices, with responsibility for coordination, planning and support at district level, Neighborhood Health Committees, with responsibility for overseeing services at the community level (ACCA, 2013). Zambia's healthcare system is decentralized; therefore, it is divided into three levels: hospitals, health centers, and health posts. Hospitals fall into three categories as primary (district), secondary (provincial), and tertiary (central). According to MoH (2017) the public health system had a total 1,956 health facilities, 1,926 at district levels comprising health posts, health centres and district hospitals targeting primary health care services. The secondary level had a total of 26 general hospitals/level two hospitals while the tertiary had a total number of 6 hospitals providing specialised health care. It suffices to state that the number of health facilities highlighted are still not adequate to meet the population demand. For instance, in rural areas, only 46% of the rural population reside within 5KM radius of a health facility, the rest have to cover more than a distance of 50KM to access their nearest health facility (ACCA, 2013).
- It offers universal healthcare to its citizens, yet Zambia's health-care system remains one of the most inadequate in the world. Since 1992, there have been efforts to address the inadequate health services through health reforms which has brought on board the private sector in the provision of health care services through

private hospitals where citizens that can afford can access services through insurance or cash (Zambia Development Agency, 2013).

b. Coverage

In Zambia, the healthcare system aims to provide services to various population groups. Healthcare services are typically available to citizens and residents. The specific coverage may vary depending on the type of healthcare scheme or program. Vulnerable groups, such as children, pregnant women, the elderly, and individuals with disabilities, may have specific programs or initiatives targeted towards their healthcare needs (MoH, 2022).

Zambia's healthcare system may have specific eligibility criteria that need to be fulfilled to receive services. These criteria can include factors such as income level, employment status, or contribution period (NHIMA, 2021). According to Health Policy Project (2016), Zambia's proposed Social Health Insurance scheme strives to cover all Zambians through a single defined financial pool. The initial phase of implementation is expected to cover 4.5 million Zambians, with a focus on formal sector employees and their dependents, as well as vulnerable populations. The second phase will expand coverage to include the general public, including more than 11 million people in the informal sector. There was a confirmation to this effect in 2022, where NHIMA had extended the membership to cover a population in the informal sector, with about 68,000 informal sector principal members out of the 1.2 million principal members who were currently enrolled. This corresponds to around 6% of the 7 million clients accessing services from a network of over 200 accredited Health Care Providers (UNICEF, 2022). The population that is not covered by NHIMA accesses health services through private insurances, that is for those in the formal employment as well as through the Universal Health Coverage for the vulnerable and poor population (Rudasingwa et al, 2022).

c. Provision

In the Zambian healthcare system, the provision of healthcare services encompasses various factors, as follows:

- Number of physicians and nurses: According to the 2020 World Bank report, the Zambia physician to patient ratio was at 1 to 12,000 compared to the ideal doctor patient ratio of 1 to 5,000. In addition, the report revealed that the nurse-to-patient ratio was 1 to 14,960, compared to the ideal of 1 to 700. Zambia faces challenges regarding the availability and distribution of healthcare professionals. The physician-to-population ratio and nurse-to-population ratio in Zambia are relatively low compared to international standards. The shortage of healthcare professionals, especially in rural areas, poses a significant challenge to providing adequate healthcare services. The government has made attempts to solve the human resource shortage by recruiting approximately over 11,000 health personnel in 2022.
- Number/density of beds in public for-profit, not-for-profit institutions: The number of hospital beds in Zambia is limited, particularly in public healthcare institutions. The availability of beds can vary depending on the region and healthcare facility. Private and not-for-profit institutions may also have a limited number of beds, although they generally offer better infrastructure and amenities. As of 2010, hospital beds per 1,000 people was at 1.0 (World Bank, 2020).
- Importance of inpatient and outpatient sectors: Both the inpatient and outpatient sectors are essential components of the healthcare system in Zambia. Inpatient care refers to services provided to patients who require hospitalization, while outpatient care includes consultations, diagnostic tests, and treatments provided without hospital admission. Given the resource constraints, outpatient care is crucial for managing non-emergency cases and reducing the burden on inpatient facilities (Reynolds et al, 2017).
- Service package inclusion: The service package in Zambia typically includes a range of healthcare services. Zambia has a strategy to strengthen health care delivery in order to attain universal quality health coverage by 2030 (Ministry of Health, 2022). The health care delivery package generally comprises of hospital care, outpatient services, preventive care, primary healthcare, reproductive maternal and child health services, basic surgical procedures, diagnostic tests, and some specialized services. However, the availability and quality of services may vary across different regions and healthcare facilities (Rudasingwa et al, 2022).

- Comprehensive assessment of the service package: In assessing the comprehensiveness of the service package in Zambia, it is important to consider the country's healthcare needs and available resources. While the service package covers essential healthcare services, there are challenges related to the accessibility, affordability, and quality of these services. The shortage of healthcare professionals, inadequate infrastructure, and limited funding affect the overall comprehensiveness and effectiveness of the service package (UNICEF, 2022).

According to UNICEF's Zambia health budget brief for 2023, the Zambian government has however made strides to address the shortage of health care professionals by recruiting 11,200 health workers in 2022 and an addition of 3,000 are yet to be recruited in 2023 (UNICEF, 2023).

d. Financing

In the Zambian scenario, the financing of the healthcare system primarily relies on multiple actors, including the government, social insurance schemes, private health insurance, and out-of-pocket payments. The government plays a significant role by allocating funds from the national budget to support the provision of healthcare services. The government's financing comes from general tax revenues and other sources. It is worth acknowledging that the allocation towards health has increased to 10.4% in 2023 from 8% in 2022 due to increased allocations towards the procurement of drugs and medical supplies (National Assembly of Zambia, 2023). A report by UNICEF (2022) shows that in 2022, 85% of Ministry of Health budget was largely from Zambia's resources. There is a notable increase recorded in 2023 to 92 % from 85% in 2022 (UNICEF, 2023). This shows a significant reduction on external financing which accounts for a 15% in 2022 to 8 % in 2023. It is however worth to note that there is still a significant external financing particularly on HIV related sources (UNICEF, 2023). The total budget for 2023 is 16 billion Kwacha (US$ 814,115.040.00) and 12.4 billion Kwacha (US$ 636,660,144.00) in 2022 and in terms of GDP, this increase translates to 3.3% in 2023 from 3% in 2022.

e. Regulation of dominant system

The Ministry of Health (MoH) is in charge of overseeing the provision of health care services in Zambia. The MoH's other primary responsibilities include policy formulation and administration. It is important noting that non-state entities are augmenting government efforts in the healthcare sector. Following a parliamentary act, the Health Professions Council of Zambia (HPCZ) was established and mandated to register and regulate all health facilities, both public and private, as well as training institutions in teaching health care sciences (Health Professions Act, 2009).

8. Co-existing systems

Various healthcare systems exist in Zambia, each with different population coverage, targeted social groups, and responsible actors for financing, service provision, and regulation. The National Health Insurance Scheme (NHIS) provides coverage for formal sector employees through contributions from employees and employers. The Social Health Insurance Scheme (SHIS) targets the informal sector and operates on a voluntary contribution basis. Community Health Insurance Schemes (CHIS) are community-based programs managed by local organizations, while donor-funded programs focus on specific health initiatives and involve international organizations, NGOs, and the Zambian government. The Ministry of Health and the National Health Insurance Management Authority play regulatory roles across these systems (Gavi in Zambia, n.d.).

9. Role of global actors

In Zambia, global actors such as international organizations, NGOs, and bilateral aid agencies play a crucial role in the provision and financing of healthcare. They offer financial aid, technical assistance, capacity building, service delivery, and resources to improve healthcare infrastructure. These global actors also influence the char-

acteristics of Zambia's healthcare system by contributing to policy development, promoting best practices, and supporting healthcare reforms. While their involvement in defining entitlements or eligibility for medical services may vary, they have regulatory responsibilities in areas where they provide funding or technical assistance. Key global actors operating in Zambia include the WHO, UNICEF, USAID, the Global Fund, Gavi, and numerous NGOs. Additionally, churches and charity organizations, particularly Catholic and Evangelical churches, are significant contributors to healthcare in Zambia, running hospitals, clinics, and healthcare facilities, especially in rural areas with limited access to government services. They rely on donations, fundraising, and congregational support to finance healthcare initiatives (ZAMPHIA, 2016).

10. List of additional relevant legal acts

In Zambia, several key healthcare acts regulate different aspects of the healthcare sector and they include the following:

- Health Professions Act of 2009: This act regulates the practice of various healthcare professions in Zambia, including doctors, nurses, pharmacists, and other allied health professionals. It sets standards for professional conduct, qualifications, licensing, and disciplinary procedures.
- Public Health Act of 1930: The Public Health Act addresses various aspects of public health in Zambia, including the prevention and control of communicable diseases, sanitation, food safety, environmental health, and the establishment and management of healthcare facilities.
- Medical and Allied Professions Council of Zambia Act of 1978: This act establishes the Medical and Allied Professions Council of Zambia (MAPCZ), which is responsible for regulating the training, registration, and licensing of medical and allied health professionals in the country. It ensures that healthcare professionals meet the required standards of competence and ethics.
- Pharmacy Act of 1941: The Pharmacy Act governs the practice of pharmacy in Zambia. It outlines the requirements for the establishment and operation of pharmacies, regulations for the sale and dispensing of medications, licensing of pharmacists and pharmacy technicians, and the regulation of pharmaceutical products.
- Mental Health Act of 2019: This act addresses the provision of mental health services in Zambia. It outlines the rights of individuals with mental health conditions, procedures for admission and discharge from mental health facilities, standards for treatment and care, and safeguards to protect the rights and dignity of persons with mental illness.
- National Health Insurance Act of 2018: The National Health Insurance Act establishes a framework for the implementation of a national health insurance scheme in Zambia. It outlines the financing mechanisms, coverage, and benefits of the scheme, aiming to provide affordable and accessible healthcare services to the population (MoH, 2017).

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