**Crunch Time: The Transformational Universal Health Coverage Agenda for Zambia**

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**Abstract**—There is a realization worldwide that health expenditure can be catastrophic, exacerbate inequalities between poor and rich households, and drive people into poverty. As such, a number of countries seek to provide universal health coverage (UHC) to all of their citizens in order for everyone to access quality health care without financial adversity. However, attaining UHC is difficult. It has also been recognized that there is no universal formula for attaining UHC and that each country must create its own. This article describes Zambia’s trajectory to achieving UHC from the 1990s to date. The article highlights some of the past institutional and financing reforms, achievements made, and gaps and challenges that the government is determined to address through an explicit transformational agenda that was launched in 2011. This agenda is being pursued with renewed vigor given that Zambia’s economy and population are growing rapidly, the time to transition from external support is fast approaching, and the disease profile is changing.

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**INTRODUCTION**

No one can fault the Zambians for not trying to improve their health system—but perhaps the criticism should be for trying too hard. Zambia has implemented a host of health reforms since 1992 aimed at attaining universal health care (UHC). Through a combination of institutional and financing reforms, in 1992, 1996, 1999, 2011, 2015, and 2016 Zambia has reorganized whole or part of the health system, focusing on various aspects of the health system building blocks. Despite differences in the nature and complexity of these reforms, health has continually been a politically important and priority sector in Zambia and, thus, the 1992 health reform vision of “equity of access to cost-effective quality health care as close to the family as possible”\(^1\) has been sustained with each successive reform. Consequently, Zambia has been in the spotlight for having implemented the
most ambitious, comprehensive, and rapidly implemented health sector reforms in the sub-Saharan Africa (SSA) region.\(^2\)

In particular, between 1996 and 2006, health service provision was decentralized while a national systemwide performance-based contracting (PBC) arrangement anchored on the new public management thinking\(^3\) and the principal-agent theory\(^4\) was implemented. Furthermore, Zambia pioneered the health sector–wide approach method of working in the health sector in 1992,\(^5,6\) which is still in existence though not as prominent as before. User fees were introduced in the early 1990s at all public and mission health facilities but removed from rural areas in 2006, peri-urban areas in 2007, and all primary health care facilities in 2012. Drug supply management reforms were also undertaken in 1996, which led to commercialization of operations at the central medical store by contracting it out and restricting its functions to storage and distribution. Manufacturing of drugs and medical supplies was also discontinued and the procurement function was transferred to the Ministry of Health.

What is evident from Zambia’s health reforms has been the desire to achieve UHC by using both supply- and demand-side instruments. Culminating from these reforms has been significant investment in the health sector over the past two decades, and this has contributed to improved service delivery and health outcomes. For example, Zambia is among the 21 countries in SSA that tripled their annual rates of reduction in under-five mortality between 2000 and 2015 compared to the 1990s.\(^7\) As a result, the under-five mortality rate declined from 182 deaths per 1,000 live births in 1990 to 63 deaths per 1,000 live births in 2016.\(^8\) Likewise, the maternal mortality ratio fell from 557 deaths per 100,000 live births in 1990 to 224 deaths per 100,000 live births in 2015.\(^9\) Despite these successes, maternal and child health and nutrition outcomes in Zambia are still poor. In fact, Zambia did not meet the health-related Millennium Development Goals even though some of the indicators were met. This could be attributed to low coverage of essential services particularly in rural areas and poor quality for the services available.

The key underlying challenges to improving health outcomes in Zambia are: (1) inadequate funds and limited options to create additional fiscal space; (2) severe shortages in human resources for health (number, distribution, skills mix, quality); (3) erratic supply of drugs and medical supplies; (4) limited availability and inequitable distribution of health infrastructure; and (5) poor governance and public finance management. In the absence of these key inputs and capacities, it will be difficult for Zambia to achieve UHC regardless of what form of health reforms are implemented. UHC, which refers to a situation where the entire population of a country has access to promotive, preventive, curative, and rehabilitative health care without suffering financial hardship, is currently on top of the health policy agenda in Zambia.

**DESCRIPTION OF ZAMBIA’S TRANSFORMATIONAL AGENDA FOR ACHIEVING UHC**

In Zambia’s perspective, UHC hinges on national development. This is confirmed from available evidence that suggests that the poor health status of most Zambians, particularly among the impoverished people, is a binding constraint to productive employment and inclusive economic growth.\(^10\) Therefore, based on lessons learned from past health reforms, an all-encompassing transformational agenda is currently being pursued with renewed vigor to achieve key health systems development objectives such as equity, efficiency, access, and quality. The key lessons learned from past health reforms are the following:

1. Sustained political will and commitment, strong partnerships, and sufficient funding are necessary for improving health service delivery. However, good governance and a focus on results are essential.
2. Decentralization of health services and PBC require clearly defined responsibilities between policy makers, implementers, and regulators to avoid duplication of functions.
3. Contracting out health services requires adequate financial resources, a comprehensive financing strategy, and technical capacities to achieve intended objectives.\(^1\)
4. User fees exacerbate inequities in access to health services by the poor. Demand creation and a people-centered health systems approach are key to improved health service delivery.
5. The health sector should operate within the government framework, procedures, and policies and with other public and private sectors that have a bearing on health.

Launched in 2011, the transformational agenda is part of Zambia’s national health policy that ascribes to the “health for all” principle. The agenda is also in tandem with Sustainable Development Goal (SDG) 3 target 3.8, which
requires all countries worldwide to “achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.” In particular, all aspects of the Zambian health system are being strengthened by using the primary health care approach with a view of shifting focus from curative to preventive community-based care. Existing inequities in access to health care by income status, geographical location, and other factors will also be addressed. To achieve this ambition, the National Health Strategic Plan 2017–2021, in which this agenda is anchored, focuses on six pillars. The six pillars are:

- Health care financing;
- Human resources for health;
- Infrastructure, equipment, and transport;
- Medicines, vaccines, and other medical supplies;
- Leadership and governance; and
- Health information technology and research.

Foremost, the Zambian government is currently exploring ways of implementing sustainable health care financing mechanisms aimed at reducing reliance on external financing and increasing domestic financing for health. This includes the introduction of a mandatory national health insurance scheme with a view of mobilizing additional funding for health to supplement existing tax and donor funding; transforming the payment mechanism from inactive to active purchasing; and providing more opportunities for both public and private health providers to serve a wider population to address inequities in access. Importantly, the payment system in the public sector will be transformed from input- to results-based, founded on local experiences from the PBC era, and results-based financing experiments that have been implemented in the country.

Secondly, the Zambian government is determined to eliminate health worker shortages by 2025. This will be achieved by increasing training, recruitment, performance, and retention of core health workers. In this regard, a national health training institute with an intake of 3,000 students per annum is currently being constructed. With this investment, the number of clinical health workers (doctors, clinical officers, nurses, midwives, and paramedics) will increase from 23,376 in 2016 to 61,020 by 2025 (Figure 1). On the other hand, the number of skilled attendants will increase from 11 to 21 providers per 10,000 population (Figure 1). This increment in human resources will be matched with investments in infrastructure, equipment, and transport. To this end, health facilities will be constructed and upgraded particularly in remote and hard-to-reach areas. This includes construction of 38 district hospitals, 650 health posts, and six specialist hospitals. Investments in human resources and infrastructure are expected to improve equity in access to health care, especially in rural areas.

In tandem with investments in human resources for health and infrastructure, a health sector supply chain strategy focusing on all of the key elements of the health supply chain cycle was developed in 2014. This strategy is expected to change the way essential medicines and medical commodities are procured, distributed, and managed in Zambia. Ten regional hubs for storage and distribution of medicines and

![FIGURE 1](image-url)
essential commodities will be established in an effort to improve the last mile distribution and access to quality drugs and essential commodities. By the end of December 2017, three hubs had already been operationalized and another three will be completed in 2018.

To develop an accountable, transparent, efficient, and equitable health sector that is responsive to the needs of the Zambians, leadership and governance structures have been realigned. For example, a department in charge of health promotion, environment, and social determinants has been created at the Ministry of Health to foster multisectoral actions on social determinants of health. In addition, multidisciplinary teams led by public health specialists have been created to follow patients in the communities and households to deliver a package of health promotion and prevention interventions focusing on wellness.

Lastly, considering that a viable health delivery system hinges on the availability of accurate, timely, and accessible health information for decision making, a fully integrated data-driven platform based on electronic health records will be developed as part of the government’s e-health strategy. The information system will aggregate data from several sources to produce a real-time performance management dashboard. This will allow implementers to instantly visualize performance against set targets and to pinpoint risks and opportunities to improve planning, resource allocation, and accountability.

PUTTING IT ALL TOGETHER

UHC is a journey that each country, regardless of its stage of economic development, should undertake to enhance economic growth and improve people’s welfare. For Zambia, the time to act is now. This is because as a lower-middle-income country, Zambia will soon be transitioning to lower levels of external health financing, which currently constitutes 48% of total health expenditure. Increasing government expenditure on health is critical for Zambia because existing evidence shows that government expenditure on health in Zambia is below what is expected for a lower-middle-income country. As such, Zambia is determined to commit sufficient government funding to the health sector, given that chances of achieving UHC are high if government or public expenditure on health is sufficient. Given that developed countries spend more on health than developing countries and that countries rely more on government funds to finance health care as their economies grow, it is likely that government expenditure on health in Zambia will increase as the economy grows.

Notwithstanding the above, there is no guarantee that higher levels of health spending automatically lead to higher service coverage and better health outcomes. This can be attributed to several factors including differences in the cost of service provision within and across countries and technical and allocative inefficiencies. For example, Zambia’s total per capita health expenditure is lower than in some lower-middle-income countries (i.e., Ghana and Nigeria) but has a much higher UHC service coverage index value of 56 compared to Ghana and Nigeria, which have values of 45 and 39, respectively. On the other hand, Kenya (a lower-middle-income country) and Zimbabwe (a low-income country) have UHC service coverage index values similar to that of Zambia even though their total per capita expenditures on health are much lower. On the other hand, there is a lower percentage of the population facing catastrophic health payments (SDG indicator 3.8.2) in Zambia compared to other countries in the SSA region. These results demonstrate that the path to attaining UHC is diverse and that each country must have its own distinct route.

In addition to increased government funding, technical and allocative inefficiencies should be addressed in order to eliminate unnecessary waste and to provide better services from available resources. This requires radical changes to strengthen health systems and to increase coverage of equity-focused priority interventions because these are key to achieving UHC.

CONCLUSION

Moving forward, Zambia is determined to build on progress made during the past health reforms by accelerating delivery of high-impact and cost-effective interventions, especially for people with the highest need. Good health is a public good, and if a few people in society become ill, the whole society is affected. The Ebola outbreak in West Africa and the 2017–2018 cholera outbreak in Zambia remind us of how disruptive and terrifying public health epidemics can be. Therefore, the time for optimism and action is now given that the Zambian economy and population are growing rapidly, the transition from external support is fast approaching, and the disease profile is changing. Indeed, the time to act is now.

NOTES

[a] The Zambian government failed to delink health workers from the Ministry of Health (purchaser) to the Central Board of Health (provider) due to inadequate financial resources to retrench all health workers. About ZMW400 million (42 million USD) was required to pay retrenchment packages to all health workers to delink them from...
the Ministry of Health. The failed delinking led to poor management of health workers in the health sector—that is, dual employment, duplication of jobs, and different conditions of service for similar jobs—which demotivated some health workers. 

[b] A skilled attendant is an accredited health professional who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period and in the identification, management and referral of complications in women and newborns. In Zambia, skilled attendants are doctors, midwives, medical licentiates, clinical officers, and nurses.

c] The UHC service coverage index is computed from tracer indicators on coverage of essential services. This index was developed to monitor UHC process on SDG indicator 3.8.1—coverage of essential health services. The index is correlated with under-five mortality rates, life expectancy, and the Human Development Index.

DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST

The authors declare no conflict of interest.

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