PART II

THE HEALTH SECTOR

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Introduction

In the previous chapters we have seen the agency demonstrated by health workers in the struggle to improve their livelihoods. Now we will see what this agency can lead to when it is played out in a national political and institutional arena. This section will trace a narrative of the health reforms, a political and bureaucratic process that aimed to change the status quo of the health sector. We will explore to what extent it succeeded. As we shall see, this process as well as other aspects of the health sector would be instrumentalised by Zambians at various levels. Was such instrumentalisation purely for private gain – self-advancement – or did it serve a political rationale, such as securing regime survival? Linked to this question, we will examine how the collective interests of health workers shaped the process of health reforms as well as the structure of power and allocation of resources in the sector.

In this section of the dissertation, we will explore the health reforms we were introduced to briefly in our first glimpse at the Zambian health sector in Chapter 1, and which we came across in health workers' accounts. In the next five chapters, we will trace the history of these reforms from their origin in Zambia's political transition of the late 1980s and early 1990s (and also further back in the mists of Zambia's colonial past), through their partial implementation up to their partial reversal in the early years of this century. We will analyse whether this experience with health reforms reflects van de Walle's 'syndrome of partial reform'. In doing so, attention will not only be paid to the policy plans and ambitions that underlay the reforms, but also to the political context that influenced these reforms. Moreover, the political arena in which the health reforms were negotiated was influenced not only by local politics but also by the donor community in Zambia, in addition to global economic and discursive realities. Therefore, the changing role of the policies and practices of international donors will also be given attention.

The narratives presented below will be based on this researcher's understanding of these developments, gained from informal interviews, formal interviews, policy documents, Zambian media articles on health, and archival material from the Netherlands Embassy in Lusaka, as well as secondary literature.

Genesis of the health reforms

In this chapter we will be introduced to the conceptual origins of the health reforms.[1] We will explore the question where the ideas behind the health reforms originated. Was this a Zambian process or driven by international aid agencies? In order to explore these questions, the focus will shift to one particular actor, Katele Kalumba, who was the midwife and progenitor of the ideas of health reform, reminiscent of the Gramscian concept of an organic intellectual. Kalumba was an academic, who in his doctoral research traced the history of the Zambian health sector from the colonial era to his contemporary times. This academic work created the inspiration for him to challenge the structure of the health sector and at the same time served as a denunciation of the eclipse of idealism: The perceived failures of Kaunda's UNIP regime.

Kalumba's dissertation, which will be dealt with in this chapter, was written at a time in which, on the one hand, technocrats within the Ministry of Health were working on ideas for reforming the health sector, while on the other hand, popular opposition to Kaunda's UNIP government was gaining momentum. Kalumba, with experience in the global North and within development agencies, was able to be a competent broker of ideas. He could mould discourse and seize opportunities to spur on a process that resulted in the health reforms that would later be heralded as an example to other developing countries. In the process, however, Kalumba also encountered opportunities to increase his own role of influence and launch his political career. As such, he would go on to play a role in the narrative he had written. However, as a result he would also become caught in the pitfalls of failed planning and reform he had accused his predecessors of. As an actor within an arena determined by various conflicting interests and realities, he failed to entirely change the structure of the health sector he had discredited, as we shall see in subsequent chapters. At the same time, he created dynamics of change that would provide opportunities for various actors to benefit from.

Introducing the health reforms

In the middle of the 1990s, Zambia's health reforms were heralded as a flagship example in the international health policy community. The state-of-the-art thinking about equitable primary health care for the population had been translated into ambitious policy plans and programmes. Moreover, under ostensibly committed leadership, concrete steps had been taken to implement these ambitions. What is more, donors were excited and eager to jump on board to back – and try to push forward – these showcase reforms.[2]

The health reforms, as with all human conceptual and discursive constructions, are extremely nebulous; in the process of conception, formulation, negotiation, and implementation, the reforms took a wide array of guises. In this process, ideas were frequently posed, elaborated, reformulated, rejected, or lay idle, as implementation of these ideas took a different turn in the political arena of different interests and influences which shape the health sector in everyday practice. By 1996, the health reforms would

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1 For a summary of the health reforms at their conceptual maturity, including a foreword by Katele Kalumba which clearly shows his academic and historical inspiration, refer to Annex I.

2 See for example, Lake and Musumali, 'Zambia'; Bennett, S., S. Russell & A. Mills, *Institutional and economic perspectives on government capacity to assume new roles in the health sector: A review of experience* (London, 1996); Bossert, T. *et al*., *Decentralization of the health system in Zambia* (Bethesda, 2000).

reach their conceptual maturity, building on insights conceived a decade earlier. By that time, a start was made in the implementation of many of the elements characteristic of these reforms. In Annex I a document that clearly captures these ideas is presented and analysed, which also shows strong links to the historical process of conceiving and developing these concepts, described below. Here we will limit ourselves to a summary of the key elements of the reforms.

The essence of the health reforms was to change the structure of the health sector, which had since its foundation been developed into a centralised set-up with a bias towards treating people in urban centres at the expense of rural areas and preventative health care. The health reforms would mean a devolution of decision-making and resources to the district level and the creation of participatory structures to better involve the community in decision-making. As the conception of the health reforms progressed and the first attempts at implementation had commenced, a secondary element of the reforms was developed. Gradually, the idea was conceived to move policy implementation tasks away form the Ministry of Health and to create a technical body which would be dubbed the Central Board of Health. In its ideal form, this would separate the technocratic realm from the political and move health workers from the civil service to contract employment. Though this element of the health reforms had not been part of the original plans, it would grow to symbolise the reforms and become the object of far-reaching power struggles.

Although the health reforms were the product of Zambian political and technocratic arenas, external transnational influences played a significant role. Donors played a large part in shaping the reforms and influencing the sometimes contradictory discourses on which the reforms were based. At the same time, the reforms also shaped donors' way of working. A key innovation on the part of donors was to fund the health reforms through a district basket fund, which meant that donor agencies would pool their funds and then channel them through Zambian allocation systems, rather than support distinct projects with reporting systems specific to each donor. However, to justify this leap of faith and in order to mitigate the risk of theft or corruption,[3] donors worked with technocrats in the health sector to develop systems. Such systems included a financial management and administration system (FAMS), operational planning and reporting systems, and a health management information system (HMIS).

The changes brought by these reforms would have a lasting impact on the further development of the health sector, despite the fact that major elements associated with the reforms would eventually be reversed. Most importantly, however, the reforms would be an object of struggle between various stakeholders. In this struggle various interests – private, group, regime, and institutional – would be defended and pursued. In the process, however, the health sector would be re-created and re-negotiated.

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[3] Known in jargon as fiduciary risks.

Kaka Wesu the developer[4]

Looking for the human factor in a political process also means giving a face to the key actors in the process. This means that due attention is given to the backgrounds and personalities of the politicians who played a role in the reforms. One personality has above all put a mark on the health reforms, as was indicated in the introduction to this chapter. This was Katele Kalumba – academic, technocrat, and politician who played the role of midwife and progenitor of the reforms. The narrative of the health reforms, its conception, implementation, stagnation, and partial reversal remarkably traces Kalumba's own professional and political breakthrough and prominence and, subsequently, his notoriety and ultimately his fall from grace.

When introducing Kalumba, let us start with his own presentation of his background. In an interview, Kalumba presented a self-glorifying image of himself. He claimed to be from a family of 'royal rebels'. His mother was from the Bwile Royal Establishment[5] in what is now Chienge District, and his father stemmed from the Mushima lineage of the Kaonde in Central Zambia. According to his account, an ancestor had fought the Lozi and refused to be subjected by the *Litunga*, the King of the Lozi, and joined Livingstone on his trek to Northern Zambia. There the ancestor stayed and married into the Katele clan of the Tabwa, a people who had fought colonial rule and had resisted Arab slave traders. Kalumba claimed that his father's participation in the colonial struggle, which led to his detention, was influenced by this background. Similarly, he suggested that his own political reformist zeal was explained by his heritage.[6]

A random encounter with a beer drinker in a Copperbelt bar gave an equally mythologized perspective on young Katele's early years. This man claimed that his father had gone to school with Kalumba. One year in secondary school, Kalumba had fallen ill and missed a large part of the year. The teacher had told him that he would probably have to repeat the year, but Kalumba studied hard and ended top of the class. While it is difficult to verify this account, it does illustrate the image Kalumba has as a driven and studious person, which is consistent with his further academic and political career.

After obtaining a bachelor's and master's degree in psychotherapy,[7] Kalumba proceeded to pursue a doctorate in Canada. In the meantime, he also carried out consultancies for donor organisations such as the World Health Organization (WHO), UNICEF, and an American aid agency.[8] A more obscure part of Kalumba's curriculum vitae was the fact that he had been an operative of the Zambian intelligence services

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4 This label was used for Katele Kalumba by his supporters in his constituency in various election campaigns in the 2000s, (see Figure 8.1). It combines the affectionate 'our' *Ka*tele *Ka*lumba with the influence he had in bringing development to the constituency. This does not represent who Kalumba was at the start of the reforms but rather who he became in local politics. The constant factor, however, was the role of being a broker who could straddle different realities to perform. Figure 6.1 shows a painting of Katele Kaluma, which adorns a bar annex guest-house he owns in Kashikishi, Nchelenge district.

5 The customary leadership of the Bwile people.

6 ML0812/01.

7 Zambian National Assembly website: http://www.parliament.gov.zm/index.php?option=com_content&task=view&id=349&Itemid=100&province=3&constid=65 (accessed 7 May 2009).

8 Lake *et al.*, *Analyzing*, 38-39.

since the 1970s.[9] According to a former colleague, this gave him contacts which were useful for politically selling the health reforms.[10] This also provides an impression of Kalumba's relative competence in melding different images and identities. Publicly and to me as a Western researcher, Kalumba was keen to present himself as a technocrat rather than a politician.[11] Indeed, as we shall see, as deputy minister and later minister of health, he played an important role in pushing the health reforms. At the same time, as we will equally see, in pursuit of a political career he did not shun getting involved in political ploys and power plays at odds with this technocratic image he cultivated. Finally, as will become clear from his greatest public controversy, his academic, technocratic image had as a counterpoint an orientation towards traditional medicine[12] and the practice of traditional 'magic'.

Figure 6.1 Tribute to Katele Kalumba

Conceiving the health reforms

Most documents produced by the Zambian government that mention the health reforms place the origin of the reforms in the political transition which brought the MMD to power. Indeed, as we shall see, the ideas presented above, which carried the reforms, were indeed formulated as the MMD was preparing its programme for the elections that brought it to power. In addition, as has been observed by others, the transition gave the

9 *Times of Zambia*, 'Mbula Unaware Katele Was Under OP', 8 March 2003.
10 ML0811/02.
11 *Post*, 'Chiluba Picks Katele As His Successor', 12 December 2000.
12 ML0810/01.

political impetus to and enabled this process, which challenged the status quo.[13] On the other hand, it is also important to recognise that these reforms built upon and reacted to earlier processes and interventions that shaped the Zambian health sector.

As the MMD was forming to call for and contest the first multiparty elections since the abolition of the one-party state, informal policy-advisory groups had been formed, comprising academics and professionals, to prepare a policy programme for the 'government in waiting'. As such, there was an MMD health committee that included three future ministers of health. Dr. Boniface Kawimbe, who would be the first MMD minister of health, chaired the group; another member was micro-biology professor Nkandu Luo, who would become deputy minister in 1996 and minister in 1998. Perhaps the most influential member of this group in conceptual terms was Dr. Katele Kalumba. He was charged with writing a health policy framework that lay the conceptual basis for the health reforms.[14]

This resulted in a policy document, 'Managing for quality: A healthy people policy', which was authored by Kalumba in September 1991 and was intended for discussions of the MMD President's advisory group. This document first launched the vision, which to this day represents the mission statement of the Zambian state-run health sector, of providing 'citizens with cost-effective quality health care ... as close to the family as possible'. Kalumba also formulated the principles of leadership, partnership, and accountability, which were required to guide this process. In order to justify the health reforms, Kalumba in this documents briefly sketched health problems and problems of service delivery that he linked to the 'general crisis of the Zambian state'. He explained that four trends underlay these problems. One was the demographic trend of a fast-growing population, and another was the increasing disease burden caused by the emergence of AIDS and drug-resistant malaria. The trends that Kalumba emphasised most, however, were more of a political-economic nature. The first trend he addressed was the economic process of structural adjustment. Rather than presenting a critique of the structural adjustment paradigm, Kalumba apparently recognised the political economic reality that health services had to be delivered in 'the context of a limited resource base'.[15] In other words, health and social policy had to be 'structural-reform sensitive', something he claimed had not been possible under 'medical-bureaucratic incompetence fuelled by UNIP political patronage'.[16]

The final trend Kalumba described as negatively impacting health and social development in Zambia was the 'increased political bureaucratisation and centralisation of health care' which caused this 'medical-bureaucratic incompetence'. He claimed this was the definitive problem that health reform needed to tackle. He explained that the 'pyramidal organisation' of the public health sector was based on the logic of state administration, which affected the distribution of resources in the sector. This meant that a geo-spatial hierarchy had been created which classified rural areas as 'less complex' whereas urban areas were considered 'more complex'. This inequity has resulted in people in rural areas 'bypassing or ignoring under-serviced rural health centres, and resisting the burdens of preventive health care strategies' as a means of enforcing their claim on public health budgets. The answer, Kalumba argued, was an 'equalisation process' that was based on a common operational level of district health governance.

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13 See Lake & Musumali, 'Zambia'; Lake *et al.*, *Analyzing.*
14 Various interview data (ML0811/02, ML0706/03, ML0706/04); Lake *et al.*, *Analyzing.*
15 Kalumba, K., *Managing for quality: A healthy people policy* (Lusaka, 1991), 4.
16 *Ibid.* 2.

Following from this, the document also articulated the essence of the health reforms that would follow: A health sector that considered the district to be the primary focus of health management, in reaction to the equity problems the sector (and the country as a whole) had faced.

After having presented his diagnosis of the health sector and the vision and principles that should guide the MMD's new health policy, Kalumba proceeded to propose a number of initiatives to arrive at 'a healthy people package' of policies. These initiatives included enhancing the roles of consumers, integrating the private sector into health care provision, and improving quality assurance. He also advocated better teamwork and conditions of service for health workers. The main focus of the proposals put forward by Kalumba, however, was on management systems. Rather than the Central Board of Health that we referred to above, Kalumba's proposal called for establishing a national health council to examine, prepare, and propose policies for the health sector. He also called for the establishment of district health councils to which decision-making authority would be decentralised and which would ensure community input into decision-making. Analysing this document, it becomes clear that though this document is more theoretical and political than the National Health Strategic Plan,[17] both in terms of the ideological justification and in terms of actual policy proposals, the contours of the health reforms as they would be presented a few years later were already clearly visible. It also shines light on the instrumental role of Katele Kalumba in the design of these reforms.

A number of people interviewed shone some light on the dynamism of these early days in which the health reforms were conceived. One former colleague of Kalumba at the Department of Community Medicine of the University of Zambia, where Kalumba worked as a lecturer, remembered how Kalumba would sit in his office at the end of the working day and work on MMD policy documents together with friends such as the prominent political analyst, Neo Simutanyi.[18] Another respondent, a medical doctor who as a student attended some of Kalumba's lectures, remembered that while Kalumba was working on the MMD health policy, he would bounce ideas on health reforms off the students. These anecdotes gave the impression that the respondents felt that they were witnesses to a significant historical process.[19]

Piecing together a narrative of the genesis of a significant policy process on the basis of eye-witness accounts from people, who have seen part of the process themselves and heard of other parts from others, one may risk contributing to the creation of a mythology. Errors can easily slip into one's understanding of events. One such misunderstanding evoked by some respondents was that Kalumba had formulated the ideas on health reforms as part of the 'MMD manifesto'.[20] In fact, the manifesto that the MMD circulated during the election campaign contained a small paragraph on health, which presented ten points and which made no reference to reforms or to the core elements of reform such as decentralising decision-making to the district level. While it did mention promoting primary health care,[21] encouraging the private health sector, and restructuring

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17 Annex I.

18 ML0706/10.

19 ML0706/13.

20 This misunderstanding influenced a publication on health reforms in an earlier phase of this research: Leenstra, M., *Beyond the façade* (Leipzig, 2007), and also H. Mahler *et al.*, *Independent review of the Zambian health reforms* (Geneva, 1997).

21 As well as psychiatric health care and maternal-child health.

the administration of the ministry, the manifesto did not reflect the language or the focus of Kalumba's document. In fact, it reflected more mainstream language on health, with arguably a curative and a hospital bias. Perhaps this paragraph was written by Boniface Kawimbe, the chairman of the MMD health committee, a surgeon more oriented towards hospitals, rather than by Kalumba.

It would be a misunderstanding to isolate the political process advocating for health reform from initiatives and ideas that had earlier been formed within the Ministry of Health. As reported by Lake *et al.*, around the same time as Kalumba was formulating his ideas, there was a group of professionals, senior officials at the ministry as well as some representatives of the donor community, who 'were tired of the mediocrity' within the sector. They had started a process of restructuring that formulated ideas on decentralisation and built on the idea of autonomous management boards within hospitals, a possibility that had been created by a medical services' act passed by Parliament in 1985 but never fully implemented. This act had not only paved the way for the creation of hospital boards but also for the introduction of cost-sharing.[22] According to one of the senior officials involved, Kalumba had interacted with them, sharing ideas which he politically sold to the MMD.[23] Indeed, Kalumba, at the time when he was a lecturer and after having completed his doctorate in Canada, served on an advisory body of the ministry, the national primary health care committee. It would thus be appropriate to assume that the political process leading to health reforms came from a concerted effort in which various individuals' ideas came together. Thus, despite the role others attribute to Kalumba[24] as well as the impression he gave himself in the interviews he gave to me, it would be a mistake to see the health reforms as merely a one-man show. Nevertheless, as Kalumba was such a prolific writer, it is easier to discern his fingerprints on the historical process than others'. As we say in Dutch: W*ie schrijft, die blijft* – "he who writes, stays".

It is evident that reform was a reaction to the structure of the health sector in the Kaunda-era, a structure that was considered to be problematic. In his political document, Kalumba had alluded to structural, political-bureaucratic deficiencies of the health system in the UNIP era. It is understandable that a member of a political movement in his discourse distanced himself from the system he was opposing. Later we will see whether in his actions he would distance himself from what went before, but first let us look back to further examine the structural deficiencies that the health reforms sought to address. Again, to do so, we have to turn to Katele Kalumba's writing in order to gain such insight, as his unpublished doctoral dissertation is the only comprehensive work on the development of the Zambian health sector from the colonial period up to the eve of Zambia's Third Republic.

'Symbolic power and urban bias: Limits to health reform in Zambia'

Kalumba's dissertation, in which he sketches the development of both the policies and the structure of the Zambian health sector, at the same time provides the justification and the rationale for health reforms. His assertion in the MMD policy framework that the health system had undergone a trend of political bureaucratisation and centralisation

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[22] Lungu, G.F., 'Decontrolling or entrenching ministerial oversight in the Zambian health services system: The case of the Medical Services Act of 1985'. *Zambian Law Journal*, 18 (1986), 93-107.

[23] ML0804/07.

[24] As reported by Lake *et al.* from their interviews, as well as by various of my own respondents.

was directly drawn from his doctoral dissertation.[25] In this dissertation he argued that the nationalist government had, at Independence, inherited a health system that was based on a structural inequity, in which divisions ran along geographic and racial lines. He contrasted an urban health system oriented towards complex health care with a rural system oriented towards less complex care for the African population. This he attributed to the phenomenon of 'rural down-classing', the result of organisational and discursive strategies that portrayed rural areas as unproductive and unable to contribute to health care and, therefore, justifiably receiving a smaller part of scarce resource allocations. He further argued that under the one-party state, health policy makers had not been able to fundamentally challenge these inequities. While the first decades of Independence showed a significant expansion of the health infrastructure, it also solidified the colonially inherited, pyramidal organisation of the health sector, which was biased towards tertiary curative care in urban centres and against the majority of the population.

Kalumba on the colonial roots of health reform

Let us now follow the data and the analysis provided by Katele Kalumba's dissertation, to examine his argument of the inequitable set-up of the health sector. This will allow us to go back to the roots of Zambia's health system and to trace its development from there.[26] Modern medicine[27] first entered what is now Zambia with Dr. Livingstone. However, as Livingstone was just a passing visitor,[28] one could not claim that this lay the basis for a health care system as such. Arguably, the same applies to the period in which the British South Africa Company administered the area. While this period saw the first establishment of health care, it was little institutionalised. Kalumba reported that around 1913, the company employed a medical staff of 15, with a matron and 5 nurses. Company doctors were allowed to privately offer their services to European settlers in the territory. While Kalumba asserts that any services that were rendered to Africans by these doctors were entirely incidental,[29] these doctors did medically examine African labour recruits. The aim of these examinations was to see if these labourers were fit for employment in the mines.

The decades between the takeover of the administration of the territory by the Colonial Office in London and the end of the Second World War saw the establishment of a rudimentary, formal health bureaucracy. This period also saw a gradual expansion of the capacity to deliver health services. In 1930 a public health ordinance was passed which defined health authorities in the territory. According to Kalumba, however, while

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[25] In fact, parts of this political document have been literally copied from his dissertation. For example, part of the wording of the fifth paragraph of the third page of the MMD policy framework is literally copied from the second paragraph of page 372 of his dissertation.

[26] Much of the remainder of this chapter provides an analytical summary of Kalumba's thesis. The justification of presenting this here is that it provides insight into the rich data on which Kalumba based his argument. At the same time, it provides a historical context for our narrative on the health reforms. This is not to suggest, however, that this section presents a proper historiography, as it merely bases itself on one source. At the same time, presenting this information here also serves to highlight the value and uniqueness of Kalumba's dissertation as both a primary and a secondary source on the history of the Zambian health sector.

[27] It would be a misnomer to refer to this as 'Western' medicine as this would disregard the medical profession's historical debt to various renowned Arab physicians.

[28] Although his heart was buried in Zambia.

[29] Kalumba, 'The practice', 66.

it had been designed as a major public health intervention, it remained irrelevant to the majority of Africans as it failed to extend medical services to Africans beyond mining camps and administrative centres. It was accepted as a practical problem by colonial administrators that it would be too costly to expand medical services meeting European standards to meet the needs of the African population. The country was seen as too large and available resources as too limited. In 1936 there were reportedly 12 government stations with medical officers, of which 10 primarily served European interests. In addition, there were 23 rural dispensaries serving the rural African population 'staffed by very imperfectly trained native assistants'.[30] By 1946, however, the number of government-run rural dispensaries had been expanded to 59. Furthermore, by that time there were 13 'African hospitals' in towns, 6 of which were along the line of rail. In 1946 over 120,000 out-patient cases were treated in these hospitals, as well as over 23,000 patients being admitted. There were also welfare clinics in urban areas accessible to Africans. Initially, the funding for these clinics was raised from 'canteen funds' (profits from beer halls), but from the 1940s, central government contributed from its revenues.[31]

The provision of health services was not only a government responsibility in colonial Zambia. Authorities held mining companies responsible for the healthcare of their own staff. In the compounds of mining townships, labourers who were found ill were taken to hospital to ensure a quick return to work. Gradually, as the mining sector grew as well as the hospital facilities mining companies provided, mining companies' medical services were expanded to also offer fee-paying services to patients other than mining staff. Mining hospitals thus formed an important contribution to healthcare provision in the towns of the Copperbelt and in Broken Hill (now Kabwe).

Healthcare in rural areas was to a large extent left to the initiative of missions. In fact, Kalumba quoted Haslam, who reported that he was told on arrival in Northern Rhodesia in 1936 that he was to leave 'African work' to the missions, who possessed the missionary spirit that government did not have. In 1935 there were 27 mission medical institutions, of which 6 were run by qualified practitioners, and by 1946 this had grown to 75 mission health posts. Kalumba reported that these mission health services were partially funded by the colonial government, and the government consulted with the North Rhodesian Christian Council about mission medical services. He also reported criticisms that missions would provide services primarily to their own congregations and that medical work was at times considered subservient to gospel work. It would not be unusual for missionary medical or nursing staff not to be replaced for over a year or for staff to be absent for weeks conducting evangelical tours. The government health department also reportedly criticised some missions for their attitudes towards venereal diseases.[32] Some would not treat these diseases, considering them sinful, while others would charge fees for this treatment when other services were free.[33]

After the Federation with South Rhodesia and Nyasaland had been created, responsibility for healthcare policy and provision was shared between the federal and territorial governments. An issue for Zambian nationalist politicians had been the equity of spending between the parts of the federation, as there was a fear of revenues from the

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30 *Ibid*. 84, quoting Haslam.
31 *Ibid*. 86.
32 In modern jargon, sexually transmitted infections (STIs).
33 *Ibid*. 86-89.

north flowing to public service provision in the south. Kalumba also wrote of inequity in healthcare spending and investment. Of course, Southern Rhodesia had a different socio-political and economic position, having undergone a more significant influx and settlement of Europeans. While there were significant internal disparities in Southern Rhodesian healthcare, there were more high-standard hospitals, and more financial and human resources than in the north. Even in rural areas, there was a healthcare system based on wide access to hospital care with 61 rural hospitals and 11 rural health centres compared with 28 hospitals and 133 rural health centres in the north[34]. In the Zambian part of the federation, the health sector expanded, despite the fact that investment was biased towards the south, but internal inequalities continued in the territory. Kalumba wrote that health services were primarily designed for the white settler population. Whereas there were 6.5 beds per 1,000 Europeans, there were 2.5 beds per 1,000 Africans in government and mission hospitals.

It will be no surprise that human resources, or manpower as it was called at the time, were lacking. We saw above that in the British South Africa Company era, available personnel were modest in numbers, and that in mission institutions qualified staff could be lacking and 'native medial assistants' were 'imperfectly trained'. Nevertheless, numbers of staff working in healthcare had expanded. By 1951, 300 Europeans were working in public health, both in medical professions and as administrative personnel. At the same, there were 786 Africans working in the sector, mostly as medical assistants and clerks.[35] In Chapter 1 it was noted that very limited education opportunities existed for Africans in the colonial period. Kalumba quoted Mwanakatwe that at Independence there were only 100 university graduates and 1200 Zambians with full secondary-school certificates.[36] It can be assumed[37] that many of the medical assistants before their training had only a few years of formal education. As regards more advanced training, it was not until 1959 that the first three Zambian men were sent to South Africa on a government bursary to study to become medical doctors.[38] Thus, at Independence, the human resource base of the health system, as with the entire public sector, was still predominantly based on European professional labour.

Having described the evolution of the public health sector that the nationalist government of Kaunda inherited in 1964, Kalumba concluded that the allocation of healthcare resources between Europeans and Africans, between urban and rural areas, remained fundamentally unequal. This was in spite of the colonial health plans that had been made by his historical 'predecessor', Haslam, as well as subsequent administrative reforms by the colonial and federal health services. In interviews,[39] also, Kalumba asserted that the colonial health sector was mainly designed to serve the white settler population and to keep Africans healthy as a labour population. Other healthcare claims were 'down-classed' by the policy discourse of administrators. 'The politico-administrative structure made it unthinkable for health policy planners to question the allocative logic of the health care benefit structure across racial or regional lines'. Kalumba further claimed that the advances that were indeed made in expanding health services to

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34 Both governmental and mission.
35 *Ibid*. 102.
36 *Ibid*. 116.
37 This was also confirmed by an elderly respondent who trained as a medical assistant. LB0809/05.
38 *Ibid*. 124.
39 This was echoed in an interview with another architect of the health reforms, a former senior official of the Ministry of Health. ML0706/03.

Africans were part of a strategy of 'normalisation' rather than the alternative strategy employed by colonial authorities: Repression. He argued that a 'scheme of perception' was created that there were welfare benefits to being a colonial subject.[40]

The perspective chosen by Kalumba in framing his narrative thus highlights the moral problem of inequity. This is, however, but one of the aspects that characterises the evolution of the health sector that Zambians had inherited from the colonial period. This moral perspective, however, phrased in social science discourse, eclipses an empirical observation that can also be made from the data Kalumba presented in his dissertation. This observation is that a system for service provision (however imperfect) had been created and had seen a significant expansion in an area where those services had been unknown before. It is easy for me to sympathise with this focus on inequity, coming from a field of work and studies that aims at pro-poor development. However, regardless of normative considerations, there is a rational explanation for the emphasis on equity, as it fits in well with the political discourse of the independence struggle. Given that the aim was to gain power though the support of the populace, this discourse naturally did not focus on the benefits created by colonial rule. Rather, the focus was on the injustice of the down-classing of the indigenous/autochthonous majority of the population: The fact that whites had access and blacks, as second-class citizens, did not. That the ideology of the independence struggle inspired Kalumba in the writing of his dissertation and his subsequent political endeavours is evident from the acknowledgements he presents in his thesis. He dedicates his research to his father Katele Mushima and a comrade who for him symbolised the 'silent UNIP nationalist majority', who were detained during the *Cha Cha Cha* nationalist struggle for independence and who together with Kalumba watched 'with awe the fading of a social democratic vision'.[41] We will now continue our exploration of the history of the Zambian health sector through Kalumba's dissertation by looking at the post-colonial period up to the mid-1980s. This will shine light on this perceived 'fading of a social democratic vision', or what Kalumba calls 'the eclipse of idealism'.[42]

Kalumba on Health 'reform' in the Kaunda era

As Kaunda's post-Independence UNIP-government came to power in 1964, it presented a political programme aimed at development based on the principles of equal opportunities. This reflected a nationalist ideology, which was initially labelled African democratic socialism but was later given the label humanism. In the health sector, UNIP undertook to provide free healthcare to its citizens and to ensure that every Zambian would be at walking distance from a health centre and at a reasonable distance from a fully equipped hospital.[43] Kalumba, however, claimed that soon after Independence these political objectives were transmuted into administrative ones and that rather than basing health sector allocation on a logic of equitable access in response to popular demands, allocations were based on a logic of scarcity, reflected in bureaucratic regulation.[44] In the first major national policy framework, the first national development

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40 Kalumba, 'The practice', 102.
41 *Ibid.* Acknowledgements, page unnumbered.
42 The title of an academic article co-authored by Freund, P.J., K. Kalumba & P.J. Freund, 'The eclipse of idealism'. *Journal of Health Policy and Planning* (1989).
43 On this, Kalumba quoted Kaunda: *Ibid*. 128 and 180.
44 *Ibid*. 130.

plan,[45] healthcare had to compete with policy priorities such as economic diversification, infrastructure development, and education and was only allocated 2.1 per cent of public investment, though actual expenditures were 50 per cent more than planned.

As healthcare had been partially a federal responsibility before Independence, the relatively small territorial headquarters in Lusaka, tasked with implementing the policies of the federal ministry in Salisbury, had to be transformed into a Ministry of Health. Meanwhile, considering the shortage of educated Zambians and the emigration of personnel following Zambia's independence, the ministry had to depend on a few colonial officers willing to stay behind. Because of the lack of staff, these officers not only bore the burden of carrying out routine tasks but also retained continued control over the sector. Formally, the head of the ministry was the minister, who was assisted by a parliamentary secretary. The top-ranking civil servant, meanwhile, was the permanent secretary, who was also director of Medical Services. While the minister and the parliamentary secretary were responsible for publicly articulating issues of public health, as well as controlling the public health bureaucracy to ensure that it was in-line with government policy, Kalumba doubted they provided effective executive leadership. He attributed this to the fact that bureaucrats saw these politicians as uneducated and unable to grasp the issues involved in public health.[46]

This tension between black politicians and white civil servants illustrates for the health sector what the entire Zambian public sector faced. How could an administrative bureaucracy, not only inherited from colonial rule but also staffed by officers who arguably retained a colonial administrative dispensation, be used as an instrument to attained nationalist political objectives. As we saw in Chapter 1, there was thus an evident political motive for tightening political control over the bureaucracy, originating in a political mistrust of bureaucracy. In the health sector this political control was ostensibly increased by replacing the parliamentary secretary with a minister of state who, like the minister of health, was also a member of the National Assembly and appointed by the president. The permanent secretary was also appointed by the president, though the secretary had to be a qualified medical doctor. At the end of the 1970s this was a Nigerian, who was also director of medical services and the president's personal physician.[47]

Kalumba provided an illustration of a concrete issue in which the struggle between Zambian politicians and expatriate technocrats came to the fore. In the years after 1964 a parliamentary bill had been drafted to create a Medical Council. This council would be charged with regulating and registering the medical and allied professions such as dentists, pharmacists, and paramedical staff. During consultations, however, the Medical Association, which represented doctors and consisted primarily of Europeans, had objected to two provisions of the draft bill. They felt that the minister could only designate qualifications for professionals after the council had approved and that members of the council should not be appointed by the minister, but rather by the professions. The Cabinet, however, rejected the modifications proposed by the Medical Association. Then in 1966, despite an appeal by the association to its members not to accept an invitation to the council, the council was established. This, according to

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45 There was no major separate policy framework for health.
46 *Ibid*. 137.
47 ML0811/02.

Kalumba, showed that the government was politically determined not to be dictated to by expatriate professional interests.[48]

In the first years after Independence, the ministry headquarters was expanded from an establishment of 63, including the minister, to 101 in 1965, to 165 by 1967. In practice, however, the actual staffing in these years was only 48, 66 and 94, respectively. The main shortfalls were at clerical and lower levels. The ministry was in practice divided into three divisions: Medical services, preventive services, and administrative services, which were headed by the permanent secretary's deputies. Also as of 1968, in-line with the government's idea of 'decentralisation within centralisation', some administrative responsibilities were delegated to the provincial level as well as the largest hospitals. At provincial level, there was a provincial medical officer assisted by a provincial medical assistant and a provincial health inspector. Administrative, personnel, and financial issues at this level were put under senior executive officers.[49]

Service-delivery level saw a truly enormous expansion in the first few years after Independence. According to figures collected by Kalumba from Ministry of Health reports, the number of hospitals in the country grew from 48 in 1964 to 76 in 1971.[50] The government constructed 17 of these new hospitals, the missions 9, and the mines 2. This meant that the total number of beds and cots in hospitals grew by 55 per cent from 7,710 to 11,919. At health centre level the expansion was also enormous. In rural areas over the same time period, the number of government and mission health centres grew from 250 to 418.[51] The number of urban and industrial clinics meanwhile grew from 56 to 138.[52] Whereas the absolute expansion of health centres was far greater in rural areas, with 168 new rural centres constructed, the relative expansion was higher in urban areas, as the number of urban clinics grew by 146 per cent, compared to a 67 per cent growth of rural clinics. Although the growth in the number of health centres (82 per cent) was relatively greater than the growth of the number of hospitals (58 per cent), the number of beds and cots in health centres grew only by 29 per cent to a little over 4,000.[53] Thus, the number of facilities grew at a faster rate in rural areas than in urban areas, while the bed capacity did not.

At the same time, this expansion of physical healthcare infrastructure was taking place in a context of a structural shortage of human resources. Kalumba reported that at the time of Independence there were only 151 doctors in the country, of which 77 were employed by the government, 47 were working for the mines, and 27 were in missionary service.[54] As reported above, only 3 of these doctors were in fact Zambian. It comes then as no surprise that training of medical staff was a considerable priority for the health sector. In 1968, pre-clinical teaching of medical students had begun at the University of Zambia. Two years later a school of medicine was established, linked to what has since become known as the UTH in Lusaka. The first batch of graduates

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48 Kalumba, 'The practice', 144-145.

49 *Ibid*. 137-139.

50 In 1971 there were 36 government hospitals, 28 mission hospitals, and 12 mining hospitals, with hospitals being differentiated by the criterion of having a full-time doctor on its staff. *Ibid*. 157a.

51 Government rural health centres grew from 187 to 339, while mission clinics grew from 63 to 79.

52 For government clinics this corresponded to an increase from 39 to 89, while for mining and other clinics this was a growth from 17 to 49.

53 *Ibid*. 157a.

54 *Ibid*. 132.

attained their full medical qualifications in 1973.[55] A consultants' report commissioned by the World Health Organization in 1966 had recommended an initial intake of between 40 and 56 students.[56] According to one of the second batch of students, however, in his output there were 13 qualified doctors, 4of whom were black Zambians.[57] In establishing the medical school, the aim had been to produce doctors in accordance with international standards and competence, though with special experience in preventative and social medicine relevant for a developing country and specifically for rural areas. At the same time, a programme of training nurses in accordance with international professional standards was established at the teaching hospital. State-registered nurses were trained in a four-year programme. The syllabus followed was the state-of-the-art in nursing, modelled after recent training reforms for nurses in Britain. The ministry disregarded the criticism of this system, that it imposed a too-heavy burden on limited resources.[58]

Since before Independence, a system of training nursing auxiliaries and female medical assistants had existed. This system was reformed to train Zambian enrolled nurses, preparing them specially for practical nursing duties. The regular nursing syllabus was condensed, leaving out more theoretical training, and the course was shortened to three years, despite protests from doctors and nurses who felt this threatened professional care. The programme for male medical assistants,[59] however, was expanded to four years. This cadre was specially trained as medical auxiliaries in smaller hospitals and for independent practice at rural health centres. The training programme, however, was structured to allow for a career perspective. As Kalumba rightly remarked, this not only meant upward career mobility but also spatial mobility: From rural to urban areas. Finally, health inspectors were trained at Evelyn Hone College, though this was under the responsibility of the Ministry of Local Government, not Health. Meanwhile, for all professional categories, examinations were conducted along the standards of the Royal Society of Health in London.[60]

Although the decision-making processes involved have not been studied in detail, it is striking to note two logics that played a role in these reforms. One logic valued international professional standards, which may have biased urban areas as it may have imparted skills less appropriate for rural healthcare: Higher standards correspond with more complex technology, which needs infrastructure and resources more commonly found in urban centres. At the same time, there was a separate categorisation made by training medical assistants to be specially suited for work in rural areas. This thus fits in with Kalumba's argument on down-classing. Another logic involved the gender roles in healthcare, which reaffirmed professional categories for men and women, by which men were categorised higher than women, as we saw in the distinction made between male and female medical assistants. Kalumba recognised the gender categorisation here, but he could have also termed this gender down-classing. Without further study, it is impossible to analyse the interests and perspectives of different stakeholders in the process that led to these policy decisions. As it would be nearly impossible to retrospectively

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55 UNZA School of Medicine. http://www.medguide.org.zm/school.htm#school (accessed 28 April 2009).
56 Kalumba, 'The practice', 148.
57 ML0811/02.
58 Kalumba, 'The practice', 149-150.
59 Who would be renamed as 'clinical officers' in the early 1980s.
60 *Ibid.* 150-152.

reconstruct this for the period discussed, it is more feasible to look at health workers' perspectives in the present, as we did in the earlier part of this dissertation.

Getting back to the late 1960s, the policy aim of the focus on training in the early post-Independence years was not only to respond to shortages, but also to Zambianise the staff establishment of the health sector. As we saw in the description of the political and bureaucratic top of the ministry and in the illustration of the creation of the Medical Council, the fault-line of African politicians and European technocrats had its tensions. In part, this was based upon the mistrust of the politicians as to whether expatriate technocrats would or could further the nationalist political aims of government. Kalumba noted that official plans framed this discourse on Zambianisation in terms of 'national security', and that 'patriotic' support was expected from policy analysts.[61] It can also be assumed that providing jobs for 'the people' UNIP was representing, including ordinary Zambians, party members, and relatives was an important motivation for this policy[62]. The policy of Zambianisation can thus be argued to have been an instrument in the struggle for control over the sector, including the benefits this meant such as access to jobs.[63]

The other side of this argument, however, was provided by the logic of valuing professional standards and qualifications, or what can be referred to as the merit principle. This limited the possibilities for Africans to claim job opportunities to the capacity to train staff. The possibilities to overcome shortages by training were limited. At the same time. the need for manpower was growing together with the physical expansion of health facilities. Thus, recruitment of expatriate medical staff remained necessary for much of the immediate future. By 1969 the number of doctors in Zambia had grown from 151 to 527, of whom only 19 were Zambian nationals. The government employed 333 doctors, including 19 at the university. The missions had 37 doctors working for them and the mines and industry employed 94.[64]

In the years running up to the establishment of the one-party state, Zambian planners undertook to create a second national development plan. This process included the drafting of sectoral development plans, including a ten-year national health plan for 1972 to 1981.[65] This plan was prepared by a committee under the chairmanship of the permanent secretary and made up of three other senior Ministry of Health officials, a member of the National Assembly, a representative of the World Health Organization, one representative of the medical services of the mines and one for the missions, two academics, and a representative from the Ministry of Planning. The committee was supported by a consultant in health planning from the World Health Organization. Only two of the members of the committee were not medical doctors, thus suggesting, according to Kalumba, a significant technical rather than political bias.[66]

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61 *Ibid.* 280.

62 Miles Larmer described how Musakanya, the first head of the Civil Service in post-colonial Zambia, complained that liberation heroes were given positions in spite of the merit principle. Larmer, 'Chronicle'.

63 It should be noted that Zambianisation also had an argument based on the rational-legal logic of cost efficiency, namely that it would have saved a great deal to replace expatriates with less expensive local professionals. Kalumba, 'The practice', 208.

64 *Ibid*.

65 Although in fact this plan served until 1983, as it not only covered the Second National Development Plan (SNDP) 1972–6 but also the Third National Development Plan (TNDP) 1979–83, *Ibid.* 180.

66 *Ibid*. 187.

The main thrust of the plan was the comprehensive development of 'basic health services', which were seen as primary needs that should be accessible to all Zambians throughout the country. 'In keeping with the socialist policies of the government',[67] both hospital and ambulatory (out-patient) care was to be available free of charge to each citizen. The plan would also place greater emphasis on the prevention of disease and on health education, which coincided with a conceptual shift from medical to health.[68] Kalumba argued in his analysis of this process that the 'basic needs' focus of this national health plan was consistent with the contemporary discourse of the World Health Organization and other agencies such as the International Labour Organization. This influence is not surprising, considering the composition of the planning committee and the fact that the plan had been realised with the technical and financial support of the World Health Organization. Moreover, Kalumba stressed that in contrast to a country like Tanzania, there was no publicly articulated challenge to the policy planning of the committee. He thus concluded that the plan was the product of an internal bureaucratic process of public resource management, influenced by the discourses of donor agencies.[69] Meanwhile, Kalumba failed to signal that this donor discourse of 'basic needs' was used alongside the political discourse of free healthcare, thus suggesting alignment of discourses rather than a conflict.

The ten-year plan analysed by Kalumba presented a reorganisation and expansion of the ministry headquarters, with a fourth department added under an extra deputy director, who would be primarily occupied with planning. While Kalumba argued that this expansion was motivated by the fact that in the years since Independence the establishment of the ministry had nearly trebled, he did conclude that this had led to the establishment of a huge medical bureaucracy that did not suggest the primacy of rural health care, but rather the 'increased concentration of central bureaucratic control'.[70] Later policy proposals recommended further expansion of the ministry headquarters, including the upgrading of assistant directors to directors, but Kalumba admitted having difficulty piecing together these policy developments and their impact owing to limited data.[71]

At the same time, the plan suggested reinforcing the provincial medical officers' offices with an extra assistant, a trained finance officer, and a statistical clerk. It was also decided to fully delegate authority over the administration of health services in a province to the provincial medical officer. On the district level, the plan proposed the establishment of 42 health districts in the areas not served by the 8 city or municipal councils. These health districts would be administered by a district medical officer, who was responsible for supervising health activities in the district and developing an integrated health service. The offices of these health districts would be located at district hospitals, where these existed, and be the link between the central administration and peripheral basic health service delivery. This means that in the early 1970s the organisational level was instituted that would receive so much attention in the later reforms, after Kalumba had shifted from policy analyst to policy maker.

The ten-year plan put forward a structure for the peripheral organisation of basic health service delivery. As was the case in the strategic plan that we analysed in Annex

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67 Ten-year National Health Plan (TNHP) cited by *Ibid.* 191.
68 Which was ill-defined in the TNHP.
69 *Ibid.* 187-188.
70 *Ibid.*192.
71 *Ibid.* 231-232.

I, in the extreme periphery of the system, health posts were proposed. These would be located in existing buildings, such as schools or church buildings, where staff from health centres would visit on a weekly basis. Health centres would see a division into sub-centres and centres, previously referred to as stage I and stage II health centres, respectively. Sub-centres would be staffed with one or two medical assistants, an enrolled nurse with midwifery training or an enrolled midwife, a health assistant, and unskilled support staff. A total of 164 of such sub-centres were proposed, at a planned rate of 20 per year over the years 1972-1976 and 22 per year in the years leading up to 1981. Health centres (stage II), of which in 1972 there were only 3, with 6 under construction, would be larger facilities and also have a supervisory role over sub-centres. These were to be staffed by two or three medical assistants, an enrolled midwife (or an enrolled nurse with midwifery training), a health assistant, a laboratory assistant, a dispenser, and a driver (and a vehicle), in addition to support staff. Forty-four of these centres were foreseen by the end of the planned period, 20 to be built in the period up to 1977 and 24 thereafter.

A special focus was given to the district health headquarters, which would combine a district hospital, or health centre where there was no hospital yet, with the office of the district medical officer. From here, not only curative care and supervision was to be provided but also programmes of preventative health and disease control. These facilities would have one or two medical doctors in addition to supportive professional and non-professional staff, and one or two vehicles. In Kabwe Rural, in central Zambia at an hour's drive from Lusaka, a demonstration project was planned with support from the World Health Organization and the United Nations Development Programme. This project would develop both curative and preventative activities in an integrated basic health programme. In the meantime, larger hospitals, such as the UTH in Lusaka, were to be re-built and expanded with extra bed-capacity, and 12 new hospitals were to be built, notably at district health headquarters.[72]

Despite these intentions, the rate of expansion of health facilities in the years covered by this plan did not mirror the impressive rate of expansion of the earlier years. In fact, in the period from 1972 to 1982, only 5 government hospitals were indeed constructed, an increase of 6.5 per cent. In comparison, the years from 1964 to 1972 had seen an increase of more than 58 per cent, from 48 to 76 hospitals. The expansion in the number of government clinics during the period of the plan, at a rate of 36 per cent, is also significantly lower than the rate of expansion between independence and 1972, when the number of facilities grew by 74 percent. Nevertheless, and it is striking that this does not appear in Kalumba's analysis but only in the data he presented, the number of rural health centres did in fact increase by 152 in the period of the plan.[73] Compared to a planned construction of 164 sub-centres and 44 centres, this does fall somewhat short, though not dramatically so.

It should be kept in mind that this period coincided with a negative change in Zambia's economic fortunes. Copper prices as well as copper production decreased and oil prices rose, and the global oil crises of the 1970s further deteriorated the country's terms of trade. This had its impact on the availability of resources. At the same time, the health sector's proportion of total government expenditure fluctuated around an average

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72 *Ibid.*193-199.
73 *Ibid.* 270-270a.

of 5.5 per cent.[74] This meant that the health sector would have to ration allocations. At the same time, however, Kalumba cited a report by the ministry and various donors that there was much under-utilisation of resources in rural areas. In fact, in 1981 he reports that only 21 per cent of the allocations to rural health centres were actually spent. While owing to bureaucratic financial constraints, millions of Kwatcha were returned to the Ministry of Finance, health centres were lacking such essentials as paper and bicycles. Kalumba attributed this institutional inefficiency to the slow re-imbursement process from headquarters and provincial authorities,[75] rather than to lack of individual initiative.[76] This problem also applied to capital development, where only the health ministry's budget was spent in 1981. This might be a factor in explaining the discrepancy between planned facilities and the number actually built.

This lack of absorptive capacity at local level, caused in part by bureaucratic constraints, might be one factor explaining the unequal distribution of financial resources at the time. In 1981, ministry headquarters, training, and research took some 23 per cent of expenditures in the health sector, the Copperbelt received 18 per cent, Lusaka including the university training hospital took 19 per cent, and all other provinces combined 40 per cent. Comparing total per capita spending, provinces along the line-of-rail were even better off, receiving on average 75 per cent more than rural provinces. The health spending of the mining medical service augmented this discrepancy. Reflecting on the Zambian state policy discourse that had problematised this rural/urban divide by defining it as unacceptable and needing change, Kalumba concluded that state planning had failed. It had not been able to significantly restructure the investment and allocation pattern in favour of rural areas. The existing patterns, Kalumba concluded, were less than optimal, not in terms of efficiency but in terms of the political question of social entitlements.[77]

Not only were financial resources lacking and unequally divided in the Zambian health sector of the Second Republic, but this also applied to human resources. It became clear above that the health sector had faced a situation of manpower shortage. The ten-year health plan continued the policies of increased training and Zambianisation. The plan set a target that by the end of the period covered, eighty per cent of the professional and technical grades of the public health service should have been Zambianised. From 1971 to 1981, the number of health workers had more than doubled from some 37,000 to some 85,000. Data from 1982 suggests that this included 220 doctors in government employment. In total there were 821 doctors and other medical specialists, of whom 300 were Zambian. These doctors were, moreover, unequally distributed over the country. Forty government doctors out of 220 were working in a single hospital, the UTH in Lusaka. Of all doctors, 82 per cent were working in line-of-rail provinces, while only 13 per cent of government doctors were working in district hospitals. None of these doctors were Zambian. Thus, the modest increase in training Zambian doctors hardly filtered down to rural areas. Moreover, there was a significant shortage of precisely the cadres that the ten-year plan had focussed on with its emphasis

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[74] *Ibid.* 243b and 275a. Unfortunately, Kalumba did not provide the data that would allow for an examination of MoH expenditures at real prices. However, from a deterioration of GDP at real prices, combined with a fluctuating proportion of health spending to government spending around a stable trend, it can be safely assumed that real allocation and spending by the ministry decreased.

[75] Lake *et al.*, *Analyzing*, indicate that by this time provincial accounting-control units had a large role to play in the disbursement of resources at lower health sector levels.

[76] Kalumba, 'The practice', 265.

[77] *Ibid.* 261-267.

on basic health, such as midwives and health assistants were lacking at health centres. Also among cadres such as medical assistants[78] and nurses, there was a bias in distribution towards line-of-rail provinces and away from rural areas.[79]

Kalumba provided little insight into the extent to which staff at the ministry headquarters had been Zambianised. From interview data, we know that in the 1970s there had been a Nigerian permanent secretary, who later moved to the World Health Organization.[80] Kalumba did indicate that there were frequent reshuffles of senior officials at the ministry. For example, after a long-serving permanent secretary, who was also serving as director of Medical Services, left Zambia in 1984, four different permanent secretaries had served up to 1986.[81] One can assume, however, that due to the trend to tighten the political grip over the ministry, many senior positions had been the first to be Zambianised as soon as qualified Zambians became available. In the periphery, meanwhile, most senior qualified staff remained expatriates, as among 53 district medical officers there were no Zambians and only 2 of the 9 provincial medical officers were not expatriates. It can thus be deduced from these data that there was a tendency for the scarcest Zambian human resources to be distributed in the socio-geographic centre of the country. The question that this raises, however, is whether this was a result of the bureaucratic structure and allocation mechanisms, or an aggregate result of the agency of the numerous individuals involved.

Assessing Kalumba's thesis

Katele Kalumba was successful in describing inequalities that have dogged the Zambian health system since its emergence in colonial times and throughout its evolution. None of the governments, neither the colonial and federal administration nor the governments of the first and Second Republic, have been able to change the unequal distribution of resources. The theoretical arguments he used to explain this, however, are predominantly reduced to structuralist arguments blind to the human factor that shaped this inequality. His argument was that owing to the statist logic driving the health sector, the pyramidal structure of the sector based upon a referral system had never been challenged by bureaucrats and policy makers. Moreover, he placed particular emphasis on the discursive strategies that were employed in what he saw as rural down-classing. He argued that policy discourses used categorisations – distinguishing the complex needs of the urban population from the less complex needs of the rural population – which followed formulaic criteria. As an example, he takes primary health care, which he sees as reducing the complexity of rural health needs and thus contributing to the status quo.[82] Furthermore, by apparently replacing curative by preventative needs, primary health care could be seen as 'political gimmicks, which are designed to repress the needs of rural people'.[83] One contradictory element in this argument is that he equally accuses policy discourse of aiming but failing to reduce rural-urban disparities. Are

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78 Who since 1984 had been called clinical officers, to reflect the responsibility they bore by, in practice, often working independently and unsupervised. Doctors had contested this change.

79 *Ibid.* 281-284.

80 A common phenomenon, as at least two other former Zambian permanent secretaries, Njelesani and Kamanga, had moved to WHO in Geneva after their tenure.

81 Perhaps as the result of the wielding of 'Kaunda's Axe'. See Chapter 1.

82 *Ibid.* 372.

83 *Ibid.* 289.

these policies then hollow and ineffective, or are they effective instruments of down-classing?

Moreover, these arguments are in my view one-sided and reductionist and do not do justice to the rich data Kalumba presented in his detailed study of policy documents. The predominant impression one gets from focussing on the gap between rural and urban areas is one of continuity: Historically there was inequality and this has persisted into contemporary times. While there are merits and logic to this argument, which we will revisit below, it passes over the fact that in absolute terms the health sector had undergone an impressive expansion and investment even in rural areas. By 1982 there were more than 500 government-run rural health centres, whereas at Independence there had been less than 200, and 50 years before that there had been none.

In his theoretical arguments Kalumba also seems to diminish the importance of the issue of scarcity of resources. He refers to scarcity as a policy discourse that justifies the logic of down-classing, rather than a reality that places limits on bureaucratic practice.[84] Considering the economic fate of Zambia throughout the 1970s and 1980s and the impact this had on public finances, scarcity must have been an objective reality rather than merely a policy discourse. In his analysis Kalumba shines little light on the arena in which the allocation of these scarce resources was contested. He merely states that rural demands were down-classed in favour of urban demands. Here it would be interesting to see what influence stakeholders' agency has in this allocative process, as such a process should be seen as the result of a negotiation process based on claims and counter-claims. Are rural populations in a position to articulate their demands as well as urbanites? Are professional interests – the desire to access high-status technologies rather than work in backward rural areas – of overriding importance? We could speculate on this, but it is clear that such human aspects were left out of Kalumba's analysis.

Certainly when it comes down to the scarcity of one factor – human resources – in the production of health services, human agency must have an important part to play. From Kalumba's data we can deduce that throughout its existence, the Zambian health sector has had to operate under conditions of striking shortages of human resources, particularly of qualified health workers of Zambian African origin. The actions and strategies of these scarce individuals must have had an influence on the distribution of resources within the sector, not least on their own spatial distribution. It seems that Zambian health workers, like so many others, seem to gravitate away from the periphery towards the centre of a society, where opportunities for accumulation of scarce resources exist. Policies may have articulated a challenge to this social law of gravity, but have not been able to reverse it. Perhaps in a context in which there was less of a shortage of resources more could have been contributed to peripheral areas. But in the context of the economic decline, this apparently was not the case.

Another shortcoming in Kalumba's analysis is his lack of focus on the inefficiencies within the system. There was no focus on spillages or leakages of resources. He demonstrated that a large part of allocations to the sector were not in fact spent and concluded that this was due to bureaucratic bottlenecks. Kalumba did not go further, however, in analysing to what extent these bottlenecks had been increased or decreased in the period after decolonisation. In the political document presented above, for instance, Kalumba made a bold statement about 'UNIP political patronage'. In his empirical analysis, however, he did not touch upon these allegations other than stating that with the

[84] *Ibid.* 130 and 366.

ideology of 'unity of political and administrative agents' the distinction between public and private spheres was increasingly diffused.[85] He failed, however, to detail what empirically observed actions or behaviours underlined this point. Thus, while he criticised the policy rhetoric of the political-bureaucratic system, he did not base his conclusions on an analysis of socio-political practice behind the façade of these policy documents.

Notwithstanding some analytical shortcomings in Kalumba's dissertation, it provided considerable insight into the background of the health reform process that Kalumba together with others would spearhead a few years later. This contribution fits into two areas: First, the insight provided into the historical background of the sector; and second, the insight into the intellectual justification for the health reforms. The dissertation described the establishment and the evolution of a health sector that was inherited by the Zambian nationalist government on Independence. Within a context of human resource shortage and a policy of Zambianisation, the sector was further expanded from the centre in Lusaka into the rural periphery. We saw how in the late-1960s some functions were delegated to provincial authorities and that health districts were later created in the early 1970s. This is thus at odds with the image of the health sector at the time as statically centralised; in fact, some steps had been taken from centralisation to decentralisation, albeit at a very slow pace. Nevertheless, this demonstrates that the decentralisation that took place as part of the health reforms was grafted onto the longer process of forming the sector.

As regards the justification for health reforms, we have examined Kalumba's argument that the UNIP government, rather than fundamentally challenging the pyramidal structure of the health sector, had reinforced a system that perpetuated inequality in access to healthcare. It is evident that this argument contrasts with the expectations that people like Kalumba and his father, the 'freedom fighter', had had of independence. It is thus clear how this conviction grounded in empirical analysis calls for a second liberation, as would be offered by the movement that led to the overthrow of the one-party state. More specifically for the health sector, it is apparent that this argument emphasised the need for a fundamental rethinking of the structure of the health sector, to ensure that the 'real social discrepancies in health care between regions and within regions' were indeed rectified. In the following sections, we will see to what extent Kalumba appeared successful in this pursuit, or whether he succumbed to the 'pitfalls' of past reform efforts, or indeed whether he lived to see his own 'eclipse of idealism'.

In the meanwhile, however, we will trace the steps he and others with him took to implement the concepts of the health reforms in a political-bureaucratic arena. First we must pause at the moment in which Kalumba graduated from being an academic and policy strategist to taking up a decision-making role. In an apparent attempt to foster the image of a technocrat, which he was keen to portray and to downplay any political opportunism he might have had, Kalumba said he did not expect to become a deputy minister after helping out in the election campaign. In fact, he claimed, he had been packing his bags to go to back to Canada, where he said he had a wife. He had received various job offers from international organisations which he was considering. Then, to his surprise, he had heard Chiluba announce his appointment as deputy minister of health[86] and nominated Member of Parliament. And, apparently, one cannot refuse the call to public service.

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[85] *Ibid.* 366.
[86] ML0812/01.

Conclusions

This chapter set the stage for our narrative on the health reforms and how they were driven and used and even manipulated by political actors. We have explored the origin of the health reforms and how they originated from their political and historical context. Thus, while external influences certainly played a role, the health reforms were firmly rooted within Zambian reality. The analysis in this chapter has highlighted that the health reforms (like any policy process) were not just a technocratic process in bureaucratic isolation. Rather, they are a historically and politically rooted set of ideas, which would have an impact on how the health sector would be organised. Moreover, since political processes of policy formulation and implementation are human processes, an attempt was made to highlight the human factor at play. One way of doing so is to pay attention to the personalities who played a role in shaping these processes. As such, we examined Katele Kalumba, a broker of ideas who played a key role in this process, and some of his writings. In later chapters other key actors will also be introduced. This will allow us to examine how the ideas presented in this chapter were used as opportunities for actors to serve both their personal interests and the political interests of the regime to which they related.

While examining Katele Kalumba's dissertation in order to understand his inspiration for assembling a discourse of Zambian health reform, we equally gained insight into the institutional history of the Zambian health sector, as a proxy of the Zambian state itself. Beyond an array of successive ideologies and discourses (varying colonial and nationalist ideologies and critiques), we saw how a sector of the state was established and how it increased its geographical presence. A noteworthy phase in this process was independence: The transfer of legal ownership of the sector from foreign to indigenous control. Independence, however, exacerbated the pre-existing characteristic of the sector: The availability of resources – and particularly human resources – was far outweighed by what was needed. From Kalumba's dissertation – though his analysis paid little attention to the human factor itself – we can deduce that Zambian politicians with little experience in managing a health sector, together with four Zambian doctors, inherited a system largely managed by foreigners. In the subsequent decades they would expand and Zambianise the sector. As we saw in the earlier Human Factor section, the relative scarcity of Zambian human resources in the health sector empowered health workers claims on the system to provide for them, while at the same time weakening the power of the system to discipline them for issues other than disloyalty. Thus, the strategies of instrumentalising state resources and systems, strategies central to this dissertation, are evidently rooted in the historical experience of the Zambian health sector.