Primary Health Care

Primary health care trading companies for sustainable development

Robert Soeters & Selestine Nzala

A programme of comprehensive primary health care in Zambia has been accompanied by the emergence of autonomous, non-profit trading and production companies that sell health-related goods to communities and health institutions and find markets for locally produced goods.

Zambia’s Western Province covers 126 000 square kilometres and its population of 600 000 lives predominantly in small villages. The people are mostly poor, subsistence farming and cattle-rearing being the main economic activities. Four-wheel-drive vehicles are necessary on most of the roads.

The government runs five district hospitals and a provincial hospital, and there are five mission hospitals. Of the 98 health centres, 94 are run by the government, two by missions and two by private companies. Following serious economic difficulties the Zambian health sector received increased financial support from the Netherlands in 1988 on condition that a study be made of how primary care could operate in the long term without external assistance.

A comprehensive decentralized approach to primary care with an important community component was adopted. The planning of activities started at community level and proceeded upwards, and it soon became clear that decentralized planning was useful only if the control of financial resources was also decentralized. Notwithstanding opposition from some civil servants at the national and provincial levels, a proposal that funds be allocated directly to the six districts was put into effect with the support of politicians. The districts arrived at different solutions to their problems and used the funds accordingly.

Unfortunately, many vital items were in short supply, ranging from seeds to cement and from stationery to soap. Many health facilities were in need of repair, and spare parts were often unobtainable for vehicles used by the health services. Neither state bodies nor private traders could meet the demand for essential goods and services. The lack of resources in both the communities and the health institutions became the main obstacle to success in the primary care programme.

The main reasons for poor performance by the public sector in Western Province are as follows.
Motivation is low because of poor salaries and working conditions; good performance is neither encouraged nor rewarded; poor performance is not discouraged.

Little cash circulates in most African communities, and rather than concentrating only on how much people should pay for health care in terms of fees or insurance it would be a good idea to consider the economic potential that might be available in exchange for health inputs.

Government garages, transport units and other bodies are not permitted to make their services available to outside organizations. This leads to gross inefficiency.

Most district and provincial health managers have little idea of the costs of vehicle repairs or of goods received.

Public sector procedures do not allow the sale of health-related goods for community development, yet this is the only sustainable way of providing them. During famines and droughts the state usually issues gifts of food to the population; regrettably, however, when the campaigns are over, the source is lost and the people become beggars without choice. Furthermore, the view has been expressed that a free medical service tends to crush people's sense of communal responsibility.

Marketing for health

In 1990 the management of the primary care programme opened shops and a garage in Mongu, the provincial capital, in order to compete with the inefficient state monopolies. Services and goods were sold at unsubsidized prices, and the districts were obliged to begin paying for the maintenance of their vehicles. By way of compensation the district budgets were increased and the provincial budget was reduced. The districts were able to use either the garage and shops attached to the primary care programme or private alternatives. The facilities could also be used by outside customers.

The garage and shops proved successful but for legal reasons were separated from the donor-sponsored primary care project and the state through the creation in 1991 of a provincial primary health care foundation. Similar foundations have been established by the districts outside the capital and by two mission hospitals. They build shops, recruit employees, and set up accounting systems. The shops sell to the general public and to health centre staff who either use the commodities in their institutions or resell them in the communities. State and mission health personnel encourage communities to find solutions to their health problems, while the autonomous foundations provide the services required.

Organization of primary health care foundations

The first objective of the primary health care foundations is to become economically independent of government and donors. The second objective is to improve the health status of the population by supporting health institutions and communities. The foundations are, by constitution, not-for-profit autonomous trading and production companies and are subject to market forces. Their non-profit status means that the profits are reinvested in health-related activities.

The managers, all business-orientated Zambians, are expected to run the foundations efficiently with no outside assistance and are free to decide on the purchasing and pricing of commodities, to determine salary levels,
and to hire and dismiss personnel. The performance of each section is calculated quarterly and all employees are eligible to receive bonuses in accordance with the profits made. The right to hire and fire is important because, unfortunately, pilfering is common in a situation where the duration of projects is quite brief and employees often feel that they do not have long-term security. The foundations have responded to this situation by developing more sophisticated procedures in connection with finance, purchasing, stores, security and auditing. The fact that the management is entirely Zambian makes employees aware that their prospects depend on performance.

Foundation boards provide guidance on broad policy issues, ensure that health-related activities are carried out, and audit management; a majority of their members are health workers familiar with the requirements of communities and health institutions. In the provincial foundation, some board members are selected from the local business community so that management can be monitored; the secretary is a lawyer, and there are representatives from the Department of Agriculture and the Provincial Planning Unit.

Assessment

Steady growth occurred between the fourth quarter of 1990 and that of 1992, when turnover amounted to US$ 93 100 (see figure); the profit of $15 000 in the latter quarter was used mainly to expand operations. Vehicle repairs and spare parts accounted for 30% of the turnover, building materials for 28%, traditional crafts for 6%, vegetable and maize seeds for 5%, ox-drawn ploughs and spare parts for 4%, and bicycle spares also for 4%; the foundations became the main suppliers of vegetable seeds and bicycle spares in Western Province. Initially the foundations only sold goods, but later began buying local produce and thus promoted income generation in the communities, making it easier for the people to purchase health-related items. By buying as well as selling the foundations improved their trading efficiency.

The main locally produced goods purchased by the district foundations are traditional crafts, tallow and timber; the crafts are resold to the provincial foundation, which sells them in its own shops, in Lusaka, or in the export market; the tallow is used by a women’s cooperative to manufacture soap in a small factory built by the foundation, which buys the product and then resells it in its shops; the

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timber is disposed of in an analogous manner, this time involving a carpenters’ cooperative. The foundations employ 60 people directly, while the subcontracting of building,
carpentry and soap production to cooperatives creates work for 40 more people; income is generated for over 100 people as a result of the purchase of crafts, tallow and timber.

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In September 1992 a survey indicated that substantially more health workers thought support for communities and health institutions was the main objective of the foundations compared with income generation. Among district and provincial staff, 66% were satisfied that the foundations achieved their objectives; 94% of health centre staff thought it was a good idea to sell goods in their institutions, largely because of the support that this represented for the communities. Health workers considered that among the items sold in the foundations’ shops it was important to include ploughs, spare parts for ploughs and bicycles, vegetable and maize seeds, soap, sugar, salt, mosquito nets and stationery.

Comprehensive primary health care, involving a participative process in which communities improve their lifestyles, requires decentralization of the control of resources. This leads to demands for goods and services in the communities and their health institutions. In Zambia, autonomous foundations have responded to these demands by opening shops and competing with state organizations. Decentralization is not just a technical step intended to increase the effectiveness of socially neutral institutions but also has to do with power and the distribution of resources among social groups (1). Since the opposition of civil servants is not uncommon, it is vital to ensure political backing, preferably before donor involvement.

The decentralization of planning and financial responsibilities requires that grass-roots health workers be trained to fulfil autonomous, community-orientated roles, rather than exclusively to provide curative care. Training in management and financial skills is also essential. Experience in Zambia suggests that money is less likely to be misused at the periphery than at the centre because of the direct control exercised by patients, community members and others in the former situation. It has to be borne in mind that the motivation of health workers, a key factor in getting them to accept the increased responsibilities implicit in decentralization, does not have to hinge entirely on financial incentives; flexible management and good training and supervision can go a long way towards sustaining morale, as the mission organizations have demonstrated.

Many civil servants are aware that their institutions are inefficient but do not know what remedial action to take. Governments should avoid rigidity in administrative and financial procedures and should allow the emergence of useful innovations at the grass-roots level with the help of suitable juridical frameworks. It is sometimes better to set up new organizations than to rely on poorly performing structures.

Donor organizations should accept the emergence of unplanned project innovations and should not be unduly concerned by risk-taking approaches to problems. Decentralization is in fact particularly desirable, because centralized control simply cannot handle the immense diversity of conditions encountered in the field. The contracting-out of catering, cleaning, security, laundry and other services
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to private organizations has been fairly successful in improving the effectiveness of the health sector (2). Competition is, of course, essential: the replacement of a public with a private monopoly is not likely to bring about desired improvements. The success of the primary health care foundations in Western Province suggests that there is considerable potential for small enterprises to provide services to the health sector in Africa. Provision for such nongovernmental initiatives should be made when primary care schemes are at the design stage.

Little cash circulates in most African communities, and rather than concentrating only on how much people should pay for health care in terms of fees or insurance it would be a good idea to consider the economic potential that might be available in exchange for health inputs. The example of Western Province shows that there is an acute shortage of marketing mechanisms and that primary care projects can use local economic potential for sustainable community development.

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References

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More people, more food – the global challenge

Over the next 20 years, food production will have to keep pace with the growth of the world population from 5300 million to a projected 7200 million, an increase of 36%, just to maintain the present situation. The great challenge for governments and the food, agriculture and fisheries sectors is to ensure food and nutrition security and sustainable growth in a way that does not place undue pressure on the environment, and leaves the world a place still fit to live in.