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The Dividend of Compromise and Patience: A Policy Win for Zambia

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Zambian Context

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Zambian Context

- Under 5 mortality (of 1,000 births) 2006
  - 182 rural / 140 urban
- Contraceptive Prevalence Rate: 34% (2006)
- Only 43% of births have skilled attendants (2003)
- Critical shortage of human resources
  - Few physicians
    - Training 40-60 per year in local medical school
    - >8,000 Zambians per registered physician
  - Extensive emigration of health professionals
    - Government cannot employ all new nursing grads
  - HIV/AIDS mortality in nurses/clinical officers was ~2.5% per year prior to general availability of ARV's
  - Nurses well trained, and there are more of them
    - ~1/600 Zambians

Why Press for Regulatory Reform?

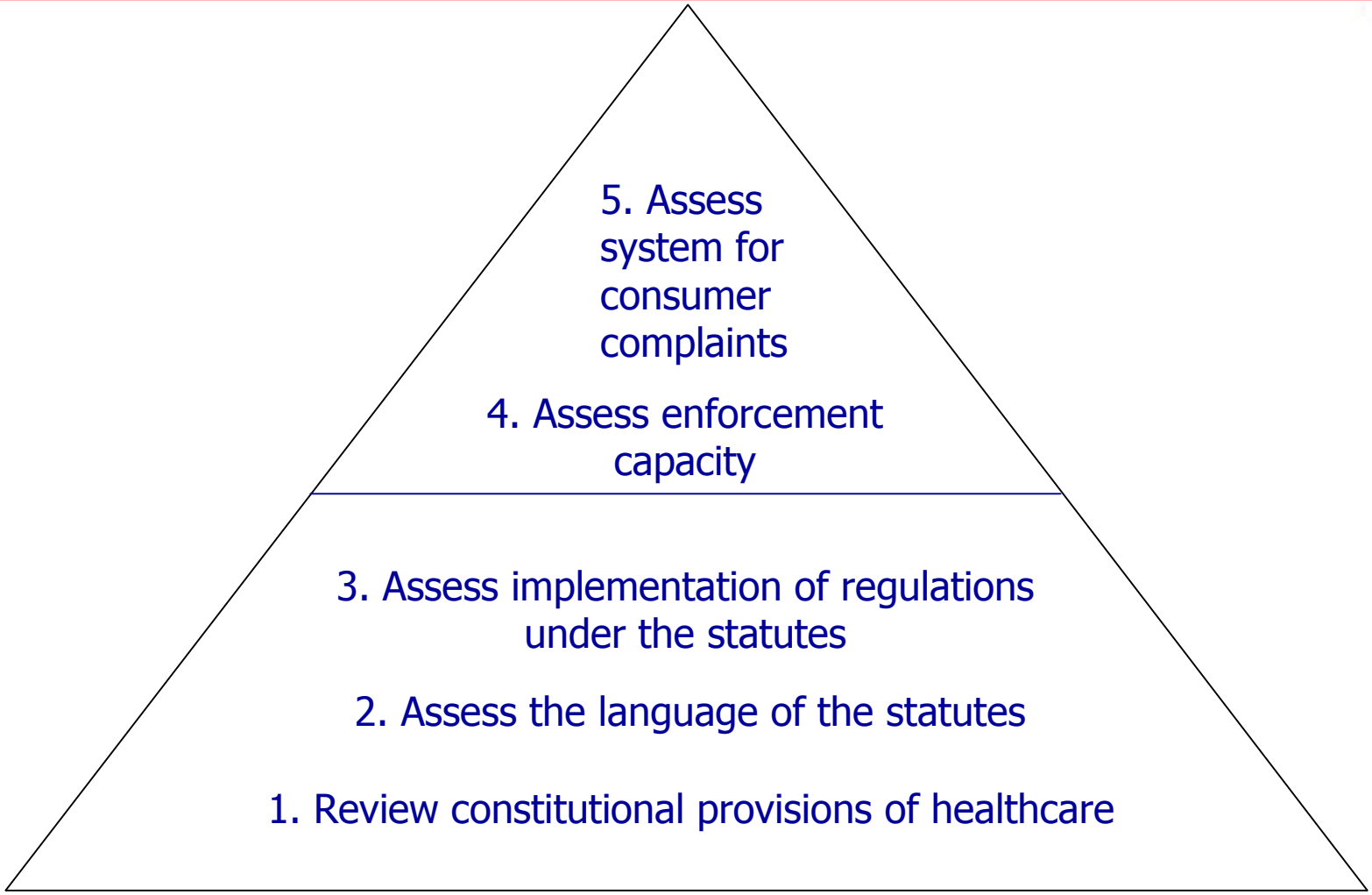
- Legitimate primary care practice by non-physicians does not exist in Zambia
  - Compare Uganda, Kenya, Ethiopia
- Well established scope of practice for nurses and midwives in public sector
  - Family planning services
  - Limited prescribing authority
- Untapped pool of professionals
  - Returned expatriates
  - Early age of retirement from public service
  - "Buy outs" from Structural Adjustment Program
  - Moonlighting potential?

Conditions Favorable for Reform Effort

- Nursing Act recently revised
- Need to regulate new health professionals
  - Physical therapists
  - Psychologists
- Doctors want changes
  - Increased control of foreign "doctors"
- A generation since last update of professional licensing law
  - New types of health facilities
  - Focus on new services (ART)
- Donor (PSP-*One)* has resources and interest

Legal and Regulatory Analysis

Legal and Regulatory Review Process



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Medical and Allied Professions Act (1977)

PSP-*One* assessment, 2006 found:

- Nurses subject to licensing from two (potentially conflicting) sources:
  - New Nursing Council Law permitted private practice BUT
  - Medical Council licenses all "clinics"
- Medical Council requires any nurse clinic to have physician supervisor
  - No such requirement for public sector nurses
- No consumer representative on Medical Council
  - With no consumer advocate, the council risks "Regulatory Capture"
- No clear, responsive patient grievance system

Setting Clear Scopes of Practice is Essential

Clear scopes of practice:

- Reduces conflicts between the health cadres (both public and private)
- Help consumers know what to expect of their public and private providers
- Identifies opportunities to task-shift
  - For example, Add defined ART responsibilities to nurse scope

The new (2009) legal structure

- Gives clear authority to set scope of practice for each health profession
  - Not nurses
  - Gives Nursing Council a seat on the Health Professions Board

Mechanisms to Resolve Past Conflicts

- Health Professions Act (2009) establishes tiered classification
  - **Class A:** Hospital (physician oversight)
  - **Class B:** Out-Patient, diagnostic, prevention, treatment facility, invasive procedures
  - **Class C:** Class B without the invasive procedures
  - **Class D:** Diagnostic services; outside a hospital
  - **Class E:** Physiotherapy, occupational and hydrotherapy
- All must be run by licensed health professional
  - Clinical officer could be allowed to run a class C or D facility
  - Will Council permit nurse clinics to run under exception for first aid and continuing treatment?
- Staffing levels determined by Council Guidelines, but now:
  - Two Consumer Representatives on Health Professions Council
  - President of Nursing Council on Heath Professions Council

Streamlined Licensing is Key to Quality

- Licensing and renewals are powerful regulatory oversight mechanism to ensure patient safety and quality
- Backlogged and antiquated licensing systems constrain effectiveness of oversight
- Streamlining the licensing procedure for facilities and professionals frees up limited public health resources to expand quality services to the poor

Consumer Empowerment Also Critical

- Consumer advocate (lay person) invited to the table
  - This prevents "regulatory capture" (self-interest of professional groups)
  - Upholds consumer's interest in health planning
  - "Patient voice" in disciplinary decisions
- Patient grievance system clarified
  - Critical for signaling problems with quality of care

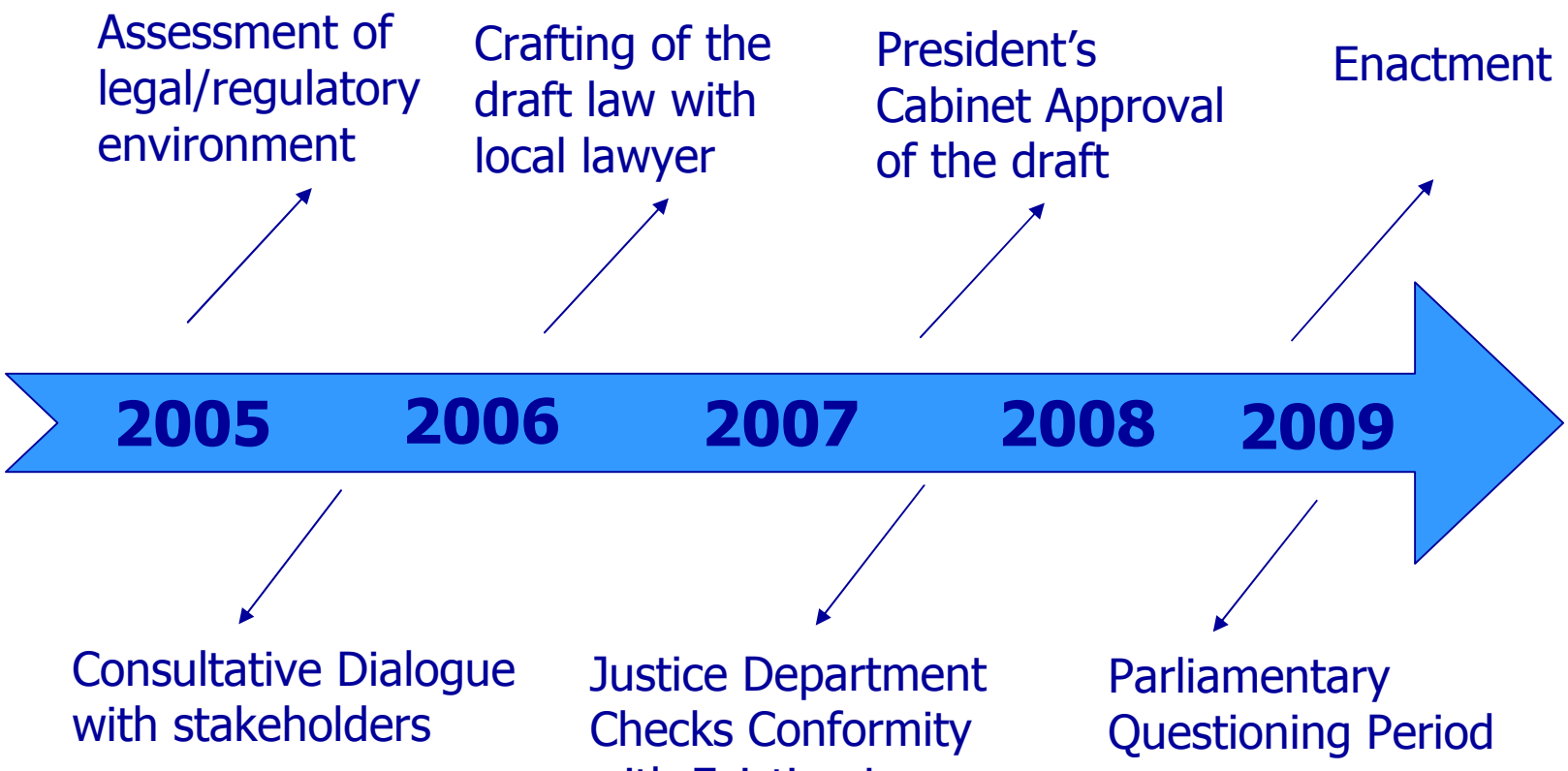
The Path to Enactment

The First Steps

- Private sector assessment by PSP-*One*
  - Identifies problems
  - No legal clinics run by nurses, midwives, clinical officers
- Convene (and fund) stakeholder workshop
- Provide
  - Local lawyer for drafting
  - Outside consultant
    - Moderator
    - Suggest alternative language
- Negotiate language that meets needs of multiple parties
- Review/amend draft language with participants

PROBLEM: MOH INVITED BUT DOES NOT ATTEND

The Path to Enactment…



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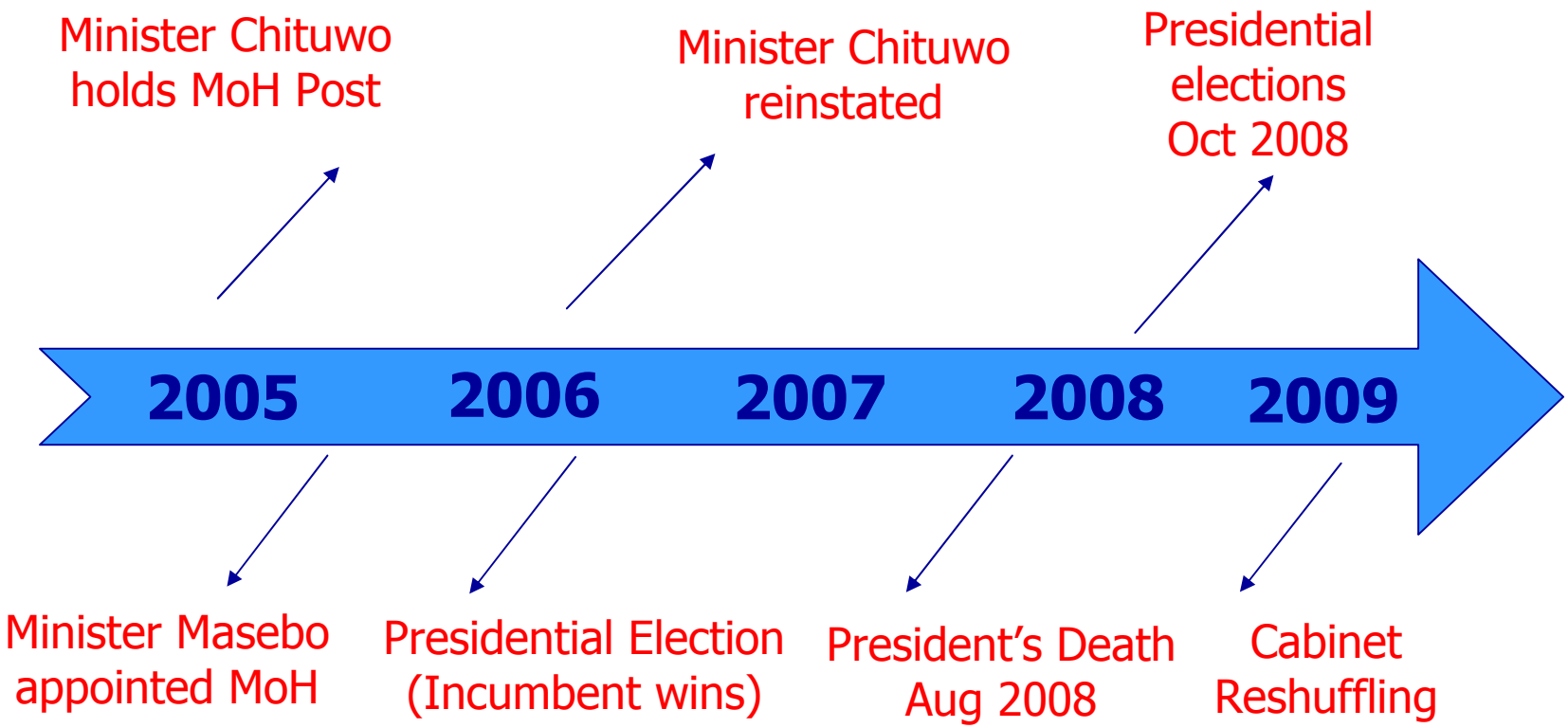
...was Bumpy...



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Results

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Policy is a Give and Take: Two Steps Forward and One Step Back is a Win

Private Sector Gains

- 2 consumer representatives + sharpened patient grievance system
- Classification of health facilities dependent on complexity of service
- Accreditation of services of high importance
- Can refuse to accredit service if "wasteful and inefficient"
- Public and private facilities require license

Private Sector Losses

- No explicit exemption for nurse run clinics
- Facility inspectors cannot review patient records

What Remains (TBD):

- Will Council accept nurse primary care clinics by regulation?

What We Learned

Lessons Learned

- Constant presence required to manage nuanced and dynamic relationships and personalities
- Still difficult for Health Ministries to see private sector regulation as an important part of STEWARDSHIP
- Do not let perfection be the enemy of progress; compromise is important
  - 2 steps forward; 1 step back is a win
- Regulatory reforms do not conform to a project life cycle
- Consultative process is critical

Lessons Learned

- Speed of reforms depends on public sector support
- Reform should include items important to regulated professionals
  - In Zambia
    - Tighter regulation of questionable physicians
    - Role for Council in regulating continuing professional education
- Regulations on paper means nothing without adequate enforcement
- Double standards of care for public and private sectors can hurt both providers and consumers
  - Limits legitimate supply of primary care services in private sector
    AND
  - Forces it underground