Privatising Zambia's copper belt

Cost to health care

The privatisation of health services at the Luanshya Copper Mines in Zambia has led to deteriorating services for workers. **Angela Tembo** examines why fewer workers now use the service and contends that quality health studies should not adopt conceptual frameworks without analysing the context in which they are applied.

During its heyday of operation, state-owned Zambia Consolidated Copper Mines (ZCCM) employees were entitled to free social services ranging from health, education, water and sanitation and skills development. With operations in seven towns, the best service of all was its health facilities. Health services provided by ZCCM were of a high quality.

My research into the social impacts of privatisation, however, indicates a decline in the quality of health care for mine workers.

LEGACY OF ZCCM

Under ZCCM, Luanshya Division operated two state of the art hospitals: Roan Antelope and Luanshya Mine hospitals with five community clinics.

These free health facilities catered for 4 000 employees and their dependants under 21 years. The facilities were also open to the general public on a fee-paying basis, but this was only at Luanshya Mine Hospital.

Prior to ZCCM's privatisation in 1997, the government allocated a larger share of the health budget to ZCCM facilities with Luanshya division receiving the biggest chunk. Between 1995 and 1998 for example, Luanshya division received 35% of the government's expenditure for its hospitals, more than any other division. This expenditure reflected in the high quality of health services provided in Luanshya.

Additionally, ZCCM was highly involved in preventive health care. One of its signature campaigns was the malaria prevention campaign. All houses in mine townships were sprayed and streams cleaned.

DETERIORATING SERVICES

During the period of my research, the mine was owned by Luanshya Copper Mines (LCM). Current employees at the mines maintain that the quality of health care has reduced. Workers compared health services before and after privatisation.

Employees alleged that quality in health care had changed due to the deteriorating levels of cleanliness at facilities. While ZCCM health facilities were praised for their cleanliness, current facilities were criticised for having 'dry lawns and unpainted floors' as one employee put it.

Lack of ambulances and increased travelling distances are another area of concern. Referral transport was available everyday from the clinics to the hospital under ZCCM. Lack of ambulance transport has obviously lowered the quality of services on offer.

Since privatisation, ambulance transport is only available twice weekly. If someone falls sick outside those days, they have to find their own way to the health facilities.

Additionally, ZCCM ensured health clinic facilities were widely distributed to provide care to the community as close as possible to patients in all sections of the mine townships.

The five clinics and two hospitals once owned by ZCCM meant that people didn't have to travel more than five kilometres to the nearest facility. The closure of selected facilities has increased travel distances to health facilities from between 10 and 15 kilometres and has greatly increased costs for workers. In some areas, people are required to pay between US$1 and US$2 (about R6.80) for public transport.

Employees also lamented the current staffing levels. Health centres used to be adequately staffed by six nurses at any given time. In addition, doctors used to visit the clinics at least three times a week. Since privatisation, clinics are run by two nurses only and at hospitals, there is only one doctor to do both the ward rounds and patient consultations.

There is also a shortage of drugs at health facilities and so doctors give patients prescriptions to buy medication from registered pharmacies, which is expensive.

Patient satisfaction with diagnosis of their ill health has also dropped. Some employees have been mis-diagnosed leading to dissatisfaction with the outcome of treatment. As an employee stated, 'Now when you go to the clinic they don't bother to do a thorough diagnosis. Diagnosis is based purely on your complaint.'

LCM REJECTS ACCUSATIONS

The new management at the mines maintains that the quality of health care at its facilities has been maintained.

Management argues that it closed some of its health facilities owing to the retrenchments that followed privatisation which reduced the labour force to 1 750 from 4 000. This resulted in LCM handing over one of its hospitals and three health centres to the government. LCM, management also argues that it is still providing services that ZCCM used to provide, such as pre-natal classes, specialist care at its hospitals as well as running malaria preventive campaigns.

The management insist that these facilities and the staff levels are adequate to cater for the current mining population. Currently 37 health workers service the one hospital and two health centres. Of the 37, three are doctors and 34 are nurses.

Management also point out that additional services have been introduced. In response to the workers' demands a workplace HIV/AIDS programme was established. Services under this include psycho-social counsellors, peer education and condom distribution.

WHAT IS QUALITY CARE?

Who do we believe – current management or worker patients using the service?

Studies on quality in health care rely heavily on providers' opinions. There is consensus that the quality of health care should meet clients' perceived needs. Providers, in this case management, cannot decide what is best for clients. During the privatisation process, employees were not consulted on their expectations and health impacts were completely over-looked.

In addition, globally evaluations on the quality of health care usually use a framework, which includes structure, process and outcomes of health care.

However, the above framework does not take into account social and economic factors. Health care does not happen in isolation of social, economic and political processes. In the LCM case privatisation had economic and social impacts which shaped employees' perceptions of quality.

Economically, the privatisation of LCM reduced mineworker households' disposable income by increasing the cost of health. The closure of some health facilities increased travelling distances and hence the cost of obtaining health care. Households now have to pay for services which were previously provided at little or no cost. Health costs have started to compete with household necessities such as water and electricity.

For LCM management with other competing priorities, health care is no longer seen as so important.

Increased health costs have influenced worker households' choice of health providers. A few households continue to use mine facilities while the majority have opted to by-pass the mine health system and seek cheaper sources of health from the informal system.

Households far from health facilities where there is a lack of drugs seek cheaper treatment, often through self diagnosis and self medication.

CONCLUSION

Privatisation of ZCCM changed the relationship between communities and the mines. Since the early 1990s when mining first started in the Zambian Copperbelt, the state-owned industry took responsibility for all aspects of workers' lives. It seems, however, that not enough consideration was given to the withdrawal of some of these services when the mine was privatised.

Development Agreements between the Zambian government and the current mine owners are shrouded in secrecy and are not available. Therefore, it is uncertain whether the lower quality of health services is due to the actions of the new mine owners or lack of consideration by the government when they handed over the mines.

The attitude of workers in mining towns towards the new mine owners has changed as has the attitude of the owners to workers. As much as the new companies have a responsibility to mining communities, their core business is still mining. They have a responsibility towards their shareholders. The onus is on the government to hold the new mine owners accountable to ensure that they operate within the stipulations of the Development Agreements. With health in particular, the new mine owners should not be allowed to compromise quality in the interests of profit.

Mine owners should address community concerns if they are to provide quality care. Owners can, for example, address important issues such as staff attitudes and inadequate diagnoses through adequate training and in some cases re-training of personnel.

Importantly, future studies on household views on the quality of health care should not be done in isolation, but should take into account the context in which the study is carried out. LB

This article is based on Angela Tembo's MA in Development Studies Research at the University of the Witwatersrand.