Community Working Group on Health (CWGH)

Position Paper on the Budget for Health – 2018 and Beyond

Key Sector Priorities

The key sector priorities include:

- Allocate at least 15% of the National Budget to health care in line with the Abuja Declaration target. Empirical evidence has shown that a 1% increase in public spending on health care reduces child and maternal mortality rates while improving life expectancy.
- To boost public spending on health without undermining fiscal sustainability government must explore a number of options for innovative domestic and sustainable financing. These options include: broadening the tax base through introducing incentives to mainstream the informal sector into the formal economy. Other options include corrective and wealth taxes. Enhancing tax administration is also vital.
- Strengthen the district health system by improving institutions (governance), enhancing human resource capacity (especially community based health workers) and addressing infrastructure deficits. This will help to adequately address the lack of access to quality healthcare, particularly for those living in rural communities and other vulnerable groups. A strong public health governance system entails a predictable, open and transparent decision-making; a bureaucracy imbued with a professional ethos; an executive arm of government accountable for its actions; and a strong civil society participating in public affairs. There is need to enhance participation and transparency in the Healthy Levy and implement recommendations from the Auditor General to enhance public financial management.
- Scale up local production of essential medicines by increasing the country's capacity to manufacture essential drugs, vaccines and consumables to ensure accessibility.

Introduction

Good health is essential for a productive and fulfilling life and is critical to spurring sustainable development. Healthier nations are wealthier nations. Zimbabwe has a strong policy and institutional environment framework to ensure healthy lives and promote wellbeing for all. The Constitution of Zimbabwe recognises health as a fundamental human right. The right to health is provided for under Section 76 of the Constitution. The Government has also developed the National Health Strategy for Zimbabwe 2016-2020 which seeks to achieve 'Equity and Quality in Health: Leaving no one behind.' The Strategy is underpinned by 4 priority areas namely: communicable diseases; non-communicable diseases (NCDs); reproductive, maternal, new-born, child and adolescents; and public health surveillance and disaster preparedness and response. Zimbabwe has committed itself to implementing all the SDGs with an emphasis on SDGs 2, 3, 4, 5, 6, 7, 8, 9, 13 and 17.

Furthermore, the Revised Gender Policy (2017) has a thematic area on Gender and Health. The policy recognises that gender inequality is responsible for most of the health issues. It further acknowledges that poor access to health services (particularly cancer management services), HIV and AIDS drugs, safe water and sanitation impacts disproportionately more on women than men and provides strategies to improve gender sensitivity in health service delivery. These policies highlight the Government's obligation and commitment to ensure healthy lives and promote well-being for all at all ages. At continental level the country has committed itself to the Abuja Declaration of 2001, the Addis Ababa Declaration of 2006 on community health, the 2008 Ouagadougou on primary health care and health systems on increasing public funding for health and the Tunis Declaration on value for money, sustainability and accountability in the health sector of 2012. To meet these imperatives and obligations, the Government must adequately and efficiently allocate resources to the health sector.

The Community Working Group on Health (CWGH) is a network of community/civic based organisations whose aim is to collectively enhance community participation in health in Zimbabwe. The formulation of the National Budget is an area that requires greater participation of the community. Community participation in health matters and budget formulation gives the citizens an opportunity for their voices to be incorporated in the National Budget as provided for in the Constitution and the Public Finance Management Act. The CWGH undertook consultations in the 10 provinces of the country were the CWGH is operational and the sample of respondents included CWGH national members, Health Centre Committee (HCC) members and District Health Executive (DHE) members with a balance between men and women. This submission captures the main issues that came from these stakeholder consultations across the country on the state of health, its social determinants and what must be done to address the challenges plaguing the health care system. This position paper is therefore a synthesis of the views of the citizens towards the National Budget.

Macroeconomic Environment

Since the mid-1990s, the Zimbabwean economy has undergone wrenching structural changes. Instead of the anticipated movement of resources, including labour, from low productivity sectors into high productivity ones, Zimbabwe is experiencing persistent de-industrialisation, heightened informalisation of the economy as well as increasing dependence on the extractives. The 2014 National Labour Force survey highlighted that 94% of the economy is now informalised up from 84% in 2011. In particular, the high levels of informality presents challenges for domestic resources mobilisation as it erodes the tax and revenue base.

Importantly, past and present macroeconomic policies have lacked a consistent pro-poor and inclusive framework that puts people and their needs first ahead of the markets and sectarian interests. This is exemplified by the high and worsening levels of unemployment, poverty and inequality. The fiscal policy remains highly consumption oriented leaving very little fiscal space for capital and social expenditures. The country is also experiencing a binding liquidity crisis. The liquidity crisis is a manifestation of structural deficiencies and distortions in the economy typified deindustrialisation, rising informality, high public debt, lacklustre export performance, dwindling capital inflows, illicit financial outflows, poor infrastructure, institutional weaknesses, weak confidence in the formal economic system, a volatile/fluid political environment among others. The liquidity crisis has negatively affected the importation of critical drugs.

As at 31 December 2016, total public debt (both domestic and external) stood at US$11.3 billion of which US$7.3 billion is external debt. Such a high public debt relative to our GDP affects our international

financial credibility and hence our ability as a country to unlock more resources and investments to finance critical sectors such as healthcare. Reducing the debt burden will help to free up resources being spent on debt servicing for the health sector. For instance, in 2016 the Government spent US$120 million on debt service.

This cost crowds out fiscal resources that could have been invested in social services such as health care and education.

According to the 2011/12 Poverty Income Consumption and Expenditure Survey about 72.3% of the population were deemed to be poor whereas 22.5% were deemed to be extremely poor. On the other hand, 62.6% of the households were deemed poor whilst 16.2% were in extreme poverty. The rural households (76.0%) were poor compared to 38.2% in urban areas. Rural poverty was most prevalent in communal lands (79.4%), followed by resettlement areas with 76.4%. Of the 6.3 million children in Zimbabwe, 78% (4.8 million) live in consumption poverty and 26% (1.6 million) live in extreme / food poverty. Table 1 is a summary of the state of poverty in the country.

Table 1: Summary

Multidimensional Poverty Index	0.127
Percentage of MPI Poor (H)	29.70%
Average Intensity Across the Poor (A)	42.70%
Percentage of Income Poor ($1.90 a day)	21.40%
Percentage of Income Poor ($3.10 a day)	45.50%
Percentage of Poor (National Poverty Line)	72.30%
Income Inequality (Gini index)	43.20%

Source: OPHI Country Briefing December 2016.

Zimbabwe's Demographic Profile

The 2012 National Census estimated the country's total population at 13,061,239 people comprising 48% males and 52% females with 67% of the population living in the rural areas. The total population almost doubled from 7.5 million in 1982. According to the World Bank as at 2016 the national population had reached an estimated 16.2 million up from 15.8 million in 2015 (see Table 2). Zimbabwe's population growth rate remains relatively high and life expectancy is improving, albeit off a lower base. Consequently, there is a large young and working-age population which presents a huge potential. The challenge is to convert potential this into a demographic dividend (tangible development benefits) through enhancing their capacity and productivity. Converting this youthful population into a demographic dividend will require scaling up investments in healthcare and education among others.

The high mortality of the reproductive age group (15-49) due to HIV and AIDS, has worsened the dependency ratio leaving an estimated 25% of children being orphans and vulnerable under the care of the elderly. The fertility rate also remains relatively high (see Table 3). There are regional variations with urban-rural disparities, where rural women have higher fertility rates than urban women. High fertility rates are associated with high poverty and inadequate economic opportunities especially among women.

Zimbabwe's demographic trends will affect government health spending. It is projected that as people will live longer owing to improvements in life expectancy there will be an increase in the population of the elderly and therefore necessitate the allocation of more resources towards social services including healthcare.

Table 2: Zimbabwe's Demographic Profile

	2000	2005	2010	2015	2016
Population growth (annual %)	1.3	1.3	2	2.4	2.3
Population (million)	12.2	12.9	14.1	15.8	16.2
Fertility rate	4.1	4	4	3.9	-
Life expectancy	41.7	41.8	49.6	59.2	-

Source: World Development Indicators.

State and Trends in Key Health Indicators

Government allocation on health care continues to account for a relatively small share of total government spending with health sector allocation standing at 6.9% in 2017. Employment costs however constitute 79% of the total health budget. The Abuja target remains an elusive target for Zimbabwe. Total government expenditure on health as a percentage of total government expenditure was less than 15% (Abuja target) over the period 2010-2017 as shown in Table 3. The Government also spends a relatively small share of its gross domestic product (GDP) on health care. Lower levels of per capita health expenditure indicate that health expenditure in the country is insufficient to guarantee adequate access and quality of healthcare. Per capita health allocation stands at US$21 down from US$24 in 2016. This implies that government will spend an average US$21 per person on health care in 2017 which is grossly inadequate. The per capita allocation is much lower when you remove the employment cost component. The per capita health allocation is lower than the SADC average of US$146. Per capita health allocation is US$650 in South Africa, US$90 in Zambia and US$200 in Angola. Total health allocation has also remained lower than the 15% Abuja target and the Sub Saharan African average of 11.3%. According to the WHO countries such as Malawi, Rwanda, Madagascar, Togo and Zambia have managed to reach the Abuja target. As of 2015, Rwanda was spending at least 23% of its budget on health care.

Table 3: Trends in Health and Child Care Allocations (2010-16)

	2010	2011	2012	2013	2014	2015	2016	2017
Health Allocation (% of Total Government Expenditure)	7.7	7.9	8.6	6.6	8.2	7.3	8.3	6.9
Public Health Spending (% of GDP)	1.7	2.1	2.8	2.8	2.5	2.2	2.3	2.0

Source: Various Government Budget Statements; World Development Indicators.

Despite challenging economic conditions and dwindling allocations of the national budget to health, Zimbabwe has made significant progress in the health front owing largely to external financing from development agencies. These gains relate to significant declines in the HIV prevalence, child mortality, maternal mortality, scaling up of vaccinations of children and increase in life expectancy. Notwithstanding these milestones there is a need to close gaps in coverage and outcomes by eliminating huge income and urban/rural differentials in key health indicators.

Key Challenges facing the Health sector

The health sector is encumbered by a number of challenges which include:

- **Inadequate public financing and overreliance on out-of-pocket and external financing.** The main sources of health financing are employers (28.4%), followed by households (25.0%), external financing (24.9%) and government (21.4%). Out of pockets payments by households have driven many households deeper into poverty. The high dependency on external financing is unreliable, unpredictable, unsustainable and highly dependent on the political environment, raising concerns on the sustainability of health financing institutions and the vulnerability of government's budget should external funding be withdrawn. This also has implications for equity, as out-of-pocket payments hit the poor the hardest. Erratic economic growth and a dwindling taxable formal sector contribute to limited domestic resource revenue raising capacity and constrain public sector health financing in the country.
- **Inadequate public infrastructure and ill-equipped hospitals.** This has led to poor service delivery, leading to preponderance in communicable diseases, and other preventable diseases, like cholera, typhoid and malaria. A number of patients are still enduring having to travel inordinately long distances to access primary health care facilities.
- **Healthcare staff shortages.** The number, quality and capability of health care workers as a ratio of the population is low. According to the World Health Organisation (WHO) as at 2011 Zimbabwe had a skilled health professionals density (per 10,000 population) of 12.7. This points to a huge deficit. WHO identified in 2006 a minimum density threshold of 22.8 skilled health professionals/10,000 people to provide the most basic health coverage. This is exacerbated by the fact that Zimbabwe's nurses' establishment was last reviewed in 1983 yet the population has increased significantly. This has left a huge nurses' deficit at public health institutions with the situation worse in rural areas. Most rural health facilities have on average 2 nurses which is highly inadequate. The working environment also needs to be addressed. In addition, the number of health centres per population is low thus burdening the healthcare workers. Another common problem is demoralisation of healthcare workers by the government through poor wages, underequipped healthcare facilities and understaffing. A number of rural clinics face water and electricity challenges.
- **Emergent shortage of medicines.** The country relies heavily on imports for drugs, equipment and other hospital consumables. The crippling foreign currency shortages have constrained such imports. Many wholesalers have temporarily stopped the importation of critical drugs such as ARVs, antibiotics, painkillers and drugs to treat non-communicable diseases owing to challenges in accessing foreign currency. The shortage of drugs has also led to an increase in the price of drugs by retailers. Some central hospitals have over the past months run out of critical drugs. Critical preventive drugs are not available in most healthcare centres, especially in the levels of dispensaries and government clinics. Owing to this problem, most patients only receive diagnostic services, but are left to search for pharmaceutical services from other places. This challenge, coupled by the fact that most individuals are poor, increases chances of mortality and morbidity. In addition to lack of drugs in most hospitals, there are no adequate facilities to carry out correct diagnosis on patients. Some vital equipment like x-ray machines, diagnostics ultrasounds, monitors among others are not available in most health facilities, with only a few being available in bigger hospitals.
- **High cost of emergency and specialist services and lack of decentralisation of such services.** Emergency medical services in Zimbabwe remain relatively under-developed and under-resourced especially in the rural areas. The cost of specialist services remains high. The high cost of blood is one of the major limiting factors hindering ordinary Zimbabweans from accessing and enjoying their health entitlements and rights as enshrined in the Constitution. For instance, Zimbabwean hospitals

charge on average between US$100-130 for a pint of blood while public hospitals in South Africa provide it for free. In Zambia a pint of blood costs an average US$50 while in Malawi the cost averages US$40. Furthermore, a dialysis session costs on average between US$200-300 at private hospitals while at public institutions it costs between US$80-200. X-rays cost a minimum US$50 while MRI and CT scans cost on average US$500. In South Africa CT scans cost an average US$200 and in Kenya US$100.

- **The unavailability of current comprehensive data on the burden of non-communicable diseases (NCDs)** and their risk factors due to failure by the country to conduct the recommended WHO NCD

  STEPWISE survey and has impacted negatively on any meaningful NCD programming. Rapid urbanisation and changes in lifestyle are causing an increase in the risk factors that cause non communicable diseases (NCDs). This is exacerbated by the high most of NCDs treatment which has made such treatment generally inaccessible to most people. For example, treatment of cancer costs on average between US100-1000 per session.
- **Corruption and misuse of resources.** Corruption diverts much-needed resources away from health care delivery and reduces patient access to services. Examples include medical staff who divert drugs and spend more time in private practice when they are supposed to be working in public hospitals. This has led to insufficient drugs in most healthcare centres in the country. Reports by the Comptroller and Auditor General have exposed poor corporate governance practices and financial irregularities owing to weaknesses in the internal control systems of the Ministry of Health and Child Care and parastatals under the Ministry.

Key Recommendations

Towards a People’s Budget

Since 1991, Zimbabwe has largely followed a market-based approach to development, with basic social and economic rights in terms of food security, access to health care, education, shelter, transport and basic utilities (mainly electricity and water) becoming market-driven. Owing to the fact that even basic rights have been put onto the market, the majority of Zimbabweans, who are living in poverty, cannot access them. It is therefore important to return to a basic needs approach (or a rights-based strategy), which begins and ends with people, the real object of development. In this regard, it is the duty of the Parliamentary Portfolio Committee on Health to ensure that a human-centred approach to development, and a people-oriented budget, is adopted. A pro-people’s budget is pro-poor, pro-women, pro-disadvantaged groups, pro-basic needs and therefore inclusive. It allocates resources to communities and not only for recurrent purposes and is concerned with broad-based ownership. The following principles must inform and guide the adoption and implementation of a people’s budget:

- Gender-sensitivity;
- Stakeholder participation in the formulation, implementation, monitoring and evaluation of development programmes and budgets at all levels;
- Sensitivity to the needs of special groups such as children, youths, those with disabilities and those living with HIV/AIDS;
- Prioritising people’s needs first and ring-fencing expenditures thereto. In particular Government must demonstrate its commitment to health and other social services by increasing budgetary allocations;
- Shift from supply-based to more demand-driven systems of delivery;
- Adopting a holistic approach to issues of development (realising everything depends on everything else and taking advantage of synergies);

- The national budget must be strongly aligned with constitutional imperatives such that the bulk of resources are dedicated towards the realisation of constitutionally mandated economic and social rights.

Implement innovative and sustainable health financing

To boost public spending on health without undermining fiscal sustainability government must explore a number of options and strategies for **innovative mobilisation of significant resources building on best practices** in global health financing which entails: (i) on the supply side, the implementation of fiscal decentralisation with increased transfers from the central government to local governments and peripheral health facilities on the basis of needs and performance. (ii) On the demand side, the establishment of a health insurance system including cross-subsidies from richer to poor categories.

Zimbabwe can learn from the experiences of other countries. A number of countries have come up with **corrective taxes that are levied on goods and services that are considered bad for the individual or society at large.** Examples include taxes on alcohol, cigarettes and products and activities with negative environmental consequences. Such corrective taxes can improve fiscal revenues while at the same time reducing socially and environmentally undesirable activities thereby promoting good public health. This levy should have been imposed on such goods, services and activities.

A review of literature in a number of countries has demonstrated that tobacco taxes reduce tobacco consumption while providing a stable and reliable source of fiscal revenues. The Philippines increased excise taxes on cigarettes and alcohol in 2013. The tax hike resulted in an increase in cigarette prices and more than doubled the tobacco tax revenue collected in 2013 over 2012. Higher taxes on tobacco and alcohol together netted revenue estimated at US$1.4 billion. Tobacco and alcohol tax revenues are allocated to tobacco-growing provinces and tobacco farmers (who receive 15%), health infrastructure (5%), and health services and health promotion (80%), largely through subsidies for poor families under the Philippine Health Insurance Corporation. As a result, the Department of Health budget for 2014 has been expanded by 58% (Asian Development Bank, 2014).

Other progressive tax options include property tax, inheritance tax, and capital gains tax. In particular taxes on property include annual taxes on land and property, stamp duties or property transfer taxes, development fees, improvement/betterment levies, estate duties or inheritance taxes, and capital gains taxes on property transfers. It has been demonstrated in empirical literature that among broad-based taxes property taxes have the least adverse effect on growth and they are more progressive as the tax value is proportional to the property value.

There may be scope for introducing a wider range of wealth taxes that might include **taxes on financial transaction flows, luxury airline travel, currency exchanges, remittance transactions and unhealthy foodstuffs and ingredients. Some countries have introduced a new tax dedicated specifically to raising funds for health. For example, Ghana has increased its VAT by 2.5% and the additional revenue contributes to the funding of its recently introduced NHI system.**

The World Health Organisation (WHO) in a 2015 report titled, 'Fiscal Policies for Diet and Prevention of non-communicable diseases' has called on governments to raise taxes on sugar-sweetened beverages to fight the scourge of non-communicable diseases and obesity. The tax apart from reducing consumption of sugary drinks also raises additional revenues for the treasury. According to the same report by the WHO if retail prices of sugar-sweetened drinks are increased by 20% through taxation there would be a proportional drop in consumption. In the same light, on 1 April 2017 South Africa introduced a 20% sugar

tax on sugary beverages. This part of the South African Department of Health's strategic objective of preventing and controlling non-communicable diseases and obesity. The goal is to reduce by 10% by 2020.

Innovative mobilisation of domestic resources will be crucial to build financial capacity and create fiscal space for sustainable health financing. This will help to reduce dependency on external financing.

Address the social determinants of health

Government must address the key health determinants related to poverty and poor living conditions. The country has been facing structural economic challenges, rising incidence of poverty, food insecurity, rising informality, increasing unemployment and underemployment negatively affecting health outcomes. These factors have to be addressed in order to improve the conditions of health and development. It is particularly important to broaden the tax base by dealing with the problem of informality (High growth and efficient tax system). The overall level of economic development is a key factor in determining the options for expanding health care coverage. The country must reaffirm its commitment to the values and principles of primary health care (PHC) namely: equity, solidarity, social justice, universal access and community participation.

Strengthen public health infrastructure and capacity (especially in the rural areas). Public health infrastructure has been referred to as 'the nerve centre of the public health system.' These are building blocks that underpin public health activities and practices and include: physical infrastructure; a capable and competent workforce; up-to-date data and information systems; and institutions with the capacity to address and respond to public health needs. Public health infrastructure provides the necessary foundation for undertaking the basic responsibilities of public health, which have been defined as the 10 Essential Public Health Services[1]:

- **Monitor** health status to identify and solve community health problems.
- **Diagnose and investigate** health problems and health hazards in the community.
- **Inform**, **educate**, and **empower** people about health issues.
- **Mobilise** community partnerships and action to identify and solve health problems.
- **Develop policies and plans** that support individual and community health efforts.
- **Enforce** laws and regulations that protect health and ensure safety.
- **Link** people to needed personal health services and assure the provision of health care when otherwise unavailable.
- **Ensure** competent public and personal health care workforces.
- **Evaluate** effectiveness, accessibility, and quality of personal and population-based health services.
- **Research** for new insights and innovative solutions to health problems.

Government must allocate funds towards improving basic health infrastructure in the urban, resettlement and rural areas.

Strengthen district and community health centres to promote preventive health care (as opposed to curative interventions). Currently there is a bias towards curative interventions and this is not sustainable and must be corrected through greater investments in preventive care. Government must increase funding

[1] Source: Public Health in America, Public Health Functions Steering Committee, Public Health Service. 1994

for urban and rural councils in order to strengthen primary health care and reduce unnecessary referrals to higher levels. Funding for mobile outreach services so that communities in remote areas and newly resettle areas can access primary health care also needs to be increased. A significant share of the national Budget should be allocated to the district level health system. Investing in district and community health systems should be a priority that can contribute towards universal health coverage and the achievement of the SDGs. Basic public health infrastructure in urban, informal, resettlement and rural areas needs to be prioritised.

Promotion of partnerships with the private sector. Capacity of the private sector, including NGOs is not fully being mobilised. It is important that the private sector be more involved in both supply of health services (including development hospital, clinics, diagnostic centres, education institutions, etc.) and demand for health services. The participation of the private sector in the health sector will help to bridge the huge resource deficit and provide state-of-the-art equipment at public health institutions. Chitungwiza Hospital is a good case study of an institution that has adopted the Public Private Partnerships (PPPs) strategy as a way of raising capital and ensuring state-of-the-art equipment. This has resulted in a significant improvement in service delivery. Consequently, Chitungiwiza Hospital became the first public hospital in Southern Africa to achieve ISO certification. There is however need for a strong regulatory and governance framework governing PPPS in the health sector.

Strengthen budget tracking and monitoring to improve the efficiency of expenditures. There is need for a more equitable allocation of funds, more aligned to health needs.

Address the human resources situation. Review the staff establishment to reflect the current environment. There is a need for the absorption of all the produced graduates by removing the moratorium on public health posts. As part of the process of expanding coverage to a larger proportion, it is imperative that Human Resources for Health (HRH) planning takes into account demographic trends and developments. Appropriate incentives must be designed to ensure equitable distribution across urban and rural areas ensuring access to under-served populations.

Address the essential drugs shortages. To address the drugs shortages there is need to build the capacity of local drugs manufacturers such as the National Pharmaceutical Company and CAPS. Pharmaceutical institutions must also be prioritised in terms of foreign currency allocation. Government should also reduce the high disease burden by prioritising health interventions and promoting primary and essential healthcare.

Embrace social dialogue in the governance of the health levy. There is a need to strengthen public accountability and management of the healthy levy by including other stakeholders such as civil society organisations (CSOs) in the management committee and also publishing the amounts collected and how much it has been used for. In a number of countries the participation of CSOs in planning, management and oversight of health policies has not only increased the quality of services but also lowered the costs of delivery.

Implementation of the findings from the Comptroller and Auditor-General's reports. Government must act on and implement recommendations from the Comptroller and Auditor General's reports in order to enhance financial management in government departments and parastatals.

Public Health Act Amendment Bill. The Bill needs to be brought before Parliament for debate and passage as it is now long overdue.

The Competition and Tariff Commission (CTC) must investigate the distortionary and uncompetitive behaviour of a number of medical aid societies that has left their members vulnerable. In particular, the cost of medical aid is much higher than in the region and some tariffs are much more than individual salaries. International best practice shows that medical insurance costs cannot go beyond 10 percent of one's earnings. Moreover, the country must adopt an independent board that balances the needs of health insurers, providers, government and the public.

Harmonisation and alignment of external funding to national funding. The fragmented nature of health financing is significant bottleneck to the transparency, efficiency, and effectiveness of national health financing. There is an urgent need and scope for the harmonisation and alignment of external funding to national funding. Factors that lead external funders to avoid using existing national channels, such as transparency and accountability of the system will need to be addressed.

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