Urban Local Government Financing and Health: Report of a Workshop

Mutare, Zimbabwe
February 5-6 2001

Training and Research Support Centre
Urban Councils Association of Zimbabwe
Zimbabwe United Residents Association
Ministry of Health and Child Welfare

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1. Background

Urban local authorities have faced particular problems in mobilising resources to meet community health needs and maintain service quality. There is increasing demand for services from residents (particularly due to HIV/AIDS) from people in surrounding farm and rural areas (due to service quality shortfalls in these areas), together with declining grants from central governments, increasing costs to consumers, shortfalls in reimbursements from the SDF and widening responsibilities for health services.

The TARSC programme on health financing in local government areas in co-operation with Urban Councils Association of Zimbabwe, (UCAZ), Zimbabwe United Residents Association (ZURA) and Ministry of Health and Child Welfare (MoHCW) Zimbabwe with IDS Sussex (UK) seeks to stimulate review by local government and civil society on the level of civil participation in local government budget processes and the nature of local –centre relations on health financing.

To support this programme and under a steering committee of UCAZ, ZURA and MoHCW, TARSC carried out a review of international experience on local government financing and health and carried out field work and interviews in two pilot local authority areas, Mutare and Marondera. These were separately reported. The findings of the field work and of the international review were presented at a meeting of representatives of UCAZ, ZURA, MoHCW, of the parliamentary committee on health, of the Mayor and councilors of the Marondera and Mutare Urban Councils, their health and town clerk departments, of residents associations in the two urban areas, of the Community Working Group on Health, Ministry of Finance, the private medical sector and the Urban Councils Health Forum. (See participants list. Appendix A). The meeting drew on the wide experience present to review the findings of the research, take input from key stakeholders on the issues arising and to identify options for strengthening local government health financing, service quality and participation in health services. This report outlines the presentations and discussions at the meeting and the recommendations made. The hospitality of the city of Mutare and active input of all delegates was gratefully acknowledged by the host organisations.

1. The opening

The meeting was opened by Clr Karumbidza representing the Executive Mayor of Mutare Hon Alderman L Mudehwe. In his opening he noted that the workshop offered a platform for discussing and identifying options for solving problems affecting the health delivery system in local authorities. The causes of these problems he attributed to ‘a bulging population and a dwindling resource base.” He noted the need

for the workshop to identify areas for improvement of leadership and management performance to create a conducive environment amongst stakeholders for improving the health system, even through the macro-economic environment may not be conducive. He called on stakeholders to be proactive and dig into their resourcefulness. He wished the delegates fruitful deliberations.

The Executive Mayor of Marondera, Hon L Mukungatu also gave opening remarks. He also noted the dramatic increase in urban populations, that had stretched the capacities of urban planning and services. He noted that health was a critical basis for all other areas of well-being and should be prioritised. This meant that there was a need to know and implement health policies, and build capacities to do so. This means that authorities and communities should work together towards the implementation of improved health services.

Dr D Dhlakama, acting for the permanent secretary for health outlined the Ministry of Health and Child Welfare policies on health and their implications at local government level. He began by defining the direction of the MoHCW, as a basis for deciding 'how to get the money to travel'. The health situation and the strategic direction of Zimbabwe's health sector are spelt out clearly in two documents, which were developed almost at the same time. These are the National Health Strategy 1997-2007 whose theme is working for Quality and Equity in Health and the report on the Commission of review into the Health sector 1999.

The MOHCW realized four years ago that post independence success in the health sector was under threat. After extensive consultation with stakeholders, 10 key performance areas, where improvement must take place in order to advance the health gains or at least protect the health gains now under threat were identified. These were

- Reducing illness and death due to major diseases
- Reforming the health sector
- Rehabilitating existing facilities
- Managing and developing human resources
- Mobilising resources and strengthening financial management
- Improving management of supplies and logistics
- Managing and using health information and research
- Restoring health financing to Usd23 per capita (last obtained in 1991/2

In acting on these priorities it was observed that:

- The major determinants of health and quality of life lie beyond the health sector, and include socio-economic, cultural environment and lifestyle factors.
- Real public health expenditure has been declining in the last five years whilst the disease burden has increased.
- There has been little or poor community participation in health planning and decision making.
- The health sector has weaknesses in organization structure and managerial capacity.
- There is dissatisfaction with the quality of service and care being provided by both the public and the private sectors. Poor maintenance of infrastructure, staff attitude and unavailability of drugs are amongst the source of this dissatisfaction.
- The public health sector is experiencing a very high attrition rate of trained experienced professional due to poor conditions of service and poor salaries.

- The HIV/AIDS epidemic is negatively affecting population, health and socio-economic status.
- Preventable diseases still explain most ill health and mortality.
- New challenges and diseases due to population, economic, occupational, cultural and other factors.
- The MOHCW has weak capacity to co-ordinate the activities of the stakeholders.

To respond to this situation the MoHCW identified some important health actions to be taken, ie:

1. Balancing the population growth rate with socio-economic development
2. Improving socio-economic and living conditions of the population
3. Improving and maintaining a healthy physical environment.
4. Promoting healthy lifestyles
5. Mobilizing more internal and external resources for the health sector.
6. Revisiting the issue of equity, availability, and accessibility to health services.
7. Getting political commitment towards improving health and quality of life.
8. Reorganizing reorienting and strengthening the health system, with emphasis on decentralization of and involvement communities in decision making and planning.
9. Improving the quality of health services and care.
10. Developing a human resource strategy that takes into account the social and economic needs of health workers.
11. Strengthening approaches towards preventing and control of HIV/AIDS and STIs.
12. Reducing mortality and morbidity due to major disease problems, especially those that are preventable.
13. Increasing education opportunities for all with special attention on woman and people with disability.
14. Preventing occupational hazards and injuries.
15. Co-ordinating the operations of the health sector.
16. Monitoring and evaluating the implementation of plans as well as health status and services.

Dr Dhlakama noted the need to look at other ways of generating resources for health to restore the Usd23 per capita needed to finance a basic level of health services, such as social health insurance. The MoHCW needed the co-operation of other partners, including local government to achieve this. At the same time it was important to ensure that prevention remained the main strategy within the health sector, and that funds for prevention, for environmental health, for children were dedicated to protect these functions.

The representative of the Urban Councils Association, C Musekiwa, also welcomed delegates. He too noted the ever increasing urban populations and the need for more active policy development to deal with this situation. He noted that there are real problems in the urban public health sector, in part resource based but also due to the sometimes contradictory political signals given on public health. He welcomed the delegates and noted that UCAZ was committed to the issue of improving urban health services.

In the discussion on the opening presentations, delegates raised a number of issues. The issue of political commitment to public health laws was raised, and it was noted that in election periods contradictory political signals are given about breach of these

roles (eg in the case of vendors) to avoid loss of popularity. This made it difficult for the authorities to implement the same laws later. It was noted that public health standards have helped to prevent epidemics such as cholera in the cities, and are thus important. Meaningful dialogue with key economic actors was critical to ensure that these laws are understood and implemented, rather than imposed.

Delegates also noted that there was across many urban council areas poor communication between communities and authorities, sometimes degenerating in confrontation with highly conflictual language used, making it difficult to resolve issues. This is part relates to political suspicions, to poor communication and negotiation skills and to weak transparency in functioning. The discussion on participation in local authority health systems should attempt to resolve these issues.

2. Presentation of the research

The findings from the international review and from the field work and interviews in the two pilot urban councils were presented by Dr R Loewenson, TARSC. The work programme under a TARSC, UCAZ, ZURA, MoHCW steering committee aimed to

i. Carry out technical analysis of local authority health delivery and health financing in Zimbabwe and internationally
ii. Review with stakeholders options for local resource mobilisation and for local-central government responsibilities in health financing.
iii. Review with stakeholders residents and civic organisations options for enhancing participation in resource mobilisation and in health budget processes.

The work is presented in two reports available separately, Local Government Financing and Health: Review of International Experience and Local Government Financing and Health: Experience and views from two Urban Councils in Zimbabwe[1].

International experience indicates that 'Money should follow functions': ie it is necessary to agree on health service functions, assign responsibilities for expenditures based on functions, then assign revenue authorities. Revenue authorities should then be provided to cover costs and avoid unfunded mandates.

In assigning functions, there needs to be legal and policy consensus on core services. Local government roles in service provision are generally based on their constitutional role of supplier of essential services, public goods or unique needs; of regulator and of facilitator of the interface between citizen and state. In assigning local government service roles, inter-jurisdictional spillover functions should be minimised, provided by central government or paid for by transfers.

Central government can ensure policy and public accountability on functions through direct service provision, law or financial measures (incentives, formulae, transfers). Financial measures need performance and programme budgeting, linking spending

[1] Loewenson R and Othieno Nyanjom E (2000) Local government financing in health: a review of international experience, TARSC Monograph, Harare
Loewenson R with Chikumbirike T, Magundani P (2000) Local Government Financing and Health: Experience and views from two Urban Councils in Zimbabwe: Prepared under the TARSC/UCAZ/ZURA/MoHCW programme on Public participation in Health in Local government in Zimabwe November 2000 TARSC Monograph 10/2000

to activities/ outcomes. Country experience indicates that community preferences can be incorporated through public information, participation in planning, integration of community evidence and contracting arrangements. Examples also exist of where public accountability is built through councils, audits, participation in budget councils and active ward based consultation. Private providers can also be brought into greater policy accountability through co-ordination mechanisms, regulation, financial measures and contracting. In doing this, experience indicates that vulnerable group needs can be protected through earmarked transfers, cross subsidisation, increased social voice and high profile support, such as from executive mayors and strong civic groups.

International experience indicates that a range of sources of local government revenue, ie:

- Locally raised revenues (local taxes, user / utility charges, levies, rents, fees, licenses, fines, parking charges and surcharges on alcohol and gambling)
- Other community co-financing
- Central transfers to deal with horizontal imbalances (uneven distribution of the tax base) and vertical imbalances (mismatch between functions and revenue sources)
- Donors and Borrowing

Where imbalances occur these are managed by transferring functions back to higher level or transferring funds down to lower levels. Central transfers downwards are made through revenue sharing formulae, agency fees, lump-sum allocations, grants or financial bailouts and matching transfers. Resource allocation formulae generally use indicators of need *and* fiscal performance (tax capacity and tax performance). Such transfers are found to function best when they are openly and objectively determined, defined through an independent statutory authority, use an agreed and clear formula, based on credible factors and simple to apply, are relatively stable for budget predictability and are renegotiated periodically, such as every 3-5 years.

How are these issues reflected within the Zimbabwean experience. Evidence was presented from the two pilot local government areas. In these areas there was evidence of increased demand for services, increased population pressure, spillover demand from other areas and widening service responsibilities. This was being met in a context of falling real per capita resources and shortfalls on central grants and reimbursements primarily through diversion of rates funds and increasing user charges, but with rising deficits on recurrent spending. It was noted that audited financial statements had not been available to the research team, who had had therefore to draw conclusions from reports of estimates of expenditure. The field work found that

- There was weak consensus and unclear law and practice on local government health service responsibilities
- Recognition of local authority spillover functions was not formalised
- While priorities for local government work on health were shared across groups, confidence that these are included in planning or delivered is not.
- There is consensus across groups that health service performance should be judged in terms of
    - increased community contribution to services;
    - reduced disease levels,
    - reliability of essential resources at services,
    - positive community responses to services,
    - community involvement in health systems.

Despite this consensus, these indicators not monitored locally and are not all reflected in benchmarks set at central level for service performance.

- There is weak co-ordination or partnerships with private for profit, not for profit and community providers.
- There have been shifts in expenditure from public goods funding (water, sanitation, refuse removal) that have strong pro-poor impacts towards personal care services that the poor may not have access to.
- Revenue has shifted from progressive tax based sources and from local economic activities
- Current equity measures such as fee capping and central transfers are no longer working and exemption systems are weak
- The current central to local transfer mechanism is ad hoc, based on central discretion, inadequate to protect equity and service objectives and generates significant local government uncertainty.
- There is weak proactive involvement of civil society, business and non government health providers in local budget processes making these groups reactive to formulated budgets and raising conflict.
- Current expenditure based budgets are useful for financial accounting but a weak instrument for relating budgets to performance areas or progress in achieving policy goals.

The recommendations made by stakeholders in the two pilot areas and as a result of the findings are as follows:

- The MoHCW and MoLG should clarify service roles and ensure that this is clearly provided for in law
- Local governments and the MoLG should monitor expenditure patterns between public goods funding and personal care services and protect pro-poor, proven areas of public health input such as the water, sewage and waste disposal services.
- Local governments can monitor and provide public information on performance on agreed priorities and ensure visible improvements in agreed key performance areas as a way of strengthening commitments towards resource mobilisation for services.
- Provider co-ordination and public participation can and should be strengthened to maximise effective roles and inputs, and this can be done through ward/ health centre committees and local council health boards/ committees. These can have a range of functions from routine information sharing, co-planning on budgets, to setting up contractual partnerships for service provision.
- Improved mechanisms are needed for protecting access to health inputs in poor communities, including enhancing their visibility in health planning, using available data to systematise information on vulnerable groups, ensuring strong elected and civil advocates, identifying revenue sources to fund programmes, strengthening preventive inputs and enhancing service uptake.
- There is a need to identify predictable tax based options for health financing (central tax sharing, local valorisation taxes, sin taxes etc) to avoid dependence on fee charges. This should include widening the insured population.
- Local and central government need to develop an agreed resource allocation formula for central transfers that is legally enshrined, predictable, objective and based on agreed factors of need, capacity and tax effort, with a baseline that the richest local authority can meet all costs of its own responsibilities from own source revenue without incurring deficits.

- Local and central government need an agreed mechanism for centre-local consultation on fiscal matters, imbalances and transfers.
- Greater stability in budget processes would be achieved by bringing civic input on budgets upstream, through
  - clear and comprehensible information on past spending and performance,
  - formulating priorities to be used by department estimates, expenditure priorities and major revenue sources,
  - formally endorsing the final budget
  - participating in budget monitoring.
- Commitment to resource inputs and management efficiency would also be strengthened by developing performance and programme budgets that also link capital investment plans with recurrent budget plans.
- This demands investments to strengthen local government capabilities for health and budget planning and monitoring and for effective interaction with key local stakeholders.

In the discussion on the research the issues of the inadequate resource base, uncertain government transfers and increased service demand were given much attention. Some delegates felt it was necessary to charge an additional health levy, such as the education levy, to give local authorities an improved tax base for services. Others felt this was simply a disguised rates increase, and that it would be better to more effectively use an earmarked share of the rates budget for health and convince residents of the returns on this spending to encourage increased contributions. In this the subsidy that was currently being drawn from the water, waste and sewage accounts to finance personal care services was felt to be inappropriate and damaging in the long term to the quality of these services. It was also noted that residents already feel highly taxed but have not adequately perceived service improvements to raise their commitment to paying these increased taxes. It was also noted that overdrafts that local authorities were now running were costing the authorities more than their health budgets to services and should be renegotiated as longer term debt through central government to reduce interest charges and free up some resources for meeting critical maintenance and service needs. Further it was noted that tax and fee collections currently being sent to central government (eg roads levy, parking fees etc) should be retained locally to increase the resource base, and that this should be followed up through the Ministry of Local Government.

The imbalance in health financing was observed to imply that there was need to review the fiscal process in a manner that fully involved local authorities, that set clear roles and identified service responsibilities and their costs. It was also observed that residents feel distrustful of the management of local authority finances as the current forms of consultation are not effective. This lack of communication has been worsened by the current political climate which has made civic matters highly politicised. It was noted that the Urban Councils Act sets out in clear terms to need for effective consultation between councils and their residents and effort should be made to 'bring people on board'. In the health sector the need for a mutli-stakeholder committee at local authority level was endorsed. This should also include local authority workers, whose union was noted to have been left out of the meeting and should be included in future discussions, as they too have an impact on the budget process.

3. Stakeholder views

3.1 Improving local government service quality and financing

Mr O Chaponda, Marondera Council Health Department outlined his perceptions and views on how to strengthen the financing and quality of health services in the council area.

He noted the decline of industry in the town and the fall in government grants, leading to council having to finance health from the rates account and other profit making areas. Industry closure has led to job losses leading to a situation where most residents have difficulties affording health care. This makes increased fees an untenable option for additional health financing. To open up options he advocated for a participatory budget process, which would only be taken in the correct light if there were less partisan interference in civic matters. It also calls for education of civic groups and council. He further noted that if there were clear commitment to agreed priorities, backed by evidence of changes in these areas, people's willingness to contribute would grow.

He also advocated greater involvement of private sector providers in a co-ordinated framework. Central government should also amend its collections and disbursements to allow local authorities to retain pollution fines, and by providing reliable, legally enshrined and formula driven grants to meet the increased duties allocated to councils.

Mr T Mushababe, Mutare City Council Health Department outlined his views on how to strengthen the financing and quality of health services in the council area.

Mr Mashababe noted that the statutory duties of local authorities in terms of health provisions is stated in the Public Health Act as follows:
"Every local authority shall take all lawful and necessary procedures for the prevention of the occurrence or for dealing with the outbreak or prevalence of any infections or communicable or contagious disease."
This covers water supplies, sanitation and the prevention of the pollution of land, water and air , control of communicable disease and food hygiene, or services are classified as environmental health services. The Urban Councils Act permits local authorities to provide personal type services such as curative services, Maternal and child health services.

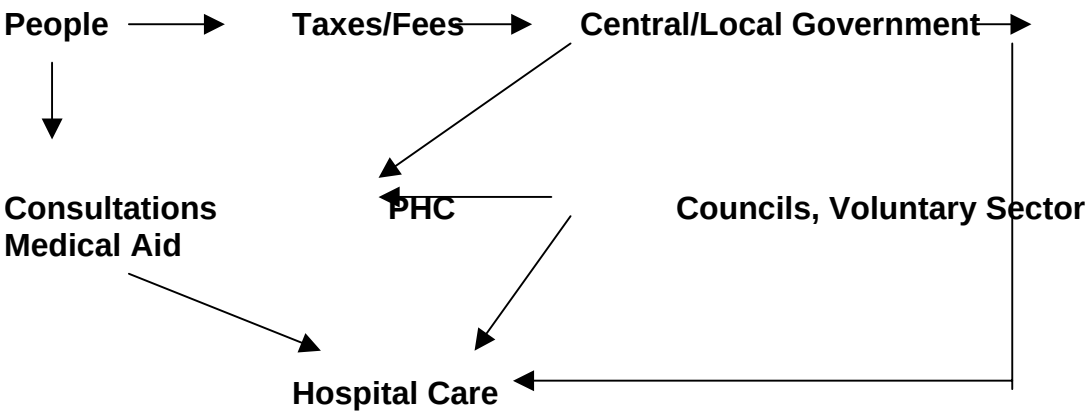
Larger urban local authorities' health departments offer the following primary health care services. He recounted the history of the Public Health Financing agreement and noted that the arrangement was honoured for only a short period, after which the share of funds provided by government has declined progressively. This share now amounts to less than 4% of costs incurred by Mutare City on personal health services. There is no formula used for the allocations, which are completely unpredictable. This makes planning difficult for the Local Authorities. Local Authorities used to receive some free supplies of drugs. From 2000 these have been replaced by slightly increased grants. This arrangement has left Local Authorities financially worse off as they have to use this money to purchase drugs from the open market because the government medical stores are always experiencing shortages of vital drugs.
Environmental health services were financed from profits from liquor sales. Councils had monopoly in the sale of beer in Local Authorities areas. Today the monopoly has been removed and the council liquor service is fighting for its own survival let alone

financing its traditional recipients. I.e. environmental health and welfare. User fees were introduced in 1980 for those earning above $150,00 per month, which was later increased to $400,00 in 1994. The fees charged are prescribed by government and local authorities have no say in the matter of who should pay and how much.

As a result of this local Authorities find themselves incurring heavy deficits, such as the $79mn projected for the year 2001 for the City of Mutare. Most other Council trading accounts posted budget surpluses. The Refuse Removal account posted surplus of more than $10 million in 2000 - enough to buy two refuse trucks for the ailing fleet. However these surpluses have had to be used to pay nurses because the government is not meeting its obligations. Sewerage reticulation, waste management, Pest Control, etc are suffering as a result.

He suggested some alternative revenue sources, including rates increases, the AIDS Levy, national taxes and social health insurance. He also observed that there should be full cost recovery for those on higher levels of medical aid.

Mr S Chihanga, of the Ministry of Health, outlined options for strengthening the resource base for local government health financing. He noted the sources of funding for public health care as below.



In the 1999 report on the national health accounts it was observed that government contributed 29% of total health expenditure and is thus a smaller contributor than for example the public through direct payments. The current local government health financing is based on the Public Health Finance agreement of 1976, which has become vague, has not maintained an agreed level of funding and where roles have become grey. This situation is further worsened by an unworkable social protection system (SDF), leading to declining health indicators and disillusionment with public health services.

The MoHCW has identified the need for health financing reforms that reduce inequity, reinforce equity in health policies, raise per capita spending to US $23, increase spending on the poor, improve quality and increase transparency in health financing. This should introduce purchaser /provider splits that allow the health providers to stick to their core business, that remove perverse incentives and enhance efficiency.

One important approach is to introduce social health insurance (SHI), not as a substitute for but as complementary to the national health budget. This is being done

in a context of a largely rural population, mostly in informal sector, and with 48% under 15yrs of age. Only paid workers and their dependants can easily be brought into SHI. SHI does however enable risk sharing, converting a small probability of a large cost to a definite small cost. It is comprehensive due to its compulsory nature, will raise revenue and improve technical and allocative efficiency if properly designed, can facilitate private sector involvement and can enhance transparency in health financing. He noted that the public will participate if they have confidence in it and that the level of ownership depends on the transparency of the scheme. To introduce the scheme he observed some work that needs to be done, including

- Enhancement of revenue collection
- Review of exemption systems and procedures
- Review of user fees so that they function as an incentive for SHI
- Organisational changes in health services
- Review of the role of current medical aid societies.

This calls for political will, information and analysis, consultation and communication.

Mr Ngorora, Ministry of Finance presented an outline of the current budget process and ways in which it could be strengthened. Within the current budget process,

1. A call circular for bids is sent to ministries in February. The circular emphasises the need for budget committees to be set up to ensure the bid encompass all programs and aspirations of the sector. The bid should also spell out the programs the Ministries will pursue in the coming year. The bids are usually submitted in April or May.
2. Budget discussions take place within the ministries: The discussions are usually to defend and elaborate some of the salient points in the bids. Most ministries bring along individuals competent in their various departments. Discussions are usually from June-July. (Tentative allocations are made at this stage).
3. The budget framework is worked out in consultation with various stakeholders like the Reserve Bank, Taxes, and Customs. The budget framework gives ceilings on expenditure and revenues. The framework is submitted to cabinet for approval.
4. Once cabinet approves the budget framework, allocations are adjusted to conform to the Budget Framework. This is done in August.
5. Ministries are advised of their allocations, which should be broken down as per the format in the current 'blue book'. The figures are submitted to Treasury where they are consolidated.
6. The budget is presented to parliament by the Minister of Finance in October, early November
7. Budget discussion approval ensues in November and December.
8. Once approved by Parliament the budget is sent to the President for approval in December. Once approved the ministries are now authorized to spend their allocations starting in January.

He noted some problems in this process. Dividing resources available for government operations against increased demands for services is a problem. The 2001 budget bids from ministries amounted to $380 billion against anticipated revenues of $140 billion.

The budget set up is such that more resources are going towards non-discretionary expenditures such as salaries, interest on debt and pensions. For the 2001 budget 80% of the budget goes to non-discretionary expenditures. Interest alone accounts for 48% of the total Government expenditures. Only 20% of total expenditure is thus

available for Government operations. This has seen a deterioration in service delivery by Government.

Mr Ngorora made some suggestions on how to improve budget performance:

- More public participation will ensure the budget encompasses the aspirations of the people.
- Enhance retention of revenue for those revenues which cost more to collect. Such resources are used to supplement the budget for the sector such as the Health Services Fund and the Agricultural Research Fund.
- More power to accounting officers on how they utilize their resources, without recourse to Treasury.
- Performance budgeting by matching programs to resources. This is still in the process of being implemented.
- Improving macro-economic performance that will improve the standard of living and thereby the health of our nation.

In the discussion on the presentations, it was noted that the current system of financing from central to local level makes grants more of a privilege than a right, and does not facilitate the blending of different sources of financing to ensure adequate resources for an agreed basic standard of health services. It was again proposed that the centre-local financing system be reviewed through the parent ministries, with council participation through UCAZ. It was also noted again that urgent attention should be given to restructuring local government debt to reduce the annual interest payments. Finally the delegates further endorsed the proposals to strengthen consultation of stakeholders around budget processes, and to build capacity and information to support this.

3.2 Improving participation in local government services

Mr Makumbe, of the Zimbabwe United Residents Association, highlighted the manner in which residents can contribute towards health systems, and the roles they should play.

Mr Makumbe noted that residents are the main users of the health services and the main contributors of the revenue through their labour, taxes. However, when it comes to budget processes and priority setting, they are not consulted. Their participation should however be recognised both in law and practice, from the beginning of the process. This will avoid conflict over the process. Residents can provide their local authorities with information on priority needs in health through Ward councillors. Residents can make contributions in kind (through labour, eg: cutting grass, cleaning sites) that reduce health costs. Residents can suggest how they can raise funding for specific projects of their choice. If residents make behavioural changes in health and hygiene practices, they reduce curative costs.

He suggested that funds for health could also provide for rates remissions for those who keep areas clean, and pollution charges on those who emit waste into rivers and culverts, or punitive charges on unused/developed land or multiple ownership for speculative purposes. He concluded by noting that the main objective should be to create health awareness in residents through participatory approach.

He noted that barriers to effective participation include political blocking, bureaucratic blocking and non delivery on promises. This raises conflict between residents and

councils and needs to be addressed. At the same time the residents associations were aiming to increase their role in raising resident awareness to enhance their constructive participation in council issues.

Ms M Madondo of the Mutare CWGH – a network of civic organisations coming together to promote health - noted some of the health problems in Mutare from a community perspective, including poor communal toilets, unhygienic flea markets, waste disposal problems and poor food hygiene. The CWGH has formed about 5 health centre committees in different wards to carry out activities to improve the currently poor standard of the health delivery system. The CWGH has met the councillors of wards where they are working to present views of the residents, health problems in the wards and ideas on how these can be dealt with. It was noted that residents often use direct channels, such as to more powerful political links, to solve problems, as they have not had effective responses from or do not know or have other means within their wards and areas. The CWGH seeks to ensure that local civic groups, elected leaders and administration officials improve their communication and co-ordination and that something is done about problems that residents see as a priority.

Hence for example, the city health officials were taken to Sakuva's toilets which were in a very bad condition. They were also notified of the people no longer able to use health services because of rising prices, including orphans from AIDS, and of people who suffered further problems because they could not afford ambulances.

She told for example the story of an expectant mother in January 2001, in Chikanga who called for ambulance who would not come because they had no money. After several calls from residents, the driver came to her rescue and found this woman had a breech birth and he had to help the woman with some other old women who were on the scene, and the baby was born dead. There was no immediate action taken, to save the child. He then took the woman and the dead child to hospital and asked for $180 and the father of the child refused to pay because his child was dead. The ambulance driver said he was going to take legal measure if the father did not pay.

"This has happened in 2001 while we are saying health for all by the year 2000. It is death for all - no one can afford these exorbitant fees and to add insult to injury there are no drugs or the drugs are limited and you pay $100.00 to get a treatment of six Panadols. The local authorities should consult the community for a better budget".

In the discussion on participation, delegates noted that the Urban Council Act should be fully known and implemented (and if necessary revisited) to clearly provide for councilor representative roles and their role in facilitation of all interest groups within their areas. At the same time it should be noted that councillors are under-resourced and poor supported in playing these roles and that public expectations of councillors also need to be reviewed. This type of dialogue needs a framework for debate that does not become polarised by partisan politics. It also calls for the Urban Councils Act to better outline the public consultation requirements and the standards of information flow to support such consultations.

3.3 Improving co-ordination with insurance and private providers

The last presentation session focused on the role of the private sector.

Mr Katsumbe, an official with a medical insurance company, presented an outline of how to strengthen private insurance participation in urban health services.

He noted that Health insurance is not a well understood concept in Zimbabwe, including in urban areas, although most Medical Aid Society (MAS) members reside in urban areas. Zimbabwe is characterised by historical and present gross inequities in terms of access, provision, and quality of health care; (rural - urban dichotomy). Public health funding has steadily declined, and medical aid is increasingly needed because of unpredictability of illness. In Zimbabwe there is 10% private voluntary health insurance coverage. The sector is a significant stakeholder in health care provision and financing, frees government resources to concentrate on the poor and acts as a patients' watchdog vis-a-vis health care providers. He noted the tiers of schemes that cater for all socio-economic groups. Despite this Health Insurance Coverage is low because of lack of a clear legal, policy or promotive framework for it. This includes cover within a large but largely neglected informal sector and in the rural areas.

He noted that local authorities also have inadequate communication with medical aid societies. Each municipality negotiates and charges own tariffs. Most Council health units operate on restricted hours, have long waiting queues, and do not always have doctors present so that patients may seek care outside these services.

He suggested a number of funding options for local authorities, including better management of resources to improve outcomes; attract insured patients through quality improvements and including local authorities as Managed Care providers in insurance plans. He noted however that these do not subsitute Central government's responsibility to compensate local authorities for treating those below the poverty line.

Dr Chakonda, a private medical practitioner, described the options for strengthening the participation of private medical providers.

Dr Chakonda observed that health is a human right, and that it should be our priority to provide the highest attainable standard of physical and mental health to every Zimbabwean. He described several barriers to health care delivery, including gaps in awareness, poverty, manpower, management and motivation. He suggested that private sector public sector cooperation should aim to support heath delivery system goals of affordability, availability, access and accountability.

Local authorities had various options for strengthening co-ordination with the private sector, including

- Contracting health personnel in private practice to do part time work in the public sector and vice versa
- Provision of rooms within hospital grounds to doctors in private practice in order to facilitate access to these doctors.
- Training, where large private institutions should assist .
- Cross referral of patients
- Supportive private sector inputs when bargaining with Medical Aid Societies.
- Contracting support services, eg cleaning, laundry, kitchen.

He suggested local authorities form health committees that include personnel from both the private and public sectors that can assist the local health authority to come up with realistic budgets, develop standard lists of equipment and consumables for health programs, promote research into costs incurred in health delivery and mechanisms to reduce these costs, assist in setting up programs to subsidize services to low income groups utilizing resources available from high-income groups. This implies mutual respect between sectors.

The delegates noted in discussion difficulties in applying full cost rates to basic-care packages for the public sector as this would hike costs to the clients, which may make these schemes unaffordable. It was however observed that private scheme clients could afford full cost bills as this is what they were paying in the private sector. The Ministry of health tariffs needed to allow for councils to negotiate with NAMAS on this issue, rather than to be taken as maximum payment limits. It was however also noted that charges on the NAMAS relative value schedule should also be linked to real service provision at the same standards. Delegates further endorsed the idea of co-ordination mechanisms between private and public providers in local authority areas.

4 Recommendations from the meeting

Where to from here?

A range of recommendations were noted during the course of the meeting in the presentations and discussions and are summarised below.

On health service quality and performance

The MoHCW and MoLG can:

- clarify service roles and ensure that this is clearly provided for in law
- monitor expenditure patterns between public goods funding and personal care services and protect pro-poor, proven areas of public health input such as the water, sewage and waste disposal services.

Local governments authorities can:

- monitor and provide public information on performance on agreed priorities and ensure visible improvements in agreed key performance areas as a way of strengthening commitments towards resource mobilisation for services.
- Strengthen provider reliability and reduce waiting times to bring in more insured patients
- Protect access to health inputs in poor communities, through enhancing their visibility in health planning, using available data to systematise information on vulnerable groups, ensuring strong elected and civil advocates, identifying

revenue sources to fund programmes, strengthening preventive inputs and enhancing service uptake.

- Ensure that the essential drugs list (EDLIZ) and cost effective health technologies and procedures are known and used in local authorities.
- Discuss with private doctors and providers in their area and with NAMAS use of managed care plans
- Improve access to private personnel through contracting, leasing of public space, sharing of equipment and subcontracting of services.

On local revenue mobilisation and use

Ministries of Finance, Local government, Health and UCAZ can:

- Identify predictable tax based options for health financing (central tax sharing, local valorisation taxes, sin taxes etc) to avoid dependence on fee charges. This should include widening the insured population.
- Negotiate for pollution /public health infringement charges/fines to be collected at local level to pay for public health improvements.
- Widen coverage of existing medical aid schemes, particularly in public/civil service employees.

Local authorities can:

- Make more efficient and clear use of existing resources for service improvements to build public confidence to contribute further to health funds.
- Develop performance and programme budgets that also link capital investment plans with recurrent budget plans.
- Earmark, protect, visibly deliver on and monitor budgets for children and for environmental health (water, waste, and dispose sewage).
- Provide for remissions on the rate accounts to areas that carry out self-maintenance.

UCAZ and local authorities can:

- Collectively negotiate with NAMAS to ensure parity with private sector charges in their area for comparable services, supported in their negotiations by private sector negotiating inputs.

On central transfers

Ministries of Finance, Local government, Health and UCAZ can:

- Develop an agreed resource allocation formula for central transfers that is legally enshrined, predictable, objective and based on agreed factors of need, capacity and tax effort, with a baseline that the richest local authority can meet all costs of its own responsibilities from own source revenue without incurring deficits.
- Restructure central government financing through a legally defined resource allocation formula and minimum level of funding.
- Identify local government taxes currently sent to central government (eg: vehicle fees.) that can be retained at local government level.
- Set up an agreed, permanent mechanism for centre-local consultation on fiscal matters, imbalances and transfers.
- Enshrine new roles and funding commitments in a new Public Health Financing Agreement
- Increase social health insurance to increase the pool of public funding, with ways found of extending insurance to informal sector and user fees retained as a policy tool for social health insurance.
- Restructure local government debt to take up central government options for reduced interest rates.

On improving participation, co-ordination and accountability

Local authorities can:

- Strengthen provider co-ordination and public participation can to maximise effective roles and inputs. This can be done through ward/ health centre committees and local council health boards/ committees, as defined in the Public Health Act. These can have a range of functions from routine information sharing, co-planning on budgets, to setting up contractual partnerships for service provision.
- Achieve greater stability in budget processes through setting up a participatory budget process with all civic groups, business, and community, non-profit providers and by bringing civic input on budgets upstream, through
  - clear and comprehensible information on past spending and performance,
  - formulating priorities to be used by department estimates, expenditure priorities and major revenue sources,
  - formally endorsing the final budget
  - participating in budget monitoring.
- Improve information flow between stakeholders in local authority health systems on health services, health priorities, and performance indicators.
- Build dialogue with vendors and community on food hygiene and other public health demands
- Clarify, formally recognise and promote resident association roles in budget process promoting public health , monitoring health service quality, providing expertise of council processes and mobilising peoples input to health.

In other areas

Ministries of Local government, Health, UCAZ and ZURA can:

- Make investments to strengthen local government capabilities for health and budget planning and monitoring and for effective interaction with key local stakeholders.

These recommendations were further discussed by the delegates in groups and the major proposals to be taken forward from the meeting in the more immediate future are noted below.

LOCAL GOVERNMENT SERVICES AND REVENUES

Ministries of Local government, Health, UCAZ and ZURA are recommended to:

1. Clarify local authority roles to include
   - Environmental health services e.g. Refuse removal, Street cleaning or cleaning services, provision of clean water
   - Personal care services, including provision of basic care at primary care level, provision of drugs for this level, immunisation, maternity services and referral to secondary care
2. Strengthen revenue sources for health to include:
   - A percent of the rates and market fees to go towards a health fund that is effectively managed to provide services. This is the first stage to build public confidence in the way their funds are used that can act as a platform for review of funding sources.
   - Pollution fines and charges for public health infringements to go into a health fund accruing at local authority level and be used to pay for public health.

- Taxes and fees collected locally but sent to central government to be retained locally.
- UCAZ should negotiate with NAMAS for children and adults to be reimbursed at the same rate across urban local authorities and review areas where NAMAS can provide comparable cost reimbursement with private sector without generating inequitable or high costs to poor public consumers.
- A more predictable and transparent Central to Local Government transfers from Consolidated Revenue Fund (See discussion below)

Local authorities are recommended to:

- Establish clear areas of service provision for the informal sector, including environmental health official regular visits and use these service provision promises as the basis for any levies on these groups
- Follow up on contracting measures to increase access to private personnel, including leasing public space, sharing equipment and subcontracting services
- Set up co-ordinating committees under local councils to include all service providers, community representatives, business etc (See later discussion).

CENTRAL GOVERNMENT TRANSFERS AND ROLES

Ministries of Finance, Local government, Health, UCAZ and ZURA are recommended to:

1. Initiate through the MoHCW a process that brings into national health budget formulation all stakeholders, including providers of health-local Authorities, consumers etc and enshrine this in national health law.
2. Ensure that government fulfil its responsibility to provide core health services for its citizens in order to achieve equity in health, and thus provide secure revenue to LGs to deliver on this mandate, viz:
   - introduce national health insurance,
   - provide for retention of local taxes currently going to central government,
   - provide for retention of fees and penalties currently going to central government
   - provide for a share of central taxes to be transferred to local level through an agreed resource allocation formula
3. Revisit the resource allocation formulae currently in use to make it more objective and to take into account vertical equity (need and resource availability).
4. Use the above measures as the basis for a new legally binding public health financing agreement for local authorities.
5. Follow up through the MoHCW to encourage the Public Service Medical Aid Society to extend its cover to all civil servants and some sectors of the population that can contribute to the scheme.

PARTICIPATION MECHANISMS

Ministries of Local government, Health, UCAZ and ZURA are recommended to:

1. Establish ward health committees or health centre committees and local authority health boards or committees as set in the Public Health Act that bring in all relevant stakeholders, including councillors, health workers, civic organisations, and health providers, churches, business and the urban councils workers union.

2. Enhance dialogue between councils and residents associations on their respective roles and interaction, including formal recognition of the resident associations and their inclusion in budget processes.
3. Set up participatory budget processes that involve all civic groups, business, community and non profit providers. These processes should involve the following:
    - Setting up participatory budget committees or ward health committees by councillors, as in (1) above.
    - Ward health committee consultations on health planning priorities with information on past performance provided by the council.
    - Local Authority health committee review of priorities from wards with technical input from health departments, town clerks.
    - Technical work on the health plan and budget implications and presentation to council
    - Council debate on the health plan and preparation of a draft budget that includes revenue and expenditure options, clear performance targets for the year
    - Draft budget review by local authority health committees and ward health committees for review and feedback to council
4. Train and provide capacity support to councillors and stakeholders for budget process, budget work etc, supported by UCAZ, ZURA and MoHCW.

GENERAL FOLLOW UP ISSUES

The meeting proposed that these resolutions be tabled at local level with the participating organisations and councils for local follow up. The report will be sent to all delegates and formally presented to the councils in the two pilot areas (Mutare and Marondera) for formal noting and resolution on follow up work. This will be done by TARSC under the auspices of the steering committee for the work, UCAZ, ZURA and MoHCW, which should also find ways of ensuring wider national dissemination of the findings. It was also proposed that the process be spread to other local authorities, through the national organisations involved (UCAZ, ZURA, MoHCW). It was noted that MoLG need to be brought into this process.

It was proposed that a follow up meeting be held within 6 months to monitor implementation of the resolutions. This should also include the urban councils workers union as a delegate and follow up to ensure that Ministry of Local Govt are able to attend at this next stage. It was also proposed that local follow up be held within the two pilot areas to evaluate the impact of the specific work carried out and reported to this meeting.

5 Closing

Mr Makumbe, ZURA chaired the closing session and thanked delegates for their constructive input. Dr Maturue, Hon Exec Mayor of Chinoyi and chairman of the Urban Councils Health Forum indicated that he appreciated the issues raised at the meeting of the need to clarify central government and local government roles, to create dialogue on the budget process and to separate political and civic matters to enable this dialogue to develop. He noted also the need to involve the private sector providers in local authority health services. He urged that the isue of health financing be included in the future UCAZ conference, including the feedback from this meeting. He thanked the delegates and organisers for their contributions and closed the meeting.

APPENDIX A: DELEGATE LIST

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