Zimbabwe Health Budget Analysis 2008

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# TABLE OF CONTENTS

Executive Summary ..........................................................................................................3

1. Introduction ..............................................................................................................6

1.1 Methods ...................................................................................................................9

2. Demographic and health indicators ............................................................................10

3. Mobilising resources for health: how adequate is the health budget?......................14

3.1 Equity in sources of health funding ........................................................................14

3.2 Adequacy of health funding ....................................................................................18

4. Resource Allocation in Health Sector: how equitable and effective is it? ..............20

4.1 Allocations across different levels of the health system ........................................21

4.2 Allocations across different programmes in the health system ...............................24

5. Discussion: Implications for resource mobilization and allocation ......................26

6 References ..................................................................................................................29

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Executive Summary

The national budget provides a concrete signal of government priorities in health. It provides an opportunity for the public, through parliament, civil society and media, to scrutinise and make input to the priorities set and resources allocated, and to assess the performance of the executive in the past year. By December 2008, the process had not yet reach the stage of review and input, meaning that the process if advancing has not received public scrutiny and input. This should also be supported by budget auditing, to assess expenditure against procedures, goals and value for money. This hasn’t been done for years, but should take place between June and August.

This report examines the performance of the health budget in 2007 and 2008. The analysis is implemented through the Training and Research Support Centre. It is intended to support dialogue within the health budget process, through the public consultations in the parliamentary budget process, and particularly by the parliamentary committee on health. The analysis draws evidence from secondary data and national surveys, from reported Ministry of Finance estimates and from the reported budget allocations provided by government, with a focus on the years 2006-2008. This review focuses on the budget allocation to the Ministry of Health and Child Welfare, although allocation to ministries that have relevance to health are also considered.

While Zimbabwe lacks recent reliable community level evidence, available data indicates that

- Households are experiencing economic difficulties that are likely to threaten health, access to inputs for health and ability to pay for the costs of health care;
- Food insecurity will undermine nutrition, increasing the risk of severe disease and undermining the effectiveness of treatment;
- Costs of health care have risen for households due to escalating prices of medical care inputs, such as drug prices, and also for health providers;
- Company closures and unemployment have undermined production of goods needed for health; incomes for households to meet health costs and private contributions to health insurance; and
- Skilled health personnel have experienced worsening working conditions, falling real wages and increasing job stress, in part due to out-migration.

It would be difficult in the hyperinflationary environment to read too much into the absolute figures. Zimbabwe’s health system is significantly under-funded, due to economic and political conditions that arise beyond the health sector.

What is perhaps more relevant are the relative levels and trends and what they suggest about prioritization of scarce resources. The analysis draws attention to trends that need to be addressed through policy and through the budget process:

In 2006, we noted increased levels of household poverty associated with AIDS, ill health, a fall in living standards and a decline in the purchasing power of people’s incomes. At that time the suggested budget priorities were for prevention, environmental health, reproductive health and community health worker programmes. In 2008 trends suggest that while the latter two areas have had some level of increased attention, areas such as access to safe water and sanitation, and the prevention budget continue to be more under-funded relative to other areas.
In 2006 it was proposed that priority be given to public sector primary health care, clinic and district hospital level with mobile and other forms of outreach to ensure coverage in the vulnerable groups. It was suggested that preference be given for public subsidies (tax deductions and grants) to go to the not for profit private health sector, eg missions (vs the for profit private health sector) and for monitoring of all supplementary budgets to ensure that they preserve and do not distort budget frameworks and policy priorities for the main budget, such as when they increase shares to administration and reduce shares to prevention.

These recommendations remain pertinent, and the trends that underlay them appear to have persisted. Supplementary allocations made directly by the central bank are nominally greater than original allocations, and have been made without parliamentary approval. The fall in the prevention share (and rising share to administration) and relatively large share of funding to central hospitals vs district services continue to be an issue and to potentially weaken areas of the system that support low income communities. While the health sector remains under-funded overall, protecting spending in public health, in prevention, in disease control and first and second line curative services is perhaps the highest priority for the budget. New resources should preferentially be allocated to prevention and to primary health care and district referral services, including through mission and local government not for profit providers. There is need to re-define the essential health package and cost it to reflect the new realities on the ground. The share to prevention should be restored to 20% allocated to proven prevention programmes with further increases annually as committed in the Government MDG report.

However the under-funding of all services and programmes make the mobilization of resources the major concern. Unless there is some improvement in resources mobilized it is difficult to make equity gains or to effectively apply resource allocation formulae that integrate equity.

The increase in out of pocket spending on health is likely to increase poverty and act as a barrier for many to care. “No fee” policies already in place need to be more rigorously enforced. This demands an injection of funds to ensure service quality at frontline services. In the absence of significant external flows, increasing the budget through tax or insurance revenues remains the most equitable way of sustaining or increasing health financing. Health insurance while mooted is not socially accepted at present, due to the already high stress on personal incomes and the contraction in formal employment. Even private sector voluntary insurance markers are contracting. New sources of tax revenue, such as from the financial market may improve domestic resources and could be explored.

The Ministry of Health budget through parliamentary appropriations has now reached 14% of discretionary government, and health has improved relative to other sectors such as defence. There are issues to address: A reducing allocation to education, undermining the key role of education in health outcomes signals the need to make clear that increased allocations to health should not be at the cost of investment in other areas of budget spending that impact on health (education, water, sanitation, food production). The parliamentary committee on health should monitor the budget spending in these areas and make clear their relevance for health.

Secondly the extent of extra-budgetary allocations through the Reserve Bank, potentially undermine the shares set by parliament. Budget appropriations should be approved
through parliament. Parliament should call for full, disaggregated and public report on the central bank spending, including on the health sector.

However Zimbabwe’s health sector needs significant new resources. In Zambia these resources drew from funds freed from debt relief. In Uganda the funds were drawn from budget and external resources. The mix of improved budget share, debt relief and external support that the AU heads of state identified as essential for health in Abuja in 2001 now seems essential for Zimbabwe.

Procedural matters are now a priority. The political impasse has left the public without portfolio committees in parliament and without a budget process to engage in. Like the direct spending by the central bank, this undermines the institution of parliament. It also undermines the rights of the public to participate in such vital matters as the spending of public funds on health.
1. Introduction

The national budget provides a concrete signal of government priorities in health. It thus provides an opportunity for the public, through parliament, civil society and media, to scrutinise and make input to the priorities set and resources allocated, and to assess the performance of the executive in the past year. The process and opportunities for this are shown in Figure 1 below.

Figure 1: Schematic presentation of the budget process.
This process could be summarized as:
- policy formulation undertaken in January to March,
- budget guidelines in March to May,
- budget drafting, parliamentary review and public input in June to September,
- legislative approval in October to December,
- implementation, review and monitoring starting January and throughout the year.

By December 2008, the process had not yet reached the stage of review and input, meaning that the process if advancing has not received public scrutiny and input. This should also be supported by budget auditing, to assess expenditure against procedures, goals and value for money. This hasn’t been done for years, but should take place between June and August.

The absence of this process in 2008 is a major democratic shortfall, with negative consequences for the health budget. In its engagement of these various stakeholders and incorporation of their various analytical output, the parliamentary committee on health has managed to advance the share of the national budget on health towards the Abuja target of 15%, and promoted equity in terms of advocating for a resource allocation formula including equity. For example the post budget Parliamentary Debate of 2007 noted that “... it is important to measure and evaluate set targets, both in country and regional, and progress such as the Abuja target of 15% of National total budget being allocated to health…” (Parliament of Zimbabwe 2007; para 2224).

While the promotion, prevention and curative care services provided or organized by the public health sector are important for health, spending on health is not limited to the health sector budget. Health is also improved by gains in various social and economic determinants of health. In Zimbabwe, these include issues such as improved production, accessibility and affordability of food, availability of safe water and sanitation, or affordable accessible pre-school, primary and secondary education services. These areas of spending are also important for the improvement of health.

However, evidence and experience shows that leveraging such actions for health across a range of sectors calls for strong public health leadership from the health sector. Illness impacts on household income, diverting time and money for caring, sometimes at the expense of food consumption, or school enrolment in children, and with longer term consequences for poverty and production, especially for agricultural production and food security. Ill health places particular demands on women and children to provide or pay for care. When public funding for health falls, people pay a rising amount for charges and out of pocket payments for health care. This has a particularly impoverishing effect on women, lower income and socially marginalized groups.

In recognition of this, in 2001, in Abuja Nigeria, Heads of States of the African Union member states committed to allocating at least 15% of annual budgets to the improvement of the health sector, and called simultaneously upon donor countries to complement these resource mobilisation efforts by fulfilling the yet to be met target of 0.7% of their GNP as Official Development Assistance (ODA) to developing countries and canceling Africa’s external debt in favour of increased investment in the social sector. They further resolved to take immediate action to use tax exemption and other incentives to reduce the prices of drugs and all other inputs to health care services for accelerated improvement of population health in Africa (AU Heads of state, Abuja, Federal Republic of Nigeria, 27 April 2001).
It is, however, not just how much money is allocated to health that counts, its also how it is spent. Health care spending levels are very different between different provinces, regions and districts, largely on historical basis rather than on the basis of need. Further, large hospitals tend to consume a large share of health care resources, with less than adequate amounts allocated to clinics and district hospitals. This can undermine the policy goal that citizens not be disadvantaged in their access to health care purely because of their place of residence. So advocacy on how the health budget is spent is necessary to ensure that spending is according to the distribution of population health needs.

In 2008, Zimbabwean people are experiencing a severe breakdown of their health and social wellbeing. While there have been some areas of reported health gain, such as in the decline in HIV prevalence post 2002, the country has experienced rising rates of maternal mortality, child under-nutrition and communicable disease (CSO Macro Int 2007). A cholera epidemic with rising incidence in nine out of ten provinces in the country has been declared a national emergency. Under-funded and under-resourced health care services have struggled to address a rising tide of ill health associated with the breakdown of environmental and economic inputs to health.

It is within this context that this report examines the performance of the health budget in 2007 and 2008. The analysis is implemented through the Training and Research Support Centre. It is intended to support dialogue within the health budget process, through the public consultations in the parliamentary budget process, and particularly by the parliamentary committee on health. It builds on an analysis carried out in 2006 commissioned through Regional Network for Equity in Health in East and Southern Africa and was implemented by the Training and Research Support Centre (Loewenson and Shamu 2006).

That analysis noted increased levels of household poverty associated with AIDS, ill health, a fall in living standards and a decline in the purchasing power of people’s incomes. It called for 2006/7 budget priorities to be:

- Increased investments in addressing under-nutrition, maternal mortality, TB, access to safe water and sanitation and housing, with a rise in programmes for these such as immunization, environmental health, nutrition, housing, antenatal care and community health workers
- Priority in allocations to public sector primary health care, clinic and district hospital level with mobile and other forms of outreach to ensure coverage in the vulnerable groups.
- Continued increases in investment in health promotion and Village Health Workers given the high level of community and home caring practices
- Increased budget allocations to support generic drug local production and outreach supplemented by international funds to support ARV procurement and distribution
- Preference for public subsidies (tax deductions and grants) to go to the not for profit private health sector, eg missions (vs the for profit private health sector)
- Revenue generated from private use of public facilities be tracked to identify how they are used and the programmes and groups that benefit from these revenues
- Establishment of a parliamentary task force across committees to monitor budget performance against performance on MDG goals.
- Monitoring of all supplementary budgets to ensure that they preserve and do not distort budget frameworks and policy priorities for the main budget, such as when they increase shares to administration and reduce shares to prevention.

In particular the analysis pointed to a need for equitable use of the available public resources in health to provide accessible, affordable primary health care (promotion,
prevention and accessible primary curative care and district level services), given their role as the entry point for low-income households and in reducing the risk of and poverty arising from ill health.

While the country is in the current (necessary) “emergency” mode of response to immediate epidemic and nutritional needs, and while the underlying economic and political causes of this emergency need to be tackled, a more widespread and deeper look at the health sector is needed within the budget process to ensure that health services are able to prevent and address the wider range of sustained health problems that affect people, particularly the poorest, and to prevent further epidemic disease.

The hyperinflationary context provides a further challenge to any budget analysis. Indeed the extra-budgetary allocations of the Reserve Bank have in 2008 overshadowed the parliamentary budget process, particularly in the context of the months the country has experienced with no sitting of parliament. Yet hyperinflation should not be a basis for undermining public scrutiny for how funds are spent on an area as vital for people as health. Any parliament will need to examine how the appropriations from the Reserve Bank were spent in relation to needs and priorities and to debate how best to align public resources to needs.

### 1.1 Methods

The analysis draws evidence from secondary data and national surveys, from reported Ministry of Finance estimates and from the reported budget allocations provided by government, with a focus on the years 2006-2008. This review focuses on the budget allocation to the Ministry of Health and Child Welfare, although allocation to ministries that have relevance to health are also considered. The analysis focuses largely on expenditures that go through official, public sources. The obvious limitation of this is the level of non-state, private and unofficial financial flows in Zimbabwe, including through remittances of finances and medical supplies. The deterioration of the country’s national statistics has led to difficulties in analyzing the current situation. Some statistics are no longer being collected in a timely manner, or at all. Others collected, such as the consumer price index and the inflation figures, are undermined by the hyperinflationary environment, which also makes it inappropriate to make any interpretation of nominal Zimbabwe Dollars. The overvalued official exchange rate poses difficulty in using some US Dollar quoted figures. Two episodes of currency re-denomination by the Central Bank took place in the period, and public documents do not always clearly state whether revalued currencies are being used, complicating trend analysis. The Central Bank’s quasi-fiscal activities, including in the health sector, have led to expenditure outside parliamentary monitoring, and without a breakdown of the expenditure of the global figures publicly announced. Outdated population figures no longer reflect the real demographic situation, casting doubt on indicators of health, ill health and health service data relative to population size. As far as possible we have tried to address or manage these issues. However, we note the uncertainty this brings to the evidence and the analysis.

The report presents an analysis of budget process issues in section 1. Section 2 looks at the demographic and health situation. Section 3 explores the overall levels and sources of health financing while Section 4 explores the budget allocations and expenditure patterns for the health sector and related ministries. Section 5 discusses the implications of the trends found and what this means for advocacy on adequacy and equity of financing for the health sector.
2. Demographic and health indicators

The unprecedented economic downturn in Zimbabwe post 1999, described earlier, coming at the end of a sustained period of high HIV prevalence has negatively affected quality of life, poverty levels and health (Table 1). While falling fertility is a positive health outcome, falling life expectancy and rising mortality are not. Since 2002 there is no clear evidence on the distribution of the population, and with high permanent and temporary out-migration, internal population movements due to resettlement and displacement, and the politicization of evidence on population distribution due to the implications for electoral boundaries, there will be question on any estimates set until a new census is implemented. This raises questions as to whether the country can wait for the next official census due in 2012.

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Crude birth rate (CBR).</td>
<td>44.0</td>
<td>Na</td>
<td>34.5</td>
<td>30.8</td>
<td>30.3</td>
<td>31.0</td>
</tr>
<tr>
<td>Total Fertility Rate (TFR).</td>
<td>6.2</td>
<td>5.5</td>
<td>-</td>
<td>4</td>
<td>Na</td>
<td>3.8</td>
</tr>
<tr>
<td>Crude death rate (CDR/1000)</td>
<td>10.8</td>
<td>Na</td>
<td>9.5</td>
<td>Na</td>
<td>17.2</td>
<td>Na</td>
</tr>
<tr>
<td>Infant Mortality Rate/1000.</td>
<td>86</td>
<td>53</td>
<td>65</td>
<td>58</td>
<td>67</td>
<td>55</td>
</tr>
<tr>
<td>Life expectancy at Birth.</td>
<td>57.4</td>
<td>Na</td>
<td>61</td>
<td>Na</td>
<td>45</td>
<td>43</td>
</tr>
</tbody>
</table>

Source: CSO Macro 2007 na = not available

This report does not intend to provide a systematic assessment of the wider economic indicators. The overview of economic indicators shown in Box 1 below reveals a context of negative real growth, a massive fall in official real Gross Domestic product (GDP) (40% during the period 2000 and 2007), hyperinflation, significant growth in money supply and in external and domestic debt.

**Box 1 Economic Indicators**

- Real GDP cumulatively declined by 40% during the period 2000-2007
- Year-on-Year inflation was 100 582.5% by January 2008.
- Public deficit as a % of GDP in 2007 was a negative –10%, worsening from the 4.3% deficit in 2006. These figures exclude quasi-fiscal activities by the Central Bank.
- Public debt was 128% of GDP in 2007, up from 78.3% in 2006.
- Total external debt in the last quarter of 2007 stood at US$4.1 billion, of which the total external arrears amounted to US$2.7 billion.
- Population below the Food Poverty Line (FPL) increased from 29% in 1995 to 58% in 2003
- Population living below the Total Consumption Poverty Line (TCPL) increased from 55% in 1995 to 72% in 2003
- The Human Poverty Index (HPI) has increased from 24 in 1995 to 40.3 in 2004.
- The Human Development Index (HDI) has declined from 0.654 in 1990 to 0.513 in 2007. Zimbabwe is ranked 151 out of 171 countries on the HDI.

Sources: SADC 2008; MPSLSW 2003; UNDP 2008
A Gini coefficient of 0.5 suggests a relatively high level of inequality using official data. With so much economic activity outside official channels it is not clear whether in reality inequality is wider, and with no poverty assessment post 2005, poverty levels are also not clear (UNDP 2008). Evidence from other countries in the region suggests that inequality is a barrier to any form of poverty reduction and needs to be more specifically addressed (EQUINET SC 2007).

Without going into detail on this economic evidence, given the uncertainty of official figures cited earlier, the trends are sufficiently clear to raise certain implications for health:

- Households are experiencing economic difficulties. For the poorest the difficulties are likely to threaten health, access to inputs for health and ability to pay for the costs of health care;
- Food insecurity will undermine nutrition, increasing the risk of severe disease and undermining the effectiveness of treatment;
- Costs of health care have risen for households due to escalating prices of medical care inputs, such as drug prices;
- Costs of health care have risen for health providers, due to the falling real value of the Zimbabwe dollar (for imported inputs) and unstable domestic production due to fuel, energy and infrastructure problems;
- Company closures and unemployment have undermined production of goods needed for health; incomes for households to meet health costs and private contributions to health insurance;
- Skilled health personnel have experienced worsening working conditions, falling real wages and increasing job stress, in part due to outmigration.
- The fiscal budget is undermined by inflation with supplementary budgets since 2000.

The changes in various indicators of health sector performance (drugs, personnel) are shown in Figures 2 and 3.

**Figure 2: Drug Availability 2004-2007**

![Drug Availability Chart]

Source: MOHCW 2008
While drug availability improved to 2006, the fall in 2007 has been profound. Data for 2008 is not available.

**Figure 3: Vacancy rates for health workers 2005-2007.**

<table>
<thead>
<tr>
<th>% Vacant Posts</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top Management</td>
<td>86%</td>
<td>91%</td>
<td>81%</td>
</tr>
<tr>
<td>Doctors</td>
<td>61%</td>
<td>62%</td>
<td>62%</td>
</tr>
<tr>
<td>Nurses</td>
<td>32%</td>
<td>30%</td>
<td>24%</td>
</tr>
<tr>
<td>Environmental Health</td>
<td>49%</td>
<td>46%</td>
<td>49%</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>42%</td>
<td>42%</td>
<td>45%</td>
</tr>
<tr>
<td>Radiography</td>
<td>69%</td>
<td>66%</td>
<td>66%</td>
</tr>
<tr>
<td>Laboratory</td>
<td>54%</td>
<td>49%</td>
<td>49%</td>
</tr>
<tr>
<td>Administration</td>
<td>14%</td>
<td>14%</td>
<td>14%</td>
</tr>
<tr>
<td>Records and Informat</td>
<td>14%</td>
<td>19%</td>
<td>19%</td>
</tr>
<tr>
<td>Program Manage</td>
<td>Total</td>
<td>Total</td>
<td>Total</td>
</tr>
<tr>
<td>2005</td>
<td>86%</td>
<td>61%</td>
<td>32%</td>
</tr>
<tr>
<td>2006</td>
<td>91%</td>
<td>62%</td>
<td>30%</td>
</tr>
<tr>
<td>2007</td>
<td>81%</td>
<td>62%</td>
<td>24%</td>
</tr>
</tbody>
</table>

Source: MoHCW 2008

By 2007, the public sector faces shortfalls above 50% in management, doctors, radiography personnel. While nursing staffing has improved somewhat with the deployment of primary health care nurses the situation for environmental health and pharmaceutical health personnel has worsened. Critical public health programmes such as water and sanitation, malaria and other disease control programmes are negatively affected by such insufficient levels of personnel.

Other shortage and costs, such as in transport, drugs and protective clothing hinder outreach programmes, including disease control (such as malaria control), prevention (such as immunization and environmental health).

While the health sector is not alone affected by these changes, in a context of massive economic decline and food insecurity the health sector is fundamental to protect households from the worst effects of the economic decline, and to protect against widening public health risks. The relevance of the health budget to attainment of the Millennium Development Goals (MDGs) is for example shown in Table 2 below.
<table>
<thead>
<tr>
<th>MDG Goal</th>
<th>MDG Indicator</th>
<th>Status in 1999 or closest</th>
<th>Current 2005/2006 ZDHS</th>
<th>Target by 2015</th>
<th>Health Sector role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eradicate extreme poverty and hunger</td>
<td>Reduce by half 2002 - 2015 proportion of people living below the total poverty consumption line (%)</td>
<td>42(1995)</td>
<td>72</td>
<td>40%</td>
<td>Public sector health care is an important factor in buffering poor households from the costs of ill health. If public sector services are not available, accessible or affordable poverty increases.</td>
</tr>
<tr>
<td></td>
<td>Prevalence of underweight children under the age of five (%). Reduce by two thirds between 2002 and 2015</td>
<td>13</td>
<td>16.6</td>
<td>7%</td>
<td>While malnutrition is due to the shortages and costs of food, health services provide supplementary feeding of the most vulnerable groups and break the link between undernutrition and mortality.</td>
</tr>
<tr>
<td>Achieve Universal Primary education</td>
<td>Gross enrolment in primary education (%). Ensure that all children complete full programme of primary education.</td>
<td>86.9</td>
<td>100%</td>
<td></td>
<td>Investments in education are an important contributor to health, and this area of the budget merits advocacy on health grounds. However ill health can undermine both teacher and pupil participation.</td>
</tr>
<tr>
<td>Promote Gender Equality</td>
<td>Ratio of boys to girls in primary / secondary education (%)</td>
<td>97</td>
<td>97</td>
<td>Parity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Women empowerment (%). 40% senior civil service positions, 30% women in parliament by 2005, and 50:50 by 2015.</td>
<td>16</td>
<td>90%</td>
<td></td>
<td>Health services can address gender disparities, such as by providing services that reach and address the needs of vulnerable women, and strengthening their control over their own health.</td>
</tr>
<tr>
<td>Reduce Child Mortality</td>
<td>Reduce by two thirds &lt;five child mortality rate per 1000 live births between 2000 and 2015</td>
<td>102</td>
<td>82</td>
<td>34</td>
<td>Preventive health services (eg immunization; prevention of parent to child HIV transmission); curative services (eg treatment of malaria, pneumonia) and child supplementary feeding are vital to prevent child mortality.</td>
</tr>
<tr>
<td></td>
<td>% one year old children immunized against measles</td>
<td>82</td>
<td>&gt;80%</td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>Improve maternal health</td>
<td>Reduce by three quarters Maternal mortality per 100,000 between 2000 and 2015</td>
<td>695</td>
<td>555</td>
<td>174</td>
<td>Access to maternal health services is essential for this, including trained and skilled health personnel.</td>
</tr>
<tr>
<td></td>
<td>Proportion of births attended by skilled personnel (%)</td>
<td>73</td>
<td>69</td>
<td>100%</td>
<td>Access to maternal health services is essential for this, including trained and skilled health personnel.</td>
</tr>
<tr>
<td>Combat HIV and AIDS, Malaria and other diseases</td>
<td>Have halted by 2015 and began to reverse the HIV prevalence rate 29.3 (peak 1997)</td>
<td>29.3 (peak 1997)</td>
<td>15.6%</td>
<td>16%</td>
<td>Access to prevention services needed to support changes in risk behaviours.</td>
</tr>
<tr>
<td></td>
<td>Have halted by 2015 and began to reverse the national Malaria Incidence rate</td>
<td>112 (2001)</td>
<td>94 (2007)</td>
<td>64</td>
<td>Use of DDT, of treated nets and improved treatment regimens have facilitated a decline and need to be sustained to avoid reversals.</td>
</tr>
<tr>
<td></td>
<td>Have halted by 2015 and began to reverse the Percentage of TB cases detected</td>
<td>399/100 000 (2000)</td>
<td>557/100 000</td>
<td>121</td>
<td>Access to TB prevention, detection and treatment services is essential for this indicator, particularly given undernutrition and homelessness.</td>
</tr>
<tr>
<td>Sustainable environment</td>
<td>Half by 2015 the proportion of rural people with sustainable accessibility to an improved water source</td>
<td>75.1</td>
<td>66.5</td>
<td>100%</td>
<td>Economic decline and increased poverty means that focused attention needs top be given to safe water and sanitation as well as to treatment of water related diseases.</td>
</tr>
</tbody>
</table>

Source: Goz 2008; MoHCW 2008; CSO Macro 2007
While economic conditions themselves undermine achievement of the MDGs, this raises as even more critical investments in primary and secondary education, safe water and sanitation, household food production, supplementary feeding, primary health care and district referral services and the transport system to access them.

3. **Mobilising resources for health: how adequate is the health budget?**

Countries need to ensure **adequacy and equity** of health financing. Adequacy is assessed by how far the level of financing enables **universal coverage**, that is that **all** citizens have access to **adequate** health care at an **affordable** cost. Equity is an outcome of the extent to which health resources are allocated in relation to health needs.

The money for the health sector comes from a range of sources:
- Government tax-based funding
- External (donor) funding
- Out-of-pocket (private) spending by households
- Firms/Employers
- Health Insurance / Pre-payment mechanisms
  - Private health insurance
  - Mandatory health insurance (social or national)
  - Community-based insurance

If universal coverage is to be met on the basis of health need, then tax or health insurance contributions are preferred, as they allow for cross-subsidies across groups on the basis of need or income in larger risk pools.

3.1 **Equity in sources of health funding**

As shown in Figure 4, Zimbabwe has a larger share of health spending from private than public sources, and as these are generally out of pocket spending these undermine both equity and adequacy in health spending.

Out of pocket spending increased to 2005 while insurance funding fell, and this negative trend is likely to have increased to 2008 as private insurance contributions increased and employment fell (Loewenson and Masotya 2008). Out of pocket payments in Zimbabwe are relatively high compared to neighbouring countries South Africa, Namibia and Malawi (See Table 3). While Zambia had a higher level of out of pocket funding it also abolished user fees in public sector district services in 2007. Government policy that fees should not be charged at clinic level is not respected or enforced in all local government facilities and efforts to regulate fee levels in the private sector are undermined by the hyperinflationary environment.

Even for urban, middle-income people, private health care services have become generally out of reach, given the decline in medical aid schemes. Co-payments, cash payments or the alternative of payment in hard currencies have reduced use of private services, but without adequate alternatives in quality public sector care. This makes investment in public health sector services an important and wide concern.
Table 3: Out of pocket payments as a percentage of total health care funding, 2004

<table>
<thead>
<tr>
<th>Country</th>
<th>Out of pocket funding as % of total health care funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malawi</td>
<td>8.9</td>
</tr>
<tr>
<td>Namibia</td>
<td>5.6</td>
</tr>
<tr>
<td>South Africa</td>
<td>10.3</td>
</tr>
<tr>
<td>Tanzania</td>
<td>46.9</td>
</tr>
<tr>
<td>Uganda</td>
<td>34.5</td>
</tr>
<tr>
<td>Zambia</td>
<td>32.3</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>26.2</td>
</tr>
</tbody>
</table>


The policy of no user fees at primary care level needs to be more systematically enforced, but this equally demands more resources to be directed to this level to ensure quality of services, or communities will continue to pay for supplies not available at services, or will bypass primary care levels to access drugs and staff at higher levels, spending on both transport and fees at higher levels of the system.

In Zimbabwe, general tax revenue is generated from tax on income and profits (50%), VAT (32%), custom duties (12%), excise duties (3%) and other taxes (2%). Income tax is progressively structured and low-income groups are exempted from paying tax. There is an element of pooling via the AIDS Levy – a levy on income tax (McIntyre et al 2008). Figure 5 shows the tax contribution from different sources in 2000-2007.

Individual taxes have fallen, as have customs duties, while VAT and company tax shares have risen. The shift from individual to corporate taxes could be seen equitable, but depends on levels of employment and whether the richest corporates are taxed- not inevitably the case.
The fall in individual tax collections is a result of the reduced numbers of the formally employed. It is estimated that 700,000 were formally employed in 2007 representing only 6% of the population, a decline from the peak employment rate of 17% in 1975 (Hawkins et al 2008). Both corporate activity and employment have shifted to the informal sector. Ivaschenko and Minh Lee (2005) observe the unfair tax burden on a shrinking formal corporate sector when the informal corporate sector grows. Formally employed wage earners also become ‘captives’ who bear the burden of high tax payments in inflationary environment due to non-adjusted inflation brackets (problem of bracket creep).

VAT places higher burdens on poor households as a share of their income and so is not progressive. While basic foodstuffs are tax exempt, the high level of VAT funding further undermines equity in health funding. Certainly any health and medical products should be VAT exempt, including basic hygiene products, womens sanitary products and so on. Equally new forms of tax revenue, such as on financial market transactions, as has been applied in Zambia and Ghana, may prove to be a more equitable source of tax revenue and should be explored.

Figure 5: Tax contribution by different revenue Heads 2000-2007

Government revenue has risen as a share of GDP, showing the trend towards increased reliance on tax based revenue (95%) and other non-tax revenue for economic activity, moreso than the general average in the region. One factor in this is the in the absence of donor assistance. Despite the decline in tax revenue in real terms, total tax revenue as a share of GDP remained at an average of almost 26%.

Figure 6: Government Revenue as a Percentage of GDP 1997-2006

The low level of external funding is an outcome of the political situation. The Reserve Bank report withdrawal of Danish Government support in 2000 valued at US$29.7 million and a US$6.4 million investment in health by Sweden that was suspended. Since 2002 the Global Fund for AIDS, TB and Malaria has approved and disbursed 2 rounds of funding for the country (Round 1 [US$10.3 million] and Round 5 [US$65.2 million]), out of 8 rounds of possible funding. While there may be further donor flows that go to non-government institutions, it is not possible to assess the scale of this external funding.

Despite this a National Health Accounts Survey done by Abt Associates in 2005 suggests that expenditure on HIV and AIDS comes largely from the donor community and households, despite the earmarking of 7% of the AIDS levy fund in the 2007 budget for the purchase and procurement of antiretroviral drugs. This expenditure pattern more specific to HIV and AIDS sub-sector, shows a lower level of public sector funding due to the higher level of external funding than in the general spending on health (See Table 4).
### Table 4: Financing Sources of HIV and AIDS in 2005

<table>
<thead>
<tr>
<th>Source of Funding</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public as a Percentage of HIV and AIDS expenditures</td>
<td>7%</td>
</tr>
<tr>
<td>Private as a Percentage of total HIV and AIDS expenditures</td>
<td>43%</td>
</tr>
<tr>
<td>Donor as a Percentage of total HIV and AIDS expenditure</td>
<td>49%</td>
</tr>
</tbody>
</table>

**broken down to:**

<table>
<thead>
<tr>
<th>Source</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Donors</td>
<td>49.2%</td>
</tr>
<tr>
<td>Ministry of Finance</td>
<td>6.9%</td>
</tr>
<tr>
<td>Local Authorities</td>
<td>0.5%</td>
</tr>
<tr>
<td>Employer Funds</td>
<td>3.1%</td>
</tr>
<tr>
<td>Household Funds</td>
<td>40.2%</td>
</tr>
</tbody>
</table>

Source: Abt Associates 2005

### 3.2 Adequacy of health funding

In the absence of significant external flows, increasing the budget through tax or insurance revenues remains the most equitable way of sustaining or increasing health financing. Health insurance while mooted is not socially accepted at present, due to the already high stress on personal incomes and the contraction in formal employment. Even private sector voluntary insurance markers are contracting. This makes tax revenue and budget allocations the major source of equitable investment in health in current conditions. An unrealistically overvalued official exchange rate has given rise to emergence of exchange rate speculation that has had a massive adverse impact on pricing of medication, consultation and general health services. Most of the health sector services are now being priced used the unofficial parallel exchange rate which is too often exorbitant and out of reach of the general population.

The Ministry of Health and Child Welfare has on average been allocated between 10% and 11% of the total budget in terms of parliamentary appropriations over the past eight years, not reaching the Abuja target of 15% (See Table 5). In 2008, a revised allocation figure for the year is calculated at 14%, only one percent less than the Abuja target. This shows a level of commitment to addressing the target. This followed significant parliament and civil society advocacy on the budget, including from people living with HIV and AIDS.

### Table 5: Budget Allocations to Selected Ministries

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Service, Labour and Social Welfare</td>
<td>2%</td>
<td>6%</td>
<td>6%</td>
<td>4%</td>
<td>4%</td>
<td>3%</td>
<td>4%</td>
<td>8%</td>
</tr>
<tr>
<td>Defence</td>
<td>15%</td>
<td>16%</td>
<td>13%</td>
<td>13%</td>
<td>10%</td>
<td>9%</td>
<td>8%</td>
<td>5%</td>
</tr>
<tr>
<td>Lands, Agriculture and Rural Development</td>
<td>3%</td>
<td>5%</td>
<td>11%</td>
<td>7%</td>
<td>3%</td>
<td>2%</td>
<td>8%</td>
<td>5%</td>
</tr>
<tr>
<td>Local Government, Public Works and National Housing</td>
<td>2%</td>
<td>3%</td>
<td>2%</td>
<td>3%</td>
<td>4%</td>
<td>2%</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>Health and Child Welfare</td>
<td>9%</td>
<td>14%</td>
<td>11%</td>
<td>11%</td>
<td>11%</td>
<td>7%</td>
<td>9%</td>
<td>14%</td>
</tr>
<tr>
<td>Education Sports and Culture</td>
<td>26%</td>
<td>36%</td>
<td>24%</td>
<td>21%</td>
<td>20%</td>
<td>16%</td>
<td>17%</td>
<td>11%</td>
</tr>
</tbody>
</table>

Source: Ministry of Finance, National Budget Blue Books 2000-2008
Table 5 suggests that the relative shares to the Ministry of Defence and Education have fallen, while those to Health; Public, Service, Labour and Social Welfare have increased. The increased demand for social protection is reflected in the budget shares. Constitutional and statutory appropriations which have always accounted for about 5% of the total budget are excluded from the vote appropriations. These statutory appropriations are mandatory and are excluded in this analysis.

Reduced allocations to defence provides fiscal space to fund essential activities such as health. More targeted allocations to areas of social protection within other ministries (water, sanitation, food production) will be discussed within the next section. The reduced allocation to education from 26% in 2000 to 11% in 2008 is cause for concern however, given the key role of education in health outcomes. Health advocacy would be as concerned about a cut of this level in education, particularly given the deteriorating standard of education.

Two factors undermine the positive signal sent from increasing budget shares to health. The first is the extent of extrabudgetary allocations through the Reserve Bank, undermining shares set by parliament. The second is the inadequacy in absolute terms of the health budget.

Certainty around the relative shares in 2008 has been undermined by Reserve Bank of Zimbabwe (RBZ) activities: “Budget measures approved by parliament have been overwhelmed by the combination of rapidly-escalating hyperinflation and the RBZ’s quasi-fiscal activities” (Hawkins et al. 2008: pp 38). This means that while parliament may approve relative shares in line with commitments made, these may be reversed by RBZ. Without clear guidelines for allocating resources, there is no predictability in budget shares nor parameters against which to oversee the performance of actors such as the Reserve Bank.

The RBZ role became more marked in the fiscal year 2006, with Z$372.9 billion, almost 83% of the total budget envelope approved by the parliament for the fiscal year 2006, falling to 45% of the overall budget expenditure for the year 2006 (Budget statement 2007). The support has not always been in terms of direct budget support to the health sector. For example, in the last quarter of 2007 the Central Bank introduced concessionary vehicle financing scheme for medical doctors and selected “critical health sector” personnel. While this was positive as an emergency response to retention of specific personnel, it ignored the wider sector wide crisis in health worker retention (noted earlier) and the need for sector wide resources and measures to address this at all levels of the health system.

In the first quarter of 2008 the Central Bank supported about 118 hospitals with medical drugs, equipment, basic food commodities and other medical provisions, under its programme called the Basic Commodities Supply Side Intervention (BACOSSI). In response to cholera outbreaks in some parts of Harare, according to The Herald, of Thursday, November 6 2008, the Reserve bank availed Z$ 374.2 quadrillion (8.7 million Rands), almost 53 times the 2008 National Budget estimates of Z$7.84 quadrillion for all government activities.
Secondly, while the health budget has increased in nominal terms since 2000, it has markedly decreased in real terms due to hyperinflation.

Real expenditure in Z$ terms has dropped dramatically for both the government and the donors (See Table 6). Although the drop in real Zimdollar expenditure for the donors does give the true picture in real terms, it should be noted, however, that, donor contribution to the health sector has overall declined.

Table 6: Zimbabwe Government and Donor Expenditure on Health (Real Z$ millions)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Government expenditure on Health</td>
<td>3674</td>
<td>2358.49</td>
<td>1106.5</td>
<td>2639.57</td>
<td>1697.44</td>
</tr>
<tr>
<td>Total Donor expenditure on Health</td>
<td>450</td>
<td>233.28</td>
<td>47.58</td>
<td>416.51</td>
<td>278.65</td>
</tr>
<tr>
<td>Combined Government and Donor expenditure on Health</td>
<td>4124</td>
<td>2591.77</td>
<td>1154.08</td>
<td>3056.08</td>
<td>1976.09</td>
</tr>
<tr>
<td>% of total expenditure from govt. funding sources</td>
<td>91.38%</td>
<td>96.86%</td>
<td>98.18%</td>
<td>97.74%</td>
<td>75.78%</td>
</tr>
<tr>
<td>% of total expenditure from donor funding sources</td>
<td>8.59%</td>
<td>3.09%</td>
<td>1.79%</td>
<td>2.25%</td>
<td>12.46%</td>
</tr>
</tbody>
</table>

Source: Ministry of Finance 1995-2006, World Health Organization 2007, Schwartz and Zwizwai 1995. NB Official exchange rates were used to calculate the donor expenditure. This may have under-valued the donor expenditure contribution, given that the official exchange rate used in the calculation was not inflation adjusted.

Table 6 does not show the figures for 2007 or 2008, which are complicated by the extra-budgetary spending referred to above. Further with a rapidly changing real (vs official) exchange rate for the US dollar it is very difficult to give any absolute per capita figure in US$.

Per capita expenditure on health was estimated at US$19 in 2006 (WHO 2008) This is half of the level estimated by the Macroeconomic Commission on Health needed for interventions for HIV, TB and malaria only, and a third of the US$60 per capita estimated to be needed for a functional health system in the public sector. The health sector is thus significantly under-funded in Zimbabwe, as it is in other countries in the region (EQUINET SC 2007). In 2004 Zimbabwe’s spending was lower than ten of the 16 countries in east and southern Africa (WHO 2007). Given this underfunding it is unlikely that universal coverage can be achieved for all communities and for all core services. The allocation of the budget and the expenditure patterns give an indication therefore of how the scarce resources available – and the deficit – are distributed.

4. Resource Allocation in Health Sector: how equitable and effective is it?

Given the scarcity of public sector resources for health, the allocation of health resources be preferentially allocated to where they are most needed, to districts with highest health need and to services most accessible to vulnerable groups and relevant to priority health needs.
Allocating resources to districts on the basis of need usually takes place after the parliamentary budget process, and often excluding resources that are centrally fixed, such as for health worker salaries. A needs-based resource allocation formula helps to distribute public sector health care resources between geographic areas (such as districts) according to the relative need for health services in each area. The indicators most frequently used in resource allocation formulae to measure the relative need for health services between different geographic areas are:

- population size;
- composition of the population, as young children, elderly people and women of childbearing age tend to have a greater need for health services;
- levels of ill-health, with mortality rates usually being used as a proxy for illness levels; and
- socio-economic status, given that there is a strong correlation between ill-health and low socio-economic status and that poor people rely most on publicly funded services (McIntyre et al 2008).

A growing number of African countries have adopted such a needs-based formula to guide the allocation of health care resources, using a mix of these indicators. Zimbabwe has developed the basis for such a formula in the early 2000s and it is suggested that such a formula be introduced as a means of guiding and monitoring allocations to districts over time.

For central budget resources, the allocation across levels of care and to different programmes also impacts on the equity and relevance of health funding.

4.1 Allocations across different levels of the health system

The trends in budget allocation shown in Table 7 suggest that Zimbabwe’s resource allocation philosophy has over the years been dominated by a policy preference for curative care. Since 2002 resource allocation has been dominated by majority allocations towards medical care services, with the bulk of these funds going to finance tertiary and secondary hospitals. The share allocated to administration has increased, while the share to prevention has decreased.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration</td>
<td>4.8%</td>
<td>6.7%</td>
<td>6.8%</td>
<td>8.3%</td>
<td>9.09%</td>
</tr>
<tr>
<td>Medical Care</td>
<td>78.0%</td>
<td>81.3%</td>
<td>80.5%</td>
<td>81.7%</td>
<td>80.56%</td>
</tr>
<tr>
<td>Preventive Services</td>
<td>16.0%</td>
<td>10.9%</td>
<td>11.3%</td>
<td>6.7%</td>
<td>9.57%</td>
</tr>
<tr>
<td>Research</td>
<td>1.2%</td>
<td>1.1%</td>
<td>1.4%</td>
<td>3.3%</td>
<td>0.78%</td>
</tr>
</tbody>
</table>


This rather static resource allocation approach has not responded to changes in the demographic, health patterns and disease burden. Under a situation of decreasing resources, increasing poverty and economic stress, the falling shares to prevention and the rising allocation to administration do not give adequate cognizance to the need to invest in prevention, particularly as infrastructures and household resources become stressed. The static relative share between medical care and prevention, including disease control, equally weakens the possibilities for disease control.
This mismatch appears to have been recognised in policy, even if not implemented in practice. According to the 2004 Government of Zimbabwe MDG Progress report, in order for the country to reduce infant, child and maternal mortality and maternal mortality to target levels, the budget for prevention must at least increase by 5.6% in real terms from the current 11% assuming a constant population growth rate of 1%. While medical care services do provide secondary prevention, for example, through services such as ANC located at curative facilities, primary prevention through outreach activities that prevent exposure or infection in exposed people are essential, or the costs of curative services will be too high. This also confirms the need for close collaboration between health and other social ministries that provide key health inputs, such as water and sanitation. It is thus a matter of priority to advocate for prevention to be given a significant budget increase in the next budget to restore spending levels, and for the 5-6% increase annually projected in the MDG report to be delivered on.

The distribution of health facilities (shown in Table 8) shows the key role of primary and district level in the health system. These levels are close to communities, and more accessible to low income communities. If these levels are not functioning effectively the cost to communities in a fall off in outreach for prevention, poor public health and untreated disease is high.

Table 8: Public Health Facilities in Zimbabwe 2006

<table>
<thead>
<tr>
<th>Provinces</th>
<th>Primary level</th>
<th>1st Referral level</th>
<th>2nd Referral level</th>
<th>3rd Referral level</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(clinic)</td>
<td>(district)</td>
<td>(provincial)</td>
<td>(central)</td>
<td></td>
</tr>
<tr>
<td>Harare</td>
<td>45</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>52</td>
</tr>
<tr>
<td>Manicaland</td>
<td>253</td>
<td>36</td>
<td>1</td>
<td>0</td>
<td>290</td>
</tr>
<tr>
<td>Mashonaland Central</td>
<td>130</td>
<td>13</td>
<td>1</td>
<td>0</td>
<td>144</td>
</tr>
<tr>
<td>Mashonaland East</td>
<td>168</td>
<td>22</td>
<td>1</td>
<td>0</td>
<td>191</td>
</tr>
<tr>
<td>Mashonaland West</td>
<td>128</td>
<td>22</td>
<td>1</td>
<td>0</td>
<td>151</td>
</tr>
<tr>
<td>Matebeleland North</td>
<td>92</td>
<td>17</td>
<td>0</td>
<td>0</td>
<td>109</td>
</tr>
<tr>
<td>Matebeleland South</td>
<td>105</td>
<td>18</td>
<td>1</td>
<td>0</td>
<td>124</td>
</tr>
<tr>
<td>Midlands</td>
<td>106</td>
<td>28</td>
<td>1</td>
<td>0</td>
<td>235</td>
</tr>
<tr>
<td>Masvingo</td>
<td>170</td>
<td>23</td>
<td>1</td>
<td>0</td>
<td>194</td>
</tr>
<tr>
<td>Bulawayo</td>
<td>34</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>41</td>
</tr>
<tr>
<td>Total</td>
<td>1331</td>
<td>179</td>
<td>7</td>
<td>14</td>
<td>1531</td>
</tr>
</tbody>
</table>

Source: MoHCW 2008

Key

<table>
<thead>
<tr>
<th>Primary level</th>
<th>1st Referral level</th>
<th>2nd Referral level</th>
<th>3rd Referral level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinics and Rural Health Centers</td>
<td>District, Mission and Rural hospital</td>
<td>Provincial Hospital</td>
<td>Central hospital and infectious diseases hospital</td>
</tr>
</tbody>
</table>

In a context of falling real spending on health there is a trade off between the shares spent at primary care and district level and that at central level. With external funding more likely to be at district and primary care level, there is a tendency for government to prefer spending at provincial and central levels. The pull of resources by the more vocal and high skills personnel at these levels is also likely to be stronger.
Figure 7 shows a fall in real expenditure in three of the five central hospitals up to 2006, with a significant increase in 2007. Figure 8 shows that spending to primary care, district and provincial levels rose in 2002, 2004 and 2007, but fell in 2003 and 2006.

**Figure 7: Real government spending at 2001 constant prices on central hospitals**

![Graph of real government spending at 2001 constant prices on central hospitals]

Source: Ministry of Finance Budget estimates 2002-2008

**Figure 8: Real government spending at 2001 prices on provincial and district services, including primary care level 2001-2007**

![Graph of real government spending at 2001 prices on provincial and district services, including primary care level 2001-2007]

Source: Ministry of Finance Budget Estimates 2001-2008
The increase in 2007 includes the spending on a large supplementary budget. The figures suggest that both central and provincial and district services are increasing and falling in similar years and there does not seem to be any clear trend in redistributing the budget, such as towards lower levels facilities, with scarce resources. What is not known from the way the figures are presented however is:

- whether funds accessed from the Central Bank are included in these expenditure figures.
- How the combined figure reported for provincial, district and primary care levels is distributed between these levels
- What the contribution of donors to the different levels has been through flows outside government funding.

Health Centres are still not cost centres so that finance information is not available at this level. Health center spending is merged within district allocations. With significant fall off in access to resources such as drugs relevant for the level from district hospital to clinic level, it is difficult for districts to allocate funds to clinics when they themselves are under-funded. If health centres can be identified as cost centers, it would be important to ensure disaggregation of expenditure information to health center level, and for this information to be monitored within the budget process to ensure that resources reach this level. Equally funds available for community level and disease control support, such as the health services fund, need to be adequately resourced.

### 4.2 Allocations across different programmes in the health system

Real expenditure across all ministry programmes has gone, with less decline in the reproductive health and village health worker programmes (See Figure 9).

**Figure 9: Real Expenditure for Programmes at 2001 Constant Prices, 2001-2007**

Source: Ministry of Finance Blue Books 2002-2008
This does not necessarily mean that the respective activity level has declined. For example immunization campaigns in 2007, externally funded, reversed the decline in immunization levels through wide coverage of rural and urban areas, with consequent immunization rates above 80%.

All programmes are underfunded, although the lack of reflection of resources from external support through channels outside government means that it is difficult to interpret the trends. Of significant concern is the low level of funding for environmental health, health education and integrated management of childhood illness.

Table 9 summarises some of the major trends found in this analysis.

**Table 9: Matrix of financing trends**

<table>
<thead>
<tr>
<th>Policy Areas</th>
<th>Goal</th>
<th>Status</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resource allocation to health</td>
<td>At least 15% of the overall national budget</td>
<td>Average of 9% over the past decade</td>
<td>The allocation, although nearing the threshold, have never gone above this threshold.</td>
</tr>
<tr>
<td>Resource Allocation to health</td>
<td>Prioritize the MOH</td>
<td>Highest allocation for 2008 budget allocation</td>
<td>Priority has always been given to the ministry of Education and Defence, with Ministry of Health normally accorded the third position.</td>
</tr>
<tr>
<td>Resource Allocation to health</td>
<td>Use of a Resource allocation Formula based on disease burden and demographics.</td>
<td>Demand based resource allocation system. More of incremental type of budgeting.</td>
<td>Although a formula for resource allocation was devised in 2001 (Equity Gauge Project) and pilots undertaken in Shurugwi, Gokwe, Lupane and Gutu Districts, it was never rolled out.</td>
</tr>
<tr>
<td>Health care financing: User fees.</td>
<td>User fees: at least 40% revenue generated by the Health Services Fund be used for prevention and promotion activities</td>
<td>National Budget only gives about 8-10% to prevention activities. 2008 Survey on Access to health care Services</td>
<td>For districts that cannot receive adequate user fees, the MOF gives an equalization grant. However, in this inflationary environment the revenue is meaningless. On the question of equity, these user fees discourage patients as evidenced by 62% of respondents not believing they should pay any user fees. User fees collections have on average accounted for less than 2% of total revenue due.</td>
</tr>
</tbody>
</table>
| Per Capita Expenditure              | US$60 (WHO 2000)  
US$22 [Bobadilla et al 1994)] | US$0.19 per capital allocation (using the government’s bank rate of Z$250 000 per US$) | The problem of an overvalued exchange rate makes it difficult to track this indicator. |
<p>| Access to health care: infrastructure | Access by all in need of health care at affordable prices: | The 2005/6 ZHDS reported good access in terms of health infrastructure. | The Land reform resulted in population movements that have altered physical access to health care infrastructure. |</p>
<table>
<thead>
<tr>
<th><strong>Primary Health Care</strong></th>
<th>Re-enforcing the Primary Health Care Approach</th>
<th>The referral system has broken down.</th>
<th>Funding from the National Budget is more hospital based. And also there are no proper enforcement mechanisms for the referrals.</th>
</tr>
</thead>
</table>
| **National Drug Availability** | 100% drug availability:  
**Optimum availability**  
Vital – 100%  
Essential – 80%  
Necessary – 60% | 20% average drug availability (MOHCW 2008 National Health Strategy Working Document) | NatPharm requires US$65 annually, but since 2004 the money availed to the National Pharmaceutical Company has been less than US$6 million. |
| **Health workers** | 95% in the MOH be staffed by competent and appropriately qualified (reduce vacancy levels by 50% across all staff categories). | 29% vacancy rate | Since most major programmes are heavily human resource driven, this vacancy rate will impact negatively on the delivery of programmes |
| **Public Finance Management systems and the Results Based Management Concept (2005)** | Reports using these management systems | Currently being implemented | Benefits of these financial management systems are yet to be realized. |

Source: MOHCW 2008

5. **Discussion: Implications for resource mobilization and allocation**

While Zimbabwe lacks recent reliable community level evidence, available data indicates that

- Households are experiencing economic difficulties that are likely to threaten health, access to inputs for health and ability to pay for the costs of health care;
- Food insecurity will undermine nutrition, increasing the risk of severe disease and undermining the effectiveness of treatment;
- Costs of health care have risen for households due to escalating prices of medical care inputs, such as drug prices, and also for health providers;
Company closures and unemployment have undermined production of goods needed for health; incomes for households to meet health costs and private contributions to health insurance; and

Skilled health personnel have experienced worsening working conditions, falling real wages and increasing job stress, in part due to out-migration.

It would be difficult in the hyperinflationary environment to read too much into the absolute figures. Zimbabwe’s health system is significantly under-funded, due to economic and political conditions that arise beyond the health sector.

What is perhaps more relevant are the relative levels and trends and what they suggest about prioritization of scarce resources. The analysis draws attention to trends that need to be addressed through policy and through the budget process:

In 2006, we noted increased levels of household poverty associated with AIDS, ill health, a fall in living standards and a decline in the purchasing power of people’s incomes. At that time the suggested budget priorities were for prevention, environmental health, reproductive health and community health worker programmes. In 2008 trends suggest that while the latter two areas have had some level of increased attention, areas such as access to safe water and sanitation, and the prevention budget continue to be more under-funded relative to other areas.

In 2006 it was proposed that priority be given to public sector primary health care, clinic and district hospital level with mobile and other forms of outreach to ensure coverage in the vulnerable groups. It was suggested that preference be given for public subsidies (tax deductions and grants) to go to the not for profit private health sector, eg missions (vs the for profit private health sector) and for monitoring of all supplementary budgets to ensure that they preserve and do not distort budget frameworks and policy priorities for the main budget, such as when they increase shares to administration and reduce shares to prevention.

These recommendations remain pertinent, and the trends that underlay them appear to have persisted. Supplementary allocations made directly by the central bank are nominally greater than original allocations without parliamentary approval. The fall in the prevention share (and rising share to administration) and relatively large share of funding to central hospitals vs district services continue to be an issue and to potentially weaken the areas of the system that support low income communities. While the health sector remains under-funded overall, protecting spending in public health, in prevention, in disease control and first and second line curative services is perhaps the highest priority for the budget. New resources should preferentially be allocated to prevention and to primary health care and district referral services, including through mission and local government not for profit providers. There is need to re-define the essential health package and cost it to reflect the new realities on the ground. The share to prevention should be restored to 20% allocated to proven prevention programmes with further increases annually as committed in the Government MDG report.

However the low funding of all services and programmes make the mobilization of resources the major concern. Unless there is some improvement in resources mobilized it is difficult to make equity gains or to effectively apply resource allocation formulae that integrate equity.

The increase in out of pocket spending on health is likely to increase poverty and act as a barrier for many to care. “No fee” policies already in place need to be more rigorously enforced. This demands an injection of funds to ensure service quality at frontline
services. In the absence of significant external flows, increasing the budget through tax or insurance revenues remains the most equitable way of sustaining or increasing health financing. Health insurance while mooted is not socially accepted at present, due to the already high stress on personal incomes and the contraction in formal employment. Even private sector voluntary insurance markers are contracting. New sources of tax revenue, such as from the financial market may improve domestic resources and could be explored.

The Ministry of Health budget through parliamentary appropriations has now reached 14% of discretionary government, and health has improved relative to other sectors such as defence. There are issues to address: A reducing allocation to education, undermining the key role of education in health outcomes signals the need to make clear that increased allocations to health should not be at the cost of investment in other areas of budget spending that impact on health (education, water, sanitation, food production). The parliamentary committee on health should monitor the budget spending in these areas and make clear their relevance for health.

Secondly the extent of extrabudgetary allocations through the Reserve Bank, potentially undermine the shares set by parliament. Budget appropriations should be approved through parliament. Parliament should call for full, disaggregated and public report on the central bank spending, including on the health sector.

However Zimbabwe’s health sector needs significant new resources. In Zambia these resources drew from funds freed from debt relief. In Uganda the funds were drawn from budget and external resources. The mix of improved budget share, debt relief and external support that the AU heads of state identified as essential for health in Abuja in 2001 now seems essential for Zimbabwe.

Procedural matters are now a priority. The political impasse has left the public without portfolio committees in parliament and without a budget process to engage in. Like the direct spending by the central bank, this undermines the institution of parliament. It also undermines the rights of the public to participate in such vital matters as the spending of public funds on health.
References


Acronyms

AIDS Acquired Immuno Deficiency Syndrome
ART Anti-Retroviral Therapy
ARVs Anti-Retrovirals
BOP Balance Of Payments
CPI Consumer Price Index
CSO Central Statistical Office
DFID Department For International Development
DOTS Directly Observed Treatment
ESAP Economic Structural Adjustment Programme
FBOs Faith Based Organizations
GDP Gross Domestic Product
GFATM Global Fund For Aids Tuberculosis And Malaria
HIV Human Immuno Virus
IMF International Monetary Fund
LFS Labour Force Survey
MDGs Millennium Development Goals
MMR Maternal Mortality Rate
MoF Ministry Of Finance
MOHCW Ministry Of Health And Child Welfare
MPSLSW Ministry Of Public Service Labour And Social Welfare
NGOs Non-Governmental Organization
NHA National Health Accounts
PPP Purchasing Power Parity
RBZ Reserve Bank Of Zimbabwe
TB Tuberculosis
TCPL Total Consumption Poverty Line
UNDP United Nations Development Programme
US$ United States Dollar
VAT Value Added Tax
WHO World Health Organization
ZDHS Zimbabwe Demographic Health Survey
ZW$ Zimbabwe Dollar