Zimbabwe National Health Sector Budget Analysis and Equity Issues 2000-2006

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for the
Regional Network for Equity in Health in east and southern Africa (EQUINET)

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Executive Summary

This study was implemented to identify trends in the health budget 2001-2006, assess the equity oriented nature of these trends and make recommendations to strengthen pro-equity dimensions of the health budget. The study was commissioned through the Regional network for Equity in health in East and Southern Africa in consultation with the Parliamentary Committee on Health in Zimbabwe and was implemented by the Zimbabwe Economic Policy Analysis and Research Unit with the Training and Research Support Centre. The review examines the budget in three major respects:

* how far are the opportunities for equity in revenue mobilization being tapped?
* how far are the allocation and expenditure patterns promoting policy targets, particularly equity?
* how far are incentives and investments levering health promoting investments (and penalizing those that undermine health)?

The study drew 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 2000-2006.

The **policy, economic and health context** for the budget indicates priorities given to the MDG goals with relatively high gaps to be closed on MDG targets in relation to poverty, HIV and AIDS, undernutrition, maternal mortality, reduction in TB, access to safe sanitation and housing construction. Severe macroeconomic constraints of the past 5 years have made it more difficult to plan for and adhere to expenditure and revenue targets and supplementary budgets can lead to high 'demand' rather than high 'need' areas of spending, as is reported in the supplementary budget in 2006. The current economic environment places pressure on households, especially the poorest, and on health budgets to meet rising costs of individual medical care while protecting spending on public health interventions that protect population health. Under conditions of falling GDP and falling real budgets this implies choices and opportunity costs- for the health sector and for households.

The public health care sector is the largest and an increasing point of care, with increased use of public services in urban areas and of traditional health care and a shift away from use of private for profit providers. Subsidies to the private for profit sector are likely to benefit a small share of people, while those to private not for profit services, like mission hospitals and faith healing will benefit a wider pool of people. A high share of home treatment and falling access to health services indicates the priority for primary health care and health promotion to support effective community health practices, to shift inappropriate care burdens away from households and to ensure and support uptake in those that *need* attention. The increased real expenditures for health education 2001-2005 and for Village Health Workers in the period is thus a positive trend to support community and household health practices. Equally the investments made in the cadre of primary health care nurses will contribute to strengthening the primary care level of service provision.

The policy, economic and health context for the budget suggests priorities for the 2006/7 budget as:

- **Increased investments in addressing undernutrition, 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 most 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 increasing shares to administration and reducing shares to prevention.**

On **resource mobilisation,** the share of GDP to health rising above 5% and of government spending to health reaching Abuja 15% targets are a positive indicator of government commitment to health sector spending. General government spending on health as a percent of total government spending, after remaining below 10% to 2003, has now risen to the 13%, still below the 15% Abuja commitment. The AIDS Levy Fund appears to have helped to shield households from greater out of pocket health spending as donor shares fell.

International estimates of funds needed to meet basic health goals or deliver a reasonable minimum of services range from $34 per capital to $60 per capita, with an estimate of $169 per capita including costs of ARVs. The 2001 National Health Accounts indicated a per capita spending on health in the public and private sector in Zimbabwe in 1999 of $37.26. Of this $13.73 was in the public sector. The evidence suggests that this has fallen since 1999 suggesting a gap in overall resource adequacy to deliver a basic national health service and a demand for choices and trade offs in public policy.

A consistent increase in out of pocket spending since 1994 is of concern, given the increased the burdens on households at a time of severe economic difficulty. The share of capital financing from the Reserve bank and other donors to the health sector has been relatively low.

The evidence suggests that

- **The commitment in terms of share of GDP and share of government spending on health be sustained**
- **The share of government spending on health not be allowed to fall below the 15% total government spending committed in Abuja**
- **Measures be put in place to reduce out of pocket spending in services used by poor households, through removal of user charges for district health services, avoidance of direct prepayment schemes that increase out of pocket spending and a shift to tax funded and national health insurance options**
- **Other progressive tax levies be explored to boost health financing such as on financial transactions**
- **The distribution of out of pocket spending and its burden on different income groups be mapped through research.**

- **Budget resources be allocated for an updated National Health Accounts for 2005/6**
- **Capital projects in health for water and sanitation, clinic and hospital infrastructure be identified in areas of increased population settlement where there is inadequate facility provision.**
- **The health sector lobby for lower interest financing for infrastructure, production and service investments in services that have high benefit to health and health care in low income communities (eg safe water, essential drugs**

On **resource allocation within the health sector,** real expenditures for provincial, district and primary care levels have remained at constant levels, but current expenditure lines do not disaggregate spending at district and at primary care level making it difficult to track policy goals for and performance of primary health care and clinic services. Major referral hospitals increased their real expenditures and it would be important to determine the functioning of the referral system to assess efficiency in use of allocated resources to these levels. Inconsistency in definitions and recording make it difficult to assess with accuracy the trends in the distribution and use of resources between programmes and levels of health care. Trends noted indicate sustained or rising real amounts to disease control, nutrition, HIV and AIDS, and TB programmes and to the village health worker programme, and low but rising amounts to health education. Low amounts have been allocated to environmental and reproductive health with some increase in 2005, although the latter has benefited from direct donor funding.

The evidence suggests that

- **Resource allocations for all line items feasible be based on transparent formulae that integrate equity and poverty and reporting on expenditures make clear how these relate to equity oriented allocations**
- **Districts that have problems with capacities to absorb resources due to service or other factors be entitled to capacity building grants that strengthen their ability to effectively use health resources**
- **Future financial management and budget tracking and reporting provide a separate breakdown of expenditure on provinces; on district hospitals and services and on primary care level services (clinics, primary health care)**
- **The allocations to preventive health be substantially increased to at least 30% of the health budget**
- **Research be implemented on the functioning of the referral system to assess efficiency in use of allocated resources to referral hospitals (eg through use of these services for primary or secondary care) and effectiveness of measures for avoiding 'level jumping'.**
- **Allocations provide for improved levels of investment in reproductive health services should donor resources decline, especially where these relate to services impacting on adolescent health and maternal mortality**
- **Specific monitoring and reporting be implemented on how resources for AIDS are being used to strengthen the wider health system and their impact on the availability and allocation of resources to other important health services.**

The process of budget analysis and oversight clearly goes beyond such desk review, to include dialogue with the executive, with civil society and health providers and with other relevant actors. The analysis, and this process of consultation would be enriched by the Ministry of Finance availing its planning and estimation procedures for everyone to have an idea of how opportunity cost and marginal benefits play a part in budget estimation. This review has taken an explicit equity lens on the budget. If the policy goals and principles underlying the budget process are made clear, this will build understanding of

how competing concerns presented from different constituencies and sectors are balanced and considered in budget debates.

1. Background

This study was implemented to identify trends in the health budget, assess the equity oriented nature of these trends and make recommendations to strengthen pro-equity dimensions of the health budget. The study was commissioned through the Regional network for Equity in health in East and Southern Africa in consultation with the Parliamentary Committee on Health in Zimbabwe and was implemented by the Zimbabwe Economic Policy Analysis and Research Unit (G Chigumira and S Shamu) with the Training and Research Support Centre (R Loewenson).

An equity oriented budget analysis is important in Zimbabwe for a number of reasons:

* An increase in household poverty, significant demands from high levels of AIDS related illness and mortality and severe economic constraints call for the most effective use of available resources for health.
* Catastrophic and chronic health costs can have severe impoverishing effects on households, exacerbating poverty. Protecting against such effects calls for accessible and affordable health inputs for both prevention of disease and care of illness.
* The public sector is the primary source of care for low income households. Ensuring that public sector funds thus reach the prevention and care services most needed by low income households, directed at the major burdens of disease is thus the most effective means of addressing health needs and reducing poverty.

1.1 Equity oriented health financing

Equity in health care financing means that individuals (or families) contribute resources to health on the basis of their ability to pay, and receive resources for health on the basis of their health need. There is debate on what this means: Should the relative shares of income contributed by different income groups be the same or different? Institutions in EQUINET argue that high poverty levels, the inability of many households to afford even relatively small payments towards health care and substantial inequities in the distribution of income across households imply that those at higher levels of wealth and income should contribute a *higher* percentage of their income than lower income groups. At present it is the other way round: there is evidence that lower income households contribute a greater share of their income to health, up to 30% in catastrophic spending (McIntyre et al 2005). The HIV and AIDS Levy is levied at a flat rate of 3% across all income groups, meaning that the impact of this tax on incomes is felt more by those in the lower income groups. This puts some focus on how public policies and budgets can reverse this.

In the context of poverty levels of over two thirds of the population in Zimbabwe, poverty related health problems and a mixed health system with public, private not for profit and private for profit providers, the budget is an important tool to:

- ensure progressing financing through the type of taxes used for health,
- directly promote equity through the pattern of expenditures in health and health promoting sectors,
- indirectly stimulate revenues for health from private sources and their allocation to priority areas through public investments and financial incentives,
- indirectly stimulate access to health inputs through public investments in and incentives for health related investments and production,
- ensure adequacy of public health spending and avoid impoverishing burdens of out of pocket financing.

This implies increasing public spending on health, but not *just* that. While tax funding is the most progressive form of health financing, studies on the distribution of benefits from tax funded services in African countries have shown that higher income groups can benefit

most from these services (Castro-Leal, 1996; Castro-Leal et al., 1999; Demery et al., 1995). This occurs for example when a major share of tax funding is allocated to large, expensive, urban-based hospitals rather than to primary care services and services in rural areas (McIntyre et al 2005). This puts some focus on how budget resources are allocated between different types and levels of care.

This review thus examines the budget in three major respects:

* how far are the opportunities for equity in revenue mobilization being tapped?
* how far are the allocation and expenditure patterns promoting policy targets, particularly equity?
* how far are incentives and investments levering health promoting investments (and penalizing those that undermine health)?

1.2 The budget and budgetary process in Zimbabwe

Budgetary transfer system is the form of provider payment mechanism mainly used in Zimbabwe. Traditionally the allocations are set out as Line-item budget allocations to health authorities, programmes and facilities. Specific line-item categories such as administration and general, medical care, preventive services and research are used. Specific instructions and regulations prohibit public administrators from switching funds across line items without prior approval from the Treasury. Such traditional budgeting systems do not hold health administrators accountable for ensuring that each line item is fully expended, but not necessarily for the performance against that expenditure, including for pro-poor expenditures.

The main purpose of line-item budgeting is to identify specific areas of spending to facilitate control on these items. Traditionally it has been used to control spending on salaries and wages, although it can also be used to track specific policy priorities and operational areas of work. This type of budgeting may leads to inefficiencies in spending patterns that affect equity and to perverse incentives. If, for example, unspent funds at the end of a financial year are used as a signal to Treasury that the next period's budget allocation should be cut, administrators may see this as an incentive to spend their allocations without regard to efficiency.

The Ministry of Health and Child Welfare (MoHCW) distributes its health care resources through a vertical budgetary system or top down approach, that is from the central to provincial and finally to the districts. The 'Blue Book' as it is referred to in Zimbabwe, includes the government's consolidated revenue estimates and budget estimates that reflect the government's policy priorities and fiscal targets. However, in a bid to involve many stakeholders in the budgetary process and make it more people oriented, the Executive introduced what is now commonly referred to as re-engineered budgeting, following the recommendations of the 1999 Commission of Review into the Health Sector. This recommended the decentralization of the health system with the attendant benefits of bringing decisions and budgeting closer to communities to make it more real for them. It is through decentralization that multi-stakeholder participation in budgeting became real and has opened opportunities for the marginalized people.

A re-engineered budget process in Zimbabwe has opened opportunities for civil society organizations and health institutions to actively engage on the budget, and lobby around issues of gender, poverty and equity, in a complementary role to the government. Mutual interaction has created new opportunities for budgetary review and strengthening of pro-poor aspects. Government has also introduced public expenditure management reforms in the form of Results Based Management to monitor the performance of line ministries. However, the Ministry of Health and Child Welfare is yet to report results using this format.

The re-engineered budget process follows a simple three step approach that starts from budget formulation, followed by analysis and then monitoring. The formulation stage begins in the month of February with a call letter from the Ministry of Finance (MoF) for ministries to present their bids. In the following 2 or 3 months after February, the Parliamentary Portfolio Committee on Health holds stakeholder consultation meetings with ministry officials and interested actors to discuss and forward priority areas that could be included in the budget. In August or September the Committee, MoHCW and other stakeholders hold a workshop at which a consolidated bids draft is crafted. During this period the MoHCW is given an opportunity to present their half-year budget performance to help in the crafting of a bids draft for consideration by the Treasury.

The final bids draft is then presented to the Ministry of Finance for consideration by the MOHCW. After the presentation of the budget at the end of October or in early November, the Parliamentary Portfolio Committee on Health and its stakeholders analyze the budget using the benchmarks and targets submitted in the bids. No changes are expected to occur in the overall budget presented by the Ministry of Finance, so analysis and discussions are centred on re-prioritizing some issues within the budget. Budget monitoring is not divorced from this process and is done through the analysis of quarterly reports from the MoHCW. In most cases Ministry officials are called upon to answer questions from the parliamentarians on its performance.

2. Methods

While budgets traditionally focus on the period to come, budget analysis equally examines current budget allocations in the context of past trends. In this case the analysis examines the period from 2000 to 2005. This makes it possible to identify consistent longer-term changes not apparent in a single year. The contextualization of the review is as follows:

The review outlines

- the **policy context** in terms of the major strategic objectives of health policy, HIV and AIDS policy and the Millennium Development Goals.
- the **economic context** for the budget at two levels:
  - Firstly, the macroeconomic context, as this defines the overall resource availability for health and the context that the health sector is operating in.
  - Secondly the level of household economic security and poverty, as this defines the household capabilities to meet health costs.
- the **health context**
  - Firstly, in terms of the patterns of ill health and the major burdens of disease to be addressed.
  - Secondly, in terms of the organisation of the health system and parameters of access to essential health care services.

Within these contexts, the review examines how far are the **opportunities for equity in revenue mobilization are** being tapped, by:

- Exploring changes in shares from different sources of health financing, particularly in relation to the share of taxes, insurance, out of pocket financing and donor financing, and their association with changes in pro-poor resource allocations
- Examining specific health related levies and taxes for their pro-poor, equity implications
- Explore specific health financing (e.g availing foreign currency for the purchase of ARVs and advancing soft loans for Capital Funding) through the Central Bank's quasi-fiscal operations.

To understand how far **allocation and expenditure patterns are promoting policy targets, particularly equity,** the analysis:

- Examines trends against set targets, both in-country and regional, and progress such as the Abuja Targets of 15% of national total budget being allocated to health, and the Millennium Development Goals (MDGs).
- Examine allocations across levels of care and types of expenditure, such as to primary health care services.
- Examine how far regressive trends such as increased out of pocket financing (for example due to absolute declines in per capita health financing) are associated with increasing pro – poor allocations of the national budget.

The analysis also seeks to understand how far **incentives and investments are levering health promoting investments (and penalizing those that undermine health) by:**

- Examining tax incentives and relief, subsidies and other measures directed to levering health or health related expenditure for their pro-poor or health equity implications.
- Examining the provider payment schemes and the funding of facilities. Examine the incentives to provide effective services at a low cost and how administrative rules and regulations may impede efficient management.

The study has drawn 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 2000-2006. An analysis of provincial and district allocations and expenditures was not carried out since this data was not publicly documented and further work would need to be done to access and analyze such expenditure data. On analyzing national health expenditure, the study used unaudited expenditure to September as a proxy for actual health expenditure. This limits the analysis to that of allocations and unaudited expenditure, to largely national level aggregates and may therefore not be conclusive enough on how allocations and expenditures are handled at both provincial and district levels. The data is analyzed within the key functional categories of the budget as shown in Table 1.

Table 1: Functional Categories of the budget

Function	Explanation
Administration and General	Funds allocated for employment, goods and services, maintenance, current transfers and capital expenditures.
Medical	Funds allocated for employment, supplies and services, transfers, programmes, hospitals and health centres as well as capital expenditures.
Preventive	Funds earmarked for preventive programmes, employment costs, general maintenance, capital expenditures and transfers.
Research	Funds allocated for research programmes, employment costs, transfers, maintenance and procurement of goods and services.
Proxies	Allocation to programmes such as nutrition, water and sanitation were used as proxies for addressing equity issues.

The data limitations also raise problems of linking data to health priorities. For example it is difficult to directly link line items to areas of policy priority like primary health care as the budget lines are not structured in this manner. These need to be more indirectly assessed from specific cost items. Further pro-poor spending demands evidence on allocations to primary care and district level, and these disaggregations are not made in the budget statement. We make recommendations in this analysis of some of the categories of reporting from the Executive with the budget estimates that would enable parliaments to better assess trends in achieving goals of equity and poverty reduction.

3. The policy context

The policy context for the health budget can be found in the major strategic objectives of health policy, HIV and AIDS policy and the Millennium Development Goals. The key

policy goals related to health equity and the targets and indicators for their assessment , as developed in work on equitable resource allocation in health (Zimbabwe Equity Gauge Team MoHCW / TARSC 2001) indicates the importance for equity of:

- Primary health care programmes covering maternal, family and child health, measured through indicators of maternal and child health; antenatal and maternity services, immunisation, nutrition and child spacing services.
- Environmental health, measured through indicators of coverage and access to safe water and sanitation.
- Reproductive health, measured through indicators of HIV/AIDS, STIs, maternal health and coverage and access to prevention and treatment services for these.
- Management of communicable disease, assessed through coverage and access to prevention and treatment services for Malaria, TB and childhood respiratory infection, that overally includes the reduction of morbidity and mortality due to the ten major killer diseases.
- Community participation in health, assessed through coverage and spread of community health workers, provisions for mechanisms for community participation at all levels.
- Overall increases in allocations to health through health budget, social health insurance and distribution of resources through integrating needs based resource allocation.
- Provision and improvement of logistics and supplies management of vital and essential drugs, laboratory equipment and health facilities equipment to all levels of the health system.
- Provisions for ensuring adequacy and retention of health personnel in key levels of the health system.
- Mobilization of financial resources for effective management, rehabilitation and utilisation of available resources.

The targets set in the Millennium Development goals coincide with these health goals and parameters, with the additional- health promoting- factors of investment in education, in poverty reduction and in fair trade. This analysis provides an assessment of the relationship between health and education allocations, and of other poverty reducing areas of the budget. Table 2 below gives a summary of the MDGs, achievements of the country to date on key indicators and targets for 2015.

Table 2 indicates relatively high gaps to address in relation to poverty, undernutrition, maternal mortality, and reduction in TB. Substantial gaps also need to be addressed in access to safe sanitation and housing construction. The investments in these areas and the health gains they produce will reduce pressure on the medical care budget. Hence progress towards these goals is important to monitor as part of the tracking that informs the health budget. According to UNAIDS, there has been a fall in HIV prevalence (UNAIDS 2005). According to the 2005/6 Zimbabwe Demographic and Health Survey, for example, while there has been an improvement in infant mortality, but a fall in immunization coverage and in access to deliveries attended by skilled personnel, challenging progress towards these goals (CSO et al 2006).

Table 2: Summary of progress of MDGs

MDG Target	Indicator	Level	Target 2015
1. Eradicate Extreme Poverty and Hunger	% population below the total consumption poverty line	80%	40%
	Prevalence of children <5 underweight	20%	7%

2. Achieve Universal Primary Education	Net enrolment in primary education	93%	100%
	% children enrolled in Grade 1 who reach grade 7	75%	100%
3. Promote Gender Equality & Empower Women	Ratio of % total in gender enrolled - girls to boys in primary education	90:96	Parity
	Ratio of % total in gender enrolled: girls to boys in secondary education	40:42	Parity
	Ratio of girls to boys in tertiary education	30:70	Parity
4. Reduce Child Mortality	Under 5 mortality rate / 1000 live births	101	34
	% children vaccinated against measles	71%	90%
5. Improve Maternal Health	Maternal mortality / 100 000	695	174
	% births attended by skilled personnel	90	100
6. Combat HIV/AIDS Malaria & Other Diseases	HIV and AIDs prevalence among pregnant women 15-24 years of age	24%	16%
	Incidence of clinical Malaria / 1000	122	64
	TB incidence / 1000	399	121
7.Ensure Environmental Sustainability	% rural households with access to safe water	75	100
	% rural households with access to safe sanitation	58	100
	New urban housing units per year	20 000	250 000

Source: Government of Zimbabwe MDG report 2004

The MDG goals call for comprehensive and inclusive approaches to addressing issues. For example, maternal mortality calls not only for access to assisted deliveries, which has improved, but also improvements in maternal nutrition, in health of women during pregnancy and in poverty reduction and gender empowerment to address social barriers to accessing health services. The social interventions that influence this call for spending in education, in access to agricultural land, inputs and services for women farmers and in provision of affordable transport. The way these sectors spend their budgets and ensure these investments thus have a direct bearing on health.

It would be important for *each* sector to identify how their budget spending 8is enabling improved performance on the MDGs, generally, and specifically for particular disadvantaged groups. A parliamentary cross committee task force on the budget that specifically addresses budget performance against the MDGs may help to support monitoring of the budget contribution towards these commitments.

For example, using the 2000 budget vote, for Goal number 5 (including a 1.1% increase population) it was estimated that health expenditure per child/mother should increase by 3.5% per year, while the average expenditure would increase health care needs from the level of US$35.4 per child/mother to U$46.4. Total health expenditure on the MDGs to 2015 was estimated in 2004 at

- US$43.2 million for health, and
- US$32.0 million for HIV and AIDS without ARVs and US$38 mn with ARVs with a further US$1.5bn for the ARVs themselves (Govt of Zimbabwe 2004).

It is difficult to identify health spending per child or per mother to track this expected growth of 3.5% per year, however a programme like immunization is specifically directed at mothers and children and is a good 'indicator' of spending. One would expect an increase of 3.5% in spending per year in this programme based on the MDG commitment. Table 3 below shows the actual real spending on this programme and the percentage change annually.

Table 3: Government Expenditure on immunization 2001-2005 (real Z$, 2001 constant prices)

Spending on the Expanded programme on immunization YEAR	**2001**	**2002**	**2003**	**2004**	**2005**
Real Z$ 000's	128 232	111 458	16 275	23 318	14 788
% change over previous year		-13.1%	-85.4%	+43.3%	-36.6%

Source: Ministry of Health Estimates of Expenditure 2001-2005

Apart from an improvement in 2004, there has been a consistent fall in real spending on immunisation over the period, undermining the achievement of this goal. This is consistent with an increase in children not immunized found in the 2005/6 ZDHS report. Spending on immunisation is reported to be constrained by foreign currency shortages, including for transport for outreach.

Restoring progress towards MDG goals for reduction of child mortality would seem to call for a significant increase in investment in and availability of foreign currency for immunization.

It would, as noted above, be important to similarly track investments in areas where gaps in achieving MDG goals are challenging, namely nutrition, TB prevention and treatment, access to safe water, sanitation and maternal health.

4. The economic context

4.1 Macroeconomic Context

Zimbabwe has in the past 5 years experienced severe macroeconomic constraints (See Tables 4a,4b), with factors ranging from falling international terms of trade, narrow tax bases, rising poverty levels, a limited capacity to absorb external price shocks, unstable exchange rates and inflation. These factors have increased the demand for long term planning, while also making it more difficult both to plan for and adhere to expenditure and revenue targets. For example, for the past 6 years Zimbabwe has had more than 2 supplementary budgets on account of expenditure overruns by line ministries.

Table 4: Selected Economic Indicators

	1988	**1990**	**1995**	**2000**	**2001**	**2002**	**2003**	**2004**
Real GDP Growth rate (%)	7.5	7.0	0.2	-7.9	-2.8	-11.1	-14.8	-5.0
Per Capita Real GDP growth (%)	4.3	3.7	-1.3	-7.6	-2.5	-10.9	-13.6	-4.7
CPI Inflation (annual average %)	7.0	12.4	22.6	55.9	112.1	126.9	365	350
Balance of Payments (BOP)	-41	-19.0	35.0	-561	-55	-117	-335	-523
Employment growth rate %	4.3	-2.2	-1.8	-5.9	-4.0	-5.8	-9.07	-1.4

Sources: IMF 2005 CSO 2004, UNDP 2003 Govt of Zimbabwe 2004

1988 is an average of previous years' indicators.

Table 4b: Economic targets and performance, 2003-2006

Indicator	2003		2004		2005		2006	
	Target	Actual	Target	Actual	Target	Actual	Target	Forecast
GDP (%)	3 – 5	-13.2	-2.5	-3.8	3.5 - 5	-6.5	5	2 – 3.5
Exports as % GDP	13.6*	17.6	-7.5*	42.6	12.7*	42.8	16.3*	26.1
Government Deficit % of GDP	0.3	7.5	3 - 5		3 - 5	8.6	2 – 3	
Inflation	3.65	365.0	382	350.0	90	237.8	20	1,216.0
Gross Savings as	-5	-21.1	-1.7	-3.7	9	-6.3	12	-3.1

% of GDP								
Gross Investment as % of GDP	4.3	-13.0	5.1	5.1	10	4.5	20	3.5

Source: CSO, RBZ, NERP and MEPF Policy documents, Budget Statements and
Note 1: * Refers to export growth

When supplementary budgets are used to deal with inflationary economic environments they can distort policy priorities. For example, the Parliamentary portfolio committee on health and child welfare report on the half -year budget performance of the Ministry of Health and Child Welfare and the National Aids Council for 2006 indicates the supplementary amounts voted in 2006 as a result of the macroeconomic conditions shown in Table 5 below.

Table 5: Budget allocations and supplementary votes 2006

	2005 Budget Allocation	% total health budget	Additional amount voted (2006)	% total supp-lement	Change in share
Administration	198,978,398	6.8%	1,163,354,449	7.7%	Increased
Medical Care	2,371,237,896	80.5%	12,815,981,001	85.2%	Increased
Preventive services	332,093,821	11.3%	809,855,197	5.4%	Reduced
Research	44,405,650	1.4%	241,524,217	1.6%	Increased
Total	**2,946,715,765**	**100%**	**15,030,714,864**	**100%**	**100%**

Source: Portfolio Committee on Health, Parliament of Zimbabwe 2006

The table indicates that the supplementary budget in 2006 reduced the prevention share of the health budget while increasing others, including administration. If supplementary budgets are used to redirect funds from pro-poor areas like prevention to areas with less proven pro-poor effects like administration they become a negative contribution to policy goals and to reduce controls on administrative spending. Supplementary budgets are also likely to increase shares to curative spending away from prevention given the greater demand driving this area. It is important that supplementary budgets are monitored to ensure that they do not distort policy priorities, until the macroeconomic conditions are such that they become unnecessary.

This is particularly important when the macroeconomic conditions that create a necessity for supplementary budgets affect households and demand particular types of health interventions to protect against impoverishing health spending. Table 6 below outlines ways in which the country's macroeconomic performance indicators affect household health and the health budget.

The table indicates that the current economic environment affects health at two levels: it places pressure on households, especially the poorest, to protect areas of health spending that promote health (such as environmental health, nutrition, education etc) and to avoid medical care costs impoverishing households. It also places pressure on health budgets to meet rising costs of individual medical care while protecting also spending on public health interventions that protect population health. Under conditions of falling GDP this implies choices and trade offs - for the health sector and for households.

Table 6: Macroeconomic trends and health impacts

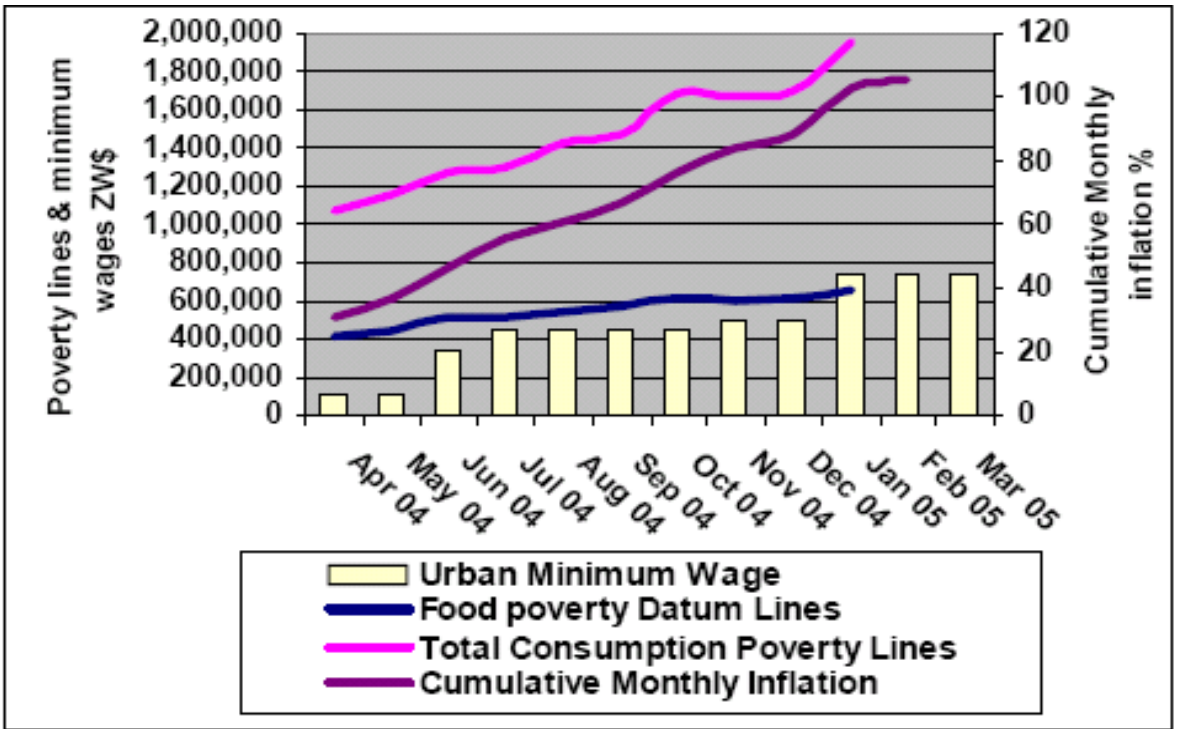
Macroeconomic factor	Outcome 2000-2005	Issue for the health budget	Issues for household health
Per capita real GDP growth	Fallen	Falling total resources available nationally for health	Falling household resources likely, although different for different income groups.
Gini coefficient* Aggregate inequality measures varying from 0 =perfect equality to 1= perfect inequality.	Falling to 1995 but still high at 56.8. No indicator measured thereafter	High inequality places demands on tax funded services to redistribute resources for health and use more resources to reach and benefit low income groups	High levels of wealth in a minority and poverty in a majority can segment population groups and their health needs.
CPI annual inflation	Significantly increased	Reduced returns on spending for health service inputs. Increase cost of health care and pharmaceutical products.. Undermines stability of planning and ability to deliver quality health care	Difficulties for households to procure health inputs and maintain health spending. Shift to traditional medicine and faith healers
Foreign reserves and Import cover	Fallen Significantly	Import cover at less than one month, and weak foreign reserves undermines acquisition of drug supplies, water treatment chemicals etc and rehabilitation and acquisition of medical technology. Local manufacturing of the generic drugs hindered by foreign currency shortage. Pull on outmigration of health workers to improve real earnings.	Reduced ability to purchase health inputs with foreign currency components (drugs, sanitary towels). Increased resources for households receiving inward remittances.
Employment growth rate	Fallen and informalized	Reduced contribution to health through tax and insurance mechanisms; reduced pool for taxation forms of financing	Reduced household income security and capabilities for meeting health inputs; potential for poverty induced by medical spending.
Formal sector unemployment rate as a proxy for the growth of the informal sector	Dwindling	Reduction in the tax base and insurance contributions and implications for revenue leading to over reliance on regressive taxes such as VAT, fuel levies and capital gains taxes.	Increased out-of-pocket payments for health care by informal producers, An increase in home based care. Burdens on women as unpaid carers.
Producer price Index	Fallen significantly	Unfavourable producer prices for food crops promoting reduced production of food crops necessary for household health	Falling agriculture production decreasing rural incomes and capabilities for improved health and nutrition.
Industrial index	Grown significantly	Incomes for those who have access to the stock exchange have risen significantly.	Increased gap between the poor and the rich as measured by the Gini coefficient.

* Literature on most countries reveals that most countries with highly unequal distribution typically lie in the range of 0.5 to 0.70, while for those that are considered to have relatively equitable distribution levels lie in the range 0.2 and 0.35.

4.2 Household poverty

Poverty in Zimbabwe is regarded as a multi-dimensional problem with both economic and socio-cultural effects. It is positively associated with social exclusion, marginalization, vulnerability, powerlessness and isolation. Besides the issue of entrenched poverty due to the effects of policies effected during the period of colonization, some of the now apparent causes of poverty are the deterioration of social services and facilities such as health and education, growing unemployment. Other causes of poverty in Zimbabwe are the inadequate access to productive resources like land, credit and technology, low-income levels arising from the hyper inflationary environment that the country is experiencing and the increasing gap between the poverty datum line and salaries and wages as shown in figure 1 below.

Figure 1: National Poverty Lines Compared to Selected Minimum Wages in Urban and Rural Areas



Source: FewsNet Zimbabwe Food Security Update March 2005.

The Second Poverty Assessment Study Survey (MPSLSW 2003) found that the proportion of households below the Total Consumption Poverty Line (TCPL), had increased from 42% in 1995 to 63% in 2003. While nationally, the proportion of very poor households increased from 20% to 48%, in some provinces (Manicaland, Midlands and Bulawayo) the proportion of very poor households grew by more than 200%. Poverty increased more rapidly in urban areas in 2003, while rural areas still had more poor people (71%) compared to urban areas (61%), urban poverty had increased more rapidly. Poverty has remained higher in female headed households (MPSLSW 2003)

An increase in household poverty and the scale of poverty now found in Zimbabwe suggests that beyond geographical targeting of pro-poor measures, there is need for more emphasis on wider poverty reducing measures in the health budget. From the literature evidence indicates that this the case when budgets are

- allocated to improving the community factors influencing health (safe water, sanitation, food security, housing)

- allocated to primary health care prevention services such as immunisation and antenatal care and the community health workers and outreach that improve coverage and use of these services
- allocated to clinic and district hospital level with mobile and other forms of outreach to ensure coverage in the most vulnerable groups.

The spending in real Z$ to some of these areas is shown in Table 7.

Table 7: Government Expenditure 2001-2005 (real Z$, 2001 constant prices)

Area of spending: YEAR	**2001**	**2002**	**2003**	**2004**	**2005**
Expanded programme on immunization					
Real Z$ 000's	128 232	111 458	16 275	23 318	14 788
% change over previous year		-13.1%	-85.4%	+43.3%	-36.6%
Environmental health					
Real Z$ 000's	1 993	0	2 103	196	15 930
% change over previous year		-100%	+100%	-92%	+8027%
Nutrition					
Real Z$ 000's	5 223	6 150	5 500	44 038	41 504
% change over previous year		+17.8%	-8.9%	+700.6%	-5.8%
Integrated management of childhood illness					
Real Z$ 000's	5 687	4 112	1 578	2 906	8 757
% change over previous year		-27.6%	-61.6%	+84.2%	+201.3%
Freedom from Hunger campaign					
Real Z$ 000's	80000	85763	257289	20490	45492
% change over previous year		+1.1%	+3.0%	-8.0%	+2.2%

Source: Ministry of Health Estimates of Expenditure 2001-2005

The table indicates that there have been fluctuations in these budgets in real terms over the period, with falling levels in 2003, and general increases in the 2005 budget. It is not clear what has driven the rather substantial real swings in these budgets, nor the effect on planning consistent growth in these programmes. Other programmes, such as the Freedom for Hunger Campaign which grew nominally, but fell substantially in real terms are very important programmes that alleviate household poverty.

The rise in urban poverty indicates that while the spatial distribution of health budgets across districts should continue to emphasise rural areas overall, there is also need for increased attention in urban areas, particularly for those in insecure employment, in insecure shelter and for orphans. Specific investments in the health sector is required to address the health gaps in rural and urban areas caused by population movements, particularly through the fast track land reform and rural to urban migration.

5. The health context

There are numerous texts on health trends in Zimbabwe and this analysis does not aim to reproduce these. Key trends are presented and their implications for the health budget are raised.

5.1 Health status

Table 2 earlier provided a summary of health status indicators. Table 8 below provides some demographic indicators for which trends are available.

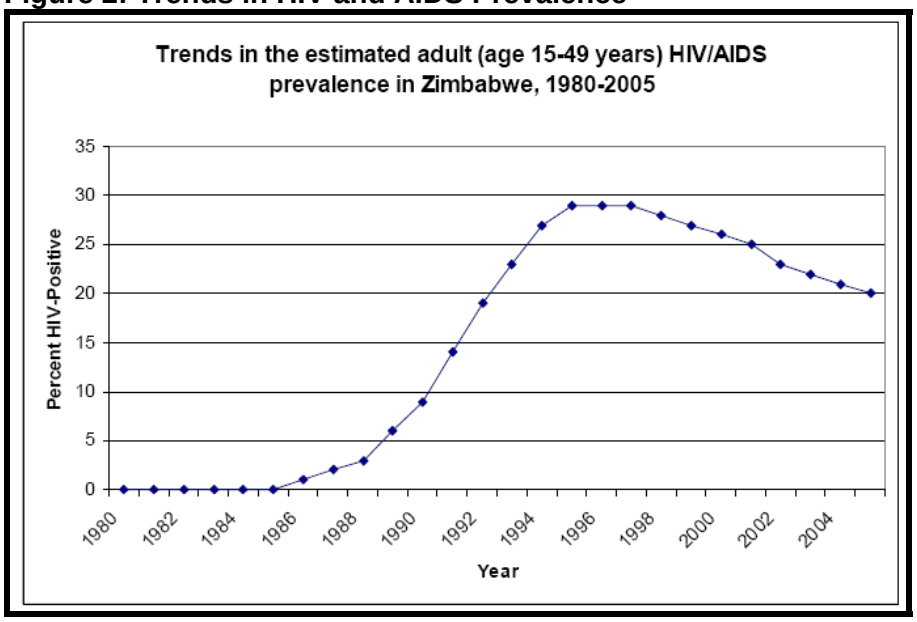
Table 8: Trend of selected health indicators (2000-2005)

Health status Indicator	2000	2002	2003	2004	2005
Population (millions)	11.6	11.6	11.87	12.9	13.0
Population growth rate %	2.5	1.1	0.6	0.6	
Total Fertility rate	3.8	4	3	3.4	
Life expectancy at birth (years)	43	43	43	37 (i) 44 (ii)	37.2 (i) 44.3 (ii)
Infant mortality rate (deaths per 1000 live births)	102.1	-	-	-	79.4

Source: Poverty Reduction Forum 2003: MDGs Report 2004 and (i) World development Indicators 2006 (ii) communication Ministry of Health Zimbabwe

The effect of AIDS on these indicators is evident in the reduced life expectancy, even in the context of relatively low fertility rates and falling infant mortality. Figure 2 shows the falling HIV prevalence rate now observed, but even with this the demand for prevention interventions needs to be sustained and current HIV cases and annual increases AIDS cases between now and 2018 mean that budget allocations for ARVs will still be significant for the foreseeable future (ZEPARU 2005).

Figure 2: Trends in HIV and AIDS Prevalence



Source: Ministry of Health and Child Welfare 2005

In 2005/6 the Zimbabwe Demographic and Health Survey reported that child stunting (29% children) and wasting (6% children) remained relatively stable between 1999 and 2005, but that under-nutrition had increased (17% children).

Access to safe drinking water in the rural areas shows a decline from 75% of households in 1999 to 68% in 2003 (MPSLSW 2003). Access to safe sanitation in the rural areas rose from 48% coverage in 1992 to 58% in 1999 and fell to 56.6% in 2003. Outbreaks of dysentery and cholera signal the need for significant expansion in the overall budget allocation to this area, and the specific health sector budget allocations for environmental health at community level. The mushrooming of open dump sites in the cities and towns, use of unsafe water and the growth of new

settlements that are not water serviced has significantly increased the risk of environmental related diseases.

The evidence indicates negative health status trends in child mortality, maternal mortality rates, life expectancy and nutrition rates. These declines emerge from the macroeconomic and household poverty context outlined earlier. With the impact of AIDS related mortality this suggests the added importance for the health budget to cushion these effects until some change is experienced in the wider social and economic environment.

In other words, the context and the resulting health outcomes suggest that this is not 'business as usual' in the health sector, that the sector is addressing a significant challenge arising from macroeconomic conditions and household poverty. Budget measures that increase investment in all those areas of health spending that have a more direct impact on household poverty appear to be a priority in this context.

The trends in relation to HIV and AIDS indicate the importance of sustaining outreach for prevention, impacting on AIDS mortality through significant increases in expenditure on counseling and testing, prevention of mother to child transmission and ART provision for parents and provision of ART more widely through basic health services.

Other programmes such as malaria control may require both national and regional initiatives, and it will be important to identify how national budget allocations are complemented by regional funds and by the investments made in neighbouring countries in these areas. Hence for example the management of multidrug resistant TB is not simply a matter for investment in Zimbabweans health budget but for the budgets in neighbouring countries.

5.2 Provision of and access to health care

As for the discussion on health trends, this analysis does not aim to repeat other texts on health service trends.

Health care providers in Zimbabwe include:

- The *public sector*: (MoHCW, Local Authorities, Uniformed Forces services and Ministry of Public Service, Labour and Social Welfare Occupational Health Services.
- *Private medical sector*: private-for-profit (private hospitals, maternity homes, general practitioners, traditional health practitioners and industrial hospitals and clinics) and Not-for-profit private sector: (Mission Hospitals, and other faith based organisations (FBOs), and non-governmental organisations (NGOs)).

Table 9 provides information on the number of facilities by type of provider in 2004.

While the analysis in the next section explores the breakdown of the different levels of budget spending in the health system, one indicator of spending on improving uptake and outreach of primary care services is that on Village Health workers. The real increases in this area shown in Table 10 are a positive contribution to improved outreach to households and improved uptake of key primary health care services. Equally the investments made in the cadre of primary health care nurses will contribute to strengthening this level of service provision.

Table 9: Selected registered health institutions at 30 September 2004

Type of health institution	Number*
Medical practitioners	1000
Nurse practitioners	170
Government clinics	550
Industrial clinics	200
Mission clinics	40
Private clinics	50
Rural District Council clinics	300
Urban Municipal clinics	80
Hospitals	500
Maternity homes	20
Medical laboratories	85
Nursing homes	20
Operating theatres	10
Pharmacies	300
Psychological practices	30

*Statistics provided by the Health Professions Authority (2004) in Kokerai et al 2005.

Table 10: Government Expenditure 2001-2005 (real Z$, 2001 constant prices)

Area of spending: YEAR	2001	2002	2003	2004	2005
Village Health worker programme					
Real Z$ 000's	23 436	13 593	14 299	12 284	21 004
% change over previous year		-50.0%	+5.2%	+14.1%	-70.9%

Source: Ministry of Health Estimates of Expenditure 2001-2005

Table 11 gives a summary of the health seeking behaviour of patients in both the urban and rural areas for the years 1994, 1999 and 2004. This table confirms that across urban and rural areas there has been a shift towards use of public facilities and away from use of private services. The growth is particularly in the urban areas signalling the effect of falling real wages. Mission hospitals are major not for profit providers in rural areas. Private for profit providers are also a big sector but there are signals in the shift to public sector that the rising out of pocket payments for care is limiting their use to higher income and formally insured groups. Subsidies to the private for profit sector (such as tax rebates) are likely to benefit a small share of people, while those to private not for profit services, like mission hospitals will benefit a wider pool of people.

Table 11: Health service use by ill persons in the previous Month by Facility, Rural and Urban, LFS 1994, 1999 and 2004

Facility	Urban			Rural			Total		
% ill using	**1994**	**1999**	**2004**	**1994**	**1999**	**2004**	**1994**	**1999**	**2004**
Public Health	44.8	48.0	59.0	53.4	67.7	61.8	51.7	62.0	59.7
Private Clinic	24.7	18.0	8.1	2.87	3.3	5.1	7.1	7.5	7.3
Traditional Healer	0.7	1.0	0.9	1.16	0.0	1.6	1.2	1.8	1.1
Faith Healer	*	*	2.1	*	*	4.1	*	*	2.7
Other Healers	1.4	2.2	0.5	2.4	2.0	0.7	2.1	2.1	0.5
Not visited	28.4	30.8	29.4	40.2	24.9	26.7	37.9	26.6	28.7
Total percent	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Source: 2004 Labour Force Survey
Note: in 1994 and 1999 LFS faith healers were combined with other healers.

There currently do exist cross-subsidies between the public sector and the private sector. Major referral hospitals have been given permission to lease out public beds and wards to private providers. Revenue generated through such arrangements go towards meeting the hospitals' needs to assist low income patients who access services from the same hospital. Government resources have been used to subsidize the private sector through tax rebates for private medical aid, through the training of health cadres who find their way into private services and through contribution of civil servants' and their dependants to private medical schemes.

Malaba (2003 in Kokerai et al 2003) suggest that health care uptake has fallen between 1995 and 2001. About a quarter of people do not seek medical care at all, and many treat themselves at home (Table 12). Outreach health promotion to support effective community health practices and differentiate those that *need* attention would appear to be a priority area to promote health under these circumstances.

Table 12: Health Facility uptake by Rural and Urban area, 1994-2004

Reason	**Urban**			**Rural**			**Total**		
	1994	1999	2004	1994	1999	2004	1994	1999	2004
Facility too far	1.7	0.6	5.8	6.8	3.6	2.3	6.1	2.6	4.9
Treatment not necessary	20.1	21.7	26	26.8	24.8	15	25.8	23.8	23.2
Cannot Afford	31.9	29	22.7	17.7	10.8	24.8	19.8	16.8	23.3
Home Treatment	40.2	44.5	44.3	40.7	50.1	47.4	40.6	48.3	47.4
Other/ Not Stated	6.1	4.2	1.3	8	10.7	10.7	7.7	8.5	1.3
Total Percent	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Source: 2004 Labour Force Participation Survey

(*)Percent distribution of Persons Who fell ill during the month preceding the Survey but did not visit a Health Facility by Reason for not doing so and by Rural and Urban

Given the critical importance of public services in pro-poor health interventions, the demand for these interventions by rising ill health and the need to use these services to counter the ill health impacts of wider economic trends, there is evidence for increased budget resources for the health system, particularly the district health system that protect against the poverty and burdens of ill health. The increased real expenditures for health education under these circumstances shown in Table 13, together with the increased expenditures for VHWs cited earlier is thus a positive trend to support community and household health practices.

Table 13: Government Expenditure 2001-2005 (real Z$, 2001 constant prices)

	2001	**2002**	**2003**	**2004**	**2005**
Health education programme expenditure Real Z$ '000s	3 441	4 139	3 395	5 935	9 622
% change over previous year		+20.3%	-18.0%	+74.8%	+62.1%

Source: Ministry of Health Estimates of Expenditure 2001-2005

Trends in health worker adequacy, distribution, out-migration and losses due to illness and death have become an increasing issue for the health budget. Table 14 indicates the inequality in the distribution of health workers between urban and rural areas affecting the coverage of and access to key services for improving equity.

Table 14: Distribution of public sector health workers

Location	Establishment	Professionals	Doctors	Nurses
Rural	30%	32%	20%	36%
(Filled post – 2000)	(29%)	(31%)	(40%)	(40%)
Urban	55%	47%	71%	47%
(Filled posts – 2000)	(60%)	(55%)	(80%)	(57%)

Source: Mudyarabikwa et al 2005

Gaps in filled posts are highest in rural areas. This has been further affected by AIDS related mortality in health workers and by out-migration, associated with an erosion of real earnings in the public sector and economic and social insecurity. The incentive programme to improve public sector conditions is an important contributor to retaining health workers, especially those increased numbers being produced to ensure adequacy of health personnel for district health services in urban and rural areas.

In summary, the policy, economic and health context for the budget suggests priorities for the 2006/7 budget as:

- **Increased investments in addressing undernutrition, 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, 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 most 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)**
- **Preference for increasing investment in financial and non financial incentives to retain local personnel in health systems over payments to external consultants, with monitoring and reporting on the effectiveness of incentive schemes**
- **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 increasing shares to administration and reducing shares to prevention.**

6. Budget trends

6.1 Revenue mobilization

A general guiding principle for taxation is that it treat individuals equitably or fairly. The burden of taxation should be according to the person's ability to pay based on economic well-being, and the proposal that vertical equity- or greater share of income payments from those with greater ability to pay has been argued earlier. A progressive form of taxation would seek to increase the relative share of corporate taxes and taxes on 'luxury' items and 'sin' taxes eg cigarettes and alcohol.

Income taxes are more progressive than Value added tax, which replaced sales tax, VAT is a regressive form of taxation since both the rich and the poor pay it, not according to incomes but the price and quantity of goods. This form of taxation, unlike the income tax which generally incorporate the ability to pay principle, affects the poor and the unemployed most. Income related taxes, like the AIDS Levy, are also more progressive than VAT, as long as income earners below poverty levels are shielded from taxes.

To date Value Added Tax has overtaken corporate taxes and income taxes in revenue generation. Income taxes and company taxes constitute a bigger proportion when they are combined together, however, their share of tax revenue has been decreasing over the years due possibly to the informalization of most business enterprises, company closures and rising unemployment. Excise taxes and customs duties have remained constant around the 5% - 12% band.

Table 15 Taxes Revenues and Relative Share 2000 - 2005

	2000	2001	2002	2003	2004	2005
Income tax and profits	63%	58%	57%	56%	52%	50%
Customs Duties	11%	14%	10%	7%	12%	12%
Excise Taxes	5%	4%	7%	7%	4%	3%
Sales tax/VAT	20%	23%	26%	29%	31%	32%
Other Taxes	2%	1%	1%	1%	1%	2%
Total Tax Revenue	100%	100%	100%	100%	100%	100%

Source: Ministry of Finance VAT was introduced January 2004 in place of Sales Tax.

Provincial and district health centres have continued to rely on the central government allocations despite powers to levy residents through their urban-rural council statutory powers. While income tax remains under the control of the central government, provinces and districts can only levy other indirect taxes to supplement budget for their health activities.

As reported in the National Health accounts Report 2001 (See Table 16) between 1994 and 1998 public sector revenue increased. The larger increase in this period was in donor financing, with a decline in health insurance and an increase in out of pocket financing from households. The latter is a regressive trend. Between 1998 and 2001 there was a substantial fall in donor financing and an increase in other government contributions, mainly through the NAC and the AIDS Levy fund, that helped to cushion aggregate donor losses. There does however appear to have been an increased private sector role and commercialization of services, with increased out of pocket financing and private sector investments in health. Employer contributions, combining health insurance have gone down with Government (the largest employer) reducing the number of dependants who qualify for the Premier Service Medical Aid Society (PSMAS) to five from previous levels of unlimited dependents. Government provides up to 60% of employer contribution, from 80% in 2005 (GoZ 2006).

Table 16: Sources of Funds

	1994 (%)	**1998 (%)**	**2001 (%)**	**Change 1994-1998**	**Change 1998-2001**
Sources of Funds for Health					
Public sector sources					
Ministry of Finance to MOHCW	29.0	28.0	30.85	-	+
Other Ministries	4.7	5.9	8.74 (i)	+	++
Local Authorities	5.3	4.7	1.82	-	-

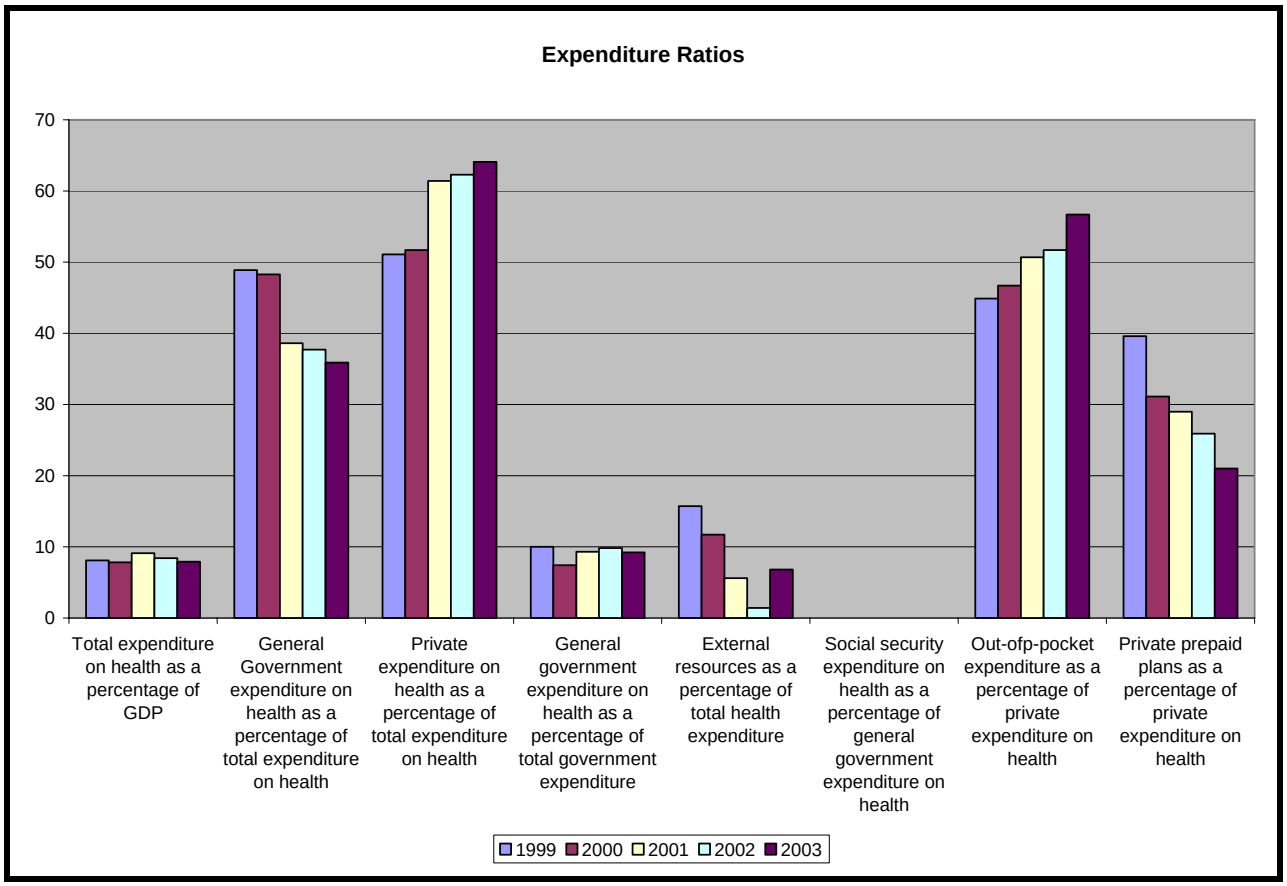
Donors to MOHCW	12.2	17.2	4.20	++	--
Sub-total	***51.2***	***55.9***	***45.61***	**+**	
Private sector sources					
Households	30.5	33.2	36.8	+	++
Health Insurance	11.8	7.2		-	
Employers	5.7	3.6	10.8 (iii)	-	
PVO's (NGOs)	0.9	0.9	6.74 (ii)		++
Sub-total	***48.8***	***44.1***	***64.09***	**-**	
Total	**100**	**100**			

Source: MoHCW National Health Accounts Report Zimbabwe, 2001.
(i) includes National AIDS Council (ii) includes other private provider investments (iii) includes insurance

The AIDS Levy Fund appears to have helped to shield households from greater out of pocket health spending as donors withdrew which is positive. The consistent increase in out of pocket spending is of concern, given the increased the burdens on households at a time of severe economic difficulty.

Figure 3 below gives some indication of post 2001 resource sources. The general government expenditure on health has fallen over the period, creating a push for the increase in private expenditure, particularly in out-of-pocket payments. The out-of-pocket share of the private expenditures is shown to have risen to above 55% by 2003, indicating decline of the welfare system and a likely burden on low income households. The falling private pre-paid share of private expenditures and a corresponding increase in out-of-pocket payments reflects a picture where one can conclude it is mostly the unemployed and the informal sectors using this form of payment for accessing health care. Co-payments are also regarded as out-of-pocket payments since insurance companies do not always reimburse patients.

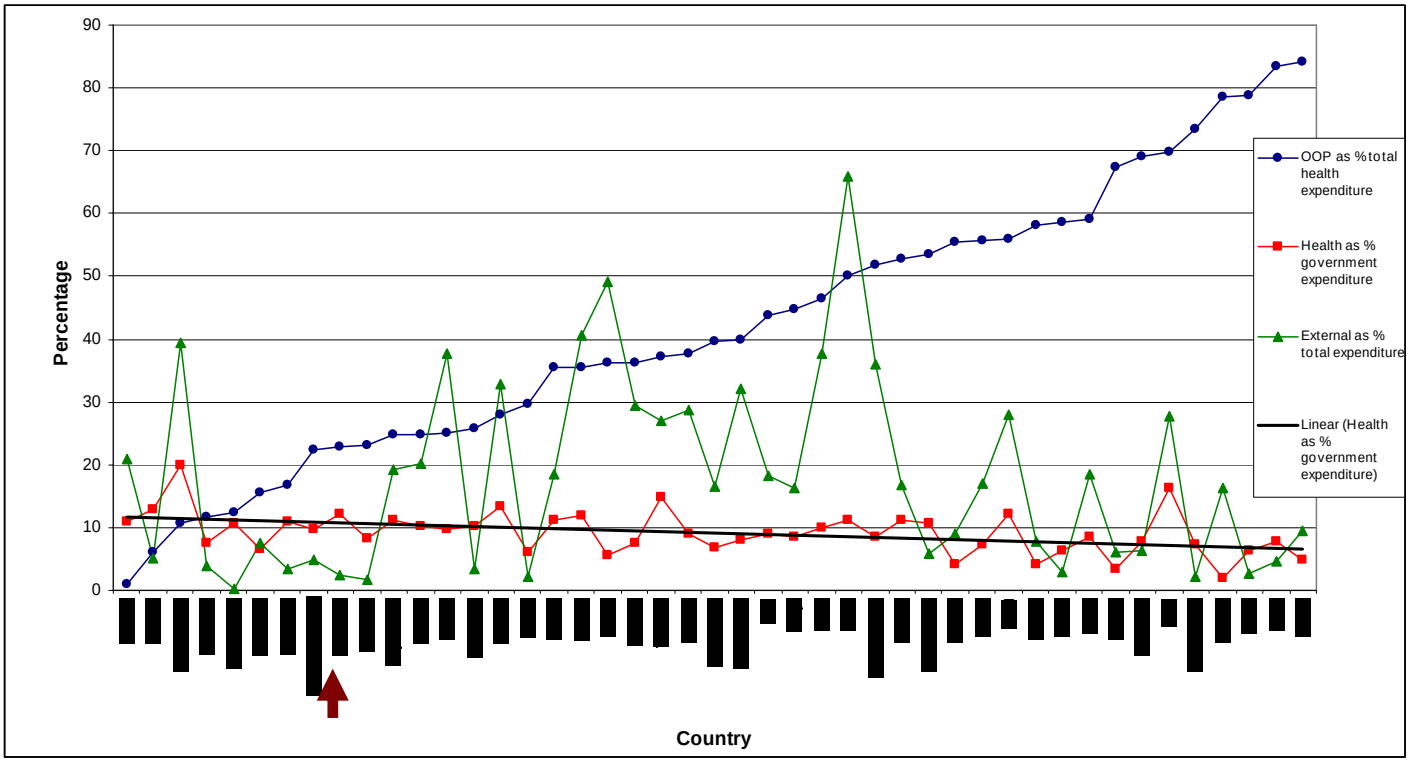
Figure 3: Health expenditure ratios



Source: World Health Organization Report 2006

Compared to other Sub-Saharan African Countries, Zimbabwe's out of pocket share, shown in Figure 4 is not as high as other countries in the region. However the trend towards a steady increase in this signals the need for measures to control the trend (review of user charges, review of pre – payment schemes, improved tax revenue, discussion of mandatory national health insurance etc). The distribution of this out of pocket spending on different income groups would also need to be mapped through research.

Figure 4: Out-of-pocket, government and donor funding, Sub-Saharan Africa (2002)

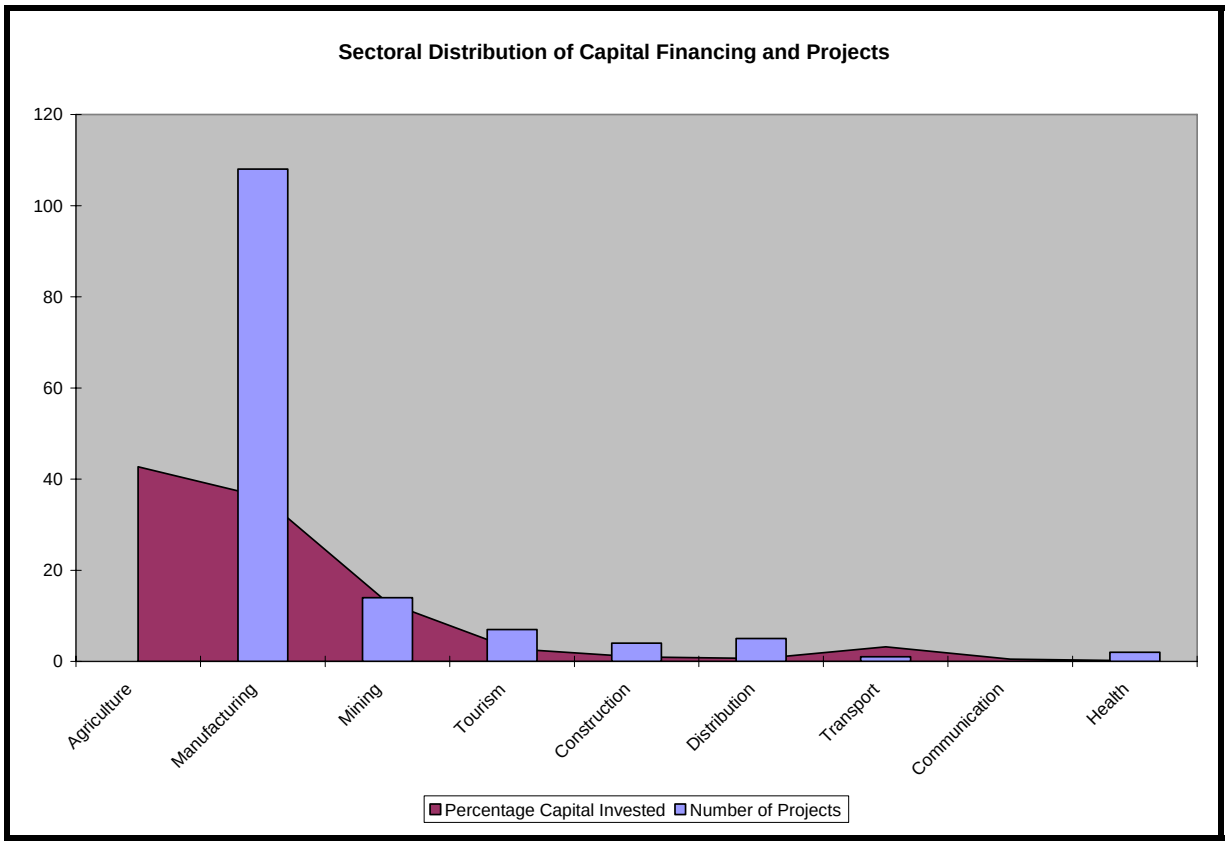


Source: World Health Organisation NHA website in McIntyre et al 2005

External assistance has fallen, with an increased inflow in 2003 from the Global Fund for AIDS, TB and Malaria. Capital financing from the Reserve bank and other donors represent a source of investment resources. Figure 5 shows the small share of these funds in the health sector.

This may in part relate to perceived priorities at national level. It may also relate to the need within the health sector to ensure adequate use of existing infrastructure through recurrent spending on personnel, drugs and other inputs, rather than development of new infrastructures. The areas of intensified population settlement may however need focus as areas for capital investments in health infrastructure, including environmental health (water, sanitation), clinics and hospitals, while urban housing is a priority area to address the gap in the MDG targets that also has high health impact.

Figure 5: Capital Financing and Projects



Source: Reserve Bank of Zimbabwe

The evidence suggests that

- **The share of government spending on health be increased to and not fall below the 15% total government spending committed in Abuja**
- **measures be put in place to reduce out of pocket spending in services used by poor households, whether through user charges or direct prepayment schemes**
- **other progressive tax levies be explored to boost health financing such as on financial transactions**
- **the distribution of out of pocket spending and its burden on different income groups be mapped through research.**
- **the budget resources be allocated for an updated National Health Accounts for 2005/6**
- **capital projects in health for water and sanitation, clinic and hospital infrastructure be identified in areas of increased population settlement where there is inadequate facility provision.**
- **The health sector lobby for lower interest financing for infrastructure, production and service investments in services that have high benefit to health and health care in low income communities (eg safe water, essential drugs**

6.2 Budget allocations to health

Given the priorities in the Millennium Development Goals (MDGs), and the health and economic challenges identified earlier, how far do budget allocations address these priority needs? Given the increased out of pocket financing at a time of increased household poverty, how far are allocations of the budget aimed at protecting low income households from ill health and its costs?

How much overall should Zimbabwe be spending on health?

Former World Health Organization Director General, Dr Brundtland in a Speech to the Winterthur Massive Effort Advocacy meeting in 2000 said: "It is becoming clear that health systems which spend less than US$60 or so per capita are not able to even deliver a reasonable minimum of services, even through extensive internal reform. It doesn't matter how good the structure is - as long as you can't afford to pay your doctors and nurses proper salaries and fill the shelves with essential medicines and vaccines, a health system will not be performing at a reasonable level."

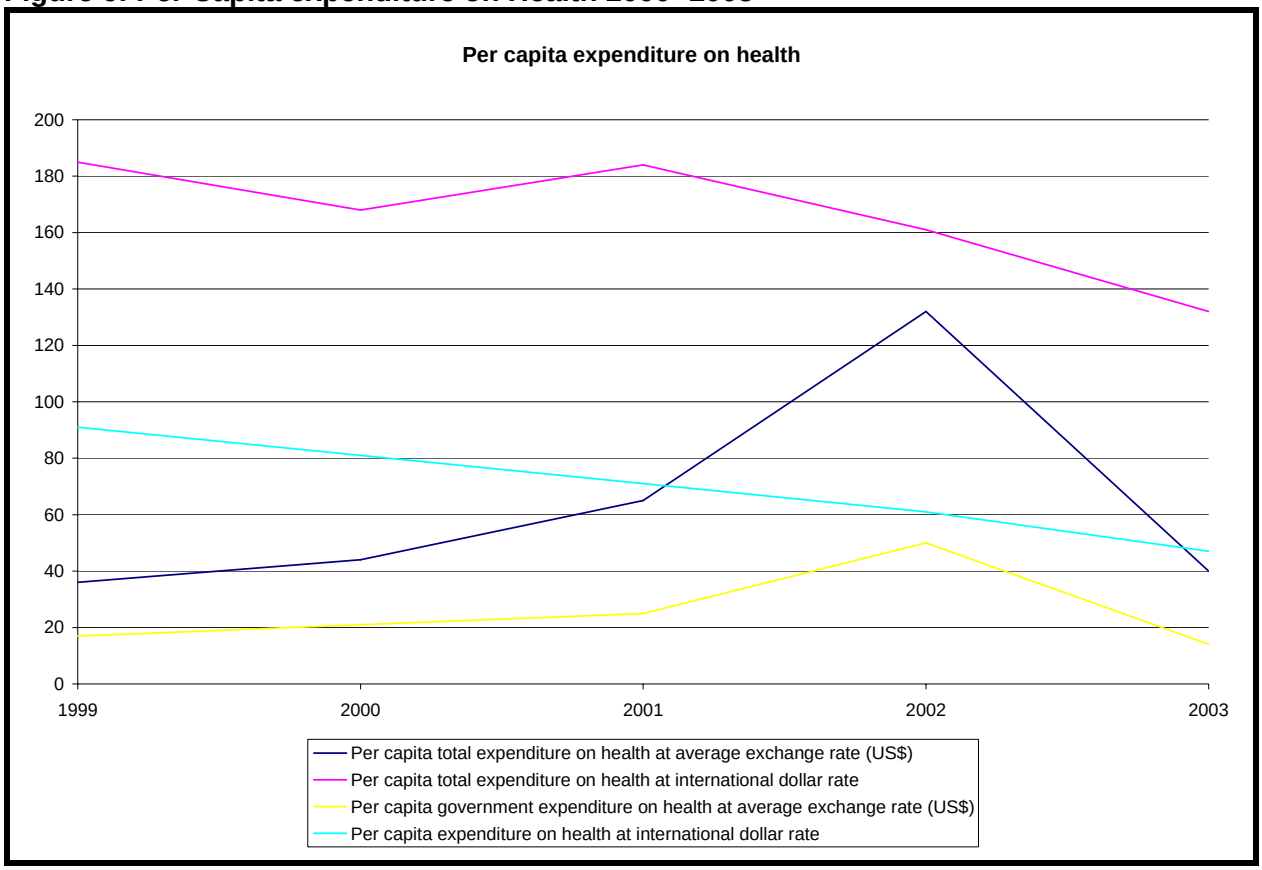
In 2004 the Macroeconomic Commission on Health costed what it termed a reasonable 'package of basic, low cost and low-tech health intervention at US$34 per capita per year. This did not represent the entire health system,' but simply the interventions (CMH 2004).

In 2004, Government estimated a total resource requirement to reach Zimbabwe's MDG 2015 poverty reduction goals as US$600 million (excluding ARVs) and US$2.2 billion (including ARVs) (Ministry of Finance and Economic Development, 2004). With an estimated population of $13 million in 2005 this would translate to $45 per capita without ARVs and $169 per capita with ARVs (Government of Zimbabwe 2004).

The 2001 National Health Accounts indicated a per capita spending on health in the public and private sector in 1999 of $37.26 (MoHCW NHA 2001**). Of this $13.73 was in the public sector.**

Figure 6 shows that per capita health expenditure has generally fallen since 1999, using both measures of average exchange rate and international dollar[1].

Figure 6: Per Capita expenditure on Health 2000 -2005



Source: World Health Report 2006

[1] The international dollar measures the country's purchasing power parity and is generally reflective of the prices of similar baskets across countries.

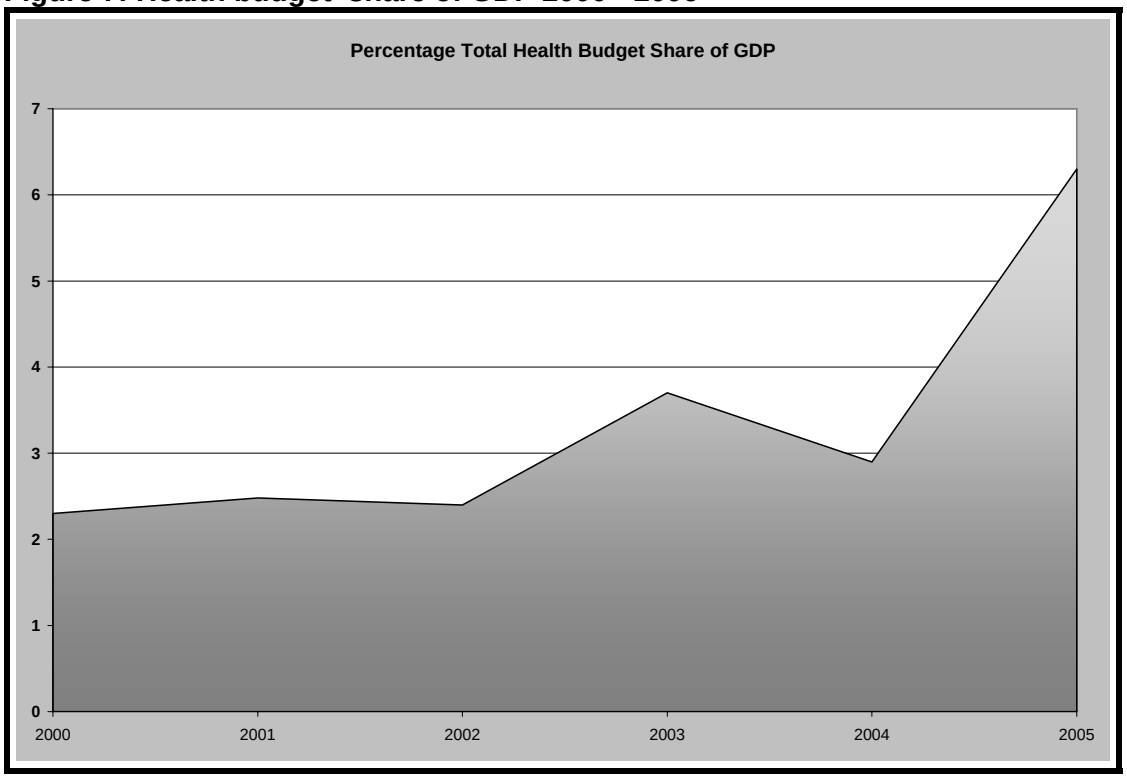
It is difficult to judge these changes in US dollar terms due to the different policy measures and shifts in fixed exchange rate and inflation. If the level judged in 1999 was less than the US$60 required for basic health services, this is likely to have worsened based on the direction of the trend since then. This is significantly affected by wider economic performance. The evidence suggests a gap in overall resource adequacy to deliver a basic national health service and a demand for choices and trade offs in public policy.

The relative shares of GDP and of government spending this give an indication of commitments to protecting health in the context of worsening macroeconomic performance. As shown in Figure 7, the health budget share of GDP has remained constant or rising to 2005, with an increase to 6.5% or above the 5% set in global commitments such as the Commission on Social Development.

Figure 8 indicates that the nominal budget allocation to the Ministry of Health and Child Welfare has increased from around 9% in the year 2000 to more than 13% in 2005, movijng towards but not reaching the Abuja Declaration of committing at least 15% government spending on health. However, this figure was revised downwards to 10% after the inclusion of the a supplementary budget allocation to the prevention Sub-Vote of more Z$70 billion primarily for HIV and AIDS (Supplementary National Budget Statement 2005).

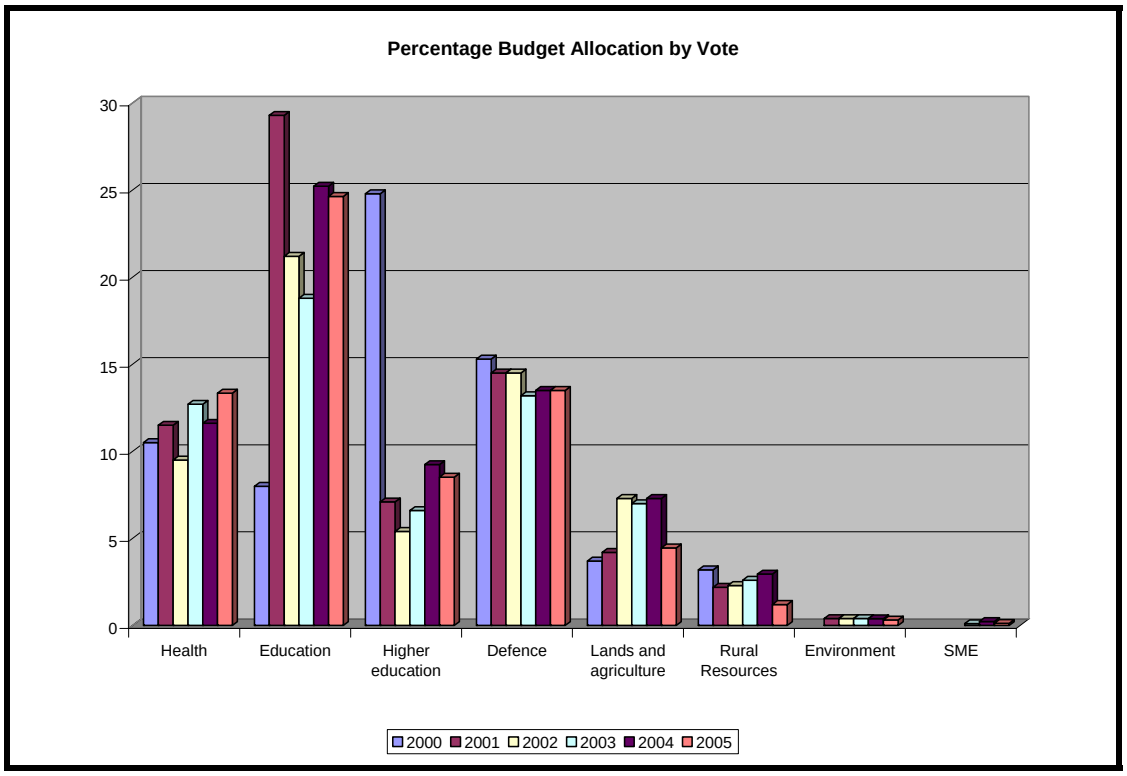
The allocation of the budget by operation shows a 5% decline from 2003 in health, with the largest allocation to the Ministry of education, sport and culture and new resources allocated to the two new ministries of Small and Medium Enterprises and Rural Resources (now Rural Housing). The sectors receiving increasing shares were Defence and Education (Figure 9).

Figure 7: Health budget share of GDP 2000- 2006



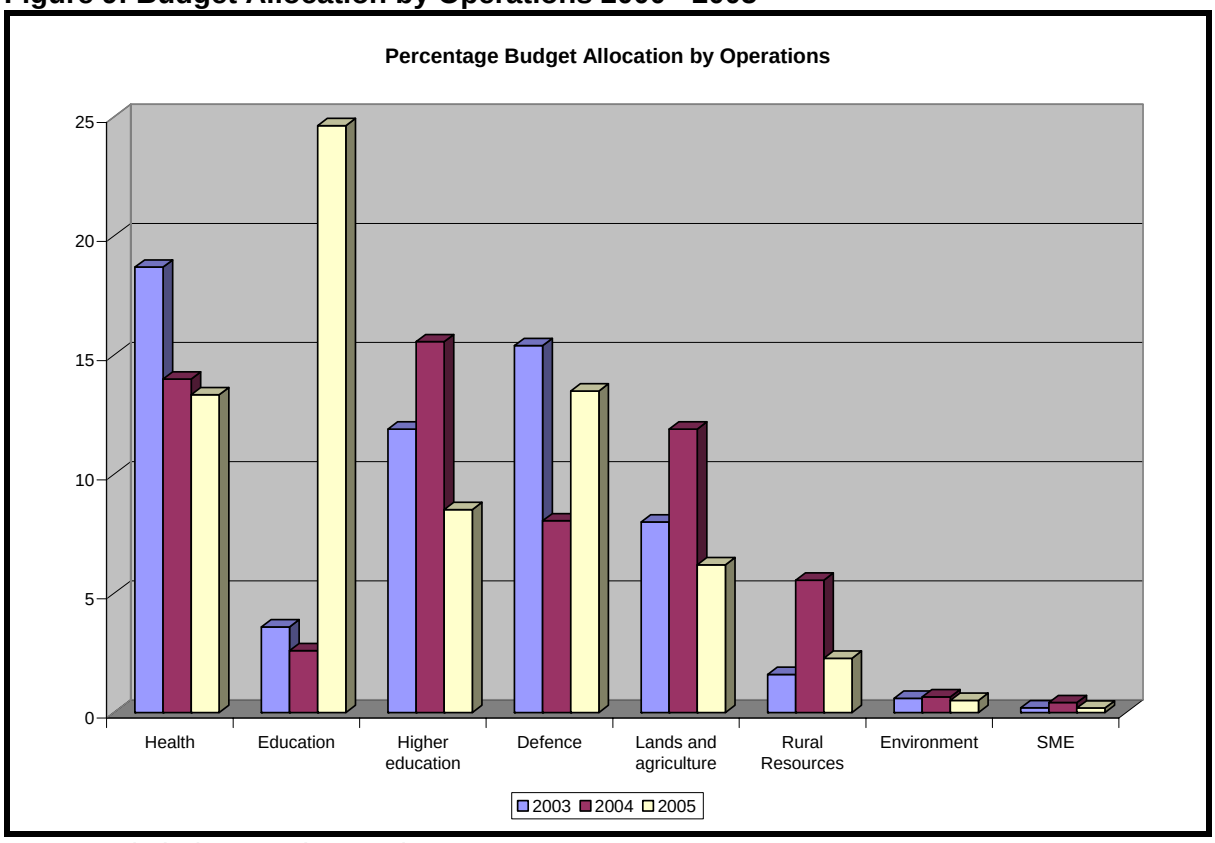
Source: Zimbabwe Budget Estimates 2000 - 2006.

Figure 8: Budget Allocation by Vote 2000 -2005



Source: Zimbabwe Budget Estimates 2000 -2006

Figure 9: Budget Allocation by Operations 2000 - 2005



Source: Zimbabwe Budget Estimates 2000 - 2006.

Clearly the actions of other sectors and the allocations for these actions influence health outcomes. This analysis does not examine these wider sectoral investments in health but they are pertinent. One entry point suggested earlier is for a cross cutting process to

explore and report on spending and allocations across all sectors on the Millennium Development Goals.

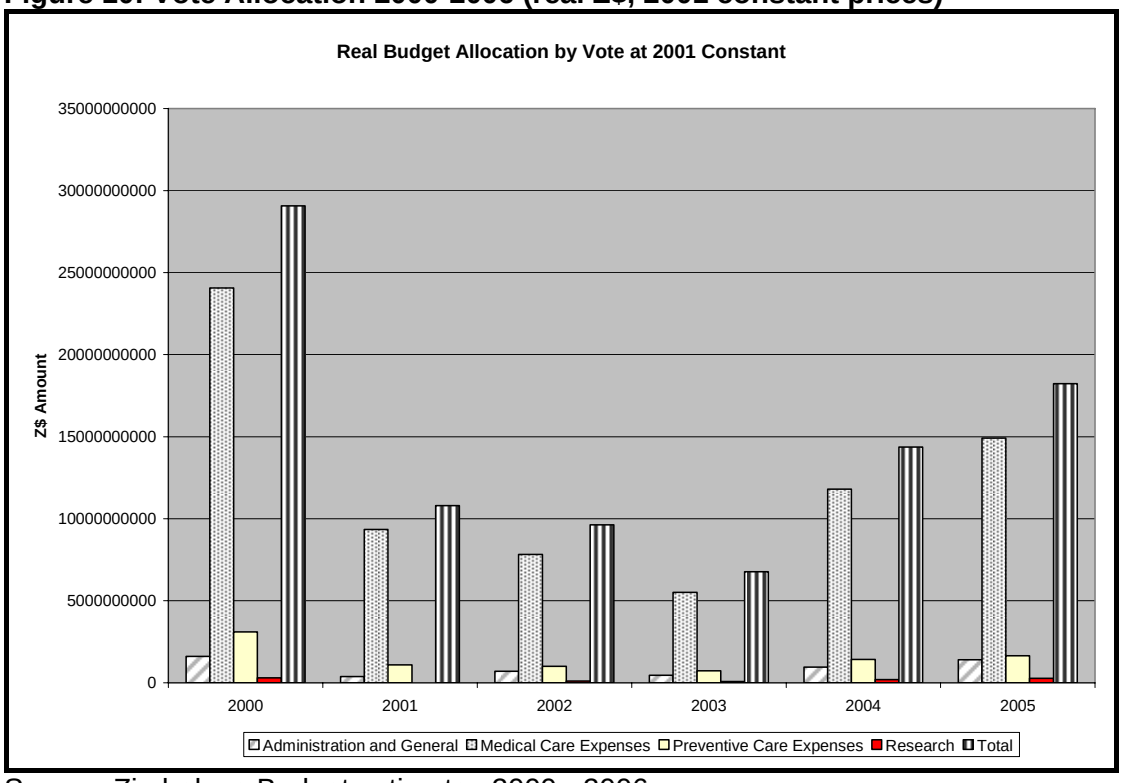
Government spending on health thus indicates prioritization of the health sector in national resource allocation, but, as noted above, does not necessarily signal adequacy. In a context of overall resource constraints, especially removing the spending on AIDS, the public policy choices and trade offs emerge in the allocations made within the health sector.

6.3 Budget allocations within the health sector

The method for distribution of revenue generated by central government is through a mix of methods, and the use of an equity oriented resource allocation formula is not a fixed requirement.

The allocations by vote (Figure 10) indicate that the medical vote dwarfs all other shares and has received substantial amounts over the years, and an increasing share since 2003, against a background of escalating preventative diseases. As noted earlier, the major health problems call for a range of prevention interventions, backed by health care services. The prevention budget has been low, fallen to 2003 and recovered slightly thereafter. As noted earlier, in year 2005, taking into account the supplementary budget, there was a decline in real funding for preventive services and an increase in administration and medical care budgets. Given the real fall in the real value of the sub-votes and the total health budget, declining shares to in preventive services do not augur well for efforts to reduce inequities, even while recognizing that prevention of ill health is not only a function of the Ministry of Health but also of other sectors financing health inputs. .

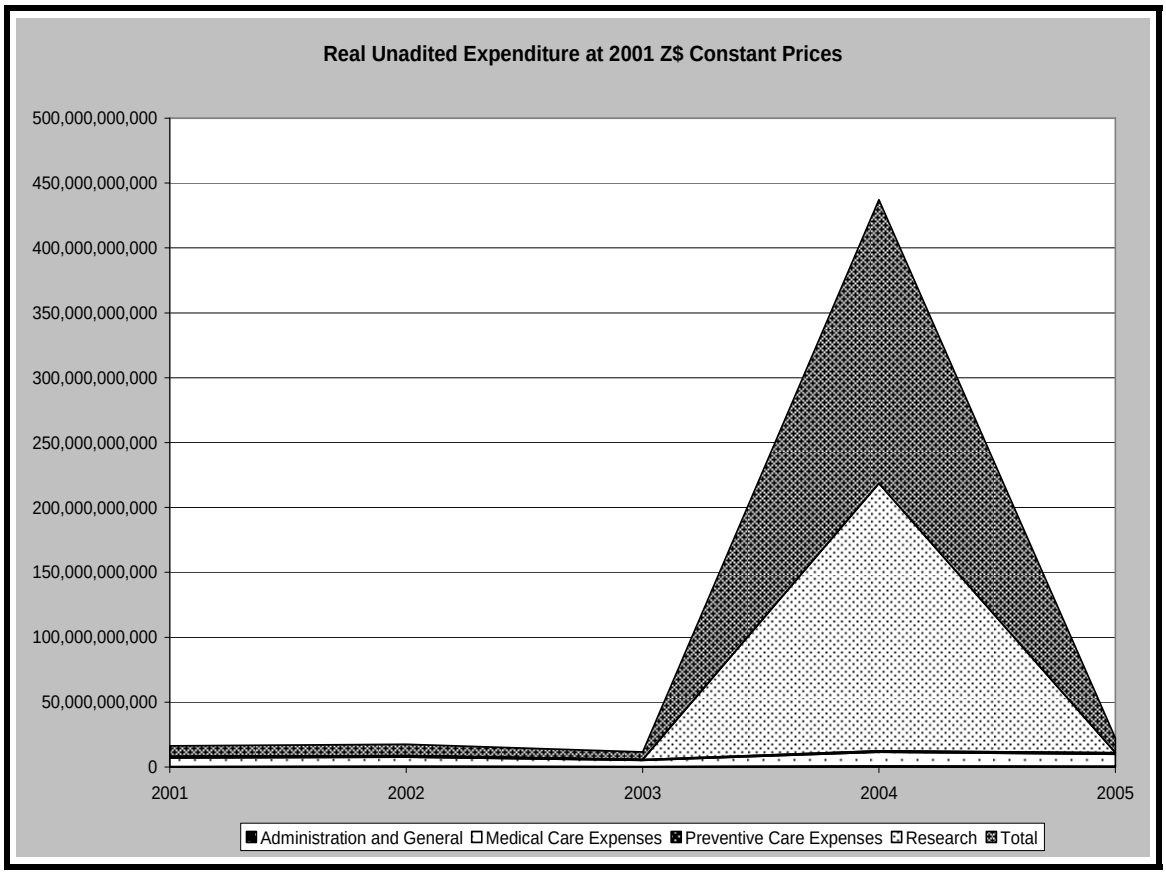
Figure 10: Vote Allocation 2000-2006 (real Z$, 2001 constant prices)



Source: Zimbabwe Budget estimates 2000 - 2006

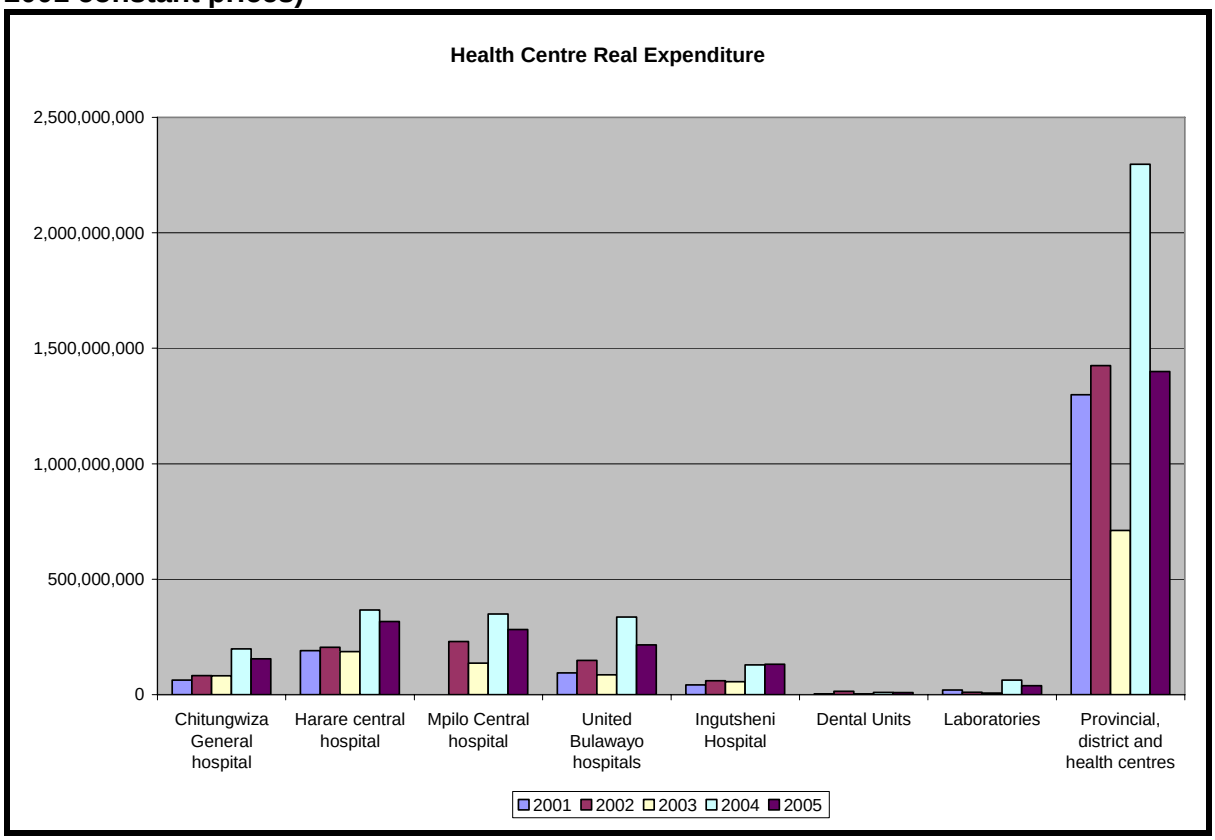
Figure 11 below shows the real unaudited expenditure for different votes between 2001 and 2005. It further indicates the low share to prevention

Figure 11: Real unaudited Expenditure 2001 - 2005 (real Z$, 2001 prices)



Source: Zimbabwe Budget Estimates 2000 - 2006

Figure 12: Real Expenditures by facility and cost centre 2001-2005 (real Z$, 2001 constant prices)



Source: Zimbabwe Budget Estimates 2000 - 2006

Figure 12 shows the real expenditures across different types of health facility at 2001 constant prices. There has been an upward trend in real expenditures for all cost centres, with a spike in 2004 inflation from a record 623% to 123%. The real expenditures for provincial, district and primary care level have remained high. However it is not possible in the current way of showing expenditures to disaggregate spending at district and at primary care level. Without this the major policy goal of ensuring primary health care and clinic services is difficult to monitor. Inadequate tracking of this level can lead to poor performance and bypassing of services, costly both for households and for the health system.

It is thus suggested that a breakdown of expenditure on

- **provinces**
- **district hospitals and services**
- **primary care level services (clinics, primary health care)**

be included in future financial management and budget tracking. While this does impose burdens on the financial management systems, it seems to be central if policy goals to ensure adequate frontline services are to be monitored.

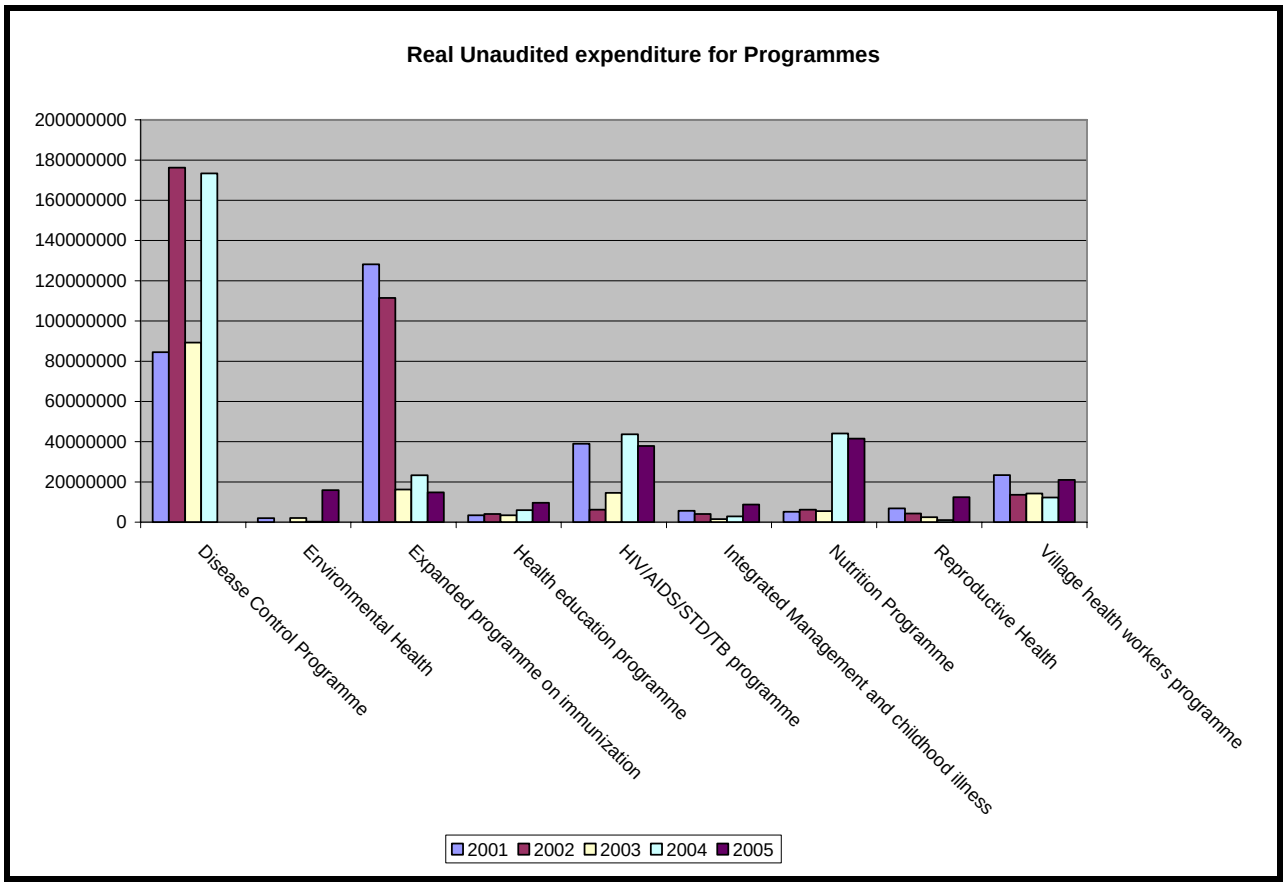
Major referral hospitals such as Mpilo and Harare Hospital increased their real expenditures over the period under study. The extent to which these increases were driven by demand from patients by-passing district and provincial hospitals is not clear and would need to be assessed through separate research. Reporting on the functioning of the referral system would be an important component of assessment of efficiency in use of allocated resources (with use of referral centres for frontline or secondary level care an inefficient use of resources allocated).

It is difficult to assess with accuracy the trends in the distribution and use of resources between programmes and levels of health care. Some programmes are introduced and discontinued after 1 or 2 years, and some have changed their mixes, hence definitions in the process. However, Figure 13 provides a trend analysis of some programmes that have at least maintained definitions for at least 3 years.

Trends noted are

- the largest expenditure in disease control programme, although the global expenditure figure does not give details of which geographic or programme areas this was directed to.
- Low amounts to environmental and reproductive health with some increase in 2005
- A falling amount to immunization, noted earlier to be problematic in terms of need to meet immunization targets
- Low but rising amounts to health education, noted to be important for the significant level of management of health problems currently taking place within communities
- Increasing amounts to nutrition, HIV and AIDS, and TB programmes and to the village health worker programme, noted to be important for MDG goals and health outreach.

Figure 13: Real unaudited expenditures for Programmes 2001-2006 (real Z$, 2001 constant prices)



Source: Zimbabwe Budget Estimates 2000 -2006

While these have been commented on earlier, the low levels of investment in reproductive health are notable given the levels of maternal mortality, adolescent reproductive health needs and the links to HIV and AIDS. This has been buffered by donor funds and expenditure under the Family Planning Line item. The decreasing expenditure in real terms since the year 2000 the suggests a need for greater investments in reproductive health, should donor spending in this area fall.

6.4 Allocations and expenditure in relation to HIV and AIDS

Any analysis of health budgets, and in particular HIV and AIDS budgets, calls for inclusion of governments' expenditure for HIV and AIDS in other government departments, apart from MOHCW. However, as raised in relation to the discussion on health spending earlier, the specific HIV and AIDS budget allocations and expenditure in other ministries and departments are not usually separated or disaggregated sufficiently from other budget line-items. This suggests that all sectors make clearer the policies, programmes and budget lines for achieving these goals in their sectoral budgets and report on these.

Zimbabwe has, as noted earlier experienced falling HIV prevalence rates related to behavioural changes and prevention interventions in the late 1990s (UNAIDS 2005). Zimbabwe has a national AIDS policy and sustainable financing of HIV and AIDS through the AIDS levy. Although the nominal budget allocations and expenditures specifically targeting HIV and AIDS have been increasing since the introduction of the AIDS Levy in 2000, no discernable increase in real terms is apparent. A significant change occurred in 2003 when a budgetary allocation for ARVs was made. In nominal terms, any increase in salaries leads to an increase in revenue from AIDS levy which is a flat tax on employers. Any increase in informal employment and company closures on the other hand leads to a decline in revenues. The positive role of the AIDS Levy in overall health financing and in moving towards the 15% Abuja commitment has been noted earlier.

Complementary financing from the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) and other donors in the health sector have significantly increased available resources for HIV and AIDS and look set to do so further. As noted earlier, the Government of Zimbabwe estimated an annual additional per capita cost of about US$124 to meet universal access to ARVs.

This demand generated by AIDS is important to respond to and equally important to ensure that the response strengthens the wider health system and does not negatively impact on the allocation of resources to other equally important health services. This needs a specific focus to assess the extent to which expenditures on AIDS are

- Strengthening community level networking, health literacy and uptake of primary health care services
- Reaching and strengthening district health services across the country
- Integrating within health services and adding incentives for rather than burdens to health personnel within districts (including through their own access to treatment)
- Strengthening health services through key points of entry, such as VCT, PTMCT linked to Antenatal care, TB management etc
- Investing in wider support services including for nutrition, OVC support etc.
- Reaching vulnerable groups and improving their uptake of wider health services

This calls for separate analysis, budget tracking and equity monitoring.

7. Discussion and recommendations

This analysis provides a broad overview of key areas of spending against policy goals and current economic and health contexts.

The **policy, economic and health context** indicates priority areas of poverty reduction, HIV and AIDS, undernutrition, maternal mortality, reduction in TB, access to safe water, sanitation and housing. Severe macroeconomic constraints of the past 5 years have made it more difficult to plan for and adhere to expenditure and revenue targets and supplementary budgets can lead to high 'demand' rather than high 'need' areas of spending, as is reported in the supplementary budget in 2006. The current economic environment places pressure on households, especially the poorest, and on health budgets to meet rising costs of individual medical care while protecting spending on public health interventions that protect population health. Under conditions of falling GDP and falling real budgets this implies choices and opportunity costs- for the health sector and for households.

The public health care sector is the largest and an increasing point of care, with an increase in use of public services in urban areas, of traditional health care and a shift away from private for profit providers. Subsidies to the private for profit sector are likely to benefit a small share of people, while those to private not for profit services, like mission hospitals and faith healing will benefit a wider pool of people. A high share of home treatment and falling access to health services indicates the priority for primary health care and health promotion to support effective community health practices and differentiate and support uptake in those that *need* attention. The increased real expenditures for health education 2001-2005, for Village Health Workers in the period is thus a positive trend to support community and household health practices. Equally the investments made in the cadre of primary health care nurses will contribute to strengthening the primary care level of service provision.

The policy, economic and health context for the budget suggests priorities for the 2006/7 budget as:

- **Increased investments in addressing undernutrition, 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, 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 most 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 increasing shares to administration and reducing shares to prevention.**

On **resource mobilisation,** the share of GDP to health rising above 5% and of government spending to health reaching Abuja 15% targets are a positive indicator of government commitment to health sector spending. General government spending on health as a percent of total government spending, after remaining below 10% to 2003, has now risen to the 15% committed in the Abuja commitment. A consistent increase in out of pocket spending since 1994 is of concern, given the increased the burdens on households at a time of severe economic difficulty. The AIDS Levy Fund appears to have helped to shield households from greater out of pocket health spending as donor shares fell. The share of capital financing from the Reserve bank and other donors to the health sector has been relatively low, perhaps indicating the pressures on recurrent spending. The evidence suggests a gap in overall resource adequacy to deliver a basic national health service. This implies a need to improve allocations to the health sector. It also calls for choices and trade offs within the health sector in directing budgets to those areas that have high impact on protecting households from ill health and its impoverishing effects.

The evidence suggests that

- **The commitment in terms of share of GDP and share of government spending on health be sustained**
- **The share of government spending on health not be allowed to fall below the 15% total government spending committed in Abuja**
- **Measures be put in place to reduce out of pocket spending in services used by poor households, through removal of user charges for district health services, avoidance of direct prepayment schemes that increase out of pocket spending and a shift to tax funded and national health insurance options**
- **Other progressive tax levies be explored to boost health financing such as on financial transactions**
- **The distribution of out of pocket spending and its burden on different income groups be mapped through research.**

- **Budget resources be allocated for an updated National Health Accounts for 2005/6**
- **Capital projects in health for water and sanitation, clinic and hospital infrastructure be identified in areas of increased population settlement where there is inadequate facility provision.**
- **The health sector lobby for lower interest financing for infrastructure, production and service investments in services that have high benefit to health and health care in low income communities (eg safe water, essential drugs**

On **resource allocation within the health sector,** real expenditures for provincial, district and primary care levels have remained at constant levels, but current expenditure lines do not disaggregate spending at district and at primary care level making it difficult to track policy goals for and performance of primary health care and clinic services. Major referral hospitals increased their real expenditures and it would be important to determine the functioning of the referral system to assess efficiency in use of allocated resources to these levels.

Inconsistency in definitions and recording make it difficult to assess with accuracy the trends in the distribution and use of resources between programmes and levels of health care. Trends noted indicate sustained or rising real amounts to disease control, nutrition, HIV and AIDS, and TB programmes and to the village health worker programme, and low but rising amounts to health education. Low amounts have been allocated to environmental and reproductive health with some increase in 2005.

The evidence suggests that

- **Resource allocations for all line items feasible be based on transparent formulae that integrate equity and poverty and reporting on expenditures make clear how these relate to equity oriented allocations**
- **Districts that have problems with capacities to absorb resources due to service or other factors be entitled to capacity building grants that strengthen their ability to effectively use health resources**
- **Future financial management and budget tracking and reporting provide a breakdown of expenditure on provinces; district hospitals and services and primary care level services (clinics, primary health care) (each separately)**
- **The allocations to preventive health be substantially increased to at least 30% of the health budget**
- **Research be implemented on the functioning of the referral system to assess efficiency in use of allocated resources to referral hospitals (eg through use of these services for primary or secondary care) and effectiveness of measures for avoiding 'level jumping'.**
- **Allocations provide for improved levels of investment in reproductive health services, especially where these relate to services impacting on adolescent health and maternal mortality**
- **Specific monitoring and reporting be implemented on how resources for AIDS are being used to strengthen the wider health system and their impact on the availability and allocation of resources to other important health services.**

This exercise of budget analysis has focused on the data sets publicly available. Where these themselves make it difficult to track policy goals or health priorities, this is noted in the report.

Some data gaps are important for policy decisions. For example, current information on household consumption, the distribution of burdens and impacts of out-of-pocket expenditures and trends in insurance expenditures is important evidence to understand how resources are being generated or used by households and the services being consumed by different population groups. Research on such issues is needed to inform taxes or subsidies. This is also important for policy dialogue for issues such as the introduction of National Health Insurance Scheme.

The process of budget analysis and oversight clearly goes beyond such desk review, to include dialogue with the executive, with civil society and health providers and with other relevant actors. The analysis, and this process of consultation would be enriched by the Ministry of Finance availing its planning and estimation procedures for everyone to have an idea of how opportunity cost and marginal benefits play a part in budget estimation. This review has taken an equity lens on the budget expenditures and revenue mobilization. If the policy goals and principles underlying the budget process are made clear, this will build understanding of how competing concerns presented from different constituencies and sectors are balanced and considered in budget debates.

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ACRNOYMS

AIDS	ACQUIRED IMMUNO DEFICIENCY SYDROME
ART	ANTI-RETROVIRAL THERAPHY
ARVs	ANTI-RETROVIRALS
BOP	BALANCE OF PAYMENTS
CPI	CONSUMER PRICE INDEX
CSO	CENTRAL STATISTICAL ORGANIZATION
DFID	DEPARTMENT FOR INTERNATIONAL DEVELOPMENT
DOTS	DIRECTLY OBSERVED TREATMENT
ESAP	ECONOMIC STRUCTURAL ADJUSTMENT PROGRAMME
FBOs	FAITH BASED ORGANIZATIONS
FEWSNET	FAMINE EARLY WARNING SYSTEMS NETWORK
GDP	GROSS DOMESTIC PRODUCT
GFATM	GLOBAL FUND FOR AIDS TUBERCULOSIS AND MALARIA
GNI	GROSS NATIONAL INCOME
HIV	HUMAN IMMUNO VIRUS
IMF	INTERNATIONAL MONETARY FUND
LFS	LABOUR FORCE SURVEY
MEPF	MACRO-ECONOMIC POLICY FRAMEWORK
MERP	MILLENIUM ECONOMIC RECOVERY PROGRAMME
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
NERP	NATIONAL ECONOMIC RECOVERY PROGRAMME
NGOs	NON-GOVERNMENTAL ORGANIZATION
NHA	NATIONAL HEALTH ACCOUNTS
PPP	PURCHASING POWER PARITY
PSMAS	PREMIER MEDICAL AID SOCIETY
PVOs	PRIVATE VOLUNTARY ORGANIZATIONS
RBZ	RESERVE BANK OF ZIMBABWE
STIs	SEXUALLY TRANSMITTED INFECTIONS
TARSC	TRAINING AND RESEARCH SUPPORT CENTRE
TB	TUBERCULOSIS
TCLP	TOTAL CONSUMPTION POVERTY LINES
UNDP	UNITED NATIONS DEVELOPMENT PROGRAMME
US$	UNITED STATES DOLLAR
VAT	VALUE ADDED TAX
VCT	VOLUNTARY COUNSELING AND TESTING
WHO	WORLD HEALTH ORGANIZATION
ZDHS	ZIMBABWE DEMOGRAPHIC HEALTH SURVEY
ZW$	ZIMBABWE DOLLAR

Equity in health *implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.*

EQUINET implements work in a number of areas identified as central to health equity in the region:

- Public health impacts of macroeconomic and trade policies
- Poverty, deprivation and health equity and household resources for health
- Health rights as a driving force for health equity
- Health financing and integration of deprivation into health resource allocation
- Public-private mix and subsidies in health systems
- Distribution and migration of health personnel
- Equity oriented health systems responses to HIV/AIDS and treatment access
- Governance and participation in health systems
- Monitoring health equity and supporting evidence led policy

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