Trends Analysis of the Government's Health Spending Patterns (2013-2022)

Research conducted by the Poverty Reduction Forum Trust (PRFT)

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Contents

1. Introduction

Zimbabwe has a progressive legal and policy framework for the delivery of health services with the right to health guaranteed in the 2013 Constitution. However, the country has experienced mixed progress in key health indicators. Progress has been noted in Maternal Mortality Rate (MMR) that declined from 651 maternal deaths per 100 000 live births in 2014 to 462 per 100 000[1] live birth in 2019 and 363 per 100 000 live births in 2022 according to the 2022 population and housing census preliminary report on mortality and orphanhood[2]. However, this is still too high and below the Sustainable Development Goal (SDG) 3 target 3.1 to reduce the global maternal mortality ratio to less than 70 per 100,000 live births by 2030.

The 2022 Population and Housing Census Mortality and Orphanhood Preliminary Results show that Infant Mortality Rate (IMR) was 24.2 deaths per 1000 live births, Child Mortality Rate (CMR) at 15.6 deaths and Under 5 Mortality Rate (U5MR) of 39.8 deaths per 1,000 live births in 2022. This is an improvement from the IMR of 47 deaths per 1,000 live births in 2019, CMR of 19 in 2019 and under5 mortality of 65 deaths in 2019 (MICS 2019). However, there are gaps in terms of health infrastructure with a national average of 1.1 health facilities per 10 000 people which is below the country's target of 2 health facilities per 10 000 people (NHS 2021-2025). While HIV prevalence at 11.8% among adults aged 15-49 years (14.8% among females and 8.6% among males) improved this is still high (ZIMPHIA 2020). Non Communicable Diseases which caused 33 percent of deaths in 2016 are on the rise and according to the NHS 2021-2025 the situation is compounded by limited investments to prevent and control them.

However, there are financing gaps in the health sector in Zimbabwe. Zimbabwe's development policies, health strategies and policies have put increasing domestic funding for health services as one of the key health outcomes. There is recognition among the participating health related agencies, of the need to support countries to increase public spending in health to move towards Universal Health Coverage (UHC), and the importance of a sustained positive trend for the growth in external development assistance for health[3]. As such given the importance of public spending in the health sector it is important to track progress and identify gaps and opportunities for increased funding.

This paper therefore tracks progress in public spending in the health sector from 2013 to 2022 assessing the adequacy of the health budget allocations and extent to which the allocations meet the health objectives set in the country's constitution, development plans, various health policies and strategies. The paper also looks at how the health budget is performing against set international benchmarks such as the Abuja Declaration target for 15% of the

[1] https://www.zimstat.co.zw/wp-content/uploads/publications/Social/Health/MICS2019/MICS-2019.pdf
[2] https://www.zimstat.co.zw/wp-content/uploads/2022/09/Preliminary_presentation_Mortality_2022.pdf
[3] https://www.who.int/initiatives/sdg3-global-action-plan/accelerator-discussion-frames/sustainable-financing-for-health

national budget to be set aside for the health sector. The paper makes a distinction between the First Republic (1980-2017) and the Second Republic (2018 to date) and makes comparison to see if there has been a shift in health financing focusing on the last 5 years of the First Republic and the first 5 years of the Second Republic. Finally, the paper proffers some recommendations to improve public financing of the health budget.

2. Zimbabwe Health Sector Overview

2.1 Legal Framework

Zimbabwe's constitution places great importance on the right to health care including the national objectives (Section 29 of the Constitution of Zimbabwe Amendment (No. 20) Act 2013) which requires that '' The State must take all practical measures to ensure the provision of basic, accessible and adequate health services throughout Zimbabwe" among others. Section 29 (2) places an obligation to the State to provide education and public awareness programmes, against the spread of disease.

The right to have access to basic health-care services, including reproductive health-care services and emergency health services is guaranteed in section 76 of the Constitution. Specifically, Section 76 has the following provisions;

(1) Every citizen and permanent resident of Zimbabwe has the right to have access to basic health-care services, including reproductive health

(2) Every person living with a chronic illness has the right to have access to basic healthcare services for the illness

(3) No person may be refused emergency medical treatment in any health-care institution, and

(4) The State must take reasonable legislative and other measures, within the limits of the resources available to it, to achieve the progressive realization of the rights set out in this section"

Section 19 (2b) provides children with rights to have shelter and basic nutrition, health care and social services. Other provisions that complement access to health include Section 77 that provides every person with a right to safe, clean and potable water, and sufficient quality and safe food. The constitution is supported by almost 20 pieces of legislation administered by the Ministry of Health and Child Care (MoHCC) and supplementary legislation administered through other sector Ministries. These include the Public Health Act and Health Services Act.

2.2 Policy Framework – Development Policies

2.2.1 Zimbabwe Agenda for Sustainable Socio-Economic Transformation, 2013-2018 (ZIMASSET)

All the national development plans that have been developed in Zimbabwe since the adoption of the new Constitution in 2013 include health as one of the key priority areas. The Zimbabwe Agenda for Sustainable Socio-Economic Transformation from 2013 to 2018 (ZIMASSET) had health as part of the Social Service Delivery cluster key result area. ZIMASSET is the First Republic's last development policy covering the period 2013 to 2018 with the outcomes, outputs and strategies as shown in Table 1.

Table 1: ZIMASSET Health Outcomes, Outputs and Strategies

Outcomes	Outputs	Strategies
• Reduced morbidity and mortality rate; • Reduced HIV infections among children and adults; • Reduced TB prevalence rate; Reduced maternal mortality rate; • Reduced child mortality rate; • Reduced incidences of other communicable diseases such as Malaria and Diarrhoea.	• 1500 facilities are functional to provide comprehensive health services including basic and comprehensive emergency obstetric care emergency • 1560 Comprehensive HIV Testing and Counselling sites operational; • 100% of ANC facilities offering comprehensive PMTCT operational; • 85% of adults and 60% of children in need of ART provided; • 90% of HIV positive pregnant women receive ARVs for PMTCT. • TB defaulter rate reduced; • All detected Multi Drug Resistance cases commenced on treatment ; • IRS coverage above 95%; • Diarrhoea incidence rate reduced by 50% ; • 12000 UBVIPs constructed for the under privileged;	• Strengthen primary health care; • Provide comprehensive health services at all health institutions including basic and comprehensive emergency obstetric care; • Increase mobile clinics and outreach services ; • Increase spraying coverage; • Increase sanitation and hygiene coverage; • Revamp to international standards health delivery facilities and services; • Improve doctor/patient ratio; • Scale up and strengthening high impact interventions for diseases and conditions responsible for the highest morbidity and mortality namely: - HIV, AIDS and STIs; - Tuberculosis.

	• At least 90% of children under the age of one year vaccinated with Pentavalent 3 and Measles vaccine; • 90% of pregnant women receive at least 4 antenatal care visits; • At least 85% of deliveries done in health facilities; • Fully functional Mothers waiting homes are available in all district hospitals by 2015; • Emergency Operations Centre for health emergencies and disasters operationalized.	• Scale up and strengthening high impact interventions for diseases and conditions responsible for the highest morbidity and mortality namely: - Diarrhoea and other epidemic prone diseases; Acute Respiratory Infections; Malaria; - Malnutrition; Injuries; Hypertension; - Diabetes; - Pregnancy Related and Maternal Perinatal complications; - Mental Health disorders.
• Improved client satisfaction and delivery service	• Medicines and medical supplies availed from the current 45% to 100%; • NatPharm re-capitalised, capacitated & well stocked with VEN medicines & medical supplies; • Health institutions especially hospitals capacitated and well stocked with VEN medicines, medical gases, blood and blood products; • The local production of selected vital pharmaceutical products facilitated; National Blood Services recapitalized and well stocked with blood and blood products.	• Recapitalize public health institutions ; • Strengthen and promote the local production of pharmaceutical products.

	• Service Charter finalized and widely distributed; • Provision of the Client Charter implemented; • All central and provincial hospitals patient satisfaction surveys conducted; • Toll free lines starting with central and provincial hospitals installed; • Weekly analysis of findings from suggestion boxes and toll free lines compiled.	• Finalize the Service Charter • Implement the provisions of the Client Charter; • Improve public relations; • Improve the health facility environment to promote patient safety and the healing process; • Conduct quarterly patient/client satisfaction surveys; • Reinforce the use of suggestion boxes; • Empower communities through health
	• Essential hospital equipment based on the standard equipment list for theatre, maternity, laboratory, casualty and X-Ray departments among others Medical Equipment Inventory procured.	• Procure diagnostics and life support equipment as well as reagents and consumables and update the list of available medical equipment.
• Reduced financial barriers to health services.	• Budget allocation to Health Increased (Aim for the Abuja target of 15% of total government allocation); • Domestic Healthcare Financing Policy document to Cabinet presented; • Paper on various healthcare financing options to Cabinet (vat, sin taxes etc) presented; • Framework for Public Private Partnership developed; • National Health Accounts Institutionalised;	• Mobilize resources and strengthen Private Public Partnerships (PPP); • Update and cost the Core Health Services package.

	• User fee policy starting with rural areas enforced; • Essential health care package redefined and costed; • Community ownership schemes health care services supported; • Donor coordination unit strengthened.	
Improved service delivery.	• All vacant posts filled; • Conditions of service improved.	• Lobby for Treasury concurrence for: - unfreezing of existing vacant posts; - increase the current establishment (by 2015); - creation of Primary Care Nurse (PCN) posts for Mission and Council Health Facilities; - creation of additional posts to cater for new health facilities, new districts; community based cadres and for emerging services; - reintroduction of health specific allowances and non pecuniary conditions of service ; - salaries for all health workers.
Improved enabling legal, policy and regulatory environment.	• Regulatory Authority to manage medical aid associations established; • Public Health Act amended ; • Medical Services Act and regulations reviewed ; • Health Service Act amended.	• Establish a Regulatory Authority to manage medical aid societies.

Improved collaboration and coordination	• Health Management Boards and Community Health Councils appointed; • Leadership training program strengthened; • Donor coordination office strengthened.	• Strengthen meaningful community participation in Health; • Strengthen the donor coordination office to coordinate all external support.

Source: ZIMASSET 2013-2018[4]

2.2.2 Transitional Stabilisation Program 2018-2020 (TSP)

The Transitional Stabilisation Program 2018 to 2020 (TSP) from 2018 to 2020 is the first development policy under the Second Republic targeted incremental investments to achieve equitable coverage and enhanced quality of health delivery. TSP also included health infrastructure projects. The TSP identified upgrading health infrastructure as key to enable provision of comprehensive health services and reestablishment of the referral system. Specific projects identified are shown Table 2:

Table 2: Government funded Health Projects under TSP

Project Description	Project Scope	Milestone to 2020	Estimated Cost (US$ million)	2019 Proposed Allocations US$ Million	2020 Proposed Allocations US$ Million
Rural Heath Posts	Construction of 6 602 Rural Health Posts nationwide, covering a staff house and basic equipment to provide care at local level	200 Health Posts established	462.1	3.5	8.4
Rural Health Centres	Construction of 250 Rural Health Centres	16 Rural Health Centres established	50	1.0	2.2

[4] https://www.veritaszim.net/sites/veritas_d/files/Zimbabwe%20Agenda%20for%20Sustainable%20Socio-Economic%20Transformation%20%28ZIM-ASSET%29%20Oct%202013%20to%20Dec%202018.pdf

	nationwide, comprising 3 staff houses, main clinic block, ablution facilities, waiting shed, water supply and incinerator				
District Hospitals	Construction of 9 district hospitals (2 Harare, 2 Bulawayo, Mberengwa, Chimanimani, Wedza, Zvamavande and Mbire	Zvamavande District Hospital completed	360	16	20
Provincial Hospitals	Construction of 5 new Provincial hospitals (Gwanda, Lupane, Bindura, Masvingo and Mutare)	60% for Lupane Provincial Hospital	240.0	18	26
Hospital Equipment	Procurement and upgrading of curative and diagnostic medical equipment for 182 health facilities		105.0	5	8
General rehabilitation	Rehabilitation of health infrastructure	6 Central Hospitals infrastructure rehabilitated	235.1	3	5

Procurement of ambulances	Procurement of ambulances for district, provincial and central hospitals		21	4.2	5
Total			1,473.2	50.7	74.6

Source Transitional Stabilisation Programme 2018-2020[5]

Additionally, the TSP targeted incremental investments to achieve equitable coverage and enhanced quality of health delivery, to address the following critical challenges:

- Sub-standard quality of maternal health services, such as ante-natal care, delivery, and post-natal care, including prevention of mother-to-child transmission of HIV, and sexually transmitted infections.
- Medicine shortages, as well as family planning, and other essential drugs.
- Inadequacy of emergency transport and communication systems, which have a bearing on mortality rates.
- A growing burden of non-communicable diseases, due to sub-optimal dietary habits, lifestyle, and poor health services.
- Inadequate mitigation of environmental pollution, poor water, sanitation, and hygiene (WASH) infrastructure, nutrition and food security issues, which continue to affect the health status of citizens.
- Strengthening of the Health and Management Information System at the facility level.

2.2.3 National Development Strategy 1: 2021-2025 (NDS1)

The NDS1 identifies health and wellbeing as one of the 14 priorities. covering the period 2021 to 2025. NDS1 Key performance targets are highlighted in Table 3 below.

[5] http://www.zimtreasury.gov.zw/wp-content/uploads/2022/09/Transitional-Stabilisation-Programme-Oct-2018-2020-1.pdf

Table 3 NDS1 Health Key Performance Targets

National Outcome	Key Performance Indicator	Baseline 2020	NDS1 Yearly Targets				
			2021	2022	2023	2024	2025
Improved Quality of Life	Life Expectancy at birth	61yrs (M) 65yrs (F)					
	Maternal Mortality Ratio (deaths per 100000)	425	388	351	314	277	240
	Under 5 Mortality	61	57	53	49	45	41
	Overall Vacancy Rate	15%	14.1%	12%	10.3%	8%	<5%
	AIDS Mortality per 100000	147.5	120	113	99.98	91.93	86.9
	TB Mortality rate	32	29	26	23	21	<20
	Cholera Case Fatality	<0.5	0	0	0	0	0
	Non Communicable Diseases Mortality Rate (Cervical Cancer)	>15%	13.5%	11%	9.5%	7.1%	<5%
	Malaria Mortality Rate	1.9	1.34	1.12	0.89	0.67	0.5
	% of availability of selected tracer medicines Vital, Essential and Necessary (VEN)	51%	55%	62%	70%	74%	80%
	Public Health Expenditure Per Capita	US$30.29	$35	$46	$57	$69	$86
	% Availability of functional equipment	40%	44%	51%	60%	66%	70%
	Sanitation Coverage	67%	69%	73%	75%	78%	80%
	Portable Water Supply Coverage	77%	79%	83%	85%	87%	90%
	Service availability index	42%	50%	57%	62%	68%	70%
	Client Satisfaction index	75%	76%	77%	78%	79%	80%

Source: National Development Strategy 1 2021-2025

2.2.4 Vision 2030

The TSP and NDS1 both draw their policy thrust from the Vision 2030 launched in 2018 to chart Zimbabwe's new development trajectory to achieve an Upper Middle Income Society by 2030. Vision 2030 emphasises provision of an efficient, integrated and quality health care system with priority being given to preventive care at community and household levels. Additionally, the Africa Agenda 2063 and Sustainable Development Goals (SDGs) including SDG3 on good health are mainstreamed in the NDS1. In addition, Vision 2030 proposes that specialist health services currently obtainable only at Provincial level will be decentralised to District hospitals. On the other hand, Vision 2030 envisions setting up of oncology and dialysis centres at the eight Provincial hospitals to reduce dependency on the Referral Hospitals in Harare and Bulawayo.

2.3 Health Strategies

The Government of Zimbabwe has also developed specific health strategies from 2013 to 2022 partly guided by the development plans during the period. These include the National Health Strategy (NHS) 2009-2013, NHS 2014-2015, NHS 2016-2020 and the NHS 2021-2025. While the NHS 2016-2020 is a creation of the First Republic, the policy also covers the first two years of the Second Republic. This shows that there is a smooth transition in terms of policy direction between the two eras.

2.3.1 National Health Strategy 2009 to 2013 and 2014 to 2015

The NHS 2009 to 2013 which was later extended to 2014 to 2015 identified 33 key goals. Some of the key specific targets included:

- To increase the levels of sustainable and predictable financial resource base to ensure provision of high quality services to the population
- Mobilize resources for the health sector including to a sustainable financial resource base of at least US$34 per capita.
- To reduce the Maternal Mortality Ratio from 725 to 300 deaths per 100,000 live births by 2015.
- To reduce the under-five mortality rate from 86 per 1000 live birth to 43 by 2013.
- To have halted, by 2015, and begun to reverse the increasing incidence of Malaria.
- To reduce morbidity due to schistosomiasis and soil transmitted helminthes by year 2015.
- Reduce the burden of non-communicable diseases by between 15 and 20% by 2013.
- To increase availability of transport to at least 75% and communication systems to 100% of the requirements levels.
- To increase physical access of the population to appropriate health infrastructure for each level of care.

- To improve overall availability of to 90% drugs, medical supplies and other consumables.

2.3.2 National Health Strategy 2016-2020 (NHS 2016-2020)

The 2016-2020 National Health Strategy builds on the 2009-2013 strategy and its extension in 2014-15 with key result areas in Table 4. The NHS 2016-2020 identified 3 main goals namely;

i. To strengthen priority health programmes
ii. To improve service delivery platforms or entities
iii. To improve the enabling environment for service delivery

Table 4: National Health Strategy 2016-2020

Key Result Area	Objective	Key Indicator	Baseline 2014	Target 2020
Goal 1: To strengthen priority health programmes				
Priority 1: Communicable diseases	To reduce malaria incidence from 39/1000 in 2014 to 5/1000 in 2020 and malaria deaths to near zero by 2020	Malaria incidence	39	5
		Malaria deaths	654	0
	To ensure timely detection and control of epidemic prone diseases	% of outbreaks detected within 48 hours and controlled within 2 weeks	30%	100%
	To reduce morbidity due to Schistosomiasis and soil transmitted helminthes and other NTDs by 50% by year 2020.	Prevalence of STH and SCH	22.7% (for SCH/STH)	10%

	To prevent new HIV infections and to reduce deaths due to HIV by 50%	% people who are tested and know their status	40.3% (men) 56% (women)	85%
		% of people on ART	TBD	90%
		% of ART patients virally suppressed	TBD	90%
	To reduce mortality, morbidity and transmission of tuberculosis by 90%	Mortality rate	10%	<5%
Priority 2: Non-communicable Diseases	To reduce the incidence of selected Non-Communicable Disease (NCDs) by 50 %	% reduction in NCDs burden	0%	5%
	To improve the mental health status of the population	% increase in number of diagnosed mentally ill to the expected mentally ill patients	TBD	90%
	To reduce disability and dependence by 50%	% patients under CBR to total rehabilitation patients	TBD	TBD
	To improve the quality of life of elderly persons and improve life expectancy from 61.5 to 65 years by 2020	% of older persons that receive geriatric care	TBD	100%
Priority 3: Reproductive, Maternal,	To reduce maternal mortality ratio	MMR	614	300

Newborn, Child and Adolescents	from 614 to 300 by 2020			
	To reduce Neonatal Mortality Rate(NMR) from 29 to 20 deaths per 1,000 live births	NMR	29	20
	To reduce the under-five mortality rate from 75 to 50 deaths per 1,000 live births	<5 mortality	75	50
	To reduce mortality and morbidity due to malnutrition by 50%	Proportion of children under 5 years stunted	28%	19%
Priority 4: Public Health surveillance and disaster preparedness and response	To strengthen environmental health services, early detection of disease outbreaks and man-made disasters from 30% to 50% by 2020	% of outbreaks detected within 48 hours and controlled within 2 weeks	30%	50%
		% of districts with functional coordination mechanism	50%	100%
		Percentage of household members using improved sanitation facilities which are not shared	35%	50%
		Percentage of household	76%	TBD

		members using improved sources of drinking water		
Goal 2: To improve service delivery platforms or entities				
Primary Care	To reduce morbidity by at least 50% through the provision of accessible, affordable, acceptable and effective quality health services at community and health centre level	Proportion of villages with community based health workers	<60	>90
		% districts implementing Essential Primary Health Benefits	0%	100%
Hospital Services	To ensure universal access and provision of complementary package of hospital services including emergency and ambulatory curative services	% of hospitals with Quality Management Systems	TBD	TBD
		% of hospitals with functional theatre services	TBD	TBD
	To ensure universal access and provision of quality tertiary specialist curative services	% of tertiary hospitals with specialists	TBD	100%
	To promote and support provision of quality palliative care services	% of patients and families needing palliative care who are receiving it	200,000 in need	40% (80,000 people)

Goal 3: To improve the enabling environment for service delivery				
Policy Planning and Coordination	To improve health outcomes through facilitation and co-ordination of an effective and efficient health delivery system	% of policies and strategies aligned to the NHS	0%	100%
Human Resources		Overall vacancy rate	17%	10%
Finance and Administration		Number of institutions audited against the plan	TBD	82 cost centres
		Number of districts with functional PFMS	0%	62%
Monitoring and Evaluation		Harmonised M&E policy framework	01	01
Provincial Administration		% of actual to planned PHT reviews convened per year	TBD	100%
Procurement and supply chain management		% availability of essential medicines	42%	80%
Multi-sectoral Partnership	To strengthen multi-sectoral collaboration with local and international partners	A policy on public/private and public/public partnerships	0	1
		% of functional national and subnational intergovernmental platforms	TBD	90%
Research and Development	To improve uptake of scientific	% health research informed by the national	TBD	70%

	research evidence for decision making and policy development by 70%	health research priorities		
		Number of clinical trials on Traditional Medicine conducted	TBD	2

Source: National Health Strategy 2016-2020

The cost of implementing NHS 2016-2020 is provided in Table 5 with NHS 2 as the preferred scenario. NHS 2 requires a total of US$7.6 billion for the period 2016 to 2020.

Table 5: Cost of NHS based on 3 Scenarios (Million USD)

Scenarios	2015 (Base-line)	2016	2017	2018	2019	2020	Total
NHS 1	$955.3	$1,179.1	$1,306.5	$1,187.0	$1,159.9	$1,149.1	$6,936.9
NHS 2	$955.3	$1,193.9	$1,325.1	$1,349.7	$1,387.1	$1,397.7	$7,608.8
NHS 3	$955.3	$1,269.7	$1,559.4	$1,630.6	$1,624.1	$1,494.1	$8,533.2

Source: MOHCC Main Report on the Costing of the Zimbabwean National Health Strategy 2016-2020[6]

2.3.3 National Health Financing Policy 2016 and National Health Financing Strategy (HFS)

The country's health policies and strategies since independence in 1980 have consistently included a policy commitment to universality, equity and quality, as a reflection of social values[7]. However the National Health Financing Policy in 2016 was the first policy meant to provide the overarching framework to ensure that required resources needed to achieve Universal Health Coverage (UHC) are raised sustainably, allocated according to need and efficiently utilised[8]. Policy objectives of the HFP are to:

1. Mobilize adequate resources for predictable sustainable funding of the health sector
2. Ensure effective, equitable, efficient and evidence based allocation and utilization of health resources
3. Enhance the adequacy of health financing and financial protection of households and ensure that no-one is impoverished through spending on health by promoting risk pooling and income cross subsidies in the health sector

[6] https://zdhr.uz.ac.zw/xmlui/bitstream/handle/123456789/1609/Zimbabwe%20National%20Health%20Strategy%20Costing%20Main%20Report%20Revised%20October%2010.pdf?sequence=1&isAllowed=y

[7] https://www.tarsc.org/publications/documents/Rebuild%20Polbrief%20Summary%20%20May2015.pdf

[8] https://documents1.worldbank.org/curated/en/840661563174110288/pdf/Zimbabwe-National-Health-Financing-Policy-Resourcing-Pathway-to-Universal-Health-Coverage-2016-Equity-and-Quality-in-Health-Leaving-No-One-Behind.pdf

4. Ensure that purchasing arrangements and provider payment methods emphasize incentivizing provision of quality, equitable and efficient health care services; and
5. Strengthen institutional framework and administrative arrangements to ensure effective, efficient and accountable links between revenue generation and collection, pooling and purchasing of health services.

In order to turn the HFP into actions towards improving financing for the health of the people of Zimbabwe, the Government came up with the National Health Financing Strategy (HFS) in 2017. Table 5 shows the key outcomes indicator for the Health Financing Strategy.

Table 5: Key National Health Financing Strategy Outcomes Indicators.

Policy Objectives	Outcome Indicators	Base-line Value (2017)	Mid-term Target (2020)	End Target (2022)	Source
Mobilize adequate resources for predictable sustainable funding of the health sector;	1. Government health expenditure as % of total government expenditure	8.72% (2015)	12%	15%	MoHCC/NHA
	2. Non-wage health expenditure as % of total Govt. health expenditure	>10%	20%	30%	MoFED/National Budget Expenditure Reports
	3. Percentage (%) of Donor funds channelled through central government	39.24% (2015)	60%	85%	MoFED/MoHCC/Donors
Ensure effective, equitable, efficient and evidence based allocation and utilization of health resources;	4. Administrative costs as % of total private health expenditure	16.7% (2015)	12%	10%	MoHCC/NHA
	5. Government spending at primary level	33.3% (2015)	35%	40%	MoHCC/Expenditure Reports
Enhance the adequacy of health financing and financial protection of households and ensure that no-one is impoverished through spending on health by promoting risk pooling and income cross subsidies in the health sector	6. OOP as % of total health expenditure	23.74% (2015)	18%	14%	MoHCC/NHA
	7. Incidence of Catastrophic Health Expenditure (CHE)	7.64% (2015)	5%	2%	MoHCC/NHA
Ensure that purchasing arrangements and provider payment methods emphasize incentivizing provision of quality, equitable and efficient health care services	8. % of Facilities with essential drugs available	78%	85%	95%	UNICEF/VMAS –survey Reports
	9. Institutional Quality Score	73.45% (2015)	80%	85%	MoHCC/Cordaid/Crown Agents Reports
Strengthen institutional framework and administrative arrangements to ensure effective, efficient and accountable links between revenue generation and collection, pooling and purchasing of health services	10. % budget execution	81.% (2016)	90%	100%	MoFED/MoHCC

Source: National Health Financing Strategy 2017[9]

[9] https://documents1.worldbank.org/curated/en/460741563174709132/pdf/Zimbabwe-Health-Financing-Strategy-2017.pdf

2.3.4 National Health Strategy 2021-2025

The NHS 2021 -2025[10] is guided by the Vision 2030, NDS1 and Sustainable Development Goals while building on the NHS 2016-2020 by addressing identified existing gaps following the Mid-Term Review of the NHS 2016-2020. The strategy identifies 11 priorities with 10 of them adapted from the NDS1 health outcomes as shown in Table 6.

Table 6: National Health Strategy 2021-2025

Outcome Description	Key Performance Indicator	Baseline (Year)	2021	2022	2023	2024	2025
Key Result Area 1 – Policy and Administration							
Increased Domestic Funding for Health	Total Government health expenditure per capita (US$)	$30.29 (2020)	$35	$46	$57	$69	$86
	Proportion of total health expenditure paid directly out of pocket of households	24% (2015)	20%	19%	18%	16%	15%
	Proportion of total Government budget that is allocated to health	10.1% (2020)	13%	14%	15%	15%	15%
Improved human resource performance in the health sector	Overall vacancy rate	8% (2020)	6%	5%	5%	5%	<5%
	Health worker density (SDG)	0.1 (2014)	0.2	0.5	0.7	0.9	1
Improved leadership and governance of the health sector	% implementation of a clearly defined Ministry of Health and Child Care organogram	30% (2020)	60%	70%	100%	100%	100%

[10] https://www.znfpc.org.zw/wp-content/uploads/2023/01/National-Health-Strategy-for-Zimbabwe2021_2025.pdf

	% Implementation of the Health Sector Coordination Framework	10% (2020)	25%	50%	70%	80%	100%
	% Operationalization of Public Health Act Implementation Framework	20% (2020)	30%	70%	80%	80%	80%
	Timeliness of reports (average for key reports)	61% (2020)	80%	80%	80%	80%	80%
	Number of audit reports with adverse observations	0 (2019)	0	0	0	0	0
Improved access to essential medicines and commodities	% Availability of selected tracer medicines	51% (2020)	55%	62%	70%	74%	80%
Improved health infrastructure and access to medical equipment for quality health service delivery	Proportion of secondary (district) level health institutions with functional theatres	43% (2020)	55%	72%	86%	99%	100%
	Proportion of institutions with tracer equipment (incinerator)	20% (2020)	34%	48%	68%	82%	100%
	Proportion of Primary Health facilities with critical equipment as per defined minimum package (SDG)	70% (2019)	75%	80%	90%	95%	100%
	% Implementation of the Local Production Roadmap	0 (2020)	40%	50%	70%	80%	100%

	Number of newly established Health Facilities	10 (2020)	15	25	30	42	50
	Proportion of population living within a radius of 10 km of a health facility	83% (2009)	85%	86%	87%	88%	90%
	Health facility density (Public Facilities)	Public HF 1:1	1:115	1:116	1:117	1:118	1:119
Key Result Area - Public Health							
Increased access to water, sanitation, and healthy environment	Sanitation coverage (SDG)	67 (2019)	69	73	75	78	80
	Proportion of population using safely managed drinking water sources (SDG)	77 (2019)	79	83	85	87	90
Reduced morbidity and mortality due to Communicable and Non-Communicable Diseases	AIDS mortality per 100,000 population	126.72 (2019)	120	113	99.98	90.95	86.57
	HIV incidence per 1,000 uninfected population (SDG)	2.81 (2019)	1.23	1.07	0.94	0.76	0.57
	TB Mortality per 100,000 population	42 (2019)	29	26	23	21	<20
	TB incidence per 100,000 population (SDG)	199 (2019)	185	167	154	142	132
	Malaria incidence rate per 1,000 persons per year (SDG)	0.56 (2019)	0.18	0.1	0.05	<0.03	0.01
	Malaria deaths per 100,000 population	1.9 (2020)	1.34	1.12	0.89	0.67	0.5
	Covid-19 Case fatality	3.8 (2021)	<1%	<1%	<1%	<1%	<1%
	Cholera case fatality	<0.5 (2018)	0	0	0	0	0

	Bilharzia prevalence	0.23 (2020)	18%	13.5%	9%	4.5%	<1%
	Soil transmitted helminths prevalence	5.5% (2020)	4.1%	2.8%	1.4%	1%	<1%
	Incidence of hypertension (per 100,000 population)	232 (2020)	184	161	150	140	132
	Incidence of Diabetes (per 100,000 population)	50 (2020)	48	45	41	37	35
	NCDs mortality rate (cervical cancer) (SDG)	>15% (2020)	13.5%	11%	9.5%	7.1%	<5%
	Cervical cancer incidence	25 (2020)	23	19	14	11	8
	Suicide mortality rate per 100,000 population (SDG)	19.1 (2016)	17.6%	16.1%	14.6%	13.1%	11.6%
Improved Reproductive, Maternal, New-born, Child and Adolescent Health and Nutrition	Maternal Mortality Ratio (SDG)	462 (2019)	388	351	314	277	240
	Under 5 Mortality Rate (SDG)	65 (2019)	57	53	49	45	41
	Neonatal Mortality Rate (SDG)	32 (2019)	28	26	24	22	20
	Prevalence of stunting among children under 5 years of age (SDG)	24 (2019)	22	22	21	20	19
	Proportion of births attended by skilled health personnel (SDG)	86 (2019)	88	89	90	91	92
	Institutional Maternal Mortality Ratio	102 (2018)	98	86	73	60	51
	Proportion of children under 1 year covered by all vaccines included in their national	91 (2019)	93	93	93	93	93

	program (PENTA 3 vaccine proxy)						
	Perinatal Mortality Rate	29 (2019)	26	25	23	22	20
	Modern Contraceptive Prevalence Rate (SDG)	67 (2019)	68	70	73	75	80
	Adolescent Birth Rate (SDG)	108 (2019)	103	100	98	95	93
	Cure rate for children with severe acute malnutrition	69 (2019)	70	75	80	85	90
	Proportion of sexual violence survivors who access health services within 72 hours	20 (2019)	24	30	39	45	60
	% of 'At Risk' under-five children screened for disabilities	30 (2018)	40	50	60	70	80
Improved public health emergency preparedness and response capacities	Proportion of outbreaks detected within 48 hours in line with IDSR guidelines	90 (2020)	100	100	100	100	100
	IHR core capacity index (SDG)	44 (2020)	47	49	51	53	55
	Proportion of outbreaks controlled within 2 weeks in line with IDSR guidelines	43 (2020)	60	70	75	86	95
KRA - Curative Services							
Improved access to primary , secondary, tertiary, quaternary and quinary	Client satisfaction index	75% (2020)	76%	77%	78%	79%	80%
	General service readiness index	50% (2019)	70%	80%	85%	90%	95%
	General service availability index	42% (2020)	50%	57%	62%	70%	75%

health care services							
Key Result Area - Bio- Medical Engineering, Bio- Medical Science, Pharmaceuticals, Bio-Pharmaceutical Production							
Improved health research and development	% implementation of the equipment local production roadmap	0 (2020)	10%	20%	30%	40%	50%
	% implementation of the pharmaceutical local production roadmap	0 (2020)	10%	20%	30%	40%	50%
	% implementation of the diagnostics local production roadmap	0 (2020)	10%	20%	30%	40%	50%
	% food samples analyzed	90 (200)	100%	100%	100%	100%	100%
	% implementation of the national health research agenda	0 (2020)	10%	20%	40%	60%	80%

Source: National Health Strategy 2021-2025

3. Progress in Health Budget Allocation and Spending

The last 5 years of the First Republic (2013 to 2017) had the following main health related policies that is the NHS 2009 to 2013, NHS 2014 to 2015, NHS 2016 to 2020, HFP 2016 and Health Financing Strategy 2017. These were supported by the main Development Plan, ZIMASSET and other supporting plans.

On the other hand, the Second Republic (2018 to 2022) health policies include the NHS 2016 to 2020, NHS 2021 to 2025 guided by Vision 2030, TSP and NDS1.

3.1 Health Budget Allocations and Actual Expenditure

The last 5 years of the First Republic had an average health budget allocation of US$313.3 million compared to an average of US$284.2 million in the first 5 years of the Second Republic. The decline in the health budget is mainly as a result of the high inflation and the depreciating currency. Annual inflation which averaged 1.78% between 2013 and 2017[11] increased to an

[11] https://www.rbz.co.zw/documents/statistics/CPI_Jan_2019.pdf

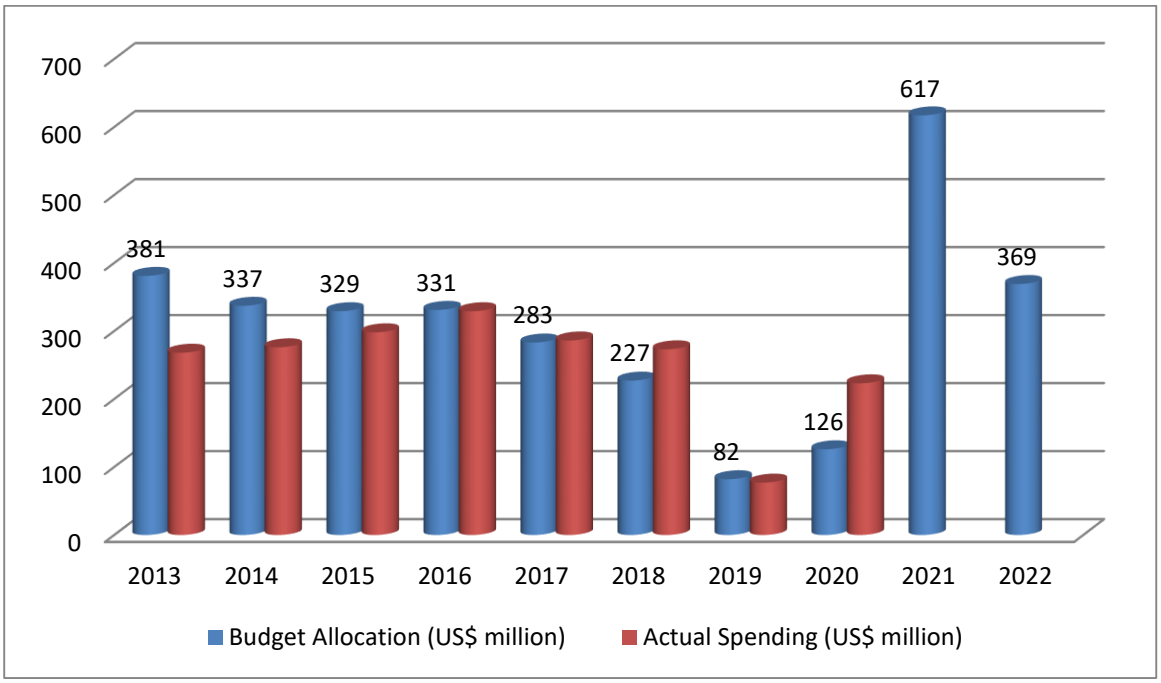
average of 200% between 2018 and March 2022. The official exchange rate moved from ZWL$1 to US$1 in 2016 (following introduction of bond notes) to US$1 to ZWL$1.30 in 2017 before reaching around US$1 to ZWL$630 in October 2022. As a result, while at the time of the budget allocation the budget allocation appears to be on the increase, the rapid losses due to the exchange rate greatly affect the final budget allocation in USD terms.

Health budget allocation fall short of the ideal funding levels envisaged in the NHS Scenario 2. For example, for 2016 and 2017, health budget allocation at US$330.8 million in 2016 and US$216.7 million in 2016 is only 28% and 16% of the ideal total health funding required respectively. The Second Republic fares worse with US$237.5 million (18% of ideal total health funding) in 2018, US$81.7 million (6%) in 2019 and US$125.9 million (9%).

Although the overall health budget allocation has declined in the Second Republic there has been an improvement in budget implementation. For the period 2013 to 2017 health budget execution averaged 89% as shown in Figure 1. The low budget execution is mainly attributed to failure by MOFED to release the allocated funds on time, as result of inadequate revenue collection (NHF 2017). The actual spending outperforming the budget allocation in most of the years during the Second Republic averaging 130% for the period 2017 to 2020.

However, the impact of increased expenditure pressures can be explained by the increase in COVID-19 related expenditures from 2020 onwards and the rising inflation and depreciating currency. This diminishes the actual benefit of improvement in budget execution. Nonetheless it is important to build and sustain the improved budget execution beyond the COVID-19 pandemic. There is also need to increase the budget allocation to deal with the increasing challenges in the health sector including the rise in NCDs, high maternal mortality rates (without taking anything away from the improvements) as well as infant and neonatal mortality which remain a challenge.

Figure 1: Health Budget Allocation 2013-2022 (USD)



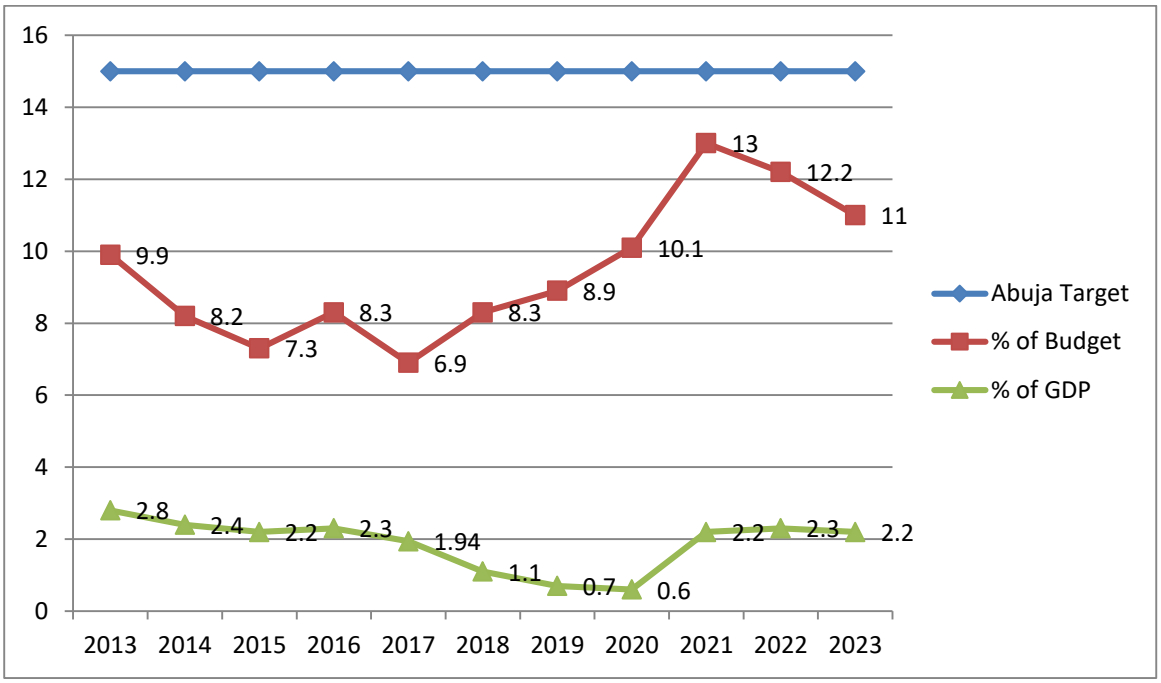
Source: Authors compilation from the Zimbabwe National Budget Statements 2013-2022

3.2 Share of Health Budget Allocation

Health budget allocation improved from an average of 8.1% in the last 5 years of the First Republic to an average of 10.5% in the first 5 years of the Second Republic. Despite the improvement this falls short of the Abuja target of 15% of total expenditure towards health as shown in Figure 2. Additionally, the health budget allocation is below the HFS mid-term target of allocating 12% of the total budget by 2020. However, the health budget allocation declined as a percentage of GDP from an average of 2.3% during the last 5 years of the First Republic to an average of 1.4% during the first 5 years of the Second Republic. This is way below the suggested health spending of 5% of GDP necessary for progressing towards universal health coverage[12]. Spending at least 5% can lead to better health outcomes including achieving a conservative target of 90% coverage of maternal and child health services. According to data from the 2010 World Health Report, public spending of about 6% of GDP on health will limit out-of-pocket payments to an amount that makes the incidence of financial catastrophe negligible[13].

[12] https://resyst.lshtm.ac.uk/resources/a-target-for-uhc-how-much-should-governments-spend-on-health
[13] https://www.afro.who.int/sites/default/files/2017-06/state-of-health-financing-afro.pdf

Figure 2: Trends in National Health Budget Allocation 2013-2022



Source: Authors compilation from the Zimbabwe National Budget Statements 2013-2022

The low health budget is reflected in poor health outcomes and gaps in access to health. According to the 2022 National Budget Estimates book, only 25% of the provincial hospitals are providing selected major surgeries, while there are no provincial hospitals offering selected specialist services. Only 20% of the hospitals are providing chemistry and haematology analysis services and only 10% of the health facilities are providing at least 80% of tracer medicines above minimal levels.

3.3 Per Capita Health spending

Zimbabwe's per capita budget is well below the WHO recommended US$86 per capita in both republics. In the last 5 years the per capita health allocation was on average US$25 before marginally increasing to US$31 in the first 5 years of the Second Republic. However, if we adjust the 2022 budget to include the supplementary budget the average per capita during the same period rises to US$34.

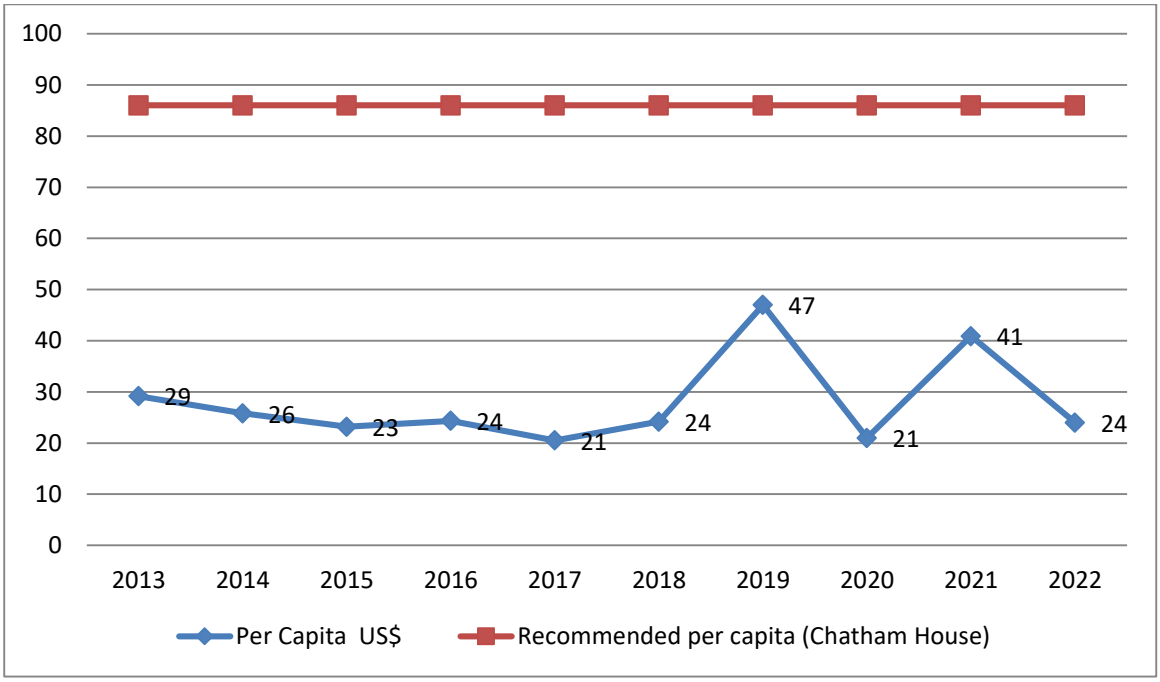
The average of US$25 health spending per capita is also lower than the NHS 2009 to 2015 target of a base of US$34 per capita during the period. Zimbabwe also fares poorly compared to per capita in Africa that averaged $US80 in 2016[14].

[14] https://link.springer.com/article/10.1007/s40258-020-00618-0

The Second Republic has seen improved per capita health allocation but the average of US$31 (or US$34 including the 2022 supplementary budget) is still far from the NDS1 target of US$57 per capita health spending. Inflation and the exchange rate threatens the achievement of the goal for per capita of US$86. In 2022 at the time of the budget announcement in November 2020, the per capita health allocation was a respectable US$74. However, when factoring the changes in the exchange rate this falls down to about US$24 per capita using the average official exchange rate as at 26 October 2022 or US$37 when factoring the supplementary budget.

When factoring other resources, the health spending per capita is above US$86 recommended for UHC (NHS 2021-2025). However due to the low reliability of external support as has already been shown during the COVID-19 outbreak and the Russia and Ukraine conflict there is need to increase the government per capita budget allocation to US$86 with external support complementing government resources. This is also necessary to cover for the high disease burden as well as to reduce the out of pocket expenditure on health.

Figure 3: Per Capita Health Allocation 2013 to 2022



Source: Authors compilation from the Zimbabwe National Budget Statements 2013-2022

3.4 Health Spending by Economic Classification

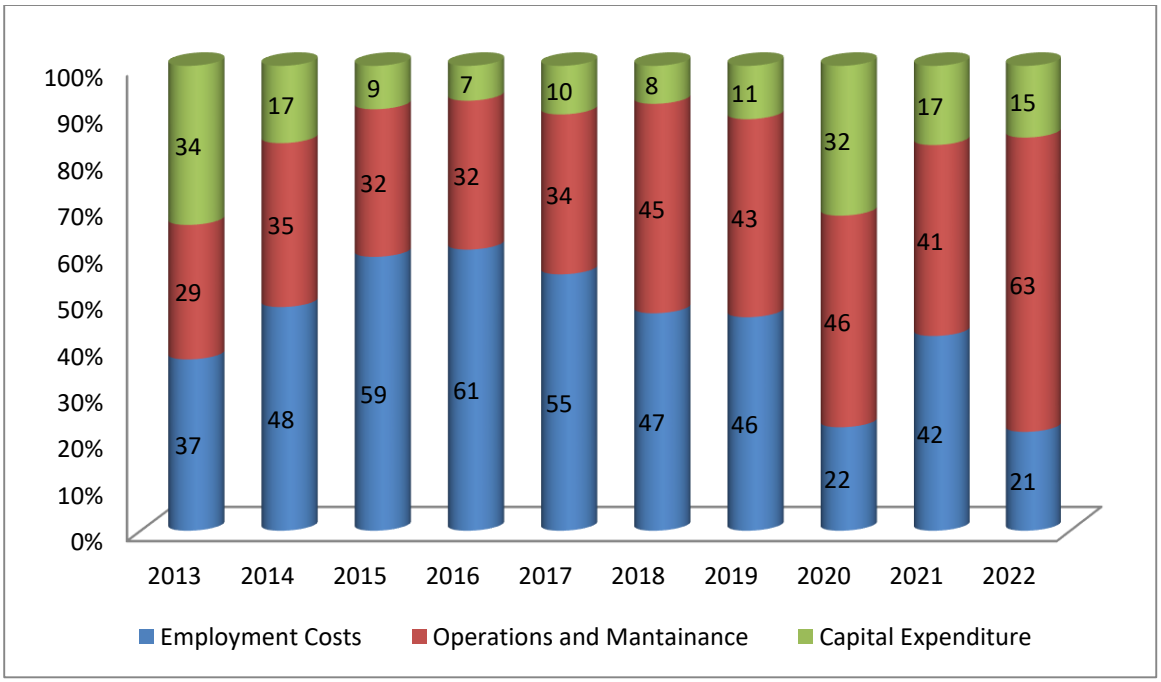
The 2017 HFS targets non-wage health expenditure as % of total Government of 20% in 2020 and 30% in 2022. During the last 5 years of the First Republic, non-wage expenditure averaged 48% of which 32% of the health budget expenditure went to operations and 16% to capital

expenditure. In the Second Republic's first 5 years the non-wage expenditure improved to an average of 64% with 47% going towards operations and 17% towards capital expenditure.

However, the slight improvement in the capital budget to an average of 17% may not be adequate for achievement of the NHS 2021 to 2025 outcome of improved health infrastructure and access to medical equipment for quality health service delivery. The 2021 National Disability Policy (NDP) identifies the need for the principles of universal design and reasonable accommodation as defined in the NDP to be adopted in healthcare infrastructure modification or initial construction of health care centres. Hence there is need for increased capital expenditure to improve access to health services for PWDs. Other health related capital expenditure include mobile clinics to improve access for the elderly and PWDs.

On another note, the reduced share of employment costs at a time the overall health budget is declining presents a risk of brain drain and increased frequent of strikes by health personnel as a result of falling incomes.

Figure 4: Health Budget by Economic Classification



Source: Authors compilation from the Zimbabwe National Budget Statements 2013-2022

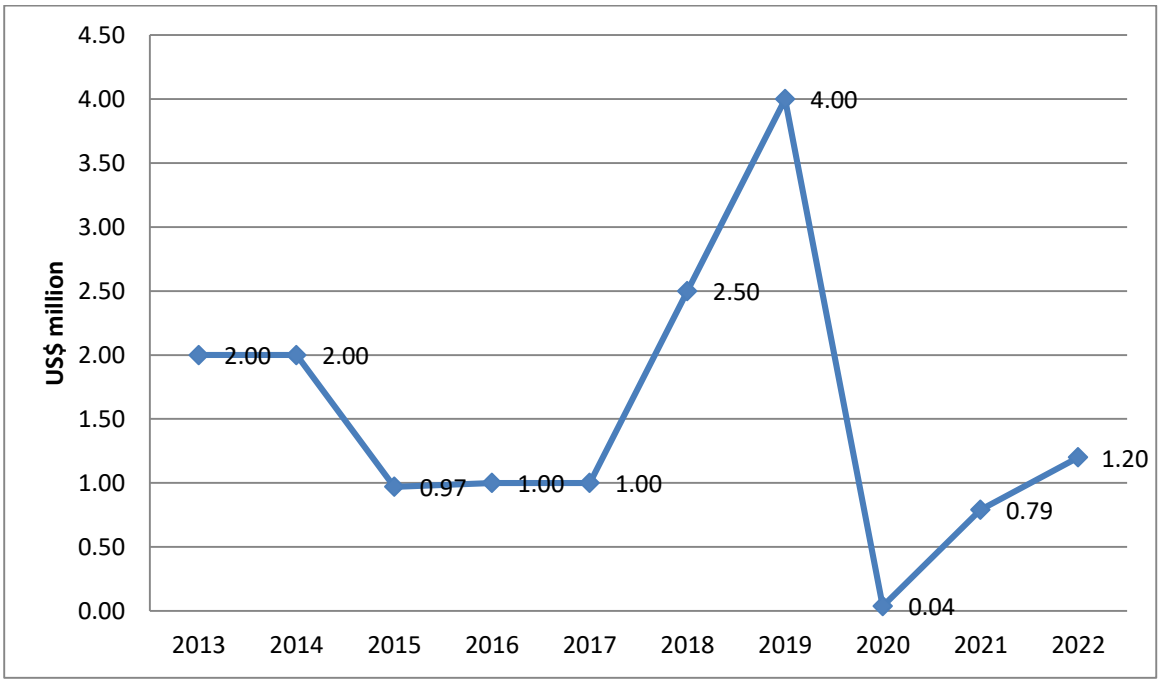
3.5 Assisted Medical Treatment Order (AMTO)

The Assisted Medical Treatment Order is the main social safety net in the health sector to cover health fees in public facilities for indigents. Government introduced the scheme in the 1990s to cushion vulnerable citizens following the introduction of the Economic Structural Adjustment Program.

The target population are: the elderly (over 65 years), the poor and indigent (who are means tested before accessing the benefit), pregnant women and children under 5 who access public health facilities (local council clinics and government hospitals). The fund is meant to reimburse providers for user fee exemptions for using local council clinics' primary health services and for referrals to hospital to enable these populations to have equitable access to care (HFS 2017).

There has been a slight improvement in the AMTO budget that increased from an average of US$1.4 million during the last 5 years of the First Republic to an average of US$1.6 million in the first 5 years of the Second Republic.

Figure 5: Health Assistance Budget 2013-2022 (US Million)



Source: Authors compilation from the Zimbabwe National Budget Statements 2013-2022

The health assistance budget allocation increased from an average of US$16.91 per person targeted to an average of US$56.63 per person. However, targeted beneficiaries fell from an average of 140 000 in the First Republic to an average of 35 000 people leaving a lot of deserving patients without health social protection. This is worsened by the fact that health insurance covers less than 10% of the population and out of pocket expenditure of over 39% of all health expenditure leading to financial impoverishment for many Zimbabweans.

Actual spending performed poorly with government spending on average 20% less than the health assistance budget in the period 2018 to 2020[15]. This has been a recurring trend with

[15] https://www.unicef.org/zimbabwe/media/5181/file/2021%20Social%20Protection%20Budget%20Brief%20-%20Final.pdf

NHS 2017 confirming that in prior years AMTO failed to cover the targeted population due to factors such as non-disbursement, a high level of debt and a lack of awareness among the target population of their entitlements (NHS 2017).

Other challenges related to AMTO include the fact that it is mainly accessible at government health institutions and is not accepted at local council clinics and private clinics or private hospitals unless one has approval from the Ministry's Head Office in Harare[16]. However, the registration process is also cumbersome hence not suitable for emergencies including when ambulance services are required (PRFT 2021). This is a challenge for the poor and vulnerable when they require specialist services which are very expensive and below reach of many patients. For example, most hospitals charge about $80 per session, while private hospitals charge $240 for dialysis which is the treatment of kidneys. A patient requires three sessions per week. This is similar to the cost of NCDs diagnosis and treatment. Treatment of cancer costs on average between US$100-1,000 per session yet in most rural health centers, the only cancer services on offer are screening using VIAC and referrals for further tests, treatment and therapy at district or provincial level.

According to PRFT 2021, the non-availability of medication at public health institutions pharmacies means AMTO ends up being used for consultations only and not covering the actual treatment. The high inflation is another cause for concern particularly where PWDs use the AMTO to purchase assistive devices. This is because of the long processes by the time disbursements are made the amounts will have been eroded by inflation and hence inadequate to purchase the equipment (PRFT 2021). Additionally, there is need for adequate funding of the Social Protection Management Information System. This will lead to an updated social protection register that will speed up the application processes for deserving persons.

The institutional arrangement which sees the Department of Social Welfare in the Ministry of Public Service, Labour and Social Welfare (MoPSLSW) administering the scheme as the Ministry in charge of the social protection has its challenges. One of the challenges includes ineffective coordination between MoPSLSW and the Health Ministry which leads to delays in deserving patients accessing services.

Addressing the above challenges as well as increasing health protection funding will go a long way towards the HFS objective of reducing out of pocket health funding.

3.6 Sources of Health Funding

Zimbabwe's health system is financed through a mixture of domestic (public and private) and external funding sources. Government public health finance has the largest proportion albeit the contribution is below recommended levels (NHS 2021-2025). Strengthening domestic resources mobilisation has been identified as one of the SDGs targets (SDG 17.1). According

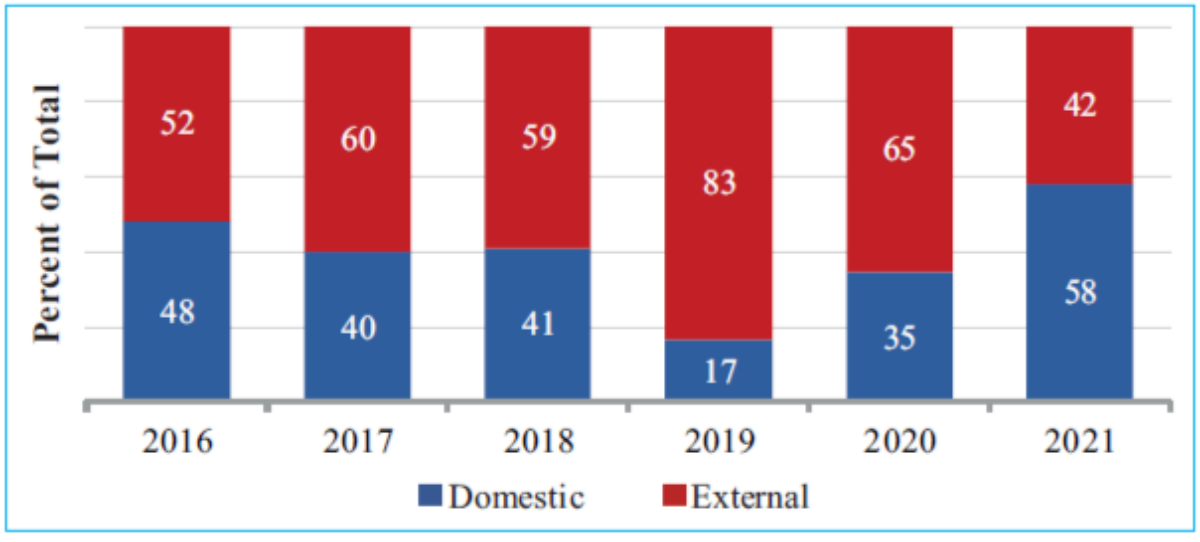
[16] https://www.prftzim.org/download/access-to-health-services-by-pwds-report-summary/

to the UNICEF Health Budget brief, domestic resources averaged 38% for the period 2018 to 2021 while the average for 2016 and 2017 is higher at 44%[17]. There is marked improvement in 2021 which has domestic funding of 58%. However, the fluctuations in the health budget are a cause for concern as it reduces predictability of health financing.

The Government has introduced various innovative health financing initiatives to increase domestic resources. These include the AIDS levy which is a 3% tax on income and taxes on incomes by formal employers and employees aimed at strengthening the national response to HIV/AIDS. The other is the 5% levy on mobile airtime data (health levy) intended for drugs and equipment in hospitals as a way of ring-fencing funds for critical health services. However, while the AIDS levy has been effective in dealing with HIV/AIDS pandemic the impact of the 5% is not yet clear.

In the 2017 HFS there were other proposals to increase domestic resources such as the introduction of sin taxes, mechanisms to tax the informal sector. While the government introduced taxes on mobile money transfers, there hasn't been much movement on the introduction of sin taxes. Additional resources can also be found if the government streamlines tax incentives particularly in the mining sector which have been found to be ineffective in attracting foreign direct investment (FDI).

Figure 6: Composition of Health Financing 2016-2021



Source: UNICEF 2021 Budget Brief

[17] https://www.unicef.org/esa/media/10211/file/UNICEF-Zimbabwe-2021-Health-Budget-Brief.pdf

4. Conclusions and Recommendations

The government has done well to come up with development plans that include the health sector as one of the key priorities. In addition, the government has come up with health related policies and strategies meant to improve the health sector as well as health policies and strategies meant to ensure healthy lives and promote well-being for all at all ages (SDG 3). There has been notable improvement in health outcomes including the decline in maternal mortality from 960 deaths per 100,000 live births in 2010/11 to 363 per 100 000 live births in 2022. Zimbabwe has also made significant strides in the fight against HIV/AIDS especially the 95-95-95 targets. In 2019, 91% of people living with HIV (age 15 years and older) knew their status, 93% of these were on antiretroviral therapy (ART) and 86% of those on ART were virally suppressed (NHS 2021-2025).

However, despite these improvements gaps still persist including health personnel shortages, lack of drugs, non-availability of ambulances, and lack of medical equipment including cancer diagnostic equipment among others. While government budget allocation has improved as a percentage of total government expenditure, the value of government contribution has fallen in absolute terms. Improvement in budget execution is welcome but the overall benefit is negated by the increasing inflation and depreciating currency making health unaffordable to the majority of the population. Improving government health financing through the national budget is one way of ensuring improved health outcomes in the country.

Recommendations

- Government must increase the health budget allocation to the Abuja target of 15% of total government expenditure and health per capita target of US$86.
- There is need to increase the health capital expenditure budget from the average of 16.5% in the last 10 years to above 20% of the health budget in order to address the challenges of inadequate health equipment and infrastructure.
- Government must increase the domestic health expenditure above 50%.
- The Government should finally implement the proposal to introduce sin taxes (targeted at alcohol, tobacco, sugar etc.) and ring fencing the taxes to the health sector which was proposed in the 2017 National Health Financing Strategy.
- Additionally, the Government should cost the NHS 2021-2025 and update the National Health Financing Strategy.
- Government should improve transparency and accountability for the health levy to ensure that it goes to its intended use of purchasing drugs and equipment and improve availability of the same in public health institutions.
- Government should evaluate all tax incentives with the view of eliminating the tax incentives with little impact on FDI in order to unlock additional revenue to fund health and other social sectors.

- The Ministry of Finance should include specific budget lines towards mainstreaming disability including for disability friendly infrastructure (new infrastructure and upgrading existing infrastructure to include ramps, disability friendly toilets, health facility waiting areas, roads and pavement etc.) in line with the 2021 National Disability Policy.
- Government must remove all duty on assistive medical devices.
- Government should invest in mobile clinics for PWDs to ease access to health care services since they experience difficulties travelling to health centres due to their various impairments.
- The Government must increase the AMTO budget to ensure better coverage for vulnerable patients.
- The increased AMTO budget should also cater for the extension of the facility to all medical facilities while the local authorities should remove health user fees for vulnerable patients including PWDs.
- Government should enhance better coordination between the Ministries of Public Service, Labour and Social Welfare, Health and Child Care, Finance and Economic Development to ensure that there is adequate and timely financing of the AMTO support scheme.

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