Post-independent economic policies and their impact on health care delivery in Zimbabwe

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Abstract

Post-independent economic policies have had a bearing on health delivery outcome in Zimbabwe. The primary function of health systems is to provide high-quality and universal health services. At the same time, through their spending and investments, health systems play an important role in the status and stability of national and regional economies. The analysis of the relationship between economic blueprints and health care delivery help to understand the institutional setting of health. The paper is based on desktop research, focusing on published articles and journals, policy documents interrogation. During the first decade of independence Zimbabwe perused the socialistic model of development, under the policy document health with equity, structural adjustments led to the adoption of neoliberal policies that led to cut in government expenditure. The research further interrogates the impact post 2000 economic policies and their impact on health delivery.

Key Words: Health care delivery, economic blueprint, Zimbabwe

1. Introduction

Zimbabwe's health problems stem from a colonial background (Bird & Mazet, 2018). Health policies often come is a by-product of public social policies enacted by the government. Health infrastructures were skewed towards the white minority concentrated within the major cities and towns whilst the blacks in countryside were relegated to the background. The glaring inequalities in the health sector can be traced to the apartheid health system(Felappi et al., 2020). With advent of independence many African countries came up with health policies critical in health care delivery to these previously marginalised natives. In the wake of the numerous political and economic problems, the country had also to face a restructuring of the health system to reach the more remote and indigent areas. Several preventive and curative health policy interventions have contributed to this progress and this chapter reviews them and draws lessons from this review. While health interventions have been important in explaining past success, health outcomes have also, to a large extent, been determined by the functioning of the health system. Policy interventions and health systems are connected through feedback relationship.

Meanwhile, policy making in the arena of public health care is a contested terrain involving trade-offs between competing interests and ideological orientations (Schoemaker et al., 2020). Health Policy framing, and implementation is influenced by environmental variables. Health does not mean absence of disease or infirmity but extent to the state of complete, social and social wellbeing (WHO, 2012) Therein health policy is holistic in nature in that include the socio-economic variables that affect desirable health care delivery outcome. Healthcare is intended to treat, influence, and care for individual and community health being. (Koon et al., 2016). Health systems research (HSR) provides a conceptual grounding for the correlation between health care delivery and economic blueprint. A health system is the sum of the structures, people and processes that together provide the vehicle for the delivery of health care and achievement of better health (Sriram, 2017). Health policy and systems research can be inserted into the policy argumentation cycle that is from the issue searching to the monitoring and evaluation of the proposed policies. It is a departure from the traditional lances that conceived health as entirely biomedical field characterised by robust scientific research. HSR is crystallised around a multi-disciplinary dimension that shape policy analysis and understand the complexes around interests and divergencies of key actors from a global to local level.

Health system framework

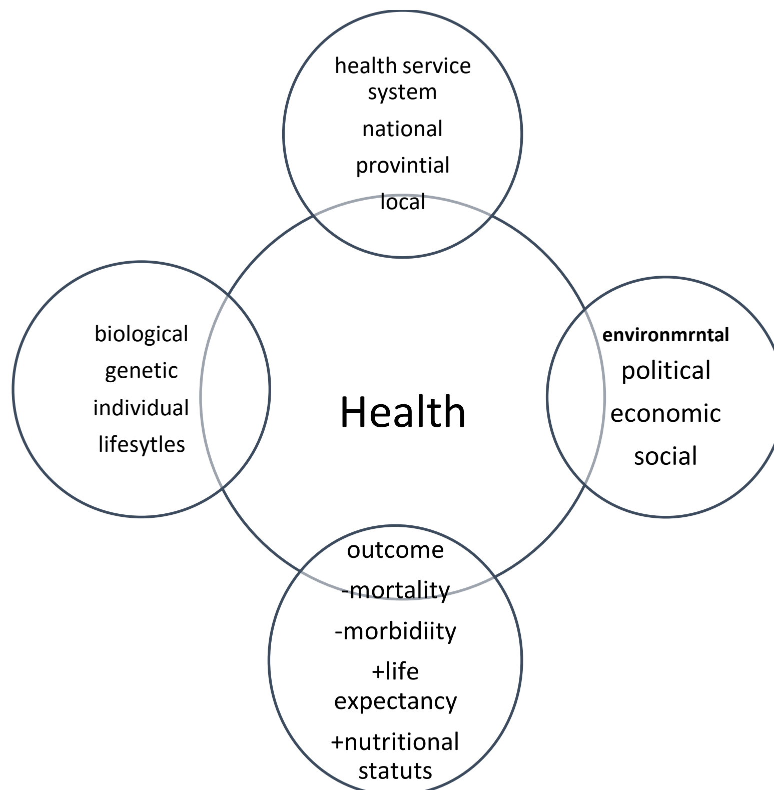

Figure 1 showing the health system framework

2. Materials and Methods

The study is based on a desktop review of literature on post-independent economic policies and their impact on health care delivery in Zimbabwe. The published sources from revered journals, books, policy documents and unpublished sources were interrogated.

3. Results and Discussion

3.1 Zimbabwe health policies nexus Economic policies

Zimbabwe's health delivery care has been the function of economic determinism dating back to its independence. At her independence Zimbabwe inherited a health institutional setting that was dualistic nature reflecting the broader interest of the white minority (Bloom, 1985). Prior to the independent the health care for was delivered through well-equipped publicly financed hospitals on the contrast blacks systematically deprived of sophisticated facilities (Manga, 1988).Rural health service centers were specifically designed for the containment and control of the communicable diseases whilst for whist the a health system catered for complex non communicable ' diseases of class's. Zimbabwe to date has come up with various policies that borders on socialistic and neo-liberal policies. Economic blueprints had a bearing on the health care system.

3.2 Socialistic mode of development impact on health delivery towards equalization

After attaining independence, the Zimbabwean government pursued a socialistic mode of development that sought to redesign the institutional setting that had proliferated inequalities and mal distribution of health care service between the blacks and whites. At the centroid of the inequalities was the dual economy anchored on separatist strategy. Against this backdrop, the Ministry of Health adopted a policy of "equity in health" which saw resources being shifted from urban to rural and from curative services to preventive services. The decade also witnessed the establishment of clinics, health centres and hospitals across the country, in both rural and urban areas In line with the Growth with Equity policy , Zimbabwe government adopted the white paper entitled Planning for Equity in Health in 1981(Manga, 1988).The major highlight of the white paper included the removal to barriers to care, creation of an integrated administrative apparatus, capital development in the rural areas and training of the village workers. The policy was skewed towards reconfiguration of resources towards preventive rather than curative medicine. Major strides were made health care delivery, increased coverage of primary health care, introduction of health services for those earning below Z$150 a month, re-orientation of medical training towards the health needs of the majority (Ndlovu-Gatsheni, 2006).This coincided economic boom premised on socialistic mode of development and mutualism that existed between government and capitals in the period 1980 to 1982 .Over the period 1981-82 to 1983-84 the ministry planned 316 new rural health centres and the upgrading of 450 existing rural primary care clinics(Brett, 2005). Government first decade of independence economic blueprints, such as the Growth with equity (1981), Three-year National Development Plan (1982-1985) and Five-year national development

plan (1986-1990), significantly shows government commitment to preventive health, specifically targeting the rural populace and low-income black communities in urban spaces who had been denied universal access to health.

3.3 Neoliberal policies (1991 to 2000) and health care delivery

The economic recession experienced in the late 1980's, that had triggered energy crisis and depletion of the foreign capital prompted the government to adopt the economic structural adjustment programme (ESAP). In tandem with the experiences of other African countries before Zimbabwe dumped the redistributive approach to economy towards a neoliberal set of blueprints that were premised on reduction in government expenditure. Structural adjustment loans are provided to countries in dire fiscal or macro-economic straits(Thomson et al., 2017).The ESAP package prescribed a reduction of budget deficit via cut in government expenditure and rationalisation of the civil service, removal of subsidies, trade liberalisation, devaluation of the local currency, enforcement of cost recovery in education and health (Biti & Fellow, 2014).The adoption of the neoliberal policies indicated a reversal in policy model towards a rationalistic thinking inclined towards reinstitution of neo-colonial paradigm that limited the universal access to health care services on socially economically marginal societies . Robust reforms in the arena of health care reforms , health equity , health governance , and health care infrastructure had halted by ESAP (Sachikonye, 1997) (Mlambo & Raftopoulos, 2010). Although health workers were protected from retrenchments, downsizing of Ministry of Health (MOH) administrative and maintenance staff reduced efficiency and added to morale problems without generating significant savings(Thomson et al., 2017).Reduction in government spending derailed maintenance of health care infrastructure, decline in outpatients and inpatients following the scrapping weaver on economically deprived who earned equivalent of Z$150. . By 1994, the health budget had declined by 30% (Thomson et al., 2017).Policy inconsistencies had a detrimental effect on the rural and urban communities who grappled with mal-distribution of health resources experienced in the pre-independent epoch. This has had negative bearing on health outcome indicators such as infant mortality rate (IMR), morbidity, life expectancy, nutritional status, and access to basic care. The situation was compounded by the occurrence of global epidemic HIV/AIDS that was claiming 2000 people per week(ZIMCODD, 2016).Outpatient declined due to user fees, that overlapped with drought and drug shortages in 1991(Kumaranayake et al., 2000). The economic downward spiral and instability facilitated the second phase of ESAP dubbed the Zimbabwe Programme for Economic and Social Transformation ZIMPREST (1996-2000) anchored on tightening monetary policies, poverty alleviation and provision of safety nets to the socio-economically disadvantaged. The economic blueprint failed to support safety nets and health delivery due to cofounding factors such the unbudgeted war compensation to the war veterans in 1997 and the unilateral decision to join the DRC war in 1998 which resulted in increased government expenditure (Mlambo & Raftopoulos, 2010). The resultant included the limited resources being channeled towards the health sector which was already grappling with the Breton hood prescription on per capita health cut. The government fall short of the health for all by 2000 target proposed by the WHO that demanded equity in health by reducing disparities between the low-income

countries and developed countries. The crisis was even more tragic in the face of growing threat of rising HIV/AIDS infections(Raftopoulos, 2007).

3.4 Turn of the new millennium.

During the turn of the new millennium Zimbabwe faced multi-layered crisis stemming from the interventionist approach, primarily the Land Reform that invited the socio-economic challenges. The populist policies had a cascading effect on the overall health delivery outcome. The health system faced rapid decline characterised by shortage of drugs, brain drain, and basic protective personal clothing. World Health Organisation (2002) outlines the impact of restructuring of land resulted in limited access to basic water and sanitation facilities The government of national unity, culminated into the stabilisation and rebounding of the economy to reverse the dire consequences of collapsed health system(Watson et al., 2012).However the period 2013-2015 was characterised by the decline in economic growth .The Zimbabwe Agenda for Sustainable Economic Transformation (ZimAsset) represents a blueprint for the country's development path from October 2013 to December 2018

3.5 The national strategic plan

The national development strategic plan sought to stabilise and contain inflation via macro-economic stability (Government of Zimbabwe 2021). Given the background of flawed economic policies NDS1 seek to improve quality of life expectancy at birth, professional health, and hospital care. In line with the universal to access to health care, the government has made efforts to open health care centres. Zimbabwe's healthcare system lacks resources critical to sustain the health care system Zimbabwe's actual domestic health spending in relation to the national budget allocation are below the Abuja Declaration target of 15%. Such an arrangement affects the health policy outcome. These trends of public health spending reflect the increased efforts at both the national and international level that have made a considerable difference in ensuring that the relevant policy interventions are incorporated into prevention and treatment programmes.

4 Discussion

Zimbabwean economic policies affect health care provision. These results indicate that the government is biased towards the market driven policies that less prioritise health. Currently the budgetary allocations fall short of the 15 % of the Abuja declaration that highlight the utility of allocating greater proportion of government revenue to health. This led to significant decline in health delivery characterized by brain drain, failure to provide basic health services. Since 1980, the economic blueprints have been affected by policy inconsistency, the first decade of independence, sought to redress unequal access to health care by perusing socialistic model of development under the growth with

equity. The equity in health policy was significance towards equitable health care. The economic blueprints adopted in 1991, under the structural adjustments programme, prescribed a cut in government expenditure. The changes that have been made in the realm resource distribution, investment in infrastructure and intensification of the primary health were put on halt. Thus, ever since the Zimbabwean government adopted the economic blueprints dictated by the Briton Hood institutions, health care delivery has been greatly affected. The neo-liberal policies that were adopted such as the ZIMPREST, NEPAD,

STERP, ZIMASSET, and NSD1 are market oriented in nature, hence part health delivery is partially addressed. The interaction of indicators of macroeconomic stability such as income distribution and poverty also worsened the health situation.

5 Conclusions and Recommendations

The study explored the post-independent economic policies and their impact on health care delivery in Zimbabwe. The health care catered for colonial administrators with separate care for the Africans. The economic policies that have been formulated and implemented have a propensity to relegate the health priorities resulting in brain drain, shortage of basic health services and degradation of infrastructure. Given the myriad of challenges confronting the health sector there is need for pro-health incremental reforms that promote universal access to health.

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