Zimbabwe

Health Sector Public Expenditure Review 2022

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HNP

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List of Acronyms

AHFoZ	Association of Health Funders of Zimbabwe
AIDS	Acquired Immunodeficiency Syndrome
AMTO	Assisted Medical Treatment Order
ANC	Ante-Natal Care
ARI	Acute Respiratory Infection
ART	Anti-Retroviral Treatment
CBD	Community-Based Distributor
CIMAS	Commercial and Industrial Medical Aid Society
DALY	Disability Adjusted Life Year
D&D	Devolution and Decentralization
DHE	District Health Executive
DHMT	District Health Management Team
DHO	District Health Offices
DMO	District Medical Officer
DP	Development Partner
DPT	Diphtheria, Pertussis and Tetanus
EPI	Expanded Program of Immunization
EU	European Union
FCDO	Foreign, Commonwealth and Development Office
GAVI	Global Vaccine Alliance
GGE	General Government Expenditure
GDP	Gross Domestic Product
GHE	Government Health Expenditure
GHED	Global Health Expenditure Database
GNI	Gross National Income
GoZ	Government of Zimbabwe
HCHD	Harare City Health Department
HDF	Health Development Fund
HIV	Human Immunodeficiency Virus

IDCC	Inter-Ministerial Development Coordinating Committee
LIC	Low Income Country
LMIC	Lower-Middle Income Country
M&E	Monitoring and Evaluation
MDA	Ministry, Department and Agency
MNCH	Maternal, Neonatal and Child Health
MoFED	Ministry of Finance and Economic Development
MoHCC	Ministry of Health and Child Care
MoLGPW	Ministry of Local Government and Public Works
MoPSLSW	Ministry of Public Service, Labor and Social Welfare
MMR	Maternal Mortality Rate
MTR	Mid-Term Review
NAC	National Aids Council
NatPharm	National Pharmaceutical Company
NCD	Non-Communicable Disease
NHA	National Health Account
NHS	National Health Strategy
NGO	Non-Governmental Organization
NPISH	Non-Profit Institutions Serving Household Spend
NSC	National Steering Committee
OAG	Office of the Auditor General
OOP	Out of Pocket
OPC	Office of the President and Cabinet
PBB	Program Based Budgeting
PCN	Primary Care Nurse
PDC	Provincial Development Team, Committee and Coordinator
PEFA	Public Expenditure and Financial Accountability
PEPFAR	President's Emergency Plan for AIDS Relief
PFMS	Public Finance Management System
PER	Public Expenditure Review
PHE	Provincial Health Executive

PHMT	Provincial Health Management Team
PMD	Provincial Medical Director
PPE	Personal Protective Equipment
PSMAS	Premier Services Medical Aid Society
RBF	Results Based Financing
RDC	Rural District Council
RGN	Registered General Nurse
RMNCH	Reproductive, Maternal, Neonatal and Child Health
RMNCAH	Reproductive, Maternal, Neonatal, Adolescent and Child Health
RMNCAH-N	Reproductive, Maternal, Neonatal, Adolescent and Child Health – and Nutrition
RTGS	Real Time Gross Settlement
SARA	Service Availability and Readiness Assessment
SCN	State Certified Nurse
SIDA	Swedish International Development Cooperation Agency
SSA	Sub-Saharan Africa
SSB	Salary Service Bureau
SSTC	Social Services Technical Committee
STI	Sexually Transmitted Infection
TB	Tuberculosis
TGE	Total Government Expenditure
THE	Total Health Expenditure
UNFPA	United Nations Population Fund
USD	United States Dollar
USG	United States Government
VHW	Village Health Worker
WHO	World Health Organization
ZACH	Zimbabwe Association of Church-Related Hospitals
ZDHS	Zimbabwe Demographic and Health Survey
ZNFPC	Zimbabwe National Family Planning Council
ZWL	Zimbabwean Dollar

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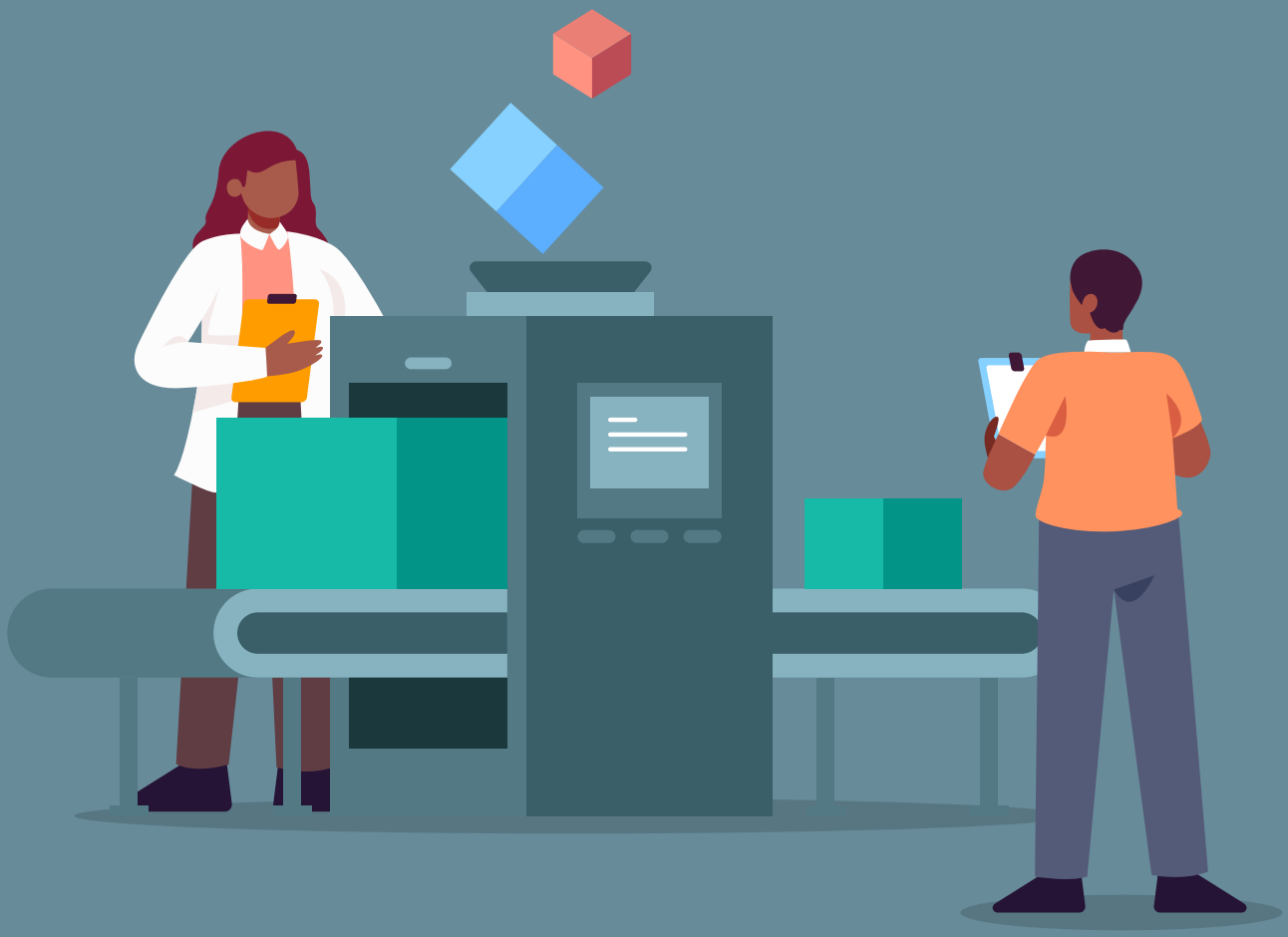
Executive Summary



This Public Expenditure Review (PER) examines the recent evolution of public health expenditures in Zimbabwe and assesses opportunities for improving their efficiency, effectiveness, and equity. The report updates findings from the last health sector PER published in 2015. The review's data analysis and stakeholder consultations were principally undertaken in the final quarter of 2020 and so provide some initial insight into the impact of the COVID-19 pandemic on the financing of the health sector.

Trends in overall health spending

Government spending for health steadily increased during a period of macroeconomic stability from 2010-17. The MOHCC accounts for the largest spending on health, followed by local authorities, the Ministries of Public Service, Labor and Social Welfare (including PSMAS and AMTO), and the National AIDS Council. Average government health spending across all agencies doubled in per capita terms from US$20 in 2010 to US$40 in 2017, with particularly impressive growth from 2010 to 2015. This period of growth reflected a broader period of macroeconomic stability and prioritization of the health sector.

Macroeconomic instability since 2018 has adversely affected health financing. The rapid acceleration of inflation (peaking at 837.5 percent in July 2020) and exchange rate depreciation has led to a major reduction in overall government revenue. As such, even though its relative share of government spending has remained largely consistent, government health expenditure (GHE) has dramatically decreased in absolute per capita terms. Adjusted for domestic inflation, government health spending in 2019 and 2020 reverted to 2016 and 2017 levels. In US dollar terms government expenditure on health has fallen significantly in 2019 and 2020 (table ES 1).

ES Table 1

Government spending on health by institution (current effective US$ millions)

Source: Please refer to Annex Table 6.2

	2017	2018	2019	2020
Local Ministry of Health and Child Care	341	280	119	83
Ministry of Public Service, Labor, and Social Welfare, including PSMAS and AMTO	115	101	31	14
National AIDS Council	38	22	11	9
Local authorities	92	76	39	31
Other ministries	4	3	1	1

While household spending on health fell, Development Partner (DP) spending surpassed government spending in USD terms in 2019 and 2020. Total Health Expenditure (THE) is estimated to have more than halved from 2015 to 2020 from US$1.7 billion to US$0.8 billion. NHA data show that household spending on health has declined, following an inflation-precipitated decline in purchasing power. The extent to which its decline is a result of the user fee removal policy and/or challenges to access to care remains to be explored. DP spending has remained on a constant trajectory since 2015. Being mostly denominated in US$, it has become increasingly important and was not affected by the same inflationary pressures. DP spending on health has exceeded government spending by a factor of 2.5 in 2019 and 2020.

Efficiency and effectiveness

Analysis of overall effectiveness of health spending shows a mixed picture. In 2015 Zimbabwe's THE per capita was comparable to the sub-Saharan average, but performance on many health outcomes was stronger. By contrast, although THE per capita was only marginally below the average for lower-middle income countries (LMICs), Zimbabwe's performance for some health outcomes was considerably worse. For example, its maternal mortality rate was more than twice as high as the LMIC average. This suggests that opportunities remain to strengthen system performance. Expenditure contractions in recent years make it even more important to ensure resources are efficiently translated into improved health outcomes.

The government has undertaken important steps to improve efficiency and effectiveness of health spending since 2015. Aside from developing a Health Financing Policy and Health Financing Strategy, progress has been made in key areas such as developing innovative mechanisms to increase resources available for health and institutionalizing the results-based financing approach for health facilities. The health sector is also now better positioned to benefit from centrally managed reforms for improving public financial management including the Program Based Budgeting reform. Data availability has benefited from National Health Accounts (2015 and 2017/18) and annual resource mapping exercises. This PER recognizes the exceptional value these actions provide and offers recommendations on how they could be further strengthened.

Spending prioritization amongst competing objectives

The health sector's COVID response led to a significant increase in communicable disease spending in 2020, crowding out spending for several programs while inflation and exchange rate variations affected the value of funds allocated to the MOHCC. MoHCC spending on the communicable disease sub-program increased from less than 1 percent during

the period covering 2017 to 2019 to 22 percent in 2020. However, since overall MoHCC spending in 2020 declined in both current US dollar and real ZWL terms, the increase in spending on the communicable diseases sub-program required both a relative and absolute reduction in spending on other sub-programs. For example, during the same reference period, hospitals' spending share fell from an average of 74 percent to 46 percent. Spending shares of several other subprograms such as Policy Planning and Coordination, Human Resources for the Policy and Administration Program, Monitoring and Evaluation, Research and Development, and Family Health also decreased. While the share of rural health centers and community level care was maintained at 10 percent, its funding in nominal US dollar terms decreased from US$19 million to US$14 million. There is evidence that prioritizing high impact interventions, specifically increasing spending on primary health centers and community-based interventions could significantly improve the number of DALYs averted.

Strategic planning and budgeting processes are not well aligned with actual spending. Allocative efficiency requires that spending is closely related to budgets and that budgets are based on an informed strategic planning and prioritization process. The link between these essential stages in the budget cycle could further be strengthened. Key sector planning documents are not always fully aligned with national budgeting processes nor have the expected sources of funding for these plans been consistently specified. This weakens the link between the longer-term strategic plans and the government's annual budget preparation process. There is also a divergence between the sector's approved budgets and actual spending. When there are reallocations during execution away from identified priorities in the budget, this can significantly reduce allocative efficiency and capacity for strategic decision making.

Coordination and consolidation of health spending

Zimbabwe's health sector is fragmented leading to inefficiencies. Facilities draw on multiple financing sources to cover their operational costs. This includes budget allocations from the MOHCC, drawing on user fees, insurance payments, and payments from DPs directly to facilities such as the RBF. As these sources have separate planning, budgeting, accounting and reporting requirements, fragmentation places an undue administrative burden on facility managers who have to manage different reporting and accounting requirements that may pull them away from their medical duties and increase management costs. It also leads to inefficiencies and complicates planning and decision making.
The MoHCC's 2019 national resource mapping exercise estimated that administration expenses as a share of total funding for health had increased from 14 percent in 2016 to 21 percent in 2019, suggesting that funding fragmentation has increased during this period.

DP spending is fragmented, volatile and insufficiently coordinated with government spending. All DP spending is effectively off-budget. DP spending has also become increasingly volatile and difficult to predict with government projections differing by up to 40 percent from what is provided in practice. While the majority (86 to 96 percent) of DP spending is managed within only three programs, the remainder is highly fragmented, with many different DPs providing relatively small amounts of separately managed financing. There is also emerging evidence that DP funding is becoming increasingly fragmented due to some gaps (e.g., insufficient centralized tracking of activities and financing) in the coordination of the COVID-19 response despite functional coordination structures in place. These issues increase the overall administration costs in the sector as well as making it harder to optimally allocate resources to maximize overall health sector performance.

Financing and Management of Human Resources for Health

The lack of integration between funding sources has created imbalances in the prioritization of HRH funding. Until 2018 MoHCC strongly prioritized employment costs, which accounted for an average 84 percent of its budget. The government actively pursued a policy of re-balancing its budget away from employment costs in line with recommendations from efficiency analyses such as the last health sector PER. This was expected to provide greater flexibility on how resources can be utilized. However, this re-prioritization coincided with a major fall in the real value of government spending, while DP spending (of which only 7 percent was for health worker payments) has remained relatively constant. This has led to a very rapid and unintended shift in the relative funding of health worker payments (falling from 41 percent of total MoHCC and DP spending in 2017 to just 19 percent in 2019). Given increasing issues of absenteeism, retention, and motivation, it is likely that this sudden shift will have created inefficiencies for overall health sector performance.

Vacancy rates have decreased but remain high, in particular for specialist positions and in rural areas, while attrition rates have increased especially among nurses, affecting health sector performance. The reported vacancy rate for all public sector health workers decreased from 15 percent in 2018 (having averaged 17.5 percent over the period 2014 to 2017) to 13 percent from May to August 2021 [2]. The number of nurses leaving their posts, however, increased from 298 in 2018 to 576 in 2020 to 1176 in the first seven months of 2021. Similarly, the number of doctors who left their posts increased from 45 in 2018 to 47 in 2020 to 57 within the first seven months of 2021. Vacancy rates are generally higher in rural areas, where there are fewer opportunities for earning potential. The increasing number of nurses and doctors leaving their posts, are likely to affect continuity and quality of service delivery. The vacancy rates for

2 MOHCC. Staff Returns Report. August 2021.

specialist positions decreased from 74 percent in 2014 to 46 percent in 2018 but remain relatively high although the MOHCC reports “little outflow” of specialists in 2021. For medical imaging and therapeutic equipment operators, the vacancy rate remained close to 50 percent from 2009 through to 2018. Shortages of staff in such specific positions are likely to reduce the overall efficiency of the sector; for example, without specialist equipment operators, spending on related medical equipment is likely to be largely ineffective.

Pharmaceutical Procurement

Progress is being made in consolidating the sector’s pharmaceutical purchasing pools into one, which will increase the potential for the sector to negotiate better prices, but there is still scope for improvement. The mandate for buying, storing and distributing pharmaceutical products rests with the parastatal NatPharm. Having one dominant agency for pharmaceutical procurement strengthens the government’s negotiating power and can reduce inefficiencies from the duplication of purchasing roles across the sector. DP programs in particular have made significant efforts to centralize procurement and supply chain management through NatPharm. There remains scope for further consolidation. Furthermore, efficiency gains can be realized by addressing concerns raised by a recent NatPharm audit report.

The domestic pharmaceutical industry has limited production capacity, which means that Zimbabwe is heavily reliant on imports. Local companies supply less than 2 percent of pharmaceutical requirements in the public sector. This is significantly less than 40 percent in 2000 and well below the 30 percent estimated capacity. Importing from overseas can be expensive and lengthen the timeframe for securing products. This makes it harder to project needs and then to manage orders, storage, and distribution. This can result in either understocked or expired commodities and can lead households and facilities to use counterfeit and unregistered medicines instead.

Efficiency and effectiveness of health service delivery units

Hospital services dominate government health spending and there is scope for improving their efficiency. Hospitals accounted for an average 74 percent of MoHCC spending from 2017 to 2019. However, hospital capacity is under-used, with bed occupancy rates just 29 percent in provincial hospitals, while majority of maternity admissions in central hospitals were comprised of normal deliveries which do not require specialist care. Strengthening the referral system

offers an opportunity to improve efficiency. The absence of a defined package of essential services beyond district level of care, may mean that the most cost-effective services are not being prioritized in hospitals. The MoHCC is concerned with having packages for the higher levels of care while capacitating lower levels to minimize people seeking care directly at central and provincial hospital levels.

In 2017 the Ministry of Health and Child Care (MoHCC) adopted Program Based Budgeting (PBB) which offers opportunities for linking health spending to outcomes including RMNCH. The MoHCC has defined four programs; Policy and Administration; (2) Public Health; (3) Primary Care and Hospital Care; and (4) Bio-medical Engineering, Bio-medical Sciences, Pharmaceuticals - each with a number of sub-programs. RMNCH-N spending is relevant to a number of different sub-programs, in particular those for the Primary Health Care and Hospital Care programs. The structure of these programs is logical relative to how the MoHCC manages its budget. While this is excellent progress in terms of how the budget is formulated, it does not yet clearly stipulate how this will address RMNCH-N objectives. A stronger link between spending and RMNCH-N outcomes though the PBB approach is needed with indicators and targets to track progress.

Spending on RMNCH services has led to increased coverage, yet progress in outcomes is lagging. Government and DP spending on RMNCH have increased the availability and delivery of connected services. For example, between 2015 and 2019, institutional deliveries increased from 77 percent of all births to 86 percent, and skilled attendance at births increased from 78 percent to 86 percent. Progress has continued in terms of some health outcomes, but neonatal mortality actually rose from 29 to 31 per 1,000 live births. The contrast between the high levels of coverage with slow progress suggests there remain opportunities for strengthening effectiveness of interventions with the sectoral aim of increasing service quality also being accompanied by an adequate increase in funding.

The use of results-based financing (RBF) has increased efficiency at the facility level by strengthening the link between payments and specific outputs, but there is scope for a broader roll-out of the mechanism. An RBF modality is being implemented in the Zimbabwe health sector since 2011. It was scaled up to all rural health facilities in 2014. This approach involves reimbursing health facilities based on their performance in the delivery of a package of maternal and child health services. A 2014 impact evaluation of the RBF initiative demonstrated the potential for significant efficiency gains through its implementation. The complexity of the modality which includes verification and counter-verification of results has meant that overhead costs have been relatively high. However, these overhead costs have been reduced over time (for example, with the use of risk-based verification) and are expected to further decrease with a greater institutionalization of the approach.

Overall sector performance management and accountability

There is scope for strengthening systems for accountability and internal control. The mid-term review of the National Health Strategy 2016-2020 highlighted gaps in the sector's accountability. For example, it found that data were missing for many performance indicators, and that there was a lack of clarity on lines of responsibilities for key objectives. National audit reports also found scope for implementing stronger internal controls to reduce waste and corruption in government health spending. MoHCC spending on the Monitoring and Evaluation and Internal Audit sub-programs has historically been low. Both sub-programs' budget allocations remained below 0.01 percent of the MOHCC's budget from 2017 to 2020. In 2020 resource availability for these activities have been even more scarce given multiple Covid-19 related spending pressures.

The Program Based Budgeting (PBB) reform creates an opportunity to monitor, manage and improve performance on specific programs relative to spending inputs. The health sector adopted the national PBB reform in 2017. Despite formidable obstacles to the successful implementation of PBB, the government has showed remarkable determination in the roll out of PBB, and some positive effects have already been attributed to the PBB reform, such as improved coordination, transparency, and outcome orientation of resource allocation. However, up until now, the PBB reform has only had a limited impact on costing, accountability, and the use of performance information to increase the efficiency and effectiveness of the sector. Implementation issues include: (i) Refining the operational processes of PBB is ongoing; (ii) The program structure has not been completely formalized below the provincial level – in particular the reform has not yet fully cascaded down to the service delivery level in terms of change management and training; (iii) DP spending is not aligned with the program-based structure. If the implementation issues are addressed and macroeconomic circumstances stabilize, PBB can be expected in the medium term to strengthen budget credibility, accountability, and transparency and to improve service delivery in the health sector.

Private Insurance Financing

There remains insufficient regulatory oversight or structured support to insurance financing. Spending by private insurance companies is estimated to have contributed between 14 and 24 percent of total health expenditures in Zimbabwe over the period 2015 to 2018. This compares to an average of 3 to 4 percent found in a study of 39 sub-Saharan African countries. However, there is no regulatory body for the private health insurance sector. Greater regulatory oversight could improve efficiency through addressing conflicts of interest where insurers both finance and provide health care leading to over-provision of services. It could also inform greater consolidation of the market, given the

major proliferation of small providers. This proliferation may be sub-optimal in terms of additional management costs and reduced opportunities for risk cross-subsidization relative to any efficiency gains from competitive pricing pressure. There is also limited support for reducing the private sector's transaction costs related to licensing, registration, certification, and importation. Inefficiencies in the private market will be reflected both in increased costs for patients and reduced quantity and quality of care.

Equity

Aspects of government health spending have an unintended effect of benefitting the rich more than the poor and there is no explicit or transparent rationale for allocating resources across provinces. Access to outpatient care is equitably distributed among socioeconomic groups, but inpatient care mainly benefits richer households. Overall government health expenditure is likely to be regressive because it prioritizes civil servants' private health insurance (who, as formal sector employees, are likely not in the poorest socioeconomic groups) and hospital services (which have been shown to be disproportionately used by richer households) over rural health centers and community care. The data for 2019-2020 does suggest, however, that the relative prioritization of civil servants' private health insurance has decreased. Geographically, the cities of Harare and Bulawayo benefit most from government spending on health, while there is no clear rationale for the different levels of funding for other provinces (by DPs and government).

Targeted health financing mechanisms for low income groups are not efficient and effective. The main formal mechanism in place for supporting poor and vulnerable members of society is the Assisted Medical Treatment Order (AMTO). This is administered by the MoPSLSW but is not adequately covering its target population. The AMTO has faced bureaucratic constraints, making it challenging for facilities to access the support (particularly given the additional issue of non-disbursement of claims) and potential beneficiaries' insufficient awareness of the existence of the support. There could be opportunities to address this gap by exploring alternative approaches, drawing on lessons from the Urban Voucher Scheme and Rural RBF. The Urban Voucher scheme, for example, provides more reliable payments to facilities using a quality-based RBF approach as well as using Community Based Organizations to raise awareness for beneficiaries.

Recommendations

The following recommendations are proposed to address the issues identified in this report and thus increase the efficiency, effectiveness, and equity of spending in the health sector. These recommendations are grouped into actions that are feasible to implement in the short-term ("Quick Wins", which are assumed to be achievable by the end of 2022) and others that may require more time ("Longer-Term", assumed to be achievable by the end of 2026).

R1

Recommendation 1

Improve the coordination and consolidation of DP and government resources.

QW1

Quick win 1 – Lead Responsibility: MoHCC – Leverage Health Sector Coordination Framework to strengthen alignment of partners in the health sector response. MOHCC has made notable strides to strengthen coordination with the establishment of a Health Sector Coordination Framework (HSCF) in 2020. The HSCF, through its Health Partners' Coordination and Inter-Sectoral Coordination platforms, has potential to accelerate the alignment of DP and other stakeholder plans and financing with MOHCC Annual Plans and Budget. The HSCF's value could be optimised by systematic engagement between MOHCC and actors in the sector with clear and timed entry points for consultation, inputs and decision making. Regular frequent interaction through the platforms, including Technical Working Groups, will allow for traction on recommended actions. In addition, structured inputs (e.g., through designed templates) from partners regarding planned funding and intervention areas to be supported in a specific period would complement the routine Annual Resource Mapping and strengthen efforts to progressively move towards virtual pooling of resources.

QW2

Quick win 2 – Lead Responsibility: MoHCC - Improve the already extensive annual resource mapping exercises to have a more direct influence on budgeting decisions. Improvements could include: (i) reporting on actions taken to achieve previous recommendations; (ii) identifying any blockages that prevented previous recommendations from being implemented; (iii) classifying as much spending as possible in terms of the MoHCC's programs and sub-programs; (iv) ensuring that the release of the resource mapping reports is timed to directly benefit the government budget preparation cycle; (v) capturing government health spending beyond just the MoHCC (including other ministries and full local council data); and (vi) incorporating greater sensitivity analysis on exchange rates and the inflation-adjusted values of funding to examine more closely the relative contributions of different funding sources.

LT

Longer-term – Lead Responsibility: DPs - Increasingly integrate DP and government funding pools. This would coordinate resources and reduce the burden of management costs across the health system. The lowest hanging fruit in this respect would be to start by increasing the consolidation of DP funding. In the short term, this could include bringing more DPs within the pooled multi-DP Health Development Fund as well as reducing the extent to which contributors run additional parallel bilateral programs. In the longer term, pooled DP funding could be increasingly integrated within the government's budget processes. With the new program budget structure there is an inherent tension, as government allocates funds by level of care and DPs seek to allocate by disease specific intervention or function. Full recognition of how budgetary programs map to health system functions and disease can be facilitated through indicators and targets. Instead of continuing to pursue vertical programs, DPs can instead help finance programs that contribute to indicators of mutual interest. For example, while it can be difficult to finance RMCH services directly, DPs could finance the primary care sub-program instead and advocate for the inclusion of ambitious RMCH indicators in the program structure.

Where challenges remain for DPs to directly provide their funding through the national treasury, this could take the form of virtual on-budget support. In practice, this would mean that DP funding is planned and executed in line with the government's own budgeting and reporting cycles so it could be reflected both in national budget allocation and, as far as possible, in real-time budget execution report. This can be facilitated, even if the funds themselves remained subject to the DPs' own accountability processes.

R2

Recommendation 2

Take full advantage of the PBB reform to improve performance management and accountability processes.

QW

Quick win – Lead Responsibility: MoHCC –Ensure that roles for program and subprogram managers are well understood and integrate the PBB structure within broader sector planning processes. The PBB design is currently well set up and aligned with government administrative structures. There is now an opportunity to take advantage of this reform to strengthen how performance is managed within the sector such that efficiency and effectiveness are maximized. A critical first step would be to address strengthening the role of budget committees particularly at local levels. Full roll-out of PBB to the subnational levels is still in process as the required training and change management which would support more efficient and effective implementation is still ongoing. Alongside this for strategic planning to properly link to actual spending the PBB structure needs to be fully integrated into sector planning tools. It is notable that recent efforts have been made to align the 2021-2025 National Health Strategy costing framework with the structure of the government's budget.

It is recommended that the Annual Resource Mapping exercises assess actual spending using the same structure. Furthermore, it is important to clearly establish the link between sub-programs, hospitals to health centers.

LT **Longer term – Lead Responsibility: MoHCC – Use the PBB structure as a foundation for M&E processes such that program managers are accountable for performance.** The extensive M&E framework developed by the 2021-2025 National Health Strategy can be integrated with the PBB structure to strengthen how indicators and targets for each program and sub-program are defined such that those in charge of delivering results with a specific budget allocation can be better held to account for how efficient and effective their performance is. It is critical that budget allocations for M&E processes be increased to support this important function.

R3 Recommendation 3

Strengthen internal control functions to minimize inefficiency and maximize the effectiveness of health spending.

QW **Quick win – Lead Responsibility: MoFED and MoHCC - Increase the prioritization of the audit function and monitoring.** Audit is critical for regular course correction that supports efficiency in operations. Extending the depth, scope and frequency of audits will require commensurate budget allocations but are likely to lead to significant efficiency and accountability gains. Specifically, it is critical that the MOHCC internal audit function be sufficiently resourced to allow for course correction on an ongoing basis. It would also be critical to strengthen and expand the use of electronic management systems to systematically track resource allocation, spending and performance.

LT **Longer term – Lead Responsibility: MoFED – Ensure that health spending by local councils is systematically captured in the central government's PFM systems.** Spending by local councils has constituted as much as 20 percent of total government spending on health. For effective planning and monitoring of its execution, it is critical that real-time data on this spending is fully available to central decision-makers. This could build on the MoFED's 2020/21 piloting of an online portal for local authorities to enter financial information into the central PFM system.

R4

Recommendation 4

Continually update strategies for improving the efficiency with which existing resources are used, considering lessons learned from the sector's COVID-19 pandemic response.

QW1 **Quick win 1 – Lead Responsibility: MoHCC - Actively target improvements in key efficiency indicators such as bed occupancy, attrition rates, specialist vacancy rates and those reflecting the appropriate use of the referral system.** A core set of indicators capturing aspects of system efficiency is important. Frequent and systematic monitoring of these indicators will allow for more strategic decision making and accountability to efficiency. For areas of insufficient progress specific actions can be taken to incentivize improved performance. It is also important to determine factors behind low bed occupancy rates (e.g., whether they are due to inadequate access by the population and/or whether this is due to shortages of staff and equipment) and whether the private sector faces similar indicators and challenges. Strengthening the referral system also requires work on accreditation of hospitals for specialist services.

QW2 **Quick win 2 – Lead Responsibility: MOHCC – Review critical sector trade-offs and emergency public financial management actions taken in the health sector to respond during the COVID-19 pandemic**. Include an analysis of available data on how spending on the communicable disease sub-program was allocated between different levels of care. Identify resource allocation and public investment management measures to continue and those to be adjusted or rolled back in the short -term and medium-term.

LT **Longer term – Lead Responsibility: MoHCC - Conduct forward looking allocative efficiency analyses to inform funding prioritization decisions.** The 2019 allocative efficiency study found opportunities for major gains in cost-effectiveness through adjusting the health sector's intervention mix based on the current disease burden. Future analyses would need to look at how this disease burden is expected to evolve over time and how sector funding could adjust to optimize its spending. In particular, the sector is likely to need to plan for how it increasingly reallocates resources towards the growing burden from non-communicable diseases.

R5

Recommendation 5

Improve the efficiency and effectiveness of private health spending by strengthening the government's regulation of and support to the private insurance sector.

QW **Quick win – Lead Responsibility: MoHCC - Produce annual reporting on progress towards the objectives set out in the Health Financing Strategy related to the private insurance sector.** This would help to identify and overcome any blockages to progress.

LT **Longer term – Lead Responsibility: MoHCC - Establish a regulatory body for private health insurance sector.** This was set out as an activity in the 2018 Health Financing Strategy and remains an important objective to improve the efficiency and effectiveness of private health spending. Key responsibilities of this body could include: (i) investigating late or non-payment of claims; (ii) regulating potential conflicts of interest when private health insurers both fund and provide health care services; (iii) creating a systematic and consultative price setting mechanism for the payment of health services; (iv) increasing the ease of operating for the private sector by streamlining the transaction costs related to licensing, registration, certification, and importation; and (v) exploring ways to balance concerns of competition and the greater efficiency of larger funding pools.

R6

Recommendation 6

Improve the availability and effectiveness of pre-payment mechanisms for poorer households.

QW **Quick win – Lead Responsibility – MoPSLW and MoHCC - Streamline or replace the AMTO with a more efficient mechanism for helping the poorest to pay their healthcare costs.** A promising alternative that is currently being piloted is the Urban Voucher Scheme. It is important that any mechanism being considered includes the full costs of treatment (including, for example, the cost of travelling to hospital and the cost of drugs) and mechanisms to increase domestic financing.

LT **Longer term – Lead Responsibility – MoFED - Put a higher priority on funding support to poorer households.** Include an equity perspective in determining the optimal balance of funding between the PSMAS and AMTO. An estimated 99 percent of the health expenditures managed by the MoPSLSW are spent on contributions to the PSMAS while only 1 percent is spent on the AMTO. Giving a higher priority in the MoPSLSW budget to the AMTO (or any

successor scheme) would be much more beneficial to the poorest and most vulnerable in Zimbabwe. Noting political economy considerations associated with health insurance provisions for civil services, such a re-balancing of resources may need to be achieved incrementally over time (for example, rather than reducing resources for PSMAS, any marginal increase in resources for the sector could be prioritized for the AMTO).

R7 Recommendation 7

Improve resource allocation formula.

QW **Quick win – Lead Responsibility – MoHCC - Develop criteria that could be used to determine funding amounts for different provinces.** These criteria might include population size, differential needs (such as disease burden or poverty rates), expected cost-effectiveness, or the amount of funding available to provinces from other sources. Even without an explicit resource allocation formula, these criteria could be compared with current actual funding amounts to identify whether any adjustments are needed in the provincial budget allocations. This can be applied for government and DP funding combined and could also be built into the MoHCC's annual resource mapping exercise.

LT **Longer term – Lead Responsibility – MoHCC - Include explicit criteria for allocating resources among provinces in the budget preparation process.** These criteria could be used to establish an explicit formula for determining funding for specific budget lines. Alternatively, the process could be more qualitative, with an assessment of pre-set criteria undertaken to inform actual funding amounts, with the final amounts determined through negotiation and discussion. The decision-making process can be documented as part of the preparation of the budget.

Further analytical work is also recommended. This includes the following:

- **Identify main factors that limit progress on this PER's recommendations and how to overcome them.** A particular focus could be on those recommendations which have been made by previous studies and strategies that have not yet been implemented. For example, the recommendation of this PER to set more explicit rationale for how funding is allocated between provinces was also made by the 2015 PER.

- **Assess what it would take to fully institutionalize RBF.** The government has already shown tremendous ownership of RBF. Going forward it will be important to fully integrate RBF into the PFM structures (including recent PBB reform) rather than maintaining a project-based approach. Analytic work on how specifically this could be facilitated is important.

- **Assess how household spending affects equity, access, and service use.** Private spending makes up an important share of total health spending in Zimbabwe. As purchasing power has declined following macro-fiscal instability so has household spending on health. An important question is how this has affected access to quality services and whether there has been a shift toward public providers due to RBF/ rollout of free health care in primary health care facilities or whether households have foregone seeking health care.

- **Review of pre-payment mechanisms**. Considering the inefficiencies of AMTO for the most vulnerable, a thorough assessment of pre-payment mechanisms in Zimbabwe and how public resources could be used more equitably and more efficiently would be useful.

- **Deep dive into human resource issues.** High inflation in recent years has eroded wages for health workers. While it is widely acknowledged in the sector that remuneration and working conditions – further affected by inflation and COVID-19 -- have contributed to increasing attrition rates since 2019, there are still other aspects such as intrinsic and extrinsic motivators for the health workforce that could be identified through efficient mechanisms such as online surveys. The information obtained through these surveys could be used to refine short to medium term strategies to motivate and retain staff.

- **Study to assess the government's approach to address cross-cutting nutrition issues.** While nutrition is not explicitly an MOHCC mandate, many interventions still relate to the health sector. Approximately one in four children are stunted in Zimbabwe, making addressing nutrition a pressing need given its impact on human capital development. Addressing chronic malnutrition requires a coordinated response and a public financial management system that can measure, track, and monitor nutrition-related resource needs and spending. A study is recommended to assess the government's nutrition response: identifying strengths, challenges, and aspects to strengthen.

Chapter 1
Introduction

This Public Expenditure Review (PER) is an analytical report to assess the evolution of public health expenditures in Zimbabwe from 2015 to 2020. The PER examines the alignment of Zimbabwe's health sector budget to the stated national health priorities and assesses the patterns and trends in public health spending from the perspective of ensuring their efficient, equitable and effective utilization. It builds on the PER conducted in 2015, including an assessment of the extent to which recommendations made in that report have been implemented. The PER also includes an assessment of the Program Based Budgeting (PBB) reform in the health sector and a case study in Harare City. It is intended to highlight issues in public spending on health to inform decisions of the Ministry of Finance and Economic Development (MOFED), the Ministry of Health and Child Care (MOHCC), other government agencies contributing to health sector goals, and development partners.

The period covered by this PER (2015-2020) is characterized by macroeconomic challenges compounded by climatic shocks and the COVID-19 pandemic. These major developments threatened the progress that Zimbabwe was making in several health indicators until 2019. Economic conditions in the country have worsened since 2019, eroding health worker salaries and reducing the availability of key supplies and equipment. The country was also hit by Cyclone Idai in 2019, which was the worst natural disaster in Zimbabwe's history. Furthermore, since the first local COVID-19 case was reported in 2020, the pandemic has resulted in 129,3605 cumulative cases and 4,602 deaths as of September 24 2021, and lockdowns and other measures to minimize the risk of COVID transmission have caused socioeconomic and service delivery challenges.

The PER mainly relies on analysis of existing budget and expenditure data, including spending by development partners. This is complemented by interviews with various stakeholders utilizing semi-structured questions as well as review of literature and various government documents.

The scope of the PER includes broad health financing issues, including analysis of spending patterns and trends before and during COVID-19. To the extent data disaggregation allows, the analysis covers allocations and actual spending on reproductive, maternal, neonatal, and child health services. Analysis of spending patterns also include several other dimensions, including spending on hospitals, rural health centers, and community care. To complement the data analysis, the PER reviews budgeting and resource allocation criteria and processes, together with other institutional and governance aspects that influence health sector spending, particularly in view of Zimbabwe's macroeconomic situation and the COVID-19 pandemic.

The report is structured as follows:

Chapter 1
Introduction

Chapter 2 provides an overview of Zimbabwe's health sector context, describing trends in health outcomes.

Chapter 3 covers trends and patterns in aggregate health spending,

Chapter 4
discusses how the spending is allocated between priorities and the consequences for efficiency and equity,

Chapter 5
discusses the efficiency and effectiveness of health financing systems.

Chapter 6
contains conclusions and recommendations.[3]

3 Annexes include a Harare city case study, an assessment of program-based budgeting reform in the health sector, descriptions of the sector's institutional and governance set-up, health service provision arrangements and fund flow mechanism and a technical annex explaining the assumptions used for estimates of health spending.

Chapter 2
Zimbabwe's Health Sector Context

This chapter presents a descriptive overview of trends in Zimbabwe's health sector outcomes to lay the foundation for the assessments made in subsequent chapters. Further details describing the governance structure, health service provision arrangements and fund flow mechanism for the health sector are set out in an annex.

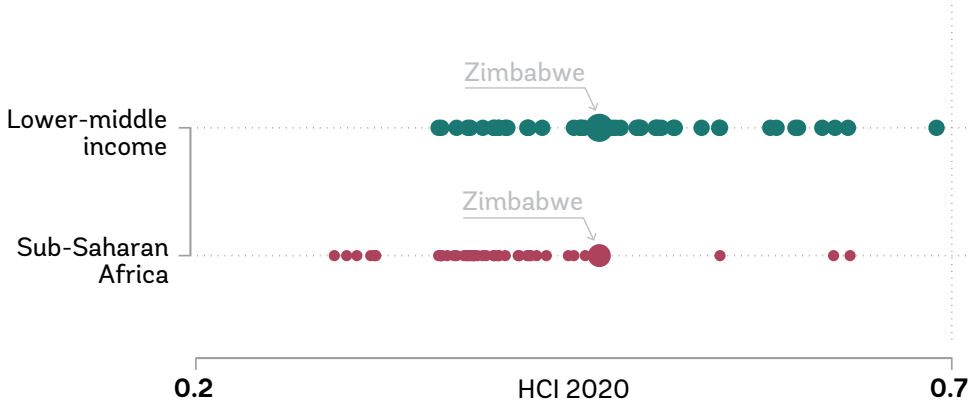
Zimbabwe's Demographic and Health Outcomes

Zimbabwe, a lower-middle-income country in Sub-Saharan Africa, has the fourth highest human capital index (HCI) among countries in its region. A child born in Zimbabwe today will be 47 percent as productive when she grows up as she could be if she had access to a complete education and full health. Among Sub-Saharan Africa countries, the only three countries that perform better than Zimbabwe are Seychelles, Mauritius, and Kenya. There are three health and nutrition related indicators that the HCI captures: survival to age 5, stunting rate among under five children and adult survival rate which captures premature adult mortality. As many as 95 percent of children born in Zimbabwe will survive to the age of 5, but the fraction of 15-year-old children who will survive to age 60 is only 65 percent. The latter is mainly because of health risks that are experienced in adulthood. Zimbabwe's recent progress in improving adult survival has been impressive; it is in the top five percent of countries globally in terms of reducing premature adult mortality.[4] But challenges remain. Its HCI is slightly lower than the average for its income group and 23 percent of children under five are stunted and, hence, at risk of lifelong cognitive and physical limitations.

Figure 2.1

Human Capital Index: 2020

Note: Each solid circle represents a country.



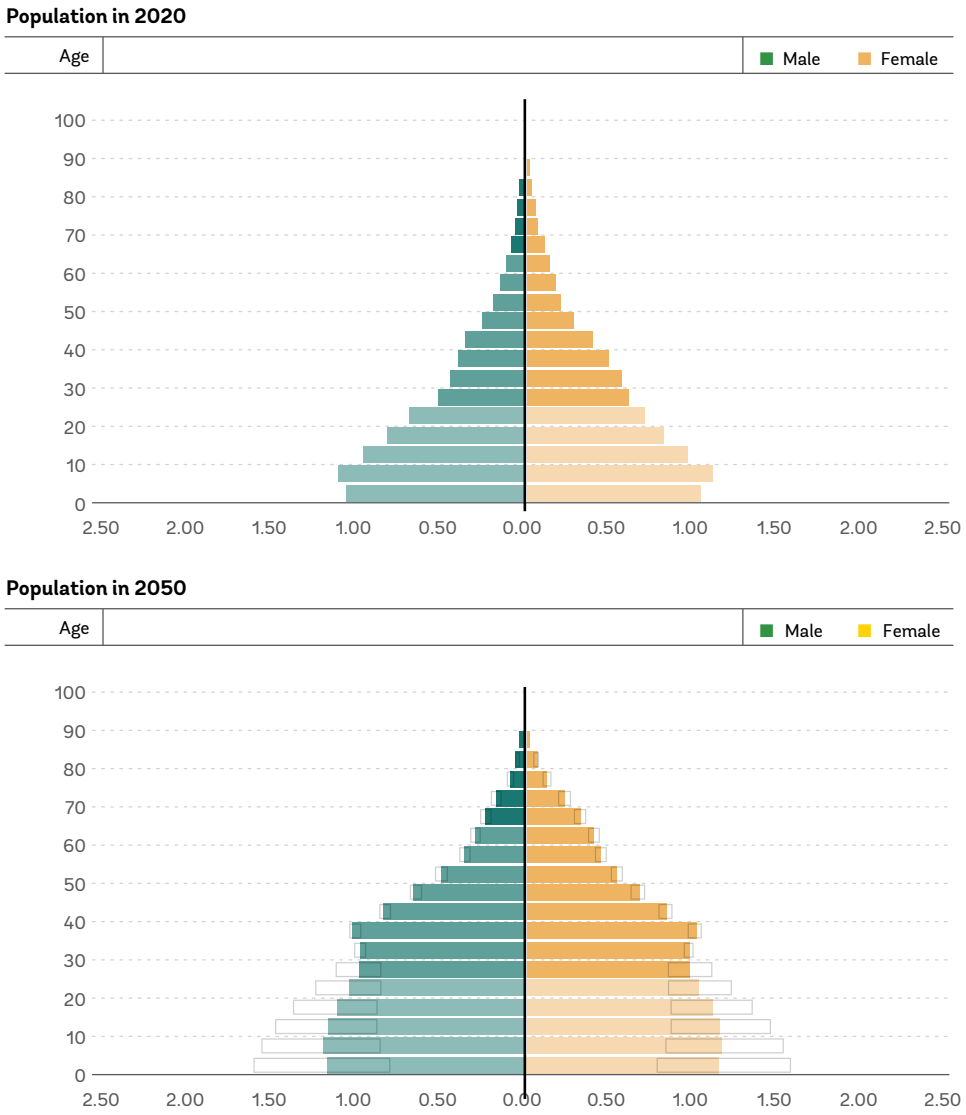
4 https://blogs.worldbank.org/opendata/what-s-ambitious-realistic-target-human-capital-progress

The country has a total population of 14.8 million and a high age dependency ratio, with a consistently young median age of 18 over the last two decades. Its annual rate of population change has been inconsistent, starting at over 3 percent per year from the 1950s until 1990, dropping to less than 1 percent a year between 1995 and 2005 and then slightly increasing to over 1 percent since 2010. The latter trend is partly due to declining mortality rate and increased longevity resulting from increased coverage of anti-retroviral therapy. The population growth rate is projected to stay over 1 percent until 2050, at which point, the population is expected to be close to 24 million (UNPD projection based on medium fertility variant). Its age dependency ratio (as a percentage of the working-age population) was 82 percent in 2019, which is close to the average in Sub-Saharan Africa (79 percent) but much higher than the average for lower-middle-income countries (64 percent). This is, however, projected, to decline to 53 percent in 2050, when the country's working age population, those between the ages of 15 and 64, is expected to reach 15.7 million (nearly double from 8.1 million in 2020).[5]

Figure 2.2

Total Population by Age Group and Sex, 2020 and 2050 Projection

Source: Population pyramids are based on medium variant of the 2019 edition of the World Population Prospects by UN Population Division.



5 United Nations Department of Economic and Social Affairs, *World Population Prospects 2019 Volume II: Demographic Profiles*, (United Nations New York, 2019), 1210-3.

The total fertility rate in Zimbabwe has been declining over the last decade, following a period of slight increase in the decade preceding that. The rate declined from 4.0 in 2010 to 3.5 in 2019. It is projected to continue to decline to about 2.4 by 2050.[6] While the mean childbearing age has remained constant at around 28 years old over the last decade, teenage pregnancy continues to be a social and health issue, with early motherhood taking a toll on the health of both mother and child.[7] In 2018, there were 83 births per 1,000 adolescent women aged 15 to 19, despite contraceptive use (any method) by females aged 15 to 49 being significantly higher (67 percent) than the regional average (32 percent).

The country's maternal and child outcomes are better than the average for the region but are worse than the average in its income group; while the trends are in the right direction, the rate of progress is relatively low. In 2019, the infant mortality rate in Zimbabwe was 38 per 1,000 live births, which is lower than the regional average of 45 but higher than the average of 30 for lower-middle-income countries (Figure 2.2)**.** However, its rate of progress in reducing infant mortality rate over the last two decades compares unfavorably with several countries in the region (most notably Rwanda, Malawi, Uganda, Angola, Burundi, and Ethiopia). On average, Zimbabwe reduced its infant mortality rate by 1.7 percent every year between 2000 and 2019, while the best performing African country, Rwanda, reduced its rate by 7.7 percent annually.[8] Although Zimbabwe's maternal mortality rate in 2017 decreased to 458 per 100,000, this was more than double the average for lower-middle-income countries (215) and slightly above the average for the region (452) (Figure 2.3). Zimbabwe's rate of progress in reducing maternal mortality over the last two decades is lower than other countries in the region such as Rwanda, Angola, Mozambique, and Ethiopia. Its MMR decreased by 2.3 percent every year between 2000 and 2020, while the best performing country in the region reduced its MMR at an annual rate of 9.5 percent.

6 United Nations Department of Economic and Social Affairs, World Population Prospects 2019 Volume II: Demographic Profiles, 1210-3.

7 Zimbabwe National Statistics Agency and ICF International, Zimbabwe Demographic and Health Survey 2015: Key Indicators, 9.

8 The calculation of rate of progress is based on non-linear regression model that accounts for the fact that these variables are bounded from above. It is also expressed as a percentage of the level to facilitate comparison between countries starting at different levels (See https://blogs.worldbank.org/opendata/what-s-ambitious-realistic-target-human-capital-progress)

Figure 2.3

Trends in the Infant Mortality Rate, 2000-2019

Source: World Development Indicators, various years (accessed on July 16, 2021)

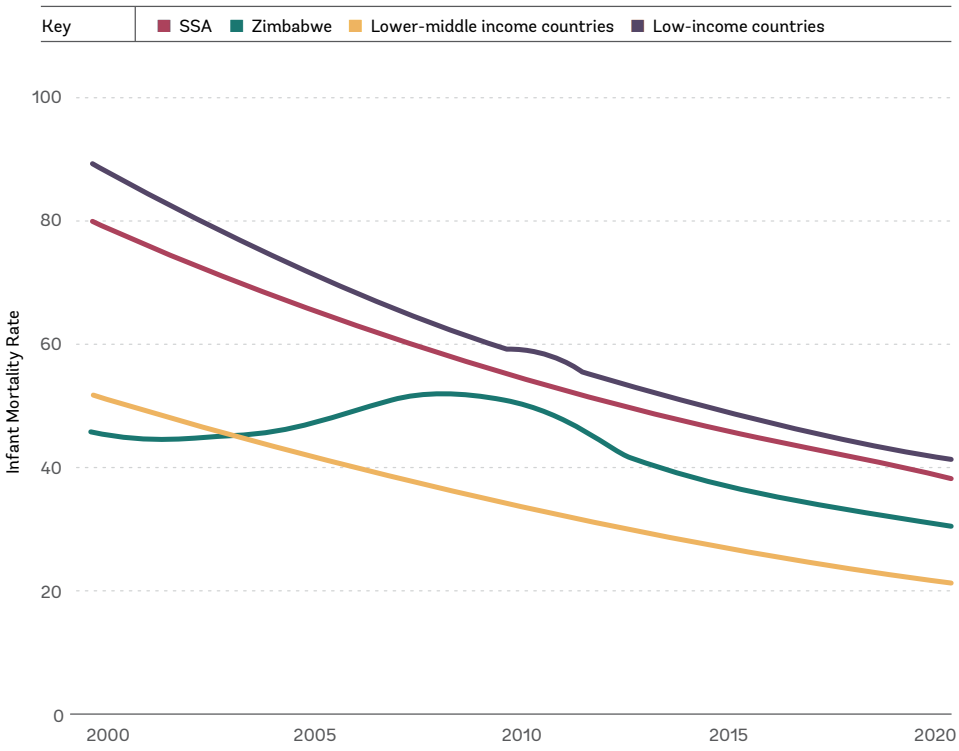
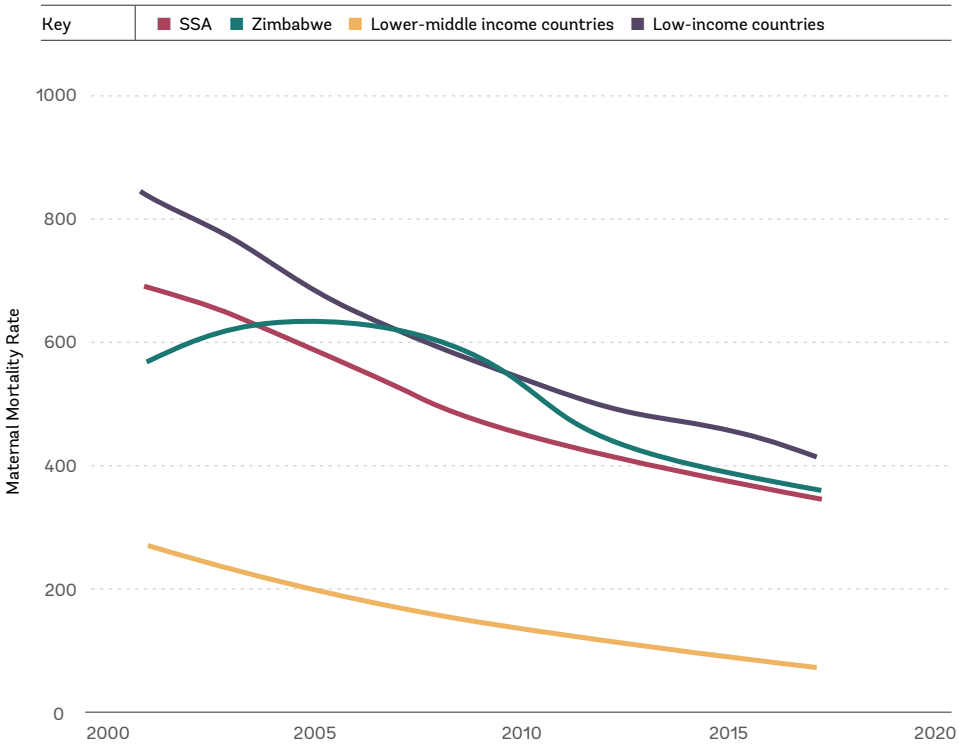


Figure 2.4

Trends in the Maternal Mortality Rate, 2000-2017

Source: World Development Indicators, various years (accessed on July 16, 2021)



Zimbabwe's health system seems to have done well in terms of child immunization rates (with some disparity between rural-urban areas), but acute respiratory infection (ARI), malaria, and dehydration caused by severe diarrhea remain as the major causes of child morbidity and mortality in the country.[9] Malaria is a major public health problem that affects all age groups. The World Health Organization's 2016 report on malaria found that 79 percent of Zimbabwe's population were at risk.[10] In 2019, 90 percent of children aged between 12 and 23 months old were immunized for DPT (diphtheria, pertussis, and tetanus), while 85 percent received the measles vaccine. The share of one-year-old children who received hepatitis B vaccine stands at 90 percent (Table 2.1). By 2015, 73 percent of children between 12 and 23 months were fully vaccinated compared with 10 percent who did not receive any vaccinations. According to a survey of over 11,000 households conducted by the Zimbabwe National Statistics Agency in 2015,[11] the percentage of children who had not received any vaccines was twice as high in rural areas (12 percent) as in urban areas (6 percent).

9 Zimbabwe National Statistics Agency and ICF International, Zimbabwe Demographic and Health Survey 2015: Key Indicators, 22.

10 Mundagowa, P.T. and P.T. Chimberengwa (2020). "Malaria outbreak investigation in a rural area south of Zimbabwe: a case–control study." *Malar J* **19,** 197 (2020). https://doi.org/10.1186/s12936-020-03270-0.

11 Zimbabwe National Statistics Agency and ICF International (2016). *Zimbabwe Demographic and Health Survey 2015: Key Indicators* (Rockville, Maryland, USA: Zimbabwe National Statistics Agency (ZIMSTAT) and ICF International, 2016), 19.

Table 2.1

Key Health, Nutrition, & Population Indicators (latest available data)

Source: WDI various years (accessed on March 3, 2021). Cells are color coded to show whether Zimbabwe's indicator is better (green color) or worse (red color) than the regional or income group average (depending on the column)

Indicator	Zimbabwe	Sub-Saharan average	Lower-middle-income countries average	Year of Zimbabwe data
Infant mortality rate	38.4	45.3	30.4	2019
Under-5 mortality rate	54.6	64.6	39.7	2019
Maternal mortality rate	458	452.5	215.7	2017
Life expectancy at birth	61.2	62.6	68.2	2018
HIV prevalence (% 15-49 population)	12.8	4.7	2.6	2019
TB incidence (per 100,000 population)	199.0	216.6	191.3	2019
Malaria Incidence (per 1,000 population at risk)	51.0	187.2	68.6	2018
Stunting (% under 5 children)	23.5	30.4	25.4	2019
Age dependency ratio	82.3	79.2	64.2	2019
Total fertility rate	3.6	4.4	3.2	2018
Adolescent fertility rate	83.2	96.0	59.2	2018
Percent birth attended by skilled health staff	78.1	67.7	80.7	2015
Percent of pregnant women receiving prenatal care	93.3	86.2	90.5	2015
Contraceptive prevalence, any method (15-49) (%)	66.8	31.7	48.3	2015
Unmet need for contraception (%)	10.4	23.1	18.6	2015
Children 12-23 months old immunized for DPT (%)	90	80.3	85.8	2019
Children 12-23 months old who received measles vaccine (%)	85	77.8	84.6	2019
One-year-old children who received hepatitis B vaccine (%)	90	80.3	85.8	2019

The toll that HIV/AIDS has taken on Zimbabwe's life expectancy is gradually being reversed. In 2018, its life expectancy at birth was 61, which was slightly lower than the Sub-Saharan Africa average (62.5) but almost seven years lower than the average for lower-middle-income countries (68).[12] Life expectancy in Zimbabwe declined between 1980s to early 2000s, mainly due to the HIV/AIDS epidemic, which drove mortality trends during this period.[13] This trend has been reversing since the mid-2000s thanks to the increased prevalence of anti-retroviral

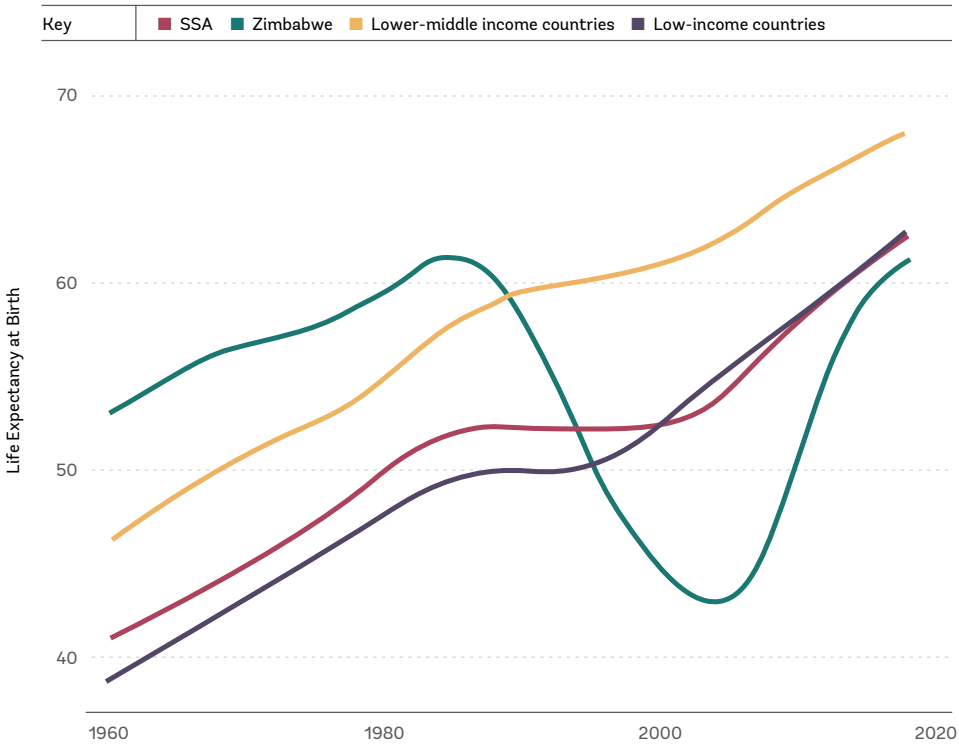
12 World Bank Open Data, "Life expectancy at birth, total."

13 "Zimbabwe 2012 Census Thematic Reports Fact Sheet," UNFPA, accessed Dec. 10, 2020, https://zimbabwe.unfpa.org/sites/default/files/pub-pdf/Zimbabwe%202012%20Census%20Thematic%20Reports%20Fact%20Sheet.pdf.

Figure 2.5

Trends in Life Expectancy at Birth

Source: World Development Indicators, various years (accessed on March 3, 2021)



therapy (ART). These lost decades mean that Zimbabwe's life expectancy in 2018 was only on a par with its life expectancy in the mid-1980s (Figure 2.5)

The estimated number of people newly infected with HIV declined from over 100,000 in the year 2000 to around 40,000 in 2016. The estimated number of deaths from AIDS also sharply decreased from 100,000 in 2000 to close to 20,000 by 2016.[14] This is largely due to the estimated 75 percent coverage of AIDS patients with ART by 2016, as well as to efforts to eliminate the mother-to-child transmission of HIV.[15]

Similar to the rest of Africa, Zimbabwe seems to have been spared with the first wave of the COVID-19 infection, but this changed dramatically around the holiday season at the end of 2020 and winter of 2021. The number of new infections and deaths peaked during the first months of 2021, slowly subsided for a while, and picked up again starting July (Figure 2.6). As of July 16, 2021, a total of 2,418 residents of Zimbabwe have died of COVID-19, and at least 78,872 people are confirmed to have contracted it. These estimates are likely to be underestimated given the challenges the health system has faced in terms of testing and contact tracing. Zimbabwe's total COVID-19 deaths per million

14 "Zimbabwe HIV Country Profile: 2016," World Health Organization, accessed Dec. 10, 2020, https://www.who.int/hiv/data/Country_profile_Zimbabwe.pdf.

15 Ibid

population surpassed the average for the African continent in the first months of 2021 (Figure 2.6). The trends in Zimbabwe seem to mirror that of neighboring South Africa, where the second and third wave also hit very hard.

Figure 2.6

New COVID-19 Cases per Million

Source: Our World in Data

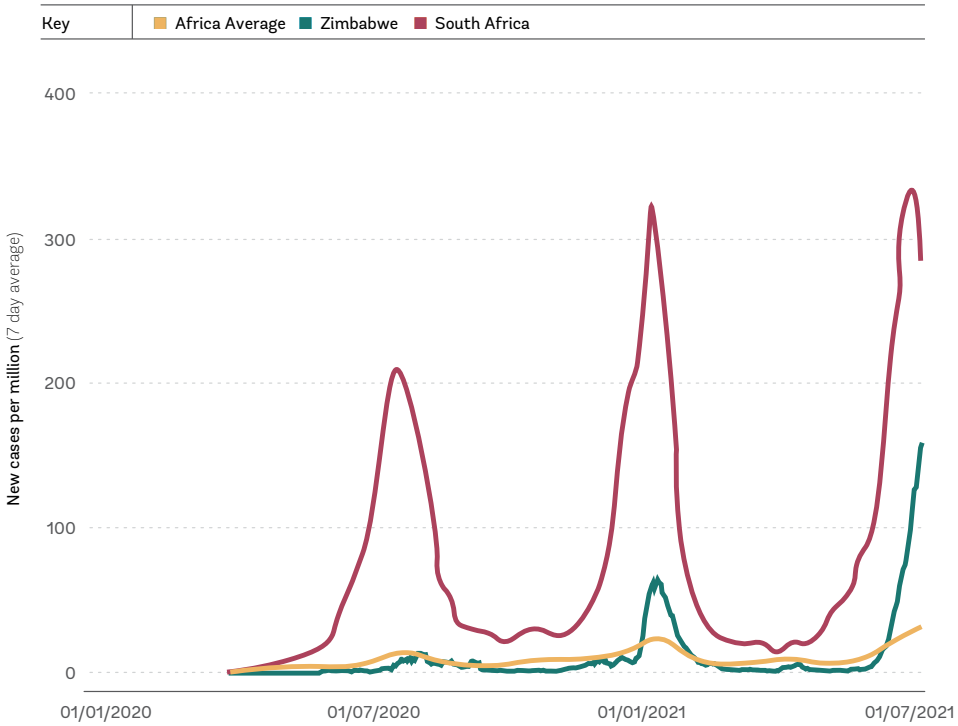
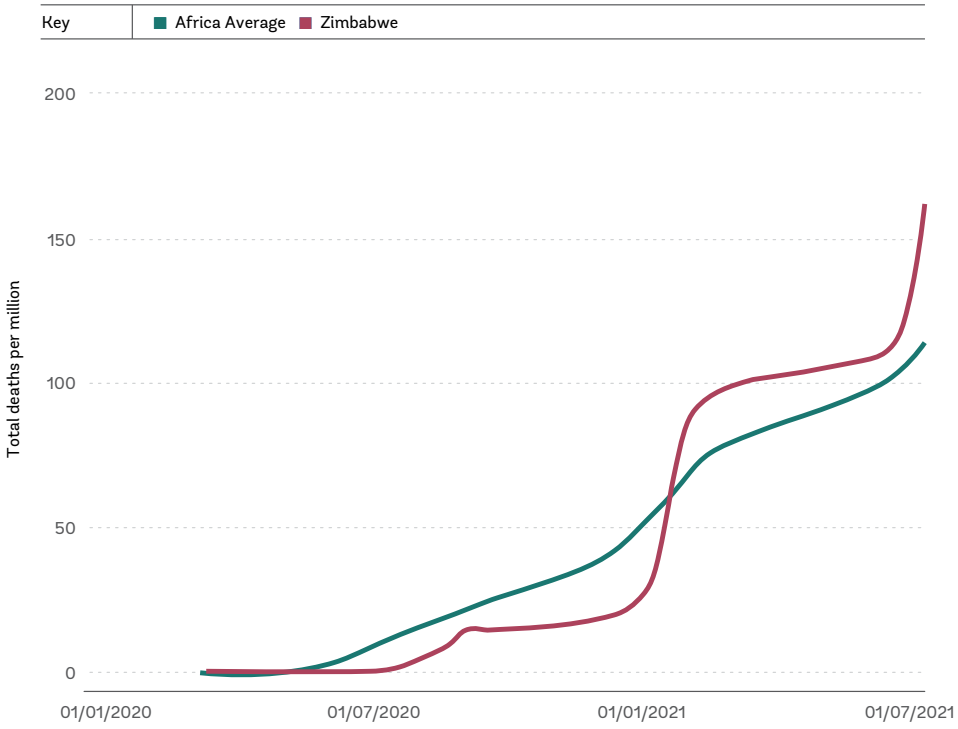


Figure 2.7

Total COVID-19 Deaths per Million

Source: Our World in Data



Communicable, maternal, neonatal and nutritional diseases, (HIV/AIDs, neonatal disorders, lower respiratory infection, tuberculosis and diarrheal diseases) constitute the top five causes of death and disability in 2019. The other five in the top 10 burden of disease include ischemic heart disease, protein energy malnutrition, malaria, stroke and road injuries.[16] While HIV/AIDs, lower respiratory infection and tuberculosis are the main three causes of death, non-communicable diseases such as ischemic heart disease, stroke and diabetes are becoming more significant causes of death, ranking fourth, sixth and eighth in 2019. Behavioral risks such as malnutrition and unsafe sex are the top two risk factors driving deaths and disability, followed by environmental and occupational risk factors such as air pollution and water, sanitation and hygiene related risk factors.

16 http://www.healthdata.org/zimbabwe

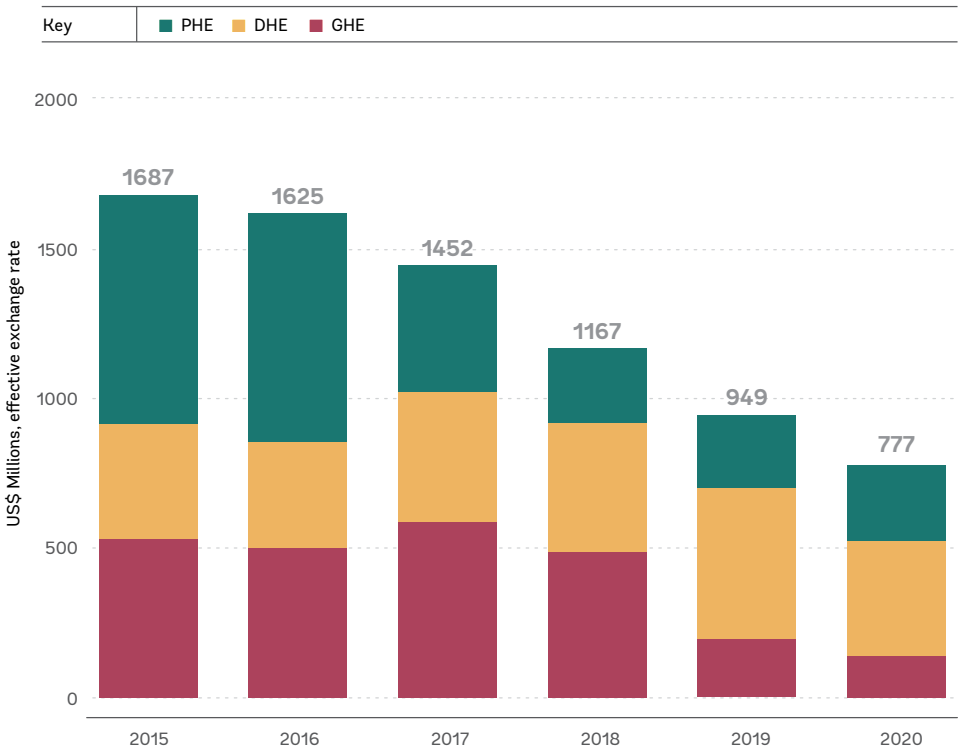
Chapter 3
Trends and Patterns in Aggregate Health Spending

Total Health Expenditure

From 2015 to 2020 there has been both a fall in Total Health Expenditure (THE) and a major shift in its composition, with DP spending becoming more important and both government and private health spending falling. Total health expenditure in 2015 was US$1.7 billion. Of this, 31 percent was contributed by the government, 23 percent by DPs, 24 percent by private corporations, and 22 percent by households.[17] In USD terms the absolute levels of Government Health Expenditure (GHE) and Private Health Expenditure (PHE) are estimated to have fallen considerably from 2015 to 2020, while DP Health Expenditure (DHE) has remained at a similar magnitude. This shift in the composition of THE has been driven by macroeconomic issues, in particular the rapid decline in the value of the local currency (see Annex 6 for further details).

Figure 3.1

Total Health Expenditure, 2015-2020
(US$ millions, Effective Exchange Rate)



Source: GHE see Table A6.2 sources. DHE see Table 3.4 sources. PHE uses NHAs for 2015, 2017 and 2018, and holds figures constant for other years.

Note: THE = total health expenditure. GHE = government health expenditure. DHE = DP health expenditure. PHE = Private Health Expenditure. See Annex 6 for detailed notes for how estimates have been developed using assumptions based on available data.

THE per capita was comparable to the region and LMIC average, but has progressively declined toward the LIC average with potential risks to health outcomes. Performance on many health outcomes was better than the SSA average with comparable levels of THE per capita. By contrast, Zimbabwe's performance for some health outcomes, such as the maternal mortality rate, was considerably worse than many LMICs with comparable THE (see Chapter 2),

17 Private corporation and household spending are taken from the 2015 National Health Accounts (NHA). Spending figures for government and DPs have been updated compared to those used in the 2015 NHA – this means the proportions stated here differ from the 2015 NHA. For example, the GHE analysis in this chapter incorporates spending on PSMAS and a more accurate figure for local council health spending than the 2015 NHA.

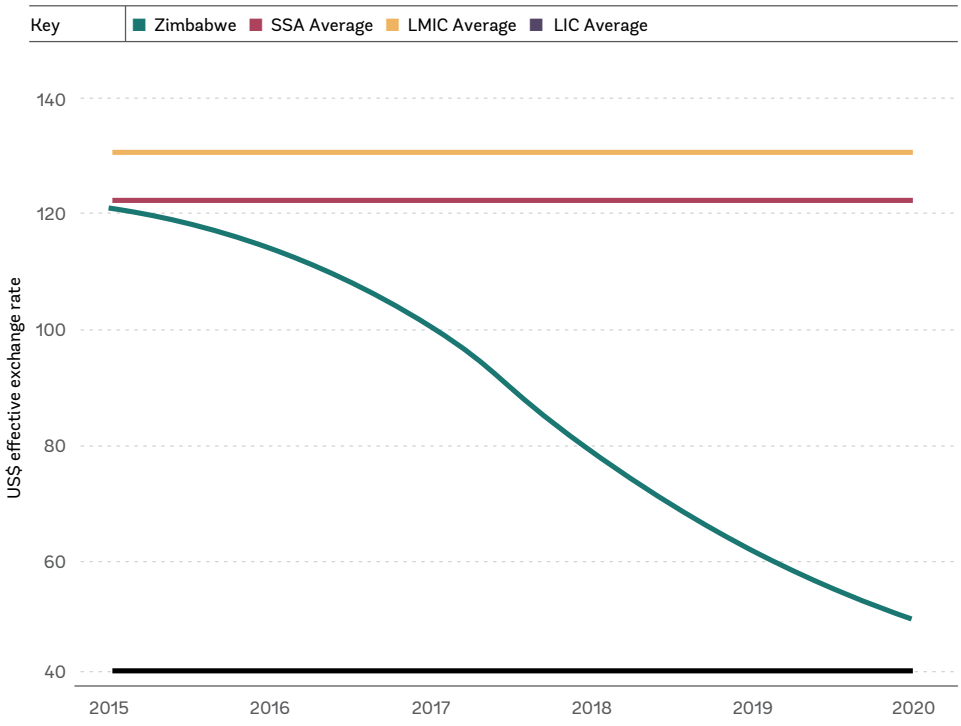
suggesting that there could be opportunities for improving the overall efficiency of health sector spending (which will be the focus of Chapters 4 and 5 of this PER). The significant decline in THE per capita since 2015 will put health outcomes under major negative pressure unless there is a large improvement in efficiency.

Figure 3.2

Total Health Expenditure, per capita (US$, effective exchange rate))

Source: Zimbabwe data from present PER; Country Average data from WHO Global Health Expenditure Database (http://apps.who.int/nha/database/Select/Indicators/en

Note: THE = total health expenditure. WHO comparison figures only consider current spending. Averages for other regions are based on latest available data which includes different years for different countries.



The fall in THE seems to have reduced utilization rates, which in turn is likely to negatively impact health outcomes. Data from the 2019 Poverty, Income, Consumption and Expenditure Surveys (PICES)[18] would suggest that reduced THE may have reduced health utilization rates. The survey found from 2017 to 2019 there had been an increase in the proportion of people who had been sick in the past 30 days but a significant fall in the proportion of people visiting a health center when sick (from 65 percent to 56 percent in rural areas and even more significantly from 62 percent to 48 percent in urban areas). This decline in health use rates compounds the fall already found in the 2017 PICES report.[19] In addition, the mini-PICES conducted in 2019 and 2020 show an increase in the share of persons not seeking treatment due to lack of funds in both rural (from 62 percent to 90 percent) and urban (from 70 percent to 93 percent) areas. Available data from a sample of facilities also show reductions in several reproductive, maternal, and child health and nutrition (RMCHN) services

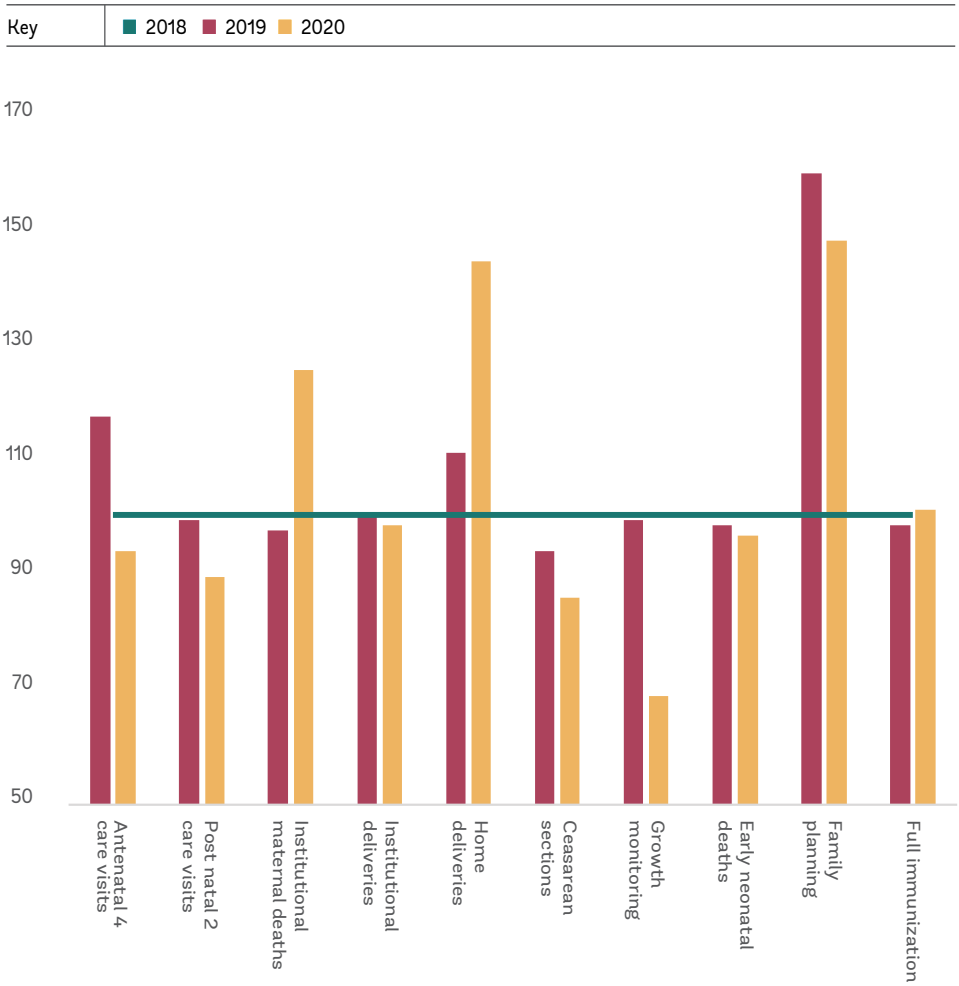
18 Zimbabwe National Statistics Agency (ZIMSTAT), 2019, "Zimbabwe Poverty Update 2017-19".
19 Zimstat (2018) "Poverty, Income, Consumption and Expenditure Survey 2017 Report", December 2018.

(e.g., antenatal care, postnatal care, institutional deliveries, family planning and growth monitoring) and indicators (e.g., institutional maternal deaths and home deliveries) that worsened since 2018.

Figure 3.3

Changes in Key Reproductive, Maternal, Child Health and Nutrition Indicators in 2019 and 2020 Relative to 2018 (Base Year)

Source: World Bank. Zimbabwe Economic Update (2021) based on MOHCC District Health Information Software (DHIS2) data



Private Out-Of-Pocket (OOP) spending in Zimbabwe is far below regional and peer group averages, reflecting high rates of insurance. In per capita terms, OOP health spending in Zimbabwe was US$10.66 in 2018, having fallen from US$24.65 in 2015. This compares to a Sub-Saharan Africa average of US$38 and an LMIC average of US$46. The 2018 figure is even below the LIC average of US$18. As a proportion of total health expenditure, OOP health spending was again substantially below the Sub-Saharan Africa and LMIC averages. Given how dramatically the expenditure level dropped from 2015 to 2018, updated research to verify the latest situation would be warranted. Nonetheless, even the higher 2015 figure was below the Sub-Saharan Africa and LMIC averages, implying that this is a consistent finding. One explanation for this is that Zimbabwe's health spending by private insurance companies is substantially higher than the regional average. A 2016 multi-country analysis found a long-term average contribution of 3 to 4 percent of total health expenditure by voluntary health insurance across 39 Sub-Saharan African

countries[20] compared to the 16 to 25 percent in Zimbabwe. High insurance rates should be positive for both the efficiency and equity of overall health spend, both by enabling greater levels of risk cross-subsidization and through reducing households' likelihood of catastrophic health spending.

Figure 3.4

OOP per capita

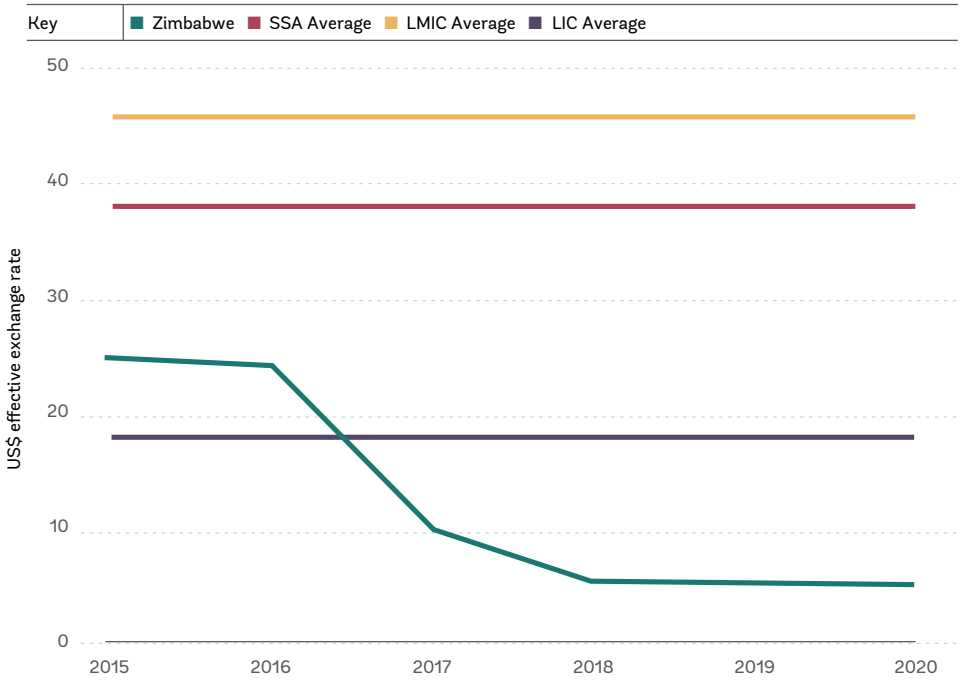
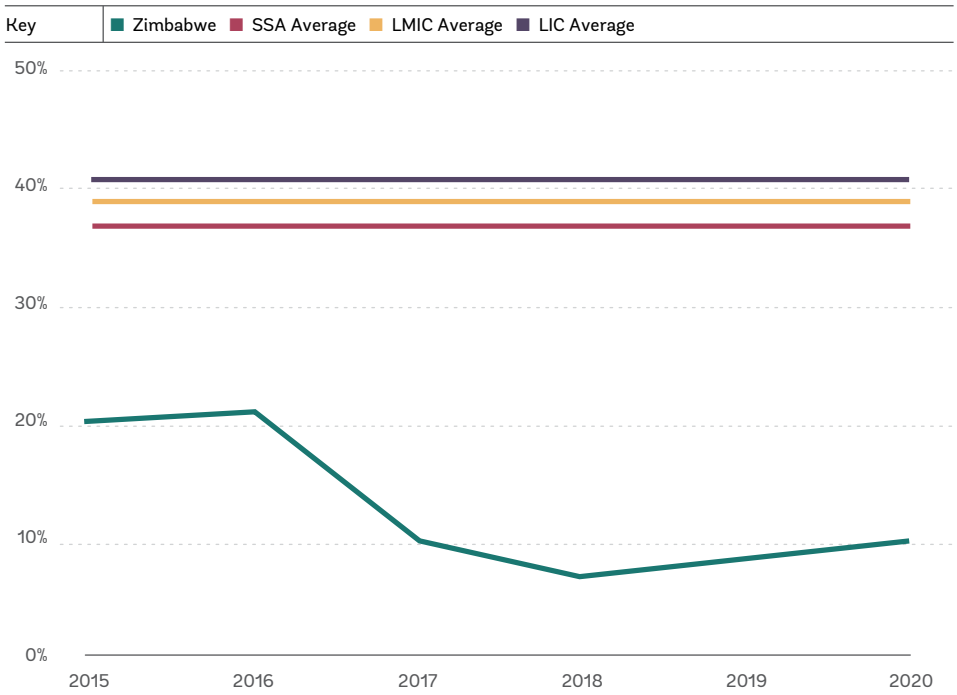


Figure 3.5

OOP as a share of THE



Source: Zimbabwe data from present PER; Country Average data from WHO Global Health Expenditure Database (http://apps.who.int/nha/database/Select/Indicators/en)

Note: THE = total health expenditure. WHO comparison figures only consider current spending. Averages for other regions are based on latest available data which includes different years for different countries.

20 Pettigrew and Matthauer (2016). "Voluntary Health Insurance expenditure in low- and middle-income countries: Exploring trends during 1995-2012 and policy implications for progress towards universal health coverage." International Journal for Equity in Health, 15:67

Government Health Expenditure

The resources for public spending on health come from the central government's general revenue, local government revenue (council revenue), and earmarked taxes in descending order of importance. Public spending includes direct public expenditure on health by central and local governments as well as the central government's contribution to the private health insurance of civil servants. The central government finances the MoHCC health facilities and subsidizes rural council and mission facilities. Local governments finance the primary health care facilities under their jurisdictions using: (i) own revenue collected through property taxes, tariffs, license fees, levies and user fees from the provision of health, education, and water services; (ii) grants to health sector received from independent government statutory bodies; (iii) grants and capital funds for infrastructure development; and (iv) loans from the central government. In addition, there are two major earmarked taxes: (i) an AIDS levy of 3 percent of income tax and (ii) a 5 percent health levy on mobile airtime data. The former goes to the National Aids Trust Fund to coordinate a multisectoral response to HIV/AIDS, while the latter is used by the MoHCC to buy drugs and equipment for hospitals.

From 2010 to 2017, a period of relative macroeconomic stability, public funding for the health sector consistently increased. In 2009, following the advent of hyperinflation and a collapse in the national currency, Zimbabwe adopted a multi-currency system, and the national budget became denominated in US dollar terms. During the period 2010 to 2017, average inflation was just 1 percent with a range of only -2.4 percent to +3.7 percent. This period of relative stability provided the backdrop for a significant increase in public funding to the health sector. Overall Government Health Expenditure (GHE) is estimated to have more than doubled from US$246 million in 2010 to US$589 million in 2017.

In 2018, Zimbabwe's period of relative macroeconomic stability came to an end with significant negative consequences for health sector financing. US dollar shortages from 2015 onwards created increasing macroeconomic challenges, which ultimately culminated in the reintroduction of the Zimbabwe dollar (ZWL) and a huge increase in domestic inflation (over 250% in 2019 and over 550% in 2020).[21] In 2019 the consequences of macroeconomic instability on government health spending significantly worsened, while in 2020 this instability was compounded by a further government income shock as a result of the Covid-19 pandemic. Per capita GHE in 2019 in US$ terms (using the effective exchange rate) fell to below half of its 2012-2017 average.[22] This reduction in financing has created significant challenges for the sector, particularly in terms of its ability to pay for medicines, equipment and supplies, which are predominantly

21 ZimStat (2021). April 2021 CPI Report.
22 See Technical Annex 6 for more details on the difference between the official and effective exchange rates.

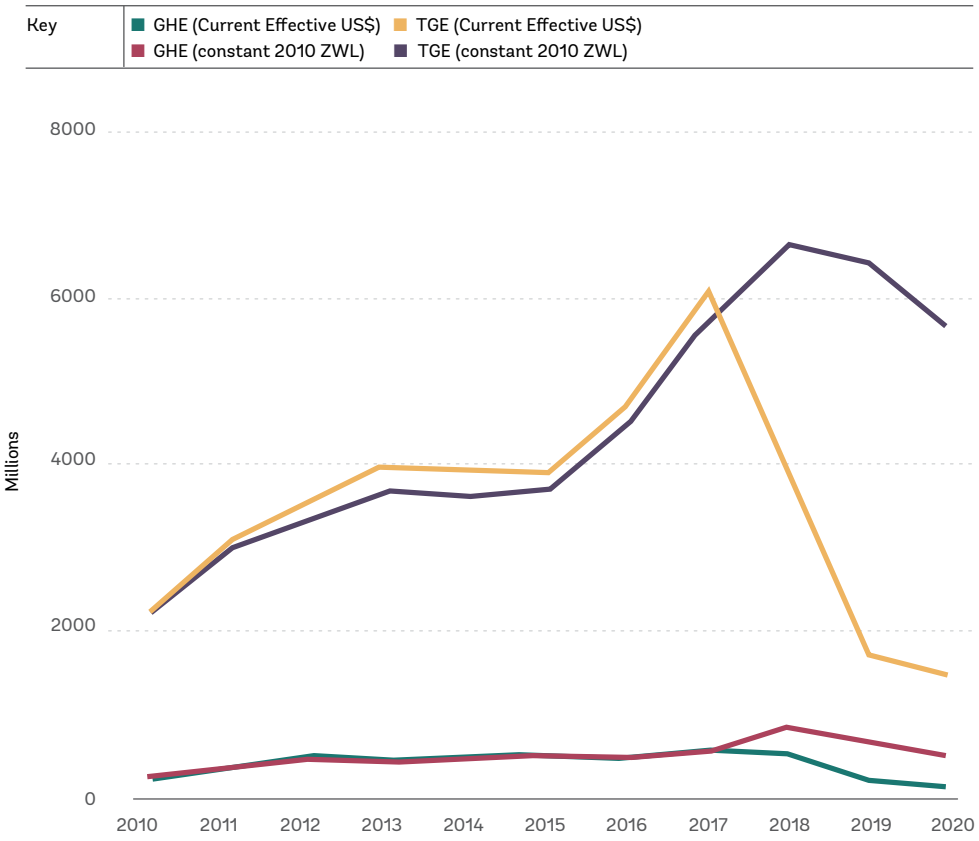
imported. Nonetheless, it is worth noting that even in 2019 the GHE per capita for Zimbabwe remained marginally above some of its regional peers (see Table 3.2).

Figure 3.6

GHE and TGE in effective US$ and constant ZWL terms

Source: See Annex 6.

Notes: GHE = government health expenditure. TGE = total government expenditure. See Annex 6 for full notes on calculations. Note effective exchange rate is proxied by the Real Time Gross Settlement (RTGS) rate for electronic transfers



The main cause of the drop in public health spending since 2019 has been the weakening of the government's income position rather than a relative de-prioritization of the sector. Overall, government health spending as a proportion of total government expenditure averaged 10 percent from 2010 to 2018. Estimates for overall government health spending in 2019 and 2020 are not fully reliable because of a lack of available data for entities other than the MoHCC. MoHCC spending alone has consistently averaged close to 7 percent of total government expenditure over the past decade. In 2019, the MoHCC's proportion of total government spending was only marginally lower than the longer-term average at 6 percent in annual nominal ZWL amounts. However, the MoHCC's spending was executed earlier in the year on average than overall government spending, and with rapid depreciation and high monthly rates of inflation, its effective proportion of total government spending was significantly higher both in US dollar terms at the effective exchange rate (7 percent) and in constant ZWL terms (6.5 percent). This confirms that the major reduction in government health expenditure in absolute terms in 2019 was principally the result of the fall in its income position as opposed to a de-prioritization of the health sector.

Table 3.1 Comparing Government Health Expenditure in Zimbabwe and Other Countries in the Africa Region

Source: Tanzania 2020 PER and author's further review of other health PERs in Sub-Saharan Africa.

Notes: GHE = government health expenditure. TGE = total government expenditure. See Annex 6 for full notes on calculations. Note effective exchange rate is proxied by the Real Time Gross Settlement (RTGS) rate for electronic transfers

Country	GHE as share of GDP	GHE as share of TGE	GHE per capita (US$)	Source
Zimbabwe 2015-17	2.4	9.5	$38	PER 2022
Zimbabwe 2019	1.6	9.5	$13[a/]	PER 2022
Tanzania 2017	2.5	6.1	$11.6	PER 2020
Kenya 2011/12	1.8	6.5	$12	PER 2014
Lesotho 2014	8.1	13.1	NA	PER 2017
Angola 2015	1.5	5.6	NA	PER 2017
Namibia 2017/18	5.3	14.5	NA	PER 2019
Seychelles 2016	3.6	10.3	$590	PER 2018

There are early indications that an improved macroeconomic climate in 2021 will improve the public financing of the health sector. Monthly inflation averaged over 20 percent in the first seven months of 2020, peaking in in July 2020 at 35.5 percent at which point year on year inflation had reached 837.5 percent.[23] Since that peak there has been consistent progress in reducing the inflation rate, with the monthly rate averaging 4.8 percent in the remaining months of 2020 and 3.2 percent in the first four months of 2021.[24] Following declines of real GDP by 6 percent in 2019 and 4 percent in 2020, the MoFED projects a growth rate of 7.5 percent in 2021.[25] There is a big intended increase in the budget allocation for the health sector, with the MoHCC allocated 12.7 percent of the total 2021 budget. If this spending allocation is achieved in the context of greater government revenue with a more stable macroeconomic context then the financing for the health sector will substantially increase in 2021 compared to 2019 and 2020.

23 ZimStat (2021) April 2021 Consumer Price Index report.
24 ZimStat (2021) April 2021 Consumer Price Index report.
25 MoFED (2021) "Economic and Fiscal Report for Year 2020, Annual Budget Review 2020", May 2021.

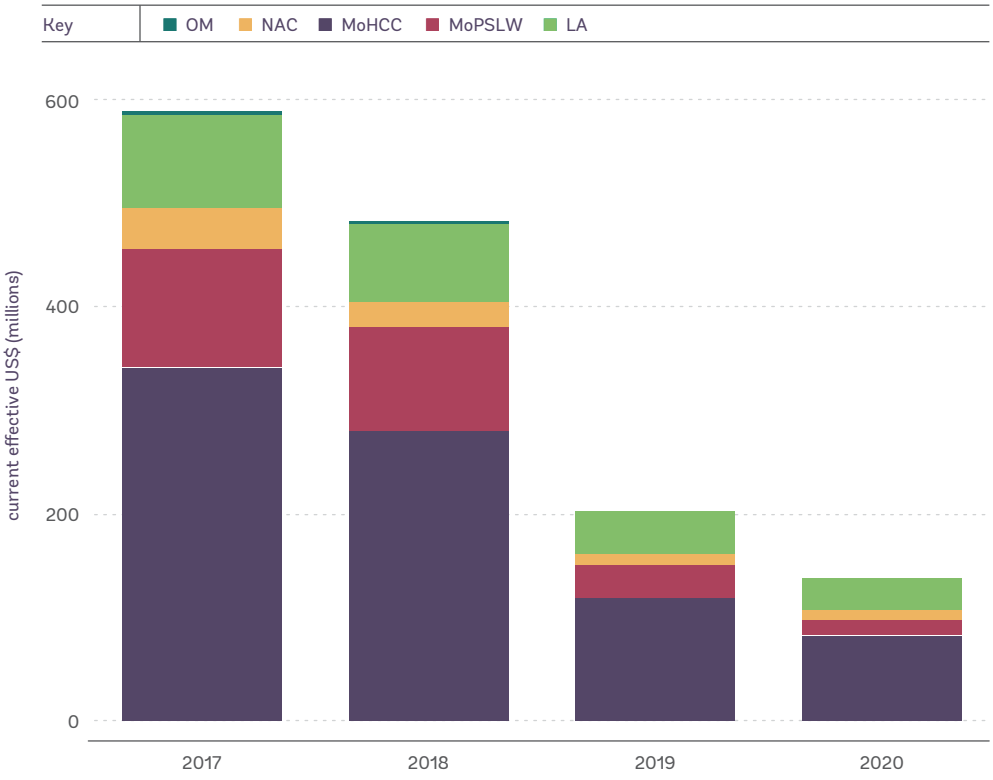
Government spending on health is predominantly managed by the Ministry of Health and Child Care (MoHCC). The availability and reliability of data on health spending by different parts of government varies greatly. Table 3.3 shows relative spending by different government institutions for the period 2017-20. Detailed spending data were most readily available for the MoHCC, MoPSLSW and the National AIDS Council (NAC). For 2017-18 the proportion of total government spending on health that was managed by the MoHCC averaged 58 percent; the MoPSLSW managed 20 percent; local authorities managed 16 percent; the National AIDS Council (NAC) managed 5.5 percent; and the final 0.5 percent was managed by other ministries (Defense, Justice, Home Affairs, and Education).[26] Of the health spending by the MoPSLSW, 98 percent went to the PSMAS, which provides insurance for public sector workers and their families, and 2 percent went to the AMTO, a health assistance scheme for poor and vulnerable members of society. In 2019-20 the share of overall government health spending managed by the MoPSLSW fell to 12 percent with the relative proportions for the MoHCC and Local Authorities assumed to have increased equivalently.

Figure 3.7

Government spending on health by institution (current effective US$ millions)

Source: See Technical Annex 6 for full sources and estimation methodology.

Notes: OM = Other Ministries; LA = Local Authorities; NAC = National Aids Council; MoPSLW = Ministry of Public Service, Labor and Social Welfare; MoHCC = Ministry of Health and Child Care.



Local authorities manage a significant proportion of government health expenditure, although this source of financing is predominantly spent in urban rather than rural areas. Around 17 percent of government health expenditure is managed by local councils. The vast majority of this spending is

26 UNICEF (2016) Health Budget Brief.

managed by the urban councils of Harare and Bulawayo. The MoHCC's 2019 resource mapping exercise estimated that only 4 percent of local authority spending was managed by rural councils. As a result, rural areas are significantly more dependent on central government funding than urban areas. The geographical spread of government spending is further considered in Chapter 4.

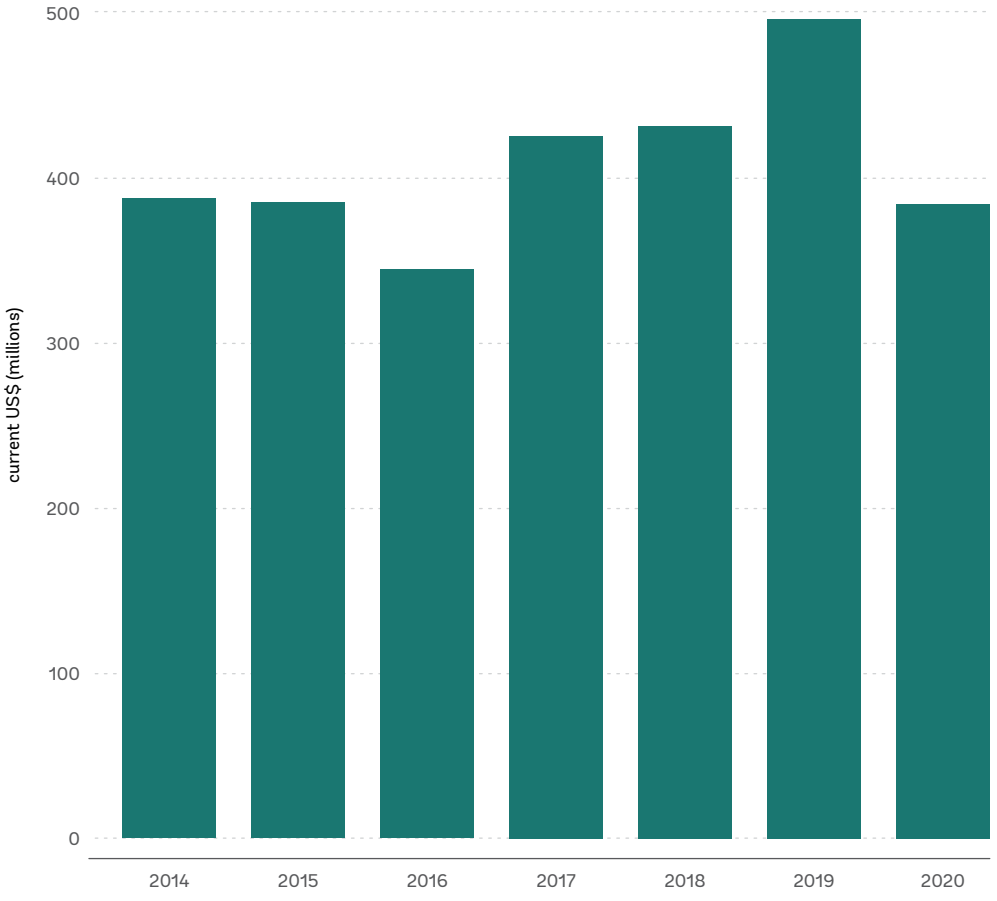
Development Partner (DP) Health Expenditure

DP spending has been consistently large over recent years. Between 2014 and 2020 DP support averaged US$409 million, varying from a low of US$346 million in 2016 to a high of US$496 million in 2019. For the period 2014-2018, average DP funding (US$397 million) was about one-third higher than the MoHCC's average spending (US$306 million[27]). With the major fall in domestic government spending in 2019-2020 in US dollar terms, DP spending became by far the most important funding source for the sector. In US dollar terms, using the official exchange rate, DP support to the health sector was almost three times greater than the MoHCC's spending in 2019. When using the effective RTGS US dollar exchange rate, DP spending was almost 4.5 times greater.

Figure 3.8

DP Support for Health 2014-2020, (current US$ millions)

Source: MoHCC's Resource Mapping Reports 2017, 2018, 2019, 2020.



27 Note that an average effective exchange rate of 2:1 was applied to MoHCC 2018 spending.

Most DP spending is off-budget, and all is off-treasury. While some estimates for DP projects are captured in the national budget, no DP projects for health are on treasury or making full use of government budget execution systems. This means that the money does not flow through national treasury systems, and the government does not lead the execution or reporting on what is actually spent. Since the last PER was conducted, the MoHCC conducts extensive resource mapping of DP spending annually. This breaks down DP spending into detailed cost categories to help the government to coordinate and plan activities within the sector. These resource mapping exercises mean the government now has much better data on DP spending with reports that provide extremely informative detail. There are further opportunities for improvement. First, the breakdown of DP spending is not aligned with the program-based budgeting approach used by the MoHCC. Second, the analysis is based on planned spending figures that are self-reported by DPs and may not match actual executed spending in practice. These issues are analyzed further in Chapter 4.

Most DP spending comes from the Global Fund, PEPFAR, and the Health Development Fund. These three sources provided between 86 percent and 96 percent of estimated DP assistance to the health sector from 2016 to 2020. The Global Fund has consistently been the largest contributor, although its share is projected to have fallen from 44 percent to 37 percent of the total in 2020. The Global Fund in Zimbabwe provides support towards fighting HIV, tuberculosis, and malaria. PEPFAR has consistently provided around one-third of all DP funding to the health sector, focusing on the delivery of a comprehensive package of HIV treatment and prevention activities. The Health Development Fund is a multi-DP pooled fund (funders include the UK Foreign, Commonwealth, and Development Office (FCDO), SIDA, Irish Aid, the European Union, and the Government of Canada) with a focus on reproductive, maternal, child, and adolescent health (RMNCH-A). The funding that it provides to the sector has progressively increased in both relative and absolute terms from 10 percent (US$35 million) of total DP health funding in 2016 to a projected 26 percent (US$99 million) in 2020.

Beyond these three main sources, the sector's external funding is highly fragmented. In 2020, over 15 DPs had separately committed to provide support collectively worth just 4 percent (US$16 million) of all projected external support to the sector. These DPs include multilaterals such as the World Bank (US$3 million), Unitaid (US$0.8 million), UNFPA (US$0.5 million), and GAVI (US$0.5 million) and bilaterals such as Irish Aid (US$3.1 million), SIDA (US$2.8 million), and the FCDO (US$1.2 million), as well as specific organizations, such as World Vision International (US$1.6 million). It is worth highlighting that the amounts here for the three bilateral funders (Irish Aid, SIDA and the FCDO) are in addition to and separately managed from their contributions to the Health Development Fund.

Zimbabwe's need for additional funding following the outbreak of COVID-19 may have exacerbated the fragmentation of DP support. Data from the MoFED in October 2020[28] showed that 29 different bilateral and multilateral DP organizations had committed additional support to the health sector totaling US$206 million in response to COVID-19. Eight of these sources committed less than US$300,000 each, while six committed in excess of US$10 million each. These data cover commitments rather than actual disbursements and focus only on support specifically in relation to COVID-19.[29] The efficiency lost due to the fragmentation of DP funding is discussed in Chapter 5.

DP funding levels have been both volatile and difficult to predict. DP funding over the period 2014-2020 averaged US$409 million, ranging from 12 percent below this average (US$346 million in 2016) to 23 percent above it (US$496 million in 2019), with no consistent upwards or downwards trend. Despite the extensive resource mapping exercises conducted by the MoHCC each year, the projected DP spending figures based on DPs' commitments tend to be significantly different from actual realized spending. The MoHCC's 2017 resource mapping report[30] over-estimated DP spending for 2016 by 40 percent (US$486 million was revised downwards to US$346 million in the MoHCC's 2018 resource mapping report[31]). The 2018 resource mapping report over-estimated 2017 DP spending by 10 percent compared to the 2019 resource mapping report[32] figure (US$475 million revised downwards to US$429 million). Finally, the 2019 resource mapping report significantly under-estimated expected DP funding for 2019, with the figure revised up from US$385 million to US$496 million in the 2020 draft resource mapping report.[33]

28 Ministry of Finance and Economic Development, October 2020, "Update on Covid Support Treasury Support_1October 2020" Excel Spreadsheet.

29 Overall DP support to the health sector in 2020 was estimated at US$387 million in the initial draft of the 2020 resource mapping report.

30 MoHCC (2017), "Health Sector Resource Mapping Report 2017".

31 MoHCC (2018), "Health Sector Resource Mapping Report 2018".

32 MoHCC (2019), "Round 4 Resource Mapping Report Draft 2019".

33 MoHCC (2020), "Resource Mapping Round 5 Overall Funding Analysis. 2020". PowerPoint presentation.

Chapter 4
Efficiency and Equity of Health Spending Allocations

This chapter considers disaggregated trends in Zimbabwe's health spending. It analyses the different ways that health spending can be disaggregated with the available data and the implications of trends in spending for the efficiency, equity, and effectiveness of the health sector's performance. In particular, the chapter focuses on the detailed breakdown of the MoHCC spending, the complementarity between DP and government spending, overall health spending by disease, intervention area, and geography, and evidence of how equitably the benefits from health spending are shared among socioeconomic groups.

Public Spending Priorities – how executed MoHCC spending is allocated

In 2017, the MoHCC adopted a new program-based budget (PBB) structure.[34] The new structure allocates spending among fourdistinct programs: (i) Policy and Administration; (ii) Public Health; and (iii) Primary Health Care and Hospital Care. Each program is made up of a set of sub-programs as can be seen in Table 4.1. This program structure was used for the budget for four years from 2017 to 2020, years which are the focus of this expenditure analysis. In the 2021 budget, the same structure is being used, but the set of programs and sub-programs has been modified. The potential implications of this are discussed in Box 1 on program-based budgeting in Chapter 5 as well as in Annex 1.

34 The term PBB is used interchangeably with RBB (results-based budgeting), which was what the program-based approach was initially called.

Table 4.1 MoHCC Spending by Program and Sub-program, 2017-2020

Source: MoHCC annual appropriations data

Notes: Numbers may not add up exactly to 100 percent due to rounding. 2019 and 2020 monthly spend data converted into USD using official monthly exchange rates before calculating proportions. A sensitivity check on figures done by keeping monthly spending figures in ZWL and controlling for month-by-month local inflation – proportions remain very similar to US dollar analysis. 2020 spending data available up to end of September 2020 only.

Programs and Sub-programs	2017	2018	2019	2020
Program 1: Policy and Administration	*4.8%*	*3.2%*	*4.2%*	*1.8%*
Sub-Program 1: Ministers' and Permanent Secretary's Office	18.8%	3.1%	2.4%	5.6%
Sub-Program 2: Policy Planning and Co-ordination	8.3%	9.4%	11.9%	5.6%
Sub-Program 3: Human Resources	18.8%	37.5%	42.9%	22.2%
Sub-Program 4: Finance and Administration	12.5%	12.5%	19.0%	33.3%
Sub-Program 5: Monitoring and Evaluation	0.0%	0.0%	0.0%	0.0%
Sub-Program 6: Provincial Administration	41.7%	34.4%	21.4%	33.3%
Sub-Program 7: Internal Audit	0.0%	0.0%	0.0%	0.0%
Program 2: Public Health	*3.1%*	*2.8%*	*2.5%*	*23.5%*
Sub-program 1: Program Management	0.0%	0.0%	4.0%	0.0%
Sub-program 2: Communicable Diseases	6.5%	25.0%	24.0%	94.5%
Sub-program 3: Non-Communicable Diseases	3.2%	3.6%	4.0%	0.0%
Sub-program 4: Environmental Health	0.0%	0.0%	0.0%	0.0%
Sub-program 5: Research and Development	19.4%	17.9%	12.0%	0.9%
Sub-program 6: Family Health	71.0%	50.0%	56.0%	4.3%
Program 3: Primary Health Care and Hospital Care	*92.2%*	*94.0%*	*93.3%*	*74.7%*
Sub-program 1: Program Management	9.4%	4.7%	14.3%	25.2%
Sub-program 2: Rural Health Center and Community Care	10.1%	12.4%	11.0%	13.3%
Sub-program 3: District/ General Hospital Services	39.2%	40.3%	31.9%	24.1%
Sub-program 4: Provincial Hospital Services	9.1%	12.4%	11.0%	7.9%
Sub-program 5: Central Hospital Services	32.2%	30.1%	31.7%	29.6%

By program, the MoHCC's spending from 2017-2019 was predominantly focused on hospital services and, to a lesser extent, on rural health centers and community care. The first year of the implementation of the MoHCC's new program-based budget structure was 2017. Hospital services accounted for an average of 74 percent of total MoHCC spending in 2017-19, while rural health centers and community care averaged 10 percent. This might reflect an imbalance of resources away from primary care, although hospitals in Zimbabwe in practice also provide primary care. There is no disaggregation of such costs in the budget data. The potential lack of emphasis on primary care in MoHCC spending was somewhat counterbalanced by DP spending being much more heavily focused on primary health care. A 2019 study that analyzed the relative funding of different health interventions estimated that 41 percent of combined domestic and DP-funded health expenditure in 2016 was delivered through primary health centers.[35] In general, greater cost-effectiveness can be achieved at the primary care level where larger numbers of people can be treated for common ailments at a lower cost.

Despite dominating MoHCC spending, hospital services are under-used, and utilization often bypasses the referral chain. Data on bed occupancy rates show a rate of just 2 to 7 percent for provincial hospitals and 4 to 6 percent for central hospitals in 2014.[36] These numbers are very low and may point to data integrity concerns. More recently, these occupancy rates have substantially increased likely reflecting improved reporting, particularly in central hospitals. However, there is still substantial potential for increasing efficiency further, with 2018 data showing an average of just 58 percent occupancy in central hospitals[37] and just 29 percent in provincial hospitals.[38] Unlike primary and secondary care services, there is no defined package of essential services for higher-level care in Zimbabwe, which may also contribute to this under-use.[39] Provincial hospitals (the tertiary level of Zimbabwe's health referral system) predominantly carry out minor rather than major operations, apparently because they do not have the necessary specialist health personnel to carry out certain services.[40] The availability of medicines in hospitals (42 percent) is also much lower than in primary care facilities (over 80 percent).[41] In the majority of central hospitals (the quaternary level of Zimbabwe's health referral system), most maternity admissions are for normal deliveries.[42] Because health care provision

35 World Bank (2019: 18) Improving Allocative Efficiency in Zimbabwe's Health Sector: Results from the Health Interventions Prioritization Tool. Note that this figure includes funding from the MoHCC, the NAC, local councils, and DPs but not from other government ministries.

36 MoHCC (2014) National Health Profile

37 MoHCC (2018), "Central Hospitals Mid-Year Report. Jan-June 2017/2018", PowerPoint Presentation, Ministry of Health and DP Committee (MODO) First Bi-Annual Meeting, Mutare, Zimbabwe.

38 MoHCC (2018), "Secondary Level Institutions (District and Mission Hospitals)", 22nd October 2018, PowerPoint Presentation, Ministry of Health and DP Committee (MODO) First Bi-Annual Meeting, Mutare, Zimbabwe.

39 MoHCC (2021) National Health Strategy 2021 to 2025 (draft).

40 World Bank (2017) Analyzing Fiscal Space Options for Health in Zimbabwe

41 MoHCC (2016) National Health Strategy 2016-2020

42 MoHCC (2014) National Health Profile

is more cost-effective when delivered at the most appropriate care level, the government has introduced penalties for patients who get treated at higher levels of care than required (patients bypassing the referral system are expected to pay user fees whilst those that follow the referral chain are supposed to be exempted). In practice these penalties can be difficult to enforce because of the government policy to provide free care for pregnant women and under-fives at all levels, meaning central hospitals continue to be overwhelmed with pregnant women requiring routine delivery support.

Spending is concentrated among a few sub-programs complicating accountability. The majority of programs are small scale and receive limited resources. 13 out of 18 subprograms (72% of all subprograms) jointly only received about 7 percent of the total budget in 2017-2019. The concentration of resources in few subprograms can be problematic and complicate accountability. For example, the "program management" sub-program of the Primary Health Care and Hospital Care program covered various functions including the purchase of medical supplies and hospital construction.

Two of the most severely under-funded sub-programs are Monitoring and Evaluation and Internal Audit, making it difficult to ensure effective accountability and PBB implementation. MoHCC spending on Monitoring and Evaluation was zero in 2017 and less than 0.1 percent of total spending in 2018 and 2019. In absolute terms, this sub-program only received US$58,000 in 2018 and US$26,000 in 2019. The consequence of underfunding is clear in the mid-term review of the National Health Strategy[43], which found that only 53 percent of its 197 indicators were both well-defined and had useable data (52 were poorly defined and 40 had no useable data). Monitoring and evaluation efforts are largely funded by DPs. Except where a DP-funded study covers the gap, the MoHCC has limited data for how well its resources are being used or if and where there are opportunities to allocate them more efficiently. Spending on internal audits was zero until 2019, and the first expenditure release for this sub-program was in 2020 and amounted to an estimated US$45,000 (less than 0.1 percent of overall MoHCC spending).[44]

In 2020, there was a large proportional increase in MoHCC spending on the communicable disease sub-program and a relative decline in the proportion spent on hospital services. Having spent less than 1 percent of total MoHCC spending on the communicable disease sub-program from 2017 to 2019, MoHCC spending on this sub-program jumped to 22 percent in 2020. In nominal US dollar terms, spending increased from US$1 million to a projected US$31 million. This large increase in centrally managed communicable disease

43 Dovlo, D., Chirenda, J., Shamu, S. & Mahvu, W. (2019), "The Mid-Term Review of the Zimbabwe National Health Strategy 2016-2020", Overall Synthesis Report, Final Submission.

44 Although it is possible that internal audit activities took place but were not correctly attributed in the spending data.

funding reflects the country's national response to the COVID-19 pandemic. However, overall MoHCC spending in 2020 declined in both current US dollar and real ZWL terms, which meant that the increase in spending on the communicable diseases sub-program necessarily required both a relative and absolute fall in spending on other sub-programs. The proportion of the MoHCC budget spent on hospital services fell to just 46 percent from its average of 74 percent over the preceding three years. In absolute current US dollar terms, spending on hospital services decreased from US$131 million in 2019 to a projected US$65 million in 2020. The proportion allocated to rural health centers and community care remained constant at 10 percent (although reduced in nominal US dollar terms from US$19 million to US$14 million). This may have partially redressed the relative imbalance in government funding between primary and higher levels of care, although no data are available on how spending on the communicable disease sub-program was allocated between different levels of care.

Spending on COVID-19 related items left limited resources for spending on routine services or administration. Spending on Policy Planning and Coordination decreased from 0.5 percent of total spending in 2019 to 0.1 percent in 2020. In absolute terms, given the overall fall in the MoHCC budget in US dollar terms, that translates into a decrease from US$1 million to US$0.1 million. Other sub-programs that were squeezed of funding in 2020 both relatively and absolutely include Human Resources for the Policy and Administration program (which mostly covers funding for the Health Services Board, responsible for appointing and managing health sector staff), Monitoring and Evaluation, Research and Development, and Family Health (which mostly provides funding for the Zimbabwe National Family Planning Council/ZNFPC).

Prior to 2017, the MoHCC's budget was allocated to four administrative units, with a clear prioritization of curative over preventive care. This previous budget structure does not map directly to the PBB structure that existed from 2017 to 2020, although there are some similarities. The Administration and General Administrative Units are similar to the Policy and Administration program, the Preventive Care and Research Administrative Units are to a large extent collapsed within the Public Health program, and the Medical Care Services Administrative Unit is similar to the Primary Health Care and Hospital Care program. As a result, it is clear that MoHCC spending has heavily prioritized curative care services over preventive care for an extended time period. The World Bank's 2015 Public Expenditure Review for Zimbabwe's health sector emphasized that other countries in the region allocated significantly more resources to preventive services – more than 20 percent of total health expenditure in the case of Kenya, Tanzania, and Uganda.[45] Directly comparable data for Zimbabwe is not available, because not all DP spending is

45 Although by considering all spending on health, this is not directly comparable to just looking at MoHCC allocations. The breakdown of other spending in Zimbabwe between curative and preventive care is not available.

disaggregated in this way. However, where a breakdown is available that includes DP spending, it shows the share for preventive care is much higher than government spending alone. For example, 70 percent of malaria funding and 15 percent of HIV funding in 2019 was for prevention activities.[46] Given that the costs of treating disease are often greater than preventing it, the small share of preventive care in MoHCC spending and the continued reliance on DP funding may be a risk to allocative efficiency. These figures may also be subject to inadequate classification of services, which needs to be carefully reviewed.

Table 4.2 MoHCC Spending by Administrative Unit 2013-2016

Source: MoHCC annual appropriations data

Notes: Numbers may not add up exactly to 100 percent due to rounding. Available data only allows this analysis by administrative unit for the 2013-2016 budgets.

(% total MoHCC spending)	2013	2014	2015	2016
Administration and General	8%	7%	4%	3%
Medical Care Services	81%	81%	83%	86%
Preventive Care	8%	8%	9%	8%
Research	3%	3%	3%	3%

Human Resources for Health Spending

Employment costs are by far the most dominant category of MoHCC spending, but their share has declined over the two years from 2017 to 2019 (reflecting a key objective of the Government's Transitional Stabilization Programme). Figure 4.1 sets out MoHCC spending allocations by economic classification over the period 2013 to 2019, which is how the MoFED has been disaggregating government spending for many years in parallel with the program budget. The highest category of spending is for employment costs. It should be noted that the classification formally labelled as Current Transfers mainly covers Employment Costs and this share is re-classified as such in the table and the following analysis.[47] From 2013 to 2019, employment costs represented an average of 84 percent of all MoHCC spending, peaking at 91 percent in 2016.

46 MoHCC (2019) Round 4 Resource Mapping Draft 2019.

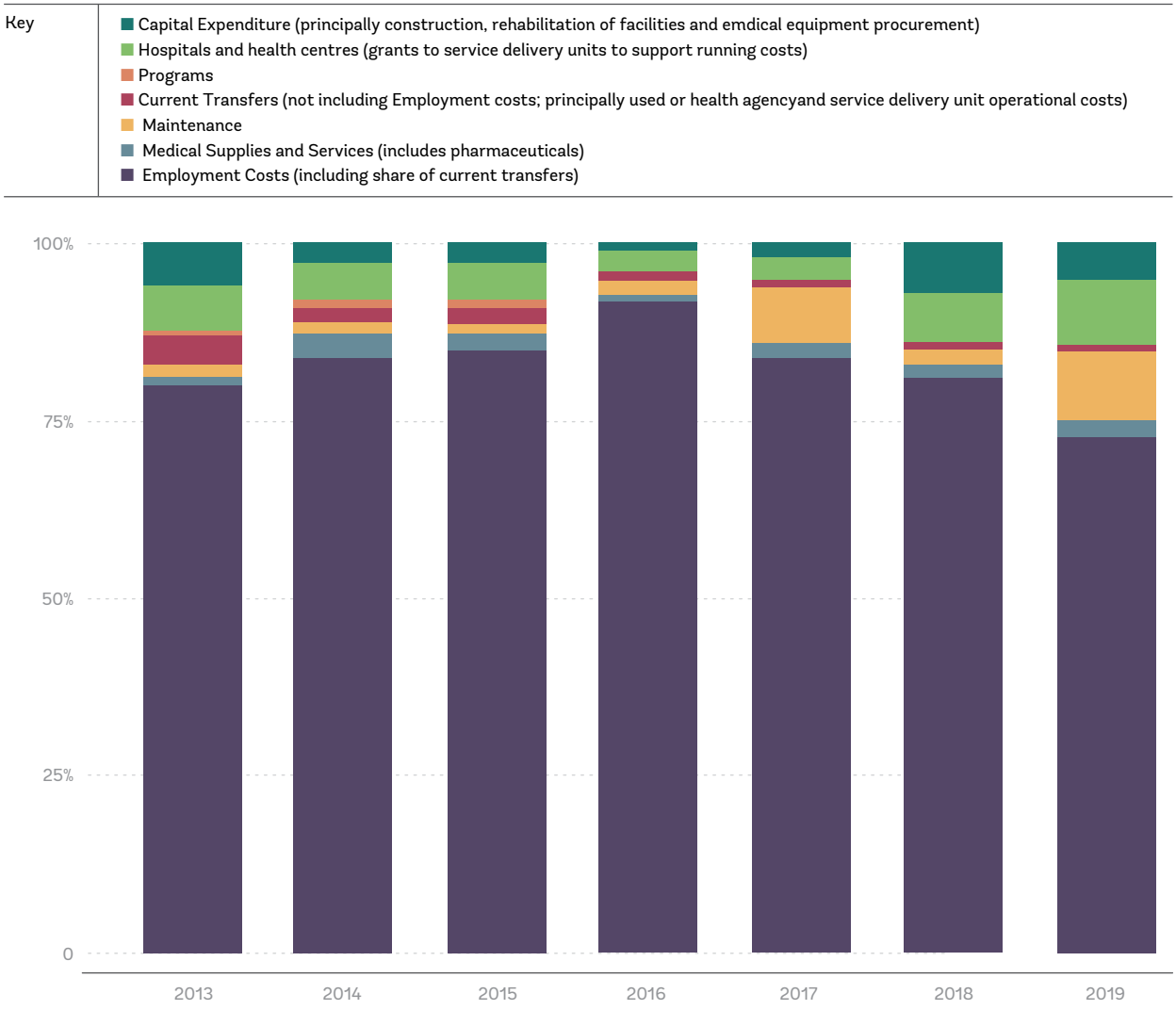
47 On average 94 percent of the 'Current Transfers' spending is used for payments to workers and so in the present report this spending has also been classified as part of the overall figure for employment costs. Current transfers include, for example, payments to health workers in the Parirenyatwa hospitals and all mission hospitals under the Zimbabwe Association of Church Hospitals

This share fell substantially to 81 percent in 2018 and further to 72 percent in 2019. This decrease matches one of the key objectives of the Government of Zimbabwe's Transitional Stabilization Programme launched in late 2018. This program targeted restructuring overall government spending such that a reduced proportion of spending on employment costs could free up resources for other parts of the budget.

Figure 4.1 MoHCC Spending by Economic Classification (2013-2019)

Source: MoHCC annual appropriations data

Notes: For 2017-2019 the proportion of current transfers that are employment costs is assumed equivalent to 2016. The 2019 spending data were not available on a monthly basis broken down by economic classification, as such the annual data was used and an assumed spread across the year was applied in line with the overall national budget monthly spending data broken down by economic classification. 2020 spending data by economic classification not yet available. Numbers may not add up exactly to 100 percent due to rounding. * Note the headline employment costs classified in the MoHCC budget are lower. However, the majority of current transfers are also for employment costs, so total employment costs are better understood to be: [Employment costs as presented as a standalone economic classification in the budget] plus [the proportion of current transfers that are in fact for employment costs]. The figure presented here for Employment Costs is this combined figure. The remainder of current transfers is principally used for health agency and service delivery unit operational costs.



The radical change in the relative value of DP and government financing for the health sector in 2019 has led to a major rebalancing away from health worker payments within the total financing for the sector. The small proportion of DP spending that is allocated to payments to health workers marginally declined from 7 percent in 2017 to 6 percent in 2019.[48] However, in 2019 there was a sudden change in the key source of financing for the sector in US dollar terms with DP funds having remained relatively constant while the value of government spending fell sharply. This means that the proportion of overall health spending accounted for by employment costs has significantly decreased. As a share of MoHCC and DP spending combined,[49] payments to health workers fell from 41 percent in 2017 to just 25 percent in 2019 (at official exchange rates). When using effective exchange rates, the share of spending on employment costs in 2019 was just 19 percent.[50]

The major decline since 2018 in the real value of funding for both health workers and their tools of trade has exacerbated pre-existing issues of absenteeism, retention, and motivation, which has negative implications for the efficiency and effectiveness of health care delivery. Industrial action by health workers has become increasingly frequent since 2018. Their stated grievances include dysfunctional and unavailable medical equipment (including a lack of PPE during the COVID-19 pandemic), an inadequate supply of medicines, ineffective human resource management processes, and low remuneration.[51] The radical declines in the real value of health worker remuneration, along with reduced financing for complementary inputs, would seem strongly correlated with the increased frequency of industrial action. A preliminary study of absenteeism during industrial action in 2019 and 2020 found that it was having a direct negative impact on key performance indicators for health service providers.[52] For example, at one provincial hospital, only 10 percent of nurses were coming to work regularly, and absenteeism among nurses in Harare City ranged between 60 and 70 percent. The same study found evidence of neonatal deaths resulting from inadequate monitoring of women in labor, leading to substantial drops in the quality assessment scores for these facilities.[53] The 2020 rapid PICES found that 11 percent of respondents could not get medical treatment because of a lack of medical personnel available. Anecdotal evidence suggests that there are high levels of attrition of staff from the workforce, both through emigration and from public to private practice.[54] The major falls in the value of remuneration in US

48 MoHCC Resource Mapping Reports, 2017, 2018, 2019, 2020.

49 Data on other government spending is not disaggregated in the resource mapping reports and given issues with the exchange rate used in the 2019 report they are excluded from the present analysis.

50 Total DP health spending data as for Chapter 3 - $429m in 2017; $483m in 2019. Proportion of DP spending for employment costs 7 percent in 2017 (2017 Resource Mapping Report) and 6% in 2019 (2019 Resource Mapping Report). Total MoHCC spending data as for Chapter 3 - $341m in 2017 and $189m in 2019 at official exchange rates ($119m with effective exchange rates). Proportion of MoHCC spending for employment costs as per Table 4.3.

51 MoHCC (2021), National Health Strategy 2021-2025, Draft.

52 MoHCC (2020), “Impact of health worker crisis on health system performance.” Draft Report in collaboration with the WHO.

53 Ibid.

54 MoHCC (2021), National Health Strategy 2021-25, Draft.

dollar terms (from 2018 to 2019, using the official exchange rate, the MoHCC's absolute spending on employment costs fell from US$ 452 million to US $136 million) are likely to have significantly increased the attraction of emigration to neighboring countries for health care workers.

Staffing numbers have been increasing but remain below the ratios required for the effective provision of universal health care. In June 2010 as part of a broader effort to improve the management of the national budget, the Government of Zimbabwe introduced a freeze on all public sector recruitment.[55] The health sector has received periodic exemptions from this policy, although constraints have remained restricting the sector's ability to expand its workforce.[56] In 2018, there were an estimated 2,025 doctors, 33,124 nurses, and 1,125 midwives in Zimbabwe.[57] Collectively, this implied a ratio of 2.45 skilled health workers for every 1,000 people.[58] This was a significant increase in that ratio from 1.70 in 2014, principally driven by a very large increase in professional nurses and midwives. However, this ratio still falls short of international targets such as the WHO's 2016 estimate that 4.45 skilled health workers per 1,000 people are required to achieve effective delivery of universal health care and the health-related Sustainable Development Goals.[59] Compared to other countries in the region, Zimbabwe performs well in terms of numbers of nurses and midwives, but less well in terms of numbers of physicians.

Vacancy rates have fallen but remain high, particularly in rural areas and for specialist positions. The The reported vacancy rate for all public sector health workers decreased from 15 percent in 2018 after having averaged 17.5 percent over the period 2014 to 2017 - to 13 percent from May to August, 2021. However, the MOHCC's recent establishment brief notes that the number of nurses who left their posts increased from 278 in 2018 to 576 in 2020 to 1,176 for the period covering January to July 31, 2021. The number of doctors particularly at the level of Government Medical Officers who left their posts ranged from 47 to 55 during the period covering 2018 to 2020 but already reached 57 for the period January to July 31, 202 The vacancy rates for specialist decreased from 71 percent in 2014 to 46 percent by 2018. The recent MOHCC brief reports "little outflow at the level of middle level to specialist doctors" in 2020 and 2021 For medical imaging and therapeutic equipment operators, the vacancy rate remained close to 50 percent from 2009 through to 2018.[60] Shortages of staff in such

55 Dieleman (2012), "Impact assessment of the Zimbabwe Health Worker Retention Scheme".

56 Mashange, W. et al. (2019), Flexibility of deployment: challenges and policy options for retaining health workers during crisis in Zimbabwe, Human Resources for Health, 17:39.

57 MoHCC (2019), Human Resources for Health Country Profile for Zimbabwe 2014-2018. Note doctor number incorporates General and Specialist Medical Practitioners; Nurse and Midwife numbers include Associate Professionals.

58 Population estimate for 2018 – 14.8 million (Zimstat (2015), "Population Projections Thematic Report", Medium Scenario).

59 WHO (2016) "Health Workforce Requirements for Universal Health Coverage and the Sustainable Development Goals", Human Resources for Health Observer Series No 17.

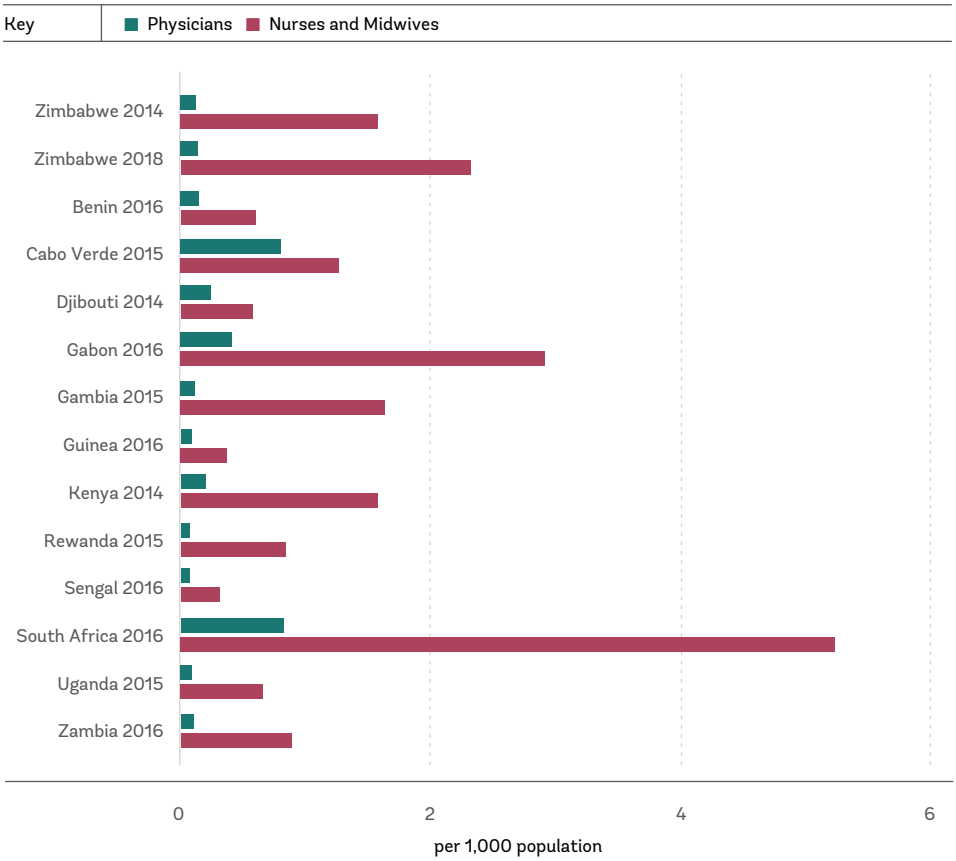
60 All data in this paragraph from MoHCC (2019), Human Resources for Health Country Profile for Zimbabwe 2014-2018 and MOHCC (2021) HRH Brief.

Figure 4.2

Sub-Saharan African ratios for Physician, Nurses and Midwives per 1,000 population

Source: MoHCC (2019), Human Resources for Health Country Profile 2014-2018, combined with Zimstat (2015) Population Projections for Zimbabwe ratios. WHO (2021), Global Health Observatory Data Repository for all other countries

Notes: Other countries included based on available data for sub-Saharan Africa



specific positions are likely to reduce the overall efficiency of the sector; for example, without specialist equipment operators, any investments in medical equipment are likely to be largely ineffective. Vacancy rates are also higher in rural areas, with the Southern region of the country most affected (particularly Matabeleland North and Matabeleland South Provinces). The Health Services Board maintains a database of unemployed nurses, but the HRH directorate has highlighted that recent emigration trends have led to this database being empty as unemployed nurses have left the country.

Non-wage government health spending

In relative terms, MoHCC allocations for capital spending, medical supplies, and services and for non-wage support to hospitals and health centers have increased since 2017. Medical supplies and services averaged 3 percent of MoHCC spending from 2013 to 2016 but reached 8 percent in 2017 and 10 percent in 2019. Non-wage support to hospitals and health centers trebled in relative terms from 3 percent in 2017 to 9 percent in 2019. Capital spending also jumped from an average of 2 percent in 2014 to 2017 to an average of 6 percent in 2018 to 2019. This re-balancing of the budget again reflects deliberate government policy, including through the Transition Stabilization Programme

launched in late 2018. A significant factor driving this relative reallocation is also likely to have been the contrast between inflationary pressures on imported goods and services that were outside the government's control and the price of domestically provided goods and services (mainly employment costs) over which the government had a greater influence. In general, given the major fall in the real value of the 2019 budget, all of these budget areas suffered significant funding reductions in absolute US dollar terms.

Maintenance spending was insufficient. It progressively declined from 0.3 percent of MoHCC spending in 2013 to 0.1 percent in 2015 and remained at that level up to 2020. The 2020 MoHCC health sector investment case[61] highlighted the lack of comprehensive infrastructure or equipment inventories or maintenance plans in the sector. As a specific example of poor maintenance of existing assets, the 2019 National Audit of MoHCC spending in 2018 found that only 134 of the MoHCC's 282 ambulances were functional. The need to increase the relative prioritization of this maintenance budget line is likely to have increased because of the relative increase in capital expenditure in the past two years.

Complementarity of DP Spending with the MoHCC

The MoHCC has conducted highly informative resource mapping exercises every year since 2017, which have highlighted opportunities for improvements in allocative efficiency between DP and government funding. These resource mapping exercises capture spending by the government (the MoHCC, the NAC, and local councils) and DPs categorized by disease area and a set of specific cost categories as used in the National Health Accounts. The analysis in these resource mapping reports would be an excellent basis for increasing the complementarity of government and DP funding to the health sector and, thus, increasing its efficiency. However, there is no clear evidence yet of any actual change in funding allocations as a result of the analysis, as is evidenced by the fact that the key findings and recommendations of the reports have been similar each year. In 2020, there was a greater effort by the government to align the resource mapping exercise with the budget cycle by presenting the key findings earlier in the year. However, the final report was not available by the time the 2021 budget year started.

The resource mapping exercise has some limitations, most of which relate to how government rather than DP spending is captured. First, the capture of government spending by the resource mapping exercise is incomplete. Figures for local council spending, for example, seem to be underestimated

61 MoHCC (2020), "Zimbabwe Health Sector Investment Case", Zero Draft / 12-01-2020.

by a factor of more than two.[62] In addition, spending by ministries other than the MoHCC are not captured. This is especially problematic since 15 to 20 percent of government spending on health is executed by the Ministry of Public Service, Labor, and Social Welfare (MoPSLSW). This contrasts with a very high rate (95 percent) of data capture of spending by DPs.[63] Second, government spending is less fully disaggregated than DP spending, with the majority of MoHCC spending being categorized under the very broad category of Health System Strengthening. As a result, there is the risk of misunderstanding the relative levels of funding for specific diseases since much of the government's contribution is not directly earmarked while most DP funding is. Third, the most recent resource mapping exercises have not controlled for the major shifts in the real value of the national currency, resulting in a vastly over-stated value of government funding relative to funding from DPs. Finally, the resource mapping exercise does not currently categorize spending by the programs and sub-programs defined in the MoHCC's budget. Adding this categorization of costs might more accurately reflect how DP and government funding is allocated as well as reinforcing the program budget's role in by improving the link between spending and intended results.

There is a difference of emphasis between government and DP spending that has some benefits in terms of complementarity, but also substantial allocative efficiency costs given volatile funding levels. Government funding focuses on hospital services and employment costs, while DP funding has been focused on primary care and almost entirely (94 percent in 2019[64]) on non-employment costs. The benefit of this division means that the two sources of funding broadly complement each other. However, it also risks substantial losses in allocative efficiency given the volatility of relative funding amounts from both external and domestic sources and the difficulties faced by each side in trying to substitute for the other's area of expenditure. In 2019 and 2020, the domestic economic crisis led to a massive real-terms reduction in funding for hospital services and employment costs. Meanwhile, DP funding remained relatively constant in absolute terms but was generally not reallocated away from its usual focus of primary care and non-employment costs (with some exceptions such as the use of results-based financing to fund health worker incentives). There are several reasons why no such reallocation took place: (i) some DPs institutionally avoid funding employment costs given the risk that governments will not be able to sustain this funding after the DP funding ends; (ii) most DPs prefer to fund primary care given its greater potential for supporting the poorest and its greater

62 The Health Financing Policy states local council spending to have been $80m in 2015 (quoting the 2015 Resource Mapping Exercise). Of this US$80 million the vast majority (80 percent) comes from Harare and Bulawayo. This figure fits well with the implication of extrapolating the Harare specific spending data this PER found in its case study on Harare City Council (which had annual spending of $34m in 2018 and $30m in 2017). The estimates for local authority spending in the 2015 and 2017/2018 NHAs as well as the 2017-2019 Resource Mapping Exercises range from US$21-37 million as a total for all authorities nationally which doesn't correspond with the findings of the Harare City Council case study. This suggests that the NHAs and most recent Resource Mapping exercises are failing to account for an important chunk of local authority spending.

63 World Bank (2019: 17) Improving Allocative Efficiency in Zimbabwe's Health Sector: Results from the Health Interventions Prioritization Tool.

64 2019 Resource Mapping Report.

cost-effectiveness;[65] and (iii) DPs often have lengthy approval processes before releasing funding with controls to avoid the rapid re-prioritization of resources. The under-funding of employment costs is likely to have substantially reduced the overall effectiveness of all health spending in 2019 and 2020. Conversely, the government's reliance on DP funding for non-employment costs will create substantial challenges should DP funding decline in the future. Politically, it can be very challenging for governments to rapidly reallocate resources away from salaries towards non-employment costs.

Spending Allocations by Disease

Zimbabwe's disease burden has long been dominated by HIV/AIDS, and this remains a high priority for Zimbabwe's health spending. The burden of disease in Zimbabwe doubled from 5.3 million DALYs (disability adjusted life years, or healthy years of life lost due to premature death, disease, and disability) in 1990 to 11.8 million in 2008 before steadily declining to 7 million in 2017.[66] The rapid increase was primarily driven by HIV/AIDS, with the subsequent reduction driven by an improvement in the national HIV response. Funding for HIV/AIDS interventions has dominated all other diseases, particularly from DPs. Two of the three main DPs supporting the health sector in Zimbabwe over recent years – PEPFAR and the Global Fund – have been predominantly focused on HIV/AIDS. The MoHCC's 2017 resource mapping exercise found that 43 percent (US$363 million) of total health expenditure in 2017 was allocated to HIV/AIDS spending. In fact, this somewhat understates the proportion of health spending on HIV/AIDS, since the vast majority (89 percent) of government health spending is not allocated by disease area but rather by the broad category of "health system strengthening." HIV/AIDS represented 78 percent of all spending in 2017 that had been categorized by specific diseases.[67] Resource mapping data for 2018 and 2019 were distorted by a substantial over-estimation of government spending (because it used a 1:1 exchange rate).[68] As most government spending is not allocated by disease, this gives the impression of a dramatically reduced share of total spending going to HIV/AIDS (reported to have dropped to 31 percent in 2018 and 27 percent in 2019). In practice, HIV/AIDS remained a high priority in 2018 (as a share of total DP spending, it declined only marginally from 70 percent to 68 percent) but appears to have fallen more significantly in 2019 (to just 56 percent

65 This can cause frustration on the government side, with the nature of DP interventions sometimes referred to as "cherry-picking" (MoHCC (2021) NHS 2021-25, draft report).

66 World Bank (2019: 15) Improving Allocative Efficiency in Zimbabwe's Health Sector: Results from the Health Interventions Prioritization Tool.

67 MoHCC (2018) Resource Mapping Report.

68 In 2018 the official exchange rate remained at 1:1, but the effective RTGS exchange rate for electronic transfers reached 3.5:1 by the end of the year. In 2019 the official exchange rate reached 16.77:1 by the end of the year, with the effective RTGS rate at 22.7:1.

of total DP spending).[69] While HIV/AIDS, combined with tuberculosis (TB), was the cause of 46 percent of DALYs in 2008, this fell to 27 percent in 2016.[70]

The relative importance of other diseases is to some extent reflected in their relative funding allocations, although relevant data on Government spending is limited. As many as 24 percent of all DALYs lost occur in the first year of life and a further 8 percent in the 1 to 4-year-old age range. Across all age groups, HIV/AIDS (14 percent), maternal and neonatal disorders (12 percent), lower-respiratory infections (10 percent), and TB (7 percent) are the leading cause of DALYs lost.[71] As most government spending is not broken down by disease area, it is difficult to establish how well Government spending reflects the current disease burden. DP spending data are broken down by disease, and in 2018, 80 percent was spent on HIV, 9 percent on malaria, 4 percent on TB, 3 percent on RMCH, and 3 percent on all other diseases (including NCDs, which received less than 1 percent).[72]

Improving the balance of funding for different interventions could significantly increase the overall DALYs averted with the same level of funding for the sector. A 2019 World Bank study[73] modelled the potential number of DALYs that could be averted with different mixes of essential universal health care interventions. Using data on Zimbabwe's disease burden and international evidence on the cost-effectiveness of different interventions, the study estimated that the actual mix of spending on health interventions in 2016 averted 1.6 million DALYs. It found that a further 1 million DALYs (or 63.5 percent more) could have been averted with the same level of spending but channeled through an optimal mix of interventions. Increasing the focus on more impactful interventions would require an increase in spending on primary health centers and community-based interventions, with a relative reduction in spending on first-level and referral hospitals. In terms of specific interventions, the most important relative increase in spending would be for integrated community case management (from US$1.5 million in actual 2016 spending to US$63.4 million in an optimized scenario). The other interventions that would require the greatest additional funding in absolute terms were testing and counseling for HIV, STIs, and hepatitis (an additional US$23 million) and basic emergency newborn and obstetric care (an additional US$17 million).

Funding for RMNCH remained relatively constant up to 2019 but has become increasingly dependent on DP resources. Spending specifically

69 MoHCC (2019) Resource Mapping Report.

70 Global Burden of Disease Collaborative Network. Global Burden of Disease Study 2017 (GBD 2017) Results. Seattle, United States: Institute for Health Metrics and Evaluation (IHME), 2018.

71 World Bank (2019: 15) Improving Allocative Efficiency in Zimbabwe's Health Sector: Results from the Health Interventions Prioritization Tool.

72 2018 Resource Mapping Report.

73 World Bank (2019) "Improving Allocative Efficiency in Zimbabwe's Health Sector: Results from the Health Interventions Prioritization Tool".

identified as being for RMNCH officially increased from US$33 million in 2016 (US$9 million from the government and US$24 million from DPs) to US$36 million (US$16 million from the government and US$20 million from DPs) in 2018.[74] Government funding was steady at US$9 million in 2016 and 2017, but the jump up to US$16 million in 2018, however, was artificially inflated by the application of a 1:1 official exchange rate to the national budget given that the end-of-year effective RTGS exchange rate was 3.5. If an average effective exchange rate of 2 were applied to government spending in 2018, then it remained close to previous levels at US$8 million in 2018, meaning that RMCH spending fell only marginally to US$28 million. In 2019, DP funding increased by US$7 million to US$27 million, mostly because of additional support provided by the Health Development Fund. No disaggregated data on government spending are available for 2019 or 2020,[75] but given the drastic decrease in the overall spending amounts in US dollar terms, it can be expected to have fallen significantly. If the same fall in overall MoHCC spending in 2019 were to be assumed for government spending on RMNCH specifically,[76] then it would have amounted to US$5 million in 2019. This means that total RMNCH spending would have been US$32 million in 2019, which would have been broadly similar to 2016 but with a higher proportion funded by DPs (84 percent versus 73 percent funded by the government).

This funding for RMNCH has enabled increased coverage of services and has reduced maternal mortality but rising neonatal mortality rates suggest that this spending is not as effective as it could be. Government and DP spending on RMNCH have increased the availability and delivery of connected services. For example, between 2015 and 2019,[77] institutional deliveries increased from 77 percent of all births to 86 percent, and skilled attendance at births increased from 78 percent to 86 percent. Progress has continued in terms of some health outcomes. For example, the maternal mortality rate fell from 651 maternal deaths per 100,000 live births in 2015 to 462 per 100,000 in 2019, but neonatal mortality actually rose from 29 to 31 per 1,000 live births. The contrast between the high levels of coverage with poor outcomes would suggest that the quality of services being provided is not good enough. Given that most of the government's spending on RMNCH cannot be discerned from the available data (principally because spending on human resources is not allocated by intervention area), it was not possible to analyze the precise link between spending and outcome data.

74 MoHCC (2019: 34) Round 4 Resource Mapping Report Draft 2019. It should be noted that the resource mapping exercise cannot fully attribute government spending to different diseases with the majority of spending treated as cross-cutting system strengthening support. The specific spending attributed to RMNCH would appear to be from a budget line specifically labelled as maternal and child health medical supplies. Data on DP spending is more readily attributable to specific diseases because of the vertical nature of many DP programs.

75 Given the rapid depreciation of the national currency in both years it is necessary to have sufficiently disaggregated spending data on a monthly basis.

76 See Chapter 3 - 2019 MoHCC spending was 55 percent of 2017 MoHCC spending, while 2020 MoHCC spending is estimated to have been 41 percent of 2017 MoHCC spending. Given that issues with the exchange rate began to become significant in the latter part of 2018, 2017 is a more reliable baseline.

77 Data from the 2015 Zimbabwe Demographic Health Survey and the 2019 Multi Indicator Cluster Survey.

Geographic Allocation of Spending

Geographically, the cities of Harare and Bulawayo benefit the most from government spending on health. National resource mapping data on spending by province shows that per capita spending on Harare and Bulawayo substantially exceeds spending on all other provinces. Bulawayo received almost four times more than Harare and around eight times more than the average for all other provinces. This is principally because Harare and Bulawayo urban councils provided far more funding than all rural councils combined. However, even after removing urban council funding from the data, there remains a bias towards these two urban provinces. Per capita funding for Bulawayo (US$11.8 in 2017) still being more than double the average for all other provinces (US$4.9). For this analysis, we considered central hospitals to cover the whole population, even though they are all based in Harare and Bulawayo. In practice, given the evidence presented earlier in this chapter about the use of central hospitals for routine medical procedures and the potential for travel costs to discourage patients from rural areas to seek treatment at central hospitals, it is likely that their services benefit urban populations much more than rural provinces. In addition, 15 to 20 percent of government health spending is allocated to the health insurance of civil servants, which, given the urban location of most government postings, is also likely to disproportionately benefit those living in the urban centers of Harare and Bulawayo. Note also that the majority of government health spending data are not disaggregated by province. This non-disaggregated spending mostly pays for salaries, which can be expected to have a similar geographic breakdown as transfers to hospitals and health centers, thus essentially magnifying the above findings.

Table 4.3 Health Spending by Province, 2017

Source: 2018 Resource Mapping Report. Zimstat 2015 Population Projections medium scenario for population figures. Author's own calculations.

Notes: 'Internal' is domestic spending by the Government of Zimbabwe. 'External' is spending by international DPs. Data for 2017 used because detailed breakdowns of full data for 2018 and 2019 not available in resource mapping reports, which becomes increasingly problematic given the rapid change in exchange rate necessitating adjustments to some of the figures. In addition, local council spending data only available for 2017. * Includes Chitungwize, which falls within Harare province but is presented separately in the resource mapping report.

	2017 Internal ($m)	2017 External ($m)	2017 Total ($m)	2017 Population	Internal p.c. ($)	Internal p.c. (excl. urban councils) ($)	External p.c. ($m)	Total p.c. ($m)
National	168	396	564	-	-	-	-	-
Central Hospitals	111	0	111	-	-	-	-	-
Bulawayo	58	3	61	740,083	78.4	11.8	4.1	82.4
Harare*	44	11	55	2,424,419	18.1	6.2	4.5	22.7
Midlands	12	9	21	1,820,619	6.6	6.6	4.9	11.5
Mash West	10	4	14	1,708,684	5.9	5.9	2.3	8.2
Manicaland	9	26	35	1,987,990	4.5	4.5	13.1	17.6
Mash East	7	6	13	1,517,611	4.6	4.6	4.0	8.6
Matabeleland North	5	7	12	843,823	5.9	5.9	8.3	14.2
Masvingo	5	9	14	1,660,352	3.0	3.0	5.4	8.4
Mash Central	4	5	9	1,316,893	3.0	3.0	3.8	6.8
Matabeleland South	3	5	8	759,665	3.9	3.9	6.6	10.5

Rural provinces depend much more on volatile external funding than urban provinces. DP spending appears to be widely spread across the provinces, with Manicaland getting significantly more than any other in per capita terms – US$13 compared to an average of US$5 for all other provinces and US$8 for the next highest funded (Matabeleland North) (see Table 4.3). On average, DP spending makes up just 12 percent of health spending in the urban provinces of Bulawayo

and Harare but 54 percent in all other provinces. However, the vast majority of DP spending data (82 percent) is not disaggregated by geography, which makes analysis problematic. According to the data that are available, the volatility in the amounts of DP funding for some provinces is quite extreme. For example, in Matabeleland North, DP funding plunged from US$7 million in 2017 to US$1 million in 2018.[78] With limited central government or local council funding to compensate, such cuts in external funding for rural provinces may have a devastating effect on the provision of health services in local communities.

There is no systematic rationale for allocating government resources among provinces. The annual MoHCC budgets do not include any explicit justifications for how funding is allocated geographically, whether in per capita terms, by differential needs (for example, disease burden or poverty levels), by expected cost-effectiveness (for example, some provinces might use resources more effectively than others), or according to a desire to rebalance total funding given amounts available to provinces from other sources (such as local councils, DPs, and the PSMAS). Little government spending is disaggregated by geography, even though this ought to be possible with data that already exists within existing systems (for example, on salaries). Likewise, despite the MoHCC's extensive annual resource mapping exercise, the majority of DPs do not provide geographically disaggregated spending data. Given the very detailed data on geographic service delivery that exists within DP programs, it seems likely that better data are available to be used, even if some assumptions would be required when DP accounting systems do not explicitly disaggregate spending. The consequence of these incomplete data and the apparent lack of a national strategy for allocating health funding among provinces seems to be that the allocation of resources is biased towards urban areas, while the allocation to other provinces is somewhat random, which is likely to be both inequitable and inefficient.

Socioeconomic Equity

Richer households disproportionately benefit from inpatient care and are far less likely to incur catastrophic health expenditures. A 2016 survey found that the richest quintile had 71 percent more inpatient admissions than the poorest, although only 2.8 percent of the richest households incurred catastrophic health expenditures (when over 25 percent of household spending is used up by health payments) compared to 13.4 percent of households in the poorest quintile.[79] Also, 1.3 percent of households fell into poverty because of health care expenditures (equivalent to nearly 180,000 households).[80] Given that out-of-

78 MoHCC (2018) Resource Mapping Report.

79 Zeng et al. (2018) "Utilization of Health Care and Burden of Out-of-Pocket Health Expenditure in Zimbabwe: Results from a National Household Survey", *Health Systems and Reform*, 00: 1-13, 2018.

80 Ibid.

pocket payments represent a far smaller share of total health spending in Zimbabwe than in other countries in the region and in countries of a similar income level (see Chapter 3), this would suggest that there are insufficient pre-payment mechanisms available to help poorer households to afford to access health care.

Access to outpatient care is more equitably distributed between socioeconomic groups than hospital care. The same 2016 survey found that households in the poorest quintile used outpatient services 21 percent more than those in the richest quintile.[81] There are no more recent data or any longitudinal data available. The government and DPs have made efforts to reduce the costs of accessing outpatient services, which may explain the greater utilization rates by the poor (alongside other potential factors such as higher incidences of illnesses and greater reliance by the poor on publicly provided primary healthcare). For example, the RBF program does not allow participating health services to charge for maternal and child health services. Fees for maternal and child health have also been eliminated in principle in the country's major cities since 2018/19, although in practice some are still being charged given funding shortages.

Government spending on health is likely to disproportionately benefit richer households given the high proportion allocated to health insurance payments for civil servants and the prioritization of hospital services over rural health centers and community care. As discussed in Chapter 3, 15 to 20 percent of government health expenditure over the past five years has been allocated to the PSMAS, which funds health insurance payments for civil servants. Although direct data on the beneficiaries are not available, given that they are formally employed, it is likely that the PSMAS payments are benefiting richer socioeconomic groups more than poorer ones.[82] In addition, as shown earlier in this chapter, between 70 and 78 percent of MoHCC spending from 2017 to 2019 has been allocated to hospital services, which the evidence suggests also disproportionately benefits richer households. A 2017 study (based on data from 2010) looked at rates of use of health services by different socioeconomic groups and found that the greater use of hospital services by richer households meant that they disproportionately benefited from public health funds.[83]

Health financing mechanisms that exist for the lowest income groups are not functioning efficiently or effectively. The MoPSLSW administers the AMTO, which is a health assistance scheme for poor and vulnerable

81 Ibid. Table 1.

82 The national unemployment rate was 16 percent in 2019; when including the potential labour force (i.e., those of employment age but not available or looking for work) it was 50 percent. A further 41 percent of those in employment were underemployed (i.e., willing and available to work full-time, but in practice working less than 40 hours per week). Zimstat (2019) Labour Force Survey.

83 Shamu et al. (2017) "Who benefits from public health financing in Zimbabwe? Towards universal health coverage", *Global Public Health*, Vol.12, No.9, 1169-1182.

members of society. It has not been possible to get precise spending data on this scheme, although the 2020 UNICEF Social Protection Budget Brief estimated that the AMTO had received a government budget allocation of US$1.9 million in 2020. Based on broader budget execution rate data (see Chapter 5), it seems unlikely that this amount was fully executed, and it is unclear which exchange rate was used for the estimation, so actual spending on the AMTO may be significantly less than this.[84] The 2017 National Health Financing Strategy document stated that the AMTO has not adequately covered its target population. Factors such as non-disbursement, a high level of debt, and insufficient awareness among the target population about what they are entitled to have been identified as the main reasons for this. Facility-level staff consulted as part of the Harare City Council case study for this expenditure review emphasized that the administrative process required to access AMTO funds was too burdensome for most applicants. They explained that local councils make their own decisions about which poor and vulnerable patients receive services for free and cover the costs from their own funding pool. However, there is no evidence of this arrangement in either the council's annual reports or in any national documents. The informal nature of this approach is likely to be less efficient than a more structured approach, which could be regularly monitored.

84 For the calculations in chapter 3 an execution rate of slightly over 50 percent was assumed, with allocations for previous years set in proportion to overall government spending.

Table 4.4 Key findings and implications for efficiency/effectiveness/equity from analysis of how Government resources are spent

	PER Finding	Implication for Efficiency/Effectiveness/Equity
MoHCC Spending Allocations	Hospital care prioritized but issues of under-utilization, inappropriate referrals and non-defined package of essential services (beyond primary and secondary levels of care).	Resources for under-utilized hospitals might be more efficiently deployed at PHC level.
		Routine services provided at hospitals could be more cost-effectively provided at PHC level.
		Lack of a defined package of essential services may mean that most cost-effective services are not being prioritized.
	Extremely low proportional spending on maintenance, internal audit and M&E.	Likely to reduce overall efficiency and effectiveness of all other GHE.
	Low prioritization of preventive care.	Possibility for more cost-effective interventions which focus on preventive rather than curative care.
HRH	GHE has re-balanced to increase flexibility for non-HRH spending.	Greater flexibility in how budget can be utilized on different inputs is likely to create opportunities for improved allocative efficiency.
	GHE and DHE financing are not aligned, which has led to a very fast de-prioritization of overall HRH financing as GHE has decreased relative to DHE.	Issues of staff absenteeism, retention and motivation, which are significantly influenced by financing amounts, may decrease efficiency of overall health spending.
	Staffing numbers and vacancy rates have marginally improved but remain problematic for specialist positions and rural areas. Attrition rate among nurses has significantly increased after 2019	Staffing gaps in specialist positions and increasing attrition rate among health workers especially nurses will decrease effectiveness of spending on complementary inputs.
		Staffing gaps in rural areas will contribute to inequitable health outcomes.
DHE	DHE off-budget, fragmented, difficult to predict and not well-coordinated with GHE.	Overall balance of spending on different health sector inputs is volatile and unlikely to maximize allocative efficiency.
		Fragmentation increases administrative costs further reducing efficiency.

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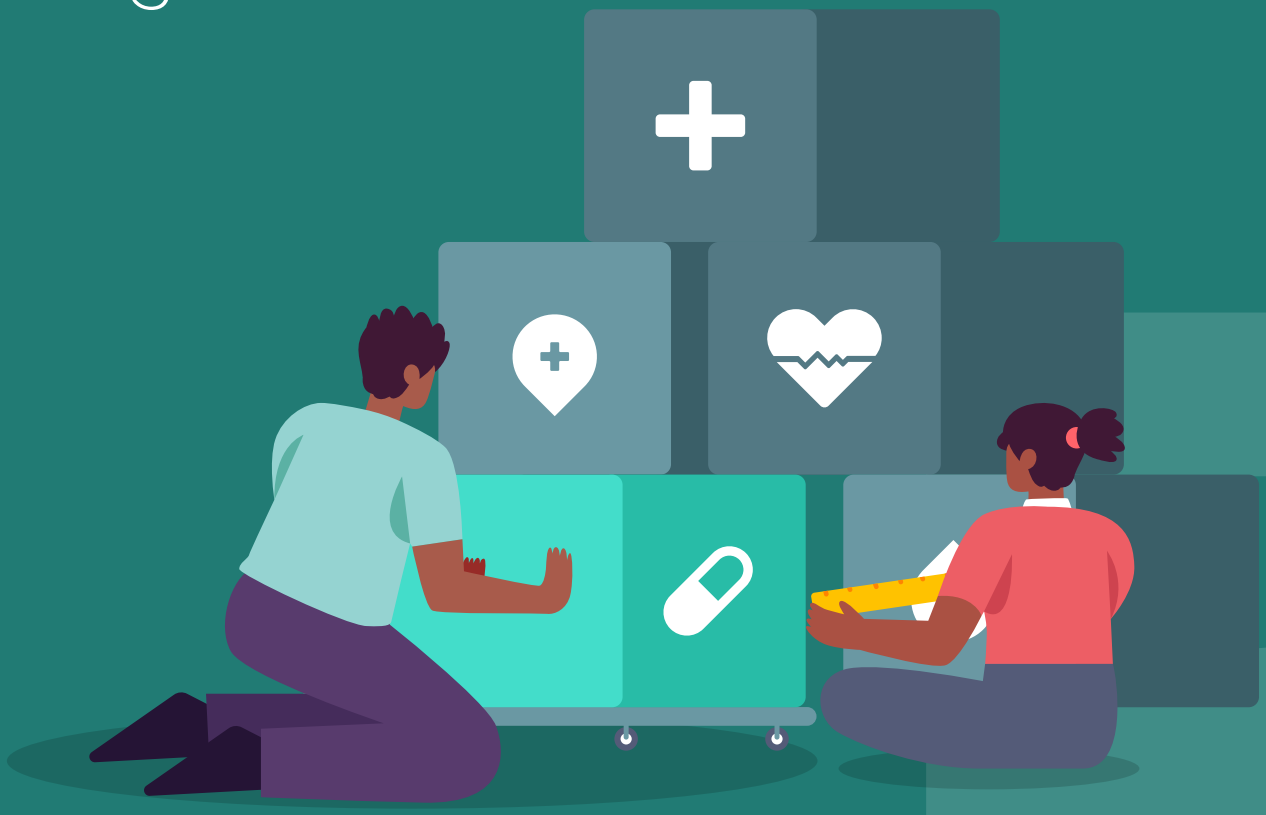
	PER Finding	Implication for Efficiency/Effectiveness/Equity
Spending by disease	Spending not optimally targeted to minimize the loss of DALYs.	Prioritizing the most cost-effective interventions relative to the disease burden could avert a further 1 million DALYs with same level of funding.
	Coverage of RMNCH services has increased, but neonatal mortality rates are rising.	The contrast between high levels of coverage and poor outcomes suggests issues with the effectiveness of the services being provided.
Spatial Equity	Bias of resources to Harare and Bulawayo.	Urban areas may be unfairly prioritized over rural areas.
	Rural provinces more dependent on volatile external funding.	Shifts in DP funding can have a devastating effect in the provision of health services in local communities.
	No systematic rationale for allocating government resources among provinces.	Actual allocation by province unlikely to maximize allocative efficiency considering need and potential cost-effectiveness.
Socioeconomic equity	CHE remains an important risk for the poor, with health financing mechanisms for the lowest income groups not functioning well.	Lack of effective pre-payment mechanisms for poor to access healthcare.
	GHE spending is predominantly used for hospital services (which are used disproportionately by the rich) and health insurance payments for formally employed civil servants (who on average are likely to be richer than informal and unemployed workers).	Richer households disproportionately benefit from public funds.

Chapter 5
Efficiency and Effectiveness of Health Financing Systems



This chapter considers how the management of health financing systems influences the efficiency and effectiveness of health spending. In particular, it analyses: (i) the strength of the link between the sector's strategic planning processes and actual spending; (ii) issues with accountability and internal controls; (iii) the extent of fragmentation of funding pools; (iv) ability to support purchasing; and (v) issues of efficiency and effectiveness in how the private insurance sector is structured and regulated. This chapter also includes an in-depth analysis of two case studies – health spending by the Harare City Council and the implementation of the program-based budgeting reform. The full analyses underpinning both of these case studies are in Annexes 1 and 2.

The Link between Strategic Planning and Budget Execution

There is only a limited correlation between health sector spending and national strategic plans. The health sector was guided by a National Health Strategy (NHS) throughout the period under review in this report. The 2009-2013 NHS was extended to 2015 and then replaced by the 2016-2020 NHS. The 2016-2020 strategy included a costing exercise that estimated the costs of delivering the strategy's objectives under three scenarios with different levels of ambition. Both the NHS and its costing exercise were only completed in late 2016, after almost a full year of the strategy's implementation period. Neither the costing exercise nor the NHS itself set out who would be responsible for which costs, and no estimates were made of the actual resources available for the sector. There was also no link from the costing exercise to the structure of the government's budget, which further reduced its potential utility as a planning tool. These issues likely explain why the available data show that there is very little correlation between actual spending and the spending assumed by the NHS.

There is a divergence between the set-up of the NHS cost modelling and the reality of budget execution processes which makes it challenging to make detailed comparisons between the two. The MoHCC's annual resource mapping exercises compare both aggregated and disaggregated NHS spending estimates with actual spending and find huge variations. At the aggregate level, the exercises have found that spending falls considerably short of even the least ambitious NHS spending scenario. At the disaggregated level, they have found spending on program areas defined in the NHS costing model such as RMNCH, TB, and HIV/AIDS to have major funding gaps between planned resources and actual execution. However, these analyses are largely invalidated by two issues stemming from the nature of the original costing exercise. First, the NHS costing model allocates costs according to its defined set of program areas whereas the MoHCC budget does not apply an equivalent disaggregation so the resource mapping exercises categorize the vast majority of government spending as

"health system strengthening."[85] This means that spending on key program areas defined in the NHS are massively under-represented in execution data (for example, they show that RMNCH received only around 10 percent of the need as estimated by the NHS cost model).[86] Second, the NHS costing model does not specify potential sources of funding. In theory, therefore, all methods of financing could be relevant, including user fees and insurance payments. In practice, the resource mapping exercises have excluded significant parts of government and private health spending in its comparisons with the NHS estimates. If only the MoHCC, the NAC, local council, and DP spending are considered (as is done by the resource mapping exercises), then health spending during the NHS period has been considerably less than even the least ambitious NHS spending scenario. If all national health expenditure is considered, then actual spending has exceeded the most ambitious NHS spending scenario. In order for there to be more congruence between the new NHS and actual resource allocations, there will need to be a cost and resource modelling section that is much more closely linked to the specific structure of health funding in practice in Zimbabwe.

There is inconsistency between planned and actual spending in the MoHCC's budget. Annual budgets reflect the MoHCC's immediate short-term plan as the MoHCC does not currently develop multi-year budgets.[87] Assessing the credibility of the budget process over the past three years is difficult given that the inflationary environment requires repeated adjustments to allocated amounts throughout the year because of the diminished monetary values of the original allocations. Tables 5.1 and 5.2 show how the proportional shares of the budget intended for different programs/sub-programs and economic classifications differed between allocation and execution, and the absolute execution rate for 2017 is shown as the last year for which a stable comparison can be made in nominal terms. This gives a clear indication of the inconsistency between planned and actual spending. For example, each year the actual shares of spending on the Policy and Administration and Public Health programs are considerably less than the original allocations. In 2017, the Program Management sub-program of the Primary Health Care and Hospital Care program had a 1,322 percent execution rate (US$30.7 million spent against an original allocation of US$2.2 million), which seems to have been caused by a major under-estimation of spending on medical supplies.[88] By economic classification, capital spending has a consistently lower share of the executed budget than its original allocations

85 The NHS cost modelling adopts two different kinds of cost disaggregation - "costs by program area" and "costs by major inputs." For the latter this issue of national resource mapping exercises categorising most government spending as 'system strengthening' is not relevant. However, even for comparing these estimates the second issue of this paragraph (i.e. limitations in the funding sources which are reported on) remains.

86 National Resource Mapping Report 2019.

87 The Ministry of Finance and Economic Development develops an over-arching three-year expenditure framework alongside the Annual Budget, which gives indicative aggregate allocations for the two years following the budget year. This 'Blue Book' includes indicative allocations for the health sector as a whole. However, the health sector does not prepare disaggregated allocations for how this funding would be prioritized.

88 The main omission was US$22.7 million spent on medical supplies funded by the newly introduced health levy (mobile airtime tax). The allocation for this budget line was revised upwards to incorporate this spend, however, the analysis here compares the original start-of-year budget allocation only.

while employment costs consistently get a higher share in execution (note also that current transfers consist predominantly of employment costs). The comparison between allocation and execution for medical supplies and services is especially inconsistent, with big relative increases in 2017 and 2019 but a significant relative decrease in 2018.

Table 5.1 MoHCC Spending Variations between Allocations and Execution by Program and Sub-program, 2017-2019

Source: Author's own calculations from the MoHCC's annual appropriations data

Notes: Absolute execution rate is nominal amount spent divided by nominal amount allocated. Relative execution rate is the proportional change in the share for each program and sub-program comparing original budget allocation to actual execution. i.e. [(program/sub-program executed % share of the budget) minus (program/sub-program allocated % share of the budget)] / (program/sub-program allocated % share of the budget).

	2017 Absolute Execution Rate	2017 Relative Execution Rate	2018 Relative Execution Rate	2019 Relative Execution Rate
Program 1: Policy and Administration	**99%**	**-18%**	**-41%**	**46%**
Sub-Program 1: Ministers' and Permanent Secretary's Office	240%	98%	-6%	56%
Sub-Program 2: Policy Planning and Co-ordination	66%	-46%	-46%	129%
Sub-Program 3: Human Resources	69%	-43%	-56%	198%
Sub-Program 4: Finance and Administration	110%	-9%	-20%	-2%
Sub-Program 5: Monitoring and Evaluation	0%	-100%	21%	-20%
Sub-Program 6: Provincial Administration	105%	-13%	-21%	-19%
Sub-Program 7: Internal Audit	0%	0%	0%	0%

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	2017 Absolute Execution Rate	2017 Relative Execution Rate	2018 Relative Execution Rate	2019 Relative Execution Rate
Program 2: Public Health	55%	-55%	-45%	-50%
Sub-program 1: Program Management	59%	-51%	-72%	-25%
Sub-program 2: Communicable Diseases	29%	-76%	-31%	-45%
Sub-program 3: Non-Communicable Diseases	30%	-75%	-94%	-89%
Sub-program 4: Environmental Health	17%	-86%	-36%	-30%
Sub-program 5: Research and Development	25%	-79%	-26%	-74%
Sub-program 6: Family Health	97%	-19%	-22%	-9%
Program 3: Primary Health Care and Hospital Care	**127%**	**5%**	**5%**	**1%**
Sub-program 1: Program Management	1,322%	994%	-44%	87%
Sub-program 2: Rural Health Centers and Community Care	86%	-29%	5%	-11%
Sub-program 3: District/ General Hospital Services	131%	8%	13%	-11%
Sub-program 4: Provincial Hospital Services	189%	57%	22%	-14%
Sub-program 5: Central Hospital Services	103%	-15%	3%	5%
TOTAL	**121%**	**-**	**-**	**-**

Table 5.2 MoHCC Spending Variations between Allocations and Execution by Economic Classification, 2017-2019

Source: MoHCC annual appropriations data

Notes: Absolute execution rate is nominal amount spent divided by nominal amount allocated. Relative execution rate shows the proportional change in the share for each economic classification comparing original budget allocation to actual execution. i.e. [(economic classification executed % share of the budget) minus (economic classification allocated % share of the budget)] / (economic classification allocated % share of the budget).

	2017 Absolute Execution Rate	2017 Relative Execution Rate	2018 Relative Execution Rate	2019 Relative Execution Rate
Employment Costs	133%	10%	18%	4%
Goods and Services	110%	-9%	-60%	-59%
Medical Supplies and Services	304%	152%	-43%	190%
Maintenance	49%	-60%	-41%	-44%
Current Transfers	119%	-1%	12%	16%
Hospitals and Health Centers	82%	-32%	-28%	-22%
Total Current Expenditure	132%	9%	4%	7%
Acquisition of Fixed Capital Assets	23%	-81%	-13%	-52%
Capital Transfers	2%	-98%	-76%	-81%
Total Capital Expenditure	21%	-83%	-34%	-55%

There is an opportunity for ensuring that the new National Health Strategy is linked as closely as possible to the budget process. The new NHS covers the period 2021-25, but the main document does not link costs or targets with potential resources, clarify expected contributions from different sources such as domestic or external, or present them in a format that could be used to inform the annual budget process. There are efforts to align the strategy's updated costing model with the new program-based structure of the MoHCC's budget. Since the PBB manual and dictionary are still being prepared, the recent NHS costing is based on PBB programme and sub-programme aggregates. There is also a difference in targets achieved by the full NHS costing model and the NHS targets. Without further strengthening links, ensuring accountability against delivery will be challenging. Furthermore, if there is only a weak connection between the strategy itself and how it is implemented, this will reduce the value of having invested in planning the strategy.

Box 5.1 | Program-Based Budgeting

The Government of Zimbabwe has gradually been rolling out program-based budgeting (PBB), starting with several pilot ministries, including the MoHCC. PBB has the potential to solve a number of current problems in the health budget, including the lack of bottom-up governance and accountability.

The budget structure accommodated PBB from 2017. The structure of the budget documents shows a well-designed and consistent approach and follows a hierarchy starting with ministries, departments, and agencies (MDAs) cascading into programs and sub programs. However, no detailed breakdown of budgetary sub-programs into activities was implemented. In 2021, the structure of the 2020 PBB budget was substantially revised at both the program and sub-program levels, thus creating some challenges related to continuity and transparency.

The budget execution process can be described as a hybrid structure as the program and administrative structures are linked but are not totally congruent. Budget allocations and budget releases are organized according to program, sub-program, cost centers, and line items, while spending is organized by spending units in accordance with the MoHCC's administrative hierarchy. Spending units can receive funds from multiple sub-programs and even from other ministries' programs and need to report to both administrative and to program managers.

The government's public financial management (PFM) systems are still in the process of fully accommodating program-based release of funds and the reallocation of resources within programs. In addition, the program structure has not been formalized below the provincial level. The reform has yet to cascade down fully to the service delivery level where change management and capacity building efforts have so far not yet involved a broad audience of managers and health professionals.

Under the current circumstances of high inflation and low budget credibility, using the budget to leverage strategic policy implementation and service delivery appears to be a distant aspiration. The sector's decreasing ability to transform inputs into capacity makes the realization of ambitious output and program outcome goals less likely. In addition, the share of DP spending is increasing, and this is largely not aligned with the program budget structure. Specific challenges that need to be overcome include unrealistic targets, incomplete and unreliable performance information, and insufficient use of the audit and M&E function in support of the reform.

Despite formidable obstacles to the successful implementation of PBB, the government has showed remarkable determination in the roll out of PBB, and some positive effects have already been attributed to the PBB reform, such as improved coordination, transparency, and outcome orientation of resource allocation. However, up until now, the PBB reform has only had a limited impact on costing, accountability, and the use of performance information to increase the efficiency and effectiveness of the sector. If the implementation issues are addressed and macroeconomic circumstances stabilize, PBB can be expected in the medium term to strengthen budget credibility, accountability, and transparency and to improve service delivery in the health sector.

Accountability and Internal Controls

Accountability is compliance oriented. The MoHCC has only limited accountability for results. The mid-term review (MTR) of the National Health Strategy 2016-2020[89] made it clear that there was a general lack of accountability for performance, with little clarity about who was responsible for which objective. The MTR found limited accountability mechanisms within the MoHCC below the level of the Permanent Secretary to drive performance to achieve key objectives and outcomes. There is also a major gap in the generation and use of data on results to provide ongoing information for appraisal processes. Key monitoring and evaluation exercises are led by the MOHCC with funding by DPs for consultants, including the MTR of the NHS itself. These reviews are also not currently published further reducing their potential for encouraging accountability. The program budgeting reform holds promise to strengthen the performance orientation in the budget.

National audits have revealed that there is considerable scope for reducing waste and corruption in government health sector spending by improving internal controls. Independent audits of government spending are conducted each year by the Office of the Auditor General (OAG). These audit reports have discovered a range of issues with the accounting of domestic resources for the health sector. These numerous issues include: (i) differences in spending figures between different reporting systems; (ii) expenditures made with no proper records such as receipts and payment ledgers; (iii) inaccurate and incomplete records of payments owed to suppliers; (iv) weak controls on the human resource management system, leading to over-payments to employees; and (v) a lack of record-keeping for the management of assets such as vehicles. The latest published audit (the OAG's report on the 2018 national budget) presented a negative picture of the lack of progress made on the recommendations of previous audit reports. This shows that there is considerable scope for increasing the efficiency with which government resources are used for the health sector.

Weak commitment control procedures and budget management issues can lead to the accumulation of arrears. A 2020 World Bank study found that the MoHCC had accumulated arrears of US$10.9 million as of March 31, 2019. The vast majority of these arrears (90 percent) related to NatPharm and were paid off during the following year. As of June 30, 2020, the arrears had fallen to US$1.7 million and were mainly related to medical supplies, utilities, and the physical maintenance of health facilities. The reasons that the study found for the accumulation of arrears were the following: (i) weak commitment control procedures mean that commitments are often incurred outside of the PFM system and the MoFED is not aware of them so cannot ensure that cash is immediately available to make the payment; (ii) budget execution reports are not

89 Dovlo, D., Chirenda, J., Shamu, S. & Mahvu, W. (2019), "The Mid-Term Review of the Zimbabwe National Health Strategy 2016-2020", Overall Synthesis Report, Final Submission

issued on time and outturns against the appropriations do not include these commitments as they were made outside the formal system; (iii) the MoHCC may not have budgeted for its previous arrears; and (iv) the MoHCC's budget may have been unrealistic with an overly optimistic resource envelope, inaccurate forecasting and costing estimates, and inadequate provision for continuing and multi-year commitments.

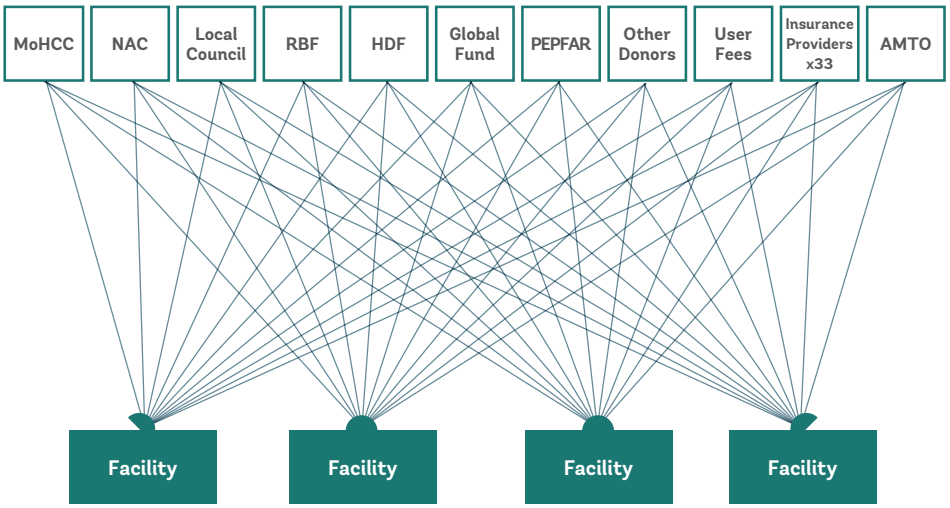
Fragmentation of Health Spending

Health facilities draw on multiple funding sources to finance their operational costs, which can lead to inefficiencies. Zimbabwe's health sector quite fragmented from the perspective of a facility manager. Sources of revenue include those from the general MOHCC budget, local authorities, NAC, user fees, direct payments from development partners such as RBF payments, user fees, insurance payments and AMTO. Management, accounting and reporting requirements across these sources is not uniform, placing an undue burden on facility managers. It also complicates strategic planning and decision making (figure 5.1 is illustrative of this problem). The MoHCC's 2019 national resource mapping exercise estimated that administration expenses as a share of total funding for health had increased from 14 percent in 2016 to 21 percent in 2019. This suggests that the negative implications of funding fragmentation have worsened during this period.

Figure 5.1:

Fragmentation of Funding Flows for Health Facilities

Source: Authors



Health facilities are burdened with having to manage multiple funding pools while also being limited in their influence over how key resources are used. As seen in Figure 5.1, health facilities have to manage different reporting and accounting requirements for a wide range of financing sources, which significantly increases their management costs. In addition, discussions with facility-level implementers conducted both for the mid-term review of the National Health Strategy and for this report revealed their frustration with how top-down management approaches dictated the nature of the key resources provided to the facilities. It can be a source of additional inefficiency if facility managers are unable to contribute their local knowledge of the specific resourcing needs and priorities of their facilities and communities to the decision-making process.

Vertical funding by DP programs contributed to fragmentation. The two largest DP funding pools are vertically funded programs focused on specific diseases (the US government program on HIV/AIDS and the Global Fund program on HIV/AIDS, TB, and malaria). While this can streamline the effectiveness of these funding pools in terms of their own specific objectives, it can also lead to a broader efficiency cost for the sector compared to a more integrated approach to service delivery. Specific examples of potential efficiency losses can be found in the areas of training, M&E, and communications. There can also be opportunities for services provided through one program to facilitate the provision of services by another (for example, antenatal care visits could also include cervical cancer screening and efforts to prevent the mother to child transmission of HIV/AIDS). However, achieving this kind of integrated service delivery is more difficult when funding pools for specific diseases are siloed, which also puts a considerable burden on the MoHCC to attempt to coordinate among multiple partners.

Spending by local authorities is not integrated into national-level finance or reporting systems. Local authorities are responsible for the delivery of health services in their areas. Their total spending is approximately 25 percent of the amount spent by the MoHCC. However, spending by local authorities on health is not included in the national PFM system. This decreases the oversight that central government can maintain over locally managed resources and potentially reduces the controls and balances placed on locally managed resources. Furthermore, it exacerbates the lack of any standardized reporting of spending, which makes it impossible to measure the performance of and within the national health system. To address this issue, in 2020/21, the MoFED has started piloting an online portal for local authorities to enter financial information into the central PFM system.

Pharmaceuticals Procurement

Progress is being made in consolidating the sector's pharmaceutical purchasing pools into one, which will increase the potential for the sector to negotiate better prices, but there is still scope for improvement. The parastatal NatPharm has been chosen to be the main player in buying, storing, and distributing pharmaceutical products. Having one dominant purchasing pool could strengthen the government's negotiating power in the purchase of pharmaceutical products and reduce inefficiencies from the duplication of purchasing roles across the sector. However, this assumes that the centralized purchasing pool is managed efficiently, but audit reports and the recent firing of some of NatPharm's managers suggest that there is significant room for improvement in this respect.[90] No data are available on what proportion of government and/or DP drug procurement is being handled through NatPharm, and it would be worth collecting and monitoring these data to measure progress in the consolidation of the sector's purchasing pools. However, DP programs in particular have made significant efforts to centralize procurement and supply chain management through NatPharm, in particular the Global Fund, the Health Development Fund, and UNICEF. However, the government's 2017 Health Financing Strategy states that 99 percent of all pharmaceuticals that are handled by NatPharm are DP-funded, suggesting that the government could make a greater effort to consolidate its own purchasing pools.

The domestic pharmaceutical industry has limited production capacity, which means that Zimbabwe is heavily reliant on imports. This creates challenges in managing the supply and distribution of pharmaceutical products. Importing from overseas can lengthen the timeframe for securing products, making it harder to project needs and then to manage orders, storage, and distribution. This can result in either understocked or expired commodities and can also cause households and facilities to use counterfeit and unregistered medicines. Local companies are now supplying less than 2 percent of requirements in the public sector (down from 40 percent in 2000).[91] The capacity utilization of local pharmaceutical manufacturing has been estimated to be below 30 percent[92], which contributes to inefficiencies in production and uncompetitive local prices and creates a vicious cycle as imported products become relatively cheaper.

90 Global Fund, Office of the Inspector General (2020), "Audit Report: Global Fund Grants in Zimbabwe", GF-OIG-20-008, 26 March 2020, Geneva, Switzerland.

91 MoHCC (2021) Zimbabwe National Health Strategy 2021 to 2025, Draft.

92 Ibid.

Results Based Financing

The use of results-based financing (RBF) has increased efficiency at the facility level by strengthening the link from payments to specific outputs, but there is scope for a broader roll-out of the mechanism. An RBF modality is being implemented in Zimbabwe since 2011. After being piloted in two rural districts in 2011, RBF has been scaled up to all 60 rural health districts since 2014. This approach involves funding health facilities based on the extent to which they deliver pre-defined results, specifically – in Zimbabwe – those related to maternal and child health. By contrast, general government funding for health facilities has historically not relied on either input or output-based formulae but has rather been based on past funding trends and planned activities alongside an ad hoc and qualitative form of RBF. A 2014 impact evaluation of the RBF initiative[93] found that it had led to faster improvements over time in a range of indicators than in facilities that were not subject to RBF. However, this evidence is not perfect. First, part of this improvement was likely as much a result of increased funding as the modality itself given that non-RBF facilities did not receive the same resources. Also, the complexity of the modality has meant that overhead costs have been high, as much as 23 percent over and above the existing management costs of districts.[94] Nonetheless, the potential for significant efficiency gains by implementing a more strategic approach to purchasing health services has been demonstrated. Efforts have also been made over time to reduce overhead cost through risk-based verification and by transferring the counter verification function from the University of Zimbabwe to the Health Professions Authority. Overhead costs could be further reduced if there were to be greater institutionalization of the approach, meaning that overall funding levels would be higher and there could be economies of scale.

Private Insurance Financing

Despite the importance of the private insurance sector to overall health financing in Zimbabwe, currently it receives little regulatory oversight or structured support. The 2017 National Health Financing Strategy set out the requirement to establish a regulatory body for the private health insurance sector, but this has not yet been done. The lack of such a body has led to issues such as conflicts of interest when insurers are involved in both the financing and provision of health care and significant amounts of unpaid claims. In the context of Zimbabwe's very rapid inflation since 2018, there are reports that some insurance providers are delaying payments of claims by several months, by which

93 World Bank (2016), "Rewarding Provider Performance to Improve Quality and Coverage of Maternal and Child Health Outcomes", Report No: 106518-ZW.

94 Witter et al. (2020), "Results-based financing as a strategic purchasing intervention: some progress but much further to go in Zimbabwe?", BMC Health Services Research.

point the re-payment is worth very little compared to the original cost.[95] The lack of a regulatory body has also contributed to the absence of a systematic and consultative price setting mechanism for the payment of health services. This may mean that opportunities are being missed to create specific incentives for service providers. Conversely, there may be opportunities to support the private sector's provision and financing of health care by making it easier for them to do business, including streamlining the transaction costs related to licensing, registration, certification, and importation. These potential areas of improvement are all highlighted in the 2017 Health Financing Strategy, although there is limited information yet on what progress has been made in addressing them. Any inefficiencies in the private market will be reflected both in increased costs for patients and reduced quality and quantity of care.

There may be opportunities for the strategic consolidation of private insurance funding pools. In the private sector, it is necessary to balance the efficiency gains from having fewer funding pools with the need for multiple providers to ensure effective competition to maximize productivity. In 2017, there were 39 insurance providers, with three dominating the sector: First Mutual AID, the PSMAS, and the CIMAS. In 2017, these three providers accounted for 85 percent of the population with health insurance coverage, with the remaining 15 percent thinly dispersed across the remaining 36 providers.[96] In developing its regulatory role, the MoHCC may want to investigate why there is such a proliferation of small insurance providers, the rate at which they enter and exit the market, and their financial sustainability. There may be market inefficiencies that can be addressed or incentives that can be provided to encourage a more efficient consolidation of private insurance provision. A lack of consistent reporting by insurers to central authorities currently makes it difficult to reach an understanding of the dynamics of the market.

95 Notes from stakeholder consultations conducted in 2019 for the Mid-Term Review of the National Health Strategy 2015-2020.

96 MoHCC (2017), "Register of Medical Aid Societies", Harare, Zimbabwe.

Mandated insurance funds are not efficiently used. There are two compulsory private sector insurance funds. The Workers Compensation Investment Fund aims to cover the health-related costs of private sector employees involved in accidents at the workplace. Their premiums are calculated using risk factors related to the employee's type of industry and employment. Anecdotal evidence quoted in the 2017 National Health Financing Strategy suggests that health providers are reluctant to accept reimbursement from this fund because of the associated administrative burden challenges. There is also a mandatory insurance requirement in Zimbabwe for third-party motor vehicle insurance, which covers insurance for medical expenses related to vehicle-related injuries. Evidence also quoted in the 2017 National Health Financing Strategy suggests that some health providers are unwilling to accept patients using this form of insurance because of a history of challenges in securing reimbursement.

Table 5.3 Key findings and implications for efficiency/effectiveness/equity from analysis of health financing systems

	PER Finding	Implication for Efficiency/Effectiveness/Equity
Link from strategic planning to budget execution	Limited correlation between planned and actual health sector spending.	Maximizing allocative efficiency requires sophisticated strategic planning to inform spending decisions.
		Investments into strategic planning and budgeting processes themselves are inefficient if they don't determine what is actually spent.
Accountability and Internal Controls	Limited accountability for performance with little clarity about who is responsible for which objective; major gaps in generation and use of data for appraisal purposes; key M&E processes are DP-led and often unpublished.	Lack of accountability reduces the extent to which the health sector can target and achieve improvements in efficiency and effectiveness of spending.
	Issues with internal controls highlighted by OAG reports and lack of actions taken against recommendations.	Weak internal controls lead to waste and corruption of health spending.
Fragmentation of Health Funding Pools	Health sector funding is highly fragmented with many resource pools and limited interaction between them.	Increased management costs, potential duplication of resources and reduced risk cross-subsidization.
		Management burden for health facilities with different reporting and accounting requirements for wide range of financing sources.
	Spending by local authorities not integrated into national level finance or reporting systems.	Decreased oversight of how locally managed resources are used; increased challenge to measure and improve overall efficiency and effectiveness of health sector performance.

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	PER Finding	Implication for Efficiency/Effectiveness/Equity
Pharmaceuticals Procurement	Progress towards consolidation of pharmaceutical procurement through NatPharm, but more so for DHE than GHE.	Having one dominant purchasing pool could strengthen the government's negotiating power in the purchase of pharmaceuticals and reduce inefficiencies from the duplication of purchasing roles across the sector.
	Audit reports show weaknesses in the management of NatPharm.	More efficient procurement from consolidation dependent on NatPharm being managed effectively.
	Local production capacity under-utilized leaving sector heavily reliant on imports.	Reliance on imports lengthens timeframe for securing products, making it harder to efficiently and effectively manage orders, storage and distribution.
		Under-utilization of local manufacturing capacity contributes to inefficiencies in production and uncompetitive prices.
Results Based Financing	GHE for facilities not generally based on the delivery of results.	RBF piloting has shown that efficiency gains can be achieved through linking financing to results.
		High administrative costs of RBF pilot could be reduced with greater institutionalization of approach.
Private Insurance Financing	Limited regulatory oversight or structured support despite significant contribution to THE.	Conflicts of interest when insurers both finance and provide health care can lead to over-provision of services.
		Lack of a systematic and consultative process for a price setting mechanism may mean that opportunities are being missed to create specific incentives for service providers relative to overall national objectives.
		Streamlining transaction costs for licensing, registration, certification and importation could enable reduced costs for patients and increased quantity and quality of care.
	Private insurance provision is highly fragmented beyond three dominant providers.	The proliferation of private insurance financing pools may be sub-optimal in terms of additional management costs and reduced opportunities for risk cross-subsidization relative to any efficiency gains from competitive pricing pressure.
	Health providers are reluctant to accept patients with mandatory workplace or motor vehicle insurance because of issues in securing reimbursement (including high administrative costs).	Greater efficiency could be achieved if these same resources were allocated to insurance funds with lower transaction costs.

Chapter 6
Conclusions and Recommendations

This public expenditure review of the health sector in Zimbabwe aimed to provide a rapid analysis of trends in health spending and potential issues with the efficiency, effectiveness, and equity of this spending. This final chapter summarizes our key findings and provides a series of recommendations aimed at improving the overall performance of the sector. It concludes with suggestions of further areas of research that might yield beneficial and informative results.

Key Findings

The deteriorating macroeconomic context in recent years has rapidly reversed the longer-term period of growth in government health financing. After significant increases in Government funding for health from 2010 onwards, that trend has been reversed since 2018. In real terms, adjusted for domestic inflation, government health spending in 2019 and 2020 declined back to 2016 and 2017 levels. In US dollar terms, however, government expenditure on health has now fallen below where it was at the start of the decade. This is particularly problematic for the purchase of medical supplies, the vast majority of which are imported. It is also making it harder for the sector to retain health workers who can now earn considerably higher salaries in Zimbabwe's neighboring countries.

In 2019 and 2020 DP funding temporarily became the main form of financing to the sector but is fragmented, volatile, and insufficiently-well coordinated with government funding. As the real value of government spending significantly decreased in 2019, DP spending increased, becoming by far the largest funding source for the sector. In US dollar terms, DP spending in 2019 was 3 to 4.5 times greater than MoHCC spending, depending on whether the official or effective exchange rate is used. Overall DP spending has been somewhat volatile and particularly difficult to predict. All DP spending is effectively off-budget (in other words, its execution is not managed, controlled, or captured by the national treasury even if initial allocations might sometimes be captured in official budget documents). While the majority (86 to 96 percent) of DP spending is managed within only three programs, the remainder is highly fragmented, with many different DPs providing relatively small amounts of separately managed financing.

Sector spending became highly imbalanced in 2019, with a radical erosion of the funding of payments to health workers. DPs have tended to provide only a very small proportion of their funding to cover payments for health workers (just 7 percent in 2017). By contrast, MoHCC spending on health has been very substantially focused on these employment costs (averaging 84 percent between 2013 and 2018). The government has actively pursued a policy of re-balancing its budget away from employment costs in line with recommendations from efficiency analyses such as the last health sector PER. In 2019 this re-prioritization coincided with a major fall in the real value of government funding, while DP funding remained relatively constant in absolute terms. This has led to a very

rapid shift in the relative funding of health worker payments (falling from 41% of total MoHCC and DP spending in 2017 to just 25% in 2019). The sudden erosion of the value of health worker payments relative to other areas of health spending may have created important inefficiencies in how other areas of health spending were used. Conversely, the reduced proportional allocation of funding for employment costs within the government budget may increase overall sector efficiency once the government's income position improves relative to the level of DP financing.

COVID-19 has exacerbated the sector's challenges. The COVID-19 pandemic has added a further shock to the already heavily strained financing of the sector. In aggregate terms, the pandemic seems to have aggravated the financing shock that the sector was already facing, with government health spending falling even lower in 2020 than it was in 2019. At the local level, many facilities have been closed for significant periods since the pandemic started, thus reducing both the availability of health services and the income stream to local authorities. Industrial action by health workers has increased because the real value of their remuneration has fallen significantly and because of issues with the supply of medical equipment, most notably a lack of PPE. The government's need to fund COVID-19 related health provision has further crowded out other already underfunded components of its budget. There is also some initial evidence that DP funding has become more fragmented becasue of the nature of their responses to COVID-19.

The achievement of key objectives such as those related to RMNCH may be under threat. Health outcome data that reflects the recent falls in government financing and COVID-19 challenges are not yet available. From 2015 to 2019, important gains were made in terms of the coverage of RMNCH services. Related health outcomes, such as the maternal mortality rate, had also improved. However, other health outcomes such as neonatal mortality had marginally worsened. In addition, even where health outcomes had improved, they were still poor in relation to the high levels of service provision, which suggests that the quality of service provision was inadequate. Interrupted service delivery in 2020 because of both the pandemic and increased strikes by health workers alongside major reductions in sector funding since 2018 is likely to lead to further setbacks in the performance of the health sector in these areas.

An improved macroeconomic climate in 2021 will improve the public financing of the health sector. The inflation rate peaked in July 2020 but has substantially stabilized since – with the monthly rate averaging 4.8% in the final months of 2020 and 3.2% in the first four months of 2021. The exchange rate also stabilized over the same period. Real GDP is projected to rebound from the falls in 2019 and 2020, while the 2021 budget's proportional allocation to the health sector has been set considerably higher. If this spending allocation is achieved in the context of greater government revenue with a more stable

macroeconomic context then the financing for the health sector will substantially increase in 2021 compared to 2019 and 2020.

The government has undertaken a number of important steps to improve the efficiency and effectiveness of its spending since 2015. The MoHCC developed a Health Financing Policy in 2016 and a Health Financing Strategy in 2017. These documents give important strategic direction for the sector's financial management, including a monitoring framework for assessing progress. The health sector has also benefited from centrally managed reforms for improving public financial management including the Program Based Budgeting reform and the Transitional Stabilization Programme. Aspects of the latter program, including reducing the dominance of employment costs within government health spending, are likely to lead to important efficiency benefits for the sector once the overall government income position improves relative to external funding. Data availability has also substantially improved as a result of the conducting of extensive annual resource mapping exercises and two National Health Account processes (in 2015 and 2017/18).

Although data availability has substantially improved, weaknesses in the available data can lead to misinterpretations of the realities of health financing. Challenges with the availability and reliability of key data can make it difficult to analyze or properly interpret the evolution of key sector financing issues. Areas for improvement include data on government health spending managed outside of the MoHCC (from other ministries, the NAC, and local governments), disaggregated private sector and household spending on health, and disaggregated monthly spending data (which is critical during a period of hyperinflation). Caution is required when interpreting partial or unreliable data. This has not always been made clear in the headline findings of some sector analyses in recent years.

There is a mismatch between strategic planning and actual budget execution. Key sector planning documents have not been developed in alignment with national budgeting processes nor have the expected sources of funding for these plans been specified. This weakens the link between the longer-term strategic plans and the government's annual budget preparation process. There is also a considerable divergence between the sector's planned spending as defined by annual budgets and the nature of actual spending as seen in execution data. These breakdowns in the links between strategic planning and actual execution reduce the value of the resources that are invested in improving strategic planning.

There are important weaknesses in the systems for accountability and internal control in the sector. The mid-term review of the most recent National Health Strategy highlighted significant gaps in the sector's accountability. It found that data were missing for many performance indicators, and there was a lack of clarity about who was responsible for key objectives. National audit reports have also found significant scope for implementing stronger internal controls to reduce waste and corruption in government health spending. MoHCC spending on the Monitoring and Evaluation and Internal Audit sub-programs has historically been extremely low and was further crowded out in 2020 with the relative reallocation of resources to the COVID-19 response.

Significant opportunities exist for further improving the efficiency with which existing funding for the sector is used. A 2019 study found that an additional 1 million DALYs could be averted through channeling the same funding to the sector towards a more optimal mix of interventions. Despite dominating MoHCC spending, hospital services are both under-used and not in line with the referral chain. In 2018 bed occupancy rates were just 29percent in provincial hospitals and 58percent in central hospitals, although it is worth highlighting these improved substantially from the extremely low rates of 2-7percent in 2014. Most maternity admissions in central hospitals (the quaternary level of Zimbabwe's health referral system) are for normal deliveries which do not require specialist referral. There is minimal financing or planning for the maintenance of existing infrastructure within the sector. There also continue to be high vacancy rates for specialist positions such as specialist equipment operators, which would be expected to contribute to inefficiency in the usage of existing medical equipment.

Aspects of government funding for the sector are likely to be regressive, and there is no explicit or transparent rationale for allocating resources across provinces. Access to outpatient care is equitably distributed among socioeconomic groups, but inpatient care mainly benefits richer households. Overall government health expenditure is likely to be regressive because it prioritizes civil servants' private health insurance and hospital services over rural health centers and community care. However, the data for 2019-2020 suggests that the relative prioritization of civil servants' private health insurance may have decreased. Pre-payment mechanisms to support the poorest, such as the AMTO, are not currently effective. Alternative approaches, including the currently piloted Urban Voucher Scheme, may help address this if scaled up using domestic resources. Geographically, the cities of Harare and Bulawayo benefit most from government spending on health, while there is no clear rationale for the different levels of funding for other provinces (whether by DPs or government).

Progress Towards Achieving the Recommendations of the Last PER

There has been considerable progress towards the achievement of key recommendations made in the last public expenditure review in 2015. Several actions have been taken towards implementing those recommendations as follows:

- The government has developed innovative mechanisms to increase its spending on health, including the introduction of a health levy on mobile airtime data that is notionally earmarked to pay for drugs and equipment for hospitals.
- Extensive annual resource mapping exercises have been introduced that provide consolidated data on DP spending and important information on how it complements government spending.
- The results-based financing approach has been increasingly institutionalized and has resulted in a reduction in the application of user fees for priority health services.
- Two National Health Accounts exercises aimed at capturing full data on health spending (private, public and DP) were undertaken in 2015 and 2017/18, with the latter being fully institutionalized within the MoHCC structure.
- The work on developing the Resource Allocation Formula has commenced (planning phase). This activity was included the Health Financing Policy and Health Financing Strategy which were launched in 2018.

There was less progress towards other recommendations, some of which are repeated in this current report. These include further mechanisms for coordinating DP resources, establishing explicit resource-allocation criteria for the geographical distribution of funding, and strengthening the frameworks for both public-private-partnerships and for-profit private sector investment in the health sector.

Recommendations

The following recommendations are made to address the issues identified in this report and thus increase the efficiency, effectiveness, and equity of spending in the health sector. These recommendations are broken down into actions that should be feasible to implement quickly ("Quick Wins", which are assumed to be achievable by the end of 2022) and others that may require more time ("Longer-Term", assumed to be achievable by the end of 2026).

R1

Recommendation 1

Improve the coordination and consolidation of DP and government resources.

QW1

Quick win 1 – Lead Responsibility: MoHCC – Leverage Health Sector Coordination Framework to strengthen alignment of partners in the health sector response. MOHCC has made notable strides to strengthen coordination with the establishment of a Health Sector Coordination Framework (HSCF)[97] in 2020. The HSCF, through its Health Partners' Coordination and Inter-Sectoral Coordination platforms, has potential to accelerate the alignment of Development Partner and other stakeholder plans and financing with MOHCC Annual Plans and Budget. The HSCF's value could be optimised by systematic engagement between MOHCC and actors in the sector with clear and timed entry points for consultation, inputs and decision making. Regular frequent interaction through the platforms, including Technical Working Groups, will allow for traction on recommended actions. In addition, structured inputs (e.g., through designed templates) from partners regarding planned funding and intervention areas to be supported in a specific period would complement the routine Annual Resource Mapping and strengthen efforts to progressively move towards virtual pooling of resources.

QW2

Quick win 2 – Lead Responsibility: MoHCC - Improve the already extensive annual resource mapping exercises to have a more direct influence on budgeting decisions. Improvements could include: (i) reporting on actions taken to achieve previous recommendations; (ii) identifying any blockages that prevented previous recommendations from being implemented; (iii) classifying as much spending as possible in terms of the MoHCC's programs and sub-programs; (iv) ensuring that the release of the resource mapping reports is timed to directly benefit the government budget preparation cycle; (v) capturing government health spending beyond just the MoHCC (including other ministries and full local council data); and (vi) incorporating greater sensitivity analysis on

97 The objective of the HSCF is to coordinate efforts by the MOHCC and all stakeholders in financing, planning, implementation including monitoring and evaluation of all health-related interventions, to maximize health outcomes among the people of Zimbabwe

exchange rates and the inflation-adjusted values of funding to examine more closely the relative contributions of different funding sources.

LT **Longer-term – Lead Responsibility: DPs - Increasingly integrate DP and government funding pools.** This would coordinate resources and reduce the burden of management costs across the health system. The lowest hanging fruit in this respect would be to start by increasing the consolidation of DP funding. In the shorter term, this could include bringing more DPs within the pooled multi-DP Health Development Fund as well as reducing the extent to which contributors run additional parallel bilateral programs. In the longer term, pooled DP funding should be increasingly integrated within the government's budget processes. With the new program budget structure there is an inherent tension, as government allocates funds by level of care and DPs seek to allocate by disease specific intervention or function. Full recognition of how budgetary programs map to health system functions and disease can be facilitated through indicators and targets. Instead of continuing to pursue vertical programs, DPs can instead help finance programs that contribute to indicators of mutual interest. For example, while it can be difficult to finance RMCH services directly, DPs could finance the primary care sub-program instead and advocate for the inclusion of ambitious RMCH indicators in the program structure.

Where challenges remain for DPs to directly provide their funding through the national treasury, this could take the form of virtual on-budget support. In practice, this would mean that DP funding is planned and executed in line with the government's own budgeting and reporting cycles so it could be reflected both in national budget allocation and, as far as possible, in real-time budget execution report. This can be facilitated, even if the funds themselves remained subject to the DPs' own accountability processes.

R2 Recommendation 2

Take full advantage of the PBB reform to improve performance management and accountability processes.

QW **Quick win – Lead Responsibility: MoHCC – Ensure that roles for program and subprogram managers are well understood and integrate the PBB structure within broader sector planning processes.** The PBB design is currently well set up and aligned with government administrative structures. There is now an opportunity to take advantage of this reform to strengthen how performance is managed within the sector such that efficiency and effectiveness are maximized. A critical first step would be to address strengthening the role of budget committees. Full roll-out of PBB to the subnational levels is still in process as the required training and change management which would support more efficient and effective implementation is ongoing. Alongside this, for strategic

planning to properly link to actual spending, the PBB structure needs to be fully integrated into sector planning tools There are ongoing efforts to cost the 2021-2025 National Health Strategy based on the structure of the government's budget Future Annual Resource Mapping exercises could also assess actual spending using the same structure. Furthermore, it is important to clearly establish the link between sub-programs, hospitals and health facilities.

LT **Longer term – Lead Responsibility: MoHCC – Use the PBB structure as a foundation for M&E processes such that program managers are accountable for performance.** The extensive M&E framework developed by the 2021-2025 National Health Strategy can be integrated with the PBB structure to strengthen how indicators and targets for each program and sub-program are defined such that those in charge of delivering results with a specific budget allocation can be better held to account for how efficient and effective their performance is. Budget allocations for M&E processes could also be increased to reflect the importance of the M&E function.

R3 Recommendation 3

Strengthen internal control functions to minimize inefficiency and maximize the effectiveness of health spending.

QW **Quick win – Lead Responsibility: MoFED and MoHCC - Increase the prioritization of the audit function and monitoring.** Audit is critical for regular course correction that supports efficiency in operations. Extending the depth, scope and frequency of audits will require commensurate budget allocations but are likely to lead to significant efficiency and accountability gains. Specifically, it is critical that the MOHCC internal audit function be sufficiently resourced to allow for course correction on an ongoing basis. Similarly, it would be important to strengthen and expand the use of electronic management systems to facilitate systematic tracking of resource allocation, spending, and performance.

LT **Longer term – Lead Responsibility: MoFED – Ensure that health spending by local councils is systematically captured in the central government's PFM systems.** Spending by local councils has constituted as much as 20 percent of total government spending on health. For effective planning and monitoring of its execution, it is critical that real-time data on this spending is fully available to central decision-makers. This should build on the MoFED's 2020/21 piloting of an online portal for local authorities to enter financial information into the central PFM system.

R4

Recommendation 4

Continually update strategies for improving the efficiency with which existing resources are used, considering lessons learned from the sector's COVID-19 pandemic response.

QW1 **Quick win 1 – Lead Responsibility: MoHCC - Actively target improvements in key efficiency indicators such as bed occupancy, health care worker attrition, specialist vacancy rates and those reflecting the appropriate use of the referral system.** A core set of indicators capturing aspects of system efficiency is important. Frequent and systematic monitoring of these indicators will allow for more strategic decision making and accountability to efficiency. For areas of insufficient progress specific actions coordinated among Government and DP institutions can be taken to incentivize improved performance. It is also important to determine whether low bed occupancy rates are due to inadequate access by the population and to compare challenges faced by private sector.

QW2 **Quick win 2 – Lead Responsibility: MOHCC – Review critical sector trade-offs and emergency public financial management actions taken in the health sector to respond during the COVID-19 pandemic**. Include an analysis of how spending on the communicable disease sub-program was allocated between different levels of care. Identify resource allocation and public investment management measures to continue and those that would need to be adjusted or rolled back in the short-term and medium-term.

LT **Longer term – Lead Responsibility: MoHCC - Conduct forward looking allocative efficiency analyses to inform funding prioritization decisions.** The 2019 allocative efficiency study found opportunities for major gains in cost-effectiveness through adjusting the health sector's intervention mix based on the current disease burden. Future analyses would need to look at how this disease burden is expected to evolve over time and so how sector funding should adjust to optimize its spending. In particular, the sector is likely to need to plan for how it increasingly reallocates resources towards the growing burden from non-communicable diseases.

R5

Recommendation 5

Improve the efficiency and effectiveness of private health spending by strengthening the government's regulation of and support to the private insurance sector.

QW **Quick win – Lead Responsibility: MoHCC - Produce annual reporting on progress towards the objectives set out in the Health Financing Strategy related to the private insurance sector.** This would help to identify and address bottlenecks to progress.

Longer term – Lead Responsibility: MoHCC - Complete steps to establish a regulatory body for private health insurance sector. This was set out as an activity in the 2017 Health Financing Strategy and remains an important objective to improve the efficiency and effectiveness of private health spending. A medical insurance bill is now with Parliament for review. Moving forward it would be important to complete the steps needed to establish said regulatory body. Key responsibilities of this body should include: (i) investigating late or non-payment of claims; (ii) regulating potential conflicts of interest when private health insurers both fund and provide health care services; (iii) creating a systematic and consultative price setting mechanism for the payment of health services; (iv) increasing the ease of operating for the private sector by streamlining the transaction costs related to licensing, registration, certification, and importation; and (v) exploring ways to balance concerns of competition and the greater efficiency of larger funding pools.

R6 Recommendation 6

Improve the availability and effectiveness of pre-payment mechanisms for poorer households.

QW **Quick win – Lead Responsibility – MoPSLW and MoHCC - Streamline or replace the AMTO with a more efficient mechanism for helping the poorest to pay their healthcare costs.** A promising alternative is currently being piloted is the Urban Voucher Scheme. It would also be important to learn from the experience of implementing the rural RBF and to determine what aspects could be adapted in urban areas. It is critical that any mechanism being considered also consider the full costs of treatment (including, for example, the cost of travelling to hospital and the cost of drugs) and mechanisms to increase domestic financing.

LT **Longer term – Lead Responsibility – MoFED - Put a higher priority on funding support to poorer households.** The optimal balance of funding between the PSMAS and AMTO should be considered from an equity perspective. An estimated 99 percent of the health expenditures managed by the MoPSLSW are spent on contributions to the PSMAS while only 1 percent is spent on the AMTO. Giving a higher priority in the MoPSLSW budget to the AMTO (or any successor scheme) would be much more beneficial to the poorest and most vulnerable in Zimbabwe. Noting political economy considerations associated with health insurance provisions for civil services, such a re-balancing of resources may need to be achieved incrementally over time (for example, rather than reducing resources for PSMAS, any marginal increase in resources for the sector could be prioritized for the AMTO).

R7

Recommendation 7

Improve resource allocation/funding criteria among provinces.

QW

Quick win – Lead Responsibility – MoHCC - Develop criteria that could be used to determine funding amounts for different provinces. These criteria might include population size, differential needs (such as disease burden or poverty rates), expected cost-effectiveness, or the amount of funding available to provinces from other sources. Even without an explicit resource allocation formula, these criteria could be compared with current actual funding amounts to identify whether any adjustments are needed in the provincial budget allocations. This can be applied for government and DP funding combined and could also be built into the MoHCC's annual resource mapping exercise.

LT

Longer term – Lead Responsibility – MoHCC - Include explicit criteria for allocating resources among provinces in the budget preparation process. These criteria could be used to establish an explicit formula for determining funding for specific budget lines. Alternatively, the process could be more qualitative, with an assessment of pre-set criteria undertaken to inform actual funding amounts, with the final amounts determined through negotiation and discussion. The decision-making process can be documented as part of the preparation of the budget.

Further analytical work is also recommended. This includes the following:

- **Identify factors that limit progress on this PER's recommendations and how to overcome them.** A particular focus could be on those recommendations which have been made by previous studies and strategies which have not yet been implemented. For example, the recommendation of this PER to set more explicit rationale for how funding is allocated between provinces was also made by the 2015 PER; the establishment of a regulatory body for the private health insurance sector was also made by the Health Financing Strategy.

- **Assess what it would take to fully institutionalize RBF.** The government has already demonstrated tremendous ownership of the RBF approach. Going forward it will be important to transition from a project-based approach to fully integrate RBF into the PFM structures (including recent PBB reform). Analytic work on how specifically this could be facilitated is important.

- **Assess how household spending affects equity, access, and service use.** Private spending makes up an important share of total health spending in Zimbabwe. As purchasing power has declined following macro-fiscal instability so has household spending on health. An important question is how this has affected access to quality services and whether there has been a shift toward public providers due to RBF/free health care rollout in primary health care facilities or whether households have foregone care

- **Review of pre-payment mechanisms.** Considering the inefficiencies of AMTO for the most vulnerable, a thorough assessment of pre-payment mechanisms in Zimbabwe and how public resources could be used more equitably and more efficiently would be useful.

- **Deep dive into human resource issues.** While it is widely acknowledged in the sector that remuneration and working conditions – further affected by inflation and COVID-19 – have contributed to increasing HRH attrition rates since 2019, there are still other aspects such as intrinsic and extrinsic motivators for the health workforce that could be identified through efficient mechanisms including online surveys. The information obtained through these surveys could be used to refine short to medium term strategies to motivate and retain staff.

- **Assess government's approach to address cross-cutting nutrition issues.** Approximately one in four children are stunted in Zimbabwe, making nutrition a pressing need. Addressing chronic malnutrition requires a coordinated response and a public financial management system that is able to identify and monitor nutrition-related resource needs and spending. A study is recommended to assess the government's cross-sectoral nutrition response: identifying opportunities, strengths, challenges, and aspects to strengthen.

Annexes and References

Annex 1: Assessment of the Program-based Budgeting Reform in Health

Context

The Government of Zimbabwe has gradually been rolling out program-based budgeting (PBB) starting with pilot ministries including the MoHCC. The reform is eventually expected to provide improved information on service delivery targets and their achievement across all ministries, departments, and agencies (MDAs) as well as on the cost associated with delivering the services under each program and sub-program (2017 PEFA).

Design and Implementation

The budget structure has accommodated PBB since 2017. The structuring of the budget documents shows a well-designed and consistent approach to informing stakeholders about funding and results. The program format offers historical and multi-annual perspectives on targets and integrates off-budget funding down to the sub-program level. The programs within Vote 14 of the MOHCC contain relevant outcomes and outputs measured by meaningful indicators. As part of PBB implementation exercise, existing line-item expenditure was divided as percentage shares to each program and sub-program. By doing so, MDAs identified how much their personnel expenses contribute to each program. Cost centers were mapped to relevant programs and sub-programs according to their estimated contribution. These estimates were based on the assumptions that were informed by past trends in expenditure according to MoFED. So, in the current budget structure, it is possible to identify how much is allocated to a specific hospital within a subprogram.

The PBB framework design does not yet feature activities, despite being in the initial design of the structure. The activity level in the budget structure this would allow for better bottom-up costing of programs, though care should be taken to not control for the activity level during implementation as this would risk introducing rigidities and implementation complexity. Analysis of existing information on budget realization and output levels from the PBB framework can also be used to inform and improve the bottom-up budget process.

Alignment of Strategy, Budget, and Administrative Structures

There is full alignment between the NDS, the NHS 2021-25, the 2021 program budget structure and the 2021 MoHCC annual plan in terms of the 10 strategic outcomes assigned to the four health programs. In addition, alignment and compliance is claimed between the 2021 MoHCC annual plan with over 15 plans and guidelines including Vision 2030 and Sustainable Development Goals. When comparing the program budget and the MoHCC annual plan however, the outputs and indicators to measure them align less well. In addition, it is unclear how outputs relate to existing budgetary and managerial accountability structures. Although spending units (e.g. hospitals) do map to sub programs financially, their contribution to delivering outputs and outcomes remains unspecified. Formalizing accountability for budget and results by contracting so far only occurs at the very top level (permanent secretary-chief secretary) and not further down towards program managers and sub program managers.

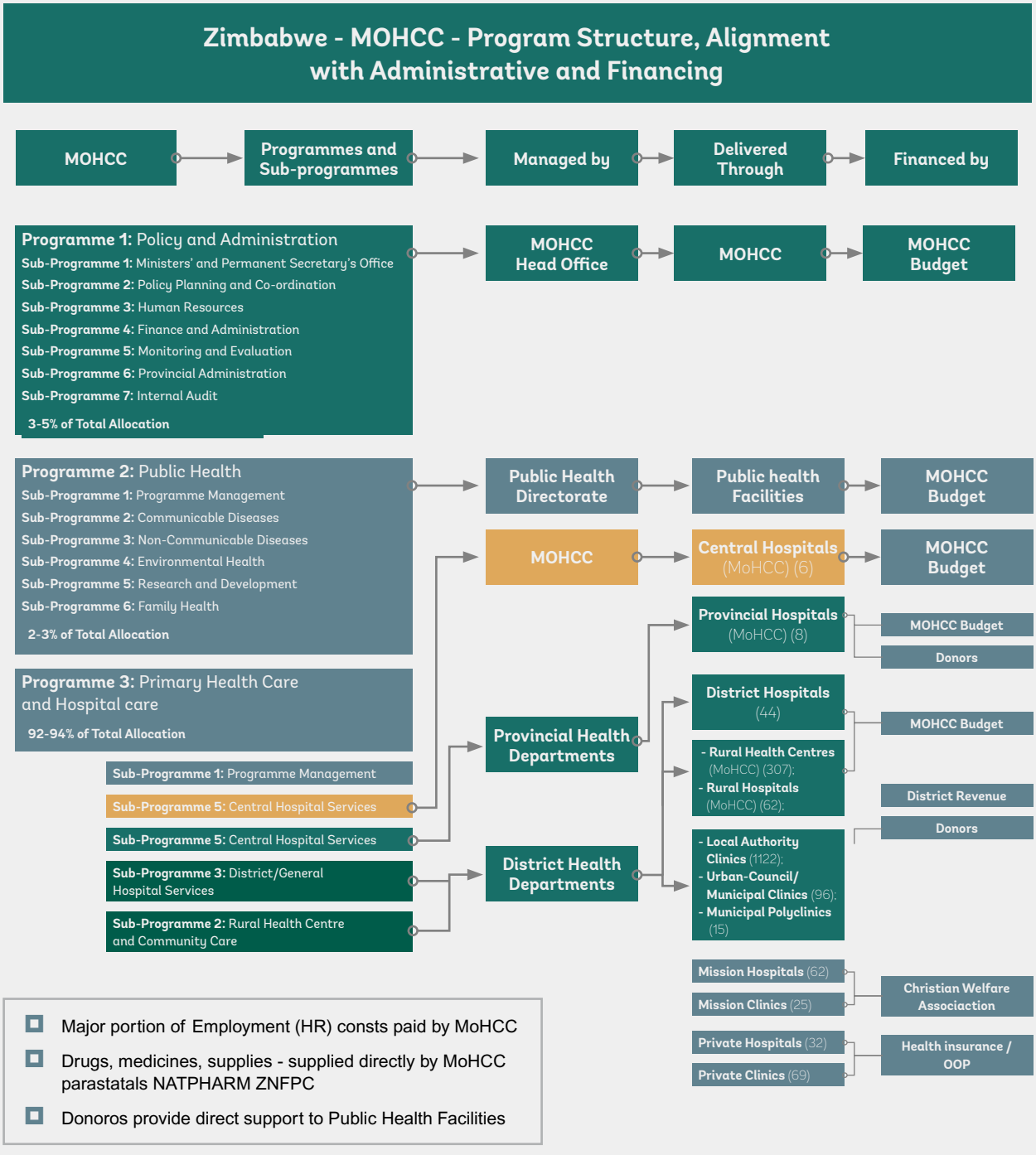
The budget execution process can be described as a hybrid structure as the program and administrative structures are linked but not are totally congruent. Budget allocations and budget releases are made according to program, sub-program, spending unit and line item. Spending is done by spending units organized according to the MoHCC administrative hierarchy. Spending units mostly receive funds from only one sub-program, but the structure is set up to allow them to receive funds from cost centers of multiple sub-programs (and even from other ministries' programs). They need to report to both administrative and to program managers. For complete accounting, expenditure transactions specify program, sub program, cost center and line item (Annex Figure 1.1).

Revision of the Program Structure

In 2021 the program structure was substantially revised at both program and sub-program level to accommodate an additional focus on research by the MoHCC. A fourth program, and four sub-programs were added to the three original programs (annex table 1.1). In return, four sub-programs were cancelled. In 2020, 35 percent of the approved budget was allocated to programs that no longer exist in the 2021 budget. This raises the question what kind of reallocations accompanied these shifts in program structure. Without this information being publicly available, the possibilities for multi-annual analysis with regard to costing or value for money remains severely limited. The performance targets in the budget show even less continuity: none of the 17 program outcome indicators in the 2020 budget remains available in the 2021 budget.

Annex Figure 1.1 Alignment of Program Structure with Administrative Structure and Financing

Source: Authors



Annex Table 1.1 Change in Program Structure for Health

Source: Authors

Key: ■ Continued or just renumbered in 2021, ■ Discontinued in 2021, ■ New in 2021.

2020 PBB structure Vote 14	2021 PBB structure Vote 14
Program 1: Policy and Administration	**Program 1: Policy and Administration**
Sub-program 1: Ministers' and Permanent Secretary's Office	Unchanged
Sub-program 2: Policy Planning and Co-ordination	Unchanged
Sub-program 3: Human Resources	Unchanged
Sub-program 4: Finance and Administration	Unchanged
Sub-program 5: Monitoring and Evaluation	Unchanged
Sub-program 6: Provincial Administration	Discontinued or re-allocated
Sub-program 7: Internal Audit	Renumbered 6: Internal Audit
	NEW: Sub-program 7: Logistics and Asset Management
	NEW: Sub-program 8: Legal Services
Program 2: Public Health	**Program 2: Public Health**
Sub-program 1: Program Management	Discontinued or re-allocated
Sub-program 2: Communicable Diseases	Renumbered 1: Communicable Diseases
Sub-program 3: Non-Communicable Diseases	Unchanged
Sub-program 4: Environmental Health	Unchanged
Sub-program 5: Research and Development	Discontinued or reallocated
Sub-program 6: Family Health	Renumbered 2: Family Health
Program 3: Curative Services	**Program 3: Curative Services**
Sub-program 1: Program Management	Discontinued or re-allocated
	NEW: Sub-Program 1: Quinary (Research Hospital)

...table continued next page

2020 PBB structure Vote 14	2021 PBB structure Vote 14
Sub-program 2: Rural Health Center and Community Care	Renumbered 5: Rural Health Center and Community Care
Sub-program 3: District/ General Hospitals Services	Renumbered 4: District/ General Hospitals Services
Sub-program 4: Tertiary Care (Provincial Hospitals)	Renumbered 3: Tertiary Care (Provincial Hospitals)
Sub-program 5: Quaternary Care (Central Hospitals)	Renumbered 2: Quaternary Care (Central Hospitals)
	NEW: Sub-program 6: Traditional Medicine
	Program 4: Bio-Medical Engineering, Bio-Medical Science, Pharmaceuticals
	NEW: Sub-program 1: Bio- Medical Engineering
	NEW: Sub-program 2: Bio- Pharmaceutical Engineering and Production
	NEW: Sub-program 3: Bio-Medical Science Research
	NEW: Sub-program 4: Bio-Analytics
	NEW: Sub-program 5: Health Research

Integration in PBB systems and flexibility to re-allocate

The PFMS also includes financial information of partner funded projects executed by the MoHCC. For reporting and monitoring performance information, a separate whole of Government performance system was created in 2020. This is currently not linked to the Public Finance Management System (PFMS) system. The two systems will need to be linked through an interface to allow combined reporting of financial and non-financial information. PFM systems are still in the process of facilitating program-based funds release and re-allocation of resources within programs. In practice, release of funds is requested by the provincial and district level based on their expected contribution to the programs. Actual release takes place by the MoFED and the MoHCC is notified when the funds are released. In theory, program managers are able to re-allocate resources between cost centers when the need arises (e.g., in response to a local outbreak of a communicable disease). In that case a request has to be made to the Treasury. The MoHCC is not yet able to do this by itself.

Current and Potential Impact

The central notion of the program budget structure is to use the budget to leverage strategy, performance planning, policy implementation and service delivery. Under current circumstances, this is still not fully possible, given high inflation and insufficiently credible budgets. Here it is difficult to attribute progress to program spending or hold program managers accountable. In addition, the government's contribution to total health expenditure has decreased significantly and a large share of total government spending is on human resources. This reduces the ability of program managers to influence program outcomes. Furthermore, a significant share of DP support is not aligned with the government program budget structure, making program costing challenging.

In spite of these formidable obstacles considerable progress has been made. The allocation of funds is now not merely to departments in the administrative structure, but meaningful programs that follow the health system structure. It is for example possible in Zimbabwe to clearly identify how much is allocated to primary care, through the respective primary care program. This structure also allows for contract management between the subprogram and spending units (e.g., primary care subprogram and individual primary care facilities), which offers an opportunity to fully integrate RBF into the program structure. The Zimbabwe program structure allows for clarity in the flow of funds, and line of sight for MOHCC management and can facilitate improved allocation decisions once the macro/fiscal situation and data situation improves. One respondent noted that within the MoHCC, PBB had a positive effect of on the level of responsibility felt within the Ministry.

> *"Program managers can no longer hide behind finance managers and avoid responsibility ('they did not give us the resources') as they are now part of costing and consolidation efforts themselves. In addition, there is more discussion on the impact of money on health results and the impact of health results on money."*

This account in line with recent observations from other sources that claim that PBB reform has helped the government gained a better understanding about its functions facilitating streamlining, address overlaps and improve coordination (Ecorys report, 2020). Budget transparency has improved over the past few years in Zimbabwe as measured by the availability of documents by the Open Budget Index (IBP, 2019). Despite the prevailing challenges Zimbabwe has made remarkable progress and the program structure is exemplary in the SSA context.

Remaining Conditions for Effective Use of PBB in the Medium Term

Despite some impressive achievements under difficult circumstances, some conditions for effective PBB implementation remain to be achieved. These are as follows:

- **PBB implementation has not fully cascaded down to facilitate financing of service delivery level (districts, provinces hospitals).** Budget implementation has not fully cascaded down to facilitate financing of service delivery level (districts, provinces hospitals). Budget programs and sub-programs lack visibility below the provincial level as they are integrated with the existing organizational structure. Knowledge of PBB at this level is limited to the budget staff directly involved in PBB implementation by the MOHCC. In addition, at the lower administrative levels, budgeting processes and reporting of information is still largely conducted in pre-PBB systems and formats. However, PFMS budget reports are PBB compliant. Program accountability is not formalized through contracting and granting authority to (sub-)program managers. For PBB to be viewed as a broader governance reform rather than just a budget reform, change management and capacity building will have to involve a broader audience of managers and health professionals at the service delivery level.

- **Existing targets tend to be ambitious relative to available resources.** Although target setting takes place within the budgetary ceilings in joint MDA-MoFED sessions, this process needs improvement and currently does not reflect a realistic balance between resources and ambitions. This is a growing problem fueled by the interrelated problems of inflation and the health worker crisis. With absenteeism and vacancies severely impacting capacity levels of health facilities, it should be questioned whether realistic performance targets can be set and to what extent health sector program managers can be held accountable for achieving them. To illustrate this: absenteeism among doctors was fluctuating around 50 percent in a recently investigated sample of health facilities (Impact of Health Worker's crisis on performance, World Bank 2020). At the same time, the majority of budget program goals in the 2021 budget have rather stretched outcome targets as they seek an improvement of over 25 percent compared to the most recent measured account in 2019 (such as increasing the Service Availability index by two-thirds). It will be very difficult if not impossible to realize such drastic improvements in health outcomes next year if operating at half the required capacity.

- **A credible and regular supply of relevant performance information is necessary to measure the outputs delivered and track progress toward intended outcomes.** Performance reporting in health faces challenges in terms of completeness, timeliness, and reliability. Audit findings over 2018 indicate that out of a set of 98 key investigated reports that are submitted on a monthly or quarterly basis, 60 scored above 85 percent completeness rate (draft MoHCC 2018 report). In a mid-term review of the 2016-2020 NHS, it was found that out of 197 indicators in the NHS Monitoring Framework, only 145 indicators were well-defined and measurable. Out of these 145, only 105 indicators had usable data and 40 indicators had no data at all (Draft NHS 2021-25). With regard to quality, some targets in the budget programs are unclear, lack historical data, or lack strategic relevance. Units of measurement are not always mentioned, and indicators sometimes lack specificity or explanation. For 18 out of the 21 output indicators for program 3, no realization figure for 2019 was provided. Although lack of historical data is not uncommon for a newly established performance framework, 14 of the programme's indicators have been around since at least 2018.

- **The M&E and audit function are not effectively deployed in support of PBB implementation.** Performance would benefit from regular auditing of the processes of collecting and dissemination performance data. PBB will not work if performance information is perceived as unreliable. Moreover, if performance incentives (either direct financial, renumeration, or reputation) become part of a functioning PBB framework, the risk of strategic misreporting of information will increase. Monitoring and evaluation are essential for processing financial and performance information so it can benefit managerial and political decision making. Underspending on MoHCC internal audit and understaffing of the M&E directorate hint at a low use of program information for analytical purposes. Instead, it seems that the current PBB structure discourages these functions. An example is a target for outcome 3 in the MoHCC strategic plan that sets the 'proportion of audit reports with adverse observations' at zero. As audits are meant to identify weaknesses and detect errors in order for the organization to learn and improve, having a target of zero may deprive the MoHCC of these opportunities to surface as it may effectively silence critical self-reflection.

- **Introducing PBB already had a considerable effect in terms of allocation of resources and accountability.** To fully realize the potential of PBB, the PFM reform program should consider the above-mentioned points in a careful and sequenced manner in close collaboration with key stakeholders. If these conditions are addressed, PBB has the potential to further strengthen budget

credibility, accountability, and transparency. It can also help mainstream RBF principles into the budget process and support an output-oriented budgeting approach.

The analysis suggests the following recommendations:

1. Align the MoHCC administrative structure as well as the delivery structures visibly with the PBB structure of Vote 14 in the National budget so it is clear which organizational units are responsible for which budgets and outputs.

2. Avoid changes in the current (sub-) program structure as much as possible. If such changes have to be made, map the financial re-allocation associated with these changes. This will allow for future multi-annual analysis.

3. Prioritize the M&E and audit functions and use their capacity to analyze cost levels and detect shortfalls in PBB implementation and service delivery.

4. Engage the health sector in the PBB reform at the service delivery level with capacity building in particular targeted at managers and relevant support staff instead of just budget staff.

5. Pilot PBB implementation at the level of provinces/districts/ spending unit level aimed at the aspects of:

    - Sub-program management and accountability including discretion and flexibility to re-allocate resources within a subprogram.

    - Analysis and use of financial and performance information for decision making.

    - Mainstreaming of RBF into the program budget structure

    - The MoHCC and MoFED can offer active support to such pilots by: (i) setting realistic goals after the level of available resources has been determined; (ii) providing user friendly access to financial and non-financial information from the PFM and whole of government information systems; (iii) targeting capacity development support to those involved in the pilots; (iv) making available analytical capacity to periodically monitor and assess progress towards realization of the contract (both budget realization and outputs); and (v) ensuring credibility and reliability of performance data with targeted audits.

Annex 2:
Harare City Case Sudy

Harare city is the capital and largest city in Zimbabwe. With about 1.5 million residents (population of over 2.5 million in broader metropolitan area accessing services in Harare city) it covers approximately 10 percent of the country's population (ZimStat 2012). The Harare city health department (HCHD) manages a wide set of clinics, and hospitals.[98] It has the mandate for the infectious disease response and for primary care delivery that includes most maternal and child health services. The HCHD reports directly to the Harare city council, but also to the Ministry of Local Government and the MoHCC. The MoHCC instead provides regulatory oversight and quality assurance. This case study aims to shed light on how resources for health are generated and utilized in Harare City and identify opportunities for improved efficiency, equity, and accountability.

Revenue comes predominantly from the Harare city rates account. Revenue collected from within the health sector (for example, via user fees or the issuing of licenses) are channeled to the HCHD revenue account from where they are pooled with other resources and become de-facto fungible.[99] This own source revenue makes up about 15 percent of total financing. Grants from external sources make up a relatively small share (0 to 8 percent) of total financing in health. This includes external grants for performance-based financing arrangements and cash donations by UNFPA. While RBF funds are sent directly to facilities, facilities report on the receipt and use of these funds to the HCHD periodically. There have not been any direct transfers from central government to the HCHD despite an agreement that the recurrent cost for service delivery would be split evenly. Some support is delivered in kind in terms of materials, medicines and trainings, but this remains unquantified. The remaining financing gap is covered by the rates account from general revenues collected by the Harare city administration.

98 Health services are delivered through two infectious diseases hospitals, 12 polyclinics, 38 satellite clinics and 10 family health service clinics" (2017 Annual Report).

99 License fees charged by the environmental division of the city are not retained by the department but channeled directly into the city main account.

Annex Table 2.1 Income Statement for Harare City Health Department

Source: HCHD Annual Report, 2018

Income type	2017	Percent	2018	Percent
Fees and charges	***4.08 M***	***14.8%***	***5.26 M***	***15.2%***
Administration, Clinics, FHS	2.73 M	66.9%	.21 M	4.1%
Dental clinic	.02 M	0.6%	.06 M	1.1%
Tuberculosis and Medical Center	.11 M	2.7%	.11 M	2.0%
Environmental Services	1.17 M	28.7%	4.82 M	91.5%
Hospitals	.05 M	1.2%	.07 M	1.2%
Government subsidy	***0.00***	**0.0%**	***0.00***	**0.0%**
Government grant	0.00	0.0%	0.00	0.0%
External donations	***.06 M***	***0.2%***	***2.71 M***	***7.8%***
External grants	.06 M	100.0%	2.71 M	100.0%
Deficit covered by rates account	***23.44 M***	***84.8%***	***24.06 M***	***69.3%***
Total	**27.64 M**	**100.0%**	**34.74 M**	**100.0%**

Facilities continue to charge user fees. This inhibits access to care and can constitute a financial risk to poor vulnerable population groups. User fees only make up a small share (around 8.5 percent in 2018) of total internally generated funds and these internally generated funds only make up 15 percent of total HCHD revenue. They could therefore be compensated, at relatively little cost to treasury, but this has not happened in practice. The reported decline in fees collected from administration, clinics and FHS between 2017 and 2018 follows the introduction of a no user fee policy for MCH services. However, based on discussions with Harare City Officials, it has been challenging for facilities to consistently comply with this policy because Treasury has not made any transfers to them. This disconnect also poses the question whether user fees are accurately being reported. Since providers are unable to retain fees at the facility level the incentive is to underreport actual values.

The waiver system for the poor could be improved. The assisted medical treatment order (AMTO) is designed to ensure the poor and vulnerable do not need to pay out of pocket at point of use. However, the identification of the poor has been challenging and reimbursement for the cost has been challenging. Facilities noted that they decide themselves when to waive fees. It is unclear how

efficient this system works and there is no transparency on how such decisions are taken. However, the inadequate public finance environment the providers operate in, makes an exit strategy from user fees difficult to envisage as this can only be done if the revenue forgone is covered through other means. The Urban Voucher scheme was appreciated as it incentivizes the poor to seek care.

There is insufficient reporting on expenditures. The annual report of the HCHD covers revenue and services provided. It does not however include information on actual expenditures, which is retained at the HCHD finance office. This constitutes an accountability concern and means it is difficult to gauge whether funds were used with regard to efficiency or equity. It also means that national health expenditure reporting is only partial. Funds provided from the rates account (70-85 percent of total resources) are said to be mostly used for the payment of salaries and wages. The functional, economic, or administrative use of other resources remains unknown, which also means it is not possible to gauge the degree to which DP and government funds are complementary.

Flexibility of resource use remains limited. The majority of resources is used for human resources, which are quasi-statutory and cannot easily be shifted. For other resources, flexibility on the use and transfer of resources requires concurrence of the Finance Director and the Finance Committee. RBF resources can be used with greater flexibility and therefore extend autonomy available to service providers.

Total resources provided by the MoHCC are insufficient for the HCHD to provide the package of services mandated by the MoHCC. The MoHCC determines the package of services that need to be provided at facilities with the HCHD. It does not however provide any direct financial support for the delivery of these services although it provides drugs and medical supplies. The relationship between what it costs to provide the basic package of services needs to be closely associated to the resources available at the HCHD, which may require the reintroduction of general government transfers from the MoHCC in addition to in-kind support to ensure the sustainability of the approach. The MoHCC has also expressed interest in a district hospital being financed and managed by the HCHD as the two available hospitals are infectious diseases hospitals and do not offer the same package of services as other district hospitals in the rural provinces, resulting in inefficiencies as patients from the city clinics are referred to the central hospitals. This would, however, also put a greater financing burden on the HCHD on construction and operationalization and may warrant subsidization from the general government budget.

Financing structures incentivizes undue referrals of deliveries. Deliveries with complications at lower-level facilities get referred to the referral hospital, which is managed and financed by MOHCC. Referrals may on the one hand simply result from lower-level facilities not having the supplies and staff to deal with complicated deliveries. However, HCHD facilities also have the incentive to refer as they then do not have to cover the financial cost of the delivery. In facilities that benefit from the RBF Urban Voucher program, facilities receive funding for each referral and are thus incentivized to retain the delivery. Further, each referral to a higher-level facility has to be accompanied by a voucher at the cost of the referring facility.

MOHCC provides some support through the provision of drugs and medical supplies. Drugs and supplies for communicable diseases such as HIV/AIDS, TB, or malaria are generally provided free of charge to the HCHD. These are generally highly subsidized by development partners such as PEPFAR or the Global Fund who finance these commodities. The MoHCC also supports commodities supplied through the assisted pull system (ZAPS), which covers the majority of RMCH requirements and other essential services. Facilities have to issue a request to HCHD, who then purchase on behalf of the facility should these commodities be available. If not, they have to be procured from the private sector. Resources used for this are generally revenue generated from within the health sector through e.g. charging patients themselves who may not be able to afford them. As such, support from MOHCC for HCHD is limited, which inhibits quality, access, and financial protection.

COVID-19 has disrupted availability of basic services. The majority of health facilities have been closed for business since April 2020 with only Wilkins Hospital, as the designated facility accepting COVID-19 patients, and facilities benefiting from the RBF Urban Voucher scheme remaining open. The closure of many facilities effectively meant that: (i) people forgo care altogether; (ii) people seek treatment in the private sector at significantly higher cost to the patient; or (iii) people break the referral chain and seek care at MOHCC tertiary/ quaternary institutions. The first two points are highly concerning as they undermine UHC principles of accessibility and affordability. The third point undermines efficiency considerations across the health system as primary care services were unavailable and the referral hospital likely became overwhelmed. While COVID-19 has reduced revenue collection by Harare City Council, it has reduced expenses by closing facilities and shifting the burden of care toward MoHCC-managed providers (higher-level providers in the referral chain). To avoid this, it is critical that HCHD providers are adequately equipped to protect staff in these facilities through, for example, ensuring the availability of personal protective equipment.

Annex 3:
Institutional and Governance Arrangements

Zimbabwe's institutional and governance arrangements for ensuring health and the provision of health services exist at four levels: the national, provincial, local authority, and facility levels. At each of these levels, there are specific actors who have the authority to execute and the responsibility for policy guidance, intersectoral coordination, and the implementation of the policies and guidance (Table A3.1). These institutional and governance arrangements take into account the multisectoral nature of health outcomes.

At the national level, policy guidance and authority to execute originates from the Cabinet and Parliament and cascades down to the provincial/ metropolitan councils and local authority/district/town councils in accordance with the Devolution and Decentralization (D&D) provisions and guidelines.[100] Provincial councils have hitherto been chaired by provincial Ministers (now called Ministers of State) who report to the President, but under the D&D provisions, an elected Council Chairman, who reports to the parent Ministry of Local Government, takes over this responsibility. A similar arrangement to that at the provincial level also exists at the district/local authority level.

There are also intersectoral coordination mechanisms at each level of governance that ensure that the multi-sectoral policies authorized by the Cabinet are internalized by individual ministries prior to being implemented. At the national level, this coordination is spearheaded by the Inter-ministerial Development Coordinating Committee (IDCC), which is chaired by the Minister of Finance and Economic Development supported by the Minister of Local Government and Public Works (MoLGPW). This arrangement ensures that central government development decisions cascade downwards through the MoLGPW to the provincial development team, which is coordinated by the provincial development coordinator (PDC), an official of the MoLGPW who also reports to the provincial Minister (Minister of State) under the Office of the President and Cabinet (OPC). At the provincial level, provincial ministers oversee the implementation of government programs including those in health and report directly to the OPC on their performance.

100 The sources of policy and authority are incorporated in the Constitutional provisions for health and well-being and are enshrined in the Public Health Act. The provisions that relate to the exercise of authority at the provincial and local authority levels are covered under the Devolution and Decentralization (D&D) guidelines.

Annex Table 3.1 Institutional Set-up and Governance Matrix

Level	Policy/Authority	Coordination	Implementation
National	Cabinet Parliament	The Inter-ministerial Development Coordinating Committee (the Ministries of Finance and Economic Development, Local Government and Public Works, Public Service, Labor and Social Welfare, the MoHCC, and the inter-ministerial task force for COVID-19 response/Chief COVID-19 coordinator)	The Ministry of Health and Child Care (MoHCC), the Permanent Secretary and national-level Program Directors and the Results-Based Financing (RBF) National Steering Committee (NSC)
Provincial	Provincial council or metropolitan council (in cities)	The provincial development team, Provincial development committee, and Provincial development coordinator (PDC) and the provincial COVID task force	The provincial health executive (PHE) and management team (PHMT), the provincial medical director (PMD), and the RBF provincial committee
Local Authorities (92)	Local authority council or town council (in urban areas)	The local authority development committee and coordinator and the district COVID task force at the community level.	The district health executive (DHE) and management team (DHMT), the district medical officer (DMO), and the RBF district committee at the local and community level
Facility	Ward	Ward development committee	The senior nurse on the health center team and the environmental health officer.

A similar but separate coordination mechanism was set up to respond to COVID-19. The Chief COVID-19 coordinator and an inter-ministerial task force coordinate this pandemic response at the national level. This coordination cascades down to the province and district level through the provincial and district COVID-19 task forces.

The provincial development committees (PDevC) consist of multisectoral technical committees of all of the heads of sectors at the provincial level. One of these technical committees is the Social Services Technical Committee (SSTC), which comprises representatives of the Ministries of Health and Child Care, Primary and Secondary Education, and Public Service, Labour and Social Welfare and also representatives of NGOs that provide health services in the given province.[101] The committee prioritizes interventions and assigns roles and

101 The SSTC may be chaired by either the provincial medical director or any of the other sector directors.

responsibilities among the relevant ministries, NGOs, and the private sector, including those for health. It coordinates responses to health emergencies[102] and produces progress reports based on the feedback from the local authorities that are at the frontline of implementation.

A similar institutional set-up for intersectoral coordination exists at the district/local authority level and is headed by the district development officer (DDC) who is supported by sector staff. The SSTC at the local authority level has the same mix of sector staff and performs similar functions as the provincial SSTC. At the level of rural health centers and clinics, coordination is managed by a committee comprising the rural health center or clinic staff, frontline staff of other relevant sectors, community development officers, volunteers such as village health workers, and representatives of the community.

At the national level, the responsibility for overseeing the implementation of health policies is held by the Ministry of Health and Child Care (MoHCC) headed by the Minister, a political appointee, and the Permanent Secretary as the accounting officer. The Permanent Secretary leads a team of heads of departments and programs, and the departmental and program heads in turn oversee implementation teams at the provincial, district, and local levels. The implementation teams include MoHCC staff, local authorities' health departments, NGOs (the biggest one of which is the Zimbabwe Association of Church-related Hospitals or ZACH), and private sector organizations that provide health care throughout the country. Medical aid societies, now under the umbrella of the Association of Health Funders of Zimbabwe (AHFoZ), have expanded their role to include the direct provision of health care through their own health facilities, laboratories, and pharmacies.

The Results-Based Financing (RBF) program, which started as a program supported by development partners, is now being adopted by the government as the preferred funding modality and has its own parallel governance structure. At the national level, the RBF National Steering Committee oversees the implementation of the program. A similar structure exists at the provincial and district levels where this responsibility lies with the RBF provincial committee and RBF district committee.

102 In response to the COVID-19 emergency, the SSTC works directly with the Director of the Emergency Response under the Civil Protection Unit in the MoLGPW. The provincial inter-ministerial COVID-19 management team, chaired by the Minister of State (provincial Minister) and supported by the PDC, oversees all COVID-19 interventions and reports to the President's Office.

The Provincial Health Executive (PHE), under the leadership of the provincial medical director (PMD), is responsible for overseeing and managing all of the public, mission, NGO, and private health programs in the province. The membership of the PHE comprises provincial-level nursing officers, pharmacists, laboratory technicians, physiologists, and other professionals who oversee their respective specialties in the province and at the provincial hospital. The District Health Executive is headed by the district medical officer and includes the same kind of members as the PHE. At the health center level, the team is led by the senior nursing and environmental health officers who oversee the community-based workers – village health workers (VHWs) and community-based distributors (CBDs). When the representatives of all the health providers in the province and districts meet annually to prepare plans and subsequently once a month or so to review plans and receive reports of the programs and program activities, they constitute the provincial and district health management teams respectively.

Annex 4: Health Service Provision Structure

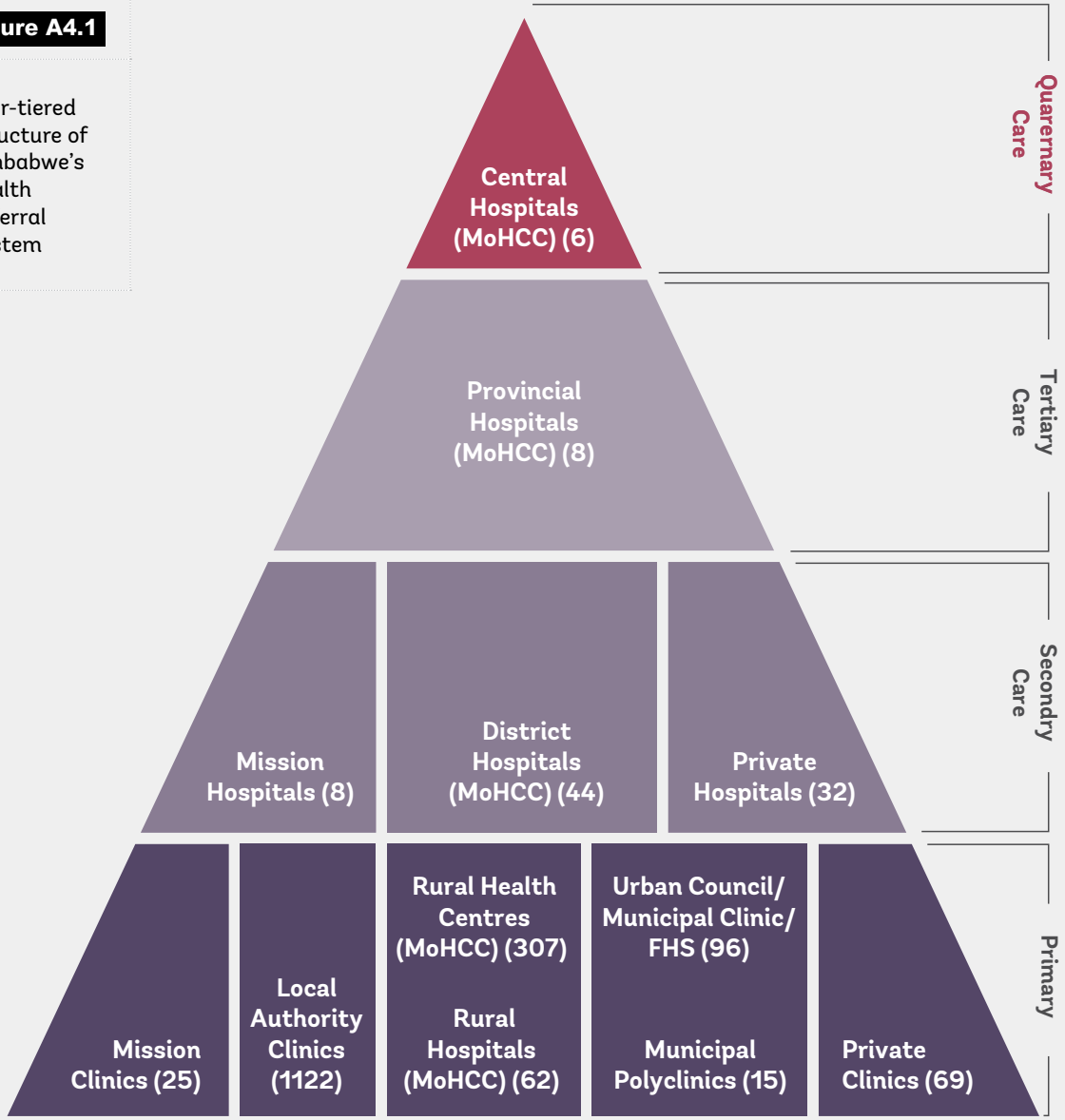
The primary health care approach has been the main strategy for health development in Zimbabwe since 1980. The country delivers health care through primary, secondary, tertiary (provincial), and quaternary (central) facilities, organized in increasing levels of sophistication (Figure A4.1 - see next page). The primary health care facilities, which constitute most of the facilities in the country, are meant to be the first point of contact for the population. This service delivery model requires the existence of an effective referral system in which complicated cases are transferred up to the next level of care. The primary and secondary levels of care each have a well-defined essential package of core health services.

While most primary care service providers are under the jurisdiction of local authorities, there are also many primary care facilities run by the MoHCC and the private sector. In both rural and urban areas, local authorities partner with the MoHCC in providing primary care services in a total of 1,122 local authority clinics, 15 municipal polyclinics, and 96 urban council/municipal clinics/ family health services (FHS). However, at the primary level, MoHCC facilities exist only in rural areas, totaling 307 rural health centers and 62 rural hospitals. There are also other public providers delivering services that cater to prisoners and specific occupational groups such as the defense force and the police. These facilities are managed by their respective ministries. Also, there

are 69 private for-profit clinics[103] and 25 private not-for-profit (mission) facilities providing primary health care services in Zimbabwe. The former operates mainly in urban areas, while the latter mostly serve rural areas.

Figure A4.1

Four-tiered Structure of Zimbabwe's Health Referral System



103 Private clinics include general practitioners, private maternity homes, traditional medical practitioners, and NGO-run services

Primary health care facilities provide the comprehensive preventive and basic diagnostic and treatment services that are critical for implementing the national health strategies. These facilities provide maternal, neonatal, and child health (MNCH) services such as comprehensive antenatal and postnatal care, the Expanded Program of Immunization (EPI), and community-level health promotion, child monitoring, and surveillance. The typical public primary care facility has two registered general nurses and other primary care cadres but no doctors. Village health workers (VHW) and other community-based cadres work as multidisciplinary teams to provide health promotion, child monitoring, and surveillance services at the community level. Altogether, these facilities are the main delivery vehicles for implementing the strategies set out in the NHS 2016-2020.

Secondary facilities are the first referral level facilities and support the primary level with emergency, ambulatory, and inpatient services. These include 44 district hospitals under the MoHCC, 62 mission hospitals, and 32 private hospitals. Each of the districts in the country has either a district hospital or a mission hospital that is run as a designated district hospital with some support from the central government. Most of the private hospitals are for-profit facilities, but there are also some not-for-profit facilities run by medical insurance companies that are established to curb moral hazard in the provision of care (much like managed-care facilities). Secondary-level hospitals have approximately two doctors who provide care with the support of nurses. They provide essential curative, rehabilitative, and supportive services to primary care facilities.

Tertiary and quaternary care facilities, all located in urban areas, provide services that involve specialist care. At the tertiary level, provincial hospitals serve as the first level of specialist referral. There are eight provincial hospitals, one in each of the eight administrative provinces (except Harare and Bulawayo, which are urban provinces), which act as a referral center for the district hospitals in that province. These facilities are staffed by specialist doctors and nurses and offer emergency, ambulatory, and specialist inpatient services. The highest level of care in the health system (the quaternary level) is provided in six central hospitals that directly report to the MoHCC. These facilities offer specialist inpatient services and are university teaching facilities. This is where most of the specialist doctors in the country are stationed.

As depicted in Figure A4.1, the health delivery system includes both private and public facilities, with the public sector being the main provider of health care services. Private facilities operate at the primary and secondary level, while public facilities exist at all four levels of the referral system. As is common in other countries, private for-profit facilities and clinics offered by medical insurance companies are mostly located in urban areas.

Annex 5:
Fund Flow Mechanisms

The MoHCC receives funds from both the Ministry of Finance and Economic Development (MoFED) and DPs. It then allocates part of these funds to central hospitals, provincial medical directorates (PMD), provincial hospitals, district cost centers, and MoHCC parastatals (such as the Zimbabwe National Family Planning Council or ZNFPC, the National Pharmaceutical Company or NatPharm, research institutes, and national laboratories) (see Figure A5.1). The MoHCC oversees the central hospitals directly and provincial and district facilities indirectly through its representatives, the PMDs and the district health offices (DHOs).[104] However, as a result of the recent decentralization of Zimbabwe's public financial management system, funds flow directly from the MoHCC to provincial hospitals and district cost centers.[105] The exception is the MoHCC funds that go to mission hospitals (which are designated as district hospitals) and rural district council (RDC) clinics as they pass through the PMDs. Provincial and district transfers are provided both in cash (the funds needed to meet the daily operations of the facilities) and in-kind (in the form of drugs and medical supplies).

Most of the salaries paid in public facilities are paid from the central government's budget, while a portion of it is covered at the facility level. The salaries of most workers in MOHCC health facilities and RDC clinics are paid centrally by the MoHCC through the Salary Service Bureau (SSB), which is under the Public Service Commission. However, some non-clinician staff that are not part of the staff establishment of the MoHCC are paid from user fees at the hospital level and from RBF subsidies in clinics. The MoHCC also pays the salaries of selected staff working in mission hospitals through the SSB.

All major capital expenditures in the sector are managed centrally by the MoHCC together with the MoFED and other relevant ministries. For example, the Ministry of Housing and Local Government is sometimes responsible for the construction and refurbishment of hospitals, and the spending is normally reflected under MoHCC budget. However, during the COVID-19 emergency in 2020, resources were transferred to the Ministry of Local Government and Public Works which implemented the construction and rehabilitation of hospitals and isolation centers. As of 2021, this spending will revert to being under the MoHCC. Some minor capital expenditures are managed by both the MoHCC and the health facility in question.

104 While the Provincial Health Executive provides direct oversight to the provincial hospital, the District Health Executive oversees district hospitals and directly administers and manages Rural Health Clinics- the lowest level of primary care that is often staffed with one nurse and no administrative staff.

105 Earlier, it used to be the PMD Executive that allocates funds to the provincial hospital and DHOs.

Parastatals in the health sector (the ZNFPC and NatPharm) transfer in-kind support directly to health facilities. These agencies receive their funds from MoHCC or development partners. NatPharm supplements its funds by operating a business that sells drugs to both public and private entities. Both parastatals allocate medical supplies and drugs directly to provincial hospitals, district hospitals, rural health clinics and, through the Department of Health Services, to local council facilities.

The main source of funding for local council health facilities is the local authority, while almost all of their in-kind transfers (drugs, consumables as well as salaries) are provided by the central government and DPs. Cash subsidies from the local authority to these facilities are supplemented by donations, patient user fees, and council fees. These facilities also get in kind support, mostly in-kind transfers, from external DPs and the central government and receive medical supplies and drugs from the MoHCC parastatals, NatPharm and the ZNFPC. While infrastructure spending in rural district facilities is provided by the rural district council, almost all salaries, drugs, and consumables are covered by the central government and DPs.

Some government health spending comes from outside the MoHCC. In addition to funding that flows through the MoHCC, the MoFED transfers funds to a few other central-level agencies to be spent on health. These agencies include the National Aids Council (NAC), the Ministry of Public Service, Labor, and Social Welfare (MoPSLSW), and other relevant ministries (Defense, Justice, Home Affairs, and Education). For example, health spending in the security sector (such as the police, the army, and prisons) is provided and managed by the appropriate ministry or government agency. These ministries receive their budget from the MoFED and spend it directly on their health facilities. In addition, the NAC receives its earmarked funds from the AIDS levy directly from the MoFED and uses them to coordinate a multisectoral response to HIV/AIDS. Part of these transfers go directly to provincial hospitals, district hospitals, and rural health clinics.

The MoPSLSW is one of the most important sources of funding for the health sector. It provides this funding through two channels: (i) the Premier Service Medical Aid Society (PSMAS) and (ii) the Assisted Medical Treatment Order (AMTO). Through the PSMAS, the ministry transfers some of its funds to pooled insurance funds by way of the government's contributions to the private health insurance of civil servants and their families. This makes up a significant share of the health sector spending by the MoPSLSW. In addition, there is a relatively small amount funding that goes through AMTO. Under this program, the MoPSLSW reimburses health facilities for providing free services to indigents (the poor and the vulnerable). AMTO reimburses not only public facilities under the MoHCC and local authorities but also mission facilities under the Zimbabwe Association of Churches (ZACH). There is no reimbursement for the use of services provided by private, for-profit facilities.

Most development assistance for health is off-budget.[106] DP funding from the Global Fund flows to public health facilities through fund agents[107] such as UNICEF and their implementing partners. Some of the funds from the Health Development Fund also go through this same channel, while others flow directly to implementing partners and from there to health facilities. The latter channel is also how funds flow from PEPFAR to health facilities. Fund agents, including UNICEF, either transfer resources directly to health facilities run by the MoHCC (both central and local) or sub-contract to other implementing partners (such as the Crown Agents for the RBF and Health Retention Scheme service contracts). The MoHCC parastatals such as NatPharm also serve as implementing partners for DP funds and handle the distribution of medicines and supplies to health facilities. Overall, most DP funding is spent on medicines, medical supplies, and other commodities.

Private spending on health comes directly from out-of-pocket payments and indirectly from pooled private insurance funds. Uninsured patients pay user fees directly at the point of service use, not only when using private facilities but also when using public hospitals run by the MoHCC. User fees are also charged in mission hospitals and rural district facilities if they are not receiving result-based financing (RBF) funds. However, rural health clinics run by the MoHCC do not charge user fees. Insured individuals also pay copayments at the point of service use. In addition to these out-of-pocket payments, some private health spending flows to facilities through pooled private insurance funds that pay for the services provided to their members.[108]

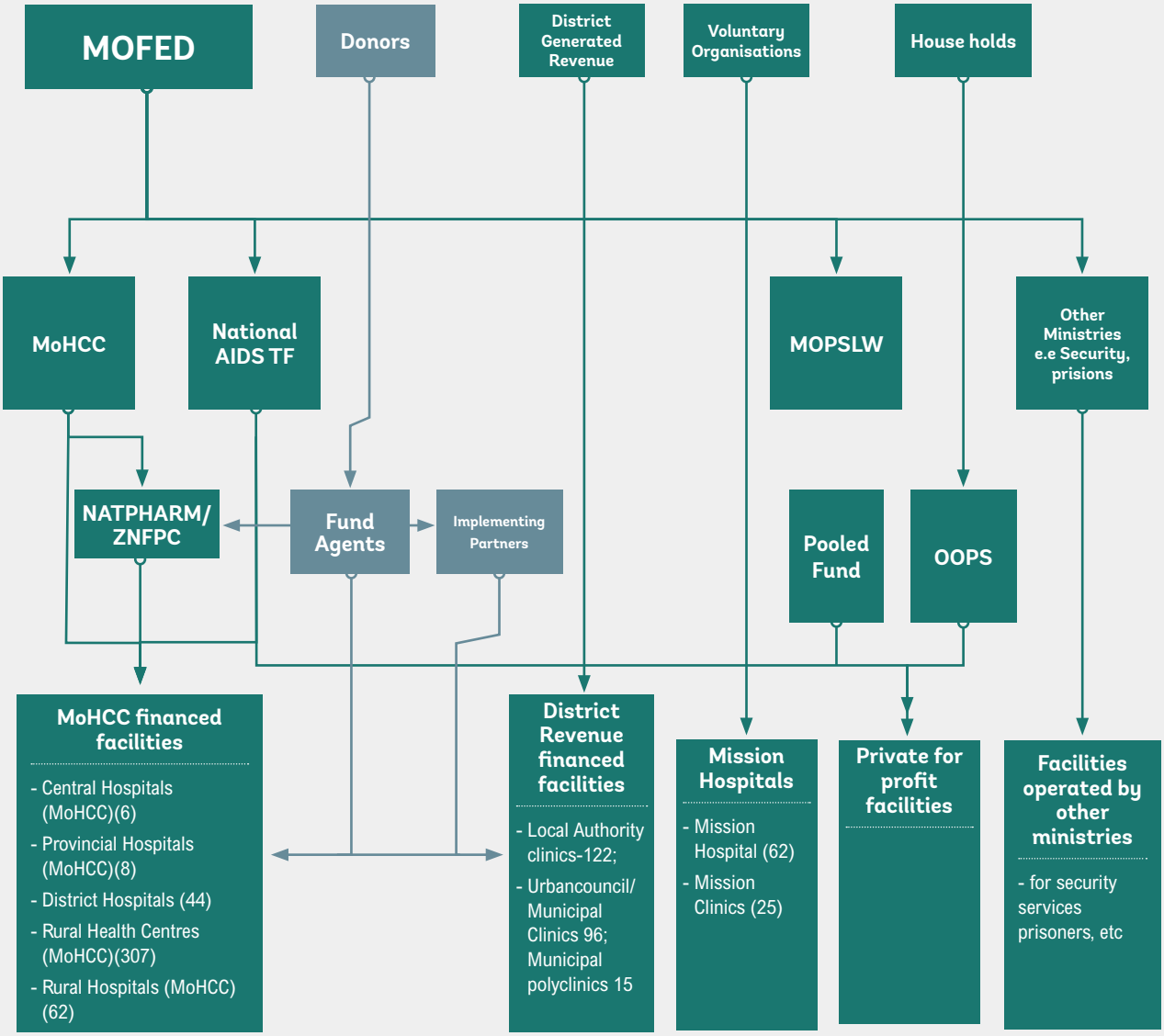
106 Off-budget in this report is used to mean funding that does not go through national treasury systems. While DP funding allocations might be partially reflected in national budget documents, the actual financing from DPs in the health sector does not flow through the national treasury nor is it managed through broader government PFM systems.

107 Agents who administer funds on behalf of DPs.

108 Overall user fees at the hospital level come from these two private sources and the MoPSLSW AMTO and DP funds (in terms of RBF as per output/quality indicator).

Figure A5.1 Financing Sources and Fund Flow Mechanisms in Zimbabwe's Health System

Source: Authors



Annex 6:
Notes and Methodology

Notes on THE data

Since the last PER, the government has conducted two comprehensive National Health Accounts exercises, greatly improving the quality of data on total health expenditure. To assess the full range of health expenditure in Zimbabwe, the government developed National Health Accounts (NHA) in 2015[109] and 2017/18.[110] These exercises collect key data on spending by households and corporations (in addition to government and DP spending as covered earlier in this chapter). For understanding Total Health Expenditure (THE) the government spending data reported in Chapter 3 will be used rather than the NHA data because the NHAs exclude spending by ministries other than the MoHCC (most notably the MoPSLSW's contributions to the PSMAS) and also significantly under-state local council spending on health (based on data from this PER's Harare City case study). The latest data from MoHCC resource mapping exercises is also used rather than that stated in the NHAs because these exercises are updated each year with some re-estimations of previous figures.

It is difficult to assess trends in total health expenditure because of gaps in the available data as well as rapid shifts in the country's economic situation. There have been major changes in Zimbabwe's economic context since the last NHA was conducted, so it is likely that the relative proportions of overall health spending will have changed considerably since the most recent data became available. In terms of private household and corporation spending there were very large changes in key figures between the last two NHA exercises. The breakdown of data on private household spending in the 2017/18 exercise was less comprehensive than that provided by the 2015 NHA, complicating the direct comparability of the data.

The data about the evolution of households' private contribution to health insurance from 2015 to 2018 present conflicting pictures. The 2015 NHA data showed almost all household spending on health to be out-of-pocket. Just US$19 million (out of a total US$366 million) was from contributions to health insurance, and US$3 million was considered to be non-profit institutions serving household spending. The 2017/18 NHA found the proportion of total household spending that was out-of-pocket spending had fallen significantly from 94 percent in 2015 to 73 percent in 2017 and then to 68 percent in 2018. The 2017/18 NHA

109 MoHCC (2017), "National Health Accounts 2015. Estimates for Zimbabwe".

110 Government of Zimbabwe (2019), "Zimbabwe National Health Accounts 2017 & 2018. Resource tracking for Universal Health Coverage: Equity, Quality and Financial Protection".

did not give a breakdown of how much of the remainder was contributed by insurance contributions or non-profit institutions serving household spending. Assuming the same 85 to 15 percent split for non-OOP spending as in 2015, then private contributions to health insurance had increased in absolute terms from US$19 million in 2015 to US$47 million in 2017 and US$31 million in 2018 (using the effective exchange rate). However, this seems to contradict the findings of Zimstat's Labor Force Reports, which showed a reduction in the proportion of the population covered by private health insurance from 9 percent (1.3 million people) in 2014 to 7 percent (984,000 people) in 2019.

Notes on GHE data

Analysis of GHE is complicated by issues of the exchange rate. In the main text of this report the headline USD figures presented apply the effective market exchange rate as proxied by the real time gross settlement (RTGS) rate for electronic transfers. This is done to enable international comparability and simplify the narrative. In practice since 2018 there are two exchange rates of relevance – the official and the effective. In 2018 the effective value of newly introduced forms of domestic currency significantly diverged from their official parity exchange rate with the US dollar.

Particular care is required to interpret GHE figures for 2018. In 2018, the official level of Government spending on health massively increased in both real (adjusting for domestic inflation) and official USD terms (using the official exchange rate). However, by the end of 2018, the effective conversion rate used by commercial banks for the government's form of US dollar had reached 3.5 (while the official rate remained at parity). Although the inflation-adjusted figures in Table A6.1 account for the 10 percent domestic inflation rate in 2018, much health spending in Zimbabwe is on imported products, the effective costs of which had more than tripled by the end of the year.

In 2019 and 2020 the divergence between the official and effective rates continued, while the depreciation of the newly re-introduced domestic currency also remained faster than the domestic inflation rate. In terms of its official exchange rate, the ZWL went from parity in US dollar terms at the start of 2019 to 82:1 by the end of 2020. Its effective exchange rate – proxied by the real time gross settlement (RTGS) rate for electronic transfers – reached 111:1 by the end of 2020. Although the domestic inflation rate also considerably accelerated in 2019 and 2020, this rise was not as fast as the fall in the value of the domestic currency, so the constant value of GHE in domestic currency terms reduced less dramatically than its value in USD terms. Nonetheless, the USD analysis is critical since the sector's ability to pay for medicines, equipment, and supplies, which are predominantly imported, is entirely contingent on the US dollar value of the budget.

Data availability for GHE at the time this PER was conducted is incomplete, requiring assumptions to be made to make comprehensive estimates. This is particularly the case for non-MoHCC spending. The notes under the following two tables set out in detail the assumptions used for estimating overall GHE.

Annex Table 6.1 Government executed spending on health, 2010-2020

Source: For GHE see Table A6.2 sources. TGE, inflation and GDP 2010-2017 data from Reserve Bank of Zimbabwe ("Macroeconomic Indicator Table"); TGE 2018 data from MoFED 2020 Budget Review (May21 draft); TGE 2019-2020 data from www.zimtreasury.gov.rw - individual monthly consolidated financial statements up to August 2020; GDP 2018-2019 data from MoFED 2021-23 Macroeconomic Fiscal Framework. Population figures for GHE per capita from ZimStat (2015) Population Projections Thematic Report Medium Scenario. 2013-2020 inflation data from ZimStat April 2021 CPI report. ZWL-US$ monthly official Interbank and effective (RTGS) exchange rates from www.marketwatch.co.zw

Notes: GHE = government health expenditure. TGE = total government expenditure. GDP = gross domestic product. a/ Given rapid inflation and exchange rate depreciation during 2019 and 2020, the US$ and inflation adjusted estimates here use the monthly breakdown of spending data with monthly exchange and inflation rates applied before aggregating for an annual figure. For this reason, the US$ numbers presented here may differ from those shown in official budget data such as the Blue Book since those estimates only apply average annual conversion rates. b/ At the time this PER was conducted spending data for 2020 was only available up to end of August 2020 for overall government spending and end of September 2020 for MoHCC spending. The analysis here extrapolates these figures to the end of 2020 by assuming that spend in the final 3-4 months of the year continues at the same rate as the first 8-9 months in both US$ and constant ZWL terms. c/ GDP data for 2020 not presented because available data at time of PER were projections only and rapid inflation has made such estimates highly variable; d/ Local council spending on health is not included in the available data for total government expenditure. Therefore, this ratio considers GHE excluding health spending by local councils. e/ Using current official US$ data. This makes an important difference to the 2019 and 2020 figures. Nominal GHE as a share of nominal TGE in annual ZWL terms was 8 percent in 2019. However, given rapid inflation and currency depreciation during the year, the specific timing of health expenditure relative to other government expenditure is of material importance. If using available monthly spending data and adjusting for monthly domestic inflation rates, the share of GHE relative to TGE was 8.7 percent. The figure presented in the table is based on monthly adjusted US$ data, for which the value of the earlier timing of health expenditure compared to other government spending further increases the proportion to 9.5%. f/ Ratio uses current official US$ figures for GHE and GDP. This differs from using ZWL figures only in 2019 and only marginally (because of slight differences in exchange rates applied for the available GDP data).

(All figures in millions, except GHE per capita)	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019[a/]	2020[a/, b/]
GHE (current official US$)	246	381	470	451	502	523	502	589	963	301	222
GHE (current effective US$)	246	381	470	451	502	523	502	589	482	201	138
GHE (constant 2010 ZWL)	246	368	438	414	461	493	480	559	825	675	495
TGE (current official US$)	2,178	3,051	3,588	3,981	3,917	3,924	4,706	6,045	7,745	2,590	2,332
TGE (current effective US$)	2,178	3,051	3,588	3,981	3,917	3,924	4,706	6,045	3,872	1,713	1,470
TGE (constant 2010 ZWL)	2,178	2,948	3,343	3,651	3,599	3,694	4,501	5,730	6,638	6,414	5,645
GDP (current official US$)	12,042	14,102	17,115	19,091	19,496	19,963	20,806	27,438	42,468	18,454	-[c/]
GHE (excl. local)[d/] **/ TGE** [e/]	9.4%	10.4%	10.9%	9.5%	10.9%	11.3%	8.8%	8.2%	10.5%	9.6%	7.7%
GHE / GDP [f/]	2.0%	2.7%	2.8%	2.4%	2.6%	2.6%	2.4%	2.1%	2.3%	1.6%	-[c/]
GHE per capita (current official US$)	20.0	30.6	36.0	33.7	36.8	37.6	35.4	40.6	65.1	19.8	14.3

Annex Table 6.2 Government spending on health by institution (current effective US$ millions)

Source: MoHCC annual appropriations data; National Aids Council expenditure data 2009-2018; Local authorities' spending data for 2015 taken from MoHCC Health Finance Policy (2016) and assumed to remain a constant share of MoHCC spending in other years.[115] Spending figures for other ministries extrapolated from 2013 estimate in 2015 Health PER (assuming constant share of MoHCC spending). PSMAS spending figures from MoFED Monthly Consolidated Financial Statements (to Aug20). AMTO data estimated from UNICEF 2020 Social Protection budget brief. Exchange rate and inflation rate data as used for Table 3.1.

Notes: PSMAS = Premier Services Medical Aid Society; AMTO = Assisted Medical Treatment Order. MoHCC spending data only available to September 2020, with final quarter spending assumed equivalent to average of previous quarters. National Aids Council spending data not available for 2019 or 2020, so assumed as equivalent proportion of actual MoHCC expenditure. Spending data for AMTO only available as an allocation figure for 2020 – assumed 50 percent execution rate and equivalent proportion of MoHCC expenditure for all other years.

	2017	2018	2019	2020
Ministry of Health and Child Care	341	280	119	83
Ministry of Public Service, Labor, and Social Welfare, including PSMAS and AMTO	115	101	31	14
National Aids Council	38	22	11	9
Local authorities	92	76	39	31
Other ministries	4	3	1	1

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