Exploring Opportunities for Strengthening Public Finance Management in the Health Sector in Zimbabwe

Southern African Parliamentary Support Trust (SAPST)

In partnership with

Zimbabwe Coalition on Debt and Development (ZIMCODD)

Research Paper

August 2020

1. Background

"When seven babies were stillborn on July 27, 2020 at Harare Central Hospital in Zimbabwe, after urgent treatment was delayed because of a nurses' strike, it captured the heart-rending health crisis in the country"[1]. This does not come as a surprise as stories of chronic drug shortages and preventable deaths have riddled Zimbabwe in the last decade. The onset of COVID-19 has worsened the situation. Post-Independence health policy placed a focus on preventative health – provision of protected toilets, safe water supplies, immunisation against childhood diseases, and family planning. Rural health centres, while providing curative treatments, were also to become centres for health education in the villages, through the training of village health workers; the general development of the economy would help to lift people out of poverty[2]. Once lauded as a marvel in the region, the health sector in Zimbabwe is no longer an image of its former self. This paper seeks to provide insights on how systemic weaknesses within the country's public finance system play a contributory role in worsening the health situation. With a focus on highlighting entry points for health oriented Civil Society Organisations (CSOs) and legislative oversight (Parliament/ Parliamentary Committees), the paper serves as an information piece that may add another dimension of understanding the situation. A key assumption underpinning the paper is that understanding specific aspects of the relationship between public finance management (PFM) and the health system and subsequent service delivery is critical to thinking through and implementing solutions. The paper also seeks to stimulate multi-stakeholder conversation, engagement and collective responsibility aimed at creating an enabling environment for effective PFM that contributes to improved health outcomes in spite of the perceived impact of the COVID-19 pandemic.

1.1 Health Policy Framework in Zimbabwe

The delivery of health services in Zimbabwe is guided by national level governance frameworks in the form of the Constitution and the National Economic Plan. The National Economic Plan then feeds into the National Health Policy and the National Health Strategy, which are directly responsible for the governance of the health sector[3]. The Constitution of Zimbabwe (2013) in sections 29, 44, 76, 81 and 82 commits the government to provide for the conditions for improvement of the health and quality of life and the health care for all people in Zimbabwe; to provide for the rights, duties, powers and functions of all parties in the public health system, to provide for measures for administration of public health ensuring access to essential health care for all within the limits of the resources available to it. The Ministry of Health and Child Care (MoHCC) is in charge of the health care system for policy planning, administration, allocation of funds and coordinating responses to national health issues with the Public Health Act Chapter 15:17 (as amended in 2018) being the principal law they administer. The Health Services Act (2002), Health Professions Act (2000) and the Medical Services Act (2002) are other major pieces of legislation that govern the health sector in Zimbabwe. The Health Services Act (2002) establishes Hospital Management Boards at central and provincial hospitals whose main responsibility is to manage the work of hospitals in line with the minimum standards of practice in

[1] COVID-19 worsens Zimbabwe Health crisis August 2020: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31751-7/fulltext

[2] Zimbabwe: Nations health in tensive care March 2005: http://reliefweb.int/report/zimbabwe/zimbabwe-nations-health-intensive-care

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

Zimbabwe and also avenues for community participation in health policy development and decision-making (ZHSA 2010)[4].

The Zimbabwe Ministry of Health and Child Care (MoHCC) is the main provider of health care services in the country whose vision 'is to have the highest possible level of health quality of life for all its citizens' (NHS 2016-2020). Having adopted the Primary Health Care (PHC) approach in 1980 which includes the provision of basic and essential preventive and curative care, maternal and child health services, health education, nutrition education, communicable diseases control and immunization, water and sanitation, and the nation's essential drugs program, Zimbabwe currently operates a four-tier health delivery system consisting of primary, secondary, tertiary and central levels of health care which are meant to function as a referral chain (ZIMFACT 2018)[5] . There are 1848 facilities that constitute the health system most of which are public health facilities. Although the delivery system is dominated by the public sector, health care services are provided by both public and private players.

1.2 The Current Health Situation

The public health system has always been the largest provider of health-care services (estimated at 65% by the Ministry of Health in 2005), complemented by Mission hospitals and health care delivered by non-governmental organizations (NGOs). To stay afloat, these health care facilities charge user-fees which are beyond the reach of many and are often applied in an *ad hoc* way and so vary from provider to provider. In the absence of substantial government financial support, user-fees provide the main income for many health care facilities, but act as a barrier to basic health services for many, especially the most vulnerable people in Zimbabwe.

Economic decline and political instability have, however, led to a reduction in health-care budgets, affecting provision of health care services at all levels and the most vulnerable in society have suffered the most. The country faces a heavy disease burden dominated by a mix of communicable and non-communicable diseases such as HIV and AIDS, malaria, tuberculosis and other vaccine-preventable diseases, diarrhoeal diseases, hypertension, diabetes and health issues affecting pregnant women and neonates. The health sector is currently grappling with numerous challenges including but not limited to shortage of skilled professionals and health-care staff; an eroded infrastructure with ill-equipped hospitals, many lacking functional laundry machines, kitchen equipment and boilers; lack of essential medicines and commodities; shortage of laboratory equipment and reagents. The system breakdown has been exacerbated by humanitarian crises including the cholera and measles epidemics between 2008 - 2010 and recently the outbreak of the Novel Corona Virus Disease (Covid 19). The impact has been most felt by vulnerable groups within the population deepening existing inequalities.

Covid-19 has overwhelmed the fragile and underfunded health sector—which, according to UNDP employs 1.6 physicians and 7.2 nurses for every 10,000 people, well below WHO recommendations[6]—which is frequently disrupted by strikes. The periodic strikes by health workers over remuneration, low morale among the workers and poor working conditions characterized by lack of essential equipment, inadequate medicines and medical supplies including personal protective equipment (PPE) has beset the health system. Currently, healthcare workers in Zimbabwe are on a national strike since the beginning of March this year protesting against poor remuneration and unsatisfactory

[4] Zimbabwe Health System Assessment 2010
https://www.hfgproject.org/wpcontent/uploads/2015/02/Zimbabwe_Health_System_Assessment20101.pdf
[5] ZIMFACT Zimbabwe's Health Delivery System 2018 https://zimfact.org/factsheet-zimbabwes-health-delivery-system/ accessed August 2020
[6] WHO Global Health Observatory is an open access data repository that provides statistics on 100 CORE health indicators including health staffing ratios: https://www.who.int/gho/health_workforce/physicians_density/en/

working conditions, leading to the closure of almost all central hospitals, children's units, provincial hospitals and the cessation of emergency lifesaving procedures throughout the country. While the government had put in place a number of preventative measures aimed at flattening the Covid 19 curve, there can be no gainsaying the fact that the health system is overstretched and not able to cope resulting in high mortality rates as the pandemic escalates. Despite the unprecedented collaborative effort between the government, the private sector, development partners and other stakeholders to mobilise resources to ameliorate the situation, corruption and mismanagement of resources has exacerbated the effects of the pandemic.

In Zimbabwe, the first case of Covid 19 was recorded on the March 20, 2020. Since then, the number of cases has been rising steadily. As of 16 August 2020, the country had recorded 5176 cases and 130 deaths. The country's healthcare system is stretched and indications are that the worst is still to come. In addition, the public health response measures to contain the pandemic have shown that, while necessary, they have also led to a disruption of economic activities and livelihoods resulting in increased poverty and vulnerability. More crucially, the Government has since instituted a number of policy, institutional and operational measures to combat and contain the pandemic and reduce its negative impact, especially on the poor and vulnerable members of society. These include expenditure restructuring away from capital projects to health-related expenditures; ring-fencing of the two percent money transfer tax for social protection and other pandemic related expenditures; ZWL$ 50 million (US$ 2 million) for urgent and immediate importation of health-related supplies; immediate hiring of over 4000 health personnel; ZWL$ 200 million (US$ 8 million) per month for a period of three months as cash transfers to an estimated one million vulnerable households. Alleged Corruption in the handling of donations in cash and kind and procurement of Covid 19 equipment, drugs and materials has left Zimbabwe struggling to contain a Covid-19 pandemic which is now spreading dangerously among health workers.

The country grapples with limited testing capacity, poor contact-tracing systems, lack of equipment to manage cases with severe disease in isolation and treatment centres (limited intensive care unit beds and ventilators), lack of PPE, staff shortage and human resources challenges, poor management of returnees in quarantine centres, weak and porous borders, corruption in COVID-19 supply tenders, among other issues.

In the area of pharmaceuticals management, Zimbabwe has maintained a centralized health commodity management system that is led by National Pharmaceutical Company of Zimbabwe (NatPharm) and is intended to be self-sufficient. The self-sufficiency of the system is further emphasized by the Medicine Control Authority of Zimbabwe (MCAZ) and its reliance on registration and licensing fees for funding its services. Regrettably, the current economic challenges have weakened support to NatPharm and MCAZ systems for providing all of the health commodity needs of Zimbabwe. This has resulted in stock-outs of essential drugs, vaccines, and medical supplies, and over-reliance on donor-supported vertical programs for various health commodities, particularly reproductive health products, malaria, and HIV/AIDS treatment and prevention products.

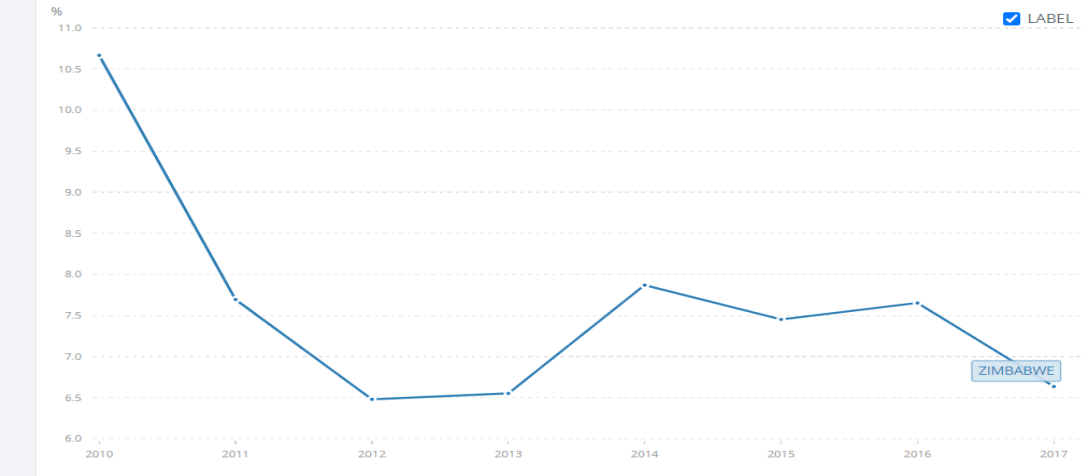
In the area of the health information system, Zimbabwe's National Health Information and Surveillance System (NHIS) used to be the best in the region. It was well structured and had a track record of excellence as demonstrated by the trophy awarded to the NHIS by the Southern African Development Community, for being the best surveillance system in 2004. This has however been eroded as it now lacks accuracy, the strongest quality element and timeliness.

2. POSSIBLE ENTRY POINTS FOR STRENGTHENING PFM IN HEALTH SECTOR

2.1 Health and Public Finance Management

It is an indisputable fact that it is not only the level of government health spending that matters for sustaining health systems that can meet positive health outcomes, but also the efficient and equitable use of those funds. Zimbabwe, on 6 June 2018 became the 17th country in the WHO AFRO Region to complete Health Financing Strategies after launching the Zimbabwe Health Financing Policy and Strategy. It focuses on addressing existing gaps and speaks to emerging challenges and most importantly seeks to sustain the gains achieved thus far, with respect to health systems strengthening and delivery of quality healthcare services. However, recent political, social, and economic difficulties have deeply affected Zimbabwe's health system. Macroeconomic challenges typified by frequent budget deficits and mounting debt burden have seen dramatic reductions in the value of funds allocated to health facilities and health offices. Regrettably, the lower value of health funds led to reduced ability to purchase commodities and equipment, pay wages, and support other health sector activities.

FIG 1: Health expenditure as a percentage of GDP



Source: World Bank

Zimbabwe's health sector is grossly underfunded compared to neighbouring countries in the SADC region. Per capita health spending is US$650 in South Africa, US$90 in Zambia and US$200 in Angola[7]

Table 1: Health allocations: Adherence to International declarations

Year	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Min Threshold

[7] Community Working Group on Health (CWGH

Health budget as a % of total budget	8.6	9.3	8.6	9.9	8.2	7.3	8.3	6.9	5.8	6.7	10.2	15% (Abuja declaration)
Per capita health expenditure USD	15.07	20.79	27.78	28.33		23.2	24.64	22	25		21	US$86 (WHO)

Source: Own compilation

When the PFM system and health financing system are working in harmony, they can reinforce one another's objectives and make the following results possible:

- Health sector policies and priorities are reflected in the budget. Health budget allocation is sufficient and stable enough to meet health sector objectives and commitments.
- Funds are directed to health sector priorities. Funds can be pooled, allocated and disbursed across populations, geographic areas and time to respond to health needs and ensure equity and financial protection for target populations.
- Funds are used effectively and efficiently to deliver high-value services. Funds are directed to priority populations, interventions and services, and payment to providers is based on service outputs and performance. Disbursements are predictable, and flexibility in purchasing and provider payment ensures efficiency and value for money.
- Funds are accounted for against priorities.

Public budget funds form the cornerstone of sustainable health financing. PFM rules and institutions (the institutions, policies and processes that govern the use of public funds) greatly affect the level and allocation of public health funding, the flexibility with which funds can be used, the effectiveness of spending and the way health sector results are accounted for. It influences how service delivery contributes to health system objectives of efficiency, equity, quality, and accountability and ultimately to better health status and financial protection.

A strong PFM system can ensure higher and more predictable budget allocations, reduced fragmentation in revenue streams and funding flows, timely budget execution, and better financial accountability and transparency. The outbreak of Covid 19 requires more flexibility than PFM systems sometimes offer, including the ability to direct funds to where interventions and services are needed and to ensure equity while creating incentives for efficiency and quality.

An efficient PFM system works to ensure that a government achieves set policy objectives in a progressive manner. To do this the PFM system must ensure that a government spends within its means (aggregate fiscal discipline); spends (limited) public resources on what has been prioritised for the set timeframe (strategic allocation of public resources) and that there is efficient and effective use of these resources obtaining value for money whilst delivering quality public services. In essence the main assumption is that the PFM system achieving its functional objectives results in public health services that progressively meet the health needs of Zimbabweans. *Equity* and *Quality* are used to describe the standard of health care services envisioned for all Zimbabweans in the National Health

Strategy (NHS) 2016-2020[8]. Before the onset of the COVID-19 pandemic, Zimbabwe already had a double burden of communicable and non-communicable diseases highly prone to epidemic diseases such diarrhoeal disease outbreaks such as cholera[9]. Other existing challenges to the health system include shortages of critical and skilled health workforce, aging infrastructure and equipment, supply of medicines and other commodities, limited health funding, and considerable challenges with the service delivery platforms or entities and the enabling environment. Despite a high service coverage of 1848 health facilities (public, private, mission) the quality of care at all levels has remained below what is committed to in the Patients Charter[10]. A key challenge affecting equitable access is the question of direct payment for health services (Out of Pocket (OOP) – formal or informal) which presents household hardships especially for those who are poor and vulnerable[11].

The effective functioning of the PFM system is the bedrock to an enabling environment that would allow for integrating resilience into an already fragile health system. In Zimbabwe, health has been riddled with instances of maladministration and financial mismanagement resulting in incidences of corruption[12]. Chronic government underfunding as budgetary allocations are rarely released in full and that makes predictability of financing difficult; insufficient regulatory oversight and lack of transparency in governance can breed corruption and reduce the quality of health care.[13] Overall, the health sector is underfunded and largely dependent on external funding for service delivery (over 40% Overseas Development Assistance – ODA - in 2012) given that most of government expenditure on health goes to salaries- approximately 80%[14] Partner support has sustained most of the programmes work with 98% of medicines being procured by partners (NatPharm, 2015). The high dependency on external financing is unreliable, unpredictable, unsustainable and highly dependent on the political environment, raising concerns on the sustainability of health financing and the vulnerability of government's budget should external funding be withdrawn. The effects of financial mismanagement and maladministration in the health sector have made patients more vulnerable[15]. A review of the latest public expenditure and financial accountability (PEFA) assessments shows that Zimbabwe has a weak PFM system based on a composite rating of 28 dimensions across the PFM spectrum including the formulation, execution, and evaluation of the budget.

A. Information management:

[8] National Health Strategy 2016-2020: Zimbabwe Ministry of Health and Child Care http://www.mohcc.gov.zw/index.php?option=com_phocadownload&view=category&id=6:acts-policies&Itemid=660

[9] UN OCHA Cholera Outbreak Emergency Plan of Action 2019 https://reliefweb.int/report/zimbabwe/zimbabwe-cholera-outbreak-emergency-plan-action-dref-operation-n-mdrzw013-pzw032

[10] The Patients Charter MOHCC https://zdhr.uz.ac.zw/xmlui/handle/123456789/1685

[11] NHS 2016-2020:24

[12] World Bank, 2016; Transparency International, 2016; OECD, 2017

[13] ZACC Health Report 2020

[14] NHS 2016-2020

[15] ACT-SA 2019 Conflict of Interest and other forms of corruption affecting health service delivery in Zimbabwe http://kubatana.net/wp-content/uploads/2019/07/REPORT-CONFLICT-OF-INTEREST-AND-OTHER-FORMS-OF-CORRUPTION-AFFECTING-HEALTH-SERVICE-DELIVE

The problem: Current information management in the PFM system and in the health system does not contribute to enabling environment that would allow for transparent and accountable public health service delivery. Tied to this is the slow pace transiting to digital information management systems for ease of implementation monitoring. According to a service delivery readiness survey administered by the Ministry of Health and Child Care (MOHCC), the item with the lowest availability in public health facilities was the computer with internet/email access, at only 21%. (NHS 2016-2020). In terms of the health information system data capturing at community and Primary Health Care (PHC) levels remains paper based which results in poor data quality. There is no clear definition of disease burden by catchment area and data is not disaggregated by catchment area resulting in low utilization of data for future strategic planning and resource allocation. Records and Information management in central hospitals are in shambles. Patients' medical records are kept in improvised exercise books. This is problematic as valuable information is lost as a result of the lack of E-management of information. In addition, the process requires an intranet to enable tracing of such records. This function, especially considering the COVID-19 environment we are in, is undoubtedly critical. Public Hospitals must be at the forefront of technology use when dealing with patient's health information and the finance management system[16]. An efficient finance management system is critical to the GOZ and MOHCC spending within set budget limits. The Capacity Development Plan 2015-2017 prioritized the development and implementation of the Public Financial Management System (PFMS) Grant Management Module and the extension of the PFMS to provincial and district levels. Some priorities that have been implemented so far include:

- ✓ The PFMS (which includes donor contributions) was configured for the health sector at national, provincial and district levels. The Ministry of Health and Child Care (MoHCC) was the first government ministry to roll out the grant management module of the PFMS, with real-time connectivity established in all but six districts. The PFMS has been customized to enable both donor and MoHCC reporting.
- ✓ Risk Management systems to ensure robust oversight were set up and implemented to support the MoHCC:
- ✓ MoHCC Internal Audit Committees were set up to ensure compliance of financial procedures funds to the health sector, to identify possible risks and to monitor implementation of audit issues.

In essence, a system exists for providing comprehensive, accurate and timely information on budget execution. However these are not easily accessible. Weaknesses in this area include inadequate impact analysis of revenue measures, limited effectiveness in Parliamentary scrutiny of overall budget estimates and of budget execution, bypassing of budget execution controls built into the PFMS and thus accumulation of excessive payment arrears[17]. Another example of an information deficiency in the health finance management system is that no procurement information is consistently available on government websites including Procurement Regulatory Authority of Zimbabwe (PRAZ).

Entry points:

- Further investment and support to fully operationalize PFMS within the MoHCC down to the district level will help to ensure that it meets national and international requirements. Health facilities should adopt an increased pace in migrating from manual records to E-management of records, since this in an important aspect in healthcare delivery. Continuous improvement,

[16] ACT-SA http://kubatana.net/wp-content/uploads/2019/07/REPORT-CONFLICT-OF-INTEREST-AND-OTHER-FORMS-OF-CORRUPTION-AFFECTING-HEALTH-SERVICE-DELIVERY-IN-ZIMBABWE.pdf

[17] Zimbabwe PEFA 2018 https://www.pefa.org/country/zimbabwe

effective leadership, greater integration and prioritized investments including fibre-optic cables to increase Internet connectivity, are needed to leverage and sustain the significant gains in strengthening systems for health in Zimbabwe.

- The MOHCC and the GOZ adopts appropriate technologies to facilitate real time monitoring of the procurement process including asset and human resource management. The GOZ leveraging of partnerships with private players on digitizing government functions at different levels is commended[18].
- Timely and proactive posting (uploading on government website) of all information outputs that have been deemed public by the legislative and regulatory framework in Zimbabwe. Improved information systems can significantly improve the efficiency and equity of government operations, and offer a great potential for increasing participation, transparency and accountability. This has a large potential to contribute to public trust and confidence in the short, medium and long term.

B. Strategic Use of Budgeted Resources for Value for Money:

The problem: Taking a focus on procurement, the health sector has seen fragmentation in the procurement of health products as these were largely procured through donor funding. Consequently, there have been inequitable commodities supply and security across referral levels particularly at hospital level. This has created a breeding ground for corruption in the health sector largely due to noncompliance[19]. Related to this is that spending is not always in line with what was planned for or on the appropriate product/quantity /quality. This is a big challenge when it comes to procurement of drugs, sundries and hospital equipment as user-departments are not always consulted. Public Finance Management Act in Zimbabwe has certainly provided legal safeguards for the management of public finances in the country. However, there is still significant room for improvement. Section 14 of the PFMA provides for accounting officers to comply with a directive issued by their ministers to commit certain payments that in the opinion of the accounting officer are not allowable. The accounting officer will comply but immediately submit a written report thereon to the Minister, the Accountant General, the Auditor General and the Secretary to Cabinet. This is a bad provision because the accounting officer has the primary responsibility for the management and disbursement of public resources allocated to the ministry. The accounting officer should never be forced to comply with orders that are not allowable. The Accountant General should approve such directives first before any payments are made. This is because section 9 (4) {b} empowers the Accountant General to refuse payment on any voucher in support of a charge on the CRF which is not allowable.

Strategic allocation of resources will be effective when available resources are allocated and used in line with government priorities aimed at achieving policy objectives. Efficient health service delivery requires use of available resources to achieve the optimal levels of public services, which are critical points of contact between citizens and government. The key processes to achieve this outcome relate to the budget formulation process, budget execution including investment management and reporting on budget execution. Even though the GOZ produces medium-term budget planning with performance objectives and targets for the health vote there is inadequate public access to budget

[18] MOFED Press Statement 8 Jul 2020 http://www.zimtreasury.gov.zw/index.php?option=com_content&view=article&id=207:zimref-public-finance-management-expansion-program-c1&catid=92&Itemid=762

[19] ZACC probe into NATPHARM Jan 2020 https://www.herald.co.zw/zacc-probes-drug-thefts-at-hospitals/

information including lack of timely budget execution reports comparable to the approved annual budget. This in turn limits the effectiveness of Parliamentary oversight of the health budget execution and limits the space for CSOs. Budget credibility is also a big concern for the health sector as disbursements rarely match allocations incapacitating service delivery. For example by September 2015, Harare Central Hospital had only received $560,000 out of a budget application of $17,500,000. This means that hospitals are primarily operating at very poor cash flow positions funded by charging patients for services and overstretching creditors thereby increasing debts. This also contributes to the inefficiency of hospital services delivery and the low quality of services produced. Lacking transparency of procurement processes and inadequate investment selection criteria indicate high risk of value for money not being achieved from much of budgetary funding. Lack of public access to comprehensive information on budget planning and execution as well as inadequate implementation of audit recommendations suggest that accountability for use of public resources and delivery of services may not be as effective as desirable[20].

Entry points:

- Increasing transparency in procurement at all levels is imperative to improving value for money and reducing opportunities of system abuse.
- Procurement processes should ensure that user-departments are involved in order to procure the correct/suitable products that meet the appropriate specifications. It is recommended to involve end users when procuring hospital equipment, sundries, drugs and consumables in order to avoid unnecessary losses and expenses.
- Procurement Committees at all levels in the health system need to either be created and/or strengthened with capacity to diligently oversee tendering processes and justify decisions made for example. The community health structures at district level as well as CSOs may undertake social audit exercises as means of verifying the quality of goods and services provided.
- Internal audit function should be sufficiently resourced with staff and money to conduct frequent checks on the internal control environment. The checks should include value for money measurement criterion as well. This information is then fed to the Office of the Auditor General and Parliament (as per legislative requirements) to influence timely corrective action
- Treasury Minutes should be produced by the MoFED through the Accountant General to complete the feedback loop on the extent to which recommended corrective action has been taken by the Executive to Parliament in this instance, the Public Accounts Committee and the Health Committee.

C. Partnerships, Coordination and Integrity as Anti-Corruption efforts:

The problem: For corruption to take place, three elements must work together: discretionary power, economic rents associated with power and a legal/judicial system that offers low probability of detection and sanctions for wrong doing. Choguya (2018) puts forward that public officials have opportunity to engage in corrupt practices due to some or all of the following: monopoly of services, discretion to make decisions, poor accountability, weak civil society and poor transparency. Moreover, individual beliefs, social norms, and eroding public service values create an environment in which corrupt practices appear justified. The low remuneration of public

[20] Zimbabwe PEFA 2018 https://www.pefa.org/country/zimbabwe

officials may pressure them to engage in corrupt practices. The Zimbabwean health sector provides powerful financial incentives to health workers to supplement paltry incomes through corrupt acts. Healthcare personnel have been involved in other economic activities during office hours (moonlighting) or make use of possibilities for private gain[21]. Health personnel, particularly middle to senior level supervisors, run their own private clinics, hospitals, surgeries and pharmacies, offering similar services that they are supposed to be offering as government employees. There are many incidences in which medical practitioners spend more time at these private businesses, including when they are supposed to be attending patients at government hospitals. Furthermore, doctors refer patients to their own private facilities for treatment and care, or use public hospitals and equipment to treat their own private patients[22]. Systems and structures of accountability across all levels have also been reported to be operating sub optimally. These structures (e.g. Health Advisory Board) need to be empowered to function effectively and establishing a social compact with the community presents opportunities for people to know what to expect from the health care system and more importantly to know what to do in cases of none or poor delivery of services.

Entry points:

- For strengthened coordination in implementation with development partners, information on donor transactions and mechanisms should be publicly disclosed for transparency purposes.
- Leveraging of relationships with private sector to explore incentives to boost the morale of the health workforce. For example staff buses for healthcare workers can also be re-introduced to ease transport challenges to and from work.
- COVID-19 presents an opportunity for the nation to consider the establishment of additional public hospitals run by a different agency from Ministry of Health and Childcare. In China, Brazil and Tanzania such arrangements are successful such as even strengthening military hospitals[23]. The opportunity also exists to review models of salary payment. For example salary based service.
- Corporate governance is the commitment to openness, honesty and transparency.[24] The role of leadership in promoting good corporate governance in public health sector cannot be overstated. Ethical leadership that is on display on a daily basis is required to set the tune for the expected standard of behaviour when handling public resources by all health staff and personnel. Adopting a Code of Ethics that promotes transparency and accountability in public health facilities would be a useful mechanism to employ to communicate what is acceptable and unacceptable behaviour in light of public interest.
- Disciplinary investigations when instituted should be completed in a timely manner in compliance with the legislative framework.
- There is need for public discussions against unethical and corrupt practices in healthcare and medicine. These efforts can be pursued together with and through other constitutional bodies such as the Zimbabwe Humans Rights Commission (ZHRC) and the Zimbabwe Anti-Corruption Commission (ZACC).

[21] Choguya, N.Z. 2018. Corruption in Health Service Delivery: The Case of Maternal Health in Rural Zimbabwe, Review of Human Factor Studies 24 (1): 81-104.

[22] Chinhamo 2019 ACT-SA Conflict of Interest in the Health sector in Zimbabwe

[23] Ibid

[24] Skyways, 2019:2.

3 A Focus on the Role of Parliament

Parliament plays a key role in promoting health and health equity through its representative, legislative and oversight roles, including budget oversight. Section 119 of the Constitution provides that Parliament is the guardian of the Constitution and has the power to ensure that its provisions are upheld and that the state and all institutions and agencies of government at every level should act constitutionally and in the national interest. Section 299 of the Constitution contains provisions that detail the role of Parliament in monitoring and overseeing expenditure by the state and all commissions and institutions and agencies of government at every level, including statutory bodies, government-controlled entities, provincial and metropolitan councils and local authorities.

Parliament reviews, monitors, and supervises operations and activities of the Executive. Oversight entails the informal and formal watchful, strategic and structured scrutiny exercised by the legislature in respect of the implementation of laws, the application of the budget and the strict observance of statutes and the Constitution. It ranges from specialized investigations by committees to annual appropriations hearings. The Constitution also gives Parliament powers to authorize collection and the use of public funds. Parliament oversight extends to the monitoring of the performance of government departments through establishing compliance with rules and regulations as well as other best practices where there are no formalized procedures.

Oversight tools range from question time, interpellation, committee enquiries, motions, debates, audit and other oversight agencies such as constitutionally mandated institutions such as the Zimbabwe Human Rights Commission (ZHRC) and Zimbabwe Anti-Corruption Commission (ZACC). Parliament performs executive oversight by scrutinizing government policies, programmes, and expenditure plans. Parliament, through its Committee system monitors all government policies and programmes to ensure efficient use of national resources. In addition, individual Members can raise questions or move motions that relate to government policies and programmes. In addition, Section 12 of the Audit Office Act [Chapter 22:18] specifies reports that Parliament must receive from the Auditor General as part of its oversight function. The Auditor General is mandated to audit the accounts, financial systems and financial management of all departments, institutions and agencies of government, all provincial and metropolitan councils and all local authorities; and to order the taking of measures to rectify any defects in the management and safeguarding of public funds and public property; measures to rectify any defects in the management and safeguarding of public funds and public property; Sec 303 (1) of the Constitution provides that no money may be withdrawn from the Consolidated Revenue Fund (CRF) except to meet expenditure authorised by the Constitution or by an Act of Parliament. Parliament, could not sit to authorize expenditure variations during the Covid 19 induced lockdown given the threat such sitting imposed on public health. It is therefore prudent that in such extra-ordinary circumstances, the principle of reasonableness applies. These extra ordinary circumstances should however not abrogate the oversight role of Parliament. Committees of Parliament, provided it is safe to do so, can meet physically or can utilise Information Technology and exercise their oversight role on the budget.

The Zimbabwean Parliament has not played an active role, beyond mere mention in reports, in advocating and engaging on the Abuja commitment, to increase budget shares to health. Public health sector allocation stood at 8,9% in 2019. Employment costs, however, constitute over three quarters of the total health budget. The Abuja 15% target remains an elusive target for the country. The sub-Saharan African average is 13%.

Parliament must also actively support interaction with civil society around the Abuja commitment and the specific country level concerns. Moreover, engagement is needed at an early stage of the budget

process, through public input mainly through public hearings. During implementation, the practice of constituency visits should be adopted as this provides a means for communication between national policy levels and communities.

A further mechanism for oversight is through questions to the Executive. Musuka and Chingombe (2006) contend that issues raised by MPs more generally in debates have less successful outcome than these more focused questions to the Executive. There is therefore need for CSOs, Media and all stakeholders to support parliamentarians to raise very specific questions on priority health issues that they want Executive action on, while using debates as a means of raising more general policy and public awareness on wider concerns. The Health Portfolio Committee also needs support with information, technical inputs, forums for dialogue and capacity building to effectively play its role. This should ideally come from budget resources, whilst resources from civil society and external funders come in to complement the work of the Portfolio Committee.

4. KEY RECOMMENDATIONS

- For Universal Health Coverage to be achieved, health sector governance will require new partnerships and opportunities for dialogue, between state and non-state actors. There is therefore need for involvement of all stakeholders including CSOs, citizens, consumers and patients. As governance becomes more widely diffused throughout society, working directly with the public can strengthen transparency and accountability.
- There is need for increasing overall funding for health by improving efficiency in revenue collection and allocating a larger part of revenue to health to reduce the financial burden of those who have no access to quality care at present. Several options exist for this, such as from earmarked taxes identified in prior MoHCC work. Zimbabwe has no national mandatory/contributory health insurance, only a few community-based health funding/insurance schemes whose equity, portability, sustainability are not evaluated and private voluntary insurance (MAS) that covers a small part of the population, with high transaction costs, late payments and weak protection for subscribers. Whatever the mandatory financing form, it needs a solid arrangement to manage pooled funds.
- Exploring issues in the public finance management system to identify and solve the governance and accountability issues that discourage external funding being channelled 'on budget'.
- A more equitable allocation of funds, more aligned to health needs.
- The government should put in place strategies to lure back all health professionals who left the country to come and work in the health facilities in the country. One possible way of implementing this is through, for instance, government providing accommodation for such personnel, allow them to import at most one car duty free and subsidize school fees for their children.
- Government should also ask the help of well-wishes, friends and donors in addressing some of the challenges in the health sector including shortage of health personnel, drugs and problem of old or dysfunctional medical equipment. In this instance, through liaising and soliciting for help from such organizations and/or donors as UNCEF, WHO etc., some of these stakeholders may offer to assist. For instance, some organizations my assist in helping medical doctors with tuition fees for their children or donating cars for use by medical personnel.
- There is need for the Ministry of Health to get more out of the current level of resources by achieving efficiency gains in order to generate fiscal space for health in Zimbabwe

- There is need to prioritise implementation of Auditor General recommendations related to budget control procedures, accounting procedures, governance and procurement system in order to move towards greater technical efficiency.
- Civil society organizations need to support capacity-building of Parliamentarians and secretariat as well as collaborate with the Health and Child Care Portfolio Committee and individual Members of Parliament to advocate for national and regional level policy-makers and managers of key state and non-state organizations and departments to include the health equity agenda and apply the social determinants of health lens in their programming.
- Parliamentary networks such as SADC-PF, IPU, among others should work closely with local CSOs and local offices of international organisations like UNICEF to draw the attention of the world's governments, civil society and international organizations to local heath constraints. Such networking between Parliaments and NGOs provides useful information and technical advice which Parliament can use to carry out its functions effectively.

In the wake of restrictions caused by COVID 19-lockdowns, Parliament must not abrogate its oversight responsibilities but resort to innovative and easy-to-use solutions for implementing standard oversight mechanisms, including video conferencing. As restrictions are eased, fact-finding oversight mechanisms should be considered in order to fulfil parliamentary informative requirements; which provide a more nuanced picture on the state of affairs.