



HEALTH AND CHILD CARE

2017 BUDGET BRIEF

Headline Messages

- The 2017 National Budget allocated US\$281.98 million, (6.88%) of the total budget to Health, representing a 14.76% nominal decline from the US\$330.79 million allocated to the sector in 2016.
- The allocation is significantly short of the levels to deliver better health outcomes. For instance:
 - The allocation is only 21.28% of the National Health Strategy (NHS) requirements for 2017, leaving a financing gap of US\$1.04 billion.
 - In addition, the 2017 allocation is, on average, 8 percentage points lower than the 15% Abuja target and 3 percentage points lower than the SADC average actual share of total expenditures of 11.3%, and 4.6 percentage points lower than the SADC average of 6.57% of GDP.
 - Zimbabwe's per capita allocation has worsened from US\$24.34 in 2016 to a projected US\$20.54 in 2017, which is significantly lower than the SADC actual average of \$134.90.
- Such levels of funding do not support the social inclusion agenda as a lot will be left behind without access, particularly children, who already suffer multi-dimensional deprivations, including access to health care.
- This also implies over-dependency on off-budget donor support which is an additional risk in the face of declining donor support for the health sector. Recent donor support has been higher than 50% of total resource flow and more than 80% of the non-wage budget.
- As in 2017, Government is targeting to spend 55.4% of the health budget on employment costs but actual outturn is estimated to be much higher as was the case in 2016, wherein actual employment costs accounted for 83.78% of the total budget, which meant very little was expended on non-wage programs.
- To mobilise additional resources for health, the Government announced the introduction of a 5% levy on airtime, which will be ring-fenced for the purchase of drugs and equipment for public hospitals. The above measures need to be complemented by actions to enhance the efficiency, effectiveness and equity of expenditures.
- There is also need to improve disbursement rates for non-wage spending and strengthening donor coordinating and efficiency in the use of Partner support.
- Some additional fiscal space could be created from expenditure prioritization within the overall Health Care budget, and across different levels of care and programs as well as innovations in health financing such as Public Private Partnerships (PPPs).
- Health care inflation was above the general inflation in 2016, although on a declining trend to close 2016 at -0.7%, which can be a positive thing for improving health care access, including by children.



INTRODUCTION

The Ministry of Health and Child Care (MoHCC) is mandated to provide health care services to all Zimbabweans in line with the Primary Health Care approach as set out in the National Health Strategy (NHS). In line with the country's economic plan – ZimAsset (2013-2018), the Ministry's strategic objectives, among others, is to reduce morbidity through the provision of accessible, affordable, acceptable and effective quality health services at community and health centre level.

The Ministry is one of the lead ministries under the first phase of Programme Based Budgeting (PBB), and 2016 marked the full year of implementing PBB. PBB entails the mapping of public expenditures according to programmes, and represents a paradigm shift, by the Government, from the traditional line item budgeting. By tying expenditures to results, the PBB enhances better monitoring and performance reporting. In that regard, the formulation of the Ministry's 2017 budget bid was guided by the PBB principle.

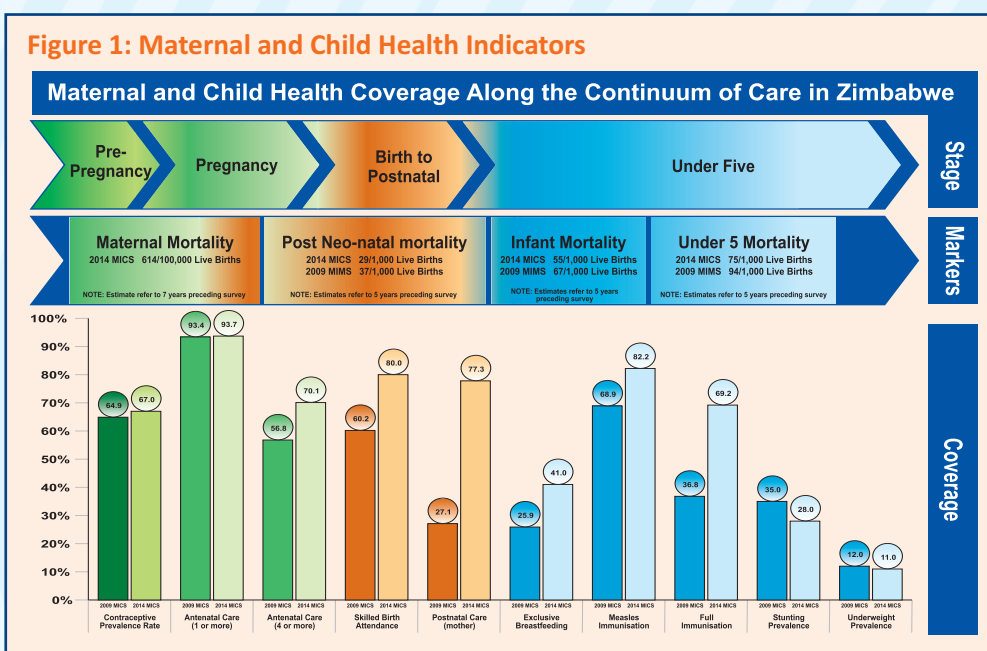
The Ministry's key budget priority in 2017 was modelled along the recommended scenario in the National Health Strategy (NHS) (2016 – 2020), aiming at reducing mortality through:

- Scale-up of RMNCH, Malaria, HIV, Nutrition and Non-Communicable Diseases (NCDs) interventions with emphasis on lower levels of care;
- Shift provision of preventive services to the primary health level;
- Infrastructure improvements at the primary level;
- Investments to improve availability and security of medicines and supplies and
- Capacitation of skilled human resources.

According to the NHS, this would be achieved with funding amounting to US\$1.33 billion in 2017, expected to rise to US\$1.35 billion in 2018. Of which a significant chunk of these resources are expected to come from the government

budget. Such level of funding will help guarantee continued improvement in the overall health care indicators, including maternal and child health, (Figure 1). Recent data from the Zimbabwe Demographic and Health Survey (ZDHS) for 2015, show that maternal mortality ratio remains high at 651 deaths per 100,000 (versus target 174 deaths per 100,000 live births); under five child mortality rate is at 69 deaths (versus target of 43 per 1000 live births); stunting prevalence is at 28%, and HIV and AIDS, TB and malaria remain major causes of morbidity and mortality. Similarly, the 2016

Figure 1: Maternal and Child Health Indicators



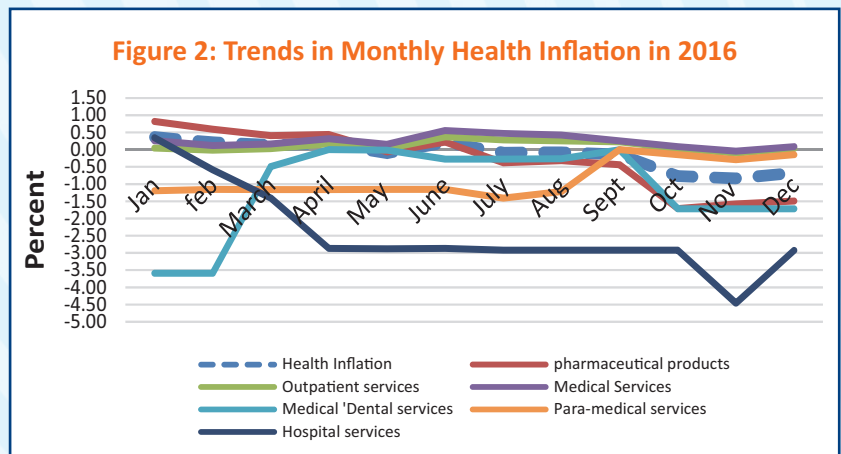
Source: MICS 2014

Multiple Overlapping Deprivations Analysis (MODA) showed that 59.6% of the children aged 0-17yrs are multi-dimensionally poor, with access to health care being among the prominent deprivations. This makes it important for the national budget of the country to make adequate, quality and equitable investment in child health. Whilst policy may have missed the older generation, there is now an opportunity to correct and make an impact on the children, for better development outcomes.

REVIEW OF THE 2017 BUDGET

Health Care Inflation

Health care inflation was above the general inflation in 2016, although on a declining trend to close 2016 at -0.7%. Health care inflation gives the general trends in the prices of health care products and services, and is an important factor determining access by all, including the poor and marginalized children. For instance, an upward trend in the health care inflation means prices of health care services in the sector are higher than they were in the previous year. This can be deterrent to seeking care, thereby increasing risks of exclusion, particularly for children, who are naturally vulnerable. For Zimbabwe, however, the general price level as measured by the CPI for health care has been trending downwards, meaning that prices in 2016 were significantly lower than they were in 2015. The major drivers of the downward trend, include hospital services, and pharmaceutical products, (Figure 2). Some upward pressure on prices, however, emanated from para-medical services, particularly during the last quarter of 2016.

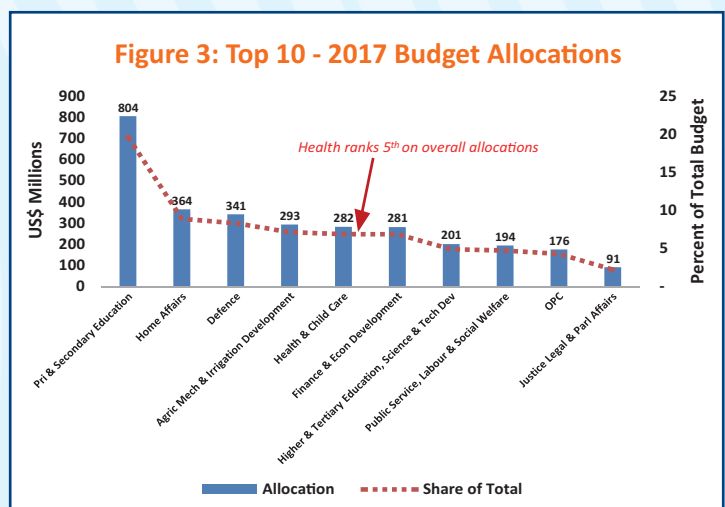


Source: ZIMSTAT monthly inflation updates (2016)

2017 Budget Allocation to the Health Sector

Health-related funding is primarily channeled through the MoHCC, which is the focus of this brief. However, other government ministries such as: Defense, Justice, Home Affairs, Education and Labor and Social Welfare also receive some funding from the budget for health related support.

The 2017 National Budget allocated US\$281.98 million, representing 6.88%¹ of the total budget (US\$4.1 billion), to the MoHCC, making it the fifth highest vote, (Figure 2). Other Ministries such as Primary and Secondary Education (19.6%), Home Affairs (8.9%), Defense (8.3%) and Agriculture, Mechanisation and Irrigation Development (7.1%) complete the top five allocations. Figure 3 shows the 2017 top ten budget allocations.



Source: 2017 National Budget Estimates

¹ The share for the Health and Child Care budget has been calculated by using the value of the total State Budget less debt-service payments as a denominator. It includes Statutory & Constitution and Vote Appropriations.

The 2017 allocation represents a 14.76% nominal decline from the US\$330.79 million allocated in 2016, (Table 1). A worrying declining trend in the health care budget has been observed, from a high of 9.9% of total budget achieved in 2013, mainly reflecting a weakening fiscal environment constraining Government spending in general, and Health and Child Care in particular.

Table 1: Budgetary Allocations to Health and Child Care (2015 – 2019)					
	2015	2016	2017	2018	2019
Total Exp & Net Lending	3,824,519,908	4,562,000,000	4,100,000,000	4,424,000,000	4,777,000,000
Vote Appropriation	3,551,469,000	3,398,128,000	3,426,289,000	3,456,289,000	328,192,000
Health & Child Care	311,925,890	330,789,000	281,976,000	290,435,000	296,536,000
As % of Total Exp & Net Lending	8.16	8.27	6.88	6.56	6.21
As % of Vote Appropriations	8.78	9.73	8.23	8.40	8.15
As % of GDP	2.22	2.34	1.94	1.84	1.74
Per Capita	23.18	24.34	20.54	20.95	21.18

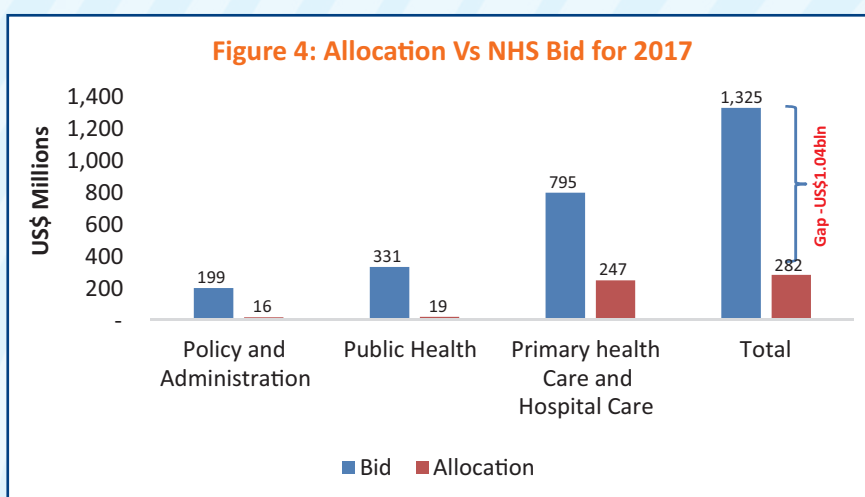
Source: Various Budget Statements (2015-2017)

Against this background of declining health care allocation, the financing gap remains high. According to the costed NHS (2016- 2020), the health sector funding for 2017 amounts to US\$1.33 billion. However, government allocation is only

21.28% of the requirement, hence a total financing gap of US\$1.04 billion, (Figure 4). The biggest shortfall of US\$548.45 million is experienced under primary health care and hospital care, which is the entry point for accessing care. Without adequate funding, the country will not be able to cope with the heavy burden of disease, including some preventable diseases such as malaria, tuberculosis and other vaccine-preventable diseases, diarrheal diseases and health issues affecting pregnant women and neonates. For instance, according to ZDHS (2015), under-5 mortality rate is estimated at 69 deaths per 1,000 live births, and the infant mortality rate is 50 deaths per 1,000 live births. About one in 15 children in Zimbabwe dies before his or her fifth

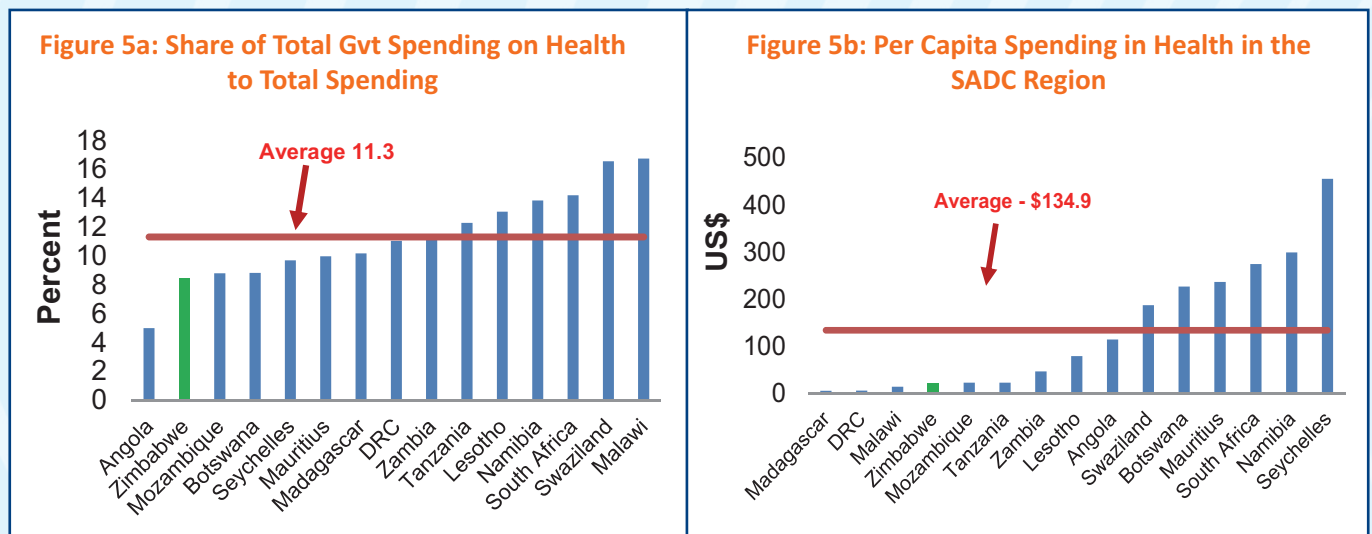
birthday, and about 70 percent of these deaths occur during infancy. A factor that is mainly attributed to, among other factors, the perennial underfunding of the health delivery system.

Despite the projected increase in allocation in 2018 through to 2019, total Health and Child Care allocation remains below the NHS requirements of US\$1.35 billion and US\$1.39 billion respectively. Furthermore, the allocation to health is projected to remain, on average, 8 percentage points lower than the 15% Abuja



Source: 2017 National Budget Statement and NHS (2016-2020)

target and 3 percentage points lower than the SADC average actual share of total expenditures of 11.3%, (Figure 5a). As a share of GDP, the Health and Child Care budget is 4.6 percentage points lower than the SADC average of 6.57%.



Source: Global Health Expenditure Database (2014)

Furthermore, Zimbabwe’s per capita allocation is significantly lower than its regional peers. The country’s per capita allocation in health care is expected to worsen from US\$24.34 in 2016 to US\$20.54 in 2017, against a SADC actual average of \$134.9², (Figure 5b) and the WHO ideal funding for health of \$86 per capita. This means many particularly the poor and vulnerable children will continue to be excluded. Based on the 2014 Global Health Expenditure Database, the highest per-capita spenders in Health within the SADC region are Seychelles (US\$455), Namibia (US\$299) and South Africa (US\$275).

Inadequacy in the Healthcare budget allocation, manifests in poor access and quality of services in many of the country’s public health care centres. For instance, in September 2016, Harare Central Hospital suspended all elective surgeries because of a critical shortage of medical supplies. Mpilo Hospital in Bulawayo had to shut its doors at some point while Gwanda Hospital in Matabeleland North is facing acute water shortages which affects service provision. The situation is dire in most centers, impacting negatively on access by citizens in general, particularly, women and children.

Composition of Budget Allocation

A high share of MoHCC allocation is earmarked for wage related costs, thereby crowding out capital investment, maintenance, and other expenditures for programs and service provision. Employment costs were allocated 55.4% of the total MoHCC allocation, whilst total non-wage investment accounts for 44.65% of the 2017 total allocation. Hence, with regards to non-wage allocations, the MoHCC ranks 5th with US\$125.9 million, 3.64% lower than the non-wage allocation of US\$130.48 million in 2016. Capital spending accounts for 10.4% of the total MoHCC budget in 2017, (Figure 6a). Such a consumptive spending pattern skewed towards employment costs is unsustainable and should thus be discouraged.



² Global Health Expenditure Database (2014)

Figure 6a: Composition of the 2017 Health Care Allocation

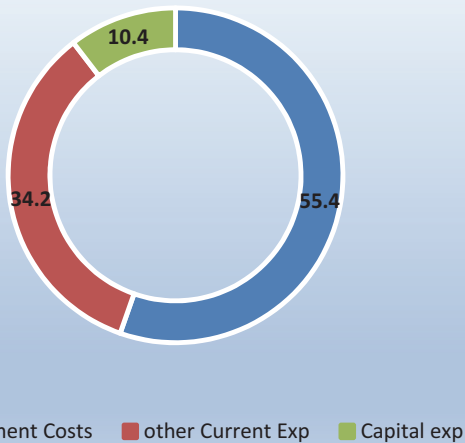
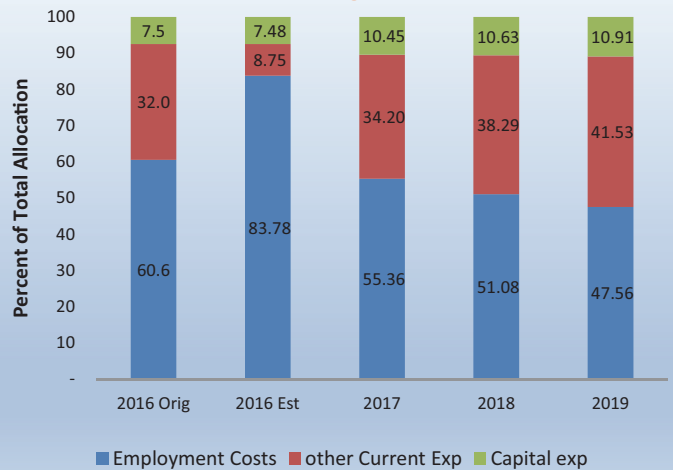


Figure 6b: Trends in the Composition of the Health Care Budget Allocations

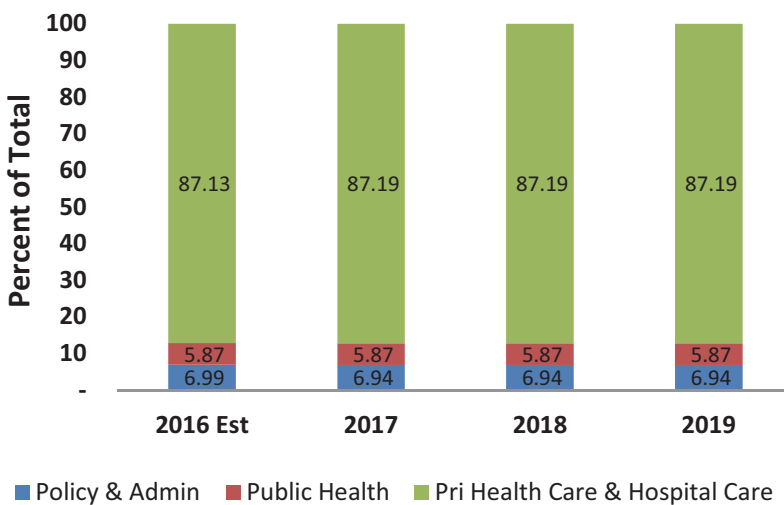


Source: 2017 National Budget Estimates

As in 2016, government is targeting a lower employment budget but actual outturn is estimated to be much higher. For instance, the 2016 Budget was targeting employment costs for Health to account for 60.6% of the budget, but the final outturn was 83.78%, (Figure 6b). With employment costs exceeding the target, the Ministry had to take resources from non-wage allocation to cover the December 2016 salaries³. This is a major concern, particularly in 2017, given the cut-back on partner support towards human resources for health. This means the government will have to increase its expenditure on employment costs to fill the gap and maintain current remuneration levels for health care staff.

The share of employment costs to the total Health and Child Care budget allocation has increased significantly from 37.7% in 2010 to the proposed 55.36% in 2017. The net effect, of which, has been the crowding out of capital investments, maintenance, and other expenditures for programs and service provision. Capital allocations have remained below 10%, which to a large extent has resulted in dilapidation and inadequacies in the health care delivery systems. Subject to increased fiscal space, the government would need to increase the share of non-wage expenses, especially on medicines and services.

Figure 7: Composition of Employment Costs by Programme



Source: 2017 National Budget Estimates

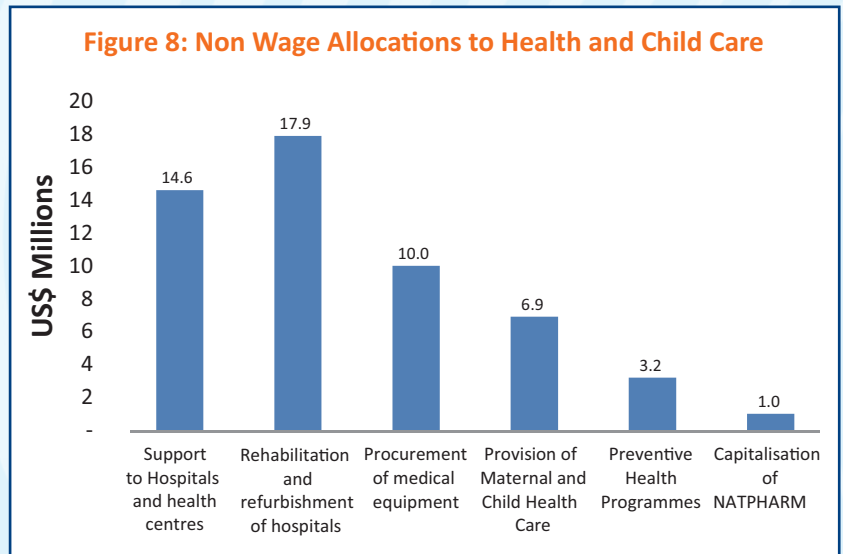
Primary Health and Hospital Care accounts for a significantly large share of employment cost for Health, mainly reflecting the number of staff within the health sub-vote, (Figure 7). However, despite the high share of employment costs, the Health sector remains understaffed. For instance, recent statistics show that there are now 1.6 doctors for every 10 000 people. Most government rural health

³ Presentation by the Ministry of Health to the Parliamentary Portfolio Committee on Health.

centers are manned by two doctors who have to perform multiple tasks. Linked to this, there are just seven nurses and trained midwives for every 10 000 people in the country⁴.

Key programs under the non-wage allocation include: support to hospitals and care centres (US\$14.6 million), rehabilitation and refurbishment of hospitals (US\$17.9 million), procurement of medical equipment (US\$10 million), (Figure 8).

Zimbabwe’s non-wage share of health care expenditures has remained lower than most SSA countries. Most public expenditure reviews undertaken by the World Bank in SSA show that employment costs average 50% of total government spending in health and above 80% of the non-wage budget. In general, although there are no specific benchmarks, Zimbabwe’s wage share of expenditures, exceeding 60%, on average, is considered too high, unsustainable and incompatible with the provision of quality and access to health care⁵.

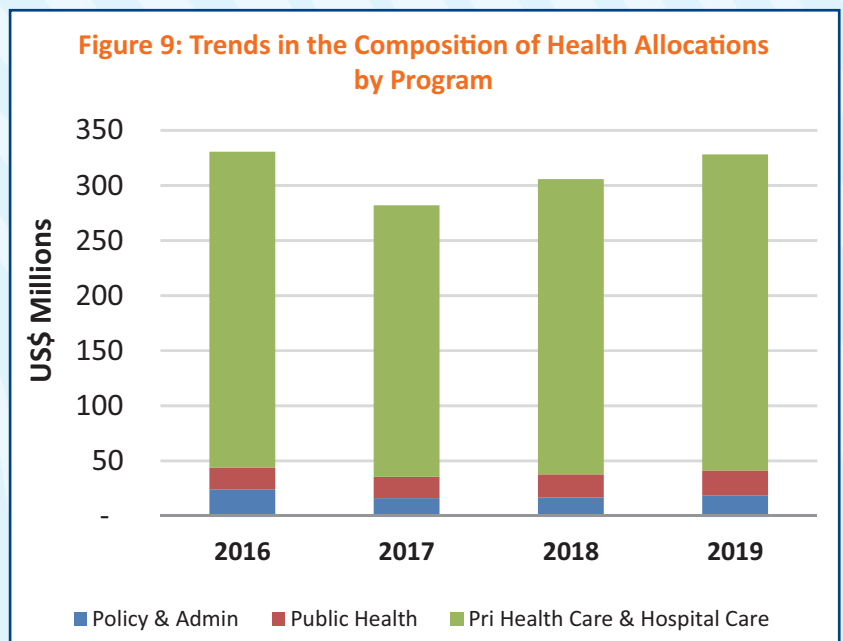


Source: 2017 National Budget Statement

Budget Allocation by Programmes

In line with the Primary Health Care approach, the biggest share (87.44%) of the health budget is allocated towards Primary Health and Hospital Care. However, as already been noted, this largely reflects huge share of employment costs, given that most of the health care staff are employed in primary and hospital care. On account of tightening fiscal space, all the 3 programmes received reduced allocations from 2016, with Policy and Administration having been reduced by \$24.2 million in 2016 to \$16.3 million in 2017 representing a 32.6% reduction, (Figure 9). Allocation towards Primary Health Care and Hospital Care was also cut by 14%, to \$246.5 million in 2017 while Public Health was reduced by 3.7%.

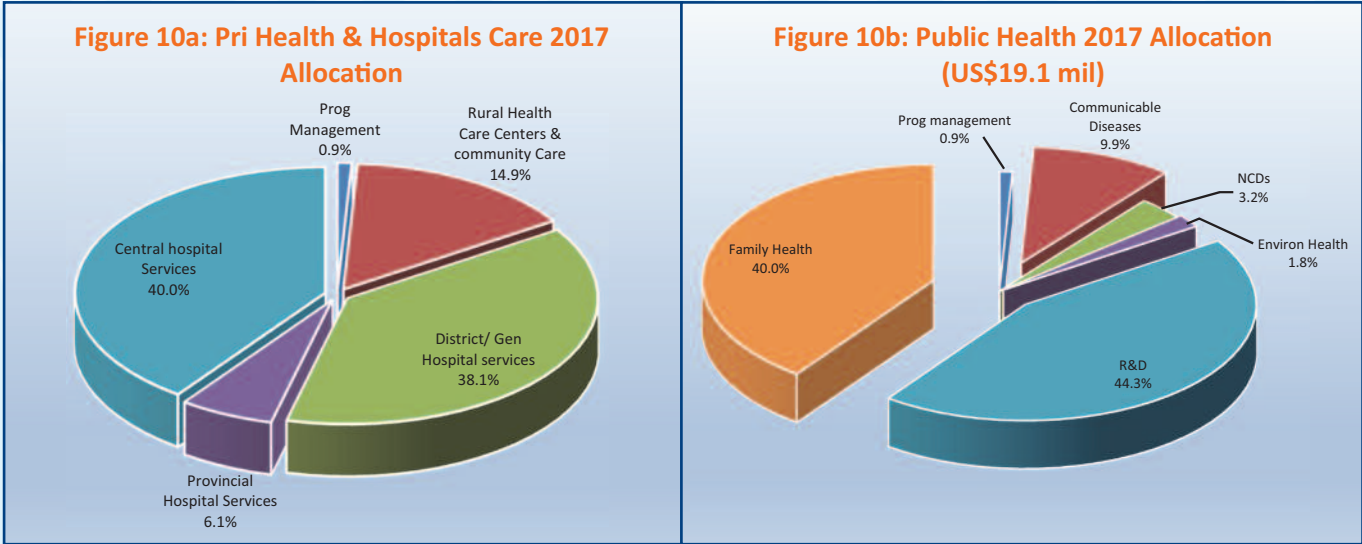
Of the US\$246.55 million allocated towards Primary and Hospital Care, 40% will be spent on Central Hospital services. District and General Hospital services will account for 38.1%, whilst Rural Health Care Centers and Community Care accounts for 14.9%. Provincial Hospital services and program management accounts for 6.1% and 0.95% respectively, (Figure 10a).



Source: 2017 National Budget Statement

⁴ 2017 Post Budget Analysis Report for the Portfolio Committee on Health and Child Care.

⁵ World Bank PER in Health Zimbabwe 2015.

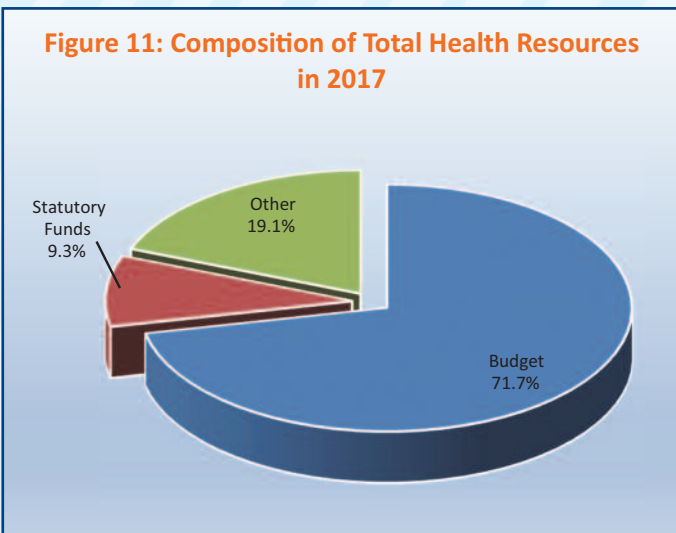


Source: 2017 National Budget Statement

With respect to the US\$19.12 million allocation towards Public Health, Research and Development accounts for the largest share of 44.3%, followed by Family Health Care, (40%), Communicable Diseases (9.9%) and NCDs (3.2%), (Figure 10b).

Sources of Health and Child Care Financing

In addition to direct budget allocations, the MoHCC is expected to receive additional funding from development partners and statutory funds. The 2017 Budget projects total resources for health amounting to US\$393 million, with government support accounting for 71.7% (Figure 11). Statutory funds, which come mainly in the form of user fees collected by health facilities, are projected to mobilise US\$36.5 million, accounting for 9.3% of total resource flow. Funds collected from user fees are administered through the Health Services Fund (HSF) established under the Public Finance Management Act (Chapter 22:19) to collect and administer fees for the purposes of supplementing the health budget for the development and maintenance of health services, programmes and related activities, within the health delivery system. Other resources, mainly from Development partners are expected to account for 19.1% of the total resources by injecting US\$74.97 million.



Source: 2017 National Budget Statement

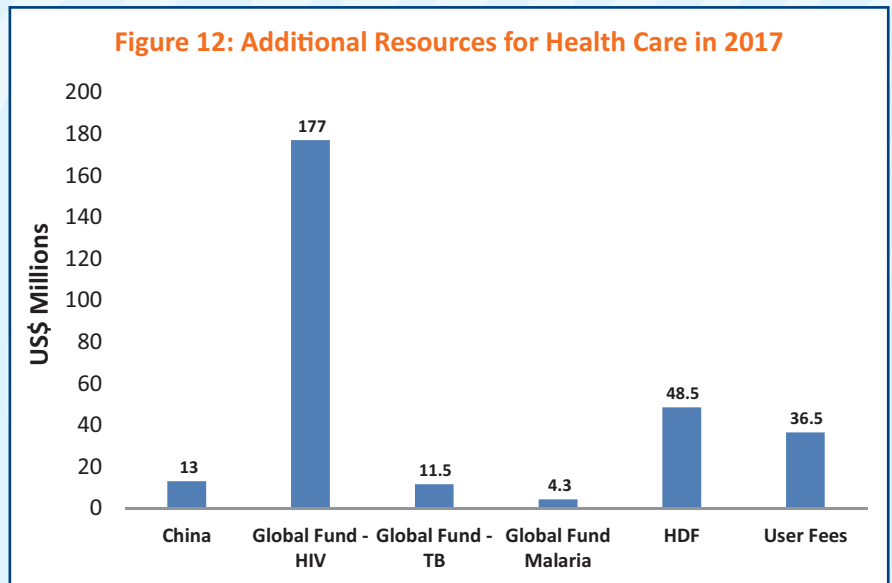
In addition to the above, the Government announced the introduction of a 5% levy on airtime. The levy, themed ‘Talk, Surf and Save a Life’, is expected to mobilise resources that will be ring-fenced towards the purchase of drugs and equipment for public hospitals. This is however, still to be quantified and the modalities and administrative arrangements are still being worked out.

Whilst Development Partners may be contributing more to the health sector, the 19.1% reflects only direct donor contributions through the government systems. Most of the funding from Development partners is being channeled direct to programmes or through pooled funding mechanisms such as the Health Development Fund (HDF). In 2017, Global Fund is expected to contribute US\$192.8

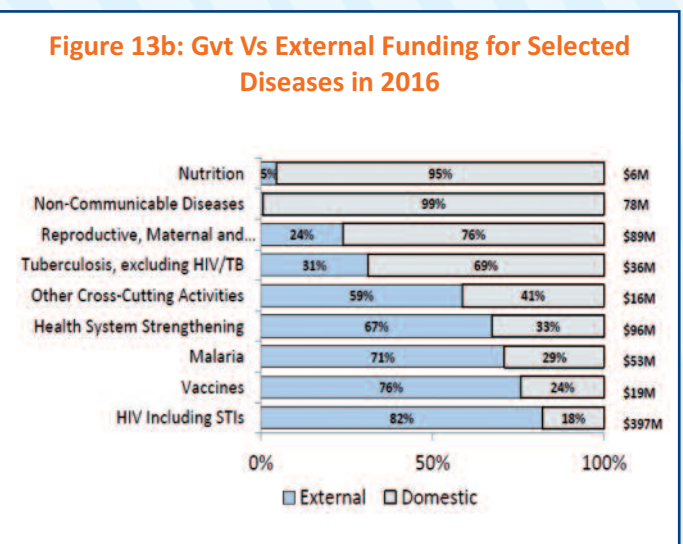
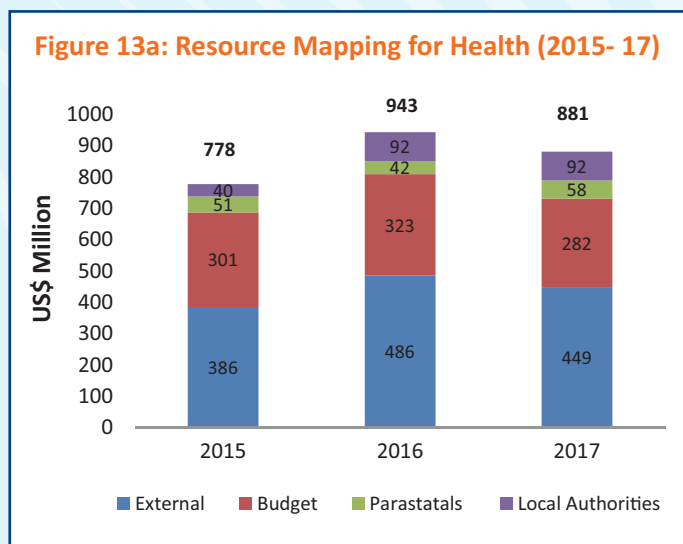
million towards HIV, TB and Malaria. Other resources are expected to come from the Republic of China – US\$13 million towards refurbishment of Natpham warehouse, whilst the UNICEF managed HDF is expected to provide support worth US\$48.5 million, (Figure 12).

A detailed resource mapping for health conducted by the MoHCC, with support from Partners estimates that total resources amounting to US\$881 million could be mobilized from the budget, external (development partners and households), parastatals and local authorities, (Figure 13).

The report noted that government funding is heavily skewed towards health worker salaries and health systems costs while partner funding goes towards disease specific activities. This represents a cost-sharing imbalance between government and partners, which requires harmonized planning to ensure optimal results. With funding partners consistently contributing above 50% of the total resource envelope, development partner contribution is estimated to have grown from US\$3.30 per capita in 2002 to US\$34.00 per capita in 2015. Whilst this has been the cornerstone of health care provision, sustainability requires that the Government raise additional domestic funding and reduce donor dependency. For instance, several disease areas receive a large portion of funding from funding partners, (Figure 13b), exposing the programs to risk if donor priorities shift or if funding ends. Moving forward, there is need to improve aid effectiveness to ensure value for money is achieved from donor funds. Better alignment of donor priority areas and government’s needs is also called for.



Source: 2017 National Budget Statement



Source: MoHCC 2016 Resource Mapping Exercise



Already, global aid flows have been declining, on account of financial and economic crises in donor capitals, meaning fewer resources to finance basic social services and infrastructures that are critical for children. Consistent with reduced aid flows, there has been shifts in donor priorities towards new emergencies and to the poorest countries, where the needs are largest. Zimbabwe, has already witnessed a decline in Official Development Assistance (ODA) from a peak of US\$1 billion in 2012 to US\$651 million by end of 2015⁶, representing a decline of 35%. The same trend is evident in aid flows to the Health sector. For instance, the Health Development Fund (HDF), which for the past few years has been a major source of predictable funding for maternal and child health care equipment and supplies, has been declining from US\$50 million in 2015 to US\$32 million in 2016 and further to US\$28 million in 2017. With future increases in aid flows in general and in health care, in particular, unlikely, Zimbabwe would need to fully embrace the 2012 Tunis Declaration by African Ministers of Finance and Health, for the mobilisation of domestic resources for health and for achieving greater accountability and value for money in delivering health services for all, including the children.

2016 Health Care Budget Execution

Health Budget implementation rate for 2016 is estimated at 98%, (Table 2)⁷. Whilst this might appear positive, it is important to note that most of the expenditures were towards employment. Expenditure overruns were experienced in employment costs hence an implementation rate of 106%, (Table 2). Seventy-eight percent of the current budget allocation was disbursed whilst just 23% of the capital budget was actually spent. It is also worth noting that a significant chunk of the disbursements were made during the last week of 2016, affecting the timeous implementation of the planned programmes. This is mainly on account of the cash flow constraints, worsened by the cash budgeting approach by the government. Cash budgeting implies that the government has to first receive cash before they can actually spend it. Where the flows are underperforming, as is the current situation, it makes planning difficult as disbursements to Ministries are often delayed.

Table 2: 2016 Health Budget Actual Disbursements

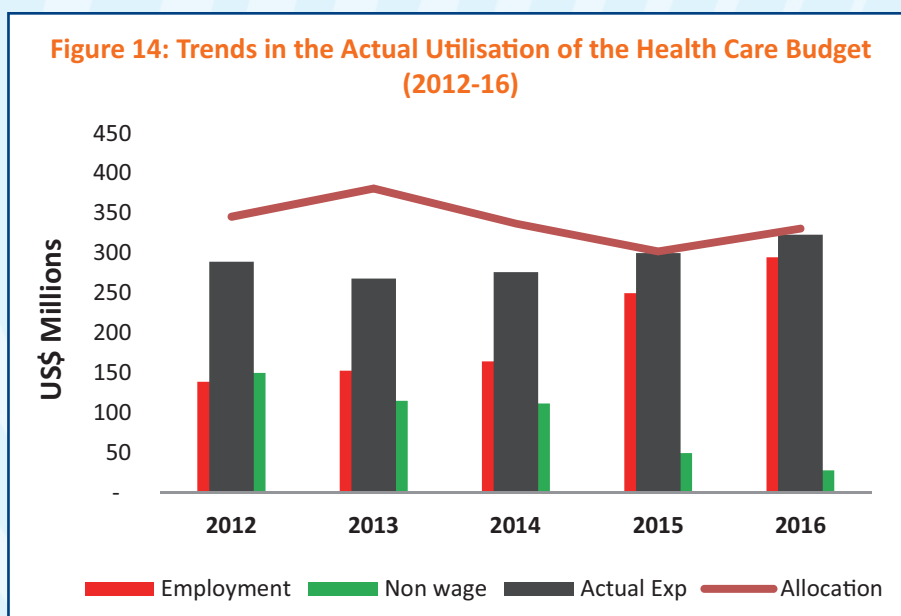
	2016 Revised Budget	2016 Actual Expenditure	Burn Rate	2017 Budget Allocation
Employment Cost	277,119,000	294,848,108	106	231,916,000
Recurrent Expenditure	28,940,000	22,537,022	78	29,600,000
Capital Expenditure	24,730,000	5,780,958	23	20,460,000
Total	330,789,000	323,166,088	98	281,976,000

⁶ Review of Global ODA flows in Financing Development, A special focus on children, October 2016 by UNICEF Zimbabwe, Harare.

⁷ MoHCC presentation during the Parliamentary Portfolio Committee on Health and Child Care, 17 January 2017.

Therefore, the per capita actual spending of US\$23.78, remains significantly below the WHO threshold of US\$86.00 and the SADC average of US\$134.90. This demonstrates the level of underfunding of the Health sector. It is therefore important for the government to explore options of increasing fiscal space, such as Public–Private Partnerships (PPPs), whilst at the same time improving its expenditure mix and prioritization of expenditures. Efficiency gains can also be achieved by ensuring value for money in service delivery.

Actual budget expenditures in health, and indeed overall budget, have been lower than allocations, reflecting cash budgeting constraints. However, the Ministry of Finance revised downwards, the Health Care allocations to match average annual disbursements to the sector (Figure 14). As such, nearly 100% of the budget was disbursed in 2015 through to 2016. Worth noting is the fact that expenditure overruns were experienced with regards to employment costs, resulting in higher actual expenditure outturn. This came at the expense of non-wage spending, which has continued to trend downwards from a high of US\$150 million in 2012 to US\$28 million in 2016, (Figure 14).



Source: Various Audited General Financial Reports

The cash flow challenges meant that some programmes/institutions did not receive anything from their 2016 Budget allocations (Table 3)⁸. Of the US\$3.86 million allocated to Grant Aided institutions only US\$1.95 million was actually disbursed, representing an implementation rate of 50.52%. Institutions such as the Zimbabwe National Family Planning Council (ZNFPC), local authorities and volunteers did not receive anything from their allocated budgets, whilst Mission Hospitals received 44% of their allocated budgets.

Table 3: Actual Disbursements to Grant Aided Institutions in 2016			
Institution	2016 Budget	2016 Expenditure	2017 Budget
Voluntary	120,000	0.00	120,000
HSB	1,000,000	380,663	1,000,000
Local Authorities	110,000	0.00	110,000
Missions	450,000	198,000	460,000
PGH	1,682,700	1,375,162	1,400,000
ZNFPC	500,000	0.00	200,000
Total Allocation	3,862,700	1,953,825	3,290,000

⁸ Ibid

CONCLUSIONS

- **It is no secret that fiscal space is shrinking, thereby limiting the government's capacity to adequately support the Health sector, along with other social and economic infrastructures.** Hence, the focus of public spending should be to improve the efficiency and quality of expenditures of the available resources.
- **Expenditure prioritization of the overall health care budget and within – across different levels of care and programs is imperative.** For instance, the Government spent more money in 2016 on foreign travel (US\$51 million), compared to non-wage spending in Health (US\$28 million). Equally, better targeting and enhancing efficiency of expenditures, especially primary care, medicines, and supplies, while reducing the share of employment costs (both overall and in the health sector), should be a key policy priority for the Government.
- **Need to improve disbursement rates for non-wage spending, to achieve better health outcomes, including for children.** Disbursements also need to be timely to ensure the implementation of programs in line with schedules, particularly towards NCDs which are now a leading cause of mortality and morbidity. This is in light of the recent shortages of drugs and commodities experienced within the health delivery chain.
- **Equally, the National Health Insurance (NHI) programme** should also be prioritized to allow universal access to healthcare services, to ensure that no one is left behind.
- **Budget tracking and monitoring is also critical.** This could help ensure that resources reach programmes and beneficiaries, to produce the intended health outcomes. Equally important is the need for public spending in health to be guided by the equity objective. Thereby, ensuring that public spending targets reach the most vulnerable, neediest areas and children to achieve equitable health outcomes.
- **In the short term, particularly in view of poor economic growth prospects, Development Partners remain crucial.** However, given the unpredictability of donor support, such resources should be considered complementary to domestic resources, whilst the country strengthens its domestic resource mobilization capacity. Sustainability requires that the government increases its domestic resource mobilisation efforts including innovative financing mechanisms such as Public–Private Partnerships, and private investments to increase resource flows into the economy in general and the health sector, in particular. It is equally important to ensure that value for money is achieved from the domestically mobilized resources. Modalities for collection and management of the 5% airtime tax need to be speedily finalized, to pave way for its implementation.
- **Related to the above, strengthening donor coordinating and efficiency in the use of Partner support could help improve resource allocation and health outcomes.** In addition, the available support could be used strategically to crowd-in domestic resources, including through, creating an environment where private sector growth directly benefits women and children.



List of Acronyms

GDP	Gross Domestic Product
HDF	Health Development Fund
HSF	Health Services Fund
MICS	Multiple Indicator Cluster Survey
MODA	Multiple Overlapping Deprivations Analysis
MoHCC	Ministry of Health and Child Care
NHA	National Health Accounts
NHI	National Health Insurance
NHS	National Health Strategy
ODA	Official Development Assistance
PBB	Programme Based Budgeting
PPP	Public Private Partnerships
SSA	Sub Saharan Africa
WHO	World Health Organization

UNICEF, 2017
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<http://www.unicef.org/Zimbabwe>