Key Messages

- The MOHCC is among three Ministries, where the Programme Based Budgeting (PBB) has been implemented as a pilot phase in 2016 budget.

- The 2016 National Budget allocated US$330.79 million, representing 8.3% of the total budget, to the MoHCC, making it the fourth highest vote.

- Total Health and Child Care allocation has remained below the 15% Abuja target and the Sub Saharan Africa average of 11.3%. As a share of GDP, the Health & Child Care budget is 0.7 percentage points lower than the SSA average of 3%.

- Zimbabwe’s per capita allocation is significantly lower than regional peers at US$24.34, against the SADC average of US$146.29.

- Employment costs to account for 60.5% of the total allocation, however there is a 30% vacancy rate across the Ministry and its health facilities/institutions.

- Off budget health development partner support is projected at approximately US$400 million exceeding the national budget allocation.

- Significant gains have been achieved in the health sector – especially in maternal and child health - but sustaining these gains is going to require further fiscal space for health.

- Sustainability of such large off-budget support is a major challenge, whilst there is a need to improve the efficiency and equity of spending.
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. In line with the country’s economic plan—ZimAsset (2013-2018), the Ministry’s main targets are to reduce morbidity and mortality due to priority diseases and conditions with special emphasis on HIV, TB, Malaria and NCDs.

The Ministry’s key budget priority in 2016 is to procure essential medicines and equipment for referral, provincial and district hospitals including recapitalization of the government’s medical supplies procurement and distribution company, NATPHARM. Other priorities includes, the need to: reduce the burden of diseases through strengthening the health system and thus improve the quality of service delivery; reduce mortality and improve life expectancy at birth; rehabilitation of health care infrastructures and promote safe water and sanitation.

Selected Health Indicators

**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 & social welfare, also receives funding from the budget for health related support. Through the Ministry of Public Service, Labour and Social Welfare, the government allocates funds to the Premier Services Medical Aid Society, mainly to cater for health care insurance for public service officials and their families.
The 2016 National Budget allocated US$330.79 million, representing 8.3% of the total budget, to the MoHCC, making it the fourth highest vote. Other Ministries such as Primary and Secondary Education (20.3%), Home Affairs (9.9%), Defense (8.9%), and Higher and Tertiary Education, Science and Technology Development (7.6%), complete the top 5 allocations.

The 2016 allocation represents a 6.1% nominal increase on the US$311.93 million allocated in 2015. As a share of total budget, the 2016 allocation is 1 percentage point higher than the 7.3% in 2015, (Figure 2). However, despite this increase, the 2016 health care allocation is 1.6% lower than the total budget allocated in 2013, mainly reflecting a weakening fiscal environment constraining government spending in general, and health & child care in particular.

Total Health and Child Care allocation has remained below the 15% Abuja target and the Sub Saharan Africa average of 11.3%. As a share of GDP, the Health & Child Care budget is 0.7 percentage points lower than the SSA average of 3%.

Furthermore, Zimbabwe’s per capita allocation is significantly lower than regional peers. Despite the per capita allocation increasing from US$23.18 to US$24.34 in 2016, it remains much lower than the WHO target of US$34 and the SADC average of US$146.29.

**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 account for 60.5% of the total MoHCC allocation, hence, with regards to non-wage allocations, the MoHCC ranks 3rd with US$130.48, (Figure 3a), being earmarked for capital and other operational costs.

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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 share of employment costs to the total health & child care budget allocation has increased significantly from 37.7% in 2010 to 60.5% in 2016. The net effect, of which, has been the crowding out of capital investments, maintenance, and other expenditures for programs and service provision. Capital investments rose from 14.9% of the budget in 2010 to 34.1% in 2013, before declining to a projected 7.5% in 2016. Under-funding of the capital investments has resulted in dilapidation and inadequacies in the health care delivery systems.

Budget Allocation by Programmes

Expenditures on medical/curative services will absorb 83.7% of all health and child care expenditures in 2016. This is some 2.7 percentage points higher than the 81% in 2015, effectively crowding out preventive services and research, which together, represent 11.3%, whilst administration and other general costs account for 5.1%, (Figure 5). Sixty-three percent of the medical care allocation goes to employment cost, with only 4.3% being spent on hospitals and health care centers, (Table 1).

Compared to other African countries, allocations on preventive services in Zimbabwe is low. For example, National Health Accounts (NHA) data in countries such as Kenya, Tanzania, and Uganda showed that these countries spent more than double what Zimbabwe

<table>
<thead>
<tr>
<th></th>
<th>MEDICAL CARE SERVICES</th>
<th>PREVENTIVE SERVICES</th>
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<tbody>
<tr>
<td></td>
<td>Allocation</td>
<td>% of Total</td>
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<tr>
<td>Employment Costs</td>
<td>173,331,000</td>
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<tr>
<td>Medical Supplies &amp; Services</td>
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<td>Current Transfers</td>
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<td>Programmes</td>
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<td>Hospitals &amp; Health Centers</td>
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</tr>
<tr>
<td>Capital Exp</td>
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</tr>
<tr>
<td>Total</td>
<td>276,722,000</td>
<td>100.00</td>
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</tbody>
</table>

Source: Various Government Budget Statements

Source: 2016 National Budget
spends on preventive services at an average of 20% total health expenditure\(^2\). Therefore, in the short term, budget allocations can be done to better align resources with health needs and achieve efficiency. This could include, prioritizing health prevention and promotion. Subject to increased fiscal space, the government would need to increase the share of non-wage expenses, especially on medicines and services.

**Sources of Health & Child Care financing**

In addition to direct budget allocations, the MoHCC is expected to receive additional funding from development partners and statutory funds. Total development partner resources – off budget - are projected at US$411.67 million, exceeding the total national treasury allocation towards health.

Given that 60.5% of the government funding goes to employment costs, the burden of programme spending and infrastructure has mainly fallen on development partners and individuals through out-of-pocket payments. For instance, as measured by facility sources of revenue, it can be noted that central government spending constitutes a small share of non-wage expenditure funding for district and primary level health facilities. As at 2013, central government spending accounted for only 21.1% and 2.0% of all revenue received by district and mission hospitals and rural health centers, respectively, (Figure 6a & b). The largest source of funding is user fees, through Out-of-Pocket Payments (OPP), which account for 54.1% and 14.5% for rural health care centers. Development partner’s account for 75.6% of the revenues received by rural health centers and 22.1% for district and Mission hospital revenues.

Whilst recent data is not available, the situation may not have changed significantly, hence, the basic level of health system in Zimbabwe is highly dependent on donor funding and OPP payments. This is unsustainable and perpetuates inequalities in access to health care. Funding health care from OOP is undesirable as it is both inefficient and regressive. Due to limited incomes, the poor people typically bear a heavier financial burden of OOP. As results, higher OPP may discourage the lower-income earners from seeking health care, there by affecting health outcomes. For example the World Bank 2014\(^3\), noted that the most commonly cited reasons for not accessing health care when ill is the cost, which accounts for 40.9% among the poor compared to 26.4% among the rich.

**Health Care Budget Execution**

There has been significant deviation from the approved budget to actual execution of the MoHCC budget. Whilst between 2010 and 2012, the difference between allocation and actual spending was small, it widened by 3.3 percentage points in

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\(^3\) World Bank Public Expenditure Review Health Sector Zimbabwe, Harare, October 2014.
2013, (Figure 7). This is mainly on account of the cash flow constraints, worsened by the cash budgeting approach of the government. Cash budgeting implies that the government has to first receive cash before they can actually spend. Where the flows are underperforming, as is the current situation, it makes planning difficult as disbursements to Ministries are often delayed or cancelled altogether.

As at September 2015, 79.2% of the budget had been disbursed, accounting for 5.8% of the total actual spending. Of which, employment costs accounted for 60.2%, whilst only 3.5% had been spent on maintenance and infrastructure investments. The actual spending in capital investments has been on a steady decline from 16.3% in 2012 to 3.5% by September 2015. This has been mainly on account of the growth in actual spending on employment, which increased from 48.1% in 2012 to 60.2% by end September 2015.

Per capita actual spending has remained below the US$34.00, World Health Organization (WHO) threshold at US$19.40 in 2014 and US$16.45 by end-September 2015. 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, whilst at the same time improving its expenditure mix and prioritization of expenditures.

**Equity in Health Care Spending**

It is important for any government to monitor its geographical budget allocation in view of the socio-economic conditions of different localities to achieve equity between regions. Zimbabwe’s public health expenditure is centralized, with over 96% of budget allocation going through the MoHCC. The remaining share of the budget (3.7%) is disbursed to government hospitals and health care centers along budget lines.

Given that no other MoHCC expenditures are broken down at provincial or district level, the equity analysis herein is based on the US$11.95 million allocated to government hospitals and health centers. Budget allocations to government hospitals and health centers account for only a small share (3.6%) of total health and child care budget.

Forty-four percent of such allocations goes to provincial and district hospitals. Central hospitals account for 25.2%, whilst the biggest state-owned hospital group in the country - Parirenyatwa Group of Hospitals - was allocated 21.5%, rural health centers and mission hospitals were allocated 4.8% and 4.2%, respectively, (Figure 8).
An analysis of the 2016 Budget allocation by province against poverty has been employed to judge whether central government expenditure for service provision prioritized poorer areas. It would appear the allocations are uniform across provinces, ranging from US$593,000 to US$712,000. This is despite the differences in population sizes and levels of extreme poverty in each province. Extreme poverty represents those households whose per capita consumption is below the Food Poverty line (FPL), of US$33.00 for one person and US$166.00 for an average household of five persons, per month. Such households are assumed to face the most difficulties in meeting the cost of health care services.

By factoring in population, it can be noted that apart from Mashonaland West, per capita spending appears slightly higher in provinces with a higher proportion of extremely poor (Figure 9). Despite lower poverty levels, Matebeleland South has the highest per capita allocation, mainly on account for the size of its population. According to the 2012 Census, the province is the least populated with 683,893 people.

However, equity seems to be improving in terms of access to health services as more and more poor people, over time, seem to be accessing maternal and child health services (Figure 10). Notice that in the poorer wealth quintiles, access is improving demonstrating the positive benefits of interventions in the health sector over the past 5-6 years since the near-collapse of the health sector in Zimbabwe in 2008/9.
CONCLUSIONS

- In view of the prevailing fiscal space constraints, the focus of public spending should be to improve the quality of expenditures in health. Better targeting 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.

- Budget tracking and monitoring could help ensure that resources reach programmes and beneficiaries, to produce the intended health outcomes. Equally important is the need to ensure that public spending targets the neediest provinces and districts to achieve equity.

- Disbursement rates in health need to improve. With an average disbursement rate of 55% (that is the non-wage rate of disbursement against the set allocation in the national budget), the sector continues to struggle. Health sector is critical for children, and should be a priority investment.

- Increased investment in preventive care is a likely driver towards long term reduction in curative investments. The current bias in favour of curative care as opposed to preventive care is a costly option for government, and should be urgently corrected to avoid long term efficiency losses.

- In the short term and in view of the sluggish economic outlook, development partner support will remain critical. However, given the unpredictability of donor support, such resources should be considered complementary to domestic resources, in the short term whilst domestic resource mobilization recovers. 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.

- Related to the above, strengthening donor coordinating could help improve resource allocation and health outcomes. It can improve targeting, whilst avoiding duplication and overconcentration in certain provinces at the expense of others.
## LIST OF ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>FPL</td>
<td>Food Poverty line</td>
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<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
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<tr>
<td>HTF</td>
<td>Health Transition Fund</td>
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<tr>
<td>MICS</td>
<td>Multiple Indicator Cluster Survey</td>
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<tr>
<td>MoHCC</td>
<td>Ministry of Health and Child Care</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>NHA</td>
<td>National Health Accounts</td>
</tr>
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<td>SSA</td>
<td>Sub Saharan Africa</td>
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