

Précis

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Meeting the Health Care Challenge in Zimbabwe

THE WORLD BANK HAS USUALLY “DONE THE RIGHT thing” in the Zimbabwe health sector, but has not always “done things right,” according to a recent Operations Evaluation Department (OED) study. Bank policy advice and project support have been well-crafted to address Zimbabwe’s epidemiological profile and health sector needs, and have helped integrate family planning into health services, improve service quality, and increase facility deliveries, inpatient attendance, and contraceptive prevalence, among other benefits. But programs have often encountered difficulties in implementation. As Zimbabwe confronts the combined challenges of severe financial constraints and the growing AIDS epidemic, a reexamination of Bank work in the sector is appropriate in preparation for the next phase of Bank support.

Background

Over the past 15 years, the World Bank has provided policy advice and project support to health, nutrition, and population (HNP) programs in Zimbabwe, and in 1991 became involved in the design and support of Zimbabwe’s Economic Structural Adjustment Program (ESAP). The Bank’s initial effort in the sector—a 1986 loan to support improvement in the quality and availability of health services in 8 target districts, including expansion of infrastructure and in-service training

for nurses—was expanded in 1991 to include an additional 16 districts. A 1993 loan funded the acquisition of drugs to treat sexually transmitted infections (STIs), as well as medical supplies and laboratory equipment.

Bank project support and policy advice have proven valuable to the Zimbabwe health sector, but the impact on health system performance and health outcomes has been undermined by economic stagnation and a devastating AIDS epidemic. Flaws in the design of ESAP con-



tributed to strains on the health sector, particularly with regard to civil service reform and health sector staffing. Yet the government's failure to control the budget deficit—and its financing of that debt by borrowing domestically at high interest rates—has led to escalating interest payments that now equal one-fourth of all government revenue. This mounting debt threatens to lead Zimbabwe into deeper economic crisis, and without a concerted effort at deficit reduction, it will further undermine the health sector.

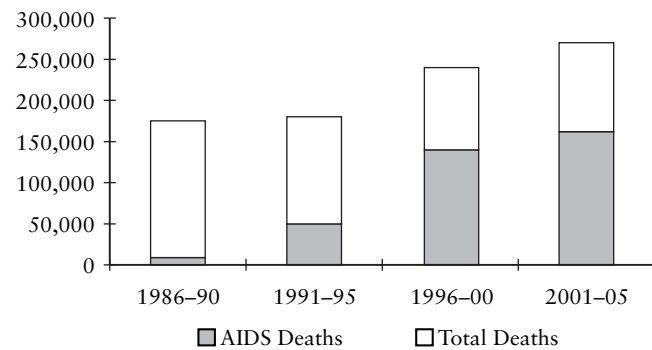
Zimbabwe is faced with the world's most severe AIDS epidemic. According to UNAIDS, 26 percent of the adult population in Zimbabwe is infected with the HIV virus that causes AIDS, and the percentage may still be increasing. The implications for the nation's health system, economy, and society are staggering. This is particularly tragic, because although AIDS cannot be cured, it can be prevented through modifications in sexual practices. Yet government has not offered leadership in behavior change, the strategy is not focusing on the most cost-effective approach (working with those most likely to transmit the virus), and several high-transmission areas in the country have not yet benefited from intervention.

Health and the Health System

In the decade following independence in 1980, Zimbabwe experienced some of the most rapid improvements in HNP indicators in all of Sub-Saharan Africa. Infant mortality declined from 90 per thousand in 1980 to 53 per thousand in 1988. Household incomes increased only modestly during this period, however, suggesting that the government's strong emphasis on basic health and family planning services, health education, and community outreach, bolstered by a strong focus on prevention, were responsible for the improvements.

In the 1990s, health and health service indicators stagnated or declined under the combined burdens of AIDS, economic crisis, and drought, although fertility continued to decline. After a decade of decline, both infant and adult mortality are increasing, as are opportunistic infections such as tuberculosis. Although economic crisis may have a role in weakening the health system, these increases in mortality are primarily attributable to AIDS (see figure 1). Although HIV/AIDS is best addressed through prevention and behavior change, declining per capita health spending and growing demands for curative care have weakened the preventive focus that characterized the successful programs of the 1980s.

FIGURE 1. DEATHS OF CHILDREN UNDER 5



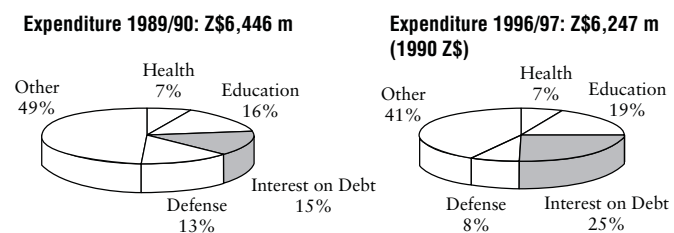
Source: NACP 1997.

Impacts

ESAP and Health

Zimbabwe's 1991 ESAP liberalized the economy but failed to control the government's budget deficit, which has averaged nearly 10 percent of GDP annually since independence. Economic liberalization without deficit reduction contributed to economic stagnation and limited job creation. Higher costs for food and social services, combined with declining formal sector wages and the lingering effects of severe drought in 1991-92, have left many of the poor worse-off than before adjustment began. Although both the government and the Bank tried to protect spending for health and education, large budget deficits fueled inflation and led to growing interest payments, which contributed to declines in real health spending and real wages for health workers. These interest payments—three-quarters of which are for domestic debt—now represent over three times the government spending on health (see figure 2). Program design failed to give priority to deficit reduction (for example, by cutting taxes), but the government regularly missed deficit targets by implementing unbudgeted programs (such as the recent payments to war veterans).

FIGURE 2. GOVERNMENT EXPENDITURE ALLOCATIONS, 1989/90 AND 1996/97



Although health workers were protected from re-trenchments, downsizing of Ministry of Health (MOH) administrative and maintenance staff reduced efficiency and added to morale problems without generating significant savings.

Although macroeconomic policies and performance have had a greater influence on the health sector than Bank project lending, the Bank has not effectively linked health sector investments and strategies to macroeconomic dialogue, particularly in health staffing and civil service reform. To prevent further deterioration in the public health sector, government must give priority to reducing the budget deficit and restructuring debt service. In the medium-term, the budget for health will remain constrained, and it will be necessary to focus on increasing efficiency and making the difficult choices necessary to fund priorities such as AIDS prevention and basic services for the poor.

Health Financing and Cost Recovery

Bank work in health financing led to increased cost-recovery efforts, but it has had limited success in mobilizing additional resources for health, improving quality and efficiency, and protecting the poor. The Bank persuaded the MOH to increase user fees in the early 1990s, but the Ministry of Finance (MOF) did not permit fee retention at health facilities until late 1997. Because fees were not retained, the quality of care did not improve. The Bank encouraged adoption of an exemption system to protect the poor from increased cost recovery in the social sectors, but shortcomings in design and implementation of the system meant that the program reached only a small percentage of the intended beneficiaries. Following fee increases, attendance for some preventive services shifted from hospitals to clinics, suggesting improved efficiency, but outpatient attendance by the poor declined in response to the fee increases, as prices increased and quality declined. In 1995, the government—with Bank agreement—abolished fees at rural health facilities, stating that the revenue collected did not justify administrative costs. Service quality rather than cost is a major concern for the rural poor, but cost has become a major barrier for the urban poor; in a recent survey 40 percent of the urban poor gave “too expensive” as the reason for not seeking treatment when ill.

Ironically, total cost recovery declined—from 3 to 2 percent of the MOH budget—primarily because government made little progress in improving hospital billing. The government continues to lose millions of dollars through inadequate billing of medical aid societies (health insurance companies) for expenses of insured patients in government central hospitals. This experience

suggests that the Bank must complement its broad policy recommendations with detailed dialogue on implementation, give greater attention to the institutional context, and coordinate sector and macroeconomic dialogue. Now that facilities are allowed to retain fees, hospital cost recovery has increased substantially, but billing remains inadequate. In the coming years, local districts and communities may wish to experiment with community-managed health centers, in which fee revenues are used to purchase drugs and improve service quality.

Strengthening Health Service Delivery

Bank support for expanding district infrastructure and staff training through the First Family Health Project (1986–91) improved service quality and contributed to increased facility deliveries, inpatient attendance, and contraceptive prevalence, but has had no measurable impact on outpatient attendance or disease patterns. Outpatient attendance in project districts actually declined following facility completion in 1991, coinciding with drought, increased fee enforcement, and drug shortages, which suggests that improved infrastructure and training alone will not improve service quality or access.

The impact of upgraded facilities on maternal attendance varied considerably, depending on the appropriateness of site selection. In genuinely underserved districts, such as Tsholotsho, maternal deliveries increased markedly following facility completion, while in others, deliveries stagnated and inpatient attendance fell, usually because the upgraded government hospital was near a mission hospital that was preferred by many patients. Domestic political influences and Bank insistence on upgrading existing facilities contributed to inappropriate site selection.

The Second Family Health Project (FHP2) improved facility design and site selection and built 16 district hospitals for the cost of the original 8. For FHP2, the Bank placed an architect within the MOH to ensure maximum efficiency in facility design. International competitive bidding (ICB) yielded construction costs that were 40 percent below government estimates, and facilities were completed on time, and below budget, in 1998. But the severe shortage of health personnel is making it difficult to staff the new facilities and threatens to undermine their impact. Once construction began, it was impossible—contractually or politically—to delay the projects or to reduce the number of hospitals pending resolution of staff shortages. This emphasizes the importance of flexibility in project design and of focusing on service quality and staffing issues rather than facility construction in the next phase of Bank support.

The Bank has been well-positioned and effective in promoting the integration of key HNP interventions.

The in-service nurse training supported by the Family Health Projects improved staff skills and contributed to the integration of nutrition and family planning into health services. The percentage of women obtaining contraceptives in health facilities has increased since the late 1980s, which is partly attributable to Bank-sponsored training in family planning. Project efforts to improve the quality of maternal delivery services in rural areas was undermined, however, by high turnover of trained nurse-midwives, who were often promoted or hired by the private sector soon after training.

Health Work Force

The current staff shortages were created by recent political decisions by government (abolishing training for state-certified nurses and firing striking health workers), high turnover of health staff, and the absence of effective manpower planning. Erosion of real wages in the public sector and increasing workloads have contributed to turnover and low morale, as has rapid growth of private health care—primarily serving urban populations—in the 1990s. Although Bank staff periodically raised concerns regarding health staffing, they were not effective in addressing the institutional constraints to action. The Bank has supported technical assistance for work force planning and discussed health staffing during supervision missions, but did not sponsor sector work (research) on health staffing issues until 1998. Responsibility for health personnel is divided among several ministries (MOH, MOF, and the Public Service Commission), and the Bank did not use its leverage at the macroeconomic level to elevate and add urgency to the dialogue. The MOH, Bank, and donors have made health staffing a priority for future support, but all parties should ensure that remediation is coordinated.

To address staff shortages, government will need to establish economic stability (to reduce inflation and prevent further budgetary declines) and develop a comprehensive health staffing strategy. The challenge is that budget constraints will not permit significant increases in personnel expenditures. Designing and implementing the strategy will require negotiation among the stakeholders, including the MOH, MOF, Public Service Commission, and health professionals. The Bank could assist by providing analysis and facilitating consensus among stakeholders.

AIDS and STIs

The presence of an STI considerably increases the likelihood that an individual will contract the HIV virus. Treating STIs can thus be one component of an AIDS prevention strategy. In the early 1990s, declines in the government's drug budget and growing demand for anti-

biotics led to critical drug shortages. Through the STI Project, the Bank has financed half of the government's drug budget for the past five years. Bank support for the purchase of STI drugs closed a major financing gap, contributed to significant cost savings in drug procurement, and initially increased drug availability. Bottlenecks later emerged that reduced drug availability, undermining program effectiveness. STI drug availability increased to 89 percent in the first two years of the project, but fell to 73 percent in 1996, primarily because of reversals of government contract awards by Bank procurement specialists and delays in registering drugs purchased through ICB. Government staff did not initially receive adequate training in Bank procurement procedures, and Bank supervision of procurement was initially inadequate to resolve the bottlenecks. Increased supervision and management attention by both government and Bank staff contributed to a recovery in STI drug availability to 87 percent in 1998.

Projects with a major pharmaceutical component require up-front training for both government and Bank staff—with periodic follow-up training—to avoid bottlenecks that could interrupt drug availability. Bank procurement procedures could be streamlined to reduce the burden on borrowers, but the cost savings achieved through ICB are essential to ensure drug availability in the face of tight budgets and growing demand for drugs.

The AIDS epidemic is the most serious problem facing the health system and, along with the deficit, the economy as a whole. But treating STIs is resource intensive, and unless done in conjunction with a concerted campaign to change sexual practices, it is unlikely to have a significant impact on AIDS. Bank-funded research has helped raise awareness in Zimbabwe regarding the seriousness of the AIDS epidemic, and the Bank has cosponsored innovative community AIDS prevention initiatives. The government's response, however, has not been commensurate with the scale of the epidemic, which may claim 1 million lives in the next decade. Experience elsewhere has shown that strong leadership and political commitment can halt the growth of the epidemic and save hundreds of thousands of lives. Recent pilot experiments in Zimbabwe show that HIV transmission rates among high-risk groups can be reduced by 30 percent or more in just a few years. The government has developed a multisectoral strategic plan to combat AIDS; the challenge now is to implement it.

Conclusions

The Bank can increase its effectiveness in the sector by fitting program design to accommodate institutional and political constraints and to take advantage of existing capacities. It can also build on its record of effectiveness

in promoting integration of programs and cooperation among government ministries to address the increasingly complex challenges confronting Zimbabwe. The approach would be particularly useful in establishing a comprehensive health staffing strategy. Because budget constraints will not permit significant increases in personnel expenditures, the design and implementation of the strategy will require negotiation among the many stakeholders.

To prevent further deterioration in the public health sector, government must give priority to reducing the budget deficit and restructuring debt service. Until this has been accomplished, maximizing efficiency and redis-

tributing available funding can do much to achieve greater balance and effectiveness in service provision. Government must also take immediate steps to give priority to AIDS prevention—particularly to substantially increase the public and private resources devoted to behavior change—and mount an effective intersectoral response to the epidemic.

The challenges of the next decade are considerable, but Zimbabwe has the tools, the experience, the innovative spirit, and the support of partners—including the Bank—needed to meet them. Past successes clearly demonstrate that once the decision is made to take on a problem, remarkable progress can be realized.

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The Impact of World Bank Support to the HNP Sector in Zimbabwe, by Timothy Johnston, Report No. 18141, June 1998. Available to Bank Executive Directors and staff from the Internal Documents Unit and from regional information service centers, and to the public from the World Bank InfoShop: 1-202/458-5454
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