A Peer Reviewed International Journal of Asian Academic Research Associates

AARJSH

ASIAN ACADEMIC RESEARCH JOURNAL OF SOCIAL SCIENCE & HUMANITIES

GOVERNMENT CONTRIBUTIONS AND DONOR FUNDING OF GOVERNMENT CENTRAL HOSPITALS IN ZIMBABWE

DR HARDSON KWANDAYI*; DR NELSON JAGERO;
MR JOSHUA MAVAMBE***; MS NGONIDZASHE CHIRIMA******

*Director,
Public Sector Management Training Program,
Africa University, P O Box 1320, Mutare, Zimbabwe

**Director Distance Education,
Africa University, P O Box 1320, Mutare, Zimbabwe

***Deputy Director Administration,
Zimbabwe Health Services Board,
P O Box A6104 Avondale, Harare Zimabwe

****Lecturer,
Faculty of Management and Administration,
Africa University, P O Box 1320, Mutare, Zimbabwe

Abstract

The aim of the study was to explore the reasons for inadequate funds for central hospitals and develop strategies for strengthening the revenue base of the central hospitals in Zimbabwe. The objectives of the study were to review the challenges faced by hospitals in accessing funds from Treasury and donors, and to suggest possible solutions to the challenges. Questionnaires, consisting of both closed and open ended questions, were used to get data from accounting personnel at the three central hospitals in Metropolitan Harare. Data gathered was analysed using SPSS.Major findings of the research were that allocations from Treasury were not meeting the hospitals' budget requirements and the releases were not coming in time. The main recommendations of the study were that the government needs to prioritize the health sector more when allocating the little resources available and that the hospitals need to employ various revenue generation alternatives.

Key terms: Donor Funding, Government Contributions, Central Hospitals

1.0 Introduction

According to Chidoko et al (2011), Zimbabwe's health background can be broken down into the pre-independence period, the post independence decade from 1980 to 1989, the Economic Structural Adjustment Programme (ESAP) era from 1990 to 1995, and the post ESAP era from 1996 and beyond.

During the years preceding Zimbabwe's independence when the country was under colonial rule, there was an imbalance in health care provision and financing which was highly skewed in favour of the white minority to the disadvantage of the black majority. In 1978, for instance, 44% government spending on health went to the urban based sophisticated curative services which mainly serviced the white populace (Chidoko et al, ibid). In the same vein, the authors go on to point out that 80% of government health resources were channeled to the whites.

The post independence period, that is the decade from 1980 to 1989, was characterized by populist policies in which the new independent government sought to redress the imbalances in provision of social services. The aim was to address the anomalies which had been created during the colonial era in which most of government resources for health were directed towards the whites to the detriment of blacks. With the attainment of independence in 1980, massive public investments were directed to the health sector (together with other social services like education) so as to improve the health and economic status of the previously marginalized black population. According to Trane and Bate (2005), between 1980 and 1987, government expenditure on health increased by 80% and stood at 2.3% of GDP, almost 3 times higher than the Sub Saharan African average of 0.8% of GDP. As a result of this concerted injection of capital by the government, significant progress in the health sector was noted. Life expectancy rose from 54.9 years in 1980 to 63 years in 1988, the rate of child immunization nearly tripled from 1980 to 1988 and infant mortality dropped by 80% in the same period (Trane and Bate, ibid). As Munyuki and Jasi (2009) observe, the government of Zimbabwe's investment in the public health sector from 1980 to 1989 bore fruit to the extent that the Zimbabwean policies were regarded as a success story in the developing world. Free public health gained prominence and there was a declining role for out-of-pocket payments during the period.

The period of the 1990s saw the implementation of the Economic Structural Adjustment Programme (ESAP) at the behest of the International Monetary Fund. The focus of ESAP public sector reforms (including health) was on economic liberalization, privatization and reduction in

public expenditure. Reduction of public expenditure also meant pronounced reduction in government allocation to public health. According to Munyuki and Jasi (2009), liberalization in the health sector also saw the emergence and developing prominence of alternative forms of health care financing which included medical aid societies (a form of private health insurance) like CIMAS, Premier Service Medical Aid Society, among others. However government public health spending suffered. Coupled with the reduction of government expenditure was the increased disease burden, for instance the burden of HIV/AIDS, and the health gains of the 1980s were being reversed. As government expenditure on health declined, there was an increased emphasis on hospital fee collection or out of pocket payments. However, exemption mechanisms were put in place to try and protect the economically vulnerable and all forms of user fees were removed at rural health centres during the period.

The period during the first decade of the millennium was characterized by an economic downturn in which government expenditure on health declined in real terms. General expenditure on health declined as the economy experienced hyperinflation and there was also withdrawal of lines of credit from international financiers. The general effects of the economic downturn on the public health sector are also elaborated on in the statement of the problem.

2.0 Statement of the Problem

Lack of adequate funds for the central hospital operations might have its origins in reduction of government health expenditure which occurred during the 1990s as part of ESAP. However the inadequacy of revenue was definitely fuelled and seriously exacerbated by the hyperinflationary period of the Zimbabwean economy between 2002 and 2008 when the value of the Zimbabwe dollar at one point fell on an hourly basis (Osika et al, 2010). Hospitals almost ground to a halt as there were simply no financial resources needed to provide the services.

The introduction of multicurrency in 2009 after the formation of the Government of National Unity (GNU) stabilized the economy. Another measure which was introduced to attempt to have the health care delivery system running again was the adoption of the targeting system where the Ministry of Finance would mobilize funds then target the resuscitation of a particular institution, for instance Harare Central Hospital (Osika et al, ibid). However, for such institutions the problems were half solved and they still persisted and the revenue base of the central hospitals needed to be strengthened.

3.0. Objectives

The objectives of the research were as follows:

1.0 To establish the proportion of government contribution to total hospital budgetary requirements and the challenges faced in accessing funds from Treasury.

2. To verify the extent of donor financing and assess challenges faced in accessing optimal donor support for central hospital operations

4.0 RELATED LITERATURE

4.1 Government Contribution to Health Care Funding

Government funding is one of the major sources of financing for public health care activities. Government funding of the health sector refers to the money especially directed towards public health institutions/ services which comes from the government or national budget (Ackon, 2003). As McIntyre (2007) explains, these budgetary funds which the government allocates to health services comes from direct taxes, which are levied on personal and corporate income, and indirect taxes, such as value added tax and customs duties. McIntyre goes on to point out that government funding can also accrue from deficit funding, where domestic or international loans are secured to finance government activities over and above what is obtained from general tax revenue. Donor funding from bilateral or multilateral international organizations, what Witter et al (2000) call official development assistance, may also come in form of loans to the government meaning that the government becomes the provider of this funding as it would have to service the debt together with interest charges. Some countries have introduced dedicated or earmarked taxes specifically for raising revenue for the health sector. For instance, Ghana increased its VAT by 2.5% and the additional income raised from this exercise is directed towards boosting the National Health Insurance system's coffers (Government of Ghana, 2003). In Zimbabwe, the government introduced a 3% AIDS levy on top of existing personal and company income tax in order to fund the interventions against AIDS (Mpofu and Nyahoda, 2008).

Many authors have written on the negative effects of the Structural Adjustment Programmes but for discussion purposes only a few are sited here. Structural adjustment programmes which occurred in the 1990s stipulated that governments had to cut on social spending and as a result, the public health budget was drastically cut resulting in a reversal of health gains which had been

realized in the 1980s (Normand et al, 1996). Dhliwayo (2001) in elaborating on the reversal of health gains, noted that in the early 1990s the quality of health services in Zimbabwe had fallen by a colossal 30% with more than double the number of women dying in child birth at Harare's hospitals than those prior to 1990. Shortage of drugs at public health institutions, congestion at casualty and mortuary became common (MOHCW and WHO, 2002).

4.2 Donor Funds and Public Health Sector Financing

Donor funding is a broad concept covering grants and loans which are given to developing countries for development projects targeted at not only improving the health status of the poor countries but various development programmes mainly aimed at fighting poverty. Donor funding is also referred to as official development assistance (Witter, 2000). Health aid or development assistance for health, which is the area of concern here, is just but one sub component of a wide range of areas that receive donor assistance in developing countries' economic activities.

Donor funds come from a variety of sources. According to Gottret and Schieber (2006), there is a complicated international official development infrastructure responsible for sourcing, disseminating and monitoring the use official health development assistance. The complicated infrastructure which provide financial health assistance include, the International Monetary Fund (IMF), the World Bank, more than 20 regional banks, 40 bilateral development agencies, the UN family of organizations, thousands of large and small non governmental organizations, and numerous private foundations (Gottret and Schieber, ibid). The tendency is towards harmonization of the numerous organisations' efforts to work together with the governments in order to achieve the 8 Millennium Development Goals, of which those dealing with health are a considerable number.

Donor support to the public health sector is disbursed through two main ways; through the country's Ministry of Finance (Treasury) which in turn disburses to the Ministry of Health through a Vote of Credit, or through direct disbursement to Ministry of Health on a quarterly basis as per plans agreed upon between the Ministry and the respective donor (MOHCW, 1999)

Critiques of donor financing have been quick therefore to point out that it is one of the most unreliable forms of health care financing. Donor funding is contingent on the recipient country maintaining cordial relations with the donors. McIntyre et al (2011) cite the example of Zimbabwe in the period between 2000 and 2005. Due to the fact that Zimbabwe's relations with

the international world was strained at that period, Zimbabwe's health budget assistance from donor funds remained at a lowly 13% of total health financing in 2005 while other Southern African countries like Malawi were receiving as much as 60% of total health budget from donors. Another challenge with donor funds is that where they come through the Ministry of Finance as part of the national budget, the Ministry of Health might receive insignificant amounts for its expenditure if the government of the day does not value health highly (Arkotsu and Abor, 2011).

Despite the challenges, in Zimbabwe, donor support has made some significant contributions especially with the development of health infrastructure, and also providing funds during the period of the economic downturn when the local currency was deeply affected by inflationary pressures. The donors provided funds for emergency health care needs like the fight against cholera in urban areas and have continued to provide assistance in the fight against communicable diseases like HIV/AIDS, tuberculosis and malaria (Osika et al, 2010).

5.0 METHODOLOGY

5.1 Population, Sample and Sampling Procedures

The research employed *multi stage sampling* owing to the complexity of the subjects involved and also in order to enhance validity of the methods used. Multistage sampling refers to the use of a variety of sampling methods for the same research project. To start with, *convenience sampling* was employed to choose the central hospitals which participated in the study. Chitungwiza Hospital, Harare Hospital and Parirenyatwa Hospital were selected in order to deal with the constraints of time and costs on the part of the researcher who was based in Harare and who would not have the sponsorship to be travelling to other central hospitals in Bulawayo.

Another sampling method which was employed was *purposive sampling* where the sample to be the study population was selected by virtue of the certain characteristics they possessed. Hospital accounting staffs were chosen to participate because they deal with hospital revenue collection issues on a day to day basis. *Stratified sampling* was employed to ensure the different levels of hospital accounting staff were proportionately represented in the sample..

After the composition of each strata was clarified, selection of members for each strata was then done using *simple random sampling* until the required number for each strata was attained.

5.2 Research Instruments

The researcher used self administered questionnaires which respondents completed and returned. The questionnaires were completed by accountants, accounting assistants and accounts clerks. The questions were logically designed starting with the closed ones to attract the respondent before open ended questions were introduced which required the respondent to think more.

5.3 Data Analysis

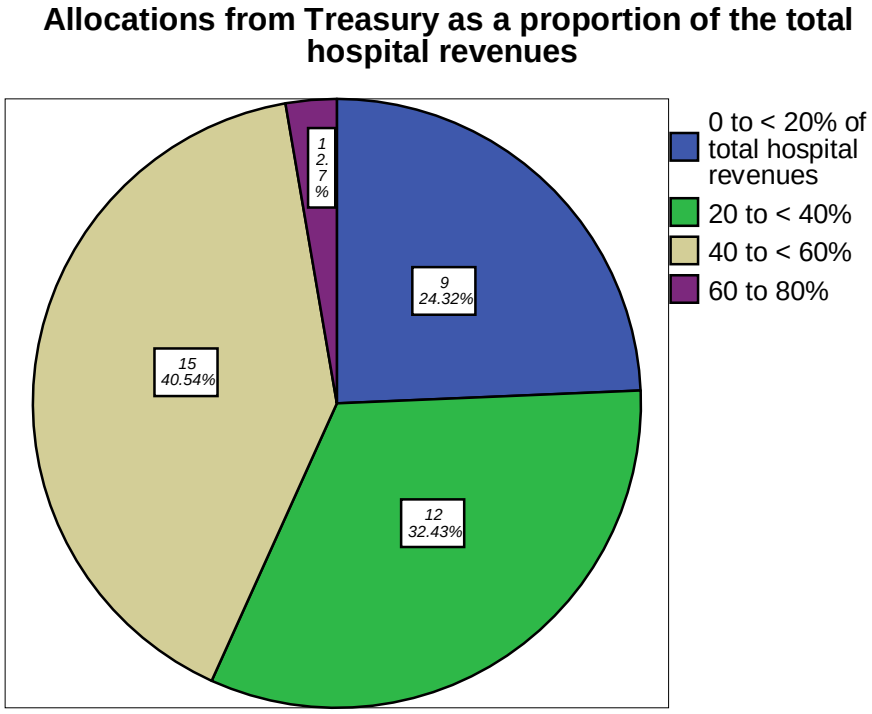
The dissertation is mainly a qualitative research was not necessarily subjected to the rigours of detailed statistical analysis. Data analysis started with presentations of general demographic or biographical issues about the respondents before a detailed analysis of the data on a research objective by research objective basis was done. Tables, graphs and diagrams were utilized to analyse the data and where applicable Statistical Package for the Social Sciences (SPSS) were used to produce the tabulations, graphs and diagrams.

Data from open ended questions was analsysed qualitatively with the researcher highlighting common trends deduced from the responses provided.

6.0 DATA PRESENTATION AND DISCUSSION

6.1 The Proportion of Treasury Contributions to Hospital Revenues; Challenges Faced in Accessing Funds from Treasury

Figure 1: Allocations from Treasury as a Proportion of Total Hospital Revenue



Source: SPSS Analysis Results (field data)

Figure 1 gives a breakdown of the respondents of the evaluation of the contribution of Treasury releases to total hospital revenues. Fifteen respondents (40.54% and the highest frequency) said that the releases from Treasury contributed between 40% to less than 60% of total revenue realized by the hospitals. Twelve respondents (32.43%) said that Treasury releases amounted to between 20% to less than 40% of total hospital budgets whilst 9 respondents (24.32%) pointed out that disbursements from Treasury amounted to less than 20% of the hospitals' total income. One respondent (2.7%) said that the contributions from Treasury formed between 60% and less than 80% of the total revenues realized by the hospitals. From the findings, it can be deduced that Treasury contributions to total hospital revenues generally do not exceed 60% of total revenues for central hospitals.

Balasubramaniam (2001) observed that in developing countries, governments contributed between 10% and 30% of public health finances. The figures for Zimbabwe have been fluctuating over the years. Chawla and Rannan-Eliya (2001) pointed out the government contributed 39% of total revenue funds in 1994. In 1996, the contribution of the Zimbabwean Government was said to be at 55%, before dropping to 33% in 2002 and rising to 52.7% in 2005. From the research, the fact that 72.97% (40.54% plus 32.43%) said the government was contributing between 20% to 60% of total hospital revenue shows that the contributions by Treasury to Central Hospitals was within the broad range of the fluctuating government contributions.

6.2 Evaluation of Frequency of Treasury Releases to Hospitals

Table 1 that follows illustrate the respondents' rating of the frequency with which Treasury released funds for hospital operations

Table 1: The Frequency with which Treasury Released Funds for Hospital Operations

Classification of Release		Frequency	Percent
Valid	Treasury releases always on schedule with actual amounts expected	2	5.4
	Releases are half the time reliable and half the time unreliable	4	10.8
	Releases from Treasury are late most of the time	6	16.2
	Treasury releases always late making expenditure planning difficult	24	64.9
	Other: Please explain	1	2.7
	Total	37	100.0

Source: SPSS Analysis Results (field data)

Table 1 shows that 64.9% said the releases from Treasury were always coming late making it difficult to plan hospital expenditure. 16.2% said the releases were late most of the time. If the percentages for the two categories or classifications are added up, the information reflects that 81.1% of the respondents (over three quarters) pointed out that the releases from Treasury were coming late. 10.8% of the respondents were undecided.

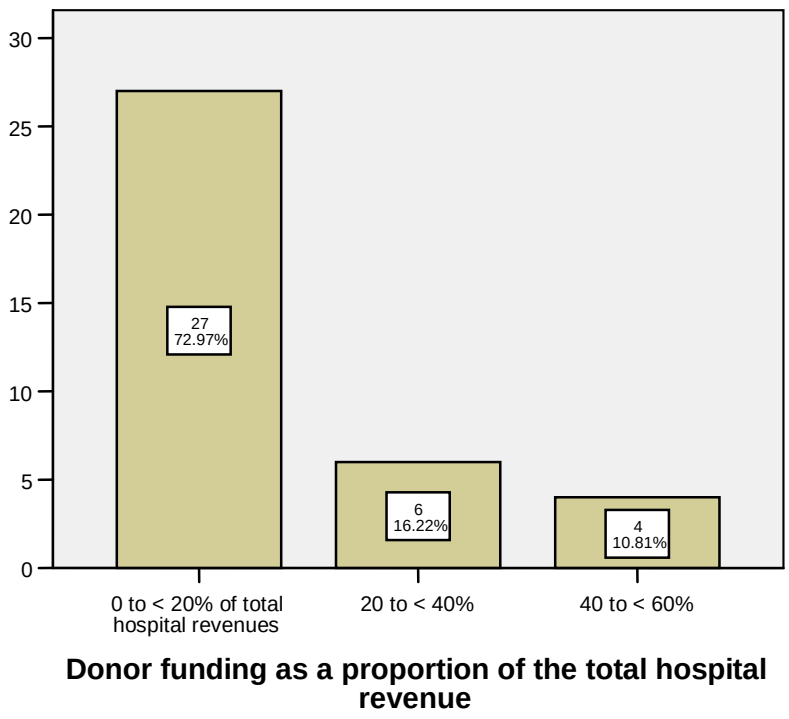
6.3 Other Challenges Experienced by the Hospitals in Accessing Funds from Treasury

Most of the respondents emphasized that the major challenges faced were late releases of funds form Treasury and inadequate funds on the part of government as the government was facing financial challenges like liquidity problems. Some pointed out that the allocations were too little and less than what had been promised.

Asked to suggest solutions to the challenges, most respondents stated that Treasury should disburse the funds on time even if the allocations were adequate. Some suggested that the Government should seriously consider honouring the hospitals' bids or budget estimates and prioritise the health sector in budget allocations. Others pointed out that the hospitals could not continue to pin their hopes on Treasury alone but to engage in income generating projects in order to boost their coffers.

6.4 Verifying the Extent of Donor Funding to Hospitals and Challenges Faced in Accessing Donor Funds

Figure 2 Evaluation of Donor Funding as a Source of Hospital Revenue



Source: SPSS Analysis Results (field data)

Figure 2 gives a breakdown of the respondents' evaluation of donor funding as a source of central hospital funding. Twenty seven respondents (72.97%) said that donor funding contributed less than 20% of total hospital funding for operations. Six respondents (16.21%) pointed out that donor funding contributed between 20% to less than 40% of hospital funding. 10.81% said that donor funding was contributing 40 to less than 60% of total hospital revenues. There was no rating for the other classifications, namely 60% to less than 80%, and 80% to 100%.

McIntyre et al (2011) observed that in 2005, Zimbabwe's health care financing support from donors constituted 13% of total health care financing while donor support to Malawi constituted

60% of total health care spending. The general view amongst respondents (over 70%) that donor funding to the central hospitals constitute less than 20% of total hospital revenue resonates with the observation by McIntyre et al (ibid).

6.5 Challenges Faced by Hospitals in Trying to Get Donor Funding

About 50% of respondents pointed out that the political environment pertaining in Zimbabwe prevented donors from financially supporting Government Central Hospitals. A third of the respondents stated that donors were not willing to finance overall hospital operations but only a selected fraction of hospital activities. Certain respondents also pointed out those donors also often lacked capacity because of inadequate funds in view of too many health needs that require funding,

The respondents suggested several solutions on how donor funding could be better accessed in order to boost hospital funding. The respondents suggested that the hospitals should be seen to be practicing good corporate governance, develop policies and plans which are marketed or widely disseminated to donors both local and foreign, then vigorously engage the donors for assistance.

7.0 Conclusions

It can be concluded that Treasury contributes less than 60% of the total revenue which is realized by the central hospitals. This leaves the hospital to rely on other forms of financing like out-of-pocket financing which greatly affect equity in health because of the problem of affordability. The research also established that funds from Treasury never meet the hospitals' bids, the funds come late most of the time and the releases do not meet the promised quantities and this greatly affects hospital financial planning and consequently, the services which the hospitals offer are bound to suffer.

The funding contributed less than 20% of total hospital finances. It can therefore be concluded therefore that donor funding is not a very significant contributor to the revenues of central hospitals. The reason given for this was that donors mainly concentrated on the rural areas or the periphery- the provinces and districts. Donors also do not support a wide range of hospital operations as the hospitals would desire but a selected number of operations depending on donor preferences. The donors are also not very forth coming because of the political environment pertaining in Zimbabwe.

8.0 Recommendations.

There is need for political will on the part of Cabinet and Parliamentarians to observe the Abuja Declaration which stipulates that at least 15% of the national budget should go towards funding the public health sector. This way, the funds available to public health institutions can be increased. The fact that the allocations from Treasury never meet the bids which the health institutions put forward might be a result of the challenges the economy is facing in terms of a constrained resource base.

While the political leadership can assist in wooing donors by implementing the appropriate policies, the Hospital Management Boards of the respective hospitals should also make individual hospital initiatives to attract and engage donors both local and foreign in order to assist in hospital financing. This calls for the preparation of hospital plans and projects which should be marketed to potential donors for them to buy in.

REFERENCES

Ackon, E.K., 2003. *Management of Health Care Organizations in Developing Countries*. Accra: Bel-Team Publishers.

Akortsu, M.A. and Abor, P.A, 2011. Financing Public Healthcare Institutions in Ghana. *Journal of Health Organization and Management*, Vol 25, No 2, pp. 128- 141.

Chalwa, M. and Rannan-Eliya, R., 2001. *Experiences with Resource Mobilisation Strategies in Five Developing Countries—What can we Learn?* Report for the Harvard University's Data for Decision Making Project. Washington: United States Agency for International Development (USAID).

Chidoko, C., Dhoro, N.L, Sakuhuni, R.S. and Gwaindepi, C., 2011. "Economic Determinants of Public Health Expenditure in Zimbabwe" in *International Journal of Economics and Research Vol 2 Iss 6* :13-25.

Dhliwayo, R., 2001. "The Impact of Public Expenditure Management under ESAP on Basic Social Services: Health and Education". University of Zimbabwe. Harare: SAPRI/Zimbabwe.

Gottret, P. and Schieber, G., 2006. *Health Financing Revisited: A Practitioner's Guide*. Washington, DC: The International Bank for Reconstruction and Development (World Bank).

Government of Ghana, 2003. *National Health Insurance Act (Act 650)*. Accra: Government of Ghana.

McIntyre, D., 2007. *Learning from Experience: Health Care Financing in Low- and Middle-income Countries*. Geneva: Global Forum for Health Research.

McIntyre, D et al. 2011. "Key Issues in Equitable Health Care Financing in East and Southern Africa." *EQUINET Discussion Paper Number 66.* University of Cape Town, IDRC Canada and Training and Research Support Centre. Harare: EQUINET.

Ministry of Health & Child Welfare, 2010. *National Child Survival Strategy for Zimbabwe 2010- 2015*. MOHCW, Zimbabwe.

MOHCW, 1999. *National Health Accounts Report-Zimbabwe, 1999*. Harare: MOHCW National Health Accounts Technical Team

MOHCW and WHO, 2002. *Rapid Needs Assessment for the Health Sector in Zimbabwe*. Human Assistance and Recovery Programme (HARP). Geneva: WHO.

Mpofu, A. and Nyahoda, P., 2008. "National Health Financing in Zimbabwe, 2005: Contribution of the National AIDS levy to Health Care Support". *EQUINET Discussion Paper Series 54*. Harare: EQUINET.

Munyuki, E. and Jasi, S., 2009. "Capital Flows in the Health Care Sector in Zimbabwe: Trends and Implications for the Health System". *EQUINET Discussion Paper Series 79*. Rhodes University, Training and Research Support Centre, SEATINI, York University. Harare: EQUINET.

Normand, C., 1996. "Resource Mobilisation for the Health Sector in Zimbabwe". Data for Decision Making Project.

Osika, J et al. 2010. *Zimbabwe Health Systems Assessment 2010*. Bethesda, MD: Health Systems 20/20 Project, Abt Associates Inc.

Rao, S., 2004. "Health Insurance: Concepts, Issues and Challenges" in *Economic and Political Weekly*, Vol 39, No. 34,pp. 3835- 3844.

Trane, R., and Bate, R., 2005. "Despotism and Disease: A Report into the health situation of Zimbabwe and its probable impact on the region's health", Africa Fighting Malaria and American Enterprise Institute: Washington, DC, available at:

http://www.reliefweb.int/rw/rwb.nsf/db900sid/EVIU-6E7B8Z?OpenDocument

Witter, S., Ensor, T., Jowett, M. and Thompson, R., 2000. *Health Economics for Developing Countries: A Practical Guide*. Oxford: Macmillan Education.