

## **Title: An evaluation of decentralization of health services in Zimbabwe.**

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### **FINANCING**

Content:

Decentralization of health services in Zimbabwe: the rationale, process, impact and public sector efficiency.

The debate for health sector reform has been heightened and some changes have already been effected. The introduction of the Economy Reform Programme (ERP) in 1990 called for innovative ways of providing health services in an efficient and effective way. Within this transitional period health services have come under scrutiny by major international donors and governments to ensure rationalization of services provision and financing. The World Bank (WB) in its 1993 report *Investing in Health*, emphasized the need to invest in health services that generate the most benefits out of limited resources. The general performance of the public health sector has raised concern as to its ability to provide adequate health services given the ever diminishing resources, and its highly centralized nature of management.

Specifically, the Ministry of Health and Child Welfare proposes major reforms in the following areas:

Decentralization.

Health financing.

Regulating the Private Medical Sector.

Management strengthening.

Contracting out.

It is hoped that a comprehensive programme in these areas will ensure the development of a sustainable health service in Zimbabwe and help meet the objectives of the current Public Sector Reform Programme (MOH&CW,1995).

A number of developing countries have implemented reform programmes designed to tackle the weaknesses of publicly-provided health care. According to Mills(1994) approaches to reform have focused on, *Inter alia*, structural changes, financing changes, improvements in the policy process, and management system improvements. A number of structural changes have been proposed to improve efficiency, the most common being decentralization of planning and management, usually to the 'district' level (Mills et al 1990). However, despite fairly substantial experience of the implementation of decentralization policies, it is still not clear precisely what actions and conditions are necessary for decentralization to be a success (Mills 1994).

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Decentralization of health services has either been focused to the provincial or district level. In Papua New Guinea health services were decentralized to provincial governments. In Tanzania and Botswana, just to name a few, decentralization of health services in

1972 and 1973 respectively was directed toward the district level (Gilson et al, 1994; Maganu, 199).

In the majority of cases the decision to decentralize has been a political one without any specific objectives by the Ministries of Health.

A review of ten countries that had implemented decentralization by Vaughan outlined some of the implicit and explicit policy objectives by governments (Vaughan,1991). According to Vaughan the following is a list of some of the benefits is from health sector decentralization;

- \* organization of a more rational and unified health service;
- \* greater involvement of local communities;
- \* cost containment and reduction in duplication of services;
- \* reduction of inequalities;
- \* integration of activities of different agencies;
- \* strengthened health policy and planning functions of ministries of health;
- \* improved implementation of health programmes.
- \* greater community financing and control; and.
- \* Improved inter-sectorial coordination.

All the countries that have implemented decentralization have recorded various levels of successes and failures as measured according to the foregoing parameters.

Collins and Green (1994), however, examined some of the negative implications of decentralization policies in which they described the dilemma of relating decentralization as the enhancement of the different, to equity, which is the promotion of equivalence. Care should be taken of the populist and romantic view of decentralization that sees it as an absolute good in its own right-(Smith, 1985).

According to a concept paper by Dr. R. Chatora (1995) the introduction of Civil Service reform in 1991 under the Economic Reform Programme marked the inception of the process of conceptualization on the mode and design of the decentralization policy in Zimbabwe. The Minister of the Public Service, Labour and Social Welfare made a statement in Parliament on the 8th December 1994 that...

government will transfer functions within Central Government hierarchy by shifting some responsibilities of Government Ministries to field offices and local authorities. Specifically for the Ministry of Health and Child Welfare (MOH&CW) functions to be transferred are Administration of Primary Health Care from the MOH&CW to Rural District Councils(RDD). (Chatora, 1995).

As expected the decision to decentralize was largely a political one with no explicit health objectives. However, the essential benefits of the proposed decentralization policy seem to focus on two main areas. namely.

- \* managing health services closer to the point at which they are delivered in order to make services;
- \* more responsive to consumer needs and preferences;
- \* and delegation of decision making to appropriate levels of management such that in the case of operational matters those

responsible for actually providing services become the decision makers.

Current problems relating to public sector inefficiency, poor perceived quality of care, poor health output and outcomes, inequalities etc. are generally linked to the centralized nature of management and administration. The nature of public bureaucracies and the lack of incentives they have provide to inefficient resource use.

Mills (1994) attributes public sector inefficiency to four broad areas; (i) low coverage by cost effective programmes e.g. immunizations, ante-natal and post natal care etc.) of those in greatest need --rural poor, (ii) services provision is biased towards hospitals (hospitals consume more than 45 per cent of MOH&CW budget in Zimbabwe), (iii) the mix of interventions financed and provided by the public sector is highly inefficient and (iv) publicly provided services are highly inefficient (technical and operational) for their use of inputs.

The ultimate aim of any decentralization policy is to improve the health status of the people. Implied in the Ministry's proposal is the fact that decentralization would help achieve this.