

NECF TASK FORCE REPORT ON HEALTH

1.0 INTRODUCTION

The Health Task Force co-chaired by the Permanent Secretary for Health and the Vice President Health Professions Authority meets regularly is to carry out an assessment of the state of the country's health care sector through presentations by the key stakeholders namely: Ministry of Health and Child Welfare, Medical Professional Associations, Medical Councils, UZ School of Medicine, Private Hospital Associations, Private Medical Laboratories Association, pharmaceutical manufacturing companies, Medical Aid Societies, AFROZ, consumers etc.

1.1 KEY PROBLEM AREAS IN THE CURRENT STATUS OF THE HEALTH SECTOR OPERATIONAL ENVIRONMENT

The Zimbabwe Health sector delivery system is cause for grave concern. The sector is characterized by the following:

1. Overall failure by the public sector hospitals to perform their intended functions resulting in excessive strain on the private sector health delivery system leading to the collapse of the entire sector. Furthermore, failure by public hospitals to function has led to the failure by the Medical school to offer clinical practical teaching to medical students from year three on wards to the extent that after two years all medical students leave the country to regional institutions and abroad in order for them to complete the medical degree programme. At the end of the day, most do not come back but are absorbed in those country's health system. Zimbabwe is the biggest loser.

2. Failure to retain our local, well-trained health care professionals due to unattractive remuneration, poor working environment and, most importantly, the current retention packages. Furthermore, the tools of trade are dilapidated and non functional.
3. Inability to recapitalize/re-equip the entire health sector by the state coupled with unstructured procurement systems for supplies right across the board.
4. Inability to provide reliable and consistent basic supplies of medicines worsened by poor services in such vital utilities such as water, communications and electricity.
5. Inability to Maintain, Upgrade, Develop, and Implement a sustainable health professional training policy to ensure production of quality skills at all levels including the special services care such as maternity, ICU, Theatre, Environmental Health etc. .
6. Inadequate coverage of benefits by health care insurance providers amid calls for an urgent review of statutory instruments that governs the functions of Medical Aid Societies to ensure that they stick to their core business.
7. Failure to carry out regular preventive vaccinations (even for the infants group) for known diseases including dealing with seasonal malaria and water borne diseases.

These highlights are some of the major challenges being faced by the Health Sector in its entirety. The Task Force therefore urges for immediate steps to be taken to address this untenable situation given that health delivery is a human right and adversely impacts on all other economic sectors.

1.2 PRESENT SITUATION IN THE HEALTH SECTOR

The health of the nation is vital to the economy and this report is prepared against the background of a totally collapsed health care delivery service. It is not surprising that as one goes through this report they have taken or are on medication of some sort. It is for this simple reason that the nation must be fully conscious of the status of national health delivery system. The mostly affected are the referral hospitals which are unable to perform such functions as referral centers. It is saddening to see many pregnant mothers loose their babies or their lives due to lack of basic facilities. Delivering mothers are now expected to bring their own gloves during delivery at clinics across the country or else medical personnel will not attend to them if available at all. If one is involved in a serious accident and break bones there are no facilities to deal with such cases currently. If available, the cost is so exorbitant that many are dying quietly at home. There are no pins anyway to restore the bone structure. One is expected to buy and bring them into hospital. In short, all that the public sector is now providing is the basic infrastructure and very little personnel.

1.3 INFRASTRUCTURE

Most hospital infrastructure is dilapidated and there is urgent need to repair existing hospitals. Most of the dilapidation is due to failure to maintain existing structures commonly found in most hospitals. Amongst them are the following:

Nonfunctional and obsolete systems such as air conditioning systems,
Mortuary refrigeration systems;
Boilers;
Medical equipment including laboratories;
Building structures;
Hospital furniture and fittings etc.

1.4 MANPOWER DEVELOPMENT

- (i) Despite the existence of the Health Services Board, new structures within Ministry of Health and Child Welfare have not been fully implemented due to budgetary constraints. The local universities personnel within the College of Health Sciences are not beneficiaries of any remuneration reviews as they fall under the Ministry of Higher and Tertiary Education yet these are the specialist consultants who must supervise the newly qualified doctors during house-manship.

- (ii) Poor remuneration and retention packages have resulted in the loss of highly skilled personnel in the health training institutions. The outcome has been half backed products thereby compromising on quality of graduates produced at all levels. This naturally means poor quality of service. This has been worsened by failure to provide teaching to medical students from year three of their degree programme because the public hospitals where they supposed to carry out clinical programmes are closed.

- (iii) These same poorly trained graduates have limited mentorship when they start practicing in both private and public health institutions. This has contributed to loss of life unnecessarily which could have been avoided. Coupled with this are poor quality of materials or equipment to be used by the newly graduated health staff, in itself a highly dangerous practice given that we are dealing with human life.

1.5 MEDICAL CONSUMABLES

- (i) It is noted with serious concern the acute shortages of basic consumables in hospitals. The items include amongst others:
 - Essential medicines;
 - Diagnostic reagents;
 - Surgical and renal consumables;

Disinfectants and detergents; and
Linen etc.

- (ii) Local pharmaceutical manufacturers for medicines are operating below capacity due to lack of raw materials most of which are imported. Similarly, the Government procurement Agent for medicines and other medical supplies, NATPHARM, which also depends on the local manufacturing capacity, is failing to provide the adequate supplies to public health institutions. Even the private medical suppliers are faced with similar crisis. Currently there are no medicines even for the prevention treatment of basic diseases in the country such as amoxicillin etc.

1.6 NUTRITIONAL AND DIETARY REQUIREMENTS

Recognizing that there is general food shortage nationwide, it has been observed that hospitals have not been spared. Of particular concern is the inadequate and unbalanced food for patients in hospitals. We preach nutrition but we are now failing to provide basic nutrition in our hospitals. The shortages of food are so serious that some hospitals have gone for weeks without food, forcing relatives to bring food from home. This, in itself poses a huge health hazard given the cholera outbreak which we are failing to control because the boreholes and most water sources being used have also become contaminated. It is no longer safe to assume borehole water is safe particularly in the high density areas where these have been sunk. In the current situation of cholera outbreaks due to poor water and sewage drainage systems and, with the heavy rainy season upon us, the situation is still very bleak. In fact, many deaths are occurring outside the health system from cholera such that the figures that we know are much lower than what is actually happening in the rural areas.

1.7 **MANAGEMENT OF BASIC UTILITIES IN MEDICAL FACILITIES**

- (i) While it is agreed that there is a national energy crisis, there is need for proper power distribution management. As such, all health institutions should never be part of the load shedding schedule. In extreme cases where the hospitals are affected, there should always be adequate supplies of fuel for stand-by generators.

- (ii) The water situation is so serious now and has negatively affected the health delivery system. The current outbreak of cholera is clear testimony of the failure of policy interventions in providing clean water and sanitation as enshrined in our national Constitution. Most boreholes in the high density suburbs and wells are all contaminated. Tests are still to be conducted for those in the low density areas to ascertain the quality of the water. Worse still, the quality of water in taps leaves a lot to be desired, in the background of the known fact that the levels of chlorine in the drinking water to households are well below the WHO standards.

- (iii) Sad reports of patients being required to bring buckets of water (from unhygienic wells) to hospitals particularly for maternity patients and other sick patients are the norm rather than a shock. This whole issue clearly illustrates the inadequacy and short-comings in the management of water supplies. Cholera is the only disease outbreak right now and we are failing to deal with it decisively. What then will happen when other water borne diseases break-out?

1.8 **FUEL AND TRANSPORT SUPPLIES**

Most of the public health institutions either have grounded ambulances or staff buses due to breakdowns, lack of spares and fuel. There are reports of patients requiring ambulance services being asked to use own transport including scotch-

carts and wheel barrows. It is particularly worrying in emergencies like accidents and maternity cases. However, in cases where these services have been adequately provided, the very same health professionals have abused them.

1.9 **HEALTH CARE FUNDERS (AFROZ)**

Provision of health services by the private sector has deteriorated despite the existence of health insurance to the extent that members of health insurance schemes are doubting its worthiness or to continue with contributions. Members are incurring huge shortfalls from services provided. It is suspected that Health Care Funders are failing to provide comprehensive benefits because they are now concentrating on non-core activities such as building hospitals, establishing clinics, laboratories, pharmacies, and investing in financial institutions. On the whole, the Health Care Funders are now competitors in the same field that they are supposed to provide a service. Thus, profitability has become the prime motive, negating their responsibility to the membership.

1.10 **HEALTH SERVICES COMMUNICATION NETWORK (LAND AND MOBILE)**

The Task Force observed, with concern, that communication within and among health institutions and practitioners is severely handicapped more by poor infrastructure. Both fixed telephone and mobile systems are completely unreliable and lives are being lost unnecessarily as a result of this situation. Of particular concern also, is failure by regulators to open up the fixed network, particularly for those with broadband and high speed data transmission capacities e.g. POWERTEL. The Beepers and Radios have since disappeared from hospitals.

1.11 **FINANCING MECHANISMS**

The costs of running a healthcare are a collaborative process which requires constant funding. This involves government, private sector, non-government

organizations, medical insurance funders etc. The lack of adequate budgetary allocation from Central Government has resulted in the sudden decay of the health sector from rural health centers to Central and referral Hospitals. Humanitarian assistance coming through is for specific needs and is targeted only to addressing urgent needs. Currently what is required is developmental assistance than humanitarian aid e.g. instead of providing water bousers, it is better to carry out major refurbishment and reconstruction of the water and sewage reticulation systems.

2. RECOMMENDATIONS

The health status of an individual is central to the performance of the economy. The Task Force therefore recommends the following for the urgent redress and resuscitation of the health sector:

2.1 Financing

Medical consumables:

(i) Government should mobilize adequate resources (local and foreign currency) to assist local manufacturers, wholesalers and distributors to rebuild capacity. For the public sector, resources should be made available through the National Pharmaceutical Company (NATPHARM). The annual requirements for the three key stakeholders in the supply chain (manufacturers, wholesalers and NATPHARM) must be made available every three months before the end of the year without fail.

(ii) The allocation for resources must now be done through an Independent Health Supplies Committee established by Government for this purpose, comprised of representatives from Ministries of Health, Finance, Economic Development, Trade and Commerce, manufacturers, wholesalers, distributors, NATPHARM, and an NECF Task Force member. Furthermore, a monitoring mechanism must be put in place to ensure the

supplies get to where they are supposed to be and used for the intended purpose. Currently, most of the supplies from NATPHARM are ending up where they are not supposed to be.

- (ii) While the RBZ initiative provided some relief, this is not a sustainable response mechanism as a long-term solution and is not encouraged especially when the health sector is not fully consulted. The procurement process becomes a convenient way of misusing the little supplies available in the country.

2.2. Manpower Development

- (i) The Health Services Board initiatives in improving structures in the public health services must be supported by Central Government through the provision of adequate and reliable resources.
- (ii) The local universities need direct funding from both the public and private sector to attract quality resource personnel. The private sector must be encouraged to play an active role in human resource development for the health sector, particularly by providing sponsorship for specialist programmes. There is urgent need to address the issue of remuneration of these skilled personnel. Salary structures must be based on expertise and experience across professional grades. The provision of transport and housing is essential for all professional and supporting staff including support manpower from College of Health Sciences.

Put in place an incentive package for health personnel that is slightly above the regional parity in order to attract those that had migrated into the region and elsewhere. Furthermore, deliberate steps must be taken to ensure that other incentives such as accommodation with sparse furniture is put in place.

2.3. Infrastructure Development and Maintenance

All Public Hospital Institutions are in need of urgent repair and restoration. Zimbabwe had the best health infrastructure in Southern Africa but over the last few years, we have neglected the maintenance all our institutions particularly the health related ones. Health Care Funders and pension funds must be engaged in resuscitating existing infrastructure e.g. Parirenyatwa Hospital, which has one of the best infrastructures in sub-Saharan Africa. Such a smart partnership can bring viability to the institution and reduce the overall costs of medical care. This approach can be replicated with other health centers throughout the country e.g. Chitungwiza Hospital has successfully partnered with private sector.

2.4. Hospital Transport and Communication

- (i) There is urgent need for the acquisition of a reliable and functional fleet of ambulances and other emergency service vehicles. Each rural service health center should be provided with a minimum of two ambulance vehicles. Key health staff should also be provided with adequate transport facilities. These fleets must be complete with adequate and reliable fuel supplies.
- (ii) Service providers (TELONE, NETONE, ECONET, TELECEL and POWERTEL) must be encouraged to support health care delivery system with reliable and affordable telecommunication mechanisms.
- (ii) All health centers must, as a matter of urgency and necessity, revive the internal communication systems (e.g. beepers and radio links).

2.5. Medical Equipment Procurement

- (i) The Task Force commends the RBZ initiative to assist with urgent supplies of essential drugs and equipment to all health facilities. However, this intervention lacked coordination amongst the key stakeholders hence there was duplication on certain products which were well supported by other multilateral funding mechanisms. This process resulted in the emptying of all medical wholesalers, and other suppliers thereby replicating what pertains in the retail sector. In the absence of an adequate recapitalization facility, these suppliers cannot restock, posing a serious threat to national capacities and capabilities to respond to emergencies. Currently, the country is not in a position to respond to a major national health emergence. This is one of the outcomes of un-coordinated approach to procurement.**
- (ii) It is recommended that a National Health Suppliers Committee be urgently established to supervise and administer the medical supplies procurement process.**
- (iii) The Task Force notes that in order to revive the health sector some US\$600 million in total is urgently needed to meet the acquisition of medical equipment, drugs, infrastructure repair, other materials and resources (see report by the Ministry of Health and Child Welfare in a document presented to NECF health Task Force on 10th February 2009.) However, in view of the crisis at hand, such resources should be sought and released as a matter of urgency. Delays will mean it keeps on becoming more and more costly to rebuild the health delivery system as the situation gets worse.**
- (iv) The Task Force notes the need to separate the Office of Chairman and Chief Executive Officer at Central Hospitals Boards in line with normal standards of corporate governance practices. This will go a**

long way in enhancing delivery service and quick response to issues as raised by the stakeholders.

2.6 Co-ordination of Research and Development in the country

(iii) The Task Force noted with concern the way in which the little resources available for research are not being properly utilized due to the absence of a prioritized research agenda for the country. Everyone is aware that animal health science is at the fore front of preventing diseases but right now, there is no linkage between what is happening in the health sector and animal sector. Other sectors are equally affected in similar fashion. There is urgent need to ensure that all local research is properly coordinated through the Research Council of Zimbabwe across all sectors without fail. This will also make it easy to come up with more innovative and scientific ways of coming up with products that not only give value to the whole research process but to the whole economy including our local currency.

(iv) The national budget allocation for research including the re-equipping and recruitment of skilled personnel is now critical. There should be a dedicated 1% of GDP allocated to R&D from Central Government whilst the Private Sector should also give a fixed percentage of its profit to R&D. Any external funding of research will be a bonus provided it is clearly understood what it is meant to achieve, (not a mere academic exercise) but to give value to a product or to develop prototypes to make life easier for mankind.

All humanitarian aid from NGOs must now be turned to developmental aid so that so emphasis is on reconstruction and development rather treating a symptom. Direct developmental aid and assistance should be channeled towards infrastructural

rehabilitation and eventually construction of new reticulation systems for water and sewage in all the towns in a concrete steps towards rebuilding the frontline against deases that are water borne.

- (v) **MEMBERS OF THE TASK FORCE STAND READY TO PLAY THEIR ROLE DILIGENTLY IN RESTORING THE QUALITY OF OUR HEALTH DELIVERY SYSTEM.**

NECF Secretariat
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