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# The Impact of Economic Performance on Health in Zimbabwe

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## Policy Brief

By

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## **1 Introduction**

The nexus between economic growth and health outcomes has been extensively studied. However the relationship between the two is not clear. Historically, decline in both infant and child mortality rates, and the fall in both male and female adult mortality rates especially since the turn of the 20<sup>th</sup> century has been attributed to a multiplicity of factors associated with economic and social advancement. These factors include rising availability of material goods, urbanization, improved infrastructure and housing, rising levels of education, improvement in personal and social hygiene, medical advances, the disappearance of slavery, and other host of significant reductions in discrimination for gender, religious, ethnic groups, etc

Whilst most studies and logical reasoning posits a positive relationship between economic growth and improved health, it is important to note that sometimes improved economic growth can result in decline in health. Granados and Ionides (2007) indicate that the negative association found between economic growth and health progress in the most recent half century. These modern studies reveal a short-term tendency of death rates to increase during economic expansions in industrialized countries in recent decades (Graham et al., 1992; Abdala et al., 2000; Ruhm 2000 and 2003). Despite existence of inverse relationship between increase in gross domestic product (GDP) and decline in health in some instances, this study is however going to dwell on the positive correlation between these two variables.

This research investigates the relationship between economic performance and health service delivery in Zimbabwe with the investigated causality running from the former to the latter. Thus, the main objective of the study is to investigate the impacts or effects of economic performance on health service delivery in Zimbabwe for the period 1980 to 2009.

### **1.1 Overview of Zimbabwe**

Zimbabwe's economic performance has been relatively sound especially since its independence in 1980. Statistical figures from the Central Statistical Office (CSO) indicates that annual gross domestic product (GDP) growth rates averaged 4.85 percent in the first decade after independence (1980 to 1989), with the annual average rate declining to 2.14 percent for the period between 1990 to 1999. The economic growth trend started declining and was consistently negative for the period 2000 to 2008 with annual average rates of negative 6.44 percent. Whilst the well-being of the majority citizens in general has been positively correlated with economic performance; the health sector in particular, among other sectors, has also been heavily impacted by the country's economic performance.

With regards to the health sector, although Zimbabwe's health system used to be relatively sound in the 1980s and 1990s, however since 2000, most of the country's health delivery institutions have been scaling down their operations, with some facilities closing down all together. Key challenges to the country's health system (since 2000) included lack of equipment, shortage of essential medical consumables, shortage of drugs as well acute shortage and loss of skilled medical personnel (Makochekanwa, 2010). Again, since 2000, medical aid insurance schemes have been rendered ineffective as members' contributions have been eroded by hyper-inflation which was rampant in the country during the period up to 2008. This has reduced the accessibility of health care in general for the majority citizens (Government of Zimbabwe 2009 Budget statement).

## **2Key findings**

The main findings from this study relates to relationship between economic performance and health services, health funding, health staffing, shortage of medical drugs, the case of HIV/AIDS prevalence. The following are the main findings:

### *2.1 Decline in health expenditure*

There was a general decline in health financing during especially between 2000 and 2008, as real government or per capita allocations towards health expenditure has declined from 5.3% of national budget (in 1980) to around 4.2% in 1998. Trends in government per capita health expenditure allocations declined from \$55.7 in 1980 to \$0.19 in 2007.

### *2.2 Decline in health preventative provision*

The decline in economic growth also has led to the reduction in health preventive provision by the government and a case in point is fall in immunisation which in turn contributed to the increase in mortality caused by preventable diseases.

### *2.3 Depleting health personnel*

The country's staffing situation in the health sector deteriorated as health professionals migrated for greener pastures and better opportunities in the region and abroad. This resulted in the remaining health personnel were being stretched, thus resulting in less than optimal health service delivery to the public, especially in the public health institutions (i.e., hospitals, clinics).

### *2.4 Dwindling health drug inventories*

The drug stock holdings in the Zimbabwe's health system severely declined. For instance, between 2004 and 2004, access to essential drugs and supplies has been greatly reduced with stock availability ranging between 29% and 58% for vital items, and 22% and 36% for all categories of items on the essential drugs list in 2008. This scenario was very much pathetic given that vital items should always be 100% available.

### *2.5 Falling HIV/AIDS prevalence rates*

Major strides have been made in reducing this epidemic HIV/AIDS. Trend analysis shows an impressive decline in the prevalence rate from a peak of above 25 per cent in the late 1990s to a lower rate of less than 15 percent by 2009. This decline has been due to a number of factors including behaviour change, increased use of preventive methods and migration.

### *2.7 Relationship between CMR and GDP*

The analysis found a clear inverse trend relationship between child mortality rates (CMR) and GDP. For instance, when GDP was on a gradually increase from 1980 to 1990, child mortality rate was on a gradual decrease trend. Conversely, when GDP started declining from 1997 until 2008, CMR started increasing for most of the years during the same period.

## *2.8 Relationship between IMR and GDP*

The study found a positive relationship between GDP and infant mortality rate (IMR) during the period 1997 until 2009. When GDP started declining from its peak figure of US\$9 billion in 1997, IMR started an upward trend, rising from a low value of 54 deaths per 1000 infants in 1998 to a relatively high value of 63.5 infant deaths per 1000 by end of 2009. Thus, this trend relationship shows that as economic performance was declining, it follows that the capacity of both the government and households to financially meet the health and nutritional needs of infants were compromised, resulting in increased infant deaths.

## *2.9 Relationship between AMR and GDP*

On relationship between adult mortality rate (AMR) and GDP, the study found that the decline in economic performance resulted in increased adult mortality rates. After initial improvements during the 1980s, from the early 1990s, adult mortality rates for both male and female rose as the combined impact increased in HIV/AIDS prevalence, shortages of medical drugs and health personnel as well as budget cuts in health expenditure began to affect the country's health delivery system.

## **3 Policy implications**

The following are the policy implications of the findings:

- a) Although the current health policies are, on paper sound, the government (and other stakeholders) need to intensify their implementation.
- b) The complexity of health delivery system in Zimbabwe, coupled with limited government resources to adequately intervene calls for collaborative work between government and all stakeholders working in this sector

## **4 Policy recommendations**

- a) The government should put in place strategies to lure back all health professionals who left the country to come and work in the health facilities in the country. One possible way of implementing this is through, for instance, government providing accommodation for such personnel, allow them to import at most one car duty free and subsidize school fees for their children.
- b) Government should also ask the help of well-wishes, friends and donors in addressing some of the challenges in the health sector including shortage of health personnel, drugs and problem of old or dysfunction medical equipment. In this instance, through liaising and soliciting for help from such organizations and/or donors as UNICEF, WHO etc, some of these stakeholders may offer to assist. For instance, some organizations may assist in helping medical doctors with tuition fees for their children or donating cars for use by medical personnel.