

# **An Overview of Health Manpower Issues in Relation to Equity in Health Services in Zimbabwe \***

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## **ABSTRACT**

This paper presents an overview of the positions raised by contributors to the workshop on health manpower issues in relation to equity in and access to health services in Zimbabwe (see Willmore and Hall, 1989). It evaluates the extent to which policy initiatives in 1980, towards equity in health care, have been achieved, and the constraints to realising these policy goals. With 'equity' defined as the provision of care in response to need, democratic control over health services is necessary to allow all potential consumers of health care a role in directing services according to their perceived needs. Hence the paper also addresses the question of how far consumers of health care control or participate in the services they use.

## **The socioeconomic context of health**

The current health services in Zimbabwe reflect their socioeconomic context and the historical legacy of British colonialism. The country continues to be characterised by great inequalities in wealth, with a private doctor earning in one month what a domestic worker earns in four years. Despite rich national resources, a large part of Zimbabwe's wealth is still under foreign control. As discussed by Sanders in his opening paper to the conference (see Sanders paper in this issue), while many sectors have shown overall economic growth, inequalities in wealth have widened: the low income consumer price index (CPI) has shown greater relative increases than the higher income CPI, unemployment has risen, real wages have not increased since 1982 and urban homelessness stands at extremely high levels. While there has been increased investment in peasant production since 1980, lack of significant land reform and continued overcrowding and poverty has meant that the benefits of these investments have been unequally distributed, resulting in widening socioeconomic stratification in communal areas (Sanders, 1989).

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By independence in 1980, this economic profile was associated with a pattern of morbidity and mortality that showed great differences with respect to race, geographical area and class. While race has been a less critical factor in determining health status than income after 1980, geographical (urban/rural) and class differences have persisted, with consequent effects on the distribution of ill health. Hence, while the largely urban, upper income groups have low infant mortality rates, an increased life expectancy, and suffer the degenerative diseases of industrialised countries, the rural majority and urban working class experience nutritional and communicable diseases and mortality patterns arising from inadequate diets and poor living and working environments.

These economic inequalities were also reflected in differential access to health care, as described in detail in the paper by Sanders. Prior to 1980, geographical area, race and class were determinants of access, with health care fragmented in to five major providers of western health care. The division between curative and preventive care, with a lack of emphasis on the latter, reflected the attitude that individuals were responsible for their ill health. Individualising health interventions distracted attention from social causes and potential collective action. Equity was an issue avoided by 'blaming the victim' for their ill health and providing only rudimentary curative care to the majority of the population. In this oppressive form of health service, communities were given no real role in discussing their problems and in defining or controlling health interventions.

### **Equity in health policy**

As expressed in the government policy paper **Planning for Equity in Health** (Ministry of Health, 1984), the independence policy of equity in health was a significant departure from colonial forms of health care. This policy defined qualitative changes in health care, including:

- redirecting the majority of resources to those most in need
- removing the rural/urban, racial and class biases in health and health care
- overcoming the fragmentation of service providers to develop an integrated, national health service
- ensuring accessible care to the majority, with other levels supporting this infrastructure
- integrating preventive, promotive, curative and rehabilitative care
- increasing the participation of and control by communities in their health services.

### **Equity in health practice**

This policy, derived from the popular and democratic aspirations of those who fought in the liberation struggle, faced a number of challenges post independence.

The continued inequalities in ownership of wealth, and in income, described above have continued to generate huge differences in the type and extent of morbidity in the different social classes in Zimbabwe. Hence, as shown by Loewenson and Sanders (1988), while expanded and qualitatively different health services have significantly reduced mortality and certain types of morbidity, the economy continues to challenge health care providers with a

burden of nutritional and communicable disease. In attempting to respond to the massive demand for expansion of services, the health sector has depended on a mix of public sector allocations, community contributions and donor agency support.

Nine years later, we pose the question: How far have we moved toward equity in health and what problems do we face?

*The racial distribution:* Race is no longer a deciding factor in most aspects of health status or access to care. It continues to play a role in that most whites are in the high income groups and most blacks are poor. Class has become a more important determinant of health outcomes, interacting with urban/rural status.

*Geographical patterns of health:* The rural/urban dichotomy in health care distribution continues to exist. While an active programme of construction and upgrading of rural facilities has taken place, manpower distribution continues to be biased towards urban areas. According to Dr Richard Laing, of the Manpower Development Section of the Ministry of Health, there are less than 10 Zimbabwean GMO's in rural areas, forcing the ministry to rely heavily on expatriate doctors to fill these posts. In the public sector, only 50% of the GMO posts in the provinces are filled, with 97 doctors altogether compared to the 109 serving Harare alone (Laing 1989). Conditions of service are poor in rural areas, a problem highlighted by the Hospital Doctors Association as a factor in the reluctance of Zimbabwean doctors to do rural service. The Zimbabwe Association of Church Related Hospitals (ZACH) reports some of the worst conditions: mission hospitals are often remote, with poor roads and inadequate transport facilities. Their staff are often more poorly paid than those in other health sectors and lack a promotion and pension structure integrated with other sections of the public service.

The rural/urban dichotomy is increased by the continued existence of multiple providers of care. The differing conditions in the mission services cited above is one example of this fragmentation. Private company health services in agroindustries and mines often do not follow Ministry of Health primary health care policies and only provide curative care to those in employment. Private health services, discussed in more detailed later, are biased towards urban practice. Local authority care in large scale farming rural council areas is poorer than in peasant district council areas. There has been little rural council financial allocation to developing social services, and contribution from workers is undermined by their non-resident status and insecure tenure (Loewenson, 1988).

This geographical bias has been justified in the past by pointing to the referral of patients from rural primary care to the sophisticated central urban hospitals in Harare and Bulawayo. This function as quaternary referral centres has justified the latter facilities absorbing a large proportion of the health budget, of manpower and of laboratory and other services. The Hospital Doctors Association has also used this referral system to justify their view that almost all doctors should be placed at central urban facilities (HDA, 1989). In reality, as the study by Sanders et al (quoted in the paper by Sanders, 1989) shows, the referral system does not operate for almost all medical conditions, and about half of those coming to central facilities come from within 10km, often using the quaternary referral centre as a frontline service. Hence a hospital like Parirenyatwa sees the primary care complaints of the higher income residents of Harare at about six times the cost allocated to a rural resident visiting a district hospital.

The study by Sanders et al calls for a close review of utilisation and referral practices in the health services, including the need for the provision of urban primary, secondary and tertiary level care. In fact, other participants to the workshop, including the Medical Students Association, the Ministry of Health, and Medical School representatives emphasised the need for compulsory rural service, but also called for improved conditions of service and improved facilities in these areas. The Medical Students Association highlighted the importance of the current inclusion of rural attachments into the new medical curriculum as a means of better preparing doctors to perform their role in district facilities (MSA,1989).

### **Class as a factor in equity in health**

Inequity in health care by class is summarised in the 'inverse care law': the wealthy who need care least absorb the greatest expenditure on health, while the needy poor get the poorest care. This is already highlighted in the utilisation study quoted above. It is also evident in the allocation of manpower within the health sector. The concentration of 'high cost' doctors in urban areas, together with State Registered 'nurses (SRNs) contrasts with the curative care for low income groups, primarily provided by the relatively poorly paid State Certified Nurses (SCN's). The President of the SCN Association of Zimbabwe pointed out that SCN's, although less trained than SRNs, carry out the bulk of curative work in rural areas. In addition to earning a ceiling salary equivalent to that of newly qualified SRN's, SCN's have a third the leave allowance of SRN's and have poorer working conditions generally. Manpower factors such as these add to the distribution of other health resources to produce a pattern of care where it costs Z\$92 per patient in Parirenyatwa Hospital, about three to four times that in a district hospital, despite the likelihood that many conditions in both services will be of a similar severity (Sanders,1989; district hospital cost estimated from World Bank,1983).

Added to these social differentials in health care within the public sector is the effect of private sector care. This has been criticised by almost every Minister of Health in Zimbabwe. The private sector was specifically targeted by health policy in 1980 as distorting the allocation of health resources. A past Minister of Health, Dr Herbert Ushewokunze, estimated in 1984 that the state subsidised private sector health care directly and indirectly by Z\$17 million (Loewenson and Sanders,1988). The private sector absorbs about 1 000 of Zimbabwe's 1 417 doctors, and a significant proportion of the total drug bill, to serve a small section of the population, primarily in the higher income groups. The private sector is largely supported by the system of medical aid payments. Its expansion is thus indicated by the increase in medical aid membership by 60% since 1980, much of this in urban workers. The private sector distorts equity in health by absorbing scarce manpower. The fee for service makes income a factor in access to health care, and has also been charged with encouraging excessive tests and interventions, and possible abuse of free claims. The private sector generally ignores preventive and promotive aspects of health care. The attraction to private care for practitioners and patients has been reported to lie in its personal, individualised care, incorporating features of continuity, decentralisation, efficiency and reduced waiting times.

However, while the recommendation that the public sector absorb some of these features has been made, the issue remains how to control the huge flow of health resources to the small private sector market, in a society where both the providers and consumers of private care are an influential and vocal group.

These problems indicate that features of the health service highlighted in 1980 as undermining equity in health care continue to exist. Despite great efforts by the public sector to meet the challenge of providing for health needs, socioeconomic factors continue to bias the delivery of care. While not a comprehensive assessment of the material limitations to equity in health care, the features described above indicate that we still have many challenges to face in distributing health care in response to need.

### **Democratic control of health services**

There are other issues raised in **Planning for Equity in Health** which are also critical to ensuring that service is responsive to need. One area is the issue of democratic control over health services. Health policy makers in 1980 called for greater control by, and communication between, all levels of health workers within the health sector, together with community decision making in health interventions.

In practice, the democratic control of health services has been greatly enhanced by the formation of district health teams and health executives, creating a mechanism for collective planning by health workers at the same level, as well as the exchange of ideas between health cadres and other representatives in local authorities. Social control over health care is, however, still limited by a number of factors:

Communities are not homogeneous and those represented on decision making bodies are often the more powerful and higher income sections of the communities covered.

VHW's were once intended to be agents of community control and facilitators in making the health sector more accountable to communities. They have now been taken over by the Ministry of Community Development and are paid by the government, giving them a perceived role as civil servants.

There are no structures for patients to exert an influence over curative care, such as ward committees in hospitals.

The mass organisations (such as the co-operative and trade union movements) have played little role in the organisation of health care.

The district health team reflects intersectoral interests, but is not necessarily democratic.

The democratisation of health care also implies changing the ideology of health care, demystifying the causes of ill health, and giving people a vital role in solving health problems. The extent to which the health sector has moved from biomedical to socioeconomic explanations for ill health, and from curative to preventive care is variable. It appears to have depended greatly on the orientation of the District and Provincial health manpower. Despite programmes such as the VHW programme, consumers still appear to be poorly organised and relatively weak in expressing collective health care demands.

Within the health sector, health workers have a strong hierarchical organisation. There are many professional associations, some of these being split into different interest groups (such as the SRN/SCN division in the nursing profession, and the many associations representing doctors). At the workshop on Equity in Health Services, health workers at all levels complained that they had no influence over ministry policy and that the dialogue between themselves and the Ministry of Health was poor. As government workers, health cadres have no industrial relations body recognised in terms of the Labour Relations Act 1985 to negotiate for improved working conditions and wages. In addition, the many professional divisions in the sector weaken any coherent approach to manpower issues. Hence, for example, while doctors use their associations to advance their own interests, as in the case of the recent doctors strike, their demands do not consider overall changes in conditions for health manpower. This has ripple effects: the wage increases recently awarded to the doctors, for example, have created expectations amongst other health manpower - while awarding a large salary increase to 400 public sector doctors is possible, giving similar relative increases to 11 000 nurses is more difficult. The impact of uncoordinated approaches to changes in working conditions and wages in any one group of health workers destabilises industrial relations in the health sector. The powerful lobbying force of doctors appears to ensure that demands are met, while the nine year long grievances of the SCNs about salary and career structures continue to be ignored.

### **The health profession and economic change**

If health is, as is generally recognised, a product of socioeconomic conditions, what is the responsibility of health workers in transforming the economy towards one which contributes towards improvements in health?

The economic context of health implies at least an intersectoral approach to health care, with health issues absorbed into policy and action in a number of other areas, such as agricultural production, education, economic planning and so on. The experience of the past nine years in Zimbabwe shows that equity in health care cannot be isolated from general socioeconomic trends. This raises questions of the relationship between the health sector and other areas of the economy. What role does a nutrition department play in agricultural and food pricing policies? What role does a maternal and child health unit play in issues like maternity leave, social security and child labour? What relationship should health professionals have with organisations representing those whose health needs are greatest, such as peasant organisations and trade unions?

### **Conclusion**

In summary, therefore, while the health sector has made significant advances in expanding and distributing health care to those in need, it continues to face the challenge of multiple dichotomy (not all of whom share the policy view of equity in health care), a rural/urban dichotomy, and social class differentials in health status and access to care. While the process has begun, there is a need for greater democratic control over services by the community, as

well as by different levels of health care providers. The sector also needs to find more effective ways of playing a role in transforming an economy which continues to generate a highly unequal distribution of morbidity and mortality.

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