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Issues of Equity In and Access to Health Care in Zimbabwe *

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ABSTRACT

The purpose of this paper is to identify and analyse, within the health care delivery system in Zimbabwe, certain categories of people or social groups who may or may not have access to health care. An attempt will also be made to give the reasons for the maldistribution of health resources and the implications this has for the population of Zimbabwe. Brief and appropriate solutions are proposed within the socioeconomic and political context of the Zimbabwean stage of development and its historical past.

Introduction

Health care is delivered within and by a hierarchically organised and structured system. The system includes the production, distribution and consumption of health services. Within the system, there are a number of major actors such as physicians, nurses, paramedics, pharmacists and the pharmaceutical industry, insurance companies, hospitals and clinics, through which curative and preventive services are administered, delivered and consumed. This group of actors in the health care delivery system have a monopoly, and control, of the technical knowledge of producing and administering medicines. Within this group of actors, doctors dominate and control the system, from production of knowledge of medical care, distribution of medical services, and, more importantly, the consumption of health care. By virtue of their educational background, life style, and incomes, doctors form part of a class of elite in society.

The control of health care delivery systems by doctors is facilitated by the state through various pieces of legislation, and regulations which apart from protecting the patients also protect the interests of doctors. The Health Professions' Council Act, for example, lays down the qualifications and experience required of the actors in the system. The doctor's task is made easier by the social order which reinforces their status. There are laws that determine, guide and protect private medical practice, pharmacies (by way of manufacturing of drugs and their mixtures), and medical aid societies in which doctors are also represented.

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Equity and access in health

A precondition for medical care is that contact is established between people needing health services and the persons providing these services. It must be possible for this contact to be realised at the time and place of need, if an optimal level of medical care is to be provided. Essentially, then, the requisites of accessibility are quantitative adequacy, appropriate geographical distribution, and the absence of cultural, economic and educational barriers to medical care (Babson, 1972). The quantitative adequacy refers to the ratio between medical personnel and technological facilities and services - for example doctors, nurses, pharmacies and pieces of capital equipment such as hospital beds.

The second factor necessary for a high degree of accessibility is that health care services be distributed geographically in such a way as to permit their mass utilisation. Further, the services must be made available at times suitable for the population served. In other words the element of accessibility requires only that all potential users have the opportunity to utilise any services, and that the point at which any specific service is rendered should not be of such distance as to seriously endanger the health of individuals who must be transferred to receive such services.

The third element of accessibility is the absence of economic, cultural and educational barriers to health care. Of these, economic barriers are the most obvious, and also the most amenable to change. If medical care is viewed as a right, as opposed to a luxury or a non-essential commodity, financial barriers to health care should not exist (Babson, 1972).

Considering the three factors identified above, from all the studies that have been carried out in this country, and from our experience, health in Zimbabwe is not adequately and equitably distributed to and consumed by all geographical areas and social groups (Gilmurray et al,1979).

The problem is not only unequal access to health care, but also that the poor and the unemployed cannot afford good health care and are therefore worse off than any other group in society. This is despite the attempts that have been made in the last years to make health care accessible to all the people in the country. The quality of health, whenever and wherever it is offered, still differs by geographical region (urban and rural), by social class (those that are on medical aid), and to some extent by sex.

High quality medical care is that which utilises all the relevant knowledge and techniques available to the health sciences. The components of quality medical care are, therefore, the individual competence of medical care providers, the availability of the equipment and drugs, and the ancillary personnel required to perform the most effective preventive, diagnostic, therapeutic and rehabilitative procedures, and the ability to gain the confidence of the patients and their cooperation with the demands of medical treatment.

In examining the general measures of health, such as life expectancy, disease patterns, infant mortality rates, etc it is observed that the poor and the rural population are the most disadvantaged. Malnutrition, for example, is higher in the most remote part of the country, as well as in the poorer communities within the urban areas. These social groups are also vulnerable to periods of economic crisis such as drought, unemployment, inflation, poor housing conditions, etc.

Reasons for the maldistribution of health care resources

Although there are many causes for the maldistribution of health resources which result in their inaccessibility, discussion will only centre on a few of these, which are enumerated below:

1. Health care is treated as a commodity. Like any other commodity it follows the general laws for the production and distribution of commodities. It is offered at a price on the market and it is purchased like food.

   The commodity view regards property relations and private capital as the determining factor in the distribution of services. When health is viewed as a commodity with a price, it tends to be differentially distributed among members of the society which in turn is also stratified in terms of power, wealth, education, etc.

   A man who is unemployed, or on minimum wage, for example, is unable to buy drugs from the drug store, when a prescription is given by a doctor. In some cases drugs that are not available in the hospital are found in the drug store where they are purchased by anybody with a prescription. A man who cannot afford the price of drugs has to do without that medicine. If he is not on medical aid he is unable to obtain treatment. To this extent medical treatment is determined by the purchasing power of the individual. If purchasing power is the determining factor, then health or medical care is not accessible to many people, particularly not to those that are unemployed or underemployed or those in the most remote parts of the country. Medical care is, therefore, differentially distributed in favour of those with purchasing power.

   On the contrary a man who is in a high income bracket, and on medical aid, can afford to purchase the drugs and claim from the medical insurance. Further he can claim rebate from his income tax. In reality he is reimbursed the amount of money he spent on drugs and on treatment by a doctor.

   If society is socially stratified in very general form into those with income and those without, health care can be regarded as reflecting the classes in our society. To this extent health is not treated as a right. Health care is not affordable, accessible nor available in the same manner to all social groups in our society.
2. Uneven development which, as a result of colonial history and capitalist economy, differentiates society into urban and rural areas. The urban area has more and better facilities than the rural area. This differentiation in the provision of services by geographical regions is not only found in health services but also in housing, transportation, education systems and other social services. Communication patterns and facilities make health or medical care inaccessible. In many parts of Zimbabwe, there is still no transportation, nor roads leading to the nearest clinic or hospital. In some cases roads are available, but are impassable with the result that transport operators do not find it profitable to operate on such roads. In these remote parts of the country there are no private doctors nor pharmacies, because they are always placed in areas where there is a huge capital from which they can make a profit.
3. About three quarters of the population live in the rural areas where clean water supplies, sanitation, and hygienic conditions are either non-existent or in their rudimentary forms.

Major diseases that can be controlled, such as malnutrition, water borne diseases, diarrhoea, measles, typhoid, etc are prevalent in the rural areas.

Another major disease group consists of the air borne diseases. This group includes tuberculosis, pneumonia, diphtheria, bronchitis, whooping cough, meningitis, small pox and chicken pox. These diseases are spread by inhaling the airborne respiratory secretions of affected persons (World Bank,1980). These disease groups account for the majority of deaths among the poorest people, particularly those resident in the rural areas. Life expectation is very low in the rural population, where environmental conditions are still very poor.

The majority of our rural population have little, if any, access to organised health care or to facilities (Ushewokunze, 1981). The environmental conditions in which the poorest of the poor live are a testimony to the inaccessibility and unaffordability of the health and medical care delivery system.

4. The rural population, though politically active and conscious, are by far the most politically powerless social group in influencing and determining the production, distribution and consumption of health services. It has been argued that capital was concentrated where there was a rapid turnover of profits, particularly in its primary circuit, that is where it drew manufactured raw materials. Capital, in my view, was responsible for the structuring of the urban areas in such a way that the rural areas provided the required commodities, such as food and labour, to the so called modern sector (towns and cities). The capitalist mode of intervention in development was characterised by:
   a) allocation of resources where there was capital concentration
   b) the ideology and organisation of services such as health, housing and education.

   This ideology strengthened class relations in our society and consequently reinforced the capitalist system. In that respect services had an ideological base and therefore the whole question of inaccessibility to the health service by the poor or rural population is political and ideological. For any meaningful change to take place within the health care delivery system, the masses, who were disadvantaged in the past, should be involved in making decisions that affect their lives. The allocation of funds for health services was done by people who were were not directly experiencing the hardships of living in the rural areas. The distribution of health resources, for example doctors, nurses and pharmacies, is without the influence of the consumers of the services in the rural areas.

   Equally important is the production of health resources. The training of doctors and nurses does not take into account the recruitment of such personnel from the rural areas. The merit principle used in the selection of medical students and nurses, though important, does not address the specific situation of the rural population nor women, another oppressed social group. The training of these human resources and their location in urban areas still have an ideological bias against the rural people.

Solutions

Below I propose actions which could be considered, as they appear to contribute to the solutions of the problems outlined here. The solutions are by no means new, but are repeated

here to extend the debate until effective tactics and strategies are identified and implemented, to the satisfaction of those who do not have access to health care. Health care delivery systems can be improved by engaging certain political and bureaucratic processes from which strategies and tactics can be formulated.

The processes outlined below are likely to enable citizens to have control over health resources and to have access to and participate in the locally available health care system, since they will not be constrained by a hierarchically, centralised, undemocratic and technically controlled system. An essential element which can facilitate these processes is the social and economic democracy spear headed by a political philosophy, and machinery, committed to change.

It should be realised that these processes are only guidelines to help bring about meaningful change, and are based on the theoretical perspective advocated in this paper. They also form the basis on which proposed strategies and tactics outlined later are formulated.

Incrementalism

Some theorists and practitioners in health have proposed that the only way to solve the problem of access to health services is to increase the number of doctors, nurses, hospitals, pharmacies, etc. This proposal is based on the philosophy (or assumption) generally referred to as incrementalism. The proponents of this theory assume that the spread of existing services, by increasing the numbers of trained human resources, will saturate the market and consequently result in doctors and nurses placing themselves in hitherto neglected areas. In my view, incrementalism will not change the overall pattern of medicine and health care from that which existed in the colonial era. Furthermore, it does not seek to fundamentally change the structure of the system so that it can be based upon egalitarian principles and philosophy.

At face value, the incrementalist approach appears to provide small material and numerical improvements while leaving intact the political structures which contributed to the inaccessibility of the health care delivery system. The approach therefore helps to preserve the political and economic system in its present form, rejecting any structural changes that are incompatible with the preservation of the system. In effect it obscures the sources of exploitation and structural inequalities in the health care delivery system.

Democratisation

It has been argued that the distribution of health services is political and that political and economic power is the source of the inequitable distribution of resources in general and of health resources in particular. As political and economic power is differentially distributed, health care will be differentially distributed and consumed. For health care to be fairly distributed, it needs to be democratised, and subjected to control by elected representatives. The representatives should be elected from those who work in the health sector (workers), those affected by the system (patients or consumers), and those chosen by the community and organised groups (for example youth, women and other interest groups).

Within the process of democratisating the health care delivery system, there is a need to consider carefully the method of electing representatives. Such an instrument should be

sharpened if there has to be meaningful and democratic representation. Avoidance of regionalism, tribalism and sex discrimination should always be borne in mind because diseases and ill health know no tribal or sex boundaries. AIDS as a disease, for example, does not choose an ethnic or racial group. The creation of appropriate political institutions is needed to guide, implement and build an egalitarian society and a fair health system.

One of the major reasons for democratising the health institutions through citizen control is that it will be more likely to be in tune with the socialist goal of distributing resources in line with the needs of the community served. The best people to decide on their priorities would surely be the beneficiaries themselves. The democratisation of such institutions will help to replace dominance by one class and race in the main decision making bodies inside and outside the health sector.

Navarro (1977), a physician, argues that when democratisation does occur, not as a token participation but as control, the pattern of priorities does indeed change. Actually, it is because of the real possibility for change that democratisation presents that there is so much resistance and opposition to it. Democratisation is not always smooth. It is a process in which conflicts and contradictions arise and are resolved. It is a process in which a majority of poor people struggle against exploitative ideas within the health sector.

Decentralisation

One of the ways of making health care more accessible is to decentralise the bureaucracy down to the regions, rural areas and neighbourhoods, based on the assumption that a decentralised health care delivery system is more responsive to local needs. The professional staff working at a decentralised level are more likely to be perceptive of the norms and needs of the local residents.

Decentralisation is not just concerned with the equalisation of resources, but also with responsibilities and facilities controlled at a local level. Within the health field, facilities such as land, buildings, and manpower to build health centres, can be utilised. In decentralising health services increased use is made of paramedical personnel, who are produced in greater numbers. These paramedicals can be recruited locally and are not likely to have language or cultural barriers to the delivery of services to the masses. A decentralised health system makes preventive work much more effective. If the locally recruited staff are elected by their communities to be trained, they are likely to be more accountable to the masses than to the bureaucracy. In a democratically decentralised system, the consumers are more likely to participate in decision making and in controlling their own health resources.

Debureaucratisation

As already discussed, health care is delivered to hierarchically designed bureaucracies. These bureaucracies are part of a larger political economy, a macro social and historical formation in which a given mode of production tends towards dominance over others. These bureaucracies are loyal and accountable to those who control resources and not those who consume them. A bureaucratic organisation according to Heyderbrand (1977) is created by the need of the employer or owner to structure and control the process of work. The

characteristic of this structure is that decision making has to be organised from the highest level to the lowest level, according to the vertical order of the hierarchy. The controllers have a picture of the processes of delivering the service and the technologies employed, which must replicate the hierarchical division of labour.

The health care delivery system, which is hierarchically organised according to class and degree of expertise, is likely to distribute health resources differentially and selectively. For these reasons there is a need to reduce the bureaucracy to a level where services, as well as consumers, play a part in decision making and delivery of service. Debureaucratisation not only reduces over centralisation of the control of services but also increases the chances of local representatives controlling the health resources.

Strategies

Based on the processes discussed above the proposed strategies for a new health care paradigm focus on health as a fundamental right, concomitant with economic and social development. A few of the strategies which I have elaborated elsewhere in more detail (Agere, 1986) are briefly discussed here:

Preventive measures of public health

Preventive measures are based on the assumptions that:

1. they are redistributive in that they play a role in minimising the gross inequalities in the availability and consumption of health resources.
2. they are cheaper than hospital based curative services which cater only to a small minority of the total population with access to them.
3. they are based on social justice - it is just and fair that all citizens receive the benefits of development, and that benefits be fairly distributed.

Environmental sanitation

Many of the diseases that account for a major number of deaths among the people are those that are faecally transmitted. Food and water can be contaminated with human waste leading to such diseases as diarrhoea and dysentery. To reduce these water borne and faecally transmitted diseases it is necessary to attack the cause by designing strategies and simple techniques of waste and water treatment.

Nutrition

Many deaths, particularly among children, have resulted from malnutrition. It is a major contributing factor in infectious disease because it impairs the body's responses to disease and reduces immunity. To eradicate malnutrition it is necessary to provide adequate quantities of food, of the right type and quality, which can bring about a change in the nutritional status of the population. To produce enough food requires the equitable distribution of suitable land.

Unity of traditional and scientific medicines

The need to combine both the scientific and traditional medicine worlds emanates from two assumptions:

1. Some traditional medicine is effective while the majority is not.
2. Eighty per cent of the population, mostly in the rural areas, still use traditional medicines outside the health sector. The use of traditional medicine is part and parcel of their culture, and the sooner those medicines which do not work are exposed the better.

Planning for health care

The present government inherited a health care delivery system that essentially served settler interests, and that was biased in favour of curative services as opposed to preventive services. The health care delivery system was highly oriented towards specialised, hospital based medicine as opposed to community medicine, urban technologically intensive medicine in contrast to rural labour intensive medicine, and personal health services as opposed to environment health services.

The first goal of restructuring such a health system is to set priorities, and to make maximum use of the present health resources, particularly for those in greatest need. Several techniques designed for maximum utilisation of available resources, such as rational planning, cost benefit analysis and emphasis on primary health care, could be used in planning for a better health care delivery system. Planning for health care not only involves primary care and medical education but also appropriate technology without which the proposed health care paradigm cannot function.

The strategies discussed above are simple, participatory and inexpensive. They enable the health care delivery system to be more available to the people, especially to the underprivileged, the majority of whom are in the rural areas. These strategies, if implemented with commitment and seriousness of purpose, are likely to make health care more equitable, and more accessible, acceptable and available to the majority of the people. These strategies avoid the competition, conflict and confusion brought about by the inherited colonial system and by hierarchically organised structures.

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