

**A SYSTEM IN CRISIS: ETHICAL CONCERNS ABOUT  
ZIMBABWEAN HEALTHCARE IN THE 21ST  
CENTURY.**

By

Farayi Moyana

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**Supervisor:** Professor Keymanthri Moodley

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## **DECLARATION**

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**FARAYI MOYANA**

**Signed:** Farayi Moyana

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## **DEDICATION**

I dedicate this work to my late father, Lazarus and mother, Elsie Dhaniye Gapara (who passed on in April 1993)-sadly before my first university degree. This would be my fifth degree, my third Master's degree-thanks to both their constant encouragement during my childhood. My mother, Elsie was icon who barely went beyond standard 3 but had all the hallmarks and characteristics of a very intelligent woman, a genius par excellence. Rest in peace. You would be proud to see this.

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## SUMMARY

Health care services in post-independent Zimbabwe have undergone turbulence with periods of seemingly significant improvements and other periods of definite decline. This thesis looks at health-care systems in general and in particular, the way in which they are reflected through the health-care system of Zimbabwean. Ethical issues and challenges in health care can take many forms ranging from debates and discussions on the fairness or the lack thereof in the health-care reform process, the ethics of inter-professional relationships, the ethical problems with doctor-patient relationships, the state of advocacy in health matters, and patient rights, ethical perspectives influencing discourses on health systems, the ethics of health-care funding, and debates on access to health care. This thesis reflects on the complexities of the challenges, needs and reform requirements of the Zimbabwean situation.

A critical analysis of the ethical principles, their impact on the Zimbabwe health care system, using largely the principlist approach as enunciated by Beauchamp and Childress (2013), is conducted. Other moral theories such as the social contract theory is also discussed in some detail because of its important application to issues related to health care. A whole chapter is dedicated to the principle of distributive justice and its relevance and implications for the health care systems in general, but also with particular relevance to the situation in Zimbabwe. Lack of or inadequate insurance is the biggest economic hurdle in accessing health care in many low income countries. There are two main arguments, which appear to support some sort of moral right to a health care funded by the government – “the collective social protection” and the “fair opportunity arguments” (Beauchamp & Childress, 2013). Both of these arguments are discussed in detail. Right to health and right health care are two concepts which confuse a lot of readers because they are close but refer to different dimensions of the concept of health. They are discussed with a particular emphasis on the ethical issues involving allocation of health resources, rationing and setting of priorities. This thesis winds up by looking at the possible solutions to the health crisis in Zimbabwe. The much-flaunted National Health Insurance, amongst other possible remedies, is analyzed. A list of recommendations is outlined, in the last chapter.

## OPSOMMING

Gesondheidsorgdienste in post-onafhanklike Zimbabwe het turbulensie ondergaan met periodes van oënskynlik beduidende verbeteringe en ander tydperke van definitiewe afname. Hierdie tesis ontleed gesondheidsorgstelsels in die algemee, met spesiale verwysing na die gesondheidsorgstelsel van Zimbabwiese. Etiese kwessies en uitdagings in gesondheidsorg kan baie vorme van debatte aanneem, byvoorbeeld besprekings oor die regverdigheid of die gebrek daaraan in die hervormingsproses vir gesondheidsorg, die etiek van interprofessionele verhoudings, die etiese probleme met dokter-pasiëntverhoudinge, die staat van voorspraak in gesondheidsake, pasiënt-regte, etiese perspektiewe wat diskoerse op gesondheidstelsels beïnvloed, die etiek van gesondheidsorgbefondsing en debatte oor toegang tot gesondheidsorg. Hierdie tesis bespreek die kompleksiteit van die uitdagings, behoeftes en hervormingsvereistes van die Zimbabwiese situasie. 'n Kritiese analise van die etiese beginsels en die impak daarvan op die Zimbabwiese gesondheidsorgstelsel, word hoofsaaklik gebruik deur die beginsel-benadering van Beauchamp en Childress (2013). Ander morele teorieë soos die sosiale kontraktheorie word ook bespreek as gevolg van die belangrike toepassing daarvan op probleme wat verband hou met gesondheidsorg. 'n Hele hoofstuk word gewy aan die beginsel van distributiewe geregtigheid en die relevansie en implikasies daarvan vir die gesondheidsorgstelsels in die algemeen, maar ook met betrekking tot die situasie in Zimbabwe. Gebrek aan of onvoldoende versekering is die grootste ekonomiese struikelblok in die verkryging van gesondheidsorg in baie lae-inkomste lande. Daar is twee hoofargumente wat blykbaar 'n morele reg op 'n gesondheidsorg wat deur die regering befonds word - "die kollektiewe sosiale beskerming" en die "billike geleentheidargumente" (Beauchamp & Childress, 2013) - ondersteun. Albei hierdie argumente word breedvoerig bespreek. Reg op gesondheid en regte gesondheidsorg is twee konsepte wat baie lesers verwar omdat hulle betekenis verwant is, maar hulle tog onderskeidelik verwys na verskillende dimensies van die konsep van gesondheid. Hulle word bespreek met spesifieke klem op die etiese kwessies wat die toekenning van gesondheidsbronne, rantsoenering en die opstel van prioriteite insluit. Hierdie tesis druk ook deur na moontlike oplossings vir die gesondheidskrisis in Zimbabwe. Die veelbelowende Nasionale Gesondheidsversekering, word onder andere ontleed. 'n Lys aanbevelings word in die laaste hoofstuk uiteengesit.

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# Chapter 1

## INTRODUCTION

### 1.0 Introduction

“Of all the forms of inequality, injustice in health care is the most shocking and inhuman.”<sup>1</sup>

Nothing epitomizes the enduring debates, controversies and centuries-old agonies surrounding the politics around health care than the above statement. In the United States of America (USA), around the time of Dr Martin Luther King’s famous statement above, there were already some unprecedented pressures for health-care reform (Hoffman, 2003). For example, in the 1950’s, the price of hospital care doubled, worsening in the early 1960’s – and leaving those outside the workplace with difficulty in accessing and affording medical insurance cover. As expected, the elderly were the worst affected. The number of companies selling health insurance sky-rocketed and a challenge emerged: A concern about a doctor shortage forced a rethink about health manpower needs. This led to federal government measures to expand education in the training of health professionals. Still in the 1960’s, the major medical insurance firms were seen to endorse high-cost medicines. This is the same period, which saw President Lyndon Johnson signing Medicare and Medicaid into law (Centers for Medicare and Medicaid).

Across the Atlantic Ocean in Europe, at the same time, health-care reforms were focused on socializing health care and making it more accessible to the general population (Altenstetter, 2003; Smith & Busse, 2010; Thomson & Dixon, 2006; Saltman & Figueras, 1998).

At the same time in Africa, in Southern Africa, a small country called Zimbabwe (called Southern Rhodesia at that time) – health services were largely organized, according to racial-segregation policies. Post-independence the health policies and interventions in Zimbabwe took an interesting turn. This thesis will focus on the crisis in health care in current day Zimbabwe.

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<sup>1</sup> “(Dr Martin Luther King Jr) <sup>1</sup>, in a speech in Chicago on March 25, 1966, to the second convention of the Medical Committee for Human Rights”.

## 1.2 Problem Statement

Health care services in post-independent Zimbabwe have undergone turbulence with periods of seemingly significant improvements and other periods of definite decline. Health services in Zimbabwe witnessed a major boom in the years immediately after independence but took a noticeable dive between 2000 and 2009 (National Health Strategy for Zimbabwe, 2009). The recovery witnessed just after the introduction of a multi-currency regime in 2009 appears to have been lost again during recent years. The deterioration in the health services has resulted in worsening maternal health epitomised by increased unsupervised home deliveries, major shortages of personnel, drugs, supplies and water while on the other hand staff morale has continued to decline (ZDHS, 2015; Moyo, 2017; Kunambura, 2015; Nherera, 2014; Mbanje, 2017). Incidents of alleged corruption by hospital and health care insurance executives have continued to grab the headlines in national newspapers (Chipunza, 2014 and 2015). In an effort to avoid exposure to the deteriorating health services the rich and politically elite are reported to be flying overseas or to South Africa to enjoy state-of-the-art health care; while the poor majority are left to wallow in their misery (Zhangazha, 2016; Mushava, 2016). Some of the poor citizens are forced to seek better health-care services across the borders in Mozambique and South Africa (Crush et al., 2012; Crush and Tawodzera, 2011; Maharaj and Rajkumar, 1997). Government's freeze on recruitment of health professionals, including doctors, has resulted in an unworkable doctor -patient ratio of 0.8 doctors per 1000 population versus an ideal ratio of 3:1000 (Katongomara, 2016). The doctor-patient ratio has been worsening since the late 1990s (Chikanda, 2008). The resurgence of typhoid and cholera (Truscott, 2009; Gumbo & Ruwende, 2016) in urban centres of Zimbabwe could be a result of the undisputed massive breakdown in public utilities such as water reticulation, sanitation, refuse disposal, provision of potable water etc.

This state of affairs in the health sector has raised major ethical questions and concerns with regard to the expectations of health services consumers, guarantees of access to health as expounded in the Zimbabwean national constitution and equitable distribution of national resources for health. "Health is recognized as one of a range of socio-economic rights, including housing, education and water and is framed as such by the Alma Ata Declaration on Primary Health Care. However,

because no government can guarantee everyone ‘s absolute health status .... the right to health is usually described in terms of creating opportunities for people to reach their full health potential, either through a right of access to health care, or through rights to the underlying conditions necessary for health, such as clean water and adequate food. Human rights are typically obligations placed on states.” (London, 2006 p. 21). The state has a responsibility for meeting a right at least in four ways (ibid): the state must respect, protect, fulfil and promote rights. There are serious doubts that the State is meeting its responsibilities in upholding “the right to health”. Therefore, it can further be argued that access to health care and the whole health care system of Zimbabwe may be facing major ethical challenges and this study, aims to assist in conducting out a deep analysis of the issues with a view to proposing recommendations.

### **1.3 Focus of each successive chapter**

Chapter two looks at health-care systems in general and the way in which they are reflected in the health delivery system of Zimbabwean. Ethical issues or challenges in health care systems can take many forms. They range from debates and discussions on the fairness or lack thereof in the health-care reform process, the ethics of inter-professional relationships, the ethical problems with doctor-patient relationships, the state of advocacy in health matters, and patient rights, ethical perspectives influencing discourses on health systems, the ethics of health-care funding, and debates on what constitutes “the right to” and “access to health care”. Full understanding of these complexities or challenges, needs and reform requirements of the Zimbabwean situation cannot be fully grasped without some form of comparative analysis. Therefore, the health systems and models in the United States of America (USA), Britain (UK) and South Africa (SA) are included to allow for a balanced comparative analysis of the Zimbabwean scenario.

Chapter three looks at the ethical principles and their implications for the Zimbabwe health care system, using largely the principlist approach (Beauchamp and Childress, 2013). The principlist attempts to solve ethical dilemmas and has philosophical thinking since the late 1970s (McCarthy, 2003). The principlist approach was ushered into fame in the 1970s and 1980s, through but not limited to famous Belmont Report, which enunciated ethical principles which have come to be a cornerstone of the regulation of biomedical research involving human beings (ibid). The social

contract theory is also discussed in some detail because of its important applications to issues related to health care.

Chapter four focuses on distributive justice and its relevance and implications for the health care systems in general, but also with particular relevance to the Zimbabwe scenario. Although there may appear to be a great diversity with problems regarding health delivery systems, the major bone of contention is around: who should get ‘what share of a society’s resources’? The major hurdle to accessing the health delivery system in many countries is the inadequacy or absence of financial resources for such people to enable them to afford care. There are two major arguments, which support the “moral right” to publicly-funded care – “the collective social protection and the fair opportunity arguments” (Beauchamp & Childress, 2013). These arguments are discussed in detail. In addition, the joint “World Health Organisation/ Office of the High Commissioner for Human Rights statement” (WHO/OHCHR) (2007) is discussed. This statement embodies the right to health based on the following seven parameters: universal accessibility; availability; acceptability and dignity to the consumers, good quality, no discrimination, transparency and accountability. All these issues have a bearing on the analysis and appreciation of challenges related to the health care system in Zimbabwe.

Chapter five explores the issues around “the right to health” versus “right to health care”. A deliberate focus regarding ethical issues involving the distribution of health resources, rationing and setting of priorities is done. Zimbabwe, like many African countries, has been faced with chronic underfunding of its health-care system (Murwira, 2016; Al Jazeera English, 2014; Tawona, 2015; Kamhungira, 2016; Nherera, 2014). This raises key ethical and value-judgmental issues in its financing and provision of health care, even though in a resource-constrained environment. The chapter will also discuss the following topics when reflecting on the issues of ethics and health-care delivery funding: ethical approaches to health-care delivery setting of priorities, best practices in health-care budgetary provisions, health-care financing and ethical approaches to distribution of health resources and medical care.

Chapter six winds up this thesis by looking at the possible solutions to the health crisis in Zimbabwe. The much-flaunted National Health Insurance, amongst other possible remedies, is analyzed. A number of recommendations are made at the end of the thesis.

## 1.5 Acronyms, Abbreviations and definitions

- **UNESCO:** “United Nations Educational, Scientific and Cultural Organization”
- **MOHCC:** “Ministry of Health and Child Care of Zimbabwe”
- **ZIMASSET:** Zimbabwe Agenda for Sustainable Socio-Economic Transformation (Economic programme, started in 2013)
- **TM & CAM:** Traditional medicine (TM), complementary and Alternative medicine (CAM).
- **NHI:** National Health Insurance
- **OBAMACARE:** Although now referred to as Obamacare in contemporary lingo, the official name is: “The Patient Protection and Affordable Care Act (PPACA) or the Affordable Care Act (ACA)”, dubbed the largest overhaul of the American (USA) healthcare system since the 1960s. Official data show that “it was signed into law by President Obama” in 2010 (Hall & Lord, 2014). Since then it has made a huge impact on healthcare with opposition largely from the Republicans.

## Chapter 2

### HEALTH-CARE SYSTEMS AND MODELS

#### 2.1 Introduction to the chapter

Ethical issues affecting health care in general range from limits in access to health care, inadequate resource allocation and availability, inadequate manpower, long waiting queues in public health facilities, compromised privacy due to space shortage, drug shortages etc. This chapter will look at the health-care systems, the models, and the way in which they are reflected in the Zimbabwean health system. Therefore, this chapter can best be understood as establishing a foundation upon which more in-depth discussions on the ethical issues around health-care delivery in Zimbabwe can be built. A full understanding of the complexities of challenges, needs and reform requirements of the Zimbabwean situation cannot be fully grasped without some form of comparative analysis. The health systems and models of the United States of America (USA), the United Kingdom (UK) and South Africa (SA) are included, to allow for a balanced comparative analysis of the Zimbabwean scenario. Before we go into details with regards to the various health models we will look at the conceptual definition of a health system.

#### 2.2 “Health-care system” defined?

Health-care systems, the need for reforms, their efficiency and effectiveness – are topics for everyday debates, disagreements and even acrimony. However, without a clear definition of the term “health system”, the debates and the comparisons risk losing direction and creating a confused discourse and misleading conclusions; as this would be akin to comparing apples and oranges (Hsiao, 2003). A consistent and adequate definition of the concept of a health system helps researchers and policy makers to identify and understand what and which interventions or instruments are associated with the improvement, sustainenance or demise of a particular health system. This information is then used to reform a health system.



Health systems can be explained and defined in so many different ways (Hsiao, 2003). In the traditional setting, the description of health systems has been based on indication of capacity and delivery activities, such as the number of admission beds, number of health care professionals, the quantity and scope of publicly funded health programmes, and so forth (Raffel, 1997). An argument has been made for the improvement of this traditional conceptualization and definition by the creation of a more elaborate inclusion of five critical elements: “productive resources; the organization of programmes; economic-support mechanisms; management methods; and service delivery” (Roemer, 1993 p.1). But the weakness of Roemer’s concept is that it doesn’t state why these activities matter most in the definition, or whether it makes a difference if their configuration is changed.

The World Health Organisation offers an improved definition over Roemer. It defines a health system “as the collection, structuring and organisation of all resources needed for the delivery of health care services to a targeted population. These resources comprise trained providers, consumers, institutions and financing arrangements” (WHO, 2007 p. 2).

*“A health system consists of all organisations, people and actions whose primary intent is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities. A health system is therefore more than the pyramid of publicly owned facilities that deliver personal health services. It includes, for example a mother caring for a sick child at home; private providers, .....health insurance organisations, occupational health and safety legislation.....”*  
(p.2)

The above definition appears to compliment an earlier WHO definition, which defined health systems based on the activities they encompass (World Health Organisation, 2000). The strength of this improved definition lays in its focus on the ‘performance (ultimate outcomes) of health systems’ and their ‘measurement’. This improved definition also adds additional focus on ‘functions of stewardship, resource creation, service provision, and financing’. However, while it introduced a new element of emphasizing the role of government stewardship, it also fell short by failing to explain the interconnectedness of major players and outcomes.

For that reason, I find the characterization of “health systems as a series of fund flows and payment methods between population groups and institutions” quite useful (Of health Care, 1992). In

addition, a system of functional components was proposed by Londono and Frenk (1997), comprising four functions: Financing, delivery, modulation and articulation. These authors went on to apply their typology to ‘health systems financed through social insurance’; and they even proposed a model which they argued can assist in fulfilling these special functions. This conceptualization is not much different from the one proposed by Mills and Ranson (2001), in which a loose framework of actors and functions was proposed. These comprised: financing, regulating, resource allocation and service provision.

While most of the conceptual frameworks and definitions of health systems described above help us to analyze and classify a health system by its internal functions, their major shortcoming is that they don’t explain clearly which goals these functions target for achievement; the strategy through which these functions stimulate the achievement of these goals; how these functions interrelate with each other; and how re-arranging these functions would affect the intended outcomes (Hsiao, 2003). I find the following “six building blocks of a health system” as enunciated by the WHO (2013 p. vi) as more comprehensive and are critical for a successful, efficient and effective healthcare delivery system:

- **“Good health services:** they must deliver safe, effective, quality and non-personal health interventions to those who need them, when and where needed with minimum waste of resources.
- **A well performing health workforce:** who are responsive, fair, and efficient to achieve the best health outcomes possible given available resources and circumstances.
- **A well-functioning health information system:** ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status.
- **A well-functioning health system:** ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost effectiveness, and their scientifically sound and cost-effective use.
- **A good health financing system:** raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them. The system must provide incentives for providers and users to be efficient.

- **Leadership and governance:** to ensure that strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system-design and accountability”.

Specific types of health systems will be discussed in the following paragraphs.

### 2.2.1 Allopathic/ Western Health Systems and Models

Health systems must be analyzed and evaluated from a perspective of the world comprising many countries. The United Nations itself has 193 members. This diversity has implications for studying, analysing and classifying the different health systems or models of the world. As a result, we need to classify health systems into manageable categories, according to their main characteristics. This helps us to pass value or ethical judgements on them, according to how they best meet the following important cardinal criteria: “Keeping people healthy; treating the sick; and protecting families against financial ruin from medical bills” (Wallace, 2013). The following four basic allopathic/western health systems or models were chosen for their simplicity and clarity. These are: “The Beveridge model; the Bismarck Model; the National Health Insurance model and the Out-of-Pocket Model” (ibid).

Traditional or Complementary/Alternative medicine is also discussed; since it is still widely used around the world, including Africa, India and many Eastern countries, such as China, Japan, Korea and Vietnam.

- **The Beveridge model**

This is the so-called “socialised-medicine model” or Single-Payer National Health Service (UK) model, named after Lord William Beveridge who was a famous British social reformer credited with designing the British National Health Service. The basic arrangement of this model is that “health care is provided and financed by government through tax payments, similar to how the other public goods like the army and police are financed” (Ninane, 1983; Musgrove, 2000). Most of the health facilities are owned by government – with some doctors being employed by government; although other doctors operate privately – while collecting their fees from government coffers (Wallace, 2013). The best example of this system is Britain; while some other

countries use a modified system, such as Spain, New Zealand, most Scandinavian countries, Canada and Hong Kong. Cuba represents the worst case of this system (ibid).

Those who support this model argue that it is superior ethically since it may reduce the temptation for the commoditisation of health services. The goes proceed as follows... “In a system of health financing, where doctors are paid on a fee-for-service basis (as is the case with the Bismarck model), the temptation exists for doctors to over-service and even to over-charge, in order to increase their profits” (Rowe and Moodley, 2013). In order to buttress support for the Beveridge model it is argued that it may offer some “form of safety net for the poorer sections of the population”. However, the main drawback of the system is the lack of competition, because of the use of a predominant single organisational system that includes financing bodies and providers, without offering much “choice between insurers” (Clougherty, 2011). “This generally tends to create inefficiency, unwieldy bureaucracy and a general unresponsiveness to consumer needs” (ibid). Some aspects of this health model appear to be found in the Zimbabwean health system co-existing with other variants, in the way the government owns many hospitals and clinics; and it also employs salaried doctors and nurses. However, private doctors do not claim any payment from government coffers but rather from private health-insurance firms and medical aid societies. Reports of the government of Zimbabwe reviving interest in coming up with a National Health Insurance Scheme (NHI), may be an attempt by the government to bring some universality and equity into health-care provision (Gumbo, 13 November 2015; Mataire, 2015).

- **The Bismarck model**

This model is also called the non-profit “sickness fund” or the “social-insurance model” (Germany). It is based on an “insurance system” funded jointly by both employers and employees through deductions from their payrolls or salaries. Ideally, it is non-profit making, and must include as many citizens as possible (Kutzin, 2011; Altenstetter, 2003). Contrary to the American insurance variant, this type of health-insurance does not make a profit; and it is mandatory to include the whole population. Health care professionals and medical facilities tend to be private; and this model is predominant in western countries such as Germany, France, Belgium, the Netherlands, Japan and Switzerland (Wallace, 2013). It takes its name from a historical Germany

Chancellor called Otto von Bismarck, whose type of Welfare State was instrumental in the unification of Germany during the 19<sup>th</sup> Century.

Zimbabwe appears to use a modified Bismarck model; because the health-insurance contributions are largely from both employers and employees; although the employer's contribution is voluntary. The biggest drawback with the Zimbabwean model is that only a few people are covered, due to the high unemployment rates. In addition, medical aid societies in Zimbabwe are expected to make a profit; but are obligated to have statutory reserves to cushion them in the event of a medical catastrophe (Medical Services Act, 1998, 2001, 2002). The Bismarck model appears to have advantages over the Beveridge model – for the simple reason that government plays a major role in regulation, assists with funding; but does not go beyond that.

Competing insurance firms are generally better for patients through offering competition, ensuring consumer choice and minimal beauracracy. An added advantage of the Bismarck model is the possibility of universal access to care and equity (Clougherty, 2011). The Bismarck model is a multi-layered model and not necessarily a single health insurance overshadowing everything else. For example, Germany has over 240 different funds/health-insurance players, but with tight regulation by government, which is the equivalent of cost-control or advantage; as in the single-payer systems, such as the Beveridge model (ibid).

In the top 10 countries in Europe, seven are not using the Beveridge, but rather the Bismarck model (the Netherlands, Germany, France, Switzerland, Austria, Luxembourg and Belgium).

There are problems to be anticipated when politicians are allowed to become involved in the direct running of health insurance. How do you avoid conflicts of interest involving politicians if they are allowed to be involved deeply in the funding and regulation of health insurances? This appears to have been the case in Zimbabwe, where serious alleged scandals regarding the involvement of the National Minister of Health have been reported in the media. The Minister of Health was alleged to have received monies under the guise of “capitation” (Chipunza, 2015). The then Group Chief Executive of one the country's major health insurance schemes (Premier Services Medical Aid Society – PSMAS) was alleged to be earning a monthly salary of over US500 000 – before he was relieved of his duties. This was a national scandal of considerable proportions (Chipunza, 2014).

- **The National Health Insurance Model**

This model corresponds to a single payer national health insurance, with best examples being found in Canada and Taiwan. It appears to comprise a combination of both the Beveridge and the Bismarck models; and is based on private-sector providers; while re-imburement is provided via a government-run insurance programme funded by the whole population in a country via a premium tax. This is the so-called universal insurance program, which the proponents argue is less expensive, with lower running costs, than the American-variant for-profit insurance plans (Wallace, 2013). Zimbabwe's neighbor to the south, South Africa is currently in the process of conducting pilot studies on this model (South Africa Department of Health, 2011). Zimbabwe has mooted plans to introduce the National Health Insurance Scheme (Mataire, 2015; Gumbo, 13 November 2015).

Proponents of this scheme argue that there may be outright advantages in this system, by having a government-administered insurance scheme, paid for by every citizen, without any requirement for promotion and advertising, no financial incentive to refuse claims, and no financial incentive for running the scheme. However, the major drawback could be the controlling of costs frequently effected by limiting the medical services paid for by the National Health Insurance, and/the long waiting periods for treatment. This quasi-rationing of medical services can create ethical challenges by possibly compromising autonomy because of the limited choices available to the consumer. While National Health Insurance may create an obvious advantage through the centralisation of market power (which may help lower prices of pharmaceuticals), it is not a sufficient justification for possible long waiting periods for procedures by health consumers (Donabedian, 1976).

In a country, such as Zimbabwe, with unemployment levels of over 90%, this system may not be viable since only a few employed people would be required to carry the tax burden unless it is made mandatory even to the unemployed and those in the informal sector like taxi drivers, vendors, rural dwellers etc.

- **The Out-of-Pocket Model**

This is also called the “market-driven model”. It is found in the majority of countries in the world, in which poverty is too high for governments or countries to provide any kind of a structured national health delivery system (Wallace, 2013). In this situation, people with money pay for and get it health care; but those without money may remain sick, or even die at home. This is the order-of-the-day in most of the rural regions of continents, such as Africa, India, China, South America – where millions live their lives without ever being seen by a doctor (Macinko et al, 2003). While some form of direct participation by governments in any health system is important, it is even more important in a society with a predominant out of pocket financing health model. At the barest minimum governments must provide some form of public health service that includes information for prevention as well some form of emergency medical care to reduce avoidable deaths (Saksena et al, 2010). There are countries with mixed models, such as Sweden, which has features of a National Health Service and those of a national health service. It has government run hospitals as doctors being re-imbursed on a fee-for-service basis (Wallace, 2013).

Zimbabwe has a significant portion of its population relying on this model, including those already on medical aid schemes; because most of the schemes have gaps in the procedures insured.

- **Emerging health-care models**

Because of the limitations in the traditional health models discussed above, there are new trends towards complementary models. This is driven partly by emerging new knowledge in life sciences and medicine – both in content and in structure (Swan, 2009). Examples of the so-called ‘emerging patient-driven health models’ include: “health-social networks”, which are website-based resource centres, where patients may be able to find information sharing and emotional support; Consumer-personalised medicine, which uses “an individual’s specific biological predisposition” to tailor come up with specific treatment for that person, as well as quantified “self-tracking”, which comprising of “easy-to-use data-entry screens” for conditions, symptoms, treatment therapies and related biological information – resulting in a graphical display of results. Examples include social networks such as PatientsLikeMe, CureTogether, MedHelp, and SugarStats (ibid).

### 2.2.2 Traditional, Complementary and/or Alternative Medicine

“Traditional medicine is a comprehensive term used to refer both to traditional medical systems, such as traditional Chinese medicine, Indian Ayurveda and Arabic unani medicine, as well as various other forms of traditional medicine” (World Health Organisation, 2002; Truter, 2007). Traditional Medicine (TM) includes such therapies as: use of herbs; animal parts and/or minerals; and non- use of medication, e.g. acupuncture and spiritual treatments. In certain countries, TM has yet to be integrated into national health-care systems; and in such a scenario, it is often known as complementary, alternative, or non-conventional medicine (ibid).

The economic importance of TM is huge as it is believed to be widely used. For example, an estimation has been made that up to 80% of African population use it to cater for their health care needs (World Health Organisation, 2005). It’s not only in Africa where TM is predominantly utilized. All over the world many people continue to utilize TM, partly as a result of ancestral and spiritual beliefs. This continued use of TM encompasses those found in China, Latin America, and in Africa (Truter, 2007). In low income countries, the growing utilisation of TM is often associated with perceived accessibility and its low cost (Abdullahi, 2011). TM is highly sort after in many low income countries; because it is linked to the popular cultural beliefs and practices. In industrialized countries, the growing utilization of TM and Complementary/Alternative Medicine (CAM) is influenced by fear of over reliance on chemical drugs, doubts about the efficacy of allopathic medicine, and the need for wider access to health information. Because of the surge in chronic diseases, such as diabetes, heart diseases, cancer, mental disorders – CAM is perceived as offering a friendlier way of dealing with those chronic diseases – in contrast to western medicine (Abdullahi, 2011; World Health Organisation, 2002).

The growing realization of the importance and indispensability of TM and CAM may be argued to be a gradual ‘return’ to the hitherto decimated basic dignity of the traditional harmony that used to exist before the advent of colonization. It can be argued that colonization destroyed the original traditional cultural, economic, political and health systems of the indigenous people. According to Gade (2011):

*“The observation is that narratives of return have often been told and discussed in the context of social transformations, where political leaders, academics, and others have*



*attempted to identify past values that they believed should inspire politics and life in the future society.....Broadly speaking, the post-colonial African narratives of return thus tend to divide history into three phases: first the pre-colonial phase, which, often but not always, is perceived as a 'golden age' characterized by harmony. Secondly, a period of decline is understood to have been brought about by intruders (Colonizers), who attempted to deprive the Africans of their resources, dignity, and culture; and thirdly, a phase of recovery, where Africans, after having gained sufficient political power, attempt to restore their dignity and culture by returning to (what are claimed to be) traditional, humanistic, or socialist values. It should be noted that in recent years, the attempt to recover African dignity has often been connected with the idea of an African Renaissance” (p.305).*

### **2.2.3 Western/Allopathic versus Traditional Medicine: The philosophical underpinnings**

The endurance of traditional, complementary and alternative medicine is probably based on its strong philosophical underpinning of Communitarianism. According to Beauchamp and Childress (2009):

*“Communitarians have little sympathy with theories based on individual rights and contracts. They see societies constructed on these principles as lacking in a commitment to the general welfare, to common purposes, and to education in citizenship.... Every major communitarian thinker has contested the thesis of the priority of individual rights over the common good.... Communitarians regard principles of justice as pluralistic, deriving from as many different conceptions of the good as there are diverse moral communities. What is owed to individuals and groups depends on these community-derived standards” (p258).*

Hunhuism (a Shona equivalent to Ubuntu, popularised by the first Zimbabwean Professor of African History) or Ubuntu, as an indigenous political philosophy of the Nguni and Shona tribes may be viewed as an enduring set-up in which harmony prevailed. TM and CAM have a major role to play, without being seen as the Cinderella of allopathic medicine; because they have both existed for many centuries. They are products of many centuries of refinement, being passed on

from generation to generation. Hunhuism is a Shona translation of Ubuntu (Samkange, 1980), translated to mean:

*“The attention one human being gives to another, the kindness, courtesy, consideration and friendliness in the relationship between people, a code of behaviour, an attitude to other people and to life, is embodied in Hunhu or Ubuntu....”*

However, before Africans started a re-awakening, and embarked on celebrating the indigenous philosophy of Hunhu or Ubuntu, communitarianism was already a moral theory recognized and propagated by the Westerners. Perhaps traditional medicine fits well with ubuntu (which I am going to equate with communitarianism) because of its emphasis on the pivotal role of human communities in shaping values and the formation of individual selves. The central theme of sharing is paramount. This is in sharp contrast to the theory of liberal individualism, which appears to be central in western medicine systems and the way consumers pay for the services (medical aid, medical schemes, and medical plans).

Liberal individualism, unlike Ubuntu or Hunhuism, emphasizes freedom and the rights of individuals as being the most important moral values. In traditional medicine, payment for services may take any form of currency (e.g. domestic animals, grain etc); while in western medicine, cash appears to be the predominant medium of exchange. It is hard to imagine a consumer of western medicine offering to pay with goats, cattle or grain.

In addition, the approach of traditional medicine focuses on the whole extended family and kinship; as healing may be inadequate, unless it extends to the rest of the kinship. Contrast this with some aspects of western medicine, which mainly focuses on the individual.

It may be argued that Western health-care systems and models adapted to the African situation must of necessity, appreciate the impact of traditional medical practices; since they may influence the effectiveness of Western medical systems superimposed on the African context.

### **2.3 The health-care system of South Africa**

The health-care system of South Africa is discussed here to provide a comparative analysis of the Zimbabwean health system so as to assist us in understanding and appreciating the status and challenges of the of the Zimbabwean health-care delivery system. The political history of that

country has had a profound impact on its health-care system, its population, as well as its health policy and services. Prior to the ushering in of democracy in 1994 – the socio-politico-economic history and land distribution policies structured the South African society, based on race, gender, and age-based hierarchies. These in turn greatly affected the provision of social services, including skewed or inequitable distribution to basic health services and resources (Coovadia et al., 2009). Therein lays the genesis of the post-apartheid stretched health system and an unusual disease burden distribution pattern. Modern South Africa is now modelled along the lines of a multi-racial democracy, with the Black majority (79.2%), minority groups of Whites (9.2%), Coloured (9.0%) and Indian (2.6%).

South Africa is undoubtedly still struggling with the past effects of apartheid and the expected challenges of transformation in health delivery and other areas (ibid p.817). The first ever medical schemes, were introduced for the first time in 1889; and they catered for needs of White mine workers only until the late 1970s. Before this development, all private health-care funding was through out of pocket payments. Private health care in South Africa developed largely from corporate capital, particularly the mining sector. Capitalism in South Africa is regarded as very powerful (Delobelle, 2013 p.826).

Building on from the earlier phenomenon of mission hospitals and onsite hospitals of industry-specific interests, such as mines, profit-oriented private hospitals expanded exponentially between 1980 and 1993 (ibid). This was partly due to the deliberate privatisation policy of government which tended to follow international trends of promoting the role of the private sector in the national economy. As a parallel development, there is a substantial difference in the numbers of doctors and specialists between the private and the public sectors, with the former garnering over 62% of general doctors and 66% of specialists by the early 1980s (Coovadia, 2009; Delobelle, 2013).

South Africa inherited a well-resourced health-care system in 1994, compared to countries with a similar economic pedigree, with a total expenditure on health-care of eight and half percent of Gross Domestic Product (GDP). Much of this expenditure took place in the private health sector. However, the following major challenges persisted according to Harrison (2009) and Goldwyer, (2014):

*“Within the public sector, large inequalities in the distribution of infrastructure and financial and human resources between geographical areas; Inefficiency in the distribution of resources between levels of care, with over 80% of resources going to hospitals; Academic and other tertiary-level hospitals alone account for 445 of total public-sector health sector spending, with only 11% devoted to non-primary care services...”*

The post-apartheid health system was dismantled with the onset of democracy in 1994, with the new universally elected government expected to address the disenfranchisement that had weakened the health system over centuries. The ruling African National Congress Party (ANC) published its party position or health plan in 1994 based on the concept of “Primary Health Care of the Alma Ata Declaration”. The plan envisaged a system of “community health centres” and an inbuilt proviso for children younger than 6 and pregnant mothers being promised to receive free health care. “The Alma Ata declaration was signed by all WHO member countries at Alma-Ata (a city in the former Kazakh Soviet Republic) on 12<sup>th</sup> September 1978. It formally adopted primary health care (PHC) as the means for providing a comprehensive, universal, equitable and affordable health care service for all countries” (Hall & Taylor, 2003; WHO, 1978).

In addition, the ANC plan abolished the 14 health administrations of Bantustans – resulting in one consolidated national and nine provincial health departments (Coovadia, 2009). Ten strategies were credited with helping bring significant progress in health care in South Africa since 1994, including five instruments of legislation, as follows: “Free primary health care, an essential drugs programme, the choice of termination of pregnancy, anti-tobacco legislation, community service of graduate health professionals, greater parity in district expenditure, clinic expansion and improvement, a hospital revitalization programme, an improved immunization programme and improved malaria control” (ibid).

Years down the line, after the advent of democracy in South Africa,

*“.... the ten biggest challenges facing the South African health sector today relate to the following areas: The prevention and treatment of HIV/AIDS; the prevention of new epidemics (especially MDR-TB); the prevention of alcohol abuse; the distribution of financing and spending; the availability of health personnel in the public sector; quality of care; operational efficiency; the devolution of authority; health-workers’ morale, and leadership; and innovation” (ibid).*

### **2.3.1 The South African National Health Insurance**

South Africa embarked on initial steps to introduce a National Health Insurance Scheme (NHI) in 2011 by publishing a policy document (The Green paper) in August of 2011. “The World Health Organisation recommends that countries spend at least 5% of their GDP on health care. South Africa already spends 8.5% of its GDP on health, way above what WHO recommends. Despite this high expenditure the health outcomes remain poor when compared to similar middle-income countries” (Department of Health, 2011 p.9).

The NHI is envisaged to bring about an improvement in the delivery of health services, to introduce efficiency and equitable distribution of services. This would entail major administrative, managerial and operational changes over a transitional period spanning over a 14-year period.

The Green Paper in August 2011, was followed by a NHI conference on 7<sup>th</sup> to 8<sup>th</sup> December 2011. Amongst other important topics the conference looked at the following: financing, lessons to be learnt from other countries, equity issues, institutional arrangements etc. During the period leading to the gazetting of the White Paper on NHI in December 2015, phase one (1) NHI implementation activities commenced on eleven projects in 2012. These included the following ([www.gov.za](http://www.gov.za)):

- Human Resources for Health Strategy
- Recruitment of District Clinical Team Specialists
- Health and Nursing college infrastructure grants
- Launch of NHI pilot districts-completion of baseline audits of facilities
- Launch of regulations on hospital designations
- Launch of integrated school health programme
- Office for Health Standards and Compliance legislation passed
- Operation Phakisa: The Ideal clinic
- District Health Systems Policy Framework and Strategy
- ICT upgrade for automation of data in 700 PHC facilities in pilot districts

### **2.3.2 The White Paper and Legislative process on NHI**

The national Health Minister, Dr Aaron Motsoaledi, gazette the White paper on the NHI on the 11th December 2015. This is a statutory requirement before any bill is crafted, as provided for in South African constitution (Act No. 108 of 1996) and the National Health Act, 2003 (Act 61 of 2003) after consultation with the National Health Council. Amongst other things, the white paper invited interested persons and parties to send any substantial inputs on the proposed NHI policy to the Director-General of Health within a period of three months from publication date ([www.gpwonline.co.za](http://www.gpwonline.co.za)). The National Department of Health, in close cooperation with the National Treasury, worked to produce the White Paper which would take the legislative and implementation processes forward.

## **2.4 The United Kingdom health-care system**

four countries: England, Scotland, Wales and Northern Ireland make up The United Kingdom (UK). By 2014, the English population was estimated at 54.3 million, constituting about 84% of the total UK population of 64.6 million people (Office for National Statistics, 2015). The United Kingdom is a constitutional monarchy governed by a parliament consisting of two houses, the democratically elected members of parliament, who sit in the House of Commons and an upper house, mainly comprising appointed members (the House of Lords). Elections to the House of Commons are held every five years using a first-past-the-post electoral system. The government is headed by the Prime Minister, who is the leader of the party with the biggest number of MPs in the House of Commons. The head of State is a hereditary monarch, Queen Elizabeth II (since 1952).

The UK is currently one of the 28 members of the European Union (EU); although a referendum in June 2016 (famously referred to as BREXIT), resulted in a popular vote to exit the EU. England itself is further divided into local government run smaller administrative regions called councils or local authorities. They number about 354 in total (Boyle, 2011). The UK provides public healthcare to all permanent residents, with a free coverage and access when needed. This service is paid for by general taxation just like the army and police. The country's private health-care sector is still growing; though still lagging behind the size of the public sector (National Health Service, 2013).

Before the founding of the National Health Services (NHS) in 1946, healthcare was only accessible to the wealthy; unless provided by charity or teaching hospitals. David Lloyd George introduced a short-lived earlier version of the NHS via National Insurance Act of 1911 operating on the premise of a small amount being deducted from an employee's wages entitling the worker to free health care. The National Health Service (NHS) was launched after second world war, with services being provided free at the point of need, and financed from central taxation. At first there was tripartite system splitting services into hospital services, primary care (General Practitioners) and community services. It was modified in 1974 because of unintended problems resulting from the separation, to allow the local authorities to support all three areas of care. A further modification was done during the Thatcher administration resulting into enactment of the National Health Services and the Community Care Act setting up independent Trusts that managed health care. The Blair administration, not to be outdone, also came up with their reform agenda, called the NHS Direct, which aimed at uplifting standards and improving costs and reducing waiting times (Beecham, 2000; Toynbee, 2007).

The NHS is not a single entity but is made up of a many specialized organizations. The first points of contact on a non-urgent basis were the providers of 'primary care' who included general practitioners (GPs), dentists, opticians and pharmacists. However, for urgent cases patients can skip these to accident and emergency departments. The NHS-funded services include both NHS provider organizations, social enterprises and private organizations. The majority of NHS services comprise either NHS trust or NHS foundation trust, with the long-term aim of having all the former gradually converting to the latter.

In order to strike a balance between budgets and effective outcomes planning and purchases of services is done by organizations and individuals known as commissioners. The purchasing of such services is not limited to certain entities. Anyone meeting the NHS standards of care and pricing can participate (Gropius et al, 2010).

## 2.5 The United States of America (USA) health-care system

The USA has a unique health-care system compared to other western countries. According to the Organisation of Economic Co-operation and Development<sup>2</sup> (OECD), it was found that:

- “The USA spends far more on health care than other high-income countries, largely driven by the greater use of medical technology and higher health-care prices, rather than more-frequent doctor visits or hospital admissions. And yet despite this, the USA has comparatively poorer health outcomes, shorter life expectancy and greater prevalence of chronic conditions.
- Private spending on healthcare is high in the USA, and second only to Switzerland. For example, out-of-pocket spending on co-payments for doctor visits, prescription drugs, and health insurance” (Commonwealth fund (2015); Karatzas, 2000; Stanton & Rutherford, 2006).
- “*Per Capita* public health spending is the highest in the basket of countries compared, despite the fact that the USA has no universal health-care system. The main public health insurance programmes of Medicare and Medicaid covered only about 34% of the population, in contrast to the UK, where every resident is covered by the public health system” (ibid).

The US (United States) health-care system, while being quite unique among advanced industrialized countries, is not the most efficient and effective system (Weaver, 2010). It is unique in so many ways, not least because it has no universal health coverage; but also it does not operate a NHS, nor a single-payer national health-insurance system, or a multi-payer universal health-insurance fund. It is simply a hybrid system of sorts. For example, in 2010, fifty per cent of US health spending came from private funds, 38% from federal funds and 12% from State and local funds. Even publicly funded or financed programmes are actually privately delivered (ibid).

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<sup>2</sup> “OECD is an international economic organisation comprising 34 countries, founded in 1961 to stimulate economic progress and trade. In addition; it annually tracks and reports on a wide range of health-system measures across 34 high-income countries, from population-health status to health-care spending and utilisation”.



- **Medicare**

Since 1966 the US federal government administered the Medicare programme. It is a national social insurance programme comprising around 30 private insurance companies across the USA, providing insurance for those aged 65 and above, who have contributed into the system during their working life. It also caters for younger people with disabilities. On average, it covers close to 50% of the health-care expenses of those enrolled – with the remainder to be covered by out-of-pocket spending or supplemental insurance. Some of the usually uncovered health needs on Medicare include long-term care, dental, hearing and vision care (Altman and Frist, 2015; Torio and Andrews, 2011; Kaiser Slides, 2016).

Medicare originally served families of individuals serving in the military. Medicare, in a way, helped with the desegregation of medical care; because before its creation, approximately 65% of those over 65 had health insurance; but the rest did not have any coverage; because the older adults paid more than three times the amount paid by the younger ones. In 1966, Medicare changed the demographics of waiting rooms and hospital floors by making payments to health-care providers conditional on desegregation (Vladeck et al., 2006). Medicare has been in operation for over 50 years; and it has already undergone several changes. Since 1965, it has expanded to include benefits on speech, physical, and chiropractic therapy (1972), coverage of almost all drug prescriptions (passed in 2003, went into effect in 2006), hospice (1982), as well as amyotrophic lateral sclerosis/ALS or Lou Gehrig's disease (1984).

The Centres for Medicare and Medicaid Services (CMS)<sup>3</sup> are components of the Department of Health and Human Services (HHS); and they are charged with the administration of Medicare, Medicaid, The Children's Health Insurance Program (CHIP), the Clinical Laboratory Improvement Amendments (CLIA) and parts of the Affordable Care Act (CMS.Gov, 2016).

- **Medicaid**

This is a programme for families and individuals whose income and resources are too low to pay for health care. It is the largest funding source for low-income persons in the USA jointly funded by each State and the Federal government but managed by the States themselves. Each State is

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<sup>3</sup> <http://CMS.gov>

given the liberty to determine eligibility criteria, as well as their implementation. There is no obligation for the States to participate, although almost all of them are participating. President Obama's Affordable Care Act (ACA) significantly expanded eligibility for Medicaid, as well as for federal funding; although the States do not necessarily have to abide by the ACA provisions. An American state does not have to participate; but if it chooses to do so, it should comply with the federal Medicaid laws. The federal Centres for Medicare and Medicaid Services monitor these State-run programmes by establishing the requirements for service delivery, quality, funding and eligibility standards (Annual Statistical Supplement, 2011).

- **Obamacare**

Although now referred to as 'Obamacare' in contemporary vernacular, the official name of the state-sponsored medical care proposed during Obama's administration is The Patient Protection and Affordable Care Act (PPACA) or the Affordable Care Act (ACA), which is understood to be the largest overhaul of the healthcare system of the United States of America (USA) since the 1960s. It accented into law in 2010 by President Barack Obama, with many of the law's provisions already in effect, with the full set of provisions anticipated to be rolled out till 2022 (Hall & Lord, 2014). The aim of Obamacare was to extend health insurance coverage to some of the estimated 15% of the USA population who lack it, and at the same time who have no assistance from their employers, and excluded from programmes for the poor and the elderly.

This law requires all Americans to have health insurance by, among other things, offering subsidies to make health insurance coverage more affordable and aims to reduce the cost of insurance by bringing younger, healthier people into the health insurance system (Kamerow, 2017). It also requires businesses with more than fifty full time employees to offer health coverage (Hall & Lord, 2014). This additional provision only became effective in 2015, a strategy meant to allow time for compliance. The law creates market places, complete with websites, where individuals can compare prices as they shop for coverage. For example, a website called *health.gov* is used by up to thirty-six states, while the other fourteen states and Washington DC have their own websites.

This law also forbids insurance companies from denying health coverage to people with pre-existing health conditions and allows young people to remain on their parents' plans till they are

26 years old, while expanding the eligibility for the government administered Medicaid health programme for the poor. The Obamacare law aims to eventually slow the growth of healthcare spending in the USA, which is the highest in the world (Feldstein, 2009).

▪ **The Donald Trump impact on Obamacare**

As soon as Donald Trump took an oath of office as the 45<sup>th</sup> President of the United States of America (USA) his first task was to sign an executive order repealing Obamacare. He signed the executive order in the famous Oval office, on his first Friday as President, literally within hours of taking oath of office. This shows how the opposition to Obamacare was not only central to Trump's campaign strategy, but also has been a perennial source of antagonism between the Republican and Democratic parties for generations going back to an enduring feud between the two USA major political parties. While Trump's maiden executive order targets the sweeping Obamacare law by giving federal agencies broad leeway to chip away Obamacare, he will still require congressional approval to get rid of it completely.

At the time of writing this script Trump's one-page executive order to "repeal" the Obamacare "... gives agencies authority to grant waivers, exemptions and delays of provisions in the Affordable Care Act. But until it becomes clear what steps federal agencies take as a result, its full impact on Americans and their insurance is uncertain" (Pae & Alonso-Zaldivar, 2017). This aspect of the executive order (waivers, exemptions and delays) appears to be aimed at the most unpopular aspects of Obamacare (as expressed by its Republican opponents) –the requirement to sign up or carry health insurance or suffer penalties. The directive also instructs States to stop expanding Obamacare and gives them flexibility to design their own programmes (Butler, 2017). The good news for the proponents of Obamacare is that there may be little impact for 2017 since many contracts with health insurance companies had already been written unless the relevant federal arm of government is prepared to override that, which is very unlikely. But the appetite to repeal and replace the Obamacare is huge, not with the Republicans now controlling both houses of Representatives and Senate. Although President Trump has been vague about what should be contained in the replacement "Trumpcare" he has made it clear he wants to keep the good aspects of the Obamacare such as the ones allowing young people to stay on their parents' insurance until age 26 and preventing insurance companies from denying coverage to people with pre-existing conditions.

The best way to describe the Republicans programme of repeal and replace for Obamacare is to say it is a ‘work in progress’. A number of high ranging Republicans, including President Trump himself, have announced their own frameworks for replacing Obamacare (Carroll, 2017). These include the Republican House Speaker, Paul Ryan and his “A Better Way Plan”, Republican Tom Price’s<sup>4</sup> “Empowering Patients First Act”, Republican Senator for Utah Orrin Hatch’s “Patient CARE Act”,

While Obamacare has achieved much, its vulnerability is in part as a result of lack of strong public support and the extreme partisanship between the Republicans and Democrats, according to Oberlander (2017). He says “.... The ACA has achieved much, including a large reduction in the uninsured population. Still, it lacks strong public support and an organized beneficiary lobby, has encountered significant problems in its implementation and has been enveloped by an environment of hyper partisanship. If the ACA were more popular and covered a more politically sympathetic or influential population, ...and if Democrats and Republicans were not so ideologically polarized and locked in a power struggle, then an incoming Grand Old Party (GOP) or Republican administration would probably be talking about reforming rather than dismantling Obamacare” (ibid).

It will wait to be seen if the Trump administration will successfully repeal and replace Obamacare notwithstanding their limited capacity majority in the Senate where an outright majority of 60 votes is needed to completely repeal the ACA without “horse trading” with the Democrats.

## **2.6 The Zimbabwe health-care system**

### **2.6.1 Organization of Health Services in Pre-independent Zimbabwe**

The landscape of health services in pre-independent Zimbabwe was characterised by bias towards urban communities, curative-health services, and with special privileges channelled towards the White community and mixed races (Mutokosi, 2015). Zimbabwe’s pre-independence health system mirrored many colonised countries, especially those under the British Empire. Black marginalisation, accompanied by skewed resource allocation and inequitable distribution, was the order of the day. This resource distribution favoured the White race and mixed races. This criterion

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<sup>4</sup>“At time of writing this script Tom Price was Trump’s nomination for Head of Department for Health and Human Services”

for resource priority setting appeared to be dictated by the racial structure of society, with the rich of the society consuming the most; and the have-nots consuming the least (Bloom, 1985). For example, the infant mortality rate amongst the blacks was much higher at 120-220 per 1000 compared to that of Whites at around 17 per 1000 (Razemba, 1998). Hospitals in towns and cities catered for only 15 per cent of the population; while absorbing about 44% of the publicly funded services; while 24% went to primary and secondary-level rural health services, despite supposedly serving over 70% of the total population (Sanders, 1990). This was also corroborated by Razemba (1998), who documented a very low life expectancy across the gender lines among Zimbabwean Africans, with males not living beyond 50 years in general terms; while the females generally died before their 54<sup>th</sup> birthday. This can be compared with the Zimbabwean European males with a life expectancy of 70 years and females at 74. This is one of the reasons why Zimbabwean health policy required urgent transformation at independence in 1980.

### **2.6.2 Organization of Health Services in Post-independent Zimbabwe**

Zimbabwe gained its independence on 18<sup>th</sup> April 1980; and it changed its name from Zimbabwe-Rhodesia to its current name, Zimbabwe. (Zimbabwe-Rhodesia was a short-lived compromise transition from Rhodesia to Zimbabwe under the disputed Prime Minister Rev. Abel Muzorewa) (Kalley, 1999). With this new dispensation, accompanied by massive euphoria, major policy changes were announced in virtually all sectors of the country. Health-care services were no exception. The ushering in of majority rule created a favourable ground and justification to discard the colonial-health services distribution and funding patterns. The previous pattern of controlling access to health services based on presumed racial superiority could not be sustained (Bloom, 1985). While the pre-independence health-service distribution philosophy was based on developing urban facilities, on the assumption that there would be an eventual trickle-down effect to the rural areas, the new Ministry of Health deliberately advocated a policy of concentrating and developing rural-health services, where the majority of the hitherto neglected communities lived.

**Figure 1: Map showing Location of Zimbabwe in Africa**



Source: <http://pubs.sciepub.com/ajmbr/4/2/3/figure/1>

### **2.6.3 Major post-independence health-policy interventions**

In order to trace the interventions that have been implemented over the years, we will look at landmark-policy pronouncements by the Government of Zimbabwe (GOZ).

- **Plan for equity in health policy<sup>5</sup>**

The first major policy announcement or implementation was the Plan for equity in health in 1980, which appeared to be largely influenced by the Alma Ata declaration of 1978 (Mutokosi, 2015; Sanders, 1990). This declaration emphasized the need for primary health care (PHC) as a fundamental human right that needs to be prioritized as a worldwide social good. Inequity in health

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<sup>5</sup> “Amongst other notable achievements of this policy were: by 1984 immunization coverage against six killer diseases for children between 12 to 23 months rose from 25% to 42% in rural areas, and 56% to 80% in urban areas. New national programmes in Nutrition, Village Health Workers, Diarrhea disease control, child spacing, and ...”

care was seen as unacceptable. The government of the newly independent Zimbabwe implemented various programmes to militate against the previously disproportionate distribution of health care resources and poor outcomes. The major sounding bites of the various programmes appeared to focus on aspects of equality, human workforce, finance, service delivery among others. For example, free health care was announced in September 1980, as a safety net for those earning less than Z\$150<sup>6</sup>. A massive donor funded infrastructure rebuilding programme was embarked upon resulting in the building of 224 rural health centres as well as upgrading of a number of provincial health care and training centres by June 1987 (Sanders, 1990:6). However, despite having a big positive impact on health outcomes there were budget implications on the state spending capacity. For example, the health budget rose from 5.1 per cent to double in 1982, and continued to rise with concomitant rise in foreign debt despite the heavy donor funding (ibid.). Having realised this shortfall a new policy intervention had to be created to remedy the new undesirable situation: Economic Structural Adjustment Programme (ESAP) of 1992 to 1996.

▪ **The Economic Structural-Adjustment Programme of 1992 to 1996 (ESAP)**

The second health policy was to be known as the famous Economic Structural Adjustment Programme (ESAP) which ran from 1992 to 1996. It was so devastating that even musicians started singing and recording about it. Its major goal and target was to restructure the economy in pursuit of health equity which the Plan for Equity in Health policy failed to achieve. The hallmark of this policy was austerity measures meant to bring economic growth through rationalisation of government expenditures being monitored by the International financial institutions (Coltart, 1991; Coltart, 1992; Sichone, 2003). As a consequence of the failure of this policy a new health policy framework was needed leading to the creation and implementation of: The National Health Strategy of 1997 to 2007.

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<sup>6</sup> *The Zimbabwe Dollar of 1980 was stronger than the USD at a ratio of 1: 1:47* <https://www.globalfinancialdata.com/gfdblog/?p=3098>. *The value steadily depreciated due to higher inflation and alleged economic mismanagement.*

- **The National Health Strategy of 1997 to 2007**

The official theme of this policy was centred on need to foster a working environment of quality and equity in health. The justification for this new policy was the realisation that the Economic Structural Adjustment Programme (ESAP) in Zimbabwe had made it very difficult to achieve equity in health. Hence the government sought to rebuild capacity in the health sector. Emphasis in this strategy was placed on coordinated stakeholder involvement in health care provisions, financing service standards setting, regulating monitoring and evaluation of performance. Various sub policies and programmes were implemented in pursuit of health care equity, mortality, morbidity. For example, the National AIDS policy of Zimbabwe was implemented in 1999, a multi-sector approach was adopted with the involvement of public sector, private corporations, non-governmental organisations, churches and community groups participating in HIV/AIDS policy through the National Aids Council (NAC)<sup>7</sup>.

This policy intervention had a mixture of positive outcomes and failures. The failure to achieve equity in health can be attributed to the harsh political and economic climate which prevailed at the time. An example of a positive outcome was the provision of testing kits and medicines for people living with HIV/AIDS by NGOs. However, most hospitals still had poor access to HIV/AIDS testing kits and other resources, gender equity was not resolved by 2005, HIV/AIDS mortality per 100 000 population remained very high, HIV/AIDS remained the biggest cause of mortality among children in the country (at 21%) and this reflected a poor equity outcome (Zimbabwe World Health Organisation fact sheet, 2003). However, on the positives the policy can be partly credited with reduction of the percentage of people living with HIV/AIDS from 26% to 15.3% in 2007 (Ray and Kureya, 2003). In response to these and other shortfalls the government again crafted yet another policy intervention: The National Health Strategy 2009 -2013 as a remedy.

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<sup>7</sup> “National Aids Council (NAC) is an organization enacted through the Act of Parliament of 1999 to coordinate and facilitate the national multi-sect oral response to HIV and AIDS. It is also mandated to administer the National Aids Trust Fund (NATF) collected through the AIDS levy i.e. the 3% collected from every workers taxable income (PAYE) and corporate tax. Its Vision is: No HIV transmission. Universal access to HIV and AIDS services”.



### **The National Health Strategy of 2009 to 2013**

This new policy was touted as a development that would give new strategic policy framework to succeed the National Health Strategy 1997-2007. The words: “A people’s Right” were inserted in the slogans to aptly portray a sense of human right paradigm shift. It had been realised weaknesses in access to health care during the period preceding this policy pronouncement had worsened mainly due to hyperinflation. During the period from 2000 to 2008 the country went through an excruciating economic upheaval epitomised the world’s highest inflation rates, which peaked in the year 2008 (National Health Strategy for Zimbabwe, 2009). There is need for a refocus on resuscitation of access to health care which had almost collapsed. The policy prided itself into having developed as an off shoot of wide consultations and input from the following documents and studies: “*Study on Access to Health Services; Vital Medicines and Health Services Survey; Community Working Group on Health Surveys; Zimbabwe Maternal and Perinatal Mortality Survey; Millennium Development Goals; Ouagadougou Declaration on Primary Health Care and Health Systems in Africa; Africa Union Health Plan Protocol; East, Central and Southern Africa Health Community Agreements; SADC Health Sector Protocol*”(ibid.).

- **The Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZIM-ASSET)**

ZIM-ASSET was officially pronounced in October 2013, a few months after the elections of the same year in August. It is expected to run from October 2013 to December 2018. It is officially serving as the nation’s economic development blueprint around all Government policies, projects and programs are molded around, comprising four economic clusters of: Food security and Nutrition, Social Services and Poverty Reduction, Infrastructure and Utilities and Value Addition and Beneficiation. There are also three enabling clusters to buttress the four standalone clusters: Fiscal Reform Measures, Public Administration, Governance and Performance Management and Aid Coordination (OPC, 2017).

A closer analysis of this policy will show that it has no specific or separate health policy or component. Health policy formulations are assumed to be subsumed under all the clusters but more importantly and naturally under the Social services and poverty reduction cluster. Literature on the performance and effectiveness of this policy is still very limited.

#### **2.6.4 Zimbabwe's Traditional, Complementary/Alternative medicine: Is it a Cinderella of Allopathic/Western medicine?**

Zimbabwe's TM and CAM have played second fiddle to allopathic medicine, since the time of colonisation. Before the advent of colonisation, TM and CAM had played a dominant role, if not the only medical practice available. The Zimbabwe National Traditional Healers Association (ZINATHA) was formed in 1980 marking a turning point in the long and protracted antagonistic relationship between allopathic and traditional medicine. The Minister of Health, Dr Herbert Ushewokunze, played a major role in its formation. The inaugural meeting consisted of 100 prominent traditional medical practitioners and Government officials (Chavunduka, 1986; Matondo, 2000; Cavender, 1988). Over the years, further developments have led to the establishment of the Traditional Medical Practitioners Council.

There is still to be wide-scale integration of TM and CAM into allopathic health-care delivery (the so-called formal health-care system). However, the Government of Zimbabwe, through the Ministry of Health and Child Care, has gone further to create a Directorate of Traditional Medicine at the Ministry's Head office. There is no public hospital in the country, which has integrated TM and CAM into its operations. However, recently a church-run community hospital, Dorcas Hospital, in Waterfalls in Harare, administered by the Zimbabwe Assemblies of God Africa (ZAOGA) church has created an integrated spiritual healing department or section (Mhlanga, 2016).

#### **2.6.5 Summary of the Zimbabwe Health-Care System**

Zimbabwe operates a four-tier allopathic health-delivery system consisting of primary, secondary, tertiary and central levels of health care, which are meant to function as a referral chain. TM and CAM largely operate as an informal entity, except for the legal provision of the registration of traditional healers, homeopathy and allied practitioners through the Traditional Medical Practitioners' Council. There is also a Directorate of Traditional Medicine at the Ministry of Health's headquarters, attesting to the importance and gradual recognition of traditional medical-knowledge systems. The Ministry of Health and Child Care (MoHCC) is in charge of the health-care system by superintending on policy planning, administration, the allocation of funds and co-

ordinating the responses to national health issues, amongst others (National Health Survey, 2009-2013; Osika et al, 2010). Although the system is dominated by the public sector, services are provided by both public and private players – giving a semblance of similarity to a mixture of the Beveridge and Bismarck models, which were explained earlier on. Government-operated hospitals and clinics are complemented by those run by private companies and church-based organisations (ibid). The District Health Office (DMO) supervises the primary health-care concept, the level at which rural households first receive formal health-care services.

This consists of rural clinics and rural hospitals offering both preventive and curative services. Health financing in Zimbabwe is broadly divided into public-health and private-health financing, with the former coming from the national budget to the MoHCC; while the latter comes from private health-insurance funds, household out-of-pocket spending and donor-supported health funding. During the 2000 – 2008 economic crisis epitomised by hyperinflation, running into billions per cent, the health sector experienced a severe fall in public-health funding. This period saw a reduction in health expenditure; and it was only saved by an increasing private-health expenditure (Munyuki and Shorai, 2009; Zimbabwe Health System Assessment, 2009).

After the economic stabilisation of 2009, characterised by the adoption of the multi-currency regime, there was a rebound in terms of public health funding from the national budget. Since 2009, a modest increase has been registered; however, public-health expenditure is still far below 15% of Gross Domestic Product (GDP)<sup>8</sup> (Osika et al, 2010). The bulk of private health expenditure has been borne by households through out-of-pocket spending on health-care services. Further compounding the deficit in access to healthcare and skewed resource allocation, is the continued underfunding of district health-care services, which have remained underfunded (ibid). The public health services have remained just a small part of Zimbabwe's economy, constituting less than 1% of GDP. The per capita health expenditure of (USD7 in 2009) is still below the World Health Organisation's requirements<sup>9</sup> for the country of US34 (ibid).

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<sup>8</sup> *“In April 2001, the African Union countries met and pledged to set a target of allocating at least 15% of their annual budget to improve the health sector and urged donor countries to scale up support. Years later, only one African country had reached this target. Twenty-six countries had increased the proportion of government expenditure allocated to health; while 11 had actually reduced it. In the remaining nine countries, there was no obvious trend up and down. Current donor spending varies dramatically.*

<sup>9</sup> *“WHO estimated that at least USD34 total health per capita per annum is needed to achieve MDGs in Zimbabwe for the provision of an essential package of health-care services to all Zimbabweans”.*

## 2.7 So, which health system or model is the best?

Allopathic Health delivery systems can be divided into two broad areas: National Health Services (NHS) on the one hand, and Social Security-based Health-Care systems (SSH), on the other hand. Examples of systems falling under each of the above sections have been discussed in some detail under health systems and models. The existing literature is largely inconclusive, in terms of which system performs better. The best health system or model is not easy to decipher under the many differing operating conditions in the world (Zee & Kroneman, 2007). Proponents of either system would argue that theirs is the better of the two. An analysis of the health performance of 34 countries shows that performance tends to be higher in those countries organised around the Bismarck model, than in those organised around the Beveridge model (Single-payer system). This may suggest that health systems that allow competition between insurance providers, and in which insurers operate independently of health care providers, tend to be the top performers. For example, the Canadian health model is known to be generally inefficient, with unwieldy bureaucracy, and being generally unresponsive to consumer needs. The reason being that it uses a single organisational system, which includes financing bodies mixed with providers; and as a result, it does not offer any real choice between insurers (Clougherty, 2011). On the other hand proponents of the National Health Insurance (NHI) model will argue that it is the best for the social justice principle in health by, guaranteeing the following: “The right to access of healthcare; Social solidarity, which refers to financial-risk protection for the entire population; Effectiveness through the adoption of evidence-based interventions; Appropriateness, which refers to the adoption of new and innovative health-service delivery models; Equity that ensures universal coverage with care, according to the needs; Affordability that means that services will be procured at reasonable costs; but which recognizes that health is a public good and not merely a tradable commodity, Efficiency, emanating from the creation of new administrative structures that avoids duplication across national and local boundaries” (ibid).

TM & CAM are largely neglected in the formal administration of health-care services in favour of allopathic medical services; and yet many populations in the third world countries rely on it (World Health Organisation, 2002; Abdullahi, 2011). In developing countries, a broad and growing use of

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TM is often attributed to accessibility and affordability (ibid). Therefore, it must be vigorously recognized as part and parcel of the essential health-care system. Even if there are some reservations on its efficacy and effectiveness as judged from the perspective of the western medicine angle, it must be appreciated, in order to be able to understand the mindset of its widespread consumers (who tend to patronize it by night; while during the day they pretend to shun it).

**Table 1: Comparison: UK, USA, South African and Zimbabwean Health Care Systems.**

	UK	USA	SOUTH AFRICA	ZIMBABWE
<b>Health Policy</b>	<p>1) National Health Service (NHS). A publicly funded social security health system. Similar to Medicare and Medicaid in the USA.</p> <p>2) Operates on principle of universal access.</p>	<p>1) Health care is structured more like health care is a privilege, rather than a basic right.</p> <p>2) Health care is private, except for Medicare and Medicaid</p>	<p>1) Two tier system of: large and overstretched public sector with small but fast growing private sector</p> <p>2) Public sector caters for 80% of the population</p>	<p>1) Government and local authorities provide <b>majority</b> of both primary care and tertiary facilities based on user fees. Private facilities compliment</p>
<b>Funding</b>	<p>1) Free at point of access but paid for through general taxation.</p> <p>2) Facilities operate publicly.</p>	Employers and employees share the cost of premiums, with Government subsidies for certain categories	<p>1) national treasury pays about 40% of total health expenditure</p> <p>2) Private sector run largely as commercial entity</p>	<p>1) About 8% of the population are on private schemes</p> <p>2) government services funded from general taxation and donor funds</p> <p>3) the National Aids &amp; new mobile phone levies supplement public coffers</p>
<b>Access to care</b>	Average waiting time in Emergency and Accident rooms, about four or less hours for 95% of the patients.	Average waiting time in ER rooms is much shorter, about 58 minutes.	<p>1) Challenges on equity and access</p> <p>2) Long waiting times</p>	<p>1) long waiting queues and drug stock outs in all public health facilities</p>
<b>Standards of Care</b>	National Standards of care guidelines set by the National Institute for Health Care and Excellence (NICE).	National Standards of care guidelines set by the Agency for Health Care Research and Quality (AHRQ).	<p>1) Office of Health Standards Compliance (OHSC), an independent public agency established by National Health Amendment of Act 2013, section 78.</p> <p>2) Health ombudsman.</p>	No clear national standards compliance body. Numerous bodies appear to be involved e.g. Health Professions Authority, Standards Association of Zimbabwe, Min of Health, professional boards, Hospitals Association etc
<b>Comments</b>	<p>1) The system is less responsive to consumers' needs compared to the USA system.</p> <p>2) Health professionals are paid relatively well and are highly motivated.</p>	<p>1) The need for more health care professionals is growing.</p> <p>2) Health professionals are paid relatively well and are highly motivated.</p>	National Health Insurance scheme is under trial in selected areas, hoping to bring equity and efficiency in the system.	<p>1) Demand for more health care professionals is high, but government is failing to timely and adequately remunerate those employed.</p> <p>2) Discussions on NHI scheme under way.</p>

## **2.8 Chapter Summary:**

Chapter two has looked at the description and comparison of health care systems and models in South Africa, UK, USA and Zimbabwe. This was intended to provide the context for the challenges affecting and influencing the Zimbabwean health care system. The next chapter, will look at ethical principles and their impact on health care systems, with specific reference to Zimbabwe.

## Chapter 3

### ETHICAL PRINCIPLES

#### 3.1 Introduction

This chapter will look at the implications and applications of ethical principles or theories to health systems, with a particular reference to Zimbabwe. A principlist approach, as enunciated by Beauchamp and Childress (2013), will be employed as the main approach; however, other useful theories, such as the Social Contract and the Ethics of care have also been included in order to deepen the discussion. This does not diminish other approaches that may be useful in the analysis of ethical principles and their relevance to health care.

##### 3.1.1 Principlism

Principlism is an approach which views moral problems as best approached by applying one or more basic principles to them. It is a “theory about how principles link to and guide practice in health professions and they provide an analytical framework of general norms derived from common morality” (Beauchamp & Childress, 2013). Four principles were proposed as follows:

- **Respect for Autonomy:** based on the principle of respect for others, and the idea that people should make their own independent decisions, respect a human being’s right to self-determination.
- **Beneficence:** we should act in order to do good for others, positive duty to do good for others, act in their best interests.
- **Non-maleficence:** Above all do no harm, negative duty to refrain from unnecessarily/needlessly harming others, either through acts of commission or omission.
- **Justice:** Act with fairness, treat others in a fair manner, non-discrimination, obey the law, treat patients in similar circumstances equally and use resources equitably. Provide a balance between burdens (especially of research) and benefits.

These four principles can be applied individually or in combinations to particular cases or situations in order to determine what the wrong or right thing to do is.



### 3.1.2 Principlism has its critics too

The strength of any moral theory is not its lack of criticism but how it stands up to criticism. Like any and many moral theories principlism has its own critics. The criticism of principlism can be epitomized by Walker (2009) as follows:

*“Principlism aims to provide a framework to help those working in medicine both to identify moral problems and to make decisions about what to do. For it to meet this aim, the principles included within it must express values that all morally serious people share (or ought to share), and there must be no other values that all morally serious people share (or ought to share). This paper challenges the latter of these claims. I will argue that as a descriptive claim about what values morally serious people do in fact share, principlism is inadequate; more principles would be needed to make this claim true. Furthermore, I will argue that while, taken as a claim about what principles we ought to share, principlism could turn out to be correct, it is either unsupported or unable to meet its aims. The only way in which principlists can avoid these problems is to add to the current four principles”* (p.229).

Walker strongly argues that “principlism is inadequate as a descriptive claim about the principles that people hold and which could be important in medical decision making. He further argues that it includes too little and that we need more than just the four principles to adequately capture the common morality”. Walker is supported in his criticism of principlism by Lee (2010) who says that principlism is thick in status but thin in content. He goes on to claim that principlism continued to lose focus and ended up weakening with each edition of the book (p. 525).

In spite of all criticism against it, I find principlism greatly useful because it provides common coin moral discourse and it has proven an intuitively appealing and a useful foundation for dialogue in health care ethics. It has the following advantages:

- Relatively easy to understand and apply
- Avoids too much difficult engagement with ‘high theory’.
- Provides a common language for talking about bioethical issues.
- Accessible enough to be communicated to the public-enhancing the possibility of transparency.

We will start with the ethical principle of autonomy.

### 3.2 The principle of autonomy in health-care systems

The word Autonomy originates from ancient Greece, where it was “used to refer to the self-rule or governance of city-states” (Beauchamp & Childress, 2013). The building blocks of the word autonomy come from the prefix *autos*, which refers to self; while the suffix *nomos* refers to rule, governance or law. Individual autonomy means rule of oneself free from control from outside, excluding those factors that may hinder an individual from exercising free choice, such as poor understanding, illiteracy and mental incapacity (ibid). The two issues of liberty and agency (capacity for autonomous action and choice) are arguably the most basic requirements for the existence of autonomy, in virtually all theories of autonomy.

There are a number of theories regarding autonomy. We will look at some of them:

- **Split-level theories of autonomy**

A theory of autonomy, which argues for agents to have a “capacity to reflectively control and identify with or oppose one’s basic (first-order) desires or preferences through higher-level (second-order) desires or preferences” (Beauchamp and Childress, 2013:103). A case is cited of a doctor who is torn between wanting to spend evenings with her mother at home (higher-order preference) versus working at the hospital for long hours at the same time (basic preference) (ibid). The proponents of this theory argue that without an agreement or cross validation between first- and second-order preferences, the element of autonomy would be missing. Criticisms of this theory include the fact that it runs in violation of the criterion of coherence when assessed against the principle of respect for autonomy. It is also criticised as being rigid and impractical in everyday life situations. Fewer everyday decisions would be accepted as autonomous, if held against the standards of this theory.

- **Three-condition theory**

This theory is much simpler; and it includes the three elements that make it relevant and adaptable to most everyday situations: intentionality, understanding and non-control/without controlling influences.

- i. **Intentionality:** While not excluding the unintended outcomes of any intentional action, this simply requires plans by an actor to have been purposely chosen and decided on. It does not really matter whether the outcome was not the original one intended.
- ii. **Understanding:** If the actor does not have a full understanding of what is happening, then the action is not autonomous. There are conditions that may limit understanding, such as illness, irrationality, deficiencies in the communication process and immaturity.
- iii. **Non-control:** A person has to be free of external or internal controls. Not all influences on a person are seen to be controlling.

- **Individual autonomy and health care**

When it comes to the individual as an autonomous agent interacting with the State as a major intermediary in the health-care system, few fundamental questions need to be asked. The first question is: Is it ethical for government to intervene? The second question is: which are the reasons compelling a government to intervene in the health-care marketplace? Rice (2001) cites three advantages for consumer sovereignty in health care: “Economic efficiency, psychology and fairness. The central tenet of economic efficiency is that health-care beneficiaries would be best off if they were allowed to make their own decisions about the goods and services they have. On the issue of psychology, the argument is that individuals are likely to get more satisfaction out of the goods and services they purchase if they choose them rather than have them assigned to them by some third party”. Lastly, an argument can also be made that it is better to allow individuals to decide about their own preferences in health care market place with little or no government control, rather than have their income taxed away by governments with a guarantee that the taxes will be used to provide health-care services to those taxed.

- **Is there a conflict between Autonomy, Authority, Community and Relationships?**

Is it reasonable to argue that autonomous action goes against the authority of governments, religious organizations (e.g. Catholicism, Jehovah’s Witness, Seventh Day Adventists), and other communities that prescribe how to behave or interact? Is there a limit in the exercise of autonomous decisions in the course of medical interaction, because of the patient’s subservient position on the medical professional’s authoritative position? There are some theorists who argue that autonomous

action is not congruent with the authority of governments, or other external organizations; because an individual must act on his/her own – without submitting to an authority or being ruled (Kuflik, 1984).

However, this position is not defensible. An individual can intentionally choose to accept institutional, traditional or communal direction, provided they see it as legitimate (Beauchamp & Childress, 2013). The same applies in the case of the relationship between a doctor and a patient. There is no conflict between autonomy and authority provided the authority of the health professional or government intervention is correctly presented, and is accepted by the patient or health-care consumer. Similarly, relational autonomy can be exercised through aggregates of persons, such as communities through their social interactions.

The following concepts, although very important in the elucidation of the concept of autonomy, will not be covered in this text, because of the lack of space: The principle of respect for autonomy; the capacity for autonomous choice; competence; informed consent; disclosure and freedom of choice.

- **Beneficence and autonomy implications on the Zimbabwe health-care system**

A government has a responsibility for meeting a right at least in four ways: the state must respect, protect, fulfil and promote rights (London & Baldwin-Ragaven, 2006). There are signs that the situation on the ground points to dereliction of duty on the part of the State. Autonomy should be more than just completing and signing informed consent forms in hospitals and service-provision centres. On a larger scale, autonomy is about how the health system of a country treats its citizens. Does it give them dignity, choices and respect? People have unconditional value; and they should be given respect and space for self-determination. Is it not about time we started to critically analyse governments “deep involvement in the organisation, financing and delivery of health services where they impinge on individual autonomy in making choices about healthcare?” According to Rice (2001), it is one thing for a government to have power to control and influence any number of aspects of a health system, and another to exercise that power ethically. A case in point is about Zimbabwe which has consistently failed to honour the Abuja declaration since 2001, “a voluntary agreement by majority of African governments to allocate at least 15% of their

national budgets to health” (Manzini, 2016; Kamhungira, 2016; Malaria & WHO, 2000). In Zimbabwe provision of HIV and AIDS preventive, diagnostic and curative services still lag behind its neighbours by far, in fact a gradual decline in the protection of the right to care for People Living with HIV (PLHIV). “While the Zimbabwe National Aids Strategic Plan (ZNASP 3) places rights as a guiding principle for the response to HIV, the reality is that the rights of people living with HIV are severely compromised and Zimbabwe stands way behind its neighbors in the region in terms of treatment, care and support available to PLHIV,” (Nyakudya, 2016).

We should not take for granted or even equate the integrity of a country’s health-care system with the extent of government involvement. Notwithstanding the moral obligation of a government to collect taxes, the question must still be asked: To what extent is the government using the meagre resources to enhance the healthcare of its population? Governments can positively or negatively influence the scope of public health care by such things as controlling the number of providers, the kinds of services delivered, and the introduction and spreading of new innovations. An argument can be made that by consistently underfunding the health care system (Malaria & WHO, 2000; Mbanje, 2017) the government has compromised the citizen’s autonomy with regard to choices on health services that could have been made available.

### **3.3 The principle of beneficence in health-care systems**

We ought to treat people as autonomous agents; and we also ought to refrain from harming them while contributing to their welfare. “Beneficence connotes acts of mercy, kindness, friendship, charity and similar descriptive terms. It includes all forms of action intended to benefit other persons” (Beauchamp and Childress, 2013). There is not much difference between beneficence and benevolence. The latter refers to “...a character trait or virtue of being disposed to act in the benefit of others” (ibid, p.203).

Contrary to non-maleficence, beneficence encourages a agent to assist or uplift those with whom he or she has a special relationship, such as family, friends, and neighbours etc. According to this principle, we are not necessarily required to help or benefit those without whom we have a special relationship. Beauchamp and Childress, (2013, p.203) defines the principle of beneficence as follows:

“.....a statement of moral obligation to act for the benefit of others”.

While there is a blurred line between the behaviour as an obligation versus an ideal, Beauchamp and Childress (2013 p.204) propose a *prima facie* list of rules and obligations supporting the principle of positive beneficence: “Protect and defend the rights of others; Prevent harm from occurring to others; Remove conditions that would cause harm to others; Help persons with disabilities; Rescue persons in danger”. Moodley’s (2011) application of the concept of beneficence is useful in health delivery systems; because it goes further to state that the provision of beneficial treatment requires rigorous and effective education. Without rigorous education, one cannot acquire clinical competence, an obvious ethical requirement.

While many acts of beneficence are generally understood to emanate from a moral obligation, not all beneficent acts are obligatory. Some may be carried out on a non-obligatory, based on optional moral ideals. These standards normally belong to a morality of higher moral aspiration. Persons or institutions adopt goals and practices not normally obligatory for everyone. Some of these higher beneficent acts fall into the category of supererogatory actions, which means performing beyond obligation or doing far more than that which is required.

- **The implications of beneficence regarding the Zimbabwe health-care delivery system**

The concept of social beneficence and the ethics of health and healthcare have profound relevance to Zimbabwe’s health care today. While the Zimbabwean health system has almost collapsed (Kamhungira, 2016; Kunambura, 2015), top government officials, including the State President and his family, have been able to enjoy first-class health services in Malaysia and Singapore – at the expense of the public purse. In 2016, the State President’s daughter went to give birth in Singapore and stayed there for at least a month (Zhangazha, 2016; Richards, 2011, Mushava, 2016). This goes against a general anticipation in social beneficence and social justice, that leaders and governments have a moral obligation to structure national systems in a way that avoids burdens, but provides benefits in a fair distribution by using a minimum standard of equality and access to health care.

### 3.4 Non-maleficence in health-care delivery systems

The most basic definition of non-maleficence is: “*primum non nocere* – first do no harm, or as the principle of avoiding harm or doing as little harm as possible” (Beauchamp and Childress, 2013). We should avoid or minimise harm to patients or consumers of health services, whether public or private. I subscribe to the argument of Beauchamp and Childress (2013) of not assigning any special priority ranking or hierarchical order to the grouping of the following principles and obligations of non-maleficence and beneficence: “One ought not to inflict evil or harm (non-maleficence), One ought to prevent evil or harm (beneficence), One ought to remove evil or harm (beneficence), One ought to do or promote good (beneficence)”.

Beauchamp and Childress also propose *prima facie* (not absolute, situational) rules, which help operationalise or specify the principle of non-maleficence: “Do not kill, do not cause pain or suffering, do not incapacitate, do not cause offense, do not deprive others of the goods of life”.

Not all the rules above are self-evident or self-explanatory, easy to accept and understand. It is not always clear-cut and unambiguous to decide where benefits end; and just where harm begins (Moodley, 2011). For example:

- a) When we attempt to alleviate our patient’s pain and suffering, and it results in death, is this killing or allowing to die?
- b) If we look at passive or active euthanasia – are we doing good or causing harm?
- c) In termination of pregnancy – whose interests are we serving, the mother or the foetus?

The concept of non-maleficence helps us to figure out responses to its implications to biomedical ethics where harm may occur. For example, it helps us “to examine distinctions between killing and allowing to die, intending and foreseeing harmful outcomes, withholding and withdrawing life-sustaining treatments, and extraordinary and ordinary treatments” (Beauchamp and Childress, 2013). Some authors distinguish the concept of non-maleficence from that of beneficence; while others combine them into one principle. For example, Beauchamp and Childress use an approach which makes a distinction between the two. We prefer not to conflate the two; as this would overshadow the peculiar and salient moral arguments aroused around non-maleficence on its own.

### 3.5 The principle of justice in health-care systems

The opening remarks by Beauchamp and Childress (2013, p.249) on their discussion on justice are instructive....

*“Are problems of inequality and cost truly problems of justice in health policy and health-care institutions? If so, is the problem that inequality and cost threaten access to, and proper distribution of, health care? If the answer is still in the affirmative, then we also need to answer by which principles of justice should health care be distributed?”*

Answering the above questions is not easy at all. It is like trying to answer a lottery question. Terms like “fairness, desert (what is deserved) and entitlement have all been evoked in trying to define what justice is, and what it is not. In simple terms, justice may be seen as something fair, equitable, and appropriate treatment in light of what is due or owed to persons” (ibid). Common to all theories of justice, there is a minimal requirement historically traced back to Aristotle, which says: *“Equals must be treated equally, and unequals must be treated unequally”* (ibid). This means that the vulnerable and disenfranchised in society require greater protection of their rights. Hence, greater effort must be made to provide health care for the poor and marginalized. That provokes a delicate debate about what constitutes “equal”? What is it that makes population groups different then, in terms of their entitlement to health services?

- **Right to health versus right to health care?**

The right to health<sup>10</sup> is probably the most contentious – and yet probably the most important – in many international treaties. Part of the dilemma is founded on the difficulties in defining what health is; and consequently, what optimum health entails under differing economic, social, political and cultural environments and settings. The right to health is defined as:

*“The human right to health means that everyone has the right to the highest attainable standard of physical and mental health, which includes access to all medical services,*

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<sup>10</sup> *“Health is defined by World Health Organisation as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Preamble to the constitution of the World Health Organisation as adopted by the International Health Conference, New York, 19-22 June 1946; signed on 22 July 1946 by the representatives of 61 States and entered into force on 7 April 1948. Now close to 200 states are signatories. This definition has not been amended since 1948.*



*sanitation, adequate food, decent housing, healthy working conditions, and a clean environment. The human right to health guarantees a system of protection for all. Everyone has the right to the health care they need, and to living conditions that enable us to be healthy, such as adequate food, housing, and a healthy environment. Health care must be provided as a public good for all, financed publicly and equitably. The human right to health care means that hospitals, clinics, medicines, and doctors' services must be accessible, available, acceptable, and of good quality for everyone, on an adequate basis, where and when needed.*" (World Health Organization, 2015; National Economic and Social Rights Initiative, 2016)

Right to health<sup>11</sup> includes both freedoms and entitlements as follows: "Freedoms include the right to control one's health and body (e.g. sexual and reproductive rights) and to be free from interference (e.g. free from torture and from non-consensual medical treatment and experimentation). Entitlements include the right to a system of health protection that gives everyone an equal opportunity to enjoy the highest attainable level of health." (World Health Organisation (WHO) & Office of The United Nations High Commissioner for Human Rights ,2008). Justice in health care has been aptly described by Cassell (2000):

*"...society and medicine itself have come to realize that no nation is rich enough to make available all that medicine has to offer. Accordingly, there have been many discussions on the need for some kinds of rationing, or the awareness that covert rationing already exists. With that awakening has come concern for fairness in distribution, whether the problem is seen as one of large-scale social institutions, such as governments, or of more local institutions..."*

Unlike the principles of autonomy, beneficence and non-maleficence, which focus on how we ought to treat individuals in the health system, the principle of justice in healthcare delivery deals mainly distribution and the fair allocation of scarce healthcare resources (Dhai & McQuoid-

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<sup>11</sup> Protected by the following articles: Article 25 of the [Universal Declaration of Human Rights](#)"

"Article 12 of the [International Covenant on Economic, Social and Cultural Rights](#); Article 24 of the [Child](#); Article 5 of the [Discrimination](#); Articles 12 & 14 of the [Women](#); Article XI (11) of the [Man](#); Article 25 of the [Convention on the Rights of Persons with Disabilities](#)"

Mason, 2011). Justice in general relates to fairness; and in healthcare, it refers to the fair treatment of patients. The obligations of justice, in general, may be divided, as follows (Moodley, 2011):

- a) Respect for morally acceptable laws (legal justice)
- b) Respect for people's rights (rights-based justice)
- c) Fair distribution of limited resources (distributive justice)

▪ **The implications of the concept of justice on the Zimbabwe health-care delivery system**

Justice in health care delivery means we ought to treat citizens with fairness by ensuring that the society through its government makes available resources and an enabling environment conducive to optimum health of its citizens. While the new Zimbabwean constitution has come a long way by inserting a liberal bill of rights guaranteeing the right to health, this appears to have only improved the legal justice aspect but the distributive justice aspect and respect for people's rights are still under fulfilled. For example, the government's freeze on recruitment of health professionals, including doctors, has resulted in an unworkable doctor -patient ratio of 0.8 doctors per 1000 population versus an ideal ratio of 3:1000 (Katongomara, 2016). The doctor-patient ratio has been worsening since the late 1990s (Chikanda,2008). While the country is in need of more doctors and nurses, it is actually training over 3000 doctors annually but is unable to employ them. Similarly, over 3000 qualified nurses are sitting at home (ibid). In any modern metropolitan city such as Harare, public utilities are essential to the sustenance of public health and prevention of water borne diseases. The resurgence of typhoid and cholera (Truscott, 2009; Gumbo & Ruwende, 2016) in urban centres of Zimbabwe maybe a result of the undisputed massive breakdown in public utilities such as water reticulation, sanitation, refuse disposal, provision of portable water etc. These examples illustrate the fact that there may be little attention being paid to the protection, promotion, fulfillment and respect of the justice principle in health care in Zimbabwe.

### **3.6 The social contract theory and health-care systems**

The social contract theory was initially propounded by the seventeenth century English philosopher, John Hobbes; but later on others, such as the French scholar Jean-Jacques Rousseau and the American thinker John Rawls, were also involved. Hobbes asked what it would be like if

there were no way of enforcing social rules, prompting his readers to imagine if the world had no government institutions, no laws, no police, no courts (Rachels and Rachels, 2012). This situation would create what he called a “state of nature”, where each one of us would be content to do as we please – for our own selfish end or survival. Human kind would be in a war of all/everybody against all/everyone or a state of perpetual warfare, in which a man is for man a wolf (Hampton, 1988; Boucher & Kelly, 2003).

Self-interested individuals acting on their own without restraint would make life unbearable, nasty and brutish; and consequently, if individuals were to have decent lives, they would need to have a contract between themselves based on mutual advantage (Glannon, 2005). This is the basis on which the Social Contract Theory is founded.

The state of Zimbabwean health care, or its deterioration over the years since political independence in 1980, has created what Hobbes called a state of perpetual warfare, in which a man is for man a wolf (*homo homini lupus*). The rich and political elite, as epitomised by the President and his family, do fly overseas to enjoy state-of-the-art health care; while the poor majority are left to wallow in their misery (Zhangazha, 2016; Mushava, 2016). Some of the poor citizens are forced to seek better health-care services across the borders into Mozambique and South Africa (Crush et al., 2012; Crush and Tawodzera, 2011; Maharaj and Rajkumar, 1997).

While the South African Constitution has a very advanced bill of rights, even in terms of access to public services, the influx of Zimbabweans appears to have created conflicts (Robins, 2009;) and the stretching of capacity of that government’s ability to cater for its nationals, as well as foreigners. This leaves the writer to conclude that the “Zimbabwe Social Contract” as is envisaged in its national constitution and public health laws, is dysfunctional or non-existent.

### **3.7 Other approaches**

Other theories and approaches related to health care in one way or another include the following: rights-based theories, duty-based theories, contractarianism, the ethics of care, narrative ethics and Communitarianism. The scope of this thesis is too limited to cover all these in detail. They, however, remain important to any discourse on the ethics and health care.

### 3.8 Discussion

Value judgements on the ethics of a health-care model are not easy to make. In order to assist, we propose that any health-care delivery model should be able to satisfactorily answer the following question:

- Should a patient who is not on health insurance, who turns up at the doorstep of a private health facility, be turned away because s/he does not make “good business”; because s/he has cash up-front or a valid medical-insurance cover? Would this not violate the traditional altruistic motive of medicine?

This and many other questions help to raise the debate about the contemporary mission of medicine. The bioethical principles of autonomy, beneficence, non-maleficence and justice can provide a useful framework for reflecting on aspects of human-rights instruments that expound and affect the right to health (Dhai & McQuoid-Mason, 2011). The ethical implications of the growing commercialisation of healthcare have given rise to serious, enduring reflections and debate. There are those who favour a trend towards healthcare for profit; and they argue that the increased role of entrepreneurs and competition in the health delivery will result in an efficient and effective system. For others, “the pursuit of profit is against the ethics and values central to medicine, epitomised by the Hippocratic Oath<sup>12</sup>” (Andre & Velasquez, 1988). At the end the problems maybe that without money, most professional services deteriorate into shambles.

### 3.9 Chapter Summary

Chapter three has looked at the ethical principles and their relevance and influence to health-care systems, using the principlist approach largely popularised by Beauchamp and Childress (2013). The social contract theory was discussed. The next chapter will go into more detail on the principle of distributive justice and its relevance to health-care systems.

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<sup>12</sup> *“I swear with Apollo Physician and Asclepius and Hygeia and Panaceaia and all the gods and goddesses, making them my witness, that I will fulfill, according to my ability and judgement, this oath; and this covenant.... I will apply.... (treatment) for the benefit of the sick, according to my ability and judgement; I will keep them from harm and injustice.”- Hippocratic oath*

## Chapter 4

### DISTRIBUTIVE JUSTICE

#### 4.1 Introduction

Justice has generated a plethora of debates. Terms, such as fairness, desert (what is deserved) and entitlement have all been used by many scholars and philosophers (Beauchamp and Childress, 2013). A simpler conception of justice, in would include the following: “a fair, equitable and appropriate treatment in light of what the majority are entitled to receive” (ibid). Discussion of the term ‘distributive justice’ would add an important element, to the whole debate. This is the focus of this chapter.

#### 4.2 Distributive Justice

Each society has its special economic framework, which influences the way economic benefits and burdens are distributed amongst the members of that society. These economic frameworks, which constantly change both across and within society, encompass all social institutions for economic production, as well as the social order (Lamont & Favor, 1996). They are a result of dynamic political processes, both positive and negative. The principles of distributive justice are important; because they provide a moral guideline on the political processes and structures affecting the distribution of economic benefits and burdens in societies (ibid). For example, the following questions can be argued to have their answers within the discourse of distributive justice arguments: *Should the rich be taxed at the same level as those living below the poverty datum line? Should all citizens be entitled to subsidized public health services, regardless of their income levels? Who should carry the burden of participating in research, the poor or the rich?* This is what constitutes the discourse about distributive justice.

### 4.2.1 Theories of distributive justice

Beauchamp and Childress (2013) approach the issue of distributive justice from the angle of what they term ‘theories of justice’. This approach is logical and easier to illustrate the basic concepts on the issue of distributive justice. The four major/traditional theories of distributive justice are clearly spelt out by Beauchamp & Childress (2013). These are: Utilitarianism, Libertarianism, Communitarianism and Egalitarianism. They have added two more recent theories: Capability and the Well-being theories.

#### ▪ Utilitarian theories

“Utilitarianism argues that policies should be judged by their consequences; and they should promote the benefits of achieving the greatest good for the greatest number of beneficiaries” (Beauchamp & Childress, 2013). Therefore, in this theory, the standard of justice is based on the principle of utility. The implication for public health care resource allocation is that as many people as possible should be supported by the available resources. The utilitarian theory was popularised in the nineteenth century by John Stuart Mill and Jeremy Bentham. Utilitarianism can further be divided into objective and subjective utilitarianism (ibid). Objective utilitarianism is based on achieving the maximum benefit from the available resources through emphasis on individual benefits defined in measurable terms. Examples include indices, such as Disability Adjusted Life Years (DALYs). Subjective utilitarianism, on the other hand, similarly focuses on the consequences, but without emphasizing the importance of a metrics or indices. Instead, individuals and consumers are allowed to apply their own valuation. Many economists subscribe to this type of utilitarianism, on the basis that consumers are the best judges. Techniques, such as cost-benefit analysis are used (ibid).

Even though utilitarian theories face a number of controversies on their application as general theories of justice, they are helpful in the analysis of health policies, especially in publicly supported institutions.

#### ▪ Libertarian theories

Unlike Utilitarianism, Libertarianism “focuses on the importance of rights and opportunities of individuals rather than on the consequences to society as a whole” (Moodley, 2011; Beauchamp and Childress, 2013). Only negative rights deserve protection, such as rights guaranteeing

individual freedom, such as freedom of speech (ibid). There is little support for State intervention in providing services – with the biggest fear being that such an active government involvement could end up being authoritarian and intrusive, and thereby reducing freedoms of individuals. In extreme cases libertarians oppose restrictions on drug use; they oppose even limits on such issues as abortion or even the licensing of doctors (ibid). Liberalism is similar to Communitarianism, insofar as both are often considered to focus more on political than on the moral aspects of social interaction (Glannon, 2005). However, the former differs substantially from the latter on the basis that liberalism says that there should not be one conception of the good, or only one overarching moral value by which all individuals live and share. According to liberalism, the interests and rights of individuals should not be sacrificed for the interests of the larger society (ibid).

The implications for health care are that this theory of distributive justice is based on the ability of individuals to pay for their health care. This tends to support private healthcare, with those who can pay being entitled to it (Moodley, 2011). The argument goes so far as to say that “Governments act coercively and unjustly when they tax the wealthy at a progressively higher rate than those who are less wealthy, and then use the proceeds to underwrite State support of the indigent through welfare payments and unemployment compensation” (Beauchamp & Childress, 2009, p.255).

- **Communitarian theories**

Communitarianism is based on the foundation that argues for the “positive rights of individuals, such as the right to health” (Beauchamp and Childress, 2009). It can be traced to traditions expounded by such scholars as Aristotle, Hegel etc. Communitarianism is not a single theory, but a collection of theories with a similar philosophical focus (ibid, p.257). Unlike in liberalism, in Communitarianism, there is little sympathy with theories based on individual rights and contracts. Individual conceptions of good cannot be divorced from the community in which such individuals live (Glannon, 2005). The common good must take precedence over the good of the individual. In this theory, the principles of justice are seen as pluralistic with communities encouraged to decide on how to allocate resources to health-care needs identified by the community itself. Community health needs take precedence over individual health needs.

Communitarianism can be divided into two main categories: Universal and Relativist Communitarianism. The former emphasizes the belief that “a single universal model should be for the good individual and the good society. While the latter form of Communitarianism recognises the wide variety of cultural practices in the world – with the emphasis on each community doing and deciding, on the basis of its own norms and mode of social organisation” (Rasmussen,1990; Bell, 1993; Tam, 1998; Kymlicka,1988). However, there are those who strongly oppose the plausible association with, or the use of utilitarianism or communitarianism as a basis for public health ethics. They argue for a different ethical foundation for public health organisation from those of Communitarianism or utilitarianism (Rauprich, 2008).

Communitarianism theory would help health-policy makers to reflect fully on such questions as: Given the limited resources, as is often the case worldwide, should we try to use the limited resources for extending life using palliative care and end-of-life futile treatments? According to Communitarianism, reasoning answers to such questions cannot and should not be resolved at the individual level but at community level. These issues require a shared understanding of the goals and values (Glannon, 2005 p.17).

The criticism of Communitarianism is based on the fact that consensus is very difficult to achieve on such issues as the goals of medical treatment at the end of life. While some people may value palliation and the so-called “futile” treatments; others may argue that the withdrawal of such treatments equally threatens the dignity to the patient. Not all patients and families have the same values and wishes about end-of-life care. Therefore, it may be argued that Communitarianism on its own curtails the freedom of individuals to act in line with their self-determination.

Both elements of liberalism and Communitarianism are needed to debate and agree upon such questions as the importance of healthcare, compared to education, environmental protection, and other social goods (ibid).

#### ▪ **Egalitarian theories**

The Egalitarian theory is based on the foundation that “all humans must be treated as equals; because they are created as equals and have equal moral status” (Roemer, 1998). Some of the most celebrated writers on this theory are Locke and Rawls (Beauchamp and Childress, 2013). Expanding on the hesitation of Rawls to apply his egalitarian theory to health care, Norman Daniels maintains that (Beauchamp and Childress, 2013):



*“..Argues for a just health care system based primarily on these principles, with a special emphasis on what Rawls called fair equality in opportunity...Daniels argues that health-care needs are special and that fair opportunity is central to any theory of justice. Social institutions affecting health care distribution thus should be arranged...to allow each person to achieve a fair share of the normal range of opportunities present in society”.*

No single egalitarian theory argues for an absolute distributive principle requiring the sharing of all social benefits to all persons (ibid). In contrast to the libertarian, this theory emphasizes the “positive rights of individuals, such as the right to health. As a result of this position, it is more likely to support strong State action or intervention to express and assure such rights, such as, for example, providing a guaranteed level of services or the resources needed to assure equality of access” (Veatch, 1998).

Daniels is also famous for drawing a distinction between the pursuits of health versus the health care. He says health is an inappropriate object to pursue; but rather the focus should be on health care and all the actions that make the achievement of such a possibility. “Thus, a right claim to equal health is best construed as a demand for equality of access to entitlement to health services” (Ruger, 2004).

I find the argument of distinguishing social goods from natural goods as being very compelling. In this argument, health should not be seen as a social good, but as a natural good; and as such, it cannot be distributed in the same way as social goods, such as political rights or income (Norheim & Asada, 2009). This distinction between natural and social goods, while at the same time, placing health in the latter category is not without its critics. It has been criticized on the basis that health is as much a product of social interactions, as other social goods. An example of the improvement of life expectancies since the late 1970s, especially in the developed countries, is often cited as an illustration of the impact of technological advances and improvement in social living conditions (Norheim & Asada, 2009 p .4).

Egalitarianism places “a premium on the responsibility of the government to provide a minimum quantity and quality of life for all, and to provide the health care needed to guarantee that minimum. The strong argument of egalitarians is that it is best to finance health-care services with redistributive taxes, unlike the libertarians, who view taxation as theft” (Ruger, 2004). Perhaps the most prominent highlight of this theory is its zeal to address the unfairness of the distribution of

health care between the haves and the have-nots, e.g. between rural and urban communities – to ensure that everyone has some minimum level of opportunity.

- **Capability theories**

This is one of the two so-called ‘Recent theories of justice’. Both of these theories are argued to have reoriented discussions about justice in biomedical ethics. Based largely on a response to Rawls’s egalitarianism, these theories are said to have also been heavily influenced by Aristotelian theories on moral virtue and moral excellence (Beauchamp and Childress, 2013; Rugar, 2004). “The fundamental basis of the capability theories is premised on the argument that the quality of people’s lives is dependent on what they are able to achieve; and a life well lived is one in which individuals sustain and exercise a group of core capabilities. The opportunity to reach states of proper functioning and well-being are issues of basic moral significance” (ibid). A minimal level of social justice requires the availability to all citizens of ten core capabilities, as follows: “Life; bodily health; bodily integrity; senses, imagination and thought; practical reason; affiliation; species; play; control over one’s environment” (Claassen and Duwell, 2013).

- **Well-Being theories**

While the capabilities theories are premised on the abilities and opportunities required for well-being, the well-being theories focus on well-being itself. The argument in these theories is premised on the glamorous ingredients, such as the freedom to act, enabling training etc. The enabling resources are not fundamental to justice; since these conditions are valuable only as means to the proper distribution of well-being (Beauchamp and Childress, 2013). Social justice should be concerned with human well-being – not merely with the capabilities for well-being or with a single form of well-being, such as health. Six core dimensions of well-being are proposed as follows (ibid): “Health, personal security, reasoning, respect, attachment and self-determination. The focus of justice should be to secure a sufficient level of each dimension for each person”. A health policy will be judged as just in the societies and in the global sphere, depending on how well it satisfies these dimensions.

### 4.2.2 Justice in health care

Although there may appear to be great diversity with the problems with health care delivery in many countries, the major bone of contention is on: Who shall get what share of a society's resources. The fundamental economic hurdle to accessing health care in many countries is the lack of resources to pay for care. There are two principal arguments, which support the "moral right to government-funded care. Amongst others, the collective social protection and the fair opportunity arguments stand out prominently" (Beauchamp & Childress, 2013). The design of a health-care system that conforms to a human-rights paradigm must be guided by the following seven parameters (World Health Organisation (WHO) (2015):

- i. Universal accessibility;
- ii. Availability;
- iii. Acceptability and dignity to consumers;
- iv. Good quality;
- v. Non-discrimination;
- vi. Transparency; and
- vii. Accountability.

#### ▪ The collective Social-Protection argument

The basis for this argument is that health needs are inherently similar to other needs that are traditionally protected by government, such as crime, fire, and pollution. Therefore, if collective actions and resources have been used to protect the public against those other threats, why not for health needs or threats as well? The proponents argue that consistency is required here (Devereux et al., 2011). Additional arguments for the support of this position are based on an expectation by society for a decent return on the investment it has made in training doctors, the funding of biomedical research and other parts of the medical system. There is a need for reciprocity – with society being expected to give a proportional return on the benefits received from individuals' contributions, such as taxation. The major criticism of this argument is on the grounds that government responsibilities are not obligatory, neither are they essential. This is mainly the argument advanced by libertarianism (Devereux & Sabates-Wheeler, 2008).

- **The fair-opportunity argument**

This argument rests on the basis that: “The justice of social institutions should be judged by their tendency to counteract the lack of opportunity caused by unpredictable misfortunes, over which the person has no meaningful control” (Beauchamp & Childress, 2013 p.272). It argues that the need for health care is even higher amongst the seriously diseased and injured; since, for them, the costs of care become even more overwhelming and unattainable. Justice requires that these people be assisted; because without amelioration of their predicament, they will not function to full capacity, in order to have a fair chance to use their capabilities.

### **4.3 Protection for consumers of health-care services**

Health policies and programmes have the ability to either promote or violate human rights. Violations, or the lack of attention to human rights can have bad effects on health. Examples include “keeping people with mental problems in institutions against their will. Women are frequently denied access to sexual and reproductive health-care services; women in certain societies are forced into procedures such as sterilization, abortions, virginity examinations and genital mutilations” (Cook, 1993). International and domestic statutes support and uphold this autonomy, justice and protection of the right-to-health principle. Examples include the following: The international Bill of Rights, The African Charter, the National Constitution and the Ministry of Health and Child care (MOHCC local patients’ charter).

#### **4.3.1 Statutes protecting the Right to Health**

Protection and promotion of the health of societies and populations have come a long way. As a result, it is almost universal that most international, regional and local/national statutes try to include sections that claim to protect and promote the right of populations or specific groups to health. The following are some of the most well-known regional and national statutes:

#### 4.3.1.1 The African Banjul Charter on Human and Peoples' Rights

The African Charter recognises the justice<sup>13</sup> principle in general, but with poor reference to health matters. It is very limited in its guarantees for the right to health for the general populace, except in specific areas, where it appears to single out women<sup>14</sup> for protection. This is probably its single greatest weakness, when it comes to protection of the right to health.

#### 4.3.1.2 The Universal Declaration of Human Rights (UDHR)

The Universal Declaration of Human Rights (UDHR) states that, “Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing, medical care and the necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of a livelihood in circumstances beyond his control”<sup>15</sup>. This is the only part or article of the whole document, which refers to the right to health. The UDHR was an aspirational document which expressed hope for a better future, and arose as a direct response to revulsion at the way the value of human dignity and values were degraded by Nazi policies that treated vulnerable groups such as jews, homosexuals, gypsies and other groups like lesser humans (London & Baldwin-Ragaven, 2006).

#### 4.3.1.3 Constitution of Zimbabwe

In 2013, Zimbabwe adopted a new constitution<sup>16</sup> replacing the much-maligned Lancaster House constitution of 1979, previously amended countless times. The big question is whether the new constitution is improved, especially when it comes to guaranteeing and protecting the right to health of the citizens. It is encouraging to note that the new constitution indeed has improved protection for citizens, when it comes to health care. Chapter 4, section 76 is instructive in this regard:

**Section 76.** *“Every citizen and permanent resident of Zimbabwe has the right to have access to basic health-care services, including reproductive health-care services.*

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<sup>13</sup> Articles 2,86,87,88 of the African Charter.

<sup>14</sup> Articles 14,18,20,21,23,24

<sup>15</sup> Article 25

<sup>16</sup> Zimbabwe New constitution amendment no. 20

- 1) *Every person living with a chronic illness has the right to have access to basic health-care services for the illness.*
- 2) *No person may be refused emergency medical treatment in any health-care institution*
- 3) *The State must take reasonable legislative and other measures, within the limits of the resources available to it, to achieve the progressive realisation of the rights set out in this section”.*

In order to enable the fulfillment of the right to health principle an enabling environment is essential. To that end there is often a need for the operationalization of other rights in conjunction with the constitutional provision for the right to health. Section 77, also under chapter four of the new constitution can be viewed in the light of being an enabler to the right to health in section 76:

**Section 77.**

“Every person has the right to:

- a) *Safe, clean and potable water; and*
- b) *Sufficient food.*

*And the State must take reasonable legislative and other measures, within the limits of the resources available to it, to achieve the progressive realisation of the rights set out in this section”.*

- **Civil, political and socio-economic rights in Zimbabwe**

The new Zimbabwean constitution is marvelous because it also guarantees the civil, political and socio-economic rights of the citizens of the country. However, there is a need to translate these guarantees into a reality for the intended beneficiaries, the citizens of Zimbabwe. Studies have shown a greater need for a more rapid realization of this category of citizen rights (Rutherford,2001; Raftopoulos & Phimister, 2004).

#### **4.3.1.4 Health-Consumer Protection in general**

Civic, statutory and non-statutory bodies can play a meaningful part in the fulfilment and promotion of health-consumers’ rights in any country and society. For example, South Africa<sup>17</sup>,

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<sup>17</sup> *Treatment Action Campaign, National Consumer Protection Act 68 of 2008, Health Professions Council of SA National Patients’ Rights Charter*

Australia<sup>18</sup> and USA<sup>19</sup> have vibrant civic involvement in the protection of health-care consumer protection. In Zimbabwe, the main statute on patient protection is the Patients' charter of the Health Professions Authority of Zimbabwe, with an explanation to members of the public on how to lodge a complaint against a health practitioner. It directs any complainant to first identify the relevant professional council to which the health practitioner belongs; and then to forward a written complaint to that applicable council. If the members of the public are not satisfied with the response from the applicable council; then they can appeal to the HPAZ. The Health Professions Authority of Zimbabwe has seven professional councils (equivalent of Health Professional Boards in South Africa); and these include the Medical and Dental Practitioners' Council, a Nurses' Council, a Pharmacy council, Environmental Health, Medical Laboratory Science, Traditional Healers, radiography and radiotherapy. South Africa is credited with having one of the most-advanced Constitutions in the world<sup>20</sup>. Consequently, it is interesting to use it as a benchmark against that which other national constitutions and civil rights protections are measured. When one focuses on health consumer protections, via patient charters of both countries, a huge variation is discernible. The Patients Charter of the Health Professions Authority of Zimbabwe<sup>21</sup> (HPAZ) appears to be quite shallow and limited in its scope compared to the South African version<sup>22</sup> under HPCSA.

While both charters focus on guidelines to patients' rights to access and treatment, the South African charter goes deeper; and it even touches on the rights of the health consumers, as far as they should be informed about the entitlements and privileges under their medical aid scheme, the patient's right to be referred for a second opinion on request, the right to refusal of treatment, and the responsibilities of the patient. The protection against poor service and the mistreatment of consumers in the UK health care system is much more robust under each of the professional councils. The General Dental and Medical Councils (GDC, GMC) have quite advanced, detailed and extensive information on their websites, including tips to potential witnesses to disciplinary

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<sup>18</sup> *Australian Charter of Health care rights*: <http://www.safetyandquality.gov.au/national-priorities/charter-of-healthcare-rights/>

<sup>19</sup> *Consumer Federation of America, National Bureau of Consumer Protection*

<sup>20</sup> *Source*: <http://www.southafrica.info/about/democracy/constitution.htm#.VrJYZNJ97IU>

<sup>21</sup> *Health Professions Authority of Zimbabwe Patients Charter*:

[http://www.hpa.co.zw/index.php?option=com\\_content&view=article&id=62&Itemid=79](http://www.hpa.co.zw/index.php?option=com_content&view=article&id=62&Itemid=79)

<sup>22</sup> *national patients' rights charter*:

[http://www.hpcs.co.za/downloads/conduct\\_ethics/rules/generic\\_ethical\\_rules/booklet\\_3\\_patients\\_rights\\_](http://www.hpcs.co.za/downloads/conduct_ethics/rules/generic_ethical_rules/booklet_3_patients_rights_)

hearings. For example, the GMC has on its website interactive sections for the public on “your concerns about the doctors”, good clinical practice, what to expect from your doctor – a guide for patients, a list of doctors under investigations, hearings and decisions, help for witnesses etc. The GDC appears to offer even more information, tips and assistance to the public for their own protection from any potential violation of their rights. It goes further, to provide a guide on the standards of care to be expected, downloadable patient information and educational leaflets.

#### **4.4 Discussion**

No single moral principle has the absolute capacity to address all the problems of justice. What is important is to find out how several principles can be balanced and specified – with the aim of equity in health care and public health. It must be accepted that scarcity may force a government, society or an organisation to make unusual choices and infringe, compromise or violate the valid principles of justice, in order to make “ends meet”. The million-dollar question is: To what extent can the shortages, deprivation and health-care deficits obtaining in any country, such as Zimbabwe, be justified because of the government being unable to adequately finance healthcare?

The right to health is not without its own controversies. A common misconception is to confuse the right to health and the right to be healthy. The right to health is not the same as the right to be healthy. The State cannot guarantee us good health; because good health is influenced by several factors outside the State’s control – amongst them, “an individual’s biological make-up, and socio-economic conditions. Rather the right to health refers to the right to the enjoyment of a variety of goods, facilities, services, and conditions necessary for the attainment of good health, rather than any unconditional right to be healthy” (Office of the United Nations High Commissioner for Human Rights-OHCHR, 2008).

A country’s difficult financial position does not absolve it from having to take action to realize the right to health of its citizens. A state actor cannot cite financial limitations as an excuse for not providing full citizen enjoyment of the right to health. Obligations by States to fulfill and help create a conducive environment for enjoyment of the right-to-health falls into three major categories (ibid p22-27): the obligation to respect, the obligation to protect, the obligation to fulfill. Some feel that health care should not be considered a human right; because of the difficulty in defining it, as well as establishing what the minimum standard of it is. It is further contended that



because generally the fulfillment of rights calls upon others to protect and guarantee them, when it comes to the right to health; it is not clear who has that responsibility (Barlow, 1999; Berkeley, 1999). A further criticism of the right to health is that it does not emphasize the huge responsibility placed upon the individual to uphold his or her own health (ibid).

Yet another major criticism is that because a right is something that is to be defined, interpreted and defended at all costs by the judiciary of any country, it is futile to make health care a right. That would force governments to spend large portions of their resources to provide its citizens with it – without much success. They further argue that the right to health is based on a misplaced assumption of unlimited resources, which in fact, are very limited. It is better to channel resources to social services. This would create a healthier society (Lamm, 1998; Loeffler, 1999).

Even if there were a consensus on the right to health and health-related goods and services, the other problem would be how to specify the entitlements. One approach would be to propose a right to equal access to health resources. However, that too is loaded with criticisms because of the ambiguity on whether it requires that others must provide anything in the way of goods, services or resources. Libertarians oppose this position; and they prefer not providing anything from public funds; although they are strongly opposed by other general theories of justice (Moodley, 2011). Perhaps a more attractive goal, and one likely to be achievable, as well as being more realistic, is the right to a decent minimum level of health care. This is based on the egalitarian theory of justice, premised on universal accessibility to fundamental health care and health-related resources (Buchanan, 2009). The proposal has a two-tier system: tier one being an enforced social coverage for basic and catastrophic health needs; while tier two is voluntary private coverage for other health needs and desires.

The first tier would meet the needs for universal access to basic services, such as public health protection (e.g. immunisations, family planning), primary health care, acute care, disability services. There would still be a need to acknowledge that social nets in health care are not limitless. Tier-two would cover better services, such as luxury hospital rooms, optional dental work, such as crowns and bridges, dental implants, tooth whitening – purchased at personal expense, through private health insurance or out-of-pocket spending.

While not completely free of criticism, the decent minimum of health care appears to be a more practical compromise among the various theories of justice; because “it covers many of the moral arguments common among most of the theories. It guarantees basic health care for all, on a premise

of equal access; while allowing unequal additional purchases by individual initiative, thereby mixing private and public forms of distribution” (Beauchamp & Childress, 2013; Buchanan, 2009). A number of shortcomings have been cited in the Zimbabwean health-care system, which seem to suggest a gross departure from many of the above standards for a human-rights based health-care system; because the political elite are frequently reported to seek better health care services in the ‘Asian Tiger Countries’ at the tax-payers’ expense (Mushava, 2016; Zhangazha, 2016; Richards, 2011; Chipunza, 2016).

## **4.5 Chapter Summary**

This chapter has focused on the concept of distributive justice in some detail. It discussed the popular theories often associated with distributive justice: utilitarian, libertarian, communitarian, egalitarian, wellbeing, and capability theories. In addition, this chapter looked at the protection for consumers of health care, assumed to be provided by statutes, and their possible limitations. The next chapter will look at health-care rationing, priority setting and financing.

# Chapter 5

## HEALTH-CARE RATIONING, PRIORITY SETTING AND FINANCING

### 5.1 Introduction to the chapter

This chapter explores the issues on health-resource allocation, rationing and the setting of priorities and financing. Zimbabwe has been facing chronic underfunding of its health-care system for quite some time now. The problems of underfunding appear to have reached a crisis level of late (Murwira, 2016; Al Jazeera English, 2014; Tawona, 2015; Kamhungira, 2016; Nherera, 2014). This raises key ethical and value-judgment issues in the financing and provision of health care in the country.

Rationing is an inevitable necessity, whether in the life of an individual, that of a country, or an organisation, or even in the global context. This is also the case with health-care resources, which need not be overt or explicit. Health-care resources are quite often implicitly rationed. Whichever way rationing is examined, whether justified or not, the consequences are limits to access in beneficial health-care services (Ubel & Goold, 1998). If this assumption is accepted, then the central question is no longer whether health-care services will be rationed; but it becomes that of how, by whom and to what degree rationing is going to be done. Obviously, the major ethical dilemma is how to balance the concepts of autonomy, beneficence and justice (especially distributive justice).

This chapter will reflect on ethics of health-care financing, priority setting and benchmarks in health-care budgetary provisions.

### 5.2 Accountability for reasonableness

The need to come up with a fair process of setting up limits to health care is an inescapable expectation. Although there are plausible ways which appear to give a temporary avoidance or solution to the demands of legitimacy and fairness in setting health priorities, they are not substitutes for the proper process of “..... *transparency about the grounds for decisions, appeals*

*to rationales that all can accept as relevant to meeting health needs fairly, and procedures for revising decisions in light of challenges to them” (Hasman and Holm, 2005).*

According to Daniels and Sabin (2002, 2008) “public accountability has obvious appeal because disclosure informs our consent to both treatments and choice of providers and health insurance plans. This informed choice in turn expresses our autonomy as well as helping markets to work responsibly and efficiently”. There are two distinct notions of public accountability:

- i) **Market accountability:** options and choices must be made available to purchasers and membership in health plans so that they make informed choices. This is the only way consumers and purchasers can force providers to improve quality of care. However, market accountability alone won’t solve the legitimacy and fairness problems and hence the accountability for reasonableness (A4R).
- ii) **Accountability for reasonableness:** a framework for the process of priority setting with four distinct components as follows: publicity, relevance, revision and appeals and enforcement/regulation. *“It is an idea that the reasons or rationales for important limit-setting decisions should be publicly available and these reasons must be ones that fair minded people can agree are relevant to pursuing appropriate patient care under necessary resource constraints”*  
(Daniels and Sabin, 2002 p.44).

These four components, working in unison, emphasize reason giving thereby creating successive opportunities for all interested stakeholders to evaluate the priorities. Daniels and Sabin (2002, 2008) have consistently argued that these elements assure accountability and reasonableness. They further argue that in a democratic and pluralist society reasonable disagreements about principles that govern priorities setting are bound to arise but the A4R process allows us a fair process to agree on what is legitimate and acceptable and if not acceptable sufficient appeal mechanism is provided to redress the anomalies. We agree with Daniels and Sabin’s arguments however with a caveat that unless if the country or society has a general positive democratic culture the A4R process may be very difficult to implement, especially on the consultative and appeals aspect of it. Zimbabwe is not a country best known for observing, protecting, promoting, respecting and fulfilling citizens’ rights in general. A lot has been documented regarding the country’s trampling of citizens’ rights, including violent electoral practices (Moyo, 2011; Sachikonye, 2011; Hatchard, 1993).

### 5.3 Allocation of health budgets, priorities and rationing

Resources are not limitless or infinite. Allocation decisions will definitely impact on other deserving areas. Nevertheless, a choice or selection must be made from amongst several desirable programmes. Rationing can be defined as “*occurring when anyone is denied (or simply not offered) an intervention that everybody agrees would do them some good and which they would like to have*” (Maynard, 1998; Glannon, 2005). According to Beauchamp and Childress (2013p280-1), “there are four distinct types of allocation, which are also very interrelated: Partitioning the comprehensive social budget, allocating within the health budget, allocating within targeted budgets, and allocating scarce treatment for patients”.

#### ▪ **Partitioning the comprehensive social budget:**

Every country or State has to divide the available resources amongst many competing social needs, such as education, housing, security etc. Health care is not the only social need in a country. Social justice demands an allocation to health-care needs commensurate with a decent minimum package for health care. The following are important and related questions: What percentage of Gross Domestic Product (GDP) is regarded as adequate for health? What is the quantum of spending by a country on its health needs? These questions can be asked with many different aspects of health spending in mind, for example with absolute terms or relative to income (Savedoff, 2005). A more holistic approach would be to go beyond the public budget and even include even policies on individuals and households spending patterns on health. Savedoff (2005) identifies four different approaches that can be used to identify and answer questions on how a country should spend on health. The approaches are:

- i) The peer pressure approach: an approach based on spending comparison between countries with similar characteristics.
- ii) The budget approach; identifies desired health outcomes and a calculation of what is required to be purchased.
- iii) The political economy approach: instead of asking “how much should a country spend on health?” a hypothetical question is asked as follows: “why is my country spending more or less on health than it should?”

- iv) The production function approach: based on explicit estimates on health production function as well as data analyses.

- **Allocating within the health budget:**

Once a budget has been made for health care, a decision still has to be made regarding which of the several areas of health care need to be prioritised. These include disaster management, primary health care, hospital services etc. This is known as allocating within the health budget.

- **Allocating within targeted budgets:**

Once a specific budget has been made for a particular sector of health care, e.g. preventive services – then a specification of particular programmes and projects still has to be done. For example, within preventive-health services, one may prioritise vaccinations and screening for communicable disease, as opposed to the prevention of rare and novel infections, such as ebola, zika etc.

- **Allocating scarce treatments for patients:**

Maynard (2001) argues that it is important to bring “the economic paradigm to the resource allocation for health debate; since scarcity is ubiquitous; and therefore, we all have to accept rationing as a fact of life. It is not a question of whether to ration, but rather how to ration”.

- **Types of rationing:**

“Rationing can affect three dimensions of coverage: breadth (share of the population covered), scope (which services are covered) and depth (the extent or cost share to which services are covered)” (Teutsh & Rechel, 2012). There are three main substantive principles of rationing: “need principles, maximizing principles and egalitarian principles” (Cookson and Dolan, 200). The need principles require that health care be distributed, according to or in proportion to the “need”. An example of need is “immediate ill health”. Maximizing principles require that health care be distributed, in order to achieve maximum benefit, e.g. maximum population health. Egalitarian

principles require that health care be distributed, in order to reduce health inequality. It can be deduced that the maximizing principle of Cookson and Dolan (2000) has a utilitarian underpinning. Beauchamp and Childress (2013 p284) give rationing at least three meanings or types. The first one is related to denial from lack of resources (in a market economy all types of goods are rationed by the ability to pay). The second type is not determined by ability or inability to pay, but from social-policy limits; as in government setting, an allowance or allotment and individuals being denied access beyond the allotted amount. Examples are the rationing of food or gasoline during periods of instability, such as war. The third meaning of rationing refers to an allotment or allowance distributed equitably to the population. However, unlike the first two types, in this type of rationing, those who can afford additional goods are not denied access beyond the allotted amount.

It may be argued that this third type of rationing, as defined by Beauchamp and Childress (2013), has a combination of egalitarian and libertarian principles in it because of the combination of a basic equitable allotment of health care, but with the freedom for additional purchases for those who can afford them.

Rationing is often a highly emotive exercise to determine which areas must be receiving priority from the health budget (ibid). Should more of the health budget be used on curative services or preventive services? Utilitarianism tends to argue for the use of the health budget in a way that maximizes the public good for the greatest number of people. Therefore, preventive services tend to carry a greater priority from a utilitarian perspective; while other theories, such as the egalitarian perspective may argue for the fair inclusion of such procedures as heart and kidney transplants; since it is seen as being discriminatory to neglect such areas.

## **5.4 Health financing**

Health financing is very important in any country's health-care provision. "It provides the resources and economic incentives for the operation of health systems. It is a key determinant of health-system performance, equity, efficiency and health outcomes" (Schieber et al., 2006). Health financing focuses on how financial resources are created, distributed and utilized in health-care systems. The ideal situation for any health-policy thrust is a focus on how to move closer to a

universal coverage of health care (World Health Report, 2010). To achieve that the following areas are critical:

- Where and whence to raise sufficient funds for health;
- How to overcome financial barriers that exclude many poor people from accessing health services; and
- How to provide an equitable and efficient mix of health services?

To achieve optimum health financing, we need to consider financing functions, which are discussed in the following section.

### 5.4.1 Health-Financing Functions

“Health financing involves the very important and basic functions of revenue collection, pooling of resources and the purchase of interventions on behalf of consumers. Depending on the health policy of a country, these basic financing functions may translate into” (Evans and Etienne, 2010; Gottret and Schieber, 2006): raising sufficient and sustainable revenues, pooling and purchase of health services. These financing functions can generally be grouped into three main health-financing models, as follows:

- i. **National Health Service (NHS):** “A compulsory universal coverage, national general revenue financing – with a national ownership of health-sector inputs” (Davis, 1975).
- ii. **Social insurance:** “Compulsory universal coverage under a social security, which is a publicly championed system, financed by employee and employer contributions to non-profit insurance funds with public and private ownership of the sector inputs” (Hsiao and Shaw, 2007).
- iii. **Private insurance:** “This is employer-based or the individual purchase of private health insurance and private ownership of health-sector inputs” (Colombo and Tapay, 2004; Sekhri and Savedorf, 2005)



**Table 2: Comparison of Alternative types of financing methods in terms of risk pooling, equity and efficiency**

<b>Financing method</b>	<b>Risk pooling</b>	<b>Equity</b>	<b>Efficiency</b>
<b>General revenue e.g. NHS</b>	Widest risk pooling	Most equitable	Inefficient
<b>Social insurance</b>	Within the covered population	Can be redistributive within the covered population	Moderate/good efficiency
<b>Private insurance</b>			Inefficient (high administration costs)
<b><i>Group</i></b>	Within a group	Can be redistributive within a group	
<b><i>Individual</i></b>	Within an age/sex group	Less equitable	
<b>Community Financing</b>	Within a community	Can be redistribution within a community	Moderate efficiency
<b>Out of pocket payments and User fees</b>	No risk pooling	Least equitable	Most efficient (though can be hard to collect)

**Source: <http://go.worldbank.org/I9NCO1V9N0>**

#### **5.4.2 The Abuja Declaration**

“In September 2000, 189 heads of State adopted the Millennium Declaration, which sought to improve the social and economic conditions in the world’s poorest countries by 2015” (WHO, 2011). Many of these poorest countries were to be found in Africa, especially the sub-Saharan African region. In tandem with this declaration, eight goals were devised as a way of monitoring progress, with three of these so-called Millennium-Development goals (MDGs) focusing on health; while two more have components relating to health (ibid). Subsequently, in April 2001, heads of State of the African Union (called the Organisation of African Unity at the time of the meeting) countries met at important meeting Nigeria, in a city called Abuja, to address the challenges of HIV/AIDS, Tuberculosis, Malaria and other related infectious diseases (Union, 2001; Malaria and WHO, 2000). They voluntarily agreed set a target of allocating at least 15% of their annual budget to improve the health sector. Simultaneously, they pleaded with donor countries to fulfill a previously promised target of 0.7% of the donor countries’ Gross National Product (GNP), as official overseas development assistance (ODA) to developing countries (ibid).

In terms of the ODA, five of the 22 countries, who are part of the Organisation of Economic Co-operation and Development Countries (OECD) were already contributing at least 0.7% of their GNP to ODA. Sensing this request and the expectation from African countries, as an opportunity to build up solidarity, the donor community made further promises at the 2004 G8 summit at Gleneagles in the UK (ibid). The issue of African countries always complaining about lack of lack of funding is a perennial problem, in our opinion, almost becoming like the analogous “spoilt child”.

- **Africa: The case of an “over-spoilt Child”**

By 2011, ten years after the Abuja declaration, only three African countries or OAU members were on-track with respect to MDGs; whereas 27 countries had made no progress, or insignificant progress. One of the few encouraging news items was that 26 countries had increased their total government expenditure allocated to health, but without reaching the “self-declared target of 15%”. Only one country (Tanzania) had reached the golden target of 15% of annual budget allocation to health. Sadly, 11 countries had even reduced their budget allocation to health during the 10-year period from 2001 and 2011.

In the other 9 countries, there were insufficient data to assess whether there was an upward or downward trend (WHO, 2011; Mburu et al, 2014). This last group includes Zimbabwe.

## **5.5 Zimbabwe: health-financing scenario**

Between 2000 and 2006, the allocations towards health in the total annual budgets for Zimbabwe appeared to increase towards the 15% mark, as prescribed in the Abuja declaration (Govender et al, 2008; Shamu et al, 2007). For a while, the total share of GDP allocated to health remained below 10%. From 2003, the share had increased to 13% by 2006 (ibid, p3). It must be noted that this is the period before the famous hyperinflation era, which was followed by the abandonment of the official Zimbabwe dollar in favour of the United States Dollar (USD), as the official currency buttressed by a basket of multi-currencies, such as the Rand, the Botswana Pula, the Japanese Yen, the British Pound, and the Australian Dollar.

Financing for health services in Zimbabwe between 2005 and 2008 was deeply affected by the country’s economic difficulties, characterized by extreme world-record hyperinflation. The

highest inflation figure reached in Zimbabwe at its worst may never be known. There are many varied estimates. They range from 2 million to 500 billion per cent annually (Pindiriri, 2012; Mpofu and Nyamadzawo, 2016). This caused a dramatic reduction in the value of funds allocated to health, reducing the ability to pay staff wages and a reduction in the purchase of commodities and equipment (USAID, 2010; Meldrum, 2008). For example, in 2005 health expenditure as a percentage of GDP was unbelievably low at 0.51%; in 2006, it was (0.62%); in 2007 (0.01%); and in 2008 (0.02%) (USAID, 2010 p40). “In 2009, a Government of National Unity (GNU) was formed, leading to the adoption of the multi-currency regime in February 2009, with the USD dollar as the main popular currency of choice. This led to the stabilization of the value of health budgets and the prices of health commodities. Since that time, however, funding has increasingly come from various international donors” (Government of Zimbabwe, 2010). Subsequent periods from 2009 onwards saw a somewhat gradual decline in the state of health care in Zimbabwe (Al Jazeera English, 2014; New Zimbabwe, 2015; News24.com, 2016; Zulu, 2016). “Major referral hospitals across the country are on the brink of collapse, owing to rising debts, outdated equipment, poor funding and maladministration – among many other pressing issues” (Kunambura, 2015). It is not clear whether the government will be able to race against time to avert the total collapse of the public hospitals. These are the same facilities that cater for the majority of the population; as fees at private-health facilities are clearly out of reach for this sector of the population. Only 10% of the Zimbabwe population is covered by health insurance, leaving out a whopping 90% without any meaningful health insurance (Ncube, 2014; Muperi, 2014).

When this is put together with the grim statistic that almost 90% are either unemployed or in informal employment, it makes the situation very dire and frightening. There are fears that the country’s public hospitals could very soon be unable to attend even to minor ailments. As we speak, more and more people are flocking across the border to South Africa, where costs appear to be relatively lower for the quality of health-care services being offered (Crush & Tawodzera, 2011). Medical insurances in Zimbabwe have increasingly started referring some of their members to India – on various medical-tourism programmes (Chidavaenzi, 2015).

Despite the Government of Zimbabwe signing up to the Abuja Declaration in 2001, and pledging to allocate at least 15% of its annual budgets to healthcare, it has actually been cutting down on health spending over the last few years (Kunambura, 2015; USAID, 2010). For example, in the 2015 national budget, the Ministry of Health and Child Care (MOHCC) was allocated USD 301

million (6.3%) representing a 2.2% decline over the previous annual budget. The highest allocation to the health ministry within the last three years was only in 2013 at 9.37% of the annual national budget. The Zimbabwean government has previously relied on donor funding to sustain the healthcare sector, which is also drying up due to donor fatigue and other issues (ibid).

Zimbabwe was once a beacon of hope in the African health setting, towering as a fine example of third-world health-care management. For example, the country's largest referral medical centre, the Parirenyatwa Group of Hospitals (formerly Andrew Fleming Hospital in the Pre-Independence era) is now a pale shadow of itself. It was once a beacon in medical excellence; and it used to offer heart surgery and advanced kidney treatment during its peak days; but now it is weighed down by huge debts and the government's inability to adequately fund the health care sector.

## **5.6 Ethical issues on health-care rationing, priority setting and financing**

It is important to bear in mind the difficulty in establishing a balance between the interests of individuals versus those of the larger society, when allocating resources for health care. The notion of social justice (response to need) will always be in conflict with that of utility or efficiency (Glannon, 2005). Any redistribution of rights (to goods, services etc) aimed at the larger purpose of responding to the majority's needs inevitably infringes on the rights of some individuals (Rawls, 1972). No single theory of justice is sufficient on its own to solve the conflict between beneficence and justice. Therefore, a global reflection of as many theories of justice (including utilitarian, egalitarian etc.) is needed to establish a sound trade-off between the need for efficiency and justice in the allocation of health-care resources and the rationing of services (Beauchamp & Childress, 2013).

A country such as Zimbabwe with seemingly a piecemeal and skewed allocation of resources to health care will inevitably expose its population to a continued failing health-care status of its citizens (Chidavaenzi, 2015; Crush and Tawodzera, 2011; Kamhungira, 2016; Kunambura, 2015).

### **▪ Is the right to health being upheld in Zimbabwe?**

An analysis of the stance of the World Health Organisation (WHO) on the right to health is revealing; and it helps to answer the question on whether the health situation in Zimbabwe helps to uphold the fundamental right to health, as enshrined in the WHO constitution. The WHO

constitution asserts “the highest attainable standard of health as a fundamental right of every human being. This right to health includes access to timely, acceptable, and affordable health care of appropriate quality” (International Health Conference, 2002). We will focus on aspects of the WHO constitution, which aptly captures the gaps and deficits in the Zimbabwe situation.

**Entitlements:** According to the WHO constitution, “entitlements include the right to a system of health protection that gives everyone an equal opportunity to enjoy the highest attainable level of health”. The health policies and programmes of Zimbabwe, as currently obtaining, do not have the ability to promote and uphold the human rights of its citizens. The incessant chronic failing to fund not only the health sector, but the whole gamut of social-service requirements may be violating the human rights of its citizens.

**Obligations of Nation States:** The preamble of the WHO constitution states an important precondition for government and parties that are signatories to the WHO and the World Health Assembly (WHA) – both of which are important organs of the United Nations system. It analyses the obligations of nations to contribute to the health of their people, an obligation not to be imposed upon from outside, but from the fundamental right of every human being. The Zimbabwe government is a signatory to the WHA. “The responsibility of governments for the health of their people can only be met by the provision of adequate health and social measures”. This is not the case right now in Zimbabwe (Kamhungira, 2016; Kunambura, 2015).

**Human rights-based approaches needed:** “if the four goals of health care are to relieve the symptoms, to cure disease, to prolong life and improve the quality of life, then access to health care must take into account important factors, such as equity, efficiency and effectiveness in the design of health-care systems, in order to meet the stated goals” (Maharaj, 2011). I argue that it is not defensible for a government to hide behind a low GDP, as an excuse for providing a health budget below the Abuja Declaration of a voluntary target of 15% of GDP.

What is important in the budgeting process is the seriousness and importance attached to the health budget, as expressed by the slice allocated to the health sector, regardless of how low the country’s GDP is. Thus, interventions designed to adhere to a human rights-based approach paradigm to health funding and support, must of necessity observe the following seven principles: Non-discrimination, Availability, Accessibility, Acceptability, Quality, Accountability, Universality (Constitution of the World Health Organization, 1946)

Due to the failure by the government of Zimbabwe to provide adequate and decent health care services to its citizens, principles number ii, iii; iv, v and vi appear to be seriously eroded (Chidavaenzi, 2015; Crush and Tawodzera, 2011; Kamhungira, 2016; Kunambura, 2015). According to Glannon (2005), any sustainable health-care system must incorporate equal access to basic medical services and good health outcomes as complimentary, and not competing goals. The following ethical questions need to be tackled, when deciding on rationing health care or medical services:

- i. What sort of balance or weight should be given to the idea of equal access to services and how much to outcomes?
- ii. Which should be given the higher priority: curative, prevention or research?
- iii. Is it morally defensible, permissible or justified to discriminate on the basis of age, giving priority to the young over the old when they compete for a particular treatment, e.g. kidney, liver or heart transplant?
- iv. Is it morally acceptable to give priority to life-saving treatments, surgery or organ transplants, according to a person's social status?
- v. Is a two, three or even a four-tier health-care system morally justifiable? And, if so, under what circumstances?

## **5.7 Chapter Summary**

This chapter has looked at the ethics of health-care rationing, priority setting and financing in general, as well as with a particular focus on Zimbabwe. It has touched on ethics and approaches to health-priority settings, health financing and the Abuja declaration and its implications for Zimbabwe's declining annual health budgets. A case was made, illustrating the potential of Zimbabwe for not fulfilling adequately its obligations under its own national constitution, as well as the WHO constitution, as far as protecting and providing for the health of its citizens. The total health budgets, as a percentage of the national budget, continue to be far below the 15% threshold as per the Abuja declaration. The breakdown of its public health system may easily be argued to be violating the human rights of its citizens. So what is the way forward? The final chapter in this thesis, will attempt to provide some suggestions and recommendations for ameliorating the situation in Zimbabwe.

# Chapter 6

## DISCUSSION, RECOMMENDATIONS AND SUMMARY

### 6.1 Introduction

The Zimbabwean health care system in the twenty-first century can be best described as being afflicted by many internal crises. These crises range from inadequate investment and poor budgetary support from the government, poor access by the population to health-care services, inadequate insurance coverage, erratic payment of staff salaries, to poor regulation of the medical-insurance industry (Kamhungira, 2016; Share, 2016). Since the late 1990s, World Bank public sector reforms have been premised on the assumption that improving the ability of government to manage its business by, among other measures cutting “bloated” government expenditure, tax reforms and price liberalisation, would lead to improved social and economic wellbeing. However, it eventually became apparent that these modes of saving were insufficient to improve the quality and quantity of social services (Bjorkman, 2004).

The preceding chapters in this thesis have looked at the following critical areas and their implications for the Zimbabwean health-care system in the twenty-first century: Health-care models and systems, ethical principles, distributive justice and health-care rationing, priority setting and financing. This chapter will look at possible reforms, policy options and recommendations to deal with the problems affecting the Zimbabwean health-care system. These and many other issues will require Zimbabwe to consider new policy options, in order to stabilise and improve the health care system.

### 6.2 Suggested Policy options and Recommendations

I propose some policy options and recommendations anchored on 5 main areas:

- i. Introduction of or strengthening of a human rights and ethics component in training at under, postgraduate and continuing education or training of health care professionals (HCPs), Government officials and other important stakeholders in Zimbabwe.

- ii. Regulation of existing and promotion of new medical aid societies or schemes, in order to improve access to and provision of quality health-care services.
- iii. Innovative funding approaches (a mixture of traditional public health finance from budgetary allocations, National Health Insurance (NHI) scheme and a transparently managed donor programme).
- iv. A new paradigm shift towards public health-facility upgrades anchored on Public-Private Partnerships or similar models.

### **6.2.1 Introduction or strengthening of a human rights and ethics component in training**

An introduction of a human rights and ethics based approach to the training of health care professionals (HCPs) and provision of health care services, as provided by international best practices and by the Zimbabwean National Constitution section 76 and 77, would assist to gradually improve the health care delivery (London, 2008). While doctors have a duty and obligation to attend to and treat their patients timeously, professionally and with dignity, the state also has an obligation to provide the much needed resources and incentives to the doctor and other health care workers. The frequency and severity of hospital stock outs on such basic things as diagnostic and therapeutic equipment and reagents, medications, linen etc is a major source of concern. At the point of writing the manuscript doctors and other health care workers had been on strike several times in a row (Mbanje, 2017). However, even if adequate provision of incentives and supplies were to be guaranteed, there is still need for an attitude change from HCPs and policy makers towards a more humane approach to service delivery. This, in my opinion, can be made possible in part by introduction of basic ethics and continuing education training.

“As the public's health-care needs increase in complexity, renewed attention is being given to the ethical dimensions of public health decision-making and the development of public health ethics as a bounded area of teaching and research..... The teaching of ethics language, concepts, and tools for decision analysis helps to prepare students for the inevitable ethical choices they will have to make in their professional practice. The teaching of ethics and professionalism and the experiences of professionals enrich each other and foster the critical link between education and



practice” (Slomka, et al, 2008). Small group teaching in bioethics has been demonstrated to have positive impact on consensus answers where ethical dilemmas are encountered (Goldie, et al, 2002). A similar study by Malek, Geller and Sugarman (2000) showed similar results.

I propose:

- Continuing education shorts courses in bioethics, human rights and health law for HCPs, policy makers, managers, politicians and administrators.

### **6.2.2 Regulation of existing and promotion of new medical aid societies and products**

Medical insurance and the private health sector in Zimbabwe play a very important role in the improvement of access to health care services and provision of high-quality health-care services although, at the time of writing this manuscript, only about 8% of the population were covered by medical aid. The proper regulation of existing medical aid societies would help to improve and sustain the health services of the country, especially considering the continued dwindling of public finances for this sector. For example, in 2001, Zimbabwe was one of the few low-income countries, that funded over 20% of its total health expenditure from private coverage (Savedoff and Sekhri, 2004; Ncube, 2014; Muperi, 2014). This coverage was mainly from private health insurance – although with only 8% of the population being covered, it represented over 23% of the total country’s health expenditure (ibid). This leaves a big percentage of the population without medical cover to access private health facilities – apparently the only sector with a ‘functional health system’ because the public health sector may have deteriorated tremendously (Nyazema, 2010). A number of scandals involving conflict-of-interest allegations against the current regulator, as well as against the medical aid societies themselves, have already shown that the current regulatory framework for medical insurance in which the Ministry of Health and Child care is both a provider of services as well as the regulator, is inadequate and needs to be revamped (Chipunza, 2014 & 2015; Ncube and Maunganidze, 2014).

**The current problems in the medical aid industry of Zimbabwe can best be summarised into two main areas:**

- a) Conflicts of interest arising from medical aid societies' (MAS) own involvement in the provision of health services, as well as being insurers for the same. Examples include the Commercial and Industrial Medical Aid Society (CIMAS), Premier Medical Aid Society (PSMAS), Railmed, Harare Municipality Medical Aid Society (HMMAS) etc who own and operate their own clinics, hospitals, pharmacies, laboratories, dental surgeries etc). Cases of unsuspecting medical aid members being re-directed to medical aid owned facilities have been recorded, some disputes ending at the anti-competition commission. In my opinion the alleged redirecting of patients by medical aid societies to their own facilities not only violates patients right to choice of practitioner but also creates a perverse incentive as well as promoting touting for patients by the HCPs employed by the medical aid societies. Perverse incentives are unethical in accordance with the guidelines of Medical and Dental Practitioners Council (MDPCZ). Touting for patients is a threat to the status of good medical and dental practice and to medicine and dentistry as a profession as this puts HCPs employed by these MASs in violation of ethical standards set up by professional traditions as well as by local and international professional bodies and associations such as the World Medical Association and the Federation of Dental Associations.
- b) Poor, inconsistent or inadequate oversight and regulation by the current regulator, the Ministry of Health and Childcare (MOHCC). Cases of allegations of the MOHCC paying a blind eye to unethical conduct by government owned or aligned PSMAS medical aid society have been cited. PSMAS is known to owe hundreds of US millions in unsettled claims to independent providers and yet it continues to have its operating licence renewed year after year without penalties.

I propose and recommend that:

- An independent medical aid regulatory body be set up through an act of parliament. This body should have the powers to register, monitor, suspend, black list or even de-register medical aid societies which do not comply with basic ethical and administrative operating rules based on international best practices. Regional and international examples include Council of Medical schemes in South Africa.

### **6.2.3 Innovative funding approaches**

Even though private health insurance and for-profit medical insurance tend to cover a small percentage of the population – and invariably mostly those in formal employment, it is important to try to preserve it and even strengthen it; because it has a sustained investment in newer technology and the training of health professionals. In our attempt to improve equity and access to the health-insurance industry, we must not “throw out the baby with the bathwater”.

I propose and recommend that:

- Mandatory publicly financed and publicly managed insurance be made available to complement and supplement the commercial, for-profit health insurance schemes already existing in Zimbabwe.

#### **6.2.3.1 National Health Insurance**

The aim of the National Health Insurance Scheme (NHI) is to improve the allocation of resources through the centralised distribution and spending of funds, and to improve the health system’s management by increasing the quality of care and operational efficiency. A discussion on the desirability of introducing a NHI has been an intermittent activity in recent years. It appears that there is a cautious approach towards moving full steam with the introduction of the NHI in Zimbabwe (Muperi, 2014). It is recommended that a full appraisal of the local conditions needs to be undertaken without rushing into introducing this scheme without proper planning. Zimbabwe needs to look also at the regional experience by analysing how the South African scheme has progressed to date. This might help to assist the country in its policy options (Nevondwe and Odeku, 2014; Wessels, 2015; Surender, 2014; Dahms, 2014).

Ghana and Taiwan are also good African and international examples that have been in existence for a long time; and they could assist Zimbabwe to evaluate its possibilities of introducing the NHI (Agyepong & Adjei, 2008; Blanchet et al., 2012, Cheng, 2003).

**The Zimbabwe government may wish to consider the following objectives for its NHI:**

- a) Improving the access to quality health services;
- b) The pooling of risks to achieve equity and social solidarity. This has an added advantage of advancing an egalitarian and distributive justice element to the health-care delivery of the country.
- c) Procurement of health services on behalf of the entire population, combined with the efficient mobilisation of financial resources.
- d) Strengthening of the under-resourced public sector and improving the health system's performance.

Governments around the world use different revenue-generating mechanisms to fund their NHI schemes. In addition to the current revenues that are being allocated to health expenditure, the following might be considered:

- An increase in the VAT rate;
- An increase in “sin taxes”;
- A surcharge on individual's taxable income;
- The phasing in of a payroll tax (payable by the employee). However, the Zimbabwean employee is already burdened by other payroll taxes, such as an AIDS levy, National Employment Council deductions, PAYE, and social-security premiums.

It is important to consider factors, such as equity, sustainability, efficiency, flexibility, ease of administration, collection and potential revenue, when contemplating any type of funding mechanism. The following are examples of other economies that have adopted a variety of funding mechanisms:

- a) The Russian Federation has a compulsory public health-care system funded by a 3.6% payroll tax (Twigg, 2002; Rozenfeld, 1996; Shishkin, 1999);
- b) Italy has a National Health Service system funded by a general tax (France et al., 2005).
- c) Albania has a public health-insurance system that is funded by the State Budget and a payroll tax that is ring-fenced for health (Hotchkiss et al., 2005; Mossialos et al., 2002).
- d) France has a combination of public and private healthcare systems, of which the public portion is compulsory with optional supplementary top-up packages. It is funded by a social-security tax on revenue and an employer tax (Mossialos et al., 2002)

If Zimbabwe wishes to embark on a NHI scheme, it is recommended that it undertakes a thorough review of similar schemes in both regional and international jurisdictions, preferably those with similar economic models. A case in point is how the South Africa approach to NHI has allowed for a planning conference and piloting of the programme in only 12 sites since 2012.

### **6.2.3.2 Public-Private Partnerships**

Globally, governments have been experiencing budget deficits. Some people argue that the solution to this problem lies in the utilization of the market system for providing public services (Watts et al., 2000). The resource scarcity theory is premised on the fact that governments do not have adequate resources to meet the ever-increasing needs of their citizens (Maserumule & Mathole, 2006). In trying to mitigate against the vagaries of ever-increasing national deficits, franchising as a public-private sector partnership, could be considered in both the developed and the developing countries of the world.

If well undertaken, this is as an option to reduce government expenditure and to achieve increased efficiency and effectiveness in the delivery of public goods. I argue that governments in general, are inherently defective and wasteful, and that the market is better equipped than the government to provide most goods and services (Watts et al., 2000).

Thus, it is recommended that Zimbabwe should consider doing more research on Public-Private Partnerships (PPPs) in its health-delivery system, in order to assess the viability of a gradual shift towards more PPPs, perhaps starting with its central and general hospitals, and then gradually cascading to the provincial hospitals. A seemingly successful experiment is taking place on the outskirts of Harare, at Chitungwiza General Hospital with its new Kidney Transplant unit partnered with a local mining company and some Indian firms (Chipunza, 2016; Yikoniko, 2016). Unlike the first generation of public sector-reform strategies, which stressed downsizing, contracting out and improved control over budgeting and public finances, the second generation of reform strategies focused on improved efficiency, decentralisation and the effectiveness of government. The more recent approach is the third generation of strategies, which focuses on emphasizing sector-wide approaches, including those for health and education, in order to produce a coherent programme for service delivery (ibid). The private health sector is already playing a

major role in developing countries; and it needs to be supported, developed and expanded even more.

This Ministry of Health and Childcare, through its Minister of Health and Childcare, publicly commended Chitungwiza General Hospital for taking a lead in the consummation of PPPs; and it urged other public-health institutions and private organizations to emulate this good example (Health Reporter, 2016).

### 6.3 Summary

- 1) The right to have access to health care as enshrined in the Zimbabwean new constitution Bill of Rights (2013) is a positive right, and it is therefore not realised if the correlated obligation imposed on the government to provide sufficient resources, including human resources is not honoured. HCPs, including doctors, are a significant human resource component in terms of this right of access to health.
- 2) The starting point for looking at how to embark on reforming the Zimbabwean health system could be benchmarks of fairness for health-care reform: a policy tool for developing countries (Daniels et al., 2000). I found this tool well suited for use in a situation, such as that currently pertaining in Zimbabwe.
- 3) Medical insurance or schemes in Zimbabwe cannot be left to market forces alone. They need to continue to be regulated and regulated fairly and properly.
  - a) Public rural health services need not be primarily financed by local and central government, civil-society and donor agencies only. Because of the severe strain on central and local government capacity, it may be time for a paradigm shift towards rural health insurance where rural communities share in the costs by not only paying user fees but perhaps participating in a rural health insurance scheme or a variant of the National Health Insurance scheme as well.
  - b) Existing and future medical schemes should be encouraged and empowered to create subsidiary health plans for the poorer sections of the population, in order to cover those people hitherto neglected over years by the lack of affordability, including the informally employed.
- 4) Good corporate governance and new statutes are a ‘must’ for any National Health Insurance scheme to succeed, if adopted at some point. Already, cases of poor financial

management and other maleficent practices like the government-controlled Premier Services Medical Aid Society and the National Social Security Scheme (NSSA) have generated doubt on the ability of current corporate structures to manage such a scheme.

- a) Any health reforms decided upon may need to be implemented in phases – in a way that reflects existing capacities, or by plugging existing gaps first. Rather than attempting to do too much all at once, it may be more helpful to identify easy entry points in which reform could be built up in an incremental fashion. For example, the Premier Services Medical Aid Society (PSMAS) and its investment arm (Premier Services Medical Investments – PSMI) has not operated properly due to a combination of theft of funds, mismanagement and erratic remittances of subscriptions for government civil servants, who make up almost 100% of the PSMAS membership. It is not strategic to rush in and embark on yet another public or semi-public health-social scheme, when government is unable to manage the existing schemes. What would stop the failure of any new scheme?
- b) A revolution towards a more ethical and human rights based health care approach is clearly needed, rather than just a paradigm shift in the administrative, institutional and statutory operating environment of Zimbabwe.

#### **6.4 Conclusion Remarks**

This thesis has managed to fulfill its main goal of carrying out an in-depth descriptive and critical analysis of the challenges affecting the Zimbabwean health care system in the twenty-first century. It has demonstrated that the initial health policies immediately after political independence in 1980 appeared to favour an egalitarian thrust at introducing an equitable access to health care. There was a gradual deterioration from the mid-1990s onwards, so much so that by 2009 access to health care in Zimbabwe had almost collapsed totally. In 2009, a Government of National Unity (GNU) was formed, leading to the adoption of the multi-currency regime in February 2009, with the USD dollar as the main popular currency of choice. This led to the stabilization of the value of health budgets and the prices of health commodities for a few years till just after the national elections of 2013 when again the health care delivery started to decline quickly. In a way, this mirrored the

general decline all public services in the country in tandem with declining government revenue and economic output. It can be argued with a bit of justification, that we are indeed in another harsh economic period much similar to the “dreaded” pre-2009 period, though without the previous hyperinflation scourge. That said, it is important to continue to acknowledge the primary importance of health services as an essential and basic public good without which a nation’s citizens cannot flourish. In order to fulfil that expectation, the Zimbabwean Health care system is in need of a major paradigm shift, particularly in terms of funding mechanisms. One such area is the issue of how budgetary provision for public health services is prioritized over other social services even in the face of declining revenues. The second area is the need for innovative and effective insurance creation and regulation to replace the current regulatory mechanism based at the Ministry of Health and Child Welfare head offices. At the end even substantial funding will not bring any dramatic changes in the training of Zimbabwe’s health care professionals unless if there is a new shift and direction in the training philosophy. This thesis strongly suggests a need for a whole-sale infusion of a bioethics paradigm into the training of all health care professionals and social workers at all levels, including under and postgraduate training. This must be complimented by short courses and seminars on corporate governance. Additionally, the scope of hospital boards oversight over corporate governance issues must be expanded to include effective financial and lifestyle audits with a view to eliminating suspected corruption tendencies. While this is a gradual process, it has to start somewhere. Every long journey starts with the first step.



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