

Policy Brief

Privatisation of Health and Education Services in Zimbabwe

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Executive Summary

The privatisation of education and health services in Southern Africa is taking place at a rapid pace. Private actors are taking over the role of governments in providing these two indispensable services. Non-state provision (NSP) of education and health is delivered by a mix of NGOs, faith-based, philanthropic, community and private providers and takes a myriad of forms including low-fee private schools, hospitals and clinics; for-profit private schools and health centres; community schools, educational public-private partnerships (ePPPs), private tutoring; and religious based institutions in schools and hospitals. In modern state governance, there is a push to establish more private institutions as opposed to the central government administration approach which takes the overall responsibility for the provision of education and health care services. The main drivers for this shift are contained within a neo-liberal agenda and the discourse of State failure. The neoliberal argument posits that central governments are not as effective and efficient enough to provide enhanced quality education and health outcomes than the private sector.

Introduction

The Zimbabwean state has an obligation to provide education and health services to its citizens and these rights cannot be retracted. They are part of the socio-economic rights enshrined in international human rights instruments and frameworks that include the Universal Declaration of Human Rights (1948) which SADC countries subscribe to as part of the Bill of Rights, the African Charter on the Right and Welfare of the Child, were particular mentions in Article 11 and Article 17 note that every child has a right to education. The Sustainable Development Goals (SDGs) Goals number 3 dedicated to the provision of universal good health and well-being and SDG 4 entail the need for inclusive and equitable quality education. Irrespective of these instruments, privatisation continues to soar and concerns regarding accessibility, affordability and quality of services across the education and health sectors have become topical as all draw down to the financial position of the consumers hence widening the social stratification gap of the citizens as those who can afford obtain quality services. Some other emerging concerns resultant from privatisation include de-professionalisation of teachers and health workers and the erosion of confidence in public institutions of health and education. The ineffectiveness of regulatory instruments and regulatory institutions also comes to the fore as these institutions within the region are either underfunded or just inefficient to deliver on their obligations.

Approach

The research was based on critical analysis of privatisation as a development approach, highlighting the context and rationale for privatisation, motivation, external and internal factors, the process leading to privatisation, the form of privatisation adopted, implications and outcomes and evaluation of privatisation on education and health.

AFRODAD engaged civil society organisations that work with ministries of education and health as well as the private sector. Key informants were sourced from civil society organisations (CSOs) that work on education and health rights in Malawi. The study used the following methods:

- Desk research to get primary sources of data, statistics, literature review, laws and policies.
- Data collection through semi-structured questionnaires to CSOs
- Field trips to acquire in-depth information on the variants of private sector involvement in education and health, impacts on human rights, and involvement of the State.
- Interviews in person and virtually via Skype and as well as observations.
- Official government positions on privatisation of education services and or its financing were obtained from relevant Ministry publications

The study employed these methods to attain the research findings, research variables and conceptual frameworks. The research also consisted of selected country case studies and evaluations. Graphs and tables were used for analysis and synthesising the report. A validation exercise was conducted to review the research findings in order to capture the different conceptual and factual dimensions of the themes.

Privatisation and Zimbabwe's Education Sector

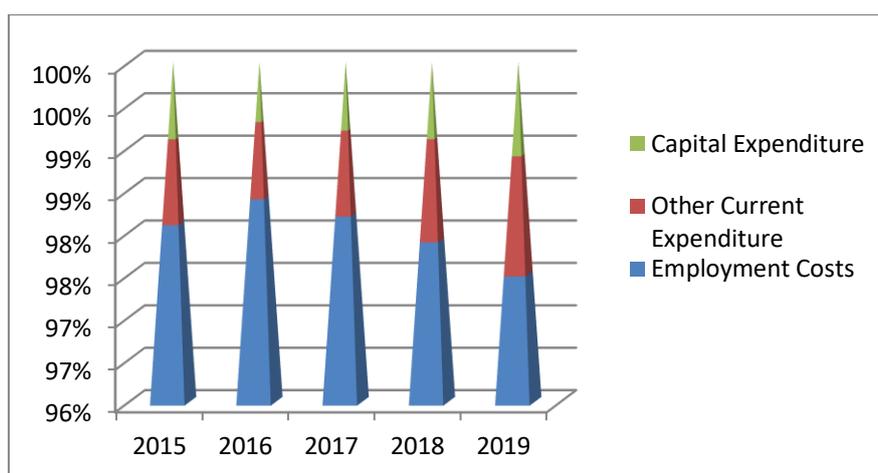
The Ministry of Primary and Secondary Education (MoPSE) and the Ministry of Higher and Tertiary Education, Science and Technology Development are responsible for education in the country. Government cuts in expenditure on education and removal education subsidies then introduction of school fees led to deterioration in educational standards and to many poor parents no longer affording to educate their children. In 1998, Zimbabwe took a policy position to adopt Public-Private Partnerships (PPPs), under which the private sector would partner with the government in service delivery. In Zimbabwe, most schools which are classified as private receive government support in the form of payment of teachers' salaries, a per capita grant for non-recurrent expenditure and building grants¹. There are also independent schools in the country under the Association of trust schools. Government schools are more affordable, but with smaller budgets than private schools, the facilities are not as good or as up-to-date. Zimbabwe's curriculum is centralized and determined by subject panels of teachers, education officers, and representatives from the teachers' association, universities, churches, and other stakeholder groups. The Curriculum Development Unit within the Ministry of Education and Culture coordinates the subject panels. This ensures that both private and public schools follow a similar pattern in their learning outcomes.

Education Sector Financing

The Ministry of Primary and Secondary Education (MoPSE) was allocated US\$803.77million, which is about 19.6% of the US\$4.1 billion total budget and 5.5% of GDP.

¹ (Latham and Blair 1999)

Figure 1: Trends in the Composition of Pri & Sec Edu Budget Allocations



Source: 2015-2018 Zimbabwe National Budget Statements

As according to the 2017 MoPSE Budget, allocation towards primary and secondary education is 0.8% lower than the US\$810.4 million allocated to the sector in 2016, mainly reflecting weak revenue projections for 2017. However, it remains higher than the Sub-Saharan Africa (SSA) average of 15.9% and 4.3% of their GDP². However, wage expenditure typically represents the single largest cost in the government budget and worse still, for the education sector, wherein employment costs account for 98.2% of the allocation as shown in Figure 1 above. Current non-wage spending of less than 2% of the budget is further fuelling the deprivations and inequities in education that Zimbabwean children face. There is equity in the level of access, as measured by Net Attendance Ratio (NAR) at primary level, but significant equity gaps are evident in secondary education, making it important for the budget to target such in its allocations.

At face value, allocation to the education sector including the Ministry of Higher and Tertiary Education for the years 2017, 2018 and 2019p which are US\$834 million, US\$973 million and US\$1,132 billion respectively are commendable, but when put under the microscope, a staggering average of 97% of the budget is gobbled on employment costs. In this regard there is need for better prioritization of expenditures within the education budget is important. The current expenditure mix is in itself a source of inefficiencies, undermining the impact of the budget on education outcomes.

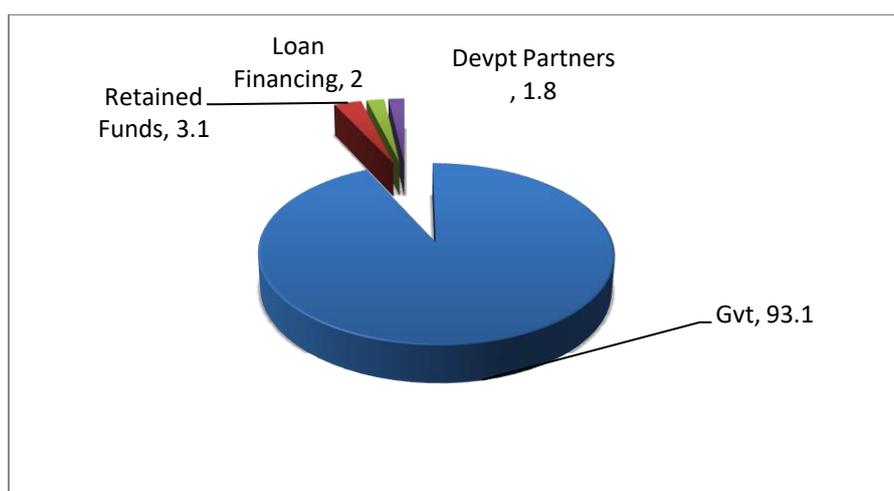
Zimbabwe's Fiscal space outlook remains poor, hence, continued dependency on donor support for non-wage education expenditure, which may-be necessary to safeguard the gains recorded to date, but at the same time is risk in terms of sustainability. On account of gaps in public funding, the system is increasingly relying on fees and levies, with implications for equity and quality. In light of the declining government expenditure on operational costs, schools have been forced to rely heavily on student fees and levies to continue operations. This contributes to disparities as communities that cannot raise fees cannot raise adequate resources.³ Denoting with the 2018 budget allocation the source of financing for education can be noted as limited as 93.1 % of the budget emanate from government revenues, 3,1% from retained funds, 2% from loan financing and 1,8% from development partners as highlighted below.⁴

² Zimbabwe 2017 Ministry of Primary and Secondary Education Budget Brief

³ <https://www.unicef.org/esaro/UNICEF-Zimbabwe-2018-Education-Budget-Brief.pdf>

⁴ Ibid,

Figure 2 Total Education Resources Composition



Source: ZIMSTAT 2016-2017, UNICEF 2018

Rationale for Privatisation of Health Services

The Ministry of Health and Child Care's (MOHCC) is in charge of health provision in Zimbabwe. Its mandate is in line with the national vision that states that "The Government of Zimbabwe desires to have the highest possible level of health and quality of life for all its citizens, attained through the combined efforts of individuals, communities, organisations and the government. Health is a basic and a fundamental human right stipulated in the Constitution of Zimbabwe. Health is also a key pillar in the Zim-Asset social cluster. Zimbabwe faces inadequate funding for health care and has not met that Abuja declaration of allocating 15% of its budget towards health. This has meant that the country has been unable to realise its full potential of providing sufficient and quality services to its people. Health delivery system continues to be adversely affected by sporadic outbreaks of epidemics such as typhoid and dysentery, increased maternal mortality, shortage of funds to procure essential drugs and equipment and to rehabilitate dilapidated infrastructure

Policy frameworks for health include the National Health Strategy 2009-2013 and its extension 2014-15 and 2016 to 2020 strategies. The policy recognizes the need for partnerships within government departments and agencies, private sector (both funders and providers), international partners and communities in health. Private sector in health is in two categories the private for profit and the private not for profit. The private-for profit sub-sector includes independent providers (clinics, hospitals, pharmaceutical, devices and equipment industries). The other category is the private not-for-profit (mission facilities, non-governmental organisations and other charitable organisations, and medical aid societies involved in funding of health care particularly for the middle class).

Health Sector Financing in Zimbabwe

Financing for the Ministry of Health and Child Care for the period 2017-2018 saw a significant increase in budgetary allocation towards health care;. The MoHCC was allocated a total of US\$473.9 million in 2018, which was a 68.1% higher than US\$281.98 million allocated in 2017⁵. This includes the additional US\$65 million allocated following serious lobbying by the Parliament to increase the health budget. The total budget allocation to health represented a 8.3% of total expenditure, some 1.4 percentage points up from 6.9% in 2017. The increased budget allocation is against a background of increased national budget, by 40.1% from US\$4.1 billion in 2017 to US\$5.7 billion in 2018. Whilst the increase has been commended, the Zimbabwe Service Availability and Readiness Assessment Report of 2015 and its subsequent updates note that health studies and surveys that have been carried out in the country all point towards inadequacies in the six World Health Organization (WHO) Health System Building Blocks

⁵ <https://www.unicef.org/esaro/UNICEF-Zimbabwe-2018-Health-Budget-Brief.pdf>

– human resources, medical products, vaccines and technology including infrastructure, health financing, health information, service delivery, leadership and governance – that are prerequisites for a functional health delivery system.

Table 1: Health Facilities Profile for Zimbabwe

Health Facilities Profile for Zimbabwe			
Facility level/Managing Authority	All Facilities	Hospitals	Primary Health Facilities
Central Hospitals	6	6	
Provincial Hospitals	8	8	
District Hospitals	44	44	0
Mission Hospitals	62	62	0
Rural Hospitals	62	62	0
Private Hospital	32	32	0
Clinic	1122	0	1122
Polyclinics	15	0	15
Private Clinics	69	0	69
Mission Clinics	25	0	25
Councils/Municipal/FHS	96	0	96
Rural Health Care	307	0	307
Total	1848	214	1634

Source: ZSARA 2015

The table 1 above presents the profile of health providers in Zimbabwe. Those not run by government in the table includes mission hospitals, private hospitals, private clinics and mission clinics. The list is not exhaustive as it does not include private surgeries, pharmacies, medicinal aid societies that operate in the health sector in Zimbabwe⁶. It should be noted that some private not for profit health facilities such as mission hospitals receive funding from government to use in their daily operations. Quantifying the proportion of private sector budgets financed by public sector subsidies is almost impossible in Zimbabwe because of lack of reliable information on private sector budgets. There are also private health financing bodies in the form of medical aid societies.

A worrying trend in the health sector is that of the total health expenditure in all the years under review private health expenditure has been above general government expenditure as a percentage of total health expenditure. For example in 2014 – 2017, government expenditure was an average of 40% while private expenditure was averaged at 60%. Given the fact that there are more facilities in public sector than in private sector, there is need for government to increase its expenditure on health. For the same period health expenditure was a mere average of 6% (est) of the GDP showing government is prioritising expenditure in other sectors as opposed to more resources for health. A review of the health expenditure from 2000 to 2014 depicts the growing significance of private expenditure on health. In 2000 it was 40% with government providing 60% of the total expenditure on health. However by 2014 the scenario had shifted with government now providing 40% of the total funding and private expenditure now at 60% as illustrated above.

Conclusions

Privatisation has been identified as a significant development issue.⁷ United Nations member states in September 2015 at the General Assembly, adopted the 2030 Agenda for Sustainable Development that pushes for greater public-private partnerships, under SDG 17. Education, health and gender have targets under the SDGs, more importantly human rights are mainstreamed across all the 17 globally selected Sustainable Development Goals and targets. This research provides a comprehensive look at the nexus of privatisation and these three themes. ⁸ In spite of the push for the privatisation agenda in the development goals evidence on the impact of privatisation on human rights, gender and sustainable development has not been clearly documented.

⁶ Zimbabwe's health delivery system, <https://zimfact.org/factsheet-zimbabwes-health-delivery-system/>

⁷ UN, SDGs Conceptual Framework, 2015

⁸ The Danish Institute for Human Rights, 2017

In Zimbabwe,⁹ over 50% of the population live under the poverty datum line and evidence shows that access to public services is worsened when education is privatised as private entities usually charge more fees.¹⁰ In the area of health, private companies often introduce user fees and other charges that result in lower utilisation of reproductive health services by women who cannot afford them. As a result, those women are forced to give birth without professional medical assistance, increasing the risks of maternal and child mortality, which is already a serious developmental challenge not only in the country but in Southern Africa as well. This interplay of developmental issues, not only presents a dilemma of opportunity costs but grave human rights, gender and sustainable development concerns.

Recommendations

- Increase education and health budgetary allocations to revive the two essential sectors in line with global standards.
- Review outdated national education and health policies, with inputs from other stakeholders inclusive of the private sector, academia and civil society organisations.
- Improve efficiency in both education and public health sectors by constantly monitoring outcomes from public institutions. In the health sector government should ensure that public institutions remain public by not privatizing aspects or departments within public institutions like hospitals.
- Ensure that there is clear rationale to engage private players in education and health. Governments should not negate their role to provide education and health services as what is currently transpiring at pre-primary level in most countries.
- In education, SADC countries can benefit from domesticating The Guiding Principles on State Obligations Regarding Private Schools.
- Domestic resource mobilisation remains key for the governments to have resources to use in education and health. They can broaden their tax base by curbing illicit financial flows, increasing their revenue streams and advocating for private sector to invest in education and health as part of their corporate social responsibility/investment.
- In education, privatisation has resulted in an encouraging teacher/ learner ratio. The ratio is way higher in public schools compared to private schools. There is need for government to ensure that that the teacher pupil ratio in public schools be revised to ensure that the learning outcomes are of high quality.

⁹ Counterview, 2014

¹⁰ Action Aid, 6 reasons why privatisation impacts women's rights, 13 September 2016.