

A Comparative Synopsis of Public Health Management in Botswana and Zimbabwe from a Public Administration Perspective

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Abstract

Governments have a huge role to play in the delivery of public health both at macro and micro levels. The provision of public healthcare is a matter of social justice and all individuals in a population should have access to the same programs despite their social status. Improving health and quality of life and reducing the impact of disease amongst the population should be the core business of public health administrators. The overall development of a country can be judged by the quality of its population's health how healthy people are across the social spectrum. Ever since their attainment of independence the two Southern African countries of Botswana and Zimbabwe have pursued aggressive public health policies within, but with varied results. This paper compares the public health philosophies of these two countries. The paper then analyses the public administration frameworks within which public health management can be located in these two countries and evaluates their impacts since independence. The paper will critique the state of public health management in these countries against the public administration ideology that each of these countries has pursued.

Keywords: *Public Health Management, Public Administration, Theories of Public Administration, Public Health.*

Introduction

The World Health Organization (WHO) defines health as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity”. (WHO: 1946). This definition is consistent with the concept of public health. In 1966 Botswana (formerly Bechuanaland) gained independence from British colonialism. It was one of the poorest countries in the world at the time of its independence and much hope was placed on the new administration of Sir Seretse Khama to deliver the basic level services. One of the most of these critical was public health care. In comparison, in 1980, Zimbabwe gained its freedom and the British left a very strong base of infrastructure and sophisticated economy which could have easily set the country on an accelerated development path.

However, they left a system that had placed the black people at a disadvantage in accessing to services like public health care compared to their white counterparts. In order to improve

access to quality health care, the Government of Botswana invested substantially in building health facilities all over the country. However, quality of health care and service utilisation remained a challenge as a result of inadequately skilled health professionals. (National Health Policy, 2011). In Zimbabwe, the largely socialist inclined government pursued a policy of free healthcare at independence and there was free public healthcare. However, in 1990, the government made a U-turn from this policy to pursue the neo-liberal policies as prescribed by the International Monetary Fund. Economic Structural Programme (as it was known) prescribed that government cut its expenditure and public health delivery was hard hit.

The government policies that followed – The fast Track Land reform Programme, DRC war intervention and the awarding of gratuities to the war veterans induced an economic free-fall which badly damaged the health sector. Combined with the isolation from the international community, the Zimbabwe

government could not fund public healthcare. This has led to the disaster in which the public healthcare in Zimbabwe is currently.

Theoretical framework

Public Health is a vital component of modern life. Extracting from the above definition given for health, Andresen and Bouldin (2011) contented that this holistic view of health, incorporating body, mind and community, is one consistent with the concept of public health. In comparing the public health state in these two Southern African neighbours of Zimbabwe and Botswana one needs to interrogate what public health entails. According to Winslow (2004), “public health is the science and art of preventing disease, prolonging life, and promoting health to ensure everyone a standard of living adequate for the maintenance of health.”

From the foregoing, the state has a very significant role in facilitating the attainment of the mission of public health which is to “fulfil society’s interest in assuring conditions in which people can be healthy” (Institute of Medicine: 1988). It therefore goes without saying, that public health is very much concerned with the needs and demands of the public. Much of the financing for public health activities comes from government. (Andresen and Bouldin: 2011).

This paper therefore seeks to investigate to what extent the governments of Botswana and Zimbabwe have been involved in the formulation, implementing and funding of all the activities of public healthcare within their jurisdictions. Both these countries define themselves as being developmental welfare states. A developmental welfare state is a form of government in which the state protects and promotes the economic and social well-being of the citizens, based upon the principles of equal opportunity, equitable distribution of wealth, and public responsibility for citizens unable to avail themselves of the minimal provisions for a good life. (Britannica online Encyclopaedia). It is my argument that a developmental state must therefore pledge to fulfil what Andresen and Bouldin (2011) term the hallmarks of public health which are pinned on a philosophy of social justice, a focus on populations and a focus on prevention.

Conceptual paradigm

Public health management is a domain that is handled by public administrators. Modern governments, just like in historical times, pursue a particular approach (either determined by ideology or by sheer lack of it) to administer the affairs of the state. Public administration has a long history which has been going in parallel with the very notion of government. (Katsamunskas: 2012). The classical model of public administration fronted by Woodrow Wilson and Fr. Taylor was thought to be the best way for organizing the public sector work and undoubtedly worked well for a long time. In general, it is characterized as "an administration under the formal control of the political leadership, based on a strictly hierarchical model of bureaucracy, staffed by permanent, neutral and anonymous officials, motivated only by the public interest, serving and governing party equally, and not contributing to policy but merely administering those policies decided by the politicians"(Hughes, Owen: 2003) . It was however criticised because it did not have a single, coherent intellectual foundation.

During the 1980’s and 1990’s there was a large-scale rethinking of governance. The new approach to public management became oriented to results, focusing on citizens, outputs and outcomes. It focuses on management by objectives and performance management, the use of market and market-type mechanisms in the place of centralized command and the control style of regulation, competition and choice, and devolution with a better matching of authority, responsibility and accountability. This is called the New Public Management approach. (Katsamunskas: 2012).

Over the last few decades the efforts across the world to conduct substantial reforms in the public sector were directed at ensuring good governance in terms of effective, ethical, accountable and transparent administration. This paper will measure the programs and reforms in public health management that have been implemented in Botswana and Zimbabwe using the new public management approach.

What is this new paradigm of public administration? Bouckert and Pollitt characterise it as follows

1. A shift from an internal orientation towards bureaucratic rules to an external orientation

towards meeting citizens' needs and wishes. The primary route to achieving this effect is not the employment of market mechanisms (although they may occasionally come in handy) but the creation of a professional culture of quality and service.

2. Supplementation (not replacement) of the role of representative democracy by a range of devices for consultations with, and the direct representation of citizens' views.
3. In the management of resources with government, a modernization of the relevant laws to encourage a greater orientation on the achievement of results rather than merely the correct following of procedure. This is expressed partly in a shift in the balance from ex ante to ex post controls, but not a complete abandonment of the former.
4. A professionalization of the public service, so that the 'bureaucrat' becomes not simply an expert in the law relevant to his or her sphere of activity, but also a professional manager, oriented to meeting the needs of his or her citizens/users. (Bouckert and Pollitt: 2004)

Background to public health management in Botswana and Zimbabwe

Public healthcare reform has been a hot topic in the last decades in the developing world. Botswana and Zimbabwe are not exceptions. Zimbabwe has well-prepared guidelines for management of key health conditions. However, there is a shortage of these guidelines at the lower level of service provision. Resource constraints (particularly transport and human resources constraints) have also limited the levels of supervision in the health system. (Osaka & Altman et al: 2010). In a nutshell, the public healthcare in Zimbabwe is a disaster.

Health governance is a challenging area for Zimbabwe. In the area of health financing, Zimbabwe's health system has been deeply affected by the country's two-decade long political, social, and economic difficulties. The high levels of inflation between 2005 and 2008 caused dramatic reductions in the value of funds allocated to health facilities and health offices. Regrettably, the lower value of health funds led to reduced ability to purchase commodities and equipment, pay wages, and support other

activities that would allow for better health service provision. (Osaka & Altman et al: 2010). After 1999 in Zimbabwe a lot of changes took place in the political landscape, and public sector, all of which had a bearing on the public healthcare services.

There are many factors contributing to Zimbabwe's health-care disaster. The economy has been in crisis since 1998 and the gross national product has shrunk by more than 50%. More than 80% of the country's 13 million people eke out an existence below the government's own poverty line. Shortages of staple foods are widespread and more than 4 million people are in need of food aid. (Meldrum: 2008).

During the Government of National Unity in Zimbabwe (2009-2013) when the ZANU PF government went into a coalition with the Movement for Democratic Change, Zimbabwe got a reprieve in the public healthcare sector.

The Government of National Unity recorded remarkable successes through cooperation with development partners. At the advent of the GNU, for instance, there was a cholera outbreak which had killed more than 4 000 Zimbabweans. This was stopped and since then the government has remained vigilant to avoid a recurrence. (Samukange: 2013). The GNU presided over the re-opening of major referral hospitals and primary healthcare institutions and improved drug availability to levels of over 80% at primary health facilities. (Samukange: 2013). Furthermore, the GNU in 2009 originated a new National Health Strategy which was organised to provide a framework for the immediate restructuring of the health sector, and to set the country back on track towards achieving the Millennium Development Goals on health.

Following the GNU, the 2013 general elections saw ZANU PF being re-elected. This resulted in a political crisis once again. Allegations of election rigging by the Opposition slid the country back into a legitimacy crisis and the social sectors to which the opposition had brought sanity, and in particular the public health sector was hard hit when the development partners decided to pull out. The 2017 coup d'état by the military in Zimbabwe worsened the crisis. The ZANU PF government under President Emmerson Mnangagwa has totally failed to come up with a

strategy to extricate the public health sector out of the mire.

In Botswana, the last Health policy had been adopted in 1995, but in 2010, the government launched its new public National Health Policy, 'Towards a Healthier Botswana, and in 2011, the national health strategy', 'The Integrated Health Service Plan'. However, of interest is whether these changes have had a significant managerial component and more importantly whether leadership has played an important role in bringing those changes on board. According to the national health policy, the provision of health services is not just merely curing the sick but also promoting healthy lifestyles in order to prevent diseases/bad-conditions for all people living in Botswana. (National Health Policy: 2011).

As much as Botswana has taken strides in offering state supported healthcare since its independence, similar problems that have bedevilled most African countries have been visited upon its health sector. According to Gobotswang (2016), modern and state of the art hospitals have been constructed in towns and major villages. Primary health facilities have been established in villages across the length and breadth of the country. However, an omission of monumental proportions was factoring in the maintenance cost of the infrastructure.

In his report Gobotswang mentions a myriad of problems that plagued the delivery of public healthcare in Botswana, namely: lack of skilled staff in clinics and hospitals, collapsed emergency services, overcrowding in public hospitals, poor meals, lack of ambulances - particularly in rural areas, failing and dysfunctional expert technology such as x-ray units and contaminated blood. (Gobotswang: 2016). According to Gobotswang, quoting from the latest report, all public health facilities except Scottish Livingstone, Mahalapye Hospital, Airstrip Clinic (Mahalapye), Xhosa Clinic (Mahalapye), and Phuthadikobo Clinic (Molepolole) failed the accreditation exercise because of poor quality of service. Among the private hospitals only Orapa and Jwaneng Hospitals are accredited. (Gobotswang; 2016)

While Gobotswang's scathing description of the public healthcare in Botswana can be described as one coming from an opposition political leader, it is important to mention two

things. Firstly that Botswana, like many of the developing countries faces a number of challenges in improving the delivery and management of public healthcare. Secondly, it is important to note that in comparison not only to Zimbabwe's public healthcare state but to some developed countries; Botswana has made huge strides in its public administrative approach to the provision of healthcare.

Public health in Botswana – a review

Botswana's economy is largely based on diamond mining, agriculture and to a lesser extent, tourism. Botswana is one of the sturdiest economies in Africa ranked top in Africa in 2017 by the Mo Ibrahim Governance Index. (yourbotswana.com). Its Human Development Index, a measure that looks at three human dimensions of standard of living, literacy and life expectancy (which is an indicator of the whole public healthcare system), is very high. HDI is measured on a scale between 0 and 1. According to Matambo (2019) Botswana's Human Development Index rose from 0.565 in 2000 to 0.717 in 2017, which was above the average of 0.537 for countries in Sub-Saharan Africa, although still below the average of 0.757 for developed countries. (yourbotswana.com)

It is important from the onset to state that while in other African countries diamonds were used to fight endless wars, in Botswana money from the diamonds were mainly used in the development of the Public health, social and physical infrastructure. Since the last national health policy of 1995 was developed the number of health sector stakeholders has increased, the population has grown and lifestyles have changed. There have also been many changes in health technologies for health promotion, prevention and treatment and the rehabilitation of people including those with disabilities. (National health Policy: 2011).

According to Ramsay (August, 2019), The Botswana government since the 1980s put up a very strong National health Policy which was meant to strengthen the delivery of all public health goods and services. This includes improving environmental health services, public health institutions and infrastructure that assist in providing efficient services. According to Ramsay, in as much as Botswana still has a long way to go in providing efficient public health

services, it is one of the leading countries in Africa.

In less than five decades, Botswana has transformed itself from one of the world's poorest countries at its independence in 1966 into an Upper Middle-Income Country (UMIC). (World Bank: 2015). To compound this point, massive improvements in the population's well-being have been achieved over the years through prudent management and investment of revenues from natural wealth into human development. Botswana spends 4.4 percent of GDP on social protection, 4.5 percent on health, and 8.5 percent on education. (United Nations: 2016). Access to clean water and safe sanitation has increased as well.

On the downside though, Botswana still needs to do a lot more to reduce the scourge of HIV/AIDS which remains an epidemiological crisis in the country. HIV/AIDS prevalence is high; 25.2 percent among 15-49-year olds and 18.5 percent when computed as a percentage of the population aged 18 months to 49 years. HIV prevalence is higher among females (20.8 percent) than males (15.6 percent). (Botswana AIDS Impact Survey: 2013). Ramsay (August, 2019) contends that the HIV/AIDS scourge has single-handedly been a major challenge to Botswana's efforts in providing public healthcare. He further explained that even as he was in government, he strongly believes more could have been done in terms of awareness, and educational programmes to reduce the incidences of the scourge. It's his contention that it indeed was an embarrassment that Botswana stood at the top as one of the countries with the highest percentage of HIV/AIDS infections in Africa.

Through its relatively competent public administrators there has been a push to improve public healthcare delivery in Botswana. There is a host of literature which this paper will not delve into that deals with epidemiology, data for public health, biostatistics, pharmacoepidemiology, environmental public health and behaviour and health which shows a new paradigmatic approach by the public officials in Botswana to provide public healthcare. This approach shows a willingness by the public administrators to focus on the needs of the citizens and a deliberate effort to efficiently and systematically ensure that government efforts are geared at improving the

state of public healthcare in the country. It is therefore a consequent result that Botswana is ranked highest in Africa on the HDI index whose aim among other things is to provide top-notch public healthcare.

Public health management in Zimbabwe – a review

It is an agreed fact that Zimbabwe's deepening economic crisis is brutally upsetting the government's capability to fund public health delivery and is restricting poor people's access to health care. As mentioned earlier, the economy had shown signs of modest improvement under the government of national unity (GNU) between 2009 and 2013, when President Robert Mugabe and his long-ruling ZANU-PF party shared power with the opposition, Movement for Democratic Change (MDC). "It is not surprising that people's right to health has been compromised by the state of the economy, health services are suffering a funding deficit because of the economic crisis, which has worsened in the post-GNU period." (<http://www.thenewhumanitarian.org>)

This brings into discussion the role of public administration in the delivery of public healthcare in Zimbabwe. The dire public health situation is attributable to bad governance, corruption and bad choices when it comes to prioritising development goals in Zimbabwe. Going into the 2018 budget planning year, there was a clarion call by many stakeholders to allocate the highest funds to public healthcare, but because of the deep-seated political issues that has always plagued Zimbabwe that call was not heeded. The Finance Minister allocated US\$400 million to the Ministry of Health representing 7.7% of the US\$5.1 billion budget in the same year.

Addressing the post budget seminar in Harare, the Speaker of the Zimbabwe's National Assembly, Advocate Jacob Mudenda said

"The deplorable state of the country's public health service delivery calls for a bigger budget in line with the 2001 Abuja Declaration. Apart from reviewing the Budget allocation for Parliament, the Ministry of Finance and Economic Development must consider revising upwards the budget for the Ministry of Health and Child Care. This Ministry should have the highest allocation, or at least comply with the 15% benchmark set by the Abuja Declaration.

This proposal is informed by the current deplorable state of our Public Health Delivery System ...health facilities are clearly not in sync with the Constitution of Zimbabwe which espouse the rights to health care for all citizens". (Mudenda; 2018)

The wider socio-economic problems in Zimbabwe are politically induced. The perennial allegations in the 39-year-old ZANU PF regime of election rigging and corruption have always evoked political illegitimacy. ZANU PF has largely been ostracised by the international money lenders and its credibility rating has had such repercussions that even independent governments and other lenders have shunned Zimbabwe. Therefore, the government of Zimbabwe is failing to fund public healthcare. It now heavily depends on donor funding for this but because of the political sanitation issues, the public administrators of public healthcare are unable to fulfil this duty. Ruth Labode, a medical doctor who heads the parliamentary committee on health and is a member of parliament for the MDC, said that not only had the government allocated too little to health in its 2014 national budget, but it was failing to fund that budget

Labode told IRIN that by the end of July the government had disbursed less than 20 percent of the budget money allocated to public health. She explained that the public health sector was receiving most of its funding from the donor community under the Health Transition Fund (HTF), a \$435 million multi-donor pooled fund established in 2011 and set to expire in 2015. The fund, which is managed by the UN Children's Fund (UNICEF) Zimbabwe with donations from several European Union countries and UN agencies, aims to improve maternal and child health and nutrition, as well as ensuring the provision of essential medicines, vaccines and basic medical equipment. (https://reliefweb.int/report/zimbabwe/zimbabwe-es-health-system-crisis)

Without the donor community therefore, the public health system practically collapsed given that they funded the majority of the health programmes. But no doubt even the international community will get faded as widespread corruption is reported. Labode (2014) added that, health service delivery had also been crippled by corruption such as theft of

drugs and equipment from hospitals, and the flouting of tender processes by hospital officials for personal gain. In addition, she said, "the migration of trained labour has hit this sector more than any other.

(<https://reliefweb.int/report/zimbabwe/zimbabwe-es-health-system-crisis>).

Dr. T. Mauswa, A doctor in one of Zimbabwe's public hospitals decried the lack of capacitation in the public healthcare system. She lamented that government has failed to provide even the smallest items needed to provide basic public healthcare such as gloves, needles and even the most basic pain killers such as panados. She suggested that it was the lack of government prioritisation of public healthcare that the resources are rather used for inconsequential things such as political rallies, ruling party fleet of cars, purchase of presidential private jets and an exclusive political dialogue yet public hospitals remained in a deplorable state of decay.

Discussion

The difference between these two countries is that Botswana has invested heavily in health (9.5 percent of gross domestic product) (United Nations: 2016), HIV&AIDS (16 percent of total health expenditure in 2013/2014). (National Health Accounts: 2014). At all material times, Botswana's successive governments have used the proceeds from the diamond mining and tourism to invest in social protection programs. A case to emphasise is that, Botswana has one of the world's highest known rates of HIV/AIDS infection, but also one of Africa's most progressive and comprehensive programs for dealing with the disease. Through fiscal discipline and sound management, Botswana has transformed itself from one of the poorest countries in the world to a middle-income country with a per capita GDP of approximately \$18,000 in 2017. Botswana also ranks as one of the least corrupt and best places to do business in sub-Saharan Africa. (www.indexmundi.com).

According to Lefika Kokorwe (September, 2019), a Botswana Accountancy College student, Botswana's public healthcare is lacking and especially with the recent announcement that the Botswana Government will not be able to provide free HIV/AIDS treatment and therapy, it all puts the public in a very dangerous place considering that Botswana is the country

with one of the highest HIV/AIDS incidences. He lamented in as far as the government has tried to put out awareness information out there for people to be educated, there is less action to support such as the availing of treatment like PREP.

He however commended the government for putting up a very strong immunisation programme for children and whenever there is outbreak of diseases such as the Flu Virus and Yellow fever. He also argued that the government and its institutions are slow to respond to the environmental health hazards such as clearing roads after flash floods, totally nothing is done in the face of heat waves as a result of climate change. All the government encourages is for people to drink water, wear protective clothes and staying indoors. In modern countries modern cooling systems have been installed in most public places for the relief of the citizens.

Botswana over the past few years has faced debilitating brain drain in the area of rehabilitation of substance abusers and mental health patients. According to him this is because of working conditions and they seek better ones in the region and overseas. This has put recovering patients and new patients into danger of relapse and worsening conditions. On the whole however there is a general agreement amongst the analysts that Botswana, in comparison to the other economies in the region has done extremely well in the provision of public healthcare.

Historically, Zimbabwe boasted a thriving teaching hospital network, a strong primary healthcare system installed in the 1980s by the government (Woelk: 1994), and a motivated, highly trained health workforce (Chikanda: 2006). However, during his reign, Mugabe undermined this health system through human rights abuses and economic mismanagement, among other actions. Authoritarian regimes such as in Zimbabwe have a penchant of centralizing power. In Zimbabwe's current system, most strategic health decisions are made at the national level rather than in district health offices. (Kidia: 2018). Innovative community health interventions would help to spread the decision-making authority and flatten the current hierarchy in a more purposeful way. This approach would grow local leadership and

ensure that interventions are socially and culturally sensitive.

Zimbabwe has become a pariah state: isolated from the international community due to decades of corruption (Transparency International: 2018), political violence (Physicians for Human Rights: 2008), and lack of transparency. Zimbabwe needs, among other things, to re-establish its legitimacy by prioritizing a human rights approach to health. Refocusing the public health debate on human rights has been a successful strategy of organizations such as Partners in Health in places such as Haiti, Malawi, and Liberia. (Farmer: 2004). In Zimbabwe, an approach rooted in the New Public Management ethos of accountability, respect for human rights and concern for citizens should include structural access to clean water, food, and humane living conditions; protection for vulnerable populations; and a zero-tolerance policy for political violence and intimidation. The government should fight corruption in the health sector and work with international organizations to create strong accountability mechanisms at both the national and district levels.

Zimbabwe is currently gripped with a debilitating public healthcare crisis which threatens to cripple the economic performance of that country as the economically active people cannot access public healthcare. According to Magombeyi, there is a slow genocide happening in Zimbabwe as serious cases of illness and complicated pregnancies are turned back home without any assistance. He contends that this situation is compounded by the fact that all other ancillary services to public healthcare are not available in Zimbabwe such as clean water, functional infrastructure and the requisite technology to match modern world standards.

In an interview with a political analyst Taziveyi Makwanya, He lamented that Zimbabwe faces a danger that because its government is largely composed of the old guard who largely have failed to transform the analogue technology in public healthcare, in the next few years it will come to a complete standstill. He said in a world where America, German and Britain are moving to electric cars and other modern technology, ambulances will cease to exist and our country will suffer as it is failing to adapt to current changes.

Concluding remarks

Public health management is a task that the government is entrusted to deliver. It is clear that public administrators have to be conscious of the need for an approach that seeks to maximize benefits for the citizens; it needs to be accountable and professional. Botswana presents a progressive experience in public health delivery as it is run by a government that believes in good governance and follows a reformist model of public administration. On the other hand, the Zimbabwean situation is dogged by a narrative of an illegitimate government whose sole object is survival at all costs despite vilification by mainly western countries. Therefore, power has been centralized to the point that public health decisions are no longer meant to cater for the citizens but are political. The disastrous state of public health delivery in Zimbabwe can only be solved through the sanitization of the politics in the country.

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