

Non-communicable disease prevention and management in health financing: What can be done at policy level? – A desk review

Introduction

Zimbabwe has a high burden of disease to which all the six building blocks that make up a health system are compromised (MoHCC 2009). These are the leadership and governance, health care financing, health workforce, information and research, medical products and service delivery (World Health Organization (WHO) 2014). Factors that led to the detriment of the blocks went beyond the confines of the health sector. Political, environmental and economic factors since independence in 1980 to date have played a role in shaping the way the health system functions (Chikanda 2007).

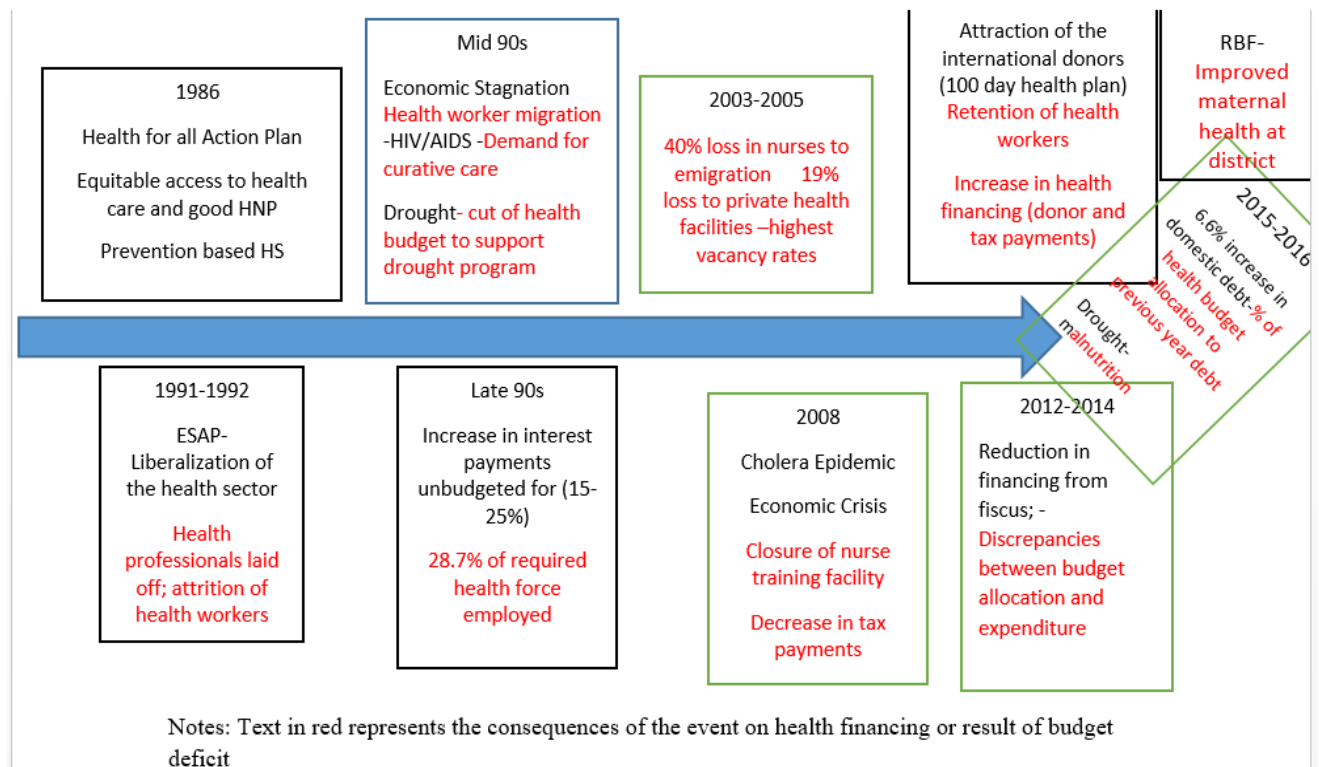
To date there has been a noticeable reduction in the prevalence of the diseases, while non-communicable diseases (NCDs) which were overshadowed by the prevalence of infectious diseases increase. (Chokunonga et.al 2010; Mutowo et.al 2014). NCDs account for 31% of morbidity (World Health Organization: WHO 2014; World Bank 2016).

The WHO attributes the high burden of disease to 1. A change in population lifestyles and 2. The underfunding of the health sector due to low revenue realised from the fiscus that funds the national budget. This has been reiterated in several academic, development and Zimbabwean government publications (Johnston 1999; Chikanda 2007; Ministry of Health and Child Care MoHCC 2009; Public Expenditure Report (PER) 2011; Shamu 2012; Sithole 2013; World Bank 2016).

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Key factors that shaped the health system



Author's Compilation sourced from Johnston 1999; Chikanda 2007; Munyuku and Jasi 2009; MoHCC 2011; Shamu 2012; Toonen et.al 2015.

In 2016, the El Nino effect created a critical drought in Zimbabwe and child malnutrition increased to a level, last experienced 15 years ago, at the same time that NCDs require attention on a system that still suffers from dilapidated infrastructure, particularly in the rural areas (Green 2016). It has compounded low production of local food which reinforced high food imports constituted mainly of processed foods. This is worrisome as consumption of western diets of processed foods, alcohol consumption and a lack of physical exercise are the major risk factors identified for prevalence of NCDs in Zimbabwe (Mutowo et.al 2015).

Leadership and Governance

Priority of NCDs management by the MoHCC, was reflected in the national budget (Mutowo et.al 2015; National Budget 2016) and internationally in the sustainable development goals (SDGs). However, disparities in health finance allocation undermines the implementation of NCD management interventions. For a resource constrained system, investment in prevention of NCDs, would make better health outcomes with minimum funding as it did in 1986, as compared to

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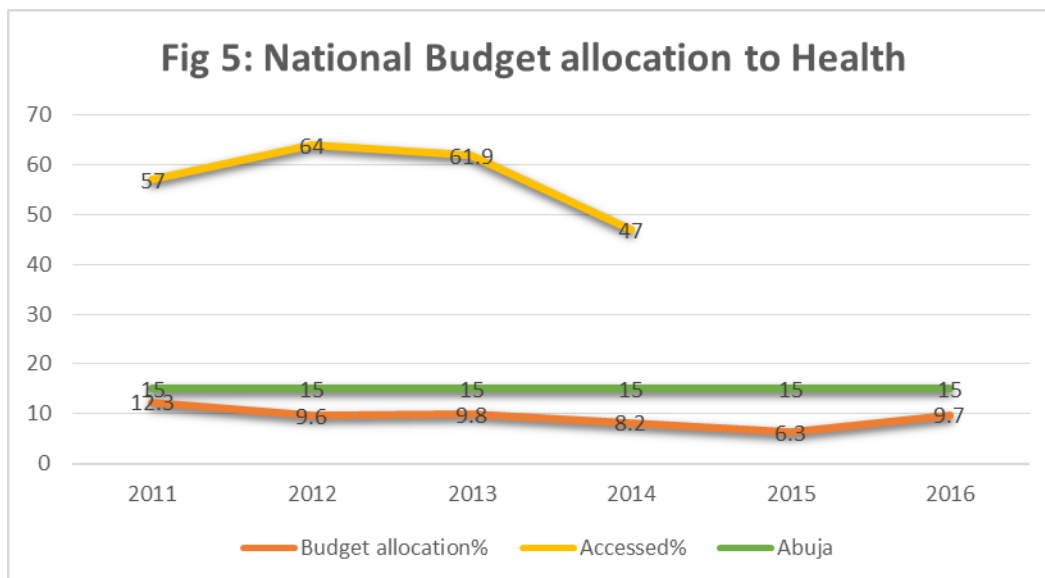
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curative care (Public Expenditure Management (Dhoro et.al 2011). Parkin et.al 2012 continues to say:

"Prevention is rightly proposed as of primary importance as it is undoubtedly more logical, and cost-effective to prevent disease than to deal with it once it has occurred. The benefits of preventive interventions take a long time to be manifest, and the more urgent needs of alleviating suffering among patients with cancer will take priority, but this should not preclude relatively modest investments to reduce the size of the problem to be dealt with in future." (Parkin et.al 2012:962)

However the bulk of health expenditure is spent on medical care while 18% is for capital expenditure (PER 2011, World Bank 2015). This is substantiated by Mutowo et.al (2014:9) who states that "health systems in Sub-Saharan Africa are currently organized for the treatment of acute rather than chronic conditions."

Funding to the health sector, has in general been falling below the stipulated 15% in the Abuja Declaration passed in 2001 that Zimbabwe ratified to. To compound the situation there are discrepancies in accessing the funds allocated as illustrated below.



Compiled by author from Shamu 2012; MoHCW 2011; 2013 Toohen 2015

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Research and knowledge is also crippled as there is barely any financial allocation to it yet, it is essential in guiding decision making in tackling NCDs (Murowo et.al 2014). While there is active data collection to inform the MoHCC and international partners on progress with the infectious diseases, WHO 2012 and Mutowo et.al (2015:1) notes that “NCD mortality estimates for Zimbabwe have a high degree of uncertainty because they are not based on any systematically collected NCD national data.” This is substantiated by two other systematic reviews that excluded Zimbabwe because of low and medium quality of data as studies has a low geographical representativeness of 10% of the total population and had a policy developed prior to 2004. (Stanifa et.al 2014; Larchat et.al 2015).

Monitoring of NCDs is done through analysis of cause of death statistics. Prevalence of Diabetes data in Zimbabwe for example, is based on program estimates for major causes and estimates based on combination of African country life tables and regional cause of death patterns (Mutowo et.al 2015). The International Diabetes Federation (2013) obtained data from a 2005 subnational survey and indicated that it is likely that the majority of the population remains undiagnosed. This is partly attributable to a situation when complication of an NCD is listed as the cause of death instead of the NCD (Mutowo et.al 2014). A health information system (HIS) for the purposes of surveillance in hospitals(HIS) was launched in Zimbabwe in 2010 and upgraded in 2014 (CDC 2015). It collects routine data including chronic diseases, representing 75% of the country. However, its primary focus is on priority infectious disease interventions (Sithole 2013).

What can be done at policy level: Policy Interventions

Policy One: Sentinel Surveillance of non-communicable diseases policy

Content -The aim of the policy is to strengthen the information and research building block. This will in turn directly strengthen the leadership and governance building blocks because MoHCC has the administrative role of distributing finances. The outcome is the true prevalence of NCDs and expected evidence based distribution of funds towards NCDs.

The policy suggests an integration of NCDs and risk factor surveillance reporting system using a combination of outpatient data and risk factors that are collected routinely in health facilities. The surveillance will be for both diagnosed patients and the population at high risk, which may vary with each NCD. The current health information system (HIS) has had good feedback on the completeness of data which is important in NCD surveillance.

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Actors -The HIS is funded by the Centre for Disease Control (CDC) and Global Fund while MoHCC through health facilities take the implementation role. The health personnel responsible for routine data are considered as actors as they are responsible for primary data collection and need to be notified on NCD data collection and collation.

Context- The current HIS is already collecting data on NCDs as part of routine data collection, covering 75% of the country. In reference to the cancer registry, this policy is important in increasing the coverage, which covered Harare, the capital city (Zimbabwe cancer registry). This is possible as the HIS has a 75% nationwide coverage. In addition, WHO (2014:1) notes that Zimbabwe has “**no evidence-based national guidelines/protocols/standards for the management of major NCDs through a primary care approach.**” There is a correlation between having the guidelines and a low NCD prevalence in Zambia and Malawi and vice versa is true for Zimbabwe, Botswana and Swaziland. (WHO 2014). Although confounding factors, such as risk factors, gender and age distribution differ between countries, the relationship cannot be ignored. A systematic review by Kroll et.al (2015) revealed that facility based surveillance can provide improved evidence on NCD and risk factors and help budget limited resources. The policy does not affect the population directly however, it may face opposition or implementation difficulties from health workers responsible for collecting and collating the data. While reporting will be part of the daily routine, health information officers will face an even bigger workload in isolating data generated for the NCD surveillance. This may cause potential problems as workload increases have contributed to poor service delivery (Chirwa et.al 2015). Furthermore the HIS does not cover the main hospitals in the urban areas where diabetes, hypertension, cardiovascular disease are more likely to occur (MoHCC 2013; Matavire et.al 2015).

Policy Two: Earmarked alcohol tax for NCD management policy

Content - Policy two intends to directly strengthen the health financing and service delivery building blocks. The outcome is the reduction or control of a risk factor to NCDs and increase in financing towards NCD prevention and management.

The policy suggests an increase in tax on alcohol imports. This tax is earmarked for the prevention and treatment of NCDs in health facilities.

The proposed policy builds on the provisions of the National Alcohol Policy that stipulates that:

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“Increase capacity of health and social welfare systems to deliver prevention, treatment and care for alcohol- use disorder and co-morbid conditions.

Introduce a system for feedback and referral for alcohol related assessments and treatment from hospital accident and emergency department to specialist alcohol services

Promote primary-care settings as an accessible non-stigmatizing opportunity for health promotion and treatment of alcohol use.” National Alcohol Policy (2010:22)

The earmarked tax will begin to fund NCD management at service delivery. One of the five major hospitals prevention and research and knowledge building blocks on NCDs will be the first point of call. This is because of the high incidence likely to occur in the urban areas (Mutowo et.al 2015).

Actors – MoHCC plays a pivotal administrative role in the distribution of the finances. Ministry of Trade and Industry, Ministry of Finance and Beverage Association will be responsible for determining the adequate tax increase to charge given the import statistics. Finally the Zimbabwe Revenue Authority (ZIMRA) will be responsible for collecting the tax.

Context – Zimbabwe lies in the top 10 of heaviest and riskiest drinkers in Africa. Overconsumption of alcohol is a risk factors of many consequences including injury from domestic violence and road accidents. In contrary alcohol is also a source of income that feeds into the fiscal revenue this may act as a barrier to the implementation of the policy among stakeholders however, targeting the alcohol imports exclusively, will not affect local production of alcohol. However, as a result of the current economic crisis, ZIMSTAT (2016) notes that import of alcohol has been decreasing and this may impact the amount of money realised from the tax. In terms of public perception on the policy, a study by Buykx et.al (2015) in both low and high income countries, showed acceptance of alcohol policy on increasing tax and price by the general public, once they were aware of the health risks associated with overconsumption of alcohol.

Review of the policies

Both policies are very crucial in laying the foundation to prioritizing NCDs in health financing. However as indicated earlier, policy to be adopted will depend on timeliness, the cooperation of actors and degree of impact on the health financing building block.

Actors- As indicated, policy one is vulnerable to health worker collation of NCD surveillance and risk factor data. An increase in workload, has been the second reason to the attrition of health

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workers(Chikanda 2006), While it has been reported that health workers favoured the health information system because of lack of time spent on administration in reporting (Pascoe et.al 2012). Policy two on the other hand, modifies the alcohol policy that has already been accepted by all the relevant actors and has prioritized NCDs in the national budget (National Budget 2016).

Timeliness - The current absence of the HIS in the central hospitals, undermines the purpose of policy one in the short- term as the population at risk is in urban areas, serviced by the hospitals. Though the 100% coverage of the Weekly Surveillance System is an indication of the HIS covering the entire nation soon, policy requires the collection of data over a period of time before analysis that will be used in finance distribution by the MoHCC. On the other hand, policy two allows direct injection of finances from the fiscus into NCD management.

Policy two directly contributes to the financing building block towards NCD management, while policy one is vulnerable to the wider context, where the current drought effects may take precedence over NCDs side lining the issue once again.

With regard to the above policy reviews, policy two should be implemented as it creates new funding for NCDs management, and thus directly strengthens the health care financing building block in a timely manner. However, policy one should be considered for implementation in the near future as information and research is an important building block in the health system.

This desk review was done with the use of published reports and papers up to 2016. Zimbabwe has very little published research and therefore any missing information has not been availed through published accredited work.

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