

Towards an Ethically Justified Model for Access to Healthcare in Zimbabwe

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Declaration

This thesis represents my own original work, produced with supervisory assistance. All the relevant sources that I have used during the course of the writing have been fully credited and acknowledged. This thesis has not been submitted for any other academic or examination purposes at this or any other university.

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Dedication

I dedicate this work to my late parents and my maternal grandparents: My mother Elisie Dhaniye Gapara, my father Lazarus Matepo, my grandmother Fanisa Gapara (née Mapungwana, Kwomukhuyu) and my grandfather Johanne “Chikimbikimbi” Gapara. My mother passed away in April 1993 - sadly before my first university degree. This will be my sixth degree, capping a lifelong period of learning and studying - thanks to their nurturing support, love and unstinting encouragement since childhood. My mother, Elsie, was an icon who barely managed to obtain standard five, but had all the hallmarks and characteristics of a very intelligent woman, a genius *par excellence*. Rest in peace all my role models, heroines and heroes. You would be proud to see this.

Acknowledgements

I would like to recognize the contributions of several people who assisted me in various ways in the preparation and writing of this thesis, many of whom cannot be mentioned by name. The list below is neither exhaustive nor in order of importance:

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- I feel greatly indebted to Professor Christopher Wareham and Dr Jillian Gardner for providing guidance and supervision during the writing of this work, and for their tolerance, patience and belief in my capability, even when they had sufficient reason not to do so. I credit both of them and their colleagues at the Steve Biko Centre for Bioethics and Health Law at the University of the Witwatersrand. A special mention must go to Prof. Kevin Behrens, who recognized and nurtured my ambition when I submitted my concept paper.
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- All those behind the scenes, too numerous to mention by name.

Abstract

This study was conducted in order to provide a possible solution to the myriad of healthcare access problems affecting Zimbabwe. A desktop analytic review of literature, reports, legal and policy documents was carried out on the historical development of healthcare delivery in Zimbabwe spanning the pre-colonial, colonial, and post-colonial periods. Relevant literature was identified by electronic searches using Mendeley, Google chrome, and other internet search platforms. Summaries of the articles were analyzed for emerging themes and conclusions were drawn.

This thesis traces the development of healthcare policies in Zimbabwe starting from the pre-independence period to the post-independence period (2020). It critically analyses the egalitarian, utilitarian, and ubuntu moral theories bringing out their potential application to the design of a new model that has the potential to address challenges of access to healthcare in Zimbabwe. Selected influential healthcare models and systems such as the Beveridge, Bismarck, National Health Insurance, Single-payer systems, Multi-payer systems, and the Out-of-Pocket Spending systems are also critiqued, based on their social, legal, and ethical relevance to the aims and objectives of this thesis.

The thesis presents a suggested new ethically justified healthcare model for Zimbabwe, called the Citizen Centred Healthcare Model (CCHM). It is premised on six fundamental building pillars or blocks which guarantee human rights and citizen-oriented service provision: Prioritized Healthcare Financing, Equitable Rationing of Healthcare Services, Social Solidarity and Human Rights Culture Promotion, Effective Monitoring and Evaluation, Inclusive Healthcare and Stable Political and Macroeconomic Environment.

Acronyms

AU: African Union, the organisation that replaced the Organisation for African Unity (OAU).

CIMAS: Commercial and Industrial Medical Aid Society

COVID-19: Coronavirus Disease 2019. It is an illness exhibiting mild to severe signs and symptoms affecting the respiratory system. It is transmitted by being in contact with contaminated material such as sneezing droplets. Signs and symptoms include fever, coughing, dyspnoea which may lead to pneumonia and respiratory problems. The disease was first encountered in China in November 2019 in a province called Wuhan.

GDP: Gross Domestic Product

GNU: Government of National Unity, a short-lived multi-party government from 2009 to 2013 in Zimbabwe.

HIV/AIDS: Human Immunodeficiency Virus, Acquired Immunodeficiency Syndrome

MDC-A: Movement for Democratic Change, Alliance

MDC-N: Movement for Democratic Change, Ncube

MDC-T: Movement for Democratic Change, Tsvangirayi

MDGs: Millennium Development Goals

MOHCC: Ministry of Health and Child Care

NHI: National Health Insurance

NHS: National Health Service

OECD: Organization for Economic Cooperation and Development

PPEs: Personal Protective Equipment

PSMAS: Premier Service Medical Aid Society

PSMI: Premier Service Medical Investments

SADC: Southern Africa Development Community

SDGs: Sustainable Development Goals

SI: Statutory Instrument

TM: Traditional Medicine

TRIPS: Trade-related aspects of intellectual property rights

UDI: Unilateral Declaration of Independence

WHA: World Health Assembly

WHO: World Health Organization

WTO: World Trade Organization

ZANU(PF): Zimbabwe African National Union, Patriotic Front

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CHAPTER 1: ROAD MAP OF THIS THESIS

1.1 Research Questions and Objectives

This thesis aims to address the following research questions:

- i. What are the economic, legal and social challenges affecting access to healthcare in Zimbabwe?
- ii. Which model of health care is ethically justified and appropriate in a Zimbabwean context?

1.1.1 The Specific Objectives of this Thesis

- i. To trace the historical development and philosophical basis for health policy enunciations in Zimbabwe spanning the pre-independence period to post-independence (up to 2020).
- ii. To describe the egalitarian, utilitarian and ubuntu moral theories which were selected based on their novelty, historical influence and how they address elements of distributive justice.
- iii. To normatively critique the ethical, legal and social aspects of selected healthcare models on access to healthcare, which has potential application to the situation in Zimbabwe.
- iv. To suggest an ethical and morally defensible model for improving and reforming access to healthcare in Zimbabwe, that builds on progressive aspects of the major moral theories, conventional healthcare system models, international, and regional and national legal provisions.

1.2 Research Methodology

A desktop analytic review of published literature, reports, legal and policy documents was carried out to trace the historical development of healthcare delivery in Zimbabwe spanning the pre-colonial, colonial and post-colonial periods. Relevant literature was identified by electronic searches using Mendeley, Google Chrome and other internet search platforms. Priority was given to published reports and articles obtained from online journals or other official publications only if they were on verifiable official websites or in peer-reviewed journals. Summaries of the articles were analysed for emerging themes and conclusions were drawn.

A critical analysis of the egalitarian, utilitarian and ubuntu moral theories was done to evaluate how they influence the formulation of operational frameworks for models of healthcare and how these frameworks differ in so far as they can guarantee improved access to healthcare. This analysis assisted with designing a new ethically justified healthcare (HC) model called the Citizen Centred Healthcare Model (CCHM), discussed fully in chapter 9, to address inadequate access to healthcare in Zimbabwe. The utilitarian theory is especially important for providing a countervailing comparative analysis to both the egalitarian and Ubuntu positions. The utilitarian moral theory is one of the oldest and most influential in normative ethics and, as such, it is critical that it be harnessed to shape any development or improvement of healthcare policy.

A waiver for ethical clearance was obtained from the University of the Witwatersrand Health Research and Ethics Committee (Medical) in 2017.

1.3 About the Author of this Thesis

Dr Farayi Moyana is a Public Health dentist with a special interest in Orthodontics, Bioethics, Health Law, the design and evaluation of medical and dental training programmes such as training programmes for dental nurses, dental therapists and village health and developmental workers. He has an expanding passion for Public Health, Community Development, Social Justice, Corporate Governance and integrity, as well as the empowerment of marginalized and underprivileged children. Born in 1967 he grew up in the rural areas of eastern Zimbabwe, in a province bordering Mozambique, called Manicaland. Like many young boys of his generation, he grew up witnessing the limitations and inequalities of the colonial healthcare system in the then Rhodesia. But despite these limitations, the healthcare system appeared efficient and functional. During the first five years of Zimbabwe's independence, he moved to Harare, the capital city. This is also the time that the country was witnessing a massive expansion in healthcare delivery to cater for the hitherto marginalised black majority. He enrolled for a diploma in dental therapy in 1985 at the then Andrew Fleming Central Hospital (now renamed Parirenyatwa Central Hospital). Over the years he has experienced the steady decline in access to healthcare by the Zimbabwean population, despite an initial improvement during the first decade after political independence.

He is a Board Member for Sunshine Kids Mushavana, a Non-Profit-Making organisation headquartered in Australia. He is the founder and director of the Zimbabwe Academy of Dental Nursing and Board Chairperson for Domboshava MedClinic (Maternity Hospital, Dental, Medical and Ultrasound Scan Centre). He carries out his dental and orthodontic clinical work in Harare. He offers Corporate Social Responsibility (CSR) to Daniye Dental Clinic, a community dental facility for the low-income group in the Kuwadzana High-Density suburb of Harare. He has been involved in dentistry for the past 35 years, starting at

the tender age of 20 years when he completed a dental therapist diploma in 1987. He is a past Honorary Treasurer for the Zimbabwe Dental Association (ZIDA), the longest-serving office-bearer in that position, from 2004 to 2018. While in that position he led an ambitious campaign to raise funds to advance the cause of dentistry and public health in Zimbabwe. In August 2020, at the occasion of the Zimbabwe Dental Association (ZIDA) Annual General Meeting, he was awarded the prestigious Protea Trophy, the highest accolade that ZIDA can bestow to someone for outstanding achievements and contribution to the voluntary professional association. He is also a member of the Research Ethics Association of Southern Africa (REASA). He is a reviewer of health research proposals at the Medical Research Council of Zimbabwe. Apart from his Bachelor's degrees in Dental Surgery and Adult Education from South Africa and Zimbabwe respectively, he has three master's degrees in Public Health, Applied Medical Ethics and Business Administration. He has post-graduate diplomas and certificates in Health Research Ethics, Health Teacher Training, Orthodontics and Dental Implantology.

This Doctor of Philosophy (PhD) degree in Bioethics and Health Law caps a childhood dream of a lifelong journey of learning and studying.

1.4 Rationale for this Thesis

This section deals with the rationale for this thesis and is divided into two sections. The first section focuses on important international, regional and national statutes protecting the right to health to which Zimbabwe is a signatory. It also provides a detailed discussion on the legal aspects of healthcare as a special good. The second section focuses on ethical justifications for a new model of access to healthcare in Zimbabwe.

Every healthcare model and any healthcare reform ought to be guided by a solid ethical foundation for it to protect, promote and fulfil consumers' legitimate right to healthcare

access. This thesis presents an in-depth normative analysis, comparison, and critique of the ethical, legal, and social aspects of various models of access to healthcare (HC), and aims to ethically justify a new or reformed model for Zimbabwe that takes into account the unique ethical, legal, social, political and economic circumstances of the country. This kind of contemporary normative research regarding access to HC in Zimbabwe cannot be overemphasized. In fact, it is my argument that this type of discourse is long overdue. Despite the fact that Zimbabwe generated a plethora of successive healthcare policies since independence, it still witnessed a gradual and progressive deterioration of access to HC starting from the 1990s (Bassett, Bijlmakers and Sanders, 1997). There is a paucity of literature on this topic and research of this kind is desperately needed to assist policymakers and politicians to craft ethically justifiable policies which can improve access to HC in the country. This thesis will go a long way towards closing this gap. In addition, this is a unique study in the sense that it focuses on a country with one of the highest literacy levels in Africa (Kickbusch and Payne, 2003) and a significant reduction in HIV/AIDS morbidity and mortality rates (Hallett *et al.*, 2006) but with the fastest decline in standards of living outside a war zone (Tamukamoyo, 2010; Crush and Tawodzera, 2011). A search of the literature reveals that this type of study has never been carried out in Zimbabwe. Similar studies elsewhere are consistent in showing a need for further research in this area (Daniels, 1982; Waymack, 1993; Russell, Bennett and Mills, 1999; Daniels, Saloner and Gelpi, 2009; Matthews, 2009; Maharaj and Paul, 2011).

1.4.1 Why Healthcare Reform?

There is a fundamental question which drives the quest for a change in the *status quo* in a healthcare system and that question is: How should a country format, programme, or structure its healthcare system? The need for the reform or complete overhaul of a healthcare

system is not just undertaken as a ritual or simply for the sake of doing it. There are critical needs and forces which drive such a mammoth task. In some countries, for example, the United States of America (USA) and the Netherlands, the driving forces behind healthcare system reform are increasing and escalating health expenditure and a lack of universal health coverage (Hsiao, 2003). In East European countries, such as Russia, the drive has resulted from somewhat a different paradigm. Following the fall of socialism, their programmes started to move from a centrally managed to a free economy and this has created a need to restructure their social protection programmes, including those for healthcare. Newly industrialized countries such as Taiwan, Singapore and South Korea have different push factors. The push factor in those countries largely emanates from the increasing or burgeoning middle-class population who now demand efficient, accessible, responsive, and affordable healthcare services. As is largely expected, the driving forces for healthcare reform in low and middle-income countries (LMIC) are different from those in highly industrialized countries and emerging economies. The impact of successive macro-economic structurally adjusted programmes on some LMIC has led to a need to reform their healthcare systems. Zimbabwe is a developing country, whose classification into that category and not into the least developed countries (LDCs)¹ is somewhat controversial, because it, together with Papua New Guinea and Ghana, declined to be included in the LDCs classification despite expert recommendations (UN, 2018). The classification of countries into and promotion from the LDCs classification has always been controversial (Hawthorne, 2011; Kawamura, 2014; Alonso, Cortez and Klasen, 2015). The government of Emerson Mnangagwa prides itself on positioning Zimbabwe towards a middle economy by 2030 (Chitiga, 2018). This aspiration

¹ *The least developed countries (LDCs) is a group of developing countries which, as defined by the United Nations, are characterised by lowest indicators of socioeconomic development, including lowest Human Development Index ratings of all countries in the world. The concept of LDCs started in the late 1960s and the initial group of LDCs was compiled by the United Nations in its resolution 2768 (XXVI) of 18 November 1971 (UN, 2018).*

and vision are not shared by others amongst the general population who have suffered and are still suffering immense economic deprivation since the 1990s (Razemba, 1998; Chattopadhyay, 2000; Andrew, 2015a). Zimbabwe has had numerous economic blueprints since political independence in 1980, without much success. The economic blueprints have not had a lasting solution on the social impact created and healthcare remains in a deplorable state (Munyaradzi, 1979; Agere, 1990; Makoni, 2000; Andrew, 2015a). It is beyond the scope of this thesis to go into details about the various failed macro-economic policies adopted and discarded by this country since independence in 1980. However, the various healthcare policies are discussed in chapter 4.

1.4.2 Healthcare as a Special Good: A Description of Legal Protections

There is a lingering debate about whether healthcare is a special social good or not and whether society, through its governments ought to guarantee the provision of healthcare to its citizens. Connected to this debate is the argument for and against the risks individuals decide to take with their lives with regard to whether they have the same claim to subsidies from the state on their healthcare services. If we accept that their lives and their health is a matter of their own determination, then, should we also accept that the risks are their own? How far should society interfere with individual choices as far as life choices are concerned? Some argue that no matter how special healthcare is, it should never be allowed to conflict with the individual's freedom, liberty or opportunity, while others counter-argue that society has a duty to protect the individual from his recklessness (Daniels, 1985a; Pellegrino and Thomasma, 1987; Hasman and Holm, 2005b; Papadimos, 2007; Maluka, 2011). For example, could the need to protect an individual from his own potential for recklessness justify the widespread lockdowns during the COVID-19 pandemic? The answer to this question may lie in what others argue to be justifiable on the grounds that the enjoyment of one's rights must not infringe on other peoples' rights. Using the example of COVID-19 above: it is both very

infectious and potentially fatal and as a result, any hesitancy in public restrictions on such freedoms, as in freedom of movement during lockdowns and quarantines, may have irreversible consequences on other innocent people. Even though the right to health² is paramount, connected to other basic and enabling rights and includes a list of entitlements, a balance needs to be struck between the enjoyment of individual rights versus the protection of the general public. Ultimately, the State is obliged to provide a sound healthcare system regardless of the choices to be made by individuals on whether to access it or not (Thomas and Buckmaster, 2010; Pinto and Upshur, 2013; Watch, 2020).

The right to health is sacrosanct and is protected by international, regional and national statutes, despite the fact that only lip service is paid to this ideal by many governments. At the international level we have the World Health Organization, a specialised agency of the United Nations (UN), established within the terms of Article 57 of the UN Charter and whose constitution guarantees and protects the right to health of the states who are parties to this constitution. The state parties who endorse the WHO constitution based on the United Nations Charter uphold the definition of health as not merely the absence of disease and disability, but must include complete physical, mental and social well-being. The enjoyment of a high standard of health is a fundamental human right which is not limited by race, religion, political beliefs, economic or social rights. Governments have an obligation to fulfil and attain their citizens' health (World Health Organization, 2006).

Zimbabwe is a signatory to the WHO constitution and is bound and obligated to fulfil the objectives of the constitution. Another internationally binding treaty to Zimbabwe is the Universal Declaration of Human Rights (UDHR), which states that: "Everyone has a right to a standard of living adequate for the health of himself and his family, including, food,

² *A fully exhaustive discussion on the right to health is beyond the scope of this thesis. The reader is referred to other sources such as Toebes (2001) and MacNaughton (2018) for full details.*

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 livelihood in circumstances beyond his control” (UNESCO, 1948, p. 52).

The UDHR is noted as an aspirational consensus position arising fresh from the Nazi atrocities and how vulnerable groups such as the Jews, gypsies and homosexuals were unfairly treated. It is still as relevant as it was then (London and Baldwin-Ragaven, 2006). In addition, it goes beyond considering healthcare protection from only a biological angle, but extends to the social protection needs of the population as well. Other pertinent international statutes that protect the right to health include the Convention on the Elimination of All Forms of Discrimination Against Women³ as well as the International Covenant of Economic, Social and Cultural Rights (ICESCR)⁴ (Marseille and Kahn, 2019).

At a regional level, there is the African (Banjul) Charter on Human and Peoples’ Rights (1986) with 68 articles, to which Zimbabwe is a signatory. Article 16 explicitly singles out the protection of health. It states that:

“1. Every individual shall have the right to enjoy the best attainable state of physical and mental health .2 State Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick ” (African (Banjul) Charter, 1986, p. 5).

A regional statute in the Southern African Development Community (SADC) protocol on health was signed in Maputo, Mozambique on 18 August 1999 and came into force on 18 August 2004. It does not provide for explicit protection, guarantees, or promotion of the right

³ Articles 12 and 14, UN General Assembly. *Convention on the Elimination of All Forms of Discrimination Against Women*, 1979 (Assembly, 1979).

⁴ Article 12, UN General Assembly ID. *International covenant on economic, Social and cultural rights*, 1966 (Oellers-Frahm and Zimmermann, 2012; UN, 2018).

to health (SADC, 1999). It appears to concentrate on administrative mechanisms for the coordination of surveillance and information exchange. The synchronisation by the SADC countries in implementing lockdowns and border closures to slow down or prevent cross-border transmission of the coronavirus (COVID-19) appears to be one of the major advantages of the SADC protocol on health (Nhongo, 2020; Tebele, 2020). Zimbabwe implemented a lockdown^{5,6} during April/March 2020, ostensibly relying partly on the SADC protocol. Along with other countries in the SADC; the lockdowns started toward the end of March 2020 with the overall aim to flatten the curve through a series of measures, of which border closures were one (Nyabunze and Siavhundu, 2020; Veritas, 2020b, 2020a). Other measures appear to have included PPE donations from the WHO, China, and corporate bodies such as ECONET Wireless (Pvt) Ltd in Zimbabwe.

In Zimbabwe, at a national level, the right to health is protected and guaranteed in the Constitution of Zimbabwe amendment number 20, (Veritas, 2013). It reads:

“(1) Every citizen and permanent resident of Zimbabwe has the right to have access to basic healthcare services, including reproductive healthcare services. (2) Every person living with a chronic illness has a to right to have access to basic healthcare services for the illness. (3) No person may be refused emergency medical treatment in any healthcare institution. (4) The state must take reasonable legislative and other measures, within the limits of resources available to it, to achieve the progressive realisation of the rights set out in this section” (Veritas, 2013, p. 37).

Section 77, while not referring directly to the citizen’s right to healthcare, can be viewed as an enabling arm of section 76. It states: “Every person has a right to: a) Safe, clean and

⁵ *Government of Zimbabwe gazetted statutory instrument 77 of 2020 Public Health (COVID-19 Prevention, Containment and Treatment) National Lockdown) Order, 2020 (Veritas, 2020a).*

⁶ *Government of Zimbabwe gazetted statutory instrument 83 of 2020 Public Health (COVID-19 Prevention, Containment and Treatment) National Lockdown) Order, 2020 (Veritas, 2020b)*

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” (Veritas, 2013, p. 38)

The Zimbabwean constitution flows from the international and regional conventions guaranteeing the protection and promotion of the right to healthcare. It is eloquent and elaborate on paper with regard to the protection and promotion of the right to healthcare, but there are questions as far as implementation is concerned. Reports from Zimbabwean Lawyers for Humans Rights demonstrate a gross non-fulfilment of this right to health (Zimbabwe Lawyers for Human Rights, 2020). Most of the non-fulfilment is expressed in the form of drug stock-outs in public hospitals, incessant job action and strikes by healthcare professionals, delayed salary payments, inadequate staffing of doctors and nurses, corruption, and theft of public funds intended for the purchase of much-needed supplies and inadequate budgetary support (Makumbe, 1994; De Castella, 2003; Raftopoulos and Phimister, 2004; Doig, 2006; Chikanda, 2007; Tizora, 2009; Nyazema, 2010; Muzulu, 2015; Petaling, 2017; Choguya, 2018; Mnangagwa, 2018; Adewayo, 2020).

The inadequacy of healthcare services was made worse by the COVID-19 pandemic, which started in November 2019. Unavailability of adequate testing centres and the unavailability of appropriate personal protective equipment for healthcare workers further diminished the scope of the Zimbabwean public healthcare system to respond timeously to the pandemic. During April 2020 the Zimbabwe Association of Doctors for Human Rights (ZDHR) lodged court proceedings with the High Court of Zimbabwe in Harare to compel the Zimbabwe government authorities to ensure, among other measures, adequate provision of personal protective equipment to healthcare professionals in the country, adequate testing kits in all public hospitals, and at airports, and ports of entry. On 14 April 2020 the High Court of Zimbabwe, sitting in Harare, ordered the government to comply with the demands of the

applicants. Incessant news of government officials, though repeatedly disowned, allegedly building exclusive COVID-19 treatment and isolation centres at Arundel Hospital and St. Anne's Hospital in Harare, further strained the citizens' trust in the government's transparency and ability to fairly apply national resources.

The contemporary discord in the way the healthcare system is administered in Zimbabwe, as well as its deficiencies, illustrate the fact that statutory provisions in the absence of an ethical model of delivery, monitoring and evaluation, accountability, and oversight measures, are not enough to guarantee and protect the citizens' right to healthcare.

1.4 Limitations of this Study

This is a normative analysis which cannot stand alone. In order to realise the success of the suggestions and recommendations emanating from this study political will and financing is required. Unless officially attributable to the source, all opinions expressed in this thesis are those of the author.

1.5 Roadmap for the Rest of the Thesis

The remainder of this introductory chapter sets out the outline for each subsequent chapter. Chapter 2 explains the concept of healthcare and why healthcare reform is important, in general, and with specific reference to Zimbabwe. It describes the healthcare challenges and problems in Zimbabwe from the pre-independent period to the contemporary situation in 2021.

In chapters 3 and 4 the historical and philosophical reasons for healthcare policy transformation in Zimbabwe, tracing the changes from the pre-independence to the post-independence period are researched. I conclude chapter 4 with a description of changes that

took place in the immediate period following Robert Mugabe's departure, a period now generally referred to as the *Post-November 2017 period*, *The New dispensation* or *Second Republic period* (Chamisa, 2018; Mazwi *et al.*, 2018; Murisa, 2018). This new dispensation is an important landmark in the post-independence period as this indicates the first change of the country's leadership in 40 years.

Chapter 5 tackles the utilitarian theory, selected for discussion in this thesis ahead of many others based on its historical and contemporary relevance to debates about access to public health care. It also provides a countervailing comparative analysis to many moral theories, particularly to both the egalitarian and ubuntu theories. The chapter will address its important aspects to public health policy and access to healthcare by tracing its historical development, describing its strengths, weaknesses, criticisms of it and how it can be applied to the proposed new healthcare model for Zimbabwe, as described in chapter 9.

The focus of chapter 6 is on egalitarianism. Egalitarianism is one of the most influential philosophical perspectives on the access to healthcare and other social phenomena, such as public finance, social welfare, law and justice. The chapter tackles questions such as:

- Is healthcare an economic good or a right?
- Is an egalitarian healthcare system feasible, and in whose perspective?
- Can a truly egalitarian society be possible, or is this a utopian ideal?
- How can we make use of the progressive aspects of this theory in the design, formulation and implementation of a new healthcare model for Zimbabwe?

In chapter 7 the African moral philosophy, which has always been at the centre of the African's social, economic, jurisprudential and religious conception of individual and community life is considered. One such philosophy is the Ubuntu/Hunhu philosophy, which is undoubtedly a prominent ethical paradigm that has been touted as central in sub-Saharan Africa. There is now a wide collection of literature on the conception of Ubuntu, much of it

having exploded into life after the demise of the apartheid system of South Africa in 1994.

This chapter attempts to deepen our understanding of the ubuntu moral philosophy and how it can shape the design and evaluation of access to healthcare.

In chapter 8, I describe and evaluate different healthcare system models used worldwide with a view to assist me in the identification of progressive aspects for adoption and implementation in Zimbabwe. In particular, the following healthcare system models are analysed in-depth for their differences, similarities, weaknesses, and strengths: The Beveridge model, the Bismarck model, the National Health Insurance model, the Out of Pocket model, and the Traditional, Complementary and/or Alternative Medicine healthcare model. In addition, the Londono and Frenk (1997) classification is also discussed in detail. At every stage, any aspect of each of the models that have current or potential expression in the Zimbabwean scenario is highlighted.

In chapter 9, a proposed novel conception for an ethically justified model for access to healthcare in Zimbabwe is espoused. The model is called a Citizen Centred Healthcare Model (CCHM). It is premised on six foundational building blocks. Progressive aspects of various healthcare system models discussed in chapter 8 influence the conception of the CCHM, particularly the Beveridge, Bismarck, and the Organisation for Economic Co-operation and Development (OECD) typology of healthcare system models. Its success and sustainability are anchored in the correction and improvement of the macroeconomic and political environment in the country. The model builds on progressive aspects of the major moral theories considered. International, regional, and national legal provisions as discussed in chapter 1. The Bill of Rights, as fully explained in chapter 2 of the Zimbabwean Constitution of 2013, is central to the argument for the fulfilment, promotion and protection of the right to healthcare in Zimbabwe.

Chapter 10 describes the policy options, the suggested CCHM implementation strategies, and recommendations.

1.6 Chapter Summary

Chapter 1 has outlined the roadmap for this thesis by highlighting the focus of each successive chapter. The following chapter gives a detailed introductory description of the background and context of the study. It also describes the rationale for the study and discusses important concepts such as health, healthcare, Zimbabwe's Healthcare System problems and ethical justification for the Citizen Centred Healthcare Model (CCHM).

CHAPTER 2: ZIMBABWE'S HEALTHCARE SYSTEM NEEDS REFORM

2.1 Introduction

Healthcare reform is a global preoccupation in recent years. This is partly influenced by of the ever-changing demographic features of the world population as well as recurrent emerging new infections such as SARS, Ebola, and Coronavirus (Tsong-mei and David, 2009; Simonet, 2010; Kevany *et al.*, 2012; Schneider and Devitt, 2017). It is critical to give a context and rationale for this research study and how it fits into the healthcare reform needs for Zimbabwe. In this chapter, I explain the healthcare system challenges in Zimbabwe and the justification for a new healthcare delivery model. I start of by explaining the concept of Health in section 2.2 below. Section 2.3 describes the healthcare challenges bedevilling Zimbabwe and how the healthcare crisis has developed over the years. In section 2.3.3 I describe how the current healthcare model being used in Zimbabwe lacks effectiveness. In section 2.4 I give a detailed explanation of the ethical Justification for the Citizen Centred Healthcare Model, which is discussed in full in chapter 9.

2.2 The Concept of Health Explained

An important distinction should be made, that of differentiating between pursuing health rather than healthcare because health is a much broader term than healthcare. A full understanding of the distinction between the two helps to set the limits to which demands on healthcare services can be realistically addressed without creating disruption in priority setting and planning (London *et al.*, 2015; Rumbold *et al.*, 2017). The two terms are often mixed up or conflated. It is important to understand the difference so that the design of any

healthcare model can be such that it influences positively improved access to and the marketplace for healthcare (Julliard, Klimenko and Jacob, 2006). A clear and concise definition of health has always been elusive. There are three eminent approaches to defining health: *a medical model, a holistic model and the wellness model*. Before the advent of the holistic model definition of health by the World Health Organisation (WHO) in 1947, the medical model of health was very dominant in the twentieth century, especially in north America (Stokes, Noren and Shindell, 1982). The medical model of health was limited in that it emphasized the biological state of the body by implying a diseased body simulating a broken machine in need of fixing. This tended to de-emphasize the mental and social aspects of health as well as diminishing the temporal nature of the disease.

While the medical model of health had its advantages such as the ease of biostatistical analysis and data collection, it soon gave way to a more progressive approach: *the holistic model*, as exemplified in the 1947 WHO definition of health: “Health is a state of complete physical, mental and social well-being, not just merely the absence of disease or infirmity” (World Health Organization, 2006, p. 1). It broadened the definition of health from the biological or medical model to include social and mental parameters. Although initially the WHO did not explicitly introduce the concept of positive health, it is believed that this definition was a major improvement from the earlier restrictive medical model. Though more progressive the holistic model definition of health was not without its own criticisms. For example, it was criticised for being limited in population measurements of health as such terms as wellness are needlessly subjective in assessment (Mcdowell, 2020). In 1984 the WHO, through its health promotion initiative, proposed a move away from understanding health as a state to viewing health as a dynamic process. This has come to be referred to as the wellness model of health, and sees health as the ability of a person or community to cope

with environmental changes and challenges (World Health Organisation, 1984; Vingilis and Sarkella, 1997).

Healthcare can be interpreted to mean several things but the definition that I prefer is the one that refers to a full range of players (an ecosystem) connected by the presence of patients or consumers. This full range of players includes all health services, goods, products and payment systems for the fulfilment of utilisation of healthcare services. These include hospitals, clinics, pharmacies, medical laboratories, radiology centres and insurance schemes. I prefer this definition for its comprehensiveness.

2.3 Zimbabwe's Healthcare System Problems

2.3.1 Background to Zimbabwe's Healthcare Challenges

Pre-independent Zimbabwe's healthcare system mirrored many a typical colonised country, especially under the British Empire. The landscape of healthcare services in pre-independent Zimbabwe was characterised by a bias towards urban communities, curative healthcare services, and special privileges directed to the racially privileged at the time – typically whites and coloured communities (Mutokosi, 2015).

The affluent of the society were consuming the biggest share of public healthcare expenditure with far less going towards the poor (Bloom, 1985). Before political independence in 1980, the infant mortality rate amongst the blacks was much higher at 120-220 per 1000 compared to whites at just around 17 per 1000 (Razemba, 1998). Hospitals in towns and cities catered for only 15% of the Zimbabwean population and absorbed close to 44% of the Government healthcare budget while 24% was directed towards health centres at lower levels such as clinics and district hospitals in rural areas, serving over 70% of the total population (Sanders, 1990). The life expectancy of blacks was comparably much lower with African males generally not living beyond 50 years while females generally died before their 54th birthday.

In contrast, European males had a life expectancy of 70 years while females had a life expectancy of 74 years (Sanders, 1990; Razemba, 1998).

Zimbabwe attained its political independence on 18th April 1980, and changed its name from its short-lived transitional name Zimbabwe-Rhodesia. Zimbabwe-Rhodesia was an experimental internal political dispensation under the disputed Prime Minister Rev. Abel Muzorewa which was rejected by the guerrilla movements waging a war from outside Rhodesia (Semmler, 2009). With the new Independence dispensation of 1980, accompanied by massive euphoria and motivation to discard the colonial health services distribution and funding patterns, major policy changes were announced in virtually all sectors, including healthcare of the country.

While the pre-independence healthcare service distribution philosophy was based on developing urban facilities with an assumption that there would be an eventual trickle-down effect to the rural areas, the new post-independence healthcare policy deliberately advocated scaling up development in rural healthcare facilities where the majority of the hitherto neglected population lived (Bloom, 1985). These initial public healthcare (PH) policies in the newly independent Zimbabwe were applauded for being transformative, corrective, egalitarian, and pro-poor. These landmark policies were the *Plan for Equity in Health Policy (1980)*, the *Economic Structural Adjustment Programme (ESAP) (1992 to 1996)*, the *National Health Strategy (1997 to 2007)*, the *National Health Strategy (2009 to 2013)*, and recently, the *Zimbabwe Agenda for Sustainable Socio-Economic Transformation* (Government of Zimbabwe, 2013).

While the health policies immediately after political independence appear to favour an egalitarian thrust aimed at introducing equitable access to healthcare there was a gradual deterioration from mid-1990s onwards, so much so that by 2009 access to healthcare in

Zimbabwe had almost collapsed totally (Todd *et al.*, 2010). At the time of the formation of the Government of National Unity (GNU) in 2009 very few hospitals were functioning properly at all, resulting in severe shortages of medicines and medical supplies (Todd *et al.*, 2010; Mlambo, 2013). Although some semblance of recovery in access to healthcare was restored in 2009, shortages are still commonplace and patients still need to buy their own drugs, intravenous sets, bandages, freshwater, and sutures. The situation is worse in rural areas (Andrew, 2015a; Kamhungira, 2016). No meaningful sustainable gain in access to healthcare has been accomplished in Zimbabwe since the advent of political independence in 1980. Currently, Zimbabwe uses a model based largely on the *Out of Pocket Spending model* with very little private insurance and grossly inadequate public healthcare services (Hongoro and Kumaranayake, 2000; Munyuki and Jasi, 2009; Shamu *et al.*, 2010; Andrew, 2015a; MacDonald, 2016). The majority of the population is not covered by any medical aid or insurance (Sekhri and Savedoff, 2005; Sibanda *et al.*, 2012; Ncube, 2014; Wendy, 2014) and therefore has to rely on *out-of-pocket spending*, and limited public health services from Central Government and local authorities as well as on traditional medicine.

2.3.2 Zimbabwe Healthcare System's turbulent Times

Since political independence from Britain in 1980 Zimbabwe's healthcare delivery system has gone through turbulent times. There are times when the healthcare system appears to have made definite improvements and others when there was a definite decline. During the first decade after independence, from 1990 to 2000 the country's healthcare system witnessed some phenomenal improvements in all aspects of the delivery system: infrastructure development, health personnel training and financing (Sanders, 1990; Zhou and Hardlife, 2012). Thereafter the healthcare system started to deteriorate dramatically with a lot of health indicators declining (Bassett, Bijlmakers and Sanders, 1997; Kevany *et al.*, 2012; Mlambo,

2013). The most noticeable decline was witnessed between the 2000 and 2009 due to the world record hyperinflation estimated to have reached 500 billion percent in the country (Hanke and Kwok, 2009; Ministry of Health and Childcare, 2009; Kramarenko, Engstrom and Verdier, 2010; Coomer and GsTraunThaler, 2011; Moyana, 2017). There was a short reprieve to the decline in 2009 with the inception of the Government of National Unity (GNU) when a new monetary policy called the multi-currency regime was introduced. The multi-currency regime allowed the concurrent use of a variety of world and regional stable currencies anchored around the United States of America dollar (USD) (Kramarenko, Engstrom and Verdier, 2010; Mapuva, 2010; Chigora and Guzura, 2011). Chapter 4 of this thesis gives a detailed description of the successive healthcare policies and their relative successes and failures since political independence in 1980.

2.3.2 Current Crisis

The improvements in healthcare delivery brought about by the GNU were short-lived. The GNU ended in 2013 and with it went away the economic and political stability that had been brought in by the cooperation between the hegemonic ZANU(PF) and the main opposition party, MDC-T. In recent years the deterioration in healthcare services has resulted in a declining child, infant, and maternal health indicators as well as an increase in unsupervised home deliveries, major shortages of personnel, drugs, supplies, Personal Protective Equipment (PPE) and water. Compounding these challenges, are frequent strikes by healthcare professionals, and worsening staff morale (Andrew, 2015a; ZNSA, 2015; Moyana, 2017; Phyllis, 2017; Mbanje, 2018), as well as persistent incidents of corruption in both the public and private healthcare sector (Chipunza, 2014, 2015; Moyo, 2014; Choguya, 2018; Muchena, 2019; John, 2020; Vinga, 2020).

At the time of writing this thesis, the Minister of Health had just been arrested for alleged corruption involving tenders for COVID-19 PPE and testing kits (John, 2020), a record number of Chief Executives Officers of five major central hospitals were fired overnight and healthcare professionals, including nurses and doctors, had been on a national strike for a record number of weeks (Taderera, Hendricks and Pillay, 2016; McCoy, 2020). The grievances are centred on lack of COVID-19 Personal Protective Equipment (PPE), low salaries and allowances, corruption in the distribution of COVID-19 PPEs and general maladministration (Columbus, 2020). All hospitals, including central, general and district hospitals were basically ghost towns after having discharged all patients and not admitting any new patients due to the crippling national strike by healthcare professionals. In a very unprecedented incident, the Zimbabwe Republic Police (ZRP) arrested union leaders of the Zimbabwe Nurses who had come to address their members at the Sally Mugabe Central Hospital in Harare. In an effort to evade the bad state of healthcare in the country the rich and the political elite embark on medical tourism by travelling to countries like South Africa, India, and China for their medical treatment while the poor have to settle with what is available (Mushava, 2016; Zhangazha, 2016; Petaling, 2017; Adewayo, 2020).

2.3.3 Zimbabwe's current Healthcare Model is Ineffective

Although healthcare services in Zimbabwe are dominated by the public sector, there is a fairly sophisticated private sector involvement, giving a semblance of similarity to a mixture of the Beveridge and Bismarck models, which are described in detail in chapter 8. Zimbabwe has a significant portion of its population relying on the *Out of Pocket Healthcare Model*. Only about 8% of the population are on medical insurance when the economy is at its best but even those people always need to pay extra because most of the schemes have gaps in the level of coverage (Hongoro and Kumaranayake, 2000; Sekhri and Savedoff, 2005; Moyana,

2017). In theory, the rest of the population is supposed to be catered for by the State at public and local authority hospitals and clinics in the country. However, the public healthcare system has deteriorated so much that it is not uncommon for people to die in the corridors of the health facilities or at home for lack of money to go to private health facilities (Kapp, 2004; Meldrum, 2008; Nyazema, 2010; Kidia, 2018). Poor funding and bad policy selection or implementation have crippled the healthcare sector (Rusvingo, 2014a). This poor funding has created a sub-optimum doctor-patient ratio of 0.8 doctors per 1000 population versus an ideal ratio of a minimum of 3:1000. This decline in the doctor-patient ratio has been consistently worsening since the late 1990s (Rusvingo, 2014a; Green, 2018b). Zimbabwe's healthcare system funding levels have consistently remained below the 15% of national budget as stipulated in the Abuja Declaration to which Zimbabwe is a voluntary signatory (UN and OAU, 2001). The public healthcare service still constitutes less than 1% of GDP while the per capita health expenditure of 24USD (in 2018 budget)(Rusike, 2018) is still far below the minimum threshold of USD86 for Zimbabwe as recommended by the WHO as well as being far below the regional SADC average of 134.90USD (Shamu and Loewenson, 2006; Sera and Beaudry, 2007; Shamu *et al.*, 2007). Zimbabwe's expenditure on healthcare is a far cry compared to its neighbours in the region (Rumbold *et al.*, 2017).

On the regulation front, reports are abounding of mediocre, unsafe, and substandard healthcare services in state facilities in Zimbabwe but there is hardly any documentation of facilities that were suspended or closed (Ministry of Health and Child Welfare, 2013; Lynnette, 2016; Gwarisa, 2019; Adewayo, 2020). In Zimbabwe, regulation or modulation of healthcare services appears to exist only for the private sector providers who end up paying for the administration of regulation without any state grants as is provided for in the laws of the country (Hongoro and Kumaranayake, 2000; Government of Zimbabwe, 2005). The concept of modulation is described in detail in chapter 8.

From the above-detailed analysis, it is not in doubt that Zimbabwe requires a new model of healthcare, which ought to address the multi-faceted problems of underfunding, elimination of wastage and corruption so that the country can attract investment, improve dwindling staff morale, bring transparency to opaque procurement procedures, an infusion of a human rights paradigm in the governance of the public health system, and a robust public oversight about the performance of the public health structures.

2.4 Ethical Justification for the Citizen Centred Healthcare Model

The Citizen Centred Healthcare Model (CCHM), discussed in detail in chapter 9, is a novel healthcare model for Zimbabwe proposed in this thesis. It envisages a radically improved access to healthcare services by proposing a model built on sound and defensible ethical foundations of progressive aspects of Ubuntu, Egalitarianism and Utilitarianism. In addition, the CCHM is founded on six critical pillars and catalysts of *Inclusive Healthcare, Prioritized Healthcare Financing, Equitable Rationing of Healthcare Services, Effective Monitoring and Evaluation, Social Solidarity and Human Rights Culture Promotion and a Stable Macroeconomic and Political Environment*.

Across the world many governments are grappling with the issue of healthcare reform (HCR). HCR is an important and necessary process, which is ongoing and inspired by the ever-changing political, economic, and disease epidemiological landscape (Roberts *et al.*, 2003). Many questions arise during deciding on whether reform is needed, including questions on what type of reform is needed and how it should be undertaken. The following important questions about HCR need to be asked: *How should we deal with doctors' demands for more money? What strategies exist to reduce costs for medical care while expanding social insurance to cover the poor? Should we expand the system of publicly provided health*

centres, or move to private practice family physicians? Should we ask patients to pay more out of pocket, or make more use of general tax revenues? Is the answer to the challenges newer technology or less? More doctors or fewer medical schools? Building more hospitals or spending more on anti-smoking campaigns? These questions have relevance to the situation in Zimbabwe. In chapter 9 I present a detailed description of a new model of access to healthcare in Zimbabwe, which is guided by a sound ethical paradigm. Zimbabwe needs a new healthcare model despite being in an economic and political quagmire (Todd *et al.*, 2010; Green, 2018b). The country has been in the doldrums of bad economic performance ever since the early 1990s when it adopted the International Monetary Fund (IMF) and World Bank (WB) inspired Economic Structural Adjustment Programmes (ESAP). The country later embarked on a controversial land reform programme in the year 2000. The country's problems were made worse by political upheavals of successive disputed elections and attendant hyperinflation of 2008 (Ciiffe, Mpofu and Munslow, 1980; Sachikonye, 1990; Sithole and Makumbe, 1997; Sithole, 2001; Kagwanja, 2005; Kriger, 2005; Daimon, 2016).

Problems about Access to healthcare, economic and governance problems that Zimbabwe finds itself in are not mutually exclusive and need to be solved simultaneously. This is all the more the reason why *an ethically justifiable new model of access to healthcare* is needed (Renfrew, 1996; Kawewe and Dibie, 2000; Makoni, 2000; Mlambo, 2013; Bonga, 2014). Any healthcare reform must be guided by core ethical values. There are many suggested ethical values but the following values are critical to transform the existing Zimbabwean situation into a new paradigm: *Universal access, equitable access, cost/affordable access, quality and choice* (Childress *et al.*, 2002). In addition, given the fact that resources will never be enough for any country or organisation there is a need to follow established criteria for resource allocation such as those recommended by the WHO and the *National Institute for Healthcare and Excellence* (NICE). There are numerous healthcare models and systems

in the world. All of them have their strengths and weaknesses, supporters and detractors but still, the question remains: which of them is the most ethical? Not even the much-vaunted *Universal Health Care System* is guaranteed to be the most ethical. A universal coverage on its own, without a sound ethical founding paradigm, may still not address the issues of limited and deficits in access. This position is highlighted by Matthews (2009):

There appears to be a widespread assumption, held both by liberals and many in the media, that a government-run health care system that provides universal coverage is the most ethical. Yet every health care system struggles with issues of access, cost containment, quality and patients' rights-every system. And every one struggles with some of those issues more than others (Matthews, 2009, p. 1).

In order to guide the process of crafting a new healthcare model or system which answers to the multi-faceted problems afflicting the Zimbabwe healthcare system, we need to first acknowledge its major problems. The Zimbabwean healthcare system suffers from many issues to do with poor patients' rights protection, issues of access or inadequate supply of basic curative services and high costs relative to populations income levels. It fails to meet the following principle used to guide our assessment on whether a system is effective or not: *the patients or consumers ought to be the ones who make important decisions about their health delivery because they know where it is failing them.* They need to be involved as valued participants, not as passengers or mere consumers (Matthews, 2009). The CCHM is designed to address this glaring deficit by promoting public and parliamentary oversight in the evaluation of quality, coverage and financing.

The CCHM, proposed in chapter 9d of this thesis is a consumer-driven model which encapsulates both the *deontological* and *teleological* aspects of the argument which promotes both a principle-based design as well as factoring in the consequences or outcomes. The current situation in Zimbabwe whereby government and insurers hold sway in policymaking and financing without adequate public involvement about the nature and scope of the healthcare system, alienates the consumer. "An ethical health care system doesn't just

promise people they will get the care they need; it empowers people so they can get that care” (Matthews, 2009, p. 5).

Zimbabwe has several consumer advocates which include the Consumer Council of Zimbabwe, the Health Professions Authority and the Patients Charter (Penchansky and Thomas, 1981; Act, 1998; Rusvingo, 2014a). However, all these appear to be not visible where they are needed most: creating adequate access to healthcare services by consumers. It does not make much sense in saying patients or consumers are free to choose the type of medical aid insurance they wish to have when unemployment and poor medical aid scheme regulation is making it almost impossible for one to afford (Shamu *et al.*, 2010; Ncube, 2014). What is the point of saying patients or consumers can choose whichever doctor or healthcare provider they want when doctors do not accept the medical aid cover available because the reimbursement is so low and consumers end up paying a lot of money as a top-up? (De Castella, 2003; Ndhlovu Ray, 2020). The CCHM is premised on a functional macroeconomic framework with a stable currency and predictable monetary and fiscal policy (a more detailed discussion on this issue will be done in chapter 9). The CCHM creates much-needed patient or consumer control or autonomy by guaranteeing reasonable out-of-pocket spending while promoting community savings and insurance starting at the community or village level. It advocates for proper regulation and adequate competition in the marketplace for insurance companies. The State insurance such as the Premier Services Medical Aid Society must be unbundled and civil servants and armed forces must be allowed to purchase medical insurance of their choice and not to be restricted to a government-run medical insurance. This distorts market forces.

The CCHM proposed in this thesis does not underestimate the complexity of arguments for and against health as a *special good* as discussed in section 1.4.2 of chapter 1. Neither does it conclusively settle the debate about which aspect of the right to health is more desirable:

right to health or right to healthcare. It nevertheless advocates for economic freedom for the citizens as a vehicle for their empowerment and autonomy. Free markets are assumed to be part of the economic freedom encapsulated in the CCHM. The Government cannot fulfil all the financing of healthcare and as such the citizens ought to be allowed to flourish economically so that they are able to purchase an optimum basket of healthcare services. The CCHM acknowledges the fact that healthcare services are a nonhomogeneous basket and have many functions: some healthcare services are more important than others, some are basic while others are more urgent (Daniels, 1982). Access itself is a very complicated concept therefore a determination of what constitutes equality or equity of access is beyond the scope of this chapter. The CCHM is primarily concerned about access to basic curative, emergency and preventive healthcare services provided by the State through efficient budgetary provisions while the citizens are enabled to purchase secondary and tertiary services through out-of-pocket spending and medical insurance. Private players play a critical role in complementing the State. All these activities can only thrive in a stable macroeconomic environment and that is why the CCHM is founded partly on a thriving macroeconomic environment.

Inequitable access to healthcare is caused and created by multiple factors. There is often very little attention paid to the ethical process that must guide any healthcare reform process because most of the debates centre around policy, economics, and politics: “Inequalities in health result from forms of social injustice that are broader than the lack of health insurance” (Daniels, Saloner and Gelpi, 2009, p. w10).

Notwithstanding the criticism against universal coverage, whether a wholly public or a mixture of public and private insurance-it remains one of the most effective ways to achieve equitable access to healthcare. Zimbabwe has no public health insurance. Access to a basic package of both curative and preventive healthcare services allow people to function

normally and be able to enjoy opportunities in life. The State and society have an obligation to protect opportunities and to ensure they are distributed equitably and fairly. A society that turns its back to people in need of urgent, basic, curative, and preventive health services is denying the same people equality to life opportunities (Daniels, 1985a, 1985b; Hasman and Holm, 2005b; Daniels and Sabin, 2008a, 2008b; Maluka, 2011). An ethical healthcare system exhibits fairness in the financing, explained as a process that protects the population against unanticipated health-related financial ruin or catastrophe and redistributing health-related resources from the well-off to the poorer in society or from the healthy to the sick. This is only fair if the cooperation among citizens allows them to share fairly the burdens and benefits of that cooperation. This anticipated fair sharing of burdens and benefits arising from this cooperation is encapsulated in the CCHM.

2.5 Chapter Summary

This chapter gave a background of the genesis of the problems and issues around access to healthcare in Zimbabwe. It gave a description of the current crisis, explanation of the concepts of health and healthcare reform and an Ethical justification for the Citizen Centred Healthcare Model (discussed in full in chapter 9). The next chapter will look at the healthcare policies in pre-independent Zimbabwe.

CHAPTER 3: HEALTHCARE POLICIES IN PRE-INDEPENDENT ZIMBABWE

3.1 Introduction

A country's economic and political system has a big influence on the country's model of healthcare, and allocation of budgetary and fiscal resources for health. It also has a huge impact on the type of general and public healthcare policies influencing access to and delivery of healthcare. This chapter traces the historical, strategic, political, and philosophical changes in healthcare policies in Zimbabwe from the pre-colonial to Zimbabwe Independence in 1980. This narrative helps to contextualize the evolutionary politico-economic stages that have been followed by the country. This political and economic evolution has an impact and influence on the healthcare system culminating in the contemporary healthcare situation as it obtained at the time of this study.

At each major historical epoch in time (pre-colonial, colonial, and post-colonial stages) an analysis and discussion of the salient features of the healthcare delivery system and its philosophical underpinnings will be presented. At each stage the dominant official healthcare policies, where documented, will be presented together with an analysis of their strengths, weaknesses, successes and failures. Where the official health policies are not explicitly documented an implied justification and motivation is made. The chapter ends with a summary of important issues raised in the discussion as well as an identification of the impact of successive economic and political policies on the current challenges related to access to healthcare in Zimbabwe.

3.2 Summary of Zimbabwe's Political History

Zimbabwe was one of the many colonies of the British Empire (Arrighi, 1967), although back then the country was known as Rhodesia. Rhodesia was officially colonised in September 1890 under the mandate of the British South African Chartered (BSAC) company headed by Cecil John Rhodes, after whom the country was named (Maylam, 2002; McFarlane, 2007; Hole, 2018). When the BSAC mandate ended Rhodesia was renamed Southern Rhodesia in 1923, following a referendum in the settler regime's legislative council (Blake, 1977; Smith, 2001; Walle, 2010). A question had been put up in a referendum to decide on whether the settler regime should join South Africa or remain independent. The referendum result favoured not joining South Africa (Mason, 1960, 1962).

The Federation of Central Africa, otherwise also known as the Federation of Rhodesia and Nyasaland was created in 1953 (Llewellyn, 1956; Rosberg, 1956; Faber, 1959). This was after the settlers in Southern and Northern Rhodesia applied immense pressure on the British to accept their demands for some sort of union. Northern Rhodesia is now the modern day Zambia and Nyasaland the modern day Malawi. The federation only lasted a mere ten years, till 1963. During its consummation, the federation was dominated by Southern Rhodesia, with Salisbury in Southern Rhodesia as its capital. The creation of the federation enabled the settlers to industrialise quickly resulting in an enormous increase in economic output in agriculture, manufacturing, and mining. Southern Rhodesia became the second-largest economy in southern Africa, after South Africa (Llewellyn, 1956; Mason, 1960, 1962; Kalinga, 2005).

After being encouraged by this expansion and growth of the economy in Southern Rhodesia the then leader of Southern Rhodesia (Ian Douglas Smith) made a unilateral declaration of independence from Britain in 1965, and changed its official name to Rhodesia. This led to the

imposition of United Nations-backed economic sanctions after Britain convinced the United Nations that the declaration was illegal (Onslow, 2005; Coggins, 2006). At around the same time, armed liberation movements sweeping through Africa caught up with Southern Rhodesia by launching an internal guerrilla war of liberation which heated up in the late 1960s and 1970s. Feeling the heat of this armed liberation *insurrection* the settler administration organised an internal election in 1979 which were largely ignored by the external and exiled liberation movements. Bishop Abel Muzorewa *won* this contest (Beri, 1979; Heads *et al.*, 1979). But this did not stop the armed struggle. Running out of options Mr Ian Smith and Bishop Abel Muzorewa (Prime Minister of the short-lived Zimbabwe-Rhodesia administration which had succeeded Rhodesia) were pressured into negotiations facilitated by Britain at the famous Lancaster House (Heads *et al.*, 1979; Novak, 2009; Onslow, 2013). The Lancaster conference resulted in a transitional constitution famously referred to as the Lancaster Agreement. This agreement and transitional constitution gave birth to the first multiracial, democratic elections in 1980 which were won by the Zimbabwe African Patriotic Union Patriotic Front (ZanuPF), and Robert Mugabe was installed as the first prime minister of the newly independent Zimbabwe (Gregory, 1981; Baker, 1982; Kriger, 2005). Zimbabwe had an estimated population size of roughly 5 million at that time (Sachikonye, 1990; Daimon, 2016).

3.3 Organisation of Healthcare System in Zimbabwe during Pre-Colonialism

This section describes the healthcare system in Zimbabwe during Pre-colonial times and explains the philosophy behind it. It is important to appreciate this background so that any benefits and unintended deleterious effects of the western medical approach on the pre-colonial healthcare system are identified and analysed with a view to make us understand the current situation.

Documented historical accounts regarding the state of pre-colonial healthcare systems and delivery in Zimbabwe, are scant and almost non-existent. Unlike the case of many other cultures who have elaborate documented historical accounts of pre-colonial medical practices or systems, much of Zimbabwe's pre-colonial medical practices and systems are poorly documented. For example, there is substantial written material about the pre-colonial history of medicine and medical practices and systems in China. This may be because of the dominance of oral traditions rather than the written form. (Feierman, Janzen and Studies, 1992; Waite, 1992).

Most of our understanding or imagination of how pre-colonial healthcare organisation or systems occurred in pre-colonial Zimbabwe can be deduced from practices during colonial and post-colonial periods over the whole sub-Saharan and West-African region covering the Bantu and Nguni cultures. The east-central Africa region, in particular, has a rich cultural influence on pre-colonial Zimbabwe as there were no political and cultural boundaries between original lands making up modern-day southern Tanzania, Malawi, northern Mozambique, Zimbabwe, Zambia, and south-eastern Democratic Republic of Congo (Waite, 1992). For example, the Khoisan tribes inhabited much of modern-day Zimbabwe, Zambia, Namibia, South Africa, Botswana, and Angola. Their medicine and medical practices are recorded in history as being greatly valued and sophisticated (Barnard, 1996; Low, 2007; Schuster *et al.*, 2010; Kim *et al.*, 2014).

3.3.1 The Philosophy behind Traditional Medical Practices

There is a tendency of classifying all other peoples' traditional cultures from a western perspective, sometimes resulting in labelling pre-colonial medical practices as primitive. Before the arrival of western medical practices with colonialization, indigenous peoples in Zimbabwe had their own health systems. According to Waite (1992): "... a certain amount of

public health existed in African societies prior to the colonial period and was not, therefore, newly introduced by the Europeans in the twentieth century” (p.212). Public health is the art and science aimed at protecting and improving the health and lives of individuals, families, communities and whole populations at local level, state or provincial level, national level, regional level and global level (Koo, O’Carroll and LaVenture, 2001; Turnock, 2012; Porter, 2020).

In the traditional African setup spirituality and medicine are inseparable amongst indigenous people. In fact, the existence of synergy between traditional religion and traditional medicine is paramount, with the latter being presumed to be subsumed under the former (Cridland and Koonin, 2001; Kazembe, 2007). Before the introduction of western medical practices with colonisation, traditional medicine was the most dominant source of healthcare provided to the population. Before the arrival of colonisation it had survived centuries of endurance, providing a source of healing and coping mechanism for the various physical, mental and spiritual ailments afflicting the indigenous peoples of Zimbabwe, as was the case in most of Africa (Waite, 1992, 2000; Sindiga, Chacha and Kanunah, 1995; Abdullahi, 2011). In the pre-colonisation period healthcare was understood to mean an equation between politics and medicine. Public health included all activities undertaken by authorities to promote the well-being of the societies over which they were in charge. These activities included such issues as rain making ceremonies and sorcery control- the principal focus of kings, chiefs, headmen and priests in those days (Waite, 1987).

Colonial and post-colonial periods in Africa and Zimbabwe, in particular, have continued the decimation and undervaluing of most of what was an indigenous medical system in favour of wholesale western medical practices. It can be debated whether the demise of our traditional and indigenous medical practices has left us richer or poorer. This dilemma is epitomised in the following passage:

What sets worlds in motion is the interplay of differences, their attractions and repulsions. Life is plurality, death is uniformity. By suppressing differences and peculiarities, by eliminating different civilisations and cultures, progress weakens life and favours death. The ideal of a single civilisation for everyone implicit in the cult of progress and technique impoverishes and mutilates us. Every view of the world that becomes extinct, every culture that disappears, diminishes a possibility of life! (Stephens *et al.*, 2006, p. 219).

Pre-colonial health systems in Zimbabwe and much of Africa had a distinct philosophical underpinning. This philosophical paradigm appeared to be based on communitarianism, possibly dominated by ubuntu moral philosophy (Makinde, 1988; Prinsloo, 1995).

Ethnographers using western sociological approaches tend to look at African indigenous culture with ethnocentric eyes and as a result may end up with biased conclusions pointing to it as being backward and primitive (Tangwa, 2000, 2007). For example, mainstream Western philosophical positions such as those propounded by Immanuel Kant and Hume claim that Africans were irrational and incapable of dignity (Papadimos, 2007). Not everyone agrees with this assertion because other schools of thought credit traditional and indigenous healing systems as full of order, merit, and value (Chimuka, 2001, 2015; Mokgobi, 2014).

3.4 Organisation of Healthcare System during Zimbabwe's Colonial Period

Zimbabwe's colonial period saw the arrival of the western medical approach into the country. Missionaries played an important part, alongside the colonial governments. It is important to describe and analyse how the healthcare system was organised and implemented during the colonial period so that we locate the genesis of the weaknesses and strengths of the current healthcare system in Zimbabwe.

3.4.1 The Early Period

The early period of colonisation stretches as far back as the times when the Arabs invaded the interior of central and southern Africa from the eastern coast of modern-day Mozambique

from Mombasa in modern-day Kenya (Mandivenga, 1992; McIntosh and Coulson, 1998; Huffman, 2009). The formal colonisation of Rhodesia (Zimbabwe) started in the late 1880s, with the granting of a charter to Cecil John Rhodes's British South African Company (BSAC) by the British imperial authority (Wolfe, 2006; Veracini, 2010b). As is now common cause this charter gave Rhodes's company authority to conquer and subjugate native inhabitants north of the Limpopo river. With the tacit approval of the British BSAC the Pioneer column of 1890 forcibly expropriated land and carried out a policy of military occupation and forced labour (Baker and Rhodes, 1934; Lockhart and Woodhouse, 1963; Tarassoff, 2002). At around the same period, there was a severe epidemic or outbreak of rinderpest which wiped out cattle and created widespread starvation. This was worsened by a simultaneous break out of smallpox thought to have been brought from the Swahili coast by Arabs in their pursuit of ivory and collection of slaves especially from the north around modern-day Malawi. Malawi was formally colonised in 1891 (Reid, 2011).

My interest here lies in the way the colonial authorities sort to enforce public health regulations to control these epidemics and how their authoritarian measures eventually shaped the way the blacks reacted with mistrust to public health measures throughout the colonial period, for many decades to come (Callahan and Bond, 1999; Setel, Lewis and Lyons, 1999). The violence perpetrated by colonial authorities in their overzealousness and racial bigoted approach to control epidemics of that time such as trypanosomiasis, influenza, venereal diseases, smallpox, malaria, -shaped early native experiences. These experiences created not only mistrust in public health measures but also in biomedicine in general and against vaccination in particular (McCulloch, 1999; Keller, 2006; Ncube, 2012).

Colonial governments in central Africa were not interested in native health needs, as was the case in much of the British colonies in sub-Saharan Africa. They were more concerned with the health needs of their own kind (Macola, 2005). This segregationist policy by colonial

authorities morphed into what scholars referred to as a *sanitization policy or syndrome*, much similar to what the Nazis did in the later years during the holocaust. Native or African people and their bodies were viewed as reservoirs of disease, a *pathologised* community, an attitude that dovetailed well with the missionary, *salvationist* mentality. The unintended benefit of this warped synergy was the marked missionary investment in health facility infrastructure, services, and training (Vaughan, 1991; Macola, 2005). Many native people had their first encounter with meaningful western medicine via missionary health provisions (Lunde, 2009). The involvement of missionaries in the provision of health services varied from region to region. For example, in Nyasaland (modern-day Malawi), the Scottish Missionaries, initially led by David Livingstone and Dr Caverhill, were more predominant while the Universities Mission to Central Africa (UMCA) was in Northern Rhodesia (now Zambia). Medical auxiliaries served a dual role of evangelism and ideological purposes. Ideological roles included translation services for missionary healthcare professionals and priests. African midwives in particular were seen as essential and critical collaborators in countering the moral and philosophical influence of elderly African traditional birth attendants (“*midwives*”) who were seen as a major stumbling block to the spread of Christian values and messages (Vaughan, 1991). This is notwithstanding the fact that the majority of the medical assistants in the early part of colonisation were deliberately males. So it can be argued that colonialization in a way reinforced the African patriarchal system of male dominance over women on the mistaken belief that women recruits were not to be relied upon, untrustworthy, weak, and undependable. In regions or settings where women were integrated into training, such training invariably ended up being highly gendered with males being promoted to higher roles while women languished in villages where they were deployed to further the countering effect against African midwives who were thought to be a barrier to evangelism (ibid).

While the first world war (WW1 or the Great War), from 28 July 1914 to 11 November 1918, surprisingly brought some positive shifts in health policy towards natives in African colonies, this is thought to have been a result of a convergence of interests (Strachan, 2004; Ncube, 2012). One such factor was the need for a productive labour force by imperial and colonial governments to replenish and support war efforts. The factors were the impact of missionary lobbying over many years and as well as a decline in the population (Page and McKinlay, 1987). The net effect was an increase in grant-in-aid by colonial governments to missionaries' healthcare facilities based on the number of hospital beds and training capacity. The severe human loss during WW1 appeared to have woken humankind to the need for more focus on health matters because after the war there is historical evidence of a more plural investment into healthcare on a global stage as well as in the colonial states. For example, though the League of Nations Health Organisation (LNHO) was born mainly to advance health issues for whites after the war, the trickledown effect was the increase in sharing of healthcare knowledge about such issues as tropical medicine in the colonies (Packard, 2016). There was also a growing realisation of the limited capacity for eradication of diseases, especially infectious ones, via chemotherapy and antibiotics alone. This positive benefit informed a new realisation that disease does not respect racial boundaries. No race can claim to be immune from disease. Thus a gradual inclusive and liberal approach to public health started to gain ground. For example, a new and slow paradigm on the eradication of malaria, rural hygiene improvement, and malnutrition reduction was started (Gelfand, 1976; McCracken, 1980).

3.4.2 The Public Health Act of 1924

The period following the referendum organised by the Rhodesia settler minority in 1923 to decide on whether to join the South African Union (South Africa) marked a full-scale

movement towards racial segregation on critical matters of land and *social engineering* (Lee, 1977; Hodder-Williams and Whiteley, 1980; Murphy, 2007). An earlier attempt to amalgamate Northern and Southern Rhodesia by Cecil John Rhodes's BSAC failed in 1916 due to the resistance of the settler white community in Rhodesia who had always advocated for autonomy from the company and British Imperial authority (West, 2002). Having obtained full political autonomy from Imperial Britain and South Africa in 1923, the settler Rhodesian government went full throttle to design and integrate health policy within the settler framework. Among the deadly segregationist policies that were to impact negatively on the health of indigenous people was the creation of African Reserves (Phimister, 1993; Ncube, 2012) and the legislation of the Public Health Act of 1924., which obliged employers, teachers, and heads of families in the disease notification process (McCulloch, 1999; Worby, 2000).

The premise of the Public Health Act was on the misplaced, immoral assumption that blacks were a reservoir of disease who needed greater surveillance as well as to be quarantined from pure European settler races. There was even settler, white social pressure groups who nudged the colonial governments to increase this segregation by making sure natives were not mixed with whites. One such group was the *Rhodesian Women's League*, which fought to protect the white settler women and children from the African domestic worker thought to be infected with syphilis (McCulloch, 1999, 2000).

The assumption of a *pathologised* African or native body inadvertently gave rise to the official policy of racial segregation in health. This saw the emergence of *European only* hospitals and clinics with its trickledown effect on segregated urban planning and housing (Beeckmans, 2016).

At about the same time a new arrival in the colony of Rhodesia from Britain, in the form of a Medical Director for the colony, reinforced this myth about natives being a reservoir for disease and being the cause of low life expectancy among the settler white community (Ncube, 2012). However, there was a positive spin from all this paranoia. For example, in the 1930s this misplaced hysteria for a buffer zone between diseased African natives and *pure settler whites* inadvertently spurred the creation of rural health facilities on an unprecedented scale. The attitude of colonial governments towards native health issues started to change gradually. Organisations such as the International Rockefeller Foundation and LNHO started to invest into research into native nutrition and improved funding for social services.

I need to underscore the fact that any improvement in native health provisions was an incidental issue arising from the primary objective of safeguarding European health needs. Therefore, there is no argument that the colonial public health policy was essentially racist, discriminatory, full of prejudice, immoral, unethical, and founded on erroneous or spurious scientific reasoning.

3.4.3 Training of Medical Auxiliaries

Native women were generally excluded from education and as a result were also denied training as medical auxiliaries, except for midwifery. This means until after the second World War (WW2) the main route to acquiring education for natives was through missionary schools (Charumbira, 2006; Ncube, 2012). The paradox of all this was that even though in the western nursing philosophy females make the bulk of the nursing profession, and on balance female nurses are highly virtuous (Sevenhuijsen, 1998; Slote, 2007), in the colonies the authorities sacrificed this ideology in order to maintain and subjugate the population. Unlike in Nyasaland where recruits to medical assistant training required at least three or four years of education, in Southern Rhodesia candidates were expected to have at least standard four

education. These requirements made it almost impossible for women to enter medical auxiliary training. Due to continued bickering between colonial governments and missionary authorities about the ideology of the curriculum for the nursing assistants, funding for medical auxiliary training in mission hospitals was eventually reduced by the government leading to the opening of government training schools in the 1930s. From 1937 schools for medical auxiliaries opened in Bulawayo and Salisbury, producing cadres with relatively expanded functions and responsibilities for rural health centres. Mission hospitals did not stop training. In fact, they offered a somewhat superior curriculum for what they termed *hospital assistants* as opposed to the government graduands known by the term *medical aides* (Gelfand, 1976).

The training of *medical aides or hospital assistants* was a necessity because doctors and registered nurses were in short supply and there was no capacity to staff rural health facilities using doctors and registered nurses. Although Southern Rhodesia opened a school for registered nurses in the 1930s, this training was only open to white settler females. There was an over-reliance on expatriate doctors and registered nurses in all the three colonies of North, Southern Rhodesia and Nyasaland. However, Southern Rhodesia tended to always take a lead in innovation. Unlike its northern neighbours, by the 1940s it had started to augment the training of medical auxiliaries focussed on curative services by training hygiene demonstrators concentrating on sanitation, health education, water treatment and housing improvement- a role that would eventually become very handy in the control of tuberculosis and disease notification (McCulloch, 2000).

3.4.4 The 1940 British Colonial Development and Welfare Act

Between 1930 and 1957 major labour unrest, riots and strikes engulfed the British empire (French, 1988; Johnson, 1995). The most devastating one was in Northern Rhodesia on the

Copper belt in 1935 (Henderson, 1975; Henderson *et al.*, 1999). The major bone of contention was the native peoples' demand for fair and equitable workplace policies and social welfare. This prompted the British to realise the need for an empire-wide programme of social improvement and to revamp infrastructure in the colonies to lift the standard of living for the colonised subjects (Home, 2000).

As a consequence of this thought, the British parliament passed the *Colonial Development and Welfare Act* in 1940. A new paradigm was born leading to long-term plans in the colonies of Northern, Southern Rhodesia, and Nyasaland- although very little happened until the consummation of the Federation of Central Africa in 1953. These plans were very elaborate, including provision for medical facilities and other infrastructure. Simultaneously a realisation rose that the African was a very useful human resource for the rapidly developing industries as well as providing the ultimate consumer of goods and services. In Southern Rhodesia the then Prime Minister, Godfrey Huggins marshalled a *futuristic plan* for universal healthcare around 1944. Scholars argue that Huggins's much vaunted universal healthcare was just that in name but in reality only catered for settler whites while service for natives remained rudimentary (Huggins, 1952; Gann, 1985).

3.5 Health Policy during the Federation of Central Africa

The story about the development of Southern Rhodesia and later Rhodesia, including of its healthcare system, became extremely political and racially fragmented, segregated and polarised. Southern Rhodesia became Rhodesia after the unilateral declaration of Independence by Ian Smith's Rhodesia Front in January 1965 (Zvobgo, 2005; Coggins, 2006). It cannot be fully explained without touching on the period immediately before the Federation of Central Africa, the federation and the post-federation period. Let me explain this part first. A federation between Southern and Northern Rhodesia (present-day Zimbabwe

and Zambia respectively) and Nyasaland (present-day Malawi) was created in 1953 (Faber, 1959). Southern Rhodesia enjoyed political autonomy from the British ever since 1923 while the other two members of the Federation were administered directly from Britain via the *British Colonial Office*- a concept meant to give a veneer of indirect rule by allowing *independent native authority* which took care of collection of taxes, organising labour and administering the law and order. Northern Rhodesia had its economy primarily based on the copper belt, Nyasaland being strong in agriculture while Southern Rhodesia had a mixed economy especially mining, manufacturing, and agriculture (Mason, 1962).

According to Valentine (2017), the Federation came about as a result of a convergence of varied political interests: The British were looking for a way to escape or reduce their financial obligations to the colonies after WW2 while Southern Rhodesia wanted to take advantage of the booming copper mining in Northern Rhodesia and counter the growing influence of the Afrikaners in South Africa (ibid). This background explanation on the formation and motives for the federation is given because it has a bearing on the evolution of the politico-economic policies and set up of modern-day Zimbabwe, in particular how the health policy would evolve later on during the subsistence of the federation and beyond.

3.5.1 Colonialism, Missionary Work and Health Services

The role of missionaries in the provision of healthcare in the British colonies in Africa and beyond has been covered extensively in literature. Southern Africa and the Federation of Central Africa are not an exception. Missionaries had a twin objective in healthcare delivery to Africans: using it as an evangelism tool as well as for spreading western civilisation and values (Vaughan, 1991). There are mixed opinions about the level of cooperation and collaboration between missionary medicine and settler colonialism. Some saw a convergence

of objectives and hence the cooperation while others argue that missionaries' medicine rode on settler colonialism in order to achieve its own objectives.

Perhaps realizing the impact of missionary medicine and fearing its unfettered influence on the indigenous populations the settler elite increasingly got interested in funding the missionary medical projects. For its part missionary medicine is credited with expanding the role played by indigenous people as medical assistants, orderlies, midwives and messengers. The settler elite seemingly embraced this as it relieved white medical professionals and allowed black medical assistants to attend to their own kith and kin, amid a huge shortage of staff (Masakure, 2015). Whichever way one looks at the role played by missionary medicine, it is clear that it was inadequate but played a major role. Colonial subjugation, dislocation of indigenous ways of life, land dispossession, and wars made the burden of disease even worse. Indigenous people in the territories embraced western medicine where it worked for them but reverted to their traditional healing processes to augment any perceived limitations of western medicine (Feierman, 2000).

Thus it can be argued that the involvement of indigenous people in western medicine as medical assistants, midwives, and dispensers did more good than harm by assimilating African healing methods into western medical practices. One notable positive outcome of the Federation health policy was gradual initiation of training for African registered nurses and medical doctors. Although this initiative was forced upon the Federation health administration due to a multitude of factors the major reason is thought to be shortage emanating from increased urbanisation, the impact of the second world war, and a softening of colonial colour bar ideology (Masakure, 2015). Just like in the South African situation about half a century earlier, when the training and integration of black African medical doctors and nurses created racial friction, the introduction of African black medical personnel in the federation also created racial problems (Marks, 1994). The dilemma was that colonial

hierarchy always placed males over women, white healthcare professionals over their black counterparts, and lastly doctors had higher seniority over nurses (van Heyningen, 1996; Wright, 1996). This arrangement was turned upside down with the entrance of black healthcare professionals. For example, how would a white nurse relate to a black African doctor? How would a black African nursing matron relate to a junior white nurse? On the whole the federal government cooperation with missionary medical services employed some sort of *public-private partnership* model with a boundary between the two being permeable. Doctors and nurses tended to enjoy better working conditions within government structures than other civil servants in general (Moul, 2018).

3.6 Godfrey Huggins School of Medicine opens in 1963

The opening of the first-ever medical school in any country appears to be viewed as a milestone, a sign of modernity, a symbol of national pride, and perhaps a commitment to sustainable progress in the health provision of a country. The lack of own medical school and capacity to train medical doctors locally in the Federation of Central Africa was identified as a yawning gap by the authorities in the federation (Huggins, 1952; Valentine, 2017). At a dinner organised by the Southern Rhodesia Medical Association one evening, Dr Adams, who was the principal of the newly opened and multiracial University College of Rhodesia and Nyasaland, made a strong plea for the need to train African medical doctors on home soil. According to his presentation and argument local training would allow a focus on diseases of interest in central Africa, a home-grown and relevant curriculum, and more importantly, encourage the training of African doctors and research into issues of local importance. This suggestion and plea were graciously accepted by the then Prime Minister of the Federation, Sir Lord Malvern-who said that: "...the government has decided that Africans should become doctors....that there was not colour bar in disease and medicinewas one

of those professions that showed no distinctions...the only decision that could be made was to accept him on the same grade (of pay) as a European doctor” (Valentine, 2017, p. 96).

This ambivalence on whether to fully integrate Africans in the developmental state was a recurring philosophical dilemma of the colonial political system. Settler European administrators regularly re-examined their conscience when faced with the need to be pragmatic and in this case the need to expand healthcare provision but at the same time preserving the privileged status of the settler race (Empire, 1997). As a compromise the Federation health service would promote the deployment of African doctors to the rural areas where they would not challenge or come in direct conflict with racial hierarchy in the urban medical settings. This position was epitomised later on when the first African medical doctor, Dr Samuel Tichafa Parirenyatwa, was to be deployed in the rural far south-eastern part of Rhodesia (Ncube, 2012). In 1956 the Nuffield Foundation of Britain funded a fact-finding and planning committee to study the feasibility of a medical school in the Federation. The following were the terms of reference for the committee:

To advise the University College of Rhodesia and Nyasaland on the desirability and practicability of establishing a medical school as an integral part of the college; to prepare proposals for the training curriculum, postgraduate training, the research facilities, the buildings, equipment and stalling required including those required for a suitable teaching hospital and other centres for clinical facilities; to prepare estimates of the capital and recurrent costs involved and a phased time-table for development, and to make any other proposals and suggestions for the development of medical education and research under the auspices of the college (Thomson, 1965, p. 297).

The committee undertook a tour of towns, hospitals, and clinics in the region which resulted in two major official reports released in 1956 and 1959 recommending the establishment of a medical school that would train African doctors, and reduce the burden of manpower shortage of the day (Davidson, 1965). The committee also recommended, among other issues, that overseas trained doctors did not meet the local challenges and that in Southern Rhodesia

in particular, the disproportionate concentration of doctors in urban areas meant that only 5% of the population received meaningful healthcare service (Gelfand, 1957).

Where to locate or site the medical school was not a foregone conclusion. The debate about the location of the medical school, as was now the case with most federal decisions, raised temperatures and allegations of domination of Southern Rhodesia over its sister territories of Northern Rhodesia and Nyasaland in the Federation. Lusaka and Livingstone in Northern Rhodesia put up a fierce fight and so was Bulawayo in the South West of Southern Rhodesia. Eventually, the medical school was opened in Salisbury. The Godfrey Huggins school of medicine as it came to be known later on (from 16th July 1968 in tribute to Godfrey Huggins, also later himself known as Lord Malvern) was unique in several aspects as follows:

- i. Its relationship with the University of Birmingham in Britain, guaranteeing a British accredited degree which ensured instant recognition and scope for advancement.
- ii. Its association with the Nuffield Foundation.
- iii. An opportunity and funding advanced by the Rock Feller Foundation for three of its founding professors to make a world tour of top medical institutions worldwide.
- iv. Exceptional planning for the teaching and hospital proximity
(Thomson, 1965; Valentine, 2017).

The location of the medical school in Salisbury was further enhanced by the fact that it was already the headquarters of the federal health service. In addition, the Bilharzia Research Laboratory was already operational in Salisbury. There was an added advantage of the existence of a major Africa Hospital-Salisbury General Hospital, later changed to Harare Hospital (popularly known as *Ku Gomo*). In 2019 Harare Hospital was renamed Sally Mugabe Hospital, in recognition of Robert Mugabe's first Ghanaian wife.

Federal authorities billed the construction of the medical school as a sign of advancement, as a pinnacle of the successes of its policies, and as an opportunity to show the outside world how the federated health approach was turning the corner in matching British standards both in training and health provision. The first intake for the medical school was in 1957 with a class of 17. In 1968 sixteen of the first Rhodesian trained medical doctors completed their studies with three coming out with honours beating even their parent university of Birmingham which had only 2 out of 90 the previous year, achieving honours. This success was attributed to the small class of medical students, the keenness of staff to teach, the appetite of the students to learn, and the careful selection of students into the programme. This medical school was now being seen as the main outlet to satisfy training needs for medical doctors in southern Africa as Universities of Cape Town, Witwatersrand and Natal had stopped taking students from the federation in order to concentrate on applications from the Republic of South Africa. In 1969 alone 135 students had applied to study medicine at the Godfrey Huggins school of medicine while the total enrolment in 1968, from first to sixth year of training, was 162 (Ross, 1970, 1971; Wakeford, 1970; Blair, 1972; Gann, 1985; Valentine, 2017).

3.7 Philosophy of the Settler Healthcare System during the Federation

The design of the settler healthcare system in Southern Rhodesia was premised on white racial supremacy, a condescending approach to indigenous African health needs, and a limited autonomy meant to assimilate the enlightened middle-class Africans (Valentine, 2017). A term called *racial partnership* was coined by the settler political establishment as a way of appeasement to the indigenous middle class. The indigenous middle class unknowingly mistook it to mean a genuine invitation to equal political participation while the settlers saw it as a way to moderate indigenous Africans' political aspirations. This

appeasement approach was to find expression even in the design of health policies for indigenous Africans (Llewellyn, 1956; Franklin, 1963).

A new law was passed by the Federal Government in March 1954, mandating the Federation government to administer the health function in all the three colonies of Southern Rhodesia, Northern Rhodesia and Nyasaland. For about ten years making up the life span of the Federation, six million indigenous Africans' health issues were in the hands of the settler authorities, with little or no direct participation of the affected population (Franklin, 1963; Valentine, 2017). This new federal health function promised an improvement on the previous desperate situation in the colonies epitomised by poor health infrastructure, inadequately trained personnel, deficits in research on local endemic conditions such as malaria, bilharzia, and sleeping sickness. In addition, native free health service was promulgated, which also absorbed those poor settler whites unable to afford user fees (Welensky, 1963; Messac, 2014). This seemingly benevolent approach was still based on a condescending mentality, partly based on a need to weaken the community solidarity espoused through traditional African medical practices.

The settler *colonial developmentalist State* approach in the 1950s during the Central African Federation was not inspired entirely by a genuine need to uplift the welfare of indigenous people but by several factors converging at the same time:

- The British empire had sensed a possible hardening of the indigenous population's attitude towards colonisation and therefore improvement of social services in all British colonies was seen as one of the ways to appease the indigenous people. This approach had already been set in motion by other European imperial masters in their own colonies, for example in the Belgian Congo (Hunt, 1999; Rich, 2016).

- The settler elite saw it as a means to consolidate their grip on power (Grischow, 2005; Rich, 2016).
- The settler colonial elite also anticipated to copy the assumed success in public health in the United States of America at the time. For example, the successes in malaria eradication with Dichlorodiphenyltrichloroethane (DDT). Therefore, the settler elite and political administrators saw this as an opportunity to create a white man's new territory free of tropical diseases (McGregor and Ranger, 2000).

In Southern Rhodesia, a vibrant private medical practice for the exclusive benefit of the settler population and their families existed while the Native health service was just meant to prepare the indigenous population to provide cheap labour. Similarly in Northern Rhodesia and Nyasaland, the Native health service was rudimentary, consisting of basic dispensaries and little preventive health services to provide cheap labour for the copper belt and tobacco farming in Nyasaland respectively (Philip, 1957; Stewart, 2017).

While the language in the new Federation Health Service policy enunciated a progressive moral paradigm emanating from the post-second world war consensus and principles from the Nuremberg health crimes and trials, it in fact masked an ideology by the settler elite and imperial forces in which they anticipated separate development for settler whites and indigenous Africans. One of the documents which influenced this *new paradigm in healthcare services* in the colonies was the *1948 Universal Declaration on Human Rights* (Cooper, 1997). The other influential document was the World Health Organisation (WHO) constitution which was also adopted on 22 July 1946 and went into force on 7 April 1948 (Conference, 2002).

It has been argued that after the first five years of the Federation's existence middle-class indigenous Africans who had seen the Federation as a way to be integrated into European lifestyle started to lose hope and dissatisfaction grew louder and louder. And because access

to good and European standard healthcare had been one of the major quests for middle-class and educated Africans, they quickly turned to Nationalist politics (West, 2002).

In summary, the philosophy of the federal health policy was based on not just a colonial ideology but a special one referred to as a *Settler colonial approach*. According to Veracini (2010), there is a difference between *typical or ordinary colonialism* and settler colonialism. The former imputes permanent oppression of the indigenous African population while the latter goes beyond by attempting to erase the African population by all means necessary including assimilation, displacement, physical destruction, deformation of cultural practices, land theft, and amalgamation (Veracini, 2010b, 2010a). The central theme in settler colonialism was land conquest. This is the basis upon which all their policies were premised (Wolfe, 2006). While many strategies were used to effect settler colonialism in Southern Rhodesia the most obvious of them was the creation of *African reserves* and *pass laws*. The African reserves were deliberately located far away from European areas. This limited the mobility of indigenous Africans; a strategy that was thought to make it much easier to control them but unfortunately resulted in high disease morbidity and mortality (Phimister, 1986, 1993; Cheater, 1990; Mlambo, 1990; Walle, 2010). In part this settler colonial sense of entitlement was started by the British South African Company's Pioneer Column which misread the sparsely populated plains of Zimbabwe as uninhabited lands (Floyd, 1962; Duggan, 1980). This denial of the potential for African civilisation extended to a point of associating the erection and building of the magnificent and eloquent Great Zimbabwe ruins with some whites who must have sneaked into Zimbabwe between the 12th and 15th Centuries. The settler colonial mentality saw the benefits of biomedicine as not only a means to uplift the African from barbarism and savagery but also a way to suppress their rich, vibrant and communitarian traditional medicine, healing, solidarity, and spirituality (Feierman, Janzen and Studies, 1992; Levers, 2006).

3.7.1 Failed Political Liberalism in the Federal Health Policy

The word liberal has an original meaning, which refers to what befits a person. Wealth and power have always been at the centre of conditions of any freedom. Freedom has a cultural value in which the free man exercises his power with open-handedness, generosity and open-mindedness (Jordan, 1936). Jordan goes on to explain a critical distinction between positive and negative political liberalism. Simply put the former refers to the exercise of fair play and tolerance in society while the latter refers to freedom and liberty from oppression (Berlin, 1969; Honneth, 1999; Gustavsson, 2011). I argue that health policy during the Federation lacked all the essential ingredients as outlined above and hence the demise of this health policy.

Despite a spirited propaganda programme at home and abroad to project the federal health policies and services as having brought significant benefits to the indigenous African population, it failed dismally to achieve this intended narrative. Least of which because it was a lie wrapped with a veneer of inclusivity and yet there appeared to be very little of inclusivity (Ehui, 2016). The political objective to legitimize the existence of colonial subjugation of indigenous African people and survival of the Federation clouded health policy from political ideology. As a result, failure of the federal health policy was inevitable. Colonial governments were not keen to train African healthcare professionals, a gap and vacuum that was later to be filled up by missionaries. The reliance on expatriate healthcare workers, such as doctors and nurses, was eventually going to prove unsustainable. The federal health policy failed because it was designed to mask a hidden objective of maintaining an unfair status quo, the continued marginalisation of the indigenous African population while at the same time investing in a superior European settler healthcare service comparable to the one enjoyed in the Imperial capitals of Great Britain, France, Belgium and

Portugal (Gelfand, 1976; Valentine, 2017). This gross inequality in healthcare access was disproportionately worse in the northern territories of the federation of Northern Rhodesia and Nyasaland- a fate that followed them into political independence.

To its credit, the federal health policy saw the gradual lifting of the racial colour bar in the training of healthcare staff. The federal health philosophy had the positive effect of bringing together various colonial health professionals who did not always follow the imperial doctrine of strict segregation. Partial integration between black and European medical staff was also a necessity borne out of shortage in both administrative and professional medical staff and hence the *multiracial partnership* in health (Crozier, 2007a, 2007b).

3.8 Health Policy during the Unilateral Declaration of Independence Period (UDI): 1963 to 1980

The healthcare policy during the Unilateral Declaration of Independence (UDI) was characterised by further segregation as the settler regime consolidated its onslaught on what had remained of colonialism from the federation. The political leaders of Northern Rhodesia and Nyasaland made spirited efforts to gain national independence despite resistance from Roy Welensky's settler elite. Roy Welensky was the Prime Minister for the federation. There was well-organised opposition to the federation from the northern territories from the Malawi Congress Party and United Independence Party of Northern Rhodesia which had a lot of support from indigenous people. After Hastings Kamuzu Banda and Kenneth David Kaunda were released from detention, they spearheaded independence negotiations with the British Government, and from 1962 Banda was almost the de facto Prime Minister of Nyasaland (now called Malawi).

After Nyasaland became self-governing in 1963 and followed by Northern Rhodesia later the British government declared the right of any of the territories to secede from the federation

and this became the *last nail in the coffin* for the federation. And with it the demise of the Federal health service was inevitable. The demise of the federal health service was at a time when some felt it had started making inroads on its stated objectives. One of its stated objectives was to make healthcare more inclusive to the indigenous black race by in part increasing the training of black people as medical doctors, registered nurses and midwives (Valentine, 2017). For example, the first medical school in Salisbury was about to open as well the completion of a State Registered Nurse training by the first group of African candidates when the Federation collapsed. There was confusion in the northern territories with regards to how the medical officers would be absorbed. Many of them left for international offers. Fortunately, Southern Rhodesia did not suffer the same fate and even benefited from those returning from newly independent northern territories. In addition, the recruitment of student nurses provided a valuable source of cheap labour, a practice still prevalent up to today in Zimbabwe.

With the failure of the federation the settlers now turned their energy to Southern Rhodesia culminating in the declaration of Independence from Britain in 1965; famously referred to as the Unilateral Declaration of Independence (UDI). The UDI unleashed United Nations-led sanctions as well as the protracted war of liberation leading to political independence in 1980. The health service in Southern Rhodesia suffered tremendously from UN sanctions as a result of the UDI, lack of foreign direct investment, international isolation, lack of levies and taxes from the Zambian copper belt, and tobacco in Malawi. A decline in funding of the Southern Rhodesia health service was inevitable. This even threatened the newly opened medical school in March 1963 in Salisbury.

After Malawi and Zambia withdrew support for the medical school after the demise of the federation the school struggled and was only saved by a cash injection from the British. To its credit, it maintained a recruitment strategy based on merit regardless of race, gender and

religion. However, the international isolation was devastating, resulting from lecturers being excluded from the Association of African Medical Schools, and the major moral and academic sponsor University of Birmingham withdrew due to the declaration of Southern Rhodesia into the republic of Rhodesia in 1970. As a result, graduates from the local medical school were no longer allowed to enjoy reciprocal registration with the British General Medical Council. Further blows were the cutting of associate status of Rhodesia from the World Health Organisation, a relationship which had blossomed from the 1950s (Valentine, 2017).

3.9 Ethical Concerns about Zimbabwe's Colonial Healthcare System

The way the health system was organised during Zimbabwe's colonial period showed a lot of bias towards the city dwellers and urban population. This bias was not only towards the urban populations but also towards curative services. Even then the bulk of services were directed at those who had special racial privileges at the time and these were the white community and coloured people (Zhou and Hardlife, 2012). This state of the biased healthcare system in pre-independent Zimbabwe was widespread in many of the colonised countries and territories of the world, especially those under the British Empire (Bloom, 1985; Peters *et al.*, 2008).

The indigenous populations were severely marginalised and discriminated against resulting in unfair health resource allocation and distribution. The critical features of distributive and social justice, Egalitarianism and Ubuntu were flouted. These critical features include access, equity, participation and human rights (Ramose, 1999; Emanuel, 2000; Lamont and Favor, 2004; Louw, 2006; Metz, 2011a; Himonga, 2013; Olsaretti, 2020). Health and other resources were prioritized and distributed according to race, with the bulk of them going to whites, Indian and coloureds-in descending order. Indigenous people were at the bottom of

the ladder (Philip, 1957; Stott, 1960; Gelfand, 1976; Valentine, 2017). For example, documented health statistics of the time paint high disproportionate bad health outcomes:

...infant mortality rate amongst the blacks was much higher at 120-220 per 1000 compared to whites at just around 17 per 1000...(Agere, 1990, p. 31). "... 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 serving 70% of the total population (Razemba, 1998, p. 5).

While there were ethical concerns about unequal access to healthcare and disproportionate distribution of public health resources based on race in pre-Independent Zimbabwe, similar and new distributive justice challenges still exist in post-independent Zimbabwe (Sanders, 1990; Loewenson, Sanders and Davies, 1991; Chikanda, 2006; Nyazema, 2010; Todd *et al.*, 2010). In some cases, access to healthcare has even deteriorated to worse levels compared to pre-independent Zimbabwe (ibid).

Healthcare policies of pre-independent Zimbabwe were essentially unjust as they promoted resource distribution biased towards the white and Indian races at the expense of the poor black majority. This was inspired by the prevailing political philosophy of racial segregation in all aspects of life. This was part of the reason for the protracted war of liberation which ended with a compromise agreement at Lancaster House brokered by the British government leading to multi-party elections in 1980. A new government was ushered in on April 18, 1980, ushering a huge euphoria and hope for a marked improvement in access to healthcare by the hitherto neglected majority poor black people of the country.

3.10 Chapter Summary

This chapter gave a detailed description and analysis of healthcare policies in pre-independent Zimbabwe. The chapter give context to and has set the stage for a detailed analysis of healthcare policies in Independent Zimbabwe. The chapter described Zimbabwe's

political history, organisation of Zimbabwe's healthcare system during the pre-colonial and colonial periods. A landmark development during the colonial period was the Federation of Southern Rhodesia, Northern Rhodesia and Nyasaland which ran between 1953 and 1963 with its headquarters in Salisbury in Southern Rhodesia. Health policies of the federation made a failed attempt to liberalise healthcare services but is credited with the creation of the first inclusive medical school, The Godfrey Huggins School of Medicine in Salisbury. The chapter ends with a description of the ethical concerns about the healthcare system during Zimbabwe's colonial past. The next chapter looks at the healthcare system in Post-Independent Zimbabwe.

CHAPTER 4: HEALTHCARE POLICIES IN POST-INDEPENDENT ZIMBABWE

4.1 Introduction

This chapter traces the journey of the health policy changes from independence in 1980 till the early twenty-first century (2021). This narrative helps to contextualize the current state of affairs in the healthcare sector. These changes in healthcare policies have an impact and influence on the contemporary healthcare situation as it obtained at the time of this study.

Zimbabwe earned its political independence on 18th April 1980 after a protracted seven-year armed struggle waged from the rear bases of the so-called *Front line states* of Mozambique, Zambia, Tanzania, and Botswana (Walle, 2010). At independence, the new government faced many hurdles and impediments. One major challenge was the need to rebuild physical and administrative infrastructure which had been destroyed during the war of liberation and international sanctions which had been declared against the Ian Douglas Smith regime after it had declared the Unilateral Declaration of Independence (UDI) from Britain in 1965 (Coggins, 2006). The other need was of realigning the new dispensation to one of an egalitarian society against the previous colonial governments' segregatory laws and processes. Healthcare delivery and education services were some of the major *social ills* requiring redress.

This new black majority government had inherited an economy largely based on inequality and disproportionate distribution of wealth and public resources with the largest share going to the white colonial privileges (Blake, 1977; Nyazema, 2010). As a result, it was only natural that the new government saw it prudent to direct significant public spending towards social sectors paying special emphasis to rural infrastructure expansion through land

resettlement programs. The emphasis in the case of urban dwellers, who were dependent on employment in largely white-owned companies, was on minimum wage determination, black affirmative action, and indigenization policies (Zimbabwe, 1981).

4.2 The First Decade of Independence (1980 to 1989)

The overall policy framework during the first decade of independence was anchored on a policy called *Growth with Equity* (Sibanda and Makwata, 2017). The implied theme in this policy of *Growth with Equity* was the philosophy of distributive justice, defined as the first virtue of institutions (Rawls, 2009). Rawls opined that:

...likewise laws and institutions no matter how efficient and well-arranged must be reformed or abolished if they are unjust. Each person possesses an inviolability founded on justice that even the welfare of society as a whole cannot override... For this reason, justice denies that the loss of freedom for some is made right by a greater good shared by others. It does not allow that the sacrifices imposed on a few are outweighed by the larger sum of advantages enjoyed by many (Rawls, 2009, p. 3).

I support a position that this was a justified policy approach because the society of Zimbabwe had been very unequal for close to a century since its colonisation in 1890. The preceding parts of this thesis (especially in chapter 3) have gone to length to explain and illustrate the impact of colonial discrimination policies in aspects of life in the country (Baker and Rhodes, 1934; Mason, 1960; Blake, 1977; Hoderness, 1985; Nyazema, 2010). The beneficial aspect of the *Growth with Equity Policy* framework was the removal of separate health services and facilities based on the colour of one's skin. For example, the former Andrew Fleming hospital (now renamed Parirenyatwa Central Hospital) was made accessible to all races and so were many of the formerly exclusive whites-only private and public health facilities (Zhou and Masunungure, 2006). A specific sectoral application of the *Growth with Equity Policy Framework* to the health sector during the first ten years of independence was

the *Plan for Equity for Health of 1980*⁷. This was a further refinement of the general policy of *Growth with Equity* framework announced in 1981 (Zimbabwe, 1981; Zhou and Masunungure, 2006; Zhou and Hardlife, 2012). This policy appeared to have been heavily influenced by the *Alma Ata Declaration of 1978* which was anchored on the primacy of Primary Healthcare (PHC) as a vehicle for attaining universal minimum preventive and curative health services using appropriate and local resources and technology (Sanders, 1980, 1990; Todd *et al.*, 2010). PHC located health as a social good and basic human right which all nations must provide, protect and guarantee. In tandem with international trends as encouraged by the World Health Organisation (WHO) Zimbabwe also latched onto the *Health for ALL by year 2000* campaign and even appeared to inscribe it as a slogan or strategy of the then Ministry of Health of Zimbabwe (Macinko and Starfield, 2002). At the end it was not clear which of the two was the really official sectoral policy for health between *Health for All by year 2000* and *Plan for Equity in Health*. It does appear like the former was an international campaign or mantra propagated by the WHO while the latter was the real official local health policy of the time. Notwithstanding this seeming policy ambiguity, the major focus of the various programmes under the general policy framework of *Growth with Equity* appeared to focus on aspects of equality, human workforce, finance and service delivery among others. For example, free healthcare was announced in September 1980, as a safety net for those earning less than 150 Zimbabwean dollars ⁸(Nyamunda, 2015, 2017).

⁷ *One of the important achievements of this policy was the significant increase in coverage of immunization against the 6 child killer diseases between age of 12 to 23 months. This coverage rose to 42% from 25% in rural communities and to 80% from 56% in towns and cities (Zimbabwe, 1981).*

⁸ *Zimbabwe's original colonial currency was the Rhodesia Pound, introduced at par with the British Pound Sterling. On February 17, 1970 The Rhodesia Dollar (RHD) replaced the Rhodesia Pound with 2 Rhodesia Dollars equal to 1 Rhodesia Pound. On April 18, 1980 on advent of political independence, The Zimbabwe Dollar in turn replaced the Rhodesia Dollar at par. At time of this conversion, a Zimbabwe Dollar was valued at 1.47 United States Dollars, and at that level the Zimbabwe Dollar was much higher than most world currencies, including the South African Rand (Nyamunda, 2015, 2017).*

Furthermore, a massive donor-funded infrastructure rebuilding programme was embarked upon and 224 rural health centres, had been completed and a number of provincial healthcare and training centres were upgraded by June 1987 (Sanders, 1990).

I support the position that this policy called *Plan for Equity in Health* was anchored around the philosophy of distributive Egalitarianism (justice) because it was aimed at redressing perceived and widely accepted discriminatory practices of previous colonial, white settler administrations. Egalitarianism is defined as:

...a trend of thought in political philosophy which favours equality of some sort, people should get the same, or be treated the same, or be treated as equals, in some respect. An alternative view expands on this last-mentioned option: People should be treated as equals, should treat one another as equals, should relate as equals, or enjoy an equality of social status of some sort. Egalitarian doctrines tend to rest on a background idea that all human persons are equal in fundamental worth or moral status...In modern democratic societies, the term 'egalitarian' is often used to refer to a position that favours, for any of a wide array of reasons, a greater degree of equality of income and wealth across persons than currently exists (Arneson, 2002a).

The new government set out to build a new society based on socialism and democratic principles in the distribution of national resources and social benefits. Health and education sectors benefited the most at the beginning of the new political dispensation.

Despite this egalitarian health policy thrust geared at redistributive justice to the hitherto underserviced indigenous population groups the policy soon ran into budgetary problems and challenges. There were too many demands on the public purse against limited government revenue and donor funds. For example, the budget for the health sector alone rose from 5.1 to about 10% of the national budget in 1982 and continued to rise with a corresponding rise in foreign debt despite the heavy donor funding (Roland, 2002). Within a few years, the goal of *Health for All by year 2000* turned out to be too ambitious for a country coming out of war and struggling to balance its spending (Nyazema, 2010; United Nations, 2013). The government started to incur huge budget deficits which were affecting the smooth running of the whole public sector. Despite the *Plan for Equity in Health Policy* having an egalitarian

thrust, it nevertheless continued to fail with each successive decade, as will be illustrated in the rest of this chapter. This goes to show that even healthcare policies with an ethical basis can fail as long as they are not underpinned by a strong monitoring and evaluation paradigm spearheaded by the citizenry and other stakeholders. The CCHM, to be presented in full in chapter 9, differs from the egalitarian healthcare policies of the post-Independence period in that it has a strong monitoring and evaluation and oversight by both people's representatives within the legislative arm of the State as well as the ordinary citizens through stakeholder involvement. The new constitution of Zimbabwe enacted in 2013 has also provided a new legal imperative in its version of Bill of Rights in chapter 4, which has potential to provide statutory obligations to the State. The CCHM fully described in chapter 9 brings a new model which encompasses the deficiencies inherent in previous healthcare models of Zimbabwe since independence. The next section describes the coming in of the International Monetary Fund (IMF) and the World Bank (WB) into Zimbabwe.

4.3 The Second and Third Decades of Independence (1990 to 2010)

The International Monetary Fund (IMF) and World Bank (WB) prescribed programme called *The Economic Structural Adjustment Programme (ESAP)*, dominated two decades of Zimbabwe's independence from 1990 to around 2010 (Bonga, 2014). The redistributive agenda immediately after political independence in 1980 had resulted in a bloated government, fiscal expansion, budgetary constraints, large civil service, and a ballooning internal and external debt. ESAP, which was an essentially neo-liberal market-driven austerity programme, was meant to correct the ills of many third world governments particularly in Africa, who were assumed not to be able to balance their budgets. There was a lot of belt-tightening resulting in forced massive civil retrenchments (target of 25%), social service subsidy withdrawals, commercialising and privatising of state-owned enterprises and

parastatals, the introduction of user fees in the public health and education sectors, deregulation of price controls, devaluation of the Zimbabwe Dollar⁹, and unrestrained interest rates, among other austerity measures (Koech, 2011). This resulted in untold suffering and social dislocation (Marquette, 1997; Chattopadhyay, 2000; Makoni, 2000).

During this decade there were two distinct health policies that we can discuss:

- i. ESAP related health policy of 1992 to 1996 and
- ii. the National Health Strategy of 1997 to 2007.

As already alluded to, ESAP focussed on restraining government expenditure to redirect resources to the productive sectors in a way that could redress the failures of the previous policy called Growth with Equity and its health sectoral policy called *Plan with Equity in Health*. This meant the introduction of user fees in public clinics and hospitals (Kanji and Jazdowska, 1993; Bassett, Bijlmakers and Sanders, 1997). ESAP was so devastating that even local musicians composed sombre songs about it. Most of the previous gains in public health statistics were reversed. The health sector started to unravel and experienced unprecedented challenges and dislocation.

It is not an exaggeration to say that the removal of social spending and severe reduction in subsidy to the health budget resulted in avoidable deaths as more people died in their homes or in donkey or cattle-drawn scotch carts on their way to health centres. All vital health statistics started to decline with Maternal Mortality Rate (MMR), Infant Mortality Rate (IMR), Ante-natal Care (ANC) and Post-Natal Care (PNC) visits declining exponentially. There was a spike in *Born Before Arrivals* (BBAs), a decline in immunisation coverage rates

⁹ The original Zimbabwe dollar of 1980 was eventually replaced by the US dollar in 2009 after record hyperinflation and after numerous devaluations (Koech, 2011).

as well increased malnutrition rates. In 1994 alone public health expenditure declined by a whopping 34% (Renfrew, 1996; Kawewe and Dibie, 2000).

This resulted in diminished purchase and supply of drugs and consumables in public hospitals. A joke started making the rounds that the mantra *Health for All by the year 2000* had become *Death for All by year 2000*. But the suffering perpetuated on the lower-income groups was not a laughing matter at all. Brain drain caused by the outward migration of health professionals such as nurses and doctors increased exponentially during this time. The majority of health professionals went to South Africa, Botswana, UK, the USA, and Australia. Many of them have never returned to settle back home (Ranga, 2004; Chikanda, 2006, 2007). The doctor-to-patient ratio plummeted from 1:7000 to 1:11 000 just in a few years (ibid). After much agonising, a realisation was arrived at that indeed the ESAP had failed to improve on the previous health policy and it had to be changed. This led to the crafting of a new health policy called *The National Health Strategy of 1997 to 2007*.

The National Health Strategy was a reaction to the failures of ESAP and was crafted with flowery words but appeared to lack significant content (Ministry of Health and Child Welfare, 2013). The argument and justification were that ESAP had failed to deliver on equity and in fact worsened the disparities between the *haves* and the *have-nots*, therefore there was a need to re-infuse equity, capacity, and quality into the healthcare delivery system again. This new policy was premised on emphasizing coordination of participation by all national sectors, communities, and individuals in the healthcare provision, financing, setting of service standards, regulatory mechanisms, monitoring, and evaluation (Ministry of Health and Child Welfare, 2013). This culminated in the setting up and implementation of various sub-committees and programmes in pursuit of a new vision and thrust towards realisation of healthcare equity, reduction and control of disease mortality and morbidity which had worsened during ESAP. A good example of the community involvement and participation

programmes was the *National Aids Policy of Zimbabwe* which was implemented in 1999 (Bhat *et al.*, 2016). This culminated in the creation of the National AIDS Council (NAC) by way of a Government Act of Parliament of 2000 (Congress, 1982; Unaid, 2015; Bhat *et al.*, 2016). The NAC administers the National AIDS Trust Fund which is financed by way of a 3% levy from every worker's *pay as you earn tax* (PAYE) as well as corporate tax. The NAC was established based on a noble vision of eliminating new HIV infections and AIDS-related deaths by the year 2030. The NAC galvanised the country and became the buzzword in the vocabulary of public officials and Civil Society Organisations (CSOs). This resulted in the adoption of a new multi-sectoral approach involving the public sector, Non-governmental organisations (NGOs), CSOs, private corporations, business formations, churches, and other community organisations. This participation in national HIV/AIDS policy debates and activism was coordinated by the NAC.

However, there was limited success from *The National Health Strategy of 1997 to 2007* policy. Very little redress of anomalies emanating from the previous health policy took place. In short, this policy framework had a mixture of positives and failures. Health services ended up being more expensive because of subsidy removal which was started during ESAP. The all-important goal of achieving equity was undermined through reduced funding and increased privatization. This reduced accessibility of healthcare services by the majority and the poor. Low-income groups found it extremely difficult to purchase healthcare services from market-based healthcare provision. This, therefore, undermined the pursuit of equity in a quest to pursue economic efficiency (Ministry of Health and Child Welfare, 2009, 2013). The failure to achieve equity was partly a result of the harsh economic climate prevailing at the time. The clouds of hyperinflation, which was to later eclipse world records, were gathering on the horizon. An isolated positive outcome of the National Health Strategy Policy was the scaled-up provision of testing kits for people living with and suffering from

HIV/AIDS by NGOs and CSOs. In addition, this policy can be partly credited with the reduction of the incidence rate of people living with HIV/AIDS from 26% to 15.3% in 2007 (Ministry of Health and Childcare, 2009; Todd *et al.*, 2010). However, most hospitals still had poor access to HIV/AIDS testing kits and other resources, gender equity was not resolved by 2005, and the 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 (Unaid, 2004).

It can be concluded that this period under review further eroded the egalitarian thrust in healthcare policy established at independence. However, like other predecessor health policies, it also did not achieve equitable healthcare in the manner anticipated.

4.4 The Fourth Decade of Independence (2010 to 2020)

By 2010 it was clear that the government of Zimbabwe was becoming notorious for firefighting as an approach to problems of the health sector (Rights, Rights and Cruel, 2006; Saurman, 2016; Bonga, 2019). Whenever a health policy doesn't seem to work their best approach was to come up with another glamorous policy statement, the crafting of which was usually funded by donors (ICAI, 2011; Rusvingo, 2014a; Chifera, 2015; James Maiden, 2020; Representative of Zimbabwe, 2020). This included expensive retreats, workshops, and full-page publicity adverts. In the following section three key health-related policies will be analysed:

- i. The National Health Strategy of 2009 to 2013: A Peoples' Right.
- ii. The Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZIM-ASSET) of October 2013.
- iii. The National Health Strategy of 2016 to 2020: Equity and Quality of Health: Leaving No One Behind.

In response to the failures and limitations of the National Health Strategy of 1997 to 2007, the government produced yet another health policy with a similar name to the previous one, called the *National Health Strategy of 2009 to 2013: A Peoples' Right*. This policy was developed to succeed the previous one, with a strategic goal of developing a better direction in the national health delivery approach. It had been realised that what were thought to be temporary setbacks during 1997 to 2007 were permanent drawbacks and health indicators were deteriorating and worsening. But the environment in which health policy was now being formulated was in uncharted territory, never experienced in the country before.

During this period Zimbabwe experienced unprecedented economic challenges characterised by severe currency problems and hyperinflation (McIndoe-Calder, 2018). This all took place within the final segment of the operational lifespan of the National Health Strategy of 1997 to 2007. The economic problems reached a peak in 2008 exacerbated by the elections violence of 2008 (Dziva, Dube and Manatsa, 2013). The leader of the opposition, Morgan Tsvangirai, withdrew from a presidential re-run election in 2008 against long-time ruler Robert Mugabe, citing unprecedented violence against his supporters by the army and Mugabe's ruling party ZANU PF (Coomer and GsTraunThaler, 2011). During this period of hyperinflation in Zimbabwe, a loaf of bread cost over 100 billion Zimbabwe dollars and inflation reached the second-highest rate ever recorded in world history, at 500 billion percent (Kramarenko, Engstrom and Verdier, 2010; Coomer and GsTraunThaler, 2011; Koech, 2011).

The political problems had a huge impact on all social and economic activities in Zimbabwe. As is usually the case the health sector, being one of the main social service sectors, was the hardest hit. The political problems were resolved temporarily by the formation of the Government of National Unity (GNU) brokered by the Southern African Development Community (SADC) and the African Union (AU), with South Africa's President Thabo

Mbeki taking the lead in the negotiations (Mapuva, 2010; Chigora and Guzura, 2011; Dziva, Dube and Manatsa, 2013).

The foregoing in-depth description of events gave rise to the formulation of the health policy called the *National Health Strategy of 2009 to 2013: A Peoples' Right*. A new minister of health called Henry Madzore, drawn from Morgan Richard Tsvangirai's opposition Movement for Democratic Change (MDC), was now in charge of the health portfolio. The main thrusts of this policy was to create an enabling environment for rejuvenation of the health sector by strengthening the health systems and getting the country back on track towards achieving the Millennium Development Goals (MDGs) (Ministry of Health and Child Welfare, 2009; Broek *et al.*, 2010). The policy prided itself on having developed from wide consultations, chief among these were the following documents and studies:

- i) Study on Access to Health Services; ii) Vital Medicines and Health Services Survey; iii) Community Working Group on Health Surveys; iv) Zimbabwe Maternal and Perinatal Mortality Survey; v) Millennium Development Goals; vi) Ouagadougou Declaration on Primary Healthcare and Health Systems in Africa; Africa Union Health Plan Protocol; vii) East, Central and Southern Africa Health Community Agreements; viii) SADC Health Sector Protocol" (ibid).

As a consequence of this policy, a modest improvement in access to health services and better outcomes were observed. However public health expenditure remained subdued and below the much-acclaimed Abuja Declaration threshold of 15% of National Budget¹⁰ (Union, 2001; Osika *et al.*, 2011). The GNU brought with it a new monetary and fiscal paradigm characterised by the use of the so-called multi-currency regime in which a wide range of

¹⁰ *The Abuja Declaration is an important standard for judging countries' commitment to budgetary to support to health. It was a voluntary commitment. 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 (Union, 2001).*

foreign currencies were accepted as legal tender. The Zimbabwe dollar was demonetized and removed from circulation (Hanke, 2008; Coomer and GsTraunThaler, 2011). The positive effect on the health sector was palpable. There was a resuscitation of budgetary provision for the health sector from the government, something that had vanished due to world-record hyperinflation obtaining from around 2005 to 2008 (ibid). However further structural problems remained in the health delivery sector as well as in all sectors of the economy. Households continued to carry the highest burden of health-related expenditures by way of out-of-pocket expenditures. To make matters worse for the already overburdened households there was a seemingly continued underfunding of district health services, skewed resource allocations, and corruption in tender allocations (Agere, 1990; Kumaranayake *et al.*, 2000). The share of public health services spending as a percentage of the GDP did not grow to any significant level, remaining under 1% while the per capita health expenditure remained at US\$ 7 against the WHO recommended¹¹ figure of 34 for Zimbabwe in 2009 (Nyazema, 2010; WHO, 2010; Dhoro *et al.*, 2011).

4.5 The Zimbabwe Agenda for Socio-economic Transformation (ZIM-ASSET)

The Zimbabwe Agenda for Socio-Economic Transformation (ZIM-ASSET) was the successor overall socio-economic policy to The National Health Strategy of 2009 to 2013: A Peoples' Right. It was officially announced in October of 2013 and it was expected to run till December 2018. This national socio-economic policy was announced just a few months after contentious national elections were held in August of the same year. It served as the official nation's economic development blueprint up until President Robert Gabriel Mugabe's

¹¹ *The per capita health expenditure is one of the most important indicators of country investment on healthcare. 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 (WHO, 2010).*

government was deposed from power through an alleged unofficial coup d'état in November 2017 (Green, 2018b; Mnangagwa, 2018). With its vision encapsulated into a mantra called *Towards an Empowered Society and Growing Economy*, it was the major policy around which all Government policies, projects, and programmes were moulded, comprising four economic clusters of *Food Security and Nutrition, Social Services and Poverty Reduction, Infrastructure and Utilities and Value Addition and Beneficiation* (Zimbabwe, 2013; Bonga, 2014). There were also two enabling clusters to buttress the four standalone clusters as follows: *Fiscal Reform Measures, Public Administration, Governance and Performance Management and Aid Coordination* (Zimbabwe, 2013; Bonga, 2014; Gerald Munyoro, 2017).

The ZIM-ASSET was billed as a Results-Based Management agenda campaigned on the premise that the socio-economic development requires significant changes in all sectors and this transformation requires multi-sectoral actions and must work horizontally and vertically to include every economic and social sector of the country.

The ministries of Health and Child Welfare, Primary and Secondary Education, Local Government and Public Works made up the Social Services and Poverty Reduction cluster. The responsibility of this cluster had, among other key result areas: *Access to basic health services, Access to water and sanitation*. The ZIM-ASSET blueprint document was very detailed and sophisticated. Unlike the preceding government economic blueprints, it was eloquently drafted. For example, each cluster was further broken down into a so-called cluster matrix elaborating on *Cluster Key Result Areas, Cluster Outcomes Cluster, Outputs Strategies and Lead Institution*. The language used in this policy framework was dazzling and flowery.

Consistent with regular government propaganda over many years, leading to the harmonized elections of August 2013 the issue of blaming western imposed economic sanctions took

centre stage. A seemingly conflation between a governing political party and government was central to the philosophy of this economic blueprint as exemplified by the following extract from the ZIM-ASSET official policy document:

Zimbabwe experienced a deteriorating economic and social environment since 2000 caused by illegal economic sanctions imposed by the western countries. This resulted in a deep economic and social crisis characterized by a hyperinflationary environment and low industrial capacity utilization, leading to the overall decline in Gross Domestic Product (GDP) by 50% in 2008. After the landslide victory by the ZANU PF Party in the 31st July 2013 harmonized elections, the Party was given the mandate to govern the country for a five (5) year term. To guide national development for these five years, Government has crafted a new economic blue print known as the Zimbabwe Agenda for Sustainable Socio-Economic Transformation (Zim Asset). This economic blue print was developed through a consultative process involving political leadership in the ruling ZANU PF Party, Government, Private Sector and other stakeholders. Source documents recognize the continued existence of the illegal economic sanctions, subversive activities and internal interferences from hostile countries. This therefore calls for the need to come up with sanctions busting strategies, hence Zim Asset's focus will be on the full exploitation and value addition to the country's own abundant resources ...(Zimbabwe, 2013, pp. 8–9).

A related health policy emanating from ZIM-ASSET was the *National Health Strategy for Zimbabwe 2016 to 2020: Equity and Quality of Health: Leaving No One Behind* (NHS 2016-20) (Kadzere, 2016). It established the direction for health planning and policy for Zimbabwe for five years from 2016 to 2020. This sectoral policy claimed to be seeking to sustain the gains achieved since Zimbabwe's political independence in 1980 through a comprehensive response to the disease burden and strengthening of the health system to deliver quality health services to all Zimbabweans. The strategy prided itself as an improvement over previous national health strategies for having incorporated detailed monitoring and evaluation framework to be used to assess progress through mid-term and end-term evaluations. This strategy also claimed to be aligned to the Sustainable Development Goals (SDG) agenda. It singled out SGD goals number 3 and 5 out of the 17 goals as its primary focus. The SGD goals number 3 and 5 are as follows: "Ensure healthy lives and promote well-being for all at

all ages...Achieve gender equality and empower all women and girls”(United Nations, 2015).

The high-sounding idealistic mantra in this policy was not new. It had been consistent through most successive national health policies of Zimbabwe since independence, despite the obvious deteriorating access to health services by the majority of citizens (Ministry of Health and Child Welfare, 2009; Todd *et al.*, 2010; Green, 2018b). As expected the NHS 2016- 20 blamed extraneous factors such as western imposed economic sanctions for the poor health outcomes in the country and not mismanagement as other critics argue. For example, turbulent global markets were seen as one of the causes of poor access to healthcare and poor delivery of health services (Ministry of Health and Child Welfare, 2013; Rusvingo, 2014a).

To its credit, the NHS 2016-20 accepted the shortfalls of the previous strategies notably the unfinished Millennium Development agenda (p.2). It lamented the continued high Maternal Mortality Rate (MMR) of 614 deaths per 100 000 live births versus the target of 174, an under 5 Child Mortality Rate (CMR) of 75 deaths per 1000 live births versus a target of 43 and numerous other shortfalls.

It can be concluded that this policy was again a monumental failure because it did not achieve the anticipated MDGs and SDGs thresholds as well as other policy deficiencies not fulfilled by the previous health policy. The negative effects of many years of healthcare decline were now very apparent forcing those who could afford to seek services outside the country (Chikanda, 2006, 2007).

4.6 The New Dispensation (The Second Republic) and Access to Healthcare

As has been alluded to earlier Emmerson Dambudzo Mnangagwa took over power in November 2017. As the new President of Zimbabwe, Emmerson Mnangagwa took over the

reins of power from the long-ruling predecessor, Robert Mugabe. There was immense optimism and hope for a new paradigm in the provision of all social services, including healthcare (Mnangagwa, 2018). Mnangagwa mesmerised admirers by his characterisation of his political project as the *New Dispensation* buttressed by the mantra of *Zimbabwe is Open for Business* (Moyo, 2018).

The opinion is divided as far as the performance of Emmerson Mnangagwa administration on health matters is concerned up to the point of submission of this thesis. Very little has been published yet on this topic. I found Kidia's publication to be most authoritative on this topic. She argues that the ushering in of the Mnangagwa government brought a huge window of potential success and reform premised on three areas: "1) repairing international relationships with the international community by focusing on human rights and elimination of corruption.2) Strengthening the health workforce through retention strategies, training, and non-specialist providers and 3) community engagement" (Kidia, 2018, p. 1).

I do agree with Kidia that these three areas were the most critical sign posts needed to be achieved in order to lift Zimbabwe's healthcare system which had fallen into limbo under Mugabe's toxic and disastrous policies (Green, 2018b). At time of writing this manuscript the optimism appears to have evaporated (Chamisa, 2018; Mnangagwa, 2018; Ndoro, 2020). It awaits to be seen if this so called New dispensation or second Republic will bring any meaningful changes to the healthcare system of Zimbabwe. Indications as of October 2021 pointed to the contrary (Chamisa, 2018; Kidia, 2018; Murisa, 2018; Helliker and Murisa, 2020; Tom, 2021). Table 1 shows a time line of events in the health sector following Emmerson Mnangagwa's assumption to the presidency. This timeline further confirms a continuation of the decline in access to healthcare which had started in the later 1990s under Robert Mugabe's rule.

Table 1: Time Line of Events in The Healthcare Sector Under The “Second Republic”

DATES	SUMMARY OF EVENTS	REFERENCES
April 2018	Public Health sector doctors and nurses embark on a major national strike resulting in about 8000 nurses being fired from work	(Maodza, 2018)
Sept 2018	<ul style="list-style-type: none"> ▪ Another major Cholera outbreak ▪ Government declares a State of Emergency. The cause is suspected to be the country’s derelict public water supply. 	(World Health Organisation, 2018)
Oct 2018	Private doctors and pharmacies decline to accept the local currency referred to as “US bond or rths” in favour of the real USD dollar bills. Government reacts by threatening to withdraw trading licences of retail and commercial pharmacies and wholesales.	(Shumba, 2018)
Oct 2018	Drug shortages worsened	(AllAfrica, 2018)
Nov 2018	Foreign Medical trips by politicians continue as in the Mugabe era. Robert Mugabe reported to be unable to walk and holed up in a hospital in the Far East	(Telegraph, 2018)
Dec 2018	Public sector doctors embark on yet another national strike. It turned out to be the longest strike ever undertaken by public sector doctors in Zimbabwe. Again Government reacts by summarily firing all the 500 doctors as a group. The public health sector is brought to a standstill as radiographers and registrars join in. Government reclassifies junior doctors as students and moves them from the Ministry of Health to Higher Education, to stop them from ever striking again.	(Thompson, 2018; Brief, 2019)
Jan 14, 2019	A massive fuel hike, making Zimbabwe’s fuel prices the highest in the world, sparks a national strike or stay away from work which turned violent resulting in looting of groceries stores and destruction of property. Government reacts by deploying security forces resulting in massive human rights abuses with public lynching of civilians, gunshots wounds, raping of women, abductions, and forced dislocations. At the time of writing 17 direct deaths are reported by independent sources. Over 1000 are arbitrarily arrested without evidence.	(BBC, 2019a, 2019b)
Feb, 2019	The Country’s first Vice President is reported flown to South Africa for a medical emergency. Angry Zimbabweans picket outside Groote Schuur hospital in Cape Town where he is reported to be admitted. Government announces a 3 day week for public health professionals due to a lack of adequate money for bus fares.	
Sept, 2019	Strike by Healthcare professionals	(GardaWorld, 2019; Muronzi, 2019)
Nov, 2019	Strike by Healthcare professionals	(Ndhlovu Ray, 2020)
Jan, 2020	Strive Masiwa, a Zimbabwean billionaire sponsors to pay doctors’ salaries to end the country’s longest strike.	(Bbc, 2020; BBC, 2020; Chingono, 2020)
March, 2020	COVID-19 pandemic hits Zimbabwe amid a crisis of infrastructural decay, drug shortages, staff low morale, macroeconomic instability, etc.	(Delloite, 2020)
March, 2020	Strike by Healthcare professionals due to shortage of Personal Protective Equipment (PPE) so that they attend to COVID-19 cases.	(Columbus, 2020)

4.7 Chapter Summary

Chapter 4 has given an in-depth description and analysis of healthcare policies in post-independent Zimbabwe. The chapter described the various successive healthcare policies

from 1980 to 2021. Improved access to healthcare in Zimbabwe cannot take place in the absence of a clear understanding of the success and failures of previous healthcare policies. This analysis is critical and helps with the search for an ethically justified model of healthcare buttressed by additional strong monitoring and evaluation (M&E) participation from citizens and other stakeholders (to be fully discussed in chapter 9). This combination of a new healthcare model augmented by strong M&E has been missing in the previous egalitarian model implemented immediately after independence. Next is chapter five, the first of three chapters which have been dedicated to the analysis of selected moral theories with a bearing on redistributive justice, equality and equity issues related to access to healthcare. The next chapter in particular will describe and critique the utilitarian moral philosophy and its implication to healthcare policy, access to healthcare and its potential application to the CCHM discussed in full in chapter 9.

CHAPTER 5: UTILITARIANISM

5.1 Introduction

Classical public health approaches and their justification have their historical foundations in several moral theories but utilitarian moral theory is probably the most prominent. It was formulated in the nineteenth century by Jeremy Bentham and John Stuart Mill (Petrini 2010). A critical analysis of this theory in the way it relates to the various healthcare models should be done to find out the way it influences the formulation of operational frameworks for models of healthcare. This analysis can assist with selecting a framework best suited to address inadequate access to healthcare in Zimbabwe and/or to evaluate the implementation of existing healthcare model(s) in the country.

The utilitarian theory has been selected for discussion in this thesis ahead of many others on the basis of its historical and contemporary relevance to debates about access to healthcare. It also provides a countervailing comparative analysis to many moral theories, particularly to both the egalitarian and ubuntu theories, which are also discussed in this thesis.

5.2 Roadmap for this Chapter

Explaining the historical development of a philosophical theory is important for the understanding of why and how ideas have evolved over centuries. This historical analysis is critical for our understanding of the reasons and motivations for the genesis of any particular philosophical theory. This chapter will trace the historical origins of the utilitarian theory, how it has evolved over centuries, its potential application to issues of access to healthcare, controversies around it, and suggestions that it brings forward for the improvement and refinement of public health policy. This historical journey follows the origins and development of the utilitarian moral philosophy over centuries from as far back as the

Socratic, Platonic, and Aristotelian eras right up to the middle and enlightenment ages. The concept of utility forms a cornerstone of the utilitarian theory and as such the chapter devotes substantial space to explaining this concept including describing the various typologies about utility. Both criticisms and counter arguments with regards to the utilitarian theory are covered. While the utilitarian moral theory has criticisms and limitations it nevertheless has strengths that makes it amenable to being useful for the purpose of designing the CCHM. Its advantages outweigh the criticisms outlined in the description of this theory. In section 5.5 I lay the grounds upon which the utilitarian moral theory is still salvageable and applicable for the purposes of designing the CCHM.

5.3 Utilitarianism

Utilitarianism is the most prominent of the consequentialist theories. It has overshadowed the history of moral philosophy for over two centuries due to its powerful persuasive arguments for normative ethics. Even though it was eventually argued fully and clearly in the nineteenth century, positions favouring pro-Utilitarianism had been lurking under the surface for many centuries as far back as the Socratic, Platonic, and Aristotelian eras (Lawhead and Philosophy, 2011). They stretch back into history, predating the birth of Jesus Christ:

Utilitarianism can trace its origins back to the father of hedonism, Aritrippus of Cyrene (approximately 435 -356 B.C). He taught that pleasure is the universal and ultimate object of endeavour. By pleasure he meant not merely the sensual gratification but also the higher forms of enjoyment, mental pleasures, domestic love, friendship, and moral contentment. Ancient hedonism was egoistic, i.e., concerned about the pleasure of the individual, and not about the pleasure of everyone (Gandjour and Lauterbach, 2003, p. 231).

The notion of maximizing pleasure and minimizing or avoiding pain indeed dates back into antiquity. In the period of antiquity, it was referred to as ethical hedonism. The most famous promoter of ethical hedonism was Epicurus (341 to 270 B.C.), who argued that a good life is

one spent pursuing pleasure, with pleasure being defined as the avoidance of pain (Robertson and Walter, 2007).

5.3.1 Classical and Neo-Utilitarianism

Classical Utilitarianism argues that the greatest happiness of the greatest number of people is the best measure or marker of the rightness or wrongness of a decision or action. It was developed by radical philosophers and social reformers in the nineteenth century who were concerned with problems in law, education, politics, economics and general morality issues in society at that time. Some of its proponents and critics include: William Godwin, Jeremy Bentham, John Stuart, Harriet Taylor Mill and Henry Sidgwick (Mill, 1859; Sen, Williams and Williams, 1982; Bowden, 2009; Driver, 2009). Neo-Utilitarianism refers to a new resurgence of utilitarian philosophical ideas which had started to wane away due to the evolution of newer approaches and as well as criticism. Talcott Parsons heavily criticised classical Utilitarianism almost to the point of its demise in the 1940s but despite this Utilitarianism got a new lease of life in the 1950s. This new resurgence of the utilitarian moral theory was premised on the argument that the concept of utility is multi-faceted and open to different interpretations. Those who countered Talcott Parsons and his followers argued that he had misinterpreted it (Joas and Knöbl, 2009).

5.3.2 Epicureanism as the Forerunner to Utilitarianism

Epicurus was born in the age of classical philosophy, a period succeeding the group of ancient Greek philosophers called the Sophists. The Sophists or fanatics of knowledge were exemplified by Socrates. The sophists and Socrates are mentioned here merely to assist the reader to locate the time epoch of classical philosophy relative to Socrates (who is very famous in the history of philosophy). Epicurus, born about 7 years after the demise of Plato, rose to fame for his unique brand of philosophy which can be dubbed the forerunner to

modern-day Utilitarianism. Epicurus says: "...the whole point of philosophy is to heal the soul and enable us to live a happy life" (Lawhead and Philosophy, 2011, p. 107). He criticized speculations based on theoretical reasoning, be it in philosophy or sciences, for as long as they did not serve the needs of humans in a practical way. Epicurus had a very radical position known as ethical hedonism. While most people would intuitively accept that pleasure is good, Epicurus went further to say categorically and emphatically that only pleasure is good. The notion of good and evil was categorically seen in the sense of pleasure versus pain. Pursuing pleasure by human beings is a form of psychological hedonism while the prescription of pleasure as the ultimate good in life was referred to as ethical hedonism. From this description of Epicurus's philosophical beliefs and reasoning, it can be illustrated without much contestation that the foundations for Utilitarianism were laid out during this period.

5.3.3 Utilitarianism in Post- Renaissance Period

Utilitarianism is probably the most influential moral theory written and popularized during the modern era or period of enlightenment (17th to 19th century). The enlightenment period follows the renaissance period, which period started around the 14th century (Lawhead and Philosophy, 2011). Utilitarianism is a prominent example of a theory emanating from a general moral theory called *Consequentialism*, a general normative moral theory that holds that the moral rightness of actions is not determined by something internal to that action but by the maximization of the value produced by that action-the consequences (Lawrence, 2007; Beauchamp and Childress, 2013). *Consequentialism* concentrates on the value of well-being and has been analyzed in terms of pleasure, happiness, welfare, preference satisfaction, and similar aspects: "...a consequentialist philosophy holds that the rightness or wrongness of an

action is determined solely by reference to the ‘goodness’ or ‘badness’ of the consequences of that action” (Robertson and Walter, 2007, p. 1).

During the modern or enlightenment era referred to above the classical utilitarian approach was spearheaded by Jeremy Bentham (1748 to 1832) and John Stuart Mill (1806 to 1873), who were both social reformers highly concerned with changing the legal and social landscape of that time (Mill, 1859; Bentham, 1961; Rwafa, 2014). Interestingly there is a parallel between what concerned both Bentham and Mill in Great Britain at that time and what concerns us about the healthcare system of Zimbabwe since the late 2000s. The social issues during Bentham and Mill’s time share a lot of similarities with the current situation in Zimbabwe. The situation in Zimbabwe, as was the case during Bentham and Mill’s times, is beset with alleged corruption, bad or ineffective laws and social injustice (Makumbe, 1994; Doig, 2006; Moyo, 2014; Bonga, Chiminya and Mudzingiri, 2015; Choguya, 2018). These vices are indeed retarding the realisation of a healthcare system which answers to the needs of the Zimbabwean population. Zimbabwe is facing a continuously deteriorating healthcare delivery system and worsening social determinants of health and wellbeing (Sanders, 1990; Thomson, 2005; Chikanda, 2006; Meldrum, 2008; Todd *et al.*, 2010; Ministry of Health, 2015). At the time of writing this manuscript weaknesses and deficiencies of Zimbabwe’s healthcare system had been compounded by COVID-19 or SARS-Cov-2. This pandemic disease greatly exposed the grave shortcomings of the Zimbabwe healthcare system, weighed down by many years of alleged economic mismanagement, corruption, and definite underinvestment (Doig, 2006; Author, Zeilig and Dawson, 2008; Tizora, 2009; Moyo, 2014; Choguya, 2018). The emergency of COVID-19, a new viral disease allegedly to have originated in November of 2019 from Wuhan city in the province of Hubei in China- had devastated many countries at the time of writing this thesis. Spain, United Kingdom, Germany, Italy and the USA carried the biggest brunt of the disease outside China itself

(Nurchis *et al.*, 2020; Peeri *et al.*, 2020; Yang *et al.*, 2020; Gebru *et al.*, 2021; Sanyaolu *et al.*, 2021). The difference between these wealthier countries and Zimbabwe is the resilience of their healthcare systems and the ability of their governments to compensate for severe social dislocation and loss of incomes across the board, something lacking in Zimbabwe (Moyo, 2020; Shumba *et al.*, 2020; Banda Chitsamatanga and Malinga, 2021; Chirisa *et al.*, 2021). Because of this resilience, they can ramp up accelerated COVID-19 testing, identification, and isolation of positive cases as well as providing for meaningful social support programmes. In addition, they have better facilities for treatment, such as intensive care units, ventilators, and more healthcare professionals per capita. By end of the year 2021 Zimbabwe was reported to have lost at least 2000 Healthcare Professionals due to migration for greener pastures (Dzinamarira and Musuka, 2021; Redaction Africanews, 2022). It is not clear if the world has seen the worst of this disease as the situation is changing fast. It is possible that the incidence and prevalence of this disease could continue to increase unless new measures in addition to accelerated production and distribution of vaccines are implemented to control, treat or prevent the disease from spreading.

Just like in Jeremy Bentham's motives for searching for a normative ethical theory, this study is motivated by similar deplorable social conditions with regard to greatly compromised and diminished lack of access to healthcare in Zimbabwe, a seemingly unresponsive healthcare model which has not produced optimum results (utility) expected by the citizenry. Jeremy Bentham had one central question to be answered: "... what is the truth about what makes an action or a policy a morally good one, or morally right..."(Driver, 2009, p. 9). Similarly, I also ask the questions: *What is an ethically justified model for access to Healthcare in Zimbabwe? What do we ought to do to make our healthcare system to adequately cater for or respond to the needs of our fellow citizens?* Bentham greatly admired and was influenced by

both Thomas Hobbes's and David Hume's conceptions¹² of human nature and social utility (ibid.). Bentham's famous invocation held that in all human motivations they seek happiness and pleasure and avoid pain and suffering. This position is in complete agreement with our intuitive behaviour as human beings. In the early part of the 18th century, Jeremy Bentham is credited with working tirelessly to reformulate and formalise Utilitarianism into a normative ethical theory (Bentham, 1961; Cranston, 1972; Hampton, 1988; Boucher and Kelly, 2003). A famous invocation of his idea on Utilitarianism and the centrality of pleasure in this theory goes as follows: "...man was at the mercy of the pleasures and it was therefore preferable to be a contented pig than an unhappy human" (Robertson and Walter, 2007, p. 1).

Bentham did not value higher pleasures or distinguish between lower and higher pleasures like reading poetry, art, intellectual activity, listening to music or walking your dog in the neighbourhood. He argued that these higher pleasures were just as good as basic pleasures like enjoying the taste of food or drink. In other words, according to Bentham, pleasure or simply happiness, no matter how it is defined, is the sole value. Later John Stuart Mill was to push the boundaries further and argued for a distinction between lower-level or physical pleasures and higher-level pleasures. However, both Bentham and Mill suffered similar hurdles when it came to trying to quantify pleasure. They both came unstuck on this issue because they could not elaborate a calculus for quantifying pleasure.

Although John Stuart Mill (henceforth to be referred to as Mill) was an avid admirer of Jeremy Bentham, his senior by almost 80 years, they disagreed on several areas- especially on the concept of pleasures and/or happiness. All this despite that in all his childhood he had admired Bentham (Driver, 2009). Bentham believed that there are no qualitative differences

¹² *Although this is also a controversial area beyond the scope of this section, both Hume's focus on character evaluation (virtue) and Hobbes's psychological egoism do not completely agree with Bentham's account of utility (Bentham, 1961; Cranston, 1972; Hampton, 1988; Boucher and Kelly, 2003).*

between pleasures except quantitative ones while Mill took an opposite view. Mill argued that if we do not distinguish between lower-level simple pleasures against higher-level pleasures the moral value of human beings would not matter much versus those of animals as the latter are not capable of enjoying the higher-level pleasures. *What would be the difference between us humans and animals, he asked?* Mill did not doubt that higher pleasures are better than mere simple hedonistic pleasures¹³. To illustrate his point on the superiority of higher or intellectual pleasures over simple sensual pleasures Mill says: "...it is better to be Socrates 'dissatisfied' than a fool 'satisfied...'" (Driver, 2009, p. 13 paragraph 2).

Mill's conception of intellectual or higher pleasures found expression in his support for women's rights and free speech. In his view, this was a form of increasing overall happiness. Denying women access to education, self-improvement and political expression was an infringement of their realization of overall happiness. Mill had a different idea on pleasure to Bentham's mere *happiness* or *feeling happy* account. One of the notable differences between Bentham and Mill's classical Utilitarianism (hedonism) was their divergent opinions on how to predict consequences. Bentham favoured an objective calculus to predict consequences, whereas Mill favoured a subjective approach. In the end, both Mill and Bentham were still in agreement about the concept of Utilitarianism as a moral theory. They only differed about its scope.

One illuminating confirmation of Utilitarianism is by Richard Hare, who carried forward Mill's conceptions and also argues for two levels of pleasure: *basic and complex*. He advances what he calls the *Golden-Rule Argument*¹⁴, which argument is much similar to

¹³ *Essentially hedonism prizes pleasure as the ultimate value. Based on this it can be argued Mill is hedonistic, because he held pleasure to have intrinsic value. Non-hedonists reject the hedonist argument that, no matter how defined, that pleasure is the sole intrinsic good that actions must produce, facilitate or promote. According to non-hedonists, we must consider the complete and full range of intrinsic goods (not just happiness) that an action is likely to produce e.g. growth, survival.*

¹⁴ *The most familiar version of the Golden Rule says, do unto others as you would have them do unto you. The golden rule is a moral principle which denotes that you should treat others the same way you*

Henry Sidgwick's *government house Utilitarianism*¹⁵, both propounding the existence of lower-level physical pleasures versus higher-level intellectual pleasures. Hare refers to his distinction between types or levels of pleasures as *intuitive and critical*; a description thought to have created the foundation for the Act and Rule Utilitarianism categorizations later on. He even goes further to draw similarities between his philosophy and Kant's categorical imperative (Mayo and Hare, 1990; Onslow, 2013). Immanuel Kant was a German philosopher who grew up to be famous for opposing Utilitarianism. Unlike utilitarians like Mill and Bentham, his main point of argument was that certain types of behaviour ought to be completely prohibited. These include murder, lying, and theft regardless of whether at times they are perceived as having some utility or benefits. According to him the moral worthiness of a theory should not depend on its consequences but on whether it fulfils the superior moral duty expected of us. What matters in an action is the motive and intention of carrying out that action. His *categorical imperative* expressed in the form of a famous maxim, only mentioned here for reference and illustration, says: "Act only according to that maxim by which you can at the same time will that it should become a universal law" (Rachels and Rachels, 1993, p. 129). This is the part that is clearly in contrast with Utilitarianism, which holds that the morality of an action depends on the extent to which it maximizes the overall good.

The overall good includes one's own good as well as the good of others. In assessing the consequences or overall good Utilitarianism insists on impartiality and neutrality, which means that everyone's good counts the same. My own good is not more important than everyone else's good (Driver, 2009). In addition, the motive for maximization of the good ought to be universally accepted, meaning that the reason why I endeavour to maximize the

would like to be treated yourself. For example, the golden rule suggests that if you would like people to treat you with respect, then you should make sure to treat them with respect too.

¹⁵ A criticism of Utilitarianism that the theory really simply reflected the colonial elitism of Sidgwick's time, that it was 'Government House Utilitarianism.' The elitism reflect a broader attitude, one in which the educated are considered better policy makers than the uneducated (Driver, 2009).

good should appeal to everyone else. Utilitarians believe that the mission of morality is to increase the amount of happiness and pleasure (utility or good things) in the world thereby making life better at the same time reducing or eliminating the amount of bad things such as pain, suffering, unhappiness, and sadness. Utilitarians frown at codified behaviour emanating from customs, taboos, commands, or directives from traditions or supernatural beliefs. They consider what is good or that which has value as utility.

From the earliest formulations of utilitarian moral theory in the nineteenth century, the concept of utility has occupied centre stage giving rise to a typology of Utilitarianism based on the varying conceptions of utility. This typology followed a gradual sophistication from lower to higher level conceptions. Utility such as pleasure-pain is assumed to be at the lower end while those to do with aesthetic values are assumed to be on the higher end. Utilitarians do not completely agree on what constitutes utility and as a result, there are many interpretations of what constitutes utility. The following questions assist to narrow the areas of debate:

- What is happiness?
- What is it that makes something good?
- Which ones are actual consequences?
- Are consequences always foreseeable?
- In whose interest should we value wellbeing: individual self-interest, group interest, or everyone affected?

These and many other questions gave rise to different versions of the utilitarian theory.

Bellefleur and Keeling (2016) give the following typology of Utilitarianism based on their conception of utility.

- a) *Utility as an absence of pleasure and suffering:* This is the basis for the earliest formulations of the Utilitarianism moral theory in the nineteenth century. Utility or the good was associated with pleasure and avoidance of suffering. Evil or the bad was equated to suffering and the deprivation of pleasure (Mill, 1859; Bentham, 1961; Sen, Williams and Williams, 1982; Driver, 2009; Bellefleur and Keeling, 2016).
- b) *Utility as the satisfaction of preferences:* Views utility in terms of satisfaction of individual preferences. Thought to be the most influential in contemporary circles by employing *willingness-to-pay analytic techniques* of economic approaches in order to explain and identify individual preferences (Singer, 1974; Mayo and Hare, 1990; Hare, 1993, 1997).
- c) *Utility as the satisfaction of informed or rational preferences:* Preferences made by people who have all the full information and in their sober minds or full cognitive capacities are more reliable as a reflection of true preferences. Compromised cognitive capacity can be diminished by such things as being under the influence of alcohol, drugs, or dementia (Brandt, 1979).
- d) *Utility as the satisfaction of interests:* The argument here is that we need to move away from the satisfaction of individual preferences. Utility as the satisfaction of interests focuses on universal basic needs such as healthcare and shelter which allow everyone to enjoy the higher needs (Ng, 1999; Millgram, 2000; Kimball and Willis, 2006).

In all this process a sound moral theory must define whether an action is right or wrong. Utilitarianism is a consequentialist moral theory and as such, every action can be seen as instrumental as long as it helps to achieve the good (utility). Unlike Kantianism which makes a huge judgement call based on the inherent moral worthiness of an action or motive, utilitarians do not see an action as either right or wrong as long as it helps to achieve the end result, the good. This is analogous to the English saying which says: *It does not matter*

whether the cat is white or black as long as it catches the mice. What if there are various options to be pursued? How do you choose the best option or action? Utilitarians undertake some calculation termed utility calculus to work out the net utility from an action or policy. The net utility is the total sum of pleasures minus the total sum of displeasures or sufferings. Utility calculus is a neutral or impartial process, done by a neutral agent as each utility must count the same in order to maximize utility. The need to have a precise way of calculating utility has given rise to two types of Utilitarianism: *Act and Rule Utilitarianism* (Honderich, 2005).

5.3.4 Act Utilitarianism

Even though no longer the most favoured variant form of Utilitarianism, it is however the most commonly understood depiction of Utilitarianism. The current most favoured variant of Utilitarianism is *preference Utilitarianism* (Gandjour and Lauterbach, 2003). In Act Utilitarianism each action or policy option needs to be evaluated in order to deduce its net utility in a specific context. To choose which action or policy is morally preferable or obligatory one would need to perform a calculus that proves maximization of utility (Honderich, 2005). The strength of Act Utilitarianism is based on its rejection of reliance on an authoritarian basis for law and religion as well as the irrationality, arbitrariness, and subjectivity of personal and cultural moral views (Bales, 1971; Singer, 1972; Frey, 2013). For Act utilitarian calculation is at the centre of ethical decisions. It creates simple ethical guidance rather than a cumbersome and winding procedure by presenting one intrinsic value:

... pleasure, happiness, or the satisfaction of preferences... Act Utilitarianism fits well to the performance-, efficiency-, and money-driven thinking which prevails in today's modern societies and which evaluates actions in terms of efficiency and outcomes with reliance on a means-end calculation. Utilitarianism uses a similar type of rationality; it simply replaces money by well-being and focusses on moral aspects of actions. Act Utilitarianism is not an individualistic ethical theory leaving out concerns for others. But a social ethic considering obligations towards the community (Gandjour and Lauterbach, 2003, p. 233 paragraph 2).

Objections and criticisms have been raised against Act Utilitarianism:

- i. It may approve of actions that are clearly wrong
- ii. It has the potential to undermine trust among people
- iii. It is too demanding because it forces people to make excessive levels of sacrifices
(Nathanson, 2014).

Perhaps the biggest challenge with Act Utilitarianism is a phenomenon called *Moral Saints*, which places heavy moral demands on people by requiring them to make the best choices out of all possible alternatives. The problem with this expectation is that it makes certain alternatives not chosen morally wrong simply because they are not among our best choices (Andre and Velasquez, 1989). Objections to Act Utilitarianism led to the emergency of Rule Utilitarianism which is discussed below. Detailed criticism of Utilitarianism in general, will be given under section 5.4 below.

5.3.5 Rule Utilitarianism

Rule Utilitarianism relies on a code, behaviour, or rule which holds that an action is morally right if the consequences of adopting it are more favourable to everyone. Any action is deemed to be morally right if it is congruent with that code or rule. Unlike Act Utilitarianism, Rule Utilitarianism does not necessarily have to deliver maximum utility in every case but when assessed over time and in all similar scenarios, conforming to the rule(s) will deliver maximum utility than on a case by case approach used in Act Utilitarianism (Harsanyi, 1977, 1982, 1985). The disagreements among utilitarians have given rise to different schools of thought concerning rule utilitarianism. There is no universal agreement on whether rules should always be followed or not while others argue that exceptions to the rules must be made when the pleasure or pain takes more value or becomes more favourable over the rule (Bales, 1971; Singer, 1972; Harsanyi, 1977; Frey, 2013).

Rule Utilitarianism solves some of the problems raised under Act Utilitarianism such as biases in the decision-making process and the disutility of calculating utility (Gandjour and Lauterbach, 2003). It is also argued that Rule Utilitarianism has other advantages over Act Utilitarianism. It is not the intention of this section to go into details about arguments about whether Rule Utilitarianism subsumes Act Utilitarianism or vice versa (Lyons and Lyons, 1965). This is an argument beyond the scope of this chapter. However, Rule Utilitarianism has its own limitations as well. One of the major limitations is the existence of an almost infinite number of scenarios for which rules may be needed rendering the exercise futile since it becomes too complicated to apply the rules and this renders the action to lose utility (Gandjour and Lauterbach, 2003). The second limitation is that Rule Utilitarianism may end up mimicking deontology if adherence to a rule at all costs precludes maximum utility. The next section looks at criticism of Utilitarianism.

5.4 Criticism of Utilitarianism

The more robust criticism of Utilitarianism has to do with how to measure the utility of a given choice. Ever since the time of Bentham, this has been an inherent criticism of Utilitarianism that has refused to be shaken off. Let's take for example the issue of people accepting less pleasure due to unexpected outcomes or low expectations, a phenomenon which has come to be referred to as *adaptive preference*. This is sometimes referred to as the case of a *contented slave* (Elster, 1982). Other challenges confronting preference utilitarians are the issues of those experiences which come as a shock because we never knew they existed (unexperienced preferences) and harmful preferences (Kymlicka, 2002).

It has been argued that pleasure and pain are not the only intrinsic values important in life. What about other intrinsic values such as *freedom of expression, personal autonomy, justice, love, and friendship*? (Gandjour and Lauterbach, 2003). Act utilitarians have countered this

criticism by saying all these other intrinsic values are a means to enjoying the final utility of pleasure. The argument is not easily resolved. Suppose there is a machine that produces experience or pleasure once it is plugged in, and it is guaranteed to work perfectly without any flaws. When it gives us this experience or pleasure we would not know that we are plugged in. Should you plug into this machine that gives you any kind of experience? *Aren't there more refined intrinsic values beyond pleasure and pain, such as autonomy, freedom, justice, and friendship?* (repeated here for emphasis). Some authors argue that there is actually a much bigger world of values beyond the seeming restriction to pleasure and pain espoused by the utilitarian theory. There is more to life than just pleasure. Humans desire a wider connection with reality than just mere pleasure (Rae, 1976). In his pursuit of proving hedonism unrealistic Nozick asks the following question: "... What else can matter to us, other than how our lives feel from the inside?" (Nozick, 1974, p. 644).

Nozick's thought experiment suggests that something valuable cannot consist of pleasure/happiness alone. People want a connection to the reality behind an experience not just pleasure at all cost. Life is much bigger than just pleasure (Nozick, 1974; Rae, 1976). He rejects hedonism with the following strong rebuttal: "Perhaps what we desire is to live ourselves, in contact with reality (And this machines cannot do for us)" (Nozick, 1974, p. 646).

A notorious criticism of the utilitarian philosophy is based on the notion called the *replaceability problem*, a notion which itself is based on a thought experiment. Is it morally justifiable, as the utilitarians seem to suggest, that it is acceptable to kill one healthy person so that his organs can be distributed and used as transplant organs to save the lives of half a dozen other people? Is this not against our natural intuitive reasoning? (Foot, 1967; Rachels and Rachels, 1993). This paradox goes back to the period of ancient Greek and Roman

philosophy wherein Thomas Aquinas expounded a similar observation and referred to it as the *doctrine of double effect*¹⁶:

The doctrine (or principle) of double effect is often invoked to explain the permissibility of an action that causes serious harm, such as the death of a human being, as a side effect of promoting some good end. According to the principle of double effect, sometimes it is permissible to cause a harm as a side effect (or “double effect”) of bringing about a good result even it would not be permissible to cause such a harm as a means to bringing about the same good end (McIntyre, 2004).

In his version of the doctrine of double effect, Aquinas seemed to argue for some acceptance for the consequences of an action causing serious harm as an unintended result of promoting some good. The emphasis is on the deliberate causation of harm as a means to end and not as a remorseful, unintended action. Thomas Aquinas is credited with blending Aristotelian philosophy with Christian thought and battled with integrating philosophy with faith, as well as arguing for the existence of God (Cavanaugh, 1997; Lawhead and Philosophy, 2011).

Another thought experiment directed at exposing the weakness of the utilitarian’s normative theory of moral philosophy is referred to as ‘*Pedro and Jim*’ and which brings to life a simulation of a situation in which utilitarians are faulted in downplaying the importance of moral agency on the basis of only utility considerations. By choosing to shoot one person in order to save 10 people in his place this thought experiment further exposes the weakness of Utilitarianism as a normative moral theory (Sen, Williams and Williams, 1982; Williams and Smart, 2012). Would this be right, even though shooting 10 people brings some utility to save one person? Robertson and Walter summarize their criticism of Utilitarianism as follows:

The negative features of Utilitarianism based moral choices are that they: involve assessments of preferences which may be biased or flawed; expect too much of the moral agent in responsibility for moral consequences of consequences and negative responsibility; may require abandonment of emotional or filial bonds; potentially involve alienation from moral agency; may involve the active disadvantage or harm of

¹⁶ *The doctrine of double effect says that if doing something morally good has a morally bad side-effect, it's ethically acceptable to do it providing the bad side-effect wasn't intended. It argues that this is true even if you foresaw that the bad effect would probably happen* (McIntyre, 2004).

individuals; and, are based on political and moral philosophy that is arguably anachronistic (Robertson and Walter, 2007, p. 3)

While they found Utilitarianism: “...to be arguably an internally coherent, simple, and comprehensive theory with exceptional output power”(Beauchamp and Childress, 2013, p. 354), they also found it to be wanting on two of the above factors when assessed against variable external situations such as human rights and justice. On the other hand, Kantian theories are highly rated and consistent with many of our intuitional tendencies.

Utilitarianism is also criticised based on its historical account. Kymlicka is quite aggressive and raises criticism of Utilitarianism by saying during Jeremy Bentham’s period Utilitarianism was indeed a powerful and progressive moral theory but as time progresses it is now just what it is, a conservative moral theory (Kymlicka, 2002).

One major area of criticism has to do with how to define and calculate the conception of utility itself, how to implement the concept in real life as well as arguments regarding counter-intuition. There are legitimate criticisms to do with the limitations of objective calculus in predicting the consequences of an action. As alluded to earlier Mill and Bentham differ from each other on this front. The former favoured a subjective approach while the latter favoured an objective approach. Critics still ask the question: *can other people be relied upon to make an objective assessment of my experiences? How about the impact of self-deception, adaption to supposedly poor outcomes, and cognitive dissonance?* Gandjour and Lauterbach (2003) give an example of a paraplegic who ends up enjoying life and having a happy life despite his or her physical limitations. This is a form of adaptation. Utilitarians would counter this argument by saying it is not possible not to have an unbiased assessment of consequences. How would a person objectively assess pleasure and pain without being biased? Assuming objective assessment of consequences is superior to subjective

measurement (as alluded by Bentham in his hedonic calculus), how reliable is it for other people to be able to measure the quantum of my wellbeing?

Apart from the limitation of third parties in being able to objectively assess another person's wellbeing, there are also issues that distort the perception of consequences such as cognitive dissonance and defence mechanisms such as denial and adaptation, a phenomenon that has been called *self-deception* (Gandjour and Lauterbach, 2003).

Another criticism is that it is futile and impractical to do calculations before a decision to act is taken. Gandjour and Lauterbach (2003) refer to it as "*disutility of calculating utility*" (p.235). The criticism goes further to argue that a golden opportunity may be lost while trying to calculate, for example making a calculation on what option to take in order to save a drowning child or house on fire. Also as the decision-making process becomes more and more complex so are the number of calculations needed to arrive at a decision. The opportunity costs may overwhelmingly outweigh the practicability of such a process. By the time we finish calculating irreparable harm would have visited the act which is supposed to benefit from our intended action. Such indecision would spell harm and misery to humanity.

An Act utilitarian may counter this by saying that we need to set up rules which help us in decision making which in turn can assist in maximizing the utilitarian benefits. These rules are flexible and do not compel a utilitarian to adopt and use them. Other utilitarians also counter this criticism by saying they do not forbid skipping calculations as long as a better alternative under the circumstances is chosen. But don't we run the risk of *egoism* if we skip doing the utility calculations? *Egoism* refers to a state where all rational beings would accept a rule if they stand to benefit from it. There is the danger of relying on intuition and egoism inherent in this route. To illustrate this point of the weakness of egoism, Flood and Drescher

designed a social hypothetical problem called the “*Prisoner’s Dilemma*”¹⁷ in 1950 (Rachels and Rachels, 1993). Because of egoism, both prisoners get away with huge punishment because each one decided to betray the other one instead of keeping quiet and getting away with minimum punishment.

There are many more criticisms of Utilitarianism but the following have been selected as the more prominent ones:

- Happiness or pleasure cannot be quantified or calculated.
- The challenge of quality versus quantity of happiness or pleasure.
- There is a problem of balancing distributive justice or unjust consequences.
- The problem with utilitarian’s assumption is that consequences are of the same value despite variable motives.
- The problem of defining happiness and using other peoples’ happiness as a supreme standard for morality.
- There is a challenge in proving the principle of utility.

As alluded to earlier on in the road map section, Utilitarianism is such an influential philosophy on public healthcare policy and as such highlighting some of its more prominent criticisms does not diminish its importance and influence but rather strengthens it.

5.4.1 Utilitarianism and Human Rights

Some have argued that Utilitarianism is contrary to the doctrine supportive of human rights. Our support for human rights is based on our intuition that it is a good thing based on our feeling and deep beliefs (Wacks, 1994; Etzioni, 2010; Hull, 2015). The challenge which

¹⁷ More details about the *Prisoner’s Dilemma* are found in *Rachels and Rachels (1993, p85)*.

arises with Utilitarianism versus human rights is the over-reliance on logic when accounting for human rights whereas this is largely an emotional subject.

5.5 Application of Utilitarianism to the Design of the CCHM

A question can be asked as to why Utilitarianism is still applicable and attractive to the design of the CCHM despite the many criticisms outlined in section 5.4 above. What is it that we can still salvage from a seemingly heavily criticised moral theory? In this section I lay my argument about why Utilitarianism can still be employed to buttress the design of the CCHM.

5.5.1 Counter Arguments against Criticisms of Utilitarianism

As is often the case with all philosophical theories the utilitarian philosophy is not without its own share of criticisms. My view is that no matter how powerful and prominent the criticism against it, this does not diminish the importance and influence of Utilitarianism but rather strengthen it. Robertson and Walter (2007) put up a plausible defence of the utilitarian theory. They argue that utilitarian theory has a vast appeal based on intuition in addition to having a scientific approach when it comes to ethical reasoning. They support their position by evoking Beauchamp and Childress's (2013)'s criteria for assessing any moral theory and conclude that out of the eight assessment categories Utilitarianism fares up very well on three of them: *output power, clarity, and practicability*.

They appear to agree with Beauchamp and Childress who concluded that utility is in sync with their concept of beneficence as well as having strong output power. A further strength of Utilitarianism is cited as its applicability to public policy approaches, as well as having a straightforward ethical decision-making process. Bellefleur and Keeling (2016) see Utilitarianism's main strengths as being both intuitive and simple. They explain that its simplicity is in fact as a result of relying on a single principle of utility. Quantitative methods

for calculating utility do give an advantage of simplicity and clarity and avoid the complexity of principle conflict that may arise if other principles such as the right to information, autonomy, and equity were to be put into the calculations (Bellefleur and Keeling, 2016).

Utilitarianism is argued to also derive its simplicity from its association with the theory of the right, interpreted to mean *maximization of the good in the world*. This is again presented as naturally intuitive (Kymlicka, 2002; Rawls, 2009). An argument is made for the merit of allowing one to suffer a temporary inconvenience in the immediate time to realize a benefit later. The process of weighing benefits against potential adverse outcomes in order to choose a better course of action is something we do every day in life. Proponents of Utilitarianism argue that it is an impartial theory. This is so because the calculation of utility of every action or rule is done in such a way as to ensure strict equality of the pleasure, suffering, interests, or preferences of all those affected. On this basis, it is argued that Utilitarianism is an ethical theory that treats individuals fairly, even when applied to political and social decisions (Kymlicka, 2002).

Utilitarianism is a potent weapon to justify the redistribution of resources and power from the hands of a few to benefit the majority. When resources and power are redistributed from those with excess to those who need them badly, we realize maximum utility because there is an element of diminishing marginal utility when left concentrated in the hands of those with excess (Carson, 1986; Rachels and Rachels, 1993; Sheng, 2004; Bowden, 2009). The rich get to a point where they no longer derive much utility from massive resources and power in their hands. Whereas the poor benefit maximally from the same resources and power if they are availed to them.

While it may sound unacceptable to human rights and other similar principles, infringing on other people's preferences and rights is sometimes necessary in order to maximize the

collective good. I state this assertion with the full realisation that it is a debatable position. Let's take for example the issue of those who refuse vaccinations on grounds of conscience or religious grounds. If certain people remain unimmunized in a community, this may compromise the realization of herd immunity¹⁸ in a population. Therefore, disease prevention measures such as mass immunizations and quarantines compel individuals to give up their strongly held beliefs and individual autonomy for the common good. In the face of an emergency or a pandemic such as the recent COVID-19 world crisis, Utilitarianism prevails because the common good overrides individual autonomy, right to privacy and liberty. Perhaps the argument should be that of the degree to which a predominant utilitarian approach should prevail. This degree should be based on the overall utility and benefit to the majority. However, we should have a mechanism for revision of our position if or as and when new evidence of diminishing utility arises.

There is no doubt that the importance and influence of Utilitarianism are not going to lose their impact any time soon.

5.5.2 Positive Ethical Implications of Utilitarianism

Utilitarianism has been a dominant cornerstone of moral philosophy following the enlightenment era. It provided a framework in ethical arguments for liberalism in political life beyond the enlightenment movement in western Europe with its attendant social justice push (Kymlicka, 2002; Robertson and Walter, 2007). In medical ethics, the famous injunction: “*first, do no harm*” (*primum non-nocere*), is attributed to Utilitarianism as one of its earliest influences (Robertson and Walter, 2007, p. 1).

¹⁸ “*Herd immunity or community immunity occurs when a high percentage of the community is immune to a disease through vaccination and/or illness making the spread of this disease from one person to another unlikely. When most of a population is immune to infectious disease, this provides indirect protection –or herd immunity (also called protection immunity)-to those who are not immune to the disease*” (Gypsyamber, D’Souza and David, 2020) .

Utilitarian moral theory has many implications in a lot of social issues including bioethics. It assists with decisions in various aspects of biomedical ethics including life sciences, biotechnology, medicine, euthanasia and related end of life decisions, abortion, artificial fertilization, preclinical studies in animals and mandatory HIV testing. Despite its many criticisms outlined in section 5.4 above Utilitarianism has many strengths and advantages. despite its potential weaknesses is in the way it may be misused to justify public health policies on the basis that a majority of people will benefit at the expense of trampling upon individual rights of the minority (Kass, 2001; Petrini, 2010; Beauchamp and Childress, 2013). In examining whether Utilitarianism has a place for application in public health policy, influencing improvement on access to healthcare, re-engineering existing healthcare models of public health, or designing new models- the following questions have been presented: “...should public health maximize utility and should it only maximize utility?”(Bellefleur and Keeling, 2016, p. 1).

The school of thought who support the adoption of Utilitarianism as a central philosophy of public health policy base their arguments on the following areas:

- a. The aim of public health interventions is the maximization of a public social good, which refers to the aggregate health of a given population (Cribb, 2009, 2010; Fenton, 2009; Viehbeck *et al.*, 2011). Principles and empirical tools for the evaluation of gains or losses in the health of populations already exist and are in use every day. These include economic measures such as QALY¹⁹ and DALY²⁰ indices which are widely

¹⁹ *The quality adjusted life year or quality adjusted life-year is a generic measure of disease burden, including both the quality and quantity of life lived. It is used as an economic evaluation of to assess the value of medical interventions. One QALY equates to one year in perfect health* (Persad, Wertheimer and Emanuel, 2009).

²⁰ *One DALY represents the loss of the equivalent of one year of full health. Using DALYs, the burden of diseases that cause premature death but little disability (such as drowning or measles) can be compared to that of diseases that do not do not cause death but do cause disability (such as cataract causing blindness)(Persad, Wertheimer and Emanuel, 2009).*

used in the economic evaluation of cost and utility (Persad, Wertheimer and Emanuel, 2009). These are important in evaluating efficiency and effectiveness, both concepts quite critical in the objective evaluation of public health programmes and interventions.

- b. It is a strength of both public health discourse and Utilitarianism that a premium is placed on the consequences. In public health interventions, the aim is to improve the overall health of a population-which is the positive consequence being sought.
- c. In conformity to utilitarian philosophy public health policy focuses on the overall good at the population level, though some interventions may appear to trample on individual rights. The overall collective good of the whole population, not the individual, is paramount in public health interventions.
- d. Again in tandem with utilitarian public health interventions and programmes have an inherent strength of being impartial.

Points in (a) to (d) above will have application in the design and moral justification for the CCHM to be fully described in chapter 9.

But some groups disagree with the above four points on the adoption of the utilitarian theory for public health policy design. They raise very valid arguments which cannot be ignored.

Since the points relating to general criticism of Utilitarianism have been raised earlier on in this chapter, I will focus on the points which relate to arguments about incongruence between goals of public health practice and Utilitarianism.

Crib (2010) and Fenton (2007) both object to the conflation of health and utility, the two assumed goals of public health practice and Utilitarianism respectively. They argue that health and utility may indeed overlap to some degree but they are not synonyms and they do not meet the same thing at all. Health can be viewed as part of utility or vice versa but maximizing either cannot be assumed to be maximizing both simultaneously. Health is not,

cannot be assumed to be the only thing with moral value neither can it always take precedence over everything else (Fenton, 2009; Cribb, 2010).

It is accepted without much argument that maximizing the health of a population is just but one of the aims, in addition to one other important goal of reducing health inequity-without which full maximization of population health is not possible (Childress *et al.*, 2002; Norheim and Asada, 2009; Butler, 2017). In addition to maximization of health as a utility, the goals of public health policy and practice must include the principle of equity and justice as well (Powers, Faden and Faden, 2006; Nixon and Forman, 2008).

Despite a special focus by Utilitarianism on consequences, public health policy and programmes seldom focus solely on consequences alone. Much of the evaluation of public health programmes also include such areas as respect for individual and community autonomy and participation. If this position is accepted, as it appears to be, then we should reject the notion that Utilitarianism is the sole goal of public health policy and programmes. Instead, a middle ground must be found which incorporates the utility principle in equal footing on the other equally important principles such as autonomy, equity, distributive justice and procedural justice. The dilemma we have is if things like autonomy are also valuable, then that gives ground to reject Utilitarianism. But it's still compatible with a form of consequentialism that allows for multiple values to be promoted. Indeed, this middle ground is exactly what the proposed CCHM for Zimbabwe is designed to address.

Utility as the primary and sole goal of public health discourse is further rejected by many others (Childress and Beauchamp, 1994; Ubel and Goold, 1998; van Der Maesen and Nijhuis, 2000; Lee, 2010; Beauchamp and Childress, 2013).

The Principlist approach, as developed and popularized by Beauchamp and Childress (2009) is one such progressive approach advocated to complement a utilitarian approach in so far as helping to clarify various ethical aspects is concerned (Bellefleur and Keeling, 2016).

5.5.3 Rationing of Healthcare Resources, Utilitarianism and the Right to Health

How does utilitarian moral philosophy assist us in the delivery of ethical public healthcare?

One of the important areas is the allocation of resources and how to ration those resources fairly and equitably. Mack (2004) defines first and second-order allocations as follows:

In healthcare rationing a distinction is made between first-order and second-order allocations. In a first-order allocation the total amount of a resource or service to be provided is first determined. In a second-order allocation, the distribution of the total among those who want a share of it is next decided. It is the feature of market distribution to bring the two orders together under a single institutional framework (Mack, 2004, p. 67).

In healthcare planning and delivery different agencies are concerned or involved in first-order and second-order rationing. First-order rationing is done at a higher level, such as government or Ministry of Finance levels. Second-order level rationing is done at the point of care, institutional or doctor-patient level. It follows then that if inadequate or insufficient resources are provided at first-order levels there is little that managers and healthcare providers at the point of care level can do. Healthcare consumers will be deprived of an optimum level of care. Thus using a Utilitarianism logic, it is incumbent upon government to direct more resources to areas such as health, which cater for the welfare and well-being of the majority of the people, rather than to areas such as defence. The case of Zimbabwe's chronic underfunding of healthcare services is instructive here (Mugwagwa, 2017). Mack (2004) advances a position that I wish to adopt from the utilitarian moral theory. He says that it is incorrect to equate or confuse the term Utilitarianism with "... the end justifies the means..." or that "...we ought to promote the greatest good of the greatest number..." (p67 - 68). He prefers to define Utilitarianism as a moral theory embodying one and only one basic

ethical principle of utility, which stipulates that: "... we ought to in all circumstances to produce the greatest possible balance of value over disvalue over all persons affected". (p.68)

When we apply Utilitarianism to the management of healthcare services we are actually referring to Neo- Utilitarianism rather than Classical Utilitarianism, according to Mack. The reason is that in this case, we have substituted pleasure and happiness with the length and quality of life, in other words maximising welfare in the place of happiness. Resources for health are always insufficient, even in the highly developed and industrialised countries such as the USA, UK, Germany, Italy, France, and Spain. This has been confirmed yet again by the COVID-19 pandemic which was still ravaging the world from 2019 up until the time of submission of this thesis. The USA spends trillions of USD dollars on its healthcare system (Xu *et al.*, 2003; Bradley *et al.*, 2011; Lorenzoni, Belloni and Sassi, 2014; Baltagi *et al.*, 2017), possibly the highest in the world. But it was still found wanting in terms of COVID-19 testing, contact tracing, isolation, quarantine, and treatment of patients. Rapid diagnostic tests and Polymerase Chain Reaction (PCR) testing capacity were not enough across all the states of the USA. Intensive Care Units (ICU) beds and ventilators were so short in supply that governors of some states had to declare directives to forcibly acquire those machines from the private health facilities. In Zimbabwe, by comparison, the situation is even worse. The government of Zimbabwe attempted to put up new COVID-19 related facilities in a matter of weeks to no avail. They ended up renovating existing healthcare facilities such as Parirenyatwa Central hospital to cater exclusively for COVID-19 patients at the expense of other illnesses (Ndoro, 2020). I do agree with Mack's proposition that: "In a situation where resources are insufficient to maximise the health of all individuals, the right and rational course of action is to maximise the health of group or population as a whole" (p.68)

Mack's suggestion for the application of a utilitarian ethical principle in pursuit of fulfilment of the right to health within the context of limited resources for health, is echoed by Marseille

and Kahn (2019): "... But the full realization of these rights-based values will, for the foreseeable future be imperfect given healthcare budgets and other constraints. Therefore, efficiency concerns as expressed in Utilitarianism and cost-effective analysis will often be the best guide to rapidly securing those rights for as many rights as possible" (Marseille and Kahn, 2019, p. 6).

Even those who prefer the adoption of a diluted version of Utilitarianism, in the end acknowledge the need to retain the utility principle in the design and delivery of healthcare programmes. This group of scholars dispute the justification of basing public health practice solely on Utilitarianism. However, they do not outrightly discard it completely (Ubel and Goold, 1998; van Der Maesen and Nijhuis, 2000; Childress *et al.*, 2002; Massé and Saint-Arnaud, 2003; Fenton, 2009). A more progressive approach could be a balancing of the utility principle against other more value-laden ethical principles which protect the rights of the consumers (Bellefleur and Keeling, 2016). This entails considering placing the utility principle at equal footing with such values as equity, justice, and autonomy. One form of this balancing act, which blends well with the Citizen Centred Healthcare Model is "the principle of proportionality of risks, costs, burdens and benefits" (Singer *et al.*, 2003; Beauchamp and Childress, 2013; Schröder-Bäck *et al.*, 2014). The principle of proportionality states that actions or responses should be proportional to the good that can be derived from an action and the harm or disvalues that can arise from the action. This principle has an important implication in resource allocation. For example, in the face of limited PPEs during a Covid pandemic healthcare professionals assume a certain risk when they treat patients with limited protection. This risk must be balanced with the good and harm likely to arise from the action (Hermerén, 2012; Andersson, 2016; Jackson-Meyer, 2020).

5.5.4 Concluding Remarks

Healthcare, access to healthcare and good health are all good things we desire in life. These goods not only give us pleasure and protect us from pain such as illness, disability, morbidity and even death but also enable us to enjoy pleasures in life. Therefore, they ought to be maximised. From this viewpoint Utilitarianism is not in conflict with any other moral theory but actually compliment them. This viewpoint applies to the other moral theories discussed in chapters 6 and 7 and is the the driving line of argument and exact purpose of the discussions of Utilitarianism, Egalitarianism and Ubuntu/Hunhu espoused from chapters 5 to 7 in this thesis. As discussed under subsection 5.5.3 above rationing of finite healthcare resources requires in part, a utilitarian approach in order to efficiently deploy the most relevant and appropriate interventions. There is no contradiction at all with other moral theories. My choice of Utilitarianism as one of the philosophical underpinnings of the CCHM does not equate to ignoring the shortcomings and limitations of this moral theory. Quite to the contrary it is an acknowledgement that while Utilitarianism has its own flaws, it has it strengths which can be harnessed in combination with other moral theories.

The approach which seems to prevail in public health ethics is positioned somewhere between the adoption and the rejection of utilitarian theory. It consists of retaining the utility principle, while rejecting the utilitarian claim of being able to base the entire field of public health ethics on this single principle. Strictly speaking, this approach is equivalent to a rejection of utilitarianism, because the maximization of utility alone is no longer advocated. The utility principle effectively loses its status as a fundamental and primary principle and is placed instead on an equal footing with other principles (equity, justice, autonomy, etc.) that must also be taken into consideration during ethical reflection and deliberation. Thus, one form or another of the utility principle is found in many public health ethics frameworks. It is often referred to as a principle of the proportionality of risks, costs, burdens and benefits (Bellefleur and Keeling, 2016, p. 8).

Thus it is now almost the norm not to rely on the utility principle alone when designing healthcare intervention programmes. The CCHM also makes a conscious effort to select those aspects of Utilitarianism which are compatible with other moral theories.

5.6 Chapter Summary

This chapter traced the historical origins of the utilitarian moral theory. Different typologies of Utilitarianism were discussed. The more practical typology of Utilitarianism is that which divides it into Act and Rule Utilitarianism. Various criticisms of Utilitarianism were discussed as well as the various supporting arguments for it. An important discussion on the ethical implications of Utilitarianism was presented towards the end of the chapter. In the end, I accept that while Utilitarianism is important as a defining moral philosophy in public health policy, it nevertheless needs tempering with other moral principles such as autonomy, right to health, reduction of health inequalities, justice, beneficence, and community participation. The chapter ends with a discussion on Rationing of Healthcare Resources, Utilitarianism and the Right to Health. Next is chapter 6, the second of three chapters that have been dedicated to the analysis of selected moral theories with a bearing on redistributive justice, equality, and equity issues related to access to healthcare. Chapter 6 in particular will delve into the egalitarian moral theory and its implications for access to healthcare and policy formulation.

CHAPTER 6: EGALITARIANISM

6.1 Introduction

A description, comparison, and critical analysis of various philosophical theories, values, and models on access to healthcare (HC) is an essential and indispensable step in enabling policymakers and administrators to craft new or transform existing HC models and systems. Reform and transformation of HC systems, models, and values are important in addressing delivery and design gaps. This process must be undertaken in an ethically responsive and responsible way. It is important to locate the paradigm in which HC is being delivered as well as shedding light on issues of access or lack of it. This analysis of the prevailing paradigm can be used as a tool to assist in coming up with an improved, reformed, or even a new model which is sustainable and defensible from an ethical and human rights-sensitive perspective. Without this in-depth discussion and critique of philosophical perspectives, it would be very difficult to pass a judgement on the existing model of HC delivery in any context. It is equally not possible to make justifiable proposals for improvement, reform, or even replacement without this in-depth analysis.

Egalitarianism is one of the most influential philosophical perspectives on access to healthcare and other social phenomena such as public finance, social welfare, law, and justice. And yet it is not without controversy, as is the case with almost all philosophical theories, values, and perspectives. This is precisely the reason why an in-depth description and critical analysis of this moral theory was included in this thesis. The liberal Egalitarianism dimension of this theory is especially instructive with regard to debates on access to healthcare and it is included in this chapter as well. Egalitarianism originated from a French word that means to be equal or *egalitarianism*. It is based on a premise that holds

that all people must be treated equally or be seen to be equal in some respects such as social status and access to resources such as healthcare (Cohen, 1989; Arneson, 2002a; Samuel, 2003; O’neill, 2008). Egalitarians argue that equality is at the centre of justice. Some of the people credited with developing the egalitarian theory include John Locke and Karl Marx.

Traditional c

hristian thought appears to have had a major influence on the development of the egalitarian theory. This influence is based on the widely held understanding that God loves all people equally without discrimination therefore every human being is basically the same in moral status (Arneson, 2002a). While there are many aspects through which Egalitarianism can be analysed, the issue of income and wealth appear to be most dominant (ibid).

6.2 Roadmap for this Chapter

In this chapter, I present the position that Egalitarianism is a central philosophy with regards to justice, fairness, and equality in improving access to Healthcare (HC). It provides an important countervailing balance to other philosophical theories and approaches in the critical analysis of the adequacy of or lack of access to HC. This is the reason why it was chosen for inclusion as one of the guiding moral theories in the crafting of the Citizen Centre Healthcare Model (CCHM) described in full in chapter 9. Equality in access to HC is indispensable as a guiding principle in the design, reform, or replacement of a HC system or model notwithstanding the fact that a similar principle was applied and failed in the immediate post-independence era in Zimbabwe. Alleged corruption in Zimbabwe, in all its various forms, appeared to be one of the main drawbacks of Egalitarianism in healthcare policies of post-independent Zimbabwe (Doig, 2006; Author, Zeilig and Dawson, 2008; Tizora, 2009; Bonga, Chiminya and Mudzingiri, 2015; Choguya, 2018). Any good policy can still fail if it is not implemented properly and without a strong ethical underpinning and if lacking in safeguards

founded on strong legal, monitoring and evaluation. The CCHM seeks to correct all these areas which were not part of the past Zimbabwean healthcare policies which appear to have failed to achieve the intended goals.

Important aspects of Egalitarianism will guide the ethical decisions regarding designing a new healthcare model which answers to a quest for just distribution of resources for healthcare. In particular Luck and Liberal Egalitarianism are quite impactful in the discourse of designing the Citizen Centred Healthcare Model in Chapter 9. Luck Egalitarianism makes a strong argument to not allow people to be disadvantaged or advantaged purely based on bad or good luck respectively. It also takes a strong stand on distributive equality. Distributive equality argues for the moral equality of making people accountable and responsible for their actions and choices.

The first part of my discussion gives a background to and a historical development of the egalitarian philosophy. Understanding the origins of Egalitarianism gives context to further discussion in view of the fact that Egalitarianism has taken different forms and dimensions over successive years.

- In section 6.4, I define various types/forms of Egalitarianism. Considerable space is dedicated to Luck Egalitarianism as it is one of the important aspects in decisions related to social assistance- particularly public health services.
- In section 6.5, I discuss weaknesses of Egalitarianism. As no moral theory is without criticism or weakness a discussion on weaknesses of Egalitarianism is critical to be included. Criticism creates a balanced view of any moral theory and this allows refinement of ideas that come out of the theory.
- In section 6.6, I discuss strengths of Egalitarianism.

- In section 6.7, I discuss the implications of Egalitarianism on healthcare delivery and policy, with emphasis on what exactly is salvageable from this theory in view of criticisms levelled against it.

6.3 Background to Egalitarianism

The fundamental basis for Egalitarianism is that all human beings are made up of a fundamental worth and as such must be treated as equal not as unequal. We all have intrinsic value because of our humanness and this is the defining parameter for Egalitarianism. Ethics has grown in its influence on Egalitarianism and this has greatly enriched the field of biomedical sciences (Afolayan, 2014). It is this flirtation of Egalitarianism with ethics that I find quite useful in my thesis as it endeavours to extend the debate on equality and fair distribution of HC and related resources. The concept of equality is so central to the philosophy of Egalitarianism that it is taken as self-evident, natural and a panacea of how burdens, benefits, goods, and services must be distributed equitably in society. The contestations about the validity and applicability of the philosophy itself are often brushed aside as inevitable. The proponents of Egalitarianism counter against criticism targeted towards them by saying that there is no theory without its own weaknesses.

6.3.1 Brief Historical Development of Egalitarianism

Historically the Greeks believed in the natural inequality of man except when moderated by social frameworks. They believed in the natural differences between humans such as personality traits and as such people will of necessity require differential treatment. The political framework such as that provided by Egalitarianism helps to equalize the inequality inherent in human beings, who are born unequal. In addition, unlike animals, human beings are gifted with the ability to reason. Though not enough, this is the greatest equalizing factor among human beings, who are otherwise born with natural inequalities (Brown, 1988).

The Middle Ages (also referring to Medieval Ages or Dark Ages) saw a renewed wave of anti-Egalitarianism particularly the struggle to reconcile the Egalitarianism doctrines implied in Judaism and the new testament Christian thought (Afolayan, 2014). The Middle Ages generally refer to the period between the fall of the Roman Empire in 500 AD and the rise of the Ottoman Empire and Renaissance in 1500 AD (Postan, Clapham and Power, 1941; de Ridder-Symoens and Rüegg, 2003; Curta, 2019). Preceding the Middle Ages, an argument had been sustained for inequality based on a social hierarchy of unequal social systems cooperating through a central government authority which was thought to be both divine and secular. This government was meant to create social order by in part, keeping in check sinners. The new testament assumption of equality before God, however, did not completely eliminate the social inequalities in the secular environment of society.

Egalitarianism is thought to have found vivid expression in a stoic philosophy during the modern period with its attendant emphasis on the natural right and natural law (Mäkinen, 2008; Mitsis, 2013; Stanlis, 2017). The seventeenth century saw an even more robust challenge to the hitherto overbearing medieval doctrine of society being ordered based on divine authority. This is the period in which prominent philosophers such as those in strong support of social contracts such as Thomas Hobbes, John Locke, and Jean- Jacques Rousseau emerged. Their swan song was that government authority can only and should only be derived from an agreement between natural equals based on voluntariness (Morris, 2000). They argued that fundamental differences between human beings are not natural but a result of the environment and social influences. One of the prominent social contract theorists, Rousseau's famous words can be paraphrased as highlighting that men are born equal with infinite potential but only society distorts their capabilities (Rousseau, 2018).

6.3.2 Defining Egalitarianism

The word egalitarian was adopted into the English language from a French word '*egalitaire*' (egalitarian), which comes from the Latin word: *aequalitas* (equality). The suffix *-ism* was then added to the word. The first appearance of the word in English was in the late 19th century, with earliest recorded citations around 1874 (Webster, 2021).

At the centre of Egalitarianism is the emphasizing of equality and equal treatment of human beings regardless of gender, religion, economic status and political positions. Egalitarianism is premised on the philosophic idea that *all individuals are born equal and should be treated equally*. In some aspects Egalitarianism focuses on income inequality and its distribution, ideas which have given rise to a number of different economic and political perspectives. It may also focus on the fairness with which individuals are treated under the law. Notably historical philosophers such Karl Marx and John Locke used egalitarian principles in their famous philosophical pronouncements. Marx, for example used it to pronounce his *Marxist philosophy* while Locke used it in his doctrine arguing that *humans have natural rights* (ibid).

Debates are continuously raging with regards to whom should egalitarian norms apply. Controversy still exist when it comes to classifying persons to whom egalitarian norms should apply. Should only human beings be entitled to equality of status? Or should only those with personhood be accorded egalitarian norms? And if so, what type of personhood criteria should be used? Can we exclude some humans from qualifying (such as unborn foetuses or severely demented adults)? Should sentient nonhuman beings, such as primates not meeting the criteria of personhood be accorded equal moral status alongside persons? (Arneson, 2002a). These and many other debates define the terrain of Egalitarianism.

6.4 Types/Forms of Egalitarianism

Many terms and concepts are used in the discourse of defining, extending, and discussing various dimensions of Egalitarianism. Detailed discussion on such terms and concepts is beyond the scope of this thesis. A few selected terms or concepts are presented in the next subsections.

6.4.1 Equality of Opportunity

Equality of opportunity is an important concept in Egalitarianism. It is an idealistic political concept that promotes a fair and alternative assignment of individuals to a social hierarchy other than a *caste hierarchy* in society. In the caste hierarchy system, individuals have their assignment into social positions predetermined at birth according to their parenthood. This is not acceptable under the equal opportunity doctrine as it is deemed unfair, unjust and negates the operation of competition and hard work. Further details and extensive discussion on this topic is beyond the scope of this thesis save to mention that the concept of equality of opportunity has been debated extensively in the literature on philosophy, politics, and economics. Arneson, for example, has proposed a classification into *formal equality of opportunity* and *substantive equality of opportunity*-both of which have helped to deepen the debate on the subject (Arneson, 2002b). Readers are referred to established texts on Arneson's classifications.

6.4.2 Analytical Egalitarianism

Best understood when seen in comparison to substantive Egalitarianism. Substantive Egalitarianism argues for the treatment of people on the basis of equality while Analytical Egalitarianism takes the opposite view. It presents an argument based on a methodological framework of equality (Afolayan, 2014). It says that considerations for socio-political

decisions must of necessity be based on an assumption of people being homogenous even though they are not really homogenous. Proponents of Analytical Egalitarianism give an example of an application of this principle in healthcare policy where they argue for the treatment of people as if they are equal rather than seeing them as having inequalities to avoid creating problems (Levy and Peart, 2008).

6.4.3 Telic/Deontic Egalitarianism

Telic and Deontic Egalitarianism look at issues from a perspective of *instrumentalism* versus *non-instrumentalism*. Deontic Egalitarianism takes the view that equality has a non-instrumental value that is intrinsically good in itself. Being worse off than other people in society is bad and unacceptable in itself regardless of whether anyone benefits from this inequality anyway. On the other hand, Telic Egalitarians hold the view that instrumentality forms the heart of Egalitarianism. They argue that for equality to be meaningful it must provide a means for the attainment of some social good or benefit such as social justice and solidarity. For them, inequality is not just bad in itself but also unjust (Parfit, 2002; Moss, 2009).

6.4.4 Non-Intrinsic Egalitarianism

This is essentially an outright rejection of the Telic and Deontic Egalitarianism positions, particularly the distinction between the two. The Telic Egalitarianism position is rejected for its too idealistic reliance on just the intrinsic value of equality alone. This is seen as too pure a position to allow recognition of other egalitarian appeals. The non-intrinsic Egalitarian rejects the Deontic egalitarian position for its argument which appeals to non-egalitarian moral values such as justice and solidarity (Afolayan, 2014). Instead, non-intrinsic Egalitarianism say that it is the effects of inequality such as the following, at the centre of problems:

...(a) servility and differential behaviour (b) objectionable relation of power and domination (c) the weakening of self-respect of the worse offs (d) stigmatizing of differences in status, and (e) the undermining of healthy fraternal social relations...(O'Neill, 2008, p. 126).

6.4.5 Conditional Egalitarianism

Conditional Egalitarians accept the intrinsic value of Egalitarianism on the condition that it brings benefit to other people not just for its intrinsic value alone. They reject a purely non-instrumental value of Egalitarianism (Mason, 2001).

6.4.6 Constitutive Egalitarianism

Equality is not seen as being intrinsic in itself but from being part of a larger framework that has an intrinsic value in itself such as healthcare or justice. For this reason, this concept makes equality to be non-instrumental (Arneson, 2002a; Afolayan, 2014). If we take access to healthcare (HC) as having an intrinsic value in itself and we agree that for a society to be just every citizen should have an equal claim to access to HC, then equality becomes constitutive to HC.

6.4.7 Pluralistic Egalitarianism

The consummation of Egalitarianism can accommodate many other values other than equality. It can be a plural interplay of values rather than being restricted to equality alone (Cohen, 1986; Walzer, 2008). For example, the value of liberty added to egalitarian pursuit need not be antagonistic to equality.

6.4.8 Domestic Egalitarianism

This is also known as Social Egalitarianism. It simply argues that the full realization of justice and its moral demands cannot be adequately served unless the standards of equality have been wholly and completely attained by all citizens of a society or country. We can only be satisfied if such goods as power, opportunities, wealth, rights, income, access to healthcare, welfare, and other morally significant values are equally distributed among the citizenry (Arneson, 2002a).

6.4.9 Global Egalitarianism

This is an extension of Egalitarianism as a necessity for equality if it transcends national and regional borders and is taken to a global scale. Social justice is not morally significant if it is confined to national borders. All human species anywhere on the planet are entitled to equality.

6.4.10 Strict Egalitarianism

Calls for the allocation of equal material goods to all members of society.

6.4.11 John Rawls's Difference Principle

It permits diversion from the strict equality in Strict Egalitarianism for as long as the inequalities in question will make those worse off in society materially better off than they could have been under strict equality. Luck Egalitarianism departs from both Strict Egalitarianism and John Rawls's Difference Principle by advocating alternative distributive justice principles which are sensitive to roles played by responsibility and luck.

6.4.12 Instrumental versus Non-Instrumental Egalitarianism

The instrumental Egalitarian values equality as a means to some independently specifiable goal while the non-instrumental Egalitarian values equality for its own sake—as an end, or as partly constitutive of some end.

6.4.13 Liberalism

Liberalism is defined as a political doctrine which places the protection and enhancement of an individual's freedom at the centre of politics. Liberals not only believe that the job of a government is to protect individuals from being harmed by others but also the fact that government can actually be a threat to the liberty of individuals. The major challenge is to design a system that allows the government to protect individual freedoms and liberties but at the same time preventing those who govern us from abusing the powers we bestow on them. Liberalism has evolved over time and the seemingly dominant position is that the main task of government is to: “to remove obstacles that prevent individuals from living freely or from fully realizing their full potential (Minogue, K. , Ball, . Terence , Dagger, . Richard and Girvetz, 1998).

It has been argued that liberalism has not always been coherent and that it has changed over time depending on the circumstances. For example, traditional liberals distasted government interference in the market place. They also used to favour capital punishment but have now changed towards accepting government interference in the running of the markets as well as opposing capital punishment (Wein, 1984). The most common thread intertwining all liberalism proponents, can be summarised as follows:

- they hold that all governments must remain neutral as far as what constitutes a good life is concerned.

- they must leave it up to the individual to define what a valuable life is all about.

Unlike the conservatives the liberals believe that the state must not be used as means to enforce a certain moral position about how life ought to be lived. That is an individual decision not a government mandate (ibid).

Liberalism is premised on a number of fundamental philosophical positions illustrated in table 2 below:

Table 2: Fundamental Principles of Liberalism

i. They advocate for programmes which help redistribute wealth so that inequalities in our contemporary societies are removed,
i. Democracy is preferred over all other forms of governments; they vouch for unimpeded access to all government positions in a fair manner,
ii. Extension and preservation of the rule of law,
iii. Advocacy for laws which protect the individual from government interference as well as from the fellow citizen,
iv. An unequivocal separation of church and state,
v. Unlike conservatives, they support affirmative action programmes,
vi. They fight tooth and nail to keep the government out of the bedroom and God out of the classroom
vii. Do not support penalizing people against ‘moral offences’,
viii. Support an open immigration policy,
ix. They defend, decriminalizes and support civil disobedience.

Source: (Wein, 1984, p. 33; Scheffler, 2005, p. 44)

6.4.14 Liberal Egalitarianism

Liberal Egalitarianism holds that a society ought to have laws which protect individuals and in the process ensuring that individuals are not only respected but treated as equals for that society to be truly liberal. It argues that a society premised on liberalism is truly superior to other philosophical positions in competition with liberalism. The liberal Egalitarian is quite persuasive when it comes to access to healthcare, because s/he has a critical argument about fairness, responsibility and priority setting. Liberal Egalitarianism argues that while it is good for people to be treated equally in communities and rightly fight to be treated equally, they

must also be held responsible and accountable for the health life style choices they make e.g. smoking or unprotected sex (Cappelen and Norheim, 2005). While society must not unnecessarily penalize an individual for burdens outside an individual's control, a choice for an indulging life style must come with responsibility. There are two critical principles to this philosophy: *the principle of responsibility* and *the principle of equalization*. The principle of equalisation holds that a society must eliminate inequalities arising from outside an individual's control, excluding inequalities arising from choices between individuals. One of the arguments against this individual responsibility is a normative one. It says that limiting or creating punitive measures such as higher health insurance premiums for individuals exercising risky health behaviour (e.g. smoking) violates other rights. Therefore, such disincentives ought not be employed as they negate other crucial rights such as the opportunity to work or study.

6.4.15 Luck Egalitarianism

A luck Egalitarian would ask the following questions: *In the society's efforts to distribute resources and opportunities fairly and justly, can an individual be held responsible for having more advantages or for being worse off than an average person due to luck or bad luck?* Shouldn't a society be more concerned with those advantages brought about by unfair distribution, individual choices to act or not to act rather than those endowments arising purely as a result of luck?

Luck Egalitarianism is a group of theories on justice that seek to explain and shed light on these and other related big questions. This group of theories on justice focuses on balancing out the effects of luck on distributive justice in people's lives (Knight, 2013). The first major theory in modern-day philosophy to have *seeds* of luck Egalitarianism was a theory by Ronald Dworkin on equality of resources; even though Dworkin himself vehemently denied any connection to luck Egalitarianism (ibid). Luck Egalitarianism was however to find a

more explicit explanation in Richard Arneson's *equality of opportunity for welfare* and Gerald Cohen's *equal access to advantage* (Cohen, 1989; Arneson, 2000, 2002a; Arneson and Kaufman, 2005).

The term luck Egalitarianism, which is sometimes referred to as *responsibility-sensitive Egalitarianism*, was brought to fame by one of its most ardent critiques, Elizabeth Anderson (Anderson, Jackson and Phillips, 2014). Knight explains how luck Egalitarianism was foreshadowed even by the twentieth-century ground-breaking expounding of the theory of justice by the American Philosopher John Rawls in his writings on *Justice as Fairness* (Knight, 2013). Rawls, according to Knight, contemplated the relevance of luck Egalitarianism even in his proposal in *fair equality of opportunity* when he allowed the influence of a form of natural lottery against his central premise arguing for equality in life chances based on equal skills and abilities (Knight, 2013). Rawls's proposal to solve this dilemma was the introduction of the *difference principle* to operate side by side with fair equality of opportunity. This way, according to Rawls, any further inequalities must be used to expand attention on the interests of the worst off in the community (Rawls, 2009). Needless to say, Rawls' ideas are not without opposition and criticism. One such opposition is that his proposal underplays the influence of the arbitrariness of luck and its moral problems. Although the proposition that Rawls' theory of justice had a bias towards luck Egalitarianism is contested, it is generally accepted that his ideas had a great influence on egalitarians of later years (Samuel, 2003; Freeman, 2006).

Luck Egalitarianism finds its foundation based on a family of theories about Egalitarianism and distributive justice which seek to cancel out the distributive impact and effects of luck on society and people's lives. Arneson says that for the luck Egalitarian the aim of justice with equality is to remove the effects and impact on society and people's lives, those circumstances arising from bad luck due not to people's choice or fault of their own

(Arneson, 2000). People must only be held responsible for inequalities resulting from their own choices, not those arising from factors beyond their control. This is the picture of an ideal luck egalitarian society (ibid.). Luck Egalitarianism is at the heart of the difference between chance and choice and their importance in distributive justice as misfortunes and disadvantages resulting from purely bad luck appear more justified for redistributive justice than those arising from conscious bad decisions and choices by the disadvantaged (Markovits, 2008).

Luck Egalitarianism is essentially a *work in progress* philosophical position, expounded by a group of very prominent philosophers. But while appearing to be lacking a central coherent position, all do advance an intuitive position which is quite persuasive. People in society should not be left disadvantaged or advantaged simply on the basis of bad or good luck.

Dworkin is probably the first to clearly explain the concepts of *option luck* and *brute luck* and the distinction between the two of them. According to him when someone makes a calculated gamble fully knowing the potential risks then wins/gains in spite of knowing the risks then they are said to be exercising *option luck*. This is clearly in contrast with *brute luck* in which a person wins or gains without exercising a choice. *Bad brute luck* is when a person is struck by bad outcomes outside of his choices. Dworkin argues that a person who earns *bad option luck* must not be assisted, unlike those with *bad brute luck*, provided they had equal access to enabling resources like everyone else (Dworkin, 1981b, 1981a, 2003).

Dworkin, in a framework referred to as *ethics and metaphysics*, raises two kinds of theories on distributive justice: *ethically sensitive/continuous theories* and *ethically insensitive/discontinuous theories*. Ethically sensitive/continuous theories on distributive justice: “make their judgements on grounds we recognise in our own ‘personal ethics’, understood as ‘our own sense of how we should live and when we are living well and badly” (Knight, 2013, p. 5,6). Ethically insensitive/discontinuous theories on the other hand don’t

utilise personal ethics to establish what is due to individuals as arising from distributive justice. In short, they do not elevate the impact and assignment of responsibility we make when leading our lives from inside ourselves. He appears to support the first set as they reflect our own personal ethics and judgements based on how well or badly we live our lives (Dworkin, 2002). He despises the second set of theories for their lack of reflection on our internal ethics as we see life the way it should be lived. They are disconnected from our own internal values. Thus he argues that compensation for bad luck and not for choices made voluntarily is intuitively pragmatic.

Proponents of Luck Egalitarianism espouse somewhat different and divergent pathways and views but eventually leading to the same destination (Arneson, 2004; Tan, 2008). The lack of a strong unambiguous philosophical stand on the theory of luck Egalitarianism is so rife that even one of its acknowledged proponents, Dworkin, has denied that he is a luck Egalitarian as time went by (Dworkin, 2003). Nevertheless, this does not subtract from the overall powerful and defining influence of this theory on distributive justice.

Weaknesses of Luck Egalitarianism

There are a number of criticisms of the luck egalitarian theory. Some of the most notable ones come from Susan Hurley, Samuel Scheffler, and a group calling itself democratic Egalitarians (Arneson, 2004; Markovits, 2008; Tan, 2008; Knight, 2013). For example, Hurley argues that luck Egalitarianism is not only unattractive but also very confused about the concept upon which its inspiration is built- referred to as *responsibility* (Hurley, 2001). According to her, there has been a lot of recent and sophisticated studies on the notion of metaphysics of *free will, determinism, causality, and moral responsibility* but all these developments have not been captured in the current account of democracy as preferred over all other forms of governments. Instead she and her supporters vouch for unimpeded access to all government positions in a fair manner.

In short Luck Egalitarianism is heavily criticised on the following areas:

- i. It is harsh to the needy and the down trodden
- ii. It may be perceived as discriminating against the disabled
- iii. It is contrary to basic humanitarian principles
- iv. It exhibits dissonance against real life situations and against basic human dignity
(Wein, 1984; Scheffler, 2003).
- v. Luck Egalitarianism is grossly incoherent (Miller, 2014).

Strengths of Luck Egalitarianism

Those who support luck Egalitarianism argue strongly in its favour as a ground breaking reason for the importance of distributive equality, explained as a requirement *for the moral equality of people to be accountable and assume responsibility* for their choices as well as carrying the burdens of the costs resulting from those choices (Cohen, 1989; Dworkin, 2003; Arneson, 2004; Gerald Allan Cohen, 2009). They also argue that no one should suffer disadvantages or be worse off in society due to bad luck. Luck Egalitarians appear to differ on where their emphasis lies: the aim of the distributive principle being to balance out the impact of luck on peoples' opportunities in society versus the aim of the distributive principle being to act as a buffer against the undesirable consequences of luck on how goods and services are distributed in society.

But they all ultimately agree on one thing: persons must not be advantaged or disadvantaged just because of good or bad luck. It is unjust, unfair, and unacceptable they argue, that benefits must accrue to persons simply because of luck and not due to their conscious choices and/or hard work. This is a position I find very appealing as a possible moral foundation for the CCHM to be fully discussed in chapter 9. In his characterisation, Arneson coins the term *luck/choice principle* in his effort to emphasize how and why the distributive justice principle should be blind to luck and be sensitive to choices (Arneson, 2004).

The group of luck Egalitarians has grown bigger over the years and they primarily all agree that society has a moral obligation to protect the living conditions of people who succumb to simple bad luck, not their choices. This is the overarching philosophical position. They include such philosophers as Dworkin, Cohen, Temkin, Roemer, and Nagel (ibid).

6.5 Weaknesses of Egalitarianism in General

Egalitarianism is not without contestation. A movement that holds general views and perspectives that are anti-Egalitarianism in their position on equality is referred to as *non-Egalitarianism*. The basic ground on which this movement rejects the egalitarian position on equality is that there are natural differences between human beings which justify inequalities such as gender, race, ethnicity, and intelligence. These differences are so inherent that we cannot wish them away.

The premise of the anti-egalitarian argument is that human beings are different and this is self-evident in how they differ in so many areas such as capabilities, character, political views, religious views, weaknesses, strengths, and virtues (Kekes, 2003). We may be born equal but the reality of the different social factors such as poverty and wealth, into which we are ushered -makes us unequal. This is an undisputed fact and the Egalitarians need to accept this fact (ibid.). Afolayan (1993) argues that Egalitarianism is just what it is –an elusive concept bereft of real complete application except as an idealistic philosophical expression.

The criticism continues: Egalitarianism is confusing because it is:

... the idea of equality that can be seen as a trans-conceptual concept because its significance is concurrent and intersects other critical ideas like liberty, rights, property, and justice. Thus, its career and meaning are bound to many disciplinary matrixes and attached to so many other concepts in a manner that begs understanding... (Afolayan, 2014).

A number of theories are anti-Egalitarianism, including Utilitarianism, Libertarianism, and Prioritarianism. Utilitarianism only accepts utility as a basis for the distribution of resources

in society. It argues that erasing inequality creates inefficiency in that agents would be demotivated to develop themselves by working extra hard if inequality were removed (Myerson, 1981; Stein, 2008). Libertarianism's foundation is built on the doctrine of liberty as the main, if not, only overarching social value. According to them, no one has a right, neither the state nor society, to compel or force an individual to live his or her life outside the autonomous choices and free will as provided by the social principle of liberty (Quong, 2011).

Prioritarianism opposes the egalitarian argument that equality is a foundational basis for justice. The reason it rejects this position is that justice is such a big and complex social good to be bounded by equality on its own. The basis for Prioritarianism's rejection of equality in Egalitarianism is the seemingly myopic focus on comparing one person against another rather than on priorities that significantly improve the status of those deprived. They favour an empirical transfer of resources for the actual improvement of priority needs rather than just comparisons (Parfit, 2002).

Notwithstanding all these seemingly strong criticisms of Egalitarianism, there are important progressive aspects of it that can be applied to the design of CCHM fully discussed in chapter 9. These progressive aspects of Egalitarianism are expanded in the section below.

6.6 Egalitarianism and the Design of the CCHM

After describing all the criticisms and weaknesses of Egalitarianism one is left wondering if there is still anything to salvage from it. Fortunately, there is still a lot that can be salvaged from Egalitarianism.

6.6.1 Egalitarianism still has some support

Those who support luck Egalitarianism argue strongly in its favour as a ground breaking reason for the importance of distributive equality, explained as a requirement for the moral equality of people to be accountable and assume responsibility for their choices as well as carrying the burdens of the costs resulting from those choices (Cohen, 1989; Dworkin, 2003; Arneson, 2004; G A Cohen, 2009). The same point explained from another angle says they argue that no one should suffer disadvantages or be worse off in society due to bad luck.

Luck Egalitarians appear to differ on where their emphasis lies: the aim of the distributive principle being to balance out the impact of luck on peoples' opportunities in society versus the aim of the distributive principle being to act as a buffer against the undesirable consequences of luck on how goods and services are distributed in society.

But they all ultimately agree on one thing: persons must not be advantaged or disadvantaged just because of good or bad luck. It is unjust, unfair, and unacceptable they argue, that benefits must accrue to persons simply because of luck and not due to their conscious choices and/or hard work. This is a point which I find very appealing in guiding me in arguing for a more egalitarian healthcare model, such as the CCHM.

In his characterisation, Arneson coins the term *luck/choice principle* in his effort to emphasize how and why the distributive justice principle should be blind to luck and be sensitive to choices (Arneson, 2004).

The group of luck Egalitarians has grown bigger over the years and they primarily all agree that society has a moral obligation to protect the living conditions of people who succumb to simple bad luck, not their choices. This is the overarching philosophical position. They include such philosophers as Dworkin, Cohen, Temkin, Roemer, and Nagel (Arneson, 2004).

6.6.2 Moral Implications of Egalitarianism on the proposed CCHM

The CCHM, to be fully described in chapter 9, is founded on the application of Egalitarianism as both a political doctrine advocating the removal of all inequalities in the exercise of accessing HC services as well as Egalitarianism as a social philosophy advocating the removal of inequalities in economic and social activities. Without removal of inequalities in economic and social activities there can't be an improvement in access to HC. Full political and economic participation of citizens is a necessary prerequisite for the realisation of optimum access to HC. Not all types/forms of Egalitarianism described in section 6.4 can be applied to the CCHM but a number have ideological relevance to the design and implementation of the CCHM. In particular application of the Telic and Deontic Egalitarianism is important because of their emphasis on instrumentality and non-instrumentality of equality-both of which require a balance to be created when designing public health models. Equality as a constitutive aspect of access to HC will be critical for the CCHM to be seen as an application of the right to health aspects of the chapter 4 Bill of Rights in the new constitution of Zimbabwe which was passed as law in 2013. The CCHM makes a deliberate endeavour to increase and improve access to HC for the disadvantaged in society as well as encouraging individuals to take responsibility through the choices they make. This does not imply that they will not be discriminated against on the basis of bad. For this reason, aspects of Luck Egalitarianism and John Rawl's Difference Principle will inspire the ideological thrust of the CCHM.

Liberal Egalitarianism has an important moral influence on the design of healthcare policy and programmes in general. It holds individuals to account for the health-related choices they make even though it is often impossible to determine directly which aspects of the choices they made created ill-health (Cappelen and Norheim, 2005; Cappelen, Norheim and Frithjof, 2006). Liberal Egalitarianism is not in contradiction with Luck Egalitarianism. Luck

Egalitarianism does not draw a line between fair and unfair health inequalities (Voigt, 2013). For a luck Egalitarian, it does not matter if the cause of poor health is as a result of biological or natural predisposition or as a result of unfair distribution of social determinants of disease. Both liberal and Luck Egalitarianism agree on the unfairness of ill health in so far as it should not be left to the individual alone to fix it. For us to hold individuals responsible for their actions such as smoking, lack of exercise, unprotected sex and obesity-we ought to establish the following: "...(ii) the illness is completely or partly a result of individual behaviour or choice (iii) the illness does not limit the use of political rights or exercise of individual capabilities; and (iv) the cost of treatment is low relative to income of patients..."(Cappelen and Norheim, 2005, p. 312).

While I am not arguing for the complete acceptance of Cappelen and Norheim positions as stated above, my position, which position can be contested, is that these types of considerations can be deployed to calculate *reasonable levels* of co-payments or shortfalls to be paid by consumers for illness and diseases that cannot be directly attributed to poor individual choices. Since resources for healthcare are not limitless and no country can ever have enough it is imperative to allow a moderate level of cost-sharing between the insurance, public HC financing and the consumer. The mantra of free health care in successive healthcare policies in Zimbabwe appears to have failed. Therefore, a balance needs to be struck in the Zimbabwean healthcare system as the cost of service is very high relative to people's incomes making even a mundane healthcare procedure such as an HIV or COVID-19 test a potential financial catastrophe. While almost everyone agrees on the need for a healthcare reform process to be done, it is difficult to agree on the type of reform needed. Part of the reason for this disagreement is due to conflicting moral perspectives. This is where a thorough understanding of Egalitarianism as one of the foundational moral theories for the CCHM come in.

It is not in dispute that as a nation, Zimbabwe decided to consider healthcare as a moral right. This is demonstrated in the way the right is endorsed and promoted in the national statutes such as the national constitution as well as the ratification of numerous regional and international statutes and conventions. A detailed description of these statutes and conventions was given in section 1.4.2 of chapter 1 of this thesis. The operationalisation of this right means that every citizen has a right to healthcare. If we suppose they do not have the necessary resources to access these services, the State and society have an obligation to ensure that poverty is not a barrier to accessing healthcare. This perspective is premised on the reasoning that healthcare is morally different from other social goods and services. This may also be known as moral Egalitarianism -a commitment to equality of opportunity dictated to by a philosophy of the sacredness of life –whose value cannot and should not be guaranteed by the amount of riches one has. Rather society must guarantee it according to the severity of need (Waymack, 1993).

On the other hand, we cannot ignore the fact that the provision of healthcare services has become a big business that does not come cheap. Cost is inherent in the provision of HC services. An ethically provision of healthcare services should not be based on market forces. Healthcare professionals are ever training to reach a peak of specialisation which allows them to earn a high income. Hospitals and clinics are also upgrading their technology so that they attract the best-paying consumers for their unique services. We should not condemn this market-driven behaviour by providers because it is us the consumers who demand it (Waymack, 1993; Teplensky *et al.*, 1995; Goldstein *et al.*, 2002; Coye and Kell, 2006; Blank and Hulst, 2009). However, while the healthcare industry is doing what it can do best in a market place (the ethic of business) it has run away from the cooperation needed to achieve the right to healthcare. An example can be made of Zimbabwe during the COVID-19 pandemic period of 2019 to 2020 where the cost of PCR COVID-19 testing per employee

was around 70USD, This was twice the average salary of a government school teacher at the time of writing this thesis (Gibbs, 2020; Silas Nkala, 2020). This became completely unattainable and many companies were unable to comply with the statutory requirement of mandatory COVID-19 testing (Chihambakwe, 2020). Situations like these clearly further compromises access to HC in an environment already beset with severe deprivation.

Finally, the perspective of health as a social good dictates that we accept that a healthy population does more to contribute to society's wellbeing by being productive and creating wealth. A healthy person is more desirable in society than a sick person. The discussion inevitably trickles down to debating how much should we spend on healthcare as opposed to other social services like police, army, education, and politics. It is about equality in the provision of social services such as healthcare, not just for the individual but to society as a whole. Egalitarian moral philosophy has an important application in social justice and the distribution of social goods such as access to healthcare. It is not without its criticisms but it is quite coherent to the extent that it should be taken as a serious moral theory that can stand its own against other normative moral theories. African communitarianism, best epitomized in Ubuntu/Hunhu, is slowly emerging as a credible indigenous moral philosophy that should be applied to solve local challenges. Ubuntu will be discussed in chapter 7.

The way healthcare is being delivered (or not being delivered) to citizens in Zimbabwe is a clear travesty to the stated positive moral right as envisaged in the legal and common moral understanding of the obligations expected of the State. Each and everyday citizens are being denied access to adequate healthcare of a higher quality and quantity as they go back home to die in their communities without dignity (Munyaradzi, 1979; Andrew, 2015a, 2015b; Nyakudya, 2016; Moyana, 2017). To satisfy this moral demand a new healthcare model is needed to ensure citizens access not only the basic minimum of healthcare services but also

services of the highest quality possible. This is the driving line of argument and exact purpose for the proposed CCHM.

6.7 Chapter Summary

Chapter 6 has looked at the ethical philosophy of Egalitarianism, which is very important in understanding issues of justice, fairness, and equality in the distribution and access to healthcare resources. Egalitarianism is also important in our efforts to reform or design a healthcare system that is both responsive to the special needs of the poor as well as redressing past imbalances. The chapter discussed the historical development of Egalitarianism, various types/forms of Egalitarianism including an in-depth discussion on Luck Egalitarianism. Various arguments for and against Egalitarianism were presented. The chapter ended up by outlining ethical implications of Egalitarianism for healthcare. The principles of Egalitarianism will be applied to the design of the Citizen Centred Healthcare Model (CCHM) in chapter 9. The next chapter focuses on the ubuntu moral philosophy and its potential application to the design and implementation of the CCHM. Ubuntu moral philosophy proposes what appears to provide a much-needed tempering of utilitarianism and an augmentation of Egalitarianism.

CHAPTER 7: UBUNTU/HUNHU

7.1 Introduction

Communitarian moral philosophy has always been at the centre of Africa's social, economic, jurisprudential, and religious conception of an individual's and community life. One such philosophy is the Ubuntu/Hunhu philosophy, which is undoubtedly a prominent ethical paradigm that has been touted as probably the most influential in sub-Saharan African moral discourse. Unless otherwise specified Hunhu will be taken as a synonym of Ubuntu in this manuscript. There is now a wide collection of literature on the conception of Ubuntu, much of it having exploded into life after the end of apartheid in South Africa in 1994. The ushering into being of multi-party democracy in South Africa seemed to have galvanized the world to explore the moral philosophy of Ubuntu and give it the much-needed respect that it appeared to lack over the centuries (Hailey, 2008a). The influence of South Africa's democratic journey on the re-awakening of the ubuntu moral philosophy is probably due to South Africa's diversity, famously referred to as the *rainbow nation* (Habib, 1997; Baines, 1998; Barnett, 1999; Evans, 2010). While the prominence of Ubuntu appears to be closely related to South Africa, it has a much wider implication both in the wider African context as well as to a growing world view. Its influence spans all aspects of human endeavour including religion, economics, education, management and healthcare policy. This chapter will explore the historical basis of Ubuntu and its related underpinnings and how it has shaped African and world views. It is important to explore how this moral philosophy can stand up to mainstream western philosophical thought such as Utilitarianism and Egalitarianism, so that it can be properly credited and applied in shaping the ethics of access to healthcare. Secondly it is important to explore and describe any differences and

convergences between it and Egalitarianism as seen from an Anglo-Saxon paradigm versus African Egalitarianism. Ubuntu is arguably one of the most significant prototypes of African Egalitarianism (Metz, 2015). Importantly this chapter endeavours to explore the application of ubuntu philosophy to the design of healthcare policy, with special reference to the effort to create a healthcare model which is both ethically justified and relevant to the Zimbabwean scenario.

7.2 Roadmap for this Chapter

This chapter will explore the divergent definitions of Ubuntu so as to properly locate its meaning in the correct context with regard to healthcare. In the opening part of this chapter, in section 7.3 I discuss the meaning of Ubuntu as a moral philosophy. Various dimensions of Ubuntu are explored, including the various ubuntu dialects through which Ubuntu is known in various tribal and ethnic groups of sub-Saharan Africa. A short description of Hunhuism as a Shona or Zimbabwean variant of Ubuntu is provided. This detailed description of Ubuntu demonstrates the near universality of this moral philosophy in Africa. No moral philosophy is without its own weaknesses and criticism and as such in section 7.4 I provide a summary of the most significant criticism of Ubuntu. In section 7.5 I will look at the application of ubuntu philosophy in shaping improved access to healthcare and its ethical implications to healthcare policy formulation, healthcare system design and reform such as the CCHM discussed in chapter 9.

7.3 What is Ubuntu Moral Philosophy?

Before Africans started a re-awakening and embarking on celebrating the indigenous philosophy of Hunhu or Ubuntu, Communitarianism was already a powerful moral theory accepted and promoted by the Westerners (Samkange, 1980). Perhaps traditional medicine

fits well with Ubuntu 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 in Ubuntu. 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 (e.g. medical aid, medical schemes, and medical plans).

Ubuntu is a form of communitarian philosophy. Beauchamp and Childress (2009) characterise Ubuntu as a form of Communitarianism as follows:

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).

Ubuntu has been associated with the peoples of Africa, south of the Sahara for many centuries. Its origin is full of mystery and ambivalence. Ubuntu is an elusive concept because it carries so many shades including such meanings as humanness, friendship, respect, sharing, community and caring. Its origin is not easily traceable. It has been despised for many centuries by some due to the presumed superiority of western philosophical thought and practices which found their way to Africa during colonialism (Cilliers, 2008; Oppenheim, 2012). While Ubuntu is an African moral philosophy, much of the written scholarly work has been done in the recent decades. This recent surge is explained as being partly due to the past historical suppression of creative ideas about ourselves arising from colonial domination. Paradoxically a lot of the scholarly works on Ubuntu have actually been written by people from Europe. The culture of writing among Africans has taken quite long before it got established among them (Gade, 2011). It can be argued that the emphasis has traditionally been on the oral tradition- not written form. This has made Africans lose some of their knowledge systems.

According to Chimuka, many scholars have tended to concentrate on the ethical aspects of Ubuntu at the expense of other important aspects such as epistemology and metaphysics (Chimuka, 2015). However, others see Ubuntu as a foundation for nation-building, as an African perspective of life and worldview, a spiritual fortress, a leadership model and managerial paradigm underpinned by superior moral motivation rather than monetary gain (Sigger, Polak and Pennink, 2010; van der Walt, 2010; Nkhata, 2011; Oppenheim, 2012). Ubuntu has a wide geographical coverage from the Zulu and Sotho Nguni cultural groups of South Africa to Kenya and the Democratic Republic of Congo. It would be inaccurate to confine it to the Bantu/African Nguni tribes of South Africa alone. This is important to explain the Pan-African nature and world-view appeal of Ubuntu, even though more interest in the Ubuntu philosophy appears to have been generated in South Africa's post-apartheid era.

7.3.1 Defining Ubuntu

Defining the term Ubuntu is not an easy exercise. The word Ubuntu has a lot of phonological variations among many African languages and dialects. According to Kamwangamalu, from a language analysis the word Ubuntu is made up of a pre-prefix: *u*, the abstract noun prefix: *bu* and, the noun stem-*ntu*, which means person (Kamwangamalu, 2013). All this taken in totality means personhood or humanness (Shutte, 2001; Hailey, 2008a; Ntamushobora, 2012; Dolamo, 2013). In some African languages Ubuntu is simply equated to quality rather than being a noun. Also in many African dialects such as in Swahili, Luhya and Kinyarwanda the concept of quality begins with vowels 'u' or 'o' (Ntamushobora, 2012). For example:

...Ubuntu is the quality of umuntu which is only possible when the umuntu does what Tutu describes in his first definition: [is] warm and generous.... knows that they are diminished when another is humiliated. So, Ubuntu is what makes a person able to differentiate themselves from other ntu (beings). This quality of humanness-though essential to individuals-is perceived in relationship. Only in relationship can Ubuntu manifest itself. And so, for example, a person who kills his or her neighbour would be

said “to have become like an animal.” Or if a person is not ashamed of doing evil, ... (Ntamushobora, 2012, p. 3).

There are diverse usages of the term Ubuntu and its synonyms in the bantu linguistic settings of the people of Africa, south of the Sahara. The reader is referred to published sources for further details (Hailey, 2008a; Dolamo, 2013; Sambala, Cooper and Manderson, 2020).

Ubuntu is viewed as ambivalent by some (Hailey, 2008a), as well as being omnipresent in many of the Bantu cultures of sub-Saharan Africa, where it takes many shades and spheres (Ramose, 2002). Different dictionaries give varying definitions of the same concept of Ubuntu. For example, the Collins English dictionary and the Oxford Dictionary both give different definitions of the same term (Hailey, 2008a). An attempt to translate it into English is an equally daunting task. Different strategies in trying to define Ubuntu have been used. These range from the use of legal language to anecdotal or personal approaches such as that used by Desmond Tutu when he said *when Ubuntu is present you feel it and likewise when it is not there you also feel the obvious absence of it* (Tutu, 1999). He sees Ubuntu as being completely and truthfully human and that you are inextricably fused and amalgamated to other people in a life bundle. He goes on to say Ubuntu is the epitome and essence of being human, a precious gift given to the world by and from Africa.

In Tutu’s conception of Ubuntu, a person is a person because he belongs, he is part of a whole, he is not an island. His concept depicts Ubuntu as full of compassion, wellcomingness, hospitality, warmth, generosity, and willingness to share even the little we have. A person with Ubuntu is full of openness, affirmation and availability to others. Ubuntu makes you feel secured and willing to be vulnerable because you know you belong to the wholeness of the community in which you live and from which you come (Tutu, 2011).

Tutu’s conception of Ubuntu is consistent with many other writers and scholars on Ubuntu. For example, Metz has highlighted a similar interpretation of Ubuntu. He characterizes

Ubuntu as focused on nurturing community harmony. He says Ubuntu produces essential recurrent themes: (1) *an obligation for a moral concern for the upliftment of the good of the community and others-solidarity* (2) *an obligation to see oneself as a moral agent who thinks of oneself as part of the community, bound by their practices and to participate in those practices-identity* (Metz, 2011b). Solidarity and identity form the cornerstone of community or harmony, according to Metz. This concept of Ubuntu as espousing community harmony has been corroborated by many other writers such as Dandala, Ramose, Tutu, Samkange, and Gade (Samkange, 1980; Dandala, 1996; Ramose, 1999, 2002; Tutu, 2007, 2011; Gade, 2011, 2012).

It would be a mistake to view Ubuntu as simply conformity to what the majority wants or adherence to the group norms, as is the case with similar influential forms of relativism and Communitarianism in western normative philosophy (Metz, 2011a). The correct interpretation is that nurturing or respect for community harmony is a purposeful desired method of interaction and alternatively guiding what the majority want as well as defining the dominant norms. Metz uses a useful metaphor in relation to actions and behaviour under Ubuntu, which he calls *a construct*: “...actions are wrong not merely in so far as they harm people [Utilitarianism] or degrade an individual’s autonomy [Kantianism], but rather just to the extent that they are unfriendly or, more carefully, fail to respect friendship or capacity for it...” (Metz, 2011b, p. 540).

African societies have unique moral codification of their interactions. According to Metz (2011b) African societies are understood as “comprehending of communal relationships as a desirable type of interaction that should serve as a guide of what majority want and which norms become dominant” (p.538). As a philosophical concept, Ubuntu captures the centrality of a community to the existence of a person (*munhu, umuntu*). It is almost impossible to

define Ubuntu without invoking the Nguni/Ndebele phrase *umuntu ngumuntu ngabantu* (*a person is a person through other persons*)(Ramose, 1999).

While everyone is born a human being, it is not automatic that they acquire humanness unless they undergo the process of socialization. This underpins the importance of the community and the togetherness that it brings. Therefore, Ubuntu cannot exist outside the community and its relationships. From birth, a person is integrated through the community and its nurturing until they acquire their humanness and dignity, which is eternally protected by their continuing observance of the dictates of that or any community (Bujo, 2001; Ng'Weshemi, 2002; Dolamo, 2013). This is part of Ubuntu which I find very useful and appealing in my design and formulation of the CCHM to be presented in full in chapter 9. A healthcare system or model ought to foster mutual beneficial relations, create community togetherness and promote health and wellbeing. It cannot do these things if a healthcare system is not access, affordable and effective. This is the running thread, argument and purpose inherent in the design and conception of the CCHM.

7.3.2 The many Dimensions of Ubuntu

Ubuntu has both philosophical and theological perspectives to it. From a philosophical perspective, it is seen as a world view from which many aspects of life are evaluated and arranged. Nyathu describes it as both a foundation, fountain, and backbone on which African societies are premised. According to him without it, one cannot qualify to be human because it embodies the fundamental ingredients of humanness (Nyathu, 2009). The philosophical dimensions of Ubuntu have been described and discussed variously in so many eloquent ways. This ranges from being a competitive worldview that can stand its own against the mainstream western philosophical paradigms such as Utilitarianism, Deontology, Social Contract Theory, and many others (Murithi, 2006). Dandala characterizes Ubuntu as a

cosmology embedded with the capacity to imbue *harmonic intelligence*, a feature that is part of the building blocks of local South African cultures. He sees Ubuntu as essentially opposed to western philosophical paradigms which tend to favour individualistic and competition goals; unlike Ubuntu which focuses on the display of the following to one another: *humanness, caring, sharing, hospitality, and respect* (Dandala, 1996). Echoing the cosmopolitan nature of Ubuntu Mangaliso explains Ubuntu as a philosophy for the wider human system capable of fostering and promoting genuine harmony and continuity (Mangaliso, 2001).

Ubuntu as a philosophy has long been established as an African philosophy mainly associated with the indigenous African cultures of Bantu descent, fostering family kinship and philosophical identity (Ramose, 2002). However, there are isolated cases outside the Bantu ethnic. For example, a concept similar to Ubuntu, called *Teranga*, exists in Senegal. Over years the concept of Ubuntu has influenced many contemporary settings in the world including film and arts, sport, politics, the United Nations business and conferences, religion, business and marketing, and music (Hailey, 2008a; Douglas, 2009; Negus, 2013; Mosher, 2014; Curle, 2015).

Even though Ubuntu is seen as and has been illustrated to be a fundamental philosophical bedrock of African thinking and practice, it is not without criticism. Some of the condescending criticism comes from none other than the expected quarters-the western philosophical paradigms. The traditional negative perception about Africa in the western culture has also rubbed onto the stereotypical reflections on Ubuntu. This is partly due to the deliberate misunderstanding about Ubuntu as a result of its dependence on the oral traditional nature of African accounts as well as the lack of written discourses on Ubuntu (Nussbaum, 2003).

Ubuntu also has a theological dimension to it. While some see it as a great humanistic model or a cosmological explanation of existence others see it as a fundamental religious springboard for the *umuntu* (Prinsloo, 1995; Louw, 2006). There is growing convergence of ideas and agreement on the synergy and closeness between Christianity and Ubuntu. Tutu is credited with popularizing the transformational concept of ubuntu theology, whose cornerstone is rooted in an ethical responsibility guided by a shared identity (Hailey, 2008b). As human beings under the ubuntu theology doctrine, we have a collective obligation to alleviate other people's suffering from, for example, hunger, disease, and social deprivation. Desmond Tutu's political contribution to the South African post-apartheid reconciliation project through the *Truth and Reconciliation Commission* is often cited as the epitome of the ubuntu theology, which he preached and wrote about extensively (Tutu, 1999, 2007, 2011; Tutu and Abrams, 2005; Riggle, 2007). Tutu merged the traditional African religious aspect of Ubuntu with Christianity to produce a transformative cross-cutting theological interpretation which he used to advance his belief that we are persons because in Ubuntu humans were made in the image of God (Battle, 1997). The creation story in the bible (Genesis) is touted as how Tutu illustrates the communal and belongings of the Ubuntu philosophy. God added or created Eve because He abhorred the loneliness of Adam. Man was never meant to live a solitary life, according to the depiction of Tutu's interpretation by Battle (1997). So as early as the creation of the first human beings, Adam and Eve, God realized the need for interdependency among and between persons. This concept was extended to apply among communities (Battle, 1997, 2000).

Tutu's Ubuntu theology can be summarized into four main areas (Battle, 2000; Hailey, 2008a):

- Interdependence is built between different communities, and this enables us to discover and strengthen who we are.

- Different or distinct identities and that we should accept and celebrate that God made us different in his image.
- Ubuntu, as a powerful and the best of African philosophies, is combined with the best of western values to produce a new and unique theology.
- Tutu used this new and unique Ubuntu theology to address the vagaries of the post-apartheid society.

In Tutu's Ubuntu theology humans are not seen in isolation but as part of the means. This sounds very similar to Kantian principles, specifically Kant's construction and interpretation of the categorical imperative:

Kant, unlike Mill, believed that certain types of actions (including murder, theft, and lying) were absolutely prohibited, even in cases where the action would bring about more happiness than the alternative. For Kantians, there are two questions that we must ask ourselves whenever we decide to act: (i) Can I rationally will that everyone act as I propose to act? If the answer is no, then we must not perform the action. (ii) Does my action respect the goals of human beings rather than merely using them for my own purposes? Again, if the answer is no, then we must not perform the action (Elizabeth Anscombe, no date).

According to Desmond Tutu, the oppressor has a humanity in need of restoration. The oppressed must assist the oppressor to be accepted and seen together with the oppressed or formerly oppressed as friends under one God. This position has been echoed and corroborated by other writers as well. Ntabushobora agrees with Tutu but gives a caveat which says that the fact that Ubuntu theology accommodates the oppressor does not mean it condones evil. According to him only an integrated conflict management approach such as offered through Ubuntu theology gives sustainable results because it counts both oppressor and victim as children of God who were made in his image (Ntamushobora, 2012).

7.3.3 Hunhu as a Shona (Zimbabwean) Translation of Ubuntu

In this section, I take a closer look at the Ubuntu from a Zimbabwean perspective.

Hunhuism is a Shona equivalent to Ubuntu, popularized by Stanlake John William Thompson Samkange. He was the first Zimbabwean Professor of African History. He presented a position which says Hunhuism may be viewed as an advanced and yet not an adequately acknowledged social setup favouring communal harmony (Samkange, 1980; Gade, 2011, 2012). Hunhuism is a Shona translation of Ubuntuism which means: “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...” (Samkange, 1980, p. 89). Samkange advocated Hunhuism as an indigenous political philosophy of the Nguni and Shona tribes.

7.3.4 Egalitarianism from an African Perspective

In this section I endeavour to answer the following questions:

- i. Is there an argument for an African Egalitarianism?
- ii. If so what form does it take?
- iii. How does it compare to the mainstream or Anglo-American perspective of Egalitarianism?

Due to the paucity of published material on this subject, I draw much of my material from Thaddeus Metz, a celebrated proponent, defender, and distinguished writer on African Egalitarianism. The main foundational theories upon which Egalitarianism is built are the mainstream western philosophical thought such as Kantianism and Utilitarianism. This has led to major eclipsing and overshadowing of what would have been an eminent African egalitarian position. As a result of this overshadowing by western philosophical thought, many of the economic and distributive principles in use are influenced by these western positions (Hull, 2015). It's unfortunate that due to differences between western philosophical and African thought on Egalitarianism many of the potential benefits from the latter have not been realized.

African Egalitarianism is also defined as *Afro-Communitarianism* in comparison to western-based egalitarian thought largely biased towards luck Egalitarianism and Kantian Egalitarianism (ibid.). Metz and others argue that African Communitarianism, which is being equated to Egalitarianism in this section, must not be seen as inferior to the largely individualistic liberal position of the western egalitarian thought simply because it puts the interests of the whole community above individual liberty (Metz, 2011b, 2011a, 2020). In the Bantu and Shona linguistic expressions of southern Africa and Zimbabwe respectively, an element of personhood has always embodied a communitarian and egalitarian perspective. An example is the saying ‘*munhu munhu ngavanhu in Shona or umuntu muntu ngabantu*’ in Xhosa (Samkange, 1980; Bhengu, 1996; Mabovula, 2011). It is not in dispute that African Communitarianism embodies an element of economic Egalitarianism, but what scholars differ on are the extents to which African Communitarianism offers serious competition to its nemesis-the Anglo-American Kantian and utilitarian-inspired Egalitarianism. For example, Metz goes further to say that African Communitarianism does not just have an economic egalitarian element embedded in it, but goes further to honour collective and communitarian values as well (Metz, 2020).

Metz makes a strong case by arguing that African Communitarianism more than adequately accounts for Egalitarianism by not only catering for libertarian values such right to freedom, voting, equality before the law- but also caters for economic equality (Hull, 2015). In particular, he cites two major areas of economic equality as: “...equal chances at positions such as education and jobs, on the one hand, and at possessions such as money, personal property and services, on the other” (Hull, 2015, p. 191).

While this may sound like an exact duplication of how the western moral philosophy on Egalitarianism looks at the same issues, there is actually a difference in the motivations. Attainment of economic equality as seen from an African communitarian moral perspective is

primarily not the satisfaction of the individualistic needs but the communitarian collective good at the end. For example, an asset such as a lorry or a dip tank is only more useful and accepted when its utility is shared among the community members. A lorry belongs to all the in the community. They anticipate benefiting from it as if they own it collectively.

There is a prima facie case for the acceptance of an African moral theory as a serious philosophy to enable the world to see issues differently, particularly when it comes to resource access and allocation by the state such as access to healthcare. I agree with Metz that the African communitarian moral philosophy is compatible with an idealistic position on access to healthcare as a collective social good. It is for this reason that I recommend that it be taken into account when designing or reforming healthcare systems such as the CCHM.

7.4 Criticism of Ubuntu

Ubuntu is not universally accepted. As is the case with many moral theories, it has its own critics too. The main areas of criticisms are that Ubuntu is a vague moral philosophy and that it sacrifices individual liberty or freedom for the promotion of group cohesion.

A lot of literature appears to be neutral or positive on their assessment of Ubuntu as a moral theory that can stand up against others very well. However, others cannot be ignored because they raise valid criticisms and arguments against Ubuntu. This body of literature, while it appears to be drowned out by the proponents of Ubuntu, does highlight the dangers of promoting Ubuntu in the community (Hailey, 2008a). Dirk Louw (quoted in Hailey 2008a) paints a gloomy picture of Ubuntu. He says Ubuntu is totalitarian Communalism that suppresses the individual and unnecessarily elevates the community above the individual. In such cases retrogressive culture is celebrated, continuity is prioritised at the expense of accepting change and a critical or questioning paradigm.

Ubuntu is further criticised as being restrictive or constrictive and tyrannical in nature by not accepting anyone beyond the community accepted norms. The conformity demanded by Ubuntu can be oppressive and the group loyalty- blind. Failure to conform to group norms can be met with disdain and ostracism. Even one of the greatest proponents of Ubuntu himself, Archbishop Desmond Tutu laments that Ubuntu is sometimes excessively encouraging conformity and conservatism (quoted in Battle, 1997). Ubuntu is also criticised as having been invented to serve a new nationalism rooted in cultural distortion to stifle public dissent. This new cultural nationalism is nothing more than an effort to reincarnate a fractured and tired precolonial cultural paradigm that is no longer relevant to the modern era (Marx, 2002).

Some argue that Ubuntu must not be touted as anything unique at all. Ubuntu does not have anything extraordinary to use as guidelines for policy and action formulation. Many of the ingredients for effective community development are actually universal. These include democracy, civil society participation, and citizen activism. They are not unique to Ubuntu and there is no justification for the over glamorisation of Ubuntu as a moral philosophy or as a guide to building of nations and development of communities (Enslin and Horsthemke, 2004). I am of the firm belief that on balance Ubuntu emerges triumphantly over its critics and I propose that it has a useful impact. In support of this conclusion, I lay out a detailed potential application of Ubuntu in the section that follows.

7.5 Ubuntu Philosophy Values and an Improved Access to Healthcare

There is an acknowledged potential tension between the libertarian individualism of the right to health against the public health approach of putting the collective good of the majority ahead of the individual rights. The Ubuntu philosophy presents an alternative narrative to the

all-familiar western, dominant philosophy of individualism by justifying how people are valued and made inseparable from their communities (London *et al.*, 2015). Ubuntu has the potential to provide a countervailing non- Eurocentric human rights paradigm that emphasizes solidarity and inclusivity as well as addressing the tension between human rights demands against the traditional utilitarian perspective of public health. The element of sharing and co-existence is an important ethical principle in the formulation and motivation for the CCHM.

Prozesky uses 10 qualities that aptly describe the overall value of Ubuntu and are useful in guiding the design of CCHM for Zimbabwe. These 10 values are: *Humanness, Gentleness, Hospitality, Empathy or taking trouble for others, Deep kindness, Friendliness, Generosity, Vulnerability, Toughness and Compassion* (Fieser and Dowden, 2011). A number of writers do agree on the overwhelming benefits and value of Ubuntu's countervailing position to the mainstream western philosophical paradigm (Samkange, 1980; Tutu, 2007; Ramose, 1999, 2002; Tutu, 1999; Riggle, 2007; Hailey, 2008b, 2008a; Metz, 2011b, 2013, 2020).

Himonga proposes four important principles through which Ubuntu can be applied:

- a) Inclusion of Ubuntu into the international human rights practices as an African-inspired and dignity-based principle.
- b) Inclusion of Ubuntu into the rights normative framework. The elements of duty and peoples' rights in the African Charter on Human and Peoples' Rights of 1986 are a good starting point.
- c) There is a good argument to illustrate that South African has already set a good precedent by incorporating Ubuntu principles in its interim Constitution of 1994 as well as in its court rulings.

- d) A strong argument can be made that Ubuntu has attributes of solidarity and interdependence which are capable of creating harmony between individual rights and health entitlement by the community with dignity. International rights need to be localized into vernacular and Ubuntu is one way through which this can be achieved. Ubuntu is an illustration of how rights can never be individual nor be wholly collective (Himonga, 2013).

Hailey (2008) identifies five areas of general application for Ubuntu after she reviews available literature: “Valuing individual identity and the community, Ubuntu’s role in community building, Ubuntu’s role in promoting collective work and consensus, Ubuntu’s potential role in conflict mediation and reconciliation and Ubuntu’s role in supporting organisational effectiveness and productivity” (*p.7 to 17*)

7.5.1 Valuing individual Identity and the Community

This is one of the most important aspects of Ubuntu due to its emphasis on collective identity in which an individual is subservient to community interests. An individual’s fullness and potential are only realised in a relationship with others, not in isolation from them. Unlike in the western libertarian or Egalitarianism paradigms, Ubuntu does accept the co-existence of a multiplicity of relations that allow individuality as well as cooperation (Ramose, 1999, 2002; Shutte, 2001; Louw, 2006).

7.5.2 Ubuntu’s Role in Community Building

Perhaps one of Ubuntu’s most influential aspects is its advocacy for community building. It's potential for capacity to instil community cohesion, underpinned by compassion, dignity, humanity, equity, justice, mutual support, and respect (Nussbaum, 2003). Unlike what is found in some of the western moral paradigms Ubuntu focuses on the “we “rather than the

“I”, a factor that is critical in accomplishing community goals as a group (Battle, 1997, 2000; Louw, 2006).

7.5.3 Ubuntu’s Role in promoting Collective Work and Consensus

Working together and consensus building is a paramount aspect of any healthcare reform. Ubuntu moral philosophy is credited with an aggressive promotion of these aspects. Through Ubuntu African societies have learnt to survive harnessing collective effort rather than individualism (Battle, 1997, 2000; Mangaliso, 2001).

7.5.4 Ubuntu’s Potential Role in Conflict Mediation and Reconciliation

The impact of successive healthcare professionals’ job actions over the years, coupled with a chronic shortage of drugs and supplies in public hospitals has created a “conflict” in Zimbabwe society (Diana, 2014; Brief, 2019; GardaWorld, 2019; Muronzi, 2019; McCoy, 2020; Ndhlovu Ray, 2020). This conflict emanates in part from the fact that the rich and political elite continue to access high-quality healthcare at the State’s expense, including foreign medical trips (Muzulu, 2015; Tendai, 2017, 2019). The same State is not allocating sufficient healthcare resources to enable the general public to access the same. If the state of healthcare in Zimbabwe is accepted as being in a conflict mode, as it should, then Ubuntu moral philosophy has a huge role to play (Mandela, 1994; Battle, 1997, 2000; Oppenheim, 2012).

7.5.5 Ubuntu’s Role in supporting Organisational Effectiveness and Productivity

Any new healthcare model, such as the Citizen Centre Healthcare Model (CCHM) being proposed in Chapter 9 of this thesis, ought to create a new organisational culture laden with effectiveness, efficiency, and productivity. The tax revenue allocated to the cause of healthcare delivery

must produce value for money to the consumers. Ubuntu has already proven to be potent moral philosophy in that regard (Jackson, 2004; Fink *et al.*, 2005).

7.5.6 Section Summary

Public health philosophy is collective in nature as opposed to the individualism of rights espoused in the mainstream western human rights paradigm (London *et al.*, 2015). This is where an African moral philosophy of Ubuntu comes in to bridge the gap. Ubuntu is a philosophy that gives a different perspective on the exercise of rights in that it promotes a collective sharing of obligations and responsibilities communally without overly relying on formal jurisdictions like courts, much similar to Liberal Egalitarianism. Rather than viewing the experience of Ubuntu as a debate of individuals versus collectives, it should be considered an expression of solidarity (Dandala, 1996; Battle, 1997; Hailey, 2008b). The right to health can be promoted to and through collectives, not individuals therefore an Ubuntu paradigm is needed to nurture the harmony between and within communities. This is one of the positive ethical aspects of Ubuntu which would enrich and guide the CCHM described in full in chapter 9.

The Ubuntu value has kept many communities together for many centuries and it needs to be rekindled or strengthened not as a new moral fabric but as a renaissance of what has worked for us before (Gathogo, 2008; Chimuka, 2015). Ubuntu is an example of a communitarian moral philosophy which may appear to play a marginal role to the so-called mainstream western moral-philosophical thought, and yet it is a very powerful normative philosophy that is slowly rising to take up its rightful place in the world (Battle, 2000; Tutu and Abrams, 2005; Hailey, 2008a; Metz, 2010, 2013, 2015, 2016, 2020). It is gradually shedding the stigma of backwardness wrongly associated with African culture. Ubuntu is a near-universal communitarian ethic in sub-Saharan Africa, with a wide ethnic vocabulary in countless

African languages ranging from the Nguni languages spoken in southern Africa to other Bantu-related languages of East, West, and Central Africa. Though not without its own criticism, the application of Ubuntu philosophy to solve societal challenges such as the healthcare challenges confronting Zimbabwe has vast potential in areas ranging from business, agriculture, education, management, public health, and politics (Mbigi and Maree, 1995; Jackson, 2004; Louw, 2006). Rather than viewing the experience of Ubuntu as a debate of individuals versus collectives, it should be considered an expression of solidarity (Dandala, 1996; Battle, 1997; Hailey, 2008b). The right to health can be promoted to and through collectives, not individuals therefore an Ubuntu paradigm is needed to nurture the harmony between and within communities. The Ubuntu value has kept many communities together for many centuries and it needs to be rekindled or strengthened not a new moral fabric but as a renaissance of what has worked for us before (Gathogo, 2008; Chimuka, 2015).

7.6 Is there a Conflict between Ubuntu, Utilitarianism and Egalitarianism?

Is there a conflict between the moral theories of Ubuntu, Utilitarianism and Egalitarianism? If there is a conflict, how can that conflict be resolved so as to select the positive aspects of each moral theory for application in the design of the CCHM, without running into a conceptual gridlock or conflict? If we want to draw on the positive aspects of each of those moral theories, then some additional justification and support needs to be given for why, given the challenges, those principles or insights still stand and so can justifiably be drawn on for the ethical framing of CCHM.

In this section I present a justification on why all the three moral theories have complementary aspects which strengthen rather weaken the moral foundations for a CCHM. Depending on which angle you are coming from there seems to be a potential conflict

between the perspective of the public health approach espoused in Utilitarianism, collective sharing and communitarianism in Ubuntu on one hand and the exercise of individual rights implied in the Egalitarianism moral theory on the other. However, we need not over play this potential conflict because each of these three moral theories have useful and complementary attributes which when taken together, makes for a vibrant and effective healthcare model. It is this usefulness and complementarity that I argue would be needed for a successful CCHM.

An important aspect of Ubuntu which naturally finds resonance with the proposed CCHM is its emphasis on collective identity in which an individual is subservient to community interests while his/her fullness and potential are only realised in a relationship with others, not in isolation from them. Taken in its holistic aspect Ubuntu does accept the co-existence of a multiplicity of relations that allow individuality as well as cooperation and for this reason it is not in conflict with Egalitarianism and Utilitarianism.

On the other hand, Utilitarianism is both intuitive and simple in analysis because of its reliance on a single principle of utility. The potential for calculating utility do give an advantage of simplicity and clarity while assisting in decision making, unlike if we only relied upon moral principles like the right to information, autonomy, and equity which are not easy to be put into the calculations. Utilitarianism derives its simplicity from its association with the maximization of the good in the world. In our everyday lives we continuously weigh benefits against potential adverse outcomes in order to choose a better course of action. Utilitarianism is an impartial ethical theory which treats individuals fairly, even when applied to political and social decisions.

In addition, Utilitarianism is a powerful weapon justifying the redistribution of resources and power from the hands of a few so as to benefit the majority. This is the main aim of Public Health. When we redistribute resources and power from those with excess to the majority

who need them badly, we achieve maximum utility. This is so because there is an element of diminishing marginal utility when excess resources are left concentrated in the hands of those with excess. Those with excess get to a point where they no longer derive much utility from excess resources and power in their hands. Whereas those without benefit more from the same resources and power if they are made available to them. Healthcare is a resource whose access is often elusive to the majority of the poor. This is where the CCHM comes in. On this basis I argue that Ubuntu and Utilitarianism moral theories are not only without conflict, but are absolutely complementary to each other. Egalitarianism emphasizes the common good while Ubuntu and Utilitarianism focuses individual autonomy, right to privacy and liberty. Both these positions are important for a healthcare model to be balanced. We need both maximisation of population health and reduction of inequalities in healthcare access. A just healthcare model may not be achieved without a balance between protection of individual autonomy and maximisation of population health through resource redistribution.

7.7 Chapter Summary

This chapter has defined and described the concept of Ubuntu as a moral philosophy. It brought out the many dimensions of Ubuntu, including Ubuntu translated into Shona as Hunhuism. Shona is one of the main dialects spoken in Zimbabwe. Progressive aspects of Ubuntu were highlighted in the section dealing with ethical implications in so far as they can be harnessed to design programmes focused on improving access to healthcare such as the CCHM discussed in chapter 9. The next chapter will look at different healthcare systems. Though not explicitly spelt out in some of the healthcare systems the impact of Ubuntu philosophy ought to be incorporated because it has a strong and persuasive aspect to it. It is important to develop this influence of Ubuntu in the design or reform of any healthcare system and the CCHM will not be an exception.

CHAPTER 8: HEALTHCARE SYSTEM MODELS

8.1 Introduction

An ethically justified model for access to healthcare in Zimbabwe cannot be complete without an in-depth description and critical analysis of various current or conventional healthcare system models (HCSMs). This chapter focuses on healthcare system models, their typologies, similarities, differences, and where applicable their bioethical implications to HCSMs in general and to the CCHM in particular. The main areas of description and critique are financing, organizational structure, effectiveness, strengths, weaknesses and bioethical implications. It is important to define and characterize conventional health systems so as to build *from the known to the unknown*. This description and analysis of HCSMs is done to assist us in evaluating which one(s), or combination thereof, best suited to the needs of crafting the CCHM for Zimbabwe. Based on the numerous health challenges besetting Zimbabwe, it is definitely a country in desperate need of a new or reformed healthcare system that enhances access, fairness and efficiency.

8.2 Roadmap for this Chapter

This chapter is organized into sections, each focusing on a specific subtheme. The chapter will take off with a lengthy discussion on the conception of a HCSM in section 8.3. Various approaches to defining HCSMs will be described. Various conventional HCSMs will be discussed with the bulk of the chapter dedicated to the most common models of Beveridge, Bismarck, National Health Insurance/service, Out of Pocket Spending, Traditional medicine, and Emerging models. Londono and Frenk's (1997) Classification of Healthcare systems models is given a lengthy discussion for their innovative classification. Various definitions of

a HCSM are discussed including those according to Londono and Frenk (1997) et al, Hurst (1991), and the World Health Organisation (2007). Section 8.4 goes into detail on explaining the concept of healthcare and health system models and the distinction between the two. It discusses different types of HCSMs, highlighting their various strengths and weaknesses.

8.3 What is a Healthcare System?

The concept of a healthcare system is not new as it goes back several centuries. The struggle to have some sort of healthcare system is tied to humankind's struggle to protect their health and treat disease. Health systems are not value-free, and as such, they are a contested terrain shaped by political and social forces in a milieu of national and international dynamic value systems (World Health Organization, 2007). However, a serious effort to have organized healthcare systems is only about 100 years old, epitomized by the *Alma Ata Declaration of 1978* and its mantra or famous principle of *Primary Healthcare* (PHC) (Gillam, 2008; Sanders, Schaay and Mohamed, 2016). The agenda and thrust to reform healthcare systems are not stationary or static. This is a very dynamic process. This is so because the disease patterns (epidemiology) are changing and modalities of care and treatment are changing as well and so are the national and international economic factors. For example, new drugs, vaccines and health technologies and systems are being discovered every day. All these new developments have an impact on health financing, staffing, training and healthcare delivery approaches. The most notable recent shock to the world healthcare system is the COVID-19 disease of 2019-20. This novel pandemic disease shook the whole world, shutting down and collapsing whole healthcare systems- even the more resilient, robust, and well-financed ones. The disease is alleged to have started from a province in China, and in no time it spread all the way from the east to as far as Africa, South and North America.

A healthcare system is defined variously depending on the circumstances at hand. This lack of consistency and enduring ambiguity has created confusion and inertia in public health policy (Hsiao, 2003). And yet it is desperately critical that a working definition be found so that policy makers derive value from comparisons of different healthcare systems to adopt the beneficial aspects of different systems. If we do not adequately describe and define the different healthcare systems, we won't be able to extract the essential structural and operational differences to improve or reform existing programmes and models. Over many years a healthcare system (HCS) has been defined according to capacity indicators, activities, and indices such as number of beds, number of healthcare providers (like nurses, doctors, dentists), clinics, and delivery programmes (Roemer, 1993; Raffel, 2007). Roemer (1993), in particular advocates a description of a HCS by five main features: "...productive resources, organization of programs, economic support mechanisms, management methods and service delivery..." (Hsiao, 2003).

Roemer's description of a HCS has been criticized for lack of clarity and specificity. For example, Hsiao (2003) questions whether it would really matter if the configuration of those five features are changed? He also criticizes Roemer for not fully explaining the importance and novelty of those five features.

Hurst's approach looks at a HCS as an *interconnected fund flow* and payment methods between funders and population recipient groups (Hurst, 1991). Hsiao credits both Roemer and Hurst's descriptions of a HCS for being informative but criticizes them both for not showing how and why particular HCS produces certain health outcomes which others don't produce. I agree with this criticism because without this information we are unable to derive much use from a HCS.

The World Health Organization's (WHO) definition and description of healthcare systems is very comprehensive, applicable, and very inclusive of most ideas on the subject. Margret Chan, an ex-Director-General of the WHO (World Health Organization, 2007) says that health systems are context-specific and that we cannot expect a single set of best practices to be advanced as a panacea for improving health performance and health outcomes (Organization, 2007). I disagree with Chan in that her assumption ignores the common thread among all successful health systems. These include a purchasing and distribution system delivering actual needed interventions to the needy. The human resource staffing levels have to be sufficiently filled with people with the right skills and motivation. These systems usually operate with fair, inclusive, and sustainable financing systems. Last but not least, the healthcare costs should not plunge households deeper into debt and poverty.

In some countries, households have been plunged deeper into debt and poverty due to escalating healthcare costs, fuelled in part by hyperinflation and poor economic policies. As a result, citizens have had to dig deeper and deeper into their own pockets to finance healthcare services because the public healthcare system is failing to cope with demand. Therein lies the biggest problem with the state of the healthcare system in Zimbabwe, a system riddled with many problems ranging from low staff morale and motivation, poor financing levels, and chronic drug stock-outs (De Castella, 2003; Diana, 2014; MacDonald, 2016; Mbanje, 2018). The Zimbabwe health budget has consistently fallen below the Abuja Declaration since Independence in 1980 notwithstanding the low parity purchasing power of the local currency (Lynnette, 2016).

The World Health Organisation (2007) defines a health system as:

A health system consists of all organizations, people, and actions whose primary intent is to promote, restore and 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 activities. It includes, for example a mother caring for a sick child at home; private providers; behaviour change programmes; vector-control campaigns; health insurance organizations; occupational health and safety legislation. It includes inter-sectoral health action by staff, for example, encouraging ministry of education to promote female education, a well-known determinant of better health (World Health Organization, 2007).

This is probably one of the most comprehensive definitions of a health system. It touches on almost all facets that are influential to the operation and fulfilment of a health delivery system in any given context (Rehfuss, Bruce and Bartram, 2009). The definition above seems to use the words *health system* synonymously with healthcare system. Where not highlighted the reader must assume that I am using the words *health system* synonymously with HCS.

Another important definition of a HCS is the one advanced by Hsiao (2003), which also emphasizes points brought up in the WHO's (2007) description. Hsiao carried out an in-depth health policy analysis on many countries' legislations based on health policy papers. He concluded that the explicit and implied health goals of most HCSs were: *public satisfaction, financing risk security or protection, and improvement of health*. Thus Hsiao fully embraces WHO's boundaries of a health system goals. However, his own definition of a health system is somewhat shorter and policy-focused: "A health system is defined by those principal causal components that can explain the system's outcomes. These components can be utilized as policy instruments to alter the outcomes" (Hsiao, 2003).

Though also heavily criticized, functional descriptions of a HCS such as those advanced by Londono and Mills show some improvement on the previous classifications. Londono and Frenk proposed a HCS description based on four core functions: *financing, delivery,*

modulation, and articulation (Londoño and Frenk, 1997) while Mills propose a similar definition based on *actors and functions* (Mills, Bennett and Russell, 2001).

In their very influential publication, Londono and Frenk (1997) argue that healthcare systems are at a critical juncture with some at very earth-shaking crossroads. The world is aggressively looking for new ways to deliver, regulate and finance health services. Even back then in 1997 Londono and Frenk saw the possibility of a breakthrough in innovation on how we deliver healthcare services.

London's approach is both systematic and systemic, which means it takes a holistic approach by looking at every feature in a well-defined health system. It scans the whole healthcare system without neglecting any analysis of the relationship amongst the major building blocks or components. I agree with their ground-breaking innovation in this approach because a piece meal approach would have simply compounded and multiplied the challenges of the previous setup if a root and branch approach is not done. I think this is one of the biggest strengths of Londono and Frenk's approach. I provide greater detail on Londono and Frenk's HCS typology later in this chapter.

Zimbabwe's healthcare problems are much similar to Latin America, whose dual problems are argued to have originated from two areas: *economic reforms and push for democratization*. This does not imply that the quest for economic reform and push for democratization are twin evils. And yet the impact of unequal development, increasing income disparities, and increasing poverty on the other hand have just compounded the previously unsolved problems. This is what is obtaining in Zimbabwe; a country faced with a myriad of alleged political but definitely economic, and social problems (OAU, 1987; Meldrum, 2008; Andrew, 2015a; MacDonald, 2016). The COVID-19 pandemic, which unfolded in the 2019-20 period, greatly exposed the weaknesses in the Zimbabwe healthcare

system. I accept that there may be contestations to whether Zimbabwe managed the impact of covid well or not compared to other countries. This debate is beyond the scope of this thesis.

Similar to Latin America Zimbabwe's healthcare challenges can be viewed from and should be tackled from two important perspectives: *population side and institutional challenges*. Population side challenges comprise accumulated or historical and emerging challenges (Londoño and Frenk, 1997). Accumulated challenges include epidemiological backlog (common or traditional infections, malnutrition, reproductive health problems etc), health gap, and inequity. Emerging challenges comprise non-communicable diseases, new infections, new healthcare service demand patterns, and political activism. Examples of new infections are *Ebola, SARS, HIV/AIDS, MERS, and Corona Virus*. Zimbabwe's contemporary demographic surveys show a persistent pattern of traditional and emerging unmet health needs (ZNSA, 2015). Institutional structures are very important in mitigating and sustaining a functional and effective healthcare system. The reader is referred to Londono and Frenk (1997) for further reading on some of the institutional challenges that a healthcare system may face.

8.4 Healthcare System Models (HCSMs)

It is important to understand healthcare system models (HCSMs) as most of them are depicted, described, or presented via models of service delivery, economic policy, and financing. Dominant literature on HCSs characterize them as three main models: *National Health Insurance (NHI), Social Security Insurance(SSI), and Private Health Insurance (PHI)* (Böhm *et al.*, 2013; Kulesher and Forrestal, 2014). Each model has no exclusive financing mechanism but a variety of styles including but not limited to: *general taxation, specific taxation, and private financing*. For example, when it comes to specific taxation in Zimbabwe there is a specific health fund levied on mobile phone transactions (Ruzvidzo, 2017) and a

National AIDS Levy funded through a pay roll tax (Mpofu and Nyahoda, 2008; Bhat *et al.*, 2016). A country's healthcare system is not comprised of one model of health delivery and financing; it is a composite of several models. The issue is about which model(s) is/are predominant. All models have some level of private insurance or out-of-pocket spending to cover services specifically excluded from the national health plans guaranteed by the state or public services. There are now many additional typologies and classifications of HCS models to the three cited above. The following additional HCS models are discussed as they are popular examples: The *Physicians for a National Health Programme classification* (PNHP), *The Bohm classification of 5 HCS models dominant in the OECD countries, the WHO and Londono & Frenk's classification (1997)*. Britain's national health services system is discussed in much more detail in this chapter because of its special significance to Zimbabwe due to the latter inheriting its original national health system in 1980 from its colonial master, Britain. Healthcare system models operate in an economic environment and that is why the following section discusses special features related to the health market.

8.4.1 The Imperfection of the Health Market

In any endeavour to describe HCS models we must be cognizant of the fact that healthcare systems and models seemingly do not fit into precise classic economic models of supply and demand. That may be in part why it is argued that health is a *special good* that requires a special place in society (Papadimos, 2007; Norheim and Asada, 2009). I discussed health as a special good in chapter 1, section 1.4.2.

Table 3: Summary of Demand-side and Supply-Side Economics

ECONOMIC MODEL	SPECIAL FEATURES
Demand-side economics	<ul style="list-style-type: none"> ▪ HCS is seen like any other good, where consumers determine what to buy and the price. ▪ Consumers and suppliers are evenly matched with the latter unable to influence price and demand. ▪ Competition for patients' revenue creates efficiency, with long term reduction in cost. ▪ Premised on the ability of patients to pay and willingness of suppliers to provide HCS. ▪ Examples of countries using this as a HC financing model include Singapore and South Korea
Supply-side economics	<ul style="list-style-type: none"> ▪ HC is a special societal good deserving of being provided in reasonable quantities to society. ▪ It is a necessity of life and an entitlement. ▪ Free market forces alone can't be let loose to control access and cost. Central Government and its agencies are required to intervene. ▪ Government plays a major role in resource allocation and setting rates of payment for providers. ▪ A notable example of this model is the former Soviet Union (Communism, socialism).

Sources: (Hsiao, 1992, p. 75; Yang, 1995; Kulesher and Forrestal, 2014, p. 60)

Table 3 gives a summary of the two main paradigms of economic reasoning or models:

Demand -side and Supply-side economics. Demand-side economics is defined by Keynesian economists as the stimulus for economic activity. This creates fluctuations in the demand for goods and services in the market. A major feature of demand-side economics is aggregate demand, which governments sometimes deliberately stimulate if consumers and businesses are unable to (Feldstein, 1986; Setterfield, 2002; Canto, Joines and Laffer, 2014). On another hand, supply-side economics argues that economic growth is a result of the production and supply of goods and services in the market (Ensor and Cooper, 2004; Croes, 2006). As can be deduced from the comparative description of Demand-side and Supply-side economics -the latter appears to dovetail with the right to health philosophy because HC is viewed as a special good to which citizens of a country have an entitlement (Hsiao, 1992; Yang, 1995; Kulesher and Forrestal, 2014). A strict demand-side economic model for HCS is deleterious

to a population's health needs, even for very wealthy and industrialized countries. I however accept that a strict supply-side economic model for health without a measure of demand-side intervention is not sustainable. I, therefore, advocate for a conscious mix between demand-side and supply-side economics.

8.4.2 The Bismarck Healthcare Model (BiHM)

The Bismarck Healthcare Model may also be referred to as the non-profit 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 (*the sickness funds*). Ideally, it is a non-profit making and must include as many citizens as possible (Altenstetter, 2003; Kutzin, 2011). Unlike the American insurance variant which is allowed to make a profit, Bismarck health insurance (the sickness funds) does not make a profit; and it is mandatory to include the whole population.

The Bismarck Model of health financing, structuring, and delivery is named after a famous German politician historically credited with uniting Germany in the nineteenth century (the Prussian Chancellor, Otto Von Bismarck). The original aim of the Bismarck Model was not universal coverage but to pre-empt labour unrest by entrenching a right associated with a labour status by maintaining the health of the labour force and improving productivity (Kutzin, 2011). He had also an implied goal of containing socialism as well as to strategically weaken *voluntary social health insurance* affiliated to labour unions as well federations inspired and managed by churches (Sigerist, 1999; Van Der Zee and Kroneman, 2007; Clougherty Tom, 2011; PNHP, 2011b).

In the Bismarck Model, Healthcare Professionals (HCPs) and medical facilities tend to be mixed but with a bias towards being largely private (Lameire, Joffe and Wiedemann, 2018). This model is predominant in western countries such as Germany, France, Belgium, the

Netherlands, Japan, and Switzerland (Wallace, 2013). It is available in certain Latin American countries (Fincham, 2011). This is the *so-called universal insurance program*, which its proponents argue is less expensive, with lower running costs than the American-variant for-profit insurance plans (ibid). Unlike the Beveridge Model where most doctors tend to be government employees and most health facilities are owned by the government or through trusts, in the Bismarck Model doctors and facilities are mostly private. Cost control is comparable to the Beveridge Model due to tight control by the government (Sigerist, 1943; Cremer and Pestieau, 2003). The percentage of GDP spent on health, per capita total health expenditure and per capita public health expenditure- all tend to be higher than in the Beveridge Model (the GDP is at 11.2%, per capita total health expenditure is at 3 700 United States Dollars (USD), and per capita public health expenditure is at USD 2875). The life expectancy is also higher at 81 years compared to 79.7 for the Beveridge Model (fully described in section 8.4.3 later). These statistics are based on 2008 OECD data (Böhm *et al.*, 2013).

8.4.2.1 Similarities and Differences between the Bismarck Healthcare Model and the Zimbabwean Healthcare System

Zimbabwe's healthcare system bears some close resemblance to the Bismarck Healthcare Model. This is so because healthcare insurance contributions or premiums are largely from both the employees and employers, similar to what happens in the sickness funds of the Bismarck Model. Perhaps one major difference is that in Zimbabwe employer contributions are voluntary whereas in the Bismarck Model they are compulsory. One other significant difference is that the Zimbabwean system has a very high unemployment rate and as a result very few people are covered. Secondly, while medical aid societies are not allowed to make a profit they are, however, required to keep a minimum of 25% statutory reserves to cover them in the event of a catastrophe or over claims (Zimbabwe Act, 1998).

8.4.2.2 Ethical Implications of the Bismarck Healthcare Model

The Bismarck Healthcare Model (BiHM) is a multi-layered insurance model without a single dominant insurance scheme over all others. This is unlike in the Beveridge Healthcare Model (BeHM) (Sigerist, 1943; Sawicki and Bastian, 2008; Kutzin, 2011). For example, Germany has over 240 health insurance players or funds with tight government regulation, which is the equivalent of cost-control function in the single-payer models such as the Beveridge/NHI. However, the BiHM appears to have an advantage over the Beveridge Healthcare Model in terms of allowing or encouraging some choice for consumers and competition among providers. In my opinion this fulfils an important ethical function of consumer or patient autonomy. This is accomplished through the fact that while government is involved in major regulation and funding, it nevertheless allows players to compete in the delivery of services (Cremer and Pestieau, 2003; Van Der Zee and Kroneman, 2007). Insurance firms are allowed to compete for funds thereby creating competition for funding, ensuring consumer choice, and minimal bureaucracy. This is how the BiHM allows a measure of the *universality of access to healthcare and equity* (Clougherty Tom, 2011).

On the negative aspect conflict of interest and potential corruption could be one of the major drawbacks of this model. There is a need for a good corporate governance culture where government regulation of healthcare funding is involved. Temptations for conflict of interest are sometimes encountered where politicians are trusted with public funds. A case in point is that of a Zimbabwean Health Minister who was allegedly involved in direct payments from a government medical aid fund to his medical practice ahead of other providers (Chipunza, 2015; Charles, 2017) . This case was widely reported and criticised but nothing had been concluded at the time of writing this manuscript (Chipunza, 2015). Another scandal was that of a Chief Executive of the biggest government medical aid society in Zimbabwe who was alleged to earn a whopping USD500 000 per month at the expense of service providers. The

scandal is alleged to have led to his eventual disgraceful exit. He was relieved from his post due to this alleged corruption (Chipunza, 2014; Rusvingo, 2014b; Charles, 2017).

I propose that the apparent potential for conflict of interest in the Bismarck Model can be ameliorated by employing ethical principles from both the Ubuntu and egalitarian moral theories. Ubuntu moral philosophy has as some of its significant principles as community solidarity and sharing of resources. If we inculcate the spirit of Ubuntu into corporate governance culture, we are likely to reduce the potential for corruption and conflict of interest. In addition, it empowers communities to expose this vice by internalising the culture of whistle blowing. Egalitarianism would also infuse a spirit of redistributive justice and fairness in resource allocation. The CCHM has some of these strengths as follows: a strong monitoring and evaluation strategy exercised through statutory bodies, consumer activism, civil society representatives and donors.

8.4.3 The Beveridge Healthcare Model (BeHM)

The Beveridge model is also commonly referred to as the National Healthcare Model. This is the so-called *socialised-medicine model or Single-Payer National Health Service (UK) Model*, named after Lord William Beveridge - a famous British social reformer credited with designing the British National Health Service. Lord William Beveridge, who is sometimes cited as Winston Churchill's Minister of Health, developed a unique national health insurance with universal coverage which became operational in 1948 on 5th July (Kulesher and Forrestal, 2014). William Beveridge was the leader of the Liberals in the British House of Lords (Fincham, 2011) while Winston Churchill started as a member of the Liberal Party and later on moved to the Conservative Party. It is argued by some that although the creation of the British National Health Service (NHS) is credited to William Beveridge, the actual architect was the undisputed Minister of Health at the time, Aneurin Bevan (Klein, 2010).

The NHS is sometimes glamorized and described as a true *cradle to grave* healthcare insurance and service system covering all British citizens and permanent residents (ibid). It has inspired many healthcare systems and models worldwide including the USA Medicaid, which is a Beveridge model in all except that the providers of Medicaid are not owned by the USA government. The basic arrangement of the Beveridge Model is that: “healthcare is provided and financed by government through tax payments, similar to how the other public goods like the army and police are financed” (Ninane, 1983b; 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 Beveridge report was issued in 1942 after being commissioned in 1941 by the British Government to find out how the United Kingdom (UK) could be rebuilt again after the devastating World War 2 (WWII). I propose that in 1941/2 UK was exactly at the same critical juncture that Zimbabwe is right now, though not as a consequence of war, but as a consequence of successive alleged failed economic policies (Razemba, 1998; Keller, Stewart and Eppel, 2008; Health, 2009; McIndoe Calder, 2009; Tamukamoyo, 2010). There are some who argue that economic sanctions have compounded the problems in Zimbabwe (Pillitu, 2003; Coggins, 2006; Masaka, 2012). Others disagree and argue that the Zimbabwean government uses sanctions as a *smoke screen or red herring*. Bad political and social policies with huge ramifications on health services have inflicted untold suffering on the population in Zimbabwe (Nyazema, 2010; Todd *et al.*, 2010; Zhou and Hardlife, 2012).

The Beveridge report detailed five *giant evils* in need of correction or amelioration: “ want, disease, ignorance, squalor and idleness” (‘Health care systems and health policy’, 2019, p. 27). This report then formed the basis of addressing healthcare delivery system problems by the UK and how it would be financed or funded (Fincham, 2011).

The best example of a national health system inspired by the National Healthcare Model is the National Health Insurance/National Health Service (NHI/NHS) in Britain; while some other countries use a modified system. Examples of countries using a modified system are Portugal, Greece, Italy, Spain, New Zealand, Sweden, Norway, Denmark, Iceland, Finland, Australia, New Zealand, Canada and Hong Kong (Graig, 1999; Mills *et al.*, 2002). Cuba represents the extreme case of this system (Wallace, 2013).

Some argue that the following have actually migrated from Social insurance systems or Bismarck models to Beveridge models between 1970 and 80: Greece, Italy, Portugal, Spain, and South Korea (Minor, 2010). This may be a sign of a lack of consensus on systems nomenclature being employed by certain countries. For example, South Korea was said to be using a pure market force driven HCS (Hsiao, 1992; Yang, 1995; Kulesher and Forrestal, 2014). *The social insurance systems* are based on the Bismarck Model (payroll taxation) and dominate in the following European countries: Austria, Belgium, France, Germany, Netherlands, and Luxemburg (Saltman, Figueras and Organization, 1997; Freeman, 1998; Flood and Haugan, 2010). In general, the north, west, and south of Europe (with examples already given above) is dominated by the National Health insurance systems inspired by the Beveridge Model while the centre (France, Austria, and Germany) of Europe is dominated by the Social insurance systems inspired by the Bismarck Model.

The advantage of the Beveridge Model is that it tends to have a low healthcare per capita cost as most healthcare professionals are employed by the state and hospitals/clinics are owned by the Government. The state is the dominant player and controls the benefits system and payments (Program, 2011). For example, according to Organisation for Economic Cooperation and Development (OECD) data published in 2008 the percentage of Gross Domestic Product (GDP) spent on health in the UK was 8.7%, total per capita health expenditure was USD 3130 and total per capita health expenditure was USD 2 585. life

expectancy in the UK in 2008 was at least 79.7 years (Program, 2011). Unlike the Bismarck Model, which was associated with uplifting the status of a worker by keeping him healthy for productivity, the Beveridge Model came much later in post-WWII. It operates generally in countries with higher incomes although it ended up spreading globally (Kutzin, 2011). The Beveridge Model made a break from the Bismarck Model by now focussing on the *universality of health as a human right not as a labour right* (ibid). A new paradigm emerged in which health coverage was now being seen as a constitutional or legal right. The new focus was now on *social cohesion* and *solidarity*.

The percentage of GDP spent on health in Zimbabwe expenditure shows a depressing trend. In the 2018 budget, even as compared against sub-Saharan averages, is so low that it is impossible to change the status quo (Health, 2018). Zimbabwe healthcare was allocated 6.9% down from 7.7%, as a percentage of total government expenditure, well below the Abuja declaration of a minimum of 15%. The sub-Saharan average is 11.3%, with countries such as Malawi, Rwanda, Togo, Madagascar, and Zambia notching the proverbial Abuja target of 15% (Health, 2018). On top of the ladder is Rwanda, out shining most sub-Saharan countries with expenditure on healthcare at around 23%. From 2016 to 18 Zimbabwe's per capita allocation for healthcare stood between a paltry 22 and 25 USD compared to regional comparisons of USD 90 for Zambia, 200 for Angola, and 650 for South Africa. This underfunding has created a crisis in healthcare of unimagined proportions (Kapp, 2007; Nyazema, 2010; Todd *et al.*, 2010).

There is so much depressed access to essential healthcare services in Zimbabwe to the extent that stories have been told of citizens literally dying on donkey-drawn scotch carts on the way to clinics or hospitals, with some dying during childbirth (Todd *et al.*, 2010; United Nations in ZIMBABWE, 2013). Paradoxically Zimbabwe, like many developing countries, tend to spend more on defence than on social services like health and education. Zimbabwe, not

wanting to be outdone, allocated 16.1% of the total budget in 2018 on defence and home affairs alone while the USA, Japan, Germany on average spend 3.8%, 1%, 1.4% of their GDP on defence respectively (London, 1974; Berthélemy, McNamara and Sen, 1994; Wulf and Esser, 2000; Collier and Hoeffler, 2002; Aizenman and Glick, 2006; Tambudzai, 2006; Tsauroi, 2014; Health, 2018). Compare this with other African countries: Eritrea spends 19.4% of its GDP on defence and only 3.2 on health, Burundi 5.9% versus a mere 0.6% on health, and on average Zimbabwe spends 6% of GDP on defence versus a mere 2% on health. With these statistics, a case can be made to illustrate how skewed Zimbabwe's allocation on health is. There is a negative relationship between poor spending on health and development (Gupta, Clements and Tiongson, 1998; Verhoeven, Gupta and Tiongson, 1999; Rusike, 2018). A healthy population makes for a productive nation.

Aspects of the Beveridge Healthcare Model appear to be present in the Zimbabwean health system in coexistence with other variants. This is expressed in the form that the government owns, finances, and operates a lot of the hospitals and clinics while at the same time employing salaried staff. While there is a sizeable number of private players, they do not claim payment for their services from the government but rather from medical aid societies and other private health funding. The National Health Service remains the most representative system of the Beveridge or National Health Model and as such, it is discussed in more detail in the section that follows.

8.4.3.1 The National Health Service

The National Health Service (NHS) was conceived in 1948, combining England, Scotland, Wales, and Northern Ireland in its implementation. The whole system is financed via general taxation, with healthcare services organized and managed through regional and public authorities. Doctors are paid through capitation, fee-for-service, and other reimbursements. Appropriations are advanced to hospitals via district health authorities while hospital-based

doctors receive salaries (Kulesher and Forrestal, 2014). There is a strong accountability function in that the NHS reports to parliament because the financing is from general taxation (Simonet, 2010). The NHS is very unique in the whole world because it combines a universal approach strategy coupled with a broad public provision of services supported by a small private sector focusing mainly on a narrow range of elective treatments (Klein, 2010, 2012). Because the system is financed through general taxation the mandate of the NHS is to deliver universal and comprehensive access to healthcare services at the point of delivery.

Drawback of the National Health Service

The major drawback in the NHS is the long waiting queues for service resulting in part from declining funding while demand for services is increasing (Mountford and Davie, 2010). Both consumers or patients and providers face huge frustrations as a result of bureaucratic delays. These frustrations and limitations on NHS efficiency have led to the exclusion of certain medicines and procedures from the NHS list as well as a tightening of inclusion criteria (Klein, 2010, 2012; Mountford and Davie, 2010; Kulesher and Forrestal, 2014). The NHS had to adapt to the new challenges, firstly by opening up and allowing hospitals to attend to more privately insured patients so that they raise their incomes. In reaction to the inefficiencies and long waiting lists in hospitals, individuals are resorting to buying more private insurance cover so that they access private medical services. In response, the NHS is reforming to keep up with the new reality. For example, *the Health and Social Care Act* empowered the NHS to establish a board that would oversee the distribution of resources and reduces bureaucratic delays in approval of treatments as well as increasing provider autonomy.

Other countries with an NHS type of healthcare service include some Nordic countries such as Denmark, Finland, Iceland, Norway, and Sweden-including two southern European countries of Portugal and Spain (Böhm *et al.*, 2013).

8.4.3.2 Ethical Implications of the Beveridge Healthcare Model

Those who support the Beveridge Healthcare Model (BeHM) argue that it is ethically superior to many others because it reduces the temptation to provide healthcare services as a commodity (*commoditisation*): “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).

The Beveridge Model provides for universal access to healthcare thereby allowing realisation of a *critical distributive justice principle*. Access to Healthcare is a basic right recognised in most developed societies in which it is even considered a positive welfare right (Daniels, 1998). If a society prides itself as indeed plural and secular, then it ought to promote, protect and fulfil the right to access to healthcare as an expression of human dignity and as one of its most crucial achievements (Daniels and Sabin, 2002; Abel-Smith, 2018). Even if social and economic circumstances restrict the full realisation, available resources must be fairly and transparently distributed to the benefit of all citizens. This position is directly or implicitly recognised, including in the Zimbabwean constitution (Dommel and Alexander, 1997; Abbing, 1998; Toebes, 2001; Veritas, 2013; Rumbold *et al.*, 2017).

If we accept that the Beveridge Model performs a function of distributive justice towards access to healthcare, as we should, then we ought to accept the argument that it also *levels the playing field* as far as *equality of opportunity* is concerned. By restricting the full range of opportunities that should accrue to each and every individual- disease, disabilities, illnesses,

and deficiencies- create injustice and unfairness. They must not be seen as mere random afflictions of nature (Dworkin, 1981a; Daniels, 1985a; Arneson, 2002b). I propose that the Beveridge Model, by universalising the right to health principle, is operationalising all the three moral theories of Egalitarianism, Utilitarianism and Ubuntu on access to healthcare. By financing healthcare services via general taxation, the Beveridge Model empowers the citizen and levels access to healthcare services.

The BeHM is also presented as a model that protects poorer sections of the population by offering some safety nets. This is however contested by some who criticise the BeHM for its lack of competition due to its reliance on a predominantly single organisational structure that encapsulates funders, insurers, and providers. This single structure does not offer much choice for the consumers. This results in an unwieldy beauracracy, inefficiencies, and general unresponsiveness to consumer needs (Wilson and Wilson, 1993; Clougherty Tom, 2011).

Unprecedented waiting lists for routine surgical procedures have been reported in the United Kingdom, a country famous for its National Health Insurance system (Rayner, 1986; Light, 2003).

8.4.3.3 Growing Convergence between Beveridge and Bismarck Models

The operating environment has largely changed from the historical context in which both The Beveridge and Bismarck HCS models were founded. Therefore, changes are emerging showing greater convergence of the Beveridge and Bismarck models. For example, there are now some single Social Health Insurance (SHI) in Estonia, Hungary, Korea, and France- something unheard of in the past. At the same time some *for-profit sickness funds* have emerged in countries such as Germany, Netherlands, Czech Republic, and Slovak Republic (Kutzin, 2011).

There are numerous SHIs in Japan but they do not compete. The reality on the ground is that the following parameters for the Beveridge and Bismarck models are all very variable and no longer cast in stone: *insurer, benefit packages, funding, management of fund, and nature of providers*. The only remaining major distinguishing feature between the two is how one is entitled. The labour market and dynamics have changed a lot during the years and therefore government is now forced to give subsidies to SHIs so that those unable to afford or employed by small enterprises can be covered.

Table 4: Comparisons between Beveridge and Bismarck Models

TYPE OF HCS MODEL	SPECIAL FEATURES
BEVERIDGE	<ul style="list-style-type: none"> • Per capita growth in health expenditure rates are higher. • Cost advantage. • Possible better health outcomes based on systematic, organized screening e.g. Breast cancer and TB screening. • Entitlement is based on citizenship/residence status. • Funding base in from all public revenues. • Insurer is the state • Managed by Government • Providers are government employed and publicly salaried.
BISMARCK	<ul style="list-style-type: none"> • Satisfaction is higher due to its decentralization structure. • Entitlement is based on contribution • Funding base in from wages • Insurer is occupational based • Independently managed • Providers are privately hired

Sources: (Van Der Zee and Kroneman, 2007; Sawicki and Bastian, 2008; Minor, 2010; Kutzin, 2011; Ystems, 2011).

Table 4 illustrate the special features of the Beveridge and Bismarck models. The position of subsidies is a concept worth supporting because everyone contributes to the economy in one way or another, even if not gainfully employed. One major example through which the public contributes is via Value Added Tax (VAT). Through subsidies, the State assists almost every

citizen simultaneously. All this brings an increasing blurring of the boundaries between these two models.

There are largely no outright conclusive positions as regards the better of the two between the Beveridge and Bismarck models. Some argue that after 1980 there was an observation that the Bismarck model or SHIs slightly outperformed the Beveridge model in terms of overall mortality rates and life expectancy but there is no significant difference when it comes to infant mortality rates (Van Der Zee and Kroneman, 2007). The SHIs tends to be more expensive although citizens residing in countries whose HCSs are run based on the SHIs tend to be more satisfied and happier than those in NHS. The NHS models offer better cost control (ibid). The following terms are often used as a benchmark for comparing HCS models, although they may require expansion to include other important parameters: *satisfaction of the services, health expenditure or cost control, and health outcomes or health statistics*. Generally speaking, the Beveridge Model has an inherent redistributive justice embedded in its operational framework while the Bismarck lacks this aspect (van Der Maesen and Nijhuis, 2000; Cremer and Pestieau, 2003).

8.4.4 The National Health Insurance Systems

The National Health Insurance (NHI) systems are a combination of structures of the NHS regulation and financing through taxation but dominated by private healthcare service providers or players. Examples of countries using the NHI systems include Australia, Canada, Ireland, Italy, and New Zealand (Böhm *et al.*, 2013). The literature largely attributes these systems with the NHS while others group them with Social Insurance or Public Contract e.g. Canada or Southern European Model in the case of Italy (ibid). I have chosen to separate them from the NHS because of their special feature whereby the government is responsible for regulating the relationship between patients, payers and providers while

consumers are given some flexibility to choose providers and hospitals. For example, in Canada, the benefit packages are negotiated between the provinces or states and the professional associations while in New Zealand an independent agency prevails over the pharmaceutical benefits at the national level while leaving the determination of other benefits to local level actors.

The following are the main advantages of the NHI:

- While the healthcare services are delivered by private providers through a publicly run health insurance programme, every citizen pays into the insurance programme.
- Unlike the for-profit insurance programme these programmes are known to be cheaper financially and simpler administratively because there is no need for marketing and there is no profit motive. There is also no motivation to deny certain claims.
- These programmes are famously referred to as the *Single-Payer insurance model* and tend to wield more leverage to negotiate lower prices in the market due to their volume (Hahn and Kleinman, 1983).

8.4.4.1 Ethical Implications of the NHI Model

The major challenge in many healthcare delivery systems is that of the scarcity of resources for healthcare and the dilemma of how to distribute the little that is available in a just, fair, and compassionate manner. The NHI model is premised on attempts to redress this challenge and thus the goal of the NHI can be summed up as attempting to strengthen the: (1) *distributive justice element and social solidarity in health* (Fuchs, 1991; Rusch *et al.*, 2012; Dahms, 2014); (2) *Equity in access to healthcare* (Rusch *et al.*, 2012; Dahms, 2014). On paper, the NHI Model achieves the strengthening of distributive justice and solidarity by employing the best aspects of the Beveridge and Bismarck models. It utilises private sector

healthcare providers (Bismarck Model) while using a government-run national health insurance for payments funded by premium tax according to the level of income (Beveridge single-payer aspects of the Beveridge Model). It does not make a profit and does not deny any claims. Access to service is according to need not according to income. The NHI strengthens the aspect of equity in access to healthcare by creating a seamless service to which everyone and anyone can have access without resorting to income levels.

Benefits of the NHI

Potential benefits of the NHI include reduction of overall medical expenditure as government may purchase drugs and consumables in bulk. Access to services may be improved due to reduction or removal of deductibles, shortfalls, and co-payments while providers are allowed to focus on patient care rather than mundane tasks like administrative work following up payments from multiple healthcare insurance schemes. Similarly, consumers may be encouraged to improve their health-seeking behaviour because of the removal of obstacles (Davis, 2001; Kunnath, 2012; Rusch *et al.*, 2012).

Criticisms of the NHI

The major criticism of the NHI is the potential for inefficiency and the removal of competition. This has the potential for creating long waiting lists for procedures. The NHI has the potential to improve both issues of distributive justice and equity by bridging the gap left open by the wide disparity between private and public healthcare delivery. The private healthcare delivery is largely funded through Out-of-Pocket and claims to medical aid societies, allowing access mostly by those who can afford. However successful adoption and implementation of the NHI requires correction of the many fiscal, monetary, political, and economic problems affecting Zimbabwe such as corruption, volatile monetary policies, high unemployment, declining GDP, and alleged bad governance practices.

8.4.4.2 The Common Denominators between the Beveridge, Bismarck, and NHI Systems

In all these three systems there is a guarantee by the government, to every citizen and legal resident, of basic universal health coverage notwithstanding the different financial and employment status of each person. Basic comprehensive health insurance packages are non-profit and in addition, they exercise key control over the pharmaceutical industry. *Social solidarity is the hallmark or biggest strength of these systems allowing consumers to pay according to their affordability but receive health services according to their need(s)*. One major criticism could be that the rich and healthy tend to subsidize the poor and sick possibly providing a disincentive for people not to exercise conscious and beneficial health behaviour (Fuchs, 1991). Paradoxically each of these major health systems is used by many of the world's industrialized countries such as Germany, the UK, Sweden, Japan, Canada, Israel, or even Hungary-but except for the world's biggest economy-the USA. The USA uses a *market-driven health system*. As a result comprehensive, universal access to healthcare is not guaranteed as a fundamental human right but provided as market-determined commodity (Fuchs, 1991).

The NHI (major examples are Canada and Taiwan) and Beveridge models are sometimes conveniently referred to as a *Single Payer system* while the Bismarck System (e.g. Germany and Japan) is referred to as a *Multiple-Payer system*.

8.4.5 The Social Health Insurance System (SHIs)

Based on a special and unique classification, the OECD produced a typology with three types of HCS Models. These three models are the National Health Service (NHS), the Social Health Insurance Model (SHI), and the Private Health Insurance Model (PHI) (Scheiber, 1987; Böhm *et al.*, 2013). The differences between these three models are based on extend of coverage, how the HCS are financed and how they are delivered. The SHI occupies a very

pivotal position in the OECD, a group of very wealthy highly industrialized countries, many of whom are in Europe.

Unlike the NHS which derives its funding from general taxation, the SHIs is unique in that it also combines universal coverage like the NHS though its contributions are from employer/employee payroll and have a public/private delivery system. The SHIs as described by Bohm et al (2013) is very similar to the Bismarck model. The Social Health Insurance models as described in much detail by Altenstetter (2003), Kutzin et al (2011), Kulesher and Forrestal 2014). The SHIs is more pluralistic, loosely controlled but lacks a power centre and cost containment measures. The government is less influential and HCS providers and insurers have more say and power in running the affairs of the system (Van Der Zee and Kroneman, 2007).

8.4.6 The Private Health System (PHS) Type

Under this section, I will also take the opportunity to describe in detail the USA healthcare system. It is important to dedicate some space to the USA healthcare system as the country with the world's biggest economy (Wright, 1990). The USA healthcare system is often cited as the most elaborate example of the private health system embodying elements like the out of pocket spending.

The Private Health System (PHS) may also be known as the *USA Market-driven Healthcare Model*. The USA healthcare system itself has been described by various terms including *A Patchwork Model, A little of this, A little of that* (PNHP, 2011a). One can argue with a measure of confidence that Zimbabwe is much like the USA, a patchwork model with a little of this, a little of that because we have just about all the different systems except that there is no consolidation (Hongoro and Kumaranayake, 2000; Kumaranayake *et al.*, 2000; Meldrum, 2008; Rusvingo, 2014a). The major features of the PHS are: coordination by market forces or

actors, financing from private sources, and profit-motivated or for-profit healthcare providers. With regards to developed and highly industrialized countries such as the OECD, this system is now only found in the USA after Switzerland moved to the Socialized Health Insurance Model in 1996 (Böhm *et al.*, 2013).

The USA healthcare system is unique in many ways. A lot has been written about it. A lot of initiatives to reform it have come and gone. The latest one being the *Patient Protection and Affordable Care Act (PPACA)* or *the OBAMACARE ACT* (Kamerow, 2017). It is highly contested and the then Republic government which succeeded the Barack Obama administration, headed by Donald Trump, tried to abolish it (Pace, 2017).

The USA healthcare system is not referred to by an informal term of *a patchwork system* for nothing. It has all the four elements of the world in one fragmented system, in varying proportions:

... when it comes to treating veterans we are Britain. For Americans over the age of 65 on Medicare we are Canada. For working Americans who get insurance on the job we are Germany. For the uninsured or underinsured the U.S is rural India, with access to a doctor available if you can pay the bill out of pocket at the time of treatment or if you are sick enough to be admitted to the emergency ward at the public hospital (Program, 2011).

Earlier on in this passage, I drew similarities between the USA and Zimbabwean HCSs as being both a patchwork of systems. That is where the comparison ends. This is so because while both systems are not well defined and hence I refer to them as a patchwork system, the per capita income in the USA is probably the highest in the world while Zimbabwe has probably one of the lowest in the world. The public hospitals in the USA are comparably in efficient working order while in Zimbabwe they have all but collapsed (Truscott, 2009; Nyazema, 2010; Andrew, 2015b; Green, 2018b, 2018a; Mbanje, 2018; Gwarisa, 2019).

Reid, a celebrated Washington Post reporter and acclaimed writer had this to say about the USA healthcare system: "... The United States is unlike every other country because it

maintains so many separate systems for separate classes of people. All the other countries have settled on one system for everybody. This is much simpler than the U.S system; its fairer and cheaper, too”(PNHP, 2011b).

Here is one of the major paradoxes about the USA healthcare system: it has one of the world’s highest healthcare expenditure as a percentage of its GDP at 16.8% (2019 figure), one of the highest per capita total health expenditure at USD 7670, per capita health expenditure at USD 3 507 but its health outcomes are not commensurate with its health expenditures as measured against other OECD countries. In fact, some argue that its health outcomes are actually appalling. For example, the life expectancy, as assessed based on 2019 OECD data, is 78.9 years versus OECD’s 81 years whose percentage of GDP spend on health is just 8.8% (PNHP, 2011a; Lorenzoni, Belloni and Sassi, 2014; OECD.org, 2019). The USA healthcare system has 2.8 beds per 1000 population versus 4.4 for OECD. Comparative avoidable mortality stands at 265 per 100 000 populations versus 199 for OECD, doctors per 1000 population at 2.6 in the USA versus 3.6 in the OECD (OECD.org, 2019). Some of the common factors militating against the realization of universal health coverage in the USA are the following: “a veto infested political system, public opinion which is sceptical about the state and Private interests/ insurance and providers/doctors powerful lobby and opposition” (Böhm *et al.*, 2013).

In moderation of the above, there is an argument that it’s not all gloomy in the USA healthcare system. Nurses per 1000 population is higher in the USA at 12 per 1000 population versus 8.8 in the OECD, effective primary care is at 194 per 100 000 population in the USA versus 171 in the OECD (OECD.org, 2019). There are some major publicly funded programmes such as Medicaid, Medicare, and the State Children’s Health Insurance Programme (SCHIP) which consume around 46% of the overall healthcare funding. Tax credits have increased the role of public intervention to reduce direct out of pocketing

spending and lack of protection for the vulnerable and the uninsured (Feldstein, 2009). The OBAMACARE, though it survived threats from the Trump administration at the time of writing this thesis, is also a feather in the cap as far as providing further access to healthcare is concerned in the USA (Butler, 2017; Kamerow, 2017). All these State interventions are largely absent from the Zimbabwe health scenario which I described as mirroring the USA system in so far as being seen as some sort of a patchwork healthcare model.

8.4.7 The Etatist Social Health Insurance Type (ESHI)

The Etatist Social Health Insurance Model is claimed to be the only completely mixed health system in existence. Its main features are a clear hierarchy of distinct three aspects: “state regulation, financing by societal actors, and delivery by private players” (Böhm *et al.*, 2013). In the OECD countries, this is noted to be the most common type. Among the countries belonging to this type are the Central and Eastern countries of Estonia, Hungary, Slovakia, Poland, and the Czech Republic. The second group is from Asia and they include Japan and Korea. The third group comprises Belgium, Netherlands, Israel, and France. The group from Central and Eastern Europe share a common historical bond, having emanated from the former Soviet Union Health financing system based on an integrated, tax-based state model called the *Semashko*. In all these three groups the common denominator is that hospital care is still almost exclusively in the hands of the state while primary care, dental care, and pharmaceutical services were delegated to private players. Insurance funding and expenditure constitute over 60% with significant out-of-pocket spending.

8.4.8 The Out of Pocket Healthcare Model

Only about 40 countries out of about 200, the majority of whom are the developed and highly industrialized countries of the world, have a well-developed healthcare system (PNHP,

2011a). The rest rely on an *out of hand or the pay-to-play* (PNHP, 2011a) survival system. This is the Out of Pocket Healthcare Model, which is sometimes called the *market-driven model* (*ibid*). It is predominant in many parts of the world, some in which poverty is too high for governments or countries to provide any kind of a structured national health delivery system (Wallace, 2013; Gabrani *et al.*, 2015; Obama *et al.*, 2016). In a situation like this, people with money pay for and get healthcare; 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 or continents, such as Africa, India, China, South America – where millions live their lives without ever being seen by a doctor (Macinko and Starfield, 2002).

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 level of coverage (Nyazema, 2010; Wendy, 2014).

8.4.9 Emerging Healthcare Models

Traditional healthcare models such as Beveridge and Bismarck are proving to be limited in the modern age of the internet and social media. As a result, new complementary models are emerging urged on in part by the development and discovery of new knowledge in life sciences and medicine. Examples of these *emerging patient-driven healthcare models* include health social networks which are largely website-based health resource centres. From these networks, patients can retrieve information, health tips as well as emotional support from individuals and groups with similar problems (Nikolajsen and Dinesen, 2015):

A new class of patient-driven healthcare services is emerging to supplement and extend traditional healthcare delivery models and empower patient self-cure. Patient-driven healthcare can be characterised as having an increased level information flow, transparency, customisation, collaboration and patient choice and responsibility-taking, as well as quantitative, predictive and preventive aspects (Swan, 2009).

Due to the ever-expanding scope of internet-based communication systems and social media, these kinds of healthcare models have the potential to eclipse traditional doctor-patient face-to-face consultation practices (Matheis-Kraft *et al.*, 1990; Mandl and Kohane, 2016).

Examples of these models include *PatientsLikeMe*, *Cure Together*, *Med Help*, and *SugarStats* (ibid). In my opinion, patient-driven healthcare models empower patients, individuals, and communities to take charge of their health issues. Every healthcare provider likes an empowered, informed and active consumer as this helps to reduce misinformation and improves health outcomes. In 2020, during the worst episode of the COVID-19 pandemic, telemedicine simply took over the diagnosis, triaging and even doctor consulting as words like social distancing and lockdown became the worldwide norm.

8.4.10 Traditional, Complementary and/or Alternative Medicine

Traditional medicine (TM) has been in existence for many centuries and still plays an important role in many communities, especially in low-income countries. Before the advent of allopathic or western medicine, it was in fact the only healthcare system available to provide prevention and cure for many illnesses and diseases in the community. Traditional Medicine is defined as

“...is a comprehensive term used to refer both to TM systems such as traditional Chinese medicine, Indian ayurveda and Arabic unani medicine, and to various forms of indigenous medicine. TM therapies include medication therapies-if they use herbal medicines, animal parts and/or minerals-and non-medication therapies –if they are carried out primarily without the use of medication, as in the case of acupuncture, manual therapies and spiritual therapies” (World Health Organization, 2005).

Some countries have incorporated TM into their national health systems while others have not. Where TM has not been incorporated it is referred to as complementary, alternative, or non-conventional medicine (CAM). According to WHO (2005), TM is serving a very important niche and its contribution is growing in importance again. For example, in Africa, 80% of the population relies on it while in China at least 40% also utilize it to meet their

daily health needs. More than 90% of rural and urban Chinese families have utilized TM and CAM at least once in their lifetimes (Xu and Chen, 2011). In Latin America, Asia, and Europe the story is the same, more and more people are openly revisiting the values associated with TM. The reason why there is such a reliance on TM is partly due to its affordability and accessibility. For example, out of the 5000 plant species in Zimbabwe, about 10% of them have proven medicinal properties (Maroyi, 2013). Secondly, TM tends to allow different options for its payment -goats, cattle, chicken, or even grain can be used as payment.

Thirdly TM is firmly embedded into the value and belief systems of the community in which it is being practiced:

...However, biomedicine is at its limits nowadays, when confronting degenerative diseases, stress-related diseases, and most chronic diseases, which are more related to the way we think and live than to bacteria and viruses. Most notably, biomedicine lacks reference to the self-healing capacity of the human mind and body and focuses on parts rather than the whole, treatment rather than prevention, the suffering disease rather than the diseased person. (Xu and Chen, 2011).

In order to efficiently utilize TM and CAM countries need to address the issues of regulation on policy, quality, access, safety, and even legislation. In 1981, hardly a year after gaining political independence from Britain, Zimbabwe established the Traditional Medical Practitioners Council through an act of Parliament to register and regulate the practice of TM and CAM. This is the official recognition of TM in Zimbabwe, which has brought its own controversies beyond the scope of this thesis.

8.4.10.1 Ethical Implication of the Traditional, Complementary and/or Alternative Medicine Model (CAM)

TM and CAM is virtually a private medicine model as it is not provided by the State. In industrialised countries, it is accessed by the wealthy while in the LMIC the low-income portions of the population almost exclusively depend on it. Both the rich and poor utilise TM

and CAM for various reasons, not necessarily out of lack of money to go for western conventional medicine (Kickbusch and Payne, 2003; Ensor and Weinzierl, 2007; Abdullahi, 2011).

Assuming TM and CAM do a lot of good and less harm it can be argued that the fact that governments do not provide it as a public healthcare service violates the ethics of distributive justice and equity. Due to the lack of its promotion and funding some citizens go without it and yet they need it. On paper, the drawbacks of inequitable distribution and access to TM and CAM can be remedied by full funding it as a public service alongside western conventional medicine. However, this creates problems of overstretching resources for a service that is not evidence-based (Ernst, Cohen and Stone, 2004). Therefore, more research on the efficacy and safety needs to be given priority before it is fully integrated into conventional medicine.

8.4.11 Londono and Frenk (1997) Classification Healthcare Systems Models

I am dedicating a detailed and special mention and description to Londono and Frenk models of healthcare systems because it is unique and innovative. Although largely based on research done on Latin American healthcare systems this classification applies to both highly developed and low-income countries such as those found in the sub-Saharan African region. This is so because of the similarities in demographic and economic systems between Sub-Saharan countries and those in Latin America. The emphasis of the classification is partly influenced by dual challenges associated with the two important HCS components of *populations and institutions*. Other classifications do acknowledge the existence and impact of components and functions of a healthcare system but Londono and Frenk's classification clearly articulates the interlinkages and collaborative natures of these building blocks of a healthcare system. These functions are *Modulation, Financing, Articulation, and Delivery*. I

will highlight similarities and differences, where they exist, in comparison to traditional models such as the Beveridge, Bismarck, NHI, NHS, and the Market Driven models. I will close this section with an insight into Londono and Frenk's description of their new innovative healthcare model called the *Structured Pluralism Model*.

8.4.11.1 The Unified Public Model

The State plans organizes, and delivers healthcare services through a single, vertical arrangement. It is only the State that finances and delivers healthcare services. It is illegal and outlawed for any other entity, other than the government, to offer insurance or deliver healthcare services. An extreme example of this model is Cuba. Horizontal integration of services across the population is achieved at a cost of freedom of choice and non-existent exit options for consumers. This model could be argued to be similar to the NHS and Beveridge models. As a result, this model tends to lack efficiency due to a lack of competition. The consumers just take what is available and go home quietly with their discontentment. A similar variant of this model exists in Costa Rica where it's not illegal for private providers to exist but they are *dwarfed* by government's capacity to provide subsidized services of reasonable quality. Their private competitors have to provide a service at a cost. As a result, the virtual state monopoly is just an unintended consequence.

One of the major disadvantages or weaknesses of this model is the lack of or ineffective function of modulation, including accreditation of facilities. The state, often through a Ministry of Health, is the major or sole provider of healthcare services so they don't see the relevance and need to regulate healthcare services, in part for fear of being found derelict or inadequate in compliance with their own rules and regulations. In cases where some form of accreditation and regulation takes place, it is so rigid and *command-like* as to make it just symbolic. In addition, the function of articulation (intermediation between regulation, financing, and consumers) is often non-existent.

I argue that in Zimbabwe we do not have evidence of this model because we do have a multiplicity of providers in the country ranging from local authorities, private players, church-related organisations, and armed forces.

8.4.11.2 The Atomized Private Model

The Atomized Private Model (APM) rarely exists in pure form, not even in Latin American where the Londono and Frenk study was carried out. However important variants do exist in Latin America: in Paraguay and *Obras Sociales* in Argentina. The major feature of the Atomised Private model (APM) is the absence of vertical integration between the consumers and providers, unlike in the Unified Public Model such as the one existing in our best example of Cuba. Consumers carry out the financing option through their out-of-pocket payments or via multiple insurance companies who in turn pay numerous providers scattered throughout the system.

The case of Paraguay is very interesting as it is unique in that almost 90% of expenditures in healthcare are private, occurring in a very unregulated environment with a large percentage of cash payments with hardly any prepayment arrangements or insurance (Govindaraj, Murray and Chellaraj, 1995). This is referred to as a *Free market modality* of the APM. Although there is an official presence of freedom of choice for services, access to healthcare is highly fragmented and segmented, with the poor being largely disconnected from accessing care due to poverty while the rich enjoy first-class service. A case could be argued that Zimbabwe, in a way, follows this model based on how consumers are free to choose between the numerous medical aid societies as well as being dependent on out-of-pocket spending. Secondly ‘the rich in Zimbabwe have their facilities while the poor have nothing’.

Just like the Unified Public model, the *Free market modality* as a variant of the APM lacks the articulation function which is supposed to connect financing and consumers. This is

unfortunate because the health market is already imperfect and as such this worsens the issue of access as aggregate demand is further eroded. It is a fact that without a deliberate state modulation and articulation the health market becomes even more imperfect. The presence of multiple financing and provider agencies in the health market without a deliberate state policy neither improves access nor competition.

The second variant of the APM is described by Londono and Frenk (1997) as the *Corporatist Modality*. Its main feature is the existence of sickness funds, just like in the Bismarck and Social Health Insurance models. However, in this model, the sickness funds are a function of segregated occupational groups which are exclusive and not in any competition because affiliation is on compulsory grounds based on occupational criteria. In rare circumstances, these sickness funds have their own health delivery facilities although in the majority of cases they outsource to private and public providers. This separation of functions between financing and delivery is a major strength of this model, in my opinion. The jury is still on out on lunch on whether it is an advantage, the fact that they do not compete and have taken on the roles of articulation due to their ability to aggregate demand. As mentioned previously in this section, the best examples of the Corporatist modality of the APM are the Obras Sociales in Argentina. This modality is also reflected in the way healthcare services are financed and delivered in Zimbabwe through the medical aid societies approach (Munyuki and Jasi, 2009; Shamu *et al.*, 2010). A case in point is the issue of the Premier Services Medical Aid Society (PSMAS...formerly known as the Public Services Medical Aid Society). PSMAS owns 100% of its own healthcare delivery subsidiary or a private company called Premier Services Medical Investments (PSMI). This PSMI owns and operates healthcare facilities ranging from dental clinics, medical clinics, hospitals, pharmacies to optical dispensaries and rehabilitation clinics. Although officially anyone can join PSMAS, membership is largely drawn from the civil service comprising the government workers,

police, army, and state enterprises. This aspect mirrors the strict occupational criteria in the Corporatist modality. The list of medical aid societies owning their own healthcare facilities in Zimbabwe is growing: CIMAS medical aid society, Generation/Sovereign Health, Harare Municipality Medical Aid Society (HMMAS), to name just a few. With this phenomenon, a new challenge of members being secretly forced or directed to the Medical aid society-owned healthcare facility has emerged. Some cases have ended at the local anti-collusion/anti-competition commission without much success (Kumaranayake *et al.*, 2000; Todd *et al.*, 2010; Josephine, 2016).

In 2010, The Commercial and Industrial Medical Aid Society (CIMAS), one of Zimbabwe's biggest private health insurance or medical aid society, was hauled before the country's Competition and Tariff Commission on allegations of restrictive practices (Mlambo, 2010).

Even though PSMAS has guaranteed government funding ostensibly on behalf of government employees it often fails to pay private providers on time or at all (Charles, 2017). Payment is erratic that some private providers have stopped accepting PSMAS subscribers.

8.4.11.3 The Public Contract Model

The unique feature of The Public Contract Model (PCM) is the combination of public financing and enhanced growth in private participation in the provision of healthcare services. In Zimbabwe, it can be equated to the so-called *Joint Ventures or Public-Private Partnerships (PPT)* for which a hospital on the outskirts of Harare (Chitungwiza General Hospital) is famous. The main framework for the separation of functions between public and private players is contracting out of services. It is possible to achieve a horizontal integration of populations if the financing function has a universal coverage dimension. Brazil is a good and fine example of this model in the Latin American region. When compared to other models, The Public Contract Model (PCM) gives more autonomy to providers as well as

giving them room for competition. Its similarity to the Unified Public Model (UPM) is that both have a global and central budget. However, that is where the similarities end. Unlike in the Unified Public Model where a budget is assigned in advance to public providers or hospitals and clinics without regard to their performance or quality, in the PCM the money is carefully assigned on a pluralistic basis determined by a set of performance indicators which in part comprise quality and productivity (Londoño and Frenk, 1997).

One of the major weaknesses of the PCM is the existence of a silent or less explicit articulation function. Articulation is a very important function of vibrant and effective healthcare systems and models. It is defined as a function that lies or straddles between financing and delivery of healthcare services. Often it is found collapsed in the PCM, which is a big mistake. Articulation has to do with managing and organizing care consumption (Chernichovsky, 1995). It also includes the aggregation of demand and representing consumer needs and issues in what the managed competition model calls the sponsor (Enthoven, 1988; Starr, 1994). Articulation allows financial resources to flow to where they are needed: *production, transmission, and consumption of healthcare services*.

Activities found in articulation include but are not limited to the following:

...enrolment of populations into health plans, the specification of explicit health of benefits or interventions, the organization of networks of providers so as to structure consumers choices, the design and implementation of incentives to providers through payment mechanisms, and the management of quality of care... (Londoño and Frenk, 1997).

The case of Chitungwiza Central Hospital on the outskirts of Harare makes a very interesting observation because in some way it resembles a failed prototype of the PCM. Chitungwiza Central hospital implemented an ambitious programme of Public-Private Partnerships (PPPs) through many of its hospital service departments in partnership with private players, such as radiology, dental, catering, mortuary, pharmacy, and laboratory services entered into joint ventures (Arthur, 2017). It started this as a pioneering initiative as a brainchild of its then

Chief Executive Officer, Obadiah Moyo. The initiative was approved by government but it was not long before all these arrangements were criticized as a failure and a corrupt way of private providers riding on public infrastructure to siphon financial resources from the hospital (Staff Reporter, 2019). Hospital revenue started to dwindle as these partners kept to themselves the “profits” without sharing them out with the hospital accounts department. In my opinion, this was a case of failure of the articulation and modulation functions.

At time of writing this thesis a case of a Health Minister was still pending in the courts. The Minister had been arrested and charged for alleged corruption related to the awarding of contracts for the supply of COVID-19 PPEs to the MOHCC. An investigation into all the PPE purchase contracts in public hospitals had just been started (Vinga, 2020)

8.4.11.4 The Segmented Model

As the name implies The Segmented Model (SM) essentially comprises three segmented healthcare systems in one pool, each segment focused on serving a specific social group: *the poor and non-poor*. If we take the so-called non-poor social group, we find that it is divided into two:

- i. Those covered by social security or medical aid/insurance because they and/or their relatives are working in the formal economic sector. This group mainly derives their healthcare service needs from state facilities or medical aid-owned facilities (in the case of Zimbabwe).
- ii. The middle or upper-income groups who may or may not be covered by social security or medical aid cover but are able to pay for their private healthcare services from *out of pocket spending*. This group increasingly gets their healthcare service needs from private providers.

The third social group, called the poor grouping is found in both rural and urban areas. They are characterized by a lack of access or affordability to social security or medical aid cover because they are not in formal employment. They get their services mainly from the Ministry of Health, which is mandated with the provision of both basic curative and public health activities benefitting the whole population. The SM basically assigns population groups according to their institutional segments of Ministry of Health and Social security. Examples in Zimbabwe would be Medical aid owned facilities such as those owned the Commercial and Industrial Medical Aid Society (CIMAS), Premier Services Medical Aid Society (PSMAS) and Harare Municipality Medical Aid Society (HMMAS) in Zimbabwe), and private providers. In Latin America, each of these three institutional segments performs their own basic functions of modulation, financing, articulation, and delivery of healthcare services but only for a particular social group. This is not the case in Zimbabwe where the Ministry of Health through the Health Professions Act, still carries out an overall regulatory function, albeit being weak. The SM has an inherent disadvantage of being strong on vertical integration but with horizontal segregation of the population groups. The following are the major disadvantages of this model:

- i. Resource wastage and duplication.
- ii. Unacceptable differences in healthcare service quality among the groups particularly services earmarked for the poor which suffer from massive drug, equipment and personnel shortages. The Ministry of Health in Zimbabwe, at the time of writing this thesis, was almost dysfunctional. The dysfunction was inflicted by massive drug and PPE shortages and recurrent Healthcare Professionals strikes (De Castella, 2003; Diana, 2014; MacDonald, 2016; Green, 2018b).

- iii. The artificial co-existence of two polar models eventually becomes an unworkable arrangement that epitomizes disadvantages of either end. For example, in Zimbabwe, each medical aid or social security-owned healthcare system exercises control and monopoly over its members and subscribers. Reports and complaints have been registered about the PSMAS and CIMAS (incidentally the biggest ones in the country) restricting their members to their clinics and hospitals and frustration private providers by not settling claims in time (Mlambo, 2010; Josephine, 2016; Charles, 2017).

Notwithstanding the above disadvantages, doctors and physicians are said to favour the SM as it allows them to seek employment and locums in multiple organizations at the same time. While this may be an advantage to doctors and physicians to be able to *moonlight* it creates a big problem of conflict of interest and violation of professional ethics and the doctors may find it easy to refer their patients to their own surgeries from the social security or Ministry of Health facilities. Social security-owned healthcare facilities tend to end up being inefficient or inadequate forcing their members to seek better care from private providers or the Ministry of Health. When this happens an additional financial burden is heaped onto the consumer. This is the cause of an additional inequality because the consumer is forced to pay again (multiple payments) and yet they have been contributing to the social security fund. In addition, the overlap in demand is one-sided because members of social security can access services from any of the three segments (Ministry of Health, Private and Social security owned facilities) while the uninsured and the poor cannot access any of the services. The poor end up being marooned. While the Ministry of health in Zimbabwe may claim to be standing for the poor, the fact is it has failed, forcing poor families to be bankrupted as they are forced to seek care from private providers (Andrew, 2015a; Mlambo, 2015).

8.4.12 The Structured Pluralism Model (SPM)

Londono and Frenk (1997) make a strong argument for a new and innovative healthcare model called *The Structured Pluralism Model (SPM)*. Their main point is that extremes have retarded the realization of efficient healthcare delivery and therefore SPM allows us to avoid the inertia associated with those extremes. The concept of Pluralism sidesteps the issue of monopoly for which the public sector is notorious while at the same time avoiding the atomization also associated with the private sector.

Similarly, the concept of being structured softens the culture of authoritarianism inherent in the *command-control-procedures* of governments and their anarchy associated with the rampant absence of transparent rules, all of which are essential to correct market failures in the healthcare market:

...in this respect it is interesting to note that opposite extremes can end up having the same deleterious effect. For example, subordination of consumers to providers and insurers is a common outcome of both the unified public model-through lack of choice –and the atomized private model-through information asymmetry. Very often the real dilemma is not real between public or private ownership of facilities, but between provider, insurer and consumer sovereignty (Londoño and Frenk, 1997).

So the argument for a structured pluralism is emphatic in its support for a more balanced distribution of power between the three entities of consumer, insurer, and provider- unlike in the other models. The main functions advocated under the SPM are modulation, financing, articulation, and delivery of healthcare services. In *modulation*, instead of the Ministry of Health being one of the competitors in delivering services- it assures balance, efficiency, and equity among all actors in the system. It does not imply increased bureaucracy and its function can be delegated to neutral agencies such as civil society, once transparent rules of the game have been set. *Financing* is a major function of social security organizations, ideally preferably to morph into universal coverage. Subsidies to be focused, preferably on the demand-side rather than the supply-side. In *articulation*, the main focus is the management of

payment. Special organizations for health services (OHSAs) would compete to enrol individuals and families. The competition fosters efficiency, choice, and pluralism. In addition, competing for annual contracts and grants is an important aspect. Lastly, direct delivery of services is opened up to a pluralistic collection of players, both in public and private. The major advantages and strengths of the SPM are as follows:

- a) It moderates and irons out the disadvantages of the extremes of all the other models described earlier under the London and Frenk classification.
- b) It has horizontal integration of the population with a clearly defined distribution of functions such as modulation, financing, articulation, and delivery of services-instead of the vertical integration with segregation of social groups.
- c) It is organized according to functions instead of social groups. It identifies the main actor for each function and promotes specialization.
- d) It minimizes conflict between efficiency and equity. It increases options for both consumers and providers with concurrent elaboration of explicit rules of the game.
- e) It amplifies the positive aspects of the Public Contract Model, which was described in detail earlier on, while at the same time blurring out its limitations. It emphasizes the functions of modulation and articulation, giving it a *structured pluralism*.

8.5 Chapter Summary

This chapter looked at the various healthcare system models and how they are implemented around the world. The following healthcare system models were discussed: The Bismarck, Beveridge, Out of pocket, National health service, National Health Insurance systems, and the Londono and Frenk. The SPM model from the Londono and Frenk classification influences the design of the CCHM in chapter 9 through its minimization of conflict between efficiency and equity. It increases options for both consumers and providers with concurrent

elaboration of explicit rules of the game. The major aspect of the Bismarck model that influences the design of the CCHM is its compulsory contributions of premiums from both employees and employers, unlike the voluntary nature currently obtaining in Zimbabwe. The Beveridge model has an inherent redistributive justice embedded in its operational framework which can be applied to the Zimbabwean situation via the CCHM. Many other progressive aspects of all these models influenced the design of the Citizen Centred Healthcare Model described in chapter 9.

The next chapter will espouse this new model for access to healthcare in Zimbabwe, called the Citizen Centred Healthcare Model (CCHM).

CHAPTER 9: THE CITIZEN CENTRED HEALTHCARE MODEL

9.1 Introduction

The healthcare system of Zimbabwe has been deteriorating gradually over many years. The system is basically dysfunctional due to numerous problems, which include poor capital and human resource investment, inadequate government budgetary support, suboptimum access by citizens to both public and private healthcare services, continuous emigration of healthcare professionals overseas and to other SADC countries, frequent strikes by healthcare professionals, poor health insurance coverage, irregular payment of staff salaries and benefits, inefficient, ineffective and inadequate regulation of the medical aid industry (Chikanda, 2006, 2007; Nyazema, 2010; Diana, 2014). The healthcare delivery landscape in Zimbabwe is in serious trouble. The COVID-19 pandemic of 2020-21 made the situation worse.

A new direction is thus needed to change this sombre situation. The need for a new healthcare system is undoubtedly overdue. While a new healthcare model may not solve all the problems afflicting the healthcare system in Zimbabwe, it nevertheless would be a good starting point to address these complex problems.

One of the strategies that can assist to improve access to healthcare services is universal coverage and expanded health insurance. The World Health Organization (WHO) emphasizes the comprehensiveness of benefit packages as one of the most important aspects of any universal coverage. The WHO advocates boosting the benefit package along three dimensions: “the number of citizens or people covered, types of healthcare services covered and the amount of shortfalls or co-payments for the covered services” (WHO, 2010).

An agreed method, formula, or process of arriving at a resolution of disagreements about what constitutes adequate coverage for the three dimensions mentioned above should be part of the process of rectification. Aspects of Londono and Frenk (1997), particularly the Structured Pluralism Model, are quite progressive and have elements that can be harnessed in coming up with a home-grown healthcare model for Zimbabwe. The WHO approach of benefit thickening as well as aspects of the Beveridge, Bismarck, Social Health Insurance, Out of Pocket Spending, and the National Health Insurance- are among the several models from which useful insights can be drawn to come up with an ethically justified model of healthcare for Zimbabwe. Some aspects of these models are already in operation in the existing Zimbabwean healthcare system but unfortunately in a discrete, uncoordinated fashion and insufficient magnitude.

This chapter proposes a new and innovative healthcare system model, which draws from progressive aspects of conventional Health System Models as well as being inspired by the egalitarian, utilitarian, and Ubuntu ethic. This proposed concept is built on a foundation of a just, fair, accountable, and equitable healthcare system. Important concepts such as universal access to healthcare, fair and just rationing, and financing of healthcare services are addressed using a multi-layered and integrated system of six building blocks. The novel healthcare system model is called the Citizen Centred Healthcare Model (CCHM). The CCHM is modelled on foundations and principles which provide a balanced and sustainable fulfilment, promotion, and protection of the right to health as enshrined in the constitution of Zimbabwe (Veritas, 2013).

9.2 Roadmap for this Chapter

The first part of this chapter discusses the concept of healthcare reform (HCR). This is important to set a background and context upon which the CCHM is described, discussed,

and justified. A historical narrative of attempts and efforts at healthcare reform elsewhere by such organisations as the World Bank is given as this illustrates why healthcare reform, in general, is a global necessity. This gives the reader the necessary background as to why Healthcare Reform is important in general and for Zimbabwe in particular. Any healthcare model or system ought to be predicated on a sound ethical paradigm buttressed by strong monitoring and evaluation spearheaded by the citizenry and other stakeholders. Cognisant of this fact, a discussion on the egalitarian, utilitarian, and Ubuntu ethical principles upon which the CCHM is built, is given before going into details about the building blocks of the CCHM. In section 9.4 the Citizen Centred Healthcare Model (CCHM) occupies centre stage as all the building blocks and pillars are discussed. The CCHM comprises pillars and catalysts (building blocks), both of which make up its elements. These elements of the CCHM are described and analysed in detail in the chapter.

9.3 Healthcare Reform (HCR)

Many high-income countries (HIC), perhaps except for the USA until 2010²¹ and some low and middle-income countries (LMIC)-provide good healthcare access to their citizens.

Recently low and middle incomes such as Korea, Mexico, and Taiwan have also started providing universal access to healthcare to their citizens (Yang, 1995; Cheng, 2003; Tsungmei and David, 2009). This universal access comprises a wide spectrum of both public and personal health services despite differentials in personal and family income and wealth. The predominant method of guaranteeing this access is the universal health coverage system.

²¹ “Nearly 50 million USA citizens, mostly the poor and unemployed went without insurance till 2010, when the Patient Protection and Affordable Care Act (PPACA)(OBAMACARE) was passed into law requiring all individuals to obtain health insurance failure of which attracts a penalty. This expanded Medicaid, a means based health insurance for the poor jointly funded by States and Federal Government. It forbade exclusion based on prior health conditions. Children could remain their parents’ schemes till 26 years of age. Approximately 16 million enjoyed coverage for the first time”(Obama et al., 2016).

However, while the principle is the same, the funding and organization of the service vary from country to country, region to region, and economic system to economic system. For example, in some HIC countries such as Canada funding is through general taxation revenues, whereas in some European countries funding is through payroll taxation while others are funded through a mixture of public and private insurance schemes e.g. Germany. Countries funded through general taxation may be viewed as more progressive than those which are funded through social security or payroll taxation (Londoño and Frenk, 1997; Sigerist, 1999; Van Der Zee and Kroneman, 2007; Norheim and Asada, 2009).

A common criticism of social security and payroll taxation is that it tends to introduce more insurance premiums. Some systems e.g. the United Kingdom and selected Scandinavian countries have medical facilities owned publicly and salaries of health professionals being paid through the public service system as well. This is similar to the current public healthcare delivery system being implemented in Zimbabwe via the Ministry of Health and local authorities such as city councils, local boards, and rural district councils. Other systems maintain a mixture of private and public ownership but with strict regulation of the benefit structure available to citizens. A good example of this set up is Germany. In the most extreme of cases found in selected countries, no other system exists except the Universal Health coverage scheme e.g. Canada. But in recent years Norway moved away from the absolute universal Health coverage system and permits private insurance and therefore now has a predominant general taxation funding supplemented by social security type of funding (Johnsen, 2006; Ringard *et al.*, 2013; Saunes *et al.*, 2020). The United Kingdom now permits additional insurance to its universal coverage variant called the National Health Insurance (NHS). The USA has attempted to reform its healthcare system over many years but still it has not managed to universalise access to care (Obama *et al.*, 2016).

During the late 1990s the World Bank (WB) advocated public sector reforms that were meant to improve a country's public healthcare system. This reform was predicated on the assumption that to improve a government's ability to increase its efficiency it should cut down on its bloated size (Wagstaff, 2009). This cutting down focussed on, among other issues, cutting public expenditure, tax reform, and price and exchange rate liberalisation. However, this failed to improve the social and economic fortunes of those countries (Govindaraj, Murray and Chellaraj, 1995). This could be referred to as the first generation of public sector reform. The second generation of public sector reforms focussed on efficiency improvement, decentralisation of functions, and government effectiveness (Pena, Guasch and Escribano, 2000). The early 2000s ushered in the third generation of strategies for public sector reform after realizing the limitations of the second generation reform approach. These strategies focus on sector-wide approaches which included the health and education sectors (Fjeldstad and Isaksen, 2008; Webb, 2008). The aim was to promote an enhanced and coherent service delivery programme. In addition, an acknowledgement of the important role of the growing size of the private health sector was recognized and the need for it to be expanded and promoted in all public policies. The most controversial World Bank and International Monetary Fund inspired attempts at reform in Zimbabwe are the famous Economic Structural Adjustment Programmes (ESAP), which started in the early 1990s (Renfrew, 1996; Kawewe and Dibe, 2000; Makoni, 2000; Ranga, 2004; Mlambo, 2013; Bonga, 2014). It is clear from the aforementioned discussion that healthcare reform has been going on for quite some time now, even in Zimbabwe. However, there is little to show for it in Zimbabwe hence the need for a more innovative approach to it.

9.4 A Citizen Centred Healthcare Model (CCHM)

In this section, I introduce the Citizen Centred Healthcare Model (CCHM) as a novel conception of an ethically justified model for access to healthcare in Zimbabwe. I describe the moral basis for its design, operation, and its justification. In doing so I draw upon the positive attributes of Egalitarianism, Utilitarianism, and Ubuntu normative moral theories, which have been discussed in detail in chapters 5 to 7.

The need for a new model for access to healthcare in Zimbabwe is evident from the detailed explanations of the problems in chapters 1, 2 and referred to throughout the whole thesis.

This new paradigm must be able to promote, protect and fulfil the right to health for all Zimbabwean citizens, immigrants, refugees, and permanent residents regardless of political status, religious beliefs, ethnicity, race, gender, sexual orientation, age nor political affiliation. These distinctions must not dictate the scope, quality, and timing of healthcare services available to the citizens and all legal inhabitants in the country. In addition, healthcare services ought to be provided in sufficient quantities and scope in such a way as to fulfil the provisions and aspirations as enshrined in the international, regional, and national statutes to which Zimbabwe is a voluntary signatory. The most significant of these statutes have been discussed in chapter 1 but also with references to them throughout this thesis. The Zimbabwe national constitution is quite clear on the full fundamental rights²², which rights the State ought to promote, fulfil and protect. This aspirational position is imperative for the realisation of the right to health. The design of this Citizen Centred Healthcare Model aspires to promote solidarity, a culture of Ubuntu, Egalitarianism, progressive aspects of

²² “Chapter 4 of the Zimbabwe Constitution: Bill of Rights (BOR) spells all the fundamental rights without which the right to health cannot be realized. Chapter 2 Section 9 of the Zimbabwe Constitution (2013) spells out the State’s obligation to Good governance compelling the State to, among other measures, adopt, implement policies and legislation to develop ...financial probity in all institutions and agencies of government at every level and in every public institution ...”(Veritas, 2013).

Utilitarianism, enhancement of cooperation and transparency between the government and the consumers or people of Zimbabwe.

9.4.1 Ethical Foundation for the Citizen Centred Healthcare Model

The design, scope, and character of an ethically justified model for access to healthcare in Zimbabwe, which I have named the *Citizen Centred Healthcare Model* (CCHM), is based on sound and defensible ethical and moral principles in terms of how healthcare services are financed, prioritized and rationed, monitored and evaluated. In addition, the protection of human rights and the dignity of the consumers is made paramount. I propose an *Inclusive healthcare system* (IHC) as part of the building blocks for the CCHM, a concept that borrows from certain aspects of the conventional universal healthcare and health insurance models. The concept of inclusivity relates to accommodating all the diverse classes of Zimbabwean citizens and all other legal inhabitants, rich or poor. The focus must not be to leave anyone behind. The IHC is more relevant and applicable to the unique situation in Zimbabwe characterised by inadequate financial resources to implement a full-blown Universal Healthcare and/or National health insurance system.

All the elements of a CCHM can only thrive and accomplish the intended goals in an environment of stable political and macroeconomic activity where the citizen's democratic right to elect its government officials at local, rural, municipal, provincial, and national levels is guaranteed and unimpeded. Furthermore, the macroeconomic environment must create and guarantee shared economic growth which produces sufficient goods and services for local consumption and export while at the same time creating employment to absorb the ever-increasing population and output from the country's tertiary institutions of learning. A fully productive economy with optimum employment levels allows the citizen to be empowered, enabling him or her to purchase healthcare services of acceptable quantities and quality with

autonomy and dignity. The CCHM derives its moral compass from progressive aspects of the ubuntu, utilitarian, and egalitarian normative moral theories.

9.4.1.1 Ubuntu and the CCHM

From the Ubuntu philosophy, I propose that we need to harness its community building and sharing principles. This has the potential to reduce and curtail corruption in the health sector (Makumbe, 1994; Doig, 2006; Choguya, 2018) and inculcate a spirit of sharing and accountability (Makumbe, 1994; Doig, 2006; Choguya, 2018). Corruption in Zimbabwe healthcare, particularly the public sector, has been a barrier to accountability. The issue has already claimed the dismissal of several public officials. Of particular significance is the case of a former Minister of Health whose case is still in the courts (John, 2020). A now-retired Minister of Health was allegedly involved in unclear advance payment of claim settlements from a government medical aid insurance scheme (Chipunza, 2015). At time of writing this thesis, a deputy Minister was under investigation for an alleged tender scam (Vinga, 2020). A strong argument can be made that Ubuntu has attributes of solidarity and interdependence which are capable of creating harmony between individual rights and health entitlement by the community with dignity. Ubuntu is an illustration of how rights can never be totally individual nor can they be wholly collective (Himonga, 2013; London *et al.*, 2015). Ubuntu has been demonstrated to improve the communication between African and western perspectives on disease causality and intercultural communication (Prinsloo, 2001). I do agree with many others that there is no single African worldview but there is a philosophical thread shared by many sub-Saharan African people of the same ethnic origin. This thread shares several common traits which have come to be referred to as Ubuntu (Metz, 2010, 2020; Behrens and Behrens, 2011; Behrens, 2013). Among many of the positive attributes of this Ubuntu philosophy is such virtues as sharing, respect, a sense of community, and accountability. These are the virtues that should shape the reform, design, or improvement of

our healthcare systems. The death of Steve Biko in detention and the reluctance of the South African Medical and Dental Council to investigate his death has been cited as a huge failure of the western bioethical approach and an antithesis of the Ubuntu values (Behrens, 2013). And yet within the same apartheid system environment the case of Albertina Sisulu can be seen as an epitome and exposition of the caring and sharing values of Ubuntu (Downing and Hastings-Tolsma, 2016). Albertina Sisulu, often referred to as the mother of the South African Nation, worked under very trying conditions to amplify the caring and sharing paradigm which is strongly advocated by the Ubuntu philosophy (ibid). These attributes of the Ubuntu philosophy will shape and influence the conception and design of all the building blocks of the CCHM.

9.4.1.1.1 Limitations of Ubuntu

The criticism of Ubuntu as a communitarian ethic that can potentially promote partiality and thus hindering the eradication of corruption as envisaged in the CCHM, is noted (Metz, 2012; Presbey, 2021). This limitation is reduced by employing Ubuntu as both a descriptive and a normative ethic rather than a purely normative moral theory.

9.4.1.2 Egalitarianism and the CCHM

The egalitarian normative theory has very important attributes which can be harnessed in support of the CCHM. Egalitarianism has a special strength in placing a premium on government's responsibility to provide a minimum quality of life and quantity of life for all, as well as a level of healthcare service needed to guarantee that minimum. Egalitarianism has a strong argument that says that it is ideal to finance healthcare services through redistributive taxes such as what happens in the National Health Services of the United Kingdom (Ninane, 1983a; Berman, 1998). Perhaps its greatest strength is the aggressive ideal to rectify the unfairness in healthcare distribution between the haves and have-nots e.g. between the rural

and urban divide- ensuring that every citizen has a basic minimum of opportunity and access to healthcare.

The discussion on Egalitarianism ought to start by making a distinction between social and natural goods (Arneson, 2002a; Moss, 2009). A social good is also known as a common good (Zalta *et al.*, 2017; Hussain, 2018). It argues that health must be viewed as a social good such as education, electricity, food, water, transportation and not as a natural good because all other goods are optimally realised when social goods are satisfied for everyone in the community (Arneson, 2002b; Papadimos, 2007; Norheim and Asada, 2009). It refers to something that benefits people or the community in the largest possible way simultaneously, such as clean air, clean environment, clean water, and literacy. On the other hand, natural goods are raw materials or resources which we get from the earth and are modified for use in our day-to-day living. Examples include crude oil, minerals, coal, metals, sand, stone, and timber. But a further argument is made that healthcare cannot be distributed like such social goods as political rights and income (Norheim, 2004; Cappelen and Norheim, 2005; Norheim and Asada, 2009). It should have a special place in society and be made readily and universally accessible. Healthcare cannot and should not be accessible to only those who can afford it. This is where the ideal of universal healthcare coverage comes in.

Daniels says it is not appropriate for us to pursue health as an object but rather we should focus all our actions for the achievement of attaining optimum healthcare (Daniels, 2001; Daniels and Sabin, 2002; Hasman and Holm, 2005b). This is also a position supported by Ruger, who says a claim for health rights ought to be appropriately construed as a demand for equality of access to entitlement to health services (Ruger, 2004). Thus the CCHM is clearly articulating a new and progressive paradigm consistent with both Daniels and Ruger's positions above. The IHC is the operational blueprint for the CCHM designed to radically improve access to a minimum basket of healthcare services through prioritized healthcare

financing, equitable rationing of healthcare services, social solidarity and human rights culture promotion and effective monitoring and evaluation. The CCHM further supports the adoption of a philosophy of health that is both holistic and accommodates the wellness approach as expounded by WHO in 1984 and the Ottawa Charter for Health Promotion of 1986.

Egalitarianism does not advocate absolute equal distribution of all social benefits to all persons in society, which would be impractical and absurd anyway because many variables are militating against this ideal. Instead, it advocates for an individual's positive rights such as a right to healthcare, and because of this principle, it is most likely to stand for strong action by the state to intervene and express and make an assurance that such a right is guaranteed and protected. An example is providing a protected level of healthcare service or a provision of an enabling environment for the realisation of equality in access to healthcare service (Beauchamp and Childress, 2013). Expanding on what he calls Rawls' hesitation in applying his famous theory of justice to healthcare, Norman Daniels (cited in Beauchamp and Childress, 2013) makes a compelling observation that a just healthcare system ought to be premised on a theory of justice and its principles.

The proposed Citizen Centred Healthcare Model (CCHM) draws heavily from what Daniels refers to as healthcare needs being special and that fair opportunity ought to be central to any theory and practice of justice. The CCHM makes a strong appeal for an inclusive healthcare (IHC system) as being distinct from the traditional universal healthcare system. The Inclusive healthcare concept will be described in some detail in sections to follow. This IHC is nourished by such enablers as social solidarity and human rights protection, effective monitoring and evaluation of services and programmes, and a stable political and macroeconomic environment. As such it is incumbent on social institutions tasked with the

distribution of healthcare services to be so arranged to assist and enable every citizen to attain and achieve a fair share of the normal range of opportunities a society has to offer.

9.4.1.2.1 Luck Egalitarianism and the CCHM

Luck Egalitarianism brings the following aspects to the CCHM:

- Egalitarianism can be seen as a ground-breaking reason for the importance of distributive equality, defined as a requirement for the moral equality of people to be accountable and assume responsibility for their choices as well as carrying the burdens of the costs resulting from those choices (Cohen, 1989; Dworkin, 2003; Arneson, 2004; G A Cohen, 2009). It also says no one should suffer disadvantages or be worse off in society due to bad luck.
- People must not be advantaged or disadvantaged just because of good or bad luck. It is unjust, unfair, and unacceptable they argue, that benefits must accrue to persons simply because of luck and not due to their conscious choices and/or hard work. The distributive justice principle should be blind to luck and be sensitive to choices.
- Society has a moral obligation to protect the living conditions of people who succumb to simple bad luck, not their choices. This is the overarching philosophical position.

9.4.1.3 Utilitarianism and the CCHM

Utilitarianism can be a potent weapon to justify the redistribution of resources and power from the hands of a few to benefit the majority. When resources and power are redistributed from those with excess to those who need them badly, we realize maximum utility because there is an element of diminishing marginal utility when left concentrated in the hands of those with excess (Carson, 1986; Rachels and Rachels, 1993; Sheng, 2004; Bowden, 2009). The aim of public health interventions is the maximization of a public social good, which refers to the aggregate health of a given population (Cribb, 2009, 2010; Fenton, 2009;

Viehbeck *et al.*, 2011). In conformity to utilitarian philosophy public health policy ought to focus on the overall good at the population level, though some interventions may appear to trample on individual rights. The overall collective good of the whole population, not the individual, is paramount in public health interventions.

The CCHM requires a prioritized distribution of resources for healthcare in a way that elevates the needs of the majority who have limited access to healthcare. Thus the positive aspects of Utilitarianism would be harnessed in the CCHM to help society to realize and fulfil a right to health by the population of Zimbabwe. This new paradigm proposes a refocus of the distribution of national resources towards a people-centred healthcare system.

9.4.2 Building Blocks (Elements) for the Citizen Centred Healthcare Model

The Citizen Centred Healthcare Model (CCHM) is predicated on a foundation that extols the supremacy of the citizen and the healthcare consumer as the focus of all programming, implementation, and evaluation of healthcare interventions. The citizen is the ultimate judge of how the healthcare system is performing and participates not only in the utilisation of services but also takes a lead in the monitoring and evaluation of such a healthcare service. The CCHM introduces a fair paradigm into many of the conventional concepts related to resources for healthcare allocation, national budgeting and prioritisation, financing strategies/equity, and rationing of healthcare services. There are three pillars for the CCHM shown in the first column, namely: *Inclusive healthcare, Prioritized Healthcare Financing, and Equitable Rationing of Healthcare Services*. The second column shows the catalysts, which make up the chain or oil of the model and these are: *Effective Monitoring and Evaluation, Social Solidarity and Human Rights Protection, and Stable Political and Macroeconomic Environment*.

Figure 1: Pillars and catalysts of citizen centred healthcare model

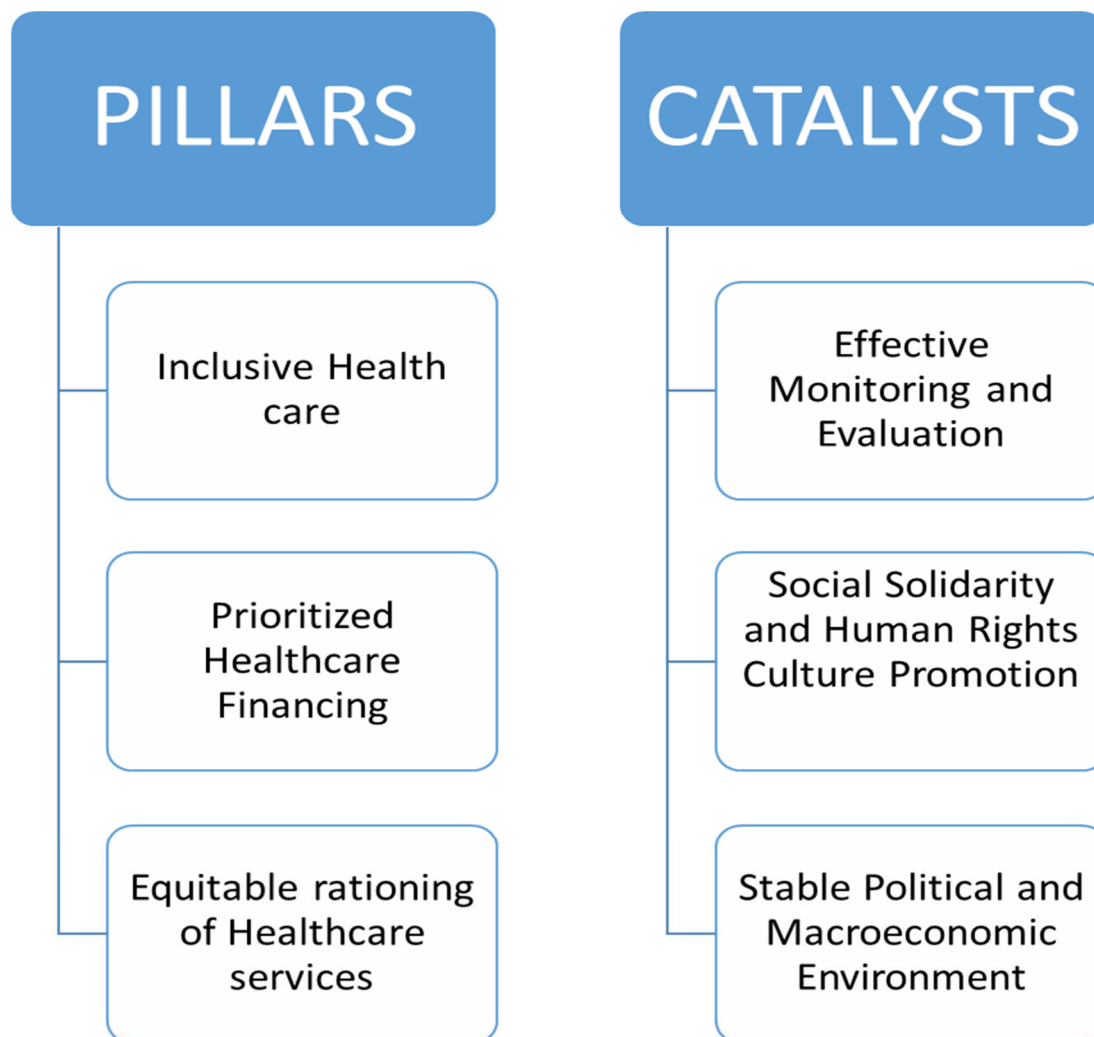


Figure 1 illustrates the elements of the Centred Healthcare Model (CCHM), divided into pillars and catalysts.

A pillar: it is clear that for something to be called a pillar it must have a very important and central function to any structure, organisation, or programme. A pillar is something used to support a critical structure. It is clear that without a pillar the structure in question can and

will collapse. The pillars of the CCHM are not just essential to its sustenance but are indispensable to its viability.

The successful operationalisation of the CCHM requires some catalysts and these are Effective Monitoring and Evaluation, Social Solidarity and Human Rights Protection, and Stable Political and Macroeconomic Environment. Consistent with the definition of a catalyst these catalysts of the CCHM act as a stimulus in bringing about the operationalisation of the CCHM. Consistent with how a catalyst behaves in chemical reactions the catalysts themselves ought to be consistently present without undergoing exhaustion or disappearance so that the CCHM delivers a predictable healthcare service, citizen and people centred and responsive to their needs. Section 9.4.2.1 discusses each of the pillars and catalysts in detail.

9.4.2.1 Why Inclusive Healthcare, Not Universal Healthcare?

The term universal healthcare is a buzzword often misused and abused. In many of the systems, there is actually nothing universal about the system at all. For example, the common healthcare system models of Beveridge, Bismarck, National Health Service have a very wide spectrum of benefit structure with some variations found at every level of specific treatments with one system allowing certain drugs to be provided while others don't. Another level of exclusion might be a whole category of treatments or procedures. For example, cosmetic surgery is often excluded in most systems while reconstructive surgery is allowed. One of the major drawbacks of any known universal healthcare system is the long waiting lists for basic surgery and interventions. The problem of long waiting lists is already rampant in countries such as the United Kingdom to Canada, Japan and some Nordic countries (Iglehart, 1988; Ikegami and Campbell, 2004; Johnsen, 2006; Tsutsui and Muramatsu, 2007; Flood and Haugan, 2010; Klein, 2012; Cylus *et al.*, 2015; Filochowski, 2015; Marchildon *et al.*, 2020). The CCHM departs from tradition and instead introduces an inclusive healthcare paradigm as opposed to universal healthcare. An IHC proposes to circumvent the common problems of a

UHC system, notably the mismatch between available resources and expectations and promises provided by the system. A distinction between universal healthcare and inclusive healthcare concepts has to be made.

The concept of Inclusive Healthcare captures the ethos of the Ubuntu and Egalitarianism philosophies, which ethos are essential for the successful remodelling of the healthcare system in Zimbabwe, in a way that does not leave anyone behind. Zimbabwe needs a new model of healthcare with unifying and equality considerations to uplift the needs of everyone by sharing health resources equitably. While every citizen has a right to choice there is a need to criticise and discourage the habit of the rich and powerful politically connected (though this is not a big group) using resources to access state of the art facilities and services in South Africa, India, Malaysia, and China while the general citizenry is confined to dilapidated and understaffed facilities with perennial drug stock-outs (Mlambo, 2013, 2015; Adewayo, 2020). When the politicians use local health services it sensitises them to the hard realities affecting the healthcare system. Zimbabwe may not afford a truly universal healthcare system, but it can afford an inclusive healthcare system. An inclusive healthcare system is all about sharing what is available at all levels in the public healthcare sectors, funded by the public purse.

The IHC has the following justifications for the unique situation in Zimbabwe:

- i. The IHC is a conceptual improvement and adaptation of the UHC to unique situations in which a UHC cannot be implemented in its traditional setup. The IHC recognises the reality on the ground, that expenditures in healthcare are rising, and rising very fast, and will continue to rise but government funding is not rising in tandem with rising costs in Zimbabwe. In the interim out of pocket spending and other health-

financing sources need to be coordinated and improved for bridging the healthcare costs gap across all countries including poor and rich ones (World Bank, 2019).

- ii. There is a need for a more coordinated approach for the incorporation of the private sector which is already playing an increasing role with better and in some cases more efficient services in ambulance services, clinics, medical laboratory services, insurance, and vaccines (Osewe, 2019; Universal Health Coverage, 2019). Most governments, including those with the traditional UHC such as National Health Insurance and National Health Services, are increasingly looking up to the private sector to cover up the delivery gaps (Johnsen, 2006; Cylus *et al.*, 2015; Filochowski, 2015; Marchildon *et al.*, 2020). The COVID-19 pandemic brought to the fore the weakness of not fully developing a vibrant private health sector. Similarly, in Zimbabwe, the COVID-19 challenge forced the rushed renovation and resuscitation of old and in some cases disused hospitals such as Arundel Hospital in Mount Pleasant (Harare) and Saint Anne's Hospital in Avondale (Harare) with the help of the private sector (Ndoro, 2020; Taruvinga, 2020). In the USA governor of the New York State enacted a directive to forcibly acquire equipment such as ventilators from private hospitals (Western New York State, 2020). This goes to show the indispensable role that can be played by the private sector.
- iii. The proven efficiency of private health insurance in Zimbabwe, albeit requiring improved regulation, needs to be harnessed to grow access to the larger population. A contentious issue requiring regulation is the perceived conflict of interest amongst health insurance companies acting as insurers and providers at the same time, thereby stifling competition and narrowing consumer choices (Munyuki and Jasi, 2009; Shamu *et al.*, 2010).

- iv. The inclusivity approach advocated under the IHC will give life to the multi-stakeholder involvement mantra often parroted just to placate critics. A full range of stakeholders for health will be brought together through ethical, administrative, and legal strategies. These comprise government, donor community, traditional leadership, traditional medical practitioners, youth groups, political formations, women groups, and religious groupings.

Figures 2 and 4 illustrate the prominent positions occupied by the IHC within the CCHM. The IHC is accorded such a high position in the CCHM paradigm because it is one of the philosophical driving forces behind this innovative model. In particular, the CCHM is innovative for its focus on proposing a modified Universal Healthcare described as Inclusive Healthcare (IHC). IHC takes into account the realistic economic peculiarities of Zimbabwe but at the same time not compromising the necessity for equitable rationing, social solidarity, and human rights culture promotion, effective monitoring and evaluation, and prioritized healthcare financing by redirecting resources from traditional major non-health-related spending areas such as defence and political parties funding.

9.4.2.2 Prioritized Healthcare Financing

A Citizen Centred Healthcare Model requires financing, funding, and allocation of such funding guided by ethical considerations. An egalitarian ethical consideration underpins the uniqueness of healthcare as a special social good and as such must be allocated the lion's share of the national budget. The prioritization process should not remain at the national budget to the Ministry of Health level but must be castigate to the Ministry of Health provincial and district levels as well. Budgets for healthcare resources need to be prioritised on the basis that the realisation of all other rights is premised on the attainment of optimum health (Pellegrino and Thomasma, 1987; Sen and Nussbaum, 1993; Cappelen, Norheim and Frithjof, 2006; Metz, 2019) .The social and economic challenges exposed by COVID-19

emphasized this reality. Health financing is indispensable for any country's implementation of sustainable healthcare delivery programmes. Healthcare financing is defined as:

"...provides the resources and economic incentives for the operation of health systems. It is a key determinant of the health-system performance, equity, efficiency and health outcomes"(Schieber *et al.*, 2006, p. 224).

Healthcare financing is a process that focuses on the creation, distribution, and utilisation of financial resources for healthcare systems. In an ideal situation, any healthcare policy must drift closer to achieving universal health coverage (Organization, 2010; Rumbold *et al.*, 2017). The IHC seeks to achieve just that. Three areas need to be analysed in an effort to fulfill this:

- i. From where and when do we raise financial resources for health?
- ii. How do we overcome financial barriers excluding many poor people from accessing healthcare services, and
- iii. How do we provide an efficient and equitable mix of health services and financing options?

History of Healthcare Budgetary Provisions in Zimbabwe is Disappointing

The history of budgetary allocations to healthcare in Zimbabwe suggests a lack of prioritisation for health. For example, between the years 2000 and 2005 the healthcare budget vote continually trailed the education and defense budgets (Shamu and Loewenson, 2006; Shamu *et al.*, 2007). From 1999 to 2003 the budget trend for healthcare for the government of Zimbabwe as a percentage of Gross Domestic Product (GDP) was below 10% in contradiction to its voluntary commitment to the Abuja declaration which compelled it to set aside at least 15% of its national budget (Union, 2001; Govender, McIntyre and Loewenson, 2008; Mburu, Folayan and Akanni, 2014). During the same period, the percentage of out-of-

pocket spending on health averaged between 45 and 60%. From 2010 to 2017 healthcare spending as a percentage of total GDP declined drastically from 10.67% to 6.64%.

Healthcare is not just a social good that can be distributed like other goods such as transportation, electricity, and leisure because healthcare is a special social good, which is essential for the realisation of all other goods in society (Daniels, 1982, 2000, 2008; Kickbusch and Payne, 2003; Papadimos, 2007; Maluka, 2011; Childress, 2015). Zimbabwe has never reached the Abuja Declaration benchmark ever since it voluntarily signed up to the declaration. The Abuja Declaration was a voluntary benchmark, self-imposed by 189 Heads of State and Government in 1989 (UN and OAU, 2001; Union, 2001; Mburu, Folayan and Akanni, 2014). The nearest that Zimbabwe came near the 15% of national budget threshold was the period between 2000 and 2006 when it allocated between 10% and 13% of its GDP (Shamu *et al.*, 2007; Govender, McIntyre and Loewenson, 2008). However, between 2005 and 2008, the percentage of allocations to healthcare plummeted to disastrous and embarrassing levels due to world-record hyperinflation in the country, going down to as low as 0.01% in 2007 (Meldrum, 2008).

There was a slight lull in the deterioration of healthcare budgetary slide and to other social services from 2009 onwards with the adoption of the multi-currency system in February of the same year. This saw a slight stabilisation and improvement in the provision of services albeit largely being bankrolled by the donor community. The role of the increased donor community was enabled due to improved government accountability resulting from the portfolio of the Minister of Finance being held by a member of the official opposition in the GNU. Even then the total budgetary allocation remained subdued, below 10% of GDP (Kramarenko, Engstrom and Verdier, 2010; Mapuva, 2010; Chigora and Guzura, 2011).

Zimbabwe needs to reprioritize its national fiscus to allocate more towards the financing of healthcare. Even with optimum donor funding, the Zimbabwe government ought to redirect funds from such allocations for defense, political campaigns, and freebies, office of the President and Cabinet, and command agriculture. Zimbabwe's defense budget has unnecessarily featured higher than other ministries despite the absence of any threats of war or external aggression. An inclusive healthcare paradigm compels a refocus on how the country allocates its national budgets.

Figure 2: The planning cycle for the CCHM

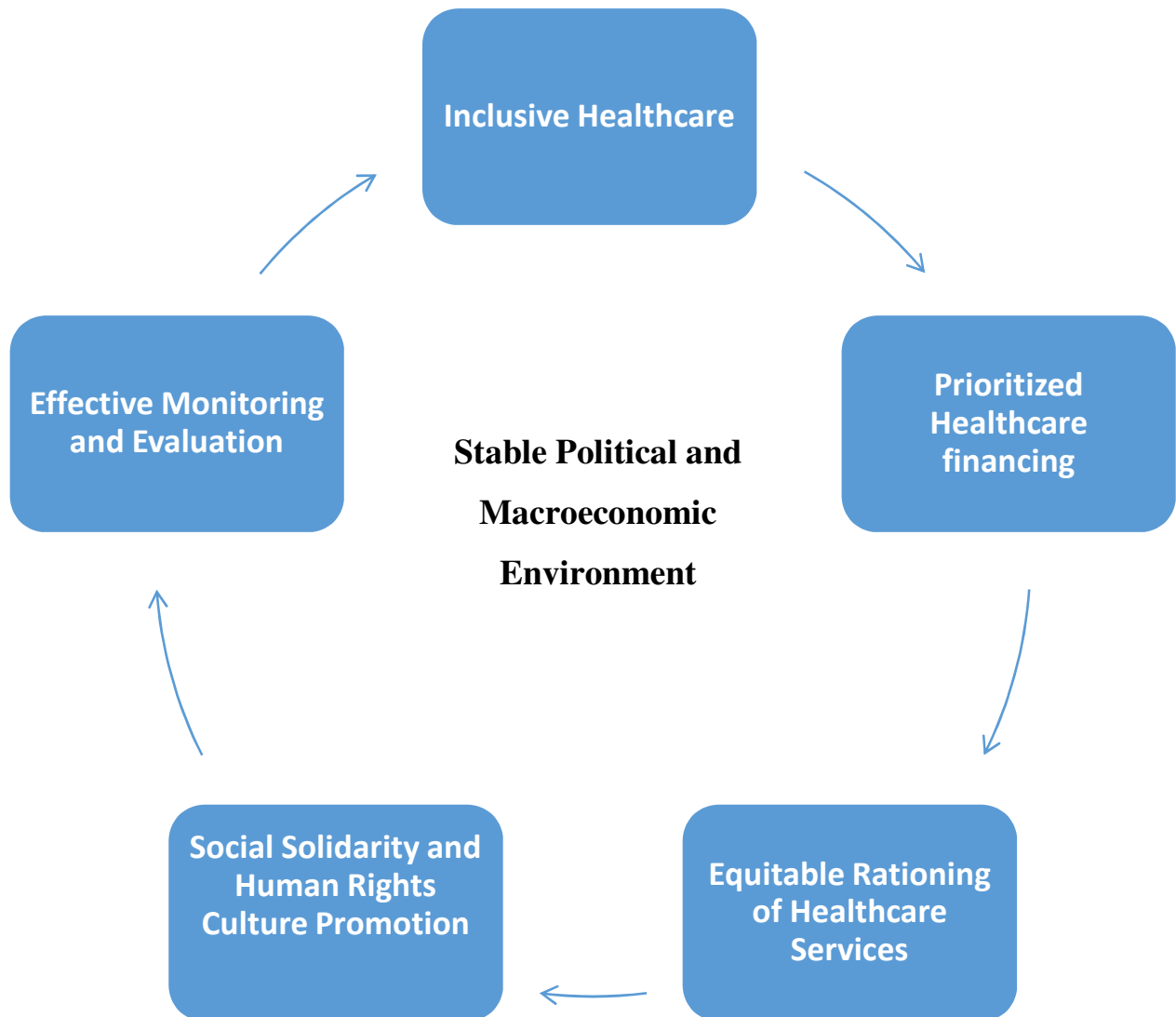


Figure 2 shows the planning cycle envisaged by the CCHM prioritized health financing approach. The road to an inclusive healthcare starts with a prioritised health financing approach in a stable macroeconomic environment. Zimbabwe has been beset with a very uncertain monetary and fiscal policy environment leading to diminishing economic confidence (Mlambo and Elhiraika, 1998; Bonga, 2019; Muzurura, 2019). The hyperinflation of the 2002 to 2008 period virtually wiped individual and corporate savings and market

capitalisation. After a period of periodic stability and growth from 2009 to 2016 a new cycle of inflation and inconsistent money policies started again (Makochekanwa, 2007; Coomer and GsTraunThaler, 2011; Koech, 2011; McIndoe-Calder, 2018). The multi-currency regime, which had brought some sense of economic stability, was banned and reinstated twice between 2016 and 2020 leading to currency instability and erosion of earnings and savings. At the time of writing this thesis, so many statutory instruments had been enacted between 2018 and 2020 that the country was virtually experiencing a new statutory instrument almost on a weekly basis. Without a stable, predictable, and confidence-boosting monetary and fiscal regulation in Zimbabwe, both private and public sources of funding for healthcare will struggle to make a meaningful impact.

By harnessing and promoting all sources of financing, including the informal sector of the economy, health financing would be improved to protect the majority of the citizens. But the country needs a stable national currency or permanent legal use of foreign currency alongside a local currency which can encourage savings and act as a store of value. In addition, the government would need to reprioritize budgetary provision to healthcare in national budgets. One area which can provide additional resources for healthcare is the redirecting of money from the defense budget to the Ministry of Health. Since the Independence of Zimbabwe, the defense budget has consistently featured at the top without any justification (Olaniyi, 2002) as Zimbabwe does not really have any military threat except for its unnecessary escapades in foreign wars in Mozambique and the Democratic Republic of Congo (DRC) (Cammack, 1987; Bennett, 1990; Koyame and Clark, 2002; Rupiya, 2002; Samset, 2002; Chimanikire, 2003; Chigora, 2008). Zimbabwe needs to increase its investment in its public healthcare sector. Since financial resources are not infinite for every country in the world, it is essential to make cuts on areas that are not essential for the improvement of access to healthcare as

well as those areas that are a catalyst to the realisation of the right to health principle.

Suggestions on innovative funding options are described in Chapter 10.

9.4.2.3 Equitable Rationing of Healthcare Services

Rationing of healthcare services is as inevitable as it is necessary. Financial resources are finite and limited and as such a way of effective and equitable rationing is needed. There are many approaches to rationing of healthcare services that appear to be workable but the ultimate benchmark is the demand for “...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, 2005a).

The need for rationing is often accepted without much contestation leading to the *how, by whom, and to what extent* aspect of rationing. This all points to a strong need for autonomy, beneficence, distributive justice, and participatory stakeholder involvement in the rationing of such services. Rationing is defined as: “occurring when anyone is denied (or simply not offered) an intervention that everybody agrees that would do them some good and which they would like to have”(Maynard and Bloor, 1998; Maynard, 2001; Glannon, 2004).

The CCHM is premised on a strong consumer and community involvement in the equitable rationing of healthcare services and as a result both the Ubuntu and aspects of distributive justice strongly underpins the equitable rationing of healthcare services in the CCHM. This strong consumer involvement ensures that appropriate services are provided in a way that takes into account the cultural, social, gender, and economic issues of the community. The principles advocated in the CCHM find expression in the approach called *Public Accountability*, which has appeal because of its emphasis on disclosure. Disclosure is critical as it informs our consent to treatment modalities, choice of providers, where treatment is to be provided, how it is to be provided, and the selection of insurance plans. This implied

informed choice does not only an expression of our autonomy but also helps the markets to work properly and respond efficiently (Daniels and Sabin, 2002, 2008a; Daniels, 2008).

9.4.2.3.1 Public Accountability has two Distinct Notions

i. Market Accountability: There should be transparency in the market for insurance plans and options available by publishing the options and choices available to potential purchasers and membership in health insurance to enable informed choices to be made. Effective regulation of healthcare insurance is needed to allow for fair competition. That way consumers and purchasers will force providers to improve efficiency, lower the cost of care and improve care. The current situation whereby medical aid schemes in Zimbabwe are allowed to own and operate health facilities seems to work against an open and transparent healthcare market. However, market accountability on its own is not enough to guarantee a legitimate and fair playing field and hence the need for accountability for reasonableness (A4R), which is discussed in the following passage.

ii. Accountability for reasonableness (A4R):

Accountability for reasonableness is defined as: “It is an ideal that the reasons or rationales for important limit-setting decisions should be publicly available and these reasons must one that fair minded people can agree are relevant to pursuing appropriate patient care under necessary resource constraints”(Daniels and Sabin, 2002, p. 44).

The A4R is a framework for the priority setting process with four distinct building blocks as follows: “publicity, relevance, revision, appeals and enforcement/regulation” (ibid). The A4R allows for a process of legitimacy based on the assumption that in a democratic and pluralistic society disagreements on what is fair can arise but there are enough safeguards for appeals. Zimbabwe has not been entirely reliable in enforcing the rule of law, ranging from

disputed election outcomes and unenforced court orders which went against the government of the day. Numerous examples are abounding (Sachikonye, 1990; Biti, 1998; Coltart, 2008; Williamson, 2010; Moyo, 2014; Mushava, 2016; Mbanje, 2018; Gwarisa, 2019; Adewayo, 2020). Fulfilment, promotion, and protection of the right to healthcare cannot thrive in an autocratic environment where democratic principles are not upheld.

Figure 3: Hierarchical relationship between building blocks (elements) for the citizen centred healthcare model

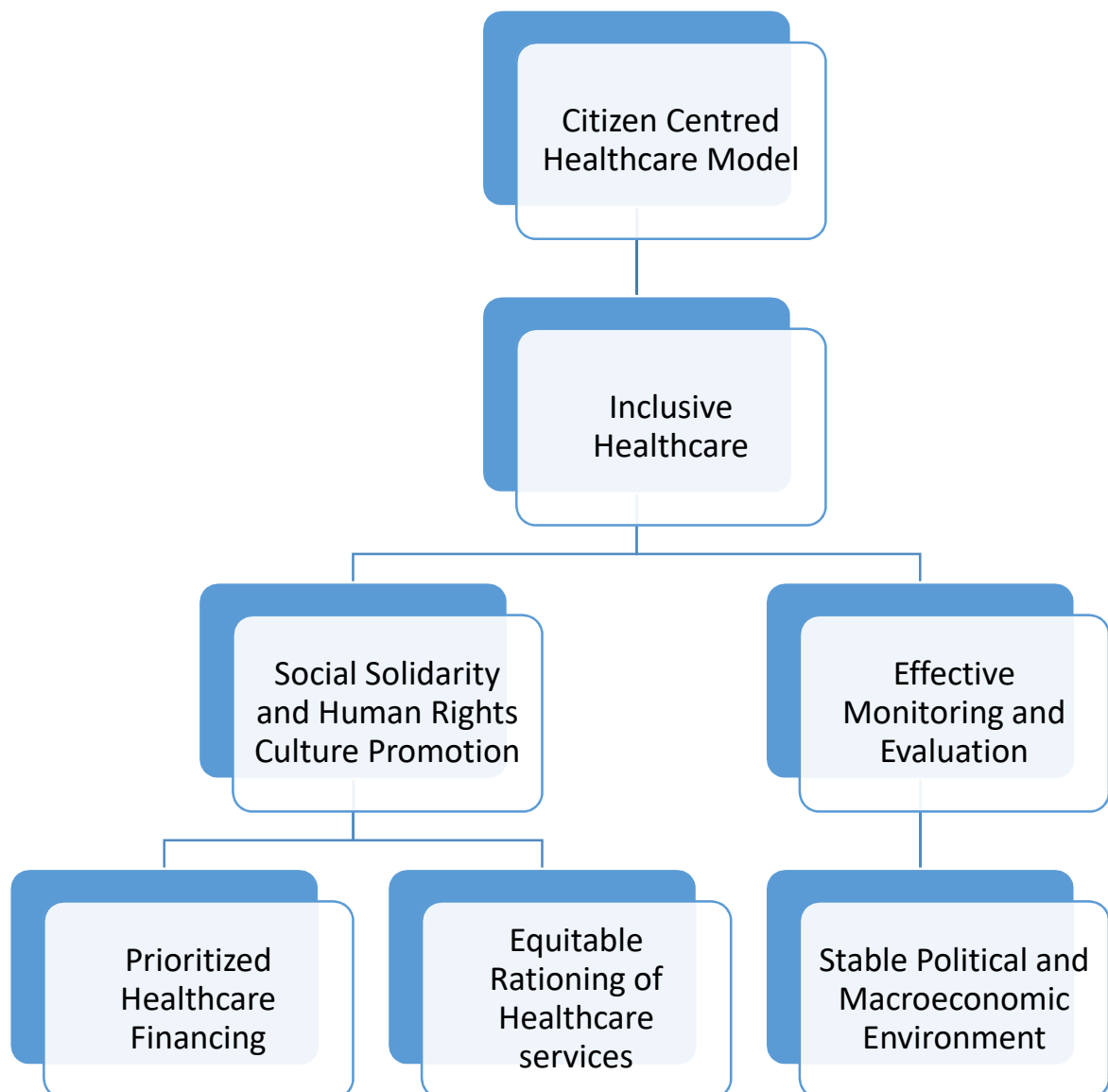


Figure 3 shows the relationship of both equitable rationing of healthcare services and prioritized health financing as buttressing and strengthening the social solidarity and human rights culture and promotion leg of the Inclusive Healthcare paradigm. On the right side of the diagram, an illustration is being made to show that effective monitoring and evaluation takes place in a situation of a stable and macroeconomic environment. Effective monitoring and evaluation work in tandem with social solidarity and a positive human rights culture such as freedom of speech, access to both private and public information as well as equal protection of the law. A detailed discussion on the complementary approaches to allocation of budgets for health is beyond the scope of this thesis but readers are referred to Beauchamp and Childress, 2013 p280-1 and other reputable sources.

Beauchamp and Childress explain the concepts of budget allocation: “partitioning the comprehensive social budget, allocating within the health budget, allocating within the targeted budgets and allocating scarce treatment for patients” (Lee, 2010). Similarly, for an in-depth discussion on the types or dimensions of rationing coverage readers are referred to standard texts on the topic (Teutsch and Rechel, 2012). Similarly, detailed texts on the substantive description of principles of healthcare resource rationing are available but beyond the scope of this thesis (Cookson and Dolan, 2000).

9.4.2.4 Social Solidarity and Human Rights Culture Promotion

Social solidarity is defined as “...an element of human association that emphasizes the cohesive social bond that holds a group together, which is valued and understood by all group members. There are different motives for solidarity. For some, affection and shared norms and beliefs are motives, while for others, rational choice and self-interest are drivers”(Douwes, Stuttaford and London, 2018).

Worrying trends have emerged in Zimbabwe over years whereby alleged state security agents (Police, Army, and Intelligence agents) have been reported to violently abuse citizens during law enforcement and crowd control operations (Cohen, 1986; Phimister and Raftopoulos, 2007; Moyo, 2019; Mutanda, 2019; Shubin, 2019). The most recent publicised incidents are the alleged shootings by the Zimbabwe army of innocent citizens during the 2018 August post-election marches in Harare as well as the January 2019 anti-petrol price increase demonstrations. During the COVID-19 *stay at home or lockdown* period of 2020, the army and police were again flagged for alleged fragrant violent abuse of citizens' rights. While the frequency of strikes by Zimbabwean HCPs is partly understandable by virtue of such deficits as inadequate personal protective equipment (PPE) and sub-survival salaries and incentives, the general lack of ethical handling of healthcare consumers at both public and private facilities has created a big blot about their professionalism (Bassett, Bijlmakers and Sanders, 1997; Chonzi and Sibanda, 2012).

Social solidarity is critical for social and community activism needed to hold the policy makers and politicians to account in terms of what the statutes prescribe, expectations of society, and the ideal healthcare goals (Hunt and Backman, 2008). The best-known contemporary example of the effectiveness of social solidarity in the sub-Saharan region is the *Treatment Action Campaign* (TAC) of South Africa (Friedman and Mottiar, 2005). In Zimbabwe perhaps the equivalent of TAC could be the *Zimbabwe Association for Doctors for Human Rights* (ZADHR) and the *Community Working Group for Health* (Rusike, 2018; Statement, 2018).

The promotion of human rights culture goes hand in glove with social solidarity. The CCHM focuses particularly on the infusion of human rights training into the healthcare professionals (HCPs) at undergraduate, post-graduate, and at college levels. In addition, policy makers

(including legislators, Ministers, Senators, Councillors, etc), administrators of both public and private healthcare funds need to have continuing education on Human rights ethos.

Figure 4: A Pyramidal ranking of the elements of the CCHM

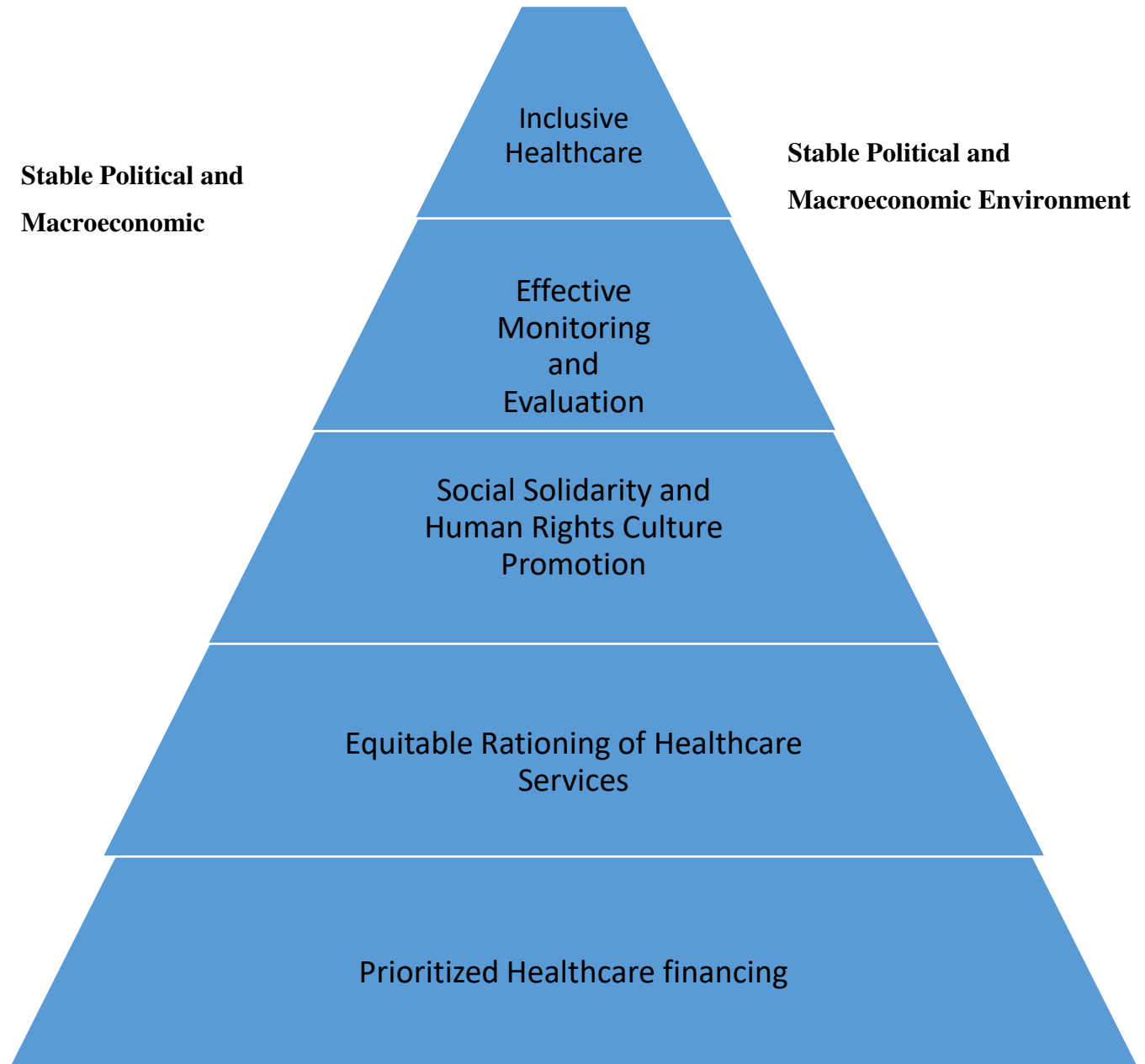


Figure 4 illustrates the pivotal position of Social Solidarity and Human Rights Culture Promotion in the hierarchical ranking of the CCHM elements.

9.4.2.5 Effective Monitoring and Evaluation

The successful operationalisation of the Citizen Centred Healthcare Model (CCHM) rests on effective monitoring and evaluation. Monitoring is defined as:

...a continuing function that aims primarily to provide the management and main stakeholders of an ongoing intervention with early indications of progress, or lack thereof, in the achievement of results. An ongoing intervention might be a project, program or other kind of support to an outcome. Monitoring helps organisations track achievements by a regular collection of information to assist timely decision making, ensure accountability, and provide the basis for evaluation and learning (Sera and Beaudry, 2007).

Monitoring is critical for the success of the CCHM so that the overall aims and objectives of introducing an ethically justified model for access to healthcare in Zimbabwe are achieved.

Monitoring goes hand in hand with evaluation. There are different types or levels of evaluation. The commonest ones are formative, continuous, and summative evaluation. All types of evaluation are important. Evaluation is defined as:

...is the systematic and objective assessment of an on-going or completed project, program, or policy, and its design, implementation and results. The aim is to determine the relevance and fulfilment of objectives, development efficiency, effectiveness, impact and sustainability. An evaluation should provide information that is credible and useful, enabling the incorporation of lessons learned into the decision making process of both recipients and donors (Sera and Beaudry, 2007).

It can be argued without much contestation that the healthcare delivery system has not achieved much of its potential since the attainment of political independence in 1980. It is now forty years down the line and we should be talking of a good story. Sadly, we are not. (Bijlmakers and David, 1996; De Castella, 2003; The Lancet, 2008; Andrew, 2015a; Gwarisa, 2019). It can also be argued that this may be partly due to the inappropriate and inadequate monitoring and evaluation of programs, from the financing, quality of healthcare services, and implementation side of things. Quality of healthcare services needs to take a centre stage in the monitoring process and this is the reason why the CCHM advocates citizen involvement so that quality is evaluated from a multi-stakeholder perspective of financier, provider, and consumer.

Progressive elements of Ubuntu and Egalitarianism underpins the process of effective monitoring and evaluation in the CCHM as elements of community solidarity, participation, accountability, and fairness find expression when multi-stakeholders are involved in monitoring and evaluation of programme effectiveness, appropriateness, and quality. Effective monitoring and evaluation help the government to see where it can relook its targeting of healthcare resources so as to realise value for money and receive feedback from consumers on such issues as quality and effectiveness. Effective monitoring and evaluation will also help other stakeholders such as the donor community since they bankroll a significant portion of public healthcare financing. Similarly, the citizenry needs to be empowered, through their parliamentary representatives and the Civil Society Organisations, to monitor and evaluate health programs that are funded by both donors and the tax revenue. The recipient is not the government but the citizenry of Zimbabwe. The government receives and distributes donations and taxes in trust for the citizens. Without effective monitoring and evaluation allegations and proven corruption in healthcare resources will continue unabated (Chipunza, 2014, 2015; Moyo, 2014; Chimberengwa, Masuka and Nt, 2015; Charles, 2017; John, 2020; Vinga, 2020). Recommendations on how the CCHM can enable effective monitoring and evaluation are described in chapter 10.

9.4.2.6 Stable Political and Macroeconomic Environment

The new government that arose following the ousting of the long-ruling former President Robert Mugabe in November 2017 modelled itself along the lines of a new dispensation (Beyrer and Donaghue, 2009; Green, 2018b; Mnangagwa, 2018). This new government subsequently submitted itself to the electorate in the disputed elections of August 2018. The dispute subsequently spilled over into Zimbabwe's Supreme Court, where the election verdict was settled in favour of the incumbent (Bratton and Masunungure, 2018; Pigou, 2018; Mwonzora and Mandikwaza, 2019; Mateveke and Chikafa-Chipiro, 2020; Mwonzora and

Xaba, 2020; Ndakaripa, 2020). The new government did not waste time in spelling out its ambitious national economic vision called *Zimbabwe to be middle economy by 2030* (Chitiga, 2018). However, the situation on the ground says a different story.

9.4.2.6.1 An Avalanche of Statutory Instruments: Confusion or Knee Jerk Reaction to deteriorating Macro-Economic Environment?

So many statutory instruments have been gazetted between August 2018 and June 2020 on monetary and fiscal issues so much that the country has lost count. In 2020 the country witnessed a new statutory instrument almost every week, ranging from currency changes to the regulation of banks and tax issues. For example, the use of multicurrency, popularly referred to as free funds in official government statutory instruments, has been banned and unbanned several times in just two years. Medical insurance players and subscribers have been left scratching their heads due to confusion caused. It's virtually impossible to plan, even for a few weeks. The year 2018 had 260 SIs, 2019 witnessed at least 285 statutory instruments (SIs) gazetted, and by 19th April 2020, at least 93 SIs had been gazetted during the year 2020 alone. It is clear that the country is operating on an ad-hoc basis judging by the increasing number of SIs each year. This makes it very hard to plan and the health sector is not spared.

9.4.2.6.2 History of Disputed Elections

The history of disputed national elections in Zimbabwe goes far back to the year 2000 (Sithole and Makumbe, 1997; Sithole, 2001; Kagwanja, 2005; Kriger, 2005, 2006; Moyo, 2009; Masaka, 2012). Ever since the country's electoral landscape has brought divided opinions on whether the outcome inspires confidence to the local and international players. I accept that there is no perfect electoral outcome but the intensity of the disagreements after each electoral process since the year 2000 has had a very damaging effect on the socio-

economic fabric of Zimbabwe. These electoral disputes are alleged to have led, in part, to the invoking of sanctions by the USA, European Union, and other western democracies.

Although there is divided opinion on the justification for sanctions, their impact has had very devastating effects on all aspects of life in the country. The Government of national unity (GNU) between Morgan Tsvangirayi's MDC and Robert Mugabe's ZANUPF in 2009 provided a needed, but short-lived, recipe (Pillitu, 2003; Grebe, 2010; Mapuva, 2010; Chigora and Guzura, 2011; Maposa, Muguti and Tobias, 2013). The GNU managed to arrest the world record hyperinflation which had afflicted Zimbabwe from 2002 to 2008, resulting in virtually wiping off the country's and individual savings. All social services, including healthcare, had collapsed (Hanke, 2008; Kramarenko, Engstrom and Verdier, 2010; Coomer and GsTraunThaler, 2011; Koech, 2011; McIndoe-Calder, 2018).

9.4.2.6.3 A Stable Macroeconomic and Political Environment is Important

The description above of the historical and current economic, monetary and fiscal situation in Zimbabwe helps to illustrate the need for and importance of a stable macroeconomic and political environment so that any viable healthcare service can operate. The following progressive elements of Egalitarianism and Ubuntu find expression in an environment of a stable macroeconomic and political environment: distributive justice, correcting income inequality and distribution, social cohesion, community solidarity, and participation. The viability of the CCHM is predicated on such a stable environment. Lessons can be drawn from countries that have instituted healthcare reform such as Taiwan, China, USA, and South Africa (their recent trial with a National Health Insurance) (Cheng, 2003; Healy, 2008; Tsung-mei and David, 2009; Simonet, 2010; Obama, 2016; Taderera, Hendricks and Pillay, 2016; Meng *et al.*, 2019). Figures 3 and 4 illustrate the omnipresence of the macroeconomic and political stability required for the viability of the Citizen Centred Healthcare Model.

On the political front it is still not certain how the initiative of President Emmerson Mnangagwa, called The Political Actors Dialogue (POLAD), would foster a more inclusive and stable political environment in Zimbabwe. POLAD²³ was initiated immediately after the disputed 2018 National elections

9.4.2.7 Discussion: The CCHM analysed using Maslow's Hierarchy of Human Needs

The Citizen Centred Healthcare Model (CCHM) has six foundational building blocks, illustrated in a pyramid analogous to Abraham Maslow's original five-tier hierarchy of human needs (Maslow, 1954). The sixth block or level (Stable Political and Macroeconomic Environment) in the CCHM does not appear directly in the hierarchy of the ranking pyramid in figure 4 but forms the environment in which the CCHM must find expression and viability.

The CCHM must be analyzed philosophically, as if it is a living human being with increasingly complex needs from lower to top levels. Just like in Maslow's pyramid ideally the lower needs (basic needs) of the CCHM pyramid must be satisfied first before we move to higher needs although in practice this is not always the case (Hoffman, 1988; Kenrick *et al.*, 2010). For example, Maslow's basic needs comprising physiological (food, water, warmth, and rest) and safety (security and safety) need at the lowest level are analogous to the CCHM's Prioritized Healthcare Financing and Equitable Rationing of Healthcare Services. Without appropriate, adequate, and innovative funding the CCHM, just like any vibrant healthcare system, would not thrive and blossom. It would shrivel and die.

The Prioritized Healthcare Financing and Equitable Rationing of Healthcare Services function to provide security and safety roles to the CCHM. The Social Solidarity and Human Rights Culture Promotion and the Effective Monitoring and Evaluation levels on the CCHM

²³ [https://www.pindula.co.zw/POLAD_\(Political_Actors_Dialogue\)](https://www.pindula.co.zw/POLAD_(Political_Actors_Dialogue))

pyramid are analogous to the Belongingness and love needs (intimate relationships and friends) and Esteem needs (prestige and feeling of accomplishment) on Maslow's hierarchy of human needs. The pinnacle of Maslow's hierarchy of human needs is the Self-fulfillment needs (Self-actualisation-achieving one's full potential, including creative activities) (Wulff, 1965; Wahba and Bridwell, 1973; McLeod, 2007). This level is equivalent to the Inclusive Healthcare on the CCHM. I propose the acceptance of Maslow's hierarchy of human needs as a valid analogy the CCHM, as we should and we ought to, it becomes easier to appreciate the argument that the lower four levels on the CCHM pyramid are deficiency needs for the CCHM while the Inclusive Healthcare is equivalent to growth or being needs on the Maslow's hierarchy of human needs. Deficiency needs must be met before we move to growth needs. It can be argued that the current Zimbabwean healthcare system has been deprived of basic needs for a very long time and it is presumed to be failing dismally. It needs urgent resuscitation (Chikanda, 2006; Moyana, 2017; Kidia, 2018). The level of healthcare deterioration in Zimbabwe is paralleled by the level of alleged human rights violations (Pincock, 2005; Keller, Stewart and Eppel, 2008; Madzimbamuto, 2008; Makoni, 2019; Ndhlovu Ray, 2020).

Inclusive Healthcare is the pinnacle of the CCHM. It is the ultimate and absolute goal of this prototype healthcare model, arguably a more ethically justifiable to confront the multi-layered healthcare problems in Zimbabwe. Inclusive Healthcare must be buttressed, supported, and sustained by the six foundational building blocks as illustrated in figure 4. Consistent with Maslow's refinement of his own original motivational theory later on-expressed famously in the hierarchy of human needs- the accomplishment of the foundational building blocks for the CCHM is not necessarily always sequential. In fact, the accomplishment of the foundational building blocks for the CCHM ideally must be accomplished simultaneously or concurrently. As we put together innovative funding, so

should we also pay attention to such fundamentals as effective monitoring and evaluation, social solidarity, and human rights culture promotion.

9.5 Chapter Summary

This chapter describes in great detail a proposal for a new healthcare model titled the Citizen Centred Healthcare Model (CCHM) presented as an answer to the myriad of health challenges in the country. The chapter starts by giving a description of healthcare reform in general, and its implication and justification to Zimbabwe, in particular. The ethical foundations of Egalitarianism, Utilitarianism, and Ubuntu are described to give the reader an ethical context from which the CCHM is designed. The building blocks of the CCHM, namely the building blocks and catalysts, are discussed and illustrated pictorially, in detail. The CCHM demonstrates a departure from the seemingly egalitarian *Plan for Equity in Health policy enunciated immediately after independence* unlike the latter the CCHM is not only based on a distributive mantra but is predicated on a strong legal foundation provided by the new Zimbabwean constitution of 2013 as well as strong monitoring and evaluation paradigm by citizens and statutory bodies. This is critical to guard against abuse, corruption, and wastage of national resources for health and to ensure that healthcare programmes focus on the intended beneficiaries. The following chapter, which is the concluding chapter, presents concluding remarks and recommendations.

CHAPTER 10: DISCUSSION, SUMMARY AND CONCLUSION

10.1 Introduction

The healthcare system in Zimbabwe has steadily deteriorated from the mid-1990s, albeit interspersed with short periods of seemingly stability and improvement. During the first decade of Independence Zimbabwe was applauded for adopting pro-poor and egalitarian health policies which were meant to redress the unfair policies of the colonial period.

However, access to both public and private healthcare services by the population has gradually diminished to levels unable to sustain promotive, curative, and preventive aims and objectives of national statutes and healthcare programmes of Zimbabwe as well international and regional, health statutes to which Zimbabwe is a signatory. One of the most important national statutes compelling Zimbabwe to guarantee access to a minimum basket of healthcare is the new constitution of Zimbabwe enacted in 2013.

The problems affecting the Zimbabwean healthcare system are varied and multi-factorial in nature. The most prominent problems are to do with inadequate investment and poor budgetary support from the government, an erratic and unstable monetary and fiscal environment, unpredictable currency policies, poor access to healthcare services, inadequate insurance coverage to the population, erratic and inadequate payment of salaries to healthcare professionals and poor regulation of the little available medical insurance. Since the 1990s several economic rescue packages were initiated by the World Bank (WB) and International Monetary Fund (IMF) to assist Zimbabwe structure its economy with the hope that the trickle-down improvement will show up the fortunes of social services such as healthcare and education in the country. The Economic Structural Adjustment Programmes of the 1990s failed to help Zimbabwe to improve its economic output with dire consequences on social

services including healthcare. The WB and IMF prescribed economic structural adjustment programmes that were premised on the assumption that if Zimbabwe is assisted with managing its affairs by cutting down on its bloated government bureaucracy, tax reforms, and price liberalisation would bring about improvement in access to healthcare as well as efficiency in service delivery. This would translate into savings that can be channelled to the productive and social sectors (Makoni, 2000; Nyazema, 2010; Mlambo, 2013; Bonga, 2014). However, it became apparent that these modes of savings are insufficient to ameliorate the economic problems partly because of the absence of a reliable economic model buttressed by political will and good governance (Bjorkman, 2004). The healthcare sector, in particular, is in need of a new healthcare model as all previous models have failed. I argue that the failure of these healthcare models was caused by a lack of a coherent ethically justified model which can go beyond just *paying lip service* to egalitarian and distributive principles but also encompass strong monitoring, evaluation, and oversight component provided by a vibrant citizenry and statutory bodies. This new model should be a full package comprising political, economic, fiscal, budgetary, and social re-alignments. Without a new paradigm change to create a new direction no amount of budgetary support from internal sources and donors will change the healthcare fortunes of Zimbabwe.

10.2 Summary of Focus of the Thesis Chapters

Chapter 1 describes the roadmap for this thesis by giving a summary of the focus of each of the ten chapters.

Chapter 2 gives a background to the genesis of healthcare problems in Zimbabwe. It also explains the legal and ethical justifications for a new model of access to healthcare in Zimbabwe. It went into detail on explaining and justifying the necessity for healthcare reform in general as well as with particular reference to the situation of Zimbabwe. Section 2.2 of the

chapter describes the genesis of Zimbabwe's healthcare problems and challenges over the years since political independence in 1980. Though Zimbabwe's healthcare problems are multi-faceted, the issues of corruption (Rusvingo, 2014a), inadequate financing (Shamu and Loewenson, 2006; Sera and Beaudry, 2007; Shamu *et al.*, 2007, 2010), lack of social solidarity, lack of effective monitoring, evaluation and lack of inclusivity in access to *a basket of functional healthcare services* feature as the most recurring issues. Section 2.3.1 presents a clear argument that Zimbabwe is in default of fulfilling, protecting, and promoting the right to healthcare as enriched in the WHO constitution, AU, and SADC statutes to which it is a voluntary signatory. More importantly, Zimbabwe is also in default with regards to fulfilling provisions envisaged in its national constitution.

Chapters 3 and 4 of this thesis focussed on the development of healthcare policies from the pre-independence period to the post-independence period (to 2020). Chapters 5 to 7 discussed three selected moral theories of Egalitarianism, Utilitarianism, and Ubuntu- with a special focus on how they can be harnessed to shape a new healthcare model called the Citizen Centred Healthcare model. A new healthcare model cannot be crafted without looking at current models being used around the world. As such chapter 8 was dedicated to discussing various models in detail. Chapter 9 described the CCHM.

Chapters 5 to 7 of this thesis focussed on selected normative moral theories of Utilitarianism, Egalitarianism, and Ubuntu. These three normative moral theories were selected on the basis of their appeal and relevance to the design of the CCHM.

Chapters 8 discussed in detail various prototype healthcare models, notably the Beveridge, Bismarck, Out of Pocket Spending, and NHI models.

Chapter 9 discusses in full The Citizen Centred Healthcare model (CCHM), best described as a hybrid between several mainstream models such as the Beveridge, Bismarck, Out of

Pocket, and the National Health Insurance. The design, operation, and justification of CCHM draw upon the positive attributes of the egalitarian, utilitarian and Ubuntu normative moral theories. This new paradigm is designed to promote, protect and fulfil the right to health for all Zimbabwean citizens, immigrants, refugees, and permanent residents regardless of political status, religious beliefs, ethnicity, race, gender, sexual orientation, age nor political affiliation. These distinctions must not dictate the scope, quality, and timing of healthcare services available to the citizens and all legal inhabitants in the country. In addition, the CCHM endeavours to provide healthcare services in sufficient quantities and scope in such a way as to fulfil the provisions and aspirations as enshrined in the international, regional, and national statutes to which Zimbabwe is a voluntary signatory. A good model may remain just a paper tiger unless if it finds expression through a coherent implementation matrix.

This chapter (chapter 10) discusses suggested policy options, implementation benchmarks, recommendations and provides an epilogue or concluding remarks about the CCHM.

10.3 Suggested Policy Options

In order for the Citizen Centered Healthcare Model to be successfully implemented several policy options need to be considered, debated, refined, and adopted. I suggest the following options.

10.3.1 Innovative Funding

Funding for healthcare resources is very critical for the successful implementation of any healthcare program. The following are some suggested funding options for the CCHM:

- i.* **National Health Insurance (NHI):** A National Health Insurance funded via general national taxation is proposed: “Under government-financed national health insurance plans, funds are collected by a government or quasigovernmental fund, which in turn pays

hospitals, physicians, health maintenance organizations (HMOs), and other health care providers (Bodenheimer and Sullivan, 1997; Organization, 2004; Reeves *et al.*, 2015).

General taxation can be defined as: “A general tax refers to a tax that applies to all or most goods and services and where all are taxed at the same rate. An excise tax refers to a tax on a single item, which may be different than the tax levied on other items” (ibid). In a tax-based financing for a healthcare system at more than half of public expenses are funded via revenues other than those from payroll taxes. It is important to distinguish this from *social security or social health insurance* in which case access to publicly funded healthcare services is open to all citizens. Readers are referred to standard texts on various modes of tax-based financing for healthcare systems as it is beyond the scope of this chapter.

This would have the advantage of covering everyone including those in informal employment. Zimbabweans would have a choice to enrol on private health insurance or keep their existing schemes as an add-on to their NHI benefits as this would not only augment national and household healthcare financial resources and reduce Out-of-Pocket Spending or shortfalls but would protect the existing private healthcare insurance industry. A possibility for discounting contributions to a private health insurance scheme on corporate tax or individual tax can be considered a way of encouraging citizens to maintain or enrol on private health insurance as well. It is encouraging to note that Zimbabwe has already put into place proposals to incorporate those informally employed into the taxation pool in their proposed 2021 national budget presented to parliament on 26th November 2020 (D. B. Y. Veritas, 2020; Startupbiz.co.zw, 2020). A cautious approach is needed as Zimbabwe has not had much success with public insurance, with the scandals at National Social Security Authority (NSSA), the National Aids Levy, and National Health levy on airtime and mobile data still fresh on the national psyche (Rwafa, 2014; Khumalo, 2015; Shumba, 2015; Bhat *et al.*, 2016; Sidindi, 2017).

- ii. **Community Health Savings Schemes (CHSS):** Community health savings schemes would cover the agricultural sector and rural areas. This health insurance would be redeemed at the district and rural health centre levels. CHSS would be treated much the same way as an add-on private health insurance subscription described above. Lessons can be drawn from countries such as China (Meng *et al.*, 2019).
- iii. **Private Health Insurance:** This would be effectively regulated to create true competition, efficiency and eliminate conflict of interest. Private Health Insurance already exists in Zimbabwe but covering a very small portion of the population (about 8%), in tandem with a very small formal employment base. Now that there are proposals to incorporate those who are informally employed into the national tax base, rebates or discounts upon enrolling on private health insurance could encourage those informally employed to get private health insurance.
- iv. **Reimbursement for Out of Pocket Spending on Health:** This could be effected by tax incentives or direct re-imbusement to encourage citizen participation in spending more on healthcare thereby assisting the State in carrying out its obligations.
- v. **Devolution of health budgets:** Government would still be expected to provide budgets and grants to statutory health organisations such as hospitals, directorates, regulatory agencies, research agencies, training programmes and administrative structures. Devolution of Health budgets to provincial, central and district hospital levels could be considered to encourage local accountability as well as timely purchases of inputs and supplies.

10.3.2 Effective Monitoring and Evaluation

The CCHM proposes that the following be mandated or strengthened, where they already exist, to carry out effective monitoring and evaluation. Their observations and

recommendations must be binding and influence the reporting, design, programming and implementation of healthcare programmes in the country.

- i. Parliamentary Select Committee on Health
- ii. Zimbabwe Human Rights Commission
- iii. Zimbabwe Civil Society e.g. ZimRights, Zimbabwe Association of Doctors for Human Rights (ZADHR), Zimbabwe Lawyers for Human Rights (ZLHR), Consumer Council of Zimbabwe etc.
- iv. Professional Associations: Zimbabwe Medical Association, Zimbabwe Nurses Association, Zimbabwe Dental Association, Medical and Dental Practitioners Council, Hospital Doctors Association, Nurses Council etc.
- v. Local community representatives on Hospital Boards

10.3.3 Handling of Complaints against Providers and Regulatory Agencies

There is need for creation of statutory or even constitutional bodies to handle complaints against healthcare providers, State institutions, Medical Aid Societies/insurance players and Healthcare Professional Associations. Successful lessons can be drawn upon from South Africa, United Kingdom and India. South Africa has offices of ombudsmen at the Health Professions Council of South Africa (HPCSA) and at Department of Health (For *et al.*, 2008; Ombudsman, 2020; The Office of the Health Ombud, 2020). In addition, it has an office of Health Standards Compliance at the Department of Health (South Africa, 2020). India has offices for Health Insurance Ombudsmen in various states (Ombudsman-India, 2020) while the United Kingdom has an office of Parliamentary and Health Service Ombudsman (Parliamentary and Health Service Ombudsman, 2020). The following are suggested for Zimbabwe:

- i. A statutory National Health Ombudsman office

- ii. Statutory Provincial Health Ombudsman offices
- iii. An Independent Health Service Ombudsman office, unit or department in each Professional Board and Professional Association such as the Nurses Council, Pharmacy Council, Medical and Dental Practitioners Council, the Zimbabwe Medical Association (ZIMA) and the Zimbabwe Dental Association (ZIDA).
- iv. The Medical Societies Regulatory Authority

Zimbabwe suffers from a huge trust deficit between potential donors on one hand and between the government and its citizens on another. The genesis of this mistrust originated in part from chronic alleged human rights abuses and governance problems. Endemic corruption is cited as one of the biggest disincentives for large scale donor activity (Makumbe, 1994; S. *et al.*, 2005; Doig, 2006; Bonga, Chiminya and Mudzingiri, 2015; Choguya, 2018). As a result, this mistrust has wormed itself right into the core of solidarity and public finance utilisation (Konadu-Agyemang and Shabaya, 2005; Coltart, 2008; Beyrer and Donaghue, 2009; Chilunjika, 2018; Muchena, 2019). As an interim way forward the following proposed formal bodies or fora can go a long way in building transitory trust build measures: An annual or bi-annual national stakeholders planning forum and a Zimbabwe Donors Trust Account.

10.4 Need for Benchmarks for Healthcare Reform

Healthcare reform needs to be based on benchmarks which would function as guideposts. The two benchmarks given below are not exhaustive but given only as examples.

10.4.1 Benchmarks for Policy Tool Analysis for Developing Countries A Benchmarks for Policy Tool analysis for developing countries in one of the suggested strategies that can be used to implement the CCHM (Daniels *et al.*, 2000). While Zimbabwe's successive healthcare policies fail to match the expectations envisaged in all the nine benchmarks of the

Policy analysis tool the deficits measured against benchmarks 5 to 9 are especially more glaring. These deficiencies need special attention during implementation of the CCHM (see Table 5).

Table 5: Extract from Benchmarks for Policy Tool analysis for developing countries

Benchmark No.	Benchmark
5.	Equitable Financing
6.	Efficacy, Efficiency and Quality of Care
7.	Administrative Efficiency
8.	Democratic Accountability and Empowerment
9.	Patient and Provider Autonomy

Extract adapted from: (Daniels *et al.*, 2000)

10.4.2 Hsiao et al (2003)'s Six Element for Healthcare Reform Process

This strategy encourages self-examination and a pragmatic approach to tailor any reform process to suit own local conditions. The process comprises of six steps, some of which have already been described and developed throughout this thesis.

- i. Policy cycle description and an identification of the critical steps needed to be addressed during the reform process. Chapters 2 and 3 have described in detail the previous policies implemented since political independence in 1980. This analysis has helped to appreciate what has been tried, what has been achieved and how and where it has failed.

- ii. Ethical foundation development to guide the moral compass of the reform agenda. This has been addressed in chapters 4, 5 and 6. Additional ethical discussions are recommended to include such philosophies such as the social contract theory.
- iii. A systematic political analysis. The CCHM acknowledges the importance of a democratic playing field as a prerequisite for the success of any reform agenda.
- iv. Core of health system performance goals and intermediate performance characteristics.
- v. Use of a diagnostic tree to unpack to identify performance problems and their causes.
- vi. Health system control knobs which illustrate options available to reformers.

It is beyond the scope of this chapter to give detailed description of this strategy. Readers are referred to (Roberts *et al.*, 2003).

10.5 Need for Ethical Training at all Levels

I propose continuing education shorts courses in bioethics, human rights and health law for at all levels of training health and healthcare related training, covering diploma, undergraduate and post-graduate training. In addition, continuing ethics and bioethics education courses, seminars and workshops are needed for practising Healthcare Professionals (HCPs) as mandatory continuing professional development. Special ethics training is also needed for policy makers, managers, political representatives at all levels and administrators.

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, p. 27).

Small group teaching in bioethics has been demonstrated to have positive impact on consensus answers where ethical dilemmas are encountered (Moyana, 2017, p. 89).

10.6 Recommendations

The following recommendations are suggested:

- 1) Presentation of the CCHM at local, national, regional and International fora for further discussions, analysis and improvement.
- 2) Publication of summarised extracts from this thesis to enhance further scholarly debates.
- 3) Comparative analysis between the CCHM and other systems in order to further improve its content and applicability.
- 4) Dissemination of this thesis at conferences and seminars such as the Zimbabwe Medical Association AGM, Zimbabwe Dental Association AGM, Parliamentary committee meetings, Health Regulatory Authorities and Ministry of Health of Zimbabwe policy makers.
- 5) Presentation of the CCHM concept to Zimbabwean government through relevant departments such as Ministry of Health, for possible adoption in whole or parts.

10.7 Epilogue

There is no doubt that Zimbabwe is in urgent need of a new model of access to healthcare, which is ethically justified and designed to fulfil, promote and protect the right to health for its citizens as enshrined in the national, regional and international statutes to which it is voluntary signatory. The Citizen Centred Healthcare Model (CCHM) proposed in this thesis is a strategy which can change the fortunes of Zimbabwe's access to healthcare. The CCHM is premised on six foundational building blocks working synergistically and complementarily to produce a coherent, defensible and ethically justified new model for access to healthcare. The CCHM has a strong ethical foundation as it draws from the progressive aspects of Ubuntu, Egalitarianism and Utilitarianism normative moral theory underpinnings. The

foundational building blocks are: Prioritized Healthcare financing, Equitable Rationing of Healthcare Services, Social Solidarity and Human Rights Culture Promotion, Effective Monitoring and Evaluation, Inclusive Healthcare and Stable Political and Macroeconomic Environment. The CCHM takes into account the unique economic and financial limitations of Zimbabwe in implementing such conventional healthcare financing modalities like National Health Insurance, Universal healthcare, Single Payer, National Health Service and instead proposes a hybrid system called the Inclusive Healthcare. The stable macroeconomic and political environment factor is argued to be an overarching catalyst for all the other five blocks, in view of the severe trust and confidence deficit in Zimbabwe.

Unlike the previous and current healthcare models of Zimbabwe, which have all but failed, the CCHM provides a paradigm shift by encompassing a strong quality control aspect expressed via its reliance on a strong monitoring, evaluation and oversight from citizenry, statutory bodies and other critical stakeholders like churches, traditional leaders and donors or external partners.

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