TRAINING AND CAPACITY DEVELOPMENT IN HEALTHCARE: WHAT ROLE CAN THE PRIVATE SECTOR PLAY?: A CASE OF ZIMBABWE

Chidziva C[1,2], Soko ND [3]

[1]Department of Surgery, Faculty of Medicine, University of Zimbabwe, Harare, Zimbabwe
[2]Harare Eye, Ear, Nose and Throat Institute, 5 Weale Road, Milton Park, Harare
[3]Department of Biochemistry, Faculty of Science, University of Zimbabwe, Harare, Zimbabwe

***Address for correspondence*:** Dr. Clemence Chidziva, Harare Eye, Ear, Nose and Throat Institute, 5 Weale Road, Milton Park, Harare, Zimbabwe. Email: cchidziva@audiomaxclinic.com

ABSTRACT

Africa is disproportionately saddled with both poverty and disease. Africa accounts for 29% of the global disease burden while Africa has only 3.5% of global healthcare personnel, of which only 1.7% are doctors. In Zimbabwe, there are 1.6 physicians and 19.35 nurses for every 10,000 Zimbabweans[1], a far cry from the World Health Organisation's recommended 1 doctor per 1000 patients. The challenges of training healthcare personnel in Africa are well documented. They include poor human resource planning priorities, low funding, old and dilapidated infrastructure, old and outdated curricula, poor remuneration and a brain drain as trained personnel emigrate from Africa to more resourced and better compensating markets.

Dr. Margaret Mungherera speaking in her capacity as the World Medical Association president in 2007 said "the responsibility of ensuring that medical education is of the highest possible standards must be shared, however, between profession, training institutions and the government." It is our view that the time has come when all stakeholders in healthcare in African countries need to participate fully in the training and retention of healthcare personnel if there is to be marked improvement in healthcare personnel output and retention on the African continent.

The case of Zimbabwe

Traditional training of healthcare personnel in Zimbabwe lies squarely on the shoulders of the government of Zimbabwe. Competing priorities and socioeconomic and political uncertainties in the past two decades have greatly reduced government funding of both training institutions and government run health facilities. In response to the decline in economic output, funding of health from the fiscus decreased. In 2009, 12% of a 12.5 billion United States Dollar GDP was devoted to health, and this figure decreased to 7.46% in 2016[2]. Prior to the year 2000, government funding of public health institutions and training institutions was adequate. Zimbabwe had a single medical school at the University of Zimbabwe in Harare training doctors and several schools that trained nurses. During this period, hospitals were well equipped, staff adequately remunerated, and patients could afford services offered by the public health system. The training was of an adequate standard and was able to meet the needs of the communities and the nation at large. High end medical procedures like open heart surgery, cochlear implants, and separation of Siamese twins by locally trained paediatric surgeons all attest to the high standard of training prior to the brain drain and the decline in patients treated in public institutions. The overall output of healthcare training was a well-trained medical practitioner. Furthermore, retention of trained healthcare workers was met the needs of the population.

After the economic and political upheaval at the start of the millennium, a new reality set in affecting both healthcare provision and training institutions. The net effect of the deteriorating economic climate was a reduction in government investment in public health institutions and state universities. Consequently, retention of academic faculty began to decline as academics left public institutions. Many left the country in pursuit of better remuneration and working conditions. Deteriorating economic conditions reduced remuneration of healthcare practitioners. A natural brain drain followed with the majority of practitioners migrating to better resourced countries whilst those that remained entered private practice. Currently, health practitioners in state institutions dedicate more time to private practice where working conditions, infrastructure, and remuneration are higher. Cycles of hyperinflation have eroded disposable income in the general population and public institutions saw a decline in patient numbers. Patients who could afford to do so chose private health care over public health systems. Dwindling patient numbers at public institutions reduced clinical exposure for trainees at both undergraduate and postgraduate levels, and for faculty. This has been compounded by outdated and dilapidated infrastructure and ill equipped training institutions; and public healthcare systems are unable

to meet the standard of quality training required at both undergraduate and postgraduate levels.

However, despite deterioration in public health systems, private health systems in Zimbabwe tell a different story. Private health care in Zimbabwe is a robust industry. There is significant investment in infrastructure and remuneration of personnel, and has much higher staff retention than does the public health system. Accountability and transparency are higher in private; hence investors find the private healthcare system to be a lucrative investment opportunity. Activities in the private sector have therefore remained steady and robust.

However, private healthcare has benefited tremendously from the health training provided by the public health system and state training institutions, but has put very little back into the training system. It is our view that it is time for private-public synergies to be actively pursued to ensure the survival and resuscitation of quality training of health personnel in Zimbabwe.

In conclusion, training and capacity development should be an obligation of all players including the private sector.

Notes on contributors

Clemence Chidziva is an otorhinolaryngologist with nineteen years in clinical practice. He is part of the otorhinolaryngology faculty at the University of Zimbabwe. He is passionate about medical business models as well as training and capacity development in healthcare.

Nyarai D Soko holds a PhD in human genetics with a particular interest in human genetic disorders in Zimbabwe. She is involved in instruction of medical students including student training in medicine, dentistry, optometry, nursing sciences in human genetics, biochemistry related sciences.

REFERENCES

1. World Health Organization. The 2018 update, Global Health Workforce Statistics, World Health Organization. Geneva. Accessed from *http://www.who.int/hrh/statistics/hwfstats/* .
2. Ministry of Health and Child Care. Zimbabwe National Health Finance Policy. "Resourcing Pathway to Universal Health Coverage" 2016. Accessed from *http://documents1.worldbank.org/curated/pt/840661563174110288/pdf/Zimbabwe-National-Health-Financing-Policy-Resourcing-Pathway-to-Universal-Health-Coverage-2016-Equity-and-Quality-in-Health-Leaving-No-One-Behind.pdf.*