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A Prototype Model for Ethically Justified Healthcare Access in Zimbabwe

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Abstract

Zimbabwe's healthcare system reflects longstanding inequities, intensified by economic liberalisation, structural adjustment, and migration of professionals. Despite constitutional guarantees, access remains unequal, particularly in rural areas. This study conducted a desktop review of academic literature, policy documents, and legal texts from the pre-independence period to 2025. Using a moral-ethical critique grounded in egalitarianism, utilitarianism, and *Ubuntu*, it evaluated Zimbabwe's healthcare challenges against international models such as Beveridge and Bismarck. Findings reveal systemic exclusion of the poor, overburdened urban and private facilities, and neglect of rural populations, with equity, solidarity, and efficiency inadequately realised. The proposed **Citizen-Centred Healthcare Model (CCHM)** integrates six interlinked pillars—

prioritised financing, equitable rationing, inclusive governance, monitoring and evaluation, social solidarity, and political stability—to promote ethically grounded, context-sensitive reforms that advance justice, fairness, and sustainable healthcare access for all.

Keywords: *Healthcare Access; Bioethics; Zimbabwe; Citizen-Centred Healthcare Model; Distributive Justice; Public Health Ethics; Equity; LMICs.*

Introduction

Zimbabwe's healthcare system has experienced alternating phases of progress and decline, shaped by colonial legacies, post-independence reforms, and recurring economic crises. The early 1980s marked notable gains in rural health expansion, yet subsequent decades suffered from chronic underfunding and shortages (Loewenson & Sanders, 2021; Chikwanha, 2012). These challenges, compounded by the migration of skilled personnel, have widened inequities—leaving rural communities, women, and people living with chronic conditions disproportionately underserved (Chigariro et al., 2023; Dzinamarira et al., 2022). Recent analyses underscore the urgency of equity-driven reforms (Chingono & Maponga, 2024; WHO Africa, 2024).

Beyond financial and logistical constraints, drug stock-outs, politicised staffing, and opaque resource allocation raise ethical concerns about justice and accountability (Maponga, Mudzengi, & Rusakaniko, 2020; Mlambo & Sibanda, 2019). Patients often endure long waiting times, limited informed consent communication, and neglect of basic dignity—reflecting systemic failures to uphold autonomy, beneficence, and respect (Beauchamp & Childress, 2019; Wareham, 2020).

To situate Zimbabwe's experience within broader global debates, the study critically engages international models such as the Beveridge, Bismarck, and National Health Insurance (NHI) systems. While these frameworks offer insights into financing and governance, their direct application in fragile or resource-constrained contexts often proves unsustainable without socio-economic and cultural adaptation (Dussault & Dubois, 2019; Mills, 2014; Gilson, 2018).

Against this background, the study applies ethical frameworks rooted in egalitarianism, utilitarianism, and the African philosophy of *Ubuntu*—emphasising fairness, utility, and communal solidarity as guiding values for health-system design (Metz, 2017; Tangwa, 2019; Van Niekerk, 2021). The

findings highlight systemic failures: exclusion of the poor through user fees, neglect of rural services, and fragmented governance structures (WHO, 2021; United Nations, 2020; Moyo & Mavhunga, 2020).

In response, the article proposes the **Citizen-Centred Healthcare Model (CCHM)**—a framework anchored in six interlinked pillars: prioritised pooled financing, equitable rationing, promotion of solidarity and human rights, inclusive governance, robust monitoring and evaluation, and political stability. The model aims to provide an ethically justified pathway towards equitable and sustainable healthcare delivery in Zimbabwe.

Objectives of the Study

This article seeks to:

1. **Critically examine** barriers to equitable healthcare access in Zimbabwe, including structural, institutional, socio-economic, and ethical dimensions.
2. **Analyse** normative ethical theories and principles—justice, equity, autonomy, and solidarity—and assess their relevance to Zimbabwe's healthcare context.
3. **Develop** a framework for ethically justified healthcare resource allocation grounded in local realities and ethical theory.
4. **Evaluate** the strengths and limitations of the proposed model in comparison with international systems.
5. **Recommend** policy measures for government, regulators, and healthcare institutions to operationalise the model.
6. **Encourage** empirical and theoretical research on ethics-driven health equity in Zimbabwe and the wider African region.

Methodology

This study employed a qualitative, literature-based approach to develop an ethically justified model for healthcare access in Zimbabwe. A scoping review design was used to capture the breadth of scholarship and policy evolution across both historical and contemporary contexts.

Search Strategy and Data Sources

Evidence was drawn from peer-reviewed journals, grey literature, legal texts, and policy documents**.** Databases searched included PubMed,

Scopus, Web of Science, Google Scholar, and African Journals Online (AJOL). Grey literature was sourced from the World Health Organization (WHO), United Nations (UN), World Bank, and Government of Zimbabwe portals, as well as parliamentary and ministerial archives. Additional materials were located through citation chaining and snowballing from reference lists of key publications.

Eligibility Criteria

The review covered literature from pre-colonial Zimbabwe to August 2025, ensuring the inclusion of major governance and policy transitions. Eligible sources explicitly addressed healthcare access, equity, governance, ethics, or policy within Zimbabwe or comparable Southern African Development Community (SADC) contexts. Exclusion criteria included **non-**English publications without translation, works unrelated to healthcare access or ethics, and documents lacking governance relevance.

Screening and Selection

The initial search yielded **478 records**; after duplicate removal, **362** remained for title and abstract screening. Of these, **156** were selected for full-text review. Screening involved a sequential process of **title, abstract, and full-text evaluation**, followed by inclusion based on **ethical relevance** and contextual fit.

Data Extraction and Analysis

Data were extracted across ethical domains—justice, beneficence, autonomy, accountability, solidarity, and human rights. Thematic synthesis incorporated systemic factors such as financing models, donor dependency, rural–urban disparities, and governance fragmentation. Ethical reasoning was guided by egalitarianism, utilitarianism, and the African philosophy of Ubuntu, forming a normative framework for evaluating healthcare access. The resulting insights informed the development of the **Citizen-Centred Healthcare Model (CCHM)**.

Ethical Considerations

The study was based solely on secondary data obtained from published sources and publicly available policy documents. No human participants

or animals were directly involved; thus, formal ethical clearance was not required**.** The research adhered to academic integrity, transparency, **and** proper attribution of all sources**,** ensuring faithful representation of authors' views and contextualisation within Zimbabwe's socio-political realities.

Statement of the Problem

Zimbabwe's healthcare system mirrors the crisis faced by many post-independence African states—marked by fragile institutions, inequitable access, and declining public trust. The system functions as a hybrid of the Beveridge and Bismarck models**,** combining public provision with private-sector supplementation. Yet, approximately **92% of Zimbabweans rely on out-of-pocket payments**, while only about **8% possess medical insurance**, often with limited coverage and exclusions (Hongoro & Kumaranayake, 2000; Sekhri & Savedoff, 2005). Persistent fiscal constraints and debt-to-GDP pressures continue to limit investment in preventive and primary care (Mutizwa & Bonga, 2024), leaving vulnerable populations exposed to catastrophic healthcare costs (Moyana, 2017).

Chronic underfunding, policy inconsistency, and weak governance have further eroded public infrastructure, producing medicine shortages, dilapidated facilities, and preventable deaths (Kapp, 2004; Meldrum, 2008; Nyazema, 2010; Kidia, 2018). The **doctor-to-patient ratio** remains critically low at **0.8 per 1,000**, far below the **World Health Organization's recommended 3 per 1,000** (Rusvingo, 2014a; Green, 2018b). Public health expenditure remains under **1% of GDP**, far beneath the **15% Abuja Declaration** target and **SADC** benchmarks (Shamu & Loewenson, 2006; Rusike, 2018).

Regulatory oversight is inconsistent and largely reactive, characterised by weak enforcement in public institutions and fragmented monitoring of private providers (Ministry of Health and Child Welfare, 2013; Lynnette, 2016; Gwarisa, 2019). As a result, **accountability and transparency** have deteriorated, fostering inefficiency, corruption, and ethical lapses within the system. The resulting inequalities disproportionately affect rural and low-income populations, who remain excluded from essential services and face financial ruin from basic healthcare needs.

The growing disconnect between constitutional guarantees and lived realities underscores a moral and ethical crisis in governance. Zimbabwe's healthcare institutions have struggled to align with principles of **justice,**

solidarity, and beneficence, leading to inequities in both service provision and policy implementation.

In response, this study proposes the **Citizen-Centred Healthcare Model (CCHM)**—a framework grounded in *Ubuntu*, egalitarianism, and utilitarian reasoning. The model's six interdependent pillars—inclusive healthcare, prioritised financing, equitable rationing, effective monitoring and evaluation, social solidarity, and political-economic stability—seek to restore fairness, accountability, and dignity in healthcare delivery. The CCHM envisions a system where ethical governance underpins access, efficiency, and sustainability, ensuring that healthcare reform in Zimbabwe is both morally justified and socially equitable**.**

The Historical Context of Zimbabwe's Health Challenges

Zimbabwe's healthcare system has evolved through distinct historical phases shaped by colonial inequality, post-independence reform, and contemporary economic instability**.** During the colonial era, health services were racially segregated, favouring the white minority while marginalising the black majority (Iliffe, 1998; Mandizadza, 2019; Vaughan, 1991). Public health infrastructure was concentrated in urban centres and mining towns, while rural communities—home to most of the population—were left dependent on under-resourced mission hospitals and traditional healers.

Following independence in 1980, the new government adopted policies promoting equity, preventive care, and rural health expansion. The 1980s witnessed a surge in health facilities, immunisation programmes, and primary care access, supported by strong political commitment and external aid (Loewenson & Sanders, 2021). However, by the 1990s, these gains began to reverse under the **Economic Structural Adjustment Programme (ESAP)**, which introduced user fees, reduced subsidies, and imposed hiring freezes. The resulting cost-recovery approach disproportionately burdened low-income families and undermined access to essential services (Kawewe & Dibie, 2000; Chikwanha, 2012).

From the late 1990s onward**,** economic decline, political polarisation, and recurring droughts accelerated health system deterioration. Hospitals faced drug shortages, staff attrition, and infrastructural decay, while donor fatigue set in due to governance concerns (Maponga, Mudzengi, & Rusakaniko, 2020; Mlambo & Sibanda, 2019). The **2000–2008 hyperinflation crisis** further crippled service delivery, with most health

professionals migrating to neighbouring countries in search of stability (Chikanda, 2006; Dzinamarira et al., 2022).

Post-2010 recovery efforts introduced new partnerships between the government and international agencies, yet these remained fragmented and donor-driven, often producing vertical programmes lacking sustainability and equity (Loewenson & Sanders, 2021). Dependence on external funding has perpetuated policy incoherence, weakened domestic accountability, and diverted focus from long-term system reform (World Bank, 2022; UNDP, 2021).

The emigration of healthcare professionals remains one of the most severe challenges to national health capacity. Between 2023 and 2025, nurse and midwife migration reached unprecedented levels, with thousands leaving for the United Kingdom, South Africa, and Australia (Chigariro et al., 2023; Mupfumira et al., 2025). This brain drain has deepened rural–urban disparities, leaving peripheral communities critically underserved and dependent on outreach services or unqualified personnel.

Ethically, Zimbabwe's healthcare trajectory exposes a persistent tension between policy ambition and moral responsibility. While constitutional provisions guarantee the right to health, practical implementation is constrained by fiscal instability, corruption, and weak institutional capacity**.** The resulting inequalities violate the principles of justice, solidarity, and beneficence**,** fundamental to equitable healthcare (Beauchamp & Childress, 2019; Rawls, 1999; Metz, 2017).

Overall, Zimbabwe's historical experience demonstrates that health reform cannot succeed through economic or administrative adjustments alone. Sustainable change requires ethical governance, moral leadership, and citizen participation to restore legitimacy and public trust. These historical lessons underpin the rationale for developing the **Citizen-Centred Healthcare Model (CCHM)**—a framework that integrates distributive justice, *Ubuntu*, and social solidarity to promote equity, accountability, and human dignity in healthcare delivery.

Ethical and Structural Analysis of Zimbabwe's Healthcare System

At the centre of Zimbabwe's healthcare crisis lies a moral and structural dilemma**:** how to reconcile limited resources with the ethical obligation to provide equitable care. The system's persistent inequities reveal not only technical inefficiencies but also profound ethical failures in governance, accountability, and distributive justice.

The study integrates **three normative frameworks—distributive justice, *Ubuntu,* and human rights**—to guide an ethical reorientation of health policy. **Distributive justice** emphasises fairness in resource allocation and the moral duty to address inequalities that undermine human dignity (Rawls, 1999; Daniels, 2008). In Zimbabwe, this principle calls for prioritising vulnerable groups and balancing efficiency with moral responsibility.

The African moral philosophy of ***Ubuntu*** complements this by framing healthcare as a collective good rather than an individual privilege. *Ubuntu* promotes solidarity, compassion, and mutual care within the health system, reinforcing the notion that well-being is shared and interdependent (Metz, 2017; Tangwa, 2019; Van Niekerk, 2021). Ethical decision-making under *Ubuntu* values human relationships and empathy as vital components of justice and accountability.

The human-rights paradigm further legitimises equitable access by framing health as a legal entitlement and moral imperative. It obliges the state to guarantee the highest attainable standard of health, as affirmed in the *International Covenant on Economic, Social and Cultural Rights (ICESCR)* and the *African Charter on Human and Peoples' Rights* (United Nations, 2020; African Commission on Human and Peoples' Rights, 2019). These frameworks converge on the view that healthcare access is not a privilege or commodity, but a fundamental expression of human dignity and social solidarity**.**

Zimbabwe's structural weaknesses—fragmented governance, donor dependency, and poor accountability—undermine the ethical ideals embedded in these frameworks. Centralised decision-making has limited community participation, while recurrent corruption scandals have eroded trust and reduced efficiency (Mlambo & Sibanda, 2019; Maponga, Mudzengi, & Rusakaniko, 2020). The neglect of primary care and overreliance on tertiary institutions reveal a misalignment between policy priorities and ethical obligations.

Building upon these insights, the **Citizen-Centred Healthcare Model (CCHM)** seeks to transform the health system by embedding ethics into its structural design. The model's six interlinked pillars—prioritised pooled financing, equitable rationing, inclusive governance, monitoring and evaluation, social solidarity, and political stability—provide a coherent ethical and operational framework. Together, they promote fairness, participation, and accountability across institutional levels.

The CCHM envisions a participatory and morally responsive health system, where citizens are recognised not merely as beneficiaries but as

partners in decision-making. Ethical governance becomes both a managerial and moral responsibility, requiring transparency, integrity, and public dialogue. By aligning distributive justice, *Ubuntu,* and human rights, the CCHM presents a normative foundation for rebuilding equity and trust within Zimbabwe's fragile healthcare landscape.

Ultimately, ethical reform must move beyond rhetoric to practical application. This involves integrating moral reasoning into budgeting, training, and evaluation processes. Strengthening professional ethics, improving regulatory oversight, and institutionalising human-rights education are essential to ensure that the pursuit of efficiency does not eclipse compassion and fairness.

The Citizen-Centred Health-Care Model (CCHM)

The **Citizen-Centred Healthcare Model (CCHM)** is proposed as an ethically grounded and contextually adaptable framework to advance equitable healthcare access in Zimbabwe. It synthesises ethical theory, health-systems thinking, and local realities to address persistent structural and moral weaknesses. Rooted in distributive justice (Rawls, 1999)**,** participatory ethics (Daniels, 2008)**,** and the African moral philosophy of ***Ubuntu*** (Metz, 2017; Tangwa, 2019)**,** the model reframes healthcare as a moral entitlement rather than a market commodity. It aligns with human-rights-based approaches that define access to health as both a constitutional and ethical obligation of the state (Benatar, 2018; United Nations, 2020).

Conceptual Foundations

The CCHM acknowledges Zimbabwe's long-standing inequalities, fragile governance, and economic volatility (Loewenson & Sanders, 2021; Chatora & Tumusime, 2017). It integrates *ubuntu*'s emphasis on interdependence and communal care with egalitarian and utilitarian principles to balance fairness, efficiency, and accountability (Van Niekerk, 2021; Benatar, 2018).

Ethical governance and social solidarity function as the moral infrastructure of the model, linking technical efficiency with legitimacy. A society that values solidarity is more likely to uphold professional ethics and institutional trust (Hunt & Backman, 2008). Embedding human-rights education in clinical and administrative training reinforces this moral culture throughout the health system.

Core Pillars of the CCHM

1. **Inclusive Healthcare** – Ensures universal access to essential services regardless of gender, geography, or income. It promotes decentralisation, community participation, and the moral duty of the state to guarantee dignity and equality in care (Loewenson & Sanders, 2021; United Nations, 2020).
2. **Prioritised Healthcare Financing** – Focuses on equitable resource mobilisation and redistribution through pooled and accountable funding mechanisms such as targeted taxation, insurance schemes, and donor alignment. Ethical financing protects the poor from catastrophic costs and improves efficiency (World Bank, 2022; Gilson, 2018; Mills, 2014).

Pillars and catalysts of The Citizen Centre Healthcare Model

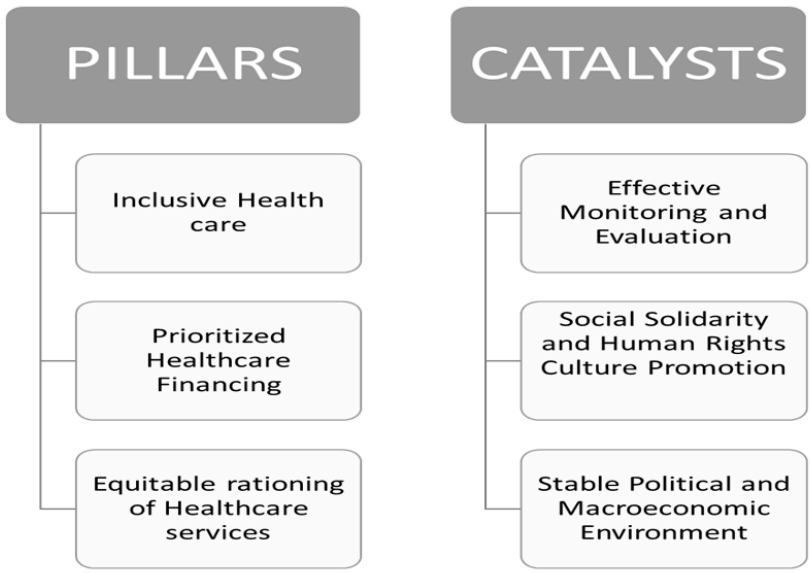

Figure 1: Pillars and catalysts of the Citizen Centred Healthcare Model

3. **Equitable Rationing and Priority-Setting** – Promotes transparent allocation of scarce resources based on clinical need and ethical justification rather than privilege or politics (Rawls,

1999; Daniels, 2008). Fair rationing builds public trust and legitimises difficult policy choices (Naidoo & Chidzonga, 2018; Beauchamp & Childress, 2019).

4. **Inclusive Governance and Citizen Participation –** Re-positions citizens as active partners in policy design and oversight. Mechanisms such as participatory budgeting and local health boards institutionalise accountability and responsiveness, reflecting *ubuntu*'s communal ethos (Metz, 2017; Tangwa, 2019; Gilson, 2018).
5. **Robust Monitoring and Evaluation (M&E) –** Establishes performance-tracking systems that measure equity, quality, and efficiency. Reliable data collection and transparent reporting enable adaptive learning and early correction of inefficiencies (Chatora & Tumusime, 2017; WHO, 2021).
6. **Social Solidarity and Human-Rights Promotion –** Embeds human rights in health governance to transform access from charity into a legal and moral duty. Solidarity fosters empathy, collective responsibility, and civic engagement (Benatar, 2018; African Commission on Human and Peoples' Rights, 2019; United Nations, 2020).

A stable political and macroeconomic environment underpins all pillars. Fiscal discipline, policy consistency, and institutional integrity sustain long-term investment and workforce stability (Chigumira, 2021; Mlambo & Elhiraika, 1998).

Operational Dynamics

The CCHM envisions a planning cycle beginning with prioritised financing anchored in macroeconomic stability. Reallocating defence and non-essential expenditure toward health would promote fiscal equity and align budgets with constitutional obligations to the right to health (Olaniyi, 2002). Transparent budgeting and citizen oversight strengthen accountability and public confidence.

Ethical decision-making is continuous across all pillars. Monitoring and Evaluation functions as the feedback mechanism that links data to action, while social solidarity ensures that reforms remain people-centred. Political stability enables consistent implementation and long-term policy coherence.

The planning cycle for the CCHM

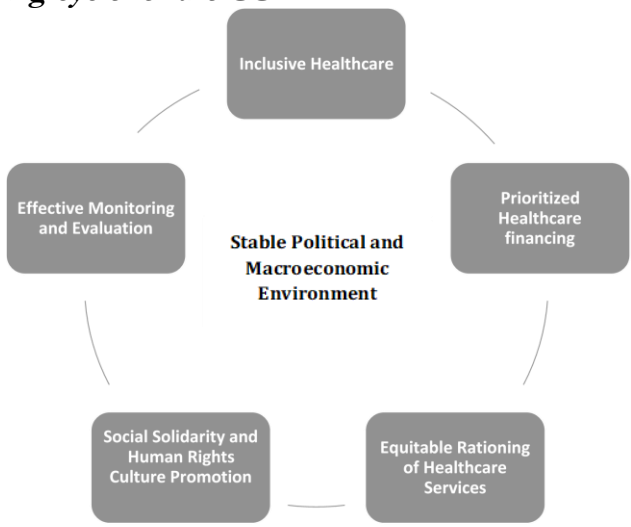

Figure 2: The planning cycle for the CCHM

Hierarchical Relationships

Hierarchical relationship between building blocks (elements) for the Citizen Centred Healthcare Model

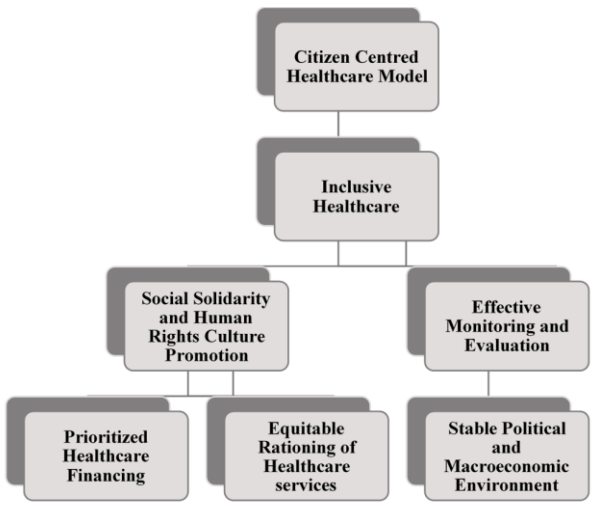

Figure 3: Hierarchical relationship between building blocks (elements) for the Citizen Centred Healthcare Model

Figure 3's conceptual hierarchy illustrates the interdependence of the pillars. Political and macroeconomic stability forms the foundation, while ethical governance and solidarity sustain participatory accountability. Financing, rationing, and service delivery depend on these lower-order elements. When stability and solidarity are compromised, higher-order functions such as monitoring and patient care weaken (Rawls, 1999; Metz, 2017; Dussault & Dubois, 2019).

A Pyramidal ranking of the elements of the Citizen Centred Healthcare Model

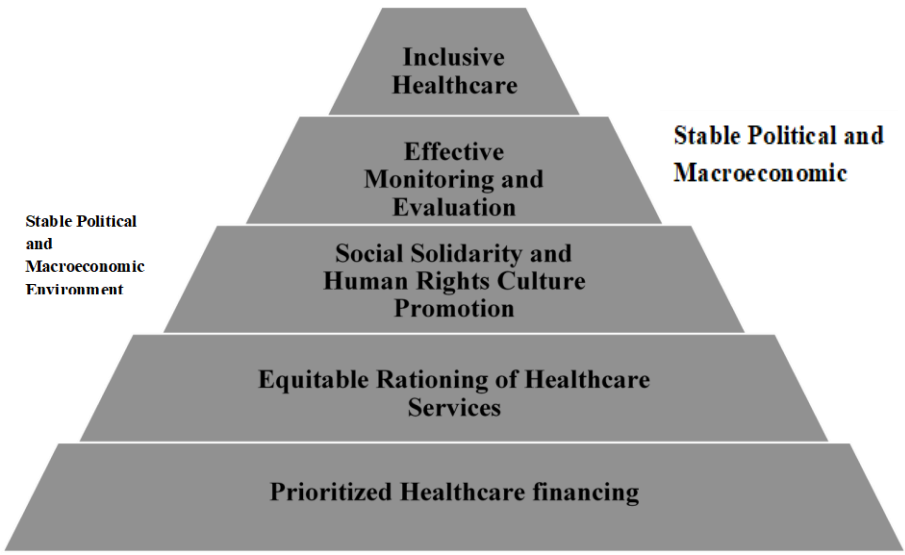

Figure 4: A Pyramidal ranking of the elements of the CCHM

Analogous to Maslow's hierarchy of needs, the CCHM's base layers secure systemic survival, and its apex—**inclusive healthcare** supported by effective M&E—represents self-actualisation within the health system, achieving equity, efficiency, and dignity (Chatora & Tumusime, 2017; WHO, 2021).

Implementation and Ethical Oversight

Recognising Zimbabwe's fiscal constraints, the model proposes phased implementation integrated into national development plans. Intersectoral collaboration across health, education, finance, and social welfare

ministries is essential, since health equity depends on broader social justice (Moyo & Mavhunga, 2020; Chigumira, 2021).

Institutional mechanisms such as an **Ethical Healthcare Commission and an Ethics Impact Assessment Tool (EIAT)** should monitor policy formulation, resource allocation, and programme outcomes through an ethical lens (Daniels, 2008; Gilson, 2018). These tools ensure that efficiency gains do not override fairness and human dignity.

Ethical Vision

The CCHM aspires to create a **citizen-driven, morally responsive health system** founded on transparency, compassion, and shared responsibility. It positions ethics not as a theoretical ideal but as a practical governance instrument guiding resource use, institutional conduct, and stakeholder engagement.

Discussion

The **Citizen-Centred Healthcare Model (CCHM)** represents both a moral framework and a governance tool for transforming Zimbabwe's fragmented health system into one that is ethically coherent and socially sustainable. Its principles—justice, solidarity, and accountability—respond directly to the systemic inequities that have persisted since colonial times.

Ethical Foundations and Policy Relevance

The CCHM situates ethics at the centre of policy and planning, affirming that healthcare access is a moral entitlement rather than a privilege. This aligns with global and regional instruments such as the *International Covenant on Economic, Social and Cultural Rights* (ICESCR) and the *African Charter on Human and Peoples' Rights*, which oblige states to guarantee equitable access to care (United Nations, 2020; African Commission on Human and Peoples' Rights, 2019). In practice, this requires the redistribution of resources, strengthening of ethical governance, and inclusive participation in health decision-making.

Ubuntu, as a moral philosophy, reinforces these obligations by emphasising compassion and mutual responsibility. It challenges utilitarian approaches that prioritise aggregate outcomes over human dignity and relational well-being (Metz, 2017; Tangwa, 2019). Thus, CCHM seeks to restore a moral

equilibrium in which efficiency serves, rather than supersedes, ethical justice.

Comparative Insights

Zimbabwe's health reforms have often mirrored global models such as the Beveridge and Bismarck systems, but without adapting them to local realities. The **CCHM diverges** from these frameworks by grounding its design in local ethics, participatory governance, and communal accountability. Experiences from **Rwanda and Botswana**, where ethical governance and decentralised management enhanced efficiency, demonstrate that solidarity and transparency can yield tangible improvements in low-resource settings (Dussault & Dubois, 2019; Gilson, 2018).

Relevance to Low- and Middle-Income Countries (LMICs)

The CCHM has broader applicability to LMICs where economic precarity and weak institutions threaten universal health coverage. By prioritising fairness and moral legitimacy, it offers a **replicable model** adaptable to diverse socio-political contexts. Ethical inclusion, pooled financing, and participatory governance collectively address structural causes of inequity—poverty, corruption, and exclusion. The model thus serves as a normative compass for reformers seeking to balance fiscal realism with moral imperatives.

Addressing Contemporary Ethical Challenges

Zimbabwe's health system faces new ethical frontiers, including **digital health, artificial intelligence (AI), and climate-induced crises**. The integration of **digital ethics**—such as data privacy, informed consent, and equitable access to telemedicine—can promote inclusion in resource-limited contexts (Wareham, 2020; UNESCO, 2023). Meanwhile, AI-driven diagnostics and e-health tools raise concerns around algorithmic bias, patient safety, and data sovereignty, which demand robust ethical frameworks (Nyatsanza & Mutasa, 2024; WHO, 2021).

Similarly, **environmental ethics** have become central to health resilience. Recurrent cholera outbreaks, vector-borne disease resurgence, and extreme weather events expose the moral imperative of environmental stewardship. Climate-sensitive health planning—incorporating

intergenerational justice—ensures that future populations inherit a viable ecological and health system balance (Benatar, 2018; WHO, 2021).

Implementation Dynamics and Governance Reform

The CCHM underscores the necessity of ethical governance as the foundation of sustainable reform. Transparency, anti-corruption mechanisms, and participatory decision-making must underpin all levels of health administration. An **Ethical Healthcare Commission (EHC)** can institutionalise moral accountability by reviewing national policies, budgets, and procurement through an ethical lens.

Monitoring and Evaluation (M&E) functions as the operational backbone of reform. By integrating ethical metrics—such as fairness, inclusivity, and accountability—into standard health indicators, M&E transforms from a bureaucratic tool into a moral instrument of justice. Periodic "Ethical Audits" could assess equity outcomes, stakeholder participation, and patient satisfaction.

The CCHM also highlights the need for ethical capacity-building. Incorporating ethics and human-rights education into training for clinicians, administrators, and policymakers fosters a culture of responsibility and empathy. As healthcare is a moral enterprise, professional ethics must evolve from compliance-based codes to relational commitments grounded in *Ubuntu* and justice.

Linking Ethics and Economics

Although moral reform is vital, economic rationality remains necessary. The CCHM does not reject efficiency; rather, it integrates it within an ethical hierarchy. A morally grounded financing structure enhances public trust and improves fiscal performance by reducing waste and corruption. Ethical decision-making, therefore, becomes an economic advantage, not a liability.

Decentralised financing—where resources flow directly to local facilities under community oversight—reduces administrative costs and strengthens accountability. When citizens participate in budgeting and evaluation, they become co-owners of the health system, reinforcing the moral contract between state and society.

Towards Transformative Change

The transformation of Zimbabwe's healthcare system demands political will and ethical leadership. Institutions must be redesigned to reflect justice, solidarity, and transparency. Policymakers should embed ethical reasoning in every stage—from resource allocation and training to service delivery.

The CCHM provides a blueprint for moral reconstruction. It demonstrates that health-system reform cannot be achieved through economic policy alone but requires **ethical consciousness and participatory governance**. Ethical reform redefines success beyond efficiency to include **trust, compassion, and social legitimacy.**

Ultimately, the CCHM bridges moral philosophy and practical governance, providing a pathway for Zimbabwe—and other LMICs—to rebuild trust and resilience in public health. When ethics guide leadership and institutions, health systems evolve from crisis management to human development, achieving not only clinical outcomes but also **dignity, justice, and solidarity.**

Limitations and Future Research

While the **Citizen-Centred Healthcare Model (CCHM)** provides an ethically grounded framework for reform, its current formulation remains conceptual and requires empirical validation. The study relied exclusively on secondary data, which may limit contextual accuracy and stakeholder representation. Future research should therefore employ mixed-methods approaches, combining qualitative and quantitative tools to evaluate feasibility, cost-effectiveness, and social acceptability in real-world settings.

Implementation studies could adopt participatory action research designs involving policymakers, clinicians, community leaders, and patients as co-researchers. Such collaborations would test the CCHM's principles—**solidarity, justice, and transparency**—within actual policy and clinical contexts (Gilson, 2018; Naidoo & Chidzonga, 2018). Cross-country comparisons with nations such as Botswana and Rwanda could further illuminate contextual enablers of ethical governance and financing efficiency (Dussault & Dubois, 2019).

Integrating quantitative indicators—including equity-adjusted health outcomes and ethical compliance indices—would strengthen evidence-based monitoring of moral performance within health systems (WHO, 2021; World Bank, 2022). However, successful implementation also

depends on political economy factors and fiscal decentralisation reforms emerging after 2023 (Mafukidze et al., 2024). Evidence generated through such research would help policymakers justify ethical investments and sustain reforms beyond donor cycles.

Future longitudinal studies should explore how ethical governance, solidarity, and citizen participation evolve over time. This would deepen understanding of the CCHM's sustainability and its potential applicability across sub-Saharan Africa. Establishing **Ethics Impact Assessment Tools (EIAT)** and pilot programmes at district level could generate practical data for scaling up nationally.

Ultimately, continuous ethical reflection, community engagement, and adaptive learning will determine whether Zimbabwe's health reforms achieve the envisioned transformation from a fragmented system to one that embodies **justice, accountability, and human dignity.**

Conclusion

The **Citizen-Centred Healthcare Model (CCHM)** offers a transformative and ethically coherent framework for reforming Zimbabwe's healthcare system. Grounded in **egalitarianism, utilitarianism, and the African philosophy of *Ubuntu***, it unites fairness, efficiency, and solidarity within a culturally relevant paradigm. The model reframes healthcare as both a **moral entitlement** and a **human right**, embedding ethical reasoning into governance, financing, and participatory structures.

The CCHM advances a vision of healthcare that balances equity with efficiency, and compassion with accountability. By integrating moral philosophy with health-system design, it provides a practical roadmap for addressing entrenched inequities, rebuilding trust, and fostering citizen participation.

Nevertheless, successful implementation will depend on political will, fiscal discipline, and institutional reform. Economic instability, limited ethical capacity, and weak accountability mechanisms pose ongoing risks to sustainability. Strengthening ethical leadership, education, and intersectoral collaboration will therefore be essential to realise the model's potential.

Ultimately, the CCHM moves beyond technical reform to promote **ethical reconstruction**—a shift from treating health as a commodity to recognising it as a shared social good. By restoring justice, compassion, and solidarity to the heart of healthcare policy, Zimbabwe can advance

toward an equitable, resilient, and people-centred health system that upholds **human dignity for all**.

Conflict of Interest Statement
The authors declare no conflict of interest.

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