ZIMBABWE HEALTH FINANCING STRATEGY 2017

Foreword

I am pleased to introduce Zimbabwe's first ever National Health Financing Strategy. This strategy is aimed at turning our National Health Financing Policy developed in 2016 into actions towards improving financing for the health of the people of Zimbabwe. This strategy presents deliberate and guided steps by the government of Zimbabwe towards ensuring affordable and equitable access to quality healthcare services to realise our goal of health for all as enshrined in the constitution.

As a country, Zimbabwe has made significant commitments towards expanding resources for health through various initiatives including strategic partnerships across government, private sector and development partners. Our national budget has continued to prioritize health with share of health spending continuing to increase towards meeting our commitment to the Abuja target of 15%. We have introduced innovative initiatives including the 5% Health Levy ring-fencing this for hospital drugs and commodities to ensure funding is directed towards where it's most needed. To date this has generated over $20million and is expected to continue to do so. To ensure financial protection for our vulnerable populations, we have made various services free at all levels including maternal care, under 5s and the elderly whilst subsidizing other services such as blood. Initiatives such as Results Based Financing, which we have moved to progressively finance from domestic resources, have gone a long way in improving services at our primary and secondary care facilities.

However, we acknowledge challenges still exist to fully realise universal health coverage. Though we have progressively increased domestic funding, more still needs to be done to reduce dependency on development aid especially for priorities such as HIV/AIDS, malaria and maternal care. Large funding gaps still exist and slow us down in fully implementing our National Health Strategy 2016-2020. In addition, with Out of Pocket Payments of 25% and only 9% covered by national health insurance, still more needs to be done to protect our population from catastrophic expenditure when seeking health care.

This strategy builds on the achievements and progress we have made to date whilst looking at creative and sustainable reforms to bridge the gap. Zimbabwe seeks to increase progressive and equitable revenue generation for health, moving towards shared health risks through enhanced pooling, and efficient technical and allocative efficiency in purchasing health services whilst embracing results based management (RBM). The strategy will catalyse reform of key institutions in health financing enhancing transparency and accountability for all stakeholders.

This strategy sets the agenda and framework for partnership and multi-stakeholder engagement towards ensuring UHC. It recognizes the role of government, private stakeholders and communities in contributing towards sustainable health financing systems. I therefore invite all stakeholders to work towards making quality and affordable health for all a reality in fulfillment of our constitution.

Dr P. D. Parirenyatwa (Senator)
Minister of Health and Child Care

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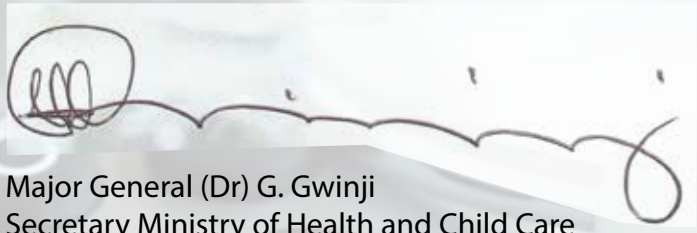

Major General (Dr) G. Gwinji
Secretary Ministry of Health and Child Care

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Acronyms

AG	Auditor General
AHFOZ	Association of Health Funders of Zimbabwe
AIDS	Acquired Immunodeficiency Syndrome
AMTO	Assisted Medical Treatment Order
ARI	Acute Respiratory Infection
CHAI	Clinton Health Access Initiative
CHP	Catastrophic Health Payments
DFID	Department for International Development
DHOs	District Health Offices
EU	European Union
GAVI	Global Alliance for Vaccines and Immunisations
GDP	Gross Domestic Product
GFATM	Global Fund to fight HIV/AIDS, Tuberculosis and Malaria
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit GMBH
GOZ	Government of Zimbabwe
HDF	Health Development Fund
HDPG	Health Development Partners Group
HFP	Health Financing Policy
HFS	Health Financing Strategy
HIV	Human Immunodeficiency Virus
HSF	Health Services Fund
IPEC	Insurance and Pensions Commission
JICA	Japan International Cooperation Agency
MCAZ	Medicines Control Council of Zimbabwe
MOFED	Ministry of Finance and Economic Development
MOHCC	Ministry of Health and Child Care
MOLG	Ministry of Local Government
MLSW	Ministry of Labour and Social Welfare
MRCZ	Medical Research Council of Zimbabwe
NATF	National AIDS Trust Fund
NatPharm	National Pharmaceutical Company of Zimbabwe
NHA	National Health Accounts
NHS	National Health Strategy 2016-2020
OOP	Out-of-Pocket
PCU	Project Coordinating Unit
PDCU	Planning and Donor Coordination Unit
PEPFAR	The United States President's Emergency Plan for AIDS Relief
PFM	Public Financial Management
PHC	Primary Healthcare
PMD	Provincial Medical Directorate
PSMAS	Premier Service Medical Aid Society
RBF	Results Based Financing
RMNCH	Reproductive, Maternal, New-born and Child Health
RBMER	Results-Based Monitoring, Evaluation and Reporting
SADC	Southern African Development Community
TB	Tuberculosis
TWG	Technical Working Group
UHC	Universal Health Coverage

UNFPA	United Nations Funds for Population Activities
WCIF	Workers Compensation Investment Fund
ZIMASSET	Zimbabwe Agenda for Sustainable Economic Transformation
ZNFPC	Zimbabwe National Family Planning Council

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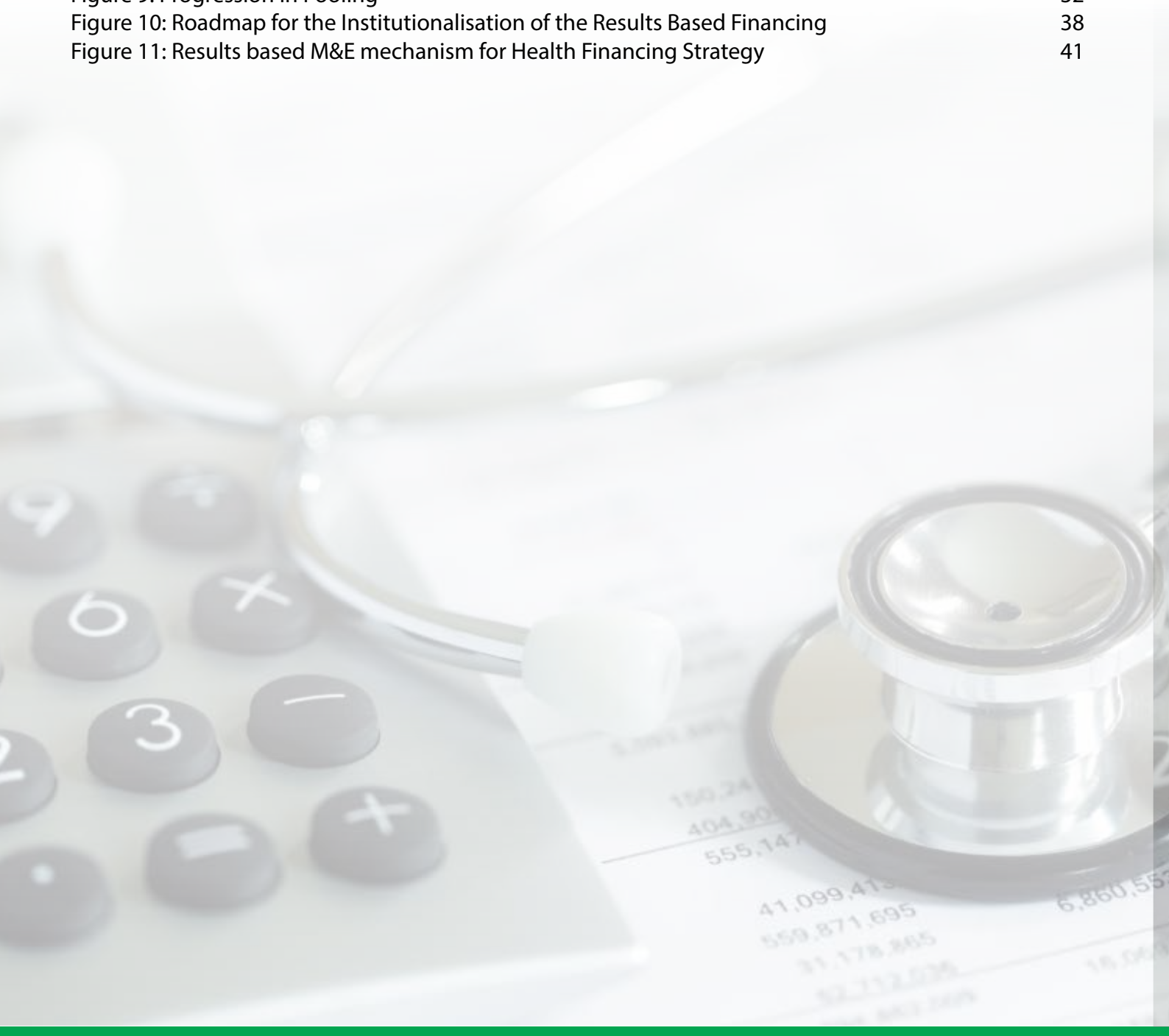

Executive Summary

Zimbabwe's first national Health Financing Strategy (HFS) translates the goals and principles expressed in the 2016 Health Financing Policy (HFP) into actionable financing reforms and interventions, with the overarching goal of achieving Universal Health Coverage (UHC). The development of the HFS has been led by the Ministry of Health and Child Care, through a Technical Working Group comprising stakeholders from other ministries, development partners, civil society organisations and academia.

Poor economic performance over the past two decades has had adverse effects on employment, poverty levels and available public resources for the health sector. Health financing is heavily dependent on donor assistance and household contributions. The government health budget has consistently grown and other innovative financing reforms have been introduced to increase available funding for health. However with a growing and changing disease burden associated with other socio-economic challenges, the resource needs still exceed available resources and more still needs to be done to effectively translate government goals into quality health outcomes.

A situational analysis of financing arrangements in the health sector identified the main challenges around revenue collection, resource pooling and purchasing of health services.

For revenue collection, challenges are:

- Low and unpredictable government budget allocation to the health sector
- Challenges with budget disbursement and budget execution
- Very low budget allocation to non-wage recurrent expenditure
- Low and varying levels of revenue collection from the different local council authorities
- Unpredictability in levels of external funding
- Inadequate levels of stewardship and coordination around earmarked and external funding
- External funding not necessarily aligned to country's priorities in context of limited resources
- High out-of-pocket expenditures, which have resulted in catastrophic payments
- Poor adherence to Public Financial Management practices
- Budgeting processes not sufficiently linked to health needs
- High reliance on user fees

Challenges identified around the pooling of health resources include:

- High fragmentation of resource pools across the entire sector
- Inadequate levels of coordination and complementarity between different resource pools
- Inadequacy of mechanisms for income and risk cross subsidization across the contributory schemes

Challenges identified around the purchasing of health services include:

- Sustainability challenges for Results Based Financing
- Inadequate capacity in Ministry of Health and Child Care (MOHCC) for strategic purchasing. Weak control mechanisms for both compliance (use of funds for the intended purposes) as well as performance (value of money and achievement results).
- Health needs not sufficiently considered in resource allocation
- Essential benefit package not fully defined for all levels of care

- Referral system not working effectively
- Inadequate coordination between levels of government and donors
- Inefficiencies in pharmaceutical supply chain management
- Separation of provider and purchaser roles not sufficiently demarcated within public sector

Key areas of intervention and specific strategies for addressing these are informed by evidence from reviews of the Zimbabwean health system and international best-practice. Consultations with a wide range of stakeholders provided guidance in ensuring feasibility of the proposed strategies, and in identifying important implementation and governance arrangements necessary to ensure that the strategies are successfully implemented. Key areas of intervention and strategies are listed below in three tables, according to the main health financing functions of raising revenue, pooling resources and purchasing health services.

Revenue Collection	
Area of Intervention	**Priority Interventions**
Increase efficiency gains from existing resources	• Place greater emphasis on investment in and implementation of interventions targeted at primary care and prevention • Strengthen planning and governance around procurement for infrastructure development and equipment • Improve operational efficiency of existing private voluntary health insurance schemes • Review of structures of the MOHCC to stimulate greater efficiency • Increase non-wage expenditure on supplies and equipment necessary for quality service delivery
Increased reliance on public resources for the health sector	• Implement evidence based advocacy for increased allocation of government resources to health at central and local government
Improve the predictability and level of external resources	• Strengthen mandate and capacity of the Planning and Donor Coordination Unit • Set up virtual pool for donors and make sure external assistance is reported on the budget, to improve transparency and accountability
Improve efficiency of external assistance for health	• Use donor resource mapping to identify redundancies and underfunded programs • Develop clear multiannual plans so that development partners can align on planned activities
Increase the contribution of prepayment to the health sector	• Assess other prepayment schemes to raise revenue • Assess appropriateness of a mandatory health insurance scheme
Innovative health financing mechanisms	• Strengthen mechanism for collecting resources due to the health sector from 3rd party insurance • Ensure optimal use of the AMTO • Ring-fence taxes on airtime and internet data • Introduce innovative revenue raising schemes such as sin taxes and ring-fence for health sector • Explore mechanisms that allow community members to contribute to health system strengthening • Strengthen innovative mechanisms to collect revenue from the informal sector
Improve budget execution	• Advocate for improved predictability and availability of public resources • Strengthen capacity to monitor performance around PFM and enforce lines of accountability
Institutional mechanisms for sustainable financing	• Generate financing and expenditure evidence to guide decision making

Pooling of Resources	
Area of intervention	**Priority Interventions**
Pooling Government (central and local) Health Funds	• Strengthen equalisation mechanism across local authorities to ensure equitable allocation of resources • Strengthen integration of monitoring and reporting of funds • Establish a virtual basket of all public funds (including those from church related missions)
Pooling Donor and Non-governmental Organisation Health Funds	• Establish a virtual sector-wide coordination of all donor and non-governmental organisation health funds • Develop virtually integrated monitoring and reporting of funds
Private Sector Health Funds	• Strengthen the regulation of the medical schemes environment
Pooling Government, Donor and Non-Governmental Health funds	• Establish a virtual basket of all public and donor health funds • Develop joint accounting, monitoring and reporting of funds

Purchasing Health Services	
Area of intervention	**Priority Interventions**
Improve procurement and supply chain management	• Streamline procurement, storage and distribution of medicines and pharmaceutical supplies through NatPharm to leverage economies of scale and reduce costs through the system • Implement sector-wide approach to use of donor funds in procuring medicines and pharmaceutical supplies
Introduce strategic purchasing	• Strengthen capacity for strategic purchasing within MOHCC and establish a dedicated purchasing unit
Strengthen Results Based Financing	• Full institutionalisation of RBF across levels of care and services • Ensure sustainability of RBF through dedicated resource allocation
Allocate resources according to need	• Develop and implement needs-based resource allocation formula
Ensure equitable and efficient delivery of Essential Benefit Package	• Articulate the core benefits package to be prioritized based on realistic resource envelope • Strengthen referral system by using financing incentives to improve quality

The health financing strategy identifies changes in institutional and governance arrangements that are required for some of the proposed strategies to be successfully implemented. The main institutions directly involved in the implementation of the health financing strategy are:

- Ministry of Health and Child Care (MOHCC)
- Ministry of Finance and Economic development (MOFED)
- Ministry of Labour and Social Welfare (MLSW)
- Ministry of Local Government
- Health Development Partners Group and Civil Society Organisations
- Private health sector providers and insurers

Progress in the implementation of the health financing strategy will be tracked with a Results Based Monitoring, Evaluation and reporting approach that ensures regular review of progress. This approach entails periodic measurement of performance indicators mapped to inputs and processes, outputs, outcomes and impacts.

Chapter 1: Introduction

1.1 Background

Zimbabwe's first national Health Financing Strategy (HFS) outlines specific reform initiatives around financing arrangements in the health sector that are necessary for achieving goals and objectives that have been set for the health system. It is underpinned by the Constitution which requires that the State take all practical measures to ensure the provision of basic, accessible and adequate health services throughout Zimbabwe.[1] This HFS derives directly from the recently developed National Health Strategy 2016-2020 (NHS), and the Health Financing Policy (HFP).

The NHS outlines system-wide interventions for sustaining gains achieved in the health sector, addressing current gaps and further strengthening of the health system in order to appropriately respond to the health needs of the population. It outlines the commitment of the Ministry of Health and Child Care (MOHCC) to ensuring a healthy population with equitable access to quality services through a strengthened health system. Stated goals for the NHS include (1) strengthening priority health programmes[2] (2) Improving service delivery platforms or entities, and (3) improving the enabling environment for service delivery. Broad strategies to achieve these include:

- Strengthening the Primary Care Approach as the main strategy for health development
- Resource mobilization for health to ensure predictable and sustainable resources
- Strengthening multi-sectorial partnerships in health services and care guided by the principle of three ones (one national plan, one coordinating mechanism and one monitoring and evaluation mechanism), and
- An adaptive and reforming health sector

The HFP articulates short and long term goals and principles for health financing in Zimbabwe, with the aim of "resourcing the pathway to Universal Health Coverage (UHC).[3]" The goal of the Health Financing Policy is to guide Zimbabwe's health system to move towards UHC, by achieving financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all by 2030. The HFP underscores the need to mobilise sufficient resources in an efficient and equitable manner to provide essential health services. Policy objectives of the HFP are to:

1. Mobilize adequate resources for predictable sustainable funding of the health sector
2. Ensure effective, equitable, efficient and evidence based allocation and utilization of health resources
3. Enhance the adequacy of health financing and financial protection of households and ensure that no-one is impoverished through spending on health by promoting risk pooling and income cross subsidies in the health sector
4. Ensure that purchasing arrangements and provider payment methods emphasize incentivizing provision of quality, equitable and efficient health care services; and
5. Strengthen institutional framework and administrative arrangements to ensure effective, efficient and accountable links between revenue generation and collection, pooling and purchasing of health services

1 The Constitution of Zimbabwe Amendment (No.20), 2013.
2 The priority programs are (1) Communicable diseases (2) Non-communicable diseases (3) Reproductive, maternal, newborn, child health and adolescents (4)public health surveillance & disaster preparedness and response program
3 Achieving Universal Health Coverage refers to the progressive development of health systems such that all people have access to basic quality health care services, and do not suffer financial hardship in utilizing these services.

1.2 Rationale for Developing a Health Financing Strategy

This Health Financing Strategy translates the goals and principles expressed in the HFP into actionable financing reforms and interventions, with the overarching goal of achieving UHC. It defines clear interventions that promote efficiency and equity in health care resource mobilisation and use, including the promotion of high quality of care for everyone in Zimbabwe.

The availability of financial resources and how they are used in the health sector determines to a large extent how much health services can be provided, which services are provided and by whom. It also determines the capacity of the health system to meet the health needs of the population it serves. With the high, changing and increasing burden of disease in Zimbabwe and the challenging economic landscape[4], it is of critical importance that available financial resources are mobilized in the most efficient way for the health sector, and that these finances are optimally utilized. The HFS has been developed using evidence from studies and reviews of the Zimbabwean health system. It provides a blueprint of clear reform interventions that will assist Zimbabwe in achieving UHC if well implemented. The interventions proposed not only address existing challenges in financing arrangements; they are also aimed at laying a foundation for a better health system of the future.

Achieving UHC requires multi-sectorial and multi-stakeholder commitment and action that extends beyond health financing arrangements. Consequently, the proposed financing strategies outlined in this document should be complemented by other non-financing reforms within and outside the purview of the MOHCC for UHC to be achieved.

1.3 Process for Developing the Health Financing Strategy

The development of the HFS was led by the Technical Working Group (TWG) that led the development of the Health Financing Policy. This TWG is housed in the Directorate of Policy Planning and Development in the MOHCC, and it also served as the steering committee for the HFS development process. The TWG comprised wide stakeholder representation that included MOHCC; MOFED; Ministry of Labour and Social Welfare (MLSW); development partners; civil society organizations; and academia. The World Bank and the Clinton Health Access Initiative (CHAI) provided technical support to the TWG in the development of the HFS. The HFS is strongly anchored on relevant and recent country-specific evidence and a review of international evidence on best practices in health financing.

1.4 Structure of the Health Financing Strategy

The HFS is organized into 6 chapters. *Chapter 2* provides an overview of the macro-economic and fiscal context of Zimbabwe. In addition, the main features of the health system are summarized. *Chapter 3* outlines the situational analysis of health financing in Zimbabwe, and provides a diagnostic assessment of health financing arrangements. These are analyzed according the three main financing functions: revenue collection, pooling and purchasing. In *Chapter 4*, strategic reforms for addressing these health financing challenges are outlined. *Chapter 5* describes governance and implementation arrangements necessary for the proposed strategies to be successfully implemented. In *Chapter 6*, a monitoring and evaluation plan for the proposed reforms is described.

4 More details on the disease burden of the country, including macroeconomic and fiscal context is provided in Chapter 2

Chapter 2: Macroeconomic Context and Health System

2.1 Macro-economic and Fiscal Context

Zimbabwe is a low-income country with a population estimated at approximately 16 million in 2016. An almost decade-long recession[5] from 2000, and a more recent financial crisis has had significant adverse implications on the economy of Zimbabwe. The number of Zimbabweans living in extreme poverty has risen from 2.3 million in 2014 to an estimated 2.8 million in 2016.[6] Although unemployment has only increased marginally (from 10.7% in 2011 to 11.3% in 2014), there has been a major increase in the proportion of those employed in the informal sector. In 2011, 84% of people employed were in the informal sector. By 2014 as many as 94.5% were employed in the informal sector.[7]

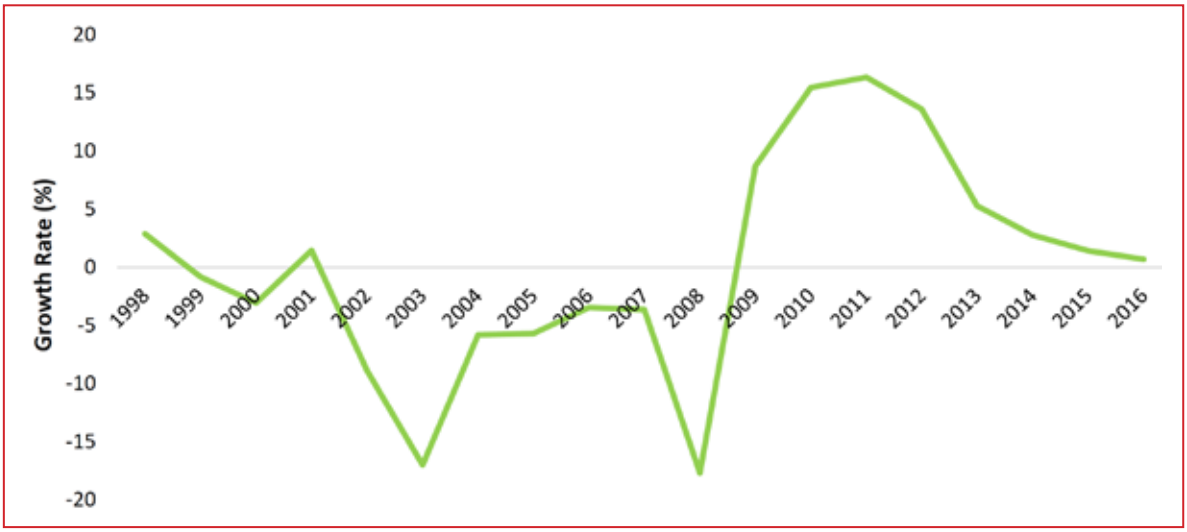

Figure 1: GDP Growth Rate
Source: World Bank Open Database[8]

In response, the Government of Zimbabwe (GOZ) is working strategically to strengthen the economy and improve the lives of its citizens. The Zimbabwe Agenda for Sustainable Economic Transformation (ZIMASSET) 2013-2018 outlines the country's current 5-year economic plan. The mission of the economic plan is to provide an enabling environment for sustainable economic empowerment and social transformation to the people of Zimbabwe. The thrust of the economic plan under social services is to enable the GOZ to improve the living standards of the citizenry for an empowered society and a growing economy. Key result areas that are under the health sector include Social Service Delivery[9], Policy and Legislation.[10]

2.1.1 Economic Outlook

Zimbabwe's gross domestic product (GDP) was estimated at US$16 billion in 2016, with a per capita GDP of US$1,005. Real GDP growth is projected to reach 2.8% in 2017. It is forecasted to slow down to 0.9%

5 World Bank Open database
6 World Bank (2017) Zimbabwe Economic Update: The State in the Economy. June 2017 Issue 2
7 ZIMSTAT (2015)
8 Annual percentage growth rate of GDP at market prices based on constant local currency
9 This includes strategies for reducing the disease burden for the main causes of morbidity and mortality; improving client satisfaction and delivery service; reducing financial barriers to health services
10 Includes the establishment of a regulatory authority to manage the operations of medical aid societies and strengthen community participation/donor coordination. These aim to improve collaboration and coordination in the health sector and improve the policy and regulatory environment

and 0.2% in 2018 and 2019, respectively (see Table 1). With a population growth rate of 2.3%, GDP per capita is expected to decline between 2017 and 2021. Despite, the challenging outlook, the GOZ has made significant progress in taking advantage of existing opportunities and interlinkages between strategic clusters in strengthening the economy. The expected positive GDP growth rate of 2.8% in 2017 is as a result of the recovery in the agricultural and mining sectors and the rebound in the manufacturing sector, which partly resulted from the implementation of the government's development policy.

Table 1: Zimbabwe's Economic Indicators (2014-2019)

Indicators	2014	2015	2016F	2017F	2018F	2019F
Real GDP Growth, at constant factor prices (%)	2.7	1.4	0.7	2.8	0.9	0.2
Nominal GDP (US$ millions)	15,834	16,072	16,124	17,105	18,904	20,601
Growth by sector						
Agriculture	23.0	-5.2	-3.7	21.6	7.0	5.5
Industry	-2.0	-0.1	1.4	0.5	0.6	2.2
Services	1.4	1.6	1.2	0.3	-0.3	-1.8
Inflation (Consumer Price Index %)	-0.2	-2.4	-1.6	2.1	9.5	10.0
Current-Account Balance (% of GDP)	-14.2	-9.5	-4.5	-3.8	-3.7	-2.8
Fiscal Balance (% of GDP)	-1.2	-2.4	-8.7	-11.0	-8.5	-6.8
Debt (% of GDP)	53.9	59.6	68.7	73.4	76.1	76.4

**F= forecast*
Source: World Bank. Zimbabwe Economic Update, June 2017

2.1.2 Government Revenue and Expenditure Trends

Based on revenue projections for the 2016 financial year, the main sources of revenue for the government are Value Added Tax, Personal Income Tax and Excise Tax. Total revenue was projected at US$ 3.5 billion.

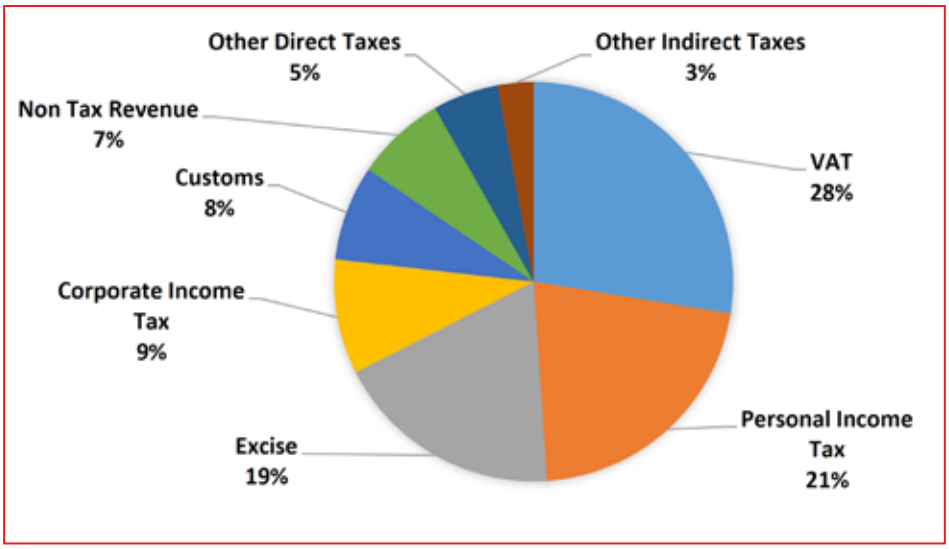

Figure 2: Sources of Government Revenue 2016
Source: MOFED 2017 Budget Highlights

Tax revenue as a proportion of GDP is 27%. Due to poor economic performance, revenue has fallen below total government expenditure. It is estimated that the government will continue to operate a budget deficit in the short to medium term. In response, the government has adopted a contractionary fiscal stance by reducing total government expenditure from US$ 4,6 billion in 2016 to an estimated US$ 4,100 million in 2017.[11]

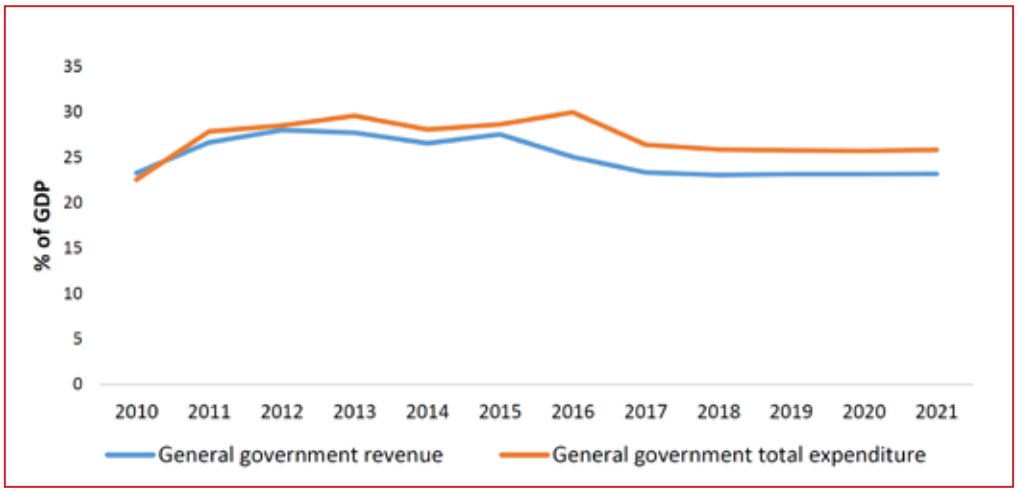

Figure 3: Government Revenue and Expenditure (2010 – 2021)
Source: Analyzing fiscal space options for health in Zimbabwe (2017) The World Bank & ZIMREF

In 2015, government expenditure on health as a proportion of total government expenditure was approximately 8%. This is an improvement from 6.6% in 2013 and 6.5% in 2014.[12] However, in comparison with neighboring countries, this is relatively low. Figure 2.3 below shows total government health expenditure (including loans and grants to government) as a proportion of total government expenditure for Southern African Development Community (SADC) countries for the year 2014. For most of the SADC countries, government expenditure on health exceeds 10% of total government expenditure.

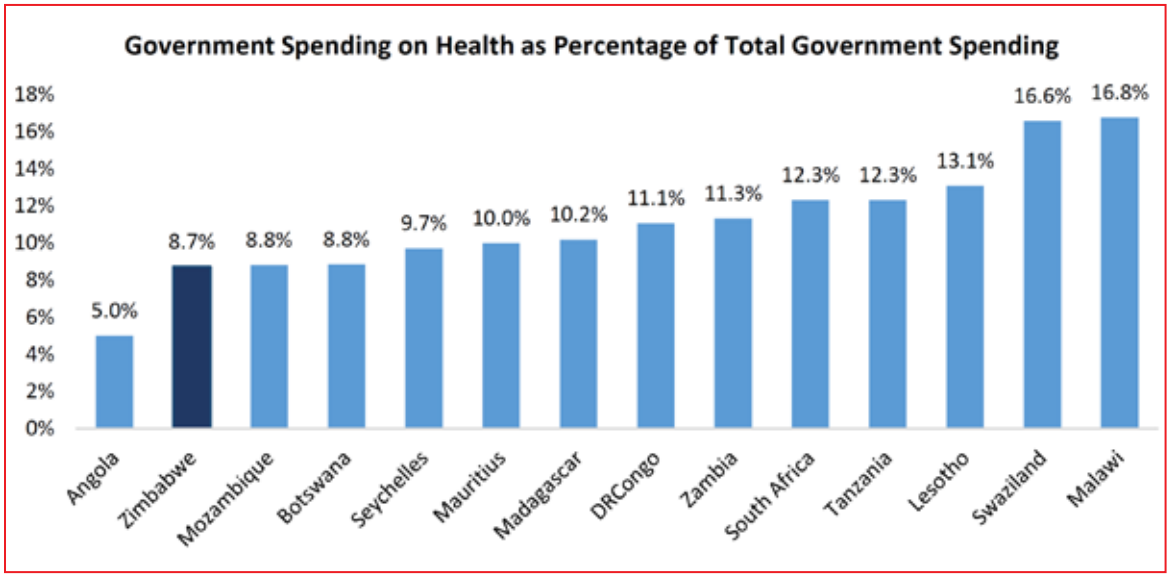

Figure 4: Government Expenditure on Health as Percentage of Total Government Expenditure (2014)
Source: Data for Zimbabwe is from National Health Accounts (2015). Data for other countries is from World Bank Open Database for the year 2014

11 Source: MOFED 2017 Budget Highlights.
12 MOFED 2015

2.2 Overview of the Health System

2.2.1 Structure of the Health System

The Zimbabwean health system has both public and private players. The public sector is the main provider of health care services. Health care in Zimbabwe is delivered through 1,848 facilities, most of which are public health care facilities. The rest are non-profit and church affiliated facilities (referred to as mission facilities), private for-profit facilities and company operated clinics.[13] Health services are provided at the primary, secondary, tertiary and quaternary levels.

The MOHCC develops policy and provides overall guidance to the national health system. It is responsible for functions such as the determination of funding allocation, policy and administrative guidance, approvals of staff hires at the district and provincial levels. The Provincial Medical Directorate (PMD) office administers provincial and all district health facilities within its province; its function is to make certain that the province's health services meet the needs of the population, as well as MOHCC objectives, goals, and health policies. A Provincial Health Executive provides direct oversight to provincial hospitals. The PMD is also responsible for allocating GOZ funds to the provincial hospitals and district health offices (DHOs). At the district level, DHOs have responsibilities similar to their provincial level-counterparts, except that they play a more direct role in administering and managing rural health clinics (the lowest level of primary care facilities), as rural health facilities may only have a nurse on staff to provide primary care services and no administrative staff. District hospitals are overseen by a District Health Executive. A district health council provides oversight to the district health office. Rural Health Clinics are also overseen by a Rural District Council. PMDs and DHOs are representatives of the MOHCC.[14]

13 There are 101 private health facilities and 87 mission facilities. Mission and private health facilities provide only primary and secondary care. Mission facilities often partly funded by the MOHCC through salary, administration and capital grants.

14 USAID (2010) Zimbabwe Health System Assessment

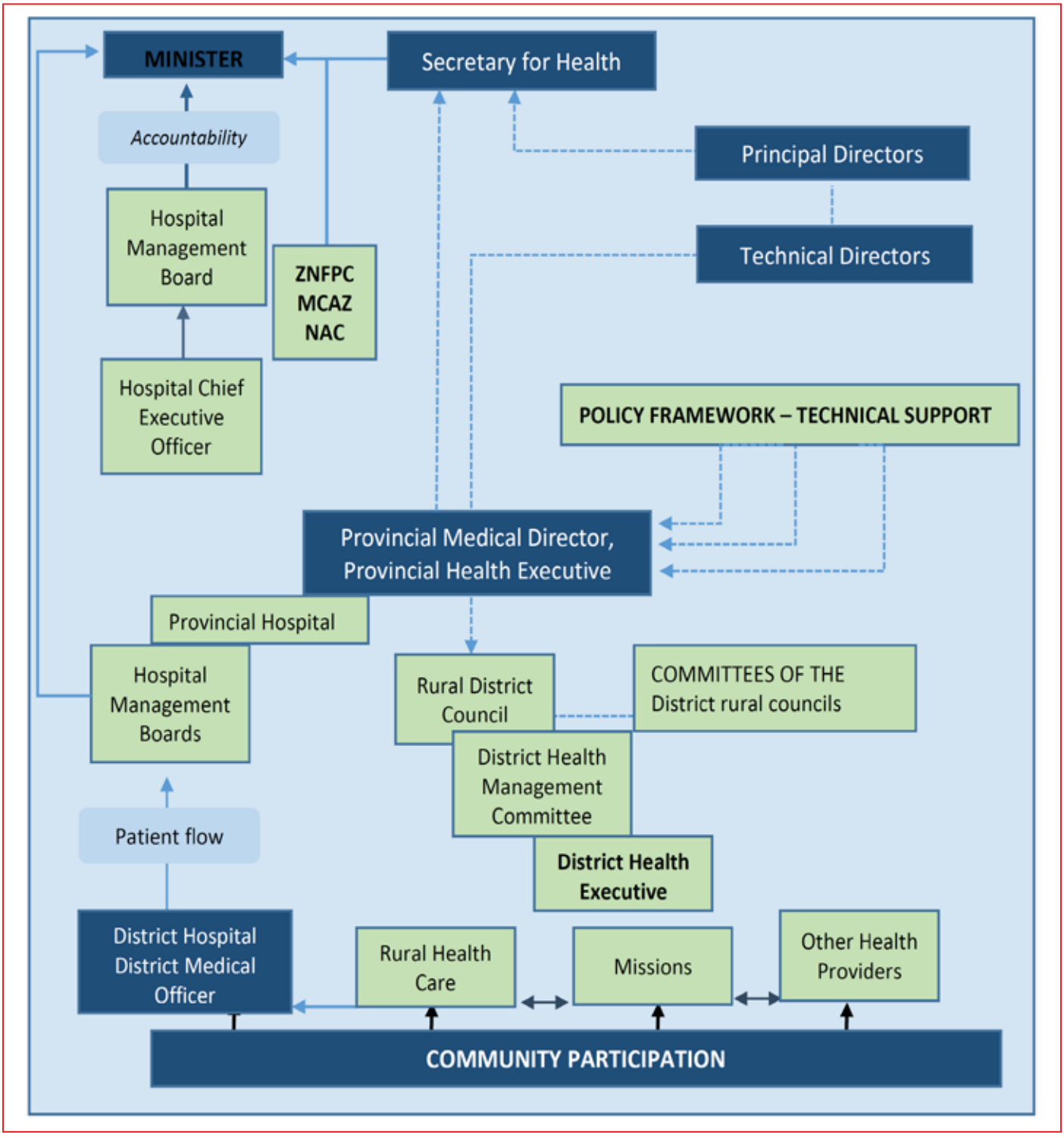

Figure 5: Functions and Linkages within MOHCC

Local governments (referred to as local councils) also fund and provide primary health care services in their areas. These health facilities are separate from those directly administered by the MOHCC.[15] Local councils generate revenue through local taxes, levies and other fees.

Other government agencies directly involved in health care delivery are:

- *National Pharmaceutical Company of Zimbabwe (NatPharm)* is a government owned company that was established to procure, store and distribute health commodities for Zimbabwe's public health facilities (including mission facilities).
- *Medicines Control Authority of Zimbabwe (MCAZ)* is a statutory body and the primary regulatory agency for pharmaceutical industry. It regulates the registration of pharmaceuticals to be used in Zimbabwe, including the licensing of pharmaceutical manufacturers, wholesalers, community pharmacies and other organizations and individuals that procure, distribute and/or sell pharmaceuticals.[16]
- *Medical Research Council of Zimbabwe (MRCZ)* - is tasked with the responsibility of coordinating and regulating health research including monitoring ethical practices in research.
- *Zimbabwe National Family Planning Council (ZNFPC)* - mandated to coordinate the provision of Family Planning services in Zimbabwe. Its operations include the procurement and distribution of contraceptives, Sexual Reproductive Health service provision, trainings and research.
- *National Aids Council (NAC)* - is tasked with coordinating the multi-sectorial response to Human Immunodeficiency Virus (HIV)/ Acquired Immunodeficiency Syndrome (AIDS). This is funded through an earmarked AIDS Levy.

These government agencies are primarily funded by government annual grants or levies, however, due to fiscal constraints, most depend on raising their own revenue through charging for the various services which they provide, with the exception of NAC, which is still highly funded from the National AIDS Trust Fund.

Private financing of health care is mainly from direct payments and from pooled insurance funds. There are currently 36 medical aid schemes in Zimbabwe covering about 10% of the population mostly through employment based contributions. Medical aid schemes pay for their members when they seek care in both public and private health facilities. However most are associated with varying co-payments at point of access. The GOZ makes contributions to medical aid schemes on behalf of civil servants.

There is a clear separation of functions and a distinct referral system across the different levels of care within the entire health system. Health centres (along with various mission and council facilities) are the first points of entry into the health system, and all cases that cannot be dealt with at primary level are referred to the district, provincial and central hospitals. The private sector also provides health care at the primary and secondary level. Zimbabwe assumed the Primary Health Care Approach to health service delivery in 1980.[17]

2.2.2 Burden of Disease

Although progress has been made in addressing the disease burden of the country, Zimbabwe still faces a double burden of communicable and non-communicable diseases. In 2016, the leading cause of death was Acute Respiratory Infection. The major causes of death are listed in Table 2 below. The prevalence of

15 See Appendix 1 for figure X that provides a diagrammatic representation of the structure of the health system
16 USAID (2010) Zimbabwe Health System Assessment
17 National Health Strategy 2016-2020

HIV/AIDS among adults is still high at 15%.[18] It is estimated that non-communicable diseases account for 31% of the deaths in Zimbabwe.[19] In response to the current burden of diseases the MOHCC has prioritized (1) communicable disease programs, (2) non-communicable diseases and conditions programs (3) reproductive, maternal, newborn, child health and adolescent services; and (4) public health surveillance and disaster preparedness and response programs.

Table 2: Top 10 Causes of death for all ages

Rank	Disease/Condition
1	Acute Respiratory Infection (ARI)
2	Slow foetal growth, foetal malnutrition, disorders related to short gestation and low birth weight
3	Human immunodeficiency virus (HIV) disease all complications, AIDS and AIDS related complex
4	All meningitis, encephalitis, myelitis & other inflammatory diseases, excluding meningococcal meningitis & HIV disease related
5	Diarrhoea and gastroenteritis due to other infectious diseases (bacterial, viral, protozoal)
6	Heart failure congestive and left ventricular
7	Respiratory infections
8	Congenital infections and parasitic diseases, excluding HIV
9	Anaemia
10	Other endocrine, vitamin, nutrients and nutritional deficiencies, obesity and metabolic disorders

Source: 2016 Annual Report for the Ministry of Health and Child Care

18 National Health Strategy 2016-2020
19 World Development Indicators 2012

Chapter 3: Situation Analysis of Health Financing

In providing good access to health care, there are three main interrelated financing functions of a health system that are critical. These are revenue collection, pooling of resources and purchasing of interventions.[20] The situation analysis of health financing arrangements in Zimbabwe conducted in this section is presented along these lines. This provides a guide for proper diagnosis of financing challenges and a framework for identification of the appropriate interventions necessary for improving health system financing.

Revenue collection is the process by which health systems receive money from households, organizations, companies and donors. Ideally, this process should ensure that revenue for the health sector is collected through fair mechanisms that are pro-poor, sustainable and do not cause catastrophe or impoverishment

Resource pooling is concerned with accumulating revenues for health on behalf of some or all of the population and whether these are combined in one or more fund pools. This is aimed at ensuring that there is: equity in allocation; and income and risk cross-subsidization.

Purchasing is concerned with the allocation of resources from the pool to the providers for service benefits, including decisions on benefit package design and rationing. Good purchasing arrangements ensure that allocated resources are based on health priorities needs, and create incentives for health providers to deliver quality health services efficiently in exchange for payment received.

3.1 Revenue Sources for Health

In 2015, the private sector accounted for 40.37% of total health expenditure. Private sector expenditure on health includes employer contributions to health insurance from private corporations, household out-of-pocket payment, household contribution to private health insurance and other contributions from non-profit entities that provide health service support to households.

The public sector represented 34.70% of total health expenditure: it is made up of contribution by the public sector (as an employer) to private health insurance (13.3% of total health expenditure) and public health expenditure on the public health system (21.4% of total health expenditure). External funding from donors accounted for the remaining 24.92% of total health expenditure.[21]

Key issues for the three main sources of health financing (public, private and external funding) are explored in turn.

20 WHO (2000) World Health Report
21 Zimbabwe NHA 2015

Table 3: Sources of Health Expenditure

Financing sources	Amount (Million USD)	Percentage (%)	Components	Percentage (%)
Public (Tax revenue)	502.43	34.70%	Government contribution to civil servants' private health insurance	13.3%
			Public expenditure on health	21.4%
Private	584.51	40.37%	Private employer contributions to employees' private health insurance	15.1%
			Household out of pocket payment	23.8%
			Household direct contribution to private health insurance	1.3%
			Non- profit institutions	0.2%
External	360.85	24.92%	Donor funds	24.9%
Total	**1447.79**	**100%**		**100.0%**

Source: National Health Accounts 2015

3.1.1 Financing from Government

Government financing of the health sector is mainly through three avenues: (1) central general revenue; (2) local government revenue; and (3) earmarked tax revenue for the health sector. These are briefly described.

3.1.1.1 Central General Revenue

This is the main source of funding for government expenditure on health. It is from revenue accruable to the central government from both tax and non-tax revenue which is allocated to various sectors through a revenue sharing and budgeting process. In 2015, this accounted for 21.4% of total health expenditure.[22] These funds are used in financing health care in government health facilities and to subsidize health care provision in mission and rural council facilities. Over the last few years, government's disbursements have been unreliable and unpredictable affecting the delivery of health services

3.1.1.2 Local Government Revenue

Local governments (also referred to as councils) finance and provide primary healthcare services from their revenue. They generate revenue through rates, levies, licenses and user fees for services provided, such as water.[23] In addition, local councils receive grants for education and health from independent government statutory bodies, and in some instances, grants and capital funds for infrastructure development through the Central Government Public Sector Investment Program. Local councils can also borrow, although rural councils are limited to borrowing from the central government. In 2015 local councils contributed 18.8% of domestic funding. In addition, lower revenue collection in some councils has led to higher user fees for patients.

3.1.1.3 Earmarked Tax Revenue for Health Sector

Currently, there are two earmarked tax revenue sources for health. The AIDS levy is 3% of income tax paid

22 Zimbabwe NHA 2015. Note that the figure for public expenditure in Table 3 includes government contribution to voluntary health insurance on behalf of public sector employees

23 Urban Councils collect revenues from rates from property (property tax, water and refuse), registration and licensing of businesses, tariffs and fees (education and health facilities user fees) from rendered services

by formal employers and employees. It is administered by the National AIDS Trust Fund (NATF)[24] and is for strengthening the national response to HIV/AIDS, and reducing donor dependence. The contribution of the National AIDS Trust Fund has increased from US$5.7 million in 2009 to US$38 million in 2014. More recently there has been a 5% levy on mobile airtime data. This is intended for drugs and equipment in hospitals as a way of ring-fencing funds for critical health services. From February 2017 to September 2017, just over US$ 18 million was raised from this levy in total.

3.1.1.4 Key Challenges Related to Public Sector Health Financing

A review of evidence from various studies highlights some key issues relating to public sector financing of health. Due to the challenging macro-economic and fiscal environment, publicly generated resources are very limited. Government expenditure on health mostly covers salaries, leaving little for non-wage inputs. Based on the costing of three scenarios[25] of the National Health Strategy, a significant increase in government spending on health is required as most resources are expected to be mobilized domestically. This is shown in table 4 below. The baseline of USD 955.3 in 2015 is an estimated amount based on what is required to adequately maintain the current levels of population and health programme coverage. This is higher than actual public health expenditure and further highlights the financial limitations faced by the public health system.

Table 4: Cost of NHS based on 3 Scenarios (Million USD)

Scenarios	2015 (Base-line)	2016	2017	2018	2019	2020	Total
NHS 1	$955.3	$1,179.1	$1,306.5	$1,187.0	$1,159.9	$1,149.1	$6,936.9
NHS 2	$955.3	$1,193.9	$1,325.1	$1,349.7	$1,387.1	$1,397.7	$7,608.8
NHS 3	$955.3	$1,269.7	$1,559.4	$1,630.6	$1,624.1	$1,494.1	$8,533.2

Source: MOHCC Main Report on the Costing of the Zimbabwean National Health Strategy 2016-2020

Government allocations to health have fluctuated significantly over the years. Although this has been partly as a result of the changing macro-economic and fiscal environment, it has resulted in unpredictability in public sector financing (see Figure 7). Also, budget execution has been a challenge; averaging 81.6% within the period 2009 to 2016. The low budget execution has been mainly attributed to failure by MOFED to release the allocated funds on time, as result of inadequate revenue collection. Budget execution has however improved in more recent years.

24 NATF was established in 2009

25 The three scenarios considered are: (1) Baseline Scenario: maintain 2015 coverage levels for all health interventions (2) High Impact Intervention: Reduce mortality associated with the 20 established leading causes within limits of the proposed financial space(3) Optimal Scenario: Scale up optimally most health service interventions

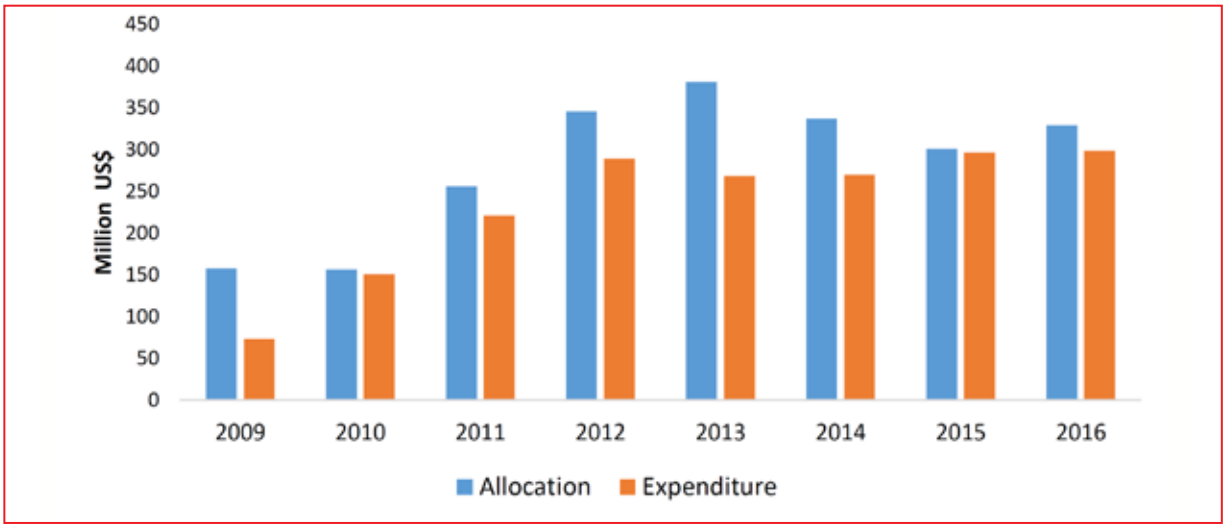

Figure 6: MOHCC Budget Allocation Vs. Actual Budget Expenditure 2009-2016
Source: MOFED 2015. The 2016 figures are from MOHCC 2016 Annual Report

Although performance based budgeting has been introduced in the health sector, line item budgeting still prevails. Also, the resource allocation process is quasi-historical and is not strongly linked to population needs. There are challenges around transparency, accountability and failure to adhere to procedures. The Auditor General (AG) has routinely documented areas where the MOHCC has failed to adhere to financial management practice as per the Public Financial Management (PFM) Act. Challenges highlighted by the AG include:

1. Weak budget control procedures, including unauthorized budget expenditures and transfer of funds between budget lines without prior MOFED authorization.
2. Non-adherence to accounting procedures and standards, especially with regard to the Health Services Fund, for which the MOHCC did not keep proper records (such as receipts, payment vouchers, goods-received vouchers, cashbooks and ledgers).
3. Weak internal budget controls and management systems, such as the weak fuel and medicines stock management, which lead to losses and facilitate corrupt practices.
4. Weak procurement systems associated with high transaction costs and financial loss to the MOHCC.

3.1.2 Private Funds

3.1.2.1 Direct Household Payment

The inadequacy of government funding has resulted in a high dependence on direct household payments, out of which around 95% is accounted for by out-of-pocket (OOP) payments. Household payments through user fees and co-payments (for those who are insured) remain a major source of health financing. Household payments accounted for around 25% of total health expenditures in 2015. Out of pocket payments are an inequitable and unfair mechanism for generating revenue for the health sector. In addition to limiting access to much needed care, out-of-pocket payments are associated with a lack of financial protection and can result into catastrophic health payments (CHP) that compromise household consumption of other basic needs. In Zimbabwe, 7.6% of all households incurred catastrophic health payments in 2015;

incidence of CHP was highest among households in the poorest quintile.[26]

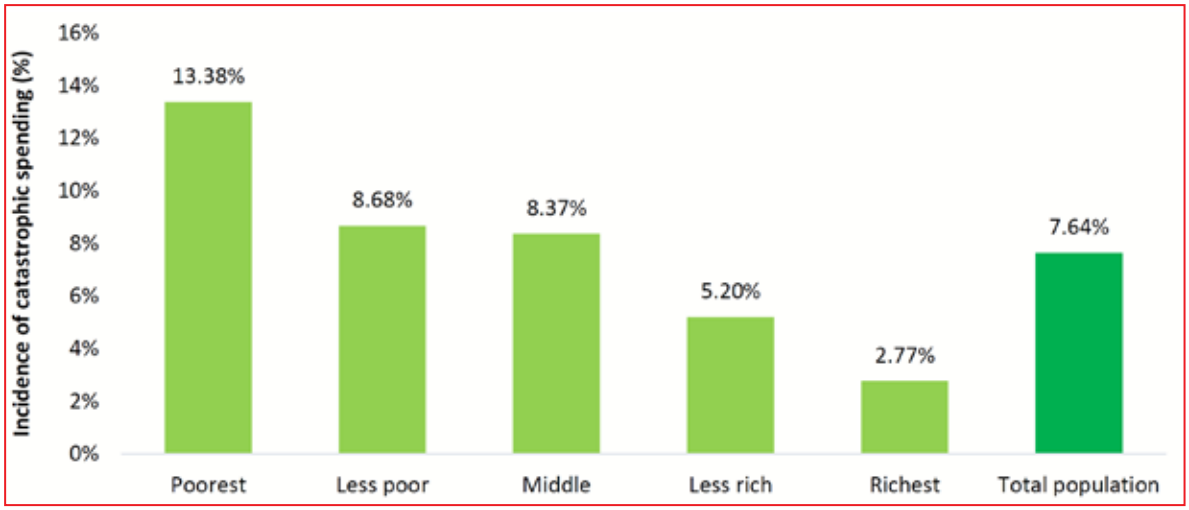

Figure 7: Incidence of Catastrophic Health Expenditure (CHE) by Expenditure Quintile
Source: Zimbabwe National Health Accounts 2015

3.1.2.2 Prepaid / Health Insurance Schemes (Medical Aid Schemes)

An estimated 10% of the population are covered by voluntary health insurance schemes. Contributions to these schemes are mainly by employers (private and public), and therefore these schemes mainly cover the formally employed and their dependents. Estimates from the NHA show that employers' contribution to private health insurance on behalf of their employees constituted 28.43% of total health expenditures.[27]

Although community-based health funding/insurance schemes are currently being piloted, their viability has not yet been fully evaluated. Zimbabwe is currently considering a mandatory health insurance scheme. However, the timing and nature of the mandatory scheme is still under debate in the policy arena.

3.1.3 Development Assistance for Health

Over the past 15 years, external funding for health has been increasing. Currently, major development partners are Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM), The United States President's Emergency Plan for AIDS Relief (PEPFAR), United Nations Funds for Population Activities (UNFPA), UNITAID, European Union (EU), Department for International Development (DFID), Irish Aid, Global Alliance for Vaccines and Immunisations (GAVI), Sweden, ,the World Bank, the Bill and Melinda Gates Foundation and a few other philanthropic organizations. A key challenge with donor funding is the unpredictability of funding from donors. In addition, most external funding is earmarked towards a few disease areas with the Resource Mapping 2016 exercise indicating that HIV/AIDS and reproductive, maternal, new-born and child health (RMNCH) receive over 54% of total external funding for health.

26 Zimbabwe National Health Accounts 2015
27 Note that government contribution to employees' private health insurance is from tax revenue and considered

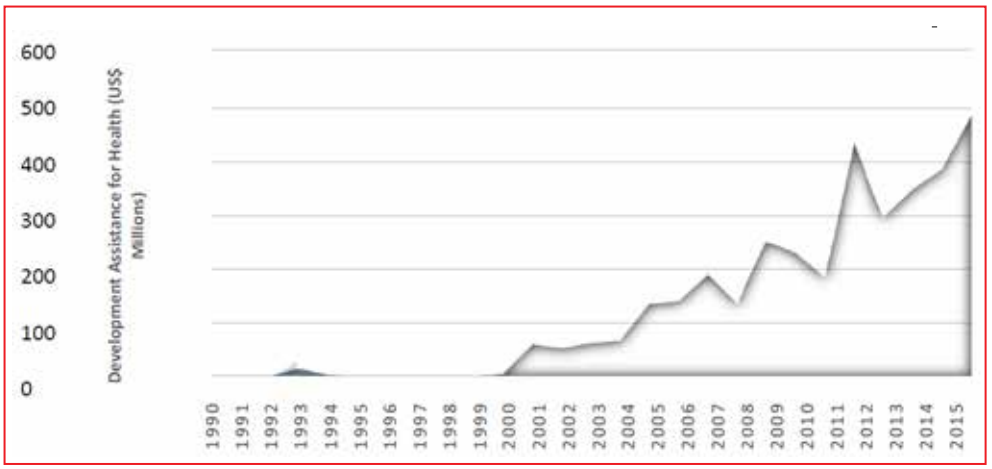

Figure 8: Trends in development assistance for health in Zimbabwe (1990-2016)
Source: IHME (2016) for the figures from 1990 to 2014 and MoHCC (2016) for the 2015 & 2016 figures

3.2 Pooling of Resources

Pooling of resources involves accumulating prepaid revenues for health on behalf of some or all the population with the view to promoting income and risk cross-subsidization. Zimbabwe's health sector is characterized by fragmentation, with multiple resource pools, most of which are small. The existing resource pools include: government pool (from general tax revenue), the AIDS Trust Fund, multiple voluntary prepayment schemes and multiple pools for development assistance for health. In this section we describe the different pools.

3.2.1 Government Pools

Government pools include the consolidated revenue fund (which includes AIDS Trust Funds that are earmarked specifically for HIV/AIDS), and funds collected by local governments. These are described below.

3.2.1.1 Consolidated Revenue Fund

The GOZ's budget allocation from the consolidated revenue fund to the MOHCC is the largest domestic health pool, with funds contributed from tax and non-tax revenue and other direct budget support. Considering the progressive nature of personal income tax in Zimbabwe and zero-rating of basic foods[28], overall contribution to this pool by design promotes income cross subsidisation. This pool is targeted at covering the entire population of Zimbabwe. The size and composition of the pool provides an opportunity for income and risk cross subsidization where the rich subsidize the poor and the healthy subsidize the sick. However, the resources available are inadequate compared to the scope of services and scale of coverage needed by the population. For example, per capita allocation is on average US$20 whereas per capita need is US$93 (NHS costed figures). Furthermore, the allocation is biased towards providing curative care at hospital level leaving primary care facilities under funded.

28 Sourced from the website of the Zimbabwe Revenue Authority (ZIMRA): www.zimra.co.zw

3.2.1.2 Local Councils

Local authorities have two major streams of revenue. The first is their own revenue which is from taxes, levies, etc.; the second is from transfers from the central government in the form of grants and revenue sharing. The grants are in the form of block grants (unconditional) and conditional grants that are tied to specific functions. Functions funded through these conditional grants have reduced over the years and now focus mainly on health and roads.[29] Local authorities, through a participatory budgeting process determine how much of their discretionary revenue is allocated to finance health services. There are 28 Urban Councils and 58 Rural Councils. Both sets of Councils run their own health facilities. In total, these Councils own and run 96 primary care clinics.[30] Each local council is an independent pool. These councils have different revenue raising capacities thus affecting their ability to adequately cover health needs for their catchment areas. With no explicit risk-equalisation mechanism, there is limited risk and income cross-subsidisation between council-pools.

3.2.1.3 Earmarked Taxes

Finances from earmarked taxes such as the National AIDS Trust Fund, 5% levy on mobile airtime/data, and the Assisted Medical Treatment Order (AMTO) are separate pools although all are derived from the consolidated revenue fund. By design, these pools promote income and risk cross-subsidisation. AMTO is administered through the Ministry of Labour and Social Welfare. It was established to cover health fees in public facilities for indigents when the government introduced the Economic Structural Adjustment Program in the 1990s. The target population are: the elderly (over 65 years), the poor and indigent (who are means tested before accessing the benefit), pregnant women and children under 5 who access public health facilities (local council clinics and government hospitals). The fund is meant to reimburse providers for user fee exemptions for using local council clinics' primary health services and for referrals to hospital to enable these populations to have equitable access to care. However, in recent years, AMTO has not adequately covered its target population. Factors such as non-disbursement, a high level of debt and a lack of awareness among the target population of their entitlements have been identified as the main challenges.

3.2.2 Multiple Pools of Development Assistance for Health

Development assistance for health is channelled through various separate donor pools. Notable pools by size of resources include PEPFAR/USAID, the GFATM and the Health Development Fund (HDF). The first two pools are largely disease specific, while the HDF pool focuses mainly on primary health care. Although the HDF pools resources together from various donors, most of the donors are still operating independently beyond this fund. The HDF is a partnership fund established to pool together the funds from external resources. This fund enables the donors to harmonize programming and directing funds towards high impact programs while also ensuring alignment to the priorities of the MOHCC as articulated in the NHS. This fund also enables the funders to reduce overhead costs and streamline reporting, operations and administration. The expenditure allocations of the HDF fall under the following pillars for support: medical products, vaccines and technology; planning and financing; maternal, new-born and child health and nutrition; and human resources for health. In addition to the PEPFAR/USAID, GFATM and HDF, there are several development partners who support the health sector with additional resources that are not channelled through these pools. Each partner (such as the World Bank, the Bill and Melinda Gates

29 Henry Mabika (2015) Liquidity crisis and service delivery in Zimbabwe local authorities. Journal of Political Science and Public Affairs 2015 3:3

30 Zimbabwe Service Availability and Readiness Assessment 2015

Foundation, Japan International Cooperation Agency (JICA), Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) and UNITAID) therefore has a pool of funds that they manage, resulting in multiple health pools.

3.2.3 Contributory Schemes

Zimbabwe has various contributory schemes covering different population groups. These include:

3.2.3.1 Voluntary Health Insurance Schemes

There are 36 medical aid schemes operating in Zimbabwe. Three main schemes (First Mutual AID, Premier Service Medical Aid Society and Commercial and Industrial Medical aid Society) provide cover for most of those with medical aid. The level of cover depends on the package subscribed to by the member. In addition, due to the various co-payments based on specific membership packages and a limited range of services covered by various medical aid funds, their ability to effectively and adequately pool risk is limited. Also, there are limited mechanisms for risk equalization across these schemes. Co-payments exist with most of these schemes, which reduces the financial protection of their members. A major concern for the GOZ in the medical aid scheme environment is the absence of adequate regulatory oversight of the operations of the medical aid schemes.

3.2.3.2 The Workers Compensation Investment Fund (WCIF)

This pool covers health related costs for employees involved in accidents at the workplace, but excludes government and domestic workers. The resources of the scheme are collected through contributory insurance where the employer is required to pay a premium that is calculated using a risk factor depending on the type of industry of employment. The scheme also gets additional funds from interest earned from investment projects financed by savings from the WCIF and occupational health and safety. It is important to note that the prevailing economic conditions in the country have resulted in a decline in contributions due to job losses as a result of company closures. This has adversely impacted the ability of this pool to provide adequate coverage for the workers. In addition, there are concerns of underutilisation of this fund. Anecdotal evidence suggests that health providers are reluctant to accept reimbursement through WCIF because of the associated administrative challenges. In addition, employers and employees often do not complete paperwork necessary for the fund to cover treatment when needed.

3.2.3.3 Motor Vehicle Insurance Based Health Support

Motor vehicle insurance, in particular the Third-Party Motor vehicle insurance is the minimum mandatory insurance required in Zimbabwe as part of vehicle licensing under the Road Traffic Act Chapter 13:11. In addition to coverage for various accident related claims, this insurance covers third party bodily injury or death (pedestrians or other road users); passenger liability (for public vehicles only); medical expenses and death benefit. However, while this pool of resources exists, it is highly fragmented as each insurance company collects and administers its funds, it is also underutilized and the intended beneficiaries do not in most cases claim from this fund; some are unaware of their entitlements, and some just use their private insurances for medical expenses. Anecdotal evidence indicates that some providers do not accept the motor vehicle insurance because of a history of challenges with reimbursement. These challenges include delays in payment and non-payment. These are resource pools for health that are underutilised, which need to be fully taken advantage of.

3.2.3.4 Health Services Fund (HSF)

The HSF allows facilities to pool collected revenues from user fees, interests, grants and donations and use these at facility level. HSF income between 2009 and 2012 averaged US$31 million, with hospital fees contributing about 99% of all income. The annual estimate for the GOZ HSF in 2016 and 2017 was US$35 million. The HSF gives facilities supplementary funds to respond to specific needs that have not been met through national budgeting. The full retention of fees at each facility means that each health facility acts as an independent pool and there is no built-in mechanism for cross-subsidy across facilities. However, in times of need, such as when there are shortages in some of the facilities, there is some cross subsidization across facilities, for instance with medicines. The main weakness of the HSF is its regressive nature and the fact that it does not offer financial protection to patients.

3.2.4 Summary of Resource Pools

Overall, Zimbabwe's health sector presents a very high level of fragmentation with many health resource pools and with limited to no interaction between these pools. This does not support income and risk cross-subsidisation. Considering the decision to achieve UHC, it is imperative that barriers to risk and income cross subsidisation be removed. The level of fragmentation of health pools has to be reduced to the minimum possible. In addition, high fragmentation of pools is also associated with waste of resources due to duplication of efforts and administrative costs of managing relatively small but numerous pools. Under the current economic dispensation, improving efficiency is imperative.

3.3 Purchasing

This section focuses on the different purchasing arrangements used in Zimbabwe by government, development partners and the prepayment schemes. The benefit package and rationing mechanisms employed are also described.

3.3.1 Public Sector

The government provides primary, secondary, tertiary and quaternary care to the population through mission, local authority (urban and rural) and MOHCC health facilities. The main payment mechanism employed by the central government is an integrated approach. This involves line-item budgets and centralised salaries for health personnel. The potential advantage of this approach is that it offers strong administrative control by government, and salaries by nature are incentive-neutral for either under-providing or over-providing services. However, the main disadvantage is that it does not offer the government good information to track and understand the right combination of interventions to use, or to promote efficiency and quality. In addition, it does not provide any direct incentive to the provider to provide the most cost-effective health interventions or to decrease costs.[31] The limited fiscal space for health exacerbates the problems associated with purchasing. As a result of declining revenues and shrinking overall government budget, most of the health budget is used to cover salaries, leaving a small proportion for non-wage. In 2016, salaries made up around 93% of total MOHCC expenditures - and in 2017, 79% of the total allocatios were earmarked for salaries. Despite this high allocation of MOHCC funds towards human resources costs, the current staffing levels remain inadequate to fully service the staffing needs of the healthcare system in Zimbabwe.

31 Langenbrunner, J.C. and Liu, X. 2005. How to pay? Understanding and using payment incentives. In: Spending Wisely: Buying health services for the poor. Eds Preker, A.S. and Langenbrunner, J.C. The World Bank, Washington D.C.

Frameworks for a more strategic approach to purchasing have recently been introduced. Results Based Financing (RBF) is being used in financing district health services.[32] Also, the NATF and AMTO are designed to purchase strategically to achieve equity. The recently introduced Program Based Budgeting is also expected to strengthen the link between inputs and outputs towards more efficient purchasing from the government resources. Programme Based Budgeting distributes money by programmes (or functional areas) and therefore aligns spending with programme objectives. Nevertheless, there remains a gap in strategic and effective purchasing, and limited incentives for both efficiency and equity in the GOZ's purchase of health services.

Budget allocations to provinces have not adequately reflected health priorities and the relative health needs of different geographic areas - provinces and districts, including rural and urban areas.[33] Research shows that there are concerns from the provincial authorities that health sector allocations received are not made on the basis of any defined needs-based framework.[34] Although health services are to be delivered based on the primary health care approach, review of public health expenditure patterns shows a bias towards hospital and curative services over primary care and preventive health services. In 2015, 36.5% of government health expenditure (including donor funds) went to hospitals. In the same year, 33.3% and 6.2% of total government health expenditure went to providers of ambulatory health care and preventive care respectively.[35]

At provincial and district levels, there is some element of active purchasing with provincial medical directorates and district health executives entering service contracts with the health facilities. The PMD is responsible for the purchasing function at the provincial level and specifically negotiates service contracts with the district and hospital service providers. On the other hand, District Health Executives negotiate service contracts with all the other providers at district level. However, as is the case with the central level, at this level there is no clear linkage between resource allocation for health care and the population needs. More so, the bulk of resources for salaries and wages are centrally controlled.

Local councils mainly pay for inputs focusing on operating costs and essential medicines and health supplies. Health facilities through the HSF are also able to purchase their inputs (operating costs and essential medicines and health supplies) supplementing the funds from central and local governments. However, the purchasing arrangement by the health facilities do not have inbuilt incentives for efficiency and equity. Poor coordination in allocation of finances by the MOHCC and Local Authorities has resulted in inequities in access to basic health services between rural and urban areas. Local Councils have in recent years experienced funding challenges for health care. Rural councils have been affected the most. Allocations to provinces by MOHCC have not adequately considered this development and many rural council facilities are characterised by deteriorating infrastructure and equipment, shrinking health worker benefits and reduction in number of health workers.[36] In addition, poor revenue collection at some local councils have led to higher use fees, further increasing the barriers to access health services.

Mission health facilities have over the years received grants from MOHCC. There has been very limited oversight around the disbursed grants to mission facilities. There is a prevailing lack of formal service contract with missions. In addition, there is limited capacity within the MOHCC to monitor the performance of mission facilities receiving these grants even where such contracts are in place. This has not created the

32 District health services include primary health services and services provided by district hospitals. More details on RBF is provided in subsequent sections of this chapter
33 World Bank; MOHCC & ZIMREF (2017) Analyzing fiscal space options for health in Zimbabwe
34 Public Expenditure review (2015)
35 Zimbabwe National Health Accounts 2015
36 National Health Strategy for Zimbabwe 2016-2020

right incentives for mission facilities to efficiently utilise public grants.[37]

3.3.1.1 Results Based Financing

The Health Financing Policy proposes a move towards strategic purchasing mainly through RBF. RBF has been implemented in Zimbabwe since 2011 in line with government policy on results-based management. RBF initially focused on RMNCH indicators and later expanded to include HIV/AIDS, Tuberculosis (TB), Malaria and non-communicable diseases. The GOZ is working on the institutional and financing sustainability for the RBF program.

3.3.1.2 Pharmaceuticals

Pharmaceuticals are a key health sector input, and the way in which pharmaceuticals are purchased has important implications for efficiency in the use of available resources and access to quality health care. The GOZ has implemented efforts aimed at streamlining medicines procurement and distribution for government facilities for all sources through the National Pharmaceutical Company (NatPharm) with the view to enhance efficiencies of pooled procurement. Despite these efforts, NatPharm remains extremely underfunded and 99% of all the pharmaceuticals handled by NatPharm are donor funded. The need for coordination of various financing streams in procurement and distribution systems for commodities must be emphasized.

3.3.1.3 Rationing and Benefit Package

User-fees are payable at all levels of care. These fees include consultation fees, and where applicable they include fees for drugs, therapeutic and diagnostic procedures, and theatre and anaesthetic charges. User-fees are a rationing mechanism often used to prevent over-utilisation. In the case of the Zimbabwean health system, it is a major source of revenue. User fees often place a significant barrier to accessing health care for the poor and vulnerable, who are most likely to require health services. To address this problem, provisions have been made to minimise financial barriers for vulnerable and target populations. Public services to the following are free of charge at the point of use for the following:

- Children under the age of 5, and maternity cases
- Patients above the age of 65, ex-combatants and those considered to be invalid.
- Economically vulnerable patients whose health fees are completely covered by the Social Development Fund.
- HIV/AIDS and TB services including prevention, diagnosis and treatment

In addition, no consultation fees or fees for drugs are charged in rural MOHCC/Mission hospitals or in rural district council clinics.

The use of levels of care higher than the primary care level is based on a referral system. The MOHCC recognises the potential for inefficiency in allowing unfettered access to all levels of care. Financial incentives have been built into the system to encourage patients to seek care at the most appropriate level. Patients that are 'unreferred' are subject to higher fees.[38] However, research evidence shows that patients still by-pass

37 National health strategy for Zimbabwe 2016 - 2020
38 Circular No. 15 of 2000: Rules for health care delivery fees applicable to all patients seeking treatment at government, mission and local authorities' health facilities effective 1 November 2000. MOHCC

the primary care facilities and present to higher level facilities with minor ailments that can be managed more efficiently at the primary care level.[39] Evidence shows that poorer members of the population rely on lower level facilities where no consultation fees or fees for drugs are charged. However, these lower level facilities are often associated with perceived poorer quality of care. The wealthier members of the population prefer to use hospital services as point of use, as they are associated with better quality.[40]

The Constitution makes broad provisions around health care entitlements.[41] Despite additional revenues from user-fees, prevailing financial limitations are such that providing a comprehensive health service package to all citizens is unattainable. To maintain realistic health services objectives and manage expectations, the MOHCC is streamlining the existing benefit package. The MOHCC is in the process of developing an essential health benefits package of services that will form the core minimum package of primary healthcare (PHC) services that the MOHCC will make available to all Zimbabweans. This essential health benefit package will be 'narrower' than the current health service entitlement and ensures that proposed health service entitlements can be covered by available public health finances. This essential health benefit package will be continuously reviewed as fiscal space for health increases over time.[42]

3.3.2 Development Partners

The resource tracking exercise in 2016 reported that domestic resources mostly support health systems costs, while donors mainly support discrete program items like drugs and commodities. Furthermore, the multiple donor pools sometimes result in duplication, inefficiencies and misalignment. For example, some GOZ priorities (such as non-communicable diseases) are not donors' priorities, and are therefore not funded by them. In addition to unpredictability, development assistance for health is also faced with the challenge of vertical financing with donor funds earmarked to specific programs. For instance, of the US$386 million spent by donors in 2015, about US$208.8 million (54%) was spent on HIV/AIDS. This limits the ability to distribute available resources from donors in in a way that fully reflects the priorities of GOZ for the health sector.

3.3.3 Private Sector

The private sector mainly provides primary and secondary care. Private health care is paid for through OOP or medical aid contributions. Patients that belong to medical aid societies mostly use private health care facilities. In these cases, the medical aid pays the required fees on behalf of the patient, with patients paying any additional charges not covered. The payment for services in these schemes is mainly on a fee-for-service basis. This reimbursement approach should be considered with caution because of its inherent incentive for cost escalation through over-servicing.[43][44] Although only around 10% of the population are covered by medical aid schemes, medical scheme expenditure accounts for approximately 30% of total health expenditure.

The country currently has a defined district heath benefit package that clearly defines what is to be expected at the primary and secondary levels of care. As mentioned previously, this is currently being revised to a narrower essential health benefit package to ensure that entitlements are in line with available

39 National Health Strategy for Zimbabwe 2016-2020
40 World Bank (2015) Health Public Expenditure Review Zimbabwe
41 Constitution of Zimbabwe Amendment (No.20) Act 2013
42 National Health Strategy of Zimbabwe 2016-2020
43 Langenbrunner, J.C. and Liu, X. 2005. How to pay? Understanding and using payment incentives. In: Spending Wisely: Buying health services for the poor. Eds Preker, A.S. and Langenbrunner, J.C. The World Bank, Washington D.C.
44 Jegers, M., Kesteloot, K.,De Graeve, D., Gilles, W. 2002. A typology for provider payment systems in health care. Health Policy 60 255-273

financial resources. Nevertheless, this current, broader benefit package was also proposed and extended to Voluntary Health Insurance schemes as an essential requirement for annual registration of the schemes. It serves as the minimum basic benefit package for medical aid schemes. Members are free to buy medical benefit options that are more comprehensive, and with greater access to private health care providers. So, unlike the Government Essential Health Benefits, the benefit packages under the Voluntary Health Insurance schemes depend on the premiums paid by the specific enrolee. This means that the scope and quality of care accessed by a beneficiary and his/her dependents is reliant on the ability to pay. Furthermore, just like government, some insurance schemes also own health facilities and do not have incentive structures in place for promoting quality health care.

3.4 Summary of the Diagnosis of Zimbabwe's Health Financing System

Table 5 summarizes the key challenges identified in the section above that need to be addressed if the country is to move towards UHC. To ensure that all citizens have equitable access to quality health services while also minimising the likelihood for catastrophic payments associated with access and utilisation of health care.

Table 5: Challenges in Health Financing Arrangements

Revenue Collection
• Low and unpredictable government budget allocation to the health sector • Challenges with budget disbursement and budget execution • Very low budget allocation to non-wage recurrent expenditure • Low and varying revenue collections from the different local council authorities • Unpredictability in level of external funding • Inadequate levels of stewardship and coordination around earmarked and external funding • External funding not necessarily aligned to country's priorities in context of limited resources • High out-of-pocket expenditures, which have resulted in catastrophic payments • Poor adherence to Public Financial Management practices • Budgeting process not sufficiently linked to health needs • High reliance on user fees – an inequitable approach to revenue generation

Pooling
• High fragmentation of resource pools across the entire sector with a high likelihood of duplication and overlap in the use of resources • Inadequate levels of coordination and complementarity between different resource pools • Inadequacy of mechanisms for income and risk cross subsidization across the contributory schemes
Purchasing
• Provider payment arrangements not sufficiently linked to health provider performance • Sustainability challenges for RBF program • Inadequate capacity in MOHCC for strategic purchasing • Resource allocation does not sufficiently consider health needs • Essential benefit package not fully defined for all levels of care • Referral system is not working effectively • Inadequate coordination between levels of government and donors • Inefficiencies in pharmaceutical supply chain management • Separation of provider and purchaser roles not sufficiently demarcated within public sector

Chapter 4: Strategies for Reform of Health Financing Arrangements

The strategies outlined in this section are organized according to the three main health financing functions. Based on the main issues raised in the previous chapter, 'key areas of intervention' have been identified. Under each area of intervention, a set of strategies has been outlined to bring about the necessary changes in financing arrangements. The strategies provide broad guidance around what needs to be done. For most of these strategies, detailed implementation guidelines and operational activities will still need to be determined by the MOHCC. For each strategy, one or more institutions are identified as responsible (or critical) for its successful implementation.

For each financing function, high priority strategies are identified. These are strategies that must be implemented at the minimum. Factors considered in identifying these priority strategies are cost of implementation, impact on priority health programmes, and sequencing of strategies. Given the current financial dispensation, strategies that require minimal cost and have the potential to significantly improve efficiency and fiscal space are prioritised. In addition, the level of success and impact of some strategies will depend on changes from other strategies. Some of the proposed reform initiatives will require institutional and regulatory changes in order for them to be successfully implemented. These required arrangements are discussed in Chapter 5.

The timelines proposed for strategies are in three categories;

- Strategies listed under *short-term* are those that are to be initiated and carried out within the first 2 years of the reform period;
- *Medium term* strategies are those that are to be implemented around 2 to 5 years from the initiation of the Health Financing Strategy;
- *Long-term* strategies are those for which implementation is estimated to be from 5 years or longer after the initiation of the Health Financing Strategy.

4.1. Raising Revenue

The Zimbabwean health system relies significantly on external assistance and direct out-of-pocket payments from households. Consequently, strategies to raise revenues should aim to increase efficiency and equity in healthcare financing. In the context of Zimbabwe, the end goal of raising revenue for health is twofold: increasing the share of public spending on health (equity lens), and moving towards more predictable and sustainable level of public funding (efficiency lens). Based on international experience in raising revenues for health, three guiding principles should prevail:

- Move towards a predominant reliance on public/compulsory funding sources (i.e. some form of taxation)
- Increase predictability in the level of public (and external) funding over a period of years
- Improve stability (i.e. regular budget execution) in the flow of public (and external) funds during any given year

As noted in chapter 3, the most critical challenge around financing of health care is the limited financial resources for health. Raising revenues based on the principles listed above requires creating fiscal space for the health sector.[45] This can be done through:

45 Fiscal space refers to the capacity of government to provide additional budgetary resources for health without any prejudice to the sustainability of its financial position

1. Improving overall macroeconomic and fiscal conditions;
2. Prioritizing the health sector within the government budget through reallocation from other sectors;
3. Increasing taxes;
4. Increase external funding of health by loans and/or grants from development assistance for health; and
5. Improving technical and allocative efficiency in the use of available resources for health.

A recent fiscal space analysis for health[46] revealed that in the short to medium term, there is limited scope for increasing fiscal space in Zimbabwe. Feasible options recommended include improving efficiency in the use of financial resources for health, and instituting earmarked taxes for the health sector. However, estimates of additional revenue that can be generated from these options still leave a significant resource gap in the health sector.[47] Notwithstanding, the GOZ will continue to explore options for raising revenue in a more equitable and efficient manner.

The strategies identified to increase revenues for health are presented in the table below. The table outlines key intervention areas and priority interventions within each of these areas. Guidance on sequencing of the interventions and the responsible institution(s) are listed in the third and fourth columns respectively.

Table 6: Strategic Interventions to Increase Revenue Collection

Area of intervention	Priority interventions	Timing	Institution(s) responsible
Increase efficiency gains from existing resources	• Place greater emphasis on investment in and implementation of interventions targeted at primary care and prevention	Short-term	MOHCC
	• Strengthen planning and governance around procurement for infrastructure development and equipment	Short-medium term	MOFED/ MOHCC/ MOLG[1]
	• Improve operational efficiency of existing private voluntary health insurance schemes	Short-medium term	MOHCC/ AHFoZ[2]
	• Review of structures of the MOHCC to stimulate greater efficiency	Medium-term	MOHCC
	• Increase non-wage expenditure on supplies and equipment necessary for quality service delivery	Medium term	MOFED/ MOHCC
Increased reliance on public resources for the health sector	• Use evidence based advocacy for increased allocation of government resources to health at central and local government	Short-medium term	MOHCC/ MOLG/ MOFED

46 World Bank, MOHCC & ZIMREF (2017) Analyzing Fiscal Space Options for Health in Zimbabwe
47 See Full details of the fiscal space analysis in: World Bank, MOHCC & Zimref (2017) Analyzing Fiscal Space Options for Health in Zimbabwe. February 2017

Area of intervention	Priority interventions	Timing	Institution(s) responsible
Improve the predictability and level of external resources	• Strengthen mandate and capacity of the Planning and Donor Coordination Unit • Set up virtual pool for donors and make sure external assistance is reported on the budget, to improve transparency and accountability	Short-Medium term Medium term	MOHCC/ MOFED MOHCC/ MOFED/ Donors
Improve efficiency of external assistance for health	• Use donor resource mapping to identify redundancies and underfunded programs • Develop clear multiannual plans so that development partners can align on planned activities	Short-term Short-term	MOHCC/ Donors MOHCC
Increase the contribution of prepayment to the health sector	• Assessment of other prepayment schemes to raise revenue • Assessment of appropriateness of a mandatory health insurance scheme	Short-Medium term Short-Medium term	MOHCC/ MOFED MOHCC
Innovative health financing mechanisms	• Strengthen mechanism for collecting resources due to the health sector from 3rd party insurance • Ensure optimal use of the AMTO • Ring-fence taxes on airtime and internet data • Introduce innovative revenue raising schemes such as sin taxes and ring-fence for health sector • Explore mechanisms that allow community members to contribute to health system strengthening • Strengthen innovative mechanisms to collect revenue from the informal sector	Short-term Short-term Short-medium term Short-medium term Short-medium term Medium-long term	MOHCC/ MOFED/ IPEC[3] MOPSLSW/ MOHCC / MOFED MOFED/ MOHCC MOFED/ MOHCC MOHCC/ MOFED/ MOLG MOHCC/ MOFED
Improve budget execution	• Advocate for improved predictability and availability of public resources • Strengthen capacity to monitor performance around PFM and enforce lines of accountability	Short term Short-medium term	MOHCC/ MOFED MOFED/ MOHCC
Institutional mechanisms for sustainable financing	• Generate financing and expenditure evidence to guide decision making	Short-term	MOHCC/ MOFED

4.1.1. Increase efficiency gains from existing resources

Getting more value from available health resources through efficiency gains is critical given the limited scope for increased allocations to health. The MOHCC will review its existing structures, processes, positions, committees and programmes within the Ministry to eliminate duplication, redundancy and wastage. Continuous review of the health system helps to identify bottlenecks and additional areas of intervention. This includes ensuring that processes for procurement and infrastructure development are free of corruption and unnecessary bureaucratic bottlenecks. Other initiatives to improve efficiency will include the following:

- Reducing the burden of ill-health through disease prevention is an efficient way of addressing health challenges and will be given greater emphasis in health expenditure going forward.
- MOHCC will conduct an assessment of its procurement and infrastructure development process to identify the factors that cause high transaction costs and financial losses. These will form the basis for corrective actions to address inefficiencies and/or misappropriation of public funds.
- Implementing an 'ease of doing business' approach to improve efficiency of operations for other stakeholders within the industry. This will apply to processes around licensing, registration, certification, and importation for example. Reducing transaction costs in the health sector reduces costs passed on to patients, especially in the private sector.
- MOHCC will drive a review of the activities of the medical schemes to ensure adherence to regulations and identify specific initiatives to increase value for money for medical scheme members.
- The MOHCC will also ensure that additional resources generated for the health sector increase the proportion of total health expenditure that is accounted for by non-wage expenditure. Although the health sector is a human-resource intensive sector, without the necessary medical supplies productivity of paid health workers (both quality and quantity) remains sub-optimal.

4.1.2 Increasing reliance on public resources for the health sector

The MOHCC will work with relevant ministries and levels of government to ensure that allocations to the health sector appropriately represent the level of priority placed on the health sector, relative to other sectors. This will include the use of both international and domestic empirical evidence on health needs and expenditure. In addition, the MOHCC will ensure that pattern of public funding of health programmes are reflective of their levels of priority even where external funding to the sector declines.

4.1.3 Improve the predictability and level of external resources

As the main point of operational engagement with development partners, the capacity of the Planning and Donor Coordination Unit (PDCU) will be strengthened to include the skills and resources necessary to effectively engage with development partners. This will include an assessment of the skills gap and subsequent hiring of required staff. In addition, to prevent inefficiencies associated with parallel engagements between development partners and government, this Unit will be empowered to engage with all development partners on behalf of the MOHCC. The specific aspects and levels of the engagements with development partners that will fall under the jurisdiction of the Unit will be determined by the MOHCC. A more capacitated PDCU is also better equipped to outline the needs of the government to development partners, and secure assistance in a manner that is more predictable and in line with the unique health needs of Zimbabwe. The use of a virtual pool will afford better coordination of donor funding. The MOHCC also intends to explore options for leveraging resources from the private sector. In addition to engaging

with donors, the PDCU will identify areas of possible collaboration with the private sector and support the development of a policy framework for public-private partnership.

4.1.4 Improve efficiency of external assistance for health

A robust mapping of donor funds will help identify who the donors are, how much they are contributing, and where these contributions are being made. Donor mapping will therefore help with the identification of areas where there are redundancies and duplication of donor effort, and gaps in the overall financing need. In addition it will be useful in identifying areas where donor support can have a greater impact on the health system. These are crucial in informing a shift in the distribution of donor funds for greater efficiency and equity. Short, medium and long-term health plans provide development partners with a better sense of current and future health priorities and are therefore useful to ensure that activities of donors are in alignment with Zimbabwe's priorities.

4.1.5 Increase the contribution of prepayment to the health sector

The long-term plan of the MOHCCC is to implement a mandatory health insurance scheme. The specific nature and structure of the scheme is still being debated in the policy arena. Options such as a National Health Insurance Scheme are under consideration. In the short-medium term, the MOHCC will assess the feasibility of other types of prepayment schemes to finance the health sector. Currently, Community Based Health Insurance Schemes are being piloted. Outcomes of these studies will be instrumental in determining the most appropriate approach to instituting prepayment schemes for the health sector in the short to medium term, while planning for mandatory health insurance in the longer term.

4.1.6 Innovative health financing mechanisms

The GOZ will explore options to improve existing mechanisms and introduce innovative approaches to mobilize resources for health. Anecdotal evidence suggests that third party insurance such as the Workers Compensation Fund and the Road Accident Fund are significantly underutilised. Similar challenges around underutilisation are being experienced with the AMTO. The MOHCC will work with the relevant Ministries/ institutions to identify the causes of underutilisation of these funds and jointly develop strategies to remove the limitations to optimal utilisation of these funds. Innovative taxes such as the AIDS levy and taxes on mobile airtime/data are already in place but could be ring-fenced to ensure they are leveraged for healthcare. The GOZ will continue to consider other ways of increasing revenue for health from taxation, especially through registration and formalisation of the informal sector, taking into account the costs of administration and enforcement as well as the incidence of tax likely to be collected (progressive vs. regressive). In addition, there are cases where individuals and communities are interested in contributing to the health system through various mechanisms. The government will establish formalised mechanisms that facilitate such contributions and partnerships with individuals and communities in strengthening the health system.

4.1.7 Improve Budget Execution

The MOHCC will work closely with the MOFED to ensure that allocations to the health sector are made on time and that there is better communication around what resources will be available to the health sector in the future. In addition, MOHCC will ensure that there is clarity and consistency in the communication of priority needs to MOFED. The MOHCC will introduce incentives to ensure adherence to public financial

management practices. Of critical importance is the strengthening of monitoring and enforcement of good practices. In addition, the MOHCC will identify and eliminate bottlenecks that prevent the prompt movement of public finances from the MOFED to health providers or other end-users of the finances.

4.1.8 Institutional mechanisms for sustainable financing

The MOHCC will ensure that routine information on health expenditure, including associated processes and outcomes, is made available when due and used to inform decision making on issues relating to health financing. In addition, the MOHCC will ensure that information on financing and expenditure is routinely generated and used to inform health financing policy.

4.1.9 Priority Strategies for Raising Revenue

Priority strategies for raising revenue achieve two important objectives in the short term. They increase fiscal space with minimal cost to the MOHCC, and improve public financial management necessary for increased efficiency and reduced leakages in the public health system. These are:

1. MOHCC to work with relevant institutions to ensure that resources for health services from the Road Accident Fund, Workers Compensation Fund and the AMTO are optimally utilised
2. Improving budget execution by strengthening capacity to monitor performance around PFM and enforce lines of accountability
3. Rationalize pharmaceutical sector supply chain to be more cost effective by improving the level of coordination among different entities involved in the purchase of pharmaceutical products, and instituting government-led price negotiation for essential medicines to the public sector
4. Improving efficiency of external assistance to health guided by donor mapping and the development of clear multi-annual plans for the health sector

These strategies can create fiscal space in the short term to allow for shifts in the pattern of health expenditure in greater favour of higher priority programmes and groups.

4.2 Pooling of Resources

An optimal configuration of resource pools for the health sector can achieve:

1. Enhanced financial and health risk redistribution
2. Better complementarity of different funding pools
3. Reduced fragmentation of pools, and
4. Simplified flow of funds for the health sector.[48]

These strategies have been considered for the Zimbabwean context and applied where appropriate. As noted in previous sections, the GOZ has a long-term vision to implement a mandatory health insurance scheme. Although the exact nature of this scheme is still under consideration, this vision offers some guidance for the strategies to be employed in improving pooling arrangements in the meanwhile. Pooling financial resources for health into a single pool is a desirable target for managing health funds. This is because of the potential to achieve efficiency gains from economies of scale, lack of duplication, easier coordination of resources and the resulting monopsony purchasing. Consequently, a reduction in the number of risk pools is often proposed as a key reform of pooling arrangements. In Zimbabwe, in the

48 Kutzin J; Witter S; Jowett M; Bayarsaikhan D (2017) Developing a national health financing strategy: a reference guide. Health Financing Guidance Series No 3. World Health Organisation

short-medium term, the reduction of risk pools will be carried out within health sub-sectors—that is, the government, private sector, and donor sectors—as a more administratively and functionally feasible reform. A single pool for all government, donor, and non-governmental funds may be implemented in the long term. Other initiatives to improve pooling arrangements are proposed below, to be implemented as and where appropriate.

Table 7: Strategic Options for effective Pooling of Health Funds

Area of intervention	Priority interventions	Timing	Institution responsible
Pooling Government (central and local) Health Funds	• Strengthen equalisation mechanism across local authorities to ensure equitable allocation of resources • Strengthen integration of monitoring and reporting of funds. • Establish a virtual basket of all public funds (including those from Christian missions).	Medium term Medium term Medium-long term	MOHCC/ MOLG
Pooling Donor and Non-governmental Organisation Health Funds	• Establish a virtual sector-wide coordination of all donor and non-governmental organisation health funds. • Develop virtually integrated monitoring and reporting of funds.	Short- medium term Short-medium term	MOHCC/ MOFED/ Donors and Non-Governmental Organisations
Private Sector Health Funds	• Strengthen the regulation of the medical schemes environment	Short-medium term	MOHCC
Pooling Government, Donor and Non-Governmental Health funds	• Establish a virtual basket of all public and donor health funds. • Develop joint accounting, monitoring and reporting of funds.	Medium-long term	MOHCC/ MOFED / MOLG, donors and Non-Governmental Organisations

4.2.1 Pooling of government resources

A single pool—such as a mandatory health insurance scheme—for the management of all government health resources has the potential for significant efficiency gains. This is the objective of the HFS in the long-term. However, in the short-medium term, certain pools will need to be preserved as they are in order to protect financial resources for key populations (e.g. the poor and vulnerable) to promote greater financial equity. These protected pools include the NAC HIV/AIDS Trust and AMTO. As the overall resource envelope grows, these pools can be merged with the larger, main health pool. Pools that are merged in the short-medium term will continue to maintain their 'separate' sources of funds but will collapse into a single virtual pool at the purchasing stage, respecting existing mutual and statutory boundaries, but working with a common framework and standard operating procedures. In addition to pooling government funds, an equalisation mechanism is proposed to ensure that local councils with lower revenue generating capacity are not hindered in their ability to provide equal access to and quality of health care services.

4.2.2 Pooling of donor funds

In the short to medium term, the objective is to increase the number and proportion of donor funds that are pooled together in the HDF. The HDF will be jointly coordinated by a Donor Coordinating Unit at the MOFED and the Planning and Donor Coordination Unit at the MOHCC. The success of the HDF has

demonstrated that multiple pools can coexist without fragmentation if there is commitment to working together and sharing common plans and frameworks. It is envisaged that in the medium to long term, the membership and participation of all donors and Non-Governmental Organisations will be mandatory. The financial and organisational autonomy of partners in accounting for and reporting their funds will be respected, but disbursements from the pool will be coordinated by the coordination units. In the long term, this virtual pool will be merged with those from the government and private sector to create a single fund for the proposed mandatory health insurance scheme.

4.2.3 Pooling of private funds

The private health insurance environment has 36 separate funding pools, but with three dominant players. Competition in this environment plays an essential role in promoting efficiency. Therefore, while reducing the number of pools can minimise administrative costs, it is important to ensure that there are enough players to avoid creating monopolistic features in the private health insurance market. Consequently, the aim to improve pooling arrangements in the private health insurance environment will incorporate other strategies that promote health and financial risk cross-subsidy, efficiency in operation and the maximisation of benefits for members. These will also encompass strategies to improve governance of the schemes and accountability towards contributors and beneficiaries of the schemes. The establishment of a dedicated regulator of the medical schemes market is critical. This regulator will oversee important aspects of the market such as provider payment mechanisms, price escalation, contribution increases, minimum benefit packages, application of co-payments, risk-rating approaches, etc.

Figure 9 provides a diagrammatical representation of a generic progression from the current state to short-medium term objectives and the long-term goal of a mandatory health insurance scheme. The long-term objective is depicted as a mandatory Health Insurance Scheme which pools resources from the government, donors, private health insurance, communities and households. A single fund would require that the pooling of funds be done at source rather than at purchasing stage. Unlike the virtual pool, this fund would involve a structural integration of all the funding pools and a simplified general tax financed scheme. For the mandatory health insurance scheme to operate effectively, some level of fiscal decentralisation may have to be sacrificed. A purely unitary fund would require that there be a single comprehensive benefit package and a single payer organisation purchasing services and using uniform rates. However, private health insurance will remain a supplementary option, especially for higher and more sophisticated levels of care.

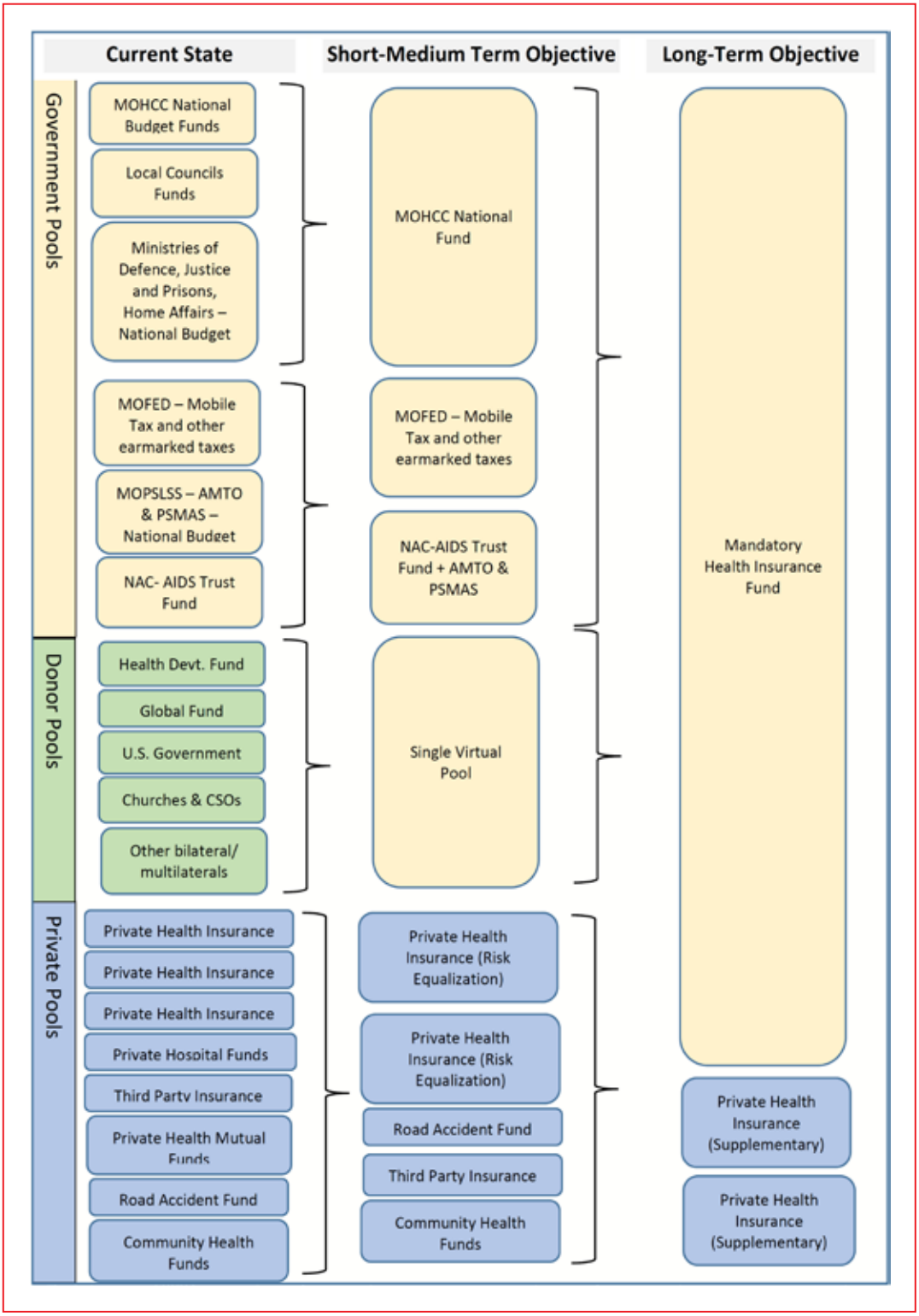

Figure 9: Progression in Pooling

4.2.4 Priority Strategies for Pooling of Health Funds

For pooling of health funds, the priority strategies in the short term are as follows:

1. Establish virtual, sector-wide coordination of all donor and non-governmental organisation health funds
2. Develop virtually integrated monitoring and reporting of the funds.

These strategies are prioritised because they provide the means for greater coordination of government and donor funds in the financing of public health care in the short term.

4.3 Purchasing Health Services

Under the very constrained economic and fiscal environment, improving efficiency in the use of available pooled financial resources for health care is of critical importance to the MOHCC. The MOHCC intends to continuously improve purchasing arrangements to maximise health system performance by adopting a more strategic approach. This includes creating the necessary incentives to promote efficiency, sustainability and equity regarding the allocation of financial resources and payment for health services, both in the public and private sector. Resources will be allocated according to need and in line with health system priorities.

The main purchasers of health services are the government (MOHCC, provincial authorities, and local authorities), development partners, and the private sector (medical aid schemes and households/ individuals). In improving the purchasing of health services, the GOZ aims to move away from input-based line item budgets and historical approach to budgeting, as they entrench and exacerbate inequities in access to care without creating necessary incentives for the delivery of high quality health care in a cost-effective manner. The strategies proposed here are designed to hold providers more accountable for the services they deliver and to be more responsive to the often unique health needs of the different (geographic, demographic, and socio- economic) population groups.

The main areas of focus and specific interventions for reforming purchasing arrangements are described in Table 8 below.

Table 8: Strategies for improving purchasing in health care

Area of intervention	Priority interventions	Timing	Institution Responsible
Improve procurement and supply chain management	• Streamline procurement, storage and distribution of medicines and pharmaceutical supplies through NatPharm to leverage economies of scale and reduce costs through the system	Short-medium term	MOHCC/ MOFED
	• Implement sector-wide approach to use of donor funds in procuring medicines and pharmaceutical supplies	Medium term	MOHCC/ MOFED/ Donors
Introduce strategic purchasing	• Strengthen capacity for strategic purchasing within MOHCC and establish a dedicated purchasing unit	Short-medium term	MOHCC

Strengthen Results Based Financing	• Full institutionalise fully RBF across levels of care and services • Ensure sustainability of RBF through dedicated resource allocation	Short-medium term Short-medium term	MOHCC MOHCC/ MOFED
Allocate resources according to need	• Develop and implement needs-based resource allocation formula	Short-medium term	MOHCC
Ensure equitable and efficient delivery of Essential Benefit Package	• Articulate the essential benefits package to be prioritized based on realistic resource envelope • Strengthen referral system by using financing incentives to improve quality	Short-term Short-medium term	MOHCC MOHCC

4.3.1 Improve procurement and supply chain management

The government is intent on reducing wastage from the duplication of purchasing roles, especially in the area of procurement of pharmaceutical supplies. Going forward, purchasing arrangements for pharmaceuticals will be streamlined to reduce cost to the health system. In the short term, this would entail improving the level of coordination among different entities involved in the purchase of pharmaceutical products, and instituting government-led price negotiation for essential medicines to the public sector. A more coordinated approach will be employed in the use of donor funds to buy medicines and other pharmaceutical supplies to reduce duplication and wastage. This will be designed with the intention to migrate to the preferred scenario where NatPharm is the main player in buying, storing and distributing pharmaceutical products. In the medium term, the MOHCC will work to strengthen the capacity of NatPharm to assume these responsibilities. This will include strengthening procurement capacity, storage and distribution, and reporting and supervision. Activities will include increasing financial allocation to NatPharm for recapitalisation and to increase its ability to procure medicines; investment in improving storage facilities and in procurement and management of vehicles for distribution of medicines; and the hiring of staff to manage storage and distribution. The MOHCC aims to reduce dependence on donor funds through the recapitalisation of NatPharm.

4.3.2 Introduce strategic purchasing

The MOHCC will assess various aspects of its current system responsible for purchasing functions to identify areas that require improvement in order to effectively institute strategic purchasing. This will include a review of skills, financial management regulations, data requirements, levels of autonomy of providers, etc. Based on this assessment, specific activities will be outlined to improve the ability of the MOHCC to strategically purchase health services. These activities will address weak control mechanisms around compliance and performance, and will precede the establishment of a dedicated unit responsible for strategic purchasing. Establishment of a Strategic Purchasing Unit will also create a clearer distinction between provider and purchaser roles within the MOHCC. Key areas of oversight and enforcement for strategic purchasing functions include price regulation, provider-payment mechanisms, and accreditation of service providers. This Unit will also be responsible for strategic purchasing from the private sector. The development of strategic purchasing capacity and the establishment of a Strategic Purchasing Unit will be coordinated with the progression in pooling arrangements. The responsibilities and scope of operations of the Strategic Purchasing Unit will expand with the merging of health resource pools.

4.3.3 Institutionalise Results Based Financing

Following the positive impact of current RBF projects on health system performance, the GOZ is committed to establishing performance based mechanisms as a core approach to health service delivery. Strategic direction for the implementation of RBF within the public health system has already been mapped out. The GOZ has proposed the establishment of a sub-unit within the Project Coordinating Unit (PCU) in the MOHCC devoted to performance improvement. This will form part of the initiative to strengthen capacity for strategic purchasing within the MOHCC. A move towards a comprehensive performance management model within MOHCC has been agreed on. This also entails movement of RBF away from a project to become part of the management arrangements of the MOHCC. In addition, RBF will be aligned to the current Performance Based Budgeting approach adopted by MOHCC. Key initiatives identified for RBF in chronological order are as follows:[49]

- In the short term: Achieve uniform implementation of RBF across all rural districts at primary and secondary levels of care schemes
- In the short-medium term: Full institutionalisation of RBF
- In the long-term: Consolidation of performance management as the principal way of doing business.

The GOZ will review new avenues for raising revenue with the view to fully fund current RBF initiatives completely.

4.3.4 Allocate resources according to need

A needs-based resource allocation formula to guide the distribution of public health funds will be developed. This formula will embody the major geographic indicators of health needs such as population size, socio-economic characteristics and supply-side capacity. Implementation of a resource allocation formula is usually more feasible when the overall resource envelop is increasing. The MOHCC will progressively implement the needs-based formula as additional resources are available to the public health sector.

4.3.5 Ensure equitable and efficient delivery of Essential Benefit Package

An Essential Benefit Package that includes secondary and tertiary levels of care will be defined. This will provide guidance to health planning and service delivery to prioritise these services. Guiding frameworks such as basis for inclusion or exclusion from the Essential Benefit Package will be developed by the MOHCC. As the resource envelop for the health sector increases, the benefit package will be revised accordingly. Improving the quality of care at the primary care level is critical to improving the operation of the referral system. The MOHCC will use innovative purchasing arrangements to improve quality of care. Other demand-side incentives to encourage the use of primary care facilities as the first point of contact with the health system will also be explored.

49 These are recommendations from the 2016 report on "Assessment and redesign of the systems for RBF, human resources for health and pharmaceuticals in Zimbabwe"

4.3.6 Priority Strategies for Purchasing Health Services

Priority strategies for purchasing health services are as follows:

1. Strengthen the capacity for strategic purchasing within the MOHCC
2. Ensure sustainability of RBF through innovative financing

The current RBF initiative improves the financing and provision of priority health care services, such as reproductive, maternal and child health care services. Institutionalisation and more sustainable financing will ensure that RBF can continue to make progress in this area. Strengthening MOHCC capacity for strategic purchasing is fundamental to the successful implementation of all other purchasing initiatives planned in the short, medium and long term.

Chapter 5: Governance and Institutional Arrangements for the Health Financing Strategy

Strategies proposed in the previous chapter will require robust governance and institutional structures. In some cases, this requires changes to the existing systems and structures in place. This section describes some of the necessary changes to governance and institutional arrangements to ensure success in implementation of the health financing strategy. Complementary actions such as capacity building initiatives are also outlined.

5.1 Institutions for Implementing the Health Financing Strategy

Changes in institutional and governance arrangements are discussed for those institutions directly involved in the implementation of strategies outlined in the HFS.

5.1.1 Ministry of Health and Child Care (MOHCC)

The MOHCC will continue to play its stewardship role in the health sector. This includes its role in policy development, planning, financing, regulation and provision of health care. Important changes in the structure and processes within the MOHCC include the review and finalisation of the draft Medical Aid Bill, which is currently in the process of being fully enacted. This Bill will establish the regulatory body necessary to provide oversight and enforce regulations for the efficient operation of the medical aid market. The move towards a more strategic approach to purchasing requires not only skill development in the area but also the establishment of a dedicated unit for purchasing within the MOHCC. Leveraging the resources in the private health sector will require the development of a public-private partnership framework that provides the basis for interaction between agencies of the MOHCC and private corporations.

5.1.2 Ministry of Finance and Economic Development (MOFED)

MoFED remains the fund holder for all government funds, disbursing them through the national budget processes and accounting for them through strict enforcement of the Public Finance Management System. In the medium to long term for donor funds, the MOFED should move towards revitalising the Donor Coordination Unit to superintend over the joint resource planning and use of donor funds. The donor coordination unit could be made up of personnel from MOFED, MoHCC donor coordination unit and the Donors.

5.1.3 Ministry of Labour and Social Welfare (MLSW)

The MPLSS plays the critical role of administering the AMTO on behalf of the indigent population, which includes those under 5, pregnant women, those over 65, and those in the poorest wealth quintiles unable to pay for health services. In the short term, the AMTO needs to be revitalised by redefining the parameters for identifying and selecting the beneficiaries, as well as ensuring that adequate funding is available. Pre-identification and selection of potential beneficiaries will enable the MLSW to accurately budget for its needs rather than the current scenario where its budget allocation from MOFED is based on claims from the previous period. The MLSW is also the parent ministry of the National Social Security Authority, which runs the Workers' Compensation Fund; while there will not be any proposed institutional changes for this fund, there is need for the parent ministry to enforce accountability in the use of this fund.

5.1.4 Ministry of Local Government

This Ministry plays the critical role of administering the Urban and Rural Council Acts and is therefore engaged in the authorisation of proposed plans for earmarking of specific levies and licensing fees for improving the local authorities' health budgets. Certain parts of the Urban and Rural Council Acts and certain portions of the local government budget manual/rules may have to be revised or realigned for the proposed initiative to work. This is also the case for the implementation of the initiative to equalise health expenditure across urban and rural councils.

5.1.5 Health Development Partners Group and Civil Society Organizations

The Health Development Partners Group (HDPG) provides a platform for joint planning and coordination of activities among donors. The HFS envisages that in the short-medium term the HDPG mandate must be strengthened to include joint planning and ownership of results/health outcomes. Joint ownership of health outcomes will encourage the donors to commit fully to joint planning and resource use. Regular consultations with Civil Society Organizations members will be conducted by HDPG to strengthen its effectiveness. Some specific initiatives are as follows:

- *Strengthening Donor Coordination Unit* – MOFED and MOHCC are in the process of revitalising this unit for future on-budget support. In the long term, the HFS envisages an environment where all donor funds are channelled on-budget and are superintendent by the Donor Coordination Unit under the Department of Policy and Planning.

- *Institutionalising Results Based Financing (RBF)* – currently funded by the World Bank (with counterpart funding from the MoFED) and the HDF, and administered through Cordaid and Crown Agents Zimbabwe. Institutionalisation of RBF is on-going, with the creation of an RBF sub-unit within the PCU of the MOHCC already at an advanced stage.

Figure 10: Roadmap for the Institutionalisation of the Results Based Financing
Source: MoHCC

5.1.6 Private Sector Players

The enactment of the Medical Aid Bill will affect the operations of the private medical aid schemes and other private health sector funds. The draft Bill proposes the creation of an independent regulatory body that will enforce regulation of the medical aid scheme operations. Regulations will cover important aspects of the medical schemes market such as purchaser-provider functions, solvency and viability issues, and a provision for an enforceable minimum benefits package.

5.2 Complementary Initiatives

In addition to the changes outlined above, other activities will be carried out to support the successful implementation of the Health Financing Strategy. The MOHCC will ensure that relevant information concerning the strategies proposed will be communicated to key stakeholders to elicit buy-in and support to successfully implement the strategies proposed. The capacity of the MOHCC and other institutions will have to be strengthened to ensure that they are able to carry out the roles they are to perform. Important areas for capacity development include PFM and strategic purchasing. The PDCU will require capacity development in the areas of health economics, public health and demography. Likewise, NatPharm's capacity for distribution and storage will need to be increased.

Chapter 6: Monitoring and Evaluation of the Health Financing Strategy

The systematic tracking of the execution of planned activities as well as periodic review of progress towards desired results is critical to the success of the HFS. Regular review of progress on activities outlined in the strategy allows for corrective measures to be taken in a timely manner when challenges are encountered. This Chapter describes the approach to be used in monitoring and evaluating the performance of the strategy.

6.1 Overview of the Monitoring and Evaluation Mechanism

A Results-Based Monitoring, Evaluation and Reporting (RBMER) approach has been adopted to track performance and ensure efficient and effective delivery of the intended goals of this strategy. The approach recognizes that the implementation of the strategies outlined in Chapter 4 should produce certain desired results; some in the short term, some in the medium term and others in the long term. These results can be differentiated along four core levels of the results chain: Inputs and Processes, Outputs, Outcomes and Impact.

The **Inputs** refer to resources such as human resources, equipment and finances that are required for strategy implementation. **Processes** refer to specific activities that are to be carried out. These include the setting up of units and committees or training of health workers. **Outputs** are the direct short-term results of implementing the activities outlined in the overall strategy, such as the institutionalization of results-based financing. With the contribution of other factors within the operating environment, the strategy envisages medium term effects or **Outcomes** that are aligned to the goals of health financing, such as the reduction in catastrophic health payments. The outputs and outcomes should have longer term effects on the health system and population health that are referred to as **Impacts**.

The RBMER approach will entail periodic assessment of performance indicators that are mapped to each of the four levels of the results chain at intervals during the implementation life of the strategy. The measurement of the lower level results (Processes and Outputs) will be more frequent and will make use of routine trackers to assess timeliness and completion of planned intervention strategies. Relatively more advanced mechanisms such as national health surveys, Resource Mapping, National Health Accounts and Expenditure Tracking Surveys will be used to measure progress on outcome and impact indicators. A strategic dissemination approach will be used to ensure that all relevant stakeholders are informed of progress on the activities of the HFS and to promote adaptive learning during implementation. Figure 6.1 provides a schematic of the RBMER approach adopted for this Health Financing Strategy.

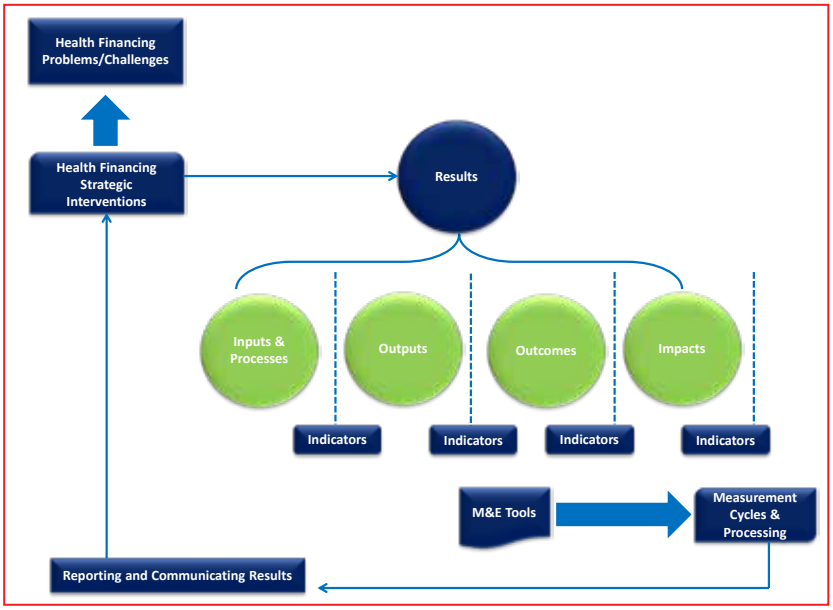

Figure 11: Results based M&E mechanism for health financing strategy
Source: Authors

6.2 The Results Framework and Performance Indicators

Progress on input and output indicators will be monitored on a regular basis by a detailed Implementation Plan. As part of its quarterly meetings agenda, the HFS TWG will review progress on activity implementation and resource availability/usage for the HFS. A Health Financing M&E Sub-Unit will be setup within the Health Financing Unit primarily to collect and consolidate data on the indicators; and reporting back to the HFS TWG.

A Quarterly Progress Checklist will be developed to collect data on the status of input and output indicators, which will be consolidated into a Quarterly Dashboard used for review by the HFS TWG. The TWG Chair will also routinely brief MOHCC Management and other stakeholders not represented in the TWG on progress.

Table 9 lists outcome indicators that will be used to evaluate progress towards achieving the objectives of the HFS. The first column of the table lists the five main objectives of the HFS. Outcome indicators have been listed for each of them. It is worth noting that certain indicators cut across more than one objective.

The status of the outcome indicators relative to their Baseline (status at 2017) and targets will be used to inform an independent Mid-Term Review that will be undertaken in the third year, and an Independent End-Term Evaluation, which will be planned at the end of the five-year implementation period. Additional reviews/evaluations will be conducted for specific reforms. Annual Joint Sector Reviews of the strategy will be conducted and chaired by the Permanent Secretary or designate.

Table 9: Key Outcome Indicators

Policy Objectives	Outcome Indicators	Base-line Value (2017)	Mid-term Target (2020)	End Target (2022)	Source
Mobilize adequate resources for predictable sustainable funding of the health sector;	1. Government health expenditure as % of total government expenditure	8.72% (2015)	12%	15%	MoHCC/NHA
	2. Non-wage health expenditure as % of total Govt. health expenditure	>10%	20%	30%	MoFED/National Budget Expenditure Reports
	3. Percentage (%) of Donor funds channelled through central government	39.24% (2015)	60%	85%	MoFED/MoHCC/Donors
Ensure effective, equitable, efficient and evidence based allocation and utilization of health resources;	4. Administrative costs as % of total private health expenditure	16.7% (2015)	12%	10%	MoHCC/NHA
	5. Government spending at primary level	33.3% (2015)	35%	40%	MoHCC/Expenditure Reports
Enhance the adequacy of health financing and financial protection of households and ensure that no-one is impoverished through spending on health by promoting risk pooling and income cross subsidies in the health sector	6. OOP as % of total health expenditure	23.74% (2015)	18%	14%	MoHCC/NHA
	7. Incidence of Catastrophic Health Expenditure (CHE)	7.64% (2015)	5%	2%	MoHCC/NHA
Ensure that purchasing arrangements and provider payment methods emphasize incentivizing provision of quality, equitable and efficient health care services	8. % of Facilities with essential drugs available	78%	85%	95%	UNICEF/VMAS –survey Reports
	9. Institutional Quality Score	73.45% (2015)	80%	85%	MoHCC/Cordaid/Crown Agents Reports
Strengthen institutional framework and administrative arrangements to ensure effective, efficient and accountable links between revenue generation and collection, pooling and purchasing of health services	10. % budget execution	81.% (2016)	90%	100%	MoFED/MoHCC

Key References

- 2016 Annual Report for the Ministry of Health and Child Care
- Constitution of Zimbabwe Amendment (No.20) Act 2013
- Henry Mabika (2015) Liquidity crisis and service delivery in Zimbabwe local authorities. Journal of Political Science and Public Affairs 2015 3:3
- Jegers, M., Kesteloot, K.,De Graeve, D., Gilles, W. 2002. A typology for provider payment systems in health care. Health Policy 60 255-273
- Kutzin J; Witter S; Jowett M; Bayarsaikhan D (2017) Developing a national health financing strategy: a reference guide. Health Financing Guidance Series No 3. World Health Organisation
- Langenbrunner, J.C. and Liu, X. 2005. How to pay? Understanding and using payment incentives. In: Spending Wisely: Buying health services for the poor. Eds Preker, A.S. and Langenbrunner, J.C. The World Bank, Washington D.C.
- Ministry of Finance and Economic Development (2017) Budget Highlights
- MOHCC Main Report on the Costing of the Zimbabwean National Health Strategy 2016-2020
- The National Health Strategy for Zimbabwe 2016-2020
- USAID (2010) Zimbabwe Health System Assessment
- World Bank (2015) Health Public Expenditure Review Zimbabwe
- World Bank; MOHCC & ZIMREF (2017) Analyzing fiscal space options for health in Zimbabwe
- World Bank (2017) Zimbabwe Economic Update: The State in the Economy. June 2017 Issue 2
- World Health Organization (2000) World Health Report 2000
- Zimbabwe National Health Accounts 2015
- Zimbabwe National Health Financing Policy 2016
- Zimbabwe Service Availability and Readiness Assessment 2015

(Footnotes)

1 Ministry of Local Government, Public Works and National Housing
2 Association of Healthcare Funders of Zimbabwe
3 Insurance and Pension Commission