HEALTH SECTOR REFORMS

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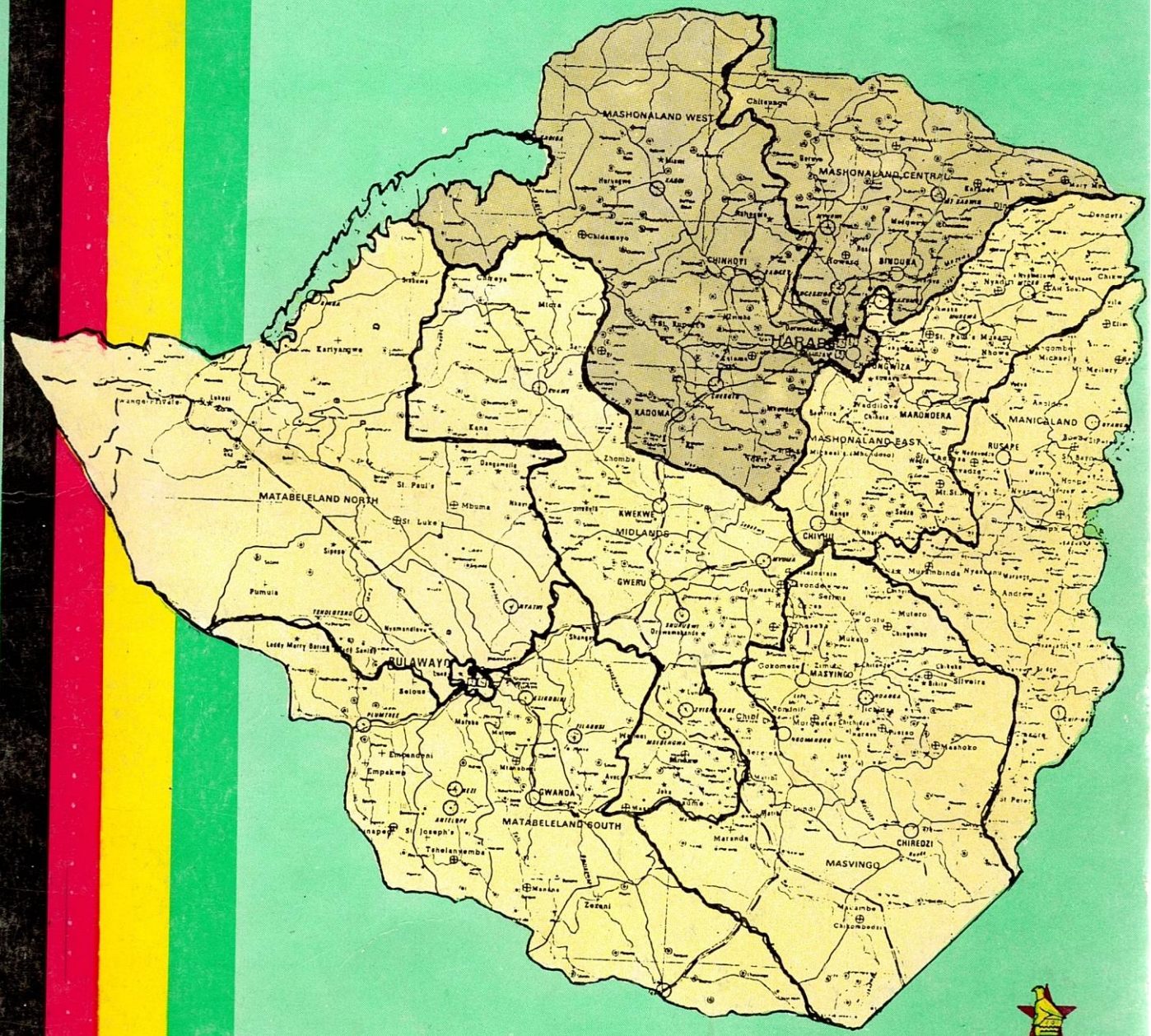

PRIMARY HEALTH CARE
A HEALTHY NATION
MINISTRY OF HEALTH
ZIMBABWE

Ministry of Health and Child Welfare

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MINISTRY OF HEALTH

AND

CHILD WELFARE

HEALTH SECTOR REFORMS

TABLE OF CONTENTS

1. INTRODUCTION

Throughout the world there is concern about the performance of public health systems. Patients and the public are dissatisfied by the quality of care, politicians complain about spiralling costs of providing health care, health professionals are concerned with equity and value for money. The Public Service Review Commission Report (1989) confirms these concerns and highlights the need for government to consider innovative ways of service provision and management. Thus, the thrust of government policy should be towards investigating new mechanisms for providing Health Services in ways which further national health objectives.

Government should, through the process of Health Sector Reform reaffirm its commitment to the following principles:

- Improving Health status and consumer satisfaction by increasing the effectiveness and quality of services;
- Obtaining greater equity by improving the access of disadvantaged groups to quality care; and
- Obtaining greater value for money (cost-effectiveness) from health spending, considering improvements in both the distribution of resources to priority activities (allocative efficiency) and the management and the use of the resources that have been allocated (technical efficiency).

These national health objectives remain as valid during this period as they were at independence. However, the mechanisms for furthering these objectives will change from time to time in response to shifting socio-economic trends. The tremendous growth of the Public Health System in Zimbabwe, and associated improvements in the Health status of the whole population, has been achieved under a highly centralised system. The challenges faced at independence demanded that control and direction be vested at the centre in order to achieve universality of access to all Zimbabweans. In the last five years however, government expenditures as a share of GDP have fallen considerably, from 48.4 percent in 1990 to 43 percent in 1994. Further, real government expenditures have declined by 17.6 percent over the same period. This downward trend emphasises the need for new ways of service delivery in the face of declining resources.

There is also increasing evidence that tax based health systems tend to use resources inefficiently because they are highly centralised both in terms of financing and management.

Other indicators of poor performance include:

- A management culture that does not focus strongly enough on objectives and accountability.

- Centralised planning and decision making resulting in the inefficient use of resources.

- Absence of a customer focus.

- Poor response to community needs due to limited authority to make decisions at the point of service delivery.

- Centralised recruitment and compensation policies contributing to poor retention of staff.

In response to these problems, many countries, including Zimbabwe, are embarking on various forms of Health Sector Reform. The general trend is towards managing services closer to the point at which they are delivered in order to make services more responsive to consumer needs and preferences.

Furthermore, resource management authority is being decentralised to the health service provider unit in order to ensure the cost effective use of resources. The central Ministries of Health maintain the responsibility for strategic planning and health financing. Zimbabwe has chosen to decentralise the management and development of health services to the newly created Rural District Councils within the context of the current Public Sector reforms. In this case, it is a means of empowering local communities, improving efficiency and management. The proposed form of the Health Sector Reforms has the potential to further current Public Sector reform objectives in a number of ways.

Specifically, the Ministry of Health and Child Welfare proposes major reforms in the following areas:

- Decentralisation
- Health financing
- Regulating the Private Medical Sector.
- Management Strengthening
- Contracting out.

A comprehensive programme of reforms in these areas will ensure the development of a sustainable health service in Zimbabwe and also meet the objectives of the current Public Sector Reform Programme.

The proposed reforms in these areas are consistent with the need for equity in service provision, efficiency and effectiveness, financial sustainability, improved health status and active participation in service planning and delivery by both the communities and the private sector. Detailed concept papers have been produced on each of these components of Health Sector Reform. These will be presented in summary form in the following sections.

2. DECENTRALISATION

A detailed discussion of the concept of Decentralisation of Health Services is presented in the Ministry of Health and Child Welfare document "Health Sector Reform in Zimbabwe - Decentralisation".

Given the difficulties of successfully managing the process of decentralisation, adequate attention needs to be paid to the political and economic context in which implementation is taking place. Policies must also take into account certain problems that seem to be inherent in the decentralisation process. These relate to tension between central control and local autonomy. For these reasons, it is strongly recommended that the proposed form of decentralisation be piloted in one province with potential for an adequate supply side response.

Further, piloting is extremely important considering the nature of the dynamics between health systems development, the financing and costs of Primary Health Care which include:

- Ways of organising service delivery and methods of financing services are closely interrelated. In other words, the organisation of the supply and financing of services should enhance public demand for services so that larger public benefits will result. They are two sides of the same coin.

- The costs of producing services are often significantly affected by and related to the way they are organised and financed.

The point of emphasis is that proposals for the implementation of the decentralisation process must be accompanied by appropriate financing mechanisms for service delivery. The Ministries of Health and Child Welfare and Public Service,Labour and Social Welfare have already prepared proposals for such a financing mechanism.

The following features of the proposed decentralised health system take into account the complementary nature of financing and management of Health Services.

The Management of District Health Services will be under the jurisdiction of the Rural District Councils. Rural District Councils will be responsible for the provision of all the core health services for the District level. The management of the district health services will be the responsibility of one of the committees of council constituted as "The District Health Services Board". The District Health Services Board will have the following functions:

- The provision of health services in the district including authority to subcontract as necessary.
- Recruitment, employment and retention of staff according to their requirements in accordance with national guidance.
- Management and ownership of capital assets, real estate and other supplies required to run the health services.
- Management of funding from central government or any other sources including getting loans (with government approval) required to run the Health Services.
- Development of strategic and operational plans with support and guidance from the ministry.

The basic principles which must be fulfilled in terms of the accountability relationships between the Board and the Minister of Health and Child Welfare are:

- The Minister of Health and Child Welfare will retain accountability for the operations of the National Health System to government and Parliament.

- Equity and universal access to services will remain national goals, thus there will be need for "seamless" provision of services between districts.

- Recognition should always be borne in mind about the complex nature of health service provision. Unlike other markets, the Health market is fraught with imperfections requiring government to continuously review its role in health financing and management.

Membership to the **Board will be** by appointment by the Ministers of Health and Child Welfare and Local Government, Rural and Urban Development. It is envisaged that membership will include stake holders, elected councillors and community interest groups.

The Chief Executive of the Rural District Council and the District Health Officer will be members of the Board in an ex officio capacity.

The Board is expected to conduct its affairs in a business like manner. The Board will report to Council like any other committee and to the Minister of Health and Child Welfare through statutory reports and the close links maintained through the provincial office. The Boards' autonomy, within national policy, should be maintained.

The day to day management of the Health service will be the responsibility of the District Health Officer (DHO) who will be the head of the department of Health in a particular Rural District Council area.

All employees engaged in service delivery and management at district level will be employees of council on conditions consistent with national guidance and norms.

The role of the provincial office will cease to be a direct management role in relation to services. Their main role will be monitoring adherence to agreed services, standards and costs amongst providers.

In other words, their role would be to monitor service contracts on the basis of which District Health Boards will provide services and receive payment either as government subsidies or capitation grants from the proposed National Social Health Insurance Fund. Further to this, the province would also provide technical support and have oversight on programmes with a national interest.

Conditions of service for employees will be guaranteed on transfer to Rural District Councils and maintained in line with national norms. It should be possible for councils and their Boards to offer additional incentives for their staff to increase productivity.

The role of existing local Health Centre Committees will be enhanced to include the management of part of the revenue retained for development, promotional and preventive activities.

The mobilisation of funds to finance personal health services will be the responsibility of the autonomous National Social Health Insurance Fund. The fund will in turn, through a capitation payment to the District Health Board, provide funding for the treatment of patients. The core health services to be provided and their cost will be agreed upon upfront.

The level of the government subsidy will depend on the circumstances of each Council and on the basis of an agreed formula, negotiated amongst Government, the Fund and the District Council and its Board. The provincial office and the fund as represented at provincial level, will have a critical role to play in this process. A situation where councils run out of money to provide agreed services should be avoided. However, the more Boards improve efficiency and the quality of services the more people would be willing to contribute to the fund. Councils will therefore have an interest to ensure that as many people as can afford to make contributions actually do so in their areas. Councils will have a major advocacy role to play.

3. SOCIAL HEALTH INSURANCE

A detailed discussion of the concept of Health Insurance is presented in the Ministry of Health and Child Welfare document "Social Health Insurance in Zimbabwe".

Social Health Insurance is based upon risk sharing, i.e., those who are healthy and do not consume health services should help pay for those who are sick.

This concept assumes that those who are healthy today will have a portion of their health expenses covered by others when they fall sick in future. Contrastingly, private health insurance is based on the expected average cost of providing health services to all beneficiaries. Another difference between the two insurance programmes is that Social Health Insurance is based on need, with contributions being made on the basis of the individual's ability to pay. Social Health Insurance, properly planned, can advance the objectives of the current public sector reform programme.

It is recognised that assembling a Social Health Insurance package which would meet Zimbabwe National Health objectives and public sector needs is a major undertaking. For this reason, it is proposed that the scheme be piloted in one province initially. The pilot should aim to contribute to the government's overall reform agenda and to national health reform objectives.

The pilot will shed light on how social health insurance can contribute to efficiency, equity, sustainability, decentralisation and private sector participation.

The pilot will also set the ground for developing the administrative and legal framework for national implementation of the programme. The pilot will also allow for the design and implementation of the National Social Health Insurance Scheme to be fully participative. It is proposed that the scheme will take the following form.

The scheme would be simple, based on capitation grants to primary level providers - possibly subsidised from the fiscus in the initial years. In return for capitation payments, providers will be obliged to provide the set benefits package to consumers on demand. The capitation grant will be shared on a pre-set basis between referral hospitals and the network of primary care centres that it is uniquely tied to.

Participation in the scheme would be mandatory for those employed in the formal sector and contributions would be wage-based. The existing tax collection system can adequately perform this function. In the informal sector, contributions would be at a fixed rate and would be collected during periods of highest income, e.g. after harvests.

The scheme would have a pro-poor exemption policy. People who are too poor to pay the required contribution will be exempt. However, they will still get a health card entitling them to services when needed. Those who are not exempted, but are non-contributors will be required to pay for services on a fee basis when receiving health care.

The benefits package would emphasise Primary Care and hospital care defined as "Core Health Services". Services beyond the core services would be paid for by the individual on a fee basis or through private health insurance. It would also be possible to develop a more generous package of (Social Health Insurance) services for those who are willing and able to pay higher contributions.

Contributors have the freedom of choice in choosing their own provider, i.e. health centre. They would be allowed to switch health centres every six months if they are not satisfied with their first choice. Each primary level provider would be expected to have affiliation with a primary level hospital (District Hospital) so that patients will be guaranteed referral to such facilities and beyond.

Providers will be contracted to provide the specified benefit package at no extra cost to the patient. Providers will be paid on a per capita basis, this encourages judicious utilization of resources. Providers will be able to retain surplus (revenue less costs).

The insurance fund will be autonomous and will have a full complement of staff at the Provincial level with representation at the District level. Contributions from the informal sector will be collected by representatives of the fund at the village level. Existing structures such as the Health Centre Committees can play this role.

The fund will allow representatives and villages they cover to retain a percentage of collections as an incentive to promote participation in the fund. The revenue retained would be used for local health activities.

The Ministry of Health and Child Welfare will decentralise its system of service delivery to give each facility a degree of autonomy to foster competition.

To ensure supplier response to increasing funding and competition of providers in the new financing arrangements, a system of "Designated Providers" could be established. Medical professionals and nurses would be allowed, on a "designated" basis, to open appropriate facilities in underserved areas and other locales as the market develops.

This proposal would help to solve many of the constraints of private sector participation -including lack of credit, regulation, training, management, accountability and quality assurance.

The government subsidy (budget allocation) would be utilised for paying administrative, management and supervision costs, cost of services in the public domain, cost of coverage of indigent and target groups, and subsidy to cover requirements emanating from national level such as national disasters like drought.

Pilot site selection could be based on the following criteria. One being that supply-side improvements and capacities should be up to standard. To capture the benefits of the scheme as described, the suppliers of services must be able to respond in an efficient and cost effective manner to demand. Prior to introducing the pilot, it is therefore important to determine the critical capacities and improvements that need to be in place, and undertake to make them take place.

The other is that performance of the scheme could most easily be evaluated in a relatively well-off province (with a relatively large formal sector) versus a relatively poor province (with an overwhelmingly large informal sector).

The pilot test would be intended to assess:

- Appropriate promotional activities.
- Client response.
- Modalities of enroling members.
- Logistics of membership card preparation.
- Process of setting and collecting membership fees.
- Practical functioning of exemption of the poor.
- Assessment of management performance and logistics.
- Cost containment analysis.

There are a number of constraints that need to be tackled before the pilot is launched. These include:

- The right of public providers to retain and programme (budget) revenues they generate.
- Public providers must control their resources, i.e., staff, equipment, transport and buildings. They must also have the autonomy to develop meaningful partnerships with other stakeholders as the situation demands. In other words they must be legal entities.
- The process of decentralisation must be allowed to proceed in the pilot province.

- The Ministry and its partners will be required to develop new forms of organisation and management in ways which are consistent with improved efficiency ad quality in service delivery.

4. REGULATING THE PRIVATE MEDICAL SECTOR

Since independence the public health service in Zimbabwe has been paralleled by an independent sector made up of private, voluntary and charitable bodies. The independent sector has complemented the health service in areas such as elective surgery where public provision is universal but is constrained by long waiting lists and also poor access in areas where health service cover is limited. There is increasing evidence that the uncoordinated growth has contributed to spiralling costs of health care.

It is considered important now that a significant partnership be created between the public and private sectors. Such a partnership:

- Increases the range of options available to patients.
- Contributes to the cost-effective treatment of patients.
- Reduces pressure on health services.

Just as the private sector has no monopoly of efficiency or of quality in hotel services so the public health service has no monopoly on caring or clinical treatment.

The Ministry of Health and Child Welfare believes that a partnership between the public health and the independent sector significantly increases the opportunities for the public health service and the independent sector to learn from and support each other.

However, if a partnership is to be successful, then, there is an urgent need to develop an overall strategy which will regulate the way in which services are provided by the private sector and also the way in which the private sector is funded. Appropriate regulatory mechanisms need to be developed to address these issues:

- Accreditation of the private sector.
- Mechanisms for regulating technological and capital investment to ensure the wider public good.
- Monitoring the private sector in relation to its financing of health.
- Strengthening the capacity of the Health Professions Council in the area of training, up-dating and retraining of clinicians.
- Expanding the capacity of the Health Professions Council to help it fullfil its role and responsibilities for inspection of public and private sector.
- Developing a framework for regulating the work of the Health Insurance Industry.
- Creating frameworks for evaluating and approving private hospital construction.

In this regard, new guidelines on the training and deployment of health workers, especially doctors, have been developed and will be enforced with effect from 1 January, 1996. Provision will also be made for the registration and inspection of health premises. A Medical Services Bill will also be presented. This will provide for the establishment of and the categorisation of hospitals, the operations of medical insurance schemes, the setting of hospital fees in public health institutions and access of private health practitioners to public hospitals. A new Health Professions Bill will also be presented. This provides for the setting up of independent councils to oversee the registration, education and discipline of health professionals. It is hoped this mechanism will expedite the processing of issues pertaining to health practitioners.

It is acknowledged that these issues may prove controversial and difficult but effective partnership can only be built on transparency and trust. It is essential that Ministry of Health and Child Welfare is satisfied with the standard of medical and clinical care being provided by the private sector. Equally, separation of the providers from Ministry of Health and Child Welfare will allow greater objectivity in assessing whether the care being provided by the public sector is satisfactory. Ministry of Health and Child Welfare must be the final arbiter of suitability and appropriateness of health services, as recent disquiet in Parliament and by the public have demonstrated.

5. HEALTH MANAGEMENT STRENGTHENING

The transition to a decentralised service represents a major challenge to management. It is essential that a programme is developed that ensures all dimensions of the reforms are both clearly understood and addressed comprehensively.

The decentralisation section deals primarily with structural matters. This section "Health Management Strengthening" is about the systems and processes that will support these structures. This is a very wide remit covering issues such as:

- Financial systems.
- Human resources and their development.
- Equipment and supplies.
- Planning.
- Building management capacity.
- Information.

Considerable work has been done and is continuing in developing these areas including the Management Strengthening Project which is supported by the ODA and NICARE.

Two key elements which must be addressed if the reforms are to be successfully implemented are recorded below.

The earlier Corporate Plan of Ministry of Health and Child Welfare provided the focus and energy for developments in the delivery of the health service. It must now be reviewed against the new requirements of the reforms. This review should enable the Corporate Plan to reflect the ideas brought about by decentralisation. The review should be closely linked to the current development of the strategic plan for the period 1995-2000.

It is also essential that the current legislative framework within which the health service operates be analyzed as to its facilitative capacity toward the reforms. This review must ensure that the responsibilities of different stakeholders in the health sector and outside the sector are made explicit. This is an essential process as it will define the structures in a way that will reflect how their different duties and responsibilities fit together without ambiguity.

Given the expected role of Districts and units, there is no doubt that technical support and the development of new skills for health managers requires careful consideration. In the last few years, a lot of diagnostic work has been done in the Ministry and this has formed the basis of the Ministry's management strengthening programme.

It is likely that the growth and development of the health sector will continue to be preoccupied with the issues identified. These include:

- Raising and allocating resources in a way which increases benefits to the wider population.
- Devising the most appropriate and cost-effective mechanisms and health care strategies to achieve the desired objectives.
- Investigation of all sources of finance, including the realignment of existing resources and creating new money sources.
- Developing a management culture that focuses strongly on objectives and accountability.
- Devolution of decision making to the appropriate level.
- Development of accepted performance indicators and criteria for performance and audit to improve levels of accountability by managers for their performance.
- Management development and training.

The Ministry, with the participation and support of some donors, has ongoing strategies to strengthen its capacity in finance, supplies management, information management, general management and the management of people working in the organisation. These strategies are being complemented by the training and development programmes for middle, senior and top managers. Whilst these strategies have been on the Ministry's agenda for some time now, the process of taking them forward has not focused on Health Sector reform as an objective towards improving the health of the population.

Decentralisation of authority tended to be viewed largely as an internal process. The decision by Government to transfer the management of local health services to local authorities has widened the implications of decentralisation.

This development poses new and far reaching challenges for managers and staff in the districts whose responsibility it will be to manage these changes. In building the capacity of districts to manage the change process, together with managing services, the Ministry recognises two key elements:

- **The need to allow the operational levels to develop and maintain systems, methods and procedures which allow health services to respond to local needs.**

- **The recognition that systems methods and procedures work best with competent staff, hence the need to integrate training and development activities into wider human resource and organisational objectives. The specific inputs required in the Districts and units will only be clear when there is agreement on what needs to be done first.**

6. CONTRACTING OUT

Following the December 1994 Government decision to market test certain services currently undertaken by Government Ministries, Ministry of Health and Child Welfare has already established a strategy for implementing this decision. The strategy is contained in the memorandum "Proposals for contracting out services Implementation Process".

The strategy emphasises that health care delivery is unique. It must be supported by ancillary services of high quality that will ensure the wellbeing of the patients and public. Thus, it is a process that must be undertaken with skill and vigour.

Contracting out services will mean major change at all levels but particularly in the provider system at hospital and district levels. It will mean a shift from traditional ways of operating towards a more commercial approach, where quality and competitiveness will be the critical success factors. It will require the development of skills in areas such as contract specification, tender management, evaluation and negotiation.

The process is complex and time consuming. It will require commitment, risk taking/sharing and above all, innovation. It is believed that contracting out, through competitive tendering, will not only produce substantial savings, but will also lead to clearer performance criteria, improved productivity and innovative ideas and techniques. Above all, it should improve morale and the concept of ownership of facilities and services.

There are a wide range of support services which the Zimbabwean health service could have considered for market testing. The Ministry of Health and Child Welfare has targeted the following four services as the first phase for contracting out.

These are:

- Security.
- Cleaning/Grounds Maintenance.
- Laundry
- Catering

Contracting out will be phased, starting with security and ending with catering as the more complex service.

It has also been agreed that in order to build capacity and experience, the contracting out process will be carried out in the first phase for the services identified above at the Central Hospitals:

- Harare Central Hospital.
- Parirenyatwa Group of Hospitals.
- Mpilo Central Hospital.
- United Bulawayo Hospitals.
- New Chinhoyi Hospital.

It is important to emphasise that contracting out is not the privatisation of services. The tendering, management, control of and payment for contracts will remain in the public service.

Indeed, it is important to indicate that the experience in other countries of competitive tendering and contracting out is that in-house staff led by their management have won 85% of the contracts. Thus, it is part of the strategy to encourage local staff to organise in-house bids where they believe they have the competence, capacity and commitment to operate contracts successfully.

In line with this process, Government Medical Stores are currently being 'commercialised'. They are being put on a commercial footing and will be operating with their own Management Board along business-like lines.

Ministry of Health and Child Welfare believes that there is scope for much wider use of competitive tendering beyond the non-clinical support services. The Government's decision to delegate decision making to the operational level through decentralisation will introduce more choice into the provider system on the future development of competitive tendering.

7. COMMUNICATIONS STRATEGY

The Managerial and organisational changes described in this paper are probably the most far reaching since Independence in 1980.

They will affect every member of staff throughout the Ministry of Health and Child Welfare to some degree. Managerial Staff at all levels will change their roles and the vast majority of staff will cease to be civil servants but will be employed by autonomous Hospital Management Boards or District Health Management Boards under the Rural District Councils. Substantial numbers will be employed by the private sector.

Members of the public, government organisations, commerce and indus which deal with the Ministry of Health and Child Welfare, professio bodies and politicians at National and Local Government levels will anxious about any change to the status quo.

Principally, they will be anxious because of what they do not know abo the future rather than specific features in the proposals with which the disagree.

Such a high level of uncertainty is likely to be de-motivating for staff an bring about resistance from those organisations and individuals outside an inside the service with an interest in the way in which Health Services ar currently operating.

This level of uncertainty can, however, be reduced substantially by an effective communications strategy. The staff, other government organisations, politicians and the wider general public must be well informed about the changes that are to take place and not just accept them but be enthused by them.

The main features of such a strategy would be:

- To explain why the changes are taking place.
- Two way communication - the service will listen to and respond to the public and the staff views.

- To create a style which will be open and comprehensive - it will tell the good news and the bad.

- To maintain the moral high ground:
  - benefits to the nation's health
  - health gain
  - benefits to individual patients
  - cost effective and efficient service delivery.
  - greater local accountability.
  - services managed closer to the patient
  - benefits to the staff and managers of working in these new health services
  - security from unjustified criticism for health personnel.

- To win hearts and minds of staff who will serve as ambassadors to the general public for the reformed Health services.

- To ensure that the language used in all published material and guidance documentation is clear and jargon free.

The methods used to communicate will include:

- Well produced communication document.

- News letters.

- Briefings.

- Briefing packs.

- Open Public Meetings.

- Technical explanations and guidance for managers and staff.

8. NEXT STEPS

Four concrete steps are envisaged as the process towards implementation of these reforms. These are:

- Health Sector Reforms Strategy Statement (this document).
- Concept papers on each of the components of the Reform Programme:
  - Decentralisation.
  - Commercialisation.
  - Regulation of Health Sector.
  - Health Financing
  - Health Management Strengthening.
- A detailed Implementation Strategy for each component.
- Implementation.

9. SUPPORT TO THE MOH&CW IN MANAGING THE REFORM PROGRAMME

There has been a considerable amount of interest shown by the donor community in the Health Sector Reform process. This has been most encouraging.

The Ministry of Health and Child Welfare welcomes their interest and their offers of support in assisting the Ministry which will undertake the lead role in the management of the whole Reform Programme.

10. KEY AREAS WHERE SUPPORT IS REQUIRED:

Health Policy development and Planning

The framework of decentralisation described above will change the process of Policy analysis, formulation and planning in the Health Sector.

In some cases, this will mean making changes to existing structures but, more importantly, the new roles and responsibilities will require the development of new skills.

The national level will require to completely develop new policy development and monitoring structures. The Ministry proposes to establish a new Division to be responsible for Health policy development and planning. Arrangements are already underway to establish this division. Support will be required to build the necessary systems, processes and competences to ensure that the new division is able to adequately respond to the challenges facing the Health sector. It will also be necessary for the Ministry to attract skills from outside the health sector, and funding will be required to finance Specialist posts, in for instance, Health Information and Health Economics.

Special Studies

In order to adequately plan for implementation, a number of specialised studies which need to be carried out have been identified.

First, there would be need to identify and cost the benefits package. This refers to the national minimum list of essential health services every Zimbabwean will be entitled to. The process of identification and costing will also help stakeholders to focus on real priorities in relation to the resources available. Specifically, the study would:

- Determine the level at which each benefit would be made available at the different levels of care.

- Estimate the demand for services.

- Estimate approximate fee schedule.

Second, there would also be need to determine the supply side response. This study would:

- Identify health care providers and assess the scope of their activities (type, amount and quality of services provided).

- Assess resources employed by facility (type and quality of staff), equipment, structures, drug availability, etc and estimate existing as well as potential capacity for service delivery.

- Assess strengths and weaknesses of existing capacity for service delivery.

This study will generally seek to "unfreeze" the health sector in order to have a critical look and understanding of its components and systems.

Third, since the success of future health goals depends on formulating strong partnerships with communities, there will be need for a study to determine the willingness and ability of the population to participate in the proposed mechanism for financing the decentralised health services.

This study would:-

- Describe the health seeking behaviour of the population.
- Estimate private expenditures per capita on modern health care services and drugs.
- Estimate the population size in the formal sector by income categories.

Generally, this study will seek to identify the factors which could affect the population's ability to participate in the proposed financing mechanism.

Fourth, the proposed reforms will have the effect of creating new relationships and changing existing ones between and amongst the different stakeholders in the Health Sector. There will therefore be need for a study to determine the legal framework required for the reforms to operate. This study would:-

- Describe the legal formulation of the reforms as they affect stakeholders.
- Describe relations between the various parties in the system.
- Describe dispute settlements.
- Describe rights and responsibility of each party.

Following the studies and achieiving consensus on the findings of the studies, detailed implementation volumes will be prepared.

Where the supply side response is found to be poor, additional resources (capital and recurrent) will be required to address supply side inadequacies before implementation begins.

During this period, considerable technical support (which has already been identified) will be required. A lot of this support is expected to be sourced from existing donors.

There however remains the need to develop supportive mechanisms for managing donor support.

The Ministry proposes to introduce "single pipe financing" i.e. all donor funding will be pooled and will flow through a single channel directed towards the activities stated in the reform implementation volumes. Further discussion will be held with donors and related Ministries to agree on such mechanisms.

Capacity Building

The existing programmes in management strengthening will require further and additional support. In some areas, new approaches will be required in order to achieve capacity quickly. Detailed work needs to follow after the definition of the roles of the different stakeholders in order to develop appropriate approaches. Resources of a capital nature will also be required in developing sustainable systems to support the reforms.

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ROCKLAND PROMOTIONS & DISTRIBUTORS (PVT) LTD
P.O. BOX 6566, HARARE. TEL: 728243