Governance and management of public health financing in Zimbabwe

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Executive summary

Zimbabwe is currently in transition from immediate economic recovery measures towards building the foundation for a long-term health system, aiming for universal health coverage (UHC), as set out in the National Health Strategy (NHS). The Ministry of Health and Child Care (MoHCC) and Training and Research Support Centre (TARSC) carried out research in 2013 on increased domestic health funding. The pooled funding for this requires strong organisational, institutional, governance and accountability arrangements and procedures at national and operational levels. This report presents the overall findings of and recommendations from studies undertaken by Zimbabwe Economic Policy Analysis Research Unit (ZEPARU) and KIT Netherlands on governance, management and accountability of public health financing in Zimbabwe. The studies include desk reviews of institutional arrangements for health financing in Zimbabwe, including of semi-autonomous health institutions and on arrangements in other African countries. They also include a qualitative study aimed at identifying and describing organisational, institutional and governance arrangements and procedures for pooling and channeling funds for health from national to operational level in Zimbabwe. These studies were implemented within the REBUILD consortium led by TARSC with MoHCC and with review from the Technical Working Group on Universal Health Coverage (UHC).

Revenue collection: Total health expenditure (public and private) in 2010 was 15% of GDP, mainly due to a low formal GDP, with government budget allocations well below the 15% Abuja commitment and the budget bid. Out-of-pocket payments increased in the last decade to more than three times higher than government spending. Dependency on external funders for health financing is high. Existing arrangements that pool health funds include the Health Transition Fund (HTF), National AIDS Trust Fund (NATF) and the Health Services Fund (HSF). Private insurance schemes are managed by the National Social Security Authority (NSSA) and the Medical Aid Societies (MAS).

Expenditure and resource allocation: The present government budget process is bottom-up, starting at facility level, aggregating at district and provincial levels – and then presented to central level, where final decisions on resource allocation take place. At operational level the field study found that Government funding of health services was delayed, unpredictable and below allocated budget. The HTF, NATF and HSF all have their own – though aligned – resource allocation regulations. HTF and NATF earmark their funds for specific areas of health spending. Distribution of money towards health facilities is based on type of facility (HTF), population size (NATF) or service use (HSF). The field study reported that the flat rate HTF allocation to be not responsive to facility needs and limited alignment of private providers to national health plans.

Purchasing quality care: For UHC, an Essential Health Benefit (EHB) has been defined; however, several funders (HTF, National AIDS Council (NAC), GFATM) purchase specific services, thus biasing the EHB. The field study found that funding arrives late, with limited or no cross-subsidies between funds. This fragmented funding was found to bring an extra administrative workload to health staff, at the expense of clinical tasks. Purchasing of care is based on negotiated budgets, not on results or performance, with the field survey also finding limited fund management and accounting knowledge and poor quality data on health outcomes from funding.New measures for results-based financing (RBF) showed increased quantity and quality of services funded by the RBF.

Governance and accountability mechanisms: Governance in the health sector is highly centralised. Some tasks are delegated to the operational level, but without transferring mandates. Fragmented health financing leads to complex, time-consuming and parallel reporting systems. The field survey reported that facility staff lacked accounting software and had heavy workloads to account, plan and manage funds. Accountability is mostly in terms of accounting on finances, less in terms of health results, and the field survey found accounting to be of poor quality. The MoHCC holds the roles of healthcare purchaser, provider, payer and verifier, bringing a risk of conflicts of interest. Heath centre committees exist, but their social accountability role is largely only in the RBF.

On collection and pooling of revenue: we recommend

- Increasing overall funding for health by improving efficiency in revenue collection and allocating a larger part of revenue to health, to reduce the financial burden of those who have no access to quality care at present. Several options exist for this, such as from earmarked taxes identified in prior MoHCC work. Zimbabwe has no national mandatory/contributory health insurance, only a few community-based health funding/insurance schemes whose equity, portability, sustainability are not evaluated and private voluntary insurance (MAS) that covers a small part of the population, with high transaction costs, late payments and weak protection for subscribers. Whatever the mandatory financing form, it needs a solid arrangement to manage pooled funds.
- Taking a high-level decision on whether to create a new structure or pool funding if current institutions can be used to create one single pool. A pooling institution needs to address pre-set conditions and criteria to ensure accountability and transparency to be trustworthy for all partners to join the pooling. A more thorough formative evaluation of existing public finance management mechanisms than was done in this study could provide options for how to improve trust in future pooling. If the choice is to use an existing pooling mechanism, the study suggests that NAC would provide a better alternative than NSSA or MAS, given the limitations of the latter.
- Exploring issues in the public finance management system to identify and solve the governance and accountability issues that discourage external funding being channelled 'on budget'.
- Improving efficiency in collecting and allocating revenues, in implementing health interventions and in pooling of funds. Revenue collection mechanisms can be streamlined to reduce transaction costs. Pooling funds is preferred as the economies of scale reduce administrative costs and personnel time, are more sustainable and accommodate risk sharing.

On expenditure and resource allocation: we recommend

- A more equitable allocation of funds, more aligned to health needs.
- More autonomy at the operational level (providers and community) to respond to context specific demand and needs, within pre-determined ceilings and set boundaries. This requires an allocation system with sound criteria for an equitable and appropriate distribution of funds.

On purchasing: we recommend

- Introducing an independent semi-autonomous organisation as a purchaser of quality care.
- Exploration if such an organization should be set-up, or if an existing pooling mechanism (like NAC or HTF) could extend its roles as a possible semi-autonomous purchaser for UHC.
- Strategic purchasing by such an autonomous institution managing pooled funds that will contract services from providers and monitor their performance. Its place between provider and patient means that it is better positioned to negotiate price quality.
- Learning from positive and negative lessons from the experiences of insurance schemes as a (semi-) autonomous purchaser of care in other countries and from a more in depth assessment of existing structures than was possible in this study.
- Ensure coherence between the RBF and UHC policies, where RBF may strengthen the purchaser function and a semi-autonomous UHC fund may reduce RBF's high transaction costs.

On governance: we recommend

- Reviewing and clarifying tasks and responsibilities of stakeholders in health financing to avoid conflicts and gaps and to strengthen accountability, especially social accountability.
- Allowing the community to co-determine how allocated funds are spent to make services more responsive to the needs and demands of the population.
- Training at the operational level, including on the Public Finance Management Act, on basic planning and operational procedures and accounting and on operational guidelines for all funds.
- Increasing administrative staff/accounting support to relieve medical staff from administration.
- Aligning and harmonising reporting of all funds (until they are pooled).
- Strengthening regulation and alignment of private sector provider payment mechanisms, with monitoring and verification in line with that in the public sector.

1. Introduction

Zimbabwe is currently in transition from immediate economic recovery measures implemented in 2009-2012 towards building the foundation for a long-term system for universal health coverage (UHC), taking into account equity in access and coverage as set out in the National Health Strategy (NHS). As part of a broad Liverpool School of Tropical Medicine/DFID-funded research programme, a consortium led by the Training and Research Support Centre (TARSC), in collaboration with the Ministry of Health and Child Care (MoHCC), the Royal Tropical Institute (KIT Netherlands) and the Zimbabwe Economic Policy Research Unit (ZEPARU), is undertaking research to support dialogue and policy making on the technical design of equitable health financing.

This report presents the main findings of a series of studies undertaken by ZEPARU and KIT. Within the REBUILD study, ZEPARU and KIT were tasked to conduct research on governance and accountability related to health financing in Zimbabwe. First, a desk review of institutional arrangements for health financing in Zimbabwe (ZEPARU, 2014) and a review of financing of semi-autonomous health institutions in Zimbabwe (Chigumira et al., 2014) were conducted. This was followed by another literature study on governance and accountability of health financing in other African countries (Vaughan et al., 2014). Lastly, a qualitative study was conducted, aimed at identifying and describing organisational, institutional and governance arrangements and procedures for pooling and channeling funds for health from national to operational level in Zimbabwe. This report summarises the main findings from the above mentioned work.

The main aim of the study was to assess the current status of and structures related to governance and accountability regarding health financing in Zimbabwe, particularly public health financing, to inform policy dialogue discussion and to make recommendations regarding the future governance and accountability arrangements in health financing.

The report is structured along four specific objectives:

1. What is the situation and what could be recommended regarding revenue collection for healthcare?
2. What is the situation and what could be recommended regarding expenditure and resource allocation for healthcare?
3. What is the situation and what could be recommended regarding governance of the health system?
4. What is the situation and what could be recommended regarding healthcare-related accountability mechanisms?

For all four subject areas, we discuss how health financing in Zimbabwe is organised in theory, how the systems turns out in practice, what can be learned from alternative ways on how health financing is organised in other African countries and based on these what conclusions could be drawn for the governance of health financing in Zimbabwe.

The report includes a discussion and conclusion section, including issues for national dialogue, focusing on future governance and accountability arrangements in health financing.

2. Methods

ZEPARU conducted in-country desk studies between September 2013 and March 2014 to establish the origin, risk pooling and partition of and cross subsidy in funds in Zimbabwe, focusing on tracing funding flows, funding sources, fund pooling, distribution and health activities funded.

A desk review of institutional arrangements for health financing in Zimbabwe included a variety of literature, reports covering the period 2009-2013 and financial records from several stakeholders. The review was mainly descriptive; a framework for the review was prepared (see Annex 1) in advance and used to guide the collection of evidence. The study focussed on:

- revenue collection and pooling
- resource allocation
- governance, institutional and accountability arrangements
- purchasing-provider payment mechanisms and
- monitoring and evaluating efficiency in using financial resources.

A desk review on financing semi-autonomous health institutions in Zimbabwe analysed the financial records and reports from the following health institutions: Health Transition Fund (HTF), National AIDS Trust Fund (NATF), Health Services Fund (HSF), Global Fund Grant for Zimbabwe for HIV and Malaria Prevention and Workers Compensation Investment Fund. The team was not able to analyse other semi-autonomous bodies, such as Natpharm and the Zimbabwe National Family Planning Council, due to unavailability of data. These institutions were selected, because of the differences in national health financing: some of the institutions seek to complement government efforts to finance health, some seek to ensure a guaranteed and predictable funding stream, some are mainly donor funded, others finance health through earmarked taxes or through mandatory employer contributions.

A literature review from other African countries in 2009-2012 by KIT (Vaughan et al. 2014)) focused on institutional, purchasing, decision making, pooling, cross subsidy, purchasing and allocation arrangements. Also included were mechanisms for stakeholder oversight and accountability and governance arrangements and procedures for the collection, management and disbursement of earmarked taxes. The literature review was conducted using a case study approach. Six countries were included in the study, based on pre-set criteria - the countries are Botswana, Gabon, Ghana, Kenya, Tanzania and South Africa. The study was descriptive in nature, trying to identify the various elements of the financing systems in the identified countries. Literature and reports were searched for information on design features, captured in a data extraction form, with specific attention to challenges or gains in terms of equitable distribution of resources, equitable access to healthcare, efficiency in using resources, accountability arrangements and systems, and enabling purchasing of quality care.

In March 2013, KIT and ZEPARU conducted a joint analysis workshop in Zimbabwe to analyze review data. The workshop identified gaps in data collection that would need further qualitative research.

A qualitative study (Chigumira et al., 2014) included primary data collection at district level, conducted by ZEPARU between April and September 2014, and completed by interviews at national level, conducted by KIT in September 2014. The field survey was conducted in three purposively sampled districts with different characteristics: Budiriro in Harare (urban), Murehwa in Mashonaland East and Lupane in Matabeleland North (rural). A semi-structured questionnaire was used to interview purposively sampled respondents at both operational and national levels, including facility administrators and local and central government officials. The central-level respondents were representatives of financing agencies, such as the MoHCC, Ministry of Finance and Economic Development (MoFED), Zimbabwe Revenue Authority, Health Services Board, National AIDS Council, National Social Security Authority, private and non-state and external funders (UNICEF, World Bank and WHO). The field survey used a questionnaire with closed and open questions, including probes that were used for interviewing PMDs, DMOs, and administrators at mission hospitals and nurse in charge at primary care facilities.

Prior to the actual field survey, the study instrument was subjected to a pilot test at Makumbe District hospital and Chinamhora clinic in Goromonzi District of Mashonaland East Province. The questionnaire was slightly adjusted after the pilot. Permission to undertake the interviews for this study was obtained from the Secretary for the MoHCC and the Harare City Health Director. Further permission was sought and obtained from the respective PMDs for the provinces visited.

Data analysis was conducted based on major emerging themes, whose narratives were written by a multi-disciplinary team of four researchers. Names of the respondents were not mentioned and not possible to be recognised in the reports.

Data collected from the above described process were analysed and reported. This report presents a summary of the data, including conclusions and recommendations on the organisational, institutional and governance (and accountability) arrangements and procedures for pooling funds, for cross subsidies and for provider payments at different levels in the public health system in Zimbabwe. The report will be used as input for stakeholder dialogue and development of policy recommendations.

3. Overview on health financing

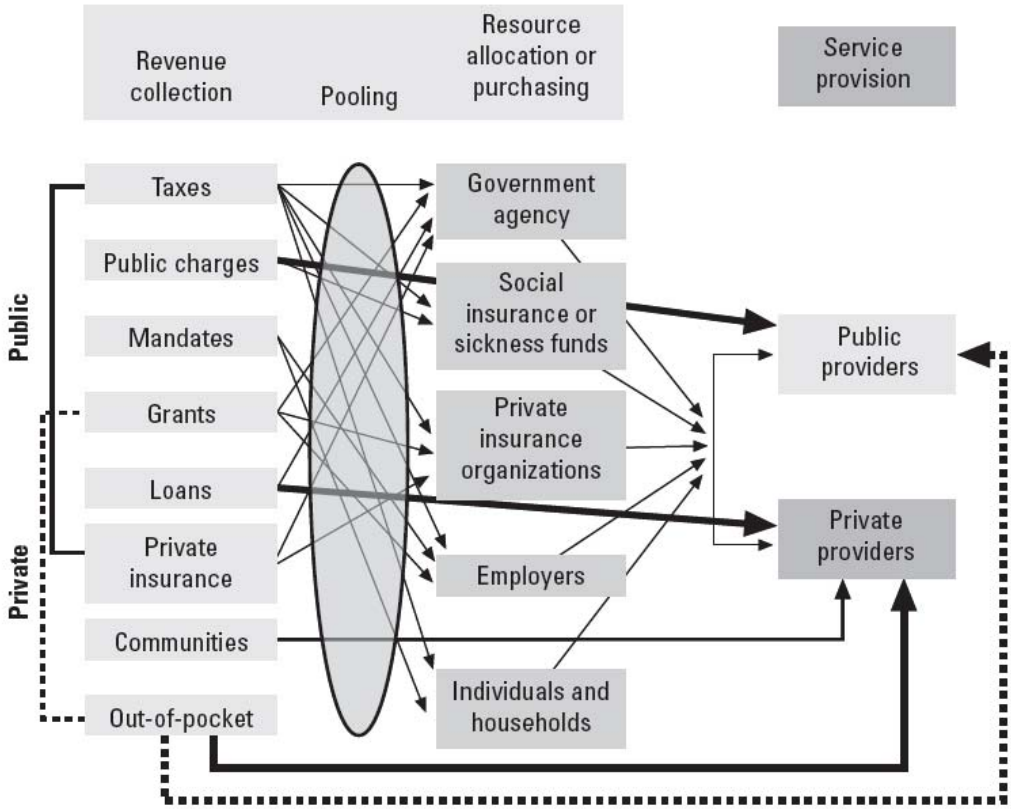
Health financing is generally understood in terms of three major discrete functions: (a) collection of revenues (source of funds); (b) pooling funds and spreading risks across larger population groups; and (c) purchasing of services from public and private providers of health services (allocation or use of funds). We have deemed service provision to fall outside the scope of this exercise. *Figure 1* shows this although missing from the figure are the ever-important governance and monitoring and evaluation mechanisms for the entire system. Although there are many models for accomplishing these three basic functions, all models essentially try to achieve three objectives (Gottret et al., 2008; Gottret and Schieber, 2006):

1. Raise enough revenue to provide a basic package of services and financial protection against catastrophic spending;
2. Equitably and efficiently manage revenues through pooling, which also pools risks;
3. Purchase health services in an allocatively and technically efficient way.

Revenue collection generally comes from some combination of taxation, mandatory and voluntary, public and private health insurances, community-based health insurances, donor funding and out-of-pocket spending. None is inherently better than another, but the choice of method(s) depends on a country's context (Gottret and Schieber, 2006). The ability to raise revenues from taxation generally depends on the strength and nature of the economy on the one hand and on the reliability of public finance management systems on the other. Many countries with formal sectors have tried mandatory insurance schemes through payroll deductions; however, countries with large informal sectors may not be able to capture tax revenue from this sector and may have to rely more on other sources of revenue. Finally, the health financing mix will depend on choices made by national politics or the 'political economy' in the country.

Revenue collection is generally judged on progressivity. The system is considered progressive if the fraction of income paid by a person rises as income rises; in other words, they pay more as their ability to pay more increases. Regressive financing systems are those in which the fraction of a person's income paid to the funding system declines as income rises; in other words, they pay less as their ability to pay declines (Gale Encyclopedia of Public Health, nd). Individual revenue sources may also be deemed to be progressive or regressive.

Figure 1: Flow of funds through the system



Source: Preker and Carrin, 2004.

In the absence of a national mandatory health insurance or fund, these funds are often not pooled into a single 'basket', but rather kept and managed separately. They may be managed by a government agency, insurance agency (either for or non profit), employer, or in the case of household spending, by an individual or household. Purchasing arrangements range from ex-ante payments based on agreed budgets, salaries and/or capitation, or ex-post payments based on paying for results such as reimbursement on a fee-for-service basis, performance-based schemes, diagnosis-related groups (DRGs) and more. Contracts with at least some part of reimbursement being linked to performance are becoming increasingly popular and are seen as a way to improve quality of care as well (Cromwell et al., 2011).

Governance includes a wide range of accountability and monitoring and evaluation measures. Their existence as part of the health financing system ranges broadly from country to country.

In terms of measuring how well a health financing system is doing, a composite indicator is not currently available and common indicators look only at individual parts of the system. For example, revenue collection is most often measured in terms of progressivity, to which level it meets the need of funding, how much it attracts according to plans, how efficient it is organised (e.g. low level of transaction costs).

This work was undertaken with an understanding of Zimbabwe's current health financing system, which is based largely on out-of-pocket payments made by patients, public revenues from taxation (complemented by other purpose-specific pools funded from earmarked taxes, e.g. the AIDS levy fund) and on external funders, including budget support (e.g. the HTF) and the not-for-profit private

sector (like faith-based organisations). Private health sector financing is through out-of-pocket payments, voluntary insurance and industry contributions. Provider payment mechanisms are mainly based on a decentralised system of payment through the Ministry of Health; a results-based financing approach is currently being piloted. Although a combination of general taxation, social insurance, private health insurance and limited out-of pocket user charges are preferred health financing instruments for middle- and higher income countries, including many countries in Africa, we understand that there is no current proposal in Zimbabwe to bring in social health insurance due to the current economic context (low formal employment, high income taxation, declining real wages and corporate shutdowns), although this may be introduced downstream when economic conditions change.

New funding options (for which technical work has been done) currently being considered and included in the Zimbabwe Agenda for Socio-economic Transformation 2013-2018, the national policy framework (GoZ, 2013), are all earmarked tax options (earmarked VAT, cigarettes, alcohol, road, mobile phone, others) and build on the experience of an earmarked tax for funding HIV interventions, which stakeholders regard positively (MoHCC and TARSC 2013). To this end, we also understand there is currently a sense of urgency within the ministry to work out the institutional arrangements for a fund to blend and manage the earmarked tax funds and other contributions from different sources.

4. Findings of the research

The results presented in this report are organised within sections on:

a. how revenue is collected
b. how expenditure is organised and resources are allocated
c. how purchasing of (quality) care is organised and
d. the governance of health services and accountability mechanisms.

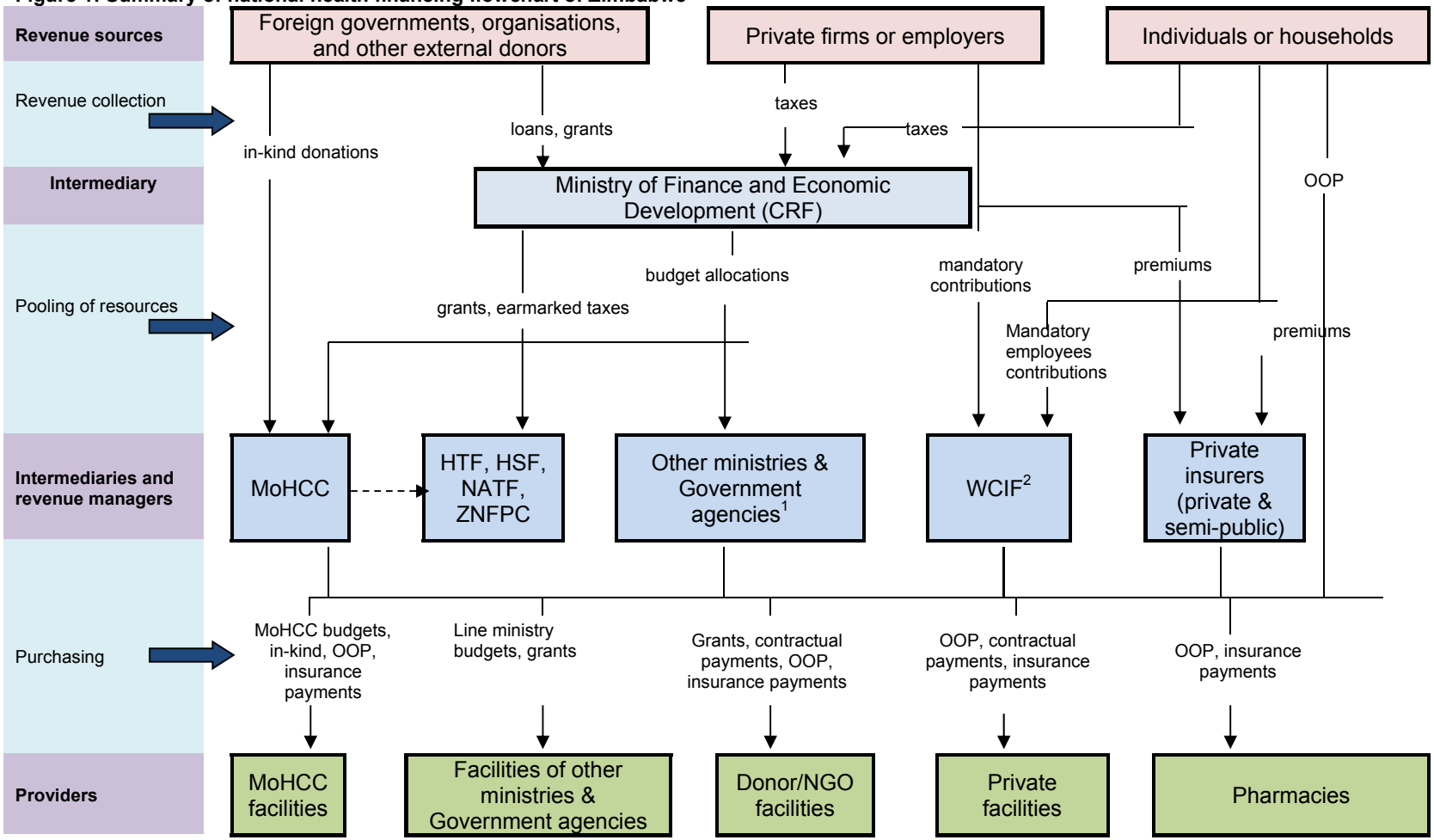
In each of these sub-chapters the same questions are posed: how is this organised in Zimbabwe in theory, how does it work out in practice – and what can we learn from other countries.

4.1 Revenue collection in Zimbabwe

The flowchart in *Figure 2* presents a summary of the flow of national health financing in Zimbabwe. The primary sources of health financing were identified as the government, the households, employers and donor community. *Table 1* shows these sources and their collection mechanisms. According to the National Health Accounts of 2010 (MoHCC, 2013), the main source of health financing as of 2010 was households (39%), followed by employers (21%), external funders (19%) and government (18%). There is high dependency on external funders for health financing that is usually unreliable, unpredictable, unsustainable and highly dependent on the political environment, raising concerns on the sustainability of health financing institutions and the vulnerability of government's budget should external funding be withdrawn.

The collection agent of **domestic revenues through taxation** and public charges is the government, specifically the Ministry of Finance and Economic Development (MoFED), with assistance of the Zimbabwe Revenue Authority (ZIMRA). general taxation is collected by ZIMRA and held by the MoFED. The MoFED also receives funds (grants, loans) from co-operating partners, which are pooled together with the tax revenues (if not specifically labeled) into to the Consolidated Revenue Fund (CRF). ZIMRA is responsible for the collection of funds and the allocation of the funds to NAC. Although total health expenditure (public and private) as a percentage of GDP was high, about 15% in 2012, rising to 17,9 in 2013 (MoFED, ZIMSTAT, 2009-2014), this did not necessarily mean that the health sector was adequately financed, but was rather a consequence of a lower level of GDP in the rebound from the economic crisis of 2000 to 2008 (MoHCC 2013)

Figure 1: Summary of national health financing flowchart of Zimbabwe



[1] Includes parastatals, universities and teaching organisations under Ministry of Education.

[2] Workers Compensation Investment Fund.
Source: Authors' compilation from MoHCC, 2013.

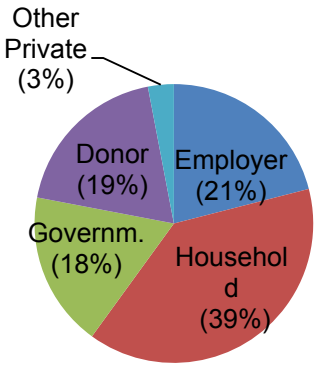
Table 1: Funding sources, collection mechanisms and organisations in Zimbabwe

Initial funding sources	Collection mechanisms	Collecting organisations
Households (individuals/ families/ employees)	**Prepayments** Taxes (direct and indirect) Rates and levies Mandates (compulsory contributions) Voluntary contributions **Direct charges** Out-of-pocket (OOP) payments including co-payments by private voluntary insurance	ZIMRA Local Authorities NSSA NAC Employer, employment councils Private voluntary Medical Aid Societies ZACH, private-for-profit healthcare providers,
Employers/ corporates	**Mandatory**: Taxes Earmarked taxes- AIDS Levy Occupational injury insurance **Voluntary:** Private voluntary health insurance premiums Allowances for medical expenses Tax rebatable charitable contributions in cash and kind	ZIMRA NSSA NAC Medical Aid Societies ZACH, private-for-profit healthcare providers
External funders	Grants and loans	ZACH, private-for-profit healthcare providers through MoFED or MoHCC

The

Lower levels of per capita health expenditure indicated that health expenditure in the country is insufficient to guarantee adequate access and quality of healthcare. Total government expenditure on health as a percentage of total government health budget was less than 15% (Abuja target) over the review period - averaging 7.46% between 2009 and 2013. The National Health Accounts of 2010 showed that households were the biggest funders of healthcare in Zimbabwe, contributing about 39% of total health expenditure (MoHCC, 2013) – in 1999, this was 23%, a reflection of the limited extent of pooling private resources and inadequate public financing, exposing the population to catastrophic healthcare expenditures and creating barriers to access to healthcare.

Figure 2: Sources of funds and their % age contribution in total health expenditure, 2010



Source: MoHCC, 2013

The MoHCC health expenditure grew in nominal terms at the same time as inflation and population growth in 2010 to 2013, indicating that the resources allocated to health at least did not go down in real terms over this period. The government's average expenditure on other comparable public goods as a percentage of total government expenditure were 18.14% for primary and secondary education, 6.11% for higher and tertiary education and 8.99% for defense (ZEPARU 2014). Nevertheless, the budget has been inadequate as a source of health funding, the population had to pay the deficit, out-of-pocket. Actual disbursements have not met the planned health expenditure (*Table 2*):

Table 2: Actual versus planned government health expenditures (US$), 2009-2013

	2009	2010	2011	2012	2013
Actual health expenditure (HE) US$ 000's	41,822	114,927	147,411	189,465	235,758
Planned HE US$000s	121,018	173,827	256,198	301,226	381,040
Deficit in HE US$000s	79,196	58,899	108,787	111,761	145,282
Deficit as % of planned expenditure	65.44	33.88	42.46	37.10	38.13
% change in actual THE	…	174.8	28.3	28.5	24.4
Change in health CPI (%, period average)	…	0.6	-0.3	1.6	2.8
Population growth		1.00	1.00	1.01	1.00

Sources: MoFED (2009, 2010, 2011, 2012, 2013) and own calculations.

The institutions and/or arrangements used to pool funding in Zimbabwe include the health transition fund (HTF), National AIDS Trust Fund (NATF) and the Health Services Fund (HSF). The National AIDS Commission (NAC), operating under the Ministry of Health and Child Care (MoHCC), manages the NATF. The NATF is an earmarked fund under the MoHCC that pools funds to support efforts to combat HIV and AIDS. The Government of Zimbabwe (GoZ) introduced an AIDS levy of 3% on individual PAYE and corporate tax to fund provider activities, and the activities of NAC. ZIMRA-collected AIDS levies go directly to the MoHCC/NAC. The HTF is an arrangement between the government and the donor community to mobilise, pool and manage funds for health financing, where earmarking is done externally but there is no earmarking internally.

Chigumira et al. (2014) using data from the MoHCC and MOFED showed that: The AIDS levy for the NATF is charged on individuals, companies and trusts at a rate of 3% of income tax assessed. The AIDS levy quarterly collections have increased from US$5.1 million in the first quarter of 2009 to $32.5 million in the fourth quarter of 2012. The sources of income for the HSF are hospital fees, interest earned from credit bank balance and from financial investments, government grants, donations/funding from development partners and fund raising. The main source of HSF income is hospital fees, which account for 98.70%, on average, over the period 2009 to 2012 – increasing from $20.3 million in 2009 to $37.7 million in 2012. The main source of HSF income is hospital fees, which account for 98.70%, on average, over the period 2009 to 2012 (Chigumira et al. 2014). Health facilities retain 100% of hospital fees, and this implies that effectively there is no cross subsidisation across health facilities. In addition to fees paid by patients to access care in the HSF, the DMO also collects health inspection fees from businesses, such as shops, restaurants/food outlets, butcheries, among others. These funds are pooled into the HSF and the district health executive determines and accounts for their usage.

Private insurance schemes are managed by independent public agencies. There are two main types: the National Social Security Authority (NSSA) and the Medical Aid Societies (MAS). NSSA manages the Workers' Compensation Insurance Fund (WCIF), covering all work-related injuries and illnesses of employees attached to private sector employers. The main contributors to this scheme are private sector employees and employers. Membership is mandatory for all private sector employees in the formal sector. NSSA limits its coverage mainly to those formally employed at the expense of the large informal sector that constitutes 84% of the economy. Employer and private revenues presented 21% and 3% respectively of the total health budget in 2010. A review of NSSA financial statements for 2010 and 2011 show that total funds pooled into the WCIF fell by 7.72% from $49.15 million in 2010 to $45.36 million. In 2011, income from premiums accounted for 85.33% ($38.70 million) of total income (Chigumira et al. 2014).

MAS, about 30 in number nationwide, manage all private voluntary insurances, covering not more than 10% of the population (ZEPARU 2014). These medical aid societies mainly cover high-income formal workers and their dependents, more in urban than in rural areas. MAS schemes are voluntary, and they deal directly with employers and consumers to avoid broker costs.

District health facilities, mission- and council-owned facilities charge user fees with the exception of government-owned primary care facilities that are not allowed to charge user fees. These user fees are determined by health executives at health facilities, namely at district and mission hospitals. Out-of-pocket payments, constituting 39% of the total health budget in 2010, are collected by healthcare providers, including district-level government, council-owned, mission and private healthcare facilities (MoHCC 2013). The fees charged are based on national government policies, and are decided upon by district level authorities. Collected user fees are part of the Health Services Fund (HSF), which was established in 1996 to supplement the health budget for the maintenance of health services using income mainly from hospital fees, interest earned on bank credit balance and other fund-raising activities. All facilities that charge user fees apply exemptions, whose criteria are determined by the MoHCC: those who cannot pay or have been approved by the NIC not to have capacity to pay are treated free of charge. It was noted that despite not being allowed to charge user fees, some primary care facilities have come up with innovative mechanisms to mobilise funding – like CBHI, primary care facilities owned by local authorities (rural district councils) charge user fees.

External funder contributions are channeled through the Health Transition Fund (HTF.) This fund pools the funding of different major donors and is managed by UNICEF, through Crown Agents. The fund is labelled for maternal and child healthcare. The total percentage of external funder contributions within the total health budget was 19% in 2010 (MoHCC 2013). At the end of 2012, actual pooled funds into the HTF amounted to $84.99 million, which is about 19.52% of the targeted $435.33 million over the 5-year lifespan of the HTF. The highest contributor to the fund was the overseas development aid from UK, accounting for 60% of the available funds. In the 2013 HTF budget, the highest budget share was allocated towards medical products, vaccines and technologies (38.5%), followed by health policy, planning and financing (28.70%), maternal, new born and child health and nutrition (17%) and human resources for health (15.7%). The expenditures for the HSF have been increasing over the period 2009 to 2012 amounting to $8.82 million and $22.82 million, respectively (Chigumira G. et al. 2014).

Between 2003 and 2013 Zimbabwe received 17 grants from the Global Fund. These grants totaled $857.65 million, with $616.15 million for HIV/AIDS, $62.60 million for tuberculosis and $178.90 million for malaria. From 2003 to 2013 disbursed funds amounted to $594.87 million, with $368.36 million going towards HIV/AIDS, $59.05 million towards tuberculosis and lastly $167.46 million towards the fight against malaria. These funds were channeled through various sub-recipients, namely the NAC, Zimbabwe Association of Church-related Hospitals (ZACH), the MoHCC and the UNDP as the principal recipient (Chigumira G. et al. 2014).

These major revenue collection mechanisms result in a variety of funds that are not pooled. Within those mechanisms, there is some pooling of funds, but generally resource pooling in health is limited in Zimbabwe. **Pooling of funds** can be organised in different ways. Taxes are by definition a pooled fund, but can be organised as a specific pooled fund for health managed by a (semi-) autonomous organisation, in which other funders, like earmarked taxes or the donor community, can contribute. Social health insurance (SHI) differs from a tax-based system where the Ministry of Health, through general revenues, finances its own network of facilities that are paid for through a mixture of budgets and salaries. Although some of the operating costs may come from earmarked tax revenues, SHI operates as an institutional separation between the ‘purchasers’ of care from the providers of care with the beneficiaries having to enroll into the autonomous insurance system. The advantage would be the sharing of risks between the beneficiaries, the pooling of funds, diminishing the financial effects of catastrophic diseases for the individuals. The disadvantage would be the mandatory contribution by the beneficiaries that may block inclusion of the poorest and transaction may be high. This depends how SHI has been developed – it may be subsidised by income from taxes to subsidise those who cannot afford to contribute. Community-based health insurance schemes are similar pooling mechanisms but at community level – with the consequent disadvantages (small schemes with limited technical expertise) and advantages (strengthening community involvement, even empowering, and funds are close to contributors so accountability will be strengthened).

In Zimbabwe there is no real social health insurance scheme, although NSSA was supposed to become one. MAS dominates private voluntary insurance and there are only a few community-based health insurance schemes. There are about 26 registered MAS, but only three key players dominate the market and together they account for 90% of the market. There is no meaningful pooling of risk among the rest of the 23 registered players who account for 10% of the market, and MAS schemes are internally segmented (Chigumira G. et al. 2014). MAS cover only 10% of the population, which is mainly formal employees, wealthy women and men, and their dependents in urban areas, excluding poor women and men, informally employed and rural inhabitants – as was found in our field study. Although their presence in most cities and towns widens geographic cover, differences between MAS and in the benefit packages covered, segmented packages and no cross-subsidies between different schemes and different income groups of beneficiaries mean that MAS do not provide any meaningful level of cross subsidy. Inequalities also exist in the form of tax credits that are based on one's expenditure on healthcare services. About 6.9% of MAS members find it difficult to get special therapy on their medical plans, and a considerable number of members find it difficult to get medicine on their plans – as was found in our field study. Few beneficiary plans give full reimbursement for services provided outside their managed care plans. This weakens the plans financial protection for members. Collectively, the MAS spend 56% of the subscriptions on administration and 44% on healthcare services, implying that they mainly use subscriptions on sustaining their organisations while their clients have to make OOP payments (Chigumira G. et al. 2014).

4.2 Revenue collection in other African countries

African governments decided the Abuja target was to be 15% of total government spending allocated to the health sector, excluding external funding. Of the countries reviewed only Botswana is reported (2009-2010 National Health Accounts analysis) to have met the target (17%) while Ghana comes close (14.5% in 2011) (Bitran, 2012). Our literature review has revealed a variety of options for **collection of taxes** and other revenues. Three countries highlight the range of revenue sources available for health, from Botswana's health financing system characterised by a high amount of public financing from general taxation to Kenya's system still largely financed by OOPS, to Tanzania's continued reliance on external funding and low uptake of national health insurance. Where a large portion of general tax revenue goes to fund health, it is particularly vulnerable to macroeconomic changes, especially when national revenue is linked to international trade. This should be a warning for Zimbabwe, as increased reliance on revenue dependent on the international market would make Zimbabwe vulnerable to global economic trends.

Three countries in our review have made progress towards universal health coverage using national **health insurance schemes** as their instrument. From Gabon's National Insurance and Social Welfare Fund, which has managed to incorporate the formal and partly informal sectors, to Ghana's National Health Insurance Scheme, introduced to help combat high OOPS, to South Africa's 14-year transition to National Health Insurance, this review has revealed a variety of ways to set up national health insurance schemes.

The term 'health insurance schemes' is a bit of a misnomer. The options used in the case study countries, and in many other countries as well, do not follow the traditional private insurance model of being financed entirely from member contributions. The health insurance schemes we refer to here are generally funded from a pooling of sources, including general or earmarked tax revenue, contributions from employers and employees, external funds and other sources. In fact, direct user contributions may account for as little as 5% of total contributions, sometimes nil. However, these health insurance schemes do pool funds (and risks) and take on an independent purchasing role. There are social health insurance schemes that take up non-members/non-subscribers too in providing services. Gabon's national health insurance system is based largely on revenue from a share of VAT being earmarked for health. It is unique in that it was first rolled out to the economically weak, then to civil servants, and finally to the private and broader public sectors. The self-employed (largely in the informal sector) pay a fixed amount based on ability to pay and the poor are cross-subsidised by other sources. For instance, mobile phone companies pay a 10% levy on their turnover, excluding tax, and a 1.5% levy is charged on money transfers

outside the country (Humphrey, 2013). These funds are collected by the tax authorities and transmitted directly to the national health insurance organisation CNAMGS, described below (Inoua, 2014). In 2009 these sources generated $30 million (approximately $18 per capita) for health in 2009 (WHO Regional Office for Africa, 2012). Ghana has also found a unique way of increasing funding for health, by adding 2.5% to the existing VAT, contributing 2.5% of social security fund paid by employers and collecting contributions from the informal sector by having them pay directly to their relevant DMHIS (McIntyre et al., 2008). In Kenya, NHIF is piloting the collection of premiums from informal workers – besides from formal workers (Lagomarsino et al., 2012). Ghana has proposed to introduce a relatively low, one-time lifetime payment, since transaction costs of ongoing fee collection may be higher than the sum of the collected fees.

Most countries had a high level of **out-of-pocket** spending that led to health financing reforms being implemented. While out-of-pocket spending has become unpopular in recent years, some formal payment at point of service is still common in most of the case study countries. In Gabon, CNAMGS beneficiaries pay 10-20% of healthcare costs themselves. User fees exist in all public and private healthcare facilities in Tanzania, although priority groups and an estimated 12% of the population with health insurance are excluded (McIntyre et al., 2008; 2012).

All the countries analysed receive some amount of **external funding**. External funding is often criticised for coming off budget and displacing (instead of complementing) government funds that are then allocated elsewhere. As a solution, several countries have set up joint external fund pools for sector budget support, such as in Kenya where a group of development partners established a joint external fund with five ‘baskets’ on particular health issues. We know from our experiences in Zambia in the 1990s that pooled external funds targeting the districts were stopped as it led to fungibility of GoZ funding, away from the health district towards issues that had received less attention in the national health plan, e.g. increased government spending on tertiary care: the national health plan became skewed.

4.3 Expenditure and resource allocation in Zimbabwe

The annual budget that the MoHCC presents to the MoFED is a consolidated budget based on costed work plans that health facilities and offices plan to carry out to meet the population’s health needs in their jurisdictions in the given budget year, based on available services. Thus, the process is bottom-up. The funds from the CRF, held by the MoFED, are allocated to various ministries through the national budget, in line with the provisions of the Constitution and the Public Finance Management Act (PFMA). The allocation from the MoFED to the MoHCC is based on the annual budget that the MoHCC submits to the MoFED based on costed activity/work plans that health facilities and offices plan in the given budget year, based on available services. The budget is costed along curative and preventive line items. In principle, the MoFED considers several factors in allocating funds to the MoHCC (Osika et al., 2010). These include the following:

- Data on key national health issues (prevalence and incidence rates of key diseases);
- Critical areas of health that need support and increased services. Provincial health officers, hospital directors and MoHCC officials are included in this discussion with the MoF;
- Cost justifications submitted by the MoHCC, as well as reporting on what will be achieved via resource allocations (consolidated provincial work plans); and
- Funds and revenues available to the Zimbabwe government.

After the resources are allocated to the MoHCC, the MoHCC in turn distributes its budget allocation to each province, in proportion to the need of the province as described in their work plan. At the provincial level, the provincial medical director (PMD) meets with district health officials and determines budget allocations for each district and its facilities, taking into account factors such as compliance with work plans, demographics, and health campaigns. Similarly, after the district health offices (DHOs) receive their budget allocation from the PMDs, meetings with facility staff (from district hospitals and rural health clinics) are convened to determine budget allocations.

The MoHCC budget can be characterised as a programme budget, which allocates expenditure according to programmes or service delivery area. Expenditures are allocated to administration, medical care services, preventive services and research. The service areas are further broken down into recurrent and capital expenditure, wherein allocations are made according to object class (i.e. salaries, electricity, etc.). Over the review period, the share of government health expenditure on salaries as a percentage of health budget ranged between 49.7% and 64.7%. A small share of government spending goes to medicines and supplies. Expenditure on medicines and supplies has decreased from 7.6% to 3.6% (MOFED, ZEPARU calculation).

The HSF is a decentralised fund and the roles of the province and the district health executive (DHE) in the management of funds are as follows. The DHE prepares an annual budget, implements financial management, ensures effective and transparent use of the financial resources for the fund and is responsible for avoiding irregular and wasteful expenditure. Funds from the HSF can be reallocated across line items by institutions that collect user fees, depending on the institution's priority needs. This can be between capital and recurrent costs and between salaries, particularly for locally recruited staff not on the public service payroll, such as hired clerks or caretakers. The HSF can also be used to supplement medicines if supplies from government are out of stock or have not been received. Basically, use of the HSF is cross cutting.

For **the HTF**, based on a 5-year plan, primary care facilities participate through operational plans crafted by health professionals in consultation with the health centre committees (HCCs) and submitted to the district medical officer (DMO) for approval. Expenditure plans under the HTF are aligned with the approved expenditures for the HTF, any deviations are normally disqualified, and hence facilities are bound to stick to the key areas of support under the HTF. Funding from the HTF can be reallocated with consultation with the DMO's office, provided that the new allocation is in line with the HTF guidelines whose focus is on maternal, neonatal and child health (MNCH). HTF funds are allocated to health facilities using flat fees per facility type.

Benefit packages for **the WCIF** (public) **and MAS** (private) are clearly specified. However, according to the National Health Accounts (MoHCC 2013), 56% of MAS subscriptions are spent on administrative costs and 44% on health services. In 2010, NSSA disbursed funds to healthcare service providers as follows: ambulatory services 22%, hospitals 14%, and retail and medicines 1%. The market for MAS is characterised by a high degree of vertical integration between funders and different providers, resulting in concerns about monopolistic behaviour across the market. Before hyperinflation, a feasibility study had been conducted on introducing social health insurance covering formal sector workers in Zimbabwe. As the economy went into decline, this possibility has not been further worked out. At that time, NSSA was put forward as a possible party to manage the health insurance. Many of the national level respondents for this study put this suggestion aside because of NSSA's high administrative costs, inadequate systems regarding quality control and lack of investments for quality improvement of health services.

Respondents in the study put forward the **National AIDS Council (NAC)** as a more reliable organisation to manage health funds, spending according to a work plan and budget approved by MoHCC. The funds allocated to NAC are spent according to guidelines set by the Board. Of the funds allocated to NAC, 55% goes towards treatment care and support, 11% goes towards prevention, 4% towards creating an enabling environment, 5% for programme co-ordination and 25% for programme logistics and support. According the 2010 National Health Accounts, 61% of the funds collected by NAC were spent on ARV medicines, 22% on co-ordination of ART programmes and 17% on administration and employment costs (MoHCC 2013). This shows that most of the funds are spent on curative rather than preventive healthcare.

We sought to explore the experience of funding in practice. In general, during the field study, particularly at primary care, the respondents could not provide a lot of information. This is mainly because primary care facilities have no track record of managing funds, given that the law prohibited them from doing so. The only experience in managing funds they have is the HTF, which has been in operation since the last quarter of 2013. District level

respondents provided information, given that they have better qualified and experienced staff in fund management.

Overall, it became clear that the current funding arrangements remain fragmented between different sources being handled separately. The different channels of funding complement each other, but their use is ring-fenced with different management rules and different reporting requirements. All funds have their own forms and procedures. Each funding mechanism has its own pros and cons – however, it represents an important additional workload to the health workers. Primary care nurses do not have strong capacities in financial management and accounting. In addition, the increased workload of nurses in charge under the HTF threatens quality of work plans as well as healthcare delivery. Another major bottleneck to health financing architecture in Zimbabwe is the (lack of) timeliness with regards to disbursements from source to operational level. However, the key constraint is that total funding is insufficient.

In MoHCC the budget process is bottom-up, starting at facility level – with the district playing a major role – and culminating in proposing a consolidated budget at the MoHCC. The provincial level, in principle, is in a position to influence the type and amounts of central allocations through annual budget bids to the central level. In this regard, the health budget is likely to reflect the needs defined by local services and their funding needs. However, this local level input may not always be included as decisions on the budget are consolidated at higher levels in the MoHCC. Historically, the budget is demand based and not needs based in allocation. The actual allocation is based on programmes and service delivery areas, making it possible to track and evaluate if funding is being applied to intended programmes. However, there is normally a great disparity between what a province gets and what it had proposed; arbitration (evaluation and prioritisation) on what finally will be allocated to the operational level is done at central level. There is no flexibility to influence final allocations. All types of facilities within the funding chain highlighted that they are not in a position to influence the level/amount of funding that they receive from the various sources. The degree of freedom in managing these funds at the primary facility level is limited: the system is very centralised. Hence, involvement of the communities as seen in the HTF and HSF could be extended to managing government funding so that it is more responsive to their demands and needs. Earmarking expenditures can constrain the flexibility of healthcare facilities and communities to decide on their priorities and responding to local needs. For instance, if the local disease burden is tuberculosis, the facility may need to allocate relatively more funding to tuberculosis (TB), at the expense of other health priorities.

Facilities are unaware of the budgetary allocations designated by the MoFED – they have little certainty that they will receive the full amount. Government funds are disbursed with an average lag of between 6 to 12 months – at times government funding is released during the last quarter of the year. Funds not spent by primary care facilities by the end of the year are returned to MoFED. While district hospitals may reallocate funds in consultation with the provincial level, other facilities need to follow the allocations as they are designated at central level.

In the last two years, the MoHCC is piloting a results-based financing (RBF) approach: instead of ex-ante negotiating needs-based budgets, funding is allocated ex post, based on results (quantity and quality of services) established in contracts with the facility. At present, the programme funded by the WB consists of management and capacity building: management of RBF cycle at the facility level, district and provincial (purchasing, verification) and the RBF national management team (strategic management). The programme monitors specific health and health systems outcomes, outputs and carries out process and impact evaluation to report to national level.

In the HSF, facilities introduced direct user fees to complement existing funding. Cross subsidisation at operational level occurs through the HSF. Funds from the HSF can be reallocated across line items by institutions that collect user fees depending on the institution's priority needs. This can be between capital and recurrent costs and between salaries, particularly for locally recruited staff not on the public service payroll, such as hired clerks or caretakers. However, funds mobilised in the HSF alone cannot sustain the demands of facilities.

Funds collected from user fees by urban city of Harare (CoH) clinics are pooled by the city treasury department together with income from the city's other sources of revenue. CoH clinics do not have the mandate and influence to reallocate funds. Funds for health financing are controlled centrally at the CoH treasury.

For the HTF, primary care facilities develop operational plans with health professionals in consultation with the HCCs and submit them to the DMO for approval – which need to be aligned to the HTF priority lines; any deviations are normally disqualified. Within these boundaries, funding can be reallocated with consultation with the DMOs. Facilities at the same level receive a fixed quarterly amount, regardless of institutional performance and needs. They receive funding according to a flat fee that does not necessarily respond to the needs of different health facilities, or, assuming that all facilities would have similar needs. For that reason, allocation may not be appropriate (according to level of demand) nor equitable (e.g. size of population) as similar institutions with different needs are given equal amounts. The HTF model comes with reasonable (but predictable) time lags and facilities are assured that they can receive a fixed amount of funding quarterly. Facilities have (though limited) control over it and are able to plan for its usage. Some districts concurred that they are reasonably sure that funds will be allocated in time, while some clinics noted that they were still waiting for disbursements of HTF funds. Facilities' delays in drawdown on the HTF resulted from a lack of training in HTF procedures and inexperience in fund management, particularly at primary level. Nurses in charge were afraid of being caught on the wrong side of the law, hence they would rather not drawdown on it (fear of being audited). Some of these nurses do not feel confident about money issues. However, this funding is earmarked for specific areas of health delivery, so contributes to the above mentioned fragmentation, and there is no room for cross subsidisation – e.g. to pre-pay for other delayed funds or between other types of funding – to be able to respond to local needs and demands.

To reduce the burden of out-of-pocket payments, some facilities accept payments from **Medical Aid Societies (MAS).** Other facilities indicated that they were not accepting medical aid because of a number of factors, including some of the following:

- User fees collected at primary and district facilities are too low to warrant collection from MAS given the bureaucratic processes. The cost of claiming is higher than the cost of service.
- Most claims made to medical aid societies are not honoured on time, resulting in health institutions facing cash flow problems. Consequently, health service providers prefer cash upfront from patients rather than accept medical aid claims.
- Some health facilities are not registered with the Association of Healthcare Funders of Zimbabwe (AHFoZ). This means they cannot be assigned a service provider number to use when making claims from participating MAS.

4.4 Expenditure and resource allocation in other African countries

Some countries are moving to **pooling** funding (such as in Kenya), but interestingly Gabon has chosen to operate the fund for the poor separate from the rest to ensure problems from one do not affect the other (Mbeng Mendou, 2012). In Tanzania, despite operating a small pool, the CHF protects against deficit spending by redistributing the funds collected from contributors as ex ante payments to the health facilities they cover, rather than as ex post payment for services used. However, this may force providers to reduce services and/or charge at the point of service, meaning the insured could still be open to catastrophic expenses, a situation countries moving towards UHC are trying to minimise.

Often there is an underspending of past budgets, as we found in Kenya, in particular, due to co-ordination issues between annual operational plans (AOPs) and the medium-term expenditure framework (MTEF) (Nyakundi et al., 2011). Most countries engage in some sort of MTEF, a process that essentially translates the country's national health priorities into budgets for the medium term (usually three to five years). In what can be a time consuming process overall, the national level usually makes the first draft and then offers it for stakeholder consultation at the provincial, district and general population levels. Once agreed, annual plans are usually developed each year based on the ceilings established in the MTEF.

Although we suspect this to be a problem in many countries, we found reports from Kenya that the annual plans that were then developed **bottom-up** were not considered at the central level to be fundable at 100%, forcing districts to adjust their plans, budgets and targets during implementation (Luoma et al., 2010). Ghana had a clever idea to give each district a budget ceiling based on population, burden of disease, etc. which they could then spend as they saw fit, but with pre-agreed targets that needed to be met. This is a kind of performance-based financing at the district level that may be worth revisiting. Unfortunately, this idea did not work in practice, mainly because of 'political economy' reasons (discussions on mandates between MoH and GHS), partly because the central level preferred to hold more control over health service spending at operational level. MoHCC explained that it did not work because there was no management capacity at the operational level.

The case study countries reveal multiple ways of setting priorities to **guide resource allocation**. In Botswana, resource allocation has been described as following "infrastructure rather than health needs of the population" (Alfred, 2012). Ghana's resource allocation formula for Ministry of Health funds redistributes pooled funds to regional and district levels, taking into account the number of people living below the poverty line, under-five-mortality rate and regional population size (McIntyre et al., 2008). However, McIntyre reports that NHIS funds are de facto distributed according to demand of services (or claims). Kenya uses two resource allocation formulas to allocate resources to primary-level facilities (dispensaries and health centres) and district hospitals: either on the basis of variables related to population structure, disease burden, infrastructure, poverty levels, utilisation and hospital capacity, or by incremental historical allocation as is done in many countries (Chuma and Okungu, 2011). Tanzania allocates resources to districts for primary healthcare and district hospitals based on a needs-based resource allocation formula. Districts then have their own mechanisms for allocating funds further. South Africa was once plagued by resource allocation problems, particularly an unequal distribution of resources across provinces. It is hoped the new NHI will further address this problem by continuing to redistribute funds between provinces and to high priority areas.

4.5 Purchasing quality care in Zimbabwe

Zimbabwe is developing a new **Essential Health Benefit** for health services that is financially accessible to be delivered to, it is aimed for, the entire (100%) population (Vaughan, 2014). The funding for EHB is not yet guaranteed – at the national level, several options for appropriate and sustainable future health financing of this package are under discussion.

The MoHCC holds the roles of healthcare purchaser, provider, payer and verifier at the same time. There are performance agreements in the public sector between councils and central government and between ZACH and central government. However, purchasing and funding of care is based on ex-ante negotiated budgets – not based on ex-post assessment of results or performance. The participating health facilities in RBF have been contracted to deliver care based on results. The functions of purchaser, provider, regulator and external verifier of the healthcare delivered have been separated in these pilot areas. The RBF approach has been implemented for two years and, though the impact evaluation has not been completed, some preliminary results of the pilot (Gwinji and Dhlakama, 2014) have been presented to the sector:

- User fees have been removed for the package of high impact services;
- Decentralised service delivery and primary healthcare have been revitalised;
- There was a 13% increase in the in-facility delivery rate;
- There was a 12% increase in post-natal care coverage;
- More women receiving full package of ANC services, including urine tests, blood tests, tetanus shots;
- There was a little change in ANC coverage – baseline rates already high;
- There was a relatively small change in contraceptive use.

For **HTF**, the budget allocations in 2013 were:

- MNCH and nutrition 17%;
- Medical products, vaccines and technologies 38.5%;
- Human resources for health 15.7%; and

- Health policy, planning and financing 28.7%. (MoHCW, TARSC, KIT, 2013).

The field study found implementation issues in practice. Time spent on preparing reports is high and needs to be minimised by synchronising reporting mechanisms, or made to share a similar template of reporting. Field staff underscored the need for budgeted/approved funding to be disbursed in a timely way to enhance implementation of the programmes. They also noted the need for communication from central level on approved government funding amounts and with justification/reasons to inform future plans. Respondents suggested that measures be put in place to ensure the availability of medicines at facility level to ensure improved health outcomes and access within the health delivery system.

Decentralising purchasing arrangements could save on administration costs and direct funding more equitably and appropriately. For instance, budgets and plans currently need to go through every administrative level before decisions are made; quotations from primary facilities need to be submitted and approved by the DMO, all together a costly process and not necessarily effective. In the RBF approach facilities are autonomous in using the funds according to the priorities at their level.

Respondents pointed out that funding under the **HTF** should be allocated in line with needs of facilities rather than the current flat rate. Such flexibility on the HTF allocations would be able to address the specific needs and demands of different facilities.

Patients subscribing to **MAS** (medical aid societies) faced challenges paying for healthcare because MAS are not honouring their claims timeously, resulting in health facilities facing cash flow problems. This has forced facilities to ask for upfront payments from patients, who in turn claim from their MAS, thus increasing the burden of patients' out-of-pocket payments. Respondents at district level felt that MAS should be compelled by law to honour claims within a specific time frame and, if not paid, the claim should accumulate interest, at a rate specified in law, payable to the facility that rendered the service. There were examples found of community-based prepayment schemes funding development projects not personal care.

4.6 Purchasing quality care in other African countries

Examples of semi-autonomous institutions that manage tax funds for specific service provision are the NACA in Botswana for services for HIV/AIDS, the CNAGMS in Gabon and the Social health insurance schemes as in Ghana. A review of Kenya's National Hospital Insurance Fund showed that 45% of total revenues in 2010 were administrative costs. Efficiency gains are therefore of the highest importance, as is controlling cost escalation. South Africa has managed to make progress in this area with regards to pharmaceuticals, although overall healthcare costs are still escalating at a higher rate than the rest of the economy (Dambisya and Modipa, 2009). The most efficiency gains have been made with regards to pharmaceuticals, with the National Drug Policy (1996) lowering the cost of drugs in both the public and private sectors and introducing measures to promote cost-effective and rational use of drugs (Dambisya and Modipa, 2009). The 2002 Medicines and Related Substances Amendment Act introduced transparent, non-discriminatory pricing (Dambisya and Modipa, 2009). In Ghana, the NHIA was said to be autonomous but was then established under control of the Ministry of Health, which also oversaw providers. This meant that the NHIA had little real autonomy and could always be overruled by the MoH.

Achieving UHC generally also means defining the **services to be provided**, or not provided. This is normally done in the form of a basic or essential health benefit package in a positive list, and/or through excluding services that are not publicly funded in a negative list. The countries included in this review with a basic benefit package have a positive list of services that are included; some also explicitly state services that are excluded. Affordability is an important issue. For example, the financial sustainability of Ghana's NHIS is reported to be questionable given the broad benefits package that covers 95% of health problems, low premiums, limited funding, no co-payments and increasing coverage (Witter and Garshong, 2009).

With regards to purchasing, the type of **provider payment mechanism** is one of the most important issues. Our case study countries have revealed a variety of options and combinations of options, from a daily flat rate (Kenyan NHIF), fee-for-service (Tanzania NHIF, Gabon's CNAMGS, private health insurance in Kenya), DRG (private health insurance in Kenya) and capitation with or without risk adjustment (CHF/TIKA in Tanzania, new NHI in South Africa). Newer and more innovative models include payment based on performance incentives (Kenya NHIF, new NHI in South Africa). There are pros and cons to each provider payment mechanism, although with all mechanisms proper accounting is required to help control fraud and split payments between relevant departments.

Provider payment mechanisms often come along with claims processing. From the example of Ghana, we believe there are many lessons to be learned. When NHIS was introduced, initially the DHMIS were not well prepared and lacked the ability to judge the appropriateness of claims. Second, providers presented their claims with many errors and claiming what was not permitted to claim. Third, delays in payments at central level (from MoF to MoH, from MoH to NHIA, from NHIA to DHMIS) meant payments from DHMIS to provider were also late and insufficient, based on the last invoice of the DHMIS, while the volume of claims was increasing steeply. There was no front-loading of DHMIS by NHIA (McIntyre et al., 2008). For that reason, providers made duplicate claims for insured patients, and eventually from NHIA received duplicate payments. They also made many fraudulent claims that were not accepted by NHIA. Providers sent complaints to the MoH (which is responsible for NHIA), and those claims were paid then, which meant that NHIA was not really autonomous. Interestingly, while Ghana's NHIA has centralised claims processing to process claims faster and less expensively, Tanzania's NHIF, in contrast, has decentralised claims processing to district offices, to bring the schemes closer to the providers and the subscribers. This issue gives rise to debate: centralising brings economy of scale, so cheaper, also through standardising – decentralising brings HIS closer to the clients – providers and subscribers – so, it is possible for the HIS to be a tier party payer, representing the patients to providers, and it can be a true purchaser, offering tailor-made solutions to the specific context, but transaction costs may be higher.

Another issue that we did not come across in the case study countries specifically but should be addressed is differential payment of public versus private providers. In many cases, costs incurred by public providers are subsidised by the government budget (i.e. training, H/MIS work), whereas private providers must fund these costs themselves and do not receive public money to do so. Ghana, therefore, has decided to pay higher unit prices to private providers than to public providers for the same services, but a careful analysis and potentially dangerous political discussion are required to determine how much more (personal experience).

4.7 Governance and accountability mechanisms in Zimbabwe

On **financial accountability,** funds and activities funded through the GoZ budgets are audited by the Auditor General at least once a year and the MoHCC internal auditors to ensure they are in line with the provisions of the Public Finance Management Act (PFMA). The district health executive audits council- and mission-owned healthcare facilities in rural areas quarterly in relation to government-funded activities such as medicines from the National Pharmacy. However, audits for the HSF for council- and mission-owned facilities are usually done on an ad hoc basis by council and church auditors to ensure collection and use of funds are in line with council standard operating procedures and church policy, respectively. Funds and activities supported by different external funders are audited by the respective external funders; for instance, the HTF is audited by Crown Agents, the designated fund managers for HTF external funders, and NAC funds are audited by the NAC internal audit department based at central level.

For **social accountability,** expenditure planning and prioritisation at facility level is done by the nurse in charge (NIC), in consultation with the HCC. The HCC consist of members of the community, councillor, village headman, villagers and members of the public service such as teachers and police. The HCC holds the NIC accountable with regards to implementation of the approved plans. A similar institutional framework is replicated at district hospital level, with the district executive committee (DEC). The DEC is constituted by similar membership as the HCC

and is responsible for holding the district hospital management to account regarding expenditure plans and priorities and their implementation. The DEC is involved in making plans and deciding on priorities for the district hospital, which is also performed by the HCC.

In practice we found in the survey that the staff establishment for persons designated to account for funds vary according to the level of facility – the accountants are usually in place, while assistant accountants are often understaffed The situation is worse at facility level, probably given that they are not, by law, expected to collect any fee. Where this is the case, the NIC is responsible for bookkeeping, whilst nurses on duty collect the fees. Facilities highlighted that their accounting staff had not been officially trained on the provisions of the PFMA. Facilities were not in a position to categorise expenditures as recurrent (employment) vs. capital or curative vs. preventive expenditure. Furthermore, some of the funding is received in kind, making it difficult for facilities to quantify and categorise their expenditures. Much of financial administration is still paper based, certainly at facility level: here it is not digitalised, they do not have any accounting software – unlike the district and provincial levels where financial administration most often is digitalised. Still most interviewees agreed that quality assurance of the FA system should be greatly improved.

Monitoring financial/administrative tasks in **MoHCC** is done in line with regulations. The Auditor General audits the funds and activities funded through the GoZ budgets at least once a year and the MoHCC internal auditors to ensure they are in line with the provisions of the Public Finance Management Act (PFMA). The district health executive audits council- and mission-owned healthcare facilities in rural areas quarterly in relation to activities funded by the government. Audits for the HSF for council- and mission-owned facilities are usually done on an ad hoc basis by the respective council and church auditors. Urban clinics are audited in line with the standard operating procedures guiding the use of resources.

The HSF operates in terms of the Public Finance Management Act, and the Secretary for Health has overall responsibility for the proper and transparent management of the fund. The NAC internal audit department based at central level audits **NAC funds**. Activities funded by NAC are monitored by provincial, district and ward level voluntary committees. Crown Agents, the designated fund managers for HTF external funders, audit **HTF**. None of the facilities visited were found on the wrong side of the law. Overall, the effectiveness of audits is determined by the time the audit reports take to be disseminated to operational levels, and audit reports are most often not being followed up. Audit reports take long to be shared with operational level (more than a year), which affects implementation of corrective measures, if any. The quality of the accountant reports may be approved – as many external funders seem to have confidence in the NAC internal accountant department, lessons may be learned here – though it needs more in-depth study to draw conclusions. Respondents proposed the NAC as a more reliable organisation to manage health funds. Accounts are fully up to date, subjected to external audits, and spent according to a work plan and budget approved by MoHCC.

User fees are managed locally by the HCC and district health executive for primary and district levels, respectively. The HCC holds the NIC accountable with regards to implementation of the approved plans at operational level. A similar institutional framework is replicated at district-hospital level, with the district executive committee (DEC). The DEC is involved in planning and deciding on priorities for the district hospital, which is the same function performed by the HCC. The DHE implements financial management in line with PFMA-related rules and regulations, ensures effective and transparent use of financial resources for the fund and is responsible for avoiding irregular and wasteful expenditures. The HTF has recently been made available for primary care facilities, which also enhanced the role of HCCs.

As noted earlier, RBF functions and responsibilities are separated between purchaser and provider of care and between regulator and external verifier – which strengthens accountability mechanisms, with a key role for HCCS and community tracer surveys in social accountability. The few community-based financing schemes meant that funds were in community members own hands, with their own governance structure and accountability mechanisms. Though it is clear

that these initiatives need to be strengthened in terms of institution building and capacity development, they may represent an interesting entry point for governance and accountability (not as a contributory system), as the involvement of the demand-side is strong.

4.8 Governance and accountability mechanisms in other African countries

Several countries have successfully devolved service delivery while ensuring co-ordination, regulation and equity. In Ghana, the Ministry of Health is responsible for the general co-ordination and oversight of the system, but operational responsibilities have been delegated to the GHS, who in turn has gradually devolved operational functions to its regional health administrations (RHAs) and especially DHA offices, albeit with problems and challenges typical in decentralised systems. In South Africa's quasi-federal system, the national level has responsibility for overall strategic direction for the health system but provincial MoHs (with their own budget) oversee all health services within the province. Future district health authorities (DHAs) will be established and charged with contracting with the NHI for purchasing, supported by NHIF's sub-national offices to manage contracts with accredited providers. Again, a word of caution that delegation of certain tasks and the creation of multiple layers in the system open opportunities for fraud that need to be carefully controlled. This is less of a problem in devolved systems with transfer of responsibilities. Additionally, before decentralising responsibilities it is important to ensure the capacities to co-ordinate exist at lower levels and that a plan exists for who will monitor equity and who has the authority to implement equity-related changes.

On the issue of **quality of care**, as previously mentioned, a large autonomous purchaser can negotiate on behalf of patients, hold providers to account through contracts and help ensure quality services are provided. However, this important part of any system must be properly funded, which was a mistake made initially by Ghana's NHIS. They have now put additional resources aside for quality control and introduced post-accreditation monitoring tools to monitor providers and ensure maintenance of quality standards. South Africa's interesting accreditation progress as part of the move to NHI should also be noted. They have introduced facility improvement teams trained in quality improvement to work directly with facilities to remedy problems found in audits. And in an interesting combination of provider payment mechanisms and quality assurance, Kenya's provider payment mechanism is linked to the facility's accreditation score.

A final note about the purchasing-provider split. Of the six case study countries Ghana is the most advanced in doing so. The DMHIS in Ghana contracts accredited providers whether public, mission or private. South Africa is moving towards this, with the NDoH scheduled to contract 600 private GPs to provide services in the 11 pilot districts starting in 2013 (Matsoso and Fryatt, 2013a).

5. Discussion

Attaining universal health coverage represents an important policy objective for the health sector, which has been acknowledged by different representatives at all levels in our study. Governance, the main focus of this study, is an important aspect of UHC. This section discusses what our findings imply for improvement, management and accountability of funds for UHC.

5.1 Revenue collection

The study highlighted a high external funder dependency for health financing that is often unreliable, unpredictable, unsustainable and highly dependent on the political environment. This raises concerns on the sustainability of health financing institutions and the vulnerability of governments budget should external funding be withdrawn. Although total health expenditure was a high share of GDP, per capita health expenditure is insufficient to guarantee adequate access and quality of healthcare. Out-of-pocket payments were more than three times higher than government spending, exposing the population to catastrophic healthcare expenditures and creating barriers to access to healthcare.

UHC in Zimbabwe is expected to be tax based. This is vulnerable to macroeconomic changes, as may be learned from the fall in Ghana's revenues for the earmarked tax-based social health insurance in 2014. Such macroeconomic changes will, however, affect health financing in all countries, whatever the approach. Other African countries have increased national and local taxes (earmarked or not) on specific products, like cigarettes, alcohol, mobile phones and on revenues from minerals used for health. While global macroeconomic factors partly influence the amount of revenue that can be collected, national priority setting determines how much tax revenue is set aside for health.

Improving **efficiency** in collecting revenues, in allocating them, and in implementing health interventions, are also important. Increasing the tax collecting power of the Ministry of Finance or Treasury, including enforcing existing regulations, closing loopholes and finding unique ways to tax the informal sector can generate significant additional revenue. A major issue for ministries of health trying to advocate for a larger share of general tax revenue is that there is often an underspending of past budgets because of inefficient procedures that need to be taken before spending can occur. Revenue collection mechanisms can be streamlined more and otherwise improved to reduce transaction costs, as funds can then be used in more efficient ways, discussed further below.

Progressivity of tax revenues is highly debated. Some argue that an earmarked VAT like the one introduced in Ghana is relatively progressive because the VAT is applied to items bought by people who do have money, and applied on other than basic goods and not charged on businesses earning below a certain level. Taxes on financial transactions and mobile phone companies are applied at the corporate level, but the final effects on progressivity are not (yet) measured as these taxes can be passed on to consumers, making them less progressive than they were designed to be. There is debate on whether taxes on alcohol and tobacco -- if the behaviours taxed may be more prevalent in lower socioeconomic groups.

Larger **pools** are often seen as the preferred option, because economies of scale help reduce administrative costs, and large pools are more likely to be sustainable since both funds and risks are shared. Tax-based health financing is of course a major step in pooling funds; in theory pooling would lead to lower transaction costs – so to higher efficiency, which is not necessarily the case for tax-based funding through the public sector. The institutions and/or arrangements that have been used to pool funding in Zimbabwe include the HTF, NATF and HSF.

Although some other African countries have set up social health insurance-type schemes for pooling funds, or have pooled funds in semi-autonomous institutions for funding specific services or wider health benefits, they may not have gone so far as to share risks. This is particularly important for countries like Zimbabwe with an HIV prevalence of around 10% and a large poor and vulnerable population. In Zimbabwe a special fund (NAC) has been set up for HIV/AIDS, deriving from taxes, which on the one hand may be seen as further fragmentation, on the other as a potential pool for financing UHC in the country. It has this potential, because it follows national regulations and procedures, has a strong internal financial-administrative system for accountability, and external funders are already channelling their funds through NAC, so funders seem to trust NAC as a funding channel.

The dependency on **external funding** will probably not change in the short term, although criticised for being unsustainable, off-budget, earmarked for specific programmes, displacing (instead of complementing) government funds and for fungibility so that national funds are allocated elsewhere, including outside the health sector. Moves have been made to encourage general budget support in which external contributions are added to the larger revenue pool, which may give more ownership to the country but risks that the funds will be spent on non-health priorities, especially where public financial management systems are weak.

In terms of autonomous funds, the HTF is an arrangement between the Government of Zimbabwe and external funders to mobilise pool and manage funds for health financing, where earmarking is done externally not internally. Although the fund avoids duplication and 'cherry

picking' of activities by external funders and uses existing systems and structures, its reliability and sustainability is affected by some external funders not being able to commit funds for the duration of the HTF and by the wider socioeconomic environments. The HSF has decentralised features that enable local participation and flexible decision making on use of funds, is governed by both law and a constitution, and is integrated within the existing systems and structures. However, it suffers from delays in reporting and lack of harmonisation between its constitution and national law. NAC is a national institution, considered to be a good practice regionally and internationally, that could extend its roles towards other diseases and services and linking funding with results as well as providing public information.

While **user fees** are not officially permitted in government-owned facilities, collection of user fees is being practised. User fees can partly help increase funding for health, may help control frivolous use and other excess demands and may empower the population, if that payment is accompanied by involving the demand side in decision-making powers on prioritisation at local level in using central-level funding. Removing user fees for a portion of society (notably the poor, pregnant women and children under the age of five) improves equity in access. However, there have been problems with the exemptions not being honoured in practice or official user fees being replaced with unofficial payments, and questions on protection of equity in quality of care, as people who do not pay might not receive the same quality of care (CREHS, 2009). The issue and administration of user fees needs debate as user fees present an opportunity for fraud and generally cover only a relatively small part of facility running costs after administrative costs are deducted.

As an alternative to paying user fees, **health insurance schemes** have appeared on the agenda to avoid catastrophic expenses, given the inequitable effects of user fees. However, in Zimbabwe social health insurance schemes did not get off the ground, and there are only a few community-based health insurance (CBHI) schemes in the country. The literature raises inequities in CBHIs (McIntyre, 2012). Contribution to health insurance (including related transaction costs) may burden poor and vulnerable people if their contribution is not subsidised by taxes, or if contributions are not progressive. Even paying for membership and membership cards may exclude some people. Most often health insurance schemes are based on deductions from salaries from workers in the formal sector – leaving the informal sector out, where most poor and vulnerable people are found.

MAS in Zimbabwe is dominated by three key players. In total, all MAS cover only 10% of the population, mainly formal employees, wealthy women and men, and their dependents in urban areas, excluding poor women and men, informally employed and rural inhabitants. Important differences exist between the benefit packages covered, there is no cross-subsidies between different schemes and or beneficiaries, financial protection of the plans for members is limited, transaction costs are high.

While other African countries have increased financing coverage using national health insurance schemes, it is usually easiest for health insurance schemes to include formal sector employees, to obtain mandatory contributions by deducting these from salaries, leaving the informal sector (where most of the non-covered are living) behind. There is also the risk that covered groups prefer to protect their own benefits than facilitate developments or cross subsidies from wider pooling and new coverage, and so become a negative factor in UHC (as has been the case in Kenya). Too often, the informal sector, and consequently the poorest, will not be included. Leaving the informal sector to CBHI with low penetration and coverage, as was tried in Tanzania, where penetration only reached 4% of the total population, was found to limit financial and risk pooling.

This implies that the term 'insurance' should not be understood in a narrow form of a direct contributory and membership scheme. Contributions for the informal sector and poor communities would be derived largely from tax-based sources and it would need to include features of pooling, cross subsidy and population coverage more in line with tax-funded national

health services. In that case, it will become more an equitable independent purchaser of quality care between demand and supply than a classical insurance scheme.

5.2 Expenditure and resource allocation

Representatives of central land operational levels agreed that health financing is **highly fragmented**, and that this represents an important constraint to national health financing, certainly for those implementing healthcare. Harmonisation and alignment of external funding to national funding is a key task. It means addressing features in the health financing system that lead external funders to avoid using existing national channels, including in the efficiency, effectiveness, transparency and accountability of the system. It would be wise to discuss between different external funders, the finance and health ministries and implementing agencies how the issues raised can be used to jointly improve transparency and accountability mechanisms of national health financing.

Instruments like national health accounts (NHA) and mid-term expenditure frames (MTEF) to translate policies to budgets have been put in place to improve resource management at **central level**. Some budget lines are not covered at 100%, raising a financing gap and a demand to find other financing sources. Financial gaps derive from bottom-up planning, which in itself is an appropriate way of planning, but where the operational level is likely to plan for more activities and resources than available. A financial gap in the national budget is an advocacy instrument to apply for external funding. However, while the system may be bottom-up, arbitration takes place at central level, from the top-down. As an option, in Ghana the operational level is asked to plan within a budget ceiling, with clear targets. In Benin, before the planning process starts, a policy-brief is sent to the operational level to make clear where national health priorities are, to be taken into account in the bottom-up planning. This sets criteria for an equitable and appropriate allocation of (financial, human, logistical) resources in the country.

Regardless of the resource allocation formula or system used, we could not find much evidence about the results: have they worked in achieving UHC? Have they improved equity? We argue strongly in favour for monitoring and evaluation systems that can track this and that results are fed back into the system and adjustments made to the resource allocation formula and process.

Allocation of resources at the **operational level** is managed mainly by the DMO and PMD, both medical doctors. They manage the health delivery system at provincial and district levels, including the health funds and accounting for it. This means they have to divide their time between managing healthcare and managing financial administrative affairs. This can be argued to create inefficiencies, limiting them in devoting time towards provision of healthcare. With the current shortages of doctors, and the investment in their training, it would be useful to discuss if there are cheaper, more efficient ways to manage health funds, including by people trained in administration.

5.3 Purchasing quality care

With regards to purchasing, the type of **provider payment mechanism** is important. Presently, providers receive fixed payments through a centralised system for salaries and based on input-based budgeting for their activities. This is done in a fragmented way, and mostly for earmarked priority health programmes, based on needs-based budgets. There is little room to move within those budgets for creative tailor-made solutions that serve the context they are working in.
The disease-related groups (**DRG**) system may be more precise in establishing how much will be paid for what kind of services, but this raises high administration and monitoring/verification costs for claims. Capitation (payment on population covered/served) reduces transaction costs, but can reduce quantity and quality of care (Macha et al., 2012). Fee-for-services may increase performance but can exclude the worse off and increase fraud, raising demand for monitoring and verification. Performance incentives may improve performance, but can lead to a focus on incentivised areas, ignoring those not linked to an incentive payment (Witter et al., 2013). Ghana uses the DRG system, but the NHI Authority had limited capacity to carry out the payments and verify if invoices were correct. Available funds were neither sufficient nor predictable, and providers had problems understanding the DRG system, with an impact on delays in payments.

For that reason, after 5 years of its NHIS, Ghana moved to piloting a capitation approach and a 'life-time premium'.

One option to become more responsive to service demand has been to use **results-based approach** (RBF) where resources are allocated if results are obtained. In RBF, payments are related to an increased number of outputs, so providers need to become more responsive to the community's demand. Quality of care is defined and measured through a quality of care score card; the score obtained is taken into account in the payments. Funding is related to results, not to proposed activities and related budgets. However, RBF targets a reduced number of services, not the EHB foreseen for the UHC programme. This makes RBF a strategic purchaser: so policy makers can put their money where their priorities are, but health staff may focus on the RBF indicators at the expense of other services in the EHB. Transaction costs may be high, as RBF requires costly monitoring and verification, but it may also strengthen the HMIS. There is a risk that the number of outputs may bypass the available budget – if RBF only pays for outputs and not within a budget ceiling. The RBF approach is already being tested, the results are promising, the pilot is being scaled up in the country and embedded in national policy making at central level by a national management team. High-ranking officials of the MoHCC reported great expectations of RBF to improve performance in the volume and quality of care and the accountability that supports UHC. The first results of an impact evaluation were promising, though it is uncertain if these positive results can be maintained. It can improve accountability if there is a real 'split of functions' between provider, purchaser, regulator and verifier of contracted health services, and if the community has a more important role than verification, but this is not the case yet in the RBF programme implemented in Zimbabwe. The role for fund-holder and purchaser (which includes verification) is currently partly held by an external NGO (Cordaid). This would need a review before becoming a national approach or model, as it has high transaction costs. Currently, community-based organisations verify at household level if services reported were provided. Verification improves the reliability of health information – a basic element for governance of the sector and its funding. The management of health funding raises questions on who will fulfil these roles in future.

Whether contributory or not, a pooled fund as an autonomous purchaser can contract services from providers, monitor the performance (quantity and quality) of providers, and can be regarded as a strategic purchaser. It can contract services that are a priority for the country and negotiate better prices and use contracts to hold providers to account on both results and quality. Pooling reduces the administration and other transaction costs that are duplicated in multiple pools. Having a purchasing authority autonomous from the Ministry of Health creates opportunities for greater accountability of all parties and may introduce a competition that can help decrease cost and improve quality (Abt Associates, 1999).

5.4 Governance and accountability

Governance and accountability are about more than financial accountant reports, although this was how many respondents understood it. It is about how health funding is managed at central and decentralised levels, being accountable on results, and about accountability systems. It concerns how governance of these funds is organised, who is responsible for decision-making on spending of these funds, and about the distribution of tasks and responsibilities of each of the different stakeholders in managing those funds. It further concerns how systems work to arrive at sound accountability mechanisms: Who holds whom to account on what, and what are the (positive and negative) consequences of attaining those results (or not). Holding to account not only means whether funds are used according to their objectives, it also means appropriate spending of the funds and whether the money is used in an efficient way to obtain as much as possible health for the funds in an equitable way. Accountability is also about results in health.

The study suggests that systems in place (like HCC) should be strengthened to enhance social accountability. This would mean sharing decision-making powers in establishing priorities in: health activities, interventions, monitoring and evaluation and financial-administrative work. It would raise health provider responsiveness to the needs and demands of the population and would require better information to these structures, defining and training for their responsibilities.

Respondents at different levels of the MoHCC claimed that systems for governance and accountability are in place and that there is no need for a change. However, we found them to be not very functional, reportedly after the system became grossly underfunded. There is a risk of conflict of interest in the way management of health financing is organised: responsibilities and mandates nowadays are in the hands of the same devolved institution of the MoHCC. Re-thinking of organising health financing in Zimbabwe would probably also mean rethinking the distribution of roles, tasks and responsibilities in decision-making/implementing/monitoring health funds to separate these functions among purchaser, provider, regulator and verifier of results to avoid the risk of conflicts of interest. Gottret and Schieber (2006) note that "public provision of health services may also face problems of corruption and inefficiencies caused by budgets that do not generate the appropriate incentives and accountability". Implementing a purchaser-provider split and having an EHB may enable private provider contribution to public goals, although this may also raise challenges for UHC.

One such challenge is fraud. WHO in its 2011 bulletin reported that more than 7% of annual global healthcare expenditure is lost to fraud. Tackling fraud is challenging and, perhaps counterintuitively, the more layers and controls put in place to help control fraud, the more opportunities exist for fraud. The more people you put in place to monitor fraud, the more people that are susceptible to corrupt practices. In devolved systems capacity must exist at all levels, particularly at lower ones, but there are capacity deficits in the health system. RBF, for example, relies heavily on capacities for verification in the health facility and counter-verification at household level to prevent fraud.

In our survey accounting staff and HCCs had limited knowledge of certain provisions of their mandate because they lacked the necessary information and training. The survey suggested a need for training in the PFMA training for all staff who account for health funds; HCCs training in the basic planning and operational procedures for the management of funds at operational level; and training PCN in the operational guidelines for the HTF and planning techniques. To improve the quality of financial accounting, there is need to roll out the PFMS to district hospitals. A roving accountant could be employed to service a number of primary facilities, to assist in planning and accounting for funds. In the mid-1990s such a task force was highly effective. Furthermore, there is need to ensure that audit reports are shared on time with operational level. This will help ensure that corrective action is taken timeously and avoid recurrence of the same bad fund management practices, if any. Punitive measures need to be put in place and also enforced to deter malpractices in fund management. Despite having internet access at district offices and mission hospitals, there was limited use of email-based communication for official correspondence. There is need to embrace and encourage the use of electronic means of communication as they are more efficient in that they reduce costs such as time and transport involved in the physical submission of reports and quotations.

It should be a legal requirement that all facilities such as hospitals **collecting user fees** must be registered (or accredited) for medical aid purposes and have procedures in place for the collection of user fees, their unit prices, decision making on their use, including those by medical aid societies. This will assist health facilities to claim payments from medical aid societies and reduce the burden of OOP on insured patients. In addition, government should set a minimum time frame for which MAS should process claims by facilities, beyond which they will accrue interests to the service provider, as a way of enforcing timeous payments.

For private for profit providers, while not a direct focus of the study, the review evidence suggests that there is need for proper incentives, regulatory and enforcement capacities to control cost escalation, risk exclusion, and other potential sources of inequity and to manage private providers' own interests in relation to public health goals. Rather than medical doctors playing these finance and administrative roles, trained managers with the proper managerial, financial and administrative skills would be best suited to facilitate the public-private relationship.

5.5 Areas for further study

The study raised a number of areas where further information would assist in policy decisions. For example:

- It would be useful to study the impact of the RBF approach as a purchaser of care and governance and accountability, including an in-depth needs assessment for staff who account for funds; in the RBF districts to explore how the funding and accounting mechanisms are different from the non-RBF districts sampled in this study; and to explore the implications of RBF funding for the EHB. This is in view of the current proposals to adopt the RBF model for funding healthcare nationwide.
- It would be useful to study community-level funding schemes to assess their purchaser function, their potential to involve communities in governance and accountability of health financing, including through HCCs, and their performance on equity, sustainability, portability and costs of care.
- It would be useful to explore the specific system features that undermine funder trust in the public financing mechanisms that would allow for fund pooling.

6. Conclusions

The findings of the survey point to a number of areas for follow up dialogue, with proposals for:

On collection and pooling of revenue:

- Increasing overall funding for health to reduce the financial burden of those who have no access to quality care at present. Several options exist for this, including improving budget allocations to health towards the Abuja commitments, and adding collections from earmarked taxes as identified in prior MoHCC work. Zimbabwe has no national mandatory/contributory health insurance, only a few community-based health funding/insurance schemes whose equity, portability, sustainability are not evaluated and private voluntary insurance (MAS) that cover a small part of the population, with high transaction costs, late payments and weak protection for subscribers. Whatever the mandatory financing form, it needs a solid arrangement to manage pooled funds.
- High-level decision on whether to create new structures or if current institutions that pool funding can be used to create one single pool. A pooling institution needs to address pre-set conditions and criteria to ensure accountability and transparency to be trustworthy for all partners to join the pooling. A more formative evaluation of existing public finance management mechanisms than was done in this study could provide options for how to improve trust in future pooling. If the choice is to use an existing pooling mechanism, the study suggests that NAC would provide a better alternative than NSSA or MAS, given the limitations of the latter.
- Explore issues in the public finance management system to identify and solve the governance and accountability issues that discourage external funding being channelled ‘on budget’.
- Efficiency in collecting and allocating revenues, in implementing health interventions and in pooling funds needs to be improved. Revenue collection mechanisms can be streamlined to reduce transaction costs. Pooling funds is preferred as the economies of scale reduce administrative costs and personnel time and are more sustainable and accommodate risk sharing.

On expenditure and resource allocation:

- A more equitable allocation of funds, more aligned to health needs.
- More autonomy at the operational level (providers and community) to respond to context specific demand and needs, within predetermined ceilings and set boundaries. This requires an allocation system with sound criteria for an equitable and appropriate distribution of funds.

On purchasing:

- Introducing an independent semi-autonomous organisation as a purchaser of quality care.
- Exploration of whether to set up a new semi-autonomous institution or to extend the role of NAC as a possible semi-autonomous purchaser for UHC.

- Strategic purchasing by such an autonomous institution managing pooled funds that will contract services from providers and monitor their performance. Its place between provider and patient means that it can better negotiate price/quality.
- Learning from positive and negative lessons from the experience of insurance schemes as a (semi-) autonomous purchaser of care in other countries and from deeper assessment of existing structures than was possible in this study.
- Defining the role of results-based financing (RBF) in a future UHC scheme, where RBF may strengthen the purchaser function and an UHC fund may reduce RBF's high transaction costs.

On governance:

- Reviewing and clarifying tasks and responsibilities of all stakeholders in health financing to avoid conflicts and gaps and stimulate and strengthen accountability, especially social accountability.
- The community to have a more important role in co-determination on how allocated funds are spent to make services more responsive to the needs and demand of the population.
- Training at the operational level, including on the Public Finance Management Act, on basic planning and operational procedures and accounting and on operational guidelines for all funds.
- Increased administrative staff/accounting support to relieve medical staff from administration.
- Alignment and harmonisation in reporting of all funds (until they are pooled).
- Strengthened regulation and alignment of private sector provider payment mechanisms, with monitoring and verification in line with that in the public sector.

As issues for follow-up discussion and debate we raise a need for **dialogue** on

a. The methods to improve the funding for health as a key measure for UHC;
b. The policy goal of a non-contributory tax-funded national health service and measures to avoid frivolous use of care, raise awareness of the costs of care and public roles in accountability often linked to payments/contributions, while protecting equity in access through services provided free at point of care;
c. The measures to strengthen pooling of budgets and cross subsidisation of risks in health financing and factors discouraging external funders from channelling funds on budget;
d. The selection of institution for a potential semi-autonomous health fund, noting that NAC has been recognised as a 'good' practice, both regionally and internationally;
e. The measures to support improved public information, strategic purchasing and accountability in a semi-autonomous fund;
f. The distribution of tasks and responsibilities to avoid conflicts, duplication, gaps in the management of health funds;
g. The latitude at operational level to adapt budgets to local needs, such as by widening operational authorities to plan within a pre-determined ceiling or by providing a pre-budget brief explaining the boundaries of their planning.
h. The implications of integrating RBF in national structures in terms of national roles currently implemented by international organisations, including that of fund holders, reducing transaction costs and how RBF would apply to the wider services in the EHB;
i. The synchronisation and harmonisation of templates and timings for reporting and role of unified simplified reporting and accounting formats to support coherence in spending;
j. The strengthening of capacities in financial accounting and the role of non-medical professionals taking over accounting tasks to free clinical personnel;
k. How private sector payment, monitoring and verification mechanisms would be defined to align to those in the public sector;
l. The sharing of decision-making powers between communities, health staff and managers to enhance social accountability and the responsiveness of the health services to population health needs.

7. References

1. Abt Associates (1999) 'Appendix 4: Purchaser-Provider Split.' Available at: http://pdf.usaid.gov/pdf_docs/Pnady330.pdf (accessed 14 March 2014).
2. Alfred JA (2012) 'Botswana National Health Accounts (NHA) 2007/08-2009/10.' Presented at 13th Public Health Congress: Addis Ababa.
3. Bitran R (2012) 'Universal health coverage reforms: Patterns of income spending and coverage in four developing countries,' Results for development Institute, USA
4. Gwinji, G and Dhlakama D (2014) 'Zimbabwe results-based financing project - Evidence and lessons', PowerPoint presentation, MoHCC, Pandhari Lodge: Harare.
5. Chigumira G, Matsika W, Nyamadzawo Chiwunze G, ZEPARU (2014) 'Financial records review for semi-autonomous health institutions' ,ZEPARU, KIT, MoHCC, TARSC: Harare.
6. Chigumira G, Chiwunze G, Nyamadzawo J, Matsika W, Kok M, Toonen J (2014) 'Report of a field study on the sources, systems and channels of funding health from central to operational level in Zimbabwe', ZEPARU and KIT, for TARSC and MoHCC in the Rebuild programme: Harare.
7. Chigumira G, Nyamadzawo J, Chiwunze G, Matsika W, (2014) 'Organisational, institutional and governance arrangements and procedures for pooling, partitioning and cross subsidy of funds', ZEPARU, KIT, TARSC and MoHCC: Harare.
8. Chuma J and Okungu V (2011) 'Viewing the Kenyan health system through an equity lens: Implications for universal coverage,' *International journal for equity in health* 10(1):22.
9. CREHS (2009) Reducing User Fees: Implementation challenges and a possible solution.' Policy brief, CREHS UK . http://www.crehs.lshtm.ac.uk/downloads/publications/user_fees.pdf (accessed 14 March 2014).
10. Cromwell J, Triscolini MG, Pope GC, Mitchell JB and Greenwald LM (2011) 'Pay for performance in healthcare: Methods and approaches.' RTI Press. Available at: *http://www.rti.org/pubs/bk-0002-1103-mitchell.pdf* (accessed 31 January 2014).
11. Dambisya YM and Modipa SI (2009) 'Capital flows in the health sector in South Africa: Implications for equity and access to healthcare,' EQUINET Discussion Paper 76: Harare.
12. Gale Encyclopedia of Public Health (no date) 'Healthcare financing', Available at: *http://www.answers.com/topic/health-care-financing (accessed 31 January 2014).*
13. Gottret P, Schieber GJ and Water HR (2008) 'Good practices in health financing: Lessons from reforms in low- and middle-income countries', World Bank: Washington, DC.
14. Gottret P and Schieber G (2006) 'Health financing revisited: A practioner's guide', World Bank: Washington, DC.
15. Government of Zimbabwe (GoZ) (2014) Zimbabwe Agenda for Sustainable Socio-economic Transformation', Office of the President and Cabinet, Harare
16. Humphrey G (2013) 'Gabon gets everyone under one social health insurance roof,' *Bulletin world health organisation* (91): 318–19.
17. Inoua (2014) personal communication, 13 March 2014.
18. Lagomarsino G, Garabrant A, Adyas A, Muga R and Otoo N (2012) 'Moving towards universal health coverage: Health insurance reforms in nine developing countries in Africa and Asia', Lancet 380 (9845): 933–43.
19. Luoma M, Doherty J, Muchiri S, Barasa T, Hofler K, Maniscalco L, Ouma C, Kirika R and Maundu J (2010) 'Kenya health system assessment 2010', Health Systems 20/20 project, Abt Associates Inc: Bethesda, MD.
20. Macha J, Harris B, Garshong B, Ataguba JE, Akazili J, Kuwawenaruwa A, Borghi J (2012) 'Factors influencing the burden of healthcare financing and the distribution of healthcare benefits in Ghana, Tanzania and South Africa,' *Health policy and planning* 27 Suppl 1: i46–i54.
21. Matsoso MP and Fryatt R (2013) 'National Health Insurance: The first 18 months,' The South African Medical Journal 103:3.
22. Mbeng Mendou JP (2012) 'Financing innovative of healthcare in Gabon,' presentation.

23. McIntyre D (2012) 'Health service financing for universal coverage in east and southern Africa', EQUINET Discussion Paper 95. Regional Network for Equity in Health in Southern Africa: Harare.
24. McIntyre D, Garshong B, Mtei G et al. (2008) 'Beyond fragmentation and towards universal coverage: Insights from Ghana, South Africa and the United Republic of Tanzania,' SHIELD, published in *Bulletin of the World Health Organization* 86: 871–76.
25. Ministry of Health and Child Care (2013) 'Zimbabwe national health accounts report', MoHCC: Harare.
26. MoHCW, TARSC (2013) Report on Stakeholder Review of options for Domestic health Financing, 16 August, Bronte Hotel, Harare, MoHCW, TARSC/ EQUINET Zimbabwe
27. MoFED, ZIMSTAT (2009, 2010, 2011, 2012, 2013, 2014) and own calculations.
28. Nyakundi CK, Teti C, Akimala H, Njoya E, Brucker M, Nderitu R and Changwony J (2011) 'Health financing in Kenya - The case of RH/FP'. Healthy Action Project, German Foundation for World Population (DSW), Institute For Education In Democracy (IED): Nairobi.
29. Osika J, Altman D, Ekbladh L, Katz I, Nguyen H, Williamson JRT, and Tapera S (2010) 'Zimbabwe health system assessment 2010', Health systems 20/20 project, Abt Associates Inc.: Bethesda, MD.
30. Preker A and Carrin G (2004) 'Health financing for poor people. Resource mobilization and risk sharing.' The World Bank.
31. Vaughan K (2014) 'Costing Zimbabwe's Essential Health Benefit: Draft costing findings', KIT, September 2014.
32. Vaughan K, Toonen J, Berghuis-Mutubuki E, Dieleman M (2014) Desk Review of institutional arrangements for health financing in selected African countries, KIT Netherlands with TARSC, MoHCC Zimbabwe
33. WHO Regional Office for Africa (2012) State of Health Financing in the African Region: Discussion paper for the Interministerial Conference: Achieving Results and Value for Money in Health, 2-5 July 2012, Tunis, Tunisia.
34. Witter S and Garshong B (2009) 'Something old or something new: Social health insurance in Ghana,' *BMC international health and human rights* 9 (20).
35. Witter S, Toonen J., Meessen B., Kagubare J., Fritsche G., Vaughan K. (2013) 'Performance-based financing as a health system, reform– Mapping the key dimensions for monitoring and evaluation', publication accepted *BMC health services research.*
36. ZEPARU (2014) Desk Review of institutional arrangements for health financing in Zimbabwe, ZEPARU, TARSC, MoHCC, EQUINET in the ReBUILD project: Harare
37. ZEPARU, TARSC, MoHCW (2013), 'Literature review on earmarked taxes for health in Zimbabwe.' TARSC, MoHCW: Harare.

Abbreviations

AHFoZ	Association of Health Funders of Zimbabwe
CoH	City of Harare
DAC	District AIDS Committee
DEC	District Executive Committee
DMO	District Medical Officer
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GoZ	Government of Zimbabwe
HCC	Health Centre Committee
HSF	Health Services Fund
HTF	Health Transition Fund
LSTM	Liverpool School of Tropical Medicine
M&E	Monitoring & Evaluation
MAS	Medical Aid Societies
MoFED	Ministry of Finance and Economic Development
MoHCC	Ministry of Health Child and Care
NAC	National AIDS Council
NATPHARM	National Pharmacy
NIC	Nurse in Charge
PCN	Primary Care Nurse
PFMA	Public Finance Management Act
PFMS	Public Finance Management System
PMD	Provincial Medical Director
RBF	Results-based Financing
RDC	Rural District Councils
RGN	Registered General Nurse
TARSC	Training and Research Support Centre
TDA	Temporal Deposit Account
UHC	Universal Health Coverage
UNICEF	United Nations Children's Emergency Fund
ZEPARU	Zimbabwe Economic Policy Analysis and Research Unit

Annex 1: Analytical Framework

Topics	Issues
Revenue collection for health financing	Funds for health, by source (taxation, earmarked funds, community financing/out-of-pocket, external funding, private insurance, grants, loans), synergies over time and pooling of funds
	Management of health funds, decision making on collection, pooling, tracking and accounting
	Funding needs vs availability of funds – e.g. meeting the Abuja goal (15% national budgets)
Expenditure and **Resource allocation for** healthcare	Volume of funds from MoF to MoH, relative to other public goods - budgeted vs. expenditure
	Public Finance Management: how policy strategies are translated to budgets (MTEF), translated to time-bound financial plans (annual, 3-year plans, …) and monitored
	Respect of funding commitments according to agreed upon budgets and budgeting procedures
	Decision-making on fund expenditure, by purposes and levels of care, only; fungibility
	Type of expenditure, and their relative importance: between capital costs, recurrent costs such as salary- and non-salary costs, like drugs, transport, training & supervision
	Actual spending on healthcare service delivery by level (management/ policy making level)
	Predictability/variability of funding
	Processes/systems for decision-making on allocation at central level of the MoH to levels of care, priority programs, etc.– in theory and practices (actual spending)
	Processes, criteria and systems for resource allocation at decentralised level, for input-based budgets in a deconcentrated system: fund flows, procedures, instances in decision making
	Funding channels used between central and decentralised levels
	Technical and allocative efficiency: measures to ensure maximum health gains are achieved with the available resources and measures to maximise the welfare of the community
	Transaction costs
	Funding arriving at frontline workers, those providing health directly care to patients (proportion of total health spending …)
	Allocation of funds (across services, facility types and areas) based on local needs
	Alternative channels in the country: direct user fees, for CBHI schemes, private insurance, etc.: fund flows, procedures, instances involved in decision-making
	Strategies for targeting the poor and the vulnerable - e.g. geographical targeting, targeting of vulnerable groups like women and children or PLWHIV
Strategic health services **purchasing** arrangements	Arrangements (payment structures, subsidies) for different services and providers
	Funding different levels of care (primary/secondary/ tertiary)
	Provider payment mechanisms in use/disbursement mechanisms, timely payments
	Use of Performance Based Financing
	Type of services purchased from different providers and levels of care
	Purchasing arrangements at operational level
	Arrangements to ensure quality of care (through accreditation, professional norms and standards for quality of care; and to meet wants/ needs/ demand of users (“acceptability”)
Governance/ institutional framework of “purchasing entity”	**At central level**: decision-making processes on funding for health; distribution of roles and responsibilities; organisation of stakeholder involvement in accountability arrangements
	Mandates (distribution of roles and responsibilities) between centralisation and decentralization (deconcentration, devolution, privatisation) – and how this is controlled for
	At decentralised level: leadership skills at different levels
	Separation of functions to avoid conflict of interests
	Governance capacity and systems; technical, and management; to adapt and self-renew, to achieve coherence, to relate to external stakeholders, to act and commit
	Availability of performance management systems at all levels
	Accountability arrangements – on what, to whom, at what level, and power relationships
	Participation of external stakeholders – especially those representing demand-side
	M&E of providers – indicators used, information flow to hold providers accountable on performance (quantity and quality of care) –use of contracts, norms and standards
	Comprehensiveness, regularity, reliability, workload
	M&E of the purchasing entity - list of indicators, architecture of information flow, analysis of information, reporting, use of information for decision-making
Affordability for users	Measures for increasing financial accessibility, financial protection – overall and disaggregated
	Availability and accessibility of services; coverage – absolute and for different groups
	Systems for cross-subsidising