Desk Review of purchasing arrangements for public health services in Zimbabwe

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for

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Executive Summary

This research is within the 'Rebuild' programme supported by Liverpool School of Tropical Medicine to Training and Research Support Centre (TARSC) and Ministry of Health and Child Care (MoHCC) Zimbabwe. The ReBUILD Programme in Zimbabwe seeks to take forward a programme of work within the context of the work in Zimbabwe on health financing policy and on Universal Health Coverage (UHC). It aims to implement health systems research and stakeholder dialogue and capacity building of the Zimbabwe health system, that seeks to move from the immediate recovery measures implemented in 2009-2012, towards building the foundation for longer term rebuilding of the Universal Health system, as set out in the National Health Strategy (NHS), taking into account equity in access and coverage. One element of this work is to identify options for improving the purchasing arrangements between central and local government, and between government and private (not for profit) providers of primary care and district services, to ensure purchaser obligations on delivery of the EHB and on financial protection. This report provides a background desk review of literature on the purchasing arrangements between central government and (i) local government and (ii) private (not for profit) providers of primary care and district services using national reports.

Purchasing of health services thus implies a contractual relationship between the purchasing agent (the entity pooling risk on behalf of a particular group or population) and the service provider (health institutions providing health care services). The contractual agreement should state the health benefit covered by the fund, the population covered and the proportion of the total cost to be met. Purchasing of health services can be done in three ways.

1. for government to provide budgets directly to its own health service providers (Integration of purchasing and provision) using general government revenues and sometimes insurance contributions.
2. for an institutionally separate purchasing agency (e.g health insurance fund or government authority) to purchase services on behalf of a population (a purchaser or provider split).
3. for individuals to pay providers directly for services.

The 100 day plan, the National Health Strategy and the Health sector investment Case are documents that prioritise health sector interventions and seek to pool resources to respond to the both the demand side and the supply side of the health system. The enhancement of the UHC objectives in the purchasing of services in the public health system in Zimbabwe is done through the following coverage mechanisms; free primary health care as a government policy commitment to the Alma Ata declaration on Primary Health Care, WHO 1978; User fee exemption for Children under five, pregnant women and the elderly for hospital services and Social safety net for the indigent groups through the Assisted Medical Treatment Order administered through the Ministry of Public Labour and Social Welfare; and free health care provision for security forces (army, air force, and police) and the Ministry of Justice Prison services. Adequate financing for these coverage mechanisms is a primary concern and whether availed funds benefit the intended beneficiaries.

The report explores further the purchasing arrangements in Zimbabwe

- in central government provided services
- from Local Authorities
- from Mission health Institutions
- by parastatals
- by bilateral and multilateral agencies
- through the National Social Security Authority, and
- by private insurers

The purchaser provider arrangements in both the provincial and district level is enshrined within the terms of reference of the purchaser/ regulator/custodian of the system at that level. There is however no clear separation of functions. Whilst work is in progress to define the cost of the essential health benefit clear contractual arrangements between central government and public providers of health services need to specify the cost sharing between the state and the patient, the population to be covered and the services to be covered. Planning documents allude to the need for MOHCC to establish a Memorandum of Understanding with ZACH to effectively purchase services from mission institution however no evidence was established to confirm whether this had been done. It finds some active forms of purchasing, such as the Global Fund and the Health transition fund, and strategic purchasing in the Results based financing for a limited set of interventions, as well as promising practices in the purchase of HIV services through the National Aids Levy and Zimbabwe National Family Planning Council. Private health insurance and private social insurance (NSSA workers compensation fund) are found to be spending more on investments and administration and other areas than on direct service provision. The enhancement of regulatory framework on the application of pooled funds for private for profit health and not for profit health insurance is an area that requires closer attention.

The report thus highlights a number of challenges in this respect, that relate to the purchasing of services, ie

The falling level of public funds has not only left households vulnerable to catastrophic health spending, but has weakened governments ability to set and implement the agreements with other providers needed to widen access to core services. The predictability of resources to purchases services is an essential function for access, equity and quality health services. This calls for improved domestic financing and draws attention to the need for more effective purchasing using the limited resources.

There is a question of whether purchasing is being effectively and formally used to ensure national policy across all providers. In the absence of more formalized arrangements it can be questioned whether policies, strategies and guidelines, such as the core health services package, are de facto binding and articulated for all including the private sector.

The third challenge is in relation to clarity on the scope of what is purchased, and the need for formal agreements to stipulate the cost sharing between the state and the patient and the services this is for, including also the prevention services.

The MOHCC has no clear separation of functions, and neither do Mission health facilities and local authority services. There are no formal agreements or contracted outputs or outcomes. Health services purchasing such as the case with the National Aids levy and the Zimbabwe National Family planning council appear to be good practices that indicate within the public system how to separate purchasing from provision and regulation functions and to make central government purchasing more effective.

Finally there are challenges in management arrangements: What is not found in the literature and will need to be further explored are the constraints to the flow of health care processes and services, due to the bureaucratic management and reporting structures. Further the working relationships of all these three parties need to be harmonised and accepted by all given the different management frameworks.

The paper outlines follow up research to further explore these issues and the options for improved purchasing.

1. Background

This research is within the 'Rebuild' programme supported by Liverpool School of Tropical Medicine to Training and Research Support Centre (TARSC) and Ministry of Health and Child Care (MoHCC) Zimbabwe. The ReBUILD Programme in Zimbabwe seeks to take forward a programme of work within the context of the work in Zimbabwe on health financing policy and on Universal Health Coverage (UHC). It aims to implement health systems research and stakeholder dialogue and capacity building of the Zimbabwe health system, that seeks to move from the immediate recovery measures implemented in 2009-2012, towards building the foundation for longer term rebuilding of the Universal Health system, as set out in the National Health Strategy (NHS), taking into account equity in access and coverage. One element of this work is to identify options for improving the purchasing arrangements between central and local government, and between government and private (not for profit) providers of primary care and district services, to ensure purchaser obligations on delivery of the EHB and on financial protection.

This report provides a background desk review of literature on the purchasing arrangements between central government and (i) local government and (ii) private (not for profit) providers of primary care and district services using national reports.

2. Health financing and the purchasing of services

2.1 Financing universal health systems

Health financing for Universal Health Coverage (UHC) as a goal is currently at the centre of debates about health service provision. UHC implies that, all people can access and use the promotive, preventive, palliative and curative services that they need (vs that they demand) --and that these services must be of sufficient quality to be effective, while ensuring that using services does not expose people to financial hardship or impoverish them. It means ensuring access and closing inequalities in health. It includes being accountable and transparent on how finances are managed and in the delivery on these entitlements.

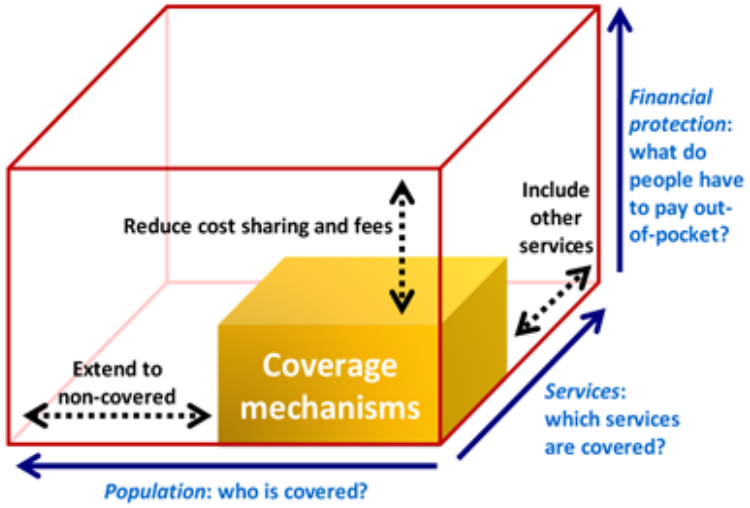
UHC and the concept of the "Right of everyone to the enjoyment of the highest attainable standard of physical and mental health" as adopted by the United Nations General Assembly 2012, compels governments to make available adequate resources for health and to ensure that more is achieved with the pooled funds (United Nations 2012). In order to achieve the latter, countries need to adopt an approach to health financing reform that looks at opportunities to improve equity, quality and efficiency at a time when money is limited. The achievement of health service delivery gains can only be obtained through government's ability to progressively realise the health expectations of its population and the continued effort to attain positive change in health indicators, with the active involvement of communities in the management of their health services. However, a macro outlook of the system does not give a true reflection of system performance (efficiency). Health financing functions need to be analysed intrinsically so as to establish the adequacy and equitable distribution of the resources. The expectations of consumers of health services on the health benefit need to be aligned with the ability of the state to meet those expectations. The arrangements to avail equitable access to the health benefit by the population from providers of health services also needs to be realigned, towards ensuring that systems deliver on universal access and coverage.

Universal health systems aim to ensure equity in the mobilisation, allocation and distribution of resources, and transparency and accountability in service provision. With limitations in resources mobilised relative to need, trade-offs have to be made in the use of scarce pooled funds. For UHC such decisions are made taking into account; (i) the proportion of the

population to be covered, particularly those with health need that are vulnerable to impoverishment from heath expenditure; (ii) the range of services to be made available (as a defined package of services for progressive realisation of the right to health); and (iii) the proportion of the total costs that can be met through resource mobilisation.

Figure 1 below illustrates these three dimensions.

Figure 1 Three Dimensions to consider when moving towards universal coverage



Source: WHO 2010

The box in Figure 1 shows the pooled funds in a hypothetical country where about half of the population is covered for about half the possible services, but where less than half of the cost of these services is met from coverage mechanism/ pooled funds.

The structure and functions of the health system reflects the influence of policy measures on the providers of health services and their ability to respond to the expected delivery of a package of health services that correspond to available resources. The progressive realisation of the health benefit is an outcome of health system planning, including with the involvement of communities in the planning and management of their health services. The total resources available is an important factor in realising the delivery of promised health benefits. Hence for example in improving the government budget allocation to health as a percentage of the total government budget (to meet the Abuja declaration 15% of government budget) and the per capita health expenditure in line with the WHO per capita health expenditure recommendations ($34 / capita for HIV, TB and Malaria and $60 / capita for wider health system costs) is one factor that influences the ability to deliver on an essential health benefit. This depends on the capacity of the state to establish revenue flows for health and to spend these resources in ways that deliver on the essential health benefit towards fulfilment of the right to health. Between the mobilisation of resources and the delivery of services, the state can exercise a range of purchasing arrangements to align health expenditures to meet national goals, such as financial protection of vulnerable groups.

2.2 Purchasing health services

The purchasing of health services determines how the available (pooled) resources are used and whether or not funds translate into effective health services that are available to all. It is thus a critical interface in the financing of universal health coverage between the mobilisation of resources and their use by providers to deliver services.

Purchasing of health services implies a contractual relationship between the **purchasing agent** (the entity pooling risk on behalf of a particular group or population) and the **service provider** (health institutions providing health care services). The contractual agreement should state the **health benefit** covered by the fund, **the population covered** and **the proportion of the total cost to be met**.

Purchasing of health services can be done in three ways.

1. One is for government to provide budgets directly to its own health service providers (Integration of purchasing and provision) using general government revenues and sometimes insurance contributions.
2. The second is for an institutionally separate purchasing agency (e.g. health insurance fund or government authority) to purchase services on behalf of a population (a purchaser or provider split).
3. The third is for individuals to pay providers directly for services (WHO 2010). Many countries use a combination of either of the three

Key Issues; in implementing coverage mechanisms the policy relevant aspect that need to be addressed to effectively purchase health services toward Universal Health Coverage include;

- Effective User fee exemptions. For these to work they require a funding mechanism to compensate facilities for lost revenue
- Reduction on overreliance on direct spending which requires the introduction and strengthening of prepayment and pooling
- Mandating of contributions by those who can afford to pay through taxation and / or insurance contributions
- Reducing fragmentation of prepaid funds by combining them into one pool rather separate funds which in turn makes it easier to achieve equity goals
- Complementarity of voluntary schemes such as community health insurance or micro insurance, where compulsory sources provide minimum levels of prepayment. If they are able to redirect some their payments into prepayment pools, they can expand protection to some extent against the financial risks of ill health.
- Use of conditional transfers for reducing financial barriers to access in instances where direct payments have been eliminated. Indirect costs such as transport and accommodation costs to obtain treatment may prove prohibitive.

Policy makers intending to move away from user fees and other forms of direct payments have three interrelated options. The first is to replace direct payments with forms of prepayment, mostly commonly a combination of taxes and insurance contributions. The second is to consolidate existing pooled funds into larger pools, and third is to improve the efficiency with which funds are used (WHO 2010).

The traditional way in which service providers are reimbursed by central government for the services rendered or are provided budgets according to the previous year's allocation is called **passive purchasing.**

Active purchasing seeks to improve quality, equity and efficiency by considering the populations health needs and the interventions that best meet those health needs using the available resources. It also includes the appropriate mix of curative, promotive, preventive and rehabilitative services as well as how and from whom the services should be purchased.

Strategic purchasing compels countries to decide where they can operate based on the ability to collect, monitor and interpret the necessary information, and to encourage and enforce standards of quality and efficiency.

The greater the effort to move towards active purchasing the more efficient the system is likely to be. The most efficient way of purchasing services is strategic purchasing as it bridges the gap between plans and budgetary allocation of resources by taking in account three process decisions;

- Which interventions should be purchased in response to the population needs and wishes, taking into account national health priorities and evidence on cost-effectiveness and cost benefit.
- How providers should be regulated and services should be purchased, including contractual, reimbursement and incentive mechanisms; and
- From whom they should be purchased in light of providers relative levels of quality, equity and efficiency (Busse et al 2007)

3. Zimbabwe's health system

The discussion in this paper on purchasing is set in the context of Zimbabwe's health system, further described in this section.

Zimbabwe has a public sector led health system, which when complemented by private not for profit services, i.e. Mission Hospitals and Non-Governmental Organizations (NGOs), is by far the largest provider of health care services in Zimbabwe.

However, years of economic decline pre 2009, political instability and a reduction in development assistance resulted in a significant decrease in funding for social services. The health system had been predominantly funded through government tax revenue which was at 39% total health spending in 2001 (MoHCW 2001a). The National Aids Levy funding for HIV services had been severely constrained due to increased levels of unemployment and decreased industrial activity. Mission health institutions were also facing hardships as they were being supported through government grants for salaries and capital and recurrent expenditure. The country's health sector was operating in an environment characterized by a humanitarian crisis, further exacerbated by the worst cholera epidemic in 2008 that the country ever experienced. The increasing levels of unemployment and poverty in the country worsened the plight of the poor in accessing health care services, and many were unable to pay the health fees levied by health providers (Sikosana 2009).

The formation of the Government of National Unity in 2009 saw the development of a plan to revitalise the health system in the form of the 100 day plan (Sikosana 2009). The plan recognised that health financing is a key to health system performance in terms of equity, efficiency and quality of services. The conceptual framework of the plan was to restore basic health services and to provide social safety nets to vulnerable groups to access health services, thereby consolidating the policy of universal access to primary health care services.

It was a government led revival plan of the health system that recognized weaknesses on both the supply side and demand side of the health system. It encompassed universal access to primary care services and predominantly focused on the capacity of the health system to provide health services. The plan was developed through an inclusive bottom-up approach that incorporated views from community leadership. The activities in the plan aimed to embrace progressive financing mechanisms, to remove barriers to access to health care, to increase the government allocation to health; to diversify the allocation of the government health budget for curative vs. preventive services; personnel vs. supplies and

investment in human resources vs. physical resources. It also set plans for working with civil society (Sikosana 2009).

The health status at the time of the plan was noted to be poor, with a burden of disease reported to be dominated by preventable diseases such as HIV/AIDS, malaria, tuberculosis, diarrheal diseases, nutritional deficiencies, vaccine preventable diseases, maternal and neonatal conditions (Sikosana 2009).

In summary, universal health coverage objectives that were embraced in the plan in terms of purchasing of services set policy options and provisions for;

- Access to services by vulnerable groups through the review of the policy on user fees. This was motivated to ensure that financial barriers to health services are removed, noting that Rural district Councils and mission health institutions charge patients for primary care services at rural health centres.
- Increased government expenditure on health to ensure efficient and responsible use of resources and to move towards the $34 per capita health spending recommended by the Commission on Macro-economics in Health for achievement of Millennium Development Goals (MDG's) 4, 5 &6.
- Incentives for health workers performance
- Strengthening partnerships in the provision of health services with local government institutions, non government organisations (NGOs) and missions, through the development and signing of Memoranda of Understanding between these organizations and the MOHCC, and through contractual arrangements based on the delivery of an agreed package of services of defined quantity and quality, with payments from MOHCC.
- A sector wide approach to health development for partners to recognize the government commitment to partnership in health development, and to transparency and accountability in the use of its own resources and those from overseas development assistance (Sikosana 2009).

These policy recommendations asserted government's commitment to reform in health services with purchasing measures taking into account key dimensions UHC.

The 100 day plan was clear on what the government would undertake to revive the health system after its near collapse at the peak of the economic recession. It was a successor to the 1997 to 2007 National Health Strategy whose thrust was to improve the quality of life of Zimbabweans (MoHCW 1997). The subsequent National Health Strategy (NHS) 2009 to 2013 was aimed at resuscitating the health sector and putting Zimbabwe back on track to achieve the millennium development goals (MoHCW 2009). The NHS recognized the need for government to take the lead in the financing of health services, as was the case before the recession. It also emphasized that partners should fund to fulfil the government plan. Recognition was given to the fact that, in a resources constrained environment, it was not possible to implement the NHS in full in the five years and a three year rolling plan was to be developed as a way of phasing the implementation of the NHS, including to meet the health MDG's. The three year rolling plan was the basis for the Health Sector Investment Case 2010-2012 that was a resource mobilization blueprint aimed at accelerating progress towards the MDG's by aiming to raise $19per capita over three years that would be used to reduce under five and maternal mortality of 38% and 17% respectively (MoHCW 2010).

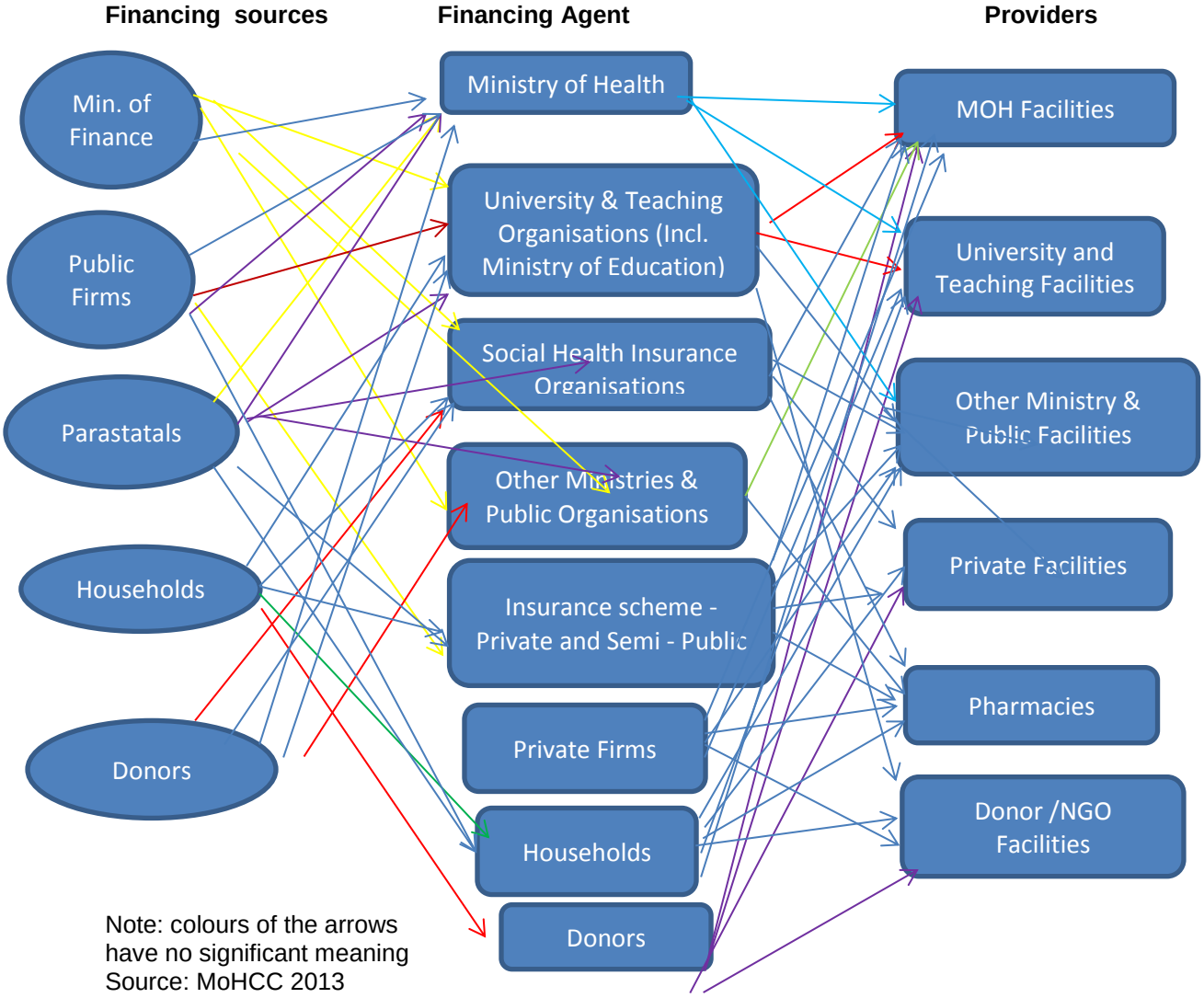
The Health sector investment case embraced the Primary health care approach as articulated in the NHS and supported the role of communities in activities that will determine their own health. Community level services were assessed to be low due to low level of knowledge, staff, medicines and compounded by socio-cultural and religious beliefs. At the health facility level user fees were identified as barriers to access.

The 100 day plan, the National Health Strategy and the Health sector investment plan are documents that prioritise health sector interventions and seek to pool resources to respond to the both the demand side and the supply side of the health system. The policy level planning integrates program planning to service provision and in so doing there is more inclination to the application of a push system in favour of the supply side to ensure availability of services, human resources, medicines and commodities, equipment and infrastructure than to the concerns of the patient which are; financial barriers to access, timely response to service need, appropriate and quality care that is adequately informative of the condition and the availability of medicines. Purchasing of health services for UHC is aimed at ensuring access to a package of curative and prevention services at the time of need without discrimination.

4. Purchasing arrangements in Zimbabwe's public health system

Purchasing of health services in the public health system in Zimbabwe is guided by the operating framework of the Ministry of Health and Child Care functions mandated to the office of the Minister of Health and Child Welfare (MoHCW 1993) as well as the provisions of the Public Health Act (Chapter 15:09). (MoHCW 2001). Figure 1 shows the relationships between and range of funders, financing agents and providers in Zimbabwe.

FIGURE 1: Spider Web Flow Of Funds From Sources To Providers



Note: colours of the arrows have no significant meaning
Source: MoHCC 2013

The services covered by from all providers of health services in the public health delivery system that is from MOHCC, MLGPW and the private Not for profit (Mission) health facilities include;

- Preventive Services
- Curative Services
- Health and Management Information Systems
- Laboratory services
- Supply of Safe Blood

Table 1 below shows the distribution of funds from sources to financing agents. The level of public funds allocated to different providers is discussed in section 4.2.

Table 1: Distribution of funds from Sources to Financing Agents

2010 National Health Accounts - Financing source by Financing Agent(FSXFA) $US

	Financing Sources										
	FS.1 Public funds				FS.2.Private Funds						
	FS.1.1.1	FS.1.1.2	FS.1.	Total	FS.2.1	FS.2.2	FS.2.3	FS.2.4	Total	FS.3	Total
Financing Agents	Central Gvt Revenue	Municipal Revenue	Other Public Funds		Employer funds	Household funds	NPISH	Other private funds		Rest of the world	
HF.1.1.1 Central Government	180,381,704.00			180,381,704.00					-	51,128,690.00	231,510,394.00
HF.1.1.3 Local/Municipal Gvt	7,870,007.00	5,672,462.92		13,542,469.92			194,308.33		194,308.33	90,256.25	13,827,034.50
HF.1.2 Social security Funds				-	43,835,378.00			31,988,459.00	75,823,837.00		75,823,837.00
HF.2.1 Private Social Insurance				-	4,016,283.33	188,477.67		90,841.67	4,295,602.67		4,295,602.67
HF.2.2 Private Insurance Enterprises				-	189,937,462.00	21,104,160.00			211,041,622.00		211,041,622.00
HF.2.3 Private Household out of pocket				-	161,057.76	434,347,660.62			434,508,718.38		434,508,718.38
HF.2.4 NPISH	20,522,121.00			20,522,121.00			2,137,318.33		2,137,318.33	166,972,586.66	189,632,025.99
HF.2.5 Private firms and corporations	239,982.00			239,982.00	2,848,061.53				2,848,061.53		3,088,043.53
HF.3 Rest of the world				-					-	9,867,260.07	9,867,260.07
Total funds Provided	209,013,814.00	5,672,462.92	-	214,686,276.92	240,798,242.63	455,640,298.29	2,331,626.67	32,079,300.67	730,849,468.25	228,058,792.98	1,173,594,538.14

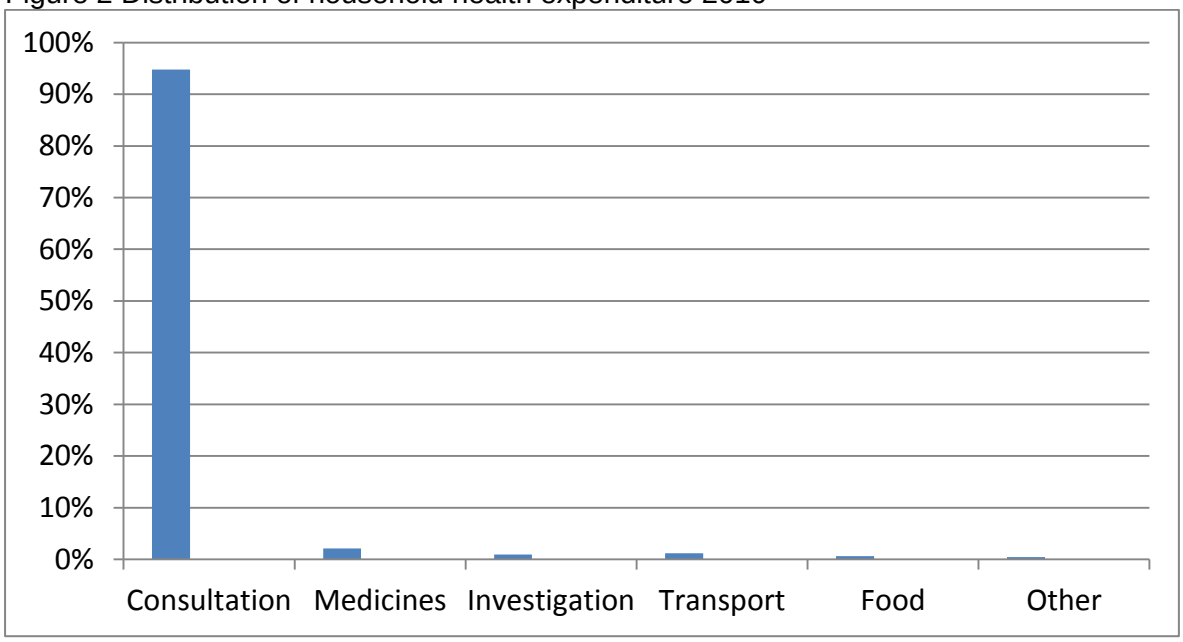
Source: MoHCC 2013

4.1 Purchasing/ Financing agents in Zimbabwe

Table 2 below shows that in 2010 the primary purchaser of health services in the health system was the household, which carried a significant health financing burden of 37% of the total health expenditure. Central Government and private insurance financed the system with 20% and 18% respectively.

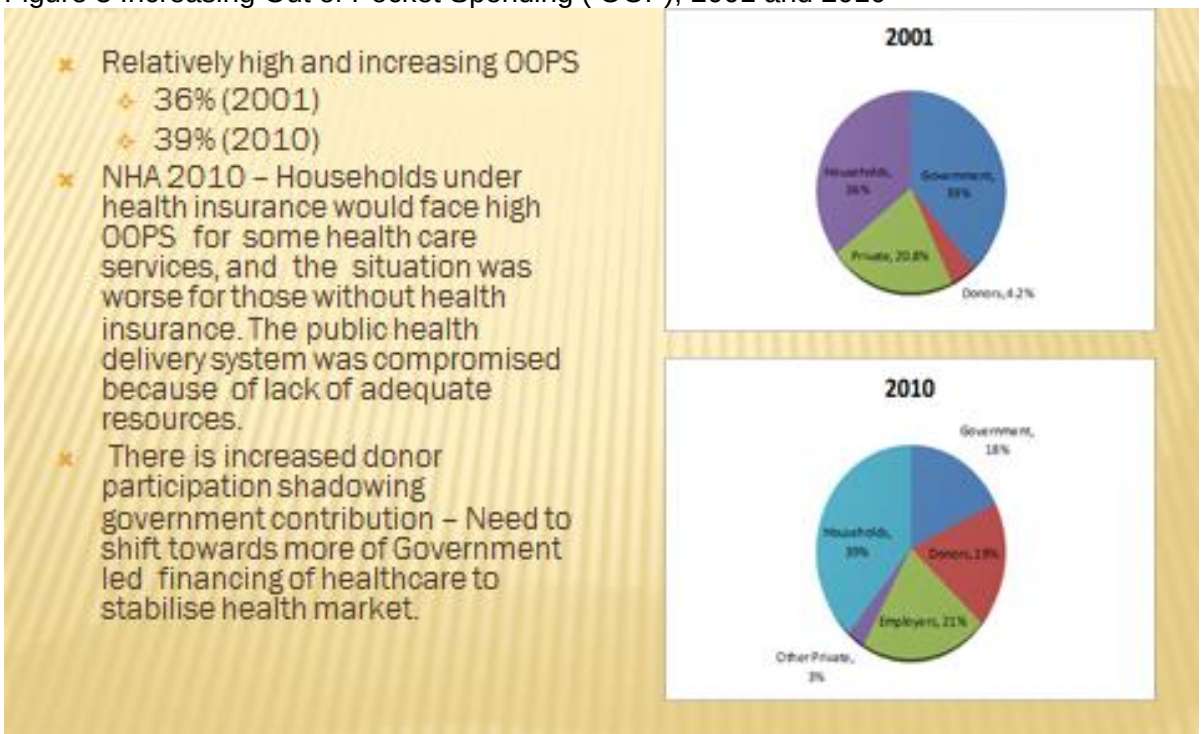
Figure 2 shows evidence from NHA 2010 that households still face user fees at point of access to health facilities, particularly for consultation costs relative to other expenditure categories. Figure 3 highlights that the burden of health financing is increasingly falling to the household, despite a central government policy to protect the public from copayments and out of pocket payments.

Figure 2 Distribution of household health expenditure 2010



Source: MoHCC 2013

Figure 3 Increasing Out of Pocket Spending (OOP), 2001 and 2010



Source: MoHCC 2013

The majority of the population access their medical services from the public system. The free user fee policy is for primary care services, which implies for district level hospitals and health centres. While the primary care level in the public sector is supposed to be free as per the primary health care policy, in practice it is evident that people are facing user fees in some public health facilities (e.g. local government) and in secondary and higher level health facilities.

Only 10% of the population is covered under private voluntary insurance, and those covered often face co-payments at point of access to services or out of pocket payments for

purchase of medicines.. With a high informal sector in Zimbabwe the few that access health services from the private providers face high out-of-pocket payments.

Table 2 Financing Agents in Zimbabwe 2010

FINANCING AGENT	AMOUNT US$	% total heath expenditure
Central Government	231 510 394	20
Local Government	13 827 034	1
Social Security Funds	75 823 837	6
Private Social Insurance	4 295 602	0
Private Insurance Enterprises	211 041 622	18
Household Out Of Pocket	434 508 718	37
Non Profit Institutions Serving Households	189 632 026	16
Private Firms And Corporations	3 088 043	0
Rest Of The World	9 867 260	1
TOTAL	1 173 594 538	100

Source: MoHCC 2013

4.2 Purchaser-provider arrangements in Zimbabwe

The different providers in Zimbabwe are shown in Figure 1 earlier and their numbers in Table 3 below.

Table 3 Health facilities by ownership and level of care, 2013

Level of Care	**Central Government**	**Mission**	**RDC**	**PRIVATE**	**TOTAL**
Primary:					
RHCs	301	55	525	109	990
Rural hospital	55	61	0	0	116
Secondary (District)	50	8	0	0	58
Tertiary (Provincial)	8	0	0	2	10
Quaternary(Central Specialist)	7	0	0	12	19
Grand Total	**421**	**124**	**525**	**221**	**1193**

Source: MoHCC 2013

The Public Sector includes the Ministry of Health and Child Care and Local Authorities as the major providers of health services in Zimbabwe. Other providers in this category of providers include the Defence Forces, the Prison Services, the Police, the Ministry of Education and the Ministry of the Public Service, Labour and Social Welfare which provides Occupational Health Services. The category of *local authorities* includes Rural District Councils (RDCs)and Urban local Authorities.

The Private Medical Sector includes the **Private for Profit Medical Sector** (Private Industrial Clinics, Private Hospitals, Maternity Homes and General Practitioners), Traditional Health Practitioners and Complementary Health Practitioners.

The Private Not for Profit Sector providers includes Medical Missions and other Non-Governmental Organizations (NGO's). The NGO's usually concentrate on the provision of specific medical interventions such as treatment of HIV and TB as is the case with MSF in Epworth which specializes in HIV and TB services. The Missions health facilities receive a grant from the MOHCC to cover the full costs of approved staff, capital projects, drug and other supplies. The Zimbabwe Association of Church Related Hospitals, ZACH, represents this group of Hospitals.

The code of professional practice for all health practitioners in Zimbabwe is regulated by the Health Professions Act Chapter 27:19 (2000). The Traditional Practitioners' Act (1981) established the Zimbabwe National Traditional Healer's Association, ZINATHA which also provides a framework for practice and regulation of its members.

The Medical Services Act provides for the establishment and the operation of both public and private hospitals and Medical Aid Societies. The Act also provides for the establishment of Hospital Management Boards at Central and Provincial Hospitals. Minimum standards of practice for both hospitals and medical aid societies are also provided for in the act (MoHCW 2001).

Hospital services are organised to function on the basis of increasing levels of sophistication. Patients with more complex health problems are expected to be referred up the referral chain. The point of entry for uncomplicated cases is the RHC and the clinic at the Primary level of the system. Clinics are staffed by two nurses.

The District Hospital provides referral and supervisory support to the network of clinics and RHCs. Patients have their first contact with a medical doctor at this level within the health delivery system.

The provincial and general hospital levels provide referral support to the district hospitals. There is a limited number of clinical specialists at the provincial and general hospitals. There are 6 Central Hospitals all located in the three major urban areas of Harare, Bulawayo and Chitungwiza. These are teaching hospitals affiliated to the Medical Schools. These hospitals provide, together with private for profit hospitals, the most sophisticated type of services within the country.

Table 4 shows the distribution of funds from financing agents to these providers for 2010

Table 4 Distribution of Funds from Financing Agents to Providers, 2010

2010 National Health Accounts - Financing Agents by Provider(FAXP) $US

	Financing Agent										
	FF.1 General Government						HF.2.Private Sector				
	HF.1.1 Territorial government			HF.1.2	HF.2.1	HF.2.2	HF.2.3	HF.2.4	HF.2.5	HF.3	
Provider	HF.1.1.1 Central Gvt Revenue	HF.1.1.2 Municipal Revenue	HF.1.1 Other Public Funds	Social Secur Funds	Private Social Insurance	Other Private Insurance	Private Household out of Pocket	NPISH	Private fir and corporations	Rest of the world	Total
HP.1 Hospitals	53,962,768.00	3,041,469.98		80,966.78	618,163.33	29,296,564.00	96,159,159.80	6,918,852.00	1,385,089.82	135,732.26	191,598,765.97
HP.2 Nursing and Residential care Facilities	780,535.00										780,535.00
HP.3 Providers of Ambulatory Services	3,108,977.00	10,962,005.74		40,883.00	945,263.00	52,640,368.00	309,482,223.29	49,345.35			377,229,065.38
HP.4 Retail Sale and other providers of Med Gds	93,730.00			7,456.30	44,278.67	11,404,151.00	25,584,393.75	66,250.00	233,212.50		37,433,472.22
HP.5 Provision and Adm of Pub Health Programmes	51,128,690.00										51,128,690.00
HP.6 General Admin Health and Insurance	122,064,709.00										122,064,709.00
HP.7 All other industries	239,982.00						811,955.80	86,466.27	2,848,061.53		3,986,465.61
HP.8 Institutions providing health related services	131,003.00										131,003.00
HP.9 Rest of the world										9,731,527.81	9,731,527.81
Provider not specified by kind/Not allocated to providers				75,694,530.92	2,687,897.67	117,700,539.00		182,511,112.37			
National Health Expenditure	231,510,394.00	14,003,475.72	-	75,823,837.00	4,295,602.67	211,041,622.00	432,037,732.65	189,632,025.99	4,466,363.85	9,867,260.07	1,172,678,313.95

Source: MoHCC 2013

Health Service Packages are organised on the basis of increasing level of sophistication and defined from community level interventions to quaternary/sophisticated hospital level services.

The primary health care package is stated in the District Core Health Services handbook 1995 by the Ministry of health and Child Care (MoHCW 1995) . The Zimbabwe government in its National Health Strategy 2009-2013 proposed to review the provision of the basic entitlements to health (MoHCW 2010). In the February 2012 a national stakeholder meeting on the Zimbabwe Equity Watch, participants agreed that defining comprehensive health care entitlements calls for technical and policy dialogue (including with Parliament and civil society) to establish, cost and raise awareness on a clear set of comprehensive healthcare entitlements for the population at the various levels of the health services (MoHCW, TARSC 2012).

As a starting point it was proposed that the District core services defined by MoHCW in 1995 need to be updated; initially at community, primary and district level- against the current epidemiological profile, be subject to review and input from communities and sectors that provide public health inputs, and be costed in various provinces, at various service levels (community, primary and secondary levels) and by various providers (central, local government, missions and other private).

An assessment was thus implemented in late 2012 by Training and Research Support Centre (TARSC), working with review input from Ministry of Health and Child Welfare and with community based researchers from various civil society organisations. The assessment aimed to determine community, local leaders and frontline workers views on key areas relevant to the framing of the Essential Health Benefit (EHB). It presented community level views on;

a. priority public health problems the EHB should address and any important features of their distribution by social and economic groups that services need to respond to.
b. the services for health promotion, prevention, PHC, treatment and care, rehabilitation and palliative care that communities expect to see in place at community, primary and district level that would (i) address these priority health needs (ii) fulfil the constitutional right to health services, and
c. the roles and contributions of ministry of health, other ministries, other agencies and of communities (households, communities and leaders) in providing these services. (TARSC 2012)

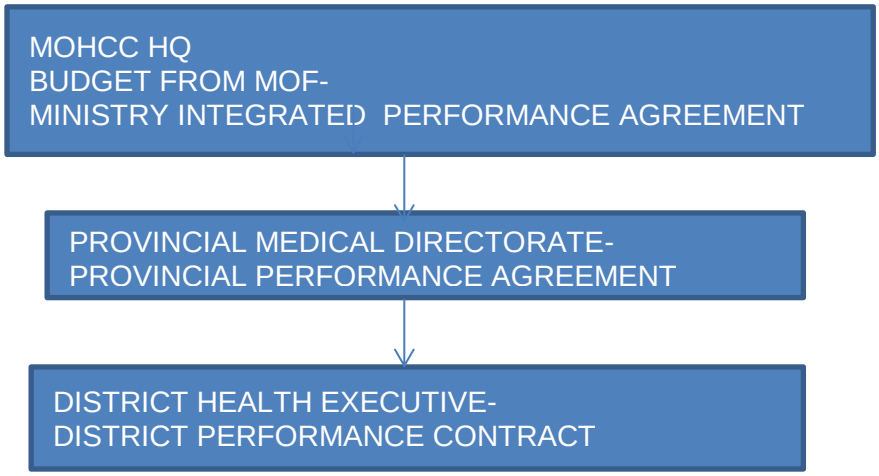
Respondents identified the major health needs and problems in Zimbabwe for which services should be provided for ALL people, no matter where they live or what social or income group they come from. The findings of this report where incorporated in the validated review of the core health services package done in 2013 by the MOHCC, which is currently being used for costing by the Ministry in collaboration with the Royal Tropical Institute (KIT) and UNICEF to determine what would be an Essential Health Benefit package that the government would afford in fulfilment of the right to health.

4.3. Purchasing arrangements in central government provided services

Central Government is represented by the Ministry of Health and Child Care (MoHCC) as a financing Agent. MoHCC purchases health services through an input system or line item budgeting for service provision from MoHCC facilities and Rural District Councils (MoFinance 2010). The MoHCC through the Health Services Board employs all health workers in the health institutions of both providers (MoHCW 2001). The supply of medicines and commodities to all institutions is done through the National Pharmaceutical company, which when fully capacitated will be able to operate the pull and push system (MoHCW 2012).

The purchasing and provider roles of each level of the public system are shown in Figure 4 below and described in this subsection.

Figure: 4 MOHCC purchasing decentralised purchasing units



Source: MoHCW 2001b

The Provincial Medical Directorate is a functional extension of the national level. The Provincial Medical Director's office is responsible for co-ordinating the delivery of health services at the provincial level and provides technical supervision and support to the provincial hospital and district health teams. The office ensures that national policies and priorities are implemented.

The office of the PMD is responsible for the following purchasing functions amongst other duties:

- Negotiate service contracts with the District Health Executive and Hospital Health Executives.
- Facilitate the development of and approve operational plans, which should be in line with national health policies on one hand and also ensuring that they cover operational level peculiarities (negotiating and concluding service contracts with providers).
- Facilitate the development of budget estimates, resource allocation, expenditure controls, and revenue collection.
- Disburse funds to support agreed upon and approved plans (MoHCW 2001b).

The District Health Executive runs the district health system and is responsible for providing and managing the strategic framework within which health services are provided. In doing so, the District Health Executive performs the following purchasing tasks/functions amongst others to ensure the provision of services to the population in the District.

- Organizing and running of the district hospital services.
- Management of all government health facilities within the district.
    - Support provider units in assessing and planning for local health needs taking into account national policies and priorities.
    - Support providers in setting targets and agreeing to service contracts.
    - Support providers in achieving targets as agreed in service contracts.
    - Monitor and evaluate the performance of providers in meeting agreed targets and ensure that quality health services are being delivered.
- Monitoring and evaluating health care performance in the district in terms of quality and continuity and to take corrective action where required (MoHCW 2001b)..

The purchaser provider arrangements in both the provincial and district level are enshrined within the terms of reference of the purchaser/ regulator/custodian of the system at that level. There is no clear separation of functions or provider and purchaser split, and there is a form of passive purchasing.

While a line item budget is intended to ensure that MOHCC and rural district council health facilities are able to deliver on the stated services for a district health system, provincial hospital and Central hospital packages, the available resources do not always allow access to the laid down services for each level of care.

Within this budget, a Results Based Management framework illustrated by Figure 2 above is applied and financed through the government budget as well as the vote of credit (donor funds). The basis for allocating resources to the MoHCC is the integrated performance agreement. This states the service interventions and targets the MOHCC plans to achieve. It includes community participation, development in health service management and health worker performance standards. This performance contract is signed between the Secretary for Health and Child Care and the Chief Secretary to the President and Cabinet. The same performance contracting process is replicated for the Provincial and District level where the Permanent Secretary signs a contract with the Provincial Medical Director and the Provincial Medical Director signs with Districts Medical Officer respectively. Within operational levels, performance contracting is done to the individual level. The resources allocated to the Integrated Performance Contract from the MoFinance are effectively the MoHCC budget. These resources are used to purchase services from providers of health care taking the following health services coverage mechanisms into account.

i. Free primary health care as a government policy commitment to the Alma Ata declaration on Primary Health Care, WHO 1978 (MoHCW 2001, 2009; Sikosana 2009)
ii. User fee exemption for Children under five, pregnant women and the elderly for hospital services (MoHCW 2001, 2009; Sikosana 2009); and
iii. Social safety net for the indigent groups through the Assisted Medical Treatment Order administered through the Ministry of labor and Social Amenities.
iv. Free health care provision for security forces (army, air force, and police) and the Ministry of Justice Prison services. (MoHCW 2009; 2011)

A Social safety net in the form of the Assisted Treatment Order for indigent people is managed through the Ministry of Labour and Social Services. Patients in need of the assistance are processed at the Hospital they present at and the medical charges are claimed against the fund (MoFinance 2010). A Social Welfare officer is stationed at a hospital and assesses the social welfare status of the person seeking to be covered under that facility. The service entitlements are not clearly defined and there is a ceiling to the number of patients processed in a year. This means that not all processed claims will be honored in that year.

The security forces receive resources for their health institutions through their Ministry budgets which also follow the Result Based Management System. The contracting process follows that particular Ministry structures. Health services fall under their department of health services. The performance of these coverage mechanisms depends on the availability and adequacy of allocated funds to pool risk for the targeted population.

A blanket approach to free services, impacts directly on the coverage of the available funds. The ability to pay is not considered and may cause moral hazard. The civil service has medical aid entitlements through employer and employee contributions, and medical entitlements within the free package for security forces are yet to be clearly defined. The distribution of resources is not linked to health needs and there is not yet a detailed costing

of the service package by level of care as this exercise is still underway, so that the budgeted amounts are linked to the services to be covered and health need.

4.4 Central Government Purchasing from Local Authorities

Local authorities are both urban, under the Urban Councils Act and rural, under the Rural District Councils Acts, with their Acts under local government. As part of functions by law in these Acts of local authorities, they are supposed to provide health services for their people. In this regard both the Urban and Rural councils own health facilities through which they provide health services at a fee. However currently due to the constrained capacity of rural councils to raise adequate resources from rates and levies, the provision of health services in rural district Councils is entirely funded by the Ministry of Health directly.

In Urban councils, the purchasing of services is centred in Council through the council annual budget, which means that heath service provision becomes a social responsibility of council to its people.

The total of sixteen Urban Local authorities receive grants from Central Government through the MoHCC. The Public Health Act empowers local authorities to provide primary health care services and the Urban Councils Act; 29 No. 15 and Rural District Councils Acts:29 No. 13 empowers local authorities to recover the costs for provision of health services. Specialist health services for infectious diseases such as TB are run city health authorities, but without a document to establish this delegated function City health department by the MOHCC. The grant disbursements to local authorities have been happening since the adoption of the multicurrency system but disbursements have been on a downward trend (MoF budget estimates of expenditure 2009-2012). The MoHCC has operated a push system since 2009 for medicines and commodities. This is secured with financial support by external partners and provided to all urban and rural council run health facilities through Natpharm distribution systems (MoHCW 2011). As the council budget largely takes care of service provision, user fees are charged in urban council health facilities, despite a policy of free care atprimary care level (Sikosana 2009). The Assisted Medical treatment order as social protection mechanism can be accessed in urban council health institutions, but as noted earlier may not always be funded. Purchasing arrangements for community health in the urban councils supported by NGO's are worked out through Memorandum of understanding with the Urban Council.

4.5 Central Government from Mission health Institutions.

The MoHCC and the Zimbabwe Association of Church Hospitals (ZACH) have had a sound working relationship since the inception of ZACH 1974. Following the 1992 Commission of Inquiry into the role of ZACH in the public health system after the President's visit to Health institutions, government has provided grants to mission institutions to cover salaries, recurrent expenditure, exemption from duty and capital grants (ZACH, 2006). The current situation regarding the grant performance, is far from adequate in covering the above stated cost areas. In the same report reference was made to the need for a Memorandum of Understanding between the Ministry and ZACH to bind the working relationship by instilling obligations on either party. This MOU is still in draft form to date and is yet to be agreed upon. The 100 day plan acknowledged the need for this MOU which would detail the purchasing arrangements amongst other functions between the two parties (Sikosana 2009).

4.6 Purchasing by parastatals

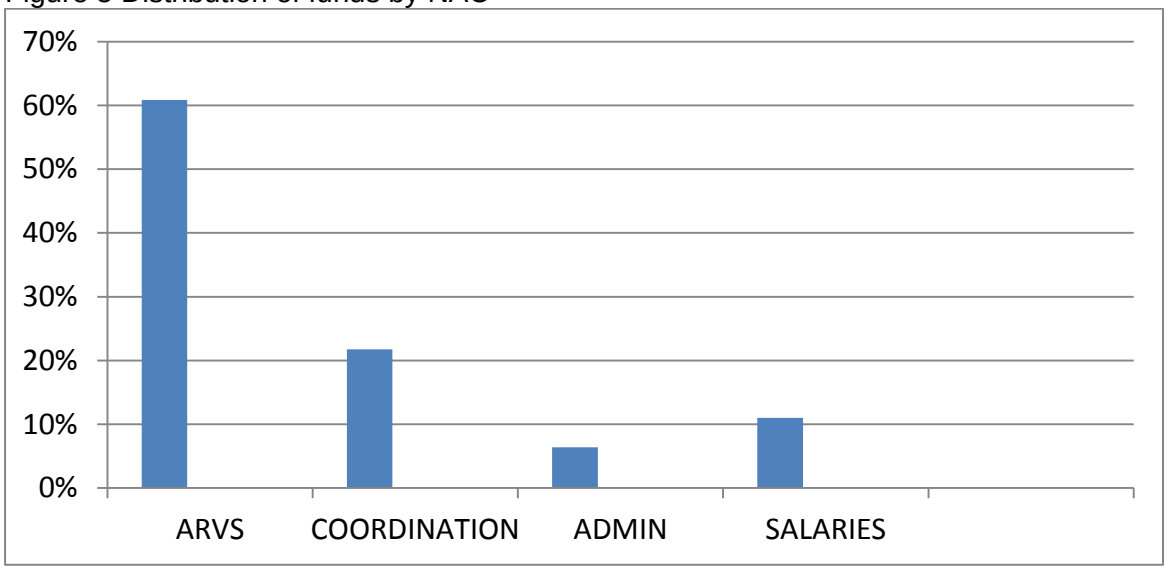
In the health system, there are two statutory bodies with the responsibility of purchasing specific services on behalf of the population.

The first is the National Aids Council that administers the National Aids levy through ACT 16/1999, 22/2001. The role of NAC is to co-ordinate all HIV/AIDS activities in Zimbabwe. The second is the Zimbabwe National Family Planning Council, established under Act, 1985

(Chapter 15:11). Its role is to coordinate all family planning services and activities in Zimbabwe. The success stories with the two entities are contained in various reports in the Ministry associated with a reduction in HIV prevalence and high levels of contraceptive uptake and management of child spacing (MoHCC 2013b).

The National AIDS Council administers the National AIDS Levy which is levied on workers income and cooperate income. The resources are channelled directly to the Parastatal from the Zimbabwe Revenue Authority and are used for the procurement of Anti-retroviral drugs, administration of the HIV interventions and advocacy of the HIV programs. The National AIDS Council works through the MoHCC, local authorities and Mission health facilities in the purchase of HIV services. The fund specifies resource allocation criteria for prevention, curative, advocacy and administration. Figure 5 shows that the National AIDS councils spends the bulk of its resources on purchase of ARV's and less about 5% on salaries. In the case of NAC there is separation of functions between the regulators, purchaser of services. This levy and its mode of management have been raised as a good practice in many forums.

Figure 5 Distribution of funds by NAC



Source: MoHCC 2013

The Zimbabwe National Family Planning Council (ZNFPC) does not get any direct earmarked tax funding, but gets an operational grant for family planning services. It coordinates all partners in family planning services delivery, such as Population Services Zimbabwe. In 2010 it was noted that there is high acceptance of use of modern methods of family planning 99.14% of the population, while only 0.86% sought family planning services from traditional healers.(MoHCC 2013).

These parastatals both have a specific function that also support the health system as a whole, both with positive health outcomes. The use of family planning services is quite high as alluded to above and the same applies to the effective purchasing of HIV services which has seen the reduction in HIV prevalence through the National Aids trust fund.

The two bodies are charged with purchasing specific services and monitoring and reporting on programme implementation. There is clear separation of the purchasing function from regulation. The bodies carry the responsibility of purchasing and payment, but the contractual mechanisms for service delivery are still contained in the Results Based Format through the MoHCC Integrated Performance Agreement (MIPA). The planning and targeting of service interventions remains with Central Government represented by the MoHCC through the MIPA. However these statutory bodies carry the delegated function of purchasing on behalf of the Ministry of Finance.

4.7 Purchasing of health services by bilateral and multilateral agencies

Bilateral and multilateral agencies purchase health services through the principal agent, who is the Ministry of Health and Child Care. In the past the Ministry of Finance would receive funds from Partners through the vote of credit and this would be disbursed to the MoHCC as part of the government budget (Mo Finance 2010).

During the recession external resources dissipated and the few that were available were being managed directly by the partners. The health sector investment case culminated in a pooled fund, the Health Transition Fund which is managed by UNICEF on behalf of partners. The focus of the HTF is to support coverage mechanisms 1 and 2 under Central Government coverage mechanisms above, which are to enhance the primary health care approach and to support the access to free treatment by children under five, pregnant women and lactating mothers (MoHCW 2011).

In this case there is focus on the resources that enable services delivery. The purchasing of services aims to address quality improvement, equity enhancement and strong monitoring and evaluation. The aim is to reduce out of pocket payments by availing pooled funds to cover medical interventions for the primary care level and by offering exemptions for services for maternal and child health care, removing financial barriers to access. The HTF enhances equity by ensuring the basic primary care packages, equipment and support for human resources retention, regardless of geographical setting (Health Transition Fund). Whilst the overall purchasing framework supports government activities, it is an active form of purchasing, as penalties for failure to report or acquit funds attract stringent measures.

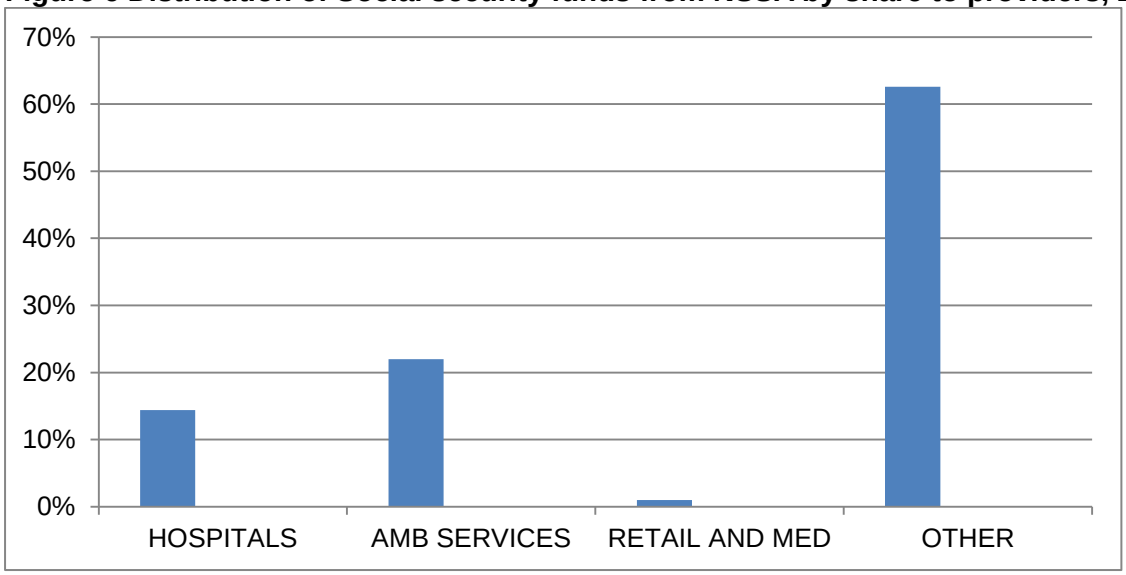
The Global Fund for TB, HIV and Malaria follows the same form of purchasing as the Health Transition Fund. The Results Based Financing mechanism that is supported by the World Bank through grant financing uses an output based approach to enhance performance. It provides incentives for the providers and attracts penalties in case of non-performance. Financial incentives are attached to specific services and an intrinsic quality assessment in service delivery forms part of the reward system (MoHCW 2012). This form of purchasing is more strategic as it aligns interventions to the indicator target and addresses efficiency, quality improvement, and equity, attitude, and access and community involvement in management of health services for these specific incentivised areas of health system performance.

4.8 Purchasing through the National Social Security Authority

Social security health funds are mainly contributions to National Social Security Authority's (NSSA) Workers Compensation Investment Fund (WCIF) by all employers and employees to cover medical claims for injuries at work, disability caused by injuries at work and retirement payments. The disbursements through this category amounted to 6% of the disbursements in 2010 (MOHCC, 2013).

Figure 6 below shows that the in 2010 National Social Security Authority spent 64% of the total WCIF on administration and investments, shown in the column labelled other (note this excludes the separate pension and long term benefits fund). Health care providers only received about 14%. The fund may not be fully utilised in relation to purpose as there may be a lack of knowledge on the demand side to claim for medical expenses when one is injured at the work place, so that individuals end up paying from out of pocket. The WCIF does however use part of its funds for health and safety promotion activities, for workplace inspections and for other prevention activities that would also be covered in the 'other' category.

Figure 6 Distribution of Social security funds from NSSA by share to providers, 2010

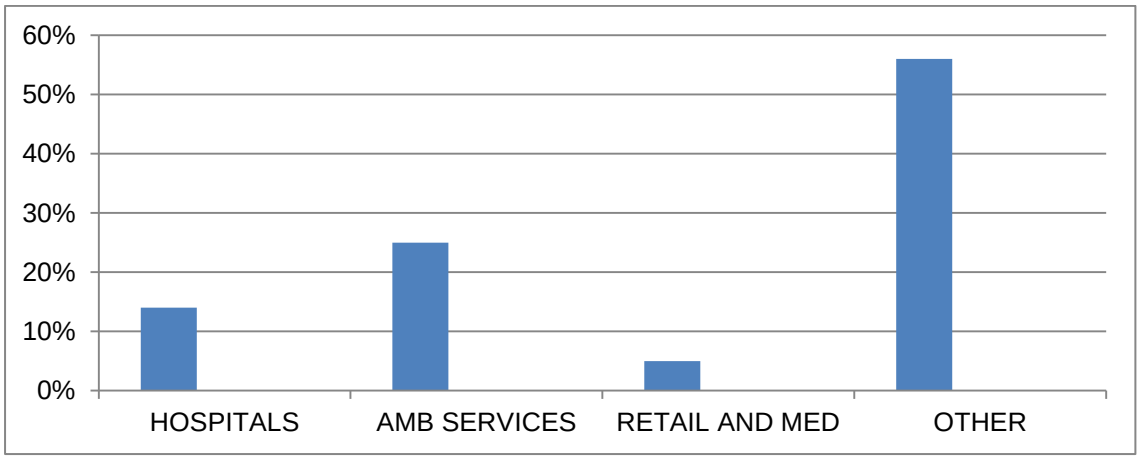


Source: MoHCC 2013

4.9 Purchasing by private insurers

This paper did not specifically explore private sector purchasing outside the relationship with the private for profit health insurance entities had a similarly low level of payment to services and a high level to administration and investment, as illustrated in Figure 7 below. This low level of use of funds for direct service provisioning suggests a need to explore further in separate work the efficiency and equity in use of the funds in meeting beneficiary needs.

Figure 7 Other private health insurance distribution of funds to providers, 2010



Source: MoHCC 2013

5. Discussion

The Rebuild work in this area aims to identify options for improving the purchasing arrangements between central and local government, and between government and private (not for profit) providers of primary care and district services, to ensure purchaser obligations on delivery of the EHB and on financial protection.

In terms of service provision, the Ministry of Health and Child Care, the Ministry of Local Government and Missions make up the majority of public health service providers. The

overall custodian of the health system the Ministry of Health and Child care with the legal mandate to provide preventive, curative health services, health management information systems; laboratory services and the supply of safe blood; training functions; national family planning services; national regulatory functions and obligations in international health. Ministry of local government has a mandate described in the different acts under the Minister and this deals mainly with the provision of services to local communities. Missions have boards of trustees that they report to which also influence service delivery interventions as per religious orientation. The report highlights a number of challenges in this respect, that relate to the purchasing of services:

The first challenge is the falling level of public funds available to direct strategic purchasing: The intention of running a strong public health system as articulated in the 100 day plan, NHS 2009-2013, and the health sector investment case, is to protect the poor from catastrophic health spending. Access to health services is not only about physical access, it is also the access to ambulatory services and medicines within the service package. However as shown in an earlier section, the 2010 National Health accounts report established that the burden of health financing is lying with the household and that this has increased from 36% in 2001 to 39% in 2010. (MOHCC, 2013). Government expenditures have dropped to around 18% compared to the previous level 2001 when it was at 39%. A falling share of public expenditure has not only left households vulnerable to catastrophic health spending, but the literature suggests that it has weakened governments ability to set and implement the agreements with other providers needed to widen access to core services. The predictability of resources to purchases services is an essential function for access, equity and quality health services. Noting the challenges that the Zimbabwe economy is facing, options for expanding fiscal space through domestic revenue sources for health as articulated the United Nations General Assembly 2012 could be a springboard for the health system with a clear framework of managing the funds. It also draws attention to the need for more effective purchasing using the limited resources.

The second is whether purchasing is being effectively and formally used to ensure national policy across all providers: Purchasing of services based on the primary health care approach is a government commitment, which binds all public entities. In the absence of more formalized arrangements it can be questioned whether this policy, and other policies, strategies and guidelines, such as the core health services package, are de facto binding and articulated for all including the private sector. Rural district Councils continue to get support in the form of grants to provide health services yet direct payments still exist in these systems, and there are no purchasing contracts that set out the terms for equitable and efficient access to services. The NHS 2009-2013, the 100 day plan and the health sector investment case specify services and resourcing for only one section of the health system, that is the public health system. However the elements of UHC, including that widening access to appropriate services, or of financial risk protection and prevention of catastrophic health spending, cannot be restricted to users of public sector services alone. All sectors need to address these features, especially given the need to control rising levels of household financing of the health system in comparison to government and all other financing agents.

The third challenge is in relation to clarity on the scope of what is purchased. The focus of public health is to prevent diseases and opportunistic infections; however the expenditure of funds in the health system which is predominantly public is not asserting this focus, since preventive programs are not getting adequate resources. In the 2010 NHA curative services received 36%, preventive services received 9%, while administration accounted for 48%. The 2010 NHA report established that the highest proportion of out of pocket payments was coming from consultations followed by medicines. One would want to know what these consultations are for. If the consultations are for ambulatory services not provided in the public sector that have then to be accessed from a different service provider,

this may undermine financial protection. Whilst work is in progress to define the cost of the essential health benefit, the current contractual arrangements between central government and public providers of health services do not specify the cost sharing between the state and the patient and what this is for. There is a lot that is left out of the district package within coverage mechanisms provided under central government purchasing. This includes, for example, medicines for opportunistic infections for patients suffering from HIV infection. The delegation of delivery of special services such as TB treatment and the City health services have to be guaranteed through sustainable purchasing arrangements with effective monitoring and evaluation systems. The same applies for Mission health facilities which in this case need to declare their capacity to provide services through declaration of available funds for service delivery the funding gap that exists to deliver the an agreed package of services. The realisation of the need to enter into a MOU as a form of purchasing contract with Central Government should guarantee obligations of all parties recognising that service delivery comes at a cost and has to be funded.

Results based financing as a form of strategic purchasing seems to have redirected resources by ensuring that the indicators that relate to prevention and curative services are weighted according to the emphasis of the intervention and financing plan. The use of central government resources to adopt such a financing mechanism across services needs careful consideration as regards the compliance with the public finance management act and treasury instructions.

The fourth challenge relates to the separation of purchasing functions from those of regulation and provision. The purchaser provider arrangements in both the provincial and district level is enshrined within the terms of reference of the purchaser/ regulator/custodian of the system at that level. The MOHCC has no clear separation of functions, and neither do Mission health facilities and local authority services. There are no formal agreements or contracted outputs or outcomes. Health services purchasing such as the case with the National Aids levy and the Zimbabwe National Family planning council appear to be good practices that indicate within the public system how to separate purchasing from provision and regulation functions and to make central government purchasing more effective.

Finally there are challenges in management arrangements: What is not found in the literature and will need to be further explored are the constraints to the flow of health care processes and services, due to the bureaucratic management and reporting structures. Further the working relationships of all these three parties need to be harmonised and accepted by all given the different management frameworks, and the literature indicates that apart from the performance agreements within MoHCC at different levels, the agreements with ZACH and local government councils are not yet established or updated. The structures and functions of councils are not adequately accommodated in the structures and functions of the public health system and neither are the management arrangements of the not for profit sector.

6. Issues for the Research

The desk review has identified some key issues for purchasing of health services that need to be enhanced through field world. It is evident that pooling of risk with whatever coverage mechanism will not avail 100% of resources required to provide 100 % coverage of the targeted population and cover 100% of the cost. Noting that the Ministry of health and Child Care as the principal custodian of health system planning, the implementation of the National Health Strategy through a national purchasing plan (MIPA) has to make choices on what it is able to cover with the available resource envelope, on how providers will be funded to ensure provision of this benefit and on how to use purchasing to ensure delivery on national policy objectives by all sectors, including that of financial protection, and of equity,

access and quality in service provision. Purchasing can easily leave the intended target group worse off and the well-off groups benefitting from the pooled funds. The incorporation of equity in purchasing and guarantee of financial protection should thus be key in follow up work.

The literature reports on what the system should be doing, but more evidence is needed on what is happening de facto to infirm a purchasing system that is oriented to achieving UHC and in line with what the system can realistically achieve, in relation to what is funded, what costs are shared; what mechanisms are used for payment, how performance is tracked and assessed and for how a separation of functions is organised.

For the follow up research it is proposed, through review and policy dialogue, to identify options for improving the purchasing arrangements between central and local government, and between government and private (not for profit) providers of primary care and district services, to ensure purchaser obligations on delivery of the EHB and on financial protection.

The work will explore the purchasing arrangements between central government and

i. MoHCC services at provincial and district level
ii. local government
iii. private (not for profit) providers
iv. military service providers

of primary care and district services.

Through field work (interviews and analysis of records) planned for one urban and one rural district it will be necessary to map the performance of *current* purchasing arrangements as reported by respondents and as verified by documents provided, in relation to

i. what are their sources of resources (Central MoHCC, OOP, external funders, other), and through what performance agreements, known, monitored and enforced by whom?
ii. With what incentives for following performance agreements? And what capacities, strengths and weaknesses in the current institutional arrangements?.
iii. With what payment mechanisms used for paying personnel and funding services;
iv. With what prepayment arrangements and charges at point of care for primary care and district services, and subject to what guidelines or rules around such charges?
v. Providing what services? – in this case it will be useful to assess performance in relation to the delivery on the EHB using a selection of tracer services; such as for maternal health (eg contraception, ANC and deliveries); child health (eg management of asthma); SRH and communicable diseases (eg ARV treatment, prevention of vertical transmission or TB case tracing) and NCDs (eg treatment and follow up of diabetes or hypertension)
vi. With what guidelines and procedures for audit, monitoring and reporting on service quality?
vii. With what measures for improving, monitoring and reporting on efficiency eg in relation to
    a. Underuse of generics and higher than necessary prices for medicines
    b. Use of substandard and counterfeit medicines
    c. Inappropriate or ineffective use of medicines
    d. Overuse or supply of equipment , investigations and procedures
    e. Inappropriate or costly staff mix, unmotivated workers
    f. Inappropriate hospital admissions and length of stay
    g. Low use of infrastructure
    h. Medical errors and suboptimal quality of care
    i. Waste, corruption and fraud
    j. Inefficient mix/ inappropriate level of strategies

viii. With what tracking and reporting on value for money?
ix. With what reporting to local communities and public on service financing, performance and outcomes?

This can be further explored by interviews to identify where those involved in these key sectors (MoHCC, Local govt, ZACH and military) see weaknesses in their arrangements above or possibilities for improvement, first within districts, and then at national level.

Interviews will be held with purposively selected managers from the districts and from the national associations for rural and urban local government and from the umbrella body of two private not for profit providers (including ZACH), as well as from MoHCC at national level to document what norms, standards and deliverables are expected to apply in these services, such as in the performance agreements. It should also explore the learning and potential of and limits in adopting focussed strategic purchasing across services such as Results based financing to wider health benefits.

This evidence will be analysed to identify strengths and weaknesses of current arrangements and the options for arrangements for (i) minimizing cost escalation (ii) guaranteeing the EHB and quality of care (iii) ensuring financial protection. and (iv) ensuring compliance with norms and standards.

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