

POLICY BRIEF

Evidence and proposals for advancing equity and universal coverage of health services in Zimbabwe

The Zimbabwe 2009-2015 National Health Strategy aimed for a universal health system that provides quality health services for all, particularly through public sector health services and primary health care. The Ministry of Health and Child Care and TARSC working with Atchison, KIT and ZEPARU steered by the Technical Working Group (TWG) on Universal Health Coverage (UHC) implemented research on options for improving domestic revenue mobilisation. Following inclusion for the first time of the right to health care in the 2013 Constitution, within a process underway to frame Zimbabwe's health financing policy, research investigated measures for the equitable allocation of resources; and for the institutional, governance and purchasing arrangements and mechanisms for managing funds to deliver an updated Essential Health Benefit (EHB). This brief presents the main findings and proposals from this work, as reviewed by stakeholders and by the top management of the MoHCC. In March 2015, a one and a half day National Research Forum on "Evidence for advancing UHC in Zimbabwe" that gathered over 100 people from a wide range of constituencies and sectors reviewed this and other research evidence on UHC and raised proposals for policy, research and debate that are also included in this brief.

Why equity in UHC... and what does it mean?

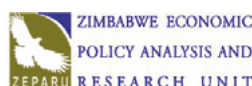
Zimbabwe's health policies and strategies since independence have consistently included a policy commitment to universality, equity and quality, as a reflection of social values. The principle of universality calls for measures that ensure that the entire population has access to health services of a sufficient quality to be effective, while the principle of equity calls for measures to close avoidable inequalities in health, for resources for health services and other social determinants of health (water, sanitation) to be allocated in relation to health need and for protection against impoverishment from the costs of using health services.

These policy principles have been confirmed by the UHC TWG. They imply that health services are provided on the basis of health need and not ability to pay, that available resources are allocated according to need, with measures to ensure that funds are used effectively. These principles, and how they are achieved become more, not less important when resources are scarce.

In 2013 the Zimbabwe Constitution for the first time guaranteed the right to health care. The World Health Organisation has posed that UHC with equity is the best way to attain this right, but that there is no single path or magic bullet to do this. Each country needs to devise its own route to achieve UHC. Universal health systems are built over years, so they need a sustained process, organised around a shared vision of a national unified health system, with the social support, technical inputs and capacities to deliver it.

Research in Zimbabwe has found that the term 'UHC' and its meaning are less well known or understood than primary health care (PHC). However, stakeholders see the current debates on UHC as an opportunity to improve and build a sustainable strategy for an integrated national health system under the country's own stewardship, domestically designed, with community and stakeholder involvement and drawing relevant learning from others. Successful experiences of advancing UHC in other countries suggest that this calls for a combination of political and policy leadership; evidence and technical options, institutional capacities and social support.

May 2015



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How well are we currently doing on equity in UHC?

The 2014 Zimbabwe Equity Watch reports on progress between 2011 and 2014 in health equity and the dimensions of UHC. The report highlights various areas of progress: The right to health care was included in the 2013 Constitution and the EHB at primary care and district level was updated and costed. Coverage of immunization, antenatal care, skilled birth attendance and services for HIV, malaria, and sexual and reproductive health (SRH) increased and social inequalities in coverage decreased for services that are closer to universal coverage.

These improvements were supported by

- The presence of a literate population, high education enrolment and gender parity in primary education, an active health civil society and revival of the village health worker (VHW) programme to support health promotion and service uptake.
- A PHC system that has played an important role in identifying and linking vulnerable households to support from other sectors.
- Strengthened primary and community level services that played a significant role in increasing coverage and reducing inequalities in access, backed by improvements in availability of medicines and nurses, doctors and pharmacy personnel in districts.
- Support for HIV and AIDS, malaria and TB control services, including from the AIDS Levy.
- Reduction/removal of fees in public/not for profit services for pregnant women and children.

- Improved use of funds for maternal and child health services and pooling of external funding in the Health Transition Fund aligning spending to national goals and services.

The evidence also highlighted a number of challenges in both universal coverage and equity. They include:

- Child survival, child under-nutrition and maternal mortality rates that are still far from MDG targets, particularly for the poorest households.
- Falling access to improved water sources and safe sanitation, with an 80 percent point difference in access between households with highest and lowest education levels.
- Cost barriers to early childhood development enrolment and school completion.
- Persistent social disparities in the uptake of SRH and HIV services.
- Much lower coverage of services for a rising level of non-communicable diseases (NCD). Projected annual costs of the top ten NCDs by 2030 are \$57.22 per capita, with a US\$1bn annual cost to the health sector and US\$3.6bn to the economy.
- A fall in domestic health financing to 8.2% of government funding in 2014, below the Abuja commitment, below the \$34 for a core package of services for the health MDGs and below the \$76 per capita needed for services to district level for the essential health benefit.
- High out of pocket spending, at 39% over double government share of spending on health.
- Late reporting for care, leading to more severe and costly disease for people and services.



Health facility, Manicaland. Photo: P Patruno undated, creative commons license.

The evidence and UHC Forum presentations identified areas for follow up action to:

- Table the 2014 Equity Watch with relevant parliament portfolio committees.
- Monitor and report on inequalities in health and health care in annual reports.
- Strengthen comprehensive PHC services for disadvantaged households
- With other sectors, especially schools, and communities improve nutrition, safe water and sanitation.
- Enforce public health law and table the Public Health Bill in parliament.
- Sustain improvements in the availability of medicines and personnel in primary care and in community health literacy, VHW and health centre committee (HCC) roles.
- Register every family with their primary care service, and move from a disease approach to a family oriented approach to care, with strengthened public health, promotion, prevention, screening services, and improved referral for complications.
- Intervene from adolescence and improve continuity of SRH services. Promote early booking for ANC. Identify and put in place measures to address gender norms and practices that affect uptake of services, such as low male involvement in HIV testing.
- Implement a risk factor and prevalence survey for NCDs and mobilise domestic resources and health worker training to implement proven cost effective measures, and screening for NCDs. Dialogue with and support health workers in primary care on the introduction of annual checks and screening for NCDs in routine care. Raise social awareness and review environment, road traffic, food, tobacco and alcohol policies to reduce risk of NCDs.
- Improve domestic health financing and reduce out of pocket spending.
- Inform parliament, councils and community leaders, to take forward debates and actions on equity and UHC. Inform, consult, involve and enable communities to play their role, including through legal recognition of HCCs.

Raising and equitably allocating public financing for UHC

Most Zimbabweans use the publicly funded or delivered health system. Based on levels of health care utilisation implied by policy and MDG commitments, the government budget to health in 2013 was US\$388mn below the Abuja commitment, US\$199 mn below the WHO target for HIV, TB and malaria services and \$332mn less than the MoHCC budget bid. This funding shortfall is associated with high levels of out of pocket (OOP) spending and a reliance on external funding. Raising the resources for universal coverage of the EHB, removing user fees for key services and addressing new challenges such as NCDs calls for increased mandatory prepaid pooled funding. This comes from taxes and /or mandatory national insurance. Pooling of funds provides opportunities for cross subsidies between rich and poor and between healthy and ill and allows for efficiencies in how funds are allocated and used.

Zimbabwe's health system is largely tax funded, providing a large pooled fund. Other arrangements that pool health funds in Zimbabwe include the Health Transition Fund (HTF), a transitional pooled fund for earmarked services, the National AIDS Trust Fund (NATF) for HIV/ AIDS services and the

Health Services Fund (HSF). The National Social Security Authority Workers Compensation and Insurance Fund (WCIF) funds prevention and care for work related injury. The management of these public funds is discussed later. There are some local community funds supporting health promotion and service improvements. Private voluntary health insurance from medical aid societies (MAS) serve about 10% of people, largely in formal employment. MAS packages are segmented, without cross-subsidies between schemes and income groups. Few plans fully reimburse services, weakening financial protection. Some have high spending on administration.

These funding streams are highly fragmented with a variety of funds that are not pooled together, despite some internal pooling within each. In terms of new revenue flows, there are fiscal and social limits to any new taxes or increases in income taxes.

However there is local support and many international examples of financing for health from earmarking of *existing* taxes. Such options have been found to be progressive in settings similar to Zimbabwe, especially if applied to services that benefit those with highest need. Earmarking a very small share of cigarette taxes, beer, wine and

spirit taxes could yield up to US\$20mn annually for health by 2022. Earmarked taxes on mobile communications have been explored. A one off 5% addition to the existing fuel levy could raise US\$14mn in the current year for capital investment for emergency services, including for road traffic accidents. The mining sector, previously exempted, now contributes to the NATF.

Value added tax (VAT), which provides about a third of tax revenue, covers the higher income informal economy but exempts basic goods and lowest income businesses. Earmarking 1% to 2% of VAT could raise US\$100mn to \$200mn in 2015 and is projected to raise sufficient funds to cover all deficits on universal coverage of community, primary care and district services by 2030.

The evidence and dialogue on the findings raise proposals to:

- Increase domestic health financing, with management capacities and systems (discussed later) and measures to use the resources more equitably and effectively.
- Increase government *own* spending to meet the Abuja commitment of 15% government spending on health.
- Implement the Zimbabwe Agenda for Sustainable Socio-Economic Transformation proposals to improve progressive tax funding, including from earmarking VAT and excise taxes, with measures to ensure equity, efficiency, transparency and accountability in their management, including through wider social dialogue on the options.
- Negotiate and provide conditions to enable external funding to come in as budget support.
- Review the performance of the MAS and ensure their funding of the EHB in all schemes.
- Identify the principles and measures to be applied in public-private financing to retain core public sector roles.

For revenue mobilization strategies to support equity in UHC, they need to be accompanied by equity and efficiency in the allocation of resources, discussed further here, and transparency, accountability and social participation in the management and use of resources, discussed later. The current allocation process is demand based, with separate allocation, management and reporting systems in the HTF, NATF and HSF. The HTF and NATF earmark specific services that they fund. Facilities surveyed reported that flat rate allocations, such as from the HTF, are unresponsive to facility needs and to the number of services they provide.

Many countries integrate health need and service workload indicators to guide the allocation of recurrent budgets from pooled funds to districts and facilities. Applying such indicators in a resource allocation is best done when budgets are increasing

or when new revenue is collected from earmarked taxes, so that *no district gets less resources*, but those with greater need get a faster increase.

It is also important to assess the facility and district capacities to absorb resources. This is done using a gap analysis, comparing infrastructure, personnel and equipment against norms, and costing the gap to plan capital and personnel investments. These measures are monitored for their impact on health and health services.

Indicators of health need and workloads were identified and a resource allocation formula developed for Zimbabwe taking into account policy and stakeholder priorities, availability and quality of data and indicators that most powerfully reflect variation across districts. The indicators that met these criteria and their relative weighting in the formula are shown in Table I below.

Table I: Indicators and their weights for the resource allocation formula

Area	Indicator	Weighting	Source of data
Population	Total population	3	Zimstat: Census
Household capability	Poverty severity index	1	Zimstat: Household income and expenditure survey
Health needs	Under 5 mortality (total under 5 year deaths per 1000)	2	Zimstat: Demographic and health survey
Health service workloads/uptake	Percent of pregnant women attending antenatal care for four or more visits as a share of those attending one ANC visit.	1	Ministry of health Health information system

If the proposed allocation formula were applied to the total 2013 MoHCC budget (excluding referral hospitals, health worker salaries and capital spending), 39 districts would have had higher allocations. These are districts that may need greater allocations to meet needs, and that may be prioritized for gap analysis to assess their capacity to absorb resources.

If the proposed formula were applied to the potential additional revenue from earmarking 1% of VAT for health, all districts would obtain *additional* resources, ranging from \$667 000 to US\$2.9mn per district.

Districts that manage provincial referral hospitals would need a supplementary allocation that takes their provincial catchment population numbers and health needs into account.

A pilot gap analysis identified and costed deficits in facility infrastructure, personnel, and in the availability and functionality of maternal and child health service equipment (as a proxy for equipment) against norms in the 2009-2015 Strategic Plan and the 2014 EHB. The pilot indicated that implementing gap analysis is feasible, but that some data gaps need to be addressed, and norms, such as on health workers, need to be updated.

From the research and review of resource allocation it was recommended that:

- A resource allocation formula be applied to guide allocation of recurrent funds, -excluding health worker salaries- that integrates population, under 5 year mortality, poverty severity and the share of pregnant women attending four or more ANC visits / those attending one ANC visit.
- The formula to be applied to specific recurrent funds (government / HTF/ new AIDS Levy fund collections) and used as a guide to raise allocations in districts with higher health need, taking into account local contexts and measures to support capacities to effectively absorb, manage and use resources.
- A gap analysis be implemented on available personnel, facilities and equipment for the next medium term expenditure framework to align capital spending to meet deficits, using a standardised tool such as the 'OneHealth Tool'.
- Electronic registers be maintained of indicator assets, with periodic audits to physically verify their use and functionality.
- Norms for health facilities and categories of health personnel be updated and regularly reviewed.

Strategic purchasing to support universal coverage

The 'purchasing' of health services determines how the available, pooled resources are used and whether or not funds translate into effective health services for all. Purchasing of health services implies an explicit or implied contractual relationship between the purchaser (funder) and the health service provider that includes the services or health benefit funded, the population covered and the proportion of the total cost met from the funds. Achieving UHC calls for active 'purchasing' of health services. In Zimbabwe's public sector, purchasing arrangements exist between central and local governments, and between government and not-for-profit providers of primary care and district services. How well do these current arrangements support the delivery of the EHB, of quality services for those with health need, and the goal of financial protection?

Various features currently exist to support this: The public system has a legal mandate and tools and generic reporting templates to set and monitor purchasing agreements, quality of care and service provision with providers. Performance agreements exist within MoHCC at different levels and compliance with norms and standards is tracked. There are performance agreements between central government and the Zimbabwe Association of Church Hospitals, albeit based on negotiated budgets. The 1995 core district health package was updated and costed as an essential health benefit (EHB) in 2014. A results-based management system tracks and rewards coverage and performance targets through a monitoring mechanism and reporting timelines, with support from HCCs and social services committees.

Research evidence also highlighted challenges in the current purchasing system:

- Falling, inadequate and unpredictable public funding, weakening government's ability to set and implement agreements with providers to widen access to quality health services.

- Fee charges being used to meet gaps in funding, with free care policies and fee exemptions known but not backed by resources and thus not adhered to across providers.
- A gap between clear treatment procedures and service guidelines – available in facilities - and what is actually funded for the different categories of services in the EHB, with unfunded services (eg for NCDs) restricting access or raising OOP spending.
- Earmarked funding of specific services by the HTF, NATF biasing delivery on the EHB.
- Limited application of formal purchasing contracts, with lack of clarity on what is purchased. Rural district councils and mission services, while they get MoHCC grants to provide health services, have no formal purchasing contracts to back these grants.
- Districts not knowing the budgets available to them to fund services, weakening planning.
- Escalating costs and underfunding, dependency on external funding, deficits in skilled personnel, competing priorities and high workloads weakening internal systems for efficiency and effectiveness and compliance with norms and standards.
- Limited fund management at primary care level, and lack of training and inexperience in HTF management.
- Public health facilities not registered for or claiming from MAS, with the costs of claiming higher than the claims in a paper-based system.
- Limited real monitoring of how purchasing measures are impacting on health institutions limiting the possibility of determining effectiveness, or of incentivising of good practice.
- Segmented funds and different reporting systems raising reporting workloads.
- Limited separation of purchasing functions from those of regulation and provision.
- Irregular and uneven functioning of health centre committees / hospital management boards and ad hoc feedback to communities weakening social accountability on services.



Reviewing health centre stocks, Mazowe.
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The evidence and discussions at the UHC Forum suggest areas for improvements in the purchasing arrangements for public sector and not for profit health services.

- Establishing an exit strategy to transit the HTF and its purchasing arrangements to domestic financing.
- Improving the adequacy and predictability of government funding, through timely adequate disbursements to deliver defined services for a defined catchment population with specified service and coverage outputs.
- Using the costing of the EHB in purchasing contracts to clarify what services are purchased, what delivery targets to meet, and what is funded free at point of care.
- Harmonising the application of user fee/ free care provisions across providers, with public information on these provisions and a body to oversee their implementation.
- Covering benefits provided free at point of care with funds channelled directly to health facilities, supported by an acquittal system for funds provided.
- Moving from 'stop-gap' retention incentives to address the basic pay of health workers across all categories. Train health personnel to meet new challenges and ensure their safe working environments.
- Sustaining a results-based management purchasing contract with review and reporting of the services funded and their costs and quality, to support social accountability.
- Identifying the strengths, limits and role of RBF in future purchasing of the EHB, and the benefits of fund pooling in reducing RBF's high transaction costs.
- Ensuring public institutions claim full fee charges from MAS and that societies improve timely and electronic claims processing.

Improving the governance of funding for UHC

Governance is an important aspect of equity and UHC. Social values of universality and social solidarity underlie UHC goals and its delivery on the right to health. Support for policy measures depends on their legitimacy. This includes the transparency and accountability with which the funds are managed, especially if new domestic funds are collected. Facility level management need to have the capacity and decision-making responsibility to be responsive to people and staff needs and to be accountable to the local community.

Governance in Zimbabwe's public health sector is centralized, with a perception reported of limited alignment of private providers to national health plans. The MoHCC central government role as purchaser, provider, payer and verifier was perceived to bring potential conflicts of interest. A field assessment indicated that some tasks are delegated to the operational level, but without transferring mandates.

While, as noted earlier there is high compliance with legal norms on financial accountability, facility staff lacked accounting software, had high workloads to account, plan and manage funds and limited or late feedback on audit reviews.

A range of mechanisms are in place for social participation and accountability. As noted earlier Zimbabwe has high literacy levels, civil society has expanded health literacy and mobile phone and communication technology (ICT) use is widespread. However, while local initiatives exist, apart from the RBF, the provisions for hospital boards and the budget process, there is limited information and social accountability on how funds are received and spent.

Stakeholders have reported support for a semi-autonomous fund under the Minister of Health to manage new revenues, such as from earmarked taxes, with National AIDS Council perceived to be a reliable and accountable organization, where accounts are up to date, subjected to external audits, and money spent according to a work plan and approved budget.

The evidence and discussions at stakeholder forums raised areas for follow up on the governance arrangements for UHC, especially for management of public funds. This includes to:

- Strengthen the mechanisms for harmonising the reporting on and services covered by different funds.
- Review the public finance management system to identify and solve the issues that discourage 'on budget' external funding.
- Establish an institutional arrangement for pooling of funding for UHC, with measures for accountability and transparency that would encourage social trust and funders to join the pooling. Identify which institution, new or existing, will play this role.
- Increase autonomy at the operational level (providers and community) to facilitate responsiveness to context specific needs, within pre-determined ceilings and limits.
- Ensure community voice in policy, in prioritizing health needs, in health service promotion, resource mobilization and in monitoring quality of care and in accountability of funds.
- Provide for HCCs and their roles, duties and functions in law.
- Make more effective use of ICT to strengthen partnerships, to provide information on services and for planning, to support uptake of screening and treatment services, to manage health information data, to monitor service quality and to strengthen direct channels between the community of users and service providers and regulators.

Issues for further research and debate on equity in UHC

The work on UHC has been strengthened by agenda setting, guidance and review from stakeholder meetings involving different constituencies and the many institutions in the UHC TWG.

Delegates in the 2015 National Research Forum saw such interaction to be essential for research to support UHC. They observed that researchers need to make greater use of routine data, that government and researchers need to draw more on evidence from communities and that government needs to engage local researchers to support strategy development.

Some issues were acknowledged to need further discussion: What we should prioritise doing now to prevent rising levels of NCDs? How can more powers be given to local level services and communities? What institution should manage pooled funds for UHC? What role should external funders play in UHC? What services should be free at point of care and what should not? What role should the private health sector play in UHC?

Some questions were also identified in the UHC Forum for further research:

- What is driving inequalities in health and health care coverage *within* urban and rural areas? How do we close the gap? Why are some districts doing better than others?
- What can be done to stop children on ART dropping out of school?
- How do we train for, assess and reward social factors in health systems, such as health worker commitment, social participation, leadership, trust and communication?
- How can emergency responses be implemented in a way that supports UHC?
- What relationship exists between levels of external funding and health outcomes across districts? What other factors affect district performance? How should this be monitored?
- What resources would be raised from a tax on airtime? How progressive is this tax?
- How sustainable and viable is community based health insurance? What lessons have been learned from NSSA's experience with its benefits schemes?
- What conditions need to be achieved to encourage different funders to pool funding? What lessons can we learn from other countries on semi-autonomous of funds for UHC?
- What is driving up costs of public and private services and how can this be addressed?
- What factors and conditions are stopping health workers from reaching optimal levels of performance and how can these be addressed? What skills mix and career path development are needed for current and future population health challenges?
- What is enabling/ disabling partnerships for health with community groups, private sector, civil society and others? What role can ICT play in this?

Forum delegates noted however that a lot of research has already been done. They recommended that we should now be using and acting on the evidence we have already gathered, to strengthen what is working, address problems, to build dialogue on the evidence and proposals between the different institutions, groups and communities and to debate unresolved issues.

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Cite as: MoHCC, TARSC, Atchison, KIT, ZEPARU (2015) Policy Brief: Evidence and proposals for advancing equity and universal coverage of health services in Zimbabwe, TARSC, MoHCC, Harare

This brief was funded under the Rebuild consortium by Liverpool School of Tropical Medicine with support to LSTM from a grant from the UK government, and also draws on work funded by IDRC (Canada). It does not necessarily represent the official views, decisions or policies of MoHCC or other institutions involved.