

**Desk Review of institutional
arrangements for health financing
in Zimbabwe**

Zimbabwe Economic Policy Analysis Research Unit



**For
Training and Research Support Centre
With
Ministry of Health and Child Care**



**With the Regional Network for Equity
In health in East and Southern Africa (EQUINET)**



March 2014



**REBUILDING THE FOUNDATIONS FOR UNIVERSAL HEALTH
COVERAGE WITH EQUITY IN ZIMBABWE**

**With support from
Rebuild Programme: LSTM**

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Cite as: ZEPARU (2014) Desk Review of institutional arrangements for health financing in Zimbabwe, ZEPARU, TARSC, MoHCC, EQUINET in the ReBUILD project: Harare

Acknowledgements to: Dr Rene Loewenson TARSC for peer review and technical edit; Jurien Toonen KIT for peer review; to Dr Gibson Mhlanga and Mr Gwati Gwati from the Ministry of Health and Child Care (MoHCC) for official documents provided; and to the Rebuild Consortium, Liverpool School of Tropical Medicine (LSTM) for funding support.

Executive Summary

This research is a literature review done under the ReBuild Programme of health systems research and stakeholder dialogue and capacity building that seeks to move from the immediate recovery measures to longer term measures for Universal Health Coverage (UHC), which encompasses equity in access and coverage. The work is supported by Liverpool School of Tropical Medicine through Training and Research Support Centre (TARSC) and the Ministry of Health and Child Care (MoHCC). Specifically, the literature seeks to identify and describe the organizational, institutional and governance arrangements and procedures for pooling funds, for cross subsidies and for provider payments at different levels in the public health system. The literature review was done based on a framework designed by KIT, based on literature review from African countries to enable identification of gaps and policy options that can be adapted for health financing in Zimbabwe. The literature review was based on reports from the Ministry of Finance and Economic Development (MoFED), MoHCC, national technical institutions, and development partners.

The primary sources of health financing in Zimbabwe are the Government, the households, employers and external funders. The main source of health financing as at 2010 was households (39%), followed by employers (21%), external funders (19%), and Government (18%). There is high donor dependency for health financing, which in principle is not encouraged, as it is usually unreliable, unpredictable, unsustainable and highly dependent on political environment. This raises concerns on the sustainability of health financing institutions and the vulnerability of Governments budget should external funding be withdrawn. Although total health expenditure (public and private) as a percent of GDP was high in 2010 at about 15% (MoHCC, 2013), this did not necessarily mean that the health sector was adequately financed, but was rather a consequence of a low formal GDP due to the economic crisis experienced from 2000 to 2008. Lower levels of per capita health expenditure indicated that health expenditure in the country is insufficient to guarantee adequate access and quality of health care. Government expenditure on health as percent of total Government budget was less than 15% over the period 2009-2013. OOP payments were high at 50.97%, reflecting the limited cover by prepayment mechanisms and inadequate public financing and thus exposing the population to catastrophic health care expenditures, creating barriers to access to health care.

Although Government expenditure on health is insufficient, the MoHCC budget kept pace with inflation and population growth, indicating that the resources allocated to health at least did not go down in real terms for the period 2010 to 2013. However, the budget was found to be unreliable and unpredictable as a source of funding as the actual disbursement was always less than planned expenditure by margins of greater than 33%. The budgeting process is bottom-up, starting at facility level (with the district playing the major role) and culminating into a consolidated budget at the MoHCC, reflects local facility participation in identifying needs, although there is need to establish the extent to which input from the local levels influence central decision making at the MoHCC. The budget is historical and demand based and there is need to integrate population measures of health needs and capacity gaps into the allocation of resources (with work on this underway in separate work in the Rebuild programme. The budget can be characterized as a programme budget, where allocation is based on programmes and service delivery areas, making it possible to track and evaluate if funding is being used efficiently to achieve intended outputs. Results based financing (RBF) is better at linking funding to health outcomes, but is being applied to limited maternal and child health interventions.

In Zimbabwe there is no social health insurance scheme, neither are there community based health insurance schemes. Private voluntary insurance is dominated by Medical Aid Societies (MAS). There are over 26 registered MAS, but only 3 key players dominate the market, and together they account for 90% of the market, implying limited pooling of risk among the rest of the other registered players who account for 10% of the market. MAS cover only about 10% of the population, which is mainly formal employees, wealthy women and men, and their dependents in urban areas. There is limited risk pooling and cross in these schemes and they cover largely formal employees, wealthy individuals and urban inhabitants at the exclusion of the poor women and men, informally employed and rural inhabitants. Although their presence in most cities and towns widens geographic cover, there are inequalities in the different benefit packages, in the segmentation within and across schemes, limiting cross-subsidies between different schemes and different income groups covered. Inequalities also exist in the form of tax credits that are based on one's expenditure on health care services. About 6.9% of MAS members find it difficult to get special therapy on their medical plans, and a considerable number of members find it difficult to access medicine on their plans. Few beneficiary plans give full reimbursement for services provided outside their managed care plans. This weakens financial protection of the plans for members. Collectively, the MAS spend 56% of the subscriptions on administration and 44% on health care services, implying that they mainly use subscriptions on sustaining their organisations while their clients have to make OOP payments.

The semi-autonomous institutions and/or arrangements that have been used to pool funding in Zimbabwe include the Health Transition Fund (HTF), National AIDS Trust Fund (NATF) and Health Services Fund (HSF). The HTF is an arrangement between the Government of Zimbabwe and the donor community to mobilize pool and manage funds for health financing, where earmarking is done externally but there is no earmarking internally. Although the fund avoids duplication and 'cherry picking' of activities by external funders and utilizes existing systems and structures, it is affected in terms of its reliability and sustainability as some external funders cannot commit funds for the duration of the HTF and as it is threatened by the political and economic environment. The HSF was established in 1996 to supplement the health budget for the maintenance of health services using income from hospital fees, interest earned on bank credit balance and from financial investments, government grants and donations from development partners, and other fund raising activities. Although the HSF has decentralized features that enable local participation and flexible decision-making on funds use and is governed by both law and a constitution, and is integrated within the existing systems and structures, it suffers from delays in reporting and lack of harmonization between constitution and law. The NATF is an autonomous national fund managed by NAC, formed in 1999 and financed through an AIDS levy to raise resources to meet increasing demand for HIV prevention, treatment care and support in compensation of declining donor financing. The NATF has been a best practice internationally. Its role in addressing other diseases and services is now being explored, and its functioning could be improved through linking funding with results and strengthening communication of information on its performance to the public.

1. Introduction

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) 2009-2013, taking into account equity in access and coverage. One element of this work is to identify options for improving the institutional arrangements for managing pooled resources, viz to describe organizational, institutional and governance and accountability arrangements and procedures for pooling funds, for cross subsidies and for provider payments at different levels in the public health system.

This report provides a background desk review of literature on the institutional arrangements for managing pooled resources in Zimbabwe, viz the organizational, institutional and governance and accountability arrangements and procedures for pooling funds, for cross subsidies and for provider payments at different levels in the public health system.

It can be noted that Zimbabwe's health financing system is based largely on out of pocket payments (OPP) made by patients, public health sector by revenues from taxation (complemented by other purpose-specific pools funded from earmarked taxes, e.g. the AIDS Levy fund) and on external funders including budget support (for example, the Health Transition Fund (HTF)), the non-for profit private sector, such as faith-based organizations. On the other hand, private health sector financing is through OPP, voluntary insurance and industry/ employer contributions. However, this report focuses mainly on public sector financing, given its prominent role in health financing in Zimbabwe.

Against this background, the report seeks to describe health financing as it is currently organized in Zimbabwe, with particular focus on the public health sector financing. It also seeks to explore and describe the rationale why health financing is organized in the manner it is organised in the country, indicating the bottlenecks and areas to overcome when reforming the existing health financing structure. It focuses in general on: revenue collection and pooling of funding for health, resource allocation, purchasing of health care, governance, governance, including institutional arrangements and monitoring & evaluation. The study period is from 2009 to 2012.

2. Methods

The literature review covered institutional, organisational and governance arrangements and procedures for pooling funds, for cross subsidies and for provider payments at different levels in the public health system. It was done through a desk review of literature from reports, financial records and research reports from several stakeholders. Financial reports and research reports reviewed included those from the MoHCC, National AIDS Council, MoFED, Zimbabwe Statistical Agency (Zimstat), TARSC and ZEPARU. A framework for the literature review was prepared by KIT Netherlands, and reviewed by TARSC, and was used to guide the collection of evidence. The methodology used focused on how different health financing issues are currently

approached in Zimbabwe, including any relevant historical background that helps explain the current situation. Data for the review was mainly covering the period 2009 – 2013. The Review is descriptive in nature, trying to identify the various elements of the financing system in Zimbabwe, focusing on:

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

3. Overview of Flow of Funds in the Health System of Zimbabwe

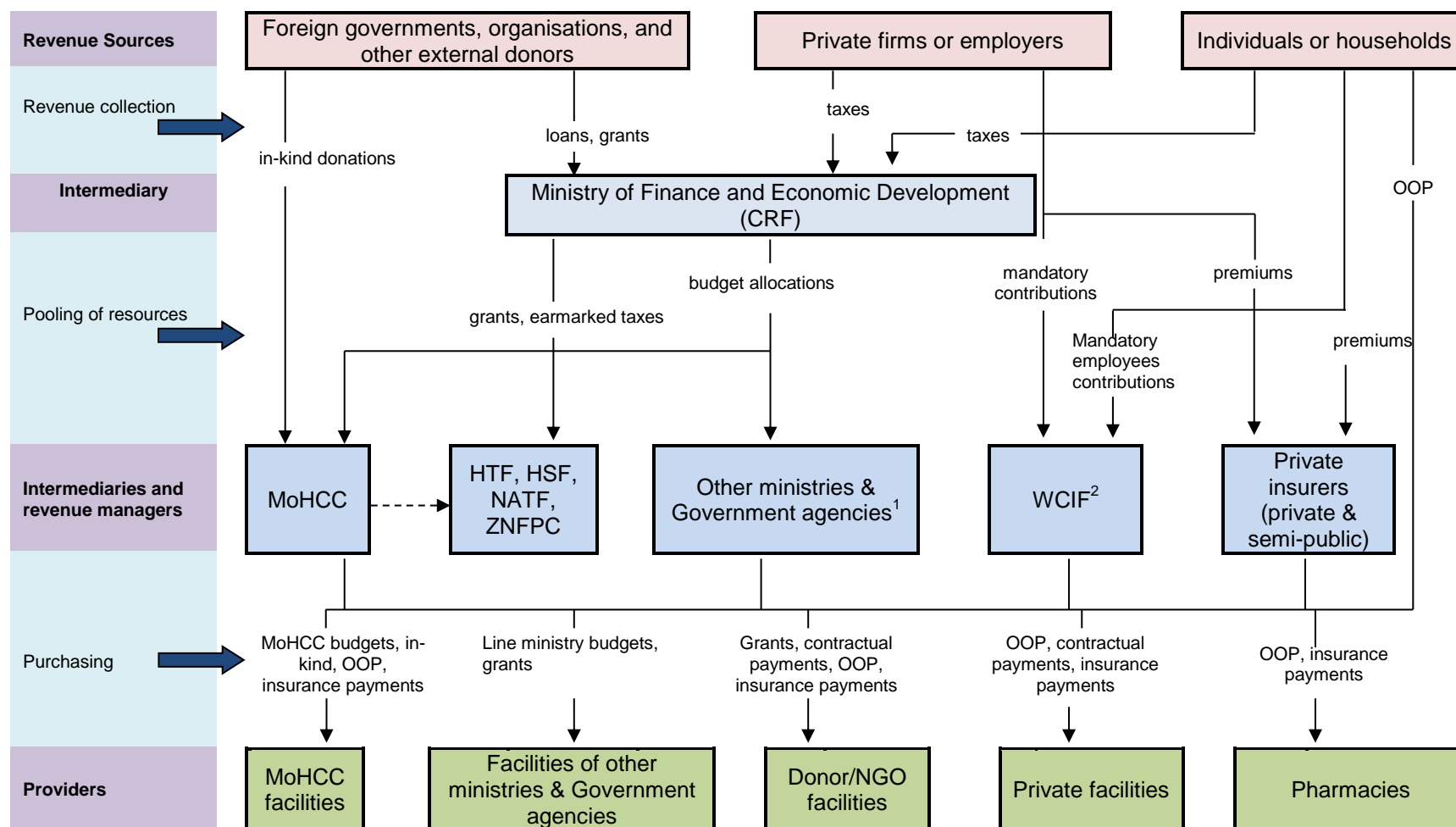
The World Health Organization (WHO) defines *health financing* as the “function of a health system concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively in the health system” (WHO, 2000). The “purpose of health financing is to make funding available, as well as to set the right financial incentives to providers, to ensure that all individuals have access to effective public health and personal health care” (WHO, 2000). Health financing has three key functions, namely revenue collection, pooling of resources and purchasing of services, which can be illustrated by the health financing flowchart in Figure 1.

The national health financing flowchart shows a general model of the flow of health care resources from sources of funds to health service providers. It helps in articulating how health financial resources are mobilized/ sourced and the channels that funds trickle down to the final health service providers. It is key in describing the overall organizational, institutional and governance and accountability arrangements and procedures for pooling funds, for cross subsidies and for provider payments at different levels in the public health system. The key institutions in the health finance flow systems in Zimbabwe includes: the MoFED, MoHCC, non governmental organisations (NGOs), private players and individuals, whose roles and responsibilities can be summarized in the following chart (Figure 1 overleaf).

3.1 Revenue Sources

Revenue sources/Fund origin is concerned with the sources of revenue for health care, the type of payment (or contribution mechanism) and the agents that collect these revenues. All funds for health care, excluding external funder contributions, are collected in one way or another from the general population or certain subgroups. In Zimbabwe, the major revenue collection mechanisms include taxation, private insurance premiums and out-of-pocket payments. Collection agents (which pool resources and purchase health care services from providers) are mainly government or independent public agencies (such as a Social Security agency), private insurance funds or health care providers.

Figure 1: Summary of national health financing flowchart of Zimbabwe



¹ Includes parastatals, universities and teaching organisations under Ministry of Education. ² Is Workers Compensation Investment Fund.

Source: Authors' compilation from MoHCC, 2013

Ministry of Finance and Economic Development

As is common place in many developing countries, the major source of health financing in Zimbabwe is the Government revenues raised from taxes, fees and other charges. The MoFED is empowered by the Constitution of Zimbabwe (Chapter 17) and the Public Finance Management Act (Chapter 22:19) to collect domestic revenues through taxation and allocate them, as efficiently as possible, to achieve set objectives, through the National Budget. The Ministry also receives funds from foreign donors as “vote of credit” (in the form of grants or loans). Funds received from cooperating partners and taxation are pooled together into the Consolidated Revenue Fund (CRF). Unless specifically targeted to health, these funds will be allocated to various ministries through the National Budget, in line with the provisions of the Constitution and the PFMA Chapter 22:19. Funding received in the “vote of credit” from development partners for specific health services sector projects is channeled to those specific programmes/ projects.

The management and use of all public funds is guided by the PFMA Chapter 22:19 whilst the Constitution of Zimbabwe Section 299 provides for Parliamentary oversight into the allocation and use of public funds. Furthermore, Section 309 of the Constitution provides for the Auditor General to audit the accounts, financial systems and financial management of all departments, institutions and agencies of government. However, there are other Acts of Parliament allowing for the retention of funds for health or health related public entities (See Table 1 overleaf).

Development Partners

Another important source of health financing is the “vote of credit”, which is funds received from Foreign governments, multilateral organisations and other external donors in the form of loans and grants. Funding from the international development partners is channeled either through the MoFED or direct to projects or service providers. The period under review has witnessed significant shift in external funding, whereby development partner funding was extra budgetary and going direct to projects, thereby precluding the government channels. This is mainly due to concerns over the Government’s public finance management, politicization of aid and sanctions, which prevented development agencies to channel direct funding to the Government. This is particularly the case with the European Union and the US. In the US, ZIDERA, prohibits US institutions and agencies from channeling funds directly to the Government of Zimbabwe. Given the need to increase health financing in a harmonized and a well-coordinated approach, development partners and the MoHCC have developed such health financing mechanism as the Health Transition Fund (HTF) (discussed further in Section 6.1).

Individuals and Private Firms

Individuals also contribute to health financing through taxes, particularly those in the formal taxable sector and through employee contribution to voluntary health insurance schemes, or mandatory limited cover sickness funds through their employment councils, such as the Engineering council medical benefit fund or to tax financing through income and corporate taxation and the Aids levy Fund. The 2011 Labour Force Survey estimates that the currently employed population aged 15 years and above, estimated to be 5.4 million, 84 % were considered to be in informal employment, 11 % were in formal employment and 5 % were in employment not classifiable (Zimstat 2012). Individuals also contribute through direct payments or out of pocket payments made at the point of need/ access to service. This relates to those without insurance schemes and or where their health insurance do not cover in full the required medical service, hence individual payments will be required to make top-up or co-payments.

Table 1: Laws Appropriating / Retaining Funds for Health or Health Related Public Entity

Legislation	Fund/ Public Entity
Health laws that appropriate funds for a particular purpose	
Health Services Act [Chapter 15:16] (HSA)	Health Services Fund: The Fund was established in 1996 in terms of section 30 of the Audit and Exchequer Act (chapter 22: 03) and operates in terms of the PFMA (chapter 22: 19) and is presided over by the Secretary for Health and Child Care. While the Secretary for Health has overall responsibility for the proper and transparent management of the fund, the PFMA governs its implementation. The HSF income comes from Hospital Fees, interest earned on bank credit balance and from financial investments, government grants and donations from development partners and other fund raising activities.
Mental Health Act [Chapter 15:12] (MHA)	Funds administered by mental hospital boards in terms of Section 69 (1), which gives them power to control and administer any funds that may accrue from any source whatsoever for a specific purpose.
Public entities in health permitted by an act of Parliament to retain public money to meet expenses	
Medicines and Allied Substances Control Act [Chapter 15:03] (MASCA)	Section 13 (1) in paragraph (a) allows the Medicines Control Authority of Zimbabwe to retain fees as are payable in terms of regulations made under Section 74.
National AIDS Council of Zimbabwe Act [Chapter 15:14] (NACZA)	Section 25 (b) provides that the funds of the National AIDS Council (NAC) shall consist of fees and charges raised for services and facilities provided and other things done by the Council.
Radiation Protection Act [Chapter 15:15] (RPA)	Section 9 permits the Radiation Protection Authority of Zimbabwe to retain any moneys accruing to the authority by way of licence fees or other payments charged in respect of any services rendered by the authority and for which fees may be charged under the RPA.
Zimbabwe National Family Planning Council Act [Chapter 15:11] (ZNFPCA)	Section 27 (2) allows the Zimbabwe National Family Planning Council to charge fees or raise levies as the board may, from time to time, determine with the approval of the Minister of Health and the Minister of Finance for the purpose of facilitating the functions of the ZNFPC.

Source: Bhala B (2013)

On the other hand, private firms contribute through taxes to fiscal revenues, which will then be allocated through the budget to various government Ministries. They also contribute through private voluntary health insurance schemes. Households are both financing sources and financing agents. They contribute as employees or directly voluntary to private health insurance organisations and present to health facilities against their subscriptions. As noted earlier this largely covers middle and high income households. Where there are shortfalls the households meet the costs. In Zimbabwe only 10% of the population is covered by private voluntary insurance (called medical aid) hence the majority meet the costs of medical services from out-of-pocket or from prepayment through tax and other revenue sources indicated above (MoHCC, 2013).

3.2 Pooling of Resources

The pooling of resources, the next step in health financing, is conducted by intermediaries and revenue managers, who includes the MoHCC and other government agencies such as the Ministry of Higher Education (in charge of medical education institutions), Ministry of Home Affairs (Police Health Services), Ministry of Justice legal and Parliamentary Affairs (Prisons),

Local Authorities and Mission Health Services and the Ministry of Defense (in charge of military health facilities); private voluntary insurance and sickness funds.

Pooling of resources is the accumulation and management of funds from individuals or households (pool members) in a way that insures individual contributors against the risk of having to pay the full cost of care out-of-pocket in the event of illness. It helps ensure the financial risk of falling ill is borne by all members of the pool and not by the individuals who fall ill. Tax-based health financing and health insurance both involve pooling, noting there is some segmentation in tax funds, and that the pools for private voluntary insurance are small and less comprehensive in cover as described earlier. Fee-for-service user payments do not involve the pooling of resources.

Informal payments in the form of OPPs are also standard practice at both central and peripheral health facilities in Zimbabwe, (see Figure 1: National Health Financing Flowchart of Zimbabwe). Fear of these costs may dissuade many poor households from seeking health care until it is too late, driving up expenses further or in some cases, they don't seek medical treatment at all, resulting in death (Smith *et al*, 2004). High out-of-pocket health costs can place an enormous financial burden on families and push people deeper into poverty (Smith *et al*, 2004). Hence, risk pooling helps to reduce the risks associated with the unpredictability of illness. In developing countries like Zimbabwe, risk pooling is particularly important given that the pattern of burden of disease (still predominantly communicable diseases) is closely related to poverty. The poor (with low ability to pay) are the ones most in need to treatment. In addition, low absolute levels of income mean that even modest financial contributions can lead to inability to seek treatment or adverse consequences from seeking treatment (such as indebtedness or trade off with other essential items).

Risk pooling can be used to transfer health care resources to poor people who are more likely to benefit from health care than the rich (Smith *et al*, 2004). Pooling can lead to improvements in the population's health, if it provides for cross subsidies between rich and poor and between healthy and ill (McIntyre, 2012). There are four classes of risk pooling:

- i. No risk pool, under which all expenditure liability lies with the individual;
- ii. Unitary risk pool, under which all expenditure liability is transferred to a single national pool;
- iii. Fragmented risk pools, under which a series of independent risk pools (such as local governments or employer-based pools) are used; and
- iv. Integrated risk pools, under which fragmented risk pools are compensated for the variations in risk to which they are exposed, (Smith *et al*, 2004).

Ministry of Health and Child Care

The MoHCC receives the government budget funds allocated for health from the MoFED. The budgetary allocations to health by the MoFED are made towards specific programmes and projects, as per the MoHCC's Budget submissions. Other ministries or government agencies also receive central government funds for expenditures on health, for example, the Ministry of Higher Education to fund University Teaching Hospitals and the Ministry of Defense for Medical facilities that are under its umbrella. Management of these funds is done in line with the provisions of the Constitution of Zimbabwe and the PFMA Chapter 22:19. This is further described in another report in the programme (Gwati 2014).

However, the government is facing a fiscal constraint. For instance, in the 2014 National budget, expenditure bids by Ministries amounted to US\$8.9 billion against projected revenues of US\$4.1 billion, (MoFED 2013). This makes it impossible for the budgetary allocations to meet the level

of funding budgeted for by line Ministries, including the MoHCC. The MoHCC, disburses funding received from the MoFED pool/ CRF to programmes and projects at national through to district level, that are operated by the MoHCC.

The Health Transition Fund (HTF)

The Health Transition Fund (HTF) is a funding mechanism aimed at mobilizing additional resources for the NHS. It was set up in 2011, following an agreement between the government and development partners to have a separate pool of funds in support of the NHS. It is governed by the HTF Steering Committee comprising government and the donor community. Its broad objective is to improve maternal, newborn and child health by strengthening health systems and scaling up the implementation of high impact interventions through support to the health sector.

The HTF's key areas of support are (i) Maternal, Newborn and Child Health and Nutrition, (ii) Medical Products, Vaccines and Technologies (Essential Medicines), (iii) Human Resources for Health (Health Worker Retention Scheme) and (iv) Health Policy, Planning and Finance (Health Services Fund and Research). The external funding partners to the HTF includes; CIDA, European Union, Irish Aid, Norwegian Government, Swiss Embassy, Swedish Government and United Kingdom Aid / DFID, (HTF Report 2011).

HTF allows for pooling of funds, thereby strengthening the health system, avoids duplication and "cherry picking" of activities by external funders. Funding is "ear-marked" to HTF, but there is no "ear marking" within HTF, meaning that funding from the Fund is not targeted for any specific project, but for the implementation of any project as agreed by the Steering Committee. Allocations from the HTF are in accordance to needs and priorities of the MoHCC as articulated in the National Health Strategy (NHS) 2009-2013, and in line with the Programme Document and annual work plans approved by the HTF Steering Committee, (HTF Report 2011).

National Aids Trust Fund

The National Aids Trust Fund is an earmarked fund under the Minister of Health that pools funds to support efforts to combat HIV and Aids. The government established an Aids unit within the Ministry of Health and Child Welfare in 1987. In 2000, the National Aids Council (NAC) was established by an Act of Parliament National AIDS council of Zimbabwe Act chapter 15:14. The Government introduced an Aids levy of 3% on an individual PAYE and corporate tax to fund NAC activities. The concept of the Aids Levy is a form of earmarking funds, for HIV interventions as a national response to the crisis, and to provide collective support for people living with HIV and Aids. However, the emphasis on the Aids levy is on community capacity building rather than payment for health care.

Workers Compensation Investment Fund (WCIF)

The contribution to national Social security in Zimbabwe is mandatory for formal sector workplaces for long term pension benefits, and for occupational injury. The funds for the latter are contributions based on the previous year's injury rating for that sector to National Social Security Authority (NSSA) from all employers and employees under the Workers Compensation Insurance Fund which is an employer/employee insurance for occupational injury only, to cover medical claims for injuries at work, disability caused by injuries at work and retirement payments, and limited largely to the formal sector

Private voluntary Insurers

Private voluntary Insurers are health insurance schemes where membership is restricted to specific sections of the population, particularly based on employment. An example of such a

scheme in Zimbabwe is the Harare Municipality Medical Aid Society (HMMAS). These schemes also include subscriptions from households and private companies for health insurance. Zimbabwe has a number of such organizations that include CIMAS, PSMAS, Generation, Cellmed and others. The Association of Health Care funders of Zimbabwe (AHFOZ) have a current membership of 30 Medical Aid societies operating in the country. AHFOZ estimates that over a million people are on medical cover, (MoHCC, 2013). This is about 8% of the population in Zimbabwe. The Premier Service Medical Aid Society (PSMAS) is the largest Private sector Insurance society. The other two large insurance schemes include CIMAS, and First Mutual, who together with PSMAS, provide cover for 90% of all people on medical insurance, (MoHCC, 2013).

3.3 Purchasing

The final stage in health financing flow involves the purchasing of the requisite health goods and services from the various providers. All intermediaries and revenue managers and individuals or households are purchasers of healthcare services. In many cases, the purchaser of health services is also the agent that pools the financial resources. Purchasers of health services are typically the MoHCC, Social Security agencies, district health boards, insurance organizations, and individuals or household (who pay out of pocket at time of using care). The key players at this stage include: the MoHCC and other Public Sector Facilities, NGOs and Private for-Profit Facilities and Pharmacies.

MoHCC and other Public Sector Facilities

Health care purchases by the MoHCC are mainly from the Ministry's annual budgetary allocation and from donor funding as the HTF. These purchases are made from public sector facilities under its purview. These purchases are made at national through to district levels, and are guided by the PFMA Chapter 22:19 and procurement guidelines under the State Procurement Act Chapter 22:14. District health institutions in the public sector submit invoices and payment requests for specific budgeted for or programmed activities from the MoHCC, who in turn make transfers for the respective purchases.

Non-Governmental Organisations (NGOs)

NGOs include donor funded health institutions and other not-for Profit Private Sector providers including church related institutions. The Zimbabwe Association of Church Related Hospitals (ZACH) represents church related hospitals. Purchases under this category are made through grants, contractual payments, OOP and Insurance payments and are mainly decided by the respective institutions' action plans. The action plans are normally prepared in consultation with the MoHCC.

Private for-Profit Facilities and Pharmacies

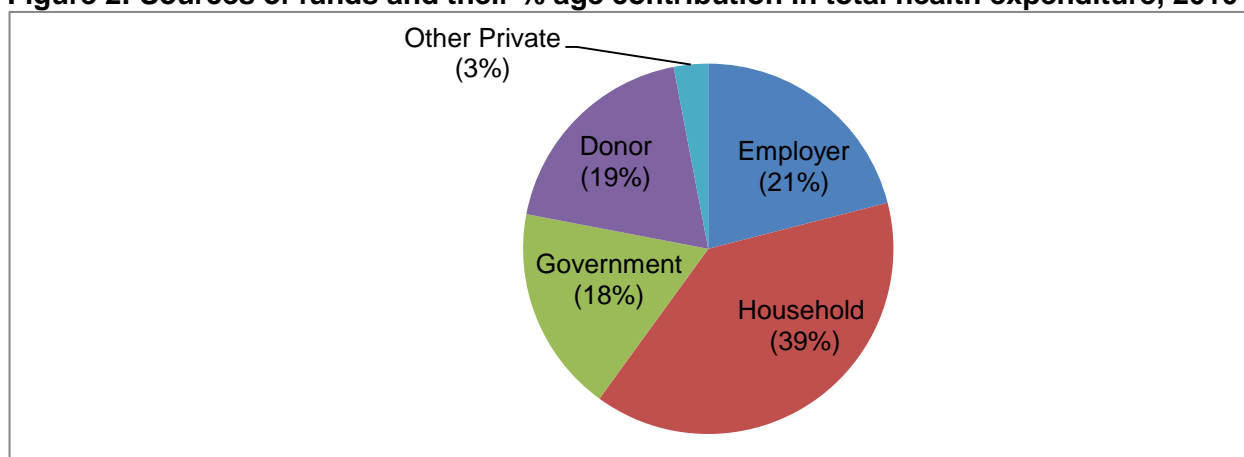
Private for-Profit Facilities and Pharmacies are private sector health providers who benefit from purchases mainly from OOP, contractual payments and insurance payments. A separate report in the Rebuild project provides more detail on this area (Gwati 2014).

4. Revenue Collection for Health Financing

4.1 Sources and Amount of Resources

As already alluded to, the primary source of institutional funds (after out of pocket funding) for the health system in Zimbabwe is the Government, which pools resources from households in the form of taxes and charges, employers and external funders. The funds form the CRF. The National Health Accounts of 2010 showed that households were the biggest funders of health care in Zimbabwe, contributing about 39% of total health expenditure (MoHCC, 2010). In 1999, households contributed 23%, reflecting that over the years their contribution has increased, partly because of the decline and inadequacy in Government health expenditure (Osika, 2010). Given that 62.6 % of households are poor in Zimbabwe (ZIMSTAT, 2013), there might be some catastrophic health expenditures faced by households when they fall ill and there is need for more progressive prepayment mechanisms. For the same year, external funders contributed 19% and the Government contributed 18%, while employers contributed 21% (Figure 2).

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



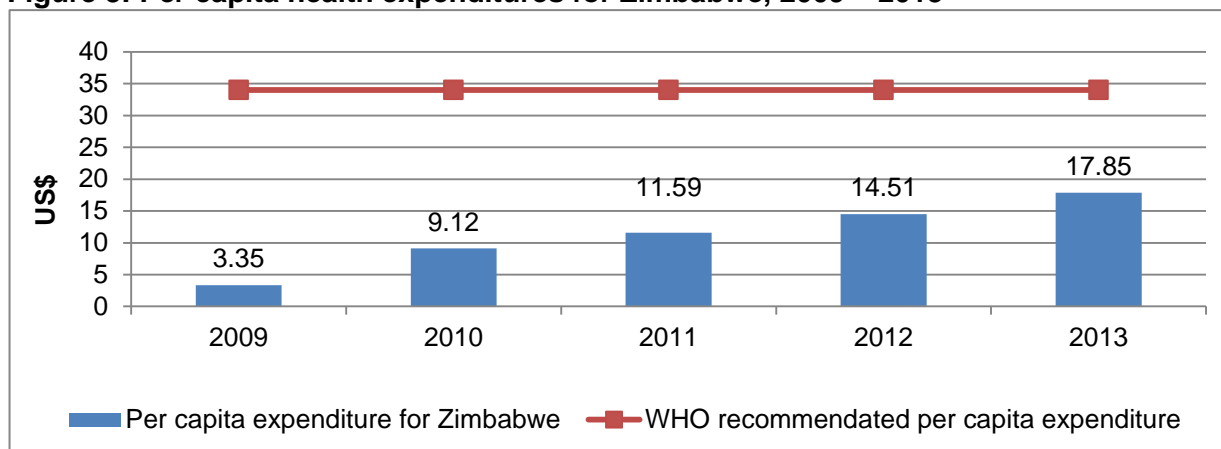
Source MoHCC, 2013

The funds which are collected through taxes, public charges, mandates, grants, loans, voluntary contributions and OOP payments are collected by different organisations, which include government agencies (e.g. ministries, statutory bodies, etc.) private insurance organisations, employers and households (individuals, families, employees). These organizations then purchase health services on behalf of the populations they represent, from private and public health commodity providers as discussed in the previous section. In the case of OOP payments, the funds are not pooled as they are paid directly to service providers. This implies lack of financial protection and cross-subsidy in funds among the population.

In 2010, total health expenditure (private and public) accounted for 15% of GDP (MoHCC 2013) However, this did not necessarily reflect that the health system was adequately financed and that the quality of health services was good, but it was a consequence of lower GDP which was rebounding from the economic crisis experienced from 2000 to 2008. This makes comparisons to GDP difficult, especially with significant flows outside the formal public domain so per capita levels are a better indicator for now. A look at per capita health expenditures from 2009 to 2013 shows that public spending on health is not adequate to achieve appropriate access and quality (Figure 3). Although the per capita health expenditure in US Dollar terms has been on the

increase since 2009, it is below the WHO recommended US\$34 for lower income countries like Zimbabwe.

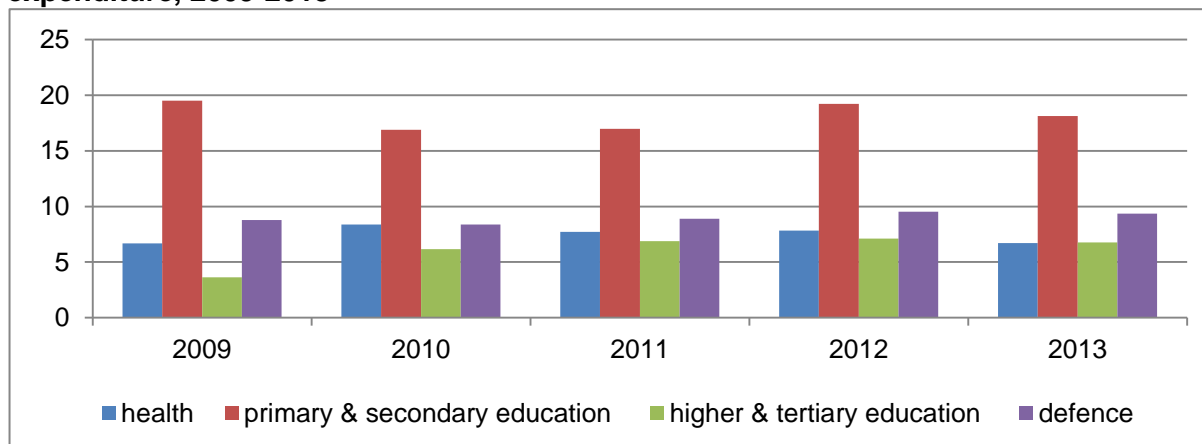
Figure 3: Per capita health expenditures for Zimbabwe, 2009 – 2013



Source: MoFED, ZIMSTAT, (2009, 2010, 2011, 2012, 2013, 2014) and own calculations
Calculations are based on actual total health expenditures on health, including the vote of credit and total population

The Government expenditure on health, as a percentage of total Government expenditure between 2009 and 2013 averages 7.46% (Figure 4).

Figure 4: Sectoral Government expenditures as a percentage of total Government expenditure, 2009-2013



Source: MoFED, (2009, 2010, 2011, 2012, 2013, 2014) and own calculations

The budget allocations have failed to meet the Abuja Declaration, which stipulates an allocation of 15% of the national budget to the health sector (AU 2001). The Government average expenditure on other comparable public goods as a percentage of total Government expenditure were 18.14% for primary and secondary education; 6.11% for higher and tertiary education and 8.99% for defence (Figure 4). As highlighted in Figure 4, the primary education sector has been receiving higher budgetary allocations compared to those allocated towards health, higher education and defense.

Government prioritises some other public goods more than health services, whilst noting that education and other ministries also contribute towards social determinants of health and to a limited extent to health care services, such as in the military health services.

4.2 Collecting mechanisms and organizations

The funds for health financing initially originate from households, corporates/employers and external funders. These funds are collected by various organisations using different collecting mechanisms as shown in Table 2.

Table 2: Collection mechanisms and collecting organizations

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

Households: Households pay for their health services through taxes (direct and indirect), voluntary prepaid contributions, out-of-pocket payments (OPP), compulsory contributions and rates (and other revenues). Under direct taxes, individuals pay the Pay-As-You-Earn (PAYE) tax to the Government. PAYE is levied on individuals' incomes earned from employment. It is progressively structured with those earning US\$250 and less being exempt from paying tax and tax brackets ranging from 20% to 45% (Chipumho, 2013). Households also pay withholding taxes. Withholding tax is levied at 15% for non-residents and 10% for residents on dividends and interest as at 2013. From 2010 to 2012 it was levied at a rate of 20%. Under indirect taxes, VAT is levied on the consumption of goods and services at a rate of 15%, with exemptions on foodstuffs identified as basic commodities to protect the poor and on small enterprises earning below \$60 000 so including many household and self-employed activities in the informal sector. Households pay for health services is through OOP payments, whereby user fees, co-payments and fee for service are charged at public and private sector facilities.

Although Government health care facilities in Zimbabwe have been allowed to collect user fees from patients since the 1990s, there are several categories of services for which user fees are supposed to be waived, including primary care level services and:

- Antenatal care in rural and semi-rural areas;
- Referrals to the next highest level of facility for services that the lower-level facility cannot provide;
- Directly Observed Treatment Short course (DOTS) for TB;
- Family planning;
- Antiretroviral therapy (ART);
- Emergency outbreak services (such as the recent cholera outbreak); and
- Health services for children under five, adults over 65, military veterans, health care providers, and individuals living below the poverty threshold (a designation that is very difficult to attain in practice) (Osika et al, 2010).

Some households (a very small share of the population) contribute to health financing through voluntary prepaid contributions. These contributions take the form of premiums which are paid to private insurance companies called medical aid societies, and are charged according to the expected cost of services or benefit package chosen. The premiums are characterized as group-based insurance premiums that are easy and cheaper to administer (Shamu et al, 2010). The premiums are not risk-rated, but rather community rated. Premiums are usually paid by formally employed workers as private insurers work through employers. Usually premiums are shared between employers and employees. However, groups of self-employed people can be accepted for membership. It is estimated that private insurers cover 10% of the population, implying limited extent of risk pooling (see section 3.2 for more detail on this). However, the introduction of low cost benefit packages to cater low income groups has allowed expansion of covered. The high level of formalization, estimated at 84% (ZIMSTAT, 2011), hinders the expansion of private health insurance.

The Health services Fund (HSF) which was established in 1996 used to provide an “equalization grant” to supplement public health facilities whose user fees were insufficient. However, due to economic crisis in the 2000s, Government’s revenues have been eroded and consequently, the “equalization grant” was eliminated, although the HSF continues to exist. Thus, public health facilities have to rely on user fees for additional resources to supplement their budgetary allocations. However, user fees are insufficient and other public health facilities do not charge user fees and survive on support from external funders. In practice there is little guidance on how user fees can supplement facility budgets (Osika et al, 2010). The process for deciding fee charges vary considerably by facilities and many facilities do not charge any user fees. Those covered by private health insurance pay co-payments for health cases included in the benefit package and full payment for health cases which are not covered by insurance. For medicines and supplies out of stock in public health facilities, patients make OOP to access them in the private sector. The OOP payments are made directly to the service providers, private or public, which include hospitals, pharmaceuticals, laboratories, clinics, etc.

Mandatory contributions are also one of the ways that individuals make contributions to health financing. Formally employed individuals pay the AIDS Levy which is deducted at a rate of 3% from every formal worker’s taxable monthly income (see section 6.2 for more details). The occupational injury insurance scheme is managed by the National Social Security Authority (NSSA) and is mandatory for all workplaces. The main contributors to the WCIF scheme are, however, formal private sector employers. NSSA also provides pension, retirement and maternity benefits to employees in the private sector.

Local authorities, both rural and urban, collect rates (and other revenues) which they use to finance public health obligations under the Public Health Act and health facilities in their jurisdictions. Local authorities contributed US\$13,827,034.50 towards health, which is about 1% of total health spending in 2010 (MoHCC, 2013). 56.9% of their health funding comes from Central Government, while 41.0% come from local taxes, and 1.4% from not-for-profit institutions serving households (NPISH), and 0.7% from external funders (MoHCC, 2013).

There are also public subsidies to private sector in health in terms of tax rebates to financiers, providers, public and private sector, and consumers of health care services as shown in Table 3 below (Mudyarabikwa 2000).

Table3: Public subsidies to private sector in health

A. Subsidies for Financiers	1 Tax Exemption 1. Private Benefits Tax Relief 2. Co-use of Gvt. Facilities 3. Low user fees at public facilities
B. Subsidies for Providers	1. For Profit Providers i) Tax Credits - land, Buildings & Tools of Trade ii) Tax Relief - Membership to Prof. Associations iii) Co-use of public facilities iv) Low user fees at Public facilities v) Liberalized private practice vi) Manpower Training and Development v) Contracting out Services 2. Not for-Profit Providers i) Running Costs grants ii) Staffing/Manpower Salaries grants
C. Private Sector to Public Sector	i) Services provision by missions ii) Designation of Mission facilities as District Hospital iii) SCN training/Manpower Development by mission iv) User fees - the poor still paying though exempted
D. Subsidies for Consumers/Users	i) Fees Exemptions ii) Free maternal & Child Health Services iii) Tax Credits - Medical aid and Medical Expenses iv) Tax Relief - Invalid Appliances v) Training and Manpower Development

Source: Mudyarabikwa 2000

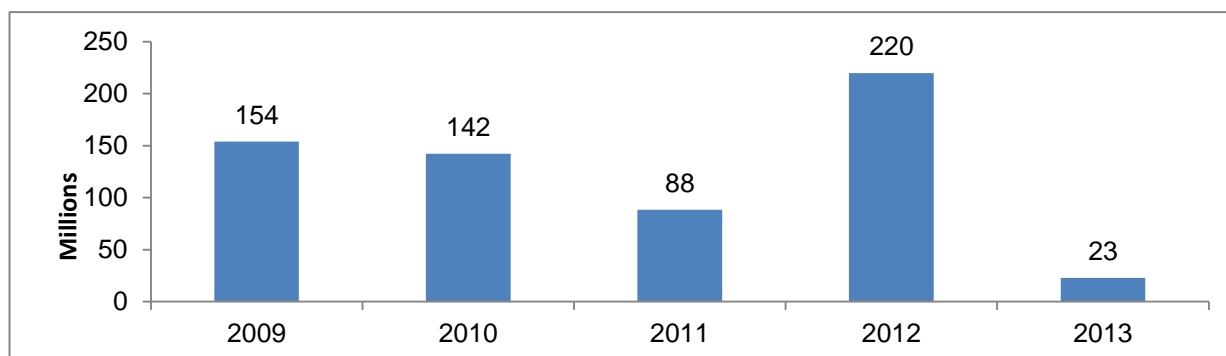
Employers: Employers contribute to health financing through paying insurance cover for their employees as a health benefit, or paying for on-site health care to their employees, or giving allowances for medical expenses to their employees, or paying hospital fees for their employees. Employers also pay taxes. Companies pay corporate tax which is levied on companies at a rate of 25% since 2010. In 2009, it was levied at 30%. The Government as an employer also contributes towards the health benefits of its employees through the Public Service Medical Aid Society (PSMAS).

External funders: External funders such as USAID, EU, DFID, and UN have significantly increased the amount of funds and commodity support for the health system in Zimbabwe (Osika et al, 2010). They disburse funds for health sector financing in a number of ways:

- Through the MOF to the MOHCC and then to the various provider institutions. The mechanism for releasing donor funds to MOHCC is through Vote of Credit (VOC) transfer.
- Some external funders disburse funds direct to the MoHCC as sector budget support, through the Health Services Fund (HSF) which was established in 1996. When the MoHCC makes a request to the donor transfers funds to the National Development Fund. These funds are immediately transferred to the National Health Services Fund commercial bank account. The funds are then disbursed to various providers, public and private, in accordance with agreed plans. This process occurs on a quarterly basis.
- Through extra budgetary funding with MoHCC involved e.g. the case of the HTF which is explained in detail in section 6.1 below.
- Through off budget support directly to providers.

External funding for the health sector shows a declining trend from US\$ 154 million in 2009 to US\$ 88 million in 2011, before shooting up to US\$220 million in 2012, a factor that could be attributed to re-engagement efforts by the Zimbabwean Government with the international community (See Figure 5). In 2013, however, external funding declined to US\$ 23 million as of September 2013. This may be attributed to uncertainty among external funders due to general elections that were held in July 2013.

Figure 5: External support from 2009 to 2013 (US\$)



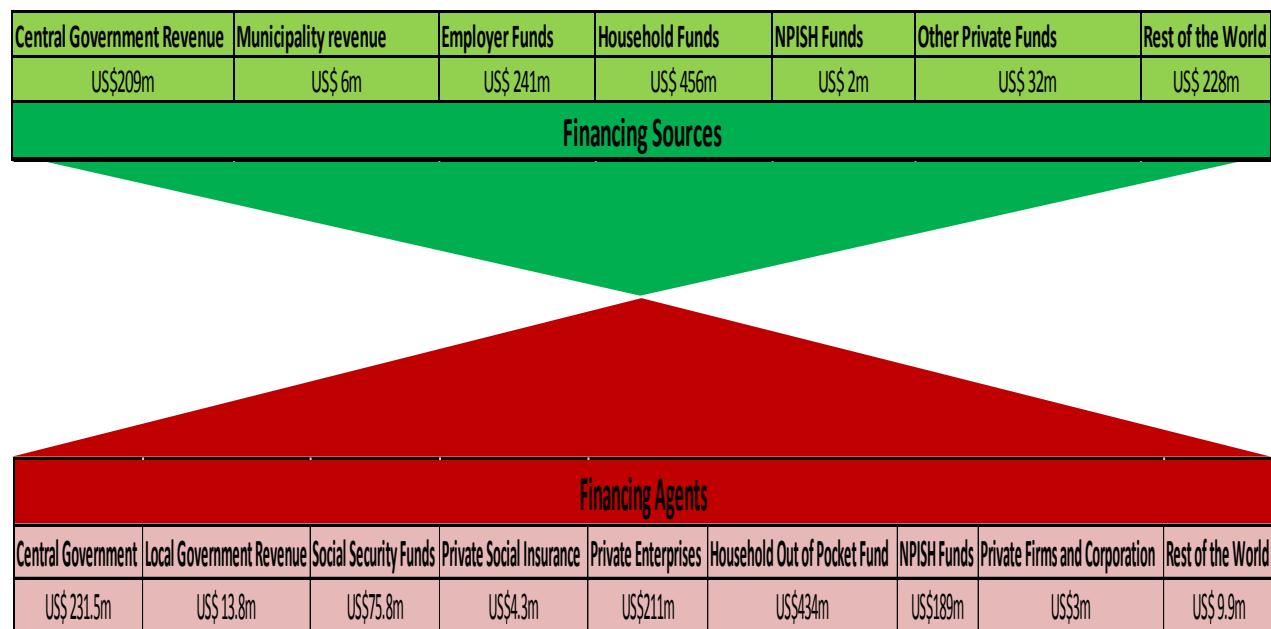
Source: MoFED, (2009, 2010, 2011, 2012, 2013)

Although external funds have played a significant role in health financing, they have challenges in sustainability and predictability. In Osika et al (2010), it is noted that external funds received were less than had been promised, and donor funds to supplement retention bonuses and for purchasing health commodities often arrived late, implying low predictability.

4.3 Cross subsidisation of Funds

Cross subsidization is defined as the practice of charging higher prices to one group of consumers in order to subsidize lower prices for another group. In Zimbabwe, the health system is arranged in a manner that the financing sources for the health sector are also the recipients of the health care funds. Financing sources raise funds in order to put the activities in the health sector in motion whilst financing agencies these institutions receive funds from financing sources and have the power to direct funding for health programs. If funds received are pooled before being disbursed, there are opportunities for risk and income cross subsidies so that funds are collected from those with ability to pay and allocated to those with highest health need.

Figure 5: Flows from financing sources to financing agents in Zimbabwe’s Health Care System, 2010



Source: MoHCC, 2013

The flow of funds in the health system is shown in Figure 5. , the majority of those who contributes less receive more to meet their financing requirements. For instance the central government contributes US\$209 million (18% of the total health funds), but in turn, they receive US\$231 million (20% of the health funds) from the financing sources in the health system to finance their expenditure. According to the NHA, Central Government its revenue comes from grants and the revenue it raises through general service provision. Whilst Social security funds are mainly contributions to National Social Security Authority (NSSA) from all employers and employees to cover medical claims for injuries at work, disability caused by injuries at work and retirement payments and the disbursements amounted to 6% of the disbursements in 2010 (MoHCC, 2013). What is not clear is how far these funds are allocated to those with highest health needs, and what explicit measures are applied in the allocation and purchasing strategies to achieve this cross subsidy.

Private Social Insurances are social insurance schemes where membership is restricted to subsets of the population. Those covered by such schemes are mainly employees or members of a sponsoring association. Their contributions were noted to be insignificant, but in turn they received 18% of funds from subscriptions by households and private companies for health insurance (National Health Accounts, 2013). There are however limited cross subsidies between private voluntary schemes, and they are highly segmented with lower income schemes separate to and not cross funded by higher income schemes. This eliminates risk and income cross subsidies within these schemes (Shamu 2010). Households are both financing sources and financing agents in private voluntary insurance. They contribute to private health insurance and present themselves to health facilities for medical attention against their subscriptions. According to the 2010 National Health Accounts (MoHCC 2013), only 10% of the population in Zimbabwe is covered by medical insurance hence the majority meet the costs of medical

services from out-of-pocket. Households contribute US\$456 million and receive US\$434 million from the health system.

The majority of external funds are channeled through financing agents such as the Ministry and Non-Governmental organisations, and there is some direct funding of their own programmes. The US\$1174 million sourced from external funds in the national health system is redistributed among other financing agents (MoHCC 2013).

5. Pooling and Allocation of Resources for Health

As already highlighted, pooling should ensure that the financial risk of falling ill is borne by all members of the pool and not by the individuals who fall ill. In the case of OOP payments, there is no pooling that occurs as individuals falling ill bear the financial risk of being ill. As such, there is no cross subsidy from those falling ill to those who are healthy. In Zimbabwe, pooling is done by several organisations using different mechanisms to allocate to/among them. From a policy perspective, it is often useful to consider pooling and allocation together (Kutzin, 2001).

As at 2010, total health financing stood at US\$1,173,594,536.2 (Table 3). The funds were distributed among agents as shown in Table 3.

Table 3: Funds pooled by different intermediaries and revenue managers, 2010

Intermediaries and revenue managers	Amount (US\$)	%age (%)
Central Government	231,510,394.2	20
Local Government	13,827,034.0	1
Social Security Funds	75,823,837.0	6
Private Social Security	4,295,602.0	0
Private Insurance Enterprises	211,041,622.0	18
Households Out-Of-Pocket	434,508,718.0	37
Non Profit-making Institutions Serving Households	189,632,026.0	16
Private Firms and Corporations	3,088,043.0	0
Rest of the World or External Funders	9,867,260.0	1
Total	1,173,594,536.2	100

Source: MoHCC 2013

Households OOP payments constituted 37% of the total health expenditures in 2010. Households OOP payments as a %age of total private health expenditure in 2010 was 59.97%. This compares unfavourably with other countries in the SADC region such as Botswana (12.69%), South Africa (13.88%), Namibia (17.87%), and Mozambique (25%) (World Bank 2014). Thus, resource pooling is limited in Zimbabwe compared to these countries in the SADC region. Households are charged at point of care. This can be a barrier to access to health care and can threaten weaken financial protection of the households.

5.1 Government Health Budget and its Allocation

The MoHCC pools and allocates health resources as it accumulates the Government general revenues collected by the MoFED through ZIMRA and distributes the resources to both public and private providers of health care. The MoHCC also pools funds from the external funders through loans and grants disbursed directly to it as sector budget support through the Health Services Fund (HSF). The funds allocated to the MoHCC from the MoFED have the advantage that the CRF is a bigger pool that accumulates funds from a wider range of sources, and thus potentially enabling cross subsidizing among these sources. Given the progressively structured

tax system of Zimbabwe (Chipumho et al, 2013), the contribution to the CRF is related to the income level, although in reality wealthier people engaging in informal activities and remuneration structures that accommodate more non-taxable allowances may negate this. However, the resources from the CRF have challenges pertinent to allocation. There is competition for the pooled funds from different ministries and Government agencies. As a result, health financing is not independent from the pressures on general government funds, leading to insufficient funds being allocated towards priority health needs of the nation. With insufficient funds for the health budget, there is likely to be a compromise on the quality of health services and inaccessibility of health services to the poor who rely on public health institutions. One way to cushion health funding from other competing ends would be to earmark funding for health from the pool.

In Zimbabwe the MoFED allocates to the MoHCC and other Ministries-Ministry of Defence, Ministry of Home Affairs and Ministry of Justice, Legal and Parliamentary Affairs - that run their health programmes separate from the MoHCC. The Ministry of Justice, Legal and Parliamentary Affairs is responsible for prison health care, while the Ministry of Defence caters for health needs of the army and air force, and Ministry of Home Affairs caters for the police – the health services are targeted to those specific groups and not open to other people. The Ministry of Labour runs a Social Safety Net scheme which pays for health care services provided to those classified as falling within the indigent group. Services for persons falling in this category are almost exclusively obtained from government facilities, and are not on any social health insurance scheme. Given that in most cases Government health facilities run out of some medical commodities or are unable to provide the commodities, it implies that these vulnerable groups of people, who exclusively depend on public health facilities under the Social Safety Net Scheme, would not access their health needs or have to incur catastrophic health expenditures to meet their health needs.

The allocation from the MoF to the MoHCC is based on the annual budget that the MoHCC submits to the MoF. The budget is costed along curative and preventive line items. According to Osika *et al* (2010), in principle, the MoF considers several factors in order to allocate funds to the MoHCC and these include the following:

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

Budget formulation process

The annual budget that the MoHCC presents to the MoF is a consolidated budget based on costed activity/work plans that health facilities and offices plan to carry out to meet the population's health needs in their jurisdictions in the given budget year, based on available services (Osika et al, 2010). As such, these budgets are needs-based budgets, which reflect actual use and funding requirements for the population's health needs, and more likely to result in the allocation of funds to areas where funds are needed, and point to health facilities that are underutilized. Facility budgets are compiled at their respective health offices. The district hospitals and rural health facilities submit their plans to DHOs, while provincial hospitals submit their work plans to PMDs, and central hospitals submit their work plans directly to the MoHCC. The health offices send the compiled work plans to the next highest level, from district to

provincial, and from provincial to the MoHCC. The MoHCC compiles all budgets into the national health budget plans. Thus, the budget process is bottom-up, implying that there is more input from local levels and facilities and hence they are likely to reflect actual health funding needs. However, as noted above, actual disbursements will also depend on the available funds

The RHCs, PHs, DHOs, and PMDs use different costing tools in preparing their work plans. Some of the information they use include: number of facilities where funds will be provided to ensure funds are more evenly distributed; seasonal trends of various illnesses (malaria incidents increase during rainy season), and funds must be high enough to cover seasonal outbreaks; and trends in the number of patients using health facilities, along with population growth (Osika et al, 2010).

After the resources are allocated to the MoHCC, the MoHCC in turn distributes its budget allocation to each province, in proportion to the need of the province as described in their work plan. However, it is difficult to define what needs are considered in each work plan. Although the government has provided a “Resource Allocation Formulae” to health offices for equitable distribution of the health budget, the formulas are not well-known. At the provincial level, the PMD meets with district health officials and determines budget allocations for each district and its facilities. The process used for determining how funds are allocated at this level is unclear as it seems to vary greatly, but factors such as compliance with work plans, demographics, and health campaigns are considered (Osika et al, 2010). Similarly, after the DHOs receive their budget allocation from the PMDs, meetings with facility staff (from district hospitals and rural health clinics) are convened to determine budget allocations. Total expenditures at all facilities are expected to comply with provincial and district work plans.

The MoHCC also disburses funds to Mission health institutions, which receive recurrent, capital and a 100% salary grant from the MoF through the MoHCC (MoHCW, 2001).. The ministry also disburses grants to private voluntary organisations which are direct providers of health services (e.g. those running old people’s homes) as a contribution towards their health and care needs.

Budget allocation structure

The MoHCC budget can be characterized as a programme budget, which allocates expenditure according to programmes or service delivery area. Expenditures are allocated to administration, medical care services, preventive services and research. The service areas are further broken down into recurrent and capital expenditure, wherein allocations are made according to object class (i.e. salaries, electricity, etc.). As noted above, the MoFED requires the MoHCC to submit cost justifications as well as reporting on what will be achieved via resource allocations in the consolidated provincial work plans. Results based financing (RBF) is now being used for selected maternal and child health interventions.

The percentage changes in Government health expenditure over the period 2010 to 2013 have kept in pace with population changes and inflation by significant margins (Table 4). Thus, there is a real increase in the purchasing power of the resources allocated to the MoHCC over the review period, implying that the level of services have been maintained above those of previous years.

The actual Government health expenditure has always been lower than the planned Government health expenditure (Table 5). This shows that the budget is inadequate source of health funding. The health budget is crafted largely according to health needs of the population, the gap between planned and actual spending indicates that the health care needs of the

population which largely depend on public health facilities are not met, or that the population meets its health care needs through catastrophic out of pocket expenditures.

Table 4: Percent Changes in Government health expenditure, population and inflation, 2009-2013

	2009	2010	2011	2012	2013
% Change in Government health expenditure	...	174.80	28.26	28.53	24.43
% Change in population	...	1.00	1.00	1.01	1.10
Inflation (end of period)	4.2	4.2	4.3	2.9	0.5*

* the inflation rate is as of November 2013
Sources: MoFED, (2009, 2010, 2011, 2012, 2013); ZIMSTAT (2013) and own calculations

Table 5: Actual versus planned Government health expenditures (US\$), 2009-2013

	2009	2010	2011	2012	2013
Actual Total Health Expenditure	41,822,370	114,927,288	147,410,861	189,465,107	235,757,841
Planned Total Health Expenditure	121,018,374	173,826,600	256,198,000	301,226,000	381,040,000
Deficit	79,196,004	58,899,312	108,787,139	111,760,893	145,282,159
Deficit as %age of planned expenditure	65.44	33.88	42.46	37.10	38.13

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

Note: health expenditures exclude vote of credit

Over the review period, the share of Government health expenditure on salaries as a percentage of health budget ranged between 49.65% and 64.65% (Table 6). A very small share of Government spending goes to medicines and supplies. Expenditure on medicines and supplies is calculated from both curative and preventive services.

Table 6: Expenditures on salaries, medicine & supplies and other recurrent costs, 2009-2013

	2009	2010	2011	2012	2013
% of total recurrent health expenditure spend on salaries	64.65	49.24	53.39	60.54	59.74
% of total recurrent health expenditure spend on medicine and supplies	7.40	4.29	3.50	4.41	3.61
% of total recurrent health expenditure spend on other recurrent costs	0.39	0.19	0.34	0.28	0.22

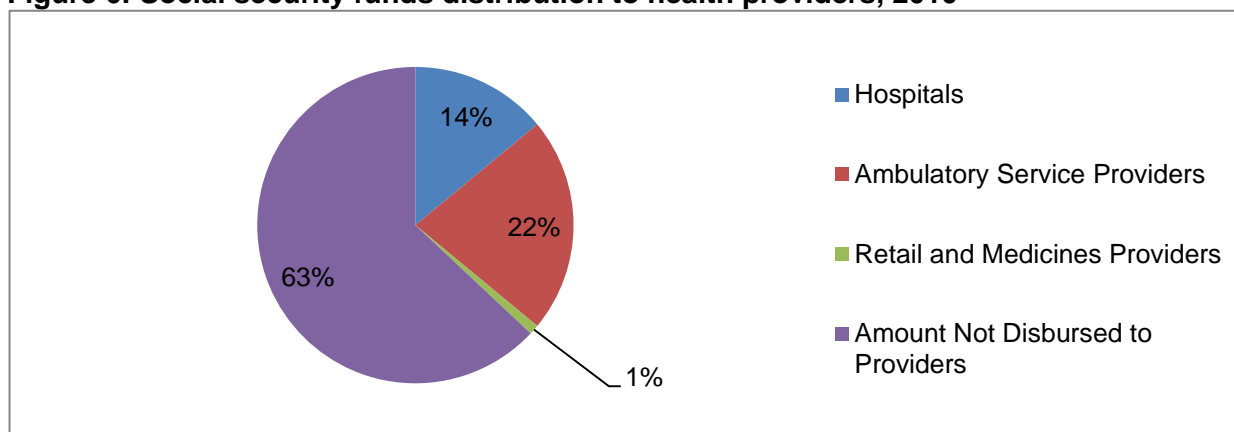
Sources: MoFED (2009, 2010, 2011, 2012, 2013)

The budget for medicines is small and this could most probably mean that people have to pay for medicines separately at the public health facility or at local private pharmacy. More importantly, since 2009, 75% of essential medicines and surgical needs at primary and secondary levels of health care facilities were funded by external funders under the Vital Medicines Support Programme (Shamu, 2012).

5.2 Health Insurance

In Zimbabwe there is no social health insurance scheme, where a mandatory government organized programme provides a specific benefit package of health services to members. There are no community based health insurance schemes also. However, there is a WCIF which is run by NSSA and provides medical cover for injuries at work and disabilities caused by injuries at work. The main contributors to this scheme are private sector employees and employers. Membership of the scheme is mandatory for all private sector employees in the formal sector. NSSA limits its coverage mainly to those formally employed at the expense of the large informal sector which constitutes 84% of the economy. This limits the propensity to pool risk among the healthy and the sick.

Figure 6: Social security funds distribution to health providers, 2010



Source: MoHCC 2013

In 2010 NSSA disbursed funds to health care service providers as follows: ambulatory services 22%, hospitals 14%, and retail and medicines 1% (Figure 6). The bulk of the funds were not disbursed to service providers.

Private voluntary health insurance is dominated by Medical aid societies (MAS) which pool funds on behalf of their members. There are at least 26 registered medical aid societies (with new societies being registered), covering about 10% of the population (Chipumho et al, 2013). This indicates a lesser extent of risk pooling as there is a smaller proportion of the population sharing health care costs across the sick and the healthy. These medical aid societies mainly cover high income formal workers and their dependents. MAS have encouraged growth of hospital services more in urban than rural areas, because of the ease of administration and greater ability to pay by users in these areas. MAS coverage has tended to be higher for working men and women and wealthier groups, with lower coverage in women and in rural and less wealthy people (Shamu et al, 2010). Thus, the coverage offers fewer opportunities for cross subsidies from the poor to the rich and from the formally employed to the informally employed. Although CIMAS and PSMAS (two voluntary insurers) has extended to most cities and towns, they do not cover the majority of income groups and other MAS have inadequate geographical spread (Shamu et al, 2010). The issue of some MAS operating managed care and some operating only as funders means that different MAS provide different benefits, and while the law prevents MAS from creating monopolies on services this practice has emerged in the country (Shamu et al, 2010).

Those with many plans show no major differences in terms of the benefits to their clients, and this only increases administrative costs and is a sign of inefficiency. According to the National Health Accounts (2010), 56% of MAS subscriptions are spent on administrative costs and 44% on health services (MoHCC 2013). Thus, MAS use the bulk of subscriptions to sustain their organisations rather than funding actual health care services delivery (MoHCC 2013). The implication is that they do not adequately finance actual health care delivery to their beneficiaries, resulting in weakening of financial protection and increased financial barriers among beneficiaries.

MAS schemes are voluntary, and they deal directly with employers and consumers to avoid broker costs. However, dealing directly with employers limits employee discretion on the choice of MAS and benefit package. Employers discriminate between low level and high level employees with regard to contributions, leading to inequality between the poorer lower level employees and the richer higher level employees (Shamu et al, 2010). With regards to taxation, individuals are given medical credit, which is 50% of one's expenditure on hospitalization, prescribed drugs, x-rays, ambulances and medical equipment (KPMG, 2008 in Shamu et al, 2010). Even if both the higher and lower level employee can get medical credit, the higher level employee enjoys more benefit than the lower one. The method to calculate premiums are different and so they could be prejudicing beneficiaries in the process.

Benefit packages are clearly specified, but segmented, and lack cross-subsidies between different levels of cover, and different income groups of beneficiaries (Shamu et al, 2010). MAS benefit packages also lack reimbursement for prevention and promotion services, reimbursements on fee for service basis and there is also cost escalation leading to benefit exclusion and risk exclusion measures widening the uncovered spectrum (Shamu et al, 2010). The information on benefit package options lacks among beneficiaries, and is evidence of restrictive practice and benefits shortfall (Shamu et al, 2010). Also, clients are requested to get approval from their MAS to use service providers outside those owned by the society. Although the market for the pooling function has 26 medical aid societies, the market is oligopolistic in nature as there are only 3 dominant medical aid societies (CIMAS, PSMAS and First Mutual) which command 90% of the total market.

MAS schemes in Zimbabwe cover 2000 health care procedures (Osika et al, 2010). Thus, a greater range of health care services is covered by insurance, in theory providing financial protection to beneficiaries covered by these schemes. However, 6.9% of MAS members find it difficult to get special therapy on their medical plans, and for a considerable number of members access to medicine on plans is very low (Shamu et al, 2010). Few beneficiary plans give full reimbursement for services provided outside their managed care plans. This weakens financial protection of the plans for members.

The market for MAS is characterized by high degree of vertical integration between funders and different providers, resulting in concerns about monopolistic behaviour across the market. In addition, there has been concerns about limiting of patient choice, prescribing of practices and use of laboratory services being driven by cost more than health need, (Shamu et al, 2010).. As a result of the situation and concerns of the Competition and Tariff Commission (CTC) this resulted in the passing and of the Medical Aid Societies Statutory Instrument 330 of 2000 which regulates vertical integration. However, regulatory oversight itself was found to have been constrained by shortages of personnel in a centralized system, ambiguities in the law, lack of information reporting from and monitoring of MAS, lack of consumer awareness and lack of advocacy of beneficiary interests by members (Shamu et al, 2010). The societies have taken advantage of these shortfalls and ambiguities to consolidate their ownership across the sector

and, for some, to default on obligations to provide annual financial reports to the Registrar or hold annual advisory council meetings. The MoHCC has limited personnel capacity to regulate and monitor MAS, does not have an updated database on key features of MAS and does not retain the fees collected from MAS as it is not a statutory body. The Ministry of Finance also has obligations to monitor MAS as financial institutions. However, the non-profit, non-tax status, their investments in non-core 'for profit' areas now raises new scrutiny on the use of their funds, with potential tax implications on profits earned (Shamu et al, 2010).

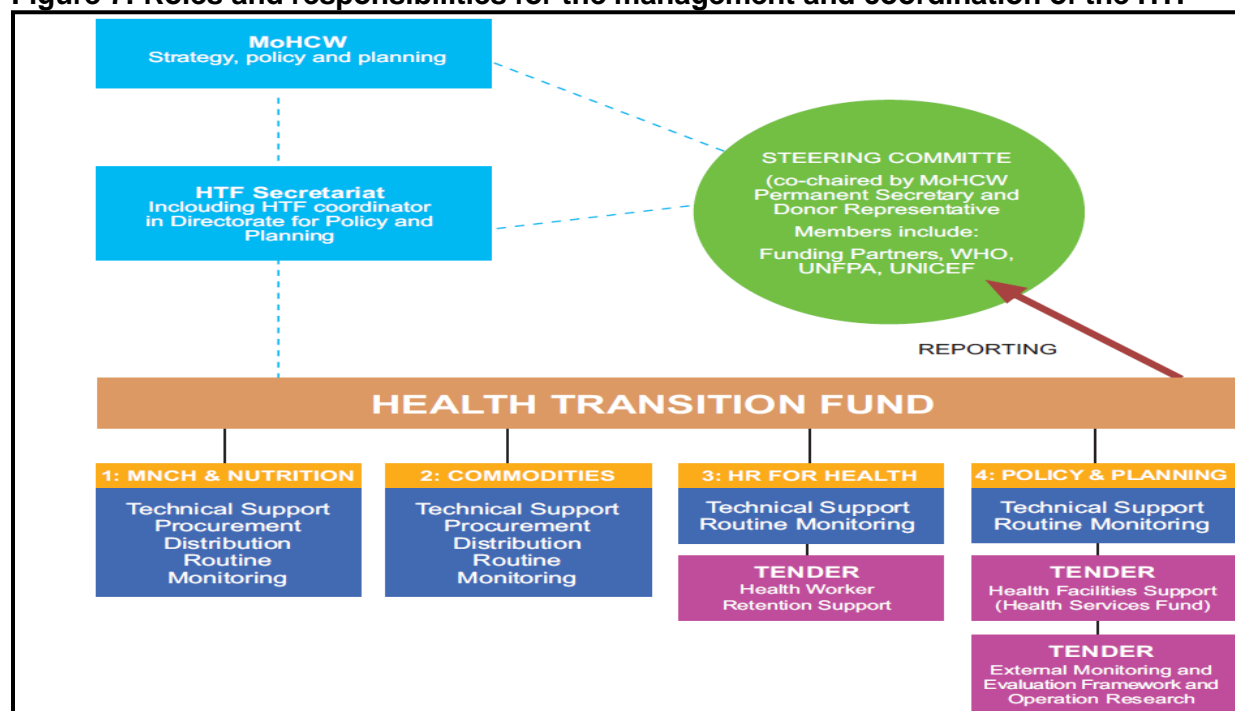
6. Semi-autonomous public institutional Mechanisms for Pooling and Management of Funds in Zimbabwe

There are several institutional mechanisms that are already existent in Zimbabwe that are used to pool and manage funds for health financing. These institutional mechanisms include the National AIDS Trust Fund (NATF), the HSF and the Health Transitional Fund (HTF). External funds for the health sector are harnessed through Vote of Credit and Health Services Fund. The vote of credit releases donor funds from the MoFED, while the HSF is directly managed by MoHCC. There is also pooling through the National AIDS Trust Fund which is funded by formal sector employees and benefits HIV/AIDS patients (Chipumho et al, 2013).

6.1 Health Transition Fund

The HTF is a 5-year plan formulated by the Government of Zimbabwe, UNICEF and other international donors to mobilize funds and resources in support of critical health interventions for the period 2011 to 2015 (See Figure 7).

Figure 7: Roles and responsibilities for the management and coordination of the HTF



Source: MoHCW, TARSC, KIT, 2013

The HTF is a multi-donor pooled funding mechanism. The HTF is not an organization, but a specific funding mechanism with no direct budget support to the Government at present. The fund focuses on four thematic areas, namely: maternal and child health care (which is provided for free); medical products, vaccines and technologies; human resources; and health policy and planning and finance. Abolishing health-care user fees is also one of the plan's key goals. It was set up to mobilize additional resources for the National Health Strategy and Health Sector Investment Case, and to manage risk, harmonize and align programming and ensure progress irrespective of political context. The fund complements resources for essential medicines, for the health worker retention scheme, and for the Health Services Fund.

Under the HTF the Government of Zimbabwe and development partners agreed to have a 3rd party – UNICEF – to pool and administer funds in support of the National Health Strategy. External funders pledge amounts to support the HTF budget Funds come into UNICEF financial systems and pooled together into one grant/several grants. UNICEF ensures financial regulations covering external funders are met. Contracts are signed between the external funders and UNICEF with signature of MOHCW (MoHCW, TARSC, KIT, 2013).. The HTF is guided by a code of conduct with a clear set of principles which are: the need to raise the health status of all Zimbabweans through an efficient and effective health system using a mechanism of transparency, openness and accountability; the observation of health-related resolutions entered into by the Government at both regional and international levels; and the observation of universal respect for human rights.

The HTF has a Steering Committee which is chaired by the Permanent Secretary of MoHCC. The Steering Committee comprises funding partners, representatives from civil society, UNICEF, WHO and UNFPA and is responsible for the oversight and management of the HTF. The partnership between Government of Zimbabwe and external funders in the HTF is guided by a Statement of Intent in executing its responsibilities (MoHCW, TARSC, KIT, 2013). The responsibilities of the HTF include, among others, the approving of funding allocations to thematic areas of work, approving Terms of Reference for implementing partners, participating in tender review Committees, approving annual, mid-term and end of programmatic and financial progress reports, and importantly, providing oversight to the appointment and oversight of independent professions to evaluate impact.

Funds come into UNICEF financial systems and are pooled together, and UNICEF ensures financial regulations are met with contracts signed between funders and UNICEF. UNICEF tracks funds received and funds spent using existing financial systems (IPSAS – International Public Sector Accounting Standards) and financial updates are shared and discussed with HTF Steering Committee at monthly meetings. If funds available are less than the estimated required budget, then goals are reduced proportionally. The budget allocations in 2013 were, for example,

- MNCH and Nutrition 17%;
- Medical Products, Vaccines and Technologies 38.5%;
- Human Resources For Health 15.7%; and
- Health Policy, Planning and Financing 28.7%. (MoHCW, TARSC, KIT,2013).

MoHCC ensures that HTF processes are in line with all rules, regulations and the legal framework for Zimbabwe.

Risk is avoided or managed by:

- Following international accounting procedures;

- National ownership of HTF by MoHCC / GOZ; working with mutual interest and shared concern;
- Ensuring a strong, functional Steering Committee that meets monthly;
- Sending of annual reports to all stakeholders including the external funders;
- Joint Annual Review (JRM) missions; and
- Including community health centre committees and civil society in governance structures.

The benefits of the HTF arrangement are:

- The Health Sector Investment Case sensitized external funders on the requirements of MoHCC to meet NHS priorities;
- The pooling of funds enables strengthening of the health system, avoids duplication and “cherry picking” of activities by external funders and allows for strengthening of the health system;
- All activities of the HTF are conducted using existing systems and structures in the country e.g. national midwifery training schools, Natpharm; and
- The mechanism thus allows for national ownership and a systems-response while transition to direct budget support is awaited. (MoHCW, TARSC, KIT, 2013).

The risks and challenges of the HTF included that some funders are unable to commit funds for the duration of the HTF and that the political and economic context could threaten the delivery of services and affect partner collaboration, especially given that all four thematic areas are interdependent (MoHCW, TARSC, KIT, 2013).

6.2 National AIDS Trust Fund

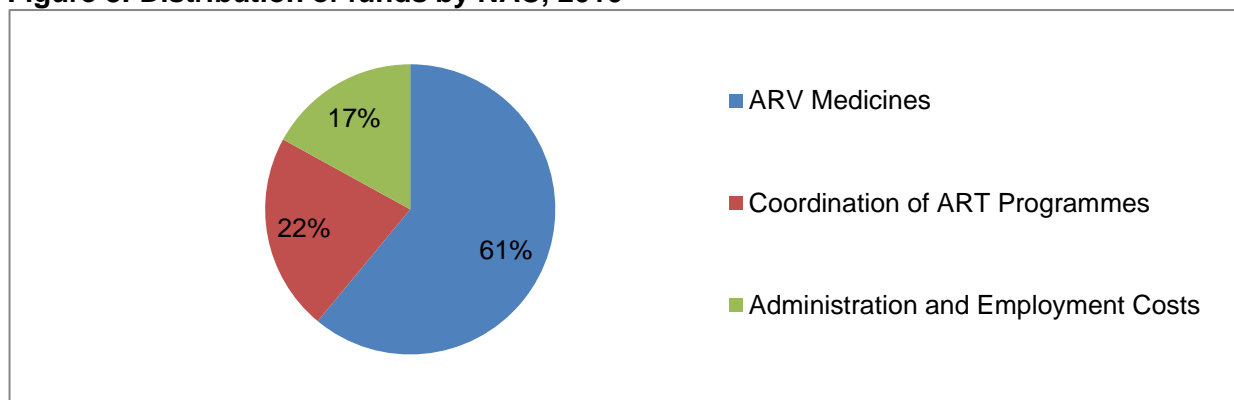
The NATF is an autonomous national fund formed in response to a recognition by Government of the growing AIDS epidemic and the need to raise resources to meet increasing demand for HIV prevention, treatment care and support. The NATF is financed through an AIDS Levy which was introduced in 1999 to compensate for declining external funder support in financing AIDS programmes. The fund has proved to be a good source of funding for the country’s HIV and AIDS patients. However, the amount collected per year is not adequate to cater for the growing requirements of the country due to low salaries and the poor performance of industry (Manenji, 2013).

The legal framework for fundraising was established through an Act of parliament that provided for an AIDS Levy which is charged on individuals, companies and trusts at a rate of 3% of income tax assessed. It was established by the Finance Act Chapter 23:04 Section 14, subsection 14 and 15, and the National AIDS Council Act Chapter 15:14, which also covers the appointment of Board & Committees, accounting and investment. The National AIDS Trust Fund administers the AIDS Levy fund, with a 12 member Board of Directors. The Public Finance Management Act Chapter 22:19 (on budgets, management accounts, appointment of both internal and external auditors) and State Procurement Act 22:14 (covering issues related to procurement by the Council) also apply as NAC is a state enterprise.

ZIMRA is responsible for the collection of funds, and the allocation of the funds to NAC. The funds allocated to NAC are spent according to %age guidelines set by the Board. Of the funds allocated to NAC, 55% goes towards treatment care and support; 11% goes towards prevention; 4% towards creating an enabling environment; 5% for program coordination; and 25% for programme logistics and support (Manenji, 2013). Accounts are fully up to date,

subjected to external audits, and spent according to a work plan and budget approved by MoHCC. According to the 2010 National Health Accounts, 61% of the funds collected by NAC were spent on ARV Medicines, 22% on Coordination of ART Programmes, and 17% on Administration and Employment Costs (Figure 8). This shows that most of the funds are spent on curative than preventive health care. Lower spending on preventive care ultimately leads to high treatment and care costs.

Figure 8: Distribution of funds by NAC, 2010



Source: MoHCC 2013

The NATF has been regarded as an international best practice in raising local funds for national response to HIV & AIDS (MoHCC 2013). There is widespread interest in replicating the NATF model outside Zimbabwe (Manenji, 2013). The NATF is sustainable, flexible, and able to respond to needs for prompt decision-making. In the NATF there is cross subsidization between the sick and the healthy as the AIDS levy is charged regardless of the health status of an individual and the funds benefit the sick. However, the decline in the size of the formal sector has severely reduced inflows to the AIDS levy fund leading to the fund's inability to meet demand (MoHCW, TARSC, KIT, 2013). The challenges faced by NATF at its inception include lack of trust and confidence by stakeholders partly as a result of lack of public awareness and information about the NATF (MoHCW, TARSC, KIT, 2013).. Hyperinflation in the period 2006-2008 also severely reduced real inflows to the AIDS levy fund, limiting its contribution to an already weakened health delivery system. The lessons drawn from the NATF, include maintaining a smaller coordination/administration structure, integrated within existing local development/health structures; having specific and clear criteria for grant allocation; ensuring transparency and accountability such as through timely audit; ensuring that key stakeholders are represented on the board; making timely disbursements; including the small to medium enterprises and informal sector; involving the private sector - medical insurance, pharmaceutical manufacturers and retailers and private medical doctors (MoHCW, TARSC, KIT, 2013).

6.3. Health Services Fund

The HSF was set up in 1996 to supplement the health budget for the maintenance of Health Services. The fund aims to collect and administer fees to supplement the health budget, recurrent and capital, to develop and maintain health services, programmes and related activities as may be approved from time to time by the Secretary for Health and Child Care in consultation with Treasury (MoHCW, TARSC, KIT, 2013)..

The Fund was established in 1996 in terms of section 30 of the Audit and Exchequer Act (chapter 22: 03) and operates in terms of the Public Finance Management Act (chapter 22: 19) 2009. The HSF is managed through a constitution under the MoHCC and presided over by the Secretary for Health and Child Care. While the Secretary for Health has overall responsibility for the proper and transparent management of the fund, the Public Finance Management Act governs its implementation.

The HSF income comes from Hospital Fees, interest earned on bank credit balance and from financial investments, government grants and donations from development partners and other fund raising activities. Guided by a clear set of principles for expenditure including accounting and expenditure, expenditures are incurred in pursuance of the objectives of the Fund; in line with an approved budget; with the chart of accounts used for government expenditure, subject to adherence to procurement procedures and as a proper charge against public funds (Mabhandi, 2013).

Value for money must be realized on all expenditure transactions. Every station of the HSF maintains a complete set of books of accounts for the Fund in terms of (Section 49 of the Public Finance Management Act Chapter 22: 19) with a cash book; general ledger and all cash collected/received should be receipted, recorded in the cash book and lodged with the bank. The funds are deposited in a Temporary Deposit Account (TDA) which is an official government bank account opened by stations and used to hold public funds on a temporary basis. Separate bank accounts may also be opened to cater for separate accounting for specific funding arrangements, as for example was requested for the Results Based Financing project and the HTF to disburse to health facilities. The district facilitates opening of the bank accounts for rural health facilities in their districts. All payments made from HSF must be recorded in the cashbook and in the general ledger under respective expenditure accounts and at the end of each month the cash book balance must be reconciled with the bank statement (Mabhandi, 2013).

The HSF is a decentralized fund and the roles of the Province and the District Health Executive (DHE) in the management of funds are as follows. The DHE

- Prepares an annual budget;
- Implements the system of financial management and internal control for the Fund in line with PFMA related rules and regulations;
- Ensures effective, efficient, economical and transparent use of the financial resources for the fund; and
- Takes effective and appropriate steps to prevent any irregular expenditure and fruitless and wasteful expenditure and any under-collection of revenue due.

The province is responsible for:

- Approving HSF budgets for districts;
- Monitoring and supervising the activities of the Fund in the province;
- Providing guidance on policy, procedures, rules and regulations to the Districts;
- Producing consolidated financial reports and accounts for province and central levels, and
- Responding to queries raised by the Accounting Officer, Director Finance and Auditors regarding consolidated financial reports, accounts and the activities of the Fund in the province (MoHCW, TARSC, KIT, 2013)..

The HSF is affected by challenges which include the recovery of outstanding fees from debtors; delays in reporting at different levels that have in turn, impacted on the timely preparation and

delivery of income and expenditure statements; staff attrition in the crisis period impacted negatively on the management of the required levels of accountability(MoHCW, TARSC, KIT, 2013).

7. Affordability and Accessibility of Health Services

7.1 Affordability of health care

The Zimbabwean economy has been recovering since 2009 from the economic crisis that hit the country over the period 2000-2008. Although the economy is stable and recovering due to dollarization and political stability, this has not translated into growth in employment. Most of the companies are struggling to operate due to liquidity challenges and some are operating below capacity. This has led to some companies closing and scaling down their operations and most of the people are being retrenched from work. With most being informally employed, it means that those under health insurance are few and most people face challenges in affording health care services. In 2010, the NHS indicates that of the people who fell ill, 18% stayed at home and did not seek medical attention at health facilities because some self-medicated their selves (5%) and some just stayed at home (13%). Although the reasons are not specified why 13% of the people stayed at home, the reasons might include challenges in affording health care (MoHCW 2010).

According to Mondal et al (2010), household expenditures greater than 40% of non-food expenditure are classified as catastrophic. In Zimbabwe, for those households who fall ill and seek medical attention, the health care expenses they incur are catastrophic as the highest figure of 94.78% of income was paid for consultation while the rest was for other services. Investigations, food and other services each accounted for proportions below 1% while drugs and transport accounted for 2.11% and 1.17%, respectively (MoHCC, 2013).

7.2 Accessibility of health care

In Zimbabwe, public health facilities constitute 70% of total health facilities while private health facilities constitute 30%. For these health facilities, private health facilities are 9 km on average from the furthest community within their catchment area, while rural health centres/clinics are 25 km, mission hospitals are 38 km, and district hospitals 121 km. Though public health facilities are many, on average they tend to be further from the people compared to private facilities, particularly in rural areas (Osika et al, 2010).. In rural areas accessibility in terms of distance is affected by poor transport infrastructure which results in lack of public transport. Health facilities do outreach programmes in order to compensate for challenges associated with distance, and most of the facilities that are far from the furthest communities do most outreach programmes than those closer to communities (Osika et al, 2010)..

Service deliver in health facilities, particularly public facilities, has been affected negatively by the macroeconomic climate and shortage of experienced health professions due to outmigration. For example, internal economic flows within Zimbabwe are weak to support the NatPharm and MCAZ systems for the provision of all health commodity needs in the country, and consequently this has resulted in stock-outs of essential drugs, vaccines, and medical supplies, laboratory equipment, reagents, and personnel to deliver comprehensive services across the country (Osika et al, 2010).

8. Conclusions

On revenue collection, the primary sources of health financing were identified as the Government, the households, employers and donor community. The main source of health financing as at 2010 was households (39%); followed by employers (21%); external funders (19%) and Government (18%). There is high external funder dependency for health financing which is usually unreliable; unpredictable; unsustainable and highly depend on political environment, raising concerns on the sustainability of health financing institutions and the vulnerability of Governments budget should external funding be withdrawn.

Although total health expenditure (public and private) as a percentage of GDP was high, about 15%, this did not necessarily mean that the health sector was adequately financed, but rather a consequence of a lower level of GDP in the rebound from the economic crisis of 2000 to 2008. Lower levels of per capita health expenditure indicated that health expenditure in the country is insufficient to guarantee adequate access and quality of health care. Total Government expenditure on health as a percentage of total Government health budget was less than 15% over the review period. Out of pocket payments were high at 50.97%, reflecting the limited extent of pooling of private resources and inadequate public financing, exposing the population to catastrophic health care expenditures and creating barriers to access to health care.

The MoHCC health expenditure kept pace with inflation and population growth, indicating that the resources allocated to health at least did not go down in real terms over the period 2010 to 2013. However, the budget has been inadequate as a source of health funding and actual disbursements have not met the planned health expenditure. The burden of funding the funding gap is borne predominantly by the population through OOP expenditures.

The budget process is bottom-up, starting at facility level –with the district playing a major role– and culminating in a consolidated budget at the MoHCC. In this regard, the health budget is likely to reflect the needs defined by local services and their funding needs. However this local level input may not always be included as decisions on the budget are consolidated at higher levels in the MoHCC. The budget is historically based and demand based and not needs based in allocation. The actual allocation is based on programmes and service delivery areas, making it possible to track and evaluate if funding is being applied to intended programmes.

In Zimbabwe there is no social health insurance scheme, and private insurance is dominated by MAS. There is also no community based health insurance. There are about 26 registered MAS, but only 3 key players dominate the market and together they account for 90% of the market. There is no meaningful pooling of risk among the rest of the 23 registered players who account for 10% of the market and MAS schemes are internally segmented. MAS cover only 10% of the population, which is mainly formal employees, wealthy women and men, and their dependents in urban areas, excluding poor women and men, informally employed and rural inhabitants. Although their presence in most cities and towns widens geographic cover, differences between the MAS, and in the benefit packages covered, segmented packages and no cross-subsidies between different schemes and different income groups of beneficiaries mean that MAS do not provide any meaningful level of cross subsidy. Inequalities also exist in the form of tax credits that are based on one's expenditure on health care services. About 6.9% of MAS members find it difficult to get special therapy on their medical plans, and a considerable number of members find it difficult to access medicine on their plans. Few beneficiary plans give full reimbursement for services provided outside their managed care plans. This weakens financial protection of the plans for members. Collectively, the MAS spend 56% of the subscriptions on administration and

44% on health care services, implying that they mainly use subscriptions on sustaining their organisations while their clients have to make OOP payments.

The institutions and/or arrangements that have been used to pool funding in Zimbabwe include the HTF, NATF and HSF. The HTF is an arrangement between the Government of Zimbabwe and the donor community to mobilize pool and manage funds for health financing, where earmarking is done externally but there is no earmarking internally. Although the fund avoids duplication and 'cherry picking' of activities by external funders and utilizes existing systems and structures, it is affected in terms of its reliability and sustainability as some external funders cannot commit funds for the duration of the HTF and as it is threatened by the political and economic environment. Although the HSF has decentralized features that enable local participation and flexible decision-making on funds use and is governed by both law and a constitution, and is integrated within the existing systems and structures, it suffers from delays in reporting and lack of harmonization between constitution and law. Although NAC has been a best practice regionally and internationally, it could be improved through extending its roles towards other diseases and services and linking funding with results as well as providing public information.

This review will be followed by field work to follow up and verify whether some of the issues identified from the documentary analysis and highlighted in this paper are consistent with the practices on the ground. Some of the issues that will be followed up, include the issue of the public health budgeting process, which although described as bottom-up, needs further examination to see in practice the extent to which local input influences central decision making at the MoHCC. It has been mentioned in the documents reviewed that there is a formula for equitable allocation of resources across health facilities but the formula is in little use and therefore there is need to investigate why the formula is little used. This component of the study will also benefit from other the review of other country experiences which is being undertaken by KIT the Rebuild research programme. There is need to explore why external funders are not keen to channel funds directly to the Government through the MoFED. The period under review has witnessed significant shift in external funding, whereby development partner funding was extra budgetary and going direct to projects, thereby creating different layers of accountability and system within the health system. Follow up work may explore why the variance between planned and actual health expenditure is very large, above 33% over the period 2009 to 2013 and what can be done to reduce the deviation. For the Rebuild programme these questions will be explored together with other issues affecting governance and management specifically in relation to the semi-autonomous funds raised in this report.

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