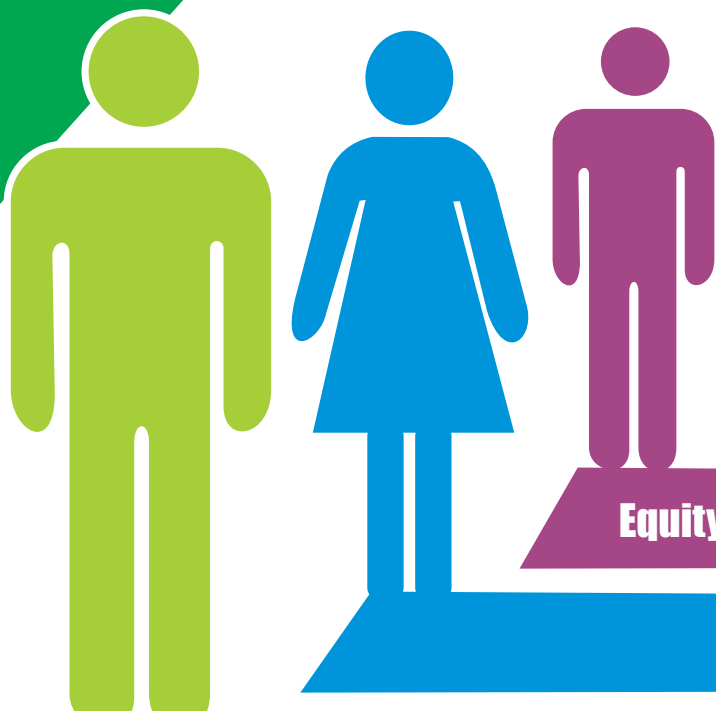


# Zimbabwe National Health Financing Policy

## “Resourcing Pathway to Universal Health Coverage” 2016



Zimbabwe



**Equity & Quality in Health: Leaving No One Behind**





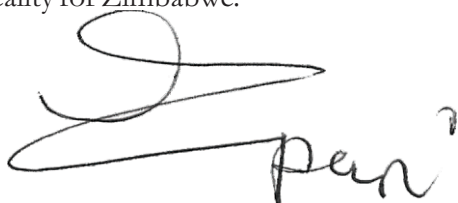
## FOREWORD

I am pleased to introduce Zimbabwe's Health Financing Policy. This policy presents the policy directions the Government of Zimbabwe will adopt to move towards Universal Health Coverage (UHC); that is, ensuring that all citizens have access to quality health services they need without suffering financial hardship.

Over the past two decades, Zimbabwe has implemented various innovative health financing reforms that have been successful. Some of the most significant reforms have been: the AIDS levy, which has seen significant funds targeted towards the hiv/aids pandemic response; and Results Based Financing, which has addressed critical gaps in the maternal and child health area. Despite these initiatives, significant challenges within health financing remain. Zimbabwe is behind in meeting the Abuja Declaration of allocating 15% of the Government's budget towards health; health insurance covers less than 10% of the population; an out of pocket expenditure of over 39% of all health expenditure leading to financial impoverishment for many Zimbabweans; and challenges in the purchasing of services and in equity in accessing health services.

Zimbabwe's first Health Financing Policy seeks to respond to these challenges by providing the overarching framework to ensure that required resources needed to achieve UHC are raised sustainably, allocated according to need and efficiently utilised. This policy presents an opportunity to analyse the current situation and plan for strategies to raise sufficient resources, assess financial and medical risks, and govern the purchasing function and health financing in general so as to meet the goal of UHC for Zimbabwe.

This policy provides a foundation for all stakeholders in the health sector to work together in addressing the current and future health financing challenges that hinder UHC for Zimbabwe. As we move towards operationalizing this policy, I urge all stakeholders to be involved and to work together with ministry to make UHC a reality for Zimbabwe.



**Dr P. D. Parirenyatwa (Senator)**  
**Minister of Health and Child Care**



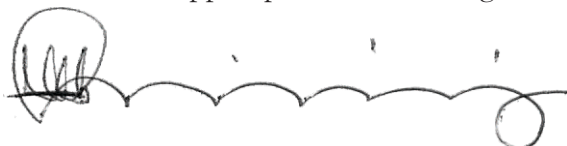
## ACKNOWLEDGEMENTS

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The Ministry would also like to thank all the organisations and individuals from the civil society, NGOs, government ministries, labour, industry and development partners who participated in the stakeholder consultation that provided critical input into the development and finalisation of this policy.

The Ministry extends its gratitude to the Department of Policy and Planning led by Dr R Mudyiradima (Principal Director) and the following members: Mr S. Banda (Director Policy and Planning), Mr G. Gwati (Donor planning and Coordination Officer and Mr T. Kadzere (Strategy and Planning Development Officer) as well as other members of the department who supported the development of this policy.

Finally the Ministry would like to thank World Bank and the Clinton Health Access Initiative for the technical and financial support provided in driving this work forward.



**Brigadier General (Dr) G. Gwinji**  
**Secretary for Health and Child Care**



## DEFINITIONS OF TERMS

**Revenue collection:** The means by which health systems raise money from households, businesses, and external sources.

**Pooling:** The accumulation and management of revenues so that members of the pool share collective health risks, thereby protecting individual pool members from large, unpredictable health expenditures.

**Prepayment:** Allows pool members to pay for average expected costs in advance, relieving them of uncertainty and ensuring compensation should a loss occur.

**Purchasing:** The mechanisms used to secure services from public and private providers.

**Universal Health Coverage:** Health care whereby all people receive the health services they need without suffering financial hardship when paying for them. The full spectrum of essential, quality health services should be covered including health promotion, prevention and treatment, rehabilitation and palliative care.

**Out of pocket expenditure:** Any direct outlay by households, including gratuities and in-kind payments, to health practitioners and suppliers of pharmaceuticals, therapeutic appliances, and other goods and services whose primary intent is to contribute to the restoration or enhancement of the health status of individuals or population groups. It is a part of private health expenditure.

**Essential benefits package:** A package of defined health service (preventive and curative) that are delivered at a minimum at each level of care.

## LIST OF ACRONYMS

ART	Antiretroviral Treatment
CBHI	Community Based Health Insurance
CRF	Consolidated Revenue Fund
DALY	Disability Adjusted Life Years
DFID	Department For International Development
DHIS2	District Health Information Software
EU	European Union
FDI	Foreign Direct Investment
GDP	Gross Domestic Product
GoZ	Government of Zimbabwe
HDF	Health Development Fund
HFP	Health Financing Policy
HTF	Health Transition Fund
IMF	International Monetary Fund
KRA	Key Result Area
MDG	Millennium Development Goals
MMR	Maternal Mortality Ratio
MOFED	Ministry of Finance and Economic Development
MOHCC	Ministry of Health and Child Care
NAC	National Aids Council
NATF	National Aids Trust Fund
NATPHARM	National Pharmaceutical Company
NCD	Non-Communicable Diseases
NGO	Non-Governmental Organisation
NHA	National Health Accounts
NHI	National Health Insurance
NHS	National health Strategy
NSSA	National Social Security Authority
OOP	Out Of Pocket payments
PDL	Poverty Datum Line
PEPFAR	President's Emergency Plan for AIDS Relief
PER	Public Expenditure Review
PICES	Poverty, Income, Consumption, Expenditure Survey
RF	Results Based Financing
RBM	Results Based Management
RDC	Rural District Council
RM	Resource Mapping
RMNCH	Reproductive, Maternal, Neonatal and Child Health
SDG	Sustainable Development Goals
SHI	Social Health Insurance
TARSC	Trainings and Research Support Centre
TB	Tuberculosis
TWG	Technical Working Group
UHC	Universal Health Coverage
VAT	Value Added Tax
WHO	World Health Organisation
ZACH	Zimbabwe Association of Church Related Hospitals
ZDHS	Zimbabwe Demographic and Health Survey
ZIMASSET	Zimbabwe Agenda for Sustainable Socio-Economic Transformation
Zimstat	Zimbabwe National Statistic Agency



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# INTRODUCTION

## 1. MOTIVATION AND CONTEXT

The Government of Zimbabwe (GoZ) is mandated to deliver quality and equitable health services to the population of Zimbabwe with the desire to have the highest possible level of health and quality of life for all Zimbabweans. This is to be attained through the combined efforts of individuals, communities, organizations and the Government which will allow Zimbabweans to participate fully in the development of the country. This vision will be attained through guaranteeing every Zimbabwean access to an essential health services package. The Ministry of Health and Child Care (MOHCC) has therefore committed to the following Goals or Key Result Areas (KRAs):

- Strengthening priority health programmes;
- Improving service delivery platforms or entities; and
- Improving the enabling environment for service delivery.

The ultimate goal is to have a healthy population with equitable access to quality services through a strengthened health system. As part of its mandate to give strategic direction in health sector financing, the MOHCC has developed this first Health Financing Policy (HFP): “Resourcing Pathway to Universal Health Coverage”, 2016-2026. The policy will be followed by an implementation strategy to be developed by the GoZ.

The HFP is fully based on evidence gathered from a large range of documents produced by MOHCC in collaboration with partners such as the Public Expenditure Review (2015), Health Sector Resource Mapping (2015), the National Health Strategy (2016), the National Monitoring and Evaluation Framework (2016), and the National Health Accounts (NHA) 2010. In addition, the development of the policy was highly informed by work done under the Universal Health Coverage Technical Working Group and the Rebuild Consortium in the evaluation of various health financing options for Zimbabwe towards universal health coverage. The HFP also greatly benefitted from recent survey and government data compiled to produce National Health Accounts.

### 1.1 Process of Policy Development

The development of this policy was highly consultative. The MOHCC established a multi-sectoral Technical Working Group (TWG) to manage the entire policy development process. The TWG was composed of government ministries, development partners, non-governmental organizations (NGOs) and academic research bodies. A core team led the technical drafting of the policy reporting to the TWG. Various stakeholder workshops were conducted with health workers, community leaders, development partners, government agencies and communities to obtain key input into the draft policy before finalization.

## 2. SITUATIONAL ANALYSIS

### 2.1 Socio Demographic Profile

The Republic of Zimbabwe is a country in Southern Africa, comprising ten administrative provinces. Each province is further divided into districts, with a total of 63 districts. In 2012, the Zimbabwean population was approximately 12.9 million with 52% women and 48% men and a life expectancy at birth of 50 for women and 45 for men. From the Zimbabwe National Statistics Agency (ZIMSTAT) 2012 census, 41% of the population is below the age of 15 and 4% of the population is above the age of 65. Approximately 55% of the population is capable of contributing to the economic activity of the country. The crude birth rate is estimated at 35/1,000 and crude death rate at 10/1,000 with a projected population growth of 3% (World Bank 2014). In terms of population distribution by geography, 70% of the population resides in the rural areas and 30% resides in the urban areas.

### 2.2 Economic Profile

Zimbabwe has a gross domestic product (GDP) of \$12.58 billion in 2015 and is projected to grow by 1.4%, with per capita real GDP of \$954 estimated to grow at 0.2% in 2015 and 0.5% in 2016 as a result of growth in mining and agricultural sectors. Over 72% of the population lives below the poverty datum line (PDL) of \$505 in 2015 (ZIMSTAT) and poverty levels are relatively higher in rural areas (84.3%) than in urban areas (30.4%) (ZDHS 2010/11). Zimbabwe has a high level of unequal distribution of wealth between individuals and households with a GINI index of 50.1 in 2006.

Approximately 10% of the Zimbabwean population is formally employed and close to 70.6% of the population informally employed. Zimbabwe has a very high proportion of tax revenue as a proportion of GDP of 27% (IMF); however, this is still lower than the proportion of government expenditure to GDP of 29%, with the government facing perennial spending deficits which are financed through borrowing.

Zimbabwe's foreign direct investment (FDI) has been steadily growing from \$105M in 2009 to \$591M in 2015 and is projected to be \$614M in 2016. Due to limited domestic and external funding and economic activity, there has been a decline in infrastructure, a lag in technological advancement, and a decline in social service delivery.

### 2.3 Epidemiological Profile

Although significant progress has been made over the last few years, the country still faces a double burden of communicable and non-communicable diseases. The top four causes of disability-adjusted life years (DALYs) in Zimbabwe are HIV/AIDS, lower respiratory infections, diarrheal diseases and tuberculosis (TB). Life expectancy at birth is 59 for males and 62 for females and mortality between the ages of 15 to 60 years per 1,000 of the population is 385 for males and 288 for females (WHO). HIV/AIDS remains a significant public health problem in Zimbabwe. The HIV prevalence for adults (15-49 years) has declined by 5.6% from 2011 to 15% in 2014 (UNAIDS 2014). Mortality has also declined due to increased ART coverage which stands at 72% for adults and 44% for children.

The number of new cases of TB notified has generally declined in the last few years, from 378/100,000 in 2010 to 269/100,000 in 2013 whilst confirmed cases are at 86/100,000 in the same year. Mortality from TB remains high at 10%, mainly due to the high HIV/TB co-infection rate of around 69% (National TB Prevalence Survey 2013), especially in poor and densely populated communities.

The country made significant strides in reducing infant mortality rates and Maternal Mortality Rates (MMR), but did not manage to meet its 2015 Millennium Development Goals (MDGs). MMR declined from 960 per 100,000 live births in 2010-2011 to 651 per 100,000 live births in 2015 (ZDHS 2015). This remains high in

1. MOFED 2013 Database

2. African Economic Outlook <http://www.africaneconomicoutlook.org/en/country-notes/southern-africa/zimbabwe/>

3. World Food Programme 2015 <https://www.wfp.org/countries/zimbabwe/overview>

comparison to the MDG target of 174 per 100 000 live births. Similarly, the under-five mortality rate dropped from 84 deaths per 1,000 live births in 2010/11 to 69 deaths per 1,000 live births in 2015 but falls short of the 2015 MDG target for Zimbabwe of 25 deaths per 1,000 live births. The infant mortality rate decreased from 57 deaths per 1,000 live births in 2010/11 to 50 deaths per 1,000 live births in 2015 (ZDHS 2015).

Recent ZDHS 2015 results indicate that there is a downward trend in stunting from 35% in 2005/6, to 27% in 2015 for moderate stunting and 9% for severe stunting with noted disparities by geography. Stunting remains high in rural areas (30%), compared to urban areas (20%) and there are gender disparities (MICS 2014). Of concern is that 10% of children are born already stunted and this points to a need for maternal, pre-pregnancy and adolescent nutrition interventions.

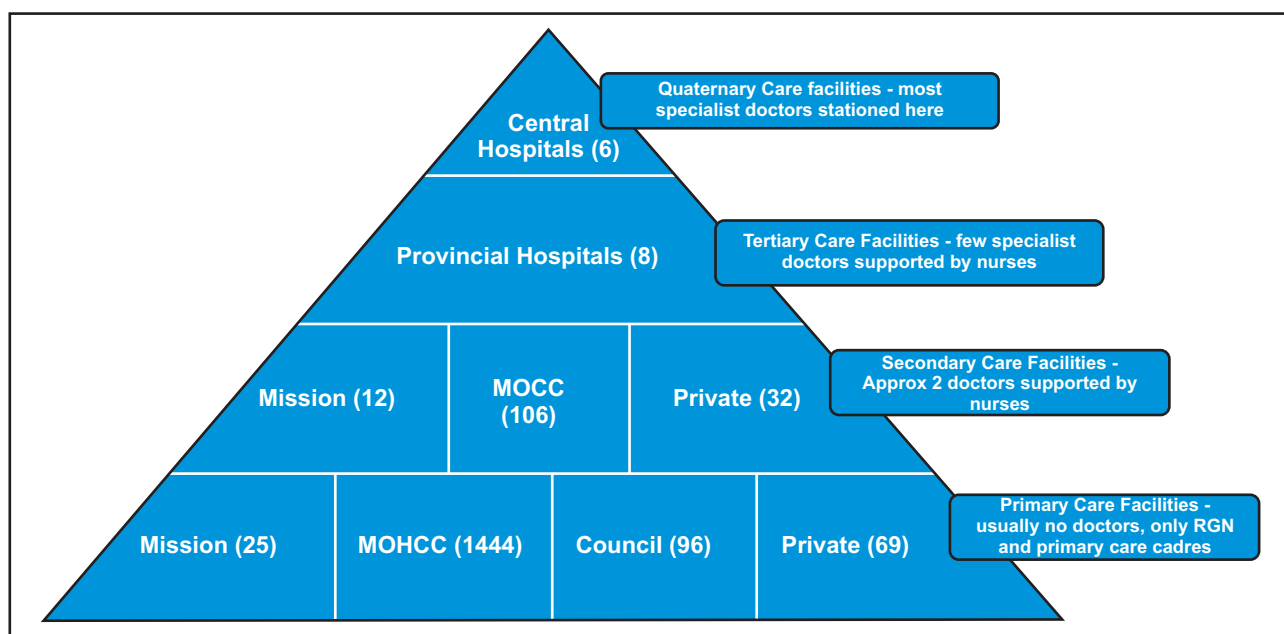
Malaria still remains an important communicable condition in Zimbabwe with 47 of the 63 districts considered high burdened. Ownership of treated nets for malaria prevention is highest in Matabeleland North and Lowest in Harare (ZDHS 2015). The incidence of malaria has declined from 58 per 1,000 of the population in 2009 to 39 per 1,000 of the population in 2014. Malaria case fatality rate reached its lowest at 6.1% in 2012 but has since exceeded its 2012 levels to 13.8% by 2014 (MICS 2014).

Besides HIV/AIDS, TB and Malaria, the Zimbabwean population now faces a high disease burden from the rise in non-communicable diseases (NCDs). In 2012, of the 138,000 total deaths from communicable and non-communicable diseases, NCDs' share was 31%. Cancers accounted for 10% of total NCD deaths followed by cardiovascular diseases at 9%, injuries at 8% and other NCDs at 4% (WHO). The burden of NCDs is expected to continue rising especially when combined with communicable diseases such as HIV infections.

## **2.4 Zimbabwe Health System Structure**

The delivery of health services in Zimbabwe is guided by national level governance frameworks in the form of the Constitution and the National Economic Plan. The National Economic Plan then feeds into the National Health Policy and the National Health Strategy, which are directly responsible for the governance of the health sector. Implementation of all ministries' activities within Zimbabwe is guided by the Results Based Management (RBM) system, which was adopted in 2013 to ensure improved public sector performance and accountability. From the RBM framework, every year the MOHCC develops operational plans to coordinate all stakeholder activities required to meet the objectives outlined in the National Economic Plan and the National Health Strategy.

Zimbabwe's health services are accessed through several platforms, including: public facilities, non-profit-run facilities, religious/mission organizations, and the private sector (for-profit facilities). The public sector is the major provider of health services in Zimbabwe and is comprised of the Ministry of Health and Child Care, Ministry of Defense, Ministry of Justice and Legal Affairs, Ministry of Local Government, Public Works and National Housing and Mission Health Services. The Poverty, Income, Consumption, Expenditure Survey (PICES) 2011/12 show that 50.5% of the extremely poor and 43.3% on the non-poor access health through public facilities in comparison to 8% and 18.8% respectively that use private facilities. The health service provision is shown in Figure 1 below, showing types of facilities and the number of facilities of each type:



*Figure 1: Health Service Provision Structure in Zimbabwe (Adapted from SARA 2015)*

There is a clear separation of functions and a distinct referral system across the different levels of care within the public health system - health centers (along with various mission and council facilities) are supposed to be the first points of entry into the health system and all cases that cannot be dealt with at primary level are referred to the District, Provincial and Central Hospitals. However, there are not adequate gate keeping mechanisms to ensure adherence to this referral system.

## 2.5 Laws and Regulations in Health Financing

Multiple pieces of legislation exist in Zimbabwe to govern the various components of health financing functions and the delivery of health care. The main legislation for health is the Constitution, which guarantees health as a right for all citizens. The Constitution of Zimbabwe Section 76 clearly states that:

- Every citizen and permanent resident of Zimbabwe has the right to access basic health care services, including reproductive health services.
- Every person living with a chronic illness has the right to have access to basic health care services for the illness.
- No person may be refused emergency medical treatment in any health care institution.
- The State must take responsible legislative and other measures, within limits of the resources available to it, to achieve the progressive realization of the rights set out in the constitution.

Within the health sector, major regulations include the Health Services Act (2002), the Public Health Act (2002), the Public Finance Management Act (2010), the Medical Services Act (year), the Mental Health Act (year), and the Health Professions Act (2000). Some regulation includes the private sector. Other acts and policies that govern specific components of the health system draw from these major pieces of legislation.

The various pieces of legislature also create various bodies and institutions that oversee enforcement of these laws and regulations.



### 3. FINANCING FOR HEALTH IN ZIMBABWE

#### 3.1 Domestic Financing for Health in Zimbabwe

Zimbabwe's health system has been consistently financed by a mixture of domestic funding sources. The major domestic funding sources include: Central Government through budget allocation, sub-national government (local authorities), households, NGOs (including religious organizations and local philanthropies), and private companies.

##### 3.1.1 Government Funding

In 2010, of the total health expenditure, government funding accounted for 18%, donors 19%, private companies and others 24%, and out-of-pocket (OOP) 39%.

Government funding to health has primarily been raised through taxes such as value-added tax (VAT) and income taxes collected through the Consolidated Revenue Fund and allocated to health in the national budget. Figure 2 below shows the Government's per capita allocations to health over the years.

In 2009, health share of total government budget was 12%. This slowly declined throughout the years to 7.46% in 2016. However, absolute allocations to health steadily rose from \$119M in 2009 to \$340M in 2016 whilst government budget grew from \$1B in 2009 to \$4.4B in 2016. The MOHCC also maintained its position as priority ministry remaining in the top five ministries to receive the largest disbursements during this period. However, throughout this period, disbursements to health remained unpredictable and below budget allocation with only around 80% of the budget allocated and most of it going to salaries. In addition to allocations through the budget, a special financing provision for AIDS, the AIDS Levy, contributes significant earmarked funds towards health. In 2009, AIDS Levy contributed \$5.7M, steadily rising to close to \$38M in 2015 (NAC). This has been critical in augmenting domestic resources to the health sector.

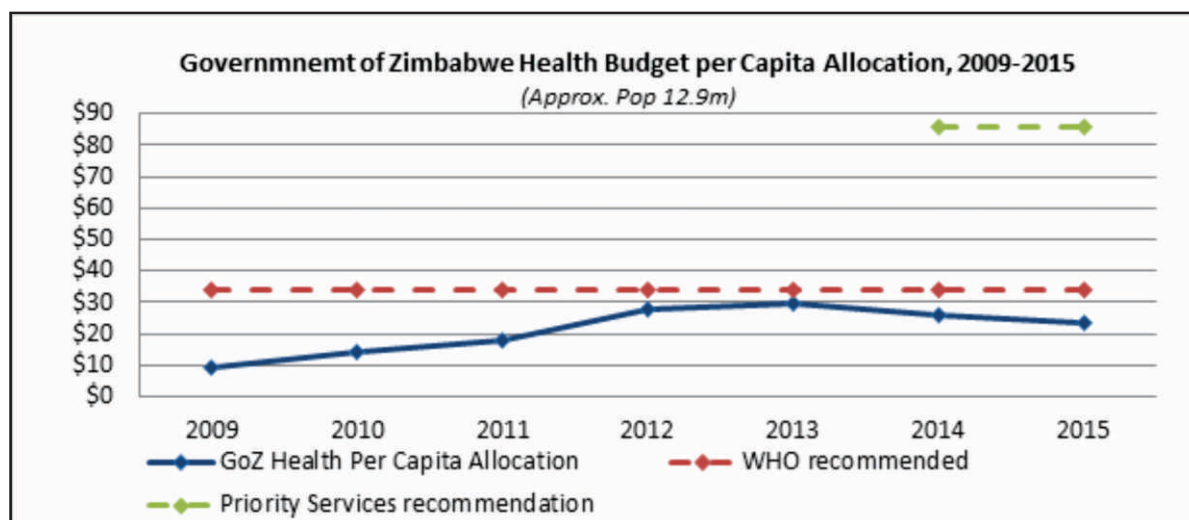


Figure 2: GoZ Health Budget Per Capita Allocations (Source: MOFED database)

##### 3.1.2 Local Government Funding

In addition to central government allocations to health, sub-national government through rural and urban councils also commits significant resources to health. Zimbabwe has 32 urban councils and 60 rural district councils. Though individual budget allocations to health differ from one council to the other, urban councils allocate higher sums to health than their rural counterparts. In 2015, Resource Mapping showed that \$80M was budgeted for health from local authorities and that the two metropolitan city councils of Harare and Bulawayo contributed 80% of the budget. Local authorities generate their revenues through various means including rates and levies on residents, charges and other fees such as licensing as well as user fees when accessing various services like health, water, etc. However, allocations are higher than disbursements as the economic environment has significantly affected revenue collection in local authorities.

## 3.2 Private Sector Funding

### 3.2.1 Private Not-for-Profit - House Hold Funding:

Individual households in Zimbabwe contribute significant resources to the health sector annually. Besides contributions made to various medical aid schemes, households also pay directly to access various health services. According to the 2010 National Health Accounts (NHA), household OOP expenditure was very significant at 39% of total health expenditure. Within government public health facilities, household payments are managed under the Health Services Fund which allows facilities to hold these funds at facility level as well as give them autonomy for their use. Within the private sector, household payments are high as only 10% of the population is covered by some form of insurance, which are also associated with various co-payments when accessing services. Individuals also contribute through insurance premium payments to private insurance. Though some employers contribute premiums for their employees, those who are not formally employed also contribute their own premiums. However, a consequence of higher OOPs is that people are deterred from seeking health services, e.g. 40% of people who did not seek health care when sick in 2012 cited higher costs of access to care (World Bank Public Expenditure Review [PER] 2014).

### 3.2.2 Private Not for Profit - NGOs and Other Philanthropic Funding:

Zimbabwe's external funding is primarily channeled through various NGOs that implement health activities. In addition to external donor funding, some of the NGOs have various sources of domestic funding; the level of domestic funding is however insignificant compared to external funding. In addition to various NGOs, church owned facilities also play a crucial role in financing and providing healthcare. Using a mixture of domestic and external charitable funds, churches own and operate various facilities from health centres to district hospital levels. Church related facilities are coordinated through the Zimbabwe Association of Church Hospitals (ZACH), an independent body which church related facilities are voluntarily affiliated. Other local philanthropic organizations also channel funds towards significant health concern areas (such as disabled needs, cancer etc.) that are usually not adequately financed by mainline sources of funding.

### 3.2.3 Private for Profit Funding

The private sector contributes to health financing in various ways such as:

- 1) Paying a portion of their employees premiums to health insurance;
- 2) Reimbursing costs of health care incurred by their employees;
- 3) Providing on-site health services in their premises and other health programmes financed by the company's resources; and
- 4) Engaging in corporate social responsibility activities for public use e.g. a mining company building a TB clinic near a mine.

Substantial private sector contributions to health care funding came from private health insurance which contributed 18% of total health expenditures according to the 2010 NHA whilst other private contributions such as workplace hospitals contributed 4%. Zimbabwe has a fragmented private insurance industry with over 30 health insurance companies that cover various sectors but mostly the formally employed.

## 3.3 External Resources for Health

External funding to Zimbabwe's health system has been an important source of financing especially in light of the impact of the 2008-09 economic crises. Since 2008, donor funding accounted for 19% of total health expenditure compared to 13% in 1999. In absolute figures, external funding for the health sector declined from \$154 million in 2009 to \$88 million in 2011, before steadily rising to \$511 million in 2015. The majority of donor funding has been earmarked and channeled through specific disease areas such as HIV/AIDS, Maternal and Child Health, and Malaria. In 2015, donor funding for health was \$511M and over 80% of this was channeled towards HIV/AIDS, Reproductive, Maternal, Neonatal and Child Health (RMNCH), Vaccines, TB and Malaria. External funding is highly dependent on a few major donors such as The Global Fund which contributed 45% of total external resources in 2015 followed by PEPFAR at 27% and the Health Transition Fund (HTF) pool with 12% (MOHCC Resource Mapping 2015). There is need to mobilize additional external funds that are not earmarked for specific activities but aimed at strengthening the overall health care system especially given that domestic resources are mostly funding salaries.



## 4. HEALTH INSURANCE AND POOLING OF FUNDS IN HEALTH

The development of health insurance in Zimbabwe has been highly limited and is not equitable. Zimbabwe has no developed systems on social health insurance or community based health insurance. The insurance sector is dominated by private health insurance which only offers financial protection to the upper quartile of the economy. Pooling of funds for financial protection and equity is mostly done through government public spending and private not-for-profit funds that are mostly externally funded.

### 4.1 Private Health Insurance

Zimbabwe has more than 30 private insurance schemes that cover approximately 10% of the population. Membership to these funds is on a voluntary contribution basis. A significant number of employers contribute funds for their employees either as full premiums or part of the premiums to which employees will also contribute the remaining portion. However with most employers, employees choose the insurer and package they prefer.

Due to the large number of private insurers covering a decreasing portion of the population, pooling of risk is not as effective as it should and the system is not equitable. Coverage is based on ability to pay and not need; various co-payments exists which reduce the financial protection of members. In addition, poor performance in paying providers results in some providers not accepting certain insurance scheme members thereby limiting their choice and freedom to access services. Some of the private insurance companies own facilities that provide health services thereby creating a possible conflict of interest. In the 2010 NHA, on average funds spent over 50% of premiums collected on administration activities. Other health insurance components such as those covered under vehicle insurance for medical coverage in case of accident injuries are highly misunderstood with most vehicle insurance clients unaware of their existence, therefore offering little or no protection.

### 4.2 Other Forms of Pooling Funds for Health

#### 4.2.1 The Consolidated Revenue Fund (CRF)

This is the largest domestic pool with various sources of funds such as taxes and other direct budget support. Through the Ministry of Finance and Economic Development (MOFED), disbursements are made to health through various line ministries. The largest allocation is to MOHCC which has the main mandate for providing and regulating health service in Zimbabwe. Other allocations to other ministries such as Defense and Home Affairs are meant to cover specific populations. Through the CRF funding for provision of public health services, the government subsidizes health care costs in public facilities even though users still have to pay certain fees to cover the remaining costs. The government subsidizes costs in government owned facilities by providing for the facility's full costs of operations including salaries. In mission and rural council facilities the government pays salaries of health personnel as well as providing small operating grants to various charities.

The CRF faces various challenges that limit its effectiveness as a pooled fund. The budget allocation is below the need based budget bid submitted annually by MOHCC to MOFED leading to a huge financing gap resulting in higher user fees, low quality of services and shortages of essential drugs. In addition, disbursement of funds allocated to the MOHCC from the MOFED have been consistently low at around 80% of the allocated budget with most of the disbursement going towards salaries. Central government spending in 2013 accounted for only 20% of all revenue in district-level hospitals (district hospitals and mission hospitals) and 2% in rural health centers. (For hospitals, the single largest source of funding is user fees and drug sales [54 %]). In addition, the majority of Government allocations are channeled towards hospital care with six central hospitals receiving the largest share of funding (PER 2015), leaving other facilities under-funded.

The Assisted Treatment Medical Order run by the Ministry of Labour and Social Welfare is another mechanism for offering financial protection. It offers user fee exemption that cover specific populations like the elderly, the poor and indigent, and various interest groups such as pregnant women and children in public facilities. However, due to various implementation challenges and lack of adequate funding from the CRF, such exemption policies do not achieve the intended equity and financial protection.

#### **4.2.2 Other Domestic Pooling of Funds**

In addition to the CRF, the government introduced various funds which pool public sector resources such as the National Aids Trust Fund (NATF), Health Services Fund and the Social Security Scheme. The NATF is a mandatory earmarked income tax on formal sector companies and employees that collects and pools funds for the HIV/AIDS Response. It allows for cross subsidization across various socio-economic and demographic strata and offers partial financial protection against the costs of HIV care; however it is still highly limited as it also does not guarantee contributors access to HIV/AIDS services. The funds are inadequate to meet rising needs of the AIDS burden especially amongst the poor.

Local authorities are a significant form of pooling of funds at the subnational level. Through a variety of levies, rates and charges to individuals, households and business administered through acts that govern councils, they collect and pool funds which are allocated towards service provision in council owned health facilities. In 2015, local authorities contributed 19% of domestic funding with the two metropolitan provinces of Harare and Bulawayo municipalities contributing over \$60M (70% of local authority's budgets) to healthcare in their annual budgets.

The Health Services Fund allows facilities to pool collected revenues from user fees, interests, grants and donations and use these at facility level. It gives facilities supplementary funds to respond to specific needs that have not been met through national budgeting. However its main weaknesses are its repressiveness and inability to offer any direct financial protection to patients. It also creates incentives for facilities to charge additional fees and can incentivize provider induced demand.

#### **4.2.3 Pooling of External Funds**

Donor funding through various mechanisms has consistently been the largest pool aside from the CRF that offers financial protection, predictability and equity. Various donor pools exist in Zimbabwe such as The Global Fund for HIV/AIDS, Malaria and TB, HTF/HDF for RMNCH and adolescent health, the European Union (EU) pool which includes funds from various EU countries and other foreign government pools such as PEPFAR. The Global Fund is the largest pool of external resources targeted at HIV/AIDS, Malaria and TB as well as various cross cutting systems strengthening. This is followed by the HTF/HDF pool funded by various development partners like the UK's Department for International Development (DFID) and EU that is targeted towards RMNCH interventions. Besides these multi-funder pools, individual pools such as PEPFAR and World Bank also contribute significant resources that are targeted at various interventions. External pools contribute over 55% of public sector resources to health though most of the funds are earmarked for specific interventions and specific geographic areas thus limiting equity and access to care for other diseases and populations.

## 5. PURCHASING AND PROVIDER PAYMENT MECHANISM IN HEALTH CARE

### 5.1 Government Function in Purchasing Health Services

Zimbabwe has various fragmented purchasing arrangements that closely reflect and follow the financing and pooling mechanisms that are used. The largest single purchaser of health services being the GoZ which purchases services through its various ministries primarily the MOHCC. The MOHCC provides inputs through line items in the national budget and also funds the wage bill for health workers. It also funds the procurement of drugs and other essential commodities while the supply of drugs specifically is by the National Pharmaceutical Company (NATPHARM). Domestically, NATPHARM is underfunded with 99% of all the drugs available at NATPHARM being donor funded. The available drugs are mostly essential medicines used for primary care resulting in perennial stock ruptures of vital medicines. Other government purchasing arrangements include the Assisted Medical Treatment Order.

The Provincial Medical Directorate is responsible for the purchasing function at the provincial level and specifically negotiates service contracts with the district and hospital service providers whilst services at the district level are handled by the District Health Executive.

The local government ministry purchases healthcare services through their budgets which are funded by general levies and rates collected from residents. However, most local authorities are facing challenges to keep their facilities running because of poor revenue collection at overall council level resulting in high user fees at point of access for patients. The central budget has been paying for salaries of some local authority health workers but challenges remain with costs to cover commodities and operating costs.

### 5.2 Private Sector purchasing Arrangements

#### 5.2.1 Private for Profit

Medical aid schemes in Zimbabwe cover less than a tenth of the population and contribute about 80 per cent of income to private health care providers. Voluntary medical aid schemes are the largest single non-government purchaser of health care services. Medical aid schemes purchase services using the fee for service method wherein members are charged specific fees when accessing various services at both private and public providers. Various challenges exist in this model. Tariffs for different services are set by the government as the regulator in consultation with providers and medical aid societies. However, it is difficult for all stakeholders to reach consensus with regards the tariffs. Due to operational issues, some schemes have not been able to settle payments to service providers within agreed timelines. This results in clients being denied access to healthcare services. A conflict of interest may arise where schemes own facilities that provide healthcare services to their members.

#### 5.2.2 Households

Households access health care services through various mechanisms with the main mechanism being fee for service especially for curative services. Preventive services are usually accessed free of charge by households even though government and donors pay for these. Through co-payments and direct user fees, households purchase healthcare services from both public and private sector.

### 5.3 Donor purchasing Arrangements

Donors purchase services for the population of Zimbabwe through varied mechanism. Most donors channel their funding through various implementing partners which can be either NGOs or direct service providers such as the MOHCC, councils and faith based organizations. In purchasing health services, various mechanisms are used by different donors. For example, the World Bank uses the Results Based Funding model. Under the HTF, an independent purchaser contracts with providers to purchase a specific

<sup>4</sup> <http://www.nssa.org.zw/index.php/template-features/2012-09-10-08-13-50>

service at a specific price of a certain quality. An independent verifier will verify results before payments are made. Other arrangements include purchasing preventive services through the use of implementing partners who will provide these services for free to the population. In addition, subsidies are provided in the purchase of certain health services such as ARVs, testing services, capital equipment etc. wherein any payments made by the user are only a small cost of providing the service. Donors and NGOs purchase these various services on behalf of the MOHCC as the mandate for providing these services rests with the government.

#### **5.4 Other Purchasing Arrangements**

Faith/Mission based Care Support (Private not for profit) organizations purchase and provide health care services in Mission health facilities. Mission run health institutions have boards of trustees that they report to and the boards influence service delivery interventions as per religious orientation. Some services are provided for free (fully purchased by the facilities) whilst others require user fees.

Other purchasing arrangements include the Accident Prevention and Workers Compensation Scheme (Under the National Social Security Authority [NSSA] for injury at the work place), Private Company Health Facility (private companies that own facilities and provide services to its workers), Uniformed forces Mandatory Health Support, Motor Vehicle Insurance Based Health Support, and donor supported arrangements.

## 6. CHALLENGES IN HEALTH FINANCING

### 6.1 Revenue Generation and Resource Mobilization

- The current per capita level of government funding at \$25 is well below the Chatham House estimated \$86 needed to provide an essential benefit package (in low and middle income countries). This represents a serious challenge in the face of rising health needs which have to be met if the country is to reach its Sustainable Development Goals (SDG) targets. Old and emerging diseases continue to take a toll on current resources. For the top ten NCDs only, assuming no major intervention to prevent or control them, direct health sector costs are currently estimated at \$39.86 per capita, with longer term care for NCDs raising costs to the health system and to households. Direct annual costs of the top ten NCDs are projected to increase to \$57.22 per capita by 2030, an increase of 44%, with a total annual cost to the health sector of \$1bn by 2030 (Loewenson et al 2013).
- Health as a share of government spending has remained below the Abuja Declaration commitment for domestic spending, reflecting to some extent fiscal pressures and downward adjustments given declining external funding. In 2016 for example, the health sector share of the total budget is 7.46%, which is well below the Abuja commitment.
- The rise in the share of total external funding increases donor dependency risk. The 2015 Resource Mapping report shows that donor resources contribute over 55% of total public sector funds budgeted towards health and in some diseases such as HIV/AIDS, 80% of such funding comes from less than five major donors. This represents major risks in the face of shifting donor priorities globally.
- An increase in OOP over the years highlights the lack of financial protection and equity of access to healthcare services. In 2010 NHA, OOPs were estimated at 39% which is higher than any share of public funding to the health sector. Given that 72% of the population lives below the poverty datum line, high OOP mean that the majority of the population cannot seek the health services they need on time, or if they do, they may face catastrophic expenditure. The World Bank PER 2015 report shows that 40% of would be patients delay or fail to seek health services due to financial barriers.
- Earmarking of non-government funds to specific diseases also reduces universality and equity. Resource Mapping results for 2015 show that out of \$945M funds targeted to the health sector, 57% of this is channeled through HIV/AIDs and RMNCH programmess leaving other disease areas underfunded. Vertical funding arrangements are able to raise funds for certain priority programmess but undermine equity and service provision for other disease areas. For example, NCDs represent a rising disease burden and yet are severely underfunded.

### 6.2 Pooling of Risk and Financial Protection

- The proportion of the population that is covered by private health insurance schemes is very small hence the rest of the population is not able to benefit from the risk pooling function of health insurance. Therefore voluntary nature of medical insurance in Zimbabwe, and the current pooling mechanisms that are fragmented result in inadequate risk pooling and does not allow for cross-subsidization across various income and population groups (health/sick and working/non-working).
- Zimbabwe has a national pool as it provides a set of publicly funded services to all Zimbabweans. However, current purchasing arrangements, limited resource availability and the lack of a prioritized minimum benefits package reduces the ability of the pool to impact financial protection and equity on a national scale.



### 6.3 Purchasing of Health Services

- Unpredictability of the flow of funds from the central government to providers of health care services. In the last five years, the percentage of funds disbursed from the appropriated amount has always been below 90 percent. This has greatly affected planning and further constrained the purchase of health care services.
- Unavailability of complete information on funding at the district level. This has resulted in the duplication of services purchased by donors and uneven distribution of health services.
- Lack of adequate information on the cost of providing health care services. The cost per capita for delivering the essential health benefit package has only been defined for primary and secondary levels of care. No costing has been done for tertiary level care.
- No prepayment arrangements for NCDs. This leaves patients to resort to user fees, which are high and costly.
- Monitoring of quality is a challenge despite the efforts to support and supervise the health providers. Lack of incentives to maintain high quality care has often been cited as the source of poor quality care.
- Lack of funding support for the policy of removal of user fees at the point of service as well as inadequate guidance on the implementation of the policy to both service providers and patients. Evidence shows that ownership of facilities (i.e. either Mission, private, City, RDC, or MOHCC) influences the decision of either to impose user fees or not on the basis that there are no third party payer mechanisms that reimburses the costs of the services rendered.
- Lack of separation between purchasing and provision of health services. Evidence presented at the UHC Forum (2015) showed various weaknesses in the governance and management of purchasing arrangements in the health sector. Even though legislation and guidelines existed within the public and private sector to separate the functions of purchasing and service provision, these were not clearly implemented and enforced resulting in various purchasers being providers of care. Where such situations exist, quality of service has subsequently declined and measures to protect consumers of health care have not had the desired outcome. Within the private sector, insurance companies pool funds, purchase services and also provide services leading to conflict of interest. In the public sector, the various ministries (such as MOHCC), local authorities and churches collect and pool resources, purchase and provide services without adequate and effective monitoring of the separation of these functions.
- Weak referral system and underfunded primary care facilities. Lower level facilities are unable to act as gatekeepers and to offer quality care; as a consequence many patients bypass primary facilities seeking care in the more expensive secondary and tertiary hospitals. For example, 60% of all deliveries at Harare Central Hospital – a tertiary referral hospital – were normal vertex deliveries in 2014 (DHIS2 2014) which are supposed to be handled at lower levels of care.

### 6.4 Governance of Health Financing

- Evidence under the UHC forum (2015) revealed that governance in the health sector is highly centralized with some tasks delegated to the operational level but without transferring mandates. Fragmented health financing functions leads to complex, time consuming and parallel reporting systems. This is notable in the arrangements and contracts between MOHCC, church facilities, local authority facilities and other public sector facilities.
- The NHS (2016-2020) notes the following needs to be achieved to improve the regulatory environment: (1) the enhancement of monitoring and supervision of health practitioners, implementing partners and (2) institutional frameworks for collection, pooling and purchasing of health resources.

## 7. EQUITY IN HEALTH FINANCING AND UNIVERSAL HEALTH COVERAGE

To achieve universal health coverage, there is need to address equity in the collection, allocation and provision of health resources and services. Inequality remains a determining feature of socio-economic wellbeing and addressing equity is key to achieving health goals under the SDGs for Zimbabwe. Addressing equity in health financing implies mobilizing revenue according to ability to pay through progressive financing; allocating resources according to health need; pooling funding for income and risk cross subsidies; analyzing key determinants of health equity across various socio-economic and demographic factors that pose barriers to access and effective coverage of health care; and ensuring financial protection. Equity challenges for health financing for universal health coverage that need to be addressed in the policy include:

- Coverage of various interventions remains low within the low income groups in Zimbabwe. The 2014 Equity Watch report indicates high differentials in health outcomes associated with socio-economic disparities in equity. Even though improvements in most tracer indicators for health outcomes have been achieved, low income population groups remain at higher risk than higher income groups. Disparities were also noted between geographical locations with rural households having worse indicators than urban households as well as variances between provinces. A comprehensive analysis of equity in access to key services using household survey data found inequalities by province, residence, wealth and education, with gaps of between 22 and 56 percent points between the highest and lowest levels of coverage for maternal and child health services included in the MDGs. (TARSC, MOHCC 2014; ZIMSTAT and ICF International 2012; ZIMSTAT 2014).
- Financial protection when accessing health services remains low, especially for the low income groups. Access to health services remains primarily dependent upon highly regressive OOP payments. Even though the government has introduced user fee exemptions in public facilities for selected services and population groups, facilities have not received the needed budgetary support, which has resulted in various challenges such as informal charges, and drug stock outs. Recent efforts, such as the introduction of Results Based Financing (RBF) mechanism for essential services, have increased access to services in selected districts included in the pilots. However none of these efforts has been scaled nationally with RBF schemes covering a limited range of selected interventions. In addition, RBF schemes are still largely donor dependent.

In light of the challenges discussed above, it is imperative that Zimbabwe implement health financing reforms. Where current mechanisms exist and are working, there is need to strengthen them and where no adequate systems or measures are available, new innovative approaches should be adopted. The challenges highlight the need for a health financing policy for Zimbabwe that should adequately set the direction and tone for health financing reforms to achieve universal health coverage and equity in health care for the population of Zimbabwe.

## 8. POLICY STRATEGIC CONTEXT

The Health Financing Policy has been formulated within the framework of:

**National Economic Plan** – The policy is aligned to the priorities set forth in the national health strategic plans and Zimbabwe's economic plans. The strategies outlined in the latest economic blueprint (ZIMASSET 2013-2018) are aimed at achieving sustainable development, social equity and increasing transparency and accountability in the budgeting and implementation processes which translate to better health outcomes and value for money.

**Results Based Management** – Implementation of all ministries within Zimbabwe is guided by the Results Based Management (RBM) system, which was adopted in 2013 to ensure improved public sector performance and accountability. Based on the RBM framework, every year the MoHCC develops operational plans and budgets to coordinate all stakeholder activities required to meet the objectives outlined in the National Economic Plan and the National Health Strategy.

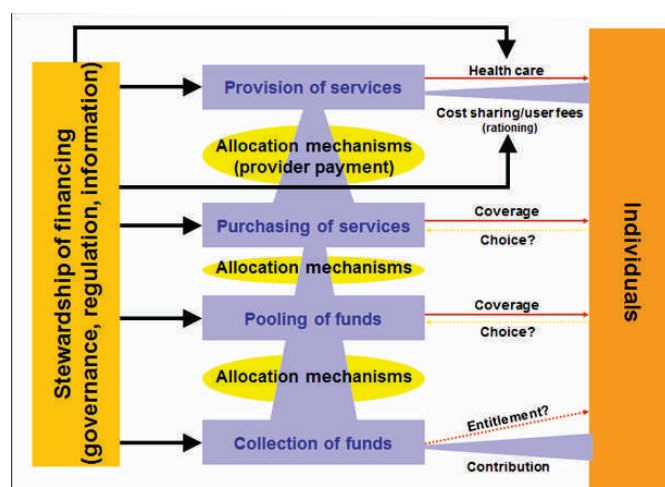
**Other regional and international frameworks** – Zimbabwe is a signatory to various regional and international frameworks on health such as the Paris Declaration on Aid Effectiveness, Abuja Declaration, and SDGs that make commitments to achieving various health care objectives critical. This policy aims to ensure the country satisfies its agenda under the various frameworks.

### 8.1 Conceptual Framework

Zimbabwe needs to mobilize sufficient resources to provide essential health services for its populations, reduce inequalities in the ability to pay for those services, and provide financial protection against impoverishment from catastrophic health care costs through explicit policies affecting the four financing functions:

- i) Revenue generation and collection;
- ii) Pooling of funds and risk pooling;
- iii) Resource allocation and purchasing; and
- iv) Governance.

In managing their health financing functions, countries also need to ensure adequate fiscal space to scale up health spending. Developing countries, particularly low-income countries, face severe challenges in mobilizing sufficient resources to meet even basic service needs. Health financing involves the basic functions of collecting revenue, pooling resources, and purchasing goods and services (WHO 2000). These functions often involve complex interactions among a range of players in the health sector as outlined in Figure 3 below.



**Figure 3: Health Financing Functions Flow Chart**

(Source: Adapted from Kutzin J. A Descriptive framework for country level analysis of Health Care financing arrangements. *Health Policy*, 2001;56:171-204.)



*Pooling* funds (so that pool members share collective health risks) coupled with *prepayment* (so that pool members are ensured compensation should a loss occur) enables the establishment of insurance and the redistribution of health spending between high- and low-risk individuals (risk subsidies) and high- and low-income individuals (equity subsidies). By breaking the link between expected health expenditures and ability to pay, prepayment is a critical mechanism for attaining equity objectives. Prepayment in the absence of pooling simply allows for advance purchase or purchase on an installment basis, a useful financial device when dealing with large predictable expenses or expenses that do not correlate with income flows (see the section below on medical savings accounts). With neither prepayment nor pooling, the service is simply purchased like any other at the time the consumer demands it, a modality not well suited to many health services on the grounds of equity, predictability, and financial protection.

*Purchasing* refers to the mechanisms used to secure services from public and private providers. How these various functions are arranged has important implications for the way health systems perform, relative to:

- Amounts of funds available (currently and in the future) and concomitant levels of essential services and financial protection (the depth and breadth of coverage) for the population;
- Fairness (equity—who bears the tax/revenue burden) with which funds are raised to finance the system;
- Economic efficiency of such revenue-raising efforts in terms of creating distortions or economic losses in the economy (the “excess burden” of taxation);
- Levels of pooling (risk subsidization, insurance) and prepayment (equity subsidization);
- Numbers and types of services purchased and consumed with respect to their effects on health outcomes and costs (the cost-effectiveness and allocative efficiency of services);
- Technical efficiency of service production (the goal being to produce each service at its minimum average cost); and
- Financial and physical access to services by the population (including equity in access, benefit incidence).

There are important equity considerations regarding financing sources, levels of prepayment and pooling, services provision, provider payment, and physical access to care. There are three broad types of efficiency concerns; efficiency of revenue collection (distortions in the economy that result from various taxes); allocative efficiency (resources being allocated to maximize the welfare of the community by producing the desired health outcomes); and technical efficiency (services being produced at the lowest possible cost). It is clear from these performance considerations that efficiency and equity are critical aspects of all health financing systems and are relevant for all financing functions.

## 9. HEALTH FINANCING STRATEGIC POLICY DIRECTIONS

### 9.1 General Health Finance Policy Guidelines

#### Vision

The whole population of Zimbabwe has access to the highest possible level of health and quality of life regardless of income levels, social status, or residency.

#### Mission

To provide, administer, coordinate, promote and advocate for the provision of equitable, appropriate, accessible, affordable and acceptable quality health services and care to all Zimbabweans while maximizing the use of available resources, in line with the Primary Health Care Approach.

#### Goal

The goal of the Health Financing Policy is to guide Zimbabwe's health system to move towards Universal Health Coverage (UHC) including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all by 2030.

#### Guiding Principles and Values

Underpinning the MOHCC's mission are the following values that will guide the Health Financing Policy at all levels:

- Social solidarity
- Equity in health and health care
- Gender equality
- Healthcare as a right and shared responsibility
- Essential quality services integrating comprehensive primary health care
- Cost benefit and value for money
- Efficiency
- Appropriateness
- Affordability
- Public participation and user and provider satisfaction
- Transparency and accountability
- Ownership and
- Partnership in health.

#### Policy Objectives

In order to address the existing gaps and to achieve the goal of equitably moving Zimbabwe's health system towards universal health coverage, the NHFP will be focused on reaching the following objectives:

1. Mobilize adequate resources for predictable sustainable funding of the health sector;
2. Ensure effective, equitable, efficient and evidence based allocation and utilization of health resources;
3. Enhance the adequacy of health financing and financial protection of households and ensure that no one is impoverished through spending on health by promoting risk pooling and income cross subsidies in the health sector;
4. Ensure that purchasing arrangements and provider payment methods emphasize incentivizing provision of quality, equitable and efficient health care services; and
5. Strengthen institutional framework and administrative arrangements to ensure effective, efficient and accountable links between revenue generation and collection, pooling and purchasing of health services.

## 9.2 Sustainable Resource Mobilization and Revenue Collection

### Guiding Principles

1. The revenue collection mechanisms must be equitable, transparent and accountable.
2. Any revenue generation and collection mechanism should ensure minimum distortions within the economy.
3. Progressively increase the share of domestic government financing relative to external financing and OOP expenditure to create an ideal balance.

### Policy Objective(s)

The overall objective is to mobilize adequate resources for sustainable funding of the health sector and to coordinate the use of these resources for improved targeting of budget allocations. Specifically it seeks to:

1. Ensure adequate funding for administrative, preventive, curative and research for health care services.
2. Ensure the government finances the minimum comprehensive benefit package.
3. Introduce progressive mandatory pre-payment financing.

### Policy Direction

1. The GoZ will seek to strengthen domestic health financing and abide by the Abuja Declaration on Health where not less than 15% of budget shall be allocated to health.
2. The GoZ will spend not less than \$60 per capita per year to ensure the minimum comprehensive benefit package is financed.
3. The GoZ will explore options for progressive earmarked taxes and levies to raise additional resources for health.
4. Current mechanism to raise additional revenue to the health sector that has been successful and sustainable will be maintained and expanded where feasible. Examples include the National AIDS Levy, Health Services Fund, Workman's Compensation Fund, Assisted Medical Treatment Order, and Accident Victims Compensation Fund on Motor Vehicle Insurance.
5. The government will encourage various forms of mandatory prepayment mechanisms such as social health insurance (SHI), community based health insurance (CBHI), national health insurance (NHI) especially for the informal sector and rural areas as a means of achieving universal health coverage.
6. Private health insurance will continue to be available as a voluntary prepayment mechanism for services not covered in the minimum benefits package.
7. Special revenue generation provisions will be requested for diseases of high national public health concern/significance as and when they emerge.
8. All external aid for health will be harmonized, coordinated, monitored and evaluated in line with health priorities and plans of the government of Zimbabwe.
9. The GoZ will continue to encourage and expand involvement of local philanthropy and charities for special health initiatives at all levels of care.
10. The GoZ will explore, ensuring consistency with its key policy principles and goals, innovative partnership mechanism with the private sector to increase resources to health such as joint ventures and outsourcing guided by a strong regulatory framework.

## 9.3 Risk Pooling and Cross Subsidization

### Guiding Principles

The pooling methods and levels should ensure income and risk cross subsidies, that is, cross subsidies between healthy and sick, rich and poor, among other varying socio economic variables.

### Policy Objective(s)

To enhance the adequacy of health financing and financial protection of households and ensure that no-one is impoverished through spending on health by promoting risk pooling and income cross subsidies in the health sector;

### Policy Direction

1. The government of Zimbabwe will explore new and strengthen existing mechanisms for promoting equity, risk equalization and reduce fragmentation with a special emphasis on ensuring that health spending does not lead to or deepen impoverishment especially in the poor and indigent population.
2. A national mandatory prepayment scheme will be introduced and expanded as a key form of pooling risk to reduce out of pocket payments.
3. There will be clear separation of functions and roles between pooling and purchasing of healthcare services.

## 9.4 Purchasing/Provider Payments Mechanisms

### Guiding Principles

1. Allocative efficiency of health sector budgets to priority areas through evidence based and transparent costing of benefits that will be purchased from pooled funding.
2. Technical efficiency through use of low cost, evidence based high impact interventions in the health sector.
3. Active and consultative monitoring and review of performance for effective responses to performance deficits

### Policy Objective

To ensure that purchasing arrangements and provider payment methods emphasize incentivizing provision of quality, equitable and efficient health care services

### Policy Directions

1. Priority will be given to the purchase of cost effective services and those essential for achieving universal health care, that is, the Essential Health Benefit package at all levels of care (primary, secondary, tertiary, and quaternary)
2. A framework for regular evaluation of benefits and cost interventions will be put in place to ensure optimal choices.
3. Services will be purchased from all registered and accredited providers (private, public and traditional practitioners).
4. There will be separation of purchasing and provision functions for health care services.
5. Health care resources will be allocated using needs based formula to achieve equity.
6. There will be strengthening of current purchasing mechanisms and developing others that ensure that those who cannot afford to pay can still access services without facing impoverishment.
7. There will be use of a mix of provider payment mechanisms that promote optimal provider performance while containing costs.
8. There will be quality assurance for services purchased irrespective of funding mechanisms and level of care.

## 9.5 Governance

### Objective

To strengthen institutional framework and administrative arrangements to ensure effective and efficient links between revenue generation and collection, pooling and purchasing of health services.

### Principles of Good Governance in Health Financing

The HFP will be guided by sound principles of governance which ensure the protection of all actors as well as the promotion of high quality service provision to all citizens.

**Transparency and Accountability** – The governance structures and mechanisms will ensure that for each function of health financing, clear systems and procedures for transparency and accountability are defined and clearly communicated. Enforcement mechanisms shall be established. Information on processes, actions and results will be made available to all stakeholders at various levels including the community for monitoring, evaluation and advocacy.

**Fairness** – The government will ensure that impartial actions can be taken in particular where citizens are given opportunities to improve or maintain their well-being through various systems that include social participation and consultation in decision making.

**Collaboration** – The government will ensure various stakeholders at all levels of health financing are involved in decision making and consultation with emphasis on strong relationships that ensure effectiveness of health financing reforms. Governance systems should not be segregated between various sectors and the agenda of universal health care and financial protection should be embedded within public and private sector health financing mechanisms.

**Routine Monitoring of Implementation** – There will be a process for regular review of health financing functions that helps to improve performance and ensure results are achieved with a goal to improve current and future management of outputs, outcomes and impact.

### Policy Directions – Institutional Arrangements

1. Establishment of a Health Financing Coordinating body within the MOHCC to coordinate the various pillars of this policy (i.e., funds collection, pooling and purchasing functions within the GoZ)
2. Financial management will be decentralized to operational levels to effectively perform various health financing functions within the confines of the Public Finance Management Acts.
3. The role of performance based financing in current and future schemes to be clearly defined where it strengthens the purchaser's function.
4. Planning, budgeting and resource allocation will be harmonized along the results based management principles in consultation with all stakeholders.
5. The GoZ will strengthen existing mechanisms and/or establish new structures and systems for coordination and harmonization of funding at all levels of health care financing.

### Health Sector Regulatory Framework

There shall be harmonization of various legislation governing health financing both within the public and private sector to ensure commonness of policy direction and implementation guidelines that protect the population and increases access to quality care.

### Implementation of the Health Financing Policy

1. Implementation of this HFP shall be based on successive Health Financing Strategic Plans and annual rolling plans that will define key health financing activities at each level of care over a period of 5-10 years.

2. The MOHCC will be responsible for implementation of the HFP along with other relevant government ministries such as the MOFED and Ministry of Labour and Social Welfare.

#### **Monitoring, Evaluation and Research**

1. The MOHCC will ensure that systems for timely and efficient routine and periodic monitoring of resource accountability are in place such as resource mapping, National Health Accounts and Nationals Aids Spending Assessment.
2. There will be use of current evidence based research for development of innovative approaches in health financing.
3. In addition to overall monitoring of the HF policy implementation, there will be monitoring and evaluation at all levels of health care to ensure that health financing reforms and policies are adopted effectively.
4. Both qualitative and quantitative indicators will be used to assess the impact of the HFP towards achieving universal health coverage.

## 10. CONCLUSION

The ultimate vision of this policy is to ensure that the whole population of Zimbabwe has access to the highest possible level of health and quality of life regardless of income levels, social status, or residency. To fulfill this vision will require the utmost solidarity from all stakeholders and the political will to implement the necessary reforms as laid out in the policy.



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