

# An Investigation into the Efficacies of Introducing a National Health Insurance Scheme in Zimbabwe: Insights from Key Stakeholders.

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**Abstract** – *There is consensus on the contribution of both public and private health expenditure on health outcomes. Several health funding schemes have emerged over time and National Health Insurance Schemes (NHIS) commands its stake. A myriad of studies were carried out on the impact of NHIS on health outcomes. Though there is a general concurrence on its effectiveness, some countries have failed to establish such schemes and Zimbabwe, the country of study is not an exception. This exploratory study sought to elicit views from selected key stakeholders on the efficacies and odds of introducing an NHIS in the country. Questionnaires and Focus Group Discussions (FDGs) were the main data collection tools used. Responses indicated that 87 % of the stakeholders threw their weight in underscoring the contribution of the introduction of an NHIS towards positively impacting health outcomes. However, all the stakeholders expressed reservation towards the near-future introduction of such owing to the prevailing macroeconomic conditions. The study proffered recommendations basing on the expressed views.*

**Keywords:** *National Health Insurance Scheme (NHIS), Health Expenditure, Health Outcomes*

## 1. INTRODUCTION

There is an increasing consensus by health experts on viewing health as a multidimensional concept capturing social, physical, emotional, spiritual and sexual aspects. As such, health can be viewed as an indicator of social development as well as an economic indicator of economic development (Rezapour, Mousari and Lotfi, 2019; Reich, Harris and Ikegami, 2016; and Tikunov and Chereshnya, 2015). Many researchers have devoted their precious time to studying the impact of health financing on health outcomes and concurrence was reached on the impact of financing on health outcomes (Rezapour, Mousari and Lotfi, 2019; Raesi *et al*; 2018; Bein, *et al*, 2017). For many countries, health financing comprises both public and private financing (Bein, *et al*, 2017). Public financing is usually raised through statutory deductions and administered by a way of legislation whereby private financing is usually synonymous with out-of-pocket financing. Appreciating the role of health financing in health outcomes, Zimbabwe in 1997 noted with concern deterioration of health indicators and proposed to redress inequalities in health service coverage, improve the quality of healthcare, separate the roles of financiers and providers of healthcare, improve the efficiency of purchasing healthcare services as well as to improve the efficiency of healthcare service delivery (Ministry of Health and Child Care, 1997). As such, on the cards is the introduction of a National Health Insurance Scheme (NHIS) and a Bill is currently in circulation to that effect.

The key principle of the NHIS is to promote social solidarity through a pooled financial risk mechanism for health access whereby the rich can subsidize the poor, the single can subsidize families, the healthy subsidize the unhealthy and the young can subsidize the old. The scheme is expected to cover over 12 million citizens who are not covered by private health insurance. The country's regulator of health funders, the Association of Health Funders of Zimbabwe (AHFoZ) revealed that only 10% of the population has

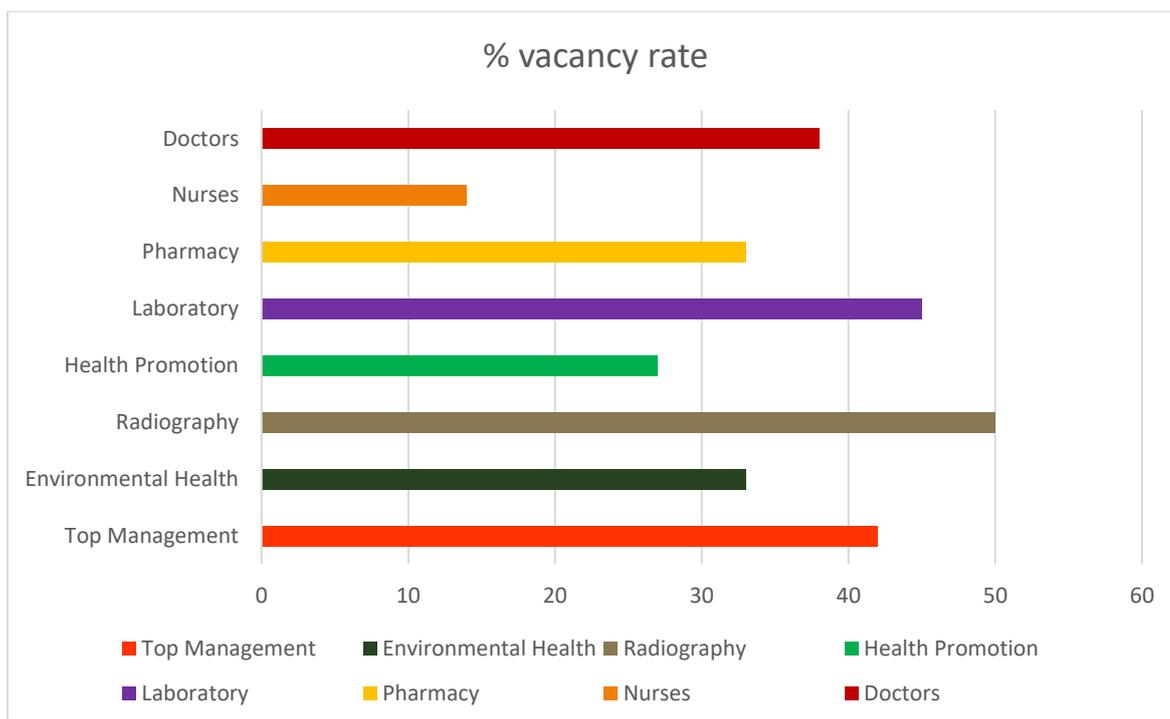
medical aid cover leaving 90% funding for their healthcare costs using out-of-pocket payments. Of the covered, the monthly contributions fall short of fully covering medical costs and patients are often asked to fund shortfalls using their funds (AHFoZ, 2019). Different countries have managed to fully implement National Health Schemes (NHSs) and stand as examples through which Zimbabwe can pick up helpful lessons (Ghana, South Korea and Singapore).

### 1.1 STYLISED FACTS ABOUT THE HEALTH SECTOR AND HEALTH FINANCING IN ZIMBABWE

Zimbabwe has been facing a decade of economic meltdown which was marked mainly by foreign currency shortages amid limited international financial support, market disruptions and distortions as well as run-away inflation, trade imbalances, dipping revenues, high unemployment and growing informal sector (World Bank, 2017). Since 2009, Zimbabwe has been operating under a multicurrency system but dumped the multicurrency on 25 June 2019 (The Herald Newspaper, 2019). These currency problems landed into the nerves of the workforce who were left with worthless salaries and health workers took it to the forefront of industrial action. The Health Services Board (HSB), the country's governing board for health workers has been in and out of the labour court over a striking workforce which resulted in many health workers being dismissed from service thereby seeking employment in European countries.

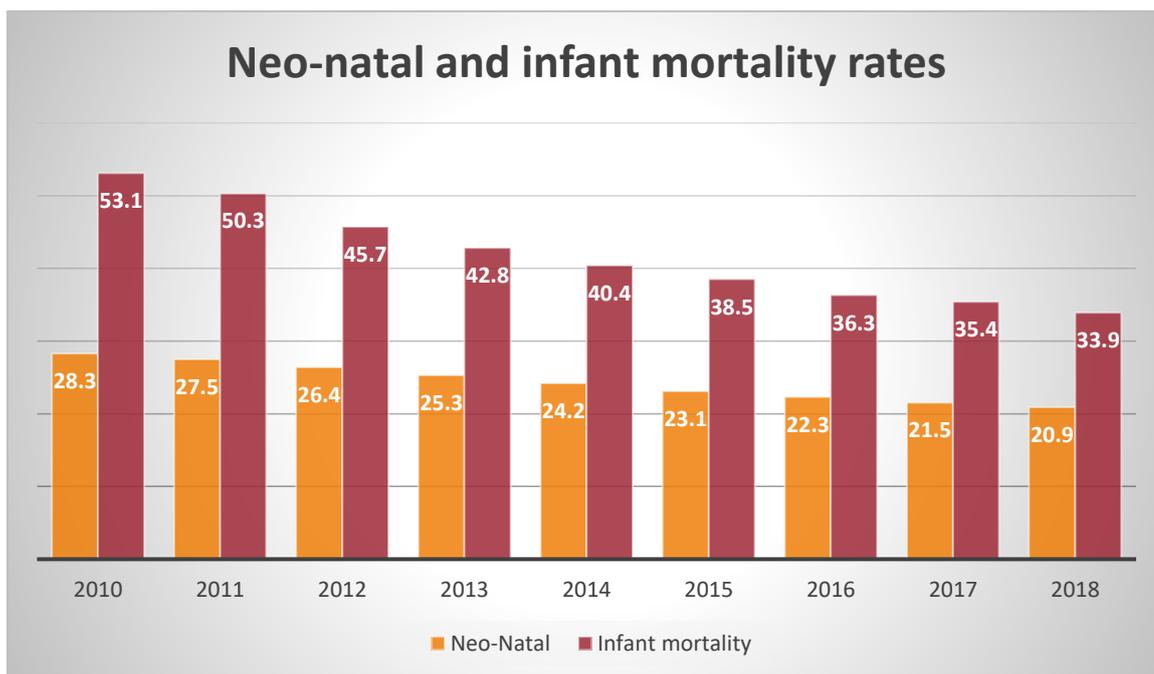
This has resulted in a worrisome ratio of health workers and the general populace. In 2019, the Ministry of Health and Child Care (MoHCC) was operating with a physician to patient ratio of 1.3 per 1000 patients. This is relatively low as compared to the World Health Organisation's threshold of 2.28 per 1000. This signifies that the MoHCC is not fully constituted to carry out duties effectively and efficiently. Figure 1 depicts vacancy rates that existed at the close of 2019.

**Figure 1: Vacancy rates**



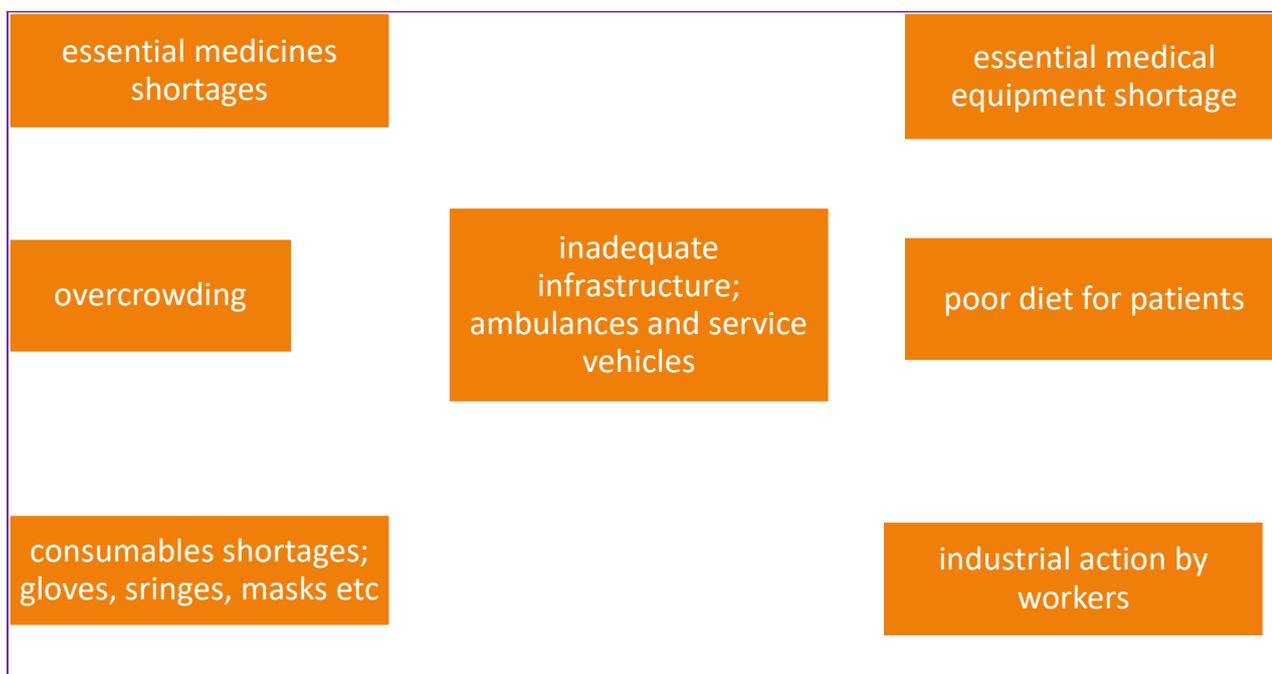
**Source: MoHCC (2020)**

From 2010 to 2017, the government made notable improvements in health indicators which includes neonatal mortality, maternal mortality rate and infant mortality rates. The country managed to make strides in reducing maternal deaths. In 2017, maternal deaths per 100 000 had reached 458 compared to 598 which prevailed in 2010. Figure 2 depicts statistics pertaining to neonatal mortality and infant mortality indicators. Neo-natal mortality represents the deaths that occur during the first 28 days of life per 1000 live births and infant mortality rate refers to a number of deaths of children before they reach one year per 1000 live births. These rates have been universally adopted as some of the proxies that can be used in measuring health outcomes.

**Figure 2: Neo-natal and infant mortality rates.**

*Source: WHO Health Indicators (2019)*

Regardless of the milestones made in health indicators, the health sector is currently reeling from many pangs which are depicted in figure 3.

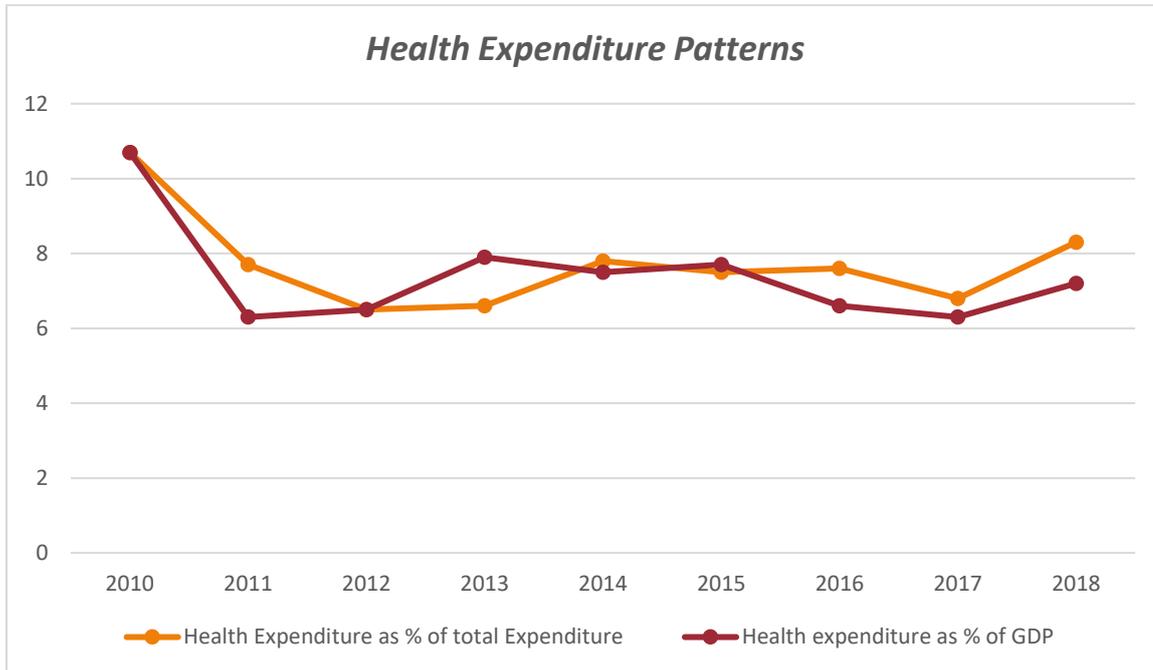
**Figure 3: Synopsis of health sector challenges**

*Source: Own compilation*

African countries in 2001 made a commitment under the Abuja Declaration to set a target of at least 15% of the government total budget being channelled towards the health sector. In relation to this, the Abuja target remains elusive for the country which has only managed to record a high percentage of 10.7% in 2010 and up to 2019, the allocation made to the health sector averaged 7.5%. This shows that there is not really consistency in terms of health financing for the country. Health expenditure expressed as a percentage of Gross Domestic Product (GDP) also remains low for the country, a situation that leaves much to be desired.

Figure 4 depicts statistics in relation to the share of health expenditure as a percentage of total government expenditure as well as the share of health expenditure as a share of GDP.

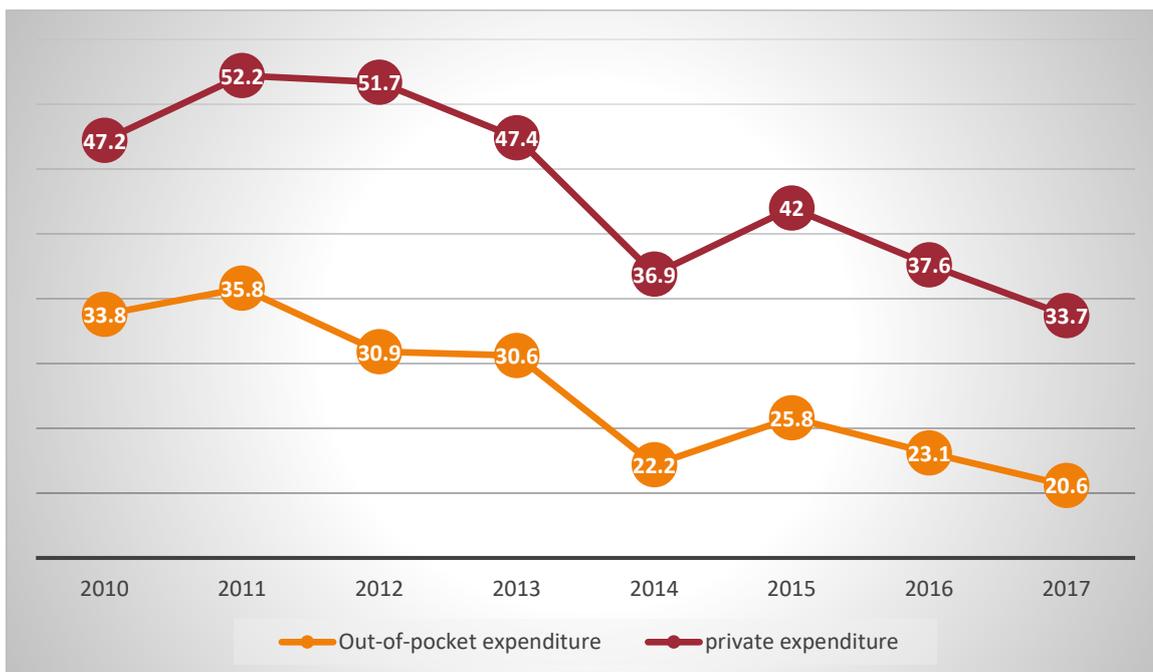
**Figure 4: Health Expenditure patterns**



**Source:** World Health Organisation (WHO) (2019)

Over the past decade, there has been a decline in the private expenditure on health's share of the total health expenditure as well as an out-of-pocket expenditure (WHO, 2019). In a normal situation, it would have been expected that government expenditure fills the void but figure 4 depicts a different situation. These developments are indicative of a serious decline in health financing, a cause of major concern given its probable negative impact on health outcomes. Figure 5 depicts statistics as they pertain to private health expenditure and out-of-pocket expenditure.

**Figure 5. Out-of-pocket expenditure and private expenditure's share of total health expenditure**



**Source:** WHO World Health Indicators (2019)

Background analysis has revealed that though healthcare expenditure remains low and failed to improve significantly, there have been strides in terms of improvements in health outcomes as supported by

information on health indicators. Low public expenditures on health coupled with a significant decline in private health expenditure as well as out-of-pocket expenditure would have been expected to lower health outcomes. However, the situation tends to prove otherwise. This paper evaluates the efficacies of the introduction of the NHIS whether it will be a panacea to the current challenges bedevilling the health sector in Zimbabwe.

## 2. LITERATURE REVIEW

Public health finance is embedded in public finance theories with its distinguishing feature being that its focus is on the pooling and allocation of resources towards the delivery of public health functions. Health systems across the world have adopted different health financing models and these are usually used as a mix. Four main health financing schemes used are government schemes, social health insurance schemes, private insurance and out-of-pocket financing schemes. Table 1 below summarises the four models.

**Table 1. Classification of healthcare financing schemes**

SCHEME	Mode of participation	Benefit entitlement	Pooling Mechanism
Government	Automatic: May target all citizens or maybe targeting as defined by law	Non-contributory	National, sub-national or programme level
Social Health Insurance	Mandatory to all those dictated by law	Contributory	National, sub-national or by a scheme
Private insurance	Mandatory for those required by law to participate and maybe voluntary	Contributory	National, sub-national or by a scheme
Out-of-pocket	Voluntary and based on the willingness to pay of the household	Contributory	No inter-personal pooling

*Source: Own contribution*

Bein, *et al* (2017) examined the link between healthcare expenditures and health outcomes focusing on 8 East African countries. As a proxy of health outcomes, indicators inclusive of mortality rates (neo-natal, infant and under-five) as well as life expectancy were used. Utilising both cross-sectional and time-series data, a panel data regression technique was used. Data obtained from World Development Indicators (WDI) from 200-2014 was utilised in the regression analysis. The study documented a strong positive link between total health expenditures and life expectancy. Disaggregating data to capture gender specifics, the study found that increasing health expenditure had more impact on females as compared to their male counterparts. In relation to the link between health expenditure and mortality rates, a negative association was registered.

Capturing the impact of healthcare expenditure on health outcomes for 25 countries grouped into four groups basing on healthcare systems, Raeesi *et al* (2018) considered infant mortality, under-five mortality and life expectancy as a proxy of health outcomes. Econometric results revealed that for countries with traditional health systems or a mixture of health systems, private health expenditure exhibited a higher impact on health outcomes as compared to public expenditures. For countries that have well established national health insurance schemes and or national health service, the impact of public expenditure was found to be higher as compared to private expenditure. These findings conform to the findings by Akinci, *et al* (2014) who went further to argue that the finding is attributed to negligible responsibility that rests on the private health sector as compared to the public sector when a country has a national health insurance system.

Consistent with the study by Raeesi *et al* (2018) in using infant mortality, under-five mortality and life expectancy as measures of health outcomes, Rezapour, Mousari and Lotfi (2019) studied the effects of health expenditure on health outcomes basing on the classification of expenditure. Through a panel data approach, results revealed that public expenditure had a higher impact on health outcomes as compared to private expenditure. The heterogeneity of this result was argued to emanate from the realisation that public expenditure is a product of political manipulation whereas private expenditure is a non-political variable. In relation to the association between health expenditure and mortality rates, the study found out that public health expenditure had a significant impact on mortality rates for all countries under review. No significant impact was recorded in terms of private expenditure.

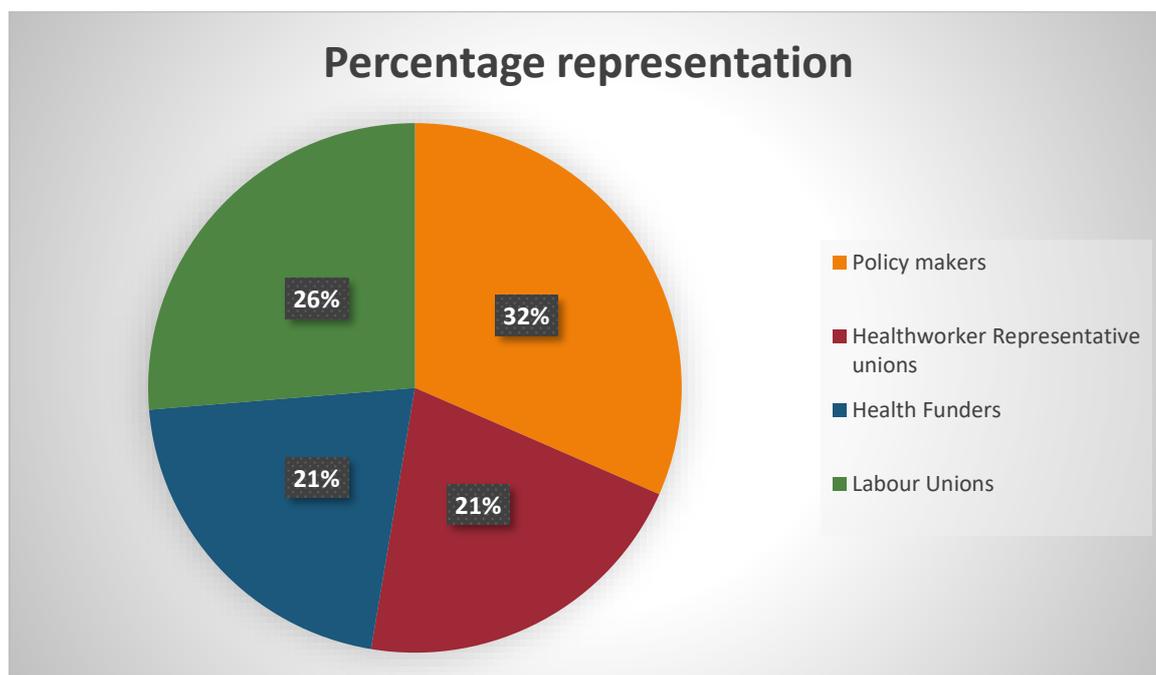
### 3. METHODOLOGY

Being an exploratory study that seeks to solicit views on the prospects of the introduction of the NHIS, questionnaire and focus group discussions were utilized in data collection. However, this qualitative approach was backed by statistics wherever necessary to foster a blended approach. Blending was done to diffuse some delimitations of using an exploratory approach in isolation. Cognisant of the study's stakeholders normally referred to as 4Ps that is Policymaker, Payer, Patient and Provider, the following stakeholders were considered;

- The Ministry of Health and Child Care (MoHCC);
- The Ministry of Public Service, Labour and Social Welfare (MPSLSW);
- The Ministry of Finance and Economic Development (MoFED);
- Zimbabwe Nurses Union (ZNU);
- Zimbabwe Hospital Doctors Association (ZHDA);
- Association of Health Funders of Zimbabwe (AHFoZ);
- Small to Medium Enterprises Association of Zimbabwe (SMEAZ);
- Confederation of Zimbabwe Trade Unions (ZFTU); and
- Zimbabwe Congress of Trade Unions (ZCTU).

The above ministries, unions and associations were classified under policymakers, health personnel, medical aid societies and contributors. However, in some instances, there were noted some intersectoral effect where a ministry can be both a policymaker and contributors like in the case of MPSLSW and MoFED. A total of four comprehensive focus group discussions where 95 questionnaires were sent to the stakeholders with the distribution shown in figure 6.

**Figure 6: Questionnaire distribution**



#### 4. FINDINGS AND DISCUSSION

From the responses gathered, it emerged that 87% of respondents to the questionnaires revealed that the introduction of an NHIS will contribute positively to health outcomes in Zimbabwe from a general perspective. However, in-depth responses registered diverse views. Health workers representative unions that are ZNU and ZHDA expressed some concerns. Apparently, they underscored the need for improvements in the remuneration of health workers as well as in the conditions of service and working environment. By this, they argued that any improvements in the infrastructure or in health funding that does not bring an improvement in their remuneration and working conditions is most likely going to yield little to no results in terms of improving health outcomes. It is against this position that they argued for a position where pooled funds under the NHIS have a ring-fenced fund that goes towards the improvement of the welfare of health workers.

From policy makers' perspective, a myriad of views were registered. A revelation was given by the MPSLSW on the exponential growth of the informal sector. It was revealed that the economy of Zimbabwe has grown overwhelmingly informal, registering 60.6%, the largest in Africa (International Monetary Fund (IMF), 2020). Owing to this, it was argued that the success of introducing an NHIS rests largely on the willingness to contribute on the part of those in the non-formal sector. Follow-up views from SMEAZ revealed that 78.9% of workers in the informal sector expressed unwillingness to contribute towards the NHIS but rather opting to use private medical insurance as well as out-of-pocket payments. In light of the responses, the MPSLSW casted a spell on the prospects of introducing the NHIS in the short-term from a policymaker perspective.

The key information collected from the MoFED was directed on ascertaining whether there are fiscal options that are available for the country to adopt as a funding mechanism towards the introduction of the NHIS. It was revealed that there are currently no fiscal space options for such. It was highlighted that the country since 2015 has been on a negative growth trajectory where fiscal revenues which remains a major source of budget financing are levelling off as such, it was revealed that options of introducing new domestic sources of funding towards the introduction of the NHIS are limited. Currently, there is an AIDS levy, tax on cigarette and airtime which are all ring-fenced towards health expenditures. Overall, the MoFED revealed that the introduction of the NHIS is not viable in the short-term given the current macroeconomic fundamentals. Fundamental forces against the introduction of the NHIS range from high informalisation rate, high unemployment and dipping tax and non-tax revenues.

Responses from the MoHCC exposed a deficiency in terms of manpower as the ministry revealed that it does not have any Health Actuaries which are very crucial in the establishment and implementation of the NHIS. From a surface point of view, the MoHCC indicated the probable positive impact of the introduction of the NHIS on health outcomes. From an in-depth enquiry, the ministry casted a spell on the introduction of the NHIS in the short-term, a sentiment shared by other policymakers though coming from different angles.

The AHFoZ, a consortium of medical aid societies that provide medical insurance across the country registered a cocktail of views. Firstly, there was consensus on the importance of the introduction of the NHIS given that the current medical insurance coverage is worryingly low at 10% of the total population, a position which supports the increase in coverage. However, it was registered that there is a need for more preliminary work before any introduction of the NHIS. Specifically, AHFoZ argued that there is a need for the government to clarify the fate of existing medical aid societies with some of them having invested in healthcare facilities in a bid to grow member benefits and reduce costs that come in the form of claims fraud.

Responses from labour unions revealed that the introduction of an NHIS is a noble idea as it will cover workers in terms of health costs. However, the unions explicitly revealed the incapacitation of workers to self-contribute towards the NHIS considering the prevailing economic conditions. It was revealed that workers are currently reeling under eroded salaries which have reduced their purchasing powers. In addition, it was revealed that most employers have made it mandatory to contribute towards health insurance. It is in this regard that additional contributions to fund the NHIS are most likely to be met with contempt by workers. As such, labour unions called for a voluntary arrangement so that workers choose which scheme to follow should the introduction of the NHIS materialise.

## 5. RECOMMENDATIONS

The success of any economic program rests on the availability of resources, a clear road map as well as the willingness of stakeholders to steer the program. It is against this realisation, coupled with responses from different stakeholders that the following recommendations are proffered;

- ❖ **Formalisation of the informal market.** Considering the realisation of dipping and flattening revenue collections which makes budgetary allocations towards the already under-funded health sector, one way of improving revenue collections is to gravitate towards formalisation. An increase in government revenues has the capacity of creating fiscal space thus aiding in fiscal options.
- ❖ **A hybrid approaches.** Being aware of the concerns raised by workers both in the formal sector and informal sector, a hybrid approach is strongly recommended. To this end, there will be co-existence of private medical insurance (which is overwhelmingly voluntary) and public medical insurance. This also takes into account the important contribution of both private and public expenditures towards health outcomes. However, there is a need to guard patients (payers) against extortionate prices usually levied in the health private sector. As such, there will be a need to adopt a single-fee schedule for all services covered under the scheme.
- ❖ **Hiring of experts.** Taking note of the personnel deficiencies within the MoHCC, it is highly recommended that Health Actuaries and Health Economists be hired within the MoHCC. This should be done on a full-time basis considering their contribution in terms of policy directions and implementations. Any introduction of the NHIS in the absence of such will create deficiencies in terms of policy crafting.
- ❖ **Sector-wide approaches.** There is a need for the government to explore sector-wide approaches which are synonymous with Development Assistance for Health (DAH) where donors and lenders collectively contribute to funding the health sector. Under this arrangement, donors and the government negotiate and agree on policy plans. Considering that payroll deductions were argued against by employers and workers, this option may fill the void. However, in implementing this approach, care should be given to the drawbacks of this option.
- ❖ **Staff recruitment and remuneration.** Considering the vacancy rates prevalent in terms of health workers, coupled with the restiveness of the workforce, it is imperative that the government considers hiring more workers to fill the gaps. In addition, there is also a need to give a listening ear in terms of salary demands that are periodically echoed by health workers. In this regard, the established collective bargaining platforms should be utilised.

## 6. REFERENCES

- Akinci, F., Hamidi, S., Suvankulov, F, and Akhmedjonov, A. (2014). Examining the impact of healthcare expenditures on health outcomes in the Middle East and North Africa. *J Healthcare Finance*. (2014); 41(1).
- Association of Health Funders of Zimbabwe. (2019). Annual Report.
- Bein, M. A., Unlucan, D., Olowu, G., and Kalifa, W. (2017). Healthcare pending and health outcomes: Evidence from selected East African Countries. *Afri Health Sci*. 2017;17(1):247-254
- International Monetary Fund. (2020). Zimbabwe`s shattered economy poses a challenge to fighting COVID-19. Accessed on (10-07-2020)
- Ministry of Health and Child Care. (1997). *The National Health Strategy for Zimbabwe (1997-2007): Working for Equity and Quality in health*. Harare, Government Printers.
- Ministry of Health and Child Care. (2019). Human Resource Survey.
- Ministry of Finance and Economic Development, (2020). National Budget Statement, Government Printers.
- Raeesi, P., Khalilabad, T., Rezapour, A., and Noughabi, J. (2018). Effects of private and public expenditure on health outcomes among countries with different health care systems. *Medical Journal of Islam Republic* (32:35)

- Reich, M., R., Harris, J., and Ikegami, N. (2016). Moving towards universal health coverage: Lessons from 11 country studies. *Lancet* 387: 811-16
- Rezapour, A., Mousari, A., and Lotfi, F. (2019). The effects of health expenditure on health outcomes based on the classification of public health expenditure: A panel data approach. *Shiraz E-Med Journal* 20(12)
- Tikunov, V.S., Chereshnya, O.Y. (2015). Public Health index in Russian Federation from 1990 to 2012. *Soc Indic Res*; 129(2): 775-786)
- The Herald Newspaper. (2019). Multi-currency scrapped. Accessed on (18-08-2020)
- World Bank. (2017). Analysing fiscal options for Health in Zimbabwe.
- World Health Organisation. (2011). The Abuja Declaration: 10 years on
- World Health Organisation. (2019). World health indicators.