

Small Applied
Research No. 15

**An Assessment of
Incentive Setting
for Participation of
Private For-Profit
Health Care
Providers in
Zimbabwe**

November 2000

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Partnerships
for Health
Reform



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Funded by:

U.S. Agency for International Development



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November 2000

Recommended Citation

Mudyarabikwa, Oliver and Denford Madhina. November 2000. *An Assessment of Incentive Setting for Participation of Private for-Profit Health Care Providers in Zimbabwe*. Small Applied Research No. 15. Bethesda, MD: Partnerships for Health Reform Project, Abt Associates Inc.

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Contract No.: HRN-C-00-95-00024
Project No.: 936-5974.13

Submitted to: USAID

and: Karen Cavenaugh, COTR
Policy and Sector Reform Division
Office of Health and Nutrition
Center for Population, Health and Nutrition
Bureau for Global Programs, Field Support and Research
United States Agency for International Development

Abstract

This qualitative study was conducted in Zimbabwe to assess incentives implemented by the government that were designed to influence the participation of the private for-profit sector in health care and services provision. Data was collected using two approaches: the first approach reviewed literature on related studies conducted in the country and elsewhere. The second approach gathered data through in-depth interviews with major actors in the public and private health sectors. Data analysis was carried out through word processing and reviews by specialists in the health services planning and financing sector.

The study's results show that there are a number of monetary and non-monetary incentives supporting operations of private for-profit health providers in Zimbabwe. Although there is no publicly announced policy statement relating the public sector to private for-profit providers, the former generally acknowledges the role of private for-profit providers in the country's health delivery system. Private for-profit providers themselves, amorphous in nature, have had a long history of providing care and services in the country. Policy makers in the public sector were generally concerned about problems that emanated from practices and attitudes inherent in private for-profit provision. Nevertheless, they were convinced that the complementary role of the private for-profit industry essentially takes responsibility for what would otherwise be the public sector burden.

Private practitioners offer a variety of high quality services otherwise not accessible by affluent consumers at public facilities. Private providers suggest that the general resource shortage in the public sector could be addressed by allocating more government responsibilities to the private for-profit sector through astute management and marginal improvement of incentives currently in place. Contracting out of select non-clinical activities to the private for-profit sector was observed as one way to improve quality and save resources at public facilities.

Public sector capacity to set and manage incentives was observed to exist but was limited by the need to mobilize extra resources to finance other social services, particularly with reduced donor support and increased pressure from international financiers.

In conclusion, policy makers in Zimbabwe, although initially skeptical of the private for-profit health sector, now acknowledge its importance and are supportive of retaining the incentives currently in place in order to expand the sector and improve quality of services. The public sector plans to restructure its functional units to focus mainly on policy formulation, coordination, and monitoring and regulation of activities due to the increased complexity of public/private mix in health care services financing and provision.

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Acronyms

| | |
|-------------------|--|
| CIMAS | Commercial and Industrial Medical Aid Society |
| CME | Continuing Medical Education |
| CPCP | College of Primary Care Physicians |
| EDLIZ | Essential Drugs List of Zimbabwe |
| HDA | Hospital Doctors Association |
| HPC | Health Professions Council |
| MASCA | Medical Aid Society of Central Africa |
| MCA | Medicines Control Authority |
| MoH&CW | Ministry of Health and Child Welfare |
| MPC | Ministry of Public Construction |
| NAMAS | National Association of Medical Aid Societies |
| NRZ | National Railways of Zimbabwe |
| NSSA | National Social Security Authority |
| PHR | Partnerships for Health Reform |
| PSMAS | Public Service Medical Aid Society |
| RAILMED | Railways Medical Aid |
| UBH | United Bulawayo Hospitals |
| USAID | United States Agency for International Development |
| WB | World Bank |
| WHO | World Health Organization |
| ZACH | Zimbabwe Association of Church related Hospitals |
| ZESA | Zimbabwe Electricity Supply Authority |
| ZiMA | Zimbabwe Medical Association |
| ZINA | Zimbabwe Nurses Association |
| ZINATHA | Zimbabwe National Traditional Healers Association |

Acknowledgments

The authors gratefully acknowledge the financial and technical support of Partnerships for Health Reform Project (PHR) through funding by the United States Agency for International Development (USAID) under the Small Applied Research (SAR) Grant.

The authors would also like to acknowledge the extensive assistance in administrative arrangements by staff from PHR, especially Jose Ravano, Ellen Bobronnikov, and Whitney Schott, without whose support, this study would have been a nightmare. Sara Benett, the study technical advisor ensured the tools and other instruments of the study were of the required professional standards.

We also wish to thank the individuals, associations and institutions that provided the information and data either through interviews or provision of written materials for the study. A list of institutions and associations that were either interviewed or submitted written data and information is appended. Also, thanks are extended to Mrs. Constance Mungoshi, who provided excellent secretarial services for the study, Nicholas Madziwanzira for professional accounting and bookkeeping, and Seter Siziya for his invaluable reviews and directorship of the study.

The study initially benefited from the expertise of Principal Researcher Mr. Denford Madhina. He was later committed by his employer to serve on the Presidentially Commissioned Health Review Commission, which occurred during the same time that this study was taking place. Although his input became minimal at this time resulting in extension of time of completion for the study, his input was greatly valued.

Finally, we would like to acknowledge the Chairman of the Department of Community Medicine without whose authority this collaborative study with PHR would not have materialized.

Executive Summary

This study, partly supported by the Partnerships for Health Reform Project through its Small Applied Research initiative, was conducted in Zimbabwe from June till the end of December 1998.

The broad objective of the study was to list and assess the incentives implemented by the government to support growth and promote quality of care in the private sector, particularly among private for-profit health providers. This was based on the efforts of major stakeholders in the country's health system, including international agencies like The World Bank and the International Monetary Fund, which urged governments to relinquish more responsibilities to private for-profit providers in order to achieve efficiency and cost containment in health services provision (World Bank 1993).

This qualitative study utilized data collected from interviews with major players in the Zimbabwean health sector and literature reviews of policy documents/publications and other research studies done on the country's health system at local and international levels.

The study took place against a background of government investigations, which were searching for viable ways to mobilize extra resources for the health sector since public allocations have become increasingly inadequate to finance national needs. The decline in resource availability has resulted in the deterioration of quality of services at public facilities. Zimbabwean health provision needs to be reformed by broadening provider base through the usage of the private for-profit sector to strengthen capacity and provide adequate access to quality care for the population.

The study reviewed the structure and size as well as some of the operational problems associated with the for-profit sector in the country. Existing incentives in the industry were categorized as either monetary or non-monetary in nature and the former included the widely recommended concept of contracting between public and private sectors. Incentives in the form of restructuring some of the functional units of the public sector were discussed in as far as they promoted operations of the private providers.

It was noted that the Zimbabwean government had a history of providing incentives to support growth and quality provision of services by the private for-profit health sector in the country. Monetary incentives are mainly ingrained in the country's tax system and range from provision for tax credits to full tax exemptions for some services, such as health financing by Medical Aid Societies. The public sector supports the principle of contracting out with private providers for the easy-to-manage activities like catering, laundry and security.

Non-monetary incentives were observed to benefit the industry at large and not individual providers as is the case with some monetary incentives. Overall, the non-monetary incentives and reorganization of some functional units are more inclined to ensure quality of care and delivered by the private for-profit providers rather than being growth focused.

The study also assessed the government's capacity to set and manage new incentives for the health sector. It established that while the government could have the political capacity, its managerial and financial incapacity limit the development of a closer relationship with the private sector. There is a need for the public sector to adopt an entrepreneurial attitude that can relate to the private sector, whose objective is profit making.

The impact of the various incentives appear to be evidenced by the growth of the private for-profit providers in recent years. More than 50 percent of doctors in the country work in private practices and more private facilities are being set up particularly in the urban areas, thus demonstrating that the incentives continue to meet the intended objectives. Astute management of current incentives could still result in more gains for the health sector.

The study nevertheless observed that most of the incentive setting opportunities have been stretched to the bare limit and there is very little room for extending them further given the country's economic decline and the need to mobilize extra resources for publicly financed social services. Towards this end, the study recommended that current incentives should be maintained and also suggested that the inevitable downward revision of some of the tax incentives should be marginally done in order to retain the gains they created. Contracting out of some public services was observed as the most unexploited incentive, and was therefore recommend as way forward to creating efficiency at public facilities with minimal cost to the government.

1. Introduction

1.1 The Private Sector in Zimbabwe's Health System; A Historical Overview

Shortly after independence in 1980, the government of Zimbabwe, like many other developing countries, elected to achieve equity in health through extensive development of government-owned and -financed health services. From 1980 to 1990, the country witnessed a rapid growth in absolute numbers of health facilities and programmes designed to promote public health. Since 1990 however, partly due to population growth and economic stagnation, the government increasingly found itself unable to adequately address the health requirements of its population because health sector resources failed to match demand. It was during this period that the government began to search for ways to alternatively finance, provide, and manage health care services in the country. Private medical care has since proved itself a reality not only in Zimbabwe but probably also in many other developing countries. In the late 1980s, the government acknowledged that despite its heavy investment to ensure public provision of health services, the private sector was playing a significant role in the provision of health care services. At this point, the government became open to policies that considered the growth of the private provider sector in general. Supporting the role of the private sector in providing and financing care and services was acknowledged as a possible means to controlling government health costs. There is scarcity of data about the coverage and size of the private for-profit health sector in Zimbabwe.

One of the obstacles to achieving universal health in Zimbabwe is funding in the public health sector. Currently, public facilities are over-stretched by the demands of a growing population and there is little development of these facilities due to the acute shortage of resources. A number of strategies for resource mobilization have been suggested, including the creation of a National Health Insurance Plan. Because the Zimbabwean population is already heavily taxed, the public is generally antagonistic to strategies involving any form of additional taxation. The need to mobilize extra resources for the health sector is however inescapable. Over the years, the government has been looking to the private sector to participate in either the provision or the financing of health care. Private providers have been present in Zimbabwe's health system for many years. Non-profit private providers in the form of missions are an integral part of the health delivery system and they have facilities throughout the country. Private for-profit providers, although concentrated in urban areas, have also been in existence for many years.

The government now accepts that there is very little scope to further increase the role of the missions. An alternative solution promotes wider involvement of the private for-profit sector in providing and financing health care in the country. In the 1980s, the government was very skeptical of this sector; however, the modern private for-profit sector is now accepted as a complementary partner in the health delivery system. To realize maximum gains from this sector however, there is a need to set certain preconditions and foster an enabling environment for the participation of the private for-profit providers

1.2 Study Objectives

The role of missions in Zimbabwe's health sector has been documented, and it is generally accepted that not much could be done now to further expand their scope of work. Not much has been documented on the size, structure and scope of operation of the private for-profit sector. The potential of this sector has however been recognized as a viable alternative that can serve to improve the quality of national health. This study specifically focused on the private for-profit providers, a previously overlooked sector. The objective was to assess the various incentives in place that promote growth and quality of services for private for-profit providers. The specific objectives of this study were to:

- > describe the existing structure and size of the private-for-profit sector in the country;
- > analyze the problems, strengths and weaknesses associated with the private-for-profit sector;
- > give an overview and assessment of existing incentives for private-for-profit providers' participation in the health sector; and
- > examine the government's capacity to set and manage incentives for promoting growth and quality services for private for-profit providers.

1.3 Study Design

The author acknowledges that the private health sector is a broad area that has not been extensively researched for the various potential areas that could improve the general provision of services. This study did not consider the details of issues, such as the regulation of private for-profit health providers and characterization of private sector services consumers. The narrow focus was to only consider the incentives in place for the sector's growth and quality generation.

1.3.1 Data Needs

To answer the study objectives, we determined that data would be required in four areas: (1) the structure of the private sector with special emphasis on private for-profit health providers; (2) provider payment methods detailing fee structures and fees determination; (3) Medical Aid Societies and employers as financiers of health care services; and (4) discussion of existing government capacity to set and manage incentives for private for-profit providers.

1.3.2 Data Sources

This study was highly qualitative, combining data from interviews and literature reviews. We interviewed major players with experience in financing and providing health care services in the country. Table 1 and Appendix 1 show which institutions and associations were interviewed and describes their roles in the health sector. Literature reviews also provided significant data and information for the study.

The principal researchers also had the opportunity to listen to submissions by various stakeholders at the Health Review Commission which was being conducted during the same time that this study was carried out.

Table 1. Interviewees List

| ORGANIZATION | ITS ROLE | NO. OF INTERVIEWS | LITERATURE PROVIDED |
|---|---|---|---|
| Ministry of Health and Child Welfare (MoH&CW) | Public Sector Representative Ministry | 3 - Under Secretary - Deputy Secretary - Consultant | - Policy Document - Other Research Reports - Reform Documents |
| Zimbabwe National Traditional Healers Association (ZINATHA) | Traditional Healers Representative Body | 1 - Secretary General | - Public Health Training Paper |
| National Association of Medical Aid Societies (NAMAS) | Representative of Medical Aid Societies (Health finances) | 1 - Executive Secretary | - Submission to the Health Review Commission |
| Commercial and Industrial Medical Aid Society (CIMAS) | Medical Aid Society (Largest Private Health Financier) | 2 - Assistant Research - Manager | - Fee structures - Review Commission Submission Paper |
| Zimbabwe Medical Association (ZiMA) | Representative body of private practitioners | 1 - Past President | - Role of Private Practitioners in Public Health Training |
| Hospital Doctors Association (HDA) | Hospital Doctors Association of Zimbabwe | 2 - Co-Presidents | |
| Public Service Medical Aid Society (PSMAS) | 2nd Largest Medical Aid Society for Civil Servants | 1 - Deputy CEO | |

1.3.3 Data Collection

Policy documents: strategic plans and to a large extent, publications on previous research were used to collect the relevant data. Literature on private health care was also sourced from the World Health Organization (WHO), the World Bank (WB) and the Ministry of Health and Child Welfare (MoH & CW). Partnerships for Health Reform (PHR) provided extra publications relevant to the study. Some data was also obtained from attending relevant meetings like the Public / Private Mix Networking (meeting held in South Africa) and attending the to Health Review Commission on invitation from stakeholders.

2. Structure and Size of For-Profit Sector

2.1 Private Sector Involvement in Health Service Provision and Financing

The private for-profit sector in Zimbabwe includes both conventional and traditional practitioners. Both have made important contributions to expanding the provision and payment of health services in the country. The central government, through the Ministry of Health and Child Welfare, has however continued to play the leading role in providing health care service. The establishment of health policy has been primarily the responsibility of central government over the years.

In 1993, the government contributed 65 percent of total health care expenditures in the country compared to 35 percent from the private sector (MoH&CW 1994). The 35 percent private contribution not only includes but also conceals the mosaic of cross subsidization, normally favoring the private sector in the country. Missions, which are not for-profit providers are known to be the second largest providers of health care after central government yet their contributions are aggregated with the private for-profit providers. Data concerning actual contribution of the private for-profit providers, apart from being very scarce, is also very fragmented

Estimates approximate that 9.5 percent of the population benefit from services provided by the private for-profit sector (NAMAS, 1998). It is not possible to accurately and reasonably compute the per capita expenditure on health by this sector because of its amorphous nature. For the central government however, per capita expenditure on health was estimated at US\$12 in 1995 (MoH&CW, 1995).

2.2 Doctors

The Health Professions Council records have 1,550 registered doctors. The Zimbabwe Medical Association (ZiMA) (1998) and the College of Primary Care Physicians (CPCP) (1998) estimate that about 66 percent of the registered medical practitioners are employed in the private sector. The government allows public sector doctors to run their own private clinics after hours and this constitutes a considerable proportion of the private provision that was cited above. The Zimbabwe National Traditional Healers Association (ZINATHA), in 1997 estimated that there were about 50,000 traditional healers, half of whom were registered with the association. The private for-profit sector also includes nurses in private homes, pharmacists and other technical specialists in complementary therapies.

Table 2. Zimbabwe: Statistics on Qualified (conventional) Medical Practitioners

| | |
|--|--------------|
| National Population | 12.2 million |
| Estimated doctors population | 1,550 |
| Doctors per million population | 127 |
| Doctors in private practice | 1,020 |
| Private doctors per million population | 84 |

Note: Adapted from 1992 Population census

2.3 The Zimbabwean Health System and Infrastructure

Of the 1,080 health facilities delivering in-and out-patient care, 72 percent are administered by Government (MoH&CW 1997). The rest are administered by the private not for-profit agents of the central government (mainly missions and local government authorities), the private for-profit sector and the Municipalities. Mission facilities offer services at primary and secondary levels where government facilities of similar capability are unavailable. The majority of private for-profit physicians provide primary care and also see patients at the secondary and tertiary levels.

While there are about 18,200 hospital beds in the country, Mission institutions, which are private not for-profit agents of central Government, constitute more than a third of the hospital beds – 38 percent, and nearly 70 percent of all rural hospital beds in the country (ZACH 1996). It is difficult to reasonably ascertain the number of hospital beds administered by the private for-profit providers for two main reasons: records are not kept and some providers fold up. It is however estimated that private for-profit providers administer about 9 percent of institutional beds in the country (WHO 1991).

Table 3. Zimbabwe: Health Sector Beds Capacity

| | | As % of Total |
|--|--------|---------------|
| National Hospital beds | 18,200 | |
| Beds per million population | 1,484 | |
| Mission hospital beds | 6,927 | 38% |
| Private beds per million population | 568 | 38% |
| Private for-profit beds (estimated) | 1,695 | 9.4% |
| Private for-profit beds per million population (estimated) | 139 | 9.4% |
| National Stock of Health Facilities | 1,080 | |
| Government facilities | 778 | 72% |
| Private sector facilities (including Missions) | 116 | 11% |
| Private for-profit facilities | N/D* | N/D |

* N/D—No data available.

Source: MoH&CW and ZACH

Almost all of the for-profit facilities except mines and estate hospitals provide mainly curative care. In the case of the 1,020 doctors in private for-profit provision, preventive care provided relates to the easy-to-price services like ante and post natal care. Because the government provides free immunizations and child growth monitoring services, for-profit providers are rarely utilized as they charge consultation fees for the same services. Otherwise the for-profit providers' preoccupation is the provision of ultra-modern curative care which is correspondingly high-tech and therefore comparatively costly. For the mines and estate hospitals, the profit motive is not so much of an issue. They primarily seek to ensure healthy workers and dependents to control absenteeism due to ill health. Their packages therefore cover preventive (including vector control), curative, promotive and rehabilitative services.

2.4 Medical Aid Societies

Private sector health services delivery in Zimbabwe is not limited to institutionally based providers of treatment and care; rather there is significant community involvement, especially in urban areas. Much of this activity is financed through Medical Aid Societies and health insurance. While Medical Aid Societies also pay for services delivered by public institutions, 75 percent of their payouts arise from attendances at private for-profit practitioners (NAMAS 1998).

Medical Aid Societies have been operational in the country for many years. All Medical Aid Societies are regarded by the government as non-profit making health societies. Currently there are 22 Medical Aid Societies operating under the umbrella of the National Association of Medical Aid Societies (NAMAS). The only medical aid societies which are not members of NAMAS are Zimpapers, First Medical Aid Society and the Public Services Medical Aid Society (PSMAS).

Most of the Medical Aid Societies are "in-house" and provide services for employees of a specific employer or group of employers. RAILMED serves employees of the National Railways of Zimbabwe and is the biggest "in-house" scheme. Only four societies are "open" and not exclusive to a particular employer or group of employers. These are Commercial and Industrial Medical Aid Society (CIMAS), MASCA, Northern, and Engineering Medical Fund. These societies accept members from any type of company and also enlist private individuals. This is probably because they are the original Medical Aid Schemes in the country and their original objective was to cover all eligible beneficiaries regardless of their employment and industrial profession. Most of the "in-house" medical aid societies were formed to cover specific categories of employees. It would seem that the motive then was to increase inducements to retain key personnel by the different private for-profit firms. At the same time, creating the medical aid societies would pool resources together and ultimately reduce costs of providing health care services to employers.

Medical Aid Societies cover about a million beneficiaries, out of a national population of 12 million (NAMAS, 1998). The three largest of these societies are Commercial and Industrial Medical Aid Society (CIMAS); PSMAS and RAILMED. These have a combined coverage of up to 90 percent of the beneficiaries under Medical Aid Schemes. CIMAS has 403,679 beneficiaries, which is about 40 percent of the medical aid market share in the country (CIMAS, 1998). The PSMAS has about 180,000 while RAILMED enlist about 50,000 beneficiaries.

During the time of this study, it was observed that although the Medical Aid Societies are treated by the Income Tax Act as non-profit making organizations. Some of them, such as CIMAS and PSMAS under professional management, are actually making large surpluses. The Societies are involved in some form of vertical integration and buy complementary facilities like X-rays and construct private laboratories to provide complete health packages to their beneficiaries.

2.5 Government Attitude Toward the Private For-Profit Sector

Just after independence, the government did not favorably consider private for-profit practice in the country. In fact, there were attempts to close this sector in favor of promoting publicly provided services. Currently, the government has a completely different view of private practice in health. This sector has been promoted due to the opening-up of the economy. Private for-profit practitioners are allowed in the country as long as they are legally and professionally registered. Government policy has been to allow this sector to conduct their own affairs with their professional bodies doing the policing for quality services.

3. Problems Associated with the For-Profit Sector

3.1 Limitations

As a general observation, one of the important limitations in understanding private for-profit providers in Zimbabwe is the lack of reliable quality data and information on the sector. Available information on the structure and size of the sector is mostly provided by associations like ZiMA and therefore only considers those providers registered with these associations as being full time private practitioners. Some private providers just do not register or belong to an association and thereby left out on statistical returns for the industry.

This study observed that there are also problems associated with the private for-profit providers. Some of these were elaborated upon by the public sector managers interviewed. The limited evidence observed mostly suggested problems related to aspects of quality as well as accessibility to services in the private for-profit sector.

3.2 Geographical Imbalances

Available data indicates that the majority of private for-profit care providers are concentrated in urban areas. A possible explanation for this is the ready market provided by formally employed and high salaried consumers who can afford the services provided. It would also appear that urban areas, because of their developed ultra-modern infrastructures, become natural residences for medical professionals who seek the comfort and prestige often linked to their professions.

Distribution imbalances is not only limited to urban versus rural locations. Even within urban locations, providers prefer and favor the major cities compared to the small towns. Of the over 1,000 privately practicing medical doctors in the urban areas, Harare and Bulawayo cities account for about 75 percent of health care providers (ZiMA 1998). The two cities' immediate catchment zones combine over 87 percent of privately practicing doctors and 59 percent of national doctors (ZiMA 1998).

Table 4. Medical Doctors Distribution by Region

| Region | No. of Doctors (ZiMA Affiliated) | % of Total |
|-------------------------------|----------------------------------|------------|
| Mashonaland | 725 | 69 |
| Matebeleland | 186 | 18 |
| Midlands | 97 | 10 |
| Manicaland | 42 | 3 |
| Total ZiMA Affiliation | 1050 | 100 |

Source: ZiMA 1998

Mashonaland region comprises three provinces including Harare City. The majority of its doctors' population are based in Harare City. It is also the wealthiest region therefore accounting for a larger doctors' population. Matebeleland region's doctors are mainly based in Bulawayo City.

The national dilemma is that the majority of the population who reside in rural areas and small towns do not have access to private medical doctors, pharmacists, X-rays or laboratories facilities. This inaccessibility is geographical in nature; often there is a long distance to travel from rural areas to urban health care facilities.

The noted distribution imbalance has created two segments of health care provision within the private for-profit sector. On the one hand, the high salaried urban based consumers are serviced by the conventional medical private doctors with ultra-modern services. On the other hand, the private sector needs of low income consumers, mostly in rural areas (and to some extent in urban areas), are provided by traditional healers who may or may not be members of ZINATHA. Although recognized by central government, the impact of ZINATHA has not been widely accepted by a majority of consumers and many orthodox practitioners view ZINATHA'S operations as counter productive in for good health practice. It is therefore not easy to assess if the majority of consumers in low income brackets in both rural and urban areas serviced by the private sector are satisfactorily and scientifically treated.

3.3 Focus on Curative Services

Private for-profit providers are by nature motivated by different incentives compared to those in the public sector. Generally, they are not involved in the provision of preventive services which are mainly provided by the public sector and private mission facilities. Private for-profit providers tend to provide easy-to-price services, such as ante-natal care and family planning services, to those clients who can afford the high fees charged by the sector.

A general impression of the private for-profit sector, particularly of general practitioners, is that they are only obliged to providing medical care at the professionally agreed standards as determined by the beliefs in modern medicine. This may be because they are remunerated by clients on a fee-for-service basis. The providers' responsibility is therefore generally reduced to focusing on management of diseases as presented by clients rather than taking a wholistic approach to focus on health care. Prevention of diseases is therefore not of paramount importance to the sector; although, it is agreeable to private providers that preventive services should take precedence over curative care. This could be because preventive services in Zimbabwe are mostly public goods and nobody in the private for-profit sector is altruistic enough to want to finance them (World Bank 1993).

Most general practitioners are of the opinion that preventive services should be the responsibility of central government. Between 1982-1983, the government attempted to provide free supplies for immunizations to the private sector. The experiment was shortly stopped because the private providers started charging patients for the services which were supposed to be free. Charges were made either directly for immunizations or consultation fees were raised (MoH&CW 1984). This questioned the sincerity of private providers to deliver preventive services.

3.4 Fees-for-Services

Financiers of health care, particularly Medical Aid Societies, argue that fees charged by the private for-profit sector are unrealistically high for the type and quality of services. This has the effect of increasing the country's overall cost of health services provision. Public sector fees are far below the private sector even for similar procedures and the same fees are also way below the cost of ensuring access by the poor consumers.

For the private-for-profit sector, fees are determined on the basis of market sensitivity. As long as the market can bear higher rates for services, fees are correspondingly high. Little consideration is given regarding the best interest of the majority of consumers who are poor or have low income.

The high charges seem to be reflection of the strong perception amongst private sector clientele that services provided have superior quality. The perceived high quality and ability to pay ensures the sector of a ready market. For this reason, charges would seem deliberately high as demand is seen to be inelastic within the sector target clientele.

It is nevertheless difficult to establish the validity of the perceived quality that is related to the high service charges, because the existence of quality assurance as an in-built facet in the fees charged is not evident. Despite high fees, demand for private for-profit services is always high; this seems to be indicative of satisfaction of customer expectations of quality.

3.4.1 Price-setting of Private Health Services

The private for-profit sector is not supportive of the central government's involvement in the setting of private fee structures. Only NAMAS and representative bodies of the sector professionals are involved in negotiating the fees for medical aid members. Providers are not required to charge non-insured patients the fees agreed with NAMAS. Usually providers charge a lower fee for the non-insured patients. However, there are no easy agreements on fees charged for different procedures when the providers negotiate with NAMAS. For instance, there was a year-long stand-off between most private for-profit providers and NAMAS in 1996 - 1997. NAMAS still view some of the charges required by private for-profit providers as being too high and unrealistic for medical aid membership. NAMAS is therefore unwilling to pay the high fees charged by providers and patients are often forced to pay cash up-front to these service providers.

3.5 Resistance to Policy Changes

The high earnings associated with the private for-profit sector make the sector very resistant to policy changes affecting the structures, operations and practices of the major players. There seems to be a desire to preserve the status quo and institute minimal changes. Some providers argued that preserving the status quo is to the advantage and best interest of patients who should be afforded the freedom of choice than being forced to adjust to initiatives by central government. Efforts aimed at rationalizing prescribing practices, such as the use of generic equivalents and discussion of alternative fee structures are resisted for a number of reasons. Private providers rely on prescriptions and dispensing of drugs for part of their remuneration.

3.5.1 Pharmaceutical Practices of the Private Sector

The Essential Drugs List (EDLIZ), which promotes use of generic equivalents of drugs rather than brand names, was established by government in the early 1980s. This practice was well accepted and used in public facilities resulting in a very cost effective means of treating patients (MoH&CW 1994). The private for-profit providers continued prescribing brand names without adopting the provisions EDLIZ.

This may be because brand names guarantee high income for those practitioners who prescribe and dispense drugs. For some general practitioners, the patient's financial interests are not considered paramount, purportedly to promote freedom of choice for the clients who would buy drugs from private pharmacies.

The pharmaceutical industry in Zimbabwe has also been expanding fast. The resultant competition has created aggressive marketing strategies on the part of manufacturers and distributors. Most drug companies now have to engage a sales force that directly deal with care providers, especially providing commercial inducements upon providers to patronize and dispense slow moving drugs not preferred in public facilities. Up until the beginning of 1998, infant food manufacturers were known to routinely take samples to mothers in hospitals to convince them that they worked better than breast milk. However, in the interest of public health, the revision of the Public Health Regulations now denies the manufacturers access to hospitalized mothers. These together with many other non-conformities inflates the cost of health care in country.

3.5.2 Differing Visions for the Future of the Private For-Profit Sector

The private for-profit sector is broad and includes industries, mines and commercial farms, individual private practitioners, traditional healers, pharmacists, nurses in private homes, and technical specialists in laboratories and X-Rays. The government's desire is for all these players to form one umbrella body so that it is easier to promote ethical practices, unify fee structures and agree on general professional roles in overall promotion of health care without neglecting public health (MoH&CW, 1997). The different health professions do not subscribe to this and would rather operate independent of each other without routine consultations on respective roles. Attempts to include traditional healers in government facilities were objected by conventional professions perhaps because of lack of clarity of the respective roles of traditional and modern disease management. The conventional medical doctors objected to this move primarily because they could not understand their roles vis a vis the traditional healers. The opportunity to have cross-profession learning in health and modern disease management was therefore lost.

3.6 Quality Assurance

3.6.1 Over-servicing of Patients

The private for-profit health sector is generally assumed to offer better quality care than the public sector. There are however practices that compromise the popular assumption about the industry. Medical Aid Societies (CIMAS, 1998) and the MoH&CW worry that there are incidents of patient over-servicing because of some practitioners calling patients for repeat visits or consultation. Due to such suspicions, Societies like CIMAS are actively pursuing plans to introduce Managed Care practices for its membership. As implied before, private providers rarely turn away patients whose presenting conditions do not warrant treatment. Either spot treatments and prescriptions are provided even under conviction that the conditions do not warrant so.

3.6.2 For-Profit Providers Running Many Consulting Rooms

Some consumers often complain of being attended to by inexperienced doctors doing locums for the senior private practitioners who run more than one consulting rooms. There are consumer doubts on the quality of care and services provided by some locums. Also the personal attention offered by the experienced practitioner is lost when employing locums yet it is one of the often cited reason for why some patients prefer the private sector.

The fact that an individual practitioner has many consulting rooms at different locations implies that at any one time, patients at the different locations have to experience long waiting time to get served. Because of this arrangement, the practitioners are bound to “kill the queues” in order to see the patients at all the locations. This practice is bound to compromise the quality aspect often cited as the strength of the private for-profit sector.

3.6.3 Traditional Healers

Zimbabwean traditional healers have been internally cited as having some of the most controversial treatment practices that compromise the quality of their services. Using unsterilized instruments during operations is not uncommon among traditional healers. Some treatment methods like smoking children, bleeding and the administration of some herbal concoctions often result in patients getting sicker than when they presented. Yet, despite all the secondary infections associated with traditional methods of treatment, these healers are almost always consulted first by most patients before seeking second opinions from conventional doctors in private and public facilities.

3.7 Moral Hazards

Over-servicing of patients in the private for-profit sector can not only be apportioned to the providers but also to the clientele. Clients of the industry are mostly individually insured or are insured by their employers. Because they are pre-paid for their health care needs, clients often consult with the providers more than is necessary. Medical aid also covers for ailments from avoidable risky behaviors that increase frequency of consultation by the clients. Insured clients do not have the financial constraints of directly paying out of their pockets for the services provided so they have no disincentives for seeking care more than necessary. Private for-profit providers on the other hand have no incentive to discourage unnecessary consultations as they stand to directly benefit from high turnover of patients. These moral hazards are partly responsible for the high cost of private health insurance and impact on the per capita cost of health care provision in the country.

4. Incentives for Private For-Profit Providers

Incentives observed in this study were categorized as non-monetary and monetary. Non-monetary incentives were designed to improve the quality of services provided by private for-profit health providers and sometimes also public facilities. Monetary incentives were primarily designed to promote growth of the private for-profit sector.

4.1 Non-Monetary Incentives (Operational Incentives)

4.1.1 Private Sector Fee Structures

The fee structures in Zimbabwe's private health sector are determined by providers themselves, and in the same manner, they determine the type of services provided on the basis of each service's relative profitability in accordance with free market forces. In the case of medical aid members, the providers negotiate fees with NAMAS and government input is not mandatory.

This incentive was seen to empower the provider while at the same time making them take responsibility for the viability of the industry. Freedom in setting fee structures is given to both the care providers (general practitioners, pharmacists, specialist practitioners, traditional healers and private hospitals/nursing homes), and health financiers like Medical Aid Societies. Medical Aid Societies' premiums are determined by the societies themselves just as the involved employers determine their proportional contributions to cover for their employees.

The general observation has been that Medical Aid Societies have not been adequately regulated, particularly because they set tariffs upon agreement with medical practitioners and private hospitals without requiring government approval for the tariffs. Medical Aid Societies are designed in such a way that subscribers are not required to pay part of the cost of services and this encourages frivolous use of services. On the whole, this becomes expensive to the country's health care services. It is partly for this reason that most policy makers in the public health sector argue for closer regulation of operations in the private medical insurance industry.

Table 5 demonstrates the fee discrepancies between the public and private sector even in similar procedures. Patients on medical aid admitted in government facilities however pay higher fees than public patients. The fees would still be lower than those charged by the private for-profit facilities. Insured patients who are referred to government facilities are charged the lower public sector fees, and this, in a way, subsidizes medical aid societies who would have otherwise paid higher fees to private sector providers. Fees paid by Medical Aid Societies to the public facilities on behalf of privately insured patients does not amount to 5 percent of their total payouts because of the low fees at the public facilities (MoH&CW, 1997). Apart from the low fees and inefficiency of public facilities' billing, Medical Aid Societies have no incentive to pay since their desire is to control cash out-flows and maximize surpluses.

Table 5. Comparison of Fee Structure Between Government and Private Health Institutions as of January 1999

| | Private Sector Providers | | | | Public Sector Providers | | |
|--|--------------------------|---|-------------------------|-------------------------|--------------------------------|-------------------------------|-------------------------------|
| | General Practitioners | Avenues | St. Annes | Clay Bank | Central Hospital | Provincial Hospital | District Hospital |
| Outpatient Consultation | \$125 | Weekdays - \$257 Weekdays - Nights \$374 Weekends - \$313 | No out patient | Not a benefit | Adults- \$52 Children \$26 | Adults- \$38 Children \$19 | Adults- \$24 Children \$12 |
| Admission to General Ward Per Day | | Twin bedded=\$1179 | \$1012 | \$980 | Adults- \$120 Children \$60 | Adults \$100 Children \$50 | Adults \$60 Children \$30 |
| | | Up to 5 beds=\$1070 | \$901 | \$893 | | | |
| | | More than 6 beds \$ 927 | \$811 | Not a benefit | | | |
| Surgery Charges | \$186 fixed | \$186 fixed | \$186 fixed | \$186 fixed | Major- \$150 Minor - \$50 | \$100 \$45 | \$25 fixed |
| Pharmacy Charges | Depends on type of drug | Depends on type of drug | Depends on type of drug | Depends on type of drug | Depends on type of drug | Depends on type of drug | Depends on type of drug |

Source: MoH&CW and CIMAS 1998

4.1.2 Co-Use of Government Facilities

The government aims to achieve higher total supply of health care in the country. This will mean a correspondingly larger share of private for-profit providers. It is partly for this reason that private practitioners are allowed to admit their patients to public hospitals. The private for-profit health sector in Zimbabwe does not have large enough facilities to house patients and significantly reduces the burden placed on public facilities. The central government acknowledges inadequacies in the industry, particularly that there are few private hospitals in the country. It supports the sector and encourages expansion of the health supply side by allowing most private practitioners to admit their patients to public hospitals. Most private patients are admitted to private and general wards at the four major hospitals, United Bulawayo Hospitals (UBH), Parirenyatwa Group of Hospitals, Harare Central Hospital, and Mpilo Central Hospital. The government determined this incentive after three major considerations:

- (i) The private sector lacked state of the art equipment and facilities to deal with some of the conditions presenting to them.

(ii) A large number of publicly employed medical personnel were using government time to go out and see patients at private consulting rooms, leaving government patients unattended. The new incentive allows providers to admit their private patients in public hospitals reduce absenteeism on the part of publicly employed doctors.

(iii) There is a shortage of public sector doctors in the country. Private sector doctors admitting private patients at public hospitals would attend to public patients instead of being charged for their patients. This would compensation for the shortage of doctors at public facilities.

There is no financial motivation on the part of government to pursue the co-use of public facilities incentive. Private for-profit providers do not directly pay for using government facilities or equipment and other costs resulting from admission of their patients. They are only expected to in turn offer their services to public patients free of charge. This arrangement is again informal and therefore subject to abuse by the target beneficiaries. For example, during the period of this study, the Ministry of Health and Child Welfare had to give instructions to its institutions to debar admission of private patients particularly in maternity wards. This occurred in response to what the Ministry observed as an unwillingness on the part of private practitioners to in turn give free services to government patients after admitting their private patients at public facilities. The decision to co-use public facilities, is not strictly respected by the participating private for-profit providers. One of the possible reasons for this is that in place of seeing public patients, private practitioners elect to be in their consulting rooms for private patients who pay for their services. It is also possible that the majority of practitioners realize the absence of strict enforcement of this informal arrangement and take advantage.

4.1.3 Opening the Private For-Profit Sector

Although the government abandoned its decision to abolish the private for-profit sector, it remained very cautious to encourage its rapid growth. Up until 1988 for instance, no publicly employed medical personnel could legally engage in private practice from any facility, private or public. Providers nevertheless continued to use government time to engage in private practice to the disadvantage of public patients. At worst, some essential health personnel left public employment altogether to seek higher earnings provided by private practice. A shortage of appropriately trained health professionals pressured the government to introduce incentives for retaining qualified staff in public facilities.

In 1988, the government determined that government employees in the health sector could privately practice from their own premises after hours. They could also co-use public facilities and in turn attend to public patients outside their normal working hours. It is uncertain whether this initiative had the effect of retaining personnel in the public sector and in the country. The MoH&CW however indicates that as of 1994, the loss of health professionals to neighboring countries was declining and enquiries were being received from some doctors intending to return. This development cannot be only attributed to allowing private practice by public employees, since there were political agreements between Zimbabwean and neighboring governments to repatriate health professionals contracted to the former.

4.1.4 Continuing Medical Education

The government recognizes that high quality of services is achievable through routine up-dating of providers' knowledge and skills to keep pace with advances in modern medicine. Therefore, one area of incentives popularly received by private for-profit providers has been the benefits built in to continuing medical education (CME) as provided and supported by the government. Private providers, particularly private physicians, who have been in the industry for a long time would require refresher courses and

training to up-date their clinical and health management practices. Due to realization of the benefits from post-graduate courses, private providers are increasingly pressuring the government to design and offer a variety of courses combining participants from all major players in the health sector for the purposes of sharing experiences across professions.

In pursuance of the demands for CME, there are incentives provided by the government to encourage private providers to regularly update their knowledge and skills in the industry.

4.1.4.1 Training Subsidies

The government assumes the responsibility of financing basic training in the country as part of its manpower development strategy. To this end, most health professionals in the private sector are graduates from publicly funded training institutions. The government does not restrict employment of graduates from its institutions to the public sector only. Its graduates occupy most of the professional private sector posts. High profitability of the private sector is therefore partly a result of employing competitively trained and skilled professionals from publicly funded training institutions at insignificant financial outlays by the sector.

The few private sector providers who sponsor their employees at public institutions are to some extent subsidized by government to induce them to invest more national manpower development. Private sector sponsored student's educational expenses have tax credits for their employers. Employers pay the direct cost which often is less than the indirect cost (for fixed facilities including instructors' salaries) financed by the government. The government pays little attention to the high costs in training for the private for-profit sector, primarily because it wants to ensure a competent and appropriately trained national workforce. Extra incentives for the private sector to finance and pay full cost of training are being determined in view of declining public sector resources, particularly for health training due to competition from other social services.

4.1.4.2 Specialized Training

Although there are cases of prioritizing training of publicly-employed health personnel in speciality areas, the private health sector, with support from the government, can access similar training if such training is not obtainable in-country. Where government to government agreements exist in health manpower training, the government does not discriminate against private sector providers, who may access specialized training through government or donor funding. The government's overriding strategy is to staff the health sector with competent personnel to improve quality of services. It does not directly pay for the training of private providers' education in this case, but recommends that the private sector be prioritized in access to specialized training when donor funded while publicly-employed providers are its primary responsibility. This incentive is however not extensively exploited by the for-profit providers, perhaps because public health practice is not financially rewarding given the limitations in pricing of services.

Self-sponsoring private providers on postgraduate training are given tax credits for their expenses to encourage knowledge and skills updating. The incentives apply only to providers with membership to an approved medical association that certifies expenses related to specialized training. The government derives satisfaction from the tax credit arrangement since training improves the health providers' capacity to provide quality services. The primary objective of CME tax incentive is to ensure adequate stock of specialists and minimize expenses made by patients seeking specialized care abroad.

Usually, senior private providers are more willing to undertake specialized training to keep pace with advances in the practices of modern medicine. The junior doctors' immediate priority is to generate income and consolidate private practice. As the private for-profit sector expands, competition is likely to occur among a variety of specialist services offered, which could in turn compel more providers to specialize and update skills for competitive advantages. To the advantage of quality, the professional and skills gap between senior and junior providers could be narrowed with subsidized specialized training.

4.1.4.3 Academic Workshops

One incentive given by the MoH&CW that effectively influenced private for-profit providers to provide preventive services and participate in public health management is the administration of routine academic workshops. Private health providers are targeted to attend intersectorial workshops that seek to identify needs and problems affecting the health sector. The public sector takes the opportunity to market new policies and initiatives in national health. The academic workshops have been used to influence the behavior of the private for-profit providers. But at the same time, the public sector has also been influenced to respond to market forces that impact on health because health is now more than a social service and is being commercialized by the private sector. Academic workshops have been able to promote interaction and consultation between the public sector and private providers much to the benefit of consumers. Strategies sharing the problem-based information initiated by the public health sector meant that private sector providers are more aware of intentions of the health sector and are equipped with skills to approach problems presenting at their facilities. One factor that compromises the impact of academic workshops is the reluctance of private providers to be away from their practice while attending academic workshops for longer durations than required by facilitators.

4.1.5 Restructuring Ministry of Health and its Functional Units

Private for-profit providers believe that setting new roles, functions and structures of the MoH&CW and its functional units would encourage more participation in health care and services provision. The process of decentralization as well as the increased complexity of a public/private mix in the health sector means that government roles are changing, not diminishing. The restructuring objective would be to reduce the involvement of MoH&CW in direct management and delivery of health services. The primary focus of MoH&CW and its functional units would be on policy formulation, coordination, monitoring and regulation. The structures of the ministry would need to provide an enabling environment for all actors, particularly the private for-profit health sector, as complementary partners. Restructuring seeks to democratize and promote registration, licensing and regulation of services providers.

4.1.5.1 Health Profession Council

National policy requires all practicing health professionals to register with the Health Professions Council (HPC). One reason for the growth of the private health sector is that the allied professions enjoy the prestige of association with an industry of high repute in terms of quality services and ethics. Without the associated quality, prestige and professional ethics in the private sector, patients are likely to be lost to public providers. The council's structures therefore need the reorganization to reflect the expectations of its membership. HPC's role is to competitively guarantee quality and standards associated with the private health sector. Reorganization would entail having a streamlined framework for registration procedures to retain the good reputation desired by providers. Restructuring of the HPC serves as an incentive for sector protection and also safeguards patients against unqualified and incompetent providers motivated by high profits accruing from private practice.

4.1.5.2 Medicines Control Authority (MCA)

The Medicines Control Authority (MCA) has the responsibility to register, license and regulate drug suppliers to ensure safety, efficacy and quality medicines as well as allied substances for the safety of patients. Private sector providers feel the MCA has inflexible structures, which limit its efficiency and therefore discourage more private sector investment in health. Their major concerns are the inconsistencies present in the control of drugs importation and distribution (ZiMA 1998). There are problems related to acquiring import clearance for some essential drugs and the authority does not support duty relief on such drugs. Consequently, the price of some drugs are beyond the reach of many patients. Fees for registering new drugs are also too high to encourage the introduction of therapies in the country.

Without compromising on quality, effective incentives for private for-profit providers to invest more in pharmaceutical industries would be the MCA support of customs and duty relief on essential drugs as well as the streamlining of registration of commonly used drugs. Drugs with good reputations in other countries should be licensed with less bureaucracy, while commonly prescribed drugs should be registered at cheaper fees to the MCA.

4.2 Monetary Incentives

4.2.1 Tax Incentives

There are a variety of government initiated tax incentives supporting small businesses including private for-profit health care providers, either as individuals, associations or companies. There are specific tax exemption incentives and tax credits under the Income Tax Act that are designed to benefit private health care providers including those operating on a for-profit basis. These incentives are primarily inducements for capital investments in services expansion and quality improvement on the part of the private for-profit providers. Tax incentives are however not obvious but “hidden” in the Tax Acts. They are inaccessible to some providers due to mere lack of awareness of their existence and how to exploit them. One possible solution is to widely publicize the existing incentives. The central government is however not likely to fully support this approach because maximum exploitation of these incentives would reduce revenue collected through taxation. The government plans for a compulsory Social Health Insurance. If it is implemented, it may change the tax incentive structures particularly as they pertain to the operation of Medical Aid Societies, which would be in direct competition with the Social Health Insurance.

4.2.1.1 Tax Exemptions – Medical Aid Societies

Recognition of the importance of private health insurance in Zimbabwe is historical. Since the 1950s, deliberate and targeted tax incentives were employed to influence the growth of private health insurance schemes, which financed the health needs of the affluent population. Medical Aid Societies were classified as not for-profit providers whose incomes were tax exempt. The Income Tax Act of Zimbabwe (3rd schedule - section 14) legally and statutorily provides for tax exemption on Medical Aid Societies’ income and accruals. This tax incentive has been retained over the years to encourage growth of private medical insurance, which finances the needs of the high income consumers. The biggest Medical Aid Societies like Commercial and Industrial Medical Aid Society, Public Service Medical Aid Society, and Medical Aid Society of Central Africa (MASCA) employ professional management which generates even more profits that can be used to sponsor vertical expansion into commercially run private hospitals and laboratories. Medical Aid Societies argue that large surpluses help subsidize members’ subscriptions without compromising quality of financing.

Medical Aid Societies are often criticized for their vertical growth and adoption of entrepreneurial behavior. The government and the private practitioners advocate some form of regulation on the operations of medical aid societies. They argue that tax exemption benefits are used to finance vertical expansion and eliminate competitors and emerging providers from the industry. CIMAS, the largest society in the country, not only provides medical insurance. Its vertical expansion has strategically positioned itself so as to allow for the provision of services and care through the ownership of laboratories and shares in up-market private hospitals. Acquisition of line facilities and equipment is funded from untaxed surpluses. For the reason that some medical aid societies are both financiers and providers of health care, they create barriers to new entrants in the private health care market.

In assessing the impact of vertical expansion, private for-profit providers are concerned that medical aid societies working as health financiers are induced to pay preferential rates to providers and facilities under their own management while delaying payment to competing providers. Vertical expansion by the largest societies not only squeezes out competing care and service providers. It also does the same to competing health care financiers by instructing their facilities to discriminate against patients insured by competitors. On the other hand, congestion at the few private for-profit facilities would continue to push patients to seek services from public facilities. At the end, such discriminated patients are likely to switch insurance societies in favor of the largest ones which own health care providing facilities. Because of these possibilities, there are fears that existing tax incentives might not promote expansion of the health insurance industry as originally intended, suggesting a need for regulation for fair competition in the sector.

4.2.1.2 Tax Credits

4.2.1.2.1 Tax Credits for Employers

There are tax credit incentives for employers subscribing medical insurance for their employees. The Tax Act states that an employer's income tax must be reduced by a proportion of the value of contributions made for medical insurance. Most private corporations therefore voluntarily contribute medical insurance for their employees and in the process also manage to retain critical staff. Contributions by large employers allows medical aid societies to pool large surpluses to finance the high-tech health care needs associated with privately insured patients. The government recognizes that more patients would finance their health care needs through medical insurance if employers contributed for all employees regardless of employment gradings. The government is contemplating a amendment of the labor laws to make employers ensure medical aid coverage for their employees. Currently medical aid is optional for employees and a compulsory approach is desirable for wider coverage. This would in turn pool risks for members and avail resources to cover the poor at cheaper rates.

4.2.1.2.2 Tax Credits – Consumer and Medical Aid Membership

Employees are usually taxed on employer-provided fringe benefits like free housing, company vehicles or education assistance. The government however has tax credit incentives for individual contributions to medical insurance. Employer contributions to medical aid are not taxable benefits to the employees (even in the case of full contribution by employer) unlike free housing and allocation of company vehicles. In the case of proportional contribution, there is the provision that the employee's contribution attracts tax relief, which is an incentive for him / her to stay on medical aid. The objective of a tax credit incentive is to achieve universal coverage through medical aid societies effecting risk sharing between the poor and the rich.

Compensation for injuries, sickness or death to the insured or their dependents is tax exempt for the recipient. Medical Aid Societies however confess that payouts relate more to reimbursement for consultations and drugs purchased rather than compensation for injuries, sickness and death. Most Medical Aid Societies do not cover for these dysfunctionalities because the Workmen's Compensation Act compels employers to pay compensation for injuries or deaths of their employees. The exemption and credit incentives aim to induce consumers to finance their care through medical aid with the hope that public sector budgets would finance the needs of the poor.

4.2.1.2.3 Tax Credits – Health Care & Services Providers

Medical practitioners and providers of other support services pay income tax on their services. They are only exempt from taxation after an audit proof indicates they made losses in a particular year. Nevertheless, there are tax credit incentives designed to encourage investments in areas that eventually improve the quality of services offered.

(a) Tools of Trade Replacement

The Income Tax Act provides for tax credits for the expansion and/or replacement of equipment and tools of trade by all small businesses including the private for-profit health providers. The incentive not only induces providers to provide quality care and services, but also cushions emerging providers particularly at infancy when expenses are mostly on new equipment and tools of trade. This incentive only applies with proof of expenditure and is not an expected annual benefit by individual providers. The high cost of medical tools and equipment makes it difficult for many providers to fully exploit this incentive which requires outlays first and then partial reimbursement through the tax system. Most private for-profit providers have no expensive equipment for complicated procedures and often refer to public hospitals. This implies that the incentive is minimally exploited either because the providers have inadequate capital for the initial outlays or the volume of their patients does not justify such heavy investment.

(b) Invalid Appliances

Tax credit incentives on invalid appliances are designed for communities to finance their health support needs through out-of-pocket payments because there is no social insurance for such items like in some countries. The government mandates that invalid appliances and medical drugs, including those purchased by individuals dependent on prescriptions, can be tax credited to the consumers. Under the same tax incentive, out-of-pocket payment for hospitalization and ambulance hire also qualifies patients for tax relief. Invalid appliances provided for under this incentive include wheel chairs, artificial limbs, crutches or spectacles and many other facilities used by individuals suffering from physical defects. Repair expenses for the appliances are partially subsidized to encourage individuals take partial responsibility for their health support needs.

Because of the general resource shortage in the private sector, the government is under pressure to mobilize funds by broadening the tax base and this might also mean the removal of some tax credits currently enjoyed by the health sector. Since 1988, there have been some revisions to the Tax Act to further reduce the maximum level of credits extended to individuals with respect to their health expenses. The objective of minimizing subsidies is to not only to collect more revenue, but to also make those who can afford health care take more responsibility to finance their health care needs.

(c) Land and Buildings

An obvious yet expensive pre-requisite for private for-profit provision is ownership of land and buildings from which care and services can be offered. These are particularly expensive in urban areas where ironically, a ready market for private health services exists. The cost of land and buildings is cited by junior doctors as being the major obstacle to expanding one's practice to include a variety of services. Significant profits are lost through expensive rentals while most senior providers own the premises and have no rental overheads. It is partly for this reason that junior private for-profit providers fold up while senior providers profitably sustain their facilities.

Providing tax credit on acquisition and rental of fixed assets is designed to promote viability and long term sustainability of all small businesses including the private for-profit health providers. This tax provision is observed to facilitate more entry into private health industry due to the subsidized initial capital outlays. Government belief is that with more providers in private for-profit practice, patient coverage would be wider and the resultant competition would increase the breath of packages and quality of care offered.

4.2.2 Contracting Out to the Private For-Profit Sector

4.2.2.1 Historical Context of Contracting Out in Zimbabwe

Since 1980, the government viewed the financing and provision of health care services to be its political and social responsibilities and almost closed down the private for-profit sector. Attempts to contract out public services were viewed as overtures towards privatization of health services and this was treated accordingly with suspicion by the top public policy makers. Instead, significant increases in health budgets were provided: - 38 percent in 1981, 13 percent in 1982 and averaged 13.9 percent between 1982 and 1988 (MoH&CW 1993). Resource utilization indicate that Central Hospitals (5) and provincial hospitals (8) consume about 65 percent of the health budget despite them offering only clinical services. The rest of the national facilities share the remaining 35 percent share of the health budget but service about 70 percent of the population.

Despite the financial plight due to declining central government allocation for the health sector, the contracting of certain health services to the private for-profit sector was never seriously considered until in the mid-1990s. It is now accepted that contracting out services allows public sector facilities to focus on their core health responsibilities. Another advantage to contracting out is that the government could possibly benefit from the perceived efficiency of the private for-profit sector without the political risk of losing control over services provision and distribution. Functional specialization through specified roles by private catering, laundry and/or security providers yield higher cost-effectiveness for the public sector facilities. However, there has not been consideration for contracting clinical services, even where government is convinced of its underperformance.

Public and private sector interaction has mostly been in the form of the latter renting clinical services space and equipment only available at public facilities. Payment to the public sector has therefore been per private patient treated, equipment utilized, prescription drugs consumed and hotel costs for private inpatients in public hospitals. The public sector's strategy has been to enforce internal contracting for most of its supplies and activities. For instance, drugs and surgical and medical equipment for all public facilities are provided through the Government Medical Stores. Until the mid 1990s, catering and dressing supplies for the health sector were provided by the Government Central Purchasing Authority.

Internal contracting minimized public sector's purchasing of services from the private for-profit industry despite quality products and management efficiency associated with the latter. Public sector rationalization in the mid-1990s eliminated most internal contracts in favor of the private for-profit providers for non-clinical services. Payments to the private for-profit sector increased for drugs; surgical and related medical equipment; catering and laundry supplies. To a large extent public facilities now "out-source" and "multi-source" supplies to their best advantage without engaging in long term contractual agreements with the suppliers. The government pays out more than it receives from private providers because its prices are usually below market rates and the collection generally poor. Public sector pricing primarily aims, to achieve accessibility to facilities by the majority of the population.

4.2.2.2 Services to Contract Out

The government is now seriously redefining its role to become the buyer of services from the private sector instead of its previous role as the seller of facilities, drugs, space and equipment. The government intends to cautiously start with contracting out easy-to-monitor health expenditures such as catering, laundry, security, equipment maintenance and other hotel functions in urban areas (MoH&CW). The majority of private for-profit facilities are inferior to those of the government. They are unlikely to handle the expected volumes and meet the expected standards and quality of care created by contracting out clinical services. The government is aware of the need to establish mechanisms for strict monitoring of the standards of care when engaged in extended contracting. There are fears that if contracting is not cautiously done, deterioration of services could cancel out the benefits expected from these policy changes.

- (1) Experience in the country is that most public facilities multi-source from the private sector for the easy-to-monitor services intended for formal contracting out. Services such as catering, laundry and equipment maintenance, security and grounds work have not been contracted out nationally but at individual facility levels. Some form of medium-term contracts could be designed particularly when the private provider monopolizes a trade, like in the case of cold storage company and Dairy Company of Zimbabwe who are the almost sole suppliers of meat and milk producers respectively.
- (2) Private for-profit providers require certain incentives to attract them to contract with the public sector. Some of the reasons often cited as disincentives by the private sector include the government's reputation as being a bad debtor unable to timeously pay creditors and inappropriate infrastructure from which to provide services upon contracting. Private for-profit providers fear that government habits are not promotive of their profit and commercial intentions. Short-term contracts with the public sector would be preferable to minimize losses. Table 6 presents the degree to which some of the target activities have been contracted out.

Table 6. Levels of Functional Contracting Out to Private For-Profit Providers

| Type of Contract | Functions to Contract | National Current Status Degree of contracting |
|-----------------------|--------------------------------|--|
| Non-clinical services | Catering | The principle is generally accepted at national level. No evidence that the functions have been contracted out at any public facility (Central, Provincial, District etc. levels). Otherwise catering at all facilities is still publicly provided. |
| | Cleaning | Still publicly provided at all facility levels. There were moves to start at Parirenyatwa Hospital in 1995 but this was shelved for some unknown reasons. All cleaning functions (personnel, equipment and materials) are owned and provided by government. |
| | Security | At all public facilities (including non-health) security is provided by government despite there being abundant private security companies with proven competencies and years of experience. |
| | Maintenance (Land & Buildings) | <ul style="list-style-type: none"> -Still largely provided by government. -All buildings belong to another Ministry (Ministry of Public Construction) who maintain them. Government employed groundsmen to do the general maintenance through the Ministry of Public Construction (MPC). -Otherwise no participation of private for-profit sector has been witnessed at all levels of public facilities. |
| | Maintenance (Equipment) | <ul style="list-style-type: none"> -Hospital equipment maintained by the public facilities themselves -A hospital equipment department exist at all facilities. -Internal contracting exist in the form of MPC doing maintenance for certain plant equipment. -For some equipment out-servicing of technical staff from specialized private providers is done - but on an as per need basis. -Government therefore purchases equipment from the private sector but largely retains the maintenance of the equipment. Only mortuary equipment maintenance contracted out at the central hospitals. |
| | Laundry | <ul style="list-style-type: none"> - Central, provincial and district hospitals increasingly out-sourcing laundry with the private for-profit launderers. - Internal contracting is still widely used with some provincial and district facilities using central hospital laundry facilities for their needs. Eg. Harare Central Hospital laundry caters for most northern provinces and districts. |
| | Billing | <ul style="list-style-type: none"> - Billing of patients is still by the public facilities themselves. - All bills are issued at central level through the Central Payments Office, run by Treasury. - Some public facilities are now using private sector debt collectors to collect outstanding patient fees. - The private sector is also contracted to install computerized billing equipment whose running and maintenance will be by the public facilities themselves. |

| | | |
|-------------------|---------------------------------|---|
| Clinical Services | Hospitalized Care | <ul style="list-style-type: none"> - Mission hospitals, although privately owned, act as agents for government and provide complete health packages in districts that could other-wise be government provided. - Hwange Colliery hospital contracted to provide clinical and other services in Hwange District (the only formalized contract). -Otherwise, all clinical services are publicly provided. - Local government authorities are required by government to provide hospital care and that get small grants from central government to provide such services. This is not necessarily a contractual arrangement but a requirement for local government authorities. |
| | Ambulatory and related services | <ul style="list-style-type: none"> -Both private and public sectors provide ambulatory services. -Private for-profit providers are however not contracted with for ambulatory services. There is a large number of private for-profit emergency facilities offering day care as well as inpatients services. -Private physicians (who form the largest proportion of for-profit health providers) offer a variety of services to self referred day patients at their private rooms and clinics. They can also bring their patients to casualty and emergency wards of public facilities. - Local government authorities also offer ambulatory services from which they collect fees, not on behalf of central government. - Public facilities also provide ambulatory services at their casualty, outpatient and emergency wings. |
| | Public Health | <ul style="list-style-type: none"> - All public health functions are largely provided by government. - There are however some private for-profit providers (like mines and agricultural facilities) who provide public health in their environments as a requirement of their industrial activities monitoring. They are not under contract to do so as this is a regulatory requirement. |

4.3 The Case of Hwange Hospital

It is not uncommon in Zimbabwe for large industrial entities to own hospitals independently but they consult with the government on policy matters. One such facility is Wankie Colliery Hospital (210 beds) which is contracted by the government to service public patients in the remote district of Hwange and act as a referral center for the small Victoria Falls Hospital.

The hospital is at the epi centre of the country's two major utilities; the Zimbabwe Electricity Supply Authority (ZESA) and Wankie Coal Mine, employing large populations between them.

The Wankie Colliery Hospital has experience in contracting with both the private and public sectors. Firstly, the hospital is contracted by two "private" entities, ZESA and the National Railways of Zimbabwe (NRZ) to provide health care services to employees and their dependents. The purchasers are contracted to pay a negotiated but full cost fee for treatment and related expenses incurred by employees and their dependents. The hospital's billing system is one of the best offered by private hospitals and minimizes patient losses. Prompt and regular reimbursement of expenses to the hospital reinforce the hospital's commitment to the contractual arrangement.

Secondly, the private hospital is contracted with the government through the MoH&CW purchasing clinical services for public patients because there are no government facilities in the district. The nearest government hospital is 100 km away but serves less than half the district population. The Colliery Hospital is ideal for contracting with because it has excess capacity that can accommodate public patients together with target employees and dependents. To sustain the contract, the MoH&CW gives the hospital the status of a district level facility and thereby challenges the provider to offer services of the variety and quality expected of that level. The contract provides for the Ministry to reimburse the hospital at a negotiated full cost fee as is paid by the private utilities.

The contractual relationship between the public purchaser and the provider is strained by the latter's prices that seek to recover costs from the employment of expensive equipment. The purchaser views the prices as incomparably higher than charges at government district hospitals. On a per case basis, MoH&CW reimbursement is a lot higher than that at a government district hospital (See Table 5) resulting delayed reimbursements to the providing hospital. At times, public sector managers discourage patients from utilizing the Colliery Hospital in preference of the cheaper but distant government hospital at Victoria Falls. This distorts hospital utilization and more importantly, discourages private providers from contracting with the public sector. Table 7 summarizes the various incentives and their intended targets and objectives.

Table 7. Summary of Incentives, Targets and Objectives

| TYPE OF INCENTIVE | SPECIFIC MECHANIZATION | TARGETED AT | OBJECTIVE |
|---------------------------|---|---|---|
| Training | CME Training Subsidies Specialized Training Academic Workshops | Individual private practitioners | Raising quality of care |
| Tax Incentives | Tax Exemption | Medical Aid Societies | Promote growth of private health insurance |
| | Tax Credits | Employers Consumers Individual private practitioners | Encourage expansion of private facilities; and increase coverage of medical insurance by employers and individual consumers |
| Other Monetary Incentives | Contracting Out | Public facilities and Private providers | <ul style="list-style-type: none"> - Improve quality at public facilities - Achieving cost-efficiency in services provision - Increase role of private sector in health - Cost containment by public sector |
| Operational Incentives | Private Sector fee Structure | <ul style="list-style-type: none"> - Individual private practitioners - Medical Aid Societies | Promote viability of private providers through use of market forces in pricing |
| | Co-use of Gvt. Facilities | Individual private practitioners | <ul style="list-style-type: none"> - Utilize excess space in public facilities - Compensating for Shortage of doctors in public facilities by using private practitioners |
| | Opening the for-profit Sector | Public doctors and other support staff | <ul style="list-style-type: none"> - Retaining personnel in public sector - Encourage growth of private provision of services |
| | Restructuring health functional Units | Private and public health sectors | <ul style="list-style-type: none"> - Creating efficiency through reducing bureaucracy - Raising quality of care |

5. Capacity to Set and Manage Incentives

To successfully confront the shortages in financing and provision of health care, it is generally agreed that ways must be found to mobilize additional resources for use in the health sector. This will require a concerted and coordinated effort between the public and private sectors, including a possible extension of incentives to private conventional and traditional practitioners as well as the industry at large.

5.1 Managerial Capacity

For the incentives to have impact, the government needs health managers, who have knowledge and skills in the field of health financing and health economics. Health managers essentially need to be able to promotionally relate to private for-profit health providers in particular and acknowledge them more as collaborators rather than competitors in the provision of services. Currently there is an acute shortage of this managerial cadre in the country and the MoH&CW has started to offer long term training in health economics to its strategic managers (MoH&CW 1993). Managerial capacity building would require support from local academic institutions and the partial financing from the private health sector. Public sector health management is currently very weak; but current developments indicate that the private for-profit sector is positioned to actively assist in strengthening national health management.

5.2 Financial Capacity

Rapid population growth, catastrophic disease outbreaks and competition from other social services have all reduced financial resources allocated for health to the extent that per capita expenditure for health has declined in real terms over the years. Government capacity to launch new programmes for improving health management and related functions has been limited. One option employed by the government to mobilize extra resources was widening its tax base. Tax incentives previously designed to cushion private providers and consumers have sometimes been revised under pressure from international financial organizations to reduce maximum credits allowed on taxable incomes. The primary objective of these revisions is to maximize revenue collection particularly from the private for-profit sector in order to finance public services and basic health care for the poor segment of the population. There is therefore limited scope of using monetary incentives to extend the role of private for-profit health providers due the financial incapacity. Instead, the government inclined to encourage private for-profit providers and individual consumers to provide and finance health services at minimum financial loss to the fiscus.

5.3 Capacity for Policy Statement

Instead of relying on a “general” understanding and acceptance of the importance and contribution of the private providers, the government needs to show its political capacity by making an open statement stating its position in relation to private for-profit health providers. Private health providers have been operating with scant knowledge of the security of their status and political acceptance by government. An open statement will not only allow all providers to come on the open, but also challenge them to exercise their full potential and fill the gaps in care and services provision. It is

probable that once openly acknowledged, the private for-profit providers would reciprocate by being transparent in their operations and help to solve some of the health sector problems. This capacity is evidenced by long term government tolerance of the private sector and acknowledgment of its role in care and services provision. Improved collaboration among health providers would chart a comprehensive course for the health sector and benefit all stakeholders including the government as a service and care provider. Illustration of support to private providers could be made through the government apportioning responsibility to the private sector to relieve public burden. Private providers accept their complementary capacity and the government has the role to referee and monitor national health services.

6. Discussion and Conclusion

6.1 The Health System in Zimbabwe

The health care system in Zimbabwe separates the public and private sectors. The private health sector, comprising of for-profit and not for-profit providers are allowed to function, with the former being guided by market forces in its operations. It is estimated that currently over 50 percent of doctors in the country work in the private sector (NAMAS 1998). Private for-profit practice by public sector doctors, which is usually called locums, is widely practiced after having been restricted in the early 1980s. The locums had two objectives: firstly to reduce the outflow of public sector doctors and support personnel to enter into private practice, and secondly, to indirectly acknowledge and support the growth of the private for-profit sector to complement government provision and financing of health.

6.2 Assessment of Incentives

Assessment of the impact of various health incentives in Zimbabwe is made difficult by the structure of the private for-profit industry. The industry is very amorphous and it is difficult to get accurate data about its size, type of services and population coverage. Some providers even operate without proper registration from their professional bodies. For these reasons, it is difficult for the government get accurate statistics to design scientifically informed appropriate and universal incentives for providers. It is possible that the government could have done more to support the industry if the various private providers were identifiable with one umbrella body instead of along professional lines with different agendas. Setting incentives for individual professional lines is not feasible for the government particularly when the professions themselves appear to be competing against each other. Private providers could also demonstrate their role through statistical returns to the National Health Information System so that public sector policy makers are able to quantify the industry's contribution to health care and services provision.

Most of the problems associated with the private for-profit providers are not unique to Zimbabwe, but are similar to those in other countries. The primary motive is to make profit so that the services with maximum returns are prioritized. There is very little the government could do for instance, to influence more doctors to relocate to out of Harare and Bulawayo which accommodate the majority consumers of private health care. In the same vein, the government can only minimally influence providers to deliver preventive services because returns from this are inferior to those from curative services. There were attempts to redress some of the shortcomings of private for-profit industry but returns were minimal primarily because the major pre-occupation of the providers was to make profit from operations.

6.2.1 Monetary Incentives

The study observed that for years the government deliberately provided monetary and non-monetary incentives to either develop, sustain and/or ensure quality provision of health by the private sector. That monetary incentives positively impacted on the growth and quality of services in the private for-profit sector is generally evident; although, access to the incentives is dependent on how formalized one's operations are. Private providers want to return existing tax incentives to cushion their services. The

government is however under pressure to mobilize extra resources to finance other social services and tax incentives and private tax incentives are likely to be further reduced in order to maximize public sector revenue. It would appear there is very little scope to increase tax incentives for private health providers. One government option would be to retain current incentives and subject them to marginal reduction as dictated by economic performance.

Most private providers interviewed in this study agree that tax incentives no longer represent options for sustainable growth and quality improvement in private health. Public sector contracting out with private providers for select health functions could be the best option for improving quality, efficiency and reducing cost to the fiscus. The government supports this initiative and encourages its facilities to buy services from the private sector instead of serving as sellers. This study however observed that contracting out has not been widely implemented. It would appear the government has no capacity to manage contracts because of lack of skilled personnel to work with private for-profit providers. Therefore, there is a need to develop management skills in health economics, health planning and health financing to capacitate the public sector for contracting with the private providers.

6.2.2 Non-monetary Incentives

Non-monetary incentives were observed to mainly reduce public sector bureaucracy. They also promote capacity utilization and guarantee training for skilled national manpower. Most non-monetary incentives aim to strengthen the health sector as an industry more so than directly benefiting individual providers, as is the case with monetary incentives. Such a holistic approach is perhaps sustainable since the industry is the beneficiary. Some stakeholders feel that non-monetary incentives should support the improvement of national health instead of being sectorially focused in favor the private sector. There is therefore the need for regulation and monitoring structures that have a holistic approach to improving both public and private health sectors. Otherwise, the gap between the two widens to create two parallel health systems in the country if incentives are designed for private providers only.

6.2.3 Impact of Incentives Designed to Encourage the For-Profit Sector

This study also showed that health system objectives seek to achieve consumer satisfaction, through promoting universal accessibility, sustainable equity in financing, and cost-effective utilization of services. Table 8 evaluates how effective the presented incentives are in achieving the overall health objectives. The obvious observation was that the various incentives are exploited to different degree levels. Maybe some providers do not identify themselves as being the targets because some of the incentives are designed to support not only health care providers, but generally all small and emerging businesses. Modern health providers however benefit more because the incentives are primarily targeted at formal industries which are seen to complement government modern care services. Monetary incentives are managed through the tax system, and those who pay tax have access to exploit them. Traditional healers have no access because they informally operate and do not pay tax.

To address the potential negative impact of incentives on competition, it is necessary to have a built in safety net to protect junior providers who could be disadvantaged by the overall management of tax incentives. The incentives equally support all categories of providers regardless of the juniors' vulnerability. Senior providers use tax savings to offer a wider selection of procedures on speciality lines as desired by patients. In turn, patients are influenced to adopt provider patronage in favor of the senior practitioners with a wider variety of services. The management of tax incentives therefore makes it near impossible to bridge the gap between the junior and senior providers. Table 8 summarizes the impact of the various incentives on national health objectives.

The study has revealed that while most public policy makers and private providers believe that the private for-profit sector could be expanded and the quality of services improved through astute management of incentives, the belief is not unanimous amongst the stakeholders in health. Some believe that the private for-profit providers need no incentives because the profit motive itself is a huge incentive. There are worries that profits resulting from the incentives are rarely reinvested in improving quality and services availability. It is difficult to establish the validity of the assertion that the profits are personalized to sponsor expensive lifestyles to the disadvantage of health services improvement.

6.3 Conclusion and Recommendations

The study indicates that private for-profit providers have been participating in Zimbabwe's health sector for a long time. Successive governments acknowledged the providers through progressive establishment of incentives to expand the industry and improve quality of care. A combination of monetary and non monetary incentives have been employed to support the providers and the impact of these incentives have been evidenced by the general expansion of the industry to now cover about 10 percent of the national population. The various incentives have encouraged private sector growth and helped improve the quality of care despite the few problems associated with the private sector as discussed. Indications for continued growth abound and there are calls for the government to allocate more responsibilities to the private for-profit providers, particularly through encouraging public facilities to contract services with the former.

Zimbabwe's health system is at a crossroad. Government funding is sharply declining while the increased population is demanding more care because of emerging diseases. The private sector has to some extent rescued the situation by taking care of the population segments that can afford private care. The various incentives described in this study are therefore worthwhile to maintain. This is because they sustain the private sector whose role in national health services is now acknowledged by the public sector. Tax incentives have been stretched to the limit and the need to raise more revenue through taxation does not support using tax incentives any further. It is recommended that the public sector prioritize effecting contracting arrangements with the private providers who are renowned for being cost-effective and quality oriented to complement the current incentives. The still largely unfinished agenda of additional investments that must be made in health care makes it imperative to further develop and exploit the private for-profit sector, because the government cannot be solely responsible for providing and financing all the health care needs of the population

Table 8. Impact of Some Alternative Incentives on National Health Objectives

| Incentives in place | Accessibility | Does it promote cost control? | Financing | Sustainability | Current Utilization | Benefits to Consumers |
|--|---|---|---|---------------------------------------|---|--|
| <u>Monetary Incentives</u> | | | | | | |
| 1. Tax Exemptions | Yes (<i>formal sector</i>) No (<i>informal sector</i>) | Strong (<i>financiers</i>) Weak (<i>providers</i>) | Progressive | Moderate | High | Moderate |
| 2. Tax credits (on medical aid, land & buildings and invalid appliances) | Yes (<i>formal sector</i>) No (<i>informal sector</i>) | Strong (<i>financiers & Providers</i>) Weak (<i>consumers</i>) | Moderate to Progressive | Moderate | High | Low (<i>selectively favour formal sector</i>) High (<i>workers</i>) |
| 3. Contracting out | Yes (<i>formal sector</i>) No (<i>informal sector</i>) | Strong (<i>formal sector</i>) | Progressive (<i>government retains clinical care</i>) | High (<i>reduces Gvt provision</i>) | Minimal | |
| <u>Non-Monetary Incentives</u> | | | | | | |
| 4. Fee structures independence | Yes (<i>formal & informal sectors</i>) | Weak (<i>formal & informal sector</i>) | Weak (<i>few can afford the high fees</i>) | High | High | Low (<i>private sector fees unaffordable</i>) |
| 5. Co-use of Government Facilities | Yes (<i>formal sector</i>) No (<i>informal sector</i>) | Strong (<i>excess space & equipment utilized</i>) | High | High | High (<i>formal tor</i>) No (<i>informal sect</i>) | High |
| 6. Open acknowledgment of private for-profit sector | Yes (<i>general</i>) | Weak | Low (<i>only urban based & seniors</i>) | High | High | High |
| 7. Continuing Medical Education | Yes (<i>all sectors</i>) | Weak (<i>require funding</i>) | Low (<i>favour urban providers</i>) | High | Moderate | High |
| 8. Restructuring health functional Units | Yes (<i>all sectors</i>) | Strong (<i>admin costs</i>) | High | High | Low | Low |

Note: Impact scores made to reflect current opinions on existing incentives

Appendix 1: Sources of Data (Written & Verbal) – Institutions and Associations

Ministry of Health and Child Welfare
P O Box CY 1122
CAUSEWAY, Harare

National Association of Medical Aid Societies (NAMAS)
No 6 King George Court
King George/Argyle Roads
AVONDALE, Harare

CIMAS Medical Aid Society
P O Box 1243
HARARE

The Hospital Doctors Association of Zimbabwe
P O Box A 1692
AVONDALE, Harare

Zimbabwe Medical Association (ZiMA)
172 Baines Avenue
P O Box 3671
HARARE

Zimbabwe Nurses Association (ZINA)
47 Livingstone Avenue
P O Box 2610
HARARE

Public Health Advisory Board
c/o Ministry of Health and Child Welfare
P O Box CY 1122
CAUSEWAY, Harare

Faculty Board of Medicine
University of Zimbabwe
Medical School
P O Box A 178
AVONDALE, Harare

The Avenues Clinic
P O Box 4880
HARARE

Public Service Medical Aid Society
P O Box 885
HARARE

Parirenyatwa Group of Hospitals
P. O. Box CY 198
CAUSEWAY, Harare

Zimbabwe Association of Church related Hospitals (ZACH)
P O Box 1556
HARARE

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