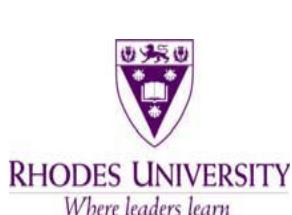


Capital flows through medical aid societies in Zimbabwe's health sector

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Executive summary

Medical aid societies (MAS) in Zimbabwe cover a tenth of the population, and about 80% of income to private health care providers in Zimbabwe comes from MAS. They contribute more than 20% of the country's total health expenditure. This paper outlines the flows of private capital that lie behind the growth of the profit medical aid and insurance health care sector in Zimbabwe. It was implemented within the Regional Network for Equity in Health in East and Southern Africa (EQUINET) by Training and Research Support Centre and SEATINI, in a regional programme co-ordinated by the Institute for Social and Economic Research, South Africa.

Evidence is drawn from content analysis of policy documents and secondary reports; data analysis of unanalysed primary data from relevant institutions; policy analysis; beneficiary surveys; and key informant interviews. A lack of documented information, the limited sample size and the political polarisation in the country made it difficult to gather all the required data and information needed for a more comprehensive analysis.

In Zimbabwe, medical aid schemes are voluntary. They deal directly with employers and consumers, avoiding broker costs, but also limiting employee discretion in the choice of society and inhibiting competition in the industry. Benefit packages are clearly specified, but are segmented, and lack cross-subsidies between different levels of cover, and different income groups of beneficiaries. MAS have encouraged growth of private hospital services in urban rather than rural areas, in order to lower administration costs and coverage is higher for the employed and wealthier groups, and lower in women, in rural areas and less wealthy people.

Members of societies were found to be relatively loyal, remaining with their first medical aid society and only migrating on change of employment. While managed care systems claim to make it easier and less costly to access medicines, this was not found in this survey. Beneficiaries lacked information on benefit package options, and there was evidence of restrictive practice and benefits shortfall.

The economic liberalisation of the 1990s provided the impetus for greater investment in MAS and medical insurance through Greenfield investments, acquisitions and expansions. MAS responded to the economic decline and hyperinflationary environment of the 2000s by acquiring related industries, to manage the costs of doctors, specialists and pharmacists. While contributions were used to finance this, other capital flows came from investors from South Africa, insurance companies, medical practitioners and banks. Despite societies aiming to use these acquisitions as a means to reduce co-payments, clients were found in this survey to be making a significant share of payments, including for drugs and consultation fees. Few beneficiary plans gave full reimbursement for services provided outside their managed care plans, and most clients reported needing to get approval from their MAS to use service providers outside those owned by the society.

These changes have led to a high degree of vertical integration between funders and different providers. This is of concern as it is associated with monopolies across all spheres of a sector, limiting patient choice, prescribing practices and use of laboratory services being driven by cost more than health need, and limits to people's ability to negotiate their interests with providers. This situation and concerns of the Competition and Tariff Commission (CTC) in part contributed to the passing and of the Medical Aid Societies Statutory Instrument 330 of 2000 regulating vertical integration. However regulatory oversight itself was found to have been constrained by shortages of personnel in a centralised system, ambiguities in the law, lack of information

reporting from and monitoring of MAS, lack of consumer awareness and lack of advocacy of beneficiary interests by members.

The societies have taken advantage of these shortfalls and ambiguities to consolidate their ownership across the sector and, for some, to default on obligations to provide annual financial reports to the Registrar or hold annual advisory council meetings. The Ministry of Health and Child Welfare (MoHCW) has limited personnel capacity to regulate and monitor MAS, does not have an updated database on key features of MAS and does not retain the fees collected from MAS as it is not a statutory body. The Ministry of Finance also has obligations to monitor MAS as financial institutions. With their non-profit, non-tax status, their investments in non-core ‘for profit’ areas now raises new scrutiny on the use of their funds, with potential tax implications on profits earned.

Certain measures are needed to improve functioning and equity in the sector and to address the current exposure of beneficiaries, including:

- i. Strengthening the regulatory environment to address legal ambiguities on investment of the industry’s ‘surplus’ funds, to ensure the multiple relevant laws from finance and health are known and applied by MAS/ insurance providers, and to fairly and firmly enforce the law.
- ii. Ensuring timely scheme reporting as required by law and maintenance of a database with basic information on schemes.
- iii. Ensuring registration of all schemes, avoiding increasing segmentation of the sector into small fragmented risk pools from individual schemes and encouraging (for example through enforcement of regulation on registration and liquidity requirements), mergers into larger and more viable risk pools.
- iv. Introducing regulatory and scheme policy measures to require and implement cross-subsidies necessary for equity and ensuring benefits packages cover personal care and personal prevention services.
- v. Taking up the shortfalls in coverage of medicines on existing plans.
- vi. Checking the degree of vertical integration in each scheme and unbundling any monopolies across the sector that are limiting patient choice (e.g. paying only for selected linked services).
- vii. Improving the outreach of consumer information on schemes, benefits packages and consumer rights to members and organisations servicing members (e.g. the labour movement and employer organisations).

Improved institutional capacity in the office of the MAS Registrar and consumer awareness in members is needed to implement these measures. Other countries have an independent state regulatory authority, established by an Act of Parliament, to implement regulations in the industry and safeguard consumer welfare. Many countries in the region are exploring Social Health Insurance (SHI) as a means of creating larger risk pools for more comprehensive coverage, within a framework of universal coverage. This has been discussed over the past three decades in Zimbabwe, without implementation or conclusion. This option needs to be revisited as the economy stabilises and confidence in governance improves, taking into account the issues raised in prior consultations and lessons from low- and middle-income countries that have already implemented SHI.

1. Introduction

The Southern African Development Community (SADC) region has prioritised combating poverty through building up the capital assets of the poor, reducing inequalities, and promoting knowledge and health in poor areas (Ruiters and Scott, 2009). Privatisation of health care services is being promoted and there are new trade-related pressures for further liberalisation (*ibid*).

An earlier paper by Munyuki and Jasi (2009) showed that between 1995 and 2007, the private-for-profit health sector expanded in Zimbabwe, with both local and foreign investors, particularly through mergers and acquisitions by medical aid societies (MAS). With vertical integration across providers (pharmaceutical, personal care services, emergency transport), there is a risk that service providers can further raise prices and profits. Public expenditure cuts in the 1990s and an economic crisis post-2000 meant that private sector growth outstripped public sector growth. With 90% of the population uninsured and thus excluded from private care there were limited public health gains, particularly as the cost of both public and private health care soared.

The Ministry of Health and Child Welfare (MoHCW) has recognised the problems but has not used its powers to monitor and regulate the expansion of private capital to serve the policy objectives of universal coverage and equity. This study collected evidence and probed perceptions of MAS, including:

- the types, extent and impact of the private capital flows through and in MAS from 2000 to 2009;
- the policy and regulatory environment, processes, actors and contexts affecting the private capital flows, and the enforcement of relevant laws;
- the associations of private capital flows documented with health outcomes, particularly access to health services; and
- the perceptions of regulators, MAS, clients/members and other key stakeholders on the trends in MAS-linked services.

Two previous papers on the private health sector in Zimbabwe (Hongoro and Kumaranayake, 2000; Kumaranayake et al, 2000) examined the regulation of private-for-profit providers, including the perceived and real effectiveness of regulation of the private sector, given its rapid growth in Zimbabwe. After reviewing the application of the Medical, Dental and Allied Professions Act of 1971/1996, the Public Health Act or 1925/1996, the Drugs and Allied Substances Control Act of 1969, the Traditional Medical and Practitioners Act of 1981, and the Medical Services Act of 1998, the authors concluded that due to rapid expansion of the private health sector, existing laws should be reviewed to manage entry into the health sector; pricing, quality of service, and distribution of the private sector; and competitive practices. They advocated for an increased role of the state in regulating the sector, with clearly defined functions and roles. Hongoro and Kumaranayake (2000) noted limited and asymmetric knowledge on regulations between government and private bodies; private providers had poor compliance and individual regulators were often compromised as they also operated as health providers. The authors' recommendations informed the amendment of the Medical Services Act of 1998 and the passing of the Medical Aid Societies Statutory Instrument 330 of 2000.

While these studies included stakeholder interviews with the public sector, private sector providers, representatives from professional organisations, local authorities, consumer/civic organisations, trade unions and MAS, they did not include interviews with households and individual MAS members. This study adds this new evidence and reviews how MAS are being

regulated, how the Medical Services Act 1998/2001/2002 is being interpreted and applied by different stakeholders, and the impact of this on access to services. The study also explores the processes and context in which policies on the private sector are developed and implemented, focusing on medical insurance and medical aid, as well as questions of how economic and policy trends have affected MAS and private capital flows through and in them.

2. Methodology

The research used a mix of methods, including:

- content analysis of policy documents and secondary reports;
- data analysis of unanalysed primary data from relevant institutions;
- policy analysis;
- beneficiary surveys; and
- key informant interviews.

The MoHCW granted authority to carry out the study; information obtained from individuals who participated in the beneficiary survey was obtained with consent and individual confidentiality was preserved. Information collection from key industry informants was facilitated by the Parliament Portfolio Committee on Health.

We analysed policy documents from MoHCW, the Portfolio Committee on Health, the Competition and Tariff Commission (CTC), and other published and grey literature. This included content analysis of documents such as speeches, conference presentations and press releases from MoHCW, MAS and grey literature from various pressure groups. Any documents related to commercialisation and privatisation of healthcare services, private health insurance and consumer health rights were included in the analysis.

Key public and private sector informants were interviewed from the parliamentary portfolio committee on health, MAS, the Association of Healthcare Funders of Zimbabwe (AHFoZ), the Registrar of Insurance at MoHCW, the Zimbabwe Association of Church Hospitals, representatives of private hospitals in Zimbabwe, and the Zimbabwe Medical Doctors Association (ZIMA).

A small interview survey of urban beneficiaries was implemented to examine current and past practice, inclusion and fall out from private insurance, charges and financing issues and the implications for access and use of health care. A sample of 100 beneficiaries was based on a statistical error of 10% and an anticipated 5% non-response rate. The beneficiaries were drawn from ten (10) MAS registered with AHFoZ, chosen on the basis of their market size (see *Table 1*). The number of beneficiaries per MAS was based on the perceived market share since there was no updated information at the Registrar of Insurance. Premier Service Medical Aid Society (PSMAS) and the Commercial and Industrial Medical Aid Society (CIMAS) were each assigned the largest number of beneficiaries interviewed (40 beneficiaries each), as these societies have a combined market share of over 84%. The interviews were a combination of exit interviews and identified employee groups. Exit interviews were done at specific provider outlets that serviced CIMAS and PSMAS beneficiaries, while employee groups were identified for in-house or restricted MAS such as Harare Municipal Medical Aid Society and open MAS that do own provider health facilities. Due to budget constraints, the exercise was carried out in Harare and Bulawayo, the two major cities only. Data was analysed using SPSS software.

Table 1: Interview samples sizes from societies

Society	Estimated membership share of MAS	Number of beneficiary interviews
CIMAS	400,000	40
PSMAS	500,000	40
Other societies	120, 000	40

Policy analysis of evidence from document review, key informant interviews, and beneficiary survey interviews was based on Walt and Gilson's (1994) policy analysis triangle, examining interactions between actors, contextual factors, processes and policy content features.

We are aware of a number of limitations in the study. The sample of interviews is small relative to the population of beneficiaries and only covered the two largest cities, where service access is likely to be better, although costs may be higher. MAS could not provide financial information as they felt that it could end up in the hands of their competitors. Even though MAS are required by law to furnish the Registrar of Insurance with their annual financial reports, such information was not available from MoHCW because MAS are not submitting such information. Political polarisation in the country made information gathering difficult, as informants were unwilling to provide what they perceived to be sensitive information; this may lead the results to present a more favourable picture of the beneficiary situation than is the reality. We cannot comment on the direction of bias of evidence withheld from us for whatever reason.

3. Findings

Zimbabwe's health sector is divided into public and private sectors. Government owns about 70% of health facilities in the country, while the private sector owns about 30%. Black Zimbabweans own 75% of surgeries, almost 90% of all nursing homes and 83% of medical laboratories (MoHCW, 2009). The private sector includes the private-for-profit medical sector (private industrial clinics, private hospitals, maternity homes and general practitioners), while the private not-for-profit sector includes MAS, church-related hospitals and other non-governmental organisations (MoHCW, 2009). Faith-based services (private not-for-profit) provide a significant share of rural hospitals and receive state grants and salaries for medical personnel from the MoHCW.

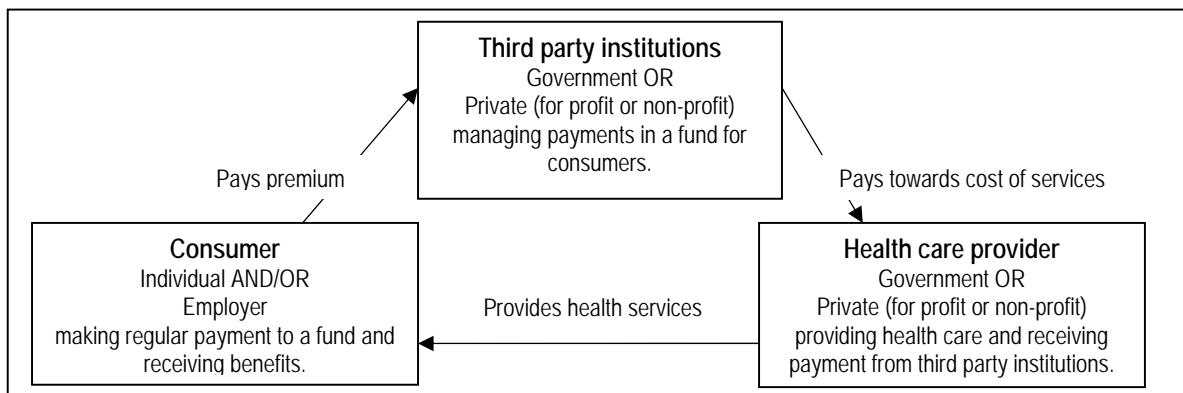
Zimbabwe has mutual healthcare funds (managed by fund managers who invest these funds for a return, such as that offered by First Mutual Life) and private insurance providers (such as CIMAS) that offer health savings and health insurance schemes, which collect and pool funds and purchase health services. There are more than 30 MAS in the country, with about ten of those being in-house or restricted to the respective industries or employees and the rest being open societies (AFHoZ, 2008).

Both public and private employers provide this insurance through participation in medical aid societies, non-profit organizations that collect premiums from business and/or government organizations and use that money to pay health care providers for services provided to beneficiaries. There are no proprietary (for-profit) health insurance companies in Zimbabwe.

Source: Campbell et al, 2000:2.

Their relationship between funders (medical insurance industry) with health service providers and consumers is shown in *Figure 1*.

Figure 1: Relationship between funders, providers and consumers



Source: Conn and Walford, 1998.

The MAS collectively service about 10% of the population, with almost all principal beneficiaries being formally employed, except for pensioners. About 80% of income to private health care providers in Zimbabwe comes from MAS and they contribute more than 20% of the country's total health expenditure (Sekhri and Savedoff, 2005).

Below we present the findings within the key areas of assessment, combining and — where possible — triangulating evidence from different sources.

3.1 Features of the medical aid sector

The private medical aid industry in Zimbabwe is a small but significant player in health care provision. It is the biggest player in the private health sector through its relationships with private hospitals, the private pharmaceutical industry and other private health care providers. As of April 2009, 24 of the 30 MAS in the country were registered AHFoZ (AHFoZ, 2009) (see Table 2).

Table 2: Medical aid societies in Zimbabwe

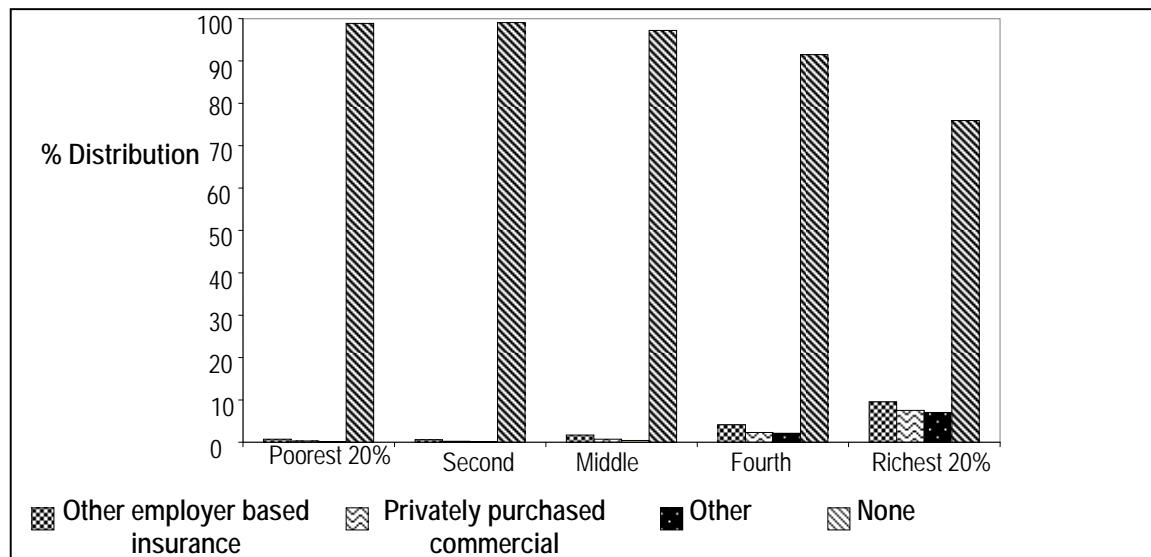
Name of medical aid	Status	Name of medical aid	Status
Alexander Forbes	Open*	PSMAS	Open
Blanket Mine	Restricted [†]	Railmed	Restricted
BP and Shell	Restricted	Strategies Health and Life Assurance	Open
Cynergy	Open	Northern Medical	Open
CIMAS	Open	Sovereign Health (Pvt) Limited	Open
Engineering medical Fund	Open	World Bank Medical Benefits Plan	Open
Fidelity Life	Open	Zimpapers	Restricted
First Mutual savings Fund	Open	Zenith Medical Benefit	Open
Galaxy	Open	Not registered with AHFoZ as of April 2009	IGI-Kuchi Holdings
Grainmed	Restricted		Cellmed
Generation Medical Fund	Open		Shelter
Harare Municipal	Restricted		Healthmed
Kwekwe City Council	restricted		Shield
MASCA	open		TN Medical savings
Municipality of Bulawayo	restricted		Royal
Municipality of Masvingo	restricted		No longer operating

* Open MAS allow anyone who can afford it to register as a member. † Restricted MAS are limited to a certain group of people, e.g. those employed in a particular industrial sector.

Source: Information gathered from AHFoZ and MoHCW.

According to interviews with MAS, they have encouraged growth of hospital services more in urban than rural areas, because of the ease of administration and greater ability to pay by consumers in these areas. Insurance coverage has tended to be higher for working men and women and wealthier groups, with lower coverage in women and in rural and less wealthy people, as shown in the *Figure 2*.

Figure 2: Health insurance coverage for women by wealth quintile



Source: CSO and Macro, 2005.

Medical insurance is shaped by the different insurance models that the industry employs. In Zimbabwe, schemes are voluntary, with membership largely from formal companies and organisations. It could thus be characterised as employer driven, through group-based insurance premiums that are easy and cheaper to administer. Although benefit packages are clearly specified, they discriminate between management and lower grades, with those designed for higher income groups having access to both private and public hospitals, while those designed for lower grades only have full access to public hospitals and limited access to private hospitals if they are able to meet any shortfalls (e.g. CIMAS Private Hospital benefit package, 2009). Members registered with MAS that have embarked on managed care, such as PSMAS and CIMAS, have access to in-house facilities and providers. Insurance premium calculations are not risk based, and there is no enforceable minimum benefit package.

The Medical Services Act of 1998 and the Medical Aid Societies Statutory Instrument 330 of 2000 require MAS to register with the MoHCW on commencement of business. MAS are also registered and accredited with the AHFoZ (formerly the National Association of Medical Aid Societies (NAMAS)). The association was formed in 1969 to standardise medical aid tariffs, form liaisons with health care providers and register and accredit MAS (AHFoZ, 2008). AHFoZ is recognised by the MoHCW through the Medical Services Act of 1998 and the Medical Aid Societies Statutory Instrument 330 of 2000. By appointment of the Minister of Health, AHFoZ has had representation on the Public Health Advisory Board, Medical Research Council of Zimbabwe and the Standing Committee on Health Services (*ibid*).

The AHFoZ secretariat is run by a chief executive officer (CEO), and a board chaired by any one of the MAS. According to interview with the CEO, Mrs S Sanyanga, it is a voluntary organisation governed by a constitution and a code of ethics. It is not a regulator per se, but has in place a peer review mechanism for its members, and thus relies on voluntary self regulation

and peer review to maintain standards in its members. It does however reserve the right to eject members who do not conform to its code of conduct, and also has statutory powers to discipline delinquent members. However, according to the CEO, larger MAS, such as PSMAS and CIMAS, have a greater say and dominance in the running and effectiveness of the association.

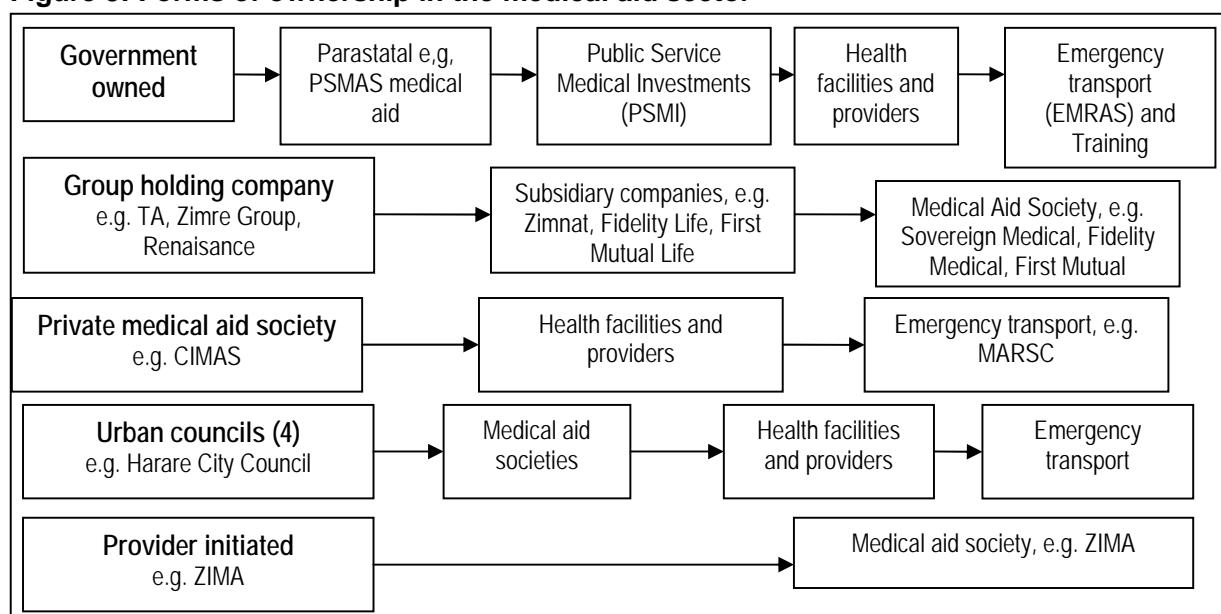
The association does not set prices of health care, but produces a schedule of tariffs — the Zimbabwe Relative Value Schedule — that guides funders and providers of health care on the fees they can charge. In the past, the relative value schedules were produced by a Tariff Liaison Committee made up of AHFoZ and ZIMA (who represented the interests of providers). The relative value schedules used to be binding and enforceable on funders and providers, but in 2003, ZIMA formed the New Independent National Tariff and Liaison Committee to devise and set fees independent of MAS due to the differences between AHFoZ and ZIMA on tariff levels and delays in reimbursements. Since then these two associations have been setting their own different tariffs, with some doctors charging consultation fees regardless of MAS or not. However, ZIMA says they have started re-engagement with MAS to review their positions.

Unlike in South Africa, where agents sell medical insurance on behalf of the insurance companies, in Zimbabwe, MAS sell directly to either employers or employees and other consumers. Key informants indicated that the societies believe that intermediate providers create an extra level of administration costs, increasing overall costs. Interviews indicated that this is to limit employee discretion on the choice of MAS and inhibit competition in the industry, as different agents actively compete for customers.

There are five different forms of ownership in the medical aid industry (see *Figure 3*):

- government
- corporate general insurance companies (where large companies have controlling shareholding in these operations)
- private not-for-profit health insurance schemes
- urban councils
- provider initiated ownership.

Figure 3: Forms of ownership in the medical aid sector



The ownership pattern has implications for the competition between MAS, the competition or complementarity between the government public sector and the private medical aid industry, their core business and growth opportunities, and the nature and implementation of regulation. *Table 3* shows the market capitalisation for companies listed on the stock exchange that have a direct link to health provision, either through pharmaceutical production, medical equipment or ownership of medical insurance companies. The total market capitalisation for all the companies is 3.8% out of the listed 75 companies' total market capitalisation of US\$4,45billion. The relationships shown in *Figure 3* suggests a level of vertical integration in the industry. It appears that some MAS are backed by large conglomerates and heavily capitalised businesses listed on the local bourse, such as TA holdings; other players own the whole chain of health care provision, such as PSMAS, a government medical aid society that, through its investment arm, owns hospitals and emergency transport services.

Table 3: Market capitalisation

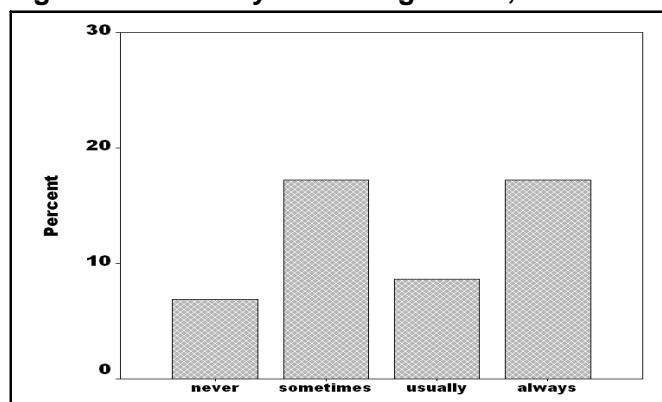
Name of company	% Market capitalisation
Caps Holdings	0.2%
Medtech	0.04%
Fidelity	0.4%
Nicoz Diamond	0.2%
TA Holdings	2.0%
Zimnat Lion	0.04%
Afre Holdings	0.4%
TN Financials	0.45%
Total	3.8%

Source: Zimbabwe Stock Exchange, 2010.

In the beneficiary survey, 55.2% of the 100 beneficiaries reported that they were covered by managed care, with 87.5% of these beneficiaries having been told or influenced by their employers to take this plan. Only 6.3% said they chose to be on managed care on their own.

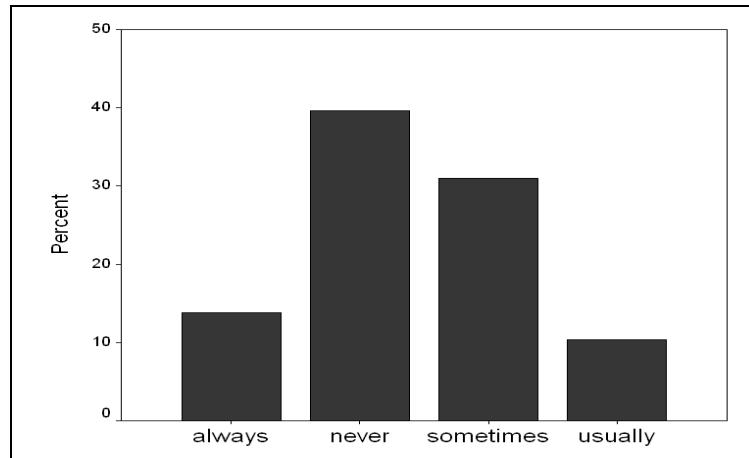
MAS members are relatively loyal: 54.3% of respondents were still with their first MAS, while 43.1% had migrated. Of those who migrated, 86% said it was due to employment. Only 2% said it was due to better service. The remainder cited healthcare providers' refusal to recognise cards from some MAS, a sign of restrictive practice. Accessing tests and treatment on plans was found to be reasonably possible (see *Figure 4*).

Figure 4: How easy was it to get care, tests or treatment from the plan?



However, 6.9% said it was not easy to get special therapy on their medical aid plans and accessing medicines on plans was significantly lower (see *Figure 5*). As this is a major reason for being on a plan, it raises questions about the return to clients. On a scale of 0–10, 21.6% of the beneficiaries rated their healthcare plans as below average, while 53.4% rated them as above average. The study did not look at whether the responses were biased by the type of healthcare plan.

Figure 5: How easy was it to get prescription medicine from your plan?



3.2 Private capital flows in MAS

Private capital flows have four entry points into the medical aid industry (see *Figure 6*) with different motivations for entry. An increase in private sector health expenditure, although mostly for consumption, provided the impetus for greater investment in MAS and medical insurance through acquisitions and expansions. Most of the acquisitions by MAS, such as acquisitions by PSMAS, were of existing capital stock. This meant that there was no increase in capital stock in the books of government.

Figure 6: Entry points for private capital in the medical insurance industry

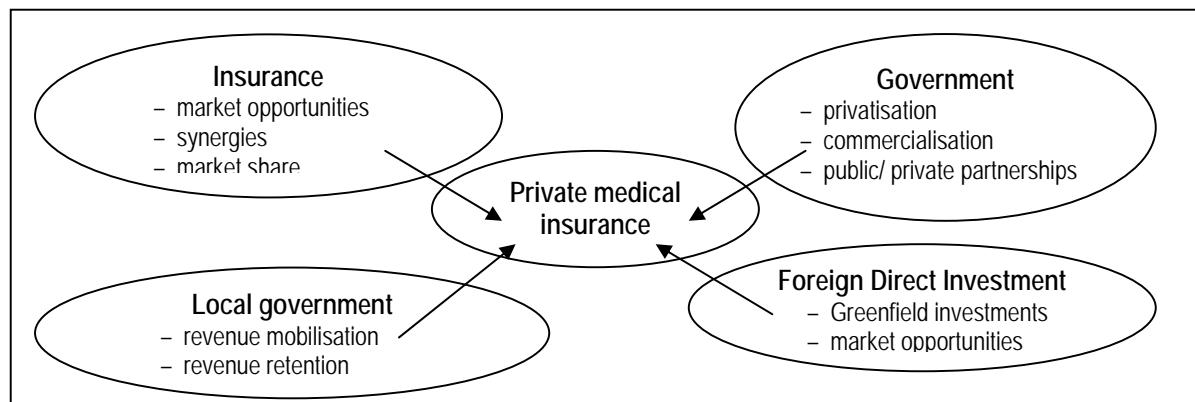


Table 4 shows decreasing Foreign Direct Investment (FDI) from a peak of US\$436 million in 1998 to US\$29.6 million in 2006. Most FDI went into the mining and other sectors, and the health sector did not witness significant inflows over the period. Direct investment capital outflows from 2000 to 2002 were marginal, and from 2003 onwards no direct investment outflow was officially recorded.

Table 4: Capital flows (US\$ millions)

	1998	1999	2000	2001	2002	2003	2004	2005	2006
Net Direct investment	436	50	16	-0.3	22.6	4.5	4.5	101.6	29.6
Of which BHP and mining investment	364							85	
Portfolio investment	11	21	-2.1	-68.3	-2.4	4.3	1.9	-11.9	
Direct investment — Capital outflows	n.a	n.a	7.5	4.1	3.2	0.0	0.0	0.0	0.0
Long term capital (net)	-279	73	-256.3	-284.8	-281	-228.2	-211.4	-203.7	-187.7

n.a = not available

Source: GoZ, 2007.

Munyuki and Jasi (2009:4) note in their analysis on capital flows in Zimbabwe that:

The period 1995–2007 saw a rapid expansion of the private-for-profit health sector. Investments were made by both local and foreign investors. Foreign direct investment (FDI) was mostly targeted at the pharmaceuticals and chemicals sector. Mergers and acquisitions were utilised as a means of getting a foothold in the private-for-profit health sector. Medical aid societies (MAS) used acquisitions aggressively to capture market shares in direct medical services provision.

Examples of acquisitions are Caps Holdings' (a pharmaceutical manufacturing company) acquisition of 34% of the central government's shareholding in the company and subsequent purchase of St Anne's private hospital, as well as its interest in the retail of pharmaceutical products, through its direct control of the QV pharmacies. Others like LonZim Plc identified a market gap, as in the example in Box 1.

Box 1: LonZim invests in Zimbabwe Healthcare Sector

LonZim — an investment company in Zimbabwe — entered an agreement to establish a new company which will import, wholesale and distribute pharmaceutical products in Zimbabwe. LonZim owns 60% of Celsys which is listed on the Zimbabwe stock exchange. It also owns 51% of pharmaceutical firm Medsure and Paynet and 100% shareholding of Millpal — a chemical manufacturing concern. Apart from these investments, it has interests in the hotel industry, through its ownership of Leopard Rock in Manicaland. LonZim invested US\$2.3 million for start-up pharmaceutical business Panafmed, representing 51% shareholding of the company. The pharmaceutical concern supplies non-governmental organisations, private providers and public providers through a secure refrigerated logistics chain. The investment company announced that its management team which will be responsible for this pharmaceutical concern would be led by Dr Richard Botha, a pharmacist by profession. Dr Botha is well known for his experience in building and managing pharmaceutical businesses in South Africa. His experiences as Group Manager for Pharmarama and as operations director at Protector Group Holdings saw him engineering the turnaround of the 158 pharmacies in the Clicks chain.

Source: LonZim Plc, 2008.

Private capital flows were actively encouraged by government. At a function to open a new clinic acquired by CIMAS in Mutare in 2006, the then Minister of Health and Child Welfare Dr David Parirenyatwa urged the private sector to complement government efforts in setting up more health facilities (CIMAS, 2006).

One of the most significant changes has been in the Premier Service Medical Aid Society, which developed as a funder of civil servant medical aid society and thus drew on government funds as employer contributions. Its investment arm, the Premier Service Medical Investment (PSMI), acquired hospitals and clinics, rehabilitation services, laboratory services, dental services,

imaging, optometry, pharmacy services and medical emergency transport in 2001–2007, transforming the society from a health funder to include a role as provider of health care, pharmacy, training and emergency transport services. Externally, it is also involved in a joint venture for medical insurance provision with a medical services provider known as Empressa Mocambicana de Seguros (Emose-Sarl) (PSMAS, 2007).

The only other known big private health care player to own a significant number of private hospitals in Zimbabwe is Avenues Clinic. According to the CEO of the Avenues Clinic, through its medical investment services arm, the clinic owns Montagu Clinic, St Clements and Avenues Clinic. The CEO pointed out that, among its shareholders are some of the country's big economic players, e.g. Anglo-America Corporation and Standard Bank Zimbabwe.

CIMAS made most acquisitions of non-core services between 2001 and 2006 as a way of adapting to the harsh economic environment; the Group CEO described these acquisitions and investments as '*disruptive innovation*' (CIMAS, 2006) — a theory where a simple product which may not be liked at first, is developed until it establishes itself and disrupts competitors. PSMAS also acquired health facilities in the same period citing the need to address overcharging, self-referrals (doctors claiming more money on reviews), over-servicing and demands by providers for co-payments from patients for consultations or treatment (PSMAS, 2007). Some insurance companies diversified to include MAS after identifying market opportunities, including Fidelity Life Medical Aid Society, First Mutual Medical Savings Fund and Strategis Health and Life Assurance. TA Holdings, an investment company with interests in insurance, hospitality and agrochemical industries, owns Freecor Holdings, which in turn owns 100% of Zimnat Life. Zimnat invested in Sovereign Health Company Ltd, which administers insurers such as the World Bank medical aid society. First Mutual Medical Savings Fund has recently entered into an agreement with Netcare South Africa, where the latter will provide medical access to premier First Mutual Medical Savings clients. Netcare is one of the largest private healthcare providers in South Africa. There have also been other sources of new investment in the industry. For example, TN Financials, which owns a commercial bank, opened a new medical society known as TN Medical Benefits society. It is also eyeing a US\$250 000 medical aid investment in Zambia (Mutandi, 2010).

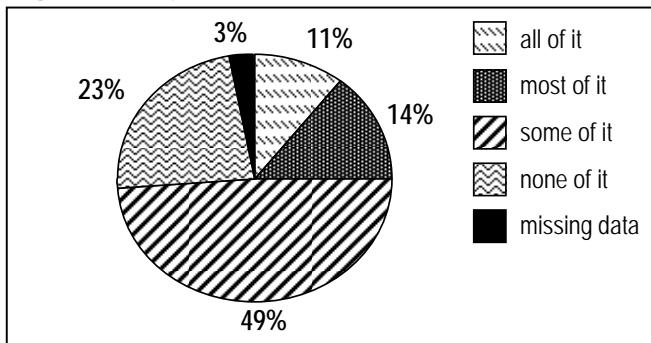
Strategis, a consortium of indigenous medical practitioners with branches in Kenya, Malawi, South Africa, Tanzania, Zambia and Zimbabwe took over the operations of the Zimbabwe Pharmaceuticals industry (Zimpharm), and thus several wholesale and retail pharmacies in Zimbabwe. The group owns South Medical Hospital (Chitungwiza) and the Suburban Medical Centre (Warren Park, Harare), and Strategis Health and Life Assurance has a strong affiliation with MASCA medical aid society, a relatively large medical aid society (Chanakira, 2004).

Urban councils, namely Harare, Bulawayo, Masvingo and KweKwe, also fund MAS, and according to information from interview with the Ministry of Health Registrar of Insurance, other local councils are reported to be considering operating their own in-house medical aid schemes. Finally, other non-medical insurance investments include the franchise arrangements between Clicks, Discom and Meikles Zimbabwe in the retail of pharmaceuticals. Clicks and Discom operate in conjunction with the Medix group a chain of fourteen pharmacies, where Meikles Zimbabwe has a significant shareholding (Ruiters and Scott, 2009).

Key informant interviews indicated that expansion and acquisition were motivated by prevailing economic difficulties in the country, a means to tap market opportunity and a way to manage the costs of doctors, specialists and pharmacists. Despite societies using these acquisitions to reduce co-payments and overcharging, in fact, as the beneficiary survey showed, clients were

still making a significant share of payments not covered by plans and thus remained highly exposed to these practices (see *Figure 7*). Only 11% of beneficiary plans are fully reimbursed for services provided outside their managed care plans. Of those who see providers not on the plan, 59.5% need approval from their MAS, while 31.9% said they did not need authorisation.

Figure 7: Payment to providers not on plan



The continued high level of additional spending by beneficiaries raises questions about the effectiveness of acquisitions against the stated purpose, and the possibility of other motivations at play. Cost escalation to beneficiaries has continued: 42.2% of beneficiaries pay part of their premiums out-of-pocket, and 53.4% have contributions paid entirely from their salaries. Combined with co-payments to access healthcare, charges for health care are likely to be high.

3.3 Competition issues

Changes in ownership in the sector have led to a high degree of vertical integration between funders and different providers. This poses competition issues that may lead to price increases, even while one of the reported motivations for acquisitions was to manage rising provider costs. Since its formation in 1996, the CTC has dealt with cases involving mergers and acquisition, restrictive business practices and competition (see *Table 5*). Some medical sector cases it handled were reported to the Ministry of Health and may have contributed to the passing of the Medical Aid Societies Statutory Instrument 330 of 2000 (Kubuda, 2009).

Table 5: Competition cases handled by CTC, 1999–2008

Case category	1999–2005	2006	2007	2008	2009 (Jan–Aug)	Total
Mergers and Acquisitions	268	50	48	32	15	413
Restrictive Business Practices	254	38	34	28	12	366
Competition Studies	19	5	4	2	1	31
Total	541	93	86	62	28	810

Source: Kubuda, 2009.

The competition cases handled by CTC have not dealt with premium prices and reimbursement rates for providers, nor the implications of how MAS use surpluses, although some cases involved competition, use of medical services and quality of care. CTC reportedly focused more on curbing the abuse of dominant positions such as unfair trade practices and monopoly pricing, rather than market share. For example, in the case of PSMI's acquisition of West End and Shashi Hospitals, the commission concluded that the mergers were not anti-competitive (Kubuda, 2009). Instead CTC noted the benefits of job creation, the availability and quality of services and the increase in market share and service provision. They noted that patients no longer needed to pay cash upfront and the recapitalisation of West End Hospital prevented its closure (Kubuda, 2009). Thus CTC focussed more on economic than consumer benefits.

The Competition Act of 1996 does not have specific provisions to address consumer welfare issues, except those dealing with pricing of goods and services which are misleading advertisements, false bargains, distribution and selling of goods above the advertised price (Competition Act of 1996, Chapter 14:28–30). Issues such as unfair trade practices, false bargains, advertising and distribution of goods and services are not dealt with. As shown in *Table 6*, most of the complainants to CTC were not consumers. Although the Competition Act was amended in 2001 to provide for treatment of monopolies and to separate the roles of investigator and adjudicator, it still did not address consumer welfare. MoHCW is therefore the main authority protecting consumer interests and ensuring promotion of equity and financial protection in the health sector.

Table 6: CTC and the health sector

Entity	Nature of transaction	Complainant(s)	Nature of investigation	Result
Caps Pharmaceutical Holdings	Acquired St Annes' Hospital	Other industry players	Anti-competitive behaviour	Promoted competition in the industry
MedTech group of companies	Merged with and acquired other health services	Other industry players	Anti-competitive behaviour	Promoted competition in the industry
Meikles Group	Acquired a stake in Medix retail pharmacies	Retail pharmacists	Restrictive practice	No restrictive practice
Ziscosteel medical benefit society	Exclusionary behaviour: patients directed to certain preferred providers	Consumers	Restrictive practice	Violated merger control laws; police opened a docket and MoHCW notified to take action.
EMF medical aid society	Advertising and promoting certain pharmacies	Medicine Control Authority of Zimbabwe	Restrictive practice	There was a misunderstanding which was cleared
PSMAS	Referring patients to its health services	CTC	Restrictive practice	No restrictive practice
PSMI	Acquisition of Shashi Hospital	CTC	Anti-competitive behaviour	No anti-competitive behaviour due to increased competition in the region
PSMI	Acquisition of West End Hospital	CTC	Anti-competitive behaviour	No anti-competitive behaviour as increased market share and employment
CIMAS	Operation of Health Guard scheme	CTC	Anti-competitive and restrictive behaviour	Health Guard discontinued in 2004
AHFoZ formerly NAMAS	Setting of tariffs	CTC	Price fixing and acting like a cartel	No price fixing

Source: Kubuda A (2004, 2006 and 2009); Munyiki and Jasi (2009).

For example, while geographic spread by CIMAS and PSMAS to most cities and towns in the country, addresses geographical equity in those areas and among clients they serve, there is no equity between clients from different MAS where the other MAS have inadequate geographical spread. The issue of some MAS operating managed care and some operating just as funders means that identical beneficiaries from different MAS do not receive the same services, which may result in different outcomes. The survey also revealed that while some MAS have few plans, others have a number of benefit plans (e.g. CIMAS has five plans and PSMAS has nineteen plans); those with many plans show no major differences in terms of the benefits to their clients, and this only increases administrative costs.

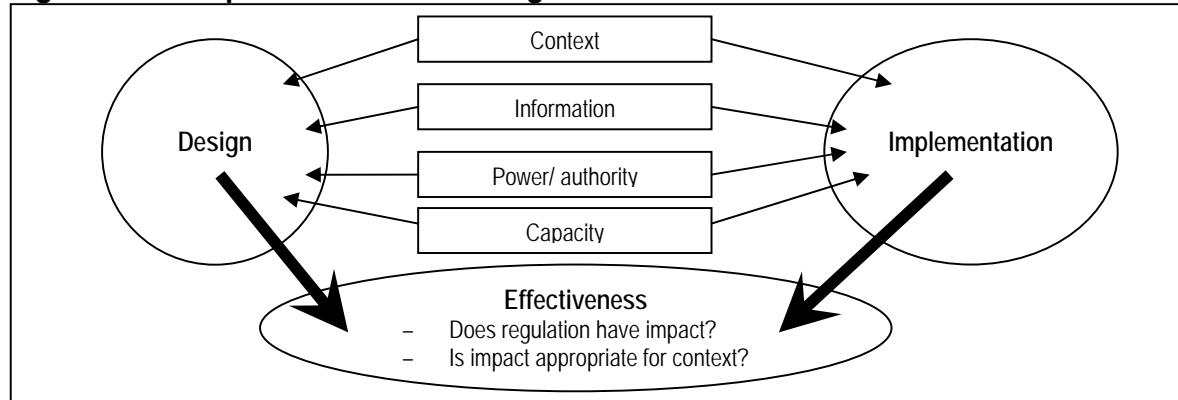
On the other hand, there is some discrimination between high level and low level employees in terms of company contributions. For example, with CIMAS the annual global limit for the executive plan is US\$16,320, while that of the lowest plan is US\$2,040, with minimum monthly contributions of US\$43.10 and US\$5.10 respectively. Since most MAS are employer-based, it shows the level of discrimination between poorer low level employees and richer, higher level employees. In terms of taxation, individuals are given medical credit, which is 50% of one's expenditure on hospitalisation, prescribed drugs, x-rays, ambulances and medical equipment (KPMG, 2008). Even if both the higher and lower level employee can get medical credit, the higher level employee enjoys more benefit than the lower one. Discussions with MAS also revealed that they use no common method to calculate premiums, so they could be prejudicing beneficiaries in the process.

3.4 Regulation of MAS by the Ministry of Health

Roberts et al (2004) note that government regulates the health insurance industry to address moral hazard and cost escalation issues, prevent adverse selection (where those with high health need are selected out), and to ensure equity in the distribution of income and health risks. Many developing countries subject the private medical insurance industry to 'material regulation' on the type of policies they can sell, pricing of these policies and arrangements with providers. They do not, however, often address issues of solvency, licensing, financial regulations, contract laws, judicial reviews and labour codes (Sekhri and Savedoff, 2005).

The conceptual framework (see *Figure 8*) highlights important elements of a regulatory framework, i.e the design, implementation and effectiveness. Regulation of MAS in Zimbabwe has been constrained by shortages of personnel, absence of clear regulation and of a body with statutory powers to enforce the regulations. Over-centralisation, lack of independence of the regulatory body, and patients' lack of information on their health rights are also reported to have weakened effective regulation (Hongoro and Kumaranayake, 2000). The Zimbabwe government enactment of the Medical Services Act of 1998 made the regulation of the sector explicit, rather than through tacit 'control'. The act created a legal and enforceable environment to regulate the health sector as a whole (MoHCW, 1999).

Figure 8: Conceptual framework for regulation



Source: Kumaranayake, 1998.

The Medical Services (Medical Aid Societies) regulations of 2000 and amendments (2004), sought to address the conduct, financial matters, amalgamation, transfers, dissolution and de-regulation of MAS. The law provided for advisory councils to monitor and regulate MAS work, but did not clearly define how MAS should operate or address limits for investment of the

industry's 'surplus' funds. *Box 2* outlines the provisions of the regulations on MAS ownership of non-core activities, and how the industry has responded to these provisions in terms of clauses in their own constitutions, citing examples from the two biggest societies in the country. MAS have taken advantage of the ambiguity to include powers in their constitutions to invest funds in a wider range of manners than perhaps the law intended (see *Box 2*). Notably CIMAS' constitution was amended to include these wider powers in 2005, five years after Statutory Instrument 330 came into effect. Their constitutional amendment of powers may have been to deal with questions of conflict of interest over potential new investments in health care. The same approach may have been taken by other societies.

Box 2: Legal provisions and medical aid society constitution provisions

Subject to sub-section (4), a medical aid society may invest its funds in any manner provided by its constitution or rules.

Conduct of medical aid societies

[A.] Constitution of the medical aid society shall provide for:

(i) Power to invest funds

CIMAS: has Power to undertake 26 broad activities which include the power to:

- purchase or acquire, in any way, stock-in-trade, plant, machinery, land, buildings, agencies, shares, debentures, and every other kind or description of movable and immovable property;
- invest money in any manner whatsoever;
- form and have an interest in any company or companies for the purpose of acquiring the undertaking of all or of any of the assets or liabilities of the company or for any other purpose which may seem, directly or indirectly, calculated to benefit the Society;
- take part in the management, supervision and control of the business or operations of any other company or business and to enter into partnerships, mergers, joint-ventures or schemes of amalgamation.

PSMAS: Has Power to undertake 9 broad activities which include:

- purchase or otherwise acquire or to take on lease or hire property, movable or immovable, and to construct buildings on property owned by the Society;
- form and have an interest in any company or companies for the purpose of acquiring the undertaking of all or of any of the assets or liabilities of the company or companies or for any other purpose which may seem directly or indirectly, calculated to benefit the Society;
- take part in the management, supervision and control of the business or operations of any other company or business and to enter into partnerships, mergers and joint-ventures.

[B.] A medical aid society which invests any of its assets in the business of or grant loans to a health-care provider, private hospital, state-aided hospital or specialist medical unit or facility on terms which enable the provider, hospital, unit or facility in question to enjoy the same exemptions from income tax as are afforded to the society in terms of the Income Tax Act, shall inform the Secretary of the nature and extent of the investment no later than twelve months after the investment was made.

Source: Medical Aid Societies Statutory Instrument 330 of 2000, amended in 2004.

The issues below indicate that regulation through the Medical Aid Societies Act has faced problems in relation to content, information, powers and capacity:

- According to MoHCW, since 2005, most MAS were faced with liquidity constraints due to the effects of hyperinflation. However, if the regulations had been followed to the letter, most societies could have been closed, but none were ordered to close (see *Box 3*).
- Although Statutory Instrument (SI) 330 of 2000 requires MAS to provide annual financial reports to the registrar, MAS are either not doing so, or doing so irregularly. According to MoHCW only 30–40% of current MAS provided compliance reports and not necessarily annual financial reports (compliance reports provide minimal information of financial issues).

- SI330 of 2000 requires societies and beneficiaries to liaise through advisory councils but these councils are not meeting. According to the MAS Registrar, they have not met for two years since he was employed by the MoHCW.
- The MoHCW has limited capacity to regulate and monitor MAS. The Registrar is only one person and the department lacks private sector experience. According to the registrar, only an Act of Parliament that creates an independent authority would give the office enough power to regulate the industry, and also enable it to retain the fees that it collects from industry players for its own use. Currently, since this office is not a statutory body, all fees it collects are surrendered to the Ministry of Finance and therefore become part of the consolidated revenue fund.
- There is limited information in the public domain on MAS. The MoHCW does not have a database on MAS with information on membership, number of benefit packages, cost of minimum benefit package, reserves, market concentration, or geographical coverage.

Box 3: Protection of consumers against solvency

Royal Medical Aid Society (RMAS) closed shop in 2006 due to financial constraints. The CEO of the Society told The Daily Mirror that the society ceased operations in November 2005 because of financial problems which he was not at liberty to disclose.

The CEO was quoted saying: 'We are no longer operating. We have since advised our members to stop subscribing to the society.'

He claimed his society had a membership of at least 8 000 subscribers country wide. Further probed on how members would be compensated for their contributions since the inception of RMAS, the CEO was quoted saying: 'With medical aid societies, you pay in advance so that when you get sick your expenses will be catered for. If you do not get sick, that will be that.'

Source: Daily Mirror Reporter, 2006.

In this respect, as further shown in *Table 7*, both the content of the regulation and existing practice only partially fulfil areas identified as necessary for protection of consumers or promotion of health equity. Beneficiaries in the survey were generally in favour of regulating the prices for medical aid (73.3%). While some of the shortfalls in regulating the sector arise due to the regulations themselves being ambiguous or needing updating, in many cases the issue lies with non-adherence to existing provisions.

Table 7: Areas for regulation of MAS and practice in Zimbabwe

Policy goal	Policy objective	Comment
Consumer protection	Financial solvency of insurers	Need to update the minimum reserve requirements given the new multicurrency environment. The reporting requirements are in place, but they are not being followed ¹ .
	Promote manageable competition to encourage affordability and consumer choice	CTC has rules to manage competition but MOHCW believes it is promoting competition by encouraging the registration of more MAS ² .
	Promote fairness and transparency in transactions between insurers and consumers	Need to update disclosure and advertising rules. There is no schedule of rules for MAS advertising. The mechanisms to resolve consumer grievances are in place at MoHCW but consumers are unaware of them ³ .
	Ensure insurance packages provide adequate financial protection	Not defined although provided for in the Medical Services Act of 1998 ⁴ .

Policy goal	Policy objective	Comment
Promote equity	Minimise adverse selection and encourage broader risk pooling	Though medical insurance in Zimbabwe is voluntary, enrolment through employer groups encourages risk pooling ³ .
	Minimise risk selection or cream skimming and encourage broader risk pooling	Provisions on guaranteed issue are not being followed. Provisions on limiting exclusions were dealt with by the CTC but are difficult to detect and deal with if consumers do not come forward and if MoHCW is not proactive ² .
	Establish premium setting guidelines that promote cross-subsidies between healthy and sick and/or between income levels	There is promotion and encouragement of group medical insurance to promote cross subsidies between income levels ³ .
Promote cost containment	Reduce supplier-induced demand	MAS are promoting managed care to dissuade supplier induced demand. MOH has not articulated a position on this ³ .
	Reduce consumer induced demand (moral hazard)	While MAS is promoting deductibles and co-payments, in reality they are limiting access to care rather than acting as a deterrent to moral hazard ³ .

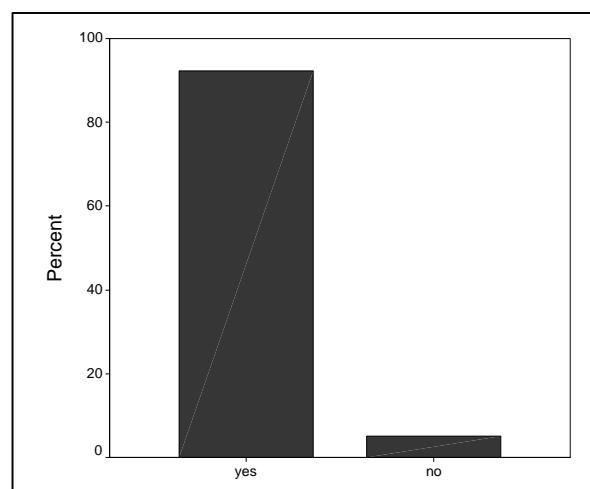
1. MoHCW, 2009; 2. Kubuda, 2009; 3. Discussions with MoHCW, Parliamentary Portfolio Committee on Health and Industry Players, 4. MoHCW, 1998.

Adapted from: Sekhri and Savedoff, 2005.

3.5 Perceptions of key actors in the sector

This section gives an overview of MAS developments and consumer survey and interview reactions to these developments. In the beneficiary survey, 58.6% of 100 beneficiaries interviewed were in favour of managed health care, while 27.6% did not know what it was or did not care as their plan did not cover it. All those in favour of the concept said it was convenient, while the 9.5% who said they were not in favour said it limited choice. Respondents were almost universally in favour of private healthcare provision (see Figure 9), not surprisingly given the near collapse of the public health sector and the access this group have to private care through medical aid. Those not in favour of private care cited huge costs. While those interviewed were generally in favour of voluntary insurance for private care, many (46.6%) rated their healthcare plans below average or average (on a scale of 0–10), while 53.4% rated them above average.

Figure 9: Are you in favour of private healthcare?



Private MAS, such as the one in *Box 4*, aim to continue expanding into non-core activities, and the industry sees its role not as **complementary** to the public sector, but to **compete** against it — contrary to the argument often given by private MAS that they are complementary to the public sector. PSMAS caters for almost 90% of the civil service and receives contributions from the government as employer. In a parliamentary hearing (27 October 2009), a PSMAS representative said it was compelled to diversify into other income generating activities such as health provision, emergency medical transport and training of medical personnel to reduce costs, and deal with a non-viable contribution from government and economic difficulties faced by government. A representative of Fidelity Life Medical Aid asked the same parliamentary hearing, ‘If you make a profit or surplus, what would you rather do with that money?’.

Box 4: Health funders’ perceptions

Question: How many clinics have so far been opened by the healthcare division?

Answer: The following clinics have been opened by the Healthcare Services Division:

Rowland Square Clinic 1/10/2005

Mutare Clinic 1/4/2006

Bulawayo Clinic 1/10/2006

Gweru Clinic 1/5/2007

Question: What is the bigger plan for the Division?

Answer: In an effort to improve access to service we intend to open another clinic in KweKwe and two more clinics in the high density suburbs of Harare in the first half of 2008. A drug wholesale outlet will also be opened before the end of the year to help improve drug availability at our Clinics.

Question: should service delivery improve in the public healthcare system, will the clinics not become white elephants?

Answer: Our clients seek to provide a comprehensive quality product which we believe our patients will become accustomed to and faithful to even in the face of competition from other providers.

Source: CIMAS, 2008.

MAS recognise that expansion into other branches of medicine might be contested; for example Campbell et al (2000:5) noted: ‘CIMAS senior managers began their managed care effort with a communications campaign. They knew that, given the overwhelming negative media treatment of the subject in the American press, that they would need to convince their important audiences that the steps they intended to take were necessary and prudent.’

Medical professionals contend that it limits their earnings and provider choice. According to one local authority doctor interviewed, MAS ‘have impoverished doctors through payment of sub-economic tariffs in order to employ them under their managed care concept’. A ZIMA representative in an interview at the Harare City Heal Department (27 October 2009) noted that through non-payment of economic tariffs and employment of health providers, MAS are now directly competing unfavourably with private providers. He highlighted that the absence of a regulatory framework compelling funders to pay providers within a stipulated time has also affected their relationship: ‘Nothing compels them to pay interest, and also there is no legal recourse for delays or defaults.’ He also pointed out that when consumers are forced to use MAS-preferred doctors and healthcare providers, MAS could be a violation of beneficiary rights.

However, MAS beneficiaries have mixed views on the development of managed care in the industry. For example, a CIMAS client (2008) expressed support for the development:

At this time of the ever increasing inflation and higher costs, my wife and I greatly appreciate the Society’s generous response in this matter. Thank you very much. [...] Incidentally, I paid my first visit to your Rowland Square Clinic last week and was

impressed by the friendly and efficient service I received from both the staff and the doctor. Not having to pay an expected shortfall on my blood pressure ‘muti’ was a further bonus. These examples of the services you render to your members certainly help to promote loyalty and support for the society.

However, a letter to another MAS (Vollenhoven, 2006) that has also acquired several health facilities included complaints about the practice:

Medical aid societies, like insurance companies in Zimbabwe, are their own worst enemies. Most of them are run by people who lack vision and foresight. Since independence, when the majority of Zimbabweans came aboard, medical aid societies moved from one crisis to the next. We all know the story of the Public Service Medical Aid Society. It was under the illusion that if it changed its name to “Premier” its inefficiency would merely fade away. Medical aid societies fail to teach its new members the concept of a medical aid society or the merits of being on such a scheme. The contributing member was under the impression that he/she was entitled to using this contribution which was to be matched with another 200% from his/her employer. Fears abound that if members failed to visit their doctors on a regular basis their contributions would be used to buy luxury vehicles for those entitled to them. At 50, I hardly visit my general practitioner — thanks be to God. But what thanks do I get from my two medical aid societies? Nothing except a slap in the face and poor, rude and arrogant service from both the management and the staff.

From CIMAS, every conceivable medical provider wants hard cash upfront. Is that feasible, if I may ask? Where in Heaven’s name do I get a cool quarter of a million dollars for my spectacles? As for my so-called Premier Services Medical Aid Society, the guy in charge is more interested in buying a polyclinic and a rundown dentistry instead of looking at the disgraceful benefits and the despicable turnaround after submitting one’s claim form. It can take anything from six months to a year. This guy hasn’t heard of Zimbabwe’s hyperinflation.

I propose a solution to all Zimbabwe’s medical aid societies. Why not give us, those who don’t abuse the facility, something back, say 50% of our total contribution if we don’t visit any provider within a calendar year? I guarantee you will be pleasantly surprised by the dramatic drop in the number of those who abuse the facility.

The chairperson of the Parliamentary Portfolio committee on Health, Hon MP Dr David Parirenyatwa (27 October 2009), felt that there is a need for MAS societies to ‘restrict themselves to their core business’. He exhorted MAS to clearly distinguish the difference between ‘surplus’ which these non-profit MAS purport to make and the ‘profit’ they invest in private business. He also suggested the need for an independent statutory body in the mould of the South African Council for Medical Schemes to regulate the medical aid and medical insurance industry.

3.6 Influence of key actors in the sector

There was almost no advocacy of consumer interests by groups outside government, including by the labour movement, whose members were the primary contributors to MAS schemes, leaving members exposed. *Table 8*, following gives an overview of the different actors in the health sector and their positions on private capital flows in the sector, on enforcement of the regulations and on their power and influence on medical aid. Information flow to beneficiaries is extremely low. Most beneficiary respondents reported receiving no information on their plans or payment levels for prescription medicines (*Figure 10 and 11*).

Table 8: Core interest groups around medical aid

Actor	Primary interests	Position on capital flows in sector and enforcement of regulatory framework	Power and influence
The public represented by Consumer Council of Zimbabwe	<ul style="list-style-type: none"> Maintain and improve existing benefits at reduced or lower prices 	Uninformed about the long term effects of changes on workers' premiums and their position in the regulatory framework. Rely on employers for advice.	Low influence: Consumers are uninformed of their rights.
Trade Unions	<ul style="list-style-type: none"> Expand and improve health care coverage for poorer groups in society Consolidate or expand current benefits available to their own members 	Largely uninformed about long term effects of the flows on workers' premiums and their position in the regulatory framework. They have no defined position.	High potential influence but, power base largely unused due to lack of information. Attention diverted to economic issues and resisting introduction of NHI as another tax and due to distrust of the state.
Employers	<ul style="list-style-type: none"> Limit costs by keeping premiums low Secure benefits for workers Improve labour relations 	Tacit approval as long as the growth of the industry keeps the premiums low.	Low influence: Have largely used medical insurance as an incentive for attracting and retaining employees.
Health professional associations	<ul style="list-style-type: none"> Provide oversight on ethics, access and quality issues Protect members from unfair practices 	<p>Providers such as pharmacists and doctors are opposed to restrictive practices and acquisitions by MAS. Other associations though do not have a clear position.</p> <p>Most feel regulations should be enforced.</p>	High Influence but, ZIMA's current focus is on starting their own MAS undermining its position. Professional associations largely unco-ordinated in their response, with health workers divided in and out of schemes and in and out of the private and public sectors.
Private insurance providers	<ul style="list-style-type: none"> Secure or improve incomes and working conditions by accessing large pool of private patients Increase access to new technologies to improve quality of care 	<p>In favour of more capital as it increases market power and profits.</p> <p>See that regulations should encourage rather than limit capital flows.</p>	High influence but, due to political influence, individual interests with some regulators also actively involved in the business of providing health services.
Medical aid schemes	<ul style="list-style-type: none"> Maintain and expand market share and revenue levels Counter proposals hostile to its interests Support government in expanding health care access 	<p>In favour of more capital as it increases market power and profits.</p> <p>Regulations should encourage rather than limit capital flows.</p>	High influence but, due to political influence, individual interests with some regulators also actively involved in the business of providing health services.
Ministry of Health	<ul style="list-style-type: none"> Improve equity by strengthening cross-subsidisation (between sectors and between population groups) Generate revenue for public health sector Improve access to health care especially for poor and rural populations, and through government controlled funding arrangements 	<p>Encouraging more participation in the health sector. Currently registering more players in the medical insurance industry.</p> <p>Regulations should be enforced.</p> <p>Cautious about profit-motivated private health sector</p>	<p>High influence but, currently lacks capacity to enforce regulations; it has not been very proactive in law enforcement. Regulation on practice of the industry mainly from the CTC.</p> <p>Government also involved in the industry through PSMAS, potentially compromising its role.</p>
Portfolio committee on health	<ul style="list-style-type: none"> To improve equity through enacting legislation that protects the poor Oversight role on expenditure 	<p>Needs more information on private capital flows and their impact on premiums and access.</p> <p>Regulations must be enforced.</p>	High influence but the current political polarisation has diverted its attention to other issues.

Figure 10: Advice on healthcare, service and equipment

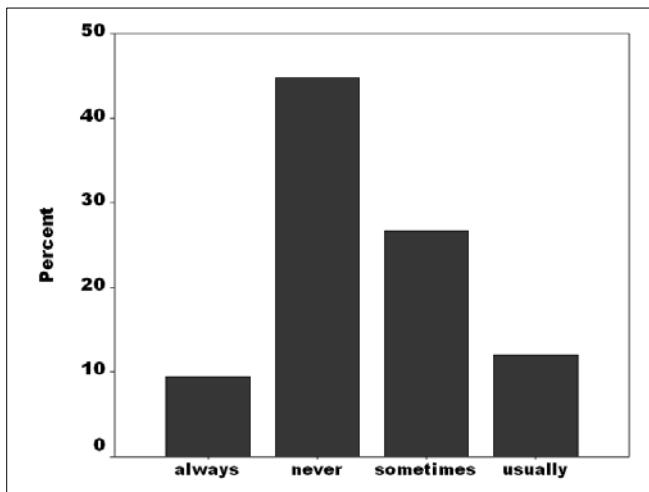


Figure 11: Advice on how much you would have to pay on specific prescription medicine

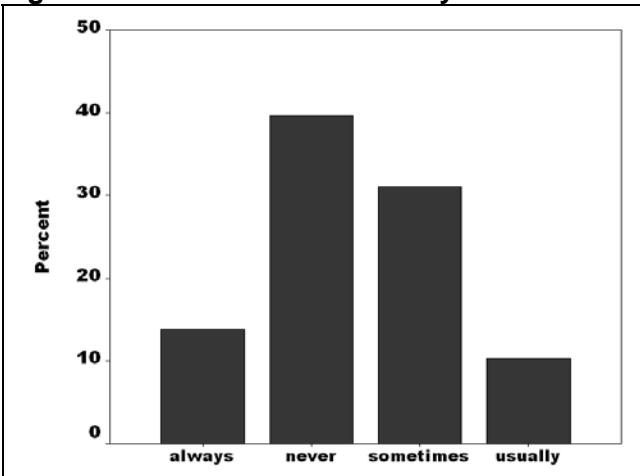
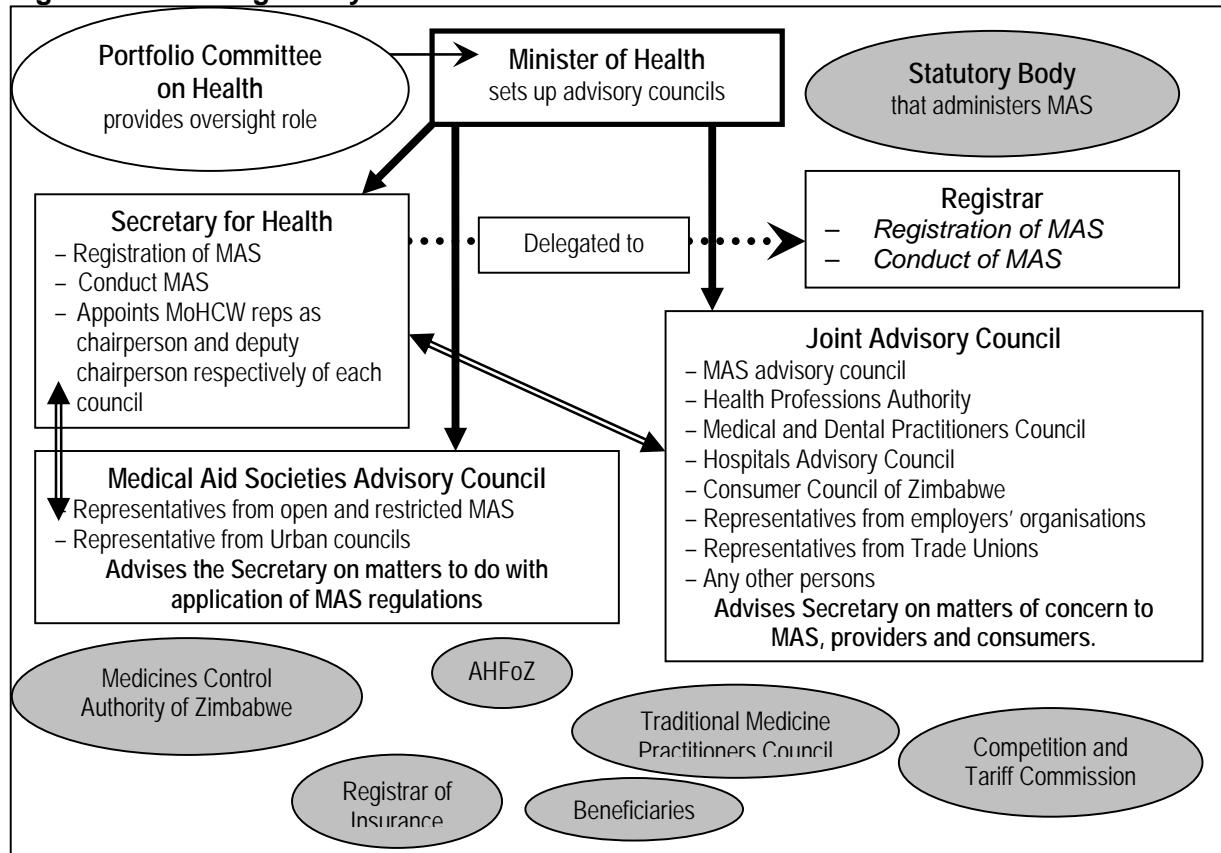


Figure 12 shows how these and other actors interact in relation to MAS, based on Medical Aid Societies Statutory Instrument 330 (2000) amended in 2004. The arrows show interactions between key actors, and absence of arrows suggests lack of a clearly defined interactions. The relationships are affected by political influence, profit motives and power dynamics.

Though the MoHCW has authority to regulate the industry, they are advised by a non-statutory body — the Joint Advisory Council which is made up of funders, providers and consumer and workers' bodies, who have interest in the issues. This raises a potential conflict of interest so the regulator needs to take this input with caution, especially if one set of interests tend to be more dominant. Decisions of the council are not binding. We were unable to adequately assess the functioning of the council in the time frame of this study, as the council has not met for over two years, despite being directed to do so in Statutory Instrument 330. Another advisory board, the Medical Aid Societies Advisory Council, has a similar composition and mandate to AoHFZ and it is unclear how this duplication is managed; similarly, the law does not make clear the role of other important actors (e.g. Medical Control Authority of Zimbabwe, AHFoZ itself, CTC, the

Registrar of Insurance and the beneficiaries themselves). The MoHCW believes these councils are too big, hence difficult to co-ordinate.

Figure 12: MAS regulatory framework and actors



Since MAS are now involved in health care and pharmaceutical provision without any barrier from the Medical Control Authority of Zimbabwe and Medical Services Act of 1998/2002, the Public Health Act of 1925/1996/2002, the Medical, Dental and Allied Professions Act of 1971/1996, the Drugs and Allied Substances and Control Act of 1969, the Dangerous and Drugs Act of 1956, the Insurance Act of 1987/2001/2002 and Companies Act of 1947/2006 raises some concern about the effectiveness of the law in managing potential conflicts of interest, for example:

- vertical integration creating monopolies across the sector and limiting patient choice;
- vertical integration leading to prescribing practices and use of laboratory services driven more by financial interests than clinical need; and
- limits to consumer choice weakening peoples ability to secure quality care or negotiate their interests with providers.

Furthermore, MAS are not taxed due to their non-profit status as health care funders. However, since they now have investments in non-core areas, there are tax implications on profits earned.

Strengthening the regulatory environment towards fair and firm regulation appears to be an urgent issue as different groups continue to secure their interests through fragmented risk pools, in contrast to the demand for larger risk pools for the cross subsidies necessary for equity. For example when the relationship between the Zimbabwe Medical Association and AHFoZ broke down due to disagreements over tariffs, ZIMA representing the doctors disengaged from

AHFOZ. In one interview, one doctor complained that MAS have impoverished doctors by delays in reimbursement and paying uneconomic tariffs so as to employ them at a lower cost. ZIMA is now in the process of setting up their own MAS. Although they claim that it will be independent from ZIMA, and will be registered like any other MAS, it will still enjoy a unique and favourable relationship with the association and thus a relatively powerful group of providers. This raises issues of unfair competition and conflict of interest and queries of how ZIMA can offer advice from practitioners on the creation of the scheme when it has direct interests in it.

A force-field analysis (see *Table 9*) shows the nature and dynamics support or opposition of the different actors to the regulation of the medical aid insurance industry (Gilson et al., 1999). While there are strong proponents and opponents most actors — as evidenced from the interviews and the literature — are still non-mobilised. The regulations on MAS are unknown to most of the actors cited in *Table 9* and for many members the choice of fund is a fait accompli of their employment, and a choice of their employer.

On the other hand, the industry has also largely remained secretive about its operations, with little information in the public domain or submitted to authorities. This weak forcefield for regulation is one factor for the rather unfettered vertical integration of medical aid into other spheres of the sector despite legal restraints.

Table 9: Forcefield analysis of positions on enforcement of regulation on MAS

Actor categories	Proponents			Opponents	
	High support	<<< <<<	Non-mobilised	>>> >>>	High opposition
Political sector		Parliamentary Committee on Health	Political parties		
Government sector	CTC	Ministry of Health			
Business sector			Employers' Confederation of Zimbabwe		MAS
Professional associations	Zimbabwe Medical Association (ZIMA) Health Professions Council		Pharmacists Council of Zimbabwe and other professions		
Consumer sector			Consumer Council of Zimbabwe, Zimbabwe Congress of Trade Unions, Zimbabwe Federation of Trade Unions		
Analysts	Public Sector Analysts				
Social sector	Community Working Group on Health (CWGH)		Transparency International and Zimbabwe NGOs working on governance		

Adapted from: Gilson et al (1999) using discussions with actors and secondary sources to assess their awareness to growth in private capital flows in the private insurance sector.

3.7 Social Health Insurance

The establishment of mandatory National Health Insurance (NHI) such as a tax-based Social Health Insurance, would provide larger risk pools for financing health, such as for cross subsidising the contributions on the ill with the healthy. According to Bennett and Gilson (2001), SHI is a principle based on mutual support and involves the transfer of funds from relatively richer and healthier people to the relatively poorer and sicker. It gives greater access to the poor and allows cross subsidies between the richer and poorer and, being based on larger risk pools makes it even better than private voluntary health insurance.

SHI has been discussed for the past three decades in Zimbabwe, without implementation or conclusion. The survey found that despite it being on the agenda for some time, 56% said they had never heard of NHI (see *Figure 13*). Most people were not sure about their position on it as they were not adequately informed, while those who opposed it were concerned about governance and transparency issues in government run organisations, given experiences with the AIDS Levy Fund and the National Social Security Association. Others cited the issue of being on private medical aid, and were concerned that NHI would mean paying twice. The 21% who said they would want it (see *Figure 14*), cited reasons of universality in terms of access to services, while those unsure needed more information to decide.

Figure 13: Have you ever heard of national or SHI?

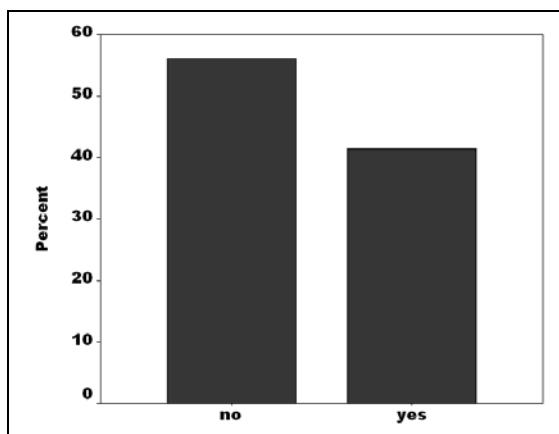
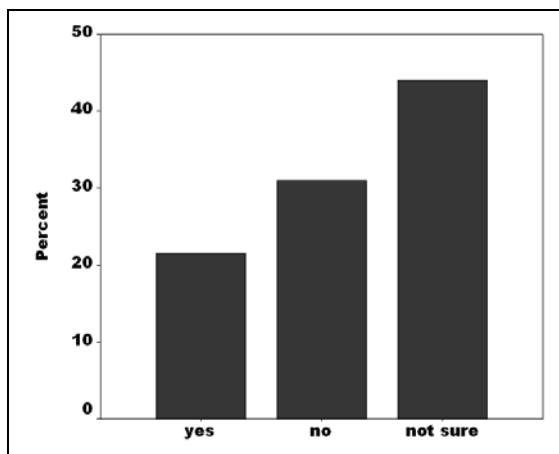


Figure 14: Are you in favour of national or SHI?



5. Discussion

While medical aid schemes are voluntary, this study found that limited use of brokers reduces administration costs from the MAS perspective, but limits employee discretion on the choice of MAS and competition in the industry. The study thus found relatively low migration between MAS, even though a fifth rated their schemes as below average and only 53% felt their schemes were above average. Plans were noted to have a number of shortfalls, particularly in reimbursing medicine costs.

MAS have become providers of health care, pharmacies, training and emergency transport services. Since MAS are officially treated as non-profit making entities, it is easy for them to invest 'surplus' funds in non-core areas, but there are questions about taxation on entities they have purchased, the transfer of funds between profit making entities like holding companies, and the non-profit making functions. This needs to be clearly differentiated and monitored.

Rather than cost containment, the study found evidence of cost escalation, leaving concerns about the 'surpluses' used by the societies to acquire various services that are no longer available to fund beneficiary care. Given the lack of a common method or public reporting on how premiums are calculated, relative to the allocation of these surpluses, it is difficult for members to judge the fairness or not of the decisions on use of funds in their schemes. The continued high level of additional spending by beneficiaries raises questions, however, about the effectiveness of the acquisitions against stated purpose.

The Medical Aid Societies Statutory Instrument 330 of 2000, regulating vertical integration, was partly introduced to limit competition and the concerns of the CTC. However the Competition Act of 1996 focus is narrow, and does not address consumer welfare issues, such as unfair trade practices, pricing, advertising and distribution of goods and services, nor issues of geographical inequity in services, proliferation of similar small plans limiting risk pools, segmentation of schemes limiting cross subsidies, or fairness of premium calculation, all of which were found to be problematic in some way.

The Ministry of Health has been constrained by personnel shortages, ambiguities in the law, and lack of consumer awareness. Ambiguities in the law have benefited the societies, and the law has also not been fully enforced.

The medical sector, MAS and medical doctors are an extremely influential and organised group, and regulatory capacity is critical to managing this market, which has a potentially high risk to the public from unsecured consequences of catastrophic illness. The closure of Royal Medical Aid society in 2005 showed that unregulated entrance into the industry may lead to a proliferation of risky insurers, with beneficiaries not in any way protected against the insolvency. Significant further regulation or excessive controls are not needed to address these concerns; rather the intentions of the existing law should be made clear and the laws should be enforced.

Limited or no advocacy on beneficiary interests by the labour movement or members themselves contributes to the deficit in consumer protection. Most beneficiary respondents were poorly informed and reported receiving little or no information on the schemes they belonged to.

6. Conclusions and recommendations

The study indicates that several measures are needed to improve functioning and equity in the sector and to address the interests of beneficiaries, including:

- Strengthening the regulatory environment to: **address legal ambiguities on investment of ‘surplus’ MAS funds**; ensure the multiple relevant laws from finance and health are known and applied by all MAS/ insurance providers; and fairly and firmly enforce the law.
- Ensuring **MAS retain focus on their ‘core business’** and clearly defining this in SI 330 to the Medical Services Act.
- Ensuring **timely scheme reporting** as required by law and **maintenance of a database** with basic information on schemes and on private providers in the country.
- **Resuscitation of Advisory and Joint Council meetings** to advise the secretary on industry matters, with smaller, effective sub-committees on specific focus areas.
- Ensuring **registration of all schemes**, avoiding increasing segmentation of the sector into small, fragmented risk pools from individual schemes and encouraging (for example by enforcing regulation on registration and liquidity requirements) mergers into larger and more viable risk pools.
- Developing regulatory and scheme policy measures to require and implement **cross-subsidies** necessary for equity and to ensure a **standard minimum benefit package** for personal care and personal prevention services.
- Taking up the **shortfalls in coverage of medicines** in existing plans.
- Checking the degree of **vertical integration** in each scheme and **unbundling any monopolies** across all spheres of a sector that are limiting patient choice, such as by paying only for selected linked services.
- Improving outreach of **consumer information on schemes, benefits packages and consumer rights** to members, organisations servicing members (e.g. labour movement and employer organisations) and bodies such as the Consumer Council of Zimbabwe and health professional bodies.

Improved institutional capacity in the officer of the Registrar of Medical Aid Societies and consumer awareness in members are essential in implementing the above measures. The MoHCW — specifically the Registrar’s office — should employ officers with a background in private company accounts (vs. public government accounts) to effectively monitor the financial practices of MAS. Given the scale of resources and activity required, it may be necessary to establish by Act of Parliament, an independent state regulatory authority to implement regulations in the industry and safeguard consumer welfare.

For beneficiaries to claim rights provided for in existing regulations, it is critical to promote beneficiary awareness of issues such as the portability of insurance coverage, for example:

- if a person changes employment, they need not migrate from their favoured MAS, even if the new employer has their own preferred MAS; and
- there should be no waiting period when a person changes from one MAS to another.

Many countries in the region are exploring SHI as a means to create larger risk pools for more comprehensive coverage, within a framework of universal coverage. Mandatory NHI has been discussed in Zimbabwe for the past three decades, without implementation or conclusion. This option should be revisited as the economy stabilises and confidence in governance improves, taking into account the issues raised in prior consultations and the lessons of other low- and middle-income countries who have already implemented it.

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Acronyms

AHFoZ	Association of Healthcare Funders of Zimbabwe
CEO	Chief Executive Officer
CIMAS	Commercial and Industrial Medical Aid Society
CTC	Competition and Tariff Commission
FDI	Foreign Direct Investment
MAS	Medical Aid Societies
MoHCW	Ministry of Health and Child Welfare
NAMAS	National Association of Medical Aid Societies
NHI	National Health Insurance
OECD	Organization for Economic Cooperation and Development
PSMAS	Premier Service Medical Aid Society
PSMI	Premier Service Medical Investment
RMAS	Royal Medical Aid Society
SADC	Southern African Development Community
SHI	Social Health Insurance
SI	Statutory Instrument
ZIMA	Zimbabwe Medical Association

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Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions. EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

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- Health rights as a driving force for health equity
- Health financing and integration of deprivation into health resource allocation
- Public-private mix and subsidies in health systems
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