HEALTH FINANCING FOR UNIVERSAL HEALTH COVERAGE: AN ANALYSIS OF THE ZIMBABWE NATIONAL HEALTH FINANCING POLICY

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57TH MASTER OF SCIENCE IN PUBLIC HEALTH /INTERNATIONAL COURSE IN HEALTH DEVELOPMENT

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Health Financing for Universal Health Coverage: An Analysis of the Zimbabwe National Health Financing Policy.

A thesis submitted in partial fulfilment of the requirement for the degree of Master of Science in Public Health

by

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Zimbabwe

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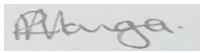
Signature: 

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Abbreviations

AFDB	African Development Bank
ART	Antiretroviral Therapy
CBHI	Community Based Health Insurance
CHE	Current Health Expenditure
DALYs	Disability Adjusted Life Years
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
IFFs	Illicit Financial Flows
IMF	International Monetary Fund
LMICs	Low Middle Income Countries
NHSO	National Health Security Office
OOPS	Out of pocket spending
PPP	Purchasing Power Parity
RBF	Results Based Financing
SADC	Southern Africa Development Community
SDGS	Sustainable Development Goals
SHI	Social Health Insurance
TWGs	Technical Working Groups
UHC	Universal Health Coverage
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organisation
ZIM-ASSET	Zimbabwe Agenda for Sustainable Socio-Economic Transformation

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Abstract

Background and Problem Statement

An estimated 7.6% of the Zimbabwean population experiences catastrophic health expenditure. Out of pocket spending (OOPS), in Zimbabwe stands at 24% according to the latest health data expenditure from World Health Organisation (WHO). High OOPS results in the population delaying seeking health services which increases the cost of care on the health system, have people forego health service or cause households to incur catastrophic health expenditure. Health financing policies that aspire to drive countries to universal health coverage (UHC) are expected to offer financial protection to people when they utilise health services.

Objectives

The objective of this thesis is to analyse the Zimbabwe National Health Financing Policy's feasibility in providing financial protection to health service users based on current literature on health financing and UHC as well as best practices in order to offer recommendations for future health financing policies.

Methodology

A literature review of peer reviewed and published journals on health financing and UHC in low and middle income countries (LMICs) was conducted. Grey literature from websites such as Government, World Bank, WHO and newspaper articles were also included in the literature reviewed. The policy triangle framework by Walt and Gilson was also used to analyse the Zimbabwe National Health Financing Policy whilst the literature review provided insight into current health financing discussions and an in depth analysis of the policy content.

Findings and Recommendations

Mandatory prepayments offer more financial protection and risk pooling. An increase of funding to 5% of the Gross Domestic Product (GDP), supplemented by a capita spending of $86 will improve progress to UHC and reduce OOPS. Community Based Health Insurance and targeted health insurance for the poor increase health utilisation and reduces the incidence of catastrophic expenditure as evidenced by Rwanda and Thailand. The success of health financing reforms is hinged on political will at the highest level in government as this will unlock additional resources needed to progress towards UHC. Strategies targeted at increasing the general fiscal space and the health fiscal space should be employed to ensure the poor have access to quality health services that they need.

Glossary

Catastrophic health expenditure. This is health expenditure that exceeds 40% of a household's income available after basic needs have been met. (WHO, 2005)

Public Policy. A set of interrelated decisions taken by a political actor or group of actors concerning the selection of goals and the means of achieving them within a specified situation where those decisions should, in principle, be within the power of those actors to achieve**.** (Engeli I, Allison C.R., 2014)

Universal Health Coverage. When all people in a country have access to the health services they need (prevention, promotion, treatment, rehabilitation and palliative care) without the risk of financial hardship when paying for them. (WHO, 2020).

Out of Pocket expenditure/spending. Payments are expenditures borne directly by a patient where insurance does not cover the full cost of the health good or service. They include cost-sharing, self-medication and other expenditure paid directly by private households. (OECD, 2009).

95-95-95 UNAIDS target. This a statistical model by UN where if the 95% of those living with HIV are tested and are aware of their HIV status, 95% of those tested are on treatment and 95% of those on treatment are virally suppressed then HIV pandemic will be contained. (UNAIDS, 2021)

Chapter 1 Background

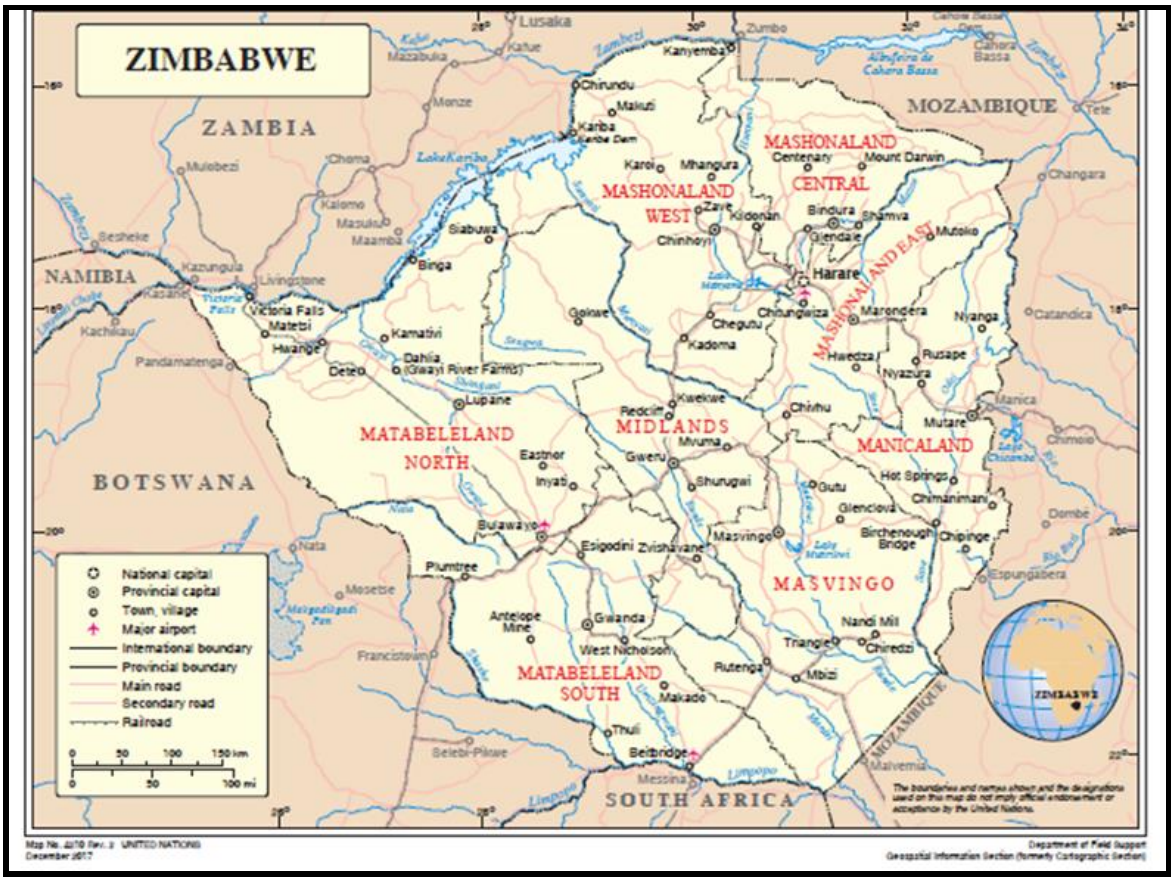

Figure 1. Map of Zimbabwe Source:
https://www.un.org/Depts/Cartographic/map/profile/zimbabwe.pdf

1.1 General Demographic Overview of Zimbabwe

Zimbabwe is a landlocked country which shares its borders with South Africa, Mozambique, Zambia and Botswana. The country is 390 757 km2 and has a population of 14,65 million of which 48% are male and 52% are female (World Bank, 2019). Zimbabwe like most African countries has a young population, an estimated 42% of the population is below the age of 15 years and 3% of the population is 65 years and above (Knoema, 2020). The Zimbabwe National Statistics Agency (ZIMSTAT, 2017) estimates that 68% of the population reside in rural areas and that the total fertility rate is 3.7%. The life expectancy in 2020 was 61.74 years, a 0.4% increase from 2019 (Knoema, 2021).

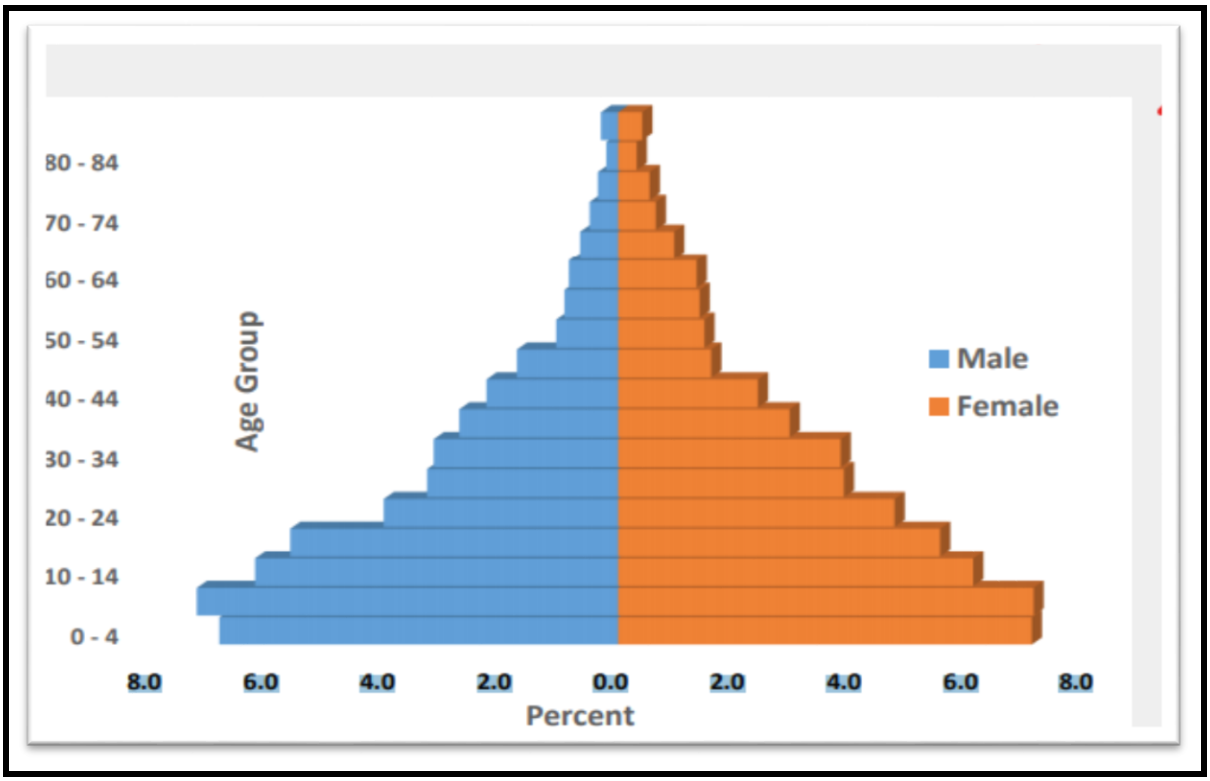

Figure 2. Population pyramid of Zimbabwe, source ICDS 2017.

1.2 Economic environment

Zimbabwe's economy has been in recession before the Covid-19 pandemic and with the pandemic it is expected to continue to contract, in 2020 it contracted by 8% (World Bank, 2021). Inflation rose to 838% in 2019 and since the Government introduced foreign exchange reforms the inflation rate fell to around 322% (AFDB, 2021; World Bank 2021). According to the African Development Bank (AFDB, 2021), Zimbabwe has to relay on domestic resource mobilisation and borrowing from non OECD countries because of its outstanding external debt ($10.5 billion) and collapsed talks with the International Monetary Fund (IMF), to help the country come up with a debt recovery plan. Despite these economic constraints, the Government of Zimbabwe aspires to be an upper middle income country by 2030.

1.3 Health and Epidemiological profile

Zimbabwe 's epidemiology landscape is characterised by a dual burden of communicable diseases and non-communicable diseases, high teenage pregnancies and acute public health outbreaks such as cholera (IHME, 2019; UHC-P, 2021). HIV remains the number one cause of disability adjusted life years (DALYS) with ischemic heart disease, stroke and diabetes being the 5th, 6th and 8th causes of DALYs in the country (IHME, 2019). There is need for concentrated efforts in the health sector if the Government wishes to address catastrophic health expenditure and progress towards UHC and the SDGs.

Maternal Mortality has been gradually declining from 614/100000 live births in 2014 to 462/100000 live births in 2019. The decline can be attributed to a number of measures such as ensuring that births take place in health facilities with skilled birth attendants, however much needs to be done if the country is to meet the 70/100000 live births SDG target. The Neonatal Mortality

rate has been unchanged in the last decade at 32/1000 live births against a target of 12/1000 live births (MICS, 2019).

A robust HIV programme has yielded positive results which if the trajectory does not change, the country can achieve the UNAIDS target to end the HIV pandemic by 2030[1] (US Embassy in Zimbabwe, 2020). The HIV prevalence amongst adults has been declining from 18.1% in 2005 (ZDHS, 2015) to 12.9% in 2020 (ZIMPHIA, 2020). With regards to the 95-95-95 UNAIDS target the statics for Zimbabwe indicate that 86.8% of all adults living with HIV are aware of their HIV status, 97% of those diagnosed were on Antiretroviral therapy (ART) and 90.3% of those receiving ART had suppressed viral load (Ibid).

1.4 Overview of the Health System

The Ministry of Health and Child Care functions as a provider of health services as well as a regulator of the health sector in Zimbabwe. The Primary health care approach was adopted in the 1980 (NHS, 2015) and that is the current approach the health sector is based on, yet funding patterns do not allude to this.

Post-independence the Government of Zimbabwe adopted a redistributive policy, Growth for Equity which saw an increase in public spending in social sectors such as health and education. During the post-independence era user fees were removed to improve access to health services. In the early 1990s the country implemented the structural adjustment program which saw a shift to a more liberalised economy and introduction of user fees with the exception of the poor (Sibanda & Makwata, 2017). In 2018 the former Minister of Health and Child Care Dr. Parirenyatwa made a policy pronouncement removing user fees for pregnant women, elderly and under 5s as well as reducing the price of blood in public health facilities (Chipunza & Mapani, 2018).

The health system is organised in a referral pyramid with the entry level being rural hospitals, health centres and rural and urban clinics. The first level of referral are district hospitals which are followed by provincial and general hospitals and the final level of referral within the country are central hospitals which offer more specialised care. The table below explains further the health system of Zimbabwe.

[1] Ending HIV pandemic by 2030 refers to more of containing the pandemic by ensuring a significant reduction in new infections.

Facility Type	Staff	Population Served	Types of Service Provided
Primary Level			
Community level	Village Health Workers	100 households	Mainly preventive and health services with minor curative and referral as appropriate
Rural health centers and clinics	2 to 4 technical staff (2 to 3 nurses, Environmental Health Teams), Nurse Aide and General Hand	5,000 to 10,000 people in rural areas Up to 40,000 people in urban areas	Both curative and preventive services including in-patient services (5 beds)
Secondary Level			
District Hospitals	30 to 53 technical staff and auxiliary staff	100,000 to 150,000 people	Both curative and preventive services including in-patient services with 25 to 50 beds, emergency surgical service and blood transfusion
Tertiary Level			
Provincial Hospitals	Over 100 technical staff	Over 500,000 people	Both curative and preventive services including in-patient services with 25 to 50 beds, emergency surgical service and blood transfusion in addition to in-patient care
Quaternary Level			
Central Hospitals	Over 300 technical staff	Over 1 million people	Specialized care

Table 1. Structure of the Zimbabwe health system, source Zimbabwe National Health Strategy 2016-2020

The Zimbabwe health sector is largely funded by public funds in the form of taxes and revenues collected on behalf of Government under the Consolidated Revenue Fund, external sources of funding are the second largest source of health funding. Private funding is through voluntary private insurance; which covers 10% of the population mainly through employment contribution and cooperate companies and out of pocket expenditure (MOHCC, 2015). The Human for Health Profile of 2009, estimates that 65% of the health services are provided by the public sector, leaving the reaming 35% to the for profit private sector and non-profit sector such as mission hospitals.

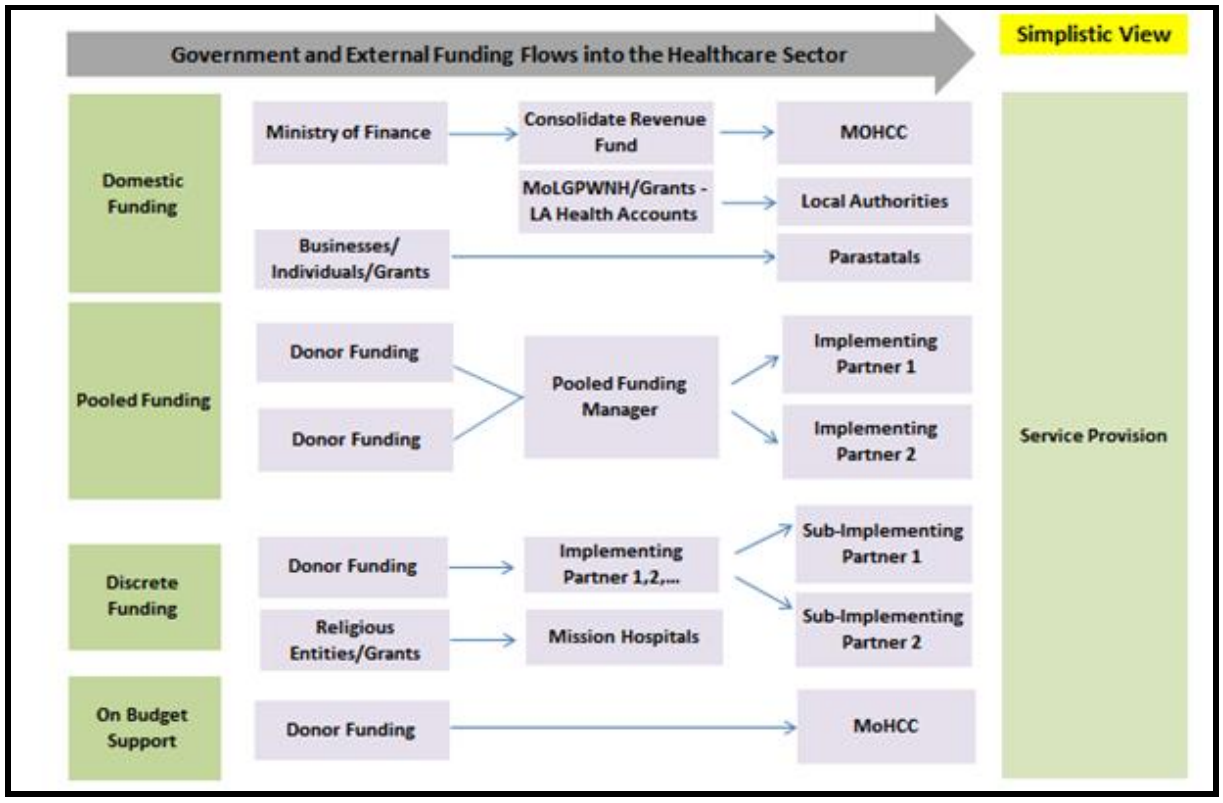

Figure 3. Zimbabwe Health Financing flows: Source, Zimbabwe Resource Mapping Report 2019.

Chapter 2 Problem statement, justification, objectives, methodology and limitations

2.1 Problem Statement

The World Health Organisation (WHO), defines universal health coverage (UHC), as "all people having access to the health services they need (prevention, promotion, treatment, rehabilitation and palliative care) without the risk of financial hardship when paying for them". According to WHO, an estimated half of the world's population do not access the health services they need and that about 100 million people get into poverty each year due to out of pocket expenditure on health (WHO, 2020).

The Zimbabwean economic crisis which heightened in the 2000s resulted in migration of skilled health personnel and a reduction of public spending on the social sector including health. Cuts in health expenditure resulted in the introduction of formal and informal user fees which reduced access to health care by the population, (Witter et al, 2019). The hyperinflationary environment and political instability has resulted in a frail health systems and low access to health care (UHC-P, 2021). In 2020, 49% of the population were classified as extremely poor, whilst in 2017 61% of the population lived on less $3.2 a day. In addition, there is widespread inequalities in wealth distribution in Zimbabwe, the GINI index for Zimbabwe in 2019 was 50.3% (World Bank, 2021).

In 1990 the UHC effective coverage index for Zimbabwe was 44.4% but it decreased to 34.3% in 2010 at the background of the 2008 political and economic crisis. In 2019 the UHC effective coverage increased by 5.1% to 54.5% (World Bank, 2021).

Zimbabwe's out of pocket spending on health (OOPS) has been gradually declining from 35% in 2012 to 24% in 2018. The decline between 2015 and 2018 has been relatively low from 25% t0 24% respectively. In 2015 out of pocket expenditure accounted for 25% of household expenditure and 7.6 % of the population incurred catastrophic health expenditure, (Wu Zeng, Lannes & Mutasa, 2018). The National Health Accounts for 2017-2018 revealed that some of the population was foregoing health due to inability to afford health care.

The Ministry of Health and Child Care developed the National Health Financing policy and strategy documents to guide the health sector in ensuring that the population is protected from catastrophic health expenditure and has access to quality and affordable health services so as to attain UHC by 2030 (MoHCC, 2016).

2.2 Justification

Jenkins (1978) as cited in Engeli and Allison (2016) defines public policy "as set of interrelated decisions taken by a political actor or group of actors concerning the selection of goals and the means of achieving them within a specified situation where those decisions should, in principle, be within the power of those actors to achieve". The WHO (2021), defines health policy as "health goals at the international, national or local level and specifies the decisions, plans and actions to be undertaken to achieve these goals". Policies are therefore Governments' way of addressing a public problem. In order to resolve a public problem, Government policies need to offer effective strategies that when implemented sustainable results are achieved.

The study is important because it will analyse whether the Health Financing Policy adequately addresses the challenges of low utilisation of health services and financial protection particularly amongst the poor as they are more likely to suffer from catastrophic health expenditure.

2.2.1 Study Questions

1. Does the National Health Financing policy adequately address how health financing for UHC can be improved?
2. How are other determinants of health financing out of the direct scope of the Ministry of Health and Child Care been addressed to ensure that UHC can be achieved.

2.3 Objectives

General Objective

To critically analyse Zimbabwe's National Health Financing Policy in order to ascertain the feasibility of Zimbabwe achieving universal financial protection by 2030 and reducing catastrophic health expenditure from the policy options stated and propose alternative policy options based on best practices from LMICs.

The objectives of the study are to:

1. Describe the current Health Financing Policy.
2. Identify best practices from other countries with successful health financing mechanisms for the informal sector and the poor.
3. Discuss challenges of the National Health Financing Policy.
4. make recommendations for achieving universal financial protection in the Zimbabwean health sector.

2.4 Methods and Analytical Framework

The main methodology of the paper will be literature review using secondary data. Search engines such as PubMed, Google Scholar and VU online library and snowballing will be used to search for peer reviewed articles and online textbooks. Grey literature from UN sites such as the WHO, World Bank and from the Government will also be reviewed. Only English language articles and full free access articles will be included. The search strategy will be limited to articles that are ten years, but older articles that allow for analysis for trends will be included. The literature review will be used to analyse the contents of the health financing policy and assess the feasibility of the policy objectives.

The conceptual framework for policy analysis by Walt and Gilson (1994) is going to be used. The framework for analysing public policy had been considered as a framework for analysis in this paper. The framework for analysing public policy, analyses policies from six dimensions of effectiveness, unintended effects, equity, cost, feasibility and acceptability (National Collaborating Centre for Health Public Policy, 2012). The framework however focuses more on the effects and implementation and neglects other factors such as the general macro political, economic and social factors that have an impact on the policy process.

The policy triangle was selected because of its ability to analyse policy from a holistic approach by addressing the what, who, why and how which are organised into content, context, actors and process Under context macro and micro political, economic and social factors will be analysed to ascertain how they influenced the policy process and their impact in future policies. The content will be analysed against the health financing mechanisms options for LMICs whilst actors will identify the roles of different actors in shaping the Health financing policy. Agenda setting and power dynamics will enable the understanding of the process aspects of the policy under analysis.

The Walt and Gilson framework will allow for understanding the policy environment and in-depth analysis of the rationale behind the policy objectives and options behind the Zimbabwe National Health Financing Policy. Under process the paper will not look into policy evaluation as the policy strategic framework was only developed three years ago. In the analysis of the policy, the paper will look at the thematic areas separately but in reality they occur simultaneously in the policy process.

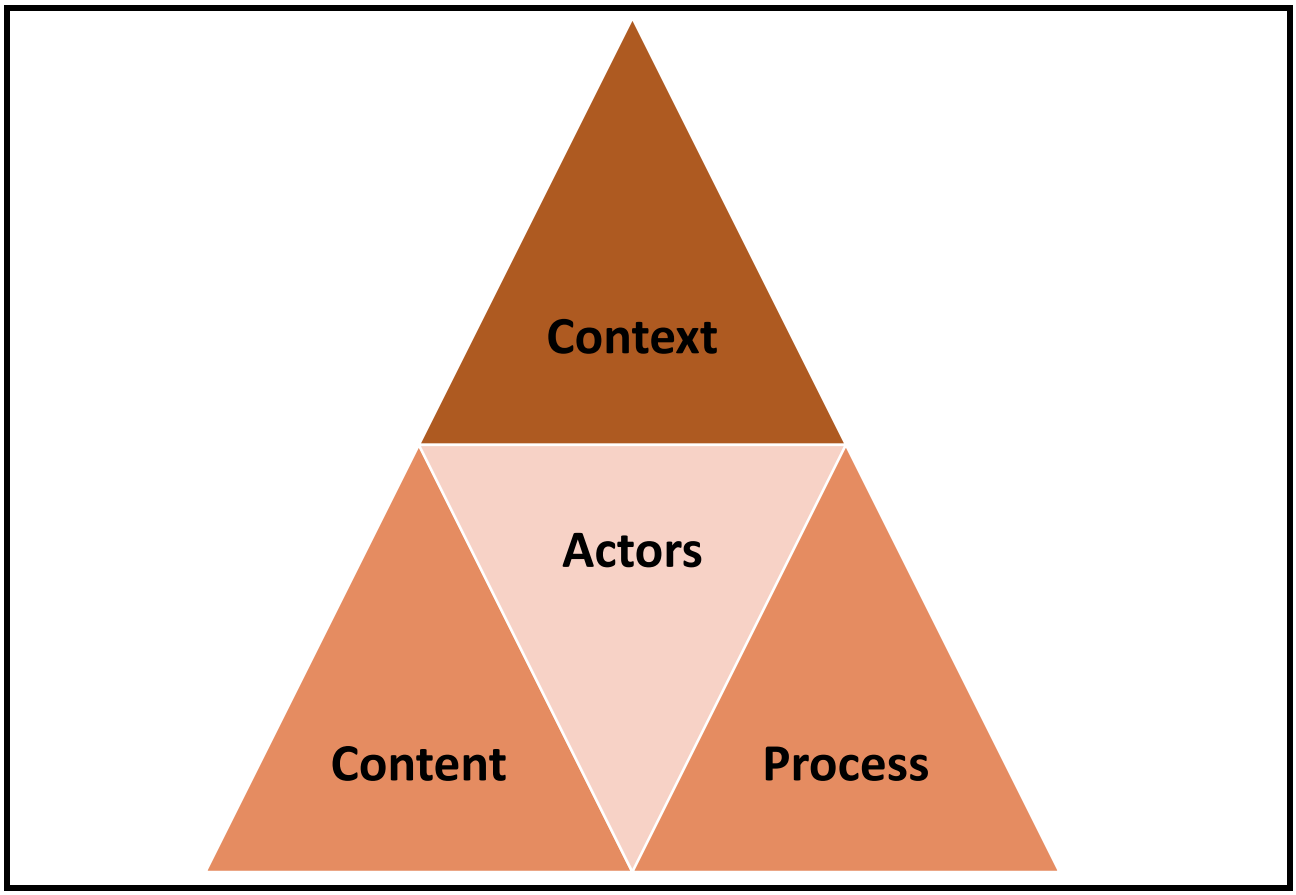

Figure 4. Health Policy Analysis Triangle, Walt and Gilson 1994

Chapter 3 Findings

3.1 Policy Documents

Zimbabwe has a National Health Financing Policy which seeks to achieve the following five objectives;

1.” Mobilize adequate resources for predictable sustainable funding of the health sector;

2. Ensure effective, equitable, efficient and evidence based allocation and utilization of health resources;

3. Enhance the adequacy of health financing and financial protection of households and ensure that no

one is impoverished through spending on health by promoting risk pooling and income cross subsidies

in the health sector;

4. Ensure that purchasing arrangements and provider payment methods emphasize incentivizing provision of quality, equitable and efficient health care services; and

5. Strengthen institutional framework and administrative arrangements to ensure effective, efficient and

accountable links between revenue generation and collection, pooling and purchasing of health services,” in order to steer Zimbabwe’s health system towards UHC (MoHCC, 2016).

A National Health Financing strategy was developed a year later in 2017 to guide implementation of the National Health Financing Policy (MoHCC, 2017). Apart from the National Health Financing policy there are a number of legislative documents that have some health financing components such as the Public Health Act that proposes a Public Health Fund (MoHCC, 2018), these will not be analysed as they are not policies. A strategy is an operational plan detailing what is going to be done by whom and when in order to fulfil the goals and objectives of a specific policy. A policy often leads to the development of an Act. An Act has set standards or norms that have to adhered to and deviation from the set standards and norms results in punitive measures which is not the case with policies.

3.2 Context

Policies are developed in multiple contexts such as change of government, economic systems, organisational and local cultures as well as the demographic profiles. The context will influence and shape the content of the policy, the policy process and the actors involved in a particular policy. This section will look at how the political, economic, demographic situations and the international environment played a role in the development of the Zimbabwe National Health Financing Policy.

The socio-economic and political environment in Zimbabwe has been mainly unstable prior to and since the development of the National Health Financing policy. Numerous factors, stemming from fiscal indiscipline, a blotted civil service and failure to service international debt amongst others are accredited to the raise of the Zimbabwean economic crisis. The payment of a once off gratuity of Z$50 000 by end of year in 1997 and the proposed monthly pension to the same group of Z$2000 which was not budget for was the catalyst of the economic crisis. Zimbabwe’s currency lost 71.5%

of its value against the US dollar in November 1997. The economic crisis prevailed from 1997 to 2008 only to reduce during the Government of National Unity(GNU). During the GNU the opposition were in charge of economic and social sectors which resulted in external confidence in these sectors and the country saw a period of economic growth (Kanyeze et al, 2017; Britannica, 2021).

The development of the National Health Financing Policy came at the backdrop of the economic blue print of that time, the Zimbabwe Agenda for Sustainable Economic Transformation (ZIM-ASSET), (MoHCC, 2016). The ZIM-ASSET was crafted at a time the country was coming out of the Government of National Unity and the ruling party was key in the development of the ZIM-ASSET as it is continuously referenced in the document. The Ministry of Health and Child Care took advantage of the window of opportunity, and submitted a whole sectoral plan from combating diseases, improving health infrastructure, accessing health technologies to health financing, (ZIM-ASSET, 2013). The ZIM-ASSET was labelled as a failure as most of the targets were not met, it was considered to be a policy document that lacked an implementation strategy and the consultative process was not extensive with key stakeholders (Kanyeze et al, 2017; Nyoni, 2014).

Reverting back to a single party government resulted in weakened economic performance. According to the World Bank (2021) inflation is expected to remain high in 2021 see figure 5 for trends in inflation rates for Zimbabwe including future projections. The High inflationary environment has resulted in the Minister of Finance and Economic Development calling for austerity measures and this contributed to weakened delivery of basic social services (Ibid), this results in reduced funding to the health sector and will likely increase out of pocket expenditure for health, possibility of impoverishment and catastrophic health expenditure for the poor.

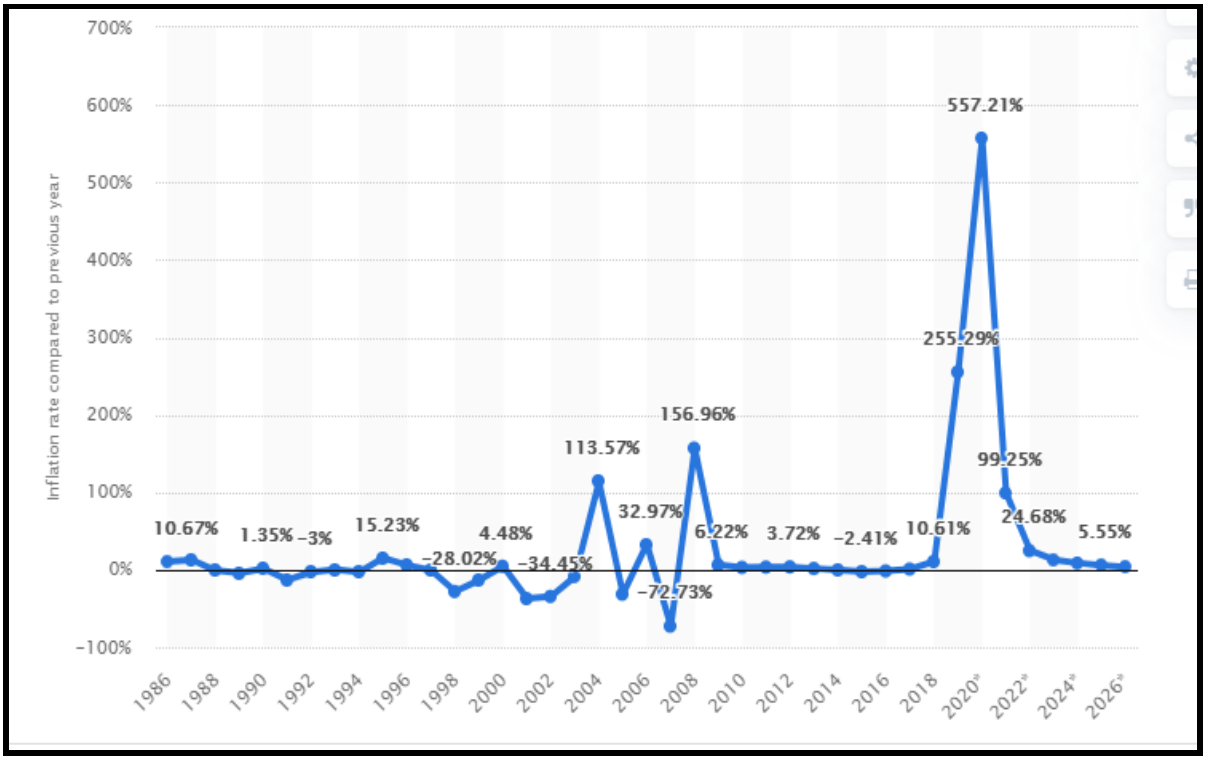

Figure 5: inflation trends for Zimbabwe from 1986 to 2026: Source: statista.com accessed 11/06/2021

Poverty levels are not expected to improve as the wages are not increasing at the same rate as prices and unemployment remains high. The poverty levels based on the population leaving on less than $1.90 a day increased from 21% in 2017 to 39.5% in 2019. One of the effects of Covid-19 on the country has resulted in more people being pushed into poverty, with figure being estimated to be 42.3% in 2020, (World Bank, 2021). High poverty levels increase the risk of catastrophic health expenditure for the poor or foregoing of health services which will result in poor health outcomes.

The health sector economy is impacted by the general fiscal space. Below is a table of the Zimbabwe public health sector financing trends from 2016 to 2021, the country has not reached the Abuja target of 15% allocation of the budget to be set for health. The Domestic General Government Health expenditure as a percentage of the GDP is 1% which is lower than the 5% target towards UHC (WHO, 2018). Employment costs continue to be high cost driver for the Government budget, in 2016 83.78% of the budget went towards this cost category (UNICEF, 2017), this reduces the amount of Government funds allocated for services including pharmaceuticals and equipment which can result in the costs of services being transferred to the patients.

Year	Domestic General Government Health Expenditure (GGHE-D) as % General Government Expenditure (GGE) against the 15% Abuja Target	Domestic General Government Health Expenditure (GGHE-D) as % Gross Domestic Product (GDP). The proposed target is 5% for countries to progress towards UHC.
2016	8.3	1
2017	6.88	1
2018	8.3	1
2019	8.9	1
2020	10.1	2
2021	13	-

Table 2: Budget allocation; Source: data from the Ministry of Finance and Economic Development.

Zimbabwe's purchasing parity power per capita has constantly been below the WHO target of $86 which is the minimum threshold required to finance towards UHC and financial protection and the Southern Africa Development Community (SADC) averages as shown in table 3 below, (World Bank, 2021; UNICEF, 2019). The Lancet Commission on Investing in Health, states that governments need to spend $50 per head to finance a high priority basic package of 108 interventions and a target of $100 per head for an essential package of 215 interventions to achieve UHC (Watkins et al, 2018). Schaferhoff et al (2019), state that in 2016 LMICs average government spending per head was $9 and when donor funds were added the total average spent per head was only $19.

Country Name	2000	2011	2012	2013	2014	2015	2016	2017	2018
Angola	42.09	108.73	105.88	118.33	94.90	87.59	80.92	85.92	69.06
Botswana	272.48	490.98	576.70	649.00	649.28	648.91	640.48	825.48	843.50
Comoros	17.42	24.48	12.93	14.81	14.75	20.26	18.45	14.51	12.43
Congo, Dem. Rep.	0.28	2.42	3.83	3.83	4.57	5.74	4.79	3.68	4.63
Eswatini	118.26	302.32	304.83	311.64	262.11	288.15	281.46	359.42	228.68
Lesotho	39.38	131.41	146.11	156.60	177.85	168.46	164.74	178.50	179.41
Madagascar	28.28	26.80	24.30	21.56	29.61	34.20	41.72	40.74	28.25
Malawi	17.43	17.81	14.92	24.06	26.66	32.78	33.81	37.08	34.51
Mauritius	145.52	293.74	331.76	358.82	479.06	480.17	533.14	548.39	595.75
Mozambique	5.85	13.76	14.46	18.43	22.49	24.59	22.56	23.66	24.94
Namibia	257.30	366.63	364.88	398.06	399.96	457.42	465.18	428.05	406.55
Seychelles	556.81	618.14	883.67	753.64	816.43	847.38	980.27	1052.83	1153.52
South Africa	211.21	497.06	532.22	539.72	557.61	579.09	574.54	584.84	610.43
Tanzania	8.34	28.86	27.49	29.22	31.21	34.07	45.74	47.30	48.30
Zambia	53.83	41.16	47.17	49.32	73.74	82.11	68.54	72.58	81.47
Zimbabwe	..	45.96	50.66	52.15	72.35	41.57	48.08	57.76	55.39
SADC Average	118.30	188.14	215.11	218.70	232.04	239.53	250.28	272.55	273.55

Table 3: shows SADC countries' domestic general government health expenditure per capita, PPP (current international $); Source: data from World Development Indicators, World Bank accessed 13/06/2021.

Raising Domestic resources is critical for increased funding in the health sector. Zimbabwe is ranked 157th out of 180 countries in the 2020 corruption index, a global indicator of public sector corruption. An estimated 25% of public service users in 2019 are reported to have paid a bribe in the previous 12 months (Transparency International, 2021). Illicit Financial Flows (IFFs) are estimated to have cost the Zimbabwean govern an estimated 12 billion US dollars between the period of 1985-2015. Corruption contributes about 5% of the revenues lost through IFFs (Transparency International Zimbabwe, 2021). According to Adeleke 2019 and Ortiz et al 2019, IFFs have an impact of reducing the government's revenue and resulting in social impact of the poor as these resources could have resulted in increased social spending and allocation towards health services.

Zimbabwe's health sector has been shrouded in controversies around corruption. There are limited studies of corruption in the health sector in Zimbabwe but most cases have been highlighted in the newspaper articles. In 2019, the Acting Managing Director for NatPharm, a parastatal company which procures and distributes drugs to public health facilities, was sentenced to jail for abuse of office for increasing health levy from 4% to 11% an action which would result in an increase in pharmaceuticals (Herald, 2019). Currently a Director in the Ministry of Health and Child Care is facing trial on charges of abusing covid donor funds by employing 28 of her relatives as community health workers and flaunting tender procedures (Herald, 2021).

Transparency International in a survey conducted in 2013 revealed that 65% of the respondents perceived the health sector to be corrupt or extremely corrupt and 22% of those that had used health services in 2012 reported to have a paid a bribe, (Chêne,2015). Corruption in the health sector deviates resources from intended use and beneficiaries mostly the poor who rely on public health services and results in lack of trust in the sector by the community and development partners.

World Health Organisation (2017) states that "health financing determines the ability of health systems to respond to health needs, spread financial risks and operate effectively and equitably". There are no strategies that address issues of service coverage from the health systems' perspective of human resources for health. Currently public health workers are paid by Government as highlighted earlier more than 80% of the budget goes to salaries. Despite the huge allocation to salaries the public health workers often go on industrial action citing poor remuneration addressing this will ensure services are available to people and they do not have to seek care from the private sector which might increases the burden of out of pocket on the poor and vulnerable groups.

International agendas have been known to influence national policies especially from resolutions passed at International meetings. The WHO provides overall guidance on health systems in order to respond to health challenges (WHO, 2017). The 2010 WHO report spearheaded a lot of LMICs to shift attention to UHC and health financing policies and this set the stage for member states to develop health financing policies in order to progress towards UHC. In addition, the WHO developed a guide on how to develop national health financing policy and strategy documents and what to consider and not consider when it comes to health financing (Kutzin, 2008; McIntyre D., Kutzin J., 2016; WHO, 2019).

International agendas such as the Sustainable Development Goals have also been a push factor for national Governments to come up with health financing policies as guidelines to "achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all" under SDGs target 3.8 (UN, 2021).

3.3 Content

Under this section an analysis of the policy objectives is carried out in order to ascertain whether they will manage to achieve the desired goal in this case which will be financial protection towards universal health coverage in Zimbabwe. Content within the health policy triangle refers to the contents of the policy. In this section the objectives, policy directions of the Health Financing Policy are analysed. The content is also influenced by contextual factors and actors as these will influence policy objectives and direction. Influential actors are able to steer the content of the policy to align to their interests through agenda setting which is highlighted in depth in the process section.

The goal of the Health Financing Policy is to move the country towards UHC as defined by the WHO. It seeks to provide financial protection, improve access to quality essential health services and access to safe, effective, quality and affordable essential medicines and vaccines for all citizens by 2030 (MOHCC,2016).

The main content focuses on the three key health financing functions of resource mobilisation, pooling and purchasing. Under each key function objectives and policy directions are spelt out.

The policy also covers governance focusing on transparency, accountability, fairness, collaborations and routine monitoring.

3.3.1 Resource Mobilisation and Revenue Collection

Resource mobilisation is the health financing function that focuses on how to raise or improve resources needed to finance health services towards UHC. According to McIntyre et al (2017) and Meheus et al (2017) raising more domestic resources is more desired and sustainable, whilst the World Report 2010 recognises that aid will still play an important aspect as a financing option for LMICs.

The health financing policy acknowledges the need for improved resource mobilisation and revenue collections which is sustainable and address inequities in accessing health services. Resource mobilisation is expected to adequately finance health services such as preventive, curative and research, finance a comprehensive benefits package and introduce mandatory prepayment financing (MoHCC, 2016).

In 2001 the African Heads of States and Government committed to allocating 15% of their national budgets towards the health sector and agreed to ensure the effective and efficiently utilisation of health resources (Abuja Declaration, 2001).

There are mixed feelings over the 15% Abuja target. McIntyre et al, 2017, state that calling for attaining of the 15% Abuja target has the potential to draw from other sectoral budgets in particular social sectors and this will have a negative impact on other social determinants of health, instead they call for a target of at least 5% of the GDP to be allocated to health supported by the $86 per capita spending in order for countries to progress towards UHC. The Health Financing policy has per capita threshold of not less than $60 per year and as one of its strategies it calls for the government to meet the 15% Abuja target (MoHCC, 2016). The Health Financing Policy does not mention the link of ensuring financing towards the other social determinants of health.

Another cited problem with the Abuja target is that only three countries on the African continent, Botswana, Rwanda and Zambia have reached the 15% Abuja target, (WHO Africa Regional Office, 2013). The Abuja target has additionally criticised for not taking into account the different levels of the economic development in Africa, as one stated “15 % of an elephant is not the same as 15% of a chicken”, (Gatome-Munyao & Olalere, 2020).

As highlighted earlier Zimbabwe’s public health is tax funded from the consolidated revenue fund and one of the policy directives is for the Government to meet the 15% of the national budget to be allocated to Health. Budget allocation to health is showing an upward trend towards the 15% Abuja Declaration target. In 2021 the Ministry of Health and Child Care was allocated 54. 7 million Zimbabwean dollars which is 13% of the budget 3% more than the 2020 allocation and 2% shy from the Abuja target (MoFED, 2020). The 13% allocation to health is coming at a backdrop of fighting the covid 19 pandemic and filling vacant posts in the health sector as a mitigation measure for reducing fatigue amongst health workers in the pandemic (Rushwaya, 2021).

As of 2018 the Current Health Expenditure (CHE) as percentage of the GDP was 4.7% a decline from 5.8% in 2017. Zimbabwe’s per capita health spending in purchasing parity power (PPP) was $55 in 2018 against a target of $86 for 2012 and $114 by 2030, (WHO, 2021).

Evidence has indicated that, mandatory prepayment systems which are predominantly tax based can improve access to health services and therefore progress towards UHC (McIntyre, 2012; Kutzin, 2016). The National Health Financing policy states that private insurance should continue being voluntary but it will cover services not covered in the minimum benefit. Equity issues are addressed if private insurance is acting under a specified complementary role (Ibid).

The importance of meeting the various funding caps or targets increases the pool fund and increases redistribution of cross subsidies which would mean the poor can be covered through Government subsidies, the current situation for Zimbabwe means the country is not investing adequately towards UHC and thereby the population particularly the poor are not having access to affordable and quality health services.

3.3.2 Pooling

Fragmentation of pools reduces the effectiveness of risk pooling as well as the size of the fund, a larger health fund results in high potential of redistribution of cross subsidies, (McIntyre and Kutzin, 2016; Mathaeur et al, 2019).

The policy objective under pooling is to offer financial protection by promoting risk pooling and income subsidies within the health sector. This is envisioned to be achieved through the development of new pooling mechanisms and strengthening of existing pooling mechanisms, introduction of a national mandatory prepayment scheme as well as separation of provision and purchasing functions (MoHCC, 2016).

Reforming pooling arrangements requires time and institutional capacity, in addition because pooling has a redistributive effect it becomes highly political understanding the political economy of the country is vital to the success of the reforms (Mathaeur et al, 2020). In order to understand the political economy a mapping and engagement of stakeholders is important in developing reforms to the pooling system in Zimbabwe.

Zimbabwe's pooling arrangement can be classified as population segmentation through different pools for different socio-economic groups (Mathaeur et al, 2019). Civil Servants have a specific insurance scheme and private sector employees may have access to private voluntary insurance through their employer contributions. Some of those in the informal sector voluntarily join private health insurance and those who cannot afford private insurance and the poor and vulnerable are expected to be covered under the budget of the Ministry of Health and Child Care. A group of development partners have pooled resources under the Health Development Fund, however the pool is managed by UNICEF and UNFPA (UNICEF, 2021) and not through direct budget support.

Mandatory prepayment schemes can effectively offer risk pooling due to diverse mix of health risks and cover catastrophic expenditure due to illness however they tend to be complex in development and implementation. National insurance schemes also require an increase in general domestic revenue (McIntyre et al, 2018; Mathaeur et al 2019; WHO, 2010). According to Mathaeur (2020), for compulsory financing schemes to be effective in the redistributive capacity, there is need for subsidisation for the groups that cannot pay contributions to the scheme. According to Chemouni the mandatory aspect of the Rwandan CBHI is only in intent as there is no enforcement and this is also has been proven in Ghana, (Nsiah-Boateng et al, 2018).

A national health insurance scheme might be a challenge to set up in Zimbabwe due to an economy that is continuously undergoing crises and its informal nature thereby reducing the Government's capability of sustainably subsidizing for the poor and vulnerable groups.

Financing arrangements proposed in the Health Financing policy include Community Based Health Insurance (CBHI), Social Health Insurance and a National Health Insurance. Community Based Health Insurance is a financing scheme where communities pool resources for health care and are usually voluntary in nature (WHO, 2020). A National Health Insurance model has the government as the single payer for medical procedures through a government run insurance program which all citizens contribute into whilst the services providers are private (verawholehealth, 2021). Social Health Insurance is "financed primarily through mandatory earnings related contributions levied on formal-sector workers", (Wagstaff, 2020).

Zimbabwe's informal sector is estimated to be 94.5% and unemployment rate of 11.3% in 2015 (The Economist Intelligence Unit, 2015) the government opted for a Social Health Insurance as a financing option for health services. SHI will depend largely on a country's level of economic development, development of the banking sector and a large formal employment sector, (Normand, Weber & World Health Organization, 1994). The biggest challenge with SHI in sub Saharan Africa is the enrolment of the informal sector as such is the case with Ghana which had an enrolment of 35% of the population 13 years after its inception (Nsiah-Boateng et al, 2018). Witter et al (2000), highlight that social health insurance can be impacted by economic down turn as this affects employment and contributions to the insurance scheme.

According to Doherty (2019), the Parliament of Zimbabwe rejected a Social Health Insurance Scheme for those formally employed in the early 2000s citing that the economic situation was not feasible for such a scheme.

3.3.3 Purchasing

Literature has shown that a resource allocation formula when linked to a country's health benefits package has the potential of creating efficient and equitable allocation of funds to local authorities (McGuire et al, 2020), this promotes active purchasing as the services to be bought are linked to the resources available. Currently the allocations to Provinces is not based on any resource allocation formula or epidemiological profiles but the resources are equally divided across the eight provinces which put the rural provinces at a disadvantage as their needs are greater and more specific compared to urban areas due to colonial legacy inequitable development of health services between white and black settlements.

According to RESYT, 2014 strategic purchasing links the revenue collected for health and the provision of quality services making countries progress towards UHC. Provider purchaser split can encourage active purchasing which results in efficiency and quality service provision. There is debate whether purchaser provider split is the route to go, countries such as New Zealand had to abandon the purchaser provider split because of high transaction costs, Ham, 2008. Simkins (2016) in a policy brief on whether South Africa should employ a purchaser provider split argues that weak economic growth will prohibit the setting up of such mechanism and that it runs a risk of being unresponsive and highly politicised. Wagstaff (2010) also states that cost savings done due to purchaser-provider split can be eroded due to the high administrative costs associated with such an arrangement The 2010 WHO World Report also indicates that implementing payment

methods such as capitation and diagnostic related group can reduce inefficiencies in a health system.

For strategic purchasing to be effective there is need for organisational capacity. Hanson et al (2019) the element of organisation capacity is often neglected yet it is necessary for the successful implementation of health reforms. The National Health financing policy calls for strategic purchasing to ensure quality, equitable and efficient health services. Actions to be taken include but not limited to developing a resources allocation formula based on epidemiological needs of the various geographical regions, separation of purchasers and provider roles and a mix of provider payment mechanisms amongst other options (MoHCC, 2016).

3.4 Process

The policy process is the whole process of developing and implementing a policy. In this paper the stages model is going to be used to analyse the process of the National Health Financing policy.

The stages heuristic model analyses the policy process through four stages which are agenda setting, policy formulations, policy implementation and policy evaluation. The assumption is that policy process is carried out in rationale manner (Buse et al, 2012). The Kingdon Model (2003) as cited in Mhazo and Maponga, (2021) argues that an issue is put on the policy agenda after the problem stream which is responsible bringing attention to problems that can be deemed to be policy worthy, the solutions stream which comes up with solutions to the problem and the political stream meet. These three streams meet when there is a political window opens such as a change in a Minster of change in government or through the actions of the actors in the solutions streams.

Zimbabwe's policy process entails the sector Ministry in this case the Ministry of Health and Child Care will be used as an example, engaging with key stakeholders in a consultative process which will culminate in a draft policy that is submitted to the cabinet inter-Ministerial committee for health. The Cabinet inter-ministerial committee on health will give inputs and send it back to the Ministry of health and Child Care who will affect the changes and submit it to a full cabinet sitting. Cabinet will make inputs and sent it back to the Ministry of Health and Child Care. If the policy gets endorsed by Cabinet, it will be then launched. Figure 6 illustrates the policy process in Zimbabwe (ZEPARU,2012).

The policy development process is stated as being highly consultative in the National Health Financing policy, "the development of this policy was highly consultative" (MoHCC, 2016, pg. 1). Zhou and Hardlife (2012), describe the policy process in Zimbabwe from the period of the GNU to date[2] to be top-down, exclusive and short range in focus. The development process was a top –down process, with the Ministry of Health and Child Care setting up a technical working group (TWG) on UHC to spearhead the policy development process. Stake holders that were not part of the TWG contributed to process through being consulted at workshops and this includes the community.

Policies are either public driven, that is the public can push for government to develop a policy to address the public problem or they can be as a result of international agreements the country is

[2] The time line reflected is the time the article was written which was 2012 but the statement is reflective of current policy process,

signatory to. Health Financing Policies as highlighted earlier in the context the National Health Financing policy was a result of international agreements or resolutions at the WHO World Assembly meetings, which the Government used to set the agenda for the policy. In the context section of the National Health Financing Policy it states fulfilling international obligations as one of the drivers for developing the policy (MoHCC, 2016).

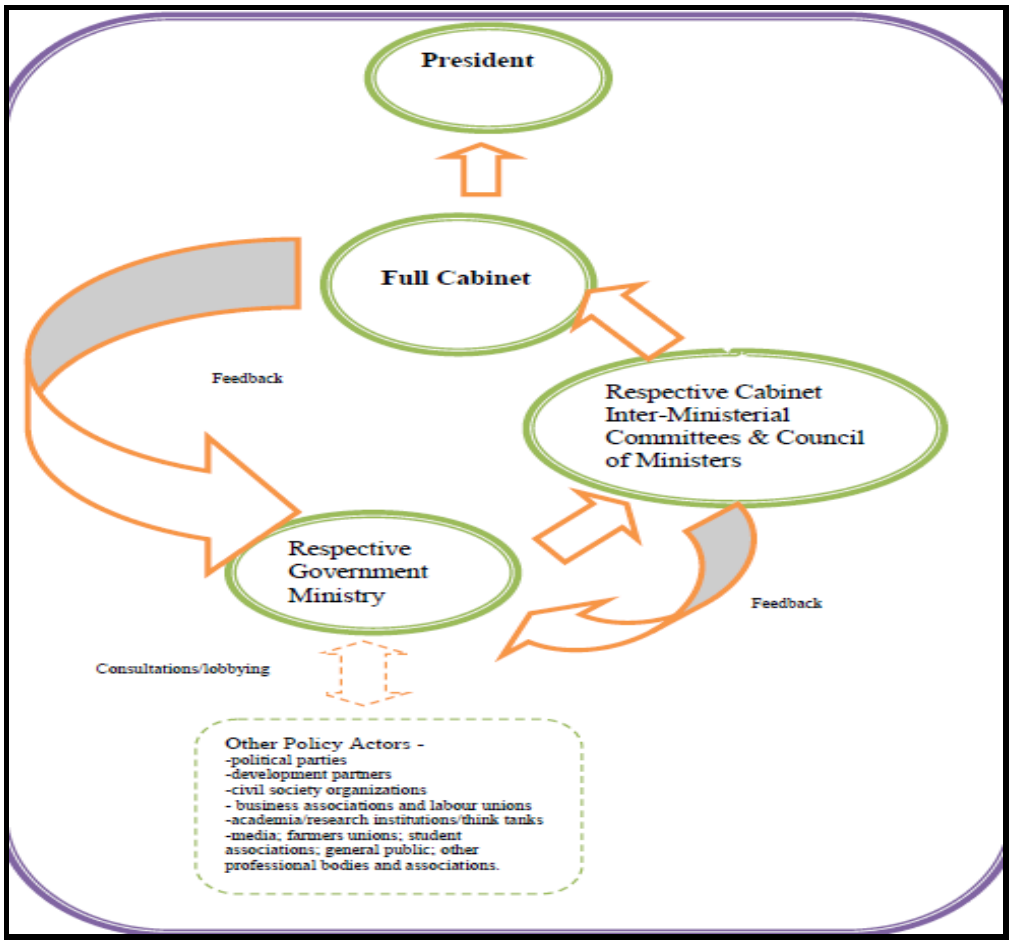

Figure 6: Policy making process in Zimbabwe, Source ZEPARU.

Gautier and Ridde (2017), categorised government ownership to health financing policies according to agenda setting, formulation, funding, implementation and evaluation. In cases where funding was provided by the donors, the donors tend to have power on policy direction such was the case of Program Based Financing in Rwanda and Burundi where government did not show ownership at the inception but it was pushed through international donors and the World Bank. This is a similar to Zimbabwe where the World Bank was lead in setting the agenda for Results Based Financing (RBF) agenda though government took a lead in the formulation and how implementation will take place (Witter et al, 2019).

The wide number of actors in the health sector and their diverging interests as well as Sub Saharan countries' dependent on foreign aid tends to limit the governments political voice and power in

ownership of health decisions and policy direction. International financial institutions set conditions for accessing financial assistance and some of these conditions can influence a government's policy direction or timeline for adopting some policy decisions, (ibid).

The problem identification was conducted through an analysis of the Zimbabwe health system financing arrangements that were in place and noting the challenges that were resulting in poor financial protection and other health outcomes (MoHCC, 2016; MoHCC, 2017).

A Health Financing Strategy has been developed to ensure the implementation of the Health Financing Policy, with a time frame for implementation set at 10 years. Proposed institutional arrangements for the Ministry of Health to ensure that objectives set in the policy are achieved are even highlighted in the health financing policy (MoHCC, 2016). Implementation processes should go beyond the development of strategies but also an analysis on the feasibility of implementing policy objective in this particular policy it is prudent to analyse the availability of the resources both financial and the technical know-how.

Political will is cited as an important aspect of the policy process as this will lead to commitment of resources to ensure the implementation of the policies. Chemouni (2018) in the analysis of CBHI schemes in Rwanda highlights that once the executive arm of the Rwanda government was interested in the CBHI the Ministry of Health had easy access to the resources required for the programme.

The WHO World Report 2010 states that political commitment is important and clear steps towards UHC spelt out otherwise UHC becomes a mere slogan. UHC is slowly becoming a slogan in Zimbabwe. In 2019 the then Minister for Health, Dr. Moyo stated that the country was at advanced stages of setting a national health insurance and the scheme would be in place by January 2020 (Chipunza P, 2019) yet two years later the country does not have a national health insurance in place. This indicates that the resources to establish a national health insurance scheme are not available and the problem is kept on the agenda because it is an issue that is now used for political popularity and is now a slogan amongst politicians.

3.5 Actors

In developing policies different actors have different interests in the agenda and they participate in the process to influence the direction of the policy as well as safe guard their interests. It is key to ensure that all critical actors are involved as this can determine the effective implementation of the policy. In the Policy Health Triangle actors are at the centre of policy making. Actors can influence the content of the policy and the policy process, whilst the context can also impact on decisions taken by actors.

A variety of stakeholders participated in the policy making process, with roles varying from being members of the technical working group, technical expertise and financial support. Other stakeholders participated through attending consultative meetings, though these are not explicitly mentioned by organisation but rather grouped and these are government ministries, civil society, labour, industry and development partners (MOHCC, 2016).

The policy formulation process missed key players in the health financing sector these are the communities themselves as they are both potential financing contributors through the proposed health financing models and users of health services and the private sector as they can play key

roles in complementing government health financing initiatives thereby contributing to progress towards UHC.

Below is a table showing the actors involved in the making of the Zimbabwe National Health Financing policy, a look at the actors involved reflects a top down approach.

Actor	Role
Local Ministry of Health and Child Care	The Members from the Central level were both members of the technical working group and coordinating the process particularly those from the Policy and Planning directorate. The Provincial Medical Directors were members of the technical working group their membership is based on their positions.
National Social Security Authority (NSSA) Ministry of Finance and Economic Development Ministry of Public Service, Labour and Social Welfare	The three government entities were made members of the TWG so that they could buy into the proposed financing activities.
International DFID EU UNICEF UNDP WHO Training and Research Centre (TARSC) CHAI World Bank	The actors were members of the technical working group. CHAI and World Bank were explicitly mentioned as providing both technical and financial support to the process.

Table 4. Actors in the National Health Financing Policy. Source: Zimbabwe National Health Financing Policy 2016.

Chapter 4 Best Practices

This chapter will look at Rwanda and Thailand as best practices towards universal health financing for its citizens and highlight lessons Zimbabwe can draw from the two countries to achieve universal financial protection for its citizens. The two countries were chosen because they have managed to offer coverage to the informal sector and the poor which is fundamental in ensuring the poor and vulnerable do not experience catastrophic health expenditure and this is currently a challenge in Zimbabwe. Whilst Thailand is a middle income country its inclusion is based on the Government of Zimbabwe's aspiration of being a middle income country by 2030, so it is important to look at experiences of a middle income country towards UHC. Analysis of the best practices will be based on the Walt and Gilson policy framework.

4.1 Rwanda

Rwanda has the highest health insurance coverage (87% when including CBHI, government employee health insurance schemes and private schemes) in sub Saharan Africa. There are three health financing mechanisms which are mandatory CBHI, mandatory SHI funded through contributions from employee payroll taxes and tax based financing from the Ministry of Health budget, (Chemouni 2018). Rwanda's high health insurance coverage is attributed to the coverage of the poor and informal sector through CBHI scheme. In 2018 OOPs as a percentage of current health expenditure was 11% compared to 24% for Zimbabwe (WHO, 2020).

Rwanda was selected as best practice as Zimbabwe is considering to implement CBHI as one of its financing mechanism for health and Rwanda is a country which has successfully implemented CBHI.

The WHO, 2021 has indicated that the following have to be in place for CBHI to progress towards UHC:

- Mandatory coverage to the population;
- General government revenues to subsidize coverage of vulnerable and poor people;
- Larger/more diverse pool (for example, by increasing the number of enrolled people, pooling beyond local pools, or a single national pool); and
- A strong and explicit role (including incentives) of local government authorities in enrolment.

4.1.1 Context

After the civil war in Rwanda, the government focused on economic and social development with the assistance of development partners (Francois, et al, 2005). The focus on social development resulted in health reforms including health financing and the emergence of CBHI amongst other health insurance schemes.

As highlighted earlier on political buy in from the executive contributed to the successful implementation of CBHI in Rwanda as the Ministry of Health was readily availed needed resources towards the financing scheme. International aid agencies also played a crucial role through financing the CBHI scheme (Ibid; Ministry of Health, 2010; Iyer et al, 2018).

According to Iyer et al (2018) the government of Rwanda discouraged the implementation of health programs by non-governmental organisations and this resulted in development partners funding the government directly for health programs. The government of Zimbabwe will need to

demonstrate that it is capable of fiscal discipline and create trust into the government by development partners to receive on budget support. As highlighted earlier on in the paper additional on budget support will increase the pooled funds and increase the risk sharing and reduce duplication of activities.

4.1.2 Actors

The actors in the CBHI were the community, central and local government, private health insurance and development partners. Rwanda's experience with CBHI revealed that community engagement and participation in the design of the CBHI schemes was instrumental in the success of the pilot project and eventual scaling up whilst the private medical insurance also contribute about 5% of their revenue towards subsidising the poor in the CBHI (ibid).

Government through the Ministry of Finance and Ministry of Health functions as a regulator and financing agent in the health insurance scheme of Rwanda, whilst the Rwanda Health Insurance Council has an advisory role. Local authorities and community health-care workers in were incentivised to support enrolment into CBHI and it was included as part of their key indicator in the performance based management system, this resulted in high enrolment (Makaka et al, 2012).

Development partners played the role of technical and financial assistance. The development partners financially supported the CBHI to cover the indigent and technical assistance in the design and implementation of the CBHI model for Rwanda. Figure 7 below shows the structure of Rwanda's health insurance.

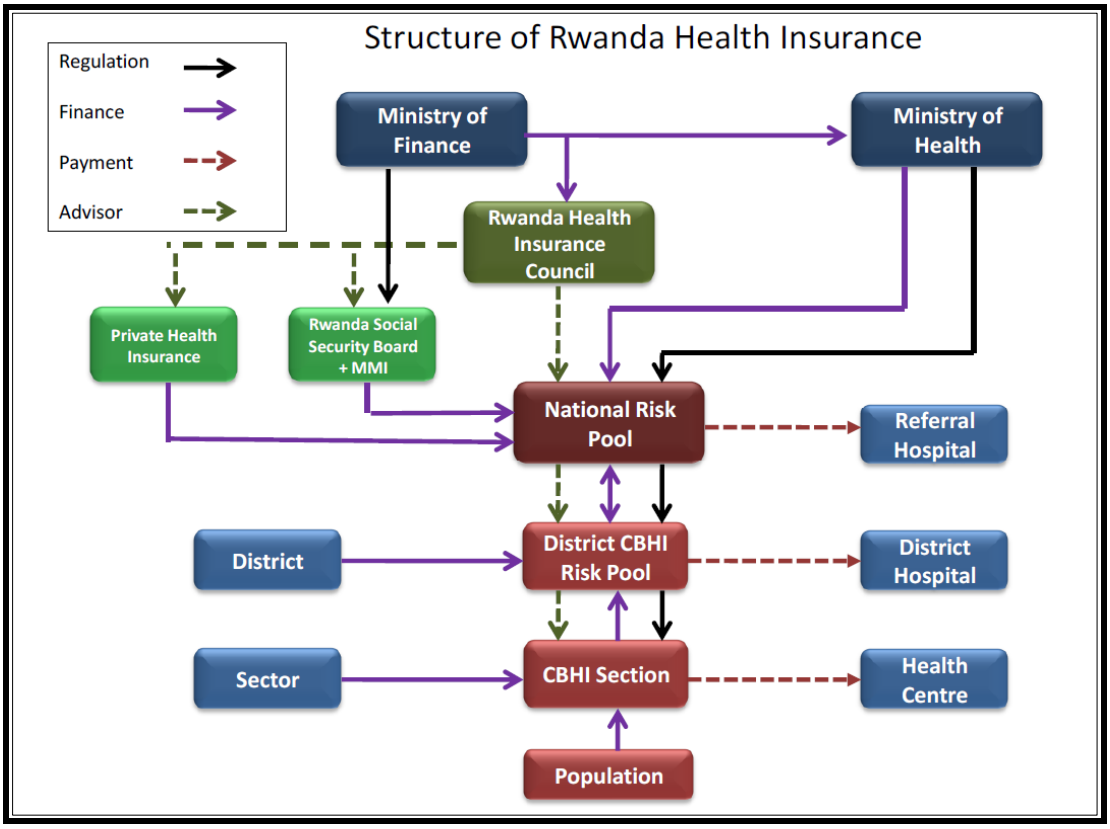

Figure 7: Source Ministry of Health CBHI Policy 2010.

4.1.3 Process

Insurance schemes that are mandatory tend to result in more enrolment. The CBHI in Rwanda evolved from a voluntary scheme to a mandatory scheme anchored on a law in 2018. Since the CBHI scheme became mandatory enrolment increased. It should be noted that in practice there is no enforcement of the law which makes the CBHI practically a voluntary insurance.

The process of setting up the CBHI was highly consultative with the communities being involved in decision making and in selecting models guided by technical experts from the Ministry of Health and development partners (Chemouni, 2018). According to the Ministry of Health, 2010, communities are also involved in the management of CBHI and they are part of the CBHI mobilisation committee through an election of members by the communities and the tenure is two years which can be renewable.

The two lowest wealth quintile in Rwanda and exempted groups are covered through Government subsidies and external financing (Chemouni,2018; WHO Africa Region, 2013). The community also plays an active role in identifying those that need to be exempted from paying premiums and "Rwanda has invested in a stratification process that has systematically identified poor groups to enable them to access all social programmes in the country, not just health insurance" (Fenny et al 2018).

Research was integral part in the design and development of the CBHI scheme. Payment modalities have been evolving in the CBHI in Rwanda in order to address inequities in subscriptions. The flat rate was found to be regressive as the poor could not afford the $2 contribution and in order to ensure that the poorest households are not excluded a tiered system was introduced, where contributions were based on the ability to pay (Chirwa et al, 2021; Kalisa et al, 2016).

4.2 Thailand

Thailand is a country that has achieved universal financial protection for its population (Piya, 2013). Health financing for services is based on Social Security Scheme which is financed by employers, employees and Government, Civil Servant Medical Benefit Scheme which is tax funded and offers health insurance to civil servants, three children under 18 years, parents and spouses and the Universal Coverage Scheme (UCS), which covered by Government and household contributions, (Viroj et al, 1999). For the purpose of this paper the focus is going to be on the UCS as it offers financial protection for the poor which are more likely to suffer catastrophic health expenditure compared to the non-poor.

4.2.1 Context

In its push towards universal health coverage, the Thailand government embarked on drive to ensure full geographical coverage, through recruiting rural students into medical and nursing and placing them in their home towns and a mandatory placement of three years in district facilities for those that would have graduated from public facilities in medicine, pharmacy and dentistry. In 2000, 99.3% of births were attended by skilled personnel; 97% and 94% of children under five years old were covered by DTP3 and measles vaccine, and there was a 79% contraceptive prevalence rate (Viroy et al, 2019).

To ensure the effective and efficient running of health insurance schemes, a purchaser provider split was implored. The National Health Security Office (NHSO), was established through

legislation, with a mandate to register beneficiaries and service providers as well as administer the fund and pay claims according to the regulations set out by the National Health Security Board. In addition, the purchaser provider split resulted in strategic purchasing, the Ministry of Health became a contractor for the National Health Security office. Private sector is also contracted as a subcontractor by contractors to provide primary care, prevention and promotive health services. Payments for services were shifted from budget towards capitation and diagnosis-related group, (Hanvoravongchai P, 2013).

4.2.2 Actors

The main actors in the reform of Thailand's health financing were government through the politicians and the technocrats within the Ministry of Health, (Hanvoravongchai P, 2013; Viroj et al, 2020). There is mention of engagement of stakeholders such as NGOs but their roles are not explicitly mentioned. Community engagement is not clearly spelt out.

The success of the NHSO to increase access to services, offer financial protection and effective monitoring to ensure sustainability has been centred on the technical expertise of the technocrats (Hanson et al, 2019).

4.2.3 Process

A key feature with Thailand was the decision to start covering the poor and the informal sector as often (Ibid) the resources to establish a health financing scheme that covers the entire population at once are a challenge in middle income countries. The Zimbabwean government might consider starting by covering the two low level wealth quintiles and the informal sector that cannot contribute to a health insurance scheme. However, it is important as coverage widens to ensure the different schemes enjoy the same benefits so as to address health inequities.

OOPs as a percentage of current health expenditure was 11% in 2018 (Ibid). Thailand managed to significantly reduce catastrophic health expenditure due to a comprehensive benefits package and a non-requirement of co-payments at the point of health services (Viroj et al, 2020). Domestic general Government expenditure on health per capita based on PPP for Thailand increased from $194 in 2004 to $551 in 2018 (Knoema, 2021). An indication that there is need to have adequate resources to ensure sustainability of health insurance schemes.

Chapter 5 Discussion

The main objective of this paper is to analyse whether the Zimbabwe National Health Financing Policy's objectives will translate into financial protection in reduced catastrophic health expenditure amongst the citizens predominantly amongst the poor and ensure that the people of Zimbabwe have access to needed quality care.

The main challenge that Zimbabwe needs to address is the economic situation which is strongly linked to the political situation. The general fiscal space within the country is very low and this results in poor investment in social sectors. Political will should not only extend towards UHC, it should reflect in dealing with corruption in both the general government system and the health sector specifically and in reduction in IFFs. Improving the general fiscal space will result in more resources in terms of actual monetary allocation and create a sustainable environment for health financing.

Rwanda managed to get development partners to invest directly into the Ministry of Health and not implement programmes through NGOs this increases the fiscal space in health as administrative costs for implementing partners are removed. Another interesting lesson from Rwanda was the ability of the Government to include CBHI in the Global Fund Grant by showing the linkage between the improved health outcomes and insuring the targeted population. The Ministry of Health and Child Care will have to deal with corruption in the health sector decisively if it wants to increase confidence in the development partners and other investors in the sector. An ethical health system with a proven record of good governance can result in on budget support despite sanctions.

Various literature reviewed identified political will at the highest level of Government as a crucial component to the successful implementation of health financing reforms. In both Rwanda and Thailand, the interest of each respective executive arm of government made it possible for the insurance schemes to be implemented and financial resources to be availed. An understanding of the political context is critical so that policy makers in the health sector can strategically leverage on political windows of opportunities. The current Minister for Health and Child Care is the Vice President and the technical experts can leverage on this by advocating for evidence based health financing interventions as the Minister has a direct ear of the President.

The policy focuses on both a capita spending and meeting the Abuja declaration as a means of increasing resource towards the health sector. The per capita threshold that the policy sets out should however ensure that Zimbabwe spends enough/ on health (at least $86 per capita) and an allocation of at least 5% of the GDP towards health, the health sector is guaranteed to make progress towards UHC as this a cap based on a costed core primary health care services. However, the policy sets the target at $60 per capita based on a minimum core package. The Ministry of Health should be setting the capita at the agreed level of $86 as this is evidence based to ensure UHC and reduce out of pocket spending. Another advantage of setting the capita spending at $86, the best alternative to the negotiated agreement with the Ministry of Finance will not be too far off from the $60 target cited in the policy.

Thailand has proved that efficient use of resources can result in the improvement of health service utilisation, reduction of OOPS and subsequently catastrophic expenditure amongst the poor. Given the constrained general fiscal space, improving on efficiencies in the health system can yield

positive health outcomes and improve the country's progress towards UHC. The Ministry of Health and Child Care can take the first step towards by developing a resource allocation formula so that funding is allocated on needs and not historical patterns or general budget allocation.

Zimbabwe's policy development process presents an opportunity for a sector developing a policy to get the attention of the executive arm of government. The Ministry of Health and Child Care should follow the process of policy development in Zimbabwe, so as to ensure that the policy captures the attention of the President who chairs Cabinet. Presenting policy proposals in Cabinet will also provide a way to engage with the Ministry of Finance without it feeling like its decisions for financing are being taken away because they will be part of the Cabinet process. Cabinet approval of a proposed policy thereby also commits resources towards the implementation of the policy. The process however does not involve community participation at the centre of the policy making process, this reflected in the role the community played in the development of the National Health Financing Policy.

In the Nairobi Declaration of the Sixth Tokyo International Conference on African Development (TICAD VI) (2016), the African Heads of States emphasised the need of country ownership and community led health systems that are supported by policy makers. The private sector and the community should have had been represented in the TWG which was the key group in formulating the policies. Communities' acceptance of the policy will be key especially in the setting up of the National Health Insurance, CBHI and the Social Health Insurance and this also builds public sector confidence as was evidenced in the Rwandan CBHI scheme. Community participation is also important because it allows for the development of policies that reflect the health needs of the community.

Mandatory health insurance has proven to be a means towards UHC. Literature has revealed that in most LMICs that have adopted mandatory health insurance, there is lack of enforcement during implementation. The lack of enforcement has not had an impact in Rwanda where as in some African countries this results in poor enrolment or opting out of the insurance scheme. The latter will hold true to Zimbabwe, if there is no enforcement of the law, people will not be obliged to join and the schemes can suffer from low enrolment thereby not improving financial protection for the poor and vulnerable.

From the Thailand case, the technical expertise of Ministry of Health officials was the key driver in translating the political will for UHC into reality. A lesson from Rwanda also point out to the importance of evidence based intervention for the successful implementation of health financing reforms. From the Thailand case, the technical expertise of Ministry of Health officials was the key driver in translating the political will for UHC into reality. A lesson from Rwanda also point out to the importance of evidence based intervention for the successful implementation of health financing reforms. An audit of the currently available skill sets is required to identify technical expertise gaps. This will enable tailor made capacity building needed for the health sector financing reforms to be implemented successfully.

More studies will need to be carried out with regards to the purchaser-provider split so as to analyse if it is effective in improving health services provision and utilisation. Literature agrees that it comes with high administrative costs and this is of concern especially in LMICs that are already grappling with a small health fiscal space. Studies could center on how to improve purchasing in developing countries without diverting much needed resources into setting up such institutions.

Limitation of the study

There was some limitation to data, for instance the figure for catastrophic expenditure is from 2015 based on the assumption that the low reduction in OOPS from 25% in 2015 to 24% in 2018 will result in catastrophic expenditure not improving. Another limitation of the study was not analysing the implementation of the Health Financing policy this is due to the infancy of the Health Financing Strategy. Researchers might decide to carry another policy analysis of the Health Financing Policy after 5 years of implementation and include an analysis of implementation and evaluation.

The framework is ideal for the type of study and can be easily adapted, however it needs to be complemented with other frameworks to critically analyse aspects such process and actors.

Chapter 6 Conclusion and Recommendation

In the Zimbabwean context resource mobilisation is the most critical component. Sufficient healthcare resources will allow for the implementation of other health care reforms such as pooling and purchasing. With the current level of funding it will not be feasible for the country to set up a mandatory national health insurance as well as ensure financial protection to the citizen particularly the poor and vulnerable who depend on public health institutions for health services. Efforts should be centered on curbing corruption and improving the current purchasing, pooling arrangements so as to create some efficiencies with the current resources.

Further research is required on how to improve health financing within the LMICs using the available resources. The current evidence dependents on the improved economic growth, whilst it is each country's aspiration to economically grow the pace is leaving the poor in a dire situation with regards to having their health needs met.

Successful health reforms will also relay on involvement of the communities and using feedback of the health systems users to provide health services that cater to their needs. It is important for the government of Zimbabwe policy process to create a meaningful space for communities to be involved from formulation, implementation and evaluation of public policies.

Recommendations

1. The Ministry should involve communities in future policy development process. The involvement should be at stages of policy development and implementation. Through consultative meetings and interviews. Communities should be represented in the TWGs.
2. The Ministry of Health may consider strongly lobbying for 5% allocation of the GDP to be allocated to the health sector coupled with a capita spending of $86. This unlike the Abuja Declaration will not result in resources being cut in other social sectors that are critical to the social determinants of health.
3. In the short term the Ministry of Health and Child Care may work on improving efficiencies so that they can buy more health services with current resources. Developing a resource allocation formula is key towards strategic purchasing by distributing resources according to health needs of the different geographical areas.
4. The Ministry of Health might consider a mixed financing mechanism where those formally employed contribute to a mandatory social insurance scheme, and those in the informal sector that are able to contribute through a mandatory CBHI and the general taxes fully cover the poor and vulnerable such as female headed households. However, this should be a long term goal and should follow economic development.
5. Develop effective strategies to combat corruption. Those convicted of corruption charges should be discharged from their duties, this will send a message that corruption will not be tolerated in the health sector.
6. The academia should further study alternative health reforms for LMICs that are not too costly to implement as they develop economically.

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