Investing in the health sector: The role and functioning of Medical Aid Societies in Zimbabwe

National Review Meeting REPORT

Harare, July 7 2010

Training and Research Support Centre,
Southern and Eastern African Trade Information and Negotiation Institute in collaboration with the
Ministry of Health and Child Welfare, Zimbabwe, and
Institute of Social and Economic Research, Rhodes University
in the

Regional Network for Equity in Health in East and Southern Africa (EQUINET)

with support from Southern African Health Trust

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We acknowledge with thanks the co-operation of the Ministry of Health, the stakeholders who participated in the meeting and the support of the Southern African Health Trust.

1. Background and objectives

The national review meeting on the role of the medical aid societies in Zimbabwe was convened by the training and Research Support Centre (TARSC), Southern and Eastern African Trade and Negotiation Institute (SEATINI) with collaboration from the Ministry of Health and Child Welfare, and support from the Southern African Health Trust through the Institute of Social and Economic Research (ISER), Rhodes University, in the Regional Network for Equity in Health and East and Southern Africa (EQUINET). The activity was one of a series in a regional programme on capital flows in the health sector in southern Africa co-ordinated by ISER.

The workshop brought together researchers, policy makers, health sector regulators and the medical aid societies to discuss issues around the flow and impact of capital flows through medical aid societies in the health sector in Zimbabwe. The review workshop guided by the research work that was implemented in Zimbabwe by TARSC and SEATINI on capital flows in the health sector, separately reported in EQUINET discussion paper 82[1]. The findings of the research were presented for discussion and review by stakeholders from Zimbabwe's health sector.

Information was analysed from secondary data and key informant interviews in 2009 on capital flows in Zimbabwe's health sector, with a specific focus on capital flows through medical aid societies (MAS). The research's main objectives were to analyse;

- the nature and extent of private capital flows through and in MAS from 2000 to 2009;
- the policy and regulatory context and systems for managing these flows;
- the health service outcomes associated with these capital flows in MAS; and
- the perceptions of regulators, MAS, clients/members and other key stakeholders on the trends in MAS-linked services.

In follow up, the meeting aimed to

- hear, review and give feedback on the findings of the research
- discuss proposals for strengthening the management of, regulatory systems and environments for capital flows in the MAS;
- discuss how the performance of capital flows in MAS can be strengthened in relation to national health service goals and strategies;
- discuss proposals for improving coverage and involvement of beneficiaries with equitable options for health care insurance.

This report has been prepared by TARSC. The programme is shown in Appendix 1 and the delegates are listed in Appendix 2.

[1] Shamu S, Loewenson R, Machemedze R and Mabika A (2010) 'Capital flows through Medical Aid Societies in Zimbabwe's health sector,' *EQUINET Discussion Paper Series 82*. Training and Research Support Centre, SEATINI, Rhodes University, EQUINET: Harare

2. Welcome, introductions

Mr Shepherd Shamu (TARSC) welcomed delegates on behalf of EQUINET and introduced the Director of Policy and Planning in the Ministry of Health and Child Welfare, Zimbabwe, Mr Simon Chihanga, who officially opened the workshop. Mr Chihanga welcomed delegates to the review meeting and presented the aims, outlined above. Delegates introduced themselves and their organisations.

Mr Chihanga informed delegates that the ministry has no monopoly on the provision of health care in Zimbabwe, and even it had that monopoly, it could not meet the need. This meant that the Ministry of Health needs partners, including the MAS, to effectively provide health care services to the population. He noted that while this partnership has been positive, of late the partnership with MAS and other players has not always provided mutual benefit for both parties. The ministry's policy is one of regulation rather than control of the medical aid societies. However, the philosophy of self regulation has created problems, including a conflict of interest by MAS, with some now involved in both funding and provision of health services.

Although regulations governing Medical aid Societies under the Medical Services Act 1998 prohibit certain investments in the sector, in the economic difficulties of the past decade some MAS invested in non-core activities citing the need to sustain their operations as the main motive. He observed that the past years have also exposed other weaknesses in the regulatory environment, including MAS taking on roles beyond their core business. Given that MAS are owned by members, members need to play an active role in their operations. However he noted that members seldom participate in the annual meetings of their medical aid societies.

Mr Chihanga observed that the Ministry had given latitude in the difficult economic conditions. He pointed out that if the Ministry had been too directional in its operations and implemented some of the MAS regulations to the letter, many of the currently operating MAS, bar about three, would have ceased operations. Taking cognisance of the economic difficulties that characterised the past decade, the MoHCW did not enforce some of the regulations in order to sustain the societies and protect the welfare of the many registered beneficiaries.

3. Regional perspectives on capital flows

The session was chaired by Mr Abisha Nyandoro, Comarton Consultancy, who introduced a regional presentation by Professor Greg Ruiters of the Institute of Social and Economic Research. He presented the impact of South Africa's capital flows on the health sectors in southern Africa. The current policy attention in South Africa on the option of National Health Insurance is regarded as a threat by industry players. As a proactive strategy, Aspen, Netcare, Clicks and Discom amongst other companies have explored investments in countries in the region, such as Tanzania and Zimbabwe. He cautioned countries over the possibility that these investments may distort their health sectors, and noted that countries need to ensure that legal provisions are in place to

regulate these new areas and enforced to ensure that any investments are matched to existing goals and systems.

In the discussion, a delegate from Zimbabwe Congress of Trade Unions felt that the government should make health a priority and give greater voiced to people, if they are to effectively engage with capital from outside the country coming into the health sector. He cautioned that poorly controlled expansion of South African capital in the sector could lead to the same situation as in South Africa, where health care provision exhibits great inequalities. Delegates debated the role of the state, with different views on the responsibilities and limits to state action. Delegates endorsed the role of communities and the right to be heard.

4. Results of the research in Zimbabwe

Mr Abisha Nyandoro, Comarton, introduced Mr Shepherd Shamu a research officer at TARSC, who presented the results of the study that was carried out in Zimbabwe on capital flows through the medical aid societies.

A summary of the research is shown in the Box below:

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. The paper outlined the flows of private capital that lie behind the growth of the profit medical aid and insurance health care sector in Zimbabwe. Evidence was 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 were found to 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.

The paper made proposals of measures 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).

Mr Shamu gave a brief context background of the research and the role of the MAS and Regulatory framework in Zimbabwe.

He noted that medical aid societies collectively service about 10% of the population in the country, although it is estimated that about 80% of income to private health care providers in Zimbabwe comes from medical aid societies and that overall they contribute more than 20% of the country's total health expenditure. MAS, play a pivotal role in the provision of health services in Zimbabwe. This meant that they should be the radar of

the Ministry of Health and Child Welfare. While the MAS have contributed a lot in terms of health care in Zimbabwe, in this environment of decreased government spending on health, a huge gap still exists between the services needed and the services provided, especially in poor rural areas. The economic liberalization brought about by the Structural Adjustment Programmes (SAPs) of the 1990s provided the impetus for greater private sector investment and growth which also included growth in private provision of health. Through acquisitions, joint ventures and expansions, many health care funders embarked on vertical integration. The economic decline and the hyperinflationary environment that characterised the last decade also forced many medical aid societies to respond to these challenges in a somewhat perverse manner.

Mr Shamu discussed the findings from the research: Some medical aid societies had acquired related industries and services, either to seek other growth opportunities or to manage the costs for service providers of doctors, specialists and pharmacists, but in the process breaching the regulations of the MAS. For example, he pointed out that at least 2 of the largest Medical Aid societies in the country have acquired hospitals, clinics, rehabilitation services, laboratory services, dental services, imaging, optometry, pharmacy services and medical emergency transport, transforming these MAS societies from their core function of health funding to provision of health care services, in the process establishing perverse vertical relationships. He pointed to the inadequacies of Medical Services Act, Public Health Act, Medicines Control Authority of Zimbabwe, Dental and Allied Professions Act, the Drugs and Allied Substances and Control Act, the Dangerous and Drugs Act, the Insurance Act and Companies Act in their ineffectiveness in managing potential conflicts of interest by the MAS: Using results from the beneficiary survey, he noted that MAS have created monopolies in all spheres through vertical integration, and that had the effect of limiting patient choice raising in the process serious equity issues. Vertical integration by MAS has implied that prescribing practices and use of laboratory services are driven more by financing interests than clinical need.

He noted that medical Aid societies are not taxed given their non profit status as health care funders, raising questions about the potential tax implications on earnings borne from investments outside their core business. Although there is a Competition and Tariff Commission Act that looks at issues of vertical integration, they focus narrowly on the sector, and do not directly address issues affecting consumer welfare, such as unfair trade practices, pricing, advertising and distribution of goods and services, nor the possibility of geographical inequity in services, the proliferation of similar small plans limiting risk pools, segmentation of schemes limiting cross subsidies, or fairness of premium calculation, all of which were issues in the industry in Zimbabwe. While Medical Aid Societies intended to use these acquisitions as a means to reduce co-payments, beneficiaries were found to perceive that they were making a disproportionate and significant share of payments, including for drugs and consultation fees. The Ministry of Health was found to have limited capacity to regulate and monitor these issues.

Mr Shamu concluded by emphasising the need for a re-look at the policy option of National Health insurance as a response to all these problems.

A discussant from the Competition and Tariff Commission (CTC), Cicilia Mushava, discussed the research results. She corrected and updated information on the cases handled by CTC. She noted that the CTC's recent court cases on MAS operations, such as on refusal to reimburse medical claims, was being done in terms of section 31 of the

Competition Act which states that “For the purposes of section *thirty one*, the Commission shall regard a restrictive practice as contrary to the public interest if it is engaged in by a person with substantial market control over the commodity or service to which the practice relates’. (Competition Act 1996 (Sec 19), amended 2001) She indicated that these were not just over competition issues, but that the best interests of consumers was also a guiding issue.

In the discussion, R Machemedze, Seatini commented on the need to look at the issues of corporate concentration and pricing. He suggested that the Competition Act meant that the Competition and Tariff Commission looked more into market structures than consumer welfare, and that the results of the research indicated that a more laissez fair approach had not worked for consumers and there was need too to reclaim the role of the state in service provision.

Mr Mbengwa, Zimbabwe Association of Church Related Hospitals (ZACH), felt that there was clearly a need to revisit the regulations for MAS to protect the consumer, and also to manage entry into the industry. Dr Loewenson, TARSC queried the number of new medical aid societies and asked what the desirable number was in a setting like Zimbabwe, commenting on the very small and unviable risk pools in the many small societies emerging. She noted that the current regulations only give the Ministry authority to regulate *after* societies are already registered or investments made, and suggested that government’s role should be more upstream, to assess *whether and where* new investments were needed. Mr Gwati, Ministry of Health felt that only the primary health approach could be the panacea for addressing some of these consumer health issues. One delegate noted that a basic health package for this needed to be defined and costed, so that MAS could be required to cover at minimum this basic package of services.

Other delegates queried whether we need to come up with instruments to explore use of the surplus funds in the MAS industry, given their non profit status; and what the MAS’ pricing models are.

5. Recommendations, follow up and closing

Three working groups was set up to discuss the recommendations, with a set of questions to guide their discussions. The report back in plenary was chaired by Mr Tonderai Chikandiwa from the Zimbabwe Health Services Board.

Group 1: Stewardship of Medical aid

This group was chaired by a representative from the Ministry of Health and Child Welfare, Policy and Planning and it made recommendations on the priorities and mechanisms for stewardship of medical aid societies. The group felt that the MAS regulations needed to be revised and strengthened. Investments in the industry should be regulated at the point of entry, ie as an application on registration, rather than after the investment has been made, and the Medical Aid Societies Statutory Instrument 330 of 2000.should be amended to reflect this. The Ministry should further come up with clear guidelines on what MAS should invest in. The group proposed that every MAS be obligated to cover a mandatory primary health care / primary care package and that this should be specified by the Ministry and included in their benefit packages. Ministry

should explore the coverage by medical aid / health insurance in the informal sector, as this is a large share of the working population that needs coverage. The group suggested that a quasi-government organisation, such as a council with state, MAS, stakeholder and beneficiary representation, should regulate, supervise and enhance the functioning of the MAS, with its income coming from annual fees paid from the MAS surplus funds. Ministry as overall regulator should have a specific desk for the private sector that includes the private for profit sector, one function of which is to oversee investments in the sector.

Group 2: Role of Medical Aid Societies in Health Sector

This group was chaired by a representative from the Medical Aid Societies and it made recommendations on the role of medical aid societies in the health sector. The group felt that while medial aid societies were non profit organisations, the surpluses they may generate should be recognised but should also be put back into their benefits and the health sector in line with guidelines and oversight by the Ministry of Health and Child Welfare, who should also get reports from the MAS and monitor how these funds are being used. Noting that funds leave beneficiaries stranded when they close or withdraw specific benefits the group proposed that a small levy on MAS funds, such as of one to five percent of surplus funds be collected centrally (such as by ministry or by a regulatory council) and placed in an earmarked fund to be used to protect beneficiaries when benefits are withdrawn due to fund financial problems or insolvency. The rising costs of personal medical care were noted, including the costs of labour, service provision and commodities. The stakeholders should do a costing projection and engage all those in the service provision / value chain to discuss where controls can be put in that do not compromise public health or beneficiary entitlements and to explore further the pricing model for MAS tariffs. Confidence in the sector is harmed by restrictive practices and slow beneficiary / practitioner reimbursement, and the group proposed that the Ministry/ regulatory council set explicit minimum guidelines for the conditions and timing of reimbursement for service provided by healthcare providers. Finally the group felt that the Ministry should update and ensure clear and specific regulations to guide the industry, and remove ambiguities.

Group 3: Benefits and Beneficiaries

This group was chaired by a representative from the trade union movement (ZCTU) and made recommendations on benefits packages, beneficiary coverage, risk equalization, and beneficiary rights and involvement in schemes. The group advocated for MAS to have open enrolment, that movement across schemes not be restricted, and that there be greater awareness on MAS in and information dissemination on benefits options to beneficiaries. The group recommended that MAS be restricted from pricing individual packages based on individual health risk or grouped risk profiles and that there be cross subsidies across schemes to enable this. Once a beneficiary is in a health provider/ facility/ hospital care, both the MAS and the hospital should be responsible and have clear obligations for the patient's welfare. The group recommended that the regulations needed to be revisted and strengthened to better protect beneficiaries, and that greater public information be provided on the regulations and reporting on their implementation. The group noted however that the fragmentation of MAS is not assisting beneficiaries and urged that to comprehensively deal with the above issues, the National Health Insurance debate should be revived and the Public Health Act more strongly enforced as superseding other acts (as it set in its clauses).

These recommendations were presented and discussed in plenary. In the plenary the proposals were adopted and further recommendations made to improve functioning and equity in the MAS sector and to address the interests of beneficiaries, as follows;

Regulation

- Ministry and stakeholders should revise and strengthen regulations to: address legal ambiguities on investment of 'surplus' MAS funds, especially in section 4 of Medical Aid Societies Statutory Instrument 330 of 2000. MAS' constitutions should be aligned with the law.
- Ministry should amend SI 330 2000 which currently provides for controls after investments and reporting within 1 year to provide for MAS to notify of proposed investments in health services, provide information on the proposed terms and practices and obtain approval from the MoHCW and the CTC *before* they are made, to ensure that the invrestments are in line with national health and competition goals
- MAS and Ministry should ensure that MAS retain focus on their 'core business' as set in the MAS regulations, regularly review MAS operations in relation to the law and deal with any amibuities in this respect.

Institutional and administrative measures:

- Ministry should ensure timely reporting by the MAS and maintain and report on an updated database for schemes and benefit packages
- Ministry should resuscitate the Advisory and Joint Council meetings to advise the secretary on functioning of MAS. (Note also the working group representation on setting up a more substantive regulatory council and a desk to co-ordinate the private for profit sector in the Ministry)
- Ministry should register all schemes in a timely and efficient manner, and in this avoid increasing segmentation of the sector into small, fragmented risk pools from individual schemes and encourage (for example by enforcing regulation on registration and liquidity requirements) mergers into larger and more viable risk pools.
- The institutional capacity in the office of the Registrar of Medical Aid Societies should be improved and officers with a background and experience in private company accounts be employed to effectively monitor the financial practices of MAS.
- ZCTU, MAS and other stakeholders should ensure greater beneficiary and public awareness on the functioning of their MAS and on the regulations, standards of practice and the performance of the sector.

Scheme provisions and Benefits packages

- Government should develop in consultation with stakeholders 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.
- Government (Ministry of Health and CTC) should implement a comprehensive audit of the degree of vertical integration of all MAS and work with the MAS to unbundle monopolies across all spheres of a sector, or integration that is leading to restrictive practices limiting patient choice, such as by paying only for selected linked services.

Consumer and member involvement

- Outreach of information on schemes, benefits packages and consumer rights should be enhanced 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.

To take the above measures forward, the delegates to the workshop set up a short term taskforce made up of members from the different sectors. This task force was mandated by the meeting to prepare a position paper that would be forwarded to the Ministry of Health and Child Welfare for it to take follow up action. TARSC was requested to convene the taskforce, including the members listed below:

NAME	ORGANISATION	POSITION
Mr Shepherd Shamu	TARSC/EQUINET	Research Officer
Mr Gwati Gwati	Ministry of Health and Child Welfare	Planning and Donor Coordinator
Mr Tonderai Chikandiwa	Health Service Board	Deputy Director: Human Resources
Ms Cicilia Mushava	Competition and Tariff Commission	Senior Economist
Mr Stuwart Musekwa	TN Medical	Finance Manager
Mr Nathan Banda	Health Dept, ZCTU	Senior Officer
Mr J Mapisire	Health Professions Authority	Secretary General

The Director of policy Planing in the Ministry of Health and Child Welfare, Mr Chihanga in his closing remarks emphasised the need to move quickly and follow through on the issues raised above.

The convenors thanked the delegates for their valuable contributions, noted that follow up actions were a responsibility of all those involved, and undertook to provide feedback on the position paper and any actions arising.

Appendix 1: Programme - Investing in the health sector: the role and functioning of Medical Aid Societies in Zimbabwe

Time	Activity	Facilitator/ presenter
08:30 - 09:00	Registration, administration	TARSC
09:00 - 09:15	Opening and overview of health sector goals in Zimbabwe Delegate introductions	S Chihanga, MoHCW
09:15 - 09:45	Regional perspective on capital flows	Chair: A Ndoro, Comarton Presenter: Prof G Ruiters, ISER
09:45 – 10:15 10:15 – 10:30 10:30 – 11:00	Presentation of the research Discussant Discussion	Chair: A Ndoro, Comarton Presenter: S Shamu, TARSC C Mushava Competition and Tariff Commission
11:00 - 11:30	**Tea/coffee break**	
11:30 - 12:15	Working Groups on recommendations i. Management of MAS ii. MAS role in Health Sector iii. Benefits and beneficiaries	Chair: T. Chikandiwa: ZHSB
12:15 – 12:55 12:55 – 1:00pm	Plenary Feedback and discussion Closing remarks	Chair: T. Chikandiwa: ZHSB S Shamu, TARSC S Chihanga, MoHCW
1:00 pm	**Meeting close, Lunch**	

Annex 2: Delegate list

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NB: Apologies received from AFHOZ and two MAS