Capital flows in the health care sector in Zimbabwe: Trends and implications for the health system

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Executive summary

The Southern African Development Community (SADC) region has identified combating poverty as a priority through building up the capital assets of the poor, reducing inequalities, and promoting knowledge and health in poor areas. The region experiences a high prevalence of diseases of poverty with lowest income groups having poor access to health care. Proponents of private for-profit sector expansion in health care argue that the private sector is cost effective, provides quality care, is able to complement government in expanding coverage and relieves pressure of public funding. Yet, the private sector has a mixed record in health systems in the region, with reports of poor quality care, limited reach beyond higher income groups, high user charges and fragmentation of risk pools. Despite these problems, privatisation of health care services is being promoted and there are new trade-related pressures for further liberalisation.

In order to understand the flows of private capital that lie behind the growth of the for-profit health care sector in the SADC region, the Regional Network for Equity in Health in east and southern Africa (EQUINET) working through Rhodes University Institute of Social and Economic Research (ISER), Training and Research Support Centre (TARSC), Southern and Eastern African Trade Information and Negotiations Institute (SEATINI) and York University are examining capital flows in the health sector in southern Africa, and have commissioned this background review with a specific focus on Zimbabwe.

This review of the capital flows in the health sector in Zimbabwe was carried out in 2008 and draws from secondary evidence. It presents evidence on the current composition of the health sector, particularly showing the public-private mix; trends over time post-1995 in private capital flows to the health sector showing key entry points for capital and the impact on the health care sector of these flows. The paper explores arguments used to support private flows, the role of trade agreements, and the policy, regulatory, institutional and public responses to the capital flows. It comments on issues arising in relation to methods used to analyse capital flows and their impacts, including data availability and bias. Data on capital flows was difficult to access, with no central authority monitoring capital flows in the health sector, despite legal empowerment of Ministry of Health in the approval of establishment of private-for-profit health care facilities. The information obtained was also limited by minimal co-operation from official circles.

Zimbabwe's health system is made up of diverse institutions. Government health care facilities operate alongside religious organisations, municipalities, private companies, and private individuals. The private-for-profit operations are mostly in the urban areas, while church health facilities are in rural areas. In rural areas, the private-for-profit health sector mostly consists of mine and estate services.

The paper describes the universal equity-oriented health care policies pursued in Zimbabwe post-1980 and the improvements in access arising from these. It examines the changes during the 1990–2000 International Monetary Fund inspired economic structural adjustment programme with rapid expansion of private sector health care facilities, contrasting sharply with declining performance in the public health sector institutions. The post-2000 period has seen a drastically negative trend in the health sector as the Zimbabwean economy has taken a plunge for the worse. A largely self-inflicted economic disaster has badly affected the operations of the health sector, and there has been a significant outflow of skilled health workers. The public sector has been the worst affected, with negative consequences for access to health care and intensified imbalances in the public-private mix.

Post-independence, government set out its policy of Planning for Equity in Health to deal with inequalities in health status and health care. In the structural adjustment era government adopted its new *National Health Strategy 1997–2007*, which proposed to create

opportunities for the private sector and stressed the need for decentralisation and contracting-out of health services. The Medical Services Act was passed to regulate the medical industry, and regulations put in place to govern the operations of medical aid societies. The Competition Act was enacted to curb restrictive business practices, damaging monopolistic behaviour and other anti-competitive practices. It is indicative of the operations in the health sector that this anti-trust law found almost immediate application in the Zimbabwe for-profit health sector, where it was used to investigate several mergers and acquisitions. However apart from the vigilance of the Competition authorities, the health sector regulatory authorities appear not to have used their powers to ensure that private capital flows respond to the health needs of the bulk of the population in Zimbabwe.

The report thus shows that total expenditure on health fell from a peak in 1998 to just 7% of GDP in 2005, with falling public expenditure on health and increasing private expenditure on health. Of this the largest increase was in household out-of-pocket expenditure to 53% (in 2003) of private expenditure on health, placing significant burdens on individuals. As government spending fell, the relative contribution of donor funding grew from a low of 2.1% (2000) to a high of 21.4% (2005) of total expenditure on health.

Between 1995 and 2007, the private-for-profit health sector expanded. Investors were both local and foreign. Foreign direct investment (FDI) was mostly targeted at the pharmaceuticals and chemicals sector. Mergers and acquisitions were utilised as a means of getting a foothold in the private-for-profit health sector. Medical aid societies (MAS) used acquisitions aggressively to capture market shares in direct medical services provision. By 2007, MAS had become major players in health care provision in direct competition with their clients. Foreign capital also targeted existing health care operations. Between 1995 and 2000, World Bank investments in the public sector provided opportunities for private capital through the system of competitive international bidding for construction and related contracts.

The rapid liberalisation of the health sector in Zimbabwe in the late 1990s created opportunities for private capital. While this was a policy objective of the time, it coincided with cuts in public expenditure during the 1990s and an economic crisis post-2000 that meant that private sector growth was not matched with public sector growth. The marked decline in public health investment reversed the major gains made during the 1980s, and private for-profit health care investments were concentrated in a few urban areas serving a minority of the wealthier population. The absence of a national health insurance system resulted in the 90% uninsured population having difficulties in accessing health services. Private health services were concentrated in a few vertically linked operations, sparking fears of anti-competitive behaviour, especially in the retail pharmaceutical sectors. Incentives given to private-for-profit health care providers did not lever public health gains, and the cost of both public and private health care soared, undermining access.

Pressures for privatisation are increasing, calling for a more focused public sector response to the private health sector in Zimbabwe. Zimbabwe's participation in negotiations for a potential Free Trade Area (FTA) with the European Union has implications for private capital flows in the health sector, with the EU keen to achieve liberalisation of the services sectors. The paper highlights areas for increased policy attention: for government to significantly increase public investment in health and control out of pocket expenditure; for the establishment of social health insurance; for the Ministry of Health to use its powers to monitor and regulate the expansion of private capital so that it serves policy objectives of universal coverage and equity. With powerful national interests gaining from profits in the health sector, including in the medical profession, monitoring and advocacy by communities is essential to engage on policy measures that protect equity and access. The paper further notes the regulatory role of the Competition and Tariff Commission with respect to curbing predatory behaviour by private health services providers.

1. Introduction

The SADC region has identified the combating of poverty as a priority. This is to be achieved through building up the capital assets of the poor, reducing inequalities, and promoting knowledge and health in poor areas. The profile of health in east and southern Africa shows a high prevalence of diseases of poverty. While access to health care has expanded, there are continuing problems of lowest income groups having poor access to health care (EQUINET, 2007). The region has also in the past decade experienced reductions in financing for public services and a growth of commercialised services, from informal sector primary care level services through to specialised private hospitals. Proponents of private for-profit sector expansion in health care have argued that the private sector is cost effective, provides quality care, is able to complement government in expanding coverage and relieves pressure of public funding (e.g. Marek et al, 2005; IFC, 2007). Evidence obtaining in the Region however does not seem to support that the private sector is as affective as claimed. The private sector has a mixed record in health systems in the region, with reports of poor quality care, apart from being inaccessible by the poor and therefore generally inequitable. Despite these problems there is evidence that privatisation of health care services is expanding and new pressures for liberalised trade in health care services is expanding through global and bilateral trade agreements, as we will show in this paper.

In order to understand the flows of private capital that lie behind the growth of the for profit health care sector in the SADC region, the Regional Network for Equity in Health in east and southern Africa (EQUINET) working through Rhodes University Institute of Social and Economic Research (ISER), Training and Research Support Centre (TARSC), Southern and Eastern African Trade Information and Negotiations Institute (SEATINI) and York University are examining capital flows in the health sector in southern Africa, and have commissioned this background review with a specific focus on Zimbabwe.

The objectives of the study were to examine:

- the current composition of the health sector, particularly showing the public-private mix and detailing the nature of the private for profit sector;
- the current situation and trends over time post 1995 in private capital flows to the health sector (differentiating sources and targets of capital flows);
- the key entry points for capital (e.g., construction of health facilities, contracting out, private-public-partnerships, management contracts, etc) including within the public sector and distribution by area, and the level of health service of capital invested;
- documented evidence on the impact on the health care sector, in terms of financing, resource allocation, service provisioning, and access;
- the arguments used to support private flows, the role of trade agreements, and the policy, regulatory, institutional and public responses to the capital flows; and
- issues arising in relation to methods used to analyse capital flows and their impacts, including data availability and bias.

2. Methods

Using a literature review, we carried out an initial mapping and review of capital flows in the Zimbabwe health sector, drawing on both qualitative and quantitative secondary evidence from 1995–2005. No formal interviews were conducted in the process of collecting data. Informal discussions were done with senior government officers who provided documents from which data was extracted. Data was collected from Annual Reports, Research Publications and Policy and Mission Statement Documents from the Ministry of Health and Child Welfare, the Central Statistics Office, the Zimbabwe Stock Exchange, the Ministry of Public Construction and National Housing, the Zimbabwe Association of Church Related

Hospitals, the Privatisation Agency of Zimbabwe, the Zimbabwe Health Professions Authority, the Competition and Tariff Commission of Zimbabwe, medical aid societies such as CIMAS and Premier Medical Aid Society.

The review faced a number of difficulties. There were definitional issues. The WHO (2007c) definition of Private health expenditure (PvtHE) is defined as the sum of expenditures on firms' expenditure on health, on-profit institutions serving mainly households (NGOs), household out-of-pocket spending and prepaid plans and risk-pooling arrangements, which are defined as:

> *the outlays of private insurance schemes and private social insurance schemes (with no government control over payment rates and participating providers but with broad guidelines from government)*

Strict application of the WHO definition of 'private expenditure on health' can ignore the contribution of the health insurance sector in Zimbabwe as it is subject to price controls like any other sector of the economy, disqualifying it from being part of the 'private expenditure' on health, according to the WHO definition. As the health insurance sector is relevant to private capital flows we opted to ignore the WHO definition in this case to allow us to explore the role of medical aid societies (MAS).

It was difficult to acquire substantive information on capital flows, primarily due to the absence of a centralised data source. The Medical Services Act gives the government an oversight role on both the conduct and investments of the private health sector, but important information to reflect the operations of the private sector is missing from the Ministry of Health. The Ministry of Health is charged with oversight and approval of investments in the health sector, but there is no visible system to show the records of such investment since the Medical Services Act was put in place. Attempts at getting such information from the Ministry were met with puzzled looks from the officials. It is possible to file a formal application for this information by using the Access to Information and Protection of Privacy Act. The researchers toyed with this idea but abandoned it after informal advice was received that given the state of paranoia in official circles such an application may even make it more difficult to acquire the trust of the public officials. However, it is still possible to draft a very friendly application requesting for this information.

With the exception of CAPS Holdings, Zimbabwe Stock Exchange (ZSE) data did not capture capital flows stemming from ZSE listed entities. There remains the possibility of disaggregating ZSE dynamics in order to reflect the possibility of other transactions which could have taken place at this level but which were not reported. Data on Foreign Direct Investment (FDI) is limited because the figures available relate to pharmaceuticals and chemicals industries, but do not disaggregate the pharmaceuticals sector. Data from the Zimbabwe Investment Centre provides indicative information on FDI into the Zimbabwe health system, but there is no systematic follow-up of FDI projects in order to assess actual implementation of the projects. Further, although Zimbabwe Investment Centre (ZIC) is supposed to act as the entry point for foreign capital it is possible that many projects by-pass this process and foreign capital establishes itself into the health system without the knowledge and approval of the investment authority.

Added to these obstacles, the researchers experienced the difficult operating environment in Zimbabwe and both government and private sector resistance to answering questions on the operations of their health sectors. This limited access to information such as the private sector involvement in the construction of public health facilities or the extent of contracting out, as the private for-profit sector is so mosaic that it is difficult to ascertain their global capital contribution with reasonable accuracy. In the public sector government officials appeared to be cautious about how information would be used, while in certain parts of the private health sector, officials were reluctant to provide even newsletters or annual reports appearing to be fearful that information might be used by the government to negatively affect

their operations. Despite these clear limitations and difficulties, the information gathered points to trends that merit policy and public attention to protect policy objectives of equity and access in the health sector.

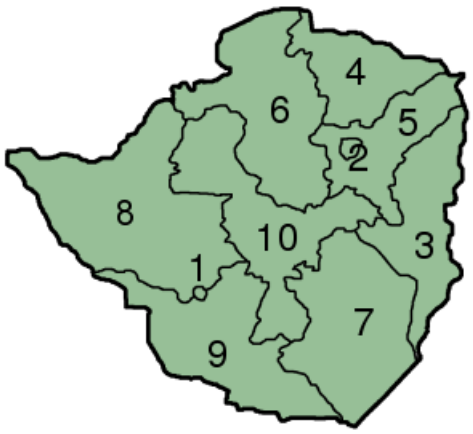
3. Background: Trends in the Zimbabwe health sector

Zimbabwe gained independence from Britain in 1980. At independence the new majority government embarked upon extensive investment in social services. Resources were deployed towards the provision of universal education and health care (Trane and Bate, 2005). By 1985, the policies were being recognised as a success story across the developing world. The Zimbabwean government focused on improving access to services for the marginalised black population, and particularly targeted the rural communities. The strategy was cemented in the 'Growth Points' policy of building 'urban' centres in rural areas. These centres were designed to provide for a complete package of services. The centres were also designed to be the major health centres for the rural population, and as such provided for a general hospital which also served as the base from which outreach health services were delivered to the remote rural hinterlands. The rural strategy was complemented by expansion of primary health facilities and the desegregation of the health delivery network in the urban areas. Huge progress was achieved in the decade between 1980 and 1989, for example life expectancy at birth rose by nearly a decade from 54.9 years in 1980 to 63 years in 1988, the rate of child immunisation nearly tripled between 1980 and 1988, and infant mortality rates fell by 80% to 49 deaths per thousand by 1988 (ibid).

The Zimbabwean healthcare system caters for a population of just over 13 million people, with over a third (39.6%) under 15 years and the majority 16–65 years. Adding to regular migration of Zimbabweans to surrounding countries, particularly South Africa, for work, recent political, economic and social strife has seen millions of Zimbabweans leaving the country, while resettlement on redistributed land and internal displacement have also affected population distribution. The current population numbers and distribution relative to health service distribution are thus difficult to assess with accuracy.

For administrative purposes Zimbabwe is divided into eight (8) provinces and two (2) cities with provincial status, as shown in *Figure 1*. The country is further divided into 59 districts and 1,200 municipalities.

Figure 1: Zimbabwe administrative map



1. Bulawayo (city); 2. Harare (Capital city); 3. Manicaland; 4. Mashonaland Central; 5. Mashonaland East; 6. Mashonaland West; 7. Masvingo; 8. Matabeleland North; 9. Matabeleland South; Midlands

Source: Wikipedia, 2007.

Zimbabwe has a diversified health care facility system. The facilities range from simple primary health clinics, reproductive health centres to sophisticated multi-complex hospitals offering state-of-the-art medical technology. The health care facilities are operated by a diverse range of actors. Government operated facilities are complemented by those run by private companies in the health care business, local authorities (municipalities), private companies operating facilities for their own employees, religious organisations (running so-called 'mission hospitals'), surgeries operated by individual doctors, and traditional medical practitioners who are scattered across the country. There is a strong presence of health care facilities which are run by churches in Zimbabwe, with churches traditionally the suppliers of essential services to the rural black community ignored by the colonial government. These facilities have also been complemented by a surge of private for-profit operations, including individual practitioners and company-based operations such as private medical aid schemes, private hospitals, nursing homes, pharmaceutical chains, etc.

Public health care is delivered at four levels which are meant to function as a referral chain (Zimbabwe Ministry of Health and Child Welfare, 2001):

- **Entry Level:** This is made up of Rural Health Centres, Rural Hospitals and Urban Clinics. The services do not require an attending physician;
- **First Referral Level:** This is made up of District Hospitals;
- **Second Referral Level:** This is made up of Provincial and General Hospitals; and
- **Third Referral Level:** This level is made up of Central and Special Hospitals.

In theory patients are required to present themselves at the entry level facilities first and then be progressively referred upwards if the condition warrants such a referral. However the Ministry of Health has admitted that:

> *…in practice the referral process functions poorly. Conditions of rural health facilities is so poor that people bypass them and self-refer to higher level facilities with the hope to get the care desired. In addition, it is only in the central and the better general hospitals that anything but the most basic medical and surgical care is available. The result is that people by-pass their local health facilities and put services pressure on larger institutions, especially the central hospitals…* (Sanders, 1990).

Three waves of social-economic developments shaped the health sector in Zimbabwe: a period of high public expenditure (1980–1990), followed by liberalisation and privatisation (1990–2000) and the current economic downturn (2000 to present). The later period has also seen severe depletion of the health sector human resources as professional personnel such as doctors, nurses and physiotherapists leave the country for better paying economies in the region and overseas. On average the country loses 20% of its medical personnel on a monthly basis. The number of new graduates from local training institutions is far from adequate to fill the gap left by emigrating medical professionals. Reports in 2004 suggested that up to 75% of the general practitioners and specialists in Bulawayo had left the country (SAMP, 2004; Chikanda, 2004).

The period 1980–1990 saw rapid expansion of public sector health facilities as the Zimbabwe government implemented the post-independence Planning for Equity in Health policy, with health sector expansion linked to other development programmes (Sanders, 1990). By 2000, 456 health centres, 612 rural hospitals, 25 district hospitals and a provincial hospital in each of the country's provinces had been built or upgraded, resulting in 85% of the population living within 8km of a health facility. Between 1980 and 1987, government expenditure on healthcare increased by 80% and stood at 2.3% of GDP, almost 3 times higher than the sub-Saharan African average of 0.8% of GDP (Trane and Bate, 2005). The major policy thrusts were: implementation of free health care to those earning less than Z$150 per month; and an expanded programme of immunisation, diarrhoeal disease control,

nutrition and health education, and child supplementary feeding. This was supported by training of about 7,000 health workers by 1987 and upgrading of skills of household level women operatives in identifying at-risk pregnancies, basic midwifery, elementary hygiene, and basic child care. The Child Spacing and Family Planning Council was established in 1981, this has now been renamed the Zimbabwe National Family Planning Council. Largely as a result of its activities, Zimbabwe had by 1990, the highest rate of contraceptive use in sub-Saharan Africa (Sanders, 1990).

This investment in public health, delivered at primary care level, and focusing on primary health care led to a significant improvement across a range of health indicators, including 25% coverage of immunisation at independence growing to 92% by 2000, antenatal coverage rose from 20% at independence to 89% (New Africa Magazine, 2000), and infant mortality rates falling by 80% between 1980 and 1998.

The period 1990–2000 saw the implementation of the International Monetary Fund (IMF) drive economic structural adjustment programme (SAP) that emphasised public sector reforms, including in the health sector. The focus of the IMF reforms included economic liberalisation, privatisation and reduction in public expenditure. The new economic policies had a direct effect on the structure of the medical sector in Zimbabwe, with growth in private hospital facilities between 1991 and 1996 (see *Table 1*).

Table 1: Changes in the number of medical institutions, 1991–1996

	1991	1992	1993	1994	1995	1996
Public facilities						
Central Hospital	4	6	6	6	6	5
General Hospital	7	7	7	7	7	7
Maternity hospital	-	6	3	3	3	3
District Hospital	41	37	37	37	37	34
Rural hospital	58	57	58	58	58	59
State clinic	-	377	370	370	370	349
Provincial clinic	-	452	451	451	451	497
Municipal clinic	-	102	105	105	105	102
Private facilities						
Private hospital	14	175	204	204	204	209
Special facilities	6	10	11	11	11	13
Church-related hospital/clinic	97	120	126	126	126	128
Statistics						
Number of beds at all facilities	18,612	16,574	16,231	16,886	18,160	22,975
Number of maternity beds at all facilities	-	3,206	2,888	2,980	3,763	4,120
Number of beds per 10,000 people	19	19	18	18	18	23

Source: Central Statistics Office, 1997

Both church-related hospital facilities and special facilities (e.g. nursing homes, maternity homes, etc.) more than doubled over the same period, while public health sector institutions stagnated or fell in number, with a marginal increase only in rural and central hospitals. Declining public expenditure certainly contributed to this, but it was also the case that the expansion of infrastructure in the 1980s now meant that the issue in the 1990s was less of adding new infrastructure than of improving quality of care in the existing facilities.

In the post-2000 period there has been a negative trend in the health sector as the Zimbabwean economy has plunged, with the public health sector badly affected. The Zimbabwe Reserve Bank Governor (Gono, 2007) described the deteriorated economic performance in 2006 in terms of the foreign exchange shortages, arising from inadequate export performance, reduced capital inflows, withdrawal of the multilateral financial institutions and scaling down of bilateral creditors. The Governor reported the negative

consequences of this for the health sector, in terms of cessation of external funding, failure to upgrade equipment and falling quality of care in the public sector.

The current health statistics reflect these difficulties. Zimbabwe lags behind regional averages with respect to the availability of critical health personnel to a proportion of the population (WHO, 2007). While there are absolute shortfalls in the numbers of personnel, these are most extreme in the public sector, where a high proportion of posts are not filled and the ratio of personnel to population are much lower (see *Table 2*).

Table 2: Numbers of medical professionals

Category	National total	Number employed in the public sector	% of required public sector posts filled	Density per 1000 population (Zimbabwe)	Density per 1000 population (Africa)
Doctors	1 634	772	28.7	0.161	0.217
Nurses	16 407	7 636	55.6	0.724	1.172
Pharmacists	524	129	18.7	0.068	0.063
Environmental technicians	1 054	942		0.139	0.049

Source: Ministry of Health, 1996; Chikanda, 2004; WHO, 2007

3.1 Nature and ownership of health institutions in Zimbabwe

According to the Zimbabwean Health Professions Authority there are 24 classes of health care facilities, covering a wide range of medical services and institutions, but notably excludes the private informal health system *vis a vis* traditional healers and faith healers. This group comprises largely of 'traditional healers', with numbers estimated at between 50 000 and 60 000, many of whom are members of the Zimbabwe National Traditional Healers Association (ZINATHA); and 'Faith Healers' who do not have an organised institution such as ZINATHA. A sizeable portion of Zimbabweans make use of these services on a fee basis. Evidence on these services in the 2001 *National Health Accounts Report* (MOHCW, 2001) shows that 3% of the sampled population sought the services of traditional healers in 1999, and 3.4% faith healers, with 88.5% paying fees for services of traditional healers and 57.6% for services of faith healers; 13% of out-of-pocket household expenditure on health was paid to traditional healers as opposed to 10% paid to private doctors. There is a mixture of public and private operators in Zimbabwe (see *Table 3*).

Capital investment varies between public and private sector and is skewed in favour of the private sector, as it owns more facilities for health, for example:

- Government runs just over 2% of the dental services with private dental surgeries widely distributed across the country, but mainly in Harare.
- The private sector accounts for over 90% of the medical laboratories, with most private medical laboratories located in Harare (55%), and the rest sprinkled across the urban centres. Private not-for-profit medical laboratories are visible in the HIV sector where they perform HIV testing services for free.
- The speech and occupational therapy sector is dominated by private service providers, all facilities being in Harare, and only one run by the state.
- The physiotherapy sector is also almost exclusively run by private individuals and organisations, with 50% of the physiotherapy services based in Harare, while all psychological service providers (64) and chiropractic providers (10) in the country are in the private sector.
- Private sector operated maternity facilities and 'nursing homes and clinics' have sprouted.

- Government operates 266 rural health clinics unevenly distributed across the country, while mines, farm estates and the manufacturing sector operate 139 clinics for the benefit of their employees.
- There are over 700 consulting rooms across the country, all in the private sector, with 44% of these in Harare and 19% in Bulawayo. Facilities in the non-profit sector, including: mission clinics; facilities for HIV testing, consultation and support centres, Red Cross Society centres, and family planning institutions.
- The 184 pharmacies in the retail pharmacy sector are private for-profit, ranging from single pharmacists to huge pharmaceutical chain stores. CAPS Holdings Limited, which controls 40% of a retail pharmacy market worth over US$5 million.
- Private and public providers both provide emergency services such as ambulance services. Government ambulances are attached to hospitals, so are not shown in the data, and the data thus shows all emergency services operators to be private, with Medical Air Rescue Services (MARS) dominating emergency services operations.
- Government also provides radiology services in certain hospitals, not disaggregated in the data, but the private sector operates the bulk of the radiology services, with 41 private radiology services, mostly located in the urban centres.

Table 3: Nature and ownership of health institutions in Zimbabwe, 2006

Type of Institution	Total	Total owned by government	Total owned by private operators
Dental surgeries	129	3	126
Medical laboratories	114	9	105
Speech & occupational therapy	12	1	11
Physiotherapy	80	1	79
Nursing homes and clinics	33	0	33
Consulting rooms[1]	769	N/A	769
Nurses' consulting rooms	101	N/A	101
Maternity homes/polyclinics	16	0	16
Mission clinics	30	N/A	30
Special clinics	42	0	42
Pharmacies[2]	184	0	184
Hospitals	195	102	93
Municipal clinics	101	101	N/A
Government rural clinics	266	266	N/A
Industrial clinics	139	0	139
Estate clinics	10	1	9
Psychological service	64	0	64
Operating theatres	5	N/A	5
Dietetics	6	0	6
Natural therapy	10	0	10
Emergency services	24	N/A	24
Radiology	41	N/A	41
Optical services	69	N/A	69
Rural district council clinics	217	217	N/A

Note: 1. The Zimbabwe Health Professions Authority classifies 1 institution as a consulting room, but it is being operated by a local authority. For our purposes we have modified this to reflect private ownership as we have classified consulting rooms as institutions run by doctors as for-profit health care facilities. 2. The 2001 National Health Accounts Report for Zimbabwe cites the Medicines Control Authority as indicating that by 1999, over 300 pharmacies had been registered in Zimbabwe. This shows a huge discrepancy in the data. For our purposes we have opted for the latest data as shown in the above table, but it is important to take note of this discrepancy.
Source: Zimbabwe Health Professions Authority, 2006

3.2 Capital flows in the hospital sector

Hospitals are highly liberalised, with government hospitals operating alongside: private hospitals operated by companies for the benefit of their staff, church-based organisations, and one hospital owned by a pharmaceutical company (CAPS ownership of St Anne's

Hospital, a private hospital in Harare). Zimbabwe has a total of 195 hospitals, with at least one public hospital in every province, totalling 95 countrywide. Local authorities operate a total of seven hospitals in the country. The remainder consists of 34 private hospitals and 59 church mission hospitals.

By 1950 mission hospitals accounted for 1,015 hospital beds as more Christian missions opened hospitals to serve the rural areas of colonial Zimbabwe (Zvobgo, 1986). These hospitals not only provided essential medical services but added to the skills base of the black majority. Government was noted to provide a small subsidy for this vital service provision (Bureau of Democracy, Human Rights, and Labor, 2002). By 1996 church related hospitals/clinics accounted for 6,927 (38% of the total) hospital beds in Zimbabwe, and nearly 70% of all rural hospital beds in the country (see *Table 4*). 2002 estimates show that the mission hospitals accounted for 45% of all hospital beds in the country and 68% of all rural hospital beds (Catholic Relief Services, 2002), indicating a steady increase in the share over the years.

Table 4: Hospital bed capacity 1996

Type of bed	Amount	% total
National Hospital beds	18,200	
Beds per million population	1,484	
Mission hospital beds	6,927	38.0
Private beds per million population	568	38.0
Private for-profit (estimated)	1,695	9.4
Private for-profit beds per million population (estimated)	139	9.4

Note: The 2001 National Health Accounts Report for Zimbabwe cites the Medicines Control Authority as indicating that by 1999, over 300 pharmacies had been registered in Zimbabwe. This shows a huge discrepancy in the data. For our purposes we have opted for the latest data as shown in the above table, but it is important to take note of this discrepancy.
Source: Mudyarabikwa and Madhina, 2000

Private hospitals are costly and mainly serve the high income urban market, particularly in Harare (where there are eleven private hospitals). The business opportunities for private hospitals have increased due to the financial, staffing, and management crisis in the state sector. Private hospitals are able to attract high income earners in the urban areas, particularly those covered by health insurance.

3.3 Capital flows in the health insurance market

The health insurance market is liberalised and allows private companies to set up health insurance schemes. These schemes operate as medical aid societies and are misleadingly described as not-for-profit operations. This is however just a description adopted for tax purposes. The proliferation of private health providers has increased the importance of medical insurance. The medical aid sector has various operators, operating ‘open’ (any person can be a member) or ‘closed’ (only admit certain people, e.g. employees of a particular industry) schemes. Just over a million people in Zimbabwe have medical aid, with Premier Medical Aid Society (PSMAS) having 520,000 members; CIMAS having 450,000 members; Engineering Medical Fund having 20,000 members; and others accounting for 110,000 members.

Premier Medical Aid Society is a public sector medical insurance scheme, catering for civil servants and their dependents. Although owned by the government, Premier operates like a private company. The rest of the medical insurance industry is privately owned. There are no private not-for-profit medical aid societies in Zimbabwe, and no national health insurance scheme, so most of the population is not insured for health needs, and cannot access the expensive private sector health facilities.

Generally, the Zimbabwean health care system is highly liberalised. The state sector operates alongside private for-profit operators in urban areas, and church-based health care in rural areas. In some provinces, such as Midlands, private not-for-profit sector provides almost all health care facilities. In Harare the private for-profit sector is very dominant. The private sector is also dominant in particular areas of service delivery. The impact of this mix of services on access to and uptake of services is less well documented, however there is an implicit inequity in that private for-profit services largely serve the urban, higher income population with lower health needs, while state and not for profit service largely serve the lower income urban and rural population with higher health needs. The coverage of the informal and traditional for profit sector is largely undocumented.

4. Findings: Capital flows in the health sector, 1995–2007

This section will present evidence on the current situation and trends from 1995 and beyond with respect to private capital flows to the health sector in Zimbabwe. The discussion will also show the source and targets of the capital flows. To contextualise, we analyse the nature and volume of Zimbabwe's expenditure on health.

4.1 Health financing in Zimbabwe, 1995–2005

National Health Accounts (NHA) provide a synthesis of the financing and spending flows recorded in the operation of a health system (WHO, 2007). *Table 5* shows total expenditure on health (THE) between 1996 and 2005, as a percentage of GDP in Zimbabwean dollars (Z$) and US dollars (US$), noting the high inflation rates in Zimbabwe[1]. To give a better picture of actual expenditures we have in some cases used parallel markets exchange rates to assess total Z$ equivalents of US$ values after the emergence of this market in 2000.

Table 5: Zimbabwe total expenditure on health (THE), 1996–2005

	THE as % of GDP	THE in million Z$	THE in million US$	THE in million US$ (official exchange rates)	THE in million US$ (parallel market rates)
1996	7.4	6 365	636.50	N/A	N/A
1997	9.2	9 380	774.56	N/A	N/A
1998	10.8	15 511	655.02	N/A	N/A
1999	7.4	16 990	443.60	N/A	N/A
2000	7.6	24 850	443.75	559.43	443.75
2001	6.4	45 491	212.57	826.35	212.57
2002	6.2	105 898	145.26	1,924.01	145.26
2003	6.5	358 021	96.76	513.35	96.76
2004	7.5	1 782 793	280.88	351.73	280.88
2005	7.0	5 802 632	333.42	259.47	333.42[2]

THE=total expenditure on health; NCU=national currency unit; N/A = not available
Source: WHO, 2007 (adapted by author)

Total expenditure on health has fallen from a peak of 10.8% of GDP in 1998 to just 7% of GDP in 2005. In US dollar terms the figures translate to total expenditure on health of about US$1 924.01 million in 2002 to just US$259.47 million in 2005. Total expenditure on health

[1] The rates used in the WHO estimates reflect official Zimbabwe rates, however these rates are unrealistic, and as will be apparent in later sections of the paper where we make use of unofficial estimates in order to make the capital flows data comprehensible. The exchange rates above were calculated by the WHO using averages of official rates in the relevant periods.

[2] The increase on the adjusted exchange rate figure is because the WHO data used an exchange rate of Z$22,363.60 to the US dollar whereas the annual parallel market average rate we used is Z$17,403. The Zimbabwe government adjusted the exchange rate in the last quarter of 2005, whereas we used monthly averages to calculate the annual parallel market rates for the same year.

peaked in 2002 using official rates, but this was the lowest level between 2000 and 2005 using parallel market rates.

General government expenditure on health (GGHE) is the sum laid out by government entities to purchase health-care services and goods. It comprises the outlays on health by all levels of government, social security agencies, and direct expenditure by parastatals and public firms. Expenditures on health include final consumption, subsidies to producers, and transfers to households (chiefly reimbursements for medical and pharmaceutical bills). It includes both recurrent and investment expenditures (including capital transfers) made during the year. Besides domestic funds it also includes external resources (mainly grants passing through the government or loans channelled through the national budget). Central government expenditure allocated to health averaged 8% of total government expenditure over the period 1994–2004 (UNICEF, 2007). By 2005 the health care budget had risen to 13% of total government spending. However this is still far from adequate for the purpose of basic health care provision in Zimbabwe. Shamu et al (2006) noted that:

> *International estimates of funds needed to meet basic health goals or deliver a reasonable minimum of services range from $34 per capital [sic] to $60 per capita, with an estimate of $169 per capita including costs of ARVs. The 2001 National Health Accounts indicated a per capita spending on health in the public and private sector in Zimbabwe of $37.26. Of this $13.73 was in the public sector. The evidence suggests that this has fallen since 1999 suggesting a gap in overall resource adequacy to deliver a basic national health service.*

Private health expenditure includes expenditures on health by: pre-paid plans and risk-pooling arrangements (outlays of private insurance schemes and private social insurance schemes); firms' expenditure on health (outlays by private enterprises for medical care and health-enhancing benefits other than payment to social security); non-profit institutions serving mainly households (NGOs); and household out-of-pocket spending (OOPs) (including household direct payments to public and private providers of health-care services, non-profit institutions, and non-reimbursable cost-sharing, such as deductibles, co-payments and fees for services).

Table 7 shows a general trend of a sharp fall in government's share of capital outlays in the health sector, lowest in 2002 when government contributed to just a third of total health expenditure. In contrast, private expenditure on health has risen from a low of 41.4% of total health expenditure to a peak of 66.9% of total health expenditure in 2002. The ten year (1996–2005) average contribution of the private sector to total health expenditure is 52.7%; the government average was 47.3% for the same period; this period saw the private sector replacing the government as the major contributor to total expenditure on health.

The bulk of private health expenditure is borne by households and this burden increased dramatically between 1996 and 2005. This reflects the fact that health insurance is available to a small portion of the Zimbabwean population. Shamu et al (2006) observed that:

> *The consistent increase in out-of-pocket spending is of concern, given the increased the [sic] burdens on households at a time of severe economic difficulty…The out-of-pocket share of the private expenditures is shown to have risen to above 53% by 2003, indicating decline of the welfare system and a likely burden on low income households. The falling private pre-paid share of private expenditure and a corresponding increase in out-of-pocket payments reflects a picture where one can conclude it is mostly the unemployed and the informal sectors using [sic] this form of payment for accessing health care.*

Table 7: Health expenditure between government and private sector as percent of total health expenditure, 1996–2005

	GGHE (million NCU)	GGE as % of THE	PvtHE as % of THE	Total PvtHE	Household expenditure	Prepaid and risk pooling expenditure	NGO expenditure
1996	3 500	55.0	45.0	2 865	1 900	600	35
1997	5 500	58.6	41.4	3 880	2 600	813	27
1998	8 663	55.9	44.1	6 848	5 151	1 124	11
1999	8 313	48.9	51.1	8 677	3 900	3 433	158
2000	12 000	48.3	51.7	12 850	6 000	4 000	350
2001	17 544	38.6	61.4	27 947	14 161	8 100	775
2002	35 100	33.1	66.9	70 798	36 292	20 759	1 987
2003	128 819	36.0	64.0	229 202	113 235	64 769	6 198
2004	821 706	46.1	53.9	961 087	467 862	267 614	25 611
2005	3 058 887	52.7	47.3	2 743 745	1 360 606	727 033	74 480

GGHE; government general expenditure on health; NCU: national currency unit; PvtHE; Private expenditure on health
Source: WHO 2007, modified by authors

The Vote of Credit (VOC) and Health Services Fund (HSF) are two mechanisms employed by the government to harness externally sourced Capital for the health sector. The VOC releases donor Capital funds from the Ministry of Finance and the HSF is directly managed by the Ministry of Health and Child Welfare.

Post-2000, donors have shifted to direct payments to NGOs and other non-state actors (MOHCW, 2001), now governed by the Private Voluntary Organisations (PVOs) Act (Chapter 17.05) of 2007. Zimbabwe's position as a significant recipient of aid to health is confirmed in *Table 8*, as is the health sector as a target of aid, which increased to 49% over the period 2002–2004. The Ministry confirms that donors are a significant source of funding for both private and public health providers under the 'external resources' category (ibid).

Table 8: How Zimbabwe compares for externally sourced health capital

1996–1998		1999–2001		2002–2004	
Nigeria	57	Eritrea	41	Barbados	63
Sudan	50	Nigeria	37	Botswana	55
DR Congo	49	St. Helena	36	Swaziland	52
St. Helena	41	Liberia	35	Zimbabwe	49
Burundi	39	Zimbabwe	32	Liberia	43
Afghanistan	36	Myanmar	31	Myanmar	42
Iraq	35	Cook Islands	30	Nigeria	39
Sierra Leone	34	DR Congo	29	Tonga	38
Dominican Rep.	33	Sudan	28	Haiti	38
Gambia	32	Suriname	26	Zambia	35

Source: OECD, undated

Table 9 shows that external funds (the bulk of which are donor funds) account for a significant portion of total expenditure on health, increasing tenfold from a low of 2.1% (2000) to a high of 21.4% of total expenditure on health (2005). Notably this is the *share* of total funds and not the absolute amount. The shares increased as absolute amounts per capita went down, as shown later, due to falling overall expenditure in health. The 2001 National Health Accounts (MOHCW, 2001) indicate that donor finances contributed 13% of total health financing for 1999 to both the Ministry, Medical Stores and to Private Voluntary Organisations. OECD (undated) data indicate that donor funding geared towards the health sector rose from 32% in 1998–2000 to 49% in 2004.

Table 9: Significance of external funding on THE

	External resources as % of THE	THE in million NCU	THE in million US$
1996	4.0	6 365	636.50
1997	5.8	9 380	774.56
1998	3.7	15 511	655.02
1999	4.8	16 990	443.60
2000	2.1	24 850	559.43
2001	5.5	45 491	826.35
2002	2.2	105 898	1924.01
2003	5.7	358 021	513.35
2004	13.1	1 782 793	351.73
2005	21.4	5 802 632	259.47

Source: WHO, 2007 (modified by author)

Most of the externally sourced capital for health comes in the form of donations and not loans. Since the downturn of the economy in 1999, this source has sustained health capital development in the country following suspension of assistance from the World Bank and IMF. Global Funding agencies providing capital to the health sector include Global Aids Fund and the Malaria Roll Back Programme.

4.2 Local capital investments in health

This section discusses the private capital flows in Zimbabwe from 1995–2007 in relation to sources and targets, including the key entry points for private capital. We identify sectors of the health system in which private capital is concentrated. The following categories of investment are included in the mapping exercise:

- mergers and acquisitions in the local health sector;
- foreign direct investment (FDI) directed at the health sector;
- incentives to the private health sector, such as training subsidies and tax incentives; and
- 'contracting out'.

4.2.1 Mergers and acquisitions

The acquisition of existing healthcare facilities has been a dominant key entry point for a number of private health providers. However data on sector-by-sector mergers and acquisitions is difficult to obtain, as the health sector has no requirements that such activities should be reported to the authorities for purposes of recordkeeping. The Competition and Tariff Commission of Zimbabwe is the principal authority with respect to general mergers and acquisitions, however it is relatively new in Zimbabwe and has only considered a handful of mergers in the health sector. The legislation under which mergers are considered in Zimbabwe does not require all mergers to be reported, so a number of mergers and acquisitions may have occurred which were not reported to the Commission for purposes of approval. Hence in the absence of a central and official source of information most of the data used under this section has been acquired from various sources.

The most aggressive player on the acquisitions market has been Premier Service Medical Investments and arm of PSMAS. This health services provider has shown an aggressive pattern of acquiring existing private health care facilities as it expands across Zimbabwe. Premier's targets have been very diverse as Premier attempts to assert itself as a competitor in the private health sector and across all medical services. Between 2001 and 2005, PSMAS acquired health facilities ranging from nursing homes, optometrics, occupational therapy, dental surgeries, medical clinics, pathological labs, pharmacies and a hospital, with a combined value of US$251,830,480 (PMAS, 2007).

The key entry point for PSMAS as a capital investor was mainly in acquisition of properties that were then used for purposes of health care. Some of the acquisitions were actually going concerns for which a fresh injection of capital was required. The acquisition of West End resulted in increased bed capacity due to investment in a new casualty facility. Before the merger West End did not have a casualty facility and its operating theatres and ICU were almost non-functional. The hospital is now fully-fledged.

CIMAS, another big medical aid society, also bought clinics across the country. CIMAS have invested in medical clinics in Harare, Chitungwiza, Bulawayo, Mutare and Gweru since 1995. The estimated cost of setting up operations which consisted of purchase of building and opening stock is shown in *Table 18*. CIMAS, with Greenfield investment and a foreign investor, Gambro of Sweden, also established the Harare Haemodialysis Centre in 2001.

Table 18: Investments in health care facilities by CIMAS, 2001–2004

	Name of Facility	Location	Estimated Cost ($US)
2001	Harare Haemo Centre	Harare	4 924 600
2002	Rowland Square Clinic	Harare	666 667
2002	Cimas Medical Clinic	Bulawayo	565 712
2003	Chitungwiza Medical Clinic	Chitungwiza	420 121
2004	Gweru Health Care Centre	Gweru	316 000
2006	Mutare Health Care Clinic	Mutare	486 000
Total			7 379 100

Source: CIMAS, 2001; 2007

Government disposed of its 34.15% in CAPS in 2002 when the company was facing difficulties and when privatisation of government owned companies was at a peak. The government shareholding was acquired by CAPS management, CAPS workers and Strategis Holdings backed by Interfin Merchant Bank (all local Zimbabwean institutions).

The acquisition of St Anne's Hospital by the pharmaceutical group CAPS Holdings in February 2005 is one of the few documented acquisitions in the public domain. The acquisition was filed with the Competition and Tariff Commission which approved it. According to the agreement of sale totalling US$42,105,263, CAPS bought the assets of St Anne's Hospital and to lease the portion of the St Anne's property on which the hospital is built together with all the improvements and buildings used as part of the hospital.

Medical Air Rescue Services (MARS) was set up in 1991 to provide road and air ambulatory services and in 1999 was acquired by the Strategis Group. CIMAS, the medical aid society also has a shareholding in MARS. The value of the transactions could not be ascertained.

Macmed (interests in hospital equipment) was placed under provisional liquidation in 2002, which gave investors an opportunity to gain entry into the Zimbabwean private health sector, particularly Westminster Holdings (Africa) Limited (Westminster), a company incorporated in Guernsey, Channel Islands. Macmed then changed its name to MedTech in the same year. The value of the transactions could not be ascertained.

Medtech and Strategies are two medical services companies which made use of the acquisition strategy to expand its range of services and market share. In 2003 Strategis acquired Zimbabwe Pharmaceuticals (Pvt) Limited. Strategis had resolved to acquire 50% of Zimpharm for 30% of the shareholding of Strategis granted to Medipharm (Pvt) Limited who owned 100% of Zimpharm. Strategis also agreed to a put/call option on the residual 50% share in Zimpharm, which they exercised to become the sole shareholder of Zimpharm. (A put option is a right or option but not an obligation to sell a share at a fixed price within a

fixed period. A call option on the other hand is an option but not an obligation to buy a share at a fixed price during a fixed period.)

In 2005 MedTech which specialises in clinical laboratories and imaging acquired Strategis MARS, which specialised in ambulatory care, for a total of US$342,465,753. In 2002 MedTech Holdings acquired Bololgna Investments t/a as Baines Imaging group. Baines is the largest imaging business in Zimbabwe. In 2003 MedTech also acquired Margolis Medicals which manufactures sanitary pads, theatre caps and plastic gloves.

Meikles Africa Limited has a presence in the hotel and financial services industries; it entered into the health sector through its acquisition of the Medix pharmacies in 2002. The Meikles interests in Medix pharmacies were further diluted when they earlier disposed of its shareholding to benefit the interests of minor shareholders. In 2002 the South African investors Clicks and Discom entered the Zimbabwean health market through Meikles Africa, which acted as franchisees and resulted in the establishment of fourteen pharmacies under the Clicks brand. It has been difficult to establish the value of this franchising agreement (Meikles Africa Limited, 2002).

In 1998 ZISCO Steel, a government owned steel maker disposed of its interests in Torwood Hospital and Redcliff Medical Centre to the private operator, Bell Medical Centre. The International Finance Corporation then also became a major shareholder in the operations of both facilities when it came in with quasi-equity of US 750,000 in a project which involved the expansion and upgrading of the two facilities at a budget of US$1.61 million (IFC, 2000).

4.2.2 Foreign direct investment directed in the health sector

A useful indicator of FDI in the health sector are the records of the Zimbabwe Investment Authority (formerly Zimbabwe Investment Centre). By law all foreign investment projects must be filed with and approved by the Investment Centre. Whilst not every approved project takes off the data is useful as an indicator of the extent of external capital flows which were targeted at the private health sector in Zimbabwe. According to the Reserve Bank of Zimbabwe, normally only a third of these approved projects are ever put into operation and it is not always easy to follow up to verify the stage of implementation of these projects until foreign currency transactions start being done (out of the above intended to total investment only about US$30,370,985 was actually invested into the sector as capital, which amounts to less than what PSMAS alone has invested in the health sector). There has also been no proposed project in the health sector for Zimbabwe since 2001. This makes sense since this is the time when problems facing the country started and these had a huge bearing on the perception the country was getting from foreign investors who are the source of FDI. Investor confidence just evaporated. *Table 19* shows the health sector projects approved by the Zimbabwe Investment Authority since 1995.

The direction of the FDI was aimed at the diverse range of activities in the private health sector. According to the World Investment Report (UNCTAD, 1999), Zimbabwe received ‘considerable’ FDI in the pharmaceuticals and chemicals products between 1996–1998 and 2000–2003 (UNCTAD, 1999: 431). ‘Considerable’ investment is defined as a share of 10% or more in total accumulated FDI inflows into the country. *Table 20* gives an indication of the FDI inflows into Zimbabwe over the relevant period. An estimated US$75 million in FDI was invested into the pharmaceuticals and chemicals products between 1996–1998, and 2000–2003. The UNCTAD data does not split the estimates to reflect the precise figures of the FDI which went into either the pharmaceutical or the chemicals products sector. (*Note:* The target investment areas for projects reported to the Zimbabwe Investment Centre do not reflect any transactions involving the pharmaceuticals sector.)

Table 19: Health sector projects approved by the Zimbabwe Investment Authority since 1995

	Company	Service	Investment US$	Source	Location
1995	Eleuthra Trading	Optician's Outlet	440 000	United Kingdom	Harare
1995	Fox-Hole Trading	Dental Service	180 000	United Kingdom	Harare
1995	P. G Smith	Dental technol. Services	240 000	South Africa	Harare
1995	Spec Savers	Optical services	580 000	United Kingdom	Harare
1996	Dental Implantology Centre	Dental services	5 000 000	Yugoslavia	Harare
1996	Educare Mobile Clinic	Health provisions	327 600	South Africa	Concession
1996	Elizabeth Parker	Reflexology, aromatherapy	240 000	United Kingdom	Harare
1996	Little Star	Orthodontic practice	280 000	United Kingdom	Bulawayo
1996	Mobile Rural Dental Clinic	Dental services	800 000	India	Masv, Gokw & Kwekwe
1996	The Dental Clinic	Dental services	2 400 000	United Kingdom	Harare
1996	Universal Health Care	Hospital	29 200 000	United Kingdom	Harare
1997	Cimas/Gambro Haemodialysis	Clinic for kidney patients	4 924 600	Sweden	Harare
1997	Satyanathan Clinical Services	Health services	640 000	India	Kadoma
1997	Zinomed	Dental equipment	992 000	Finland	Harare
1997	Zinomed	Dental surgeries	3 968 000	Finland	Harare
1998	Bucahaman Medical	Medical equipment	2 482 545	Germany	Harare
1998	Mehnaaz Investments	Medical school	36 363 636	South Africa	Chinhoyi
1999	Henswick Technical	Medical consultancy	45 545	South Africa	Harare
1999	Traditional M W M Clinic	Clinic	363 636	United States	Harare
1999	Zimbabwe Medical Admin	Medical Aid Admin	1 863 636	South Africa	Harare
2000	Axum Investments	Surgery	603 909	Yugoslavia	Harare
2000	Men's Clinic International	Medical/health	98 182	South Africa	Harare
Total			**92 033 289**		

Source: Zimbabwe Investment Centre, 2007

Table 20: Estimated FDI inflows into the pharmaceuticals and chemicals products, 1996–2003

	Total FDI inflows (million US$)	Estimated FDI inflows in pharmaceuticals and chemicals products (million US$)
1996	81	8.1
1997	135	13.5
1998	444	44.4
2000	30	3
2001	5.4	0.54
2002	26	2.6
2003	30	3
Total	**751.4**	**75.14**

Source: UNCTAD, 1999

The World Bank is a further source of FDI. World Bank investments have largely been aimed at the public sector, but have also provided points of entry for private capital, especially for the construction of health care facilities. In the Second Family Health Project (World Bank, 1991), the Bank insisted on international competitive bidding (ICB). While this was reported to yield construction costs that were 40% below government estimates, timely and below budget completion, it provided significant entry points for international construction companies, including for the procurement of furniture and equipment valued at $11,254,821.71 (MOHCW, 2004). The World Bank wholly funded the project with the government supplying labour (see *Table 21*).

The IFC also invested in the private health sector (the spike in FDI in 1998 was as a result of one major project, the Hartley Platinum Mine, the resulting proportional estimate of the FDI inflows in the pharmaceuticals and chemicals products sector should therefore be read with caution). The most notable was Belvedere Private Hospital, with an estimated cost of US$1,540,000. The project involved the expansion of the Belvedere Maternity Home which was owned by sixteen private doctors and had an IFC investment of US$352,000. In 2000 the IFC also invested in the expansion of Torwood Hospital and Redcliff Medical Centre in Kwekwe, in partnership with the Bell Medical Centres Ltd which owns the two health facilities.

4.3 Incentives to the private health sector

The nature of the incentives offered to the private health sector has a direct link with the flow of capital in the private health system. Mudyarabikwa et al (2000) analysed the monetary and non-monetary incentives offered to the private health sector in Zimbabwe, which included opportunities for key entry-points for private capital, such as contracting out. Training subsidies and specialised training for private healthcare providers are some examples of non-monetary incentives targeted at the private sector. This study noted that:

- Government assumed the responsibility of financing basic training in the country as part of its manpower development strategy. High profitability in the private sector is therefore partly a result of employing competitively trained and skilled professionals from publicly funded training institutions.
- The few private sector providers who sponsor their employees at public institutions are to some extent subsidised by government to induce them to invest more national manpower development. Private sector sponsored student's educational expenses have tax credits for their employees.

Table 21: Capital costs for World Bank health sector investments (US$)

Capital cost estimation equipment and furniture					Capital cost for building new departments	Total cost of project
Hospital	**Total cost : ex-warehouse**	**Transport: delivery, training & maintenance**	**Spare parts**	**Total**	**Actual rehabilitation - building, plumbing, electricity etc**	**Total**
Chivi	846.016,03	93.061,76	42.300.80	981.378,59	2.944,135,77	3.925,514,36
Mwenezi	792.733,06	87.200,64	39.636,65	919.570,35	2.758,711,05	3.678,281,40
Siakobvu	201.954,75	22.215,02	8.078,19	232.247,96	696.743,88	928.991,84
Kariba	42.950,70	4.724,58	1.718,03	49.393,31	148.179,93	197.573,24
Kadoma	702.087,82	77.229,66	35.104,39	814.421,87	2.443,265,61	3.257,687,48
Chimhanda	751.854.74	82.704,02	37.592,74	872.151,50	2.616,454,50	3.488,606,00
Guruve	751.854.74	82.704,02	37.592,74	872.151,50	2.616,454,50	3.488,606,00
Mutawatawa	751.854.74	82.704,02	37.592,74	872.151,50	2.616,454,50	3.488,606,00
Kotwa	751.854.74	82.704,02	37.592,74	872.151,50	2.616,454,50	3.488,606,00
Nkayi	600.951,99	66.104,72	30.047,60	697.104,31	2.091,312,93	2.788,417,24
Inyathi	751.854,74	82.704,02	30.074,19	864.632,95	2.593,898,85	3.458,531,80
Plumtree	751.854,74	82.704,02	30.074,19	864.632,95	2.593,898,85	3.458,531,80
Maphisa	751.854,74	82.704,02	37.592,74	872.151,50	2.616,454,50	3.488,606,00
Hauna	683.396,87	75.173,66	34.169,84	792.740,37	2.378,221,11	3.170,961,48
Bonda	42.950,70	4.724,58	1.718,03	49.393,31	148.179,93	197.573,24
Murambinda	201.657,33	22.182,31	8.066,29	231.905,93	695.717,79	927.623,72
Beitbridge	299.795,96	32.977,56	17.987,76	350.761,28	1.052,283,84	1.403,045,12
Silobela	694.975,64	76.447,32	34.748,78	806.171,74	2.418,515,22	3.224,686,96
Kwekwe	42,950.70	4.724,58	1.718,03	49.393,31	148.179,93	197.573,24
Sadza	751.854,74	82.704,02	37.592,74	872.151,50	2.616,454,50	3.488,606,00
Chivhu	42.950,70	4.724,58	1.718,03	49.393,31	148.179,93	197.573,24
TOTAL	11.254,821,71	1.239,805,06	554.360,66	13.048,987,43	39.146,962,29	52.195,949,72

Although there are cases of prioritising training of publicly-employed health personnel in specialty areas, the private health sector, with support from the government, can access similar training if such training is not available in the country. Self-sponsoring private providers on postgraduate training are given tax credits for their expenses to encourage knowledge and skills updating.

With respect to monetary incentives, Mudyarabikwa et al (2000) highlight:

- **Tax Incentives:** Various government initiated tax incentives support small businesses including private for-profit health care providers, either as individuals, associations or companies. These incentives are primarily inducements for capital investments in services expansion and quality improvement by for-profit private providers.
- **Tax Exemptions:** Since the 1950s targeted tax incentives were employed to influence the growth of private health insurance schemes, which financed the health needs of the affluent population. The Income Tax Act of Zimbabwe provides for tax exemption on Medical Aid Societies' income and accruals. This tax incentive has been retained over the years to encourage growth of private medical insurance, which finances the needs of the high income consumers.
- **Tax credits for employers:** There are tax incentives for employers subscribing to medical insurance for their employees.
- **Tax credits:** The Income Tax Act provides tax credits for the expansion and/or replacement of equipment and tools of trade by all small businesses including the private for-profit health providers. The incentive not only induces providers to provide quality care and services, but also cushions emerging providers particularly at infancy when expenses are mostly on new equipment and tools of trade.

By 1984 the level of incentives given to the private health sector was so substantive that the then Minister of Health, Dr Ushewokunze made critical statements against the private health sector and estimated that in 1984 the state subsidised the private health sector directly and indirectly by Z$17 million (Loewenson, 1990).

4.4 Contracting out

Mudyarabikwa et al (2000) treat contracting out as an incentive for expanding the private sector in the health system in Zimbabwe. They observe that the contracting of certain health services to the private for-profit sector was never seriously considered until in the mid-1990s. This was because the initial focus of the government of Zimbabwe was financing health care as its political and social responsibility, hence attempts at contracting out to the private sector were viewed suspiciously by policy makers. However this changed in the 1990s resulting in the elimination of most internal contracts in favour of the private for-profit providers of non-clinical services. Mudyarabikwa et al (2000) note that payments to the private for-profit sector increased for drugs, surgical and related equipment, catering and laundry supplies. They conclude that 'to a large extent public facilities now 'outsource' and 'multi-source' supplies to their best advantage without engaging in long term contractual agreements with the suppliers. Contracting-out opportunities accruing to the private sector are shown in *Table 23*.

Table 23: Levels of functional contracting out to private for-profit providers

Type of contract	Functions to contract	National current status degree of contracting
Non-clinical services	Catering	The principle is generally accepted at national level. No evidence that the functions have been contracted out at any public facility (Central, Provincial, District etc. levels. Otherwise catering at all facilities is still publicly provided.
	Cleaning	Still publicly provided at all facility levels (Moves to start at Parirenyatwa Hospital in 1995 were shelved.) All cleaning functions are owned and provided by government.
	Security	At all public facilities security is provided by.
	Maintenance (land & building)	Still largely provided by government. All buildings belong to another Ministry (Ministry of Public Construction) who maintain them. Government employed grounds men to do the general maintenance through the Ministry of Public Construction (MPC). Otherwise no participation of private for-profit sector has been witnessed at all levels of public facilities.
	Maintenance (equipment)	Hospital equipment maintained by public facilities themselves, through the hospital equipment department that exists at all facilities. Internal contracting exists in the form of MPC doing maintenance for certain plant equipment. For some equipment out-servicing of technical staff from specialised private providers is done- but on an as per need basis. Government therefore purchases equipment from the private sector but largely retains the maintenance of the equipment. Only mortuary equipment maintenance contracted out at the central hospitals.
	Laundry	Central, provincial and district hospitals increasingly out-sourcing laundry with private for-profit launderers.Internal contracting is still widely used with some provincial and district facilities using central hospital laundry facilities for their needs e.g. Harare Central Hospital laundry caters for most northern provinces and districts.
	Billing	Patient billing is still being done by public facilities. All bills are issued at central level through the Central Payments Office, run by Treasury. Some public facilities are now using private sector debt collectors to collect outstanding patient fees. The private sector is also contracted to install computerised billing equipment, although running and maintenance will be done by the public facilities.
Clinical services	Hospitalised care	Mission hospitals, although privately owned, act as agents for government and provide complete health packages in districts that could otherwise be government provided. Hwange Colliery Hospital contracted to provide clinical and other services in Hwange District (the only formalised contract). Otherwise all clinical services are publicly provided. Local government authorities are required by government to provide hospital care and that get small grants from central government to provide such services. This is not necessarily a contractual arrangement but a requirement for local government authorities.
	Ambulatory and related services	Both private and public sectors provide ambulatory services. Private for-profit providers are however not contracted with for ambulatory services. There is a large number of private for-profit emergency facilities offering day care as well as inpatients services. Private physicians offer a variety of services to self-referred day patients at their private rooms and clinics. They can also bring their patients to casualty and emergency wards of public facilities. Local government authorities also offer ambulatory services from which they collect fees, not on behalf of central government. Public facilities also provide ambulatory services at their casualty, outpatient and emergency wings.
	Public health	All public health functions are provided by government. There are however some private for-profit (like mines and agricultural facilities) who provide public health in their environments as a requirement of their industrial activities monitoring. They are not under contract to do so as this is a regulatory requirement.

4.5 General trends

Although extensive information was not easily obtained, the information obtained suggested that there was a period where mergers and acquisitions were the most favoured entry point for private capital. Medical aid societies, without any direct ownership of medical facilities, used the acquisition process to gain access to the health care market, and this strategy was mostly deployed by PSMAS. PSMAS targeted small medical practices spread out across urban Zimbabwe in order to establish a network of clinics. As a result PSMAS has a formidable presence in virtually all aspects of the health care market. Other health care providers such as MedTech and Strategies used the same strategy to expand their product ranges and gain market shares in existing products.

Bankrupt health care providers offered opportunities for foreign investors to gain access to the Zimbabwe health care market. FDI was mostly directed at the pharmaceuticals market, but it was also targeting basic and specialised health care such as dentistry and optical services. The acquisition process has enabled private companies to build vertically integrated structures and create cross-ownership of health services, such as CAPS Holdings' acquisition of St Anne's Hospital. Competitive international bidding as used by the World Bank financed projects created opportunities for international construction and construction-related companies although the study could not specify particular companies that benefited from the World Bank projects. The Zimbabwe health system attracted investors from across the world, mostly from the developed world, but also from India, South Africa and Yugoslavia.

5. Impact of private capital flows in the health sector in Zimbabwe

Zimbabwe presents a problem with respect to weighing the effects of liberalisation and private capital on the health system. This is because two processes have had an effect on the economy in general and on certain sectors of the economy in particular. The health sector has been affected by SAPs but has also been victim of post-SAP national economic and political processes. It is not always simple to mark the dividing line between these two processes, or to establish direct cause-effect relationships in terms of impacts.

Liberalisation in the health care sector led to a growth of operations considered to be more profitable, which led to a distribution of private health care facilities that is largely fee paying and urban, especially in Harare, outside the reach of the majority of the population. This is exacerbated by the limited coverage of voluntary health insurance and the absence of social health insurance. The withdrawal of subsidies and the introduction in 1991 of 'user-fees' in the health sector affected the ability of millions of people to access essential health services.

Perhaps the most comprehensive assessment of the situation with respect to access to health was the *HARP Rapid Health Assessment Report* (2002) (MOHCW and WHO, 2002) which found a range of issues affecting the health sector generally, which are covered in this report. Generally it found a decline in quality of public sector health service provision despite increased health need, with high levels of vacant posts, reduced access to services by women and children due to fee charges; compromised access to health services, safe water supplies and sanitation due to the large-scale movement of people, and a skewed distribution of drugs, leading to some institutions being adequately stocked and others remaining in a critical situation. There was some diversity in the mission sector. Mission Hospitals also had critical stock levels in general, but a few had procured drugs externally.

This study suggested that economic decline post-2000 exacerbated a decline in public sector service quality noted in a number of studies after the implementation of SAPs between 1991 and 1995. This suggests that impacts of liberalisation and public sector

expenditure falls lead to decreasing real government allocations to the health ministry, falling coverage and access in primary and district level services; shortages of drugs and equipment; exodus of qualified staff; nutritional deficiencies; congestion at casualty and mortuaries; reversing health gains made in the 1980s (Dhliwayo, 2001; Bowtchey et al, 1998; MOHCW and WHO, 2002). Dhliwayo (2001) observed that the reversal of earlier gains in health was noted by a 1993 UNICEF study which noted that the quality of Zimbabwe's health services had fallen by a colossal 30%, twice as many women were dying in childbirth in Harare hospitals than before 1990, and fewer people were visiting clinics and hospitals because they could not afford hospital fees. The IMF (Bowtchey et al, 1998) noted that the volume of health care services has increased while the value of these services decreased substantially, with like deterioration in quality. The Community Working Group on Health (CWGH) (1998) and the Parliament Committee on Health in 2000 concluded in contrast that private health facilities were experiencing a boom (Dhliwayo, 2001). This was confirmed by other sources (Bowtchey et al, 1998).

The environment in the ESAP period facilitated expansion of the private health sector, but also enhanced inequalities in access to care. According to Mudyarabikwa et al (2000):

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

The private sector focus on curative services left the declining government funded services to deal with prevention without little complimentary contribution from the private sector. This is a major gap in the health services sector, given the huge proportion of the population experiencing poor living and working conditions. The 2001 National Health Accounts Report recommended that health insurance providers should be made to invest in preventive medical services.

The expansion of the private health care system has not confirmed the claim that competition creates cost cutting benefits for consumers. The major users of the private health care system are high earning individuals and MAS who serve the interests of high earners. The MAS have themselves critiqued the increasing cost of medical services in the private sector as unnecessarily high. They have thus opted to provide direct medical services to their beneficiaries in open competition with the private for-profit healthcare providers. This is evidenced by such innovations as the CIMAS and Premier (MAS) schemes which are versions of the 'managed healthcare concept' under which MAS argue that they are cutting unnecessary costs of medical care. This is contested. Mudyarabikiwa et al (2000) cite fee discrepancies pertaining to patients on medical aid as having the effect of raising the costs of medical care in Zimbabwe. They argue that 'patients on medical aid admitted in government facilities pay higher fees than public patients. The fees would still be lower than those charged by the private for-profit facilities. Insured patients who are referred to government facilities are charged the lower public sector fees, and this, in a way, subsidises medical aid societies who would have otherwise paid higher fees to private sector providers'.

The desire by a number of private for-profit health providers to cut medical costs and increase profits has compromised Zimbabwe's Essential Drugs List (EDLIZ), the list of cheaper generic rather than brand name drugs. Mudyarabikwa et al (2000) note that private for-profit providers have continued to prescribe brand names without adopting the provisions of EDLIZ. They suggest that this may be because brand names guarantee high income for

the practitioners who prescribe and dispense drugs, hence for some general practitioners, the patient's financial interests are not considered paramount. MAS such as CIMAS through the 'managed health concept' do not support the EDLIZ, and in some cases contradict its use. Conflicts are apparent between the EDLIZ and the funding decisions of MAS on the one hand, and of private medical practitioners on the other hand. In some instances MAS openly complain when practitioners decide about drugs on the basis of their own links with the pharmaceutical industry, while on the other hand, MAS themselves support their own private pharmaceutical providers through the 'managed health care' concept compromising the EDLIZ. Hence, while the post-1995 period created huge opportunities for the private retail pharmaceutical sector, the cost of drugs is often out of the reach of most citizens and increases out-of-pocket spending on health, undermining equity.

One of the innovations in favour of private for-profit practitioners was the decision by the Ministry of Health to allow private doctors to use government facilities to treat their own patients. Private doctors were allowed to admit private clients to public hospitals. Government hoped to benefit from this arrangement by private doctors attending to public patients for no fee and by retaining skilled personnel at public hospitals. However, Mudyarabikwa et al (2000) note that the informal arrangement of accessing expensive facilities in exchange for free services to public patients is open to abuse. For example, during the period of this study, the MOHCW had to give instructions to its institutions to debar admission of private patients particularly in maternity wards when they observed an unwillingness on the part of private practitioners to, in turn, give free services to government patients after admitting their private patients at public facilities.

The expansion of the MAS into private service acquisition has been noted earlier, with the MAS taking advantage of business investments, while enjoying tax-exempt status. As Mudyarabikwa et al (2000) noted:

- The biggest Medical Aid Societies like CIMAS, PSMAS and MASCA employ professional management which generates even more profits that can be used to sponsor vertical expansion into commercially run private hospitals and laboratories.
- MAS are often criticised for their vertical growth and adoption of entrepreneurial behaviour. The government and the private practitioners advocate some form of regulation on the operations of MAS. They argue that tax exemption benefits are used to finance vertical expansion and eliminate competitors and emerging providers from the industry.
- CIMAS, the largest society in the country not only provides medical insurance. Vertical expansion has strategically positioned it to allow for the provision of services and care through the ownership of laboratories and shares in up-market private hospitals. Acquisition of line facilities and equipment is funded from untaxed surpluses. Because some medical aid societies are both financiers and providers of health care, they create barriers to new entrants in the private health care market.
- In assessing the impact of vertical expansion, private for-profit providers are concerned that MAS working as health financiers are induced to pay preferential rates to providers and facilities under their management while delaying payment to competing providers.
- Vertical expansion by the largest societies squeezes out competing care and service providers and also does the same to competing health cared financiers by instructing their facilities to discriminate against patients insured by competitors. Such patients are likely to switch insurance societies in favour of the largest ones which own health care providing facilities.

MAS have expanded into the pharmacy sector by taking direct ownership of chains of pharmacies. Where they have not taken direct ownership, MAS have built close relationships with the pharmacy chain stores and created special business contracts which favour them and in some cases which are directly beneficial to their members. MAS routinely direct their

members to their own pharmacies or to the pharmacies with whom they developed close business links. This strategy has created complaints from a significant sector of the retail pharmacies, especially from the small neighbourhood pharmacies which are owned by individuals. The smaller emerging pharmacists argue that they are being eliminated from the market through the use of unfair business practices.

At the same time the MAS have served their traditional membership and have not branched out beyond the urban, high earning and formal market minority. Incentives given to MAS such as tax exemptions have not had the effect of expanding the private health insurance service beyond its traditional minority. Rather such incentives have enabled MAS to make significant capital outlays towards the acquisition of direct interests in the medical services provision. As early as 1996, Normand et al concluded that the MAS in Zimbabwe developed without a strong policy or legislative framework, and in response to a perceived need. While they were largely independent and well managed, they are also limited to the higher income, urban population. While their members receive support in the form of subsidised care and tax relief on premiums, this does not extend to low income, rural communities, with highest health need, who are now making high shares of out-of-pocket spending on health. The 2001 National Health Accounts Report confirms this:

> *Ninety per cent of private facility users are covered by insurance, virtually all of whom are formal sector employees or their dependents. It has also been estimated that in 1997, about one million people were covered by some sort of medical insurance, and most of these would have utilised the private sector at sometime. Despite the fact that public facilities can now retain all revenue from fees, they have not been able to attract clients from this group. It is thought that perceived poor quality of service is the main cause. Seventy five per cent of insurance payments are to the private sector.*

These trends suggest that while there has been significant growth of the private for-profit health system in Zimbabwe, it is limited to major urban centres of Harare, coverage of the highest income earners, limited benefit to public health institutions, lack of competition and consolidation of business interests to some extent using tax and public incentives provided to the medical aid societies, and this has undermined equity in the health care system in Zimbabwe. The private health system has seen increased consolidation of business interests and greater concentration of infrastructure in a few business interests. This is demonstrated in the expansion of the retail pharmacies sector, and the concentrated ownership of the private hospital market in Harare. The direct capital outlays made by MAS have had the effect of creating vertically integrated ownership of medical infrastructure by MAS, putting them now in direct competition with the service providers whose custom they initially sought. Drug manufacturers have moved beyond manufacturing and wholesale to direct ownership of retail pharmacies in direct competition with retailers they initially provided with drug stocks at a wholesale price. CAPS Holdings has even acquired a private hospital, bringing complaints from competing medical services providers (Competition Commission, 2004).

6. Private capital flows and the policy issues

In 1980 the health policy, *Planning for Equity in Health* was adopted by the government to deal with inequalities in health status and healthcare. However in the 1990s, a new approach was adopted under the *National Health Strategy (1997–2007)*, decentralising responsibility for services, liberalising the private sector, strengthening of management and outsourcing of non-essential services. Regulation of the private sector was a focus indicating that the State had accepted private health care providers as a formal part of the health sector.

Mills and Broomberg (1998) note the contesting beliefs around the role of the market in the health sector, with pro-market beliefs identifying inefficiencies in the public sector due to

weakening of private property rights, with few incentives to allocate resources efficiently, and politicians and bureaucrats seen as untrustworthy in controlling public resources in the public interest, as they are more likely to serve their own interests. In response to these analyses 'new public management' envisages the use of market mechanisms to generate appropriate price and demand signals, and to weaken the influence of politicians and professionals over public service delivery, thus ensuring that these services are more responsive to market signals and customers. It is also argued that private organisations can bring the advantages of functional specialisation, as well as speed and flexibility in adjusting to changing factor prices, technology and demand conditions. In this context, the state is seen as a facilitator of service delivery rather than a direct deliverer of services. Mills et al (1998) note that since health services account for a large portion of public services such arguments have been used to support the changes in health policies and to justify the marketisation of health delivery through such devices as contracting out.

Harding (2001) argues that the way forward for virtually all developing countries must include enhanced interaction with private health providers; policy makers in developing countries should pursue options of working with private health care providers, not for its own sake, but as integral means to achieving health sector objectives. These views directly contradicted the policy of the Zimbabwean government in the health sector, which aimed to achieve equity in health delivery and the ability of government to deliver health for all. The policy did not envisage the private sector as an important player in the health sector.

Loewenson (1990) notes the consistency of this policy position pre-1990, with criticism of the private health sector by almost every Minister of Health in Zimbabwe and specific target in health policy of the private sector as distorting the allocation of health resources. Government policy (MOHCW, 1984) thus set its health care priorities as:

- redirecting the majority of resources to those most in need;
- removing the rural/urban, racial and class biases in health and health care;
- overcoming the fragmentation of service providers to develop an integrated, national health care service;
- ensuring accessible care to the majority, with other levels supporting this infrastructure;
- integrating preventive, promotive, curative and rehabilitative care; and
- increasing the participation of and control by communities in their health services.

However official attitudes shifted to follow the 'new public management' models in the aftermath of SAPs, as stated explicitly in the National Health Strategy (1997–2007):

> *Within the context of the National Health Strategy (1997–2007), it has been recognised that continued provision of quality health services will depend on action being taken to address basic issues affecting the entire health system of the country. It is no longer prudent to look exclusively at the government health care system, without examining the role other sectors, both public and private, can play.*

In this regard, the role of the Ministry of Health and Child Welfare is to 'support, promote, and advocate for the provision of quality health services and care to all citizens'. To achieve this, five main areas of reform were targeted:

- Decentralisation — with the expressed aim creating an enabling administrative, managerial and operational environment for all stakeholders in the health sector to ensure that investment in health, public or private is linked to the achievement of national health objectives.
- Management strengthening and the development of managerial and institutional capacity.
- Subcontracting of non-core services, involving the private sector in service provision at all levels, and

- Regulation of the health sector, with enactment of the Medical Services Act (1998), to regulate the operations of stakeholders in the health sector as a whole.

Zimbabwe's membership of the World Trade Organisation (WTO) has added further pressure to service liberalisation. The General Agreement on Trade in Services (GATS) (WTO, 1994) is a multilateral treaty which governs trade in services amongst the member states of the WTO. The health sector falls within the GATS and is one area where private sector participation is expected to increase with the rate of liberalisation. The fact that Zimbabwe is a signatory to the GATS indicates that the official position favours services liberalisation and the resulting private sector participation in services provision. However the structure of the GATS allows a member state to pick which services it wishes to liberalise, and as such make binding commitment to the rest of the membership. As noted by EQUINET (2004), GATS have the potential to impact on governments' abilities to regulate the health sector, for example, by forcing local health providers (including government) to compete with foreign providers, creating a favourable environment for private foreign investors, blocking government's from controlling the number of hospitals in a region, and limiting government's abilities to issue compulsory licenses on medicines.

In general developing countries have made very limited commitments to liberalise services in their respective economies, and to date, Zimbabwe has not made any commitments with respect to the health sector. This shows that at WTO level, the Zimbabwean position is more cautious against deeper and wider services liberalisation, preferring instead to make limited commitments in areas other than the health sector. However, strong private sector presence in the Zimbabwean health sector and the number of international investors that have established themselves as key players in private for-profit health delivery mean that the health sector is already liberalised and there may be significant future pressure to commit health services to GATS.

This pressure has been added to by the recent negotiation of Free Trade Areas (FTAs) Economic Partnership Agreements (EPAs), with Zimbabwe covered by the agreement being negotiated between the European Union and selected countries in east and southern Africa. A framework agreement was recently (November 2007) signed to pave the way for further negotiations in 2008 for the final EPAs to be in place. The EU has a very clear interest in the liberalisation of the services markets across all the African-Caribbean-Pacific regions, as this will enable EU-based services companies to set up physically in these regions, with scope for further changes in the Zimbabwean health system. The extent to which services are liberalised within these agreements will be a marker for the expansion and intensification of private capital flows into the health sector in Zimbabwe, and more importantly of the erosion of state authorities to regulate these flows.

6.1 Regulatory responses

The state has various instruments with which to manage private capital in the health sector. The use of incentives has been discussed in an earlier section, indicating the weakness of use of these measures in Zimbabwe to achieve more equitable outcomes. Regulation is a second major instrument for achieving policy goals. When service liberalisation intensified post-1990, the most important regulatory intervention in the health sector was the enactment of the Medical Services Act (1998). The Act was however only made operational in 2001, almost a decade after the major changes in the private-public mix.

The Medical Services Act introduced a regulatory environment that acknowledged the importance of the private sector in providing health services in Zimbabwe. Private sector health providers had been operating in an unregulated environment. The Act was made to:

- ensure provision and maintenance of comprehensive hospital services in Zimbabwe;

- provide for the admission of persons to government hospitals and the fixing of fees in respect of services provided thereat;
- provide for the granting to medical practitioners and dental practitioners of the privilege of access to certain government hospitals and for the appointment of consultant medical and dental practitioners;
- provide for the registration of medical aid societies; and
- set conditions for the registration of private hospitals.

It recognises that the provision of health services is not restricted to the government and requires the state to provide and maintain comprehensive and constantly developing medical services. However the Act (Section 3) also explicitly requires the Minister of Health to encourage the participation of 'other persons' in provision of health services, encouraging entities such as the private for-profit health care companies as an essential part of the health system. This is a clear policy position in favour of private capital flows in the health care system and the Minister of Health is actually required to encourage the participation of entities other than the state in provision of medical services.

The shift of policy towards the encouragement of the private for-profit health care providers is further amplified by incentives granted to private medical practitioners under the Act. Section 5 of the Act gives the Minister power to grant private doctors privileged access to government hospitals for the purpose of treating their private patients. This incentive assists private practitioners who would otherwise fail to service their patients for lack of appropriate premises and equipment. The incentive may be considered as a form of subsidy made for the benefit of the private for-profit medical providers.

Section 8 of the Act gives the Minister power to fix fees and charges payable for services provided at government hospitals and state-aided hospitals. These powers reflect SAPs policy prescriptions which recommended slashing government public health subsidies and introducing service fees at public health institutions. However an attempt to mitigate the potentially harsh consequences of hospital fees at public hospitals is reflected in the discretion granted to the Minister of Health to specify that no fees for certain specified classes of patients. Further a public hospital superintendent may waive or reduce the fees for hospital services, although situations in which hospital fees may be waived are not spelt out. Hence one can only read social equity considerations into the Act. The Act does not specifically address equity issues with respect to payment of hospital fees at public hospitals. Given the prevalence of poverty in Zimbabwe this is a serious omission in the legislation.

The Act directly regulates the operations of medical aid societies. Section 9 makes it mandatory for medical aid societies to be registered with the health ministry. Failure to do so is a criminal offence. An applicant for registration as a medical aid society must prove that they have adequate funds to cover medical services. The Act allows for the cancellation of the registration of a medical aid society where the society fails to meet the requirements of the legislation, for example, failure to maintain adequate funds for medical services. Regulating medical aid societies protects the membership of medical aid societies from the potential risks that are found in the medical aid societies market.

The Act is to be read with the Medical Aid Societies Regulations (S.I. 330/2000) which provide for a more detailed regulatory regime. The regulations are a policy reaction to the perceived flaws which affected the medical aid societies market. The regulations make a distinction between 'open' and 'restricted' medical aid societies. 'Restricted' medical aid societies are those for whose membership an individual is required to employed or formerly employed by a specific employer or industry. This distinction is important in that it creates boundaries in the operations of medical aid societies. One common complaint which has

been made by health services providers in the past has been that medical aid societies distort the health services market by directing their beneficiaries towards particular health services providers at the expense of others, (e.g. there have been instances where some pharmacy operators have complained that they do not get the benefit of customers who are beneficiaries of certain medical aid societies because the medical aid societies direct the beneficiaries towards particular pharmacies. In some instances the medical aid society concerned would have a direct financial interest in the pharmacies concerned). S.I. 330/2000 was designed to deal with this type of abuse of market dominance. In this context the regulations prohibit 'open' medical aid societies from directing their membership towards the use of favoured health services providers.

Section 11 of the Act also directly regulates the operations of the private hospital sector. After 2001 all new private hospitals can only be set up after the health ministry has approved such investments. The Act sets two conditions which should be met before an application to set up a private hospital can be approved, as follows:

- the private hospital concerned, must have regard to the national needs, the nature of the services and facilities to be provided at the hospital and the proposed location of the hospital; and
- the financial resources of the applicant are sufficient for intended medical services.

The first condition aims to curb poorly planning and the proliferation of private hospitals, and to strike a balance with national health needs. However, the law does not seem to have had any effect with respect to the concentration of private hospitals in a few urban centres. The regulations (as already noted) make it a criminal offence to establish a private hospital without the permission of the minister and to fail to comply with conditions stipulated for the existence of a private hospital. These conditions include matters concerning the size or nature of the private hospital or the services provided at such a hospital.

Racial factors have been inherent in Zimbabwe's health delivery system, with black people pre-independence period largely excluded from both private and public health services. The Act (Section 12) outlaws discrimination in the exercise of private hospitals' rights to admit patients. This provision would have not been necessary but for perceptions that the private health sector, and specifically private hospitals were still excluding some patients on the basis of race, tribe, place of origin, gender, political opinion, etc. The legislation takes this seriously enough to make contraventions of the anti-discrimination provisions a criminal offence. There is a defence availed to the person charged with contravening the gender discrimination clause, providing that the person can justify the discrimination on the grounds that it was reasonably necessary in the interest of defence, public safety or public morality. While this could be interpreted to open certain groups, like homosexuals, to negative discrimination, it may also be used to allow gender specific services such as 'well women clinics', which would not otherwise be allowed.

Although rarely used at all, Section 13 of the Act imposes price restrictions on private hospital services. The restrictions prescribe maximum fees that may be charged by a private hospital and limit the percentage by which the said fees may be increased. Private hospitals are required to seek the permission of the minister to effect a price increase, and failure to do so is a criminal offence. These price controls could be seen to be an attempt to ensure access to private hospitals. Price controls are not new in the Zimbabwean economy, having been in place since independence. However by specifically providing for controls on private health services, the Act breaks new ground. Sadly they have had limited effect and have not generally increased the general public's access to the private hospital sector.

The introduction of competition legislation in Zimbabwe was also a major policy shift towards protecting both consumers and industry from the effects of negative monopolistic behaviour,

collusive business practices such as price fixing, and other abuses of the market. The Competition Act 7 of 1996 introduced wide-ranging interventions in the economy. The Act established the Competition and Tariff Commission whose functions include to:

- encourage and promote competition in all sectors of the economy;
- reduce barriers to entry into any sector of the economy or to any form of economic activity;
- investigate, discourage and prevent restrictive practices;
- study trends towards increased economic concentration, with a view to the investigation of monopoly situations and the prevention of such situations, where they are contrary to the public interest;
- advise the Minister in regard to:
  - all aspects of economic competition, including entrepreneurial activities carried on by institutions directly or indirectly controlled by the State;
  - the formulation, co-ordination, implementation and administration of Government policy in regard to economic competition; and
  - to provide information to interested persons on current policy with regard to restrictive practices, acquisitions and monopoly situations, to serve as guidelines for the benefit of those persons.

The Act applies to all sectors of the Zimbabwean economy, including health services. The latest merger control law concentrates on the value of the transaction; mergers above a certain level of value of assets or turnover must be notified to the Commission for approval purposes. However before the use of the transaction values the law specifies certain sectors of the economy in which mergers and acquisitions had to be notified to the Commission for approval. So prevalent were transactions in the health care sector that the Commission targeted this sector by requiring all mergers and acquisitions to be notified for approval. Proposed mergers in the 'health care industry' were made notifiable by statutory instrument 63A of 2000. 'Health care industry' was defined as:

… the industry in which undertakings are engaged for gain in any one or more of the following activities –

a) operating a hospital, clinic nursing home;
b) operating an ambulance service;
c) manufacturing or supplying -
  i. pharmaceuticals; or
  ii. medical or surgical appliances or equipment; or
  iii. orthopaedic or prosthetic devices, wheelchairs or other such devices or equipment for disabled persons or invalids.

The regulations show that the Commission was concerned about the potential anti-competitive effects of the capital flows in the health sector and sought to regulate the transactions. The Competition Act is important in the context of this paper because a number of cases relating to the operations of the private health sector have been handled by the Competition Commission, and as such, the Commission is regarded in this paper, as an example of the regulatory responses to the operations in the private health sector. The Commission has responded in two ways which are relevant to this paper.

First the Commission has looked into matters concerning private capital flows in the private health sector; this has been done through investigations of mergers and acquisitions in the private health sector. In this regards the Commission has scrutinised such capital flows for the purpose of ensuring that the public interest element is maintained when such mergers and acquisitions occur. Examples of such scrutiny include the following:

- The acquisition of St Anne's Hospital by CAPS Holdings (Competition Commission, 2004). CAPS Holdings a major drug manufacturer and an operator of retail pharmacies purchased St Anne's a major private hospital in Harare. Some private health providers

(mostly drug manufacturers) were not happy with this transaction and they made their views known to the Competition Commission. The biggest concern was that CAPS Holdings would prevent St Anne's Hospital from purchasing drugs from other drug suppliers as a result of its direct ownership of the hospital. The Commission analysed these fears and concluded that there was no real risk of this happening since even some of CAPS Holdings retail pharmacies actually handled more drugs from competing manufacturers than from the parent company. The important point is that the Commission was keen to ensure that the transaction would not distort competition in the health services market.

- The Commission (2005) investigated a number of acquisitions involving the MedTech Group of companies. The company chose mergers and acquisitions as the most profitable method of expanding its business. The Commission conducted a comprehensive analysis of the potential effects of these acquisitions on the health sector in Zimbabwe. Again the analysis was meant to ensure that there would be no serious competition concerns that would arise as a result of the acquisitions in question.
- In 2002 the Meikles Group which operated the Clicks shops as a franchisee took a stake in the Medix Pharmacies (Competition Commission, 2002). This acquisition was challenged by the Retail Pharmacists Association. The Association was concerned that the transaction could have a negative effect on competition in the retail pharmacy sector. However analysis of the transaction concluded that there was no evidence of any restrictive practices as a result of the transaction.

Second the Commission has also looked at how the private health sector conducts itself in anti-competitive ways l. Interestingly the Commission has dealt largely with complaints against the medical aid societies. In 2001, the Commission investigated in terms of section 28 of the Competition Act the allegations of restrictive practices in the retail pharmacies services sector in the Kwekwe/ Redcliff area following the establishment of a prima-facie case for such an investigation. The Commission concluded in its investigation that Ziscosteel Medical Benefit Society (ZMBS) abused its dominant position in the health delivery sector in the area through the highly exclusionary conduct of arbitrarily closing its accounts with most community pharmacies in the area and directing its members to use pharmacies owned by a company called Jenita Pharmaceuticals (Pvt) Limited (Jenita) when buying prescription medication. It was concluded that Jenita was a front for ZMBS's participation in the retail pharmacies sector in the area. The Commission thus issued the following remedial orders in terms of section 31(1) of the Competition Act:

- that ZMBS stop directing its members to use community pharmacies owned by Jenita when purchasing prescription medication;
- that ZMBS shall not direct its members to use community pharmacies owned by Jenita or any other particular/ specific pharmacy as a condition for such members being able to benefit from ZMBS' Drugs Fund; and
- that ZMBS shall ensure transparency and objectivity in reviewing the performance of community pharmacies utilising its drug fund.

The Commission also recommended that the MOCHW and Medicines Control Authority of Zimbabwe ensure full enforcement of the following regulations in the health delivery sector:

- Medical Practitioners (Professional Conduct) Regulations, 1987 (SI 252 of 1987)
- Pharmaceutical Chemists (Professional Conduct) Regulations, 1989 (SI 232 of 1989)
- Medical Services (Medical Aid Societies) Regulations, 2000 (SI 330 of 2000)

The case was very important in that it was also the first time that the Commission resorted to the use of the criminal law to ensure compliance with the Competition Act. A police docket was opened against one of the parties for refusing to provide the Commission with specific information on the case. The case went as far as the courts.

In 2002 the Commission investigated allegations of restrictive practices levelled by the Medicines Control Authority (MCAZ) against the Engineering Medical Fund (EMF). According to the complaint submitted by the MCAZ, in January 2002, EMF had advertised the services it provided in the local media. In the advertisements EMF was claiming that it owned some pharmacies from which its clients could get medicines. A visit by MCAZ officers to EMF's offices revealed that the fund was directing its members to go to Els Pharmacy located in the same building as EMF for their supply of medicines even though there were other pharmacies within walking distance from the EMF offices. The medicines from Els Pharmacy were supplied on EMF's account. Thus according to the MCAZ allegations EMF was engaging in restrictive practices by directing its members to go only to Els Pharmacy for the supply of medicines on the EMF account. At the conclusion of the Commission investigation the Commission found that EMF did not own any pharmacies nor was it involved in selling drugs. Els Pharmacy was an independent entity run by independent directors. The advertisement by EMF had thus created the wrong impression and had misled the public into believing that EMF owned Els Pharmacy which is an offence in terms of the Competition Act. The Commission however also decided that it might not have been EMF's motive to mislead the public as it had apologised for the impression created by the advertisement. It was thus agreed that the Commission should invoke the provisions of Section 30 of the Act and negotiate with EMF for the publication by the fund in the national newspapers of a suitable corrective advertisement that it did not own and direct its members to a particular pharmacy. The Commission held negotiations with EMF in terms of the Act and at the conclusion of the negotiations, EMF advertised in the newspapers that the fund did not own Els Pharmacy and also stated that it treated all claims for drugs purchased from any pharmacy equally and did not give preferential treatment to any particular pharmacy.

In 2003 the Commission conducted a full scale investigation into allegations of restrictive business practices in health insurance and pharmaceutical services sectors of Zimbabwe. The Commission concluded that there was a possibility that PSMAS was abusing its dominant position through engaging in exclusionary restrictive practices of favouring its health centres and limiting the custom of its members to other centres. The Commission also concluded that there was a possibility that CIMAS could engage in an anti-competitive practice by excluding certain medical practitioners and health institutions from participating in its HealthGuard managed healthcare scheme. The Commission thus, issued an order, in terms of Section 31(1) of the Competition Act, against CIMAS to the effect that:

> *CIMAS forthwith stops abusing its dominant position through engaging in exclusionary or exploitative restrictive practices such as directing its members to its health centres or discriminating against other centres in meeting its members claim.*

and:

> *Cimas managed and administers its HealthGuard managed healthcare scheme in a transparent, fair and non-discriminatory manner that ensures the equal inclusion and participation of all eligible medical practitioners, pharmacies and other health institutions in the scheme.*

According to Cimas, the Health Guard Scheme was discontinued in December 2004 in order to alleviate the concerns of the Commission.

The National Association of Medical Aid Societies (NAMAS) also attracted the attention of the Competition Commission, when in 2002 it was briefly investigated for potential price-fixing arrangements based upon the circulation of a notice suggesting that all NAMAS members use a certain tariff to calculate membership dues.

The regulatory system in Zimbabwe was found in 2000 to have a number of weaknesses relative to the scale and nature of capital flows within the sector (Kumaranayake et al, 2000):

- they focus on individual inputs rather than health systems organisations;
- they aim to control entry and quality rather than explicitly quantity, price or distribution;

- they fail to address the market-level problems of anti-competitive practices and lack of patient rights; and
- there is no regulation of private insurance.

This has to some extent been addressed by the overarching role of anti-trust legislation in Zimbabwe, by the medical aid societies' regulations which have a clear bias towards the prevention of anti-competitive practices in the health sector, and by the regulation of the private health insurance sector by both the Medical Services Act and the medical aid societies' regulations.

The regulatory environment is nevertheless rooted in a policy framework that encourages private sector participation in the provision of health care and is thus focused on measures aimed at regulating the quality and quantity of private sector health provision. Anti-trust (in the form of the Competition Act) law was also put in place to curb anti-competitive business practices and to protect the public interest. This anti-trust law has relevance to the health sector and has been used to deal with specific cases where anti-competitive behaviour has been alleged, and also to deal with the potentially negative consequences of capital flows involving mergers and acquisitions in the private health sector.

However the Medical Services Act appears to be inadequate to deal with the numerous problems that affect the health sector and the equity provisions in the Act have not been applied. While the regulatory framework provides for prohibition of discrimination on racial grounds and the provision for price controls on private health services, these are insufficient measures to deal with the range of ways that privatisation impacts on equity in provision of and access to health services. There is still no explicit provision for private providers or MAS to cover prevention services, to cover specific high need population groups or to cross-subsidise provision to ensure financial protection using solidarity principles, for example.

7. Moving forward: areas of focus for research and policy

In conclusion, we identify a number of methodological problems and suggestion for follow up in future research, *vis a vis*: the operating environment; information on capital flows; Zimbabwe Stock Exchange listings; data on FDI; and defining 'private expenditure on health'.

The first obstacle to data collection was the very difficult operational environment in Zimbabwe. Government officials are openly hostile to any questions on the general operations of the health sector. There is a degree of paranoia which is informed by the suspicion that researchers are in general operating as agents of the west. Requests for simple information were met with this degree of suspicion and were consequently turned down. Health ministry officials approached for assistance with information were clearly afraid of releasing data, and were not confident that this exercise was purely for the benefit of the public. The researchers were therefore restricted with respect to the generation of information such as the private sector involvement in the construction of public health facilities. Equally the extent of contracting out was not clearly ascertained because officials suspected that details would be used to reveal the extent of corruption in Zimbabwe. Ironically this attitude was replicated in certain parts of the private health sector.

However, for the purposes of follow-up studies we are confident that the data captured can give a good indicator of the capital flows in the Zimbabwean health sector. The major difficulty encountered in the collection of data for capital flows was the absence of a centralised data source. Though the Medical Services Act gives the government an oversight role on both the conduct and investments of the private health sector important information to reflect the operations of the private sector is missing from the Ministry of

Health. The Ministry of Health is charged with approving investments in the private health sector, but there is no visible system to show the records of such investment since the Medical Services Act was put in place. Attempts at getting such information from the Ministry were met with puzzled looks from the officials. It is possible to file a formal application for this information by using the Access to Information and Protection of Privacy Act.

With the exception of CAPS Holdings the data did not capture capital flows stemming from ZSE listed entities. This data is also useful in capturing capital flows in the health sector. There remains the possibility of disaggregating ZSE dynamics in order to reflect the possibility of other transactions which could have taken place at this level but which were not reported.

Data on FDI was utilised above in order to inform the study on foreign capital flows into the Zimbabwean health system. Although useful for indicative purposes the data is limited because the figures available relate to pharmaceuticals and chemicals industries, and is not disaggregated to reflect the FDI into the pharmaceuticals sector which is relevant to the study. The data from the Zimbabwe Investment Centre is also useful in providing indicative information on FDI into the Zimbabwe health system. The limitation of the data from ZIC is apparent in the fact that ZIC does not appear to have a systematic follow-up of FDI projects in order to assess actual implementation of the projects. Further, although ZIC is supposed to act as the entry point for foreign capital it is possible that many projects by-pass this process and foreign capital establishes itself into the health system without the knowledge and approval of the investment authority.

The strict application of the WHO definition of “private expenditure on health” will result in the study ignoring the contribution of the health insurance sector in Zimbabwe. This is because the health insurance sector in Zimbabwe is also subject to price controls like any other sector of the economy, and such controls disqualify the health insurance sector from being part of the “private expenditure” on health in accordance with the WHO definition. This poses a problem for the discussion on capital flows, and in particular on the dynamics with respect to ‘private expenditure on health’ as well as total expenditure on health. The health insurance sector is an extremely relevant part of the Zimbabwean health sector, for this reason we have opted to ignore the definition which would have had the result of minimising the role of MAS in Zimbabwe’s expenditure on health.

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Acronyms

ACP	African-Caribbean and Pacific
CIMAS	Commercial and Industrial Medical Aid Society
CSO	Central Statistical Office
DAC	Development Assistance Committee
EDLIZ	Zimbabwe essential drugs list
EPA	Economic Partnership Agreements
EMF	Engineering Medical Fund
EQUINET	Regional Network for Equity in Health in East and Southern Africa
ESAP	Economic structural Adjustment Programme
EU	European Union
FDI	Foreign direct investment
FTA	Free Trade Area
IFC	International Finance Corporation
ISER	Rhodes University Institute of Social and Economic Research
GATS	General Agreement on Trade in Services
GDP	Gross Domestic Product
GGHE	General Government Expenditure on Health
MAS	Medical aid societies
MARS	Medical Air Rescue Services
MCAZ	Medicines Control Authority
MOHCW	Ministry of Health and Child Welfare
NAMAS	National Association of Medical Aid Societies
NCU	National currency unit
NHA	National Health Accounts
NSSA	National Social Security Authority
PMAS	Premier Medical Aid society
SADC	Southern African Development Community
SEATINI	Southern and Eastern African Trade Information and Negotiations Institute
THE	Total expenditure on health
TRIPs	Trade-Related aspects of Intellectual Property Rights
USA	United States of America
WFP	World Food Programme
WHO	World Health Organization
WTO	World Trade Organization
ZIC	Zimbabwe Investment Centre
ZINATHA	Zimbabwe National Traditional Healers Association
ZSE	Zimbabwe Stock Exchange

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

EQUINET implements work in a number of areas identified as central to health equity in east and southern Africa

- Protecting health in economic and trade policy
- Building universal, primary health care oriented health systems
- Equitable, health systems strengthening responses to HIV and AIDS
- Fair Financing of health systems
- Valuing and retaining health workers
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