Public sector subsidies to the private health sector in Zimbabwe

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with
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EQUINET POLICY SERIES NO 8

Zimbabwe,
September 2000

Produced with support from
International Development Research Centre (Canada)

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Executive summary

Many developing countries largely depend on publicly funded and provided health services. There are new ideas changing this and advocating for multiplicity of health financing and providing agencies. Ideas on Public - Private Mix in health are taking a centre stage in most developing countries because of the realized benefits from mixing the two sectors in health services provision. The public sector is not comfortable with losing total control of the health sector mainly because of worries that privately provided services are inequitable as often the poor cannot afford the high fees associated with services provided. The reality is that public sectors cannot ban the private health providers without political risk from the consumers who demand quality care associated with the private sector, and can afford the services offered.

Agencies such as the IMF and the World Bank pressurize governments to relinquish some responsibilities for private health providers to control public expenditure and achieve cost-efficiency in services provision. Indeed, many of the developing countries now accept the complementary role of the private health sector and are agreeable to this co-existence. In response to the challenges, the public sectors have determined a variety of policy instruments and methods of control for participation of the private health providers.

The most common methods of control put in place are regulations, taxes and subsidies. There is use of price mechanisms, offering of social and private benefits and other policy instruments to deal with divergences, taxes, subsidies and regulations as ways of public sector support of the private health industry. However, the impact of these instruments on equity has not been clearly documented in most countries.

A baseline qualitative study was undertaken in Zimbabwe to examine and assess the impact of subsidies on equity when provided as private sector support instrument by the government. The study also considered reciprocal subsidies from the private sector.

The rapid growth of the private health sector since independence in Zimbabwe is testimony to the support provided by the public sector through subsidization of part of its activities. The private sector providers now service about 10% of the population. The missions, who are not for-profit providers serve about 70% of the rural population in Zimbabwe which is about 49% of the total population. Because of the perceived quality of care offered, the private sector generally attracts many consumers in formal employment. This slightly reduces congestion at public facilities. The public sector provides subsidies as incentive for the private sector to assume more responsibilities for providing services to those consumers who can afford to sponsor themselves. Subsidies have been provided to:

1. the private for profit sector;
2. the private not for profit sector;
3. the consumers/users of health services; and
4. the public sector by the private not for-profit providers.

Their broad objective is to achieve equity through access to services at affordable prices and ensuring sustainable quality care.

The study observed that both monetary and non monetary subsidies tend to benefit the formal sector conventional health providers more than the providers in the informal sector.

In Zimbabwe, a significant number of rural and urban poor consumers consult more with traditional healers for their health needs. Some rich consumers at times use traditional healers and the conventional providers simultaneously.

Missions providers offer more subsidies to the public sector than they otherwise receive. They contribute a third of national health facilities. For this recognition, the public sector seek to work hand in hand with them and provide grants to cover recurrent expenditures. The public sector has over the years demonstrated its commitment to equity promotion through provision of a variety of subsidies to private providers and financiers. The public sector also provides free health for the indigent.

Quantifying the proportion of private sector budgets financed by public sector subsidies is almost impossible in Zimbabwe because of lack of reliable information on private sector budgets. With regards to missions, there are fears that disclosure of receipts from donors and mother churches could influence the public sector to allocate them less grants.

Application of subsidies represent lost revenue by the public sector. The dilemma is that while the public sector is always under pressure to maximize revenue collection to finance health and other social services, it cannot easily remove some of the subsidies as they have demonstrated their effectiveness in promoting equity and availing health services to those in most need.

Three major observations from this study were that:

1. Public Sector subsidies directed at the private not for-profit providers and consumers have higher consumer benefits and higher impact on equity than those directed at the private for-profit providers.
2. The public sector is reinforced to subsidise more, the operations of agencies (eg missions) whose activities are not antagonistic to public sector health objectives and also take a significant workload off the government through serving the poor, especially those in rural areas.
3. Subsidies themselves do not eliminate but only minimise inequities when there is political will to equitably allocate resources to major stakeholders in the health sector for the ultimate benefit of consumers.

It is hoped the study findings will precipitate similar and related studies in other countries whose health status could be comparable to Zimbabwe.

1. Introduction

Zimbabwe, like many other countries, has the dilemma of finding the best ways to address the health needs of its population and economically develop the country to boast of a population with a satisfactory quality of life.

Prior to independence, the country's health system largely favoured the urban based minority sections of the population. At independence in 1980, the Government sought to redress this by adopting the policy of promoting Equity in health that would extensively develop and finance government owned services. There was a rapid growth in number of health facilities and public health programmes between 1980 and 1990.

From 1990, partly due to population growth and economic stagnation, government resources increasingly became inadequate to match and satisfy the population's health needs. Government embraced policies that allowed multiple providers to sustain past achievements. The private sector has already proved itself as a reality in providing and financing health. Available data demonstrate that the government has historically supported the sector to prove itself in this manner.

The public sector realized the importance of an open statement indicating the status of the private sector as a complementary partner in health provision. In the past, the private sector (particularly the private practitioners) had operated with scant knowledge of the security of their status and acceptance by the public policy makers. The new development helped some private providers to appear out of the shell with challenges to exercise full potential in improving the quality of care.

The public sector demonstrated its desire to involve the private sector and other stakeholders in the provision and management of health services by providing support mechanisms in the form of monetary and non-monetary subsidies. The private sector has since in many ways enjoyed such subsidization by the public sector than it reciprocates.

It is easy to list available subsidies in the health sector. To quantify and ascertain the subsidies in monetary terms with reasonable accuracy is almost impossible because the data is scarce. It is however estimated that subsidies account for one third of national health expenditure (MoH & CW 1998).

Like in most African countries, the government is the major provider of health in Zimbabwe. To retain this status is however increasingly becoming difficult due to public sector resource shortage caused by fiscal deficits, heavy external debts, shrinking donor funds and in some cases, looting of public funds by civil servants. There is realization that salvation in financing health and other social services could be from collaboration with the private sector. The government would require aggressive courtship strategies that entice the private providers to invest in health, upholding their profit motives, but not compromising equity by excluding the poor. Subsidies were observed as possible baits since they can also be equity instruments to cushion the indigent.

2. Study objectives

The broad objective of this study was to examine subsidies provided by the government for the private health sector and vice versa. The study would provide baseline information for similar and related studies in other regional countries. The specific objectives of the study were to:

1. provide an understanding of the environment and context under which subsidies are provided by indicating the size, structure and composition of the private health sector in Zimbabwe.
2. list the major public sector subsidies provided to the private sector and vice versa
3. discuss the respective strengths and weaknesses of the subsidies with respect to impact on equity and other health objectives.
4. indicate the target groups for the subsidies.

3. Study methodology

The study was mainly a qualitative analysis of literature and policy documents on public and private health sectors in Zimbabwe and other regional countries. Interviews were done with top managers in Zimbabwe's health system to confirm literature data. Table 1 shows the major institutions who were interviewed during the study.

Table 1: Source of Data - Interviewed Institutions

Organization	Its role	No. of interviews
MoH&CW	Public Sector Representative Ministry	1 - Under Secretary 1 - Deputy Secretary
NAMAS	Representative of Medical Aid Societies (Health finances)	1 - Executive Secretary
CIMAS	Medical Aid Society	1 - Chief Executive
ZIMA	Representative body of private practitioners	1 - Past President
PSMAS	Medical Aid Society for Civil Servants	1 - Deputy CEO

4. The private health sector in Zimbabwe

4.1 The private health providers

Private health providers have operated in Zimbabwe for many years. The industry includes conventional and traditional health practitioners. There are also private health financing bodies in the form of medical aid societies. The public sector however retains the responsibility for health policy formulation as well as provision and financing of services for the majority of the population. For instance, in 1993, the public sector contributed as much as 65% of health finance, with the private sector, including donor agencies contributing the remaining 35% (MoH&CW 1995). This private sector contribution however conceals the cross subsidization that exist in the health sector, usually flowing more to the private providers than the public sector. In 1991, 7.6% of public sector expenditure was to finance health (MoH&CW 1996). It is not always possible to accurately ascertain the private sector's expenditure on health because of tis amorphous nature. It is improbably that more than 10% of the population benefit from private sector services.

4.2 Composition and size

The private health sector in Zimbabwe includes private corporations in the form of industries, mines and commercial farms; individual practitioners and institutionalized medical providers. The industry comprise of about 1,020 conventional doctors (ZiMA 1996) and about 50,000

traditional healers, 60% of whom are registered with ZiNATHA (ZiNATHA 1999). There are also nurses in private homes, pharmacists and other technical specialists in medical laboratories as well as those in complementary therapies privately working along for-profit basis. Medical Aid Societies form the largest body of private health financiers in the country.

4.3 Type of health services

The type of health services provided by the private sector dependents on the respective motives for incorporation. The majority of the for-profit facilities and private practitioners mainly provide curative care which guarantee them maximum returns on investment. Exceptions are the Mines and Estates hospitals who also offer a range of preventive, promotive and at times rehabilitative services. Preventive services offered by the private practitioners are usually the easy to price services like ante and post natal care. Mission hospitals, by their nature are not for-profit providers. They offer complete health packages similar to those at public facilities.

4.4 Community participation

There is limited community participation provision and management of health services in Zimbabwe. Community participation in the private health sector is mainly restricted to consumer financing services with direct out of pocket payments as well as health insurance coordinated by the Medical Aid Societies. This is however strongest only in urban areas.

4.5 Medical aid societies

Medical Aid Societies have operated in the country for many years as private entities responsible for paying for health services consumed from both the public and private sectors. It is nevertheless estimated that about 75% of the Medical Aid Societies payouts finance services of conventional private practitioners (NAMAS 1998) . Medical Aid Societies are for the purpose of covering employers or group of employers. Only four societies can be classified as “open” in that they are not industry or employer specific in recruiting membership. NAMAS (1998) estimated medical aid societies financed the health needs of as many as 1 million consumers in Zimbabwe with the three largest societies covering about 90% of these consumers.

4.6 General observation

As a general observation, the private for-profit sector was almost closed in 1980 as it was blamed for the inequities in health through the providers’ adherence to curative services only. Missions were preferred for subsidies because they provided complete health packages to majority consumers in line with government objectives. The public sector later realized that banning private provision was politically unacceptable to consumers who could afford private health care. The viable alternative was to court the sector through different forms of subsidies for it to be more complaint to equity promoting objectives. It is partly because of the subsidies that the private providers make profits for reinvestment in quality services to attract clients.

5. Study results

5.1 Public subsidies to the private health sector

This study examined three categories of subsidies. There are subsidies to health financiers, subsidies to health providers (for-profit providers; not for profit providers; and public sector providers) and subsidies to users or consumers. This categorisation and mechanisms for subsidies application are summarised in Table 2. Some of the subsidies were observed to be common to all categories. There are also some public sector operational inefficiencies

that unintentionally subsidize the private sector but these cannot be easily fit into any of the three examined categories. The identified subsidies are examined in greater details below.

Table 2: Identified and Examined Subsidies in the Health Sector

Subsidy category/application mechanism	Specific targets
A. Subsidies for Financiers	
1 Tax Exemption 2. Private Benefits Tax Relief 3. Co-use of Gvt. Facilities 4. Low user fees at public facilities	- Medical Aid Societies - Employers - Individual Consumers & Medical Societies - Medical Aid Societies
B. Subsidies for Providers	
1. For Profit Providers i) Tax Credits - land, Buildings & Tools of Trade ii) Tax Relief - Membership to Prof. Associations iii)Co-use of public facilities iv) Low user fees at Public facilities v) Liberalized private practice vi) Manpower Training and Development v) Contracting out Services 2. Not for-Profit Providers i) Running Costs grants ii) Staffing/Manpower Salaries grants	 - Private Practitioners and Service Providers - Private Practitioners and health professionals - Private practitioners - Private practitioners & services providers - Public Sector health professionals - Private sector health institutions - Private Practitioners and other providers - Private Sector Industries in general - Mission facilities - Mission facilities
C. Private Sector to Public Sector	
i) Services provision by missions ii) Designation of Mission facilities as District Hospital iii)SCN training/Manpower Development by mission iv) User fees - the poor still paying though exempted	- Public Sector and Consumers - The Public Sector - Public Sector and Consumers - Public Sector facilities and local authorities - The Public Sector
D. Subsidies for Consumers/Users	
i) Fees Exemptions ii) Free maternal & Child Health Services iii) Tax Credits - Medical aid and Medical Expenses iv) Tax Relief - Invalid Appliances v) Training and Manpower Development	- The indigent/poor consumers - Mothers and Children - Medical Insurers and ordinary consumers - All other consumers - The disabled and other disadvantaged - All at formal public institutions

5.2 Subsidies to financiers and the private for-profit providers

Most of the public sector subsidies to the private health sector are managed through the tax system. The country's Income Tax Act provides for the subsidies to support all small businesses including the private health care providers.

5.2.1 Tax Exemptions - Medical Aid Societies

1. Medical Aid Societies in Zimbabwe are classified under the Income Tax Act as being non-profit making organizations. They are therefore tax exempted on income accruing through subscriptions and operational surpluses. The idea is to allow for reinvestment of the surpluses in minimizing the membership contributions, which would translate to lower cost for national health provision. Professionally managed societies now realize huge surplus channelled to finance diversification into health providing facilities, again for utilization by private consumers.
2. Vertical integration by medical aid societies has not demonstrated the potential to promote equity. Private facilities are not easily accessible to the poor due to price and

distance barriers. Competing individual private practitioners in Zimbabwe are probably correct when they suggest for regulation of medical aid societies to reinvest surpluses in services that can also be accessed by the poor instead of services that stifle competition through restricting utilization of services from emerging providers. Being both financier and provider sometimes tempt medical aid societies to pay preferential rates timeously to their own facilities than to competitors. This restricts growth of emerging providers who are usually targeted for the subsidies. Ultimately, there would be no benefits to ordinary consumers. The public sector belief is that with more private providers, there would be competition in the industry to ultimately benefit the users through lower costs and a wider variety of quality services.

5.2.2 Private Benefits - Employers

One of the subsidies accessed by the private sector is the tax relief for employers' contributions to medical insurance and other health expenses for their employees. There are set maximum limits for such allowances. The upper limits allowed for treatment vary depending on conditions treated for the employees while for contributions to medical aid, there is a fixed proportion of the contributions that is allowed as relief for the employers. The objective of this subsidy is to encourage the private and formal sectors to finance the health needs of their workers, particularly for the expensive but necessary services the workers could otherwise not afford through out of pocket payment.

5.2.3 Private Benefits - Private practitioners and Services Providers

There are subsidies provided to all small and emerging businesses including the private health sector. They basically serve to promote growth and sustain the providers. Some seek to ensure quality of care and services provided. Their administration is again through the tax system.

1. **Land and Buildings:** The public sector encourage private health providers to own land and buildings from which they operate. The sector therefore provides tax relief on incomes as cushion against the high cost of land and erection of appropriate structures from which care and services can be safely provided. The subsidy allows the small providers to accumulate reasonable profits to improve their capacity to offer a wider range of services. Because consumers in formal employment usually prefer privately provided services, the subsidies are designed to enable private providers to adequately meet the needs of these consumers to reduce congestion at public facilities. There is public sector belief that competition from a bigger private health sector increases the health packages and improves the quality of care offered as well as increasing the choice of providers (MoH&CW 1999).
2. **Tools of Trade Replacement:** In Zimbabwe, the Income Tax Act provides for tax relief to subsidize private health providers who purchase new or replace their trade tools and equipment. The objective is to ensure that patients access quality services with the providers employing appropriate equipment as dictated by developments in medical technology. The providers are also afforded the opportunity to diversify services with minimum constraints associated with equipment cost as is usually the case without subsidies.

5.2.4 Co-use of Government facilities

Private practice at government facilities has been prohibited over the years. It is however now acknowledged that the private health sector, except for some Missions, lack necessary infrastructure including essential equipment to achieve higher supply of care to reduce dependence on public facilities. The public sector therefore provides subsidies for the private providers to buy access to public facilities at central and tertiary levels for their patients. Private patients requiring services such as maternity or other expensive and

complicated surgical operations can now be admitted by private practitioners at public facilities. Although the patients are charged the public sector fees for admissions, the providers themselves do not directly pay for using the public facilities and equipment. Instead, there is an informal arrangement for them to attend to government patients free of charge in return. This subsidy arrangement addresses two other equity concerns of the public sector, that:

1. co-use allows for cost-effective utilization of excess space available at some public facilities at no disadvantage to public patients.
2. public patients are given access to doctors who could have otherwise stayed in the private sector despite shortage of doctors at public facilities.

5.2.5 Subsidization through user fees

The private sector providers determine their own fees without public sector consultation. The fees are too high compared to those charged by the public sector. They are based on what the market can bear rather than what is in the best interest of consumers as is probably the case with public sector pricing. Table 3 below shows the fees differentials for services at private and public facilities. Although insured patients pay higher fees than the uninsured at public facilities, they still pay far less than at private sector facilities. The fee discrepancy is not a significant subsidy to consumers only, but also to medical aid societies who would have otherwise paid higher fees at private facilities. Partly for this reason, private providers tend to refer more patients and overuse government hospitals. Such subsidization is evidenced by the observation that public facilities receive only 4% of payments by medical aid societies (MoH&CW 1997). Half of this is received by only one hospital (Parirenyatwa) which sees more of the private patients.

Table 3: Fee differences between Private and Public facilities: 1999

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

Source: MoH&CW and CIMAS 1999

5.2.6 Liberalized private practice

Up until 1988, health sector civil servants could not legally engage in private practice, even from non-public facilities. This was however very difficult to enforce. Public sector doctors, nurses and other technical support staff can now do private practice outside their normal working hours. This was allowed as a strategy to retain health personnel in the public sector within the country as opposed to emigrating to neighbouring countries and further afield. They can now open private facilities without restrictions from the public sector as long as they meet the basic requirements of their profession and industry. There is further allowance for the same civil servants to admit private patients at public facilities under similar co-use conditions enjoyed by non-civil servant private providers.

In theory, practitioners risk being penalized should it be discovered that they operate privately during Government working hours. The nature of private practice in the country makes it difficulty to quantify lost public sector hours. The MoH&CW (1999) however complain that a great majority of public sector doctors do private practice during public sector working hours.

5.2.7 Manpower Training and Development

Most training institutions in Zimbabwe are publicly owned and funded. They have responsibility for national manpower development without sectorial segregation. The objective is to produce a national stock of appropriately trained manpower for quality provision of services in both the private and public sectors without over reliance on expatriates. The private sector is subsidized in as far as it recruits from a publicly trained pool without its input. Further subsidization is through poaching of essential and skilled public sector manpower by the private sector. The sector deliberately provide unmatched perks to lure the government professionals. Usually no compensation is paid by the private sector inspite of the high cost for developing these professionals. When individuals are publicly bonded, the private sector is ready to buy out contracts realizing it is cheaper than to train own manpower. Rarely do medical doctors stay in the public sector longer than their training period. The public sector therefore never recover cost through long service as its graduates are quick to join the private sector.

Tax Relief for Training Expenses

There are tax concessions provided by the public sector to induce the private sector to invest in national manpower development. Private providers who sponsor the basic education or specialization of their employees and dependents receive proportional tax relief from the public sector. Private practitioners who individually sponsor their specialization are equally treated for the subsidy. The Tax Act provides for this subsidy on condition the providers belong to an approved medical association that certify the expenses and relevance of such training to the profession. Membership fees to such professional associations are also allowed tax credits to individuals.

The public sector also sponsor most of Continued Medical Eduction received in the country. Both the civil servants and the private providers are equally afforded the opportunities for skills and competence upgrading as dictated by advances the health sector. Subsidised specialization and CME narrow the skills gap between junior and senior providers and ultimately benefit consumers.

5.2.8 Contracting Out Services

The public health sector is gradually moving towards contracting out non clinical services with the private sector. To help the providers to firmly establish themselves at the public

facilities, they are subsidized through free utilization of government installations necessary for performing the contracts, such as catering and laundry. The subsidy spares the providers set-up costs and otherwise purchasing or hiring the equipment necessary for the contracts at market rates.

5.3 Subsidies for consumers/users of health services

5.3.1 Exemptions for the indigent

1. To redress some of the pre-independence equity concerns, the Zimbabwe Government
2. adopted to subsidize health needs of the unemployed and low income groups of the population in 1980. Such consumers qualified for free health services at public facilities. The Z$120 threshold for free health in 19980 was increased to Z$200 in 1985 and Z$400 in 1992 due to the depreciated local currency. To date the exemption still apply at the Z$400 threshold for the majority indigent population to access care and services without financial limitations.
3. The public sector also compels public facilities to treat patients first and ask for payment
4. later, even for those consumers who can afford to pay. While this could tempt defaulting by consumers who are able to pay, the overriding objective is to protect the indigent and minimize inaccessibility caused by desire to enforce fee collection at public facilities.

5.3.2 Free Maternal & Child Health Services

Most preventive services are freely provided by the public sector as public goods. However, individually consumed services like maternity and child health services still received almost full cost subsidization at public facilities until 1995. Preventive and promotive services like immunizations, growth monitoring and other welfare services are freely provided by the public sector regardless of the social status of the consumers. Public sector provided immunization inputs and related expenses valued at over Z$15 million per year (MoH&CW 1999) and there are no intentions to directly recover costs from these services. Consumers who utilize public sector facilities for maternity and related services do not pay full fees as the public sector contributes the largest proportion of such services. It is partly for these subsidies that significant reductions in maternal and child mortality have been achieved over the years.

5.3.3 Private Benefits - Consumers

Whereas consumers are taxed for employer provided perks and benefits such as free housing and eduction assistance, health related perks such as health insurance have partial tax relief for the employees. The same employees also have tax relief on their individual contributions for health insurance and other medical expenditures. The objectives is to encourage consumers on gainful employment to acquire medical aid and finance their health needs rather than depend on public sector financing, which would be left to care for the unemployed.

5.3.4 Invalid Appliances

Tax relief provided for purchase of invalid appliances is an incentive for communities to use out-of-pocket resources for their health support needs. This replaces the need for social insurance to finance such needs as done in some countries. The subsidies have wide coverage including long term prescription drugs for patients and cost for hospitalization. Purchases or repairs for wheel chairs, artificial limbs, crutches, spectacles and other facilities for persons with physical defects are also subsidized proportionally through the same tax arrangement.

5.4 Subsidies for private not-for-profit providers

5.4.1. Justification for subsidies to Mission providers

Missions are the only significant private not for - profit health providers in the country because of their large geographical and consumer coverage. There are few other private providers in the form of NGOs who mostly provide counselling services for terminal conditions such as cancer and HIV/AIDS. Their coverage is limited to urban areas.

Mission hospitals in Zimbabwe are generally situated in the rural areas. Some are in the remotest areas where they are at times the only source of health service available to local community. By nature of their location, they usually service the socially and economically deprived groups of the population. Mission facilities vary from sophisticated hospitals to small clinics.

For many years, missions depended on their foreign based parent churches for resources necessary for their health activities. Accordingly, the quality of their services vary, depending on the capacity of the parent churches to fund them. Generally, mission hospitals who boast of strong ties with external donors are comparatively better equipped and have modernized infrastructure. Those relying more on local donors are conversely poorly equipped and have almost collapsing infrastructure.

Compared to government facilities, missions are inferior in most respects. It is now politically acknowledged that unless missions are rescued by the public sector, the majority of the country's population domicile in rural areas will not have access to medical facilities of acceptable quality.

The overriding government objective is to standardize the service rendered to patients throughout the country in pursuance of equity. It therefore provides subsidies as a way of availing resources for upgrading services offered by the mission hospitals. The subsidies also seek to equalize missions and government health facilities for equity advantage to consumers. While providing subsidies is an expensive task on the part of the public sector, the significance of mission hospitals in Zimbabwe justify this.

5.4.2. Significance of Missions Contribution

Mission facilities form the largest private providers of services in the country. In 1998, the MoH&CW estimated that missions administered about 25% of the 1,080 health faculties in the country, mostly working as agents of the public sector.

In 1998, the Zimbabwe Association of Church related Hospitals (ZACH) reported that mission institutions contributed more than a third (38%) of the about 18,200 national hospital beds. Mission facilities also account for 68% of all rural hospital beds in the country (ZACH 1998). It is therefore evident that they are the largest providers of health and service to the largest population in view of the fact that about 80% of Zimbabwe's population is in the rural areas (CSO 1995). For this level of contribution, it is logical that missions receive subsidies, more so because they operate as not for-profit providers. The private for-profit providers contribute no more than 4% of the national hospital beds (MoH&CW 1998) while the public sector still remains the largest provider at national level. Table 4 shows the private and public sector contributions for the different health indicators in Zimbabwe in 1999.

The public sector recognizes that mission facilities perform a function that should be undertaken by the government. For this reason, it reciprocates with financial grants and other technical expertise to subsidize the activities of the mission facilities.

Table 4: Zimbabwe: Health facilities and Hospital beds contribution by Sector, 1999

	Total	Public Sector	Private Sector
National Hospital beds	18,200		
Government beds		9,578	
Missions			6,927
Municipality & For-profit providers			1,695
National Stock of Health facilities	1,080		
Government facilities		778	
Municipalities & For-profit providers			186
Missions Facilities			116

Source: MoH & CW and ZACH 1999

5.4.3. Subsidies for running costs

The public sector provides annual grants to Mission facilities for recurrent expenses. Usually, the level of subsidies is determined by the size of the facility but these are not full cost of running the facilities. The missions reallocate the received grants to finance salaries (75%), drugs from the Government Medical Stores (16%) and recurrent expenses (9%) (ZACH 1997). Operational deficits are also partly financed by donations from mother churches and other charitable organizations. For the period 1988 to 1998, ZACH estimated that Missions received between Z$27-30 million from overseas donors to subsidize their activities (ZACH 1998).

5.4.4. Staffing subsidies

For a variety of reasons, there is a high attrition of experienced health professionals in Zimbabwe. Both the public sector and the missions are unable to match the private sector reputation of better conditions of services and attractive salaries to retain key personnel. Even with the subsidies to the missions, the public sector conditions are far better than at the missions. The public sector grants aim to narrow the gap between the two providers to avert severe shortage of qualified health personnel. The missions themselves continue recruiting essential staff and almost all of the doctors they pay for are recruited from outside the country. Government subsidizes through grant-aided posts for essential personnel at mission hospitals. For control, it seeks to influence decisions on size of the establishments at grant receiving facilities. As indication of the extent of this public sector subsidy, Table 5 shows the essential personnel on grant aided posts at mission facilities in Zimbabwe in 1990.

Table 5: Public Sector Grant-aided Posts at Mission Facilities (National 1990)

Staff Category	Approved Grant-Aided Posts	No. Filled
Doctors	74	58
SRNs	286	224
SCNs	700	638
Other Support staff	2,615	1,746

Information on the actual national establishment for the respective category of health workers at mission facilities is not readily available at ZACH. It is therefore not possible to establish how much of the establishment is grant aided by the public sector and how much is funded by the missions themselves. This is possibly because missions fear such disclosures could influence the public sector to reduce grant aided posts at their facilities.

6. Private sector subsidies for the public providers

There are no significant subsidies originating from the private to public health sector, especially from the private for-profit providers. Save Mine, Mission and Agricultural Estate facilities who provide preventive and vector control programmes on behalf of the government, the rest of the private providers have no formal arrangements to subsidise the public sector. Missions' subsidies to the public sector have existed for a long time and are significant for this study discussion.

6.1 Missions subsidies to the public sector

Missions are probably the only private providers with quantifiable reciprocal subsidies to the public sector. That missions contribute 116 health facilities and 6,927 hospital beds in the country represent huge subsidization of the public sector. Over and above this, missions further subsidize the public sector in three main ways:

6.1.1 Services provision

Mission facilities perform a function that is otherwise the Government responsibility. They are the major providers of health services to consumers living in remote areas. Like government, they offer a variety of services including curative, preventive and promotive services. The services rendered by the missions is invaluable particularly to the rural community who are the most vulnerable groups. It could be necessary to quantify the level of these reciprocal subsidies to counter public sector health managers who argue for scaling down public sector grants to the missions.

6.1.2 Designation as district hospitals

District hospitals in Zimbabwe are the first level referral centres for patients. The public sector however lack resources to develop the size and capacity of all its facilities to play the role of District Hospitals. Some districts have no government district hospitals. Mission hospitals with the capacity and better infrastructure than neighbouring public facilities are therefore designated as District Hospitals. Such mission hospitals assume full responsibility of the district's health delivery, working as agents of the public sector. Out of the 58 administrative districts, 11 mission hospitals are designated District Hospitals. In 1999, one mission hospital (St Luke's - Lupane) was even designated a Provincial Hospital. To demonstrate the level of subside is to the public sector, the table below shows the number of mission hospitals that are designated District Hospitals in Zimbabwe.

Table 6: Mission Hospitals Designated as District Hospitals: 1999

Name	District	Doctors in Post	No. Salaried by Mission
St Luke's (Lupane)	Kusile	3	3
Mnene	Mberengwa	3	3
Gutu	Gutu	3	3
Silveira	Bikita	2	2
Morgenster	Masvingo	4	4
Murambinda	Buhera	3	3
Bonda	Nyanga	2	2
St Albert's	Muzarambani	1	1
Mary Mount	Rushinga	1	1
Howard	Chiweshe	2	2

Mr St Mary's	Hwedza	2	2

Source: ZACH, 1999.

6.1.3 Training of nursing staff

The commonest nursing cadre in rural Zimbabwe is the State Certified Nurse (SCN). The missions are the largest producer of this cadre for both the private and public sector. Other private sector providers who train nursing and other health personnel do so for the very minimum output to fill strategic posts in individual organizations. There were 21 mission institutions that offered SCN training until 1996 when the public sector stopped this training (ZACH 1998). Without this augmentation from the missions it is probable that national shortage of nursing staff could be more acute, particularly in rural areas. Table 7 illustrates the level of subsidization to the public sector by the missions through training of SCNs.

Table 7: Comparative Analysis of SCN Training, Zimbabwe, 1992

National SCN output per year	780
Gvt Hospitals output per year	210 (27.1%)
Mission Hospitals output per year	570 (72.9%)

Adapted from: President tours Mission Hospitals, 1992.

It is evident that missions significantly subsidize the public sector in the training of SCNs. The public sector grants to the missions are significant but still fail to meet the full cost of training SCNs considering the output size and duration of training.

6.1.4 Contracting out services

There are also benefits the public sector earns through contracting arrangements. Contracting out allows the public sector to achieve cost-efficiency in services provision through utilizing management and technical skills abundant in the private sector. At facilities where contracts have been practised, there is evidence that consumer satisfaction is achieved by the high quality of services provided. Usually the contracted services are not the public sector's core businesses that are best provided by those specializing in such services. The public sector is spared the costs of hiring management expertise as consultants from the private sector through contracting arrangements.

6.2 Summary of the subsidies

The major observation of this study was that all subsidies are intended to achieve some specific objectives. They are also targeted for some specific groups amongst providers, financiers and consumers. Mechanisms for the application of subsidies vary according to their objectives and target beneficiaries. The common objective of the subsidies is the public sector desire to achieve equity in access to quality care and services by the majority of the population. The desire to also exploit private sector resources and skills for the general improvement of the country's health delivery system was also observed. Table 8 summarizes the various subsidies, their basic objectives, their application mechanism and their respective target beneficiaries.

Table 8: Subsidies: Direction, Application, Target Beneficiaries and Objectives.

Subsidy type & *Direction*	Mechanism of Application	Target Beneficiaries	Basic Objectives
Training *i. Public to Pvt sector*	Manpower Training and Development	-Private practitioners -Employers	-Ensure quality care -Skills Development -Ensure adequate stocks
Taxation and other Private benefits *i. Public to Pvt providers ii. Public to Pvt Financiers & Consumers*	-Tax exemptions	-Medical Aid Societies -Employers & private practitioners	-promote growth of private health sector and the medical insurance
	Tax Breaks (Credits) -Contributions for medical aid -Health insurance as "perks" -Land & Buildings -Trade tools & invalid appliances	-Employers & Employees -Consumers -individual private practitioners	-Improve quality -sustain private facilities -Increase medical aid coverage by employers and employees
Grants *i. Public to Pvt non profit providers*	-Grant for salaries, drugs and other recurrent expenses	-Mission hospitals	-Equity in financing -Quality in services -Equity to access in remote areas
Exemptions *i. Public to Consumers*	-Free health services	-The indigent	-Equity in access and financing
Co-use of Public facilities *i. Public to Pvt for profit*	-Free admission of private patients in public facilities by private providers	-Private practitioners -Private hospitals	-Utilize excess space -private practitioners to see public patients free
Reverse Subsidies *i. Pvt not for- profit to public sector*	-Missions services to the public -Training nurses &, being district hospitals	-The Government -The poor and rural consumers	-Pursuit of Christian values - Complementing Gvt efforts to disadvantaged

7 Discussion: Impact of Subsidies on Equity and other health objectives

In Zimbabwe, the expansion of the private health sector, especially the private for profit sector, is partly due to two factors. Firstly, consumers associate the sector with the provision of quality care and as a result those who can afford the services will tend to utilize them more. Secondly, apologists for private medical care claim it takes a middle class workload off the Government health services, enabling the public sector to devote more resources to the care of the poorer sections of the population. For these reasons the public sector deliberately seek to develop and sustain the private sector through providing a combination of subsidies.

This study observed that the health care system in Zimbabwe distinctly operates along public and private provision. The private sector, which comprises the for-profit and not for-profit providers continues to grow and over 50% of doctors in the country work in the private sector (NAMAS 1998). At independence, the private sector except for the missions was viewed with suspicion, and was nearly closed in 1980. The sector's importance is now

recognized, and mechanisms for collaboration and support are in place. The provision of subsidies to private providers is one such mechanism for promoting its growth. The common objectives of most of the subsidies are to achieve equity through easy access to services as well as guaranteeing quality of services provided by all health facilities including the private providers.

The growth of the private for-profit sector is partly due to the protection offered by subsidies from the public sector. The missions, who are not for-profit providers also manage to sustain their activities because of the grants despite that these are inadequate for the size of some facilities and the population served (MoH&CW 1991). While the major concern of the public sector is to make health services accessible and affordable, especially for the poor, subsidies benefits also significantly accrue to individual private practitioners, employers and private health financiers. The public sector view subsidies as encouragement for private providers to price their services at affordable levels to give access to more consumers. Provision of extra subsidies to the private sector is however limited by general resource shortages and pressure on the public sector to maximise revenue collection to reinvest in health and other social services. The public sector is widening the tax bands to include previously exempted consumers as well as perks and services that formerly enjoyed tax relief. Scaling down of access to subsidies for some providers to control abuse also impact on their overall effectiveness to meet original objectives. For instance, the MoH&CW contemplates debarring admission of private maternity patients at public facilities because of non adherence to the co-use arrangement by private practitioners (MoH&CW 1999). The arrangement bears no financial motives on the part of the public sector. Instead, there is lost revenue from equipment hire and other possible fees yet some private providers never attend to public patients as required by the arrangement. They prefer seeing private patients who pay more at their rooms. Shortage of doctors at public facilities is therefore never alleviated as intended by this subsidy.

The exemption subsidy is specifically targeted at the indigent consumers. Those earning above the threshold are expected to provide revenue for public facilities through user fees. Enforcing this naturally requires management skills that ensure exclusive benefits to the targeted consumers. In Zimbabwe this is weak because the system allows those earning above the threshold to receive free treatment and at times force the poor to pay. Medical Aid Societies are the biggest winners because they will not reimburse for consumption by the insured civil servants in rural areas. Because the public sector billing system is also highly centralized and civil servants are incompetent in debt collection, more revenue is lost to the private sector. Medical aid societies and other private providers have no incentive to honour obligations resulting from inefficiency of the public sector. They are determined to retain all unclaimed funds which could otherwise boost the public sector coffers for reinvestment in health.

Beneficiaries for most of the examined subsidies are mostly the providers, financiers and consumers in the formal sector. The informal sector, such as the traditional healers are only subsidised in their capacity as consumers and not as providers, yet they serve the majority of rural consumers and the poor in urban areas. There are no immediate plans to make the subsidies accessible to the informal providers because traditional medicine is not yet formally recognized in the country (ZiNATHA 1998). It could be necessary to also consider mechanisms for subsidizing the informal sector because of the large population it serve. One other limitation cited by the MoH&CW (1999) is the amorphous nature of traditional healers' industry that cannot allow for effective application of standard subsidies.
That the private sector has freedom to determine and set fees for its services partly create inequities in health. The fees are too high and unaffordable except for the middle and upper income consumers who mostly are insured. The public sector cannot regulate private sector

fees because free market economies do not provide for this, yet there is need to minimise profiteering by private providers and make the industry accessible to more consumers for equity.

Because the private health sector comprises the for-profit and not for-profit providers, subsidies are differentiated along the same categories. Subsidies provided to for-profit providers basically aim to enable the industry to serve the affluent consumers and the insured who can afford the fees. The profit motive sometimes undermine some public sector health objectives. To minimize sectoral friction, the public sector cannot advertise some subsidies, lest they aide in expanding an uncontrolled industry not supportive of national health objectives. One such accusation is that profits are not reinvested into health related projects but sponsor activities and life styles that are not promotive of good health. Public sector managers also suggest for reduction of subsidies to the private sector as they argue that it is inequitable to finance a sector that serve only less than 8% of the population.
It is evident that the mission facilities receive more direct subsidies from the public sector than any other private providers. This is probably because they work as agents of Government particularly in rural areas where their services also include some public health activities sometimes not provided by the Government (ZACH 1999). Both the MoH&CW (1991) and ZACH (1993) agree that grant subsidies are still inadequate for the missions' work load despite increases in recent years. The grants are far less than budgets of similar size Government hospitals, yet missions sometimes serve more patients than the comparable Government facilities. Equitable allocation of resources could be on the basis of size and workload of facilities as is the case with Government facilities. Table (4) illustrates the funding discrepancy between government and mission facilities in the country.

Table 8:Comparison of Government Allocations to Public facilities and Grants to Mission hospitals (1990)

Government Hospital	**Z$ Allocation**	**Mission Hosp**	**Z$ Grant**
Mutoko	568,000	Mtshabezi	184,177
Plumtree	468,000	Mt. St. Mary's	301,289
Nyanga	446,000	Manama	204,695
Mt. Darwin	516,750	Matibi	106,662
Filabusi	403,000	Regina Coeli	64,471
Ndanga	167,000	Muvonde	213,960
Gvt District Hospital		**Mission Designated District Hospital**	
Karoi	807,000	Mnene	554,312
Zvishavane	703,000	Morgenster	505,270
Makumbe	1,395,000	St. Luke's	313,051

Adapted from: President Tours Mission Hospitals; Min of Infor. PTC, 1992

Mission facilities strongly linked to external donors and parent churches tend to be better equipped and have better infrastructure than those depending on local donations and public sector grants. The later group of facilities is in most need of subsidies from the Government. Lack of funds for extra requirements like equipment, transport, communication and expansion of facilities affect the quality of care and variety of services offered at these facilities. It is ironical that missions are expected to finance such requirements through user fees, when the majority of the served population qualify for exemptions. The Christian values of missions also discourage fee collection to enable the poor gain access to services.

While it is fairly easy to identify public to private sector subsidies, other than for the missions to public sector subsidies, it is difficult to identify reciprocal private to public sector subsidies. This is probably because the private health sector is relatively too small to reasonably subsidize the public sector. However, Medical Aid Societies' enforcement of prescription of cheaper generic drugs by private providers is a managerial subsidy effective in controlling the national cost of drugs. The private sector at times also provide managerial and technical skills to the public sector by assuming unrenumerated posts in Advisory Boards of public hospitals as community service.

Most consumers have scanty knowledge of subsidies and their utilisation. An ARA-TECHTOP study for the MoH&CW (1995) established that a disturbing 48% of rural and 56% of the urban consumers entitled to free treatment, did not know the documentary proofs required for exemptions at public facilities. Also some poor patients do not receive necessary treatment because at times councilors and social welfare workers designated to grant exemption certificates are never readily available and at times ask for unaffordable bribes. Claiming exemption is therefore a cumbersome process that is made no easier by unqualified administrators at public facilities. In Zimbabwe and Tanzania (2000) it is reported that some patients entitled to exemptions would rather sell essential assets for fees to avoid the hassles in proving eligibility for free care. Thus in the process, the indigent subsidise the public sector instead of the other way round.

Counter suspicions between the private and public sectors also limit the freedom for full disclosure of the extent to which one sector is subsidized by the other. Some private providers are insecure about their status as viewed by the public sector. They fear to compromise themselves further by disclosing the degree of subsidisation received from the public sector. Quantifying subsidies therefore overally becomes problematic for lack of information. The public sector compounds this by having no motive to widely publicize the subsidies for fear that full exploitation would reduce revenue due to it.

Mere provision of subsidies to either sector is not likely to minimise inequities in health without complimentary investment in human resources development and retention. Adequate staff levels at health facilities is likely to enhance the effectiveness of subsidies, as does optimal distribution of staff functions to benefit peripheral health consumers. Despite the commendable subsidies in Zimbabwe, equity could be elusive because of inadequate staffing levels at health facilities. In 1990, Zimbabwe had a doctor - population ratio of 1:7,180 and a nurse-population ratio of 1:1,000 (World Bank, 1991). Both ratios worsened to 1:7,500 and 1:1,200 respectively in 1998 (MoH&CW 1998). This sad statistics imply that a great number of the population, especially in rural areas lack easy access to quality care and services. Phasing out training of State Certified Nurses (SCNs) who were the commonest cadre in rural areas, together with the high attrition for State Registered Nurses (SRNs) impact on equity through worsening the nurse - patient ratio.

Lack of commitment to public health agendas by some private providers in Zimbabwe is partly a result of some subsidies that are not promotive of public health in the private sector. The mechanism of application, and management of some subsidies therefore sometimes impact on the effectiveness of the national health system. A good and fair health system requires identification of specific and priority services for subsidization yet most of the discussed subsidies are not focused at public health priority areas and therefore benefit the non vulnerable consumers. The distribution of good health between population groups in Zimbabwe is far from equal and in some cases the inequality is growing in- spite of the subsidies. Apart from maternal and child health services, most subsidies favour curative services and do not seem to empower consumers to improve their health status. Higher equity effects are probably realised through subsidizing primary health care (Phc) as this

reduces the gap in health status between the poor and the rich. Management of current subsidies could also be realigned for the public sector to look beyond the boundaries of the Ministry of Health, through coordinating the pooling of resources and efforts of other ministries, local authorities and NGOs to subsidize services that determine health, such as food supply, social security and adequate housing.

Subsidies on their own cannot guarantee equity in health. They are only instruments for enhancing and strengthening the effectiveness of policies in creating fairness in a health system. Thus, a combination of good policies and subsidies is more likely to yield higher equity for consumers, while priority services for subsidies should be those that ultimately empower local communities to assume responsibility for management of health systems at local levels. The challenge is for routine review of subsidies to assess their relevance and effectiveness in achieving national health objectives because of the ever changing socio-economic environment. Health Sector Reforms emphasize public sector subsidisation for competition among health providers so that there is high production of quality care and wider choice of services for the high income consumers (World Bank 1993). While there are arguments that inequities in health result from competition which creates fragmentation and duplication of services, poor information sharing and at times competition for ever declining health resources, there could be gains from managed collaboration between the private and public sectors, particularly if priorities for each sector are clearly defined.

Table 9 below evaluates the impact of subsidies on equity and benefits accruing to consumers. It is evident that subsidies have higher impact on equity and consumer benefits if provided directly to consumers and private not for-profit providers. They are less equitable if provided for the private for-profit providers.

Table 9: Impact of subsidies on equity and other consumer benefits

Type of subsidy	Impact on equity and consumer benefits (strength : +/-)
Subsidies for Financiers 1. Tax Exemptions 2. Pvt benefits / Tax Relief 3. Co-use of public facilities 4. Low user fees at public facilities	Less impact on equity as the subsidies only cover the formal sector The subsidies also do not directly benefit consumers They also reduce public sector revenue for reinvestment in health since the public sector remains the largest provider of health for the majority population. (Strength: - - / +)
Subsidies; Pvt for -Profit Providers 1. Tax credit- Land, blg & tools 2. Tax Relief- Associa. Members 3. Co-use of public facilities 4. Low user fees at public facilities 5. Liberalized pvt practice 6. Manpower training & develop. 7. Contracting out services	Impact on equity is low to moderate for these subsidies. They are inequitable because they are mostly applied to the formal sector, therefore subsidizing the already well to do. However, they allow for availability of more provider for those consumers who can afford the fees. (Strength : + / - -)
Subsidies: Not for-Profit Providers 1. Running Cost Grants 2. Staff/Manpower salaries	These probably have the highest impact on equity and consumer benefits for all subsidies. They enable missions to provide adequate curative and preventive services in rural areas for majority poor consumers. (Strength: + + + +)
Subs: Pvt Sector to Public Sector 1. Service provision 2. Designation as District Hospital 3. SCN Training 4. Out of pocket user fees-exempts	High impact on equity and high benefits from majority consumers, especially the poor in rural areas. Missions take responsibility of what is otherwise public sector duties and provide affordable services under competent health personnel for quality services to consumers. (Strength: + + + +)
Subsidies for Consumers	These also have high impact on equity and benefits to

1. Fees exemption 2. Free MCH Services 3. Tax Credits- medical aid 4. Tax Relief- Invalid Appliances 5. Training & Manpower develop	consumers. Such public sector subside is are mostly provided to cushion the poor who are the majority consumers who can not afford the services and those provided by the private sector. Similarly, training guarantees availability of skilled, competent and appropriately trained personnel for the benefit of consumers. (Strength: + + + +)

8. Conclusion

This study provided a qualitative examination of subsidies available in the Zimbabwe health system. The results of the examination indicate a diversity of public sector subsidies to support activities of the private health providers. Overally, there are more subsidies flowing from the public to the private sector although missions significantly reciprocate to the public sector.

Of the five categories of subsidies discussed (Table 9), it can be concluded that only subsidies directly provided to private not of -profit providers, consumers and to the public sector have high and significant impact on equity and consumer benefits. Subsidies directly benefit the poor consumers in both the formal or informal sectors. Subsidies to financiers and the private for-profit providers have less impact on equity and do not significantly benefit consumers, especially the vulnerable and majority poor in rural areas. They only benefit the formal sector which constitute a small proportion of the population. In deciding for health subsidies, the public sector could therefore achieve higher coverage by targeting not for-profit providers and consumers, than targeting financiers and private for-profit providers.

Subsidies provided are mostly formalized and therefore managed through the tax system for the financiers, providers and consumers. Special and formalized subsidization exist for missions who are not for-profit providers. These are subsidized directly through grants for salaries, drugs and recurrent expenses. Comparatively, mission providers get more subsidies than the for-profit providers. This is because they work as agents of the public sector in remote rural areas, servicing the majority of the population. For-profit providers receive less because their operations are at times not supportive of some public sector health objectives like the provision of preventive and promotive health services.

The objectives of public sector subsidies emphasize achievement of equity in health; improvement of quality of care, expansion of coverage and sustainability of the private health sector to cater for the wealthy consumers who prefer private sector health services. Application of subsidies does not suggest elimination of inequalities in health. Inequities could be minimized with political will to equitably allocate health resources amongst the major stakeholders. Fairness in health provision is a function of how the system is designed, managed and financed. Subsidization therefore only reminds of the proper social location of inequities in health. The problem lies not in shortages but in discriminatory resource distribution to providers - often favouring the public sector owned facilities to the disadvantage of the private sector, whose role in health care provision can no longer be ignored.

While this study was limited to Zimbabwean health system, the results could stimulate debates for similar investigations in other regional countries. The major likely limitations for such studies could be the unavailability of adequate data about the private health providers. Share of regional information in the application and management of subsidies is desirable as public sectors are promoting the public-private sector mixes in health provision.

9. Further possible research questions

It was observed that the study was rather too broad. It could have been narrowed down to focus on specific category of providers given that there are many such players in the country's health system. In this way, in-depth understanding of the different private providers could be achieved. The following is a brief of the potential study questions on equity arising from this study.

9.1 Private Health Sector Subsidies to the Public Sector

Since this study established that the flow of subsidies is more in favour of the private sector, little attention was given to in-depth investigation of the subsidies provided by the private sector to the public sector. The thinking amongst many public sector managers is that the government is robbed by the private sector. Investigation of the extent of private sector subsidization of the government could perhaps prove such conceptions wrong because not much is documented regarding how the private sector also subsidizes the public sector. This could be very significant. Still this would be a broad research area, given that the private health sector itself is a big industry with many categories of providers each deserving separate attention.

9.2 Evaluation of the impact on Equity and Other health objectives for the Public Sector Subsidies to Private Sector Health Providers

There already is some information on the types and level of subsidies provided by the public sector as listed in this study. Without suggesting any new forms of subsidies, it would be desirable to evaluate and detail the impact each of the subsidies has on equity and other health objectives. This study attempted this but not to expected depth because of its scope. Some subsidies could be counter productive while others are discriminatory to some sections of the consumers as suggested in some parts of this study. Careful evaluation of the subsidies would help in policy reviews for or not retaining some of the subsidies, particularly in the current times when the public sector is eager to maximize revenue collection through taxation and other means.

9.3 Other countries' Experiences.

The framework of this study and tables 8 and 9 provide a list of subsidies existing in Zimbabwe. This provides a structure for looking at other countries' experiences in the design and management of subsidies. There is need for cross country comparison of experiences as this study primarily focused on the Zimbabwean situation.

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List of abbreviations

CIMAS	Commercial and Industrial medical Aid Society
CME	Continuing Medical Education
EDLIZ	Essential Drugs List of Zimbabwe
HPC	Health Professions Council
MASCA	Medical Aid Society of Central Africa
MoH&CW	Ministry of Health and Child Welfare
MPC	Ministry of Public Construction
NAMAS	National Association of Medical Aid Societies
NRA	National Railways of Zimbabwe
NSSA	National Social Security Authority
PSMAS	Public Service Medical Aid Society
RAILMED	Railways Medical Aid
WB	World Bank
WHO	World Health Organization
ZACH	Zimbabwe Association of Church related Hospitals
ZIMA	Zimbabwe Medical Association
ZINA	Zimbabwe Nurses Association
ZiNATHA	Zimbabwe National Traditional Healers Association
EQUINET	Network on Equity in Health

Acknowledgements

The author acknowledges the network on Equity in Health (EQUINET) Steering Committee plus Training and Research Support Centre, for the technical and financial support.
The author also wishes to thank all those who provided literature, data and other information for this study. A list of some of these is appendixed. Also, thanks are extended to Charles Hongoro for being link person during literature search. The study would not have been possible without the Department of Community Medicine (UZ) who allowed me time for it.

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

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