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Equity In Healthcare Financing in Zimbabwe

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Abstract:-
Purpose: This paper studies equity in health care financing in Zimbabwe with the objective of assessing a model which promotes universalism and equitable access to healthcare services.

Design/Methodology/Approach: The research adopted a survey design in which questionnaires were used to collect data from knowledgeable individuals in the Bulawayo Metropolitan Province. A sample of 100 respondents comprising of 40 insurance practitioners, 30 insurance academics, 25 economist and 5 tax academics were targeted.

Findings: The research findings revealed that out-of-pocket payment negatively affect equity in health care financing and government financing positively affect equity in health care financing.

Practical Implications: The study also revealed that healthcare financing design should be in such a way that a public- private model of health care is used. The study indicated that those with wealth should subsidise the poor and the government should provide financing to health care.

Keywords: *Out of Pocket, Universalism, Healthcare System Financing.*

JEL Classification : G22, G41

Article Type : Research study

I. INTRODUCTION

Universal health care is receiving increasing attention global. The world health organisation (WHO,2020) reported that between 2000 to 2018 the global health expenditure reached US$8.3 trillion. The continuous increase and the forecasted continuous increase healthcare expenditure has been attributed to technological advances and disease burden in the world and increase in consumer demand (Chopra M, 2012; Augustine Asante, 2016). In Africa, including Zimbabwe, they is a loud cry of insufficient resources which is causing poor healthcare outcomes. The government of Zimbabwe has made noteworthy developments in changing the landscape of healthcare provision and funding, however they is still inequalities in access to healthcare services. They is a sense that those who are rich are accessing quality healthcare services which are funded by medical aid services and the poor receive basic services which are funded by the Ministry.

The government is committing to ensuring that they is equitable access to healthcare services and that they are affordable across the whole populace. Although they is an evidence in the increase in the national budget allocation, the financing base is getting smaller relative to health demands of the population. According to available statistics most Zimbabweans have no access to health insurance (Ministry of Health and Child Care, 2020). Existing medical aid societies all combined just cover less than 10 percent of the population in formal employment while some may be employed but are not covered (Association of Healthcare Funders of Zimbabwe, AHFoZ,2020). Equity in healthcare financing system is of paramount concern in Africa Equitable health care financing system (Mulenga, 2017). (Ali Ahangar, 2019) opines that worldwide they is a paradigm shift on healthcare financing that is bringing a proposition of moving away from direct out of pocket financing to a model that will protect the poor. The strong view is parallel to the concept of universal health coverage (UHC). Effective implementation of the concept requires a deliberate and intentional funding model which guarantees a fair distribution of the burden of paying for health care and benefits from health care spending according to need. Currently, Zimbabwe with high levels of people living below the poverty datum line and demographical and provincial inequalities is proposing the implementation of overhaul healthcare reforms through a National Health Insurance scheme. This has been the basis of World Health Assembly on financial protection of citizens. Universal health coverage (UHC) concept is within the human right for health framework which advocates for equitable access to health services to everyone. Furthermore, the UHC concept has a tremendous public health, health economics and humanitarian connotations which altogether call for inclusiveness and expansion of health services coverage and financial protection to all residents with special emphasis on protection of the poor and vulnerable population groups (Abiiro and De Allegri,2015).

In examining the problem of equity in health financing (which is the main focus of the current study), consideration has to be given to the precise form that the differential treatment of un equals should take. This study assesses, equity in health financing in Zimbabwe informed by the government pipeline dream to have a National Health Insurance Scheme. Member states with vibrant formal sectors have tried to initiate a mandatory insurance schemes through payroll deductions((Mulenga, 2017)) however, to countries like Zimbabwe with a higher percentage of the economy being informal((Echendu D Adinma, 2010)) and underground it is impossible to capture tax revenue through payroll deductions from may have to rely more on other sources of revenue.

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II. LITERATURE REVIEW

A. Zimbabwe`s Current Healthcare Financing System

In this section an exploration of Before attempting to measure the health care financing burden, it is important to briefly look at the health care financing system of Zimbabwe from an equity perspective. According to Toonen et al., (2015), the healthcare financing model in Zimbabwe is largely reliant on out of pocket payment systems, specific earmarked taxation(AIDS levy fund), donor funds(Non-governmental organisation funding),faith based organisation funding and governmental support. Healthcare financing in the private sector is largely through fee for service, voluntary insurance, and industry contributions. Provider payment mechanisms are mainly based on a decentralised system of payment through the Ministry of Health; a results-based financing approach is currently being piloted.

Notwithstanding that a hybrid system comprising of earmarked taxation, community schemes, private medical aid and limited out-of pocket user charges are preferred health financing instruments for middle- and higher income countries, including many countries in Africa, we understand that the current proposal in Zimbabwe, was rejected, to bring in social health insurance due to the current economic context (low formal employment, high income taxation, declining real wages and corporate shutdowns), although this may be introduced downstream when economic conditions change.

B. Concept of Equity Health Financing

The International Association for Equity in Healthcare Services defines equity as "the lack of systematic and potentially removable differences in one or more aspects of health in a population and its economic, social and geographical subgroups, which can be investigated in three areas of equity in financing, equity in access to services, and equity at the community health level. Fair financial contribution in healthcare financing is one of the main goals and challengeable subjects in the evaluation of world health system functions. Diana De, et al. (2017) posits that they is no agreed definition of what constitutes equity and fairness. Philosophers and economist have described the two in different ways ie they is libertarian view point and the egalitarian view point. The libertarian view point proffers that healthcare is funded privately and the population access services according tho their willingness and ability to pay. The egalitarians also defines it along the lines of ability to pay but gravitating towards public financing. Who pays how much for health care is the central question in any discussion of equity in health financing? Healthacre equity on the other hand is providing healthcare services to the population regardless of socio economic status, geographical area,gender and location(Institute of Medicine,2016).

Equity in health policy has not been receiving the attention that is commensurate to the effect is has on access to healthcare (Faride Sadat Jalali, 2019). Instead, there has been biased towards the efficacy as and making better use of available resources within the public sector ((Boe, 2015). A key recommendation that came from the efficiency perspective focused on the need to restrict public sector health care financing to an essential package of services which are cost-effective and which maximise overall health gain, i.e. to improve the value for money obtained from the public sector dollar (World Bank). This study will focus on equity in health financing in Zimbabwe. In generic terms when studying equity in healthcare financing is to consider the quality of funding systems (earmarked tax, out of pocket payments, social health insurance and community based health insurance) either collectively or individually (Ahmed,2020). Many studies in this area of equity in healthcare financing have focused on earmarked tax, social health insurance, private health insurance and out of packet payments((O'Donnell, van Doorslaer et al. 2008; Yu, Whynes et al. 2008; Yates 2009) and this is so because many studies on equity in healthcare financing has been doen in developed nations(High and Middle Income countries) whose financing mechanism towards healthcare is a mixture of two or the combination of the four methods(earmarked tax, private health insurance, social health insurance and out of pocket payments).

III. METHODS

The research adopted a survey design in which questionnaires were used to collect data from knowledgeable individuals in the Bulawayo Metropolitan Province. A sample of 100 respondents comprising of 40 insurance practitioners, 30 insurance academics, 25 economist and 5 tax academics were targeted. Data was gathered from both the primary and secondary sources.

A. Ethical Statement

The researcher sort the consent of the respondents before data was collected. The respondents had the right to maintain their privacy and were allowed to decline to take part in particular aspect of the research or even withdraw. In conducting this research, the researcher maintained confidentiality to any information that was collected and at all times anonymity was encouraged so as to protect the research participants from any harm or danger that may arise after giving out information.

IV. RESULTS

		Out of pocket	Equity
Out of pocket	Pearson Correlation	1	-.123
	Sig. (2-tailed)		.335
	N	63	63
Equity	Pearson Correlation	-.123	1
	Sig. (2-tailed)	.335	
	N	63	63

Table 1 : Correlation Analysis : The relationship between out of pocket financing and equity in health care
Source : Author`s Calculation

The correlation coefficient is -0.123. This indicates a weak negative relationship between out of pocket payments and equity in access to health care. An increase in the out of pocket payments reduces equity in the access to healthcare services and this is corroborated by (Whynes et al. 2008; Ataguba and McIntyre 2009; Chuma, Musimbi et al. 2009; Hajizadeh and Connelly 2009) who revealed that out-of-pocket payment contributes to inequitable access to healthcare services and utilisation of health care services.

A. Equity in Health Financing

	N	Minimum	Maximum	Mean	Std. Deviation
Government should finance healthcare	63	1.00	2.00	1.0794	.27248
Each person should contribute to health care	63	1.00	3.00	1.8095	.91329
Taxing formal employed	63	1.00	2.00	1.3175	.46923
Valid N (list wise)	63				

Table 2 Financing Health care in Zimbabwe
Source : Author`s Calculation

The respondents stated that healthcare in Zimbabwe should be financed by government, each and every person and through taxing formal employed people. The mean for the fact that government should finance health is 1.8095. The mean for the fact that each person should contribute to healthcare is 1.0994. The mean that health care should be funded by taxing formal employed people is 1.3175. This means that the healthcare should be financed by both government and taxing formal employed people as they have highest mean and according to McIntyre's (2007, p 3-11), this will be a variation of the Bismarck and Beveridge model, government funding plus taxing formal employed(compulsory health insurance).

	N	Minimum	Maximum	Mean	Std. Deviation
Government funding	63	1.00	4.00	1.6667	1.21814
Those with wealth should subsidy the poor	63	1.00	4.00	1.7143	1.11339
Some combination of the above	63	1.00	4.00	1.5556	1.08921
Increase tax by tax on individual	63	1.00	4.00	1.5397	1.10461
Valid N (list wise)	63				

Table 3 Methods of financing and equity in health care access
Source : Author`s Calculation

The mean for the fact that government financing brings equity to access to health care is 1.6667. The mean for the fact that those with wealth should subsidy the poor is 1.7143. The mean for the fact that increase in tax on individual brings equity to access to health is 1.5397. The mean for the fact that government financing, increasing tax on individuals and those with wealth should subsidise the poor is 1.5556. This means that in order for equity to prevail those with wealth should subsidise the poor and the government should provide financing to the health as these have highest mean of 1.7143 and 1.6667 respectively. In other words, the nexus between ability to pay((McIntyre et al. 2002) and funding for health care should be progressive. According to O Donnel et al. 2008, a system is considered progressive if the fraction of income paid by a person rises as income rises; in other words, they pay more as their ability to pay more increases.

B. Regression analysis and equity

Regression Model
Equity = a + β1 (out of pocket payments) + β2 (government financing) + μ

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.123[a]	.015	-.018	.38606

Table 4: Model Summary
Source : Author`s Calculation

The coefficient of determination (R Square) is 0.015 . This shows that government financing and out of pocket financing are the weak explanatory variables for equity in the access of the health care in Zimbabwe. This means that out of pocket payments and government financing determine 1.5% of equity in the access to healthcare.

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	1.989	.245		8.121	.000
	Out of pocket payment	-.333	.352	-.187	-.946	.348
	Government financing	.172	.278	.123	.621	.537

Table 5: Regression analysis results
Source : Authors Calculation

The p values for out of pocket payments is 0.348 and government financing is 0.537 which are greater than 0.05. This shows that out of pocket payments and government financing are less significant in explaining equity in the access to health insurance in Zimbabwe.

Equity = 1.989 -0.033 (out of pocket payments) + 0.172 (government financing)

Holding other explanatory variables, a percentage increase in out-of-pocket payments would result in the decrease in equity in the access of health care by 33.3%. This means that out of pocket payments are not affordable by many people especially the poor and hence they fail to access health care and this results in lack of equity in health care. as suggested by Kutzin (2007), OOP payments lack a risk pooling mechanism and key tenets that makes healthcare funding equitable and affordable.. Holding other explanatory variables constant, a percentage increase in government financing would increase equity in the access of health care by 17.2%. Government finance acts as a subsidy to everyone on the cost of health services and makes everyone to be able to access health care.

V. CONCLUSIONS AND RECOMMENDATIONS

It can be concluded that payments by patients from their pockets does not contribute to equity in health care access. This concurs with Toonen et al., (2015), the healthcare financing model in Zimbabwe is largely reliant on out-of-pocket payment systems, specific earmarked taxation (AIDS levy fund), donor funds (non-governmental organisation funding), faith based organisation funding and governmental support. Healthcare financing in the private sector is largely through fee for service, voluntary insurance, and industry contributions.

They seem to be a broad consensus that nations both in the developed and developing nations want to implement a healthcare financing system that will protect the poor against catastrophic financial losses. Therefore, health care financing that will promote universalism is a method whereby people who are able to contribute, must do so, and those who cannot are exempt, but make indirect contributions through value-added tax. Basing on the above findings and conclusions, the researcher makes the following recommendations that there should be private –public partnership in provision of health care this ensures equity and efficiency in the finance of health care, The government should subsidize health care so that it is affordable to many people. The government should also ensure that those in the informal sector contribute to health financing through indirect taxes. The Non-Government Organisation should also assist in financing healthcare, The private sector should assist in pioneering a sustainable health fund in Zimbabwe. There should be provision of scholarships for the training of health expert so that the health institutions have enough human resources and expertise.

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