

Impact of user fees on the household economy in Zimbabwe

NEW HOSPITAL CHARGES WITH EFFECT FROM 01 JUNE 2013

	New charge USD
General Wards per day	
Adult	
Child (above 5 years)	9-00
Maternity ward	6-00
Ante-natal, General ward / day	9-00
Post-natal, General ward / day	9-00
Maternity (all inclusive up to 3 days) NVD	45-00
Intensive / Coronary Care Unit per day	
Adult	12-00
Child (above 5 years)	7-00
Psychiatric Unit	
General ward per day	
Committed patient per day	6-00
Consultation Fees	
Adult	9-00
Child (above 5 years)	5-00
Consultation - Chronic	12-00
Adult	6-00
Child (above 5 years)	6-00
Prescribed medicines at cost	
Sundries at cost (up to \$25-00)	15-00
Search fee	15-00
Laboratory	20-00
Full blood count	20-00
Haemoglobin	18-00
Urea and electrolytes	10-00
Glucose	20-00
Liver function tests	20-00
Serum Crag (spinal cord test)	12-00
Micro/Urinanalysis	20-00
Culture and sensitivity	20-00
C.S.F	25-00
X-Ray	25-00
skull	25-00
Abdomen	1-60
Chest	
Ambulance charges per km	

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The ReBUILD Research Programme Consortium is an international research partnership funded by the UK Department for International Development (DfID).

ReBUILD is working for improved access to effective health care for the poor and reduced health cost burdens in post-conflict and post-crisis countries. We are doing this through the production of high quality research on health systems financing and human resources for health, and working to promote use of this evidence in policy and practice.

ReBUILD is implemented by a partnership of research organisations from the UK and from our four core focus countries.

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- Biomedical Research and Training Institute, Zimbabwe

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1. INTRODUCTION

1.1. Country story

Zimbabwe inherited a colonial health care system upon independence in 1980. Health services were divided along racial lines and there had been profound socio-geographical imbalances in the allocation of physical, financial and human resources in the health sector prior to independence (UNICEF, 1985; Manga, 1988; Herbst, 1990; Auret, 1990; Sanders, 1993). For example, Herbst (1990) noted that the average expenditure for the private sector medical aid society that benefited mostly white patients was ZWD 144 per person per year during 1980, whilst public health care expenditure for predominantly black people was ZWD 31 per person, reducing to four dollars per person for those in rural areas. Auret (1990) also noted that 32% of the total government budget for health care during the financial year 1979/80 was allocated to the Andrew Fleming Hospital in Harare (later renamed the Parirenyatwa Central Hospital) which served the white community.

Following independence, the government made a commitment to the pursuit of equity initiatives in Zimbabwe to address the existing inequalities by investing in health services, particularly in rural areas. Considerable progress was recorded from independence until the late 1980s as demonstrated by the fact that 316 new rural health centres were constructed and 450 existing ones were upgraded over the three-year transitional period from 1981 to 1984/85. By 1989 the number of rural health centres and clinics had increased from 247 at the time of independence to 1062 (Auret, 1990). The government viewed health services as an integral part of development and their access as a human right (Government of Zimbabwe (GoZ), 1981); and this guided the post-independence government's health policy, resource allocation decisions and human resource development (Bijlmakers, 2003). In 1980, the government introduced a policy stating that all Zimbabweans earning less than ZWD 150 per month were entitled to free health services; with about 90% of the population falling below that income threshold in 1985. This implied that the government provided free health care to a large majority of the population including almost everyone living in rural areas (Bijlmakers, 2003). The government's commitment to primary health care resulted in the improved geographical accessibility of primary care services. During the 1980s and early 1990s these health centres were adequately staffed with a doctor-to-patient ratio of, on average, 1: 6000 per year within public institutions (Chikanda, 2004). The economic crisis that the country experienced from 1997 resulted in the deterioration of services in the health sector; the dramatic decline in the health budget translated into an increased reliance on user fees, which has had a significant impact on all service users, the poorest in particular. This study focused on user fees and particularly their impact on patients who are suffering from chronic diseases.

1.2. Purpose of the study

The research looked at the impacts of user fees on household patterns of expenditure among poor families, and provides evidence to inform future policy decisions on instituting user fee charges. Therefore, this study contributes towards finding ways in which current health financing policies can be improved to ensure the achievement of the desired financing outcomes in the health sector,

particularly increasing access to health services for the poorest households. Patients living with chronic diseases were specifically selected because the frequency in which they seek health care services means that they are consequently bound to incur significant out-of-pocket expenses in the absence of health insurance.

The assessment will give the stakeholders in the health sector and policy makers a perspective of the access barriers faced by poor families. Therefore, the results will be the basis for planned user fee reforms. The study was part of a qualitative measurement exercise focusing on the weaknesses of user fee charging regimes and has added to the existing body of knowledge on how household economies are affected by the health financing systems in Zimbabwe.

1.3. Scope of the study

The study focused on the following:

- Economic impacts on poor households of changing user fee charging regimes and practices from the 1990s to the present day in Zimbabwe, with a special focus on changes in household expenditure patterns among vulnerable, low-income groups.
- How poor households cope with increasing health care costs, with a particular focus on health care for chronic illnesses.
- Equity implications of user fee policies and practices in Zimbabwe since 1990, with emphasis on the social protection policy of the Assisted Medical Treatment Order (AMTO).
- Based on the above, to derive policy recommendations for increasing access and financial protection for vulnerable populations.

1.4. Research questions and objectives

1.4.1. Project goals

The main goal of the assessment was to provide useful, empirically-driven information about the impacts of existing health financing options within the health sector of Zimbabwe. The information will feed into decision-making for general administrative review so that poor households are able to access health care services in the short and long-term, thus making health financing approaches more relevant and efficient.

1.4.2. Objectives

- i. To assess the impact of changes in user fee charging regimes and the exemption policy on the utilisation (changes in health-seeking behaviour etc.) of health care services by poor households since 1990 in Zimbabwe.
- ii. To explore the perceptions of poor women and men of the changes that have taken place over time in health policy and financing, as well as how this shapes health spending in different groups.

- iii. To provide recommendations for a policy intervention on health subsidy to support the poorest households in rural areas.

1.4.3. The research questions

The research team seeks to answer the following questions:

1. What are the impacts of user fees on household consumption patterns?
2. What are the changes in user fee charges in the health sector in Zimbabwe, including those that have been brought about by 'dollarisation'?
3. How do poor households cope with health care costs? What trade-offs do they make in order to pay for health care?
4. How are individuals paying for the cost of their health care? How does it affect household incomes?
5. What exemption policies are in place and how are these perceived by providers and service users? Are there any incentives that exist for providers to apply exemptions? How are beneficiaries selected for exemptions? What are the constraints/restrictions faced by service providers in applying the exemptions?

2. METHODS

The study design was qualitative, using the following methods:

Document review: A review of documents related to health financing, and user fees in particular, was carried out. This included published peer-reviewed articles, official government documents, Equinet, World Health Organization (WHO), United Nations (UN)/non-governmental organisational (NGO) documents/evaluation reports and academic publications retrieved from various journals and internet sources. Key words that were used in the search included 'user fees in Zimbabwe', 'equity in health', 'health financing' and 'impacts of user fees', among others. The objective of the review was to map the policy (both user fees and exemption policy) in the context of the economic crisis and social environment in Zimbabwe. This then enabled the research team to relate the issues arising from the review to the life history stories.

Life histories: The study targeted the households of patients with chronic diseases. This group is likely to experience shocks related to health that compel them to spend part of their incomes on the purchase of health care products and services on a regular basis. The study therefore sought to understand how patients living with chronic diseases are vulnerable to health shocks and whether they have been protected under the current health system in Zimbabwe. The life histories were conducted between February 2013 and September 2014.

Key informant interviews: Key informant interviews were carried out over the same period with health workers drawn from district health facilities and Social Services Officers. The objective was to understand how user fees were being charged and the changes that have taken place over the relevant time. The study also sought to understand the perspectives of the key informants about the AMTO and whether this was an effective policy in helping patients to access essential services.

2.1. Selection of districts

The samples for the qualitative study were drawn from six districts within six provinces in Zimbabwe. The selection of the districts was based on the following criteria using indicators from the Incomes, Consumption and Expenditure Surveys (ICES), and the Poverty Assessment Study Surveys (PASS):

- percentage distribution of average annual household expenditure on health,
- total average annual household consumption,
- proportion of households living below the poverty datum line.

The 1995 ICES report and the 2003 PASS report showed the following results:

Table 1: Selection of study sites

Province	Indicators						Total score (target provinces by priority)	Overall rank
	% on health 1995 (ICES 1995)		Average annual household consumption (ICES 1995)		Percentage living below poverty datum line (PASS 2003)			
	%	Score A	Z\$	Score B	%	Score C		
Bulawayo	4.8	1	20381	2	66	5	8	9
Manicaland	1.4	7	8337	9	66.5	7	23	2
Mashonaland Central	1.4	7	9665	6	46	1	14	7
Mashonaland East	2.5	3	10737	4	63.5	4	11	8
Mashonaland West	1.3	10	9881	5	66	5	20	3
Matabeleland North	1.9	6	7094	10	68	9	25	1
Matabeleland South	2.3	4	8424	8	66.5	7	19	4
Midlands	2.1	5	13097	3	68	10	18	5
Masvingo	1.4	7	8848	7	59.5	3	17	6
Harare	3.8	2	22551	1	58	2	5	10

Six provinces were then selected based on the total scores, as follows:

- four with the worst total scores,
- one with a total score in the middle, and
- one with the best total score.

Using this criteria, the provinces that were selected to participate in the study were Matabeleland North (Nkayi), Manicaland (Makoni), Mashonaland West (Chegutu), Matabeleland South (Insiza), Masvingo (Chivi) and Harare.

Figure1: District map of Zimbabwe



2.2. Selection of respondents

2.2.1 Life histories

Inclusion criterion was based on the following social and demographic variables:

- age above 45 years,
- suffering from a chronic disease,
- not having medical/health care insurance,
- living within the catchment area of the health facility.

The respondents for the life histories were drawn from within the six districts. Because they were required to provide documented histories of their experiences of the implementation of user fees from the late 1980s to the present, we sought to include individuals who would have been young adults during the mid-1980s and all were therefore above the age of 45 years at the time of the study. Households that experienced sickness during the period of interest were considered the most suitable participants in this research.

Patients with chronic diseases were randomly selected from the hospital/clinic registers. The aim was to select patients with significant health care needs in order to investigate how they have coped with

user fees. The registers were recent, which increased the probability of finding the patient at the stated address. A total of 51 life history interviews were carried out.

2.2.2 Key informants

The research sought to identify a maximum of six key informants from the relevant public institutions within each district/province who were knowledgeable about the implementation of user fees at district level. A total of 28 key informant interviews were conducted, including one donor. The aim was to understand implementation processes and policy issues from the perspective of government and donor agencies in the country. Although Provincial Medical Directors were initially part of the respondent list, they directed the researchers to the District Medical Officers (DMO) for the information. Ultimately, the DMOs, District Nursing Officers, matrons/sister-in-charge, the accountant, the District Social Services Officer and a donor were targeted in each district.

2.3. Data collection tools

Data was collected using a life history guide. The respondents were approached in their homes, asked to draw a timeline and then plot important life events such as marriages, childbirths, episodes of sickness, hospitalisations and deaths along the line. The data collection tool contained a wide range of questions on health expenditure (including any user fees, transport and other costs), how participants coped during each key life event, whether they had access to exemptions and the types of health care costs that those exemptions covered etc.

The key informant interview guide looked at sources of finance for hospital operations, whether there were any schemes to benefit the poor, how such schemes were implemented and the constraints and challenges surrounding implementation, as well as the changes that took place over time.

2.4. Study limitations

The full story of user fees, particularly their effect on individuals with chronic illnesses, could not be obtained through the life histories, firstly because some of the respondents began to suffer from the chronic ailments in more recent years e.g. after 2005. It was therefore not easy to find a patient with experience of user fees covering the entire period since the 1980s, which the researchers were looking for. Secondly, the Zimbabwean economy suffered astronomic inflation from the period covering the year 2000 to 2008, and it was difficult for the respondents to compare user fee charges during the inflation period and after the multi-currency system was introduced in 2009. Several revaluations of the currency were carried out during that period making recall bias a real issue that the research had to contend with. Participants were not able to respond accurately to all of the questions and the data obtained therefore constituted general perceptions, rendering it difficult to determine patterns.

The researchers also observed that the key informants such as the District Medical Officers were quite young (in part due to skills flight and the high turnover of health professionals in Zimbabwe), and could offer little or no information about user fee charging before the multi-currency system was introduced. As a result, no data was provided from this source for the 1990s and 2000s. Supplementary evidence was obtained, however, from the Ministry of Health and Child Care headquarters to cover some of the information gaps. However, even the headquarters did not hold all of the details because there was no formal regulation of user fees particularly during the hyperinflation period from 2003 - 2008). This was because regulation was seen as tantamount to

completely destroying the provision of health care services. During this time, the government adopted a neo-liberal approach to user fee regulation.

3. STUDY FINDINGS

3.1. Documentary review

3.1.1. Major health policy developments since 1980

A lack of financial resources to improve the functioning of health systems compelled governments to seek alternative health financing models, thus leading to the introduction of user fees during the 1980s. Much of the debate surrounding user fees was centred on efficiency and equity. Proponents supporting the introduction of user fees argue that this enabled resource allocation for the provision of health services, thus making the system more efficient by guiding demand to cost-effective health care (Creese, 1991; Waddington et al., 1989). In addition, they suggest that user fees also improved equity as the revenues raised could be re-allocated to fund services designed to address the health needs of the poor. Contrary arguments suggest that in practice, effective re-allocation of resources is in fact difficult to implement, at both institutional and administrative levels, so that the poor are effectively priced out of the market with potentially dire consequences for their health status (Arhin-Tenkorang, 2000).

Many governments in Africa have experienced shortages of financial resources in relation to the demand for their health services and this has resulted in the wide-spread adoption of user charges as a financing mechanism to improve poorly-functioning primary health care systems (Carrin and Vereecke, 1992). The assumption was that user fees would increase revenue that could be used to improve the availability of drugs and support exemption policies to protect the poor, which is seen as the key to increasing the utilisation of primary health care.

Policy goals contained in the Zimbabwe government's *Planning for equity in health* (MoHCW, 1984) and *Health for all action plan 1985-90* (MoHCW, 1985), focused on equity (the universal provision of health services) as a principle of primary health care. This was to be achieved through the integration of fragmented curative and preventative services into a comprehensive health care delivery system, with a special focus on maternal and child health, drug procurement and distribution, increasing accessibility through the upgrading of existing and the construction of new health facilities in rural areas and the development of human resources for health. Equity refers to equal opportunities for equal needs. All other developments in the health sector had to be consistent with the primary health care objectives that the government sought to promote in pursuit of the millennium vision for the Ministry of Health: "Health for all by the year 2000".

The re-allocation of health care resources towards the rural areas and the urban poor made a significant, favourable impact on the health care indicators, but this was threatened by significant changes in health care financing and organisation, as the government introduced economic structural adjustment programmes which departed from the welfare-centred policies of the 1980s. The implementation of these equity policies in health care was seriously challenged during the 1990s. The

slow growth of the economy from 1983 created pressure to collect fees from patients for services rendered (Loewenson et al, 1991). Representatives of the international donor community and the World Bank believed that the government had little choice but to implement a policy shift because the existing health service model had become unsustainable and was visibly under stress. There was also inadequate support of equity policies by the international community, especially the non-communist/socialist countries during the 1980s (Bijlmakers, 2003).

In this regard, the health policy and legislative framework changed during the 1990s. Whilst the second *Health for all action plan* for the period covering 1991-1995 maintained the focus of its predecessor on equity, this plan increased the emphasis on quality of care, effective use of resources, value for money and appropriateness of services (MoH, 1991). It highlighted equity at a time when the economic and social climate had changed considerably with the introduction of the Economic Structural Adjustment Programme (ESAP), that reduced budgetary allocations to the health sector. Decentralised planning was promoted within the sector, however there was very little corresponding delegation of authority in the area of budgeting and finance, which restricted effective programme implementation at district and at individual health facility level (Bijlmakers and Chihanga, 1996). Even though the *National Health Strategy for Zimbabwe 1997-2007* (MoHCW, 1999), reaffirmed and maintained the theoretical and core principles and values that had guided health policy making in previous years, the implementation processes represented major paradigm shifts. Institutions outside of government would now deliver services whilst the government itself would play a regulatory and monitoring role. The reforms that were introduced during the period of ESAP made provision for the co-existence of business-like health care delivery systems, whereby private institutions and companies operated on the basis of competition and price quality comparisons of their products (Bijlmakers, 2003). This remained consistent with the operation of market forces advocated in the ESAP guidelines. This system served to widen the disparities in the allocation of health resources as well as the receipt of and payment for services according to gender, age, level of education, socio-economic and geographic groups within the country (Chidavaenzi et al, 2001). In 1994, an estimated 49% of the total expenditure on health was private, mostly through individual direct payments (Schwartz and Zwizwai, 1995).

As the role of the government in the provision of health care services weakened, there was a steady increase in the number of private facilities consisting of relatively small industry-owned clinics and large institutions with highly sophisticated facilities. This was followed by the mushrooming of even smaller facilities such as general practitioner clinics and surgeries. Quality of services in the public health sector continued to deteriorate and this spurred the expansion of the private sector in response to the new demand. According to Bijlmakers (2003), this expansion was also facilitated by the fact that doctors employed by the government were allowed to do part-time private work. Hongoro and Kumaranayake (2000), estimated that in 1996 about 45% of registered doctors in Zimbabwe worked full-time in the private sector. The 1995 annual report of the Ministry of Health and Child Welfare reported 39 industrial and private hospitals, out of a total of 199 hospitals recorded nationwide (MoHCW, 1995).

Since the late 1990s, the country has experienced protracted political crises accompanied by economic and social decline, accentuated by the sharp reduction in development assistance and by frequent

droughts. Whilst the 1980s showed a general improvement in most of the major health indicators and service utilisation, attributable to the expansion and improvements in the area of primary health care including nutrition, water and sanitation (UNICEF, 1990 and 1994; Sanders, 1993), signs of deterioration were evident during the 1990s. These trends were a reversal of the gains made in the previous decade (Bijlmakers, 2003). The World Bank (2008) estimated that the gross national income (GNI) per head declined by 54% between the years 2000 and 2005. Gross domestic product (GDP) declined by nearly 35% between 1999 and 2006, and the estimated GDP rate per capita¹ of USD \$268 places Zimbabwe as one of the poorest countries in the world. A declining national income, a huge national debt, recurrent droughts and widespread cases of HIV and AIDS all contributed to a weakening health system since 1990.

The huge investment in the health sector has also been threatened by the exodus of critical health and medical skills through migration (Clemens and Moss, 2005). By 2003, the health sector had lost over 2,100 medical doctors and 1,950 State Certified Nurses, mostly to South Africa, Botswana, Namibia, UK and Australia. According to Chikanda (2005), it was estimated that more than 80% of the doctors, nurses, pharmacists, radiologists and therapists who had trained since 1980 had left the country by 2005. During that period, Zimbabwe was losing an estimated 20% of its health care professionals every year; 18,000 nurses have left since 1998 (Chikanda, 2005). In the health sector, the total number of registered nurses declined from 15,476 in 1998 to 12,477 in 2001 although the number of doctors countrywide increased slightly from 1,575 in 1995 to 1,626 in 1998 (Chikanda, 2004).

Medical health insurance is provided by Medical Aid Societies (MAS), covering mainly the formally employed and their dependants and collecting premiums through employers. According to Normand et al, (1996), both employers and employees make contributions to the premium on agreed and usually matched ratios. The Public Services Medical Aid Society (PSMAS) covers mainly employees in the public sector. Some Medical Aid Societies are “in-house” and provide services for employees of a specific employer or group of employers e.g. RAILMED for the National Railways of Zimbabwe employees. Others, such as The Commercial and Industrial Medical Aid Society (CIMAS), Medical Aid Society of Central Africa (MASCA), Northern, and Engineering Medical Fund are open and accept members from any type of company as well as private individuals. According to National Association of Medical Aid Societies (NAMAS now called [Association of Healthcare Funders of Zimbabwe](#)) (1998) and NHA Report (2001), Medical Aid Societies cover about a million beneficiaries (8-10% of the population), out of a national population of 12 million. About 80% of income to private health care providers in Zimbabwe comes from MAS and they contribute more than 20% of the country’s total health expenditure (THE) (Sekhri and Savedoff, 2005). However, the high share of private health insurance (PHI) spending is not reflected in equally significant coverage rates (Campbell et al, 2000; Drechsler and Jutting, 2005), as the figure of 20% of THE covers only 10% of the population. There is no national health insurance scheme in Zimbabwe and therefore most of the population is not insured for health needs, and cannot access the expensive private sector health facilities (Munyuki and Jasi,

¹ At purchasing power parity.

2009). The absence of a national health insurance system has resulted in the 90% uninsured population having difficulties in accessing health services.

Due to the reduction in public expenditure and increasing private investment in health, THE fell from a peak of 10.8% of GDP in 1998 to 7% in 2005, translating to about USD \$1924.01 million in 2002 to just USD \$259.47 million in 2005 in US dollar terms. Whilst THE peaked in 2002 using official rates, this was the lowest level between 2000 and 2005 using parallel market rates (Munyuki and Jasi, 2009). Consequently, household out-of-pocket expenditure increased to 53% of private expenditure on health in 2003 (thus placing significant burdens on individuals) whilst donor funding grew from a low of 2.1% in 2000 to a high of 21.4% of total expenditure on health in 2005 (ibid).

Health financing mechanisms are an important component of a health system. A low percentage of GDP spent on health suggests that not enough resources are mobilised for health care, that access to care is insufficient and that the quality of services is poor. The World Health Organization (2008), estimated that a minimum per capita THE of USD \$34 (at the average exchange rate) for 2004 (US \$38 for 2008), was needed to cover essential health services. Total health expenditure per head fell by 56% between 2000 and 2005 to \$21, of which \$9 was government expenditure (WHO, 2008). External funding contributed 21% of total health spending, a low proportion compared with that in most African countries.

Zimbabwe's THE as a percentage of GDP was 7.0% in 2006. This is low but remains higher than the average for countries in Sub-Saharan Africa (5.3%). Donor spending on health as a percentage of THE in 2006 was 18.7% in Zimbabwe, compared with the Sub-Saharan African average of 22.39%. In 2006, households in Zimbabwe financed 24.08% of THE through out-of-pocket spending at the time of service. This compares with an average of 39.05% in Sub-Saharan Africa (ibid). According to Zimbabwe's 2010 National Health Accounts, out-of-pocket spending increased to 39% of THE in 2010.

When out-of-pocket spending represents a large share of health expenditure, the pooling of private resources is limited. It means that most of the time households need to produce funds at the time of seeking care, which can be a barrier to accessing care and can threaten the financial status of the household (e.g. push some families into poverty).

3.1.2. Important user fee events

As pointed out earlier, after independence the government of Zimbabwe gave priority to increasing the availability of health care services in underserved rural areas. An exemption policy based on income (less than ZWD 150 per month) was put in place in 1980 and, according to Manga (1988), this resulted in a threefold increase in clinic attendance throughout the country. In 1982, an estimated 550,000 workers on commercial farms and in domestic employment and 46% of the 750,000 wage earners had incomes of less than ZWD 150 per month and thus qualified for free health care (Hecht et al, 1993). The latter further states that the World Bank felt that the system of exemptions was 'imperfect' and inadequate to achieve the equity objective in view of the fact that even those who earned more than ZWD 150 benefited from free health care services. In addition, the system underestimated people's ability to pay for the services because the exemption criteria did not consider self-employed people who may have earned substantial incomes (Bijlmakers, 2003).

According to Bijlmakers et al (1996), the Zimbabwe government began to enforce the systematic collection of user fees for health services in 1991, when measures were put in place by the Ministry of Health to strengthen cost recovery. Revenue targets were set at facility level, manuals on service fees to be used by health facilities were prepared, clerks were trained and monitoring systems were developed. The revenues needed to be generated in line with the aims of ESAP (Bijlmakers, 2003). It is important to note that until 1997, revenues from user fees generated by government-run health facilities were not retained by the facilities where they were collected, nor were they retained by the Ministry of Health (Bijlmakers, 2003), they were sent instead to the Ministry of Finance. According to Zigora et al (1997), this situation constituted a disincentive on the part of the individual health facilities and the Ministry of Health. The table below shows the changes in the user fees policy during the 1990s.

Table 3: Changes in user fee policy during the 1990s

Early 1991	Enforcement of user fee collection at all health facilities at the start of ESAP
November 1992	User fee exemption level raised from ZWD 150 to ZWD 400
January 1993	Temporary abolition of fees at rural health centres because of the drought
June 1993	Reinstitution of user fees at rural health centres
January 1994	Substantial increase in user fees at all health institutions
March 1995	Abolition of user fees at rural health centres and rural hospitals
October 1996	Increase in user fees at all referral hospitals: services at rural hospitals and health centres remain free of charge
January 1997	Start of the Health Services Fund (policy authorising decentralised financial management i.e. the retention of user fee revenues at the facility and district level): reinstatement of user fees at some rural mission hospitals
1998	No more health grants for the municipalities; higher than average increase in user fees charged by municipal health facilities
November 1999	Substantial increase in user fees at government health institutions to fund the provision of health care services due to reduced government expenditure on health.

Source: Bijlmakers, 2003

Even though the income-based exemption threshold was reviewed upwards in 1992, the new threshold was lower in real terms than when the exemption was first instituted. This was due to inflation, which had practically eliminated the exemption for the country's entire waged labour force. Even back in 1989, estimates showed that fewer than five percent of non-agricultural and non-

domestic workers qualified for free health care (Bijlmakers, 2003). According to Osika et al (2010: 48), exemptions were also applied for the following services and groups:

- “Antenatal care in rural and semi-rural areas,
- Referrals to the next highest level of facility for services that the lower-level facility cannot provide,
- Directly Observed Treatment Short course (DOTS) for tuberculosis (TB),
- Family planning,
- Antiretroviral therapy (ART),
- Emergency outbreak services (such as the recent cholera outbreak),
- Health services for children under five, adults over 65, military veterans, health care providers, and individuals living below the poverty threshold (a designation that is very difficult to attain in practice).”

The severe drought of 1991/92 caused the government to stop charging fees at rural health centres, however by 1993 there was mounting pressure from the World Bank for the government to take steps to reinforce the cost recovery system (Hecht et al, 1993). The World Bank estimated that recovery could increase fourfold, from 5% to 20% of government spending for clinical care if the right measures were taken. Part of such measures included the fact that fees needed to be adjusted in line with inflation in the cost of medical treatment, strengthening the invoicing system and actual collection of fees and developing incentives for revenue generation (Bijlmakers, 2003).

January 1994 came with a drastic review of the system of user fees and substantial increases in charges for all services were imposed. The structure of the fees was such that patients who went straight to a referral hospital would be charged more, the intention being to encourage patients to seek care from their nearest health facility and therefore reduce patient numbers at provincial and district hospitals. March 1995 saw the abolition of user fees in rural health facilities and at government, council and mission institutions; the rationale being that there should not be any financial barrier to service utilisation at the primary care level (Bijlmakers, 2003).

The Health Services Fund, established by the government in January 1997, allowed the retention of revenues collected from user fees by the Ministry of Health and Child Welfare. Management structures were put in place for the administration of funds at the national, provincial and district level. The aim of retaining user fee revenues at the points of collection was to improve quality of care, referral patterns and local participation in the management of health institutions. Retention of fees at higher levels meant that providers who attracted more patients also collected more revenue (Normand et al, 1996).

The economic situation worsened from 2003 to 2008. Zimbabwe’s macroeconomic situation became critical with a national debt exceeding US\$ three billion (UNDP, 2008). During those yearsthe

government failed to control inflation and introduced the multi-currency system² in early 2009 as the only feasible option. Although prices of goods and services in foreign exchange remained relatively stable, anecdotal evidence has shown that the dollarised economy in Zimbabwe discriminates against those who do not have access to foreign currency – specifically - vulnerable populations, the rural poor, and those without relatives abroad.

As a further step, in March 2009, Zimbabwe's Government of National Unity (GNU) launched its *Short Term Emergency Recovery Programme* (STERP), which identified the core challenges in the provision of health care services and sought to restore Zimbabwe's health sector. The priorities of the STERP were spelt out as re-establishing well-managed primary health-care programmes within functioning district health systems, providing cost-effective essential services such as immunisation, integrated care of sick children, nutrition programmes, maternity services, improved management of tuberculosis, malaria, and sexually transmitted infections (including HIV/AIDS), and basic curative care including surgery. Inter-sectoral work addressing determinants of health and involving agriculture, education, water and sanitation was identified as a core activity of district health systems (Todd et al, 2009). This programme was further prioritised through the development and adoption of an ambitious 100-day recovery plan for the health sector (MoHCW, 2009; Todd et al, 2009), and the design of the 2009-2015 *National Health Strategy*. The start of the implementation of this 100-day action plan resulted in health workers returning to work and health facilities functioning again. The Health Service Board submitted a comprehensive salary structure, which was comparable to the Southern African Development Community (SADC) salary structures, to the Ministry of Finance. Retention allowances for health personnel were reviewed upwards. The funds for the retention scheme were secured up until September 2009 from the European Union (EU), Expanded Support Programme (ESP), Global Fund (GF), United Nations Population Fund (UNFPA) United Nations Children's Fund (UNICEF), Australian AID and other bilateral donors (Todd et al, 2009). The funding also included essential drugs, vaccines, laboratory supplies, and HIV commodities. The Global Fund took over payment of incentives for health workers and started paying the allowances from October 2009. However, the available pledged funds could not cover the whole of 2011 (MoHCW, 2009). Kureya et al, (2010) noted that, without a political settlement, donors to the health sector will continue to shun direct budget support. To deliver on the STERP, the National Health Strategy underscored the importance of developing and implementing effective public health policies and well-targeted, evidence-based programmes that are feasible to implement given the political, economic

² The introduction of the United States dollar as an official currency, supported by the South African rand and other stable currencies such as the British pound and Botswana pula. This resulted in the de jure abandonment of the Zimbabwe dollar and the ipso facto adoption of multiple stable currencies as legal tenders in transactions.

and human resource constraints. The government of Zimbabwe requested support in the development of these policies and programmes within the health sector.

At present, specialised services in the public sector such as cancer care, dialysis, and advanced imaging are not affordable for patients. An early policy of the GNU was to impose substantial foreign-currency user fees at government hospitals (Shoko, 2009), to generate funding for health services, but accepting these cost-recovery initiatives frequently disadvantaged the poorest people (Gilson and McIntyre, 2005). Revenue collection increased from just over USD \$5 million to \$70 million per month between late 2008 and the second quarter of 2009 (Bhebhe, 2009). This level of cost recovery for services relevant to non-communicable diseases, combined with the impact of the economic crisis, has particularly impacted “the elderly and adults with chronic illnesses.” (Chimhowu et al, (2010):100).

Furthermore, Zimbabwe required an annual health sector allocation of \$120 million from 2010 to meet its Abuja Declaration commitment (Kureya et.al, 2010) and therefore the collection of fees continued being strengthened even though the Ministry of Health started reviewing the issue in 2009 (MoHCW, 2009). As an alternative revenue source, Zimbabwean taxpayers are levied a 3% income tax towards the National AIDS Trust Fund and the amounts collected compare to the Global Fund (Round 8) which sought to mobilise USD \$496 million from 2010–2014 (Global Fund Round 8).

Whilst Zimbabwe is moving towards the direction of increasing user fees, there is considerable international recognition that the ‘user fee for public service’ reforms of the 1980s and 1990s could not address the health care resource gaps in low to medium income countries (LMICs) (Gilson, 1998; Gilson, Russell and Buse, 1995, Kutzin, 1995). There has been recent ‘backtracking’ on user fee reforms, with even the arch protagonist of user fees in the 1980s and 1990s, the World Bank, acknowledging that “out-of-pocket payments for health services - especially hospital care - can make the difference between a household being poor or not” (Claeson et al, 2001), and indicating that alternative financing mechanisms such as insurance may be preferable. There is also increasing international advocacy for the removal of fees, particularly at the primary health care level, but many LMICs are resisting fee removal (McPake et al, 2013; McIntyre et al, 2006).

3.1.3. Social protection in Zimbabwe

The main forms of social protection in Zimbabwe are related to formal work and include schemes such as medical insurance, pensions and compensation for accidents at work. These are contributory schemes, which largely cover workers in both the private and public formal sectors but exclude many in the informal and agricultural sectors. According to Chikova (2013), regardless of the growth of employment within the informal sectors, workers are excluded due to difficulties related to the collection of contributions because of the absence of employer-employee relationships. Nationally, less than 20% of the labour force is covered by social security (National Social Security Authority, 2012 cited in Chikova, 2013). Over the years, donor organisations have played a significant role in the provision of social protection in the health, education and other social sectors.

The government provides a number of means-tested social protection schemes mainly through the Ministry of Public Services, Labour and Social Welfare (MoPSLSW), aimed at reducing the disparities

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and inequalities related to poverty and exclusion. The table below shows the list of some key social protection schemes that operate in Zimbabwe.

Table 2: Social protection schemes in Zimbabwe

	Scheme	Description
	Basic Education Assistance Module (BEAM)	BEAM is a non-contributory, means-tested scheme that was established in 2001 as a key component of the Enhanced Social Protection Programme (ESPP) and is funded by the government with support from technical partners such as UNICEF and the UK Department for International Development (DFID). The programme pays school fees for orphans and vulnerable children (those having ill, disabled or single parents or who come from very poor families), with the aim of reducing the number of children dropping out of school due to economic hardships..
	War Victims Compensation	This was established under the War Victims Compensation Act that came into effect in 1980 and is administered by the MoPSLSW. The Act provides for compensation for injuries or death which occurred before 1 March 1980 as a result of the war of liberation. The scheme is non-contributory and is intended to compensate claimants for impaired capacity to earn income resulting from war and is also extended to their dependents.
	Assisted Medical Treatment Order (AMTO)	The AMTO is a means-tested, non-contributory scheme financed by the Government of Zimbabwe through the MoPSLSW. This programme pays for the health costs of indigent persons and targets those who cannot pay for services.
	Harmonised Social Cash Transfers	This is a donor-funded, means-tested, public, non-contributory scheme introduced in 2011. The programme involves direct cash transfers to ultra-poor and labour-constrained households, with UNICEF as the main technical partner.
	Food Deficit Mitigation Strategy	This is a means-tested, public, non-contributory scheme which targets labour-constrained and food-vulnerable insecure households. It is financed by the government and the World Food Programme. Qualifying households are supported with grain.
	Child Protection Services	This is a public scheme financed by the government and donors with UNICEF as a technical partner. The programme provides child protection services in the form of children's courts, registration of institutions for the custody and care of children and juveniles, protection from abuse, the supervision of children and juveniles and the adoption of minors.
	Support to Older Persons	This is a means-tested, public, non-contributory scheme established to cater for older persons above the age of 65 years who are in institutions.

Support to Persons Living with Disability	This is financed by the government to provide grants to institutions housing people living with disabilities and includes welfare and rehabilitation services.
Social Insurance Schemes	
The National Social Security Authority (NSSA)	The National Social Security Authority (NSSA) is a statutory body established under the terms of the NSSA Act of 1989, Chapter 17:04. NSSA runs two compulsory schemes; the Pension and Other Benefits Scheme (POBS), also known as the National Pension Scheme, and The Accident Prevention and Workers' Compensation Insurance Fund. The scheme was introduced after the GoZ identified that social protection provided under occupational schemes did not cover the Zimbabwean workforce adequately and that most were not compulsory. Occupational schemes were largely fragmented and only catered for loss of income due to retirement.
Pension and Other Benefits Scheme (POBS)	This is a 7% contributory scheme (both employer and employee contribute 3.5%) that covers all employed persons between the ages of 16 and 65 years who work within the formal sector and excludes domestic and informal sector workers. The scheme pays old-age pensions, disability pensions, survivor's benefits and provides funeral assistance.
Private Occupational Pension Schemes	Employees contribute towards their occupational pensions with the employers usually matching their employees' contributions. A labour force survey carried out by Zimbabwe Statistical Agency (ZIMSTATS) in 2011 showed that these private schemes cover only 11% of all pensioners in Zimbabwe.
Private Medical Aid Schemes	These are employment-based, contributory schemes where both employers and employees contribute to private health insurance providers to ensure that employees' can access health services when they fall ill. These schemes have a very low rate of coverage estimated at 8-10% of the population.

Source: Chikova 2013 and Masuka et al, (2012).

The Assisted Medical Treatment Order (AMTO) scheme is implemented by the Department of Social Services (DSS) and is designed to benefit poor patients who are between the ages of six and 64 years. The categories of the poor exempted include economically deprived households, orphans and vulnerable children (*Dzirikure and Garth, 2014*), and chronically ill people and the disabled, who are treated free within public health facilities (*Kaseke, 2015*).

A number of challenges have been observed in the existing social protection schemes in Zimbabwe, the principal concern being low levels of coverage. Chikova, (2013) noted that most of the viable schemes cover only those who are or have been formally employed at some point in their lives and have contributed to the schemes for a specified period of time. Hence, the government faces huge challenges in providing universal access to social security. In addition, the sustainability of cash transfer schemes is questionable because they are donor-supported. The government does not have the financial capacity to fund the schemes, coupled with the transitional nature of the economy which

has experienced many episodes of instability over the past two decades. According to Gandure (2009), the AMTO scheme has faced many challenges due to insufficient government funding and inefficiencies in the health delivery system caused by shortages of drugs. Another weakness is that the scheme pays for services received from public facilities but not from private institutions. It was also noted that most of the schemes worked very well at inception, however the delivery of services deteriorated due to the economic situation that prevailed from the late 1990s onwards (Masuka et al, 2012).

3.2. Key informants

In this study 28 key informants, drawn from six districts were interviewed and these included the District Medical Officers, District Nursing Officers, Matrons/Nurses in Charge, hospital accountant and the Social Services Officers from the Social Services Department.

3.2.1. Sources of financing for health care

The key informants reported a mix of public and private financing sources which include GoZ budgetary funding, medical aid/health insurance for the public and the private sector, as well as out-of-pocket payments through the Health Services Fund (HSF). They also highlighted the introduction of a recent donor supported initiative, the Health Transition Fund (HTF) and public assistance grants from other government budgets to socially protected groups such as pensioners, war veterans, the police and AMTOs (DSS) to help vulnerable people to meet health care fees. These findings concur well with the findings of the document review above.

3.2.2. Exemption schemes

As noted above, a scheme exempting children under the age of five, adults aged over 65 years, the indigent and pregnant women covered by GoZ funds has been in place since the early 1990s. Donors such as UNICEF and the World Bank among others fund maternal health programmes, immunisations and the treatment of children under five. Programmes for HIV and AIDS patients were funded through the Global Fund.

Despite the relatively comprehensive list of priority groups that were supposed to benefit from the government-funded exemption scheme, the reality was that not everyone within these groups has received sufficient protection to guarantee their access to health care services and drugs. The government scheme is resource-constrained due to the economic decline that the country has been experiencing over the past one-and-a-half decades.

“The problem in Zimbabwe is that there is a policy which makes health a basic right. Though health is a basic right for every Zimbabwean the hospital needs user fees for its survival.” (DSS, male, 31).

“We have different groups of schemes responsible for medical aid, uniformed forces (war veterans and police), social welfare, those who are over 65 years of age, exemptions from companies, NGOs paying for HIV patients and also cash debtors between the ages of 6 – 64 years of age.” (Health worker finance, female, 48).

3.2.3. Health Transition Fund

Key informants reported that in 2011, the government embarked on considerable financing reform efforts in the health sector, particularly in the area of maternal health. There was advocacy for the abolition of fees for maternity services and the subsequent treatment of infants after delivery, and from 2011, user fees for pregnant mothers were removed. Funds to support the fee removal were channelled to health facilities through the Health Transition Fund (HTF), a multi-donor pooled fund managed by UNICEF. The HTF started as a transitional fund supporting the provision of essential medicines but evolved into comprehensive maternal, newborn and child health (MNCH), and health systems support, including human resources and support for recurrent costs at health facility level (Salama et al, 2014). The HTF sought to achieve three objectives; 1) to improve the coverage, quality and accessibility of MNCH services; 2) to tackle AIDS-related illnesses and deaths through the increased provision of anti-retroviral therapy (ART), particularly treating young children; and, 3) to enhance the overall financial sustainability of the health system. The implementation of the HTF has been slow in practice and the amounts available were reported to be below the requirements of the health facilities. Hospital accountants stated that the implications of such policy changes on the wider health system were quite huge because of funding gaps that were created as hospitals failed to purchase consumables for the deliveries and food for the mothers.

Respondents reported that not all facilities had dropped user fees for deliveries. The main reason cited for not doing so was that it meant that the clinic would not be able to finance their operations. Fees for some were reported to be as high as USD \$120 and pregnant women were asked to bring their own consumables.

3.2.4. Social protection/public assistance

The key informants referred to a range of government social assistance schemes for pensioners, war veterans and the police, and the Assisted Medical Treatment Orders (AMTOs) referred to in section 3.1.2, funded by the government through the Ministry of Labour and Social Services. The AMTOs have existed since 1980 (Siampondo, 2015), under the Essential Drugs and Medical Supplies. The AMTO is a form of voucher/fee waiver that allows the holder/patient or indigent person to obtain medical treatment with the government paying at a later date on a reimbursement basis (Masuka et al, 2012). It is a government-funded social protection scheme that targets people who are between the ages of six and 64 who cannot afford to pay for their health care costs.

Whilst there have been no significant changes in the policy since the scheme was established in the early 1980s, the economic environment has shaped how the policy has been implemented over the years. During the time of the Economic Structural Adjustment Programme (ESAP) during the 1990s, donors funded the scheme after it was established that vulnerable groups needed to be protected during the implementation of the programme.

“When ESAP was introduced it took everyone as if we were all involved in gainful economy activities. It did not say whether some people were unemployed or employed but living below the poverty datum line, some who were breaking even and some who were in the upper bracket. We were all lumped together as a homogenous group. Later it was discovered that there were some people who needed

special protection from the government. So that is when the AMTOs were introduced.” (DSS, male, 56).

The Social Dimensions Fund (SDF) was established for the purpose of protecting vulnerable groups during ESAP, and was donor-funded.

“Through ESAP the donors were funding the Social Dimensions of Adjustment where this one (AMTO) fell into. During ESAP there was the Enhanced Social Dimensions Programme whereby we were specifically looking at the social issues which affected the general public apart from the economic ones. We had a dedicated section for that and it is still there and is part of this programme.” (DSS, male, 56).

The end of ESAP also marked the end of the donor-funding for the SDF, but the way that the scheme operated did not change. According to respondents from the DSS, one of the weaknesses that has bedevilled the funding mechanism for the scheme was the non-payment or delay in disbursements by the treasury to the DSS. This problem started around the year 2000 but worsened after the introduction of the multi-currency system.

“When they (donors) left, the government continued with the scheme in the normal way. There was no change in policy, but the government’s ability to pay has been affected by the economic meltdown.” (DSS, male, 56).

Since then, the scheme has not been adequately funded by the government, which has resulted in inconsistencies in policy and practices as shown by the results of this study.

A respondent from DSS headquarters reported that there are steps for legislative reform which were underway during the time of the interview:

“Right now we are in the process of renewing the Public Assistance Act because we have noticed that there are some gaps. We want to try and come up with something that is friendlier to the vulnerable. The Health Assistance Policy is riding on the Social Welfare Assistance Act. We are looking at making health assistance a stand-alone policy. Once we have a policy we will be compelled to fund it. We are finding ways on what could constitute a better Health Assistance Act instead of it riding on the Social Welfare Act. We are in the process of engaging a consultant who is looking at the different modalities. The process started early this year (2013).” (DSS, male, 56).

3.2.5. What the AMTO covers

The scheme was designed to cater for all costs related to treatment and includes consultation fees, diagnostic tests, medication and surgical procedures. Both officials from the Ministry of Health and the Department of Social Services confirmed this was the policy position, yet there were certain diagnostic tests that were not included.

“Under normal circumstances the AMTO is supposed to cover everything but there are other services which are essential areas for revenue collection such as CT scan. So they do not accept AMTOs for such services.” (DSS, male, 31).

“According to policy the AMTO is supposed to cover all health care costs in government and mission hospitals.” (DSS, male, 56).

“They are supposed to pay for everything. Social welfare and free patients access everything for free. But since dollarisation they have not been able to pay.” (Health worker finance, female, 48).

3.2.6. AMTO Implementation

The DSS is allocated funds annually from the Treasury, and is responsible for the assessment of scheme beneficiaries through a means test. It then issues an AMTO for the patient to present at a public health facility. Respondents from the DSS reported that no threshold for costs is indicated, thereby implying that the AMTO should cover all services irrespective of charges. Each AMTO has a serial number which the public health facility uses when processing claims for payment for the services that the patient has received. The claims are sent to the district office of the DSS, which then compiles all claims for that district and then sends these to the provincial offices for assessment and to be forwarded to the headquarters in Harare for payment. The system is centralised.

The means test was described as a lengthy process because the officer who issues the AMTO is not housed in the health facility. It is carried out through an interview and in some cases the officer is required to visit the home of the patient in order to conduct a thorough assessment. Several criteria are used to assess individual applicants for the AMTO scheme, and these include the following:

- i. certain social indicators such as where a person lives,
- ii. the size of their family,
- iii. the type of disease that the patient is suffering from,
- iv. the financial implications of the sickness,
- v. whether the patient has relatives who can assist them,
- vi. whether the patient has any dependents who rely on them.

“In general, we look at the nature and condition of the social circumstances surrounding that individual patient.” (DSS, male, 31).

3.2.7. Changes in the effectiveness of the AMTO

During the 1990s, before hyperinflation, the scheme was reported by both the DSS and the MoH to be very effective. There were no problems relating to the disbursement of funds from the treasury to the DSS and from the DSS to the Ministry of Health. This was during the time that the scheme was being funded by donors in addition to funds that were coming from the government.

“Those are government workers who implement government policy. There is no room for your own sentiments.” (DSS, male, 56).

“It is sustainable because it is a statutory provision and the treasury has always been allocating funds.” (DSS, male, 56).

Resource challenges during and since the hyperinflation period have, however, weakened the effectiveness of the implementation of the AMTO in a number of areas as discussed below: inadequate funding of the health sector by the government; problematic reimbursement of the AMTO to the

provider; non-compliance with government policy by MOHCC facilities and the perception that the assessment process or means test is not robust enough.

3.2.8. Inadequate funding of the health sector by the government

One of the sources of funding for a hospital or health facility are funds from the Government of Zimbabwe (GoZ). These funds are allocated to the Ministry of Health and Child Care (MoHCC) when the Minister of Finance formulates the annual budget. Respondents from the MoHCC called this ‘money on paper’ because a large proportion of the allocated funds will never be given to the Ministry to fund its operations.

“What we receive from fiscus and revenue is not even a 10th of what we need in order to run the hospital efficiently. The impact of poor funding is the unavailability of drugs, the machines are not well-maintained and staff are highly demotivated. The ratio of what we get and what we need is so poor.” (Health worker finance, female, 48).

In essence, hospital operations are funded through other sources, especially user fees collected through the Health Services Fund. Government support of the health sector has been low and the systematic collection of user fees has remained the most viable financing option for the health sector.

“The lack of funding from the government affected the health system negatively. The government would disburse money to health institutions late and because of inflation the money would have lost value, so health institutions had no money to service machines or even to replace them.” (DSS, male, 56).

It was noted by respondents from both the DSS and the MoHCC that the government was not generating much foreign currency to fund social services. As a result:

“Since 2011 the bill has accumulated and we are failing to cope with the payments.” (DSS, male, 56).

“Funds from the treasury are not consistent; the government promises thousands to hospitals but it never comes. Hospitals end up struggling to make ends meet. Revenue is collected from patients.” (DSS, male, 31).

3.2.9. Problematic disbursement of funds to the MoHCC

The DSS acknowledged that there are problems relating to the disbursement of funds to the MoHCC and that this affects the functioning of the health system. Inefficiency in the delivery of services by the government has been attributed to a poor capacity to finance the scheme as a result of economic instability.

“During this period of hyperinflation the government could still pay the hospitals but at a later date. It had depreciated by the time the money got to the hospitals, and the hospitals could not afford to buy medicines and service their machines.” (DSS, male, 56).

“Before the economic meltdown the AMTO was effective because funding was there. The government was always up to date with its payments. The problem started in 2007/2008 during the era of

hyperinflation. As we got into dollarisation the economy was a bit squeezed. Right now there is little funding to support the scheme so people are not benefitting well." (DSS, male, 31).

"The problem of payment started in 2000. Before that we used to pay on time and medications were there in the hospitals and also our clients were getting services as long as they had the AMTO. Things fell apart in 2008." (DSS, male, 56).

3.2.10. Non-compliance by the MoHCW

Given the consistent problems with reimbursement for the medical costs incurred by individuals with AMTOs, health facilities have failed to comply with policy guidelines, and resort to collecting user fees even from exempt patients as an alternative strategy to sustain their operations.

"Since the government is not paying it is difficult for hospitals to comply because they need to survive. The operation of the hospital requires huge sums of money so if they continue accepting everyone with an AMTO and the government is not honouring its promise to pay, it means the hospital will close. The hospital is forced to ask patients to pay user fees for survival." (DSS, male, 31).

Government directives to health facilities to accept the AMTOs without questioning were ignored in some institutions.

"Of late we have been having challenges with this facility. Since 2 July 2013 there was a directive from our accounts department not to accept anyone for services which are not consultation and hospitalisation." (DSS, male, 31).

"Yes, gradually it has been effective especially in the 1990s where many people were coming to our offices to seek help because of HIV/AIDS. The AMTO made it possible for those without money to access health services. Right now because of delays in payment there are hospitals which have been refusing to take our AMTOs for example Parirenyatwa, Harare and Chitungwiza Hospitals." (DSS, male, 56).

The results showed differences in the implementation of the AMTO. DSS has the mandate to assess the household's capacity to pay and to subsequently issue the AMTO when the patient meets the eligibility criteria, but some health facilities were still not accepting the exemption. Patients were subjected to further assessment by the authorities at referral centres. The accountants reported that in some cases patients were called upon to pay even when they had the AMTOs. This is irrespective of the fact that they are obliged to accept the AMTO as required by government regulations or statutory instrument. That introduced systemic inefficiencies in the delivery of health care services that were meant to benefit the poor.

The eligibility criterion has remained the same in the policy, but the selection of beneficiaries has been tightened to ensure that the most deserving patients are granted the AMTOs. The scarce resources that are available have to be used to make the most impact. Health facilities refuse to accept the AMTOs even though the authorities are mandated by a statutory instrument to process the document without questioning.

"There has not been any national change in policy after dollarization. The refusal to accept the AMTO by the hospital is because of economic hardships and the fight for survival. I believe that these changes came as a response to the economic hardships that the hospital is going through which is caused by lack of funding from the government. The challenge that we are facing with these AMTOs is that they

were meant to cover everyone who cannot afford to pay, but because the numbers were overwhelming the hospital decided to restrict the use of AMTOs.” (DSS, male, 31).

Authorities within the health facilities reported that user fee removal and in particular, the government pronouncement of the Health Transition Fund enabling pregnant mothers deliver for free against a background of erratic disbursement of GoZ funds, creates operational challenges as many health facilities fail to sustain themselves. One compensatory strategy to counter the effects of such reforms was to increase charges and systematically collect user fees for other services. The authorities recognise the implications of the reform on the wider health system, and have maintained the stance that when a health facility collapses or fails to provide services, the blame falls on its management and administrators. In that case, they have to make the right decision to meet the increased demand for services.

“The government may feel we are breaching the AMTOs policy in some cases. Some time ago we faced a lot of challenges and we had to start charging patients in United States dollars (USD) without the government’s authority.” (Health worker finance, female, 48).

There are some services which providers categorised as strategic for revenue collection. These include CT scans and blood transfusions among others.

“We have made priorities, for example on getting blood, patients just have to pay for that blood. Renal haemodialysis is very costly. We try to subsidise consumables for haemodialysis because a session is \$80 but we incur \$100 for procurements for each session. We only compromise this policy on cases of emergency.” (Health worker, finance, female, 48).

According to the service providers, charging user fees for these services is an effective and sustainable way to ensure their continued availability. Their contention is that no money comes from the GoZ or DSS as these mechanisms are poorly funded hence they are not sustainable.

“A certain hospital (name given) used to do CT scans for free, but found that it is not sustainable and patients are now paying.” (Health worker, finance, female, 48).

Service providers also reported that they assess the condition of the patients themselves, provide the service and agree on payment arrangements with the patients.

“Sometimes we put patients on payment schemes if they do not deserve the AMTO and when they say they do not have cash. We always tell patients the status of the hospital and they are willing to pay after we explain to them. We ask where the patients stays, confirm if they have any relatives and also we get information on their income status. For deserving patients we just see it.” (Health worker, finance, female, 48).

3.2.11. Assessment/ Reassessment of AMTO holders

It has been noted that health facilities would discontinue operations if all patients with AMTOs were accessing services for free. The researchers observed that there was a feeling among service providers that the systems for the assessment of eligibility were weak and they therefore felt it was necessary to reassess AMTO holders. Differences in practices were observed between facilities. Reassessments were more common in urban referral hospitals whilst those in the rural districts complied with the policy i.e. accepted the AMTOs without questions.

“The government pays social welfare bills but what we get from them is not enough. We are now reviewing the process of AMTOs ourselves because we discovered that most of the people who come

do not deserve and the other reason is there is increasingly more patients in need of free treatment hence we had to be more strict.” (Health worker, finance, female, 48).

This is linked to flaws in the assessments for eligibility. The Ministry of Health holds the perception that AMTOs are being given to patients who do not deserve them hence the huge number of patients with exemption letters, who still cannot be assisted for free due to the scarcity of resources.

“We have a shortage of officers. Shortage of money has impacted on the efficiency of the operations which is our major cry as a Ministry. One moment they unfreeze posts for a short time and the next thing you hear is they are frozen again because the money they thought they could use will be gone. The government has been trying to pay the health institutions but the money is too little. It is failing to match up with the current bill.” (DSS, male, 56).

However, although social services officers are required to visit the patient at home for them to make informed decisions to assess eligibility for the AMTO, officers reported that they were faced with resource constraints:

“Assessments are no longer being done in the proper way now because of lack of funds e.g. we are supposed to do home visits to verify whether a person cannot really pay. Around 2006/2007, 80% of people who were hospitalised had AMTOs. The hospital argued that there were some people who were holders of the AMTO but they could pay or had relatives who could help them pay.” (DSS, male, 31).

On the other hand, respondents from the DSS reported that service providers had negative attitudes towards holders of AMTOs, who felt stigmatised.

“Not everyone in the health facility understands that there are poor people. The attitude of health workers is generally bad towards holders of AMTOs. On worse scenarios people are chased away completely. It emanates from lack of government funding and support.” (DSS, male, 31).

“The AMTO has not been effective in terms of meeting the health needs of the people. Here at the hospital the AMTO carries with it a lot of stigma and discrimination such that they are failing to access services easily. The moment they go to the cashier so that their card gets stamped, they are referred back to us. If we don’t have answers for them we refer them back to the accounts department again. When they come they expect to get services quickly so that they can go back, but that is not the case here. They have to go through a re-screening process before they get access to services. Those who are not successful go back home without treatment.” (DSS, male, 31).

Patients perceived the funding mechanisms as not very effective considering the frequency of their visits to the health facilities for consultation and monitoring and to receive new supplies of drugs or medication.

3.3. Findings from patients through life histories

Life histories were conducted with 50 patients with chronic diseases drawn from hospital registers in six districts. The study was interested in such patients because they are frequent users of health care services and therefore most suitable to provide information about the impacts of user fees on their households.

Table 4: Life histories by type of disease

Fifteen females and five males had multiple, chronic illnesses

Site	Type of chronic disease (F=Female M=Male)											Total (50)		Total
	Dia betic	Psych iatric	Hyperte nsion	Stroke	Asthma	Epi lepsy	TB	HIV	Brain Tumour	Chronic Cardiac Failure	Renal Failure	Male	Female	
Chegutu			6F, 1M		1 M	1M						3	6	9
Chivi	1F		2F, 1M		1F	1M	2M	2F, 1M				5	6	11
Insiza	1F	1F	2F, 1M					1F, 1M	1M			3	5	8
Nkayi	1F		2F		1M		1M	1F		2F		2	6	8
Harare	3F		1M			1M				1F	1M	3	4	7
Makoni			2F, 1M	1F	2F	1F						1	6	7
Total	6F	1F	14F,4M	1F	3F,3M	1F, 3M	3M	4F,2M	1M	3F	1M	17	33	50

3.3.1. Health care costs

As noted earlier, Zimbabwe has had fluctuating levels of out-of-pocket health expenditure: from 23% in 1999 to 62% in 2005 to 39% in 2010 (Chirwa et al, 2013), reflecting the impact of the economic crisis on people's access to health care. The results from the life histories showed that the burden of direct payments was borne by the patients themselves in view of the fact that they were not covered by any form of health insurance and the non-compliance of health facilities with regard to AMTOs. The health care-related costs that the patients identified were as follows:

- medical consultations and drugs,
- transport, which may include another person accompanying the patient,
- food whilst at the health facility.

Payments for medical consultation and drugs constitute the main substance of health expenditure for the patients. The expenses associated with accessing services such as transport and food were not generally considered a burden, although in fact these two elements significantly raised the total cost of health care for households.

In particular, people with chronic conditions are required to attend facilities frequently for routine monitoring visits and need to take medication regularly, both of which have a significant impact on their ability to meet health care costs. Some patients had multiple chronic conditions which increased their vulnerability to the risks of inadequate financial protection. Such patients pay larger amounts for drugs for different ailments and not consultation fees. As a result, there were quite a number of challenges that these patients faced in the process of getting access to services. These included the following:

- being denied free access to services despite having the relevant exemption letters,
- building up debt at the health facility,
- drug shortages at the health facility.

For some participants, the AMTO, when it ran smoothly and reimbursements were timely, was considered an important factor in meeting health costs. For example, one patient said:

"Yes, we were paying but we had no money. That is the reason why I was going only when I was in pain. In the majority of times I used to stay without taking my medication. We were failing to pay and will go to hospital whenever I was in asthmatic attack and that is when I was advised to go to Department of Social Welfare." (19 LH044 Makoni F).

Another participant revealed that the AMTO they were granted had completely altered their access to health services:

"The change I have seen is that I used to pay for consultation but I'm no longer paying for it. At first I was paying \$5 for consultation but now I do not pay any more. BP tablets are for free." (14 LH034 Chegutu M).

However, as reported by the key informants in section 3.2.3, despite patients having an AMTO issued by the Department of Social Services, these were often not accepted by the facility management. For example, one patient who was admitted into hospital and accrued bills - even though she had an AMTO - said:

"2012 and 2013, I have a bill still to be settled at the hospital, was admitted again in 2013 and I have bills which are slightly above \$40, I have two papers (referring to the bills/invoices) in the house). Some sisters (nurses) were even asking why I was asked to pay for hospital admission when I had that letter (referring to the AMTO)." (19 LH044 Makoni F).

The demand for payment at facilities often led to a significant debt building up, as noted in the following statements:

"We have paid a lot of money. So far our bill is at \$336 but there is a bill that they said will come later and we do not know how much it is." (32 LH051 Harare M).

"I am getting no help; I am just raising the funds alone. I usually pay what I have and pay later if the money is not enough." (29 LH043 Makoni F).

Another patient, acknowledging debt for previous treatment said:

"Umm, it's a challenge, that \$27 that I left I haven't paid it yet, because every time I go there I have to cover the costs for that particular day but it is still needed at the hospital." (31 LH046 Harare M).

Some patients made payment arrangements with the health facility and paid their bills in instalments. This was a common strategy - also reported by the key informants, - that the health facilities adopted to recover their costs. It was reported that in 2008/9 some health facilities engaged debt collectors to follow up the payments, but this was later discouraged by the government. Health facilities even sought to recover patients' debts from their relatives. After the government discouraged the engagement of debt collectors, persuasion was being used to collect the payments and the health facilities began to send reminder letters to patients.

"I was admitted for four days, I was told to pay \$240 but I told them that I was a health promoter and there was nowhere I could get all the money from, so they then wrote that I was supposed to pay \$100 so I don't know if \$100 was only for that day, and that day I did not pay because I did not have the money. So I came back home and I just thought that it was good that I pay the money because one day I would need to go back again for treatment so I went back and I paid \$50. I then asked them if it was enough and they said no, you still have to pay the whole \$240. They said they could open an account for me so that I could pay in instalments. So I'm still paying, whenever I get some money." (21 LH048 Harare F).

“Even if you were not able one was mandated to pay the fees, my husband would negotiate for payment terms and in the end the fees were paid.” (25 LH037 Makoni F).

Another participant had gone for four months without getting drugs at the hospital because of the increase in the fees. She said:

“Yes; it is even more than that, I have not managed to get drugs since July since they increased the fees from \$4 to \$10. I was supposed to go for a check-up on 4 July but I did not go. You go to the dispensary and you are told they do not have the drugs.” (25 LH037 Makoni F).

3.3.2. Patients’ health care decisions

In the participants’ responses, some adverse effects of insufficient financial protection for patients with chronic diseases who are not on any form of health insurance or where exemptions/AMTOs were not recognised were observed. Patients reported some of the ways that this has affected their care-seeking behaviour, as follows:

- delaying seeking treatment until such time as they get the money that is required for both consultation and drugs,
- by-passing health facilities and seeking medication from pharmacists directly,
- reducing the dosage of prescribed drugs,
- sharing drugs with other patients with similar conditions.

Delaying seeking treatment

Some patients reported that they ignored the illness and delayed seeking medical attention, including getting diagnostic tests, when they did not have the money to pay for the consultation fees, medications or the bus fare to go to the hospital.

“I was asked to come for a review on 29 January, if I fail to raise the money I will not go. My husband also failed to go for his review because we didn’t have the money. We only managed to buy his tablets.” (21 LH048 Harare F).

“I cannot afford to pay for the costs. I was supposed to go for my monthly review on the 25th which was last week but I could not be treated because I didn’t have the \$10 for consultation. I asked the accounts department at the hospital to assist me and then pay at the end of the month but they refused, so I went back home without treatment. I came back home without treatment and I had to wait until I had the money and I still haven’t bought my tablets this month.” (30 LH045 Harare F).

“When I don’t have the money I do nothing. I just sit at home until I raise the money to go to the hospital. (09 LH028 Chegutu F).

By-passing the health facility

Some patients reported that they by-pass the health facility to avoid paying the consultation fees and go straight to the pharmacy to purchase their drugs. In this regard, they can save between six and nine dollars in most instances.

"At one point the pharmacists were refusing to give me medications without a current prescription from the doctor, but I had to beg him to help me because I did not have the money for consultation." (16 LH036 Chegutu F).

When asked about attending the hospital for regular check-ups one patient said:

"I have a machine to test my blood sugar but I went for BP check-ups last month. The problem why I may not go regularly is that I have to pay \$6 for consultation but I don't get the tablets." (24 LH021 Chivi F).

"For the past six months I have not been going to the hospital to avoid consultation fees. I am going straight to the chemist because I am trying to cut the costs. Tomorrow I have to go to the hospital, but I do not have the money for consultation at the moment. I will just go and if they refuse to help me, I will come back home." (16 LH036 Chegutu F).

Reducing the dosage of prescribed drugs or sharing drugs

Drugs sold from the hospital pharmacy are generally cheaper than similar ones from private pharmacies. However, it was reported that public hospitals/clinics usually run out of drugs and patients have no option but to wait until the drugs are available in the public pharmacies. Patients had various ways of coping with these problems: either by taking fewer drugs or sharing their prescription drugs with their peers until such a time as they had the money for transport or drugs.

A patient reported that when she could not afford her medication, she took less:

"I sometimes skip taking the tablets or where I am supposed to take two tablets I take one and I only do that when I feel that my condition is better at that time. I must make sure I remain with four or six tablets before I go back to the hospital. That is what they want and if you do not have they do not give you." (17 LH038 Makoni F).

Other patients reported sharing drugs with friends or neighbours who had similar conditions in order to save on costs:

"If I go to the hospital and there are no tablets it means I will have to go back again to collect the tablets. Sometimes I borrow the tablets from friends who have the same problem as me and I will give them back when I get them, especially HCT." (09 LH028 Chegutu F).

Many patients reported that they fail to get their drugs because of lack of money. When asked what they do when they cannot buy those drugs one participant said:

"I have trauma but sometimes borrow asthmatic drugs from friends who also have asthma." (19 LH044 Makoni F).

"So many times. I usually borrow from a neighbour who is a village health worker; she is also asthmatic so we share pills sometimes." (29 LH043 Makoni F).

Transport

Transport has two components, one being financial and the other being the means of travel, which may not be available in some rural settings. Some patients reported that they could not access services at the appropriate times because they had no money to pay the bus fare. Even with an AMTO, transport costs are not covered.

“For me to be able to pay it I would have done piece jobs and make sure that the money is enough to pay for my transport.” (06 LH025 Chivi M).

“I had to sell my chickens to get money for transport to go to Mbuma and Bulawayo to seek treatment. Now I have no chickens they are all finished. The doctor in Bulawayo is the one who advised me to get the social welfare letter. But unfortunately it doesn’t cover transport to go to Bulawayo.” (02 LH011 Nkayi M).

“They have a very negative effect on us, all my grandchildren are HIV positive except for the little one whom I have not yet gone with for testing, so I’m supposed to raise bus fare after every three months to take them to the hospital although they pay half ticket. At times I come with them when they have other illnesses so it means I have to raise money for their bus fare.” (09 LH028 Chegutu F).

3.3.4 Coping strategies – meeting health care costs

In this study, the researchers sought to understand the effects of recurrent health care costs on resources within the household and how people were coping. Meeting such recurring costs created significant challenges and difficulties and often meant individuals had to take on piece jobs to meet costs or repay loans, sell key livelihood assets, ask their children for assistance or borrow money.

Piece jobs

Doing piece jobs is an important coping strategy for poorer households. The participants reported that they do piece jobs to create income to pay for their health care. Some respondents reported, however, that they could not do piece jobs because of weakness caused by their illness. In some cases, other household members would assist in doing the piece jobs to raise the money for the patient to be able to access health care services.

“..... Sometimes I have to go and do some piece jobs in people’s fields in order to raise money for medications. Now I am skipping hospital visits to avoid paying consultation fees.” (29 LH043 Makoni F).

Selling household assets

Patients reported that they had sold their household assets such as refrigerators, livestock (such as goats, cows, chicken or turkeys), agricultural produce (grain and vegetables) and traditional beer for them to raise money for medication, medical operations and to pay for transport expenses associated with the treatment.

“We had to resort to other means to raise the funds. We had to sell goats to raise the money for the medication of my child. We had to borrow from others as well, as things were getting worse.” (03 LH013 Nkayi F).

"Yes, I have sold some cattle in order for me to buy food, school uniforms, medications and to pay for transport costs." (09 LH028 Chegutu F).

"We once sold our fridge and failed to replace it." (11 LH030 Chegutu M).

".....I had to sell two beasts in order to arrange for my operation; however the money was not enough, it was all spent on travelling expenses." (14 LH034 Chegutu M).

"We had to sell a Toyota twin cab as well as two beasts. We sold it (the car) for \$2500 dollars, and the cattle for \$600." (27 LH005 Insiza F).

"I have sold my goats. I had 10 but now I am left with only three." (29 LH043 Makoni F).

Assistance from children

Participants with working sons and daughters receive remittances from them, which they use to pay for health care costs – or to repay loans from neighbours as shown here:

"Our life is very hard. As from 2010 we have never harvested anything from the fields. My child and grandchildren are the ones that send me money to survive. I always have to wait for my daughter to send the money so that I can repay my neighbours." (05 LH016 Nkayi F).

"We get money from farming that is cotton and maize, we use that money. My daughter and her husband are the ones who are taking care of us here. They provide food and money to buy drugs. The other boy child assists us here and there if he gets money; he sometimes gives us \$20 for me to buy drugs. My elder son does not work, he sells firewood in Chegutu." (13 LH033 Chegutu F).

Remittances were reported not to be reliable because some of their sons and daughters were not always employed.

"It is difficult because they also do not have enough. Yes, they may get a bar of soap to give us but they are also struggling to make ends meet. Their husbands are not working also." (10 LH029 Chegutu F).

Another said:

"Umm, as you know that jobs are a problem and also that if someone is married and has his/her family to look after; it is difficult to get any assistance from the children." (12 LH032 Chegutu F).

Sometimes, the participant would acknowledge the difficulties that their children faced in trying to assist with their parents' health costs:

"It was better when both my children were alive. They would make contributions to pay for my medications. At the moment my surviving son is really struggling to pay as his family is now big." (17 LH038 Makoni F).

Borrowing money

Patients reported that they borrow money to pay for their health care costs from friends, the church and their neighbours. Some reported that they pay back after receiving some remittances from children, others do piece jobs for their lenders or may sell some chickens or other small livestock in order to pay back the debt.

"Sometimes I cannot afford because my children would have failed to send money due to the fact that some of them would have failed to take responsibility. I go to my neighbours and borrow because I can't do without my drugs." (24 LH021 Chivi F).

"I have borrowed from the church and from my friends because I did not have the money." (30 LH045 Harare F).

"Yes, borrowing is common among people, I once borrowed (about \$100) in order to go to the hospital, I think it happened for about two times. I returned the money." (31 LH046 Harare M).

"I borrow from my neighbours and pay back later when I can. The problem is that these bills are now affecting our income. We can no longer afford to lead a decent life my child. As soon as you get anything, you have to pay the hospital bills." (27 LH005 Insiza F).

"When my husband was ill we borrowed some money from the church. At times he would fail to even go to the hospital because we did not have the money." (20 LH047 Harare F).

"Yes, if my son delays to send the money I borrow from friends. They give me because they understand my condition." (17 LH038 Makoni F).

3.3.3. Effects of health care costs on households

The study looked at how meeting the health care costs affected patients' households. Some coping strategies that participants adopted led to impoverishment, declining standards of living, asset depletion, displacement of other household needs (e.g. school fees, food), and some vulnerability based on gender. The reports were similar across the study sites.

Reduced standard of living

Some patients reported that cash payments to meet their healthcare needs led to increased impacts on household budgets and negatively affected the standard of living within their households.

"Our standard of living as a family is decreasing because I'm taking a lot of money for my medications. Before I used to pay \$15 a month for my medications but now the consultation fee has been increased so the total amount per month has also increased." (16 LH036 Chegutu F).

Asset depletion

Selling assets to pay for health care costs, mostly small livestock such as chickens and goats, was one coping strategy that patients used. However, very few reported selling other household assets like televisions and cars.

"I have never borrowed money to get treatment. I sold all my chickens. I was selling each one at \$3. I don't know how many chickens I have sold, but plenty. I need at least \$20 to travel to and from Bulawayo." (02 LH011 Nkayi M).

"Yes, we sold our chickens and turkeys to get the money. At one point we had to sell two cows. We were not able to replace them and we do not think we will be able to replace the assets." (14 LH034 Chegutu M).

Delaying or displacing other household needs

Patients reported using money that would have been earmarked for other household expenses, even school fees for children, to pay for their healthcare costs.

"Yes, to buy soap and cooking oil but I have to decide on my own that I should buy my medication, so whatever I am given I should buy medication first." (13 LH033 Chegutu F).

Failing to pay school fees on time resulted in their children not attending classes.

"Sometimes, I fail to pay school fees and to buy uniforms for my grandchildren. Though part of the school fees is paid by BEAM I struggle to top it up." (09 LH028 Chegutu F).

"...we would divert the little money that we had for food to buy tablets. At some point we failed to pay school for our children such that they were being refused access to attend lessons. We had to go and talk to the headmaster who agreed to put them under Basic Education Assistance Module (BEAM)." (10 LH029 Chegutu F).

"At times we take the money that we are supposed to pay school fees and we use it for transport and other health bills." (14 LH034 Chegutu M).

"We failed to raise school fees for our children and seven of our children went to school up to grade seven and only one went to school up to form four." (20 LH047 Harare F).

"We took \$20 that was meant for school fees for the children and we used it to pay for my health care costs. My husband did some thatching for the Headman to replace the money." (28 LH039 Makoni F).

"It is really a challenge. At times we fail to pay school fees for my son and grandson because we would have used the money to buy my medications." (29 LH043 Makoni F).

Gender and health care costs

As Kaseke (2015, notes in his critique of social assistance in Zimbabwe, gender "determines access to social assistance and women tend to be disadvantaged," particularly as "women cannot apply in their own right," but through the male breadwinner.

The life histories depicted a pattern where financial burden in households increased with the loss of a husband/breadwinner, which indicates that in general terms, out-of-pocket spending tends to increase more rapidly than income in the absence of regular monthly wages. Some widows reported that the death of the husband/breadwinner or the loss of a job led to termination of health insurance

and ultimately to an increase in financial shocks related to health. However, “widows and divorced women can apply in their own right” (Kaseke, 2015), for social assistance, such as AMTOs.

Death or the loss of a job by a husband or breadwinner and subsequent termination of health insurance has other unexpected social consequences for women. A widow reported that she had to relocate from Hwange Colliery, a mining settlement, to the rural area. She could not cope with the dramatic changes and the living standards, so she had to make adjustments because of the shocks accompanying the decrease in disposable income. This resulted in her suffering from hypertension, and she admitted that the severity of the illness was linked to stress. This increased the costs of her medical treatment.

An epileptic female patient had this to say:

“What I can say is that ever since my husband came back from work in 1998, life became difficult for us. We have been struggling to make ends meet. When I got sick I was never able to go and seek health care consistently because we did not have the money. I stopped going to the hospital for years and I only started going to the hospital in June this year (2013). After I was diagnosed in 2003 I was taking my medications for almost a year because I would get them for free.” (28 LH039 Makoni F).

Commented [12]: Is this correct, it's just a guess?

A woman suffered a stroke and had hypertension and because of the sickness her husband who is a truck driver decided to find another wife. She was not receiving full support for her medication from the husband.

“I have to buy HCT, and the other drug (Nifedipine) which is written on my card but I have never taken it so far because I'm supposed to buy it from the pharmacy. So at the moment I cannot afford to go to the pharmacy, I don't have the money, so every time I go to the hospital they give me HCT and write down the other type but I can't afford to buy them. For me to have those tablets I have to go to Masvingo, but I can't afford it. If I tell my husband that I am supposed to buy some tablets he always says he doesn't have the money at the moment. He promises to give me but he has never given me the money. So nowadays I no longer tell him, I have decided to keep quiet.” (08 LH027 Chivi F).

4. DISCUSSION

Although Zimbabwe does not charge user fees at primary care level, the results of this study show that the country is moving towards the direction of increasing user fees at referral facilities. It was observed that user fees have been rising since 2009 when the multi-currency system was introduced. In the absence of health insurance, this creates additional financial barriers for poor people to access health care products and services and they need adequate financial protection. It might be necessary to investigate why user fees and associated costs increased steadily since 2009, when the multi-currency system was introduced. However, there is considerable international recognition that the ‘user fee for public service’ reforms of the 1980s and 1990s could not address the health care resource gaps in low to middle income countries (LMICs): (Gilson, 1998; Gilson, Russell, and Buse, 1995; Kutzin, 1995). International advocacy for the removal of fees, particularly at the primary health care level, is being resisted by many LMICs (McIntyre et al, 2006). Even the World Bank has acknowledged that “out-of-pocket payments for health services - especially hospital care - can make the difference between a household being poor or not.” (Claeson et al, 2001). Accordingly, alternative financing mechanisms such as insurance are now deemed preferable.

Declining government budgets to the health sector in Zimbabwe is widely documented in local and international literature. Health facilities' budgets are, in the respondents' words, "money on paper" because the bulk of the promised funds are never disbursed. Hence, public institutions resort to fees collection. Despite the fact that the list of priority groups that are supposed to benefit from the government-funded exemption scheme is comprehensive, the reality was that not all of these groups have sufficient protection to guarantee their access to health care services and drugs. The results show that even when policies to cushion vulnerable people from financial health-related shocks exist, the effects of poor funding and inefficiencies in their implementation and the costs of drugs from private suppliers tend to be ignored. However, such financial burdens are higher than expected and have multiple socio-economic impacts on households such as the displacement of family budgets and asset depletion. In this regard, the health protection inadequacies for the patients cannot be blamed on the attitudes of health workers/authorities.

As shown in the findings, patients suffering from chronic diseases have been negatively affected by user fees as far as access to health care services is concerned and therefore, because of poverty, their levels of service-utilisation are low. Participants reported having to postpone visits, by-pass facilities, and ultimately access less quality care because of delays and barriers to some services, which they then have to forgo. For example, they may decide to decline the diagnostic tests or routine monitoring during their monthly consultations because they cannot afford to pay.

The researchers observed that some characteristics of the health system contribute to the vulnerability of patients with chronic diseases. One is the shortage of drugs in the public institutions, which means that they have to purchase medication from private suppliers. For example, some patients reported that drugs cost \$4 when dispensed from the public pharmacies and \$6 at the private pharmacies. The unavailability of drugs in the public institutions impoverishes patients and creates other indirect costs, as patients may return to their homes without the medication and then have to incur additional transport costs to return and make the purchase when they eventually get the money. Hence, out-of-pocket expenditures become more significant for the patients if there is a mix of both public and private supply of health services. The extent of out-of-pocket spending is much higher than poor patients can afford and therefore has other multiple impacts and implications for equity and access to health care services. Patients pay consultation fees at the public health facilities and purchase drugs from private pharmacies. They cannot obtain the full package of services from the public sector providers. This further implies that they forgo any subsidies which they may have been entitled to if the drugs were available at the public institutions. Patients noted that postponing visits might lead to future hospitalisations which may be more costly and may also be unavoidable depending on the type of disease. The necessary reforms, particularly regarding the supply of health care products, should be implemented. It is important to assess the healthcare needs, not only for patients living with chronic diseases but also for other disadvantaged priority groups that remain either unmet or partly met because of financial barriers to access. Ideally, this will help in revealing systemic inefficiencies that lead to under-utilisation of healthcare services by the poor and most vulnerable.

Although the key informants perceived the AMTOs as leading to increased demand and access to services by the poor, delays in the disbursement of funds compromised the delivery of quality services by providers and those administering the schemes. The government's delayed disbursements can stretch the financial resources that the health facilities receive mainly through the Health Services Fund (HSF). As a result, compliance with the exemption policy cannot be effectively implemented even though healthcare service providers are mandated by a statutory instrument to do so. The researchers observed that there were differences between urban and rural referral health facilities when it came to accepting or rejecting the AMTOs. However, it is worth noting that these differences

are based on the economic and administrative rationality of the respective health facilities. Failure to collect the money may totally cripple the institutions' capacity to continue providing services. These differences may no longer exist if the problems of the scarcity of health care products and the lack of financial resources necessary for the delivery of quality services is addressed. Whilst the government can enforce the implementation of the policy, previous government directives yielded undesired outcomes which have led to the neoliberal approach that the government has adopted. Hospitals are forced to recover all or at least part of the cost even when a patient has the AMTO. The researchers noted that whilst there is political will for greater equity to prevail in terms of access to health care services, this is not followed by the allocation of the required financial resources by the government to support the implementation of exemption schemes, due to economic austerity as revenues fall below projections as well as other factors. There also appears to be an expectation that the donor community will pour in resources to support the government once the programmes/schemes are formulated.

The coping mechanisms that the patients reported can have multi-faceted effects on their welfare. For example, it can lead to the worsening of the health condition as it deprives the patient of appropriate care. For example, some patients prioritised purchasing drugs over having diagnostic tests or medical check-ups which would require them to pay the consultation fees.

The results suggest that patients with chronic diseases who are not covered by health insurance are more vulnerable due to out-of-pocket expenditure which they incur partly as a result of drugs being out-of-stock in public health facilities. Even when a patient is exempt from payments, they are likely to pay something due to drug shortages when they have to purchase from private suppliers.

5. Conclusion

Social protection schemes for the health sector do exist in Zimbabwe. There are government schemes to provide health protection for the poor, but there are inherent systemic barriers to access, which are - by and large - attributable to poor funding. The results can be clearly linked to some specific features of the wider health system. There are barriers created out of economic and administrative rationality which can be averted by ensuring that the resource requirements of health facilities are met. Results denote that the two government ministries implementing the exemption policy should review the existing institutional arrangements pertaining to the assessment of patients for the exemptions. From the standpoint of ensuring equity in access to health care services, uniformity and consistency in the implementation and enforcement of the exemption policy needs to be promoted.

Delayed disbursements by the Department of Social Services to the Ministry of Health and Child Care has negative impacts on the wider health system as health facilities are forced to overstretch their budgets and this ultimately affects the quality of the services that patients receive. This can be the reason why the poor eventually have to utilise more expensive health care products/drugs, although they should have access to less costly options within the public institutions. It is the same reason why hospitals seek to recover costs from patients requiring expensive procedures such as dialysis (for renal failure) so that they can continue to provide the service, etc. In the case of the patients who are living with chronic diseases, they cannot afford to pay for services because of the cost recovery approach that many health facilities have adopted in the country which may be contrary to the existing exemption policy.

It was observed that user fees have been rising since 2009 when the multi-currency system was introduced in the country. Furthermore, shortages of drugs have contributed to increases in health

spending by vulnerable groups because they have to purchase drugs from private pharmacies. In the absence of health insurance, this creates additional financial barriers to accessing healthcare products and services by the poor, and adequate financial protection is needed. However, it might be necessary to investigate why user fees and associated costs steadily increased to above optimum levels since 2009, and the introduction of the multi-currency system.

There is no doubt that many people suffering from chronic diseases are not covered by any form of health insurance, particularly those living in rural communities. Overall, these results suggest that people living with long-term conditions become more vulnerable due to out-of-pocket expenditure which they incur partly as a result of drugs being out-of-stock in public health facilities. Even when a patient is exempt from payments, they are likely to pay something due to drug shortages which compel them to purchase from private suppliers.

Assuming that schemes are efficient and effective is not enough, evaluating their performance and impacts is also crucial. Periodic reviews should be carried out in line with the dynamics of the economic and social environment in which the schemes are being implemented. It is also imperative to assess the existing institutional arrangements.

References

- 1) Arhin-Tenkorang, C. (2000). *Mobilising resources for health: The case for user fees revisited*. CHM Working Papers Series, Paper No: WG3:6, CMH.
- 2) Auret, D, (1990). *A decade of development Zimbabwe. 1980-1990*. Mambo Press, Gweru, in association with the Catholic Commission for Justice and Peace in Zimbabwe.
- 3) Bhebhe, N. (2009). Zimra surpasses revenue collection targets. *Zimbabwe Independent* Sept 10, 2009.
- 4) Bijlmakers, L. (2003). *Structural adjustment: source of structural adversity; Socio-economic stress, health and child nutritional status in Zimbabwe*. Amsterdam Research Institute for Global Issues and Development Studies (AGIDS).
- 5) Bijlmakers, L.A., Bassett, M. and Sanders, D. (1996). *Health and structural adjustment in rural and urban Zimbabwe*. Uppsala, Research Report No 101.
- 6) Bijlmakers, L. Chihanga, S. (1996). District health systems in Zimbabwe: cost, resource adequacy, efficiency and the core service package. A comparison of three districts. *Bamako Initiative Technical Report Series, no. 36*. New York: UNICEF.
- 7) Campbell P, Quigley K, Yeracaris P, Chaora M (2000): Applying Managed Care Concepts and Tools to Middle and Lower Income Countries – The Case of Medical Aid Societies in Zimbabwe, Data for Decision Making Project, Harvard School of Public Health, Publication No. 84.
- 8) Carrin, G. and Verreecke, M. (1992). *Strategies for health care financing in developing countries*. EDI, World Bank, Washington.

- 9) Chidavaenzi, M., Brouwer, A. and Chandiwana, S. (2001). *Tools for management strengthening of health districts*. Unpublished.
- 10) Chikanda, A. (2004). Skilled health professionals' migration and its impact on health delivery in Zimbabwe. *Centre on Migration, Policy and Society Working Paper No. 4, University of Oxford*.
- 11) Chikanda, A. (2005). Medical Leave: The exodus of health professionals from Zimbabwe, Cape Town. *Idasa, Southern African Migration Project, Migration Policy Series No. 34*.
- 12) Chikova, H. (2013). Social Protection in Zimbabwe – Country paper presented at the International Conference SASPEN – FES *Social protection for those working informally. Social & income (in)security in the informal economy*. 16-17 September 2013, Birchwood Hotel Johannesburg, NSSA Zimbabwe.
- 13) Chimhowu A, Bare T, Chiripanhura B, Chitekwe-Biti B, Chung F, Magure T, Mambondiyani L, Manjengwa J, Matshe I, Munemo N, Mtisi S, Nxele M, Sibanda D. (2010). *Moving forward in Zimbabwe: Reducing poverty and promoting growth*. The University of Manchester, Brooks World Poverty Institute.
- 14) Chirwa Y, Witter S, Munjoma M, Mashange W, Ensor T, Mcpake B and Munyati S, 2013, The human resources implications of improving the financial risk protection for mothers and new borns in Zimbabwe, *BMC Health Services Research* 2013,13;197.
- 15) Claeson, M., Griffin, T., Johnston, M., McLachlan, A., Soucat, A., Wagstaff, A., et al. (2001). Health, nutrition and population. In *W. Bank (Ed.), Poverty reduction strategy papers' sourcebook*. Washington: World Bank.
- 16) Clemens, M. and Moss, T. (2005). *Cost and causes of Zimbabwe's crisis*. Washington DC, Centre for Global Development, 2005.
- 17) Creese, A. (1991). User charges for health care: A review of recent experience. *Health Policy and Planning* 1991; 6:309- 19.
- 18) Drechsler D. and Jutting Johannes P. (2005). *Private health insurance in low and middle-income countries: scope, limitations, and policy responses*. OECD Development Centre.
- 19) Dzirikure, M. and Garth, A. (2014). Voices of Zimbabwean Orphans: A New Vision for Project Management in Southern Africa. *Africa Studieceentrum Series ISSN 1570-9310; Vol 33, Netherlands*.

- 20) Gandure, S. (2009). *Baseline Study of Social Protection in Zimbabwe*. A report prepared for the Social Protection Technical Review Group (SPTRG) of the Multi-Donor Trust Fund.
- 21) Gilson, L. and McIntyre, D. (2005). Removing user fees for primary care in Africa: the need for careful action. *BMJ* 2005; 331: 762–65.
- 22) Gilson, L. (1998). The lessons of user fee experience in Africa. In: Beattie, A., Doherty, J., Gilson, L., Lambo, E. and Shaw, P. (Eds.), *Sustainable health care financing in Southern Africa*. Washington, DC: World Bank.
- 23) Gilson, L., Russell, S. and Buse, K. (1995). The political economy of user fees with targeting: Developing equitable health financing policy. *Journal of International Development*, 7(3), 369–401.
- 24) Global Fund to fight AIDS, Tuberculosis and Malaria. Zimbabwe Country Coordinating Mechanism proposal form round 8. http://www.theglobalfund.org/grantdocuments/8ZIMH_1784_0_full.pdf (accessed Oct 25, 2009).
- 25) Government of Zimbabwe, (1981). *Growth with equity: an economic policy statement*. Harare.
- 26) Hecht, R., Overholt, C. and Holmberg, H. (1993). Improving the implementation of cost recovery for health: lessons from Zimbabwe. *Health Policy* 25, 213-242.
- 27) Herbst, J, 1990, *State Politics in Zimbabwe*, University of Zimbabwe Publications, Harare, Zimbabwe.
- 28) Hongoro, C. and Kumaranayake, L. (2000). Do they work? Regulating for-profit-providers in Zimbabwe. *Health Policy and Planning* 15 (4), 368-377.
- 29) Kaseke E, 2015, National Social Protection Floors and Income Security for Older Persons: Prospects for Zimbabwe, *Social Development Issues*, Volume 37, Number 1, February 2015, pp. 25-37(13)
- 30) Kureya T, Zetterlund K, Mecaskey J.W, 2010, Zimbabwe’s health sector: the way forward, www.thelancet.com Vol 375 April 3, 2010.
- 31) Kutzin, J. 1995. Experience with Organizational and Financing Reform of the Health Sector. Strengthening Health Services Paper No. 8. Geneva: World Health Organization, Division of Strengthening of Health Services, National Health Systems and Policies Unit.

- 32) Loewenson, R., Sanders, D. and Davies, R. (1991). Challenges to Equity in Health and Health Care: A Zimbabwean Case Study. *Social Science and Medicine*, 32:10:1079-1088.
- 33) Manga, P. (1988). The transformation of Zimbabwe's health care system: a review of the white paper on health. *Social Science and Medicine* 27 (11), 1131-1138.
- 34) Masuka, T., Banda, R. G., Mabvurira, V. and Rangarirai, F. (2012). Preserving the future: Social protection programmes for orphans and vulnerable children (OVC) in Zimbabwe. *International Journal of Humanities and Social Science*, Vol. 2 No. 12 [Special Issue - June 2012].
- 35) McIntyre, D., Thiede, M., Dahlgren, G. and Whitehead, M. (2006). What are the economic consequences for households of illness and of paying for health care in low and middle-income country contexts? *Social Science & Medicine* 62 858–865, Elsevier.
- 36) McPake, B., Witter, S., Ensor, T., Fustukian, S., Newlands, E., Martineau, T. and Chirwa, Y. (2013). Removing financial barriers to access reproductive, maternal and newborn health services: the challenges and policy implications for human resources for health. *Human Resources for Health* 2013, 11:46.
- 37) Ministry of Health and Child Welfare, 1984, *Planning for Equity in Health*, Government Printers, Harare.
- 38) Ministry of Health and Child Welfare, 1995, *Annual Report*, Government of Zimbabwe, Harare.
- 39) Ministry of Health and Child Welfare, 2010, *National Health Accounts*, Government Printers, Harare.
- 40) Ministry of Health and Child Welfare, 1985, *Health for all action plan 1985-90*, Government Printers, Harare.
- 41) Ministry of Health and Child Welfare. (2009). *Getting the Zimbabwe health care system moving again. Health action plan for the first 100 days*. March–June 2009. Harare: Government of Zimbabwe, 2009.
- 42) Ministry of Health and Child Welfare. *Maternal and peri-natal mortality study 2007*. Harare: Government of Zimbabwe, 2009.
- 43) Ministry of Health, (1991). *Zimbabwe health for all action plan 1991-95*. Harare.
- 44) Munyuki, E. and Jasi, S. (2009). *Capital flows in the health care sector in Zimbabwe: Trends and implications for the health system*. EQUINET Discussion Paper Series 79. Rhodes University, Training and Research Support Centre, SEATINI, York University, EQUINET: Harare.

- 45) Normand, C., Chapman, G., Mudyarabikwa, O., Chawla, M. and Needleman, J. (1996) *Resource mobilization for the health sector in Zimbabwe*.
- 46) Osika, J., Altman, D., Ekblad, L., Katz, I., Nguyen, H., Rosenfeld, J., Williamson, T., and Tapera, S. (2010) *Zimbabwe Health System Assessment 2010*. Bethesda, MD: Health Systems 20/20 Project, Abt Associates Inc.
- 47) Salama, P., Wei, H., Negin, J. and Muradzikwa, S. (2014). Post-crisis Zimbabwe's innovative financing mechanisms in the social sectors: a practical approach to implementing the new deal for engagement in fragile states. *BMC International Health and Human Rights*.
- 48) Sanders, D. (1993). The potential and limits of health sector reforms in Zimbabwe. In: Rohde, J., Chatterjee, M. and Morley, D. (eds.) *Reaching health for all*. Oxford University Press, Oxford.
- 49) Schwartz, J.B. and Zwizwai, B.M. (1995). *Economics of the health sector in Zimbabwe*. United States Agency for International Development, USAID.
- 50) Sekhri, N. and Savedoff, W. (2005). Private health insurance: Implications for developing countries. *Bulletin of the World Health Organization* 83(2): 127–134.
- 51) Shoko, B. (2009). Zimbabwe: Stakeholders moot 100 days to improve health. *The Standard (Zimbabwe)*. March 14, 2009. http://www.thezimbabwestandard.com/index.php?option=com_content&view=article&id=19925:stakeholders-moot-100-days-to-improve-health&catid=31:zimbabwe-stories&Itemid=66 (accessed July 24, 2009).
- 52) Siampondo, D. (2015). The socio-economic impact of harmonised social cash transfers on orphans and other vulnerable children in Zimbabwe: A case of Zvimba district. *International Journal of Politics and Good Governance*, Volume VI, No. 6.1 Quarter I 2015, ISSN: 0976 –1195.
- 53) Todd C., Ray, S., Madzimbamuto, F. and Sanders, D. (2009). What is the way forward for health in Zimbabwe? *Lancet* 2010; 375: 606–09.
- 54) UNDP. *Comprehensive economic recovery in Zimbabwe*. A discussion document. UNDP Zimbabwe, 2008. <http://www.undp.org.zw/images/stories/Docs/Publications/>
- 55) UNICEF, (1994). *A review of Social Dimensions of Adjustment in Zimbabwe 1990-94*. United Nations Children's Fund, Harare, revised edition (September).

Commented [13]:

- 56) UNICEF, (1985). *Children and women in Zimbabwe – a situation analysis*. United Nations Children’s Fund, Harare.
- 57) UNICEF, (1990). *Children and women in Zimbabwe – a situation analysis update, July 1985-July 1990*. United Nations Children’s Fund, Harare.
- 58) United Nations Children’s Fund (UNICEF). Zimbabwe (2009). Health Department Feedback from Round Two Site Facility Survey.
- 59) Waddington, C.J. and Enyimayew, K. A. (1989). Price to pay: The impact of user charges in Ashanti-Akim District, Ghana. *Int JHealth Planning Management* 1989;4: 17-47.
- 60) World Bank. World development indicators database. World Bank, 2008. <http://ddp-ext.worldbank.org/ext/ddpreports/>
- 61) Zigora T, Chihanga S, Hongoro C, Ropi F and Nhindiri P (1997) Hospital fee retention: Management and impact, Ministry of Health and Child Welfare, Mimieo.
- 62) ZIMSTAT, Labour Force Survey, 2011