Policy Brief on Access to Health Insurance in Zimbabwe

1.0 Introduction

Zimbabwe as a signatory to the Sustainable Development Goals Agenda has committed to implement the SDGs that include goal number 3 on Ensuring Health and Wellbeing underpinned by the Principle Leaving No One Behind. There are many persistent and emerging challenges that have to be addressed to ensure the achievement of good health and wellbeing in the country. Firstly, the cost of medical insurance in the country is relatively high for ordinary citizens. Secondly, the requirements of private medical insurance membership are still discriminatory and exclusive. For example, demanding proof of formal employment as a major requirement for membership tends to shut out a majority of the unemployed and people working in the informal sector from accessing private medical insurance. Zimbabwe has had a relatively big private health insurance compared to other countries and currently the sector is comprised of 30 medical aid societies with an estimated membership of 1.2 million[1]. However, this sizable growth has not resulted in significant impact on coverage of health insurance as the sector currently services less than 10% of the population[2]. Medical insurance should be accessible by a large segment of people especially women who seek reproductive health related services. This policy brief seeks to unpack challenges that are propelling unaffordability and inaccessibility of medical health insurance by the poor and people in the informal sector. It also proffers alternative policy interventions that can enhance improved access to medical insurance and help the country achieve SDG goal 3 on health and wellbeing.

1.2 The implications of social and economic factors on affordability and accessibility of Private Health Insurance

The private medical health insurance schemes in Zimbabwe have been for a long period of time designed to cater for the formal sector in Zimbabwe for both the private for profit and private companies owned for profit medical insurance[3]. Medical insurance remains inextricably linked with formal employment in an economy that is unfortunately transitioning to informal. This has seen the membership of medical aid firms falling drastically by 31 percent to 400 000 due continued deindustrialization and job losses in the formal

[1]http://www.sundaymail.co.zw/ultimatum-for-medical-aid-societies/

[2]Munyuki E and Jasi S (2009) 'Capital flows in the health care sector in Zimbabwe: Trends and implications for the health system' EQUINETDiscussion Paper Series 79. Rhodes University, Training and Research Support Centre, SEATINI, York University, EQUINET: Harare.

[3]https://www.hsph.harvard.edu/ihsg/publications/pdf/No-45.PDF Resources Mobilisation for the Health Sector in Zimbabwe (1996)

sector.[4]According to the ZimStats Labour Force survey, in 2015 the country's unemployment rate stood at 11.3% with the majority of the people moving into the informal sector and the women and youth represent a large proportion of the informally employed with women constituting 53%[5]. This regression entails that the majority of Zimbabweans especially women are disproportionally affected due to of lack of social protection. Earlier researches on private health insurance in Zimbabwe have revealed that the growth in the number of medical aid schemes since 1996 has been attributed to a large formal sector relative to the informal sector. To date, most Medical Aid Societies are still dependent on the formal sector since it is cost effective to collect premiums through formal employers. This has two effects namely:

1) Keeping the subscriptions very high as medical aid societies are targeting a smaller market
2) Demanding proof of formal employment as a major requirement for membership tends to discriminate the poor and those who are informally employed, a practice which is only profit oriented but inconsistent with the leaving no one behind thrust of the SDGs agenda. This model fuels the cycle of poverty and health inequality as it allows only the middle to higher income earners to access health insurance and services.

Given that a large segment of the Labour force in Zimbabwe is now operating under the informal sector, there is need for private medical health insurance schemes to rope in the informally employed to promote the realization of SDGs goal on inclusive and sustainable growth. PRFT applauds the recent attempts by some private health medical aid companies in Zimbabwe to target the informal sector. For example, Altfin Medical Aid Scheme in partnership with Netone launched a mobile based medical insurance (MedAcess) which required subscribers to pay a $3 dollar monthly subscription. The limitation of the Altfin scheme was that it only allowed medical aid subscribers to access medical care services from municipal clinics and government hospitals. Although the price is relatively affordable however, most people are discouraged from joining due to the poor health service delivery standards in government hospitals and clinics. Public health institutions are generally poorly resourced and the situation is worse in the rural areas where for example a patient would need to wait for days before being attended to by a doctor. Some people end up selling their assets in order to afford services at private hospitals and this exacerbates the vicious cycle of poverty and makes the task of achieving human development immense.

High levels of unemployment and constrained household income streams also affect the demand side of health insurance. PRFT's April 2016 Basic Needs Basket survey conducted in Gweru, Bulawayo, Shurugwi and Mutare revealed a household average income of US$346,18 which was far below the average Basic Needs Basket requirement for a family of five which is US$ 502,66. The current income levels do not allow an average family of five to commit on health insurance since the large part of the income is consumed on basic food requirements and rentals. This makes it impossible to have money released towards health investment. PRFT has gathered evidence which shows that many people can afford to own funeral policy insurances because the premiums of medical health insurance are far much

[4]Association of Health Funders of Zimbabwe, 2014
[5]Zimstats' Labour Force participation survey (2014)

higher than the cost of most funeral covers. For example, the monthly contribution for CIMAS's individual private scheme requires a member to fork out $146, while a spouse will pay $146. A child under the same scheme will pay $71 and a student $118 respectively. Whereas on average people pay US$14,40 monthly on funeral insurance. The survey also reveals that the consultation fee for private clinics is pegged at US$ 20 which is out of reach for the poor. This is unfortunate because preservation of life should come first before preparing for funeral.

High costs of health care services in Zimbabwe have an effect of keeping the medical aid premiums at very high levels. Zimbabwe's drugs and other medical services are very expensive compared to other countries despite its low per capita income status[6]. High costs of drugs pushes up the cost of the medical premiums as membership subscriptions are swallowed by the high cost of service. The situation has been further worsened by economic collapse and the failure of the government to redress the deficiencies in health care investments to improve the production of local drugs at reasonable cost. Government budgets are skewed towards recurrent expenditure and there is no resource allocation and disbursement to resuscitate and improve operations of local dug manufacturing companies such as CAPS.

1.3 Recommendations

There is need to remove barriers to access health insurance and improve the effectiveness and efficiency of the existing of medical health schemes to achieve affordability and universal access to health and wellbeing. The following are PRFT's recommendations

1. Private medical aid providers should avail more packages that carter for the low income earners and the poor as well as those in the Informal Sector. Broad consultation is required in coming up with these packages.

2. Government should allocate and disburse more resources towards local drug manufacturing and strengthening procurement system to make sure that drugs are in constant supply and are affordable both in the public and health care providers. This would help in reducing the costs of accessing health and medical aid premiums. The government has to commit more public resource to the health sector to cushion the poor who cannot afford expensive medical services.

3. Government should ensure that national health insurance that had been put on the cards does not see the eminent collapse as recently reported by the Minister of Health and Child Care that the process has been set aside due to economic challenges[7]. Its services are mostly required by the poor.

[6]Association of Health Funders of Zimbabwe, 2014
[7]http://www.zbc.co.zw/index.php/news-categories/top-stories/69323-national-health-insurance-scheme-delays

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