7 September 2017
Medical Aid Societies are currently governed by:

- Medical Services Act, 1998; Sections 9, 10 and 16
- Medical Services (Medical Aid Societies) Regulations, 2000; SI 330/2000; Amended by SI 35 of 2004

*With Secretary for Health and Child Care directly in charge*
Medical Aid Societies

Components of SI 330/2000:

- Registration of Medical Aid Societies
- Conduct of Medical Aid Societies
- Unfair Practices by Health Care Providers and Societies
- Financial Matters
- Amalgamation, Transfer, Dissolution, and Deregistration of Societies
- Advisory Councils
- General provisions
Medical Aid Societies: gaps and weaknesses:

- There is no section explicit on issues of governance resulting, for example, in the PSMAS challenges *(SA, Medical Schemes Act, Chapter 12, Section 57)*

- Structural weaknesses - Secretary for Health is directly involved in day to day issues of Societies and that office is already overstretched for it to provide the due attention required to matters of Medical Aid Societies *(SA, Medical Schemes Act Sections 3 and 13)*

- Current legislation is inadequate to resolve the current impasse on Minister’s gazetted tariffs, and stakeholders are exploiting the weakness *(SI 330/2000 section 16B)*
The role of MAS in Zimbabwe

- MAS in Zimbabwe were established as a result of the need by wage earners to finance the costs of medical services.
- Sources of Health Financing in Zimbabwe
Renewal of Registration by MAS

- All MAS are required to renew their registration annually.

Reflection on 2017 renewal

  - Conditions for 2017 renewal
    - Claims settlement
    - Audited accounts
    - Statutory returns
    - Audit committees
Mandatory returns/Notifications

- Annual financial statements 6 months after the end of each financial yr.
- There is a slight improvement in submission of audited financial statements
- Investment initiatives and other issues as enunciated in the governing SI.
  - The investment initiatives are meant to boost the funders pool and expand their cover.
Unfair practice

- Unfair practice by Funders to Providers
  - Failure to reimburse in time
  - Directing patients to specific providers
  - Conflict of interest in investments

- Unfair practice by Providers to Funders/Members
  - Denying treatment to all valid medical aid holders
  - Charging fees that are in excess of the amount agreed between AHFoZ and ZIMA or amount fixed by the Minister in the Gvt gazette.
  - Over-pricing and over-servicing
Challenges

- **Member**
  - Shortfalls/out of pocket payments
  - Refusal of cards at points of care
  - Inequity in levels of contributions

- **Provider**
  - Slow reimbursements for the services rendered

- **Funder**
  - Dwindling membership- effects of the macro economic environment
  - Huge, sometimes unpredictable and varying claims.
  - Fraud
Medical Aid Societies Bill

Gaps and weaknesses of the current legislation:

• There is no section explicit on issues of governance resulting, for example, in the PSMAS challenges (SA, Medical Schemes Act, Chapter 12, Section 57)

• Structural weaknesses - Secretary for Health is directly involved in day to day issues of Societies and that office is already overstretched for it to provide the due attention required to matters of Medical Aid Societies (SA, Medical Schemes Act Sections 3 and 13)

• Current legislation is inadequate to resolve the current impasse on Minister’s gazetted tariffs, and stakeholders are exploiting the weakness (SI 330/2000 section 16B)
THANK YOU
Community Participation
Primary health care was ratified as the health policy of WHO member states in 1978.

Participation in health care was a key principle in the Alma-Ata Declaration.

The fourth article of the Declaration stated that, —people have the right and duty to participate individually and collectively in the planning and implementation of their health care,

and the seventh article stated that primary health care —requires and promotes maximum community and individual self reliance and participation in the planning, organisation, operation and control of primary health care
Primary health care is essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.
Background: Primary health care

- It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community.

- It is the first level of contact of individuals, the family, and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first elements of a continuing health care process.
Government ownership in PHC

- Government ownership has been shown to be important; the state can play a role in ensuring its citizens' right to health, while respecting participatory and empowering processes.

- Actions through organized communities plays an essential role in ensuring the implementation of adequate government policies to address health inequities
Community ownership in PHC

in the context of health development “Community ownership” refers to a representative mechanism that allows communities to influence the policy, planning, operation, use and enjoyment of the benefits arising from health services delivery.

- This results in increased responsiveness to the health needs of the community
- It also refers to the community taking ownership of its health and taking actions and adopting behaviors that promote and preserve health. (Community organizations, NGOs as well as intersectoral interaction play an important role in facilitating creation of enabling environment for communities to accept their roles.)
Community participation, in this sense, is a means to increase people’s autonomy over health care service.
Health can also therefore be defined as part of the common good, and all people therefore have the right and duty to participate individually and as a community in the process for improving and maintaining their health. Further, achieving improved health status is linked with and helps the promotion of development in general.
A partnership for health between the government or an institution and the community is based on the commitment of both actors to actively collaborate to support the quality of health services or to make public health programmes more effective.
The term community participation’ is commonly understood as the collective involvement of local people in assessing their needs and organizing strategies to meet those needs.
Steps taken by The Government of Zimbabwe towards community ownership and participation

- **Policies and guidelines in place to strengthen community participation and ownership**
  - Public Health Advisory Board (PHA)
  - Hospital Managements Boards (Health Services Act)
  - Operational guidelines for the Health Centre Committees (MoHCC HCC Guidelines): *(Current Public Health Bill will recognize HCC)*
  - Village Health Worker (Health Review Commission of 1999) *(MoHCC VHW Strategic Direction 2010)*
Steps taken by The Government of Zimbabwe towards community ownership and participation

- Primary Health Care level-(DHE+HCC+CBOs)
- Secondary level-(DHE+PHE+ District RBF Steering Committee)
- Provincial level( PHE+ Provincial RBF SC)
- Provincial Hospital-(PHE+ RBF SC +Hospital Management Board)