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The Health Funder

THE ASSOCIATION OF HEALTHCARE FUNDERS OF ZIMBABWE

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STAKEHOLDERS COALESCE AROUND COMMON GOAL

Greetings and a warm welcome to our second edition of The Health Funder. This issue takes a step into the profound transformation occurring in healthcare today, which is creating an entirely new state of being in the 21st Century.

The magnitude of these changes implies a completely different model of understanding, creating and providing healthcare that will encompass the full continuum of discovery, development and delivery.

As we go through a wave of insightful discussion and debate, we highlight the trends, organisations and enabling technology that will define the next-generation health ecosystem at our 9thAHFoZ All Stakeholders Conference on health under the theme: *"The Healthcare Ecosystem and Quality of Life".*

In this new era, we see stakeholders coalescing around a common goal: Delivering better care to more people at a reasonable cost. Getting there will require vision, skill and the confidence to invest in this value-creation process surrounded by innovation.

It is our hope that the 2017 AHFoZ Conference will create a platform for stakeholders to harness the power of collaboration and knowledge sharing to improve care, stretch budgets and spark innovation, as they seek to deliver the highest level of patient care with limited economic and human resources.

Convergence will be a dominant trend in this dynamic healthcare era.

The most successful stakeholders will be those that exploit the tremendous value potential of cross-boundary integration and innovative technology partnerships working together under one healthcare ecosystem.
We hope you find your time well spent as we navigate through the healthcare ecosystem, coming up with flexible strategies that can evolve in step with the changing economic, technological and regulatory landscape and through it all renew old friendships while forming new ones.

Thank you for taking time to share your experiences and expertise

Until next time,

Tracey

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CONSTRUCTIVE REGULATORY FRAMEWORK CHANGES WOULD BENEFIT NATION

> The purpose of medical aid societies is to reimburse the whole or part of any expenses incurred by their members when they access healthcare services. The ability to reimburse must be supported by their ability to collect contributions from members when they fall due.

The anticipated Bill for the setting up of a regulatory authority for medical aid societies is a welcome development. The Regulatory Authority would reduce some of the workload of the parent Ministry.

As the Authority would be focussing specifically on medical aid societies, it is expected that it would be well placed to understand the dynamics in the sector and help create a conducive operating environment in which local and international entrepreneurs are encouraged to invest, in line with the broad national strategy guidelines and the Zimbabwe Agenda for Sustainable Socio-Economic Development blueprint.

This would benefit all players in the healthcare supply chain through protecting the interests of patients, medical aid societies and service provider groups.

Among other things, it is expected that the Regulatory Authority would establish and introduce a National Reference Tariff which is scientifically derived. The scientific approach is paramount as it would ensure that the fee structures set are relevant to the economic environment prevailing and are viable and sustainable for all players.

The reference tariff would be a neutral reference tariff which is not owned by any party and should not be subject to conflict. It would provide a guideline for funders and providers to negotiate for competitive prices within the price reference range. Prices above the reference prices would be considered as exorbitant.

This would allow for competition in pricing, which would encourage better service delivery and a more effective reimbursement system. Service providers and medical aid societies would be able to negotiate discounts and premiums, provided they did not exceed the agreed national tariff. Healthcare providers and medical aid societies should be allowed to establish and operate agreed service level agreements. A reference tariff would remove the need for the regulatory authority to superintend and mediate on tariff disputes.

Compliance is key to the establishment of an effective medical aid society regulatory system. However, harsh enforcement measures, such as punitive fines and cancellation of licences, should not be used as a first option. They should be a last resort.

The proposed Bill should provide for the issuance of corrective orders and a reasonable compliance period for parties that are non-compliant with the letter of the law, It should provide mechanisms to protect medical aid societies from premature licence cancellation or deregistration.

The Regulatory Authority should establish guidelines on engagement between service providers and funders. Among other things, there should be a clear conflict resolution procedure, which should be followed in the event of a conflict between any parties. In instances where an issue is referred for arbitration, there should be fair adjudication of complaints.

The Authority should explore and offer a solution to the anomaly that is created by the failure of employers to remit contributions to medical aid societies by their due date. There should be agreement between all parties on the mechanisms and turnaround time for claims payments. For this agreement to work it would be important for members' contributions to be paid on time.

The requirement that medical aid societies should be licensed annually should be reviewed under the new dispensation. The uncertainty created by annual licensing inhibits business continuity and investment by medical aid societies.

Part of the Regulatory Authority's role should be to enforce observance of the agreed ethical practices by medical aid societies, their members and health service providers and to ensure robust measures are in place to deal with non-compliance by any of the parties.

Robust supervisory structures should be put in place to ensure that all stakeholders are protected and that the Authority can identify signs of distress at an early stage. Members of the of the Regulatory Authority's board should be appointed on merit.

If the proposed regulatory changes embrace constructive provisions, the sector would operate in an environment that is fair to all parties, protecting the interests of medical aid society members/patients, healthcare providers and medical aid societies. The result would be that the country would benefit.

A healthy nation is a wealthy nation!

Shylet Sanyanga

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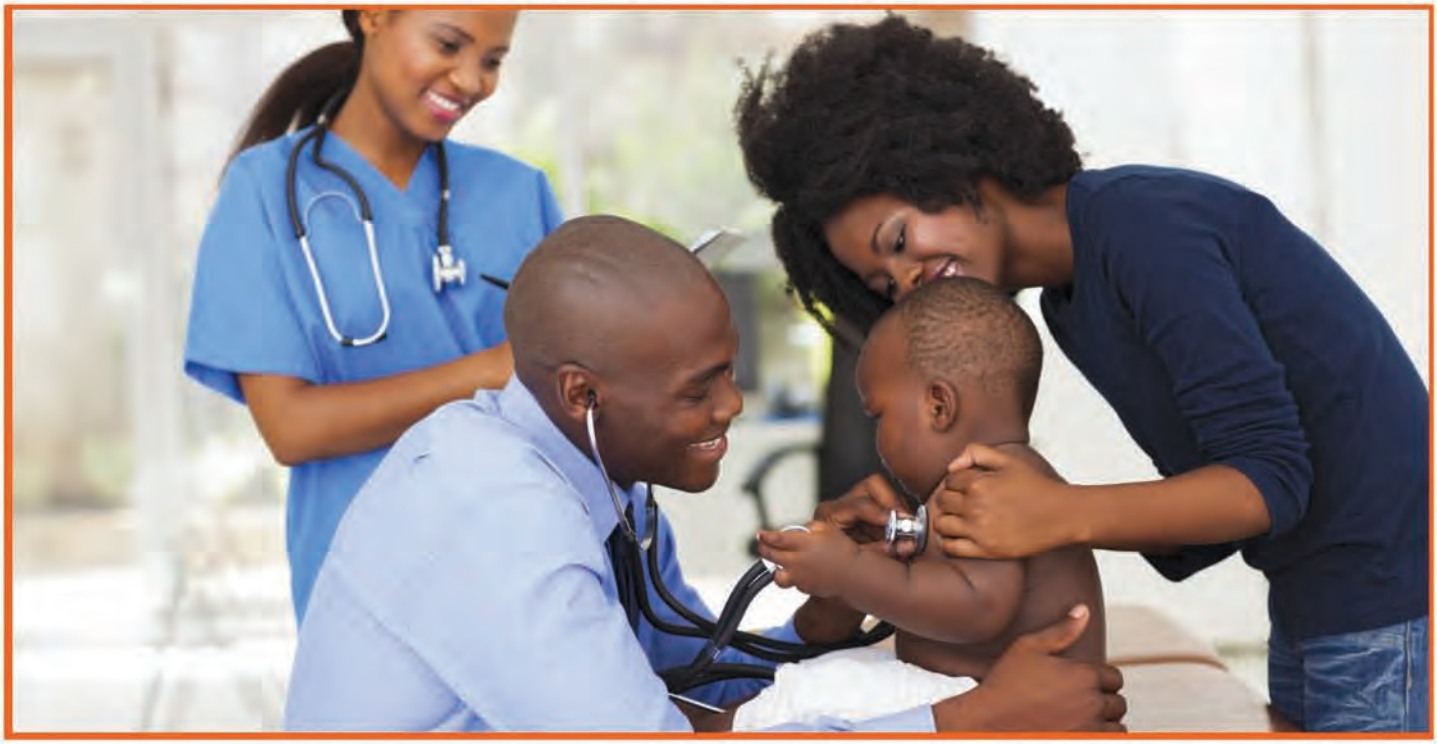

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Establishing a quality healthcare ecosystem

The 2016 Association of Healthcare Funders of Zimbabwe All Stakeholders Conference provided some insightful presentations from eminent speakers aimed at supporting and empowering delegates in their efforts to achieve and improve the outcomes of the health system in Zimbabwe.

We are, however, living in a time of great economic and social upheaval, with healthcare businesses and organisations contending with extraordinary new financial, demographic and regulatory pressures.

What does this all mean for industry stakeholders? At a minimum, stakeholders will need to prepare for a world of escalating complexity and volatility. Navigating this new environment will not be easy.

Flexible strategies, smart investments and strategic partnerships will be needed to help stakeholders thrive in this environment.

Thus the theme for the 2017 conference is: "*The Healthcare Ecosystem and Quality of Life.*"

One might then ask: Who are the stakeholders in the healthcare ecosystem?
At the highest level, we all are.

The architecture of the healthcare ecosystem begins with the Patient — the first "P" in what has been called the "5 Ps" of the healthcare ecosystem.

The 5 Ps of the healthcare ecosystem are the:

- Patient – That could be any one of us when we fall ill.
- Policymakers – Government agencies and industry organisations that set healthcare policy, write and enforce regulations, and oversee industry standards.
- Providers — Doctors, nurses, therapists, hospitals, physician groups, clinics and other medical professionals and organisations that provide medical care to patients.
- Pharmacies and pharmaceutical companies – Makers and dispensary units of drugs prescribed by doctors and healthcare providers are sometimes overlooked players in the healthcare ecosystem. Pharmacies represent a greater part of the industry in terms of claims payment. They often provide critical guidance to patients.
- Payers — Health insurance funders that cover the cost of medical care, as well as businesses, organisations and individuals who either directly pay for healthcare or pay for insurance coverage.

The quality of health ultimately depends upon ecosystem products and services which are requisite for good human health and productive livelihoods.

As we go through the 2017 Conference we seek to work on capitalising on this new appetite for information and to harness the self-interest and autonomy of informed consumers towards becoming more aligned with and integrated in a healthcare ecosystem.

Through high level presentations and discussions we hope to set a new paradigm that reflects a "sys-

Sudoku

		3			4		5	7
	9	5		6		8		3
						4		1
			4			6		2
			5				9	
	3	2			9		7	4
8						3		6
		1	7					
							4	5

Sudoku #333 (Hard)

ANSWERS

5	4	7	8	1	3	9	2	6
6	8	2	9	4	7	1	5	3
9	1	3	5	6	2	7	4	8
4	7	5	6	8	9	2	3	1
8	6	1	2	3	5	4	9	7
2	3	9	1	7	4	6	8	5
1	9	4	3	5	6	8	7	2
3	2	8	7	9	1	5	6	4
7	5	6	4	2	8	3	1	9

tems thinking" view of an industry where the walls separating stakeholders are steadily crumbling; where the success of one depends on the success of others; and where new business models of coexistence and co-development are rapidly becoming the norm.

Building up the healthcare "system" is now better understood as building up an ecosystem of interconnected stakeholders, with a mission to improve the quality of care.
It is widely accepted that, as a patient, one should communicate openly with one's doctor and ancillary service providers for one's personal well-being. Yet for too long the industry has tolerated a relative lack of dialogue between the health plan and the provider in coordinating care for their mutual customer: me.

This is not surprising, given that the traditional assumptions are that funders (payers) pay and providers provide care (and argue with payers about how much they should be paid).

However, as the healthcare sector moves towards setting up value based healthcare ecosystems, where true care coordination demands a comprehensive approach to the patient, both medically and as a consumer of care, meaningful funder-provider collaboration is essential for improving patient outcomes, driving down costs and delivering consumer value with the aid of policy maker engagement.

Today the healthcare industry finds itself on the threshold of a new era in which key stakeholders, empowered by technology, are breaking down barriers and redefining what's possible in medical care.

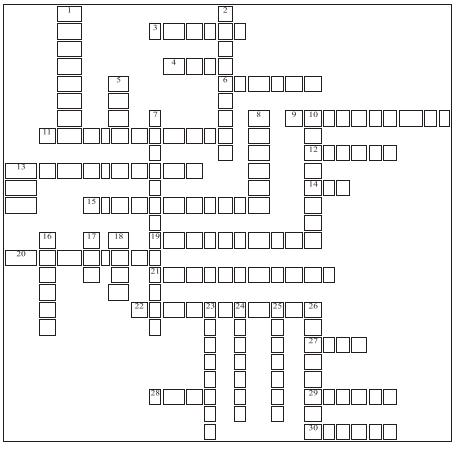
In this new ecosystem everyone involved will have to rethink financing, technology sharing and use of analytics and collaborative measures to understand and improve the healthcare experience. These collaborations will become the heart of the healthcare ecosystem. Through it all, we can establish accountable and trustworthy care organisations which enhance the quality of life.

With the coming in of real-time information sharing, healthcare providers have started thinking of all stakeholders in healthcare as direct partners in patient care, not just the executors of their orders.

Integrating all parties involved into the web of care will save money and resources, while improving patient satisfaction.

First Aid Challenge

Read the Clue and figure out the answer.



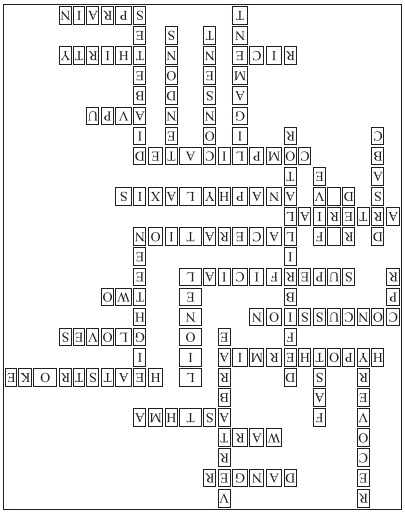
Read the Clue and figure out the answer.

Across

3 First thing to check for when finding a casualty.
4 Acronym for the treatment of shock
6 Condition which affects the airways - difficulty in breathing
9 Happens when a person's core temperature rises above F).?C (104?40
11 Occurs when a person's normal body temperature 37C (98.6 F), drops below 35C (95 F).
12 What you use to prevent cross infection
13 Describes a blow to the head
14 Number of breaths to give after each cycle of chest compressions
15 Describes the outer layer of skin is burnt causing redness, tenderness and inflammation
19 Describes a rough tear of the skin
20 Describes bright red blood spurting from a wound in rythym with the heart beat
21 An alergic reaction by the human body to a substance
22 One of the three types of fracture
27 Checking for Response (acronym)
28 Treatment of soft tissue injuries (acronym)
29 Number of compressions to give in the CPR cycle
30 A type of soft tissue injury

Down

1 Position to place breathing unconscious casualty in
2 Name of the segmented bones that make up the spine
5 Acronym for recognition of a stroke
7 Device use for assessing and shocking casualties heart in VF
8 The (acronym) for contacting emergency services
10 The distance in metres to keep people away from a high voltage electrical source
13 Physical action of first aider to help circulate blood in unconsious non breathing casualty
16 What the primary survey consists of (acronym)
17 Colour of blood cells that transport oxygen via haemoglobin
18 Number of abdominal thrusts to give a choking adult
23 They hold moveable joints together
24 What you must ask the casualty for before commencing first aid.
25 They hold muscle to the bone
26 Condition wherby the body is unable to regulate glucose due to insulin levels



Dennis **Chinoda**

COMPETITION RESULTS in better value for customers

The Competition and Tariff Commission, as a regulatory body, aims to encourage and promote competition in all sectors of the economy.

It values its co-operation with institutions and associations in the healthcare sector in providing a competitive framework that gives Zimbabweans access to affordable healthcare.

It is the desire of the Commission to facilitate an environment where small to medium enterprises are thriving and dominant firms do not strategically enhance barriers that inhibit growth and innovation in the Zimbabwean economy.

Competition among businesses has long been encouraged as a mechanism to increase value for customers. Competition in general encourages the provision of better products and services to satisfy the needs of customers.

In the healthcare markets, benefits to consumers accrue when firms contain costs, improve quality and encourage innovation.

One of the Commission's key function's is to encourage firms to operate in a competitive manner for the benefit of consumers.

Through participation in various public platforms such as the AHFoZ Annual Conference, the Commission is able to provide guidance to market participants, including healthcare funders, physicians, other health professionals, hospitals, other institutional health service providers, pharmaceutical companies, other sellers of healthcare products and insurers, to help them comply with the country's Competition Laws.

Rivers P A and Glover S H (2008), in one of their papers submitted that the organisation of healthcare has been a subject of debate for a long time. The appropriate role of competition in healthcare markets has been intensely argued about. Varying views have been expressed at both ends of the spectrum.

While some see competition as having no place in services aimed at protecting the sick, others strongly believe that competition is the antidote for bloated, inefficient services and even saves lives.

It is a basic principle of economics that a competitive market is one in which buyers and sellers come together in an exchange relationship. In a perfectly competitive market, where buyers have complete information and all firms are price takers, this theoretically should deliver the best possible outcome for both buyers and sellers.

However, in the healthcare sector patients have little information, especially on general product quality, while firms have an opportunity to control prices.

As individual firms are self-maximising agents and in the absence of competition there is a general tendency for rent-seeking behaviour, consumers may end up being exploited.

> Competition among businesses has long been encouraged as a mechanism to increase value for customers.

This is termed market failure, a situation which requires regulation to ensure that consumers are not exploited.

Rather than consider the merits of competition versus absence of competition, the debate that follows relates to the degree of competition, as well as the degree of regulation, that would produce the best outcomes.

The Zimbabwean economy has been fluid since independence. There has been no clear policy regarding competition in the healthcare sector. This is probably because the market is mainly comprised of public health institutions.

Liberalisation of this market generally requires caution, because the majority of patients still rely heavily on government support. Growth in the Zimbabwean private healthcare services has generally been sluggish, as it depends heavily on private healthcare funding.

It has been observed that overall economic performance is directly related to the key performance indicators, including per capita health spending.

In 2016, deflationary pressures persisted, with inflation registering -2% for the year to October 2016, according to the Zimbabwe National Statistics Agency. Disposable income declined as a result of job cuts, company closures and salary cuts. This has put pressure on healthcare funders, who generally perform well with huge economies of scale.

Some healthcare funders, as a strategy to contain costs in a hostile environment, have opened their own health facilities.

This has been the main source of anti-competitive behaviour investigated by the Commission. Since 2010, the Commission has received at least one complaint per year in the sector. Allegations have been raised against healthcare funders who direct consumers to their own facilities.

The Commission has carried out investigations into these complaints. The majority of them were resolved either through orders or negotiations. The Commission was created by the Zimbabwe government to provide one form of regulation that addresses the aforementioned market imperfections.

In 2015, the Commission received an International Competition Network award for its advocacy and co-operation with the Postal and Telecommunications Regulatory Authority of Zimbabwe and the Reserve Bank of Zimbabwe on issues concerned with the provision of inputs to mobile money service providers. These relationships can be extended to other sectors, including the health sector, to ensure the Commission carries out its mandate effectively.

***Dennis Chinoda is an economist in the Competition and Tariff Commission's Competition Division.**

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PRIVATE healthcare is a privilege few could afford without medical aid or health insurance. This is as true in South Africa as it is in Zimbabwe.

Fraud and abuse rife in private healthcare medical aid claims

As the cost of private healthcare continues to escalate with above inflationary increases year on year, choosing a medical scheme that is able to control costs is critical, says Paul Midlane, general manager at Medscheme, a subsidiary of the AfroCentric Group, in South Africa.

He points out that a stay in an intensive care ward of a hospital can quickly run into millions of rands, which few have as disposable income.

"There are the hospital costs, the anaethetist fees, surgeon fees, medication and a whole range of incidental expenses linked to a single health event. A 20-minute consultation with a specialist can easily cost more than R1 000 a time, excluding the potential pathology and radiology costs if you need blood tests or x-ray scans done," he said.

South Africa's Council of Medical Schemes has reported that medical scheme contributions increased by about nine percent between 2014 and 2015. The average contribution increase announced by open medical schemes for 2017 is 10,3 %.

According to the council, medical scheme contributions in South Africa increased by 8,1% to R151,6 billion as at December 2015 from R140,2 billion in December 2014. The total gross medical healthcare expenditure increased by 8,9% to R138,9 billion from R127,6 billion in 2014.

Total hospital expenditure by medical schemes comprised R51,4 billion, or 37,1%, of the R138,6 billion medical schemes paid to all healthcare providers in 2015. Total medical scheme expenditure on private hospitals increased by 9,36%.

The amount paid to allied healthcare professionals increased by 12% from R8,9 billion in 2014 to R10 billion in 2015. This category accounted for 7,2% of all benefits paid by schemes in 2015.

The heart of the problem is that private healthcare is treated as a commodity. However, it is anything, but that for the consumer who gets sick. To the medical scheme member it is a necessity.
"The bottom line is that it has become expensive," Midlane said, because no one questions the cost. To ensure that their members can have direct access to healthcare treatment, medical schemes generally reimburse healthcare practitioners, pharmacies and hospitals directly, unless there is a good reason not to.

"As a result of this practice and the complex nature of healthcare coding and medical scheme benefits, members do not check their statements or question the cost of the services they receive.

"Members do not shop around for the cheapest hospital, nor do they negotiate the lowest rates with their doctor. They just accept what they are told because they have no incentive to do otherwise. Their only incentive is to get healthy as quickly as possible."

It is much easier to fight with the medical scheme to pay for everything after you are healthy again, than to negotiate upfront with your practitioner or surgeon when you need to get the treatment urgently.

"This is the underlying problem," Midlane said.
"It has become too easy for healthcare providers to get paid without questions being asked.

"Healthcare providers and facilities are remunerated on a fee-for-service basis and every life is associated to a rand value — private healthcare has become a commodity."

He says administrators and managed-care organisations are constantly accused of unnecessarily increasing medical scheme costs, yet they exist to be the gatekeepers for the non-profit medical schemes by ensuring a member receives the highest quality treatment for the most cost-effective price.

"Medical schemes pay more than 92% of contributions they receive directly towards healthcare expenses, which is phenomenal when compared to other general insurers who often spend anywhere between 10% to 20% on claims processing and administration, in a much simpler and less complex environment than healthcare," he said.

He says medical schemes and their administrators have to invest substantial sums of money on analytical software capable of detecting irregular claims and ensuring only valid healthcare claims are paid to healthcare providers and facilities. With the benefits of using predictive analytical software and data, Medscheme is now uncovering the real extent of fraudulent and abusive claiming. The picture is not pretty.

"Opportunistic fraud and abuse is rife among healthcare practitioners and facilities, where it is estimated that at least 10% to 15% of all claims are fraudulent or highly abusive in nature. In a R150 billion industry that is a substantial expense, Midlane said.

"Healthcare fraud and abuse occur in many creative and different ways. However, it is much harder to contain due to a variety of factors, including the volume of claims associated to one healthcare event, the need for quick access to healthcare, the emotive nature of the story linked to every claim submitted, the unintended consequences of prescribed minimum benefits and the assumption a healthcare provider or facility is compelled to act in your best interest, with little consideration to potential downstream costs to your medical scheme."
All these factors combined have created a perfect storm, according to Midlane.

"As long as a medical scheme continues to pay, a person will not ask whether the physiotherapist or dietician was a necessary expense, nor whether that 15-minute specialist consultation was worth R1200, or if the pharmacist has dispensed the generic but claimed for the more expensive original, or if your medical scheme also paid for that pathology account you keep getting in the mail," he said.
He says the only time questions are asked is when there is a double-digit increase to members' contributions at the end of the year.

Government must prioritise primary healthcare

Michael **Gwarisa**

According to the Alma Ata Declaration, Primary Health Care (PHC) is essential health care made accessible at a cost a country and community can afford, with methods that are practical, scientifically sound and socially acceptable.

Due to continued economic decline and inadequate funding of the health sector, healthcare services have become inaccessible to the majority of Zimbabweans. As a result, people are dying from some diseases which are curable.

According to statistics, more than 90% of Zimbabwe's population are unemployed. Few can afford medical aid services.

As a result, accessing treatment from private clinics and hospitals, where medicines and drugs are always available, becomes a major challenge.

In an interview, Bulawayo legislator Jasmine Toffa who is a member of the Parliamentary Portfolio Committee on Health, said it was high time government focused on making primary health care (PHC) accessible and affordable for all.

She said while it was unable to meet the Abuja Declaration stipulation that 15% of budgetary expenditure should be allocated to health, government should at least ensure that the public health service receives the 10% that has been allocated to it.

"Government should make sure that the 10% the Health and Childcare Ministry it receives goes to the services as opposed to what is happening now where it goes to administration costs," she said.

Not only were the high fees that public sector hospitals charged a challenge, but the hospitals did not have the necessary medication, she said. Only a few drugs were available at these hospitals, such as one particular antibiotic, paracetamol and anti-retroviral drugs.

Often there was not much else, she said.

Most Zimbabweans are of the view that private hospitals offer better services than community clinics. As a result they shun local health centres.

Many people have called for the scrapping of hospital fees for the underprivileged and old in a bid to help them access PHC.

Training and Research Support Centre programmes manager, Artwell Kadungure, said that, while scrapping user fees completely would be a welcome move, it was impossible for this to happen, because hospitals had to be able to meet their daily expenses.

"Scrapping user fees is impossible. However, what we are doing is to talk to government about subsidising these fees, so that even the most vulnerable can access primary health care," he said.

Government, through donor partners such as Save the Children Zimbabwe and the Community Working Group on Health, have established community health committees in a bid to boost community participation in health activities in order to improve access to Primary Health Care. Save the Children Zimbabwe Communications Advisor, Sophie Hamandishe, said strengthening community participation in health projects had been transformative.

"It has seen rural health centres benefiting from increased community involvement through resuscitation of Health Centre Committees and improvements to infrastructure that include newly constructed waiting mothers shelters, renovation of clinics, staff houses, as well as the scrapping of user fees.

"It has empowered patients to know their rights in relation to health services, while effectively increasing demand for, access to and utilisation of maternal and new-born child health services.

"Statistics from all the project's partner health centres indicate an increase in institutional deliveries and a reduction in home deliveries as well as maternal and infant deaths. For example, Twin Tops Clinic in Mhondoro/Ngezihas had no maternal deaths or under-fives deaths since 2015," she said.

Pfee!

Team hombe yapinda.

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Healthcare insurance suffers from fraud, waste and abuse

Pamela **Kawadzah**

The healthcare domain has become an easy target for people seeking easy money through fraudulent means. Healthcare fraud is on the rise, even though only an estimated 10 percent of lives in Zimbabwe are insured by medical aid funders.

This rise in healthcare fraud has increased the demand for medical aid benefits, causing an imbalance between medical aid contributions and benefit payments, as there is a limited supply of contributors to medical aid funds.

Additionally, fraudulent billings and medically unnecessary services billed to healthcare insurers are prevalent throughout the world. Fraudulent schemes are becoming increasingly complex. They can be corporate-driven or the result of systematic abuse by certain types of health service provider.

Historical fraud detection methods only uncover about 10% of losses. Because of the post payment nature of such methods and the resulting pay-and-chase recovery process, less than 5% of losses detected are ever recovered.

Fuelled by technology advancements that have made crimes such as identity theft and multiparty fraud schemes both easy to commit and hard to detect, healthcare fraud continues to grow. It holds particular appeal for organised crime syndicates, which account for a growing proportion of healthcare fraud, waste and abuse.

How do we then restore a balance in the health ecosystem?
More claims audit rules? — NO!
Audit rules involve tedious manual work. One needs to audit all the claims one by one to detect the fraud. Swindlers keep updating their fraudulent activities more frequently than the models are updated.

Invest in technology to assist in fraud detection? — MAYBE!

The advent of data analytics makes healthcare fraud detection more reliable and quicker, although there is capital investment involved. It might go a long way in assisting fraud detection efforts. Data analytics have the ability to sift through a huge amount of historical data in a relatively short amount of time, so that business transactions fraud detection can take place in real time.

Going back to basics: Track moral and ethical considerations? – YES!
Trust
Relationships
Accountability
Cooperation
Keep it simple

Trust — Create trust through stakeholder involvement — If your stakeholders understand what you are trying to do and you understand what is important to them, this makes it easier to ensure the needs and expectations of both of you are met. This element of trust is slippery but needs to be harnessed in fraud management initiatives.

"You may be deceived if you trust too much, but you will live in torment if you don't trust enough." — Frank Crane, American minister and author.

Relationships — Know your clients' needs and be familiar with who they are. Put yourself in their shoes. It is always important to evaluate the level of service delivery by envisioning ourselves being treated the way we treat others.

Often we may feel life would be great if it was not for other people! Yet it is through relationships with others that you often obtain the greatest rewards. If fraud takes other people down, we are also taken down in the process.

Accountability — Take responsibility for your mistakes. You should always strive for high quality output. If something does not come out right, admit it and correct it.

Keep your promises. Stick to your word. If you need more time, let those you have promised know before you miss the deadline. Honouring commitments is important. The organisation that is transparent and accountable in matters that are important to others creates healthy partnerships.

Cooperation — Keep clients updated. Clients can have time-sensitive situations. Try to respond as soon as you can. Give reasonable timelines. If you are unable to accomplish the task, be considerate and offer alternative arrangements.

Status updates make clients feel they are involved in the project. If you have nothing major to report on, even a reminder that you value their business goes a long way. If you have an option to go that extra mile to keep your client satisfied then do it. Excellent service provision means keeping our clients delighted.

Keep it simple — Do not confuse clients with jargon. Try to explain whatever the problem is as best you can without making anyone feel left out. What maybe simple day to day language to you may be Greek to the next person. Be patient. Never show your agitation. If a client oversteps boundaries, let him or her know in a cordial and professional manner. Often fraudulent activities may arise out of a desire to fix someone.

Growing healthcare

Proctor **Nyemba**

In countries with private health insurance, fraud accounts for five percent to 10% of all claims paid out, according to some estimates.

Healthcare fraud in those countries in which government health care plans are provided is perpetrated primarily by healthcare service providers.

It is important to appreciate that healthcare is a dynamic and segmented market made up of parties that deliver or facilitate the delivery of health information, healthcare resources and the financial transactions that move along all components.

To fully appreciate what healthcare fraud is, it is important to understand traditional and non-traditional players. The patient is the individual who actually receives a healthcare service or product. The provider is an individual or entity that delivers or executes the healthcare service or product.

The payer is the entity that processes the financial transaction. The payer may be the party that takes on risk or manages risk for a member who pays contributions for a plan that covers the services. The member is the party that funds the transaction.

A service provider is any entity that provides a professional service or materials used in the delivery of patient care.

Who commits healthcare fraud?

Do not limit your imagination or develop tunnel vision when it comes to healthcare fraud. Fraud can be committed anywhere and by anyone. The list includes:

- Providers and insured patients;
- Individuals, both domestic and foreign;
- Approvers (employees) who pay claims to themselves or friends;
- Rings or a group of criminals who commit healthcare fraud;
- Non-providers or non-medical, non-related healthcare players, such as payers, agents, personnel and criminals who create fraud schemes;
- Vendors and suppliers providing services within the healthcare industry.

They are found as employers providing benefit coverage; personnel employed by providers, payers, employers or various vendors; and formal organised crime entities.

Limiting the focus to a particular player in the market merely creates opportunities for other players to concentrate their efforts on bleeding the system dry. Every player is capable of committing healthcare fraud.

Definition of healthcare fraud

Healthcare fraud involves a deception or misrepresentation that an individual or entity makes, knowing that the misrepresentation could result in some unauthorised benefit to the individual or to the entity or some other party. The most common fraud involves a false statement or a misrepresentation or deliberate omission that is critical to the determination of benefits.

Provider fraud: Provider fraud is perpetrated by a physician, clinic, medical supplies vendor or other provider against patients to increase income.

Providers have access to sophisticated equipment, such as computers, that make it easy to generate bills. They possess knowledge of medical and dental techniques and terminology that normally will not be questioned by claims-handling personnel.

Patients are usually reluctant to accuse physicians of wrongdoing because they rely on their continued service and they are not personally responsible for paying the bill. Insurance service providers range from laboratories to attorneys and doctors.

There are several types of healthcare fraud which include the following:

Provider services charged for but not rendered: A provider might submit charges for services not performed. This type of fraud is difficult to uncover because it involves omission of an activity.

Over-utilisation: This occurs when a physician prescribes unnecessary or excessive patient services. There are two possible explanations for this. The first is monetary gain by the provider. The second is that the physician may have believed additional visits were necessary for proper treatment or to reduce potential malpractice liability.

Unnecessary medical testing: This is where a service provider advises the insured client that additional medical testing is needed to diagnose the problem. In most cases, the testing is not necessary. The fee for the unnecessary work is often

fraud affects everyone

shared with the service provider or the laboratory may offer an incentive to the service provider for recommending more tests. In some cases, physicians own the medical testing service.

Additional medical testing, which is later viewed as excessive, is not always fraud. Many doctors have a genuine fear of their patients. They are afraid of malpractice suits that might result from a delayed or erroneous diagnosis. It is imperative for the claims assessors and adjudicators to link the tests required and the patient's diagnosis.

Fictitious providers, bogus doctors: An individual who is not a doctor may open a medical practice and obtain or create a doctor's identification number to appear legitimate. Thereafter, the fake doctor bills the insurance company for the medical services. Some may use payee numbers of other doctors or those who are no longer practising in Zimbabwe.

Photocopied claim forms with benefit assignment repeatedly submitted by a provider with new date of service: In this scheme a provider alters a genuine claim form signed by the patient. This method is usually used by a provider with a small business or by an accounting secretary who submits fictitious bills for his/her own benefit.

Double billing: Double billing occurs when the insured and/or the provider seek to be paid twice for the same service. The fraud might be perpetrated by the insured or by the provider alone. The bill might be submitted to two or more different insurers or it might be submitted twice to the same insurer with documentation intended to show that two separate expenses have been incurred.

Some providers seek cash payments upfront then submit a claim to the medical insurer as well, thereby double claiming. For example, a doctor has his own practice and is also affiliated to a clinic. The clinic submits bills under its letterhead and payee number and the doctor also submits a charge using his own payee number for the same service.

False billing codes and unbundling of tariffs: False billing takes place if the physician or other primary provider knowingly enters an incorrect tariff code or multiple tariff codes.

Coding fragmentation involves the separation of one medical procedure into separate components to increase charges. Instead of charging for a hysterectomy, for instance, under one code, the provider charges for a laparotomy as well as for the removal of each individual organ.

Mutually exclusive procedures, which is another form of unbundling, involves billing for procedures that are either impossible to perform together or, by accepted standards, should not be performed together. This is commonest in dental practice.

Up-coding involves billing for a higher level of service than was rendered. One common form of up-coding involves generic substitution. A less expensive generic drug than that prescribed is dispensed, but the service provider bills for the more expensive drug.

Alteration: A dishonest claimant can inflate a prescription or medical bill by placing an additional number in front of the amount charged. The claimant can also alter the date of service so that it becomes a recoverable expense rather than one incurred prior to eligibility.

The individual submitting a claim may change the name on the bill from an uninsured family member to one included in the insurance plan.

Doctor shopping: Patients may shop around for multiple doctors that will provide controlled substances. However, one physician does not know that another has already prescribed the drug. In addition, the patient may shop for drugs in emergency rooms, complaining of soft tissue injuries, sprains and strains.

Third-party fraud: This category involves unauthorised use of an insured member's identification card by another known or unknown person. Ineligible dependants such as a mother, father, nieces and sisters are usually treated with the knowledge of the service provider.

This type of fraud is difficult to trace unless the circumstances become difficult to handle, such as when the person dies while his/her medical records are under the name of the insured person, who is alive.

It may also happen that when the primary insured passes away, a beneficiary does not notify the insurance carrier and continues to submit fictitious claims for medical expenses after the death of the insured.

Where the person is not known to the member, the insurance company is usually notified by the insured once he or she receives a benefit statement for services rendered. The service provider will suffer a loss if the claim has not yet been paid but it is mostly the insurer that suffers such losses.

Red Flags

The following are red flags raising suspicion of fraud:

- misspelled medical or dental terminology;
- unusual charges for a service;
- similar handwriting by the claimant and the provider of the service;
- drug receipts from the same pharmacy but on different paper;
- claim alterations;
- lack of any provider's signature on a claim form;
- pressure by claimant to pay a claim quickly;
- threats of legal action if the claim is not paid quickly;
- continuous telephone inquiries regarding the status of a pending claim;
- over-utilisation of outpatient services such as reviews.

Employee claims fraud

Employees of insurers, especially claims examiners and customer service representatives, can present additional problems to the fraud examiner. Due to their ability to access claims and subscriber files, the scope of fraud perpetrated by them can be almost limitless.

Claims fraud using employee's contract: Employees generally have access to claims data and claim forms. They can sometimes adjust claims or pull out someone's claim, change the claimant's contract number and have the claim processed.

Claims fraud using another insured's contract number: Employees who have access to an insured member's enrolment file can locate an insured with a similar name as the employee. From there, the employee can easily complete a claim form and submit the claims through the regular processing system. The employee only has to put his or her own address in order to have the payment sent to him or her.

Claims payment using a relative's contract: Employees can fabricate claims and submit them under a relative's contract number.

Claims adjustment system: Claims that are legitimately paid incorrectly need to be adjusted. An adjustment examiner can adjust a claim for fraudulent purposes also.

Payment for cancelled contracts or deceased person: If an adjuster has access to the enrolment files, he might run across a deceased insured. By submitting or processing a claim before cancellation, an examiner can manipulate the claims system and divert payment to his/her own account.

Improper payee: A claim approver can override a claim payment system and pay out claims to improper payees. The claim approver inserts details of a friend or relative as payee. Payments are made to another person other than the insured.

•Proctor Nyemba is a forensic audit and accounting expert and licensed private investigator.

Dr Farayi **Moyana**

DO MY KIDS NEED DENTAL BRACES?

A common question I am asked by parents is: "Does my kid need dental braces?" Even at birthday parties, once they hear I am a dentist, parents pull me aside and ask me to quickly peep into their children's mouths.

They want me to ascertain whether the crooked teeth will straighten out on their own or whether they need braces.
A modern woman must place matters to do with her and her family's health uppermost on her list of priorities. The whole family must look good and confident.

This may be difficult to achieve if one is not able to trust her/his smile or has bad breath, cavities, loose teeth or bleeding, inflamed gums with food particles collecting in between teeth.
This is where a visit to the dentist becomes important. One of the causes of poor dental health is dental malocclusion, which can present as crooked teeth, an open bite, deep bite, jutting out of upper front teeth, crowded or bunched up teeth in the front, narrow tooth arches, "drifted teeth", space shortage, or extra-big teeth.

Normal or good alignment of teeth not only contributes to optimum oral health, but also goes a long way in ensuring the overall wellbeing, confidence and positive personality of an individual.
Parents often wonder whether the benefits of the dental braces make them worth the time and expense. When considering dental braces, I want parents to remember that dental braces are normally the last resort.

It is important to visit your dentist regularly in order to receive preventive dental care. That way many expensive orthodontic procedures can be avoided. For example, by simply preserving baby teeth until their shedding time by getting them filled by an ordinary dentist, a parent can save a fortune later in life.
Why are orthodontics so important?

Crooked and crowded teeth are hard to clean and maintain. Such problems can contribute to tooth decay, gum disease and tooth loss.

A bad bite can also cause abnormal wear of tooth surfaces, difficulty in chewing and/or speaking, excess stress on supporting bone and gum tissue, and possible jaw joint problems.

There's also the emotional side of an unattractive smile. When you are not confident about the way you look, your self-esteem suffers. Children and adults whose malocclusions are left untreated may go through life feeling self-conscious, hiding their smiles with tight lips or a protective hand.

Finally, without treatment, many problems become worse. Orthodontic treatment to correct a problem may prove less costly than the additional dental care required treating the more serious problems that can develop in later years.

The advantages of orthodontics do not stop with cosmetics alone. Patients receive important medical benefits as well. By ensuring the teeth and jaws are properly aligned, it is possible to prevent or alleviate potential physical health problems.

When the teeth are aligned properly, there is a reduced chance of decay, fewer cases of gum or periodontal disease and a decrease in the risk of injury. Straight teeth are easier to keep clean and thus collect less plaque, a risk factor in periodontal disease.

Reducing periodontal disease can also reduce the chances of inflammation that is often associated with an increased chance of stroke and heart disease. In addition, when teeth are straight, they are less likely to be broken in an accident.

Thus the correction is helpful in protecting the natural smile and allowing individuals to keep their teeth through their entire adult life. Braces can be used to help close gaps and spaces in order to reduce the need for bridges or other oral devices later in life.

If the teeth are in need of orthodontic correction, but left untreated, the individual may suffer tooth decay, digestive difficulties and periodontal disease.

When the teeth are misaligned, surfaces may wear abnormally. The chewing may be inefficient and the gum tissues and bones that support the teeth be under stress.

By taking steps early in a child's life, the cost of care is often much less than that of treating the serious problems that can develop as the individual ages and experiences increased wear and tear on the teeth.

While the physical benefits alone may be enough for many parents to consider braces for their children, there are also many psychological benefits. Once the teeth are straightened, many teens have the greater confidence needed for success in the things they are asked to do. Youths can also have greater self-acceptance, enhanced attractiveness and an increased sense of well-being.

The benefits of orthodontics have long been documented through both scientific studies and personal observations. They begin with a great smile. The smile is often the first impression others have of an individual. It is a large part of one's identity as well as of how a person is perceived by peers. Improving the smile is one of the greatest investments one can make.

Dental braces (orthodontic treatment) are typically used in a variety of cases with bad tooth alignment. Common problems are those where orthodontic treatment is a long-term treatment procedure, continuing for several months. For this reason it requires considerable commitment from child and parent alike.

Good oral hygiene (brushing, flossing) and proper eating habits according to instructions from the dentist or orthodontist are a must. Treatment typically starts off by the taking of specialised x-rays, tooth models and pictures of the face and teeth. A contract is often drawn up and appropriate motivational sessions arranged. Braces work by slowly moving and shifting teeth into new and good positions by applying light pressures. Bands, wires and elastic are placed on the teeth to move them in the right direction. This takes place slowly and carefully over an extended period of time, which may be months or years.

It is important to continue to wear the braces or appliance for however long your dentist or orthodontist recommends in order to ensure a successful outcome. If you quit at any point during treatment, the teeth can shift back into their old positions. Orthodontic treatment may be provided by your dentist or an orthodontist.

An orthodontist is a dentist who specialises in the diagnosis, prevention and treatment of dental and facial irregularities. The treatment will depend on the orthodontic experience of your dentist and the severity of your case. Since abnormal bites usually become noticeable between the ages of six and 12, orthodontic treatment often begins between the ages of eight and 14. Treatment that begins while a child is growing helps produce optimal results.

That doesn't mean that adults can't have braces. Healthy teeth can be orthodontically treated at any age. Treatment plans will vary based on your situation. Most people are in treatment for from one to three years. This is followed by a period of wearing a retainer that holds teeth in their new positions. Today's braces are more comfortable than ever before. Newer materials apply a constant, gentle force to move teeth and usually require fewer adjustments.

While you have braces it's important to maintain a balanced diet for the health of your teeth. Of course, a healthy diet is always important but eating too many sugary foods with braces can lead to plaque build-up around your brackets that could permanently stain or damage your teeth.

Avoiding foods like popcorn, corn on the cob, chewing gum, whole apples and other sticky foods is a good idea. Ask your dentist about foods to avoid while you are on treatment.

Not all of us are born with beautiful smiles but with a good oral hygiene routine and a little help from orthodontics you can have a beautiful and healthy smile.

H.M.M.A.S

HARARE MUNICIPAL MEDICAL AID SOCIETY

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Committed To Your Peace Of Mind

Committed to your peace of mind

Promoting wellness benefits everyone

Joseph **Nkani**

WE all need to critically look at the issue of wellness. We need to consider and reconsider our lifestyle routines and the food we eat to ensure we are healthy and remain healthy.

Wellness can loosely be defined as a deliberate way of living based on the choices we make which ultimately influence the conditions we end up in.

The key operative word for me is the "choices" we make, which then determine where we end up in as far as our well-being is concerned.

Wellness discussions generally focus on physical wellness, which by extension encompasses physical wellbeing or our health status.

However, wellness encompasses many other domains as well, which include social, emotional, spiritual, intellectual and occupational or environmental wellness. However, for the purposes of this article I will focus on physical wellness.

One could be forgiven for suggesting that in general people have over time considered wellness to mean just the absence of sickness. When they are not feeling any form of discomfortin their body that means they are well. Little or no collective attention has been paid to the other domains.

However it is encouraging to notice that over the past few yearspeople have been making a deliberate effort to focus on general wellness.

Physical wellness has arguably proved to have gained the most traction. We have seen people taking up body conditioning programmes and adopting measured eating habits.

People have also taken time for and given attention to preventative measures to ensure general physical wellness. More and more people are now being pro-active in promoting their physical wellness. Attitudes are shifting. Due care is being taken to ensure people stay healthy.

It is presumed that this "pro-active culture" when passed onto our children and then to the next generations will mean much better health than we are currently experiencing. In particular it should mean fewer people suffering from preventable and lifestyle diseases.

We are beginning to see more people of both genders taking up either group or individual fitness programmes.

More healthcare funders are making efforts to make their members aware of the importance of adopting healthy lifestyle habits.

All these efforts point to a crop of people who are conscious of the role that lifestyle choices play in their wellness and willing to change their lifestyles and thus increase their longevity.

It is imperative, therefore, that all stakeholders come up with deliberate strategic initiatives which promote general physical wellness within their own spaces.

Employers will tell you how much of a costly inconvenience it is to have an unwell employee whose down time negatively affects productivity within their organisations. The employee will not only need time off but will also most likely request cash assistance to cover the medical bills.

Health funders will tell you how heavy their claims burden becomes when medical claims come through. Many of these claims could have been avoided had the individual started years back to watch his or her lifestyle habits and general physical wellness.

This, therefore, becomes a clarion call to all of us to consider and reconsider our lifestyle routines and food intake.

Employers may consider rolling out wellness programmes at their work place. Such initiatives could start with less expensive lunchtime or end of day aerobics sessions as well as shutting down escalators from the first to the third floor so that people have to climb the stairs.

The car park could be relocated so that its parking bays are some 50 metres from the office door. This would encourage indirect cumulative kilometres walks as a weekly routine.The lunchtime menu selection could be guided by a dietician in collaboration with the kitchen staff.

Medical funders may find it useful to engage their clients for periodic wellness programmes which will provide screening and monitored mitigation programmes. This will be in their own interests to reduce claims, especiallyclaims for the treatment of chronic conditions.

Wellness has to go beyond just providing an individual with clinical data. It needs to go a step further to manage the condition, be it latent or evident.

Individuals should also be encouraged to watch what they eat and how they conduct their lifestyles in as far as their physical activities are concerned.

How often and how far do motorists walk? On a lazy weekend how do you go to your nearest shopping centre to buy your newspaper? Do you look for your car keys or your trainers?What distance do you say is too far for you to walk?

Such affordable daily habits as walking can be a starting point for a healthy lifestyle before one starts to think of gym fees and which personal trainer to engage. If your body still allows you to engage in some form of routine sporting activity which will help you regulate your body, please indulge yourself.

In conclusion, one cannot emphasise enough the need for collaboration between healthcare funders, employers and individuals in this wellness challenge. It is a win-win situation for all stakeholders. Life must be enjoyed alive. Live well and live healthily. Make the right choices and take the appropriate action.

•Joseph Nkani writes in his personal capacity. He is a Health Risk Advisor and Broker. For assistance and roll out of corporate wellness programmes he can be contacted at joenkani@yahoo.com or +263 772 415 660.

FIGHTING FRAUD, WASTE AND ABUSE

In the fight against healthcare fraud it is actually the small things that matter. It may look like a small thing but at the end of the year your voice can save billions of dollars lost through fraud, waste and abuse.

"An ounce of prevention is worth a pound of cure"- *Benjamin Franklin*

SO WHAT ARE YOU WAITING FOR? CALL US!

CANCER EDUCATION, PREVENTION

EFFORTS CAN REDUCE ZIMBABWE'S CANCER BURDEN

Darrell **Ward**

Cancer is a growing problem in Zimbabwe and worldwide. According to the National Cancer Prevention and Control Strategy 2014-2018, more than 5 000 new cancer cases are diagnosed in Zimbabwe each year. About 1 500 Zimbabweans die of cancer annually.

"This is just the tip of the iceberg," says Health and Child Care Minister, David Parirenyatwa, in the cancer strategy document.
He notes that resource constraints and other reasons prevent many cancer cases and cancer deaths being reported to Zimbabwe's National Health Information System.

Globally 12 million new cancer cases and 7,6 million cancer deaths occurred in 2008. The World Health Organisation expects those worldwide numbers to grow to 26 million new cases and 17 million deaths annually by 2030. These increases will largely be due to the natural growth and aging of each nation's population.
About 60% of the world's cancer cases and 70% of cancer deaths occur in low and middle income countries, nations that can least afford the high cost of cancer diagnosis and treatment.

Zimbabwe carries a heavy burden of infectious diseases that demand immediate attention. As an oncologist told me recently, infectious diseases such as HIV, TB and malaria consume much of the nation's scarce health resources. "Cancer is often given a low priority," the oncologist said.
I know that cancer, while not as visible as Aids, TB and malaria, is a cause of great suffering in Zimbabwe. Since 2000, I have worked in various ways to help the doctors at St Albert's Mission Hospital in Centenary provide care for the people in its district.
I worked closely with Dr Elizabeth Tarira until her death from breast cancer in 2012. I have worked since then with the hospital director, Dr Julia Musariri. I have visited the hospital and Zimbabwe many times.

In 2009, a group of friends and I started Better Healthcare for Africa (BHA), a non-governmental organisation that would enable us to help St. Albert's more broadly.

Since 2012, BHA has worked closely with Dr Lowell Schnipper, an oncologist with Beth Israel Deaconess Medical Center in Boston, USA, to help St Albert's and Karanda Mission hospitals initiate cervical cancer prevention programmes to reduce suffering from that disease,

Cancer education programmes can promote national and local cancer prevention efforts.

the leading cause of cancer death in women in Zimbabwe and other counties in southern Africa.
Based on my experience in Zimbabwe and as a medical writer on cancer at Ohio State University, I have two practical suggestions that will not eliminate Zimbabwe's cancer burden but can help reduce it and the suffering it causes.

First is a concerted cost-effective emphasis on cancer-prevention at the national and local levels. This might be done through stand-alone efforts and by including cancer awareness and prevention messages in HIV/Aids awareness campaigns.

Sustained cancer prevention efforts also help prevent other serious non-communicable diseases such as heart disease, hypertension, diabetes and obesity.

A national cancer-prevention effort would include actions to control the use of tobacco, alcohol and cancer-causing chemicals It would involve bringing the HPV vaccine to Zimbabwe and encouraging parents to have their adolescent and pre-adolescent children vaccinated, as well as reminders to wear a hat and guardagainst excessive sun exposure to prevent skin cancer, particularly in people with less skin pigmentation.

Cancer rates in Zimbabwe are closely intertwined with the nation's 15% HIV prevalence rate. An estimated 60% of Zimbabwe's cancer cases are associated with HIV infection. HIV infection leads to cancer indirectly.

Without antiretroviral therapy, the virus damages the immune system, leaving a person susceptible to cancers caused by infectious agents. Those cancers include Kaposi's sarcoma, bladder cancer and liver and cervical cancers.

Zimbabwe has taken steps to prevent cervical cancer. This prevention programme is often called VIAC (Visual Inspection with Acetic Acid and Camera) screening. It is designed to identify precancerous changes on a woman's cervix and to treat the changes before they become cancerous, thereby preventing the disease.

VIAC screening is offered at national and provincial hospitals and some mission hospitals, such as St Albert's and Karanda.

These programmes have been well accepted by women in the districts these hospitals serve. From the beginning of the St Albert's programme in 2013 through the end of 2016, the hospital screened nearly 7 000 women, identified 308 women with precancerous changes on the cervix and 71 cases of probable advanced cancer, and conducted 143 community cancer awareness campaigns.

Another step Zimbabwe can take to reduce the national cancer burden is to promote broad-based cancer education. Zimbabwe's National Cancer Prevention and Control Strategy calls for an 80% cancer literacy rate by 2018. There is much to be gained by a sustained cancer education effort.

A better understanding of cancer, its causes, diagnosis, treatment and prevention will encourage a stronger commitment to cancer prevention. A better understanding of cancer at local levels can reduce the unnecessary suffering caused by myths and misinformation about cancerand the serious problem of cancer stigma. The oncologist I mentioned earlier spoke of a patient who said, after learning she had cancer: "Doctor, I wish I had HIV."

A cancer education effort will be aided by Zimbabwe's 90% literacy rate and should be aimed at the professionals who provide health information to the public. These include doctors, nurses, community health workers, social workers, health reporters and news editors, secondary school teachers and nursing and medical students.
A cancer education effort could begin by identifying physicians, nurses and other public health professionals who can train trainers in the basics of cancer.

Help in providing this training is available online. One possibility is a free, non-credit online course called "Introduction to the Science of Cancer". It is provided by The Ohio State University Comprehensive Cancer Centre — Arthur G James Cancer Hospital and Richard J Solove Research Institute (OSUCCC-James). I was closely involved in developing the course and frequently had the staff of St. Albert's in mind as I worked on its content.

The full course has five modules and 35 videos, each 10 to 15 minutes long. In the videos, OSUCCC-James oncologists and cancer researchers explain cancer-related concepts in understandable terms.

The course covers the nature of cancer; the diagnosis, treatment and prevention of cancer; and cancer research. It includes downloadable readings and slides that contain the information provided on each video. (To watch the first course video, visit

Darrell E. Ward is the President of Better Healthcare for Africa and Associate Director for Cancer Communications at the Ohio State University Comprehensive Cancer Center – Arthur G. James Cancer Hospital and Richard J. Solove Research Institute (OSUCCC – James).

Universal health coverage
requires sustainable funding

Itai **Rusike**
Executive Director
Community Working Group on Health (CWGH)

The way a healthcare system is designed, financed and performs has consequences for inequality. User fees, for example, prevent people from accessing healthcare and push the majority poor people each year into greater poverty.

The Abuja Declaration signed by African governments in 2001 committed them to allocating at least 15% of their budgets to health with the goal of ensuring that every member of society has access to healthcare when it is needed without risk of financial ruin.

Sixteen years later, less than 10 countries in Africa have increased their health budgets to at least 15% of their national or provincial budget, as stipulated in the declaration.

Less than 10% of Zimbabweans are reported to be protected from the financial risks associated with using healthcare services, even though healthcare plays an important role in the over ambitious business of achieving the Sustainable Development Goals.

Unless health budgets are adequate to meet priority health needs, inequalities in access to health services will remain high and these goals will not be achieved for all.

The concept of universal health coverage (UHC) offers an opportunity to address these challenges. UHC is seen as a means to deliver on the principle of health for all that was set out more than 35 years ago in the Alma-Ata declaration.
In 2005 there were calls to revitalise primary health care (PHC). The principle of universal coverage was reaffirmed in the 2008 World Health Report on PHC and various subsequent World Health Assembly resolutions.
In May 2012 in the World Health Assembly, World Health Organisation director general, Margaret Chan, asserted that UHC is "the single most powerful concept that public health has to offer" to reduce the financial impoverishment caused by people's spending on healthcare and to increase access to key health services.

In December of that year, the United Nations General Assembly adopted a resolution on UHC, urging governments to move towards providing all people with access to affordable, quality healthcare services, given the important role that healthcare plays in achieving international development goals.
Achieving these goals is, however, first and foremost a political process. It involves a political negotiation between different interest groups in society over what services are provided, how services are allocated and who should fund them.

Moving towards Universal Health Coverage calls for progressive steps year by year to widen access to services, to ensure that services are adequately financed and expanded, to not burden people financially and to expand services appropriately to address major health problems, such as the increasing levels of non-communicable diseases.

The 2013 Zimbabwe Constitution provides the legal framework in terms of the right to health services. The Public Health (Amendment) Bill, which is now at an advanced stage, will provide an updated umbrella law for UHC.

A number of measures need to be implemented to improve access to healthcare services. Among these are re-equipping and supporting primary care and community level services, including Community Health Workers (CHWs). This will require unfreezing nursing posts, training and deploying primary healthcare nurses and improving the supply of vital and essential medicines at primary care level.

Domestic health financing must be improved in order to sustain delivery of such measures, to address new challengessuch as the rising levels of non- communicable diseases (NCDs) and to meet the policy goal of total enforcement of user fee abolition at primary care level and fee abolition for specified essential services at district level.

While financing initiatives such as the AIDS Levy Fund, the Health Transition Fund (HTF) and the Health Services Fund have complemented budget resources, these are insufficient to meet the costs of health services for the SDGs or the wider set of health needs that include the rising levels of NCDs.

Zimbabwe has gone through several variations of free healthcare over time. Although the current policy provides for free services for children under five years old, pregnant mothers, those above 65 years old and those with specified chronic conditions and infectious diseases, experience has shown that access has been denied to many, especially from mid-2000, mainly due to financial constraints.

There are efforts to implement free health services for selected groups but this is often reliant on external funding. There is a need to look seriously at a sustainable mechanism for domestic health financing.

The Constitution of Zimbabwe Amendment (No. 20) Act (2013) 76 Right to Health Care page 37/38 clearly states that every citizen and permanent resident has a right to access basic healthcare services, including reproductive healthcare services, and that no person may be refused emergency medical treatment in any healthcare institution.
The State must take reasonable legislative and other measures, within the limits of the resources available to it, to achieve the progressive realisation of the rights set out in this section.
The advent of the new Constitution means that government, as the guarantor, must commit itself to health as a human right and mobilise domestic resources to fund a health benefit that is accessible to all.
UHC implies that all people can access and use the preventive, palliative and curative services that they need (as opposed to demand). These services must be of sufficient quality to be effective, while their utilisation must not expose people to financial hardship or impoverish them.
It also means closing inequalities in healthcare provision and being accountable and transparent when it comes to how finances are managed in the delivery of these entitlements.

Progress will depend on political leadership in navigating it. The constitutional obligation to deliver health services is now a bottom line that the Ministry of Health and Child Care will have to ensure it delivers on. We also need to act and learn by doing!

http://go.osu.edu/cancercourse). The videos can be viewed individually and in any order.

In 2015, I worked with St Albert's to organise a cancer education workshop for hospital staff. A physician at the hospital conducted the workshop, which included 12 videos covering the topics of greatest interest. One or two videos were shown at a time, followed by discussion about how the information pertained to Zimbabwe and answering questions from staff.

With limited ability to diagnose and treat cancer, efforts to prevent these diseases become urgent. Encouraging cancer education through the use of free online courses such as "Introduction to the Science of Cancer" can help improve cancer literacy among key professionals who can then provide accurate information that promotes cancer prevention and reduces suffering.

Medical drugs **flood** streets

Tendai **Makaripe**

Harare's central business district is a hive of activity when dusk falls, as innumerable vendors flood the streets selling their products.

"*Mapiritsi emusana aripo pano, svikai padhuze mukoma titaure...* (sexual enhancement drugs available)," bellowed a vendor as I strolled by, immediately triggering interest in me and I walked back to enquire.

"Which ones would you want to have, I have a number of them?" queried the vendor.

Upon telling him that I did not want to buy the sex enhancing pills, but just wanted to know how much they cost, where they were coming from and their side effects, the gentlemen ignored most of the questions and said, in a hushed tone: "Boss, I also have various types of pain killers and tablets for various ailments. I can give you those at half the price you buy them for in pharmacies!"

Bewildered I stood rooted to the spot as he showed me countless drugs that he was selling on the streets, some of which, I later discovered, were actually prescription drugs.

Asked where he gets the drugs, among them prescription drugs that legally require a medical prescription to be dispensed, and sensing that I was not going to buy, the gentleman immediately dismissed me saying: "*Madhiri ekutsvaga kurarama patonaz mdhara* (These are deals I carry out to irk out a living boss)," as he arrogantly walked back to his stall.

This scenario is not restricted to this gentleman only but, as investigations later revealed, is replayed in many areas in and out of Harare where the need for cheap drugs is endangering people's lives.

In an investigation around the streets of Harare vendors, who opened up to this publication, said selling medical drugs on the streets is now brisk business.

Drugs for the treatment of chronic ailments such as high blood pressure, antiretroviral drugs, aphrodisiacs, birth control pills and antibiotics such as amoxicillin and cotrimoxazole have flooded the streets. Some of the drugs being sold on the streets, especially sexual enhancement drugs, are not even licensed by the Medical Control Authority of Zimbabwe (MCAZ).

"The authority is in the process of withdrawing some substances from the market that are being sold as sexual enhancement products, but were not declared as such to the authorities," MCAZ spokesperson Richard Rukwata said.

"Our enforcement unit is also assisting the police with some investigations regarding the sale of these products. The authority enjoys good relations with the Zimbabwe Revenue Authority (ZIMRA) and Port Health Authority, so we are constantly collaborating to curb these vices," he said.

A chronic shortage of drugs in Government hospitals has compounded the problem.

The harsh economic environment has pushed people to look for drugs in the streets where they buy them at cheaper prices than in local pharmacies, risking their health in the process.

The flooding of streets with these drugs has been attributed to rampant smugglingthrough the country's porous borders.

The World Health Organisation (WHO) estimates that worldwide 200 000 deaths per annum could be prevented if people did not use counterfeit or sub standard drugs.

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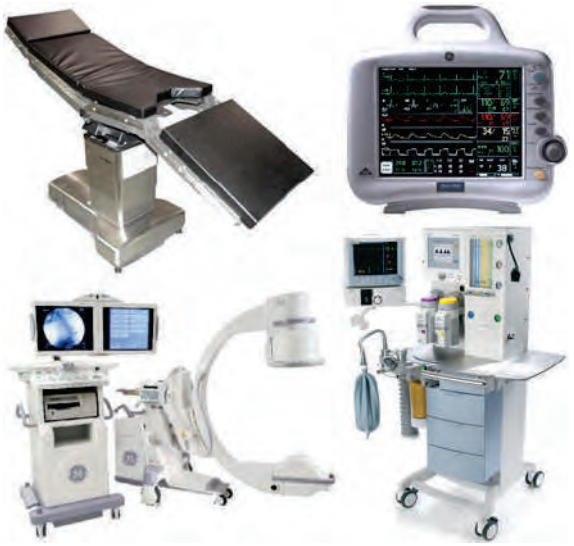

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