Community Working Group on Health (CWGH)

POSITION PAPER - PROPOSED NATIONAL HEALTH INSURANCE
JUNE 2024

Key Messages

- The Community Working Group on Health (CWGH) welcomes and lauds the Government's efforts to introduce the long-awaited proposed National Health Insurance (NHI) which affirms Government's commitment to ensure Universal Health Coverage (UHC). However, CWGH remains deeply concerned about the Government's ability to steer and sustain this noble project given the huge challenges facing the country.
- To fully achieve the full potential of a National Health Insurance scheme, actions to address the social determinants of health must be implemented. The social determinants of health are defined as the social and environmental contexts in which people 'are born, grow, live, work, and age' and make lifestyle decisions. These social determinants include: economic stability, community and physical environment, education, community and social context, and the health care system. Addressing these factors must be prioritized.
- Experiences from countries that have successfully introduced NHI schemes underscore the importance of prioritizing preventive measures and health promotion, aiming to keep the population healthy and reduce the burden of preventable diseases. Strengthening Primary Health Care (PHC) is therefore critical in sustaining the NHI. A robust primary care system can manage acute, chronic and social conditions affordably and effectively and could be the answer to both controlling costs and improving people's health and well-being. Primary care lowers the costs of health services through cost–effective preventive health care. A strong, well-funded and accessible primary health system keeps people healthier and out of hospital by supporting them to manage their health issues, including chronic conditions, in the community. This reduces reliance on costly acute care, such as specialists, emergency department or other hospital services.
- It is important to strengthen public health infrastructure. Public health infrastructure has been referred to as 'the nerve centre of the public health system.' Public health infrastructure provides the necessary foundation for undertaking the basic responsibilities of public health and of a strong resilient health system akin to that of Zimbabwe in the mid-80's to late 1990s.
- There is need to ensure the sustainability and competitiveness of the health workforce, particularly to secure adequate numbers of health professionals in remote areas as well as improving working conditions, remuneration and career prospects, especially for nurses, to support retention.
- Ensuring the financial sustainability of the NHI requires that sources of funding be diversified and extended beyond payroll contributions to include a range of earmarked taxes such as value-added tax, sin taxes, and sugar taxes. In Zimbabwe, because of the huge informal economy, solely relying on payroll taxes and contributions will not be sustainable, hence the need for diversified funding mix. Most countries have relied on a combination of general tax- and contribution-based financing mechanisms through modalities that reflect the specific characteristics of their economies and the needs of their people. For instance, Thailand and Ghana have successfully implemented a NHI based on a diversified financing mechanism including payroll contributions, sin taxes, sugar taxes, and value added tax.

- Enhancing the health service delivery through leveraging digital economy platforms such as telemedicine is also critical as it helps to reduce costs and enhance efficiencies. In many countries, the use of electronic health records, telemedicine, and digital platforms has improved efficiency and patient outcomes. This technological integration could serve as a valuable lesson for Zimbabwe in enhancing its healthcare infrastructure.
- It is vital to improve data availability for quality monitoring and regular evaluation of health system performance is critical.
- While governance and stewardship of the NHI as well as the health system are ultimately the responsibility of the Minister of Health and Child Care, it is important to involve key stakeholders including the private sector, trade unions, informal economy associations and CSOs to ensure greater transparency and accountability. In Kenya, the Social Health Insurance Act (2023) provides for the nomination of four persons from the Kenya Medical Association; the informal sector association; the consortium of healthcare providers; and the Central Organization of Trade Unions-Kenya to the board of the Social Health Insurance Authority.
- Strategic Health Purchasing and Pooling: There is need to plan for efficient strategic purchasing, defragmentation, and cost-reference package development.
- Given the capacity constraints, a phased approach in terms of implementation and not a big bang approach may be more feasible. This observation is in line with experiences from a number of countries.

Introduction

Access to basic health services is a right that is enshrined in Section 76 of the Constitution. Health and Well-being is also one of the 14 priorities under the National Development Strategy 1 (NDS 1). The overall outcome of the Health and Wellbeing priority area during the NDS 1 period is to improve quality of life, increase life expectancy at birth, benefiting from underlying strengths within the Health System that include; skilled, knowledgeable and professional health workforce, firm foundations of Primary Health and Hospital Care and improved quality of Public Health Expenditure. The wealth of any country depends on the health of its citizens. Therefore, any country seeking to achieve sustainable development must improve the health of its citizens so that they can meaningfully contribute to economic growth.

Many countries around the world have adopted universal or national health insurance schemes as a means to ensure Universal Health Coverage (UHC) while also, protecting patients from the financial risks of ill health. Universal health coverage (UHC) asserts that everyone should have access to the care they need, regardless of their ability to pay for it. Sustainable Development Goal (SDG) 3.8 aims at attaining UHC, which includes financial risk protection, access to high-quality essential healthcare services, and access to safe, effective, high-quality, and affordable necessary medications and vaccinations. To achieve UHC, people must have both financial and healthcare access. Financial hardship is one of the most significant effects of paying for healthcare out-of-pocket (OOP) expenditures at the time of service use. When people make OOP payments for healthcare services at a point of use that exceeds their ability to pay, they face financial hardship. Inpatient care or hospitalization is more likely to create financial hardship due to out-of-pocket healthcare expenses than outpatient care. For the uninsured, hospitalization care can be expensive due to the many different aspects of care that add to the costs. These costs may include hospital beds, meals, treatment, health checks, blood tests, etc. According to the World Health Organization (WHO), 90 million people are driven into poverty each year because they have to pay for health care.

In many countries, health insurance is becoming more and more popular as a way to protect households from the financial hardship and attendant impoverishment that comes with paying OOP costs. The World Health Organization (WHO) acknowledges health insurance as a promising mode of achieving UHC. About 7% of Zimbabweans have access to medical insurance and this number is insufficient to ensure decent public healthcare. The implementation of a national health insurance scheme in the country can improve healthcare delivery as more resources for health become available. The Community Working Group on Health (CWGH) therefore welcomes and lauds the Government's efforts to introduce the long-awaited proposed National Health Insurance (NHI) which affirms Government's commitment to ensure UHC[1].' However, CWGH remains deeply concerned about the Government's ability to steer and sustain this noble project and to ensure that competing private sector interests, and the inevitable inequalities and trade-offs that could be created, are better managed. The CWGH therefore calls upon all citizens of Zimbabwe and civil society to unite behind a People's NHI to ensure that the principles of the Right to Health, Universality and Social Solidarity are adhered to throughout the implementation process.

The State of Health

The country's health sector continues to face myriad challenges that include: inadequate and depleted healthcare workforce; high disease burden; inadequate and poor maintenance of healthcare infrastructure and ill-equipped hospitals; prohibitive cost of emergency and specialist services with a lack of decentralisation of such services; lack of financial risk protection mechanism; inadequate budgetary allocation and gross public under investments; public health threats including pandemics against a background of a fragile health delivery system. The poor continue to bear the highest burden of diseases and experience high levels of financially crippling healthcare costs. According to the World Health Organisation (WHO), in terms of the Universal Health Coverage (UHC) Service Coverage Index, the country has an index of 55.04 as at 2021 up from 54.00 in 2017. Zambia has an index of 55.84 while South Africa has an index of 70.95. The Universal Health Coverage (UHC) Service Coverage Index is measured on a scale from 0 (worst) to 100 (best) based on the average coverage of essential services including reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access[2].

Table 1 shows the trends in Public Health Expenditure over the period 2016-2024. Government spending on health and child care as a percentage of total public expenditure is projected to decline 11.2% in 2023 to the projected 10.8% in 2024. Health spending as a share of total government expenditure, an indicator of the priority given to health. The Abuja target remains an elusive target for the country. The Government also spends a relatively small share of its Gross Domestic Product (GDP) on health care projected at 4.0% in 2024 up from 2.2% in 2023. Per capita health spending on health is however expected to increase to US$71.8 in 2024 up from US$48 in 2023.

According to the 2021 Global Expenditure on Health by the World Health Organisation (WHO), global average health spending per capita was US$1,105 in 2019, but there was wide variation across different income groups. For instance, the average per capita health spending was only US$39 a person in low-income countries, compared with US$ 3,191 in high income countries—

[1] A health service that is available to all persons and that includes promotive, preventative, curative, rehabilitative and palliative health services regardless of people's socio-economic or health status.

[2] https://www.who.int/data/maternal-newborn-child-adolescent-ageing/indicator-explorer-new/mca/uhc-service-coverage-index-(sdg-3.8.1)

more than 80 times larger, and about four times the average GDP per capita in low-income countries (US$693 in 2019). On the other hand, health spending per capita was US$119 in lower-middle income countries and US$472 in upper-middle income countries. Most of the countries with low health spending were in South Asia and Sub-Saharan Africa, while most of the countries with high health spending were in Europe, North America and East Asia. The WHO estimates that an additional US$ 41 per person per year in health spending, on average, is needed in low- and middle-income countries to make progress towards the health targets of Sustainable Development Goal (SDG) 3 by 2030. This implies more than doubling current health spending in low-income countries and a 34% increase in lower-middle income countries. Health spending relative to the size of the overall economy (GDP) also varied across income groups. For example, health spending as a percentage of GDP in 2019 ranged from 4.9% on average in lower-middle income countries to 8.2% in high income countries.

Table 1: Trends in Public Health Expenditure, 2016-2024

	2016	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**
Public Health Expenditure (percent of total Public Expenditure)	8.3	6.9	9.0	7.0	10.1	13.0	10.6	11.2	10.8
Per capita public health expenditure (US$)	23	18	20	7	14	45	20	48	71.8
Public health expenditure (percent of GDP)	2.3	1.9	2.7	2.8	1.4	2.5	1.7	2.2	4.0

Source: Calculations based on Ministry of Finance figures.

The inadequate public financing of health has resulted in an overreliance on out-of-pocket and external financing which is highly unsustainable (see Table 2). Health spending in low-income countries was financed primarily by out-of-pocket spending (OOPS; 44%) and external aid (29%), while government spending dominated in high income countries (70%) (2021 Global Expenditure Report on Health). The 2024 National Budget Statement, revealed that development assistance towards the health sector was US$309.4 million during the first 9 months of 2023, and it is projected at US$436.0 million for the year 2023. In countries that are highly dependent on external aid, health priority in government spending tends to fall in line with the increased aid. Development assistance for health has crowded out government resources and created donor dependence. According to the WHO, the out-of-pocket expenditure per capita on healthcare as at 2019 in Zimbabwe was USD50.8[3] which is way higher than the public spending per capita of USD7 as shown in Table 1.

[3] https://ourworldindata.org/grapher/out-of-pocket-expenditure-per-capita-on-healthcare

Table 2: Sources of Health Spending (%)

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Government transfers	26.28	26.23	28.89	28.38	33.58	20.82	21.19	25.12	34.14	14.27	22.09
External Aid	27.48	19.21	15.34	20.13	20.22	24.26	28.68	37.15	29.77	61.94	55.67
Out-of-Pocket spending	34.43	37.22	34.97	29.76	24.83	25.79	23.96	10.55	8.8	9.08	10.41
Voluntary Health Insurance contributions	11.55	16.88	20.19	21.05	20.97	28.92	25.7	26.34	26.06	14.06	7.39
Other	0.26	0.46	0.61	0.68	0.39	0.22	0.48	0.84	1.23	0.66	4.43

Source: **https://apps.who.int/nha/database/country_profile/Index/en**

Lessons from other countries

It is important to synthesize the lessons on what has and has not worked to ensure success and sustainability. National Health Insurance (NHI) has been successfully implemented in a number of countries around the world. By pooling resources and implementing efficient healthcare delivery systems, these countries have improved health outcomes, reduced healthcare disparities, and ensured that their populations have access to the care they need. Evidence shows that universal eligibility for insurance with a substantial public subsidization and support can reduce or eliminate the financial barrier to access and thereby benefitting the poor.

Canada has a universal, publicly funded health-care system (known as Medicare) which provides basic medical services to Canadian residents, regardless of their income or employment status. Medicare provides medically necessary hospital, diagnostic, and physician services on a pre-paid basis and it is financed through general tax revenues and provided free at the point of service, as required by the Canada Health Act of 1984. Supplementary services, or those not covered under Canadian Medicare, are largely privately financed, either from patient out-of-pocket payments or through employer-based or private insurance.

In Germany, the Public Health Insurance System (Gesetzliche Krankenversicherung – GKV) is the country's predominant form of health coverage. It is funded through a combination of contributions from both employees and employers, and self-employed persons have the option to contribute to the system voluntarily. The Public Health Insurance System provides comprehensive medical services that include doctor visits, hospital stays, prescription medications, medical treatments, preventive care, and rehabilitation. However, while the public health insurance system covers most medical expenses, insured individuals may be required to make co-payments for certain treatments and medications. To support the public health insurance system, the government provides subsidies to ensure the affordability of healthcare services, especially for low-income individuals.

Norway has universal health and social insurance coverage, known as the National Insurance Scheme (NIS), or Folketrygd. It is currently regulated by the 1997 National Insurance Act and the 1999 Patient Rights Act. The establishment of universal coverage has a long history in Norway. Norway has a decentralized system with healthcare mostly provided by the government through municipal health services. The government ensures that citizens receive an equal standard of care at all hospitals. Only about nine percent of the Norwegian population holds

private health insurance, which is supplemental. General lessons from the Norwegian case study include: the need to reform the hospital system by making it more efficient, cutting down on costs by cutting down on bureaucracy, improving services for mental health patients, focusing on prevention rather than treatment, and investing in technology – this will help them reduce costs without compromising patients' access to quality care.

In France, the public health insurance system, known as Sécurité Sociale, provides basic coverage to those who qualify. The system covers most costs for hospital, physician, and long-term care, as well as prescription drugs; patients are responsible for coinsurance, copayments, and balance bills for physician charges that exceed covered fees. The insurance system is funded primarily by payroll taxes (paid by employers and employees), a national income tax, and tax levies on certain industries and products. To ensure financial sustainability, sources of health funding have been extended beyond payroll contributions in the past decades to include a broader range of sources of income, including financial assets and investments with a range of earmarked and value-added taxes. Ninety-five percent of citizens have supplemental insurance to help with these out-of-pocket costs, as well as dental, hearing, and vision care.

Australia has a universal health insurance scheme known as Medicare that guarantees all Australians (and some overseas visitors) access to a wide range of health and hospital services at low or no cost. Medicare provides medical appointments, medications, and hospital care at low or no cost. Medicare also covers some costs for physiotherapy, community nursing programs, and basic dental care for children. Healthcare in Australia is enhanced through Primary Health Networks (PHNs). There are 31 PHNs across the country. They are responsible for supporting community health centers, hospitals, doctors, and nurses. PHNs also coordinate activities between different parts of the healthcare system. As needed in different regions, they may provide more services: examples are after-hours clinics, mental health services, and health promotion programs. The costs of healthcare in Australia are covered through taxes. Residents pay 2% of their income to the Medicare Levy, which funds the public system. As a result, most patients never pay medical fees at their appointments and they can claim reimbursements if they do. Medicare covers the cost of GP visits, hospital visits, and 85% of specialist costs. It also subsidizes prescription medications to provide them at a discounted cost.

In Thailand, financing for UHC is predominantly non-contributory, financed by general government taxation. This mode of financing is based on several assumptions: health insurance premiums are unaffordable to the large numbers of poor people whose need for health subsidies was the reason for the policy in the first place; identifying and collecting premiums from people who should be able to contribute is not logistically straightforward; and increasing the rate of premiums in accordance with rising expenditure could be politically challenging. The Thailand model has demonstrated that financing UHC through general taxation is currently the most equitable and efficient way of paying for health care.

Israel has one of the most technologically advanced health systems in the world. Israel's UHC scheme is based on the National Health Insurance Law of 1995. Israeli citizens are required to be insured through one of four health insurance organizations (HMOs). Citizens pay a compulsory health tax (often deducted from their wages by their employer) to the National Insurance Institute, which redistributes the funds to the HMOs based on several criteria, including a capitation formula. Each HMO also receives some direct funding from the government. There are several exclusions from the health tax, including active-duty military and disabled Veterans whose health insurance is covered by the Ministry of Defense. The law requires that the four HMO's offer a regulated 'health basket' or set of health care services to their members.

Insurance coverage covers all costs of medical diagnosis and treatment in the areas of family medicine, hospitalization (general, maternity, psychiatric, and chronic), preventive medicine, surgery (including elective surgery), transplants, drug abuse, and alcoholism; medical equipment and appliances; first aid and transportation to a medical facility; obstetrics and fertility treatment; chronic diseases; and mental health. The basket further includes coverage for most medications, updated annually, and medication co-pays can apply in certain circumstances. Supplemental insurance plans can also be purchased through the HMO to some extent of insurance level, and private insurance plans that go beyond the regulated health basket can also be purchased from commercial insurance companies. Citizens choose to which HMO they will subscribe, and they can easily change that election.

South Korea's healthcare system has been widely praised for its efficiency and accessibility. The country adopted a national health insurance system in 1977, aiming to provide universal coverage for its citizens. The key features of the South Korean model include a single-payer system, mandatory enrollment, and a mix of public and private healthcare providers. South Korea has successfully integrated technology into its healthcare system, and this has been a key hallmark of its success and sustainability. The use of electronic health records, telemedicine, and digital platforms has improved efficiency and patient outcomes.

A number of African countries have established their own national health insurance schemes. In Nigeria, the National Health Insurance Scheme (NHIS) was established by Decree 35 of 1999 to ensure that every Nigerian has equal access to good quality healthcare services. The actual implementation of the NHIS commenced in 2002 and was consolidated in 2005. Despite the NHIS's goal of providing affordable healthcare it faced a number of challenges that include: inadequate funding, drug stockouts, inefficient supply chain management, and regional disparities in pharmaceutical infrastructure. In 2022, a National Health Insurance Authority Act (NHIA) was signed into law to supplant the NHIS. The NHIA aims to secure mandatory health insurance for every Nigerian and legal resident, and establishes a fund for the vulnerable groups, which will provide 'subsidy for health insurance coverage for vulnerable persons and payment of health insurance premiums for indigents.' In October 2023, the Nigerian government launched the operational guidelines for the 2022 National Health Insurance Authority (NHIA) Act as part of efforts to ensure all Nigerians have access to affordable healthcare services.

In Kenya, the Social Health Insurance Act, 2023 (the Act) and Social Health Insurance Regulations (the Regulations) have been introduced as part of the government's plan to achieve Universal Health Coverage for its citizens. The effect of the Act and the Regulations has been to do away with the with the National Health Insurance Fund. The Act has introduced the Primary Health Fund; Social Health Insurance Fund (SHIF); and the Emergency, Chronic and Critical Illness Fund (the Funds). The Regulations are geared towards the implementation of the Funds. The Regulations place the rate of contribution to the Social Health Insurance Fund at 2.75% of a contributor's income. Where a household does not have salaried income, the contribution to the SHIF shall be on annual basis on proportion of household income as determined by the means testing. The Social Health Authority shall collect data from households for the purposes of conducting proxy means of testing.

In Ghana, the National Health Insurance Scheme (NHIS) was established by the National Health Insurance Act, 2003 (Act 650) and administered by the National Health Insurance Authority (NHIA), which was also established under the same Act. However, in 2012, the National Health Insurance Act, 2003 (Act 650) was replaced with the National Health Insurance Act, 2012 (Act 852). The purpose for this was to integrate all hitherto semi-autonomous District-wide Mutual

Health Insurance Schemes into a Single Payer System (NHIA, 2013). The main objective of the health insurance is to provide social health insurance for all residents of Ghana by making sure that individuals access healthcare without difficulties, ensuring patient satisfaction and improved health status, thereby trying to achieve the universal health insurance coverage. The sources of financing are well diversified and include the following:

- The National Health Insurance Levy (NHIL): This is 2.5% VAT on all goods and services.
- 2.5% of workers' contribution to the basic Social Security and National Insurance Trust (SSNIT).
- Monies that are allocated by parliament to the Fund.
- Returns on investment by the Fund.
- Grants, donations, gifts from donor communities and volunteers.
- Fees charged by the National Health Insurance Authority (NHIA) in discharging its duties.
- Premiums paid by members to the scheme.
- Money accruing under section 198 of the Insurance Act, 2006 (Act 742), which is a percentage of the emergency motor insurance premium.

In South Africa, the National Health Insurance Act 20 of 2023 (NHI Act) was signed into law by on 15 May 2024. Even though the NHI Act has been signed into law, the NHI Act is not yet operationalized. The purpose of the NHI Act is to achieve improved universal health coverage of the South African population, in line with Section 27 of the Constitution, which provides that 'Everyone has the right to have access to health care services, including reproductive health care [and] No one may be refused emergency medical treatment'. The plan set out in the NHI Act is to consolidate various sources of healthcare funding within the country, in a National Health Insurance Fund (NHI Fund), that will eventually be the only entity that purchases and pays for healthcare services on behalf of the population. The primary intervention is the establishment of the NHI Fund, the entity that must become the single purchaser and payer of healthcare services. The Act also creates a Benefits Advisory Committee (BAC), which will determine what the healthcare service offering will be; a Health Care Benefits Pricing Committee, which will determine what the NHI Fund should pay for and the available services included; a District Health Management Office, which will co-ordinate the roll-out of primary healthcare (PHC) treatment at district level; a Contracting Unit for Primary Health Care, which will contract with service providers at district level; and a Health Products Procurement Unit (HPPU)(within the NHI Fund) to determine what health products the NHI Fund should procure and to manage supply chain and pricing matters. The HPPU and the BAC must collaborate to determine the national Essential Medicines List, Essential Equipment List and Formulary. According to the NHI Act, the NHI Fund must be funded by Parliament through new taxes, including a general surcharge on personal income tax and an employer and employee payroll tax, as well as by the removal of the individual medical schemes tax credit and reallocation of almost the entire provincial health budget to the NHI Fund.

Financing mechanisms for UHC

Developing sustainable financing mechanisms and modalities that mobilize adequate funds to actualize UHC is of critical importance. Ultimately public health expenditure determines the availability, affordability, accessibility, and quality of health services. Without sufficient public funding of health sectors, quality health care is not available for all in need. In a number of countries, the approaches to mobilize resources typically include a mixture of general taxation as well as contributions to public health systems and private health insurance schemes. The choice

of approach will determine who bears the financial burden, the amount of resources available and who manages the distribution of the resources. However, the selected approach to financing should allow the collective pooling of risk that contributes to meeting the broader objectives of equity, solidarity and affordability. Equity takes place at different levels: equity in financing, equity in access to health care, equal level of health status and equity in terms of risk protection offered.

When selecting the optimal financing mechanisms there is no one-size-fits-all model; the criteria for selection must be based on specific and unique national contexts including the structure of the economy. For instance, in many countries with huge informal economies such as Zimbabwe relying solely on payroll taxes may not be sustainable as the tax base becomes narrow. Most countries have achieved UHC through a combination of general tax- and contribution-based financing mechanisms using schemes that reflect the specific needs of their people. Thailand and Ghana have successfully implemented a NHI based on a diversified financing mechanism including payroll contributions, sin taxes, sugar taxes, and value added tax. The Thailand model has demonstrated that financing UHC through general taxation is currently the most equitable and efficient way of paying for health care. In Canada, sin taxes have been a mainstay of their tax policy for a long time. Denmark has introduced sugar taxes targeting chocolate, candy and ice cream and sugary beverages. Other countries have also introduced taxes on saturated fat.

Conclusion and Recommendations

National health insurance is critical for the for achievement of Universal Health Coverage (UHC). This is important in a country where currently only about 7% of Zimbabweans have medical insurance. No country has made significant progress toward UHC without increasing reliance on public revenues. Mobilising domestic public funds is therefore essential for universal health coverage (UHC). There is need to ensure a diversified pool of resources that extends beyond payroll contributions to include a range of earmarked taxes such as value-added tax, sin taxes, and sugar taxes. In Zimbabwe, because of the huge informal economy, solely relying on payroll taxes and contributions will not be sustainable, hence the need for diversified funding mix.

To fully achieve the full potential of a National Health Insurance scheme, actions to address the social determinants of health must be undertaken. The social determinants of health are defined as the social and environmental contexts in which people 'are born, grow, live, work, and age' and make lifestyle decisions. These social determinants include: economic stability, community and physical environment, education, community and social context, and the health care system. The 1976 charter of the World Health Organization (WHO) has defined health as "a state of complete physical, mental and social well-being" and not simply as the absence of disease or infirmity. Thus, the concept of health is not only defined from a medical perspective, but also as something influenced by other non-medical factors, such as the state of the economic (or macroeconomic environment); education; water and sanitation; housing; and the physical environment.

The public health insurance system must prioritize and place significant importance on preventive measures and health promotion, aiming to keep the population healthy and reduce the burden of preventable diseases. A robust primary care system can manage acute, chronic and social conditions affordably and effectively and could be the answer to both controlling costs and improving people's health and well-being. Primary care lowers the costs of health services through cost–effective preventive health care. Primary health care is the frontline of any health

system. It is usually the first point of contact people have with their health care system, and ideally should provide comprehensive, affordable, community-based care throughout life. A strong, well-funded and accessible primary health system keeps people healthier and out of hospital by supporting them to manage their health issues, including chronic conditions, in the community. This reduces reliance on costly acute care, such as specialists, emergency department or other hospital services.

It is important to ensure the sustainability of the health workforce, particularly to secure adequate numbers of health professionals in remote areas as well as improving working conditions, remuneration and career prospects, especially for nurses, to support retention. According to the WHO database, Zimbabwe has a skilled health professionals' density (per 10,000 population) of 12.44. This points to a huge deficit. WHO identified in 2006 a minimum density threshold of 22.8 skilled health professionals/10,000 people to provide the most basic health coverage. Most rural health facilities have on average 2-3 nurses. This is grossly inadequate as the catchment area of the clinics is increasing with population increase (13,061 million in 2012 and 15,179 million in 2022), land resettlement and with the influx of gold panners and this negatively affects service delivery.

It is important to strengthen public health infrastructure. Public health infrastructure has been referred to as 'the nerve centre of the public health system.' Public health infrastructure provides the necessary foundation for undertaking the basic responsibilities of public health and of a strong resilient health system akin to that of Zimbabwe in the mid-80's to late 1990s.

While governance and stewardship of the NHI as well as the health system are ultimately the responsibility of the Minister of Health and Child Care, it is important to involve key stakeholders including the private sector, trade unions, informal economy associations and CSOs to ensure greater transparency and accountability. In Kenya, the Social Health Insurance Act (2023) provides for the nomination of four persons from the Kenya Medical Association; the informal sector association; the consortium of healthcare providers; and the Central Organization of Trade Unions-Kenya to the board of the Social Health Insurance Authority.

As the CWGH we remain available and committed to work with government as we have already:

- Been convening the Global Financing Facility (GFF) CSO Platform which took over from the World Bank funded support for Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition.
- Conducted an assessment of PHC for UHC and developed a policy guidance note to assist the country build on its previous successes implementing PHC
- Convened a pre-financing dialogue & stakeholder's conference on the health financing situation in the country now and en route to 2030.

CWGH has consistently advocated for increased domestic resources and the NHI. We are therefore happy to continue our collaboration with Ministry and other stakeholders and move this agenda forward. Our annual pre-and post-budget consultations, close collaboration with parliament as well as communities through the health centre committees and institutional management councils provide us with details of the realities on the ground. To this extent we also add the need for a strong health system strengthening agenda to accompany the NHI; devolution of decision making with deliberate capacity building on governance and management functions in order that more lives are saved at sub national levels. We therefore demand a

PEOPLE'S NHI where community participation is central and equity is fundamental, and where a one-payer system finances a pro-public health system.

The Community Working Group on Health (CWGH) is a network of national membership based civil society and community-based organizations who aim to collectively enhance community participation in health in Zimbabwe.

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