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Shared Value between Medical Aid Societies and Medical Healthcare Service Providers Key. A Case of Zimbabwe

[1]Marisa Johannes, [2]Matemadanda Victor and [3]Marisa Clever
[1] PhD Student @ Zimbabwe Open University
[2]PhD Student @ Chartered Institute of Management and Leadership
[3]Part-time Lecturer @ Zimbabwe Open University

Abstract
Medical Aid Societies (MAS) in Zimbabwe cover a tenth of the population, and about 80% of income to private medical healthcare providers in Zimbabwe comes from medical aid societies. They contribute more than 20% of the country's total health expenditure. The medical aid societies have encouraged growth of private hospital services in urban rather than rural areas, in order to lower administration costs and coverage is higher for the employed and wealthier groups, and lower in women, in rural areas and less wealthy people. Members of the societies were found to be relatively loyal, remaining with their first medical aid society and only migrating on change of employment. While managed care systems claim to make it easier and less costly to access medicines, this was not found in this study. The study reviewed the presented data or commentaries particularly on shared value between Medical Aid Societies and Medical Healthcare Service Providers. This paper recommended that all stakeholders should carry their own water to understand the value of every drop, members should pay their subscriptions religiously so that the fund can pay medical healthcare service providers satisfactorily, medical healthcare service providers should charge economic tariffs without bleeding the healthcare funds or should be involved in one way or another in safeguarding the fund, the governance structures should be inclusive of service providers, patients, community and should draw professional legal, financial and actuarial services to complement the structure and information technology should be enhanced because it is key in bringing much needed transparency in managing the financial resources by a fund that is grounded on integrity, knowledge, accountability, continuous improvement and ethical standards.

Keywords: *Shared Value, Medical Aid Societies, Medical Healthcare Service Providers, Patients, Subscribed Members*

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I. Introduction

The medical aid environment has been characterised by escalating cost of health care affecting the accessibility and long long-term viability of medical insurance. The triadic nature of the industry, that is, the medical aid society, medical healthcare service provider and client, means that at any point, two or three members of the triad are in contact, without the presence of the other member. This set up requires high level of trust and uttermost faith. While medical aid societies have been regularly reviewing products, benefits and contributions in a bid to balance affordability and accessibility, the medical healthcare service provider has become disgruntled by failure of the medical aid to pay for the services rendered. This has been worsened by the precarious economy that has seen inflation going up in the last few years.

Background to the Study

The medical insurance market size has remained stagnant at about 1.5 million people, if not shrinking. The cake has definitely got shrunken with a good number of organisations failing to remit funds to their respective medical aid societies. What has ensued is a battle for survival, typically, in austere conditions, good faith and trust evaporate, leading to a breakdown of the triadic set up in the healthcare industry. The shrinking formal sector coupled with poor organisation of the informal sector on top of medical aid societies' reluctance to sign up new individuals because of perceived adverse selection risk of some age groups, has thus kept the figure of the insured at about 9% of the population, leaving about 91% uninsured.

Fingers have been pointed at one another with medical aid societies raising their grievances against medical service providers. The medical service providers have often blamed the medical aid societies for failure to honour their ethical expectations. However, both these protagonists remain key in our set up as Zimbabwe. What should be realised by these protagonists is the concept of shared value. Originally, an academic concept, the idea was co-created by Harvard Business School Professors, Michael Porter and Mark Kramer and was

introduced in 2011 in the Harvard Business Review article, 'Creating Shared Value'. The establishment of shared value came after the global financial crisis when capitalism and the reputation of business were under siege. Shared value made the radical proposition that corporate success and improved social and environmental conditions are inherently linked and when achieved together, they could dramatically enhance our future prosperity.

Methods for review of literature

Inclusion and exclusion criteria

This paper included studies that presented data or commentaries on shared value between Medical Aid Societies and Medical Healthcare Service Providers. Studies could be in any setting. We also included articles that covered the health insurance globally and excluded articles that did not have data on health insurances, Medical Aid Societies and Medical Healthcare Services that were not relevant to this study.

II. Related Literature Review

Doetinchem, Carrin and Evans (2010) indicate that social health insurance (SHI) is one of the possible organisational mechanisms for raising and pooling funds to finance health services, along with tax-financing, private health insurance, community insurance, and others. Shamu, Loewenson, Machemedze and Mabika (2010) say that medical healthcare service providers include doctors, nurses, pharmacies, hospitals, labs, clinics and many other entities. Therefore, a healthcare provide becomes either a person or organisation, which provides a healthcare service to individuals (Anderson, 2011). For medical health insurance, the working people and their employers, as well as the self-employed, pay contributions that cover a package of services available to the insurees and their dependents. In most cases, they are obliged to make these contributions by law. WHO (2010) reports that many governments also pay subsidies into these systems in order to ensure or improve their financial sustainability.

Doetinchem, Carrin and Evans (2010) further posit that no health financing mechanism is an end to itself but it contributes to the objectives of the health system. The objectives specified in the WHO health systems framework after extensive consultation with countries are (a) improving health and reducing health inequalities (b) being responsive to people's expectations, and (c) ensuring fairness of financing (Anderson, 2011). As noted by Mapendere and Chinyoka (2019), the private for-profit health sector have been expanded in Zimbabwe, with both local and foreign investors, particularly through mergers and acquisitions by medical aid societies (MAS). According to Doetinchem, Carrin and Evans (2010), with vertical integration across providers (pharmaceutical, personal care services, emergency transport), there is a risk that service providers can further raise prices and profits. Many medical healthcare service providers have talked about the Capitation Model especially considering the instability in the financial sector. By combining capitation with provider-sponsored health plans, where practitioners participate on what to charge for what package of services, one gets a hybrid product that already has a buy in from key stakeholders. Access Health Fund, fronted by Dr Enock Tatira, has lately been on the drive for capitation (Chanakira, 2020). Practitioners have welcomed the new model, putting into cognisance the fragility of the health sector at the moment. Patients are seen without paying co-payments as practitioners are already covered.

Capitation comes in many forms. The health fund can come in and offer practitioners a fixed monthly , quarterly or even a yearly lump sum payment for looking after its members in that community. Madzimure and Maushe (2020) claim that medical aid societies like PSMAS, First Mutual, CIMAS and many others have the capacity for such. The Fund does its budgets and offer a comprehensive package or prior-agreed packages to members of the community. Capitation model has thus been credited for avoidance of over-servicing of patients (Blewett, L. (2010). Only necessary tests and investigations are ordered in order to preserve the fund.

Mapendere and Chinyoka (2019) say that Zimbabwe has mutual healthcare funds (managed by fund managers who invest these funds for a return, such as that offered by First Mutual Life) and private insurance providers (such as CIMAS) that offer health savings and health insurance schemes, which collect and pool funds and purchase health services. There are more than 30 MAS in the country, with about ten of those being in-house or restricted to the respective industries or employees and the rest being open societies (AFHoZ, 2018). Blewett (2010) indicate that both public and private employers provide this insurance through participation in medical aid societies, non-profit organizations that collect premiums from business and/or government organizations and use that money to pay health care providers for services provided to beneficiaries. However, Madzimure and Maushe (2020) find no proprietary (for-profit) health insurance companies in Zimbabwe. To this end, their relationship between funders (medical insurance industry) with health service providers and consumers is shown in Figure 1 below.

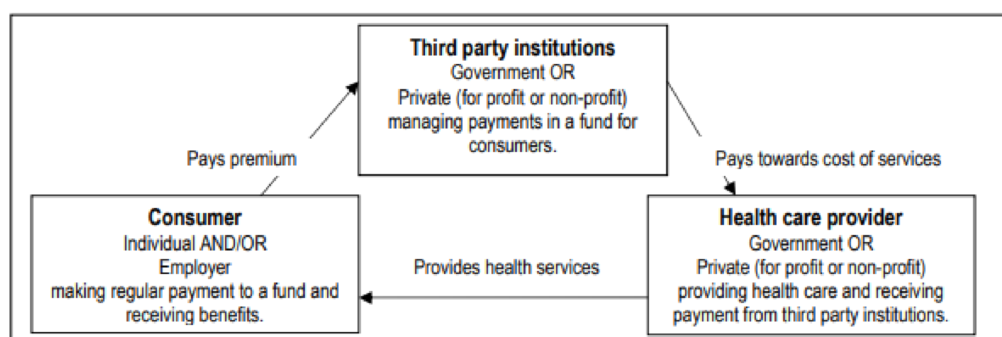

Figure 1: Relationship between Funders, Providers and Consumers

Source: *Shamu et al. (2010)*

The Medical Aid Societies (MAS) collectively service about 10% of the population, with almost all principal beneficiaries being formally employed, except for pensioners. About 80% of income to private health care providers in Zimbabwe comes from Medical Aid Societies (MAS) and they contribute more than 20% of the country's total health expenditure (Shamu et al., 2010).

III. Conclusion and Recommendations

It is thus imperative that the medical aid societies, the medical service provider need to collaborate and stop being adversaries. Both have valid complaints against each other with the funder complaining of unwarranted over-servicing by service providers and high claims. The funder and the medical healthcare service provider must work together and deal with everyone's hands about the table. This transparency allows for fair claims by providers and timeous payments by funders, ultimately reducing the cost for the customers and thus increasing access to healthcare. The silos within the industry and the asymmetry of information between funders and providers has created a ticking time bomb where everyone is a loser at the end. Shared value concept makes the funder, the medical healthcare service provider as well as the client exist in a perpetuating ecosystem where no one is working to destroy it but all are fighting to preserve the integrity of the system. Bilateral communication is thus important between the medical aid and the service provider and any form of perceived aggressive behaviour by one part will not be tolerated. Bullies are now unwelcome.

The protagonists should thus bear in mind that a vibrant health system requires the cooperation of all those that are directly involved in healthcare discharge. The following can be of importance if solutions are to be found in the near future:

- All stakeholders should carry their own water to understand the value of every drop and members should pay their subscriptions religiously so that the fund can pay medical healthcare service providers satisfactorily.
- Medical healthcare service providers should charge economic tariffs without bleeding the healthcare funds or they should be involved in one way or another in safeguarding the fund. The main purpose of the fund should be to coordinate without imposing anything on any of the players.
- The governance structures should be inclusive of service providers, patients, community and should draw professional legal, financial and actuarial services to complement the structure.
- Information technology should be enhanced because it is key in bringing much needed transparency in managing the financial resources by a fund that is grounded on integrity, knowledge, accountability, continuous improvement and ethical standards.
- Both medical aid societies and medical healthcare service providers need to sing from the same hymn book.

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