AFRICA UNIVERSITY

(A United Methodist-Related Institution)

DELAY IN HEALTH CARE SERVICE FUNDS DISBURSEMENT BY PREMIER SERVICE MEDICAL AID SOCIETY, ZIMBABWE

BY

ALFRED MAKARA

A DISSERTATION SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF EXECUTIVE MASTER IN BUSINESS ADMINISTRATION IN THE COLLEGE OF BUSINESS, PEACE, LEADERSHIP AND GOVERNANCE

2020

Abstract

Premier Medical Aid Society, by June, 2020, had not settled health service providers' claims on time. They owed health service providers hundreds of millions of United States Dollars. The aim of the study was to examine how delays in the settlement of claims by Premier Medical Aid Society affected health service providers. The objectives of the study were, to identify the causes of delayed payments to health service providers by Premier Service Medical Aid Society (PSMAS), assess the legislation available in the disbursements of funds to health service providers, measure the real impact of these payment delays on the general welfare of health service providers and suggest possible solutions to the delays in payment to health service providers. The study used descriptive research design to summarise and organize data in an effective and meaningful way. Mixed research approach was used. The study targeted the private health service providers located in Gweru. For the purpose of this study, 55 participants (from selected health service providers) were purposely selected to answer the questionnaire. Seven (7) top executives from service providers with the highest amounts owed to them were selected and three (3) PSMAS managers as key informants to participate in the interview. Statistical Package for Social Science (SPSS) version 21 software was used to analyse the data. Pie charts, graphs and tables were used to present data. The major findings of the study were that health service providers' claims were not settled within the stipulated time of 60 days. The majority of health service providers indicated that non-settlement of claims affected their daily operations and hence forcing them to ask their clients for cash upfront before serving them in order to stay in business. One of the recommendations was that medical aid societies and health services providers should work together to eliminate delays in the settlement of claims.

Keywords: Health services provision, medical claim, and medical payments

Declaration Page

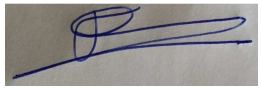
I declare that this dissertation is my original work except where sources have been cited and acknowledged. The work has never been submitted, nor will it ever be submitted to another university for the award of a degree.

Alfred Makara

Student's Full Name

04/06/2020

Student's Signature (Date)



08/06/2020

Mr Tendai Nemaunga

Main Supervisor's Full Name

Main supervisor's Signature (Date)

Copyright

Acknowledgements

I thank the Lord God Almighty for the wisdom, knowledge, understanding and strength to see me through this exercise. My sincere gratitude goes to my supervisor, Mr Tendai Nemaunga, for the direction and efficient marking of my work. My dissertation would not have been incomplete without the cooperation and support of the Association of Health Funders of Zimbabwe (AFOZ), Zimbabwe Medical Association (ZiMA), Ministry of Health and Child Welfare, Premier Service Medical Aid managers and the private health service providers in the Gweru.

I would also like to thank all my lecturers and library personnel for their support during my entire time at Africa University. A special acknowledgement goes to my wife, children, parents and siblings for the encouragement to complete the dissertation.

Dedication

To my wife, Patience and children, Joseph,Yeukai, Chidochashe, Talent, Tanatswa, Fadzai, Rufaro, Alfred, Ruvimbo and Runako.

List of Acronyms and Abbreviations

AHFoZ	Association of Healthcare Funders of Zimbabwe (AHFoZ)
MAS	Medical Aid Societies
MoHCW	Ministry of Health and Child Welfare
NAMAS	National Association of Medical Aid Societies
PSMAS	Premier Service Medical Aid Society
ZiMA	Zimbabwe Medical Association
SPSS	Statistical Package for Social Science

Definition of Key Terms

In order to create a common understanding of all the concepts in this study, the following words are defined.

Health care provider is a person or company that provides a health care service to individuals (Mugwagwa, 2017). Consist of medical professionals, organizations, and ancillary health care workers who provide medical care to those in need.

Nurse: For the sake of this research a nurse is a formally educated and experienced individual responsible for the caring of people who are sick.

Public Hospital: Generally, it is those hospitals that are funded and owned by the government (Mugwagwa, 2017).

Table of Contents

List of Tables

List of Figures

List of Appendices

CHAPTER 1 INTRODUCTION

1.1 Introduction

This chapter briefly dealt with the framework of the study. In particular it highlighted the background to the study, statement of the problem, objectives of the study and research questions. Significance, scope, delimitation and limitation of the study were also covered in this section.

1.2 Background to the study

Zimbabwe, like several other countries, has the impasse of finding the best ways to address the health needs of its population and economically develop the country to boast of a population with a satisfactory quality of life.

The health insurance market is liberalised and allows private entities to set up health insurance schemes. These systems function as medical aid societies and are misleadingly described as not-for-profit operations (Mhere, 2013). To support the view of market liberalisation, Mhere (2013) attributed the above to the proliferation of private health providers that has increased the importance of medical insurance. The medical aid sector has various operators, operating ‘open’ (any person can be a member) or ‘closed’ (only admit certain people, e.g. employees of a particular industry) schemes. Just over a million people in Zimbabwe have medical aid, with Premier Medical Aid Society (PSMAS) having 520,000 members; CIMAS having 450,000 members; Engineering Medical Fund having 20,000 members; and others accounting for 110,000 members (Munyuki & Jasi, 2009).

Premier Service Medical Aid Society as one of the biggest health insurance providers caters mainly for civil servants and their dependents (Munyuki & Jasi,

2009). There are no private not-for-profit medical aid societies in Zimbabwe, and no national health insurance scheme, so most of the population is not insured for health needs and cannot access the expensive private sector health facilities (Munyuki & Jasi, 2009).

In 2016, Zimbabwe experienced a period of non-payment of medical claims to some medical and health service providers. (ZIMA, 2016) reported that some claims remained un-paid for periods in excess of the statutorily stated 60 days cut off period and sometimes for periods of up to 6 months or more. The association went on to establish that it remained apparent that most providers felt they were being taxed for what they had not earned. The economic challenges facing the country have resulted in state hospitals being overcrowded, underfunded and understaffed. More private facilities offering far more luxury to those who can afford it have also mushroomed. Medical inflation has quadrupled resulting in a trend that is likely to continue until the economy recovers.

Substantiating the increasing impact of the health sector, the Private Hospitals Association of Zimbabwe (PHAZ) was formed in 1996 (3http://www.phaz.co.zw/). The portfolios covered by the members included hospitals; for example Mater Dei (Bulawayo) and South Medical (Chitungwiza); clinics, medical insurance firms' own clinics, maternity hospitals, 24 hours accident and emergency centres, and specialist centres such as Harare Haemodialysis Centre (Mugwagwa, 2017).

The growth of private healthcare centres was underpinned by an extensive private sector health insurance system, through what is locally known as Medical Aid Societies. Underscoring the message that the private sector has a long history in healthcare in Zimbabwe, the first association of medical health insurers, the National

Association of Medical Aid Societies (NAMAS) was formed in 1969. NAMAS became Association of Healthcare Funders of Zimbabwe (AHFoZ) in 2004 when it embraced other funders besides medical aid societies. Premier Service Medical Aid Society (PSMAS) is one of the oldest funders in the country having been established in 1930 after appointment of a special committee by the Public Service Commission. PSMAS grew from a membership of under a thousand in 1931 to over 600 000 members today, and it caters mostly for civil servants.

Mhere, (2013) noted that there are about 30 medical aid societies in Zimbabwe and both public and private employers provide medical insurance through participation in medical aid societies. He also highlighted that health insurance coverage is generally on the low side in Zimbabwe. According to Zimbabwe demographic and health survey (2006), 91% of women do not have health insurance. Of the 9% that are covered, 4% have insurance through their employer, 3% are covered under a privately covered commercial plan and the remaining 2% are covered through some other mechanism.

Mugwagwa, Chinyadza & Banda (2017) indicated that the onset of the economic challenges that began in the late 1990s and culminated in the hyperinflationary era of the 2000s strained the public health system. Fiscal provision for the public health system in real terms was reduced drastically and this forced citizens to resort to out of pocket health expenditure, and for those who were still gainfully employed, medical insurance was the best option for accessing healthcare. With the gradual increase in unemployment, the citizens depended more on out of pocket expenses or subscription of the elderly and other dependents onto medical insurance (cash

subscriptions in addition to salary deductions) by on or offshore relatives or children.

In a study by Mugwagwa et al., (2017), it has been revealed that fraud and corruption cost more than just the money some get away with. The effects of corruption and fraud in the health care system is noted as causing rippling effects ranging from costs and resources in the health sector. In the same study it was also revealed that corruption and fraudulent claims remain some of the biggest challenges the sector continues to face (Pacific Prime, 2017). Fraud and corruption can be viewed from various angles where different health incidents fraudulently forward claims. Some relate to actions by a patient and others by doctors. Mtomba (2016) noted that Zimbabwe Medical Association (ZiMA) indicated that health services providers like doctors, hospitals and other health providers would stop accepting medical aid and highlighted that medical or health insurance firms owed them $220 Million.

It is against this background that the study examined the inconsistencies in the payment of the health or medical fees to the health service providers.

1.3 Statement of the Problem

Public Service Medical Aid Society (PSMAS) is not paying health care service providers within the stipulated time frame. Medical aid societies, as stated in the Medical Schemes Act receive contributions monthly form members and pay or reimburse medical expenses to health service providers according to set scales and within a period of 60 days. Although the government remains committed to the provision of primary health care countrywide and selected facilities providing

advanced specialist services at affordable rates, the sector has not been spared by the current economic challenges. The Daily News (2017) reported that some doctors are suing PSMAS for owing $208 000 in unsettled claims. Further to this, it was reported that medical aid societies are not paying claims for health services provided to their clients. Some health insurers have gone for three years without paying service providers. It is against this backdrop that this study examined inconsistencies being faced by Premier Service Medical Aid Society (PSMAS) in Zimbabwe in paying health service providers.

1.4 Aim of the study

The aim of the study was to establish how delay in payment of medical expenses by medical insurer affected the health service providers

1.5 Research Objectives

The objectives of the research were to -

1. Identify the causes of delayed payments to health service providers by Premier Service Medical Aid Society
2. Assess the legislation available in the disbursements of funds to service providers
3. Measure the real impact of these payment delays on the general welfare of health services providers
4. Suggest possible solutions to the delays in payment to health service providers

1.6 Research Questions

The research study intended to answer the following questions: -

1. What were the causes of payment delays to health service providers by Premier Service Medical Aid Society?
2. What is the legislation available in the disbursements of funds to heath service providers?
3. To what extent did payment delays have on the welfare of health service providers?
4. What were the possible solutions to the delays in payment to health service providers?

1.7 Research Assumptions

It was assumed that delays in payment of medical expenses by the medical insurer affected the welfare of health service providers

1.8 Significance of the Study

The purpose of the study was to analyse the inconsistencies in the payment of medical expenses or costs to health service providers by health insurer.

1.9 Rationale of the Study

Most of the workforce in Zimbabwe has health insurance cover, which again has its own fair share of challenges including shortfalls and the longstanding disharmony between the insurers and the service providers. This study was significant in a variety of ways. It was ground-breaking in the sense that this topic had not been given a close analysis, more so in the Zimbabwean context in the wake of medical

aid insurance companies' failures that have been witnessed on the market. It would assist the existing medical aid societies to come up with appropriate strategies to manage organizational change influenced by the rapidly changing external market. It would also assist the government to come up with policies that would regulate medical aid societies so that the interest of the stakeholders would be served. The study would also help other scholars who intend to dig deeper into how medical aid societies operate. Hence, the need to explore the discord in the payment of medical expenses by health insurers in Zimbabwe so that the findings of this would assist in overcoming inconsistencies that are against the benchmarks of health service provision.

1.10 Delimitation of the study

All possible steps were taken to provide the findings in a holistic way, but no research is free from limitations (Creswell, 2013). The following is a list of delimitations observed in the study: The study was limited to health services providers located in Gweru and claimed medical expenses from PSMAS.

1.11 Limitations of the Study

The study could have focused on all health services providers in Zimbabwe, but due to limited time, the researcher therefore focused to limited health service providers in Gweru, Zimbabwe. However, the researcher utilized the available limited time to focus only on health service providers located in Gweru.

Participants experienced difficulties in answering some of the questions. Others were not free to answer some of the questions because of sensitivity of exposing or revealing vital information about their employers. In cognizance of all the stated

risk, the researcher collected data from respondents individually and assured them that the details would be treated with confidentiality and anonymity. The raw data that was collected was destroyed after the research project.

The researcher was also one of the heath service providers who claimed from PSMAS. Although all measures were taken to avoid being biased in favour of health care providers, some traces of bias could exist in the research work.

1.12 Structure of the study

This study has five Chapters as summarized below -

Chapter 1 – This Chapter provided a summary of the study; the introduction, the background of the study, statement of the problem, research questions, purpose of the study, significance of the study, research assumptions, rationale of the study, delimitations of the study, limitations of the study, and structure of the study.

Chapter 2 – In Chapter 2 the researcher gave a review of pertinent literatures in relation to the study topic. The chapter delved into past and present global empirical evidence on health insurer disbursement of funds to health service providers. It then narrowed down to the local context of the area of study.

Chapter 3 – It provided step by step review of how the research was conducted. It stated research design, population and sample, sampling technique, instrumentation, primary data gathering and statistical analysis.

Chapter 4 – It presented findings, interpretation and analysis of primary research data with a view of matching it with the existing literature outlined in chapter two. The responses from the research instruments were presented in various graphical models to ensure clarity and consistency.

Chapter 5 – This chapter included an analytical discussion of the findings presented in the previous chapter in order to extract information that could either be associated with the existing literature or refute findings of previous research. The chapter assessed whether the study had met the set objectives that had been presented.

CHAPTER 2 REVIEW OF RELATED LITERATURE

2.1 Introduction

Chapter two presents a review of the literature pertinent to the theoretical and conceptual basis of this study which is the assessment of problems faced by private health service providers when obtaining payments after claims on health service provision.

Literature review plays a crucial role in this research. Muranda (2004) concur that literature review tells about prior research and findings in the same field. This chapter encompasses the different theories and /or models related to the topic and also identify knowledge gaps, as well as strengths and weaknesses in previous studies so as to determine what has already been done and what is yet to be studied and improved. This will assist in discovering connections and other relations between different research results by comparing various investigations. This section encompasses studying of pros and cons of research methodology used in other research related studies in order to adopt them in this study. In other words, its purpose is also to improve upon them in the context of this research. The subsequent thematic areas will be reviewed encompassing the causes of delayed payments to health service providers, impact of these payment delays on the general welfare of health services providers and possible solution to the delays in payment to health service providers.

2.2 Theories and models of health care services financing

2.2.1 Conventional theory and Nyman's access theory of demand

The conventional theory of demand for health insurance and Nyman's access theory of demand for private health insurance seem to dominate the health insurance literature. According to Santerre and Neun (2010), many of the choices individuals make as health care consumers and providers, involve a substantial level of uncertainty. This uncertainty stems from illnesses occurring randomly, unpredictable timing and amount of medical expenses, and therefore patient load and types of treatment also become unpredictable. Santerre and Neun (2010) further argue that people generally dislike risk and are willing to pay some amount of money to avoid it. Consumers thus gain from entering some risk pooling arrangements as this reduces the variability of the expected losses.

The conventional theory explains factors affecting demand and the uptake of health insurance based on the expected utility model. Santerre and Neun (2010) maintain that the pricing mechanism of insurance, one's degree of risk aversion, the preferential tax treatment of health insurance premiums, and government subsidy on the purchase of health insurance, are all key determinants of health insurance participation or involvement. They further underscored that the subjective probability of an illness occurring affects the amount of health insurance demanded. Feldstein (2005) tends to concur with Santerre and Neun (2010) in underlining the tax-exempt aspect of health insurance premiums and the price effect of health insurance on medical care services as key in the consideration to purchase health insurance coverage. It is thus possible to deduce from such assertions that the uptake

of health insurance products may be motivated by the perceived decline in the cost of medical services and the subsidy component from government.

On the other hand, Nyman's access theory of demand for private health insurance suggests that people value medical insurance because they desire an income transfer from those who remain healthy in the event, they become seriously ill (Nyman,2005). According to Nyman (2005), his access theory of demand for health insurance holds that people purchase health insurance to obtain additional income when they become ill. Insurance companies thus merely transfer insurance premiums from those remaining healthy to those becoming ill. The new theory appears to present a departure from the conventional theory's emphasis on risk avoidance as the major drive in health insurance participation, to the income transfer, as a desired objective when deciding to take up health insurance cover.

According to Pacific Prime, (2017), health insurance is widely believed to be one of the most viable and authentic health financing systems. It does not only help in meeting the needs of the health system, but also provides less hurting health payment systems for households. To this extent it is preferable to cost recovery strategies and user fees in much of the developing world. Much of the literature on demand for health insurance, tend to subdivide between the conventional theory, originally explained by Pauly (1968) and the new theory, for which Nyman (2005) is one of the proponents. Whilst the conventional theory places emphasis on the price effect of insurance with moral hazard and adverse selection as key challenges of the insurance market and hence welfare decreasing, the new theory looks at insurance as a process facilitating income transfers from those who remain healthy after subscribing to a pool of central finds, to those who become ill. Nyman (2005)

suggests that health insurance is thus purchased to obtain that transfer, which is the difference between the payoff and the premium.

The conventional theory according to Nyman (2005) holds that people purchase insurance because they prefer the certainty of paying a small premium to the risk of getting sick and paying a large medical bill. One can quickly see that according to this conventional theory, risks and certainties are an important explanatory variable in the demand for health insurance. People are thus compelled to participate in health insurance because they do not want to get stranded in the event of unforeseen need to pay large health care bills (Mack, 2011).

As seen by Newhouse (1978), for the purpose of researching the association between health insurance and demand, the central point is that insurance corresponds a subsidy to purchase medical care. Therefore, it lowers the per unit price of care. This philosophy is also in line with Nyman (2005) who argues that the conventional theory of health insurance has held that becoming insured acts like a reduction in the price of health care, just as if the price reduction had occurred exogenously in the market.

Parkin (2000) noted that everyone demands healthcare at some point in their life, but the people with the largest demands are the elderly, the very young and the chronically sick. They further assert that the costs for most people are high though the frequency of use is low. They emphasize that it is the uncertainties about future incomes that make planning healthcare expenditures difficult, hence in a purely private market system most people choose to finance their health care by insurance. It should thus be evident from the foregoing discussion that uncertainties, age and one’s health status feature as key determinants of participation in health insurance.

2.2.2 Models of Health care services financing

2.2.2.1 Tax based system of health financing

Health financing systems like tax-based system in which government revenues are the predominant source for health care expenditures began in two different ways (Nessef & Ennajar, 2018). The Tax-Based System in the first set of countries was built on a basis provided by the earlier development of social or private health insurance. For instance, Britain passed its National Insurance Act in 1911, financed through payroll contributions, and did not adopt a universal tax-supported health system until after World War II (Haseltine, 2013). This design is most prevalent among Western European countries. In the second set of countries, the Tax-Based System developed from health services administered directly by colonial regimes.

2.2.2.2 Bismarck's Model

Bismarck's model is the oldest health insurance system, and it originated in Germany (Prussia) in 1883. It was named after Otto Bismarck, former Chancellor of Prussia, who first applied it. The basis of this model is compulsory social security funded from insurance funds. Health insurance funds collect funds and pay for services. Funds are collected from employee and employer contributions from gross income, and the state pays health insurance fund of health services for protected population groups. Payment of contributions is proportional to revenues, and this system allows fairness according to principle of financing according to the possibilities. In this type of insurance, principle of solidarity is the most important, which means that contributions are paid by everyone and those who need it during the year. Health facilities and equipment are mainly state-owned. The countries in which this model

is represented are Germany, the Netherlands, France, Austria, Belgium, Luxembourg and Slovenia (Khaled Ennajar & L.Nessef, 2018).

Mack (2011) established that the issue of National Health Insurance (NHI) scheme became one of topical issues debated in most countries. It was also noted that Germany became the first country to provide NHI under the leadership of Prince Otto von Bismarck, enacted a compulsory sickness-insurance law. This was introduced because Bismarck had a socialist mentality of governance. Germany also became one of the first countries to have a modern social security system. Mack (2011) in his study indicated that they are about 39 countries that provide NHI.

2.2.2.3 Semashko's Model

The model initiated in the Soviet Union and countries of Eastern and Central Europe that had socialist social order. Semashko advocated the view that socialist state institutions are obliged to provide everyone in the country with the best possible free health care services (Saltman; Busse and Figueras, 2004). In socialist system, the property was state-social, so it was with the infrastructure in health care, and all health services were available to every member of society. Health services are financed from a tax-filling budget (Haugen, 2014). The government is directly responsible for the amount of funds allocated for health. The planning of allocation of funds and investment management was under the jurisdiction of state administration.

Though this model was initiated out of the need for social order it was criticized for insufficient utilisation of primary health care and excessive hospital treatment, mismatch of health services with the needs of population, deviation from international standards in the quality of health services and the amount of salaries

paid to healthcare employees, limited access to modern technology, and inadequate planning of trained personnel per population. This model was blamed for its market dysfunctional with the reforms that took place in countries of Eastern and Central Europe (Saltman et al., 2004).

2.2.2.3 The Beveridge Model: single-payer National Health Service

The Beveridge Model was first developed by Sir William Beveridge in 1948. Established in the United Kingdom and spreading throughout many areas of Northern

Europe and the world, this system is often centralized through the establishment of a national health service. The government acts as the single payer, eliminating competition in the market and generally keeping prices low. Funding health care through income taxes allows for health care to be free at the point of service – after an appointment or operation, the patient does not have to pay any out-of-pocket fees because of their contribution through taxes. Under this system, a large majority of health staff is composed of government employees. A central tenant of this model is health as a human right. Thus, universal coverage is guaranteed by the government and anyone who is a citizen has the same access to care (Chung, 2017)

With the government as the sole payer in this healthcare system, costs can be kept low and benefits are standardized across the country. However, a common criticism of this system is the tendency toward long waiting lists. Because everyone is guaranteed access to health services, over-utilization of the system may lead to increasing costs. There are fears that adoption of a single-payer national health service in the US would lead to an increase in demand for all procedures, even medically unnecessary ones because citizens would not pay upfront costs for these services. However, other analysts argue against this problem, stating that current

American practices waste a similar amount of money covering the uninsured. (Chung, 2017)

Another practical concern is the government response to crisis. In the case of a precarious national emergency, such as war or a health crisis, funding for health services may decline as public revenue decreases, exacerbating the financial burden inherent in a large influx of patients. Such a situation would require careful allocation of emergency funding before the crisis. Examples: The United Kingdom, Spain, New Zealand, Cuba, (Chung, 2017)

2.2.2.4 The national health insurance model

The national health insurance model has its origin in the Canadian system of health care that originated in Saskatchewan in the late 1940s (Centers for Medicare and Medicaid Services, 2010). It was established that Saskatchewan Premier Tommy Douglas was the architect of the plan, providing public coverage for residents through the Saskatchewan Hospitalization Act (Stefanacci, 2006). Through debate, short-term strikes by the medical community, rancour and discussion, the will of the Canadian people remained steadfast for a health care system nationwide. The Canadian Health

Act, providing for a universal plan throughout Canada, was passed by the Canadian Parliament in 1984 (Reid 2009). Each of the 10 Canadian provinces and three territories administers its own plan (Reid 2009). This model of structure, delivery, and financing contains elements of both the Beveridge and Bismarck models. This system uses private-sector care providers coupled with universal coverage with one payer – the Canadian government. The Canadian system is a true national health insurance model, and is guided by following principles: publicly administered

throughout all provinces, comprehensive coverage for all services, universal, home jurisdiction covers the individual until residency status is settled during any waiting periods.

In a study by Mack (2011) it was noted that the Taiwanese (Republic of China), when constructing a revised health care system in the 1990s, chose a model most like the national health insurance model, with elements of the Beveridge model. South Koreans followed the same model in its health care service delivery. The formula for payment to physicians and the process for paying physicians on behalf of Medicare clients are in need of alteration (Cox, 2009). Three times in 2010 before the end of the fiscal year, stop-gap intercessions were made to stem the implementation of a 21–23% decrease in payments to physicians. In 1997, as part of the budget reconciliation, the US Congress passed a balanced budget law that put the current formula in place, determining how doctors will be paid.

2.3 Health services provision concept

Health services provision is mostly provided by the government in most African countries (Mudyarabikwa, 2000). Kenya Healthcare Federation and Task Force Health Care (2016) in its report noted that the healthcare sector falls for a large part in the public domain in which the Government of Kenya is very dependent on external donor funding. This has however increasingly become difficult due to public sector resource shortage caused by fiscal deficits, heavy external debts, shrinking donor funds and in some cases, looting of public funds by civil servants (Mudyarabikwa, 2000). Further to this analysis, like many other countries, Zimbabwe has the dilemma of finding the best ways to address the health needs of its population and economically develop the country to boast of a population with a

satisfactory quality of life. Due to this reason the public sector realized the importance of the private sector as a complementary partner in health provision. Private health providers in Zimbabwe include conventional and traditional health practitioners as well as private health financing bodies in the form of medical aid societies.

Traditionally, the rise in personal health costs is that, as Medicare and Medicaid (government-sponsored coverage) have attempted to stem health care cost increases, costs have shifted from providers (hospitals, physicians) to the private sector (private health insurance payments) (Chernichovsky and Leibowitz 2010). Medicare and Medicaid have also amplified both in terms of numbers of covered individuals as well as the expenditures paid on their behalf. Examples of this cost shifting include private out-of-pocket payments for deductibles, co-payments, co-insurance, and/or payment for items not covered under health insurance plans such as over-the-counter drug products, eyeglasses, and dentures.

The majority of health services in Zimbabwe are provided by the public sector (Ministries of Health and Child Welfare and Local Government, and to a lesser extent through Ministries of Education, Defence, MOHCW, Home Affairs and Prison and Correctional Services, both in rural and urban areas. Public sector health services are complemented by the private sector, which includes both private for profit (e.g. industrial clinics, private hospitals, maternity homes and general practitioners) and not-for-profit private sector (e.g. mission clinics and hospitals and Non-Governmental Organizations) health facilities.

2.4 Causes of delayed payments to health services providers by Health insurers or Medical Aid Societies

Mudyarabikwa (2000) noted that Medical Aid Societies have operated in the Zimbabwe for many years as private entities responsible for paying for health services consumed from both the public and private sectors. It is nevertheless estimated that about 75% of the Medical Aid Societies pay-out finance services of conventional private practitioners (NAMAS 1998). In the National Assembly, Thursday, 23rd June 2016 the then Minister of Health and Child Care Dr. Parirenyatwa acknowledged inconsistencies of the health care services funds disbursement by health service insurer. In his address he noted that providers claim and having in some instances provided a proof that their claims usually remained unpaid for periods in excess of the statutory 60 days and sometimes for periods of up to 6 months or more. This has prompted health service providers to resort to cash charges until such a time that their insurers where ready to meet their obligations in a timeous manner. He further raised concerns that the given situation will obviously disadvantage and stress the client who is rightfully insured but has to be exposed to out of pocket expenditures.

Historically, insurers have not been very customer centric. Sagan and Thomson (2016) postulated that insurers reimburse providers in regards to negotiated tariffs, which can differ from provider to provider; big hospitals, for example, often dictate reimbursement mechanisms to insurers, which means insurers are passive price-takers and do not engage in active purchasing. Insurers' capacity to engage in active purchasing is limited for a variety of reasons as most of them do not have specialists with skills in active purchasing, lack of standard treatment guidelines makes it more difficult for insurers to negotiate terms with providers and some providers have monopoly power (Martirosyan, 2012). Adamchak (1996) is of the view that the scale

of fees reimbursable by the medical aid societies is negotiated annually in collaboration with physicians, represented by Zimbabwe Medical Association. This kind of tariff code is known as the Zimbabwe Relative Value Schedule, but while not all physicians charge according to the tariff code, most do so (Adamchak, 1996).

Medical aid has historically been on average below costs resulting in payment shortfalls. However, hospital payment rates are often bolstered by additional supplemental payments in the form of Disproportionate Share Hospital Payments (DSH) and other supplemental payments. After accounting for these payments, many hospitals receive Medical aid payments that may be in excess of cost. Understanding how much Medical aid pays hospitals is difficult because there is no publicly available data source that provides reliable information to measure this nationally across all hospitals. Different data sources use different definitions of what counts as payments and costs, so estimates are sensitive to these data limitations.

In other studies, changes in policy have been cited as one of the causes of delayed payments the Affordable Care Act (ACA) is leading to changes in hospital payer mix, especially in states adopting the Medicaid expansion where studies have shown a decline in self-pay discharges and a corresponding increase in Medicaid discharges (Rudowitz 2015; Bachrach, 2015 and Nikpay et al., 2016).

Society of Actuaries (2015) indicated that medical expenditure globally has been complex and continue to attract much attention amongst the various stakeholders including government. A consequence of payment reform is that the models can result in less revenue for the provider in terms of serving existing patients. In addition, the large amount of start-up and ongoing administrative costs makes these models even more expensive to providers. For payers and members, curbing trends

in health care costs is desirable, leading to both lower premiums and lower member out-of-pocket (OOP) costs. However, patients, providers and insurers do not want lower medical costs to equate to lower quality and continued lack of coordination, which can lead to serious complications, readmissions, and unnecessary pain and suffering for patients and their families.

One of the causes of delayed payment in countries like Ghana is time to claim resolution (Unge, et al 2008). Most of the loopholes are primarily within a transfer from claimants, insurers and policyholders and their representatives to Medicare or MedicAid, the appropriate degree of such transfers is largely a normative question about which different stakeholders may disagree. Nevertheless, all things being equal, the system would desire less delay in determining cases, as delay intensification of administrative costs for all parties increases reserving costs for insurers, and reduces the value of settlements for claimants and Medicare and Medicaid due to time preference (Alaro, 2017)

Over time, state or government budget pressures have caused an increasing reliance on supplemental payments (versus base payments) to finance private health service providers and Medicaid hospital services (USAID, 2012). Nonetheless, a number of imminent policy changes, including reductions in DSH payments and limits on other supplemental payments, will restrict the use of supplemental payments. Federal officials from the United States believe that reform of Medicaid supplemental payments is needed to make payment more targeted, transparent and consistent with delivery system reforms that reduce health care costs and increase quality and access to care (Willis-Shattuck et al, 2008). However, these policy changes are causing concern among hospitals that have long been dependent on Medicaid revenue for their financial viability (America's Essential Hospitals, 2016; Weaver, 2015;

Kentucky Hospital Association, 2015). In addition, payment changes are occurring against the backdrop of coverage expansions under the ACA, which are affecting payer mix for some hospitals.

2.5 Minimizing delays in payment to health service providers

Payment system is changing in healthcare globally. In this changing climate, revenue must be managed differently to ensure that have value delivered to patients is paid for appropriately both in terms of accuracy and timeliness. One of the ways that can minimize delay in payments is understanding claim in the context of the revenue cycle (Eijkenaar, 2012 and Infante, Meit, and Hargrave, 2010). It is envisaged that health service providers like hospitals and physician practices to ensure that their claims are paid, they must first understand how the different components of claims management affect reimbursement.

Obstacles to accessing health services can stem from the demand side and/or the supply side (Ensor and Cooper 2004; O'Donnell 2007). Demand-side determinants are factors influencing the ability to use health services at individual, household or community level, while supply-side determinants are aspects inherent to the health system that hinder service uptake by individuals, households or the community. The need to differentiate demand-side from supply-side barriers is related to the formulation of appropriate interventions, although O'Donnell (2007) notes that both sides have to be addressed concurrently. This is reinforced by James et al. (2006), who argue that access barriers may not always be mutually exclusive and may interact and influence each other.

It has been revealed that some of the nation's biggest insurance companies like Allstate, AIG, and State Farm among others have denied valid claims in an attempt to boost their bottom lines. These companies have rewarded employees who

successfully denied claims, replaced employees who would not, and when all else failed, engaged in outright fraud to avoid paying claims (American Association for Justice).

The delays in the payment of the claims made by health service provider in low and middle incomes countries is largely placed on major constraints on government budgets. It has been realized that the major funding source for healthcare expenditure in most countries is the government. The international Monetary Fund has recommended that countries increase the scope of private sector provision in health care as part of loan conditions (Stuckler and Basu, 2009) often to reduce government debt (Elliott, 2009).

Several studies suggested that the process of privatizing existing public services increased inequalities in the distribution of services. Analyses of the Tanzanian and Chilean health systems found that privatization led to many clinics being built in areas with less need, whereas prior to privatization government clinics had opened in underserved areas and made greater improvements in expanding population coverage of health services (Elliot, 2009; Scarpaci, 1987). Privatization in China was statistically related to a rise in out-of-pocket expenditures, such that by 2001, half of Chinese surveyed reported that they had forgone health care in the previous year due to costs; out-of-pocket expenses accounted for 58% of healthcare spending in 2002 compared with 20% in 1978 when privatization began. The cost burdens of privatization related to an increase in disparities in healthcare coverage and infant mortality between urban and rural areas (Blumenthal and Hsiao, 2005). One survey based study using Demographic Health Survey data from 34 sub-Saharan African countries found that privatization was associated with increased access, and reduced disparities in access between rich and poor (Yoong,, Burger, Spreng and Sood,

2010). A second analysis of the same dataset, however, found no change in inequality in use of modern contraceptives with the expansion of the private sector (Agha, 2008).

Randall et al., (2014) revealed that there are four different ways of organizing systems and contracts in health care systems as shown in Figure 2.1. System I is a private good market, in which consumers buy health care services directly from providers. This system is still used in all countries for non-prescription drugs and many developed countries for certain specialized goods (like routine dental and eye care, and elective cosmetic surgery,) but is rare for the majority of health care services. Most consumers in Singapore and uninsured consumers in the US rely on a private good market, and pay for their health care when needed, without insurance.

In some cases, it has state that developed countries vary significantly in how they generate revenue used to fund health plans. In most countries, proportional or progressive taxes earmarked for health care use as the primary source of revenue (like Canada, Germany, Singapore and Japan) although in some cases general tax revenues predominate. In the US and Japan, since employers are the primary sponsors, revenue comes from premiums paid by each worker (Hall, 2013). In the US, the premium is typically shared between the employer and the employee with the employer free to choose the portion of the premium paid by the employee. State and federal tax systems partially subsidize health insurance in the US, by allowing these health insurance contributions to be exempt from income taxes, a widely discussed subsidy of health insurance and potential distortion. In Japan and Germany, premium contributions are set by law at a fixed rate which is evenly split between employees and employers.

Randall et al (2014) in his study established that there are challenges of controlling health care cost and countries vary significantly in their methods for doing so. Fundamentally there are only four broad strategies for controlling health care costs: demand-side cost sharing, or using prices imposed on consumers to encourage them to reduce utilization; supply-side cost sharing, or using prices paid to suppliers to reduce utilization and/or reduce plan payments per unit; non-price rationing, or setting limits on the quantity of key resources available to provide health care, whether done by the government sponsor or by individual health plans; and information provision that influences care provision and demand.

The National Health Services in UK is funded by taxation with a fixed budget available to spend on services for the whole population (Mack, 2011). The challenge faced by the NHS is how to spend that budget in a way that results in the best possible outcomes for individual patients and delivers value for money for the public (Erasmus,2016). This planning and purchasing of NHS services is undertaken by organisations (or individuals) known as commissioners. They are responsible for assessing the reasonable needs of their populations and using their buying power as purchasers to secure services that are affordable and of the highest quality. They can buy services from any provider that meets NHS standards of care and prices. Slowly increasing cost of health care and rapid increase of population and unexpected changes on average incomes courses difficulties to provide with the right service and financing of those services. Purchasing of necessary health care was not a problem for the modern countries which were at average or higher income level.

In Australia, for instance, a single private policy may cover out-of-pocket costs for some services, cover new services and also allow the enrollee to opt out of using the public insurance system for a specific hospitalization (Parekh, 2011). In a study by

Udaychandran (2010), it was observed that there was need for new products predominantly long term in nature specifically in health insurance sector, health savings account would be a wise proposition and by designing the product that would be outstandingly unique but given that it should be within the constraints of regulatory approval.

Germany allows specified high-income households to purchase replacement policies instead of the primary policy. The type of secondary insurance available in a country depends on the regulatory environment and the structure of the primary insurance mechanism (Campbell, et al., 2009; Pauly and Swanson, 2013). For example, replacement insurance is banned in Canada, but encouraged in the US for elderly or disabled Medicare enrollees. In countries where primary health insurance does not exploit consumer cost sharing, consumers will have no incentive to purchase complementary insurance. Almost every health insurance system as highlighted by Pauly and Swanson, (2013) create a demand for supplementary insurance, that is, coverage for services not covered by the primary policy. Chiropractic care, dental care, optometry, physical therapy, and pharmaceuticals are cited as common examples of services excluded from primary insurance but often covered by supplementary insurance. Vian (2008) is of the view that coverage for non-hospital based prescription drug purchasing is in some cases covered in the primary policy in countries like Germany, Japan, and some Canadian provinces but not in others (many US plans, Singapore), though in Singapore there is a short list of prescription drugs that can be obtained free from charge from approved providers.

Economic theory suggests that the magnitude or size of the reward should be proportionate to the effort required to obtain the performance improvement, but in reality this relationship is often unclear and the optimal size of the reward remains

uncertain (Policy Innovation Research Unit (PIRU), 2013 and Glasziou, et al, 2012). In theory, larger incentives are associated with greater improvements in performance compared with smaller incentives (Werner, et al., 2010), with the latter risking being insufficient to incentivise change. However, as the size of the reward increases, so too does the risk of adverse consequences. In the context of health care, some have challenged the theoretical framework above, and have argued that the size of the reward should be proportionate to the likely health gain and thence the value associated with achieving each performance target, rather than the amount of effort required by the provider to reach that target (Fleetcroft and Cookson, 2006 and Gupta and Bhatia, 2019). While this could be attractive in theory, in most cases pay-for-performance (P4P) schemes have to be negotiated with providers (for example as part of the industrial relations bargaining between professional groups and public funders) who are far supplementary possible to prefer effort-related performance payments than value-related performance payments as the likely relative costs of achieving the necessary target are built into the former but not the latter.

2.6 Conceptual Framework

The conceptual framework explains the path of a research and grounds it firmly in theoretical constructs (Adom, Kamil and Agyem, 2018). The overall aim of the framework is to make study findings more meaningful, acceptable to the constructs in the study field and ensures generalizability. A research without the conceptual framework makes it difficult for readers in ascertaining the academic position and the underlying factors to the researcher's assertions and/or hypotheses (Adom, Kamil and Agyem, 2018).

The conceptual framework offers many benefits to a research. For instance, it assists the researcher in identifying and constructing his/her worldview on the phenomenon to be investigated (Grant & Osanloo, 2014). It is the simplest way through which a researcher presents his/her asserted remedies to the problem she/he has defined (Liehr & Smith, 1999; Akintoye, 2015). This renders the research sloppy and not appreciable as contributing significantly to the advancement of the frontiers of knowledge. The conceptual framework shows the relationship between Payment System and Effective Health Service in Gweru, Zimbabwe.

Source: Student's own construct adopted from the ideas of (Anfara, 2008)

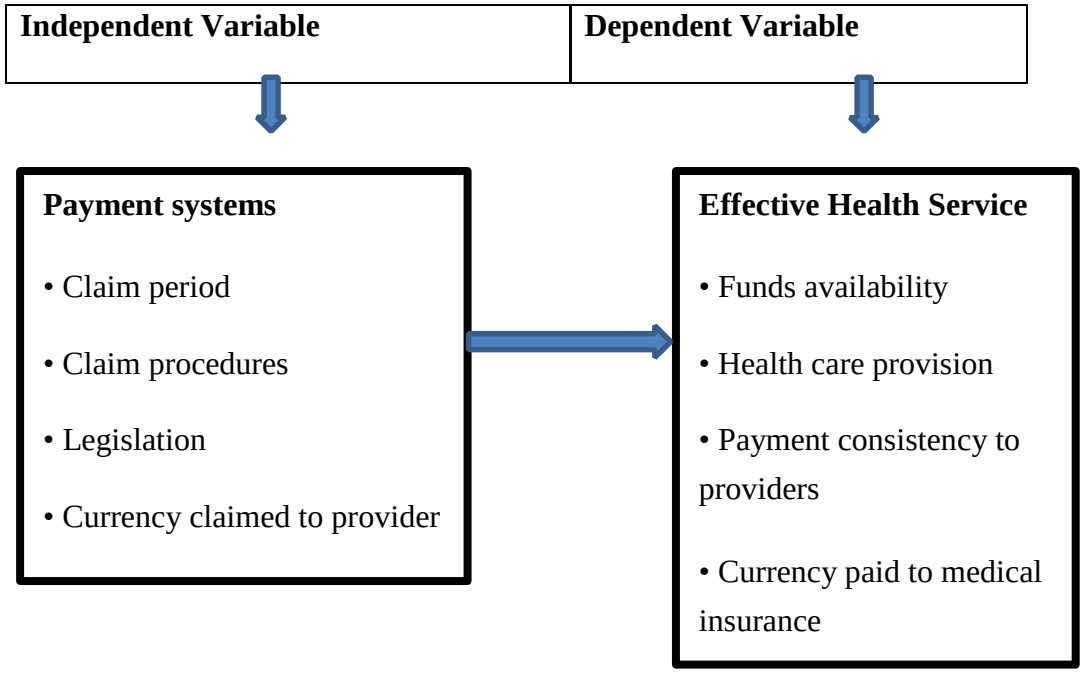


Figure 2 1: Conceptual framework on examining delayed payments

2.6.1 Independent and dependent Variables

The independent variable is the variable that is varied or manipulated by the researcher, and the dependent variable is the response that is measured (Anfara,

2008). An independent variable is the presumed cause, whereas the dependent variable is the presumed effect. Independent Variables are defined as a characteristic that researcher manipulate to identify a particular factor. Independent variables are also known as factor or prediction variable. The fact about the independent variable is that the participants of the study do not change it.

Dependent Variables are the second type of variables that are measured using independent variables. Dependent variables answer the question: 'What is it that individuals are testing?' and 'What is the measured response to various levels of the independent variable? Dependent variables are the result of the participants' actions and can be altered as the outcome of the participants' actions.

2.6.2 Payment systems as Independent variables

In the figure above, claim period, claim procedures, legislation and currency claimed to provider are independent construct in this study. The payment of health care service is taken as a complex process. It encompasses claim period, claim procedures, legislation, and currency claimed to provider. The above constructs will determine the effectiveness of the payment systems. Amasha (2015) indicated in their study that the delays in reimbursement are fraud, bureaucracy from National Health insurance. This delay is also attributed to inaccuracy of information filled by health service providers to the National Health insurance. It was concluded in the study that the delay has negative impact on the stock of medicines and medical consumables and timely provision of salary and incentives to health facility staffs. In a study by The Health Association of America (2003) it was mentioned that there are four reasons for delay in payment to health services providers. These were

unmatched codes and prior authorization necessity on pre-existing medical conditions.

2.6.3 Effective Health Service

Provider payment mechanisms (PPMs) create incentives or signals that influence the behaviour of health care providers (Kazungu et al., 2018). Understanding the characteristics of PPMs that influence health care providers' behaviour is essential for aligning PPM reforms for improving access, quality, and efficiency of health care services. WHO (2007) stated that effective health care services depends on funds availability, health care provision, level and structure of provider payments. It is further noted that to pay providers has been an area of contention among policy makers. It has been deduced that payment of health service providers could be via a budget remunerating a set of pre-defined health related activities in a lump-sum fashion. Ellis et al (2007) suggested that the payment system encompasses payment rates which are a key factor to providers and often reduces incentives for quality if they are too low. A high payment rate would increase health care providers' revenues (Perry, 2017), thus relaxing budget constraints and therefore enabling them to invest more in-service provision such as to increase the number of staff.

2.7 Chapter summary

Health care service provision is a crucial necessity of the modern world. The goal of health services provision is to improve health outcomes in the population and to respond to people’s expectations, while reducing inequalities in both health and responsiveness. In this chapter the researcher analyzed key academic literature on the research topic to position the study within the context of pertinent scholarly debates and thus show literature gaps depicting the relevance of the study. In

particular, the chapter contained the theoretical framework and empirical evidence of the study. The review of the literature related to delays in medical or health services provision and circumstances surrounding medical aid societies and how they process claims. This ending chapter provided theoretical background and helpful solutions to improve the mechanism for the processing of medical cost claims by the medical aid societies.

CHAPTER 3 METHODOLOGY

3.1 Introduction

This chapter focused on the research methodology of the study. Rajasekar et al (2013) states that the research methodology outlines the procedures to be followed by a researcher in order to describe explain and or predict a phenomenon. This means that, the research methodology was determined by the appropriateness of the research tools. The chapter looked at research designs chosen, population, sample and data collection instruments which were used. It also looked at data presentation, analysis and collection procedures used. Finally, it addressed the issue of research ethics to be observed.

3.2 Research design

Nachmias and Nachmias (1996); Creswell and Plano Clark (2011) state that, a research design is a program that guides the investigator as he or she collects, analyses and interprets observations. It is also a rational model of proof which permits the researcher to draw conclusions with regard to relationships among variables under investigation. The research design determines whether the results obtained can be generalized to a larger population or not.

The study used descriptive research design to summarise and organize data in an effective and meaningful way. Mugenda and Mugenda (2003) notes that a descriptive survey research attempts to collect data from members of a population in order to determine the current status (delay in payments of medical fees) of that population with respect to one or more variables. This study was descriptive survey as it set out to describe and interpret a situation (Etemesi 2004). According to Best

and Kahn (1993) study (as cited in Muchire, 2003), descriptive research is also concerned with: conditions or relationships that exist, practices that prevail, beliefs, point of view, or attitudes that are held by people, processes that are going on, effects that are being felt, or trends that are developing. It is concerned with what exists and related to the preceding event that has influenced or affected a present condition or event. Therefore, this study required such research design as data was collected from various health services providers.

3.2.1 Case study justification

A case study, which is one of the research designs that can be employed in several studies, entails an empirical investigation of a contemporary phenomenon. It can be applied to investigate real life using multiple sources of evidence and is especially valuable when the boundaries between phenomenon and context are blurred (Yin, 2009). This design is widely used in research fields and disciplines of relevance to health service provision as well as community psychology.

The decision by clients to use services or adhere to treatment advice represent responses to many influences such as past experience from health services providers, the availability of cash to cover costs, the gender dynamics influencing household decision making and advice from family and friends. A case study can also involve either single case (of health service providers) for example individual health service providers. A case study is also regarded as a rigorous way that is secured by full reporting on the methods of data collection and analysis, so that readers can assess whether the analysis and interpretation is credible. The case study as a research design has the ability to deal with a full variety of evidence like documents, artifacts, interviews and observations.

3.3 Population and Sampling

3.3.1 Population and Target Population

To solve the problem of size, it is necessary to select a sample from the target population that would form the basis of the research study. A sample is a small proportion of the population that is selected for observation and analysis (Best & Kahn, 2006). For the purpose of this study, 55 participants (Those responsible for the finances from selected private health services providers) were purposely selected to answer the questionnaire and 10 top executives from services providers with highest amount owed to them were selected as key informants to participate in the interview. Probability sampling allows the investigator to generalise results of the study from the sample to the population from which it was drawn. Since generalisation in a statistical sense is not a goal of qualitative research, probabilistic sampling is not necessary or even justifiable in qualitative research (Merriam, 2009). Non-probability sampling was thus the method of choice.

3.3.2 Sample and sampling techniques

Sampling entails that a small group is chosen to represent the rest of the population (Cooper & Schindler, 2007). The targeted sample was from selected health services providers in Gweru. The respondents were picked on a judgemental and convenient basis which enabled the research to collect data at a possible available time. Hence, census and purposive sampling techniques were used in this study. The participants from selected private health services providers in Zimbabwe were for interviews and questionnaires. A timetable was drawn to determine the times of the field visits and interviews.

The targeted population was private health service providers that are providing health care services in Gweru. The study selected all 55 health service providers that were registered under the Zimbabwe Medical Association (ZiMA) in Midlands Branch. Hence, this allowed the researcher to select at all the participants (Curry, 1988). The selection of the sample size adopted and employed Dr John Curry's rule of thumb which denotes that for a population of 100 or below, a census is recommended.

Size of Population	Sampling Percent
0-100	100%
101-1,000	10%
1,001-5,000	5%
5,001-10,000	3%
10,000+	1%

Figure 3 1: The Rule of Thumb on sample selection Source: Yount (2006)

3.4 Data Collection Instruments

Questionnaires and key informant interviews, as data collection instruments, was applied in this study to collect data. Questionnaires were distributed to selected employees from the selected private health care providers in Gweru, Zimbabwe. Semi structured interviews were used to get primary data from key stakeholders in the private health services provision in Gweru.

3.5 Pilot Study

Pilot study was done to validate the research instruments. Creswell, (2012) postulated that a pilot study is a preliminary study conducted in order to assess the validity and reliability of the research instruments. Pilot study was done with 10 Health service providers in the private health services who were outside the sample fame. These pilot study respondents were located in Bulawayo. Four (4) executives from health service providers were also selected for interviews. The total number of respondents who were considered for pilot study was 14.

After conducting pilot study, the researcher adjusted the research instruments as some of the questions were vague or difficult to understand. The researcher took note of the issues raised and the research instruments were adjusted.

3.6 Reliability and Validity

The researcher carried out a pilot study which helped establish the instruments that were used in order for the instruments to measure what they were intended to measure before using them in the main study. The researcher made use of simple language and desisted from using technical terms that would confuse the respondents. Great care was used in choosing words and phrases which the target population could understand.

3.7 Data Collection Procedures

Alder, et al (2008) describes data collection as a process of gathering and measuring information on targeted variables in an established systematic fashion, which then enables one to answer relevant questions and evaluate outcomes.

Research letter from the AUREC warranting the investigation was presented to the Zimbabwe Medical Association, Midlands Branch, seeking permission to carry out the study. Permission was granted prior to data collection. Appointments were done with respondents pertaining to the date, time and venue for conducting interviews. Each interview lasted 20 to 30 minutes. The researcher also used questionnaire to collect data from the study area. Questionnaires were distributed to health services providers in Gweru. Participants were given one 2 days to complete the questionnaires.

Completed questionnaires were collected after 2 days. The researcher moved around interviewing the key informants from the sample frame.

3.8 Analysis and Organization of Data

The quantitative and qualitative data was analyzed. The collected data from interviews (qualitative) was categorized into thematic areas, presented as narrative and analyzed. The data collected from questionnaires (quantitative) was coded, entered and analysed using SPSS software. This allowed the researcher to present findings in graphs, pie charts and test the relationship of the variables. Qualitative data that was collected was presented and analyzed matching common trends deduced from quantitative data.

3.9 Ethical Consideration

The current study was subject to certain ethical issues. The researcher ensured that the following ethical considerations were fully observed in conducting the study.

Consent: All respondents were fully informed about the purpose of the research being conducted and assured that the purpose of the study and its findings will be used for academic purposes only.

Confidentiality: Any information obtained was not made available to or accessed by anyone but the researcher until published by Africa University.

Voluntary participation: Participation in this study was at the discretion of the respondents, and free from coercion.

Privacy: Under no circumstance was any individual asked to reveal their identity during and after the study.

3.10 Chapter Summary

This section has looked at the several aspects of the research methodology for conducting the study. It has described the research designs that were used that is mixed research approach and descriptive designs. The chapter also described the population and sample, sampling method and techniques with justifications for using them. Data collection, analysis, presentation procedures have been described and reasons for their adoption have been elaborated as well. The issue of validity and reliability was also explained. Finally the researcher also looked at some ethical issues to be considered when conducting the research.

CHAPTER 4 DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.1 Introduction

This chapter emphasizes data presentation, interpretation and analysis of the study findings. The findings have been presented in the form of descriptive statistics. The structured questionnaires were used to collect data. Statistical Package for Social Science (SPSS) version 21 software was used to analyze the data. Pie charts, graphs and tables were used to present data. The objectives of the study were to identify the causes of delayed payments to health service providers by PSMAS, measure the real impact of these payment delays on the general welfare of health service providers and suggest possible solutions to the delays in payment to health service providers.

4.2 Data Presentation and Analysis

4.2.1 Response rate

Research Instruments	Instrument distributed		Response rates	
	N	%	N	%
Questionnaire respondents	55	100%	50	90.9%
Interviews	10	100%	10	100%

Table 4. 1: Response rate

The researcher distributed 55 questionnaires and 50 were returned to give a response rate of 90.9 % to establish how delay in payment of medical expenses by medical insurer affect the health service providers. For the interviews there was a 100% response meaning all were able to air their views and these will be captured by respondents in the data analysis and interpretation to follow.

4.2.2 Section A Demographic Characteristics

Below are the findings on demographic characteristics of the respondents that include sex, age, and marital status, length of services in the organisation and levels of the respondents in the organisations.

4.2.3 Sex of the respondents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	31	62.0	62.0	62.0
	Female	19	38.0	38.0	100.0
	Total	50	100.0	100.0	

Table 4. 2 : Sex of the respondents

The table 4.3.3 above shows the sex of the respondents in the study which were 62% males and 38% females. The study was therefore dominated by males which constituted 31 males. This can be attributed to the dominance of males in the Health sector.

4.2.4 Age of the respondents

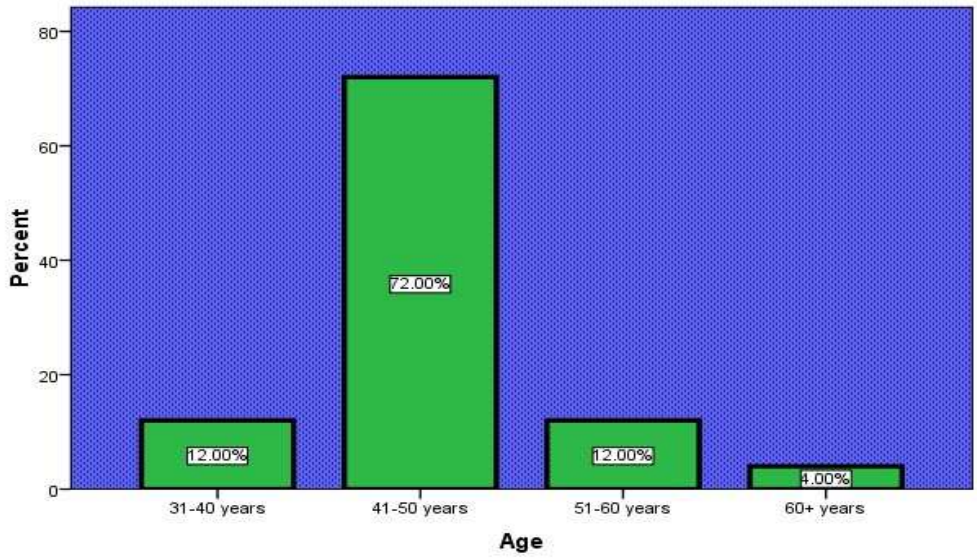


Figure 4. 1: Age of the respondents

The age of the respondents was 12% that were 31-40 years, 72% were 41-50 years, 12 were 51-60 years and those above 60 years plus were only 4%. The study population was dominated by those that were between the age ranges of 41-50.

4.2.5 Marital status of the respondents

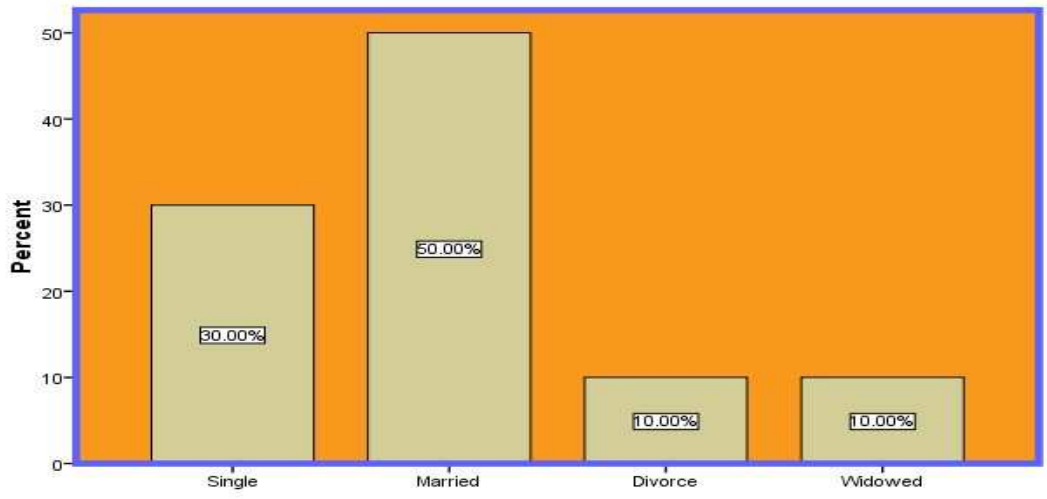


Figure 4. 2 : Marital status of the respondents

In the figure 4.3.3 above it shows the marital status of the respondents. The findings of the study indicated that 30% were single, 50% were married, and 10 % were divorce whilst 10% were widowed. The study was dominated by those who were married which constituted a half (50%) of the study population. The findings indicate that most of the health service providers were married.

4.2.6 Educational level of the respondents

In the figure 4.3.4 below shows the responses on the educational level of the respondents.

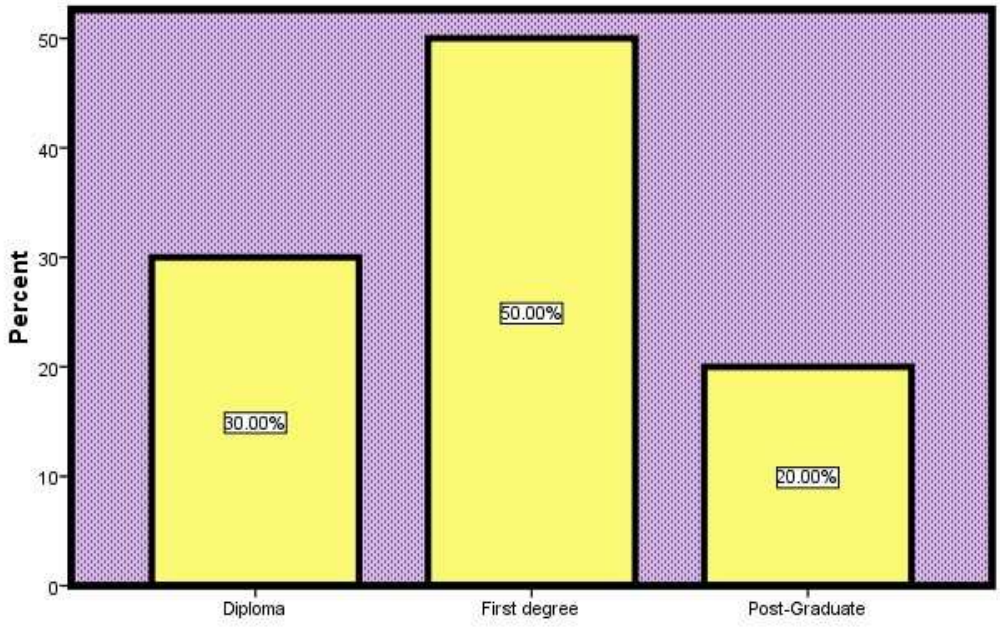


Figure 4. 3 : Educational attainment level of the respondents

The figure 4.3.4 above shows that 30% of the respondents were holders of diploma, 50% had first degree and 20% were holders of the post-graduate. The results indicate that the population under study was dominated by those with first degree followed by diploma holders. Those with undergraduate degrees could be health practitioners.

4.2.7 Length of service in the organisation in years

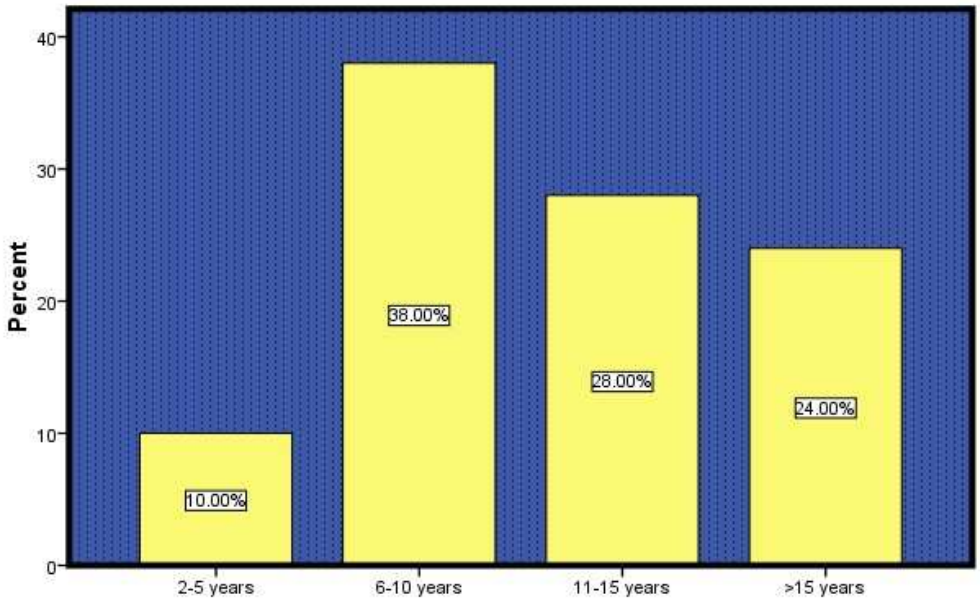


Figure 4. 4: Length of service in the organisation in years

The figure 4.35 above exhibit the findings of the study on length of service (years) in the organisation under the study population. It is indicated by the findings that 10% had 2-5 years, 38% had 6-10 years, whilst 28% and 24% had 11-15 years and more than 15 years, respectively. It can therefore indicate that the study was dominated by those who had 6-10 years and 11-15%. The findings of the study show that there are a number of players in the health services that had 6-10 years of services.

4.2.8 Levels of the respondents in the organisation

The respondents were asked to state their level in the organisational organogram

.		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Board member	20	40.0	40.0	40.0
	Executive management	22	44.0	44.0	84.0
	Middle management	8	16.0	16.0	100.0
	Total	50	100.0	100.0	

Table 4. 3 : Level of respondents in the organisation

The table 4.3.4 above indicates that 40% were board members, 44% represented by executives, while 16% were middle management. In the study it could be noted that board members and the executives constituted a larger percentage.

To identify the causes of delayed payments to health service providers by PSMAS

The findings below were the findings on the causes of delayed payments to health service providers by PSMAS.

4.2.9 Claims are not handed in time by the health services providers

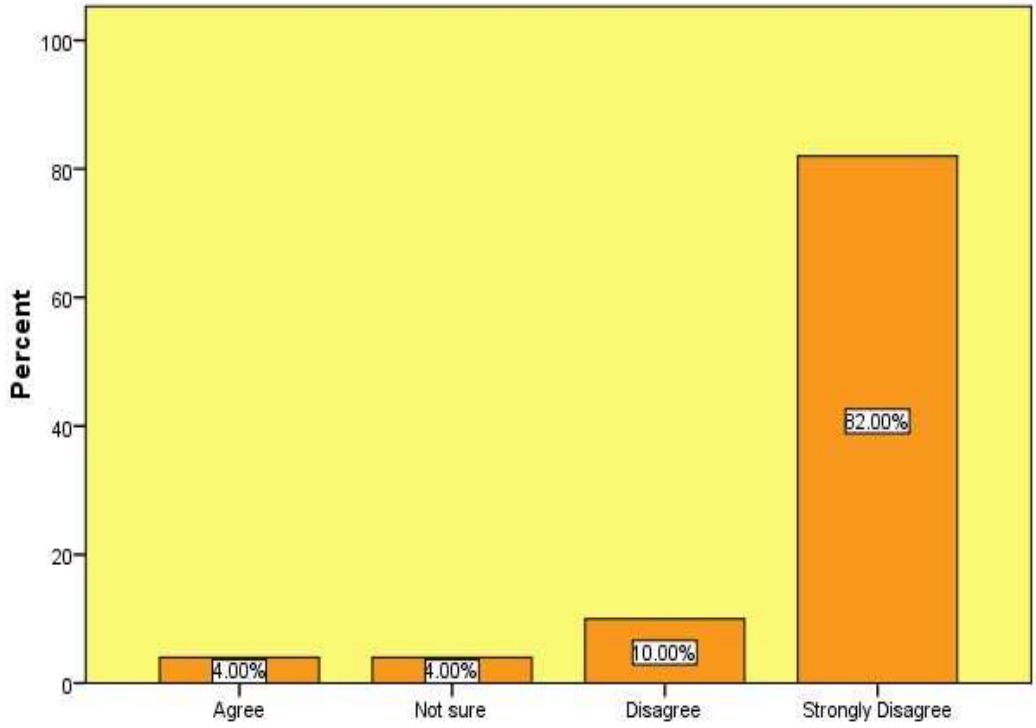


Figure 4. 5: Claims are not handed in time by the health services providers

Respondents were asked to rate the time taken by health service providers to hand in their claims to the medical aid society. The findings, as illustrated in figure 4.4.6 above, noted that 4% agreed, 4% were not sure, 10% disagreed and 82% strongly agreed. It was noted that most of the respondents disagreed (92%) that the claims were not handed in time. They dismissed any notion that the claims were not sent to health issuers in time. The same sentiments were highlighted in the interviews. Most of those interviewed indicated that claims were sent in good time, before the expiry period which was three months.

One of the interviewees noted that, “We hand claims in good time for PSMAS to process them.” (Key Informant 5)

4.2.10 The medical aid society takes more than 3 months to process payments

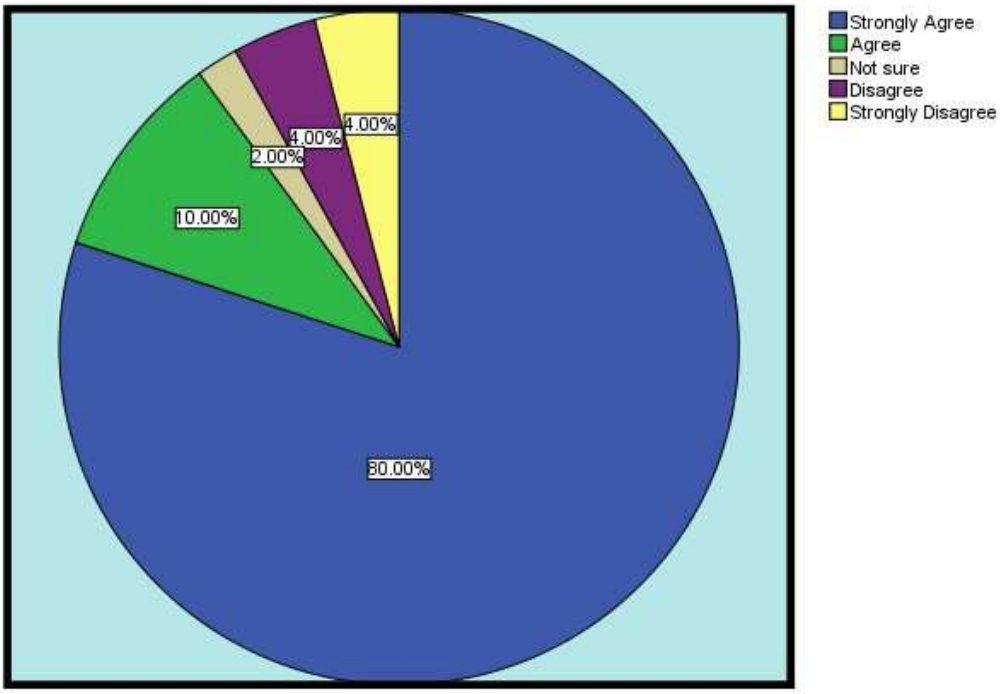


Figure 4. 6: Medical aid society takes more than 3 months to process payments

The figure 4.4.7 above summarizes the question asked on rating of the duration taken by the medical aid society in processing payments (from day claims are handed in by the health service providers up-to the processing of payments). It was noted from the findings (in figure 4.4.7) that 80% and 10% strongly agreed and agreed respectively, while 8 % cumulatively disagreed and 2% were "not sure". The findings indicated that the medical aid society did not process the payments in stipulated 3 months as indicated in the statutory instrument. Most of the responses from the interviews noted that the medical aid society took time to process the payments. One of the interviewees stated that the medical aid society (PSMAS), always blamed their biggest client (Government) for not paying subscription on time. One of the interviewees said that**, "**When payment is delayed, we follow-up

with PSMAS, they always site lack of funds from government as a reason for delayed payment." (Key informant 4)

4.2.11 Verification process done by medical aid society takes too long

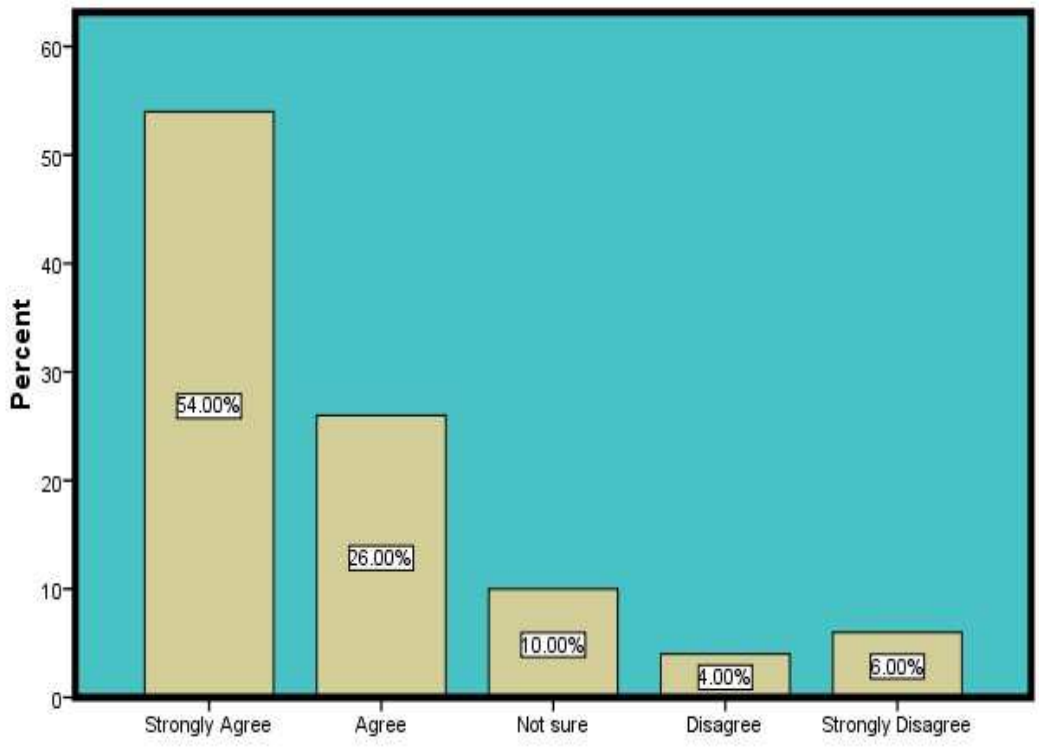


Figure 4. 7: Verification process done by medical aid society takes too long

Respondents were asked to rate the verification process period done by the Medical Aid Societies. The findings, as noted in the figure 4.4.8 above, indicate that 54% strongly agreed, 26% agreed, 10% were "not sure" whilst 10% disagreed that the verification process took long. The results indicated that verification process by the medical Aid Society took long, hence the delayed processing of health service providers' payment.

4.2.12 Medical Aid Society does not use proper technology to help in processing of claims

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	31	62.0	62.0	62.0
	Agree	9	18.0	18.0	80.0
	Not sure	8	16.0	16.0	96.0
	Disagree	1	2.0	2.0	98.0
	Strongly Disagree	1	2.0	2.0	100.0
	Total	50	100.0	100.0	

Table 4. 4: Medical Aid Society does not use proper technology to help in processing of claims

Respondents were asked to rate whether the Medical Aid Society was using proper technology to assist in processing of claims. The findings, as noted in table 4.4.5, indicated that 80% cumulatively agreed, 16% were not sure and only 4% did not agree with the notion that Medical Aid Society was not using proper technology to help in processing of claims. It was noted that most of the respondents agreed that there were some challenges in the application of technology on the processing of claims. Though, this could be one of the challenges on why processing took long, there were other factors that could contribute to the delay of the process.

4.2.13 Medical Aid society does not have strong financial base to settle claims within 90 days

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	**Strongly Agree**	3	6.0	6.0	6.0
	Agree	2	4.0	4.0	10.0
	Not sure	5	10.0	10.0	20.0
	Disagree	5	10.0	10.0	30.0
	Strongly Disagree	35	70.0	70.0	100.0
	Total	50	100.0	100.0	

Table 4. 5: Medical Aid society does not have strong financial base to settle claims within 90 days

The respondents were asked to rate whether the medical aid society had a strong financial base to settle claims. The findings, as stated in table 4.4.6 above, shows that 10 % cumulatively agreed, 10% were not sure and 80% cumulatively disagreed. The findings of the study concluded that the Medical Aid Society had a financial base that could accommodate the payment of claims by the health service providers. This could be substantiated by the response from the key informant interviews where most of the interviewees stated that the medical aid had a strong financial base of subscribers who are mostly government workers. The government as the

largest employer in the country does the largest contributions to the medical aid society.

One of the interviewees said that, “Some of the top management executives in the medical aid society were reported to be probably the highest paid in the country, earning about USD500 000 per month. (Key informant 6). The medical aid society was therefore regarded as an entity that had financial resources that could be sued to pay its creditors. Time taken for payments

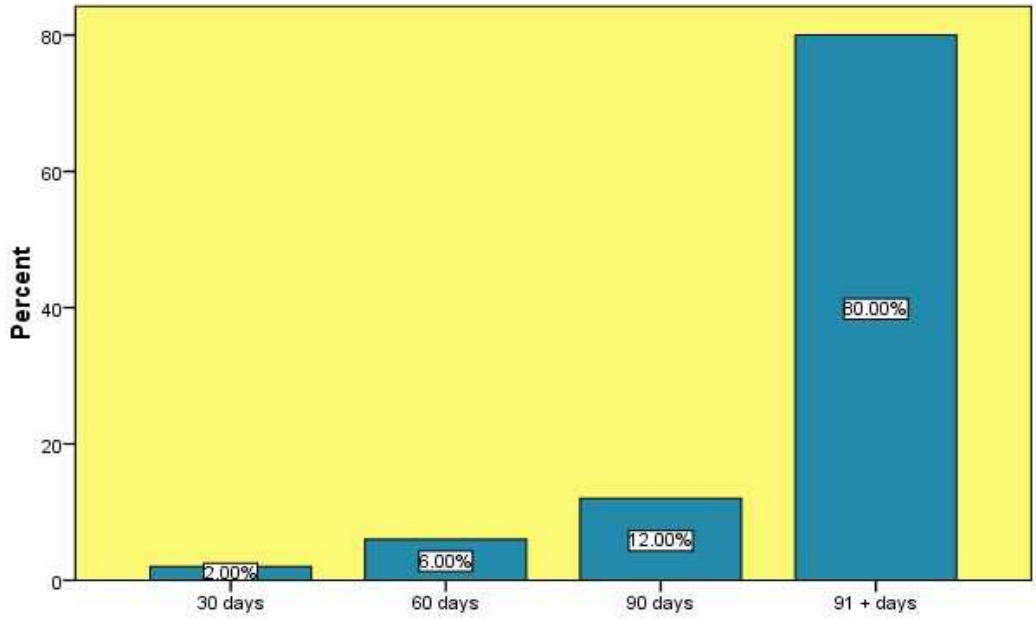


Figure 4. 8: Time taken for payments

Respondents were asked about time taken for payments. The times were categorized into 30 days, 60 days, 90 days and 90 plus days. It was (figure 4.4.9) noted that large percentage of the respondents indicated that most payments were received after 90 plus days (80%), whilst 12 % received their payments within the 90 days window period and very few (6%) received their payments within 30 and 60 days.

The finding indicates that most of the payments were received after 90 days, which was beyond the stipulated settlement period.

4.2.14 Do you have pending PSMAS claims that have not been paid within 90 days

Do you have pending PSMAS claims that have not been paid within 90 days					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	49	98.0	98.0	98.0
	No	1	2.0	2.0	100.0
	Total	50	100.0	100.0	

Table 4. 6: Pending PSMAS claims that have not been paid within 90 days

From Table 4.4.7 above, findings noted that 98% indicated that they had pending PSMAS claims that had not been paid within the stipulated 90 days while 2% denied. It can be noted that most of the respondents within the study indicated that their payments were still pending even after the 90 days window period. This is a clear indication that the medical aid society delayed in settling claims with health service providers.

4.2.15 To measure the real impact of these payment delays on the general welfare of health Services providers

Below are the findings on the rating of the effect of delayed payment of claims in regards to day to day operations of the health service business

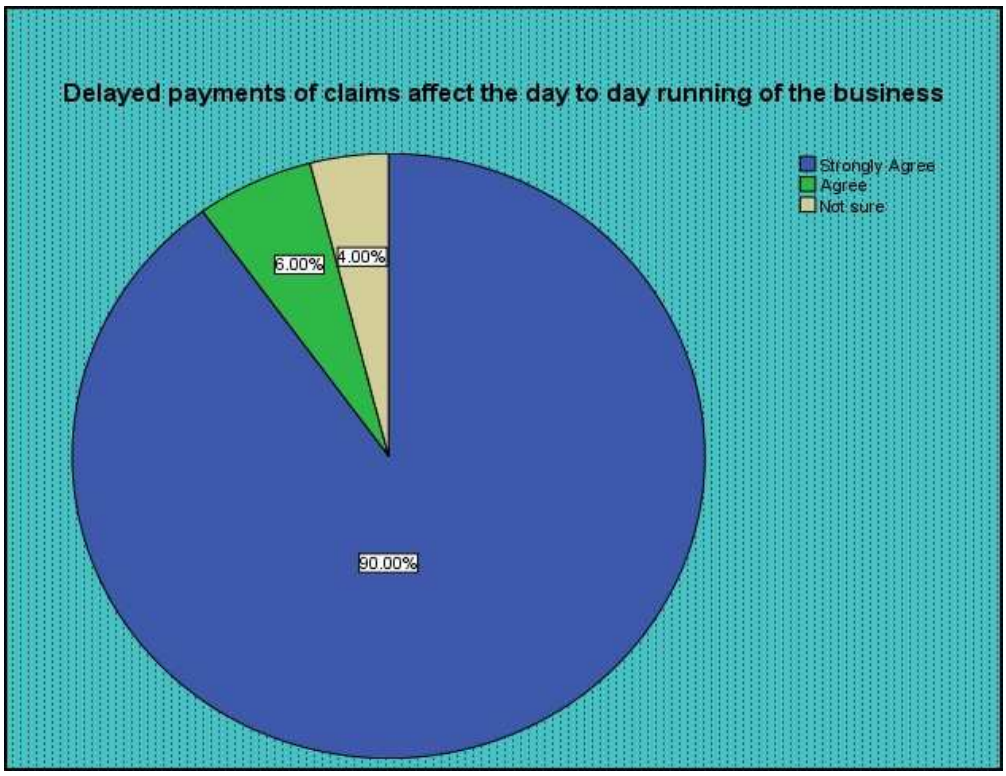


Figure 4. 9: Delayed payment of claims affected the day to day running of the business

Figure 4.5.10 above depicts that 90 % of the study population indicated that they strongly agreed, 6% agreed and 4% were not sure about the effect of delayed payment of claims on day to day running of the health service providers business. From the findings above it can be deduced that delayed settlement of claims negatively affected the health service providers' daily operations.

4.2.16 The health service providers will struggle to pay their creditors

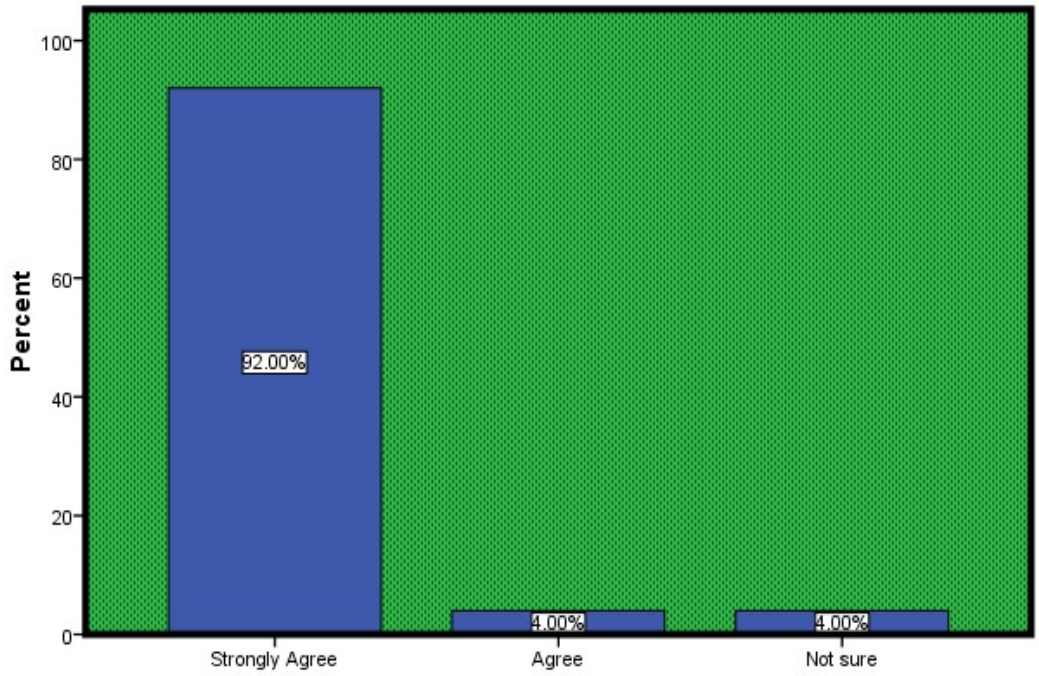


Figure 4. 10: The health service providers will struggle to pay their creditors

Figure 4.5.11 above shows that 92% of the study population indicated that health service providers struggled to pay their creditors, 4% agreed and the other 4% were not sure. The result was an indication that health services providers were struggling to pay their creditors due to the delayed payment as noted in section 4.5.1 where claims took time to be processed.

Interviews with key informants indicated that most of them echoed the same sentiments. Some of the responses from the interviews highlighted that some of the health providers were finding it difficult to pay their workers on time hence they relied on patients that were paying cash and some of them had to introduce a part payment upfront for some medical aid card holders.

One of the interviewees said that

"For us to survive, we had to resort to giving first preference to clients without medical aid since they had to pay cash up front".

4.2.17 Health service providers cannot provide pharmaceuticals to PSMAS patients

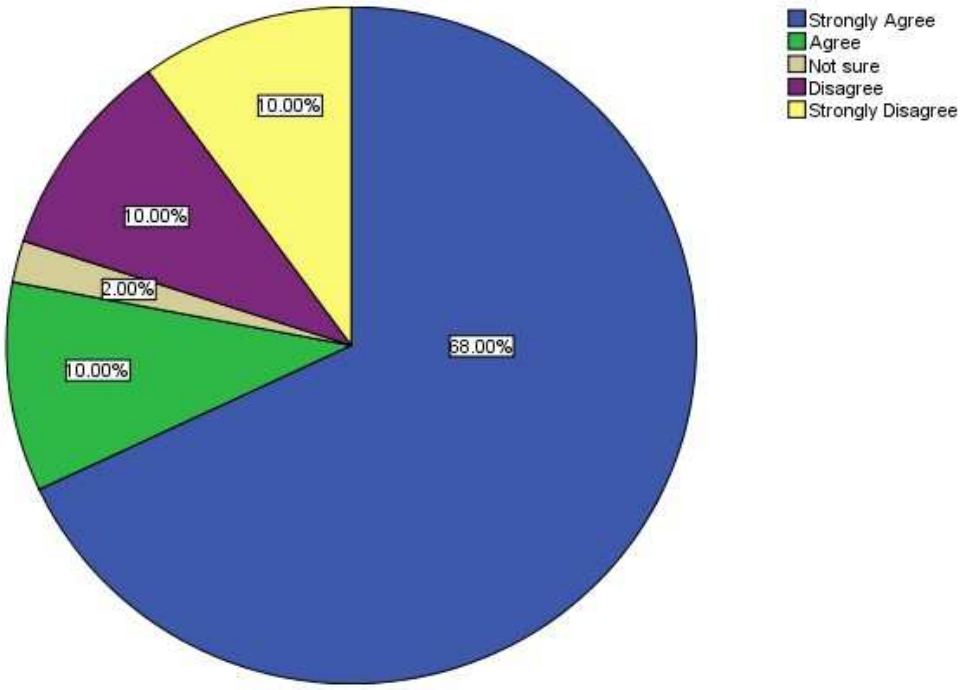


Figure 4. 11: Health service providers cannot provide pharmaceuticals to PSMAS patients

Respondents were asked to rate whether or not the health service providers could not provide pharmaceuticals to the patients. The findings from figure 4.5.12 show that 68% of the respondents strongly agreed, 10% agreed, 2% were not sure, whilst 20% disagreed that health service providers could not provide pharmaceuticals to the patients. From the interviews held with health service providers it became prominent that most of them indicated that acquiring pharmaceuticals was difficult especially in a recessive economic environment.

An interview with key informants from health service providers indicated that some of them doubted their capacity to provide pharmaceuticals. One of the interviewees noted that,

"It is hard to neglect some of our regular patients, especially those taking medication for chronic conditions. It is unfair not to provide them with drugs. So on humanitarian grounds we selectively give pharmaceuticals". (Key informant 7)

The responses from the interviews indicated that there were mixed reactions to whether health services providers can assist their clients with pharmaceuticals.

4.2.18 Health service providers are not able to accept patients on PSMAS

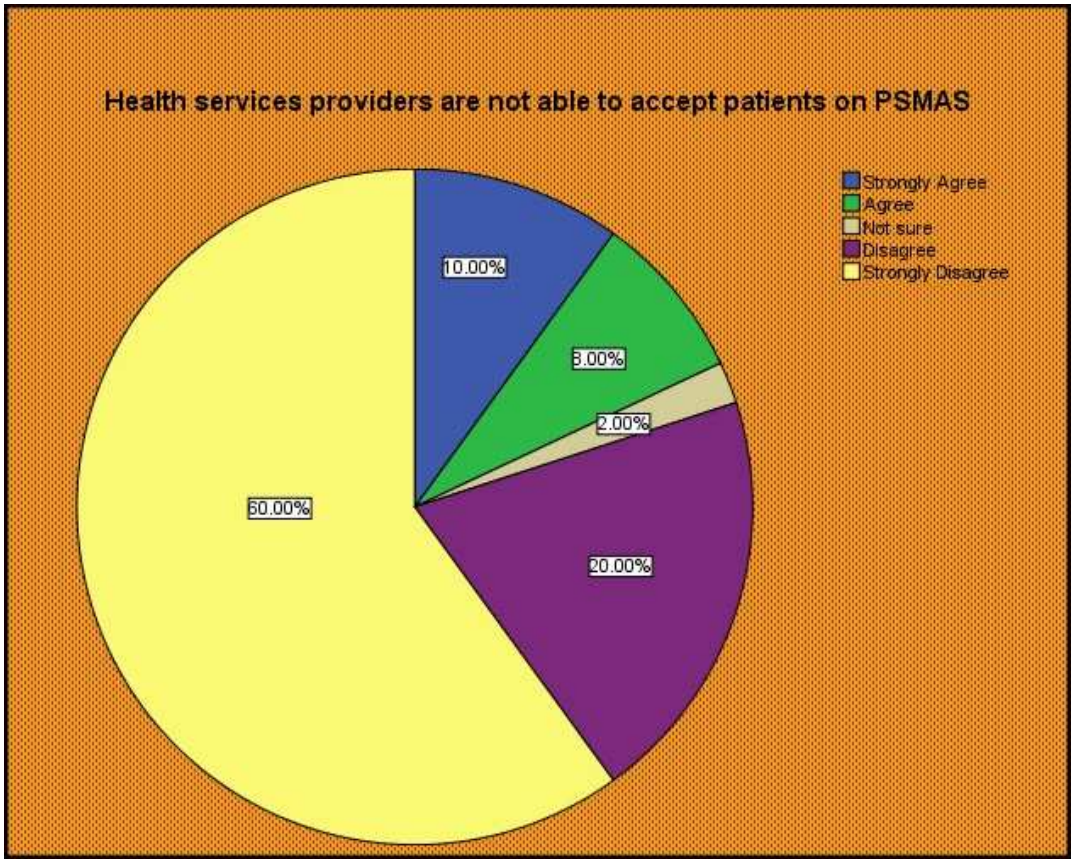


Figure 4. 12: Health services providers are not able to accept patients on PSMAS

From the figure 4.5.13 above it was noted that 60% and 20 % strongly disagreed and disagreed respectively, whilst 2% were not sure and 18 % agreed to acceptance of patients on PSMAS by the health service providers under the study population. This was an indication that while PSMAS's credibility was adversely affected by the delayed settlement of claims, most health service providers would still assist PSMAS patients. The finding was cemented by responses from interviews where most of the respondents stated the need to be considerate when dealing with their patients and still attend to patients.

4.2.19 Health service providers demand upfront co-payments even to patients under PSMAS

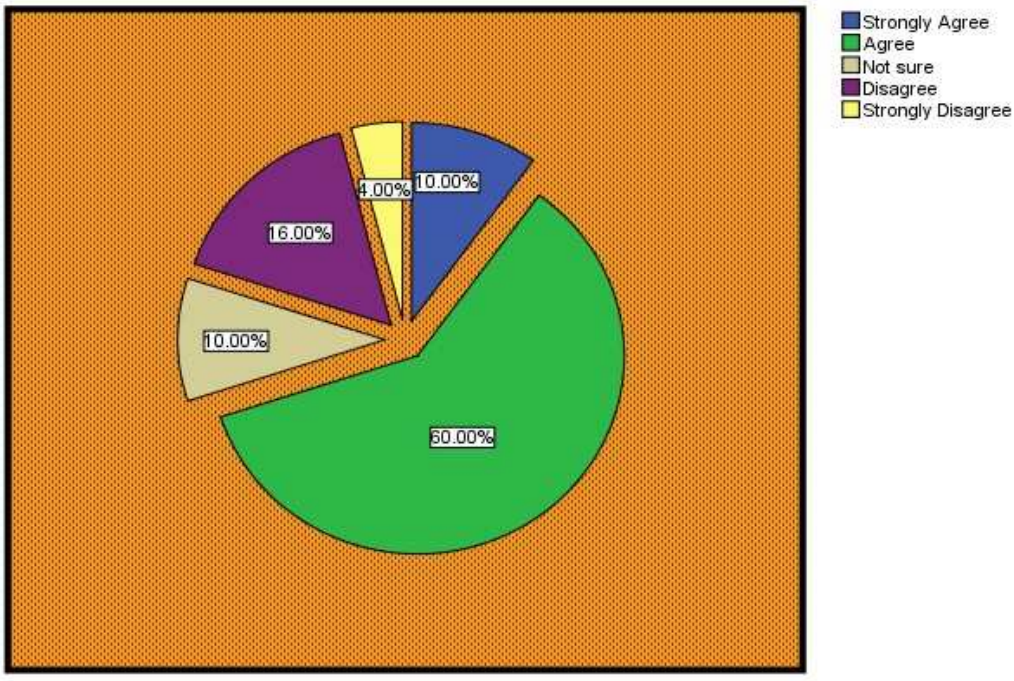


Figure 4. 13: Figure 4.5.14 Health service providers demand upfront copayments even to patients under PSMAS

Figure 4.5.14 above shows the response from the study on rating whether the health service providers demanded cash up-front (co-payments) to patients under PSMAS. It was noted that 60 % and 10% agreed and strongly agreed respectively while 10 % were “not sure”, 16% disagreed and 4% strongly disagreed. The result above is an indication that most health service providers from the region under study demanded cash upfront for somebody to get the health care services. This can be attributed to past reports of the medical aid society taking too long to settle claims. The response from interviews also suggested that it was no longer sustainable to support patients on PSMAS and other medical aid societies that were not honouring up their claims.

4.2.20 To suggest possible solutions to the delays in payment to health service providers

The findings revealed that the respondents from interviews indicated some solutions to lessen the delays in payment to health services.

Some of the interviewees noted that the medical aid society should have robust

Enterprise Resource Systems (ERPs) to run their own information technology departments. Though there are limited number of business models that fit into challenges being faced by health service providers, there is need to put thoughts together to deal with an unstable operating environment. Medical aid societies need innovative ideas that meet the demands of the businesses in a turbulent economic environment.

The findings from interviews also noted most of the interviewees claimed that corruption in the medical aid society was rampant. It was also noted that there is a lack of transparency in the way the society conducts its business. Some of the

interviewees highlighted the presence of high packages for the top executives which were draining a lot of resources from the coffers of society.

One of the interviewees noted that.

“Top PSMAS executives and middle management are paid huge salaries, for example, the former chief executive officer of PSMAS was being paid USD500000.00 per month when most health service providers were receiving no payment for a period exceeding 2 years. Corruption is draining all the money from PSMAS coffers. (Key informant 8)

The society is also associated with high personnel expenditure that includes extremely generous remuneration for top executives. This can be substantiated by some of the interviewees who suggested that the medical aid society should review downwards, salaries of top executives.

4.2.21 Research Assumptions

It is assumed that delays in payment of medical expenses by the medical insurer affects the welfare of health service providers

4.3 Discussion and Interpretation

4.3.1 To identify the causes of delayed payments to health service providers by PSMAS

The study identified many causes that delay payments to health service providers by the PSMAS that range from time for submission of claims by the health services providers, period of processing of claims, verification process done by the Medical Aid Society, use of technology and financial base to settle claims within 90 days. It was noted that 92% of the respondents disagreed that the claims were not handed in

time. This could not be a contributing factor to the delay in disbursement of funds by the medical aid society.

Calculating from the time claims were handed in, it became prominent that payments were taking time to process. The health services providers would get their payments well after three months. The findings indicated that 80% of the respondents agreed that the medical aid society takes more than 90 days to make payments. It is not whether the time payments are processed is calculated from the time claims were handed in or claims are made. It was also noted in the findings that since the claims were not handed in on time, it would take long time for the medical aid society to verify and process the payments. The findings of the study also stated that 78 % of the respondents agreed that the medical aid society takes time to verify the claims. This could mean that the verification process also demands for work by the medical society. This process may be argued by the medical society as a precautionary measure to reduce fraud cases that has been experienced in the health care services sector. Caliyurt (2018) in his study indicated that the European Union spends one trillion euros on health and 3-10 percent of this amount (30-10 Billion euros) goes to waste with fraud. The growing numbers in the health sector also whets the appetites of frauds. Fraud in the health sector, contrary to other sectors, can affect human life directly. The medical aid societies in Zimbabwe are not an island in the number of fraud cases, hence the need for scrutinisation of claims to minimize the risk of fraud.

Most of the respondents cited the lack of technology where 80 % agreed. Lack of technology use by the health sector remains critical in Zimbabwe. This has adversely affected the speedy processing of claims. Technology use has become an enabling tool in health service delivery. In fact, the use of technology in the health sector has led to the implementation of electronic health (e-health) services which

facilitate the swift action on processes. Many developed nations, as noted by Furusa and Coleman (2017) and Busagala & Kawono (2013), have made massive investments in e-health systems and the developing states are also making efforts to implement these systems

A report by NAMAS (1998) substantiated that there are inconsistencies in the health care services funds disbursement by health service insurer. It was noted that health service providers claim and having in some instances provided a proof that their claims usually remained un-paid for periods in excess of the statutory 60 days and sometimes for periods of up to 6 months or more. This has prompted health service providers to resort to cash charges until such a time that their insurers where ready to meet their obligations in a timeous manner.

The findings of the study concluded that the Medical Aid Society has a financial base that accommodates the payment of claims by the health services providers. This was supported by 80% of the respondents who disagreed that the medical aid society does have the financial capacity to pay the health services providers. This was also substantiated by the responses from the key informant interviews where most of the interviewees stated that the medical aid had a strong financial base. The government as the largest employer in the country does the largest contributions to the medical aid society.

4.4 Chapter summary

This chapter presented and analysed the findings made in the study delayed payments by the medical aid society to the health service providers. Originally presented in the chapter were the response rate and demographic characteristics

which were followed by presentations and discussions of the findings with respect to the research objectives.

CHAPTER 5 SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

The chapter presents summary of the findings, discussions, conclusions and recommendations following the objectives of the study. The study examined how delay in payment of medical expenses by medical insurers affect health service providers. The objectives were to identify the causes of delayed settlement of health service providers' claims by PSMAS, measure the real impact of these payment delays on the general welfare of health service providers and suggest possible solutions to the delays in payment to health service providers.

5.2 Discussion

Titled. "The health care service funds disbursement by Premier Service Medical Aid Society, Zimbabwe.

The aim of the study was to establish how delays in payment of medical expenses by the medical insurer affect health service providers' daily operations. The objectives were centred on identifying the causes of delayed payments to health service providers by PSMAS, measuring the real impact of these payment delays on the general welfare of health service providers and suggesting possible solutions to the delays in payment to health service providers.

The study focused on the delayed payments by the medical aid societies on claims made by health service providers in Zimbabwe with particular focus on Gweru, Midlands region. The major reason for undertaking this study was the persistent delayed settlement health service providers' claims of by PSMAS. It was noted that most health services providers were struggling meet their daily expenses, not able to

acquire pharmaceuticals, and some demand cash up-front for certain medical procedures.

The major findings of the study were that the delay in payments was caused by a number of factors like claims processing and verification period, availability of a technological system to process payments, PSMAS corruptly diverting clients' subscriptions to pay huge salaries to executives rather than paying Health Service Providers. In a study by Mudyarabikwa, (2000), "Zimbabwe has the dilemma of finding the best ways to address the health needs of its population and economically develop the country to boast of a population with a satisfactory quality of life". In a report by NAMAS (1988) it was noted that there are some instances where health service providers needed to provide their proof of claim. It was further stated that claims should be paid within 60 days. This has prompted health service providers to resort to cash charges until such a time that their insurers where ready to settle their claims in a timely manner. They further raised concerns that the given situation would obviously disadvantage and stress the client who is rightfully insured but has to pay cash up front to access health services.

Over time, state or government budget pressures have caused an increasing reliance on supplemental payments (versus base payments) to finance private health service providers and Medicaid hospital services (USAID, 2012).

Contrary to the findings of the study which indicated the causes of delayed payment, in other countries different causes were mentioned. One of the causes of delayed payment in countries like Ghana is time to claim resolution (Unge, et al 2008). Most of the loopholes are primarily within a transfer from claimants, insurers and policyholders and their representatives to Medicare or MedicAid, the appropriate

degree of such transfers is largely a normative question about which different stakeholders may disagree.

It was noted that non-payment of claims had an adverse effect on the general operations of the health services providers. Findings revealed that 90% of the respondents noted that delayed payment the stipulated periods affect the daily operations of the health services providers. Some of the health service providers were not able to offer pharmaceuticals and not able to accept patients from some medical aid societies. The findings from interviews also noted that some health services providers resorted to charging a co-payment on each visit by the patients. NAMAS (1988) states that understanding how much Medical aid pays hospitals is difficult because there is no publicly available data source that provides reliable information to measure this nationally across all hospitals. Different data sources use different definitions of what counts as payments and costs, so estimates are sensitive to these data limitations.

5.3 Conclusions

5.3.1 The business of health care provision by private health care providers was negatively affected by delays in the settlement of claims by PSMAS. Private hospitals, private pharmacies, surgeries and many other private entities providing health care to the people, suffered loss of revenue due to payment delays by PSMAS. The health service providers' personal welfare and that of their workers and families was also affected.

5.3.2 The legislation that compelled Medical Aid Societies to settle heath care providers' claims within 60 days was largely being ignored by PSMAS.

5.3.3 Literature also supported the above research conclusion. Society of Actuaries (2015) was of the view that medical expenditure globally was complex and continued to attract much attention amongst the various stakeholders including governments.

5.3.4 There were several factors that affected the processing of funds and their disbursement. Health services providers had to play their own part, for instance submitting claims early so that the time taken for verification process could be reduced. It was generally indicated that PSMAS had to improve its system so that settlement of claims was done on time. Using modern appropriate technology could also speed up payment process.

5.4 Implications

The delay in the payment of claims to the health service providers by the medical aid societies has proved to have many implications. It was noted from findings that the delay in payment of claims negatively affects the day to day business operations of the health services providers. These delays also have implications on patients as they are asked for a co-payment when seeking services. Findings from the study by Willis Shattuck et al, (2008) noted that the Federal officials from the United States believe that reform of Medicaid supplemental payments is needed to make payment more targeted, transparent and consistent with delivery system reforms that reduce health care costs and increase quality and access to care.

The impact of delayed payments affected the medical supplies where health services providers would rely on other sources of income. Some of the responses from interviews noted that the medical aid societies should adhere to policies to avoid delayed payments to the health services providers. Government is the largest

contributor to PSMAS where most of its employees are medical insurance policy holders. Its involvement in the medical aid society would improve the payments to health service providers. The international Monetary Fund has recommended that countries increase the scope of private sector provision in health care as part of loan conditions (Stuckler and Basu, 2009) often to reduce government debt (Elliott, 2009).

5.5 Recommendations

From the above findings, the following were cited as areas for further improvement:

5.5.1.1 There are several causes of delays in payment of funds to the health services providers by the medical aid societies, where some of them can be minimised through improving the turnaround time on processing of claims.

5.5.1.2 The legislative framework to do with honouring of financial objections in this case the funds disbursements is available and what is needed to make proper follow-ups when there are delays and also the measures to be followed in getting a recourse.

5.5.1.3 Lack of proper ICT systems became more apparent in the study, hence the need for the medical aid society to come up with innovative ways to improve the existing systems.

5.5.1.4 Most of the claims for payments to the health service providers are settled after 90 or more days. There is need to lessen this period in way that accommodates the current economic environment.

5.6 Suggestions for Further Research

The following were singled out as areas for further studies

5.6.1 A cross sectional survey on the delay of payment to all health service provision by the medical aid societies and insurers in Zimbabwe.

5.6.2 An analysis on the impact of medical aid societies on the private health care delivery systems in Zimbabwe.

REFERENCES

Adamchak, S.E. (1996). *Assessment of the private medical sector in Zimbabwe*. Harare. Zimbabwe. USAID. Retrieved from citeseerx.ist.psu.edu

Adom,D., Kamil, E., & Agyem, J. (2018). *Theoretical and conceptual framework: Mandatory ingredients of quality research*. Kumasi, Ghana. International Journal for scientific research. Retrieved from http://www.researchgate.net/publication/322204158

Agha, S. (2008). *Does an expansion in private sector contraceptive supply increase inequality in modern contraceptive use?*, Health Policy and Planning, Volume 23, Issue 6, November 2008, Pages 465–475. Retrieved from https://doi.org/10.1093/heapol/czn035

Akintoye, (2015). *Theoretical and conceptual framework: mandatory ingredients of a quality research*. International Journal of Scientific Research 7(1):438-441. Retrieved from https://www.researchgate.net/publication/322204158

Alaro, T. (2017). *Video voice diaries to understand the perspectives of community health volunteers in ethiopia: Insights from collaborative qualitative.* Ethiopia. UCL Qualitative health research symposium. Retrieved from https://bmjopen.bmj.com/content/7/Suppl_2/bmjopen2017016492.12.abstract

Alder, N. J. (2008). *Educational theory*. Illinois, USA. Retrieved from https://onlinelibrary.wiley.com

Amasha, M. (2015). *Causes and effects of delayed reimbursement to accredited health facilities by national health Insurance fund in delivery of health services: A case of regency medical hospital and NHIF head office.* Mzumbe University. Retrieved from http://scholar.mzumbe.ac.tz/handle/11192/1752

America's Essential Hospitals. (2016). *Health Care and Balance Billing Problem: The solution is the common law of contacts and strengthening the free market for healthcare*. USA. Retrieved from *http*://heinonline.org/HOL/LandingPage?handle=hein.journals/vllalr62&div=7&id=&page

Anfara, V.A. (2008). *Theoretical Frameworks.* University of Tennessee, Knoxville, USA. Retrieved from https://us.sagepub.com/en-us/nam/theoretical-frameworks-in-qualitativeresearch/book240859

Arora, V. (2015). *The Challenge of Understanding Health Care Costs and Charges*. Chicago, USA. AMA Journal of Ethics: Illuminating the Art of Medicine. Retrieved from https://journalofethics.ama-assn.org/article/challenge-understanding-health care-cost-and-charges/2015-11

Bachrach, D., Boozang, P., & Lipson, M. (2015). *The Impact of Medicaid Expansion on Uncompensated Care Costs: Early Results and Policy Implications for States*. Retrieved from: http://www.rwjf.org/en/library/research /2015/06/theimpact-of edicaid-expansion-on-uncompensated-care-costs.html.

Best, J.W., & Kahn, J.V. (1993). *Research in education.* (7th ed.). New Delhi India. (cited in Muchire, 2003)

Blumenthal, D., & Hsiao, W. (2005). *A comparison of the health systems in China and India*. Santa Monica, California. USA. Retrieved from: https://www.rand.org/content/dam/rand/pubs/occasional_papers/2008/RAND _OP212.pdf

Busagala, L.S.P., & Kawono, G. (2013). *Underlying Challenges of E-Health Adoption in Tanzania 1.* Morogoro, Tanzania. Retrieved from: siteseerx google scholar. https://scholar.google.com/scholar

Chernichovsky, D., & Leibowitz, A. (2010). *Integrating public health and personal care in a reformed US health care system.* USA. American Journal of Public Health.

Chung, M. (2017). *Health Care Reform: Learning from other Major Health Systems.* Princeton, USA. Retrieved from https://academic.oup.com/europace /article/20/1/e1/4158475

Cox, K., (2009). *Health care systems and health policy*. London, UK. Retrieved from: *https://www.pharmpress.com › files › docs*

Creswell, J. W. (2013) *Steps in Conducting a Scholarly Mixed Methods Study*. Lincoln, USA. Retrieved from: http://digitalcommons.unl.edu/ dberspeakers/48

Eijkenaar, F. (2012). *Pay-for-performance for healthcare providers design, performance measurement, and (unintended) effects Rotterdam, the Netherlands*. Retrieved from: https://repub.eur.nl › pub › Proefschrift-F.-Eijkenaar.pdf

Elliot, (2009). *Comparative performance of private and public healthcare systems in low- and middle-income countries: A systematic review.* Retrieved from: https://journals.plos.org/plosmedicine/article/authors?id=10.1371/journal.pme d.1001244

Embassy of the Kingdom of the Netherlands (2016). *Kenyan Healthcare Sector Market Study Report: Opportunities for the Dutch Life Sciences & Health sector.* Netherlands. Retrieved from https://www.tfhc.nl/publication/kenyan-healthcare-sector-report-2016/

Ensor, T., & Cooper, S. (2004). *Overcoming barriers to health service access: influencing the demand side*. Health Policy and Planning, page 19(2), 69-79. Heslington, York, UK

Ennajar, K., & Nessef, L. (2018). *Overview of World Health Systems:* International Journal of Scientific and Research Publications, Volume 8, Issue 9, September 2018 511 ISSN 2250-3153. Retrieved from http://www.ijsrp.org/research-paper-0918/ijsrp-p8171.pdf

Etemesi, C. (2004). *The analysis of the effect of process operations on service delivery in selected insurance firms in Kenya. Nairobi*. Kenya. Kenyatta University. Retrieved from https://ir-library.ku.ac.ke/handle/ 123456789/1753?show=full

Feldstein, M. (2005). *Rethinking Social Insurance. American Economic Association.* USA. Journal Volume 95, issue 1, pages 1-24 of American Economic Review.

Fleetcroft, R., & Cookson, R. (2006). *Do the incentive payments in the new NHS contract for primary care reflect likely population health gains?* UK. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/16378529

Furusa. S.S., & Coleman, A. (2017). *Factors influencing e-health implementation by medical doctors in public hospitals in Zimbabwe.* Gweru, Zimbabwe. South African Journal of Information Management 20(1), a928. Retrieved from: https://doi.org/10.4102/sajim.v20i1.928

Glasziou, H., & Buchan, C, & Del Mar, J., & Doust, M,. & Harris M. (2012). *When financial incentives do more good than harm: a checklist*. BMJ 2012; 345:e5047. Retrieved from

Gonzalez, J. G. (2009). *Health Insurance coverage and working Latinos in California, 2001: A three part analysis of the impact of Acculturation, self-rated health and years of US residency on Latinos take up of Health Insurance.* Thesis and Dissertations. UNTHSC Scholarly Repository Paper 75.

Grant, C., & Osanloo, A. (2014). *Refining Your Qualitative Approach in Healthcare Simulation Research.* New York, USA. Healthcare Simulation Research ppb 79-83: Retrieved from: https://doi.org/10.5929/2014.4.2.9

Gupta, S.D., & Bhatia, V. (2019). *Comparisons of Health Care Systems in the United States, Germany and Canada.* Bosnia and Herzegovina. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3633404/

Hall, R. (2013). *Comparisons of Health Care Systems in the United States, Germany and Canada.* Sarajevo International University, Sarajevo. Retrieved from https://www.ejmanager.com/mnstemps/16/16-336502968.pdf?t=1576429860

Haugen, T. (2014). *The Politics of Health Care Financing Models - Does the Source of Funding Matter for Health Care Outcome?* https://www.semanticscholar.org/paper/The-Politics-of-Health-Care Financing-Models-Does Haugen/d6bb1ebe7c6bb501ec7da4ba162eeaea48a9e610

Haseltine, W.A. (2013). *Affordable excellence: The Singapore Health System.* Singapore. Brookings Institution Press. Retrieved from http://jstor.org/stable/10.7864/j.ctt6wpcs5

Holloway, I., & Galvin, K. (2016). *Qualitative research in nursing and healthcare, (4th ed.). Published by Wiley. J & Sons.* United Kingdom

Infante, A., Meit, M., & Hargrave, E. (2010). *The medicare physician quality reporting initiative: Implications for rural physicians (Final Report).* Bethesda, Maryland, USA. Retrieved from: https://www.ruralhealthresearch. org/publications/756

James et al. (2006) *Addressing access barriers to health services: an analytical framework for selecting appropriate interventions in low-income Asian countries*. London, UK. Retrieved from: https://www.who.int/alliancehpsr/resources/alliancehpsr_jacobs_ir_barriershealth2011.pdf

Kazungu, J. (2018). *What characteristics of provider payment mechanisms influence health care providers' behaviour? A literature review.*USA. Retrieved from: https://doi.org/10.1002/hpm.2565

Kentucky Hospital Association. (2015) *Understanding Medicaid Hospital Payments and the Impact of Recent Policy Changes.* USA. Retrieved from http://www.nationaldisabilitynavigator.org/wp-content/uploads/newsitems/KFF_medicaid-hospital-payments-and-the-impact-of-recent-policychanges_June-2016.pdf

Kenya Healthcare Federation and Task Force Health Care. (2016). *Healthcare sector report 2016*. Nairobi, Kenya. Retrieved from https:// www.tfhc.nl/publication/kenyan-healthcare-sector-report-2016/

Kimani J., Ettarh, R., Kyobutungi, C., Mberu, B., & Muindi, K., (2012). *Determinants for participation in a public health insurance program among residents of urban slums in Nairobi, Kenya: Results from a cross sectional survey,* BMC Health Services Res, 2012, 12: 16. Retrieved from https:// www.ncbi.nlm.nih.gov/pubmed/22424445

Kincheloe J., Frates J., & Brown R. (2007). *Determinants of children's participation in California's Medical Aid and SCHIP programmes,* Health Research and Educational Trust, April: 42.2. California, USA. Retrieved from https://www.coursehero.com/file/p2m09p20/Kincheloe-J-Frates-and-Brown-R-2007-Determinants-of-childrens-participation/

Liehr, R., & Smith, J. (1999). *Thinking through the framework of research*. Winneba, Ghana. Retrieved from: *https://www.academia.edu*

Mack, N. (2011). *Qualitative research methods: a data collector's field guide*: North Carolina 27709, USA. Retrieved from: http://www.fhi.org

Martirosyan, A. (2012) & Adamchak, M. (1996). *Affordable Care Act*. Canada

Mhere, F., (2013). *Health insurance determinants in Zimbabwe*. Case of Gweru Urban. Gweru, Zimbabwe: In Journal of Applied Business and Economics vol. 14(2) 2013. Retrieved from http://businesspress.homestead .com/JABE/MhereF_Web14_2_.pdf

Mtomba, (2016). *MedAid shocker doctors to disregard med cards patients to pay cash upfront:* Harare, Zimbabwe. The Herald: Zimbabwe-10 December 2019

Mudyarabikwa, O. (2000). *An examination of Public Sector subsidies to the Private Health Sector*: *A Zimbabwe Case Study, September 2000.* Harare, Zimbabwe Retrieved from http://catalogue.safaids.net/sites/default/files/publications/ private/%20health %sector%zimbabwe.pdf

Mugenda, O. M., & Mugenda, A. G. (2003). *Research methods: Quantitative and qualitative Approaches*. Nairobi: African Centre for Technology Studies. Retrieved from: http://www.sciepub.com/reference/85966

Mugwagwa, J., Chinyadza, J., & Banda, G. (2017). *Private Sector Participation in Health Care in Zimbabwe: What's the Value-Added?* Harare, Zimbabwe: In Journal of Healthcare Communications, Vol. 2 No. 2: 10

Munyuki, E., & Jasi, S. (2009). *Capital flows in the health care sector in Zimbabwe: Trends and implications for the health system*. Equinet discussion paper 79. August. ISERRU and TRSC. Harare, Zimbabwe.

Muranda, Z. (2004). *Dissertation Writing*. *Concepts and Practice*. Harare Zimbabwe ZOU Institutional Repository (ZOU Space). Retrieved from *www.lis.zou.ac.zw › dspace › handle*

Nachmias, C.F., & Nachmias, D. (1996). *Research Methods in the Social Sciences, 5th Edition*. London: Arnold

Nessef, L., & Ennajar, K. (2018). *Overview of World Health Systems.* International Journal of Scientific and Research Publications (IJSRP) 8(9) (ISSN: 2250-3153), DOI. Retrieved from http://dx.doi.org/10.29322/IJSRP.8.9.2018.p8171

Newhouse (1978). *Comparison of Alternative Models for the Demand for Medical Care. USA.* Journal of Business & Economic Statistics *1983* American Statistical Association

Nikpay, S., Buchmueller, T., & Helen L., (2016). *Affordable care act Medicaid expansion reduced uninsured hospital stays in 2014," Health Affairs. 35, no. 1 (2016): 106-110*. Maryland, USA. Retrieved from: http://content.healthaffairs.org/content/35/1/106.abstract.

Nyman, J., (2005). *Health insurance theory, the case of the missing welfare gain*. University of Minnesota, Minnesota, USA.

O'Donnell, C.A. (2007). *"They think we're OK and we know we're not"*. A qualitative study of asylum seekers' access, knowledge and views to health care in the UK. Glasgow, UK. Research article. Retrieved from. https://doi.org/10.1186/14726963-7-75

Pacific Prime. (2017). *Cost of international health insurance report*. Hong Kong. Retrieved from https://www.pacificprime.com/cohi-2017/

Parekh, N., & Rose, T. (2011). *Health within the Leeds Migrant Roma Community; An Exploration of Health Status and Needs within One UK Area*. Health, Vol.9 No.4, April 27, 2017. Retrieved from https:// www.scirp.org/(S(i43dyn45teexjx455qlt3d2q))/reference/ReferencesP apers.aspx?ReferenceID=2021268

Parirenyatwa, D. (2016). *Challenges in Working Relationships between Medical Aid Societies, AHFoZ and Providers of Health care Services*. Harare, Zimbabwe. In the National Assembly. Ministerial Statement.

Parkin, D. (2000). *Health insurance determinants in Zimbabwe: Case of Gweru Urban Journal of Applied Business and Economics, Vol. 14, Iss. 2, pp. 62-79 Citation by Francis Mhere, (2013).* Gweru, Zimbabwe

Pauly, M. (1968). *The Economics of moral hazard*: *comment.* American economic review. USA. Retrieved from http://static.stevereads.com/papers_to_ read/the_economics_of_moral_hazard

Pauly, M., & Swanson, A. (2013). *Social impact bonds in non profit health care: new product or new package.* Retrieved from https://www.researchgate .net/publication/256060825_Social_Impact_Bonds_ in_Nonprofit_Health_Care_New_Product_or_New_Package

Policy Innovation Research Unit (PIRU). (2013). *Evaluation of the Social Impact Bond Trailblazers in Health and Social Care: Final report.* Retrieved from http://piru.lshtm.ac.uk/publications/publications.html

Rajasekar et al. (2013) *Research methodology. Chapter111*. Indonesia. Retrieved from: repository.upi.edu

Randall, E., & Michelle, M. (2008). *Provider Payment Methods and Provider Incentives*. Encyclopaedia of Public Health. 10.1016/B978-012373960-5.00173-8. Boston, United States. Retrieved from: https:// www.researchgate.net/profile/Randall_Ellis3

Reid, (2009). *Health Policy and Ethics Page 29.* Canada. Retrieved from: *https://books.google.co.zw › books:*

Rudowitz, R., & Garfield, R., (2015). *The effects of Medicaid expansion under the ACA.* Washington DC, USA. Retrieved from http:// files.kff.org/attachment/Issue-Brief-The-Effects-of-Medicaid-Expansion-Under-the-ACA-Updated-Findings-from-a-Literature-Review

Sagan, A., & Thomson, S., (2016). *Voluntary health insurance in Europe: Country experience World Health Organization.* Retrieved from http://euro.who.int/_data/assets/pdf_file/0011/310799/Voluntaryhealth_insuarance-Europe-country-experience.pdf

Saltman, R., Busse, R., & Figueras, J. (2004). *Overview of World Health Systems: Western Europe*. New York, USA. International Journal of Scientific and Research Publications, Volume 8, Issue 9, September 2018

Santere, R., & Neun, S., (2010). *Health Economies theory, Insights and Industry studies. (5thed.).* United Kingdom

Scarpaci, J.L. (1987). *Applied research on decentralization of health systems in Latin America: Chile case study*. Chile. Retrieved from: https://www.paho.org/hq/dmdocuments/2010/33Applied_Research_Decentralization_Health_Systems_LA-Chile.pdf

Society of Actuaries, (2015). *How to fix the funding of health and social care*. United Kingdom. Retrieved from http://www.instituteforgovernment.org.uk/sites/default/files/publications/IFG_Funding_health_and_social_care_web.pdf

Sodzi-Tetty, S., Unge, C., Aikins, M., & Agyepong, I. (2008). *Challenges in provider payment under the Ghana National Health Insurance Scheme: A case study of claims management in two districts.* Ankra, Ghana. Ghana medical journal.

Stefanacci, R.G. (2006). *Saskatchewan Hospitalization Act*. Canada. Retrieved from http://www.rootsweb.ancestry.com/~cansk/surnames/Medicare/

Stuckler. D., & Basu, S. (2009). *The International Monetary Fund's Effects on Global Health: Before and after the 2008 Financial Crisis.* Retrieved from:https://www.researchgate.net/publication/40020898/The_International_Monetary_Fund's_Effects_on_Global_Health_Before_and_after_the_2008_Financial_Crisis/citation/download

The American College Health Association. (2005). *The American College Health Association National College Health Assessment (ACHA-NCHA),* Spring 2003 Reference Group Report. *Journal of American College Health, 53*(5), 199– 210.

The Daily (2017). *Doctor sues PSMAS over $208 000 in unsettled claims.* Harare Zimbabwe. July 25, 2017

Vosko, L.F., & MacDonald, M., & Campbel, I. (2009). *Gender and the Contours of Precarious Employment.* Business & Economics. Retrieved from https://scholar.google.com

Weaver. (2015). *Getting people to behave: Research Lessons For Policy Makers*. USA. Retrieved from https://doi.org./10.1111/puar.12412

Yin, R. K. (2009). *Case study research*: Design and methods (4th Ed.). Thousand Oaks, CA: Sage.

Yoong, J., & Burger, N., & Spreng, C., & Sood, N. (2010). *Private Sector Participation and Health System Performance in Sub-Saharan* Africa. Retrieved from: https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0013243

Yount, R (2006). *The Rationale of Sampling*. Retrieved from https://www.academia.edu/The_Rationale_of_Sampling

Willis-Shattuck, M., Bidwell, P., Thomas, S., Wyness, L., Blaauw, D., & Ditlopo, P. (2008) *Motivation and retention of health workers in developing countries: a systematic review*. Dublin 2, Ireland. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/19055827

Zimbabwe demographic and health survey. (2006). *Central Statistical Office.* Harare, Zimbabwe

Zimbabwe Medical Association. (2016). *Zima engages Govt on PSMAS debt.16 November, 2016.* Zimbabwe Chronicle. Bulawayo, Zimbabwe.

APPENDICES

Appendix 1 Questionnaire for Private Health Service Providers

Sector A: Demographic Information

Kindly tick the appropriate box to the best of your knowledge

Sex

☐ Female ☐ Male

Male

Age

20-30	31-40	41-50	51-60	60+

Marital status

Single	Married	Divorce	Widowed

Educational attainment

Secondary education	Certificate	Diploma	First degree	Post-Graduate

State the length of service in the Organization in years.

0-1	2-5	6-10	11-15	>15

Which level are you in the organisation?

Level in the organisation	
Board member	
Executive management	
Middle management	
Lower level management	

Section B: To identify the causes of delayed payments to health service providers by PSMAS

Please rate the following causes of late payments by the medical aid society to the Health service providers

Strongly Agree; 4 – Agree; 3 – Not sure; 2 - Disagree; 1 – Strongly Disagree

	5	**4**	**3**	**2**	**1**
1. Claims are not handed in time by Health service providers					
2. The Medical aid society takes more than 3 months to process payments.					
3. Verification process done by Medical Aid Society takes too long					
4.Medical Aid Society does not use proper technology to help in processing of claims					

5.The Medical Aid society does not have strong financial base to settle claims within 90 days					

Time taken for payments

Please tick the average period of time one would be able to get payments after submitting claims forms

30 days	**60 days**	**90 days**	**91 + days**

Do you have pending PSMAS claims that have not been paid within 90 days

Yes	**No**

If yes please state the response you obtained from PSMAS

……

……

……

Section C: To measure the real impact of these payment delays on the general welfare of health services providers

Please rate how the payments delays have on the operations of your Health service provision

	5	4	3	2	1
1. Delayed payments of claims affect the day to day running of the business					
2. The health services provider will struggle to pay their creditors					
3. Health services providers cannot provide pharmaceuticals to the patients					
4. Health services providers are not able to accept patients on PSMAS					
5. Health service providers demand upfront co-payments even to patients under PSMAS					

Section D: To suggest possible solution to the delays in payment to health service providers

What solution would you recommend to health service providers and PSMAS?

Appendix 2 Interview guide

a. What do you understand on process of payment systems of claims?

b. Please identify and describe the causes of payment delays to health service providers?

c. To what extent did payment delays have on the welfare of health service providers?

d. What are the possible solutions to the delays in payment to health service providers

Appendix 3 Introductory letter

Consent Letter

Dear Respondent…….

My name is **Alfred Makara.** I am an EMBA student at the Africa University, Graduate School of Business. I am carrying out a study on **DELAY IN HEALTH CARE SERVICE FUNDS DISBURSEMENT BY PREMIER SERVICE MEDICAL AID SOCIETY, ZIMBABWE.**

I kindly ask you to participate in the research by giving verbal responses or completing this questionnaire, where applicable, giving correct information as per your knowledge. The answers are only for academic purposes. Your contributions will be highly appreciated. Please do not write your name on the questionnaire. The responses will be treated with high degree of confidentiality.

There are no anticipated risks or discomforts related to this research. The person interviewing you, however, I can give you the name and telephone number of some counselling if you wish.

Several steps will be taken to protect anonymity and identity. While the notes will be taken during the interviews, the notes will be destroyed once findings have been typed. The typed findings will not contain any mention of your name, and any identifying information from the interview or questionnaire will be removed. The typed interview and completed questionnaire will be kept in a locked filing cabinet at the researcher's work place and only the researcher and research assistant , who will be doing the coding and data entry (sword to confidentiality) will have access to the raw data (interviews and completed questionnaires). All information will be destroyed after the university's stipulated time (2 years).

Your participation in this research is completely voluntary. If you decide to participate, the researcher will set aside time that will be convenient to you. However, you may withdraw from the study at any time for any reason.

The results from this study will be presented to the university in writing as a research project, read by academics, lecturers, students and the community at large, to help them better understand the payments made by Medical Aid Insurers like PSMAS, Zimbabwe. The results may be presented in persons to the Ministry responsible for Health and Child Welfare. At no time, however your name be used, or any identifying information revealed. If you wish to receive the copy of the results from the study, you may contact the researcher on 0712763104.

If you require any information about this study, or would like to speak to the researcher, please call Alfred Makara at +263 0712763104 from Africa University. If you have any other questions regarding your rights as a participant in this study, you may also contact The Research Ethics Committee on +263 (020) 60075 or research.services@au.ac.zw

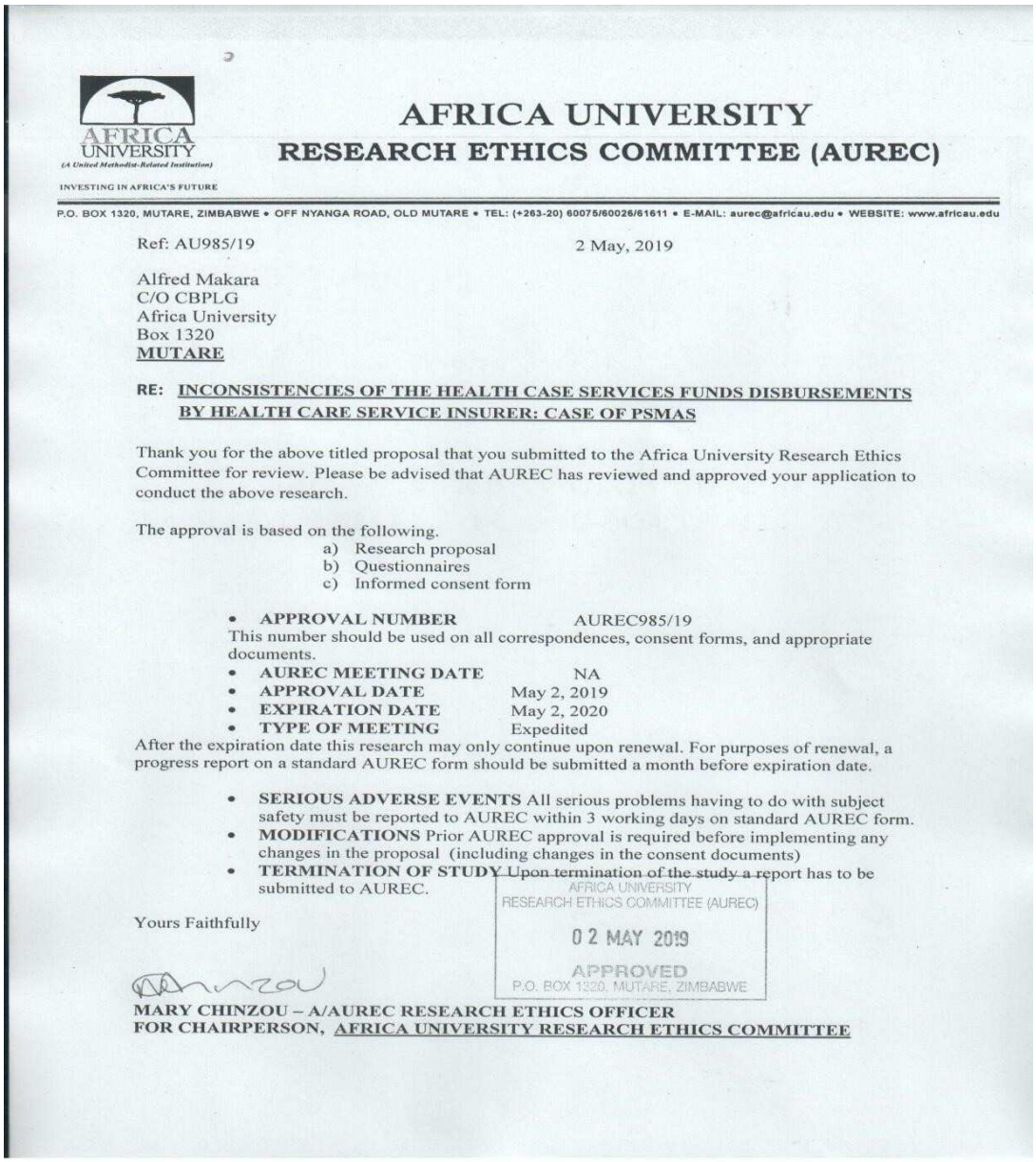
I have read the above information regarding this research study on Delay in Health Care Service Funds Disbursement by Premier Service Medical Aid Society, Zimbabwe

_____(Name Printed)

_____(Signature)

_____(Date)

Appendix 4: AUREC Approval Letter



AFRICA UNIVERSITY
(A United Methodist-Related Institution)
INVESTING IN AFRICA'S FUTURE

AFRICA UNIVERSITY
RESEARCH ETHICS COMMITTEE (AUREC)

P.O. BOX 1320, MUTARE, ZIMBABWE • OFF NYANGA ROAD, OLD MUTARE • TEL: (+263-20) 60075/60026/61611 • E-MAIL: aurec@africau.edu • WEBSITE: www.africau.edu

Ref: AU985/19 2 May, 2019

Alfred Makara
C/O CBPLG
Africa University
Box 1320
MUTARE

RE: INCONSISTENCIES OF THE HEALTH CASE SERVICES FUNDS DISBURSEMENTS BY HEALTH CARE SERVICE INSURER: CASE OF PSMAS

Thank you for the above titled proposal that you submitted to the Africa University Research Ethics Committee for review. Please be advised that AUREC has reviewed and approved your application to conduct the above research.

The approval is based on the following.

a) Research proposal
b) Questionnaires
c) Informed consent form

- **APPROVAL NUMBER** AUREC985/19

This number should be used on all correspondences, consent forms, and appropriate documents.

- **AUREC MEETING DATE** NA
- **APPROVAL DATE** May 2, 2019
- **EXPIRATION DATE** May 2, 2020
- **TYPE OF MEETING** Expedited

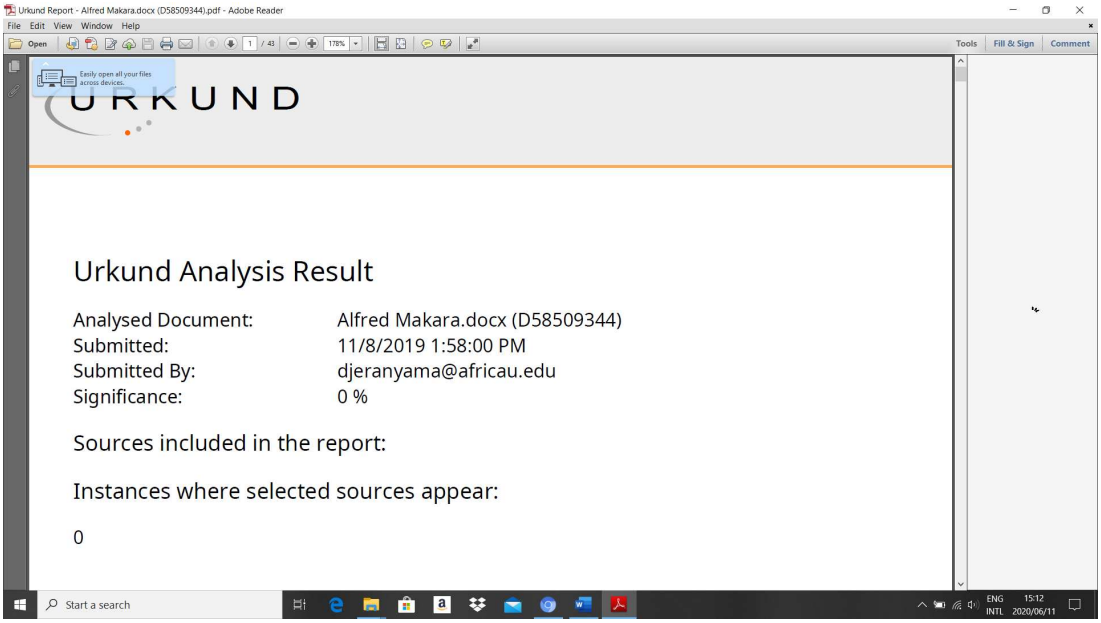
After the expiration date this research may only continue upon renewal. For purposes of renewal, a progress report on a standard AUREC form should be submitted a month before expiration date.

- **SERIOUS ADVERSE EVENTS** All serious problems having to do with subject safety must be reported to AUREC within 3 working days on standard AUREC form.
- **MODIFICATIONS** Prior AUREC approval is required before implementing any changes in the proposal (including changes in the consent documents)
- **TERMINATION OF STUDY** Upon termination of the study a report has to be submitted to AUREC.

AFRICA UNIVERSITY
RESEARCH ETHICS COMMITTEE (AUREC)
02 MAY 2019
APPROVED
P.O. BOX 1320, MUTARE, ZIMBABWE

Yours Faithfully

MARY CHINZOU – A/AUREC RESEARCH ETHICS OFFICER
FOR CHAIRPERSON, AFRICA UNIVERSITY RESEARCH ETHICS COMMITTEE


Urkund Report - Alfred Makara.docx (D58509344).pdf - Adobe Reader
File Edit View Window Help
Open
Tools
Fill & Sign
Comment
URKUND
Urkund Analysis Result
Analysed Document: Alfred Makara.docx (D58509344)
Submitted: 11/8/2019 1:58:00 PM
Submitted By: djeranyama@africau.edu
Significance: 0 %
Sources included in the report:
Instances where selected sources appear:
0
Start a search
ENG
INTL
15:12
2020/06/11