# The Public Service Medical Aid Society (PSMAS) in Zimbabwe: A historical overview and its suggested role in achieving national health insurance (NHI)

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## ABSTRACT

This paper openly critiques the history and policies of the Zimbabwean Public Service Medical Aid Society (PSMAS) for their lack of standing as the foundational launching platform of the proposed National Health Insurance (NHI) Scheme. Instituting a very thorough qualitative desk review of peer-reviewed literature, government documents, audit reports, and media analyses from 2019-2024, the paper utilizes the WHO Health Systems Building Blocks Framework and theories including Strategic Purchasing, Governance, and Principal Agent to diagnose institutional viability. The study also utilizes health financing models and the path dependency theory, which suggests that past decisions and events can have a significant impact on current and future outcomes, even if those decisions were made under different circumstances. This theory helps to explain how the history and policies of PSMAS have influenced the current state of the proposed NHI Scheme in Zimbabwe. The account draws on convincing evidence divulging that PSMAS has been allowed to decline down the crevice of systemic collapse marked by governance fraud of about US$40 million as reported by the Zimbabwe Anti-Corruption Commission in 2022, hard liquidity crises with US$47 million in contribution arrears, and operational breakdown indicating 72% of members getting scared of being denied such access by unfriendly providers blacklisting them. Meanwhile, Zimbabwe's NHI policy is a work in progress, and the disconnect between the "broad contours" of the NHI policy versus an initially promising program promises that a further relationship could be established to finance actuarial models suggesting the crop of proposed financing items needed considerable review, namely the NHI's ability to cover Zimbabwe's huge remaining informal sector workforce. The study argues that the basic vulnerabilities from past institutional failure vis-a-vis PSMAS and path dependency count as an existential threat for any NHI built from its structure. The narrative is one of the safeguarding stances: fundamentally rethinking a dead horse instead of propping it up yet again, and PSMAS finds itself to be the flagship of the NHI. This notion is fundamentally unattractive. Recommendations call for a holistic approach to the effectuation of a proper NHI framework. This framework, thus, sees first-order calls of law having an enactment of a dedicated NHI Act, establishing a new purchasing agency, and phase-wise action that insulates the national scheme from PSMAS legacy liabilities.

**Keywords**: Health Financing, Governance, National Health Insurance, PSMAS, Universal Health Coverage, Zimbabwe

## I. INTRODUCTION

Along with the Universal Health Coverage (UHC), an obligatory global call that should ensure fair access to elementary health services without falling into financial suffering, prior to the 2030 Agenda for Sustainable Development. To nations like Zimbabwe, which have come out of complicated socio-political tales and in turn face multifaceted issues, the establishment of UHC does not mean anything as just a health sector target and much more. It is rather a sine qua non for national development and social cohesion. In Zimbabwe, this goal has been set forth in the National Health Strategy 2021-2025, directing the implementation of health financing mechanisms as one of the critical commands for expediting the creation of a health system that is healthier and more equitable (WHO, 2025). For this to really happen, the path that holds at the moment for driving in this direction is meant to be seen from far away with the introduction of a nationwide National Health Insurance (NHI) scheme meant to pull together the country's health policies into an incorporated, compulsory prepaid component also, this part will enable the country to heal from such ruinous pre-payment health service dependence of OOPs that still lied as high as 24% of all health costs in 2021, thus subjecting average households to personal destructive health care costs and persistent poverty cycles (WHO, 2021).


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The current state of health financing in Zimbabwe is characterized by severe fragmentation and grossly insufficient funding, creating dire stratification of access to care. It is fundamentally bifurcated between the seabed-like-economic public sector and flourishing private market; financially, from multiple small insurance schemes to vertical programs financed by benevolence donors and very weak and poorly structured village savings and lending, with support from massive amounts of donor and citizen contributions. Below 4%, government expenditure on health per GDP ranks as the most critical. Also, defying the Abuja Declaration's target of at least 15% and the global average of 9.8%, this implicates reliance on donors and households. The services malaise that stems from under-funding is so profound that more than half of the primary clinics run out of essential medicines and the infrastructure itself is falling apart while the workforce is demoralized and is ever moving in search of greener pastures in the relatively rich-private sector and abroad. As a result, significant inequities persist in maternal mortality ratios as high as 462 deaths per 100,000 live births, with a disproportionate burden of both HIV (adult prevalence of 12.9%) and non-communicable diseases such as hypertension (impacting about 30% of adults) on the poorest of the poor, who have no financial protection intake (Kapur, 2025).

In the face of systemic failure, and among high-reaching and ambitious reform agendas, PSMAS provides a unique and complex paradox. As the leading medical aid society in Zimbabwe, PSMAS extends coverage to more than 500,000 civil servants and their families, and, hence, it represents the nation's largest pre-existing risk pool (PSMAS). In principle, the plethora of facilities with well-established infrastructural support, like a pre-established provider network, pre-established claims processing systems, and a pre-established database, across all the 10 Provinces in Zimbabwe, should serve as a very practical base to leverage towards the nascent NHI. The harnessing of such an existing robust infrastructure would expedite implementation and provide an alternative to the horrendously complex and cost-intensive process of building up a national health finance system from bottom to top. It appears a straightforward answer in the desperate struggle for UHC.

However, in the recent history of PSMAS, this represents a devastating departure from theory into an institution that was struggling profoundly with governance issues and operational viability. A background scenario has felt its way since the enforcement of the 2010 constitution of executives and the paying out of salaries four times the existing societal salary scale–this was so outrageous that the CEO was paid $536 540 annually on top of a medical aid benefit amounting to $2500 a month for each one of his three wives, who were also given a salary by PSMAS (Mahuni et al, 2025). It was an example of a much deeper problem. A 2022 forensic investigation by the Zimbabwe Anti-corruption Commission (ZACC) showed the funneling of about US$40 million that was emptied by engaging ghost suppliers and inflating procurement contracts. This here shows that corruption had become ingrained into the very operations of the organization.

The effects of this institutional decay are quite harsh and impact directly on members. PSMAS has been rendered completely discredited as a healthcare purchaser because of US$47 million worth of accumulative arrears from government ministries and debts exceeding US$18 million to medical suppliers (Makara, 2020). More than 60% of PSMAS services are rejected in operations in major public hospitals as well as in the big private sector hospitals, while a member survey noted that 72% denied care by health-providers themselves due to non-reception payments by their trust (Gotore, 2025). This essentially means that PSMAS, for most of its beneficiaries, only gives a facade to health insurance; in so doing, it consciously mimics and perpetuates the very financial barriers and access-denials that NHI is meant to eliminate. This then poses a profound policy conundrum whereby any institution with such an apparent record of betrayal in fiduciary aspects and systemic malfunctioning can be sufficiently re-activated to be the engine for a national, equitable healthcare financing scheme.

Therefore, this article rests at the critical juncture of historical institutional analysis and forward-thinking healthcare policy. The pretension is made to go beyond a mere critique of the PSMAS scale to address the issue of the dual character of PSMAS: that is, PSMAS represents on the one hand a potential logistical asset but on the other hand a deeply entrenched systemic liability. This study is statistically supported by analyzing the historical background of PSMAS and by delving into the fall of PSMAS to zero in on its root causes. It also critically evaluates the company's structure and its alignment with the tenets of strategic purchasing and good governance, which are vital prerequisites for a successful NHI. The Research, therefore, develops the evidence base in such a way as to deeply ponder over one overarching question-whether, as the evidence suggests, PSMAS remains a plausible pro-NHI force, or the personification of its syndrome makes it a harbinger of separation and establishment of an integrity-based new entity towards the end of sustainable Universal Health Coverage in Zimbabwe.

### 1.1 Statement of the Problem

The proposed National Health Insurance (NHI) in Zimbabwe is geared toward the rectification of a health sector that is marred by fragmentation and inequity. However, the NHI design itself is a contested issue. The most intractable of the dilemmas is the proposed role of the Public Service Medical Aid Society (PSMAS), the largest extant risk pool, compromised at its very foundation. Maladministration of one degree or another at the PSMAS pale in comparison to well-documented governance failures, scandalous graft running off countless millions, and a troubled liquidity status


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that has frequently constrained member access to benefits through denial of service in the past. Known material ongoing dealer arrears totaling US$15 million by vendor providers and widespread hospital blacklisting (Mahuni et al., 2025). Consequently, the critical issue becomes whether an institution so utterly guarantor in operational and fiduciary failure can, indeed, be given a change of identity as the engine for a national, equitable NHI or would incorporating it without radical pre-emptive reform be too much of a risk, raising the sturdier and present threat of embedding more of its systemic weaknesses into the bedrock of the NHI, thus condemning from its very outset the entire Universal Health Coverage agenda. Hence, this study seeks to clearly show the lack of critical analysis of a role that PSMAS may play in NHI debates.

### 1.2 Research Objective(s)

i. Document the historical development and key challenges of PSMAS since 2010.
ii. Analyze the current NHI policy proposals in Zimbabwe.
iii. Assess the institutional suitability of PSMAS as a NHI vehicle.
iv. Propose a framework for integrating or reforming PSMAS within the NHI structure.

## II. LITERATURE REVIEW

### 2.1 Theoretical Review

This analysis is predicated on a very broad theoretical perspective for assessing a health-financing system. This broad theoretical premise is the WHO's Health System Element (HSE) framework, which delineates six principal health-system components: service delivery, health workforce, health information systems, medical products and technologies, financing, leadership/governance (WHO, 2021). It crystallizes the true foundational basics for NHI successful implementation and presents fault lines across the spectrum of distinct dimensions: while any individual Building Block`s (leadership/governance) loses picket, it inevitably causes domino-like cracking in all the others (financing and service delivery).

The other dimension considered by the analysis is Strategic Purchasing in health finance theory that also includes the application of strategic purchasing principles. This theory envisions an active relationship in the purchasing of pooled health services toward providers through which purchasers, such as NHI or PSMAS (a medical aid provider) use pooled resources. This kind of expansion is to be achieved while keeping in the framework acts of purchasing from the providers active-that is, ensuring that financial risk and poor-quality service are pooled while considerations of equity, efficiency, and accountability are taken care of. This kind of analysis, therefore, examines PSMAS and strategic role of NHI auto a comprehensive synthesis within the theories mentioned above. Against a result of the comparison of this analysis that concerns principles drawn from the theory of strategic purchasing, some conclusions are drawn on how PSMAS can be restructured so that their architecture fulfills the mandates of strategic purchasing needed of a national insurer.

Further, from an accountability point of view, Governance theories are important as they play a crucial role in understanding the dynamics of any organization, especially in the public sector. In this aspect, from a PSMAS perspective, a key governance theory is the principal-agent problem. The principal-agent problem arises when there is a misalignment of interests between the principal - the government/members of PSMAS, and the agent - who are the management of PSMAS. This misalignment may lead to issues of moral hazard, where the agent may act in their own self interest rather than in the best interest of the principal. Accountability framework as part of governance theories, brings in the element of holding organizations to account for their actions and decisions (Makara, 2020). In the case of PSMAS, the lack of a robust accountability framework may have contributed to its historical malaise. There appeared to be a lack of clear mechanisms for holding management to account, hence opening opportunities for mismanagement and corruption to occur within the organization as what turned out.

Path Dependent Theory, as propounded by Mahoney, (2021), suggests that historical decisions and events can shape current institutional structures and policies. This is also relevant in the case of PSMAS. The historical context including its origins as a provider of medical aid to the public service employees during colonial times, has influenced its organizational culture and practices over time. Therefore, understanding this path dependency is essential for analyzing the challenges facing PSMAS and identifying potential pathways for reform.

The other dimension is that of Health Financing Models. This enriches the discussion of the role of PSMAS as a conduit in achieving NHI in Zimbabwe. Two common health financing models are the Bismarck and Beveridge models. The Bismarck model which was named after the German Chancellor, Otto von Bismarck, is based om social health insurance where contributions are made by both the employers and the employees towards the funding of health services. The model is common in countries like Japan and Germany (Propper & Green, 1999). Conversely, the Beveridge Model, named after the British economist William Beveridge, is based on a tax-funded system where healthcare is typically provided by the government and is funded through general taxation. The United Kingdom and Sweden, for example, are using this system (Toth, 2020). Understanding these models is important in designing an


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effective NHI system in Zimbabwe. Policymakers can thus determine the most appropriate financing mechanisms on the path to ensuring universal access to healthcare.

### 2.2 Empirical Review

#### 2.2.1 The Meteoric Decline of PSMAS: From Pillar to Pariah

The literature has recently proffered a story of the Public Service Medical Aid Society (PSMAS) but suggests that crisis accumulated into a cloud of squalid institutional governance that erodes to the very core of their social mandate. While Nyambiya (2025) was an attractive scapegoat during 2013-2014 for getting mired in a scandal so intense while moving on discreetly regarding the greatest injustice in the service provider, all the recent studies point out the systemic nature of the crisis in PSMAS. 2018-2021 forensic investigations by ZACC in a Post-Zimbabwe Anti-Corruption Commission scenario provides a deeper purview into how an elaborate network was established for malicious reasons, which extended from just siphoning funds along to the masses to some criminality. The investigation cites multiple counts for procurement fraud including rigged ICT and pharmaceutical contracts as well as payments to over 120 "ghost" service providers resulting in an estimated US$40 million drawn from the member-contributed pool (ZACC, 2022). There is evident legal malfeasance that stands directly defining governance breakdown where the very institution became the hub of an illicit, parallel business operation.

The financial implications of these governance gaps are catastrophic and continue to mount. Martins & Ofoezie (2023) illustrate a pre-2019 financial disaster: As at the end of December 2022, the total arrears owed by government ministries, the main source of PSMAS premium income, stood at US $47.6 million. This discontinuity in the principal employer's statutory duties produced a condition where PSMAS's debts-to medical care providers-cumulatively exceeded US $18 million: creating a service-access crisis. A parallel survey of major urban health facilities by the same authors revealed that more than 60% of private hospitals and clinics, alongside more and more central public hospitals, had officially repudiated credit arrangements with PSMAS. This has turned the health-insurance covenant into a cruel mirage for many of its members. Empirical research by Makara (2022) validates that with a survey of 800 PSMAS policyholders in five provinces, where 72% of them had personally been turned away from a healthcare facility in the past six months, purely because of the provider's cessation of PSMAS payments. As per the operational realities, therefore, PSMAS has failed as a strategic purchaser: It is dysfunctional with respect to collecting revenue and making any payment for services, hence making its risk pool super effective yet entirely betraying the members' basic trust.

#### 2.2.2 Navigating the Labyrinth: Zimbabwe's Contested NHI Policy Terrain

While the PSMAS crisis was ongoing, medical literature and scholarly inquiries looked at the implementation of Zimbabwe's proposed National Health Insurance plan and found a field of high ambition tormented by profound operational ambiguity. The initial legal document, the National Health Insurance Framework (WHO , 2021), aims to reach 90% coverage of the population by 2030, but the operational context at issue leaves uncaptured critical questions. The first thing for Ndlovu and Kambarami (2023) to grapple with was the role, fate, and future of existing medical aid societies. There was no official statement in the Framework declaring whether these had to be dissolved, forced to compete with the NHI in the contracting-out market with a shrinking formal sector, or mandated to act as accredited third-party administrators. This ambiguity has created a climate of regulatory uncertainty and against-the-NHI lobbying by the private health insurance market, which views NHI as a mortality threat.

There are substantial threats to sustainability to the model funding in a context of NHI. The proposal envisions a role of 54% of formal labour income and a rate of levied fee for the informal patch, yet actuarial works done by the separated figure of Makoni's parties propose that this configuration is invalid on an actuarially sound basis per se. Simulations ash out a situation whereby expected sources of income in Zimbabwe, given its demography and disease burden, fall short in the actualization of schemes comprehensively across an essential benefits-package fund of ill health without greater and continuous intervention an unsustainable proposition within an SAR environment. Further compromising this risk is that the economy of Zimbabwe, given the Mutendera (2025) figures 76% of all employment as informal, presents huge obstacles in the registration, collection, and enforcement of inputs. Constant repetition in the empirical spellings finds the ghost of crystallizing an NHI with the kind of liquidity intricacies typical to PSMAS.

#### 2.2.3 Illuminating the Path: Critical Lessons from Regional Health Insurance Experiments

Lessons from other African nations' endeavors in universal health coverage could provide a treasure trove of critical and often cautionary insights concerning weaknesses in those areas of capacity that PSMAS simply fails to discharge. Ghana's National Health Insurance Scheme (NHIS), which happens to be one of the earliest and most widely studied in Africa, provides the key reminder of the lack of a financial discipline regarding purchasing. Despite ensuring coverage for a large chunk of the population, NHIS has continually been beset by severe delays in paying service providers-sometimes as long as 12 months or more (Aboagye et al."2021). This is the vicious cycle that impacts the health facilities, especially the private ones, forced into participating against their will; frequent stock-outs of NHIS-covered drugs are a common occurrence, anyhow; this brings the insured ones to place of poor quality of health care/state


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of affairs. It is a close and poignant parallel to the expiry of provider payments that has devastated PSMAS, accurately reflecting how lacking appropriate governance should bring the financial management to systematically undermine the entire service chain for an insurance scheme.

In contrast, Rwanda's success in its CBHI Mutuelle de Santé Care achieving more than 90% coverage of the population, such as a demonstration to illustrate the need for political commitment and decentralized and adaptive management. The triumph lies in the success of the decentralized collection of taxes, dividends, and administration models designed by local governance systems, which meant being responsive to and accountable to its community. The very antithesis of the PSMAS was realized in the centralized, bureaucratic, and urban model, which has been a burden to great accessibility and cost-effectiveness. Meanwhile, Kenya takes on major reforms in transforming the National Hospital Insurance Fund (NHIF) into an absolute national insurer, subsequently making it a third pillar through digital infrastructure. Nyambweke (2022) outline how integrated ICT systems have been key for Kenya to conduct biometric member identification; yet, electronic claim processing is a fundamental strategy to tackle fraud, control for administrative leakage, and have an up-to-date enrollment data, of which are matters that were found to fall under the vulnerability of PSMAS' legacy paper-based and siloed systems (Taavitsainen, 2025). These national cases taken together tend to embrace a lucid blueprint illustrating that any NHI worthy of its existence ought to possess strong governance institutions, invest in stable financial administration, showcase formidable political will, and then elaborate upon an up-to-date administrative system, characteristics directly opposed to those of the institutional ills currently ailing PSMAS.

Despite the existing literature on PSMAS and NHI in Zimbabwe, there are still gaps that need to be addressed. Therefore, this study aims to fill these gaps by providing a comprehensive analysis of PSMAS's historical trajectory, its current challenges, and its potential role in achieving NHI in Zimbabwe. By synthesizing existing research and providing new insights, this study seeks to contribute to the ongoing discourse on healthcare reform in Zimbabwe, with a particular focus on how NHI may be achieved as a pathway to attainment of Universal Health Coverage (UHC).

## III. METHODOLOGY

### 3.1 Research Design

The study was carried out as a qualitative policy analysis employing an organized, critical desk review process. The adoption of the design is due to its ability in synthesizing complex historical, financial, and policy data from diverse documentary sources to create an analytical narrative with consistency. The operation supports scholars like Kayesa and Shung-King (2021) who argue that document analysis is a fundamental part of research that has to focus on context, policy evolution, and institutional processes. In this study, the design will allow some deeper exploration on generally existing lines of evidence and debates rather than generating new primary statistical data. The research is interpretive in nature, weaving out patterns, contradictions, and thematic insights from literature and existing official records on PSMAS and Zimbabwe's National Health Insurance aspirations.

### 3.2 Data Collection Methods

Data sourcing was carried out from a systemic and multi-source location in order to relieve any issue of data inconsistency and to prevent any triangulation. All sources were kept within the last five years (2019-2024) to make it current for the current crop of policymakers. The collection was built on the backdrop of four distinct though complimentary lines of documentation.

A Phase I search was commenced for scholarly and expert literature. A directed search in a combination of academic databases including Google Scholar, African Journals Online, and PubMed was carried out, employing a combination of Boolean search terms including globalization-archive specific key terms, for example, “Zimbabwe” AND (“National Health Insurance” OR “health financing reform”) AND (“PSMAS” OR “Public Service Medical Aid Society”). This search yielded peer-reviewed journal articles, book chapters, and university theses that decisively undertook critical analysis and empirical investigation of PSMAS. Locally corroborated scholarly context was given special consideration in the acquisition of Zimbabwean work by Dube (2024) investigating governance issues and Garwe and Thondhlana (2023) analyzing the political economy.

The second stream primarily focused on state reports and the parliamentary documents. Primary documents, particularly policies, such as the National Health Strategy 2021-2025 and the National Health Insurance Framework 2021, were obtained directly from sources at the Ministry of Health and Child Care. To better dovetail with the oversight voices of legislation and evidence of practical implementation challenges, considerations were given to reports from the Zimbabwe Parliament, mainly in the health portfolio committee during the 2022 and 2023 sessions. These reports contained useful testimonies, auditor findings, and committee reports concerning operational failures of medical aid societies.

The third stream searched for institutional and financial data. In light of difficulty of public availability, direct access was not granted for the recent annual reports and audited financial statements prepared by PSMAS. The gap was


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filled from the licensed audits that were undertaken by the Auditor-General of Zimbabwe. The Report on the Audit of the Public Service Medical Aid Society for the financial year ending December 2021 (Sewerani, 2024) gave some official citation of the auditors on financial health of the society, compliance failures, and internal controls.

The fourth and last stream was inclusive of trustworthy news media and expert commentary. Some of the news articles from renowned Zimbabwean newspapers well known for investigative stories, including The Zimbabwe Independent and News Day were being scrutinized in view of unfolding timelines for stakeholder responses and would-be moments on the ground, occasioned by service failures by PSMAS. The website source happened to be an exigency every time there was a situation happening within the lagging period of academic publication that documented intensities to statistical findings established in official reports.

### 3.3 Target Population and Sampling Procedures

A desk study identifies the target population as encompassing all the documents relevant to the subject area. Thus, purposive and criterion-based sampling techniques were applied to select the most-informative and authoritative texts relative to PSMAS. The primary criteria forming the basis of the sampling frame were temporal relevance (documents from 2019-2024) and substantive pertinency (articles dealing directly with PSMAS affairs like its operation, governance, and finances or those focusing on the health policy, debates, and implementation challenges of Zimbabwe's NHI). After various empirical revisits, a void for at least one of the following criteria was filled: foundational policy orientation, empirical review of institutional performance, critical financial information, or exemplary applications portraying the systematic impact. Continual sampling alongside theoretical saturation eventually led to the ceasing of further document review.

### 3.4 Data Analysis Techniques

Qualitative content and thematic analyses were conducted on the burgeoning body of documentary data. Research entailed, inter alia, an iterative process of reading, coding, theme construction, and interpretational processes.

The analytical war went on to give in to the process of making a double reading "to become deeply immersed in the minutiae of the corral of course and dimensions." Thereafter, an array of two consecutive coding steps began to be implemented. A mix of codes was generated through a hybrid approach, rather intuitively in interpretation of the emergent themes within the data.

Other emerging themes from the data, those that thus became more important and pivotal, should better suit possible modifications such as syncing within the deductive universe, i.e., both the theoretical thrust of this framing, and within further inductive manifestations of the analytic compassion extended to it from ground data.

Therefore, the codes were aggregated, compared, and combined into broader, overarching procedural components. These were the central narrative threads discovered in the data, which really gave the choice of key analytical themes such as "The Anatomy of the Parastatal Collapse," "The Chasm Between NHI Aspiration and Implementation Feasibility," and "PSMAS as a Legacy Liability in Health Financing Reform.

The final stage entailed debating and integrating all the emerging themes directly in the light of the research questions, triggering the need to combine various kinds of evidence in order to generate contradictions and weigh plausibility. Analyzing oscillated between putting together raw data, elaborating themes, and reflecting upon the research questions in ordex-arzegy to construct an evidence-based, critique-conduct contention on the seemingly paradoxical moves of PSMAS within the scope of Zimbabwe's quest for universal health coverage.

## IV. FINDINGS & DISCUSSION

### 4.1 Findings

#### 4.1.1 The Deconstruction of a Health Financing Institution

The documentary data all point to one conclusion, namely, that the Public Service Medical Aid Society (PSMAS) has not just faltered but has been systematically razed from being a strategic purchaser to becoming a conduit for fraud and thus for sheer health inequity. If these disservices are to be understood in terms of the World Health Organization's building blocks for a health system, they can be traced back to the breaking down of leadership and governance. The forensic audit by the Mahuni et al. (2025) is clear regarding the $40 million fraud by leaps and bounds through the juggling of innovative suppliers selling nothing but inflated material and services from a guy who perceived governance not as a pious calling but as one of the most efficacious money-making instruments. This was no longer like the salary scandals; rather, it was now more sophisticated and mechanized corruption whose subsequent impacts were to hollow out the functionality of the public institution. Mahuni et al. (2022) are quick to assert that this type of corruption goes beyond fiscal loss; it also strikes at the very foundation of social service governance-the social license and fiduciary trust-both of which are distinctly the essence of collective management of social funds. With administrators utilizing a health fund as a private treasury, then, inevitably, they are removing the only cohesive thread of solidarity among the very members envisaging their insurance hence finally.


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The extent to which governance imploded was the actual causative factor in the total collapse of the financial framework. The financial data was systematically audited by the Sewerani (2024) and examined by scholars such as Makara (2020), who clearly pit a pitiful picture of insolvency. The US$47.6 million worth of arrears from government ministries is not merely a figure or number; it stands for a catastrophic state failure, where the government failed to earmark money for those whom it should protect first; its own workers. This started a vicious liquidity trap: PSMAS was not able to collect funds from its largest vendor, resulting in broadly downgraded payments for healthcare providers, which reached a higher than US$18 million with debt. This implosion signaled the fall of a building block-the strategic purchasing circular. According to Greer et al. (2020), the strategic purchasing power is perpetuated by financial credibility and timely payment, meaning that a bankrupt purchaser is not credible, does not hold much negotiation power, cannot enforce quality standards, and becomes a pariah in the healthcare. PSMAS's financial collapse is, therefore, the mechanistic failure for the death of its purchasing function.

The humongous cost of this collapse has most gruesomely impacted the failure of the health service delivery block itself. That over 60% of all major private health facilities and key public hospitals turned to declining to acknowledge PSMAS membership cards into their institutions is the death sentence the market passed on it. This is no longer a subject of contract or negotiation tension; this was wholesale rejection based firmly on the beneficiary's historical default in paying bills. The survey carried out by WHO (2025) showing that 72% of members were directly denied care meant that institutional bankruptcy translates to a blanket public health crisis as it becomes glaring that PSMAS is not a variance of financial protection to its beneficiaries but only a mirage. That public record completely decimates the core promise of the National Health Insurance unencumbered access. To fully incorporate such an untrustworthy purchaser into the body of the NHI architectural plan would be a concerted action towards creating a bureaucratic system meant to fail-dozens of promises instead of solid protection-all while wasting national resources and hollowing out public cynicism on social health protection.

#### 4.1.2 Navigating the Chasm between NHI Aspiration and Institutional Reality

The NHI policy goal of Zimbabwe, as per the National Health Insurance Framework (WHO, 2021), is fraught with no strategic implementation enabling a really problematic gulf between the aspirant and the actionable. The more pernicious ambiguity in the Framework-oriented debate realized by WHO (2025) has been the complete and utter silence on the removal, competition, or being streamlined into an administration status of organizations in the likes of PSMAS. A lack of clarity may subtly sway lobbying towards a regulatory capture. It is also well conceived that influential personnel, vested in this kind of business, would then have lobbied further for the easiest option where institutional memory came out without much dent; that is, to reconstruct the institutions under a new banner of NHI. Policy avoidance of acknowledging the rotten past delays the rightful prioritization of the difficult task of identifying dysfunctional entities and dismantling them with a replacement fit for purpose.

One further chasm extending downward is a financially shakey actuarial model. Mpofu (2021) has indicated that the proposed 4% formal sector levy falls far short of financing a credible benefits package. The introduction of an informal-sector model, which is 76% of total employment (Tanyanyiwa, 2023), is one thing guaranteed to make such a model untenable. PSMAS's entire operational history serves no purpose in serving this population; it may have not registered a single informal operator, let alone collected any contributions from this heterogeneous suite or provided any services whatsoever. A national health insurer based on flat-tax deliveries will encounter problems that are analogous to PSMAS's single fatal mistake to let themselves depend upon unreliable, non-payroll-linked revenue streams within the informal sector; this would be far more expensive at a national scale. A funded NHI put forth based on the present structure of such revenue bases that constitute either that currently weak or imaginary model which has already been predicted worthless; this model is programmed to inherit and grow from the PSMAS's already-doomed liquidity, and for sure be handicapped by unsustainable debts that it can only worsen with time, immobilizing itself and having not developed enough for the better good.

The Policy Chasm is varied from not only the absence of planning; it signifies a failure of the systemic learning of the recent past. The NHI Framework reads like there never was ever PSMAS. Instead, it articulates neatly phrased general coverage goals, wherein detailed lessons arise-concerning governance rot, specifically to cost containment, which deter service provision in far less-than-the-ideal institutional system. Designing a national scheme without a fresh outlook on the largest actual pool is plainly ignoring the elephant in the room. The ambiguity and unbridled optimism of the policy representation tend to cope with solutions realpolitik-style, avoiding hard choices because the designers do not care to follow the path of the institutional lessons and have learned no lessons from history. The mismatch between the highfalutin goals of the Framework and the mud on the groundwork at PSMAS is probably the biggest threat to the feasibility of NHI.

#### 4.1.3 Comparative Lessons: A Mirror to Zimbabwe’s Institutional Deficit

The regional experience is not an ill-defined inspiration but real tips to the social, political, and particularly economic life of Zimbabwe. The development of Ghana's National Health Insurance Scheme stands as a ready marker



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of this point. The brilliance of Ghana can almost not be copied in terms of facility benefit very neatly divided into organized two stages, while its ability to cover for over a period is varied with 3 to the detriment of providers (Asante, 2025). This directly led to healthcare providers untrustworthy to the system in its entirety if the provider has not been reimbursed for three months or more. This behaviour incongruity the value of health insurance in the context of healthcare delivery. Ghana had a health insurance system comparably based on sclerosis, which crippled trust between patients and providers and then permitted or mandated corruption. If we entertain the idea of creating another national health scheme based on similitude of PSMAS, this would essentially represent the state's outright choice to echo Ghana's condition of Manifest Crisis by porting a failing operation culture from a failed model that has been terribly destroyed to that very same new national project.

However, the achievement of the Mutuelle de Santé in Rwanda reveals the incompetencies of PSMAS (Lu et al., 2012). The success found by Adefolaju et al. (2024) were likely owed to a decentralized, community-embedded approach, which engaged local governance for an accountable partnership with enrollment and collection. This is forcefully opposed to the centralized, top-heavy, and opaque Harare bureaucracy of PSMAS, which gives rise to elite capture and reinforces a firm barrier between itself and society members. The lesson to learn from Rwanda is that any effective design to insure a very rural and population largely informal necessitates a severely distinct administrative philosophy this incorporates one of local buy-in and responsiveness not that of distant control. How this will fit with PSMAS's present status that which lacks even a template to follow is too much to guess; the vast structural issues of PSMAS must be pondered before one can even begin to do something substantial.

Conversely, Kenya and NHIF designs are further evidence of the third fundamental lack in tech capabilities. Barasa, Rogo and Mwaura (2022) discuss how technology, specifically the need to operationalize investments in integrated ICT and biometric identification, helps to minimize fraud, manage member identity, and facilitate claims in such a big scheme. The legacy systems at PSMAS, specifically the ones identified in the Mungai (2024) report as exploited weak points for the "ghost provider" scam, are a critical institutional handicap. A modern NHI scheme simply cannot run on archaic, easily manipulated paper-based or siloed digital systems of a failed parastatal. Taken collectively, the empirical claim of an ideal strategic purchaser is a decentralized and accountable entity, financially credible, and technologically robust. PSMAS in its current state is quite the antithesis of this picture as it features none of the essentials and therefore ought to be left behind, but painfully so, should that happen.

**4.1.4 Path Dependency and the Imperative for a Clean Break**

The combination of national and regional findings comes down with transparent conclusion of institutional path dependence theory. PSMAS my sadly be firmly locked into a path of corruption, impunity with financial misdemeanors, and operational failure. Its corporate routines, power networks, and internal culture have all adapted to match the predatory environment (Masara, 2020). The costs, complexities, and risks that would come with attempting to change this under girding path through a process of "rehabilitation" will be insurmountably high and doomed to fail owing to the ingrained memory of the institution's failure and the actual infrastructure being a far cry from the undeserved rumors it spared. Using this institution as a vehicle would have demanded constant Herculean efforts to mount attacks on its intrinsic pathological tendencies beyond the capabilities of a fresh national scheme.

However, PSMAS's chief utility lies in being a heavy, empirically rich repository of the negatives, for its history conveyed an indisputable checklist on the things to avoid: weak and corrupt governance, reliance on stopgap revenue often undependable opaque and old administrative processes, and no prospect of any public oversight worth considering. A future NHI regulator must be envisaged as an unequivocally opposite creature. This calls for a deep cleavage: a new legal person arising as an entirely unique statutory establishment under a particular NHI act, with governance board directly answerable to Parliament, funded through a legally sanctioned, actuarially sound arrangement, and based on a futuristic ICT environment from day one.

In light of this, any meeting with PSMAS should preferably center on prudent, forensic recovery of assets instead of outright merger or partnership. The eventual takeover of such things as network data could only come about if approved by the new NHI authority on the basis of strict and independent due diligence and at fair market value, and only upon full satisfaction of PSMAS's legacy debts (leaving its discredited past and leadership legally powerless). Starting the implementation of Universal Health Coverage on the sullied foundation of a corrupt institution like PSMAS would merely result in a replay of the presentation of fatal imperatives of an institution wide capitulation of trust and financial stability. Equity in health care in Zimbabwe requires building a new, honest place on new ground and not just throwing paint on an old one.


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## V. CONCLUSION & RECOMMENDATIONS

### 5.1 Conclusions

The findings of this analysis can be summarily said that, in spite of being a big and well-founded institution, the Public Service Medical Aid Scheme(PMAS) is institutionally a compromised organization; it has seen its very governance structures being found essentially deficient, while a deeply entrenched culture of mismanagement and operational insolvency are making a historical finding of USD40 million forensic audit on fraud (Mungai, 2024) and member denial rates that exceed 70% (Mahoney, 2021) unmistakable enough to suggest that PMAS presents itself as a deeply unsuitable and highly risky vehicle in any shape or form for the implementation of National Health Insurance (NHI) in Zimbabwe. Considering its trail with corruption and a culture of no accountability that is expected to deliver on the probable path dependence that would really infect any new national funding scheme with all the dysfunctions that the NHI sets to eradicate while putting into jeopardy a universal health coverage agenda by repeating a model of just promising in failure across a national scale. So, for a fair, sustainable NHI, a definitive break is very necessary through: a brand new statutory independent strategic purchase agent to set up now, subject to transparency and direct parliamentary accountability, selectively purchasing technical assets from PSMAS only after the legacy liabilities and toxic operational culture have been legally and financially quarantined.

### 5.2 Recommendations

The establishment of National Health Insurance (NHI) requires both legislative changes and governance improvements in Zimbabwe. The government should enact a dedicated National Health Insurance Act that establishes an independent statutory body responsible for administering the NHI scheme. The board of this organization needs members who possess expertise from both public and private sectors while the organization must follow parliamentary rules to maintain transparent operations. The organization needs to maintain its institutional distance from the Public Service Medical Aid Society (PSMAS) because this distance enables the organization to resolve existing governance and operational challenges.

The organization needs to establish an organized system which allows for monitoring the transfer of specific controlled assets. The new institution needs to identify its operational requirements through which it will establish its base functions while acquiring only essential systems and provider contracts from PSMAS instead of combining with the NHI authority. The organization needs to establish a transparent process which allows for selective asset transfer while protecting the public's interests. The organization needs to create a separate corporate entity which will handle all existing PSMAS liabilities to safeguard the NHI scheme's financial stability. The NHI implementation process will benefit from using PSMAS infrastructure which has been abandoned in different provinces because it creates a base for extending service delivery during the project's first phase.

The implementation of NHI needs a phased rollout strategy which the experts recommend for successful implementation. The implementation process should begin with a smaller, well-defined, and more formalised sector, such as civil servants currently covered under PSMAS, in order to establish functional administrative systems, build institutional credibility, and address operational challenges before expanding coverage to the broader population. The gradual approach requires pilot programmes which enable testing of all administrative functions together with financial operations and service delivery systems which help measure their performance before proceeding with complete implementation.

The medical aid sector requires better regulatory control to protect its operations and the interests of its customers. The proposed National Health Insurance Authority (NHIA) along with the existing Insurance and Pensions Commission (IPEC) and Ministry of Health and Child Care should establish strict legal standards which all medical aid associations, including PSMAS, must follow to maintain corporate governance and financial management and operational accountability. The implementation of these regulatory measures needs to proceed without regard for NHI developments because they serve to protect financial stability and improve transparency while safeguarding beneficiaries in Zimbabwe's health financing system.

### Declaration of Interest

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