

MARKET POWER, CONDUCT AND CONSUMER WELFARE IN ZIMBABWE'S MEDICAL AID INDUSTRY

by

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ABSTRACT

The medical aid societies play a critical role in financing healthcare services in Zimbabwe, particularly in a context of low insurance penetration, high out-of-pocket expenditure, and increasing concerns over anti-competitive conduct. Growing complaints regarding delayed reimbursements, restrictive provider networks, and preferential treatment of affiliated healthcare facilities have raised questions about the extent to which dominant medical aid societies may be exercising market power to the detriment of consumers and healthcare providers. Thus, this study to: (i) examine the structure of the medical aid market and measure concentration levels; (ii) analyse conduct by dominant firms and assess whether such conduct constitutes abuse of dominance; and (iii) evaluate the impact of market power on consumer welfare. The study mainly relied on secondary data obtained from literature, Competition and Tariff Commission case reports, industry reports, and broader empirical studies on healthcare competition. The findings reveal that Zimbabwe's medical aid industry is highly concentrated, with Premier Service Medical Aid Society (PSMAS) controlling approximately 61% of the market, while the top three schemes collectively account for about 83% of total lives covered. The estimated Herfindahl–Hirschman Index (HHI) of 3,954 confirms extreme market concentration. The study identified several competition concerns, including exclusionary practices, discriminatory reimbursement systems, vertical integration, and self-preferencing by dominant medical aid societies such as PSMAS, CIMAS, and CellMed. These practices have negatively affected consumer welfare through reduced provider choice, increased out-of-pocket healthcare costs,

declining service quality, and weakened competition among healthcare providers. The study recommends stronger competition oversight by the Competition authority, regulatory separation between medical aid financing and healthcare provision, improved transparency in claims and tariff systems, and measures to promote market entry and consumer mobility in the medical aid sector.

Disclaimer: The views and opinions expressed in this study are solely those of the author and do not necessarily reflect the official position or views of the Competition and Tariff Commission.

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1. Introduction

The financing of healthcare through prepayment and risk-pooling mechanisms is widely recognised as a critical pillar of modern health systems. Globally, health insurance whether public or private, serves to reduce catastrophic out-of-pocket expenditure and enhance access to quality care (World Health Organization (WHO), 2023). However, in low- and middle-income countries, private health insurance markets often evolve in contexts characterised by macroeconomic instability, limited public funding, and weak regulatory capacity, raising concerns about market concentration and unequal bargaining power (World Bank, 2022). Zimbabwe presents a particularly compelling case. The country's health system is financed through a mix of government funding (general taxation), donor support, out-of-pocket payments, and private medical aid schemes. Despite policy commitments to universal health coverage, private medical aid plays a disproportionate role in financing access to private healthcare services for mainly formally employed and higher-income households (WHO, 2023). Nevertheless, coverage in Zimbabwe remains low estimated at below 10% of the population indicating persistent financial vulnerability among households (World Bank, 2022).

The Zimbabwean medical aid industry has increasingly attracted regulatory and policy attention due to concerns about high market concentration, recurring disputes over reimbursement tariffs, delayed claims payments, and alleged imbalances in bargaining power between medical aid societies and healthcare providers (Competition and Tariff Commission, 2024). OECD (2019) explains that where a small number of firms control a substantial share of a market, the risk of market power increases, potentially enabling dominant firms to influence prices, contract terms, and market access to the detriment of both competitors and consumers. In health insurance markets, market power mainly manifests not only through higher premiums but also through restrictive provider networks, delayed reimbursements, and exclusionary contracting practices (OECD, 2019). These concerns are not unique to Zimbabwe, but similar competition issues have arisen in other jurisdictions across the world, where competition authorities have scrutinised consolidation and buyer power in healthcare financing markets (OECD, 2019). Vertical integration has become a concern in the sector where medical aid societies (MAS) also offer medical health services on preferential terms compared to independent health service providers. This has been seen with big players who in most cases abuse their dominance for the detriment of the consumers.

It is against this background that a systematic assessment of market structure, firm conduct, and consumer welfare outcomes becomes necessary to unravel the competition dynamics with the intention of proffering suggestions to ensure improved health access and safeguarding consumers in the sector. Thus, this study seeks to:

- ✓ Examine the structure of the medical aid market and measure concentration levels.
- ✓ Analyse conduct by dominant firms and assess whether such conduct constitutes abuse of dominance.
- ✓ Evaluate the impact of market power on consumer welfare.

2. Methodology

This study mainly relies on secondary data obtained from literature that include reports on cases that have been handled by the Competition and Tariff Commission (the Commission), industry reports and broader empirical literature.

3. Overview of Zimbabwe's Medical Aid Industry

Zimbabwe's medical aid industry constitutes the principal mechanism for private health financing outside direct out-of-pocket expenditure. Medical aid societies (MAS) operate as member-based risk pooling arrangements established under the Medical Services Act [Chapter 15:13]. Their core function is to collect contributions (premiums) from members and reimburse healthcare providers for services rendered in accordance with specified benefit packages. Although structured as mutual entities rather than profit-maximising insurance companies, medical aid societies compete for members, negotiate tariffs with healthcare providers, and operate within a market environment shaped by both sector regulation and competition law. The interaction between sector regulation and competition enforcement is therefore central to understanding the industry's structure and performance.

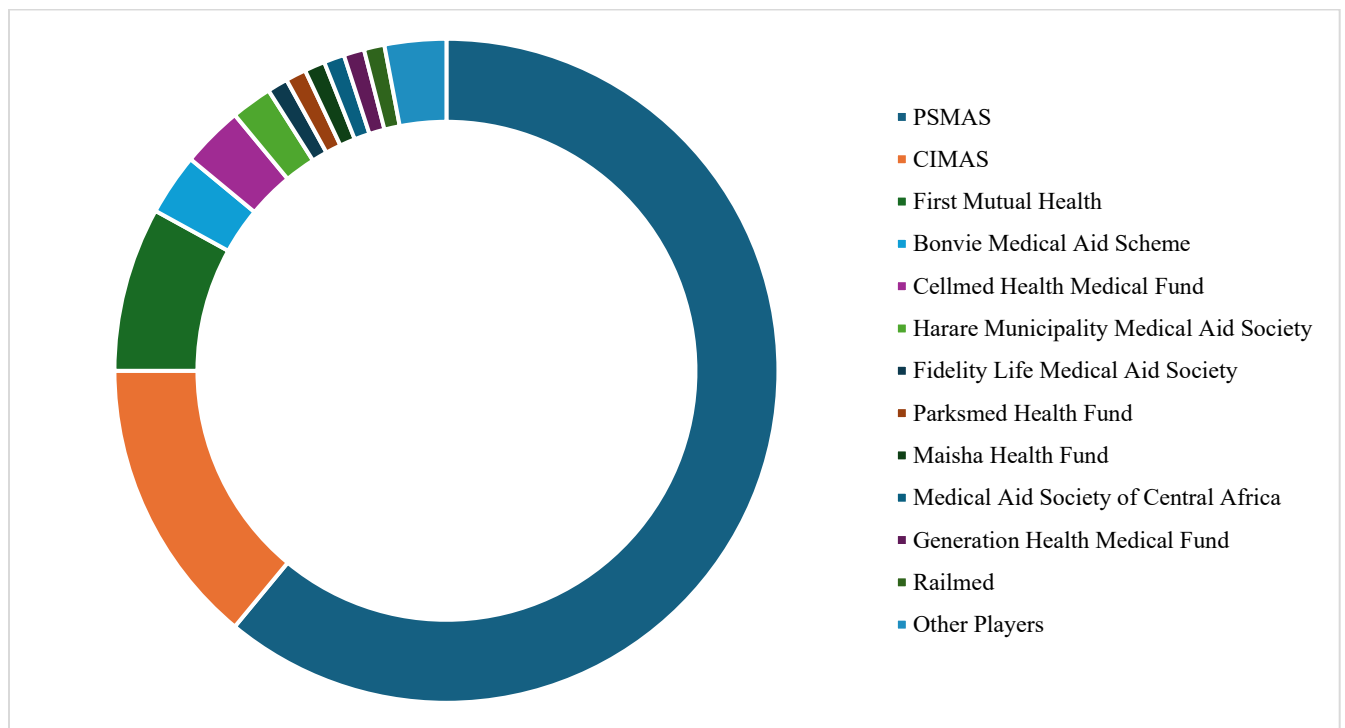
The governance of Zimbabwe's medical aid sector is primarily anchored in the Medical Services Act [Chapter 15:13], which provides for the registration, regulation, and supervision of medical aid societies. The sector is governed by the Ministry of Health and Child Care which provides an oversight role including the approval of benefit structures and general compliance matters.

However, where issues of restrictive practices, abuse of dominance, or anti-competitive mergers arise, jurisdiction falls under the Competition Act [Chapter 14:28], enforced by the Competition and Tariff Commission (*the Commission*). This dual regulatory structure creates an important interface between health policy objectives and competition principles. While sector regulation seeks to ensure financial sustainability and access to healthcare services, competition law aims to preserve market rivalry, prevent abuse of market power, and protect consumer welfare. In concentrated markets such as health insurance, the risk of dominance and buyer power is heightened. MAS particularly large schemes, negotiate reimbursement tariffs with hospitals, clinics, specialists, and pharmaceutical providers. Where a single scheme accounts for a substantial proportion of covered patients, healthcare providers may become economically dependent on that scheme, potentially creating imbalances in bargaining power. Such dynamics make competition oversight particularly relevant.

4. The structure of the MAS in Zimbabwe

The size of Zimbabwe's medical aid market has remained very small and is estimated to be around 8% to 10% of the total population (MoHCC, 2026). This implies that the majority of Zimbabweans rely either on public healthcare services or direct out-of-pocket payments. According to WHO Global Health Expenditure Database (2023), out-of-pocket expenditure continues to account for over 20% of total health expenditure in Zimbabwe, highlighting the limited depth of insurance penetration and the financial vulnerability faced by households. The market structure is characterised by a small number of large open medical aid societies and several smaller schemes, including employer-based (closed) funds. The largest medical aid society accounts for more than half of total lives covered, while the top three schemes collectively control a significant majority of the market.

Figure 1: Composition of MAS in Zimbabwe



Source: Cimas/ Avenues Merger Report (2022)

Figure above shows a clear indication that the sector is dominated by few large players which are Premier Service Medical Aid Society (PSMAS) (61%); Commercial and Industrial Medical Aid Society (CIMAS) (14%); First Mutual Health (8%); Bonvie Medical Aid Scheme (3%) and CellMed Health Medical Fund (3%) being the biggest four (4) players in the sector. The analysis of market share forms the basis for quantitative indication of potential dominance in the sector.

Table 1: Estimated Market Shares & Concentrations in the Medical Aid Market

Medical Aid Society	Lives Covered	Market Shares	CR4	HHI
PSMAS	957452	61%	61	3673
CIMAS	215000	14%	14	185
First Mutual Health	117880	8%	8	64
Bonvie Medical Aid Scheme	45240	3%	3	8

CellMed Health Medical Fund	44247	3%		8
Harare Municipality Medical Aid Society	30464	2%		4
Fidelity Life Medical Aid Society	22909	1%		2
Parksmed Health Fund	20790	1%		2
Maisha Health Fund	20466	1%		2
Medical Aid Society of Central Africa	18466	1%		1
Generation Health Medical Fund	17944	1%		1
Railmed	13805	1%		1
Other Players	55138	3%		3
Total Lives Covered	1,579,801	100%	86	3954

Source: Cimas/ Avenues Merger Report (2022)

The evidence on market shares and concentration ratios demonstrates that Zimbabwe's medical aid industry is highly concentrated, with a single dominant player controlling more than half of all insured beneficiaries. According to the market share estimates, PSMAS alone accounts for approximately 61% of the market, while CIMAS and First Mutual Health hold much smaller shares of around 14% and 8% respectively. Collectively, the three largest schemes control about 83% of the entire market, leaving only a very small portion covered by numerous minor schemes. Such a distribution reflects a highly asymmetric market structure in which one firm possesses overwhelming market presence relative to its competitors. In competition economics, a market where one firm exceeds a 50% market share is generally viewed as structurally dominant because competitors are too small to exert sufficient competitive pressure (Whish and Bailey, 2018). The concentration ratios therefore suggest that rivalry within Zimbabwe's medical aid sector is limited, as the market is effectively controlled by a few large players rather than a broad range of competing firms. This concentration is reinforced by barriers to entry such as high capital requirements, economies of scale in claims administration, actuarial expertise, technological systems, and strong brand loyalty developed over many years of operation.

The Herfindahl–Hirschman Index (HHI) further confirms the extreme concentration of the sector, with an estimated HHI of approximately 3,954, well above the international threshold of 2,500

used to classify highly concentrated markets. An HHI at this level implies that the market is highly susceptible to competition concerns because dominant firms may possess substantial market power to influence prices, reimbursement tariffs, contractual conditions, and service terms without fear of losing significant market share.

In Zimbabwe's healthcare financing system, this creates important competition risks because healthcare providers may become economically dependent on the dominant medical aid societies for patient volumes and revenue streams. Such dependence may weaken providers' bargaining power during tariff negotiations and potentially allow dominant schemes to impose unfavourable reimbursement conditions. High concentration also increases the likelihood of coordinated behaviour or tacit alignment among the few major schemes, particularly in areas such as benefit design, pricing structures, and reimbursement models. Furthermore, consumers may experience reduced competitive benefits because switching between schemes is often constrained by employer-linked medical aid arrangements, waiting periods, and information asymmetries. As a result, members may face limited choices, weaker incentives for innovation, and potentially higher costs or lower service quality. The structural indicators presented therefore suggest that Zimbabwe's medical aid industry exhibits characteristics associated with oligopolistic dominance and warrants close regulatory and competition oversight to prevent abuse of market power and protect consumer welfare.

5. Conduct by Dominant Medical Aid Societies in Zimbabwe

Dominant medical aid societies in Zimbabwe have increasingly attracted competition scrutiny due to conduct that may restrict competition and limit consumer choice within the healthcare financing sector. The most prominent concerns relate to exclusionary practices, discriminatory reimbursement arrangements, and the use of market power to favour affiliated healthcare providers. A notable example involved CIMAS in 2012, when kidney dialysis patients alleged that the society was refusing to reimburse claims for treatment obtained at B. Braun Avenues Centre while simultaneously directing members to Harare Haemodialysis Centre, a facility in which CIMAS reportedly held a 51% ownership stake. The Commission concluded that this conduct constituted a restrictive practice under the Competition Act [Chapter 14:28] because it limited patients' freedom to choose healthcare providers and disadvantaged competing dialysis centres.

The Commission consequently ordered CIMAS to stop directing patients to specific facilities and to reimburse claims for dialysis services obtained from any licensed provider in Zimbabwe. Such conduct may amount to abuse of dominance because a firm with substantial market power used its position to foreclose competitors and channel demand toward an affiliated entity.

Another recurring concern in Zimbabwe's medical aid industry involves discriminatory treatment of healthcare providers through selective reimbursement systems and exclusion from direct payment arrangements. In 2013, CIMAS was again investigated following allegations that its members were required to pay cash upfront for pathology services obtained from Lancet Clinical Laboratories, while services from preferred providers continued to enjoy direct payment arrangements. The complainant argued that the conduct unfairly disadvantaged Lancet and damaged its reputation in the market. Similarly, in 2022, complaints were raised after Family Medical Clinic was allegedly removed from CIMAS's direct payment system, making it difficult for patients to access services without incurring immediate out-of-pocket expenses. In highly concentrated markets, such conduct can significantly distort competition because healthcare providers heavily depend on large medical aid societies for patient volumes and revenue. Excluding providers from reimbursement networks or imposing restrictive payment conditions may therefore amount to exclusionary abuse under competition law if the conduct lacks objective justification and has the effect of weakening competitors or reducing consumer choice.

Competition concerns have also emerged in relation to vertical integration and self-preferencing by dominant medical aid societies. In 2023, complaints were lodged against CellMed, which allegedly reduced tariffs for external healthcare providers after establishing its own medical facility, Nectacare (Pvt) Ltd. It was further alleged that some providers were removed from direct payment arrangements and instructed to operate on a cash-upfront basis for CellMed members. Such practices may constitute abuse of dominance where a dominant purchaser of healthcare services discriminates against independent providers in order to favour its own downstream operations. This type of conduct raises foreclosure concerns because smaller healthcare providers may lose access to insured patients and struggle to compete effectively against facilities linked to dominant medical aid societies. Under the Competition Act [Chapter 14:28], abuse of dominance may arise where a dominant firm directly or indirectly imposes unfair trading conditions, limits

market access, or engages in conduct that substantially prevents or lessens competition. In the Zimbabwean medical aid sector, these practical examples demonstrate how concentration and vertical integration can create incentives for dominant schemes to engage in exclusionary conduct that undermines competitive neutrality, weakens provider competition, and ultimately harms consumers through reduced choice and potentially higher healthcare costs.

6. Impact of Market Power and Abuse of Dominance on Consumer Welfare in the Medical Aid Sector

The high concentration of Zimbabwe's medical aid sector has raised significant concerns regarding the exercise of market power and potential abuse of dominance by large medical aid societies. This section discusses some of the major ways in which market power and abuse of dominance are affecting consumer welfare in Zimbabwe's medical aid sector.

6.1 Reduced Consumer Choice and Restricted Access to Healthcare Providers

The high concentration of the medical aid market has enabled dominant medical aid societies to influence where members obtain healthcare services, thereby limiting consumer choice. For example, CIMAS was previously accused of directing dialysis patients toward Harare Haemodialysis Centre, a facility in which it reportedly held a controlling stake, while allegedly refusing to reimburse treatment obtained from competing providers such as B. Braun Avenues Centre. Similarly, PSMAS, through its healthcare subsidiary Premier Service Medical Investments (PSMI), has often been criticised for operating an integrated system of hospitals, clinics, pharmacies, and laboratories that many members were effectively compelled to use after independent providers increasingly stopped accepting PSMAS cards due to reimbursement disputes and delayed payments. Thus, consumers become locked into provider networks associated with dominant schemes, even where alternative providers may offer better quality or more convenient services. This weakens competition among healthcare providers and reduces consumer sovereignty in choosing healthcare services, ultimately undermining welfare through fewer alternatives and potentially lower service quality.

6.2 Increased Out-of-Pocket Costs and Financial Burden on Consumers

Market power in the medical aid sector has also contributed to rising out-of-pocket healthcare costs despite consumers paying monthly medical aid contributions. Reports from healthcare providers and consumer organisations indicate that delayed reimbursements, low tariffs, and disputed claims by dominant medical aid societies have forced many hospitals, pharmacies, and doctors to demand cash upfront from insured patients. In the case of PSMAS, many healthcare providers reportedly stopped accepting PSMAS medical aid cards altogether because of prolonged non-payment and debt accumulation, leaving civil servants and other beneficiaries to pay cash for consultations, medication, and medical procedures despite maintaining active subscriptions. Similar concerns have also been raised against CIMAS regarding reimbursement disputes and selective payment arrangements. These practices impose substantial financial burdens on consumers because insured patients are forced to make additional direct payments for healthcare services that should ordinarily be covered by their medical aid schemes. As a result, some consumers delay seeking treatment, reduce healthcare utilisation, or experience catastrophic health expenditures, thereby reducing the overall welfare benefits associated with medical insurance coverage.

6.3 Declining Service Quality and Erosion of Consumer Confidence

The conduct of dominant medical aid societies has also contributed to declining confidence in Zimbabwe's healthcare financing system. Consumers increasingly complain about claim rejections, delays in authorisation approvals, inadequate reimbursements, and poor responsiveness from medical aid societies. In the case of PSMAS, recurring reports of rejected cards, shortages of medicines at PSMI facilities, and long waiting periods significantly affected members' confidence in the scheme. Many beneficiaries reportedly struggled to access treatment because healthcare providers doubted whether claims would be honoured. Likewise, healthcare practitioners have repeatedly raised concerns about low reimbursement tariffs and administrative delays from large schemes such as CIMAS and PSMAS, arguing that these practices undermine their operational viability and compromise healthcare quality. Where dominant medical aid societies possess substantial market power, consumers often have limited alternative schemes to switch to, especially where employer-based arrangements exist. Consequently, consumers may remain trapped in underperforming schemes despite declining service standards, leading to reduced welfare, dissatisfaction, and weakened trust in the medical aid system.

6.4 Exclusionary Conduct and Weakening of Competitive Healthcare Markets

Abuse of dominance by powerful medical aid societies also distorts competition among healthcare providers, ultimately harming consumers through reduced innovation, limited-service diversity, and weakened competitive rivalry. Dominant schemes that own healthcare facilities may have incentives to favour affiliated providers through reimbursement policies, tariff structures, and direct payment arrangements. For example, concerns have repeatedly been raised regarding both CIMAS and PSMAS because of their ownership of clinics, pharmacies, and hospitals while simultaneously controlling reimbursement systems for insured patients. In the case of CellMed, allegations emerged that external healthcare providers were subjected to reduced tariffs and removal from direct payment arrangements after the establishment of its own medical facility, Nectacare (Pvt) Ltd. Similarly, independent healthcare providers have complained that PSMAS-owned facilities may receive preferential treatment while rival providers experience delayed reimbursements and liquidity challenges. Such conduct can amount to exclusionary abuse where dominant firms use their market position to disadvantage competitors and foreclose market access. Over time, this may drive smaller independent clinics and pharmacies out of the market, reducing healthcare competition and innovation. Consumers ultimately suffer because healthcare delivery becomes increasingly concentrated around a few dominant institutions with reduced incentives to improve service quality, lower costs, or expand healthcare options.

7. Recommendations

In light of the high concentration levels and recurring competition concerns identified in Zimbabwe's medical aid sector, this study recommends that:

- The Commission should continue monitoring the sector for detection and redress of any abuse of dominance and exclusionary practices by medical aid societies.
- The Government should introduce rules separating medical aid financing from ownership of healthcare facilities to reduce self-preferencing and unfair competition.
- Medical aid societies should be required to improve transparency in tariffs, claims processing, and provider networks to protect consumers from unfair practices.
- Government should promote easier market entry and switching between medical aid schemes to increase competition and improve consumer choice and welfare.

8. Conclusion

This study examined market power, firm conduct, and consumer welfare in Zimbabwe's medical aid industry using competition economics. The findings reveal a highly concentrated market, with one dominant scheme controlling over half of insured beneficiaries and the top three firms accounting for more than 80% of the market. The high Herfindahl–Hirschman Index indicates strong potential for the exercise of market power. Evidence of tariff disputes, delayed reimbursements, selective contracting, and vertical integration points to significant competition concerns and bargaining imbalances. These challenges negatively affect consumers through rising contributions, service disruptions, restricted provider networks, and possible declines in service quality. Given that medical aid coverage remains below 15% of the population, effective regulation is essential. International experience shows that concentrated health insurance markets can function efficiently with strong competition enforcement, transparency, consumer protection, and policies that encourage market entry, innovation, and long-term sustainability in healthcare financing.

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