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Original Article

The political economy of national health insurance schemes: evidence from Zambia

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Abstract

Governments in low and middle-income countries (LMICs) are increasingly considering the introduction of national health insurance scheme (NHIS) as a strategy to achieve universal health coverage (UHC) targets. The literature has widely documented the technical challenges associated with implementing UHC policies in LMICs but much less is known about the political process necessary to pass UHC legislation. In this article, we document the political economy issues surrounding the establishment of the Zambia NHIS in 2018. We adapted a political economy framework incorporating, semi-structured interviews with diverse stakeholders and document analysis of policies, operational reports and legislatures from 1991 and 2018. Our findings show the 26-year journey towards the establishment of the NHIS in Zambia involved a long sequence of policy dialogue, technical review and stakeholder engagement. Our interviews with key stakeholders suggest that the act was eventually passed due to strong political will and dominant leadership of the Ministry of Health. Passing the law required trade-offs between choices influenced by stakeholder pressures and recommendations from research and actuarial studies. Another equally critical factor was the high public support and legacies of past policies, such as the removal of user fees that had created quality gaps and inequities in the health system. Furthermore, global ideas about UHC and initiatives implemented by other countries also generated support for Zambia's NHIS. Overall, this study highlights the complex set of political economy factors that need to align in order for governments to be able to adopt health insurance in low-income settings. We show that political leadership and commitment to getting reforms passed is crucial. We also highlight how certain narratives about countries in the global health sphere can shape policies in other countries.

Keywords: Health insurance, political economy, health financing, politics, Zambia

Introduction

Globally, countries have proposed various policies for achieving the 2030 universal health coverage (UHC) agenda (Fenny *et al.*, 2021; Odoch *et al.*, 2021). These policy interventions seek to move countries closer to UHC goals of increasing equitable access to quality services and financial risk protection (World Health Organization, 2014).

In Zambia, the National Health Insurance Scheme (NHIS) was introduced in 2018 through the National Health Insurance Act No. 2 of 2018. The NHIS is mandatory for all citizens and legal residents aiming to provide comprehensive healthcare and reduce catastrophic health spending at hospital levels (Government Of Zambia, 2018). It also seeks to harmonize funding and enhance strategic purchasing arrangements in the health sector (Chilufya and Kamanga, 2018). Managed by the National Health Insurance Management Authority (NHIMA), a statutory institution under the Ministry of Health (MoH), the scheme is financed through a 2% contribution equally shared by employers and employees in the formal sector, interest on investments on the local money market, accreditation fees from health facilities, grants and donations. Individuals registered with the NHIS can enrol up to seven household members.

Unlike other countries such as Ghana, where the 'cash and carry' system motivated the establishment of its NHIS (Novignon *et al.*, 2021), Zambia had relatively strong financial risk protection before its reform with an estimated catastrophic health spending of 3.39% in 2014 (population with household expenditures on health >10% of total household expenditure or income) (Kaonga *et al.*, 2019). Furthermore, between 2010 and 2015, while the NHIS was under discussion, the percentage of poor households incurring

Key messages

- We examined the political economy factors that influenced Zambia National Health Insurance Scheme's adoption after nearly three decades on the policy agenda.
- Data were gathered through interviews with various stakeholders who participated or had an interest in the reform and by reviewing key documents.
- We applied a political economy framework to analyse the reform along four variables: interests, institutions, ideas and ideology.
- Strong political will and dominant leadership of the Ministry of Health, a well as the willingness to compromise to appease stakeholders played crucial roles.
- The reform was also influenced by legacies of past reforms such as user fees that had created gaps in the health system gave public support and global ideas about UHC and narratives from other countries

catastrophic health spending declined from 10% to nearly 3% (World Bank, 2019). This reduction was partly due to institutional and financing reforms that Zambia had been implementing since the early 1990s to 'improve equity of access to cost-effective quality health care as close to the family as possible' (Ministry of Health, 1991).

A key reform was the purchaser–provider split initiated in 1996 with the establishment of the Central Board of Health (CBoH), which purchased health services from district health boards, which in turn purchased services from public health facilities (Government of Zambia, 1995). However, the government dissolved the CBoH in 2006 due to perceived duplication of duties with the MOH. On the health financing front, a significant reform was the introduction of user fees at all government and faith-based missions' health facilities in the 1990s. User fees were subsequently removed in rural areas in 2006, in peri-urban areas in 2007, and at all primary health care (PHC) facilities nationwide in 2012 (Ministry of Health, 2007; Rudasingwa *et al*., 2022). Thus, from a technical perspective, adopting a NHIS was not an obvious choice given Zambia's previous reforms.

From an economic perspective, Zambia's macroeconomic context did not align with the conditions stipulated by studies for introducing a contributory health insurance scheme (Hsiao and Shaw, 2007; Doetinchem *et al*., 2010; Yazbeck *et al*., 2023). Following a decade of strong macroeconomic performance with real gross domestic product (GDP) growth averaging at 5.4%, Zambia attained lower-middle income status in 2012 (International Monetary Fund 2012, 2012). However, economic growth slowed in subsequent years and remained modest when the NHIS bill was passed in 2018. The International Monetary Fund (IMF) estimated that real GDP growth declined from 6.7% in 2013 to 5.6% in 2014 (International Monetary Fund, 2015), with a per capita GDP of $1480 in 2018 (International Monetary Fund, 2024). Additionally in 2018, >60% of the population lived below the income poverty line, the unemployment rate was 11.4%, and 60.5% of the labour force worked in the informal sector (Ministry of Labour and Social Security, 2019; United Nations Development Programme, 2023).

A growing body of literature suggests examining health financing reforms through a political economy perspective recognizing it as a complex and unpredictable process involving multiple stakeholders with different interests (World Bank, 2008). Political economy theories that consider political and economic institutions and the distribution of power and resources among interest groups are better suited for assessing policy decisions (Hsiao, 2023). In this paper, we reviewed relevant documents and key-informant interviews to examine the historical path and factors that influenced the adoption of the NHIS in Zambia.

Analytical framework

We applied the framework by Fox and Reich (2015), which builds on theoretical and empirical literature from health policy and political science to analyse reforms for UHC. The framework consists of four variables that can influence reforms, namely: interests, institutions, ideas and ideology.

'Interests' consist of all groups of stakeholders who are directly affected by the policy, i.e. may benefit or be negatively affected by the policy (Fox and Reich, 2015). Stakeholders' interests in a reform can also be driven by principled ideas or values. Based on their interests, stakeholders can mobilize or lobby against a reform. Ultimately, the ability of groups to influence the outcome of a reform will depend on their relative power and position of other groups who will be affected by reform efforts.

'Institutions' relate to the formal political structures that affect policy formulation and implementation such as veto points (Fox and Reich, 2015). Veto point is part of the process of having the consensus of specific groups or persons. Therefore, in political systems where a greater number of veto points are required, it is difficult for a reform to pass. Institutions also involve informal structures, cultural norms and legacies of past policy choices to shape or challenge a reform.

'Ideas' includes particular policy solutions, information, conceptions and transformations that influence thinking on a subject (Fox and Reich, 2015). The ideas rely on narratives or persuasive stories that are appealing and may not necessarily be from evidence.

'Ideology' is closely linked to ideas, and it represents a worldview that is used to rationalize and formulate ideas (Fox and Reich, 2015). Ideologies can shape policy recommendations such as the use of the private or public sector to deliver services.

The aim of the study was to use the four elements of the Fox and Reich (2015) to describe the process of enacting a NHIS in Zambia after being on the policy agenda for nearly 26 years. The specific objective was to examine, through a political economy lens, how despite lacking the technical, theoretical and economic foundation for the introduction of a contributory health insurance, Zambia selected a NHIS as its part of its UHC strategy. Hence, our research question was 'how did interests, institutions, ideas and ideology influence the establishment of Zambia's NHIS in 2018?' The Zambia case study can provide valuable lessons to other low- and middle-income countries (LMICs) considering the adoption of health insurance as a strategy to advance UHC.

Methods

Study design

This study employed a retrospective qualitative case study design to understand the political economy factors that influenced the establishment of the NHIS in Zambia. We drew

from semi-structured interviews with key stakeholders, policy documents, party manifestos, strategic plans and operational and research reports related to the reform.

Key informant interviews

Based on our knowledge of the health policy landscape, we employed a purposive sampling approach by developing a preliminary list of stakeholders who had participated or had an interest in the reform process. During interviews with these key informants, they identified additional individuals for the study. The final study participants (20 in total) constituted of broad spectrum of stakeholders, such as current and former officials at key government institutions, international organizations, civil society organizations and health professional associations (Table 1).

Document review

We analysed policies and legislatures, strategic plans, operational reports and guidelines. A snowball technique was applied by checking the references of these documents. During the key-informant interviews, participants were also asked to share relevant policy documents they referenced. The documents are presented in Table 2.

Table 1. Key informant summary

Key informants	Total
MoH	3
Other ministries and public institutions	7
Development partners	6
Civil society (NGOs, academia)	2
Trade unions	1
Health professional associations	1
	20

Table 2. Documents reviewed

	Year published
National Health Policies and Strategies	1991
National Health Services Act	1995
Assessing the Feasibility of Social Health Insurance in Zambia	2002
Revised Guidelines on the Removal of User Fees	2007
First Actuarial Assessment Report on Setting Up a Social Health Insurance in Zambia	2008
Patriotic Front 2011–2016 Manifesto	2011
Second Actuarial Assessment for the Establishment of a Social Health Insurance in Zambia	2012
Medical Levy Repeal Act No. 11 of 2012	2012
National Social Protection Policy	2014
Zambia Household Health Expenditure and Utilization Survey	2014
Health Financing Strategy 2017–2027	2017
Seventh National Development Plan 2017–2021	2017
National Health Strategic Plan 2017–2021	2017
The National Health Insurance Act No. 2 of 2018	2018
National Health Insurance Communication Strategy 2018–2021	2018

Data collection and analysis

The interviews were conducted using a semi-structured interview guide that was developed based on the Fox and Reich (2015). The interviews also included questions on the historical path to the establishment of the NHIS and the successes and challenges that were encountered during the agenda setting and design phases. Most of the interviews were conducted at the participants' workplaces or private locations selected by the participants. Some interviews were conducted online in circumstances where it was not possible to meet physically. The first author conducted all the interviews in English from late November 2020 to early February 2021. The interviews were recorded with the consent of participants. They were later transcribed verbatim and identifying information of participants was removed.

We conducted a framework analysis guided by the Fox and Reich (2015) political economy framework consisting of five steps: familiarization, identifying a thematic framework, indexing, charting, mapping and interpretation (Ritchie and Spencer, 2002). The analysis was assisted using Atlas.ti version 8.0. We used the findings from additional data sources (Table 2) to triangulate and complement the findings of the interviews.

Results

First, we present an overview of the historical context connected to health financing and the NHIS in Zambia. We then present the analysis in the establishment of the NHIS along the four domains of the Fox and Reich political economy framework: interests, institutions, ideas and ideology.

Historical context of health financing and NHIS in Zambia

Health insurance as a policy option to finance health services was initially explored by the government of Zambia under the Movement for Multi-Party Democracy era through the 1991 National Health Policy and Strategy (Table 3) (Ministry of Health, 1991). The main strategy involved introducing cost-sharing mechanisms, including user fees and both compulsory and voluntary health insurance schemes, to provide sustainable domestic financing for quality care improvements. This initiative was motivated by the declining economy in the 1990s, which reduced government spending on health. Consequently, the government introduced user fees at all levels of the health system in 1993 and the CBoH was established in 1996 to purchase health services from district health boards.

After the 1990s, subsequent governments continued to explore health insurance as a health financing strategy, conducting feasibility studies and actuarial assessments. Health insurance remained on the policy agenda through several policies and strategic plans. For instance, in 2002, the feasibility of introducing social health insurance (SHI) was assessed, but the government decided not to implement it due to inconclusive results. In 2008, the MoH conducted the first actuarial assessment of SHI feasibility, proposing a 5% contribution rate shared between employers and employees to support a benefit package including outpatient, inpatient and surgical services over the projected a period of 15 years. The study concluded that SHI would be feasible only if the contribution rate of 5% was achieved (Ministry of Health, 2008). However, the government deemed this rate unaffordable and did not

Table 3. Timeline of health financing reforms in Zambia

1991–1995	• Health insurance in National Health Policies and Strategies • Introduction of user fees at public health facilities • Establishment of the Central Board of Health
2002	• Assessment of the feasibility of introducing SHI
2006–2007	• Removal of user fees in rural and peri-urban areas • Abolition of the Central Board of Health
2008–2012	• Voluntary medical aid scheme for government workers • First actuarial assessment to establish a SHI scheme • Removal of user fees at primary health care level • National Health Policy • Second actuarial assessment to establish a SHI scheme
2014	• National Social Protection Policy
2016–2019	• Health Financing Strategy 2017–2027 • National Health Insurance Act No.2 of 2018 • National Health Insurance Communication Strategy 2018–2021 • Statutory Instrument No.63 of 2019 • Implementation of NHIS

implement SHI. Instead, the government signed an agreement with a private health insurance company from Zimbabwe to implement a voluntary medical aid scheme for government workers. This scheme faced challenges, including its financial viability and service coverage effectiveness, leading to its cancellation in 2012.

On the policy front, the national health and national social protection policies, respectively, identified health insurance as a potential source of additional revenue for the health sector and a means of enhancing social protection (Ministry of Health, 2012; Ministry of Community Development, Mother and Child, 2014). Consequently, in 2012, the MoH commissioned a second actuarial assessment, which echoed the 2008 recommendations and emphasized the immediate implementation of the NHIS (Ministry of Health, 2012). The report proposed a 5% contribution rate and suggested implementing the scheme in phases, commencing with public sector employees, due to limited resources. It also highlighted the need to reach the large informal sector to achieve universal coverage

Furthermore, financing of the Zambian Health Sector remained heavily dependent on external resources, with external health expenditure as a percent of current health spending representing an average of 42% between 2008 and 2018, whereas domestic resources constituted only 40% of current health spending during the same period (Table 4). The 2017–2027 Health Financing Strategy thus further underscored the necessity of additional domestic resources to fill the financial gap in the health sector (Ministry of Health, 2017). Despite this recommendation, there was no progress towards implementing SHI until 2016, when a new Minister of Health was appointed. Within 2 years of his appointment, the NHIS bill was passed in parliament, marking the end of a 26-year journey on the national policy agenda.

Interests

In this section, we analyse the positions, interests and power of relevant actors involved in establishing the NHIS. Our

Table 4. Zambia Health Expenditure Indicators between 2008 and 2018

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Domestic General Government Health Expenditure (GGHE-D) as % current health expenditure (CHE)	35	32	39	40	38	29	49	47	38	53	44
Domestic General Government Health Expenditure (GGHE-D) as % General Government Expenditure (GGGE)	8	9	9	8	7	5	8	8	7	10	8
Out of Pocket (OOP) spending as % of Current Health Expenditure (CHE)	21	15	15	12	13	12	14	12	12	11	10
External Health Expenditure (EXT) as % of Current Health Expenditure (CHE)	38	49	43	46	46	56	33	36	43	32	44

Source: WHO Global Health Expenditure Database.

interviews revealed that several interest groups and stakeholders supported the reform, while a few academic researchers expressed concerns about the unfavourable macroeconomic conditions and the high level of informality in the economy at that time. Critics highlighted the challenges of ensuring equitable and consistent premium collection from the large and diverse informal sector.

On the other hand, public sector employees had been petitioning the government to establish a medical scheme for civil servants to reduce their financial burden from health services. The Zambia Medical Association also supported the reform expecting health insurance to improve equitable access to quality health care.

> *The other issue was that we felt that access to quality healthcare was unequal so we felt that maybe, just maybe, a national health insurance scheme would help bridge the gap in terms of access to quality healthcare for everyone, everywhere. And we were also of the view that maybe…just maybe this thing would help improve quality*. (KI 13)

Between 2016 and 2018, there was strong political support for the NHIS from the ruling party—Patriotic Front, the President, cabinet ministers and senior officials at the MoH. Interviewees credited the Minister of Health and his senior technocrats for advancing a long-standing reform agenda.

> *I can say for more than twenty years ago even when I worked in the Ministry of Health, things were happening but to a certain level but things didn't move. But it's only after Minister Chilufya became Minister of health…he pushed the agenda and [he] made sure that health insurance bill was passed into an Act and made sure that the health insurance was put in place*. (KI 12)

After a new minister was appointed in 2016, he established a transformational agenda that included a mandatory NHIS to provide sustainable financing for the health sector. This agenda led to the formation of a joint technical committee comprised of representatives from all the nine government ministries, development partners, non-governmental organizations and trade unions.

Despite setting the agenda for the NHIS, the government faced resistance from some actors regarding the design and implementation modalities of the proposed scheme. Labour unions and employers were particularly concerned about the proposed contributory rate. The 2012 actuarial assessment recommended a 5% contribution rate shared equally by employees and employers. However, public sector unions opposed this rate due to their negative experience with the earlier voluntary medical aid scheme for government workers. They were concerned about the actual benefits workers would receive after contributing.

> *From the employees and the unions, I think it had to do with…we had a medical scheme at one time, which was voluntary, and people used to contribute voluntarily but maybe they never used to see the benefits. People were a bit sceptical about having an additional levy*. (KI 7)

Additionally, public sector employees and unions perceived the contribution rate as too high given their salaries and other social responsibilities.

> *It is a matter of how much you take home, that a member can afford [to contribute to the health insurance]. You see, it is very true that the more you pay, there may be better [services] but you also need to live. There is livelihood. You need to maintain your family. You need to maintain other social challenges*. (KI 14)

The Ministry of Finance also resisted the 2.5% contribution for its employees, arguing it was excessive for the government. Due to these concerns, cabinet decided to lower the contribution rate.

> *The levels of drag, resistance and friction towards the scheme were substantial. But for us who understood what the scheme could do, we didn't want to be bogged down by the difference of 1.5% or 2%. We then said if we can show the public the potential this program has, then there would be opportunities for engagements in the future*. (KI 8)

Ultimately, the rate was set at 2% of the basic wage for formal sector workers, shared equally by employers and employees, and 1% of declared income for the self-employed. Exemptions were provided for vulnerable groups including the elderly (>65 years), and those with mental or physical disabilities (Government of Zambia, 2019).

There were also discussions about which ministry should oversee the health insurance agency. The Ministry of Labour and Social Security (MoLSS), responsible for social security systems and the MoH, which leads health financing and service provision-both wanted to govern the scheme.

> *For us [Ministry of Health] our argument was, this is not a labour issue. Health is not a labour issue. Health covers everybody whether you are working or not. So what we are doing, it's going to affect the formal sector, one way or the other but it's going to affect other sectors as well, even those that are not working*. (KI 7)

Eventually, cabinet tasked the MoH with designing and implementing the NHIS to raise additional resources for the health sector and improve financial risk protection for all Zambians. Development partners played a subsidiary role, providing financial and technical support as needed. For example, the World Bank, WHO and other bilateral and multilateral organizations supported the reform by generating evidence and hiring health financing experts for the MoH, and participating in the health financing technical committee that contributed to the design of the insurance bill.

Institutions

Institutional approaches emphasize how legacies of past policies can shape a country's reform trajectory. In Zambia, previous health financing reforms, such as the purchaser–provider split during the CBoH era influenced the path towards NHIS (1996–2006) (Government of Zambia, 1995). The legacy of contracting under CBoH helped facilitate a culture in the health sector that was receptive to the idea of a NHIS. The structures and systems developed during this period were key in associating NHIS with improvements in quality, efficiency and service coverage. Stakeholders felt that a new

semi-autonomous institution was necessary to facilitate strategic purchasing and increase service utilization, efficiency and quality.

Another significant legacy was the removal of user fees at the PHC level. While this change was not expected to lead directly to a NHIS, some interviewees argued that it actually enabled the reform. They noted that, despite eliminating user fees, out-of-pocket (OOP) spending remained high at higher levels of care, highlighting the need for pre-payment mechanisms, such as an insurance scheme to manage these costs.

> *User fees were abolished, yes, but…And that was the other reason that pushed us to do this was because in as much as user fees were abolished, out-of-pocket expenditure was still on the higher side. They were still high*. (KI 13)

Meanwhile, according to the 2018 National Health Accounts, OOP spending on health accounted for 12% of total current health expenditure in 2016 (Ministry of Health, 2018). Although relatively low, OOP payments might have still been unaffordable for the poorest, leading them to forego care. Additionally, some interviewees noted that the loss of user fee revenues at facilities and district levels created service delivery gaps, which garnered public support for establishing an NHIS.

> *So when we were trying to introduce [the health insurance]…talking to the community leadership, churches and even the traditional leadership, it was very easy for the idea to be embraced. Because they would make comparisons to what was happening now [after removal of user fees][, to how it was then when they were paying user fees because the facilities themselves had the autonomy to procure drugs, clinic equipment and so on and so forth…right at the facility. They didn't have to wait for the [monthly operational] grant. At that time, I think the grant was erratic in terms of disbursement*. (KI 7)

Interviewees explained that public support for the NHIS was evident in the 2014 Zambia Household Health Expenditure and Utilization survey where 80% of households were willing to pay (Ministry of Health, 2015).

While the insurance scheme had support from key actors, some interviewees pointed out relatively low resistance due to a political culture that did not necessarily encourage an open discourse on policy development. Interviewees indicated that this contrasted the inclusive culture from previous administrations that fostered inclusive debate and the use of scientific evidence in health reform discussions.

> *I think [before] we had a more open-minded [culture], which we believe is the essence of public health. Open up your mind, look at the evidence and then you decide. Do not set out, 'No we are going to do that and regardless, this was a different context and unfortunately for me that was the approach. Instructions had been issued. 'Let's implement social health insurance' and that is the route that it took regardless of what is happening worldwide to social health insurance*. (KI 12)

Due to the political environment, some interviewees perceived that even if individuals or groups opposed the bill during the agenda-setting stage, they hesitated to voice their concerns. Political actors leveraged on these institutional conditions to mobilize civil society organizations in support of the reform. In parliament, opposition parties argued that health insurance would impose unnecessary taxes on citizens. However, proponents viewed this argument as a politically motivated argument noting that previous governments had also considered introducing health insurance and that the opponents feared that the reform would increase the ruling government's popularity.

> *It got to a place where the debates degenerated into a political battlefield rather than a technical one. And I think the feeling was that people were trying to kill the bill and I think, the ruling party felt this was going to be a major reform which was also going to make them more popular. Because of course, this was about giving people benefits*. (KI 5)

Ideas

At the time that the conversation on health insurance in Zambia gained momentum, the Millennium Development Goals were ending. Narratives on how certain countries had been successful in achieving the Millennium Development Goals heightened the discussion on health insurance in Zambia.

> *So, if you look at Africa, we were given the examples of Rwanda and one of the things when we took a study tour to Rwanda, we found was that one of the things that they were proud of was their national health insurance scheme. We were taught about Thailand and how they had attained their millennium development goals, years before 2015…So it became a running theme, that those of us who seemed to have not done too well seemed to have missed out something on the financing arm and so it was one of the things as well that helped us push*. (KI 5)

The technical committee undertook study tours to other African countries, including Ghana and Tanzania to gain insights on health insurance design. Policymakers mentioned that in Ghana, they learned the importance of not making the Insurance Act overly specific about contribution rates and benefit packages. Those details were included in a statutory instrument due to the evolving nature of health financing and policy landscapes (SI 2019).

Another initiative that influenced the establishment of NHIS was the health results-based financing programme implemented by the MoH from 2012 to 2019. The primary objective of Zambia's health results-based financing programme was to enhance accountability and improve access to quality maternal and child health care. Specifically, the programme, supported by the World Bank, provided lessons for integrating results-based financing approaches into the NHIS.

> *I think the idea from World Bank was to show proof of concept. From a sustainability point of view, our feeling is that Zambia should embed it, should institutionalize it into the health insurance scheme and maybe some other purchasing schemes as well but our feeling definitely under National Health Insurance is that we should introduce some performance-based*. (KI 5)

Ideology

As previously mentioned, the ruling party, Patriotic Front demonstrated strong political will to establish NHIS aligning with social democratic ideologies outlined in its 2011 manifesto. This included improving social protection through cash transfer programmes, scaling-up the abolition of user fees to the entire primary health care system, and provision of basic health care based on need rather than ability to pay (Patriotic Front 2016,).

Additionally, senior technocrats from the MoH appeared to be in favour of these values, advocating for a NHIS rather than a medical scheme limited to public sector employees.

> *Their proposal to us was to have a [medical] scheme for [public sector] workers only but as policymakers that created some…it was uncomfortable for us. Because us, the MoH, our concern is health for all, so we said we cannot have it for [public sector] workers, it is for everybody* (KI 7).

During the adoption phase, there were calls to ensure the NHIS covered poor and vulnerable populations in line with the motto of 'leaving no one behind'. However, when the bill was passed, there was no clear solid plan for mobilizing financial resources to include these groups. The bill assigned the health insurance authority with this responsibility but the implementation strategy remained unclear.

Discussion

In this paper, we present a retrospective case study on the political economy factors that enabled the introduction of Zambia's NHIS in 2018. The study highlights that strong political commitment and power were instrumental in implementing the reform. These findings align with other studies on health financing reforms in Zambia and sub-Saharan Africa, which underscore the importance of political influence in shaping the design and implementation of health financing reforms (Gilson *et al*., 2003; 2012; Chemouni, 2018; Lavers, 2019; Novignon *et al*., 2021). The Minister of Health played a key role in advancing the reform that had stalled for years. However, to move the reform forward, the proposed contribution rate by actuarial studies had to be reduced. This decision seemed to go against the primary objective of NHIS which was to provide additional resources to the health sector through contributions. Furthermore, literature on contributory health insurance shows that schemes that increase health spending generally require government subsidies to remain financial viability (Jacobs and Goddard, 2000; Kwon, 2009; Wagstaff, 2009) and are not always associated with better health outcomes (Wagstaff, 2009; Matthew Oluwatoyin *et al*., 2015).

The study also showed that policymakers can use partial evidence to suit their agendas. At the peak of the reform, some stakeholders noted a lack of adequate consultations and the absence of the typically 'open-minded' culture associated with Zambia's health sector. Even years into NHIS implementation, some interviewees remained strongly opposed to the scheme due to insufficient supporting evidence. These dynamics could threaten future collaborations in using scientific evidence to guide the NHIS implementation.

Additionally, institutions, particularly legacies of past policies, played a crucial role in establishing the NHIS in Zambia. Interviewees highlighted that removing user fees at the primary healthcare level without additional government funding, created quality gaps. Therefore, health insurance was viewed as necessary to address the financing gap in the health sector. However, since the NHIS only covers hospital-level services, the loss of user fee revenues at PHC facilities remains unaddressed. Moreover, the low contribution rate of 2% could undermine the goal of generating additional funding for the health sector. In our interviews, supporters of the reform acknowleged that this rate was insufficient but hoped that positive outcomes from the scheme might justify future increases. Evidence from high-income and other low-income settings suggests that increasing contribution rates among the formal sector is challenging (Onoka *et al*., 2013; Mcdonnell *et al*., 2019). Low contribution rates have been challenging in other schemes in LMICs (Global Financing Facility, 2019). Given the NHIS's low contribution rate, generous benefit package, and plans for expansion, there are potential risks to its financial viability. Therefore, there is a need to either increase the contribution rate or introduce other non-contributory revenue mobilization measures such as government subsidies and earmarked tax revenues to increase available financing. Studies show that high insurance coverage often relies on government subidies (Lagomarsino *et al*., 2012; Cashin and Dossou, 2021).

In contrast to Malaysia, where removing subsidized health services created public resistance (Croke *et al*., 2019), a 2014 national survey indicated strong public support for Zambia's NHIS. Interviewees attributed this support to better experiences at health facilities compared to the user fee era. However, the same survey revealed that while respondents were willing to join the NHIS, their willingness to pay was insufficient to fund quality health services (Kaonga *et al*., 2022). Inadequate financial resources could jeopardize the NHIS's effectiveness as strategic purchaser (Cashin and Gatome-Munyua, 2022). This necessitates the need for increased government spending to ensure NHIS's success.

Another key driver for the reform was the global focus on UHC and health insurance as exemplified by countries such as Thailand and Rwanda in achieving certain global targets. This international attention strengthened the case for introducing NHIS in Zambia as a critical step towards UHC. This finding contributes to the literature on how prevailing ideas about certain countries in the global health policy sphere can shape the ideas of policymakers and politicians (El-Jardali *et al*., 2012; Lavers, 2019). However, Zambia's political and health system differ from those in Rwanda and Thailand. Both Thailand and Rwanda built UHC on strong PHC contributing to their health-related Millennium Development Goals (Waage *et al*., 2010; Abbott *et al*., 2017). Additionally, Thailand uses different schemes, including the tax-financed universal coverage scheme for the informal sector.

The UHC goal of equity in health service coverage and financial risk protection influenced the ideologies of policymakers in Zambia's on NHIS. However, our study reveals that during the design, adoption and initial implementation phases, there was no concrete strategy to ensure coverage of the poor. The focus was primarily on the formal sector, which appeared to be the major focus of the reform process. This phenomenon is common in other LMICs where insurance coverage among the informal sector groups and the poor is often low (Global Financing Facility, 2019). Inequitable coverage under health insurance schemes in LMICs have also

been raised by other studies (Yazbeck *et al.*, 2020, 2023; Yates, 2021). Therefore, as Zambia advances with its NHIS, it is imperative to address equity through mechanisms for premium setting, subsidization and exemptions for the poor. Many LMICs struggle with extending health insurance coverage to these populations (Fenny *et al.*, 2018; Barasa *et al.*, 2021; Osei Afriyie *et al.*, 2022) and thus subsequent phases of NHIS expansion in Zambia should consider incorporating other financing mechanisms such as government tax revenues for strengthened sustainability.

Nevertheless, this study has some limitations. First, our stakeholder sample was limited because some participants were not available due to the COVID-19 pandemic, while some participants had moved to new positions and relocated. Although we interviewed most of the main stakeholders who were directly and indirectly involved during the reform, there were three respondents from development agencies and trade unions that we could not reach. Second, as some stakeholders had moved into new positions within the MoH and the health insurance authority, their institutional mandates and interests could have influenced their responses. Last, not all relevant documents, such as minutes of technical committees, were included in the study as these documents were either unavailable or confidential.

Conclusion

This study highlighted the crucial role of leadership and political power in catalysing health financing reforms from policy discussions to implementation. It illustrates how legacies of past policies and informal political structures can shape the adoption of new policies. Global ideas about UHC and experiences from other countries can drive policymakers to pursue such reforms. Furthermore, research should explore how NHIS contributes to strategic purchasing and attaining UHC goals of ensuring that everyone can access quality health services without financial hardship.

Data availability

Summaries of the interview transcripts are available from the corresponding author upon reasonable request.

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Author contributions

D.O.A.—conception, design of the study, data collection, data analysis and drafting of the article; R.T.O.—data analysis and interpretation, critical revision of the article; F.M.—design of the study, data collection and critical revision of the article; C.C.—data analysis and interpretation, and critical revision of the article; G.F.—design of the study, data analysis and interpretation and critical revision of the article.

Reflexivity statement

The authors include two females and three males and span multiple levels of seniority. Of the five authors, three are from sub-Saharan Africa, two from Zambia and one from Ghana. All the authors have been trained in health economics or public health. The authors have extensive research experience in health financing and knowledgeable about health systems and policy research in LMICs.

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