

Investigating the Inclusion of Vertical Programmes in Health Benefit Packages

A Case Study of Zambia

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INTRODUCTION

Zambia has been steadily working towards achieving Universal Health Coverage (UHC) since the 1990s, first outlining an essential package of care for the whole population in 1998 (Luwabelwa et al., 2017). Achieving UHC is a crucial part of Zambia's Vision 2030, the strategy towards Zambia's goal of being a prosperous, middle-income country by 2030 (Republic of Zambia 2006).

Zambia's current efforts to achieve UHC centre around the delivery of several concurrent Health Benefits Package (HBPs), covering different levels of care and programmatic health areas. However, the country's UHC ambition rests primarily on the delivery of two HBPs: the National Health Care Package (NHCP) and the National Health Insurance Management Authority (NHIMA) Benefits Package. The NHCP aims to provide free, government-funded, basic primary healthcare services, with the central objective that "all the services in the package should be available as an integrated whole, rather than being available piecemeal or as individual services or only through vertical programmes" (Ministry of Health, 2012). The more recent (2018) NHIMA Benefits Package focusses on hospital services (although not exclusively), organised according to disease priorities. It currently covers 700,000 Zambians and their households but there is an ambition to extend coverage to the entire population (MoH Zambia 2021).

The establishment of a HBP is central to all aspects of the UHC policy from resource mobilisation (what is included and excluded will define what it will cost to deliver UHC) to implementation (planning of human resource, links with clinical guidelines). Bredenkamp et al. (2015) find that developing a HBP that is responsive to countries' health challenges and is financially sustainable is one of the biggest challenges in implementing UHC. A number of resources have been produced to support countries towards defining their own HBPs, including the guidance from the WHO (WHO 2014) and the 'What's in what's out: Designing Benefits for Universal Health Coverage' (Glassman, Giedion, and Smith 2017).

However, despite the relevance of the topic to all LMICs seeking to achieve UHC, our previous review (Regan et al. 2021) highlighted a gap in this guidance on how countries manage the integration of disease programmes in the HBP, especially such programmes rely significantly on funding from external partners, such as in Zambia. Close to 45% of the total current health expenditure in the country comes from external partners. This is over twice the regional average of 22%¹ and the 5th highest aid dependency in the health sector in the Africa region (WHO 2018). External funds play an important role in funding the delivery of several vertical programmes. One example is the HIV/AIDS programme, where external funds account for 86.4% of total funding to the programme (Hangoma et al. 2019).

Integrating vertical programmes in the two HBPs will require policies to not only integrate the entitlements, but also the 'systems' (e.g., procurement, infrastructure, staff, funding) that could lead to improvement in access, delivery, and efficiency. A full integration of vertical programmes into HBPs would mean that those seeking care have one set of entitlements regardless of funding (domestic or external), integrated and managed in a single scheme (Regan et al. 2021). Given the health financing context in Zambia (including the high reliance on external funding), this type of integration will require co-developing policies with development partners and the Ministry of Health (MoH). This will be challenging: as pointed by others, external funding in Zambia has become in the last decade more

¹ unweighted average for Sub-Saharan countries

'verticalised' as a greater proportion of funding from partners comes in the form of off-budget support (Masiye and Chansa 2019).

In this resource, we aim to look at the inclusion of vertical programmes in the entitlements of Zambia's two main HBPs: the NHCP and the more recent NHIMA benefits package.

Using the lens of the local policy context, we address the following key evaluation questions:

1. How were the two HBPs developed and how were entitlements prioritised?
2. What was the initial decision to exclude or include disease programmes into the HBPs?
3. What contextual factors were important in shaping those policy-decisions?

We build on a desk review of the literature, as well as 5 structured interviews with stakeholders who actively took part in the definition process of the HBPs, both working in national health institutions or as external development partners (see Annex 1 for a description of our interviewee sample). We use inductive coding methods to analyse the interviews. Our research methods are described in Annex 2. In this case study, we are only able to focus on the integration of entitlements (i.e., whether they are listed in the HBPs and the reasons stated for those decisions), and we are not able to investigate the delivery or coverage of services in practice.

The present study is organised as follow. In the first section, we discuss Zambia's health financing situation, with a focus on the role of external partners and review the country's progress on UHC. In the second and third section, we review the two main HBPs in the country (NHCP and NHIMA's HBP) and discuss inclusions alongside six programmatic areas (contraception, HIV, immunisation, malaria, maternal and child health, TB), building on interviews and literature review. Finally, in the conclusion, we discuss the role played by those two HBPs in achieving UHC and the path forward with regards to inclusion of those programmes.

HEALTH FINANCING IN ZAMBIA

In 2018, current health expenditure per capita in Zambia was \$76 (current US dollars), which is above the median health expenditure in the region (\$60). The first and the second largest share of current health expenditure come from external sources and domestic government expenditure. Commitment to spending on health has increased and remained high in the country (compared to others in the region): the government allocation to the health sector relative to the national budget was 9% in 2017, although health spending as a share of GDP remains low and falls short of the 5% target recommended by the Chatham House report (MoH 2017).

Table 1. Summary health financing indicators

Health financing information (2018)	
Current health expenditure per capita (US current dollars)	\$76
Current health expenditure (% of GDP)	4.9%
Domestic general government health expenditure (% of current health expenditure)	39.1%
Out-of-pocket expenditure (% of current health expenditure)	10%
Domestic private health insurance expenditure (% of current health expenditure)	6.4%
External health expenditure (% of current health expenditure)	44.6%

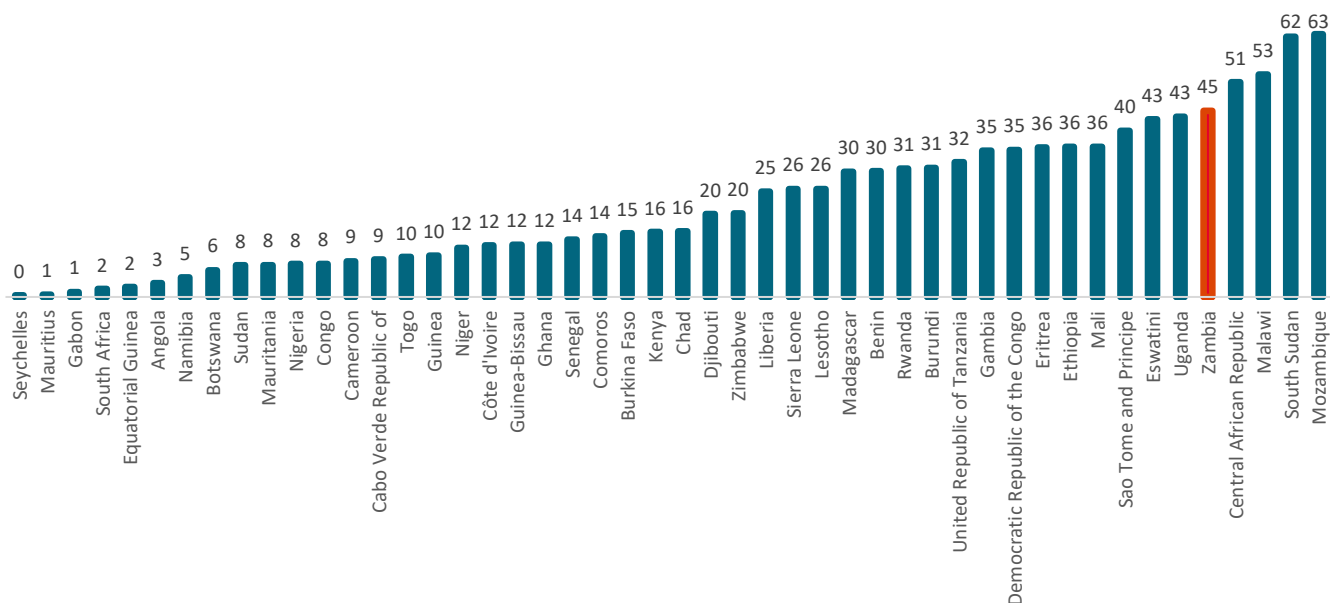
Source: WHO Data Bank (2018)

Since the mid-1990s, the country's health sector has been managed through a decentralised system (Mulambia 2021). An analysis of health spending found that 60% of domestic government resources are directed towards paying for personnel emoluments or salaries, 17% to essential drugs, 9% to infrastructure and equipment, and 7% to service delivery (Ministry of Finance 2016). In addition, while disbursement rates for salaries is 100%, operational budget disbursements are not as well executed (only between 66% and 93%) (MoH 2017).

Zambia is highly reliant on external donor resources for funding its health system: external health expenditure constitutes 44.6% of total current health expenditure, double the regional average of 22%². In the Africa region, only four other countries (the Central African Republic, Malawi, South Sudan and Mozambique) have a higher reliance on external resources (WHO 2018) (see figure 1). While the percentage of total current health expenditure from external sources has not decreased in the last decade (42% in 2008), it has fluctuated significantly. In 2013, external sources accounted for 55% of current health expenditure and this declined to 36% in 2016. Zambia achieved middle income status (as per World Bank classification) in 2011 and as a result, transition from aid is becoming a policy priority (MoH 2017)

² unweighted average

Figure 1. External Health Expenditure (EXT) as % of Current Health Expenditure (CHE) in Africa



External funding has become increasingly verticalized in the last decade (Masiye and Chansa 2019), and a large portion is received ‘off budget’ and earmarked to certain activities (Hangoma et al. 2019), meaning the funds are disbursed directly to recipients (e.g. Non-governmental organisations (NGOs)) which deliver health services without oversight of Treasury or the MoH. This situation has developed at a time “when perceptions about weaknesses in the country’s public finance management and accountability systems have become commonplace, and caused significant uncertainty among donors” (Masiye and Chansa 2019).

External funds are also particularly concentrated in a handful of programmatic areas: for example, for HIV, of the \$316 million spent in 2016, 86.4% was from external sources, 12% from government, and 1.4% from other private sources (Hangoma et al., 2019). The diseases supported by partners represent a huge burden of disease in the population: Zambia has among the highest prevalence rates of infectious diseases in Sub-Saharan Africa, with HIV, TB, and malaria being the first, sixth, and seventh leading causes of burden of disease, respectively, as measured by disability-adjusted life years lost (IHME 2017). These diseases make up a high percentage of the disease burden in Zambia, as of 2019, 26% total DALYs were from HIV, TB and Malaria (IHME 2019). Within those programmes, external programmes also appear to support the procurement of commodities: half of the country’s total expenditure on pharmaceutical was spent on HIV/AIDS and Malaria, and this was largely financed by external partners (MoH 2017)

External support has contributed to achieving relatively high access to services in those programmes. For instance, the percentage of people living with on antiretroviral treatments is high (81%) (UNAIDS 2020). Similarly, 80% of births were delivered by a skilled provider, an increase from 68.7% in 2017 (DHS 2020) (MoH 2020). Similarly, access to at least one antenatal appointment remained above 90% in the past three years (although there are disparities in use of antenatal services across districts and between rural and urban areas) (MoH 2020). However, there are still important gaps. For those with TB in Zambia, only 59.8% accessed TB testing, with 55.4% diagnosed with TB and only 45.1% who

completed treatment (Lungu et al. 2021). One in five married women in Zambia have an unmet need for contraception (Silumbwe et al. 2018).

ZAMBIA'S PROGRESS ON UHC

Zambia's attempts to achieve UHC started with a series of health system reforms implemented since 1992, which aimed to provide "equity of access to cost-effective quality health care as close to the family as possible" (Chilufya and Kamanga 2018). Those reforms consecutively led to the decentralisation of provision of care, implementation of performance-based contracting, development of the Basic Health Care Package (BHCP), creation of health sector wide approaches, gradual removal of user fees for all primary health care facilities (first for children and vulnerable group, then for rural facilities and then to all facilities) in 2012 (Luwabelwa et al. 2017)).

One of the main challenges to achieving UHC in the country is the inadequate funding of the healthcare sector and the limited options to create additional fiscal space (Chilufya and Kamanga, 2018). As a result, the country has adopted a pragmatic strategy that allows the expansion of access to services through the strengthening of more targeted, vertical, disease programmes, or packages of care, typically funded through external partners. A summary of the various HBPs in the country is provided in Box 1. However, as we will discuss in the following section, it is worth noting that the NHCP developed in 2012 is the overarching prioritised package and aims to support UHC intervention through those multiple programmes.

BOX 1. SUMMARY OF MAIN HBPS IN ZAMBIA

NHCP: Overarching prioritised package, established in 2012. Includes all levels of care, the most comprehensive package in Zambia. Currently undergoing revision.

NHIMA Package: Established in 2018 and implemented in 2019. Focussed on hospital/tertiary level care, although it includes a number of services provided in lower care settings Funding relies on member contributions to NHIMA.

The Global Fund ATM: A disease specific programme with focus in HIV/AIDS, Tuberculosis and Malaria. The Global Fund ATM is delivered at all public facilities including faith-based institutions run by the Churches Health Association of Zambia (CHAZ). The budgets and funding for the package are provided for by the Global Fund.

GFF RMNCAH-N Investment case: A package of services focused on Reproductive, Maternal, New-born, Child and Adolescent Health. It builds on an investment case that has been developed by the country, with additional funding through the Global Financing Facility (GFF). The intention is to form a list of services available to everyone at all public facilities.

Source: MoH Zambia 2021b

NB: while we list the four packages, we will only discuss the NHCP and the NHIMA package as those have been the two packages developed by the country to achieve UHC.

Zambia has for some years been exploring mechanisms to increase mobilization of domestic resources to build a more predictable and sustainable health financing mechanism to support a national health insurance, including relying on private funding (Lockton Global Compliance 2019). NHIMA was established in 2018 through the enactment of the National Health Insurance Act No. 2 of 2018 (Government of Zambia 2018). The Act lays the ground for the establishment of a governance structure for NHIMA and “sound financing” of the national health system to provide “universal access to quality insured healthcare services.” The Act also mandates all Zambians and established residents to register as a member of the scheme, but this work is ongoing. At present, only 700,000 principal members (and their dependents) are enrolled (MoH Zambia 2021).

DEVELOPING THE NHCP AND ITS CURRENT STATUS

Zambia’s first attempt to develop an HBP goes back to 1993–1996, when the Basic Health Care Package (BHCP) was developed with the following objectives: reduction of disease burden, improving access to cost-effective services and equity between rural and urban areas (MoH Zambia 2012) or health taxes on sugary drinks (Hangoma et al. 2020). The BHCP was finalised in 2000 and formed the basis for the creation of the NHCP, initiated in 2009. A national working group was convened to review the BHCP in view of aligning its content with the Sixth National Development Plan and the Vision 2030, as well as further developing the hospital level services. A consultation process was set to include feedback from stakeholders, including NGOs and other partners in the sector. The NHCP took roughly three years to be developed and was signed off by the MoH in 2012.

A description of the NHCP includes that “all of the services in the package should be available as an integrated whole, rather than being available piecemeal or as individual services or only through vertical programmes.” However, despite those initial plans, whole implementation of NHCP has not occurred. Interviewee A states: “*It’s an aspirational package [...] it was ideally not meant to be aspirational it was meant to be a package that was supposed to be available at all times.*” At its inception, it was envisaged that a social health insurance scheme would be introduced alongside a pooling mechanism for government resources and pre-payment (e.g., member contributions), a national health fund, to fund and support implementation of the NHCP (MoH Zambia 2012). However, the necessary reforms to enable this have never been implemented.

Instead, interviewee A highlights that the government has taken a pragmatic approach to NHCP implementation, by using it as a basis for developing other funded HBPs in the country; “*the NHCP has been used as a reference holistic package for defining funded subset benefit packages as the NHIMA benefits package and more program-specific packages. The NHIMA is funded through mandatory contributions [...] in this way, the NHI is delivered using a resource envelope that is known.*” As a result, while current implementation is incomplete, it is assumed that parts of the NHCP are funded through a mix of government funding and budget support or direct funding from external partners. It is worth noting that the package was never costed (Luwabelwa et al. 2017). Evidence of the NHCP’s connection to other policies such as the Zambia Essential Medicines List was not found.

The NHCP covers a set of prioritised interventions provided across all levels of care from health posts to specialised units in tertiary and teaching hospitals (referred to as Level 4 facilities). It also includes a diagnostic, therapeutic, rehabilitative, equipment maintenance services and supply chain management. The WHO building blocks were used as a framework for planning and priority setting in

the HBP, however the approach was not ‘fully followed through’ according to some local experts (Luwabelwa et al. 2017). The location is specified for each service, and there is a ‘bi-directional referral system’ to ensure the service is provided in the ‘correct’ location. Services are further categorised into 25 disease control priorities and clinical areas as shown in Table 2. Under each clinical area, a more detailed description of services were developed.

Table 2. Clinical areas included in NHCP

Malaria	Lung disease	AIDS
Trauma	Diarrhoea	Anemia/hematological diseases
Maternal conditions	TB/Leprosy	Cardio-vascular disease
Perinatal & immunizations	Malnutrition	Gynaecology conditions
GI conditions	Musculo-skeletal conditions	Genitourinary diseases
CNS diseases	Endocrine diseases	Neoplasms/cancers
Skin infections & conditions	Dental/maxillofacial diseases	Eye diseases
ENT diseases	Mental illness	Acute abdomen
Other surgical conditions		

Since 2017, there have been discussions to revise the NHCP (Turner 2017) in part initiated by a team of experts University of Zambia, the MoH, and other stakeholders (Luwabelwa et al. 2017). Many Zambian experts have highlighted that the implementation of the NHCP is incomplete, resulting in underfunding of primary healthcare in the country. Only 23% of government resources spent on health reach the providers of primary healthcare (MoH Zambia 2018). Further, others pointed to the inadequate level of health sector consultation in the development of the NHCP, that it did not adequately build on experience and that it failed to validate and institutionalise the services (Luwabelwa *et al.*, 2017). Formal plans to organise a whole package review started in the summer of 2021 as a part of the Zambian government’s “transformative initiative” [Interviewee A]. The aim of this review is to revise the HBP and develop corresponding implementation strategies within the available resources.

INCLUSION OF VERTICAL PROGRAMMES IN THE NHCP

We reviewed entitlements listed in the NHCP package for six programmatic areas: contraception, HIV, Immunisation, Malaria, MCH and TB and classified them in three different categories: green signals a high level of inclusion (across the entire continuum of care), orange a medium level of inclusion (not comprehensive) and red a low level of inclusion (none or a handful of services only).

We find that the NHCP has a high inclusion of HIV, Malaria, MCH and TB services. On the other hand, there are no listed services under contraception, and the only immunization service included is ‘health improvement messages and ‘support’ for immunisation programme deployed through Expanded Programme on Immunisation (EPI)’.

Table 3. Summary of inclusion along six disease programme areas in NHCP

Disease programme	NHCP	
Contraception		None
Immunisation		Health improvement messages and 'support' for immunisation programme deployed through Expanded Programme on Immunisation (EPI)
MCH		<p>Maternal health:</p> <ul style="list-style-type: none"> • Integrated Reproductive Health, Wide ranging support at provincial level for maternal health promotion • Health improvement messages on IRH with the community of women, men and children in schools, including: Antenatal care Safe delivery Postnatal care • Screening at ANC including: FBC, Urine glucose, Urine protein, Blood pressure • Monitor nutrition • Treatment for worms, anaemia, malaria, PTMCT • Safe normal delivery • Work with local partners including businesses, faith groups, NGOs on danger signs & transport in referral pathways + • PNC including feeding • Caesarean section • Management of PPH • Specialist care of ANC, delivery, PNC where : Hypertension, eclampsia, Cardiac, Severe Sickle cell anaemia, TB , Thyroid conditions, Previous ruptured uterus, PPH requiring hysterectomy • VVF repair <p>Child health:</p> <ul style="list-style-type: none"> • Infection control population awareness and school health programmes • Health improvement messages (cleanliness, clean water, safe deliveries, awareness of vaccinations, danger signs on the growth curve, infant + child nutrition, including breast feeding guidelines & paediatric ARV scale-up) • Specialised paediatric care including Laboratory investigations, Ultrasound, CT
TB		<ul style="list-style-type: none"> • Messages on signs & symptoms • Ongoing TB/Leprosy health prevention and screening IEC • Sputum analysis • HIV Treatment • Follow-up on 'lost to follow-up' • Clinical examination • Lab diagnosis where capacity: FBC, U+E, CXR, HIV+/- CD4 count, skin snip and scrapping • Treatment management • Refer possible MDRTB • Clinical care of chronic lung problems • Specialised care only including resistance monitoring • Laboratory quality assurance programme; interaction with decentralised lab services (PCR, sensitivity studies)

Malaria	<p>Simple and Severe:</p> <ul style="list-style-type: none"> • Diagnosis using RDT • Treatment of uncomplicated malaria • Malaria awareness for environmental exposures and control measures i.e. spraying and LLITNs • Ongoing malaria prevention through work with local NGOs, faith groups and local businesses • Microscopical diagnosis • Investigation and management of complications: FBC, Serum creatinine, urinalysis • Treatment with 2nd line drugs • Respiratory and renal investigations and support • Wide ranging support at provincial level for malaria prevention IEC • Screening at ANC including treatment for worms, anaemia, malaria, PTMCT
HIV	<ul style="list-style-type: none"> • HIV/AIDS prevention IEC • Knowledge of VCT and PMTCT • Ongoing HIV/AIDS counselling and screening. • Treatment of OIs • Palliative care (pain relief and management of common illnesses) • Management of severe symptoms • Investigations: Urine protein creatinine ratio, FBC, LFTs, CXR, U/E & creatinine, HIV +/-CD4 count • VL and genotype for treatment failures • Metabolic complications management • ARVs resistance • Drugs for salvage care

NB. The write-up contained in the Table was directly lifted from the NHCP description
Source: NHCP 2012

DISCUSSION: FACTORS LEADING TO DECISIONS ON INTEGRATION OF PROGRAMMES WITHIN THE NHCP

From its inception, the NHCP was meant to be an overarching UHC package for the whole population. As a result, its intention was to cover all levels of care and a wide range of interventions across the continuum of care (e.g., public health and preventative measures). Moreover, one of the intentions of the NHCP was to focus on primary care [Interviewee E], which is the primary location of services for the programmatic areas reviewed. Given those elements, it is not surprising that our review shows a high degree of inclusions in the reviewed disease priorities.

As highlighted in our interviews, one of the explanation for those inclusions was the **engagement with external partners at the time of developing the HBP**. Partners were invited to map out what they considered to be their priority interventions, as interviewee A note; *“to a large extend, you’d actually say that development partners were at an advantage in terms of how they did influence the selection of priorities interventions.”* One exception that stands out is immunisation, perhaps owing to the fact that a large programme had already been instituted by the government prior to the development of the NHCP. The interviewee points to the lack of some flexibility with regards to some of those ‘legacies’ that have to be incorporated in the decision-making.

As discussed above, **there was also an intention from the start to use the NHCP to channel donor spending to high priority interventions**; “As the government has got this overarching package, there are resources which the government is able to mobilise to finance aspects of that package through donors” [Interviewee A]. For instance, speaking of the Global Financing Facility package on RMNCAH-N, interviewee A highlights “They supposedly should speak to the National Health care package.”

However, this situation has created challenges when it comes to understanding what of the NHCP is implemented through external programmes or other government funding streams. As interviewee A sums up: “For the NHCP we might say that they [the interventions] are in the package, but they're not really in the package. When you look at the financing modality a greater portion of that final funding is through donor support in the vertical program.” Interviewee B agrees that there is a lack of visibility on how much of the NHCP is accessible: “Most of the services that were being offered by the facilities were not actually there because they were not being funded. And in as much as Primary Health care provides for free health care services, what is free can only be accessed if it's actually available.” This may also be compounded by the fact that most of Zambia’s external funding comes in the form of off-budget support (including direct funding to NGOs, for instance in the HIV/AIDS programme), limiting the visibility of what the funding is used for.

The **low levels of government resources allocated to delivery of the package, and across the health sector generally** were also cited as an implementation challenge. The restrictions on fiscal space were further amplified by the recent COVID-19 pandemic “The whole world is dealing with the whole issue of COVID. That's added pressure to already strained social sector budgets that the country had so a lot is a balancing act” [Interviewee C]. COVID also stalled some partner level works in the country; “Things have been [...] to some extent slowed down and disrupted because of COVID.” [Interviewee D].

The **lack of revision of the NHCP means that it is considered outdated and may not be used to inform donor programming**. As interviewee A puts it: “the NHCP remains static, but the development partner breadth of what they could support has increased. So it went over and above what was in the NHCP to a large extent.” This is echoed by our interviews on the RMNCAH-N programme, which highlights the alignment of the programming with more recent documents and the use of additional data. As interviewee E explains about the prioritisation of the RMNCAH-N investment case “the guiding document is [Zambia’s] national strategic plan, Vision 2030” showing there a high-level country-led approach has been taken for this work. Interviewee D highlights the practicality around the prioritisation of the RMNCAH-N investment case “There is the aspiration, the ideal and then the reality [...] In the end, we've had to use a lot more informed judgment expert opinion.” They further explain the prioritisation process for this package and the need for a longer-term approach; “we talked together with all stakeholders, including non-governmental stakeholders about which interventions would seem to matter the most in terms of achieving RMNCAH-N outcomes, and that those outcomes actually are going to ultimately be achieved through systems investments and systems reforms.”

Finally, another challenge with the NHCP appears to be the **way in which the NHCP is defined**. Interviewee A highlights “the entitlements were not clearly spelled out, it was only there to describe the overarching goals that Zambia had,” in contrast to the ‘clarity’ about the interventions supported by the other HBPs in the country.

DEVELOPING THE NHIMA PACKAGE AND ITS CURRENT STATUS

Following the NHI Act 2 of 2018, NHIMA was created and work to develop a corresponding HBP shortly followed. The NHIMA HBP is different in two main ways from the NHCP. First, it focusses strongly (although not exclusively) on hospital care: as interviewee A puts it “*Primary Health care was heavily funded by default, but it was the transition of a patient from Primary Health care to hospital level care that introduce in out-of-pocket payments. This is where the National Health insurance came into play.*” Second, a dedicated funding pool was created to support NHIMA’s operations, and the delivery of services listed under the package. Providers (accredited public and now private providers) are paid through a mix of fee-for-service, capitation and diagnosis related groups. It is not stated whether services listed under the package are completely free of charge to patients.

As with the NHCP, the package is also organised around disease priorities, which includes communicable diseases, RMNACH, non-communicable diseases and cancer. It covers a range of services, including: consultation (in hospital setting), pharmaceuticals and blood products, ambulance, laboratory investigations, chemotherapy, physiotherapy, dialysis (MoH Zambia 2021). In addition to positive entitlements, NHIMA’s HBP also includes a negative list (i.e., list of excluded services) such as cosmetic surgery, long-term care, and explicitly, any public healthcare services currently under government or donor vertical programmes.

The NHI benefit package prioritisation process involved numerous stakeholders brought together under a multisectoral committee consisting of clinicians, academicians, line ministries, regulating authorities, cooperating partners, civil society organization, trade unions and other stakeholders (MoH Zambia 2019). The prioritisation process was led by “*a steering committee driven by the Ministry of Health and supported by Academia through University of Zambia*” [Interviewee C].

In 2019, a financial feasibility assessment was conducted, combining costing of the HBP, population coverage, macroeconomic outlook and utilisation (MoH Zambia 2021). NHIMA currently covers all formal sector employees in the country (Chilufya 2018), collecting contributions amounting to 1% of basic salary for both employers and employees (Bester 2020). However, the formal labour sector (~15% of the labour force) in Zambia face an already high tax burden and the high proportion of informal sector workers limits the ability of NHIMA to raise sufficient resources to finance the provision of a HBP to the entire target population (Hangoma *et al.*, 2019). There is currently no system to waive contributions for indigents, although this is a current policy priority as highlighted by Interviewee A and Interviewee C.

Interestingly, the NHIMA package has a built-in revision process. After the first full year of implementation, revisions for the NHIMA package are also now being considered, including amending interventions and financing structures by looking at utilisation data and cost drivers. One interviewee [C] highlights “*through the utilization history of this scheme we have noted there some very risky cost drivers that are that are sort of driving a claim from facilities that sort of exceeded our target expected levels of claims, [for instance] spectacles, Cancer, dialysis, orthopaedic implants, and especially those that really relate to specialized services, and these are drawing resources from what we what we deemed would have been more cost-effective services at district level.*”

INCLUSION OF VERTICAL PROGRAMMES TO NHIMA HBP

Compared to the NHCP, NHIMA’s inclusions in the six programmatic areas are limited. For instance, no TB intervention has been found in the package entitlements. On contraception, only implants have been included. On HIV, rapid testing and viral load analysis are covered, but none of its management is included.

Interestingly, Malaria stands as an exception as it has relatively high inclusions compared to other programmatic areas. As interviewee B *“adding malaria was pretty affordable, and already the commodities were really sort of in-country. It was too big a burden to ignore, as the number one cause of morbidity and mortality. So, though it's a vertical programme our feeling is that, based on priorities that if we're able to knockout malaria both for the case management point of view, supplementing governments efforts on the prevention side, we would help to lessen the burden from our number one cause of DALYs.”* It is worth noting that the NHIMA package does not include Malaria prevention services.

Table 4. Summary of inclusion along six disease programme areas NHIMA HBP

Disease programme	NHIMA
Contraception	Contraceptive implant only
Immunisation	Only tetanus and rabies vaccine. No mention of childhood vaccination series (diphtheria, pertussis, polio, BCG, measles, hepatitis B, Hib, rubella) or Pneumococcus vaccination.
MCH	Deliveries both normal and caesarean, obstetric and gynaecological interventions, New-born and paediatric services as listed in the package. Does not specify detection and treatment of childhood infections, or detection of neonatal complications and infections except for neonatal sepsis (i.e., no meningitis or pneumonia).
TB	None
Malaria	Malaria blood slide and rapid diagnostic tests. Antimalarials Inpatient care for uncomplicated and complicated malaria, general and paediatrics.
HIV	Rapid testing and viral load analysis. HIV DNA PCR

Source: NHIMA 2019 (Government of Zambia 2018)

DISCUSSION: FACTORS LEADING TO DECISIONS ON INTEGRATION OF PROGRAMMES WITHIN THE NHIMA HBP

Unlike the NHCP, the **inclusions of disease programmatic areas in the NHIMA package are limited** (with the exception of Malaria services). As discussed, the exclusion list specifically mentions all “public health care services under government or Donor vertical programs, epidemic and disasters.”

This is confirmed by interviewee A *“with the National Health insurance package, it was more explicit to remove interventions that are being financed by other alternative financing sources.”*

Because of the strong focus of NHIMA’s package on implementation and fiscal sustainability, **a large contributing factor to those exclusions has been the availability of resources** (as it relies on pre-payments from members). As interviewee C explains, the contribution rates had to be reviewed down: *“The contributor rates is what really then lead to some conditions dropping out [...] the initial assessment said that we needed a 5% contributor rates during the bargaining process, the trade unions are there would only say that the acceptance was to go with a 2% instead of a 5% and so we moved from a very generous initial to actually make a number of adjustments to try and balance up the benefit package with the contributor rate of just 2%.”* This meant that the **package went through an acute prioritisation process**, and activities that received funding from other streams were not prioritised in the first instance. As interviewee C further elaborates: *“at the end of the day, we tried to combine the burden of disease, the costing affordability budget considerations, but I’ll be honest, out of all these decisions, it really boiled down to can NHIMA really afford to cover these conditions? [...] The honest truth, it bogged down to the numbers, how affordable was it to include those benefits in the package. When we looked at the HIV program and, just the cost of the medication was over 100 million U.S. dollars and really, at the start of the program it was felt that it would be totally unsustainable. It’s actually more than our entire drug budget as a country.”* On the other hand, as highlighted above, Malaria services were included, as they comparatively were found to be more affordable (Interviewee B).

Exclusions may also be explained by the focus of the HBP on hospital services as opposed to primary care, where the bulk of services for the programmatic areas under review is typically provided. In addition, the NHIMA package was meant to be working alongside the NHCP and programmes supported by donors. Interviewee A shared this assessment plainly: *“A lot of HIV AIDS related interventions were removed from the National Health Insurance benefits package because it was assumed they are already being publicly financed by the government. [...] also, there was a lot of donor involvement like the Global Fund.”* As interviewee B goes into more detail; *“The National Insurance scheme itself was not taking away the fact that government and its partners are supposed to continue financing the health sector, but simply supplementing. Looking at the purchasing arrangements, most of the diseases were actually provided for at Primary Health care level, where actually not included in the [NHIMA] benefit package for one simple reason, that these will continue being financed by government and by partners.”*

These exclusions were, however, met with **significant stakeholder management challenges**. Interviewee C explains: *“There was a lot of vested interests [...] The most valuable lesson is that you need to deal with the politics you need to deal with the stakeholders. Everyone wants to be heard, everyone wants to have a voice and you need to balance out different concerns, different interests. [...] Initially we thought it would be the technical work, calculating the costs of the benefit package and the real work is around stakeholder management and we found that to be the most involving, different power plays around the benefit package, even after we launched it.”*

Finally, there were some concerns that **some double counting may be occurring if including those services, given the overlap for some services between NHIMA, NHCP and other packages**. Interviewee C describes; *“In terms of the benefit package, some conditions that have that presented prior to this revision were basically excluded [...] That created a lot of difficulty for NHIMA because the ministry would at many times revert back to NHIMA to find a solution to try and find a way to support facilities to provide services that perhaps may not have been explicitly stated in in the scheme, so it became a very difficult position for NHIMA whenever confronted with such requests. In essence because of the scheme rules, many such requests were rejected because it would obviously be in an instant audit query.”* However, it is worth noting that both NHIMA and the NHCP

includes Malaria services (across the entire continuum of care), which are also covered by the Global Fund through the malaria programme.

However, as highlighted in two interviews, **this narrow coverage may a temporary situation**, given the tight deadlines given to the team to develop the package and the mechanism in place to facilitate the review the NHIMA HBP on a regular basis. As interviewee C describes *“I’ll be honest with you, political decision was made because this scheme had been given sort of a deadline by which to launch by the Minister [...] but there is a strong commitment to revisions for the NHI, understood by all stakeholders. [...] [there is a] clause there that says that the benefit package would be reviewed on annual basis to ensure that we keep pace with the availability of services and also any price changes.”* Interviewee B similarly points out: *“As a department of the Ministry, we just had to come up with a conclusion like, OK, this is how far we can go on. This is what we should do for now. Let’s have this game started and then the benefit package of course is not cast in concrete. It’s a living document.”*

Interviewee C also foresees **potential changes to those inclusions if donor contributions could be brought in to expand fiscal space**. The interviewee points to prior discussions about financing premiums for certain key populations; *“The discussions really were around whether we could ask donors to support subsidies for the vulnerable populations that were already getting support through other programs.”* This could be an approach taken in the future for donors, as opposed to financing just commodities for some of the disease programmes as interviewee C continues; *“PEPFAR are still supporting the commodities side. I’m feeling at this point that perhaps we’d get additional value by reducing the inequities in access for the vulnerable populations. Moving forward, I think that’s the approach.”*

DISCUSSION: ACHIEVING UHC AND THE PATH FORWARD WITH INTEGRATION

Both the NHCP and NHIMA’s HBP have been seen as instruments to implement UHC. For this reason, the topic of integration of disease programmes into those packages is essential, especially in Zambia given those address the largest burdens of disease in the country. Integration of disease programmes, on the other hand, is especially complex given the high reliance on external funds for the delivery of such programmes (compared to other countries of a similar income level and in the region).

Our review shows the patterns of inclusions are, unsurprisingly, very different in the two packages. The NHCP lists many services under the six programmatic areas under consideration, although it is worth noting that the package does not include contraception and immunisation. On the other hand, NHIMA’s package has very few inclusions, with the exception of Malaria services, and is only meant to supplement the NHCP and other donor or government investments in the healthcare sector.

This highlights two important points. First of all, while the NHCP is conceived as the ‘overarching package’ for achieving UHC in the country; its definition, implementation and funding is still muddled almost a decade since its finalisation. This is a concern given the NHCP does include services for six programmatic areas that account for a vast majority of the country’s burden of disease. It has also led to a situation where implementation of services still occur largely in the context of vertical programmes, and there is a lack of clarity of what is implemented through those parallel systems and what is being left out from the NHCP. On the other hand, given the health financing landscape in the country, it appears appropriate to rely on a combination of funding sources (including from external partners) to deliver the package. However, we have found no mechanism to enable, track and organise the combination of funding to the NHCP.

In contrast, NHIMA has a strong focus on implementation and aims to achieve fiscal sustainability (by linking strongly to available budgets) and there are clear intentions, for instance through the NHI Act 2 of 2018, to use it as a platform to achieve UHC in the country. However, NHIMA's HBP only covers some Malaria services at present and has a specific provision that services covered under vertical programmes are excluded from the package. Our interviews highlight that periodic revisions of NHIMA's HBP may lead to broader inclusions, especially if external partners are successfully brought in (for instance through covering contributions of vulnerable populations) to financially contribute to its delivery.

As a result, for both packages, it appears essential to define pragmatic, tailored and concrete solutions to navigate constraints on both the Government of Zambia and the partners' side, to enable contributions from external partners. In this study, we do not make recommendations about such solutions. However, our interviewees raise potential options ranging from mechanisms to allow donors to contribute financially to the NHCP and NHIMA (e.g., for vulnerable populations), to align donor programming to package interventions, or to track implementation/delivery of services from different mechanisms (NHIMA, NHCP or other packages). This experience would also provide insights for other countries where reliance on aid is significant in the health sector on how to successfully achieve UHC through a combination of domestic and external funding sources.

Looking at the efforts in Zambia, one interesting example is Malaria services. As noted throughout the case study, Malaria has been prioritised for integration into both Zambia's NHCP and NHIMA packages and has been identified as a priority given the relatively high percentage of support from government sources: in 2016, domestic sources represented two thirds of the programme spending (MoH 2017). This is in contrast to the HIV/AIDS programme, where domestic resources account for about a third (MoH 2017). We were not able to explore in more depth the reasons for such an exception or how, in practice, this inclusion of services was organised (e.g., how external partners may have worked together with the Government of Zambia or NHIMA to organise the delivery of those services). Further research focussing on Malaria could support discussions in Zambia (for other programmatic areas) and in other LMICs.

Despite the challenges discussed above, there are beginnings of beneficial arrangements to enable full integration -the strong relationships with partners, experience with integration and donor coordination- should this be Zambia's desired goal for their journey to UHC. For example, strong relationships with external partners is a key ingredient for future integration as interviewee A describes; *"I think another enabler is having a very good relationship with stakeholders. The government has got a very good relationship with donors, with implementing partners. And they have been able to exploit that relationship."* Donors and development partners have a history of integration within Zambia, as one external partner [Interviewee E] explains; *"Zambia have a long history of using sector wide approaches and coordination mechanisms have been in place."* Another external partner agrees [interviewee D]; *"[Zambia] had already established structures and they had already the working groups that were needed to basically inform all of the things that they're doing."* They continue that there has been discussion on how to coordinate donors for RMNCAH-N; *"We had early discussions, and to a degree and sporadic ongoing discussions, with some of the key donors in country and the principal ones on the bilateral side that seemed to be interested in using this process to help also identify their own priorities for investment in some coordinated way."*

There is also high political commitment to the programmatic areas reviewed in this case study, which has been one of the driving forces behind the broad inclusions in the NHCP. Moreover, the country's eventual transition from aid is becoming a policy priority, making the question of inclusion (and increase in domestic ownership of programmes) more pressing. As interviewee B states; *“we're transitioning into a lower middle income country and donor support would definitely be affected in terms of resources coming into the health sector, we are alive to the fact that, our donor dependencies is quite high [...] So what we're trying to do is also to look at how we can sustain drugfund in view of probably partners pulling out.”*

For integration to occur, it will be essential to build a process to look beyond the listing of entitlements, and make services part of a whole package funding and implementation strategy, for both the NHCP and the NHIMA HBP. Because of the funding realities in the country, this conversation will need to happen both at the level of the Zambian MoH but also involving external partners.

Some important limitations to our research are to be noted. First of all, while efforts were made to have interview a number of relevant stakeholders, it was not possible to interview a representative sample, and to capture all perspectives, within the time allocated to this project. It is worth noting that we tried to include a plurality of views from government officials as well as development partners in our interview sample. Moreover, we rely on interviews for the discussion part, which may be prone to biases (e.g., if interviewees did not feel they could speak freely or biases on the part of the research team on the interpretation of the transcripts). As a result, this present case study should be seen as preliminary work and our findings should be interpreted in the context of those limitations.

ANNEX 1. INTERVIEWEE SELECTION PROCESS

Interviews were sought with a wide range of stakeholders, the two primary groups being external partners and government officials. We identified stakeholders based on contacts from our networks, reviews of official documents (e.g., review of contributors' list).

We sought to target interviews to capture the views of officials working in the development or revision of Zambia Health Benefit Package, head of disease programmes, and major funders. 25 invitations were sent out for consultation, resulting in 5 1-hour structured interviews completed. All interviews were conducted online over the course of the months of July and August 2021 by the two research staff (YLC and LR).

Interviewee list

	Affiliation
A	Health Economist Consultant
B	Health Financing, MoH government official
C	National Health Insurance Management Authority
D	Development partner 1
E	Development partner 2

ANNEX 2. INTERVIEW TRANSCRIPT INDUCTIVE CODING METHODOLOGY

Each interview was recorded, and a complete transcript was produced using the online meeting tool, with the exception of one interview where detailed notes were taken due to technical issues.

To analyse the information garnered through the interviews, inductive coding was used. Inductive coding allows thematic analysis of qualitative interviews, through grouping together key information into themes, and allows comparison of information provided across different respondents on common themes (and identify any source of discrepancy) (Thomas 2006).

Interviews were split between the two research staff (YLC and LR), and each staff was responsible for steps 1 to 4 described below. Once interviews were coded, an excel spreadsheet bringing together all statements and codes was generated, and pivot tables were created to summarise the categories and codes. Those pivot tables were then subsequently used to create broad themes that were used to discuss the enablers and the challenges linked to integration.

The below step-by-step methodology describes the process developed for this case study.

Step 1: Interview transcripts

1. Interview transcripts are reviewed and cleaned up (e.g., removal of any wrong text input from Microsoft teams)
2. Researchers read through all interview transcripts to get a feel for the information and make notes of initial impressions

Step 2: Coding

1. Transcripts were reread line by line
2. The researchers began coding by highlighting and labelling relevant words, phrases, sentences or sections. These included functions, activities, concepts, challenges, opinions, processes, or anything deemed relevant to objectives of the study.
 - In particular, researchers highlighted information that is repeated, surprising, interviewee explicitly stated is important, or related to information found in published literature through the desk review.
 - These codes included interviewee's summarising a topic or data, (e.g. organisations, team roles, etc), direct quotes on feelings, perspectives and descriptions of processes.

Step 3: Creating categories

1. All highlighted excerpts were brought together in an excel spreadsheet, a code per cell.
2. Categories were created by bringing several codes together. The categories used were the following: Funding, inclusion/integration, challenges, benefit package design, donor coordination, political aspects, stakeholders, transition, malaria, department/function, capacity, HIV, HSS, Family planning, communication, economy, collaboration, enabler, Covid, prioritisation, progressive/incremental, opinion, maternal child, evidence.
3. Some initial codes were dropped at this stage when deemed not as relevant.
4. Each excerpt was labelled with at least one associated category.
5. Pivot tables were created then to view the most populous categories. The pivot tables were used to review and revise categories making sure they are distinct, relevant. The categories were narrowed down to the 8 most relevant to the study objectives.

Step 4: Writing up of results

1. The categories were used to create broad themes that were used to discuss the enablers and challenges of integration of vertical programmes within HBPs.
2. The discussion section of this paper describes the researchers interpretations of these themes, including information from other literature, theories and concepts.

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