

## Navigating the path to universal health coverage: A comprehensive framework for the implementation of national health insurance in Zimbabwe

Matipedza Lole<sup>1\*</sup>  
Lubinda Haabazoka<sup>2</sup>

<sup>1\*</sup>tolematy@gmail.com  
<sup>2</sup>lhabazoka@yahoo.com

<sup>1,2</sup>. The University of Zambia, Zambia

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### ABSTRACT

Universal Health Coverage (UHC), which provides all people with necessary health services, has not been achieved in Zimbabwe because government health funding remains below 4% of Gross Domestic Product (GDP). The research creates an extensive method for implementing Zimbabwe's National Health Insurance (NHI) program, a road map to achieve Universal Health Coverage (UHC), which currently exists as an aspirational legislative requirement yet remains pending. The researchers used a qualitative comparative case study research design to carry out qualitative analysis through document reviews together with a comparative evaluation of health insurance systems from Kenya, Ghana, and Rwanda to identify problems within the national health financing system, which exists in a state of emergency. A systematic documentary review of Zimbabwean policy documents, which included the NHI Act, the National Health Strategy 2021-2025, and budget statements from 2019 to 2024. For Kenya, sources such as NGO reports and census data were utilized for the systemic review. In Ghana, sources used for the review include World Bank reports and health surveys, which provided valuable information. Rwanda's sources that were systematically reviewed include conflict resolution reports and economic development studies. Zimbabwe's health expenditure shows a strong dependence on out-of-pocket costs, which make up 34% of total health expenditures, while government health funding operates at less than 4% of Gross Domestic Product (GDP). This then creates financial disasters for 30% of households and produces extreme differences in healthcare access. The proposed framework creates three distinct phases for a ten-year transformation process, which includes foundational piloting (Years 1-3), national expansion (Years 4-6), and maturation and integration (Years 7-10). The main changes involve creating an independent NHI Fund through statutory requirements, implementing biometric IT systems, requiring formal sector payroll payments, developing a subsidized hybrid system for informal workers, and moving to capitation and diagnosis-related group (DRG) payment systems through strategic purchasing. The framework evaluation process uses a critical approach to assess organizational risks, which include two major threats: financial sustainability challenges from the high level of informal employment (76% of employment) and governance risks through corruption, which regional situations demonstrate. The NHI legislation needs transformation through an evidence-based phased approach that focuses on financial sustainability and governance strength and equality to become the main element of Universal Health Coverage in Zimbabwe.

**Keywords:** Health Financing, Health Systems Strengthening, National Health Insurance, Sustainable Development Goals, Universal Health Coverage, Zimbabwe

### I. INTRODUCTION

Universal Health Coverage (UHC) stands as a fundamental principle that underpins the 2030 Agenda for Sustainable Development while its definition appears in Sustainable Development Goal (SDG) 3.8. The United Kingdom Department of Health and Social Care works to establish budgetary frameworks through their Budgeting for Better Health program which aims to create efficient health systems that deliver essential healthcare treatment to every individual without causing them financial disaster. The concept extends beyond healthcare delivery to include financial risk protection and access to medicines and full-service coverage. UHC functions as a fundamental requirement for Zimbabwe because the nation requires this system to achieve national growth benefits and social stability according to its current state of post-colonial development and economic recovery efforts. The country maintains a durable health system which handles multiple crises that include the COVID-19 pandemic but its operational capacity suffers from a combination of economic adjustment policies and ongoing economic instability and persistent lack of funding which leads to inconsistent delivery of fair healthcare services. The UHC challenge exists today because historical systems need complete overhaul instead of minor fixes which require proof-based policy changes to establish a health system that serves every citizen in full capacity.

The current health financing system in Zimbabwe seems to be creating two fundamental problems which result in divided resources and unequal access to healthcare services. The system equivocally gives financial support to 34% of the entire health expenditure through direct Out-of-Pocket (OOP) payments which create unsustainable dependency.

The total government health expenditure shows nominal growth but it remains critically low because it spends less than 4% of Gross Domestic Product, (GDP) and 8% of the government budget which falls far short of the 15% target established by the Abuja Declaration and the global health expenditure average of 9.8% of Gross Domestic Product, (GDP) (Megbowon & Zerihun, 2025). Public sector facilities face a dangerous cycle of financial deprivation because their lack of funding leads to essential medication shortages which extend beyond 50% at primary care facilities and to their damaged facilities and their insufficient personnel which results in an erosion of public confidence that drives wealthy customers to select private treatment thus removing resources and medical professionals from the public healthcare system.

The financing crisis has created measurable human impacts which produce serious health disparities between different social-economic groups. The maternal mortality ratio in Zimbabwe stands at 462 deaths per 100000 live births which serve as an essential health system indicator for assessing system performance and system access equality. The under-five mortality rate has shown progress yet it still affects a greater number of children from poor households who live in provincial areas which demonstrates how the system fails to provide necessary resources. The system faces increased pressure from two health problems because people between ages 15 and 64 have a 12.9% HIV rate which requires them to take medication for their entire lives and non-communicable diseases such as hypertension now impact approximately 30% of adults requiring the transition to chronic care treatment systems which the current framework lacks capacity to deliver (Kamkuemah, 2021). The current system which provides formal private insurance to 7-10% of people while most others depend on informal community savings creates a health system where rich people in urban areas receive better medical services than poor people in rural areas.

In response to the national health emergency, Zimbabwe created the National Health Insurance (NHI) framework through Act (Chapter 15:20) which establishes a mandatory social health insurance system that will operate across the country. The policy direction seeks to establish social health insurance systems which several African countries have used as their main path to achieve universal health coverage. Rwanda developed community-based health insurance which now serves 90% of its residents due to strong government support for low-income citizens while Ghana's NHIS has improved access to its informal sector despite facing payment and sustainability challenges (Domapielle, 2021). The National Health Insurance system in Zimbabwe aims to create a unified risk pool which will separate health service use from payment at service locations while establishing one entity to control spending which will boost healthcare efficiency and quality. The gap between legislative goals and actual practices presents numerous difficulties which include developing a funding system which can handle the informal economy that employs more than 70% of workers and constructing strong anti-fraud systems and determining fair provider payment rates and handling integration of private health insurance companies with government regulations while maintaining current healthcare operations.

The study investigates the primary implementation barrier which prevents Zimbabwe from achieving its NHI program. The study demonstrates the need for reform yet neither academic sources nor policy documents provide a complete plan which shows the actual needs of the situation. The paper establishes an implementation plan through detailed construction of multiple execution stages. The project will analyze funding constraints together with Zimbabwe's institutional abilities to operate through three steps which will also identify its advantages and limitations during financial assessment and operational assessment. The National Health Insurance Act needs to become a successful operational system which will drive universal health coverage while developing a healthcare system that provides better future protection and serves all Zimbabwean citizens equally.

### **1.1 Statement of the Problem**

The NHI Act has remained in effect for more than five years yet Zimbabwe still needs to develop a specific implementation plan which provides localized details for its execution because the country has no effective solution for this policy gap. The scheme has been inactive for an extended period which maintains a health financing system that shows clear proof of three major faults, because the World Bank (2025) report shows that 30% of households face catastrophic out-of-pocket expenses while the system fails to allocate resources correctly by directing them toward advanced medical care in tertiary hospitals instead of funding essential primary and preventive healthcare services. The Act needs research and policy development because it requires an effective implementation strategy, which needs to be developed as a complete implementation strategy through technical methods that utilize multiple stages and complete financial planning for the distinct socio-economic conditions of Zimbabwe. The solution requires three main components which include identifying sustainable revenue sources for the economy, which suffers from low formal employment and developing an inclusive benefits package that has legal guarantees yet people find politically acceptable and financially trustworthy while building governance systems that protect against rent-seeking behavior. The process requires two steps which involve merging existing private medical aid societies with donor-funded vertical programs, which need to join the NHI fund, while protecting current service delivery during the transition process.

## 1.2 Research Objective(s)

- i. Critically analyse the current health financing landscape and its barriers to UHC in Zimbabwe.
- ii. Synthesize lessons from NHI implementation in selected low- and middle-income countries, particularly in Africa.
- iii. Propose a structured, phased framework for NHI roll-out in Zimbabwe, detailing governance, financing, benefits design, and provider payment mechanisms.
- iv. Identify potential risks and mitigation strategies related to political will, economic volatility, and institutional capacity.

## II. LITERATURE REVIEW

### 2.1 Theoretical Review

The research bases its theoretical framework on two complementary models which help develop and assess health financing reforms that aim to achieve Universal Health Coverage (UHC) standards. The WHO UHC Cube serves as the main framework which requires progress assessment through three connected measurement dimensions which include the percentage of population coverage and service delivery range and the level of financial protection against out-of-pocket expenses that needs evaluation (Rahman et al, 2022). The model shows that when one measurement dimension expands while two other dimensions stay unchanged then the system becomes both ineffective and unfair because broad population coverage with basic benefits will not protect people adequately. The study uses the Social Health Insurance Theory which explains Social Health Insurance (SHI) through three main principles that include mandatory prepayment and large population risk pooling and cross-subsidization from healthy individuals to sick people and from wealthy people to low-income individuals. The National Health Insurance framework uses this theory as its normative basis because it believes that healthcare outcomes will achieve greater equality through solidarity-based financing than through disjointed voluntary systems. The two frameworks work together to create an analytical tool which helps evaluate Zimbabwe's NHI system through two aspects: its goals and its expected results which require a system design that will grow its user base through all three objectives.

### 2.2 Empirical Review

#### 2.2.1 Critical Lessons from African Health Insurance Reforms

Empirical research on health insurance reforms in Africa provides essential information about the factors which determine whether national health insurance NHI programs succeed or fail. The studies investigate three aspects of health care coverage which include coverage expansion and financial sustainability and governance arrangements that exist in various economic and institutional settings. African nations face common difficulties because they have substantial informal economies and limited budget resources and inadequate government systems yet their reform processes have produced different results. A comprehensive review of evidence from Rwanda and Ethiopia and Ghana and Kenya and Tanzania displays both effective strategies and ongoing structural difficulties which affect Zimbabwe's progress toward universal health coverage.

#### 2.2.2 Successful Models of Coverage Expansion: Rwanda and Ethiopia

Rwanda's Community-Based Health Insurance system which people refer to as Mutuelle de Santé achieves successful health coverage expansion through its implementation according to research studies which prove this statement. The research conducted by Rwagitare in 2024 studied the national implementation of CBHI in Rwanda and discovered that three factors drove the system to achieve above 90 percent coverage of its population. The research showed that financial protection reached better results while people from low-income backgrounds started using healthcare services more frequently. The research study concentrated on coverage results while it did not examine how financial resources would sustain operations or how administrative expenses would impact operations thus creating a need for future research.

The study conducted by Ndayishimiye et al. (2025) employed a political economy approach to assess Rwanda's health insurance reforms and discovered that three factors which included centralized leadership and performance-based financing and strict enrolment enforcement improved implementation results. State capacity together with political will power stood as the primary factors which made the program successful. The research discovered its results based on the specific governance conditions of Rwanda which restrict their application to nations that possess weaker governance systems like Zimbabwe.

The study by Koch and his colleagues in 2022 examined how Rwanda's Community-Based Health Insurance program affected financial risk protection. The research demonstrated that insurance coverage led to lower catastrophic health expenditure for households which had purchased insurance. The study showed how targeted subsidies together with cross-subsidisation systems created better outcomes through financial support mechanisms. The researchers failed to investigate all aspects which create problems for service expansion in areas with limited resources.

The Community-Based Health Insurance program which Mebratie et al. (2025) studied in Ethiopia served as a health coverage solution for both rural and informal worker populations. The researchers evaluated three aspects of their study which included enrolment rates and healthcare usage patterns and financial protection results. The researchers found that decentralized administration through local governance systems led to better enrolment rates and better healthcare access in rural areas. The study discovered two main problems which included difficulties maintaining voluntary enrolment and difficulties controlling ongoing premium payments.

Kebede (2024) studied the factors that affect enrollment in Ethiopia's CBHI program and discovered that three factors community awareness and trust in local administrators and perceived service quality showed major impact on program enrollment. The research found two main obstacles which created ongoing problems for the organization because it needed to handle adverse selection and it lacked sufficient funds to support at-risk groups. The research demonstrated that institutional frameworks require strengthening to ensure ongoing progress in coverage maintenance.

Rwanda and Ethiopia studies show that political commitment and decentralised governance and targeted subsidies function as essential elements which need to operate together to achieve better coverage results but their research focuses on stable institutional environments and rural insurance systems. There is limited empirical evidence on how such strategies operate in countries experiencing macroeconomic instability, high inflation, and fragmented health financing systems. The study examines how Zimbabwe needs to modify its coverage expansion methods to suit its economic situation which includes a major informal sector and unstable economic conditions.

### **2.2.3 The Challenge of Financial Sustainability: Ghana and Kenya**

The implementation of national health insurance programs throughout Africa faces its largest obstacle in achieving financial sustainability. The National Health Insurance Scheme of Ghana has been extensively researched as an example of how to achieve rapid program growth while managing financial difficulties. Domapielle (2021) examined the financing system of Ghana's National Health Insurance Scheme and discovered that the program increased healthcare accessibility while it decreased direct medical expenses but the funding method which depended on a value-added tax-based National Health Insurance Levy generated financial burdens that resulted in ongoing budget deficiencies. The study found that providers faced payment delays which resulted in a decline of both service quality and trust between providers and their patients.

Tan (2025) conducted an assessment of Ghana's NHIS using a health systems performance framework which revealed that administrative inefficiencies together with claims fraud and rising healthcare costs created threats to the system's long-term sustainability. The study found that the scheme increased access to healthcare services but it failed to achieve financial stability because of its ineffective cost containment procedures. The study examined fiscal imbalances but it failed to present any specific policy recommendations that would solve the issue.

Akweongo et al. (2021) studied how both patients and providers view Ghana's NHIS system and their findings showed that payment delays resulted in decreased provider involvement which ultimately affected service quality. The study demonstrated that efficient claims processing together with transparent fund management should function as the essential components for financial sustainability. The research mainly examined how service delivery results developed but it did not explore how macroeconomic elements affected financing stability.

Mbau et al. (2020) conducted their research in Kenya to evaluate the National Hospital Insurance Fund reforms which aimed to provide coverage for informal sector workers. The study found that three factors which included voluntary contributions and administrative complexity and irregular income made it difficult for informal workers to join the program. The researchers found that contribution systems which operated for formal work settings failed to function in regions that contained significant informal work sectors.

Kabia et al. (2022) studied equity issues together with financing problems which impacted Kenya's National Health Insurance Fund. The researchers found that the contribution system used by the National Health Insurance Fund contained two main problems which resulted in insufficient funds to provide universal health coverage. The study conducted by Srinivasagopalan (2023) demonstrated that weak governance systems together with inadequate pooling structures created barriers which prevented effective risk sharing and financial stability.

The studies show that expanded coverage leads to fiscal crises because providers become dissatisfied which results in reduced service quality. The existing research focuses on stable economies but it fails to show how macroeconomic instability and currency volatility together with inflation impact health insurance financing. The study investigates how Zimbabwe's economic situation affects the development of sustainable National Health Insurance financing systems.

### **2.2.4 Governance and Strategic Purchasing as Differentiators**

The two elements of governance capacity and strategic purchasing systems act as essential factors that determine how successfully national health insurance programs will be executed. Naher et al. (2020) conducted their research on health financing governance systems across developing nations and discovered that independent insurance organizations

with effective accountability systems achieved higher operational efficiency and better public trust and transparency. The research study did not provide sufficient analysis of specific African nations.

Uhakula (2023) studied strategic purchasing changes which occurred in Kenya and found that three factors which included inadequate regulatory capabilities and faulty provider payment systems and insufficient data systems prevented successful purchasing activities. Health insurers operate as passive payers because they do not engage in active service purchasing which guarantees high-quality medical treatment. The research study concentrated its efforts on investigating the Kenyan case study while neglecting to study other areas of Africa.

Venkateswaran (2024) assessed the pilot programs which Tanzania used to test its primary healthcare capitation funding model. The study discovered that capitation funding system showed better cost management capability and better healthcare preventive services and better healthcare provider responsibility. The researchers identified two implementation problems which included insufficient administrative resources and healthcare provider resistance.

The research conducted by Simpungwe (2023) shows that African nations experienced health purchasing problems because their risk pools remained uncoordinated and their Health Management Information Systems (HMIS) functioned inadequately and their claims management systems operated inefficiently. The research demonstrated how digital health systems with performance tracking capabilities functioned as essential elements of the study while resource-limited environments failed to provide sufficient proof of their actual use.

Afriyie et al. (2021) examined health financing reform governance difficulties which Sub-Saharan African countries encountered and discovered that political involvement together with weak institutional independence and insufficient transparency rules destroyed scheme effectiveness. The study showed how essential independent oversight institutions functioned but it failed to investigate systems which would work in areas with fragile economic conditions.

The existing research body identifies governance capacity and strategic purchasing and digital claims management as essential factors for success yet only a few studies investigate how nations with weak institutional frameworks and unstable economies establish proper governance frameworks. The study investigates how governance systems and strategic purchasing methods that work for Zimbabwe's institutional framework and economic conditions should operate in the study area.

## III. METHODOLOGY

### 3.1 Research Approach

The study uses a Case Study design, qualitative research approach that creates policies to establish an execution framework which operates in real-world situations. The research methodology establishes health financing reform which requires multiple evidence sources to create recommendations that connect with Zimbabwe's political system and international case studies. The method depends on realist synthesis principles which aim to identify the basic systems and situational elements that determine policy outcomes in different environments. The framework establishes a deep understanding of how National Health Insurance functions in Zimbabwe which requires researchers to move beyond basic methods of policy transfer according to Mhazo et al, (2023).

### 3.2 Research Design and Data Collection

The research used a complete desk-based policy analysis approach which combined various secondary data sources to achieve strong analytical results through triangulation. The researchers gathered data using two main collection methods which happened in sequence. The first stream involved a systematic documentary review of the domestic policy and fiscal environment. The research team examined important documents which included Zimbabwe's National Health Insurance Act Chapter 15, 20 and the National Health Strategy for 2021, 2025 and the National Development Strategy 1 and 2. The analysis of national budget statements from 2019 until 2024 and International Monetary Fund reports revealed essential details about the country's fiscal limitations and potential economic growth areas. The research team used major health sector documents which included the National Health Accounts and the latest Zimbabwe Demographic and Health Survey to create an initial assessment of health system efficiency and funding patterns and accessibility shortfalls which existed in the country (WHO, 2021).

The second data collection method used a detailed comparative case study analysis to gather information. The research team studied multiple African countries to identify which aspects of their implementation processes could help them develop successful practices. The research selected Rwanda and Ghana and Kenya as essential case studies because they used social health insurance in different ways which resulted in different levels of population coverage and financial sustainability and success in including informal sector workers. The research team used peer-reviewed studies and systematic reviews and health system case studies from the past five years as the sources for the analysis.

### Table 1

*Framework for Comparative Case Study Analysis of Health Insurance Schemes*



Analytical Dimension	Rwanda ( <i>Mutuelle de Santé</i> )	Ghana ( <i>National Health Insurance Scheme</i> )	Kenya ( <i>National Hospital Insurance Fund</i> )	Relevance to Zimbabwe
Primary Financing Source	Sliding-scale premiums + Substantial government subsidies (~50% of funding)	National Health Insurance Levy (VAT) + Formal sector payroll deductions	Mandatory formal sector payroll deductions + Voluntary premiums for informal sector	<b>Assessment of a viable mix:</b> The need for tax funding, payroll contributions, and explicit government subsidies for the poor.
Informal Sector Enrollment Strategy	Near-universal via community mobilization & heavy subsidization for poorest groups	Significant but volatile; challenges with direct premium collection from the informal sector	Persistently low; despite reformed voluntary products, enrollment remains a major hurdle	<b>Critical Design Question:</b> How to mandate, incentivize, or subsidize enrollment for Zimbabwe's large informal economy (>70% of workforce).
Key Governance Challenge	Maintaining service quality and provider readiness during rapid scale-up	Chronic provider payment delays undermining fund credibility and provider participation	Fraud control, administrative capacity constraints, and fragmentation of coverage	<b>Institutional Priority:</b> Designing for transparency, timely financial flows, and anti-corruption from the outset.
Notable Outcome & Lesson	>90% population coverage; drastic reduction in OOP spending. <b>Lesson:</b> Political will + subsidization = rapid scale-up.	Expanded access but recurrent financial crises. <b>Lesson:</b> Sustainable financing is paramount; design flaws can lead to systemic distrust.	Improved coverage for formal sector & targeted groups. <b>Lesson:</b> Without mandatory inclusion, informal sector enrollment lags severely.	<b>Synthesis:</b> Zimbabwe must sequence reforms, prioritize financial sustainability, and build robust IT and governance systems from the start.

Through its comparative approach this study investigates how particular design elements which include premium collection systems and governance frameworks lead to the results which enable Zimbabwean planning to assess its performance (Akweongo et al. 2021).

### 3.3 Target Population and Sampling Procedures

The desk study targets its research on policy documents and fiscal reports alongside academic and grey literature which relates to health financing reform in Zimbabwe and the selected comparator countries. The researchers used purposive sampling to choose sources which provided them with the most valuable and trustworthy information. The team selected documents which they found suitable for studying NHI operational challenges because these documents originated from official governmental bodies and respected international organizations and they existed in current policy frameworks which had developed after 2019. The selection of Rwanda, Ghana, and Kenya as comparator cases was deliberate, following a critical case sampling logic wherein each country offers in-depth insights into specific implementation challenges Zimbabwe is anticipated to face.

### 3.4 Data Analysis Techniques

The analysis followed a predetermined framework which included multiple steps to transition from initial descriptive analysis to the creation of a synthetic framework. A thematic analysis of Zimbabwe-specific documents started the investigation. The research team used an inductive coding framework to identify and classify primary themes and challenges and policy goals and stakeholder viewpoints. The research team applied established qualitative analysis methods to arrange data according to major research themes which included "revenue sourcing constraints" and "governance capacity gaps" and "benefits package design dilemmas" (Braun & Clarke, 2023).

The researchers evaluated case study data using a framework analysis method which is shown in Table 1. The research team created a pre-structured matrix which used essential analytical aspects from both Zimbabwean conditions and existing literature to develop its structure. The researchers created a matrix which allowed them to compare evidence from multiple countries to see how different situations impacted their policy results. The synthesis of multiple cases helped researchers find both generalizable principles and critical mistakes which should be avoided.

The final stage of the research process required researchers to combine domestic documentary findings with the results from their comparative study. This synthesis was not merely summative but generative because it created an implementation framework which exists in a logical structure. The research team used all elements of their proposed framework because they wanted to establish evidence-based solutions which match specific contexts through documented evidence from previous analytical work.

### 3.5 Framework Evaluation

The evaluation of the proposed framework will confirm its strength and practical value through assessment against four established criteria which health financing reform literature identifies as essential for successful implementation. The framework assessment uses three criteria which include relevance to Zimbabwean policy goals and existing system deficiencies, feasibility to evaluate current political and fiscal conditions, and equity to assess how well the framework protects disadvantaged groups from financial difficulties. According to Braun & Clarke, (2021) the assessment examines the framework's financing and institutional structure to determine its potential for sustained operation. The evaluative lens requires the framework to undergo critical evaluation before it can become a policy instrument because it needs to meet the requirements of real-world implementation.

## IV. FINDINGS & DISCUSSION

### 4.1 Findings

The section delivers the combined results obtained from both the documentary analysis and the comparative study which produced an implementation plan for NHI deployment in Zimbabwe. The framework undergoes assessment through a critical analysis that examines its elements in relation to evidence from comparable reforms and the unique limitations present in Zimbabwean conditions.

The integrated results of the documentary analysis and the comparative case studies show evidence which supports the research objectives and the identified variables of the study. The dependent variable successful NHI implementation for Universal Health Coverage (UHC) is examined through its core dimensions: population coverage, financial protection, and service access equity. The researchers examine how health financing mechanisms and governance structures and informal sector integration strategies and provider payment systems affect implementation results as independent variables.

#### 4.1.1 The Proposed NHI Implementation Framework for Zimbabwe

The analysis concludes that a successful NHI in Zimbabwe cannot be a "big bang" reform but must be a decade-long, strategically sequenced transformation. The proposed framework is structured across three distinct phases which each contain specific goals and defined activities and measurable success criteria that will develop institutional capacity and public trust and financial sustainability.

##### *Phase 1: Institutional Foundation and Piloting (Years 1-3)*

The NHI framework requires its legal components to be established through this phase which will test its institutional and technical elements while controlling potential risks through pilot projects. The National Health Insurance Fund (NHIF) establishment requires its transformation into a public entity with statutory status and operational independence through a board which includes key stakeholders from government and healthcare and civil society and contributors to maintain its legitimate operating status (Afriyie et al. 2021). The development of a complete Integrated Health Financing Information System requires simultaneous progress with this project. The IT backbone system requires mandatory implementation because it needs to support beneficiary registration through biometric identification which prevents fraud and enables provider accreditation and claims management and real-time monitoring functions.

The Phase 1 financing process begins through legislation which requires formal sector employees to contribute, say 3%, of their gross salary while employers must pay a matching 3% payroll tax. The system establishes a revenue stream which delivers consistent income to the organization. The government must provide complete premium funding for all indigent individuals who undergo verification through the multi-source means-testing registry which connects with existing social protection databases. Piloting will begin in two provinces which have different demographic and epidemiological profiles (e.g., Harare Metropolitan and Masvingo). The pilot program will deliver an Essential Health Services Package (EHSP) that includes primary care services through outpatient consultations and maternal and neonatal care and essential medicines for acute conditions and vaccinations. The limited package testing period through fiscal spending capacity results in predictable financial outcomes.

##### *Phase 2: Consolidation and Nationwide Expansion (Years 4-6)*

Phase 2 achieves its goals through geographic expansion of pilot projects while implementing benefits for additional areas. The NHIF system requires public engagement work to reach all ten provinces throughout its nationwide implementation. The EHSP program expands its operations to manage chronic diseases which include hypertension and diabetes and HIV because these conditions affect a significant part of the population and lead to catastrophic expenses. The system now provides coverage for surgical and medical treatments which hospitals offer at their secondary-level facilities.



The phase includes its most difficult challenge which involves creating an organized system to enroll informal sector workers who make up more than 70 percent of the total workforce. The framework designed to scale Rwandan model operations uses a hybrid system that requires users to pay a fixed monthly fee between USD 2 and 4 through mobile money systems while government support extends to people who exceed the indigent level (Simpungwe. 2023). The phase enters its active purchasing phase which represents its first step toward strategic buying. The NHIF system will change its reimbursement system to active contracting which links it to public and private healthcare providers who meet its accreditation standards. The payment system will use a combination of two methods which include capitation payments for primary care clinics to encourage preventive and comprehensive care and Diagnosis-Related Group (DRG) payments for hospitals which will drive operational efficiency and create uniform cost structures.

*Phase 3: Maturation, Integration, and Sustainability (Years 7-10)*

The final phase aims to achieve near-universal population enrollment (>90%) and mature the NHI into the central pillar of the health system. The EHSP will undergo ongoing evidence-based development through a permanent Benefits Package Review Committee which will utilize health technology assessment principles for priority evaluation of cost-effective treatment options. The task of combining existing private medical aid societies into one system presents both critical importance and political difficulties.

The framework establishes two operational routes for societies to choose from which include i) functioning as accredited healthcare providers who follow NHIF payment regulations and ii) acting as administrative intermediaries who must transfer all monetary resources into the single NHI risk pool that will finance care for their members. The system maintains member options but prevents two issues which occur when smaller groups face higher costs due to their lack of healthy members (WHO, 2019). The framework establishes revenue diversification as the method which will guarantee financial stability for the organization to achieve its objectives. The mandatory payroll contribution is complemented by a direct allocation of a percentage of sin tax revenues (e.g., from tobacco and alcohol) and the introduction of a minimal levy (e.g., 0.5%) on high-value mobile money transactions, a sector that processed over USD \$100 billion in 2023 alone (WHO, 2025).

**Table 2**  
*Summary of the Three-Phase NHI Implementation Framework*

Phase & Duration	Core Objectives	Key Activities & Interventions	Financing Mechanisms	Success Indicators
Phase 1 (Y1-3): Foundation & Pilot	Establish governance, build IT systems, test processes, build public trust.	1. Establish autonomous NHIF Board. 2. Deploy biometric IT system. 3. Pilot in 2 provinces. 4. Offer limited EHSP (Primary/Maternal care).	1. Mandatory formal sector payroll tax (3%+3%). 2. Full govt. subsidy for indigents.	1. NHIF legally operational. 2. >70% target population enrolled in pilot areas. 3. <15% OOP spending for pilot services.
Phase 2 (Y4-6): Consolidation & Expansion	Achieve national scale, expand benefits, enroll informal sector, initiate strategic purchasing.	1. National geographic roll-out. 2. Expand EHSP to include chronic diseases & secondary care. 3. Enroll informal sector via mobile platforms. 4. Implement capitation & DRG payments.	1. Maintain payroll tax. 2. Informal sector flat-rate premiums + targeted subsidies. 3. Increased govt. tax allocation.	1. National enrollment >50%. 2. Reduced drug stock-out rates for chronic medicines. 3. 95% of claims processed within 30 days.
Phase 3 (Y7-10): Maturation & Integration	Achieve universality, integrate private insurers, ensure fiscal sustainability.	1. Continuous benefits package review. 2. Integrate private medical aid societies into single pool. 3. Institutionalize innovative financing.	1. Payroll tax. 2. Sin tax allocation. 3. Mobile money transaction levy. 4. General tax revenue.	1. Population enrollment >90%. 2. Catastrophic health expenditure reduced by >50% from baseline. 3. NHIF annual audit published and clean.

#### 4.1.2 Critical Discussion of the Framework

The proposed framework needs assessment to determine its actual operational capacity through testing against two standards which include international research findings and the actual conditions which exist in Zimbabwe. *Financing Sustainability: The Paramount Challenge:* The framework's phased financing plan solves the major problem which African NHI schemes face because they use unsustainable design. The formal sector payroll establishes a revenue base which can be managed through administrative processes. Phase 2 testing will determine whether the informal sector functions correctly. The proposed flat-rate premium makes it easy to understand but it will exclude extremely poor people from access to services unless there are strong subsidies which will lead to service gaps similar to those found in Kenya. The framework will succeed only if the government maintains political support to provide continuous subsidy funding which would require the government to redirect funds from inefficient fuel and agricultural subsidies according to IMF fiscal space analyses for Zimbabwe (Mhazo et al., 2023). The mobile money levy shows promise because of its sector coverage but its legal and administrative design must protect against negative impacts which would limit financial inclusion and turn into a tax burden for low-income individuals.

*Governance and the Peril of Corruption:* The establishment of NHIF as an independent organization requires essential implementation work. The situation in Ghana regarding provider payment arrears together with Kenya's NHIF fraud problems demonstrate that legal autonomy needs to implement complete transparency combined with technical expertise. The digital biometric system of the framework functions as a primary risk management solution which prevents "ghost" beneficiaries from accessing the system to create fraudulent claims. The system requires both substantial initial financial resources and protective measures against cybersecurity threats. The multi-stakeholder board must be more than symbolic; it should have real oversight powers, including the appointment of external auditors and the public disclosure of all procurement contracts and financial statements, creating a culture of accountability absent in many state-owned enterprises.

*Strategic Purchasing and Quality Assurance:* The implementation of capitation and DRG payments during Phase 2 will serve as the main method to achieve cost control and provider behavior modifications. The shift presents several potential dangers. When clinics receive capitation rates that fall below their operational needs (which becomes probable during fiscal challenges) they will reduce their treatment services and start charging illegal co-payments which leads to treatment quality decline and trust loss which researchers observed during the initial stages of Tanzania's capitation testing (Srinivasagopalan, 2023). The NHIF needs to develop effective monitoring systems which should include patient satisfaction surveys and clinical quality audits while the organization needs to establish valid penalties for providers who fail to meet compliance standards. The timely payment of providers which represents the main reason for Ghana's system failure needs to become a mandatory Key Performance Indicator that NHIF management must treat as essential.

*Political Economy and Phased Implementation:* The 10-year period serves as a beneficial element because it demonstrates that system changes require time to develop. The pilot phase enables organizations to learn through practical experience while they detect and fix registration and claims processing problems before those issues escalate into national crises. Pilot areas create a base of beneficiaries who will support the program's future development. The extended timeline of the project creates a potential threat to its success. The project duration extends through various political and electoral periods which exposes the project to potential policy changes and decreased progress. The National Health Insurance framework needs to become part of the National Development Strategy while political parties reach agreement through a dedicated parliamentary committee which will oversee its implementation.

The presented framework in this study does not guarantee success yet it creates a path of navigation through dangerous territory. The organization learns from regional failures and successes while maintaining its focus on three key areas which include sustainable financing and strong governance and adaptive learning. The system will reach its final evaluation point when political leaders maintain their dedication to its implementation while they work to balance complete coverage with Zimbabwe's financial and institutional constraints.

#### 4.2 Discussion

The successful implementation of National Health Insurance (NHI) in Zimbabwe requires financing mechanisms which must generate permanent financial resources from multiple income sources. The proposed framework needs pooled funding which will be generated through formal sector payroll contributions and government subsidies for indigent populations and informal sector premiums and new revenue sources which include sin taxes and mobile money levies. Existing literature establishes that countries need diverse funding sources to decrease out-of-pocket costs while they protect their citizens from financial risks in Rahman et al. (2022) and World Health Organization (2025) studies. Rwandan evidence shows that community-based insurance programs which receive government funding provide better financial protection to citizens and decrease their risk of facing major healthcare costs (Koch et al., 2022; Rwagitare, 2024). Ethiopian research shows that informal workers base their insurance decisions on three factors which include price and trust and their assessment of service quality (Mebratie et al., 2025; Kebede, 2024). The findings show that Zimbabwe needs to balance its National Health Insurance model between offering affordable health services and

providing sufficient financial support which will achieve fair health service distribution during times of economic hardship and social inequality (Mhazo et al., 2023).

The study shows that NHI implementation needs strong governance frameworks and operational independence of institutions for its success. The proposed establishment of an independent National Health Insurance Fund supported by biometric registration systems and integrated health financing information systems is intended to enhance transparency, reduce fraud, and strengthen accountability. The findings of this study show that governance capacity and institutional coordination actually determine how successful health financing reforms will be according to existing research evidence (Afriyie et al., 2021). Research shows that corruption together with poor administrative supervision creates barriers to service delivery which damages public confidence in health systems within developing nations (Naher et al., 2020). The proposed framework uses digital monitoring systems together with multi-stakeholder oversight mechanisms to create efficient health financing institutions which follow best health system governance practices and develop accountability mechanisms.

The research results demonstrate that health systems need to implement their operations in stages and use their resources through planned purchasing methods which both boost their operational efficiency and enable their operations to continue. The three-phase method enables organizations to develop their capabilities through capacity building which training tests various operational processes before they implement their methods at a national level since world health organizations recommend that major health financing changes should be executed through step-by-step implementation (World Health Organization, 2021; Domapielle, 2021). The implementation of strategic purchasing systems through capitation payments and diagnosis-related group reimbursement systems will establish better cost management and service delivery methods which will make healthcare providers more accountable to their work because research from Kenya and Tanzania demonstrates that active purchasing creates better results when supported by powerful regulatory frameworks (Mbau et al., 2020; Kabia et al., 2022; Venkateswaran, 2024). The results demonstrate that monitoring needs to be done continuously while policies must adapt because these two factors will determine whether Zimbabwe successfully implements NHI programs.

## V. CONCLUSION & RECOMMENDATIONS

### 5.1 Conclusions

The path to UHC via NHI in Zimbabwe is necessary but complex. The paper presents a structured framework which uses evidence as its foundation to direct the process of transformation. The study demonstrates that economic fragility and institutional capacity gaps together with the challenges of a diverse population create substantial obstacles which can be overcome. The successful implementation of NHI requires organizations to establish funding mechanisms together with processes that support strategic purchasing and strong governance while maintaining their focus on equitable outcomes. The proposed phased model balances ambition with pragmatism which supports constant development based on local conditions and global and regional research findings.

### 5.2 Recommendations

The NHI Fund needs immediate implementation through statutory instruments by the government which should also provide initial funding for its implementation through the national budget. The NHI Fund needs multiple revenue streams which should be established through a complete fiscal space assessment that identifies sustainable funding sources including sin taxes and mobile financial service levies. The NHI Fund needs immediate funding for training programs that will prepare its administrators and healthcare financiers and hospital managers to handle strategic purchasing and claims management and anti-fraud activities. Infrastructure like clinics, hospitals, pharmacies etc will also need immediate funding as most provinces are facing challenges in this regard.

**Stakeholder Engagement** The project will establish a permanent communication campaign that uses public and private sector channels to build trust and explain its benefits while creating inclusive design solutions for informal sector background workers. **Monitoring & Evaluation** The organization will create a strong monitoring and evaluation system which includes specific performance indicators that will measure enrollment rates and outpatient expense distribution and medical service access by the lowest income group.

### Declaration of Interest

The authors declare that they do not have any known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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