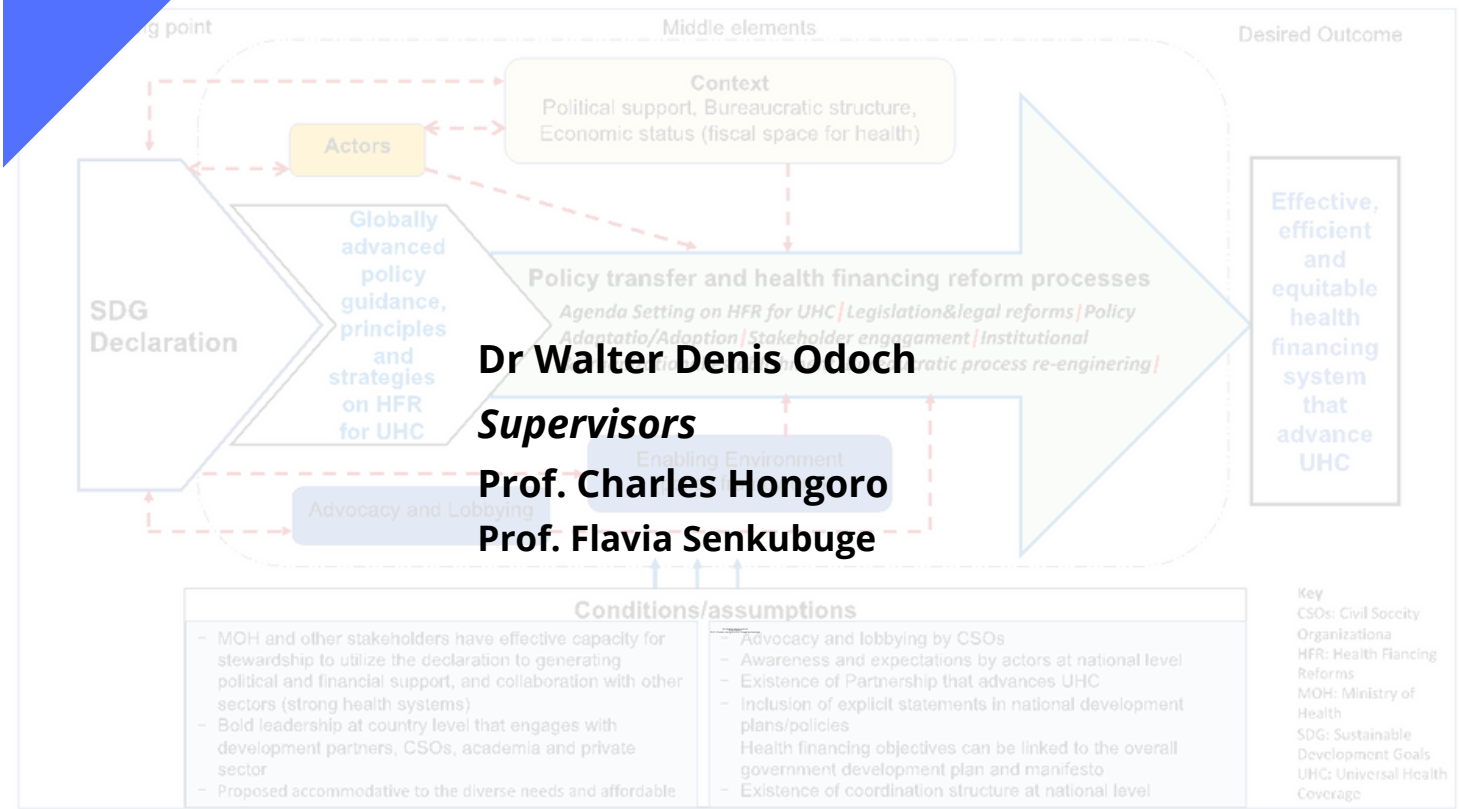
ASSESSMENT OF THE INFLUENCE OF SUSTAINABLE DEVELOPMENT GOALS DECLARATION ON HEALTH FINANCING REFORMS FOR UNIVERSAL HEALTH COVERAGE IN UGANDA

A stakeholders' perspective



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Faculty of Health Sciences

School of Health Systems & Public Health

Assessment of the influence of Sustainable Development Goals declaration on health financing reforms for universal health coverage in Uganda

A stakeholders' perspective

Thesis submitted in fulfilment of the requirements for the degree

PhD (Health Systems)

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DECLARATION

I declare that the thesis, which I hereby submit for the degree PhD (Health Systems) at the University of Pretoria, is my own work and has not previously been submitted by me for a degree at this or any other tertiary institution.

16 February 2023

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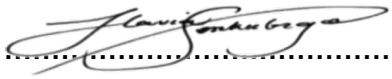

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Co-Supervisor's Signature **Date**

ETHICS STATEMENT

The author, whose name appears on the title page of this thesis, has obtained the required research ethics approval for the research described in this work.

The author declares that he has observed the ethical standards required in terms of the University of Pretoria's Code of ethics for researchers and the Policy guidelines for responsible research.

DEDICATION

This thesis is dedicated to the person who struggled the most through my academic journeys – My Mother, Silvia Akullo. Unfortunately, she will not be able to enjoy the celebrations having heeded to the Almighty's call earlier; before the completion of this last piece.

May She Rest in Peace

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This PhD journey was a mixed bag of exciting, depressing and emotional moments, the journey challenged me professionally and technically. However, I am heartened to have endured the journey and achieved this work amidst rivalling circumstances and pressures of life; from attending to my ailing mother, managing family and relationship complexities and balances, and keeping mid-life crisis in check to holding a full-time dynamic job located afar from my homes. Managing these complexities while undertaking this research could only be possible with the mighty hand of the ALMIGHTY.

Given my life experiences, I was keenly aware it is not only me who faces such circumstances and as such it was my intention not to take much of the time of my supervisors rather to efficiently absorb whatever guidance they would offer when they schedule time to support my thesis work. Therefore, the specific guidance they offered was efficiently utilized and facilitated the completion of this thesis. Thank you Prof. Charles Hongoro and Prof. Flavia Senkubuge for making this possible, your inputs were not in vain.

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THESIS ABSTRACT

Background

Achieving universal health coverage (UHC) requires health financing reforms (HFR) in many countries. Health Financing Reforms are inherently political. The sustainable development goals (SDG) declaration provides a global political commitment that can potentially influence HFR for UHC at national level. However, how the declaration has influenced HFR discourse at the national level and how ministries of health and other stakeholders are using the declaration to influence reforms towards UHC were yet to be explored. Therefore, this thesis explored how SDG declaration has influenced health financing reforms for UHC in Uganda and proposed a framework for examining such complex processes needing multidisciplinary lens of health systems financing, health policy analysis and policy transfers.

Aims and objectives

This thesis aimed at exploring the influence of the SDG declaration on health financing reforms in Uganda, and to develop a theory of change for desired health financing reforms for UHC.

The study objectives were: -

i. Exploring changes in health system financing towards UHC in Uganda between financial years 2000/2001 and 2019/2020.
ii. Examining how the SDG declaration has influenced health financing reforms for UHC in Uganda.
iii. Identifying factors that have facilitated or inhibited SDGs declaration in influencing health financing reforms for UHC in Uganda
iv. Developing a theory of change on how the SDG declaration influence health financing reforms for UHC.

Methods

This was an exploratory and explanatory qualitative study using a case study approach, with Uganda being the case. Detailed literature reviews were conducted and in doing literature reviews, document review guides were used for data collection. Key informant interviews (KIIs) with purposely selected respondents were also conducted to enrich the findings from the literature reviews and to refine the theory of change. Relevant theories, frameworks, and concepts especially Kutzin's health financing conceptual framework, Dolowitz and Marsh policy transfer theory and concepts from health policy analyses guided data collection and analysis.

Results

Uganda has had a variation in the focus of health financing policy objectives over the four strategic plan periods running between 2000/2001 and 2019/2020 financial years, from equity and mobilizing more funding to financial risk protection and UHC. The variation in policy intentions over the four strategic plan periods were informed by low level of national health sector funding, global level discussions on SDGs and UHC, and financing reform discourse focusing on establishing a National Health Insurance Fund (NHIF). However, policy objectives were not followed by the necessary structural changes in the organization of the health financing functions and thus the health financing organization architecture have not changed much over the years. Some reforms such as the abolition of user fees in public health facilities, development of National Minimum Health Care Package (NMHCP) as the benefits package, Sector Wide Approach (SWAp), movement towards performance-based financing were noticeable. The policy objective statements, and the reforms were generally aligned to World Health Organization (WHO) policy principles of reforms that advance UHC. However, given the limited structural changes in health system financing there have been very subtle progress in terms of improvement in financial risk protection. Furthermore, there have been limited studies on global to national policy transfers especially in the health sector and particular on health financing reforms. Majority of studies on health financing reforms in Uganda have focused on the technical aspects using rather rigid health financing conceptual frameworks for analysis that do not cover aspects of policy transfers.

On how the SDG declaration is influencing health financing reforms in Uganda, the declaration has raised and sustained the issue of health financing high on the national agenda and provided a framework for development of policies such as national UHC roadmap and health financing strategy 2016. The declaration has also energized the process of developing National Health Insurance Fund (NHIF), with a number of stakeholders who are not traditionally involved in health financing discussion showing interest. Civil Society and Professional Associations are using the SDG declaration as a tool for engagement with other stakeholders as they seek support for health financing reforms towards UHC with a focus on NHIF.

Factors favouring the SDG declaration to influence health financing reforms in Uganda include the high media attention and the reporting requirement on countries. These ensure there is continuous discussion on health financing in relation to SDGs. Having a specific indicator on UHC and therefore health financing in the declaration has also ensured the SDG declaration continues to influence the health financing discourse at the national level. Other factors include strong partnership between MOH and other stakeholders, and development partners' support. However, the push for reforms in health financing for UHC based on the SDG declaration is tempered by factors such as limited fiscal space for health as reforms require funding, lack of relevant recent evidence grounded in country data and complexity of the health financing issues which are not well understood by the general population and other key stakeholder groups.

Conclusion

The SDG declaration has influenced health financing reforms in Uganda with national policy intentions aligning with proven global policy principles. However, much needs to be done to go beyond aligning policy principles to proven global reform principles to ensuring there is commensurate changes in health financing system architecture and functions. Previous reforms can provide lessons for better adaptation of the global health financing reform principles that advance UHC. In addition, use of theory-driven frameworks such as the theory of change (TOC) can provide a more comprehensive set of information to support reform drivers to design appropriate strategies for engaging stakeholders for buy-in and development of context appropriate policies.

Keywords

Sustainable Development Goals, Health Financing Reforms, Uganda, Policy Transfer, Policy Analysis, Theory of Change

PUBLICATIONS AND OTHER DISSEMINATION PROCESSES

In line with the thesis' objectives, the following articles have been published or being prepared for publication:

1. **Odoch WD**, Hongoro C, Senkubuge F. A critical review of literature on health financing reforms in Uganda – progress, challenges and opportunities for achieving UHC. Afr Health Sci. *In press*
2. **Odoch, W.D**., Senkubuge, F., Masese, B.A. & Hongoro, C. How are global health policies transferred to sub-Saharan Africa countries? A systematic critical review of literature. Global Health 18, 25 (2022). https://doi.org/10.1186/s12992-022-00821-9
3. **Odoch, W.D**., Senkubuge, F. & Hongoro, C. How has sustainable development goals declaration influenced health financing reforms for universal health coverage at the country level? A scoping review of literature. Global Health 17, 50 (2021). https://doi.org/10.1186/s12992-021-00703-6
4. **Odoch, W.D**., Senkubuge, F. & Hongoro, C. How has sustainable development goals declaration influenced health financing reforms for UHC in Uganda: a stakeholders' perfective – *Submitted to HealthCare*
5. Application of theory-driven frameworks in analyses of health financing reforms for UHC in Low- and Middle-Income Countries - *manuscript in preparation*

Study findings have also been presented to relevant stakeholders at regional and international conferences:

- 8th East African Health and Scientific Conference & International Health Exhibition and Trade Fair Under main theme: East African Community Sustainable Development Goal on Health: Reflection and Path Ahead to 2030 and subtheme: Universal health coverage: Status of the Health Universal Coverage in East Africa: challenges and solutions to attain the SDG3:
    - *Abstract No.120: Critical review of literature on health financing reforms in Uganda – progress, challenges and opportunities for achieving UHC. Walter Dennis Odoch, Charles Hongoro, Flavia Senkubuge*
- 13th Best Practices Forum of East Central and Southern Africa Health Community (ECSA-HC)

- *Title: How is sustainable development goals declaration influencing health financing reforms for UHC in Uganda: a stakeholders' perfective.*

– Abstract accepted for Poster Presentation at the 7th Health Systems Symposium

Two abstracts qualified for poster presentation at the 7 Global Symposium on Health Systems Research (HSR 2022). Only one was presented (only one per author allowed)

- *Title: How are global health policies transferred to sub-Saharan Africa: critical systemic review of literature. ID: 251*

LIST OF ABBREVIATIONS AND ACRONYMS

AAI	Accelerating Access Initiative
CBHI	Community-Based Health Insurance
CSO	Civil Society Organization
DCE	Development, Capable and Ethical State
DFID	Department for International Development
DOH	Department of Health
DOTS	Directly Observed Therapy
EU	European Union
FY	Financial Year
GIZ	German Corporation for International Cooperation
GTZ	German Agency for Technical Cooperation
HDREC	Higher Degrees Research and Ethics Committee
HFR	Health Financing Reforms
HIV	Human Immunodeficiency Virus
HSSP	Health Sector Strategic Plan
iCCM	integrated Community Case Management of Childhood illnesses
ICFD	International Conference of Financing for Development
KII	Key Informant Interviews
LMIC	Low- and Middle-Income Countries
LPDR	Laos People Democratic Republic
MakSPH	Makerere University School of Public Health
MDGs	Millennium Development Goals
MOH	Ministry of Health
NGOs	Non-Governmental Organizations
NHIF	National Health Insurance Fund
NHIS	National Health Insurance Scheme

NMHCP	National Minimum Health Care Package
NORAD	Norwegian Agency for Development Cooperation
IUATLD	International Union Against TB and Lung Diseases
NPA	Non-Project Assistance-Based Aid
OOP	Out of Pocket
PBB	Program Based Budgeting
PEO	Population, Exposure and Outcome
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PFM	public financial management
PHC	Primary Health Care
PHI	Private Health Insurance
PNFP	Private-Not-For-Profit
PRISMA	Preferred reporting items for systematic review and meta-analysis
RBF	Results Based Financing
RBM	Roll Back Malaria
SAP	Structural Adjustment Program
SDGs	Sustainable Development Goals
SHSPH	School of Health Systems and Public Health
SIDA	Swedish International Development Cooperation
STI	Sexually Transmitted Infection
SWAp	sector wide approach
SUN	Scaling Up Nutrition
TB	Tuberculosis
THE	Total Health Expenditure
TOC	Theory of Change
UHC	Universal Health Coverage
UNAIDS	United Nations Programme on HIV/AIDS
UNGA	United Nations General Assembly
UNICEF	United Nations International Children's Emergency Fund

USAID	United States Agency for International Development
WHA	World Health Assembly
WHO	World Health Organization

DEFINITION OF TERMS

In the context of this study, we adopted the following definition or description for the key words used. These are: -

- *Advocacy*: Public support or recommendations made for a change to policies, practices or attitudes.
- *Health managers*: These are health sector leaders, bureaucrats and technocrats at national and sub-national level charged with managing and providing strategic direction to the health sector.
- *Health Advocates*: These are CSOs and health professional groups or associations.
- *Health financing reform*: Deliberate action to alter arrangements for mobilizing resources, paying for, allocating, organizing, and managing health resources towards an efficient and equitable health financing system.
- *Lobbying:* Strategic, formal and informal means of influencing specific decision makers on a specific issue.
- *Policy Transfer*: The occurrence of, and processes involved in, the development of programmes, policies, administrative arrangements, institutions and ideas in one political and/or social system based upon the ideas, institutions, programmes and policies emanating from other political and/or social systems
- *Stakeholder*: Individual who, or institution which can influence the process of health financing reforms for UHC in Uganda or is directly affected by such a process or have an interest in the outcome even when not directly involved. We reviewed the use of the term stakeholder, its synonyms and hyponyms and found in health policy and systems research and found inconsistencies in its use. In this study we have deliberately used the term as described above.
- *Universal Health Coverage:* Refers to a situation where all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship

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PART 1. GENERAL INTRODUCTION, SYNOPSIS OF LITERATURE, AIM AND METHODOLOGY

Overview

This part of the thesis has five chapters covering introduction to the thesis topic, a synopsis of preliminary literature that informed the conception of the thesis, aim and the methodology adopted.

CHAPTER 1 : INTRODUCTION

1.0 Chapter overview

This chapter introduces the topic of this thesis work. The research problem is defined and rationale for conducting the study is also elaborated in this chapter.

1.1 Background

Global declarations such as the Sustainable Development Goals (SDGs) are meant to shape public policy priorities and associated socio-economic development financing. Examples of global and regional declarations with anticipated effects on health or how health is financed and delivered include among others; - Health-for-All (the Alma Ata declaration in 1978), Abuja Declaration on Health Financing in 2001, the Millennium Development Goals (MDG) declaration in 2000 and more recently the SDGs

The 1978 Alma Ata Declaration of Health for all, energized global and national discourse in health care provision. Using Primary Health Care (PHC) as a vehicle to deliver Health for All, World Health Organization (WHO) member countries made progress on health, including on the level of funding for health, notwithstanding challenges in achieving the PHC goal. [1]

According to the WHO report titled, “Public Financing for Health in Africa: from Abuja to the SDGs”, most African countries increased their budget allocations to health over the past 15 years following the declaration. [2] The report indicates that the average level of per capita public spending on health rose from about US$70 in the early 2000s to more than US$160 in 2014. For the health sector, the MDGs declaration was instrumental in resource mobilization for some of the pertinent global health challenges, particularly maternal and child health, HIV/AIDS, TB and Malaria; providing evidence that global commitments and action work. [3]

In September 2015 in New York, the United Nations (UN) member states leaders, meeting under the theme, *“Transforming our world: the 2030 Agenda for Sustainable Development”,* adopted 17 SDGs as the post Millennium Development Goals (MDGs) development blueprint. The SDG declaration addresses the issue of health explicitly in paragraph 26 of the agenda:

> "To promote physical and mental health and well-being, and to extend life expectancy for all, we must achieve universal health coverage and access to quality health care. No one must be left behind"

Achieving universal health coverage (UHC) is one of the overarching targets of the 2030 agenda for sustainable development. Universal health coverage is based on the precept that all people should have access to the health services they need and do not suffer financial hardship while accessing the services. [4] Therefore, an effective, efficient and equitable health financing system is a critical and essential component contributory to the UHC targets under the SDG declaration, especially with SDG 3. [5-7] Health financing influences progress on the three UHC goals of equity in the use of health services, quality of care and financial protection through effects on UHC intermediary objectives as diagrammatically depicted in figure 1.1.[5,8]

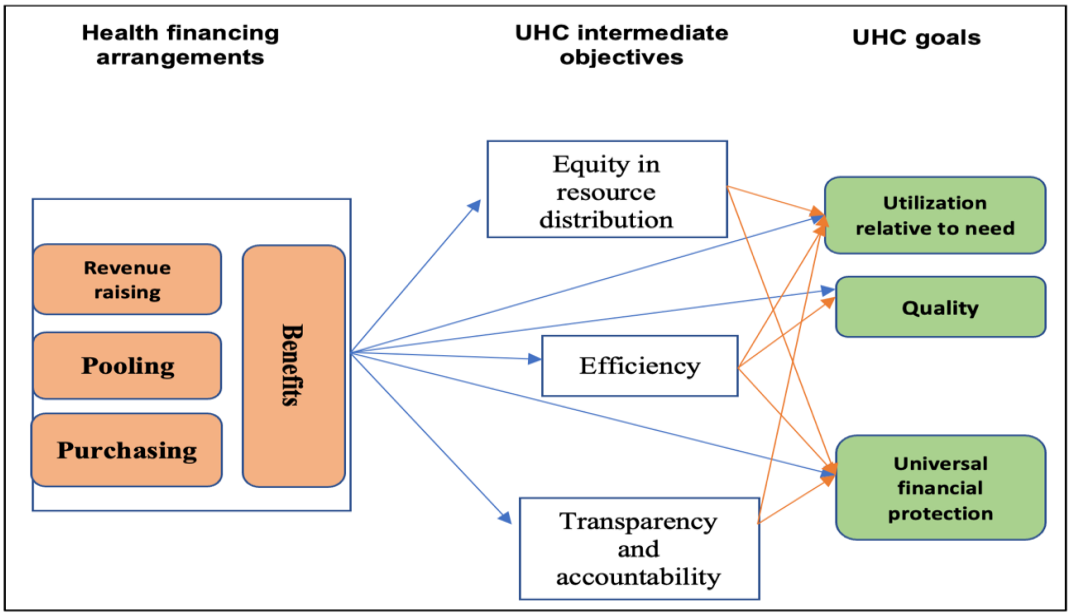

Figure 1.1 Goals and objectives of UHC that the health financing system influences

Achieving UHC require reforms in the health financing system among other undertakings. Such reforms need political will, commitment and support. The SDG declaration is one such political commitment at the global level where UHC is one of the 169 targets under

goal 3. The SDGs as a political declaration should therefore provide impetus for reforms in health financing systems, since effective, efficient and equitable health financing systems are critical in ensuring a move towards UHC. However, for such declarations to be useful, efforts are needed to transfer and translate such global agenda and policies into national level strategies, plans, and interventions. For the health sector, translation of the global agendas into plans and strategies is predominantly steered by bureaucrats and technocrats who are national and sub-national level health managers, with support of other stakeholders including Civil Society Organizations (CSOs)/health advocates and health development partners.

1.2 Problem Statement

Cognizant of the weak health financing systems, many African countries including Uganda, through Ministries of Health, have been attempting to reform their health financing towards UHC. [9-11] However, attempts in Uganda in reforming health system financing including introducing a national health insurance scheme (NHIS) has been slow as reflected in national level discussions and Ministry of Health reports. [12-16] For example, the process of introducing a NHIS has been ongoing since early 2000's and by the end of 2021, the process was yet to be completed; the parliament passed a Bill, however the President did not ascent to the Bill. It has since been returned to the Ministry of Health for further stakeholders' engagement and refinement.

The terrain where various efforts toward strengthening or reforming the health financing system interplay occurs may likely be different with the SDG declaration. This is because UHC has been explicitly made one of the 169 targets of the SDG declaration and health system financing is critical for a move toward UHC. As noted in the preliminary review of literature (Chapter 2), the are no comprehensive documentation of the effect of regional and global declaration on health financing systems especially in low- and middle-income countries, including in Uganda. Literature reviewed mostly reports on observed improvement in specific aspects of health financing like increased total funds for the health sector-usually as result of external funding following global declaration, and no information on the adoption/adaption process and system-wide effects of global policy agenda at national level in health financing field.

There has been no study examining how the SDG declaration has influenced or is influencing health financing reforms for UHC in Uganda. Given the slow pace of the health financing reforms for UHC prior to the declaration, it is prudent to examine whether and how the SDG declaration is influencing or has influenced this process and whether the changes from the influence aligns with recommended health financing reform principles for UHC. Moreover, this will add insight into how desired health financing reforms for UHC at the national level can be influenced through relevant international and regional declarations. Specifically, the information from the study is important to stakeholders (health managers and advocates) driving the reforms. This is because the information can be used by the stakeholders to better strategize for reforms taking advantage of the country's commitments to regional and global political declarations.

1.3 Rationale

The perspective of stakeholders and the underlying factors informing these views provide understanding on how the SDG declaration and by inference other related global agendas can influence financing reforms for UHC. Generally, literature on policy making, and implementation acknowledges that stakeholders' perspectives and preferences play a major role in policymaking and implementation processes.[17] Disagreements in stakeholders' views for example can provide explanations on why certain policy propositions are not implemented despite broad global consensus on their coherence.[18] Therefore, synthesized and contextualized information from participants at national level was to provide the missing elements between a global declaration in this case the SDGs and health financing reforms for UHC and propose a framework for systematic analysis that can be used by public health practitioners and researchers for policy/program design, evaluation or research for complex processes such as the translation of global declarations to desired national level outcomes.

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CHAPTER 2 : LITERATURE REVIEW

2.0 Chapter Overview

This study sought to explore the influence of the SDG declaration on health financing reforms (HFR) for UHC and propose a framework for analysis of health financing in the context of global processes. This chapter provides highlights of the initial and preliminary readings undertaken to shape the thesis topic. It thus provides a snapshot of the likely effects of regional and international declarations on health systems financing. Frameworks and theories used for assessing or analyzing HFR are also explored to provide context. In addition, this section provides examples of empirical application of health system financing theoretical frameworks, gaps in literature and justification for this thesis work.

2.1 The influence of global and regional declarations on health financing

Conventions, treaties, declarations or commitments agreed upon internationally are instruments meant to create consensus on how to mitigate or address social and political development agenda and/or challenges.[1] Over the years, there have been a number of international agreements and declarations with effects on how health systems function, including their financing at the national level. Examples include the SDGs, MDGs, Abuja declaration, and consensus from International Conferences on Financing for Development among others. These global and regional policy agendas are transferred to the national level by agents situated at international and national levels.

2.1.1 Sustainable development goals

Hege and Demailly[2], reports that in Germany and France, the SDG declaration is being used as a window of opportunity to influence national political strategies and holding the government to account for its promises. This is being done through following and participating in policy processes at the national level relating to the SDGs. In addition, they report that NGOs see the value addition of the SDG declaration as firstly, allowing NGOs to speak with a united voice; to establish common positions and secondly, as an advocacy tool that strengthens and legitimizes their argument.

Fryatt and Bhuwanee[3] contend that with the SDG declaration, the case for investing in health systems is stronger and more acceptable. They add that, Ministries of Health[3] can use the commitment and existing data to negotiate for additional resources by demonstrating that increased health spending will improve life expectancy and cause financial empowerment of households. However, they also argue that this requires the right policies and allocation systems and effective leadership with a long-term vision, both at national and sub-national levels.[3] The paper reports on the likelihood of good outcomes from the SDG declaration in terms of health financing if utilized by the stakeholder (MOH) to negotiate or lobby for additional funding.

A document by WHO and other partners[4]; "Towards a global action plan for healthy lives and well-being for all: Uniting to accelerate progress towards the health-related SDGs", indicates that the SDG declaration has reinforced health as a political priority. It notes that world leaders have set an ambitious agenda with UHC cutting across all health targets which also contributes to achievement of other targets in non-health SDGs such as on economic productivity and social stability. The paper notes that health related SDGs will require bold leadership at country level that engages with development partners, CSOs, academia and the private sector.[4] The report points out that one of the most effective ways to reach the health-related targets is to improve generation, allocation, and use of funds for health[4]; these are health financing functions.

Chu et al[5], reports that countries in the western pacific region are introducing health financing policies that advance UHC, which is serving as a foundation for achievement of health-related SDGs. They contend that moving towards UHC requires strong health systems that are well governed and sustainably financed.[5]

2.1.2 Abuja Declaration on Health Financing

The Abuja Declaration on health financing was an important call on governments in Africa to orient their health financing reforms to mobilize more monies for health. The WHO report, "Public Financing for Health in Africa: from Abuja to the SDGs" indicates that the share of public resources allocated to health has increased over time in many African countries.[6] In Sierra Leone, civil society organizations (CSOs) basing on the Abuja declaration, advocated for the government to honour its commitment. Awareness and

expectations created about key health financing issues espoused in the Abuja declaration amongst CSOs contributed to effective advocacy that resulted into a positive effect on the health system in Sierra Leone.[7] Similar effects from CSOs engaging governments to fulfil its commitment to the Abuja declaration have been observed in other countries such as Malawi. The CSOs advocacy in Malawi for example led to explicit statements and inclusion of strategies to mobilize resources in advancement of the Abuja Declaration and other commitments by the Malawi government.[1]

2.1.3 Millennium development goals

Millennium development goals (MDGs) is reported to have brought about a new understanding to development and new approaches that have shaped partnerships around achievement of global political commitments at all levels; national and international.[8] The MDGs led to a significant increase in development financing, especially for health. For example, Development Assistance for Health (DAH), tripled between 2000 and 2013 and there were strong growths in domestic funding for health during that period.[9]

2.1.4 Consensus from International Conferences on Financing for Development (ICFD)

The ICFD (Monterrey and Addis Ababa) called for increased mobilization of domestic resources to achieve sustainable development targets. The agreement from these conferences is reported to have led to increase in development financial flows and domestic financing of social services[10]. It is likely the ICFD agreements have increased fiscal space for health in some countries.

2.1.4 Alma Ata Declaration on PHC

In the Alma Ata Declaration, Primary Health Care (PHC) defined as essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self- determination was adopted as the vehicle for delivering health care for all by the year 2000.

The Alma Ata declaration has had major influence on how health services are financed and delivered especially in low-income and middle-income countries (LMIC). Much of the

new ways of financing the Declaration were tested in LMIC. However, there is limited data exploring the effect of the Declaration on health financing.

2.2 Health financing reforms: description, frameworks and theories

2.2.1 Brief description of health financing reforms

Health system financing is the process by which revenue is collected from various sources, accumulated in fund pools and allocated for specific interventions provided by various health providers.[11] Health financing reforms for UHC refers to rearrangements in revenue raising, pooling of funds and risks, benefit design and purchasing that aims at improving one or several objectives and goals, as measured at the population or system level.[3] Although there is consensus on the importance of health financing reforms for UHC globally, this has not made the reform process any easier to implement at the national level as yet.[12-13]

Fan and Savedoff[14] argue that, due to ethical implications of health financing reforms, there are usually negotiations involving many stakeholders; both technical and political. This, they add, is because the anticipated changes are likely to affect a range of stakeholders and institutional processes that have varying degrees of interests, power, and influence. Health financing reforms are also influenced by demographic, epidemiological, socioeconomic, cultural, and historical considerations. [14-16]

2.2.2 Frameworks for assessing health financing reforms

In general terms, frameworks provide a structured way for data collection and analysis. In health financing, conceptual and descriptive frameworks provide the basis for the development of hypotheses on causal links amongst the various elements and outcomes of a health financing system. In the early and late 1990's, the approach adopted by health financing analysts were generally descriptive, with a focus on the effects of reforms on one or a combination of the following outcomes: - sustainability, equity, access, effectiveness, efficiency, quality, and roles of public and private sector.[17-21] The analyses focused on revenue raising approaches, resource re-allocation, and alternative organizations. After the 2000's more refined frameworks were developed or proposed.

The commonly used frameworks for analyzing health financing development or reforms include: -

Kutzin frameworks

Between 2001 and 2008, Kutzin proposed descriptive and conceptual frameworks based largely on the health system functions described in the world health report 2000.[22-24] The 2001 Kutzin's[22] conceptual framework for describing health financing organization is as depicted in the figure 2.1

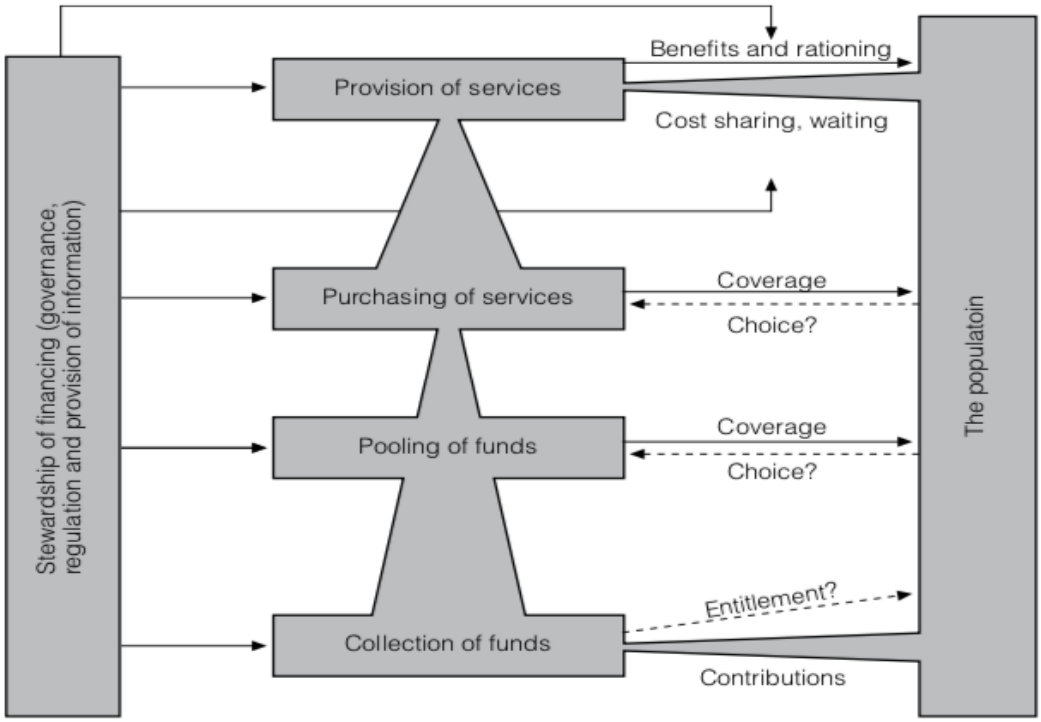

Figure 2.1 Conceptual framework for understanding the organization of health financing systems

This framework describes the elements or functions of the financing system i.e., collection of funds, pooling of funds and purchasing of services. It makes explicit how financing functions interact and how they relate to the population and to the health system functions of service provision and stewardship for financing. This approach, as opposed to the 1990's, facilitates emphasis on the interactions between different parts of the system rather than a narrow focus on a particular reform instrument or outcome.

In 2008, Kutzin[25] related the health financing role to the overall health system functioning, firstly by distinguishing three pillars for consideration in the development of the health financing system and secondly by illustrating the connection between health financing functions, other health systems functions, policy objectives and overall health system goals.

The three pillars diagrammatically depicted in figure 2.2 are: -

- Set of policy objectives which provide the direction in which reforms push the system
- Functions and policies of health financing, and
- Contextual factors

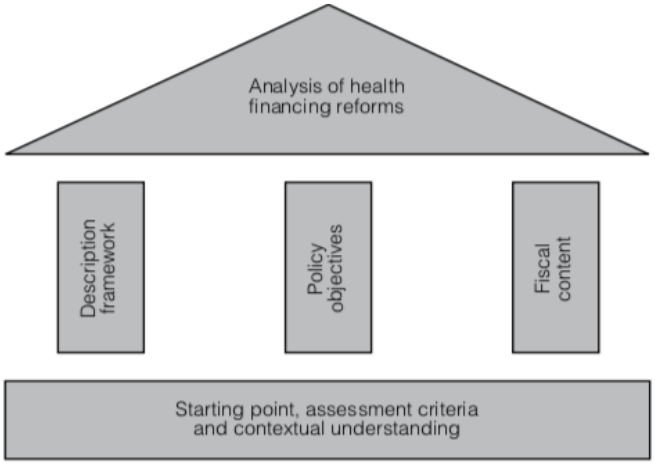

Figure 2.2 Three pillars for analyzing health financing policy

The Kutzin's[25] illustration of how health financing functions relate to policy objectives, other system functions and overall health system goals is elaborated in the descriptive framework in figure 2.3.

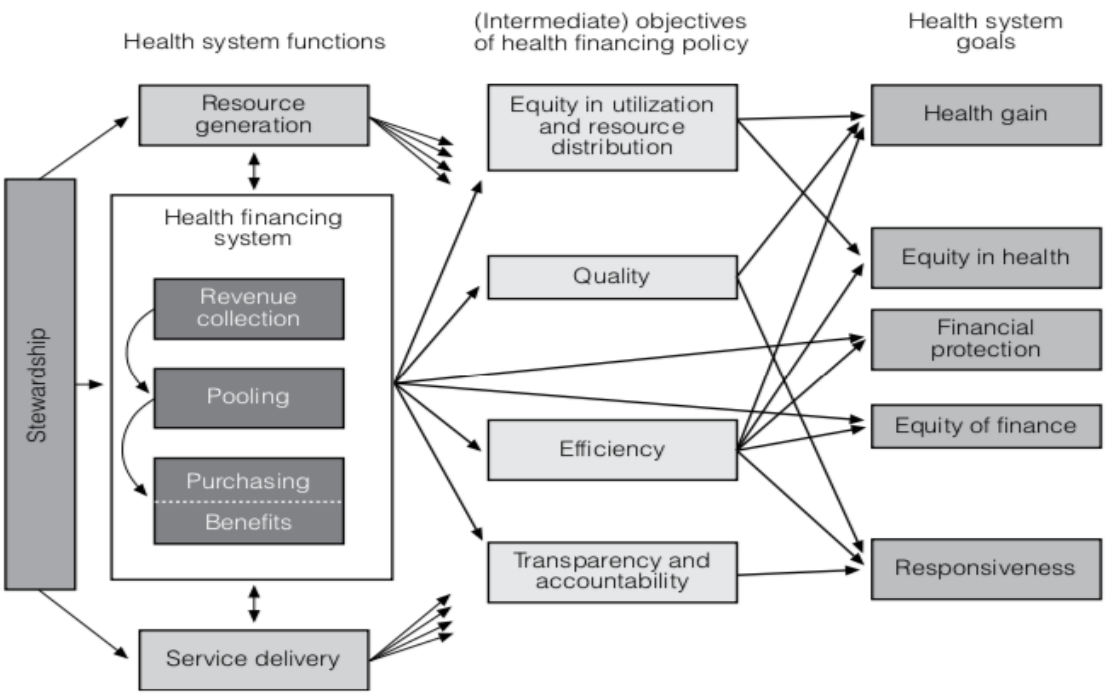

Figure 2.3 Links between health financing system and policy objectives, other system functions and overall system goals

The Hsiao Framework

The Hsiao's framework[26] takes a similar approach and structure to that of Kutzin. Like Kutzin, Hsiao's framework identifies the links between health system functions particularly financing functions and system outcomes. However, in Hsiao's framework, health financing functions are described in terms of causal links, rather than through funds flow.

The Hsiao conceptual framework (figure 2.4) models the role of health financing within the systemic aspects of the health system[26-27]. The three components of the framework are: -

- Final goals: health status, financial risk protection and consumer satisfaction.
- Intermediate outcomes: access, quality and efficiency of service delivery.
- Means: financing, organizational structure, payment mechanisms, regulation and persuasion (information provision).

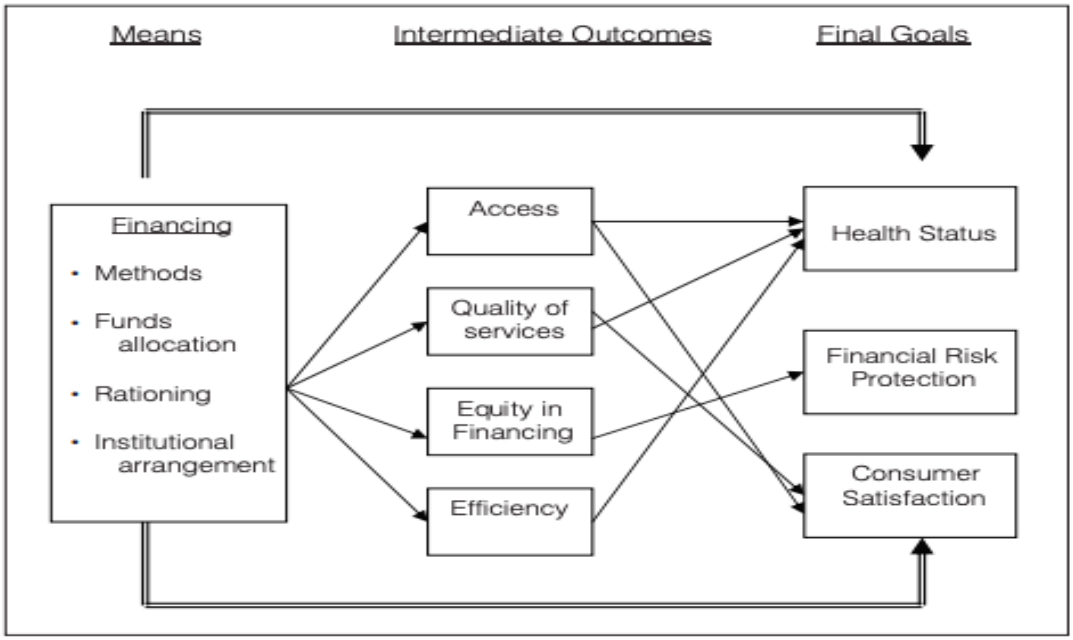

Figure 2.4 Relationships between Financing Instruments and Goals

Mossialos and Thomson Framework

The Mossialos and Thomson[28] framework identifies determinants of health financing (see figure 2.5). These determinants are important in analyzing health financing reforms. However, this framework focuses primarily on the capacity for revenue raising and accumulation. The framework does not elaborate on how other health financing system elements relate to broader health system goals.

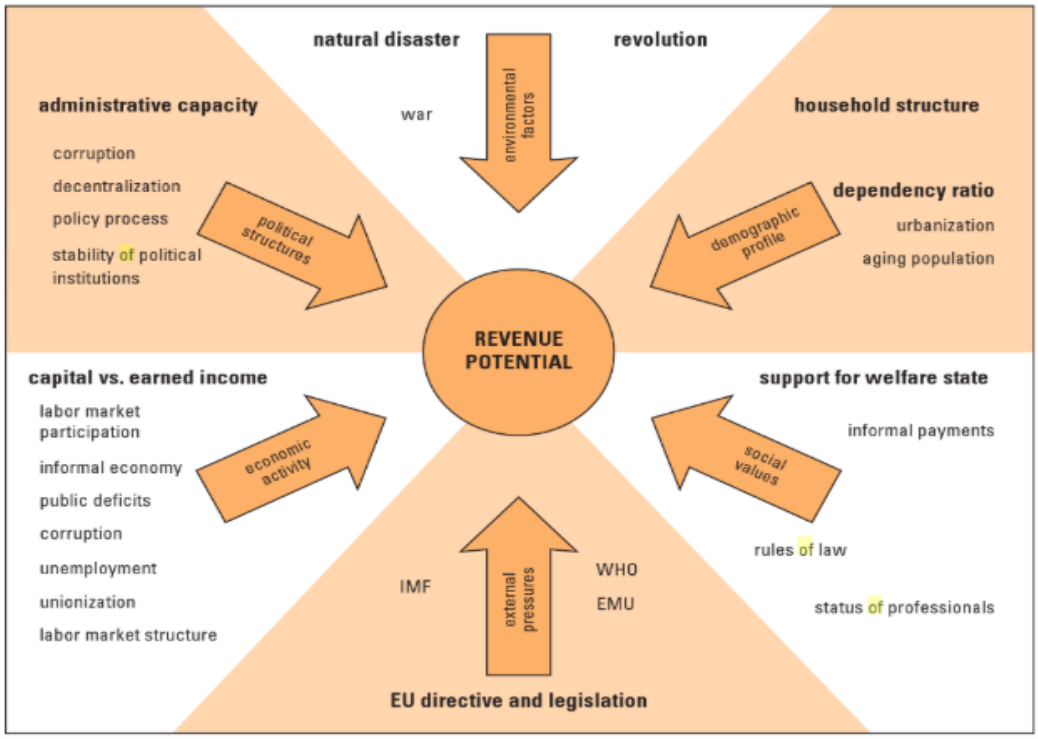

Figure 2.5 Mossialos and Thomson Framework for health revenue potential

2.2.3 Gaps in utilizing only health financing frameworks in exploring how global declarations influence financing reforms for UHC

Kutzin's frameworks provide a starting point for analyzing effects of health financing reforms. It highlights the intersection of health financing functions with the systems' policies, and the context, specifically the fiscal capacity. The system elements are described structurally and are presented as following the flow of funds making it easy to describe and explain alignment or fragmentation amongst different elements.[29] Therefore, it can be used for a coherent analysis of the reform package. However, health systems are complex and fluid, for example the salient values or value systems that affect reforms or the process of policy development are unlikely to be captured using Kutzin's frameworks.

Hsiao's framework gives greater recognition of multiple, potentially competing, objectives, portraying the need to balance the impact of different objectives in health financing policy making. However, contextual factors, a critical element in health financing reforms are given less attention. In addition, health financing policy development process are difficult to capture using this framework.

Mossialos and Thomson framework attempts to address some of the drawbacks in Kutzin's and Hsiao's frameworks by identifying determinants of health financing which are important in the analysis of the health financing system of health financing policy reforms. However, it focuses mainly on revenue collection and accumulation leaving out other important elements of health system financing such as purchasing and design of benefit packages and the relation to health system goals.

More importantly, health financing frameworks highlighted above lack a component that takes into account global to national policy transfer processes in the health financing field. In addition, these frameworks above do not address intrinsic political issue and deep-seated political economy of health financing policy processes that interested stakeholders need to understand, negotiate or navigate. Therefore, frameworks described above are good tools largely for gathering and analyzing technical information for understanding a health financing system, particularity in terms of its policy objectives, organization and functioning. They are less useful in guiding analysis of the reform process, especially the interaction amongst actors and influence variables such as power, values, interest and ideologies, and other contextual factors such as institutional, demographic, socioeconomic, environmental, external and political factors and policy transfer mechanisms that are part and partial of health financing reforms. Therefore, social and political economy theories and models to facilitate deeper reflection on the process have been used. Examples of political economy theories that have been used in assessing HFR are highlighted in the following section.

2.2.4 Socio-political economic theories for analyzing health financing reforms

Campos and Reich political economy analysis framework

From the political economy paradigm, Campos and Reich,[30] recently proposed a framework that has six major categories of stakeholder groups in the health policy reform process. Therefore, the reform process will involve managing politics of each group depending on their power, interest and position, i.e., interest group politics, bureaucratic group politics, budget group politics, leadership group politics, beneficiary group politics, and external actors' politics. The empirical application of this framework is found in the work of Sparkes and colleagues in the political economy analysis of the health financing reform process in Turkey and Mexico.[31-33] This approach focuses on the role and position of actors, power dynamics and their relationship, and institutional context.

Kingdon's multiple stream theory

The multiple stream theory[34] presupposes that there must be a convergence of three streams, creating a window of opportunity for an issue to form a policy agenda. The streams are problem stream - a problem is defined and brought to the political agenda in a way that would require action or policy solution; policy stream - feasible and sustainable policy options proposed by actors; and the political stream - political agreement to the problem and proposed policies.

Kingdon's theory looks at policy as an output and a process of decision-making, however, the scope of the theory is largely limited to the policy context. [35] Empirical applications of Kingdon's theory in health financing reforms are many, examples include Moradi-Lakeh and Vosoogh-Moghaddam analysis of Iran health sector evolution[36], Pillay and Skordis-Worrall on health financing reform in South Africa[37] and a study on setting performance-based financing in the health sector agenda in Cameroon[38], among others.

Walt and Gilson Policy Triangle framework

The policy triangle framework is based on the political economy perspective, and considers how the four elements; actors, context, process and content interact to shape policy making[39]. The framework has influenced health policy research in many settings and has been used to analyze a number of issues including health financing[21,40-41].

However, the framework is critiqued for not being explanatory enough because it often leads to analyses which are mainly descriptive and do not provide insight into the drivers of the policy process in details, i.e., it pays less attention to other factors that explain why and how policies change.[42-43] In addition, it lacks lens of examining the policy transfers mechanisms, apart from mention of the actors that some of whom may be external.

2.3 Conclusion

From the above initial literature review, three key issues emerged. Firstly, key stakeholders at national level can potentially use international declarations to advocate for or negotiate for policy change. Secondly, literature reviewed mostly reports on observed improvement in specific aspects of health financing like increased total funds for the health sector, and no information on the adoption/adaption process (policy transfer process) of global policy agenda at national level in the health financing context. Information on the process component of advocacy, strategy development and enabling or constraining factors to effective health financing systems resulting from the global declarations were limited.

Thirdly, although existing frameworks and theories can be used for technical analysis of reforms, they are individually inadequate for identifying elements and salient values in the interval of global declaration and desired outcome at the national level. A more appropriate tool for comprehensive analysis or evaluation of the reforms or design for a programme or policy to achieve the desired outcome informed by a global declaration would be a combination of the above frameworks and theories or theory-driven frameworks such as Theories of Change (TOC) [44-45].

Theory driven frameworks are flexible formats and can be used to demonstrate more explicitly the causal pathways through which the declarations and broad interventions lead to the desired impact (equitable, effective and efficient health financing for UHC).[46-47] Theory driven framework have been applied in field of programme evaluation and programme development and have been discussed for many years.[48-50] However, none of the literature reviewed reporting on the effects of a global declaration on health financing indicated use of theory-driven frameworks for evaluation, assessment or design of a health financing policy.

Socio-political and economic theories provide for the long-term outcome and preconditions. However, they are usually devoid of illustration of intermediate outcomes needed to achieve the outcomes, activities needed to move from one outcome to the next and the assumptions that must hold true for each of the intermediate outcomes.[51] Therefore, theory driven frameworks are more flexible thinking tool than logical framework and socioeconomic theoretical approaches that should be used for exploring complex public health issues such as health financing reforms process involving global to national policy transfers, within the context of international declaration.

2.4 Knowledge gap and Justification of the study

Presently, there is limited information on how the SDGs, a global declaration, is influencing health financing reforms for UHC. Literature assessing health financing reforms have focused on policy and stakeholder analyses with emphasis on actors' power and interest or position. And recent political economy analyses of health financing reforms have adopted or adapted the six stakeholders' politics dimensions (interest, bureaucrat, budget, leadership, external and beneficiary groups' politics)[31-33]. Other analysts have used Kingdon's multiple stream theory in analyzing the reform processes.[36-38] **However, these literatures have focused on outcome of reforms with limited information on the processes**. There was also limited literature examining the policy transfer processes of global agendas to national level, yet examination of the transfer of global policies such as those meant to achieve the SDG targets are especially important for countries such as Uganda as they seek to adopt/adapt these principles during national policy reform processes. For example, such information when generated provides a basis on which health managers and advocates can better utilize the SDG declaration as a rallying point to hasten health financing reforms for UHC.

In addition, initiatives to achieve SDGs including targets on UHC requiring health financing reforms are inherently a complex process with multiple interacting components operating at multiple levels. This makes it difficult to only use existing descriptive and conceptual frameworks or theories described above, to design or evaluate such policies and programs. Understanding or designing complex processes require application of theory-driven frameworks. However, theory driven frameworks have not been used in health

financing reforms even though it's usually a complex process. Therefore, this thesis systematically identified the enablers and inhibitors of the use of the SDG declaration to measurably impact on health financing reforms from literature and the viewpoints of national level stakeholders, thus providing information on the 'missing middle elements' between the global declaration and the desired outcome. In this case the 'process elements' between the SDG declaration and equitable, effective and efficient health financing system for UHC towards development of a theory of change.

2.5 Study conceptual and analytical frameworks

This study aimed firstly, to appraise the influence of the SDG declaration on health financing reforms in Uganda, from the perspective of stakeholders that are primarily involved in this process and from literature. Secondly, based on the information and through an iterative process of engaging stakeholders, develop a theory of change that can be used to systematically explore process that leads to effective health financing system that advance UHC with the SDG declaration being the starting point (Figure 2.6). Given the challenges of each framework and theory discussed in the literature review section, especially in terms of providing a comprehensive picture, this study's conceptual framework combined policy triangle concepts[39], with Campos and Reich group politics[30] and Kutzin's descriptive health financing system frameworks.[23]

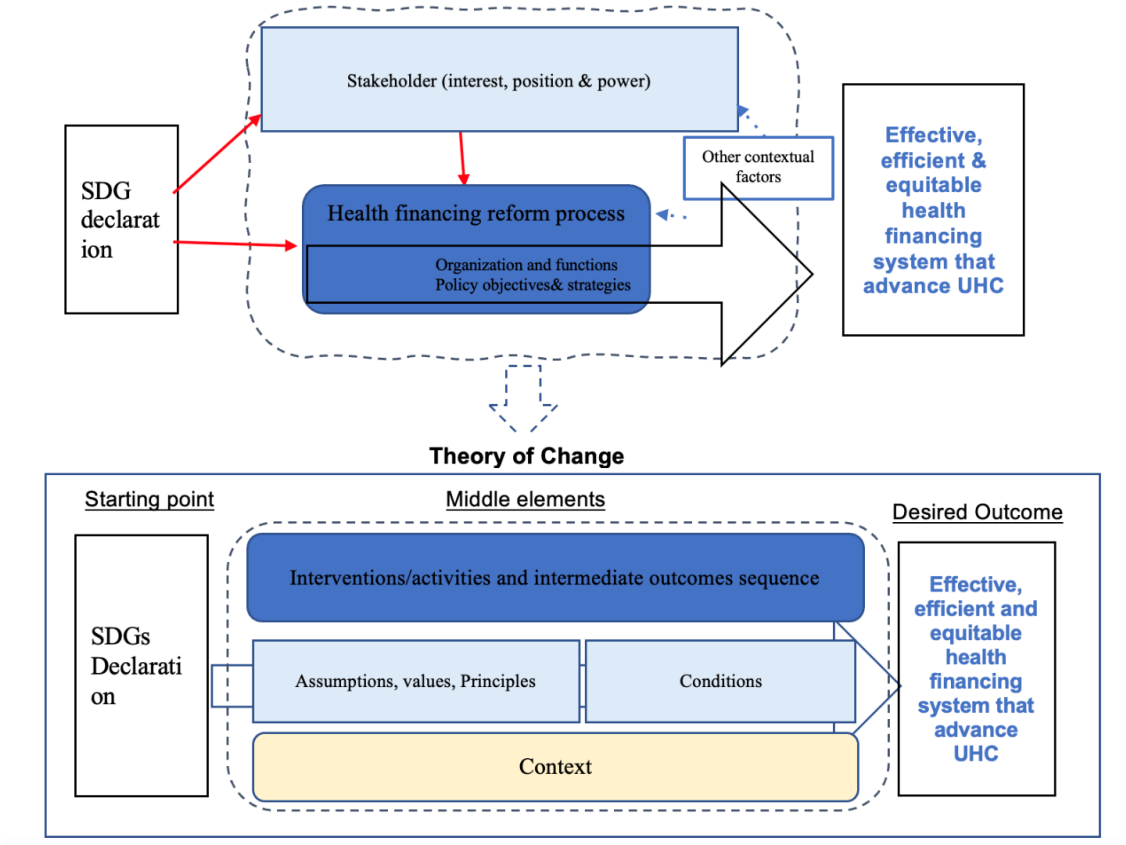

Figure 2.6 Study's conceptual framework

The policy triangle looks at actors, context, content and process. For this study, the *process* and *content* components are depicted as a *health financing reform process.* Nested within this process, the changes in health financing over the years were unpacked using Kutzin's descriptive framework[23] with a focus on changes in the organization of financing functions and policy objectives over the years, between 2000 and 2020, segmented based on the Ministry of Health strategic plan periods. In addition, the global to national level policy transfer mechanisms were examined to shed light on how international policy principles for reforms that advance UHC are adopted at the national level.

The major contextual factor being explored in this study is the SDG declaration; how it has influenced the actors and processes in relation to health financing reforms for UHC. The SDG declaration came into effect in 2016, however there were likely other contextual

factors at play that were perhaps already influencing health financing reforms in Uganda. Critical to note though, is that the reform process, especially the development of the national health insurance has been slow. In this study, these contextual factors were identified and explored as well. Therefore, in the study's conceptual framework, the SDG declaration is depicted separately from the "other contextual factors". It is also likely that the SDG declaration as a contextual factor may have had effects on other contextual factors such as political posturing or ideology of the political party in government.

The information generated through literature review and stakeholders on the health financing reform process and how SDGs have influenced health financing reforms for UHC have informed a theory of change developed in this study. The development process for the theory of change is described in Chapter 8.

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CHAPTER 3 : AIMS AND OBJECTIVES

3.0 Chapter overview

This chapter presents the aim, objectives of this thesis and the research questions.

3.1 Aim

This study aimed to firstly explore the influence of SDG declaration on health financing reforms in Uganda, and secondly develop a theory of change for desired health financing reforms for UHC.

3.2 Study objectives

The study objectives were to: -

i. Explore changes in health system financing toward UHC in Uganda between years 2000 and 2020.
ii. Examine how SDG declaration has influenced health financing reforms for UHC in Uganda.
iii. Identify factors that have facilitated or inhibited SDG declaration in influencing health financing reforms for UHC in Uganda
iv. Develop a theory of change on how SDG declaration influence health financing reforms for UHC in LMIC.

3.3 Study questions

Therefore, in line with the study objectives the broad research questions were: -

- How have policy objectives, organization/structure and performance of the health financing system changed overtime?
- Are the health financing system changes in line with UHC principles?
- What have been the major drivers or factors for these changes?
- Is the SDG declaration influencing or has influenced health financing reforms for UHC? And how?

- Which factors have facilitated or inhibited SDG declaration in influencing health financing reforms for UHC?
- What are key issues or elements, assumptions, conditions and how are they linked (or should they be linked) or sequenced in order to ensure the SDG declaration is utilized effectively to drive health financing reforms for UHC.

CHAPTER 4 : METHODOLOGY

4.0 Chapter overview

This chapter summarizes the overall methodological approach for this thesis. The specific methodology for each of the study objectives are presented in Chapter 5 to Chapter 8.

4.1 Study setting

The study was conducted in Uganda at the national level. The Central Government through the Ministry of Health including specialized agencies and institutions oversee formulation and monitoring of national policies, strategies, guidelines and standards; policy dialogue with health development partners (HDPs); resource mobilization and budgeting. Directly under the Ministry of Health is the provision of tertiary healthcare by the regional and national referral hospitals. The delivery of primary and secondary healthcare services is devolved to district local governments.[1]

The organization of Uganda's health system mirrors the administrative and political organization at all levels. Figure 3.1 below illustrates how governance and partnerships are structured at the national level.

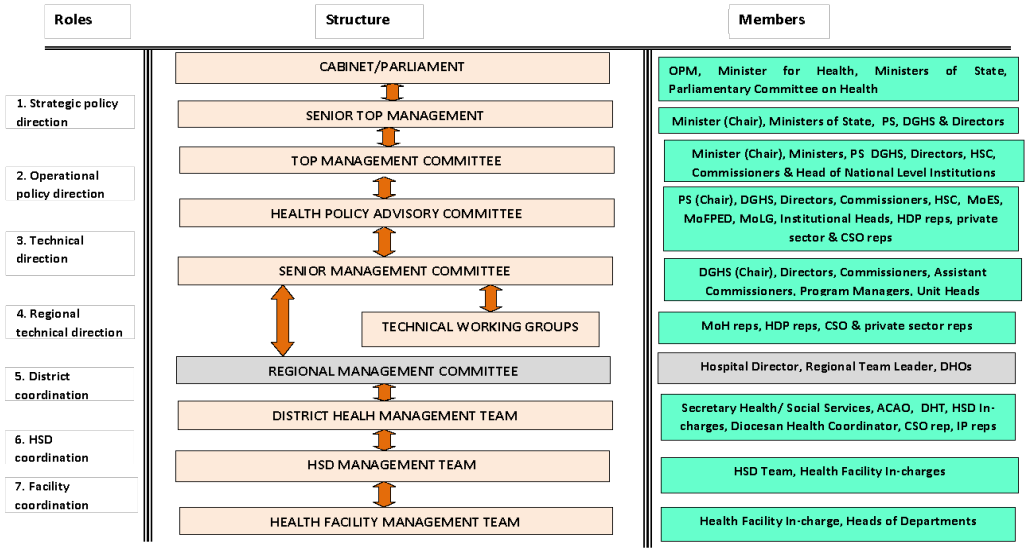

Figure 4.1 Health sector governance and partnerships structure in Uganda

Figure 3.2 illustrates organization of management at the Ministry of Health headquarters.

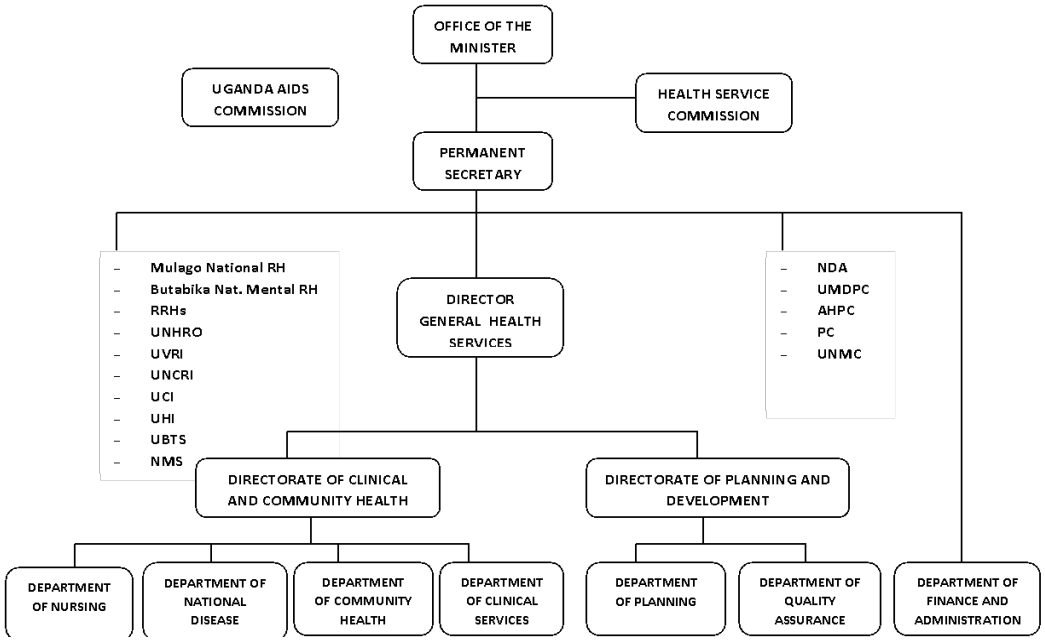

Figure 4.2 Organization of the management at the Ministry of Health headquarters

Key: RRHs-Regional Referral Hospitals, UNHRO-Uganda National Health Research Organization, UVRI-Uganda Virus Research Institute, UNCRI-Uganda National Chemotherapeutic and Research Institute, UCI-Uganda Cancer Institute, UHI-Uganda Heart Institute, UBTS-Uganda Blood Transfusion Services, NMS-National Medical Stores, NDA-National Drug Authority, UMDPC-Uganda Medical and Dental Practitioners

4.2 Study Design

This was an exploratory and explanatory qualitative study using a case study approach as described by Yin and others.[2-4] Uganda was the case in this study. A case study approach supports generation of an in-depth, multi-faceted understanding of a complex issue in its real-life context.[4] This approach was appropriate for this study, as it sought to understand how the SDG declaration is influencing health financing reforms for UHC based on lived experience of the study participants[5], in this complex process of translating global declaration into national action.

Data collection methods included key informant interviews (KIIs) with purposively selected respondents and documentary review. Key informant interview is recommended for case studies. This is because it adopts a broad, open-ended questions approach, which focuses on describing the process of change, including the wider socio-political perspective in which policy changes occur.[6] The qualitative method is the best approach for exploring the influence and identifying the factors that have facilitated or inhibited the use of the SDG declaration to influence health financing reforms for UHC, from the perspective of stakeholders. This is because the qualitative research method in which key informants involved in the policy process change are identified and interviewed yields rich findings incorporating an understanding on the interaction of various players in the system.[6-7] Key issues emerging from study objectives (i), (ii) & (iii) supported the development of a theory driven framework; the theory of change for the desired outcome in health financing reforms as a result of the SDG declaration (objective iv). Objective (i) was design to explore reforms in health financing even before the SDG declaration, the reason for this was two-folds. Firstly, to provide a general contextual background to health financing system in Uganda, and secondly to make it easy to isolate potential effect of the declaration on health financing reforms in comparison to other contextual factors that have been at play, even before the SDG declaration.

4.3 Data Sources, Collection and Analysis

4.3.1 Data sources

The detail of the sources of data are reported in Chapter 5 to Chapter 8. Generally, the data sources were documents and respondents (study participants).

Documents

The documents for review as sources of data included grey (unpublished) and published literature relevant for answering the study objectives. The literature included Government of Uganda health policies and strategies, plans and/or roadmaps, health sector performance reports, meeting reports, health insurance scheme Bill/Act; World Bank and WHO documents on financing for UHC, and selected databases and journals as described under method sub – sections in Chapters 5 to 8.

Study participants

For this study, 22 purposively sampled participants from a wide array of key stakeholder groups most active in health financing in Uganda participated as respondents. Views from all key stakeholder segments[8] (leadership, bureaucratic, interests, external (development partners) and budget groups) usually involved in health financing reforms were considered. For details see Chapter 8.

The Ministry of Health officials selected were those concerned with driving the health financing reforms for UHC. While CSOs were those that were particularly involved in health sector budgeting and financing advocacy activities. Representatives from health development partners were those that are involved with supporting health system financing in Uganda. The Ministry of Finance was represented by an official who is the focal person for the health sector. Leaders of health professional associations were selected purposively targeting those who were conversant with issues around health financing.

The sample size for study participants in qualitative studies remains an area of contestation. One approach referenced in literature is the concept of data saturation. It entails bringing new participants continually into the study until the data set is complete, as indicated by data replication or redundancy.[9-10] However, in as much as data saturation is an excellent and standard concept that may be applied in qualitative research, there are no published guidelines or tests of adequacy for estimating the sample size required to reach saturation.[11] Guest et al[12], after reviewing 24 research methods books and 7 databases, noted that not much progress has been made regarding use of the saturation concept in justifying the qualitative sample size prior to conducting a study.

Marshall *et al*[13], recommends 3 ways of justifying sample sizes in qualitative studies. These are: - recommendations by qualitative methodologists, precedent set by similar studies where the objectives were met, and lastly internal justification. The later method involves statistical demonstration of saturation within a dataset during the parallel conduct and analysis using tests such as the Cronbach's alpha test.[14] In terms of qualitative methodologists' recommendations, the number suggested as sufficient for saturation

varied widely. For example, Creswell[15] recommended 20 to 30, Denzin and Lincoln[16] 30 to 50, while Morse[17] suggested 20 to 30 interviewees in order to reach saturation.

As aforementioned, the concept of saturation remains an area of contestation. Most qualitative methodologists indicate that, with no agreed number, the sample size should depend on the purpose of the inquiry, what will be useful, what will have credibility, and what can be done within available resources.[5] For this study, the plan was to interview 30 key informants, however 22 study participants were interviewed. By the 18th interview, there was no new information by the successive respondents, and thus a consideration of reaching saturation was made.

Why these stakeholder groups? Health sector managers are the stewards of the sector and as such are expected to be in-charge or to play a significant part in the transfer of the global health policy agenda to the national level such as in the reforms in health financing to advance UHC. At the national level CSOs and health professional associations (health advocates) are considered legitimate based on their aim of ensuring public good and holding governments and other stakeholders accountable on behalf of the population. They are therefore expected to be among national agents in the global to national policy transfer process. Health development partners have significant power inform of technical expertise, networking and financial resources. They tend to be the principal agents in the global health policy transfer to national level. Researchers bring in evidence/expertise and play roles in the policy transfer and reforms. While political leaders especially members of parliament play an important role in the establishment of legal and regulatory frameworks that guide health system work in the country, including health financing. The Ministry responsible for Finance is a key stakeholder especially in terms of revenue collection and allocation for public services including health and can play a key role in the relevant policy transfers. Other stakeholders including the private sector play significant roles in a country's health system performance including health financing and can be a major force in health system reforms.

4.3.2 Data collection and analytic approaches

The data collection and analytic approach adopted for the specific study objectives are presented in Chapter 5 to Chapter 8. The approach is dependent on the study objective. Under objective 1, health financing reform for UHC between 2000 and 2020 was explored. The research questions under this study objective were, firstly, what has been the changes in the policy objectives, organization and functioning of the health financing system? Secondly, were these changes in line with the UHC aspiration? And thirdly, what have been the major factors for these changes?

For the first question, data collection and analysis were guided by the Kutzin's[18] health financing framework. Data was collected on key variables of health financing functions and policy objective on benefits and entitlement (see table 4.1)

Table 4.1: The main variables for analysis of health financing functions

Health financing System function	Variable
1. Revenue raising	– Funding sources – Predictability in level of funding – Stability in flow of funds – Collection of funds
2. Pooling of revenue	– Pooling organization/structure – Number of pools – Complementarity of funding sources – Funding flow
3. Purchasing services	– Purchaser of services – Payment mechanisms/methods
4. Benefit design and rationing mechanisms	– Defining benefit package – Population awareness on benefits/obligations – Relation between benefits and payment mechanisms

Health strategic plan periods (table 4.2) were used as timeframes in exploring changes in the variables under each of the health financing system function and policy objectives over time.

Table 4.2: The Uganda health sector strategic plan periods

Strategic Plan	Time
Health Sector Strategic Plan I	July 2000 – June 2005
Health Sector Strategic Plan II	July 2005 – June 2010
Health Sector Strategic & Investment Plan	July 2010 – June 2015
Health Sector Development Plan	July 2015 – June 2020

The second question under this study objective relates to whether these changes are in line with the UHC principles. The WHO provides pointers for judging whether health financing reforms are geared towards UHC, as indicated in table 4.3. These WHO[19] principles for reforms that advance UHC were compared with observed changes between financial years (FY) 2000/2001 and 2019/2020 in health system financing reforms in Uganda.

Table 4.3: WHO guiding principles for health financing reforms for UHC

Health Systems financing functions	**Pointers to reforms for UHC**
Revenue raising	– Move towards a predominant reliance on public/compulsory funding sources (i.e., some form of taxation) – Increase predictability in the level of public (and external) funding over a period of years – Improve stability (i.e., regular budget execution) in the flow of public (and external) funds
Pooling of revenue	– Enhance the redistributive capacity of available prepaid funds – Enable explicit complementarity of different funding sources – Reduce fragmentation, duplication and overlap – Simplify financial flows

Health Systems financing functions	Pointers to reforms for UHC
Purchasing services	– Increase the extent to which the allocation of resources to providers is linked to population health needs, information on provider performance, or a combination of both – Move away from the extremes of either rigid, input-based line-item budgets or completely unmanaged fee-for-service reimbursement – Manage expenditure growth, for example by avoiding open-ended commitments in provider payment arrangements – Move towards a unified data platform on patient activity, even if there are multiple health financing / health coverage schemes
Benefit design and rationing mechanisms	– Clarify the population's legal entitlements and obligations (who is entitled to what services, and what, if anything, they are meant to pay at the point of use) – Improve the population's awareness of both their legal entitlements and their obligations as beneficiaries – Align promised benefits, or entitlements, with provider payment mechanisms

The third research question under this objective is about drivers or factors influencing the changes in health financing between financial years 2000/2001 and 2019/2020. The key variables were in terms of context and actors. The findings are reported in Chapter 5 and Chapter 8

Objective ii: Examine the influence of the SDG declaration on health financing reforms (changes) for UHC

The research question under this objective was, how has the SDG declaration influenced health financing reforms for UHC? A literature review was conducted to see how the SDG declaration is influencing health financing systems globally and this is reported in chapters 7. Secondly, purposively selected stakeholders in Uganda at national level were interviewed to get their perspectives on the influence of the SDG declaration on health financing in the case of Uganda. This is reported in chapter 8.

Objective iii: Identify the factors that facilitated or inhibited the SDG declaration in influencing health financing reforms for UHC

The research question under this objective was, which factors have facilitated or inhibited the SDG declaration to influence health financing reforms for UHC from the perspective of Stakeholders in Uganda? This is presented in Chapter 8.

Objective iv: Develop a theory of change on how the SDG declaration influences health financing reforms for UHC

The question here was, what are the key interventions, assumptions and conditions in the pathway to health financing reforms for UHC from the SDG declaration from literature and the perspective of stakeholders in Uganda? This is presented in chapter 8.

4.3.3 Data collection procedures

Documentary review

For document review, data was abstracted using document review guides based on the research questions and study objectives. These are reported in relevant sub-sections in chapters 5 to 8. Generally, searches were conducted for both grey and published literature. In searching databases and search engines such as google scholar, PubMed, Global Health, Web of Science, Popline, etc. key search words and acronyms depending on a particular study objective or sub-topic as reported in Chapters 5 to 7, were combined using the Boolean operators (AND, OR and NOT) to narrow or broaden record as appropriate during the search process. Inclusion and exclusion criteria were used as appropriate, see Chapters 5 to 8 for details on each report.

Key Informant Interviews

This was done as detailed in chapter 8. The starting point was purposively selecting respondents from the Ministry of Health who are involved in the processes of health financing reforms. From literature and interaction with the Ministry of Health officials, respondents from other stakeholder groups were then selected.

Appointments for the interviews were made with purposely selected respondents. The preference for key informant interviews was face-to-face. However, with the COVID-19 outbreak the approach was changed to virtual interviews through telephone, zoom and virtual flatforms. Consent forms were sent to study participants in advance. However, in the event where this was not possible, consent was administered verbally to the

participant at time of the interviews by reading the contents of the form to the study participants.

The data collection tool used for key informant interviews was improved based on the literature review information. The data was managed using NVIVO 12 Mac Version 12.1.0 from QR International. A research assistant was hired to assist in data collection and transcription. The research assistant had master of public health and she was competent in the collection of qualitative data.

4.3.4 Data Analysis

The analytic approach depended on the sub-studies conducted for answering the individual study objective. These have been reported in Chapters 5 to 8. Generally, for literature reviews the analyses were mostly thematic and guided by various theoretical frameworks such as the Kutzin's[18] framework for health financing reforms for UHC based on the health financing functions and policy transfer theory of Dolowitz and Marsh[20]. All interviews were transcribed, backed up and uploaded on NVIVO software to facilitate the analysis. Selected articles were uploaded on NVIVO[21] to facilitate analysis. For KII transcripts a qualitative thematic analytical approach was used. The thematic analysis involved the coding and categorizing of textual information unobtrusively to determine trends and patterns, frequency, and their relationships. The data were coded to categorize the concepts while preserving the core meaning. In interpretation and use of quotes, some sections from the interview were edited for purposes of maintaining the participant's anonymity and/or making the quotes more concise.

In the development of the theory of change, information from literature was used to draft the framework that was then validated by study participants. A face-to-face validation group workshop was planned; however, with the outbreak of COVID-19, this was not possible. Instead, I held virtual meetings separately with each participant as it was also difficult to have them accept to schedule time for the group discussion. Based on the inputs from the participants, a final version of the theory of change was developed.

4.4 Trustworthiness of the study

In terms of originality, this study is an extension of the current ideas on how global declaration can be used to inform and accelerate developments at the national level. Processing of the KIIs was consistent and well documented to allow ease of follow up, and critique of the research thus increasing dependability of the study. In terms of credibility of the theory of change developed, this was through familiarization with the context and was based on the data collected and inputs from stakeholders. The theory of change developed is modifiable, depending on the contexts.

4.5 Ethical Considerations

Ethical approval was obtained from the University of Pretoria Faculty of Health Sciences Research Ethics Committee and Makerere University School of Public Health (MakSPH) Higher Degrees Research and Ethics Committee (HDREC) (See Annex 1). The study adhered to ethical principles including privacy during interviews, explanation on benefits of this research, risk minimization, sharing of findings, confidentiality and voluntary participation.

This being a non-biomedical study, there were no significant risks anticipated to be faced through participation in the study. The only risk anticipated was exposure of disagreements or fissures among stakeholders involved in the health financing reforms, and thus likely impact on ongoing processes. This was mitigated through anonymizing respondents in the analysis. In addition, study participants were given an opportunity to review the draft report from the study prior to publication.

There was no anticipated direct cost of participation to the study participants. However, with COVID-19 outbreak that necessitated change from face-to-face to virtual interviews meant the participants were likely to face costs associated with internet data. Therefore, where this was needed, the participants were provided with funds for data bundles.

Informed consent of all research participants was sought, and their confidentiality and privacy kept. The study participants were duly informed about the research project during the recruitment phase and a summary of the study information was provided. Informed consent was obtained from all the study participants. The study participants were also

informed of no direct benefits to them. However, the participants were informed that the study would develop a theory of change that can be applied to guide the translation of global and regional declarations into desired reforms at national and sub-national level in the area of health financing.

4.6 Dissemination of research findings

The standard process for undertaking graduate study at the University of Pretoria that includes, among others, publication of the study findings was followed. In addition, the findings of the study were disseminated at regional conferences where key stakeholders from Uganda were present; the EAC Health and Scientific conference and the East Central and Southern Africa Health Community best practices forum.

Three articles have been published in peer-reviewed journals, and a fourth manuscript has been submitted while a fifth manuscript is under preparation.

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PART II. FINDINGS AND DISCUSSION

Overview

Part II presents findings and discussion in relation to specific study objectives. The first study objective was to, *"explore changes in health system financing toward UHC in Uganda between the years 2000 and 2020"*. This was aimed at providing contextual background to health system financing in Uganda more generally as part of this thesis. In doing so, a critical review of literature entitled*," Critical review of literature on health financing reforms in Uganda – progress, challenges and opportunities for achieving UHC"* was conducted. This is presented in *Chapter 5.* In addition to providing contextual background, the review examined how the reforms in Uganda have been aligned to WHO principles on health financing reforms that advance UHC, a key SDG 3 target. This was also to make it easier to describe the likely effects of the SDG declaration on the reforms, when compared to reforms prior to the SDG declaration.

The second study objective was to explore how SDG declaration has influenced health financing reforms for UHC in Uganda. To this end, I conducted a literature review to understand how global health policy agendas are transferred from international to national level, especially in sub-Saharan Africa. The review study entitled, "*How are global health policies transferred to sub-Saharan Africa countries? a critical review of literature"* is presented in *Chapter 6*. The review provides possible mechanisms with which some of the envisaged global policies enshrined in SDG declaration may get to be transferred to countries such as Uganda. Findings from this review also informed the development of the theory of change that this study sought to develop as part of study objective (iv). In addition, as part of answering study objective (ii), I conducted a literature review to explore how SDG declaration is influencing health financing at national level globally. The literature review entitled, *"How has SDG declaration influenced health financing reforms for UHC at the country level? A literature review",* is presented in *Chapter 7*. Still as part of answering study objective (ii) which was really the fulcrum of this thesis, I conducted key informant interviews with key stakeholders in Uganda to get their perspectives on how

SDG declaration is influencing health financing reforms for UHC. This is presented in *Chapter 8.*

Chapter 8 reports finding in respect to study objectives (i)(ii)(iii) & (iv). The key informant interviews with stakeholders at the national level enriched findings from literature on influence of SDG declaration on health financing reforms for UHC and the factors that facilitate or inhibit SDG declaration in influencing reforms in the context of Uganda. Based on the draft TOC framework developed through information from review of literature, KII provided additional information and study participants validated the TOC.

CHAPTER 5 : A CRITICAL REVIEW OF HEALTH FINANCING REFORMS IN UGANDA – PROGRESS, CHALLENGES AND OPPORTUNITIES FOR ACHIEVING UHC[1]

5.1 Abstract

Background

Universal health coverage (UHC) is one of the sustainable development goals (SDG) targets. Progress towards UHC necessitates health financing reforms in many countries. Uganda has had reforms in its health financing, however, there has been no examination of how the reforms align with the principles of financing for UHC.

Objective

This review examines how health financing reforms in Uganda align with UHC principles and contribute to ongoing discussions on financing UHC.

Methods

I conducted a critical review of literature and utilized thematic framework for the analysis. Results are presented narratively. The analysis focused on health financing during four health sector strategic plan (HSSP) periods.

Results

In Health Sector Strategic Plan (HSSP) I, the focus of health financing was on equity, while in HSSP II the focus was on mobilizing more funding. In HSSP III & IV the focus was on financial risk protection and UHC. The changes in focus in health financing objectives have been informed by low per capita expenditures, for HSS P IV it is also likely to have been influenced by the global level discussions on SDGs and UHC, and the ongoing national health financing reform discussions. User fees was abolished in 2001, sector-

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wide approach was implemented during HSSP I&II, and pilots with results-based financing have occurred. These financing initiatives have not led to significant improvements in financial risk protection as indicated by the high out-of-pocket payments in excess of 40% of the total health expenditure on average over the 4 strategic plan periods.

Conclusion

Health financing policy intentions were aligned with WHO guidance on reforms towards UHC, however actual outputs and outcomes in terms of improvement in health financing functions and financial risk protections remain far from the intentions.

Key Words

Health Financing Reforms, Uganda, Universal Health Coverage, World Health Organization, Health Sector Strategic Plan, Sustainable Development Goals

5.2 Background

In recent years, universal health coverage (UHC), advanced by the World Health Organization (WHO) has gained momentum and dominates global and national discourses. In 2005, the World Health Assembly (WHA) passed resolution WHA58.33 urging member states on UHC and health financing.[1] The United Nations (UN) member states adopted sustainable development goals (SDGs) as the international development blueprint with achieving UHC as one of the targets under goal 3.[2] The SDG target 3.8 is to achieve UHC, including financial risk protection and access to quality essential health care services and access to safe, effective, quality, and affordable essential medicines and vaccines for all.[2-3] In 2019, at the United Nations High Level Political Forum meeting in Tokyo Japan, UN member states recommitted to the achievement of UHC.[4]

Universal health coverage means ensuring access to health services for all without financial hardship.[5] Therefore, an effective, efficient and equitable health financing system is critical and essential for the achievement of the UHC target under the SDG declaration.[6-8] Health financing is the process by which revenues are collected from various sources, accumulated in fund pools and allocated for specific health interventions provided by various healthcare providers to achieve health system goals.[9] The collection of revenue, pooling and accumulation of revenue, and purchasing of health services form the three health financing functions.

Health financing influences progress on the three UHC goals of equity in the use of health services, quality of care and financial risk protection through effects on UHC intermediary objectives of transparency and accountability, efficiency and equity in resource distribution.[6,10] The movement towards UHC requires health system financing reforms in many countries.[6] Reforms for financing UHC encompasses rearrangement in revenue raising, pooling of funds and risks, purchasing and benefit design that aims at improving one or several objectives and goals of health (financing) system, usually measured at the population or system level.[11-12] Health financing reforms that facilitate movement towards UHC share certain characteristics, even though policy and programmatic approaches may vary by country.[6,13]

There are reports on health financing reforms in Uganda such as those that describe the introduction and later abolition of user fees, implementation of sector wide approach (SWAp) and the proposed national health insurance scheme (NHIS).[14-31] However, there had been no study examining health financing reforms in Uganda in terms of changes in policy intentions (health financing policy objectives), outputs (organization and management of financing functions) and their linkage to outcome (level of financial risk protection) over time, as well as how the reforms have been aligned to WHO principles of reforms that advance UHC.

The current study identifies key characteristics, outputs and outcomes of health financing reform processes in Uganda between Financial Years (FY) 2000/2001 and 2019/2020 and shows how they have been aligned (or not) to the aspirations for achieving UHC. These findings contribute to ongoing discussions on the national health insurance fund (NHIF) and future health financing strategy development. Findings of this review may also be useful to stakeholders from similar contexts who are in the process of reforming health systems financing towards UHC.

5.3 Methods

***Study design and approach*:** In exploring key features of health financing reforms in Uganda, a thematic synthesis approach to the critical review of literature was used. Thematic synthesis is a qualitative approach that involves selecting, recording and categorizing key issues into themes.[32] For each article, the process involved familiarization with information, identification, recording, and categorization. [32] Words, texts and figures were used to summarize and explain findings on health financing reforms in Uganda between financial years 2000/2001 and 2020/2021.

Publicly available grey literature and peer-reviewed publications that contained information on health financing in Uganda were reviewed. These included government development plans, strategies and policies relevant to health financing and reports of other organizations discussing health financing development in Uganda. Additionally, electronic databases including Medline (Ovid), PubMed, EBSCO (Medline and CINAHL), Web of Science and Scopus were searched for eligible articles. Boolean operator ‘OR’ was used to combine various conceptual terms of “health financing” and subsequently

Boolean operator 'AND' was used to combine the results of health financing search with "Uganda" (see section 5.6 for the search string on PubMed as an example). Reference lists of included studies were also screened. The inclusion criteria were: - the document had information on health financing or health financing reform in Uganda, published between 2000 and 2020 and in English. The financial year 2000/2001 was chosen as a baseline because discussions on UHC gained momentum in the early 2000 culminating in the WHA resolution on UHC and health financing in 2005. The exclusion criteria: - the document that only had a mention of health financing but did not further describe health financing reforms in Uganda. Non-English documents were also excluded as the translation processes would have required additional resources. However, it was likely that the available English documents would provide adequate data. All eligible documents were exported to EndNote X9[33] where duplicates were removed. The documents were then exported to NVIVO for analysis.

Analytical framework: The analytical approach was informed by McIntyre and Kutzin's[10] framework that illustrates the relationship between health financing and UHC goals and Kutzin's framework for analyzing health financing systems.[34] McIntyre and Kutzin's framework indicates that health financing influences progress toward UHC goals via UHC intermediate objectives of equity in resource distribution, efficiency and transparency and accountability. The UHC goals are equity in the use of services, quality of care and financial risk protection.[10] Kutzin's framework is based on three pillars which include a set of policy objectives that provide the direction in which reforms push the system, functions and policies of the health financing system, and contextual factors.[34] Financial risk protection and equity in the burden of funding the system are generic health financing system objectives (they are also amongst generic health system goals). While transparency and accountability, promoting quality, and efficiency are intermediate health financing objectives.[34]

Therefore, in line with the aim of this review, the following themes were used in the analysis: - Health financing policy statements in the MOH policy documents as policy objectives or intentions (theme 1); how health financing functions are organized and managed to indicate the outputs (theme 2); and level of financial risk protection to indicate

outcomes of the health financing reforms (theme 3). The three themes are related by the fact that health financing functions are organized and managed as a process for achieving health policy objectives (policy intentions) and outcomes (demonstrated by the level of financial risk protection among other indicators) (theme 3). Changes in Uganda's health financing system over four health sector strategic plan periods were analyzed, i.e., July 2000 – June 2005 (Health Sector Strategic Plan I (HSSP I)[35], July 2005 – June 2010 (Health Sector Strategic Plan II (HSSP II)[36], July 2010 – June 2015 (Health Sector Strategic & Investment Plan (HSSIP)[37], and July 2015 – June 2020 (Health Sector Development Plan (HSDP)[38] These were used as timeframes in the analysis. The HSSIP and HSDP are hereafter referred to as HSSP III and HSSP IV respectively.

Under theme 1, analysis was done on how health financing policy objectives were stated between HSSP I and HSSP IV, noting areas of relative emphasis and the likely reasons for the changes. In theme 2, on health financing functions, organization and management, analysis focused on a set of variables under each of the sub-functions and policy on benefits and only a few health system financing indicators were used for illustrative purposes on changes over the 4 strategic plan periods. It was not the intention of the review to delve into all or many of the indicators used in assessing health system financing performance, but to use a few to shed light on the changes that have happened in the various aspects of health financing system over the four strategic plan periods. Under theme 2, in the revenue raising the variables included the source of funds, collection and allocation, and the level of funding. In the pooling function, the variables examined included the pooling agencies, approach to pooling and cross-subsidization. Under purchasing, variables were purchasing organizations and purchasing mechanisms. On the policy on the benefits package, analysis focused on how it has been defined and financed. The variables were adopted from the WHO guiding principles for health financing reforms that support the achievement of UHC.[39]

In analyzing changes in financial risk protection (theme 3) over the four strategic plan periods, trend in out-of-pocket (OOP) expenditure over the timeframe was analyzed instead of impoverishing or catastrophic expenditure having anticipated paucity in getting

data. However, in low- and middle-income countries OOP expenditure is considered a good proxy for financial risk protection.[40]

Data extraction: From each of the documents included for analysis data was extracted based on the following thematic areas: - health financing policy objectives, management and organization of health financing functions; and financial risk protection. Quantitative data on selected health financing indicators including the level of financial risk protection are presented as tables in the following section.

5.4 Results and Discussion

Forty-three (43) documents were identified for the review (see Figure 5.1 and supplementary information section 5.6). Of these, twenty-two (22) were journal published articles while twenty-one (21) were from the government of Uganda, and other institutions' documents that met our inclusion criteria. Findings and discussion are presented on the following thematic areas: Health financing policy objectives, health financing system organization and financial risk protection. In discussing findings, how changes in health financing were aligned or otherwise to the WHO principles of reforms geared toward UHC have been highlighted.

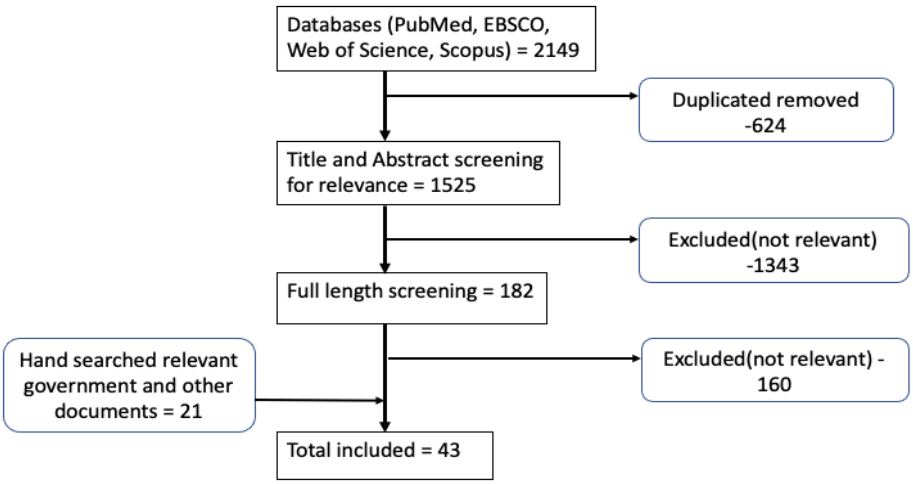

Figure 5.1 Flow diagram of document selection procedure and results

Health financing policy objectives

The health financing policy intentions as reflected in policy objective statements have varied in relative emphasis over the four strategic plan periods. In HSSP I the policy emphasized equity and efficiency in resource mobilization, allocation and utilization.[35] The focus of the health financing policy objective during HSSP II was on raising sufficient financial resources for the health sector.[36] During HSSP III and IV, the health financing policy objectives focused on financial risk protection.[41-43] The HSSP III emphasized ensuring financial risk protection for poor households while HSSP IV envisioned the health financing system attaining UHC through availing required resources for delivery of the essential package of health services.[41-42]

Although Uganda's health financing policy objectives have varied in areas of relative emphasis over the four strategic plan periods, they all fall within the broad generic health financing objectives described by Kutzin et al.[34] These include promotion of universal protection against financial risk, equitable distribution of the burden of funding the health system, promotion of equitable use and provision of services relative to need, improving transparency and accountability, and improving efficiency and promotion of quality.[34]

The WHO notes that the relative emphasis with which each country places on a particular generic health financing policy objective varies and may be influenced by specific contextual situations[34,44]. In Uganda, the shift in emphasis to resource mobilization as the main health financing policy focus during HSSP II from HSSP I of equity and efficiency was likely occasioned by the low average per capita health expenditure realized during HSSP I. The MOH designed benefits package, the Uganda National Minimum Health Care Package (NMHCP) was costed at $28 per capita for HSSP I, however the expenditure within that period ranged between $5 and $10 per capita.[22,24,36] This could have influenced the change of health financing policy focus during HSSP II to mobilization of funding. Financial risk protection and achieving UHC were major focus of health financing policy objectives during HSSP III and HSSP IV periods. This is likely due to the global level discussions on SDGs and UHC at the time, and the on-going consultations on NHIF.

Health financing system organization

Revenue raising

The major sources of revenue for health financing throughout the 4 strategic plan periods were: - general government revenue (taxes, concessional loans, grants); private sources (households, private firms, local non-governmental organizations (NGOs); and development partners, donors, global health initiatives (GHI), philanthropists and international NGOs.[26-28,31,35-36,38,41-43,45-52] Although the sources have remained the same, there has been some variations over the strategic plan periods in terms of their relative contribution to the total health expenditure (THE) as reflected in the national health accounts reports.[42,48-49] (see table 5.1)

Table 5.1: Sources of funds of health financing in Uganda from FY 2000/01 to FY 2015/16

Funding Sources	**Percentage relative contribution from each source over the years**							
	2000/01	*2006/07*	*2008/09*	*2009/10*	2012/13	2013/14	2014/15	2015/16
Public	18.2	*15*	*16*	*15*	16.8	17.7	13.8	15.3
Private (households, private firms and local NGOs)	54.4	*57*	*49*	*48*	43.3	41.1	41.4	42.6
Development partners/donors, INGO, GHI	27.4	*28*	*34*	*37*	38.9	41.2	43.4	41.7
Total Health Exp. (billion Uganda shillings)	745	*1609*	*2808*	*3234*	4866	4952	4944	5309

Source of data: National Health Account reports[42,48-49]

The two major sources of health financing; households through Out-of-pocket (OOP) (which is over 90% of private expenditure) payments and development partners' contribution suffer inherent weaknesses. Firstly, OOP payment is associated with inequity in access, catastrophic expenditure and impoverishment. Secondly, development partners funding is unpredictable, unstable and is fragmented.[27,52-55]

In the public sector, the Ministry of Finance, Planning and Economic Development (MFPED) mobilizes revenue and allocates it to different sectors including health according to priorities set by the government.[56-58] Health care providers also collect funds from households through payments made at the point of care. The other agencies that collect funds for financing health care are the Private Health Insurance (PHI) and Community-Based Health Insurance (CBHI) schemes.[42,48-50,59-60]

Government allocation has been predictable and in real terms increased over the years, with budget execution exceeding 80% of planned health budgets.[50] However, the public fund remains far below the level recommended for the provision of essential health care for a Sub-Saharan Africa country and delivery of NMHCP.[53-58] (see Table 5.2)

Table 5.2: Per capita general government expenditure vs estimates required for delivery of NMHCP between FY 2000/01 and FY 2015/16

Financial year	2000/01	2001/02	2005/06	2007/08	2015/16
Per Capita Government Health expenditure (US dollars)	3.1	7.6	9.98	8.2	9.0
Per capita expenditure required to deliver NMHCP during HSSP I, II&IV (US dollars)	28		34		117

Source of Data: National Health Accounts reports and other reports[42,48-49]

According to WHO, reforms that advance UHC include a move towards a predominant reliance on public/compulsory funding sources, increase in predictability in the level of funding over a period of years and improvement in stability in the flow of public (and external) funds.[39] Apart from the predictable level in government funding, albeit low, and the policy intentions, the revenue raising function has not changed measurably towards contributing to achievement of UHC as the finding on the performance of revenue rising function over the four strategic plan periods indicate.

Pooling of revenue

During HSSP I&II, the MOH and development partners implemented SWAp as a mechanism of pooling development partners funding to finance the national health sector strategic plan. Despite showing promise during HSSP I&II, many partners got discouraged

and pulled out of the SWAp arrangement due to concerns about misuse of funds. [60-61] As a result, many resorted to providing off-budget support directly to service providers.

The MOH first included social health insurance (SHI) as an alternative health financing mechanisms in HSSP I following studies conducted in the 1990's. However, not much progress was registered until the HSSP III period when an NHIF Bill was drafted following a cabinet directive.[62] During HSSP III&IV there was a back-and-forth movement in the process of establishing NHIF. However, by the end of FY 2019/2020 the NHIF law was yet to be enacted. The slow progress has been attributed to challenges including lack of consensus among the reform drivers at MOH; concerns about costs, administrative set-up, institutional capacity for purchasing and regulation of pricing of services in the public and private sectors; and political economy factors including push-back by key political constituencies such as employer groups, implications on the cost of industrial productions and regional competitiveness, among others.[43,62-63] Key stakeholders driving the process of establishing the NHIF may consider proposing other options, especially in terms of sources of financing. For example, as a starting point, reorganize and use existing sources of funding without the need for the proposed requirements of additional sources of funds from employees and employers as is the case with the United Kingdom National Health Service. This may require some reforms in organization of the health system, however it may be more acceptable as it can be fronted as an efficiency improvement intervention since there will be no significant extra funding for its establishment.

The only large and predictable prepaid fund remains the public funds allocated to MOH and those mobilized from external sources and managed by MOH which accounts for only about 18% of total health expenditure (THE). Non-pooled funds contribute the largest proportion to THE; accounting for between 37% and 51% of THE over the four strategic plan periods.[42-43,49] Therefore, the picture of pooling in Uganda departs from principles of reforms in health financing for UHC where there should be progressive reliance on pooled public funds, progressive reduction in the proportion of OOP payment to THE, and reduced fragmentation.[6,34]

Purchasing

The purchasing entities of health services were the same throughout the four strategic plan periods.[27,35-36,38,41,54] They included MOH and local government authorities, households, NGOs and private health insurers. In terms of total purchase, the government and NGOs purchased about 25% of health services each, while households purchased about 50%, and PHI and CBHI scheme purchased less than 1% during the strategic plan periods.[27,42,48-49]

Payment mechanism in the public sector has remained line-item input-based through government budgetary allocation during all the 4 strategic plan periods. Government allocation to public and private-not-for-profit (PNFP) health facilities is based on a formula that takes into account historical costs, geographical location, and epidemiological and demographic characteristics.[27,64-65] The government conditional grants to PNFP are in return for access to health care by the catchment area population at subsidized cost.[23,46,65] Private Health Insurance Schemes and households pay private health providers and for selected services in public facilities based on a fee-for-service arrangement. Before its abolition in 2001, households paid user-fee in all public health facilities.[24,60,66] Abolition of user fees in 2001 was due to a combination of factors such as its low contribution to health financing of 5% of total health facility funding[66], high administration costs, limited access to care by the poor and need to lower OOP expenditure.[36] However, this has not lowered OOP payments which remain the main approach to purchasing of health care.[24,43,66]

During the HSSP III period, a national framework for results-based financing (RBF) and its implementation manual were developed based on results from pilot RBF projects. [43] The pilot projects were scaled-up during HSSP IV period.[50,67] However, RBF does not form the main mechanism for purchasing health care, it rather targets improvement in the demand and supply side interventions mainly for maternal and child health services.[82-83] In addition, the government introduced an output-oriented budgeting approach; the program-based budgeting (PBB) from the financial year 2016/17. This led to a progressive incorporation of performance measures into the public financial management system.[43,50]

The NHIS is being developed as an output-based purchaser and to facilitate provider-purchaser split in the public sector to encourage strategic purchasing. However, as noted above, after a two-decade process, efforts to establish a NHIS as an output-based

purchaser has stalled over several concerns by section of stakeholders.[28,43,58,62] Therefore, apart from the pilots with RBF and some PBB, the traditional formula input-based approach quarterly payment to public agencies and conditional grants to PNFP remains the main mode of health care purchasing in the public sector. The purchasing approach during the 4 strategic plan periods is counter to the WHO recommendation of an effective provider-purchaser split as one of the mechanisms that facilitate strategic purchasing and enable a move towards UHC.[6,34]

Policy on the benefits package

The NMHCP remains the package entitled to the population. It describes the type of health services offered at each level of the health system. This package should be free of charge at the point of care in public health facilities (except in the private wings)[35,38,41,68], and is subsidized in PNFP health facilities. However, availability of this package is not guaranteed as it depends on the availability of funding allocated yearly to MOH and this has always fallen short of levels required over the four strategic plan periods (see table 4.1.2).[36,47,50,56] The PHI and CBHI schemes offer various categories of insurance premiums to their members, each with defined sets of services and prices. The WHO recommends transparency and accountability in the delivery of the benefits package with clearly defined legal entitlement to benefits and transparent rationing mechanisms. [63]

Financial risk protection

National health accounts reports[42,48-49], indicate that the OOP expenditure ranged between 37% and 51% of total health expenditure (THE) over the four strategic plan periods (Table 5.3).

Table 5.3: OOP expenditure as a percentage of total health expenditure between FY2000/01 and FY2015/16

Financial Year	2000/01	2006/07	2008/09	2009/10	2012/13	2014/15	2015/16
OOP as % THE	41	51	40	40	41	33	37

Source of data: National Health Account reports[42,48-49]

As a measure of financial risk protection, it has been observed that household catastrophic health spending and impoverishment remain low in countries where OOP is less than 20% of Total Health Expenditure.[69] Among the government intentions of abolishing user-fee in 2001 was to increase access to care especially for the poor and reduce unwanted effects of OOP payments. However, abolition of user fees plus the increasing donor flow for health, government subsidies to PNFPs, OOP payment remains the largest form of payment for health care in Uganda.[22,24-25,28,64,66] Therefore, the policy reforms in terms of the abolition of user fee, subsides at PNFP health facilities and harnessing development partners funding including through the SWAP and RBF has not improved financial risk protection.

5.5 Conclusion

The general structure of how the health system financing is organized in Uganda has not changed appreciably over the last twenty years, despite variation in health financing policy objectives over the four strategic plan periods. The composition of the three main health financing sources; the public funds, the development partners, and households maintained the same trend. Household payment via OOP remained the main source of health financing. Nevertheless, some features of reforms in health system financing can be discerned. These include the abolition of user fees in public health facilities, development of NMHCP as the benefits package, establishment of SWAp, movement towards performance-based financing exhibited by RBF pilot projects and PBB.

Uganda has had good policy intentions as demonstrated by the health financing policy statements during the 4 strategic plan periods that were aligned to the WHO health financing reform principles that advance UHC. However, reforms such as the abolition of user fees in public health facilities, SWAp, RBF, PBB and government subsidies to PNFP health facilities have not led to desired health financing system outcome in terms of improved financial risk protection (the OOP remained very high). The slow progress to achieving health financing goals may be attributed to political, technical and economic challenges often associated with designing, developing and implementation of policy reforms. This paper did not examine other health financing systems objective of equity in the distribution of the burden of funding the health system as an outcome, however where

OOP is high, the system tends to be very inequitable as the sick who are usually the poor also tend to pay more.

Attempts to establish a NHIF and use it as a catalyst towards a comprehensive health system reform has been prolonged for over two decades. There is need for a comprehensive assessment of the bottlenecks as well as consideration of other options for improving pooling, purchasing and accountability. The drivers of the reform could also benefit from a better appreciation of the political economy issues and harness existing high-level commitment on UHC enshrined in the SDGs[2-4], the recent high-level meeting of the UNGA where member states recommitted to achieving UHC. In addition, policy lessons from abolition of user-fees and the implementation of SWAp need to be considered during the development of NHIF and in the improvement of the overall health financing functions.

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5.7 Supplementary materials

Example of a database Search in PubMed

((((((((((((((((((((((((Health financing reform*) OR (Health system* financing)) OR (Health system* financing reform*)) OR (Financing health system*)) OR (Financing health*)) OR (Financing health care)) OR (Health system* reform*)) OR (health care reform*)) OR (Health* reform*)) OR (Health reform*)) OR (reforming health financing)) OR (Reforming health system* financing)) OR (reforming health care financing)) OR (reforming healthcare financing)) OR (Reforming health*)) OR (Reforming health care)) OR (Reforming health system*)) OR (Reforming healthcare system*)) OR (Reforming health care system*)) OR (Health financing)) OR (Hospital reform*)) OR (Hospital Financing)) OR (Hospital financing reform*)) OR (Financing hospital*)) AND (Uganda) Filters: Humans

List of included documents in the analysis

A. Ministry of health and other organizational reports

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CHAPTER 6 : HOW ARE GLOBAL HEALTH POLICIES TRANSFERRED TO SUB-SAHARAN AFRICAN COUNTRIES? A CRITICAL REVIEW OF LITERATURE[2]

6.1 Abstract

Background

Most sub-Saharan Africa countries adopt global health policies. However, mechanisms with which policy transfers occur have largely been studied amongst developed countries and much less in low- and middle- income countries. The current review sought to contribute to literature in this area by exploring how health policy agendas have been transferred from global to national level in sub-Saharan Africa. This is particularly important in the Sustainable Development Goals (SDGs) era as there are many policy prepositions by global actors to be transferred to national level for example the World Health Organization (WHO) policy principles of health financing reforms that advance Universal Health Coverage (UHC).

Methods

Arksey and O'Malley framework for conducting reviews was followed during the conduct of this critical review of literature. The data bases searched included EBSCOhost, ProQuest, PubMed, Scopus and Web of Science. Google scholar was also searched for articles. Concepts and synonyms of "policy transfer" with those of "sub-Saharan Africa" were combined using Boolean operators in searching databases. Data were analyzed thematically, and results presented narratively.

Results

Nine articles satisfied our eligibility criteria. The predominant policy transfer mechanism in the health sector in sub-Saharan Africa is voluntarism. There are cases of coercion,

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however, even in the face of coercion, there is usually some level of negotiation. Agency, context and nature of the issue are key influencers in policy transfers. The transfer is likely to be smooth if it is mainly technical and changes are within the confines of a given disease programmatic area. Policies with potential implications on financial, bureaucratic and political status quo are more challenging to transfer

Conclusion

Policy transfer, irrespective of the mechanism, requires local alignment and appreciation of context by the actors, availability of financial resources, a coordination platform and good working relations amongst stakeholders. Potential effects of the policy on the bureaucratic structure and political status are also important during the policy transfer process.

Key Words

Policy transfer, health, sub-Saharan Africa, review of literature

6.2 Introduction

Background

Global policy agenda is comprised of those issues in which international and national actors pay particular attention – and it changes over time.[1] In terms of global agenda development process, in the intergovernmental governance system of the United Nations (United National General Assembly (UNGA)) and its agencies, deliberations on a particular issue may result in a convention, treaty, declaration, agreement, resolution or charter which countries are expected to adopt to guide implementation of specific initiatives. In the development of global agendas, in addition to governments, other actors may also play critical roles. For example, epistemic communities and other non-state actors including civil society organizations (CSOs) may advance and/or advocate for actions to be taken to address an issue of concern.[2-4]

Many national health policy responses are guided by ideas marketed and/or promoted by international organizations.[4-6] This is particularly so in sub-Saharan Africa where there is greater reliance on international organizations for standards, technical assistance and financial support.[4-6] As a percentage of total health expenditure, the external funding accounts on average 24% in the WHO African region countries, but can be as high as 74% (Malawi).[7] For programmatic diseases ((Human Immunodeficiency Virus (HIV), Malaria and (Tuberculosis) TB)) external funding account for over 80% of total funding, for example in eastern and southern Africa when South Africa is excluded, only 20% of the HIV response is funded domestically.[8] Therefore, global agendas are bound to influence national development processes and financial flow, thereby shaping national public policy prioritization.[9-12]

Global agenda once adopted at the international level, be it as a resolution, convention, treaty, or declaration is usually taken up at the national level through policy transfer.[13-14] Dolowitz and Marsh refers to such policy transfer as “the occurrence of, and processes involved in, the development of programmes, policies, administrative arrangements, institutions and ideas in one political and/or social system based upon the ideas, institutions, programmes and policies emanating from other political and/or social

systems"[15](p. 5). In this review, policy transfer is referred to as the development of national level health programs or policies based on a global health policy agenda.

Most policy transfer studies analyze transfers among developed countries[16] and in particular, "health is not usually directly analyzed in *most* policy transfer literature"[4] (p.191). There are few policy transfer studies on developing countries, yet they present different issues in policy transfers compared to developed countries.[16] Marsh and Sharman contends that developing countries provide a powerful testing ground for confirming existing policy transfer hypotheses or developing new ones as well as examining the relationship between policy transfer and effectiveness.[17] For developing countries, policy transfer studies are particularly important in the era of the sustainable development goals (SDGs). This is because there are many policy ideas on how to achieve health targets including UHC under goal 3, with anticipated lots of policy learning and adoption.

Therefore, this review sought to firstly contribute to scholarship in the policy transfer field by reviewing how global policies are transferred to sub-Saharan African countries with a focus on the health sector. The health sector was chosen because it is an area neglected in policy transfer studies and in most sub-Saharan Africa, the sector heavily relies on normative and other guidelines promoted by international organizations.[4] The reliance on guidelines by international organizations can be seen in a number of countries in sub-Saharan Africa including Uganda, Kenya, Zambia and South Africa that have been reforming their health financing towards achieving UHC target of the SDG declaration.[18-23] The health financing reform principles being adopted are based on the global norm as advanced by the WHO in its guidance of reforms that advance UHC.[24-25] Secondly, this review sought to highlight lessons that can be considered by actors at national level as they seek to adopt the WHO policy principles of reforms for UHC from other global health policy transfers that have been documented in similar context in sub-Saharan Africa.

Policy transfer theories, actors and context

In theory, mechanisms with which policy transfer occurs may be voluntary or coercive. The voluntary mechanism entails learning, competition, and mimicry while coercion may be through force or other tools such as conditionality on access to development

funding.[17,26-27] In learning, a government adopts a foreign institution's approach and practice rationally with the view that it will produce more efficient and effective policy or program outcomes through lessons drawing. In mimicry, a country copies a foreign model not based on technical or rational thinking, rather on account of symbolic or normative factors such as being perceived as advanced, progressive or because it is a model advanced by an international organization. Coercion involves powerful entities such as a multilateral organization or a high-income country providing support to a lower income country based on fulfilment of some conditions such as adoption of certain policies. While in competition, a country adopts certain policies so that it is not at a disadvantage compared to other countries.[17,26-27]

The transfer can be to varying degrees; emulation (adaptation), copying, hybridization and/or synthesis and inspiration.[26] In emulation, a policy from another setting is adapted or modified usually to suit the local context while in copying the policy is usually transferred as it is without modification. In hybridization, policies from a number of settings are used to inform a policy while in inspiration, policy elsewhere triggers or motivates policy development in a learning country.[26]

Policy transfer can be multidimensional and multilevel i.e., global, international and transnational, domestic and inter-organizational.[28-29] Based on these levels, Dolowitz and Marsh identified 30 permutations of possible policy transfer pathways.[27] This review was concerned with the global and/or international to national level policy transfer.

Bennet *et al*[30] suggests that understanding policy transfers necessitate understanding of both the actors and their motivation in the process. Global to national policy transfer usually involves actors at global/international and national level, with variable nature and degrees of power which also varies with the stage of the process. The various forms of power usually at display include technical expertise and knowledge, financials, networking capability, legitimacy/moral imperative, access to decision makers, authority, charisma, etc.[31] However, the actions by the various actors during the policy transfer process are tempered by contextual factors. The contextual factors constrain or privilege the actors' actions.[15] Contextual factors may be social, political, and economic in nature. Leichter

cited by Buse and colleagues[31] categorized contextual factors into situational, structural, cultural and exogenous factors.

6.3 Methodology

Study design and review question

A systematic critical review of literature was conducted with a focus on exploring the mechanisms with which international policy agenda is transferred to national level in sub-Saharan Africa and the role of agency and context in the transfer process.

Arksey and O'Malley[32-33] framework for reviews was adopted to guide data collection where the review questions were defined; potential articles were identified and selected; data abstracted, and the results were synthesized and interpreted. The review questions were a) What policy transfer mechanism was at play in the policy transfer process for the identified global health policy agenda to a sub-Saharan African country, b) Who were the actors and what roles did they play in the policy transfer process? c) What was the role of contextual factors in the transfer process? d) Was the policy transfer successful? Defining what is considered policy transfer success or failure remains an area of contestation[17,34], and delving into these argumentations is beyond the scope of the current review. For the current study, policy transfer was considered successful when a national health policy or program was developed based on the international health policy agenda and failed if no national policy or program guidelines were developed.

Criteria for considering studies for the review

All study designs were considered for this review. The inclusion criteria were: - the article is an empirical study, article describes a policy transfer of global or international health agenda, the policy transfer study is on a sub-Saharan African country and the article is published in the English language. Policy transfers studies between or among specific groups of countries, articles purely on theoretical issues around policy transfer, and studies on policy transfer in developed (high-income) countries and non – Sub-Sharan Africa countries were excluded.

Search methods for identification of studies

Google scholar was searched as well as the following databases for potential articles for the review: EBSCOhost, ProQuest, PubMed, Scopus, and Web of Science. The search was conducted between 15th June and 25th July 2021. The search was not restricted by year of study or publication. In searching google scholar the term policy transfer was used. On google scholar a manual screening was made up to the tenth page of the search for the term to identify a relevant article based on the inclusion and exclusion criteria above. In searching the electronic databases, the concepts and synonyms of policy transfer with those of sub-Saharan Africa were combined using Boolean operators "OR" and "AND". An example from PubMed is provided in Supplementary section 6.8. In addition, reference lists of included studies from the databases were searched for additional eligible studies.

Data collection, extraction and analysis

Selecting studies: All retrieved articles from the databases were exported to EndNote X9[35], where duplicates were removed. The titles and abstracts of identified articles were screened for potential eligibility. Full text of articles judged as potentially eligible were retrieved. The articles retrieved were screened in detail for eligibility using a standardized screening form (see section 6.8). The number of studies included and excluded are as illustrated in the flow diagram (Figure 4.2).

Data extraction: The study characteristics extracted included bibliographic details of the study (author, year of publication), objectives (purpose of the study), setting (country); global health policy agenda examined, policy transfer mechanisms, policy transfer strategy, the actors and contextual factors.

Synthesis and Interpretation of results: NVIVo and a thematic framework table were used to facilitate analysis. Thematic framework synthesis is a qualitative approach that involves selecting, recording and categorizing key issues and themes[36]. For each article, the process involved familiarization with information, identification, recording, categorization and interpretation. For this review, Dolowitz and Marsh[15] policy transfer framework was adapted to guide the analysis. The framework is based on six questions including: Why do actors engage in policy transfer? Who are the key actors involved in the policy transfer process? What is transferred? From where are lessons drawn? What are the different

degrees of transfer? What restricts or facilitates the policy transfer process? And how is the process of policy transfer related to policy "success" or policy "failure"?[15] (p.8). In line with the aim for this review, the analysis focused on: Why engage in policy transfer? Who was engaged in the policy transfer? What was the role of actors and context in policy transfer? Did the policy transfer succeed or fail? - based on our definition indicated under study design and review questions sub-section.

6.4 Results

Overview

The article selection process is summarized in the flow chart (Figure 6.1) while the lists of the databases searched, search dates and the yield are in section 6.8. Out of 1,114 citations, 9 articles satisfied the eligibility criteria after title, abstract, and full-length screening.

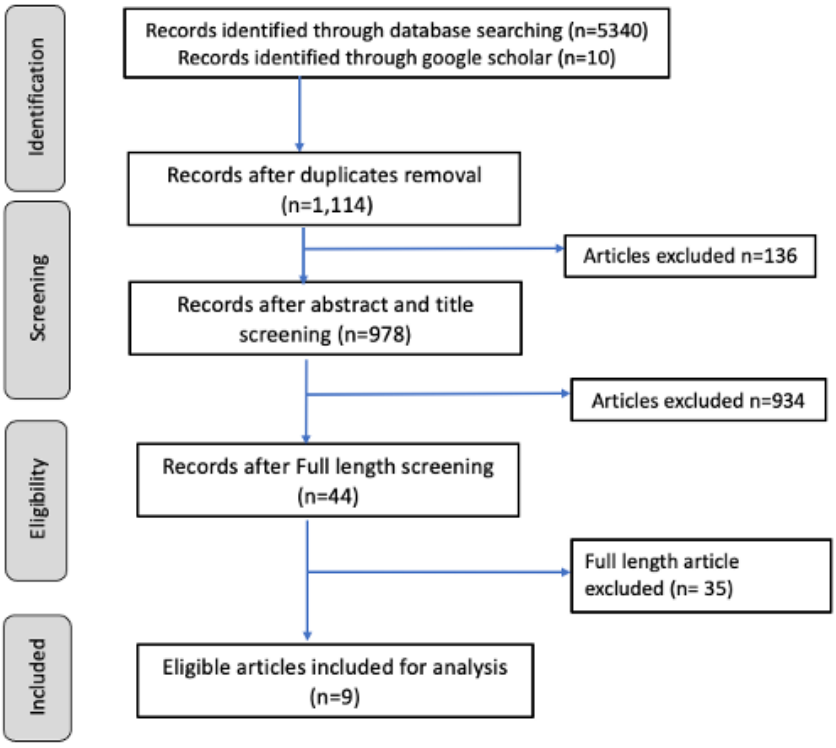

Figure 6.1 Article selection flow chart

Characteristics of included studies

The characteristics of the included studies in terms of country of study, year of publication, and health policy issue reported on are summarized in table 6.1. Each of the nine articles included for analysis reports an empirical case of a health policy transfer from international to national level in a sub-Saharan Africa country. Two articles describe policy transfers in Malawi; one on hospital autonomy reforms[37] and the other one on health sector decentralization.[38] One article reports on policy transfer in Uganda, with another one studying both Uganda and Ghana.[5,39] One article each reports a policy transfer case in Cameroon[40], Mozambique[41], South Africa[42] and Zambia.[43] One article describes policy transfer of integrated Community Case Management of Childhood illnesses (iCCM) in six (6) countries including Burkina Faso, Kenya, Malawi, Mali, Mozambique and Niger.[30] All policy issues described in the articles included in this study can be linked to a global or international policy agenda or issue (table 6.1). These include health related MDGs[30,40-43], SDGs[5], World Bank advanced structural adjustment programme (SAP) [37-38] and World Health Assembly resolution on child dosage medicine formulations.[39]

From the review of the nine articles, the three major themes were policy transfer mechanisms, policy transfer strategy, and whether the transfer was successful or not. These are summarized in Table 6.1 and are elaborated below.

Table 6.1: Summary of key finding on policy transfer

Policy/Country	**Related global policy agenda**	**Transfer mechanisms**	**Strategy**	**Successful or failed**
DOTS for TB and syndromic management for STIs in Mozambique[41]	MDGs	*Voluntary* through *Lessons drawing*	– Inter-country visits (visit to Zimbabwe to learn about syndromic management of STI) – Scientific and technical cross-national linkages between international players and the national stakeholders – Financial support	Successful

Policy/Country	Related global policy agenda	Transfer mechanisms	Strategy	Successful or failed
Global health policies for malaria and HIV/AIDS/ Cameroon[40]	MDGs	*Coercive: funding conditionality*	– Conditionality in accessing funding – Policy negotiation	Successful
Health sector decentralization in Malawi[38]	World Bank Structural Adjustment Program	*Coercive: funding conditionality*	– Conditionality on aid – Participatory learning and formal training – Bureaucratic bypass	Successful
Hospital autonomy reforms in Malawi[37]	World Bank Structural Adjustment Program	*Coercive*	– Conditionality on aid – Technical support	Failed
Child-appropriate dosage formulations policy from the global to national level/ Uganda[39]	WHO resolution (WHA60.20)	*Voluntary through lessons drawing*	– Policy negotiation – Technical support	Failed
Policy transfer in the context of the UNAIDS '90–90–90' treatment targets in Ghana and Uganda[5]	SDGs	*Voluntary involving lessons drawing*	– Policy negotiation – Technical support – Financial support	Successful
Introduction of new molecular tuberculosis diagnostics in South Africa[42]	MDGs	*Voluntary involving lessons drawing*	– Technical support	Successful
Advocacy coalitions and the transfer of nutrition policy to Zambia[43]	MDGs	*Voluntary*	– Technical cross-national linkages between international players and the national stakeholders – Systematic advocacy – Technical assistance – Funding to the national drivers of the process	Successful
Understanding the role of	MDGs	*Mixed (voluntary and coercive)*	– Policy negotiation	Successful

Policy/Country	Related global policy agenda	Transfer mechanisms	Strategy	Successful or failed
international organizations in iCCM policy transfer in six African countries[30]		*involving lessons drawing and conditional funding*	– Technical support (Provision of technical assistance) – Financial support (External funding targeted at iCCM) – International conferences – Publications in peer review journals – Study tours and global guidelines	

Policy transfer mechanisms

Based on the reviewed literature, the main policy transfer mechanism in sub-Saharan Africa at least in the health sector is voluntary. This was discernible in five of the nine articles reviewed.[5,39,41-43] Three articles describe coercive policy transfers; the adoption of the global Roll Back Malaria (RBM) and the Accelerating Access Initiative (AAI) strategies into national policies and programs in Cameroon[40], hospital autonomy, and decentralization reforms in Malawi.[37-38] One article describes a mixed policy transfer mechanism i.e., the adoption of iCCM policy in six countries.[30]

Policy transfer strategies

The policy transfer strategies especially where the transfer has been coercive was conditioning of development grants and loans on adoption of a global policy[38,40] or initiating the process to adopt the global policy being advanced.[37] The adoption of the global Roll Back Malaria (RBM) and the Accelerating Access Initiative (AAI) strategies into national policies and programs in Cameroon were preconditions for accessing Global Fund and World Bank funding.[40] Similarly, Bender and colleagues reporting[38] on the health sector decentralization in Malawi also notes that "…because of international pressure and incentives, the Malawian politicians were very motivated to conduct the reform" (p.22). Also, in Malawi to realize hospital autonomy reform, United States Agency

for International Development (USAID) conditioned its non-project assistance-based aid (NPA) on adoption of hospital autonomy.

Other prevalent policy transfer strategies were technical support or assistance by global stakeholders at national level[5,30,37,39,42-43], policy negotiations[5,30,39-40], strong networking and linkages amongst national and global technical teams[41,43], cross-country learning such as intercountry learning tours[30,38,41], keeping away other stakeholders from the process through 'bureaucratic' bypass[38] and dissemination of information to national level stakeholders on a policy issue either through supporting their participation in relevant global conferences or national dissemination workshops and publications.[30,38] Even where the policy transfer mechanism was coercive through conditionality on development aid - policy negotiations, technical assistance, bureaucratic bypass etc. were part of the usually combined strategic approaches by the global stakeholders.

Therefore, the current study found that irrespective of the transfer mechanism, be it voluntary or coercion, there is need for a combination of policy transfer strategies as a single strategy may unlikely suffice. The policy transfer strategies can be applied to varying degrees depending on the issue and approach. These include: - peer learning through intercountry visits and conferences, cross-national linkages, financial support of the policy transfer process, conditionality on aid and technical assistance, competency building of national level stakeholders through participatory learning and formal training, systematic advocacy, bureaucratic manoeuvring such as 'bureaucratic bypassing' and negotiations. However, better characterization of health policy issues and their likelihood of being successfully transferred or not from global to national level, as well as description and definition of policy transfer strategies are areas that need further scholarship and development.

Policy transfers - success and failure

Policy transfer in seven of the nine articles reviewed were successful as exemplified by adoption and/or development of national policies and strategies based on global agendas.[5,30,38,40-43] Two articles describe cases of failed policy transfer; the adoption of WHA resolution on child appropriate dosage formulations[56] and hospital autonomy reform in Malawi.[37] The success or failure of policy transfer seems to not necessarily be related

to the mechanisms but a combination of the mix of strategies used, the actors involved and their inter-relationship and the contextual factors. For example, the Mozambique's successful adoption of her national policies and programs of the Directly Observed Therapy (DOTS) and syndromic management of Sexually Transmitted Infection (STI)[41] were due to a mix of close networking between national actors; Ministry of Health (MOH) staff and international stakeholders including WHO, United Nations Children's Fund (UNICEF), Norwegian Agency for Development Cooperation (NORAD) and European Commission that provided the funding, and International Union Against TB and Lung Diseases (IUATLD) that provided technical support.

Similarly, successful policy transfer in Cameroon for Malaria and HIV/AIDS global strategies[40], health sectors decentralization reforms in Malawi[38], adoption of 90,90,90 AIDS target in Uganda and Ghana[5], new TB diagnostics in South Africa[42], nutrition policy in Zambia[43] and iCCM strategies in six Africa countries[30] were a combination of favourable contextual factors, actors' level of influence and the policy transfer strategies mixes. Favourable contextual factors included epidemiological factors such as high HIV and Malaria burden in Uganda, Ghana, South Africa and Cameroon; economic factors and low prioritization of health leading to reliance on external funding in most of the countries studied in the reviewed articles. Other factors were the strong coalition of international (United Nations Programme on HIV/AIDS (UNAIDS), World Bank, WHO, German Agency for Technical Cooperation (GTZ);now German Agency for International Cooperation (GIZ), Department for International Development (DFID), USAID and European Commission, U.S. President's Emergency Plan for AIDS Relief (PEPFAR)) and national stakeholders active in a given policy areas such as HIV and Malaria[40,42-43], iCCM policy (the WHO, UNICEF, USAID, Save the Children and Ministries of Health) [30], nutrition policy (DFID, Irish Aid, Swedish International Development Cooperation Agency (SIDA), World Bank, European Union (EU) and USAID, Scaling Up Nutrition (SUN), MOH and National Central Statistics Organization)[43]; commitment on funding[30,44]; policy negotiation.[30] Another facilitating factor for policy transfer is the existence of institutional mechanisms anchored within MOH for dialogue such as the Central Technical Group and National Programmes Committees in Cameroon.[40] In addition, for certain policy issues such as

adoption of the iCCM strategy, the iCCM policy, the readiness of health system was a key determinant.[30] For the case of iCCM, the ministries of health were also under pressure especially by politicians to deliver on the MDGs. The iCCM was seen as one of the key strategies to achieve child health related targets.[30] The nature of the policy issue within a given context is also a key determinant of the policy transfer process for example nutrition in Zambia is not a politically sensitive issue[43], while hospital autonomy and decentralization are high political issues, hence the smooth process in Zambia compared to Malawi cases.[37-38]

The failed hospital autonomy reforms in Malawi was anticipated to lead to improved efficiency, effectiveness, quality and accountability.[37] Initially the political leadership agreed with the process of the reform, however as Tambulasi[37] notes, the initial commitment to adopt the hospital autonomy programme was only motivated by the desire to secure aid from the USAID NPA program. The proposed hospital autonomy reforms were rejected at the Cabinet level, despite the initial commitment and large amount of resources spent on the policy transfer project.[37] These attest to the need for a mix of policy transfer strategies, understating of the country context and the motivation of actors.

Similarly, in Uganda as part of the better medicines for children program that followed the World Health Assembly resolution 60.20 (WHA60.20), the WHO member countries were to adopt and implement a policy on child appropriate dosage formulation. The policy transfer negotiations in Uganda did not result in the transfer of the WHA policy resolution on better medicines for children due to non-commitment by development partners on funding the initiative. The government stakeholders felt it would be a costly initiative and thus the child appropriate dosage formulations were not included in the national essential medicines list.[39]

6.5 Discussion

In this review, how global health policies are transferred to national level in sub-Saharan African countries was explored. Literature indicates that policy transfer in Lower- and Middle-Income Countries (LMIC) from global or international level to national level are predominantly coercive in nature.[16] However, this review finding indicates that the

common policy transfer process, at least in the health sector in sub-Saharan Africa are predominantly negotiation based and/or voluntary. Six of the nine articles reviewed indicate that the transfers were voluntary or negotiated in nature involving policy dialogue and technical support. The health sector is complex and in sub-Saharan Africa, the health sector is largely funded by development partners. Therefore, one may argue that the health sector stewards are inherently programmed to accept international policies due to the perceived fear of losing funding as a sector, should they not support/or adopt international policy being advanced. However, the failed hospital autonomy reform in Malawi (country national budget is 50% externally funded[37]) attests otherwise. There is also the presumption that the international agents come with money as a coercing tool to national stakeholders. However, the case of iCCM policy adoption indicates that as part of the policy negotiation, the national stakeholders can condition acceptance of an international policy based on further funding support and in the process sending back the international agents to drawing boards on how to fund such policy initiatives. This approach of not fronting funding beforehand could also be due to the mounting criticism of international organizations of their approach on policy transfer to developing countries that has led to failures at policy implementation stage where the initial acceptance is based purely on the funding on offer.[28,45]

Marsh and Sharman[17] note that transfer mechanisms may operate concurrently and sometimes it may be difficult to distinguish which one is working during a particular policy transfer process. This is because it is possible for both voluntarism and coercion to operate concurrently as mechanisms during a particular global policy agenda transfer. This seems to have been the case in the iCCM policy transfer[30] in the six countries and the malaria and HIV policy transfers[40] in Cameroon. Therefore, in the current study, I confirmed the notion of concurrent operation of mechanisms and in particular this review makes it clear that irrespective of the policy transfer mechanism, there is need for a right mix of policy transfer strategies. However, this area needs further exploration especially in terms of better characterizing or developing a framework for examining policy transfer strategies.

The current review confirms the critical role of actors and context in policy transfer as illustrated in both cases of policy transfer failure and success. Contextual factors such as

epidemiologic factors are instrumental in policy transfer. They are important because in-country national policy makers would already be looking for possible policy solutions to certain health conditions and they are likely to see policies being advanced by international organizations as best practices. This is discernible in the reviewed literature examining disease conditions; TB policies (Mozambique and South Africa)[41-42], HIV/AIDS (Cameroon, Ghana and Uganda)[5,40] and Malaria (Cameroon)[40], Nutrition (Zambia).[43] For policies that are directed typically at specific health conditions, the epidemiological factors such as the high burden tend to favour successful transfer. This is because disease programs tend to be more technical areas with policy content from international level requiring majorly technical programming with limited political implications.[43]

In sub-Saharan Africa, the disease programs of international interest tend to also be largely funded externally. However, where the required reforms are more systemic and require inputs beyond the health sector, such as enactment of Laws, the policy transfer process tends to be more difficult, whether voluntary or coercive. This can be seen in cases of decentralization and hospital autonomy reforms in Malawi (coercive processes) and the child dosage appropriate formulations in Uganda (voluntary process). Decentralization always has political implications and pharmaceutical supplies at national level involve multi-sectorial engagements than specific health condition policies and usually the stakes are higher given the amount of funding involved.[46] Therefore, stakeholders driving health financing reforms that advance UHC as recommended by the WHO need to better understand their political and bureaucratic environment given the wide-ranging systemic requirements of such reforms. In addition to epidemiological factors, other favourable factors for policy transfer in the health sector from global to national level in sub-Saharan Africa is the predominant reliance of external funding, existence of local platform or structure situated at and led or coordinated by MOH[47], good working relation between global and national level actors, high level political support and good understanding of the contextual factors by stakeholders driving the reforms.

6.6 Conclusions

The divide between coercive and voluntary policy transfer mechanisms in sub-Saharan Africa requires more nuanced examination before one can conclusively say which

mechanism is predominant. However, the current study indicates that even though the health sector is heavily donor depended in most sub-Saharan African countries, health policy transfer processes are generally negotiation-based and voluntary. National level stakeholders are receptive to international health policy agenda if it suits their interest and reject it if it does not, as the case of Malawi points out, and would reject reforms or make it impossible to implement if they can potentially lead to unfavourable political standing amongst the voters or make them loose their controlling powers.

In sub-Saharan Africa, funding by development partners is key to the success of policy transfer, even where the transfer is voluntary. Nsabagasani et al[39] argues that even though it is the responsibility of member states to adopt WHA resolutions, the role of global influence, especially through funding of global health agendas are very important for the process of policy adoption and implementation at the national level.

Therefore, irrespective of the policy transfer mechanism that may operate for example in the transfer to national level of WHO health financing reform principles that advance UHC to achieve SDG 3, actors at all levels need to take into account a number of considerations. Key amongst the factors that need to be considered for a successful policy transfer include alignment with local need, understanding of context by global actors, existence of a national anchoring institution/platform for coordination and engagement, technical and financial support by the international actors, close linkages between international and national stakeholders, and limited potential effect of the policy on the bureaucratic structure and political status quo.

There is need to expand policy transfer studies to better define and characterize policy transfer strategies especially in sub-Saharan Africa where there is a lot of fluidity in the political and bureaucratic landscape. One key limitation of this study is that it did not explore how a policy will fare in terms of implementation once adopted from the Global level. The current review defined success of policy transfer only in terms of development of national policy or strategy document based on adoption of the global agenda and not in terms of implementation at the national level. Implementation of the policy once transferred to national from global level is an area that needs further exploration especially amongst sub-Sharan African countries. The other limitation of this study is the few

numbers of articles that were available for analysis. However, this is not surprising given that policy transfer studies especially in the health sector is an area with limited scholarship. Despite the limitations, this study makes contribution in terms of questioning the notion that transfers in Africa is predominantly voluntary and makes explicit the need for development of robust frameworks for examining policy transfer strategies.

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6.8 Supplementary materials – screening tool, database yield, and list of included articles

1. Tool for eligibility screening of articles

a) Screening for potential eligibility

- Duplicate removal
- Title and abstract information screen against the following
    - Mention of policy transfer (or policy diffusion or lessons drawing) and health topic in the title that is/was a global issue

b) Eligibility for inclusion for full-length articles screening for analysis

- Describes in at least one of the article sections:
    - Empirical study on health policy transfer from global to national level
    - Policy transfer study on a global health agenda to a country in sub-Saharan Africa

2. Results from the search strategy

Database/ search engine	**Date Searched**	**Hits**	**After Duplicate removal**	**Potentially eligible (Title/abstract screening)**	**Eligible Full length screening**	**Eligible for analysis**
Google scholar	15 June 2021	10^	2114	978	44	9
PubMed		3160				
EBSCOhost *	20 June 2021	529				
ProQuest	25 July 2020	1412				
Scopus	25 July 2020	249				
Total		**5350**	**2114**	**978**	**44**	**9**

^ *Potentially eligible (abstract) from google scholar*

**EBSCO (CINAHL, EconLit, Health Source: Nursing/Academic Edition, Humanities Source, MEDLINE, APA PsycArticles, APA PsycInfo, Social Work Abstracts)*

3. Example of Search string - PubMed

(((((policy transfer) OR (policy diffusion)) OR (policy convergence)) OR (policy learning)) AND (((((((sub-Saharan Africa) OR (Low income countr)) OR (low and middle income countr*)) OR (LMIC)) OR (LIC)) OR (developing countr*)) OR ((Angola) OR (Benin)) OR (Botswana)) OR (Burkina Faso)) OR (Burundi)) OR (Cape Verde)) OR (Cameroon)) OR (Central African Republic)) OR (Chad)) OR (Comoros)) OR (Democratic Republic of the Congo)) OR (Republic of the Congo)) OR (Cote d'Ivoire)) OR (Djibouti)) OR (Equatorial Guinea)) OR (Eritrea)) OR (Ethiopia)) OR (Gabon)) OR (Gambia)) OR (Ghana)) OR (Guinea)) OR (Guinea-Bissau)) OR (Kenya)) OR (Lesotho)) OR (Liberia)) OR (Madagascar)) OR (Malawi)) OR (Mali)) OR (Mauritania)) OR (Mauritius)) OR (Mozambique)) OR (Namibia)) OR (Niger)) OR (Nigeria)) OR (Réunion)) OR (Rwanda)) OR (Sao Tome and Principe)) OR (Senegal)) OR (Seychelles)) OR (Sierra Leone)) OR (Somalia)) OR (South Africa)) OR (Sudan)) OR (Swaziland)) OR (Tanzania)) OR (Togo)) OR (Uganda)) OR (Western Sahara)) OR (Zambia)) OR (Zimbabwe)))) AND (health)*

4. Data abstraction form

Reviewer: ________________________________ Date of data extraction: ____________

Bibliographic details of study (author. Year. Title.)

____

Country of Study: ____

Data Analysis

- Policy transfer mechanisms, process, strategies described

  ____

- Actors involved and their role in the policy transfer process ______________________________

- The contextual factors and their roles in the process

____

____

5. List of included study in the analysis

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CHAPTER 7 : HOW HAS SDG DECLARATION INFLUENCED HEALTH FINANCING REFORMS FOR UHC AT THE COUNTRY LEVEL? A LITERATURE REVIEW[3]

7.1 Abstract

Background

Achieving universal health coverage (UHC) requires health financing reforms (HFR) in many of the countries. HFR are inherently political. The sustainable development goals (SDG) declaration provides a global political commitment context that can influence HFR for UHC at national level. However, how the declaration has influenced HFR discourse at the national level and how ministries of health and other stakeholders are using the declaration to influence reforms towards UHC have not been explored. This review was conducted to provide information and lessons on how SDG declaration can influence health financing reforms for UHC based on countries experiences.

Methods

In conducting this rapid review of literature, I followed the preferred reporting items for systematic review and meta-analysis (PRISMA) guideline. We conducted a comprehensive electronic search on Ovid Medline, PubMed, EBSCO, Scopus, Web of Science. In searching the electronic databases, various conceptual terms for “sustainable development goals" were combined with "health financing" using Boolean operators. In addition, manual searched using google scholar was conducted

Results

Twelve articles satisfied our eligibility criteria. The included articles were analyzed thematically, and the results presented narratively. The SDG declaration has provided an

[3] Published in Globalization and Health

- Odoch, W.D., Senkubuge, F. & Hongoro, C. How has sustainable development goals declaration influenced health financing reforms for universal health coverage at the country level? A scoping review of literature. Global Health 17, 50 (2021). https://doi.org/10.1186/s12992-021-00703-6

enabling environment for putting in place necessary legislations, reforming health financing organization, and revisions of national health polices to align to the country's commitment on UHC. However, there is limited information on the process; how health ministries and other stakeholders have used SDG declaration to advocate, lobby, and engage various constituencies to support HFR for UHC.

Conclusion

The SDG declaration can be a catalyst for health financing reform, providing reference for necessary legislations and policies for financing UHC. However, to facilitate better cross-country learning on how SDG declaration catalyzes HFR for UHC there is need to examine further the processes of how stakeholders have used the declaration as window of opportunity to accelerate reforms from their perspectives.

Key words

Sustainable Development Goals, Health Financing Reforms, Universal Health Coverage

7.2 Background

Global declarations shape public policy priorities and guide development finance flows.[1-3] The declarations can energize governmental processes and provide a reference point that guides national policies toward priority development issues. Therefore, global and regional declarations can be powerful tools for shaping policy and programme response on issues that are of public concern.[4] The United Nations General Assembly (UNGA) meeting in New York in September 2015 under the theme, *"Transforming our world: the 2030 Agenda for Sustainable Development",* adopted 17 sustainable development goals (SDG) as the post millennium development goals (MDGs) development blue print.[5] Health is explicitly addressed in paragraph 26 of the SDGs declaration[6]

Achieving universal health coverage (UHC) is one of the overarching targets of the 2030 agenda for sustainable development, under goal 3 *(Ensure healthy lives and promote well-being for all at all ages)*. Universal health coverage is based on the principle that all people should have access to health services they need and do not suffer financial hardship while accessing the services.[7] This implies that an effective, efficient and equitable health financing system is a critical and essential component that contributes to achievement of UHC target under the SDG declaration.[8-11] It is only when resources are adequate, efficiently used and equitably mobilized, pooled and spent that all people can enjoy sustained progress towards UHC.[12-13] Health financing influences progress on the three UHC goals of equity in the use of health services, quality of care and financial protection through effects on UHC intermediary objectives of transparency and accountability, efficiency and equity in resource distribution.[8,14]

For many countries, achieving UHC require reforms in their health financing systems so that people have financial protection while accessing quality health care.[15] Therefore, a number of countries in the African region have been attempting to reform the way health is financed to ensure sustainable progress towards UHC.[15-19] However, these attempts, largely spearheaded by Ministries of Health have been slow and intermittent as reflected in the slow and/or forward and backward movements in the reform processes.[16,20-22]

The process of introducing comprehensive National Health Insurance Scheme (NHIS), for example, has been ongoing in the last 2 to 3 decades in Uganda, Kenya, Zambia and South Africa.[16,20-24] In South Africa, Uganda, Kenya and Zambia, Health Insurance Bills were (or have been) drafted, however they have not reached parliament for legislation. In cases where the parliament passed the Act, it never became Law due to failure by the Executive arm of governments to ascent to the Bills or the process took very long.[22,25-26] However, the policy landscape where various efforts for strengthening or reforming health financing systems occur may be different with the SDG declaration. This is because health financing reforms are a political process, and SDG is a global political declaration with UHC as one of its targets. Effective, efficient and equitable health financing systems are critical for the achievement of UHC.[27-28] Therefore, given the overarching importance of UHC as an SDG target, it is likely that the declaration has influenced health financing reforms and if so, lessons on the how and the outcomes of those reforms are relevant for intercountry learning. So far, there has been no comprehensive review of literature on how health financing reform processes have been influenced by the SDG declaration at national level. This review study contributes towards filling this knowledge gap and more broadly to the 2013 WHO[29] call for evidence-based research that inform initiatives to advance UHC in addition to answering study objective two of this thesis.

7.3 Methods

Study design, review questions and definition

The initial plan was to conduct a systematic review. However, due to resource constraints a scoping review of literature was conducted instead. The review was conducted on findings from studies and reports on how the SDG declaration is influencing or has influenced health financing reforms for UHC. For this review, health financing reforms for UHC is conceptualized to refer to changes in arrangement and management of health financing system sub-functions of revenue collection, pooling, and purchasing, and policy on benefits and rationing towards efficient and equitable system.[30] The reforms explored are linked or can be attributed to have resulted from global discourses on sustainable development agenda or SDG declaration.

In order to improve the transparency and methodological robustness of this scoping review of literature, preferred reporting items for systematic review and meta-analysis (PRISMA) guidelines was adopted[31], where the review questions were defined; studies were identified, selected and appraised; and data was abstracted; and results synthesized and interpreted. The review questions were: a) How has the SDG declaration influenced the process of health financing reform for UHC? b) What dimensions of health financing have been influenced by the SDG declaration? and c) How have Ministries of Health and other stakeholders used the SDG declaration to influence health financing reforms for universal health coverage?

Criteria for considering studies for the review

All study designs were considered for the review. This was to account for the complex nature of health financing reforms. Specifically, randomized and non-randomized studies, evaluation studies, policy analyses, stakeholder analyses, and peer-reviewed case studies and commentaries were included. Proposals and studies published in abstracts only were excluded.

The inclusion criteria based on population, intervention (exposure) and outcome (PEO) [32], required that the study reviewed: *(i) Is* on health systems reform, or other government reforms where health financing is a part of the reform process, or is specifically on health financing reforms, and is published between Jan 2012 and June 2020. This date was chosen to include studies conducted after the 2012 Rio de Janeiro United Nations Conference on Sustainable Development, where the process of developing SDG was initiated. (ii) Describes how SDG declaration has influenced reforms in health systems financing for UHC as the intervention. (iii) Reports on changes to at least one of the following health financing dimensions of management or organization i.e., revenue collection, pooling, purchasing, and policy on benefits and rationing as the outcome.

Search methods for identification of articles for the review

A comprehensive electronic search of six databases was conducted using indexed and free text words in the following databases: Ovid Medline, PubMed, EBSCO, Scopus, Web

of Science between March and September 2020. In searching the electronic databases, various conceptual terms for “sustainable development goals" and "health financing" were searched. Boolean operators, ‘OR’ was to combine the terms within each concept and ‘AND’ to combine the two concepts. In the search, filters for study type, language (anticipated the use google translate for non-English articles), country or geographical area were not used in order to find as many studies on the topic as possible. In addition, reference lists of included studies from the databases were screened for additional eligible articles. A manual search for relevant articles from publications on websites of WHO, online journals (health systems and reforms, health policy and planning), UHC2030 partnership was conducted. Google scholar was also searched using the same terms used in databases search.

In order to gauge the viability of the review, a pilot electronic search on PubMed using the aforementioned terms was first conducted. The search yielded 692 potential articles. From initial screening of titles and abstracts, 69 articles were considered potentially eligible. Of the 69 articles, one was in Chinese and one in Spanish, the rest were in English. From the 69 articles identified, 68 full length articles were retrieved, the exception being the one published in Chinese. The article in Spanish was translated using google scholar. After review of full-length articles of the 68 studies, two studies were found to meet our eligibility criteria; Agustina *et al*[33] and Wang and Zhou.[34] In addition to gauging viability of the review, the pilot search enabled improvement in screening and eligibility, data abstraction and quality assessment tools in terms of appropriateness and uniform application of criteria across articles, thus enhancing the validity of the process and minimizing bias in the study identification and selection.

Data collection, extraction and analysis

Selecting studies: All retrieved articles from the databases were exported to EndNote X9[35], where duplicates were removed. The titles and abstracts of identified articles were screened for potential eligibility. Full text of studies judged as potentially eligible were retrieved. The text retrieved were screened in detail for eligibility, using a standardized screening form (see Section 7.8). The number of studies included and excluded are documented and illustrated in the PRISMA flow diagram (Figure 7.1). The full texts of all

relevant studies found to meet the inclusion criteria were retained for the final synthesis.[36] The studies that failed to meet the inclusion criteria at the full-text screening phase were excluded from the analysis.

Data extraction: Data was abstracted using standardized data abstraction form adapted from the Joanna Briggs Institute (JBI) data abstraction format (see section 7.8).[37] Study characteristics extracted included the bibliographic details (study title, author, year of publication), objectives (purpose of the study), study design, setting (country); influence of SDGs declaration on health financing reforms; the dimension or aspect of health financing system reformed; and how ministries of health and other stakeholders have used SDGs declaration to drive health financing reform for UHC (Table 7.1).

Appraisal of studies: For this study, the plan was to assess the quality of included articles for analysis using the Joanna Briggs Institute's critical appraisal checklists for qualitative, quantitative and mixed-methods studies, however after reflections of the eligible articles, this was not conducted. This was because some studies included for analysis did not typically use the conventional approaches to conducting studies, these were mainly the commentaries and health system reviews, yet they met our eligibility criteria. Quality assessment was meant to support judgement on the relative contribution of each study to the development of explanations and relationships between SDG declaration and health financing reforms. However, given the review questions, quality assessment of articles would not have swayed these explanations of the relationship between SDG declaration and health financing reforms for UHC.

Synthesis and Interpretation of results: NVIVo and a thematic framework (Section 7.8) were used to facilitate analysis. Thematic framework synthesis is a qualitative approach that involves selecting, recording and categorizing key issues and themes.[38] For each article, the process involved familiarization with information, identification, recording, categorization and interpretation of the influence of SDG declaration on health financing reforms, and how Ministries of Health and other stakeholders have used the SDG declaration to advance health financing reforms towards UHC. Kutzin's[8] framework for analyzing health financing systems was used to examine the changes in the organization and/or management of health financing functions. The documented changes in health

financing were then related to the SDG declaration. Findings on the three review questions are presented narratively in the following section.

7.4 Results

Overview

The study selection process is summarized in the PRISMA flow chart (Figure 7.1), while section 7.8 indicates the databases searched, searched dates and the yield. Out of 1,313 citations, we identified 12 eligible studies. We excluded 71 articles at the full-text screening phase due to the following reasons: - the study did not discuss or indicate SDG declaration as a factor in health financing reform process, not a health financing study but discusses other UHC dimension like improving services coverage, study on trends in health financing indicators with no discussion on how it has been affected by SDG declaration, and studies on SDG not related to health financing reforms.

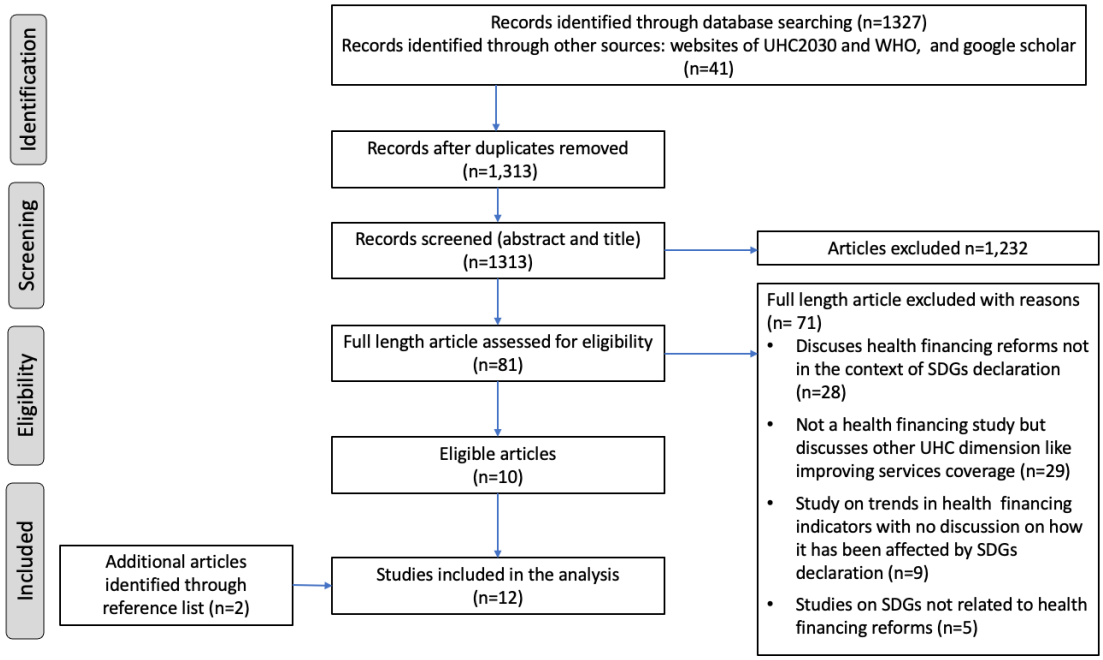

Figure 7.1 PRISMA Flow Chart

Characteristics of included studies and methodological appraisal

Table 7.1 describes the characteristics of the included studies in terms of study design, country of study, and year of publication and summary of findings related to the three review questions. The twelve (12) articles included for analyses related the global sustainable development agenda or SDG declaration to health financing reforms, either as part of the background statements, findings, discussion or conclusion sections and made reference to a particular country. Two articles each were from China[34,39] and Philippines[40-41], and one each from Indonesia[33], India[42], Bangladesh[43], Zambia[44], Iran[45], Republic of Korea[46], Lao People's Democratic Republic (LPDR)[47] and Nepal.[48]

Three (3) of the articles[40-41,43] can be described as mixed method studies, however they had limited or no statistical analysis rather simple trends or graphs of health financing quantitative indicators such as the level of out-of-pocket expenditure, health expenditure as proportion of total government expenditure and level of household impoverishment due to health spending. Two studies were quantitative[45,47], four were qualitative studies[33-34,46,48] while three were commentaries.[39,42,44] The three commentaries were informed by personal experience and backed up by literature citations. Of the three mixed studies, one[41] was a health system review using non-conventional approach to the conduct of research studies. All studies and commentaries reviewed were based on data collected through documentary review except the one study by Capuno *et al*[40], that also involved key informant interviews.

Table 7.1: Characteristics of the included study and findings

Author, Year, Country, study design	**How has SDGs influenced the process of health financing reforms (HFR) for UHC?**	**What dimensions of health financing have been influenced by SDGs declaration?**	**How stakeholders used the declaration to influence HFR for UHC**
Agustina e*t al*, [33] 2019, Indonesia, *Study design:* Qualitative,	– SDGs led to discussions on health financing sustainability for UHC – Establishment of a scheme that was adaptable,	<u>*Revenue Collection*</u> – Intense solicitation of payments from self-enrolled members	

Author, Year, Country, study design	How has SDGs influenced the process of health financing reforms (HFR) for UHC?	What dimensions of health financing have been influenced by SDGs declaration?	How stakeholders used the declaration to influence HFR for UHC
documentary review	accommodate diverse needs, assures financial risk protection – In 3 years (by 2019), the NHIS became the largest single-payer health insurance scheme in the world	– Categorization of contributors/sources of revenue for pooled fund *Pooling of funds* – Reduced fragmentation in risks pools – Establishment of Social Security Agency for Health (SSAH) – Law of mandatory % allocation of government budget to health *Purchasing* – A Single payer for UHC established – Payment-capitation and diagnostic-related group based on Indonesia tariff. *Policy on benefit entitlements* – Scope of services covered by capitation payment is determined by Indonesian Medical Council – Decrease in fee-for-service payment	
Fahim *et al*, [43] 2018, Bangladesh, *Study design: Mixed method,*	– The national health policy 2011-2032 updated to address contemporary issues of SDG and UHC – Health financing policy emphasizing solidarity in financing, equity of	*Pooling of funds* – Policy emphasis on allocating a significant percent of government spending to health – Exploring ways of reducing OOP	

Author, Year, Country, study design	How has SDGs influenced the process of health financing reforms (HFR) for UHC?	What dimensions of health financing have been influenced by SDGs declaration?	How stakeholders used the declaration to influence HFR for UHC
documentary review	access and provision of quality care		
Chilufya and Kamanga, [44] 2018, Zambia, *Study design:* Commentary *Study aim:*	– Zambia's transformational health agenda is in tandem with SDGs target 3.8 – Health sector strategic plan 2017-2021 was informed by the SDG agenda – Country building on the progress past health reforms during SDG era.	*Revenue Collection* – Exploring ways of implementing sustainable health care financing – Mandatory pre-payment contribution being established *Pooling of funds* – Commitment to allocating sufficient government funding for health – Establishment of NHIF fund as a pooling agency *Purchasing* – Exploring reforming payment mechanism from inactive to active purchasing	
Ahmadnezhad et al, [45] 2019, Iran, *Study Design:* Quantitative, document review	– Health transformation plan recalibrated to form part of government commitment on SDG agenda	*Purchasing* – Ministry of Health and Medical Education (MOHME) reduced co-payment *Policy on benefit entitlements* – Basic health insurance coverage extended from 83.2% of population to 93.2% – Aim to decrease prevalence of catastrophic	

Author, Year, Country, study design	How has SDGs influenced the process of health financing reforms (HFR) for UHC?	What dimensions of health financing have been influenced by SDGs declaration?	How stakeholders used the declaration to influence HFR for UHC
		expenditure to less than 1% by end of 2021	
Lee et al, [46] 2019, Republic of Korea, *Study design:* Qualitative, documentary review	– In 2017, government announced NHI reform 'Moon Jae-in care' to increase coverage rate to 70% by 2022 and its considered a government's commitment to health-related SDG – Reinforcing the benefits and financial coverage of national health insurance (NHI) is a core aspect of the reform – The advent of SDGs and inclusion of the President's name in the health financing reform indicates how seriously the government has taken health financing reforms for UHC	*Policy on benefit entitlements* – The population already covered, reform focuses on increasing the scope/depth of coverage and reducing cost-sharing – Reducing out-of-pocket (OOP) from the cost sharing component to minimize the catastrophic and impoverishing expenditure	
Nagpal et al, [47] 2019, LPDR, *Study design:* Quantitative,	– Approved national health insurance (NHI) Law in 2017 – To achieve the health targets in the SDG and meet new and emerging challenges, the Government of	*Pooling of funds* – In 2016/17, free MCH program was consolidated with 3 other social protection schemes into a single national health insurance scheme	

Author, Year, Country, study design	How has SDGs influenced the process of health financing reforms (HFR) for UHC?	What dimensions of health financing have been influenced by SDGs declaration?	How stakeholders used the declaration to influence HFR for UHC
review of surveys data	LPDR accelerated its efforts towards universal health coverage, e.g. the nationwide scale-up of free at point of care MCH services – The NHI was quickly rolled out in 15 provinces by the end of 2017, and covered the entire country except Vientiane capital by the end of 2018	(reducing number of risk pools), *Purchasing* – User fee payment by pregnant women and children under 5 replaced by case-based payment under the MCH initiative	
Capuno et al, [40] 2018, Philippines, *Study design:* Mixed method, depth interviews and documentary review	– Duterte government's aims to attain the health-related SDG targets through extending health insurance coverage to all, thus ensuring each Filipino "financial freedom when accessing services", – The Philippines Health Agenda 2016-2022 was informed by and has taken into consideration Philippines commitment to SDG agenda – Main health goals and strategic policies including on health financing are reflected	*Revenue Collection* – Continued preservation of Sin Tax for health – Earmarking has helped to sustain progress towards achieving of SDG target on UHC *Purchasing* – PhilHealth as single purchasing agency *Policy on benefit entitlements* – Poor, marginalized and vulnerable protected from cost of health care through Sin Tax	– There is stronger link between DOH's national objective for health and the national development plan following the SDG declaration – DOH was successful in generating political and financial support to pursue universal health access and in legislating various proposal e.g. Sin Tax Law

Author, Year, Country, study design	How has SDGs influenced the process of health financing reforms (HFR) for UHC?	What dimensions of health financing have been influenced by SDGs declaration?	How stakeholders used the declaration to influence HFR for UHC
	in the Mid-term Philippine Development Plan developed based on ambition to achieve SDG targets		
Dayrit et al, [41] 2018, Philippines, *Study design*: Health system review, mix method	– SDGs has informed Philippine Health Agenda [Administrative Order No. 2016-0038] which is about reforming PhilHealth into main national purchaser of health services – SDGs is seen as facilitator of natural progression towards universal health access	*Pooling of funds* – Changes in pooling arrangement with mandatory PhilHealth cover *Purchasing* – Reformed capitation and no-balance billing arrangement for members – Fee-for-service phased out and case-rate payment applied by PhilHealth *Policy on benefit entitlements* – Increased benefit ratio - expanding enrollment of the poor in the NHIP & promoting quality of services	
Ranabhat et al, [48] 2019, Nepal, *Study design*: Systematic review	– National health system has prioritized achievement of UHC in line with UN SDG declaration	*Policy on benefit entitlements* – Free maternal and child health (MCH) services at point of care – Development of MCH service package – Nationwide scale-up of the scheme following limited geographic scope	– Lobby by visionary health care professionals, international organization and interest groups that consistently made reference to government

Author, Year, Country, study design	How has SDGs influenced the process of health financing reforms (HFR) for UHC?	What dimensions of health financing have been influenced by SDGs declaration?	How stakeholders used the declaration to influence HFR for UHC
			commitment to SDGs led to establishment of national health insurance program. – In 2016 the government through Ministry of Health and Population started social health insurance scheme in some district and extended to 22 other districts by 2018.
Gera et al, [42] 2018, India, *Study design*: Commentary	– Government has taken important policy level initiatives in the recent years, especially after the launch of SDGs that include establishment of National Institution for Transforming India (NITI Aayog) and roll out of national health policy 2017. – The Integration of SDG agenda in NHP-2017 and NITI Aayog's Vision for Health (2032) has provided an unprecedented	<u>*Pooling of funds*</u> – Establishment of new flagship National Health Protection Scheme recently launched by the union government <u>*Policy on benefit entitlements*</u> – Exploration on how to incrementally expand coverage to cover larger population proportion and the range of services covered	– Leadership of federal Ministry of Health (MOH) has fostered a collaborative effort with other Government ministries and agencies, and state governments in the SDG era leading to the formation of national health protection scheme. – Effective stewardship

Author, Year, Country, study design	How has SDGs influenced the process of health financing reforms (HFR) for UHC?	What dimensions of health financing have been influenced by SDGs declaration?	How stakeholders used the declaration to influence HFR for UHC
	opportunity for health financing reforms for UHC		from the federal MOH, reorganization of health care service delivery and strengtehing community participation and accountability.
Wang et al, [34] 2020, China, *Study design*: Qualitative, documentary review	– As part of Healthy China 2030, health is considered crucial entry-point to achieving SDGs because of its ability to lift people out of poverty – "Healthy China 2030" will improve access to essential health services covered by health insurance and financial assistance scheme	*Policy on benefit entitlements* – 95% of the population covered by health insurance schemes – Improved medical care insurance for targeted poverty-stricken population	
Tan *et al*, [39] 2018, China, Study design: Commentary	– Healthy China 2030 was a response to the 2030 United Nations SDGs – A momentous endeavour to enhance public health	*Revenue Collection* – Encourage development of commercial health insurance schemes to supplement National Health Insurance Schemes *Policy on benefit entitlements* – Improved health insurance system targeting economically backward region	

Author, Year, Country, study design	How has SDGs influenced the process of health financing reforms (HFR) for UHC?	What dimensions of health financing have been influenced by SDGs declaration?	How stakeholders used the declaration to influence HFR for UHC
		– Healthy China 2030 has led to financial protection for the poor	

The focus of this study was on finding descriptions or explanations of the relationship between SDG declaration and health financing reforms for UHC. Therefore, analyses did not focus on the quantitative aspect of the articles reviewed, rather identified qualitative data from either the background, findings, discussion and conclusion sections that provides explanation or describes the relationship between SDG declaration and HFR for UHC.

Influence and use of SDG declaration in health financing reforms for UHC at national level

How has the SDG declaration influenced reforms in health financing for UHC?

On this review question, three themes emerged, these are: - national discussion on best ways to achieve UHC (agenda setting for UHC), legislation on health financing and budgets, and update or revision of national health (financing) policies and plans.

National discussion on how best to achieve UHC in the SDG era (Agenda setting): From the reviewed articles, the SDG declaration has informed, caused or intensified national level discussions of health financing for UHC[33-34,39-41,48] and in some instances accelerated the pace with which governments considered the issue of UHC and its financing.[42,46-47] Agustina and colleagues[33] report that national level discussions in Indonesia on UHC scheme concluded that the scheme to be established should be adaptable, accommodative to the diverse needs and affordable as mandated by SDG declaration. These discussions resulted in consensus on four policy areas for implementation to ensure health financing sustainability for UHC, these were - increase in premium to be paid by national health insurance contributing members, designing and implementation of cost containment measures, improving reimbursement process and

promoting efficiency.[33] In Philippines, the Health Agenda 2016-2022 which include reforming PhilHealth as the single purchaser of health services and deepening health insurance coverage was informed by government's commitment on SDG.[40-41] While in Nepal, following the SDG declaration, the issue of financial risk protection when accessing health care has been prioritized by the government.[48]

Tan and colleagues[39], reports that Healthy China 2030, a Chinse government blueprint on health (including financing of health care services especially for the poor regions) and socio-economic development was in response to SDG declaration. Health is considered a crucial entry point to achieving sustainable development goals, majorly due to its ability to lift people out of poverty. [34] In the Republic of Korea, the issue of improving financial coverage for the underprivileged has been on-going for years, however with the advent of SDG, this has now been taken more seriously by the government.[46] Nagpal *et al* [47] indicates that to achieve health targets in the SDG, the government of Lao People Democratic Republic (LPDR) accelerated its efforts toward UHC. While Gera and colleagues[42], report that the rollout of India's national health policy had been delayed many times. However, this process was accelerated, demonstrating proactiveness by the government following the SDG declaration.

Legislation on health financing and budgets: The global discussions on sustainable development and the eventual SDG declaration in 2015 has led to the passing of specific Laws on health financing in some countries. As part of national reforms for achieving UHC, the Indonesian government passed a Health Law mandating that 5% of national budget goes to the health sector and local governments were directed to allocate 10% of its budget to health services. [33] In the LPDR, a national health insurance (NHI) Law was approved in 2017 as part of the national health financing strategy 2017-2020, which was informed to a great extent by the SDG declaration and the need to achieve UHC. [47] Following the global sustainable development declaration, the Philippine Government through an Administrative Order reformed the PhilHealth into the single and main national health purchasing agency with the aim of attaining health related SDG targets through extending health insurance coverage to all Filipinos.[40-41]

Revision of national health policies and plans: Reviewed studies indicate that countries updated their national health (especially financing) policies to address issues in the SDG[40,42-44] Bangladesh for example, updated its national health policy 2012-2032 to address contemporary issues of SDG and UHC.[43] In particular, the health financing policy objectives were revised to ensure reduction in out-of-pocket expenditure on health care to below 32% of total health expenditure.[43] In Zambia, the health sector strategic plan (HSSP) 2017 in which health related SDG targets are anchored focusses on six pillars, with reforming health financing to ensure UHC one of the key pillars.[44] In the Philippines, the health goals and strategic policies including on health financing have been developed based on the ambition to achieve SDG target on UHC.[40] India's Government has taken important policy decisions after the launch of the SDG such as the establishment of National Institute for Transforming India and rolled out the national health policy (NHP) 2017.[42] Gera et al[42], reports that the SDG agenda was incorporated into NHP 2017 before it was rolled out and that this provided an opportunity for health financing reforms for UHC. China launched the Healthy China 2030 following the SDG declaration.[39] One of the major aims of Healthy China 2030 is the protection of citizens especially in poor regions from financial risks associated with access to health care through reforming rural health insurance schemes.[39]

What dimensions of health financing have been influenced by the SDG declaration?

The reviewed articles demonstrate that since the SDG declaration, there have been observable changes in either the process or outcome of the health financing functions, and policies on benefits and entitlements. These are elaborated below.

Revenue collection: Reviewed studies report changes in aspects of revenue collection or that countries are exploring alternative approaches to revenue collection for health services. Following the SDG declaration, Indonesian government through its Ministry of Health (MOH) embarked on the categorization of contribution into three sources of pooled funds, this was to enable identification of population proportion that has to be paid for through general tax revenue.[33] In addition, there has been intense solicitation of payments from self-enrolled members to national health insurance scheme.[33] In Zambia, the government has embarked on development of approaches for implementing a sustainable

health care financing, especially the establishment of pre-payment contribution to supplement tax and donor funding.[44] Capuno and colleagues[40] report that the SDG declaration has made it easier to justify continued allocation of 100% of Sin Tax to health in the Philippines. While in China, as part of Healthy China 2030, the government has encouraged the development of commercial health insurance schemes to supplement the national scheme.[39]

Risk Pooling and purchasing: Following global discussions and the declaration on sustainable development, the reviewed studies indicate that countries in effort to improve financing towards UHC established pooling agencies or transformed the operations of the existing national insurance pooling or purchasing agencies. In Indonesia, LPDR and Philippines, there have been consolidation and reduction in fragmentation of risk pools to improve efficiency.[33,41,47] Indonesia established Social Security Agency for Health (SSAH) as the main (single) national purchaser of health services[33] and the Philippines transformed PhilHealth into a single purchasing agency.[40-41] In Bangladesh, the policy has emphasized solidarity in health financing and increased government allocation to health. [43] In Zambia the process of establishing a national health insurance fund as a pooling agency is in advanced stages.[44] Meanwhile in India a new national health protection scheme was established to provide health insurance cover by pooling risks, not covered by state governments.[42]

On the purchasing function, payment mechanisms were changed from fee-for-service to capitation and/or diagnostic related group (DRG) based on the case-based payment in Indonesia, Philippines and LPDR.[33,41,47] Zambia's government is also exploring ways of making Ministry of Health an active (strategic) purchaser as opposed to the current inactive purchaser of health services, including instituting a purchaser-provider split mechanism.[44] In Iran and Philippines, balance billing or co-payment were removed to drive down out-of-pocket payments.[41,45]

Policies that define and ration benefit: The reforms occasioned by SDG declaration on health financing has led to improvement in depth of coverage (extent to which covered services are paid for) in Indonesia and Korea[33,46] and increase in population coverage (proportion of population eligible for covered services) in Iran, Philippines, India and

China.[34,39,41-42,45] The 'Moon Jae-in' reform launched in 2017 increased coverage rate by 70%, and reinforced benefits and financial protection provided by the national health insurance scheme in the Republic of Korea.[46] While in Iran, the basic health insurance coverage has been extended to 93.2% of the population.[45] The Philippines government has focused on extending coverage to the poor, marginalized and vulnerable population, ensuring they are protected from cost of health care through allocation of Sin Tax to cover for their premium.[40] In China by 2019, 95% of the population were covered by health insurance schemes thus increasing access with protection from financial risk.[34] In addition, the range of services covered under insurance schemes have been improved in the poverty-stricken regions of China.[34,39]

How Ministries of Health and other Stakeholders are using SDG declaration to influence health financing reforms for universal health coverage?

Reviewed articles indicate that Ministries of Health have put efforts on fostering collaboration with other government agencies[42] and focused on linking health objectives with overall national development plans.[40] Capuno and colleagues reports that the Department of Health (DOH) established a strong link between national objective for health and the national development plan and national budget formulation process following the SDG declaration.[40] This was through generating successful political and financial support from the entire government. This has enabled the Ministry to pursue universal health care access agenda, including support for legalizing various proposal such as Sin Tax Law, where 100% goes into insurance coverage premium for the poor. In India, the leadership of national Ministry of Health and Welfare has actively fostered a collaborative effort with state governments leading to formation of national health protection scheme, to supplement state governments' health insurance schemes. In addition, effective stewardship from national Ministry of Health and Welfare has led to reorganization of health care services delivery to implement a system-wide change that ensure financial protection against health costs through community participation and by being accountable.[42] Health care professionals and non-governmental organizations lobbied for the establishment of a national health insurance scheme in Nepal, arguing that health insurance will contribute to socio economic growth that will spur the achievement of other SDG targets.[48]

7.5 Discussion

This review explored how global discussions on sustainable development agenda and the SDG declaration influenced health financing reform processes for UHC at the national level. The review indicates that SDG declaration has influenced health financing reforms. The influence is majorly through two ways; (i) putting and sustaining health financing reforms (HFR) for UHC on the national agenda, and (ii) providing enabling context for debating and passing of Health Laws and reviewing of national health policies to strengthen health financing systems for UHC. Since the start of global discussions on sustainable development in 2012 and the eventual declaration on SDG in 2015, the issue of how to sustainably finance health more efficiently and equitably has dominated national discussions or gained momentum.[33-34,39-42,46-48] Countries have enacted Health Laws[33,47] or reviewed and revised national health policies and strategies so that they are in tandem with the international commitment on SDG and UHC.[40,42-44] These findings demonstrate the potential of SDG in promoting a more expansive and interrogative approach to creating systems for better health financing. This is through pushing various stakeholders to engage and seek ways of collaborating and finding appropriate mix of legislation, regulation, policies and guidelines to drive sustainable financing for UHC.

The outcome of the SDG declaration influence can be observed in changes (or proposed changes) to the organization and arrangement in health financing functions and policies. Countries such as Korea and China, where population coverage is over 90% are focusing on two of the three dimensions of UHC i.e., increasing the number of services covered and the extent to which a service is covered (depth of financial coverage), and not merely proportion of population coverage with basic health care. China and Korea are examples of countries demonstrating that UHC is a journey, even when majority of population is covered with basic health care, breadth and depth of coverage can still be improved. The SDG declaration has provided a catalyst for the needed improvements.[8,49]

In terms of revenue collection, countries such as China, Republic of Korea and Indonesia are looking at covering the poor and indigent via general tax revenue. In addition, China is encouraging growth of commercial insurance schemes to supplement public health insurance scheme. Philippines is using Sin Tax (earmarked tax) to cover the premium for

the poor while Indonesia is utilizing a Law that compels government to allocate a specific percentage to health sector budget. Zambia wants to develop national health insurance scheme as a way to supplement government general tax revenue and donor funding. In all these manoeuvres by countries to improve available funding for health, the attainment of UHC as one of the SDG targets is being cited. However, as has been noted by Kutzin and WHO[8,14,50], it is prudent for governments to appreciate that all the revenues come from the people, in one way or another. Therefore, the focus should be on equity and efficient pooling and use of these resources.

Increasing the share of total public spending devoted to health or increasing the level of compulsory prepaid revenues for health, strategic purchasing, minimizing fragmentation of risk pools, and simplification and promotion of the benefit package to increase people's awareness of their benefits are pointers of reforms in health financing directed towards UHC.[8] Most of the reviewed articles point to the fact that countries' changes to health financing functions are towards UHC. However, aspects such as encouraging commercial health insurance, as in China or explicit introduction of insurance scheme as a supplement to government and donor funding, as indicated for Zambia's case may run counter to UHC aspiration and needs to be undertaken with caution.

Ministries of health and stakeholders within the health sector have leveraged on the SDG declaration to pursue health reforms through lobbying[48] and strategic engagement of stakeholders to generate political and financial support and buy-in into the reforms.[40,42] The successful use by Ministries of Health and other stakeholders of government commitments to international agenda seems to depend in part on the leadership capacity and the ability to demonstrate that the health objectives are in tandem with overall national development plan and global aspirations. As Agyepong[51] argues, strong leadership and administrative capacity is required within countries to determine, design and implement contextually appropriate policies for UHC.

Given the political nature of reforms, approaches that make a political leader recognized or appear to be behind the reform such as including their name in the reform is another strategy that may work in some contexts, for a whole of government buy-in. This can be seen in the case with Republic of Korea and in the Philippines.[40-41,46] Active engagement

of sub-national governments and other stakeholders by Ministries of Health can smoothen the process of introducing new health financing policies, as the case of India demonstrates.[42] The UHC2030 partnership[52] argues, "Parliamentarians, Ministers and Local Government officials play a major role in promoting, financing and implementing UHC, and their commitment and action are critical for global commitments to be translated into local solutions".

To the best of my knowledge this is the first review literature examining the relationship between SDG declaration and health financing reforms for UHC. The strength of this study is the methodological approach adopted includes the pre-publication of a protocol where peers provided comments that helped to improve the method section, a rigorous and transparent review process, and adherence to standard methods of reporting reviews. In addition, multiple databases were searched and references of identified articles were screened for additional eligible articles.

A limitation was anticipated related to finding adequate number of studies reporting on reforms in health financing in countries that have been driven by SDG declaration. The reform processes take time and yet the SDG declaration was only made towards the end of 2015. This was addressed by not restricting search by country, language or study design, and searching gray literature. This still appears to have remained a weakness in this study as only twelve articles were eligible (Figure 7.1). However, this review remains a valuable addition to the field of health policy and systems research as it is the first review of literature exploring the linkage between SDG declaration and health financing reforms for UHC at the national level.

Only two of the twelve articles[42-43], made attempts at describing how ministries of health and other stakeholders have utilized SDG declaration to influence health financing reforms for UHC. They identified lobbying, aligning health objectives to national development plan and budgeting process, and engagement of local governments while referring to government commitments to SDG as some of the approaches used to influence health financing reform process. Apart from one study[40], all the reviewed articles used documentary review as sources of data. To fully understand how SDG declaration is influencing health financing reform processes for UHC, it is better to interview

stakeholders at the national level. This is because document review only is unlikely to unearth salient approaches being used by stakeholders in ensuring SDG declaration provides opportunity for health financing reforms for UHC. Through document reviews only, it is also difficult to examine other contextual factors including values that are influencing the use of SDGs declaration in reforms towards UHC. Therefore, it is difficult to draw conclusive lessons that can be adapted by stakeholders attempting to achieve similar outcomes reported in some of the reviewed articles as being influenced by the SDG declaration.

7.6 Conclusion

Global declarations can be used as tools for lobbying, negotiation, re-strategizing and political mobilization. The SDG declaration has influenced reforms in health financing towards UHC by putting the issue on the national agenda, providing reference for the passing of national Laws to facilitate better health financing, and causing countries to revise their national health financing policies. The effects of these are observable in processes or outcomes in health financing functions and polices. These include among others seeking alternative approaches to revenue collection and earmarking of revenue for health, improving pooling arrangements such as reduced fragmentations, pursuance of strategic purchasing methods, expanding coverage with a focus on all the three dimensions of UHC (population coverage, financial coverage and number of services paid through pool funds).

A critical gap in literature is the documentation of how the stakeholders, including Ministries of Health have used the declaration as opportunity to cause change in health financing towards UHC. Most authors only report on outcomes, while neglecting what explains what happened; an aspect that are better appreciated through getting the perspectives of stakeholders through interviews. There is need for studies to document the countries experiences for shared learning on how the stakeholders in the health sector including Ministries of Health are utilizing SDG declaration in fostering desired reforms from their perspectives.

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7.8 Supplementary Material

Eligibility screening of articles

a) Screening for potential eligibility

- Duplicate removal
- Title and abstract information screen against the following
    - Mention of health financing or health reforms in title or abstract
    - Mention on SDGs title or abstract
    - Published in 2012 or after

b) Eligibility for inclusion of full-length articles for analysis

Year of publication:

Variables for assessments	***Yes/No***
Population (*health financing reforms, health systems reform with aspect on financing*)	
Exposure (SDGs used to influence reforms: put on national agenda, the speed of the reforms, stakeholders-number, interest, power)	
Outcomes (Description of the change in financing)	
Impact (Equity, Protection, Quality)	
Include	

Results from the search strategy

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Data abstraction form

Reviewer: _____Date of data extraction: _____

Bibliographic details of study (author.Year.Title.Journal/vol,no.pg)

Purpose of study:

_____

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Study design (methods/methodology):

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Participants_____

Country of Study: _____

Data Analysis_____

Health financing reform process examined

_____

Outcomes of the health financing reform _____

Role of the SDGs declaration in the reform

_____

Comments_____

Complete. **Yes**_____ **No**_____

Findings	Illustration form publication (page number)

Extraction of findings complete. Yes_____ No_____

Thematic framework analysis format for summarizing changes in health financing occasioned by SDGs declaration

Study	How SDGs has been used to/or influenced financing reforms (emerging themes)	Aspects of the health financing reformed or being reformed (health financing sub-functions* organization and management)	Key issues or lessons and impact (quality of care, financial protection, equity)

*Revenue collection, revenue pooling, benefits design and service purchasing

CHAPTER 8 : HOW IS THE SUSTAINABLE DEVELOPMENT GOALS DECLARATION INFLUENCING HEALTH FINANCING REFORMS FOR UHC IN UGANDA: A STAKEHOLDERS' PERFECTIVE

8.1 Abstract

Background

Health financing reforms (HFR) are required for the achievement of Universal Health Coverage (UHC) in Uganda. UHC is a key sustainable development goals target and with the Uganda being a signatory to the sustainable development goals (SDG) declaration, it is anticipated that this global development agenda will influence the HFR for UHC. However, how the declaration has influenced or is influencing HFR for UHC discourses at the national level have not been explored. This study was therefore conducted to add scholarship in this area and add information to ongoing discussions on health system financing in Uganda.

Methods

This was a qualitative study involving respondents purposively selected at the national level. The data were analyzed thematically, and results presented narratively. In addition, the respondents refined a theory of change (TOC) proposed for examining how global declarations influence national level policy reforms.

Results and discussion

Twenty-two (22) respondents participated in the study. Findings indicate that there have not been major reforms in the health financing functions and policy on benefits. Limited reforms were in the areas of abolition of user fees, results-based financing (RBF), and programme-based budgeting (PBB). However, these reforms have not had major effects on the health financing system's goals of universal financial protection. The SDG declaration has resulted in increased interest in health financing for UHC amongst stakeholders. The declaration has led to health financing becoming a key national agenda item especially with discussions on establishing a national health insurance fund (NHIF) which has appeared in the campaign manifesto of the ruling party twice. The HFR for UHC

has also been well elaborated in the national development plan as part of efforts to achieve the SDGs. In addition, the SDG declaration has also informed the development of health financing strategy and the drafting of the NHIF law. However, this catalytic phenomenon by a global agenda to influence national level processes is tempered by factors such as the nature of the policies to be transferred, potential effect on the political and bureaucratic status quo, the financial and technical support by partners and alignment with the government agenda.

Exploring complex processes such as the health financing reforms within the context of SDGs requires theory-driven frameworks. Therefore, as part of this study and through an iterative process with the selected respondents, a TOC has been proposed for examining national level reforms and the global to national policy transfer processes happening in the context of the global agenda discussions related to such reforms.

Conclusion

The SDG declaration has provided a platform for advocacy, reactivated health financing reforms processes such as the establishment of a NHIF, put health financing issue firmly of the national agenda in Uganda and is providing a reference point for development of legislations and policies on financing UHC.

Key Words

Sustainable development goals, Universal health coverage, stakeholders, Uganda, health financing reforms

8.2 Introduction

Global policy agendas such as sustainable development goals are meant to influence national level policies. The influence involves policy transfers by agents at international and national level. The study explored the perspectives of stakeholders in Uganda on how the SDG declaration is influencing health financing reforms (HFR) for universal health coverage (UHC) and secondly, developed a theory of change (TOC) that can be used in exploring or evaluating the influence of the SDG declaration on HFR for UHC.

Understanding the influence of the SDG declaration on HFR for UHC is important for countries such as Uganda where the health financing reform process for UHC was already ongoing, albeit slowly.[1] The findings from this study also contributes to our understanding of how the global health policy agendas are transferred to the national level in sub-Saharan Africa, an area of policy transfer scarcely studied in low- and middle-income countries (LMIC).[1]

Most studies on the global health agendas have focused on documenting the outcome at the expense of the process yet understanding of the process can help to explain how the outcomes were achieved.[1] In addition, national level stakeholders' perspectives can provide explanations on why certain policy propositions are not transferred to or implemented at the national level despite broad consensus on their coherence at the global level.[2] Therefore stakeholders' perspective play a critical role in understanding policy transfer processes[3] and the current study contributes to scholarship in this area.

Scarce scholarships on policy transfer of global health agendas especially in the field of health financing is likely related to limitations in existing frameworks and theories. Existing scholarships have focused majorly on technical and political economy analysis without identifying elements, salient conditions and policy transfer mechanisms in the interval between a global declaration and the desired outcome at the national level. Theory-driven frameworks such as a theory of change (TOC) would be more appropriate frameworks for comprehensive analyses or evaluation of complex processes on how global health agendas, policies and principles such as those embodied within the SDGs get transferred to the national level and cause desired outcomes.[4] For example, a TOC provides a description and illustration of how and why a desired change is expected to happen in a

particular context by mapping out middle components between what a global health agenda or initiative does and how it leads to the desired goals.[5]

A theory of change for health financing reforms for UHC following the SDG declaration at the national level would provide a better framework for evaluation and identifying key assumptions, sequence of intermediate outcomes or events, preconditions, enablers or inhibitors etc. between the outcome (the effective and equitable health financing systems for UHC) and the SDGs declaration.[6] Therefore, this study also set to propose a TOC that can be used for exploring causal linkages or the 'missing middle' elements between the SDG declaration and the desired outcome. In this case the 'process elements' between the SDG declaration and equitable, effective and efficient health financing systems for UHC from the perspective of national level stakeholders.

8.3 Methodology

Study design

An exploratory and explanatory qualitative study using a case study approach as described by Yin and others was conducted.[7-9] Uganda was the case in this study. A case study approach supports generation of in-depth, multi-faceted understanding of a complex issue in real-life context.[9] A case study approach was appropriate for this study, because this study sought to understand how the SDG declaration is influencing health financing reforms for UHC based on lived experiences of the study participants[10], in this complex process of translating global declarations into national action.

The study was conducted through a two-stage process. Firstly, comprehensive literature reviews on health financing reforms in Uganda; how global health policy agendas are transferred to national level in sub-Saharan Africa; and how SDG declaration is influencing health financing reforms at national level across the globe was conducted. A summary of findings from the three reviews are presented in Box 1. Details of the approaches and findings from each of the three review studies have been published[1,11-12], and are elaborated in Chapters 5 to 7. The reviews provided a contextual background for the thesis and informed the development of a draft theory of change (Figure 8.1) on how the SDG

declaration influences HFRs for UHC. Secondly, an in-depth key informant interviews were conducted with purposively selected informants from the national level on how SDG declaration is influencing health financing reforms for UHC in Uganda. The findings form the interviews is reported in this chapter.

Data collection

Key informant interviews (KIIs) were conducted with 22 purposively selected study participants from a wide array of key stakeholder groups active in the health financing field in Uganda (Table 8.1). This was done to ensure findings of the study have views from across all the key stakeholder segments who are usually important in health financing reforms including bureaucrats, political leaders, development partners (external group), budget group, and interest group as elaborated by Campos and Reich. The interviews focused on exploring changes in health system financing in Uganda between Financial Years (FY) 2000/2001 and 2020/2021, the influence of SDG declaration on health financing reforms for UHC in Uganda, factors that have facilitated and inhibited the use of the SDG declaration in influencing health financing reforms for UHC and what stakeholders consider important for successful transfer of SDGs policies to the national level for effective health financing of UHC.

Qualitative research methods in which key informants involved in the policy process are identified and interviewed enriches literature findings.[15-16] Respondents also improved the draft TOC (Figure 8.1) that was drafted based on literature review findings summarized in Box 1 into the final TOC that illustrates the desired outcome in health financing reforms as a result of the SDG declaration (Figure 8.2)

Table 8.1: Stakeholder groups that participated in the study

Stakeholders	Stakeholder group	Number of study participants
Senior Ministry of Health officials (MOH)	Bureaucratic &Leadership	4
CSOs representatives	Interest	4
Health Professional Associations	Interest	3
Health development partners officials	External	3
Researchers/Academics	Interest	2
Parliamentary committee on health	Leadership	2
Ministry of Finance	Budget	1
Other interest groups (e.g., private health insurance companies, private health service providers, Ministry in-charge of social protection)	Interest group	3

Key informant interviews lasted on average 40 minutes. The data was managed using NVIVO 12 Mac Version 12.1.0 from QR International.[13]

Data Analysis

Key informant interviews were recorded, transcribed, backed up and uploaded on NVIVO software[13] to facilitate the analysis. Data was analyzed thematically. The thematic analysis involved systematic coding and categorizing of textual information to determine trends and patterns, frequency, and their relationships.[14-16] Data was coded to categorize concepts into preconceived and emerging themes while preserving the core meaning. The pre-conceived broad themes were health financing functions of revenue rising, pooling and purchasing. In examining favourable factors facilitating use the SDG declaration to influence HFR and how the declaration is influencing HFR themes were allowed to emerge organically. In interpretation and use of quotes, some sections from the interview were edited for purposes of maintaining the subjects' anonymity and/or making the quotes more concise, or to correct the grammar. The draft TOC framework (Figure 8.1) guided the final interview guide used for the KII (Annex 3).

Ethical considerations

Ethical approval was sought from Makerere University School of Public Health (MakSPH) Higher Degrees Research and Ethics Committee (HDREC) and the University of Pretoria, Faculty of Health Sciences Research Ethics Committee as part of the overall thesis project (Annex 1). This study adhered to ethical principles including privacy during interviews, explanation on benefits of the research, risk minimization, sharing of findings, confidentiality and voluntary participation. During analysis where direct quotations are used, the respondents were assigned letter 'A' followed by a number, for example A1, A2, A3, etc.

This being a non-biomedical study, there were no significant risks anticipated to be faced through participation in the study. The only risk anticipated was exposure of disagreements or fissures among stakeholders involved in the health financing reforms, and thus impact on ongoing processes. However, this was not apparent during data collection and analysis process. The respondents were anonymized during analysis and study participants reviewed the final draft report. There were no anticipated direct costs of participation in the study. However, internet data bundles were provided to some of the respondents. This was due to a change from the planned face-to-face to virtual method of data collection occasioned by the COVID 19 outbreak.

Informed consents were obtained from the participants prior to interviews (Annex 2). Participants were informed about the recording of their voices before the interviews. None of the respondents refused the recording of their voices. The study participants were informed of no direct benefits from the study to them.

8.4 Results

Overview

The study explored how the SDG declaration has influenced or is influencing HFR for UHC in Uganda from the perspective of national level stakeholders. The findings were also used to develop a theory of change for exploring such complex processes.

To provide context, key informants first highlighted major reforms in health financing in the recent 2 decades before delving into how the SDG declaration is influencing HFR for

UHC in Uganda. The findings have been presented thematically, firstly highlighting the major reforms in health financing in Uganda, secondly outlining the factors stakeholders consider important for successful global to national policy transfers in the context of SDGs and health financing, thirdly the influence of SDGs on HFR, and lastly the development of theory of change.

8.4.1 Health financing reforms

Responses from key informants indicate that there have only been limited reforms in the organizational arrangement and functioning of the health system financing in Uganda in the last 20 years. The noticeable reforms and various attempts at reforming health system financing in Uganda from the perspectives of key informants are elaborated below.

Revenue rising**:** Responses under this function relates to sub-themes on source of funds, stability of fund flow and collection of funds. Generally, in terms of resource mobilization, the approach has remained the same as the quote from a respondent indicates.

> "*Resource mobilization has not had any major reforms. It is only the removal of the user fee. I think that happened around 2000-2001, it is the only key one that happened back then". A7*

Box 1: Summary of findings from three literature review studies[1]

Review study 1: A critical review of literature on health financing reforms in Uganda – progress, challenges and opportunities for achieving UHC

⇒ Health financing objectives during the 4 strategic plan periods spanning 2001 to 2021 have varied in focus from equity, to mobilizing additional resources to UHC. The variation in focus were informed by the low per capita expenditure on health and global level discussions on SDGs including adoption of UHC as one of the targets.
⇒ Reforms attempt for achieving the objectives were all aligned to the WHO health financing reform principles that advance UHC.
⇒ The key actors supporting reforms especially were the World Bank, WHO, Enabel and USAID
⇒ Comprehensive reforms in health financing especially establishing NHIF has been slow and is attributed to political, technical and economic challenges often associated with designing, developing and implementation of policy reforms.
⇒ Contribution of development partners to total health expenditure from 2001 to 2016 ranged between 27.4% and 43.4%. While private health expenditure (mainly through out of pocket) was between 54.4% and 42.6% in the same period.

Review study 2: How are global health policies transferred to sub-Saharan Africa countries? A systematic critical review of literature

⇒ The predominant policy transfer mechanism in the health sector in sub-Saharan Africa is voluntarism. There are cases of coercion, however, even in the face of coercion, there is usually some level of negotiation
⇒ Success or failure of policy transfer, irrespective of the mechanism depends on a combination of the mix of strategies used, the actors involved and their inter-relationship and the contextual factors (a combination of favorable contextual factors, actors' level of influence and the policy transfer strategies mixes)
⇒ Actors, context and nature of the issue are key influencers in policy transfers.
⇒ Strategies used by actors to ensure policy transfer include: - peer learning through intercountry visits and conferences, cross-national linkages, financial support of the policy transfer process, conditionality on aid and technical assistance, competency building of national level stakeholders through participatory learning and formal training, systematic advocacy, bureaucratic maneuvering such as 'bureaucratic bypassing' and negotiations.
⇒ Policy transfer, irrespective of the mechanism, requires local alignment with local need,
⇒ Appreciation of local context by the actors, availability of financial resources, a coordination platform with adequate capacity for national and global level engagements and good working relations amongst stakeholders, technical and financial support by the international actors, close linkages between international and national stakeholders, and limited potential effect of the policy on the bureaucratic structure and political status quo.

Review study 3: How has sustainable development goals declaration influenced health financing reforms for universal health coverage at the country level? A scoping review of literature

⇒ The SDG declaration has led to putting and sustaining health financing reforms (HFR) for UHC on the national agenda, provided an enabling environment and context for putting in place necessary legislations (passing of specific laws on health financing), reforming health financing organization, and revisions of national health polices to strengthen health financing systems and alignment of the countries' commitment on UHC
⇒ SDG declaration is catalyst for health financing reform, providing reference for necessary legislations and policies for financing UHC
⇒ Stakeholders have used the declaration as window of opportunity to accelerate policy reforms
⇒ SDG declaration has informed, caused, or intensified national level discussions of health financing for UHC and in some instances accelerated the pace with which governments considered the issue of UHC and its financing
⇒ Nature of proposed reforms should be adaptable, accommodative to the diverse needs and affordable
⇒ Since the SDG declaration, there have been observable changes in either the process or outcome of the health financing functions, and policies that define and ratio benefit entitlements
⇒ Ministries of Health have put efforts on fostering collaboration with other government agencies and focused on linking health objectives with overall national development plans
⇒ Generating political and financial support from the entire government by Ministries of Health is important

The major sources of funding over the years have remained households and development partners. Key informants indicated that the government proportion of funding is little and health insurance plays a negligible role as a source of finances for the health care.

> *"Out of the total health expenditure, 40% of it is coming from households through out-of-pocket payments; you know, that's very regressive in nature; you know, you can't subject Ugandans to this". A1*

> *"42% is from out of pocket, 41% donors, the government coming in with about 15%, and insurance remaining with a small proportion, and it has been like this for many years". A18*

Attempts have also been made at earmarking revenue for some disease conditions like HIV/AIDS, which has an established AIDS Fund. However, its implementation has so far been shelved due to the need to have a comprehensive health financing system than verticalization as the quote from a respondent indicates.

> *"On the issue of earmarking tax for health, we had so far gotten an AIDS trust fund. But implementation hasn't taken off because of the thinking that we should not have such funds, we should have one single fund instead". A11*

Pooling and Purchasing: Under this theme, the sub-themes that emerged were results-based financing (RBF), program-based budgeting (PBB), national health insurance fund (NHIF) and out-of-pocket payments. Key informants indicated that reforms in pooling and purchasing have included out-put based approaches especially introduction of RBF and PBB. There has also been an ongoing process for establishing a national health insurance fund.

Respondents noted that the government has steadily moved to PBB approach as a way of removing duplication, improving synergies across sectors, and increasing efficiencies. Fifty percent (11/22) of respondents singled out PBB as a major reform that is taking place with implications on how health is financed. In PBB there is aggregation of ministries and agencies with similar outcomes or goals. They are put together in what is called a program. For example, where many sectors contribute to the same outcome there is joint

budgeting and allocation of funds. For instance, health, education and water belong to a program called human capital development program; therefore, resources are pooled and allocated to activities that result in outcomes that these sectors contribute to.

> *"In 2017 or 2018, am not so sure of the year, we moved from the output-based budgeting to program-based budgeting; the PBB, and I guess you have heard of this reform, it's quite a big one, it's a whole of government reform". A4*

The other traditional type of pooling through a national health insurance scheme in health systems financing is being developed. However, the development of the scheme has been frustratingly slow for many of the respondents as the following quotes illustrate.

> "*Over the last 20 years or so, there has been discussion about the National Health Insurance and as you know, we have not yet made head way on that despite health insurance appearing two to three times in the NRM [ruling party] election manifestos. So, the National Health Insurance here is still part of the future at least the way I understand it". A15*

> *"…national health insurance scheme has become a joke because this thing has been around for 30 years; the talk around National Insurance Scheme, I think it is now 40 years, you know, since 1987, and nothing has really been put on the ground. The law has been moving back and forth, Parliament, State House, and Cabinet - confusion all over the place. Everybody is talking everything except implementing it, yet countries around us have really moved ahead". A8*

> *"Making any major reforms in this [health financing] functions take lots of effort and resources and sometimes policy makers may not want to put both feet in the water, they may want to do it with some great degree of hesitation". A19*

Respondents pointed out key challenges in the establishment of a national health insurance fund as being lack of buy in by the political leadership, failure by the Ministry of Health to constructively engage dissenting stakeholders especially the large-scale employers including the manufacturers. In addition to the difficulty related to the complexity of establishing and running NHIF, the projected revenue to be collected through the fund is estimated to be relatively small compared to existing revenue sources.

"If you look at it, we have the national development plan, which puts health insurance on the forefront, and we are not moving further, we have a bill which was approved by the parliament, the President says it cannot be signed because the manufactures are saying there will be increase in the cost of doing business". A16

"In the last 10 years, it [NHIF] has been on the forefront and as you know we had by last year, actually this year, we had reached parliament, and Bill was sent to the President, unfortunately, it has been brought back by the President and we're working on addressing the concerns raised". A18

The other disadvantage is that the anticipated fund to be mobilized through the NHIF is actually very small and thus difficult to convince stakeholders. Other disadvantage is, of course, running a national health insurance scheme is a big endeavour. It comes with lots of commitment, lots of commitment on resources, putting up new structures, governance arrangement and agreeing on these different parts is not an easy thing". A13

In the PBB, budgeting is based on outputs, although as indicated by key informants, in the public sector the government still largely pays for inputs and households pay at the point of care through out-of-pocket in private health facilities.

"...if you look at the out-of-pocket expenditure, if you look at the trends in catastrophic health expenses, they have worsened". A4

In recent years there have been pilot projects on results-based financing (RBF) in the country targeting quantity and quality improvement, mainly in maternal and child health services. Respondents note that these RBF pilot projects have also led to improved beneficiaries' participation in delivery of health services.

The RBF programme is largely funded by development partners. Nonetheless, respondents indicated that Ministries of Health and Finance, and Development Partners are preparing a transition strategy for RBF so that it fits within the overarching public

finance management mechanisms. Some key informants also expressed pessimism on RBF, arguing that the management capacity is yet to be adequately developed.

> *"Results-based financing is another key reform that we've had, obviously it is not to scale, and it has been mostly pilots here and there and the World Bank supporting a few districts". A17*

> *"Uganda has been implementing results-based financing, in the first years as pilots mainly in very few geographical locations or covering very few services. One hundred and thirty one of the 136 districts are now implementing result-based financing through World Bank support to the Ministry of Health. The remaining four or five districts are also covered by financing from the USAID under a project run by Enabel, a Belgian government bilateral agency. But this is mainly covering public facilities and private-not-for-profit facilities, we are talking about 1300 facilities in total. But as you know, the country has close to 6000 facilities, majority private-for-profit". A6*

> *"…and of course, financing to the health sector has largely been input based, but as you know, RBF comes with other incentives. However, it is not very easy to sustain such reforms because you have to put more money in operations, it needs management, and you have to put more money just basically beyond the input-based financing and that's why most countries never sustain it". A9*

> *"Personally, I don't feel that we have had enough information to guide full institutionalization and scale up of RBF across the country. Of course, you know RBF has the potential to really streamline our purchasing mechanisms, but I feel that [name withheld] is best placed to give you a response on that*". A9

Other reforms mentioned by respondents included decentralization and government subsidies to private-not-for-profit (PNFP) health facilities in form of grants and staffing. This has led to improved access by the population to health services provided at district level and PNFP health facilities.

8.4.2 What stakeholders consider important for successful transfer of the SDG relevant policies to the national level

In the context of the SDG declaration, the transfer of global policy propositions on health financing reforms to the national level are influenced by a number of factors as noted the respondents. These include buy-in by key stakeholders, capacity in country to coordinate and implement the policy transfer, financial situation of the country, availability of locally grounded evidence, awareness and knowledge of the policy amongst key stakeholders, alignment with government agenda and manifesto, and existence of a national coordination mechanism to lead the process.

In promoting country ownership of policy transfer process and implementation of the policy once transferred to national level, key informants noted need for timely information and dialogue to facilitate buy-in and support of the process by stakeholders such as the legislature (parliament), civil society organizations (CSOs), development partners, media, and political leadership at national and sub-national level.

The following quotes from respondents demonstrate the issue of country ownership and stakeholder engagement:

> *"…it will remain a fallacy the transfer of global resolution if it's happening in the HDP space only, I mean the health development partner groups and local development partner groups and there is no country ownership. Country ownership, I mean government taking lead on these kinds of reform process". A2*

> *"Once the CSOs are aware and knowledgeable about global resolutions, government will be reminded on a regular basis, to implement their commitments that they have signed at the global level, as well as those signed at the regional and African Union level". A8*

> *"Once the President has buy-in on a global resolution or on a financing reform, that's definitely going to happen, however if the president is struggling with, you know, making that decision of having the buy-in or it's looking like it's donor driven it becomes hard for a country to fully adopt that and bring it to scale". A3*

> *"Timely communication and building their capacity [members of parliament] to understand these declarations and the need to implement them in the country is important, as you know our resources are appropriated in parliament. Therefore, fully involving the political leadership both at the top but also at the parliamentary level as well as key technical teams is key going forward". A21*

> *"There's the need for visibility in the media, in the national newspapers, on television to disseminate some of these global decisions". A17*

> *"Closely working with development partners is also important because they play roles such as provision of technical assistance, expertise, skills and even the financial resources". A7*

The capacity to drive the policy transfer process was noted as important by key informants. This capacity if not adequate in a country or amongst key government technical staff may be leverage from the development partners or externally.

> *"Yeah, do we have the capacity in-country to implement some of these resolutions that are coming down from the global level? In addition, sometime as development partners we leverage on our headquarters offices and our regional offices technical assistance support in event that we need or would need that". A2*

> *"The issue of knowledge, understanding what, how exactly health financing can support moving towards UHC is some area that still needs capacity development amongst key national technocrats. At the moment a lot of the health financing reforms are actually backed by large scale TA [technical assistance] from external partners". A6*

Respondents from development partners also acknowledged working closely with the Ministry of Health to transfer the skills and build capacity within the Ministry. Due to the need for enhanced capacity of national level players and especially staff at Ministry of Health to spearhead health financing reforms, a health economic unit is being established at Makerere University School of Public Health.

Key informant noted that national level stakeholders are likely to be swayed and support the global to national level policy transfer if such reforms address the local need as informed by the available evidence grounded in local data than on evidence based on projections, assumptions or modelling.

> *"What's our current situation? And that is informed by the data of the country, you know, not the modelling exercise that's happening somewhere in Geneva, but in Uganda?" A14*

> *"Local researchers would have to carry out studies which are showing the advantages of global policy once adopted here, of having the National Insurance for example compared to the current situation". A22*

The financial situation of the country is critical in policy transfer. The issue of sustainability of implementation once the policy is adopted is very important. In addition, the process of policy transfer needs financial support.

> *"…financial sustainability should be at the center of any global resolution or policy that are coming in from top down because unfortunately or even fortunately we cannot run away from the issue of sustainability and financing". A2*

> *"Stimulating funds or some funds to allow them [the group driving the reform process] to create that dialogue platform for stakeholders is necessary". A17*

> *"Here we are talking about total health expenditure per capita of $37 instead of $112 for UHC, you know. So, at the end of the day, these global health financing policy principles remain a matter of discussion, a matter of consideration, but they are not then optimally adopted into practice, and the biggest problem is really the issue of resource constraints". A 19*

How aligned the global policy is to the government agenda or the manifesto of the ruling party is a key factor in the global to national policy transfer. Once the global policy prepositions are similar to that of the government it will easily sail through.

"You know the Government [In reference to the Ruling Party] by nature have got an agenda and of course they will have a manifesto and so on and so forth and where a global policy supports such an agenda, the transfer will be eagerly supported". A13

For the ministry of health, key informants noted the need to have a specific office that handles and follows health commitments being made at the global level. Also important, especially for the transfer process there is need to have a dedicated coordinating unit with staff at the Ministry of Health to facilitate the stakeholder engagement and lead the process of policy transfer, as noted by key informants.

> *"There is need for a specific office that handles issue of international agendas at Ministry of Health. But I'm not sure that there is a desk which is monitoring what is agreed at internationally of those treaties with implications on how health systems function; like a secretariat that follows up". A21*

> *"In the health sector, we have a working group we call the health sector budget working group of the health policy advisory committee where key stakeholders involved in health financing congregate and discuss matters including universal health coverage and health financing and I think through this arrangement, the country has been able to develop the national UHC roadmap". A22*

8.4.3 How is the SDG declaration influencing health financing reforms?

Respondents indicated that the SDG declaration has to an extent influenced health financing reforms in Uganda. The influence has been in terms of awareness creation, raising interest of traditionally non-health financing stakeholders, agenda setting, and development of national strategies.

In terms of awareness creation, raising stakeholders' interest and agenda setting, key informants noted that following the declaration there were significant media attention in the country. In addition, the declaration requires amongst others regular reporting including on financial risk protection and these figures get to be known by many stakeholders triggering their interest as the following quotes from key informants illustrate.

> *"The big advantage of the SDGs is that we have been able to measure and track financial risk protection indicators on a more regular basis. This has sort*

of started influencing the discussion and the agenda in terms of trying to improve health financing". A2

"There is a specific indicator, SDG 3.82 dedicated to financing for health and financial protection where in general countries report on. This has caused self-awareness amongst countries that achieving UHC requires proper financing. Because of this reporting, stakeholders have started seeing numbers and this has triggered their interest". A6

"Before you have the numbers then you don't have any ground to have any debate or make parliament argue in a certain thought of direction because the data is not there…What I can tell you very authoritatively is that there has been an increase in interest amongst stakeholders in the country on health financing in general following the SDG declaration. This is partly because there is a whole SDG target dedicated to UHC and health financing". A18

Following the SDG declaration, the number of stakeholders participating or getting involved in health financing discussions have increased, including within the Ministry of Health than before and quotes from key informants illustrate this point.

"I think from the health sector perspectives, there are those departments in the health sector, which typically focus on, say RMNCAH, HIV/AIDS, TB, NCDs, you see from Monday to Friday, from January to December they would be discussing numbers of people attending care, numbers of people dying, medicines, and you would rarely actually hear issues of health financing in those discussions before 2015/2016". A19

"SDGs have influenced the thinking around health financing and health systems. There is some kind of influence, we may not be able to quantify it but subjectively I think there's been some influence. As you know, before the SDGs, stakeholders in the health sector were largely focusing on service [delivery] and they were focusing less on the systems that are needed to actually deliver those services such as health financing". A9

"Before 2016, Health financing was largely something left to very few experts, where you would find one in the university, another one from an agency like WHO, the rest of the people were either not interested or they didn't actually know what to do. However, with the coming on board of the SDG declaration especially SDG 3, where I think financing is under target 3.8 or around there, and we can now see a lot more stakeholder groups even civil society organizations taking this agenda forward. In fact, I think yesterday there was a health financing conference organized by CSOs. I think this is something that was very rare before the SDG declaration. So yes, I think that the declaration has been important". A5

Civil society organizations, professional groups and even the Ministry of Health have used the SDG declaration to advocate or lobby for reforms of improvement in health services and health financing by reminding the political leadership of the global commitment to which the country is signatory. There is also a wider and better involvement of stakeholders by the Ministry of Health as highlighted by respondents in the following quotes.

"As doctors or as a fraternity, SDGs have been at the fore of our gran doctors' conferences' themes, especially health systems strengthening aspects of human capital and financing. And whenever we have the opportunity as a fraternity to meet anybody who is important to speak to, be it Parliamentary Committee on Health, Ministry of Finance, Committee on Budget in Parliament, etc. we have emphasized SDG 3 and financing for UHC". A9

"SDG declaration most definitely has had some effects through the campaigns of civil society organizations, but also the Ministry of Health realigning itself with these SDGs with support from WHO has been key". A2

"We now look at the civil society organizations, we look at the health development partners, since health being a multi sectoral issue, we look at other ministries, departments and agencies as well, we hope this [improved engagement] will lead to acceptable version of national health insurance scheme". A7

Respondents indicated that the SDG declaration has provided a framework for the development of national policies and plans including a national UHC roadmap.These developments are also influencing resource appropriation by Parliament as the following quotes by respondents indicate.

> *"We have developed a roadmap for universal health coverage and in it we have tried to have health financing reforms that should take us towards that [UHC] and also other SDGs". A9*

> *"The SDGs kind of provide the framework for developing country specific health sector development plans, but also national development plans for example the third national development plan is slightly different from previous ones; it has been aligned with the SDGs and the issue of financing health and UHC is stated more clearly". A6*

> *"To a large extent we may say it has influenced positively; on planning, on resource allocation, on resource mobilization in the country… Generally, it has acted as a platform for developing fair health financing policies and has made universal health coverage to take root in Uganda". A11*

Some key informants indicated that although the SDG declaration is influencing some of the reforms, the influence is not direct but also depends on the current focus and priority of government. Key informants noted that as opposed to government, development partners can easily be swayed to support issues on financing in relation to the SDGs as their work revolve around issues agreed up on internationally especially within the social sector. The following quotes illustrate these points.

> *"I wouldn't say that there has been a very direct positive correlation between SDGs and financing for the health sector, I mean there is not much, we have not seen a sharp increase for instance in allocation from the government of Uganda to the health sector as a result of the SDGs, you know! However, SDG declaration has required us to monitor advancements on universal health coverage, because SDG 3.81 is on UHC in general that's coverage and access and 3.82 is on financial risk protection which is really how you measure". A1*

"It is easy for Ministry of Health and even civil society to spin the story the SDG way in engagement with development partners because those global resolutions resonate more with them, but to say that Ministry of Health has the capacity to leverage these resolutions to try and get additional funding to their sector from government, I would say the answer to that is a no". A15

8.4.4 Factors facilitating and inhibiting the use of SDGs in influencing health financing reforms

A key factor noted by respondents in facilitating the use of the SDG declaration as a tool for influencing health system [financing] reforms is the reporting requirements for the United Nations (UN) member states. They noted that as countries report, they have some kind of 'peer pressure' that motivates them towards undertaking certain reforms in order improve certain indices so that they are not seen to have been left behind by their peers. This is illustrated by a respondent quote.

"UHC measures are reported on and as a country you find that, you are prompted to go and work on that, because you have to go and report, and you would be embarrassed in case you have poor indicators always". A3

Respondents noted that a lot of stakeholders have developed interest in health financing and there is better engagement between the government and other stakeholders on SDGs; this is evidenced by the large media attention when it was launched. The declaration has also led to strong partnerships amongst key stakeholders in health financing in Uganda. The other factor noted by respondents that facilitates use of the SDG declaration for advancing health financing reforms is a target that focuses on UHC. Health financing is a key component for achieving the UHC target. The development partners have also been aligning their support to achieve global targets. Therefore, national stakeholders advancing reforms have allies in the development partners. The other important factor has been the active reminders by stakeholders especially the CSOs for government to honour its commitments at the global level.

The existence of political will at all levels has also facilitated the use of SDGs as a framework for catalyzing reforms that are being planned or implemented on health financing in Uganda. This especially so given the political benefits likely to be received by

achieving the SDG targets and as such there is increased demand for accountability, especially on the technocrats leading the reform process.

Factors inhibiting utilization of the SDG declaration as an advocacy tool for health financing reforms relate to the complex nature of health financing systems. The issue of knowledge, understanding what, how exactly health financing improves UHC is an area that needs improvement as the following quote illustrates.

> *"It [health financing] is, it is a bit complicated area because, and one has to see it in the realm, within the framework of the overall macro-economic dynamics of the country and the region and the globe. So, it will take some time to get more traction as more and more people come to appreciate what health financing actually is and how it means to the achievement of UHC and how it means to the economic growth and stability of countries". A17*

Respondents also noted the limitation in fiscal space for health in Uganda as a factor disfavouring utilization of the SDG declaration to be used by the stakeholders including the Ministry of Health. The other factor is limited awareness amongst the public, this affects effective articulation by the public the issue of SDGs and health financing as noted by a key informant.

> *"But I think the general public in my opinion may not be understanding the relationship between the SDG and needed to improve health financing and so they may not be able to push for it". A11*

Lack of recent evidence on the issue of health financing limits the stakeholders from utilizing SDGs as rallying points for reforms. For example, the national development plan puts health insurance on the forefront but there is no tangible improvement along that direction because there is limited recent local evidence to back up the impact of some reforms that have been adopted or proposed following the SDG declaration.

> *"To the best of my knowledge there is no systematic study following up user fees abolition and its impact in the country. You find that many studies were done from 2001 to 2005. Thereafter there have not been much study other than what we get in UDHS [Uganda Demographic and Health Survey]". A18*

8.4.5 Theory of Change development

The draft TOC (Figure 8.1) is based on the reviewed literature guided by the overall study conceptual framework. The TOC identifies the goal, outcomes, assumptions and activities. In this case, the goal is to establish an effective health financing system for UHC. While outcomes include results from the global to national policy transfer and health financing reforms processes and established legal and regulatory frameworks. These outcomes are a result of a number of activities including advocacy and lobbying, bureaucratic and technical process re-engineering, stakeholder engagement, and creation of relevant organizations and institutional structures among others.

Successful achievement of the goal and the outcomes is based on certain conditions and assumptions that must hold true. For global to national policy transfer, success is based on assumptions that there is: -a financial support for the process, close linkages between international and national stakeholders, minimal effect of the policy reform on the bureaucratic structure and political status quo. The global policy guidance must also be adaptable, affordable and accommodative to the diverse needs of actors. For health financing reforms, the process is likely to be successful where there is political support, technical and financial assistance and adequate capacity within the MOH to lead and/or coordinate the process.

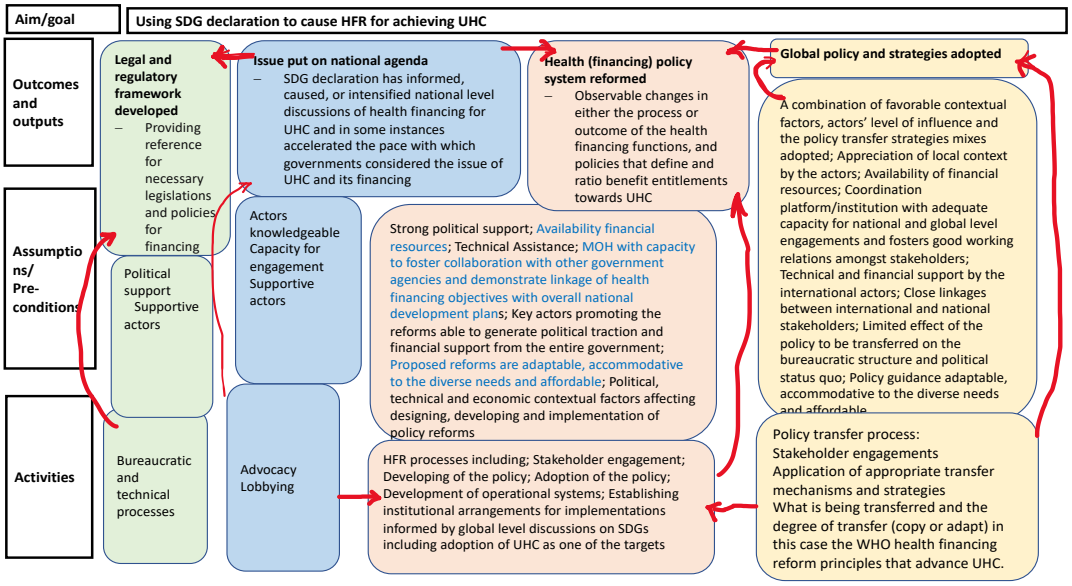

Figure 8.1 Draft Theory of Change

Through an iterative process with respondents, the draft TOC was modified through editing, removal and adding elements. Based on this process a final TOC was developed and it is represented diagrammatically in Figure 8.2.

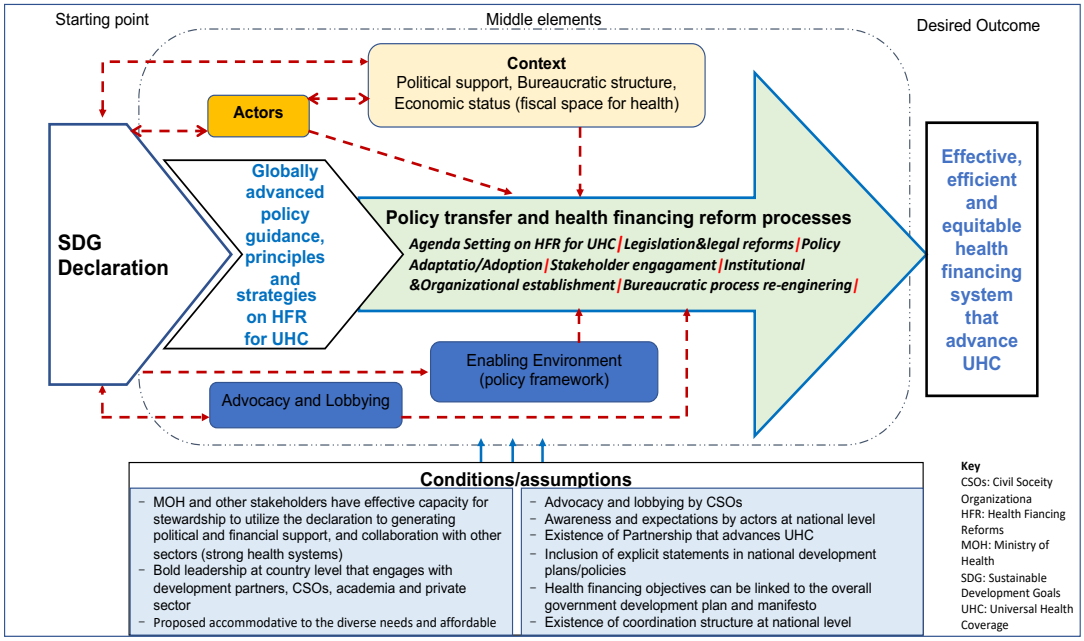

Figure 8.2 Final Theory of Change developed

8.4.5.1 TOC Narrative

(i) Goal and starting point

The goal of having an effective and equitable health financing system that advances UHC using the SDG declaration as a starting point.

(ii) *The middle components*

Activities and outcomes: To achieve the goal, a number of casually linked processes, interventions and activities have to be undertaken. Firstly, on the SDG declaration and with regards to health financing there are globally advanced policy principles on reforms that advance UHC. These global health financing policy principles have to be transferred to the national level through appropriate policy transfer mechanisms involving specific strategies and activities (see Chapter 6 and box 1 for details on policy transfers). Secondly, the national health financing reform process is an elaborate process that is informed by national and global discourses. Key activities in the reforms include having the issue defined as a national agenda item, development and/or adoption of contents of the policy, establishing necessary legal instruments, creating an institutional and organizational structure, and bureaucratic process re-engineering amongst the key activities in the interval between the SDG declaration and the goal of having an effective health financing system that advances UHC.

In terms of outcomes, these causally linked activities are expected to lead to HFR being a key national agenda item, existence of a legal framework for HFR, and the health financing system reformed to achieve UHC.

Context and actors: The process of global to national policy transfer of global policies and the HFR process are affected by the political, economic and bureaucratic contextual factors. For example, policy transfers from global to national level is influenced to an extent by the nature of the ruling party political agenda, bureaucratic structure and the adequacy of fiscal space to accommodate costs associated with the proposed changes. Actors play critical roles in framing the policy agenda and in deploying their resources based on interest, position, nature and magnitude of their power on the issue.

Assumptions: Successful processes of policy reforms and policy transfers are underpinned by certain assumptions. In the case of health financing for UHC these include among others, existence of a strong health system (especially stewardship), strong ability of CSOs to conduct advocacy and lobbying and existence of a reform coordination structure at the national level.

8.5 Discussion

This study explored health financing reforms and how the SDG declaration is influencing health financing reform for UHC in Uganda from the perspectives of national level stakeholders. The study confirms the literature review findings which indicated that there have been limited changes in the overall health financing approach in Uganda in the last two decades. Reforms that have been implemented such as removal of user fees in public health facilities have not significantly changed how health is financed, as the majority of funding is still from households and development partners. These findings are in line with the national health accounts reports and findings from other studies. [17-24] The only source of pooled funding remains the government revenue and grants from development partners to government. Attempts at establishing the NHIF has been slow as literature review findings indicated.[11,18,25-31] The slow reforms, especially the introduction of the NHIF is similar to findings from other low-income countries where such reforms were undertaken. The slow progress is usually occasioned by a limited resource enveloped, vested unclear actors' interests, limited national capacity and lack of will to destabilize the status quo. However, the process of establishing the NHIF seems to have gained momentum as reported by key informants following the elaboration of UHC in the SDG declaration, and its subsequent inclusion in the 2016 national health financing strategy.[27] However, the MOH continued engagement on the issues being raised by stakeholders on health financing and reforms undertaken are other factors that seem to also be influencing discussions on the establishment of NHIF beyond the SDG declaration.

Key informant interviews provided more information on RBF than what was found in literature in terms of scale of the program and development of a strategy for mainstreaming RBF into national processes and public financial management (PFM)

procedures. More information about PBB was also provided by the respondents compared to what was found in literature. These developments in approaches to health financing in Uganda were considered largely after the SDG declaration. Therefore, one may infer that such progress in reforms in recent times are to an extent influenced by the SDG declaration and associated discourses at the global level. In addition, this study adds to calls for the need to undertake key informant interviews with actors involved in national policy development or reforms than to rely only on available literature in studies of such nature.[2-3]

The study also confirms the literature review findings that the SDG declaration is indeed influencing health system financing for UHC by ensuring issues of health financing reforms remains high on the national agenda, providing a framework for development of national laws and policies such as the National Health Insurance Bill, health financing strategy and the UHC roadmap.[1] The SDG declaration has led to an increase in the number of stakeholders participating in health financing discourse in Uganda. Health financing discussions is no longer confined to a few experts, rather to an array of stakeholders including civil society organizations (CSOs) and other interest groups such as health professional associations. These findings also indicate that stakeholders especially the Ministry of Health and health advocates (CSOs and health professional associations) are using the SDG declaration to advocate and lobby for reforms in health financing that advance the move towards UHC. Similar findings on the use of the SDG declaration have been reported in other settings including India[32], Germany and France[33], and western pacific countries.[34] The SDGs have also made the MOH to improve its level of engagement within and outside cabinet to facilitate buy-in of the proposed reforms such as the NHIF. This is similar to reports in India, where Gera *et al*[32] indicated that the central MOH of India improved the way it engages with other government agencies in order to get 'whole of government' support on proposed reforms in health financing for UHC.

Key factors facilitating the use of SDGs to influence HFR in Uganda are the media attention on the SDGs and the reporting requirements for the government to the UN. These ensure the issue of financing for UHC keeps attracting the attention of the stakeholders and thus agitation for reforms in health financing. The other factor has been the top political leadership buy-in to the global processes and the existing overall national

policy framework elaborated in the national development plan. This study also confirms findings from literature that policy transfer, irrespective of the mechanism, requires local alignment and appreciation of context by the actors, availability of financial resources, a coordination platform, good working relations amongst stakeholders, political will and country ownership of the process

The proposed health financing reforms particularly the NHIF for example have appeared on more than 2 occasions in the manifesto of the political party in government and campaign agendas, yet the process for its establishment remains slow according to a section of stakeholders despite the SDG declaration. Therefore, inasmuch as the global agenda may be aligned to the government agenda and as such is thought to ease the process of policy transfer from global to national level, other economic and social pressures may attenuate such political desires. This has been illustrated by the case of Uganda, where the private sector urged the President against signing the NHIF Bill into Law.

This study also aimed at developing a theory of change framework that can be used to examine complex processes. Complex processes and/or interventions comprise multiple components acting both independently and in conjunction with one another.[35] Therefore, the two processes elaborated in this case study; health financing reforms and global to national policy transfer within the context of a global declaration fits the description linked complex processes. Examining such complex processes requires theory driven frameworks such as the TOC that helps to identify how various components relate and interact with each other to achieve a particular goal.[35] Baum et al[36] argue that in studying of complex systems, the use of overarching framework developed by putting multiple theories and concepts together has more explanatory power for the policy processes. Therefore, the TOC developed identified the aim, activities, outcomes, contextual factors, causal links and assumptions while utilizing multidisciplinary lenses of political science (policy transfer) and health policy analysis (health policy and systems research) is the more appropriate for examining complex social processes and interventions, such as how global declaration leads to health financing reforms for UHC.

The TOC advocates for the framework to be developed through an iterative process involving engagement stakeholders.[37-39] This TOC was developed with a selected group of national level stakeholders in Uganda through a process of reflection, addition, and modifications of components, thus incorporation of multiple points of view in the framework developed. The TOC developed has not been empirically tested due to limited time available during the thesis period, there for it is a weakness in the TOC development process. However, by engaging the respondents in its development, the TOC may be applicable in other areas where there are policy reforms with likely influence from global agendas.

8.6 Conclusion

Health financing reforms in Uganda in the past two decades included abolition of user fees in public health facilities, RBF, PBB and decentralization. However, these reforms have not generally had a major effect on the overall organizational and management rearrangement in the health financing functions and policy on benefits. The NHIF is one proposed reform likely to have major effects on the revenue raising, pooling of revenue and risks, purchasing and policy on benefits. However, the process of its establishment has been slow and only started picking momentum in about the last 5, perhaps due to the global discourse on UHC and the SDGs in general.

The discourse on UHC involves health financing reforms and there are policy propositions at the global level on reforms that advance UHC. These require policy transfer and these transfers from global to national level require local alignment and appreciation of context by the actors, availability of financial resources, a coordination platform and good working relations amongst stakeholders and the effects of adaptation of such policy elements on the bureaucratic and political status should be minimal.

The SDG declaration has provided a platform for advocacy and development of necessary legislations and policies for financing UHC. It has also raised interest among other stakeholders who have traditionally not been involved in health financing to start advocating and lobbying for health financing reforms. Therefore, the issue of financing UHC has become a national agenda in Uganda.

Health financing analytical frameworks and the policy transfer theories' limitations in exploring complex phenomenon such as the health financing reforms that involve global to national policy transfers processes amongst others require theory driven frameworks such as a theory of change framework. The TOC developed therefore allows for a better and detailed exploration of how a global declaration influences reforms and the impact of such a process at the national level. The TOC makes explicit the linkage between the issue and goal and demonstrates how sets of interventions of reform processes informed by ideas from the global level (policy transfer) are causally linked and the assumptions therein. Therefore, this study has proposed a theory-driven approach to examining the complex process of transferring global policy principles to the national level by adapting and integrating existing frameworks for studying health financing reforms and policy transfer theory into a single framework; the Theory of Change (TOC).

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PART III CONCLUSION AND RECOMMENDATIONS

Overview

This part provides conclusions on the thesis in relation to the study aim. It draws recommendations with a focus on health financing reforms in Uganda, areas for further development or research, application of the framework developed, and strengths and limitation of this thesis.

CHAPTER 9 : CONCLUSION AND RECOMMENDATIONS

9.0 Chapter overview

This chapter provides overall conclusions on the thesis in relation to the study aim. It also draws recommendations with a focus on health financing reforms in Uganda, areas for further development or research, application of the framework developed, and strengths and limitation of this thesis.

9.1 Conclusions

This thesis sought to explore how the SDG declaration is influencing HFR for UHC in Uganda and used the case to develop a framework (a theory of change) that can be used in analyzing how such global declarations influence reforms in health financing systems at the national level. In doing so, detailed literature reviews were conducted, firstly to provide the health financing contextual background of Uganda, secondly to explore how global policy agendas are transferred to the national level in the context of sub-Saharan Africa, and thirdly to understand more generally how the SDG declaration has influenced or is influencing health financing reforms across the world. Based on these reviews a draft theory of change was developed on how the SDG declaration influences health financing systems towards UHC.

Following the literature reviews, key Informant Interviews (KII) were conducted with key stakeholders in Uganda to get their perspectives on the influence of the SDG declaration on health financing reforms for UHC in the context of Uganda. The KII and literature review findings were then used to develop and refine the theory of change on how SDG declaration leads to health financing reforms for UHC.

9.1.1 Health financing reforms (HFR) in Uganda

In answering study objective one, a literature review that explored changes in health financing in Uganda between financial years 2000/2001 and 2020/2021 was conducted (Chapter 5). This was followed by Key Informant Interviews of purposively selected participants at the national level that enriched the findings of the literature review (Chapter

8). The findings provided a contextual background that enabled exploration of how the SDG declaration might have influenced or is influencing reforms in health financing in Uganda. Kutzin's conceptual framework[1], which relates health financing functions and other health systems functions and goals was used to guide data collection and analysis.

Findings from literature review and KIIs indicated that Uganda has had variations in health financing policy focus over the 5 strategic plan periods reviewed, from equity (HSSP I) and resource mobilization (HSSP II) to financial risk protection (HSSP III) and UHC (HSSP IV). Changes in focus in health financing policy objectives were informed by low per capita expenditures, global level discussions on SDGs and UHC as well as the on-going health financing reform discourse focusing on establishing the National Health Insurance Fund (NHIF). Noticeable reforms in health financing directed at achieving the policy objectives were: - abolition of user fees in 2001 (HSSP I), sector wide approach during HSSP I&II, results-based financing, programme base-budgeting and decentralization amongst others (Chapters 5 and 8). However, there has not been major reforms in the organizational architecture that affects in a substantial manner the health financing functions and policies on benefits to results in desired outcomes such as those advanced by the WHO that is meant to lead to universal financial risk protection.

The major sources of funding for the health sector remain households and development partners with both contributing over 84% of the total expenditure on average over the 5 strategic plan periods. The government through public revenue contributed on average 15% of the five strategic plan periods. Household expenditure is through out of pocket at the point of care, while development partners funding is largely not pooled, and a significant percentage is extra budgetary. Proposed reforms to address some of these issues particularly, the national health insurance fund has been slow; with the process in its third decade and yet to be finalized. Therefore, inasmuch as health financing policy intentions in Uganda are aligned with the WHO guidance on reforms towards UHC, actual organization and thus outcomes in terms of improvement in health financing functions and financial risk protection remain work in progress.

9.1.2 Global to national health policy transfers and the influence of the SDG declaration on HFR

In answering study objectives two and three, i.e., examining how the SDG declaration has influenced health financing reforms, and identifying factors that have facilitated or inhibited the SDG declaration in influencing health financing reforms for UHC in Uganda, literature reviews were conducted (sections Chapter 5 and 7) and findings were subsequently enriched with KIIs in Uganda (Chapter 8).

Firstly, how global health policy agendas are transferred to sub-Saharan Africa was explored. This is because, following the SDG declaration there are several policies and strategies conceptualized by global actors to operationalize initiatives for achieving SDGs that need to be transferred and adopted or adapted at the national level. For example, UHC as a target of SDGs, an effective health financing system is a critical aspect and there are policy reform principles advanced by the WHO and other actors for reforms in health financing that advance UHC.[1-2] Therefore, this review was to provide in broad terms an understanding of how such global policy principles are being transferred to the national level in sub-Saharan Africa and what the key influencing factors are, in the context of health financing in Uganda (Chapters 6 and 8). To guide our analysis, we used the Dorowitz and Marsh[3] policy transfer framework focusing on who are the key actors, why they engage in policy transfer, what is the role of actors and context in policy transfer are and whether the policy transfer succeeded or failed.

Findings from literature review indicated that the predominant policy transfer mechanism in the health sector in sub-Saharan Africa is voluntarism. There are cases of coercion, however, even in the face of coercion, there is usually some level of negotiation. Findings from both literature and KIIs indicated that agency, context and the nature of the issue are key influencers in policy transfers. Policy transfer, irrespective of the mechanism, requires local alignment and appreciation of context by the actors, availability of financial resources, a coordination platform, good working relations amongst stakeholders, political will and country ownership of the process.

Secondly, we examined how the SDG declaration has influenced health financing reforms and the associated factors. Findings from literature review and KIIs indicated that the SDG declaration has influenced reforms in health financing towards UHC by putting the issue on the national agenda (agenda setting), acted as a framework for the development of relevant national Laws to facilitate improvement in health systems financing and led countries to revise their health financing policies. Particularly in Uganda, the SDG declaration has raised the interest and participation of many stakeholders in the health financing discourse, provided a framework for development of a UHC roadmap, led to the National Health Financing strategy 2016 and third National Development Plan. The SDG declaration has also reinvigorated the process of developing the NHIF to some extent. The Ministry of Health, Professional Associations and Civil Society are using the SDG declaration as a tool for engagement with other stakeholders as they seek support for reforms in health financing towards UHC with a focus on the NHIF.

Factors favouring the use of the SDG declaration in influencing health financing reforms included strong media attention on the SDG declaration and reporting requirements for countries - these ensure that there are continuous discussions on health financing in relation to the SDGs. Other factors are: - having a specific indicator on UHC and thus health financing in the declaration, strong partnership between the MOH and other stakeholders and the support of development partners. Factors disfavouring the use of the SDG declaration included: limited fiscal space as reforms requires funding, lack of relevant recent evidence grounded in country data and complexity of the health financing issues.

9.1.3 Theory of Change

In answering study objective (IV), a framework in the form of a theory of change (TOC) on how the SDG declaration influences health financing reforms for UHC was developed. A draft TOC was developed using concepts emerging from the three literature review studies and refined with information from respondents. The process of TOC development entailed addition and modification of some components, removal of less relevant ones, renaming some inputs, retaining some components and eventually providing a narrative

to the final TOC. Background reading and systematic literature reviews had indicated that existing frameworks are inadequate for examining national level reforms that are occasioned or accelerated by developments at the global level[4-5]. Health financing reforms are typically analysed through frameworks that are rigid with a focus on the health financing functions. On the other hand, health policy analytical frameworks and theories consider only to a limited extent the influence of external actors within the national context[5], while policy transfer theories focus on specific questions on specific issues. Therefore, the TOC developed provides a better framework for exploring the technical aspects of health financing reforms while incorporating policy analysis and policy transfer theoretical dimensions which are important for understanding complex processes involved in reforms leveraging on developments at the global level.

In conclusion, by answering the four study objectives, the aim of this thesis which was to explore the influence of SDG declaration on health financing reforms in Uganda and develop a theory of change for desired health financing reforms for UHC has been attained.

9.2 Recommendations

These recommendations are drawn based on the findings of this study that aimed at exploring how the SDG declaration is influencing health financing reforms for UHC in Uganda and developing a theory of change. The recommendations target various audiences depending on information generated for each study objective. The objectives related to the health financing reforms in Uganda, how SDG declaration is influencing health financing reforms for UHC and the theory of change development. Therefore, the recommendations target the Ministry of Health, development partners and researchers as elaborated below

A) Ministry of Health and Health Advocates

⇒ *Commission research that utilizes multidisciplinary lens and theory driven frameworks such as the one proposed in this study to inform health financing reforms with evidence based on country's data*

In Uganda, the lead driver of reforms in the health sector including health financing reforms is the Ministry of Health, as the sector steward and supported by some CSOs. Findings from the review on health financing reforms in Uganda between FY 2000/01 and 2020/21 indicated that reforms such as the removal of user fees at point of care, SWAp, decentralization among others did not impact on health financing functions to lead to desirable financial risk protection. Therefore, as the Ministry seeks new reforms such as the establishment of NHIF and other options for improving pooling, purchasing and accountability it needs to commission studies to inform these reforms. The studies should target providing data that shall result in better appreciation of the political economy issues and provide current evidence on the effects of some of the past and current reforms effort in order to project future situation based on data. The evidence generated shall support better conceptualization of designs in reforms that can measurably cause changes in the organizational structure and functions of health financing system. This will ensure that Uganda's good policy intentions elaborated in the health financing strategy document, and which are aligned to the WHO health financing reform principles for UHC are achieved. The research, which should be based on the country data should focus on implementation level constraints after the policy transfer and formulation have been completed.

⇒ *Create or establish internal cohesions before engaging other stakeholders and use existing commitments to advocate and lobby for reforms*

Amongst the critical factors for delayed establishment of the NHIF was lack of consensus within the Ministry of Health. The Ministry of Health needs to build internal cohesion and consensus on the reform components, steps to be taken, and likely implications on the stakeholders and existing arrangements before engaging other key actors with contrary opinion on the proposed reforms in health financing be PBB or NHIF. As part of consensus building, the Ministry should harness lessons from reform processes such as the removal of user fees that have not led to improvement in financial risk protection, and leverage on the political interest where for example NHIF was included in the ruling party manifesto and national development plan. Still as part of leveraging on the political will, the Ministry of Health can utilize the high-level commitments on UHC enshrined in the SDGs and the high-level meeting of the UNGA where member states recommitted to achieving UHC to advance the health financing reforms in the country.

⇒ *Build internal capacity for political economy analyses and policy engagement for leading or coordinating reforms or transfers of global health agendas to national level*

One of the findings from this study is the need to have at the national level within MOH strong capacity to coordinate the process of global to national policy transfers and policy reforms. Such units are instrumental in underrating the political environment and exploring the gaps in terms of technical and financial resources necessary for such processes.

b) Health Development Partners and Ministry of Health

⇒ *Create awareness on the health financing reforms and related global commitments amongst the public*

Findings indicated that the public is less informed about the global commitments by government and its relationship to health financing. The lack of awareness amongst the populace limits public's participation in health financing reform discourses. When the public is informed about the issues of SDGs and the need for health financing reforms for example, they are likely to put pressure on the elected leaders to initiate or support necessary reform processes.

c) Health Policy and Financing Researchers

⇒ *Apply theory driven frameworks in analyses of health financing reforms especially where there is potential influenced on the process by global declarations or global agendas.*

This study found that individual conceptual frameworks, health policy and policy transfer theories and frameworks are not holistic enough to analyze complex reforms within the context on global developments such as SDGs individually. Therefore, researchers should apply the theory of change developed when exploring complex and multifaceted aspects of national policy development or reforms which can potentially be influenced by global policy agendas.

9.3 Study limitations

The outbreak of COVID-19 pandemic necessitated a change in approach to key informant interviews and validation of the TOC which were planned for a group face-to-face meeting.

It was difficult to convene the respondents as a group to validate the theory of change. However, the draft theory of change was presented to respondents and who individually added and/or proposed areas of refinement. These inputs were taken into consideration while refining the final version of the TOC. In addition, given the limited timeframe of the PhD program, the developed TOC is yet to bet tested empirically and as such the author encourages that users may modify and adapt it to suit the context in which it is being used. This study focused on national level, however there could have been some valuable contributions from sub-national level in terms of understanding how the SDG declaration is influencing reforms in financing especially at the decentralized government level. Key informant interviews are also fraught with biases, notably recall biases and "interests" bias. However, this was not a challenge as the KII were triangulated with literature review findings.

Despite the limitations, this study makes contribution in terms of development of a TOC that links a global declaration to health financing reforms at the national level; a first of its kind to the best of the author's knowledge. The thesis also questions the notion that policy transfer in Africa is predominantly coercive and makes explicit the need for development of robust frameworks for examining policy transfer strategies in LMIC.

9.4 Contribution of the thesis

This thesis has contributed to research by developing a TOC that combines the conceptual framework of health financing functions with policy transfer theory and health policy analysis frameworks into one. Answering a call by other researchers such as such as Jones et al[5] of the need for use of theory-driven frameworks in health financing policy processes. The TOC developed is especially appropriate for exploring complex issues that involve influence of global policy agenda on the national health financing reform processes, where there are aspects of policy transfers.

This thesis also adds knowledge to one of the fields i.e., policy transfer studies, which has very limited scholarship in low- and middle-income countries (LMIC). For developing countries, policy transfer studies are particularly important, as a number of these countries

rely heavily on ideas developed in upper income countries and at the international level, thus the more reason for conducting policy transfer studies in LMIC.

Empirically, this study comprehensively synthesizes major issues of health financing reforms in Uganda, notes how the SDG declaration has influenced reforms in Uganda to date, an area to the best of the author's knowledge has not been studied, i.e., exploring the linkage between of the SDG declaration and health financing reforms.

9.5 Areas for further research and development

In the context of this work, two areas are pointed out requiring further research and/or development. Firstly, the refining and use of theory-driven frameworks for analyzing health financing reforms at the national level where there are anticipated significant influence from global level processes. Secondly, the need to conduct more health policy transfer studies in sub-Sharan Africa to complement other disciplines such as health policy analysis and political economy analysis of health financing reforms in the LMIC

The theory of change framework developed in this study allows researchers and policy entrepreneurs to think of health financing reforms beyond the national boundary and to acknowledge that global policy principles may be transferred to national level with implications on the processes. The TOC developed addresses some of the limitations of the existing frameworks as it considers the interplay between technical constructs, policy analysis and transfer theories. However, as noted above under study limitations, this TOC has not been tested empirically and therefore further development and refinement of the TOC is encouraged.

On the policy transfer scholarship, there is need to expand on the policy transfer studies in sub-Saharan Africa. The major gaps are in terms of better characterizing or development of frameworks for examining policy transfer strategies given the fluidity in the political and bureaucratic landscape of the region.

9.4 References

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ANNEXES

Annex 1. Ethical approvals

a) University of Pretoria Faculty of Health Sciences Research Ethics Committee

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences

The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.

- FWA 00002567, Approved dd 22 May 2002 and Expires 03/20/2022.
- IRB 0000 2235 IORG0001762 Approved dd 22/04/2014 and Expires 03/14/2020.

30 January 2020

Approval Certificate
New Application

Ethics Reference No.: 38/2019
Title: Assessment of the influence of sustainable development goals declaration on health financing reforms for universal health coverage in Uganda: A stakeholders perspective

Dear Dr WD Odoch

The **New Application** as supported by documents received between 2019-10-25 and 2020-01-29 for your research, was approved by the Faculty of Health Sciences Research Ethics Committee on its quorate meeting of 2020-01-29.

Please note the following about your ethics approval:

- Ethics Approval is valid for 1 year and needs to be renewed annually by 2021-01-30.
- Please remember to use your protocol number (38/2019) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, monitor the conduct of your research, or suspend or withdraw ethics approval.

Ethics approval is subject to the following:

- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

Additional Conditions:

- Approval is conditional upon the Research Ethics Committee receiving approval from Ministry of Health.

We wish you the best with your research.

Yours sincerely

Dr R Sommers
MBChB MMed (Int) MPharmMed PhD
Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes, Second Edition 2015 (Department of Health).

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Tel +27 (0)12 356 3084
Email: deepeka.behari@up.ac.za
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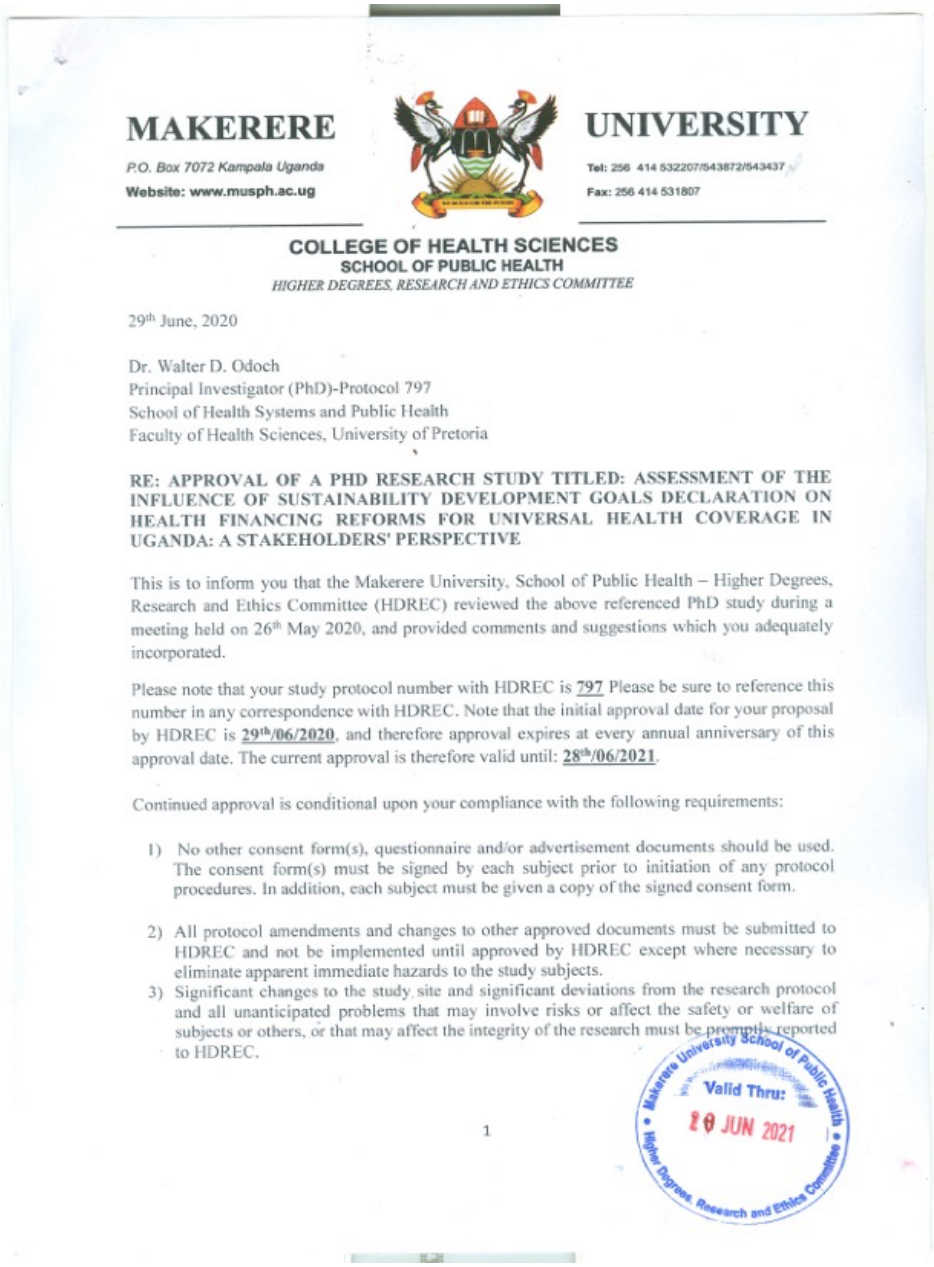
Fakulteit Gesondheidswetenskappe
Lefapha la Disaense Tša Maphelo

b) Makerere University School of Public Health (MakSPH) Higher Degrees Research and Ethics Committee (HDREC)



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COLLEGE OF HEALTH SCIENCES
SCHOOL OF PUBLIC HEALTH
HIGHER DEGREES, RESEARCH AND ETHICS COMMITTEE

29th June, 2020

Dr. Walter D. Odoch
Principal Investigator (PhD)-Protocol 797
School of Health Systems and Public Health
Faculty of Health Sciences, University of Pretoria

RE: APPROVAL OF A PHD RESEARCH STUDY TITLED: ASSESSMENT OF THE INFLUENCE OF SUSTAINABILITY DEVELOPMENT GOALS DECLARATION ON HEALTH FINANCING REFORMS FOR UNIVERSAL HEALTH COVERAGE IN UGANDA: A STAKEHOLDERS' PERSPECTIVE

This is to inform you that the Makerere University, School of Public Health – Higher Degrees, Research and Ethics Committee (HDREC) reviewed the above referenced PhD study during a meeting held on 26th May 2020, and provided comments and suggestions which you adequately incorporated.

Please note that your study protocol number with HDREC is **797** Please be sure to reference this number in any correspondence with HDREC. Note that the initial approval date for your proposal by HDREC is **29th/06/2020**, and therefore approval expires at every annual anniversary of this approval date. The current approval is therefore valid until: **28th/06/2021**.

Continued approval is conditional upon your compliance with the following requirements:

1) No other consent form(s), questionnaire and/or advertisement documents should be used. The consent form(s) must be signed by each subject prior to initiation of any protocol procedures. In addition, each subject must be given a copy of the signed consent form.

2) All protocol amendments and changes to other approved documents must be submitted to HDREC and not be implemented until approved by HDREC except where necessary to eliminate apparent immediate hazards to the study subjects.
3) Significant changes to the study site and significant deviations from the research protocol and all unanticipated problems that may involve risks or affect the safety or welfare of subjects or others, or that may affect the integrity of the research must be promptly reported to HDREC.

Makerere University School of Public Health
Valid Thru:
29 JUN 2021
Higher Degrees, Research and Ethics Committee

1

4) All deaths, life threatening problems or serious or unexpected adverse events, *whether related to the study or not,* must be reported to HDREC in a timely manner as specified in the National Guidelines for Research Involving Humans as Research Participants.

- Please complete and submit reports to HDREC as follows:

a) For renewal of the study approval – complete and return the continuing Review Report – Renewal Request (Form 404A) at least 60 days prior to the expiration of the approval period. The study cannot continue until re-approved by HDREC.

b) Completion, termination, or if not renewing the project – send a final report within 90 days upon completion of the study.

- Finally, the legal requirement in Uganda is that all research activities must be registered with the National Council of Science and Technology. The forms for this registration can be obtained from their website www.uncst.go.ug. Please contact the Administrator of the Higher Degrees, Research and Ethics Committee at hdrecadmin@musph.ac.ug or telephone number (256)-393 291 397 if you encounter any problems.

Yours sincerely

Makerere University School of Public Health
Valid Thru:
28 JUN 2021
Higher Degrees, Research and Ethics Committee

Dr. Suzanne Kiwanuka
Chairperson: Higher Degrees, Research and Ethics Committee

Enclosures:

a) A stamped, approved study documents (informed consent documents):

2

Annex 2: Informed consent and participant information

1. Project information

1.1 Title of research project

Assessment of the influence of sustainable development goals declaration on health financing reforms for universal health coverage in Uganda: A stakeholders' perspective

1.2 Researcher details

Dr Walter Denis Odoch, PhD Student, School of Health Systems and Public Health

1.3 Research study description

I am inviting you to participate in this study that aims to (1) explore the influence of SDGs declaration on health financing reforms for UHC in Uganda, and (2) develop a theory of change on how SDG declaration can lead to desired reforms in health system financing for UHC.

This study is being conducted in Uganda and the specific objectives of the study are: -

i. Explore changes in health system financing in Uganda from 2005 (before WHA resolution on UHC) to 2020 (after SDGs declaration with UHC as a one of the targets)
ii. Examine the influence of SDGs declaration on health financing reforms (changes) for UHC in Uganda.
iii. Identify the factors, that has facilitated or inhibited the use of SDGs declaration by health advocates and health managers to influence health financing reform for UHC
iv. Develop a theory of change on how international declarations such as SDGs leads to desired health financing reforms in Low Income Countries such as Uganda.

Presently, there is limited information on the viewpoints and the factors underlying those viewpoints amongst national and sub-national health stakeholders. The views can provide an indication on how national and sub-national health managers and health advocates are leveraging on SDGs declaration to accelerate health financing reforms. The perspectives of stakeholders and the underlying factors informing these views will improve our understanding of how global (and

regional) declaration such as SDGs, has influenced financing reforms for UHC. Such information and the frameworks or theories of change from such information is useful to stakeholders including health development partners and regional organizations such as East Africa Community, and East Central and Southern Africa Health Community in their efforts to support national and sub-national health managers and advocates to utilize SDGs as rallying point to accelerate health financing reforms for UHC.

You are being invited to take part in this research because of your experience and knowledge, which can contribute much to our understanding on the linkages between health financing for UHC and SDGs declaration. In taking part, we are requesting a research interview with you lasting for approximately one hour.

Your participation is voluntary, and you can opt out of the study at any time. The information you provide will be considered confidential, and your response will be anonymized in the write-up of results. In this way, no participants in the study will be identified by name in the report, nor by any other details of professional affiliation that may suggest their identity.

The plan is for this study to be completed by the early 2021. Between 2019 and 2020, we will conduct interviews at national and district level. We will share a report on preliminary findings among study participants in late 2020 for their review before nay publication. Policy briefs will be produced and disseminated at national level. In addition, findings will be published in a scientific journal that provides open access to readers.

The study will provide no direct benefits to you, but your participation is likely to help us develop a theory of change that can be used by countries including Uganda to ensure the requisite steps are taken to translate SDGs and other regional declarations into desired outcomes such as effective and equitable health financing for UHC.

If you have any questions/concerns, please do not hesitate to contact University of Pretoria Faculty of Health Sciences Ethics Committee or Chairperson, Health Higher Degrees Research and Ethics Committee Makerere University School of Public

UP Faculty of Health Sciences Ethics Committee	Faculty of Health Sciences Research Ethics Committee, University of Pretoria Room 4-60, Level 4, Tswelopele Building University of Pretoria, Private Bag x323 Gezina 0031, South Africa Tel +27(0)123563084 Email: deepeka.behari@up.ac.za
Makerere University School of Public	*Chairperson*, Health Higher Degrees Research and Ethics Committee Makerere University School of Public. Email: hdrecadmin@musph.ac.ug, skiwanuka@musph.ac.ug PO Box 7072 Kampala, Uganda

2. Informed consent

2.1 I, _____ hereby voluntarily grant my permission for participation in the project as explained to me by **Dr Walter Denis Odoch**

2.2 The nature, objective, possible safety and health implications have been explained to me and I understand them.

2.3 I understand my right to choose whether to participate in the project and that the information furnished will be handled confidentially. I am aware that the results of the investigation may be used for the purposes of publication.

2.4 Upon signature of this form, the participant will be provided with a copy.

Signed: _____ Date: _____

Witness: _____ Date: _____

Researcher: _____ Date: _____

Annex 3: Key Informant Interview Guide

A. Explore changes in health system financing in Uganda from 2000/01 to 2020/21

1. What some of the events you can points as landmark changes to health financing system in Uganda (2000/01-2020/21): *Probes*
   - General organization in financing arrangement
   - Revenue raising
   - Pooling of revenue
   - Purchasing methods
   - Benefits package design
   - Financing policy objectives
2. What were the factors that led to the changes have mentioned? *Probes*
   - Who have been key stakeholders (main players at different time periods)?
   - How have the positions of stakeholders changed over time (at different time periods)?
   - Elaborate on some of the contextual (economic, political, epidemiological) factors that have influence the changes
3. To what extent does the reforms you mentioned above align with WHO principles of reforms that advance UHC such as
   - More funding is from public sources
   - Financial protection
   - Strategic purchasing
   - Number of pools
   - Use according to need
4. How are these policy principles (WHO principles) being transferred (or been transferred)?

   Probe for

   - Policy transfer mechanisms
   - Degree of Transfer

B. Examining the influence of SDG declaration on health financing (reforms) for UHC in Uganda.

1. How is SDG declaration influencing health financing system in Uganda?

Probes

- Specific changes in health financing functions or objectives after the SDG declaration (***From literature: Agenda setting, Legislation, Policy reforms, changes in Health financing organization)***
- How would you describe, in terms of speed of process of health financing reforms after the SDG declaration? (from Lit: there was acceleration in reform processes)
- How has SDG declaration influenced actors who are involved or interested in health financing reforms: position, power and interest?
    - Are national actors using SDG declaration to advance, advocate, accelerate the process of health reforming health financing towards SDG
- Any specific legislation on health financing developed as result of SDG declaration
- Was a national health (financing) strategy or policy developed or revised following the SDG declaration? OR How does national framework, strategy or plan on the SDGs relate to health financing strategy?

C. What are some of the factors that have facilitated and inhibited the use of SDG declaration in influencing health financing reforms for UHC?

Probes

- How have health officials and health advocates used SDGs declaration to advance health financing reforms for UHC?
    - *Probes*
        - capacity
        - optimally utilized the declaration as tool of advocacy or lobbying

- What factors have facilitated (or would facilitate) SDG declaration to influence health financing reform for UHC?
    - *Probes*
        - Contextual factors: funding, policy, politics, bureaucratic structure.

D. Development of a theory of change on how SDG influences health financing reforms for UHC

1. What would you consider as elements in the process of ensuring international declarations is translated at national level?
2. In the context of SDGs declaration and health financing for UHC
    - What are the key issues or elements needed in the process of reforming health financing reforms for UHC?
    - What are the necessary conditions that ensures SDGs declaration can be utilized effectively to drive the health financing reforms for UHC?
    - Key stakeholders (who should be engaged), what structures/systems

Annex 4: Snapshot of published and accepted papers

1. A critical review of literature on health financing reforms in Uganda – progress, challenges and opportunities for achieving UHC

African Health Sciences - Decision on Manuscript ID WKR0-2021-06-1075.R2
1 message

African Health Sciences <onbehalfof@manuscriptcentral.com> Mon, Feb 14, 2022 at 5:11 AM
Reply-To: kabaleimc@gmail.com
To: wodoch2018@gmail.com, wodoch@ecsahc.org

13-Feb-2022

Dear Dr Odoch:

It is a pleasure to accept your manuscript entitled "A critical review of literature on health financing reforms in Uganda – progress, challenges and opportunities for achieving UHC" in its current form for publication in the African Health Sciences. The comments of the reviewer(s) who reviewed your manuscript are included at the foot of this letter.

Thank you for your fine contribution. On behalf of the Editors of the African Health Sciences, we look forward to your continued contributions to the Journal.

Sincerely,
Professor James Tumwine
Editor-in-Chief, African Health Sciences
kabaleimc@gmail.com

Reviewer(s)' Comments to Author:

2. How are global health policies transferred to sub-Saharan Africa countries? A systematic critical review of literature

Globalization and Health

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How are global health policies transferred to sub-Saharan Africa countries? A systematic critical review of literature

Walter Denis Odoch ✉, Flavia Senkubuge, Ann Bosibori Masese & Charles Hongoro

Globalization and Health **18**, Article number: 25 (2022) | Cite this article

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3. How has sustainable development goals declaration influenced health financing reforms for universal health coverage at the country level? A scoping review of literature

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How has sustainable development goals declaration influenced health financing reforms for universal health coverage at the country level? A scoping review of literature

Walter Denis Odoch ✉, Flavia Senkubuge & Charles Hongoro

Globalization and Health **17**, Article number: 50 (2021) | Cite this article

3421 Accesses | **4** Citations | **8** Altmetric | Metrics

Abstract