International Journal for Equity in Health

REVIEW

Open Access

Global strategies for implementing health financing equity – a state-of-the-art review of political declarations

Alexandre Nimubona[1*], Innocent Yandemye[2], Chartière Nigaba[3] and Beatrice Abura[4]

Abstract

Background Implementing health financing equity plays a determining role in achieving Universal Health Coverage. For this reason, the global health community stated multiple political declarations to guide health financing equity implementation in countries. The aim of this study was to investigate the global strategies for implementing health financing equity that emerged from political declarations made before 2024.

Methods Using a state-of-the-art review design, we identified the political declarations from the search of United Nations databases and the snowball search. We used textual and theoretical thematic analysis methods to extract the global strategies of health financing equity implementation that emerged from the political declarations. We grounded the global strategies in the existing practical framework – the Health Financing Progress Matrix of the World Health Organization. We employed a time-based descriptive analysis method to document the results. Quantitative information was used to shape the analysis.

Results In total, 40 political declarations were included in the review. From these declarations emerged the strategies of targeted, selective, contributive, universal, claims, proportionate, experimental, united, and aggregated financing to implement health financing equity in countries. Thirty nine of the 40 political declarations that labelled the global health community from 1944 until 2023 placed more efforts on duplicating the prevailing strategies. The declarations, categorised into nine groups (target, unity, universality, selectivity, contribution, aggregation, claims, experience, and proportionality-oriented political declarations), were insistent to press countries effectively implement the strategies.

Conclusion The political declarations proved to be the essential markers of the global health community's efforts to raise the profile of health financing equity in countries. Although some of the global strategies that emerged from the political declarations have been shown promise in different countries, any global strategy is neither effective nor optimal for providing efficient and sustainable UHC in all countries. This lays the groundwork for careful management and adaptation of the global strategies to the diverse needs of the diverse population.

Keywords Political declaration, Health financing equity, Global strategy, Health financing progress matrix, Universal health coverage

*Correspondence:
Alexandre Nimubona
fbpalexine.bi@gmail.com
Full list of author information is available at the end of the article

Background

Extensive research has shown that countries implement differently health financing equity to advance towards Universal Health Coverage (UHC) worldwide [1–4]. The UHC is globally recognised as a context in which everyone can have quality health services in need at any time and from anywhere without financial constraints [5]. The UHC became a benchmark goal for all countries [5]. Implementing health financing equity plays a determining role in achieving UHC because, by definition, health financing equity consists of disconnecting people's needs for health services from the ability of such people to produce income and pay for these services – health services are financed by people with the ability to sufficiently produce and pay but accessed, used and consumed by everyone in need regardless of their capacity to pay [2–4].

The health financing equity that resembles what we think of today began in the eighteenth century when the global health community observed a disproportional distribution of health problems and resources in the world [6, 7]. On this matter, the global health community stated multiple political declarations to guide health financing equity implementation in countries [1, 2, 6, 8–10].

In this study, political declarations are agreements that arise from globally recognised assemblies, conferences, summits, or forums on the global strategies required to implement health financing equity and achieve UHC in countries [11–13].

Reviewing the political declarations is of considerable interest because: (i) the political declarations govern countries' behaviours when implementing health financing equity [13], however, global strategies (referred to here as globally planned actions or normative statements that shape expectations through giving national policy guidelines to ensure sustainable financial coverage [14]) that emerged from the political declarations remained understudied, imprecise, and ambiguous [15, 16]. To illustrate this further, the 1978 Alma Ata declaration on primary health care did talk about equity and community participation where the community resource broadly interprets the capacity of state-facilitated health care institutions are jointly managed by the community [17]. The declaration is recognised as too broad – the specific contribution of community participation for implementing the health financing equity is as understudied [17]. In the similar way, the 2018 Astana declaration committed to prioritising disease prevention and health promotion [18]. In this context, countries of all income levels continue to face challenges in financing primary health care in a way that affects health financing equity throughout the whole health system [17, 18]; (ii) the political declarations are supposed to build on key health issues, nevertheless, evidence shows that health financing inequity that dominates all challenges to country's health systems [19] remains – health financing inequity is causing death of people on large-scale and, this is expected to persist in countries in the coming decades [20, 21]. A well-known example of persistent health financing inequity is the pro-rich distribution of health financing services in resource limited countries [2]; (iii) as the political declarations often arise from past experiences (e.g., COVID-19 pandemic and the 2023 political declaration on pandemic prevention, preparedness and response [22]),we believe that a health financing equity oriented review of these declarations may offer lessons for further development of health financing equity.

The health financing equity is not new in the global health debates [23]. This can be illustrated briefly by various global financing strategies such as targeted, contributive, universal, etc. financing that have long been advised by the global health community to implement health financing equity and achieve UHC [24–26]. Nevertheless, the achievement remains ineffective [23]. A classic example of this ineffectiveness is that people with financial constraints when seeking quality health services have globally increased from 12.6 per cent in 2015 to 13.5 per cent in 2019 [27].

Situation is such whereas the global health community set up over time these political declarations with one of the main intentions of pressing countries to implement health financing equity in their respective contexts [23, 28]. Worryingly, there is no much scientific debate that these political determinants of health financing equity implementation (political declarations) [23, 28] have significantly influenced the country-level UHC advancements [29].

Since they are sometimes deemed to ignore the myriad circumstances that enter into the health financing equity implementation in different countries [29], the political declarations remained symbolic in some countries and have received insufficient countries attention when trying to implement health financing equity [23, 28].

The aim of this study was to investigate the global strategies for implementing health financing equity that have emerged from the political declarations made before 2024. This is one of the scarce reviews of political declarations that aimed at implementing health financing equity in the world. This review should significantly aid in the observance of political declarations when implementing health financing equity in countries – the paper tracks the global health community agreements towards health financing equity, and may be useful to align domestic and global health initiatives to close gaps in implementing health financing equity.

Methods

Design

The state-of-the-art (SotA) review was appropriate to address the aim of this study – this design offers a time-based overview of ideas on an interesting topic (which in this study is health financing equity) for future policy considerations [30, 31].

We followed six steps for reporting a SotA review proposed by Barry et al. to perform this review [30] as indicated in the following figure (Fig. 1):

> The first three steps involved framing the study question, topic and time: what global strategies for implementing health financing equity emerged from political declarations made before 2024? The fourth step was about gathering political declarations using relevant search strategies. The fifth step consisted of analysing and interpreting political declarations from a health financing equity implementation perspective. The last step described the study team's expertise, which influenced their interpretations of political declarations (reflexivity). Plus, we followed the recommendations for specifying and reporting implementation strategies offered by Enola K. et al., as well as the EQUATOR network [32, 33]. This consisted principally of identifying the global strategies and their emergence/reemergence over time.

Search strategies

Countries recognised and accepted health financing equity thanks to the efforts of the United Nations (UN) [6]. For this reason, we conducted a systematic search (at the global level) for the terms "political declaration" AND "health" in four most relevant UN databases including the UN Digital Library: https://digitallibrary.un.org, the World Health Organization's (WHO) Institutional Repository for Information Sharing (IRIS), which is available at: https://apps.who.int/iris/; the International Labour Organization (ILO) Library, available at: https://labordoc.ilo.org/; and the World Bank (WB) Open Knowledge Repository (OKR): https://openknowledge.worldbank.org. We used the MeSH term "health" instead of "health financing" to broaden the coverage and capture the maximum of political declarations dealing directly or indirectly with health financing.

We exploited the "snowball search", also known as "citation pearl", etc. [34, 35] to identify additional political declarations (Fig. 2). This strategy builds on one document (termed here political declaration) that is identified as most relevant to a study topic – the document is designated "pearl" [34, 35]. Here, the "pearl" was the 2023 political declaration on UHC [27] because this was the most relevant latest political declaration that met the inclusion criteria in 2023.

To find relevant political declarations from the "pearl", we manually checked declarations that were cited in

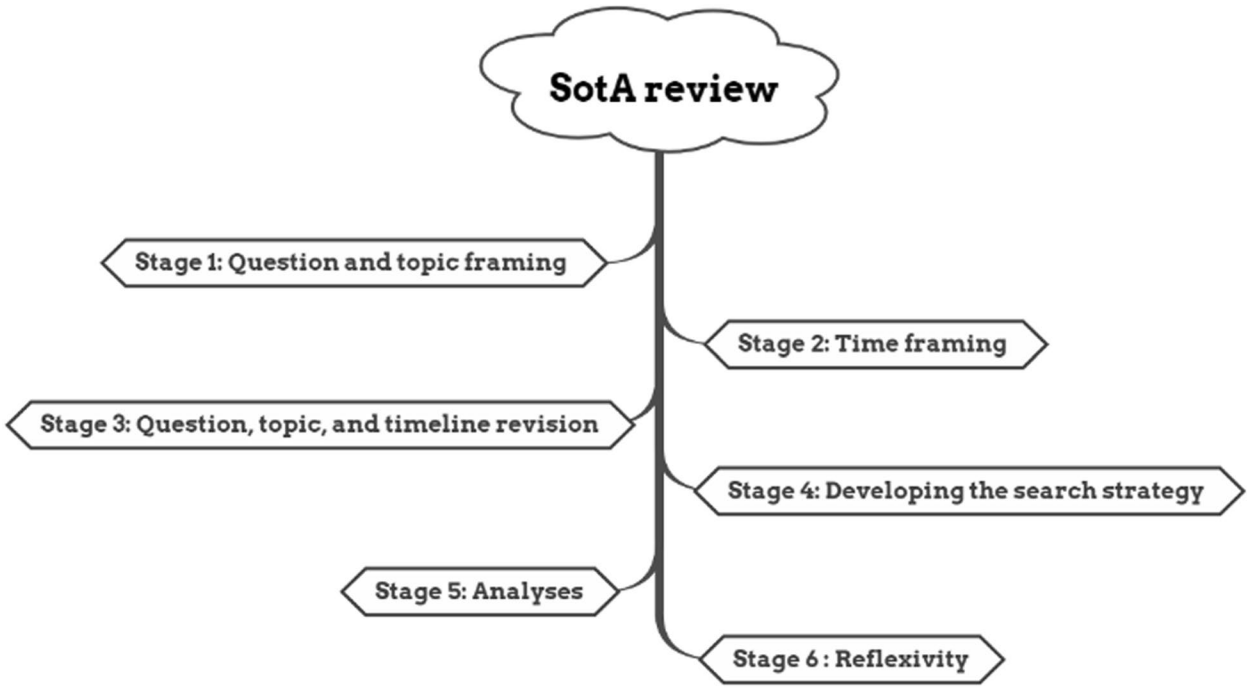

Fig. 1 Six steps for reporting a SotA review

Source: adapted from [30, 31]

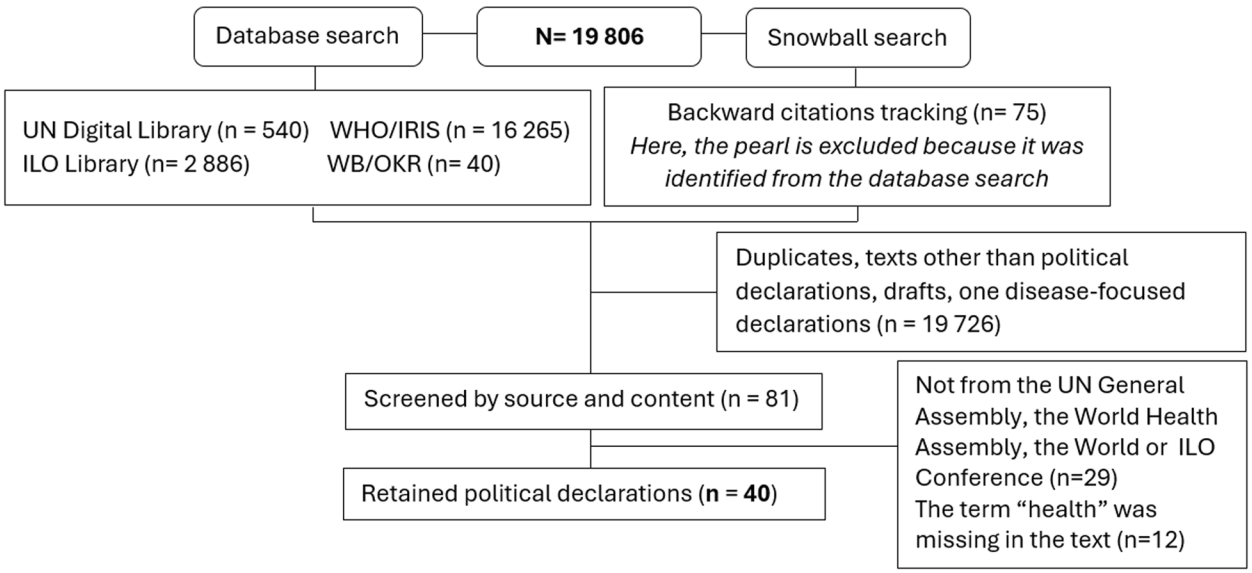

Fig. 2 Selection of political declarations

the "pearl" text – citation tracking [34, 35]. We continued to search backward citations until any further citation of relevant political declaration had been found. We searched Google for the quoted declarations in the citations string.

We chose the "citation pearl" for two main reasons: (i) the strategy can be effective to master how a piece of knowledge on a researcher's topic of interest (health financing equity in this study) has evolved [34] – this conforms with the present study aim and design; (ii) the "citation pearl" can be more effective than searching databases in narrowing down relevant literature to a particular topic [34].

We exported the political declarations from both the database and snowball searches into Mendeley software to remove duplicates.

Eligibility criteria

We included political declarations in English or French that met the criteria in table below and made before 2024 (Table 1).

Data extraction

We used textual and theoretical thematic analysis methods, which are both driven by the topic of a researcher's interest [37, 38].

Table 1 Criteria for inclusion and exclusion

Inclusion	Exclusion
The document is listed in the category of resolutions and decisions	Document other than the text of the political declaration itself (e.g., reports, papers, etc.)
The text of political declaration is an outcome of the UN General Assembly, the World Health Assembly, the ILO Conference or any other world conference, summit, forum or congress (i.e., gathering people from diverse regions of the world under the authority of the UN, WHO, WB, or ILO)	Draft political declaration because it is not validated by the assembly, conference, summit, forum, or congress
	Continental, regional, or national declarations that can be implemented without considerable implication of the global health community
The title or text of political declaration contains at least the term "health" to ensure that it has a health financing view	The one disease-specific political declaration because, the disease-based initiatives are time-limited, i.e., may end with the end of the disease or the disease-related efforts may decline with the decreased severity or magnitude of the disease [36]. Furthermore, we estimate that such a kind of declaration lacks universality character on which health financing equity is grounded – the declaration deals with one disease coverage instead of variety of health issues.

Source: Authors' elaboration

Using a health financing lens, we performed textual analysis by making descriptive summaries of political declarations – this fits in the purpose of a SotA review [30, 37]. We employed the Scholarcy Article Summariser to generate the descriptive summaries. The scholarcy is an artificial intelligence tool that can be used in academic research to generate automated summary from a text [39].

To perform theoretical thematic analysis, we turned the summaries into health financing equity-related themes referred to here as global strategies. To do so, each author followed four stages: a) asking the Scholarcy to generate a health financing related summary from each political declaration – automated summary; b) reviewing and synthesising by hand the automated summary into five to 15 words; c) extracting manually a health financing-related message from each political declaration, considering the context – human summarisation in no more than 15 words; and d) confronting the human summary with the synthesis from the automated summary to build a global strategy or theme.

We grounded the global strategies on the 19 desirable attributes of the Health Financing Progress Matrix (HFPM) [40, 41] for six major reasons. First, the HFPM is the WHO's global qualitative framework to appraising health financing strategies in terms of development and implementation. Second, the HFPM pools all the existing health financing strategies in a single framework. Third, the HFPM is certified as a useful tool to summarise, interpret the existing strategies of financing, and provide guidance on the future health financing directions. Fourth, the HFPM can be applied in any context and/or country that aims to implement health financing equity and reach the UHC. Fifth, the HFPM aligns with the political declarations' focus on global macro-economic governance of health financing equity implementation by providing a framework for assessing and improving health financing systems tailored to each country and global health goals [40, 41]. Sixth, to provide a robust theoretical foundation to the theoretical thematic analysis method used in this study.

The authors synthesised the 19 attributes of the HFPM into nine global strategies of health financing equity implementation: (i) targeted financing aligns benefits package with the available resources and population in need; (ii) selective financing uses a public budget (occasionally supported by external aid) to universalise a specific package of health services in specific health facilities for a specific or whole population; (iii) contributive financing wherein citizens financially contribute to a health insurance scheme in order to have access to comprehensive health services. The richest can contribute for both themselves and the poorest. Although the contribution amount may vary according to income, health services are made available to anybody in need at any time; (iv) universal financing mobilises the general government budget to finance health services as a fundamental right for everyone. All country residents, regardless of social status, have access to the similar package of health services at no or lowest costs; (v) proportionate financing in which a country designs different proportionate shares of financial contribution for different groups of the population depending on income level, as well as different benefit packages for different groups of the population based on needs. The contribution (via taxes, payroll, insurance premiums, user fees, etc.) is relative to the ability to pay, whereas access to one of the various preset benefit packages is determined by needs; (vi) claims financing is founded on self-determination and uprightness of people towards health services. People claim their health services financing needs. The financer or purchaser evaluates the rightfulness of the claim and, if appropriate, grants the funds to the claimant; (vii) experimental financing involves testing new approaches or ideas to finance health services in a more effective way; (viii) united financing (different from diversified financing, which refers to fragmented but well-coordinated financing) includes the joint financing from multiple strategies for an effective coverage – a country combines two or more strategies that work in complementarity rather than in competition to fill each other's gaps and broaden coverage; (ix) aggregated financing, in which a country adopts one or more of the aforesaid strategies per population group, set of services, and/or geographical area. In this way, people with different statuses have several kinds of work and workplaces that can fit in different strategies within a same country [40, 41].

The authors organised three online meetings to compile and revise each other's global strategies deduced from the political declarations. If the authors identified different strategies (where the declarations are linked to different strategies of financing), they debated until they reached a consensus. The EQUATOR Network's scale for expressing agreement [33] was used to measure the authors' consensus on each strategy. The scale has nine points, with one denoting "strongly disagree" and nine denoting "strongly agree" [33].

Practically the first author presented the global strategies deduced from each political declaration. Each author had to secretly fulfil the nine-point scale for each presented strategy, considering the content of the political declaration. There was consensus on a strategy when all of the authors selected 7–9. The global strategies that received this score were immediately considered final. Strategies with a score of less than 7 from at least one author were subjected to revision. This implies that if more than one global strategies emerged from one

political declaration, the authors retained the more consensual strategy.

Data analysis

We used a time-based descriptive analysis of the global strategies to help understanding. This involved describing the strategies in a language that is compatible with the existing literature on the HFPM [42–46].

For the validity of this analysis [47], the authors compared their results with the other illustrative studies chosen randomly from different countries of the world (discussion).

Some quantitative information (e.g., the prevalence of global strategies in political declarations) was included to shape the analysis.

Results

The figure illustrates that 40 of the 19 806 political declarations initially identified were included in the review. This stresses the rigorous methods applied to guarantee the relevance and quality of the selected political declarations.

Global strategies

Table 2 shows that implementing health financing equity involves multiple optional strategies from the global health perspective.

From 1944 until 2023, multiple global strategies emerged in an iterative way (except the strategy of proportionate financing) from 40 political declarations to move the world closer to UHC.

The most prevalent (occured10 times) and common global strategy was targeted financing. This strategy has been emerged in the global health world first in 1994, and reemerged in 1995,2000, 2001, 2002, 2005, 2012, 2014, 2022, and 2023 with the purpose of suggesting countries to direct gradually funds to the most vulnerable people, services, and/or geographical areas [27, 48, 54, 56–58, 68, 70–72, 74, 76, 86].

The other popular strategy in the global health community was united financing, which has occurred seven times in 1945, 2005, 2008, 2011, 2015, 2016, and 2019 to highlight the importance of financing health in a joint and complementary way amongst eventual multiple strategies of financing in place for an effective coverage [49, 53, 61, 64, 67, 84].

The strategy of universal financing has been repeated six times in 1944, 1948, 1976, 1995, 2002, and 2015 as one of the key focusses to ensure services and financial coverage for all, regardless of needs or particularities [55, 69, 73, 80, 83, 85].

Selective financing has been replicated five times in 1990, 2005, 2011, and twofold in 2018, to emphasise the necessity of choosing best providers from specific locations to purchase health services for a specific group of the population (from whom, where and for whom to purchase health services?) [51, 59, 66, 77].

The strategy of contributive financing has been appeared four times in 1972, 1978, 1987, and 1992 with the aim of narrowing gaps between the poor and the rich in terms of financing and quality services coverage, and increase the accountability of the population in services utilisation and consumption [78, 79, 82].

Aggregated financing occurred three times in 2008, 2014, and 2019 to stimulate countries to track the financial flows amongst multiple existing strategies of financing and ensure that all of those strategies remain coherent with equity in population, services, and geographical coverage [50, 63, 65].

The strategy of claims financing has been emerged twofold in 1973 and 1993 with the aim of financing health services after they are delivered and consumed [75, 81].

Experimental financing has been endorsed two times in 2011 and 2023 with the goal of testing on the fields novel strategies to move ahead in terms of effectiveness and quality in coverage [22, 60].

The most innovative strategy that has emerged from political declarations was proportionate financing because the strategy emerged once in 2008. Within this strategy, coverage may vary amongst different demographic groups according to needs – those in greater needs receive more coverage (in both services and financing) and vice-versa [62, 87].

Political declarations and financing strategies – linkages

The Table 3 indicates the main linkages that the authors established between the political declarations and the global strategies of financing. These linkages resulted from the confrontation of the automated and human summarisation of the political declarations. The linkages helped the authors in determining what types of global strategies were, by consensus, appropriate.

In accordance to this table, a package of political declarations are linked with each of the nine global strategies.

A range of one to 10 political declarations were in each package.

Discussion

Political declarations

This study found 40 political declarations from which emerged the global strategies of health financing equity implementation from 1944 until 2023 [22, 27, 48–87]. The statement years of these declarations (Table 2, column 3) indicated that health financing equity has long

Table 2 Time-based overview of political declarations and emerging global strategies of health financing equity implementation

No	Political declarations	Year	Synthesis of automated summary	Authors' summary	Global strategies
1	Declaration on UHC [27] (Pearl)	2023	Sustainable, equitable and efficient health financing	Observing the UHC targets	Targeted financing
2	Declaration on pandemic prevention, preparedness and response [22]	2023	Global cooperation to pandemic management	Trying new approaches to pandemic financing	Experimental financing
3	Declaration on improving global road safety [48]	2022	Integrating traffic safety financing into health development agendas	Setting extra-health targets for everyone's health security	Targeted financing
4	Declaration on UHC [49]	2019	Universal access to quality care	All in better health and financial security	United financing
5	Declaration for the future of work [50]	2019	Healthful and coherent working financial conditions	Greater coherence within multiple financing systems	Aggregated financing
6	Declaration on primary health care [51]	2018	Leaving no one behind	More people protected from health issues	Selective financing
7	Declaration on prevention and control of non-communicable diseases [52]	2018	Exploring innovative financing ways and partnerships	Connecting with the most vulnerable people	Selective financing
8	Declaration on antimicrobial resistance [53]	2016	Ensuring public return on investment and engaging with multiple financing mechanisms	Equitable access to affordable medicines is a shared responsibility for everyone	United financing
9	Declaration of sustainable development goals [54]	2015	Increasing budget for health risks management	Leading everyone to healthy and productive life	Universal financing
10	Action agenda on financing for development [55]	2015	Global financing facility to address the disproportionate health issues	International coordination and multi-stakeholder partnerships for health financing	United financing
11	Declaration on small Island developing States [56]	2014	Comprehensive policies to address health challenges	Engagement of all stakeholders to mobilize health resources and drive change	Aggregated financing
12	Declaration on landlocked developing countries [57]	2014	Innovative financing mechanisms to address the challenges of landlockedness	Mobilizing domestic and external resources to address health-related landlockedness issues	Targeted financing
13	Declaration on sustainable development [58]	2012	Increased health financing for improved access to health technologies and health care	Efficient financing to improve the health of women, youth and children	Targeted financing
14	Declaration on prevention and control of non-communicable diseases [59]	2011	Cost-effective interventions for non-communicable diseases	Scaling-up cost-effective interventions for UHC	Selective financing
15	Declaration on social determinants of health [60]	2011	Strengthening risk pooling systems to prevent catastrophic health expenditure	Trials of innovative pooling mechanisms across large groups of people	Experimental financing
16	Declaration on the least developed countries [61]	2011	Setting up policy measures to strengthen domestic and international financing mechanisms	Building sustainable domestic financing mechanisms with the support from development partners	United financing
17	Declaration on financing for development [62]	2008	Modernizing and broadening tax systems that channel savings to all groups of the population	Efficient financing that meets the needs of poor, medium, and rich people	Proportionate financing
18	Declaration on social justice for a fair globalisation [63]	2008	Extending safe working conditions and social security to all	A just share of progress on financial protection in health for all kinds of workers	Aggregated financing
19	Declaration on African's development needs [64]	2008	Increasing official development assistance to reduce mortality	Increasing debt sustainability and effectiveness to improve gross national income	United financing
20	Declaration on disaster reduction [65]	2005	Integrating disaster risk reduction planning into the health sector	Protecting critical health facilities and assisting vulnerable populations affected by disasters	Targeted financing
21	Declaration on aid effectiveness [66]	2005	Aligning aid with national health development strategies	Transparent and reliable budget reporting systems to map people left behind	Selective financing
22	World summit outcome [67]	2005	Supplementing traditional financing sources to improve health systems	Improving health outcomes and health gains	United financing
23	Declaration on sustainable development [68]	2002	Increasing domestic and international financing to deliver efficient and equitable health services	Quality health services for all, especially the poor and vulnerable populations	Targeted financing
24	Consensus on financing for development [69]	2002	Effective, efficient, transparent, and accountable financing	Effective resource mobilization for all segments of society	Universal financing

Table 2 (continued)

No	Political declarations	Year	Synthesis of automated summary	Authors' summary	Global strategies
25	Declaration on the least developed countries [70]	2001	Increasing public expenditure for achieving health targets	Prioritize the needs of the most vulnerable populations	Targeted financing
26	Declaration on millennium development goals [71]	2000	Facilitating duty- and quota-free access for exports to finance health initiatives	Increasing financial and technical resource mobilisation for health	Targeted financing
27	Declaration on social development [72]	1995	School-based and community-based health financing programs	Providing equal opportunities in healthcare financing for women and children	Targeted financing
28	Declaration on equal treatment of men and women [73]	1995	Gender-sensitive health financing programs	Gender perspectives in all health financing policies	Universal financing
29	Declaration on sustainable development of small island developing States [74]	1994	Supplementing national efforts by providing concessional assistance	Prioritizing the enhancement of the quality of life	Targeted financing
30	Declaration on human rights [75]	1993	Effective financing remedies for victims	Concerted efforts of financing	Claims financing
31	Declaration on environment and development [76]	1992	Practical and acceptable community-based health financing systems	Burden-sharing among developed and developing people	Contributive financing
32	Declaration on survival, protection, and development of children [77]	1990	Supporting debt relief initiatives	Prioritize children's health and well-being in all financial decisions	Selective financing
33	Charter for health promotion [78]	1987	Coordinated action amongst various stakeholders to support health promotion	Equipping people with the financial skills needed to combat social inequalities	Contributive financing
34	Declaration on primary health care [79]	1978	Combination of community and government efforts for effective health financing	Fostering people's ownership and responsibility in financing	Contributive financing
35	Declaration of principles of income distribution and social progress [80]	1976	Setting up policy framework to guide resource allocation within the society	Creating a comprehensive framework that addresses the health needs of the population	Universal financing
36	Declaration of non-aligned countries [81]	1973	Tackling health financing issues via international cooperation	Responding to financial needs of developing countries and people	Claims financing
37	Declaration on the human environment [82]	1972	Transferring financial and technological assistance to developing countries	Sovereign rights and responsibilities of people when sharing benefits from natural resources	Contributive financing
38	Declaration of human rights [83]	1948	Supporting financial systems that provide security or circumstances beyond an individual's control	Creating financial systems that align with the principles of equality and non-discrimination	Universal financing
39	Charter of United Nations [84]	1945	Promoting solutions to international economic, social, and health problems to address disparities in health financing	Collaborative efforts amongst nations to ensure fair health financing systems for all	United financing
40	Declaration on international labour organisation [85]	1944	Extending social security measures to provide income and comprehensive health services to those in need	Stabilising world prices of primary products for the overall health and well-being of populations	Universal financing

Table 3 Linkages between the political declarations and global strategies of financing

No	Political declarations	Year	Linkages between the declarations and financing strategies
1- Targeted financing			
1	Declaration on UHC [27] (Pearl)	2023	The important and core content of this set of political declarations was about setting priorities for closing gradually health gaps
2	Declaration on improving global road safety [48]	2022	
3	Declaration on landlocked developing countries [57]	2014	
4	Declaration on sustainable development [58]	2012	
5	Declaration on disaster reduction [65]	2005	
6	Declaration on sustainable development [68]	2002	
7	Declaration on the least developed countries [70]	2001	
8	Declaration on millennium development goals [71]	2000	
9	Declaration on social development [72]	1995	
10	Declaration on sustainable development of small island developing States [74]	1994	
2- United financing			
1	Declaration on UHC [49]	2019	This package of political declarations called for concerted efforts amongst multiple stakeholders to address governance concerns
2	Declaration on antimicrobial resistance [53]	2016	
3	Action agenda on financing for development [55]	2015	
4	Declaration on the least developed countries [61]	2011	
5	Declaration on African's development needs [64]	2008	
6	World summit outcome [67]	2005	
7	Charter of United Nations [84]	1945	
3- Universal financing			
1	Declaration of sustainable development goals [54]	2015	The most relevant discourse from this pack of political declarations is removing out-of-pocket from health systems
2	Consensus on financing for development [69]	2002	
3	Declaration on equal treatment of men and women [73]	1995	
4	Declaration of principles of income distribution and social progress [80]	1976	
5	Declaration of human rights [83]	1948	
6	Declaration on international labour organisation [85]	1944	
4- Selective financing			
1	Declaration on primary health care [51]	2018	This group of political declarations favoured allocating resources on high-impact areas and/or populations to address inefficiencies
2	Declaration on prevention and control of non-communicable diseases [52]	2018	
3	Declaration on prevention and control of non-communicable diseases [59]	2011	
4	Declaration on aid effectiveness [66]	2005	
5	Declaration on survival, protection, and development of children [77]	1990	
5- Contributive financing			
1	Declaration on environment and development [76]	1992	This category of political declarations focussed on improving the accountability of the population towards health systems
2	Charter for health promotion [78]	1987	
3	Declaration on primary health care [79]	1978	
4	Declaration on the human environment [82]	1972	
6- Aggregated financing			
1	Declaration for the future of work [50]	2019	This class of political declarations aimed at curbing fragmentation of health systems
2	Declaration on small Island developing States [56]	2014	
3	Declaration on social justice for a fair globalisation [63]	2008	
7- Claims financing			
1	Declaration on human rights [75]	1993	These declarations pointed out the economic cooperation to ensure the right to health
2	Declaration of non-aligned countries [81]	1973	

Table 3 (continued)

No	Political declarations	Year	Linkages between the declarations and financing strategies
8- Experimental financing			
1	Declaration on pandemic prevention, preparedness and response [22]	2023	These declarations aimed at changing health systems behaviours in risks management
2	Declaration on social determinants of health [60]	2011	
9- Proportionate financing			
1	Declaration on financing for development [62]	2008	Categorisation of benefit packages and financial coverage

been a foundation for the political declarations to force countries to move closer to UHC. Comparison of these findings with those of the study of Yao et al. confirms that even before the first political declaration in 1944 [85], health financing equity was always one of the conditions for countries striving to develop their health systems [6]. Health financing equity has become one of the prerequisites to UHC attainment in countries [1–5].

The results of this study demonstrated that except the 2008 political declaration on financing for development [62], the remaining 39 political declarations placed more efforts on duplicating the prevailing strategies – these declarations were insistent to press countries effectively implement the strategies. However, we believe that when under pressure, countries may sometimes behave in ways that do not help solving the targeted issues. This also corroborates the observation from the *Horton R*'s study, which showed that the political declarations focus more on recycling the ancient strategies, and often do not align with reality of the moment in different contexts [28].

The global strategies

The present study found nine global strategies that labelled the nine groups of political declarations for implementing health financing equity from 1944 until 2023 [22, 27, 48–87].

Targeted financing

The first group of ten political declarations was target-oriented. The repeated adoption of targeted financing in the last four decades (10 times from 1994 until 2023) underscores the importance given by the global health community to this strategy in implementing health financing equity – this crucial global strategy directs funds where they are most needed first. The ten target-oriented political declarations demonstrated that targeting should principally involve priority-setting. In this regard, we estimate that countries can use the available resources to target which services are achievable first for whom and/or in which geographical areas. Nonetheless, findings from Medicaid study (public insurance for low-income people in the United States of America) have proved that the strategy of targeted financing is weakened by its lack of universality [88]. For example, many African countries such as Nigeria and Eritrea applied targeted financing during the last decades and have never reached health financing equity [2, 89].

United financing

The second group of seven unity-focussed political declarations favoured the strategy of united financing to mainly address the governance issues via regular concertation efforts amongst stakeholders. This strategy that has been adopted seven times from 1945 until 2019 highlights the complementarity function that should label the governance of the health financing equity implementation. The complementarity function may help multiple strategies in place strengthening each other and broaden coverage. This result goes in line with findings reported in Thailand and Malaysia (Asia) [25]. Thailand combined targeted, contributive, and selective financing to fill gaps from each strategy since the 2000s [24, 25]. This combination filled benefits package and health spending gaps from targeted, contributive, and selective financing. So, the country is now recognised as one of the advanced countries in achieving UHC [24, 25]. By combining contributive and universal financing [90], Malaysia reached roughly 100% population coverage [91]. Contributive financing shifted focus on designing and enforcing standards to broaden service coverage. As reimbursement was conditional on reaching standards in Malaysia, services were gradually made available, especially in remote areas [91]. When effectively managed, contributive financing can fill gaps in service coverage, whereas universal financing may close gaps in population coverage [90, 91].

Universal financing

There is a group of six universality-oriented political declarations that supported the strategy of universal financing. This strategy has been endorsed six times from 1944 until 2015 to emphasise the need for a sensitive approach of financing to everyone – reaching everyone without exception. The universality-oriented declarations advocated the removal of out-of-pocket from the health systems as one of the expert ways to implement health financing equity. However, findings from multiple

Brazilian studies (Latin America) revealed poor quality of coverage as one of the main effects of removing out-of-pocket to establish universal financing. To illustrate this further, all legal residents in Brazil have equal and free access to public health services [92]. Consequently, Brazil faces over-crowdedness at the points of health services – this lowers quality of coverage [92–95]. This implies that universalising population coverage can de-universalise (decline) coverage in quality health services, and vice-versa [92–95].

Selective financing

A group of five selectivity-driven declarations defended the strategy of selective financing to address inefficiencies throughout allocating resources on high-impact areas and/or population. The strategy appeared five times as one of the cost-effective strategies in 1990, 2005, 2011, and 2018. Contrarily, existing evidence show that regardless of its form, selective financing conflicts with the universality character of health financing equity [96, 97]. For example, a study undertaken in sub-Saharan Africa illustrate that many countries applied the strategy of selective financing in the form of selective free health care in public health facilities for pregnant women – this misaligned with universality [96]. Such a kind of misalignment has been observed in other countries such as India (Asia). This said, India focused on controlling few diseases that were more morbid and fatal, and for which effective treatment was available [97].

Contributive financing

The four contribution-founded declarations endorsed four times in 1972, 1978, 1987, and 1992 the strategy of contributive financing as one of the fundamental strategies to enhance the accountability of the population in health services utilisation and consumption. Existing studies indicated that many countries from all income levels such as Germany, Belgium, France, Japan, Netherlands, Russia, some countries from Latin America and Sub-Saharan Africa adopted a mandatory contributive financing to develop an assisted accountability of the population in addressing health financing inequity [2, 98]. Worryingly, the study of Geloso et al. showed that the mandatory financing excels in addressing linear inequities of health financing (e.g., a compulsory payroll deduction in order to make a deadlier disease treatment financially available for every employee) and fails to address complex inequities of health financing [99].

The mandatory financing can also weaken economic system of a country and harm progress on health financing equity [99]. For example, employees can compensate payroll deductions by doing informal activities. To clarify this further, contributive financing is not fully mandatory in Ghana, a country deemed as successful in strategic purchasing for health financing equity in Africa [100]. Nevertheless, contributive financing pushes some Ghanaian employees into tax evasion (e.g., by doing extra informal activities) ranging from 4 to 14% of GDP [100, 101]. The study of O'Hare et al. found that 1% of tax evasion in a country is indirectly responsible for 1% of health coverage loss [102].

Contributive financing, when democratic (voluntary), gives people direct control over their health spending (unassisted accountability), however this strategy has sometimes no positive effect on out-of-pocket [100, 103]. Senegal is one of the countries frequently referred to in the literature as having mastered contributive financing in francophone Africa [104]. A survey on the Senegalese financing system revealed that, whether compulsory or democratic, contributive financing remains subject to poor acceptability by the population [104].

The strategy of contributive financing appeared almost successful in high-income countries and nearly unsuccessful in resource-limited countries [98–104]. From this standpoint, countries should neither disregard or purblindly implement contributive financing, but rather manage it carefully.

Aggregated financing

A group of three aggregation-oriented political declarations endorsed the strategy of aggregated financing to curb fragmentation in the health systems. That said, this strategy has been emerged in 2008 and reemerged in 2014 and 2019 to deal with coherence amongst multiple strategies of financing in place and alleviate fragmentation in population, services and/or geographical coverage. In line with this finding, previous studies specified that Canada is one of the emerging countries in UHC that adopted aggregated financing and reached the UHC service coverage index of 89% [105, 106]. Each Canadian province has its own strategy comprising universal, selective, or contributive financing, or a combination of two or more strategies [106, 107]. Canada teaches that aggregated financing can lead to UHC, however, the cost-effectiveness of quality services delivered to achieve the UHC is widely compromised [106, 107]. This means that implementing aggregated financing may result in a cost-ineffective UHC [106, 107]. In the current resource-constrained world, we believe that countries need to implement health financing equity in pursuing not only effective but also efficient UHC.

Claims financing

Two claims-based political declarations encouraged the strategy of claims financing as a pathway to economic cooperation. Claims financing has been endorsed twofold

in 1973 and 1993 to ensure that the financed health services comply with the UHC standards – this may increase efficiency and effectiveness [75, 81]. The declarations indirectly considered meeting UHC standards as a human right (Table 3) – less progress on UHC may occasionally imply a form of human rights violation (throughout corruption for example) or omission in countries with insufficient public accountability. Research conducted in Australia give some lessons, worth considering in claims financing [108–110]. Since claims are subject to control before approval for payment (providers must achieve quality indicators established by the government), the quality of health services is good but limited to preset indicators [111]. Providers in Australia are free to claim payment for health services delivered – this frequently leads to inefficient payment (probably false claims) [109–111]. As opposed to Australia, implementing claims financing in the United Kingdom led to less health spending and low levels of unmet financing needs compared to many other high-income countries [112].

Other research shown that claims financing has been executed in resource-limited countries in the form of performance-based incentives to promote providers skills in quality health services provision [113]. Claims financing entailed incentivising those who remarkably achieve the intended UHC standards [113]. Multiple research efforts have proven that increasing incentives in resource-limited countries may result in transitory progress, posing a sustainability issue [113, 114].

Experimental financing

The strategy has been adopted by two experience-based political declarations in 2011 and 2023 in seeking effective and quality coverage. The declarations highlighted that risks management is of importance in offering effective and quality coverage. On this regards, research conducted in China offer greater conclusions. The country executed universal financing for essential services to reduce the incidence of impoverishing health spending observed in prevailing strategies. This resulted in significant but insufficient intended equity outcomes (e.g., zero impoverishing health spending) [115]. After, China applied contributive financing, which also failed to avoid impoverishing spending [115]. Now, the country moved to aggregated financing [115] – a study in the United Kingdom validated that if not closely managed, implementing aggregated financing can result in socio-geographic inequities [98].

Proportionate financing

This sole innovative strategy that has emerged from the 2008 proportionality-oriented political declaration on financing for development emphasised the need for efficient, effective and sustainable way of financing health services by categorising both benefit packages and financial coverage [62, 87]. Such a kind of strategy has been observed in Sweden (Europe), where services coverage varies differently across the population depending on health needs – financial coverage is universal, but on a scale proportional to the level of the needs of the population [116, 117]. The study of Francis-Oliviero F. et al. found that this innovative strategy has not yet clear guidelines of implementation. Subsequently, the strategy is not largely executed all over the world [118].

Strengths and limitations

This study employed manual citation tracking in addition to the database search to identify political declarations – no citation graph was possible to present the citation network because the political declarations have no bibliographic references on which the graph is normally created. The manual citation tracking proved to be more objective than other scholar search strategies [119, 120]. Together, the two search strategies used may ensure the generalisability of the political declarations reviewed. These search strategies are replicable to guarantee transparency.

The search strategies did not yield all political declarations made until 2023. The results stressed duplications in the global strategies that emerged from the political declarations. In this regard, we are convinced that the missed political declarations could offer no additional relevant information to the declarations reviewed. As illustration, it is known that political declarations relating to one disease are selective [36].

The declarations reviewed were from grey literature (not peer-reviewed). These declarations were validated by globally recognised assemblies, conferences, summits, or forums attended by academics, Member States, policy makers, etc. The final texts of political declarations were subjected to validation by attendees after initial drafts were prepared by experts [12]. Validation by participants is one of the ways to scientifically approve knowledge [47]. It seems clear that the political declarations should raise no concern about peer-review.

A state-of-the-art review is vulnerable to subjectivity [30]. The authors' meetings allowed for critical debates to mitigate the risk of biased interpretations.

The study excluded the political declarations that focused on one disease. We recognise that in situations where the health system as a whole is weak or when a quick action is required to contain a more serious disease, such political declarations may be useful as a stopgap guideline.

We are uncertain that all of the conclusions made from the 40 political declarations support the opinions of the

participants in the general assembly, conferences, summits, or forums that validated the declarations. Although all of the political declarations cannot have the uniform and universal interpretation in all contexts, we acknowledge that further studies using primary data from the attendees should complete the present study.

For practical considerations, we compared findings from this study with evidence from studies conducted in other countries with different contexts. While the study did not discuss results using evidence from all countries, we are certain that countries from all income levels (high, middle, and low) were represented, and that the results are feasible.

Reflexivity

The authors have expertise in health financing acquired through experience (in their country of origin) and/or training. The reflexions derived from the authors' expertise. The first author has considerable expertise in health financing equity and confessed to dominating the study process. None of the authors participated in the country studies and experiences used to discuss and validate the findings. However, we acknowledge that what is reported in papers cannot always mirror reality in the field. The authors had an outsider position and could not mediate the findings with field experiences in each country. Any country-specific context has influenced this review – although findings can be interpreted differently in different contexts, they have an acceptable level of objectivity.

Conclusion

The present study confirmed that political declarations are the main markers of the global health community's efforts to raise the health financing equity profile in countries. The study found nine global strategies for implementing health financing equity, which are all imbedded in 40 political declarations. These declarations have been categorised into nine groups based on the financing strategies they favoured and adopted: target, unity, universality, selectivity, contribution, aggregation, claims, experience, and proportionality-oriented political declarations. The nine global strategies that labelled the global health community from 1944 until 2023 included targeted, united, universal, selective, contributive, aggregated, claims, experimental, and proportionate financing. Whereas some of these strategies have been shown promise in different countries, health financing inequity persists in countries. Hence, any global strategy is neither effective nor optimal for providing efficient and sustainable UHC in all countries. This lays the groundwork for careful management and adaptation of the global strategies to ensure that the strategies effectively address the diverse needs of the of the diverse population.

Abbreviations

HFPM	Health Financing Progress Matrix
ILO	International Labour Organization
IRIS	Institutional Repository for Information Sharing
OKR	Open Knowledge Repository
UHC	Universal Health Coverage
UN	United Nations
WB	World Bank
WHO	World Health Organization

Acknowledgements

To the reviewers and editor for their insightful remarks and thorough reading of the manuscript.

Provenance and peer review

Not commissioned – peer reviewed externally.

Disclaimer

Not applicable.

Authors' contributions

A.N. initiated, conceptualised, designed, and led the study process; drafted the initial and final manuscripts. I.Y. commented and added ideas. C.N. suggested some changes. B.A pre-reviewed the manuscripts and suggested inputs. All of the authors revised, edited, and approved the final manuscript.

Funding

None.

Data availability

No datasets were generated or analysed during the current study.

Declarations

Ethics approval and consent to participate

Not applicable.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

Author details

[1]Independent Researcher, Brussels, Belgium. [2]Health Care Supply and Demand, Ministry of Health, Bujumbura, Burundi. [3]Public Health Department, Universite Sagesse d'Afrique, Bujumbura, Burundi. [4]Epidemiology Section, Médecins Sans Frontières Belgique, Nairobi, Kenya.

Received: 18 November 2024 Accepted: 1 February 2025
Published online: 15 February 2025

References

1. De Foo C, Verma M, Ying Tan S, et al. Health financing policies during the COVID-19 pandemic and implications for universal health care: a case study of 15 countries. 2023. www.thelancet.com/lancetgh.
2. Asante A, Price J, Hayen A, Jan S, Wiseman V. Equity In Health care financing in low-and middle-income countries: a systematic review of evidence from studies using benefit and financing incidence analyses. PLoS One. 2016;11(4):e0152866. https://doi.org/10.1371/journal.pone.0152866.
3. Rostampour M, Nosratnejad S. A systematic review of equity in healthcare financing in low- and middle-income countries. Value Health Reg Issues. 2020;21:133–40. https://doi.org/10.1016/j.vhri.2019.10.001.
4. Ataguba JE, Kabaniha GA. Characterizing key misconceptions of equity in health financing for universal health coverage. Health Policy Plan. 2022;37(7):928–31. https://doi.org/10.1093/heapol/czac041.

5. Moses MW, Pedroza P, Baral R, et al. Funding and services needed to achieve universal health coverage: applications of global, regional, and national estimates of utilisation of outpatient visits and inpatient admissions from 1990 to 2016, and unit costs from 1995 to 2016. Lancet Public Health. 2019;4(1):e49–73. https://doi.org/10.1016/S2468-2667(18)30213-5.
6. Yao Q, Li X, Luo F, Yang L, Liu C, Sun J. The historical roots and seminal research on health equity: a referenced publication year spectroscopy (RPYS) analysis. Int J Equity Health. 2019;18(1):152. https://doi.org/10.1186/s12939-019-1058-3.
7. Smalley KB, Warren JC, Fernández MI. Health Equity: Overview, History, and Key Concepts. In: Health Equity. New York: Springer Publishing Company. 2021:3–12.
8. Faure MC, Munung NS, Ntusi NAB, Pratt B, de Vries J. Mapping experiences and perspectives of equity in international health collaborations: a scoping review. Int J Equity Health. 2021;20(1):28. https://doi.org/10.1186/s12939-020-01350-w.
9. Schieber G, Baeza C, Kress D, et al. Financing Health Systems in the 21st Century. In: Jamison DT, Breman JG, Measham AR, et al., editors. Disease Control Priorities in Developing Countries. 2nd edition. Washington (DC): The International Bank for Reconstruction and Development/The World Bank; 2006. Chapter 12. Available from: https://www.ncbi.nlm.nih.gov/books/NBK11772/. New York: Co-published by Oxford University Press.
10. Dieleman J, Campbell M, Chapin A, et al. Evolution and patterns of global health financing 1995–2014: development assistance for health, and government, prepaid private, and out-of-pocket health spending in 184 countries. Lancet. 2017;389(10083):1981–2004. https://doi.org/10.1016/S0140-6736(17)30874-7.
11. Berner-Rodoreda A, Jahn A. Commercial influence on political declarations: the crucial distinction between consultation and negotiation and the need for transparency in lobbying comment on "Competing Frames in Global Health Governance: an analysis of stakeholder influence on the political declaration on non-communicable diseases." Int J Health Policy Manag. 2022;11(7):1219–21. https://doi.org/10.34172/ijhpm.2021.132.
12. Buse K, Mialon M, Jones A. Thinking politically about UN political declarations: a recipe for healthier commitments—free of commercial interests. Int J Health Policy Manag. 2022;11(7):1208–11. https://doi.org/10.34172/ijhpm.2021.92.
13. Taylor AL. Global health law: international law and public health policy. In: International encyclopedia of public health. Elsevier Inc.; 2016. p. 268–281. https://doi.org/10.1016/B978-0-12-803678-5.00238-1.
14. Barad M. Definitions of strategies. In: Strategies and techniques for quality and flexibility. SpringerBriefs in Applied Sciences and Technology. Cham: Springer. 2018. https://doi.org/10.1007/978-3-319-68400-0_1.
15. Paul E, Deville C, Bodson O, et al. How is equity approached in universal health coverage? An analysis of global and country policy documents in Benin and Senegal. Int J Equity Health. 2019;18(1):195. https://doi.org/10.1186/s12939-019-1089-9.
16. Amri MM, Jessiman-Perreault G, Siddiqi A, O'Campo P, Enright T, Di Ruggiero E. Scoping review of the World Health Organization's underlying equity discourses: apparent ambiguities, inadequacy, and contradictions. Int J Equity Health. 2021;20(1):70. https://doi.org/10.1186/s12939-021-01400-x.
17. Rifkin SB. Alma Ata after 40 years: primary health care and health for all-from consensus to complexity. BMJ Glob Health. 2018;3:e001188. https://doi.org/10.1136/bmjgh-2018-001188.
18. Walraven G. The 2018 Astana Declaration on primary health care, is it useful? J Glob Health. 2019;9(1):010313. https://doi.org/10.7189/jogh.09.010313.
19. Gaudin S, Yazbeck A. Identifying major health-system challenges in developing countries using PERs: equity is the elephant in the room. Health Syst Reform. 2021;7(2):e1902671. https://doi.org/10.1080/23288604.2021.1902671.
20. Brown GW, Rhodes N, Tacheva B, Loewenson R, Shahid M, Poitier F. Challenges in international health financing and implications for the new pandemic fund. Global Health. 2023;19(1):97. https://doi.org/10.1186/s12992-023-00999-6.
21. Chang AY, Cowling K, Micah AE, et al. Past, present, and future of global health financing: a review of development assistance, government, out-of-pocket, and other private spending on health for 195 countries, 1995–2050. Lancet. 2019;393(10187):2233–60. https://doi.org/10.1016/S0140-6736(19)30841-4.
22. The General Assembly of United Nations. Political declaration of the general assembly high-level meeting on pandemic prevention, preparedness and response annex political declaration of the general assembly high-level meeting on pandemic prevention, preparedness and response. 2023.
23. Ottersen OP, Dasgupta J, Blouin C, et al. The political origins of health inequity: prospects for change. Lancet. 2014;383(9917):630–67. https://doi.org/10.1016/S0140-6736(13)62407-1.
24. Kaikeaw S, Punpuing S, Chamchan C, Prasartkul P. Socioeconomic inequalities in health outcomes among Thai older population in the era of Universal Health Coverage: trends and decomposition analysis. Int J Equity Health. 2023;22(1):144. https://doi.org/10.1186/s12939-023-01952-0.
25. Tangcharoensathien V, Tisayaticom K, Suphanchaimat R, Vongmongkol V, Viriyathorn S, Limwattananon S. Financial risk protection of Thailand's universal health coverage: results from series of national household surveys between 1996 and 2015. Int J Equity Health. 2020;19(1):163. https://doi.org/10.1186/s12939-020-01273-6.
26. Barasa E, Kazungu J, Nguhiu P, Ravishankar N. Examining the level and inequality in health insurance coverage in 36 sub-Saharan African countries. BMJ Glob Health. 2021;6(4):e004712. https://doi.org/10.1136/bmjgh-2020-004712.
27. World Health Organization. Political Declaration of High-level meeting on universal health coverage. "Universal Health Coverage: Moving Together to Build a Healthier World". 2023.
28. Horton R. Offline: political declarations—clichés and lies. Lancet. 2023;402(10407):1028. https://doi.org/10.1016/S0140-6736(23)02023-8.
29. Atim C, Koduah A, Kwon S. How and why do countries make Universal Health Care policies? Interplay of country and global factors. J Glob Health. 2021;11:16003. https://doi.org/10.7189/JOGH.11.16003.
30. Barry ES, Merkebu J, Varpio L. State-of-the-art literature review methodology: a six-step approach for knowledge synthesis. Perspect Med Educ. 2022;11(5):281–8. https://doi.org/10.1007/s40037-022-00725-9.
31. Grant MJ, Booth A. A typology of reviews: an analysis of 14 review types and associated methodologies. Health Info Libr J. 2009;26(2):91–108. https://doi.org/10.1111/j.1471-1842.2009.00848.x.
32. Proctor EK, Powell BJ, Mcmillen JC. Implementation strategies: recommendations for specifying and reporting. 2013. http://www.implementationscience.com/content/8/1/139.
33. EQUATOR Network. A Proposal of Essential Reporting Items for Practice Guidelines in Health Systems (RIGHT) RIGHT Working Group BACKGROUND. https://www.surveymonkey.com/. Accessed 23 Feb 2024.
34. Hadfield R. Pearl growing as a strategy in systematic literature searches. 2020. https://www.mediwrite.com.au/medical-writing/pearl-growing/. Accessed 1 Feb 2024.
35. Haddaway NR, Grainger MJ, Gray CT. Citationchaser: A tool for transparent and efficient forward and backward citation chasing in systematic searching. Res Synth Methods. 2022;13(4):533–45. https://doi.org/10.1002/jrsm.1563.
36. Chattu VK, Knight WA, Adisesh A, et al. Politics of disease control in Africa and the critical role of global health diplomacy: a systematic review. Health Promot Perspect. 2021;11(1):20–31. https://doi.org/10.34172/hpp.2021.04.
37. Fairclough N. Analysing discourse: textual analysis for social research. Psychology Press; 2003.
38. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006;3(2):77–101. https://doi.org/10.1191/1478088706qp063oa.
39. Roy BK, Mukhopadhyay P. Digital Access Brokers: Clustering and Comparison (Part II – from Summarization to Citation Map). SRELS J Inf Manag. 2023:337–351. https://doi.org/10.17821/srels/2022/v59i6/170786.
40. World Health Organization. The health financing progress matrix: country assessment guide. 2020.
41. Jowett M, Kutzin J, Kwon S, Hsu J, Sallaku J, Solano JG, World Health Organization. Assessing country health financing systems the health financing progress matrix. World Health Organization; 2020.
42. World Health Organization. Health financing progress matrix assessment, Zambia 2024: summary of findings and recommendations. 2024.

43. World Health Organization. Health financing progress matrix assessment 2023: summary of finding. 2023.
44. Ministry of Health & WHO. Health financing progress matrix assessment: Kenya 2023. 2024.
45. World Health Organization. Health financing progress matrix assessment: Bangladesh 2021 summary of findings and recommendations. 2021.
46. World Health Organization. Health financing progress matrix assessment: Georgia 2022 summary of findings and recommendations. 2022.
47. Elliott R, Timulak L. "Descriptive and interpretive approaches to qualitative research." A handbook of research methods for clinical and health psychology 1.7. 2005. p. 147-159.
48. United Nations. Political declaration of the high-level meeting on improving global road safety "The 2030 Horizon for Road Safety: Securing a Decade of Action and Delivery". https://www.un.org/pga/76/wp-content/uploads/sites/101/2022/06/23-June-Political-Declaration-on-Road-Safety.pdf. Accessed 7 Jan 2024.
49. United Nations General Assembly. Political declaration of the high-level meeting on universal health coverage. Universal Health Coverage: Moving Together to Build a Healthier World. 2019. https://documents-dds-ny.un.org/doc/UNDOC/GEN/N19/311/84/PDF/N1931184.pdf?OpenElement. Accessed 1 Feb 2024.
50. International Labour Conference. ILO Centenary Declaration for the Future of Work Adopted by the Conference at Its One Hundred and Eighty Session, Geneva. 2019. https://labordoc.ilo.org/permalink/41ILO_INST/j3q9on/alma995030892602676. Accessed 7 Jan 2024.
51. World Health Organization. Declaration of Astana. 2018. https://iris.who.int/bitstream/handle/10665/328123/WHO-HIS-SDS-2018.61-eng.pdf?sequence=1. Accessed 7 Jan 2024.
52. United Nations General Assembly. Political declaration of the 3rd high-level meeting of the general assembly on the prevention and control of non-communicable diseases: Resolution / Adopted by the General Assembly. 2018. https://digitallibrary.un.org/record/1648984?ln=en. Accessed 7 March 2024.
53. United Nations. Political Declaration of the high-level meeting of the general assembly on antimicrobial resistance : resolution / adopted by the general assembly. United Nations; 2016. https://digitallibrary.un.org/record/845917?ln=en. Accessed 7 Jan 2024.
54. United Nations. Transforming Our World: The 2030 Agenda for Sustainable Development. United Nations. https://sdgs.un.org/sites/default/files/publications/21252030%20Agenda%20for%20Sustainable%20Development%20web.pdf. Accessed 8 Jan 2024.
55. United Nations. 69/313. Addis Ababa Action Agenda of the Third International Conference on Financing for Development (Addis Ababa Action Agenda) Annex Addis Ababa Action Agenda of the Third International Conference on Financing for Development (Addis Ababa Action Agenda). 2015. https://unctad.org/system/files/official-document/ares69d313_en.pdf. Accessed 8 Jan 2024.
56. United Nations. Small island developing states accelerated modalities of action (Samoa Pathway). United Nations. https://www.un.org/ohrlls/sites/www.un.org.ohrlls/files/samoa_pathway.pdf. Accessed 8 Jan 2024.
57. The General Assembly of United Nations. Resolution Adopted by the General Assembly on 12 December 2014 69/137. Programme of Action for Landlocked Developing Countries for the Decade 2014–2024. United Nations; 2015. https://documents-dds-ny.un.org/doc/UNDOC/GEN/N14/696/14/PDF/N1469614.pdf?OpenElement. Accessed 8 Jan 2024
58. RIO+20 United Nations Conference on Sustainable Development. The Future We Want.Outcome Document Ofthe United Nations Conference OnSustainable Development; 2012. https://sustainabledevelopment.un.org/content/documents/733FutureWeWant.pdf. Accessed 8 Jan 2024.
59. United Nations. Political Declaration of the high-level meeting of the general assembly on the prevention and control of non-communicable diseases. 2011. https://documents-dds-ny.un.org/doc/UNDOC/LTD/N11/497/77/PDF/N1149777.pdf?OpenElement. Accessed 8 Jan 2024.
60. World Health Organization's Team for Social Determinants of Health. Rio political declaration on social determinants of health. World Health Organization; 2011. https://cdn.who.int/media/docs/default-source/documents/social-determinants-of-health/rio_political_declaration.pdf?sfvrsn=6842ca9f_5&download=true. Accessed 8 Jan 2024.
61. United Nations. Report of the fourth United Nations conference on the least developed countries. United Nations; 2011. https://documents-dds-ny.un.org/doc/UNDOC/GEN/N11/376/42/PDF/N1137642.pdf?OpenElement. Accessed 8 Jan 2024.
62. United Nations. Doha Declaration on financing for development: outcome document of the follow-up international conference on financing for development to review the implementation of the monterrey consensus. 2008. https://www.un.org/esa/ffd/wp-content/uploads/2014/09/Doha_Declaration_FFD.pdf. Accessed 8 Jan 2024.
63. International Labour Organization. ILO Declaration on Social Justice for a Fair Globalization, 2008. 2008. https://www.ilo.org/wcmsp5/groups/public/---ed_norm/---declaration/documents/genericdocument/wcms_371208.pdf. Accessed 8 Jan 2024.
64. United Nations. Political Declaration on Africa's development needs: resolution / adopted by the general assembly. 2008. https://digitallibrary.un.org/record/637569?ln=es. Accessed 8 Jan 2024.
65. World Conference on Disaster Reduction. Hyogo declaration. United Nations; 2005. www.unisdr.org/wcdr*.
66. High Level Forum. Paris declaration on aid effectiveness. United Nations Development Programme; 2005. https://www.undp.org/publications/paris-declaration-aid-effectiveness. Accessed 8 Jan 2024.
67. General Assembly of United Nations. World summit outcome. United Nations; 2005. https://documents-dds-ny.un.org/doc/UNDOC/GEN/N05/487/60/PDF/N0548760.pdf?OpenElement. Accessed 8 Jan 2024.
68. United Nations. Report of the world summit on sustainable development. Johannesburg: United Nations; 2002. p. 167. https://digitallibrary.un.org/record/478154?ln=fr. Accessed 29 Jan 2024.
69. United Nations. A/CONF.198/11 Monterrey consensus of the international conference on financing for development. 2002. www.un.org/esa/ffd.
70. United Nations General Assembly. Report of the Third United Nations conference on the least developed countries. 2001. https://documents-dds-ny.un.org/doc/UNDOC/GEN/G01/528/33/PDF/G0152833.pdf?OpenElement. Accessed 29 Jan 2024.
71. United Nations General Assembly. United Nations millennium declaration. 2000. https://digitallibrary.un.org/record/422015?ln=fr. Accessed 29 Jan 2024.
72. World Summit for Social Development. Report of the world summit for social development. Copenhagen: UN; 1996. https://digitallibrary.un.org/record/198966?ln=fr. Accessed 30 Jan 2024.
73. Fourth World Conference on Women. Chapter I. Resolutions adopted by the conference. Resolution 1 Beijing Declaration and Platform for Action. 1995. https://www.un.org/womenwatch/daw/beijing/platform/index.html. Accessed 30 Jan 2024.
74. United Nations General Assembly. Global conference on the sustainable development of small island developing states. 1994. https://www.un.org/esa/dsd/dsd_aofw_sids/sids_pdfs/BPOA.pdf. Accessed 18 Jan 2024.
75. The World Conference on Human Rights. Vienna Declaration and Programme of Action. Vienna; 1993. https://www.ohchr.org/en/about-us/history/vienna-declaration. Accessed 10 Jan 2024.
76. United Nations Conference on Environment and Development, Rio de Janeiro, Brazil. 1992. https://www.un.org/en/conferences/environment/rio1992. Accessed 10 Jan 2024.
77. United Nations Children's Fund. First call for children: world declaration and plan of action from the world summit for children. 1990. https://www.unicef.org/documents/world-summit-children. Accessed 10 Jan 2024.
78. World Health Organization.The 1st International Conference on Health Promotion. The Ottawa Charter for Health Promotion. https://www.who.int/teams/health-promotion/enhanced-wellbeing/first-global-conference. Accessed 10 Jan 2024.
79. World Health Organization and United Nations Children's Fund. Report of the International Conference on Primary Health Care, Alma-Ata, USSR. 1978. https://www.who.int/publications/i/item/9241800011. Accessed 10 Jan 2024.
80. World Employment Conference. Declaration of Principles and Programme of Action Adopted by the Tripartite World Conference on Employment. In: Income Distribution and Social Progress and the International Division of Labour, Geneva. Geneva: ILO; 1976. https://www.ilo.org/public/libdoc/ilo/1976/76B09_692_engl.pdf. Accessed 10 Jan 2024.

81. United Nations General Assembly. 4th Summit Conference of Heads of State or Government of the Non-Aligned Movement. 1973. http://cns.miis.edu/nam/documents/Official_Document/4th_Summit_FD_Algiers_Declaration_1973_Whole.pdf. Accessed 10 Jan 2024.
82. United Nations Environment Programme. Stockholm Declaration: Declaration on the Human Environment. 1972. Available from: https://Wedocs.Unep.Org/20.500.11822/29567.
83. The General Assembly of the United Nations. Universal Declaration of Human Right. 1948. https://www.un.org/sites/un2.un.org/files/2021/03/udhr.pdf. Accessed 8 Jan 2024
84. United Nations. Charter of the United Nations and Statute of the International Court of Justice. 1945. https://treaties.un.org/doc/publication/ctc/uncharter.pdf. Accessed 8 Jan 2024
85. International Labour Organisation. ILO Declaration of Philadelphia. Declaration Concerning the Aims and Purposes of the International Labour Organisation. 1944. https://www.ilo.org/static/english/inwork/cb-policy-guide/declarationofPhiladelphia1944.pdf. Accessed 8 Jan 2024.
86. United Nations General Assembly. Political Declaration, Guiding Principles of Drug Demand Reduction and Measures to Enhance International Cooperation to Counter the World Drug Problem; 1998. https://www.unodc.org/pdf/report_1999-01-01_1.pdf. Accessed 26 Jan 2024.
87. International Labour Organization. ILO Declaration on Fundamental Principles and Rights at Work and Its Follow-Up. 1998. http://www.ilo.org/declaration/info/WCMS_716594/lang--en/index.htm. Accessed 8 Mar 2024.
88. Mazurenko O, Balio CP, Agarwal R, Carroll AE, Menachemi N. The effects of medicaid expansion under the ACA: a systematic review. Health Aff. 2018;37(6):944–50. https://doi.org/10.1377/hlthaff.2017.1491.
89. Habtom GK. Journal of Public Administration and Policy Research Designing innovative pro-poor healthcare financing system in sub-Saharan Africa: the case of Eritrea. 2017;9(4):51-67. https://doi.org/10.5897/JPAPR2017.0395.
90. Jabeen R, Rabbani U, Abbas N. Financing mechanisms applied for successful Universal Health Coverage in Malaysia, Thailand and Singapore - lessons for Pakistan. J Pak Med Assoc. 2021;71(11):2611–6. https://doi.org/10.47391/JPMA.01204.
91. Wong JHW, Ng CW, Su TT. Malaysia's Rural Health Development: Foundation of Universal Health Coverage (UHC). J Sains Kesihatan Malaysia. 2019;17(01):31–41. https://doi.org/10.17576/jskm-2019-1701-05.
92. Roman A. A closer look into Brazil's healthcare system: what can we learn? Cureus. 2023. https://doi.org/10.7759/cureus.38390.
93. Guimarães T, Lucas K, Timms P. Understanding how low-income communities gain access to healthcare services: a qualitative study in São Paulo, Brazil. J Transp Health. 2019;15:100658. https://doi.org/10.1016/j.jth.2019.100658.
94. Castro MC, Massuda A, Almeida G, et al. Brazil's unified health system: the first 30 years and prospects for the future. Lancet. 2019;394(10195):345–56. https://doi.org/10.1016/S0140-6736(19)31243-7.
95. Viana AL d'Ávila, da Silva HP, Yi I. Universalizing health care in Brazil: opportunities and challenges. In: Towards universal health care in emerging economies. Palgrave Macmillan UK; 2017. p. 181–211. https://doi.org/10.1057/978-1-137-53377-7_7.
96. Ansu-Mensah M, Danquah FI, Bawontuo V, et al. Quality of care in the free maternal healthcare era in sub-Saharan Africa: a scoping review of providers' and managers' perceptions. BMC Pregnancy Childbirth. 2021;21(1):1–9. https://doi.org/10.1186/S12884-021-03701-Z.
97. Bhattacharya J. Revitalizing primary care is the key to people's health in the post-COVID era. J Family Med Prim Care. 2023;12(5):807–11. https://doi.org/10.4103/jfmpc.jfmpc_621_23.
98. Tulchinsky TH. Bismarck and the long road to universal health coverage. In: Case studies in public health. Elsevier; 2018. p. 131–179. https://doi.org/10.1016/b978-0-12-804571-8.00031-7.
99. Geloso V, Berdine G, Powell B. Making sense of dictatorships and health outcomes. BMJ Glob Health. 2020;5(5):e002542. https://doi.org/10.1136/bmjgh-2020-002542.
100. Adjei-Mantey K, Horioka CY. Determinants of health insurance enrollment and health expenditure in Ghana: an empirical analysis. Rev Econ Househ. 2023;21(4):1269–88. https://doi.org/10.1007/s11150-022-09621-x.
101. Wiafe PA, Armah M, Ahiakpor F, Tuffour KA. The underground economy and tax evasion in Ghana: implications for economic growth. Cogent Econ Finance. 2024;12(1):2292918. https://doi.org/10.1080/23322039.2023.2292918.
102. O'Hare BAM, Lopez MJ, Mazimbe B, et al. Tax abuse—the potential for the sustainable development goals. PLOS Global Public Health. 2022;2(2):e0000119. https://doi.org/10.1371/journal.pgph.0000119.
103. McIntyre D, Obse AG, Barasa EW, Ataguba JE. Challenges in Financing Universal Health Coverage in Sub-Saharan Africa. In: Oxford Research Encyclopedia of Economics and Finance. Oxford University Press; 2018. https://doi.org/10.1093/acrefore/9780190625979.013.28.
104. Ridde V, Gaye I, Ventelou B, Paul E, Faye A. Mandatory membership of community-based mutual health insurance in Senegal: a national survey. PLOS Global Public Health. 2023;3(9):e0001859. https://doi.org/10.1371/journal.pgph.0001859.
105. Frank J, Pagliari C, Donaldson C, Pickett KE, Palmer KS. Why Canada is in court to protect healthcare for all: global implications for universal health coverage. Front Health Serv. 2021;1:744105. https://doi.org/10.3389/frhs.2021.744105.
106. Marchildon GP, Allin S, Merkur S. Health systems in transition Canada health system review. 2020;22(3):2020. www.healthobservatory.eu.
107. Moir M, Barua B. Comparing performance of universal health care countries, 2022. 2022.
108. Biggs A. Medicare: a quick guide. 2016.
109. Angeles MR, Crosland P, Hensher M. Challenges for Medicare and universal health care in Australia since 2000. Med J Aust. 2023;218(7):322–9. https://doi.org/10.5694/mja2.51844.
110. Reece LJ, McInerney C, Blazek K, et al. Reducing financial barriers through the implementation of voucher incentives to promote children's participation in community sport in Australia. BMC Public Health. 2020;20(1):1–7. https://doi.org/10.1186/s12889-019-8049-6.
111. Dixit SK, Sambasivan M. A review of the Australian healthcare system: a policy perspective. SAGE Open Med. 2018;6:2050312118769211. https://doi.org/10.1177/2050312118769211.
112. Papanicolas I, Woskie LR, Jha AK. Health care spending in the United States and other high-income countries. JAMA. 2018;319(10):1024–39. https://doi.org/10.1001/jama.2018.1150.
113. Ridde V, Gautier L, Turcotte-Tremblay AM, Sieleunou I, Paul E. Performance-based financing in Africa: time to test measures for equity. Int J Health Serv. 2018;48(3):549–61. https://doi.org/10.1177/0020731418779508.
114. Paul E, Albert L, Bisala BNS, et al. Performance-based financing in low-income and middle-income countries: isn't it time for a rethink? BMJ Glob Health. 2018;3(1):e000664. https://doi.org/10.1136/bmjgh-2017-000664.
115. Fu XZ. Financial protection effects of private health insurance: experimental evidence from Chinese households with resident basic medical insurance. Int J Equity Health. 2021;20(1):122. https://doi.org/10.1186/s12939-021-01468-5.
116. Burström B, Marttila A, Kulane A, Lindberg L, Burström K. Practising proportionate universalism– a study protocol of an extended postnatal home visiting programme in a disadvantaged area in Stockholm, Sweden. 2017. https://doi.org/10.1186/ISRCTN11832097.
117. Tikkanen R, Osborn R, Mossialos E, Djordjevic A, Wharton G. International Profiles of Health Care Systems: Australia, Canada, China, Denmark, England, France, Germany, India, Israel, Italy, Japan, the Netherlands, New Zealand, Norway, Singapore, Sweden, Switzerland, Taiwan, and the United States. 2020.
118. Francis-Oliviero F, Cambon L, Wittwer J, Marmot M, Alla F. Theoretical and practical challenges of proportionate universalism: a review. Rev Panam Salud Publica. 2020;44:110. https://doi.org/10.26633/RPSP.2020.110.
119. Worrall JL, Cohn EG. Citation data and analysis: limitations and shortcomings. J Contemp Crim Justice. 2023;39(3):327–40. https://doi.org/10.1177/10439862231170972.
120. Price DJ. Networks of scientific papers. Science. 1965;149(3683):510–5. https://doi.org/10.1126/science.149.3683.510.

Publisher's Note