# Better Governance, Better Health?

## Composite Evidence from Four Literature Reviews

**March 2018**

Marshaling the Evidence for Health Governance

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The views expressed in this report are solely those of the authors and should not be attributed to the funders.



# CONTENTS



# LIST OF FIGURES

# ACRONYMS

**HFG** Health Finance and Governance project

**lMIC** Low- and Middle-Income Country

**PFM** Public Financial Management

**TWG** Thematic Working Group

**UHC** Universal Health Coverage

**WHO** World Health Organization

# I. WHY GOVERNANCE?

The importance of governance in health systems is well recognized, but there is still considerable debate on how governance interventions affect change in health outcomes and which interventions are appropriate for different contexts. This lack of clarity often reduces health governance efforts to a limited set of interventions, or justifies their exclusion altogether. As governments and development partners increase emphasis on efficiency, accountability, and transparency of health systems to achieve universal health coverage (UHC), there is an urgent need for greater evidence on governance impacts on health.

To help address the evidence gap, in September 2016 USAID's Office of Health Systems, the World Health Organization (WHO), and the USAID Health Finance and Governance (HFG) project launched the initiative Marshaling the Evidence for Health Governance to consolidate the evidence base on how governance contributes to health system performance and improves health outcomes.[1] The overall objective of the initiative is to increase awareness and understanding of the evidence regarding what works, and why, in strengthening health governance to improve health system performance, with a focus on country-level systems.

# II. OVERALL APPROACH

## Framing the problem and defining objectives

A multi-stakeholder group was convened to start the work; it included experts from USAID, WHO, and the World Bank; academics; and civil society groups. Their aim was to clarify the problem to be resolved; come to agreement on conceptual links between governance interventions, health system performance, and health outcomes; and agree on priority thematic areas. A secretariat was established, with representatives from all groups, to agree on methods and approaches, set timetables, and ensure sufficient resources to complete the work.

### *Thematic Working Groups*[2]

Four Thematic Working Groups (TWGs) were formed to consolidate evidence by conducting literature reviews and key informant interviews from low- and middle-income countries (LMICs) in selected areas:

1. Accountability
2. Laws and Regulation
3. Public Financial Management (PFM)
4. Uses of Knowledge in Health Systems

These areas were chosen because of their comprehensive nature and importance to health systems, and because of the lack of an international consensus on priority interventions. The TWGs consisted of a small group of experts from various organizations and academic institutions from different parts of the world. The TWGs consulted with various policymakers and experts globally. Each TWG was led by two

[1] Marshaling the Evidence Webpage*:* https://www.hfgproject.org/marshaling-evidence-health-governance/
[2] List of TWG members and co-chairs: https://www.hfgproject.org/marshaling-evidence-health-governance/

co-chairs from different organizations, and included a member from WHO and the HFG project. Each TWG drafted a report on their findings and on the gaps in evidence for their subject area.

### *The Cross-Cutting Synthesis Analysis*

The Marshaling the Evidence secretariat agreed that a cross-cutting synthesis paper was necessary to frame the work in the wider context of governance in health systems, drawing distinctions and consensus across all four TWG papers. Members of the secretariat, some of whom also were members of the TWGs, conducted the analysis across each TWG report and wrote the synthesis report. The report compiles results from the TWGs into a searchable database, contained in Annex 1. The report also lays the foundation for future action—from dissemination to further research agendas and policy plans.

### *Dissemination*

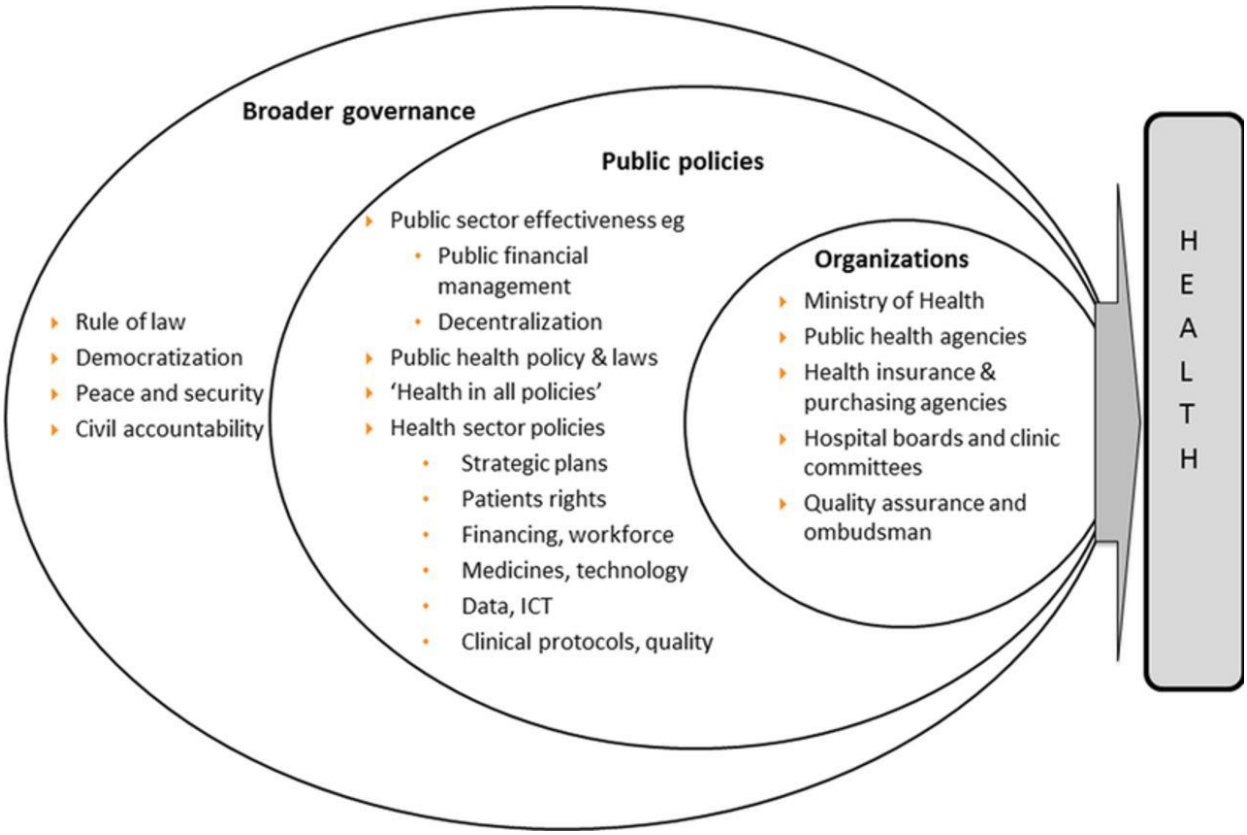
The four TWG reports and synthesis report identified consensus, and gaps in the evidence, to inform research and policy agendas at the international, regional, and country level. The five reports were launched at the Marshaling the Evidence Event on November 8, 2017 in Washington, DC. Global stakeholders discussed each report and the overall findings, and the analysis was revised to reflect these input. Key findings were subsequently disseminated at various global and regional events—including the Collaborative for Health Systems Governance event held as part of the UHC 2030 Day events in Tokyo on December 12, 2017. Findings will also be shared more broadly at the World Bank/International Monetary Fund Spring Meetings in Washington, DC, on April 15-20, 2018.

# III. METHODOLOGY

## The TWG Reports

The TWGs conducted scoping literature reviews, supported by key informant interviews, to identify evidence, areas for further study, and the policy implications of their own conclusions. The reviews used the Marshaling the Evidence conceptual framework to broadly orient understanding of how governance might contribute to health systems outcomes and health impacts (see Figure 1, below; Fryatt, Bennett, and Soucat 2017). The literature reviews used scoping methods to characterize the range of research studies and the content of the literature, and any gaps that require further exploration.

Figure 1. Conceptual Framework for Health Governance

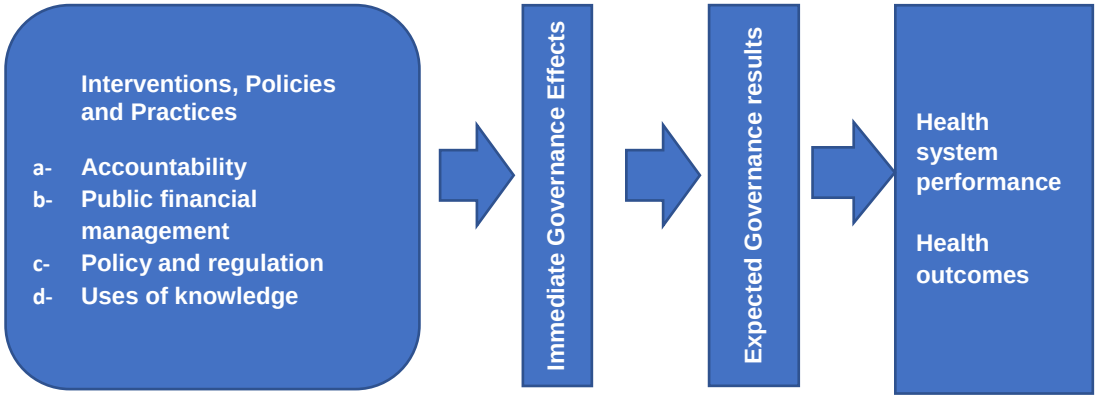



# Synthesis Methodology

The synthesis analysis attempted to bring consistency across the TWG reviews through the development and application of a common health governance framework (see Figure 2 and Annex 1), defined further below. The framework facilitated the identification of: common findings, consensus in the evidence, discrepancies in evidence, and gaps in the literature on important health governance topics.

The health governance framework was based on a review of active health governance frameworks. The framework relied on Siddiqi et al. (2009) to emphasize seven categories of health governance results, defined further below—Responsiveness, Efficiency and Effectiveness, Transparency, Accountability, Voice and Empowerment, Rule of Law/Anticorruption, and Equity—that are consistent with categories of governance results from other research. While there are some overlap and definitional challenges in the seven categories, they prove a useful tool for further characterizing the often amorphous term "governance." Applied to the TWG areas, the framework uses a simplified, linear theory of change that analyzes categories of governance interventions, policies, and practices for immediate governance effects, each with implications for health system performance and health outcomes. Findings from each TWG were run through the framework and are further detailed in Annex 1 of this report.

Figure 2. Marshaling the Evidence Health Governance Framework




# Definitions of Governance Results

*Responsiveness.* The general definition of responsiveness is individuals or organizations reacting in a way that is needed, suitable, or right for a particular situation. Siddiqi et al. (2009) define responsiveness as the capacity of institutions and processes to serve all stakeholders and to ensure that the policies and programs are responsive to the health and non-health needs of users.[3]

*Effectiveness and efficiency***.** This the extent to which a specific intervention, procedure, regimen, or service, when deployed in the field in routine circumstances, does what it is intended to do for a specified population.[4] Efficiency in particular refers to the capacity to produce maximum output/outcome for a given input.

*Transparency.* Transparency is built on the free flow of information. Processes, institutions, and information should be directly accessible to those concerned with them, and enough information should be provided to understand and monitor results compared to expected outcomes.[5]

*Accountability.* Obligation for individuals or agencies to provide information about, and/or justification for, their actions, along with the imposition of sanctions for failure to comply and/or engage in appropriate action.[6] Accountability can take both "long" and "short" routes that engage institutions, citizens/clients, and service providers in different forms (see Figure 3; Brinkerhoff 2014).

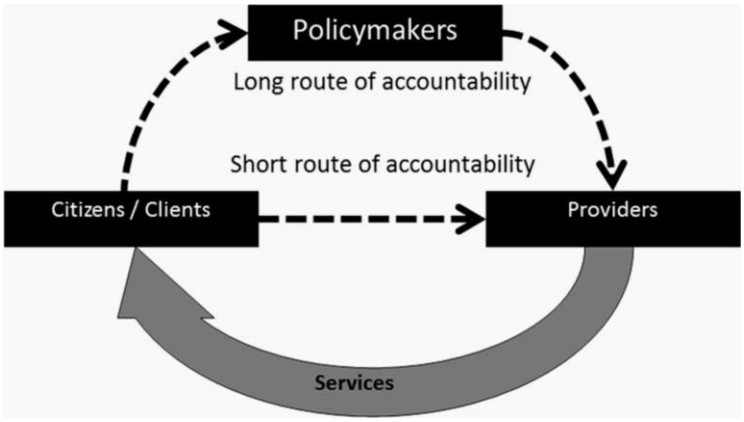
[3]See also the USAID Vision for Health Systems Strengthening's definition of responsiveness: the way health services are delivered must ensure dignity, confidentiality, autonomy, quality, and timeliness of services for poor and marginalized people. USAID's focus is on improving the satisfaction of poor and marginalized people with essential services provision.

[4] WHO Health System Strengthening Glossary. World Health Organization. http://www.who.int/healthsystems/hss_glossary/en/index4.html

[5] See also Mikkelsen-Lopez et al. 2011: "Transparency is therefore not just about performance indicators but also about roles and responsibilities, available resources and their use."

[6] See also Travis, et al., 2002: "Accountability includes ensuring that the state governs institutions and service delivery in an ethical and conducive manner. For the health sector this involves: establishing shared values and ethical base for health improvement, enhancing clarity in roles and responsibilities of health system actors, reducing duplication and fragmentation, and ensuring mutual accountability and transparency. Indicators for accountability include: existence of rules, publication and dissemination of these rules, existence of independent watchdog committees, access to political representatives, self-audit of professional bodies, free press etc."

Figure 3. The Routes of Accountability




*Voice and empowerment***.** Voice is defined as the possibility for all stakeholders to participate in decision-making, either directly or through legitimate institutions that represent their interest.[7] Empowerment may be a social, cultural, psychological, or political process through which individuals and social groups are able to express their needs, present their concerns, devise strategies for involvement in decision-making, and achieve actions to meet those needs.[8]

*Rule of law and anticorruption.* Legal frameworks pertaining to health and institutional effectiveness, transparency, and accountability are fair and enforced impartially.

*Equity.* Equity is a measure of the degree to which government policies and regulations and their implementation ensure the fair distribution of services across the population for the wellbeing of all. For health systems it can refer to equity in access to care, fair financing for public health services, and or the absence of systematic or remediable differences in health status or access to health care.[9]

# IV. SUMMARY OF FINDINGS

The TWGs found consistent evidence of positive impacts of governance interventions on health system performance. A summary of the main findings is discussed below, including additional analysis where findings overlapped. More-specific findings from each TWG report, including citations, are detailed in Section V.

1. **Governance interventions work.** Improved governance appears to universally lead to more effectively implemented policies and increased achievement of intended UHC outcomes. In contrast, health programming that ignored governance dynamics consistently underperformed, or in some cases exacerbated underlying issues and caused harm. Two points to be kept in mind:
    a. **Governance is both a contextual factor and an intervention strategy.** Quicker governance results can be achieved in settings with good governance, where interventions do not depend upon more-complex, systemic change. The relationship between governance interventions, health system components, and UHC outcomes is not linear, and these are often mutually reinforcing.

[7] See also European Commission 2004: "There should be balanced and adequate representative participation; space for the voicing of expectations and concerns and taken [sic] them into consideration; and costs of participation accounted for and included in operating budgets."
[8] Health Promotion Glossary. World Health Organization 1998. http://www.who.int/healthpromotion/about/HPR%20Glossary%201998.pdf
[9] WHO Health System Strengthening Glossary. World Health Organization. http://www.who.int/healthsystems/hss_glossary/en/index4.html

b. **Governance interventions are not standalone actions.** They are rarely successful when they are treated as a "widget" and transferred without considering context.

2. **Participation, voice, and empowerment increase equity in and responsiveness of health services.** The TWG literature reviews identified a number of policy and programming mechanisms as increasing voice and empowerment of citizens and local communities. Each had impact on equity, responsiveness, accountability, and effectiveness and efficiency of health services. Some key points include:

   a. **Social accountability efforts work most effectively under certain conditions.** These efforts —including citizen scorecards, user committees, participatory budgeting, pay-for-performance financing, and financial audits—improve accountability and health system performance, but only when they are 1) used together, 2) developed in a way that incorporates community dialogue and capacity-building, and 3) implemented over a long enough time period to evolve from answerability to sanctions. Social accountability interventions face challenges of scale and sustainability when donor-led. Sustainable results are more likely to be achieved when demand-side and supply-side interventions are pursued in tandem in ways that are mutually reinforcing (Wetterberg et al. 2016, Fox 2016). Incorporating formal citizen participation as part of an integrated and institutionalized policy and program framework enhances the prospects for sustainable social accountability impacts at scale. While health outcomes can improve through decentralization and mechanisms for greater participation, these approaches face challenges in capacity, power, data quality, and incentives. Support from capable NGOs can translate complex budget and procedural information to more-concrete accountability targets around which citizens can mobilize demand.

   b. **Improved health policy dialogue comes from more-participatory approaches.** Positive results came when space for civil society input was created and proactively encouraged, which in turn resulted in better representation, equity, and accountability. Studies by Coelho (2013), Kaseje (2010), and Gomez (2012) showed improved health policy dialogue when space for civil society input was created and proactively encouraged, which resulted in better representation and accountability. In other instances, civil society used advocacy and strategic litigation to challenge government policy that was in conflict with the law, particularly laws establishing UHC. In this regard, greater freedom of information and press freedom can contribute to improved health policy dialogue.

3. **Decentralization, if designed properly, can improve responsiveness in the health sector**. Much of the research treated the topic of decentralization as homogeneous, failing to distinguish between important forms and characteristics—e.g., delegation v. de-concentration v. devolution, the processes through which the implementation takes place, or the socioeconomic and financial context of decentralization. Despite this lack of specificity in the analysis, lessons emerged on decentralization and health systems governance. Decentralization of service delivery shows improvements in transparency and responsiveness when there is the right balance of centrally retained authority (pooled funding levels and protection for minority groups) and local decision-making. Authority of central governments may positively influence local policy-making and implementation, but should not compromise the autonomy of local decision-makers. However, in countries with a high degree of fiscal decentralization for collecting revenues and setting priorities for expenditures, and in the absence of a strong equity-based mechanism of redistribution, pooling may become fragmented and jeopardize the objectives of financial and social health protection—for example, as observed in Tajikistan,

where a post-Soviet rapid devolution of both revenue and expenditure authority to local governments led to poor risk pooling and a high degree of inequity (Cashin 2017).

4. **Performance-based mechanisms increase effectiveness and reduce corruption.** Findings under performance-based mechanisms covered three principal areas: 1) results-based financing, 2) performance-based financing, and 3) pay for performance. Complementary analysis from different TWGs found that performance-based payments have the potential to bring positive results, but depend on many other factors, such as the management capacity of institutions implementing these reforms, recipients' awareness of performance measures, compensation directly to front-line workers for high performance, transparent and public data, and collaborative working arrangements between the many stakeholders involved in these types of management reforms. A combination of approaches is the most effective. For example, introducing performance-based payments while also introducing citizen scorecards, empowering health facility committees, and providing forums for dialogue between communities, providers, and government increases effectiveness and reduces corruption.

5. In addition to performance-based mechanisms, **other PFM approaches can have positive effects on health system efficiency,** but only when there is capacity to implement and opposing incentives do not derail.

    a. **Introduction of multi-year budgeting/medium-term expenditure frameworks** in relation to poverty reduction strategies encouraged better planning, but governance structures and PFM systems must be sound, or in the process of reform, for such frameworks to be effective.

    b. **Gender-sensitive budgeting** showed promising results to improve health outcomes, particularly when it was part of program-based budgeting, as opposed to the more standard input-based budgeting.

    c. Though evidence overall is limited, **financial audits** seem to improve transparency, reduce corruption, and contribute to improvements in efficiency, though their value for money may be variable. Open contracting also appears to improve transparency as expected, and to reduce corruption, albeit with variable changes to timeliness.

    d. **Consumption taxes** that reduce the ability of the poor to afford essential goods were associated with increased rates of post-neonatal, infant, and under-5 mortality rates. In contrast, pro-poor tax policies, such as progressive income taxes and taxes on capital gains and profits, were associated with positive health results.

6. **Removal of user fees** does not adequately address supply- and demand-side health financing issues, and therefore does not have the desired impact on health outcomes. Similarly, formalization of user fees does not have the desired positive effect on health outcomes, because of other, more- powerful external factors—such as informal payments, or geographical barriers to care. Earmarking for health expenditure is effective only when employed as softer earmarking with broad expenditure purposes and more-flexible revenue sources.

7. **Some services are more responsive to accountability interventions.** Attributes of particular health services (the micro-context) can make accountability interventions more or less likely to succeed. For example: accountability interventions are more likely to succeed where users can see tangible outputs and benefit directly from service (e.g., improved water supply versus improved disease vector control).

# V. SPECIFIC FINDINGS

The following section details the specific findings for each TWG. Further detail can be found in the individual TWG reports. These results, including the specific academic citation, are organized according to the Marshaling the Evidence Governance Framework in Annex 1.

## Accountability Working Group[10]

The Accountability TWG analyzed accountability interventions and strategies according to six sub-categories. Vertical and horizontal accountability refer to the state-citizen structures that create potential dynamics of accountability. Vertical generally refers to relationships between citizen and state. Horizontal refers to internal state institutional relationships. The Accountability TWG found that there is a solid evidence base on the variety of accountability interventions that have been tried and tested; however, the extent and nature of impacts depend greatly on *how* interventions are carried out. A key message is that the individual interventions selected may be less decisive than the result of their interactions with contextual factors such as power dynamics, institutional mandates, and sociocultural histories.

Social accountability efforts, for example, have benefitted from the greater collective experience of researchers pursuing studies of those interventions. Tools such as citizen report cards, service charters, multi-stakeholder committees, participatory budgeting, and pay-for-performance have been studied across a wide range of contexts. It is likely that other areas of accountability interventions with mixed evidence will be clarified by greater research efforts with an emphasis on context, which can help to nuance the understanding of the conditions under which those interventions achieve outcomes in health governance. Simon O'Meally's (2013) study of accountability dynamics defines six characteristics of context that can shape accountability—political society capacity and willingness, civil society capacity and willingness, the political settlement among elites, the social contract of the state, inequality and relations within society, and global dimensions around the state.

From this body of evidence come a number of key findings:

- Social accountability efforts are associated with improved accountability and better health system performance when multiple techniques are used together and when the overall effort is well tailored to fit the social and institutional context, through dialogue created by the interventions, and over a long enough time period to move from answerability to sanctions. To enhance impacts for social accountability interventions, analysts and practitioners recommend variations on Fox's (2015) sandwich strategy, which marries bottom-up advocacy and collective action from below with top-down bureaucratic pressure and support from above.
- The attributes of particular health services (micro-context) make accountability interventions more or less likely to succeed (Batley and Mcloughlin 2015). Predictable and regular use of a service can make it easier for users to organize to demand accountability around that service (e.g., primary schooling versus hospital health care). Accountability is more likely in the following contexts:
  - when benefits go to private users (e.g., household water connections versus mains sewerage)

[10] See https://www.hfgproject.org/accountability-health-governance-health-systems-uncovering-linkages/

  - where users benefit directly (e.g., water supply rather than disease vector control)
  - where the provided service is visible (e.g., construction of schools or clinics rather than improving maintenance)
  - when the information about the service is widely understandable and involves less discretion (e.g., vaccinations rather than obstetric care)
- There is little robust evidence around activities that use ombudsman offices, engage parliamentary committees or members of parliament, or use litigation and court intervention specifically to achieve better health governance.
- More research is needed on specifying the conditions under which social accountability contributes to governance and service delivery results, and on the complementary investments that enhance those results.
- There is some empirical support for the utility and effectiveness of performance-based contracting and related pay-for-performance schemes, with an emphasis on which conditions facilitate impact.

## Laws and Regulations Working Group[11]

This TWG focused on the processes involved in developing, implementing, and enforcing policies, and the effects of policies themselves. The TWG examined evidence on the factors that led to a particular policy being more or less effective than an alternative policy in a similar context.

Studies pertaining to health financing dominate the identified evidence base. Most reforms associated with achieving UHC do not focus on governance, per se, but on raising revenues through tax-based financing, increasing insurance coverage, or addressing demand-side financing, such as conditional cash-transfers and vouchers. Other areas of policy focus included reduction of informal payments through increased transparency and accountability initiatives; reforms to implement a single-payer system; reforms creating a split between purchaser and provider; accountability and fighting corruption in supply chain management; and policies to promote better human resources for health.

Specific findings from the TWG include:

- Improved governance appears to universally lead to more-effectively implemented policies and increased achievement of intended UHC outcomes.
- The majority of the policies reviewed were related to structural and financial reforms whose impact was to reduce corruption through increased transparency and accountability—an essential focus, as many health programs, like free provision of drugs at public facilities, unintentionally create avenues for corruption.
- Policy instances focused on decentralization initiatives came up frequently as a basis for strengthening capabilities and performance at each level of the health system by increasing responsiveness at the local level—and tended to be more successful when they incorporated strong accountability measures.
- Many governance-related effects can be mutually reinforcing in the way policy changes impact

[11] See https://www.hfgproject.org/better-laws-regulations-promote-universal-health-coverage-review-evidence/

health systems. For example:

- Reforms that improve transparency of health-related rules (e.g., for user fees and exemptions/waivers) may also help to increase the accountability of providers to patients.
- Reforms that increase accountability (e.g., opening consumer redressal mechanisms for health services, or seeking survey-based opinions on quality of care) may also support reduced corruption and increased responsiveness across the system.

- Policies were identified that worsen equity, affecting health outcomes for the poor and other socially excluded populations. For example, as stated above in the summary of findings:
  - Consumption taxes that reduce the ability of the poor to afford essential goods were associated with increased rates of post-neonatal, infant, and under-5 mortality.
  - Removal of user fees does not adequately address supply- and demand-side health financing barriers that inhibit access, and therefore does not have the desired impact on health outcomes when used in isolation.
- Provider-purchaser split and new provider payment mechanisms are often implemented in tandem as part of major health financing reforms. However, without effective monitoring and oversight from the purchaser and regulators, an unintended focus on curative and hospital-based care can drive inefficient spending at the expense of higher-quality primary, preventive, and promotive care.
- Governments may face political and process constraints on the number of legal and regulatory changes they can make as part of health sector reform. However, it is important to consider when multiple changes that target different health system stakeholders may be necessary to make any one, overarching reform effective. For example:
  - Task-shifting policies, aimed at increased efficiency in the use of clinical health staff, were often ineffective if they were not implemented as part of a suite of policy reforms related to pre-service and in-service training, and accreditation and regulation by medical and nursing bodies.

# PFM Working Group[12]

The PFM TWG defined public financial management according to the following categories:

1. Resource Mobilization and Revenue Management
2. Budgeting and Public Expenditure Management
   a. Budget Planning and Prioritization
   b. Budget Formulation
   c. Budget Execution
   d. Budget Monitoring and Reporting
   e. External Audit and Parliamentary Oversight

[12] See https://www.hfgproject.org/public-financial-management-report/

3. Fiscal Decentralization and Local Governance

The PFM TWG concluded that the evidence shows a positive association of strong financial management with stronger, more effective health systems, but that the evidence is variable depending on the type of intervention, overall governance structure, and country context. Further research is needed, as causality is still largely inconclusive.

Specific findings from the review include:

- More tax revenue does not necessarily translate into more health spending or better health results. The evidence shows that domestic tax revenue is integral to achieving UHC, but results depend on the type of tax levied and the overall administration and governance structures. To achieve health results, tax policy must be specifically engineered not to adversely affect the poor. One study shows a strong association between health spending and taxes on capital gains, profits, and income, but not between health spending and consumption taxes on goods and services.
- Formalization of fees, for example by publishing a fee schedule and introducing systems for reinvesting fee revenue into the facility to benefit patients, can improve service quality and governance and therefore health outcomes. However, studies show that the formalization (much like removal) of user fees alone does not have the desired positive effect on health outcomes, because of other powerful external factors—such as informal payments or geographical barriers to care—that confound the positive effect of removing user fees.
- Earmarking has been more effective when practices come closer to standard budget processes —that is, softer earmarks with broader expenditure purposes and more-flexible revenue.
- Introduction of multi-year budgeting/medium-term expenditure frameworks in relation to poverty reduction strategies encouraged better planning, but governance structures and PFM systems must be sound, or in the process of reform, for medium-term expenditure frameworks to be effective.
- Results-based financing on the whole had mixed results, but was more effective when paired with significant domestic financing and nationwide training and reform rollouts. Government buy-in through domestic financing to support a results-based financing program before implementation was shown to have a positive effect on such programs.
- Reduction of gender inequality through gender-sensitive budgeting showed promising results to improve health outcomes. Program budgeting tends to lend itself better than traditional input-based budgeting to the incorporation of gender-oriented objectives into the budget process.
- Areas where there was insufficient evidence to reach a conclusion:
  - Very few studies had been conducted on the effect on the health sector of integrated financial management information systems and other PFM budget execution solutions.
  - A study of e-procurement in India and Indonesia found no evidence that e-procurement reduced prices that the government paid, but e-procurement was associated with quality improvement—e.g., average road quality, reduced delays in the completion of public works projects.
  - There is inadequate research on the impacts of improved financial reporting on misalignment between budget structure, expenditure management, and reporting systems (how expenditure are made and reported).

- Formal auditing processes for both the public and private health sector had positive impacts on delivery of service.
- Effects of fiscal decentralization in health were mixed to negative. In some cases, fiscal decentralization interventions may be linked to improved decision-making on the distribution of resources according to local needs. In other cases fiscal decentralization contributed to the fragmentation of risk pool financing, which can contribute to adverse outcomes for health system performance.

# Uses of Knowledge Working Group[13]

The Uses of Knowledge TWG identified a total of 53 articles from 1999 through 2016 that considered institutionalization of knowledge in health policymaking. The majority of articles in this review used research findings, and to a lesser extent, technical reports, routine health systems data, and survey data aimed at informing policymaking.

The TWG concludes there is growing evidence on the multiple uses and institutionalization of knowledge for policymaking. There is limited evidence on corresponding health systems outcomes and health impacts of these processes in LMIC health systems. Most of the articles centered on domestic public sector employees and their interactions with civil society representatives, international stakeholders, or academics. There was little evidence about how think tanks and the media contribute to this process in LMICs.

Health impacts of knowledge use and institutionalization were reported for a small number of articles with varying levels of specificity. Nearly half of the articles reviewed (n = 24) described health systems outcomes of varying specificity, but mostly policy formulation through the establishment of guidelines, provision of care, or organizational development. Few articles (n = 7) described health impacts, with the majority (n = 47) either focusing on health systems outcomes or not explicitly identifying any outcomes or impacts. Thus, while there remains evidence of how different uses and institutionalization of knowledge can strengthen health systems, the evidence on how these processes can improve health outcomes remains unclear.

Other specific findings from the review included:

- Knowledge utilization to enhance the quality of service delivery was noted in research on integrated community case management in Malawi (Rodriguez et al. 2015), non-communicable disease service delivery in five Asian countries (Rani et al. 2012), multiple primary care services in Nigeria (Onwujekwe et al. 2015), and male circumcision for HIV prevention in Uganda (Odoch et al. 2015).
- It is difficult to determine the extent to which the results can be directly attributed to institutionalization of knowledge use. For example, though alcohol consumption and tobacco use in youth dropped over the first few years of the Thai Health Promotion Foundation (ThaiHealth), it is difficult to determine the extent to which the results can be directly attributed to knowledge use within institutions.
- Zida et al. (2017) argue that for institutionalization of knowledge use, attention should be

[13] See https://www.hfgproject.org/scoping-review-uses-institutionalization-knowledge-health-policy-low-middle-income-countries/

devoted to incorporating the perspectives of high-level policy elites that are in a better position to know the intricacies of social dynamics in the health sector.

- Institutionalization of knowledge use for health policymaking is politically and socially contingent on identifying success in fulfilling its mandate to provide timely knowledge for use by policymakers while securing financing mechanisms to ensure its long-term sustainability.
- Institutionalization of knowledge for health policymaking in LMICs is an emerging area of interest for HPSR scholars. While the exact nature of this process is still poorly understood, or at least in its infancy, there is clearly a need to devote more research and attention to furthering this particular process of knowledge utilization in LMIC health systems.

# VI. EVIDENCE GAPS

As noted by most TWGs, the research on governance for health outcomes is severely lagging that of other research topics, such as health finance. Thus, one of the important goals of this exercise is to identify the conceptual and evidence gaps in the literature. In some cases TWGs identified complete gaps where governance intervention areas had received no research attention to date. In other instances, the evidence base was incomplete and thus hampered consensus or the use of evidence for tailored policy recommendations. Key gaps the TWGs identified include:

- **Effect of democratic deficit on health governance and outcomes.** Most studied countries are democracies, whereas many health programs target countries with non-democratic systems or democratic systems with large deficits in accountability and transparency to citizens.
- **Role of parliamentary oversight and policy environment.** Executive action in health, particularly in developing countries, remains one of the executive's top priorities. But—as we have often seen despite the planning and even execution of health budgets—many priority measures are never fully implemented. It is, therefore, the parliament's responsibility to oversee budget formulation and the implementation of policies to ensure that health remains a top priority.
- **Role and effects of external review mechanisms, such as audit agencies and anti-corruption commissions, on the health system.**
- **Improvements in the budget classification system**, such as removing duplicates, recoding, and consolidation of off-budget transactions, are a fundamental aspect of budget management, providing a normative framework for decision-making, accountability, and day-to-day administration. While improved budget classification systems are a key PFM intervention in many settings, no research was found regarding the relationship between such improvements and health.
- **How think tanks and the media contribute to the process of capturing and using knowledge for health policy decision-making in LMICs.**
- Ways in which knowledge is effectively used and institutionalized to advance collective understanding of the governance of health systems to strengthen policy formulation.
- Deeper understanding of the interactions between accountability mechanisms and specific contextual features.

This set of gaps can serve as the foundation of a comprehensive research agenda for further advancing understanding of the role governance plays in health system strengthening.

# VII. POLICY IMPLICATIONS AND ACTION POINTS

The evidence identified in the reports supports the conclusion that governance is important to health systems and outcomes. There is also growing consensus on how this happens and what governance interventions, or combination of interventions, yield positive results. The results presented here and in each TWG report can be used by policymakers and health system actors to ensure that health systems incorporate mechanisms for reducing corruption, increasing efficiency, and promoting transparency, voice, accountability, and equity in service delivery. However, the other overarching conclusion is that still more research is needed, including how to effectively build research and evaluation into health sector actions so that local stakeholders learn what works in different contexts. There are key evidence gaps in our greater collective understanding of governance and health dynamics; filling these gaps can reduce costs, improve quality, and expand UHC.

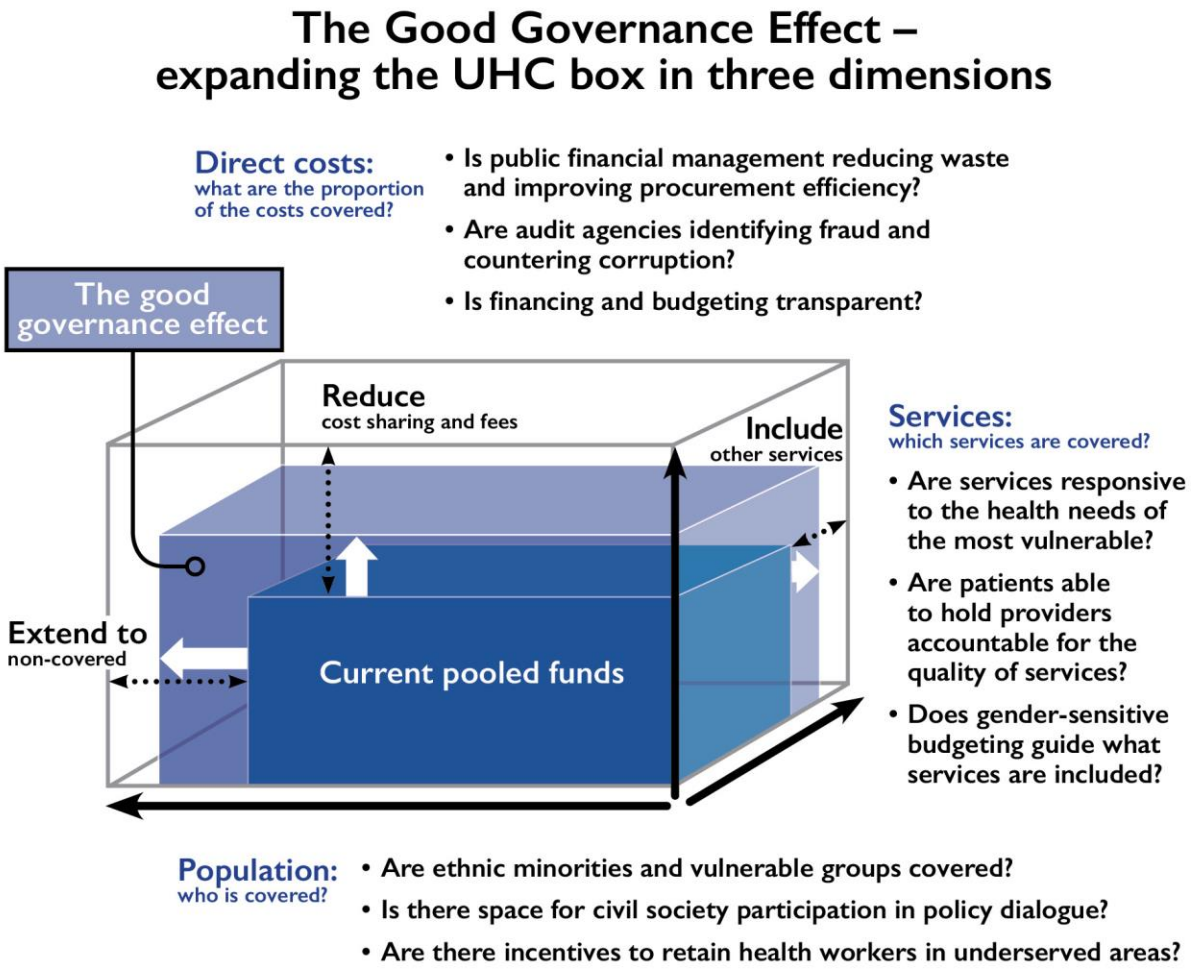
From the compiled evidence and subsequent discussions with stakeholders, a few key themes have emerged that offer concrete guidance and actionable steps to international and domestic policymakers:

1. **Social accountability approaches**—including citizen scorecards, user committees, participatory budgeting, and financial audits—reduce corruption and improve accountability and health system performance when used in concert with each other. Governments and donors should support the integration of social accountability mechanisms into all community health services, ensuring community input. This should be accompanied by building local capacity over a long enough time period to have communities making demands and tracking the improvement of services.
2. **Tackling corruption**. It is essential that policies increasingly focus on anticorruption, as several policies, like free provision of drugs at public facilities, unintentionally create avenues for corruption. Policymakers should consider oversight and audit mechanisms as an indicator of overall strength of internal controls, but should also ensure a high quality of data being used or reviewed for audit. More research is needed on modalities for reducing corruption and patient empowerment.
3. **Civil society inclusion**, **citizen engagement,** and pro-poor policies improve equity of health service delivery. Proactive space for civil society policy input (including freedom of information and press freedom) will create more-effective health policy dialogue, which in turn results in better representation, equity, and accountability.
4. **Gender-sensitive and program-based budgeting** is effective in improving health outcomes for vulnerable populations, particularly where health goals are centered on gender-related issues such as STDs, maternal and child mortality, and contraception.
5. **Public financial management interventions** improve efficiency, reduce costs, and enhance quality of health services. Governments and donors should create performance-based financial incentives for health services, with significant attention to operational detail, sufficient technical support, and sufficient capacity. This should include building awareness of recipients, compensation directly to front-line workers, and transparent and public data.
6. **Domestic tax revenue** is integral to achieving UHC, but results depend on the type of tax levied and the overall administration and governance structures. To achieve health results, revenue generation policies must be specifically engineered not to adversely affect the poor, such as through regressive taxes (sales tax, “sin” taxes, or flat income taxes). When considering revenue policy, lawmakers should trend toward pro-poor tax policy and administration if they are looking

to achieve health coverage goals, as well avoid revenue generation activities that undermine the socioeconomic conditions of vulnerable populations.

7. **Understand and promote the "Good Governance Effect" on UHC.** Donors and policymakers need to engrain understanding of the need for better health system governance to achieve UHC, and incorporate governance considerations into the UHC efforts in order to maximize the effect of limited funds, as captured in the UHC Cube graphic in Figure 4, below.

Figure 4. The Good Governance Effect




- Population dimension:
  - Social accountability interventions with marginalized and vulnerable populations lead to demands for better and equal coverage of health services.
  - Inclusive policies based on evidence and civil society engagement expand population coverage and target subsidies to the poor.
- Cost dimension:

  - Improved public financial management raises domestic revenue for health, improves procurement, and reduces waste and corruption.
  - Decentralization of service delivery increases accountability and responsiveness of health services, and eliminates under-the-table payments.
- Service dimension:
  - Evidence-based benefit packages prioritize high-value, essential services.
  - Social accountability creates citizen/user engagement mechanisms that demand quality services and patient safety.

8. **Develop and adopt a common Development Hypothesis and Theory of Change** on using governance to improve and expand access to essential health services. Through a Theory of Change model, establish intermediate health governance results and impact, and related output and outcome indicators, including process indicators. Integrate the Theory of Change into donor health strategies and programming models.
9. **Develop a "Thinking and Working Politically" guide** for health programming—to include applied political economy analysis tools—that can help national and civil society actors construct strategies and messages toward improving health system governance.
10. **Mobilize civil society networks,** and create advocacy tools and materials that identify reforms that can facilitate civil society's role in promoting good governance for health outcomes.

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# ANNEX 1: MARSHALLING THE EVIDENCE SYNTHESIS DATA

| TWG | Governance interventions | Sources | Immediate Governance Effects | Expected Governance Outcomes | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Efficiency & Effectiveness | Transparency | Accountability | Voice & Empowerment | Rule of Law/ Anticorruption | Equity | Responsiveness |
| Accountability | **Access to information (FOI)** | Fox, 2015 | Depends on availability - Few studies that relate these interventions to service delivery improvements, whether in health or other sectors. It is important to discriminate between access to information and availability. The existence of FOI laws may, in principle, provide access. However, availability—as the studies reviewed here indicate—is mediated by institutional and social factors that limit the extent to which average citizens can obtain timely and comprehensible information that they can, or may be motivated to, use for accountability purposes. ....; some support in the literature for the value of independent media in supporting accountability in some instances, and the studies of FOI initiatives cited above usually addressed the role of the media. | | **X** | **X** | **X** | | | |
| | **ICT-enabled accountability** | Peixoto and Fox, 2016 | Review of 23 ICT platforms to distinguish between the roles that information and transparency platforms can have in informing upwards accountability and bolstering downwards accountability through either individual feedback or collective action. Among their findings related to vertical accountability is that ICT platforms can contribute both to upwards accountability, helping senior managers to address service delivery issues, and to | | | **X** | | | | |

| TWG | Governance interventions | Sources | Immediate Governance Effects | Expected Governance Outcomes | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Efficiency & Effectiveness | Transparency | Accountability | Voice & Empowerment | Rule of Law/ Anticorruption | Equity | Responsiveness |
| | | | downwards accountability. This latter result depends upon whether the ICT feedback was shared publicly among citizens. A second finding is that institutional capacity to respond to citizen input can be usefully distinguished from motivation. In several of the cases, senior officials were personally committed to acting upon the ICT-enabled feedback, but it is a challenge to craft institutional incentives to encourage all officials to care about responding to citizen input. | | | | | | | |
| | **Performance-based contracting and related pay-for-performance scheme** | Key Informant Randolph Augustin; Eichler et al., 2009 | Some empirical support for the utility and effectiveness of performance-based contracting and related pay-for-performance schemes - work when there are clear and appropriate expectations, compensation directly to frontline workers, and transparent and public data around performance. Not whether performance incentives can change behaviors and improve services, but rather under what conditions do they fulfill their potential - select service providers and beneficiaries, the results to be rewarded, and the mechanisms to monitor performance. Terms of contractual arrangements, including how recipients will be monitored and performance rewarded, need to be clearly specified. Staff and systems to | **X** | **X** | **X** | | | | |

| TWG | Governance interventions | Sources | Immediate Governance Effects | Expected Governance Outcomes | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Efficiency & Effectiveness | Transparency | Accountability | Voice & Empowerment | Rule of Law/ Anticorruption | Equity | Responsiveness |
| | | | administer performance-based payments need to be organized, and both technical and financial resources need to be dedicated to assessing, learning, and revising the approach (failure examples: failure to tailor pay-for-performance schemes to the levels of capacity, poor understanding of financial incentives and personal incentive structures embedded in the health system | | | | | | | |
| | **Public expenditure tracking** | Tolmie, 2013 | Public expenditure tracking can support improvements in transparency and reduced corruption, though studies indicate that citizen engagement in public expenditure tracking faces capacity, power, data quality, and incentives issues - a focus on budgets and financial flows provides concrete accountability targets around which citizens can mobilize demand, particularly if they are supported by capable NGOs that can serve as translators and simplifiers of complex budget and procedural information | | **X** | | **X** | **X** | | |
| | **Participatory budgeting** | Gonçalves, 2014; Boulding and Wampler, 2010 | Participatory budgeting increases citizen voice in decision-making and leads to greater responsiveness in resource allocation in line with citizen preferences, but it is not clear the extent to which these increases in participation lead to improvements in service-delivery efficiency. | | | | **X** | | | **X** |

| TWG | Governance interventions | Sources | Immediate Governance Effects | Expected Governance Outcomes | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Efficiency & Effectiveness | Transparency | Accountability | Voice & Empowerment | Rule of Law/ Anticorruption | Equity | Responsiveness |
| | **Financial audits** | Goryakin et al., 2017; Cantarero and Pascual, 2008 | Evidence overall is limited with respect to improving health outcomes, but financial audits seem to improve transparency, reduce corruption, and contribute to improvements in efficiency, though their value for money may be variable. | | X | | | X | X | |
| | **Political decentralization** | Smoke, 2015; Gilson et al., 1994; Bossert and Mitchell, 2011; Avelino et al, 2013; Pruce, 2016 | Showed mixed results tied to health governance. While some instances showed decreased corruption, others showed that reductions in decentralization correlated with greater investments in health. The politics of decentralization, the characteristics of particular health services, and the intent of donors that support country decentralization seem to explain to a large extent these mixed results. | X | X | X | X | X | | X |
| | | Mitchell and Bossert, 2010 | Mitchell and Bossert (2010) apply decision-space analysis to six countries (Bolivia, Chile, India, Pakistan, the Philippines, and Uganda). The authors map patterns of discretionary autonomy across health system functions. They discuss how the balance of authorities and responsibilities between central and local health officials can promote achievement of health system outcomes: improved health status, financial risk protection, consumer satisfaction, and equity. However, they also argue that from a perspective that foregrounds health system | | | | | | X | X |

| TWG | Governance interventions | Sources | Immediate Governance Effects | Expected Governance Outcomes | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Efficiency & Effectiveness | Transparency | Accountability | Voice & Empowerment | Rule of Law/ Anticorruption | Equity | Responsiveness |
| | | | performance, decentralization can produce some negative outcomes – improvement is not automatic, and depends on how the decision space is structured. | | | | | | | |
| | **Fiscal and financial decentralization** | Avelino et al., 2013; Transparency International, 2017 | Some evidence that under the right conditions, fiscal and financial decentralization can improve responsiveness, increase efficiency, and limit corruption. Avelino's study shows that higher capacity health councils had less corruption than lower-quality ones according to the metrics of the study. | **X** | | | | **X** | | **X** |
| | **Recentralization** | Malesky et al., 2014 | Recentralization improved the delivery of services favored by central government, which included health. This improvement resulted from the reform's impact on limiting the power of local elites to dominate investment and spending decisions and profit from corruption. | **X** | | | | **X** | | |
| | **Coupling demand and supply-side accountability** | Wetterberg et al. 2016; Fox, 2016; O'Meally et al., 2017 | Analysts and practitioners recommend variations on Fox's (2015) sandwich strategy, which marries bottom-up advocacy and collective action from below with top-down bureaucratic pressure and support from above - demand-side and supply-side interventions are pursued in tandem in ways that are mutually reinforcing. | **X** | | | | | | **X** |

| TWG | Governance interventions | Sources | Immediate Governance Effects | Expected Governance Outcomes | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Efficiency & Effectiveness | Transparency | Accountability | Voice & Empowerment | Rule of Law/ Anticorruption | Equity | Responsiveness |
| | **Social accountability** | Holland et al, 2016 | Social accountability is effective in improving local-level service delivery, but has a limited effect at scale. Adding formal, invited citizen participation, as part of an integrated and institutionalized policy and program framework enhances the prospects of social accountability impacts at higher levels of service delivery. Social accountability can contribute to improving access to services for marginalized populations, but for sustained impact it needs to be accompanied by supply-side measures that directly target these populations. | | | **X** | **X** | | | |
| | **Service charters; Health facility committees** | McIntosh et al., 2015 | Accountability tools - service charters and quality assurance reviews to reinforce accountability between levels of government, while also using the same charters, health facility committees, and integrated supportive supervision to embed vertical accountability. | | **X** | **X** | | | | **X** |

| TWG | Governance interventions | Sources | Immediate Governance Effects | Expected Governance Outcomes | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Efficiency & Effectiveness | Transparency | Accountability | Voice & Empowerment | Rule of Law/ Anticorruption | Equity | Responsiveness |
| | **Citizen involvement in the health policy process** | Rodriguez, 2015; Onwujekwe, 2015; Rani, 2012; Coelho, 2013; Drake et al, 2010; Becerra-Posada et al, 2014; Nabyonga-Orem et al, 2016; Cash-Gibson et al, 2015; El-Jardali et al, 2015; Rizk et al, 2015 | Knowledge utilization to enhance the quality of service delivery was mentioned in research on integrated community case management in Malawi, non-communicable disease service delivery in five Asian countries, multiple primary care services in Nigeria, and male circumcision for HIV prevention in Uganda. Institutionalization of lessons learned from citizen involvement heavily present in Brazil, three NGO case studies in policymaking, and West Africa. | | | | **X** | | | **X** |
| | **Institutionalization of knowledge use - political will** | Zida, 2017 (policymaking); Zida, 2017 (institutionalization); Barth, 2013 | Institutionalization attention should be devoted to incorporating the perspectives of high-level policy elites who are better positioned to know the intricacies of social dynamics in the health sector. Similarly, political will of key bureaucratic and political figures, as well as a robust civil society, help to enforce the regular use of and production of data to inform policymaking. Elements include existence of an institutional framework (policy unit's government mandate), | **X** | | | | **X** | | |

| TWG | Governance interventions | Sources | Immediate Governance Effects | Expected Governance Outcomes | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Efficiency & Effectiveness | Transparency | Accountability | Voice & Empowerment | Rule of Law/ Anticorruption | Equity | Responsiveness |
| | | | consistent data production and report preparation, adequate financial and human resources, and infrastructure capacity to routinely produce and use data in policymaking. | | | | | | | |
| | **Institutionalization-regulative aspects** | Liverani et al, 2013; Tapia-Conyer et al, 2012; Becerra-Posada et al, 2014; Jirawattanapisal et al, 2009; Teerawattananon et al, 2009 | Three review articles reflect on the regulative aspects of instituionalization of knowledge, and two more discuss regulations around using this knowledge in policy design. Still, there appears to be a gap in the health literature on regulative forms of institutionalization that adhere to binding rules and structured incentives for the purpose of expedient knowledge transfer. | **X** | | | | | | **X** |
| | **Creation of specialized units** | Zida, 2017; Banta and Almeida, 2009; Gomez-Dantes and Frank, 2009; Teerawattananon et al, 2009; Buasai et al, 2007; Rani et al, 2012; Renzi, 1996; World Bank, 2010 | These papers use institutionalization language to analzye the creation of specialized health system units, such as a health policy rapid response unit. They outline five steps to institutionalization, including awareness, experimentation, expansion, consolidation, and maturity. Authors frequently illustrate the political and socially contingent process of | **X** | | | | | | **X** |

| TWG | Governance interventions | Sources | Immediate Governance Effects | Expected Governance Outcomes | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Efficiency & Effectiveness | Transparency | Accountability | Voice & Empowerment | Rule of Law/ Anticorruption | Equity | Responsiveness |
| | | | institutionalization knowledge use for health policymaking, identifying success in fulfilling its government mandate of providing timely knowledge that could be used by policymakers, but questioning the extent to which financing mechanisms exist to ensure its long-term sustainability. Further research needed into addressing these resource constraints. | | | | | | | |
| | **Processes of accreditation or certification** | Zielinski et al, 2014; Rutta et al, 2015 | The literature is largely focused on creating an ideal environment for facilitating knowledge transfer, exchange, and dialogue to better inform policymaking. Unlike regulative institutionalization, which seeks to induce knowledge utilization through binding agreements, the literature suggests that greater emphasis in LMIC health systems has been placed on developing norms and best practices. Few sources focus on accreditation or certification processes in these contexts as methods of insitutionalization. | **X** | | **X** | | | | **X** |

| TWG | Governance interventions | Sources | Immediate Governance Effects | Expected Governance Outcomes | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Efficiency & Effectiveness | Transparency | Accountability | Voice & Empowerment | Rule of Law/ Anticorruption | Equity | Responsiveness |
| | **Regulatory policy design** | Jirawattanapisal et al, 2009; Teerawattananon et al, 2009 | These sources also focus on regulatory instances of instituionalization (see above). | **X** | | | | | | **X** |
| | **Deliberative policy making through exchanges between domestic governments, international stakeholders, and civil society** | Coelho, 2013; Kaseje 2010; Gomez 2012; Rodriguez et al, 2015; Ade et al, 2016; Beesley et al, 2011; Gomez and Atun, 2012; Koduah et al, 2016; Hawkes et al, 2016 | Literature regarding multi-country efforts to strengthen individual, organizational, and institutional capacity to use research for policymaking. Relative consensus that deliberative modes of policy governance through engagement with civil society organisations which resulted in better representation and accountability. | | | | **X** | | **X** | **X** |
| | **Agenda setting for policy process** | Gilson and McIntyre, 2008; Koduah et al, 2016 | Difficult to link use of knowldege with improvements in specific health outcome categories. Many studies reported knowledge use that resulted in macro-level health system changes that didn't fit neatly into specific categories. This included the incorporation of research findings into national level policy and strategy documents, the creation of new state agencies or units, and agenda-setting for the policy process. | **X** | | | | | | **X** |

| TWG | Governance interventions | Sources | Immediate Governance Effects | Expected Governance Outcomes | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Efficiency & Effectiveness | Transparency | Accountability | Voice & Empowerment | Rule of Law/ Anticorruption | Equity | Responsiveness |
| | **Incorporation of research findings into policy and strategies** | Nabyonga-Orem, 2014; Knaul FM, Arreola-Ornelas H, 2006; Contreras-Hernandez, 2012; Rutta et al, 2015; Drake et al, 2015 | Many examples in the literature of use of research and routine system information informing drug policy, essential medicines, andother pharmaceuticals. Utilization of knowledge to improve financial protection was illustrated in research from Mexico which resulted in a reduction in out-of-pocket expendituresand research from Colombia that noted a decline in spending for oncological treatment by users. Access, quality, and financial protection regularly discussed with respect to institutionalization in the literature, with equity less represented. | **X** | | | | | **X** | **X** |
| | **Increased resilience of health systems** | Knaul FM, Arreola-Ornelas H, 2006; Nabyonga-Orem J, Ssengooba F 2014; Drake, Hutchings, 2010; Rutta E, Liana J, 2015 | Some research suggested that health impacts were achieved indirectly through health systems improvements such as improved malaria treatment in Uganda, reduced catastrophic expenditures in Mexico, improved drug availability in Tanzania [75], increased access to emergency contraception in multiple countries. Gap in evidence as to which health system governance interventions | | | | | | | **X** |

| TWG | Governance interventions | Sources | Immediate Governance Effects | Expected Governance Outcomes | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Efficiency & Effectiveness | Transparency | Accountability | Voice & Empowerment | Rule of Law/ Anticorruption | Equity | Responsiveness |
| | | | trigger these improvements and causality. | | | | | | | |

| TWG | Governance interventions | Sources | Immediate Governance Effects | Expected Governance Outcomes | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Efficiency & Effectiveness | Transparency | Accountability | Voice & Empowerment | Rule of Law/ Anticorruption | Equity | Responsiveness |
| Public Financial Management | **Spending and health outcomes** | D Rao, 2014 | Overall economic growth and revenue mobilization on its own does not necessarily amount to more health spending or health outcomes. This casts doubt on the argument that PFM interventions in revenue mobilization could have the capacity to improve health outcomes by facilitating greater allocations towards health spending. | **X** | **X** | **X** | | | | |
| | **Domestic revenue mobilization** | Elovianio, 2017 | This study associates low domestic health spending and high dependence on out-of-pocket payments with poor health outcomes. | **X** | | | | | **X** | |
| | **Consumption taxes** | Reeves, 2015 | This study argues that consumption taxes reduce the ability of the poor to afford essential goods, and are associated with increased rates of post-neonatal mortality, infant mortality, and under-5 mortality rates. These adverse associations were not found with taxes on capital gains, profits, and income. | | | | | | **X** | |
| | **Removal of user fees** | Meessen et al., 2011 | This study finds the removal of user fees does not adequately address supply and demand side health financing issues and therefore does not have the desired impact on health outcomes that recommend the practice. The study looks across several countries in sub-Saharan Africa and found, in most countries, that there was no comprehensive approach in addressing all the barriers (financial and non-financial) that households encounter in their utilization of health services | **X** | | | | | **X** | **X** |

| TWG | Governance interventions | Sources | Immediate Governance Effects | Expected Governance Outcomes | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Efficiency & Effectiveness | Transparency | Accountability | Voice & Empowerment | Rule of Law/ Anticorruption | Equity | Responsiveness |
| | **Earmarking** | Soe-Lin et al, 2015; Cashin, 2017 | Empirical data in 188 countries over 18 years shows that found that increased tax revenues do not necessarily translate to increased health spending. Further, Cashin's study of several countries in Sub-Sarahan Africa show that between 10-30% of allocated budgets go unspent, reinforcing the perception that public spending on health can be inefficient. | X | | | | | X | |
| | **Medium-term expenditure financing (MTEF)** | Bevan and Palomba, 2000; Foster, 2002 | Introduction of an MTEF reform in Uganda did not prevent a decline in the proportion of budgets being allocated to health. The study mentions, however, that the Ugandan health sector was very reliant on donor financing at this time.This example could have mixed implications for government spending. | X | | X | | | | |
| | | Wilhelem, Vera, et al, 2008 | Review of case studies that documented the status of MTEF in a sample of nine low-income countries found that the introduction of MTEF, in close relation with poverty-reduction strategies, encouraged higher prioritization, enhanced country ownership and customization. The introduction of MTEF also more fully encapsulated poor and vulnerable groups by linking them to domestic decision-making processes – particularly in health. | X | X | | | X | | X |
| | **Gender-responsive budgeting** | Durojaye, Ebenezer, et al. 2010 | A study of GRB in several African countries notes that investments in girls and women (including reproductive health investments) offer a “double dividend” because | | | | | | X | X |

| TWG | Governance interventions | Sources | Immediate Governance Effects | Expected Governance Outcomes | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Efficiency & Effectiveness | Transparency | Accountability | Voice & Empowerment | Rule of Law/ Anticorruption | Equity | Responsiveness |
| | | | they have pay-offs in terms of women's reproductive roles, as well as their (economic) productive roles. | | | | | | | |
| | **Strategic purchasing** | Annear, 2015 | This study analyzes a number of middle-income and low income countries (particularly in the Asia Pacific region) that are introducing or considering the implementation of Diagnosis-Related Groups (DRGs) to contain inpatient costs. Annear's study finds that DRGs tend to affect the non-hospital sector by shifting costs from inpatient to out-patient. Other trends include a decrease in the length of hospital stays. Volume of hospitalizations tended to increase in countries that use DRGs to set hospital budgets, while volume tends to decrease in countries that shifted from a cost-based reimbursement system to a DRG-based payment. | **X** | **X** | | | | | **X** |
| | **Results-based financing/PBF** | Vian and Bicknell, 2014 | This study, based in Lesotho, found that RBF did not have the desired effect at the hospital level because staff lacked the capacity to implement the reform. The authors of the study noted that the policy goals in Lesotho were also not adequately translated from the national to facility level – which contributed to the lack of adoption. | **X** | **X** | **X** | | | | **X** |
| | | Ilse, 2016 | This study, conducted in Cameroon, found concerns that RBF may inadequately address inequalities in access to care. After testing the PBF intervention targeting the poorest in communities in Cameroon, the study concluded that a system of targeting the poorest of society in PBF programs may help reduce | | **X** | | | | **X** | **X** |

| TWG | Governance interventions | Sources | Immediate Governance Effects | Expected Governance Outcomes | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Efficiency & Effectiveness | Transparency | Accountability | Voice & Empowerment | Rule of Law/ Anticorruption | Equity | Responsiveness |
| | | | inequalities in health care use, but only when design and implementation problems leading to substantial under-coverage are addressed | | | | | | | |
| | | Petrosyan, Varduhi, et al, 2014 | A study conducted in Armenia found that the RBF program contributed to a substantial increase in the utilization of PHC services and improved provider performance. This intervention, however, was coordinated with well sequenced reforms and supported by nationwide training and bonus payments to keep participants motivated. Researchers hypothesized these factors may have significantly contributed to the success of the program. They also cited domestic finance as a major source of success because it encouraged country buy-in and ownership | | X | | | | | X |
| | **Auditing** | Powell-Jackson, 2007 | This study reviewed National Health Accounts (NHA) noted that NHAs are at most a framework, and therefore can do little to address the underlying problem of weak government public expenditure management and information systems that provide much of the raw data. The emergence of budget support aid modalities poses a methodological challenge to health resource tracking, as such support is difficult to attribute to any particular sector or health program. | X | | | | X | | X |
| | **Fiscal decentralization** | Goryakin, 2017 | A literature review that finds that municipalities which implemented participatory budgeting reforms were more likely to allocate increased | X | | | | | | X |

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| | | | | Efficiency & Effectiveness | Transparency | Accountability | Voice & Empowerment | Rule of Law/ Anticorruption | Equity | Responsiveness |
| | | | funding to health and sanitation services after controlling for municipal fixed effects and a range of other control variables. | | | | | | | |
| | | Sumaha, 2016 | A systematic review of the effects of decentralization on health-related equity, Most or all cases did not isolate differente aspects of decentralization but, rather the studies examined decentralization as a broad concept with an implication for overall governance - implications of decentralization are varied and often depend on pre-existing socio-economic and organizational context, financial barriers to access, the form of decentralization implemented and the complementary mechanisms executed alongside decentralization. | X | | | | | X | |
| | | Village Reach, 2016 | A study highlighting a supply chain issue in Mozambique - the district-level government funding the immunization supply chain is often managed through a single person, the district secretary, who may quickly become a bottleneck if many departments are submitting requests simultaneously resulting in cash flow problems. The author concludes that harmonizing treasury operations and cash processes can potentially improve the budgeting and planning processes of health. However, if treasury operations are inefficient, and rely on old outdated processes, then these operations can become entrenched. Inefficient treasury operations are also subject to a lack of transparency, and are often unreliable to the communities it needs to service. | X | X | X | | X | | |

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| | | | | Efficiency & Effectiveness | Transparency | Accountability | Voice & Empowerment | Rule of Law/ Anticorruption | Equity | Responsiveness |
| | | Robalino, 2001 | A cross-country analysis that concludes that if central governments retain some authority to influence local policy and implementation without compromising the autonomy of local decision-making, it is more likely that the benefits of a devolved system will be realized. The study also concludes that countries which achieve a more fiscally decentralized system is associated with lower mortality rates and improving health outcomes in environments with high levels of corruption. | | | | X | | | |
| | | Cashin, 2017 | In countries with a high degree of fiscal decentralization for collecting revenues and setting priorities for expenditures, pooling is more fragmented if there is not a strong equity-based mechanism for redistribution. This lessens equity and financial protection in the health sector. In post-Soviet Tajikistan, rapid devolution of both revenue and expenditure authority to local governments led to poor risk pooling and a high degree of inequity. | X | | | | | X | |
| | **Deconcentration** | Kwamie, 2016 | Deconcentration defined as revenue and expenditure management through local administration. This study finds that, in Ghana, the lack of coherence in district financing, mandated managerial responsibilities, and strong vertical accountabilities has negatively influenced the authority of district health managers, thereby deterring deconcetration. This has resulted into a limited transfer of autonomy fomr national to sub-national levels. | | | X | | | | X |

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| | | Mohammed, 2016 | In Fiji, decentralization has had an inconclusive effect on empowering local actors (with most of the power and authority staying centrally located) and on health systems and outcomes. Decentralization has caused a 300% increase in the utilization of health services at the health center level since its introduction, but a decline in funding for ambulatory care. | X | | | | | | X |
| | **Devolution** | Bossert, 2003 (Zambia) | In Zambia, a country with declining health budgets where district health officials exercise a moderate degree of choice for many key functions, devolution did not worsen inequalities among districts or reduce the utilization of health services. It allowed the districts to make decisions on the internal allocation of resources and on user fee levels and expenditures. However, districts choices were quite limited over salaries and allowances and they did not have control over additional major sources of revenue, like local taxes | X | | X | X | | X | |
| | | Bossert, 2003 (Colombia, Chile) | Decentralization can contribute to, or at least maintain, equitable allocation of health resources among municipalities of different incomes - data from Colombia shows that a population-based formula for national allocations is an effective mechanism for achieving equity of expenditures. Successful budget autonomy can be seen in Colombia and Chile, where equitable levels of per capita financial allocations at the municipal level were achieved through different forms of intergovernmental transfer | | | X | X | | X | |

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| | | | | Efficiency & Effectiveness | Transparency | Accountability | Voice & Empowerment | Rule of Law/ Anticorruption | Equity | Responsiveness |
| | | | of public funds (i.e. allocation formula, local funding choices, and horizontal equity funds). | | | | | | | |

| TWG | Governance interventions | Sources | Immediate Governance Effects | Expected Governance Outcomes | | | | | | |
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| Policy and Regulation | **Decentralization policies** | Kelsall, T., T. Hart, and E. Laws, 2016 | This study finds that lack of competition and corruption in procurements related to the pharmaceutical sector could undermine the benefits of an increase in coverage of health financing mechanisms. It focuses on exmaples of monopolistic drug markets in Vietnam resulting in few options to purchase affordable drugs, while in China corruption in the bidding process for drug procurements allowed certain providers to receive bribes. | | | X | | X | | |
| | | OECD Reviews of Health Systems: Mexico, 2016 | In the early stages of decentralization in Mexico under the National Decentralization Agreement, funding was channeled through the states (provinces), which gave them the incentive to increase enrolment of population into the program. However, this system had weak accountability; states had decision-making responsibility on how to spend their funds but without central oversight that set efficiency or quality targets. As a result, there were variable achievements in quality of care. | X | | X | | | | |
| | | Cortez, R. and D. Romero, 2013. | This study describes the functioning and performance of Argentina's Provincial Maternal and Child Health Investment Program, commonly referred to as Plan Nacer. Though overall evidence of the health impacts of decentralization is mixed, this program successfully promoted fiscal autonomy to local health centers, allowing for greater health coverage of its target population. | X | | | | | | X |

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| | | Chao, S., World Bank, 2013 | Jamaica decentralizes the functions of its Ministry of Health by making four Regional Health Associations responsible for healthcare delivery but retains the central functions of "policy, planning, regulating, and purchasing" to increase efficiency and responsiveness of the system. Core finding of this study is that decentralization needs to be accompanied by clear, transparent allocation of responsibilities. | X | X | X | | | | X |
| | | Gottret, P.E., G. Schieber, and H. Waters, 2008 | Estonia sought to rapidly decentralize both its financing system and the healthcare provider system. However, this was not accompanied by an increase in capacity of the regional providers. This led to a situation of uncoordinated planning and funding, combined with fragmented revenue collection; with an overall outcome of more inefficiency and inequality | | | | X | | X | |
| | | Francke P., 2013 | Peru attempts to decentralize health management functions to different regional offices, while maintaining control over core policy and decision-making matters. However, without clearly understood accountability across levels, citizens were unable to ascribe performance to the relevant authority that has jurisdiction, diluting overall responsiveness towards improved performance. | | X | X | | | | |
| | | Aantjes, C., T. Quinlan, and J. Bunders, 2016 | Efforts in Zambia to decentralize its health system to regional and specialized health units successfully improves quality, expands coverage, and cuts costs. | X | | | | | X | X |

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| | | Fernandes, A.M., et al., 2016. | Study in Portugal suggests that stronger local health governance may be vital for improving health services effectiveness and health outcomes in a decentralized health system. | X | | | X | | | X |
| | **Voice and citizen empowerment** | Ham, C. and M. Brommels, . 1994. | Analysis of citizen choice and empowerment in the Netherlands, Sweden, and the United Kingdom. UK has less choice in terms of providers and insurers, and therefore relys more on medical training and professional bodies to ensure patient rights. The Netherlands and Switzerland have more choice and citizen participation, with similar health outcomes. | | X | | X | | | X |
| | | Key informant interview August 2017; (pg 20/34) | Uganda presents an example of where strategic litigation has been used effectively by civil society to bring about much needed improvements in maternal health. Similarly, in Indonesia, civil society-led legal challenges against the government for not implementing single-payer health insurance reform within the stipulated timeline of the related act spurred the eventual rollout. | | X | X | X | | | X |
| | | Atun, R., et al., 2013 | Community participation can help define goals for the healthcare system and to hold providers accountable to attaining them. In Turkey, annual household surveys are undertaken by Turkish Statistical Institute to gauge patient satisfaction with health care services. | | | X | X | | | |

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| | | Gottret, P.E., G. Schieber, and H. Waters, 2008 | Costa Rica has promoted citizen involvement by legal means which established Health Boards that comprise of democratically elected community leaders who oversee the delivery of services. However, despite the existence of a policy regarding community participation in health in Costa Rica, community activists may still not have voice and influence due to lack of capacity in such citizen bodies. | | X | | X | | | |
| | **Transparency policies** | Balabanova D, 2013 | Investments in transparency and accountability enabled the success of reforms laid out in Kyrgyzstan's Manas and Manas Taalmi plans to be successful in reducing informal payments and improving financial protection from effects of ill-health. | | X | | | | | |
| | **Uniform service pricing** | Key informant Interview (page 12/34) | Uniform service pricing for inpatient services within five specified regions under the Jaminan Kesehatan Nasional (JKN) system were helpful in increasing transparency and reducing corruption in Indonesia. | | X | | | X | | |
| | **Published fees** | Ensor T, 2017 | A study based in Cambodia finds that published user fees are a useful tool to increase transparency. To be effective in promoting transparency, fees need to be formally published and clearly communicated to patients, with defined exemptions in place for those who need them. These would need to be alongside other mechanisms to reduce financial barriers to patients at point of care. | | X | | X | | | |

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| | | | | Efficiency & Effectiveness | Transparency | Accountability | Voice & Empowerment | Rule of Law/ Anticorruption | Equity | Responsiveness |
| | **Accountability frameworks** | Governing Mandatory Health Insurance: Learning from Experience, 2008, World Bank | In Estonia, appropriate accountability frameworks were implemented when restructuring their single-payer system. Efficiencies were therefore generated through a single-payer healthcare system, unlike other instances where lack of these frameworks caused reduced responsiveness and corruption. | | **X** | **X** | | | | |
| | **Responsiveness through split between purchaser and provider** | Lagomarsino G, 2012 | One of the fundamental rationales for the split between purchaser and provider is to promote the ability for funding to follow the patient, who can register at a facility of choice; and hence providers must compete on access and quality to earn revenue, which improves the responsiveness of the system and health outcomes. This overview of health systems in nine countries in Africa and Asia finds that funding often does not fully follow the patient, and local registration requirements can limit choice and entry points for patients. It also takes more than just the purchaser-provider split, as strategic purchasing mechanisms need to be implemented to create the right incentives for providers along with effective monitoring and oversight from the purchaser. | | | | **X** | | | **X** |
| | **Transparency and responsiveness in Supply Chain Management** | Mano L, 2013; Agyepong I.A., 2014; Hughes, 2007; Lagarde M., 2008; Ravindran T.S., 2012; | Policies introduced targeting the supply chain management (SCM) component of the health system are typically aimed towards increasing equity, coverage, and financial risk protection. However, there are many instances of these policies relying on transparency and responsiveness to operate effectively. In Ghana for example, the fee schedule for | | **X** | **X** | | | | **X** |

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| | | Honda A., 2015; Honda A., 2012 | medicines is based on the NHIS medicine list and undergoes periodic revision. In Argentina, Bolivia, Peru, and Uruguay, physicians are required to prescribe generic brands of medicines whenever possible, and this is well understood by pharmacists, who can then question the use of brand name medicines when there is a cheaper alternative available. | | | | | | | |