# Do Better Laws and Regulations Promote Universal Health Coverage? A Review of the Evidence

**October 2017**

Marshalling the Evidence for Health Governance

Thematic Working Group Report

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# ACRONYMS

| | |
|---|---|
| **COPE** | Client-Oriented, Provider-Efficient |
| **HFG** | Health Finance and Governance Project |
| **HP+** | Health Policy Plus Project |
| **GP** | General Practitioner |
| **JKN** | Jaminan Kesehatan Nasional |
| **LAC** | Latin America and the Caribbean |
| **MENA** | Middle East and North Africa |
| **MTE** | Marshalling the Evidence for Health Governance Initiative |
| **NHIS** | National Health Insurance Scheme |
| **OECD** | Organization of Economic Cooperation and Development |
| **PFM** | Public financial management |
| **SCM** | Supply chain management |
| **SDGs** | Sustainable Development Goals |
| **SSA** | Sub-Saharan Africa |
| **TWG** | Thematic Working Group |
| **UHC** | Universal health coverage |
| **USAID/GH/OHS** | USAID's Office of Health Systems |
| **WBG** | World Bank Group |
| **WHO** | World Health Organization |

# EXECUTIVE SUMMARY

The importance of policies, laws, and regulations (referred to collectively below as “policy instances”) as instruments to support progress towards Universal Health Coverage (UHC) in low- and middle-income countries cannot be understated. However, there has been insufficient focus in the literature on the role of these instruments, leading to a lack of evidence as to what constitutes a supportive legal environment that can consistently provide a strong basis for UHC reform processes. In this review, we explore how policies implemented in different country contexts have had an impact on their achievement of UHC goals.

In order to better differentiate the effect of various policy instances on the achievement of UHC goals, we developed a typology for policy instances and then ascribed the different aspects of governance to the instances identified in the literature, based on how they were designed and implemented. Finally, we considered the success of each policy instance identified, in terms of achieving intended UHC-related outcomes.

A literature review was performed and supplemented by interviews with international governance experts, to understand the additional context around the implementation of several key health system reforms. Experts spoke to the critical enablers for good governance in policy instance implementation, the roles of institutions, and the evidence for subsequent impact on intended UHC outcomes.

We compiled 234 unique policy instances across countries that were relevant to this analysis. Primary legislation was the dominant form of policy instances found in the review, and these were mostly national (88%) in contrast to regional (7%) or local (5%) laws. The majority of policy instances were designed to take effect through improved responsiveness and accountability. This seems appropriate given the number of policy instances focused on making progress towards UHC goals of increased coverage (212 instances), improved equity (191) and increased financial risk protection (186), in other words, designed to be responsive to the general population’s needs. When policy instances were focused on increasing coverage, the majority of these sought to expand services to new population segments and vulnerable populations (125 instances). The remainder focused on expanding service coverage geographically (87 instances).

Most of the reforms linked to the policy instances and associated with achieving UHC tended to have a health financing focus, such as; raising revenue through tax-based financing, increasing insurance coverage, or addressing demand-side financing. There were also several linked reforms that sought to address user fees and implement subsidies. Promoting greater accountability of actors in the health system, insurance agencies and providers in particular, and improving transparency, especially regarding fees and subsidies, were critical aims in many of these policy efforts. Policy instances focused on drugs and supply chain issues aimed to increase accountability and reduce corruption in the sector. Human resources for health was also a major policy focus with efforts to increase accountability and responsiveness at the regional and local levels. There was relatively less frequency of policy instances focused on health information systems. Those found focused on improving quality and access through more accountable and transparent systems.

Policy instances focused on decentralization initiatives came up repeatedly as a basis for strengthening capabilities and performance at each level of the health system across a country. These policy instances appeared more likely to be noted as a success when they included strong accountability measures, while allowing for increased responsiveness at the local level.

Key informants emphasized the role of citizens' voices in enabling major health system reforms towards UHC. This role is often less documented as the impact is harder to isolate. It is nevertheless critically important in the policy formulation and implementation process.

Countries on the cusp of undertaking major health system reforms through the drafting and implementation of relevant policy instances will have to prioritize their governance interventions based on the risks specific to their existing health system contexts. At a minimum, they should do all that is possible to avoid some of the negative or unintentional aspects of sub-optimal policy instance design, that can reduce efficiency and quality. Where possible, emphasis should be placed on capturing synergies in governance interventions that increase responsiveness, accountability and transparency, as this review has found an abundance of evidence that these governance results can be mutually reinforcing and lead to step change improvements in the functioning of the health system.

Governments may have political and process constraints on the number of policy instances they can design and implement in a period leading up to and during health sector reform. In terms of which health system component to focus such change on, we have more evidence for policy instances focused on health financing, given that designing effective financing mechanisms can shape the entire health sector. Following this, policy instances that address human resources for health and supply chain management should be prioritized as they appear to have key strengthening effects on the provision of health care by increasing efficiency, equity, and quality.

This review of the evidence to date of governments' policy-making experience highlights the importance of effective policy design and implementation with a clear orientation towards better governance, and in particular increased responsiveness and accountability.

# INTRODUCTION

## Background

While the importance of governance in health systems is well recognized, there is an overall lack of evidence and understanding of the dynamics of how improved governance can influence health system performance and health outcomes. There is still considerable debate on which governance interventions are appropriate for different health contexts. This ongoing lack of evidence can result in policymakers avoiding health governance efforts or an over-reliance on a limited set of governance interventions. As development partners and governments are increasing their emphasis on improving efficiency, accountability and transparency of health systems, and strengthening country policies and institutions to move towards UHC, the need for this evidence is rising.

To address this evidence gap, in September 2016, the USAID's Office of Health Systems (USAID/GH/OHS), the World Health Organization (WHO), and the USAID-funded Health Finance and Governance (HFG) Project launched the '*Marshalling the Evidence for Health Governance'* (MTE) initiative to consolidate the evidence base on how governance contributes to health system performance and improves health outcomes. The overall objective of the initiative is to increase awareness and understanding of the evidence—what works and why, how governance contributes to health system performance, and how the field of health governance is evolving at the country level.

### *MTE Thematic Working Groups*

Four thematic working groups (TWGs) were formed to consolidate evidence by conducting literature reviews and key informant interviews from low- and middle-income countries in selected areas: Accountability; Policy and Regulation; Public Financial Management (PFM); and the Use of Knowledge in Health Systems. These areas were chosen because they were comprehensive subjects in their own right, had importance to health systems, and because of the lack of an international consensus on priority interventions in each area. The TWGs consisted of a small group of experts from various implementing and technical organizations as well as academic institutions from different parts of the world. In their work, they consulted with policymakers and experts globally. Each TWG was led by a pair of co-chairs from different organizations and included a member from WHO and the HFG project.

### *Dissemination Plan*

The goals of this paper focused on the policy and regulation area are to make the available evidence more accessible and relevant to countries as well as identify gaps in collective knowledge. This paper is one of five – one for each of the four TWGs plus a synthesis— and captures the findings for the Policy and Regulation TWG. It is intended to complement the findings of the other three TWGs. These papers will be launched at a public event scheduled for mid-November 2017 in Washington, DC and will subsequently be disseminated at various global events, including UHC 2030 Day, to be held in Tokyo on December 12, 2017.

### *Policy and Regulation TWG: Conceptual Approach*

Policies, laws and regulations (defined individually below and hereafter referred together as 'policy instances') are critical instruments to support the achievement of UHC in low- and middle-income

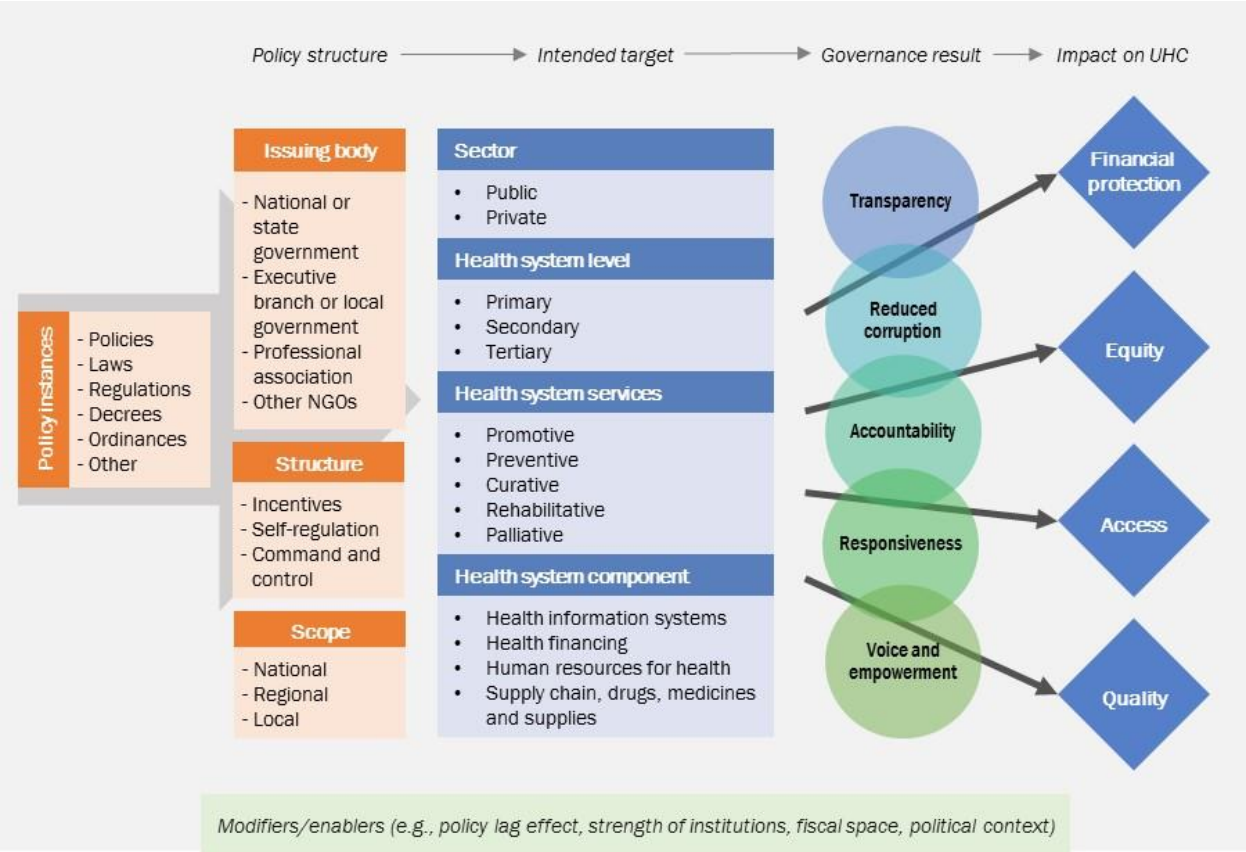
countries, and best practices related to their development and implementation have been relatively neglected in the literature [1].

Due to insufficient focus on these instruments, there is a lack of evidence as to what constitutes a supportive legal environment that can consistently provide a strong basis for UHC-related reform processes. As a result, global efforts to implement health system reform and move towards UHC may not be achieving maximum impact. In this review, we explored how policies, laws and regulations implemented in different country contexts have had an impact on the achievement of UHC goals.

This review focused on both the processes involved in developing, implementing, enforcing and monitoring policy instances, and the effects of these. We looked deliberately at policies, laws and regulation as tools of governments and other bodies to influence the system and examined the factors that led to a particular policy instance being more or less effective than an alternative from a similar context. Key informant interviews were especially helpful in revealing the often undocumented contextual factors surrounding success or failure for a particular policy instance. Extending analysis towards the effects of policy instances requires an assumption that they were adequately developed, implemented and enforced. Any instances which are developed through good design practice [2], but are poorly enforced through insufficient commitment, coordination and cooperation [3] were less able to support our understanding of the effect of health governance on UHC. However, to the extent possible, this review captures the influences of different policy instances on UHC aspirations with a specific focus on inherent aspects of governance that served as enablers.

Figure 1 illustrates the conceptual framework for this review, linking the impact of policy changes on the achievement of UHC goals. This framework aligns with guidance received from the MTE Secretariat on an overall health governance framework (adapted from Bennett, 2015). In order to better differentiate the effect of various policy types on the achievement of UHC goals, we first propose a typology for policy instances, also covering the enforcement and intended target. We then link the aspects of governance that are expected to be directly related, given how the policy instance was designed and implemented. Finally, we consider how successful a policy instance can be in achieving intended UHC-related outcomes, based on the main components of UHC as established by the WHO. The intermediate “governance result” provides a lens through which each policy instance operates from a governance perspective, and guides thinking on a pathway through which the policy instance was effective in enhancing UHC outcomes.

**Figure 1: Conceptual framework for impact of policies on UHC**




Given the potentially vast scope of relevant policy instances and the general definition of UHC-relevant progress, we applied a rigorous definition for policies, laws and regulations; the governance result area; and other key terms involved in the framework. This helped ensure consistency in our approach and application across review steps. The following section on definitions of key terms mirrors the Policy and Regulation TWG's approved scope of work, as drafted in consultation with the TWG members.

# Policies, Laws and Regulations

*Policies* when distinguished from laws and regulations are any guiding documents or frameworks in which governments or other institutions outline objectives, guiding principles and strategies for achieving those objectives; and give authority to undertake actions in pursuit of those objectives. Policies are often developed through consultative processes. There could be different levels of policies. *Global policies* can be normative guidelines; health sector development frameworks and goals; health-related conventions, agreements, or financial commitments; health and human rights instruments; and treaties developed by global bodies. To maintain focus on the impact of the policy, this review only considered global policies to the extent these have been ratified, adopted, and implemented by national governments. *National or provincial* policies include health sector development strategies, strategic action plans, executive branch directives, and budgets. Finally, *institutional or agency policies* are documents issued by line ministries and departments that specify how laws, decrees, and other high-

level policies should be implemented. Policies also include documents issued by ministries of health defining the roles of actors and expected outcomes for key processes, such as public-private partnerships, pharmaceutical sector development, and others. Also, there can be *operational policies* which are rules, codes, guidelines, plans, budgets, and service and administrative norms that governments, organizations, professional associations, and health facilities use to translate national laws and policies into programs and services. Generally, in this work we are concerned with policies at a level above the operational, in order to limit the scope of a potentially vast inquiry.

*Policies* act as guidance for the actions of organs of the public health system. A key distinction between policies and laws/regulations is in the latter's greater legal significance. Policies can be considered norm-setting documents that stop short of being law. They are produced as a part of the routine role of key institutions engaged in stewardship of the health sector and can be informed by consultations with different actors, including those outside government. While there may be enforcement action for non-compliance with policies, action would likely preclude legal consequences that would fall within the court system and rather would be enforced through consequences as defined and implemented by the issuing body.

The distinguishing feature of *laws* are that they are the product of the policymaking activity of government and include primary legislation (i.e., acts passed by legislature); secondary legislation issued by the national executive or local government action, e.g., decrees, ordinances; and laws made by judicial action through binding precedent in common law systems. Laws can be promulgated at multiple levels of the health system. For example, laws can be passed by supra-national bodies like the European Union, as well as national, state, and local governments. In many contexts, statutory and common laws must co-exist with customary laws. For the purposes of this review, we focused on statutory and common laws only.

Finally, we defined the term *regulation* to mean the promulgation of rules by government accompanied by mechanisms for monitoring and enforcement, usually assumed to be performed through a specialist public agency, as well as, rules made by non-state actors in the health sector (e.g. various forms of self-regulation).

Together, laws and regulations constitute the legal bedrock on which many processes of the health system lie. For example, legislative action may define the rights of individuals to a certain standard of healthcare or institute a new/reformed health insurance system.

# Structure for Policies, Laws and Regulations

As part of the process to define and implement policies, laws, and regulations, there has to be consideration of the enforcement mechanisms to be employed to address non-compliance by the actors subject to the policy instance. Various enforcement mechanisms could be employed to detect and incentivize behavior that complies with the intent of the policy, law or regulation. Our review seeks to assess which broad category of enforcement strategies seems to lead to effective implementation of policies, laws, and regulations. The three enforcement strategies considered are outlined in Box 1.

***Box 1: Enforcement Strategies***

*Incentives* are inducements to do or not to do something, such as a tax credit for locating a clinic in a rural area.

*Self-regulation* is regulation put forth by a professional association, as well as by internal motivations, such as a desire to attract more patients, for example.

*Command and control* consists of mechanisms established by law, such as a licensing requirement or the authority of a ministry to issue safety or quality standards and enforce compliance with them.

# Governance Results

There are several operating definitions for each of the five governance areas of effect we considered in our review. We adapted these definitions to provide a more objective approach to assessing if a particular policy instance flowed through a particular governance result area. There may be overlap between some of these governance areas. For example, "transparency" may reduce the scope of corruption by increasing the availability and accessibility of information and thus reducing information asymmetries that could have previously been exploited. Similarly, the government and the private sector tend to be responsive when they are likely to be held "accountable" for their policies and actions. We define the five governance result areas in Box 2.

***Box 2: Definitions of Governance Results***

*Transparency*: policy instances that lead to increased documentation requirements related to health sector processes, mandated requirements to share data or documents from government and private sector to citizens and civil society, or improved accessibility of information shared by government to civil society, citizens and other non-state stakeholders.

*Responsiveness*: policy instances that require or incentivize the government or the private sector to pursue citizen's needs by collecting information on satisfaction and expectations or be more flexible in their ability to react to citizen's needs, or act in response to citizens' needs.

*Accountability*: policy instances that require justification for behavior by duty holders (government, providers etc.) and/or impose sanctions/costs on duty holders on non-performance or underperformance of portions of the health system they have influence over, particularly against a political backdrop that has been actively promoting UHC outcomes.

*Reduced corruption*: policy instances that reduce systemic problems in the health system that lead to embezzlement, bribes or other leakages, or that reduce costs/risks to citizens for reporting such incidences (whistleblower protection).

*Voice and empowerment*: Citizens' participation in policymaking, service design, and provision is key to promoting good governance. Involvement can go beyond citizen consultation practices to active citizen participation in the co-production and co-delivery of public policies [4]. However, the data shows this is a nascent area for governments at the forefront of these participatory initiatives. Thus for the purposes of this review we have focused on policy instances that embed consultative processes as follows: a) require an increase in citizens' level of information about the health system, their benefits and own care, and b) provide citizens with the capacity to act on this information and inform their own decision making, or c) provide a forum to report on health sector performance regarding this information.

# Intended UHC Outcomes

UHC is defined by the WHO as ensuring that all people have access to needed promotive, preventive, curative, and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services [5]. For the purposes of the review undertaken for this paper we provide interpretations of the key components of UHC in Box 3.

***Box 3: Definitions of Key UHC Outcomes***

*Financial protection:* Financial protection is achieved when direct payments made to obtain health services do not expose individuals to financial hardship and do not threaten living standards. Therefore this review focused on policy instances that aim to reduce the number of people exposed to financial hardship due to direct out-of-pocket payments made to obtain needed health services at point of service. The removal of user fees or the implementation of health insurance (with subsidized contributions for those unable to afford premiums) are key policies to promote financial protection as health systems need to have a predominate reliance on public revenue sources: mandatory, pre-paid, and pooled to achieve financial protection.

*Equity:* Equity in health involves more than just equality with respect to health determinants, access to the resources needed to improve and maintain health, or health outcomes. It also entails a failure to avoid or overcome inequalities that infringe on fairness and human rights norms. Groups that commonly experience inequalities can be defined socially, economically, demographically, or geographically and commonly include poor or marginalized persons, racial and ethnic minorities, and women. For the purposes of our review, policy instances that had a pro-poor orientation were the focus, in other words, how effective were the policy instances in improving equity in access to health services. We defined improved equity for key populations and geographically under Access.

*Access:* Access has three dimensions: physical accessibility, in terms of the availability of quality health services within reasonable reach; financial affordability, in terms of people's ability to obtain services without financial hardship; and acceptability, where patients perceive services to be effective and they are not discouraged from using them by social or cultural factors. For the purposes of this review, we sought to identify policy instances that improve access to care for specific populations whether defined by geography (e.g. urban vs. rural) or population group (e.g. sex workers, migrants). We also attempted to identify policy instances that improve access to better services whether an increased number of services available or improved technology or drugs for existing services.

*Quality:* There are six aspects that pertain to the quality of healthcare services: safe, effective, patient-centered, timely, efficient, and equitable. Our review focused on policy instances that promote the provision of safe (avoiding unnecessary injury or complication), effective (using proven interventions, and only as necessary), and timely (limiting harmful delays to receiving care and reducing wait times) services as the other aspects were adequately covered under our definitions of access and equity.

# METHODOLOGY

## Literature Review Methodology

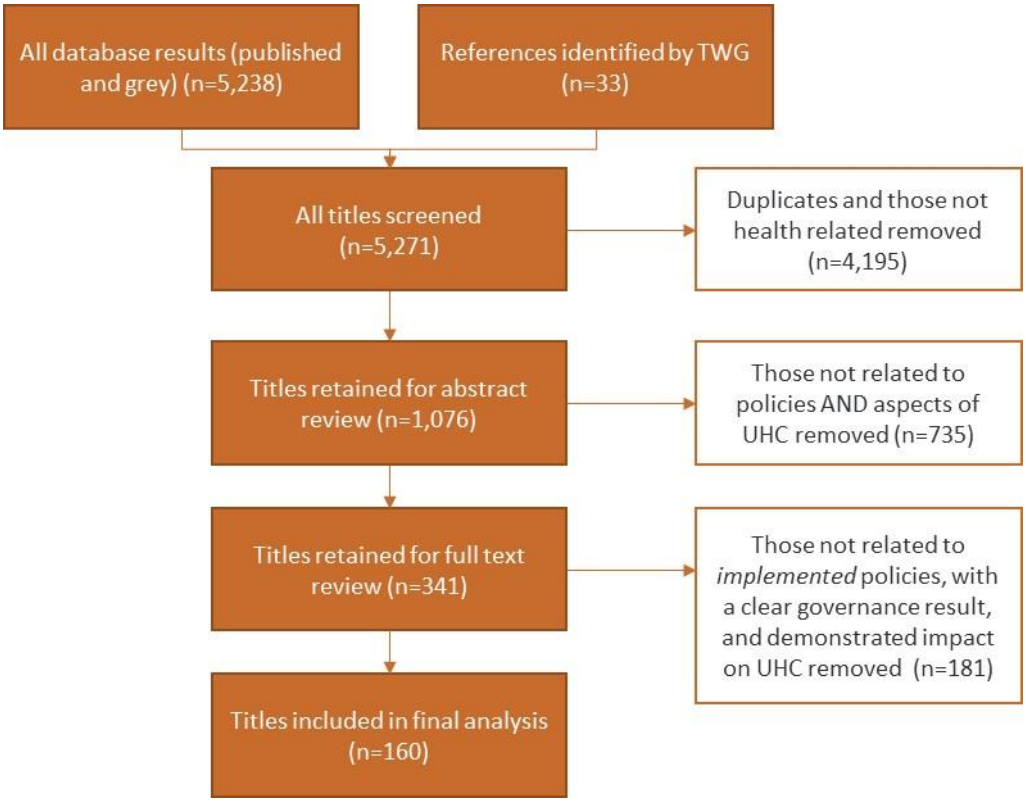
A scoping review methodology [6] was adopted, given its flexible approach, lack of narrow parameters, and suitability for examining the breadth and depth of literature (both published and grey) in the policy space. The evidence found was predominantly in the form of reviews and case studies. As expected, we did not find any randomized control trials in this subject area. The search strategy covered the peer-reviewed literature as well as published book chapters, project reports, and academic dissertations. For published literature, the following databases were used: EMBASE, Medline/PubMed, POPLINE, Care & Health Law, Global Health, and Cochrane Library. For grey literature, we relied on NYAM Grey Literature Report, DocuTicker, general Google searches. The search was conducted in English only and focused on papers published since 1990.

Several search terms were used in various combinations, including: 'universal health coverage', 'universal health care' 'stewardship and governance in health', 'health insurance and regulation', 'UHC policies', 'impact of policies on health systems', 'effect of policies on UHC', 'policies that promote UHC', 'policies that inhibit UHC', 'impact of new health policies', 'health policy assessments', 'Sustainable Development Goal 3.8', 'legislation', 'Act', 'Code', 'mandate', 'jurisprudence', 'decree', 'access to health care', 'health equity', 'service delivery', 'failures', 'pharmaceuticals', 'health care delivery', 'health service delivery', 'primary health care', 'access to health care', and 'maternal health care'.

As the search relied on general keywords, many results were returned, and a strong and multi-stage exclusion process was required. The title review excluded documents pertaining to policy instances that were clearly unrelated to the health sector, were published before 1990, or were not in English. The abstract review was conducted independently by two reviewers. The inclusion criteria required that the abstract provided evidence of policy instance effects on the health system and related to a relevant measure of UHC. The exclusion criteria required that the abstract did not relate to a policy, regulation, or law or did not relate to a relevant measure of UHC. The abstract reviews were conducted independently by two reviewers who marked each paper as either included, excluded, or 'for further assessment'. Once the abstract review was complete, a third reviewer made a final determination on those papers where the first two reviewers disagreed, or that were marked for further assessment. For the full paper review, a data extraction table was used to guide the reviewers in their assessment of whether the paper should be included or excluded. For inclusion, the paper had to pertain to a policy instance that had already been implemented, had a clear governance result or governance results, and demonstrated impact on UHC. Papers that proposed policy reforms or that could not be linked to an impact on a relevant UHC measure were excluded.

Figure 2 displays a flow chart summarizing the review process. In total there were 5,271 results identified and screened through the search. We retained 1,076 titles for the abstract review and 341 for a full paper review. We included 160 papers in the final analysis.

**Figure 2: Literature Review Flow Chart**




# Key Informant Interviews Methodology

TWG members identified experts based on their area of academic expertise and professional experience to supplement the findings of the literature review and to share their views on key gaps in current practice. This list of experts was vetted by the Secretariat to avoid multiple TWGs requesting the time of the same expert. Using semi-structured key informant interviews, nine interviews were conducted during July–August 2017. The interview protocol focused on key UHC successes and gaps in countries relevant to the interviewee's expertise, then explored the influence of different governance interventions on that success or failure. Lastly, the interviews addressed the critical enablers for good governance in policy implementation, the roles of institutions, and the evidence for policy instances' impact on intended UHC outcomes. Findings from these interviews are documented anonymously within the results that follow.

# RESULTS

## Summary of Evidence

We summarize the pattern of evidence pertaining to the type of the policy instance, the conditions in which they have been implemented, and their intended targets for the 160 relevant studies identified through the literature review. While the majority of studies focus on a single policy instance implemented in a country, some of the studies present evidence from a cluster of countries or a cluster of policy instances within a country and hence the number of unique policy instances exceeds the number of studies. We have 234 such unique policy instances.

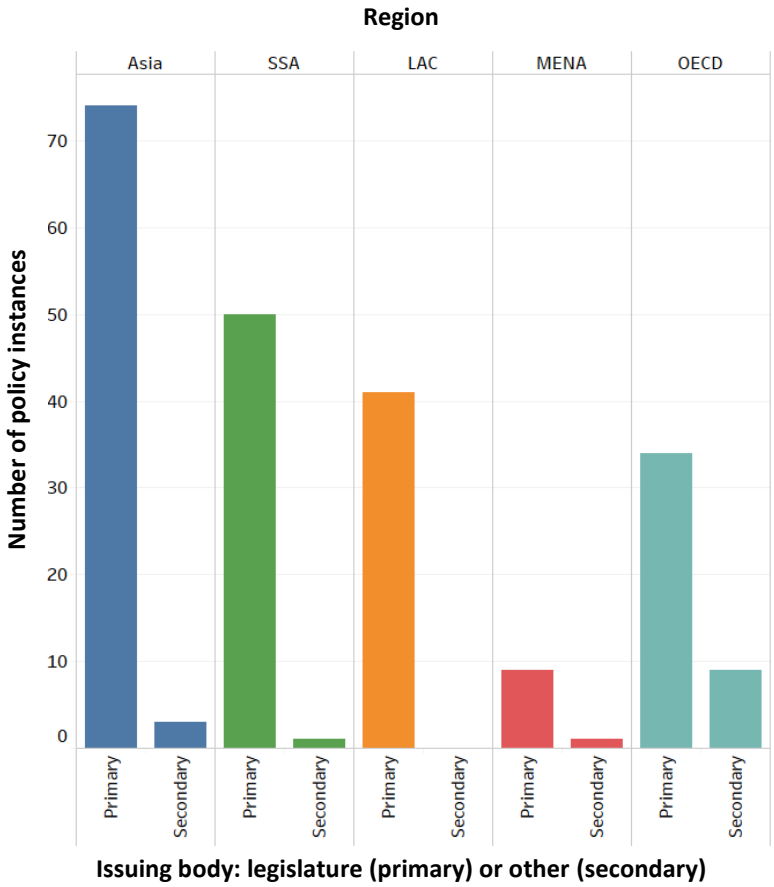
## Distribution of Evidence by Type of Policy Instance

All UN member states have agreed to work towards UHC, as captured in the targets set through the Sustainable Development Goals (SDGs). The resolution, adopted on December 12, 2012, urges governments to move towards providing all people with access to affordable, quality health-care services. Accountability for progress toward the SDGs lies with national governments and the nature of the reforms has necessitated action at the national level. Figure 3 illustrates that primary legislation issued by national governments was the prominent form of policy instances. Primary legislations were the dominant form of policy instances found in the review, and these were mostly national (88%) in contrast to regional (7%) or local (5%) laws. This was an expected result, as formalized laws were more likely to be codified and studied in the literature than policies or other instruments that may not have been fully ratified or implemented.

Implemented by national governments and covering a wide range of institutions, very few policy instances were of the kind that would modify incentives of health system actors (13%) or promote self-regulation (1%); rather the majority were policies structured as command and control. As most of the policies instances pertaining to UHC were intended to increase health service coverage over wide geographical areas, it is relatively easier for governments to do so through command and control in comparison to incentive-based policies [key informant, July 2017].

The nature of the policies reviewed involved some that were designed to radically overhaul the healthcare delivery system while others involved a step-wise approach, with a focus on primary healthcare and maternal and child health services delivered through the public sector featuring prominently. Finally, the policies analyzed through our review covered both private and public sectors, with a slightly larger emphasis on public sector entities delivering primary healthcare.

**Figure 3: Number of Policy Instances by Policy Structure (Issuing Body) and Region**




SSA: Sub-Saharan Africa, LAC: Latin America and the Caribbean, MENA: Middle East and North Africa, OECD: Organization of Economic Cooperation and Development

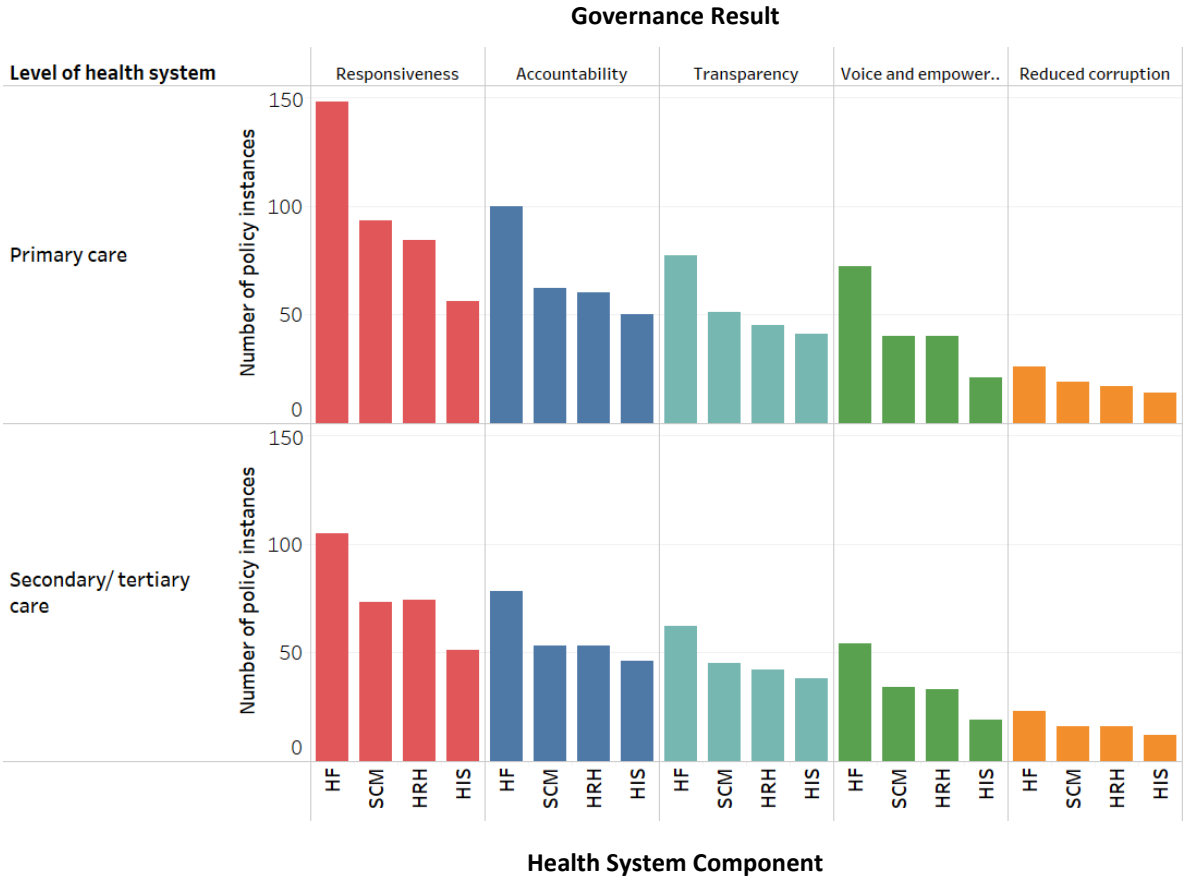
# Distribution of Evidence by Four Main Health System Components

The five governance result areas defined in Box 2 are not mutually exclusive, and any policy instance aimed at achieving UHC could flow through a combination of governance areas. We found the most evidence for “responsiveness” and “accountability” with 197 and 129 references, respectively, among the 234 policy instances. This is consistent with the premise that responsive and accountable governance at national and sub-national levels is critical; a cross-cutting enabler of development towards the SDG goals, including UHC [7]. Policy instances that aimed to improve “transparency” and “voice and empowerment” were found in 108 and 101 references, respectively. Policy instances that aimed to “reduce corruption” to improve governance and move towards UHC had the least evidence with only 33 policy instances. Figure 4 illustrates the distribution of studies by level of the health system, the targeted component of the health system, and the governance result area. The charted values represent the relative frequency of policy instances within a governance result area at the level of the health system, disaggregated by the health system component. We assessed which governance area(s) was most relevant to the policy instances’ design and implementation. Several policy instances applied to both levels of the health system and multiple health system components and were designed to flow

through multiple governance result areas. Across all governance results there appears to be a greater number of policy instances that focus on strengthening primary health care.

Policy instances in several countries, including Brazil through their Unified Health System, Nigeria through their National Health Act, and Thailand through their UHC Policy, emphasized the importance of primary healthcare as the target for improvement within the health system, coupled with an effective referral system to secondary and tertiary care for managing higher-level facility capacity and costs [8-22]. Many country governments face the major challenge of establishing an essential package of services at the primary level that can be reliably funded and would promote access to essential interventions for the majority [key informant, July 2017]. Acknowledging the critical role of primary care for its communities, the Ministry of Health in Nigeria increased financial autonomy for primary care facilities to revitalize its previously inefficient primary care services.

**Figure 4: Number of Policy Instances by Health System Level, Health System Component and Governance Result**




HF: health financing, SCM: supply chain management, HRH: human resources for health, HIS: health information systems

## *Health Financing*

Studies related to health financing dominate the identified evidence base. This fact was re-emphasized during a key informant interview where it was noted that to operationalize the various policies, laws and regulations required to achieve UHC, countries first need a robust health financing strategy [key informant, July 2017]. Our results suggest that most health sector reforms associated with achieving UHC tended to focus on either raising revenues through tax-based financing [14, 23-29], increasing insurance coverage [17, 23, 30-38], or addressing demand-side constraints through conditional cash-transfers [14, 39], and vouchers [40, 41]. There were also several reforms that sought to address user fees [11, 23, 25, 26, 28, 42-50] and implement subsidies reducing the cost of care for the poor and vulnerable [12, 23, 38, 51-58]. Several of the government-funded subsidy schemes (including subsidized insurance premiums), like the National Drug Policy Act in Bangladesh and the 30 Baht Scheme, had a focus on primary healthcare for their provision of free or heavily subsidized drugs or for affordable access to care for a pre-defined list of conditions [16, 38, 59].

### (a) Informal payments and user fees

Even in situations where user fees had been reduced or eliminated, especially for the poor, the continuation of informal payments to physicians and other clinical providers suggests reduced transparency and accountability in the system. Such informal payments contribute to inequality in access and increased financial burden on poorer patients. We found evidence of health sector reforms which addressed this. Significant investments in transparency and accountability underpinned reforms laid out in Kyrgyzstan's *Manas* and *Manas Taalmi* plans, which were successful in reducing informal payments and improving financial protection related to effects of ill-health [60]. Under its healthcare reforms, China attempted to reduce informal payments to physicians by increasing reimbursements to providers for labor-intensive services, thereby allowing hospitals' wage structure to adjust. China also attempted to lower incentives for undesirable behavior in the form of supplier-induced demand for drugs and diagnostic services [61]. In Indonesia, uniform hospital-based case reimbursements for outpatient and inpatient services within each of five specified regions under the *Jaminan Kesehatan Nasional* (JKN) scheme were set. In order to increase transparency and eliminate informal charges, these reimbursement rates are officially published and recirculated after every revision [Key Informant, July 2017].

User fees at the health facility in low- and middle-income countries are understood to create a barrier to utilization, particularly for lower-wealth quintiles, and so can be problematic for achieving UHC. Many health facilities rely on these for essential revenue to finance services, especially when government tax-funded or other financing is inadequate. User fee or cost-sharing policies, laws and regulations need to be implemented carefully and targeted to reduce undesired effects. In this context, where they exist, increased transparency is required with how user fees will be levied and any available exemptions or waivers. As this is a continuing issue which also contributes to informal payments, to be effective in promoting transparency these fees need to be formally published and clearly communicated to patients, with defined exemptions in place for those who need them, as in the case of Cambodia [41]. There is voluminous literature on user fee introduction and removal/reduction policies. We found cases where follow-up policies may require to be viewed through the transparency lens as well. In Thailand, while the country currently does not have any health-related user fees for those covered under the government-supported schemes, there is strong advocacy for the reintroduction of some co-payments (which were eliminated in 2006) to co-exist with the various reimbursements providers receive, e.g., bundled

payments for inpatient care. Co-payments can play a role in reducing supplier-induced demand, as it makes patients more inquisitive as to the necessity for certain procedures [Key Informant, August 2017]. Generally, we find that increased transparency and accountability around the managed introduction of co-payments is important to reduce opposition and ensure patients' understanding, as long as these changes are to promote scheme sustainability, and will be channeled towards increasing resources available to deliver priority health services.

## (b) Reforms moving towards single-payer system

Countries considering pathways to increase coverage of pre-payment systems and consolidate risk pools could design and implement a single-payer health insurance system. These reforms are often predicated on projected efficiency and access gains in a single entity purchasing care for a majority of the population, and driving improved quality through its purchasing and agenda-setting power. The governance arrangements and the administrative structures of the single payer agency are critically important to ensure adequate regulatory oversight and to follow principles of strategic purchasing, which among other benefits, would align incentives of providers towards higher efficiency, quality, and responsiveness to demand. In Indonesia, the single payer agency BPJS-K (Bahasa acronym) was created from separate for-profit, social security institutions administering formal sector schemes as a public entity to oversee JKN, the national health insurance scheme. Realizing the benefits of a single payer in this context was a critical aspect of Law 24 of 2011, especially with regard to two objectives: first, to make BPJS-K subject to the government's accountability office on the submission of audited financial statements, and second, to turn the entity into a non-profit, run solely for the benefit of insured members [Key Informant, July 2017]. Without effective regulation and government oversight of such a single national insurance payer, the related reform risks cost escalation in scheme operation, inadequate controls, and poor responsiveness of the payer to emerging trends in utilization and quality. In Thailand, managing the competing goals of various institutions has proven challenging at times. The National Health Security Office (the purchaser - whose aims include controlling health care expenditure) and the Ministry of Health (the provider - whose aims include securing sufficient funding for public facilities) are both politically influential institutions that are in tension when it comes to setting appropriate reimbursement levels. To date, this has resulted in overall cost escalation, placing additional financial burden on the scheme [Key Informant, July 2017]. However, the case of Estonia shows that by implementing appropriate accountability frameworks, efficiencies can be generated through a single-payer healthcare system [62].

## (c) Reforms enforcing a split between purchaser and provider

Many countries on the path towards UHC introduce policy changes that distinguish and then enforce a split between the purchaser and the provider of health services. This is a basis of most policy instances we found that instituted or scaled up health insurance, i.e., through the establishment of a health insurance agency to act as a purchaser of services from both public and private health facilities. Many countries have successfully implemented this type of reform, including Thailand under the Universal Coverage Scheme, the Philippines through PhilHealth, and others. A fundamental rationale 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. This incentivizes providers to compete on access and quality to earn revenue. This competition, if well-designed and fostered, should improve the responsiveness of the system and ultimately health outcomes [63]. In practice, in health insurance schemes funding is seldom fully tied to the patient as public facilities often receive additional general budget funding for expenses

such as salaries and overhead. In addition, to ease scheme administration there are often requirements to only register with facilities in the patient's residence area (vs. near the place of employment) for a minimum period (e.g. at least three months), limiting portability and ultimately choice and healthcare entry points for patients. Our review suggests that reaping the full benefits of reform here takes more than just the initial separation of purchaser and provider, and strategic purchasing mechanisms need to be implemented additionally to create the right incentives for providers to deliver quality and efficiency, alongside effective monitoring and oversight from the purchaser. For example, the implementation of strategic purchasing contracts between insurers and providers in Colombia, Costa Rica, and Peru, compared to previous general budget funding, enabled the subsequent implementation of incentives to improve performance [64]. The methods for contracting services from providers could be linked more specifically to national and regional healthcare needs to enhance responsiveness.

A purchaser-provider split and strategically procuring care from diverse providers–public, private commercial, and non-profit–will encourage increased access through improved choice for consumers. Growing the total healthcare market through improved procurement should encourage private investment in health infrastructure in less developed areas, which also aids access. Bringing private providers into a government-supported financing scheme can improve financial risk protection in mixed health systems, as experience from Ghana shows. Before private providers were included in Ghana's National Health Insurance Scheme (NHIS), they charged relatively high user fees, placing a burden on the patients across socioeconomic categories that relied on these facilities [48]. The introduction of contracting from the private sector under the NHIS also featured increased transparency, as patients only paid co-pays when required, and according to an itemized, published fee schedule. As these examples show, to be effective, purchasing mechanisms used within an overall reform towards separating purchasers and providers should be based in a fully developed policy, legal and regulatory architecture. This architecture should envision the impact desired and establish and enforce the rules, performance criteria, audit framework, and penalties required [65].

## *Supply Chain Management*

Health financing reforms were closely linked in the review with policy instances related to the provision of free or subsidized drugs at the primary care level. The programs were often focused by health area, e.g., vaccines or drugs for essential health conditions, and by socio-economic and demographic status, often for the poor and elderly. Similarly, some policy instances that targeted the supply chain management (SCM) component of the health system were aimed at increasing equity, coverage, and financial risk protection. The impacts on UHC outcomes here also flow through specific governance result areas. For example, policymakers intend that drugs should be made available according to population need to ensure equitable distribution of resources, and patients are typically provided clear information on which drugs they have access to within the system. In this context, we found SCM-related policy instances which flow through responsiveness and transparency to attain several UHC goals [38, 48, 59, 66-69]. In Ghana, the fee schedules for medicines at facilities is based on the published prices on the NHIS Medicines List that undergoes periodic review and revision [48]. 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 then can query the use of branded medicines when there is a cheaper alternative available, thereby improving access and financial protection [70].

Accountability is a critical aspect of a successful SCM-related policy instance, especially through quality assurance of the clinical aspects of care. Such policy-making manifests in the authorities assuming responsibilities for unintended effects of pharmaceutical policies. In the absence of appropriate policies,

laws and regulations, risk-averse citizens who do not trust the quality and efficacy of generic medicines supplied preferentially through government facilities may shift towards branded medicines, which imposes a higher cost on the poor and vulnerable. This shift, exacerbated by corruption and leakages rooted in mislabeling, poor pharmacy behaviors, and lack of quality (perceived or real) of medicines—can lead to high out-of-pocket costs and inequity, as was noted in a study in the Philippines [71].

Lack of competition and biases in procurement related to the pharmaceutical sector could also undermine the other benefits of an increase in coverage of health financing mechanisms. In the past, the near monopolistic structure of the Vietnamese drug market resulted in few options for community health centers to purchase affordable drugs, while in China corruption in the bidding process for drug procurements meant certain providers received kick-backs despite the government's attempt to implement a more competitive process [9, 72]. Corruption in the supply-chain management of drugs in South Africa was linked to reduced supply at the health facility level [73]. Similarly, in Indonesia local government hiring practices for facility-level staff are seen to be influenced by personal connections more so than competence, and as a result, stock-outs are common due to poor quantification and purchasing system management [key informant, July 2017]. In Vietnam, as with other countries undergoing UHC-oriented reforms, drugs are distributed based on government drugs formularies. However, the process to determine the inclusions and exclusions in the formulary suffered from irregularities, resulting in significant increases in the prices of drugs [9]. Hence, policy instances tackling corruption and instituting improved transparency and accountability in the process of determining drug formularies, conducting pharmaceutical procurement, and strengthening systems and competencies for distribution are needed to achieve the aims of UHC.

## *Human Resources for Health*

Progress on UHC is associated with increasing capacity of the health system to provide a larger share of the population access to a defined list of services, with schemes offering financial protection in the context of utilizing these services across geographic areas, and improved quality. In this context, a major constraint is the availability of skilled human resources for health across public and private providers. The health workforce in low- and middle-income countries can lack sufficient in-service or pre-service training; at the service delivery level the skills mix is often inadequate, and there can be insufficient use of task-shifting and task-sharing to achieve more efficient and responsive care. Hence, policies, laws and regulations geared towards increasing the number of healthcare providers and their competency and related management practices form the third largest group of policy instances in our review [11, 12, 14, 19, 38, 57, 73-78]. An increased number of medical professionals was associated with increased responsiveness of the system in a few instances, especially when they were deployed in a manner able to cater to local health needs [79, 80]. We observed that several health sector reforms were accompanied by additional policy instances focused on human resources, e.g., increasing the supply of skilled healthcare staff in key areas through expanded training, providing incentives for relocation to priority areas, and through providing in-service training to improve quality [19, 57, 78, 81-84].

Appropriate policy, legal and regulatory frameworks are needed to promote the recruitment of competent clinical and health administrative staff and to retain them with good incentives. Poor hiring criteria can ultimate impact the quality of care. In Indonesia, healthcare quality improved when recruitment decisions for healthcare and administrative staff were made based on competence rather than personal connections [key informant, July 2017]. If there is lack of transparency and accountability in the hiring system, such that healthcare workers are more interested in cultivating a patron in hope of career benefits, then the system will not be responsive to the effort required in implementation of new

healthcare delivery policies [85]. Incentives for performance, both monetary and non-monetary, should be provided to retain staff, improve service quality and reduce the incidence of seeking informal payments and moonlighting. A governance response here can involve policy instances ranging from instituting performance management systems to orient staff to service priorities, to developing a patient-centered models of care, and even to orienting staff to delivery of specific health outcomes [key informant, July 2017].

A reorientation to value-based healthcare is linked with improving quality, however it is important to be aware of unforeseen effects. In Colombia for example, where public sector physicians are paid hourly rates (to be revised in 2017), there is concern that emphasis on efficiency and value-based care will reduce the incentive for physicians to train as specialists, thereby affecting long-term quality of complex care and access to secondary and tertiary care [key informant, July 2017]. It is also important to recognize that there can be intrinsic motivations unrelated to any formal health workforce frameworks that play a role in clinical performance. Policy-making needs to be aware of culture and tradition in order to be effective. In Thailand, physicians garner significant respect from their patients, and reciprocate this by their levels of dedication and low rates of absenteeism even in remote areas [key informant, July 2017].

Policies which limit delivery of specific types of services to a particular cadre of clinical staff are a recurring aspect of healthcare systems in low- and middle-income countries. Implemented well and for the correct objectives, such policies support effective use of the health workforce, reinforce quality of care, and protect health outcomes [key informant, July 2017]. However, relaxing rigid policies which restrict which cadres can provide clinical care may be warranted at times. Change in related policy instances to allow a nurse-driven clinical model in appropriate health areas, partnered with continuing education for nursing staff, showed the potential to increase overall access to care, especially in settings where the nurse-doctor ratio is high. Providing autonomy and decision-making power to local medical teams, as under the Client-Oriented, Provider-Efficient (COPE) program in Kenya, was also found to be beneficial. COPE enabled the facility teams to resolve local staffing and service delivery issues without central intervention and improved staff working conditions and efficiency. The overall effect was reduction in patient waiting time, increase in coverage and access as measured by increase in attendance and the immunization rate, and quality of care [70]. In contrast, more restrictive guidelines around clinical care seen in Colombia, prevented primary care physicians from providing basic services like screening for blood pressure or ordering related diagnostic tests [135]. As a result, patients were referred to secondary care institutions, increasing the total time for a course of treatment as well as cost for patients and for the system. The Colombian guidelines also restrict the maximum consultation time and physician's ability to prescribe medicines, thereby inhibiting flexibility and reducing quality of care. In Thailand, the implementation of the UHC policy resulted in an increase in demand for curative services, and without policies or incentives to counteract this, physicians' focus shifted away from delivering preventive and promotive care. [85].

Expansion and strengthening of primary care requires an increase in human resources at lower-level facilities. In many contexts there is excess demand for health services that physicians are unable to satisfy. As a result, we found several policy instances that instituted task-shifting at the primary care level, whereby certain clinical tasks are moved or transferred from physicians to nurses. With many countries facing an aging population and increase in non-communicable diseases, routine monitoring of chronic conditions and managing repeat prescriptions can be led by nurses with little additional training. Task-shifting in Thailand was critical in promoting access to care and reducing waiting time for patients [key informant, July 2017]. In some contexts, task shifting policy instances can be implemented through

guidance put forth by medical and nursing accreditation bodies. In Turkey, primary care physicians, in addition to an expanded role in preventive care services, were also required to provide mobile health services to increase reach and responsiveness [86].

Human resources for health policy can also affect staff at the administrative level in central or local government levels. Constructive policy instances would set their roles to plan, prioritize, and implement health sector policies, laws and regulations; and define the incentives for them to do so effectively. This is because administrative capacity of the government is critical to set up and oversee broad health sector reforms [key informant, July 2017]. An administrative system with rewards based on merit, a wage structure commensurate with work-effort, and clearly defined rules across performance and benefits is more likely to successfully implement health sector reforms [87]. In addition to providing adequate training, resources, and incentives, it is essential that proper accountability mechanisms are set up within the administration structure. For example, to improve accountability and efficiency, Costa Rica via its Law 7852 on decentralization eliminated lifetime tenure for hospital administrators and instead instituted incentives for performance management [51].

## *Health Information Systems*

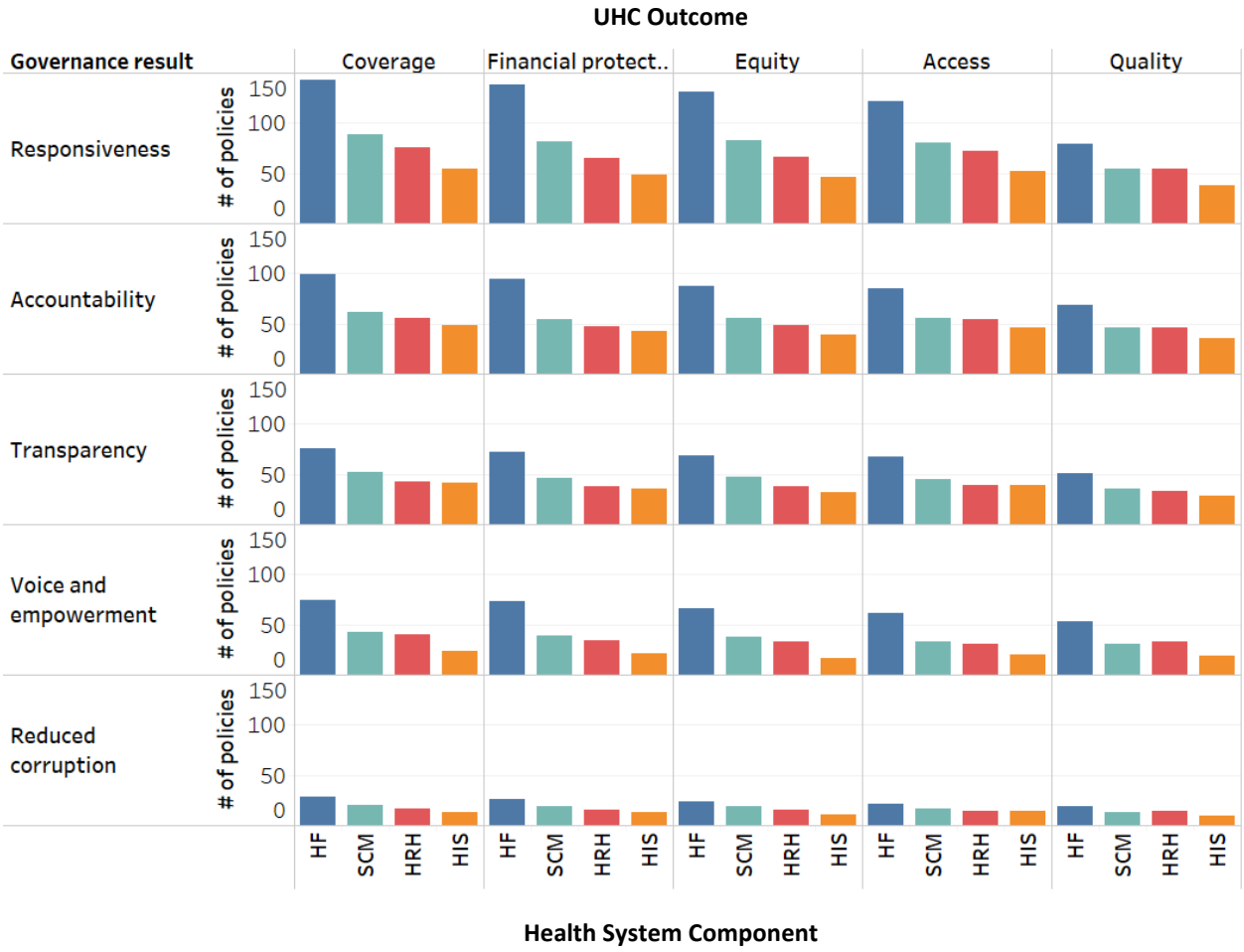
The literature offered less evidence about the role of health information systems and the policies, laws and regulations that support this area in achieving UHC goals. There were a wide range of policy instances about implementing and enhancing health information systems. These included basic interventions that require health workers to maintain records of treatment provided in their catchment area [88], to more complex systems of recording the results of means-testing potential beneficiaries [47, 77], or extensive epidemiological and socio-economic databases and electronic health records [89]. Overall, these policy instances were associated with improved quality and increased access to care. Policy instances requiring health units to base their healthcare intervention decisions on local data showed improved responsiveness.

Information systems are necessary for any tracking and rewarding of performance and hence are associated with increased accountability within the health system [83, 90]. In this category, there were policy instances covering interventions like establishing databases with local demographic, epidemiological, and economic indicators; monitoring and evaluation systems; electronic health records; and national health accounts systems that document the overall expenditures and sources of spending and can help track evolving trends in resource allocation and mobilization [11, 12, 14, 38, 52, 86]. Health information systems also have a role to address corruption. Issuing identification cards required for accessing subsidized healthcare are often based on means testing, i.e., using various measures to triangulate household income and assets, including soliciting community input. These systems, choosing from a variety of means testing procedures, have been challenging to implement, and hence the impact of these policy instances on ultimate UHC outcomes can take time. Without appropriate systems and processes to verify means testing output related to identifying the poor, inclusion and exclusion errors can occur, and the increased discretion of officials in making the appropriate determination can open avenues for side payments [91]. Further, providing an identification card was not seen as synonymous with increased access, especially if recipients were not well-informed about what the card entitles them to receive.

# Distribution of Evidence by Five Governance Result Areas and Intended UHC Outcomes

We reviewed a high number of policy instances that were designed to take effect through improved responsiveness and accountability. These instances can be related to the finding that the majority were aimed at achieving the UHC goals of increased coverage (212 instances), improved equity (191 instances) and increased financial risk protection (186 instances). When policy instances focused on increasing coverage, the majority sought to expand services to new population segments and vulnerable populations (125 instances). The remainder focused on expanding service coverage geographically (87 instances). Figure 5 illustrates the disaggregation of policy instances by UHC outcomes, governance results and health system components.

**Figure 5: Number of Policy Instances by Health System Component, Governance Result and Intended UHC Outcome**




HF: health financing, SCM: supply chain management, HRH: human resources for health, HIS: health information systems

# Distribution of Evidence by Regions

Since 2010, the WHO, the World Bank Group (WBG) and several other bilateral donors have provided financial support and technical assistance to more than 100 countries in implementing UHC-related reforms. However, the summation of the progress and challenges from a governance as well as geographic perspective is not well documented. We summarize our findings by region in Table 1.

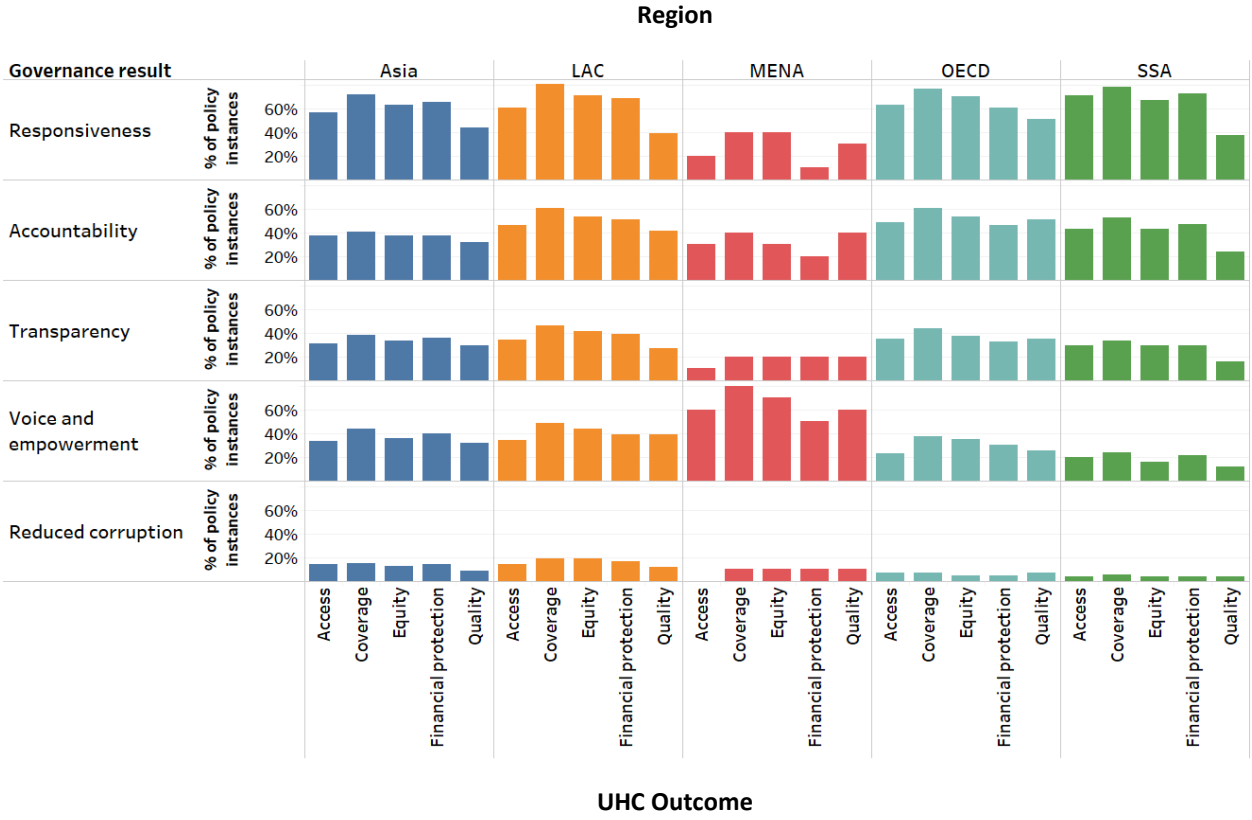
**Table 1: Number of Policy Instances by Region**

| Region | Number of Policy Instances |
|---|---|
| Asia | 81[1] |
| Sub-Saharan Africa | 51[2] |
| Latin America and the Caribbean | 39[3] |
| OECD countries | 42[4] |
| Middle East and North Africa | 7[5] |

[1] [9, 10, 13, 16, 20, 23, 25, 33-35, 41, 43, 45, 54, 56, 59, 61, 71-73, 76, 77, 85, 90, 92-119]
[2] [11, 15, 19, 21, 26-28, 32, 44, 46, 48-50, 57, 58, 66, 68, 69, 80-83, 120-130]
[3] [8, 14, 17, 30, 39, 42, 47, 51-53, 67, 74, 75, 79, 88, 89, 91, 131-138]
[4] [12, 16, 18, 31, 36-38, 48, 49, 53, 78, 120, 139-163]
[5] [24, 55, 84, 86, 140]

We found that the majority of the policy instances were from Asia, where most countries seemed further along in the implementation of UHC-related reforms. There were also several studies from sub-Saharan Africa (SSA) and Latin America and the Caribbean (LAC). The LAC region is one where citizens have increasingly demanded greater accountability in the health sector from their governments. Our review focused on the low- and middle-income countries, however it did not exclude evidence from Organization for Economic Cooperation and Development (OECD) countries that have made significant progress towards universal health coverage, as their experience could be instructive for middle-income country contexts. There was only a small set of results from the Middle East and North Africa (MENA) region (predominantly from Turkey and Israel, which are also OECD countries), as the volume of results may have been limited by the constraint on searching for studies written only in English. Figure 6 shows the disaggregation of policy instances by region, governance intervention, and intended UHC outcome.

**Figure 6: Proportion of Policy Instances by Region, Governance Result and UHC Outcome**




Within Asia, the evidence base strongly focuses on policy instances that increase coverage through financial risk protection. Equity was the second most common intended UHC outcome. Thailand with its Universal Coverage Scheme has been well-documented [10, 51, 59, 67, 76, 85, 91, 100, 103, 106, 109, 110, 113, 116, 117], as have India with its various state-based schemes [67, 92-94, 96, 104, 105, 111] and the Philippines regarding the PhilHealth scheme [54, 71, 91, 101, 108]. These countries contributed a significant base of evidence, given the relative maturity of their health financing systems and progress in large-scale efforts to achieve UHC.

For countries in LAC, we note the focus on increasing access, closely followed by improving equity. Like the *Seguro Popular* in Mexico and *Sistema General de Seguro da Salud Social* in Colombia, reforms in the region were focused on increasing coverage to the majority of the population [30], with heavily subsidized care for 90% of the medical interventions and associated drugs in outpatient departments [67]. Apart from responsiveness, accountability has been a major enabler of reforms in countries from the LAC region. For example, in Brazil, implementation of UHC came through modification of the constitution, as the country's large population and regional disparities required concerted decentralization efforts. Five thousand municipalities were given decision-making power to be more responsive to local needs, and strong accountability features were built in to the program [134].

Our review had the least number of studies from MENA. Some studies covered reforms in Israel [24, 55], Tunisia [51], and Turkey [84, 86, 140]. Improving equity and quality of care appear to be the focus of the reforms in this region with the health interventions employing a voice and empowerment governance tool as a major enabler of reforms [84].

The studies pertaining to OECD countries show that responsiveness and accountability were the primary governance interventions in these countries to achieve coverage and equity [12, 18, 36, 37, 78, 101, 139, 141-146, 148-159, 161, 163, 164]. Separation of provider and purchaser function in Georgia and Sweden was closely associated with increasing accountability of the providers [37, 160].

Several countries in SSA have implemented reforms to attain UHC goals. Increasing coverage, improving equity [127], and access to care were the primary aim of these reforms. Most of the schemes like the National Health Insurance Scheme in Ghana and *mutuelles* (community health insurance) in Rwanda were about increasing financial protection, often through the removal of user fees, among other interventions [26, 28, 48-50, 81, 124, 125, 129], extending maternal and child healthcare [126, 130, 165], and ensuring a minimum set of services [15, 28, 48, 82]. Responsiveness and accountability were the major features of these interventions.

# Other Findings

In this section we summarize some other themes that occurred frequently in the reviewed studies and the key informant interviews. In the literature, there was frequently discussion about or associated with decentralization as an initiative to improve health system functions through increased autonomy at the regional and facility levels, thereby increasing accountability and responsiveness. Similarly, through the key informant interviews, “voice and empowerment” was mentioned as an often overlooked but critical governance intervention that could promote advocacy towards improvements in health system performance.

## *Promoting Accountability and Responsiveness through Decentralization*

Some of the studies reviewed described approaches to reorganize delivery of care, including decentralization in the health system. Centralization of any kind of decision-making power in one branch of government was linked to corruption and rent-seeking [9]; decentralization was justified on the basis of strengthening capabilities, performance, and responsiveness at each healthcare level. While China moved towards centralized procurement of equipment to ensure quality and cut costs [72], policy instances from Argentina, Brazil, Peru, Rwanda, Spain, Zambia, among others, suggest a move towards a more decentralized system and devolving procurement functions to local administrative units [11, 12, 47, 52, 128, 134]. In Brazil, the Organic Law for the health system defines the separation of responsibilities between the state (province) and municipal authorities, provides the framework for transfer for funds, and also enables participation by the community [64]. A study used econometric methods to assess the Brazilian reform in the context of primary healthcare, especially the relationship between the *Estratégia de Saúde da Família* (Family Health Strategy) and mortality, and whether this association varied by governance arrangements across a sample of municipalities. The findings suggested that stronger local health governance may be vital for improving health services effectiveness and health outcomes in a decentralized health system [93]. Similar to Brazil, decentralization in Cuba, Uruguay and Venezuela was accompanied with community participation to increase accountability and responsiveness to local populations and their needs [39, 166].

Policy instances that aimed to manage the process of decentralization were seen as attempting to harness its full benefits. Setting the speed of decentralization is critical to maintaining solvency and sustainability across the health system. Under the Health Service Organization Act (1994), 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 [51]. Successful health sector decentralization maintained a role for the ministry of health at the central level for oversight, coordination, and regulation. Decentralization can spell welcome levels of autonomy for local administrative units, but must be accompanied by performance targets for these units that will be closely monitored [65]. 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 population enrollment into the program [65]. However, this system had weak accountability; states had decision-making responsibility on how to spend their funds but without central oversight that helped set efficiency or quality targets. As a result, there were variable achievements in quality of care.

A deliberative process of resource allocation is needed, based on principles of equity and a desire to increase access, and this process should be transparent to local bodies [key informant, July 2017]. France has autonomy for local administrative units, but some health sector planning is conducted centrally and via regional plans, which influences the goals and funding for hospitals for a defined time-period. Similarly, under the National Health Services Act of 1997, Jamaica decentralized the functions of its Ministry of Health by making four Regional Health Associations responsible for healthcare delivery. However, it retained the central functions of "policy, planning, regulating, and purchasing" to increase efficiency and responsiveness of the system [42]. Policy instances reviewed suggest that such division of responsibility among the federal/central vs. local/state/regional bodies must be clear and transparent to all actors, as well as citizens. Without such clearly understood accountability across levels, citizens are unable to ascribe performance to the relevant authority that has jurisdiction, and this dilutes overall responsiveness towards improved performance [47]. Additionally, to improve accountability, autonomous sub-national units could also be given incentives such as additional resources to improve timely reporting and record-keeping, as was implemented in Italy [65].

## *Voice and Empowerment: Citizens/Patients' Role in Health Policy*

A stated right to health for citizens can underscore a motivation to amend or introduce new legislation to achieve universal healthcare in several countries. In drafting related legislation, policymakers could ascertain whether their proposed policies meet the four norms of availability, accessibility, acceptability, and quality and provides for principles of participation, accountability, and equality [key informant, August 2017]. For example, laws enacted in Turkey (Directive on Patient Rights and Patient Rights Legislation) clearly articulated the right to health insurance and services, stated the responsibilities of the providers (with respect to patients' rights, information provision, privacy, and right to choose a provider), and defined the citizen's expectations from the healthcare system.

Although the fundamental right of citizens to health as the basis of legal process can instigate necessary policy changes, legal challenges overall on the basis of right to health should only be formulated and used with caution [key informant, July 2017]. Uganda presents an example of strategic litigation 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 [key informant, July 2017]. However, in Latin America the tool of litigation yielded mixed results in some countries as disparate cases were held up in the court system rather than generating momentum for more systemic reform [key informant, July 2017]. In Colombia, for example, restrictive clinical guidelines alongside a lack of competition and irregularities in the insurance sector have severely limited access to

certain drugs for conditions like cancer; the only recourse left to patients is to petition the courts [key informant, July 2017]. The practice became widespread as NGOs supported citizens with services to draft and submit numerous petitions. The result is that the judicial system became overwhelmed by petitions and critical cases in this group were severely delayed in adjudication. Such governance through ad-hoc judicial action may divert political and legal resources from other healthcare priorities, and may limit the ability and will of the government to systematically plan and provide for services.

Community participation can help define goals for the healthcare system and hold providers accountable to attaining them. Routinely collecting data from citizens on their healthcare use and related barriers is one modality. In Turkey, annual household surveys are undertaken by the Turkish Statistical Institute to gauge patient satisfaction with healthcare services [86]. Costa Rica has promoted its citizens' involvement through Law 7852, which provided for establishment of Health Boards that comprise of democratically elected community leaders who oversee the delivery of services [51]. However, despite a policy regarding community participation in health in Costa Rica, there is not much evidence that community activists have voice and influence, possibly due to lack of capacity in such citizen bodies [key informant, August 2017]. Community members' ability to exert influence was seen in studies to be limited if citizens do not have adequate knowledge and their organizations cannot find individuals who understand legal issues, or financial and medical terms, and the groups were not well-acquainted with methods of organizational governance. In response to these weaknesses and due to their own incentives, hospitals and local governing bodies can attempt to limit the influence of citizens to token participation.

Finally, citizen choice is a contentious issue in determining the priorities of the healthcare system. In the United Kingdom's National Health Service, there is an explicit split of provider and purchaser functions, and the role of general practitioners (GPs) as gatekeepers to the health system is given a high priority. The system is highly reliant on the quality of medical training and the role of professional bodies around these providers. Patient's rights therefore revolve around choosing the GP based on established rules, registering with them, and then being subject to that GP practice's own charter [37]. In the Netherlands and Sweden, citizens' voice and preferences were assigned a higher priority in policy formulation, reflective of an expectation of increased transparency and accountability of professional and government bodies that regulate health systems [37].

# STUDY LIMITATIONS

Our study has certain limitations. First, we restricted our review to English language literature and English-speaking key informants, due to the time and resources available for this study. However, we acknowledge that Spanish- and French-speaking countries are a rich source of data on health governance interventions, particularly civil law countries that tend to codify much more of their health system policy instances and interventions.

Second, the relationship between health system interventions, governance areas of effect, and ultimate UHC goals is inherently complex and multi-faceted. The conceptual framework (Figure 1) provides a useful visualization of how instances of policy, law and regulation can translate into UHC impact in a linear fashion. However, we were unable to directly ascribe attainment of any specific UHC goal to a particular governance intervention or mix of interventions, nor conclusively to a particular policy type, given the mix of UHC goals and governance interventions, and multiple avenues of the health system, that any given policy instance may be intended to affect.

Third, a health financing policy instrument related to a change such as introduction of user fees may or may not define specific governance elements in how it will be implemented and regulated. Therefore, the governance area of effect is open to interpretation based on definitions of what constitutes improvement in each area. Hence, it is also challenging to delineate the effect of any one governance feature. Overall, the interventions at the heart of most policy instances are directed towards a health system need, for example, increasing the number or quality of physicians, and rarely toward improving a particular governance area such as accountability. The subjective evaluation of the reviewer to attach a particular governance result area to a given policy instance is based upon description of the policy instance, its features, implementation approach, and reviewers' experiences with similar policy instances.

Fourth, the reviewers had to grade the relative impact of various governance results on UHC outcomes on the basis of 'number of policy instances'. This metric will be biased towards the countries and reforms with a relatively larger number of publications in the literature and does not speak fully to the success of any particular policy instance in generating the desired health outcomes relative to other similar policy instances.

Fifth, the majority of the studies reviewed were descriptive, such that they enumerated the process of healthcare reform in a country or compared the features of reforms in several countries. Our final review did not include a significant number of studies that were randomized control trials of enacting changes in a policy, law or regulation in the health sector; or a related governance intervention, such that we could report conclusive evidence on the effect sizes of such interventions.

# CONCLUSIONS

Governments' efforts to increase coverage, access, equity, quality, and financial protection for their populations are likely to continue to expand as the SDGs and the UHC agenda draws into focus in the coming years. This review summarized the evidence on the effects from designing and implementing effective policies, laws and regulations with a clear orientation towards better governance, and in particular increased responsiveness and accountability.

Experience across countries and regions varied with the maturity of their UHC efforts and political context. More effectively implemented policy instances had a greater likelihood of being associated with improved governance functions which can together lead to increased achievement of intended UHC outcomes. Progress towards UHC involves a mix of policy changes which can significantly benefit from a channel of governance-related effects for their greater success. The expansion of the insured population was a common UHC-related reform effort, and requires clearly defining and legislating a core package of services and communicating it effectively to members and providers. This reform agenda thereby relies on increased transparency in the system to enhance the improvement in coverage and equity. Similarly, emphasizing the role of community health posts and providers, and determining and allocating the resources available to them will increase access to services and quality. This is a reform that channels critical areas of better governance—improved responsiveness as well as voice and empowerment.

In other instances, health sector reforms focused on a specific intervention can contribute to overall improvements in health governance. Several health reforms focused on improved purchasing methods with a strong component of performance-based financing, and governments implemented these with legally binding contracts and stated penalties for underperformance. These reforms increased levels of accountability in the health system.

The majority of policy instances reviewed were related to structural and financing reforms in the health sector that affect several segments of the population. We noted that there was little evidence for direct emphasis on the reduction of corruption within the policy instances, but the impact of the policy instances was still to reduce corruption through increased transparency and accountability. It is essential that future policy instances emphasize this governance aspects to avoid downstream complications. Several policy instances, like free provision of drugs at public facilities, unintentionally create avenues for informal payments or corruption. For policy instances associated with health financing and human resources for health, the relative strength of evidence for responsiveness, accountability and transparency as key governance interventions should support countries to develop better policy, legal and regulatory design processes.

Countries on the cusp of undertaking major health system reforms through the drafting and implementation of relevant policy instances will have to prioritize their governance interventions based on the risks specific to their existing health system contexts. At a minimum, they should do all that is possible to avoid some of the negative or unintentional aspects of sub-optimal policy instance design, that can reduce efficiency and quality. Where possible, emphasis should be placed on capturing synergies in governance interventions that increase responsiveness, accountability and transparency, as this review has found an abundance of evidence that these governance results can be mutually reinforcing and lead to step change improvements in the functioning of the health system.

Governments may have political and process constraints on the number of policy instances they can design and implement in a period leading up to and during health sector reform. In terms of which

health system component to focus such change on, we have more evidence for policy instances focused on health financing, given that designing effective financing mechanisms can shape the entire health sector. Following this, policy instances that address human resources for health and supply chain management should be prioritized as they appear to have key strengthening effects on the provision of health care by increasing efficiency, equity, and quality.

In terms of the future research agenda, we find that the relative lack of policy evidence for the effects of reduced corruption and patient empowerment policy instances may spur more enquiry in associated policy, law, and regulation development and implementation.

The conceptual framework used in this paper is relatively novel and helped to define and organize a vast and potentially hard-to-define topic area. This framework allowed results to be analyzed from different perspectives, including type of policy instance, policy instance structure, health system component, governance result, UHC outcome, and various combinations thereof. However, as discussed above, the use of a relatively linear flow between policy changes within health system components, to governance results, and onward to UHC outcomes may be limiting. Follow-on work in this area should take a country case study approach to consider the context-specific factors, viewed over a longer time period, which are important attributes as well as explanatory factors in the ability of improved health governance and the related policies, laws and regulations to generate successful UHC impact.

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