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Landscaping review part 1: Review of comparative health systems literature

Learning for Action Across Health Systems

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Abstract

Low- and middle-income countries cannot afford to waste scarce financial and human resources, and political capital, on programmes that are not effective, efficient, equitable or sustainable. There are many lessons from individual country experiences about ‘what works’ – and what does not work – in terms of strengthening health systems in low- and middle-income countries. Research that makes comparisons between health systems may be an important source of information for policy makers about ‘what works best’. This paper reviews the comparative health systems literature that includes empirical analysis, in a bid to describe this body of information.

This report is the first of three landscaping papers that lay the foundation for a larger project. The larger project will develop recommendations for the Bill & Melinda Gates Foundation (as well as the wider community) on fruitful future investment into the state-of-the-art of learning from the successes and failures of other health systems by low-income countries, and using those lessons to achieve improved health outcomes. We have termed this *Learning for Action Across Health Systems*. All three landscaping papers are available online.

Landscaping review part 1 is this review of comparative health systems literature:

www.opml.co.uk/publications/learning-action-across-health-systems-landscaping-review-part-1

Landscaping review part 2 is a review of institutions and platforms that currently exist and aim to facilitate learning across health systems: www.opml.co.uk/publications/learning-action-across-health-systems-landscaping-review-part-2

Landscaping review part 3 is a review of published analyses of international policy transfer in health: www.opml.co.uk/publications/learning-action-across-health-systems-landscaping-review-part-3

Executive summary

Research that makes comparisons between health systems may be an important source of information for policy makers about 'what works best'. It also tells us about the types of things that may be learnt through looking at 'other' health systems as well as variation between health systems and the analytical methods available.

The objective of this review was to understand what types of comparative health system analysis have been undertaken in the empirical literature (from both peer reviewed and grey sources). Methods of systematic literature review were used to identify the relevant studies. They were then classified by two key dimensions: the topic/focus of the study and the methodological approach adopted. The resulting typology was used to explore some of the patterns, identify significant gaps and formulate questions for future stages of the Learning for Action Across Health Systems project.

178 studies were identified from indexed databases. These were supplemented by 106 studies from key websites and a further 10 from expert sources. After removing duplicates, this left 289 studies for detailed review. After review of the full-text studies, 231 studies were included in the landscaping analysis.

The classification of studies examined what was being compared and the methods used in the comparison. The subject of the analysis was further sub-divided into: "System", "Inputs", "Service delivery" or "Outputs/outcomes". Methods used to undertake comparisons could be broadly divided into three: quantitative, qualitative and mixed-methods and reviews.

The process highlighted a number of key points for discussion:

Comparative health systems analysis is an expanding field of empirical analysis. There appears to have been a sharp increase in the rate of publication over the past 15 years.

There is a substantial body of learning from LMICs. Just over 30% of the studies identified address LMICs. While our website search focused on those sites most likely to contain studies from LMICs, a similar proportion of LMIC studies were identified on indexed databases.

There is learning across a range of health system elements. Just over half of the studies identified looked at health system functions. Forty percent of these undertook whole system analysis, while health financing studies (the most common function of analysis) made up another 40%.

Two health system inputs which appear to be relatively neglected are drugs supply chains and health information systems. While these appear not to be areas of major focus for academic research published in health related journals, they do receive a lot of attention from those engaged in direct health system strengthening efforts.

There is learning through a variety of methodological approaches. Over half (58%) of the studies from LMICs used qualitative / mixed methods, but only 14% used quantitative methods. This breakdown contrasts with studies that looked at high income countries, where 43% used qualitative / mixed methods and over 40% used quantitative methods.

There are a number of limitations to this review. Most notably, some important sources have not been searched (WHO database, for instance) and evidence from Latin America is mostly missing as the search was limited to English and French language publications.

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List of abbreviations

HICs	High-income countries
LMICs	Low- and middle-income countries
OECD	Organisation for Economic Co-operation and Development
WHO	World Health Organization

1 Introduction

This review is part of a larger project which seeks to understand the ways in which health system decision-makers in low-income countries learn from the experience of other countries, and how such learning can best be supported. The overall project has a series of stages. The first stage, informed by this study, is to develop an understanding of how comparisons of systems are currently undertaken. This is followed by an investigation phase, which seeks to understand how these analyses and other types of cross-country evidence help to inform health system policy in low-income countries.

The objective of this review was to understand what types of comparative health system analysis have been undertaken in the empirical literature (from both peer reviewed and grey sources). To achieve this overview of the empirical landscape, we used the methods of a systematic literature review, and we classified studies by reference to two key dimensions: the topic/focus of the study and the methodological approach adopted. The resulting typology was used to understand some of the patterns in the published evidence, identify significant gaps, and formulate questions for future stages of the project.

This paper is structured as follows. Section 2 describes the search strategy. Section 3 presents the main findings both in terms of bibliometrics and the resulting landscaping typology. The implications and limitations of the findings are discussed in Section 4.

2 Methods

The search focused on a comparative analysis of health systems and their elements. The objective was to understand the breadth of studies undertaken, but not to grade the evidence. We included countries of all income levels within the scope of the study, since although our eventual focus is on their application in low-income countries we are interested in a broad range of experiences that might be used to inform country systems.

The search covered three academic databases: Global Health, Medline and Cairn (in French). In addition, we searched the websites of bilateral and multilateral agencies (the US Agency for International Development, the UK Department for International Development, the World Health Organization (WHO), World Bank), philanthropic foundations (Rockefeller Foundation, Bill and Melinda Gates Foundation, Wellcome Trust) and international think tanks and research programmes (Results for Development, Abt Associations/Health Financing and Governance Project, Centre for Global Development, RESYST, REBUILD, Chatham House, the Organisation for Economic Co-operation and Development (OECD), and Alliance for Health Policy and Systems Research). Some articles were also obtained through direct contact with experts in the field. Articles written in English and French were eligible for inclusion, with no time period restriction. We noted articles found in other languages but did not include them in the review. The initial database search was conducted by one researcher. Two researchers subsequently were involved in the screening of all the identified abstracts to determine eligibility and to classify each study according to the typology (described below). Each study was screened by a single researcher but in cases where it was difficult to confirm a study's relevance or allocate it to specific typology categories these studies (around 3.5% = 40/1,124 papers) were referred to the second researcher and, if necessary, to one of the project leaders.

Search terms used to interrogate the databases were specified to capture the cross-country nature of the comparisons and health system or sub-system focus (Box 1). The French database is smaller and it was feasible to implement a broader search of that database. Most of the websites are not amenable to an advanced search and a simplified search was specified.

Box 1: Search terms

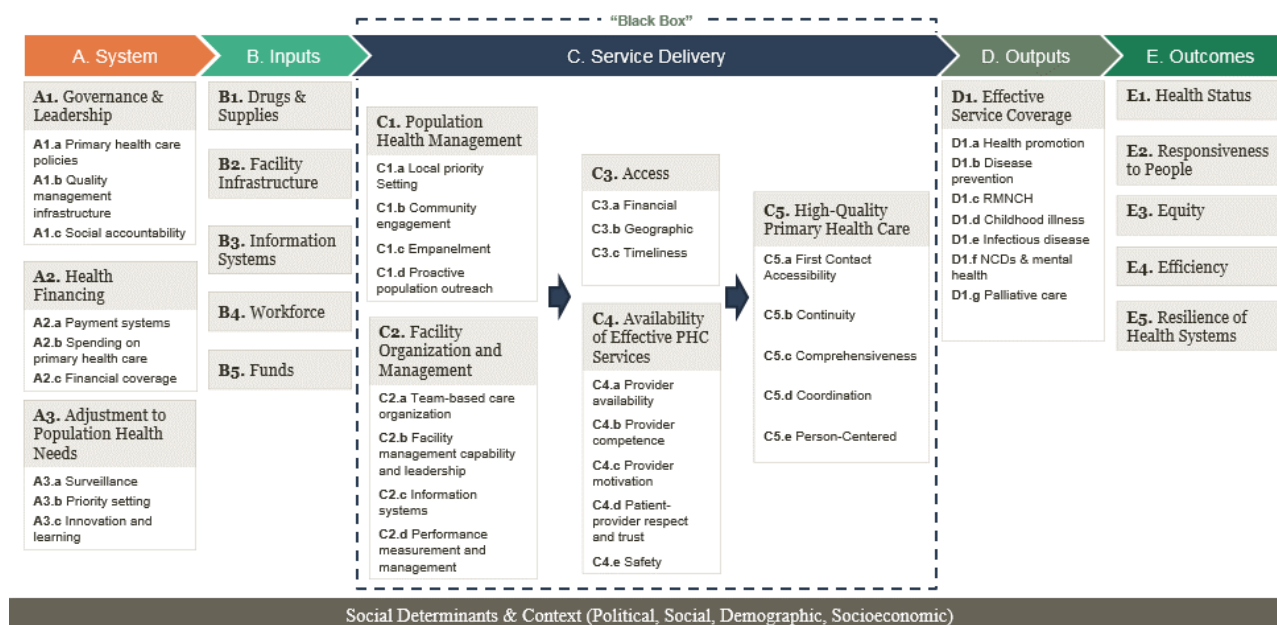
Medline and Global Health databases: (cross countr* OR multi countr* OR countries OR international) ADJ2 (compar* OR analys* OR descri* OR evolution) AND (health system OR health service OR health polic* OR health strateg* OR health plan* OR health financing OR health insurance OR health resource allocation OR health information OR health research OR health worker OR human resources for health OR health regulation OR health reform)

Cairn: compar* AND (systeme de sante OR systeme de soins)

Websites: compar * AND health system

No explicit quality criteria were used since our aim was to understand the range of types of analyses undertaken. Case studies focusing on a single country without any cross-country dimension were excluded, as were cross-country analyses of individual diseases, disease protocols and health interventions. We did not include studies that reported data series on countries if they did not also include an interpretation as to their value as performance indicators for the health system. Comparisons that examined groups of health facilities were excluded unless they were compared and discussed as part of the wider health system.

Data for each included study were extracted using a data summary form, which captured the year and language of publication, countries included, level of analysis, and nature of data and methods of analysis.

Figure 1: Primary Health Care Performance Indicators Conceptual Framework

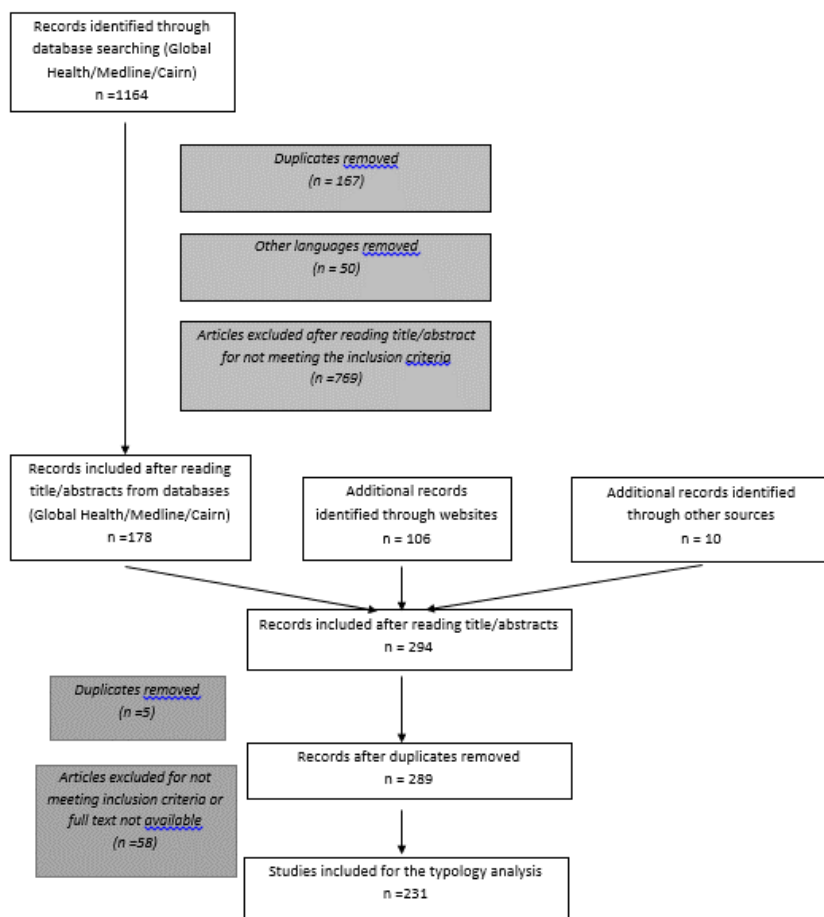
An initial typology was created based on a small scoping review, which classified studies according to two dimensions. The first was the topic or level of analysis. Studies were either ‘whole system’ studies, or examined one or more specific health system elements. For the latter, we used categories based on the Primary Health Care Performance Initiative conceptual framework (‘system’, ‘inputs’, ‘service delivery’, ‘outputs and outcomes’) (Figure 1)¹. The second dimension was the analytical approach/method used. The categories in the typology were updated and revised when included studies did not fit into an available ‘cell’ in the matrix. The typology was used only to categorise studies not drive the initial search.

¹ <http://phcperformanceinitiative.org/about-us/measuring-phc>

3 Results

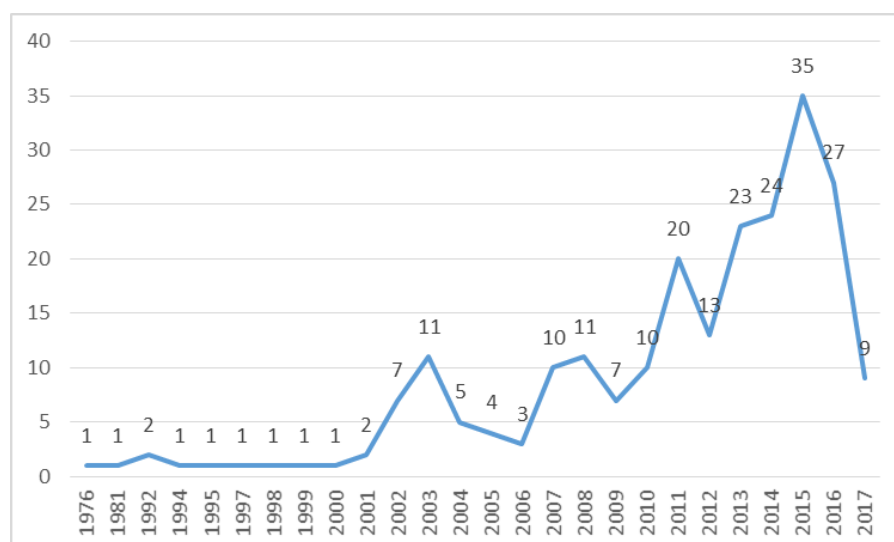
3.1 Study bibliometrics

Figure 2: Search flow



The initial search identified 1,164 articles in the databases (Figure 2). After review of the titles and abstracts, 178 studies remained for detailed examination. These were supplemented by a further 106 studies from the websites and 10 from expert sources. After removing duplicates, this left 289 studies for detailed review. After review of the full-text studies, 231 studies were included in the landscaping analysis.

Although the searches did not restrict the range of publication dates, it is noticeable that the overwhelming majority (83%) of studies were published in the last 10 years (Figure 3). This suggests that comparative systems analysis may be becoming more routine, although it also probably reflects the lower level of availability of older research in current databases, particularly websites.

Figure 3: Studies by year of publication

One hundred and twenty-two of the studies (53%) focused on comparisons of high-income countries (HICs), 72 (31%) on low- and middle-income countries (LMICs) and 37 (16%) included comparisons of both. The distribution is biased to the extent that the websites interrogated have particular regional interests (OECD – HICs, World Bank – LMICs). However, the distribution of the 134 studies extracted from the three peer reviewed databases is similar to the overall distribution, with 71 studies (53%) from HICs, 40 studies (30%) from LMICs and 23 (17%) including comparisons of both. Most of the LMIC studies (22) are comparisons across continents: 19 studies focused on African and Middle Eastern countries, seven on Asia, three on the former Soviet Union /central and eastern Europe, and one on Latin America. Three of the studies extracted focused only on countries recently affected by conflict.

A wide variety of different journals publish comparative system analyses (Table 1). *Health Policy* is the most widely used journal particularly for studies in HICs (27 articles)². *Health Policy and Planning*, *Social Science and Medicine*, the *Lancet* and, for studies with a reproductive health systems focus, *BMC Pregnancy and Childbirth* all publish regularly on comparative health system topics.

² *Health Policy* used to publish LMIC studies but now focuses on HICs outside the US (see www.journals.elsevier.com/health-policy/).

Table 1: Health systems comparisons by journal of publication

	HIC	LMIC	BOTH	TOTAL
Health Policy	22	1	4	27
BMC Pregnancy & Childbirth	0	7	0	7
Social Science & Medicine	3	3	1	7
BMC Health Services Research	4	1	1	6
Health Policy & Planning	0	5	1	6
European Journal of Public Health	5	0	0	5
Lancet	0	3	2	5
Health Affairs	4	0	0	4
PLoS Medicine	1	2	1	4
Vaccine	2	0	2	4
Issue Brief (Commonwealth Fund)	3	0	0	3
Applied Health Economics & Health Policy	1	0	1	2
BMC Public Health	1	1	0	2
Bulletin of the World Health Organization	0	2	0	2
Global Health	0	1	1	2
Health Services Research	1	0	1	2
International Journal for Quality in Health Care	2	0	0	2
Journal of Epidemiology & Community Health	1	1	0	2
Journal of Health Economics	1	0	1	2
Journal of Health Services & Research Policy	2	0	0	2
Journal of Medical Internet Research	2	0	0	2
Others (35 journals. 1 paper in each)	14	13	8	35
Total	69	40	24	133

3.2 Types of health system analyses

The classification of studies examined what is being compared and the methods used in the comparison.

Topic or level of analysis:

The subject of the analysis was further sub-divided into: ‘System’ (Governance, Finance), ‘Inputs’ (Drugs & Supplies, Infrastructure, Information Systems, Workforce), ‘Service delivery’ or ‘Outputs/outcomes’ (Responsiveness, Health Outcomes, Efficiency, Equity, Quality).

Whole system approaches examine the way in which countries have developed their health systems in response to changing internal and external priorities and influences.

Studies focusing on a **single element** of the health system were classified according to the PHCPI³ framework: ‘system’-level factors (health financing, and governance and leadership); ‘inputs’ (medical products, information systems, health workforce); service delivery; and studies examining outputs and outcomes. Governance and leadership includes a range of ideas including development of policy and strategy, leadership and stewardship, regulatory strategies, decentralisation and the role of the community in influencing and taking decisions.

Outcome studies focus first on a comparison of single system outcomes or cluster of outcomes, from which is developed an analysis of system strengths and weaknesses. The typology initially included the three outcomes typically used in health system frameworks – responsiveness, health

³ <http://phcperformanceinitiative.org/>.

outcomes and financial fairness. A reading of the abstracts suggested that separate attention is often made to quality and efficiency outcomes and these were added to the typology. Financial fairness was expanded to include other measures of access equity which appeared frequently in the studies reviewed.

Methods used to undertake comparisons can be broadly divided into three: quantitative, qualitative and mixed methods and reviews. Three types of quantitative studies were identified:

- **Quantitative descriptive** methods, largely using quantitative data to develop a comparison of systems. Some basic transformations of data are undertaken (e.g. computation of indices, Lorenz curves), together with simple statistical analysis. Studies principally rely on secondary data although some collect primary data.
- **Quantitative, econometric or statistical** studies, using multivariate quantitative data analysis to examine the association of process, output, or outcome indicators with system variables. Confounding factors are examined and controlled for and studies often before and after comparisons and relevant counterfactuals/controls
- **Longitudinal quantitative** methods, which make use of panel and longitudinal data to undertake over-time analyses of health systems interventions and policies across multiple countries.

Comparisons that mainly use qualitative and mixed methods data were of five main types:

- **Case studies** are structured, in-depth analysis of a series of cases (countries) undertaken in order to understand the general principles underpinning functioning and outcomes. They generally use a mix of methods but in particular they use in-depth analysis of a small number of cases, sometimes taking an historic perspective.
- **Secondary narrative studies:** these utilise a range of secondary data sources that are largely qualitative, including policy documents, qualitative datasets and other published studies, in order to develop a narrative comparison between systems or sub-systems.
- **Primary qualitative studies:** these utilise one or more qualitative methods (focus group, key informant, in-depth interviewing) to compare different system characteristics.
- **Tools-based methods** focus on comparisons based on established tools and frameworks that in turn utilise a variety of secondary data sources, both qualitative and quantitative. Examples include maternal and newborn bottleneck analysis, functions of health systems framework and the Whitehead framework [1].
- **Longitudinal qualitative** are studies that examine the evolution of health systems in a number of contexts over time. This acknowledges the increasing importance in the literature of the gradual evaluation of systems in response to particular policies and contextual factors, and the resulting path dependency of the change. There is overlap with the case study approach since many case studies have some intertemporal discussion.

Finally, we observed a number of **review studies**, utilising a range of methodologies (systematic, scoping, narrative) to contrast aspects of health systems based exclusively on a search of peer reviewed and grey literature.

Table 2: Number of studies identified by type

	Descriptive and multivariate quantitative				Cross sectional narrative, qualitative, mixed methods, case studies						Reviews	TOTAL	%
	Cross sectional quantitative (indicators)	Cross-sectional quantitative (econometric, bio-stat, epi demio)	Longitudinal quantitative	Total quantitative	Case studies	Narrative secondary analysis	Primary qualitative	Tool based	Longitudinal historical, predictive	Total qualitative/ mixed-method			
A. System													
Whole system	6	5	4	15	7	6	3	6	3	25	6	46	20%
Financing (resources, revenue collection, pooling, insurance, resource allocation)	8	11	3	22	5	6	2	1	7	21	6	49	21%
Governance & Leadership (including organization, policy, planning, HSR, decentralization)	6	2	0	8	4	5	4	0	3	16	2	26	11%
B. Inputs													
Medical products, technologies, vaccines, innovations	2	3	2	7	3	3	1	0	0	7	3	17	7%
Information and research	3	0	0	3	2	5	3	0	0	10	1	14	6%
Health workforce (including financial incentives, supportive supervision)	2	0	0	2	0	4	4	0	4	12	2	16	7%
C. Service delivery (including Health promotion interventions)	3	3	0	6	1	8	3	0	2	14	4	24	10%
D & E : Outputs and outcomes													
Multiple outcomes	1	0	0	1	0	1	0	0	0	1	0	2	1%
Responsiveness	4	9	0	13	0	1	0	0	0	1	0	14	6%
Efficiency	0	0	0	0	0	2	0	0	0	2	0	2	1%
Quality	2	2	0	4	0	1	0	0	0	1	1	6	3%
Equity	4	4	0	8	0	2	0	1	0	3	0	11	5%
Health status	3	0	0	3	0	0	0	0	0	0	0	3	1%
TOTAL	44	39	9	92	22	44	20	8	19	113	25	230	100%
%	19%	17%	4%	40%	10%	19%	9%	3%	8%	49%	11%	100%	

One hundred and twenty-one studies (52%) focus on system-level elements, of which 46 studies (20% of the total) focus on a comparison of the entire system, 49 studies (21%) focus on health financing and 26 (11%) address health system governance and leadership. Forty-seven studies (20% of the total) compare health system inputs; 24 studies (10%) look at service delivery; and 38 studies (17%) focus on one or more system outcomes. The role of the community is apparent in a variety of ways (mentioned in 11 studies). This includes community involvement in governance (5 studies), community financing (3 studies) and the role of community health workers (2 studies). Although the limitations of the search terms and databases is likely to have excluded studies that focus on inter-sectoral action, four studies were found two focused on controlling unhealthy behaviours (sugar and alcohol consumption)[2, 3], one on mobilising revenues for health [4] and one on broader measures of health system responsiveness [5]. Examples of each type of study are included in the more detailed table in Annex C.

Studies focusing on the entire system use a range of analytical methods. Based on a review of the literature Dummer and Cook examine how the Chinese and Indian systems have evolved in response to changing disease burdens and economic changes resulting from globalisation [6]. Squires, using cross-sectional multivariate methods, focuses on health system influences in the US and 10 other HICs on a range of outcomes, include health spending, service utilisation and health outcomes [7]. Enweronu-Laryea *et al.*, undertake a bottleneck analysis to understand how the health system impacts on maternal and newborn outcomes [8].

A large number of studies focusing on one, sometimes two, functions of the system were found. The most frequently analysed functions are financing (49 studies), governance (26) and service delivery (24). Unsurprisingly, there is a preponderance of quantitative studies on financing, whereas studies of the other functions are more likely to utilise qualitative methods. Amongst the financing studies are a number of studies focusing on resource requirements, including essential packages in LMICs and high-cost services in HICs [9, 10], and the size and incidence of health care spending [11-13].

Studies focusing on governance largely make use of qualitative or review methods (18/26 studies), while quantitative studies are mainly descriptive in nature. The search found two studies using more sophisticated statistical techniques: one that analyses policies on health across 114 countries using multivariate models and another that examines decisions about medical innovations by regulatory bodies in HICs [14, 15]. Studies on governance fall into two main categories: 13 of the studies focus on comparisons of the policy-making process, while 12 studies focus on aspects of regulation, including assessment of medical technology [16-19] and methods for regulating the quality of care [20]. Just over half (14/26) of the studies relate to HICs.

A diverse range of studies examine the impact of health system resourcing, regulation and other policies on service delivery. These include assessments of the adequacy of resourcing to support service delivery at district level [21], comparisons of service quality in the public and private sectors [22], integration of mental health services into primary care [23] and methods used to manage hospital volumes across OECD countries [24]. Several studies relating to service delivery and regulatory issues might have been placed into the governance category [22, 25]. Most of the service delivery studies (18/24) are qualitative or review based. The most frequently examined outcomes in the studies reviewed are health system responsiveness (14 studies) and equity (11). Studies examining responsiveness cover health system determinants of responsiveness [26, 27], determinants of public satisfaction [28], adjusting responsiveness to differential reporting behaviour [29], trends in waiting times [30] and patient attitudes to inequality [31]. Studies focusing on equity as an outcome include a number focusing on income-related inequalities in OECD countries [32, 33], system factors affecting geographic access to services [34], access to general practitioner

care in HICs [35], services for high need patients [36] and access by indigenous and ethnic groups [37, 38].

A number of the studies (22/230) focus on a sub-set of health services. While our exclusion criteria ruled out looking at comparisons of the protocol for treatment specific diseases, comparisons were included where the focus of the paper was on whole system responses to particular priority health service areas. The review found 16 studies that focus on reproductive, maternal and child health [8, 23, 39-51], a further six studies that focus on the primary health care system [52-57] and two studies included a focus on HIV services [37, 58]. Ten of these studies look across the whole system at these services, while the remainder focus on one function. Most of these studies (16/22) were undertaken in LMIC settings, with six focusing on primary care in HIC or mixed settings. Sustainability is clearly important in a many of the financing studies and implicit in studies with a focus on the whole health system. Five studies mentioned sustainability explicitly: two with a main focus on finance [59, 60], one on health service delivery [22], one on governance [61] and one where sustainability is seen as a dimension of responsiveness [62].

Almost half of the studies (113/230) make use of methods that largely rely on a mix of qualitative methods of analysis. Forty-four of these studies can be described as narrative secondary analyses, drawing on a variety of existing sources to develop a comparative picture of health system functionality. Detailed country case studies were found in 22 studies (10%) while 20 studies (9%) report primary qualitative data collection using a range of methods.

Quantitative methods are used in a significant minority of the studies reviewed (92/230). The largest group of such studies are those that use descriptive and simple statistical methods of analysis (44/230). Multivariate cross-sectional studies are also relatively common (39/230). Quantitative studies accounted for a smaller proportion of studies in LMICs (24%) compared to HICs (41%) or multi-context studies (52%) (Annex B).

A number of studies make use of quantitative panel data to investigate the intertemporal-spatial impact of policy interventions on health systems. Moreno-Serra and Wagstaff, for example, examine the impact of changing provider payment systems across eastern Europe and central Asia on the health systems of those countries [63]. Another study uses panel data on 184 countries to predict health system spending [64].

4 Discussion

The objective of the review was to identify the empirical evidence that compares health systems, and to understand the nature of the evidence that has been generated to date, with an emphasis on its scope and methods.

A number of observations arise from the analysis above that have implications both for the project and for the field of comparative health system analysis.

An expanding field of empirical analysis: From the bibliometric analysis of publication dates it is clear that this is a growing field, with a sharp increase in the rate of publication over the past 15 years. This could be due to the greater availability of health system data, enabling comparisons to be made, and/or greater (academic) interest in learning from health system comparison. Some reflection on the usefulness of this evidence for decision-making may help to shape how analytical efforts are targeted in the future.

A substantial body of learning from LMICs: Just over 30% of the studies we identified address LMICs. While our website search focused on those sites most likely to contain studies from LMICs, such as the Alliance for Health Policy and Systems Research and the Asia-Pacific Observatory on Health Policies and Systems – and therefore might be biased towards finding LMIC studies – a similar proportion of LMIC studies were identified in the searches conducted using indexed databases, for which no such bias would be expected. However, the database search may not have captured the full range of health systems analyses from HICs, where the term ‘health services research’ is often applied to system-level factors [65]. Nonetheless, the absolute number of studies from LMICs demonstrates the richness of the empirical evidence base on which those seeking to learn from others’ experience can draw.

Learning across a range of health system elements: Just over half of the studies identified look at health system functions. 40% of these undertake whole system analysis, while health financing studies make up another 40%; this was the single largest category within our classification. This focus on health financing is not surprising, given the early interest in health systems shown by health economists, the fact that health financing is (relatively) easily measured and quantified, and the preponderance of tools for conducting health financing analysis. The next largest category of evidence relates to health system governance and leadership, which has attracted increasing interest since it was highlighted in the 2000 World Health Report.

Two health system inputs which appear to be relatively neglected are issues related to supply chains and health information systems. We have reflected on this, and suspect that while these areas are not a major focus of academic research output, they nonetheless receive a lot of attention from those who are engaged in direct health system strengthening efforts. For instance, there are major projects supporting countries to strengthen their national health information systems through the DHIS2 platform, and there are substantial programmes of work to strengthen the management of essential drugs and supplies. The outputs of these activities are rarely captured in the form of research studies, and are more likely to be discussed in internal reports. They are also more likely to be single country studies, and less often cross-country analyses (see discussion of this issue below). This pattern may also suggest a different form of cross-country learning – through technical assistance projects, supported by consultants who have experience of multiple countries and who bring this experience to their activities in a particular country. This type of cross-country learning could be explored through the country studies.

Learning through a variety of methodological approaches: Over half (58%) of the studies from LMICs use qualitative / mixed methods, and only 14% of studies from LMICs use quantitative

methods. This breakdown contrasts with studies that look at HICs, where 43% use qualitative / mixed methods and over 40% use quantitative methods. This might reflect the greater availability of quantitative health system data in high-income settings, though this is changing, with an expanding set of national data on, for example, health financing (National Health Accounts), provider surveys (such as Demographic and Health Survey Service Provision Assessments and World Bank Service Delivery Indicators), and the new PHCPI data platform, which will produce national-level data on a range of health system levels. An important question to explore in the country studies will be what sort of evidence decision-makers find most useful, and whether the preferred types of evidence are presented with sufficient contextual detail for users to judge the likely transferability of findings across settings.

The review has a number of limitations, imposed both by conceptual challenges and the time available to conduct the literature review.

Although the review was intended to scope out the landscape rather than be comprehensive, there are several important databases that have currently been omitted, notably the WHO Global Health Observatories and the WHO Iris database, which could be added later in the project.

The search was limited to literature in English and French. We noted a range of other languages and in particular we expect there be to studies missed on Latin America in Spanish and on the former Soviet Union in Russian.

The review focused only on studies that considered more than one country and had a systems perspective which was specified explicitly in the search terms. This means we excluded studies that examined the health system of a single country. This was primarily because including all single health system studies would have made the review unfeasibly broad in scope. However, reflecting on the experience of another country is likely to be an important form of health system learning, and how this happens will need to be explored in the field interviews.

A related limitation is that we excluded reviews or comparisons that looked at the management of specific diseases, unless they also related these to broader health system elements. It is also probable that international reviews of disease management that shape system operation are used by national decision-makers. Recent *Lancet* series, for example, cover topics that while not explicitly system focused nevertheless have huge potential to influence the way the system develops. The 2015 *Lancet* Commission on Surgery, for example, focuses on unmet surgical need and the readiness of health services [66]. Tools were developed that assess system readiness that are offered to countries when developing their own surgical provision⁴. These could have a substantial impact on the shape of the overall system – they relate to staff ratios and skills, blood banking and operating theatre capacity – but were outside the scope of this review. These influences will also be explored in our country studies.

The search undertaken was a compromise to ensure that the task was tractable in the time allowed but also broad enough to pick up the major studies. Although we believe we have obtained a wide range of studies we know that there are a few key studies that were not picked up by the research (e.g. [67, 68]).

The typology is necessarily a simplification of the reality of health system research. Many of the studies could be placed in more than one category and it was left to the judgement of the researcher, albeit with a second opinion where there was doubt, to categorise studies. We have not attempted to categorise the quality of the methods used since our objective was to survey the

⁴ <http://www.lancetglobalsurgery.org/implementation-tools>.

breadth of the empirical literature, as a precursor to our study of what evidence is used, and how it is used, for health system learning.

4.1 Next steps and questions

There are a variety of ways that this work could be extended: for example, by searching additional databases and websites, or by conducting additional bibliometric analysis (e.g. where authors of these studies come from, both countries and types of institution – academic, government, or agency). We particularly seek advice on the following:

- Does the literature identified capture the key features of the comparative health systems landscape?
- Is there value to be gained by extending this analysis, and in what directions? What additional sources should be included?
- What questions does the review of evidence raise for the field interviews?
- Does the review suggest additional mechanisms of cross-system learning (i.e. beyond the use of published evidence) that should be explored in the field interviews?

Based on the discussion in the expert consultation, we will finalise this document and use it to inform the design of the field interview guides.

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Annex B Disaggregated data on studies surveyed

B.1 HICs

	CROSS QUANTI INDIC	CROSS QUANTI E	LONG QUANTI	Total Quantitative	CASESTUDY	NARRATIVE	QUAL INTERVIEWS	TOOL	LONG QUALI	Total qualitative /mixed-method	REVIEW	TOTAL	
A. System													
Whole system	4	1	2	7	0	5	1	0	2	8	1	18	13%
Health Financing	7	5	1	13	0	6	1	0	4	11	1	29	22%
Governance & Leadership	5	1	0	6	0	2	2	0	3	7	1	17	13%
B. Inputs													
Drugs, supplies & infrastructure	1	1	1	3	2	2	0	0	0	4	2	9	7%
Information Systems	3	0	0	3	0	3	2	0	0	5	1	9	7%
Workforce	1	0	0	1	0	4	0	0	3	7	1	12	9%
C. Service Delivery	2	1	0	3	0	7	1	0	0	8	1	12	9%
D & E: Outputs and outcomes													
Multiple outcomes	1	0	0	1	0	1	0	0	0	1	0	2	1%
Responsiveness	4	3	0	7	0	1	0	0	0	1	0	8	6%
Efficiency	0	0	0	0	0	2	0	0	0	2	0	2	1%
Quality	2	1	0	3	0	1	0	0	0	1	1	5	4%
Equity	3	2	0	5	0	2	0	1	0	3	0	8	6%
Health status	3	0	0	3	0	0	0	0	0	0	0	3	2%
TOTAL	36	15	4	55	2	36	7	1	12	58	9	134	100%
	26.9%	11.2%	3.0%	41.0%	1.5%	26.9%	5.2%	0.7%	9.0%	43.3%	6.7%	100.0%	

B.2 LMICs

	CROSS QUANTI INDIC	CROSS QUANTI E	LONG QUANTI	Total Quantitative	CASESTUDY	NARRATIVE	QUAL INTERVIEWS	TOOL	LONG QUALI	Total qualitative /mixed-method	REVIEW	Total	
A. System													
Whole system	0	3	1	4	5	1	2	6	0	14	5	23	31%
Health Financing	1	5	0	6	5	0	1	1	1	8	2	17	23%
Governance & Leadership	0	0	0	0	3	1	1	0	0	5	1	6	8%
B. Inputs													
Drugs, supplies & infrastructure	0	0	0	0	1	0	1	0	0	2	0	2	3%
Information Systems	0	0	0	0	1	2	1	0	0	4	0	4	5%
Workforce	0	0	0	0	0	0	4	0	1	5	1	7	9%
C. Service Delivery	1	1	0	2	1	1	2	0	1	5	2	10	14%
D & E: Outputs and outcomes													
Multiple outcomes	0	0	0	0	0	0	0	0	0	0	0	0	0%
Responsiveness	0	2	0	2	0	0	0	0	0	0	0	2	3%
Efficiency	0	0	0	0	0	0	0	0	0	0	0	0	0%
Quality	0	1	0	1	0	0	0	0	0	0	0	1	1%
Equity	1	1	0	2	0	0	0	0	0	0	0	2	3%
Health status	0	0	0	0	0	0	0	0	0	0	0	0	0%
TOTAL	3	13	1	17	16	5	12	7	3	43	11	74	100%
	4.1%	17.6%	1.4%	23.0%	21.6%	6.8%	16.2%	9.5%	4.1%	58.1%	14.9%	100.0%	

B.3 Both contexts

	CROSS QUANTI INDIC	CROSS QUANTI E	LONG QUANTI	Total Quantitative	CASESTUDY	NARRATIVE	QUAL INTERVIEWS	TOOL	LONG QUALI	Total qualitative /mixed-method	REVIEW	Total	
A. System													
Whole system	2	1	1	4	2	0	0	0	1	3	0	7	19%
Health Financing	0	1	2	3	0	0	0	0	2	2	3	8	22%
Governance & Leadership	1	1	0	2	1	2	1	0	0	4	0	6	16%
B. Inputs													
Drugs, supplies & infrastructure	1	2	1	4	0	1	0	0	0	1	1	6	16%
Information Systems	0	0	0	0	1	0	0	0	0	1	0	1	3%
Workforce	1	0	0	1	0	0	0	0	0	0	0	1	3%
C. Service Delivery	0	1	0	1	0	0	0	0	1	1	1	3	8%
D & E: Outputs and outcomes													
Multiple outcomes	0	0	0	0	0	0	0	0	0	0	0	0	0%
Responsiveness	0	4	0	4	0	0	0	0	0	0	0	4	11%
Efficiency	0	0	0	0	0	0	0	0	0	0	0	0	0%
Quality	0	0	0	0	0	0	0	0	0	0	0	0	0%
Equity	0	1	0	1	0	0	0	0	0	0	0	1	3%
Health status	0	0	0	0	0	0	0	0	0	0	0	0	0%
TOTAL	5	11	4	20	4	3	1	0	4	12	5	37	100%
	13.5%	29.7%	10.8%	54.1%	10.8%	8.1%	2.7%	0.0%	10.8%	32.4%	13.5%	100.0%	2.7%

B.4 All studies

	CROSS QUANTI INDIC	CROSS QUANTIE	LONG QUANTI	Total Quantitative	CASE STUDY	NARRATIV E	QUAL INTERVIE WS	TOOL	LONG QUALI	Total Qualitative /mixed- method	RE VIEW	Total	
A. System													
Whole system	6	5	4	15	7	6	3	6	3	25	6	46	20%
Health Financing	8	11	3	22	5	6	2	1	7	21	6	49	21%
Governance & Leadership	6	2	0	8	4	5	4	0	3	16	2	26	11%
B. Inputs													
Drugs, supplies & infrastructure	2	3	2	7	3	3	1	0	0	7	3	17	7%
Information Systems	3	0	0	3	2	5	3	0	0	10	1	14	6%
Workforce	2	0	0	2	0	4	4	0	4	12	2	16	7%
C. Service Delivery	3	3	0	6	1	8	3	0	2	14	4	24	10%
D & E: Outputs and outcomes													
Multiple outcomes	1	0	0	1	0	1	0	0	0	1	0	2	1%
Responsiveness	4	9	0	13	0	1	0	0	0	1	0	14	6%
Efficiency	0	0	0	0	0	2	0	0	0	2	0	2	1%
Quality	2	2	0	4	0	1	0	0	0	1	1	6	3%
Equity	4	4	0	8	0	2	0	1	0	3	0	11	5%
Health status	3	0	0	3	0	0	0	0	0	0	0	3	1%
TOTAL	44	39	9	92	22	44	20	8	19	113	25	230	100%
	19.1%	17.0%	3.9%	40.0%	9.6%	19.1%	8.7%	3.5%	8.3%	49.1%	10.9%	100.0%	

Annex C Typology with examples

	Cross sectional quantitative (indicators)	Cross sectional quantitative (econometric, bio-stat, epidemiological)	Longitudinal quantitative	Cross sectional narrative, qualitative, mixed methods, case studies	Longitudinal historical, predictive	Reviews
A. System						
Whole health system (at least 3 health system functions)	5	5	4	22	3	6
	OECD 2016 Health at a glance Asia Pacific: Measuring progress towards UHC WHO & WB 2015 Tracking universal health coverage: First global monitoring report	Oliphar 2014 Multi-country analysis of routine data from integrated community case management programs in sub-Saharan Africa Frognier 2015 Comparing efficiency of health systems across industrialized countries: a panel analysis	Varabyova 2013 International comparisons of the technical efficiency of the hospital sector: panel data analysis of OECD countries using parametric and non-parametric approaches Rebling 2013 The international performance of healthcare systems in population health: capabilities of pooled cross-sectional time series methods	Liu 2015 Antenatal corticosteroids for management of preterm birth: a multi-country analysis of health system bottlenecks and potential solutions Egami 2012 Can health systems be enhanced for optimal health services through disease-specific programs? Results of field studies in Viet Nam and Cambodia	Laplace 2002 Les systemes de sante francais et anglais: evolution comparee depuis le milieu des annees 90 WB 2013 Getting Better: Improving Health System Outcomes in Europe and Central Asia	Varabyova 2016 The efficiency of health care production in OECD countries: a systematic review and meta-analysis of cross-country comparisons WB 2013 The Impact of Universal Coverage Schemes in the Developing World: A Review of the Existing Evidence
Financing (resources, revenue collection, pooling, insurance, resource allocation, payment)	4	11	3	23	6	6
	Koechlin OECD 2014 Comparing Hospital and Health Prices and Volumes Internationally Squires 2012 Explaining high health care spending in the United States: an international comparison of supply, utilization, prices, and quality	Niens 2010 Quantifying the impoverishing effects of purchasing medicines: a cross-country comparison of the affordability of medicines in the developing world Bae 2015 Same drugs, valued differently? Comparing comparators and methods used in reimbursement recommendations in Australia, Canada, and Korea	Dileman 2016 National spending on health by source for 184 countries between 2013 and 2040 WB 2009 Social Health Insurance vs. Tax-Financed Health Systems—Evidence from the OECD	HFG 2017 Case studies on provider payment mechanisms in Kyrgyz Republic, Nigeria, and Zambia Doh 2009 Comparative analysis of health insurance systems in the United States and South Korea	Loresmoni OECD 2017 Cyclical vs structural effects on health care expenditure trends in OECD countries Morgan OECD 2014 Health Spending Continues to Surge in Many OECD Countries	Lydon 2008 Government financing for health and specific national budget lines: the case of vaccines and immunization Preker 2002 Effectiveness of community health financing in meeting the cost of illness
Governance & Leadership (including organization, policy, planning, HSR, decentralization)	2	2	0	35	5	3
	OECD 2008 Pharmaceutical Pricing Policies in a Global Market Siciliani 2013 Measuring and Comparing Health Care Waiting Times in OECD Countries	Lang 2015 Government capacities and stakeholders: what facilitates ehealth legislation? Lexchin 2012 International comparison of assessments of pharmaceutical innovation		Lee 1998 Family planning policies and programmes in eight low-income countries: a comparative policy analysis Brand 2007 Comparative analysis of alcohol control policies in 30 countries	Docteur OECD 2003 Health Care Systems: Lessons from the Reform Experience Hassenteufel 2011 Les transformations du mode de gouvernement de l'assurance maladie: une comparaison France-Allemagne	HFG 2017 Governing Quality in Health Care on the Path to Universal Health Coverage: A Review of the Literature and 25 Country Experiences Mrazek 2002 Comparative approaches to pharmaceutical price regulation in the European Union
B. Inputs						
Medical products, technologies, vaccines, innovations	3	6	2	12	0	3
	Dickson OECD 2003 Pharmaceutical Use and Expenditure for Cardiovascular Disease and Stroke Nobrega 2007 Retail prices of essential drugs in Brazil: an international comparison	Sinnott 2017 The international generalizability of evidence for health policy: a cross country comparison of medication adherence following policy change Kanitz 2012 Variation in adult vaccination policies across Europe: an overview from VENICE network on vaccine recommendations, funding and coverage	Daemrich 2014 Healthcare reform in the United States and China: pharmaceutical market implications Kyle 2008 Does reimportation reduce price differences for prescription drugs? Lessons from the European Union	Wiktorowicz 2012 Pharmacovigilance in Europe and North America: divergent approaches Ciani 2014 The role of health technology assessment bodies in shaping drug development		Denis 2010 A comparative study of European rare disease and orphan drug markets Alfonso 2015 Definition and Classification of Generic Drugs Across the World
Information and research	1	0	0	13	0	0
	Moses 2015 The anatomy of medical research: US and international comparisons			OECD 2015 Health Data Governance Naude 2015 Research evidence and policy: qualitative study in selected provinces in South Africa and Cameroon		
Health workforce (including financial incentives, supportive supervision)	1	0	0	12	4	1
	WHO 2011 Sexual and reproductive health: core competencies in primary care			Simons OECD 2006 The supply of Physician services in OECD countries RESYST 2016 What is the contribution of private training institutions on nurse production and availability in rural areas?	Ono 2013 Health Workforce planning in OECD countries Maru 1976 Health manpower strategies for rural evolution?	Coombs 2007 Advanced nursing roles in critical care—a natural or forced evolution?

	Cross sectional quantitative (indicators)	Cross sectional quantitative (econometric, bio-stat, epidemiological)	Longitudinal quantitative	Cross sectional narrative, qualitative, mixed methods, case studies	Longitudinal historical, predictive	Reviews
C. Service delivery (including Health promotion interventions)	5 Santoro 2000 Meso-level comparison of mental health service availability and use in Chile and Spain WHO 2015 State of inequality: Reproductive, maternal, newborn and child health	10 Lorenzoni 2010 International comparison of South African private hospital price levels Benova 2014 The role of the private sector in delivery in low- income countries	0	18 Nunnar 2010 Managing Hospital Volumes: Germany and Experiences from OECD Countries Berchet 2016 The effectiveness of...	2 Praker 2003 Innovations in HS D Buchan OECD 20015 Skill- Mix and Policy Change in the Health Workforce	1 Groenewegen 2010 Strengthening weak primary care systems: steps towards stronger primary care in selected Western and Eastern European countries
D & E: Outputs and Outcomes	1	1		3	2	1
At least 2 two outcomes	Hussey 2008 Trends in socioeconomic disparities in health care quality in four countries	WB 2002 Health Outcomes in Poor Countries and Policy Options : Empirical Findings from Demographic and Health Surveys		Tawfik 2007 Comparing health system performance assessment and management approaches in the Netherlands and Ontario, Canada WHO 2015 Strengthening health system accountability: a WHO European Region multi-country study	Wubulhasimu 2015 The impact of hospital payment schemes on Healthcare and mortality Evidence from hospital payment reforms in OECD countries WB 2013 Getting Better : Improving Health System Outcomes in Europe and Central Asia	Basu 2012 Comparative performance of private and public healthcare systems in low- and middle-income countries: a systematic review
	2	5	0	7	0	0
Responsiveness	Siciliani OECD 2013 Measuring and Comparing Health Care Waiting Times in OECD Countries Klarenbach 2003 International comparison of health resource utilization in subjects with diabetes: an analysis of Canadian and American national health surveys	Tinelli 2015 Decision-making criteria among European patients: exploring patient preferences for primary care services Valentine 2016 Exploring models for the roles of health systems' responsiveness and social determinants in explaining universal health coverage and health outcomes		Siciliani 2003 Explaining Waiting Times Variations for Elective Surgery Across OECD Countries Valentine 2015 Health systems' responsiveness and reporting behaviour: Multilevel analysis of the influence of individual-level factors in 64 countries		
Efficiency	0	0	0	3 OECD 2009 Achieving Better Value for Money in Health Care OECD 2010 Value for Money in Health Spending	0	1 Varabyova 2016 The efficiency of health care production in OECD countries: a systematic review and meta-analysis of cross-country comparisons
	0	2	0	4	0	1
Quality		Rosen 2011 Adherence to standards of care by health maintenance organizations in Israel and the US A WB 2008 The Quality of Medical Advice in Low-Income Countries		OECD 2010 Improving Value in Health Care Wagner 2006 The implementation of quality management systems in hospitals: a comparison between three countries		OECD 2017 Caring for Quality in Health -Less ons learnt from 15 reviews of health care quality
Equity	4 WHO 2015 State of inequality: Reproductive, maternal, newborn and child health Bramley 2005 Disparities in indigenous health: a cross- country comparison between New Zealand and the United States	2 Siddiqi 2010 A cross-national comparative perspective on racial inequities in health: the USA versus Canada Meyer 2013 Inequities in access to healthcare: analysis of national survey data across six Asia- Pacific countries	0	7 Ono OECD 2014 Geographic Imbalances in Doctor Supply and Policy Responses Samak 2016 How High- Need Patients Experience the Health Care System in Nine Countries	0	1 Praker 2002 Effectiveness of community health financing in meeting the cost of illness
Health	3 OECD 2016 Health at a glance Europe State of health in the EU cycle Gay OECD 2011 Mortality amenable to healthcare in 31 OECD countries	0	1 Moreno 2009 System-Wide Impacts of Hospital Payment Reform -Evidence from Central and Eastern Europe and Central Asia	0	0	0