Table S3 – Systematic reviews incorporating financing incentives in LMIC found through the search

Author, Year of Publication, Country	Financing intervention examined	Methods of study	Number of studies included	Main Result	Equity considerations
Asante et al 2016, Multi-Country	Equity in allocation of health sector financing	Meta-analysis of 24 benefit incidence analysis (BIA) and/or financing incidence analysis (FIA) studies	24; twelve studies originated from sub-Saharan Africa, nine from the Asia-Pacific region, two from Latin America and one from the Middle East.	Health care financing in LMICs benefits the rich more than the poor but the burden of financing also falls more on the rich. There is some evidence that primary health care is pro-poor suggesting a greater investment in such services and removal of barriers to care can enhance equity.	Benefit and financing incidence analyses were used to evaluate how well health systems perform on achieving equity in financing of health care delivery
Li et al 2015, China	Service delivery models	Systematic review to compare three service delivery models: government managed, hospital managed and privately owned Community Health Centers (CHCs).	13	Government and hospital managed CHCs were more competent and provided better primary care than privately owned CHCs. The latter provided the lowest quality of care, had the smallest workforce, the lowest share of government funding, the highest share of out-of-pocket payments, and the lowest coverage rate of health insurance schemes.	Privately owned CHCs may also be the least equitable service delivery model as lower insurance coverage usually results in lower use of health services among the elderly and migrants
Nachtnebel et al 2015, Multi-Country	Contracting and demand-side incentives	A narrative summary of systematic reviews, and grey literature through a policy lens.	15 Asia Pacific region	Both vouchers and contracting can improve outcomes in regards to access and utilisation of health services in underserved areas. However, contextual factors, the type of services delivered, and	NA

				governance capacity must be considered.	
Oyo-Ita et al 2016, Multi-Country	Demand-side incentives	Systematic review and random-effects meta-analyses and GRADE to assess the certainty of evidence.	14 studies from Georgia, Ghana, Honduras, India, Mali, Mexico, Nicaragua, Nepal, Pakistan, and Zimbabwe	There was low-certainty evidence that household monetary incentives (in the form of vouchers, conditional, and unconditional cash transfers) may have little or no effect on immunisation coverage. The affordability and sustainability of incentive programs in LMICs is also uncertain.	NA
Witter et al 2012, Multi-Country	Provider incentives (pay for performance)	Narrative summary of peer reviewed literature reporting on at least one of the following outcomes: changes in targeted measures of provider performance, such as the delivery or utilisation of healthcare services, or patient outcomes, unintended effects and/or changes in resource use.	9 studies from the Philippines, Tanzania, Zambia, Rwanda, Burundi, the Democratic Republic of Congo, Vietnam and China	The current evidence base is too weak to draw general conclusions; more robust and also comprehensive studies are needed.	NA
Wiysonge et al 2017, Multi-Country	Public stewardship of private for-profit healthcare services	Narrative summary of peer reviewed literature	6 studies from Kenya, Indonesia, Lao People's Democratic Republic and Vietnam	Training of private healthcare providers probably improves the quality of healthcare services, enhanced regulation may make little or no difference to quality of care and educational visits may improve quality of care.	NA
Yip et al 2010, China	Provider incentives (incl pay for performance)	Narrative summary of peer reviewed studies and grey literature	NA	China is innovating with different provider payment methods but rigorous and objective assessments are required. Secondly, medical professional	NA

				ethics and norms should be re-established to prevent inappropriate treatment and expenditure.	
Yuan et al 2017, Multi-country	Provider incentives (incl pay for performance)	Used a fixed-effect model for meta-analysis to synthesise the effect measures of relevant peer reviewed studies	21 studies from Afghanistan, Burundi, China, Democratic Republic of Congo, Rwanda, Tanzania, the United Kingdom and the United States	Using pay-for-performance systems for outpatient services will probably lead to a slight improvement in providers' use of tests and treatments. However it may lead to little or no difference in patients' use of health services; little or no difference in patients' health status; and little or no difference in providers' compliance with quality assurance criteria.	NA