

Table S1 – Peer reviewed studies of financing interventions included in systematic review

Author, Year of Publication, Country	Financing intervention examined	Method of study	Population covered	Main Result	Equity considerations
Alonge et al 2014, Afghanistan	Contracting out primary health care services	Used difference-in-difference methods to estimate the odds that a client attending a facility was poor	Rural	Models that allowed contractors to decide how funds are allocated within fixed budgets increased the odds of PHC attendees being poor.	Two of the models tested included performance bonuses (money payments) based on health equity targets
Engineer et al 2016, Afghanistan	Pay for performance (P4P)	Cluster RCT where services in the P4P arm received bonus payments based on the volume of MCH services provided. Arms were compared based on coverage, quality and equity measures.	All	No significant differences in any MCH coverage or equity indicators were detected, despite improvement in some quality indicators.	Services in the P4P arm received bonus payments based on two measures of equity of service utilization
Hawley et al 2014, American Samoa	Demand-side incentives	A review of medical records and in depth personal interviews were conducted to assess the adequacy	Urban	Utilization of prenatal care was poor, with 85.4 % of the sample classified as receiving	The adequacy of received services improved in 2007–2008 versus earlier years, after demand-side

		of prenatal care received		inadequate care based on a combination of the timing of initiation of prenatal care and the adequacy of received services after initiation	incentives were introduced (contingent on women attending their first prenatal care visit before the end of the first trimester)
Heard et al 2013, Bangladesh	Contracting out primary health care services	Three geographic areas were non-randomly contracted to an NGO or local government. Performance was assessed by household surveys, endline facility survey and routinely collected data.	Urban	NGO contracted services performed better in terms of increasing coverage and quantity of services, quality of care, efficiency and equity.	Service coverage of the poor included as a measure of equity
Loevinsohn et al 2009, Pakistan	Contracting out primary health care services	Analysis of health facility surveys, household surveys, and routinely collected information were used to compare the experimental district with a neighbouring and equally poor district.	Urban	Contracting out led to more than a 50% increase in out-patient visits in the experimental district. Community satisfaction also increased and physical infrastructure	Direct out-of-pocket costs were lower for patients in contracted out areas

				improved in the experimental district.	
Mahmood et al 2015, China	Coverage and cost of a voluntary insurance scheme	Interviews of 397 community members and 297 patients to assess utilisation of village clinic services, the cost of care and membership rates of the insurance scheme.	Rural	More than 80% of community members had used village clinic services in the past year despite the high cost of care (about US\$8 per episode). Membership rates were around 50% but financial reimbursements rates were seen as too low.	Rural people are unlikely to benefit from such schemes unless more substantial subsidies are provided.
Martins et al 2009, Timor-Leste	Food as an incentive for patients to enhance completion of TB treatment	RCT in 3 primary care clinics in Dili. Participants started standard TB treatment and were randomly assigned to intervention (daily meal and food package) or control (nutritional advice) groups.	Urban	The intervention had no significant beneficial or harmful impact on the outcome of treatment or adherence but did lead to improved weight gain for the intervention group.	The majority of patients (80%) in the trial had no formal income and were thus classified as poor

Nguyen et al 2010, Vietnam	Introduction of free primary care service provision in commune health centres (CHCs)	Archival administrative data was used to calculate utilization rates and mixed linear regression models were used to estimate the effects of the intervention policy on utilization rates.	All	Communes exposed to the intervention policy have higher utilization rates, but these effects are conditional upon the achievement of benchmark standards.	CHC utilization rates were highest in poor and remote communes suggesting the policy is pro-poor
Powell-Jackson et al 2009, Nepal	Supply and demand side financial incentives to promote facility based deliveries	Interrupted time series using household data to assess the impact of the programme on neonatal mortality and health care seeking behaviour at childbirth in one district.	Rural	In places where women's groups existed the program substantially increased skilled birth attendance but didn't impact neonatal mortality or caesarean section rate.	Wealthier households were disproportionately more likely to receive cash transfers, reflecting existing inequality in the use of government maternity services

Powell-Jackson et al 2015, China	Increased the benefit package and replacing fee for service with capitation and P4P	Quasi-randomised experimental design with three arms: 1) increased benefit package, 2) increased benefit package and change to capitation and P4P, 3) control. Data was collected through a panel household survey and difference-in-difference approach used to estimate impact on use of outpatient and inpatient care.	Rural	Increasing the benefit package, in isolation, led to a 47% increase in the use of outpatient care at village clinics and greater intensity of treatment. The two policy changes in combination showed no effect on utilisation over and above that generated by the increased benefit package.	NA
Sato et al 2015, Nepal	Removal of user fees	Comparison of two pairs of primary care facilities through document reviews, informant interviews at district and central levels, in-depth semi structured interviews and group interviews at case facilities.	All	Several implementation challenges were experienced including drug shortages, insufficient and delayed resource inputs, staff shortages and reduced quality of services.	The most impoverished groups experienced the largest increase in utilisation

Sun et al 2016, China	Replacing fee-for-service with capitation and P4P for outpatient visits.	Longitudinal claims data, administrative and facility data were used to assess changes in outpatient visits, inpatient admissions, expenditure per outpatient visit and prescribing indicators over time. Segmented regression analyses of interrupted time series data was used.	All	The new benefit expanded access to primary care and may have reduced use of specialist inpatient services. Outpatient visits increased while inpatient admissions, the cost of outpatient visits and injectable use all dropped.	NA
Tang et al 2013, China	Supply-side subsidies (the impact of government subsidies on injection prescription)	Randomly sampled prescriptions were collected from a representative sample of PHC institutions and a matched pair design with propensity score matching (PSM) used to analyse the correlation between government subsidies received by the facility and injection use. An international standard was adopted for determining the	Rural	The use of injections in primary health care institutions does not meet the standard; the overall percent of people who received an injection prescribed was 36.96%. Facilities that receive a higher general subsidy were more likely to have a rational	NA

		rational injection use rate (<24.1%).		approach towards injection prescription practices.	
Tang et al 2014, China	Health insurance benefit package design (exact structure unclear from article)	Difference in difference method used to analyse panel and household survey data	Rural	The new benefit package reduced the probability of no treatment in the past 3 months for those with hypertension and increased probability of choosing a village clinic for treatment.	NA
Thanh et al 2010, Vietnam	Removal of user fees	The impacts of the intervention on household health care expenditure were assessed by a double-difference propensity score matching method using panel data of 10,711 households in 2001, 2003, 2005 and 2007	Rural	The intervention significantly reduced health care expenditure as a percentage of total expenditure and increased the use of the local public health care among the poor.	The intervention policy targets the poor
Vellakkal et al 2017, India	A public insurance scheme with demand-side financial incentives	Data from four national household and facility surveys	Rural	Inequities in institutional delivery declined at	The intervention is pro-poor and poor states were

		collected before and after the intervention were used to estimate wealth-related and education-related relative indexes of inequality, and pre-post difference-in-differences models for wealth and education tertiles.		steeper rates following the intervention. Uptake of institutional delivery increased among all socioeconomic groups, with greater effects among the lowest and middle wealth and education tertiles.	targeted in the study
Wei et al 2015, China	Ownership models of health care centres	Interviews were conducted with 60 staff in 13 community health centres (CHCs) with different ownership models. Interviews focussed on: PHC services, organisation, financing and human resources.	Urban	Government-managed CHCs received the largest public funding and private CHCs received the least. Private CHCs provided lower quality services compared with the other models. Compared with private CHCs, employees of other models of CHC	NA

				were better educated and were better paid	
Wei et al 2017, China	Ownership models of health care centres	Multistage stratified random surveys were conducted in 3 cities with different ownership models. Quality scores were measured using the primary care assessment tool. Sociodemographic characteristics and health care measures of participants were also collected.	Urban	Lower quality and less equitable care were associated with private ownership, suggesting that it may be beneficial to promote public-owned and non-profit providers in China.	Equity was examined by comparing the quality of primary care among different household income groups within each city.
Wong et al 2012, China	Ownership models of community health centres (CHCs)	Multistage cluster random sampling method was used to collect patient data from facility management records of CHCs in six cities. Outcome measures included the treatment and control rate of hypertension as a	Urban	Privately funded CHCs attained the poorest treatment and control rates. Hospital funded CHCs had significantly higher treatment rates than other CHCs. Government funded CHCs had	NA

		proxy measure of clinical performance.		the highest BP control rates.	
Yip and Hsiao 2009, China	A public insurance scheme	Household survey data linked to claims records were used to simulate the effect of the insurance scheme on reducing the share of individuals falling below the poverty line due to medical expenses. These effects were compared to the Rural Mutual Health Care (RMHC), an alternate scheme.	Rural	The RMHC was more effective at reducing medical impoverishment. This is primarily because the insurance scheme does not cover outpatient services for chronic conditions.	The insurance scheme aimed to reduce impoverishment as a result of health care expenditures
Yip et al 2014, China	Capitation combined with pay for performance	Matched-pair cluster-randomized experiment to evaluate the effects of the intervention on primary care providers' antibiotic prescribing practices, health spending, outpatient visit volume, and patient satisfaction.	Rural	The intervention led to a moderate reduction in antibiotic prescriptions and a small reduction in total spending per visit to village posts-essentially, community health clinics.	NA