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Review Article

A Scoping Review of Evidence-based Decision-making in Health Financing Reforms: Conceptual Frameworks and Experiences to Inform Health Policy in Cameroon

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Abstract

Evidence-informed decision-making is increasingly recognized as essential for health financing reforms. It can improve effectiveness, equity, and accountability while supporting progress towards Universal Health Coverage (UHC). However, its integration into decision-making to inform health policy processes remains uneven across different contexts. This review aims to synthesise the available knowledge on the use of evidence in health financing decision-making, including international experiences and lessons learned from Cameroon. A scoping review was conducted using the Arksey and O'Malley framework, later refined by Levac et al. Reporting followed the PRISMA-ScR guidelines. Searches were conducted in PubMed, Scopus, and Web of Science, as well as in institutional sources such as WHO and the World Bank. Studies published between 2000 and 2025 in English or French were considered. Eligible studies included empirical and conceptual work on the use of evidence in health financing policies. Data were extracted using a standardized template and analysed thematically. A supplementary analysis of the case of Cameroon was carried out. Twenty-eight studies were included. The use of evidence appears to be multidimensional, encompassing quantitative, qualitative and economic data. Four main types of use were identified: instrumental, conceptual, strategic and interactive. High-income countries showed more institutionalized processes. In contrast, low- and middle-income countries faced fragmented practices, often influenced by external actors. The main determinants include governance structures, stakeholder interests, institutional capacities and the political context. Reforms were generally associated with improved access to care and financial protection, with varying effects on equity and quality. The use of evidence in health financing reforms is progressing but remains uneven. To accelerate progress towards Universal Health Coverage, policymakers should institutionalize evidence-informed decision-making. They should also strengthen national health information and financing data systems, invest in local analytical capacity, and promote transparent multi-stakeholder governance mechanisms. In low- and middle-income settings, reducing dependency on externally driven agendas and aligning reforms with national priorities will be critical to achieving equitable, efficient and sustainable health financing outcomes.

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Keywords

Health Financing Reforms, Evidence-based Decision-making, Health Policy, Universal Health Coverage, Scoping Review, Knowledge Sharing, Cameroon

1. Introduction

Over the past few decades, health systems worldwide have faced growing challenges in resource mobilization, equitable access to care, and financial sustainability. Against this backdrop, health financing reforms have emerged as a key strategic lever for improving the performance of health systems and advancing towards Universal Health Coverage (UHC) [1]. Recent analyses show that these reforms contribute significantly to improved health outcomes, particularly in maternal health in low- and middle-income countries [2]. These reforms encompass a wide range of interventions. They include health insurance schemes, reduced out-of-pocket payments, strategic purchasing, performance-based financing, and investment in primary healthcare research and development. Primary healthcare reforms are seen in particular as a key pillar of health system transformation [3]. Their role in improving financial protection and access to care is now well documented in the literature [4].

However, these reforms are designed and implemented in complex environments. Economic constraints, political dynamics, and institutional capacities vary across countries [5]. Several recent studies highlight that decision-making in healthcare is strongly influenced by the multiplicity of stakeholders and power dynamics within institutions, particularly at the hospital level [6]. This complexity underscores that decisions regarding healthcare financing are not solely a matter of technical reasoning, but result from interactions between stakeholders, institutions and socio-political contexts.

From this perspective, the integration of evidence into decision-making processes (evidence-informed decision-making) is increasingly recognised as a key lever for improving the quality, effectiveness and legitimacy of health policies. In this study, evidence is broadly defined as all information used to inform decisions. It includes scientific research, administrative and routine data, and the contextual and experiential knowledge of stakeholders. This approach reflects the complexity of health decision-making processes, where different forms of knowledge interact.

The use of scientific, operational, economic, and contextual data can improve policy choices. It can also optimize resource allocation and support more effective and sustainable reforms. Recent work shows that strengthening institutional platforms dedicated to the use of evidence is a key factor in improving health decisions [7], whilst international initiatives highlight the growing role of global partnerships and mechanisms in promoting evidence-based policies [8]. International organisations emphasise the need to establish transparent, inclusive and evidence-based decision-making processes to strengthen the legitimacy of reforms [4, 9].

Nevertheless, despite this normative recognition, the effective use of evidence in health financing reforms remains uneven and often limited. Decisions are guided not only by scientific and operational evidence. They are also shaped by political, ideological, institutional, and contextual factors that influence how evidence is selected, interpreted, and used. [7]. Furthermore, the literature highlights that the legitimacy of health financing decisions also depends on compliance with criteria of procedural justice, including transparency, stakeholder participation and the fairness of decision-making processes [10]. The institutionalisation of evidence-based decision-making thus remains a major challenge, as demonstrated by recent studies on health prioritisation processes [11]. In many low- and middle-income countries, particularly in sub-Saharan Africa, constraints related to institutional capacity and stakeholder dynamics continue to limit its systematic integration [12]. Case studies on financing reforms, particularly in South Africa and Zambia, indicate that technical expertise and available data are not always utilised consistently due to the complexity of decision-making processes, the role of institutional actors and the political environment [13].

In the face of this complexity, conceptual frameworks and analytical theories play a central role in understanding how decisions are made and how evidence is utilised in reform processes. These frameworks enable the analysis of interactions between actors, institutions, contexts and processes, and the identification of the mechanisms through which evidence influences or fails to influence public policy decisions.

However, despite the abundance of research on health financing reforms, the literature remains fragmented with regard to the joint analysis of evidence use, the analytical frameworks employed, and comparative experiences across countries. This fragmentation limits our understanding of the actual dynamics of decision-making and the contextual factors that shape the integration of evidence into financing policies.

In this context, this study aims to fill this gap by providing a structured synthesis of the existing literature. Using a scoping review approach, it systematically examines: (i) the types of evidence used in health financing reforms, (ii) the conceptual frameworks and theories used to analyse these processes, (iii) international experiences of integrating evidence into reforms, and (iv) the contextual factors facilitating or limiting

the use of evidence in decision-making.

To complement this global analysis, a case study of Cameroon is presented to illustrate, in a real-world context, the dynamics of evidence use in health financing reforms. Cameroon is a particularly relevant case due to the recent reforms undertaken towards universal health coverage, in an environment marked by institutional, financial and political constraints. The lessons drawn from this analysis offer useful insights to inform health financing reforms, particularly in resource-constrained settings.

2. Methods

2.1. Type and Scope of the Study

This study is a scoping review. It maps international experiences of evidence use in health financing reforms and the conceptual frameworks used to analyze these processes. The Cameroon case was analysed alongside the scoping review through a targeted literature review. This provided contextual insight into how evidence is used in the design and implementation of reforms. The methodology adopted is based on the framework proposed by Arksey and O'Malley (2005) [14], expanded upon by Levac et al. (2010) [15]), which advocates a multi-stage approach:

1) Definition of the research question
2) Identification of relevant studies
3) Selection of studies
4) Data extraction and organization
5) Analysis, synthesis and presentation of results
6) Consultation with experts (where relevant)

The conduct and drafting of this review followed the recommendations of the PRISMA-ScR (Preferred Reporting Items for Systematic Reviews and Scoping Reviews) guidelines. A flowchart detailing the study selection process was developed to ensure the transparency and reproducibility of the approach [16].

2.2. Research Question

The review was guided by the following question: How is evidence used in health financing reforms across different international experiences, and how does this use manifest itself in the context of Cameroon?

More specifically:

1) What types of evidence are used in health financing reforms?
2) What conceptual and analytical frameworks are employed to analyse the use of this evidence?
3) What international experiences exist regarding evidence-based health financing reforms?
4) What factors facilitate or constrain the use of evidence in decision-making processes?
5) How is evidence used in health financing reforms in Cameroon?

2.3. Eligibility Criteria

2.3.1. Inclusion Criteria

1) Scientific articles published in peer-reviewed journals
2) Empirical studies (quantitative, qualitative or mixed-methods) or conceptual analyses
3) Publications explicitly addressing the process of designing, implementing or evaluating health financing policies in relation to the use of evidence
4) Articles examining the effects of evidence on the design, implementation or evaluation of reforms
5) Documents in English or French
6) Relevant grey literature (reports from international institutions, national policies, etc.).

2.3.2. Exclusion Criteria

1) Studies not directly addressing health financing reforms
2) Publications lacking usable data (editorials, commentaries, unsubstantiated expert opinions)
3) Articles for which the full text was not available
4) General theories or programme evaluation models unrelated to the analysis of the public policy process

2.4. Literature Review Strategy

We have developed a search strategy based on three dimensions:

1) Thematic focus: health financing reforms; Keywords: *"health financing", "health expenditure", "health insurance", "performance-based financing", "user-fee removal", "community-based insurance",* etc. (with corresponding French translations for French-language databases).
2) Process and policy change focus: Terms related to policy processes and governance: *policy, political, decision-making, reform, agenda-setting, implementation, evaluation, actors, institutions, governance, etc. (translated into French for French-language databases).*
3) Geographical focus: The research covered international experiences, with a particular focus on low- and middle-income countries.

The search was conducted in the following databases: PubMed, Web of Science, Scopus, MEDLINE, the Cochrane Library, the World Health Organisation (WHO) databases, those of the World Bank, as well as Google Scholar and Cairn.info for French-language literature. The period covered was 2000–2025, and only publications in English or French were included.

An iterative approach was used to develop the search strategy, which was subsequently adapted to each database.Terms were combined using Boolean operators (AND, OR) to optimise the sensitivity and specificity of the results.

For example, the query used in PubMed was as follows: *('health financing' [tiab] OR 'health insurance' [tiab] OR*

'health reform' [tiab] OR 'health system reform' [tiab] OR 'health expenditure' [tiab] OR 'health systems' [tiab]) AND ('evidence' [tiab] OR 'evidence-based' [tiab] OR 'evidence-informed' [tiab] OR 'data use' [tiab] OR 'research utilisation' [tiab] OR 'knowledge translation' [tiab]) AND ('policy' [tiab] OR 'public policy' [tiab] OR 'policy analysis' [tiab] OR 'decision making' [tiab] OR "governance" [tiab] OR 'policy process' [tiab] OR 'health policy' [tiab]).

An equivalent search query has been developed in French for French-language databases: *(«financement de la sante» OU «assurance sante» OU «reforme du système de sante» OU «depenses de sante» OU «systèmes de sante») ET («donnees probantes» OU «base sur les preuves» OU «fonde sur les preuves» OU «informe par les preuves» OU «utilisation des donnees» OU «utilisation de la recherche») ET («politique» OU «politiques publiques» OU «analyse des politiques» OU «prise de decision» OU «gouvernance» OU «processus decisionnel»).*

2.5. Study Selection Process

The selection of studies took place in several stages:

Deduplication of identified references

Screening of titles and abstracts against eligibility criteria

Reading the full text of potentially relevant articles

This selection was carried out independently by at least two reviewers. Disagreements were discussed and resolved by consensus or with the intervention of a third reviewer. A reference management tool was used to facilitate the selection process and ensure the traceability of decisions.

2.6. Analysis of the Cameroon Case

The Cameroon case was analysed as a descriptive case study based on a targeted literature review. The documents analysed included institutional reports, public policy documents and empirical studies.

The analysis drew on institutional capacity-building initiatives and pilot experiences that generated evidence. It also relied on analytical categories derived from the scoping review, including types of evidence, modes of use, and conceptual frameworks. This helped ensure consistency between the international analysis and the national case study.

2.7. Data Extraction

A standardised template was used to collect:

1) General information: author, year, country, affiliation
2) Type of study and methodology
3) Type of funding reform studied
4) Conceptual frameworks and theories employed
5) Type and source of evidence used
6) Key findings regarding the integration of evidence
7) Contextual factors influencing the use of evidence (institutional, political, economic, etc.)

Data extraction was carried out by one evaluator and verified by a second to ensure consistency and reliability.

2.8. Data Analysis and Synthesis

The data were analysed using a narrative and thematic approach, appropriate for scoping reviews. Initial coding was carried out inductively based on the extracted data, enabling the identification of emerging categories. These categories were then grouped into analytical themes aligned with the study's objectives.

The analytical process was iterative, involving a back-and-forth between the data and the analytical categories to ensure the consistency and validity of the classification.

The analysis identified:

1) A typology of the conceptual frameworks and theories employed
2) Geographical and contextual differences in the use of evidence
3) Links between types of evidence and the success of health financing reforms
4) Factors facilitating or limiting the integration of evidence into financing reforms

2.9. Expert Consultation

A consultation with experts was carried out to validate the methodology and initial findings. Participants included public health researchers, health economists and multi-sectoral policy-makers involved in health financing reforms in Cameroon. This consultation helped to enrich the interpretation of the findings and strengthen the external validity of the study.

2.10. Ethical Considerations

As this study is based exclusively on secondary data from the existing literature, no ethical approval was required. Consequently, there was no patient or public involvement in the study.

3. Results

3.1. Study Selection

Studies were identified using a structured search strategy combining the concepts of health financing, evidence-based practice and policy-making.

The study selection process was conducted in accordance with the recommendations of the PRISMA-ScR guidelines. A total of 559 records were identified across the various databases consulted. After removing duplicates, 482 unique articles were selected for the initial screening.

Titles and abstracts were screened against predefined inclusion criteria. Eligible studies focused on health financing or insurance systems, examined evidence use, and addressed decision-making processes or health policy development.

This stage led to the exclusion of 389 articles for the following main reasons:

1) Focus on strictly clinical or biomedical topics, unrelated to funding policies (e.g. therapeutic trials or pharmaceutical studies),
2) Lack of explicit reference to evidence in the decision-making process,
3) Or lack of connection to health reforms or policies.

At the end of this phase, 93 articles were selected for full-text evaluation.

The 93 selected articles were read in depth to assess their final eligibility. This stage aimed to verify:

1) The presence of an explicit analysis of the links between evidence and funding decisions,
2) The contribution to understanding health system reforms,
3) And analytical relevance in relation to the study's objectives.

During this phase, 71 articles were excluded for the following reasons:

1) Lack of in-depth analysis of decision-making processes,
2) Primarily descriptive content without an analytical framework,
3) Or a focus on peripheral themes (e.g. clinical interventions unrelated to funding).

At the end of this selection process, 28 studies were retained for the final qualitative synthesis. These studies demonstrate diversity in terms of: geographical contexts, types of health systems and methodological approaches. They provide a robust analytical basis for examining: the types of evidence utilised, the conceptual frameworks employed, international experiences, and the factors influencing their use in health financing policies.

The reduction from 559 identified records to 28 included studies reflects the specificity of the research question. Few studies simultaneously address health financing, evidence use, and decision-making processes.

3.2. Overview and Characteristics of the Included Studies

The 28 selected studies exhibit significant diversity in terms of publication period, geographical contexts, methodological approaches and the themes addressed.

Although many studies were initially identified, few met all inclusion criteria. This confirms that the field remains emerging and insufficiently structured.

3.2.1. Temporal Distribution of the Studies

The included studies cover the period from 2010 to 2025, with a notable concentration between 2016 and 2021. This temporal pattern highlights:

1) A gradual increase in scientific output on the use of evidence to guide health financing reforms,
2) A growing interest in issues related to universal health coverage (UHC) and insurance mechanisms,
3) An intensification of research in the context of health system reforms in low- and middle-income countries.

For example, several studies published after 2015 analyse health insurance system reforms and their link to evidence [17, 18]. More recent work also forms part of this trend, analysing the effects of reforms aimed at universal health coverage on health outcomes, particularly maternal health in low- and middle-income countries [2].

This trend suggests that, although there is a wealth of scientific output, studies explicitly integrating the dimensions of evidence use into financing reforms remain relatively recent and are still taking shape.

3.2.2. Coverage of Studies by Country and Income Group

The studies cover a variety of contexts, allowing for a comparative analysis of evidence integration practices.

1) Low- and middle-income countries (LMICs): the majority of studies concern sub-Saharan Africa and certain regions of Asia. In Africa, the influence of donors on financing policies is often documented, which may limit national ownership of the evidence [19]. Studies such as that by Kiendrebeogo et al. in 2021 highlight the importance of local solutions in the implementation of universal health coverage [20].
2) Middle-income countries (focus on China): Several studies focus on China, illustrating a context of rapid and structured reforms. This research highlights: the central role of governance, the growing use of empirical data to guide policy, and efforts to expand insurance coverage [17, 21, 22].
3) High-income countries: Studies conducted in high-income countries, particularly in the United States, offer a different perspective. They are characterised by a stronger institutionalisation of the use of evidence, but also by significant political constraints. Analysis of the reform of the US healthcare system shows that even in advanced contexts, decisions remain influenced by political factors [23].

The results show that low- and middle-income contexts are characterised by a strong influence from international partners and donors, which can affect how evidence is used. Conversely, high-income countries demonstrate a more advanced institutionalisation of evidence use, although decisions remain strongly influenced by internal political dynamics.

3.2.3. Types of Studies and Methodological Approaches

The included studies exhibit considerable methodological diversity, dominated by secondary data analysis approaches.

1) Systematic reviews and meta-analyses: A significant proportion of the studies are systematic reviews, which enable the synthesis of existing knowledge [24-26]. These studies play a key role in identifying factors influencing health policies.
2) Public policy analyses: Several studies directly analyse

decision-making processes and reforms [23, 27]. This work helps to understand the interactions between evidence and policy decisions.

3) Empirical studies (quantitative and qualitative): Some studies are based on empirical data. Quantitative analyses using databases and health indicators, and qualitative studies using interviews and institutional analyses. For example, Andoh-Adjei et al. (2018) use a mixed-methods approach to analyse retention in insurance systems [28].

This methodological diversity highlights the absence of a single approach to analysing the use of evidence in health financing reforms, and underscores the need for interdisciplinary approaches to capture the complexity of decision-making processes.

3.2.4. Main Themes of the Studies

The included studies address several central themes:

1) Health financing and health insurance,
2) Health system governance,
3) Health policy reforms,
4) Evidence use in decision-making,
5) Equity and access to care.

These themes are closely interconnected and align with the study's objectives.

3.2.5. Justifications for Studies and Health Financing Reforms

The studies included and the reforms analyzed are primarily motivated by objectives to improve access to care, strengthen financial protection for populations, and advance toward universal health coverage (UHC).

In low- and middle-income countries, these reforms particularly aim to reduce out-of-pocket payments and improve equity in access to health services.

Beyond health objectives, they also respond to imperatives of efficiency, financial sustainability, and improvement in the performance of health systems. In certain contexts, they are also influenced by national political dynamics, institutional priorities, and the agendas of technical and financial partners.

3.2.6. Indicators and Outcomes of Health Financing Reforms

The included studies use a variety of indicators to evaluate the effects of health financing reforms, including:

1) Access to health services,
2) Financial protection for households,
3) Quality of care and health outcomes,
4) Efficiency and performance of health systems,
5) Equity in access to health services.

Reforms generally improved access to care and financial protection. However, effects varied across settings and were sometimes limited for equity and quality of care, depending on implementation and the extent of evidence use.

3.3. Typology and Sources of Evidence Mobilized in Health Financing Reforms

The selected studies show that the use of evidence in health financing reforms is multi-dimensional, reflecting the complexity of health systems and public policies. The evidence mobilized can be classified into four main types:

1) Quantitative data from administrative databases and health information systems,
2) Systematic reviews, meta-analyses, and literature syntheses,
3) Qualitative data from field studies, interviews, and policy analyses,
4) Performance indicators and economic or epidemiological evaluations.

Overall, evidence use relies on multiple complementary sources. This reflects the multidimensional and context-specific nature of health financing decisions.

3.3.1. Quantitative Data and Administrative Databases

Quantitative data form the primary basis for decision-making in financing reforms. They mainly come from:

1) National health insurance databases [29],
2) Public health or hospital databases [30],
3) Coverage and health performance indicators [18].

These data are particularly useful for measuring: access to health services, population coverage, quality of care, and financial outcomes of insurance systems.

For example, a 2017 study demonstrated how data collection from rural insurance systems in China identified coverage gaps and allowed local policies to be adapted [17].

3.3.2. Scientific Syntheses and Literature Reviews

Systematic reviews and meta-analyses provide a global overview of intervention effectiveness, facilitate international comparisons, and identify best practices that can be locally adapted.

For example:

1) Dror et al. (2016) synthesized factors influencing voluntary enrollment in community-based health insurance in Africa and Asia [24].
2) Dwicaksono et al. (2018) evaluated the impact of decentralization on health system performance in several low- and middle-income countries [25].

These syntheses enable decision-makers to rely on a robust scientific corpus while reducing biases associated with isolated studies.

3.3.3. Qualitative Data and Policy Analyses

Qualitative studies provide an in-depth understanding of decision-making processes and the political context, often absent from quantitative data. They include:

1) Semi-structured interviews with policymakers,

managers, and healthcare providers [27],

2) Discourse and public policy analyses,

3) Field observations and case studies [19].

These data are essential for understanding institutional and cultural barriers, power dynamics, and the conditions for success or failure of reforms. Some studies specifically analyze health decision-making processes, particularly in hospital settings, highlighting the multiplicity of actors involved [6].

3.3.4. Performance Indicators and Economic Evaluations

Finally, the studies include impact measurements and economic evaluations that often combine quantitative data and statistical models.

These evaluations cover the cost-effectiveness of interventions, financial protection, and the efficiency of health coverage [18, 31].

They allow decision-makers to prioritize policies based on performance and cost-effectiveness criteria.

3.4. Modalities of Evidence Use in Health Financing Reform Processes

The included studies describe four main approaches to evidence use in financing reforms: instrumental, conceptual, strategic, and interactive/co-constructive. These categories reflect how policymakers mobilize evidence to guide or legitimize reforms. This classification aligns with approaches described in international guides for evidence-informed decision-making [9].

This demonstrates that evidence use is not limited to a technical application but is embedded in complex political, institutional, and social dynamics. It also confirms that evidence can be mobilized differently depending on the contexts and actors involved.

3.4.1. Instrumental Use of Evidence

Instrumental use refers to the direct application of evidence to guide the design, implementation, or adjustment of reforms. For example, a study in Rwanda showed that the results of a randomized impact evaluation were used to adjust financial incentive mechanisms in the health system [32]. Similarly, in China's rural health insurance system, data on coverage and service utilization enabled targeted policy adjustments [17].

This approach optimizes the relevance and operational effectiveness of reforms by directly linking evidence to concrete decisions.

3.4.2. Conceptual Use of Evidence

Conceptual use refers to the indirect application of evidence to structure problem understanding, guide debates, and influence policymakers' cognitive frameworks.

For instance, economic studies and burden-of-disease analyses have redefined financing priorities and guided policy choices toward universal coverage [33]. Systematic reviews show that this type of use is common in the early stages of reforms, during agenda-setting and strategy definition [34].

This approach informs decisions conceptually without imposing immediate action, enriching the decision-making framework.

3.4.3. Strategic or Symbolic Use of Evidence

Strategic (or symbolic) use involves mobilizing evidence to justify or legitimize pre-existing decisions or to support political positions.

Several studies report this type of use in sensitive reform contexts, particularly those involving changes in financing mechanisms or resource redistribution. In some sensitive African reforms, evidence was used to reinforce the credibility of already-decided actions rather than directly guiding them [35]. In the United States, some analyses were used to defend modifications to the Affordable Care Act (ACA) before Congress and stakeholders [36].

This approach highlights the political and symbolic role of evidence, complementing direct and conceptual uses.

3.4.4. Interactive Use and Co-construction of Evidence

Some studies describe an interactive and co-constructive use of evidence. This involves continuous exchanges between researchers, policymakers, and other stakeholders.

This type of use relies on the establishment of knowledge translation platforms, which adapt scientific data to the contextual needs of policymakers and promote local appropriation of results.

In sub-Saharan Africa, Fillol et al. (2020) show that these platforms facilitate the co-production of evidence and enable sustained dialogue between researchers and policymakers, making decisions more informed and contextually relevant [27].

Other international examples illustrate this interactive approach. For instance, in Ghana, the establishment of a national platform for evaluating health financing policies enabled government officials and researchers to co-construct recommendations for universal coverage [19].

These experiences demonstrate that interactive evidence use enhances the local relevance of policies and fosters better adoption of reforms. This approach promotes local ownership of data, sustainable adoption of reforms, and contextualization of recommendations.

3.5. Conceptual Frameworks and Theories Mobilized for Analyzing Evidence Use in Health Financing Reforms

The studies included in this review (n=28) employ a variety of conceptual frameworks and theories to analyze the processes of health financing reform and the integration of evidence. These frameworks primarily fall into two broad categories: (i) frameworks for analyzing public policies and (ii) frameworks for knowledge translation and evidence use.

The Walt and Gilson framework emerges as the most frequently used framework due to its ability to integrate the contextual, institutional, and political dimensions of health financing reforms.

However, the results show that these frameworks are often employed partially, without systematically linking theoretical dimensions to empirical data, which limits their explanatory capacity.

The studies included show an evolution in the theoretical frameworks used to analyze health financing processes, with increasing attention paid to the procedural dimension of decisions. Recent studies also highlight the importance of transparent and inclusive decision-making processes in health financing, considered essential for ensuring the legitimacy, accountability, and social acceptability of reforms [4].

Furthermore, equity issues are closely tied to principles of procedural justice in financing decisions. These principles include transparency in decision criteria, stakeholder participation, and the possibility of contesting or revising decisions, thereby strengthening the legitimacy of choices made within the framework of health financing reforms [10].

These analytical frameworks thus help to better understand not only the outcomes of reforms but also the quality of the decision-making processes underlying them.

3.5.1. Walt and Gilson Analytical Framework

The Walt and Gilson analytical framework (1994), frequently used in studies analyzing health policies, identifies four main dimensions: content, context, process, and actors [37].

1) Content: Characteristics of financing mechanisms, objectives pursued, and target populations.
2) Context: Institutional, socio-economic factors and the influence of international actors.
3) Process: Steps of formulation, adoption, and implementation of reforms.
4) Actors: Individuals and institutions involved, such as ministries, insurers, providers, civil society, and financial partners.

In the retained articles:

1) Yuan et al. (2017) used this framework to analyze the governance of the rural health insurance system in China, examining the role of actors and institutional context [17].
2) Gautier & Ridde (2017) applied the content-context-actors triangle to study financing policies in sub-Saharan Africa, identifying the influence of donors and local dynamics [19].
3) Kiendrebeogo et al. (2021) combined this framework with a logic model to examine universal coverage mechanisms in Benin, Namibia, and Uganda [20].

3.5.2. Adaptations and Extensions of the Walt and Gilson Framework

Several studies have enriched the Walt and Gilson framework to better capture the complexity of reforms:

1) Integration of Temporal Dynamics and Evolutionary Processes: The literature emphasizes the importance of observing changes over time and iterative interactions between actors, context, and content [38].
2) Articulation with Technical Dimensions of Financing: Kutzin (2013) proposes a framework structuring financing around three key functions (resource mobilization, risk pooling, and strategic purchasing) complementing the operational reading of the Walt and Gilson framework [33].
3) Political Economy Perspective: Savedoff et al. (2012) show that reforms toward universal coverage involve trade-offs and political resistance, necessitating the integration of this dimension into analyses [39].

3.5.3. Frameworks from Public Policy Analysis

Other frameworks from political science have been used to study reforms and evidence use:

1) Multiple Streams Model (Kingdon, 1984): Distinguishes the streams of problems, policies, and solutions. Used by Gautier & Ridde (2017) to identify moments of reform adoption [19].
2) Advocacy Coalition Framework (Sabatier & Jenkins-Smith, 1993): Analyzes interactions between groups of actors sharing common beliefs, applied in studies on community-based health insurance policies [24].

3.5.4. Knowledge Translation and Evidence Use Frameworks

Knowledge translation frameworks have been widely used to analyze how evidence influences decisions:

These frameworks are applied in studies on sub-Saharan Africa:

1) Tambo et al. (2016): Knowledge Translation Platforms facilitate the co-construction of evidence adapted to policymakers [40].
2) Fillol et al. (2020): Analyzes evidence use to inform public policies in African contexts [27].

3.5.5. Combinations and Modalities of Framework Use

The studies reveal a combined use of frameworks:

1) Governance + Knowledge Translation: To capture both political and technical dimensions [41].
2) Financing + Institutional/Governance: To analyze the implementation of reforms [28].
3) Some articles use frameworks only partially, such as Phillips et al. (2015), to evaluate the integration of technological innovation into health systems [42].

Table 1. Overview of empirical and conceptual studies on the use of evidence in health financing reforms, by country context, study design, and analytical framework.

Author (year)	Country / Region	Type of study	Conceptual / theoretical framework	Objective related to evidence
Yuan et al., 2017	China	Empirical study, qualitative	Walt & Gilson	Governance, integration of evidence
Velez et al., 2014	LMICs	Literature review	Policy & social change	Use of data for child survival
Tambo et al., 2016	Africa	Descriptive study	Knowledge Translation Platform	Knowledge translation
Mwisongo & Nabyonga-Orem, 2016	Africa	Scoping review	Governance & policy	Integration of evidence in global initiatives
Herrera et al., 2017	Low-income countries	Systematic review	Walt & Gilson	Governance and organization
Gautier & Ridde, 2017	Sub-Saharan Africa	Scoping review	Kingdon, Walt & Gilson	Adoption of reforms
Kiendrebeogo et al., 2021	Benin, Namibia, Uganda	Case study	Walt & Gilson + logic	UHC implementation
Odeyemi & Nixon, 2013	Nigeria, Ghana	Comparative review	Financial framework	Equity in health insurance
Fenny et al., 2021	Africa	Comparative analysis	Walt & Gilson + financing	SHI strategies
Dror et al., 2016	LMICs	Systematic review	Advocacy Coalition, Walt & Gilson	CBHI adoption
Andoh-Adjei et al., 2018	Ghana	Mixed study	Walt & Gilson	Impact of capitation payment
He, 2017	Hong Kong	Quantitative survey	Financial framework	Voluntary private insurance
Liu et al., 2017	China	Systematic review	Walt & Gilson	Health reforms
Obama, 2016	USA	Review	Kingdon	ACA reform
French et al., 2016	USA	Review	Kingdon, Walt & Gilson	ACA analysis
Dwicaksono & Fox, 2018	LMICs	Systematic review	Financial framework + governance	Decentralization and performance
Contreary et al., 2017	USA	Narrative review	Evidence-based practice	Use at point of care
Phillips & Merrill, 2015	USA	Integrative review	Innovation / knowledge translation	Technological transformation
Mues et al., 2017	USA	Database study	Knowledge translation	Use of Medicare data
Fillol et al., 2020	Africa	Documentary analysis	Knowledge translation	Policy and evidence
Ansu-Mensah et al., 2021	Sub-Saharan Africa	Scoping review	Governance & policy	Quality of maternal care
Amimo et al., 2021	Africa	Review	Financing & access frameworks	COVID-19 and UHC
Aden et al., 2025	LMICs	Scoping review	UHC + system reform	Maternal health outcomes and UHC
Shirjang et al., 2025	Global	Scoping review	PHC reforms	Primary health care reforms
Zomorrodi et al., 2024	Global	Scoping review + meta-synthesis	Hospital governance	Decision-making process in hospitals
World Bank, 2023	Global	Institutional report	Fair financing / UHC	Equitable financing processes
PAHO, 2022	Global	Technical guide	Evidence-informed	Evidence-based decision-

Author (year)	Country / Region	Type of study	Conceptual / theoretical framework	Objective related to evidence
			decision-making	making
Dale et al., 2023	Global	Scoping review	Procedural fairness	Procedural justice in health financing

3.6. International Experiences in Integrating Evidence into Health Financing Reforms

The analysis of the 28 articles included in this review highlights several international experiences where evidence integration has been a central element of health financing reforms. These experiences span different economic and institutional contexts, including high-income countries (USA), middle-income countries (Mexico, Ghana, Benin), and low-income countries (sub-Saharan Africa).

The results show that countries with formalized institutional mechanisms, such as knowledge translation platforms or policy evaluation systems, exhibit more systematic, structured, and sustainable use of evidence.

Conversely, in contexts where these mechanisms are underdeveloped, evidence use appears more fragmented, often opportunistic, and strongly influenced by political or external factors.

The experiments can be classified according to three main axes:

1) Reforms based on health insurance and universal coverage
2) Innovative financing policies and technical adjustments
3) Platforms and institutional mechanisms to promote the use of evidence

3.6.1. Reforms Based on Health Insurance and Universal Coverage

Several articles illustrate how evidence has been used to design and adapt health insurance systems:

1) United States: Patient Protection and Affordable Care Act (ACA). The adoption of the ACA was guided by quantitative and comparative analyses of existing systems, integrating data on access to care, costs, and coverage [23, 43]. Evidence supported the calibration of Medicaid expansion mechanisms and subsidies for insurance markets, illustrating a direct integration of evidence into the reform's design.
2) China: Rural Health Insurance Reform. Yuan et al. (2017) demonstrated that governance and financing decisions were adjusted based on data on service utilization, coverage gaps, and feedback from local managers [17]. Policies included incentive payment mechanisms, with adjustments informed by the analysis of local evidence.
3) Sub-Saharan Africa: Community-Based Health Insurance (CBHI) and Social Insurance Programs. Fenny et al. (2021) and Dror et al. (2016) emphasized the importance of using evidence to identify barriers to enrollment and to design subsidy mechanisms tailored to local contexts [18, 24]. The results show that evidence integration improved the design of premiums, population awareness, and member retention.

3.6.2. Innovative Financing Policies and Technical Adjustments

Health financing reforms often integrate technical elements based on empirical evidence:

1) Performance-Based Financing (PBF): Andoh-Adjei et al. (2018) evaluated capitation payments in Ghana, integrating data on member retention and provider performance [28]. Evidence analysis guided adjustments to incentives and monitoring mechanisms.
2) Cost-Effectiveness Analysis and Targeted Interventions: Pandey et al. (2021) demonstrated that economic data guided resource allocation for targeted treatments in intermediate health systems [44]. Evidence integration enabled prioritization of interventions with high health and economic impact.

3.6.3. Platforms and Institutional Mechanisms Supporting Evidence Use

Certain experiences highlight the use of formal platforms to facilitate evidence integration:

1) Knowledge Translation Platforms (KTPs) in Sub-Saharan Africa: Tambo et al. (2016): These platforms support the co-production of evidence tailored to policymakers and facilitate evidence flow between researchers and policymakers [40].
2) Observatories and National Databases: Mues et al. (2017): The Medicare database was used to guide financing policies and resource allocation for elderly populations [30].
3) Systematic Integration into Governance: Fillol et al. (2020) and Ansu-Mensah et al. (2021) describe how systematic evidence use in advisory councils and steering committees influences reform implementation [27, 45].

These experiences demonstrate that successful evidence integration depends as much on the quality of the evidence as on institutional structures, coordination platforms, and stakeholder participation.

3.6.4. Specific Experiences in Sub-Saharan Africa

African countries face particular challenges in using evidence, but several innovative initiatives deserve documentation:

1) Cameroon and Uganda: Knowledge Translation Platforms (KTPs) such as EVIPNet Cameroon and REACH-PI Uganda have been established to bridge research and policy, produce knowledge briefs, and organize policy dialogues based on evidence syntheses tailored to policymakers' needs [46].
2) Ghana: The integration of evidence into health financing reforms, particularly the national health insurance scheme, was supported by quasi-experimental impact evaluations measuring the effects of reforms on health outcomes. These evaluations informed adjustments to technical mechanisms and national priorities [47].
3) Rwanda: Performance-based financing (PBF) programs were developed and adjusted based on rigorous evaluations showing measurable results in maternal and child health, which reinforced the continued adoption of these reforms in national planning [32].

3.6.5. Specific Experiences in High-income Countries

High-income countries have often relied on evidence-informed decision-making processes to guide complex financing reforms, leveraging economic analyses, impact evaluations, and robust institutional frameworks:

1) United States: The adoption and adjustment of the Patient Protection and Affordable Care Act (ACA) heavily relied on evidence from comparative analyses of costs, access to care, and health expenditure projections. These elements guided both the design of the reform and subsequent modifications to expand coverage, reduce catastrophic expenses, and improve access to health services [36].
2) International Analysis: A review of recent reforms in 31 high-income countries shows that governments increasingly rely on evidence to structure reforms around four priority areas: expanding insurance coverage, renewing payment mechanisms, strengthening governance, and restructuring hospital care. This systematic use of evidence (through comparative analysis and consultation with national experts) illustrates the evolving integration of evidence into decision-making in developed countries [36].
3) Economic Evaluations: In many developed countries, formal economic evaluation mechanisms (cost-effectiveness evaluations, prospective modeling) are systematically used to revise financing policies, particularly in public expenditure allocation and technical decision-making processes within health insurance agencies [48].

3.6.6. Middle-income Countries

Middle-income countries have also made notable progress in integrating evidence into financing reforms, particularly in advancing universal health coverage (UHC) and optimizing financing mechanisms:

1) China: China represents a major example where health financing reform has been supported by empirical evaluations to improve equity and financial protection. Recent studies show that reforms in health insurance and payment adjustments (including the introduction or expansion of systems like diagnosis-related groups) influence equity and household expenses, providing evidence to guide national policies [49]. Comparative evidence from East Asia further indicates that well-designed pooling and subsidization mechanisms can significantly enhance financial protection for low-income populations, highlighting the importance of targeted equity-oriented reforms in middle-income countries (Zhang et al., 2025).
2) Other Middle-Income Countries (e.g., Indonesia, Turkey): Research on financing mechanisms in middle-income countries highlights that resource pooling and fund-merging approaches have been considered or implemented based on evidence from comparative analyses and impact studies to improve access and resource redistribution [50].

Across the various reported experiences, the studies describe several modalities of evidence use in health financing reforms:

1) Use of economic evaluations to inform coverage decisions,
2) Reliance on impact studies to adjust financing mechanisms,
3) Mobilization of administrative data and surveys to guide reforms,
4) Establishment of knowledge translation platforms to facilitate evidence use.

Some studies also report that multiple types of evidence are combined within a single reform process.

3.7. Factors Facilitating or Limiting the Use of Evidence in Health Financing Decisions

The analysis of the articles included in this review reveals that the integration of evidence into health financing decisions is influenced by a set of institutional, organizational, political, and individual factors. These factors can be categorized as facilitators and barriers, often interconnected and dependent on the national or institutional context.

3.7.1. Facilitating Factors

Governance and political leadership

Strong political leadership and transparent governance structures promote the integration of evidence. Rural health financing reforms in China illustrate that policymakers who actively use evidence to adjust financing mechanisms improve the efficiency and equity of health systems [17].

In sub-Saharan Africa, Knowledge Translation Platforms in

Cameroon and Uganda facilitate the research–policy interface, enabling decision-makers to access rapid syntheses tailored to local contexts [46].

Organizational capacity and technical resources

Access to reliable databases, robust health information systems, and qualified research teams enhances both the production and use of evidence. For example, Ghana's national health insurance system was preceded by pilot studies that allowed adjustments to local contexts and improved access to care [51].

Partnerships and networks

Collaboration between universities, research centers, and government institutions strengthens evidence use. Rwanda, following the genocide, established rigorous monitoring and evaluation mechanisms to continuously adjust reforms, particularly performance-based financing [32].

Decision-support frameworks and tools

The availability of analytical frameworks and synthetic tools (policy briefs, guidelines, economic evaluations) facilitates the translation of data into practical recommendations. The experience of the Affordable Care Act in the United States showed that policy briefs and cost–benefit analyses are essential for guiding implementation and reform adjustments [23].

3.7.2. Limiting Factors

Political and economic constraints

Reforms are often hindered by conflicts of interest, political pressures, or budget constraints. In sub-Saharan Africa, dependence on donors may reduce national autonomy and limit the local use of evidence [19].

Insufficient institutional capacity

A lack of trained personnel or adequate IT infrastructure limits the systematic use of evidence [18].

Data communication and interpretation

Even when data are available, inadequate dissemination or overly technical language may hinder their uptake [52].

Cultural conflicts and perceptions of evidence

Decision-makers may prioritize political experience or social pressure over evidence. This dynamic is observed in some African contexts, where the perceived legitimacy of data influences their adoption [41].

3.8. Cameroon's Experience in the Use of Evidence in Health Financing Reforms

Several health financing reforms have been implemented in Cameroon in recent years, including performance-based financing (PBF), demand-side financing mechanisms such as health vouchers, interventions aimed at reducing user fees, and initiatives related to Universal Health Coverage (UHC). These reforms have often been introduced through pilot phases accompanied by data collection and analysis systems.

These pilot phases have generated operational evidence derived from health information systems, impact evaluations, qualitative and quantitative surveys, and administrative reports, which have been used to document intervention effects and inform decisions regarding scale-up.

3.8.1. Types of Evidence Used in Health Financing Reforms in Cameroon

In Cameroon, evidence is primarily operational, produced in pilot contexts, and complements quantitative data with qualitative insights. The evidence generated during pilot phases can be grouped into several categories:

Routine data and health information systems

Health facilities routinely produce data on activities such as consultations, deliveries, vaccination services, and family planning. These data are collected through national health information systems and are used for both monitoring interventions and verifying results in performance-based financing mechanisms (PBF) [53]. They constitute the main source for tracking short-term operational effects.

Impact evaluation data

Some reforms have been accompanied by impact evaluations using experimental or quasi-experimental approaches. In the case of PBF, a randomized impact evaluation was conducted with data collected from households, health facilities, and communities. These data help measure the effects of interventions on service utilization, quality of care, and health expenditures [54], and serve as a basis for validating interventions prior to scale-up.

Programmatic and administrative data from pilot experiences

Health financing programs also generate administrative data, including:

1) Financial data (payments, subsidies),
2) Program management data,
3) Implementation reports.

These data ensure operational monitoring and document management mechanisms at different levels.

Qualitative data and field surveys

Collected through:

1) Interviews with healthcare providers,
2) Discussions with beneficiaries,
3) Field observations.

These data provide insights into implementation processes, stakeholder perceptions, and operational constraints [55].

3.8.2. Pilot Phases, Evidence Generation, and Scale-up of Reforms

Performance-Based Financing (PBF)

PBF was introduced in Cameroon through pilot phases implemented in several health districts before scaling up. These phases were accompanied by structured data collection systems including:

1) Baseline and follow-up household surveys,
2) Health facility surveys,
3) Routine data,

4) Data verification mechanisms.

A randomized impact evaluation was conducted between 2012 and 2015 using a four-arm design (PBF, unconditional financing, enhanced supervision, control group) [54].

Findings from these pilot phases documented:

1) Increased utilization of certain services (particularly vaccination and family planning),
2) Improved availability of inputs and equipment,
3) Reduced out-of-pocket payments in some facilities.

These data were used to:

1) Compare the effects of different financing modalities,
2) Document implementation mechanisms,
3) Guide scale-up strategies.

Health Voucher Scheme (Demand-Side Financing)

The health voucher scheme is a prepayment mechanism implemented in the Northern, Adamawa, and Far North regions to reduce financial barriers to maternal and neonatal care, with support from partners including GIZ and the French Development Agency [56].

Evidence from the pilot phase includes surveys among beneficiaries and non-beneficiaries, as well as operational data from accredited health facilities, used to assess maternal health service utilization [57].

Empirical analyses showed mixed effects on antenatal care and assisted deliveries, highlighting implementation challenges [58]. Additional studies indicate increased access to obstetric care and reduced neonatal mortality in some pilot areas [59]. These findings informed decisions regarding program scale-up.

Reduction of User Fees for HIV Services

In Cameroon, HIV-related services (including testing, antiretroviral treatment (ART), laboratory monitoring, and prevention of mother-to-child transmission (PMTCT)) have undergone progressive reductions in user fees, supported by partners such as the Global Fund and PEPFAR.

Implemented approaches include:

1) Free provision of ART [60],
2) Subsidization of laboratory tests (CD4, viral load),
3) Financial compensation mechanisms for health facilities,
4) Equity incentives integrated into some PBF schemes.

Data collected include:

1) Remaining out-of-pocket expenditures for people living with HIV,
2) Trends in service costs,
3) Access to testing, treatment, and follow-up,
4) ART initiation and retention rates.

Findings show that user fees remain a significant barrier even in subsidized contexts [61]. Reducing these fees has led to:

1) Increased ART access,
2) Improved retention in care,
3) Reduced financial barriers, though with contextual variations.

Despite free ART, residual costs (transport, additional tests) persist. These data have been used to adjust policies, identify residual costs, and inform sustainable financing strategies, particularly within the UHC framework.

Universal Health Coverage (UHC)

The progressive implementation of UHC in Cameroon relies on evidence generated from multiple health financing reforms, including PBF, voucher schemes, user fee reductions, and disease-specific programs such as HIV.

Data sources include:

1) Routine health information systems (service utilization, coverage),
2) PBF program data (service volume, quality, provider payments),
3) Impact evaluations and program analyses,
4) Financial and economic data (costs, subsidies, out-of-pocket spending),
5) Disease-specific data systems (e.g., HIV testing, treatment, retention).

These data inform key UHC dimensions:

1) Definition of essential service packages,
2) Cost estimation and financing design,
3) Identification of financial barriers,
4) Development of strategic purchasing mechanisms,
5) Testing and comparison of financing models,
6) Planning for financial sustainability and transition from donor funding.

Cameroon's experience shows that UHC implementation relies on the combined use of operational evidence generated across multiple reforms. These data contribute to:

1) Structuring health financing policies,
2) Guiding strategic decisions,
3) Improving resource allocation,
4) Reducing financial barriers to care,
5) Supporting the progressive scale-up of UHC.

4. Discussion

This section contextualizes the main findings within the broader scientific and operational landscape. It draws on studies from different countries, income levels, and health systems. This diversity enables a comparative understanding of health financing reform dynamics. This heterogeneity helps shed light on the implementation dynamics of health financing reforms and the conditions under which evidence is mobilized. Recent post-COVID-19 literature reinforces these findings. It shows that the pandemic disrupted health financing systems, increased out-of-pocket spending, and accelerated emergency and adaptive financing mechanisms in both low- and high-income countries [62, 63]. These studies highlight that resilience and flexibility of financing systems have become central analytical dimensions in the post-pandemic era.

This convergence toward more integrated health systems is also reflected in recent literature. However, the literature does not present a fully homogeneous convergence: some studies emphasize the technical effects of reforms, while others highlight the decisive role of institutional and political factors in the effective implementation of health financing policies [2, 3].

For example, reforms aimed at universal health coverage (UHC) show overall positive results on health indicators, but their effectiveness is highly dependent on governance capacities and resource allocation mechanisms within health systems [2]. Complementarily, primary healthcare reforms emerge as a major structural lever, but their impact is conditioned by the effective integration of evidence into national decision-making cycles [3].

The discussion also considers the methodological approaches used in the included studies. These combine quantitative, qualitative, and review methods. This diversity reflects the complexity of health financing reforms and the need for multiple sources of evidence. This methodological diversity enriches the understanding of the mechanisms through which evidence is used in health policies, while also highlighting a significant tension in the literature: quantitative approaches enable the measurement of policy effects, while qualitative approaches reveal the underlying mechanisms of decision-making and power, often invisible in purely statistical analyses.

The results show that the use of evidence in health financing decision-making processes is far from linear. It is rather the result of an interactive and political process, in which scientific data are filtered, interpreted, and sometimes reappropriated by institutional actors according to their interests, constraints, and room for maneuver [6].

Finally, this section highlights the main implications of the findings for improving health financing and advancing toward universal health coverage (UHC). It specifically analyzes how evidence is used in decision-making processes, the factors that facilitate or limit its integration, and its potential contribution to more effective, equitable, and resilient health systems.

The findings of this review align with recent literature on health financing reforms and the mobilization of evidence in health systems. Recent studies indeed show a convergence toward an integrated approach combining universal health coverage, strengthening primary healthcare, improving governance, and using evidence in decision-making processes [2-4]. Recent scoping evidence also confirms that health financing reforms increasingly combine governance transformation, equity objectives, and evidence-informed decision-making [64].

4.1. Mobilization and Role of Evidence in Health Financing Reforms

The analysis of the selected studies highlights that the use of evidence in health financing reforms is not limited to a simple technical transfer of information to decision-makers. It is rather embedded within a complex negotiation space between data producers, political decision-makers, and technical institutions, which explains the significant variations in the actual use of evidence across national contexts. On the contrary, data are mobilized within complex configurations, reflecting both scientific imperatives, institutional constraints, and political dynamics specific to national contexts.

This observation is consistent with previous studies. They show that the use of evidence in public health decisions depends more on perceived relevance, organizational structures, and power relations than on simple data availability. [65]. While this review includes evidence from countries such as the United States and China, these cases are not used for direct economic comparison but rather as “system-level benchmarks” to illustrate how institutional maturity, governance structures, and data infrastructure shape the integration of evidence into financing decisions. Similar comparative logics are widely used in health systems research to contrast institutional pathways rather than economic size per se. Decision-making dynamics are also strongly influenced by actor interactions and complex organizational structures, particularly at the hospital level, where decisions are both technical and political [6]. Recent analyses further reinforce this perspective by showing that health financing systems operate as politically embedded structures where technical evidence interacts with institutional and governance constraints, shaping reform trajectories across countries [66]. Furthermore, recent European evidence (e.g. reforms in France, Germany, and the United Kingdom) demonstrates similar post-COVID trends toward strengthened strategic purchasing, increased public spending on health, and reinforced use of economic evaluation in coverage decisions, highlighting that evidence-informed financing is a shared global trajectory across diverse welfare regimes [67].

The diversity of data sources (quantitative, qualitative, and synthetic) shows that evidence cannot be reduced to a single type. Quantitative data from health information systems and administrative registers are useful for measuring coverage, access, and service performance. However, they are insufficient on their own to explain policy trajectories. However, their interpretation remains strongly dependent on the political and institutional frameworks within which they are produced and used. This limitation is also reflected in empirical evidence showing that variations in health expenditure levels and structures are closely associated with differences in health system performance, highlighting those financial inputs alone do not automatically translate into improved outcomes without effective governance and allocation mechanisms [68]. As shown by Campbell et al. in 2018, taking into account socio-political contexts and interactions between actors is necessary to understand why some data are considered and others are not; a piece of data may be scientifically robust but politically inoperative if it does not correspond to the local decision-making agenda [69]. This is particularly evident in contexts of fiscal pressure or crisis, where decision-making becomes increasingly shaped by political economy dynamics, including negotiations between actors, institutional resilience, and competing priorities [70].

Qualitative data from interviews, policy analyses, and field studies complement quantitative evidence. They help explain institutional dynamics, stakeholder perceptions, and organizational or cultural constraints. They notably reveal that financing decisions are often influenced more by institutional

compromises than by strictly technical evidence. These elements are often decisive in explaining why certain data are integrated while others are ignored. Kumar et al. (2020) confirm that decision-makers favor contextualized evidence interpreted according to national priorities, highlighting the importance of adapting evidence to the local context in order to maximize its use and relevance in financing decisions [12]. Recent scoping evidence further supports this view, indicating that evidence use in health financing reforms is increasingly embedded in multi-level governance systems where contextual adaptation and institutional negotiation determine policy outcomes [71]. In this context, requirements of transparency and inclusiveness appear as essential determinants of the quality of decision-making processes, but their implementation remains uneven across countries and levels of governance [4].

Scientific syntheses, meta-analyses, and literature reviews constitute another level of evidence. They make it possible to situate national experiences within a global knowledge framework and to identify recurrent patterns or general lessons. However, this structuring does not automatically guarantee equitable decisions, as equity issues remain deeply linked to principles of procedural justice such as participation, accountability, and transparency [10].

However, these syntheses remain largely consultative and conceptual, providing academic legitimacy to decisions, without necessarily guaranteeing their operational adoption if local constraints are not simultaneously taken into account. A systematic review on the role of scientific knowledge in health policies recalls that "the quality of evidence is not in itself sufficient to guarantee its impact on decisions" and that institutional mechanisms promoting interaction between researchers and decision-makers are indispensable [34]. Lavis et al. (2006) emphasize that for systematic reviews to be truly usable by health managers and decision-makers, it is necessary to adapt syntheses to local priorities and contextual constraints, by providing clear messages, practical recommendations, and accessible interpretation tools [72]. In addition, recent international evidence highlights that when systematically synthesized and aligned with policy priorities, evidence can directly inform the design of financial protection mechanisms, particularly for vulnerable populations in low- and middle-income countries [73].

The interaction between these forms of evidence reflects broader knowledge translation dynamics. Scientific data do not move linearly into decision-making. They are transformed, interpreted, and negotiated within political and institutional settings. This dynamic is particularly relevant in contexts where fragmented health financing systems require coordinated policy responses, as illustrated by recent analyses of health system reforms in complex governance environments [66]. Furthermore, recommendations from international organizations emphasize that high-performing health systems are those that succeed in articulating evidence-based decision-making and inclusive governance, particularly in resource-limited contexts [9]. This process is illustrated in cases where knowledge translation platforms have been established, particularly in sub-Saharan Africa, facilitating the adaptation of research results to local policy needs [27].

In summary, beyond the mere availability of data, the effectiveness of their mobilization depends on the capacity of institutions to interpret them, to translate them into formats usable by decision-makers, and to build cognitive bridges between science and policy.

4.2. Conceptual and Theoretical Frameworks Mobilized for the Analysis of the Use of Evidence in Health Financing Reforms

The analysis of the results shows that the integration of evidence into health financing reforms cannot be fully understood without taking into account the conceptual and theoretical frameworks mobilized. These frameworks make it possible to explain differences in the instrumental, conceptual, and symbolic use of evidence, as well as the variations observed according to geographical, institutional, and political contexts.

4.2.1. The Health Policy Triangle (Walt & Gilson, 1994)

The model of Walt & Gilson, encompassing actors, processes, content, and context, provides an analytical method to understand why certain evidence is incorporated into reforms while others are set aside.

In the case of reforms based on health insurance in sub-Saharan Africa, the framework makes it possible to understand the combined influence of donors, ministries, and local providers on the prioritization of evidence [19].

It also explains the impact of the institutional context on the translation of quantitative and qualitative data into policy decisions: for example, in rural financing systems in China, decisions to adjust insurance mechanisms were strongly dependent on local governance structures and data collection capacities [17].

Thus, the Walt & Gilson triangle makes it possible to interpret results related to institutional barriers and variations in the adoption of evidence, by linking the characteristics of actors and the decision-making process to the actual use of data.

4.2.2. Mid-range Theories and Political Science

Mid-range theories such as Kingdon's Multiple Streams Theory (MST, 1984) and the Advocacy Coalition Framework (ACF) of Sabatier and Jenkins-Smith (1993) shed light on the results concerning the selectivity of evidence and the facilitating or limiting factors.

1) The MST makes it possible to explain why certain reforms, such as performance-based financing (PBF) programs in Rwanda, were adopted rapidly: the convergence of a health crisis, financial solutions, and favorable decision-makers created a window of opportunity to mobilize evidence [74].

2) The ACF, by analyzing coalitions of actors sharing common beliefs, helps to understand why certain quantitative evidence or economic evaluations are used in an instrumental manner, while others, considered less of a priority or politically sensitive, are ignored [24].

These theories also illustrate that dependence on donors and political pressures may limit the local appropriation of evidence, as observed in certain reforms in sub-Saharan Africa [19].

4.2.3. Theoretical Bricolage

Theoretical bricolage in the analysis of health policies refers to the combined and adaptive use of several conceptual frameworks and theories in order to apprehend complex systems and multidimensional reform processes. This approach is particularly relevant for analyzing health financing reforms in low- and middle-income countries, where the dynamics between political, institutional, and technical actors are often non-linear and interdependent.

The studies examined show that the bricolage approach allows researchers to go beyond the limits of a single framework by combining frameworks from different disciplines in order to better capture the multiple dimensions of policy change. For example, several policy publications have jointly applied models specific to political science such as Kingdon's Multiple Streams Theory and the political economy framework of reforms by Grindle and Thomas, as well as models specific to health systems such as the Walt & Gilson Health Policy Triangle. These combinations facilitate the analysis of institutional structures, actor interactions, and mechanisms of change in financing reforms [75].

Theoretical bricolage is not a disordered juxtaposition of frameworks; it implies methodological reflection on the limits and complementarities of each approach. It makes it possible to adapt analytical frameworks to different levels of analysis (national, regional, local) and to different stages of the policy cycle, while taking into account contextual constraints. This flexibility is essential to understand why certain reforms succeed in translating evidence into concrete decisions, while others fail or remain incomplete.

4.2.4. Knowledge Translation Frameworks

Knowledge translation (KT) frameworks constitute essential tools for understanding how scientific evidence is transformed, adapted, and applied in health policy decisions. Contrary to purely instrumental approaches, KT emphasizes the contextualization of knowledge, its interpretation by decision-makers, and the co-construction of evidence between researchers and policy actors.

Foundational literature such as Graham et al. (2006) proposes the Knowledge-to-Action model, which describes a stepwise process: knowledge production, adaptation to the local context, targeted dissemination, evaluation, and feedback. This model makes it possible to understand why certain quantitative or qualitative evidence is integrated into decision-making and others are not. Lavis et al. (2006) confirm that decision-makers favor contextualized evidence interpreted in light of national priorities, which highlights the importance of local adaptation of evidence [72].

In practice, these frameworks have been applied through the establishment of Knowledge Translation Platforms (KTPs) in sub-Saharan Africa, such as EVIPNet Cameroon or REACH-PI Uganda [46]. These platforms facilitate dialogue between researchers and decision-makers, translate scientific evidence into operational recommendations, and strengthen the local appropriation of reforms. They also make it possible to identify institutional and cultural obstacles to the integration of evidence, by adjusting messages to political priorities and contextual constraints.

KT frameworks are not limited to dissemination; they support the co-construction of evidence, where decision-makers and researchers collaborate from the design of studies, the selection of indicators, and the interpretation of results.

Thus, knowledge translation emerges as a key mechanism for transforming scientific evidence into effective policy decisions, ensuring that recommendations are not only based on robust data but also adapted to the institutional, cultural, and political context.

4.3. International Experiences in the Integration of Evidence in Health Financing Reforms

The integration of evidence into health financing reforms across different international contexts reveals the importance of contextual adaptation, institutional structures, and governance to translate scientific evidence into effective policies. Documented experiences show that the simple availability of quantitative or qualitative data is not sufficient to guarantee a successful reform; appropriation by political and institutional actors constitutes a determining factor. Post-pandemic analyses across OECD and European health systems show a marked increase in health expenditure, fiscal pressure on public financing systems, and renewed emphasis on evidence-informed priority setting, particularly in contexts such as France, Germany, and the United Kingdom, where cost-effectiveness and burden-of-disease evidence increasingly guide reimbursement and coverage decisions [67].

In high-income countries, such as the United States, the adoption and adjustment of the Patient Protection and Affordable Care Act (ACA) largely relied on empirical data derived from comparative analyses of costs, coverage, and access to care. The integration of economic evaluations, combined with prospective simulations, made it possible to calibrate subsidy mechanisms and the expansion of Medicaid, illustrating an instrumental use of evidence to guide concrete decisions [43]. These experiences highlight that the institutionalization of evidence, through specialized agencies and advisory committees, facilitates the translation of data into financing decisions.

In middle-income countries, China illustrates how governance and administrative data can be integrated to guide

reforms. The systematic use of rural insurance databases made it possible to identify coverage gaps and to adjust financial incentives to improve access and equity [17]. These experiences show that the articulation between empirical data, economic analysis, and institutional feedback is crucial to adapt policies to complex environments.

In sub-Saharan Africa, several initiatives have demonstrated the effectiveness of formal knowledge translation platforms (Knowledge Translation Platforms). Projects such as EVIPNet Cameroon and REACH-PI Uganda have made it possible to produce synthesis briefs and to organize interactive policy dialogues, promoting the local appropriation of evidence by decision-makers [27, 40]. These platforms facilitate the translation of complex information derived from systematic reviews, economic evaluations, or qualitative data into concrete recommendations adapted to the institutional and socio-political context.

The analysis of international experiences highlights several key lessons:

Contextual adaptation is essential: evidence must be contextualized to take into account local constraints, political priorities, and institutional dynamics [19, 20].

Governance and leadership influence the integration of evidence: in all contexts, transparent governance structures and committed political leadership promote the instrumental and conceptual use of data [17, 28].

Collaborative mechanisms strengthen the adoption of evidence: the integration of interactive platforms, researcher–decision-maker dialogues, and co-construction of recommendations contributes to reducing the gap between scientific evidence and political decision-making [27, 40].

Economic and impact evaluations strengthen the legitimacy of decisions: the use of cost-effectiveness analyses, performance indicators, and statistical models provides a common language for decision-makers and technical actors, facilitating the prioritization and justification of reforms [28, 44].

However, these experiences also highlight potential limitations: dependence on external donors, insufficient local capacity to interpret data, and political or cultural conflicts may restrict the appropriation and impact of evidence.

The analysis of international experiences demonstrates that the effectiveness of the use of evidence depends on the combination of the quality of evidence, appropriate institutional structures, and political commitment. This combination makes it possible to transform data into operational decisions, promoting more equitable, efficient, and context-adapted financing reforms. The inclusion of high-income countries such as the United States and China is not intended to suggest economic comparability with Cameroon, but rather to identify transferable governance and institutional mechanisms for evidence use. Health systems literature increasingly supports such "functional comparison approaches", where systems are compared based on decision-making architecture, financing tools, and evidence integration capacity rather than GDP level.

4.4. Factors Affecting the Use of Evidence in Health Financing Decisions

The integration of evidence into health financing decisions does not reduce to the simple availability of information; it is conditioned by a complex set of institutional, organizational, political, and cultural factors that interact to affect the adoption of evidence. Political leadership and governance play a central role: when decision-makers actively engage in the interpretation and use of data, this strengthens the coherence and legitimacy of reforms, as shown by Yuan et al. [17] in the rural insurance system in China and Gautier & Ridde (2017) in sub-Saharan Africa, where the involvement of political actors promoted the alignment of national priorities with scientific evidence [19]. Transparent institutional structures and knowledge translation platforms (Knowledge Translation Platforms) also facilitate the circulation and appropriation of data, reducing the risks of misinterpretation and promoting a conceptual and instrumental use of evidence.

Organizational and technical capacities constitute a second determining factor. Access to reliable databases, robust health information systems, and qualified research teams makes it possible to produce and interpret data in the local context, as observed in Ghana's health insurance system, where pilot studies made it possible to adapt financing mechanisms to local realities and to improve access to care [28]. Furthermore, the availability of structured analytical frameworks such as the Walt & Gilson policy triangle, policy briefs, and economic evaluation syntheses enhances the translation of complex evidence into operational decision-oriented guidance, thereby establishing a common analytical language that bridges technical rigor and political considerations in health policy processes [27, 72].

Partnerships and institutional networks represent a third factor facilitating the use of evidence. Collaborations between government institutions, research centers, and international partners strengthen the legitimacy of evidence and enable the co-construction of policies. Rwanda constitutes a convincing example, where the establishment of rigorous monitoring and evaluation mechanisms made it possible to continuously integrate evidence into performance-based financing reforms [49].

However, several barriers limit the adoption of evidence. Political and economic constraints, such as dependence on donors or budgetary pressures, may restrict local autonomy and reduce the capacity of decision-makers to use data to guide policies [20]. Insufficient institutional and technical capacity constitutes another major limitation: the lack of trained personnel, analytical resources, and adequate infrastructure prevents the systematic use of data [28]. Recent evidence from South-East Asia also shows that health financing reforms implemented during crisis periods are strongly shaped by political economy dynamics, including power negotiations, fiscal pressures, and institutional resilience [70].

These findings show that effective evidence use requires a systemic and contextual approach. This includes capacity

building, political leadership, co-production of knowledge, and adaptation of analytical frameworks to local realities. Such an approach makes it possible not only to maximize the impact of reforms on access to care and equity, but also to transform scientific evidence into concrete and sustainable policy decisions, even in heterogeneous and politically sensitive institutional contexts.

4.5. Specific Features of the Cameroonian Experience

The analysis of Cameroonian experiences in the use of evidence for health financing reforms reveals several key lessons on how operational evidence can guide policies and support progress towards Universal Health Coverage (UHC).

4.5.1. Importance of Pilot Phases to Generate Evidence

Reforms of PBF, the health voucher, and the reduction of user fees for HIV-related services have systematically been introduced through structured pilot phases, making it possible to produce reliable data before scaling up. This pilot-centered approach presents several advantages:

1) Operational validation: pilot phases make it possible to identify contextual obstacles, logistical constraints, and capacity-building needs before generalizing the intervention, as documented in PBF evaluations in Cameroon [54] and health voucher implementation reports [76].
2) Production of multi-source data: data come both from routine health information systems, beneficiary surveys, administrative analyses, and impact evaluations, offering a holistic view of the performance and effectiveness of interventions.
3) Flexibility and adjustments: the evidence collected made it possible to adjust financing modalities, calibrate PBF incentives, and modify health voucher mechanisms to maximize access and equity.

This strategy confirms the importance of an empirical and contextual approach, where decisions are based on local data, reflecting the real needs of populations and the operational capacity of health facilities.

4.5.2. Use of Evidence in Specific Reforms

PBF and the health voucher illustrate the instrumental use of evidence: impact evaluations and routine data directly guided the design and expansion of programs. Results show that access to essential services, quality of care, and availability of inputs improved, confirming the relevance of systematic monitoring and rigorous data verification.

The health voucher, in particular, highlights challenges related to the variability of effects according to regions and target populations, which underlines the importance of combining interventions with detailed contextual analyses [57, 76].

Measures to reduce user fees for HIV services have demonstrated that the removal or partial subsidization of costs is essential to improve access and retention in care, especially for vulnerable populations. Evidence shows that despite the free provision of ART, residual costs persist (transport, additional tests), which requires operational adjustments to maximize equity. These interventions also illustrate a combined use of data: financial data for monitoring payments, routine data for tracking access to care, and qualitative evaluations to understand patient perceptions and behaviors.

4.5.3. Universal Health Coverage (UHC)

The experience of UHC in Cameroon shows the systematic integration of evidence derived from multiple reforms to define service packages, estimate costs, reduce financial barriers, and develop strategic purchasing mechanisms.

1) This approach illustrates the combined conceptual and instrumental use of data: conceptual to guide the structuring of UHC, instrumental for operational and financial decisions.
2) It also highlights the importance of transparency and consistency of data sources to strengthen the credibility of policy choices and the trust of stakeholders involved.

4.5.4. Comparative Positioning of the Cameroonian Experience Within International Trends

The Cameroonian experience in integrating evidence into health financing reforms reflects a broader global shift toward evidence-informed health systems reforms aimed at achieving Universal Health Coverage (UHC), particularly in low- and middle-income countries [77].

Across Sub-Saharan Africa, countries are increasingly adopting contributory insurance schemes and performance-based financing mechanisms; however, their effectiveness remains constrained by fragmented health financing systems, limited fiscal space, and dependence on external partners [77, 78].

In this regard, Cameroon is aligned with regional trends where reforms are often implemented through pilot phases generating operational evidence before scale-up, particularly in performance-based financing and maternal health interventions [74, 79].

Similar patterns are observed in Nepal, where UHC reforms rely heavily on incremental evidence generation through pilot interventions and phased implementation due to fiscal and institutional constraints [66].

In contrast, middle-income countries such as China demonstrate a more institutionalized use of administrative and claims databases to continuously adjust insurance design and provider payment mechanisms, enabling stronger integration between evidence and policy decisions [73].

Similarly, Chile has adopted structured comparative policy learning approaches, systematically using international evidence and scoping reviews to inform national health financing reforms, reflecting a more institutionalized evidence-to-policy cycle than observed in most African contexts [71].

High-income countries such as the United States further illustrate advanced institutionalization of evidence use, where economic evaluation, modeling, and formal advisory institutions play a central role in shaping reforms such as the Affordable Care Act, contrasting with the more fragmented and project-based evidence use observed in Cameroon [80].

More broadly, recent comparative analyses indicate that across countries, the effectiveness of evidence use in health financing reforms depends less on data availability than on governance structures, political commitment, and the existence of institutionalized knowledge translation platforms [77].

In this perspective, Cameroon illustrates a transitional model where evidence is increasingly generated and used through operational systems and pilot programs, but where the institutionalization of evidence-informed decision-making remains limited compared to more mature systems in Asia and high-income countries. In the post-COVID-19 context, Cameroon's experience is particularly relevant as many low- and middle-income countries have faced increased fiscal constraints and rising health expenditures, reinforcing the need for adaptive, evidence-informed financing systems capable of responding to shocks while maintaining progress toward Universal Health Coverage.

4.5.5. Strengths and Limitations of the Cameroonian Approach

Strengths

1) Empirical and progressive approach: the use of pilot phases made it possible to generate reliable local evidence before scaling up.
2) Multidimensional data: combination of quantitative, qualitative, administrative, and financial data, allowing a comprehensive view of reforms.
3) Alignment with international priorities: HIV and UHC programs are consistent with WHO recommendations and technical partners, strengthening the integration of interventions into national planning.

Limitations

1) Heterogeneity and quality of data: data quality varies between districts and programs, which may limit comparability and generalization of results.
2) Dependence on partners: some reforms remain highly dependent on funding and evaluations from external partners, which may affect local sustainability.
3) Limited integration of scientific research: most data come from operational systems and internal evaluations, with limited use of scientific literature to inform certain strategic decisions.

4.5.6. Implications for Policy and Research

1) Adaptive financing policies: local evidence must continue to guide the adjustment of PBF, health voucher, and UHC mechanisms to maximize efficiency and equity.
2) Strengthening of information systems: improving the quality and uniformity of data across all regions is crucial to support national decisions.
3) Systematization of scientific evidence: combining operational data and scientific analyses (systematic reviews, international evaluations) could strengthen the robustness of policy decisions.
4) Integrated approach: UHC must continue a holistic approach, drawing on data from pilot reforms and specific programs such as HIV to inform national planning and resource allocation.

The experience of Cameroon illustrates that health financing reforms can leverage operational evidence from pilot phases to guide policy decisions. The combination of quantitative, qualitative, and administrative data makes it possible not only to measure the impact of interventions but also to inform the progressive scale-up towards UHC. However, to strengthen effectiveness and sustainability, it is necessary to consolidate information systems, systematize the integration of scientific research, and reduce dependence on external partners. These lessons have direct implications for the design of evidence-based financing reforms in other resource-limited countries.

5. Strengths and Limitations of the Study

This scoping review presents several strengths. It made it possible to systematically explore a still heterogeneous field of research, by integrating studies from varied contexts. The use of diverse theoretical frameworks, including interdisciplinary approaches, fostered an in-depth understanding of decision-making processes related to health financing. Moreover, the attention paid to African contexts strengthens the relevance of the findings for resource-limited countries engaged in the path toward Universal Health Coverage.

However, certain limitations must be highlighted. Like any scoping review, this study does not include a formal assessment of the methodological quality of the articles, which may limit the appraisal of the robustness of the evidence. The selection of studies may also have introduced biases, notably related to the languages and databases used. Finally, the heterogeneity of approaches and contexts makes direct comparison of results difficult and limits the generalizability of the conclusions.

Despite these limitations, this review provides a relevant and integrated analysis of the mechanisms of use of evidence in health financing policies, and constitutes a useful basis for guiding future research and reforms.

6. Conclusion and Implications for Policy and Research

This scoping review highlights that the integration of evidence into health financing decision-making constitutes a

complex, multidimensional process that is highly context-dependent. The analysis of the included studies shows that the use of evidence does not rely solely on the availability of reliable data, but on the capacity of health systems to mobilize these data through appropriate institutional, political, and organizational mechanisms. In particular, the role of political leadership, local analytical capacities, conceptual frameworks, and interactions between actors appears to be determinant in the transformation of scientific knowledge into operational decisions.

The findings also emphasize that the analytical approaches mobilized in the literature, often characterized by theoretical bricolage, make it possible to better grasp the complexity of decision-making processes in health financing. This conceptual flexibility promotes a more nuanced understanding of power dynamics, institutional constraints, and mechanisms of change, particularly in the contexts of low- and middle-income countries.

From a public policy perspective, several major implications emerge. First, it is essential to strengthen institutional mechanisms for knowledge translation, particularly through the establishment or consolidation of platforms for dialogue between researchers, decision-makers, and stakeholders. These mechanisms make it possible to contextualize evidence and facilitate its appropriation by political actors. Second, strengthening technical and analytical capacities at the national level appears to be an indispensable condition for improving the use of data in decision-making processes. This includes the development of robust health information systems, the training of actors in data analysis, and the production of syntheses adapted to the needs of decision-makers.

Third, the results highlight the need to systematically integrate economic evaluations and impact analyses into the processes of policy formulation in health financing. These tools provide a rational framework for prioritizing interventions and contribute to strengthening the transparency and legitimacy of decisions. Fourth, taking into account political and institutional dimensions, notably actor dynamics, power relations, and external influences, is essential for understanding and improving the use of evidence in reforms.

From a research perspective, this review highlights the importance of developing interdisciplinary analytical approaches capable of capturing the complexity of health systems. Future research should move toward the analysis of concrete knowledge translation mechanisms, placing greater emphasis on interactions between actors, negotiation processes, and institutional contexts. In addition, it appears necessary to produce more empirical evidence from African contexts, in order to better document local specificities and strengthen the relevance of policy recommendations.

Finally, in countries pursuing Universal Health Coverage, particularly Cameroon, improving evidence use in health financing requires a systemic approach. This includes capacity strengthening, inclusive governance, and adaptation of analytical frameworks to local realities. Such an approach is essential to ensure effective, equitable, and sustainable reforms, capable of responding to population needs while optimizing the allocation of limited resources.

Abbreviations

UHC	Universal Health Coverage
WHO	World Health Organization
PRISMA-ScR	Preferred Reporting Items for Systematic Reviews and Scoping Reviews
LMICs	Low- and Middle-Income Countries
HIV	Human Immunodeficiency Virus
ARVs	Antiretrovirals
PBF	Performance-Based Financing
KT	Knowledge Translation
KTPs	Knowledge Translation Platforms
ACA	Affordable Care Act (United States Health System Reform)
HEREG	Health Economics & Policy Research and Evaluation for Development Results Groups

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Conflicts of Interest

The authors declare no conflicts of interest.

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