



Working Paper # 1

**Health System Stewardship
and Evidence Informed Health Policy**

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Abstract

This Working Paper reviews the recent international debates on the role of the state in health system governance, and uses those discussions to establish the legitimate role of the state in ensuring the appropriate use of evidence for health policy making. Specifically it examines the concept of *stewardship* which has emerged within recent global health governance debates, applying this concept to the stewardship of evidence. The stewardship function of national ministries of health was originally introduced by the World Health Organization in the 2000 World Health Report, but has been subsequently debated by authors who have associated the concept with a range of government and service provision functions. This paper develops a clearer and more nuanced understanding of the concept of stewardship to differentiate it from the related, yet distinct, concept of governance. We argue that the unique, and therefore conceptually useful, aspect stewardship lies in the way it allocates a single ultimate responsibility for the health of the population. The WHO has further established that it is national ministries of health, specifically, which possess the legitimacy to assume the functions as stewards of population health. The stewardship concept has been established with a range of functional characteristics, including the appropriate use of information to guide health planning and decision making. Taken together, these elements have direct implications for conceptualising how to ensure appropriate use of evidence in health policy. Ministries of health, as population health stewards, tasked with appropriate information use, possess a responsibility to ensure health system decisions are appropriately informed by evidence. In order to do this, they must establish institutional structures and procedures that function to synthesise, disseminate and apply health information and research evidence for use in policy making.

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Introduction

A key debate in global health over the last decade has concerned the role of the state in the health sector and health systems governance (WHR 2000, p. 119; Saltman and Ferroussier-Davis 2000, p. 732; Reich 2002; Alvarez-Rosete 2008). This in part has grown from a renewed focus on the importance of health systems for improving population health (Durán *et al.* 2011; Hafner and Shiffman 2012), while simultaneously acknowledging the growth and diversity of agencies involved in health care provision. At the same time, there have been growing calls to ensure that health services and health sector planning is informed by the rigorous use of evidence, and a parallel body of literature that has engaged with strategies to improve the uptake or use of evidence (Kammen *et al.* 2006; Dobbins *et al.* 2009; Lavis *et al.* 2010). Yet in the changing health sector landscape, questions arise about whose role or responsibility it is to ensure health policy is informed by evidence, particularly when there are shifts away from centralised state roles to broader and more complex systems of health sector governance (Lavis *et al.* 2004; Starr *et al.* 2009; Brownson *et al.* 2009).

This paper analyses recent international debates on the role of the state in health and health system development. It examines the concept of stewardship which has emerged within this context, exploring the range of meanings and concepts often placed within the term. It seeks to distil the functionally useful elements of the stewardship concept, in particular, distinguishing it from the more ubiquitous (and often very loosely applied) concept of governance. We then use the stewardship concept to specifically explore the issue of evidence-informed health policymaking, and the stewardship of evidence. Operationalising the calls for evidence-informed policy will require establishing key institutional forms that can bridge the so-called 'know-do gap' (Kammen *et al.* 2006; Lavis *et al.* 2010; Hanney and González-Block 2011). These institutional arrangements can take a variety of forms – such as formal advisory bodies, knowledge brokering, or established rules and procedures for evidence use. What has been missing in the evidence-informed policy literature,

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however, is significant consideration of the question of who should be taking responsibility for choosing these forms, and setting the rules and processes through which the appropriate and rapid use of evidence in health policy making can be ensured.

From Government to Governance

Recent decades have seen widespread debate about the capacity of the state to deliver policy outcomes and its right to intervene in the lives of the citizens it governs (Richards and Smith 2002; Bell and Hindmoor 2009). At the same time, there has been scepticism about the ability of the state to govern. Debates have emerged about where political power lies in contemporary societies and whether the state enjoys the same degree of control and power as in the past. Within the context of globalisation and privatisation, political power is ever more diffuse. At the same time, the policy making process has become increasingly complex due to the range of actors involved and the number of arenas in which policies are made. The boundaries between the public and private sectors have become more blurred through co- and self regulatory regimes. Implementation and regulation are often undertaken by autonomous and semi-autonomous agencies. Consequently, central government's command over a much more complex policy process has receded (Rhodes 1997; Bell and Hindmoor 2009; Bevir 2010).

These changes have led to a shift in the vocabulary used by scholars to describe the process of government. The term governance began to replace government within political science discourse (Rosenau 1992; Kooiman 1993; Rosenau 1995; Rhodes 1996; Rhodes 1997; Stoker 1998; Pierre 2000¹). In essence, the idea of governance reflects a profound transformation of state-society relationships in recent decades (Richards and Smith 2002). It describes the de-centering of the state in the development and implementation of policy, thus resulting in a process of government by multiple actors in a range of settings beyond the traditional institutions of the state. The term governance implies that the policy process in modern states is not only more diffuse, but also more

¹ For overviews of this shift in terminology and focus, see Pierre and Peters 2000; Weller 2000; Richards and Smith 2002; Kjær 2004; Bell and Hindmoor 2009; Kjær 2011

complex than before. In addition to the increased number of actors and institutions involved, the boundaries between the public and private sectors have become blurred, and central government's command over the policy process has receded.

Within traditional conceptualizations of government, "governing was basically regarded as one-way traffic from those governing to those governed" (Kooiman 2000). By contrast, the shift from government to governance (Rhodes 1997) over the past decades implies that governments are no longer the sole or perhaps, at times, even the most powerful actor in the policy arena.

"Globalisation, Europeanization, devolution and decentralization (to local authorities and non-governmental agencies) have opened up policy making arenas which were previously limited to the central government level" (Alvarez-Rosete 2007). Due to this blurring of boundaries and the multiplicity of actors involved, from a governance perspective, political power no longer rests exclusively within formal political structures (Pierre and Peters 2000).

This shifting conceptualization of government as governance has occurred in the arena of health, not only in respect of global health governance (Dodgson 2002), but also health sector and health systems governance at the national and sub-national levels (Kickbusch 2002; Lewis *et al.* 2006). In contemporary health systems, the number of old and new actors and institutions has multiplied, the boundaries between the public and private sectors have become more blurred, and central authorities command over a much more complex policy process may be now challenged (Lewis *et al.* 2006; Alvarez-Rosete 2007; Saltman *et al.* 2011). The inherent complexity this implies means that contemporary health systems can only be governed through processes of steering, coordination and goal-setting for the range of different stakeholders involved and by developing a wide range of tools and strategies to this end. Finally, within this conceptually shifting landscape there is the continued concern for ensuring that health policy decisions are based on rigorous or systematic uses of appropriate evidence. Yet with diffuse and multi-centred arenas of decision

making, this raises questions about who should be the ultimate authority tasked with ensuring evidence is used in health policy and planning.

Enter Stewardship

The shifts in terminology from ‘government’ to ‘governance’ has primarily focussed on the management and arrangements of structures performing functions that might, in the past, have been assumed to be the role of the state governments. Yet in the health sector, the World Health Organisation (WHO) introduced and championed the concept of *stewardship* of health systems as an essential government function in the World Health Report (WHR) 2000. The WHR 2000 was devoted to the understanding, functioning and performance health systems. The report took a broad view of health systems as including: “all the organizations, institutions and resources that are devoted to producing health actions. [Continuing:] A health action is defined as any effort, whether in personal health care, public health services or through inter-sectoral initiatives, whose primary purpose is to improve health” (WHR 2000, p. xi).

The WHR 2000 is widely held up by the health community as a key document championing and reinvigorating the focus on health systems. Many subsequent WHO reports and policies have aimed at strengthening systems as well as the institutional mechanisms for governing them (WHO 2003; WHO 2008a; WHO 2007). Similarly, WHO regional offices have also had the intertwined topics of health systems development and state governance roles at the heart of their discussions (WHOROE 2008; Kickbusch and Gleicher 2012; see also McQueen *et al.* 2012). These issues, however, are not confined to the WHO community. Other international and national organisations have also engaged with this debate over recent years (see Lagomarsino *et al.* 2009). There seems to be an emerging consensus that a new role for the state is required to ensure better health outcomes, focussing on systems and their institutional forms, all within the context of modern governance arrangements. This implies a more strategic and effective – although not necessarily more powerful – role for the state.

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Reflecting this quest for a new approach to governing health systems, there has been a proliferation of terms introduced to the debates to replace the old terminology of *planning*, *directing*, and *administering* (Reeves *et al.* 1984; Spiegel and Hyman 1987). In their place, terms such as *steering*, *managing*, *facilitating* and *modulating* (or arbitrating) actors' interests has entered the policy lexicon (Osborne and Gaebler 1992; Hunter 1999). The requirement for 'leadership' was closely aligned with these terms (Goodwin 2006). Despite the change in tone, references to *regulation* and the exercise of *oversight* of the health systems have remained central to these discourses (Wendt *et al.* 2009). The move towards *evidence informed* health planning implies there is a particular need to understand where evidence synthesis and utilisation fit within these new arrangements.

The terms *governance* and *stewardship* have often been taken as synonyms by those working in the health field. However, despite being closely related, there are important functional distinctions which can be drawn between the terms which have important implications for the roles national governments play in the use of health evidence. In the most useful delineations of the terms, stewardship and governance mean subtly different things. Health governance refers primarily to the management arrangements of increasingly complex health systems. The concept of health stewardship, on the other hand, implies a broader over-arching responsibility over the functioning of the health system as a whole and, ultimately, over the health of the population.

Stewardship as Responsibility

Despite the shift in tasks managed by different groups in recent changes from central government to multi-level and multi-agency governance, national Ministries of Health still maintain important roles in steering health care systems as a whole. Although countries vary greatly in the way they organise their health systems and services (reflecting cultural, historical, economic and policy factors), all health systems are expected to pursue certain goals and objectives. According to WHR 2000, the

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three objectives of a health system should be: 1) to improve the health of the population they serve; 2) to respond to people's expectations; and 3) to provide financial protection against the costs of ill-health (WHO 2000, p. xi). To achieve these objectives, the WHO further outlined four health system functions in the report:

- Service provision;
- Resource generation;
- Financing;
- Stewardship.

Briefly, *resource generation* refers to the need to ensure that sufficient health systems resources (such as staff, equipment, facilities and medicines) are available. *Financing* encompasses the funding arrangements to pay for these resources; while *service provision* requires care services to be organised, set up and ultimately delivered. Finally, *stewardship* is a term that is used in a variety of ways in the report, including referring to the stewardship roles of bodies and agencies tasked with undertaking specific health sector tasks. However, the report also states categorically that:

The ultimate responsibility for the overall performance of a country's health system lies with government, which in turn should involve all sectors of society in its stewardship... The health of the people is always a national priority: government responsibility for it is continuous and permanent. Ministries of health must therefore take on a large part of the stewardship of health systems (WHO 2000, p. xiv).

The concept of health stewardship as defined by the WHO thus implies *responsibility*. In every health system, some individual(s) or institution(s) must assume ultimate responsibility for the overall functioning of the system and thus the health of the population. Within this conceptualisation it is national governments, and ministries of health in particular, who are tasked with that responsibility on behalf of citizens.

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According to the WHR 2000, such responsibility is exercised over three distinct dimensions of stewardship (WHO 2000, p. 122):

- Formulating health policy – defining the vision and direction;
- Exerting influence – approaches to regulation;
- Collecting and using intelligence.

Whilst the first two components indicate a responsibility to oversee health policy and the conduct of health actors, the third dimension is particularly relevant for considering the role of governments and ministries of health in particular in the use of evidence. If ministries of health are stewards of the health system, and their remit includes the flow of knowledge and information for decision making in this system (defined as an ‘intelligence’ function), it follows that ministries bear a responsibility for establishing institutional arrangements which can facilitate the utilisation of health evidence as part of this intelligence role. Indeed, the other roles of formulating policy and regulation can equally be seen to implicitly encompass a responsibility for evidence use, given the priority placed on evidence informed policy and practice in the health sector more broadly.

Expanding Stewardship

In the period following the publication of the WHR 2000, there was a perception that it had failed to arrive at a “detailed, operational definition of stewardship that can be used in identifying how countries might strengthen stewardship” (WHO 2001, p. 2). Thus, the WHO’s work on stewardship after the 2000 report continued through two key events: the Policy-Makers Forum, and the WHO Meeting of Experts on the Stewardship Function in Health System, both held in 2001. The WHO Meeting of Experts linked stewardship to the concept of governance (WHO 2001). The meeting concluded that “stewardship differed from governance more in its style or approach to particular tasks than in its scope” (WHO 2001). More specifically, stewardship was described as “good”, “ethical”, “inclusive” or “proactive” governance, whilst recognising that such terms might have culturally-specific interpretations (WHO 2001, p. 2). The meeting emphasised, however, that

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“stewardship does not equate to centralised control.” In contrast: a key element of stewardship involves “fostering a culture of self-determination and self-direction among individuals and organisations in the system within an overall framework of agreed norms and values” (WHO 2001, p. 2). In this description, stewardship was imbued with a range of concepts, drawing it away from its more functional basis in the original WHR 2000 definition.

In October 2001, the WHO Director-General set up a Scientific Peer Review Group (SPRG) on Health Systems Performance Assessment (HSPA) to advise on methods being developed within WHO to measure health system performance (including stewardship) which reported in May 2002. The SPRG concluded that the concept of stewardship was virtually identical to the concept of governance, the only difference being that stewardship “may better reflect the element of directing a health system” (SPRG 2002, p. 46). The SPRG document mentioned the opinion of members of the Technical Consultation that understood stewardship as an “intelligent” function (potentially implying something more proactive in terms of planning or management), while governance was “a more structural one— a set of activities that have to happen” or a “more procedural notion” (SPRG 2002, p. 46).

By 2007, the WHO’s framework for Action *Everybody’s Business* appears to have given up on the attempt to develop an operational definition of stewardship and replaced the term with *leadership and governance* instead - a proposal that has been recently taken up by some scholars (Balabanova *et al.* 2008; Smith *et al.* 2011). However, the concept of stewardship has continued to attract the interest of researchers discussing the evolving role of the state in health policy, including the terms applicability in developing country contexts (Nafees and Nayani 2011) or to specific components of the health system (Hunter *et al.* 2005; Brown *et al.* 2010).

The academic debate on the concept of stewardship has particularly focused on unveiling the domains over which stewards should exercise their responsibility. While, as stated above, the WHR 2000 – and the WHO Regional Office for Europe (2005, p. 8) – identified 3 distinct dimensions of

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stewardship, later contributors have suggested alternative and more extensive definitions. For example, Travis *et al.* (2002) suggested six domains or sub-functions of the stewardship function:

- Generating intelligence;
- Formulating strategic policy direction;
- Ensuring tools for implementation: powers, incentives and sanctions;
- Building coalitions and partnerships;
- Ensuring a fit between policy objectives and organizational structure and culture;
- Ensuring accountability.

More recently, Veillard *et al.* (2011) suggested an alternative list of six stewardship sub-functions:

- Defining the vision for health and strategies and policies to achieve better health;
- Exerting influence across all sectors and advocate for better health;
- Ensuring good governance supporting the achievement of health system goals;
- Ensuring the alignment of system design with health system goals;
- Making use of legal, regulatory and policy instruments to steer health system performance;
- Compiling, disseminating and applying appropriate health information and research evidence.

A fundamental problem with these attempts to develop the term stewardship further is that the addition of so many elements to the stewardship concept risks ‘conceptual stretching’ (Sartori 1970) which can undermine the usefulness of the term as an analytical or operational tool. This multiplicity of dimensions probably reflects the inherent difficulty in clearly defining the scope of the concept, and may explain its limited use after it was originally presented by WHO in WHR 2000. We argue that it is therefore necessary to draw out the essential characteristics that define stewardship in order to distinguish it from broader concepts of governance, organisation, or good governance. One common feature of all of accounts of stewardship, however, is either a clear statement on the importance of research evidence to inform planning, or an implicit inclusion of this by emphasising

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the importance of use of ‘knowledge’ or ‘intelligence’ listed in parallel with a planning or decision making role.

Stewardship as a Normative Concept

The notion of stewardship in the WHR 2000 seemed to include both a functional definition of the term as well as a set of normative assumptions about what constitutes the ‘good governance’ of health systems. These normative assumptions were later strengthened and developed into a model for state decisions in the health sector in the context of WHO expert discussions as noted above.

Others have also seen stewardship as including efficiency and ethical concerns. Saltman and Ferroussier-Davis’ (2000), for example, argue that:

Stewardship can infuse normative, content-oriented values into what remains a set of largely technical, process-oriented institutions. The pursuit of policy-making that is both ethical and efficient distinguishes stewardship from other concepts but it also presents obstacles to the full development of a theory of health sector governance (Saltman and Ferroussier-Davis 2000, p. 735).

In the same vein, Veillard *et al.* (2011) emphasise that Stewardship is a model which “incorporates concerns about efficiency into a more socially responsible, normative framework reinvigorating the broader social contract on which the state is based” (Veillard *et al.* 2011, p. 192). They highlight, however, that this is a model which is difficult to implement. Another problem with this normative use of the term stewardship is that it does not seem to be able to include how responsibility over people’s health is exercised in non-democratic regimes.

The focus on this normative component of stewardship, therefore, has led to some overlap between the concepts of stewardship and that of ‘good governance’ in particular. This lack of distinction may partly explain the limited use of stewardship in health system research and policy to date. The normative elements of ethics, trust and well-being are already captured in common conceptualisations of good governance in health (Siddiqi, Masud *et al.* 2009; Saltman *et al.* 2011). Similarly, attempting to introduce ideas of pluralist or elitist control into the concept of stewardship

it also undermines its functional use by confusing it with broader concerns of democracy and representation.

We suggest that to remain a useful concept, stewardship can be distilled to its more unique functional features, which focus on a single authority taking responsibility for the health sector, with national governments holding a particular mandate to serve that role. Thus defined, *governance* and *good governance* remain distinct concepts, which can be deployed alongside stewardship to analyse state involvement in health systems. A simplified concept of stewardship set out as such is advantageous in three principle ways:

- Stewardship can be seen as a necessary function of any health system which can, therefore, be exercised in non-democratic as well as democratic political regimes. The normative concepts of good governance can then be used to judge specific aspects of stewardship if so desired;
- Stewardship implies overarching responsibility for steering the health system, rather than management of individual system elements (which exists in any complex organisation). This places the stewardship function in the hands of specific bodies (e.g. a ministries of health or parliaments);
- As the attribution of this responsibility is a political act, health stewards are mandated by their citizens to exercise their responsibilities and, as such, can be held accountable for their actions (Durán *et al.* 2011). In other words, not every actor, regardless of their influence over health policy, or their support from citizens and patients can be considered stewards of the health system if they have not been entrusted with ultimate responsibility for the oversight of the health system.

Stewardship and the Broader Determinants of Health

While the above discussion attempts to distil a functional concept of stewardship that establishes the idea of responsibility for health, it is important to consider on what this means given the recent increased calls in the public health literature to address the broader social determinants of ill health and health inequalities (Wilkinson and Marmot 1998; Commission on the Social Determinants of

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Health 2008). Work on the social determinants of health points to a number of ways that population health is influenced by the actions of other sectors (e.g. housing, labour or fiscal policies).

Consequently, efforts to promote population health outcomes and to influence health determinants may emanate from outside the health system itself. These ideas underlie conceptualisations which see the health 'sector' more broadly conceived to a narrower view of the health 'system' which is primarily concerned with health service provision (Durán *et al.* 2011). An extended consideration of the need to address determinants of health outcomes that lie outside the immediate health system also lies at the heart of the Health in All Policies (HiAP) movement, which is defined as "the policy practice of including, integrating or internalizing health in other policies that shape or influence the Social Determinants of Health" (McQueen *et al.* 2012, p. 12).

Recognition of the fact that health outcomes depend on decisions made in a range of other social areas, however, raises particular issues for the concept of stewardship. Veillard *et al.* (2011), for example, argue:

the boundaries of stewardship in the health sector cover not only the stewardship of health system functions and of the health system as a whole, but also the stewardship of secondary, health-enhancing factors (such as education, employment, transportation policies, etc.) as well as the wider economic and social factors influencing health (Veillard *et al.* 2011, p. 193).

Yet while national governments clearly must consider how to address the multiple, interconnected social outcomes of their population, there is a conceptual problem in expanding the boundaries of health stewardship to factors within the jurisdiction of other government departments. A large number of social outcomes are interconnected through complex causal chains. So, just as health depends on transportation or housing, issues such as employment or crime may equally be affected by health policies. This interconnectedness and bi-directional causality makes it impossible to allocate stewardship roles according to impact, as this would result in competing stewards (and no ultimate responsibility). Instead, ministries of health retain the stewardship function for health, despite this role being affected by policies of other departments; and health ministries are not called to take on stewardship roles in crime prevention or job creation.

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Instead, the interconnected nature of health determinants (and many other social goals) requires inter-sectoral collaboration (McQueen *et al.* 2012). In a collaborative system, stewards of each sector can be tasked with providing inputs and information that can help inform the planning or decision making of other areas, but the stewardship function is retained in the mandated ministries. Indeed, the WHO Regional Committee for Europe argues that health stewards have a role to “influence policies and actions in all sectors” (WHO Regional Office for Europe 2005, p. 8).

This influencing role provides an operational way forward in particular with regards to how the health stewardship role can be applied in intersectoral collaborative planning. Ministries of health cannot be the stewards of other sectors, but they can remain the stewards of health evidence in particular: Situated as the legitimate sources of knowledge on the health implications of other sector actions, and establishing the standards through which health evidence is considered by decision makers in other sectors.

Conclusions: The Stewardship of Evidence

This paper set out to analyse the literature on health system stewardship, in order to develop a clearer idea of how it can be functionally distinguished from broader concepts of governance (or good governance) and draw out the implications of the concept on calls for evidence informed health policy making. We argue that the unique features of the stewardship concept of most relevance include the importance of a body taking ultimate responsibility for the health of the population, the mandate implicit in national governments to serve this role, and the inclusion of the use of intelligence and knowledge in pursuing this mandate. Combined, these concepts provide a strong case to argue that Ministries of health, as the mandated stewards of health, should be explicitly tasked with establishing the institutions through which health related evidence can be used in decision making – both within the health sector, but also to provide inputs to other sector planning.

As with modern concepts of governance, there is not a requirement that Ministries themselves undertake all the activities required for improved evidence use. Rather, they can serve as the *stewards of health evidence* by overseeing and maintaining ultimate responsibility for the institutional structures and arrangements in place to improve evidence use. There are, of course, a wide variety of systems and structures that can be established which serve improve the use of evidence in health policy and planning. Autonomous or semi-autonomous evidence synthesis agencies, national expert committees, advisory bodies and working groups all can function to undertake roles of gathering, synthesising and recommending evidence on which to act. Ministries can not only establish, or authorise, these bodies, but further they can establish the rules, processes, and procedures by which they function and fit within the other governance structures of the state. Finally, with the growing interest in looking at determinants of health that lie outside the health sector, the stewardship of evidence role held by Ministries of health additionally can include the need to establish procedures and standards by which health evidence is fed into, or considered by, other Ministry decision making in an influencing role.

To date, there has been limited exploration of the role of stewardship in the health sector, and even less attempt to explore the implications of this concept for the use of evidence to inform policy and practice. We argue that the literature on stewardship, governance, and good governance presents a clear way forward for both research and practical planning. Identifying Ministries of health as stewards of health evidence maintains their legitimate responsibility for the establishment of the official agencies, rules, and procedures that can shape how health evidence gets used in policy processes. While many Ministries of health have undertaken some efforts to establish bodies that serve these roles, the stewardship responsibility requires more explicit consideration and analysis of the different ways they may do this.

A wide range of questions remain about the nature and functions of different institutional arrangements, and how they may help different countries fulfil their stewardship roles. This is one of

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the key research areas that the GRIP-Health programme will address. While we recognise the important roles played by knowledge brokers and other users of evidence in shaping policy, we specifically are interested with the structures that national ministries of health can put into place to improve the use of evidence. Further working papers in this series will engage with the additional questions this approach raises, such as what might constitute 'good practice' in the use of health evidence, and what the institutional studies literature can say about how to structure evidence-utilisation bodies. Empirical work consisting of comparative analyses of different country institutional arrangements for the use of evidence further is planned, with the ultimate goal to learn lessons that can help guide Ministries of health establish their own structures to improve the use of health evidence in policy and planning.

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