

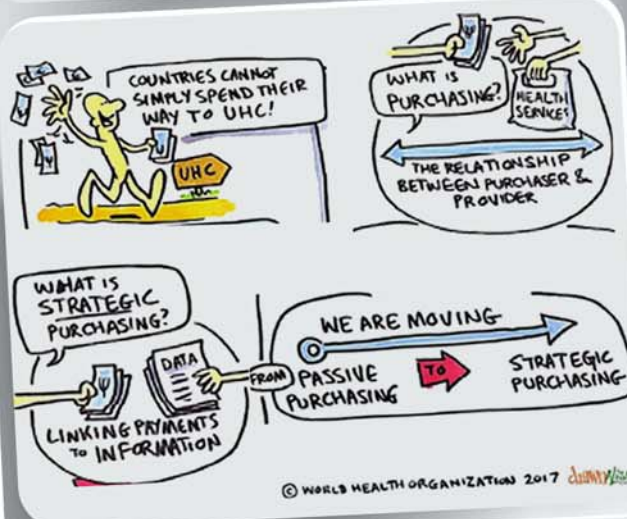
# ANALYTICAL GUIDE TO ASSESS A MIXED PROVIDER PAYMENT SYSTEM



**STRATEGIC  
PURCHASING**

**Governance**

**Payment methods**



**Benefits**

**Information management**



HEALTH FINANCING GUIDANCE NO. 5

# **ANALYTICAL GUIDE TO ASSESS A MIXED PROVIDER PAYMENT SYSTEM**

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**World Health  
Organization**

**Analytical Guide to Assess a Mixed Provider Payment System / Inke Mathauer and Fahdi Dkhimi**  
(WHO/UHC/HGF/Guidance/19.5)

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## LIST OF ABBREVIATIONS

CBHI	Community-based health insurance
DRG	Diagnosis-related groups
GHED	Global Health Expenditure Database
GoB	Government of Burkina Faso
GoM	Government of Morocco
JLN	Joint Learning Network
MPPS	Mixed provider payment system
NGO	Nongovernmental organization
OECD	Organisation of Economic Cooperation and Development
OOP	Out-of-pocket spending on health
RESYST	Resilient and Responsive Health Systems international research consortium
SHA	System of Health Accounts methodology
UHC	Universal health coverage
VHI	Voluntary health insurance
WHO/HGF	Department of Health System's Governance and Financing, World Health Organization

# PURPOSE AND OVERVIEW

WHO's *Health financing country diagnostic* (McIntyre & Kutzin, 2016) provides guidance on undertaking a situation analysis of a country's health financing system and on assessing the existing system in relation to the goal of universal health coverage (UHC). As one of the core functions of a health financing system, purchasing –

including the provider payment system – is gaining increasing attention in country policy analysis and reform development. Consequently, a more in-depth assessment of purchasing and payment methods, beyond the overall diagnostic, may be demanded.

The present document presents an analytical guide with questions to assess a country's provider payment system in greater detail in order to identify options for better aligning the payment system with the objectives of UHC. The purpose of the analysis is to inform and improve the national policy dialogue on purchasing. It assists in making the case for and drawing attention to the need of aligning payment methods within and across purchasers as an important step towards strategic purchasing.

The key audience comprises health financing and purchasing specialists who work in teams with country experts to improve or reform the provider payment system.

There exist various provider payment assessment guides and manuals (JLN, 2016; Langenbrunner, Cashin & O'Dougherty, 2009; WHO OASIS approach/modules on purchasing and provider payment methods, 2011). For a detailed assessment and revision or setting of payment rates of a specific provider payment method, countries may choose to apply these materials.

While building upon these publications, **this guide adopts an explicit systemic perspective and focuses on the**

**combination of all provider payment methods which, seen together, constitute a mixed provider payment system (MPPS).** The document is also informed through recent studies and evidence on purposively aligned payment systems (e.g. OECD, 2016) as well as through country case studies that revealed the challenges resulting from nonaligned payment systems (WHO/GoM, 2017; WHO/GoB, 2017; WHO/GoT, Nguyen et al., 2015).

This document consists of two parts. Part 1 provides definitions of the key concepts and outlines the analytical approach underpinning the guide. It briefly explains what strategic purchasing is and what is meant by an MPPS. The core conceptual components are then

presented in more detail. The final section of Part 1 gives methodological guidance on how to undertake such an assessment.

Part 2 of this document contains a detailed set of guiding questions to direct the assessment of a country's MPPS with regards to the five key steps outlined below.

- **Step 1:** Mapping the MPPS, i.e. the health financing reform context, the purchasers, the different providers (by level of care and sectors) as well as a detailed description of the different payment methods in place;
- **Step 2:** Assessing the incentives created by the mixed payment system and their influence on provider behaviour and UHC objectives;
- **Step 3:** Assessing other effects of the mixed provider payment system on the overall health system;
- **Step 4** (to be undertaken in parallel to Steps 2-3): Assessing governance arrangements and their effects on the mixed provider payment system;
- **Step 5:** Developing policy options to better align a mixed provider payment system.

Step 1 is already very comprehensive and important and could constitute a short assessment in itself. Steps 2 and 3 contain the core elements of such an assessment. Step 4 should be undertaken in parallel to Steps 2-3, but could also be undertaken separately at a later stage depending on the needs and the reflections.

The output of this assessment would be a report which should serve as a basis for feeding into and informing the policy dialogue on strategic purchasing and aligned payment systems.

While this guide attempts to be comprehensive, it cannot capture all details relating to strategic purchasing and payment methods since the aim is to stay focused and concise. Various other (WHO) frameworks are available to assess or give guidance on other purchasing-related issues such as disease- or intervention specific tailored payment methods, information management, governance arrangements for strategic purchasing, cross-programmatic efficiency and budgeting. These will link to each other, and each of them will allow for a close examination of a specific component of strategic purchasing.

(See also [www.who.int/health\\_financing/tools/en](http://www.who.int/health_financing/tools/en))

# PART 1. ANALYTICAL GUIDANCE

## STRATEGIC PURCHASING

Purchasing (Box 1.1) is one of the three core health-financing functions. It refers to the allocation of resources to public and/

or private health-care providers for the provision of services from one or several purchasing agents (WHO, 2010).

### Box 1.1: Who is a purchaser?

A purchasing agent is the organization or organizational unit which transfers funds to providers to pay them for their service provision and which takes explicit or implicit decisions on resource allocation and related conditions.

Examples of purchasers include the Ministry of Health, the Ministry of Finance, a subnational health authority (e.g. at provincial or district level), a social health insurance scheme, a voluntary health insurance (VHI) scheme (e.g. commercial or not-for-profit insurance company, community-based health insurance scheme), or an agency operating a results-based financing scheme.

Within the Ministry of Health, there may be several purchasing units or departments with assigned responsibility for allocating resources to providers. It will be important to clarify the distinction between the purchasing agency/unit (responsible for allocating to providers) and the funding agency (the revenue source for the purchasing unit), or to note where these are the same. For example, in the case of a pooled donor fund channelled through the district, the purchasing agency is the district health authority, while the funding agency is the donor (which may have taken some purchasing decisions).

There is a growing consensus that a move towards more active or strategic purchasing of health services is a necessary condition for countries to make and sustain significant progress towards UHC. Strategic purchasing means linking the allocation of funds to providers with information on aspects of their performance and/or on the health needs of the population that they serve (WHO, 2010).

Strategic purchasing aims to contribute to improving intermediate and final UHC objectives (Kutzin, 2013), namely:

- increased efficiency in the use of funds, including expenditure growth management;
- equity in the distribution of resources;
- improved accountability;
- equitable access to health services (utilization in line with need);
- financial protection;
- improved quality of care (including continuity of care).



Strategic purchasing involves the following core elements:

1. Specification of benefits:  
Which services are covered, by which providers and how are entitlements and obligations specified? What is the process through which the specification of benefits is revised and updated?
2. Provider payment methods and contracting:  
How are providers paid for these covered services and how are the payment methods aligned with each other and with health-sector objectives? What type of contractual and other (non-)financial incentives are available to purchaser to increase provider performance?
3. Data generation and information management:  
How is relevant information generated,

managed and analysed to inform purchasing decisions (e.g. on resource allocation, payment system design, monitoring and accountability purposes)?

4. Governance arrangements:<sup>1</sup>  
How is oversight of individual purchasing agencies exerted and how is coordination and harmonization across different purchasing agencies ensured? How is alignment with other support mechanisms achieved to strengthen system performance?

The focus of this guide document is on provider payment methods and particularly on the MPPS, as outlined in the next section, with the primary emphasis of the analysis given to providers and provider behaviour.

## MIXED PROVIDER PAYMENT SYSTEM AND INCENTIVES ON PROVIDER BEHAVIOUR

A provider payment method is defined by the features that determine when, how and under what conditions an amount/quantity of resources is transferred from a purchaser to a provider, and how that amount/quantity is determined or calculated to pay or remunerate the latter for the defined services provided to a defined population. The main payment methods in place are line-item budget allocations, salaries (which can be part of budget allocations), global budget allocations, fee for service, capitation, case payment (including by diagnosis-related groups (DRG)), and bed-day (per diem) payments. In-kind provisions to providers (e.g. supplies, drugs) – whether as part of

budget allocations or originating from donor funding – can also be considered as provider payments. The table in Annex 1 gives a brief overview of these main payment methods and the incentives they offer.

A payment method consists of several parameters (Langenbrunner, Cashin & O’Dougherty, 2009), namely:

- the unit of payment (per budget line, service or action, per time, per case (or episode), per capita (patients or served population));
- the amount of payment for this unit – i.e. the payment rate;
- the underlying principle of payment

<sup>1</sup> Governance can be defined as “ensuring strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system-design and accountability” (WHO, 2007). It is an overarching health system function, which is of particular relevance to strategic purchasing.

- (input-based, output-based, performance-based)”, i.e. based on the achievement of certain pre-defined targets);
- the timing of payment (retrospective or prospective payment);
- the mode of payment (e.g. in-kind, cash).

The first two parameters define the level of expenditure risk that the provider bears and, together with the other parameters, sets the direction and the degree of intensity of the incentive that this payment method creates.

Incentives can be defined as “economic signals that direct individuals and organizations toward self-interested behaviour” – i.e. they take actions in line with and in order to optimize their interests, namely their income and other features which they see as beneficial (Langenbrunner et al., 2009).

As such, each payment method creates specific incentives for providers, with over-provision and under-provision being the most important. When assessing payment methods, it is important not only to understand their design (what they are supposed to be and how they are supposed to operate) but additionally to understand how they operate in practice, as this is where treatment choices materialize.

The behaviour of providers is motivated and influenced by multiple factors, particularly professional ethics, workplace atmosphere and organization, support from supervisors and colleagues, training and career opportunities, and availability of supplies and other resources to deliver good health services. Providers also respond to incentives embedded in the provider payment methods through which purchasers pay them. There are also many other factors beyond the immediate health facility context that have an influence. While acknowledging the multiplicity of factors affecting the behaviour of staff, this guide focuses specifically on how provider payment incentives influence the behaviour of providers (i.e. health facilities as a starting point).

In nearly all countries, several payment methods co-exist and constitute a mixed provider payment system (MPPS)<sup>2</sup> which is the main focus of this guide. Providers are paid by several payment methods and are faced with several incentives that are created through these payment methods and/or rates.

Box 1.2 provides common examples of mixed provider payment systems (see also a schematic illustration in Figure 1.1).

### Box 1.2: Examples of mixed provider payment systems

- Multiple insurance funds pay the same provider with different payment methods and/or rates.
- The Ministry of Finance paying salaries directly, other line items are paid by the Ministry of Health, a separate agency provides add-on performance related payments (performance-based financing), all to the same provider.
- The Ministry of Finance pays salaries, whereas a health insurance fund pays for services, all payments going to the same provider.

<sup>2</sup> A related terminology used by RESYST is “multiple funding flows”. This puts the primary focus on the provider’s perspective, whereas the term “mixed provider payment system” emphasizes the system perspective (including all purchasers and all providers) (Hanson, 2018).

The payment methods are ideally complementary and in alignment, and send a coherent overall signal to providers through a set of coherent incentives (WHO, 2017). An ideal and fully aligned mixed payment system would provide incentives to providers in order to:

- deliver the right treatment, following clinical guidelines and good practices, including the right level of provision (no under- or over-provision);
- provide equal treatment to patients according to need;
- deliver the services in a timely manner at the right level of care to ensure a continuum of care with appropriate referral and counter-referral;
- allocate and shift resources within the facility according to evidence-based health priorities and needs;
- abide by payment and billing rules, as set by the purchaser.

Nevertheless, a frequent challenge in numerous countries is that multiple payment methods and/or different payment rates are in place and are not aligned with each other. In such an uncoordinated mix of payment methods (and/or rates), providers receive several funding flows from one or several purchasers and manage several programmes with separate funding flows and separate data management systems. Such non-aligned payment systems often exist in fragmented health-financing systems with many different pools

(Mathauer et al., 2017). This misalignment in payment methods might also exist within health facilities as well as across different provider types.

In general in an MPPS, multiple funding flows generate an overall set of incentives for providers which does not equate to the sum of each individual incentive associated with each individual payment method (as it operates in practice). The various incentives may indeed be complementary (or one may off-set the disadvantage of the other<sup>3</sup>), but they may also be incoherent or even contradictory. This mix will shape, at least partly, the behaviour of providers – especially with regard to what services they will produce and how they will produce them.

Mixed provider payment systems are better understood when applying a system perspective: it is not about one instrument or one payment method – what matters is how all these individual payment methods come together and whether they generate a coherent set of incentives at the level of providers that works towards the UHC goals. **This system perspective puts strong emphasis on the provider perspective and combines it with a purchaser perspective so as to look at the combined effects on the overall UHC objectives (WHO, 2017).** Here, we focus on efficiency, equity in access, quality and financial protection, as defined in Box 1.3.

<sup>3</sup> E.g., i.e. when combining a budget cap with fee-for-service (FFS), this helps to maintain productivity incentive FFS while managing overall spending growth.

### **Box 1.3: Definitions of efficiency, equity and quality of care**

#### **Efficiency**

Efficiency refers to using resources in a way that maximizes the production of the right outputs from a given set of inputs. For purchasing of health services this can mean: focusing on cost-effective health services, providing the right level of care (no over-provision and no under-provision) at the right level (primary care delivered at the primary care level rather than at hospital level), creating incentives for providers to adjust their input mix/cost structure, decreasing administrative costs in a reasonable way, and shifting resources within the health facility in line with health needs and priorities (WHO, 2010).

#### **Equity in access to health services**

This UHC objective is that all people have access to health services in line with their needs, independently of their ability to pay. People with higher health-care needs would thus have higher utilization rates. Equity in access to health services can be measured through indicators on service use (outpatient and inpatient care), disaggregated by income quintiles, urban versus rural residence, age, ethnicity, vulnerability and coverage schemes (WHO/WB, 2015). If data that allow for an assessment of service coverage are available, comparing use of specific services to underlying population need, these should be used as well, with similar disaggregation.

#### **Quality**

Quality of care can be defined as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge” (Institute of Medicine, 2001 in WHO/World Bank/OECD 2018). It is acknowledged that “... quality health services [...] should be effective, safe, and people-centred. In addition, in order to realize the benefits of quality health care, health services should be timely, equitable, integrated and efficient” (WHO 2018). Quality can be measured along three dimensions (Donabedian, 1988), namely: 1) structure, defined as material and human resources as well as the organizational structure of the facility; 2) process, defined as actions taken by the provider in making a diagnosis or treating the patient; and 3) outcome, reflecting the effects of care on health status, behaviour and satisfaction of the patients and the population.

In this guide and the proposed assessment, the particular focus is on the process dimension. Quality indications that are commonly influenced by provider payment incentives include for example: absence of under-provision or over-provision (such as the provision of adequate attention/time, needed diagnostics/tests and medicines), responsiveness/friendliness, the existence of a care continuum, the equal treatment of patients, and compliance with clinical guidelines. National regulatory frameworks for providers might also include quality indicators.

### Box 1.3. (cont.)

#### Financial protection

Financial protection is achieved when direct payments made to obtain health services do not expose people to financial hardship.

Monitoring of out-of-pocket spending by households is important to ensure that official cost-sharing (co-payments, user fees) as well as balance billing<sup>4</sup> by providers or informal payments do not put at risk progress towards UHC achieved through expansion of coverage by various schemes. Household surveys or income statements of providers include information on direct payments to providers at the point of service (at least the official payments).

## LINKAGE BETWEEN A MIXED PAYMENT SYSTEM AND UHC OBJECTIVES

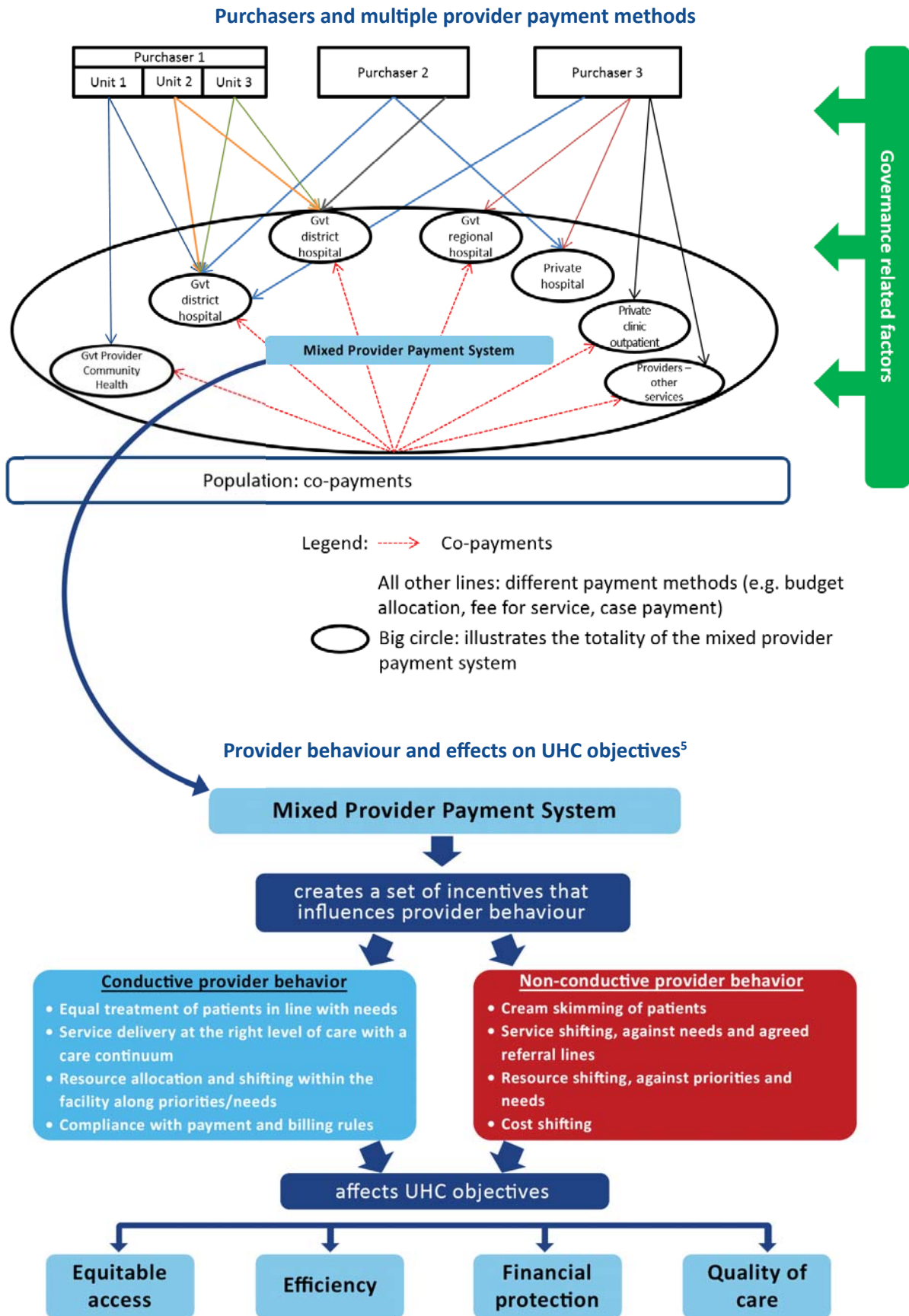
An understanding of how the mixed payment system and its set of incentives operate and influence provider behaviours is critical for developing a vision of an aligned payment system with the aim of improving UHC objectives.

Figure 1.1 provides a visualisation of an MPPS by mapping purchasers, providers and payment methods, including cost-sharing mechanisms. It also outlines how such an MPPS creates a set of incentives that influence provider behaviour and how the sum of provider behaviour affects the achievement of UHC objectives.

In the ideal case, the set of incentives results in behaviours that contribute to UHC objectives. However, an MPPS as it exists in practice may also translate into contradictory and even sometimes conflicting incentives for providers, who may also engage in behaviour that is non-conducive as to UHC objectives. Table 1.1 outlines in more detail these provider behaviours and their positive and negative effects on UHC objectives. Other potential and broader impacts of a MPPS on the health system are presented in Table 1.2.

<sup>4</sup> Balance billing is the practice of a healthcare provider billing a patient for the difference between what the patient's health coverage scheme (usually a health insurance) pays to the provider and what the provider chooses to charge overall.

Figure 1.1.



Source: Authors

<sup>5</sup> Efficiency is not a final UHC objective, but an important intermediate objective, and payment methods are decisive in determining the level of efficiency.

**Table 1.1. Possible provider behaviour and effects on UHC objectives**

Possible provider behaviour	Definition	Possible effects on UHC objectives ...	... with a specific focus on possible effects on out-of-pocket expenditures
<b>Cream-skimming of patients</b>	Providers give priority to patients with financially more attractive remuneration rates (patients with higher remuneration rates or patients who are less costly to treat)	Inequity in access, inefficiency, lower quality (possibly over-provision to preferentially treated patients and under-provision to discriminated patients), reduced access (and possibly financial protection) for less profitable patients	Increased OOPs for excluded patients
<b>Service-shifting (or avoiding service provision)</b>	Refers to a situation where a provider prefers to shift (refer) a patient to another provider in order to avoid the costs of his/her treatment	Inefficiency, reduced quality, reduced financial protection OR Better quality at the facility to which the patient is shifted	Increased OOPs through multiple contacts and unjustified referrals
<b>Resource-shifting (towards wards/ units/ services which are financially more profitable)</b>	Resources (staff time and attention, beds, material) are shifted to certain services or hospital wards/units/ departments/technologies/ equipment which providers consider financially more attractive	Variable effects: Non-conductive: inequity in access, inefficiency, quality deterioration, reduced financial protection, certain services (e.g. preventive and promotive care) are less or not available OR Conductive: (if there are incentives to produce higher volumes of services): improved efficiency and quality	Increased OOPs for patients who need services or treatment in departments from which resources are shifted Potentially increased OOPs as a result of over-provision in departments to which resources are shifted, especially for diagnostic tests using equipment with higher technology
<b>Cost-shifting to a purchaser with a more attractive payment method</b>	Providers charge more to purchasers with higher payment rates or with other attractive payment features, such that one purchaser overpays whereas another relatively underpays (shifting compared to expected burden) This may occur in the form of over-billing (charging above the official rate) or extra-billing (for services that are not medically justified) to purchasers and to self-paying patients	Variable effects Non-conductive: unequal /inequitable financing, reduced financial protection, reduced quality OR Conductive: when the provider decides to cost-shift for internal cross-subsidization as a way to allow treatment of insolvent patients or financially less “attractive” patients <sup>6</sup>	Increased OOPs (through over- and balance billing)  OR Decreased OOPs for the « less » wealthy population (through cross-subsidization)

Source: Authors.

<sup>6</sup> However, there are more efficient ways to cross-subsidize via the pooling function.

**Table 1.2. Other potential impacts of a mixed provider payment system on the health system**

Possible effects	Definition	Potential impacts on the health system	Potential effects on out-of-pocket expenditures
<b>Service/care fragmentation</b>	Occurs when multiple providers work in an uncoordinated manner	Inefficiency, quality gaps (lack of continuum of care)	Excessive OOPs through multiplication/duplication of services
<b>High administrative costs</b>	Multiple payment modalities and multiple claims management processes create an administrative burden for health providers	Inefficiency, overall increase in health expenditure	
<b>Staff migration to the private sector or to higher levels of care</b>	Occurs when doctors and nurses are attracted by higher income opportunities in the private sector or at higher care levels	Inequitable access and poorer quality of care for those seeking care in the public sector (staff shortages) Inefficient resource allocation	Higher OOPs (through informal payments) to pay for service gaps by those seeking care in the public sector
<b>Skewed public spending</b>	When higher remuneration rates are paid to private-sector providers or to higher levels of care, relatively more financial resources flow to the private sector or to higher levels of care	Resource shortages in the public sector, resulting in inequitable access and quality gaps for those seeking care in the public sector; reduced financial protection	Higher OOPs (through informal payments) to pay for service gaps by those seeking care in the public sector
<b>Price increases across the system</b>	Higher remuneration rates to private-sector providers may put pressure on the prices for medical supplies and goods across the whole system	Increases in health expenditure; inefficiencies	Higher OOPs

Source: Authors.

Figure 1.1 also points to the importance of governance arrangements that influence the functioning of the MPPS. These entail, for instance, effective oversight and supervision of purchasers and providers, clear accountability and reporting lines, appropriate levels of purchaser and provider autonomy (commensurate with capacity), and data generation and analysis through effective information management systems. However, the ways in which governance arrangements operate may contribute to a

divergence between the intended design of a payment method and how it is operated in practice. For example, lack of control and oversight may create opportunities for balance billing or for charging informal fees and thus can influence provider behaviour and the level of over-provision that a provider engages in. The systematic assessment of governance arrangements is consolidated in Step IV; however, it is suggested to undertake step IV in parallel with the previous steps (Box 1.4).



## Box 1.4: Overview of the five steps to analyse a mixed provider payment system

### Step 1

#### Mapping: overall context, purchasers, providers and payment methods

- Map and assess how recent key reforms of the health system and health financing may have an impact on the payment system in the short or medium term.
- Map the different purchasers and providers.
- Map the different payment methods in place, including cost-sharing mechanisms, considering how they operate in practice.

### Step 2

#### Assessing incentives created by the mixed payment system and their influence on provider behaviour and UHC objectives

- Explore the level of provider autonomy and managerial flexibility in using the different revenue sources.
- Identify the incentives that each payment method, as it operates in practice, would create for each type of provider.
- Assess the effects of mixed payment methods by each key purchaser on the behaviour of each type of provider.
- Assess the effects of the mixed payment system across purchasers on the behaviour of each type of provider.
- Combine the effects on each provider type and identify the overall effects of the mixed payment system on UHC objectives across all provider types and for the whole population.

### Step 3

#### Assessing other effects of the mixed payment system on the health system

- Explore other impacts on the health system.

### Step 4

#### Assessing governance arrangements and their effects on the mixed provider payment system

- Throughout this analysis: explore how the governance arrangements in place enhance or hinder the functioning of the payment system, as well as the alignment of payment methods, and:
- Explore how governance-related factors lead to a divergence between the design of the payment method and how it is operated in practice.

### Step 5

#### Developing policy options

- Explore what should be changed in the mixed provider payment system in order to contribute to achieving UHC objectives or reducing negative effects on the health system.
- Identify possible entry points:
  - alignment of payment methods within a purchaser (i.e. modifying or adjusting payment methods to make incentives coherent);
  - alignment of the mix of payment methods across purchasers (i.e. harmonization of payment methods and rates, and harmonization in claims management, reporting and other administrative procedures);
  - concurrent measures addressing governance-related factors that affect the functioning of the mixed provider payment system.

# METHODOLOGY TO ASSESS A MIXED PROVIDER PAYMENT SYSTEM

It is difficult to assess and measure providers' behavioural responses to the incentives created by payment methods. Most often, data to quantify their behaviours are not easily available. A starting point is to identify signals pointing to the existence of a particular provider behaviour or indicating that there is a risk that non-conducive provider behaviour could exist.

**The guiding questions presented in Part 2 will help to undertake a systematic and comprehensive analysis. However, this process is not about answering each and every question. Instead, the guiding questions give an idea of the issues and directions to be explored during the analysis.**

Such an MPPS study requires a mixed method approach. It is initially of qualitative nature but should be combined with the analysis of quantitative data where possible (see further below). The proposed methodology consists of the following activities:

- document review (of published and grey literature related to purchasing in the country);
- interviews with the main purchasing agencies and governance actors, as well as other resource persons and stakeholders;
- interviews with a (purposive or representative) sample of providers from the public and private sectors, and from various levels of care (primary, secondary, tertiary);
- discussions with patients or representatives of patients' associations;

- collection and analysis of secondary data (e.g. from claims data, health accounts reports, household surveys, Demographic Health Survey [DHS], Service Availability and Readiness Assessment [SARA]);
- if possible and where needed, collection and analysis of primary data, including observation.

The scope of the study, the mix of methods applied, the number of facilities visited and of people interviewed, the amount of data collected and the analysis of secondary data will vary greatly according to the chosen focus of the study based on the country's priorities, as well as on the time and resources available. The study team must therefore adjust the guiding questions to its purpose by fully applying them or choosing a leaner approach.

Moreover, the MPPS assessment could focus on a specific region of the country (e.g. a state, region, or district) to provide a zoom-in focus on a specific purchasing situation. Alternatively, the study could compare the situations of various subnational territories that have undertaken different payment reforms, or compare interventions and controls in sub-territories.

Table 1.3 provides examples of the possible interview partners. A purposive sample of providers can be chosen across urban/rural, wealthier/poorer contexts. Examples of quantitative data/metrics are presented in Table 1.4 as well as in Boxes 2.2 and 2.3 in Part 2.

**Table 1.3. Examples of interview partners**

Governance actors	Purchasers	Providers	Patients, beneficiaries	Other resource persons and stakeholders
<ul style="list-style-type: none"> <li>– Ministry of Health</li> <li>– Ministry of Finance</li> <li>– Ministry in charge of oversight of the national health insurance</li> <li>– Ministry in charge of CBHI<sup>a</sup></li> <li>– Provincial and local government health authorities</li> </ul>	<ul style="list-style-type: none"> <li>– Ministry of Health (this may involve various departments that are in charge of specific coverage schemes)</li> <li>– National health insurance scheme</li> <li>– CBHIa/mutuelle</li> <li>– Voluntary health insurance scheme</li> </ul>	<p>Purposive sample:</p> <ul style="list-style-type: none"> <li>– Health centres (at primary health care level)</li> <li>– District hospitals</li> <li>– Regional and university hospital</li> <li>– Private clinics</li> <li>– Private hospitals</li> </ul>	<ul style="list-style-type: none"> <li>– Patients</li> <li>– Patients’ groups/ associations</li> <li>– Users’ associations</li> </ul>	<ul style="list-style-type: none"> <li>– Development agencies</li> <li>– Researchers working on purchasing</li> <li>– Civil society organizations</li> </ul>

**Table 1.4. Examples of quantitative data for collection**

Expenditure data from health accounts reports disaggregated by purchasers, provider types and functions.
Utilization rates, disaggregated along population groups or different coverage schemes.
Patient record data
<p>Claims, such as:</p> <ul style="list-style-type: none"> <li>– number and type of diagnostic tests undertaken for similar episodes</li> <li>– number of services provided for similar episodes</li> <li>– number and type of drugs prescribed for similar episodes</li> <li>– claim amounts for similar individual episodes</li> <li>– most common diagnoses claimed compared to burden of disease: mismatch?</li> </ul>
<p>Observations, such as :</p> <ul style="list-style-type: none"> <li>– waiting times of different population groups</li> <li>– number of physical examinations per visit</li> <li>– amount of time (in minutes) spent in consultation per visit</li> <li>– simulating patients (with a standardized presentation of symptoms).</li> </ul>
<p>Tracer conditions, such as:</p> <ul style="list-style-type: none"> <li>– C-section rate for different income groups and different coverage scheme beneficiaries.</li> </ul>

# PART 2. GUIDING QUESTIONS

## STEP 1. MAPPING: OVERALL CONTEXT, PURCHASERS, PROVIDERS AND PAYMENT METHODS

### CORE OBJECTIVES

- Map and assess how recent key health system and health financing reforms may have an impact on the payment system in the short or medium term.
- Map the different purchasers and providers.
- Map the different payment methods in place, including cost-sharing mechanisms, considering how they operate in practice.
- Identify the incentives that each payment method offers, as it operates in practice, to each type of provider

Core key questions are in bold.

### A. Overall context

Identify key health system and health financing reforms that may have impacts on the payment system and its effects on

service provision in the short or medium term (e.g. public finance management reforms, hospital reform).

### B. Overview of health service providers

- 1. Which types of providers are there in your country?** (Specify whether they are public, private-for-profit or private-not-for-profit, and the levels of care – i.e. primary health care, secondary care and tertiary care). If they are public, what is the extent to which they have autonomy over their internal resource allocation and can they adjust their expenditure structure?
- 2. What is the total number of facilities of each type of provider?**
- 3. On the basis of available utilization data: What is the share of different types** of services provided by each type of provider? What are the trends over the past 5 years in terms of service provision?
- 4. On the basis of health accounts data<sup>7</sup>: What is the share of spending on each type of provider? What are the shares of different revenue streams to each type of provider?**
- 5. Overall expenditure growth? Which types of providers have an expenditure growth above the overall average?**
- 6. What is the number of health staff (by categories) in the public and private sectors, and across urban and rural areas?**

<sup>7</sup> The Global health expenditure database provides health accounts data for each country. <http://www.who.int/health-accounts/en/>

7. When a sample of providers is selected for visits and interviews, collect data on the following:
  - number of staff (by categories and by units/departments/wards);
  - number of beds (when applicable);
  - number of services provided (e.g. for primary health care centres: consultation delivery, immunization; for secondary and tertiary care providers: outpatient departments, inpatient departments, delivery, surgical procedures);
  - size of the population catchment area.

### C. Overview of the purchaser market

*Note: If there are multiple purchasing agencies of the same type (such as several voluntary health insurance companies or several community-based health insurance schemes), and these use the same payment mechanisms and rates, it may be more manageable to group them together as a single type of purchaser (e.g. “VHI” or “CBHI” in this example). When there are significant differences between such health insurance agencies in terms of payment mechanisms, rates, or population groups served (e.g. a social health insurance for private-sector employees and another social health insurance scheme for civil servants), keep them apart. Also note that within one purchaser there may be several purchasing units with different purchasing approaches, using different payment methods, such as within a Ministry of Health.*

1. **Describe the key features of the public financial management rules related to budget formation and budget execution for government purchasers and government providers, and what are the issues?**
  2. **Which purchasers** (e.g. Ministry of Health, Ministry of Finance, public insurance scheme, voluntary health insurance, community-based health insurance, NGOs) **are there in your country?**
- Outline the key features of each purchaser:
3. What is each purchaser’s share in total health expenditure? *(This information can be calculated on the basis of GHED data.)*
  4. What is each purchaser’s share in terms of total service volume by provider type? Differentiate for different levels of care/types of providers (e.g. primary, secondary, tertiary). For example, of all primary health care in the country, what is each purchaser’s share of total health expenditure on primary health care and what is the share in terms of the volume of primary health care service (either in terms of expenditure or outpatient cases)? Then apply the same questions to the secondary and tertiary care levels.
  5. Which population groups does the purchaser target? What are the eligibility criteria for coverage? What share is this target population out of the total population?
  6. What services does the purchaser cover and at which levels? (primary health care, secondary, tertiary hospital care, etc.)?
  7. **Which types of providers does the purchaser pay** (public and private; primary, secondary, tertiary care levels)?
  8. How does each purchaser negotiate with providers?
  9. Is there selective contracting<sup>8</sup>? If yes, what are the selection criteria? Is there a functioning accreditation system in place?
  10. Does the purchaser undertake utilization reviews and administrative checks to compensate for anticipated negative effects of payment incentives?

<sup>8</sup> Selective contracting means that a purchaser can select the providers which it wishes to contract with, i.e. the purchaser has the right not to contract with all providers.

## D. Overview of payment methods

- 1. Describe in detail how each purchaser pays each type of provider from which it purchases services: explore the provider payment method in place as it is operated in practice and consider public financial management regulations** (differentiate in terms of ownership, services and levels, where needed):
  - a. Are payments made in the form of financial (bank) transfers, as credit lines or in-kind (e.g. provision of equipment, staff, medicines etc.)?
  - b. Are payments based on input, output/volume, or according to other performance metrics?
  - c. Are payments prospective (i.e. payments are made at the beginning of a period before any services are provided) or retrospective (i.e. “reimbursements” made after the use of services)?
  - d. Does the purchaser pay providers directly or does it reimburse the patients for their expenses? Does it channel its payments through an intermediary institution (e.g. district governments)?
  - e. For each revenue source, to what extent are providers paid on time with the full amount in accordance with the contract, agreement, or budget process? How long are any delays, or how irregular is the release of funds?
  - f. Is there a clear basis for calculating payment rates; are providers aware of the methodology and do they understand it?
- 2. Who bears most of the financial risk associated with health service utilization by beneficiaries? Is the biggest risk on the provider side, the purchaser side, or the patients?**
- 3. Which payment and claims management modalities operate in practice?**
  - a. What are the concerns from the perspective of providers?
  - b. What are the concerns from the perspective of purchasers?
- 4. Is there an integrated national information management system in place or are there links between interoperable databases of the various purchasers?**
- 5. Describe the reporting and information management requirements and actual practices in relation to each payment method in place:**
  - a. What are the concerns from the perspective of providers?
  - b. What are the concerns from the perspective of purchasers?
  - c. Are there sanctions for false reporting or false claims management?
- 6. What is the share of funds from each type of payment method?**
- 7. What is the share of funds received by each type of provider from each purchaser?**
- 8. When there are performance-based financing methods:**
  - a. What are the performance metrics, and how are they measured/assessed?
  - b. How are rewards paid and how can they be used?
- 9. What are the main concerns from the purchaser’s perspective?**
- 10. Over the past 5 years: Which new provider payment method(s) have been introduced or modified, how and when?**

For each type of provider:

- 11. List the payment methods in place. How many payment methods does each provider have to deal with from the various purchasers?** (Please also consider the fee schedule/tariffs for patients paying fully out of pocket with no other coverage.)
- 12.** From how many different purchasers does the facility receive payments?
- 13. Are there different payment rates by the same purchaser for the same services for different population groups?**
- 14. Are there different payment rates by different purchasers for the same services for the same or different population groups?** (*This information may be compiled from tariff agreements/fee schedules.*)
- 15.** What is the share of income from each payment method in the total revenue (or income) of the facility? How has this evolved over the past 5 years?
- 16.** What is the share of income from each purchaser out of the total revenue (or

income) of the facility? How has this evolved over the past 5 years?

- 17.** What types of cost-sharing mechanisms or exemption arrangements for defined population groups are associated with each payment method (e.g. fixed amount, percentage of total bill, gate-keeping)?
  - a. What share of the total revenue of the facility do the official cost-sharing arrangements represent?
  - b. Are cost-sharing arrangements respected by providers as well as patients in accordance with the regulations? If not, what are the problems? (e.g. informal payments)
  - c. Are there any signs of extra-billing – i.e. amounts charged to patients for services that are charged above the official rate or are not medically justified (also called balance-billing)?
- 18. Overall, what are the main concerns from the provider's perspective? Where do providers feel that there are disincentives?**

*Note: The following questions are focused on integrated/coordinated care in relation to noncommunicable diseases. You may select a tracer condition (e.g. a cardiovascular disease).*

- 19.** In your country, who are the main providers of your tracer condition for prevention, case-finding, management, treatment and rehabilitation?
- 20.** For the services related to the tracer condition, which provider payment method is used for each type of provider?
- 21.** Is there any built-in incentive (through provider payments) to coordinate/integrate care along the whole spectrum of providers for the tracer condition?
- 22.** Are there any other coordination mechanisms in place to incentivize continuity of care across levels and sectors?

## STEP 2. ASSESSING INCENTIVES CREATED BY THE MIXED PAYMENT SYSTEM AND THEIR INFLUENCE ON PROVIDER BEHAVIOUR AND UHC OBJECTIVES

### CORE OBJECTIVES

- Assess the levels of provider autonomy and managerial flexibility on how to use payments
- Analyse the incentives created by the mixed payment system (in combination with the respective levels of provider autonomy over payments in place), and how these influence the behaviour of providers and UHC objectives
- Assess the effects of mixed provider payment methods by each key purchaser on the behaviour of each type of provider.
- Assess the effects of the mixed payment system across purchasers on the behaviour of each type of provider.
- Combine the effects on each provider type and identify the overall effects of the mixed payment system on UHC objectives across all provider types and for the whole population.

*Do the following analytical steps for each type of provider:*

#### A. Assessing the extent of provider autonomy to use payments flexibly

1. Explore the different degrees of provider autonomy for different payment methods: do providers have managerial flexibility over the management of different revenue sources?
2. Is this provider autonomy coupled with appropriate oversight to ensure that resources are used in an optimal way and commensurate with managerial capacity of providers?
3. Do they have to keep these different revenue sources separate (in separate bank accounts) or can they “pool” at the provider level?
4. Is the provider autonomy and managerial flexibility appropriate for providers? Do providers have the capacity to respond to incentives?
5. Are reporting requirements appropriate and providing the necessary information on provider activities and performance?
6. Is there a functioning information management system in place?
7. Is there a functional claims management system in place? Are provider payments paid on time?
8. Do purchasers monitor provider performance effectively and do they have the technical expertise and resources to do so?
9. How is effective gate-keeping assured, and how are providers made to comply with referral rules?
10. How is illicit billing controlled and addressed?



## **B. Assessing the incentives created by the mix of payment methods in combination with the extent of provider autonomy**

### Interim analytical step

*This step allows for reflecting on the incentives that would be created if a payment method were to exist and operate in isolation. It is an interim analytical step because the actual analysis (next section) will focus on the incentives created by multiple payment methods that operate in practice.*

- 1. What incentives would each of the payment methods (in combination with the respective extent of provider autonomy in using the funds flexibly) separately create (without considering the other payment methods that are in place)?** (The table in Annex 1 gives a first indication of the direction of the incentive.)
  - b. Is a coherent set of incentives signalled to the provider?
  - c. Does the payment mix cover the costs of the services that it is supposed to pay for (i.e. all parts of the services necessary for providing care for a case or episode – such as a consultation, diagnostic test, medication, treatment)?
- 2.** Does the respective payment method cover the costs of what it is supposed to cover and pay for?
- 3.** Which payment method is most attractive for the provider?
- 4.** If key purchasers pay a provider through several payment methods, assess the payment mix for each of the key purchasers:
  - a. Does this payment mix (in combination with the provider autonomy of these different payments) generate incentives for conducive provider behaviour?
- 5.** Which incentive(s) (created by which payment method) would be most dominant in influencing provider behaviour? (Providers may resist some incentives but respond to others)  
*Note: The incentives created by the payment method that represents the most important income source could be found to be the most dominant one. Alternatively, the incentives related to the payment method that enhances staff bonuses or extra payments may be the dominant one.*
- 6.** What would be the dominant provider behaviours?

### Assessment of all payment methods from all purchasers combined

- 1. Assess the multiple purchasers' provider payment mix**
  - a. **Does the multiple purchasers' payment mix lead to a coherent set of incentives for conducive provider behaviour?**
  - b. To what extent is the mix of payment methods aligned across the different purchasers?
- 2.** Are the payment methods and rates considered by the provider to be adequate and acceptable?
- 3.** When payment methods and/or rates are considered inadequate and unacceptable, how does the provider compensate for this?
- 4. Which incentive(s) (created by which payment method) seem most dominant**

**in influencing provider behaviour?  
(Providers may resist some incentives.)**

*Note: The incentives created by the payment method(s) that represent(s) the most important income source could be found to be the most dominant one.*

*Alternatively, the incentive related to the payment method that enhances staff bonuses or extra payments may be the dominant one, provided that the providers have some autonomy and flexibility in use over this one.*

**C. Coherence between provider payment methods and cost-sharing mechanisms**

1. Can providers set their own fee schedule/ tariff for patients who pay fully out of pocket?
2. What kinds of incentives do the cost-sharing methods create for patients as well as for providers?
3. Are some intended payment method incentives distorted by their respective cost-sharing mechanism?
4. **Are the incentives created by the cost-sharing mechanisms coherent with the incentives created by payment methods?**

**D. Assessing the effects of incentives on provider behaviour**

1. **Assess how the dominant incentives created by the provider payment mix and the respective levels of provider autonomy over payments affect provider behaviour.**
2. **To what extent are the resulting provider behaviours conducive or non-conductive with respect to the objectives of UHC?**

*Boxes 2.1 and 2.2 offer more detailed questions for assessing provider behaviour.*

**Box 2.1: Key questions for assessing whether provider behaviours are conducive**

Does the set of incentives created by the mix of payment methods in combination with the respective levels of provider autonomy over payments maximize conducive provider behaviour?

And how does it do so?

For example:

- Does the set of incentives encourage the provision of the right level of care for a patient?
- Does it ensure cost-containment? Does it help manage expenditure growth? (e.g., through close-ended payment methods, which create a volume or budget ceiling)
- Does it allow for managing the payment administration efficiently (i.e. administrative efficiency)? (Indications are: workload considered appropriate, unified data collection with different payment and claims management modalities, coherent reporting procedures, etc.)
- Does it encourage the right treatment and enhance the provision of quality services?
- Does it enhance equal treatment of all patients according to their needs?
- Does it promote a continuum of care with appropriate referral and counter-referral?
- Does it allow for and encourage resource allocation and shifting in terms of priorities/ needs within the facility?
- Does it ensure compliance with payment and billing rules?

## Box 2.2: Key questions for identifying whether provider behaviours are non-conductive

Does the set of incentives created by the mix of payment methods lead to non-conductive provider behaviour?

### 1. Cream-skimming

Are there indications of preferential treatment of certain patients?

For example, are there systematic differences between different population groups or patient groups treated in a given facility in respect of:

- waiting times;
- time to receive an appointment with a specialist;
- consultation time (for comparable patients and episodes);
- number and type of diagnostic tests undertaken for a similar episode;
- number of services provided for a similar episode;
- number and type of medicines prescribed for a similar episode;
- claim amount for comparable episodes?

*Note: This could reveal under-provision for financially less attractive patients. Yet, there could be over-provision for financially more attractive patients, although this may not always imply better quality. This information could also be retrieved from claims data by comparing different population groups.*

Does cream-skimming lead to higher out-of-pocket expenditure (OOPs) for less preferential patient groups (through formal cost-sharing or informal payments)?

### 2. Resource-shifting

Are there indications of resource-shifting?

For example, are there peculiar differences across service units/wards (that are not explained by other external factors such as epidemiological patterns and profile) in respect of:

- staffing availability and levels;
- available medicines and supplies;
- waiting times, especially to consult specialists;
- number of services produced;
- relatively higher OOPs in the units/wards/for services from which resources are shifted?

### 3. Cost-shifting

Are there indications of providers shifting costs from one purchaser to another? For example:

- Do providers charge higher rates or more items to one purchaser (over-billing) compared to what they charge to another purchaser?
- Do providers use resources from one group of patients (e.g. patients with health insurance) to lower the price/cost-sharing to be paid by other patient groups (e.g. patients without health insurance, or the very poor)?

## Box 2.2 (cont.)

Are there indications that costs are “shifted” to patients? For example:

- Are there any indications of additional cost-sharing payments by increasing charges for direct payment, balance billing or informal payments?
- Does this affect all patients or does it affect specific patients or services?

### 4. Service-shifting

Are there indications of service-shifting for financial interests? For example:

- Are there high rates of cases being referred unnecessarily to higher levels of care or to other providers although the initial provider had the capacity and ability to treat them (especially expensive cases)?
- Does service-shifting lead to higher OOPs (through formal cost-sharing or informal payments) for patients whose service provision/treatment is shifted?

## E. Assessing impacts of provider behaviours on the UHC objectives

1. How do the behaviours of each provider affect progress towards UHC objectives?
2. What are the combined effects of provider behaviours on progress towards UHC objectives?
3. **Across all providers, what seem to be the most dominant incentives and resulting provider behaviours and hence the main effects on UHC objectives?**

*Note: The effects on UHC objectives should, whenever possible and useful, be disaggregated for different populations, incomes and/or patient groups.*

*Where needed, the analysis can also be differentiated between national and subnational levels or can focus on a selected subnational territory (i.e. a specific district).*

*Box 2.3 offers more detailed questions for assessing the impacts of provider behaviour on UHC objectives.*

### Box 2.3: Potential impacts of provider behaviour on the objectives of universal health coverage

#### Efficiency

- How do cream-skimming, resource-shifting, cost-shifting or service-shifting lead to suboptimal use of resources?

#### Expenditure growth management

- How does one judge the expenditure growth trend of each type of provider, when compared to the overall expenditure growth rate of the whole health system?
- Can this be considered as appropriate expenditure growth?

### Box 2.3 (cont.)

#### **Quality**

- What is the effect of cream-skimming, resource-shifting, cost-shifting or service-shifting on the quality of care of patients and of specific population groups?
- Are there indications that the continuum of care is interrupted? (i.e. patients are not followed across provider levels)

#### **Equitable use of resources according to need**

- Are there indications that specific populations and/or patient groups are disadvantaged/ discriminated against or lose out, with inequitable access to services for them, because of patient cream-skimming, resource-shifting, cost-shifting or service-shifting?
- When there is cost-shifting from one purchaser to another, ask: Which purchaser benefits? How do these shifts in cost burden affect the level of equitable financing? Is it a pro-poor or a pro-rich shift?

#### **Financial protection**

- What effects do cream-skimming, resource-shifting, cost-shifting or service-shifting have on financial protection?

#### **Indicators to look for include:**

- utilization rates, which are disaggregated along different population groups, income groups or patient groups.

## STEP 3. ASSESSING OTHER EFFECTS ON THE HEALTH SYSTEM

### CORE OBJECTIVES

- Explore other impacts on the health system

- 1. When aggregating the effects occurring at each type of provider, what are the system impacts across all provider types and for all population groups?**
- 2. How do these effects contribute to or cause other spill-over and health system challenges?**

*Box 4 below provides more detailed questions to guide this analysis.*

### Box 2.4: System effects

#### Service fragmentation

- Are there indications of service fragmentation between different providers or provider levels, or between different health interventions/programmes (i.e. patients do not receive continuous/integrated care)?
- Are there indications of service fragmentation in that some parts of the treatment of an episode are covered but others are not (e.g. certain diagnostic tests, medicines, supplies such as soap and linen)?
- What are the observed consequences of this service fragmentation for the patients (e.g. lack of coordination of care, issues of quality/safety)?
- Does service fragmentation cause higher OOPs?

#### High administration costs

- To what extent do multiple payment modalities and multiple claims management processes create administration burdens and increase administrative costs for the different provider types, thus increasing overall health expenditure at system level?

#### Staff migration to the private sector

- Does the MPPS encourage migration of health workers to the private sector or to higher care levels for financial reasons? What is the extent of this?

#### Skewed public spending

- Does the MPPS lead to skewed public spending (i.e. a disproportionate share of spending going to tertiary care and/or to the private sector)? What is the extent of this? What does this mean for equity and efficiency?
- Does the MPPS lead to pro-rich public spending whereby large shares of public funds are spent on health coverage schemes for better-off population groups via payment methods and related remuneration rates that draw a lot of public funding?

#### Price increases

- Do higher payment rates paid to the private sector lead to spill-over effects in the public sector (i.e. pressure on prices – for staff, supplies, etc.)?

## STEP 4. ASSESSING GOVERNANCE ARRANGEMENTS AND THEIR EFFECTS ON THE MIXED PROVIDER PAYMENT SYSTEM

### CORE OBJECTIVES

- Throughout the analysis, explore how the governance arrangements in place enhance or hinder the functioning of the payment system and the alignment of payment methods, and
- Explore how governance-related factors lead to a divergence between how the payment method is designed and how it is operated in practice.

1. Assess the general governance arrangements for the whole purchasing market, including policy objectives, regulatory frameworks for the health sector, public financial management rules, and regulations that apply to private providers. There should be a specific focus on information management and the capacities of key actors.
2. Assess the governance arrangements for each purchaser, including their ability to act as a strategic purchaser.
3. Assess the governance arrangements that address providers and see how these arrangements allow providers to react to incentives.
4. **Explore how the combination of these governance-related factors lead to a divergence between the design of payment method and how it is operated in practice.**

*Box 2.5 provides more specific questions for undertaking this analysis.*

### Box 2.5: Governance arrangements at various levels

#### Governance of the whole purchasing market

1. Is there a policy which includes clear, specific and operational objectives for strategic purchasing? Is there a process which allows the achievement of these objectives to be monitored and which can propose or enforce adjustments to payment mechanisms if they do not contribute to these objectives or in response to new data and analysis?
2. Who are the actors in charge of and involved in the coordination, harmonization/alignment and regulation of the purchaser market – e.g. with respect to the benefit package, payment methods and rates, contracting procedures, reporting, market entry, competitive practices, safety and quality standards?
3. What mechanisms are in place to coordinate, regulate and harmonize the different purchasers?
4. Do these actors have the operational capacity to undertake the governance tasks? What gaps exist?

### Box 2.5 (cont.)

5. What works well with respect to coordinating, regulating and harmonizing the purchaser market? Which areas are well coordinated/regulated/harmonized? Where are the gaps?
6. What are the challenges in coordination, regulation and harmonization?
7. Do the actors in charge of coordination and regulation of the purchaser market have access to a full range of information?
8. What capacities would be needed to improve coordination, regulation and harmonization of the purchaser market?
9. Are there rules in place (or ongoing policy processes that aim) to guarantee uniform or inter-operable data bases and uniform or harmonised claims forms across all purchasers and health coverage schemes across different population groups?
10. What other policy instruments would be needed to strengthen the coordination, regulation and harmonization of the purchaser market?

#### **Governance arrangements related to a purchasing agency**

11. Does the purchaser organization enjoy an adequate level of autonomy to apply and adjust the payment system in an effective way to increase efficiency, manage expenditure growth and ensure quality of care by providers?
12. Who determines which provider payment methods are used? Who determines the provider payment rates? What process is in place to set provider payment methods?
13. Are there mechanisms to hold the purchasing organization accountable for using the funds efficiently, for ensuring that those in need are able to access the health services they require, and for providing services of high quality?
14. What do the purchasers see as enabling factors, as well as challenges, in performing their strategic purchasing functions?



## STEP 5. DEVELOPING POLICY OPTIONS

### CORE OBJECTIVES

- Explore what should be changed in the MPPS in order to contribute to achieving UHC objectives or to reducing negative effects on the health system.
- Identify possible entry points in order to increase:
  - alignment of payment methods within a purchaser (i.e. modifying or adjusting payment methods to make incentives coherent);
  - alignment of the mix of payment methods across purchasers (i.e. harmonization of payment methods and rates, and harmonization in claims management, reporting and other administrative processes);
  - concurrent measures addressing governance-related factors that affect the functioning of the MPPS.

- 1. What are the most important findings on the MPPS? Where are the core challenges?**
  - alignment of the mix of payment methods across purchasers;
  - concurrent measures addressing governance-related factors that affect the functioning of the MPPS.
- 2. What is most worrying in terms of equity of access to care and financial protection?**
- 3. What should be changed in the MPPS in order to contribute to achieving UHC objectives and specific public health objectives (e.g. increasing facility-based delivery, use of primary health care facilities, utilization of noncommunicable disease prevention measures) or reducing negative effects on the health system?**

Identify possible entry points, such as:

  - alignment of payment methods within a purchaser;
- 4. Which short-term measures are possible within the existing legal framework?**
- 5. Which medium-to-long-term measures require changes to the existing legal framework or are likely to create resistance from stakeholders?**
- 6. Which issues relating to governance arrangements could be, or should be, addressed?**
- 7. Who are likely supporters and opponents of the proposed changes?**

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# ANNEX 1: MAIN PAYMENT METHODS USED IN HEALTH SYSTEMS AND EXPECTED INCENTIVES

Payment method	Definition	Incentives
<b>Prospective:</b>		
<b>Line-item budget</b>	Providers receive a fixed amount to cover specific input expenses (e.g. staff, medicines), with limited flexibility to move funds across these budget lines	Under-provision, no focus on quality or outputs unless specified and held accountable
<b>Global budget</b>	Providers receive a fixed amount of funds for a certain period to cover aggregate expenditures. The budget is flexible and is not tied to line items.	Under-provision, also in terms of quality or outputs unless specified and held accountable; more potential for efficiency due to budget flexibility
<b>Capitation</b>	Providers are paid a fixed amount in advance to provide a defined set of services for each person enrolled for a fixed period of time.	Under-provision, over-referral (if unit of payment does not include some referral services)
<b>Retrospective:</b>		
<b>Fee-for-service</b>	Providers are paid for each individual service provided. Fees are fixed in advance for each service or group of services.	Over-provision
<b>Case-based ("DRG")</b>	Hospitals are paid a fixed amount per admission depending on patient and clinical characteristics.	Increase of volume, reduction of costs per case, avoidance of severe cases
<b>Per diem</b>	Hospitals are paid a fixed amount per day so that an admitted patient is treated in the hospital.	Extended length of stay, reduced cost per day; cream-skimming

Source: Adapted from Cashin (2015).



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