JOINT LEARNING NETWORK
For Universal Health Coverage

ASSESSING HEALTH PROVIDER PAYMENT SYSTEMS

A Practical Guide for Countries Working Toward Universal Health Coverage

Joint Learning Network
For Universal Health Coverage

ASSESSING HEALTH PROVIDER PAYMENT SYSTEMS

A Practical Guide for Countries Working Toward Universal Health Coverage

AUTHORS

Cheryl Cashin, Results for Development Institute (technical editor)
Batbayar Ankhbayar, Mongolian Development Research Institute
Hoang Thi Phuong, Vietnam Health Strategy and Policy Institute
Gerelmaa Jamsran, Ministry of Health, Mongolia
Oyungerel Nanzad, Ministry of Health, Mongolia
Nguyen Khanh Phuong, Vietnam Health Strategy and Policy Institute
Tran Thi Mai Oanh, Vietnam Health Strategy and Policy Institute
Tran Van Tien, Ministry of Health, Vietnam
Tsolmongerel Tsilaajav, Ministry of Health, Mongolia

THIS GUIDE WAS PRODUCED by the Joint Learning Network for Universal Health Coverage (JLN), an innovative learning platform where practitioners and policymakers from around the globe co-develop global knowledge that focuses on the practical "how-to" of achieving universal health coverage. For questions or inquiries about this guide or other JLN activities, please contact the JLN at info@jointlearningnetwork.org.

This work was funded in whole or in part by a grant from the Rockefeller Foundation. The views expressed herein are solely those of the authors and do not necessarily reflect the views of the foundation.

RECOMMENDED CITATION:
C. Cashin, ed. *Assessing Health Provider Payment Systems: A Practical Guide for Countries Working Toward Universal Health Coverage.* Joint Learning Network for Universal Health Coverage, 2015.

CONTENTS

PREFACE

The Joint Learning Network's Provider Payment Technical Initiative has been working with JLN countries since 2010 to identify practical challenges and creative solutions related to health care provider payment systems and how they can be designed and implemented to help advance universal health coverage goals. In the process, the JLN countries often expressed a need for a systematic way to determine whether they were on the right track with their payment systems or if they could do better using other methods to pay for health services. The countries found little practical guidance in the theoretical literature on provider payment and discovered that there are no "gold standards" or perfect payment systems to use as benchmarks. All payment systems involve trade-offs and may lead to unintended consequences, so it is challenging to assess whether payment systems can be refined or reformed to better support health system goals. Some of the countries relied on local or international consultants to help answer these questions, but rarely did they get comprehensive answers or approaches that strengthened their policy processes.

This guide is meant to be a practical tool to help countries get answers to their provider payment policy questions using a participatory process. It was developed through virtual and in-person collaboration over four years and draws on provider payment policy processes in several countries. It aims to help countries answer their questions not just about individual provider payment systems but also about how payment systems work together within a country's overall payment system architecture—without the expectation of definitive solutions and without reliance on ad hoc external assessments.

After an initial framing of the scope, structure, and content by a group of international experts on provider payment policy, an initial pilot of the guide was carried out in the Maldives, with support from the World Bank. After that initial pilot, the Ministries of Health of Vietnam and Mongolia carried out full field tests of the guide. The experiences in Vietnam in 2012–13 and Mongolia in 2013–14 provide the basis for much of the process guidance in this final version of the guide.

Mongolia and Vietnam have very different country contexts and health system characteristics. Mongolia is in east-central Asia, bordered to the north by Siberia and to the south by China. It has a population of about 3 million people. Mongolia is categorized by the World Bank as an upper-middle-income country, with a per capita national income of $4,320 and per capita health spending of $244 in 2014. Vietnam is a country in Southeast Asia with a population of about 90 million people. It is categorized by the World Bank as a lower-middle-income country, with a per capita national income of $1,890 and per capita health spending of $111 in 2014.

These two countries also have similarities, however, in that they are in transition from a socialized health system with centralized government financing and service delivery to a more pluralistic model with the introduction of social health insurance and a growing role for the private sector. As a result of this common legacy, the countries' provider payment systems have some common features, such as line-item budgeting for a large network of publicly owned health facilities implemented side-by-side with more modern output-oriented payment systems such as capitation and case-based hospital payment. Given these similarities in the provider payment contexts in Mongolia and Vietnam, the results of their assessments may not be representative globally. Nonetheless, the experience of the assessment exercises in these countries holds useful lessons for other countries as they embark on their own provider payment assessment exercises.

We hope that the guide will provide a technical structure for countries to develop their own processes for examining and assessing provider payment systems from the perspective of all stakeholders, especially providers. These processes will continually evolve to meet the need for fine-tuning, major adjustments, and even a complete overhaul of the country's payment systems. The analytical approach offered by this guide will provide a foundation for this ongoing work. In the spirit of joint learning, we also hope that the guide will help create a common language across countries so they can share their provider payment experiences and build new knowledge together.

ACKNOWLEDGMENTS

Rockefeller Foundation
Innovation for the Next 100 Years

THE AUTHORS GRATEFULLY ACKNOWLEDGE THE GENEROUS FUNDING from the Rockefeller Foundation for the JLN Provider Payment Mechanisms Technical Initiative that made this guide possible.

THIS GUIDE IS A JOINT EFFORT by a wide range of contributors in countries that are working toward universal health coverage, as well as international partners who support these efforts. Their knowledge and experience helped shape the approach to assessing provider payment systems and defining ways to refine them or implement new models.

Significant technical expertise and input came from the Provider Payment Expert Group convened by the Joint Learning Network (JLN) and hosted by the World Health Organization (WHO) Barcelona Office for Health Systems Strengthening in February 2012. This group helped identify the appropriate scope, structure, and content of the guide as well as the approach to field testing. In particular, John Langenbrunner and Sheila O'Dougherty contributed specific technical content and reviews of earlier drafts of the guide.

The guide was greatly enriched by the experience of the field tests in Mongolia and Vietnam. Many country stakeholders and international partners worked together to make the field tests possible and useful for the policy processes in their countries. The World Bank and WHO provided financial and technical support for field testing the guide in Mongolia, and the World Bank provided support for the field test in Vietnam.

Finally, the authors wish to acknowledge the many policymakers, health care providers, and other stakeholders who generously contributed their time, experience, and personal views during the field tests. Their input helped ensure that the guide is grounded in the practical realities of designing, operating, and managing provider payment systems in support of universal health coverage and other health system goals.

CONTRIBUTORS

John Langenbrunner
World Bank

Sheila O'Dougherty
Abt Associates

Joseph Kutzin
World Health Organization

Chris Atim
African Health Economics and Policy Association / Results for Development Institute

Dorjsuren Bayarsaikhan
World Health Organization

Surabhi Bhatt
JLN / Results for Development Institute

Danielle Bloom
JLN / Results for Development Institute

Michael Borowitz
Global Fund to Fight AIDS, Tuberculosis and Malaria

Tamás Evetovits
World Health Organization

Frank Feeley
Boston University School of Public Health

Alice Garabrant
JLN / Results for Development Institute

Jennifer Hennig
GIZ

Kari Hurt
World Bank

Melitta Jakab
World Health Organization

Matthew Jowett
World Health Organization

Gina Lagomarsino
JLN / Results for Development Institute

Inke Mathauer
World Health Organization

Bruno Meessen
Institute of Tropical Medicine Antwerp

Laurent Musango
World Health Organization

Stefan Nachuk
Global Health Group, University of California San Francisco

Somil Nagpal
World Bank

Toomas Palu
World Bank

Phusit Prokongsai
International Health Policy Program (Thailand)

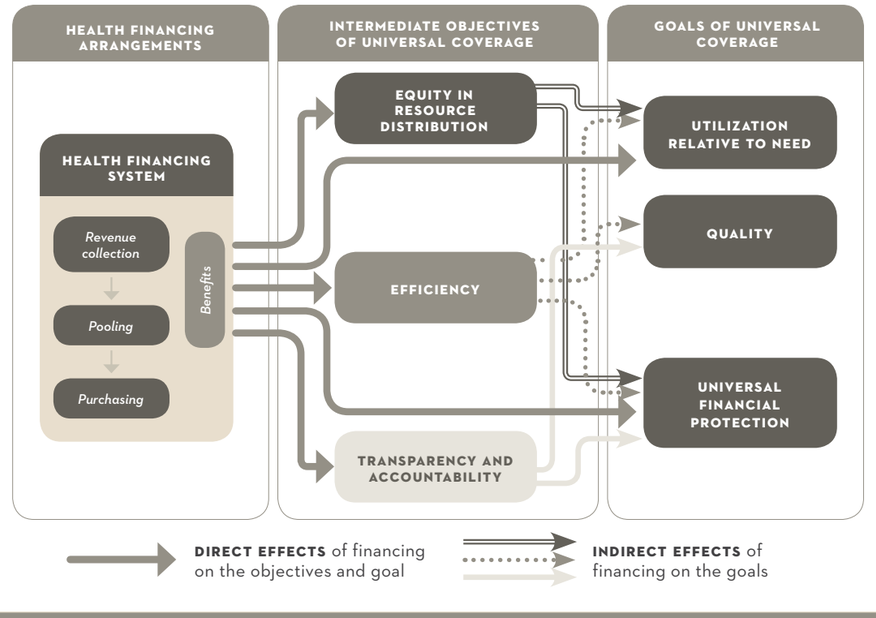
Aparnaa Somanathan
World Bank

Winnie Yip
Oxford University

INTRODUCTION

ACHIEVING UNIVERSAL HEALTH COVERAGE—ensuring access to basic health services for an entire population without risk of financial hardship or impoverishment—is a challenge that confronts many countries. To achieve and sustain universal health coverage, governments must generate resources for expanding coverage, distribute the resources equitably, and use them efficiently to achieve the most benefit in terms of meeting health care needs, ensuring quality of care, and protecting users from financial hardship due to out-of-pocket expenses. (See Figure 1.)

FIGURE 1.
Effects of Health Financing Arrangements on Universal Health Coverage



Source: Kutzin, 2013

Health financing policies—policies that govern the resources and economic incentives of the health system—affect the efficiency, performance, and equity of the health system and ultimately health outcomes. Health financing policies apply to three main functions:

- Collecting revenue from public, private, and external sources to finance the health system
- Pooling health funds to spread financial risk and achieve greater equity and financial protection
- Purchasing health care goods, services, and interventions for covered populations from provider institutions using pooled funds

A country's macroeconomic and fiscal context greatly affects the amount of resources—particularly public resources—available for the health sector. Many countries initially focus on generating enough revenue to achieve universal coverage, but as coverage expands, issues of financial sustainability, efficiency, and quality of care quickly emerge. Simply increasing revenue for the health sector is not enough to meet a country's health system goals. The funds must be strategically directed toward priorities such as expanding access to services and interventions, improving the quality of care, and advancing equity and financial protection.

To better match health funds with these priorities, many countries have implemented pooling and purchasing reforms to ensure that funds flow to those who are most in need, allow public funds to be used to purchase services from private as well as public providers, and create incentives for providers to improve efficiency and quality. Strategic purchasing approaches include, for example, leveraging provider payment systems to promote efficient service delivery and negotiating with pharmaceutical suppliers to manage drug costs.

Health purchasing is closely linked with the other health financing functions and plays an important role in governance. For example, when funds from each revenue source flow through a different pooling agent, the structure of the pooling arrangements is often carried through to purchasing arrangements. This fragmentation can limit the ability of the health financing system to improve equity and efficiency by setting consistent incentives for providers. On the other hand, some countries have mitigated the effects of fragmentation in pooling by harmonizing purchasing arrangements and equalizing payment rates across populations.

A *health purchaser* is any institution that buys health care goods, services, and interventions on behalf of a covered population. Health purchasers can include:

- Ministry of Health (MOH)
- Social health insurance agency
- Special purchasing agency
- Local government authority
- Other ministries (e.g., Ministry of Defense)
- Area health board
- Private insurance fund/company
- Member-owned/community-based insurance fund
- Employers

Health purchasers make strategic decisions in five areas:

- **Coverage:** for whom to buy health care goods, services, and interventions
- **Benefits packages:** which health care goods, services, and interventions to buy (and what to exclude) and cost-sharing by covered individuals
- **Contracting:** from whom to buy which health care goods, services, and interventions, and at what prices
- **Provider payment:** how and how much to pay providers
- **Quality:** how to ensure that purchased health services are of good quality

Strategic health purchasing requires authority to make purchasing decisions and enter into contracts with providers, flexibility to allocate funds, and well-functioning information systems. It also requires purchasing power; fewer, larger purchasers have more power to influence the price and quality of health services. The legal environment governing health purchasers should ensure that purchasers have the authority and decision rights to make policies related to contracting and provider payment, data management and IT, and provider monitoring.

The way health purchasers pay health care providers to deliver covered services is a critical element of strategic health purchasing. These *provider payment systems* consist of one or more payment methods and all supporting systems, such as contracting and reporting mechanisms, information systems, and financial management systems. Nearly every country that is working toward universal health coverage is developing or improving strategic provider payment systems.

Provider payment systems create economic signals, or incentives, that influence the behavior of provider institutions—specifically, what services they deliver, how they deliver them, and the mix of inputs they use. This affects both the value obtained from pooled funds and the financial sustainability of coverage. The right incentives can direct provider behavior in a way that serves health system goals such as better quality of care, expanded access to priority services, greater responsiveness to patients, and more efficient use of resources. How these incentives reach frontline health workers is critical; in systems where health worker salaries are not part of payment to provider institutions, efforts to achieve health system goals by improving the distribution, quality, and motivation of human resources are often impeded.

Each payment system is based on one or more provider payment methods. Each payment method creates a different set of incentives, and each method has strengths and weaknesses in different contexts. The most commonly used payment methods are:

- Capitation (per capita)
- Case-based (e.g., diagnosis-related groups)
- Fee-for-service (tariffs or fixed fee schedule)
- Global budget
- Line-item budget
- Per diem

Table 1 summarizes these methods, the incentives they create, and when each method may be useful.

The mix of provider payment methods that is best for a country, region, or institution to pay for different health services at different levels will change over time. The effective use of provider payment to advance health system goals is an ongoing process that involves constant refinement as providers adapt and change their behavior and as goals change. Even small changes in payment systems can have a significant impact on provider behavior. Starting with a simple payment model and adding complexity over time will allow the supporting systems to mature and develop the capacity to handle more sophisticated mechanisms.

THE PURPOSE OF THIS GUIDE

Countries that are taking on the challenge of implementing universal health coverage have expressed the need for a systematic way to assess their current provider payment systems and identify refinements (minor updates or revisions to payment system design or implementation) or reforms (major changes to the payment method mix, design, and/or implementation arrangements) that can help them achieve their health system goals. This guide provides a structured process for doing just that. The process cannot generate definitive answers, but it can help structure data analysis and discussions and provide a basis for decisions, policies, and refinement or reform proposals. The guide can be used in its entirety, but in some cases only portions of it may be useful.

The guide defines an assessment exercise that a country, region, or institution can use for one or more of the following purposes:

- Assess current provider payment systems, identify objectives for refinement or reform, and evaluate reform options
- Establish a baseline assessment of provider payment systems that have already been selected, to aid in monitoring and evaluation
- Contribute to an evidence base for provider payment policy across countries

TABLE 1.
Main Provider Payment Methods and the Incentives They Create

PAYMENT METHOD	DEFINITION	INCENTIVES FOR PROVIDERS	WHEN THE METHOD MAY BE USEFUL
Capitation (per capita)	Providers are paid a fixed amount in advance to provide a defined package of services for each enrolled individual for a fixed period of time.	Attract enrollees, improve the output mix (focus on less expensive health promotion and prevention), improve efficiency of the input mix, decrease inputs, underprovide services, increase referrals to other providers, attempt to select healthier (less costly) enrollees.	Management capacity of the purchaser and providers is moderate to advanced, choice and competition among providers are possible, strengthening primary care and cost control are top priorities, a broader strategy is in place to strengthen primary care and increase health promotion.
Case-based (e.g., diagnosis-related groups)	Hospitals are paid a fixed amount per admission or discharge depending on the patient and clinical characteristics, which may include department of admission, diagnosis, and other factors.	Increase admissions, including to excessive levels; reduce inputs per case, which may improve the efficiency of the input mix or possibly reduce quality; unbundle services (e.g., through pre-admission testing); reduce length of hospital stays; shift rehabilitation care to the outpatient setting.	Management capacity of the purchaser and providers is moderate to advanced, there is excess hospital capacity and/or use, improving efficiency is a priority, cost control is a moderate priority.
Fee-for-service (tariffs or fixed fee schedule)	Providers are paid for each individual service delivered. Fees or tariffs are fixed in advance for each service or bundle of services.	Increase the number of services, including above the necessary level; reduce inputs per service, which may improve the efficiency of the input mix or possibly reduce quality.	Management capacity of the purchaser and providers is at least moderate; increasing productivity, service supply, and access are top priorities; there is a need to retain or attract more providers; cost control is a low priority.
Global budget	Providers receive a fixed amount for a specified period to cover aggregate expenditures to provide an agreed-upon set of services. The budget can be spent flexibly and is not tied to line items.	If global budgets are formed based on inputs: underprovide services, increase referrals to other providers, increase inputs. If global budgets are formed based on volume: increase the number of services, increase referrals to other providers, decrease inputs. Mechanism exists to improve efficiency but may need to be combined with other incentives.	Management capacity of the purchaser and providers is at least moderate, competition among providers is not possible or not an objective, cost control is a top priority.
Line-item budget	Providers receive a fixed amount for a specified period to cover specific input expenses (e.g., personnel, medicines, utilities). The budget is not flexible, and expenditure must follow line items.	Underprovide services, increase referrals to other providers, increase inputs, spend all remaining funds by the end of the budget year. No incentive or mechanism to improve efficiency.	Management capacity of the purchaser and providers is low, cost control is a top priority; financial management and monitoring are weak.
Per diem	Hospitals are paid a fixed amount per day for each admitted patient. The per diem rate may vary by department, patient, clinical characteristics, or other factors.	Increase the number of bed-days, which may lead to excessive admissions and lengths of hospital stays; reduce inputs per bed-day, which may improve the efficiency of the input mix or possibly reduce quality.	Management capacity of the purchaser and providers is moderate, improving efficiency and increasing bed occupancy are priorities, the purchaser wants to move to output-based payment, cost control is a moderate priority.

The approach used in the exercise is based on the following principles.

SELECT THE RIGHT MIX OF PAYMENT METHODS.

The mix of methods and ongoing improvements to the mix should be based on:

- How the incentives created by the individual payment methods and the method mix (including unintended consequences) may affect health system goals given the current context
- How provider payment systems work together within the country's overall payment system architecture
- The capacity of the purchaser to design and manage payment systems of varying complexity
- The autonomy, flexibility, and capacity of providers to respond to payment incentives
- How the payment systems align with and strengthen other health financing functions such as pooling of funds and defining benefits or essential services packages
- Other factors that influence institutional relationships and provider behavior, including political, legal, and public financing factors

DESIGN PAYMENT SYSTEMS STRATEGICALLY.

Provider payment systems should be designed to:

- Be appropriate for the goals and context of the country and the current capacity of the purchaser and providers
- Be transparent about roles and relationships (particularly among providers, the purchaser, and the population), the basis for payment, and the parameters and formulas used to calculate payment rates
- Create consistent incentives that maximize beneficial incentives and minimize unintended consequences to advance health system goals
- Set payment rates based on a combination of cost information, the resource constraints of the purchaser, and other policy considerations

ENSURE APPROPRIATE IMPLEMENTATION ARRANGEMENTS.

Certain institutional relationships, regulations, and health system policies must be in place to support the effective implementation of payment systems. These implementation arrangements should:

- Create the conditions necessary to operate and manage the payment system
- Give providers the flexibility to respond to incentives
- Make it possible to balance financial risk and manage costs
- Include systems for monitoring and improving quality
- Ensure that stakeholders on all sides are accountable and adverse consequences can be managed

These principles and how they can be applied to assessing provider payment systems and making decisions for refining or reforming them are discussed in more detail in the next section of the guide, "Provider Payment Policy Decisions: Basic Principles."

The guide draws on and can be used in conjunction with other resources, including the following:

The World Bank and USAID's *Designing and Implementing Health Care Provider Payment Systems: How-To Manuals*

http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/Peer-Reviewed-Publications/ProviderPaymentHowTo.pdf

The JLN's *Costing of Health Services for Provider Payment: A Practical Manual*

www.jointlearningnetwork.org/resources/costing-of-health-services-for-provider-payment-a-practical-manual

The World Health Organization's OASIS (Organizational Assessment for Improving and Strengthening Health Financing) Excel Aid

www.who.int/health_financing/tools/systems_review/en

USAID's *Health Systems Assessment Approach: A How-To Manual*

www.healthsystemassessment.com/health-system-assessment-approach-a-how-to-manual

HOW THIS GUIDE IS ORGANIZED

This guide is organized into modules so it can be adapted to the needs of different countries, regions, or institutions at different points in time. The steps and outputs for each module are color coded:

Steps shown in blue are carried out by the **Provider Payment Working Group** with the support of the **Facilitator**.

Steps shown in orange are carried out by the **Analytical Team**.

MODULE 1

LAYING THE GROUNDWORK

This module provides guidance on describing the current state of the health system and role of provider payment, identifying objectives for provider payment refinement or reform, and establishing the objectives, scope, and process of the assessment exercise.

MODULE 2

ASSESSING CURRENT PROVIDER PAYMENT SYSTEMS

This module provides guidance on describing the current provider payment systems, including the linkages among health purchasers, providers, and payment systems; compiling the design features and implementation arrangements of each payment system; and assessing the strengths and weaknesses of each payment system and how the payment systems work together.

MODULE 3

ASSESSING CURRENT PURCHASER AND PROVIDER CAPACITY

This module provides guidance on assessing the capacity of the main purchaser and the level of autonomy and managerial capacity of providers, as well as data availability.

MODULE 4

IDENTIFYING OPTIONS FOR PROVIDER PAYMENT REFINEMENT OR REFORM

This module provides guidance on assessing options for refinement or reform of current payment systems, such as changing the mix of payment methods or improving the design and implementation of the payment systems. It may result in a roadmap for implementing the reforms.

A

APPENDIX A

Appendix A shows the output templates for the **Working Group**.

B

APPENDIX B

Appendix B shows the output templates for the **Analytical Team**.

LINK TO RESOURCES

Go to http://bit.ly/1RUsYek to access the following additional resources:

- A digital version of the *Analytical Team Workbook* in Microsoft Word format. The interview tools and **Analytical Team output templates** in the workbook can be customized for the particular objectives of the assessment exercise and the country context.
- A digital version of the **Working Group output templates** in Microsoft Word format. The templates can be customized for the particular country.
- Resources from the provider payment assessment exercises in Mongolia and Vietnam, including workshop agendas; **Working Group** and **Analytical Team** outputs; and reports, policy notes, and other publications.

HOW THE ASSESSMENT EXERCISE IS STRUCTURED

This guide is meant to be used by a steering committee called the **Provider Payment Working Group**, with guidance from a **Facilitator** and substantial support from an **Analytical Team**. The assessment exercise uses available secondary data and draws on stakeholder interviews and expert opinion. No quantitative data collection is required, although the process may identify a need for additional data to support the design, implementation, and monitoring/evaluation of new provider payment systems.

Roles and Responsibilities

Three main parties have roles in the exercise:

- The **Provider Payment Working Group** has overall responsibility for the exercise and may later oversee the design and implementation of new provider payment systems. The **Working Group** is the main liaison with higher-level decision makers for provider payment policy.

  It should have representation from all key stakeholders in the country and should include individuals who have direct operational experience with provider payment systems. The **Working Group** may include representatives from:
  - Ministry of Health (national and regional)
  - Health insurance or purchasing agencies (national and regional)
  - Ministry of Finance
  - Primary and secondary/tertiary care providers (public and private)
  - Pharmaceutical sector
  - Academia or research institutes
  - Consumer/patient groups

  The group may have subcommittees that focus on particular aspects of the process or particular payment methods.
- A **Facilitator** who is a health financing expert and a neutral contributor (i.e., does not represent any of the stakeholder institutions) guides and documents the process of the **Working Group** and helps interpret the outputs of the **Analytical Team**.
- An **Analytical Team** of technical experts carries out the main analytical work of the exercise under the oversight of the **Working Group**. The team collects and analyzes policy documents and available secondary data, conducts stakeholder interviews, compiles quantitative and qualitative results, and provides analysis and preliminary conclusions for the **Working Group** to interpret and use in making policy recommendations. The skill mix of the **Analytical Team** may include health financing expertise, research experience, and clinical qualifications. The **Facilitator** may also be part of the **Analytical Team**.

The process is designed so the **Analytical Team** brings the analysis and preliminary conclusions to the **Working Group** and the **Facilitator** guides the group in interpreting the results and reaching consensus. The overall structure of the process is shown in **Table 2.** The steps may happen sequentially or at times simultaneously.

The field tests in Mongolia and Vietnam suggest that under ideal conditions, the steps in Modules 1 through 3 could be completed in about four months, but the length of the entire process can vary greatly depending on political commitment and practical challenges. The length of time needed to complete Module 4 (Identifying Options for Provider Payment Refinement or Reform) is particularly dependent on the country context. Vietnam completed the entire process, including Module 4, in 9 months, while Mongolia took 18 months due to challenges such as reaching agreement on adapting the interview tools, the need for additional facilitation, and time constraints within the Ministry of Health. **(See Table 3.)**

The cost of the entire assessment was about US$65,000 in Vietnam and US$50,000 in Mongolia, excluding international technical support. Costs included funding the **Analytical Team** and its field work, workshops, and production and dissemination of a final report. The cost of the exercise will be affected by local consulting costs, the number and geographic dispersion of the stakeholders interviewed, and the number and size of the workshops.[1]

Output of the Assessment Exercise

The exercise should produce a report or a policy note. A sample report outline is shown in **Box 1.** Additional outputs may include a proposal to pilot a new provider payment model (as in Vietnam), a roadmap for provider payment reform (as in Mongolia) or other outputs specific to the requirements of the policy process in the country.

[1] The length of the process and cost of the assessments in Mongolia and Vietnam may be on the high end because they were field tests. This guide includes enhancements and more detailed guidance based on those experiences, which could reduce the length and cost of the exercise for others. Countries may also choose to do an abbreviated exercise using the principles in the guide but with a more streamlined process to get rapid results at a lower cost.

TABLE 2.
Provider Payment Assessment Process

MODULES	STEPS	TIME NEEDED (MINIMUM)	ACTIVITIES	OUTPUTS	RESPONSIBLE PARTY
Module 1: Laying the Groundwork	**DATA COLLECTION AND ANALYSIS**				
	Step 1. *Identify the health system context and goals*	2–4 weeks	Collect background data to identify health system goals, current health financing and service delivery arrangements, and the status of key health system indicators.	**Analytical Team Output #1**	**Analytical Team**
	WORKSHOP #1: PLANNING THE ASSESSMENT EXERCISE				
	Step 2. *Define the objectives of provider payment refinement or reform*	1–2 days	Confirm health system goals or problems that can be addressed by provider payment refinement or reform, and agree on the objectives of reform.	**Working Group Output #1**	**Working Group with Facilitator**
	Step 3. *Agree on the objectives and scope of the assessment exercise*		Identify the objectives of the assessment exercise, which specific questions it should answer, and its scope (which perspectives, quantitative analysis, providers, and geographic areas to include).	**Working Group Output #2**	
Module 2: Assessing Current Provider Payment Systems	**DATA COLLECTION AND ANALYSIS**				
	Step 4. *Adapt and pre-test the interview tools*	2–4 weeks	Adapt the interview tools in the *Analytical Team Workbook* to the country context and the objectives of the assessment exercise. Pre-test and finalize the tools.	**Revised interview tools**	**Analytical Team**
	Step 5. *Analyze health system data*	2–4 weeks	If data are available, conduct quantitative analysis related to health system goals and the consequences of current provider payment systems.	**Quantitative analysis**	**Analytical Team**
	Step 6. *Interview stakeholders on current payment systems*	1–2 months	Using revised interview tools, interview stakeholders on the design features and implementation arrangements of current payment systems and their consequences.	**Interview notes and/or recordings**	**Analytical Team**

TABLE 2.
Provider Payment Assessment Process, *continued*

MODULES	STEPS	TIME NEEDED (MINIMUM)	ACTIVITIES	OUTPUTS	RESPONSIBLE PARTY
Module 2: Assessing Current Provider Payment Systems	**DATA COLLECTION AND ANALYSIS**				
	Step 7. *Compile information from stakeholder interviews*	1–2 weeks	Compile information from the interviews, including linkages among purchasers, providers, and payment systems; the design features and implementation arrangements of each payment system; and the perceived consequences of each payment system. Identify relationships between provider payment systems and pooling and other purchasing arrangements, including essential services/ benefits packages, etc.	**Analytical Team Outputs #2, #3, and #4**	**Analytical Team**
	Step 8. *Analyze information from stakeholder interviews*	1–2 weeks	Analyze the current mix of payment methods and the design and implementation of payment systems against criteria and/or benchmarks.	**Analytical Team Outputs #5 and #6**	**Analytical Team**
			Analyze the strengths and weaknesses of current payment systems, including beneficial and perverse incentives and unintended consequences	**Analytical Team Output #7**	
	WORKSHOP #2: INTERPRETING THE RESULTS OF THE ASSESSMENT				
	Step 9. *Assess the current provider payment systems against health system goals*	1–2 days	Reach consensus on the assessment of current payment systems, including the mix of methods, against health system goals.	**Working Group Output #3**	**Working Group with Facilitator; input from Analytical Team**

TABLE 2.
Provider Payment Assessment Process, *continued*

MODULES	STEPS	TIME NEEDED (MINIMUM)	ACTIVITIES	OUTPUTS	RESPONSIBLE PARTY
Module 3: Assessing Current Purchaser and Provider Capacity	**DATA COLLECTION AND ANALYSIS**				
	Step 10. *Interview stakeholders to assess purchaser and provider capacity*	1–2 months (can be concurrent with Step 6)	Using revised interview tools, interview stakeholders on the current capacity of the main health purchaser and the autonomy and capacity of providers. Assign capacity ratings. Document the availability of data and the level of data disaggregation and automation.	**Analytical Team Outputs #8, #9, and #10**	**Analytical Team**
Module 4: Identifying Options for Provider Payment Refinement or Reform	**WORKSHOP #3: DEVELOPING RECOMMENDATIONS FOR PROVIDER PAYMENT REFINEMENT OR REFORM**				
	Step 11. *Develop recommendations to refine or reform provider payment systems*	1–2 days (plus time to develop optional roadmap)	Discuss and agree on payment system refinement and reform options, such as changing the mix of payment methods or improving the design and implementation of current payment systems. Identify improvements to supporting systems and complementary measures for current or new provider payment systems, as well as key external factors to address.	**Working Group Output #4**	**Working Group with Facilitator; input from Analytical Team**
			Create a roadmap for reform (optional).	**Working Group Output #5**	

TABLE 3.
Characteristics of the Assessment Exercises in Mongolia and Vietnam

	MONGOLIA	VIETNAM
Working group representation	• Ministry of Health • Health Department of the Social Insurance Agency (SIGO) • Ministry of Finance • Health care providers	• Ministry of Health • Vietnam Social Security (VSS) • Health care providers • Provincial-level stakeholders (provincial health department, Social Security, and providers)
Analytical Team	• MOH technical staff (2) • Researchers from Mongolian Development Research Group (2)	• MOH technical staff (1) • Researchers from Health Strategy and Policy Institute (4)
Facilitator	International consultant	International consultant
Number of interviews	40	101
Stakeholders interviewed	• Ministry of Health • Ministry of Finance • SIGO (purchaser) • Hospitals and specialized centers • Regional diagnostic and treatment centers • District health complexes and maternity homes • Family health centers • Sanitoriums	• Ministry of Health • Ministry of Finance • VSS (purchaser) • Provincial Health Department • Provincial Social Security office • Provincial finance department • Hospitals • District health centers • Commune health stations
Number of workshops	3	3
Time frame	18 months (April 2013 to October 2014)	9 months (November 2012 to July 2013)
Stakeholder interviews	4 months	4 months
Budget *(including stakeholder interviews, quantitative analysis, and workshops; excludes international technical support)*	~US$50,000	~US$65,000

BOX 1.
Sample Outline of a Provider Payment Assessment Report

SECTION 1.
Introduction and Objectives (1–2 pages)
- Overview of the health system, main issues, and goals
- Key indicators
- Objectives of the assessment exercise

SECTION 2.
Overview of Current Health Financing and Service Delivery Systems (1–2 pages)
- Structure of health financing (revenue sources, pooling arrangement, purchasing agencies, and funding flows)
- Structure of service delivery
- Key challenges and the role of provider payment

SECTION 3.
Assessment Methods and Process (1–2 pages)
- Representation of the Working Group and technical subcommittees
- Composition of the Analytical Team
- Number of stakeholder interviews and representation
- Analytical methods

SECTION 4.
Results (5–10 pages)
- Linkages among health purchasers, providers, and payment systems
- Design and implementation arrangements of current payment systems
- Positive and negative consequences of current payment systems
- Current capacity of the purchaser and providers
- Assessment of the strengths and weaknesses of current provider payment systems and the mix of methods and the impact on health system goals

SECTION 5.
Payment System Refinement and Reform Options and Recommendations (3–5 pages)
- Overview of factors affecting provider payment refinement and reform
- Recommendations for provider payment refinement reform and external factors to address

Lessons from the Field Tests

"It is necessary to have all three parties—the Working Group, the Analytical Team, and a neutral facilitator with technical expertise."

"The facilitator can be an international partner, but it is better to look in-country to build capacity and expertise. Universities and policy research institutes can be helpful."

PROVIDER PAYMENT POLICY DECISIONS: BASIC PRINCIPLES

THREE MAIN PRINCIPLES should guide policy decisions for provider payment:
- Select the right mix of provider payment methods.
- Design payment systems strategically.
- Ensure appropriate implementation arrangements.

The provider payment assessment exercise outlined in this guide systematically examines these dimensions of provider payment systems and assesses them against criteria of effectiveness. This section describes these policy dimensions in detail and suggests assessment criteria.

SELECTING THE RIGHT MIX OF PROVIDER PAYMENT METHODS

There is no gold standard or perfect payment method, and every method has strengths and weaknesses and can produce unintended consequences. But all payment methods can be useful at particular times and in particular contexts to address different underlying obstacles to increasing efficiency, equity, or access or to enable specific service delivery improvements. For example, fee-for-service payment will lead to cost escalation in many contexts, but the method can be useful if a priority objective is to increase productivity or service utilization. Countries should identify the mix of payment methods that will create incentives that align with their health system priorities and goals.

How provider payment systems work together within the country's overall payment system architecture is critical. For example, if capitation payment for primary care is combined with fee-for-service for outpatient specialty services and case-based hospital payment, the result could be either a more efficient shift toward primary care services or the opposite, with excess referrals and more high-cost tertiary care services. The result will depend on how the payment systems are designed and the implementation arrangements for all payment systems together. Putting a cap on fee-for-service payment, for example, and adjusting the base rate in the case-based payment system to counteract excessive increases in admissions can strengthen the beneficial incentives of capitation payment for primary care. Choosing a mix of payment methods that complement one another, designing them strategically, and putting the right implementation arrangements in place are crucial for getting the most benefit for the health system from provider payment policy.

The choice of payment methods may be constrained by the capacity of the health purchaser and the autonomy of providers. More complex payment methods require more information and technical capacity to design and manage the payment system, so the capacity of the purchaser may limit the options for payment methods. The degree of provider autonomy is also an important factor. Payment systems create powerful incentives for providers to alter the services they deliver and how they deliver them. If providers do not have the flexibility to respond to the incentives, the results will be either diminished or in some cases perverse. For example, if the payment method—such as capitation—creates strong incentives for efficiency but providers do not have the flexibility to alter the mix of inputs they use, such as by shifting staffing, service quality could suffer.

Any of the payment methods can be combined with specific performance-based rewards or penalties (known as *results-based financing* or *pay-for-performance*). Payment methods can also be combined to create *blended payment systems*, or *mixed models*. A blended payment system can maximize the beneficial incentives (and minimize the potential unintended consequences) of each payment method. For example, a capitation payment system for primary care can incorporate a small amount of fee-for-service payment for priority preventive interventions, such as prenatal care and immunization, to counteract the potential perverse incentive in capitation to underprovide services. Blended payment systems are becoming more common because all payment methods have weaknesses—perverse incentives and opportunities to "game the system"—and payment systems must continually evolve. Blended payment systems are also commonly used as purchasers transition from paying for inputs (as with input-based line-item budgets) to paying for outputs (as with capitation for primary care complemented by fee-for-service for priority preventive services) and eventually to paying for results or outcomes.

Some emerging models of provider payment are more complex, such as those that aim to bundle services over the course of an episode of illness or cycles of chronic disease management. These methods often come with challenges in defining the unit of payment and have not been implemented widely. Little evidence is available on the effectiveness of these methods in achieving health system goals, particularly in low- and middle-income countries.

Provider payment systems affect and are affected by other health financing functions, particularly pooling, and other aspects of health purchasing. The mix of payment methods should therefore align with and strengthen overall health financing strategies. In particular, when essential services or benefits packages are defined, the payment methods must be able to be linked to those services and benefits. At the same time, the way services and benefits are defined should facilitate optimal payment systems and the assigning of payment rates.

Finally, the overall payment system architecture that will be most effective at a particular time will depend on many country-specific factors, including the roles and relationships among different actors, the political environment, legal constraints, and the public financial management system.

DESIGNING PAYMENT SYSTEMS STRATEGICALLY

A payment system can be designed so a payment method is tailored to the specific country context and health system goals. Strategically selecting the design features helps shape the resulting incentives. (See Table 4.) The main design features of payment systems are:

- **Basis for payment:** the primary unit of payment and other parameters and calculations used to compute payments to providers
- **Included services:** the services that are paid for using the payment system
- **Cost items:** the categories of costs covered by the payment rates (e.g., salaries, utilities, medicines)
- **Adjustment coefficients:** coefficients that are applied to the base payment rate to adjust for systematic cost differences associated with certain patient or provider characteristics
- **Contracting entities:** the types of providers that can be paid to deliver services using the payment system

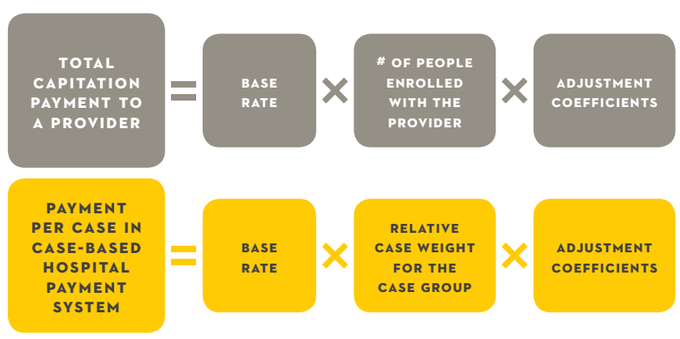
Basis for Payment

A payment system's defining characteristic is the *unit of payment*—per service, per visit, per case, per bed-day, or per person per month. Whatever the unit of payment, providers have an incentive to increase the number of units they are paid for while decreasing their cost per unit so they can make a profit or generate a surplus. Fee-for-service payment, for example, creates incentives for providers to deliver more services while reducing their cost per service. Capitation, which pays the provider a set amount per enrollee for a defined set of services, creates incentives for providers to enroll more people while reducing their total cost per person.

Services can be bundled into a unit of payment. The level of bundling influences how financial risk is shared between the purchaser and the provider. Lower levels of bundling put greater financial risk on the purchaser, while higher levels of bundling shift more risk to providers. For example, fees may be set for each office visit and for each procedure performed during the office visit (low level of bundling), or a single fee may be set that includes the office visit and all procedures done during the visit (higher level of bundling). The higher the level of bundling, the more opportunity providers will have to increase efficiency by improving their input mix or reducing unnecessary services. A higher level of bundling is also administratively simpler in terms of billing and payment. However, with more bundling, the payment rates are less directly linked to the cost of providing specific services within the bundle, so there is more incentive for providers to underprovide services. Providers often argue for less rather than more bundling to limit their financial risk with payment rates that are better matched to their costs of delivering services and to have greater opportunity to increase revenue by increasing volume. Purchasers often prefer more bundling to limit their financial risk and motivate providers to be more efficient by reducing unnecessary services and using fewer high-cost inputs.

The basis for payment also includes other parameters and the formula used to calculate the final payment to provider institutions.

FIGURE 2.
Payment Parameters and Formulas for Capitation and Case-Based Hospital Payment Systems



Take, for example, a payment formula for capitation payment. The capitation method uses the enrolled or registered individual as the primary unit of payment (for all included services for a fixed period of time). The payment parameters therefore include the base rate (fixed payment per enrolled individual) and the number of individuals enrolled with the provider. The payment formula is the base rate multiplied by the number of enrolled individuals multiplied by any adjustment coefficients. (See Figure 2.) For a case-based hospital payment system, the primary unit of payment

TABLE 4.
Design Features of Provider Payment Systems

DESIGN FEATURE	DEFINITION	DESCRIPTION/EXAMPLES			
		PAYMENT METHOD	**UNIT OF PAYMENT**	**PAYMENT PARAMETERS**	**PAYMENT FORMULA**
Basis for payment	The primary unit of payment, other parameters, and the formula used to calculate total payment to a provider	Capitation	Enrolled individual for all included services for a fixed period of time	• Base rate • # of enrolled individuals • Adjustment coefficients	**CAPITATION PAYMENT TO A PROVIDER =** base rate × # of people enrolled with the provider × adjustment coefficients
		Case-based hospital payment	Hospital case (admission or discharge)	• Base rate • Case groups • Relative case weights • Adjustment coefficients	**CASE PAYMENT TO A PROVIDER =** base rate × relative case weight **TOTAL PAYMENT TO THE PROVIDER =** sum of case payments across all case groups
		Fee-for-service	Each individual service or bundle of services	• Fixed fees • Number of services provided	**TOTAL PAYMENT TO THE PROVIDER =** sum of fee payments across all services or bundles of services
		Budget	Fixed payment to a provider institution for a period of time	Input-based line items: • Cost/unit of input • Number of units of inputs Volume: • Payment rate per service • Projected number of services Or other basis	Depends on basis of the budget
Included services	Which services or packages of services are paid for using the payment method	• Preventive services (e.g., immunization, family planning, antenatal care) • Primary care • Labor and delivery • Chronic disease management • Laboratory tests • Other diagnostic tests • Specialty consultations • Inpatient services • Specific diagnoses or conditions • Other			

TABLE 4.
Design Features of Provider Payment Systems, *continued*

DESIGN FEATURE	DEFINITION	DESCRIPTION/EXAMPLES
Cost items	Which inputs or cost items are included in the payment rates	• Personnel • Medicines • Supplies • Utilities • Equipment • Buildings • Other
Adjustment coefficients	Factors applied to final payments to account for systematic cost differences associated with certain provider or patient characteristics	• Geography • Age/sex • Chronic diseases • Facility type (e.g., teaching hospital) • Other
Contracting entities	The types of provider that can be contracted to receive payment under the payment system	• Solo practitioner • Public or private health facility (primary care, secondary hospital, tertiary hospital, outpatient department of a hospital, diagnostic center, etc.) • Provider network • Other type of organization

is the hospital case (discharge or admission). The payment parameters include the base rate (or average fixed payment rate per hospital case), the case groups, and relative case weights for each case group. Adjustment coefficients may also be applied to the payment formula to calculate case-based payments.

Included Services

The "included services" are those services or packages of services that are paid for using the payment method. Which services are included in the payment system will affect provider incentives. For example, some countries pay for preventive services separately, through a different budget, so those services are not included in the package of primary care services paid through capitation. This can limit the incentive typically created by capitation for providers to offer more preventive services.

The definition of "included services" often defines the boundary between one payment system and another, which also affects incentives. For example, the services included in a capitation package often include primary care but not referrals outside of the package. If some primary care curative services are considered outside of the capitation package but are delivered by the same contracting entity, the provider has an incentive to increase "internal referrals," or referrals within the same provider institution. Case-based payment typically includes all hospital inpatient cases, but if a country is gradually implementing this method and starts by covering only certain types of cases or diagnoses, providers will have an incentive to shift to diagnoses outside of the case-based system in order to be paid more through a method that is more advantageous to them, such as fee-for-service.

Cost Items

Cost items are inputs or resources that are used to provide health services; these include both recurrent cost items and capital assets. Typical cost items include personnel (salaries, benefits, allowances, and payroll taxes), medicines and supplies, utilities, equipment, and buildings. Some provider payment systems include all cost items, but certain items are often paid for through other sources. Health worker salaries and investment costs, for example, are often paid directly out

of the government budget. The cost items that are included or excluded will affect the overall incentives of the payment system, and efficiency incentives in particular may be reduced for inputs that are paid directly out of the government budget.

Adjustment Coefficients

Adjustment coefficients may be included in the formula to adjust for systematic cost differences associated with certain patient characteristics (such as age and sex) or provider characteristics (such as urban/rural or teaching hospitals).

Contracting Entities

Contracting entities are the types of providers that can receive payment for services under the payment system. Contracting entities may be defined by type of provider or by level of care. In a capitation payment system for primary care, for example, the contracting entities may be defined as all primary care providers (which may or may not include hospital outpatient departments). The definition of contracting entities may also specify whether private providers can be paid using the payment system.

Making Strategic Choices

Each decision about the design of the payment system offers an opportunity to help achieve the goals of the health system or address challenges. For example, in selecting the contracting entities and service package for capitation payment, the country has an opportunity to define what primary care means for its population and which providers should be delivering primary care.

Each payment system should be consistent with pooling objectives and allow payments to contribute to equity and better financial protection. If pooling arrangements are fragmented, the payment system should be designed to mitigate negative effects on equity. For example, purchasing arrangements across different pools can be harmonized and payment rates can be equalized across different covered groups. The payment system should also allow payments to align with and be matched to services in the essential services or benefits package. In a line-item budget, for example, payments are matched to buildings, beds, and other inputs; the link to services is weak, which makes it difficult to ensure that funds follow entitlements to services.

Each payment system should also account for the capacity of purchasers and providers and the amount of autonomy that providers have to respond to incentives. If the purchaser has limited information and data analytics capacity, simpler parameters and payment formulas may be appropriate, as in a case-based hospital payment system that defines the case group parameter at the level of the hospital department rather than the diagnosis-related group (DRG).

The design of each payment system will be constrained by policy, legal, and regulatory factors, but a payment system can also exploit opportunities. For example, if public financial management rules limit which cost items can be included, the payment system might still create flexibility to include contracting entities that have more autonomy, which may lead to greater autonomy for all providers over time.

ENSURING THE RIGHT IMPLEMENTATION ARRANGEMENTS

Certain conditions must be in place for payment systems to realize benefits for the health system and avoid adverse consequences. (See Table 5.) These *implementation arrangements* shape the rules for computing, disbursing, using, and tracking payments and ensuring accountability. Implementation arrangements include:

- Institutional relationships among purchasers, providers, the covered population, and other stakeholders
- Quality monitoring and assurance
- Other supporting systems and complementary policies
- Public financial management (PFM) rules and financial flows
- Other laws, regulations, and policies that affect how payment rates are calculated and how funds are distributed and used

Like the design features of a payment system, implementation arrangements affect provider incentives and the ability to achieve health system goals.

Institutional Relationships

Institutional relationships between purchasers and providers may be governed formally by contracts that specify what services providers will deliver, how they will deliver them, and the terms of payment. These relationships can also be influenced by the degree of provider autonomy, the bargaining power of professional associations, and informal rules and norms.

Other important institutional relationships include those between the purchaser and the Ministry of Health (if the MOH is not the main or only purchaser) and between the pooling and purchasing agents (if they are different). Institutional relationships also involve the covered population, such as the rules that govern how they access services.

Quality Monitoring and Assurance

All provider payment systems can create perverse incentives, opportunities for gaming the system, and other unintended consequences. Furthermore, no provider payment method inherently creates incentives to improve quality of care. Therefore, systems should be in place to monitor quality of care and identify and address quality problems. Quality monitoring and assurance systems can include accreditation, clinical audit, and routine monitoring of provider performance against a set of quality indicators.

Other Supporting Systems and Complementary Policies

Some systems and policies are not central to the payment system design but can facilitate implementation and help shape incentives or manage potential adverse consequences. Supporting systems might include a health management information system (HMIS) that is used to calculate and manage payments and support reporting and monitoring. Complementary policies might put caps on total payments to individual providers or groups of providers, or reward providers for better performance, either financially or in some other way. Complementary policies aimed at the covered population might include copayment policies to help shape service utilization behavior.

Public Financial Management Rules

The PFM system—the way public budgets are created, disbursed, and accounted for—strongly influences the choice of provider payment methods, how they can be designed, and how funds will flow when they are implemented. If PFM rules allow budgets to be created based on outputs, such as programs or services, most payment method options will be available. If budgets can be based only on inputs, it can be difficult to create an effective payment system.

Other aspects of the PFM rules that can affect the design and implementation of a provider payment system include the funds flow across administrative levels (e.g., whether fiscal decentralization limits equalization of payment rates) and to providers (e.g., if lower-level providers receive their funds directly or through hospitals), and financial management systems (including cash management, procurement, and accounting systems). Other PFM rules that can greatly affect incentives include rules on whether providers can keep surpluses (when the cost of delivering services is less than payment to providers) and rules on whether providers must bear the cost of overruns (when the cost of delivering services exceeds payment rates).

OTHER LAWS, REGULATIONS, AND POLICIES

Many laws, regulations, and policies that are not implemented specifically for provider payment can affect the implementation of provider payment systems and shape provider responses. Within the health sector, these can include the structure of service delivery, norms and guidelines for clinical practice, regulations that affect provider autonomy, rules governing private providers, and clinical coding practices. Outside the health sector, they can include civil service laws, macroeconomic and fiscal policies, and trade policies governing imports and exports (which may affect the prices and availability of medicines and other medical supplies and equipment).

CHARACTERISTICS OF EFFECTIVE PAYMENT SYSTEMS

While there are no established benchmarks for payment system design and implementation arrangements, certain criteria can be helpful in evaluating whether current payment systems are designed and implemented effectively. These are described in the following sections.

Effective Payment System Design

A well-designed payment system should have these general characteristics:

- Transparency
- Consistent incentives
- Appropriate rate-setting

Transparency

In a transparent payment system, the roles and relationships among the stakeholders—particularly the purchaser, providers, and the covered population—are clear. The system should have well-defined payment parameters and a clear formula for calculating payment rates based on those parameters. Providers should know how payments are calculated and how the payment parameters were derived. They should have this information in advance so they can plan and manage their resources. Transparency in payment formulas and calculations also relates to governance by clarifying institutional roles and relationships and ensuring that all stakeholders understand how payments match covered services or the benefits package.

TABLE 5.
Implementation Arrangements for Provider Payment Systems

IMPLEMENTATION ARRANGEMENT	DEFINITION	EXAMPLE	DESCRIPTION
Institutional relationships	Formal and informal rules governing relationships among policymakers, purchasers, providers, the covered population, and other stakeholders	Relationship between the purchaser and the MOH	Whether the MOH is in a direct supervisory role over the health purchaser and has responsibility for aspects of purchasing and provider payment policy
		Relationship between pooling and health purchasing agents	Whether the pooling and purchasing agents are the same institution and, if not, which institution has the authority to make policies (such as equalization of payment rates)
		Rules governing contracting between purchasers and providers	Rules governing whether and how public purchasers can enter into binding agreements with public and/or private providers to deliver covered services under specified terms of payment and other conditions
		Rules governing population entitlement and responsibility	Rules governing how the population accesses coverage (enrollment rules and procedures), services and medical products they are entitled to receive, the amount of financial coverage, and copayment and balance billing policies
Quality monitoring and assurance	Systems to monitor quality of care and identify and address quality problems	Accreditation	Predetermined standards established by a professional accrediting agency that the purchaser may use as criteria for contracting with or adjusting payments to providers
		Clinical audit	Reviewing of patient records to determine whether services provided were consistent with clinical guidelines, contract requirements, or other standards of care
		Routine performance monitoring	Routine monitoring of provider performance against a set of quality indicators
Other supporting systems and complementary policies	Systems and policies that are not central to the payment system design but affect how the system functions and how providers respond	Information systems	The HMIS, claims reporting and billing system, and other automated information systems
		Payment caps	Policies about whether total payments to a provider or group of providers under that payment system are subject to limits and what happens when those limits are approached or exceeded
		Service utilization management	Rules that govern how the covered population can access services, such as gatekeeping rules and referral requirements

TABLE 5.
Implementation Arrangements for Provider Payment Systems, *continued*

IMPLEMENTATION ARRANGEMENT	DEFINITION	EXAMPLE	DESCRIPTION
Public financial management rules	Rules governing how public funds for health are budgeted, disbursed, and tracked	Budgeting rules and processes that specify how payments are disbursed and can be used by providers	• Whether payments are received as a lump sum or according to budget line items and whether they can be used flexibly • Whether payments can be made in advance • Frequency of revising or updating budgets and/or payment rates
		Funds flow	• How funds flow, including across administrative levels (level of fiscal decentralization) and to providers (including fundholding arrangements, in which part of the payment to one provider covers costs incurred by other providers) • Administrative requirements to request and receive funds • Whether funds flows are consistent and predictable
		Payment surpluses and deficits	Whether providers can retain any payment surpluses over the cost of delivering services and whether they are responsible for deficits when costs exceed payment
		Financial management systems	Systems for general financial management, cash management, procurement, accounting, internal and external controls, etc.
Other laws, regulations, and policies	Laws, regulations, and policies that are not part of the provider payment policy but affect the implementation of the payment systems and provider responses	Clinical governance rules and guidelines	Rules governing which services can be provided at which level, clinical practice guidelines, diagnosis and procedure coding, etc.
		Provider ownership and autonomy policies	Laws, regulations, and policies that determine the decision rights that providers have over aspects of management, including, for example, staffing, use of other inputs, and service mix
		Civil service laws	Laws and regulations governing categories of government employees, conditions of employment, and compensation
		Macroeconomic and fiscal policies	Government policies related to taxation, spending, interest rates, and other interventions that affect economic growth, government revenue, and other economic conditions of the country
		Trade policies	Policies that govern the quantities, prices, and other terms of imports from and exports to international trading partners, including tariffs (taxes on imports), subsidies on exports, and quotas (limits on the quantity of certain imports)

For **capitation payment** to be transparent, it should be based on a formula that links the payment parameters (base per capita rate, number of enrollees, and any individual or provider-level adjustments). The package of services paid through capitation should also be clearly defined. Because payment to providers under capitation is influenced by the base per capita rate and the number of individuals enrolled with that provider, the enrollment list or database must be accurate. Otherwise, providers will not be paid for the actual number of patients who could visit and expect care. The method of creating the list and giving providers access to it should be transparent so providers will trust the list and their final payment amounts. Also, there should be a limited number of adjustment coefficients, all with a clear basis and justification.

For **case-based payment** to be transparent, it should be based on a formula that links the payment parameters (base rate, relative case weights, and any adjustment coefficients). The case groups should be clearly defined and mutually exclusive. (That is, one diagnosis or type of case should not fit into more than one case group.) The case groups and relative case weights should be appropriate for the country context and clinical practice patterns. If the case groups and relative case weights were imported and adapted from an international source, country experts and clinicians should be involved in the process of adaptation and validation.

In **fee-for-service payment**, the main payment parameter is the fee schedule or list of tariffs, which should be fixed and understood by providers. For budget payment to be transparent, rates should be based on objective parameters such as volume and case mix rather than on historical allocations, which are often not transparent, or some other ad hoc basis.

Consistent Incentives

A payment system should also be designed in a way that creates consistent rather than conflicting incentives, and that strengthens the incentives that are advantageous for health system goals while minimizing unintended consequences. Consistent incentives are important both within each payment system and in the relationships among all of the payment systems in use. For example, if output-based payment such as capitation or case-based payment is combined with line-item budgets, there might be conflicting incentives. The provider might have an incentive to use staff more efficiently under capitation or case-based payment but at the same time have an incentive to increase the number of higher-paid staff to receive a higher salary allowance in its budget.

For **capitation payment**, the basis for payment is all necessary care within the capitation service package for each enrolled person. Capitation payment should improve equity and create incentives for providers to improve the efficiency of their input mix, reduce unnecessary services, shift services toward primary care and prevention, and attract additional enrollees. The payment system design should strengthen these incentives while minimizing behaviors such as underproviding care, reducing quality, avoiding sicker patients, and making unnecessary referrals.

The incentives to increase efficiency and shift services to primary care and prevention are strongest when the base rate is set in advance and is the same for all providers (with adjustments for legitimate differences in the cost of delivering services, such as with different geographic locations or different health needs). These incentives are diluted when any part of payment is linked to utilization or provider capacity, or when higher-level facilities receive capitation payment for primary care. If specialty providers or hospitals are able to receive capitation payment for primary care, they will have an incentive to shift to services outside of the capitation package that they can be paid for at a higher rate through another method. The incentive for providers to attract additional enrollees is diluted (or completely eliminated) if the population does not have free choice of capitation provider and enrollees are assigned administratively, or if effective choice is limited by geography or the availability of providers.

For **case-based payment**, the basis for payment is the hospital case (admission or discharge) and includes all necessary services to diagnose and treat that case. Case-based payment should create incentives for providers to increase productivity and improve the efficiency of their input mix and reduce unnecessary services within a hospital case. All aspects of the payment system design should strengthen these incentives while minimizing perverse incentives to excessively increase admissions, underprovide care within a hospital case, reduce quality, or avoid sicker or unprofitable patients. This can be accomplished by paying the average cost per case across a relatively large and representative set of hospitals (or the average cost per case across the most efficient "benchmark" hospitals). As with capitation, the efficiency incentives are strongest when the base rate is set in advance and is the same for all hospitals (with adjustments for legitimate differences in the cost of delivering services, such as with different geographic locations or teaching hospitals). The incentive to increase efficiency is diluted if there are too many case groups and the payment system approaches fee-for-service. The incentive to avoid sicker patients is stronger if there are too few case groups and a wide variation in cost per case within a payment group. Striking the right balance in the number of case groups is a critical aspect of case-based payment design.

For **fee-for-service payment**, the basis for payment is the individual service, so the main incentive is for providers to deliver more services, particularly services whose fees are higher than the cost to the provider of delivering the service. This incentive can be beneficial if the health system aims to increase utilization and access to services or boost provider productivity. In particular, fee-for-service can serve as a complementary measure to the budget and capitation payment methods, which create incentives to underprovide services. The same incentive can be harmful if more services are delivered than necessary or if providers increase delivery of higher-cost, lower-priority services. Countries can set fees to favor higher-priority services and reduce the provision of lower-priority or less cost-effective services. But it can be challenging to create incentives for greater productivity without encouraging overprovision of services, particularly high-cost services. Fee schedules with more bundling can help limit some overuse of services but may not be sufficient to avoid cost escalation. International evidence shows that this adverse result is difficult to avoid; serious cost escalation almost always occurs when fee-for-service is the main payment method.

For **budget payment**, the basis for payment is the set of units used to form the budget, which can be related to inputs, outputs, case mix, or other criteria. If the budget is based on inputs, the main incentive for providers is to increase inputs, such as staff or beds, over time to ensure that the budget continues to grow. This incentive might be beneficial if a health system goal is to increase capacity, but if staff and building costs overtake other inputs, such as supplies and medicines, quality can suffer. In line-item budget payment systems, it is often difficult to move expenditures across line items, so there is typically no incentive or mechanism to improve efficiency. Providers also have an incentive to underprovide services once the budget is paid. If the budget is a global budget based on outputs with flexibility to allocate expenditures, providers have an incentive to increase the volume of services over time but deliver the currently agreed-upon volume efficiently. This incentive could be beneficial but then become perverse if providers start to reduce inputs too much, reduce quality, or avoid sicker patients. These adverse effects can be mitigated somewhat by basing global budgets on both volume and case mix.

Appropriate Rate-Setting

Payment rates should reflect the average cost of service delivery by efficient providers delivering good quality of care, the resources available for purchasing covered services, and specific policy considerations. Average costs are used as the basis for rate-setting because the cost to individual providers will vary based on the clinical needs of individual patients, as well as inefficiencies such as use of outdated technology or overreliance on physicians and specialists for routine care.

Appropriate rates should be financially sustainable for the purchaser but not significantly and chronically below the average cost to efficient providers of delivering the services, and they should not be subject to ad hoc increases based on provider pressure. A purchaser budget impact analysis should be carried out when payment rate increases are proposed. All providers in a payment system should be paid the same rate for delivering the same service or serving the same type of population. Adjustments can be made to compensate for legitimate cost differences across providers, such as rural/urban cost differences or different patient needs.

Effective Implementation Arrangements

If the implementation arrangements are working well, they should do the following:

- Create the conditions for operating and managing the payment system
- Give providers the flexibility and information they need to respond to the incentives
- Balance financial risk among purchasers, providers, and the covered population and provide levers for managing costs
- Monitor and improve quality
- Provide accountability mechanisms and levers for managing adverse consequences

Conditions for Operating and Managing the Payment System

All provider payment systems need certain conditions or mechanisms in order to operate, including reliable information to calculate and make payments to providers and monitor the

use of funds. For example, capitation payment to a provider is calculated by multiplying a base per capita rate times the number of covered individuals enrolled with the provider. Implementation arrangements must therefore include a mechanism to enroll individuals with providers and to manage changes resulting from individual choices or births, deaths, and migration. Case-based payments are made by matching payment rates to the case group a patient is assigned to. Implementation arrangements should ensure that hospital cases are properly coded and recorded in a discharge database, and the information must be submitted to the purchaser in the form of a claim. Fee-for-service payment requires some sort of claims submission and processing mechanism, and budget payment requires rules for budget creation, payment, and accounting.

Flexibility and Information for Providers to Respond to Incentives

For a provider payment system to be effective, providers must have sufficient flexibility, information, and capacity to respond to incentives. The implementation arrangements should make it possible for providers to understand the effects of the payment system on their revenue. They need to be able to make changes to their management, organization, and delivery of services so they can manage costs within payment rates and benefit under the payment system. Providers, including public providers, should have decision rights over key management decisions, such as staffing, other inputs, physical assets, organizational structure, output mix, and use of surplus revenue. Insufficient provider autonomy is one of the main reasons that provider payment systems, and strategic purchasing in general, fail to deliver health system results. Fixed payment rates that are stable for an appropriate period of time are also important so providers can plan and manage in response.

Ways to Balance Financial Risk and Manage Costs

Each provider payment system creates a different balance of financial risk between the purchaser and the provider. Systems that pay for services in a more unbundled way and do not impose any limits on the number of services that can be billed for put most of the financial risk on the purchaser. In that case, the purchaser has little control over total expenditure and may not be able to balance costs with available revenue. When payment rates are set prospectively (before services are delivered) and bundled across groups of services, more risk is shifted to providers. When payment rates are set for more bundled sets of services, such as all services needed during a hospital stay in case-based payment, the hospital bears financial risk for cases with costs higher than the payment rate. If payment rates are set chronically below the cost of delivering services, patients often bear the financial risk because providers will bill them (formally or informally) for the excess cost.

The purchaser has the ability to vary the amount of competition and financial risk that providers are exposed to within a payment system, which can enhance or reduce the power of the incentives within the system. For example, if enrollees are permitted to choose their primary care provider under a capitation system, providers with fewer enrollees will receive less revenue. Thus, the incentive for providers to respond to patient needs and demands is stronger, and the incentive to underprovide services or reduce quality is weaker. If the amount of competition or the risk exposure for providers is lower, the incentive is weakened.

Implementation arrangements should balance risk among the purchaser, providers, and patients so the purchaser and efficient providers can remain financially viable and patients will not face financial hardship from seeking necessary health care. In capitation payment, for example, if some providers do not have the capacity to deliver the entire package of services, referrals may be higher and excess financial risk may be shifted to the purchaser or to patients who bypass their primary care provider and pay out of pocket. Implementation arrangements should ensure that all providers have adequate capacity to deliver the capitation package by, for example, encouraging provider groups or networks that together can deliver the entire package.

Payment systems that are based on volume and therefore place a higher share of the risk on the purchaser, such as a fee-for-service system, should have mechanisms such as volume or payment caps to shift some of the risk back to providers. Payment systems that put more risk on providers, such as a case-based hospital payment system, should have mechanisms such as payment for outlier cases—both to balance risk between the purchaser and the provider and to protect patients from having to pay costs that are not covered. Hospitals can shift some risk back to the purchaser by increasing the number of cases. But the purchaser can manage this by using the base rate as a lever, decreasing the base rate if the volume of cases increases excessively and the budget is too far out of balance.

Systems for Monitoring and Improving Quality

Provider payment systems by themselves do not ensure high-quality care. The implementation arrangements—including the institutional relationships, quality monitoring and assurance systems, HMIS, claims review, and other processes—should make it possible to monitor and improve quality through the implementation of provider payment systems.

Accountability Mechanisms and Levers to Manage Adverse Consequences

All provider payment systems potentially create adverse consequences through perverse incentives or opportunities to game the system. Accountability mechanisms need to be in place—such as monitoring systems or other measures to ensure that providers, purchasers, and covered individuals are receiving their entitlements and meeting their obligations. Accountability measures should at least ensure that expenditures are managed and controlled (e.g., accounting, internal controls, and auditing) and that health spending buys the right services at the right prices to gain value for money.

MODULE 1

LAYING THE GROUNDWORK

IN THIS MODULE, the Analytical Team assembles background data and reviews documents to identify health system goals, the current role of provider payment, and key problems to be solved with provider payment refinement or reform. The Working Group uses this information to reach consensus on the objectives of provider payment refinement or reform and of the assessment exercise.

STEP 1. IDENTIFY THE HEALTH SYSTEM CONTEXT AND GOALS

The Analytical Team should assemble key policy documents on priorities in the health sector and background data on health financing and service delivery trends in the country for the past three to five years, including per capita health spending, government contribution to health expenditures, service delivery organization and utilization, and pooling arrangements (Analytical Team Output #1).

The accompanying *Analytical Team Workbook* provides a recommended set of indicators to document; the Analytical Team can also choose a subset of indicators or collect additional data depending on the country's needs and the availability of data. (Box 2 describes the findings of this background analysis in Vietnam.)

Box 2. Health System Goals and Financing Trends in Vietnam

Analytical Team Output #1

HEALTH SYSTEM GOALS

The Minister of Health declared the following goals for 2012 to 2016:

- Reduce hospital overcrowding.
- Reform public financial mechanisms based on the full costing of health services and health provider payment methods.
- Implement the Health Insurance Law, revise some of its provisions to align with the current situation, and activate a roadmap for universal health coverage.
- Strengthen and develop the health care network at the grassroots level (including district and commune levels) in terms of infrastructure, equipment, and human resources for better performance in primary health care, preventive health, health care for the insured, traditional medicine, and population-based health promotion, contributing to the reduction of hospital overcrowding and increasing equity in health care.
- Focus on carrying out national target programs with an emphasis on noncommunicable diseases and injury prevention.
- Improve the quality of human resources for health, especially at the commune level, ensuring more equitable and rational distribution of personnel among regions.
- Enhance the effectiveness of health education and communication in order to change people's behavior in health care. Promote intersectoral coordination in health care.

BOX 2.
Health System Goals and Financing Trends in Vietnam, *continued*

ANALYTICAL TEAM OUTPUT #1

HEALTH FINANCING TRENDS

INDICATOR	2008	2009	2010
Overall Health Financing			
Total health expenditure (billion VND)	89,056	108,662	137,358
Total health expenditure (US$)	$5,462,804,214	$6,367,504,798	$7,379,713,908
Per capita health expenditure (US$)	$64	$75	$85
Government share of total health expenditure (%)	38.4	42.2	44.6
Private share of total health expenditure (%)	61.6	57.8	55.4
Out-of-pocket share of total health expenditure (%)	54.3	50.5	47.7
% of total health expenditure through social health insurance (VSS)	17.6	17.9	17.0
Financing of Primary Health Care (at the Commune Level)			
% of government budget health expenditure at district and commune levels	31.2	22.4	N/A
% of VSS expenditure at district and commune levels	29.7	30.0	32.0
Pharmaceuticals			
% of total health expenditure on pharmaceuticals	43.8	35.7	N/A
% of total government health expenditure on pharmaceuticals	14.1	7.7	N/A
% of VSS expenditure on pharmaceuticals	44.2	53.0	N/A
% of total household expenditures for health on pharmaceuticals	51.9	47.5	N/A

STEP 2. DEFINE THE OBJECTIVES OF PROVIDER PAYMENT REFINEMENT OR REFORM

In Workshop #1, the Analytical Team and the Facilitator help the Working Group review the current health system context and confirm broad health system goals and key challenges that could be addressed through provider payment refinement or reform (WORKING GROUP OUTPUT #1). (TABLE 6 shows the main points discussed in Workshop #1 in Mongolia and Vietnam.)

TABLE 6.
Health Reform Objectives in Mongolia and Vietnam

WORKING GROUP OUTPUT #1

During Workshop #1 in both Mongolia and Vietnam, the Working Group reviewed the stated health system goals of health policymakers and other high-level government officials. The group also confirmed the highest-priority goals that could be addressed through provider payment policy and identified objectives for provider payment reform.

MONGOLIA	VIETNAM	
Reform Objectives	***Challenges***	***Reform Objectives***
• Achieve universal coverage • Improve cost efficiency at the macro and micro levels • Put in place the right incentives for different stakeholders • Stimulate competition in the health sector • Promote primary care • Improve child health care • Increase access to medicines	• Balancing available funds with benefits • Achieving quality, efficiency, sustainability, and equity • Lack of payment transparency • Patient benefits are not ensured • Financial incentives lead to oversupply of high-tech services • Payment rates are not sustainable for providers and not based on adequate costing	• Improve management efficiency and use of funds • Redesign the incentive system to improve efficiency in use of resources • Harmonize the need for quality with available funding • Strengthen health care at the grassroots level

STEP 3. AGREE ON THE OBJECTIVES AND SCOPE OF THE ASSESSMENT EXERCISE

In Workshop #1, the Working Group agrees on the objectives of the assessment exercise, which specific questions it should answer, and its scope. The scope should include the perspective(s) or point(s) of view from which payment systems are assessed, the quantitative analysis of health system data, categories of stakeholders to be interviewed, provider types to be included, and geographic areas to be covered (Working Group Output #2). (See Table 7.)

The Working Group should identify the number of stakeholder interviews to conduct and the country-specific questions to be addressed. In Vietnam, for example, the Working Group decided to include questions about the effects of fundholding arrangements that put district hospitals at risk for the cost of referrals to higher-level facilities. (See Table 8.) Decisions about the quantitative analysis can be made during Workshop #1 or deferred until later in the assessment exercise, when the priority issues and questions begin to emerge more clearly. The results of this workshop will inform the roles and responsibilities, timeline, and budget of the assessment exercise.

TABLE 7.
Template for Defining the Scope of the Assessment Exercise

Working Group Output #2

SCOPE DIMENSION	OPTIONS	
Perspectives	• Policymakers • Purchasers • Providers • Other stakeholders	
Quantitative analysis	• Assessment of the consequences of current provider payment systems • Relationship between current payment systems and health system goals *(These options depend on data availability.)*	
Provider types	• Level of service: - Primary - Secondary - Tertiary • Facility type: - Clinic - Hospital - Specialty facility - Pharmacy	• Ownership: - Public (government) - Public (corporatized) - Private for-profit - Private not-for-profit
Geography	• Geographic regions • Urban/rural	
Other	• Other dimensions that should be captured in the assessment exercise	

TABLE 8.
Scope of the Assessment Exercises in Mongolia and Vietnam

WORKING GROUP OUTPUT #2

During Workshop #1 in both Mongolia and Vietnam, the Working Group identified the perspectives, provider types, and geographic areas to be covered by the assessment exercise. In both countries, the Analytical Team deferred making decisions about the quantitative analysis until a later stage in the assessment exercise.

SCOPE DIMENSION	MONGOLIA	VIETNAM
Perspectives	• Policymakers: MOH, MOF, Ministry of Population Development and Social Protection • Purchaser: Health Department of the Social Insurance Agency (SIGO) • Providers: all levels of health facilities; pharmacies and other service providers • Patients • Other stakeholders: offices of mayors; professional associations, international organizations, nongovernmental organizations; Treasury Department	• Policymakers: MOH and MOF (central and provincial levels) • Purchaser: VSS (central, provincial, and district levels) • Providers at all levels, public and private
Quantitative analysis	• Regression analysis of the impact of the introduction of capitation and DRG payment systems on health outcomes	• Descriptive analysis of the effect of capitation on equity • Descriptive analysis of the effect of capitation on cost containment
Provider types	• Tertiary facilities • Central hospitals • District hospitals • District health centers • Family practitioners • Specialty facilities (maternity hospitals, pharmacies, dental clinics) • Private hospitals • Sanitoriums (state, rural)	• Central hospitals • Provincial hospitals • Provincial specialized hospitals • District hospitals • District health centers • Commune health stations • Private providers
Geography	• 3 regions (1 with regional treatment and diagnostic center, 1 with dense population) • 3 districts of the capital city (Ulaanbataar)	• 7 provinces • Criteria for selecting provinces: - Socioeconomic and geographic representativeness - Representative of all current provider payment methods - Provinces that are implementing capitation with surplus and deficit

MODULE 2

ASSESSING CURRENT PROVIDER PAYMENT SYSTEMS

IN THIS MODULE, the Analytical Team collects and analyzes information that will help the Working Group assess the current provider payment systems and make recommendations for refinement or reform. The team also reviews available policy documents and other materials that define and describe the design features, implementation arrangements, and results of the payment systems currently in use.

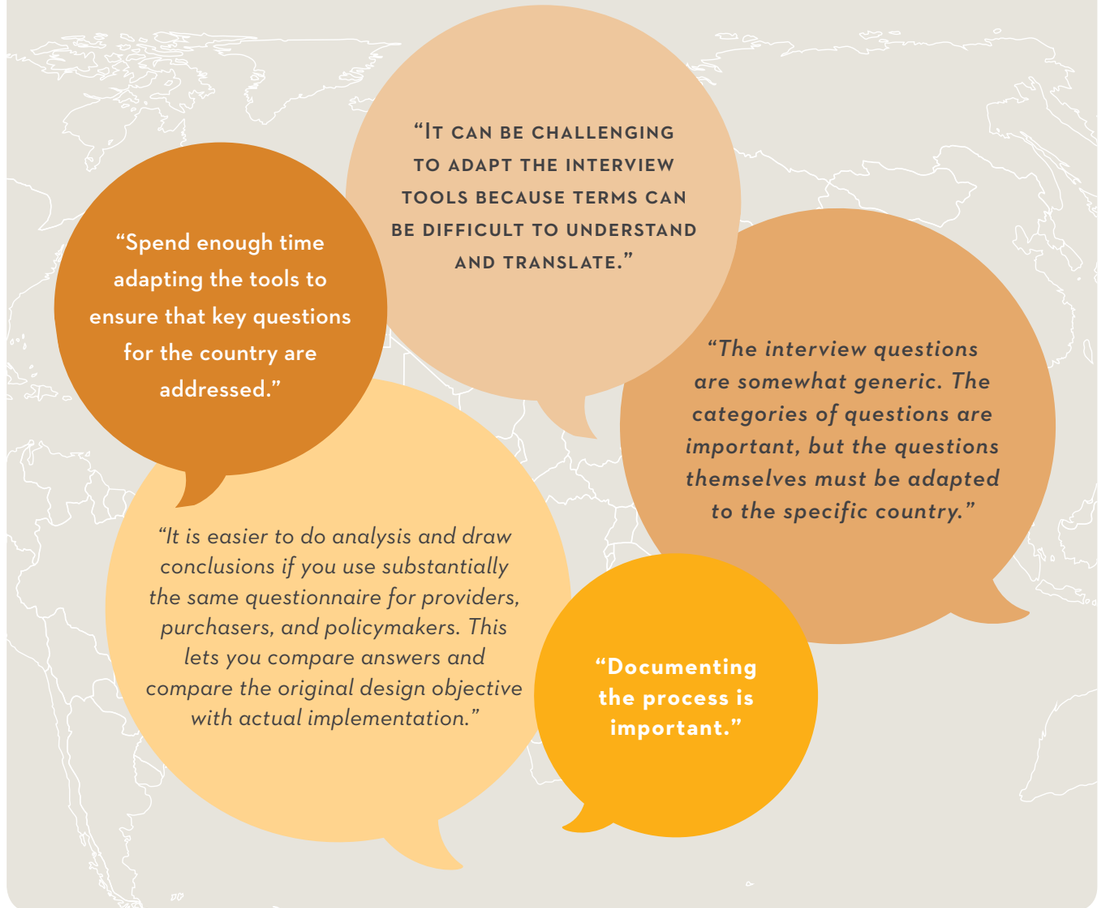
The Analytical Team interviews stakeholders to document their understanding of and perceptions about all payment systems in use for primary care, outpatient specialty services, inpatient services, and (if applicable) pharmacies. The interviewees are asked to describe key aspects of each payment system and indicate the consequences of each. The team also carries out any quantitative analysis of payment system consequences and the effects of the provider payment systems on health system goals.

Based on the interviews and quantitative analysis, the Analytical Team evaluates the strengths and weaknesses of each payment system against assessment criteria or benchmarks, potential provider payment consequences, and the country's health system goals. This input is brought to the Working Group for discussion, conclusions, and recommendations in Workshop #2: Interpreting the Results of the Assessment.

STEP 4. ADAPT AND PRE-TEST THE INTERVIEW TOOLS

The Analytical Team should adapt the interview tools in the *Analytical Team Workbook* to reflect the country's specific context and goals and to address specific issues on the country's policy agenda. These interview tools may need to be translated into the local language(s). Provider payment also has its own highly technical terminology, so countries may have to reword or elaborate on certain terms so they can be understood. The Analytical Team should pre-test the adapted interview tools to ensure that they are appropriate, will generate the necessary information, and are not overly burdensome to administer.

Lessons from the Field Tests



STEP 5. ANALYZE HEALTH SYSTEM DATA

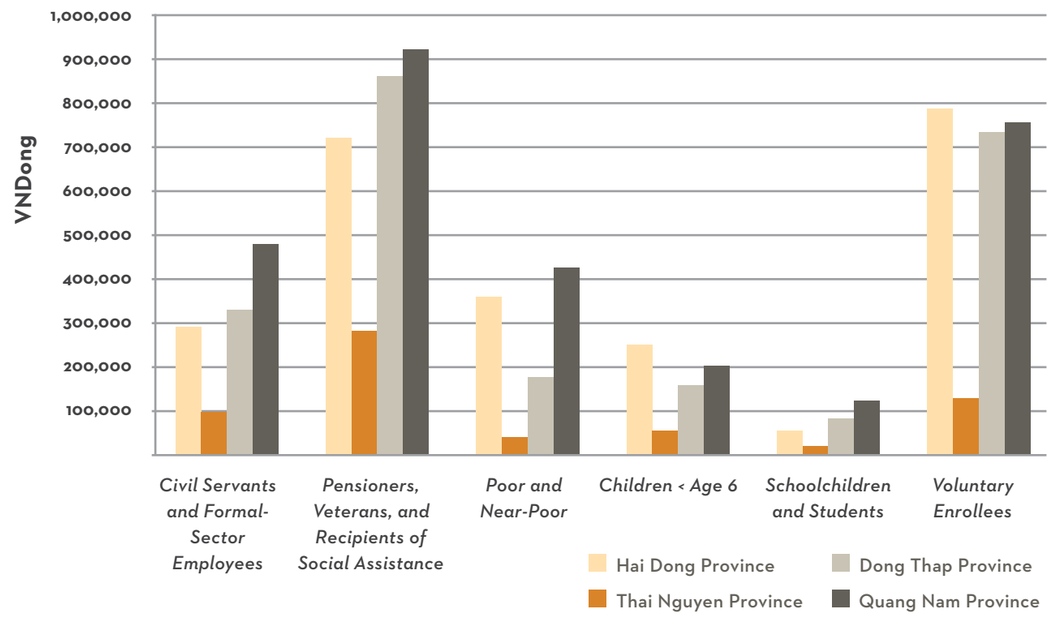
If health system data are available, quantitative analysis can help clarify the relationships between current provider payment systems and health system goals. The results can be explored more deeply through the stakeholder interviews. (Box 3 describes the data analysis in Vietnam.) Quantitative analysis also can be used to assess provider payment consequences and validate stakeholder perceptions of provider payment consequences. (See the upcoming section titled "Perceived Consequences of Each System" under Step 7.)

Lessons from the Field Tests

BOX 3.
Health System Data Analysis in Vietnam

In Vietnam, the Analytical Team conducted a quantitative analysis to determine the impact of capitation payment on the goal of improving equity. The analysis involved examining variations in the average per capita payment rate across six different insured population groups using routine data from the provincial branches of the purchaser (VSS). The analysis revealed a high degree of inequity, with a nine-fold variation in per capita payment rates across different population groups in different provinces. This inequity originated in fragmented pooling arrangements that separated the revenue for each insured group without allowing cross-subsidization. The stakeholder interviews revealed that the payment system perpetuated the inequities by calculating capitation base rates from the revenue available for each insured group. Vietnam's capitation pilot program addressed the need to equalize capitation base rates to achieve the equity goal.

PER CAPITA PAYMENT RATES FOR SIX INSURED POPULATION GROUPS IN FOUR PROVINCES OF VIETNAM



STEP 6. INTERVIEW STAKEHOLDERS ON CURRENT PAYMENT SYSTEMS

In this step, the Analytical Team uses the adapted interview tools to interview the stakeholders identified in Step 3. The interviewees should be asked about each payment method that they know is being used by any of the purchasers. Not all interviewees will be able to discuss every payment method in use. It is important to ask each person about the design and implementation of each payment system as he or she understands it. This will reveal differences in perception, which may be important in determining why a payment method is more or less effective in practice.

NOTE
The stakeholder interviews on purchaser and provider capacity in Step 10 can be conducted at the same time as the interviews in this step.

Lessons from the Field Tests

"It is best to have two members of the Analytical Team in the interviews, one to conduct the interview and the other to take detailed notes (or operate recording equipment). Let interviewees know that the interview will take one to two hours."

"To address weak knowledge of provider payment systems among respondents, it can be useful to provide a brief overview of the principles of provider payment systems and the terminology."

"IF THE TERMINOLOGY USED TO DESCRIBE PROVIDER PAYMENT DESIGN, IMPLEMENTATION, AND RESULTS IS TOO ABSTRACT, RESPONSES MAY BE LESS IN-DEPTH THAN EXPECTED."

"INTERVIEWERS SHOULD BE CAREFUL TO MAINTAIN OBJECTIVITY. POOR UNDERSTANDING OF PAYMENT SYSTEMS AMONG RESPONDENTS CAN MAKE THEIR RESPONSES SUSCEPTIBLE TO LEADING QUESTIONS OR EXPLANATIONS FROM THE INTERVIEWERS."

STEP 7. COMPILE INFORMATION FROM STAKEHOLDER INTERVIEWS

In this step, the Analytical Team compiles three categories of information from the interviews in Step 6: (1) linkages among health purchasers, provider types, and payment methods; (2) the design features and implementation arrangements of each payment system; and (3) the perceived consequences of each payment system.

LINKAGES AMONG PURCHASERS, PROVIDERS, AND PAYMENT SYSTEMS

ANALYTICAL TEAM OUTPUT #2 maps the linkages among the purchasers of health services, providers, and payment methods and the share of payments that flow through each. This will reveal how each payment method is being used, its relative importance in terms of provider revenue, and possible issues of fragmentation and conflicting incentives. (TABLES 9 AND 10 describe the results in Mongolia and Vietnam, respectively.)

Lessons from the Field Tests

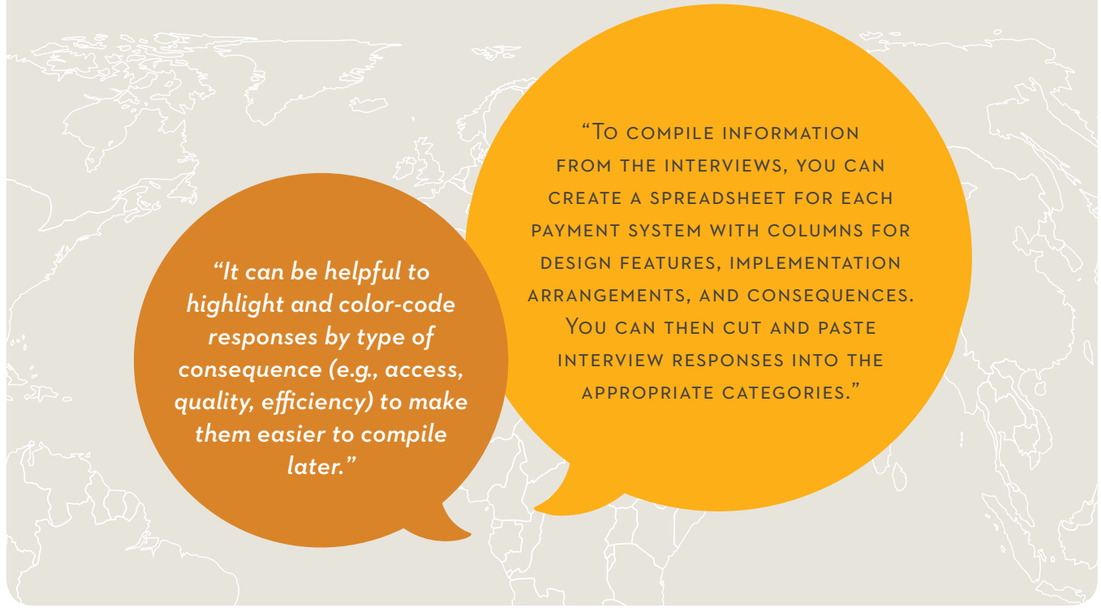


TABLE 9.
Mapping Purchasers, Providers, and Payment Methods in Mongolia

ANALYTICAL TEAM OUTPUT #2

The mapping of purchasers, providers, and payment methods in Mongolia showed that three payment methods are used: line-item budget (LIB), case-based hospital payment using diagnosis-related groups (DRGs), and fee-for-service (FFS) for direct payments by patients. The mix of methods used to pay individual providers varied widely, even within one provider category. Overall, the LIB method accounted for at least half of all revenue for most public providers.

PROVIDER TYPE	PURCHASER AND PAYMENT METHOD (% OF REVENUE)		
	MINISTRY OF HEALTH	SOCIAL INSURANCE AGENCY (SIGO)	CLIENTS
Central hospital and specialized center	LIB (12–83%)	DRGs (7–83%)	FFS (4–10%)
Province general hospital	LIB (58–60%)	DRGs (30–40%)	FFS (1–10%)
Regional diagnostic and treatment center	LIB (60%)	DRGs (34%)	FFS (6%)
District and inter-district hospital	LIB (75–96%)	DRGs (4–20%)	FFS (0–5%)
District health complex and maternity home	LIB (17–100%)	DRGs (0–80%)	FFS (0–3%)
District health center	LIB or Capitation (100%)	–	–
Family health center	Capitation (100%)	–	–
Sanitorium	–	DRGs (19–90%)	FFS (no response)
Private hospital	–	DRGs (10–30%)	FFS (70–90%)
Private pharmacy	–	Reference prices	FFS

TABLE 10.
Mapping Purchasers, Providers, and Payment Methods in Vietnam

ANALYTICAL TEAM OUTPUT #2

The mapping of purchasers, providers, and payment methods in Vietnam showed that four methods are used: global budget (GB), line-item budget (LIB), fee-for-service (FFS), and capitation. Most hospitals received payment from two different purchasers through three different payment methods, creating a high degree of fragmentation and conflicting incentives.

PROVIDER TYPE	PURCHASER				
	MINISTRY OF HEALTH	PROVINCIAL HEALTH DEPARTMENT	OTHER MINISTRIES	VIETNAM SOCIAL SECURITY	PROVINCIAL SOCIAL SECURITY
Central hospital	GB			FFS	FFS/Capitation
Provincial hospital		GB			FFS/Capitation
Provincial preventive center		GB/LIB			
District hospital		GB			FFS/Capitation
District health center		GB/LIB			
Commune health station		Salary			
Other ministry hospital			GB/LIB		FFS/Capitation
Private hospital					FFS/Capitation
Private clinic					FFS

DESIGN FEATURES AND IMPLEMENTATION ARRANGEMENTS OF EACH PAYMENT SYSTEM

The interviewees are asked to describe the design and implementation of each payment system. The aim is to document their perceptions and identify common trends and important areas of divergence and variation. (TABLES 11 AND 12 describe the results in Mongolia and Vietnam, respectively.) The Analytical Team compiles the responses and cross-checks them with policy documents and other available materials to create an accurate snapshot of payment system design features and implementation arrangements. The Analytical Team should note any areas where there is disagreement among stakeholder responses (ANALYTICAL TEAM OUTPUT #3).

TABLE 11.
Design and Implementation of Payment Systems in Mongolia

ANALYTICAL TEAM OUTPUT #3

PAYMENT METHOD	DESIGN FEATURES					IMPLEMENTATION ARRANGEMENTS		
	BASIS FOR PAYMENT AND ADJUSTMENTS	INCLUDED SERVICES	COST ITEMS	CONTRACTING ENTITIES		HOW PAYMENTS ARE DISBURSED, USED, AND TRACKED	CAPS	SURPLUSES AND DEFICITS
Capitation	• Base rate is calculated using MOF primary care allocation formula • Payment is adjusted for age/sex groups (0–5, 5–16, 16–49, 49–60, and >60), and payments are higher for migrant population • Payment is made to providers based on the estimated registered populations	• Preventive services • Primary care	• Salaries • Medicines • Supplies • Administrative costs • Minor repairs and equipment • Training	• Family health centers and district hospitals		• District hospitals receive funds according to line items • Family health centers receive funds monthly by lump sum and can allocate expenditures across line items	• Hard payment cap; overruns are not reimbursed	• District health centers are able to retain surpluses by line item • If surpluses are above a certain amount, providers must obtain permission from MOF; if less than that amount, permission can be granted by provincial health departments • Family health centers can retain surpluses and use flexibly, but they pay 10% tax
Case-based (DRG)	• 115 case groups • Payment rates set as tariffs for case groups based on a costing survey • Tertiary hospitals receive higher DRG tariffs • Private hospitals receive 50% of DRG tariff	• Outpatient specialty consultations • Diagnostic services • Inpatient stays • Medicines and blood products	• Salaries • Medicines • Supplies • Administrative costs • Minor repairs and equipment • Training	• Public and private hospitals and sanitoriums • Percentage of high-cost DRGs is paid directly to physician		• Payments are disbursed based on claims, but providers receive funds according to line items • Funds are used and accounted for according to input-based line items	• Hard budget cap; overruns are not reimbursed	• Deficits are not allowed • Surpluses are returned to the Treasury • Providers are legally permitted to retain up to 50% of surpluses, but in practice it is not allowed
Fee-for-service	• Fee schedule approved by MOH and MOF • Unclear how fees are calculated	• Preventive services • Primary care • Outpatient specialty consultations • Diagnostic services • Inpatient stays • Medicines and blood products	• Salaries • Medicines • Supplies • Administrative costs • Minor repairs and equipment • Training	• All providers except health centers and family health centers		• Fees are paid in cash, and revenue can be allocated flexibly up to the line-item limits in the provider's budget cap • Expenditures are accounted for by budget line item	• Hard budget cap; overruns are not reimbursed	• Excess fee revenue over the provider budget cap is returned to the Treasury
Line-item budget	• Varies by provider • Historical budget, input norms, catchment population, cost estimates, morbidity/mortality burdens, etc. • Residual of provider revenue cap after DRG and fee-for-service revenue are deducted • Final budgets approved by line item	• Preventive services • Primary care • Outpatient specialty consultations • Diagnostic services • Inpatient stays • Medicines and blood products • Rehabilitation services • Traditional medicine • Transportation for referrals	• Salaries • Medicines • Supplies • Administrative costs • Minor repairs and equipment • Training	• All public providers except family health centers and district health centers that are paid by capitation		• Funds are disbursed, used, and accounted for according to 38 input-based line items • Budget is paid monthly in equal installments	• Hard budget cap; overruns are not reimbursed	• Surpluses are returned to the Treasury • Deficits are not allowed

TABLE 12.
Design and Implementation of Payment Systems in Vietnam

ANALYTICAL TEAM OUTPUT #3

PAYMENT METHOD	DESIGN FEATURES					IMPLEMENTATION ARRANGEMENTS		
	BASIS FOR PAYMENT AND ADJUSTMENTS	INCLUDED SERVICES	COST ITEMS	CONTRACTING ENTITIES		FUNDHOLDING	CAPS	OVERRUNS AND SURPLUSES
Capitation	• Historical expenditures for enrolled members (premiums, payroll taxes, and subsidy payments) in each of 6 insured population groups • Flat-rate adjustment of 1.1 as an across-the-board top-up payment; no adjustment for age, sex, or other population characteristics	• All district-level outpatient and inpatient services (or higher-level outpatient services if individuals choose provincial or central hospitals as their capitation provider) • Referrals and self-referrals to provincial hospitals • Some high-cost services are excluded from capitation and are paid by fee-for-service	• Medicines • Medical supplies and consumables • Operations and maintenance	• District, provincial, and central hospitals		• District hospital is fundholder for higher-level referrals and self-referrals by registered individuals • Hospital has no control over referral expenditures	• Cap is a soft cap	• Providers are permitted to keep up to 20% of surplus, but in practice providers rarely receive surpluses they have earned • Up to 60% of overruns can be reimbursed by VSS
Fee-for-service	• National fee schedule adapted by provinces • Lack of consistent and concrete guidelines for adapting national fee schedule • In practice, fees calculated with incomplete cost basis	• 1,400 individual services (out of estimated 4,000 delivered by providers)	• Medicines • Medical supplies and consumables • Operations and maintenance	• All health providers/ facilities		• District hospital is fundholder for higher-level referrals and self-referrals by registered individuals • Hospital has no control over referral expenditures	• Cap is applied based on revenues from health insurance or cap for referral payment	• Providers are not permitted to keep any surplus • Overruns can be reimbursed by VSS
Global and line-item budget	• # of staff or beds • Budget norms vary by province	• All services delivered by the health provider/facility	• Salaries • Operations and maintenance (some) • Training and research	• All public providers/ facilities		• Health centers or district hospitals hold budgets for commune health stations	• Cap is a hard cap	• Autonomous hospitals and health facilities can keep surplus and use in accordance with regulations • In practice, only budget shortfalls, no surplus

PERCEIVED CONSEQUENCES OF EACH PAYMENT SYSTEM

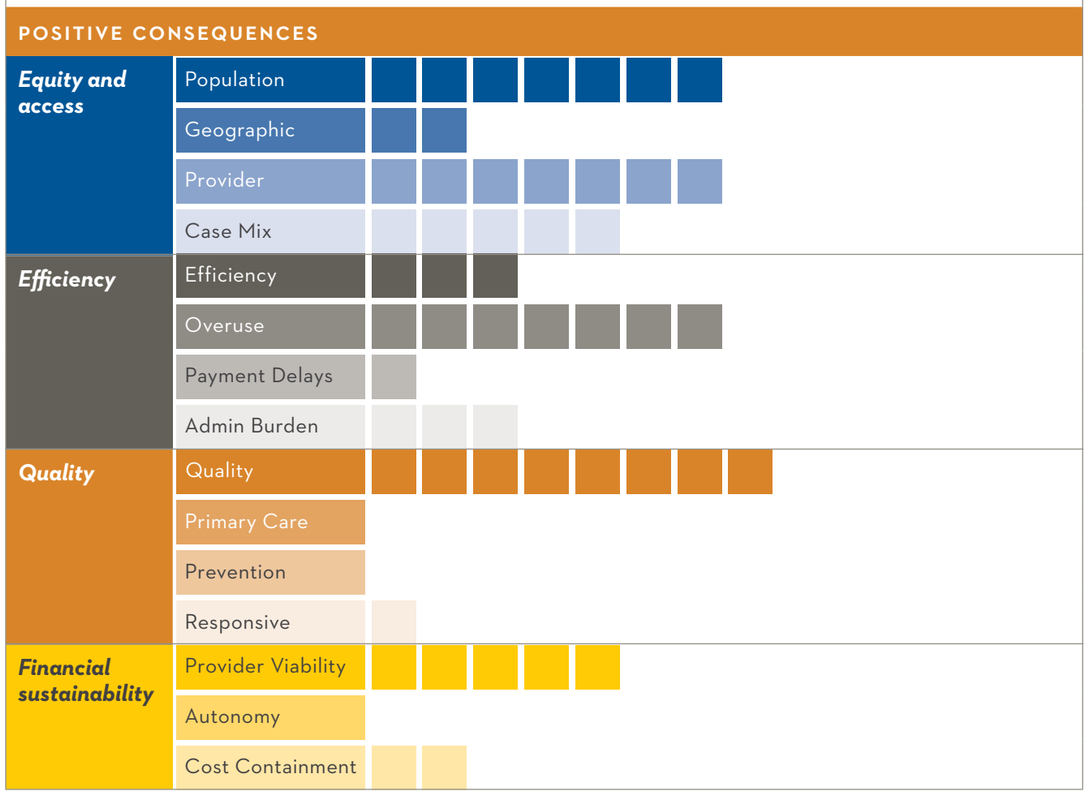
Interviewees are asked about the strengths, weaknesses, and consequences of each payment system. The *Analytical Team Workbook* provides a series of guided questions that correspond to a list of potential consequences related to equity, access to services, efficiency, quality, and financial sustainability.

The Analytical Team compiles the responses in ANALYTICAL TEAM OUTPUT #4. The responses may also be grouped by type of stakeholder to identify differences in perception between providers, purchasers, and other stakeholders. Although this is not meant to be a quantitative analysis, it can provide a picture of the main positive and negative consequences as well as conflicting incentives within and across payment systems. (BOX 4 describes the responses in Mongolia.)

BOX 4.
Perceived Consequences of Case-Based Hospital Payment in Mongolia

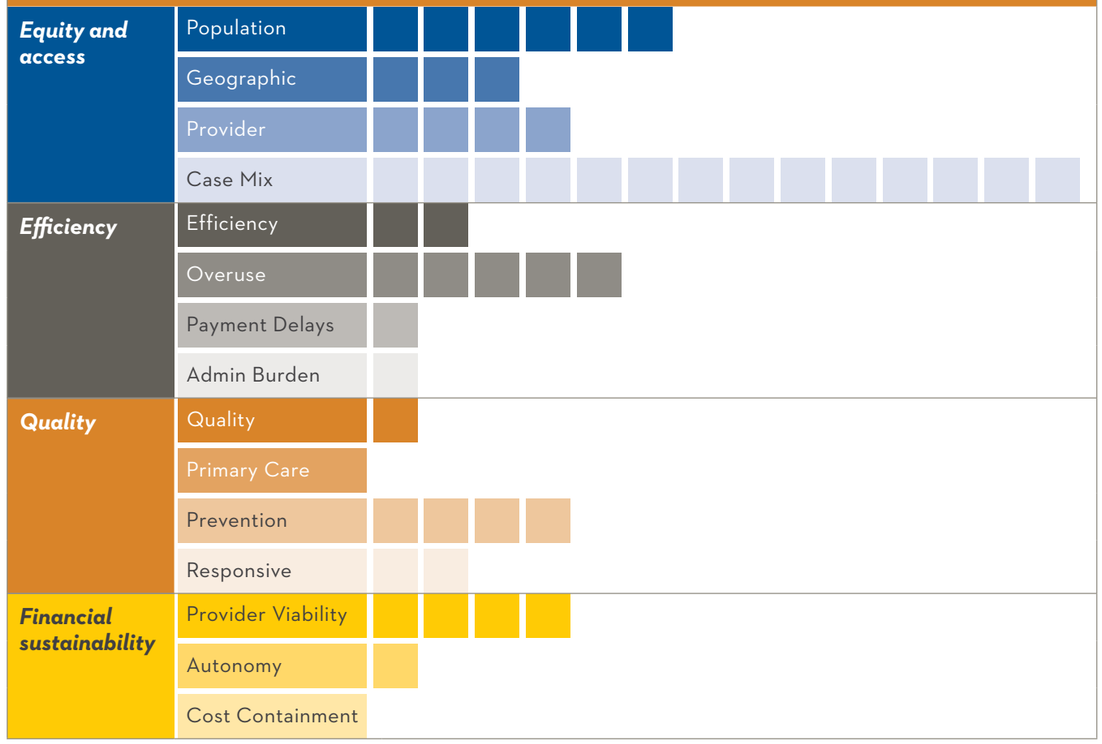
ANALYTICAL TEAM OUTPUT #4

The interview responses in Mongolia revealed mostly positive perceptions of the DRG-based payment system—the only payment system that was generally perceived as promoting equity, efficiency, and quality. The main negative perception was lack of fairness because the case groups did not account for complications and co-morbidities. Each block in the diagram represents a response related to the type of consequence.



BOX 4.
Perceived Consequences of Case-Based Hospital Payment in Mongolia, *continued*

ANALYTICAL TEAM OUTPUT #4



STEP 8. ANALYZE INFORMATION FROM STAKEHOLDER INTERVIEWS

In this step, the Analytical Team analyzes the current mix of payment methods, the design and implementation of each payment system, and the consequences, including beneficial and perverse incentives. In Step 9, the Working Group will use these outputs to assess the strengths and weaknesses and overall results of the current payment systems and method mix.

ANALYZING THE PAYMENT METHOD MIX, DESIGN, AND IMPLEMENTATION ARRANGEMENTS

The Analytical Team analyzes the current mix of payment methods through a series of questions that help identify whether the mix of payment methods is appropriate for the country's priority issues and health system goals, is appropriate for purchaser and provider capacity, and aligns with and strengthens other health financing arrangements in the country (Analytical Team Output #5).

The analytical team identifies specific criteria or benchmarks against which to compare the design features and implementation arrangements of each payment system (Analytical Team Output #6). There are no established benchmarks for payment system design and implementation, but the *Analytical Team Workbook* provides some general criteria and questions that can serve as a starting point and be refined for the specific country context. The Analytical Team can also identify international good practices and benchmarks for each payment method based on current literature and international experience, as the teams in Mongolia and Vietnam did. **Tables 13 and 14** compare the design features and implementation arrangements in Mongolia and Vietnam with benchmarks identified by the Analytical Team in each country. In both countries, the Analytical Team focused on a subset of design features and implementation arrangements that they considered to be most critical.

Lessons from the Field Tests

"Analyzing the design and implementation of provider payment systems against pre-established criteria or benchmarks will help make the assessment more objective."

"The benchmarks should be set by consensus based on international experience and evidence that is relevant to the country."

ANALYZING STRENGTHS, WEAKNESSES, AND RESULTS OF PAYMENT SYSTEMS

For each provider payment system in use, the Analytical Team should analyze the strengths, weaknesses, and consequences for the health system of the mix of payment methods and the design and implementation arrangements for each payment system (Analytical Team Output #7). This is a first draft of the overall assessment of the payment systems; it is then validated and finalized by the Working Group and represented in Working Group Output #3 (described in Step 9).

TABLE 13.
Comparing Case-Based Payment in Mongolia with International Benchmarks

Analytical Team Output #6

ASSESSMENT CRITERIA	DESIGN FEATURES AND IMPLEMENTATION ARRANGEMENTS	BENCHMARKS	DESIGN AND IMPLEMENTATION IN MONGOLIA
DESIGN FEATURES			
Transparency	Basis for payment	The payment system is most transparent when the basis for payment is a formula.	Basis for payment is a set of tariffs rather than a formula
Consistent incentives	Case groups and relative case weights	Incentives are most consistent when case groups and relative case weights capture significant variations in cost per case, with case weights based on relative costs across case groups, and adjustments for co-morbidities and outlier cases.	115 groups capture some variation in cost per case • Co-morbidities not captured • No adjustment for outlier payments
	Base rate	Incentives are most consistent when the same base rate is applied to all hospitals.	• Tertiary hospitals receive higher rates for the same DRG • Private hospitals receive lower rates for the same DRG
Appropriate rate-setting		The base rate is set most appropriately when it is derived from the pool of funds available for hospital services with appropriate adjustments.	Tariffs based on estimates from costing studies (now outdated)
IMPLEMENTATION ARRANGEMENTS			
Flexibility to respond to incentives	How payments are disbursed, used, and tracked	Providers have the most flexibility to respond to incentives when payments are disbursed based on claims without line items.	• Payments disbursed by strict line items • Heavy administrative burden to move expenditures between line items
	Caps, surpluses, and deficits	Providers have the most flexibility to respond to incentives when they are allowed to keep some portion of surpluses, with financial accountability.	• Providers do not retain any portion of surpluses
Balanced financial risk		Financial risk is most balanced when there is a hard budget cap or overruns are carefully managed and controlled.	• Hard budget cap • Overruns not allowed

TABLE 14.
Comparing Capitation Payment in Vietnam with International Benchmarks

Analytical Team Output #6

ASSESSMENT CRITERIA	DESIGN FEATURES AND IMPLEMENTATION ARRANGEMENTS	BENCHMARKS	DESIGN AND IMPLEMENTATION IN VIETNAM
DESIGN FEATURES			
Transparency and consistent incentives	Basis for payment	The payment system is most transparent when the basis for payment is a formula.	• Basis for payment is an unclear calculation of the capitation fund for each district hospital
		The incentives are most consistent when capitation payment is not linked to volume.	• Payments are linked to volume
	Package of services	Transparency is greatest and provider incentives are most consistent when the capitation package is clearly defined, is appropriate for provider capacity, and includes referral guidelines.	The capitation package: • Is not clearly defined • Excludes prevention • Includes all outpatient services as well as referrals and self-referrals, putting providers at excessive financial risk
	Population enrollment	Provider incentives are most consistent and transparency is greatest when there is free choice of provider and the enrollment database is accessible to providers and kept up-to-date to capture births, deaths, and migrations.	• Enrollment with limited choice • Enrollment lists not always clear to hospitals
Appropriate rate-setting	Base rate	The base rate is most appropriate when it is a single base rate applied to all providers, and it is derived from the pool of funds available for primary care with appropriate adjustments.	• Provider-specific base rates calculated from historical expenditures for different groups of insured individuals and not adjusted for individual health needs
IMPLEMENTATION ARRANGEMENTS			
Flexibility to respond to incentives	How payments are disbursed, used, and tracked	Providers have the most flexibility to respond to incentives when payments are disbursed as prepayment based on the enrolled population, without line items.	• Payments disbursed based on claims with limited prepayment • Providers can make expenditures flexibly
	Caps, surpluses, and deficits	Providers have the most flexibility to respond to incentives when they are allowed to keep some portion of surpluses, with financial accountability.	• Providers can retain up to 20% of surpluses, but surpluses are calculated against potential fee-for-service revenue • Soft budget cap; overruns are reimbursed up to 60%
Balanced financial risk		Financial risk is most balanced when there is a hard budget cap or overruns are carefully managed and controlled.	

STEP 9. ASSESS THE CURRENT PROVIDER PAYMENT SYSTEM AGAINST HEALTH SYSTEM GOALS

In Workshop #2, the Facilitator guides the Working Group in interpreting the analysis conducted by the Analytical Team in Step 8 and agreeing on the strengths and weaknesses of the method mix and design and implementation arrangements, their main results, and whether the payment systems support or detract from the achievement of health system goals (Working Group Output #3). The group also assesses whether the results of the provider payment systems are driven by the mix of payment methods, payment system design, implementation arrangements, or issues with pooling, benefits packages, or external factors. In addition, the Working Group identifies gaps in the assessment and any additional analysis that is needed to refine current payment systems or create a provider payment reform roadmap. (Tables 15 and 16 show the assessments for Mongolia and Vietnam, respectively.)

Lessons from the Field Tests

"In assessing payment systems, look at their strengths and weaknesses individually and also collectively. The strengths of one payment system may offset the weaknesses of another, resulting in an effective mix."

"At this stage, it is important to look at the whole picture—the mix of payment methods and the payment system design and implementation together with overall health financing policy (particularly pooling and benefits design) and contextual factors."

TABLE 15.
Assessment of Provider Payment Systems in Mongolia

WORKING GROUP OUTPUT #3

STRENGTHS	
Capitation	• Capitation improves efficiency largely because providers have flexibility to use the funds and retain any surplus.
Case-based (DRG)	• Case groups and case mix adjustment using relative case weights capture some variation in cost per case, which provides some incentive to improve efficiency without reducing quality.
Fee-for-service	• Providers gain some benefit from fee-for-service because revenue can be used more flexibly and is based on activity. • The usual negative consequences of fee-for-service are minimized because this payment method accounts for a small share of total revenue (~5% for public facilities), the overall payment cap functions well, and the current economic situation limits patient demand.
Line-item budget	• The line-item budget is generally seen as an important source of guaranteed, stable income that is important for provider financial viability. • For some providers, the budget drives efficiency and limits overuse of services, but this is largely due to the hard budget cap and limited funds.
WEAKNESSES	
Capitation	• Capitation has no serious weaknesses other than the current low per capita rate and how enrolled populations are estimated.
Case-based (DRG)	• The major shortcoming of this payment system is inadequate case mix adjustment and lack of adjustment for multiple diagnoses. • The efficiency (and possibly quality) incentives could be enhanced if hospitals were able to generate and retain some surplus revenue.
Fee-for-service	• Fee-for-service results in some quality benefits, but responsiveness to patients is negatively affected by misunderstanding of fees and patient responsibilities. • Some providers (secondary hospitals and private providers) perceive the fee structure as unfair.
Line-item budget	• The rigidity of the budget and inability to keep surpluses are barriers to improving efficiency and quality. • Inflexibility is a greater problem than the inadequate budget.
KEY CONSEQUENCES	
Capitation	• The capitation method has potential for improving efficiency and increasing health promotion and prevention.
Case-based (DRG)	• The DRG method is widely accepted and seems appropriate and fair to providers because it pays according to activity. • It is the only payment system perceived to support equity, efficiency, and quality.
Fee-for-service	• This method leads to greater productivity and efficiency without the typical negative consequence of overuse of high-cost services.
Line-item budget	• This method has serious negative consequences for efficiency.

TABLE 15.
Assessment of Provider Payment Systems in Mongolia, *continued*

WORKING GROUP OUTPUT #3

CONCLUSIONS ABOUT THE PAYMENT METHOD MIX

- The payment methods complement one another by balancing activity-based payment methods (DRG and fee-for-service) with fixed payment methods (budget and capitation), and all have some positive features.
  - Providers appreciate the fixed, stable, and predictable budget portion of their revenue.
  - Providers think the activity-based funding through DRGs is fair.
  - Providers rely on the small amount of fee-for-service revenue to supplement their total revenue and provide some staff motivation.
- The overall budget cap at the provider level is effective at harmonizing incentives across payment systems, containing costs, and forcing some efficient behavior.
- The constraints on reallocating expenditures in the line-item budget limit the efficiency incentives of all the payment methods.
- There is no opportunity for retaining surpluses, which limits motivation and efficiency incentives.
- None of the methods creates incentives to shift toward primary care.
- There is no mechanism or funding to pay for health promotion and prevention.

OVERALL IMPACT ON HEALTH SYSTEM GOALS

GOAL	EFFECTIVENESS OF CURRENT PAYMENT SYSTEMS	
Achieve universal coverage	+	• Providers perceive greater access for the covered population. • Copayment policy and capitation adjustments may enhance equity. • Effective cost containment from the overall budget cap may enable deeper coverage.
Improve cost efficiency at the macro and micro levels	+/-	• Effective budget cap helps macro-level efficiency. • Capitation promotes micro-level efficiency. • DRG payment is unclear. • Constraints on reallocating expenditures in the line-item budget limit micro-level efficiency.
Create the right incentives for different stakeholders	-/+	• Providers have little incentive for health promotion, prevention, or shifting to primary care. • Providers have some incentives to skimp on care (budget method) and generate excess admissions (DRG). • But providers have no obvious incentives for high-cost services or over-referral.
Stimulate competition in the health sector	?	Relationship between payment systems and competition is unclear.
Promote primary care	-	Providers have little incentive for health promotion, prevention, or shifting to primary care.
Improve child health care	-	Providers have little incentive for health promotion, prevention, or shifting to primary care.
Increase access to medicines	?	Pharmacies perceive that access to medicines has increased, but when payment caps are reached the burden is shifted to the patient.

TABLE 16.
Assessment of Provider Payment Systems in Vietnam

WORKING GROUP OUTPUT #3

STRENGTHS	
Capitation	• Stakeholders identified no strengths.
Fee-for-service	• New fee schedule pays the same fees to different levels of hospitals for the same services, which increases fairness across facilities in the province. • The negative aspects are not dominant mainly because of the cap, but the cap is flexible and can be gamed by providers because it is based on historical expenditures.
Line-item budget	• Method is considered fair and equitable.
WEAKNESSES	
Capitation	• In practice, there is little difference between capitation and fee-for-service. • Because of weak design and implementation, capitation is not realizing potential positive results (strengthened primary care, cost containment, equitable resource allocation). • Fundholding creates risk for providers, who do not have adequate financial and management capacity to handle the risk. • Efficiency incentives of deficits and surpluses are diluted by long processing delays and soft caps.
Fee-for-service	• Because fee-for-service payments also cover the cost of referrals, hospitals may have to provide more services to be financially viable. • Autonomous hospitals receive higher fees for privatized services, which makes the negative consequences of fee-for-service payment more severe. • Payment caps are soft caps, and two of the strongest cost drivers in the system are not subject to caps: provincial hospital services and self-referrals. • The efficiency incentives of deficits and surpluses are diluted by long processing delays and soft caps.
Line-item budget	• This method does not improve quality or responsiveness to patients because of lack of incentives and low levels of funding.
KEY CONSEQUENCES	
Capitation	• No positive consequences identified • Exacerbates inequity because the payment system design reinforces the fragmentation of the pooling arrangements • Excessive financial risk for district hospitals, which may affect access and quality at the grassroots level
Fee-for-service	• More efficient management of resources • Simplified administrative procedures • Supports increased provider autonomy • Creates incentive for providers to deliver too many services and deliver high-cost services
Line-item budget	• Promotes fairness and equity • No incentives for efficiency

TABLE 16.
Assessment of Provider Payment Systems in Vietnam, *continued*

WORKING GROUP OUTPUT #3

OVERALL CONCLUSIONS ABOUT THE PAYMENT METHOD MIX
• The current mix of payment methods and the design and implementation of the payment systems are not consistent with international good practices and do not support Vietnam's health system goals. • The methods do not complement one another.
OVERALL IMPACT ON HEALTH SYSTEM GOALS
• None of the payment systems is viewed by stakeholders as bringing strongly positive results to the health system. • The two mechanisms used to reduce overcrowding in provincial hospitals and manage costs—capitation and fundholding—are not achieving these goals: - Because of weak design and implementation, capitation is not shifting service delivery to primary care or helping to manage costs. - Fundholding creates risk for providers, and they do not have the financial and management capacity to handle the risk. - Self-referrals cannot be controlled by district hospitals, so enrollees can bypass the district hospitals and go directly to higher-level facilities. District hospitals are at financial risk for these self-referrals.

MODULE 3

ASSESSING CURRENT PURCHASER AND PROVIDER CAPACITY

IN THIS MODULE, the Analytical Team analyzes the capacity of the main purchaser, the capacity and autonomy of providers, and the availability of data to help inform payment system design and implementation.

Strategic health purchasing requires institutional authority to make purchasing decisions and enter into contracts with providers, flexibility to allocate funds, and well-functioning information systems. It also requires purchasing power.

A large purchaser or multiple purchasers operating under a unified set of rules and regulations can exert influence over how health care resources are used and how providers deliver services. Since pooling arrangements are often reflected in purchasing arrangements, fragmentation in pooling weakens purchasing power and the effectiveness of payment incentives. On the other side, providers need the autonomy and capacity to respond to incentives created by provider payment systems and other purchasing mechanisms. Purchasers and providers both need reliable data and information to make good strategic decisions.

STEP 10 INTERVIEW STAKEHOLDERS TO ASSESS PURCHASER AND PROVIDER CAPACITY

STEP 10. INTERVIEW STAKEHOLDERS TO ASSESS PURCHASER AND PROVIDER CAPACITY

The next step for the Analytical Team is to interview stakeholders on purchaser capacity and provider autonomy and capacity using interview tools adapted from those in the *Analytical Team Workbook*. The interviews can be carried out at the same time as the interviews in Step 6 or separately. The Analytical Team should compile the responses and assign low, medium, or adequate/high ratings in each capacity area and each provider autonomy area (Analytical Team Outputs #8 and #9). The team should also document data availability and the current status of coding systems (Analytical Team Output #10).

PURCHASER CAPACITY

The main areas of purchaser authority and capacity are:

- **Strategic planning, policy development, and institutional management.** The purchaser should have the authority and technical capacity to do strategic planning and policy development, identify institutional objectives that align with national health system goals, and manage its institutional functions to implement plans and meet objectives.
- **Financial management.** The purchaser should have sound internal financial policies, procedures, and systems and the ability to reasonably predict annual revenues from various sources and expenditures on services, medicines, and administration in a given year.
- **Data management and information technology (IT).** The purchaser should have the capacity to develop, implement, and make effective use of data and IT. Key databases include the enrollment database, claims database, and financial management database. Information systems should be interoperable, and information should be able to be synthesized through routine analytical reports. Unique identifiers for enrollees and providers are critical.
- **Contracting.** The most important instrument of strategic purchasing is the contract. The purchaser should have the institutional authority and technical capability to enter into legally binding agreements with health care providers that specify the characteristics and minimum requirements of contracted providers, services that providers will deliver, the methods and terms of payment, reporting requirements, and processes to resolve disputes.
- **Provider monitoring and quality assurance.** The purchaser should have the capacity to determine whether funds are being used appropriately, effectively, and efficiently by providers. The purchaser should be able to routinely measure and monitor provider performance and analyze and use performance results for decision making. The purchaser should also have the capacity to establish and enforce consequences for poor performance and/or rewards for exceptional performance (e.g., pay-for-performance, provider benchmarking, or public reporting of provider performance).

Table 17 describes the minimum technical capacity required for the purchaser to manage line-item and global budgets, capitation, fee-for-service, and case-based payment methods. As a payment method becomes more complex (for example, when performance incentives are added), the required capacity and staff expertise in areas such as provider monitoring and data analytics will increase. Line-item budgets require the least capacity—they only require adequate staff to carry out planning, budgeting, basic accounting, and a system to monitor quality. The global budget method requires health financing expertise and contracting capacity to specify the terms of the global budget, including which services are included, expected volumes, and the payment rate. Capitation requires additional capacity in data management and IT to manage population enrollment databases and link covered individuals to providers so capitation payments can be accurately calculated.

Fee-for-service and case-based hospital payment require more capacity because payment is linked to utilization and claims. Claims processing capacity is needed, as well as capacity to project and manage revenues and expenditures to avoid the cost escalation that almost always accompanies open-ended payment systems based on utilization. Case-based hospital payment requires the most capacity because an algorithm called a *grouper* (with an accompanying computer program) is needed to assign cases to case groups with payment rates. Clinical and analytical capacity are also needed to develop and refine case groups and monitor the statistical spread of cases and average cost per case to ensure that case groups are appropriate.

Box 5 describes the assessment of purchaser capacity in Vietnam.

TABLE 17.
Minimum Health Purchaser Capacity for the Most Common Payment Methods

ANALYTICAL TEAM OUTPUT #8

CAPACITY	LINE-ITEM BUDGET	GLOBAL BUDGET	CAPITATION	FEE-FOR-SERVICE	CASE-BASED
Strategic planning, policy development, and institutional management	Adequate staff to carry out planning and budgeting functions				
		Health financing expertise on staff			
		Clinical expertise on staff			
		Analytical capacity on staff			
	Basic accounting				Cost accounting system to calculate and monitor relative case weights
				Ability to project revenues and expenditures	
				Lever(s) for when expenditures exceed revenues (such as reserve funds or adjusting base rates downward)	
Data management and IT			Management of enrollment database	Automated claims processing	Programming and operation of DRG grouper
Contracting		Clear contracts with providers specifying rates and terms of payment, services, and data submission requirements			
				Claims processing and management system	
Provider monitoring and quality assurance	"Early warning system" that generates indicators of unintended consequences; routine quality assurance system				

BOX 5.
Assessment of Purchaser Capacity in Vietnam

The Analytical Team collected responses about purchasing capacity from 18 stakeholders representing Vietnam's health purchasing agency at the national and local levels. Capacity in a particular area was rated low if fewer than half (<9) of the respondents agreed with the statement, medium if half to two-thirds (9–12) of respondents agreed, and adequate if more than two-thirds (>12) agreed. Overall, institutional management capacity was rated medium, with strong leadership and organizational structure but inadequate staff to carry out main functions (especially staff with clinical expertise). Contracting capacity was rated mostly adequate, but contracts failed to specify key information for providers, such as the number of insured they were serving and the terms of payment. Data management and IT capacity was rated adequate for functions related to enrollment and accounting, but it was much more limited for analytical tasks such as actuarial analysis and monitoring and evaluation. Capacity for provider monitoring and quality assurance was considered to be almost nonexistent.

CAPACITY AREA	RATING
Strategic planning, policy development, and institutional management	
Strong leadership with clear organizational structure and lines of responsibility	Adequate
Authority and decision rights to make policies related to contracting and provider payment, data management and IT, and provider monitoring	Low
Adequate staffing to carry out main functions	Low
Adequate health financing expertise among the staff	Medium
Adequate clinical expertise among the staff	Low
Financial management	
Adequate funding to cover claims from providers	Adequate
Not in debt to providers	Adequate
Ability to project future expenditures and revenues	Adequate
Contracting	
Clear and transparent contracting with providers	Adequate
Service packages are clearly specified in contracts with providers	Medium
Payment rates are clearly specified in contracts with providers	Medium
Number of insured members is clearly specified in the contract	Low
Terms of payment, nonpayment, and payment adjustment are specified	Low
Reporting requirements of providers is clear in the contract	Adequate
Well-functioning claims management process with adequate review and timely payment to providers	Adequate
Measures are taken if providers do not perform according to the contract	Adequate
Measures are taken to prevent or address fraud	Adequate

BOX 5.
Assessment of Purchaser Capacity in Vietnam, *continued*

CAPACITY AREA	RATING
Data management and IT	
Individual enrollment automated	Adequate
Premium collection automated	Adequate
Individual eligibility verification automated	Medium
Provider contracting automated	Low
Billing and claims processing automated	Low
Accounting and financial management automated	Adequate
Routine quality indicators automated	Low
Actuarial projections carried out	Low
Routine automated monitoring and evaluation carried out	Low
Provider monitoring and quality assurance	
Position or department for quality assurance	Low
Quality assurance system in place	Low
Consequences for poor provider performance	Low

PROVIDER AUTONOMY AND CAPACITY

Managerial and operational autonomy refers to the right to make financial, personnel, service delivery, and other decisions. The more areas over which providers have decision rights, the more flexibility they will have to respond to (both beneficial and perverse) incentives. Based on stakeholder responses, the Analytical Team should determine whether each provider type has no, partial, or full autonomy in each of the following areas:

- Budgeting and financial management
- Internal allocation of funds
- Staffing levels (staff mix, hiring, firing)
- Personnel compensation (salary level and bonuses)
- Recurrent input use (e.g., types and amounts of medicines and other supplies)
- Service mix
- Use of surplus revenue
- Partnerships with other providers
- Assets and investment

Flexibility and autonomy in these areas must be accompanied by information and management capacity to make strategic decisions. Based on stakeholder responses, the Analytical Team should rate the provider's capacity level in these areas:

- General management
- Data management and IT
- Provider monitoring and quality assurance

Box 6 describes the assessment of provider autonomy and capacity in Vietnam.

DATA AVAILABILITY

Next, the Analytical Team should document data availability and the current status of coding systems. The level to which financial and service delivery data can be disaggregated is an important factor in the level of sophistication that is possible in a new provider payment system. The Analytical Team should compile information about the lowest level to which each type of data can be disaggregated, whether the data collection is automated, and coding practices (Analytical Team Output #10).

BOX 6.
Assessment of Provider Autonomy and Capacity in Vietnam

Analytical Team Output #9

In the Vietnam assessment, the Analytical Team did not assign ratings to provider autonomy and capacity areas; it drew general conclusions. The assessment showed the following:

- Although most hospitals had a legal status that gave them partial autonomy, decision rights were limited in areas such as physical assets, service pricing, and procurement of equipment and medicines.
- Most providers had adequate IT capacity, with most facilities—even the commune-level primary care facilities—reporting that they had a computer and reliable Internet services.
- Most hospitals reported using computer networks to facilitate hospital management.
- Key clinical and management functions were not yet computerized. They included quality assurance and clinical management, medical records management, and billing and claims submission.

MODULE 4 IDENTIFYING OPTIONS FOR PROVIDER PAYMENT REFINEMENT OR REFORM

IN THIS MODULE, the Working Group considers how to improve the design and implementation arrangements of current payment systems and/or change the mix of payment methods.

At this point, the Working Group will have a relatively clear picture of the current provider payment systems, their strengths and weaknesses, and the capacity of the purchaser and providers. In Workshop #3, the Working Group considers the assessment results together with contextual factors that are critical for provider payment policy to make recommendations for the way forward. Module 4 includes the optional step of creating a proposal and/or roadmap for provider payment reform.

STEP 11 DEVELOP RECOMMENDATIONS TO REFINE OR REFORM PAYMENT SYSTEMS

STEP 11. DEVELOP RECOMMENDATIONS TO REFINE OR REFORM PAYMENT SYSTEMS

In Workshop #3, the Facilitator guides the Working Group in reaching consensus on whether the challenges with current provider payment systems can be solved by adjusting their design or implementation arrangements or whether any payment method should be abandoned and replaced by a different method (Working Group Output #4).

The Working Group identifies contextual factors that are critical to provider payment and should be addressed by complementary policy reforms. Contextual factors might include political, legal, and public financial management considerations. The Working Group also develops policy recommendations that consider the policy directions of health sector leadership and other aspects of the overall policy environment in the country.

The final output of the assessment exercise (Working Group Output #5) can be a report with policy recommendations, a proposal for piloting a new payment model (as in Vietnam), or a roadmap for provider payment reform (as in Mongolia). This can be developed in Workshop #3 or by a smaller team that includes representatives from the Working Group and/or the Analytical Team.

Table 18 summarizes the assessment of provider payment reform options in Mongolia.

Lessons from the Field Tests

TABLE 18.
Assessment of Reform Options in Mongolia

WORKING GROUP OUTPUT #4

WHAT IS WORKING WELL AND SHOULD BE MAINTAINED?	
Balanced mix of payment methods that complement one another	
WHAT IS WORKING WELL BUT DESIGN AND/OR IMPLEMENTATION SHOULD BE REFINED?	
Overall pooled budget cap	• Move toward budget caps based on volume
Capitation	• Improve basis for population estimates to calculate capitation payment
Case mix adjustment of DRGs	• Refine the case groups for DRG payment to better capture variation in the severity and cost of different categories of admissions and to include adjustments for co-morbidity
Geographic adjustment	• Develop a technical basis for geographic adjustment of payments under all of the payment systems
WHAT IS NOT WORKING WELL AND SHOULD BE CHANGED OR DISCONTINUED?	
Line-item restrictions in the planning, execution, and management of the total budget	
CONTEXTUAL FACTORS	
Budget Law and public financial management rules	

IDENTIFYING KEY CONTEXTUAL FACTORS

The design, implementation arrangements, and provider responses to payment systems are affected by the larger political, legal, and public finance context. These contextual factors must be considered when deciding on reform options and developing a roadmap. (SEE FIGURE 3.)

Contextual factors generally fall into one of three categories:

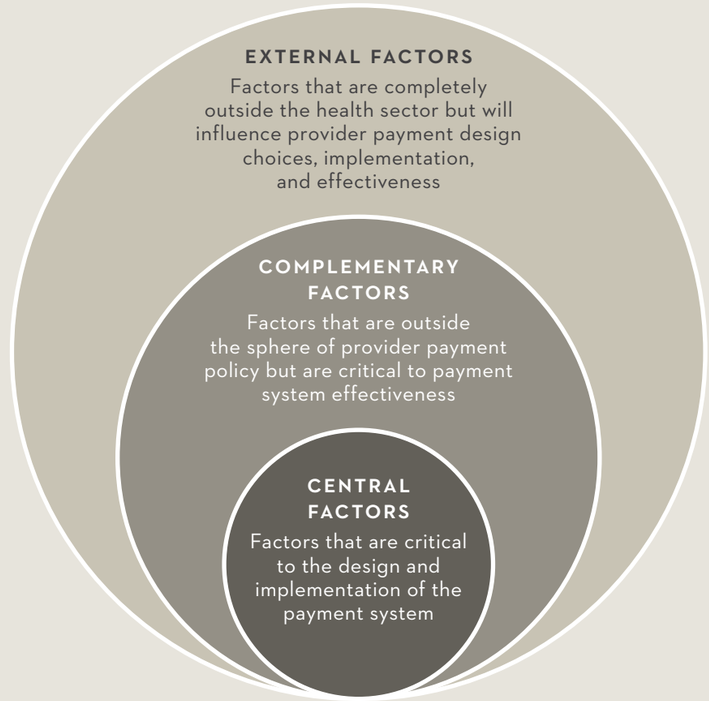
- **Central factors.** These factors are central to the provider payment system and must be addressed directly by provider payment reform or immediate complementary measures. For example, the ability of all providers to deliver a basic package of services is central to the implementation of capitation payment. Variations in provider capacity must be addressed through complementary measures, either within the payment policy (e.g., support to providers to establish provider groups or networks) or through complementary policies (e.g., investments to upgrade all primary care providers).
- **Complementary factors.** These factors are outside the sphere of provider payment policy but are critical to the effectiveness of the payment system in achieving health system goals over the medium term. For example, if the current public financial management system contains rigidities that make it difficult to pay providers for outputs, this is not directly governed by provider payment policy but will severely constrain the choice of payment methods. Complementary reforms may be needed over the medium term to address such factors.
- **External factors.** Some factors that are completely external to the health sector will influence options for provider payment methods, design choices, implementation, and effectiveness. For example, civil service policies are external to provider payment policy but will greatly affect payment system design if salaries are determined outside of the health sector.

The central, complementary, and external factors will be different for each country and for a given country at different points in time. The assessment exercise should identify complementary measures or reforms to address the key factors in each category.

Political factors are particularly important to address, especially if private-sector providers are expected to be part of provider payment reforms. The assessment exercise and the reform roadmap can help identify and manage the politics of reform.

BOX 7 lists key contextual factors that have been important for provider payment policy in many countries.

FIGURE 3.
Categories of Contextual Factors in Provider Payment Policy



BOX 7.
Categories of Contextual Factors in Provider Payment Policy

Structure, capacity, and organization of the health services delivery system:

- Autonomy/governance of providers
- Provider market structure
- Variation in the ability of providers to deliver services (urban/rural, geographic, by type)
- Relationship between public and private sectors (including "dual practice," in which public-sector health workers also work in private practice)
- Number and distribution of providers (urban/rural, geographic, by type)
- Continuum of care (particularly the role of primary care)

Institutional structure of health financing:

- Pooling arrangements
- Institutional structure of health purchasing
- Design of essential services or benefits packages

Political environment:

- Stakeholder interests, power, and relationships
- Presence and profile of champions
- Expectations of the population
- Provider income expectations
- Timeline and time pressure to implement reforms
- Donor dynamics, collaboration processes, fungibility of funds

Economic environment:

- Fiscal space and overall budget envelope
- Current health expenditure mix
- Investment and capital allocation

Other public policies and institutions:

- Public finance and administration system
- Civil service constraints
- Legal issues (including constitutional)
- Regulation and enforcement capacity
- Centralization/decentralization
- Accountability, transparency, and corruption

ROADMAP FOR PROVIDER PAYMENT REFORM

The optional roadmap for provider payment reform can lay out key steps to refine and improve the method mix, design, and implementation arrangements of provider payment systems as well as steps to address the contextual factors that are central or complementary to successful provider payment policy implementation. Mongolia developed a roadmap for comprehensive provider payment reform as the final output of the assessment exercise. (SEE BOX 8.) Vietnam focused on correcting fundamental problems with the capitation payment system. The final output of the assessment was a proposal for piloting a new capitation payment model in four provinces.

BOX 8.
Mongolia's Provider Payment Reform Roadmap

WORKING GROUP OUTPUT #5

SHORT TERM
6 MONTHS: URGENT ADJUSTMENTS

- **Line-item budgets:** Make proposal to MOF to begin gradually consolidating and reducing budget line items (within the current budget law).
- **Volume/demand-based budget caps:** Conduct analysis of volume, need/utilization, and geography/access across providers.
- **DRG-based hospital payment:** Conduct analysis to review current case groupings and cost-per-case distributions in each group.
- **PHC capitation payment:** Use population projections of the National Statistics Office for capitation payment. Analyze legal and regulatory status of family group practices to ensure flexibility. Conduct cost analysis of primary care package to inform base rate and develop geographic adjustment coefficients.
- **Outpatient specialty services payment:** Conduct analysis of volume and delivery of day surgery, rehabilitation, cancer, long-term care, emergency care, and dialysis.

MEDIUM TERM
18 MONTHS: FUNDAMENTAL REVISIONS

- **Line-item budgets:** Begin consolidating and reducing line items for budget formation, execution, and reporting.
- **Volume/demand-based budget caps:** Aim for new formula for setting budget caps by 2017 that gradually introduces volume element over several years.
- **Efficiency and quality incentives:** Explore options for keeping surpluses and using them most effectively for the health sector.
- **DRG-based hospital payment:** Develop alternative scenarios for new case groups and adjustable base rate to maintain budget neutrality. Conduct simulation analysis.
- **PHC capitation payment:** Introduce new formula for calculating base rate, add geographic adjustment coefficients, introduce mechanism to account for mobile and migrating populations, and introduce population choice where effective choice is possible.
- **Outpatient specialty services payment:** Explore bundled payment options, including case management payment for chronic diseases.

LONG TERM
3–5 YEARS: REALIGNMENT OF PAYMENT SYSTEMS

- **Mix of payment systems under a global and provider-level cap**
  - Inpatient services: (1) guaranteed global budget, (2) DRG-based payment, and (3) limited fee-for-service
  - Primary care: capitation payment with a quality incentive
  - Outpatient specialty services: (1) limited or no guaranteed budget, (2) bundled activity-based payment with a cap and incentives for disease management, and (3) limited fee-for-service
- **Caps and budgets based on activity and population need**
- **Flexibility for providers to move expenditures across line items**
- **Additional efficiency and quality incentives—** e.g., strengthen role of performance contracts, some reinvestment of surpluses.
- **DRG-based hospital payment:** Expand number of groups and account for severity and co-morbidities; use adjustable base rate to maintain budget neutrality.
- **PHC capitation payment:** Expand incentives for health promotion and prevention; use e-registration population database for capitation.
- **Outpatient specialty services payment:** Introduce bundled activity-based payment with a cap and chronic disease management incentives.

APPENDIX A

WORKING GROUP OUTPUT TEMPLATES

The following templates are models that the Working Group can use to structure the outputs of the workshops in which they interpret the findings of the provider payment assessment exercise. These templates are based on the output formats that were found to be most useful in the field tests in Mongolia and Vietnam. Each country should adapt these templates for its own context and the objectives of its assessment exercise. They can be dowloaded from **http://bit.ly/1RUsYek** and customized for the particular country.

Objectives of Provider Payment Refinement or Reform — Working Group Output #1

PRIORITY HEALTH SYSTEM GOALS	KEY HEALTH SYSTEM CHALLENGES	ROLE OF PROVIDER PAYMENT	OBJECTIVES OF PROVIDER PAYMENT REFINEMENT OR REFORM

Defining the Scope of the Assessment Exercise

Working Group Output #2

SCOPE DIMENSION	OPTIONS	WHAT TO INCLUDE
Perspectives	• Policymakers • Purchasers • Providers • Other stakeholders	
Quantitative analysis	• Assessment of the consequences of current provider payment systems • Relationship between current payment systems and health system goals *Note: Depends on data availability*	
Provider types	**Level of Service:** • Primary • Secondary • Tertiary **Facility Type:** • Clinic • Hospital • Specialty facility • Pharmacy **Ownership:** • Public (government) • Public (corporatized) • Private for-profit • Private not-for-profit	
Geography	• Geographic regions • Urban/rural	
Other	• Other dimensions that should be captured in the assessment exercise	

Assessment of Current Provider Payment Systems

Working Group Output #3

STRENGTHS: *Design features, implementation arrangements, or external factors that strengthen beneficial incentives or limit perverse incentives*	
Capitation	
Case-based	
Fee-for-service	
Global budget	
Line-item budget	
Other	
WEAKNESSES: *Design features, implementation arrangements, or external factors that limit beneficial incentives or strengthen perverse incentives*	
Capitation	
Case-based	
Fee-for-service	
Global budget	
Line-item budget	
Other	
KEY CONSEQUENCES: *Transparency and fairness, equity, efficiency, access, quality, administrative burden, cost management*	
Capitation	
Case-based	
Fee-for-service	
Global budget	
Line-item budget	
Other	

CONCLUSIONS ABOUT THE METHOD MIX

OVERALL IMPACT OF CURRENT PAYMENT SYSTEMS ON HEALTH SYSTEM GOALS	
Health System Goals	***Effectiveness of Current Payment Systems***

Recommendations to Refine or Reform Provider Payment Systems

WORKING GROUP OUTPUT #4

What is working well with the current method mix, design, and implementation of payment systems that should be preserved and/or strengthened?

Should any of the payment methods be abandoned because they work against the health system's goals by their very nature?

Should any other payment methods be adopted because they are, by their nature, more likely to support the health system's goals?

Which aspects of payment system design and implementation can be improved in the short term and the long term to address priority problems and support health system goals?

What key policy decisions must be made to refine the design and implementation of current payment systems that are within the control of health sector policymakers?

What complementary policy changes are needed to refine or reform provider payment systems that are outside the control of the health sector?

What external factors will affect the options for refining or reforming provider payment systems, and how can they be managed?

Roadmap for Reform

WORKING GROUP OUTPUT #5

ROADMAP ELEMENTS

- **Urgent steps** to correct design features or improve implementation arrangements
- **Longer-term steps** to improve the design and implementation arrangements of payment systems and the method mix
- **Supporting systems and complementary measures** to improve the incentives and implementation of payment systems
- **Contextual factors** to consider or address to improve the incentives and implementation of payment systems
- **Processes** to implement for making ongoing policy and technical decisions to refine the payment systems over the longer term

APPENDIX B

ANALYTICAL TEAM OUTPUT TEMPLATES

The following output templates can be adapted and used by the **Analytical Team** to assemble key background data and information, conduct interviews, carry out the main analytical tasks, and present information to the **Working Group**. They are found in the companion ***Analytical Team Workbook*** and can also be downloaded from **http://bit.ly/1RUsYek**.

ANALYTICAL TEAM OUTPUT #1: HEALTH SYSTEM CONTEXT

Health system goals	
What are the stated goals of the Ministry of Health?	
Have any other health system goals been declared by the government and other high-ranking officials?	
If data are available, what progress has been made toward these goals over the past 3 to 5 years?	
Summary of health financing trends	
What have been the recent trends in total health expenditure per capita?	
Has total health expenditure kept pace with the growth of the economy?	
Has the government share of total health expenditure been increasing?	
Has out-of-pocket spending as a share of total health expenditure been decreasing?	
Has the priority for health in total government expenditure been steady or increasing?	
Pooling and purchasing arrangements	
How fragmented are pooling arrangements, and what are the effects on equity (e.g., number of pools; spending per person in different pools or coverage schemes)?	
How do pooling arrangements relate to purchasing arrangements?	
How are essential services, benefits packages, and copayment policies defined?	
Organization of health service delivery	
What are the main issues or challenges with health service delivery?	
What is the role of private-sector providers?	
Can private providers be contracted by the public purchaser(s)?	
Main health sector challenges	
What are the 3 most critical challenges and priority concerns facing the health system?	

ANALYTICAL TEAM OUTPUT #2.
MAPPING PURCHASERS, PROVIDERS, AND PAYMENT METHODS

		PURCHASER			
PROVIDER TYPE		MINISTRY OF HEALTH	PUBLIC PURCHASER	PRIVATE PURCHASER	OTHER
Tertiary hospital	Public				
	Private				
Regional hospital	Public				
	Private				
Local hospital	Public				
	Private				
Outpatient specialty clinic	Public				
	Private				
Diagnostic center	Public				
	Private				
Laboratory	Public				
	Private				
Primary care provider	Public				
	Private				
Pharmacy	Public				
	Private				
Other	Public				
	Private				

ANALYTICAL TEAM OUTPUT #3.
DESIGN AND IMPLEMENTATION OF EACH PAYMENT SYSTEM

Payment Method: _____		
	DESCRIPTION	**NOTES ON AREAS OF AGREEMENT/DISAGREEMENT**
Design features		
Basis for payment		
Adjustment coefficients		
Included services		
Cost items		
Contracting entities		
Performance-based incentives		
Implementation arrangements		
Institutional relationships		
Supporting systems and complementary policies		
Public financial management rules and funds flow (fundholding, caps, overruns, and surpluses)		
Relationship to pooling		
Relationship to essential services or benefits package		
Other legal, regulatory, and policy factors		

ANALYTICAL TEAM OUTPUT #4.
CONSEQUENCES OF PAYMENT SYSTEMS

Payment Method: _____			
Main strengths of the payment system			
Main weaknesses of the payment system			
		CONSEQUENCES	**NOTES ON AREAS OF AGREEMENT/ DISAGREEMENT**
Equity and fairness			
Geography	Does the payment system contribute to fair and equitable distribution of resources across geographic areas (different regions, rural/urban, remote areas)?		
Population	Does the payment system contribute to fair and equitable distribution of resources across populations with different health needs?		
Provider	Does the payment system contribute to fair and equitable distribution of resources across providers?		
Case mix	Does the payment system contribute to fair and equitable distribution of resources across types of cases with different severity?		
Efficiency			
Efficient use of resources	Does the payment system help health providers/facilities manage resources more efficiently?		
Productivity	Does the payment system encourage higher productivity and/or reduced absenteeism among health workers?		
Overuse of services	Does the payment system make it beneficial or more profitable for health providers/facilities to: – Deliver too many services? – Deliver services in a costly way? – Increase unnecessary referrals?		
Payment delays	Does the payment system contribute to payment delays to health providers/facilities?		
Administrative burden	Is the payment system burdensome to administer?		
Access to services			
Skimping on services	Does the payment system make it beneficial or more profitable for health providers/facilities to deliver fewer services than necessary or skimp on care in other ways?		
Service or treatment delays	Does the payment system contribute to waiting lists, queues, or other barriers to patients accessing necessary services?		
Risk selection	Does the payment system make it beneficial or more profitable for health providers/facilities to avoid sicker or more costly patients?		

		CONSEQUENCES	**NOTES ON AREAS OF AGREEMENT/ DISAGREEMENT**
Quality and continuity of care			
Quality	Does the payment system make it beneficial or more profitable for health providers/facilities to provide higher-quality care?		
Provider teams	Does the payment system encourage health workers to work more closely as a team?		
Primary care	Does the payment system make it beneficial or more profitable for basic care to be delivered at the primary level?		
Prevention	Does the payment system make it beneficial or more profitable for health providers/facilities to focus on health promotion, prevention, and chronic disease management?		
Responsiveness	Does the payment system make it beneficial for health providers/ facilities to be responsive to patients?		
Financial sustainability			
Provider financial viability	Does the payment system help health providers/facilities stay financially viable and avoid deficits?		
Provider autonomy	Does the payment system help increase the autonomy of health providers/facilities?		
Cost containment	Does the payment system help total expenditures in the health system stay within available resources?		
Unintended consequences			
Gaming or fraudulent behavior	Does the payment system encourage any gaming or fraudulent behaviors?		
Suggested improvements to the mix of payment methods			
Suggested improvements to design and implementation			
Capitation			
Case-based			
Fee-for-service			
Budget			
Other			
Suggested improvements to communication and exchange of information among stakeholders			
Other suggestions for improvement			

ANALYTICAL TEAM OUTPUT #5.
ANALYSIS OF THE PAYMENT METHOD MIX

Questions for Analyzing the Current Payment Method Mix	
Appropriate for the country's priority issues and health system goals	
Does the mix of payment methods create the right incentives to address priority issues and achieve health system objectives?	
Does the mix of payment methods create adverse consequences that are too difficult to manage?	
Do the methods complement one another and create the right balance of incentives without conflicting incentives?	
Appropriate for purchaser capacity and provider autonomy and capacity	
Does the mix of payment methods match the capacity of the purchaser to design and manage complex payment systems?	
Does the mix of payment methods match the flexibility and capacity of providers to respond to provider payment incentives?	
Aligns with and strengthens the other health financing functions	
Does the mix of payment methods align with and strengthen pooling arrangements?	
Does the mix of payment methods align with and strengthen the definition of and access to essential services and benefits packages?	
Limits the opportunity for gaming and fraudulent behaviors	
Does the mix of payment methods limit opportunities for gaming and fraudulent behaviors?	
Appropriate given country contextual factors	
What are the key contextual factors that affect the mix of payment methods that would be possible and most effective for the country?	
How does the current mix of payment methods take these factors into account?	
How does the current mix of payment methods make use of advantageous contextual factors and manage limiting contextual factors?	

ANALYTICAL TEAM OUTPUT #6.
ANALYSIS OF PAYMENT SYSTEM DESIGN FEATURES AND IMPLEMENTATION ARRANGEMENTS

DESIGN FEATURE	KEY QUESTIONS OR BENCHMARKS (General criteria: transparency, consistent incentives, appropriate rate-setting)	ANALYSIS AND GAPS
Capitation		
Basis for payment		
Adjustment coefficients		
Included services		
Cost items		
Contracting entities		
Case-based		
Basis for payment		
Adjustment coefficients		
Included services		
Cost items		
Contracting entities		
Fee-for-service		
Basis for payment		
Adjustment coefficients		
Included services		
Cost items		
Contracting entities		
Global budget		
Basis for payment		
Adjustment coefficients		
Included services		
Cost items		
Contracting entities		
Line-item budget		
Basis for payment		
Adjustment coefficients		

Included services		
Cost items		
Contracting entities		
Other		
Basis for payment		
Adjustment coefficients		
Included services		
Cost items		
Contracting entities		

IMPLEMENTATION ARRANGEMENTS	**KEY QUESTIONS OR BENCHMARKS** (General criteria: conditions to operate the payment system, flexibility of providers to respond to incentives, balance of risk, quality, and accountability)	**ANALYSIS**
Capitation		
Institutional relationships		
Complementary policies and supporting systems		
Public financial management rules and funds flow		
Relationship to pooling arrangements		
Relationship to essential services or benefits packages		
External factors		
Case-based		
Institutional relationships		
Complementary policies and supporting systems		
Public financial management rules and funds flow		
Relationship to pooling arrangements		
Relationship to essential services or benefits packages		
External factors		
Fee-for-service		
Institutional relationships		
Complementary policies and supporting systems		
Public financial management rules and funds flow		
Relationship to pooling arrangements		

Relationship to essential services or benefits packages		
External factors		
Global budget		
Institutional relationships		
Complementary policies and supporting systems		
Public financial management rules and funds flow		
Relationship to pooling arrangements		
Relationship to essential services or benefits packages		
External factors		
Line-item budget		
Institutional relationships		
Complementary policies and supporting systems		
Public financial management rules and funds flow		
Relationship to pooling arrangements		
Relationship to essential services or benefits packages		
External factors		
Other		
Institutional relationships		
Complementary policies and supporting systems		
Public financial management rules and funds flow		
Relationship to pooling arrangements		
Relationship to essential services or benefits packages		
External factors		

ANALYTICAL TEAM OUTPUT #7. ANALYSIS OF THE STRENGTHS, WEAKNESSES, AND IMPACT OF CURRENT PAYMENT SYSTEMS

STRENGTHS	
Design features, implementation arrangements, or external factors that strengthen beneficial incentives or limit perverse incentives	
Capitation	
Case-based	
Fee-for-service	
Global budget	
Line-item budget	
Other	
WEAKNESSES	
Design features, implementation arrangements, or external factors that weaken beneficial incentives or strengthen perverse incentives	
Capitation	
Case-based	
Fee-for-service	
Global budget	
Line-item budget	
Other	
MAIN CONSEQUENCES	
Transparency and fairness, equity, efficiency, quality, gaming and fraudulent behaviors, administrative burden, cost management	
Capitation	
Case-based	
Fee-for-service	
Global budget	
Line-item budget	
Other	
OVERALL CONCLUSIONS ABOUT THE METHOD MIX	

OVERALL IMPACT OF PAYMENT METHODS ON HEALTH SYSTEM GOALS		
Goal	***Impact of current payment systems***	
	+/-/?	
	+/-/?	
	+/-/?	
	+/-/?	
	+/-/?	
	+/-/?	
	+/-/?	

ANALYTICAL TEAM OUTPUT #8. ASSESSMENT OF PURCHASER CAPACITY

KEY QUESTIONS OR CRITERIA	**RATING**
Strategic planning, policy development, and institutional management	
Financial management	
Data management and IT	
Provider monitoring and quality assurance	

ANALYTICAL TEAM OUTPUT #9.
ASSESSMENT OF PROVIDER AUTONOMY AND CAPACITY

AUTONOMY AREA	DEGREE OF AUTONOMY FOR DIFFERENT PROVIDER TYPES
Budgeting and financial management	
Internal allocation of funds	
Staffing levels (staff mix, hiring, and firing)	
Personnel compensation (salary level and bonuses)	
Recurrent input use (types and amounts of medicines and other supplies)	
Service mix	
Physical assets	
Use of surplus revenue	
Partnerships with other providers	
Other	
CAPACITY AREA	**DEGREE OF AUTONOMY FOR DIFFERENT PROVIDER TYPES**
HMIS capacity	
Management capacity	

ANALYTICAL TEAM OUTPUT #10.
DATA AVAILABILITY FOR PROVIDER PAYMENT REFORM

AVAILABILITY OF DATA	LEVEL OF DISAGGREGATION													
Data elements	NATIONAL	AUTO-MATED?	PROVIN-CIAL	AUTO-MATED?	REGIONAL	AUTO-MATED?	HOSPITAL	AUTO-MATED?	HOSPITAL DEPT.	AUTO-MATED?	HEALTH CENTER	AUTO-MATED?	PATIENT	AUTO-MATED?
1. Demographic data	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2. Outpatient service utilization	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
# and type of outpatient visits	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
# and type of procedures	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
# and type of diagnostic tests	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diagnosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diagnosis coding used*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3. Hospital activity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
# of discharges	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Length of stay	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diagnosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diagnosis coding used*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
# and type of procedures	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
# and type of diagnostic tests	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4. Financial and input data	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Budgets	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Expenditure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Staffing	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Medicines and supplies	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Equipment	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Coding	YES	AUTO-MATED?	YES	AUTO-MATED?	YES	AUTO-MATED?	YES	AUTO-MATED?	YES	AUTO-MATED?	YES	AUTO-MATED?	YES	AUTO-MATED?
1. Unique patient identifier	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2. Unique identifier for individual providers	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3. Unique identifier for facilities	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4. Department codes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5. ICD-9 codes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6. ICD-10 codes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

* E.g., ICD-9, ICD-10, other.

GLOSSARY

ADJUSTMENT COEFFICIENT. A coefficient applied to the base payment rate to adjust payment for the cost of meeting the health service needs of different population groups or legitimate cost differences related to specific provider characteristics (e.g., being located in a rural or remote area or serving as a teaching facility).

AVERAGE LENGTH OF STAY. The average number of bed-days (inpatient days) for each patient discharged from the hospital. The average length of stay can be calculated for an entire facility, a department, or a diagnosis-related group classification.

BALANCE BILLING. The practice of a health care provider charging a patient for the difference between what the purchaser agrees to pay for the service and what the provider chooses to charge.

BASE RATE. The average payment rate paid by the purchaser to the provider per unit of service, bundle of services, or registered individual.

BASIS FOR PAYMENT. The primary unit of payment, payment parameters, and formula for calculating total payment to a provider.

BED-DAY. A day during which a patient stays overnight in a hospital. Also referred to as an *inpatient day* or *patient day*.

BLENDED PAYMENT SYSTEM. A payment system that combines elements of multiple payment methods to maximize the beneficial incentives (and minimize the perverse incentives) of each. Also called a *mixed-model payment system*.

BUDGET-NEUTRAL PAYMENT SYSTEM. A payment system that calibrates payment rates so total payments to providers (after any weights and/or adjustments are applied) are less than or equal to the total budget of the purchaser.

BUNDLED SERVICE PAYMENTS. The allocation of a fixed payment to a health care provider to cover all services, tests, and procedures grouped into a higher aggregated unit (e.g., a service package or hospital discharge) rather than payment for each individual service.

CAPITATION PAYMENT. A payment method in which all providers in the payment system are paid a predetermined fixed rate in advance to provide a defined set of services to each individual enrolled with the provider for a fixed period. Also called *per capita provider payment*.

CASE-BASED PAYMENT. A hospital payment method that pays hospitals a fixed amount per admission or discharge depending on the patient and clinical characteristics, which may include department of admission, diagnosis, and other factors. The payment rate covers all tests, procedures, and other services provided during the hospital stay. If the cases are grouped according to diagnosis, it is a case-based diagnosis-related group (DRG) payment method.

CASE GROUP. A group of hospital cases defined for a case-based hospital payment system that includes cases with similar clinical characteristics and that require similar resources to diagnose and treat cases or complete a phase of case management.

CASE MIX. The average relative complexity and resource intensity of services required to diagnose and treat patients in a hospital due to diagnosis, disease severity, and personal characteristics such as age.

COMPLEMENTARY MEASURES. Policies or activities that are implemented together with a provider payment system to improve the operation of the system, enhance beneficial incentives, or minimize adverse consequences. Examples include quality monitoring systems, performance-based incentives, and payment caps.

CONTRACTING ENTITY. A type of provider that is permitted to receive payment under the payment system.

COST. The value of resources (inputs), expressed in monetary terms, used to produce a good or service, carry out an activity, or achieve a goal.

COST ACCOUNTING METHODS. Methods that use accounting principles to classify and measure all costs incurred in producing a good or service, carry out an activity, or achieve a goal.

COST ITEM. An input, or resource, used by providers to deliver health services to which costs are attached. Cost items include both capital and recurrent items.

DIAGNOSIS-RELATED GROUP (DRG). A classification of hospital case types into groups that are clinically similar and are expected to have similar hospital resource use. The groupings are based on diagnoses and may also include procedures, age, sex, and the presence of complications or co-morbidities. DRGs are an example of a system of case groups and relative case weights. See also *case-based provider payment*.

FEE-FOR-SERVICE PROVIDER PAYMENT. A payment method that pays providers for each individual service provided. Fees or tariffs are fixed in advance for each service or bundle of services.

FIXED-FEE SCHEDULE. The list of fees or tariffs set in advance in a fee-for-service payment system.

FORMULA-BASED PAYMENT CALCULATION. Calculation of payments to providers based on a transparent mathematical formula with predefined parameters rather than the use of fixed tariffs or other non-formula bases.

FUNDHOLDING ARRANGEMENT. An arrangement whereby payment to a provider covers all or some of the costs of services provided by another provider or providers. The fundholding provider is at financial risk for the services delivered by the other provider(s).

GLOBAL BUDGET PROVIDER PAYMENT. A payment method that allocates a fixed amount to a provider for a specified period to cover aggregate expenditures to provide an agreed-upon set of services. The budget can be used flexibly and is not tied to specific line items for input expenses (e.g., personnel, medicines, utilities).

GROUPER. An algorithm that assigns hospital cases to groups with associated relative case weights to calculate case mix or final payment rates for each case in a case-based hospital payment system. The grouper is typically accompanied by a computer program to automatically run the algorithm.

HEALTH PURCHASER. An entity that transfers pooled health care resources to providers to pay for covered health care goods, services, and interventions. Purchasers can include health ministries, social insurance funds, private insurance funds, and other entities that manage health funds on behalf of the population.

HEALTH PURCHASING. The allocation of pooled resources to health care providers on behalf of the covered population to pay for covered health care goods, services, and interventions.

INCENTIVE. An economic signal that directs individuals (e.g., health workers) or organizations (e.g., health provider institutions) toward self-interested behavior. The incentives created by a provider payment system will affect provider decisions about the services they deliver, how they deliver them, and the mix of inputs they use for delivery.

INPUT. A resource (e.g., personnel time, supplies, equipment) that is used to produce a good or service, carry out an activity, or achieve a goal.

INSTITUTIONAL RELATIONSHIPS. The formal and informal rules governing interactions between and among purchasers, providers, the population, and other stakeholders.

LINE-ITEM BUDGET PROVIDER PAYMENT. The allocation of a fixed amount to a health care provider for a specified period to cover specific input costs (e.g., personnel, medicines, utilities).

MIXED-MODEL PAYMENT SYSTEM. See *blended payment system*.

OUTPUT. The result of a production process—a good or service, a completed activity, or an achieved goal. See also *unit of service*.

PACKAGE RATE. The payment rate for a bundle of services, such as a surgery and all related pre- and post-surgery services.

PAYMENT CAP. A limit on the total payments to a provider or group of providers under a payment system.

PAYMENT DEFICIT. The amount by which the cost of delivering services exceeds the payment to a provider.

PAYMENT SURPLUS. The amount by which payment to a provider exceeds the cost of delivering services.

PAYMENT SYSTEM PARAMETERS. The factors that are used to calculate payment rates, such as relative case weights in a case-based hospital payment system or the enrolled population in a capitation payment system.

PER CAPITA PROVIDER PAYMENT. See *capitation payment*.

PER DIEM PROVIDER PAYMENT. A payment method that pays a fixed amount per inpatient day to hospitals for each admitted patient. The per diem rate may vary by department, patient, clinical characteristics, or other factors.

PERFORMANCE-BASED INCENTIVES. Measures that reward better performance (or penalize poor performance), either financially or in some other way. Performance-based incentives can be incorporated within any payment system to strengthen the beneficial incentives or minimize the perverse incentives in the payment system.

PERSPECTIVE. In a provider payment assessment exercise, the point(s) of view from which payment systems are assessed. The perspective can be that of the purchaser, provider, patient, and/or society.

POOLING OF HEALTH CARE FUNDS. Accumulation of funds allocated to pay for covered health care goods, services, and interventions for the covered population.

PRE-TEST. A pilot study, feasibility study, or small-scale preliminary study that tests the feasibility of the exercise methodology and enhances the quality and efficiency of the main exercise.

PROSPECTIVE PAYMENT. Payment system in which rates are set in advance and/or providers are paid before services are delivered.

PROVIDER AUTONOMY. Decision rights of a health care provider to make key management decisions, such as those related to staffing, salaries and bonuses, use of other inputs, physical assets, organizational structure, output mix, and use of surplus revenue.

PROVIDER BENCHMARKING. Comparing the performance of health care providers to average performance or against high-performers, using specific indicators or measures.

PROVIDER PAYMENT. The allocation of resources to a health care provider to deliver the covered package of health care goods, services, and interventions to the covered population.

PROVIDER PAYMENT METHOD. The way in which a purchaser pays health care providers to deliver a service or set of services. A provider payment method is defined primarily by the unit of payment. See also *unit of payment*.

PROVIDER PAYMENT RATE. The amount of money that a purchaser pays to a provider to deliver a service or set of services under the payment system.

PROVIDER PAYMENT SYSTEM. One or more payment methods and all supporting systems, such as contracting and reporting mechanisms, information systems, and financial management systems.

PUBLIC FINANCIAL MANAGEMENT SYSTEM. The rules governing how public budgets are created, disbursed, and tracked.

RATE-SETTING. The process of determining provider payment rates.

RECURRENT COSTS. Resources that are consumed within one year or have a working life of less than one year and must be regularly replaced. Also called *operating costs*.

RELATIVE CASE WEIGHT. A coefficient applied to the base rate in a case-based hospital payment system to adjust the payment for a case upward or downward to reflect the cost of treating cases in a particular group relative to the average cost per case for all cases. Used to calculate case mix. See also *case mix*.

RELATIVE COST. The cost of a good or service as it compares with the cost of other goods and services, expressed in terms of a ratio between two costs or between one cost and a weighted average of all other goods or services available.

RELATIVE PRICE. The price of a good or service as it compares with the price of other goods and services, expressed in terms of a ratio between two prices or between one price and a weighted average of all other goods or services available.

SCOPE. The parameters of a provider payment assessment exercise. Dimensions of scope include the perspective, quantitative analysis, provider types, geography, etc.

UNIT COST. The cost incurred to deliver a single good or service or a bundle of services (e.g., a lab test or a hospital bed-day). The average cost per good or service is the total cost of each good or service divided by the number of goods or services provided.

UNIT OF PAYMENT. The unit of output for which a health care provider is paid under the payment method—per service, per visit, per case, per bed-day, or per person per year.

UNIT OF SERVICE. A unit of output of inpatient or outpatient health care delivery (e.g., bed-day, discharge, visit, lab test, exam, surgery, prescription).

UNIVERSAL HEALTH COVERAGE. Ensured access to essential health services for an entire population without risk of financial hardship or impoverishment.

BIBLIOGRAPHY

Apablaza, R., C. Pedraza, A. Roman, and N. Butala. "Changing Health Care Provider Incentives to Promote Prevention: The Chilean Case." Harvard Health Policy Review. Fall 2006. 7(2): 102–12.

Berenson, R., and E. Rich. "US Approaches to Physician Payment: The Deconstruction of Primary Care." Journal of General Internal Medicine, 2010. 25(6): 613–18.

Brantes, F., and J. Camillus. Evidence-Informed Case Rates: A New Health Care Payment Model. Commonwealth Fund, 2007.

Busse, R., J. Figueras, R. Robinson, and E. Jakubowski. "Strategic Purchasing to Improve Health System Performance: Key Issues and International Trends." Healthcare Papers, 2007. 8(Sp): 62–76.

Cashin, C., B. Ankhbayar, T. Tsilaajav, O. Nanzad, G. Jamsran, and A. Somanathan. Assessment of Systems for Paying Health Care Providers in Mongolia: Implications for Equity, Efficiency and Universal Health Coverage. World Bank Group, 2015.

Cashin, C., Y. Chi, P. Smith, M. Borowitz, and S. Thomson, eds. Paying for Performance in Health Care: Implications for Health System Performance and Accountability. Berkshire, Eng., and NY: Open University Press, 2014.

Figueras, J., R. Robinson, and E. Jakubowski, eds. Purchasing to Improve Health Systems Performance. Open University Press: 2005.

Fuenzalida-Puelma, H., S. O'Dougherty, T. Evetovits, C. Cashin, G. Kacevicius, and M. McEuen. "Purchasing of Health Care Services." In J. Kutzin, C. Cashin, and M. Jakab, eds., Implementing Health Financing Reform: Lessons from Countries in Transition. World Health Organization, 2010.

Glazier, R., J. Klein-Geltink, A. Kopp, and L. Sibley. "Capitation and Enhanced Fee-for-Service Models for Primary Care Reform: A Population-Based Evaluation." CMAJ, 2009. 180: E72–E81.

Goroll, A., R. Berenson, S. Schoenbaum, and L. Bardner. "Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care." Journal of General Internal Medicine, 2007. 22: 83.

Islam, M., ed. The Health System Assessment Approach: A How-To Manual. Submitted to USAID in collaboration with Health Systems 20/20, Partners for Health Reformplus, Quality Assurance Project, and Rational Pharmaceutical Management Plus. Arlington, VA: Management Sciences for Health, 2007.

Kringos, D., W. Boerma, E. Spaan, and M. Pellny. "A Snapshot of the Organization and Provision of Primary Care in Turkey." BMC Health Services Research, 2011. 11–90.

Kutzin, J. "Health Financing for Universal Coverage and Health System Performance: Concepts and Implications for Policy." Bulletin of the World Health Organization, 2013. 91(8): 602–11.

Langenbrunner, J., C. Cashin, and S. O'Dougherty, eds. Designing and Implementing Health Care Provider Payment Systems: How-To Manuals. Washington, D.C.: World Bank, 2009.

Mathauer, I., and G. Carrin. "The Role of Institutional Design and Organizational Practice for Health Financing Performance and Universal Coverage." Health Policy, 2011. 99(3): 183–92.

Mechanic, R. "Opportunities and Challenges for Episode-Based Payment." New England Journal of Medicine, 2011. 365: 777–79.

Nguyen, P., O. Tran, P. Hoang, T. Tran, and C. Cashin. "Assessment of Systems for Paying Health Care Providers in Vietnam: Implications for Equity, Efficiency and Expanding Effective Health Coverage." Global Public Health, 2015.

Özaltın, A., and C. Cashin, eds. Costing of Health Services for Provider Payment: A Practical Manual Based on Country Costing Challenges, Trade-offs, and Solutions. Joint Learning Network for Universal Health Coverage, 2014.

Paris, V., M. Devaux, and L. Wei. Health Systems Institutional Characteristics: A Survey of 29 OECD Countries. Paris: Organisation for Economic Co-operation and Development, 2010. OECD Health Working Papers, No. 50.

Schieber, G., C. Baeza, D. Kress, and M. Maier. "Financing Health Systems in the 21st Century." In Jamison, T., et al., eds., Disease Control Priorities in Developing Countries, 2nd ed. New York: Oxford University Press, 2006.

Struijs, J., and C. Baan. "Integrating Care Through Bundled Payments—Lessons from the Netherlands." New England Journal of Medicine, 2011. 364: 990–91.

Tsiachristas, A., C. Dikkers, M. Boland, and M. Rutten-van Mölken. "Exploring Payment Schemes Used to Promote Integrated Chronic Care in Europe." Health Policy, 2013. 113(3): 296–304.

Tuggy, M., et al. "Primary Care Payment Reform: The Missing Link." Annals of Family Medicine, 2012. 10(5): 472–73.

World Health Organization. OASIS: Organizational Assessment for Improving and Strengthening Health Financing (Excel Aid).

ADDITIONAL RESOURCES

You can access additional resources at:

http://bit.ly/1RUsYek

A digital version of the *Analytical Team Workbook* in Microsoft Word format, including the interview tools and Analytical Team output templates.

A digital version of the Working Group output templates in Microsoft Word format.

Resources from the provider payment assessment exercises in Mongolia and Vietnam, including workshop agendas; Working Group and Analytical Team outputs; and reports, policy notes, and other publications.

JOINT LEARNING NETWORK
For Universal Health Coverage

www.jointlearningnetwork.org