This technical brief summarizes the potential use of different payment methods for strategic purchasing for UHC.

**What is strategic purchasing? How does it contribute to fairer and more efficient use of resources?**

The 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 health coverage. However, simply increasing spending is not enough to meet a country’s health goals. The funds must be directed toward priority populations, programmes and services to increase access to priority services, improve the quality of care, and advance equity and financial protection.

To better match health funds with these priorities, many countries have implemented reforms to ensure that funds flow to those with greatest need; create incentives for providers to improve efficiency and quality, and also in some cases to allow public funds to be used to purchase services from private as well as public providers. This international trend is away from “passive purchasing”, which simply allocates historically determined line-item budgets to providers or pays unlimited fee-for-service, toward using more “active” or “strategic” purchasing to maximize health system performance and get the most value for money.

**What decisions does strategic purchasing involve?**

Strategic health purchasers may be a Ministry of Health, a local authority, a social health insurance agency, etc. Such purchasers make deliberate decisions in five areas:

- **Coverage**: for whom to buy health services
- **Benefit packages**: which health services to buy (and what to exclude)
- **Contracting**: from whom to buy services, which services, at what price
- **Provider payment**: how and how much to pay providers
- **Quality**: how to ensure that purchased health services are of good quality.

**What do we mean by provider payment methods?**

Provider payment methods refer to the way in which purchasers transfer funds to health provider institutions to deliver agreed services. Different payment mechanisms create different economic signals or incentives that influence provider behaviour – what services they
deliver, how they deliver them and the mix of inputs they use. The right incentives can direct provider behaviour 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.

Frequently used provider payment methods. The most commonly used payment methods are:

- line-item budget
- global budget
- per diem
- case-based (e.g. diagnosis-related groups)
- fee-for-service
- capitation (per capita).

Table 1 summarizes the definition of each payment method, the incentives it creates and when that payment method may be useful.

Choosing the best provider payment method. 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. Countries should identify the mix of methods that will create incentives that align with their health system priorities and goals. The mix of provider payment methods that is best for a country, region or institution will change over time as providers adapt and respond to the incentives, and as goals and challenges change.

The following questions can help select the right mix of provider payment mechanisms:

- What incentives should be created for providers?
- What is the capacity of the purchaser to design and manage complex payment systems?
- How much flexibility and capacity do providers have to respond to incentives?
- What contextual factors are important – the political environment, legal constraints and the public financial management system?

All provider payment systems may create adverse incentives and unintended consequences, so many countries combine payment methods to create a blended payment system or mixed model. 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 include a small amount of fee-for-service payment for priority preventive interventions (e.g. immunization) to counteract the potential incentive of capitation to underprovide services.

Provider payment policy will be shaped by the country context, including the health system capacity and objectives, the overall health financing architecture, public financial management systems, and the stage of development of health information systems (Fig. 1). Choosing a mix of payment methods that complement one another in the country context, designing them strategically, and putting the right implementation arrangements in place are crucial for getting the most benefit for the health system from the provider payment policy.

Institutional relationships, regulations and health system policies must also 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 (e.g. effective public financial management systems);
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<td>Line-item budget</td>
<td>Providers receive a fixed amount for a specified period to cover input expenses (e.g. personnel, medicines, utilities).</td>
<td>Underprovide services, increase referrals, increase inputs, spend all remaining funds by the end of the budget year. No incentive or mechanism to improve efficiency.</td>
<td>Management capacity of the purchaser and providers is low; cost control is a top priority.</td>
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<tr>
<td>Global budget</td>
<td>Providers receive a fixed amount for a specified period to cover aggregate expenditures to provide an agreed-upon set of services. Budget is flexible and not tied to line items.</td>
<td>Global budgets formed based on inputs: underprovide services, increase referrals, increase inputs.</td>
<td>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.</td>
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<td>Per diem</td>
<td>Hospitals are paid a fixed amount per day for each admitted patient. May vary by department, patient, clinical characteristics or other factors.</td>
<td>Increase the number of bed-days (may lead to excessive admissions) and lengths of hospital stay; reduce inputs per bed-day (may improve the efficiency of the input mix).</td>
<td>Management capacity of the purchaser and provider 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.</td>
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<td>Case-based (e.g. diagnosis-related groups)</td>
<td>Hospitals are paid a fixed amount per admission or discharge depending on the patient and clinical characteristics, which may include department, diagnosis, etc.</td>
<td>Increase admissions, including to excessive levels; reduce inputs per case, which may improve the efficiency; unbundle services (e.g. through pre-admission testing); reduce length of hospital stay; shift rehabilitation care to the outpatient setting.</td>
<td>Management capacity of the purchaser is moderate to advanced; there is excess hospital capacity and/or use; improving efficiency is a priority; cost control is a priority.</td>
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<td>Fee-for-service</td>
<td>Providers are paid for each individual service provided. Fees are fixed in advance for each service or group of services.</td>
<td>Increase the number of services, including above the necessary level; reduce inputs per service, which may improve the efficiency of the input mix.</td>
<td>Increased productivity, service supply and access are top priorities; there is a need to retain or attract more providers; cost control is a low priority.</td>
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<td>Capitation (per capita)</td>
<td>Providers are paid a fixed amount in advance to provide a defined set of services for each enrolled individual for a fixed period of time.</td>
<td>Improve efficiency of the input mix, attract enrollees, decrease inputs, underprovide services, increase referrals, improve output mix (focus on less expensive health promotion and prevention), attempt to select healthier (less costly) enrollees.</td>
<td>Management capacity of the purchaser is moderate to advanced; strengthening primary care and equity are objectives; cost control is a priority; choice and competition are possible.</td>
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Source: Adapted from Langenbrunner et al. 2009 (1).
give providers the flexibility and capacity to respond to incentives (provider autonomy and management capacity);

make it possible to monitor and improve quality (e.g. health information systems);

ensure accountability of both the purchaser and providers (e.g. effective governance arrangements).

**Institutional capacity needed for effective use of provider payments for strategic purchasing.** A health purchaser is any institution that buys health-care goods and services on behalf of a covered population. Health purchasers can include the Ministry of Health, local government authorities, social health insurance agencies, etc. The right institution to serve as the health purchaser will depend on the country context. Some countries have successfully established a purchasing department within the Ministry of Health to avoid fragmentation and ensure the continued stewardship of the Ministry over health financing. Other countries have found that a purchasing agency that is independent of the Ministry of Health and has semi-autonomous status is better able to effectively contract with both public and private providers, and use funds flexibly for purchasing.

Regardless of the institutional arrangement, certain conditions and capacities need to be in place. Strategic health purchasing requires:

- institutional authority to make purchasing decisions and enter into contracts with providers;
- flexibility to allocate funds to pay for outputs and outcomes; and
- well-functioning information systems to design and implement purchasing mechanisms.

Institutional authority to make purchasing decisions typically comes from the legislative documents establishing the purchasing entity or department within an existing entity. The budget law and other rules governing public financial management will determine whether a public purchasing institution can enter into contracts with private providers, and whether
funds can be allocated flexibly to pay for outputs rather than only input-based line-item budgets.

In addition to having a clear mandate to purchase health services strategically, the purchasing institution needs to develop a set of required capacities and effectively employ them to carry out its main functions. These functions and capacities are shown in Fig. 2. Factors in the external context, including the regulatory environment and the autonomy and capacity of providers greatly influence how much the purchaser can ultimately leverage strategic approaches to shape outcomes in health service delivery.

It may take one year or more to establish an effective health purchasing function in an existing ministry or agency, and possibly even more time to establish a new agency. If the policy and regulatory environment allow some flexibility in the use of public funds, however, some purchasing and provider payment changes can be initiated while the broader institutional structure for purchasing is being defined and established.

Even small changes in payment systems can have a significant impact on provider behaviour, so 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. For example, several countries have seen significant improvements in the equity of resource allocation and greater efficiency at the provider level in a relatively short time when they moved from historical or input-based line-item budgets to a simple per-capita payment system for primary healthcare providers. Over time, experience and more data and information make it possible to revise and improve in an iterative way, as long as investments are made in the institutional arrangements, and in capacities for analysing experience and data, making refinements and improving implementation.

**Fig. 2.** Health purchasing functions and capacities

References


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