**Data Collection Tool**

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| **Name of the scheme:** **Data Collector Name:** **Date:** |
| S.N. | Data Elements | Normative | Actual | Subjective (KII 1-2) | Conclusion |
| **PLANNING AND PREPARING** |
| **I. Background** |
| **I.a. Background** |
| I.a.(1) | % of total population covered |  |  |  |  |
| I.a.(2) | % of total health expenditure flowing through the purchasing agency |  |  |  |  |
| I.a.(3) | % of government health expenditure flowing through the purchasing agency |  |  |  |  |
| I.a.(4) | What are the sources of revenue (% of each source)*Sources of revenue may include (1) general tax contributions including consumption taxes like value-added taxes and excise taxes (2) payroll taxes/contributions (3) non-tax contributions e.g. from mineral or oil revenues (4) non-payroll member contributions (5) any other sources e.g. revenue from investments of a national or social health insurance fund* |  |  |  |  |
| I.a.(5) | Total expenditure per beneficiary/year (local currency and $US) |  |  |  |  |
| I.a.(6) | Has the scheme been identified or prioritized as the primary scheme to achieve UHC?*As you answer this question, think through the political importance of this scheme, and is it designated as a high-priority scheme to achieve UHC?* |  |  |  |  |
| I.a.(7) | Describe the requirements of entitlement for coverage and the steps people have to take to enroll*Requirements for entitlement may include (1) being a citizen or resident (3) having specific documentation e.g. birth certificate or identity card, resident's card or school identity card (4) living in a specific geographic location (5) being employed or working in a specific industry or area**Steps that may be taken include (1) having to visit a specific physical office (2) providing specific documentation e.g. birth certificate, identity card, resident's card, school identity card, marriage certificate, or photos (3) endorsement by a public official or religious leader, etc.* |  |  |  |  |
| I.a.(8) | Does this scheme or funding source target any specific population groups?*Who are the targeted beneficiaries of the scheme? Is it all citizens or specific sub-groups within the population e.g. economic group, by age e.g. children or elderly, by employment status, by gender, etc?* |  |  |  |  |
| I.a.(9) | How are groups targeted and what other benefits, subsidies, and exemptions are they entitled to?*How are the members of the group identified or targeted is it based on geographic location, socio-economic status, etc.? Are members or a sub-set of members entitled to additional benefits e.g. cash transfers or other social benefits?* |  |  |  |  |
| **GOVERNANCE AND EXTERNAL FACTORS** |
| **II. Governance arrangements and institutional arrangements** |
| **II.a. Institutional arrangements and capacity of the purchaser** |
| II.a.(1) | For each of the following purchasing functions, list the designated purchasing agency |  |  |  |  |
| II.a.(2) | *Benefit specification* |  |  |  |  |
| II.a.(3) | *Contracting arrangements* |  |  |  |  |
| II.a.(4) | *Provider payment* |  |  |  |  |
| II.a.(5) | *Performance monitoring* |  |  |  |  |
| II.a.(6) | Are there multiple purchasers within a scheme? *List them* |  |  |  |  |
| II.a.(7) | How do the different purchasers within the scheme relate to one another? *Skip if N/A* |  |  |  |  |
| II.a.(8) | Are there any overlaps or gaps in the responsibilities of the different purchasers? *Skip if N/A* |  |  |  |  |
| II.a.(9) | What is the mandate of each of the purchasers? |  |  |  |  |
| II.a.(10) | Which decisions/functions do the purchasing agency have autonomy to carry out? |  |  |  |  |
| **II.b. Expenditure Management** |
| II.b.(1) | How is the purchaser's budget set each year? What is the basis for the budget? Ex: *historical expenditure, previous claims cost, projected revenue, a combination of different strategies* |  |  |  |  |
| II.b.(2) | Are budget over-runs/deficits allowed? |  |  |  |  |
| II.b.(3) | What happens when there are budget over-runs/deficits? |  |  |  |  |
| II.b.(4) | What is the capacity of each agency listed above to execute its purchasing functions strategically? *Base your assessment on the following: defining the benefits and cost-sharing arrangements, contracting providers, setting clear expectations for service delivery and quality of care, negotiating and setting payment rates, and monitoring the performance of providers.* |  |  |  |  |
| II.b.(5) | What, if any, are the main gaps in each agency's capacity to execute these purchasing functions strategically? |  |  |  |  |
| **II.c. Legal/regulatory environment** |
| II.c.(1) | What are the key laws and regulations that govern financing for each scheme? |  |  |  |  |
| II.c.(2) | Are there any national laws that conflict with or constrain the purchasing agency's ability to function effectively? |  |  |  |  |
| II.c.(3) | What steps are being taken to improve the coherence of the legal/regulatory framework? *Skip if N/A* |  |  |  |  |
| **II.d. Governance structures** |
| II.d.(1) | What governance structures are in place and how do they operate? |  |  |  |  |
| II.d.(2) | Which stakeholder groups are engaged? |  |  |  |  |
| II.d.(3) | Are lines of accountability clear? |  |  |  |  |
| II.d.(4) | Are the mechanisms effective? |  |  |  |  |
| II.d.(5) | Does the purchasing agency produce an annual report? |  |  |  |  |
| II.d.(6) | Are there beneficiaries/patient appeal mechanisms in place? |  |  |  |  |
| **III. External Factors** |
| **III.a. Power of the providers and provider autonomy** |
| III.a.(1) | What is the power and market structure of providers? |  |  |  |  |
| III.a.(2) | What is the share of public and private providers? |  |  |  |  |
| III.a.(3) | Are they well organized? E.g. do they strike? |  |  |  |  |
| III.a.(4) | Do providers have any autonomy over decision-making and resource allocation to respond to provider payment incentives? |  |  |  |  |
| III.a.(5) | Describe which internal financing and management decisions public health facilities have the authority to make *Skip if N/A* |  |  |  |  |
| **III.b. Public Financial Management Rules** |
| III.b.(1) | What is the national budget classification system based on? *Implementing institutions (administrative), inputs-based line items (economic), programs, or a combination* |  |  |  |  |
| III.b.(2) | Is there separate budgeting for vertical programs? |  |  |  |  |
| III.b.(3) | If there is program-based budgeting: How are budget programs and subprograms structured? What are the programs and subprograms for health?  |  |  |  |  |
| III.b.(4) | What information or criteria are used to set budget targets or ceilings? |  |  |  |  |
| III.b.(5) | Are parts of the health budget (such as health worker salaries) determined outside of the budget allocation process? |  |  |  |  |
| III.b.(6) | Which health budget execution decisions are made at the national level? Subnational level? Service provider level?  |  |  |  |  |
| III.b.(7) | Do any public procurement laws affect the ability of the purchaser(s) to be strategic? |  |  |  |  |
| III.b.(8) | Describe any challenges in the public financial management system that limit the opportunity for output-based provider payment systems to be introduced or to be effective. |  |  |  |  |
| **III.c. Service readiness** |
| III.c.(1) | How would you assess the readiness of the service delivery system? *Data for this question may be derived from any Service Availability and Readiness Mapping (SARAM) surveys, Household Health Utilization Surveys, Demographic Health Surveys, etc.* |  |  |  |  |
| **PURCHASING FUNCTIONS** |
| **IV. What to purchase (Benefits Specification)** |
| **IV. a. Benefits package** |
| IV.a.(1) | Is there a benefits package? |  |  |  |  |
| IV.a.(2) | Who is involved in defining the benefit package? |  |  |  |  |
| IV.a.(3) | Select the services below covered in the benefit package offered by the purchaser: |  |  |  |  |
| IV.a.(4) | *Outpatient/ambulatory care* |  |  |  |  |
| IV.a.(5) | *In-patient/hospitalization* |  |  |  |  |
| IV.a.(6) | *Labs* |  |  |  |  |
| IV.a.(7) | *Surgery* |  |  |  |  |
| IV.a.(8) | *Drugs* |  |  |  |  |
| IV.a.(9) | *Traditional or alternative therapies* |  |  |  |  |
| IV.a.(10) | *Imaging* |  |  |  |  |
| IV.a.(11) | List the services excluded from the benefit packageThese are the exclusions not covered in the benefit package and may include high-cost services or services that may not be considered cost-effective. |  |  |  |  |
| IV.a.(12) | Are there any discrepancies between the list and the services that are delivered by providers? |  |  |  |  |
| IV.a.(13) | Is there an explicit benefits package?An explicit benefits package means that all services covered are clearly listed and exclusions are clearly defined in the benefit package. |  |  |  |  |
| IV.a.(14) | Does the benefits package also specify any cost-sharing requirements? |  |  |  |  |
| IV.a.(15) | Are channels in place to inform citizens about their entitlements and obligations under the benefit package? |  |  |  |  |
| IV.a.(16) | Describe the process for revising the benefit package. |  |  |  |  |
| IV.a.(17) | Who is involved in the benefit package revision process? |  |  |  |  |
| IV.a.(18) | What criteria are used? |  |  |  |  |
| **IV. b. Service delivery standards** |
| IV.b.(1) | Does the purchaser further define or use existing service delivery or quality standards as part of purchasing decisions or contracts? |  |  |  |  |
| IV.b.(2) | How do purchasers use gatekeeping and referral guidelines for purchasing decisions? *Skip if N/A* |  |  |  |  |
| IV.b.(3) | How do purchasers use quality standards for purchasing decisions? *Skip if N/A* |  |  |  |  |
| IV.b.(4) | How do purchasers use clinical guidelines for purchasing decisions? *Skip if N/A* |  |  |  |  |
| **IV. c. Medicines** |
| IV.c.(1) | Is there a medicines list used for purchasing? |  |  |  |  |
| IV.c.(2) | Which agency defines the medicines list and how is it defined? *Skip if N/A* |  |  |  |  |
| IV.c.(3) | Is there a generics-only policy for purchasing? *Skip if N/A*A generics-only policy means the purchaser defines the specific medicines that are included in the benefit package, the conditions for using generics, and any exclusions to the generics-only policy that would allow for branded medicines to be used |  |  |  |  |
| IV.c.(4) | Describe how prescribed medicines are accessed and paid for by beneficiaries.  |  |  |  |  |
| **V. From whom to purchase? (Contracting Arrangements)** |
| **V. a. Selective contracting** |
| V.a.(1) | Does the purchaser contract with providers? Purchasing decisions include how services and medicines are selected for coverage with pooled funds (benefits specification), how providers are selected to provide covered services (selective contracting and contracting arrangements), and how these providers are paid (provider payment) |  |  |  |  |
| V.a.(2) | **Individual doctors or providers (Public)** |  |  |  |  |
| V.a.(3) | For this type of provider, please describe the following:  |  |  |  |  |
| V.a.(4) | *Is the contracting selective and who is involved?* |  |  |  |  |
| V.a.(5) | *What are the criteria for selective contracting - e.g., geography, type of provider (public, private or individual doctor, PHC, hospital)?*  |  |  |  |  |
| V.a.(6) | *What are the requirements to be contracted (e.g., registration, licensing, accreditation, credentialing) and what is the process for assessment?* |  |  |  |  |
| V.a.(7) | *Are any providers ever denied a contract or have their contracts terminated?* |  |  |  |  |
| V.a.(8) | **Individual doctors or providers (Private)** |  |  |  |  |
| V.a.(9) | For this type of provider, please describe the following:  |  |  |  |  |
| V.a.(10) | *Is the contracting selective and who is involved?* |  |  |  |  |
| V.a.(11) | *What are the criteria for selective contracting - e.g., geography, type of provider (public, private or individual doctor, PHC, hospital)?*  |  |  |  |  |
| V.a.(12) | *What are the requirements to be contracted (e.g., registration, licensing, accreditation, credentialing) and what is the process for assessment?* |  |  |  |  |
| V.a.(13) | *Are any providers ever denied a contract or have their contracts terminated?* |  |  |  |  |
| V.a.(14) | **Individual doctors or providers (NGO)** |  |  |  |  |
| V.a.(15) | For this type of provider, please describe the following:  |  |  |  |  |
| V.a.(16) | *Is the contracting selective and who is involved?* |  |  |  |  |
| V.a.(17) | *What are the criteria for selective contracting - e.g., geography, type of provider (public, private or individual doctor, PHC, hospital)?*  |  |  |  |  |
| V.a.(18) | *What are the requirements to be contracted (e.g., registration, licensing, accreditation, credentialing) and what is the process for assessment?* |  |  |  |  |
| V.a.(19) | *Are any providers ever denied a contract or have their contracts terminated?* |  |  |  |  |
| V.a.(20) | **Clinic/Primary Healthcare Facility (Public)** |  |  |  |  |
| V.a.(21) | For this type of provider, please describe the following:  |  |  |  |  |
| V.a.(22) | *Is the contracting selective and who is involved?* |  |  |  |  |
| V.a.(23) | *What are the criteria for selective contracting - e.g., geography, type of provider (public, private or individual doctor, PHC, hospital)?*  |  |  |  |  |
| V.a.(24) | *What are the requirements to be contracted (e.g., registration, licensing, accreditation, credentialing) and what is the process for assessment?* |  |  |  |  |
| V.a.(25) | *Are any providers ever denied a contract or have their contracts terminated?* |  |  |  |  |
| V.a.(26) | **Clinic/Primary Healthcare Facility (Private)** |  |  |  |  |
| V.a.(27) | For this type of provider, please describe the following:  |  |  |  |  |
| V.a.(28) | *Is the contracting selective and who is involved?* |  |  |  |  |
| V.a.(29) | *What are the criteria for selective contracting - e.g., geography, type of provider (public, private or individual doctor, PHC, hospital)?*  |  |  |  |  |
| V.a.(30) | *What are the requirements to be contracted (e.g., registration, licensing, accreditation, credentialing) and what is the process for assessment?* |  |  |  |  |
| V.a.(31) | *Are any providers ever denied a contract or have their contracts terminated?* |  |  |  |  |
| V.a.(32) | **Clinic/Primary Healthcare Facility (NGO)** |  |  |  |  |
| V.a.(33) | For this type of provider, please describe the following:  |  |  |  |  |
| V.a.(34) | *Is the contracting selective and who is involved?* |  |  |  |  |
| V.a.(35) | *What are the criteria for selective contracting - e.g., geography, type of provider (public, private or individual doctor, PHC, hospital)?*  |  |  |  |  |
| V.a.(36) | *What are the requirements to be contracted (e.g., registration, licensing, accreditation, credentialing) and what is the process for assessment?* |  |  |  |  |
| V.a.(37) | *Are any providers ever denied a contract or have their contracts terminated?* |  |  |  |  |
| V.a.(38) | **Hospital/Secondary or Tertiary Hospital (Public)** |  |  |  |  |
| V.a.(39) | For this type of provider, please describe the following:  |  |  |  |  |
| V.a.(40) | *Is the contracting selective and who is involved?* |  |  |  |  |
| V.a.(41) | *What are the criteria for selective contracting - e.g., geography, type of provider (public, private or individual doctor, PHC, hospital)?*  |  |  |  |  |
| V.a.(42) | *What are the requirements to be contracted (e.g., registration, licensing, accreditation, credentialing) and what is the process for assessment?* |  |  |  |  |
| V.a.(43) | *Are any providers ever denied a contract or have their contracts terminated?* |  |  |  |  |
| V.a.(44) | **Hospital/Secondary or Tertiary Hospital (Private)** |  |  |  |  |
| V.a.(45) | For this type of provider, please describe the following:  |  |  |  |  |
| V.a.(46) | *Is the contracting selective and who is involved?* |  |  |  |  |
| V.a.(47) | *What are the criteria for selective contracting - e.g., geography, type of provider (public, private or individual doctor, PHC, hospital)?*  |  |  |  |  |
| V.a.(48) | *What are the requirements to be contracted (e.g., registration, licensing, accreditation, credentialing) and what is the process for assessment?* |  |  |  |  |
| V.a.(49) | *Are any providers ever denied a contract or have their contracts terminated?* |  |  |  |  |
| V.a.(50) | **Hospital/Secondary or Tertiary Hospital (NGO)** |  |  |  |  |
| V.a.(51) | For this type of provider, please describe the following:  |  |  |  |  |
| V.a.(52) | *Is the contracting selective and who is involved?* |  |  |  |  |
| V.a.(53) | *What are the criteria for selective contracting - e.g., geography, type of provider (public, private or individual doctor, PHC, hospital)?*  |  |  |  |  |
| V.a.(54) | *What are the requirements to be contracted (e.g., registration, licensing, accreditation, credentialing) and what is the process for assessment?* |  |  |  |  |
| V.a.(55) | *Are any providers ever denied a contract or have their contracts terminated?* |  |  |  |  |
| **V. b. Private Sector Engagement** |
| V.b.(1) | Summarize differences in the process of contracting private providers as compared to public providers.  |  |  |  |  |
| **V. c. Contracting** |
| V.c.(1) | Is there an explicit contracting process with public and private providers?Indicate if this is a formal contract signed by both purchaser and provider (or umbrella organization representing the group of providers); or a loose agreement between the purchaser and provider that may be based on compliance to norms and standards, service guidelines, clinical protocols and quality standards, expected of providers. |  |  |  |  |
| V.c.(2) | What is included in the contract? *Skip if N/A*Items included in the contract may include (1) obligations of providers e.g. expected services, medicines, interventions, diagnostic procedures, etc. (2) compliance to any standards e.g. clinical protocols, service guidelines, quality guidelines (3) terms of the contract and expected period for review (4) complaints or recourse in case of disputes |  |  |  |  |
| V.c.(3) | Is the contract linked to performance? *Skip if N/A* |  |  |  |  |
| V.c.(4) | Is the contract linked to specific objectives? *Skip if N/A* |  |  |  |  |
| V.c.(5) | Is the contract based on quality standards? *Skip if N/A* |  |  |  |  |
| V.c.(6) | Does the purchaser negotiate the terms of contracts with individual providers or associations? *Skip if N/A* |  |  |  |  |
| V.c.(7) | Describe the negotiation process. *Skip if N/A* |  |  |  |  |
| **VI. How to purchase (Provider Payment)** |
| **VI. b. Provider payment** |
| VI.a.(1) | List the provider payment system(s) used to pay providers for primary care.These may include line-item budgets, capitation, fee-for-service, or a combination of these mechanisms |  |  |  |  |
| VI.a.(2) | *Is payment linked to services in the benefit package?* |  |  |  |  |
| VI.a.(3) | *Are payment systems linked to the purchaser resource envelope and do they allow for purchaser budget management?* |  |  |  |  |
| VI.a.(4) | *If there are multiple payment systems, are the incentives aligned or conflicting with one another?* |  |  |  |  |
| VI.a.(5) | *Describe the consequences for provider incentives of multiple payment systems.*Consequences may include shifting of care from ambulatory to hospital care, undertreatment, charging informal charges to beneficiaries, etc. |  |  |  |  |
| VI.a.(6) | List the provider payment system(s) used to pay providers for secondary and tertiary care (hospital). |  |  |  |  |
| VI.a.(7) | *Is payment linked to services in the benefit package?* |  |  |  |  |
| VI.a.(8) | *Are payment systems linked to the purchaser resource envelope and do they allow for purchaser budget management?* |  |  |  |  |
| VI.a.(9) | *If there are multiple payment systems, are the incentives aligned or conflicting with one another?* |  |  |  |  |
| VI.a.(10) | *Describe the consequences for provider incentives of multiple payment systems.*Consequences may include charging informal charges to beneficiaries, shifting patients across schemes if allowed, denying patients care or undertreatment, early discharge, etc. |  |  |  |  |
| VI.a.(11) | *Are payment systems harmonized across levels of care (primary healthcare and secondary and tertiary care)?* |  |  |  |  |
| VI.a.(12) | How are provider payment rates determined? |  |  |  |  |
| VI.a.(13) | *Which agency has the authority to set rates?* |  |  |  |  |
| VI.a.(14) | *What information/data is used?*E.g., cost information, available resources, policy priorities, and negotiation |  |  |  |  |
| VI.a.(15) | *Is there any negotiation with providers?* |  |  |  |  |
| VI.a.(16) | *Is the process different for public and private providers?* |  |  |  |  |
| VI.a.(17) | Is patient data included in the invoice (e.g., services performed, medical records, etc.)? |  |  |  |  |
| VI.a.(18) | Is that data part of the provider monitoring? *Skip if N/A* |  |  |  |  |
| VI.a(19) | Describe the billing and payment system. Is it electronic or paper-based? |  |  |  |  |
| VI.a.(20) | Describe the process of requesting and process payment (i.e., claims, billing, etc.) |  |  |  |  |
| VI.a.(21) | How long does it usually take from the time payment is requested until it is received? |  |  |  |  |
| **VII. Performance Monitoring** |
| **VII. a. Provider monitoring** |
| VII.a.(1) | How is provider performance monitored? |  |  |  |  |
| VII.a.(2) | Is provider-level information collection and analysis automated? |  |  |  |  |
| VII.a.(3) | How is provider performance information used? |  |  |  |  |
| VII.a.(4) | Is provider performance information linked to payment or other purchasing decisions? |  |  |  |  |
| VII.a.(5) | Describe how provider performance information is used in purchasing and payment decisions. *Skip if N/A*Performance monitoring is used to track the effectiveness of purchasing incentives and decisions, quality of care, and provider behavior, and improve/tweak the three functions of benefits specification, contracting arrangements, and provider payment. |  |  |  |  |
| **VII. b. System-level monitoring** |
| VII.b.(1) | What form of performance analysis is carried out at the system level?E.g., budget and revenue tracking, claims ratio, expenditure ratio, renewal ratio, claims ratio |  |  |  |  |
| VII.b.(2) | Is the system-level analysis automated and carried out routinely? |  |  |  |  |
| VII.b.(3) | Describe how information and analysis are used for system-level monitoring and purchasing decisions. |  |  |  |  |
| **OTHER CAPACITIES** |
| **VIII. Information Technology** |
| **VIII. a. Information system architecture - Purchasers** |
| VIII.a.(1) | To what degree is the purchaser’s information system unified for all types of population groups and coverage schemes (as compared to being fragmented)?  |  |  |  |  |
| VIII.a.(2) | If it is not unified, describe the main sources of fragmentation at the purchaser level. |  |  |  |  |
| VIII.a.(3) | Are claims data in a format that can easily be analyzed? |  |  |  |  |
| VIII.a.(4) | Is patient-level data available and analyzable while still maintaining patient privacy? |  |  |  |  |
| **VIII. b. Information system architecture – System level** |
| VIII.b.(1) | To what degree is the system-level information system unified for all types of population groups and coverage schemes (as compared to being fragmented)?  |  |  |  |  |
| VIII.b.(2) | If it is not unified, describe the main sources of fragmentation at the purchaser and scheme levels. |  |  |  |  |
| VIII.b.(3) | Describe any information governance policy and mechanisms in place. |  |  |  |  |
| **VIII. c. HMIS capacity** |
| VIII.c.(1) | Is there dedicated and trained staff involved in health information management? |  |  |  |  |
| VIII.c.(2) | Is software for key functions typically developed in-house or procured from external sources and adapted? |  |  |  |  |
| VIII.c.(3) | Describe any routine analyses carried out by the purchaser to make purchasing decisions.This includes provider-level and system-level analyses.E.g. of provider-level analyses may include service quality and financial analyses such as quality and medical audits, claim audits, claim ratios, etc. |  |  |  |  |
| **IX. Communication** |
| **IX.a. Communication with providers** |
| IX.a.(1) | Does the purchasing agency have staff dedicated to communication with providers? |  |  |  |  |
| IX.a.(2) | Is there a communication strategy? |  |  |  |  |
| IX.a.(3) | What channels are used to communicate with providers? E.g., mass media, social media, scheduled provider meetings or forums, etc. |  |  |  |  |
| IX.a.(4) | How frequently are various communication channels used? |  |  |  |  |
| IX.a.(5) | Are there channels to obtain feedback from providers? |  |  |  |  |
| **IX. b. Communication with beneficiaries** |
| IX.b.(1) | Does the purchasing agency have staff dedicated to communication with beneficiaries? |  |  |  |  |
| IX.b.(2) | Is there a communication strategy? |  |  |  |  |
| IX.b.(3) | What channels are used to communicate with beneficiaries?E.g., toll-free lines, USSD codes, feedback, specific complaint channels, market days, chiefs’ meeting/chiefs camp, mass media, social media, community forums, etc. |  |  |  |  |
| IX.b.(4) | How frequently are various communication channels used? |  |  |  |  |
| IX.b.(5) | Are there channels to obtain feedback from beneficiaries?Suggestion boxes, toll-free lines, USSD, etc. |  |  |  |  |
| **RESULTS ANALYSIS** |
| **X. Purchasers have leverage to directly influence:** |
| **X.a. Appropriate incentives** |
| X.a.(1) | To what extent do provider payment methods incentivize delivering high-value services (e.g., PHC) and serve vulnerable populations?Are there schemes or designated funding within the scheme that targets vulnerable populations or services for specific population groups (e.g. subsidies for the poorest to access health services and maternity services)? |  |  |  |  |
| X.a.(2) | To what extent are provider payments harmonized or not harmonized across schemes/revenue sources to ensure coherent incentives for providers?E.g., resource shifting, cost shifting, and provider shifting as defined [here](https://academic.oup.com/heapol/article/36/6/861/6264892?login=false) |  |  |  |  |
| X.a.(3) | Are there any adverse incentives in the system, leading to inefficiency or poor quality?E.g., low reimbursement rates, delays in payments affecting quality and delivery of service, informal charges, fee-for-service encouraging the oversupply of services increasing costs to the system |  |  |  |  |
| **X.b. Cost-effective resource allocation** |
| X.b.(1) | Is there evidence that funding allocations and provider payments reflect population health needs? |  |  |  |  |
| XI.b.(2) | Specifically, has any progress been made ensuring funds are not concentrated in urban wealthy areas?Use household health expenditure and utilization of service and/or public expenditure tracking as data sources. |  |  |  |  |
| X.b.(3) | Have purchasing arrangements and provider payment systems encouraged an increase in the share of funds allocated to PHC?Possible data sources: government budget data, national health accounts, Global Health Expenditure Database |  |  |  |  |
| **X.c. Accountability for quality** |
| X.c.(1) | To what extent do provider payment methods and purchasing arrangements promote quality of care and coordination across levels of care?  |  |  |  |  |
| X.c.(2) | To what extent are purchasing arrangements used to promote or encourage quality of care at the provider level? Some examples are shifting costs from primary care to hospital care, quality of care connected to provider payment, gatekeeping guidelines, protocols, definition of service delivery standards, accreditation systems, selective contracting of providers, medical audits, claim audits, etc.  |  |  |  |  |
| X.c.(3) | How are providers held accountable for providing high-value services (e.g. PHC) and serving vulnerable populations? |  |  |  |  |
| X.c.(4) | What are the main challenges to improving quality? What role do purchasing and provider incentives play? |  |  |  |  |
| **XI. Goals and objectives for UHC** |
| **XI.a. Intermediate objectives for UHC** |
|  | Is there any evidence that purchasing arrangements and provider incentives have led to better: |  |  |  |  |
| XI.a.(1) | Equity *(resource distribution)*Equity in resource distribution is ensuring that resources are channeled to high-value services, populations most at need, and PHC as opposed to resources being concentrated in urban or wealthy areas or benefiting just the rich. |  |  |  |  |
| XI.a.(2) | Allocative efficiency *(resources directed to PHC and other cost-effective services)* |  |  |  |  |
| XI.a.(3) | Technical efficiency *(lowest cost for highest quality services)* |  |  |  |  |
| XI.a.(4) | Transparency *(citizens are aware of their entitlements in the benefit package)* |  |  |  |  |
| XI.a.(5) | Accountability *(transparency and accountability of health financing agencies – e.g., extent of corruption, public reporting on performance)* |  |  |  |  |
| XI.a.(6) | Financial sustainability of the purchaser *(managing within budget constraints and limiting unproductive cost growth)* |  |  |  |  |
| **XI.b. Long-term UHC goals** |
| XI.b.(1) | Utilization relative to need *(coverage of priority services; utilization)* |  |  |  |  |
| XI.b.(2) | Quality *(clinical quality, patient experience)* |  |  |  |  |
| XI.b.(3) | Financial protection and equity in financing *(reduced out-of-pocket payments and progressivity in contributions)* |  |  |  |  |
| **BENCHMARKS** |
|  | Benchmarks | Normative | Actual | Subjective (KII 1-2) | Conclusions |
| **Benchmarks for progress on governance and institutional arrangements** |
| **Institutional arrangements and capacity** |
|  | The main purchasing agency does not have a legal public interest mandate, the allocation of purchasing functions is not well defined, and capacity is weak. |  |  |  |  |
|  | An agency or agencies have responsibility for carrying out most or all purchasing functions and capacity is improving, but some overlaps and gaps in responsibilities remain. |  |  |  |  |
|  | An agency or agencies have responsibility for carrying out all purchasing functions with a public interest mandate, appropriate autonomy, and effective accountability, and there is meaningful stakeholder participation; there are no overlaps or gaps in responsibilities; and the institutional and technical capacity of the purchasing agency is strong. |  |  |  |  |
| **Expenditure management** |
|  | The process used to set the purchaser’s budget is not transparent; mechanisms are in place to track budget execution/spending, but these mechanisms are not enforced and overruns routinely occur. |  |  |  |  |
|  | A transparent process is used to set the purchaser’s budget; mechanisms are in place to track and manage budget execution/spending, but these mechanisms are weakly enforced and budget overruns occur. |  |  |  |  |
|  | A transparent process is used to set the purchaser’s budget, and mechanisms are in place to track and manage budget execution/spending; these mechanisms are enforced, and budget overruns rarely occur. |  |  |  |  |
| **Health provider autonomy** |
|  | Public providers have very limited or no autonomy to receive funds and carry out managerial and financial functions; they are unable to respond to the financial incentives of the provider payment systems. |  |  |  |  |
|  | Public providers are given a larger degree of managerial and financial autonomy, but the ability to respond to the financial incentives of the provider payment systems is still limited and accountability mechanisms are weak. |  |  |  |  |
|  | Health care providers can directly receive funds and flexibly manage them to respond to the financial incentives of the provider payment systems, and they are held accountable for appropriate spending and service delivery results. |  |  |  |  |
| **Benchmarks for progress on purchasing functions** |
| ***Benefits Specification*** |
| **A benefit package is specified and aligned with purchasing arrangements.** |
|  | A benefit or service package is defined and reflects health priorities, but it is not well specified, is not a commitment, and/or is not aligned with provider payment systems. |  |  |  |  |
|  | A benefit or service package is defined, reflects health priorities, and is a commitment, but it is not well specified and/or not aligned with provider payment systems. |  |  |  |  |
|  | A benefit or service package is well specified and periodically revised through a transparent process, reflects health priorities, is a commitment to the covered population, and is aligned with provider payment systems, and a transparent process for revision is specified. |  |  |  |  |
| **The purchasing agency further defines service delivery standards when contracting with providers.** |
|  | The purchaser defines some general service delivery standards (e.g., for gatekeeping), but enforcement through contracts is weak. |  |  |  |  |
|  | The purchaser defines some general service delivery standards and some specific service delivery standards (e.g., number of prenatal care visits) that are at least partially enforced through contracts. |  |  |  |  |
|  | The purchaser specifies service delivery standards in line with national service delivery policies and clinical protocols, and service delivery standards are enforced through contracts. |  |  |  |  |
| ***Contracting arrangements*** |
| **Contracts are in place and used to achieve objectives.** |
|  | Loose agreements are in place between the purchaser and public providers for specified services in exchange for payment instead of or in addition to input-based budgets. Formal agreements may be in place with some private providers. |  |  |  |  |
|  | Formal agreements are in place between the purchaser and public providers for specified services in exchange for payment instead of or in addition to input-based budgets. Formal agreements are in place with some private providers. |  |  |  |  |
|  | Explicit agreements are in place between the purchaser and public and private providers that specify obligations on both sides, and contracts are used to achieve specific objectives. |  |  |  |  |
| **Selective contracting specifies service quality standards.** |
|  | The purchaser has loose, nonselective agreements or contracts with all public providers and selective contracts with some private providers based on some definition of quality standards. |  |  |  |  |
|  | The purchaser contracts at least somewhat selectively with public and private providers based on accreditation or some other definition of quality standards. |  |  |  |  |
|  | The purchaser contracts selectively with public and private providers based on uniformly applied quality standards. |  |  |  |  |
| ***Provider payment*** |
| **Provider payment systems are linked to health system objectives.** |
|  | Some output-based payment is used to pay providers to deliver services in the benefit package. |  |  |  |  |
|  | Output-based payment is used to pay providers to deliver services in the benefit package, and payment systems are linked to specific service delivery objectives. |  |  |  |  |
|  | Output-based payment is used to pay providers to deliver services in the benefit package, and payment systems are linked to specific service delivery objectives, effective allocation across levels of care, and purchaser budget management (“closed-ended” payment). |  |  |  |  |
| **Payment rates are based on a combination of cost information, available resources, policy priorities, and negotiation.** |
|  | Provider payment rates are determined based only on the purchaser’s available budget. |  |  |  |  |
|  | Provider payment rates are determined based on the purchaser’s available budget and at least one other factor (e.g., cost information, priorities, or negotiation with providers). |  |  |  |  |
|  | Payment rates are based on a combination of cost information, available resources, policy priorities, and negotiation. |  |  |  |  |
| ***Performance monitoring*** |
| **Monitoring information is generatied and used at the provider level.** |
|  | Some form of monitoring happens at the health provider level (e.g., supportive supervision visits, monthly activity reporting, claims audits, quality audits). |  |  |  |  |
|  | Provider-level monitoring is at least partially automated and is used for purchasing decisions. |  |  |  |  |
|  | Provider-level information is automated, fed back to providers, and used for purchasing decisions. |  |  |  |  |
| **Information and analysis are used for system-level monitoring and purchasing decisions.** |
|  | Some form of analysis is carried out at the system level (e.g., budget and revenue tracking, claims ratio, expenditure ratio, renewal ratio, claims ratio). |  |  |  |  |
|  | System-level analysis is automated and carried out routinely. |  |  |  |  |
|  | Information and analysis are used for system-level monitoring and purchasing decisions. |  |  |  |  |