SP4PHC
Strategic Purchasing for Primary Health Care

Rapid landscaping tool for quality-related measurement systems and health purchasing

Version 1 (for piloting)

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BREAKING NEW GROUND

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INTRODUCTION

This Rapid Landscaping Tool is intended to provide health purchasers and other stakeholders a means of understanding the prevailing quality governance and measurement practices in their health system. The tool guides inquiry from the perspective of a single, (ideally) prominent purchaser within the health system. It focuses on aspects of quality that could potentially be connected to incentives created by purchasing, for example, through contract eligibility policies and provider payment systems.

The theoretical underpinnings for this tool are elaborated in a companion paper that reviews how different aspects of purchasing can influence quality via purchasers' relationships with providers, citizens, and other government organs.[1] This tool is concerned primarily with the purchaser-provider relationship, while aspects of the purchaser's relationships with citizens and other government agencies feature selectively throughout. Users can apply the tool to the health system in general or to issues more narrowly relevant to a specific set of health needs, services, or provider types.

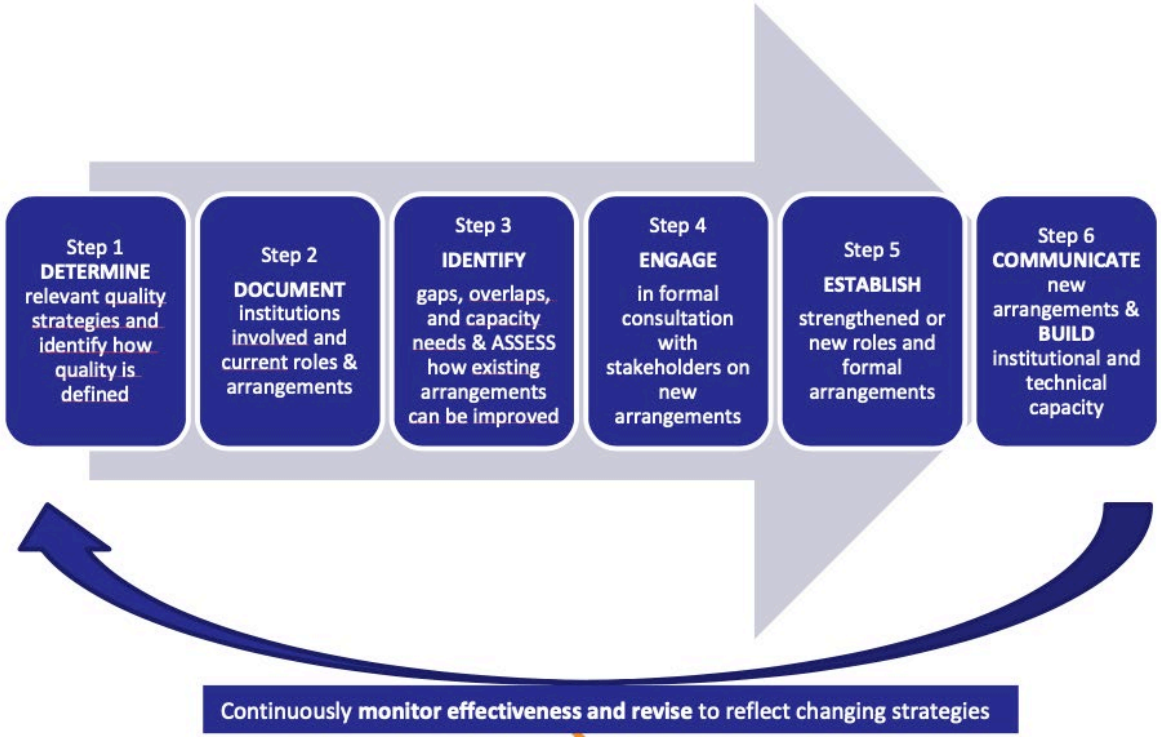
Although the tool is designed from the perspective of a single purchaser, users will need to contextualize the information they collect within the broader purchasing landscape. Consequently, the tool includes questions about both the practices of *any* purchasers and the opportunities available to *the* purchaser for which the landscaping exercise is being completed.

[1] See Chaitkin, Michael, Ileana Vîlcu, and Matt Boxshall. 2022. *A framework for linking purchasing to quality and its governance in health systems*. Washington, DC: ThinkWell. **https://thinkwell.global/wp-content/uploads/2022/11/SP4PHC_Purchasing-Quality-Framework.pdf**

STRUCTURE AND APPROACH

The tool is modeled on portions of a methodology described in Cico, Laird, and Tarantino (2018) for "establishing institutional arrangements linking health financing to quality," and draws on relevant questions and indicators in other assessment approaches. Cico and coauthors (2018) outline a six-step process for analysis, consultation, reform, and monitoring (Figure 1). This tool offers more detailed guidance for steps 1–3, which focus on current quality strategies, definitions, and measurement systems, and also identifies opportunities to improve or expand upon existing arrangements.

Figure 1. Process for establishing effective institutional arrangements



Source: Figure 3 in Cico, Laird, and Tarantino (2018), reproduced with permission

The tool is organized by the main areas of inquiry. The first section focuses on how policies and stakeholders **define quality and quality-related objectives** for the country. Subsequent sections delve into different domains of quality-related information, including mechanisms for building and verifying **provider readiness** to deliver services (section 2), assessing **management and care processes** (section 3), tracking **utilization and outcomes** (section 4), and collecting patient and community feedback on **user experience** (section 5). Users seeking to delve deeper into the specific design and contents of measurement and information systems will find illustrative questions in the Annex.

The tool guides users to answer a series of questions for each area of inquiry. Users will need to gather information by reviewing documents and consulting with relevant officials and experts. Some users may also be able to answer a portion of questions based on their own knowledge of the health system. The primary focus should be on systems and activities that are part of the health system's routine business, as well as connections to existing purchasing policies and practices. It will also be useful to note "special" practices, such as reporting by a subset of health facilities as part of a donor-funded quality improvement or results-based financing (RBF) initiative. Information sources are likely to include general and quality-specific policies, strategies, and plans; a health financing strategy; systems' operational guides; donor program descriptions and evaluations; and stakeholder interviews.

Each section has three components:

1. Questions about existing measurement systems and practices for that section's information domain. In several sections, these questions are organized into multiple sub-domains.
2. Questions about links between existing purchasing practices and the quality information domain. This will help purchasers consider how their efforts to encourage quality improvement relate to the broader purchasing environment in which providers operate. General information on purchasing can often be found in countries' health financing strategies, health financing or system assessments, or other analyses.[2]
3. Questions that prompt users to synthesize and reflect on the gathered information. Users will need to consider what aspects of the measurement systems could be linked to purchasing incentives, with which other quality-minded actors the purchaser will need to coordinate its efforts, and whether there may be more promising options than purchasing to encourage quality improvement.

As they work through the tool, users will be encouraged to think broadly about quality and quality measurement systems. In some contexts, it may be tempting to limit the analysis to formalized quality frameworks or the activities of a ministry of health's quality directorate. These are essential to any country's approach to quality, but they may only capture a small portion of the quality ecosystem. Of interest will be a wide range of actors (such as government bodies, training authorities, public and private providers, and professional associations) and measurement

[2] For example, the Strategic Purchasing Africa Resource Center (SPARC) compiles information about health purchasing approaches in countries around the world (see **https://sparc.africa/curated-resources/**). Country-focused purchasing briefs may also be available from technical assistance initiatives such as the Strategic Purchasing for Primary Health Care project (**https://thinkwell.global/projects/sp4phc/resources/**), USAID's Sustaining Health Outcomes through the Private Sector (SHOPS) Plus project (**https://www.shopsplusproject.org/**), and others. If there is minimal documentation or awareness of purchasing practices in a country, users may need to consider combining this protocol with a more detailed purchasing assessment. For illustrative methods and questions, see: Cashin, C., ed. 2015. ***Assessing Health Provider Payment Systems: A Practice Guide for Countries Working Toward Universal Health Coverage*** (Joint Learning Network for Universal Health Coverage).

systems, including but not limited to the health management information system (HMIS). By casting a wide net, users should be able to discover both where policymakers and purchasers already look for data on quality *and* what additional routine data can inform purchasing decisions.

Before using the tool, users should clearly define the scope of their landscaping exercise, including objectives and focus areas, as well as a profile of the purchaser whose decisions the findings are meant to inform. The following table can help users organize and summarize the scope of the landscaping exercise.

Scope of Landscaping Exercise		
Question	Answer	Source(s) (if relevant)
What is the name of the purchaser organization that will use the findings of the landscaping exercise?		
Is it a public or private organization? **If public, is it part of or otherwise falls under the authority of a government ministry? Describe the basic governance arrangements for the purchaser.**		
What is the purchaser's revenue model? **For example, describe what share of its funding pool(s) are sourced from general and earmarked revenue, member contributions,**		

development partners, and other sources.		
What is the purchaser's market share? **For example:** - **For what portion of the population does the purchaser buy services?** - **What share of provider revenue does the purchaser account for?**		
Why is this landscaping exercise being conducted? What are the objectives?		
Based on the objectives, what are the health needs, service areas, and/or providers of interest for this exercise?	Health needs: Service areas: Provider ownership[3]:	

[3] Throughout the protocol there are mentions of public and private providers. The latter is intended broadly to include for- and not-for-profit, faith-based, and other providers not owned by the government. Users should adapt terminology to country context.

	☐ Public ☐ Private – for-profit ☐ Private – not-for-profit/NGO ☐ Private – faith-based ☐ Other (specify: _____) Service level(s): ☐ Primary (e.g., health post, clinic, general practice) ☐ Secondary (e.g., specialized outpatient, basic hospital) ☐ Tertiary+ (e.g., general or specialized hospital) ☐ Other (specify: _____)	

After specifying the scope and objectives, users should systematically update the questions throughout the tool based on the scope. For example, a purchaser may specifically be interested in improving the quality of maternal health services, in which case they would want to focus on the providers and measurement systems for antenatal, delivery, and postnatal services. A certification program that qualifies providers to deliver other kinds of services would be less relevant (though there may be opportunities to learn across service areas too). Users should note that the questions throughout are written with general terminology; for example, they should be adapted to the country context based on local names for health worker cadres, regulatory bodies, and so on. Each section contains a glossary of key terms to provide users a guide for their use in this tool. Users may also need to create tailored questionnaires for interviews and then synthesize responses across multiple respondents to formulate answers to the tool questions. As they finalize and deploy their questionnaires, users should consistently seek insights into both policy and practice (see Box 1).

Finally, users of this tool will likely produce a report or other outputs (e.g., policy briefs, presentations). These should be designed in consultation with the purchaser and mindful of which formats will enable effective engagement with other key stakeholders (i.e., as input to some version of step 4 and beyond in Figure 1). This tool entails collecting a large amount of information that users will need to synthesize. Depending on the context, it may be useful to organize one or more opportunities to review, validate, and make sense of findings with the purchaser and others, as appropriate.

Box 1. Insights are needed into both policy and actual practices.

It will likely be easy for users to assemble relevant documents and collect information from stakeholders about *how systems are supposed to work* based on established policies and norms. This information is useful but insufficient for this exercise. It is essential that users also collect information on *how systems work in practice* so that the purchaser can benefit from richer insight into the viability of existing systems. Consequently, many of the questions prompt users to look into whether systems are used everywhere or only in certain geographies or sectors, to what extent providers actually fulfill routine reporting requirements, whether measurement data are actually used for any planning or performance management activities, and so on. In addition to consulting with ministry officials, users will likely need to visit individual providers and district health teams to have candid conversations about how systems operate at the frontlines. Users should be mindful of potential sensitivities around these issues and take care to protect people's identities, as needed.

SECTION 1: QUALITY DEFINITION AND OBJECTIVES

Section 1 examines key aspects of the country's policies and priorities with respect to quality. Purchasing decisions should be anchored by a consensus definition of quality and shared understanding of quality-related objectives. The section also touches on key characteristics of the current purchasing environment.

Quality Definition and Objectives		
Question	Answer	Source(s)
1. How does the country (or government) define quality and quality improvement? ***(If no definitions are codified, stakeholder perspectives can be synthesized.)***		
2. Which government organizations or offices are responsible for quality assurance or quality improvement? (These can be at the national and/or subnational levels.) **In practice, what activities do they undertake with respect to quality?**		
3. Do individual facilities or health workers have responsibilities for quality or quality improvement? **If yes, describe their responsibilities.** **How are they held accountable?**	☐ Yes ☐ No Details:	

4. What aspects of quality are considered the most important to address? Why?		
5. Are there specific quality targets at the national, subnational, and/or facility levels? **If yes, what are they? Who sets them? How are they supposed to be measured and tracked? How well and reliably are they measured and tracked?**	☐ Yes ☐ No Details:	
6. How are initiatives, processes, and policies related to quality passed between different levels of government? ***(For example, to what extent are centrally driven programs implemented locally? Do locally driven initiatives receive political and/or financial support from higher levels?)***		
7. How are professional associations organized for doctors, nurses, and other health workers? **Are they charged with any roles or responsibilities with respect to quality?**		
8. Are there ongoing discussions or activities related to using purchasing to encourage or incentivize quality?	☐ Yes ☐ No Details:	

If yes, what are they, who do they involve, and to what extent are they seen as a promising direction for the country? ***(Reminder: Users should think broadly about purchasing to include ministries and districts, not just standalone purchasers like health insurance or social security agencies.)***		

STATE OF PURCHASING

These questions are meant to prepare the user to analyze connections between existing purchasing approaches and quality measurement systems in later sections of the tool. Users should note that if available sources do not contain the necessary information to answer the questions below, it may be necessary to combine this tool with a more detailed assessment of the entire purchasing landscape. They should consult footnote 1 for suggestions on where to find detailed purchasing information and a purchasing assessment methodology.

Quality Definition and Objectives – State of Purchasing		
Question	Answer	Source(s)
9. For the health needs, services areas, and/or providers of focus, which are the most relevant purchasers? ***(Note: these may include the Ministry of Health, a health insurance agency, clients, etc.)***		
10. Which purchasers are most important to shaping provider behaviors with respect to the health needs or service areas of interest?		

(For example, if available, users could compile data on the share of provider revenue different purchasers account for and what funds from each purchaser are meant to pay for.)		
11. For each purchaser, what are the sources of revenue?		
12. For each purchaser, what benefits or services are covered?		
13. For each purchaser, what types of facilities are included?		
14. For each purchaser, what are the main provider payment mechanisms?		
15. For each purchaser, does any aspect of provider payment rely on donor resources? **If yes, describe.**	☐ Yes ☐ No Details:	
16. Do any purchasers link payments to performance, including quality indicators or improvement processes? **If yes, describe.**	☐ Yes ☐ No Details:	

REFLECTIONS ON QUALITY DEFINITION AND OBJECTIVES

Quality Definition and Objectives – Reflections		
Question	Answer	Source(s)
17. To what extent do policies and stakeholders recognize the potential for purchasing to contribute to quality objectives? **For example, is purchasing mentioned in national quality improvement strategies? Does the health financing strategy discuss opportunities to improve quality through purchasing?** **How much interest and enthusiasm are there in purchasing-quality links?**		
18. What legal obstacles might arise as the purchaser explores ways to link purchasing to quality?		
19. What political obstacles might arise as the purchaser explores ways to link purchasing to quality? ***(For example, it may be politically difficult for a purchaser to only selectively fund or contract with public providers.)***		
20. Which other organizations, including other purchasers, regulatory bodies, provider organizations, and others, would need to be part of any		

discussions of linking purchasing to quality?		

SECTION 2: PROVIDER READINESS

Section 2 focuses on ways the health system measures providers' readiness to deliver services. Measurement systems can focus on individual health workers, facilities, or both. Of special interest here are routine or embedded systems that could involve any and all providers, *not* sampling-based approaches such as the Service Availability and Readiness Assessment (SARA) or Service Provision Assessment (SPA).

Key Terms for Provider Readiness

Accreditation = process by which a recognized body determines whether a health care organization meets pre-determined standards.

Certification = process by which a recognized body determines whether an individual or organization meets pre-determined standards. When applied to individuals, certification typically means they have completed additional education or training and demonstrated specialized competence beyond the minimum requirements for licensure.

Credential = a degree or other official recognition granted by an educational or training institute to an individual.

External evaluation = a general term referring to accreditation, certification, or similar processes by which a body other than the individual or organization is assessed and recognized for meeting pre-determined standards.

In-service training and continuing medical education = any formal training or learning experience undertaken by health care workers after they have already been providing services for some period of time.

Licensure = process by which government grants permission to an individual or organization to operate or engage in a profession.

Registration = an alternative to or component of licensure for a health care organization to be granted permission by government to operate.

Renewal = process for sustaining an individual or organization's accreditation, certification, licensure, or other status. Renewal may entail periodic payment of fees and/or onsite evaluations by recognized bodies or panels of peer reviewers.

HEALTH WORKFORCE

The following questions should be answered for each cadre, including any unregulated or informal categories of health workers that play an important role in the services. Typical public sector cadres include specialist doctors, general practitioners, dentists, pharmacists, nurses, midwives, nurse assistants, community health workers (formalized or lay), various allied health professions, and more. Clinical roles may be less standardized in the private sector, and in many countries, unregulated or informal providers serve a significant share of the population.

Users should copy and paste the table for as many cadres as they need.

Provider Readiness – Cadre 1 (e.g., medical doctors)		
Question	Answer	Source(s)
21. What credential qualifies someone to be a member of the cadre?		
22. Are there renewal requirements for the credential? **If yes, how is renewal managed in practice? How often?**	☐ Yes ☐ No Details:	
23. Who defines credentialing requirements or standards?		
24. Who issues or certifies credentials?		
25. Does a government or professional authority maintain a database of credentialed individuals? **If yes, who maintains it?** **How often is it updated?** **Is it available online?**	☐ Yes ☐ No Details:	
26. What license and/or registration does a member of the cadre need to practice? **Is it required?**	☐ Required ☐ Voluntary ☐ None Details:	
27. Who defines licensing or registration requirements or standards?		

28. Who issues or certifies health worker licenses or registration?		
29. Are there renewal requirements for the license or registration? **If yes, how is renewal managed in practice? How often?**	☐ Yes ☐ No Details:	
30. Are credentials, licenses, or registrations ever revoked, or renewals ever denied, for example, due to poor performance or malpractice? **If yes, describe.**	☐ Yes ☐ No Details:	
31. Does a government or professional authority maintain a database of licensed individuals? **If yes, who maintains it?** **How often is it updated?** **Is it available online?**	☐ Yes ☐ No Details:	
32. What share of cadre members are licensed and/or registered? **Does compliance differ between the public and private sectors?**		
33. What in-service training or continuing medical education (CME) opportunities are there for members of the cadre?		

34. Is there an annual minimum requirement for in-service training, supervised practice, and/or CME? **If yes, how is it tracked? By whom? What share of the cadre satisfies the requirements each year?**	☐ Yes ☐ No Details:	
35. What differences are there in credential, licensing, or in-service training/CME requirements between the public and private sector?		

HEALTH FACILITIES

The following questions should be answered for each facility type, again including unregulated or informal providers (to the extent they differ from those included under Health Workforce). Some users will only need to examine one level of care (e.g., primary health care [PHC]), while others may need to look across levels. It is likely all users will need to look across both the public and private sectors.

Users should copy and paste the table for as many facility types as they need, depending on the extent to which answers are likely to vary across facility types. At minimum, they should complete two copies, one for the public sector and one for the private sector.

Provider Readiness – Facility Type 1 (e.g., primary health center – public)		
Question	Answer	Source(s)
36. What requirements are there to be classified as this facility type?		
37. Do facilities of this type need a license to operate? **If yes, what is the licensing process?**	☐ Yes ☐ No Details:	

Do licensing requirements align with how facilities of this type are staffed and managed in practice? **(*For example, in some countries, all licensed facilities must have an affiliated medical doctor even if, in practice, the facilities are fully managed nurses or midwives.)***		
38. Are there renewal requirements for facility licenses? **If yes, how is renewal managed in practice? How often?**	☐ Yes ☐ No Details:	
39. Does anyone maintain a database of licensed facilities? **If yes, who maintains it?** **How often is it updated?** **Is it available online?**	☐ Yes ☐ No Details:	
40. Is there a required or voluntary accreditation process? **If yes, describe.** **If voluntary, what are the main reasons providers do or do not participate?**	☐ Required ☐ Voluntary ☐ None Details:	
41. How many accreditation levels or tiers are there for this facility type?		

42. What organization or agency defines accreditation standards?		
43. What organization or agency grants accreditation status?		
44. Does anyone maintain a database of accredited facilities? **If yes, who maintains it?** **How often is it updated?** **Is it available online?**	☐ Yes ☐ No Details:	
45. Are there renewal requirements for accreditation? **If yes, how is renewal managed in practice? How often?**	☐ Yes ☐ No Details:	
46. What share of facilities of this type are accredited?		
47. Can facilities of this type earn other certifications, such as those indicating their readiness to deliver specific services? **If yes, describe, including any re-certification requirements.**	☐ Yes ☐ No Details:	
48. What organization or agency grants additional certifications?		
49. Does anyone maintain a database of certified facilities?		

If yes, who maintains it? How often is it updated? Is it available online?		
50. Are there renewal requirements for certifications? If yes, how is renewal managed in practice? How often?	☐ Yes ☐ No Details:	
51. Is accreditation or certification ever revoked, or renewals ever denied due, for example, to poor performance or malpractice? If yes, describe.	☐ Yes ☐ No Details:	
52. What share of facilities of this type are certified? Does participation differ between the public and private sectors?		
53. Are there any other external evaluation programs for facilities of this type? If yes, describe.	☐ Yes ☐ No Details:	
54. What differences are there in accreditation or certification requirements or practices between the public and private sector?		

CURRENT PURCHASING AND PROVIDER READINESS

Provider Readiness – Existing Purchasing Links		
Question	Answer	Source(s)
55. Do any purchasers currently encourage or require credentials, licenses, and/or training for health workers? **If yes, how?** ***(For example, an insurance scheme may factor these into the contracting eligibility, performance standards, or reimbursements of a facility or individual clinician.)***	☐ Yes ☐ No Details:	
56. Do any purchasers currently encourage or require licensing and/or accreditation? **If yes, how?** ***(For example, a purchaser might only contract with licensed or accredited facilities, or it might offer them higher payment rates as they move to higher accreditation tiers.)***	☐ Yes ☐ No Details:	
57. Do any purchasers currently encourage or require additional certifications? **If yes, how?**	☐ Yes ☐ No Details:	

(For example, a purchaser might only allow certified providers to be reimbursed for select services, or instead offer certified providers higher payment rates.)		
58. ***If answers to any of the above questions are "Yes"*:** **What effect are the requirements or incentives having? For example, is there evidence that participation in accreditation has increased?**		
59. Are any requirements documented above effectively monitored and enforced? **Describe what enables or hinders monitoring and enforcement.**	☐ Yes ☐ No Details:	

REFLECTIONS ON PROVIDER READINESS

After completing all the needed tables for the health workforce and facilities, the user should reflect on the information gathered to answer the questions below.

Provider Readiness – Reflections		
Question	Answer	Source(s)
60. What opportunities are there for the purchaser to introduce or reinforce incentives for enhanced provider readiness?		
61. How feasible would it be for the purchaser to access information about the readiness of health workers and facilities? **For example, are databases complete, regularly updated, and available online? Are information sources linked or interoperable?**		
62. Which indicators of provider readiness could be feasibly linked to purchasing? Are any viewed favorably by key stakeholders?		
63. Which indicators of provider readiness are less promising to link to purchasing? Why?		
64. What kind of relationships does the purchaser already have with the bodies responsible for measuring or verifying provider readiness? What opportunities are there to strengthen them?		

SECTION 3: MANAGEMENT AND CARE PROCESSES

Section 3 focuses on ways the health system measures management and care processes, which help to determine whether providers convert health system inputs and service encounters into desirable health outcomes and positive user experiences. Once again, measurement systems can focus on individual health workers, facilities, or both.

Key Terms for Management and Care Processes

Contraindication = a condition or other factor due to which a medical treatment should be withheld because of potential patient harm.

DHIS2 = a district health information system common to many low- and middle-income countries.

Diagnostic and procedural codes = schemes typical of computerized health management information systems that allow standardized coding of the reasons for visits and services rendered.

HMIS = health management information system, of which the DHIS2 is one common component.

Inspection = a routine or ad-hoc visit by a supervisory authority to monitor a health facility's performance.

LMIS = logistics management information system.

Patient file = written or computerized record of an individual's encounters with health care providers, which may include patient history and information related to diagnosis, treatment, and routine care.

INSPECTIONS

Routine supervision or inspections of providers is a common way that health systems try to encourage high-quality service delivery. It may be possible to answer the following questions in general terms, or users may want to repeat them for different types of providers or services. Users will want to be particularly mindful of likely differences between public and private sector providers when it comes to management and care processes. If both sectors are within scope, users should replicate and adapt these questions for each.

Management and Care Processes – Inspections		
Question	Answer	Source(s)
65. What are the current supervision standards and guidelines?		

66. In practice, what routine supervision or inspection activities actually occur? **How frequently?** **Are they pre-planned or unannounced?** **Do they cover all facilities or a subset?** **Do they cover private providers?**		
67. Is there a standard checklist or protocol for supervisory or inspection visits? **What does it include?** ***(Users may find of interest both general information, for example with respect to cleanliness, absenteeism, and operating hours, as well as information specific to priority service areas.)***		
68. How are findings reported? **Is the information reliably and timeously digitized?** **Are results shared back with providers?**		

What consequences (financial or other) arise from the findings?		
69. Is the quality of supervision evaluated in any way? **If yes, describe.**	☐ Yes ☐ No Details:	
70. Does any government body, professional association, or other stakeholder routinely conduct surprise or clandestine inspections? **If yes, describe how they are conducted and by whom.** **Are all facilities covered in a particular timeframe (e.g., each year)?**	☐ Yes ☐ No Details:	
71. Are there any important differences between supervision policies and how supervision and inspections occur in practice? **If yes, what are the main causes of the differences? What would be needed to bring practices closer to the standards?**	☐ Yes ☐ No Details:	

STOCK MANAGEMENT

Much of what determines the availability of essential medicines and supplies occurs elsewhere in the supply chain, but providers still play a role in effectively managing their stocks. These questions are intended to illuminate what information may be available about provider-level practices for inventory management, proactivity to avoid or respond to stockouts, and avoidance of product expiry. Users may want to tailor these questions to focus on management of essential medicines and supplies for specific services or health needs of interest.

Management and Care Processes – Stock Management		
Question	Answer	Source(s)
72. What responsibilities do providers have for management of essential medicines and supplies?		
73. In practice, how effectively do providers manage their stocks?		
74. Is there a logistics management information system (LMIS) in place? **At the provider level, is it paper based or computerized?** **Do all public providers participate? Do private providers participate?**	☐ Yes ☐ No ☐ Paper based ☐ Computerized ☐ Public ☐ Private-voluntary ☐ Private-mandatory Details:	
75. Can the LMIS or another system track provider-level inventories of essential medicines and supplies? **If yes, is the information available at provider or higher levels in real time?**	☐ Yes ☐ No Details:	

APPROPRIATENESS OF SERVICES

High-quality services are appropriate to a person's health needs. Here the focus is on the more objective aspects of care processes, such as whether services are evidence based and anchored in rigorous assessment, counseling, and diagnosis. The next sub-section focuses specifically on patient safety. Equally important are the more subjective aspects of how users experience services—these are the focus of section 6.

Users interested in specific health needs or service areas may need to tailor or expand on these questions. For example, for questions regarding a user focused on maternity eservices may want to specifically investigate whether any information system tracks the timing and frequency of prenatal visits, the share of pregnant women screened for preeclampsia, the share of preeclampsia cases managed with indicated medications, and so on. Similarly, a user focused on family planning might search for information systems that shed light on whether a provider typically has a robust mix of contraceptive methods, what referral relationships exist to direct women to providers that can provide long-acting methods, what share of women are counseled about contraceptive options as part of delivery and postnatal care, and so on.

Management and Care Processes – Appropriateness of Services		
Question	Answer	Source(s)
76. Is there a HMIS in place? **At the provider level, is it paper based or computerized?** **Do all public providers participate? Do private providers participate?**	☐ Yes-DHIS2 ☐ Yes-other ☐ No ☐ Paper based ☐ Computerized ☐ Public ☐ Private-voluntary ☐ Private-mandatory Details:	
77. How frequently do providers submit HMIS data?		
78. Describe the HMIS data flow from providers to higher levels. **At what level are HMIS data systematically digitized?** **Are HMIS data stored online? If yes, with what levels of disaggregation?**	☐ Yes ☐ No Details:	

79. Do district- or higher-level authorities track the timeliness, completeness, or accuracy of providers' HMIS data? **If yes, what do they do in response to good or poor provider practices?**	☐ Yes ☐ No Details:	
80. Who can access HMIS data after it is submitted by providers? **Describe how HMIS data are accessed. For example, is there a cloud-based system? Does the system automatically organize data into summary tables, figures, or dashboards?**	☐ PHC facilities ☐ District hospitals ☐ Higher-level hospitals ☐ Private facilities ☐ District health teams ☐ Other (specify:_____) Details:	
81. Are there unique identifiers for patients? **If yes, how are they assigned? Are they linked to broader civil registration or social benefits system (e.g., national ID, cash transfer, social security, etc.)?**	☐ Yes ☐ No Details:	
82. Are patient files paper based or computerized? **If computerized, are they networked such that multiple providers can access the same patient file?**	☐ Paper based ☐ Computerized Details:	
83. For the service areas of interest, are there codified clinical guidelines, standard treatment protocols, care pathways, checklists, or similar?	☐ Yes ☐ No Details:	

If yes, who develops and distributes them?		
84. Is provider compliance with clinical guidelines and standards monitored? **If yes, how and by whom?** **Are there consequences for strong or weak compliance?** **Are there differences in monitoring between the public and private sectors?**	☐ Yes ☐ No Details:	
85. Is there a referral system between different levels of care? **If yes, how is it supposed to work?** **How does it work in practice?** **Are there referrals between public and private providers?**	☐ Yes ☐ No Details:	
86. Are referral rates tracked? **If yes, how and by whom?** **What share of PHC patients are referred to other providers?** **Are reasons for referrals documented?**	☐ Yes ☐ No Details:	
87. Are rates of inappropriate referrals tracked? **If yes, how?** **What share of referrals are inappropriate?**	☐ Yes ☐ No Details:	

88. Is there any formal or informal system for down-referrals (e.g., from hospitals to PHC facilities)? **If yes, how does it work?** **Are down-referrals tracked?** **Are there any incentives for providers to down-refer versus retain patients?**	☐ Yes ☐ No Details:	
89. Do any existing health financing schemes use providers' routine data on care processes? **If yes, how?** ***(For example, an insurance scheme might conduct its own analysis of provider practices or base a portion of provider remuneration on data provision and/or aspects of care processes.)***	☐ Yes ☐ No Details:	

PATIENT SAFETY

One of the most important—and often most visible—consequences of provider readiness and care processes is patient safety. Safe services minimize risks and harm to users. There are several threats to patient safety, including unsanitary facilities and practices, unnecessary or contraindicated interventions, errors, negligence, and adverse events.

Users interested in specific health needs or service areas may need to tailor or expand on these questions to address the most relevant patient safety issues.

Care Processes – Patient Safety		
Question	Answer	Source(s)
90. Are there any specific initiatives led by government, professional associations,	☐ Yes ☐ No Details:	

or stakeholders to identify, track, or address patient safety issues? **If yes, describe who is involved, what the objectives are, and what activities have been planned or undertaken.**		
91. Do routine inspections or supervision visits include attention to cleanliness and sanitation? **If yes, elaborate. What specific criteria or attributes are looked for?** **Are there any consequences for unclean or unsanitary conditions?** ***(Users may be able to draw on and enrich information gathered in the Inspections subsection above.)***	☐ Yes ☐ No Details:	
92. Do any government or non-government entities track medical errors and/or adverse events? **If yes, describe.** ***(For example, professional associations might encourage voluntary reporting by their members. Drug and device manufacturers may also encourage or require reporting of adverse events linked to their technologies.)***	☐ Yes ☐ No Details:	

93. Do any government or non-government entities regularly offer training to health workers and/or facilities on safety? **If yes, describe.** **Who offers the training?** **Who pays for the training costs?** **How widespread has uptake been?** **Is participation systematically tracked?**	☐ Yes ☐ No Details:	
94. What are the main differences in monitoring management and care processes between the public and private providers? **Are there any discussions about sharing information between the sectors?**		

CURRENT PURCHASING AND MANAGEMENT AND CARE PROCESSES

Management and Care Processes – Existing Purchasing Links		
Question	Answer	Source(s)
95. Do any purchasers currently use information from routine facility inspections or supervision? **If yes, describe.** ***(For example, a purchaser might factor***	☐ Yes ☐ No Details:	

information gleaned from inspections into quality-based payments.)		
96. Do any purchasers currently link purchasing to how effectively providers manage their stocks of essential medicines and supplies? **If yes, describe.** ***(For example, a purchaser might factor stockouts into quality-based payments, or purchasing contracts might shift financial risk for drug expiry to providers.)***	☐ Yes ☐ No Details:	
97. Do any purchasers currently encourage the use of higher-value commodities? **If yes, how?** ***(For example, a purchaser might set rates such that providers make at least as much profit when they prescribe generic medicines as branded ones. Or a purchaser might impose higher co-payments, paid by patients, for branded drugs. Or a purchaser might refuse to reimburse for drugs that have not met standards for safety or effectiveness set by a national or international body.)***	☐ Yes ☐ No Details:	

98. Do any purchasers currently link purchasing to the completeness, timeliness, and/or accuracy of providers' routine data? **If yes, how?**	☐ Yes ☐ No Details:	
99. Do any purchasers currently link purchasing to the appropriateness of services? **If yes, how?** ***(For example, a purchaser might conditionalize reimbursement on adherence to clinical guidelines.)***	☐ Yes ☐ No Details:	
100. Do any purchasers currently link purchasing to information about patient safety? **If yes, describe in detail.**	☐ Yes ☐ No Details:	
101. ***If answers to any of the questions above are "Yes"*:** **What effect are the incentives having? For example, is there evidence that management and/or care processes have improved since the introduction of incentives?**		

REFLECTIONS ON MANAGEMENT AND CARE PROCESSES

After completing all the needed tables for inspections, stock management, appropriateness of services, and care processes, the user should reflect on the information gathered to answer the questions below.

Management and Care Processes – Reflections		
Question	Answer	Source(s)
102. **What opportunities are there for the purchaser to introduce or reinforce incentives for strong management and care processes?**		
103. **How feasible would it be for the purchaser to access information about the management and care processes?** **For example, are information systems complete, regularly updated, and available online? Are information sources linked or interoperable?**		
104. **Which systems for measuring management and care processes could be feasibly linked to purchasing?** **Which systems are consistently applied across the country?** **Are any generally considered to work fairly well?**		

105. **Which systems for measuring management and care processes are less promising to link to purchasing?** **Why?**		
106. **What kind of relationships does the purchaser already have with the bodies responsible for monitoring management and care processes? What opportunities are there to strengthen them?**		

SECTION 4: UTILIZATION AND OUTCOMES

Section 4 focuses on the broad categories of utilization and outcomes that may be measured in various ways in a health system. Here utilization refers both to general service coverage and volume of specific services of interest. Likewise, outcomes can be measured for populations and individual patients.

This section may require the most user effort to customize because most utilization and outcome indicators are specific to health needs. Other indicators may also be relevant depending on the country's objectives (e.g., equity).

Key Terms for Utilization and Outcomes

CRVS = civil registration and vital statistics, government system(s) that record births, deaths, and changes in civil status such as marriage.

Empanelment = process of enrolling people with specific health care providers, typically for primary health care.

POPULATION MANAGEMENT

In some contexts, provider performance can be assessed based on coverage and outcomes for an identified population. For example, a district health team may be responsible for the health of every one of the district's residents. Alternatively, in some systems PHC providers are responsible for a population that either selects the provider or is assigned to it. Measuring population-level indicators may require using information from systems outside the health sector.

Utilization and Outcomes – Population Management		
Question	Answer	Source(s)
107. **Are there generally accepted and routinely updated data on population sizes within political and/or health geographical units (e.g., districts, facility catchment areas)?** **If yes, describe.** ***(Note: these may be under the***	☐ Yes ☐ No Details:	

auspices of a national statistical agency.)		
108. **What information is captured in the civil registration and vital statistics (CRVS) system? (check all that apply)** **What proportion of births, deaths, and causes of death are known or believed to be captured in the CRVS?** **How often is the CRVS updated?** **Are the data available online?** **Can they be disaggregated geographically?**	☐ Births ☐ Deaths ☐ Causes of death ☐ Marriages ☐ Divorces ☐ Other (specify) Details:	
109. **Are districts, facilities, and/or individual health workers considered responsibility centers for designated populations?** **If yes, describe which provider entity is considered responsible for which population.**	☐ Yes ☐ No Details:	
110. **How are people assigned to providers?** **If there is an empanelment process, describe the process and frequency for updating the official lists of empaneled individuals and how**	☐ Implicit based on geography (e.g., district health team is responsible for all district residents) ☐ Empanelment based on geography (e.g., individuals are assigned to the nearest PHC provider) ☐ Empanelment based on choice (e.g., individuals can select their preferred PHC provider) ☐ Other ☐ n/a	

frequently someone may change their selection of provider.	Details:	
111. **Does the HMIS track the number of encounters between providers and members of the population (check all that apply)?**	☐ # of visits to a facility ☐ # of non-facility encounters (e.g., in the community) ☐ # of individual services provided (i.e., a single person-visit can contribute more than once to this count) ☐ Other (specify) ☐ None	
112. **Do districts or higher levels routinely prepare a performance report or dashboard for facilities?** **If yes, what does it include?** **How frequently is it produced?**	☐ Yes ☐ No Details:	
113. **Is there any routine system to determine how equitably utilization is distributed across the population of the district or provider?** **If yes, describe.**	☐ Yes ☐ No Details:	

SPECIFIC HEALTH NEEDS

The amount of data generated by service providers can be substantial, so it may not be practical for users to take stock of everything. Instead, they will likely want to focus their inquiry on utilization and outcome measurement that relate to the health needs or service areas of particular interest to the purchaser.

Users should copy and paste the table for as many health needs or service areas as are part of their landscaping effort.

Utilization and Outcomes – Health Need/Area 1		
Question	Answer	Source(s)
114. **List the key services or interventions for this health need and what level(s) of care and provider type(s) that can be accessed. Refer to these as you answer the next several questions.**		
115. **For which of these services do providers report utilization data?** **What are the HMIS indicators for each?**		
116. **Do private providers report utilization data for these services?** **If yes, do they report through the HMIS or another system? Describe.**	☐ Yes ☐ No Details:	
117. **Are there generally accepted and routinely updated data on how many people need these services at the district or provider level?** **If yes, describe.**	☐ Yes ☐ No Details:	
118. **Is there a national or local utilization or coverage target for these services?**	☐ Yes ☐ No Details:	

If yes, what are they, and how is progress toward them tracked?		
119. **Do providers report complications from these services?** **If yes, what complications are tracked, though what system, and what are the indicators for them?**	☐ Yes ☐ No Details:	
120. **Do providers track and report patient retention for these services?** **If yes, describe.** ***(Note: retention could be measured over the course of a care episode, such as for maternity services, or over the course of a year, such as for HIV and other chronic disease.)***	☐ Yes ☐ No Details:	
121. **Do providers track and report patient outcomes for these services?** **If yes, describe.**	☐ Yes ☐ No Details:	
122. **Does any other government or non-government entity routinely track patient outcomes for these services?** **If yes, describe.**	☐ Yes ☐ No Details:	

123. **What are the main differences in monitoring utilization and outcomes between the public and private providers?** **Are there any discussions about sharing information between the sectors?**		

CURRENT PURCHASING AND UTILIZATION AND OUTCOMES

Utilization and Outcomes – Existing Purchasing Links		
Question	Answer	Source(s)
124. **Do any purchasers currently base the services they cover (i.e., benefits package) on an evidence-based process for priority setting?** **If yes, describe.** ***(For example, some countries rely on health technology assessment and other economic evaluations to determine whether to cover new interventions.)***	☐ Yes ☐ No Details:	
125. **Do any purchasers currently require empanelment or otherwise encourage population health management?**	☐ Yes ☐ No Details:	

If yes, elaborate, including any incentives or indicators (e.g., PHC visits per capita).		
126. **Do any purchasers currently base any portion of provider payment or eligibility on utilization or outcomes data for the service areas of interest?** **If yes, elaborate, including any specific incentives and the indicators to which they are linked.**	☐ Yes ☐ No Details:	
127. ***If answers to any of the above questions are "Yes"*:** **What effect are the requirements or incentives having? For example, is there evidence of more proactive preventive and promotive care by providers? Or of improved access or quality of priority services?**		
128. **What are the key enablers or obstacles for purchasers that have linked eligibility and/or payments to utilization or outcomes indicators?**		

REFLECTIONS ON UTILIZATION AND OUTCOMES

After completing all the needed tables for population management and specific health needs, the user should reflect on the information gathered to answer the questions below.

Utilization and Outcomes – Reflections		
Question	Answer	Source(s)
129. **What opportunities are there for the purchaser to introduce or reinforce incentives for increased utilization and/or improved outcomes?**		
130. **How feasible would it be for the purchaser to access information about the management and care processes?** **For example, are information systems complete, regularly updated, and available online? Are information sources linked or interoperable?**		
131. **Which systems for measuring utilization and outcomes could be feasibly linked to purchasing?** **Which systems are consistently applied across the country?** **Are any generally considered to work fairly well?**		
132. **Which systems for measuring utilization and outcomes are less promising to link to purchasing?**		

Why?		
133. **What kind of relationships does the purchaser already have with the bodies responsible for monitoring utilization and outcomes? What opportunities are there to strengthen them?**		

SECTION 5: USER EXPERIENCE

Section 5 focuses on the ways in which people and communities experience the health system.

User Experience		
Question	Answer	Source(s)
134. **Does government attempt to track individual user experience or patient satisfaction in the public sector?** **If yes, who collects feedback and how? How often or from what share of users?**	☐ Yes ☐ No Details:	
135. **Does anyone attempt to track individual user experience or patient satisfaction in the private sector?** **If yes, who collects feedback and how? How often or from what share of users? Who is the information shared with?**	☐ Yes ☐ No Details:	
136. **Are there any routine or ad hoc mechanisms for collecting community feedback on provider performance?** **If yes, who collects feedback and how? How often?**	☐ Yes ☐ No Details:	
137. **If any of the above feedback mechanisms**		

exist, who uses the information and for what purposes?		
138. **Is there a formal complaint or redress mechanism in the public sector?** **If yes, how does it work?** **Do people use it?** **What evidence (systematic or anecdotal) is there about its effectiveness?**	☐ Yes ☐ No Details:	
139. **Is there a formal complaint or redress mechanism in the private sector?** **If yes, how does it work?** **Do people use it?** **What evidence (systematic or anecdotal) is there about its effectiveness?**	☐ Yes ☐ No Details:	
140. **Are there any efforts to track waiting times?** **If yes, what are they?** **Does anyone use the data? For what?**	☐ Yes ☐ No Details:	
141. **Are there any efforts to track the length of consultations?** **If yes, what are they?** **Does anyone use the data? For what?**	☐ Yes ☐ No Details:	

CURRENT PURCHASING AND USER EXPERIENCE

User Experience – Existing Purchasing Links		
Question	Answer	Source(s)
142. **Do any purchasers currently base any portion of provider payment or eligibility on indicators of user or community experience?** **If yes, elaborate, including any specific incentives and the indicators to which they are linked.**	☐ Yes ☐ No Details:	
143. **Do any purchasers currently base any portion of provider payment or eligibility on information learned through complaint or redress mechanisms?** **If yes, elaborate. For example, are there types of complaints that can lead to providers losing their contracting eligibility?**	☐ Yes ☐ No Details:	
144. **Do any purchasers currently base any portion of provider payment or eligibility on indicators related to waiting times or consultation times?** **If yes, elaborate, including any specific incentives and the indicators to which they are linked.**	☐ Yes ☐ No Details:	

145. ***If answers to any of the above questions are "Yes"*:** **What effect are the incentives having? For example, is there evidence of improved user experience, reduced waiting times, less frequent complaints, etc.?**		
146. **What are the key enablers or obstacles for purchasers that have linked eligibility and/or payments to user experience indicators?**		

REFLECTIONS ON USER EXPERIENCE

After completing all the needed tables for User Experience, the user should reflect on the information gathered to answer the questions below.

User Experience – Reflections		
Question	Answer	Source(s)
147. **What opportunities are there for the purchaser to introduce or reinforce incentives for improved user experience?**		
148. **How feasible would it be for the purchaser to access information about user experience?** **For example, are information systems complete, regularly updated, and available**		

online? Are information sources linked or interoperable?		
149. Which systems or processes for measuring user experience could be feasibly linked to purchasing? Which are consistently applied across the country? Are any generally considered to work fairly well?		
150. Which systems for measuring user experience are less promising to link to purchasing? Why?		
151. What kind of relationships does the purchaser already have with the bodies responsible for monitoring user experience? What opportunities are there to strengthen them?		

ANNEX: ADDITIONAL QUESTIONS

In some cases, users may want to more deeply examine the detailed contents of monitoring and information systems, particularly with respect to management and care processes, utilization, and outcomes. The questions below are meant as a starting point.

Question	Answer	Source(s)
152. **Do providers need to proactively reorder essential medicines and supplies?** **If yes, could LMIS data be used to determine how timeously a provider requests resupply? How?**	☐ Yes ☐ No Details:	
153. **Does the LMIS or another system track provider-level stockouts of essential medicines and supplies?** **How are stockouts reported by providers?**	☐ Yes-incidence ☐ Yes-duration ☐ No Details:	
154. **Does the LMIS or another system track provider-level expiry of essential medicines and supplies?** **How are expirations reported by providers?**	☐ Yes ☐ No Details:	
155. **Is there any system for tracking the availability of personal protective equipment (PPE) at the provider level, such as masks, goggles, gowns, gloves, etc.?** **If yes, describe what items are tracked and**	☐ Yes ☐ No Details:	

how. **Do providers report shortages to a particular authority?**		
156. **Is there any system for tracking health care-associated infections (HAI)?** **If yes, describe how HAI are identified, who reports the data, and who responds to reports (if anyone).**	☐ Yes ☐ No Details:	
157. **Are providers supposed to report medical errors and/or adverse events?** **If yes, to whom?** **Do providers reliably report in practice?** **What happens when an error or adverse event is reported?**	☐ Yes ☐ No Details:	
158. **For what percentage of visits are diagnoses documented?** **Do providers use standardized diagnostic codes (e.g., ICD)?** **Do practices differ between the public and private sectors?** ***(Note: here, "diagnoses" can also be read generally to include justifications for***		

services, such as the basis for a provider's recommendation of contraceptive method to a patient.)		
159. **For what percentage of visits are services rendered documented?** **Does the this include medicines administered or dispensed?** **Do providers use standardized codes?** **Do practices differ between the public and private sectors?**		
160. **Is it possible to link diagnoses and services rendered to individual patients or patient encounters?** **If yes, does anyone currently analyze these data to understand trends or assess the appropriateness of services based on patient needs?**	☐ Yes ☐ No Details:	
161. **Is it possible to link diagnoses and drugs administered or dispensed to individual patients or patient encounters?** **If yes, does anyone currently analyze these data to identify potentially unsafe medicine use (e.g., due to contraindications or potentially dangerous drug interactions)?**	☐ Yes ☐ No Details:	

(Note: this is a similar question to one in the previous subsection but with greater focus on medicines in particular.)		

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