**Presentation 3: Country case study from Malawi**

*Background:*

Malawi has made some progress towards universal access to effective and quality health services, though major challenges remain. Improving the purchasing function is crucial in order to effectively link resource allocations to actual population health needs and improve both allocative but also technical efficiency of the health system. This is one of the core objectives of the Health Sector Strategic Plan 2 covering the period 2017-2022. Following this decision, a review of the Mixed Provider Payment System has been identified as one of the most relevant one entry points to take the dialogue on purchasing to the next level.

*Methodology:*

The study applied the WHO guidance for Mixed Provider Payment assessment.

Undertaking the analysis systematically and comprehensively requires the issues to be explored by a mixed method approach that is initially of qualitative nature, but should be combined with the analysis of quantitative data, where possible. The proposed methodology consists of the following activities: document review, secondary data analysis (household surveys and DHIS2), and qualitative primary data collected through interviews with key stakeholders (both at national and district levels, providers from the public and private sector, and from various levels of care (primary, secondary, tertiary), as well as users.

*Results*

In Malawi, such review reveals two key findings:

* First, in the public sector, most financial flows received by providers of all levels of the healthcare pyramid are mostly input-based, channelled through rigid line-item budget lines. Budget allocations are typically determined by Treasury based on historical patterns. Primary and secondary care is largely purchased by district councils based on input-based line items. Performance-based Financing is being implemented as a remedy against the negative incentives created by these rigid payment methods, with mixed results so far;
* Second, in the private sector (mostly non-for-profit), services are mostly paid on inputs for salaries (line item budget allocated by the MoH) and on outputs for the consumables, quasi systematically through cost sharing – i.e. private payments from patients.

Beyond the detailed description of the current situation, the study makes also surface important issues of misalignments between the different incentives, the existence of perverse incentives across the health system and a lack of any coordination mechanism, a precondition to any attempt to optimize the Mixed Provider Payment Mix.

*Conclusions:*

Several policy recommendations have been developed in order to move towards more harmonized Provider Payment System.