

# **FINANCING AND PAYMENT MODELS FOR PRIMARY HEALTH CARE**

**SIX LESSONS FROM JLN  
COUNTRY IMPLEMENTATION  
EXPERIENCE**





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## ACKNOWLEDGMENTS

This document was produced by the Joint Learning Network for Universal Health Coverage (JLN), an innovative network of practitioners and policymakers from around the world who collaboratively solve implementation challenges and develop practical tools to help countries work toward universal health coverage. More information is available at [www.jointlearningnetwork.org](http://www.jointlearningnetwork.org). For inquiries about this document or other JLN activities, please contact the JLN at [jln@r4d.org](mailto:jln@r4d.org).

The work was funded by the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) through the Global Alliances for Social Protection program, along with grants to the JLN Provider Payment Mechanisms Technical Initiative from the Bill & Melinda Gates Foundation and the Rockefeller Foundation.

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***“Primary health care is not the entry point to the health system but the center. And at the center of the center are people.”***

*Dr. Isabella De Ferari*

*Office of the Under-Secretary for Health Services Networks*

*Ministry of Health, Chile*

## Introduction

In most countries, primary health care (PHC) providers are the first point of contact that people have with the health care system. This part of the system is used the most and can have the greatest impact on health, particularly among vulnerable populations. International evidence confirms that a stronger PHC sector is associated with greater equity and access to basic health care, higher patient satisfaction, and lower aggregate spending for the same or better outcomes. The role of the PHC sector also determines many of the interactions among the government purchasers, providers, and the population throughout the health system. Many countries find it challenging to improve their PHC systems, however. (See **Box 1**.) Financing and payment models for PHC can be important tools for addressing issues of access, quality, and equity in health care.

Financing and payment models for PHC should allow adequate resources to flow to the PHC level and make priority interventions accessible to the entire population. These models should also create incentives across the health system to manage population health, use resources efficiently, and avoid unnecessary services and expenditures at the secondary and tertiary levels.

In many countries, financing and payment models do not help strengthen PHC; in fact, they tend to exacerbate imbalances that favor expensive tertiary hospitals. This hinders efforts to improve population health, increases the total costs of the health system, and often imposes financial burdens on households. Financing systems can be fragmented and can involve many different agencies (including national and local governments, insurers and purchasing agencies, development partners, faith-based organizations, and nongovernmental organizations), each with their own funding and payment mechanisms.

### **BOX 1.**

#### **OBSTACLES TO EFFECTIVE AND EFFICIENT PHC FINANCING AND SERVICE DELIVERY**

- ▶ Difficulty defining primary health care, the services it includes, and the providers who deliver it
- ▶ Underprovision of high-priority services and overuse of tertiary facilities
- ▶ Overreliance on hospitals to deliver basic PHC services
- ▶ Poorly functioning referral systems
- ▶ Difficulty managing costs and efficiently allocating limited resources
- ▶ Challenges with designing payment methods that will help strengthen PHC and advance other health system objectives
- ▶ Obstacles to effectively engaging private-sector providers
- ▶ Lack of monitoring and performance measurement

Countries find it challenging to develop financing and payment systems for PHC that align with payment systems at other service delivery levels and create both opportunity and incentives to provide better PHC, ensure more equitable access, and shield families from impoverishing out-of-pocket payments. Little evidence is available on effective payment models for PHC that help shift the balance of resources and service use toward PHC and expand prevention to improve population health. Many countries, including those in the Joint Learning Network for Universal Health Coverage (JLN), have tried a variety of approaches and models for PHC financing and payment, but few of those experiences have been evaluated or their lessons well documented for an international audience.



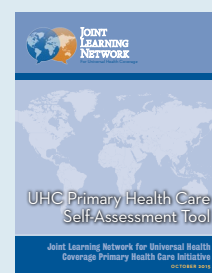
*JLN country members share their experience with PHC financing and payment at a session in Santiago, Chile.*

The JLN Provider Payment Mechanisms (PPM) Technical Initiative is hosting a collaborative learning exchange so countries can share their experiences with different PHC financing and payment models. This effort is generating a deeper understanding of how the design and implementation of financing and payment models for PHC can support effective, sustainable health systems that improve population health and financial protection in low- and middle-income countries. This paper presents six important early lessons emerging from the collaborative learning exchange that can be adapted and applied by other countries that face similar challenges or are embarking on PHC reform efforts. This is not an exhaustive synthesis of country experience, but rather a sample of experience that illustrates these early lessons. The paper also points out helpful resources with guidance that countries can adapt to their own contexts.

## HELPFUL RESOURCES

The **UHC Primary Health Care Self-Assessment Tool** helps countries quickly identify opportunities to improve the relationship between health financing and PHC improvement efforts.

[www.jointlearningnetwork.org/resources/uhc-primary-health-care-self-assessment-tool](http://www.jointlearningnetwork.org/resources/uhc-primary-health-care-self-assessment-tool)



## Lessons from JLN Country Experience

Since the collaborative learning exchange on PHC financing and payment began in January 2016, policymakers and practitioners from 15 JLN member countries and three resource countries (nonmember countries that have been willing to engage with the JLN and share valuable experience) have shared their experience and reached consensus on a set of early lessons that can be adapted and used by other countries to guide implementation of effective PHC financing and payment models.

### BOX 2.

#### COLLABORATIVE LEARNING EXCHANGE PARTICIPANTS

##### JLN COUNTRIES

	BAHRAIN		KENYA		PERU
	BANGLADESH		MALAYSIA		PHILIPPINES
	GHANA		MOLDOVA		SOUTH KOREA
	INDIA		MONGOLIA		SUDAN
	INDONESIA		NIGERIA		VIETNAM

##### RESOURCE COUNTRIES

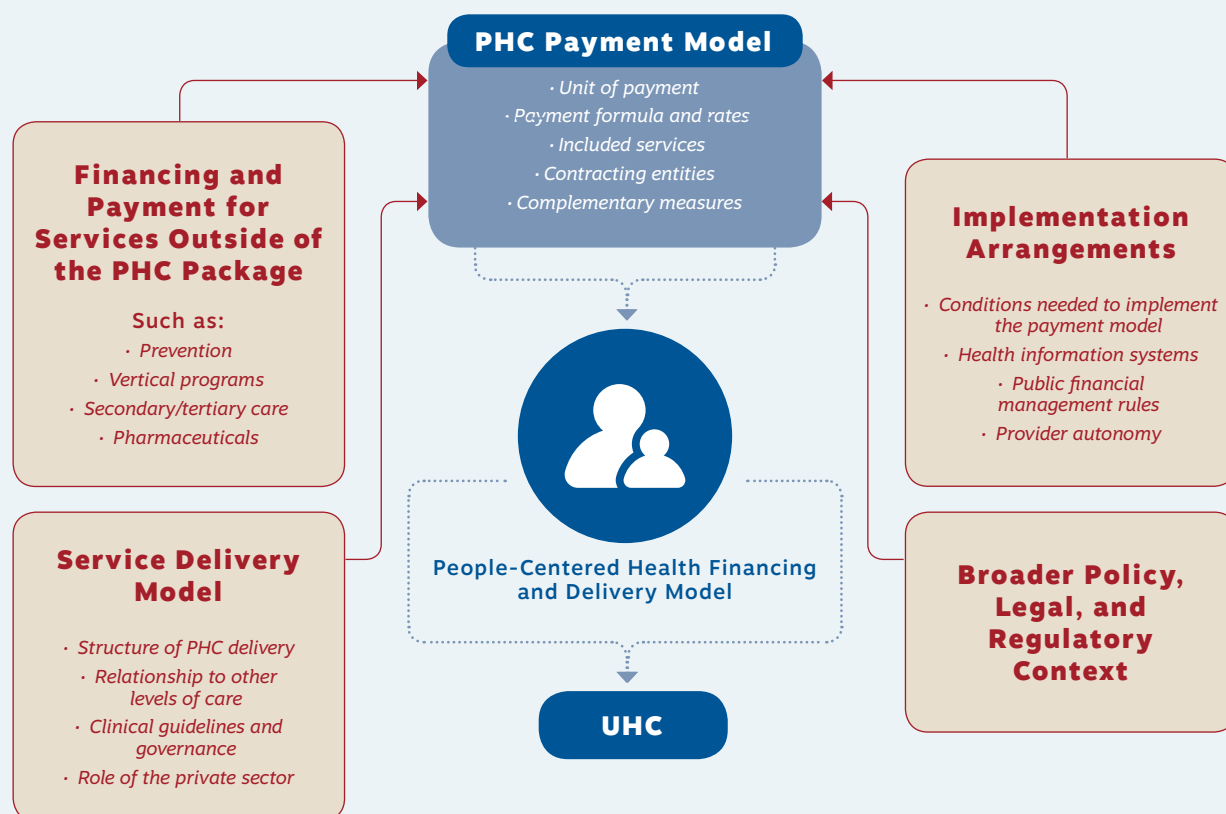
	ARGENTINA		CHILE		ESTONIA
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Since 2010, the PPM Technical Initiative has worked with countries to develop and refine a framework for understanding the role of PHC financing and payment models in the context of broader health financing and service delivery systems. (See **Figure 1.**) The framework also acknowledges the influence of policy, legal, and regulatory factors such as the public financial management system, government decentralization, and civil service laws.

**FIGURE 1.**

**PHC FINANCING AND PAYMENT MODELS IN CONTEXT**



This framework is being used by participants in the collaborative learning exchange to discuss and synthesize country experience and understand how that experience can be adapted to other country contexts.

## Choose financing and payment models that advance the country's PHC service delivery objectives

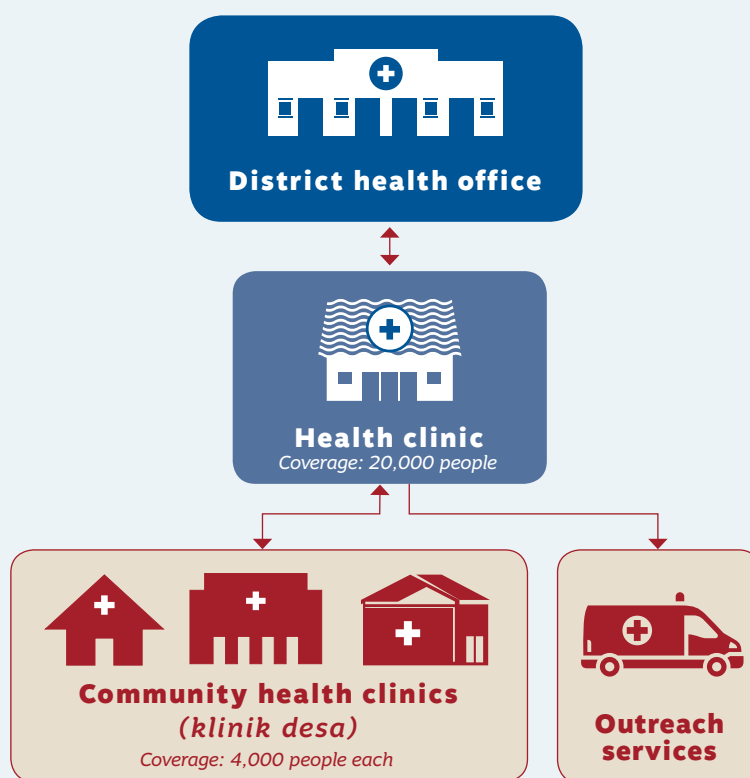
Countries should first determine their objectives for PHC service delivery and then identify financing and payment models that will support that vision and create the right incentives to ensure seamless, well-managed access across levels of care.

Both Malaysia (see **Figure 2**) and Bangladesh have a well-defined PHC service delivery model that provides continuity across levels of care, but in both countries the funding model is based on line-item budgets, which has led to concerns about inefficiency, long waiting times, and difficulty engaging with the private sector.

Several JLN countries, such as Ghana and the Philippines, are considering implementing integrated models that encourage public and private PHC providers to come together in groups or networks to provide more accessible and comprehensive services. These new service delivery models may, in turn, lead to demand for more creative ways to pay providers.

**FIGURE 2.**

### PHC SERVICE DELIVERY IN MALAYSIA



### HELPFUL RESOURCES

The **Primary Health Care Performance Initiative** has identified eight foundational characteristics of strong PHC systems.

<https://phcperformanceinitiative.org/8-core-tenets-primary-health-care-improvement-middle-and-high-income-countries>



## Define the PHC service package before selecting payment methods

To adequately fund PHC, it is important to define the PHC benefits or service package. PHC packages are typically defined as entitlements of basic and essential health services, but some countries design those packages around the health service delivery structure and scope of services. Some countries have difficulty defining PHC and the services that should be in the package.

Countries with a defined PHC package typically define that package through a combination of stakeholder consultations and use of some objective criteria. Some countries, such as Kenya, define their PHC package to prioritize access to free or low-cost PHC as a pathway to UHC. As more resources become available, the PHC package may become more generous. Malaysia's PHC package started out as a basic package focused on maternal and child health; as the country's resources have grown, the scope of PHC services has become more comprehensive and includes more complex services. The following table lists the PHC service packages in seven JLN countries.

### THE PHC SERVICE PACKAGE IN SEVEN JLN COUNTRIES

COUNTRY	PURCHASER	DEFINITION OF PHC PACKAGE AND SCOPE OF SERVICES	
BANGLADESH	Ministry of Health and Family Welfare	<ul style="list-style-type: none"> <li>• Maternal and newborn care, child health, and immunization</li> <li>• Adolescent health</li> <li>• Family planning: preconception, postpartum, post-abortion, post-menstrual regulation</li> <li>• Child, adolescent, and maternal nutrition</li> <li>• Communicable diseases, including tuberculosis, leprosy, malaria, HIV/AIDS, and neglected tropical diseases</li> <li>• Noncommunicable diseases: hypertension, diabetes, breast and cervical cancer, mental health</li> <li>• Sexual and gender-based violence</li> <li>• Other common conditions: eye, ear, skin, dental, emergency, geriatric care</li> <li>• Support services: laboratory, radiology/imaging, pharmacy</li> <li>• Integrated behavior change and communications</li> </ul>	
INDIA	State-level Ministry of Health	<ul style="list-style-type: none"> <li>• Prenatal services</li> <li>• Neonatal and infant services</li> <li>• Immunization</li> <li>• Family planning</li> <li>• Communicable diseases</li> <li>• Tuberculosis</li> <li>• Leprosy</li> <li>• HIV</li> <li>• Noncommunicable diseases (screening and treatment)</li> <li>• Provision of essential drugs</li> </ul>	<ul style="list-style-type: none"> <li>• Dental health</li> <li>• Ophthalmic services</li> <li>• Mobile medical unit for hard-to-reach areas</li> <li>• Skin disorders</li> <li>• Emergencies/injuries</li> <li>• Disaster management</li> <li>• Safe water and sanitation</li> <li>• Health education</li> </ul>

COUNTRY	PURCHASER	DEFINITION OF PHC PACKAGE AND SCOPE OF SERVICES
INDONESIA	Badan Penyelenggara Jaminan Sosial Kesehatan (social security agency)	<ul style="list-style-type: none"> <li>Promotive and preventive services: individual health counseling, basic immunization, family planning, health screening</li> <li>Medical examination, treatment, and medical consultation</li> <li>Nonspecialty medical treatment (surgical or nonsurgical)</li> <li>Medicine and medical consumables</li> <li>Blood transfusion</li> <li>First-level laboratory examinations</li> <li>First-level inpatient care</li> </ul> <p>The PHC service package is further defined by the Ministry of Health in terms of minimum service standards for health care in first-level health facilities, including 144 competencies (services) that those facilities must provide.</p>
KENYA	National Hospital Insurance Fund	<ul style="list-style-type: none"> <li>General consultation by a general physician, clinical officer, or nurse</li> <li>Diagnosis and treatment of common ailments</li> <li>Prescribed basic and routine laboratory tests, including prenatal profiling</li> <li>Basic X-ray investigation services</li> <li>Maternal care and reproductive health services</li> <li>Treatment of sexually transmitted infections</li> <li>Minor surgical services</li> <li>Daycare procedures</li> <li>Drugs and dispensing services</li> <li>Physiotherapy</li> <li>Kenya Expanded Programme on Immunization</li> <li>Health education, wellness, and counseling</li> <li>Routine screening for conditions such as cervical and prostate cancer</li> </ul>
MALAYSIA	Ministry of Health	<ul style="list-style-type: none"> <li>Family planning</li> <li>Outpatient services</li> <li>Environmental health</li> <li>School health</li> <li>Dental care</li> <li>Pharmacy services</li> <li>Laboratory services</li> <li>Children with special needs</li> <li>Adult health</li> <li>Elderly health</li> <li>Cardiovascular diseases</li> <li>Mental health</li> <li>Adolescent program</li> <li>Occupational health</li> <li>Sexually transmitted infections</li> <li>Tuberculosis/leprosy</li> <li>Emergency services</li> <li>Health informatics</li> <li>Rehabilitation services</li> <li>Dietary services</li> <li>HPV vaccination</li> <li>Needle exchange program</li> <li>Methadone maintenance therapy</li> <li>HIV</li> <li>Dialysis</li> </ul>
MONGOLIA	Ministry of Health	<ul style="list-style-type: none"> <li>Maternity, pregnancy monitoring, obstetrics, infant care</li> <li>Services for different age groups</li> <li>Communicable diseases</li> <li>Noncommunicable diseases</li> <li>Services for other conditions</li> <li>Ambulance care</li> <li>Public health programs</li> </ul>

COUNTRY	PURCHASER	DEFINITION OF PHC PACKAGE AND SCOPE OF SERVICES	
PHILIPPINES	Philippines Health Insurance Corporation (PhilHealth)	<p>Consultations:</p> <ul style="list-style-type: none"> <li>• Blood pressure and body measurements</li> <li>• Breast exam and breastfeeding education</li> <li>• Digital rectal exam</li> <li>• Counseling for smoking cessation and lifestyle modification</li> </ul> <p>Diagnostic examinations:</p> <ul style="list-style-type: none"> <li>• Complete blood count</li> <li>• Urinalysis</li> <li>• Fecalalysis</li> <li>• Chest X-ray</li> <li>• Sputum microscopy</li> <li>• Lipid profile</li> <li>• Fasting blood sugar</li> </ul>	<p>Medicines:</p> <ul style="list-style-type: none"> <li>• Inhaled corticosteroids</li> <li>• Short-acting beta 2 agonists</li> <li>• Oral or systemic corticosteroids</li> <li>• Oral rehydration salts</li> <li>• Amoxicillin</li> <li>• Macrolides</li> <li>• Beta lactams with beta lactamase inhibitors and/or second-generation cephalosporins</li> <li>• Oral fluoroquinolones and co-trimoxazole</li> </ul>

## HELPFUL RESOURCES

The **JLN Health Benefits Policies collaborative**, which explores ways to design and revise PHC benefits packages, offers resources produced in collaboration with JLN countries.

[www.jointlearningnetwork.org/technical-initiatives/benefits-design/resources](http://www.jointlearningnetwork.org/technical-initiatives/benefits-design/resources)



**What's In, What's Out: Designing Benefits for Universal Health Coverage** provides guidance on defining a health benefits package.

[www.cgdev.org/publication/whats-in-whats-out-designing-benefits-universal-health-coverage](http://www.cgdev.org/publication/whats-in-whats-out-designing-benefits-universal-health-coverage)



## Use a combination of costing and other information to match resources to the PHC package

Information on the cost of delivering health services is one important element of sound decision-making on establishing or expanding a PHC service package, strategically purchasing covered services, and implementing policies that will promote efficient service delivery and cost-effective services. But costing alone is not enough and must be combined with other information, such as the amount of available resources and policy priorities.

A costing exercise typically involves estimating the unit cost of each service in the package and projecting utilization to arrive at the total annual cost of making the services in the package accessible. The Philippines periodically validates the cost estimates for its PHC packages, and Chile frequently updates expenditure requirements for PHC packages using new costing studies. In 2017, Bangladesh finalized costing of its updated PHC package (called Essential Health Service Package).

In practice, countries often use approaches other than costing exercises to allocate resources to PHC, as shown in [Figure 3](#).

**FIGURE 3.**

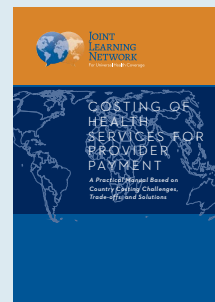
### APPROACHES TO ALLOCATING FUNDS FOR PHC

APPROACH	COUNTRIES	CHALLENGES
Costing exercise	Chile Peru	<ul style="list-style-type: none"> <li>• Requires a defined UHC service package and standards</li> <li>• Costs may exceed revenue</li> </ul>
Available revenue	Philippines Vietnam	<ul style="list-style-type: none"> <li>• Mismatch between revenue and need</li> </ul>
Negotiation with Ministry of Finance	Mongolia	<ul style="list-style-type: none"> <li>• Competing priorities</li> </ul>
Annual program budgeting at the county level	Kenya	<ul style="list-style-type: none"> <li>• Possible lower priority for PHC at the county level (leading to inequity and underfunding)</li> </ul>
Historical budgets	Malaysia	<ul style="list-style-type: none"> <li>• Historical budgets may not match current need (leading to inequity and underfunding)</li> </ul>

## HELPFUL RESOURCES

The JLN's **Costing of Health Services for Provider Payment** offers guidance on step-down cost accounting and overcoming challenges such as data constraints, resistance from public and private health providers, and weak cross-institutional collaboration.

[www.jointlearningnetwork.org/resources/costing-of-health-services-for-provider-payment-a-practical-manual](http://www.jointlearningnetwork.org/resources/costing-of-health-services-for-provider-payment-a-practical-manual)



## Consider that most countries are moving toward some variation of capitation payment for PHC

While there is no ideal payment method and each model has its strengths and weaknesses, many countries are moving toward some variation of capitation payment for PHC. Capitation is structured around financing all necessary health care for a defined population rather than tying payment to specific diagnostic and curative services when those services are delivered. Among all of the payment methods it is the most consistent with the philosophy of PHC. In general, countries are moving toward capitation because the alternatives—fee-for-service and line-item budgets—have demonstrated shortcomings in supporting a PHC-centered health system.

Other reasons cited by JLN countries for favoring capitation for PHC include:

- It ensures accountability for managing the health of the entire population.
- It provides some financial stability and flexibility for PHC providers.
- It can allow choice for the population.
- It can incorporate data and information about the health status of the enrolled population.

Capitation is based on covering all care within the service package for each enrollee. Capitation can improve equity and create incentives for providers to improve efficiency by reducing unnecessary services, shifting services toward PHC and prevention, and attracting additional enrollees. Some positive results of capitation have been observed in JLN countries and other countries, including lower hospitalization rates in Chile and increased preventive care in Peru. Other experience indicates that capitation has in some cases contributed to better cost management for public purchasers, some guaranteed income for providers, and flexible and responsive services for patients.

Some adjustments to capitation are typically needed, however, depending on factors such as health needs, geography, and poverty. Other measures may also be necessary to counterbalance potential negative consequences of capitation, such as underprovision of services or inappropriate referrals. Most JLN countries that use capitated payment for PHC implement additional measures such as monitoring, performance-based incentives, and supplementary fee-for-service payments to boost utilization of priority services. The resulting payment model, including country-specific complementary measures, works best when services are delivered within networks by family health teams, and when information systems at every level are integrated.

Capitated payment models are designed to align with the country's definition of PHC. Most JLN countries start with a simple capitation model that is transparent, with simple payment calculations, and easy to administer, particularly in places where data automation is limited. Most of them eventually adjust capitated payments based on demographic variables such as age and sex, and some adjust for geographic differences, poverty, and other factors. An important consideration is whether to include PHC medicines in the capitation payment system. The most effective way to pay for medicines depends on the context; the learning collaborative will take up this challenging issue in the next phase.

Some countries combine payment methods to create a *blended payment system*, or *mixed model*, to maximize the beneficial incentives and minimize the unintended consequences of each payment method. For example, a capitated payment system for PHC can incorporate a small amount of fee-for-service payment for priority preventive services, such as prenatal care and immunization, to counteract the potential perverse incentive in capitation to underprovide services. (See [Box 3](#).) Any payment method can also be combined with specific performance-based rewards or penalties (known as *results-based financing* or *pay-for-performance*).



### BOX 3.

## ESTONIA: A BLENDED PHC PAYMENT MODEL WITH PERFORMANCE INCENTIVES

In Estonia, the Estonian Health Insurance Fund (EHIF), which is responsible for financing health care, has used a blended payment model for PHC for many years. The EHIF has carefully crafted a blend of payment methods to provide incentives for family doctors to take more responsibility for diagnostic services and treatment, as well as to compensate them for the financial risks associated with caring for older patients and working in remote areas. Family physicians under contract with the EHIF are paid through a combination of a fixed monthly allowance (for a second nurse and to cover infrastructure and utilities costs), an age-adjusted capitated payment per enrollee per month, some fee-for-service payments, additional payments based on the distance to the nearest hospital, and performance-related payment through the Quality Bonus System (QBS).

The proportion of family physicians participating in the QBS and earning a quality bonus has increased steadily since the QBS was introduced in 2006. Participation became mandatory for all family physicians in 2016. The QBS uses a points-based system in which the practitioner earns a fixed number of points for meeting the expected threshold of each indicator (or earns 0 points for not meeting that threshold). The thresholds are revised annually based on previous-year coverage to ensure a stepwise increase. It takes about one year to develop a new indicator.

The bonus system includes three performance domains:

### DOMAIN 1: PREVENTION – 160 POINTS

- ▶ Vaccination of 90% of children ages 0 to 2
- ▶ Child development follow-up for children ages 0 to 2
- ▶ Examination for preschool-age children

### DOMAIN 2: MANAGEMENT OF CHRONIC DISEASES – 480 POINTS

- ▶ Type 2 diabetes
- ▶ Hypertension (including international nonproprietary name prescribing indicator)
- ▶ Hypothyreosis
- ▶ Myocardial infarction

### DOMAIN 3: BROADER ACTIVITIES – MINIMUM VOLUME OF PROCEDURES OR ACTIVITIES UNDERTAKEN FOR QUALITY IMPROVEMENT

- ▶ Pregnancy follow-up
- ▶ Gynecological examination
- ▶ Minor surgery
- ▶ Recertification of a family doctor and nurse
- ▶ Participation in the Estonian Family Physician Association's quality management audit

When the design and implementation arrangements are appropriate, even simple capitation models can improve equity, efficiency, and provider responsiveness. In Mongolia, the urban PHC sector was restructured in 2000 into family group practices, now called family health centers. PHC is financed through a needs-based per capita allocation from the Ministry of Finance to the local level, which in turn makes capitated payments to family health centers. Equity in resource allocation and the ability of providers to respond to the health needs of their populations are considered to be much better than under the line-item budget and fee-for-service payment systems, which are used to pay for most services outside of PHC in Mongolia.



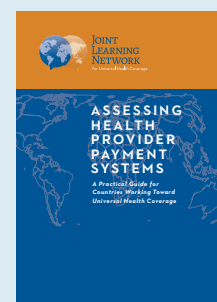
*JLN country members view Chile's integrated information system for PHC, which allows patients and providers to have paperless interactions.*

Capitation can lead to unintended consequences, however. Paying providers in advance can lead to underprovision of necessary services or overreferral. Also, if providers lack the capacity to deliver the package of services, referrals will be higher and excess financial risk may be shifted to the purchaser or to patients who bypass their PHC provider. There is also the practical challenge of defining PHC providers, linking them to individual enrollees for a fixed period of time, and making and accounting for prepayments.

## HELPFUL RESOURCES

The JLN's **Assessing Health Provider Payment Systems** is a step-by-step guide that helps countries assess their current payment systems and identify refinements or reforms to ensure that those systems help advance health system goals.

[www.jointlearningnetwork.org/resources/assessing-health-provider-payment-systems-a-practical-guide-for-countries-w](http://www.jointlearningnetwork.org/resources/assessing-health-provider-payment-systems-a-practical-guide-for-countries-w)



The **JLN/GIZ Case Studies on Payment Innovation for Primary Health Care** offer lessons based on the experiences of Argentina, Chile, and Indonesia in implementing innovative payment models for PHC. Each case study describes the context, objectives, design, and governance structure of the respective country's PHC payment innovation and how well the payment innovation has met its objectives.

[www.jointlearningnetwork.org/resources/jln-giz-case-studies-on-payment-innovation-for-primary-health-care](http://www.jointlearningnetwork.org/resources/jln-giz-case-studies-on-payment-innovation-for-primary-health-care)



## Use simple, flexible monitoring systems that make use of existing data

Monitoring systems provide essential and timely information on whether PHC financing and payment models are meeting their objectives. This information can help identify the need for more analysis about specific providers or services, and it can reveal where modifications are needed to the payment system design or implementation. It can also support dialogue among purchasers, providers, and other stakeholders about improving service delivery and can be useful for making the case for additional resources.

JLN countries find that provider payment monitoring systems work best when they are simple and flexible. It is best to select a few simple indicators at the outset and ensure that only useful data and the right amount of data are collected. The institutional roles and responsibilities across the monitoring system should also be clear. Monitoring should be presented not as a mechanism of control but as a way to help improve health system performance and health outcomes. Data should also be fed back to providers to help them improve their management and ensure overall quality of services.

Primary health care data are often collected through different data systems (such as a district-level health management information system and a separate health insurance claims system) and can therefore be fragmented and difficult to analyze and use. To avoid data fragmentation, some countries, such as the Philippines, establish joint committees that are responsible for data oversight and governance. Information technology plays a critical role in data collection and analysis, but country experience shows that effective monitoring systems need human involvement and humanizing of the analysis and results. Indicators can only show what is happening, not why or how. Dialogue among the purchaser, providers, and other stakeholders is needed to interpret the findings from monitoring systems and decide on the actions needed for continued improvement.

### HELPFUL RESOURCES

The JLN's ***Using Data Analytics to Monitor Health Provider Payment Systems*** offers guidance and tools to help countries monitor the results of health provider payment systems.

[www.jointlearningnetwork.org/resources/data-analytics-for-monitoring-provider-payment-toolkit](http://www.jointlearningnetwork.org/resources/data-analytics-for-monitoring-provider-payment-toolkit)

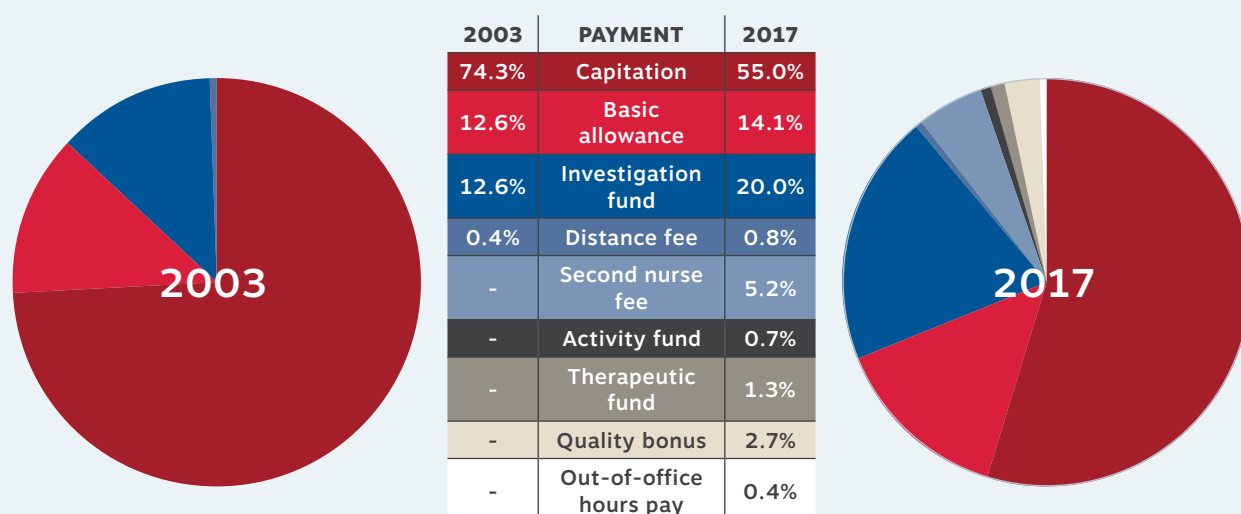


## Support continuous improvement of PHC financing and payment systems

Improving financing and payment for PHC is an ongoing process—one that JLN resource countries such as Chile and Estonia have been engaged in for more than 20 years. (See [Figure 4](#).) Getting the right mix of financing and payment instruments for the country's context and objectives requires a mix of approaches, which will evolve as the context and objectives change. Countries have found it helpful to establish stakeholder platforms for discussing and analyzing the results of PHC financing and payment models in an ongoing way, supported by evidence from routine monitoring systems and periodic evaluations.

**FIGURE 4.**

### **EVOLUTION OF ESTONIA'S PHC CAPITATION PAYMENT SYSTEM (2003–2017)**



## Concluding Thoughts

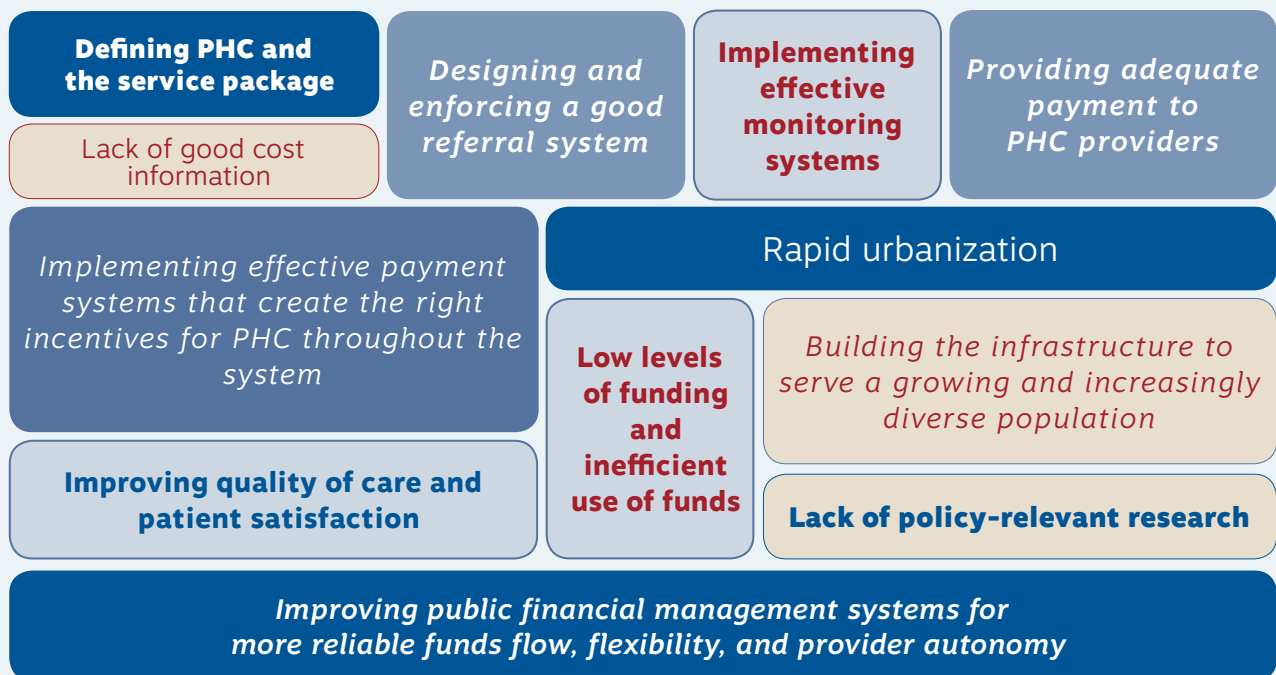
Most JLN countries are engaged in implementing provider payment systems that can strengthen PHC and ensure its central role in the health system. The JLN collaborative learning exchange is helping to capture practical experience and lessons in real time as the countries take on the day-to-day challenges of implementation. Many challenges remain (as shown in **Figure 5**), and JLN countries will continue to jointly seek and share solutions.

Key topics for the learning exchange participants going forward include:

- Ensuring that payment models serve the chosen service delivery model
- Defragmenting and harmonizing payment systems
- Addressing payment for medicines for PHC
- Building implementation capacity and arrangements that make provider payment systems work better
- Engaging stakeholders and managing their expectations and interests
- Implementing processes for building new PHC provider payment systems and continually refining them

**FIGURE 5.**

### **REMAINING IMPLEMENTATION CHALLENGES IDENTIFIED BY JLN COUNTRIES**



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