

# Leveraging Provider Payment to Achieve Health System Goals

The Joint Learning Network for Universal Health Coverage has a membership of 33 countries – and growing – committed to achieving universal health coverage (UHC). Provider payment is an important lever for UHC that can improve efficiency in resource use thereby facilitating access to good quality health services and financial protection.

The Primary Healthcare (PHC) Financing and Payment collaborative consists of 20 JLN associate and full member countries, who have a common interest in sharing implementation experience on financing and provider payment for PHC. The definition of PHC and primary care may differ from country-to-country, but key concepts for these services include: first contact of care for new health problems, comprehensive care for most health problems, continuity of care, long-term person-focused care and care coordination. There is growing consensus that PHC is the cornerstone of a sustainable health system for countries working towards achieving UHC as PHC provides cost-effective interventions with the biggest health impact.

On February 18-20, 2020, the PHC Financing and Payment collaborative convened 60 participants from 14 countries in Addis Ababa, Ethiopia to discuss and share how countries are leveraging provider payment to achieve their health system goals. The participants, representing Ministries of Health, National Health Insurance Agencies and Provider Associations, provided a rich blend of perspectives and experiences on provider payment from these countries. This brief summarizes the discussions from the three-day meeting and the key insights from country implementation experiences.



## Key Messages:

### **There is no one approach that works everywhere all the time, and no endpoint.**

It was noted that all countries are implementing, or planning to implement, **new payment models**, and while line-item budgets persist, there is an increasing trend to introduce output-oriented provider payment systems. Countries are at different stages of maturity and while some countries have established systems to assess provider payment mechanisms (PPM) and introduce new changes, most countries are still working to **improve the fundamentals** such as designing service packages; costing; provider payment design and implementation; and monitoring. These foundations are critical to get the right systems in place and establish sustainable institutionalized processes for improving them and continue building on progress to achieve health system priorities.

There have been many positive steps in shifting priority to PHC that have led to improvements in service coverage and utilization. For instance, Nigeria increased funding for health through a basket fund – the Basic Healthcare Provision Fund (BHCPF). This fund receives 1% of Nigeria’s consolidated revenue and will pool this allocation with funds from development agencies and private sector. The fund will finance a benefit package that prioritizes maternal and child health services at PHC level.

In Kenya, a recent review of the benefit package was an opportunity to reprioritize PHC as an integral component of the benefit package. While in Malaysia rising cases of obesity due to unhealthy habits and lifestyles has resulted in rising incidence of non-communicable diseases (NCDs). In response, Malaysia designed and launched PeKa B40 that

provides preventive screening services for diabetes, hypertension and cancer for the bottom 40% of the population and provides pathways for management of these NCDs.

Each country will develop its own pathway as country change processes are usually dynamic – stakeholders change, and politics of the day may change – creating new challenges and in some cases windows of opportunity for change. Furthermore, as progress is made, future challenges become more complex, requiring an adaptive, iterative approach to PPM improvements. Solutions are contextual and, in some instances, barriers in one country were an opportunity in another, while solutions that worked in one country were unsuccessful in another. The opportunity for joint learning allows participants to better understand the “when,” “where,” “why,” and “how,” of what works so that countries are better informed when selecting options for implementation.

#### **Mongolia: Mature systems for provider payment improvement**

Mongolia has been at the forefront of adapting JLN knowledge products and over the years has developed a systematic process of introducing improvements to their provider payment systems. In 2014, Mongolia used JLN’s PPM assessment guide to identify gaps in their PPM systems and develop a PPM reform plan. As part of their reform plan, they used the JLN costing manual to redesign capitation for public PHC providers. Two years later, Mongolia used the JLN data analytics toolkit to develop 26 indicators for their new P4P system.

In 2019, Mongolia introduced a blended PPM that uses capitation for PHC services; case-based payment for diagnostics, homecare, rehabilitation services; and P4P bonuses for achievement of targets.

**There are many ongoing country innovations to learn from.**

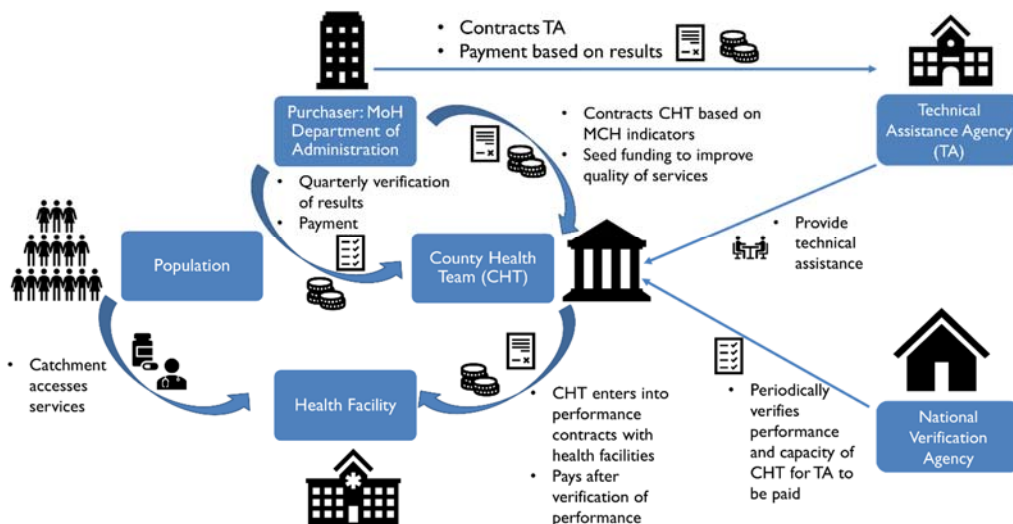
At the meeting, countries shared interesting innovations to improve PHC Financing and Payment.:

**Countries are implementing new coverage schemes**, presenting an opportunity to test out new purchasing arrangements and payment systems for PHC. Egypt is working on the implementation arrangements for the Universal Health Insurance Authority – a new purchasing agency that will use blended PPMs – capitation, fee for service and P4P – to purchase personal health services including PHC, from public and private providers. Bangladesh is piloting *Shasthyo Suroksha Karmosuchi* (SSK) to achieve UHC. SSK provides a defined package of services to the population below the poverty line and intends to scale the pilot to more districts. While Ethiopia began implementing Community Based Health Insurance as a pilot, it has since been scaled up countrywide and now plans are underway for the Social Health Insurance scheme.

These emerging schemes and pilots are an opportunity to build and test purchasing approaches, but it is imperative to get on the right path early. A lesson from countries that have mature coverage schemes is that payment systems put in place during a pilot phase may work well in small settings but may present challenges during the scale up phase. Therefore, it is important to put in place sustainable operational processes and PPMs as early as possible as making critical design changes later becomes very difficult and/or near impossible.

**Countries are becoming more sophisticated in their use of pay-for-performance (P4P).** In some countries, P4P is used as blunt instruments to incentivize provider behavior very mechanically, while in others, P4P has been used in a more sophisticated way, by integrating P4P into payment systems to incentivize provider performance and improve quality of health services. For example, Mongolia designed their PPM monitoring systems to facilitate evidence-based decisions and integrated this with P4P to incentivize provider performance and quality of care. Liberia has a performance-based financing (PBF) system linked to the national health management information system and that pays PHC facilities and organizations providing technical assistance to county health teams, based on achievement of targets outlined in performance contracts. Liberia is reviewing how they can integrate successes from the PBF program into the new strategic purchasing strategy and design of the Liberia Health Equity Fund.

**Liberia: PBF program for health facilities and technical assistance organizations**



In addition, Moldova has an annual, iterative process for setting measurement targets that capture progress on major public health issues, including preventive services, early diagnostic services and the monitoring of service quality – especially for NCDs. A key lesson from Moldova was the need to balance the number of indicators with the administrative burden of collecting information for these indicators. While many indicators give a broader picture of providers' performance, the downside is the administrative burden and resource consumption by both providers collecting this data and the purchasers analyzing this data. Meanwhile, fewer indicators allow for simple implementation and monitoring, but there is a danger of oversimplifying the system. With time, Moldova has been able to identify six indicators that provide a good overview of the health system which has also improved compliance and accuracy of reported data.

**Countries are introducing new PHC service delivery models** to form networks of providers that serve beneficiaries more holistically. In addition, countries are increasing private sector engagement in service delivery and increasingly formalizing the role of community providers. Myanmar designed a strategic purchasing pilot to contract private for-profit general practitioner clinics and Ethnic Health Organizations (EHO) to promote access to PHC services for underserved poor and vulnerable households and incentivize private providers to serve this population. Lessons from this pilot are being used to design a strategic purchaser that will contract public and private facilities to provide a defined benefit package.

Defining these new service delivery models requires elaborate strategies for stakeholder engagement to obtain buy-in from providers, communities, local administration and politicians. For example, in Lao PDR, a review of their PHC infrastructure showed a large network of PHC infrastructure but many times these PHC facilities were inadequately staffed and did not have the necessary equipment to deliver the defined benefit package as defined in the country's norms for health services. The Ministry of Health used this evidence to restructure the PHC service delivery system, which required closures of some facilities to consolidate human resources and equipment needed within fewer facilities. This was initially met with resistance from communities and local authorities and necessitated a stakeholder engagement strategy to address concerns and obtain their buy-in to successfully implement this reform.

#### **Ghana: Testing the preferred primary provider (PPP) network**

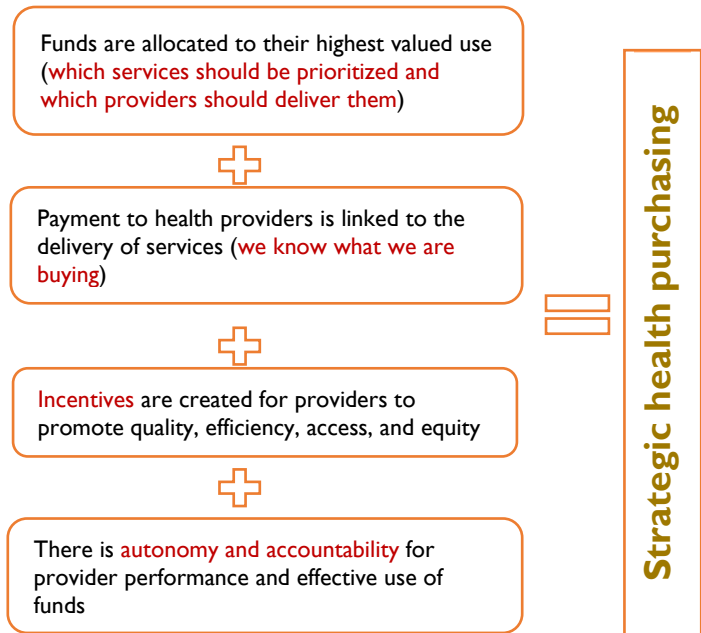
The PPP Network pilot was initiated based on findings from a 2014 provider mapping survey which showed high variability, and often inadequate human resource and equipment, to provide the benefit package. The survey recommended to test networking of providers into group practices to address capacity gaps. A pilot was subsequently designed and 10 networks comprising 42 facilities were launched, informed by draft guidelines for group practice prepared by a steering committee, and designed to align with the existing sub-district health structure. The main aim of the pilot was to test network models and referral arrangements that enable community health services to thrive, and to make policy recommendations for scale-up.

Implementation of the PPP network was complemented by targeted capacity support, including training, facility upgrades, quarterly supervision visits and on-site coaching visits for priority service delivery areas. Ghana is in the process of evaluating findings of this pilot that will inform future plans for scale up of the PPP network and the design of the PPM to purchase services from these networks.

**Being a strategic purchaser starts with analysis...and analysis starts with using what you have.**

Strategic purchasing relies on good data to make the right decisions on what to buy, identify the best providers to buy from and design ideal provider payment systems and incentives that promote equity in access, quality and efficiency in service delivery. Provider payment monitoring, and systems to support evidence-based decision making, continues to be a challenge for many countries in the collaborative.

In Moldova, the information system is the backbone of the provider payment monitoring and P4P system. A nationwide information system was established with fully digitalized patient records, medical registers and electronic prescriptions, so that the data needed is always available and easily managed. The information system allows the payer to track P4P indicators on a daily basis. The information system is sophisticated, but it is not yet integrated with providers and relies on paper-based reporting of P4P indicators from providers. This has necessitated an audit process to mitigate opportunities for errors and fraud related to paper-based reporting,



However, countries should start from the basics and build on the systems already in place. Ethiopia is making the most of their paper-based system to provide monthly aggregated statistics per *woreda* (district) for their CBHI. Data is collected at facility level and submitted to the *woreda* CBHI scheme office where it is analyzed to provide an overview of the scheme performance. Illustrative indicators tracked include number of enrollees, contributions collected, claims paid per provider, and top ten causes of illness. By creating a solid foundation and a culture of data use, they are better placed to digitize and establish an electronic system in the future.

**Future Directions: Thinking in systems instead of schemes**

Countries participating in the PHC Financing and Payment collaborative are on a spectrum between establishing new purchasing agencies and introducing new PPMs on one end, to more established purchasing agencies with capacities to monitor and adapt new provider payment systems on the other end. However, what is common amongst all of them is that they are effecting change often in difficult contextual environments. Across the collaborative, a majority of the countries grapple with how they can be more strategic purchasers while line-item budgets continue to dominate, how provider payment models can be effectively managed when information systems are not perfect, how systems can move away from fee-for-service once it is entrenched, and how administrative burdens can be reduced and/or streamlined. As countries work to overcome these challenges, each participant has something important to share and something important to learn. It is in in these imperfect situations – when conditions are not ideal – that real learning happens.

Participants agreed that provider payment improvement should be part of a systemic approach. This means looking beyond individual schemes to assess strategic purchasing approaches holistically to be able to identify a coherent approach that provides the right incentives across the health system. For those establishing new purchasing arrangements, it is important to take early steps to get on the right path to create an enabling environment for strategic purchasing of PHC. Further, there was consensus on the guideposts alongside to keep in mind as participants continue to implement changes in their provider payment systems.

As the collaborative kicks off for the next year, participants will be digging deeper on the next generation of system-wide issues such as leveraging provider payment for financial sustainability, designing provider payment for integrated service delivery models and refining the role, design and indicators for provider payment monitoring and pay-for-performance to incentivize provider performance and quality of health services.

Some guideposts to keep in mind:

- ✓ Matching provider payment systems with objectives
- ✓ Being ready for **political windows** to open
- ✓ Define benefits package with **gatekeeping and referral guidelines, reinforced by incentives**
- ✓ Establish **clear roles, responsibilities, and relationships** between purchasers, providers and population specified in contracts
- ✓ **Integrated approach to purchasing** health services from the public and private sector
- ✓ Ensure **provider autonomy and capacity to use funds flexibly** and respond to incentives
- ✓ **Negotiate payment rates early** (especially with private providers)
- ✓ Aim for a **low administrative burden**
- ✓ **A strong, integrated information system** that is used effectively for monitoring and quality assurance

