IMPROVEMENT STRATEGIES MODEL: HEALTH FINANCING

[This module is under final review by the PHCPI Partnership and may be subject to change.]
CORE PRINCIPLES OF HEALTH FINANCING

Health financing refers to how resources are raised, pooled and allocated or spent to ensure that each person has access to health services of good quality without financial hardship [1]. Health financing impacts the entire health system’s performance, including the accessibility, quality, and efficiency of primary health care.

This improvement strategy focuses on key health financing questions that matter for PHC. First, we explore how policymakers can track how much is currently being spent on PHC. Next, we consider approaches to mobilizing resources for health and ensuring that enough is allocated to PHC. We discuss how policymakers can ensure that people do not face financial barriers or burdensome costs when obtaining PHC. Finally, we look at how purchasing arrangements can be used to promote more efficient, high-quality PHC.

Financing for PHC should always be considered as part of a country’s holistic health financing strategy. Just as PHC policies, plans, and service delivery should be addressed in the context of the wider health system, financing for PHC is linked to and influenced by the health financing system as a whole.

HOW MUCH ARE WE SPENDING ON PHC? HOW MUCH SHOULD WE SPEND?

Tracking how much is being spent on primary health care

Global health spending has grown dramatically since 1978, when the Declaration of Alma-Ata emphasized the importance of primary health care (PHC). Unfortunately, it is unknown exactly how much of that spending has gone to PHC, partly because a standard methodology for tracking PHC spending was only recently established [2]. Defining spending on PHC has been difficult due to its multisectoral, multi-dimensional aspects, as well as data limitations and differences in service delivery modalities across contexts [3]. WHO staff recently developed guidelines for defining and tracking PHC spending [2], based on the standard System of Health Accounts 2011 functional classifications. PHC spending includes expenditures on “first-contact” curative and preventive primary care – sometimes provided at different levels of the health system, and by a variety of different health workers depending on country context - as well as community outreach and public health strategies that prevent illness and promote well-being [2,4].

Tracking expenditure on PHC in a standard manner is a critical first step to understanding variations in PHC performance and health outcomes and determining where efforts can be made to improve performance [2]. Tracking levels and trends in PHC spending is essential for advocating for increased investments in PHC. Tracking PHC spending can also help health system managers identify regions, populations, or health conditions that are underfunded.

How much should we allocate for PHC?

There is no global standard for the “right” percentage of total health spending to allocate to primary health care. For the 50 countries in the WHO’s Global Health Expenditure Database for which values have been estimated, the proportion of current health spending allocated to PHC ranged from 37% to 89% in 2016 [5]. Various organizations [6,7] have estimated [8] the cost of a “basic” or “essential” package of services [9], although these often do not include the value of investing a more comprehensive set of cross-cutting interventions that impact health such as health literacy, sanitation, and nutrition. WHO published estimates for a set of low and middle-income countries (see [10]) of the additional resources...
required to strengthen health systems to provide equitable access to a comprehensive package of health services targeting the health SDGs. In an ambitious scenario, total health-care spending would increase to a population-weighted mean of US $271 per person (range $74-$984) across country contexts (2014 dollars). Stenberg et al. [10] further expanded the model in 2019 to project the resources needed to strengthen PHC over the next ten years. Estimated investment needs to facilitate delivery of a core set of preventive and outpatient PHC services range from $65 per capita in low-income countries to $334 (2014 dollars) per capita in upper-middle-income countries (recurrent costs only).

But in many low-income countries, these estimates are much higher than total health spending levels—on all levels of care combined [11]—which averaged just US$36 per capita in 2016 (based on analysis of WHO GHED data [5]). Raising enough money for health overall, and spending enough on PHC specifically, remain challenging in many contexts.

Investing in public health

In addition to funding clinical services, spending on PHC also includes public health initiatives and other sector programs that address the underlying social determinants of health. This includes expenditure on health education (including health literacy in schools); environmental health (clean air, water, and sanitation); safe transportation systems and road safety; workplace safety; affordable housing and housing standards; food safety; children’s nutrition; and quality assurance of pharmaceuticals and medical technologies, among other programs.

Public health funding and health-promotive spending in other sectors can easily remain invisible to political constituencies and decision makers, especially in contrast to “visible” spending on disease priorities. Civil society organizations play a critical role here in advocating for spending on these less-visible but essential efforts. Learn more about the role of civil society organizations in the Social Accountability Improvement Strategies module.

HOW CAN WE RAISE AND ALLOCATE ENOUGH RESOURCES FOR PHC?

Raising revenues for health

To allocate enough funding to PHC, countries first have to raise enough revenues for health overall. But in many low- and middle-income countries, raising enough money for health remains challenging. Generating more health funding from domestic sources is increasingly important given uncertainty about continued funding from international donors.

Resource mobilization strategies vary across countries; most countries usually consider a mix of domestic funding sources for the health system [12]. Domestic resources for health can come from compulsory payments (such as consumption or income taxes, or public insurance contributions like payroll taxes) or private voluntary payments (by employers and businesses, private foundations, voluntary health insurance payments, or household out-of-pocket spending). Relying on a mix of funding sources can help countries weather economic and political cycles. However, governments should aim to move towards greater reliance on public (compulsory) sources of funding for health, as evidence shows this increases access to health services and improves financial protection for the population [13].

Making health spending more efficient is another way of expanding “fiscal space” for health -- the budgetary room that allows a government to spend on public purposes without undermining fiscal sustainability [14]. By increasing efficiency, limited resources can go farther, opening up funding for health sector priorities such as PHC. Providing evidence of more efficient spending on health services can also help health sector leaders make the case with legislators for greater investment in the health system.
[13]. The section below on strategic health purchasing provides more information on increasing efficiency.

**Making the case for PHC funding: Efficiency, cost-effectiveness, and impact**

To make the case for budget allocations to PHC, health sector leaders can demonstrate the efficiency, cost-effectiveness, and impact of PHC. There is evidence that increased investment in primary care can reduce use of secondary care and reduce overall health costs [15, 16]. Effective primary care can reduce the total number of hospitalizations, including avoidable admissions and emergency admissions [17]. Moreover, evidence shows that higher spending on public health areas is associated with lower population-level mortality and morbidity rates [18]. Likewise, a review of the evidence also confirms that outpatient and community-based delivery of primary care is more cost-effective compared to inpatient or emergency department delivery of primary care services [19].

Conversely, an emphasis on hospital-based service delivery can lead to escalating health care expenditures without leading to better population health outcomes. Historically, many countries have allocated the bulk of funding to secondary and tertiary hospitals in urban areas, while underinvesting in primary care [20]. This can occur when national health strategies emphasize delivery of disease control programs through hospitals [21] or emphasize curative hospital care at the expense of less-visible, less politically popular public health endeavors. It can also occur when provider payment methods incentivize facilities to deliver more expensive, complex care than may be needed.

**Defining guaranteed PHC benefits**

Guaranteeing access to a defined PHC benefit package can help ensure that spending on PHC is prioritized. Since “[n]o country, no matter how rich, is able to provide its entire population with every technology or intervention that may improve health or prolong life” [1], countries cannot guarantee coverage for all diseases and treatments. But because primary health care is highly cost-effective and prevents many minor conditions from becoming more serious and expensive conditions, it is important to promote access to PHC services by ensuring that families have coverage for PHC-related costs [22].

A systematic priority-setting process driven by data on health needs and population preferences, with explicit decision-making criteria that include cost-effectiveness and disease burden as well as equity, is most likely to maximize health benefits given finite resources (see the Priority Setting module). And because PHC services are highly cost-effective, such systematic processes are likely to prioritize coverage of PHC benefits. Switching from current practice to covering more cost-effective services can lead to substantial health gains without an increase in spending [23,24].

Health financing and benefits policies should make explicit which PHC services will be covered by government funds, who is entitled to that coverage, and where and how services will be provided [23]. Useful policy instruments for defining which benefits will be funded by the government [25] include creating essential medicines lists [26]; defining health benefit plans [27]; and establishing a health technology assessment process. Ideally, health system managers should set priorities for financing PHC services as part of a broader system-wide priority-setting process. A transparent, inclusive process for defining this list of priority services is important for political buy-in and sustainability over time [24,27].

**Exploring the pros and cons of “earmarking” funds for PHC**

*Earmarking* is when a specific revenue source or a protected expenditure stream is dedicated to health [28]. For instance, revenues from a tax on tobacco might be allocated to a national health insurance scheme. Earmarked revenues may bring additional resources for priority programs and can protect those priorities from changing political preferences. However, some caution should be used when deciding to earmark funds for health or PHC. Earmarking can create rigidities in the budget that can be inflexible to shifting government priorities. Earmarked funds can be susceptible to “capture” by special interests, and
can be economically distortive since earmarks are typically funded through a consumption or payroll tax [28]. Also, over time any increased revenues from the earmarked source may be offset by other budget reductions, resulting in little if any increase in total public funding available [13]. Decisions about earmarking funds for PHC should be considered relative to each country’s political context.

**HOW CAN WE ENSURE THAT PEOPLE CAN AFFORD PHC AND ARE PROTECTED FROM FINANCIAL HARDSHIP?**

**Minimizing out-of-pocket payments as a source of financing for health and PHC**

To ensure that people can afford PHC, policymakers should avoid relying on out-of-pocket payments. Out-of-pocket payments reduce people’s use of needed services, especially among the poor. When PHC is financed this way, a household’s ability to pay determines whether or not they use health services, and payment is often incurred exactly when the household is most vulnerable - at the time of sickness. Health systems funded on the basis of a large share of out-of-pocket payments tend to be regressive in who makes financial contributions, requiring a larger percentage of income from low-income earners than from high-income earners, as well as inequitable in who uses care and who experiences better health outcomes [29]. There is a large body of evidence concluding that user fees can negatively impact demand for health care [30,31,32], contribute to household impoverishment, and promote general inequities in health access [33,34].

While an individual primary care consultation may not be high-cost in absolute terms, out-of-pocket expenditure for primary care services can be prohibitively expensive for many people when the need for care becomes chronic or when medicines are needed (for instance, treatment for TB or routine care for chronic diseases). Spending on basic services can also sometimes be catastrophic (exceeding a substantial share of a household’s income or consumption, like 10% or 25%) or impoverishing (pushing a family below the poverty line or further into poverty) [35,36,37].

As a general guideline, PHC services should be funded by public funds with minimal cost-sharing for beneficiaries. To ensure that a person’s ability to pay does not determine their access to health care, health policymakers can reduce cost-sharing to finance health care (or rely on small fixed cost-sharing payment amounts rather than proportional cost-sharing); services can be offered free of charge to defined population groups with certain easily observable socio-demographic criteria (such as age or poverty status); or high-priority health services such as those at the primary care level can be provided free of charge [38]. See further discussion of targeting in the section below.

**Moving towards compulsory prepayment and pooling for health care (including PHC), based on ability to pay**

**Prepayment** means people are asked to make their financial contributions to the health system before they need health care, not when they fall ill [1]. To protect people from financial hardship associated with health care costs, health care contributions should be collected in advance in a predictable manner, unrelated to when health care is needed. Prepayment should rely on compulsory payments, such as taxes or national health insurance contributions.

Health systems should also strive to ensure that contributions to financing for health are based on households’ ability to pay. This aligns with the UHC objective of fairness in financing. A progressive system implies that those with higher incomes should contribute more, and the poor should contribute very little if anything. Raising revenues through progressive taxation (families with higher incomes or wealth proportionately are taxed more) or health insurance contributions based on a percentage share of income can help achieve this goal [39].
Finally, countries should move towards compulsory (rather than voluntary) prepayments for health care, and these funds should be pooled to purchase health care. Moving toward compulsory payments enhances redistributive capacity and also allows for cross-subsidization across the population. Evidence indicates that no country has achieved UHC based on a system organized around voluntary contributions [40]. Voluntary health insurance can provide some financial protection for those (often few) who are covered, but insurers have an incentive to exclude sicker, higher-risk individuals from coverage, and/or charge them higher premiums. As a result, those most in need of health services and financial protection may be unable to afford voluntary health insurance premiums and remain without adequate health coverage [29]. Moreover, voluntary health insurance creates many risks and potential spill-over effects for the rest of the health system, such as shortages of skilled health workers in government facilities and rising prices and costs across the health system. Therefore, “VHI needs to be managed and regulated in such a way that it contributes to equitable progress towards UHC, or at least does not harm such progress” [41].

There are various ways to pool funds and to address fragmentation (see for instance [40, 42]. Pooling serves to spread the financial risk associated with the need to use and pay for health services, so that this risk is not fully borne by the individual who falls ill. The desirable attributes of a pool are (1) large size in terms of the number of people covered by the pool, and (2) diversity of health risks within the pool. At best, the country’s pooling arrangement avoids fragmentation, which may be characterized by multiple segmented pools, health insurance coverage for the formal sector employees only, or multiple territorially overlapping pools [42].

**Using targeting to ensure access and financial protection for disadvantaged populations**

Various geographic, sociocultural, and economic factors limit access to PHC among poor and vulnerable groups, even if they are eligible “on paper” to have coverage. Targeting (actively identifying) those vulnerable groups and funding their coverage can expand access for those groups.

Targeting approaches can include means testing (identifying eligible households by measuring their income, housing characteristics, or assets), geographic targeting (identifying eligible households based on location, such as a malaria-endemic region or highly mountainous area with difficult access to health services), and characteristic targeting (identifying eligibility based on characteristics such as ethnicity, age, gender, education, pregnancy or disease) [43]. Targeting can be used to exempt vulnerable groups from user fees at the point of care; this is more feasible if the eligibility criteria are based on easily observable characteristics, such as age, sex, or pregnancy status. Alternatively, the identification process could be handled outside the health facility and individuals could be provided with an exemption card.

Another approach is to enroll eligible groups in a health coverage scheme and have their “contributions” paid on their behalf by the government [44]. Ideally, eligible individuals should be pre-identified through other existing mechanisms [40] to minimize administrative costs. Various countries use a combination of characteristic targeting and means testing under this option.

Significant investments in infrastructure may also be needed to expand coverage to underserved groups. To ensure that targeted free care policies are successful, facilities will likely need increased funding to compensate for the loss of user fees and increased demand for care. New incentives for providing the “free” services and efforts to strengthen providers’ capacity to deliver those services are important [38]. In addition, the targeting process has administrative costs; targeting mechanisms require adequate administrative capacity to be effective and to minimize errors of inclusion or exclusion.
Purchasing refers to the transfer of pooled funds on behalf of the covered population to health service providers to deliver health services. Strategic purchasing means linking the allocation of funds to providers with information on their performance and on the health needs of the population that they serve [1]. How countries purchase health care is a critical policy lever that can have a large impact on health system performance, including access to and quality of PHC services. A well aligned mix of provider payment methods can encourage providers to promote access to necessary health services for patients, incentivize quality of care, and improve equity, while promoting the efficient use of resources, and when appropriate, cost-containment [45,46].

Carefully consider and align incentives of different provider payment methods for PHC

Given the diverse set of services required for strong PHC, there is no single best provider payment method that will work for all services in all settings. All payment methods have trade-offs, but a carefully designed blend of provider payment methods can incentivize health workers to deliver the right care in the right setting at the right time. Understanding and managing the incentives associated with different provider payment methods is important [47]. Patient cost-sharing arrangements are also important influences on patient care-seeking behavior and also need to be aligned with payment methods and adequately designed [47]. Patients might be unaware of the full cost of the services they are using (and thus possibly use more than they really need), while providers may dispense unnecessary care. Alternatively, providers may not provide enough high-quality care if they are trying to limit their financial outlays. Purchasing agencies can influence provider behavior and patients’ care seeking behavior through payment methods and cost-sharing, helping to achieve a more optimal allocation of resources while ensuring that good quality care is being provided [45]. But in a nutshell, mitigating some of the harmful effects of user fees or cost-sharing requires “that they be kept simple [a fixed amount rather than a percentage] and clear and low- with protection for the most vulnerable” [48].

Before deciding on the mix of provider payment methods for PHC, policymakers should review and prioritize among the overall objectives for the system, whether they be increased health spending efficiency, cost-containment, improved access, improved quality, administrative simplicity, or a combination of multiple objectives. Policymakers should then determine which mix of payment methods establishes a coherent set of incentives and an adequate balance in expenditure risks among purchasers and providers [27] such that high-quality, accessible PHC is encouraged [20].

The table below lists common provider payment methods [49] for PHC. These are listed in increasing order of the amount of expenditure risk faced by the purchasing agency - in other words, how much they can predict and control in advance what their financial obligations will be. Next to each method is a description of the provider’s financial incentives as well as possible mechanisms for holding providers accountable for good quality, accessible, efficient care provision.
### Inputs > Health Financing > What It Is

Table: [common provider payment methods](#) for PHC [49]

<table>
<thead>
<tr>
<th>Payment Method</th>
<th>Description [49]</th>
<th>Incentives for PHC Providers</th>
<th>Monitoring measures and possible adjustments needed to achieve desired service delivery outcomes [6]</th>
</tr>
</thead>
</table>
| **Line-item budget** | Providers receive a fixed budget per specific input expenses, such as equipment, drugs, or staff, per year.                                                                                                           | - Use up available funding for line-item inputs by the end of the year  
- Under-provision of services and increase of referrals to other providers  
- Difficult to reallocate funding across line items  
- Focus on cost containment                                                                 | - Evaluate providers based on access or quality measures such as patient contact rates, non-specialty referral rates, or vaccination rates  
- Collect data on cost-effectiveness of service line-items within budget and use this to inform budget allocations  
- Increase flexibility; allow facilities or health workers to carry over unused funds to the following fiscal year and reallocate across line items |
| **Global budget**  | Providers receive a fixed facility budget per year, either formed on the basis of inputs or volume of services.                                                                                                      | - If budgets formed based on inputs: under-provision of services, increase in referrals and inputs  
- If budgets based on volume of services: incentive to increase the number of services, increase the referrals to other providers and/or decrease inputs to control costs. Limited mechanisms for efficiency. | - Evaluate providers based on access or quality measures such as patient contact rates, non-specialty referral rates, or vaccination rates  
- Combine with fee-for-service payments for highly prioritized services  
- Conduct random in-person audits to review quality of services  
- Allow facilities or health workers to carry over unused funds to the following fiscal year |
| **Capitation**     | Providers receive a fixed per-patient payment for a defined set of services over a period of time.                                                                                                                                                   | - Increase the number of assigned patients  
- Put less emphasis on expensive health services  
- Reduce volume of services, regardless of their value to a patient population (underprovision of needed services). | - Set minimum quality & volume standards  
- Set limits on total number of patients a provider can be assigned  
- Allow patients to choose their provider (within the limits of any empanelment systems in place)  
- Provide budget autonomy for how facilities spend their funding |
### Inputs > Health Financing > What It Is

<table>
<thead>
<tr>
<th>Case or episode-based payment</th>
<th>Providers receive an overall payment per case or per episode of care. The “bundle” or case definition can vary (per pregnancy; per case of pneumonia; etc)</th>
<th>- Increase the number of specialist referrals, even for primary care-sensitive diagnoses (if not financially responsible for higher-level care).</th>
<th>- Make the capitation a base payment, and layer case-based or fee-for-service payments on top of the capitation package for particularly high-value services, such as immunizations or antenatal care.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case or episode-based payment (e.g. diagnosis-related group)</td>
<td>Providers receive an overall payment per case or per episode of care. The “bundle” or case definition can vary (per pregnancy; per case of pneumonia; etc)</td>
<td>- Increase efficiency: reduce costs per case, reduce average length of stay - Increase admissions or cases seen (even above necessary level) - Reduce the number of services per case or episode, by either selecting healthier patients who require less care, or decreasing the inputs for each episode (fewer tests and interventions).</td>
<td>- Develop case-specific process measures to evaluate providers on adherence to case-specific treatment guidelines - Create payment adjustments for facilities treating high-risk patients (likely to be cost outliers) - Conduct random in-person audits for cost or utilization outliers (high and low volume providers)</td>
</tr>
<tr>
<td>Fee-for-service</td>
<td>Providers receive a set fee per service that they deliver.</td>
<td>- Increase the number and intensity of services during a patient visit (may be beneficial to increase provision of priority services) - Increase number of services (even above necessary level) - Reduce inputs per service (can improve efficiency, may reduce quality)</td>
<td>- Collect patient data to determine if intensity of services match patient risk - Conduct random in-person audits for utilization outliers (high-volume providers) to identify unnecessary service provision - Limit fee-for-service payments to a subset of health services that are proven to be particularly valuable such as immunizations or antenatal care visits.</td>
</tr>
</tbody>
</table>
Example: Capitation payments for PHC

A number of countries have adopted a capitated payment method for PHC services [20]. Capitation minimizes expenditure risk for the purchasing agency because the payment per person for a defined period is set in advance. When paired with patient registration (based on patient choice of their primary care provider or assigning patients to individual primary care providers) [50], and strong quality monitoring systems, capitation can promote efficiency and population health. However, in the absence of patient registration and strong monitoring, capitation can also lead to under-provision and poor quality of essential care, as well as excessive referrals of sick patients to higher-level settings of care. To offset some of the perverse incentives associated with capitation, some countries have had success with blended payment models, such as adding fee-for-service payments for priority services like immunizations or PHC-sensitive communicable diseases [51].

Establish contracts with providers, continuously monitor how payment methods affect PHC delivery, and apply complementary administrative mechanisms.

All payment methods can have unintended consequences [49]. Careful monitoring as well as complementary administrative mechanisms measures are thus needed to counter undesirable incentives of a given payment method and also to ensure that payments over time continue setting the right incentives to providers [46]. As a foundation, health system managers can establish contracts with providers to set expectations and ensure that there are minimal perverse incentives that might lead to lower service quality. For example, this could include making payments to health workers and facilities conditional on meeting service readiness or accreditation standards. Health system managers can then use data recorded during patient encounters to monitor patient outcomes and quality of care. They can make adjustments if payment arrangements are leading to detrimental effects. Service utilization trends at the community level can also be used to evaluate whether providers are achieving improved health outcomes for their patients, and payments can be adjusted to reward or incentivize good performance.

KEY TERMS

Earmarking: Earmarking means ring-fencing, or protecting, all or a portion of a tax or other revenue source for a particular purpose, such as a specific health program or service [28].

Financial protection: Financial protection means that individuals and households do not experience catastrophic or impoverishing expenditure as a consequence of paying for health care [1].

Fiscal space for health: Fiscal space for health is the budgetary “room” that allows a government to spend on health without undermining its fiscal sustainability [53].

Pooling: Pooling is the accumulation and management of financial resources to ensure that the financial risk of having to pay for health care is borne by all members of the pool and not by the individuals who fall ill. The main purpose of pooling is to spread the financial risk associated with the need to use health services. [1]

Prepayment: Prepayment refers to persons or households making payments to the health system before they need health care, not when they fall ill [1].

Provider payment method: Provider payment methods refer to the mechanisms used to transfer funds from a purchaser of health care services to providers [45].

Revenue raising: Revenue raising is the way money is raised to pay health system costs. Money is typically received from households, organizations or companies, and sometimes from contributors outside the country (called “external sources”). Resources can be collected through general or specific taxation
including payroll taxes; voluntary health insurance contributions; direct out-of-pocket payments, such as user fees; and donations. [1]

**Strategic purchasing:** Purchasing refers to the transfer of pooled funds on behalf of the population to health service providers to deliver health services. *Strategic* purchasing means actively linking the allocation of funds to providers with information on their performance and on the health needs of the population that they serve. It includes decisions on what to buy (including designing benefits policies) from whom to buy, and how to pay (including selecting provider payment methods); as well as establishing the governance and institutional arrangements as well as information management systems necessary for monitoring and managing purchasing arrangements [29,46].

**System of Health Accounts 2011:** The System of Health Accounts (SHA) 2011 is a methodology for tracking all health spending in a country. It generates consistent and comprehensive data on the magnitude of health spending, disaggregated by the sources of financing, financing schemes that manage health spending, the kinds of health care goods and services consumed and the health care providers who deliver these goods and services [54].
WHAT HAS BEEN DONE ELSEWHERE TO IMPROVE HEALTH FINANCING

KENYA: MAKUENICARE - RAISING AND POOLING REVENUES FOR PHC

In 2016, Makueni County in Kenya implemented a health coverage scheme called MakueniCare, aiming to expand Makueni residents’ access to equitable, affordable, and quality primary health care. A large proportion of health services in the County is provided in County-owned health centers, but funding for these county health centers had been minimal, forcing families to pay for primary care services out-of-pocket. The coverage scheme aimed to minimize out-of-pocket spending on prioritized PHC services at Makueni-owned health centers [56]. MakueniCare pooled funding from the central government and county government along with donor funding (e.g. from the World Bank) and household contributions to allocate additional resources for primary care at county-owned health centers. This has helped strengthen supply-side infrastructure and enable better data capture for the program’s evaluation.

In addition, Makueni County encouraged the provision of PHC services at lower-cost settings by introducing a gatekeeping mechanism. Referring facilities must receive prior authorization from the referral facility. To incentivize high-priority PHC services within the Kenya Essential Package for Health [27], the scheme paid providers on a fee-for-service basis.

As the owner of county health centers, the County government prioritized and channeled allocations to primary care facilities in order to strengthen the PHC orientation of their health system. The Kenyan government is currently reviewing the MakueniCare program to assess whether the model should be brought to scale.
ESTONIA: BLENDED PROVIDER PAYMENT MECHANISMS TO PROMOTE PHC

After the fall of the Soviet Union, Estonia inherited a health system that was oriented towards hospital-based care. Primary care physicians were mainly a point of contact who would refer patients to their preferred specialist. In 2006, Estonia introduced a series of health reforms to strengthen various aspects of primary care, which included health system governance reforms, promoting more evidence-based approaches in medicine, strengthening the health workforce, improving health management information systems, and creating new, blended payment mechanisms).

Under the reforms, primary care physicians who participated in the Estonia Health Insurance Fund were paid through a combination of provider payment methods: a fixed monthly allowance, a per-patient capitation payment, fee-for-service for priority treatments, adjustment payments based on the distance to the nearest hospital, and the Quality Bonus System (QBS) performance-related payment mechanism. The majority of funds flowed through fee-for-service (20%) and capitation payments (60%) [57]. While representing a small proportion of Estonia’s primary health care budget (less than 2%), QBS was introduced in order to incentivize primary care health workers to focus on prevention and management of chronic diseases, and to reduce avoidable hospitalizations [58]. Providers received additional payments based on how they performed on a series of indicators for disease prevention, chronic disease management, and additional activities.

In the first nine years after implementation, Estonia saw improvements in chronic disease prevention and management for 24 out of the 27 QBS indicators. The increases ranged from 5% to 45%, with an average improvement across all indicators of 18.5 percentage points. Service coverage for most indicators jumped from about 50% of target population covered to about 70% [59]. Additionally, there was some evidence that patients of participating physicians were less likely to be hospitalized for chronic conditions compared to patients of non-QBS participating physicians.
INDONESIA: CAPITATION FOR PRIMARY CARE WITH SOME PERFORMANCE ADJUSTMENTS

In 2014, Indonesia launched Jaminan Kesehatan Nasional (JKN), a new national health insurance system that merged different existing public insurance schemes and expanded coverage to the informal sector. To promote efficiency, Indonesia implemented a new capitated payment system for PHC providers under the scheme. Capitation is intended to cover a basic package of primary care services, including 144 services that all community health centers are expected to provide [60]. The base rate for this capitated payment is determined by facility characteristics (such as availability of doctors, dentists, and 24-hour services) and adjusted for geographic location.

Capitation payments are also linked to three indicators: higher contact rate (proportion of enrolled patients who visit the facility in a month), lower referral rate (the proportion of referrals to specialists for primary care diagnoses - meant to be as low as possible), and chronic disease management program measures (proportion of individuals with hypertension or diabetes who participate in a facility’s fitness and wellness club). If PHC facilities fail to meet specified benchmarks, their financial allotment is lowered by a maximum of 10% [61].

Certain challenges have emerged during early phases of implementation of the capitation payment method. Payments for providers in remote areas are considered inadequate given high fixed and transportation costs in those areas. In addition, many remote facilities are not able to provide the full set of 144 services because of lack of critical supplies and challenges with health worker availability. The PHC information system is weak, making it difficult for policy makers to continuously monitor provider performance [61]. Addressing these wider system constraints -- strengthening supply chains, rural infrastructure, health worker retention, and information systems -- will be necessary for the “performance-based capitation” payment method to achieve its full potential. The full impact of the payment reforms on patient care seeking behavior, provider referral patterns, and overall population health in Indonesia remains to be seen.
WHAT QUESTIONS SHOULD BE CONSIDERED WHEN IDENTIFYING OPTIONS TO IMPROVE HEALTH FINANCING FOR PHC?

The questions below may be a useful starting place for assessing health financing in your context and how one might begin to plan and enact reforms.

**HOW MUCH IS THE COUNTRY SPENDING ON HEALTH OVERALL? DOES THE COUNTRY NEED TO INCREASE SPENDING ON HEALTH IN GENERAL?**

To enable increased allocations to PHC, the most important first step may be increasing overall funding for health through revenue raising (including improved tax collection) and improvements to efficiency [55], relying mainly on public funds. Government revenues for health can be mobilized in various ways, including through income taxes, payroll taxes, consumption taxes, import duties, and taxes on natural resources [13].

**HOW MUCH OF CURRENT HEALTH EXPENDITURE IS SPENT ON PHC (PRIMARY CARE SERVICES AND PUBLIC HEALTH INTERVENTIONS), COMPARED TO SECONDARY OR TERTIARY MEDICAL SERVICES?**

Spending on PHC makes sense because it is a “best buy” for the health sector - maximizing health outcomes for the population given finite resources [21]. Health spending should be tracked systematically using the System of Health Accounts 2011 methodology [54], and the WHO’s recently-developed approach to tracking PHC spending in particular [2]. Health system leaders can use resource tracking data to advocate for greater allocations to PHC.

**WHAT ARE THE PRIMARY SOURCES OF FUNDING FOR HEALTH AND FOR PHC IN PARTICULAR, AND HOW MUCH COMES FROM HOUSEHOLDS’ OUT-OF-POCKET SPENDING, GOVERNMENT BUDGET, OR DONORS?**

To ensure sustainable financing for PHC and promote financial protection, it is important to understand the sources of funding for the health system. Numerous low-income countries rely heavily on donor funding. Countries that face declining donor support will increasingly need to determine how to allocate enough funds for PHC using domestic public resources. It is also important to reduce reliance on household out-of-pocket spending as a source of health financing, as it reduces financial access to care and increases the risk of impoverishment.

**WHAT TYPE OF SUPPLY-SIDE INVESTMENTS SHOULD BE MADE TO PROMOTE PHC?**

Encouraging greater use of primary care services by making services free or more affordable can only improve health outcomes if there is adequate infrastructure, a supply of capable health workers, and sufficient medicines and supplies to absorb the increased demand. Policymakers should conduct subnational analyses to inform where there are critical gaps in service provision capacity, and needed funding should be allocated to strengthen that capacity.

**ARE PEOPLE PROTECTED FROM FINANCIAL HARDSHIP? WHICH POPULATION GROUPS ARE MOST AT RISK OF CATASTROPHIC HEALTH EXPENDITURES?**

Countries can use household expenditure surveys, which measure household socioeconomic status and levels of health care spending, to identify which income level groups are spending a burdensome fraction of their income on health care costs. Understanding who is most at risk of catastrophic expenditures...
(e.g., elderly people, poor and vulnerable groups?), and for what kinds of health care costs (e.g. paying for medicines, hospital care, chronic disease care?), can help health policymakers develop strategies for improving financial protection. Household surveys can also indicate whether households forego careseeking for PHC due to financial barriers.

**WHAT ARE THE CURRENT PROVIDER PAYMENT METHODS AND FINANCIAL INCENTIVES FOR PROVIDERS DELIVERING PHC?**

It is important to understand the financial incentives associated with current payment methods to identify where reforms in provider payment methods may be needed. Systematically assessing a country’s provider payment system in detail can help identify options for better aligning the payment system with the objectives of UHC [47].

**WHAT IS THE CAPACITY OF PURCHASING AGENCIES TO SET UP AN ALIGNED MIX OF PAYMENT METHODS?**

Provider payment arrangements that balance purchasers’ and providers’ expenditure risk with promotion of quality require both effective institutional governance and effective information management systems. In particular, managing a blended payment scheme with different incentives for different services and types of providers is highly complex and data-intensive. Purchasing agencies will likely need strong political support (especially if payment reforms are unpopular with provider groups), investments in managerial capacity, and modern information systems to implement an aligned mix of payment methods.
RELEVANT TOOLS & RESOURCES

Tags: Designing benefits packages, Earmarking, Efficiency, Financial Protection, General, Pooling, Provider Payment, Strategic Purchasing, Revenue Generation, Tracking PHC spending

**ANALYTICAL GUIDE TO ASSESS A MIXED PROVIDER PAYMENT SYSTEM** *(WHO, 2019)*

Overview: This assessment guide seeks to inform national policy dialogue on strategic purchasing and assist in drawing attention to the need for aligning payment methods within and across purchasers as an important step for strategic purchasing and progress towards UHC.

Tags: Provider payment, strategic purchasing

**ASSESSING HEALTH PROVIDER PAYMENT SYSTEMS: A PRACTICAL GUIDE FOR COUNTRIES WORKING TOWARD UNIVERSAL HEALTH COVERAGE** *(JOINT LEARNING NETWORK FOR UNIVERSAL HEALTH COVERAGE, 2015)*

Overview: This practical, step-by-step guide is designed to help countries find answers to their provider payment policy questions through a country-led participatory process.

Tags: Provider payment, strategic purchasing

**COSTING OF HEALTH SERVICES FOR PROVIDER PAYMENT: A PRACTICAL APPROACH TO COSTING CHALLENGES, TRADE-OFFS AND SOLUTIONS** *(JOINT LEARNING NETWORK FOR UNIVERSAL HEALTH COVERAGE, 2014)*

Overview: The manual is the first costing-specific resource that bridges costing theory with practical, step by step guidance to address multiple challenges related to costing for provider payment in low- and middle-income countries (LMICs). It provides tools and templates based on the day-to-day experiences of a network of practitioners that can be adapted to a variety of contexts due to the unique, collaborative approach used in its design.

Tags: Provider payment, strategic purchasing

**DESIGNING AND IMPLEMENTING HEALTH CARE PROVIDER PAYMENT SYSTEMS: “HOW-TO” MANUALS** *(WORLD BANK, 2009)*

Overview: This book includes chapters on primary care per capita (capitation) payment, case-based hospital payment, and hospital global budgets. It also includes a primer on contracting. The volume’s final chapter provides an outline for designing, launching, and running a health management information system, as well as the necessary infrastructure for strategic purchasing.

Tags: Provider payment, strategic purchasing

**FREE HEALTH CARE POLICIES: OPPORTUNITIES AND RISKS FOR MOVING TOWARDS UHC** *(WHO, 2017)*

Overview: This policy brief outlines what is meant by free health care policies and why it is important to discuss these in relation to universal health coverage.

Tags: Financial protection
FINANCING AND PAYMENT MODELS FOR PRIMARY HEALTH CARE: SIX LESSONS FROM JLN COUNTRY EXPERIENCE (JOINT LEARNING NETWORK FOR UNIVERSAL HEALTH COVERAGE, 2017)

Overview: This paper presents six important early lessons emerging from a collaborative learning exchange on provider payment reforms that can be adapted and applied by other countries that face similar challenges or are embarking on PHC reform efforts. The paper also identifies helpful resources with guidance that countries can adapt to their own contexts.

Tags: Provider payment

HEALTH FINANCING COUNTRY DIAGNOSTIC: A FOUNDATION FOR NATIONAL STRATEGY DEVELOPMENT (WHO, 2016)

Overview: The Health Financing Country Diagnostic provides step-by-step guidance on how to undertake a situation analysis of a country’s health financing system.

Tags: General, revenue generation, pooling, financial protection, provider payment

HEALTH SYSTEMS FINANCING: THE PATH TO UNIVERSAL COVERAGE (WHO, 2010)

Overview: In this seminal report, the World Health Organization maps out what countries can do to modify their financing systems in the pursuit of universal coverage. It builds on research and lessons learnt from country experience and provides an action agenda for countries at all stages of development.

Tags: General, revenue generation, pooling, financial protection, provider payment

MEASURING PRIMARY HEALTHCARE EXPENDITURE IN LOW-INCOME AND LOWER MIDDLE-INCOME COUNTRIES (BMJ GLOBAL HEALTH, 2019)

Overview: This paper examines different measurement options using the System of Health Accounts (SHA) 2011 for systematic monitoring of primary healthcare (PHC) expenditure.

Tags: Tracking PHC spending

EARMARKING FOR HEALTH: FROM THEORY TO PRACTICE (WHO, 2017)

Overview: This paper discusses the theoretical foundations of earmarking, and it analyses country experience with earmarking for health and its impact on health sector budgets and the broader fiscal environment. The goal is to provide useful information to health and finance authorities, and to the international partners who support them, on the practical realities of designing, adopting and implementing earmarking policies.

Tags: Earmarking, revenue generation

PRIORITY-SETTING IN HEALTH: BUILDING INSTITUTIONS FOR SMARTER PUBLIC SPENDING (CENTER FOR GLOBAL DEVELOPMENT, 2012)

Overview: The report identifies core features of priority-setting processes and institutions worldwide, and recommends creating fair and evidence-based national and global health technology assessment systems.

Tags: Designing benefits packages, efficiency
WHAT’S IN WHAT’S OUT: DESIGNING BENEFITS FOR UNIVERSAL HEALTH COVERAGE (CENTER FOR GLOBAL DEVELOPMENT, 2017)

Overview: This book argues that the creation of an explicit health benefits plan—a defined list of services that are and are not available—is an essential element in creating a sustainable system of universal health coverage. It considers the many dimensions of governance, institutions, methods, political economy, and ethics that are needed to decide “what’s in and what’s out” in a way that is fair, evidence-based, and sustainable over time.

Tags: Designing benefits packages, efficiency

RAISING REVENUES FOR HEALTH IN SUPPORT OF UHC: STRATEGIC ISSUES FOR POLICY MAKERS (WHO, 2015)

Overview: What issues do policy makers face in decisions about raising revenue? How do decisions about raising revenue have an impact on UHC? This policy brief answers these questions in the context of growing political momentum for UHC, and the challenges that many countries face to increase levels of domestic public funding for health.

Tags: Revenue generation

ALTERNATIVE FINANCING STRATEGIES FOR UNIVERSAL HEALTH COVERAGE (WORLD SCIENTIFIC SERIES IN GLOBAL HEALTH ECONOMICS AND PUBLIC POLICY, 2016)

Overview: While there is no one “best” financing strategy that applies in every context, this chapter synthesizes both theory and practice into principles that can be used to guide country progress with their financing reforms, while also highlighting pitfalls to avoid on the path to UHC.

Tags: General, pooling, financial protection

PURCHASING OF HEALTH SERVICES FOR UNIVERSAL HEALTH COVERAGE: HOW TO MAKE IT MORE STRATEGIC? (WHO, 2019)

Overview: This policy brief aims to show how strategic purchasing contributes to progress towards UHC and how countries can make their purchasing more strategic.

Tags: Strategic purchasing, provider payment

VOLUNTARY HEALTH INSURANCE: ITS POTENTIALS AND LIMITS IN MOVING TOWARDS UHC (WHO, 2018)

Overview: This policy brief explores how voluntary health insurance (VHI) fits within health financing policy and what we know from theory and practice about VHI. It highlights the inherent challenges of VHI, the overall limited coverage improvements and the potentially distorting impacts on the health system.

Tags: Financial protection

GLOBAL HEALTH EXPENDITURE DATABASE (WHO, 2017)

Overview: The Global Health Expenditure Database (GHED) provides internationally comparable data on health spending for close to 190 countries from 2000 to 2017. The database is open access and supports the goal of Universal Health Coverage (UHC) by helping monitor the availability of resources for health and the extent to which they are used efficiently and equitably.

Overview: The System of Health Accounts (SHA) 2011 tracks all health spending in a given country over a defined period of time. This global reference manual guides the compilation of health expenditure accounts.

Tags: Tracking health spending

REFERENCES


References:


