The Lancet Global Health Commission on Financing Primary Health Care

TECHNICAL BRIEF 3

April 2022

Getting incentives right for primary health care

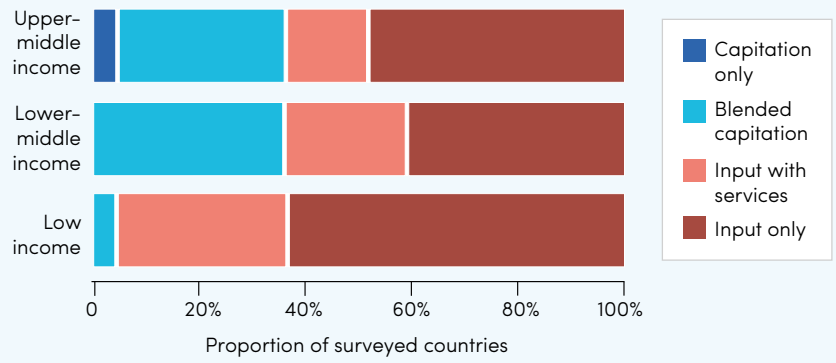
Health financing arrangements provide the fuel for primary health care (PHC) as the engine for achieving good health and universal health coverage. These arrangements need to be right to drive effective, efficient, and equitable PHC service delivery.

The Lancet Commission on Financing Primary Health Care has identified the best evidence on ways to strengthen financing arrangements for PHC and sets out a new vision of how to place people at the centre of PHC financing. This is the third in a series of technical briefs that focus on different elements of health financing arrangements. This brief is on provider payment mechanisms and incentives.

The need to get incentives right

The way health care providers are paid often works against the objectives of PHC, for example, by creating financial incentives that prioritise curative rather than preventive care. Studies from low- and middle-income countries have documented that the typical PHC provider receives funding from multiple payers using different payment systems for different population groups. The status quo for many countries, as shown in figure 1, is input-based budgets (e.g., line-item or global budgets) that are not only rigid but also fail to provide the incentive environment required for delivery of PHC that is centred on people and focused on equity.

Figure 1: Payment methods for public PHC providers in 75 low- and middle-income countries, 2020



KEY MESSAGES

- Incentive policies for health care providers and users are inextricably intertwined: provider payment policies are integral to the elimination of user fees and informal payments for PHC services.
- Incentives alone cannot solve all PHC financing problems, but they should at least not work against PHC service delivery objectives.
- Countries should move towards a context-specific blended payment model with capitation at its centre because it is most aligned with the principles and objectives of PHC.
- The blended payment model purposively combines capitation with elements of other payment methods to maximize beneficial incentives and offsets perverse incentives of each payment method, while ensuring other service delivery objectives, such as access, are met.
- Countries should only embark on provider payment reform when they are ready. The transformation of the PHC provider payment system is a complex process with distinct political economy challenges. The aim is to make incremental progress that involves continually strengthening supporting systems as the payment model evolves.

Towards a blended payment model for PHC with capitation at its core

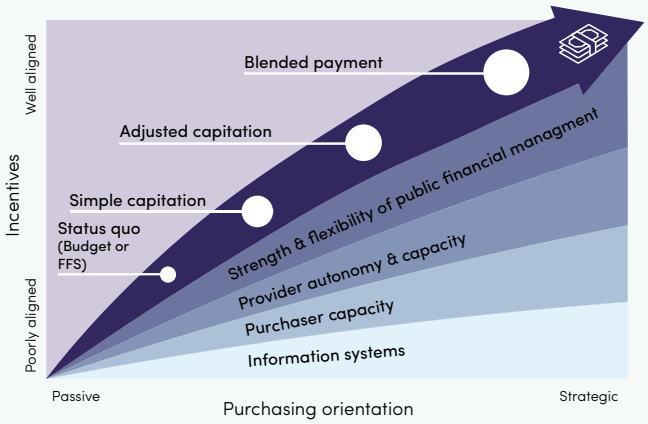
Population-based, or capitation, payment systems are far from widespread in low-income countries. However, this payment system is most likely to create incentives for providers to deliver people-centred PHC. Capitation is the only payment method that is based on the principle of equity, as its starting point is an equal fixed payment per person, which can then be adjusted based on health needs. It is also the only method that pays PHC providers to prioritise the preservation of good health through health promotion and prevention. It provides a predictable and stable revenue stream to PHC providers that can be used to flexibly deliver services in responsive ways that optimally manage care for individuals and populations.

Countries should work towards using a blended payment model for PHC with capitation at its centre. Blended payment models bring the benefits of capitation as the starting point and then use elements of other payment mechanisms to deliberately offset capitation's disadvantages and support achieving other specific health system objectives. They typically include: a budget payment to cover unavoidable fixed costs, particularly in low-population or hard-to-serve areas; some fee-for-service 'carve-outs' for health conditions or services that are high priority or at higher risk of being under-provided in capitation; and, in some cases, performance-based payment to incentivise reaching coverage targets for priority services and improving quality of care.

Making incremental progress

The right choices of when and how to transform the PHC payment model depends on the country context. Reforming the payment system requires a clear vision backed by strong political commitment, deft management of competing interest groups, significant time, and consistent investment. Figure 2 presents the pathway of how countries can pursue a blended payment system, showing the interim steps in the evolution. The introduction of equity- and efficiency-oriented payment system reforms starts with a basic capitation model, involving simple per capita payments. Most payment systems then eventually introduce risk adjustments. Complexity continues to increase over time as additional payment methods are added. Countries almost always find that the precise blend of payment changes as the system matures. Even a well-designed payment system cannot work without basic supporting functions in place. These will need to develop and evolve as the payment system becomes more sophisticated.

Figure 2: Strategic pathway for moving to a blended capitation-based payment



Addressing the problem of user fees

Provider payment policy goes hand in hand with eliminating user fees and informal payments for PHC. Progressive universalism – in which pooled funds should first be used to cover PHC to reduce out-of-pocket payments and replace the lost financing – requires action across all the health financing functions. In particular, removing financial barriers for PHC involves more than just changing user fees policy. It means ensuring patients do not face informal fees and are not sent to pharmacies to purchase medicines because public health providers are under-resourced. Provider payment rates and health worker salaries must be high enough to eliminate the need for user fees and informal payments. There may be a role for cost-sharing in some contexts but its impact on the poorest should be carefully considered and mitigating measures put in place.

IMPLICATIONS FOR ACTION

- Develop a clear vision of the provider payment model for PHC. A context-specific blended payment model built on capitation embodies principles that should form the core of PHC financing.
- Make incremental progress towards this vision. This involves establishing a baseline capitation payment system; defining the PHC package; managing enrolment; adjusting for risk levels to compensate health providers appropriately; and blend payment methods.
- Strengthen basic functions in support of reform. In anticipation of and during the implementation of reforms, continually strengthen information systems, purchaser capacity, provider autonomy and capacity, and public financial management systems.
- Manage the politics of provider payment reform. This means anticipating the effect of the new reform on influential stakeholders and engage with those most likely to be affected. Health providers should be closely involved in the design of provider payment reforms.

FURTHER READING

Cashin C, Ankhbayar B, Phuong HT, et al. Assessing health provider payment systems: a practical guide for countries working toward universal health coverage. Joint Learning Network.

Langenbrunner, John C.; Cashin, Cheryl; O'Dougherty, Sheila. 2009. Designing and Implementing Health Care Provider Payment Systems : How To Manuals. Washington, DC: World Bank.

Tan SY, Melendez Torres GJ. Do prospective payment systems lead to desirable providers incentives and patients outcomes? A systematic review of evidence from developing countries. *Health Policy Plan* 2018; 1;33(1):137 153.

FULL REPORT: Hanson K, Brikci N, Erlangga D, et al. The Lancet Global Health Commission on financing primary health care: putting people at the centre. Lancet Glob Health 2022; https://www.thelancet.com/commissions/financing-primary-health-care

FUNDING: This work was funded by a grant from the Bill & Melinda Gates Foundation. However, the views expressed in the report are those of the authors and do not necessarily reflect the views or policies of BMGF.

ACKNOWLEDGEMENTS: Technical brief edited and formatted by Becky Wolfe