

# Purchasing for quality chronic care

## Policy brief series

Purchasing for quality chronic care: policy brief series

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## Purchasing for quality chronic care: lessons learned

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### Summary

- Improving the quality of care for people with chronic conditions is central to advancing universal health coverage, given the large burden of premature mortality from noncommunicable diseases.
- This research study aims to describe experiences with purchasing arrangements and payment methods and how they have been used to improve quality and better health outcomes for people with chronic conditions.

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### Methods

- Scoping reviews of the literature and summaries of Cochrane and other systematic reviews were conducted to identify the effects of payment methods on process quality and outcomes for chronic care.
- Eight case studies were commissioned to describe implementation arrangements for payment methods that reward quality for chronic care in Australia, Canada, Chile, China, Germany, Indonesia, South Africa and Spain.

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### Results

- A challenge in most settings was to balance the incentives in blended payment methods (i.e. a combination of two or more payment methods).
- Very little information was published about the decisions made to distribute payments across and within teams, which may create uncertainty among health care providers.

- A mix of process and outcomes measures was used in all studies, with a reliance on information collected by existing administrative systems.
- Only two case study schemes were independently evaluated and peer reviewed, and these evaluations faced important methodological challenges, including selection bias.
- Key facilitating and inhibiting factors included those related to governance, service delivery, quality standards, the health information infrastructure, as well as the financial and regulatory environments.

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### Lessons learned

- Emphasizing **health care delivery models** more strongly and systematically identifying obstacles that inhibit quality enables policy-makers to focus on quality and health outcomes for the population as a whole and to identify the appropriate mix of purchasing mechanisms that support service delivery reforms to achieve quality objectives.
- Using process **quality indicators** that are significant to clinical health may ensure strong linkages between provider practice and improved health outcomes, particularly if based on established professional practice norms and guidance. Relative or progressive targets may encourage providers and facilities to strive towards gradually improving standards of care.
- **Adjusting the quality measures for patient health risk and complexity** may help ensure that providers do not face incentives that inhibit them from caring for the sickest patients. Adjusted metrics may more accurately reflect performance for providers working with populations that have higher health risks.

- Metrics can also be **adjusted for social risk factors** to redress equity in provider payments. Such adjustments made for geographic settings, for example, can avoid penalizing health facilities that serve poor and vulnerable patients.
- **Balancing financial incentives** in payment methods is a critical design challenge. Relatively small incremental payments may not be sufficient to counter stronger incentives in activity-based base payment methods that produce a larger share of provider payments.
- The case studies suggest that withholding payment as a penalty had important negative effects. **Penalties for poor performance should be considered carefully** so as not to undermine a programme’s overall objectives and reduce the resources available for quality improvements.
- A key design element is **payment certainty**, which may affect providers’ willingness to participate in a programme or accept changes to their practice. Confidence is increased in the payment method where there are clear and transparent rules for distributing performance payments across or within teams, related to salary or effort.
- Financial incentives to improve quality need to be embedded in **broader quality assurance mechanisms**. This likely requires investments in strengthening the standards for health systems input and processes to provide a foundation for purchasing for quality.
- **Sequenced implementation** can be done in which new payment methods are initiated while broader capacities in human resources and service delivery are also built.
- Key design elements in the payment method should be **carefully monitored and adjusted** to provide optimal incentives and identify unintended effects.
- **Selection bias** is the most common challenge in evaluations, and it should be identified and addressed to the greatest extent in analytical plans; it should also be considered carefully when interpreting results.
- There is a lack of good evidence and documentation about other complementary purchasing instruments commonly thought to promote quality. **Close monitoring and evaluation of these purchasing instruments is essential to determine their effects on behaviour.**
- There is a need to learn from past experiences about the design and evaluation of payment methods, including how lessons learned can be systematically adapted across different country contexts. While proactive learning takes time and effort – particularly across countries and among different stakeholders – it is essential to share experiences to avoid continually repeating mistakes and implementation failures.

This policy brief is based on *Purchasing for quality chronic care: summary report*. Geneva: World Health Organization, Organisation for Economic Co-operation and Development; 2023.

## Australian Health Care Homes offer some promise but fail to meet expectations

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### Summary

- Australia's health system is a mix of public and private funding and provision, with the aim of universal coverage and good health outcomes at reasonable cost. Primary care is a key component. General practices are almost entirely independent, privately owned businesses for which the major source of revenue is fee-for-service with a primary care physician. Improving models of care, particularly for those with chronic disease, is a challenge shared with other countries.
- The Australian Health Care Homes Trial was conducted from October 2017 to June 2021. It featured voluntary enrolment of more than 11 000 patients across 227 participating primary care practices; 106 practices and 7754 patients completed the trial.
- The model was intended to encourage shared (multidisciplinary) care for patients with chronic disease, supported by a move from fee-for-service doctor-oriented care to a bundled payment for chronic disease management that did not require a patient-doctor encounter.
- The new payment provided more flexibility in that it could fund nurses and allied health staff as well as alternative types of service delivery, such as telephone consultations. It provided more certainty in that it assured an annual revenue stream. The trial aimed for a stronger emphasis on team-based care and continuity with providers, which were expected to deliver better services and better health outcomes.

- While there were promising results in indicators for chronic disease management, the overall impacts on patients' reported health and the use of secondary and tertiary services did not show significant improvement. There was no net reduction in health care costs.

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### Key elements of the programme

- Voluntary enrolment of patients with a practice, including nominating a general practitioner (GP) as a preferred clinician, to provide continuity of care with the practice and one practitioner to improve care coordination
- Risk adjustment based on the complexity of the patient's illness using a standardized tool and bundled payment for chronic disease
- Shared-care planning within the practice and with other community and hospital services

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### Results

- Less than half the participating practices completed the trial (106/227); practices were more likely to withdraw if they had relatively few enrolled patients, were owned by a corporation or felt that the payment did not cover the costs of care.
- Compared with a matched group of patients not participating in the trial, enrolled patients had more contact with GPs and were more likely to have clinical measures of risk factors recorded – such as blood pressure, lipids and HbA1c (glycated haemoglobin, as a marker of diabetes severity). The number of GP consultations was reduced, but there was little impact on other services.



- Patients were positive about having more frequent encounters with the practice nurse and the opportunity to telephone and email the practice.
- The Health Care Homes model did not reduce the overall costs of caring for these patients compared with costs for the matched group.

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## Facilitating factors

- Practices and participating GPs volunteered for the trial so were likely to be supportive of the model before implementation.
- Substantial sign-on incentives were provided to support making changes to the practice before the trial commenced.
- Training and support for practice staff were provided from national resources and coordinated locally.
- Payments were changed to align with the model of care.

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## Inhibiting factors

- The Trial faced entrenched opposition from some stakeholders and some parts of the medical profession. Practices had insufficient lead time to make the necessary changes.
- Not only practices but also individual practitioners within practices had to agree to participate. There was less impetus for change where only a small proportion of doctors agreed or where only a small proportion of practice patients were enrolled.
- Financial incentives were directed at the practice; it was not clear how these flowed to individual practitioners and how this affected individual participation.
- The payment was perceived as being too low for some cases; the three tiers of payment were not adequate for patients with more severe and complex conditions. As a result, practices were exposed to high financial risk, and were unlikely to enrol more complex patients.

- Many aspects of the new information-sharing platforms were reported to be cumbersome and time-consuming for staff to learn.
- The coronavirus disease (COVID-19) pandemic occurred during the final 16 months of the trial, which added other pressures to general practices, particularly difficulties in retaining staff while dealing with the roll out of vaccinations.
- Uncertainty about the future of the Health Care Homes model towards the end of the trial increased the drop-out rate.

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## Lessons learned for other settings

- Trials are a valuable approach to testing reforms but need to be designed for better understanding of how behaviours among providers, patients and organizations will change in response to altered incentives.
- Sufficient time is required to ensure detailed design of the reform and adaptation of service delivery and provider business models so that the transition to reform is smooth.
- The scale of the changes must be considered – that is, practices and payments must be sufficiently large so that the investment in change is justified by increased rewards and the changed exposure to risk is manageable. It is important to understand how incentives flow within an organization and how rewards and penalties are shared.
- A clear agreed upon strategic direction can increase certainty. A staged roll out of new reforms should involve not only increasing the scale of participation but also investing in change management, monitoring and evaluation to refine the intervention while addressing ineffective elements and barriers to successful implementation.

This policy brief is based on Hall J, van Gool K, Haywood P, Pearse J, Mazevska D, Yu S, et al. *Australian Health Care Homes trial: case study*. Geneva: World Health Organization, Organisation for Economic Co-operation and Development; 2023.



## Building trust to integrate funding and care for chronic diseases in Ontario, Canada

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### Summary

- The Integrated Comprehensive Care (ICC) 2.0 programme in Ontario, Canada, uses bundled episode-based payments for patients with chronic obstructive pulmonary disease (COPD) or congestive heart failure (CHF).
- First implemented in a single hospital, the programme was expanded in 2015 to include nine acute care hospitals, representing about 10% of hospital volume in Ontario. Between October 2015 and March 2018, 3010 patients voluntarily enrolled in ICC 2.0, representing 44% of all eligible patients admitted to these hospitals for COPD and CHF.
- The goal of ICC 2.0 is for patients to have one team deliver integrated patient-centred care to reduce unwarranted variation in quality, while improving the experiences of patients and caregivers, and value for money.
- A single, integrated payment is shared between the hospital and the home care provider for patients admitted for CHF or COPD for one episode of care beginning with acute hospital care and extending to home-based care after discharge for up to 60 days.
- An external independent evaluation reported positive effects but the evaluation could not fully control for differences in clinical severity between the intervention and comparator populations, nor could it capture other key factors that may have biased the findings.

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### Key elements of the programme

- The most important design elements included having a single organization to coordinate and provide all postacute care, including clinical services, and having telehealth systems available 24 hours/day 7 days/week for the entire episode of care.
- A designated care coordinator facilitated the provision of care across multiple health care settings, while standardized integrated care pathways ensured patients received optimal, evidence-based care, thus reducing variation across providers.
- Using information technology (i.e. to share electronic records across providers) ensured that complete information was available to providers regardless of whether patients were in the hospital or receiving home care services. However, in some cases, this required providers to learn how to use different information systems across different organizations.

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### Results

- Stays in ICC 2.0 hospitals were associated with reductions in the mean length of stay, rates of readmission, visits to emergency departments and deaths after 60 days relative to comparators.
- For the 60-day bundle period, the total cost savings was US\$ 2705 (2019) greater per episode for patients enrolled in ICC 2.0 relative to comparators between October 2015 and March 2018.
- The analyses could not control for several factors that may bias the findings, including differences in clinical severity between the intervention and

comparator populations, nor could it capture key outcomes, such as hospital-acquired infections, gaps in follow up or functional decline, and patients' experiences of care. Moreover, patients who returned after the 60-day episode window were considered new cases thus artificially reducing readmission rates.

- Different perspectives on union regulations came into play. Positions for hospital-based integrated care coordinators were disputed by pre-existing home care coordinators over concerns that the new positions were taking work away from them. There was a lack of oversight of and orientation for coordinators in the expanded programme that led to nonstandard practices.

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## Facilitating factors

- Many participating hospitals had pre-existing working relationships that facilitated programme implementation and sharing of resources and data in real time.
- Differences across professions, organizations, systems and sectors were bridged by fostering trust and allowing each profession to voice what was important from their perspective.
- Working through risk scenarios, encouraging input from clinicians and administrators, and accounting for different perspectives in the acute care and community care sectors allowed a model to be developed that was applicable across the programme.
- Building confidence among clinicians was done by involving them in developing the model, utilizing integrated care coordinators who had pre-existing relationships with physicians and identifying clinical champions.

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## Inhibiting factors

- Factors inhibiting information-sharing included the lack of a single electronic medical record system and differing organizational interpretations of privacy regulations.
- Coordination of programme roll out was hindered when organizations differed in size and levels of resource availability.
- Patients satisfied with their existing home care organization hesitated to enrol, given that ICC 2.0 employed care coordinators and service providers specific to the bundled care programme, requiring patients to switch caregivers. This limited the number of patients enrolling in ICC 2.0, which interfered with programme scale and spread.

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## Lessons learned for other settings

- Successful implementation relies on aligning the programme with the context in which it is being implemented. Involving stakeholders in the various stages of designing and implementing ICC 2.0 ensured there was sustained engagement from local providers. This involvement allowed health care providers to voice their concerns, building a sense of trust and encouraging their active participation.
- Information-sharing across providers is a crucial component of providing integrated care. This requires a strong infrastructure for information technology that can be used across participating organizations.
- Financial stability is vital for successful implementation. Having a stable source of funding increases support for the programme from local clinicians, allowing providers to focus on improving patient outcomes. In addition, cost savings resulting from the provision of integrated care essentially become additional revenue for participating organizations when a bundled-care approach is used.
- Nonmedical determinants of health and outcomes must also be considered. These may include transportation, food security and even housing. Providers are often reluctant to assess these determinants if there are not relevant linked programmes or funding.

This policy brief is based on Wodchis WP, Rashidian L. *Integrated Comprehensive Care programme in Ontario, Canada*. Geneva: World Health Organization, Organisation for Economic Co-operation and Development; 2023.

## Limited effect of performance-related payment incentives on improving the quality of primary care for people with chronic conditions in Chile

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### Summary

- Since 2012, the Family and Community Integrated Health Care model (known as MAIS for its acronym in Spanish) has provided a guiding framework for municipalities to implement their strategies for primary health care (PHC)<sup>1</sup> according to their capacities and the needs of the population they are responsible for.
- PHC networks are responsible for the prevention, early detection and treatment of mild conditions; routine control of chronic conditions; rehabilitation; and referral to other levels of care. MAIS uses incentives to encourage PHC networks to improve access to health care, enhance the quality of health services and increase social participation.
- MAIS uses four methods to fund municipal PHC networks: capitation, direct transfers from the central government to strengthen specific areas of care delivery (for programmes known as PRAPs, for their acronym in Spanish), a pay-for-performance scheme and municipal budget allocations.
- About 95% of PHC networks have consistently received 100% of the pay-for-performance bonus. Moreover, all health workers get a 10.3% salary bonus even if the PHC network's performance is poor. As such, the overall effectiveness of the pay-for-performance scheme is limited.

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### Key elements of the programme

- The capitation payment is adjusted by three factors to account for differences in health needs and risks and their related expenditures: the poverty or deprivation index, the degree of rurality, and geographical isolation. In addition, two add-on payments to the adjusted capitation amount are made based on the number of people 65 years and older registered with the PHC network and whether an area is considered as difficult to provide PHC (i.e. it is socioeconomically deprived and difficult to retain health personnel).
- PRAPs are not in place in all PHC networks. The participation of a network in a particular PRAP, and the consequent allocation of resources, is determined by an agreement between the Health Service Network and the municipal administration of the network. Agreements stipulate health-promotion activities, performance goals, clear timelines and a proposed budget. Part of the allocation for a PRAP may be linked to achieving defined performance goals.
- The incentive for the pay-for-performance scheme includes base and variable components. The base component is a bonus of 10.3% of annual remuneration for every PHC employee. The variable component represents 11.9% of annual remuneration if the PHC network meets more than 90% of its service delivery goals; 5.95% if the PHC network meets between 75% and 90% of the health goals; and zero if the PHC network meets less than 75% of the health care goals.

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1 We differentiate between primary health care (PHC) and primary care. In the Chilean context, the former refers to the formal primary health care system, managed by local health authorities. The latter is any form of care provided at the first level.

- Allocations from municipal budgets cover costs related to addressing the urgent health needs of the population, also identified through dialogue with communities.

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## Results

- The capitation mechanism has proved effective in improving equity in the distribution of resources across municipalities, thus making per capita spending more equal. Funding from capitation has also helped provide essential resources, especially to poorer municipalities.
- About 95% of PHC networks have consistently received 100% of the pay-for-performance bonus. Moreover, all health workers get a 10.3% salary bonus even if the PHC network's performance is poor. Furthermore, only a subset of health system goals relates to chronic care. As such, the overall effectiveness of the pay-for-performance scheme is limited.

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## Facilitating factors

- The willingness of municipal authorities to support and improve the PHC system has been identified as a critical element in improving performance. Municipal support translates to direct budget allocations to PHC networks and also to a push to implement interventions, such as PRAPs, that respond to a population's health needs.
- Municipalities provide direct budget allocations to PHC networks to implement interventions to respond to the specific health needs of their population, including those of people with chronic conditions. Regular meetings between community representatives and policy-makers at the local level facilitate a more responsive health system that is conducive to providing better quality care.

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## Inhibiting factor

- Health workers receive their performance bonus of 10.3% regardless of the performance of their PHC network. By design, this payment method does not function as a performance incentive. Moreover, the majority of the networks achieve more than 90% of their performance goals, so little additional effort is needed to receive the 11.9% variable component, which lessens its effect on improving the quality of care.

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## Lessons learned for other settings

- PRAPs are both financing arrangements and quality improvement initiatives. These initiatives are planned, designed and funded centrally by the Ministry of Health. Because PRAPs are created to address critical health care needs and funding is partly linked to performance, these programmes – only a few of which target care for patients with chronic disease – could effectively contribute to improving the quality of PHC.
- A pay-for-performance method should be designed to actually reward improvements in performance and should avoid assigning most providers to the top tier of performance.
- Bonus payments need to be clearly linked to improved performance.
- To enhance continual improvement in the quality of care, targets should be partly based on performance observed during the previous year.
- Capitation alone cannot provide incentives to improve health care quality per se; therefore, it is important to combine it with other payment methods to reduce the inherent incentive to skimp on quality.

This policy brief is based on Urriola R, Larrain N. *Effect of the payment mix for primary care services on the quality of chronic care in Chile: case study*. Geneva: World Health Organization, Organisation for Economic Co-operation and Development; 2023.

## Capitation with performance payments for universal basic public health services in China: challenges in implementation

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### Summary

- The Government of China established and funded the National Basic Public Health Services Programme (NBPHSP) in 2009 to ensure equal access to basic public health services (BPHS). By 2015, the Programme included the management of four chronic conditions - hypertension, type 2 diabetes, severe mental disorders and tuberculosis.
- BPHS are funded through a capitation payment to public primary health care facilities. The amount has increased in real terms from US\$ 3.10 in 2009 to US\$ 13.00 in 2022. The minimum capitation level can be increased subject to local fiscal capacity.
- The capitation payment is financed from central, provincial, and municipal resources, with the central government covering 80% of the funding for low-income regions.
- The central government had initially recommended that at least 5% of the total capitation payment should be performance based; this recommendation was later withdrawn, leading to variations in the share allocated for performance-based pay. By 2022, the central government share used for performance pay amounted to 0.5%, with variations in the share by region.
- The central government reduced its share of contributions to 14 mainland provinces (mostly low-income regions) because of lower-than-expected performance, and funds from the central government were reallocated to 17 other provinces with better performance scores.

- The impact of the BPHS program on health outcomes is difficult to disentangle from other ongoing reforms. The performance assessments were regressive in that central level funding was reduced primarily to low- and lower-middle-income provinces, which was likely to further reduce quality of services in less-developed areas.

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### Key elements of the programme

- The central government covers up to 80% of the capitation payment for 12 low-income provinces, 60% for 10 lower-middle-income provinces and 50% for three middle-income provinces. The remaining funding is provided by the provincial, municipal, and county levels.
- Most of the payment is made at the beginning of the fiscal year. At the end of the fiscal year, the second instalment is paid based on a performance assessment.
- Performance assessments are carried out at each administrative level to determine the amount of the second instalment, which can be reallocated across regions based on good or poor performance (i.e. scores  $\geq$  or  $<$  80)
- Performance is evaluated using a 100-point grading system based on assessments of organizational and financial management (30%), the volume of services delivered (45%) and Programme outputs (25%); weighting of the assessment criteria varies by province.
- The capitation payment was implemented alongside support to human resources and capacity building at primary level.



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## Results

- No formal external evaluation has been undertaken. National monitoring shows improved access to services between 2009 and 2019. However, national trend data reflect progress not only on BPHS but other ongoing health care reforms.
- The purchasing mechanisms for BPHS (including payments and capacity building) were insufficient to overcome systemic problems at the primary care level.
- Relatively low levels of performance pay provided weak incentives to improve quality and offset the incentives in the salaries for primary care providers and incentives to increase the volume of services delivered.

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## Facilitating factors

- The NBPHSP represents a strong central government commitment to address inequities in access to BPHS as demonstrated by the increasing minimum capitation payments over time.
- Fund payments allocations from central level aimed to support low-income regions.
- The NBPHSP was implemented alongside a series of comprehensive reforms in the health sector, including an expansion of rural and urban health insurance, and reforms of essential medicines and public hospitals.

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## Inhibiting factors

- Interviews with stakeholders suggested that NBPHSP payments were insufficient to cover the program costs, which led to staff engaging in cost saving activities that also affect quality.
- The program could not address some fundamental structural issues that determine quality, including shortages and retention of qualified health care workers at the primary care level.
- Fragmented health information systems and the absence of synergies between BPHS preventive services and basic medical services compromised the coordination of care.

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## Lessons learned for other settings

- Government commitment to investing in equitable access to basic public health services is essential.
- The performance-based payments should consider differences in local capacities across wide geographic regions at primary care level.
- Additional support is needed for service delivery at the primary care level, including coordinating care and encouraging collaboration.
- Independent evaluations of the NBPHSP are needed to provide policy-makers with information for evidence-based decision-making.

This policy brief is based on Long Q, Jia Y, Li J, Lou Z, Liu Y. *National Basic Public Health Services Programme in China: case study*. Geneva: World Health Organization, Organisation for Economic Co-operation and Development; 2023.

## Shared-savings model of integrated care in southwest Germany: promoting patient self-management

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### Summary

- Healthy Kinzigtal (HK; in German, Gesundes Kinzigtal) is an integrated care network in southwest Germany, introduced in 2005, with the objective to promote integrated care for chronic illnesses and lower health care costs. Participating providers receive incentives to promote prevention and improve care coordination based on a shared-savings arrangement contracted between two health insurance funds and the programme management company.
- In 2020, of some 71 000 inhabitants in the region, 33 000 were members of the eligible insurance funds. Among these, 8 150 patients (25%) were enrolled in the program that year.
- Providers and affiliated facilities taking part in the programme include 24 general practitioners, as well as hospitals, nursing homes, community centres and pharmacies.
- Providers are primarily reimbursed on a standard insurance fee-for-service basis for usual care and receive add-on payments and performance-based reimbursements for additional services considered important to attain quality improvements.
- Profits come from realized savings relative to the average cost norm for care, which are shared between the management company and the insurance companies. Providers share in the company's profits based on their individual performance. One estimate suggests that these payments comprise up to 15% of a provider's income, with values around 5% being common.

- An evaluation covering the period of 2006 to 2015 found no significant impact on the quality of care. Since 2007, the HK programme has been able to sustain itself financially through the shared savings arrangement.

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### Key elements of the programme

- The approach is patient-centred; patients are encouraged to actively participate in shared decision-making, engage in self-management and take part in health promotion activities.
- Designated trusted doctors work with enrolled patients to develop an individual care plan and mutually agreed treatment goals by integrating health and community-based activities (such as taking part in sports and community associations); they also work cooperatively with other practitioners in the region, including those providing primary, secondary and long-term care.
- The programme management company (the regional "integrator") facilitates care coordination, designs and implements health-promotion programmes, develops infrastructure for information technology (IT) and data analysis, and performs managerial tasks. Efforts are made to reduce wait times for patients who need to be seen urgently through better coordination of care, and health insurance funds' cost and utilization data are analysed to identify high-risk patients.
- Savings in health care spending are calculated by comparing actual spending to a cost norm. This cost norm is determined using the national morbidity-based risk-adjustment scheme, which estimates health care costs for a population based on several risk factors.



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## Results

- A 2021 external evaluation of the 10-year impact of HK implementation (2006 to 2015) reported no significant impact on care quality, suggesting that a positive trend observed during the first years of implementation cannot be confirmed.
- Internal evaluations report that health care expenditures for the covered population have remained below the expected norm cost, enabling savings for the company.
- Internal surveys of patient satisfaction are largely positive but not fully available and methodologically limited.

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## Facilitating factors

- Start-up costs of €4 million (est. US\$ 4.8 million at the time) covered the first years of implementation before the model became self-sustainable financially in 2007. An initial contract duration of several years encouraged providers to make long-term structural investments.
- Investments were made in a transparent and inclusive governance structure and in an advanced IT system.
- As a private entity, two-thirds of the programme management company is owned by a physician network, so that physicians are involved in implementation and related decision-making processes, which likely enhances their support for and motivation to actively participate in the project.

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## Inhibiting factors

- Population coverage is limited. Benefits are available only to those who actively enrol, leading to concerns about risk selection related to voluntary patient enrolment.
- It is unclear whether a balance has been achieved that addresses the risks inherent in a shared-savings contract of underproviding needed care, as well as the incentives for overprovision under the usual fee-for-service system.
- A great deal of implementation detail is not publicly available, thus inhibiting rigorous evaluation of programme impact and the translation of lessons to other settings.

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## Lessons learned for other settings

- Patient self-management is a key part of chronic disease control and can be incorporated into integrated service delivery that includes health and community-based services.
- Payment mechanisms that promote better integration of care require investments in the structure of the health care system and care processes.
- Payment mechanisms require close monitoring and evaluation to ensure optimal quality outcomes.
- Publicly available information about implementation and independent external evaluations could support learning in other settings.
- A shared vision among participating providers and funders, and mutual trust and support can contribute to the better functioning of integrated care models and prevent or help resolve any conflicts.

This policy brief is based on Lindner LE. *Healthy Kinzigtal Programme in Germany: case study*. Geneva: World Health Organization, Organisation for Economic Co-operation and Development; 2023.

## Balancing incentives in performance-based capitation for chronic care: the PROLANIS programme in Indonesia

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### Summary

- The Government of Indonesia has set up several programs for managing patients with chronic conditions under its national health insurance scheme (Jaminan Kesehatan Nasional; JKN) covering 86% of the population (235 million people) in 2021. One of these is PROLANIS (Program Penanggulangan Penyakit Kronis), a programme to improve the management of care for patients with hypertension and/or diabetes at the primary level and to control costs.
- JKN pools revenue from contributions paid by individuals and employers, and budget transfers for subsidies for poor families. Primary care providers are paid through capitation with pay for performance (P4P).
- The assessment to determine the P4P is based on uniform national weighted scores for three indicators: a minimum of 15% contact rate among JKN members (40% weight); a non-specialist referral rate below 2% (50%); and a minimum of 5% of patients enrolled in PROLANIS whose blood pressure or blood glucose levels are controlled (10%).
- The total monthly capitation payment per JKN member ranges from US\$ 0.25–0.60 for public providers and US\$ 0.60–1.08 for private providers. The capitation payment from JKN accounts for more than 93% of funding for the 22 373 participating primary care facilities.
- Since JKN was introduced in 2014, nearly 1 million members have registered with PROLANIS. An independent evaluation reported significant but relatively small program effects.

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### Key elements of the programme

- Patients with diabetes and/or hypertension who voluntarily enrol in PROLANIS receive monthly medical consultations and health status monitoring, including a blood glucose check for patients with laboratory testing for metabolic control and renal function every six months as required. Peer club activities (e.g. health education) are also offered.
- Linked to PROLANIS is a separate mandatory program, Program Rujuk Balik (PRB). PRB moves clinically stable patients from secondary to primary care. PRB automatically enrolls these patients in PROLANIS, so that they can access monthly medications through PROLANIS pharmacy networks without returning to secondary care.
- Providers participating in JKN must meet credentialing requirements - primarily quality standards. Since 2019, provider participation in PROLANIS has been mandatory, with optional peer club activities that require a minimum of 30 patient participants.

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### Results

- Patient enrolment in PROLANIS is low. In 2020 and 2021, respectively, only 12% and 14% of JKN members diagnosed by a primary care provider with one of nine chronic conditions (asthma, diabetes, epilepsy, hypertension, heart disease, chronic obstructive pulmonary disease, schizophrenia, systemic lupus erythematosus and stroke ) were registered with PROLANIS. More than 50% of those registered were members of PRB.

- Approximately 63% of PROLANIS patients visited a primary care facility monthly; 16% had a monthly blood glucose check and 7% had 6-monthly laboratory testing. However, only 3.9% of patients with chronic disease had controlled blood pressure or blood glucose levels; across the three cities surveyed for this study, the range was 1.2% to 10.6%.
- In 2021, 6.5% of public health centres received 100% of the performance-based capitation payment, having met the minimum targets for the three indicators.
- It is more difficult to implement PROLANIS in rural areas where there are a limited number of health facilities, wide catchment areas and low levels of staffing. Some facilities in rural areas that could not meet quality standards were unable to participate.

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## Lessons learned for other settings

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### Facilitating factors

- Facilitating factors for program success include the participation of a large number of primary care providers and facilities that increases the opportunities to enrol more patients.
- JKN views the management of chronic disease patients as a priority; meeting the PROLANIS patient care target was thus included as one of three indicators within the weighted performance payment for providers.
- The links between PROLANIS and PRB aim to ensure that comprehensive curative and preventive services are available to patients.

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### Inhibiting factors

- The threshold for the PROLANIS performance indicator is considered difficult to achieve, does not consider facilities' capacities, and is influenced by patients' behaviour.
- Primary care providers selectively enrol patients who would be more likely to comply with medical recommendations to maximize their revenue from capitation payments.
- The involvement of other key stakeholders (i.e. Ministry of Health, Provincial and District Health Offices and providers' associations) is limited. Linkages between PROLANIS and other non-communicable disease programmes are weak resulting in poor complementarity.

- It is important for blended capitation-performance payment arrangements to strike a good balance between disincentives (reduced payment for poor performance) and incentives (higher payments for good performance).
- A single national threshold for the target for performance payments does not account for different provider capacities across regions or promote gradual improvements to ensure quality and promote equity in access and quality and can thus be perceived as a demotivating penalty. Facility or regional specific thresholds may better promote performance and recognize effort.
- Comprehensive monitoring and independent evaluation are critical to identify improvements made to the processes of patient care to provide better incentives for providers.
- Purchasing arrangements to improve care for patients with chronic conditions should be better integrated into other national programmes for chronic disease management to avoid duplication and inefficiencies in service delivery.

This policy brief is based on Nappoe SA, Djasri H, Kurniawan MF. *Chronic disease management programme (PROLANIS) in Indonesia: case study*. Geneva: World Health Organization, Organisation for Economic Co-operation and Development; 2023.

## Value Care Team model in South Africa: small-scale pilot of performance-based capitation for better quality primary care

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### Summary

- The PPO Serve value-based care (VBC) pilot of its Value Care Team (VCT) model began in September 2019 and currently covers 5620 patients in Pretoria North, Gauteng province, South Africa. It is funded by the Government Employees Medical Scheme (GEMS), a closed, private voluntary insurance scheme for civil servants.
- The model aims to overcome the limitations of fee-for-service (FFS) payments, including supplier-induced demand, unnecessary admissions, and poor coordination and measurement of outcomes. It also aims to shift care to the primary setting to reduce hospital admissions and length of stay.
- The four components of the model include a multidisciplinary health provider team, a comprehensive risk management strategy, an information technology tool that triggers health interventions, and a contract between GEMS and PPO Serve that specifies a risk-adjusted capitation payment and a quality-based payment for providers.
- The average monthly payment is approximately 115 South African rand (US\$ 7.20) per patient, similar to the average FFS paid by GEMS to the practices. The performance payment is based on quality scores, ranging from 0 to 100 and multiplied by a baseline remuneration amount of 140 South African rand (US\$ 8.80). The best performing health providers receive approximately 240 South African rand (US\$ 15.00) per patient monthly. It amounts to 25–33% of a provider's income.

- No formal evaluation has been done. Trend data in 2021 indicate shorter hospital length of stays and fewer admissions, and higher rates of surgical admissions.

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### Key elements of the programme

- The local multidisciplinary team (MDT) is managed by a PPO Serve coach with a group of four general practitioner (GP) practices, involving some 17 GPs, three nurse care coordinators, and other allied health care professionals.
- A contract between the insurer and PPO Serve uses a performance-based capitation payment. The capitation payment is adjusted to account for the volume of patients and disease burden. Additionally, providers receive a performance payment.
- A comprehensive risk management strategy helps to identify individual and population risks and their associated clinical and social interventions.
- The Intelligent Care System (ICS) collates data from insurers and clinicians and generates operational and performance reports to drive continual improvement efforts and trigger proactive intervention tasks in care plans.

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## Results

- No formal evaluation has been done. Trends in 2021 suggest declines in hospital admissions and length of stay. The surgical admission rate was 20.5% higher than expected. Aggregated scores of performance quality for all GP practices showed a positive trend. However, some metrics were unchanged.

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## Facilitating factors

- The ICS, an integrated electronic information system that includes patients' records, facilitates continuity of care among providers, facilities and the funder. It forms the backbone of the VBC approach in which the measurement of quality (in this case, processes and outcomes) is critical for performance-related payment.
- GEMS is willing to experiment with VBC models.

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## Inhibiting factors

- The Value Care Team model's population is only a fraction of each provider's practice, which hampers the ability to drive population-level change. The focus on a small geographical area meant that appropriate providers were difficult to find, apart from nurse care coordinators.
- Small scale pilots imply higher implementation costs; efficiencies and cost savings from a large volume of care have yet to be realized.
- The effective functioning of the model relies on effective clinical leadership of the MDT and on providers who are interested in adapting their processes to improve care quality. The reluctance of providers to engage critically with performance reports hindered improvements in clinical practice.
- While the quality-linked payments are a significant proportion of reimbursement on the level of the individual patient, the low patient volume and the small scale of implementation meant that these incentives were insufficient to drive changes in providers' behaviour.

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## Lessons learned for other settings

- The regulatory environment in which a VBC model is employed must be conducive to developing alternative purchasing arrangements as well as service delivery. This includes regulations that govern fee-sharing and multidisciplinary teamwork.
- Capacities in leadership and governance for both clinicians and managers are critical. These include skills and knowledge about improving care quality, service delivery models and team management.
- Integrated and robust information systems that can follow a patient throughout their care journey are necessary for improving quality outcomes as well as preventing unnecessary or duplicated care. Additionally, automating the delivery of certain alerts and services to both providers and patients decreases the possibility of missed opportunities for care.

This policy brief is based on Smith A, Mosam A. *Value Care Team model in South Africa: case study*. Geneva: World Health Organization, Organisation for Economic Co-operation and Development; 2023.



## Combining global budgeting with other purchasing instruments to strengthen the quality of chronic care in Spain

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### Summary

- Global budgeting and framework agreements normally used to purchase services in the Spanish National Health System do not provide sufficient incentives to improve care quality. As such, regional governments have implemented a range of initiatives that aim to deliver integrated person-centred care, promote value through providing appropriate care for high-need patients and improve health outcomes for patients with chronic illnesses.
- Integrated Health Care Organizations, phased in from 2010 to 2016 in the Basque Country, cover 2.2 million people with a special focus on patients with chronic disease. The population's risks are identified, and services and access conditions are specified under a framework agreement that includes a risk-adjusted global budget.
- The Strategy on Integrated Care for Patients with Chronic Conditions and Multimorbidity, implemented in 2013 in Navarre, covered approximately 3500 high-need patients. A risk stratification tool is used to determine the appropriate services to be purchased at each level of the health system (i.e. primary, secondary or tertiary) under a global budget.
- In 2014, the Regional Health Department in Aragon implemented the Plan for Integrated Diabetes Care; by 2021, 94 000 patients had been enrolled. Global budgeting is complemented with guidance identifying which high-value services and from which providers care should be purchased, specifying rules for referring patients.

- No formal evaluations have been done. Monitoring data from early during implementation show trends towards reducing avoidable hospitalizations in the Basque Country and Navarre and increasing the utilization of targeted services in Aragon.

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### Key elements of the programme

- Global budgeting and framework agreements between Regional Health Departments and health facilities were blended with other purchasing instruments to target patients with chronic disease and the need for high-value services.
- Risk stratification was used in the Basque country and Navarre to identify patients at highest risk and the most appropriate services for addressing their care needs.
- Health information systems were used extensively for monitoring and for informing programmatic decisions.

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### Results

- In the Basque Country, trend data indicate a reduction in potentially avoidable hospitalizations, hospital admissions and emergency department visits. Patients reported good coordination between care levels and with social services.
- In Navarre, trend data showed reductions in emergency department visits and specialist consultations and an increase in outpatient visits, with a smaller increase in their average annual cost of care compared to the matched control group.

- In Aragon, trend data showed an increase in the utilization of targeted services critical to people with diabetes, including foot and eye examinations, and reductions in avoidable hospitalizations.

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## Facilitating factors

- Political agreements to implement integrated care were translated into binding strategic plans and dedicated resources.
- Fit-for-purpose information systems and the deployment of electronic health infrastructure allowed for data collection and sharing across care levels. Health information systems enabled monitoring of implementation and supported managerial and clinical decision-making across different care levels.

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## Inhibiting factors

- The lack of complete mutual trust and recognition between primary care and hospital care professionals hindered the implementation of purchasing mechanisms for integrated care that were meant to define referral rules and role-shifting between primary care and hospital care.
- The rigid legal framework for allocating resources to hire civil servants (e.g. doctors and nurses) does not sufficiently address the required competencies for developing new roles. In particular, the resourcing of professionals relies more on the length of their professional careers than on the specific competencies required to care for chronic patients. As a result, the need for highly qualified professionals may not be met.

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## Lessons learned for other settings

- Successful implementation of purchasing instruments requires wide consensus and commitment, as well as professional leadership from the main actors, including health professionals, technical staff and executive managers.
- Strong regulatory instruments can facilitate implementation, but they do not guarantee sustainable change towards integrated care, which is key to maintaining institutional and professional commitment.
- Fit-for-purpose information systems are key to foster improvements in the quality of care. These allow for clinical follow up across care professionals and all levels of the system, continual clinical and organizational learning and the continual evaluation of purchasing policies. Investments in technological infrastructure are required.

This policy brief is based on Bernal-Delgado E, Angulo-Pueyo E. *Purchasing arrangements to strengthen the quality of chronic care in three Spanish autonomous communities: case study*. Geneva: World Health Organization, Organisation for Economic Co-operation and Development; 2023.





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