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Provider perspectives on financing primary health care for universal health coverage

Published Online
April 4, 2022
https://doi.org/10.1016/S2214-109X(22)00173-5

See The Lancet Global Health Commissions page e715

Health is seen as complete physical, mental, and social wellbeing, with good quality primary health care (PHC) characterised as first-contact care that is comprehensive, continuous, and coordinated.[1,2] Universal health coverage (UHC) must be linked to service delivery that is organised around people's needs, integrating public health with primary care and including the private sector. Unfortunately, many health systems, especially in low-income and middle-income countries (LMICs), are still centralised and bureaucratic. In reorganising PHC, African health-care providers such as myself feel it is vital to bring care closer to people, with an empowered PHC team taking care of a well-defined population.[3] There are many challenges in doing this.

Providers feel that political commitment to PHC is not reflected in the funding of PHC—as if it can be done on the cheap. I therefore agree with the conclusions of the *Lancet Global Health* Commission on financing primary health care[4] that funding and investment need to be increased and payment systems reorganised. Funds need to directly reach the PHC team on the ground without being waylaid by layers of managers and interests in between. Pooling of funding, including from donors, not only addresses equity but also reduces fragmentation of funding and service delivery. Adjustments in capitation rates (ie, the amount paid to a provider to cover all services for a patient) can target equity—eg, by considering high-risk groups and the multimorbidity, rurality, or socioeconomic status of enrollees. Systems with centralised budgets nominally allocated to facilities make services unresponsive to the population served. Nationally defined mixed or blended capitation contracts offer great opportunity for PHC because enrollees can vote with their feet and change providers if they do not receive good quality care. A dominantly per-capita payment system is better suited to the complex biopsychosocial nature of PHC, which includes important elements of service that are hard to reimburse—eg, teamwork, community work, group work, or health promotion—than are fee-for-service payments.

Primary care providers struggle with the poor definition of primary care services within many LMICs, resulting in difficulty measuring the financial and human resource allocations needed. PHC services, especially the primary care service delivery platform, needs to be defined well and with ringfenced resources. The number of doctors, nurses, and other members of the PHC team available in the country is often not easily or reliably available. To compound the issue, governments often do not take their stewardship role over the private sector very seriously and have not created systems to measure the total number of professionals across the country, with planning merely based on public health service "shortages".

Private health services are a threat to public services in many LMICs because they grow exponentially when populations are disaffected by what they see as a poor service in the public sector, further drawing out human resources into the private sector. Turning this back can be extremely difficult, but the situation offers a great opportunity if governments get ahead of the curve. Pooled funding, strategic purchasing, and mixed capitation payment systems not only create efficiencies in the public health service, but also draw the private sector into this more regulated environment, provided governments embrace a systems approach. Such systems can include private providers, services, and administrators but require less bureaucracy and a greater focus on simple outcomes.

A project by the South African National Treasury to test the feasibility of private general practitioner (GP) capitation contracting for the planned National Health Insurance (NHI) system in South Africa produced a design based on global best practice and consultation with the private sector. The project was reoriented to suit both public and private providers but using a bottom-up approach in contrast to current NHI plans for PHC. The plan started with a country estimate of the core of the PHC team: doctors, nurses, clinical associates, and community health care workers (CHWs). It was estimated that a minimum team of one doctor, five nurses or clinical associates, and ten CHWs could care effectively for a panel of 10 000 patients. Enabling this would mean adding one doctor to public clinics and mostly solo GPs adding a team to their practices. With around 14 000 GPs and 1000 public medical officers in PHC in South Africa, just 6000 would cover the country's population of 60 million in a nationally defined mixed capitation contract, easily administered through private administrators in tendered markets across

provinces in South Africa. Just 3000 GPs contracted could alter private sector dynamics, with knock-on effects to the costing of the overall NHI.[5]

In this design, the PHC team (with an accountable doctor) is contracted, after accreditation, to provide services to up to 10 000 enrollees from within a district. Capitation payment covers all visits, estimated at an average of four per year based on private sector experience. Capitation payment dominates (at 70% of resource envelope), with rates adjusted for equity; medicines, investigations, procedures, and a range of preventive services are paid by a defined fee-for-service (at 20% of resource envelope); and an estimated 10% of resource envelope is allocated to payment of a performance management plan laid out over 5 years, to create a predictable change plan that progressively embraces electronic health records in a market-based system with interoperability requirements. Risk mitigation strategies need to address risks providers face, including high visit rates.[6] These can be addressed with a strong community-oriented primary care approach, based on work in Soweto.[7] Management of risk for GPs, especially growth in organisational size, needs to be managed with progressive growth of the minimum 2000 panel size. Moral hazard, which might result in patients being denied access or over-referral, needs to be addressed through defined referral pathways, peer review, and training in family medicine.[5]

This design is informing the position by PHC team members across Africa, organised through the African Forum for Primary Health Care. Although countries across Africa differ in the availability of resources, the model of PHC teams taking care of defined populations is still relevant, with ratios of PHC team members to populations needing to be worked out per country. A key question is how governments and global organisations are helping PHC providers to explore such solutions where frontline health-care providers, especially professionals, are treated with respect and empowered to produce results in PHC as they are trained to. Forcing providers into capitation with low rates is a poor strategy. Instead, as Aneurin Bevan, in successfully overseeing the creation of the National Health Service in the UK, was quoted to say: “I stuffed their mouths with gold”.[8]

For the **African Forum for Primary Health Care** see https://afrophc.org/

I declare no competing interests.

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