ASIA & THE PACIFIC HEALTH FINANCING FORUM

Health Financing for Service Delivery Redesign

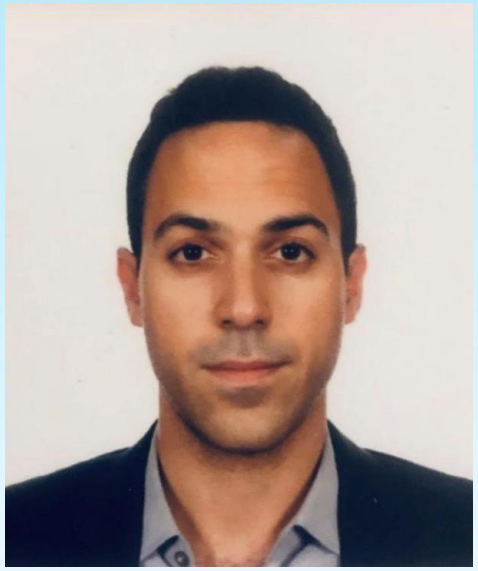
Financing Primary Health Care: Opportunities at the Boundaries

September 15-16, 2022
Bangkok, Thailand

Co-hosted by: WORLD BANK GROUP, Australian Aid, GLOBAL FINANCING FACILITY, USAID FROM THE AMERICAN PEOPLE

Supported by: The Global Fund, Joint Learning Network, Gavi The Vaccine Alliance, Bill & Melinda Gates foundation

Moderators



Dr. Ali Hamandi
Economist, World Bank

Dr. Supriya Madhavan
Senior Heath Specialist, World Bank

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AGENDA

Agenda Item	Speaker
Setting the Stage: Overview of SDR (7-8 min)	Mickey Chopra, Global Lead in Service Delivery, World Bank
Risk-Stratification in India (7-8 min)	Marion Cros, Senior Economist, World Bank
Financial Incentives for SDR (10 min)	Ellen Van De Poel, Senior Economist, The Global Financing Facility
Country Experiences (40 min)	*Cambodia*: **Youk Sambath, Secretary of State, Health** *Bangladesh*: **Habibe Millat, Honorable Member of Parliament** *Afghanistan*: **Habibullah Ahmadzai, Senior Health Specialist, World Bank** *Bhutan*: **Tshering Wangdi, Senior Planning Office, Policy and Planning Division, Ministry of Health** *Indonesia*: **Lily Kresnowati, Director, Health Service Assurance, BPJS-K (National Health Insurance Agency)** Moderator: Supriya Madhavan, Senior Health Specialist, the Global Financing Facility
Q and A and Closing Remarks (25 min)	Ali Hamandi, Economist, World Bank

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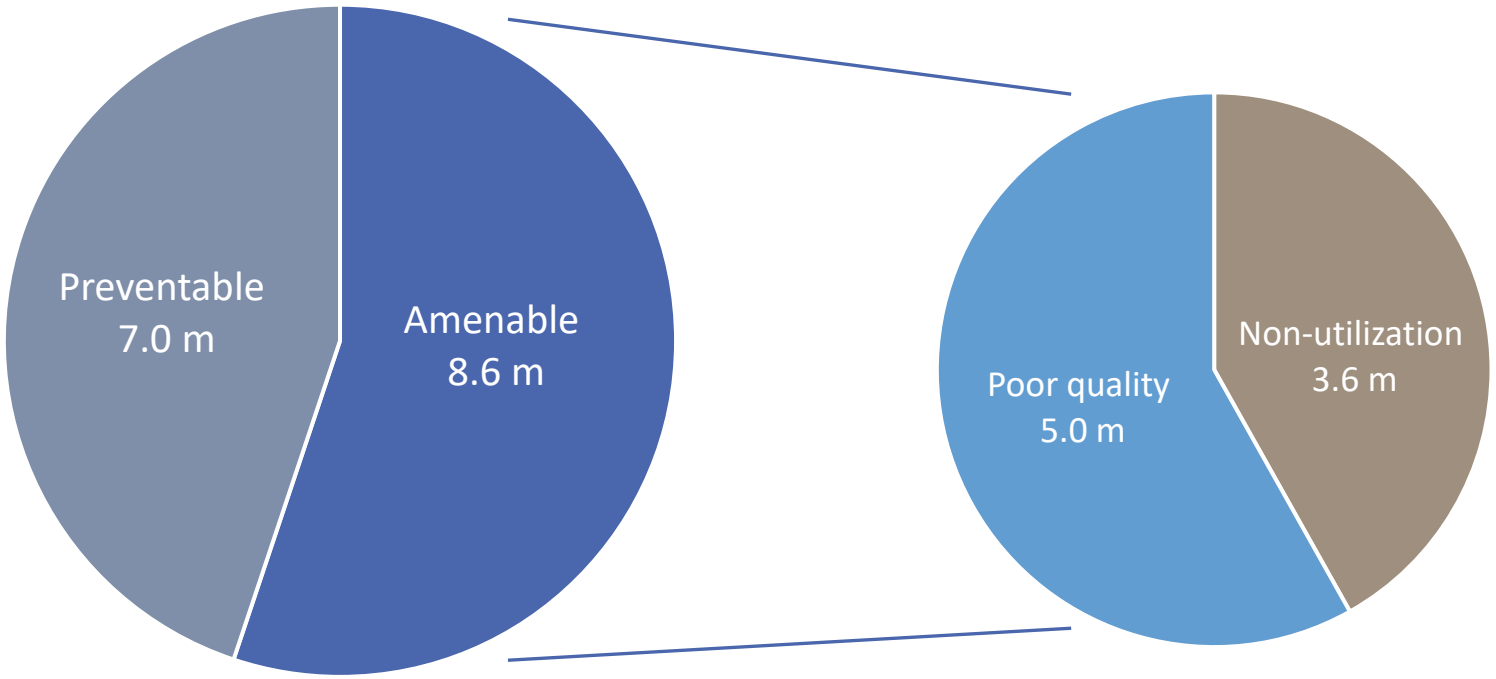
Service Delivery Redesign: Setting the Stage

Mickey Chopra

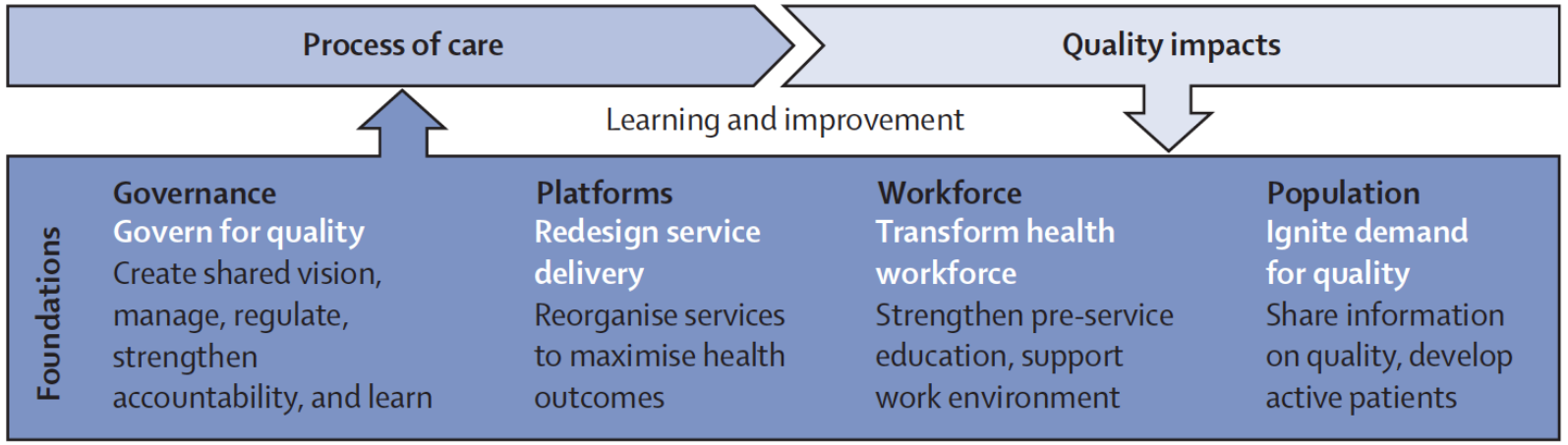
In 2018, the Lancet Global Health Commission on High Quality Health Systems concluded that high quality health systems could save 8.6 million lives each year in low- and middle-income countries



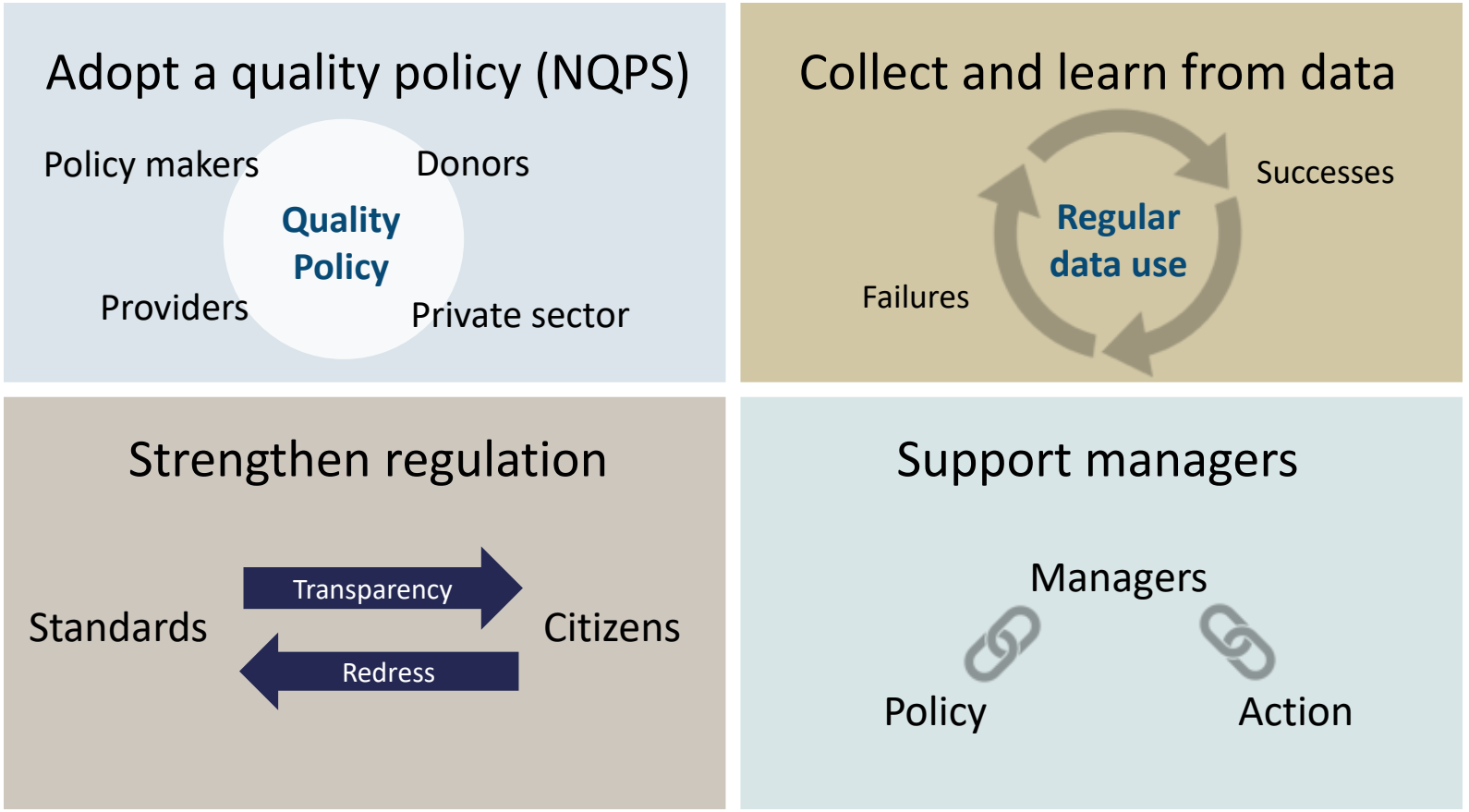
5 million deaths are due to poor quality among people using care

Lancet Commission recommended four **universal actions** for improving quality at scale

1. Govern for quality
2. Transform health workforce
3. Ignite demand for quality
4. Redesign service delivery



1. Govern for quality



2. Transform the Workforce

1. Shift away from in-service training-only approaches, which have modest effect sizes and decay with time, and towards pre-service education reforms and learner-centric approaches to performance improvement

2. Create an enabling environment for health workers to meet their potential

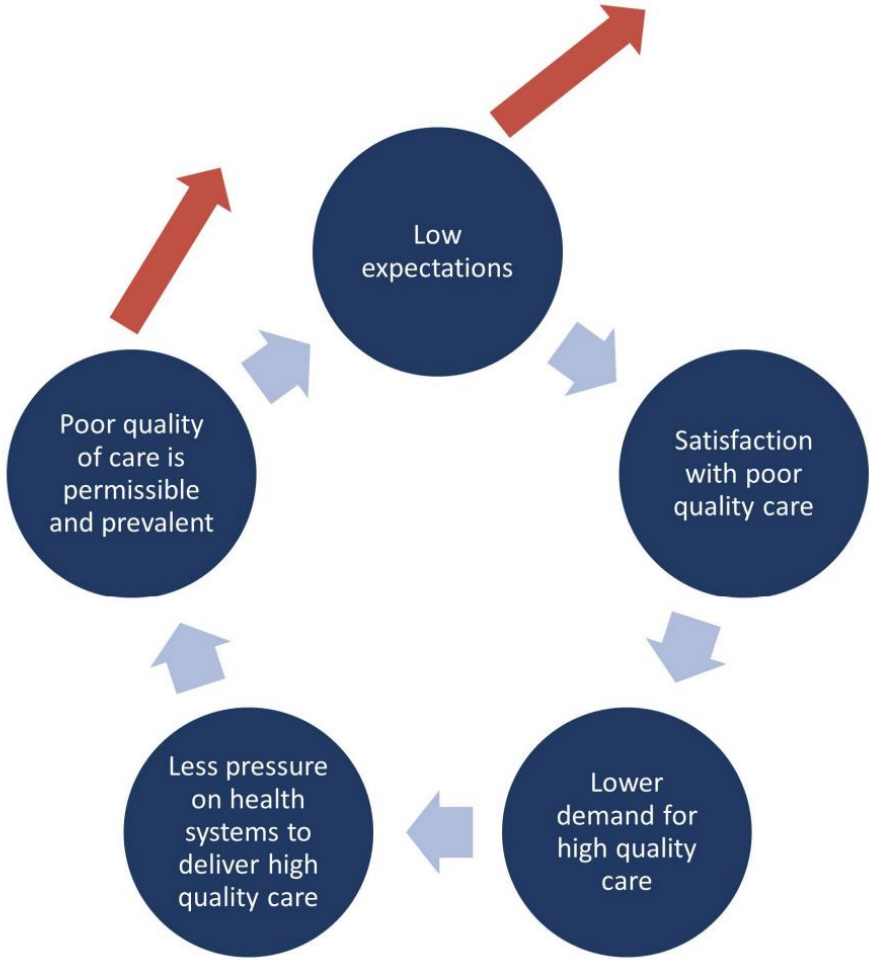
	Training only	Training plus supervision	Supervision only	Printed information or job aid
Absolute percentage point change in provider performance	9.7	17.8	11.2	1.5
Total number of studies	76	26	16	8
Average number of health facilities in intervention group	6	7	7	8
Median duration of study follow-up	4.0 months	4.5 months	5.0 months	1.9 months

Rowe AK, Rowe SY, Peters DH, Holloway KA, Chalker J, Ross-Degnan D. 2018. Effectiveness of strategies to improve health-care provider practices in low-income and middle-income countries: a systematic review. *The Lancet Global Health*

3. Ignite demand for quality

Raise expectations of quality and support patients to become active agents

1. Quality reporting
2. Community monitoring
3. Participatory women's groups

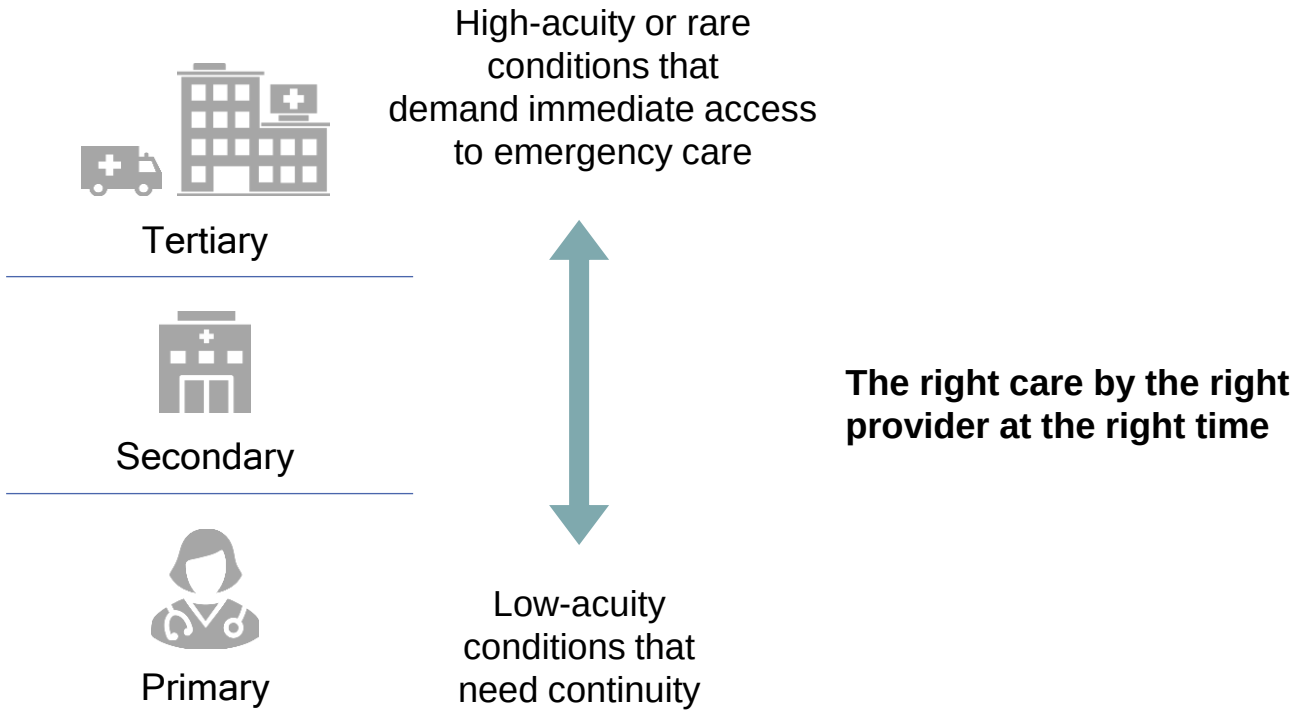


Roder-DeWan S, Gage AD, Hirschhorn LR, Twum-Danso NAY, Liljestrand J, Asante-Shongwe K, Rodriguez V, Yahya T, Kruk M 2019 Expectations of healthcare quality: A cross sectional study of internet users in 12 low- and middle-income countries. PLOS Medicine

4. Redesign Service Delivery

Service Delivery Redesign (SDR) is the intentional reorganization of a health system to improve quality and outcomes

Reorganization may include where services are delivered (geographically or by level of the health system), when services are delivered, and by whom



For maternal and newborn health services, SDR means that all women have access to comprehensive emergency obstetric and newborn services within 30 minutes of place of birth

Danilack, V. A., et al. Unexpected complications of low-risk pregnancies in the United States. Am J Obestet Gyencol. 2015.
Gabrysch S. et al. Does facility birth reduce maternal and perinatal mortality in Brong Ahafo, Ghana? A secondary analysis using data on 119 244 pregnancies from two cluster-randomised controlled trials. Lancet Glob Health. 2019
Kruk M, et al. High quality health systems—time for a revolution: Report of the Lancet Global Health Commission on High Quality Health Systems in the SDG Era. Lancet Global Health 2018.
Roder-DeWan S, et al Health system redesign for maternal and newborn survival: rethinking care models to close the global equity gap BMJ Global Health 2020

For low-acuity services SDR means moving services from hospitals to primary care

- Best for conditions requiring frequent visits and nuanced understanding of socioeconomic context
  - Non-communicable disease chronic care management
  - HIV maintenance care
  - Antenatal care
- Rationalizes the health system by decongesting hospitals
- Improves adherence and follow-up by decreasing geographic access barriers
- Reduces costs by limiting expensive hospital care

Borgen Magazine

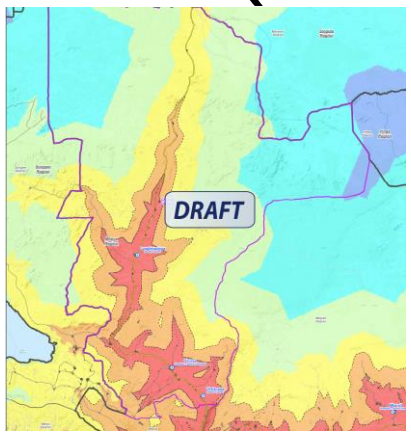
MNH SDR by upgrading health centers (Tanzania)

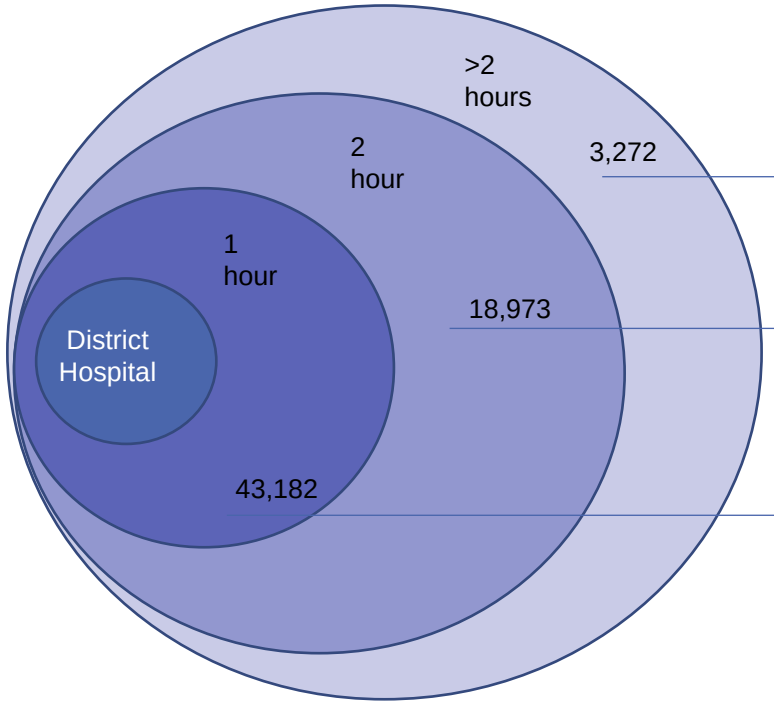
- Thamini Uhai and Government of Tanzania
- Expanded access to comprehensive emergency obstetric services within 30 minutes by **upgrading health centers** in remote areas of Tanzania
- Majority of providers were nurses and associate clinicians
- 40% increase in met need for emergency obstetric and newborn services
- 33% decrease in direct obstetric case fatality rate

Dominico S, et al.Comprehensive Approach to Improving Emergency Obstetric and Newborn Care in Kigoma, Tanzania. Glob Health Sci Pract. 2022

MNH SDR by optimizing existing resources (India)

- Meghalaya Government and World Bank
- Ensuring that existing advanced MNH service facilities are working to capacity
- Expanding capacity at these sites using near-site midwifery-led units
- Improving access through targeted interventions based on geographic accessibility data





Emergency transport

Maternity waiting options for all women

Urgent transport for women in early labor

Emergency transport

Maternity waiting options for high risk women

Routine transport where possible

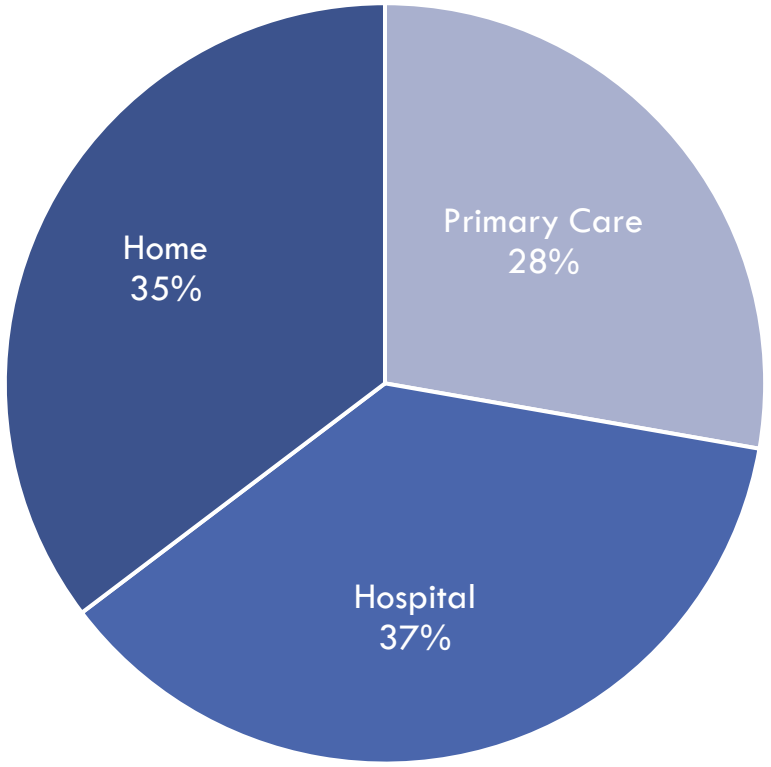
Urgent transport for multiparas in early labor

Emergency transport

MNH SDR by centralizing childbirth care (Kenya)

- Jacaranda Health, Harvard Public Health Pilot and County Government
- Goal is to shift all births to hospitals and reduce the number of facilities offering childbirth care
- Interventions
  - Increase and improve capacity of HR
  - Ensure all delivery hubs have access to blood
  - Strengthen health financing
  - Improve infrastructure and equipment
  - Improve transportation and access
- Robust implementation research and impact evaluation underway

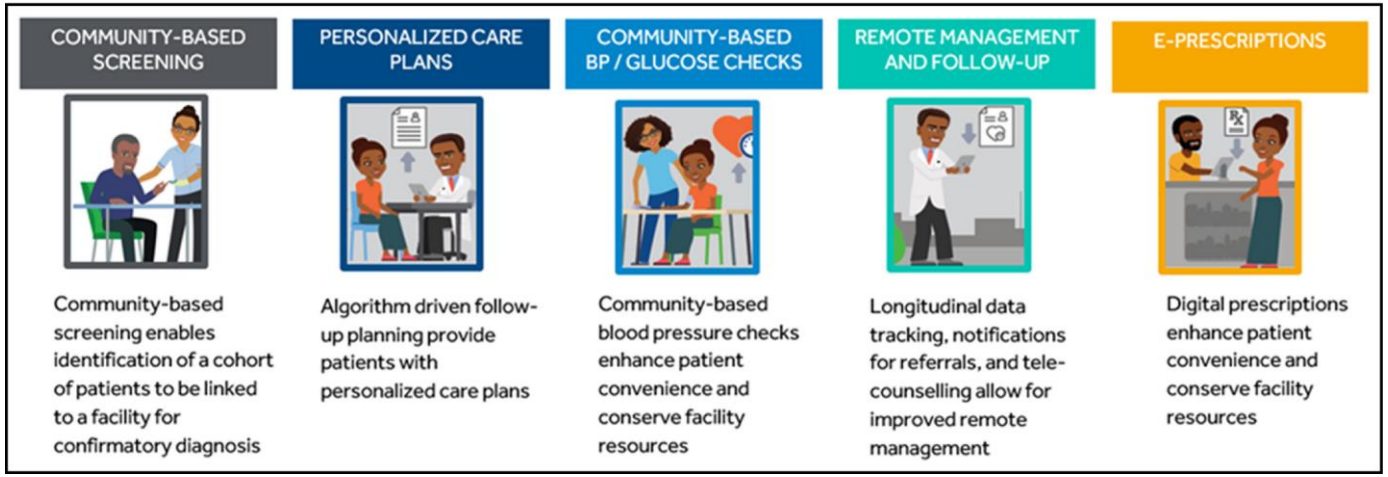
Distribution of 70,000 deliveries in Kakamega County in 2018



86% of facilities in country perform fewer than 30 births/month

PHC SDR by shifting low-acuity services into the community (Ghana & Kenya)

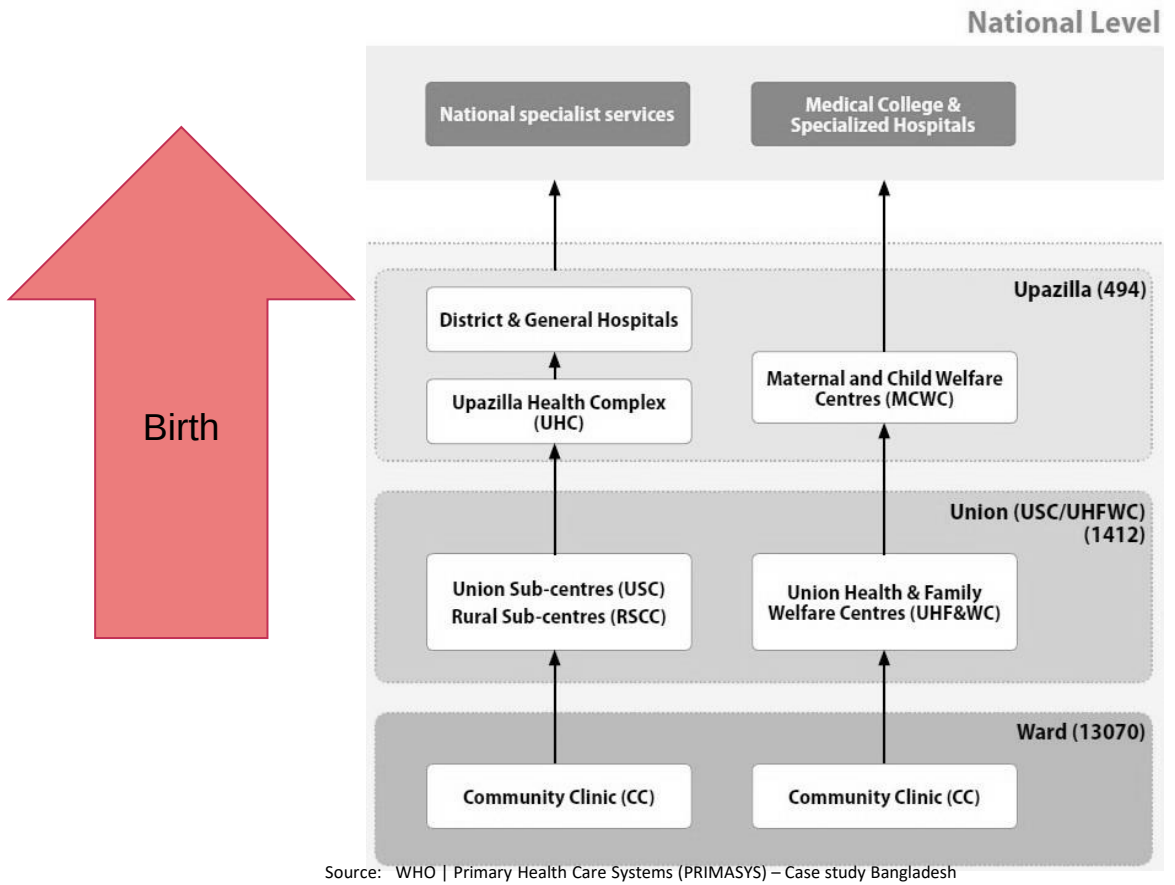
- Medtronic international consortium
- Goal was to increase access to and improve quality of chronic hypertension services
- Personalized care planning
- Community-screening and follow-up
- Remote management and e-prescriptions
- Proportion of patients with control blood pressure increased from 46% to 76% in 12 months



Otieno, HA, Miezah, C, Yonga, G, et al. Improved blood pressure control via a novel chronic disease management model of care in sub-Saharan Africa: Real-world program implementation results. *J Clin Hypertens*. 2021

PHC SDR by swapping services (Bangladesh)

- Government of Bangladesh and World Bank
- Rationalize rural Upazila Health system by increasing births in CEMONC facilities and decreasing routine NCD care in hospitals
- Pilot under-development and designed to inform next health sector program



Source: WHO | Primary Health Care Systems (PRIMASYS) – Case study Bangladesh

HEALTH FINANCING *for* SERVICE DELIVERY REDESIGN:

Risk-Stratification for Improving Birth Outcomes in India?

Marion Cros (Senior Economist) & Ajay Tandon (Lead Economist)
Global Practice on Health, Nutrition, Population, World Bank
September 2022

WORLD BANK GROUP

Lots of Major Health Reforms Happening in India

2005

Janani Suraksha Yojana (JSY)
Conditional cash transfer program under National Rural Health Mission (NRHM) for promoting institutional deliveries

2008

Rashtriya Swasthya Bima Yojna (RSBY)
Tax-financed non-contributory health insurance for the poor for inpatient care introduced by Ministry of Labor & Employment

2011

Janani Shishu Suraksha Karyakaram (JSSK)
Entitles all pregnant women delivering in public health institutions to free delivery, including C-section, free transport from home to institution, between facilities in case of a referral and drop back home

2015

RSBY
Administration of RSBY transferred to Ministry of Health & Family Welfare

2016

Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA)
All pregnant women in the country provided fixed day, free of cost assured and quality ANC at public facilities

2018

Surakshit Matritva Aashwasan (SUMAN)
Provide assured, dignified, respectful and quality healthcare at no cost and zero tolerance for denial of services for every woman and newborn visiting the public health facility in order to end all preventable maternal and newborn deaths and morbidities and provide a positive birthing experience

2019

Pradhan Mantri Health Infrastructure Mission (PM-ABHIM)
Pandemic preparedness and urban health and wellness centers

Ayushman Bharat
Two pillars: Health and Wellness Centers and Pradhan Mantri Jan Arogya Yojana (PM-JAY), the latter is the world's largest tax-financed insurance scheme

2021

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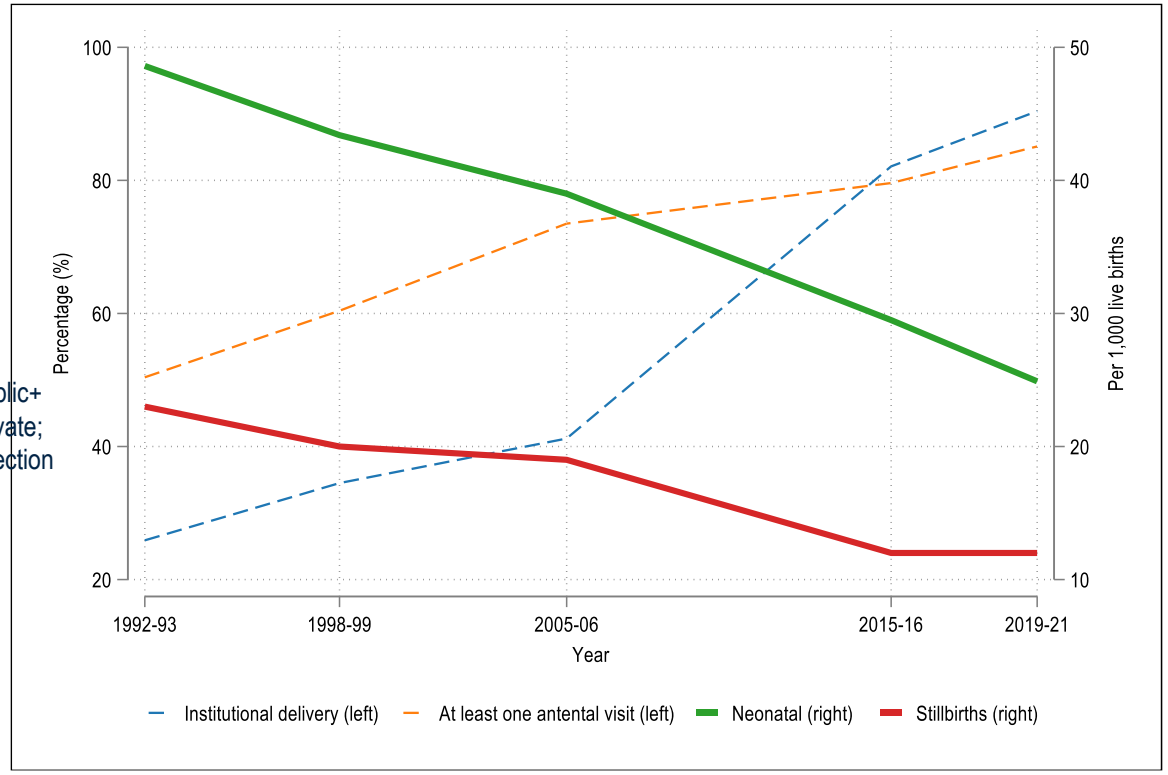
Huge Gains in Coverage in Recent Years…

Programs such as the National Health Mission have helped improve outputs, especially for RMNCH and infectious diseases

Variable	Value
ANC (at least one visit)	85%
ANC (4+ visits)	59%
Skilled birth attendance	89%
Institutional delivery rates	89%
Measles vaccination	88%
Neonatal tetanus vaccination	92%
Access to basic sanitation	69%

62% public+
27% private;
22% C-section



Maternal/child health, communicable diseases remain problems (MMR 103 per 100,000 live births; neonatal mortality 25 per 1,000 live births, stillbirths 12 per 1,000 live births, infant mortality 35 per 1,000 live births; non-communicable disease burden rising

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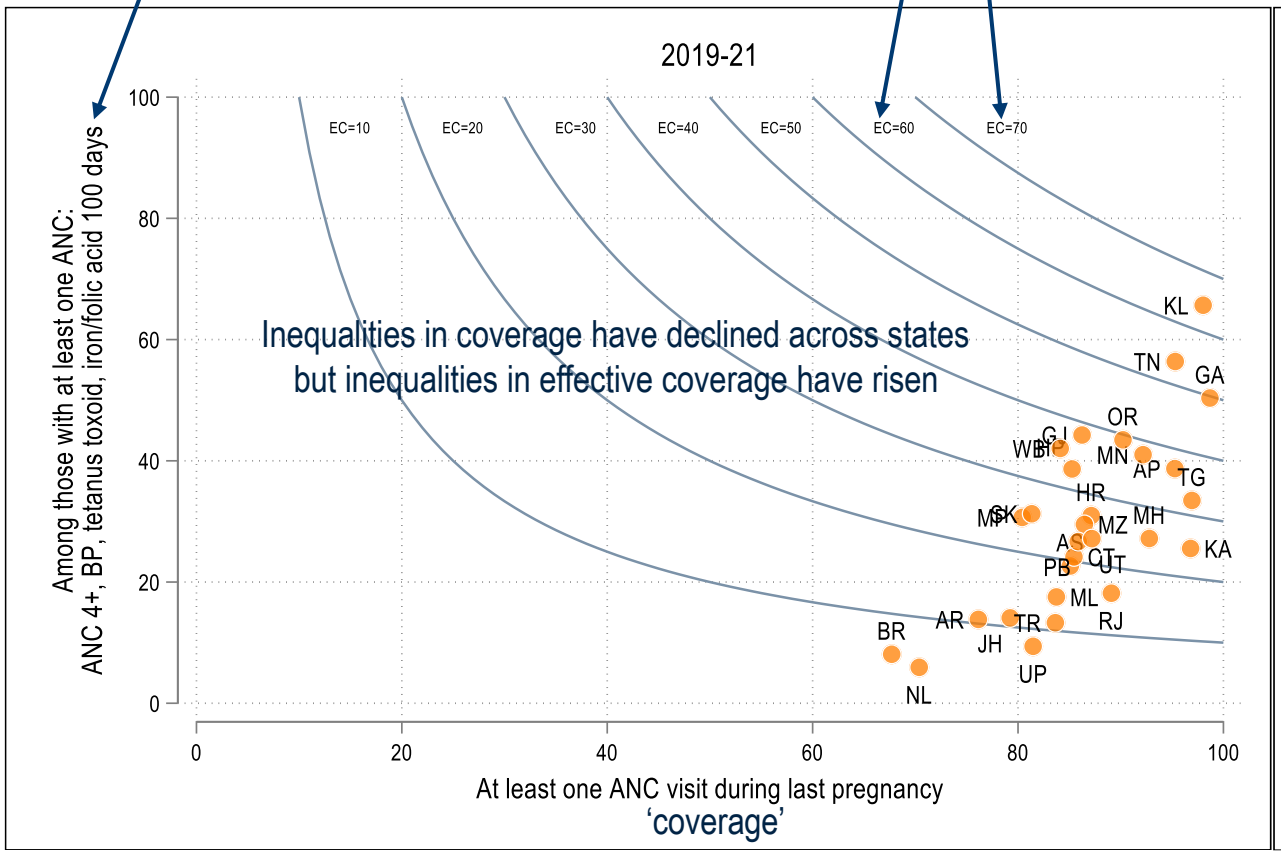
…But Effective Coverage Remains Challenge



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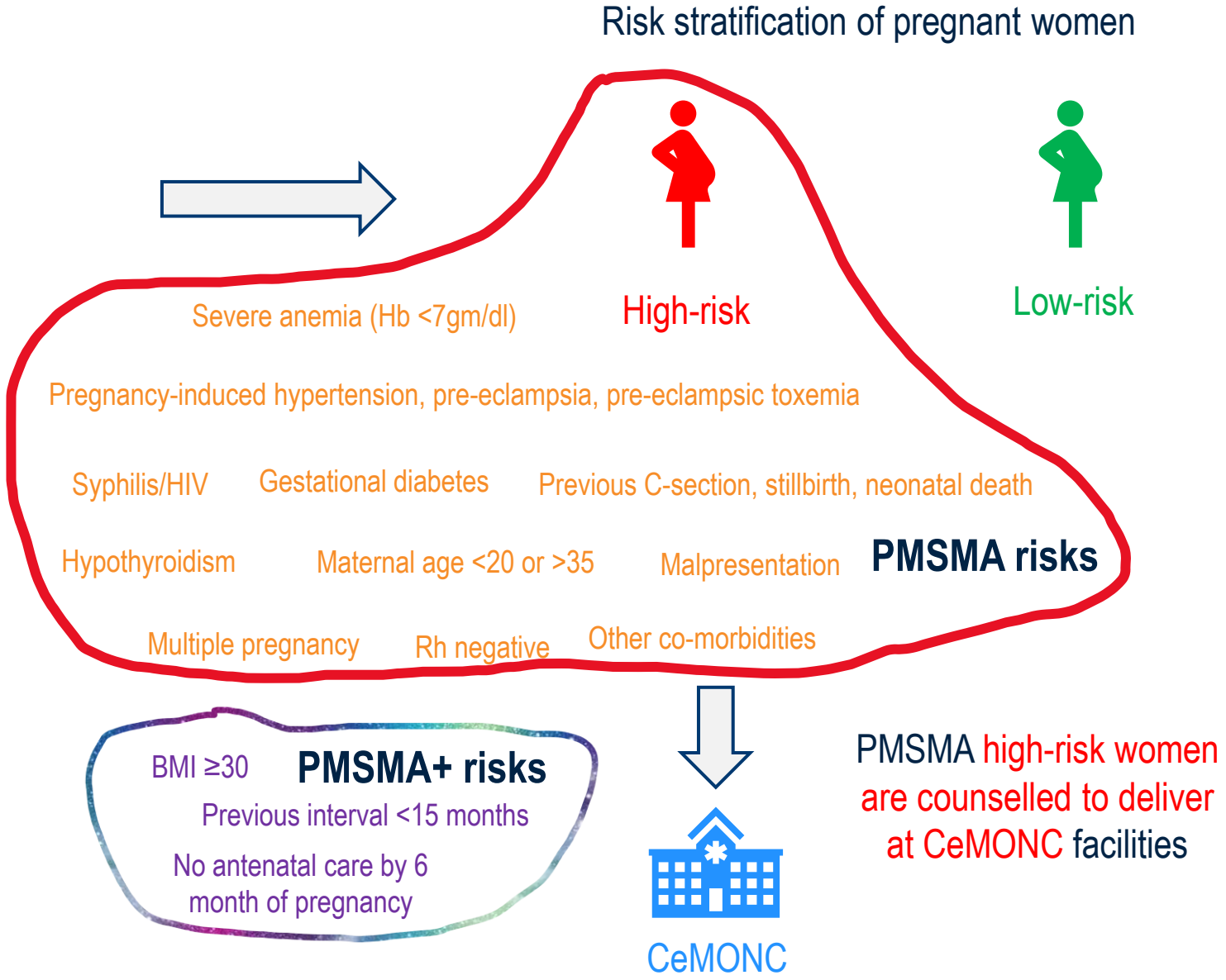
Risk-Stratification of Pregnancies Under PMSMA

Fixed-day facility-based antenatal care (9th of every month) in addition to routine antenatal care

Available at designated public health facilities: rural (primary health centers, community health centers, rural hospitals, sub-district/district hospitals, medical college hospitals); urban (urban dispensaries, urban health posts, maternity homes)

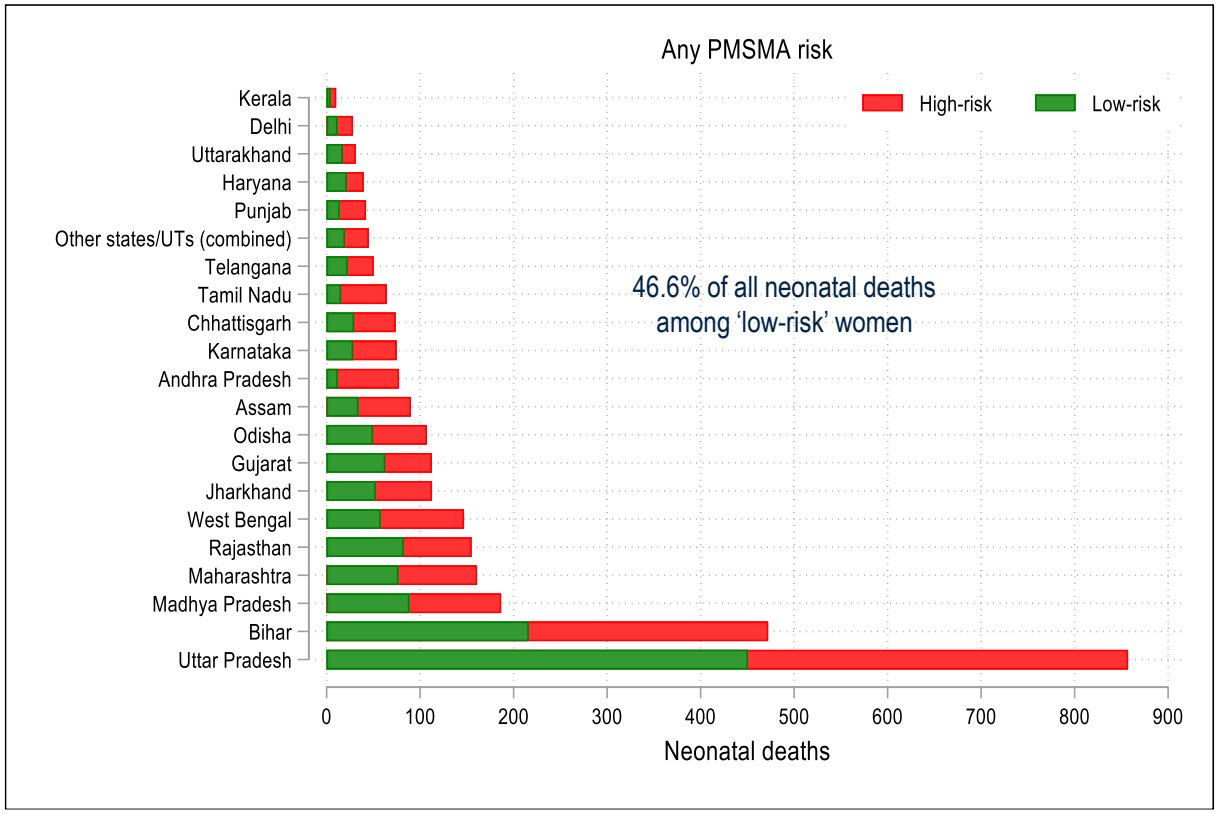
Includes accredited private facilities that have volunteered to participate

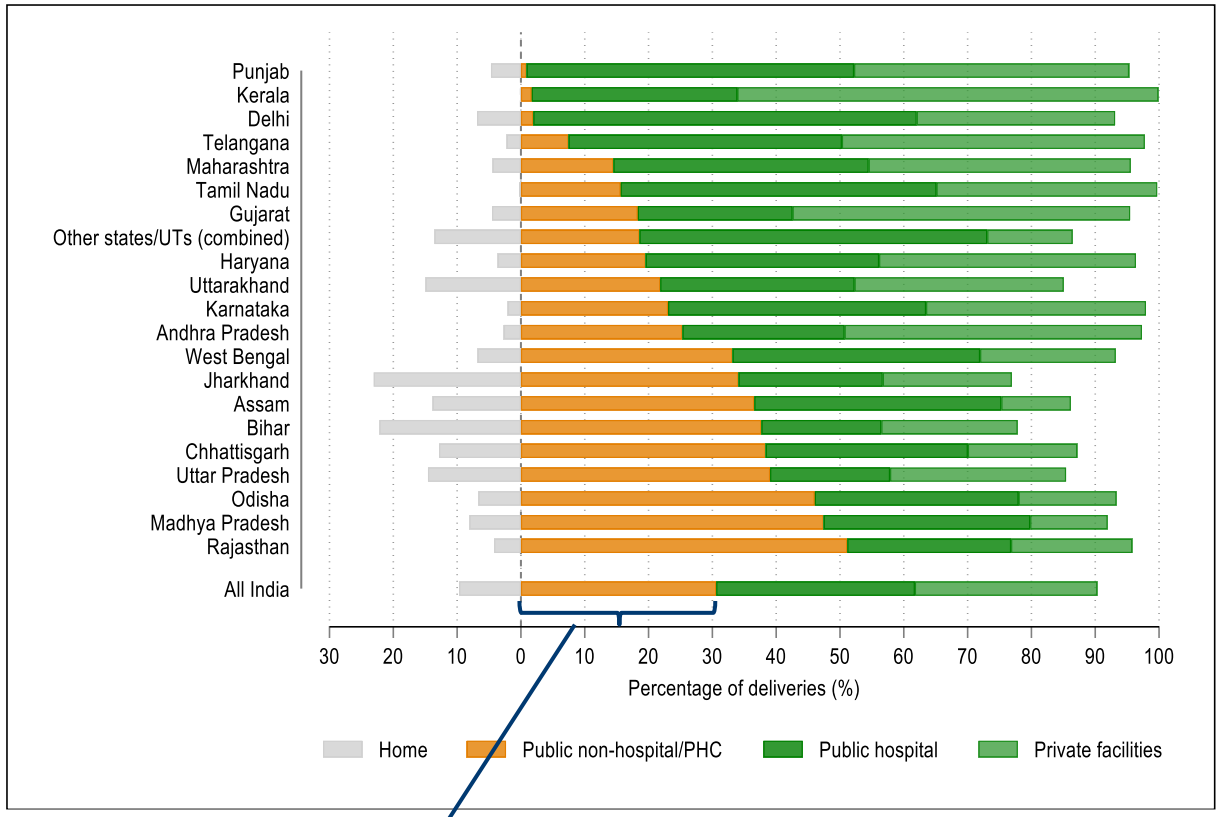
Ensure at least one antenatal checkup for all pregnant women in their second or third trimester by a physician/specialist, including by voluntary contracted-in private doctors



Almost Half of All Neonatal Deaths Among Low-Risk Pregnancies

Neonatal deaths are highest in states where deliveries occur at home/lower-level facilities





Lower-level facilities
(non CeMONC)

Summary/Key Messages

- India is undergoing major transitions: economic, demographic, epidemiological and implementing several major reforms in its health system.

- Unfinished agenda remains on maternal and child health and infectious diseases such as TB with a rising burden from chronic non-communicable diseases. Geographic, socioeconomic inequalities remain large, quality of care is lagging, and health financing remains inequitable and inefficient.

- For maternal and child health, coverage rates have improved but effective coverage lags: e.g., institutional deliveries have risen to almost 90%, but one-third of all births – especially among women from lower socioeconomic strata – are occurring at lower-level primary health facilities that lack access to comprehensive, emergency, maternal, obstetric, and neonatal care (CeMONC).

- Given impossible to predict risk of adverse birth outcomes at individual level, instead of risk stratifying women as is currently being done, it would be better if India considers a strategy where all births occur in or near CeMONC facilities, not just those that are 'high risk' using health financing reforms such as PM-JAY and JSY.

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FINANCIAL INCENTIVES FOR SERVICE DELIVERY REDESIGN

Bangkok, September 2022

What is specific about this?

HF agenda that incentives timely use of ANC and PNC at primary care facilities and deliveries at or near CEmONC facilities, while avoiding over-use:

- move from line item to more **strategic forms of purchasing**
- incentivize **quality** of care
- leverage **private sector** capacity for service delivery
- address **demand side barriers**

- What are we trying to redesign? Purchasing reform needs to respond to the underlying barrier:
  - Under- or Overprovision?
    - **Lack of/too much supply**
    - Lack of knowledge
    - **Know do gap**
    - **Demand side barriers**

Financing reforms to steer supply

- In many countries, resources follow supply (#hospitals, services provided) which perpetuates mismatch between need and supply
- Health insurance schemes risk exacerbating this

- SDR requires deliberate investments in supply of CEmONC facilities
  - E.g. Cote d'Ivoire is constructing 9 *poles of excellence*

Strategic purchasing

- Incentivizing efficiency at lower level through capitation for PHC package (ANC, PNC) + higher level care (delivery) when needed through DRGs but …
  - **Top up capitation with Fee-for Service** top up to avoid neglect of preventive services or increase timeliness (ANC)?
  - **Only reimburse** hospitals for deliveries and only reimburse PNC/ANC at PHC level
  - **Avoid over-use of C-sections** by including average (hospital-level) targets in performance formula

- Pay a **network of care** on the basis of outcomes and have the network figure out how and where to deliver care most efficiently
  - Incentivize midwives to refer deliveries to specific facility

Performance Based Financing

- **Promising early evidence of Performance Based Financing projects in low-income countries-- Rwanda, Burundi triggered a lot of experimentation with PBF with the goal to boost coverage of key MCH services**

- **Performance pay**: $12 for institutional delivery, $1.20 for ANC visit, $0.80 for child immunization (example from Nigeria) + Quality checklist
- **Operating budgets/autonomy**
- **Transparency/accountability**:
  - Facilities report performance on the purchased services– typically every month.
  - Payments based on these reports.
  - Third party audit of the reports, often every quarter.
- **Community engagement**: ward or village development committees attend facility management committee meetings

The bottom line: financial incentives should be used on the margin

- **Coverage**
  - In most contexts, some improvements
  - Nigeria: 15 pp increase in institutional deliveries (from 47%)!
- **Quality**
  - Largest impacts on quality of care are observed for structural quality. Cheaper alternatives?
  - Not entirely surprising given large gaps in facility infrastructure
  - Limited impacts of performance pay on clinical quality even with fewer competing constraints– US, UK

- **Flexible operating budgets and associated accountability measures can deliver gains by themselves**
  - Can avoid the additional costs and complexity of design of performance pay

Financial incentives to address demand side barriers

- Removing financial barriers increases utilization
- Even when services are free, conditional cash payment for CHW and women to deliver at facilities can be cost-effective (e.g. JSY)
- Strength lies in the appropriate combination of supply and demand side incentives
  - e.g. PBF found 4 times as effective when combined with vouchers in increasing institutional deliveries in Cambodia

- Leverage demand side incentives for SDR:
  - Make CCTs conditional on delivery in CeMONC facilities
  - Cover transportation costs

Challenges

- How to make the economic argument? Better PHC + reduced mortality + efficiencies -> what impact in fiscal space in 10 years?

- What if deliveries near CEmONC is not possible because of geographical and budget constraint
  - Maternity waiting homes? Limited success so far

- Having an insurance/purchasing agency in place facilitates strategic purchasing and have money follow patient rather than the provider level

- Bundled payment has high data/system requirements: knowing who uses what care with whom when and having resources flow between facilities
- Feasibility of paying for outcomes

- Human Resources – should midwives also move up in the system?

PANEL DISCUSSION

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QUESTIONS AND ANSWERS

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