

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

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recommended that at least 5% of the total capitation payment should be performance based; this recommendation was later withdrawn, leading to variations in the share allocated for performance-based pay.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.

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.

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.

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.

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.

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.