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# Intermediaries: The Missing Link in Improving Mixed Market Health Systems?

*A brief for leaders seeking to improve health systems*

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**The Center for Health Market Innovations (CHMI)** promotes the diffusion of programs, policies and practices that improve the quality and affordability of health care for the world's poor. Managed by Results for Development, CHMI works through regional partners around the world. Details on more than 1,400 innovative health enterprises, nonprofits, public-private partnerships, and policies can be found online at [www.HealthMarketInnovations.org](http://www.HealthMarketInnovations.org).

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# Background

Private health care providers often deliver the majority of care in many low- and middle-income countries. In these “mixed market” health systems, where government-provided health services operate side-by-side with private providers of care, patients often choose their providers based on perceptions of quality, affordability, and convenience. The private sector, which can include small scale providers, non-profit or for-profit health clinics, local pharmacies, traditional healers, and high-end multi-specialty hospitals, often fills in gaps in public sector delivery. While many of these models are responsive to patient demand and sometimes innovative, these private sector providers are also often not monitored and regulated in practice, leading to a wide variance of quality care at an individual facility level.

Within mixed market health systems, the structure of primary care markets tends to be especially fragmented, with numerous small-scale health providers – such as single provider clinics, drug shops, and informal providers – attempting to solve specific needs in the health system. With patients “shopping” around for care, it is rare for one provider to have complete information on a single patient in order to proactively coordinate preventative care and manage care across various levels (e.g. primary to secondary care) when needed.

A key driver of this fragmentation is the siloed nature of the public and private health sectors, which each generally operates in parallel utilizing different funding streams and rarely organized under a single stewardship framework or regulatory body. For forward-thinking policymakers who see potential for engagement with the private sector, in practice aligning incentives with hundreds of small scale providers is quite difficult to do. For instance, if a national government wanted to purchase care from private providers for its citizens (e.g. through empanelment in a national health insurance program, for instance), this would usually mean developing separate individual contracts for hundreds of small, single provider primary care clinics – no small feat.

Yet research by Results for Development’s Center for Health Market Innovations (CHMI) reveals an increasing recognition that “intermediary” models that enable government engagement with small, fragmented private sector players while helping to improve quality are important in managing and improving mixed health systems.

*While we recognize that the term, “intermediaries” may be used to describe a disparate set of organizations with various functions, we define the term here to mean: **organizations that form networks between small-scale private providers in order to interact with governments, patients, and vendors while performing key health systems functions that are challenging for individual private providers to do on their own.** These include proactive population management, quality improvement, management capacity, and integration into payment systems and universal health coverage.*

One such example of an “intermediary model” as defined above is the Christian Health Association of Malawi (CHAM), a network comprised of 180 church-owned health facilities. Rather than set up individual contracts with each of these 180 small scale private facilities, the existence of CHAM as an intermediary allows the Government to strategically purchase health services for its rural citizens through one Service Level Agreement (SLA) with CHAM, who then routes government funding to its network facilities -- while also maintaining quality through regular inspections and training on clinical guidelines. Access to public funding serves as an incentive for these small scale providers to ensure and improve quality; if a clinic fails to meet the standards of CHAM and the Ministry of Health and Population, the clinic loses its CHAM membership and therefore access to government funding. At a systems level, this arrangement reduces redundancies in the health delivery system, as the Government of Malawi need not construct public facilities where a CHAM health facility already exists. Since many low- and

middle-income countries already have a network similar to CHAM, one can begin to see the promise that an effective intermediary holds when it begins to move beyond networking and advocacy, into functions that incentivize the improvement of quality and integrate small scale providers into larger systems of payment.

Indeed this is but one example of how contracting with intermediary models can help health systems actors and leaders achieve their aim of ensuring accessible quality health care for all citizens. Research has revealed that intermediary models hold the potential to address the four major challenges of fragmentation inherent in mixed market health systems, namely:

1. Lack of proactive population management and continuity of care;
2. Lack of quality of care that is safe, effective, patient-centered, timely, efficient and equitable;
3. Lack of long term management capacity; and
4. Lack of integration of providers into larger systems for payment and universal health coverage (UHC).

While some existing intermediaries address elements of these challenges, rarely is it the case that existing intermediaries effectively address all key challenges. In this way, there is tremendous opportunity for policymakers, donors, and thought leaders to create an enabling environment that:

- 1) Encourages the creation of networks of providers, or "intermediaries", which enable small private providers to maintain their own identities, while also engaging collectively with the government. These groupings of providers make it easier for governments pursuing universal health coverage to engage with private providers as one group, rather than engaging one small clinic at a time, while also engaging intermediaries as partners to improve quality, proactively manage population health, and build management capacity.
- 2) Helps shape the market and incentivizes the strengthening of existing intermediaries to more effectively address the challenges of fragmentation through actions such as competitive bids, payment systems, and policy incentives.

# Approach

In 2015 the Center for Health Market Innovations, through support by the Bill and Melinda Gates Foundation, launched a research initiative to investigate the challenges caused by fragmentation in LMIC's and to better understand how "intermediary models" may play a more effective role in strengthening mixed market health systems. While recommendations stemming from that research initially focused on Nigeria, a country with a highly fragmented system of care, this article generalizes our findings in a way that is applicable for intermediaries, policymakers, and donors, who are interested in better understanding how to develop stronger intermediaries that more effectively address the key challenges of fragmentation.

Through in-depth research that identified over 120 intermediary models in low, middle, and high-income countries, we identified six different functions that a strong intermediary can perform to address the key challenges of a fragmented, mixed health system, namely:

## 1. **Lack of proactive population management and continuity of care:**

"Shopping" for health care has become the norm in many low- and middle-income countries, rather than having a single provider who feels ownership across a population of patients. Continuity of care systems are weak, often leading to a chasm between levels of care (e.g. primary to secondary) that is exacerbated by the absence of good information management systems.

Intermediaries in high-income countries, such as Southcentral Foundation's Nuka System of Care and Kaiser Permanente, support proactive population management through an integrated care team who is assigned a particular "panel" of patients, allowing the care team to see who is overdue for services and receive performance-based measures focused on quality and health outcomes.

## 2. **Lack of quality of care that is safe, effective, patient-centered, timely, efficient and equitable:**

Many health care systems globally lack national clinical standards that are reliably implemented consistently across all providers. Effective monitoring of these regulation and quality standards tends to be weak in many low- and middle-income health settings.

Intermediaries can play a role in improving quality by assessing providers based on quality standards, utilizing and training providers in their networks on clinical guidelines, and incentivizing around quality.

## 3. **Lack of long term management capacity:**

Small private providers often face barriers to access capital, as they are often seen as high-risk, low-return investments. This creates challenges in investing in innovative solutions, strong data systems, and management capability.

Intermediaries have the potential to invest in innovative solutions, such as IT and data systems for their providers, as well as encourage knowledge sharing amongst its providers. For instance, PurpleSource of Nigeria applies operational procedures and policies to management, as well as fosters knowledge sharing across its member clinics.

## 4. **Lack of integration of providers into larger systems for payment:**

Distrust for government and provider competition has left very little room for providers to recognize the benefits in being aggregated into larger systems for payment and procurement. This lack of integration results in challenges to providing care to patients with government or community health insurance, as well as prevents bulk-buying across a network of providers to help with ultimately reducing costs to patients.

Intermediaries can help by creating incentives (such as access to government purchasing of services) to group providers into a network to help enable utilization of private sector services for countries pursuing universal health coverage.

# Summary of Findings

Our research reveals **six key elements that an “ideal” effective intermediary has in order to successfully address the core challenges of fragmentation** addressed above:

1. **Proactive population management** by “matching” patients to a primary care team who anticipates their health needs
2. **Facilitating comprehensive care** so that every patient receives all the services they need across the preventive, promotive, and curative spectrum at the time they need it
3. **Providing effective systems for quality and quality improvement** in order to provide care that is safe, effective, patient-centered, timely, efficient and equitable
4. **Building management capacity** and enabling long-term investment in key areas for growth and quality, e.g. data systems
5. **Providing platforms for community engagement and patient partnership**, working alongside communities, patients, and caregivers
6. **Providing platforms for payment coordination and bulk buying** to help enable governments to purchase services and improve quality and equity

This list serves as a guidepost for policymakers who may wish to help develop intermediary models and/or strengthen existing ones, acknowledging that many existing intermediaries tend to focus on particular functions within this list. Within each of these key elements, we have provided two to three specific “promising practices” that put these ideas into action (all described in further detail below). By incentivizing the development and strengthening of intermediary organizations, mixed market actors have an important tool at their disposal in the creation of an “ideal” mixed market health system, in which:

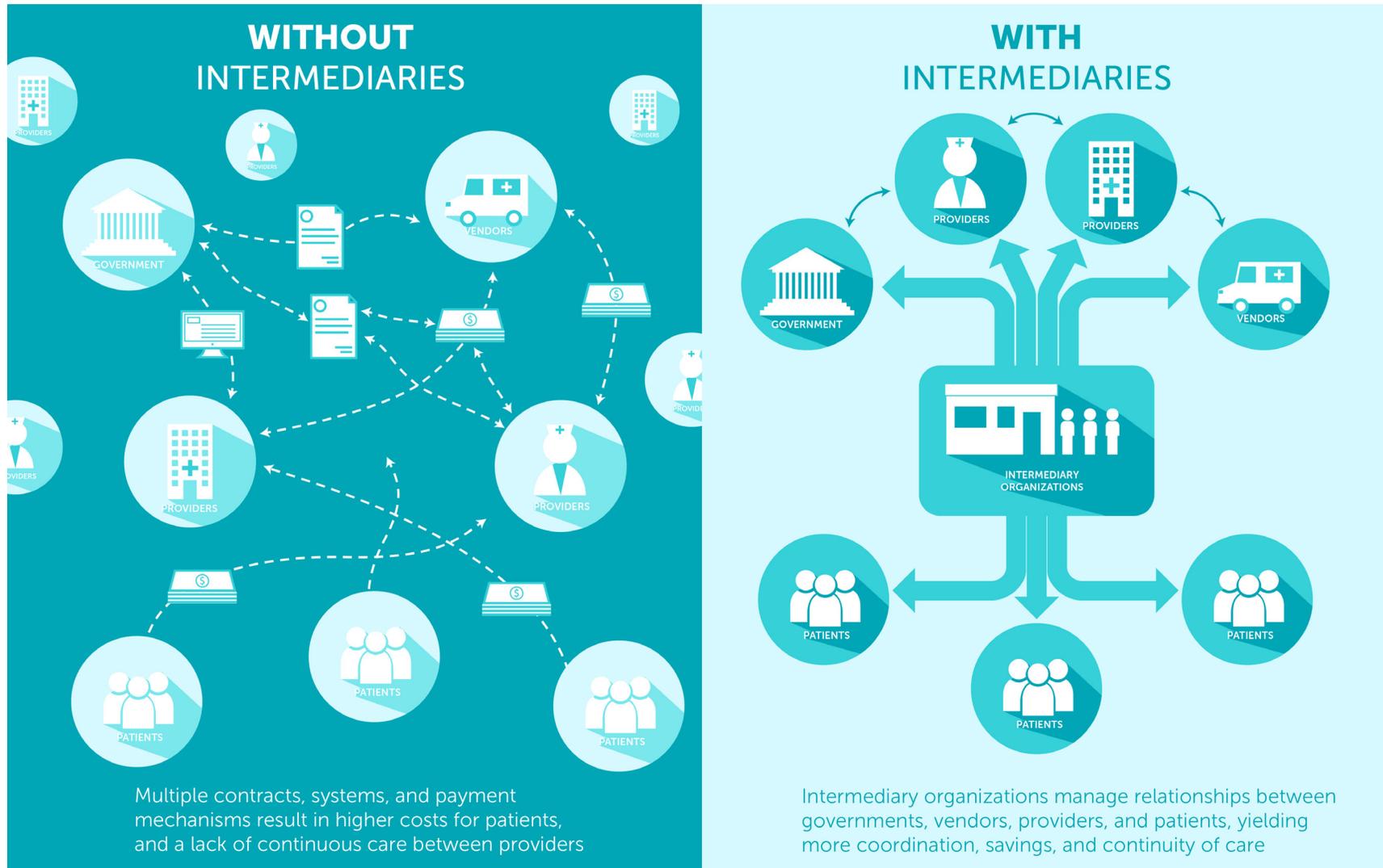
- Effective government stewardship oversees both public and private providers;
- Government actively works with private providers to meet the needs of the population through public-private partnerships, shared data, and collaborative planning; and
- Strong data systems exist that cut across both the public and private sectors and is used to continuously improve the quality of the health system in order to improve the health outcomes of the population.

A summary of the six key elements of an effective intermediary, along with corresponding promising practices, is shown on the next page and discussed in detail in the following section:

## The Six Key Elements of an Effective Intermediary

	Key Elements	Promising Practices
1	Proactive population management by "matching" patients to a primary care team who anticipates their health needs	<ul style="list-style-type: none"> <li>• Develop an integrated care team who the patient sees every time</li> <li>• Proactively identify populations' health needs by mapping needs and available resources, and offering incentives to meet gaps in services</li> </ul>
2	Facilitating comprehensive care	<ul style="list-style-type: none"> <li>• Utilize electronic medical records to maintain continuity of care within a network</li> <li>• Develop a primary call center with referral systems</li> </ul>
3	Providing effective systems for quality and quality improvement	<ul style="list-style-type: none"> <li>• Assess providers in network based on quality assurance standards</li> <li>• Utilize clinical guidelines and standards protocols for treatment</li> <li>• Focus on value over time rather than short-term services provided</li> </ul>
4	Building management capacity	<ul style="list-style-type: none"> <li>• Improve management performance through data driven tools</li> <li>• Encourage innovation and disseminate learnings within intermediary network</li> </ul>
5	Providing platforms for community engagement and patient partnership	<ul style="list-style-type: none"> <li>• Engage the individual patient and community</li> <li>• Create a patient "archetype" in order to develop a package based on their needs</li> <li>• Publicly report data to drive patient demand for quality</li> </ul>
6	Providing platforms for payment coordination and bulk buying	<ul style="list-style-type: none"> <li>• Simplify contracting with the government through formation of a negotiating body</li> <li>• Encourage and incentivize preventive care through capitation payment models</li> <li>• Incentivize providers to join network for cost-savings through bulk buying</li> </ul>

# Key Roles of **Health Intermediaries** in Mixed Health Systems



## The **Six Key Elements** of an Effective Intermediary

- 1 Match patients to primary care
- 2 Facilitate comprehensive care
- 3 Provide effective systems for quality improvement
- 4 Build management capacity
- 5 Provide platforms for community engagement
- 6 Provide platforms for payment & bulk buying

# Six Key Elements of an Effective Intermediary

## Key Element #1: Proactive Population Management

### “Matching” Patients To A Primary Care Team Who Anticipates Their Health Needs

The first foundational element of an effective intermediary is the ability to “match” patients to a primary care team for all their regular care. There are two key components of this: (1) Making sure each patient knows where to go for regular care; and (2) Ensuring that providers feel a sense of ownership over the health of a set group of patients. This results in the health care team proactively ensuring that patients receive preventive care in at the moments they need it, while coordinating care over time for longer-term needs such as chronic illness.

In fragmented health care systems, there is no such “matching.” Instead patients seek out providers for specific health care needs, or choose a new provider because they offer a marginally lower cost service. The practice of shopping around for a cheaper health care provider can be detrimental to both the individual patient and to population management efforts, as providers lack incentives or systems that enable them to follow patients over time. When a patient visits the same primary care provider team for all of their health care needs, the provider is able to build a medical history and better understand the underlying causes of illness when a patient is unwell, preventing misdiagnosis and the purchase of unnecessary medicines. This matching of patients to a primary provider also provides a base denominator for primary care providers to track and manage their population’s health, such as the percentage of their patients who have received immunizations or the incidence of malaria.

## Promising Practice: Develop an integrated care team who the patient sees every time

Intermediaries such as integrated health care systems have been shown to successfully enable proactive population management by forging accountable relationships between providers and patients.

**Southcentral Foundation’s Nuka System of Care** is a health care system created, managed, and owned by Alaska Native people. Nuka’s proactive population management rests on integration and inclusiveness with Alaska Native culture, so primary care is delivered with integrated care teams that incorporate behavioral health, pharmacists, midwives, nutritionists, tribal doctors, chiropractors, massage therapists, and acupuncturists.<sup>1</sup>

Structurally, what this means is that each customer chooses his or her own Primary Care Provider (PCP) and is supported by a small, integrated core primary care team comprised of this PCP, a full-time nurse case manager who focuses on care coordination, a behaviorist who focuses on behavioral issues, one or two medical assistants, and an administrative assistant who provides care management support. Selected high volume specialists and ancillary providers are also assigned to each primary care team. All members of the care team works “at the top of their license”; and the system is designed so that each customer usually sees the same team every time. By coupling this with teams seeing only their panel (which averages about 1,200), accountability and responsibility is developed.<sup>2</sup> Tactical tools around this accountability and responsibility include monthly provider packets that show how each team is performing on clinical measures (including comparisons to the clinic average and clinic best); listing which customers are overdue for services, have been hospitalized in the last month, and are high utilizers of particular services. From a motivation and incentive perspective, all staff, including providers, are salaried and

1. R4D interview with Katherine Gottlieb (President/CEO) and Douglas Eby (Director of Medical Services), November 13, 2015.

2. Katherine Gottlieb, Ileen Sylvester, and Douglas Eby, “Transforming Your Practice: What Matters Most,” *Family Practice Management*, January 2008.

provided with specific performance-based measures, focused on quality and outcomes, rather than volumes and revenue.<sup>3</sup>

### **Promising Practice: Proactively identify populations' health needs by mapping needs and available resources, and offering incentives to meet gaps in services.**

In fragmented health systems, single provider clinics generally are launched based on the expertise of the provider-owner, who then waits for patients to come to the clinics suffering from those particular health needs the clinic is meant to address. This is generally based on market demand in addition to health needs. For instance, if eye care is deemed to be a profitable business, one may find dozens of eye care providers in the same catchment area, while other specialties in need by the population are fewer and far between. Effective intermediaries offer the potential to turn this traditional model on its head by: (1) proactively mapping population' health needs, and then (2) responding to these needs in a coordinated manner across the system, offering incentives to private providers to respond to important health needs with traditionally lower market demand.

**Local Health Integration Networks** (LHINs) are community-based non-profit organizations which receive funding from the Ministry of Health in Ontario to plan, fund, and coordinate public health care services delivered by hospitals, long-term care homes, community care access centers, community support service agencies, mental health and addiction agencies, and community health centers. The LHINs conduct extensive needs mapping of subpopulations in a particular catchment area (e.g. the elderly, the homeless, refugees, immigrants, the LGBT community, etc.) through focus group sessions that allow the LHINs to identify challenges leading to gaps in the health outcomes of these sub-groups relative to the rest of the population. Once LHINs identify gaps, they tender requests for proposals from private local health care providers, offering them government funding to provide the missing health care service. LHINs outline clear

expectations of these contracted health care providers, which are reinforced by performance measurement and evaluation systems that are transparent to the public.

### **Key Element #2: Facilitating Comprehensive Care**

#### **Ensuring all patients receive all the services they need across the preventive, promotive, and curative spectrum at the time they need it**

In fragmented health systems where patients often "shop around" for health care, no one provider generally has a full picture of a patient's holistic health. Continuity of care systems are often weak, with poor coordination across various levels of care (e.g. from primary to secondary and tertiary). An effective intermediary would facilitate and coordinate comprehensive care through strong referral networks and information management systems.

### **Promising Practice: Utilize electronic medical records to maintain continuity of care within a network**

An effective intermediary can provide an integrated technology system that any one individual provider would generally be unable to afford, such as electronic medical records that can be accessed by various providers within the same network. This leads to more informed continuous care when patients are referred to other specialists for items such as chronic disease management, prescription drugs, and lab work. These comprehensive medical records would allow primary care providers to not only see the full range of services a patient undergoes, but also enables primary care providers to flag when to reach out to specific patients (e.g. through text messages or community health workers) for specific services that are due, such as antenatal care visits for pregnant women, immunizations for babies, or key services for a patient with a chronic illness.

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3. Katherine Gottlieb, Ileen Sylvester, and Douglas Eby, "Transforming Your Practice: What Matters Most," Family Practice Management, January 2008. Follow-up discussions with Nuka team via email.

**Nationwide Primary Healthcare Services of India**, which has 36 clinics based in Bangalore and Delhi, matches subscribing members with a primary care doctor, but also provides additional services that a standalone general practitioner would typically be unable to provide – such as access to specialists, labs, and pharmacies. These additional services are supported by their electronic medical record system, which facilitates communication between the staff members of the health care network. When members receive referrals to specialists, labs, and pharmacies within the network, these providers add information to the patient’s electronic health records, allowing the primary care physician to view the services received. Although their primary care physician may have specific office hours, access to care can be received 24/7 through the program’s On-Call Hotline, staffed by physicians who have access to the patient’s medical history through the EMR system.

### **Promising Practice: Develop a primary care call center with referral systems**

Intermediaries can perform a role in facilitating referral systems between providers by efficiently routing patients to the providers who are best able to serve them.

**MedicallHome** of Mexico is a telemedicine service with a strong referral network. The health care needs of approximately two-thirds of the patients who call MedicallHome (over 90,000 monthly) can be met over the phone, while the rest are referred to a hospital or an in person physician. If the patient is in need of immediate assistance, MedicallHome provides a one-time free ambulance service, with subsequent ambulance calls offered at a reduced price. MedicallHome’s referral network includes over 6000 physicians, and 3500 hospitals, clinics and laboratories where members are able to receive discounted services.

## **Key Element #3: Providing Effective Systems For Quality And Quality Improvement**

**Assuring that care is safe, effective,  
patient-centered, timely, efficient and  
equitable**

Fragmented health systems are often characterized by a wide variance of quality at individual provider levels, often due to a lack of consistent quality monitoring and enforcement, particularly in the private sector. A strong intermediary can help drive quality improvement in the health care system by ensuring that facilities are up to quality standards with functioning equipment, providers are trained in the latest clinical protocols, and pharmacies have access to high quality drugs and supplies. Beyond traditional regulation and quality control, effective intermediaries can proactively promote continuous quality improvement by getting providers to own their quality – through training staff around quality improvement, helping providers set goals and encouraging testing of ideas to achieve them, giving facilities comparison data to motivate improvement, and encouraging friendly competition with other providers.

### **Promising Practice: Assess providers in network based on quality assurance standards**

Social franchises frequently use quality assurance standards to prevent franchisees from providing poor quality services under the franchise brand. When a franchisee fails to meet necessary quality benchmarks, it may be forced to leave the franchise network. Similar strategies have been developed by other health care models, including insurance groups who will only reimburse providers that have demonstrated a commitment to collecting data for quality improvement. Intermediaries that facilitate frameworks for quality improvement across a network of providers have the potential to leverage pooled data for understanding best practices to model and “shift the quality curve” towards higher quality.

**Population Services International** (PSI) leverages the social franchise model to provide poor populations with quality, reliable access to family planning, and reproductive health products. PSI operates a total of 33 social franchises in Asia, Africa and Latin America, in which commercial franchising strategies have been applied to improve health. Through quality assurance officers, PSI conducts regular inspections of health facilities to ensure that the facility is following standard operating procedures. PSI provides continued training on clinical guidelines, as well as monitoring and evaluation of individual clinics.

### **Promising Practice: Utilize clinical guidelines and standards protocols for treatment**

Clinical guidelines and protocols are a tool for health care providers that systematize decisions about appropriate health care treatment for specific conditions, based on best practices and empirical evidence. Following clinical protocols can reduce practitioner misdiagnosis, help practitioners arrive at the correct diagnosis more quickly, and improve the outcomes of treatment. In a fragmented health care system isolated providers may follow their own conceptions of what is the best course of treatment for a patient, and may provide care that is not ideal. Instead, clinical protocols can align treatment procedures around more broadly accepted best practices. While defining these clinical protocols is often done by government, effective intermediaries can play an important role in putting these protocols into practice by training providers and continually assessing whether these protocols are being followed consistently.

**Kaiser Permanente** houses a Care Management Institute that synthesizes knowledge about the best clinical approaches for specific conditions. Guidelines created by the Care Management Institute are evidence-based and intended to provide the best overall population health. Clinical Practice Guidelines are available to practitioners within the Kaiser Permanente network through the online Community Provider Portal, as well as a large online clinical library.

### **Promising Practice: Focus on value over time rather than short-term services provided**

Value-based care is a financial incentive strategy that reimburses providers and hospitals on the value of care they provide, rather than the number of visits and tests they order. Reimbursement through value based care is typically government funded through public-private agreements, or donor funded.

**Medicare** in the United States serves an intermediary function through its facilitation of payments from taxpayers to a large group of health care providers and operates several value-based care services. The Hospital Readmissions Reduction Program authorizes Medicare to reduce payments to hospitals with excess readmissions, with a focus on patients that are readmitted for high cost or high volume conditions such as hip or knee replacements, heart attacks and COPD. Hospitals are incentivized to provide lower cost, but higher quality care to patients to reduce readmissions. Medicare's Hospital VBP Program implements a pay for performance system in which the amount a hospital is reimbursed for inpatients is dependent on the hospitals quality score across a number of measurements, and how much they have improved their score compared to a baseline period. Medicare is also empowered to reduce payments to hospitals with high rates of hospital-acquired conditions.

## **Key Element #4: Building Management Capacity**

### **Supporting long-term investment in key areas for growth and quality, e.g. data systems**

Strong health information systems are crucial for achieving better health outcomes. When a health information system is functioning correctly, it is capable of getting the right information into the right hands at the right time, enabling data-driven policymakers, program managers, and individual service providers to make informed choices about everything from patient care to national budgets. But though there has been investment in strong health information systems to enable greater transparency and accountability, health systems in many low- and middle-income countries still have a long way to go towards achieving these

goals. Intermediaries across both the public and private sectors can provide a platform for training managers of hospitals and clinics in better management strategies across a range of topics within health information systems, such as fiscal management, staffing and supply chain coordination.

## Promising Practice: Improve management performance through data driven tools

Management capacity of a health program can be strengthened with continued performance evaluation that gathers data to determine weaknesses. Iterative trainings that target weak points can be used to fortify the program's impact.

**Health Builders** of Rwanda, for example, acts as an intermediary for government-owned and staffed clinics to build their management capacity. Health Builders works to train all levels of management in staffing, stock and physical infrastructure management, ensuring durability and adaptability among staff even when there are management changes. Health Builders utilizes a performance evaluation tool to then track facilities in which they have trained the management team. The performance evaluation tool's yes/no scoring system prioritizes essential improvement for health care centers. The data collected through the performance evaluation tool has cut down on financial losses in pharmacies and transportation costs, and allowed for increased staffing expenses and reliable availability of essential medicines.

## Promising Practice: Encourage innovation and disseminate learnings within intermediary network

Fragmentation of health care providers can lead to a system in which innovation is stagnant, simply because good ideas tend not to be shared among health care providers, who may view one another as competitors. An intermediary can help to collect and disseminate learnings to a broader group of providers.

**PurpleSource** of Nigeria is a health care management and investment company that aggregates providers through investment and an integrated network approach. PurpleSource improves efficiency and quality of small health care facilities by applying operational procedures and policies to management,

clinical and ancillary functions, increasing the revenue of its member clinics. Most importantly, PurpleSource fosters knowledge sharing amongst its member clinics, adapting to new learnings by encouraging member clinics to uptake innovative approaches.

## Key Element #5: Providing Platforms For Community Engagement And Patient Partnership

### Working alongside communities, patients, and caregivers

There is growing recognition in the vital role that communities and patients can play in taking ownership of their own health care. Community and patient engagement can be loosely defined as involving community members and/or patients with key decision-making at various levels of the health care system.

## Promising Practice: Engage the individual patient and community

Fragmented health care systems lack the ability to gather community feedback and implement systematic changes, because isolated providers are limited in how to respond. Intermediaries can play a role in facilitating community and patient engagement with the health care system, by brokering the communities needs to a large group of providers, who can then react effectively and in a coordinated manner.

**Southcentral Foundation's Nuka System of Care** is an integrated health care system, significant in that it represents change in ownership of the Alaska Native health care system – from government control to "customer ownership." In Nuka, funds are taken directly from the Federal Government to the Alaska Native community itself (through the Indian Self-Determination and Education Assistance Act of 1975), whose members are then able to own, design, and manage their own health care delivery. Nuka's governance is comprised of a Board made up of all Alaskan Native people, and the system employs tactical strategies to listen to customer-owners, including surveys, focus groups, mystery shoppers, project teams, advisory councils, learning circles, and functional committees (comprised

of process improvement, quality improvement, quality assurance, and operations).

## Promising Practice: Create a patient “archetype” in order to develop a package based on their needs

Knowing that not all patients can “own” their health care like in the Nuka System of Care example, intermediaries can also help the development of patient-centric services by continually asking, “what matters most?” to a particular type of patient. Intermediaries who have done this well often use a patient “archetype” to ground all decisions back to the patient they are most trying to serve.

**Project Esther**, based in Sweden, is designed to help health care providers (e.g. physician organizations and hospitals) improve the way elderly patients flow through the system of care by strengthening coordination and communication among providers. The name “Esther” does not refer to a specific individual, but rather to senior citizens with chronic conditions. Project Esther team members work with providers to answer the following questions three questions: (1) What does Esther need or want? (2) What is important for Esther when she gets sick? (3) What is important for Esther when she comes back home from the hospital? Project Esther works with providers to design systems that best answer patients’ needs based on these discussions, with the Esther “archetype” providing a basis for decision-making – “what’s best for Esther?”

## Promising Practice: Publicly report data to drive patient demand for quality

Data transparency in a health care system is a necessary tool for patients to demand better quality and outcomes. Fragmented health care systems often lack data collection mechanisms as governments do not always require or enforce data reporting from private facilities, and when they do data reporting may be of different quality or indicators. An intermediary that is able to standardize reporting across a large group of providers and make the data publicly accessible can drive patient demand for improvements.

**Hygeia Community Health Care**, which provides health insurance to low-income earners in Kwara State, Nigeria, works closely with the state government and SafeCare to address quality-related issues of providers who participate in the insurance scheme. HCHC and Safecare make their quality assessment reports available to not only officials within the organization, but to government officials in the MOH and online to the public.

## Key Element #6: Providing Platforms For Payment Coordination And Bulk Buying

### Enabling governments to purchase services and improve quality and equity

A strong payment system—defined as the payment method combined with all supporting activities, such as contracting, accountability mechanisms, and management information systems—is necessary for intermediary organizations, in order to enable facilities to have a consistent and predictable flow of revenue, as well as to allow them to invest in infrastructure like strong information technology systems and internal capacity building.

Intermediaries can build strong payment systems in a number of ways. For example, they can link with governments to engage in “strategic purchasing” to purchase services from private sector primary care providers that would be integrated into government or private health insurance programs. They could also encourage and incentivize promotive and preventative care through payment models like partial or full capitation to name a few approaches.

## Promising Practice: Simplify contracting with the government through formation of a negotiating body.

Small scale health care facilities and providers may encounter difficulties responding to government RFPs and negotiating contracts. An intermediary can provide

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4. Beattie, Allison, ed. Sustainable Health Care Financing in Southern Africa: Papers from an EDI Health Policy Seminar Held in Johannesburg, South Africa, June 1996. Vol. 434. World Bank Publications, 1998.

a unified voice for otherwise fragmented health care providers to more easily negotiate contracts. Sharing administrative services reduces costs for the facilities, and the larger body of facilities under the intermediary umbrella is able to leverage its size to gain clout in the negotiating process.

**The Christian Health Alliance of Malawi** (CHAM) for example, was founded to simplify the process for contracting between Christian health missions in Malawi and the government. Beginning in 1964 when Malawi gained its independence, missionary health services grew tremendously as a faction delivering health care, particularly in rural locations where the Government of Malawi continues to struggle to provide services.<sup>4</sup> The Ministry of Health and Population (MOHP) lacked the capacity to interact with this large number of small scale, faith-based health care providers working in isolation. In order to decrease fragmentation and improve communications with the MOHP, missionary leaders of health programs from a broad spectrum of Christian affiliations united to form the Private Hospital Association of Malawi (PHAM) in 1966, which was later renamed the Christian Health Association of Malawi (CHAM) in 1992. CHAM provides a unified voice for the government of Malawi to interact with, and develops mutual cooperation between its members.

The Government of Malawi recognized that their services did not extend to many rural locations, but that CHAM did have associated clinics in these areas. By communicating with CHAM's central body, the Government of Malawi was able to enter into a service level agreement (SLA) with CHAM members to provide care in locations where no government health facilities yet existed. As part of the SLA, the Ministry of Health and Population does not construct government health facilities within the catchment area of the CHAM facility, which is defined by either a radius of 8 Km around the health facility or a population of at least 7,000 people. This relationship was driven by the constitutional requirement that the government provide free health services to its citizens.

## Promising Practice: Encourage and incentivize preventive care through capitation payment models

Capitation payments are used by health care management organizations (HMOs) and insurance providers to ensure that physicians can only be

reimbursed for reasonable health care procedures. Through a capitation model HMOs or insurance providers will pay member physicians a fixed amount of money per patient per unit of time to provide care. The physician is at financial risk if the patient's care exceeds the amount paid to them by the HMO, which incentivizes the physician to provide preventative care, which is inexpensive when compared to secondary or tertiary care interventions. As a result, HMOs role as an intermediary in coordinating payments to a large group of providers can be used to shift health care providers towards preventative care.

**Hygeia**, the largest HMO of Nigeria, offers patients access to services through a corporate network of 1,608 hospitals and clinics. The network of hospitals and clinics are bound by a capitation model, incentivizing them to provide primary, preventative care to a large segment of the Nigerian population.

## Promising Practice: Incentivize providers to join network for cost-savings through bulk buying

Fragmentation in the health care system leads to increased costs to the provider, which in turn is passed on to patients because isolated providers are unable to leverage economies of scale through bulk purchasing of supplies and health care equipment. Intermediaries that coordinate bulk buying for a group of providers can therefore reduce the overall cost of care for patients.

**PurpleSource Healthcare** in Nigeria organizes strategic purchasing for its member facilities and develops relationships with vendors to reduce cost further over time through partnerships with vendors such as pharmaceutical and laboratory companies, and support services such as facility cleaning services, laundry and medical waste management. Service agreements between PurpleSource as the intermediary and these vendors makes the cost of procuring these products less than it would have been should the providers be procuring as individual entities. This reduction in the cost of procurement reduces the overall cost of care provision – savings that are passed onto patients.

# How Health Systems Leaders Can Engage To Create And Strengthen Intermediaries

To put these findings into practice, health systems actors can test some of the following in their own contexts to encourage the creation and development of intermediary models:

- 1 A national, state, or local government can identify a priority area or important health gap linked to the challenges of fragmentation, and develop an RFP for a private sector intermediary to apply to;** for instance, around population management for a specific patient population (e.g. those with chronic diseases). This has happened in states across India, linked with the provision of emergency services and ambulances, as well as mobile clinics. Rather than grouping together existing providers, this approach is more proactive around government's key priorities and results in market development and market shaping.
- 2 Policymakers and/or donors can support the partnership between a successful intermediary globally, with a local partner.** For instance, World Health Partners expanded from India to Kenya through local partnerships to bring its social franchising telemedicine model to Kenya.
- 3 Policymakers and/or donors can develop an experimental space for testing and learning around better integrating health care and addressing the challenges of mixed market fragmentation.** There have been successful examples of this in the UK and the US, through Vanguard UK and the Center for Medicare and Medicaid Innovation. In the UK, the NHS provided resources to enable experimentation within Vanguard, with the goal of creating different care models for different populations. In the US, the Center for Medicare and Medicaid Innovation created a space for experimentation with the goal of "creating the health care of the future", providing states payment leverage with Medicare free to experiment with various reimbursement means. This has led to state-level experimentation, learning, and competition to create innovative solutions.

- 4 On the demand side, government can drive public demand for quality – thereby influencing the development of a demand-side intermediary – by developing a system to publicly report quality indicators across public and private facilities.** In South Korea, the Health Insurance Review and Assessment Service (HIRA) publishes quality indicators that South Korean citizens can access on their smartphones through an app. In Mexico, Citizens Endorsement Groups are community organizations that group individuals in a community and publicly "endorse" their local health facilities through patient-facing quality metrics.
- 5 Academic institutions and thought leaders can influence ongoing research into this space, including evaluations on the impact of intermediaries.** This can be especially helpful in environments and contexts in which a new intermediary has been created in the health system.
- 6 Intermediaries can review their existing practices to determine how they fit with the six promising practices of effective intermediaries, share their practices and learnings with others, and test improvements based on examples shared globally.**

Once intermediary organizations have been developed or in environments where they already exist, health systems leaders can encourage the strengthening of the six key elements of effective intermediaries through the following:

- 1 Contract and use purchaser "clout" to improve quality.** This involves setting more stringent requirements to receive government funds. For example, the government may withhold payment unless quality data and metrics are reported; or the government may provide higher reimbursement for better quality outcomes. Global examples of this can be seen in Moldova, whose National Health Insurance Company requires facilities to report data in order to be reimbursed; the government

of Andhra Pradesh and Telangana's Aarogyasri insurance scheme mandates that its facilities engage in a quality improvement collaborative (push), but also plans on higher reimbursements for higher quality outcomes (pull).

- 2 Mandate the use of quality standards when contracting.** For instance, some programs in Nigeria, such as PurpleSource, are adopting existing standards systems, such as the SafeCare Standards, which are ISQua-accredited.
  
- 3 Utilize a capitation or capitation-“plus” model of payment to incentivize proactive population management.** This can be coupled with the encouragement of utilizing data and patient records towards a more proactive model of population management, across specific patient populations (e.g. chronic care).
  
- 4 Develop independent agencies responsible for stronger regulation and monitoring.** Governments can set up a national agency to be responsible for setting comprehensive quality standards, with this same organization regulating the practice of facilities. This stems from learnings from the government of Ireland, who set up the Health Information and Quality Authority (HIQA), which works with government and private sector to prioritize population needs and sets standards, protocols, and guidelines in the same direction.



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