MEDTRONIC **LABS**

REWIRED ECONOMICS:

PAYING FOR OUTCOMES, NOT ACTIVITY

Sita’s story

Sita, a young mother in rural India, knew that government programs promised free maternal and newborn care. Yet when complications arose, her family still faced unexpected costs — transport to a distant facility when the local clinic doctor wasn’t available, out-of-pocket purchases for medicines that were out of stock, and fees at a private lab when urgent tests couldn’t be done nearby. What was meant to be free care still left them borrowing money they hadn’t anticipated.

At the same time, Josephine, the community health worker who supported Sita through her pregnancy, faced her own frustrations. Her stipend depended on the number of forms submitted, not on whether Sita and her baby stayed healthy. Hours went to paperwork instead of counseling or follow-up.

For Sita, the problem was unpredictable expenses and patchy access. For Josephine, delayed incentives caused by fragmented reporting systems. For the clinic, the problem was knowing when and where to send resources — medicine shortages, limited staff, and patient demands surfaced too late and from too many disconnected systems. Together, they were left in a system that failed to translate effort into outcomes, continuity, or fairness.

The Problem: Paying for the Wrong Things

Many health systems still pay for volume, not value. Fee-for-service remains the default, rewarding activity, not outcomes. Money is often misallocated: budgets follow history or politics, not population need, so remote clinics are underfunded while urban facilities are oversupplied.

For patients, this means unpredictability and strain. Families like Sita’s face catastrophic costs, each step billed separately, while stockouts force them to pay out-of-pocket for care meant to be free.

For health workers, incentives are skewed. Josephine is paid for activity, not outcomes. Her clinic struggles with shortages because allocations follow last year’s budgets, not today’s needs. For systems, financing is fragmented and inequitable. Programs fund narrow activities, creating disjointed reimbursement streams where money flows without improving outcomes. The result: **misallocated resources and misaligned payments reinforce fragmentation — the very silos rewiring must break.**

Rewired Financing Models

Rewiring turns allocation into a **data-driven, equity-adjusted process**: resources flow to facilities and communities based on need and results, not history.

Alongside smarter allocation, rewiring ensures proven payment models can work together at scale. Capitation, bundled payments, performance-based incentives, and fee-for-service all exist — but each comes with complexities that make it hard to sustain. Capitation requires **reliable data on enrolled populations,** bundles demand **coordination across providers**, outcomes-based payments depend on **long-term tracking**, and fee-for-service risks **runaway costs without checks.** In most systems, these challenges are magnified by delayed and fragmented information across facilities, programs, and payers.

Rewiring overcomes these barriers by linking data, workflows, and financing. Shared patient profiles give clarity on who is covered; workflow engines track care across episodes; registries verify providers and services; and payment rails ensure money flows predictably and transparently. With these building blocks in place, countries can combine models flexibly — applying each where it fits best — while keeping them accountable, equitable, and adaptable over time.

Importantly, countries don’t need to invent new payment or data rails for health. Proven models can ride on existing payment infrastructure, while health data exchanges connect with systems in other sectors — showing health can build on, not duplicate, what already exists.

WHY THIS MATTERS

Financing is not an abstract problem, it shapes everyday experiences.

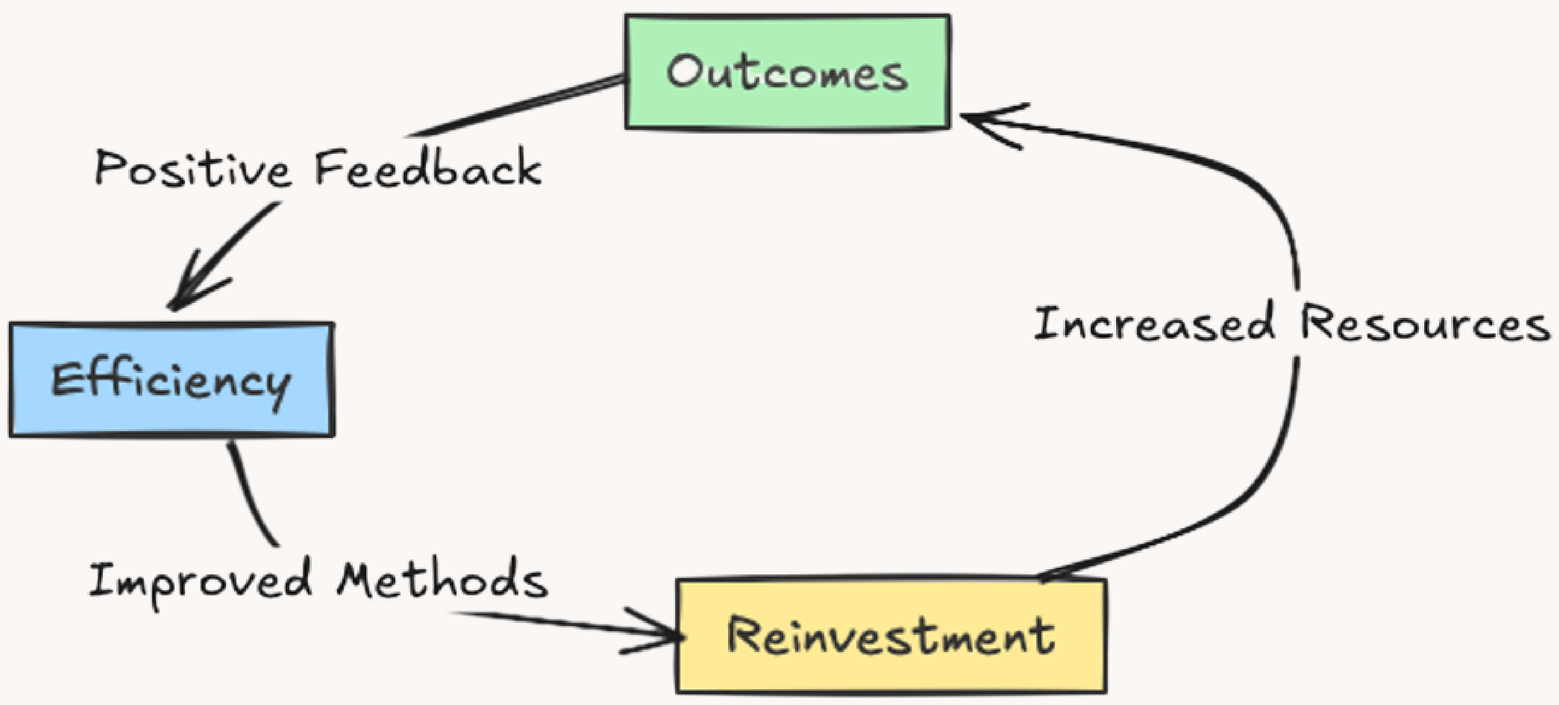
- **For patients and caregivers:** Rewiring reduces unpredictability. Families like Sita's can anticipate costs.

- **For health workers:** Rewiring aligns incentives with outcomes. Providers are reliably rewarded for healthy mothers and completed treatments.

- **For governments and funders:** Rewiring means money flows by need and outcomes, not history or politics. Fragmented reimbursements give way to integrated funding tied to improvements like lower maternal mortality or better chronic disease control.

At every level, financing decides whether systems fragment or flow.
When it follows outcomes, a virtuous cycle emerges:

better outcomes → more efficient funds → reinvestment → even better outcomes.



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In Closing

Sita’s unexpected expenses and Josephine’s delayed payments highlight that how we pay for care and how we allocate resources matters as much as how care is delivered. Financing based on siloed information leaves families exposed and workers unrewarded, **while financing backed by rewired systems creates the flow health systems require.**

Rewiring doesn’t discard old models; it enables them work together. Capitation for continuity, bundles for episodes, outcomes for quality, and service fees where appropriate can coexist — supported by shared infrastructure that ensures accountability, fair allocation, and adaptability.

Article 1 showed why rewiring is necessary. Article 2 explained how building blocks create the architecture. Article 3 revealed what it means for people. This article has shown how financing can follow outcomes and needs, not just activity or history.

Next, we turn to stewardship: if systems are rewired, **who governs the shared infrastructure, who sets the rules, and how do we ensure fairness and trust?**

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