FINANCING PRIMARY HEALTH CARE PUTTING PEOPLE AT THE CENTRE

RESEARCH BRIEF | APRIL 2022

KEY MESSAGES

- Health financing arrangements provide the fuel for primary health care (PHC) as the engine for achieving good health and universal health coverage. These arrangements need to be right to drive effective, efficient, and equitable PHC service delivery.
- In many low- and middle-income countries, PHC does not meet the needs of the people it serves, who should be at the centre. Current levels of government spending on PHC are insufficient and a considerable share of financing comes from out-of-pocket, not pooled, resources.
- The Lancet Commission on Financing Primary Health Care has identified the best evidence on ways to strengthen financing arrangements for PHC and sets out a new vision of how to place people at the centre of PHC financing.
- All countries need to both invest more and invest better in PHC by designing their health financing arrangements in ways that place people at the centre and focus on addressing inequities first.
- Advancing financing for PHC relies not only on technical strategies but also a nuanced understanding of the political, social and economic conditions in each country.

The Lancet Global Health Commission on **Financing Primary Health Care**

BACKGROUND

Fundamental importance of PHC

Primary health care (PHC) is a key component of all high-performing health systems, an essential foundation for universal health coverage (UHC), and a prerequisite for meeting the Sustainable Development Goals. It is a pathway to achieving good health at low cost by providing basic health services and managing the growing burden of non-communicable conditions. The COVID-19 pandemic has demonstrated the essential role that PHC plays in responding to epidemics, including in the rollout of vaccines and in providing essential public health functions.

When successfully delivered, PHC can improve equity and, by promoting good health and reducing risk of disease, it can avert the need for expensive secondary and tertiary health care. This limits the financial burden of health care for households and saves money for governments.

PHC Challenges in the 21st Century

Despite its fundamental importance and enormous promise, PHC is not performing well in many countries and is failing to meet the needs of the people – users, providers, and communities – who should be firmly at its centre. Funding for PHC is insufficient, access to PHC services remains inequitable, services are of inadequate quality and patients are often required to make out-of-pocket payments to use services, exposing households to financial risk or pushing them deeper into poverty.

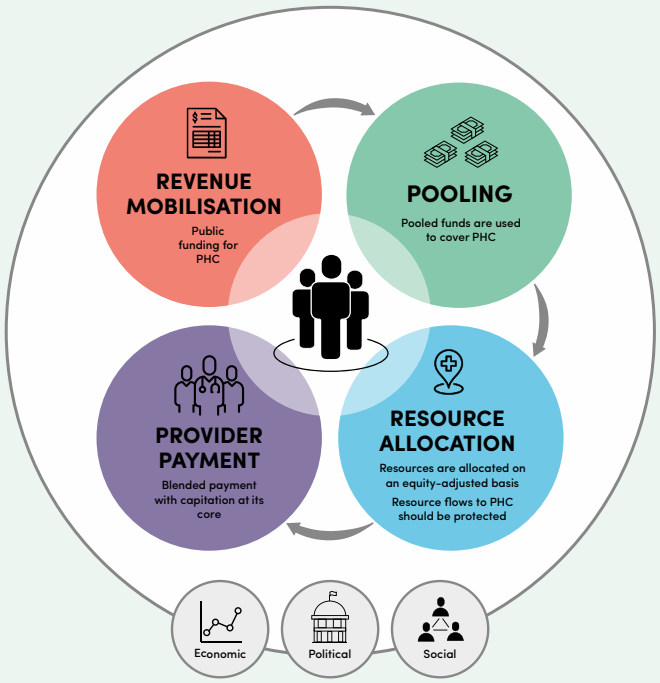
When public funding falls short of what is needed, the health financing landscape can become fragmented. In such contexts, PHC financing systems are characterised by multiple sources of funding that are used to purchase different services with different payment systems for different population groups. This fragmentation creates inefficiencies: resources fail to match healthcare needs, medicines and high-cost services are overused, and poor populations are left behind.

PLACING PEOPLE AT THE CENTRE OF PHC FINANCING ARRANGEMENTS

Drawing on country case-studies, secondary data analysis, reviews of published and grey literature, a new survey of provider payment methods for PHC and discussions with experts, the Lancet Global Health Commission on Financing PHC sets out a vision for placing people at the centre of arrangements for financing PHC. This financing vision serves a greater ambition: health systems that provide equitable, comprehensive, integrated, and high-quality PHC delivered through platforms that are responsive to the needs of the populations they serve and fully aligned with the objectives of UHC. To reach this ambitious goal, PHC platforms must be supported by financing arrangements that have equity and social justice aims.

Each element of the health financing system - from the mobilisation and pooling of funds, to the allocation of resources and purchasing arrangements - should be designed and implemented to drive improvements in PHC, giving due consideration to the political economy context (figure 1). This brief sets out the Commission's vision for these elements in greater detail.

Figure 1: Framework for people centred financing of PHC



FINANCING LANDSCAPE FOR PHC

Although PHC is prominent in political commitments and policy statements, limited information is available on levels of, and trends in, financial resources for PHC. Differences in methods of calculating PHC spending, and in defining PHC, make it hard to compare data across countries. Despite these limitations, there are some notable patterns in the levels and sources of PHC spending.

Low levels of government funding for PHC

Total expenditure on PHC in low- and lower middle-income countries is US$24 per capita and US$52, respectively. Government spending on PHC is even more meagre, at US$3 in low-income countries and US$16 in lower-middle income countries, which falls far short of any commonly used benchmark of the minimum amount needed to provide a basic package of health services.

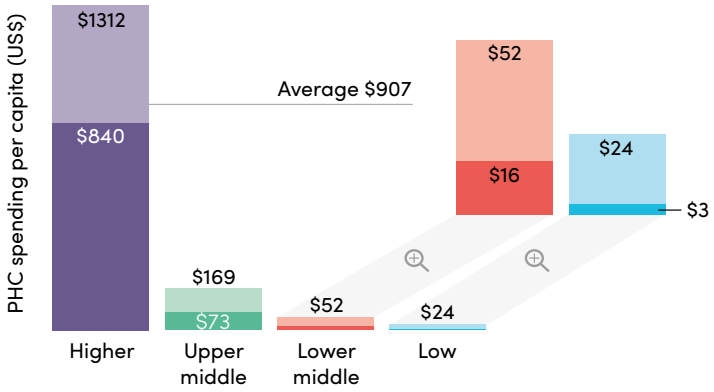


Figure 2: Total spending on PHC (light) | Government spending on PHC (dark), by income level in US$ per capita, 2018

Financing for PHC is dominated by relatively unregulated private expenditure, most of which is out-of-pocket payments.

At all country income levels, households are more exposed to out-of-pocket payments for PHC than for other health care spending. The high level of out-of-pocket payments for PHC is particularly worrisome in low- and middle-income countries (LMIC) where the majority of people die from preventable causes that could be managed at the PHC level.

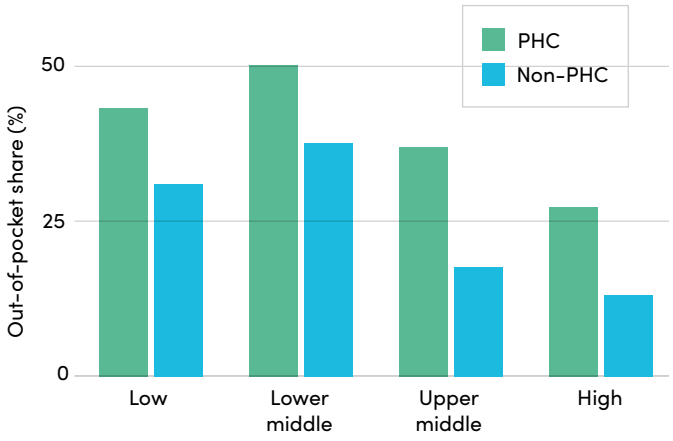


Figure 3: Median out-of-pocket household spending as a share of total spending for PHC and non-PHC by income level, 2018

To address critical data gaps, the Commission conducted its own survey in more than 70 LMIC on how PHC is organised and on how PHC providers are paid.

Population-based, or capitation, payment systems are rarely used in low-income countries.

The most common method for paying public providers for PHC is input-based budgets or a combination of this with fee-for-service. At higher income levels, there is wider use of blended payment methods that combine different payment mechanisms.

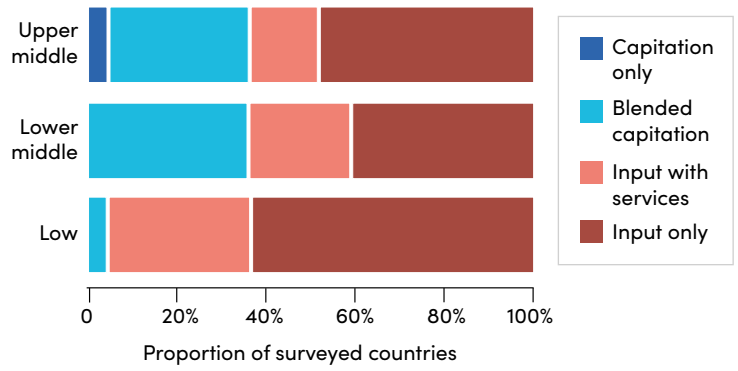


Figure 4: Payment methods for public PHC providers by income level, 2020

MOBILISING & POOLING FUNDS FOR HEALTH

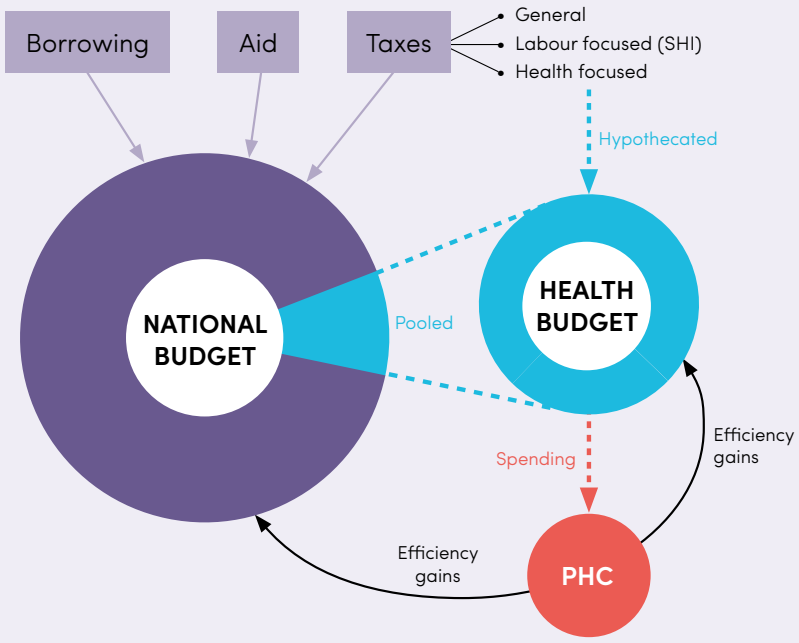
Mobilising sufficient public resources for health is essential to support PHC and limit the need for harmful user fees, which continue to pose a barrier to health care. Countries need to move towards removing user fees for PHC, yet in many LMIC generating additional resources is a challenge – fiscal capacity remains constrained by macroeconomic conditions and tax revenue is limited.

Increasing public funding through tax revenue is possible. Country experiences show that it is feasible to expand government revenue via taxation, by improving collection of existing taxes, increasing the tax base, and expanding the number and types of taxes levied. Expanding national taxation capacities requires overcoming significant challenges in collecting tax revenues (e.g., incomplete property registers, large informal economy) by strengthening institutions, systems, and skills. Countries will also need to decide on the appropriate mix of direct and indirect taxes where there is a trade-off between administrative complexity and equity.

Despite these challenges, general tax revenue has advantages over other options for mobilising resources in low-income countries: social health insurance is constrained by the small size of the formal (taxable) labour force and attempts to increase funds through efficiency savings alone takes time and may not necessarily yield savings for health.

Better pooling of existing and new resources is needed. Whether or not total health spending increases, a shift from out-of-pocket spending towards pooled arrangements can radically improve the equity and efficiency of health financing. Redistribution of resources from people and places of lower need to those of higher need is more effective in larger, more diverse pools. Pooling arrangements must cover PHC. Where PHC and medicines are not covered by coverage schemes, out-of-pocket payments can accumulate to produce substantial burdens on households, particularly in the case of chronic conditions requiring ongoing treatment.

Figure 5: Government resources for health



ALLOCATING RESOURCES TO PHC

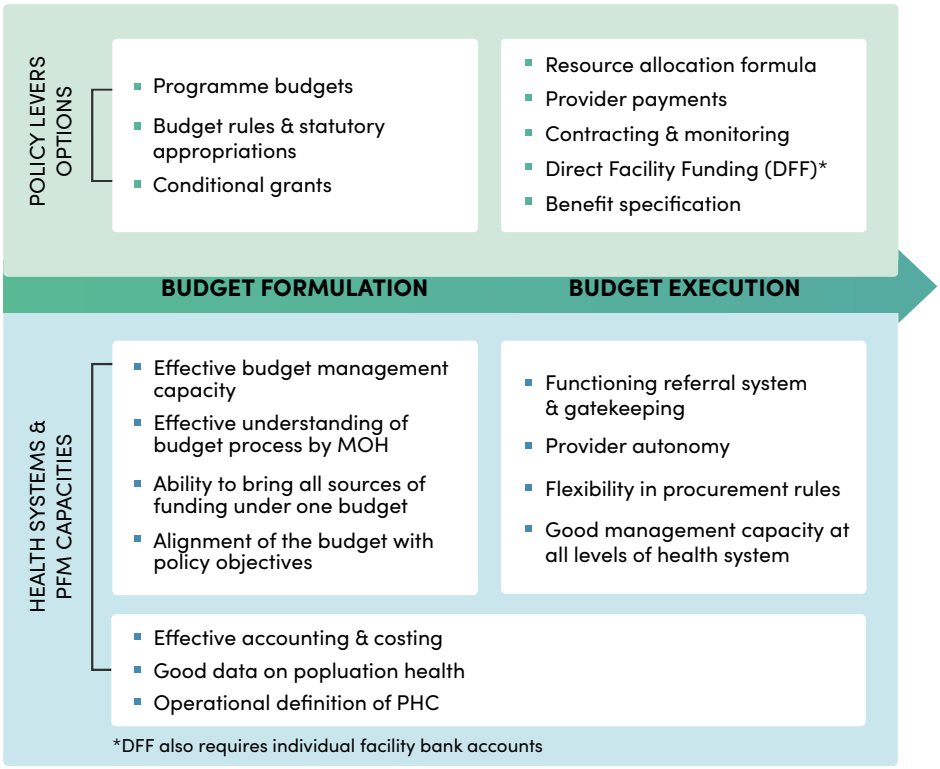
More resources must be allocated to PHC and be visible in budget. Levels of government spending on PHC are insufficient to provide a basic package of health services that is universally accessible and places minimum financial burden on users. More resources must be allocated from the health budget to PHC and protected as they flow through the system to reach frontline service providers and patients.

The process of securing budgets for PHC is not merely technical but is also influenced by political forces operating at all levels; it might involve redistributing resources away from other sectors, or within the health sector away from hospitals. PHC struggles to attract sufficient resources because it typically does not elicit much political support in budget discussions, and because there is often no clear department responsible or accountable for PHC within Ministries of Health.

A range of policy levers are available to channel and protect PHC resources in budget formulation, budget execution, and service delivery arrangements. At the budget formulation stage, the use of programme budgets, with specific allocations to PHC services rather than inputs, would create greater visibility in health budgets. Budget rules and statutory appropriations, which mandate minimum budget shares for specific sectors, can also help to ensure sufficient budgets to PHC.

With regards to budget execution, a resource allocation formula, which allocates an equal or need-based per capita amount across units, can help to direct resources to PHC and promote equity in allocation. Other purchasing tools, such as benefit specification, provider payment method, and contracting and monitoring arrangements can also protect allocations to PHC. The way PHC services are organised and how they relate to and interact with the rest of the health system also affects

Figure 6: Health & PFM system capacities needed to exercise PFM policy levers



resource allocation. Policy tools that improve the organisation of services can help to drive users and resources to PHC including: the adoption of a clear and operational definition of PHC, the use of norms and standards to establish resource requirements, and effective referral and gatekeeping functions.

For these levers to be feasible, various health system and financial capacities need to be strengthened, in particular the public financial management (PFM) system through which budgets are developed and executed (figure 6).

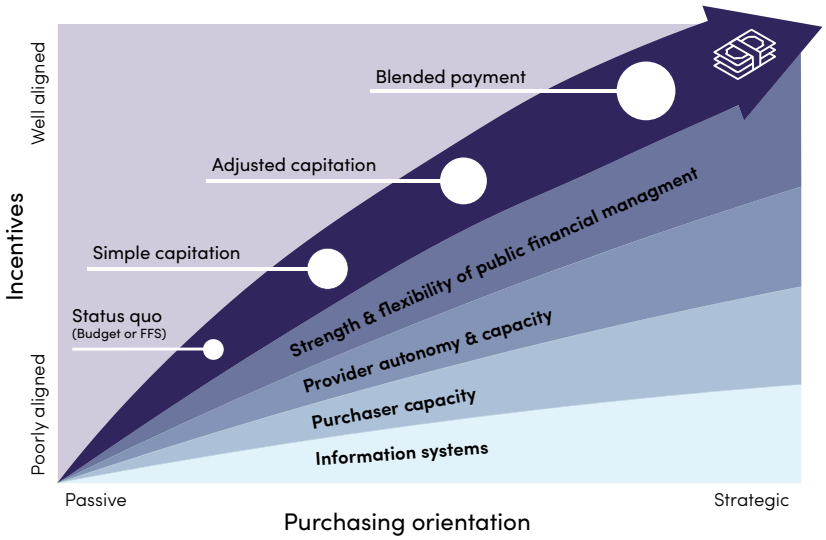
PROVIDER PAYMENT MECHANISMS & INCENTIVES

The way that PHC providers are paid and the incentives that these payment mechanisms create, are another tool that can ensure resources reach frontline providers and are used efficiently. In many countries, public providers typically receive line-item budgets with resource flows tied to inputs rather than to activities, levels of care, or population health needs. While they are the simplest to administer, such budgets may distribute resources inequitably and their rigidity does not encourage efficient or flexible use of resources.

Population-based, or capitation, payment systems, create the strongest incentives for providers to deliver people-centred PHC. This is because capitation has as its starting point an equal fixed payment per person, which can then be adjusted based on health needs. It is also the only method that pays PHC providers to manage population health, prioritising both health promotion and prevention. Capitation provides a predictable and stable revenue stream to PHC providers that can be used to deliver services flexibly and responsively, encouraging providers to optimally manage care for individuals and populations.

Countries should work towards using a blended payment model for PHC with capitation at its centre. Blended payment models bring the benefits of capitation as the starting point and then use elements of other payment mechanisms to offset capitation's disadvantages and support the achievement of other specific health system objectives. Moving towards a blended payment model, as with any reform process, requires anticipation and deft management of a complex political economy, collection and analysis of data to address emerging issues, and flexibility to address unintended consequences in a timely manner. This process can seem dauntingly complex—however, the alternative is to remain with a status quo that is failing to provide the incentive environment required for delivery of PHC to improve health outcomes and equity (figure 7).

Figure 7: Strategic pathway for moving to a blended capitation-based payment



THE POLITICAL ECONOMY OF FINANCING PHC

Political, social and economic conditions are as important as technical elements in the design and implementation of efficient and equitable financing for PHC. These political economy factors represent both constraints and opportunities. Advancing people-centred financing for PHC relies on politically informed technical strategies – this means that policy making in PHC financing and reform must be underpinned by political economy analysis. (Figure 8)

Political conditions shape financing for PHC. Change in financing PHC can be driven by different actors representing various political powers, economic interests, or social movements. In some settings, strengthening PHC financing has been part of a consistent political drive to guarantee basic human rights and equity, whereas in others, change has been driven by political leaders seeking to serve the interests of specific constituencies. The balance of power among different groups evolves over time, leading to the emergence of new agendas, new actors, and new coalitions.

Given the dynamic nature of political processes, having a clear long-term vision, upheld and publicly stated over time, is important in supporting PHC financing. Technical solutions can be developed in line with this vision while waiting for a window of opportunity for change, arising as a result of political dynamics and social and economic forces.

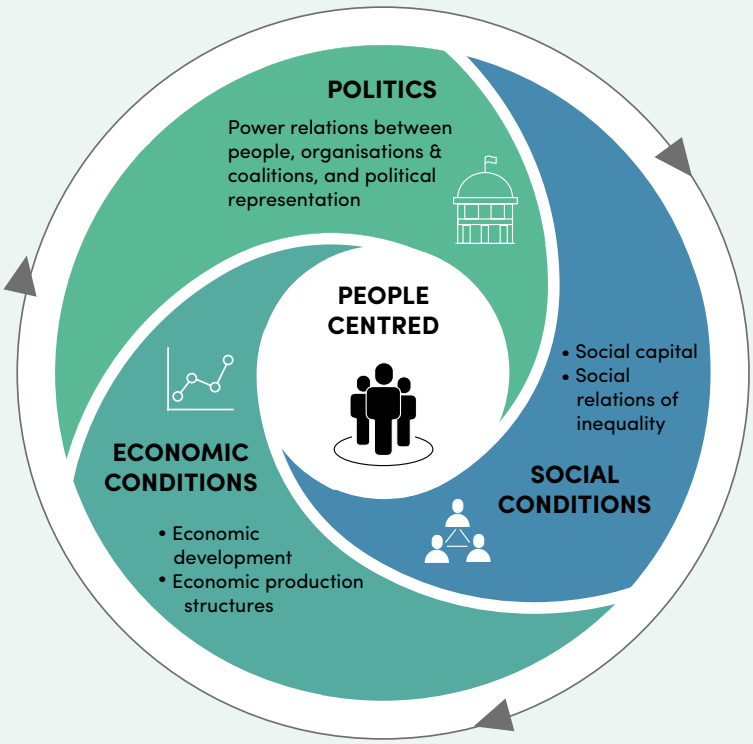
A range of social conditions can trigger PHC financing change. These include: the degree of inequality in a society, the availability of health workers with the capacity to implement reforms, or prominent social grievances that propel certain issues to centre stage. Crises of any type can be conveyed into opportunities for PHC reform if reformers are poised to act. The Covid-19 pandemic was a particularly severe global shock that has affected societies and economic outlook.

National and global economic conditions have significant influence over PHC financing. These conditions include the structure of the economy, economic cycles of stagnation, recession, or growth, the structure of the health care provider market, the size and dynamics of the private sector, and the importance of aid as a source of financing for health.

Strategic compromise and focusing on what is feasible are often required for changes in PHC financing to be politically viable. This may include iterative stepwise health care reforms until a critical mass of supportive PHC providers emerges or piloting, evaluating, and adapting PHC financing innovations before their scaling up.

Applying a political economy lens to technical solutions that explicitly recognises the evolving roles of actors beyond the health system, their relative resources and power, as well as the economic constraints and social relations, is therefore necessary to strengthen the PHC financing architecture.

Figure 8: A political economy analysis conceptual framework for health financing reform



IMPLICATIONS FOR ACTION

All countries need to both invest more and invest better in PHC in ways that place people at the centre and address inequities first. The achievement of people-centred financing arrangements for PHC requires a whole-of-government approach, involving all ministries whose remit interacts with health as well as civil society.

1 Invest more in PHC

Invest more in PHC to achieve the SDGs, UHC and be better able to cope with the next health crisis.

➤ **Increase public funding for health**

- Ministries of Finance must enable the mobilisation of sufficient revenue to adequately finance people-centred PHC - honouring their countries' commitment to UHC and to the multiple spending benchmarks they have signed up to.
- Donors should continue to provide development assistance to low-income countries to secure sufficient funding for health.

➤ **Build taxation capacity and tax base**

- Ministries of Finance must drive an ambitious taxation agenda, focusing on increasing the tax base, expanding the types of taxes levied, and tax collection capacity.
- Ministries of Finance should pair the better implementation of taxes that target the wealthy with visibly beneficial public spending.
- Ministries of Health must also strengthen their understanding of taxation and domestic resource mobilisation approaches to facilitate dialogue with Ministries of Finance.

➤ **Secure funds for PHC from the health budget**

Ministries of Health should:

- Lead efforts to prioritise PHC, ensure that sufficient resources are made available and support improvements in PHC financing.
- Clarify which departments/units are responsible for the financing and delivery of PHC to ensure accountability.
- Develop the technical expertise to make the case for more funding for PHC.

➤ **Reduce financial barriers to accessing PHC**

- Where governments are introducing new schemes to protect households against health spending, these must begin by covering PHC and prioritise coverage of the poorest and most vulnerable communities and individuals.
- Ministries of Health should work towards removing user fees and informal payments. Identify what additional resources are needed for this reform, devise a plan that considers both the health system strengthening needs as well as bolster support for this reform with those who will implement it.

2 Invest better in PHC

Protect people and promote equity by allocating PHC resources on the basis of population health need, and ensure that adequate resources reach frontline PHC providers.

➤ **Ensure resources intended for PHC reach front line providers**

Ministries of Health and Finance should work together to:

- Estimate resource requirements for PHC based on accurate assessments of population health needs.
- Use the full range of resource allocation tools at budget formulation and execution stages to make allocations to PHC visible and protect PHC resources to reach frontline PHC service providers and patients.
- Invest in and strengthen system capacities including budget management capacity at the Ministry of Health and effective accounting practices.

➤ **Make equity a driving principle to allocation of resources to PHC**

- PHC financing policies should be based on the principle of progressive universalism whereby allocation of resources prioritises coverage of the poorest and most vulnerable communities and individuals. Only once universal coverage with PHC is achieved, should pooled resources be extended to cover other entitlements.
- At the budget execution stage, use a resource allocation formula to improve the allocation of financing to PHC and foster equity. A simple per-capita formula, with risk equalisation and performance and quality incentives added as the system is developed, can begin to foster equity in universal coverage of a basic package of primary care services.

➤ **Progress towards a blended payment model for PHC with capitation at its core**

Ministries of Health should:

- Take incremental steps to reform the provider payment system to one that combines capitation with other payment methods to directly link the allocation of resources to the population entitled to PHC.
- Strengthen supporting systems as payment systems become more sophisticated. Basic supporting functions include: information systems, provider autonomy and capacity, public financial management systems, and capacity of purchasers.

3 Adopt a politically informed technical strategy

Each country should strategically plot its own pathway towards people-centred financing for PHC. Technical strategies to transform financing should be underpinned by analysis of the political economy.

➤ **Clear vision for financing PHC**

- Ministries of Health should articulate a clear, long-term vision for people centred PHC financing, allowing decision makers to plot a strategic technical path and identify what political engagement is needed from stakeholders to support progress.
- The country's vision should be operationalised by mapping out a clear set of steps to pursue its chosen course, while also preparing to capitalise on unexpected opportunities and creating room to manoeuvre as needed to adapt to political and socioeconomic changes, crises, and other shocks.

➤ **Make politically informed decisions**

Ministries of Health and other actors should:

- Develop political strategies to expand and improve people-centred financing in support of PHC, manage the interests of different actors, and align support for the health financing reforms.
- Conduct political economy analysis at the outset of any reform process to explore and recognise the political, economic and social conditions at sub-national, national and global levels.
- Invest in building the capacity of people working in government, academic and donor partners, to undertake political economy analysis.

"I will take the recommendations forward in Sierra Leone by going back to the health financing unit at the Ministry of Health. This would help with advocacy in getting more resources mobilised for financing primary health care.

HAJA WURIE,
University of Sierra Leone

I believe that this work by the Commission provides a template that leaders in low- and middle-income countries can ride on as they take steps to serve their countries and their citizens towards achieving health security.

CHIMA ONOKA,
University of Nigeria

I will share the recommendations of the commission with government to take the recommendations forward, to generate evidence, and to build systems and capacities in the country.

RAJEEV SADANANDAN,
Health Systems Transformation Platform, India

Full report

Hanson K, Brikci N, Erlangga D, et al. The Lancet Global Health Commission on financing primary health care: putting people at the centre. Lancet Glob Health 2022; published online April 4.

https://www.thelancet.com/commissions/financing-primary-health-care

Further resources from the Commission

A series of **scoping reports**, **working papers** and **country synopses** have been produced from 10 country case studies: Brazil, Chile, China, Estonia, Ethiopia, Finland, Ghana, India, New Zealand and the Philippines. All outputs are available on the Commission website.

Technical briefs

1. Mobilising and pooling funds for health
2. Allocating resources to primary health care
3. Getting incentives right for primary health care
4. Harnessing the political economy factors at the core of primary health care financing

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