The Lancet Global Health Commission on

Financing Primary Health Care

Bill & Melinda Gates Foundation
The challenge

Priority to health is limited, political and professional pressures favour hospitals

- Insufficient funding for PHC
- Resources don’t reach the frontline
- PHC funding is fragmented, inflexible, inefficient

Allocate more resources to PHC
Allocate equitably, protect to the frontline
Align funding flows, incentives

Spend more and spend better on PHC
Objectives

• Present new evidence on levels and patterns of global expenditure on PHC
• Analyse key technical and political economy challenges faced in financing PHC
• Identify areas of proven or promising practices that effectively support PHC across the key health financing functions
• Identify actionable policies to support LMICs in raising, allocating, and channelling resources in support of the delivery of effective, efficient, and equitable, people-centred PHC
Current landscape of PHC financing
Government spending on PHC in low- and lower-middle income countries is very low.

- Low: $3
- Lower-middle: $16
- Upper-middle: $73
- High: $840

Government spending on PHC per capita (US$), 2018
Out-of-pocket payments remain an important source of PHC financing, even in upper-middle income countries.

![PHC spending by source (%)](image-url)

- **Low**: OOP 35%, Govt 13%, DAH 52%
- **Lower-middle**: OOP 17%, Govt 34%, DAH 49%
- **Upper-middle**: OOP 4%, Govt 51%, DAH 45%
Financing for PHC is highly fragmented:

- Low government spending and high OOP
- High share of external spending
- Patients pay for drugs, donors for prevention, governments for outpatient care
Higher government spending on PHC is strongly associated with better service coverage
Public PHC providers are predominantly paid through input-based and service-based budgets.
Key findings
Allocating resources to PHC

**Budget Formulation**
- Programme budgets
- Budget rules and statutory appropriations
- Conditional grants

**Budget Execution**
- Resource allocation formula
- Provider payments
- Contracting and monitoring
- Direct Facility Funding
- Benefit specification

**Service Delivery**
- Operational definition of PHC
- Norms or standards
- Referral system and gatekeeping
- Service delivery models
Provider payment and incentives

• The way that PHC providers are paid, and the incentives that these payment mechanisms create, are a tool that can ensure resources reach frontline providers and are used efficiently.

• Population-based, or capitation, payment systems create the strongest incentives for providers to deliver people-centred PHC.
  • An equal fixed payment per person
  • Adjustment based on health needs
  • Pays providers to manage population health, prioritise health promotion and prevention
  • Provides a predictable and stable revenue stream to PHC providers

• Capitation also has drawbacks – e.g. underprovision, unnecessary referrals

• Countries should take steps to work towards their own context-specific blended payment model for PHC, with capitation at its centre
  • E.g. a budget payment to cover unavoidable fixed costs; some fee-for-service ‘carve-outs’ for high priority health conditions or services; and, in some cases, performance-based payment to incentivise reaching coverage targets for priority services and improving quality of care
Paying providers: Blended payment with capitation at the core

• Capitation places people at the centre
• But all payment systems have weaknesses: Blending can mitigate

Estonia’s blended PHC payment system

- Capitation
- Basic allowance
- FFS
- Additional allowances
- Bonus for training
- Quality bonus system
Pathway to a more strategic provider payment system
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.

• PEA refers to the power dynamics between stakeholder groups in relation to the distribution of resources, the economic and social conditions.

• These political economy factors represent both constraints (the limits of what technical solutions) and opportunities (e.g. entry points).

• A need for politically informed technical strategies – understanding and navigating the evolving political economy context.
Spending more and spending better on PHC
Attributes of people-centred financing for PHC

- Public resources should form the core of PHC funding
- Pooled funds should cover PHC first, and include essential medicines
- Resources should be allocated equitably and be protected to reach frontline providers
- Provider payment through blended mechanism with capitation at the core
PHC also requires

• A whole of government approach to spending more and spending better

• Technical strategies underpinned by an understanding of the social, economic and political conditions

• Revisiting how PHC expenditure data are collected, classified and reported to support national decisionmaking
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