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INTRODUCTION

The Annual Health Financing Forum (AHFF) is one of few global platforms that regularly convenes key actors from health and finance to discuss key issues in health financing. In 2022, the AHFF focuses on Financing Primary Health Care (PHC). It builds on the work of the Lancet Commission on Financing Primary Health Care (Hanson et al., 2022). In the tradition of previous forums, the AHFF 2022 focuses on opportunities at the boundaries, that is, areas where the way forward on PHC financing remains controversial or unclear.

This note serves as the background paper for plenary five of the AHFF 2022. Plenary five explores issues and opportunities in financing comprehensive PHC. In addition to individual-based health care services, often referred to as primary care, the concept of comprehensive PHC includes public health activities carried out at the base of the health system, close to people and communities they benefit.

The work of the Lancet Commission focused on primary care, yet, recognized that *"essential public health functions are part of PHC"* and *"require different arrangements, sectoral engagement, systems, and capacity from individual primary care. However, many of the same principles and policy levers apply."* Furthermore, the Commission concluded that its *"explorations raise[d] many additional questions"*, among others, *"what strategies have been effective in ensuring financing for essential public health functions and linking them to PHC"* and how they can be replicated.

The literature on financing essential public health functions (EPHFs), especially at the first level of the health system is scarce. And the issue has been almost invisible in the global health debate. Only with the advent of COVID-19, it received some attention, primarily concerned with the challenge of integrating primary care and EPHFs.

Plenary five and this note respond to the Lancet Commission's call for further explorations of the challenges and opportunities to strengthen the financing of comprehensive PHC, including primary care and EPHFs, for better health outcomes in low- and middle-income countries. More specifically, the note aims to identify key issues in the financing arrangements and outcomes of comprehensive PHC with specific attention to EPHFs and their coordination and integration with primary care, and how these are shaped as the result of system-wide health financing and service delivery arrangements. Following this introduction, the note first introduces some of the underlying concepts and develops an operational definition of comprehensive PHC. The second part highlights some key issues in financing comprehensive PHC. The third part offers a summary of a study from the Ekiti state in Nigeria and the fourth and last part introduces the topics of the panel discussion at the AHFF session which will provide insights into how some countries are addressing some of the key challenges.

1. Comprehensive PHC

The vision for PHC adopted at the Alma Ata conference in 1978 reflects a holistic approach to protecting, promoting, and improving health, combining primary care and EPHFs. The COVID-19 pandemic has been a stark reminder of the importance of such a holistic approach. Only when individual-based primary care services are delivered in coordination with population-based public health activities, health services can meet the needs of communities and manage the origins of health problems.

1.1. Primary care and Essential Public health Functions (EPHF)

Primary care refers to the first level of professional care where people present their health problems and most of their curative and preventive health needs are met. It also plays a key role in the coordination and integration of individual-based care services across diseases and system levels.

Essential public health functions, first defined by the US CDC (1994) and WHO (1998) and since then framed with some variation across WHO regions and other institutions, include protective, promotive, and disease prevention services and cross-cutting enabling functions (box 1). Some of the frameworks exclude individual-based health care to emphasize the role of protective, promotive, and preventive population-based services (WHO, 2018).

Box 1: Essential Public Health Operations to Deliver Public Health Services

Since the first publication of a list of EPHF in the 1990's, multiple frameworks emerged. One of the most prominent is the WHO Europe Ten Essential Public Health Operations. This framework excludes health care as a function to emphasize the role of public health and frames the functions as operations. The ten EPHO include:

Service Delivery

- Health protection including environmental occupational, food safety and others
- Health promotion including action to address social determinants and health inequity
- Disease prevention, including early detection of illness

Intelligence

- Surveillance of population health and wellbeing
- Monitoring and response to health hazards and emergencies

Enablers

- Assuring governance for health and wellbeing
- Assuring a sufficient and competent public health workforce
- Assuring sustainable organizational structures and financing
- Advocacy communication and social mobilization for health
- Advancing public health research to inform policy and practice

Source: WHO, 2015

1.2. Taking A "primary" and "Health Sector" Perspective on EPHF

To arrive at an operational definition of comprehensive PHC, requires a bottom-up health system perspective identifying the EPHF activities that are and should be carried out at the base of the health system hierarchy. The base of the health system hierarchy refers here to the "primary" or first level of delivering EPHF activities, closest to the people and communities they benefit. For the same reason, the proposed operational definition of comprehensive PHC also takes a health sector perspective, limiting the

scope of activities to those with at least a co-responsibility of health in their delivery. Several of the EPHFs are not only inherently multi-sectoral, but rest with activities outside the health sector. For example, addressing social determinants requires improvements in education outcomes of children and women. These and similar activities are considered outside the realm of comprehensive PHC.

Taking a "primary" and health sector perspective on EPHF to define comprehensive PHC shifts the focus among EPHFs on its core functions falling into the broad categories of service delivery (health protection, health promotion, and disease prevention) and intelligence (surveillance of population health and monitoring of health hazards and emergencies).

While the base of the health system plays a role in almost all EPHFs, in past global discussions, it remained a matter of debate what role is sufficient to include a function in the definition of primary health care. This may seem at first an academic question, yet, what is in or out matters from financing and especially from an accounting perspective.

1.3. Comprehensive PHC and its Delivery Platforms

To explore challenges and opportunities in financing comprehensive PHC, it is important to define comprehensive PHC not only as a set of functions, services and activities, but also as the platforms that deliver them. While financial transactions can be classified into items, programs and functions, financial resources flow after all to organizations, agencies, their departments, and units.

In health, service platforms commonly refer to the level within the organizational hierarchy of a health system at which services and activities can be appropriately, effectively, and efficiently delivered (Jamison et al, 2006). Given its breadth of functions and services, the delivery of PHC hinges on multiple platforms at different levels of the health system hierarchy in both of its components – primary care and public health functions. In many settings, primary care spans different delivery platforms, from service outposts to multiple tiers of primary care centers, pharmacies, and laboratories in both the public and private sectors. Furthermore, some activities are dependent on collaboration with higher levels of care, for example, specialized diagnostic services in hospitals. In public health, the setup may even be more complex, including community and local government platforms across different sectors, for example, health, education and environment, often also with support and under supervision from higher levels of government.

Given the reliance of comprehensive PHC on multiple platforms, several organizational questions arise that are also of relevance for financing. First, what is the most appropriate role for each platform to play? Second, what are critical areas and means of coordinating services and activities across platforms, for example through planning and budgeting? And finally, what are critical operational linkages, especially in

the realms of human resources (e.g., the role of community health workers) and information technology (shared data platforms). Traditionally, these questions have been discussed at the interface of primary care and public health, but they also apply also to the cross-section of delivery platforms for EPHF.

2. Financing comprehensive PHC

In a first attempt to identify key issues in financing comprehensive PHC, two broad categories of challenges emerged. Questions derived from the little that the literature has to offer, expert consultations, and a first case study in Ekiti State, Nigeria (see next section). The first set of issues is concerned with the financing arrangements of comprehensive PHC itself. The second set is concerned with the impact of system-wide health financing and service delivery arrangements on the financing of comprehensive PHC. In practice, many of the identified issues seem interlinked, within and across the two categories.

2.1 Financing arrangements of comprehensive PHC

Key issues in the local arrangements for financing comprehensive PHC can be organized into four broad categories: (i) sources, levels, and flow of funds, (ii) distribution of resources across functions, platforms and inputs, (iii) flexibility in the use of them, and (iv) financial and non-financial performance incentives.

Levels and sources of funding

Government funding for comprehensive PHC is essential to ensure the affordability of individual-based services and the sufficiency of funding for public health activities with significant externalities. As the Lancet Commission demonstrated, however, government funding for primary health care is, in low and lower-middle-income countries, insufficient to respond to local health needs.

Public funding for comprehensive PHC typically stems from all levels of government, different sectors, and is dependent on the health system financing arrangements, from social health insurance schemes. Some countries have established separate financing mechanisms for public health. In developing economies, donors often compensate for the low levels of government funding.

Distribution of funds across functions and platforms

The distribution of funds must enable all functions and platforms to operate effectively. Low overall levels of funding for comprehensive PHC typically complicate the challenge of distributing funds appropriately. Chronic underfunding of some functions and platforms may perpetuate their reliance of some functions and platforms on user fees and voluntary work.

Imbalances in the distribution of funds across functions and platforms can have multiple causes. Due to the fragmentation of funding sources and flows, funding decisions are taken at different places in the financing architecture, often with little or no coordination. Budgeting and planning functions often tie resources to narrowly defined spending items. Joint activities across functions and platforms are typically not a funding priority. The lack of legal frameworks can leave some of the essential public health functions without any funding at all.

Distribution of funds across inputs

The distribution of funds across inputs also matters. Financing arrangements must ensure that all inputs are available at the right time, at the right place, and in the right amount. Some flexibility in the use of funds is therefore imperative in ordinary times, and even more so in crisis times. Yet, platforms may not receive any revenue at all. For efficiency reasons, some inputs may also be purchased at higher levels in the system and are only transferred in kind. Where platforms receive revenue, budget execution rules often limit the reallocation across items. Local financing arrangements typically lack any contingency financing mechanisms, limiting the ability to respond to unforeseen events.

Performance incentives

While line-item budgets limit the flexibility in the use of fund, paying primary care providers under fee-for-service arrangements creates disincentives for them to support and collaborate in population-based health activities. Where levels of funding for comprehensive PHC are low, monitoring and supervision activities typically receive little priority in funding decisions. As discussed above, the same applies to the funding of investment in activities and infrastructure that cut across functions and platforms, including investment in data and information systems, which compounds the challenge of effective monitoring and supervision.

2.2 System-wide determinants

System-wide policy choices for both the health and public sector determine the local financing arrangement for comprehensive PHC. These include policy choices on health financing and service delivery arrangements and the politico-administrative setup, notably decentralization. These system-wide arrangements cascade to the local level where they condition local choices for the financing of comprehensive PHC functions and platforms. Three of these system-wide determinants are discussed below.

Multiple health financing schemes

As discussed earlier, multiple sources of funding may lead to the fragmentation of local financing arrangements. Often, the fragmentation into multiple sources of funding originates at the central level. One cause of this fragmentation is the organization of health financing arrangements into multiple schemes. In

addition to government schemes, countries may establish compulsory social health insurance, voluntary health insurance schemes, or other financing arrangements through which people obtain health services. While these schemes primarily finance individual-based health services, and thus are a cause of the fragmentation of fund flows to primary care providers, they have a stake in the effective delivery of essential public health functions for reasons of their effective functioning and financial sustainability. Therefore, administrators of these schemes often seek opportunities to pay for and create other financial incentives for the sufficient supply and demand for health protection, health promotion, and disease prevention services.

Decentralization

Another cause of the fragmentation of local financing arrangements is the decentralization of critical functions of comprehensive PHC to sub-national levels of government. While the intent commonly is to move decision-making processes closer to communities, the authority and capacity of sub-national and local governments to raise resources are often constrained. As a result, higher levels continue to play an important role in the funding of comprehensive primary care, at times, using conditional grants to augment local funding for comprehensive primary care, but often also paying for services or providing inputs in-kind.

Public-private mix of primary health care provision

Following the COVID-19 crisis, policy makers are not only paying increasing attention to the coordination and integration of primary care and public health functions, but also considering an increasing role of care providers in the delivery of public health services. In countries where the private sector has a large role in the provision of care at the PHC level, the question is how to best integrate these providers into a comprehensive PHC model. This question is particularly relevant where the private provision of primary care is the predominant form and the capacity to deliver public health functions weak. However, in many settings, private primary care services providers operate informally, the quality of care is low, and regulatory frameworks remain weak.

3. Ekiti case study

A case study in Ekiti State, Nigeria systematically mapped local comprehensive PHC priorities, delivery platforms, and their financing to strengthen their coordination and impact. The case study drew on interviews with key informants, including the State Health Commissioner and a group of senior health officials, as well as on an ongoing public expenditure review. The case study surfaced a set of key financing challenges and captured efforts to rectify them. Some of these challenges seemed typical for lower-income countries, others context-specific. Some are also interconnected and reinforcing. They are summarized in the following.

3.1 Numerous sources, low levels of funding

In Nigeria, the organization and financing of comprehensive PHC is the responsibility of local government authorities with the support of state governments. In Ekiti state, comprehensive PHC is funded from allocations of local and state government revenues, including block grants and internally generated funds, from federal programs, and from donors. Under federal programs, local and state governments also receive in-kind contributions, especially medicines, including vaccines.

An ongoing public expenditure review in Ekiti state estimates government spending on primary health care from both local and state government authorities to amount to approximately US$ 2.0 per capita in 2020. In the same year, the entire health spending envelope from local and state governments totaled roughly US$ 7.0 per capita. From the US$ 7.0, 10% was spending from LGAs, of which almost all funds, or US$ 0.7 benefitted PHC activities. From the US$ 7.0, 90% was spending from the state, of which 85% was allocated to hospital services, leaving approximately US$ 0.95 to spend on comprehensive primary care.

Recognizing the low levels of investment in health and human capital, the state government substantially increased the budgets of the Ministry of Health and Human Services and other sector agencies starting in 2020. In response to COVID-19, budgets have been further augmented since the onset of the pandemic.

With the goal to accelerate progress toward universal health coverage, the federal government has been advancing the setup and implementation of the Basic Health Care Provision Fund, which, established under the National Health Care Act of 2014, provides federal funding through State Primary Health Care Development Agencies and State Social Health Insurance Schemes for essential personal health services. The Ekiti state government committed to co-finance the program and has also made funds available.

3.2 Imbalances in fund allocations

The low levels of funding for primary health care generally fall short of the spending needs to effectively operate primary care as well as all public health functions with some variation across functions and platforms. The numerous sources of funding and subsequent fragmentation of fund flow drive some of these imbalances, as funding decisions are taken at different administrative levels and across multiple sectors.

The state ministry of health and human services plays a central role in orchestrating actors to agree on sector priorities and coordinate sector-wide planning, including primary health care. Officers from state

and local government authorities also work closely in the planning and execution of priority public health programs. At times, their work is hampered by insufficient legal frameworks. Most recently, the state passed a mental health law to fill one of these critical gaps.

In close coordination with the ministry of health and human services, the State Primary Health Care Development Agency (SPHCDA) plays a critical role in coordinating funding decisions and securing and boosting the funding for primary health care. The SPHCDA has a structure with strong links to the federal and LGA levels. Its board has the mandate to plan and coordinate EPHF activities, notably for health promotion, also with the objective to drive the integration of primary care and EPHFs. The SPHCDA also coordinates and operates federal funding for primary care and EPHFs, for example, funding from the Basic Health Care Provision Fund to strengthen the quality of primary care.

The state ministry of health and human services also works closely with other ministries in coordinating public health activities, for example, with the ministry of environment to ensure the supply of safe water, especially in times of outbreaks of waterborne diseases.

At the time of the case study, some public health functions and platforms remain void of any regular funding. Most importantly, community-based platforms rely exclusively on voluntary contributions, including community boards and community informants. Without steps to professionalize some of these roles, their effective and sustainable functioning is at risk. There often is little or no funding for joint activities, not for lack of prioritization, but often capacity constraints to prepare comprehensive funding proposals (e.g., IT platforms).

The low levels of funding for PHC platforms also result in very limited funding for operational expenditures. Local budgets often are only sufficient to cover the salaries of health professionals, which are in Ekiti low in comparison with other states and the national average. As a result, activities beyond office work often rely on the ad-hoc mobilization of additional resources. State organizations or donors may step in to fill these gaps, often through in-kind donations. For example, LGA has established rapid response teams, however, response activities depend at times on the state government to provide materials and cover travel costs. Similarly, community health workers rarely support community health activities, but work exclusively in care facilities, where they compensate for the lack of higher-skilled health workers. In the absence of operational budgets, some functions also rely on user fees, for example, they supply medicines and some occupational health activities.

3.3 Limited Flexibility

The imbalances in funding allocations are compounded by rigidities in the PFM system. The problem is especially visible at the LGA level. Until recently, primary health care facilities lacked any form of revenue, except user fees. Some of these fees, most importantly for medicines were earmarked for the purchase of replacements. With the recent launch of the Basic Health Care Provision Fund, the situation is improving. The Fund started channeling funds to primary health care facilities to improve, under the supervision of the SPHCDA the quality of care. In the future, the Fund will also pay primary health care facilities for the delivery of essential health services, providing them also with some autonomy over the use of these funds.

For public health activities carried out by local government authorities, not only the lack of budgets, but also delays in the release of funds for operational items can be a recurrent problem. Therefore, as discussed earlier, activities often hinge on the support from the state government, by default through in-kind support. The capacity of the state government to fill funding gaps is however limited to approved budget items, with little flexibility to reallocate funds.

4. Country cases for the session panel

The fifth plenary session of the Annual Health Financing Forum 2022 will discuss key issues in financing comprehensive primary health care with high-level government representatives from Argentina, Finland, Georgia, Indonesia, and Ekiti State in Nigeria.

The panel discussion will focus on the following key issues: (i) levels and sources of funding for comprehensive PHC, (ii) securing investment in public health functions, (iii) financing of critical inputs, (iv) getting the financial incentives right, and (v) comprehensive financing reforms of primary health care.

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