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Financing primary health care: seeing the bigger picture

The current COVID-19 crisis has exacerbated pre-existing distortions and exposed underlying weaknesses in the health system. Countries that have invested sufficiently in primary health care (PHC) have responded more effectively to COVID-19 because they have a foundation on which to build essential public health and health security functions.1–3

In addition to analysing the key technical and political economy challenges faced in funding PHC, the Lancet Global Health Commission on financing primary health care4 has not only identified areas of proven practice but also actionable policies. These will help low-income and middle-income countries (LMICs) invest more and better in people-centred PHC. However, universal coverage with people-centred PHC cannot be achieved in a context of fragmented health financing. According to the Commission, which incidentally does not explore the question sufficiently, this fragmentation is linked to dependence on donor funding.

In this regard, the Commission notes that in the same country, different financing strategies can be implemented to improve financial access to PHC. This combination of mechanisms is unfortunately rarely considered in a strategic way; it is most often the historical accumulation of uncoordinated decisions which result in a loss of efficiency, but also increased inequities: some groups of people have an advantage in access to health services because they are covered by several financing mechanisms.5

Such situations, quite recurrent in our contexts, are not conducive to progress towards universal PHC coverage, which cannot be built on such a disjointed combination of health financing mechanisms. Progressing towards universal coverage of people-centred PHC is much more about bringing coherence and efficiency to the combination or articulation of existing mechanisms.6 This is not new, as a study on the mapping of financing mechanisms in 12 French-speaking African countries7 revealed. That study showed that: (1) in many countries, gaps and redundancies coexist in the coverage of populations, and the verticality in terms of covered services and the selectivity of target populations result in very partial coverage, which does not guarantee continuity in the management of PHC; (2) there is a heavy dependence on external financing, which has a considerable influence on the structure of health financing and aggravates not only the problem of fragmentation, but also of governance and state leadership; and (3) there is a lack of consistency in terms of predictability and regularity of the methods of financing health-care structures, constituting a major obstacle to the effective extension of universal health coverage (UHC). This problem is therefore a key issue in health financing, and was taken up in the recent WHO matrix on progress in health financing,8 which stipulates in its first stage that all analysts should first produce a map of the financing arrangements in the country.

Despite previous work, many questions remain unanswered, such as: How can we achieve more synergy between these health financing mechanisms for better progress towards universal coverage of PHC? How can we manage to structure or adapt these mechanisms (ie, what is the specific trajectory)? And for which contexts and organisational models of PHC?

Several strategies7,8 are needed. (1) A critical assessment of the extent of structural fragmentation within the health system, which involves determining the financial weight and relevance of each mechanism as well as the description of their fundamental characteristics. (2) Reflections on the questions of articulation and complementarity of these mechanisms and on the way in which their arrangement must be dynamically managed. They must take into account the diversity of definitions, approaches, and intervention logics of these different funding policies, but also the diversity of schools, power relations, or belief systems. (3) A collaborative approach emphasising the efficiency and leadership of states in identifying possible synergies (or incompatibilities) between financing methods with a view to achieving UHC objectives. Thus, we could harmonise the methods of verification and payment of health-care providers, which would generate substantial gains and thereby improve the efficiency of the system as a whole.

It is also incumbent on ministries of health to use the process of developing a national health financing strategy to reform the architecture of health financing and the institutional arrangements that this entails. This process is a good opportunity to combine the various financing modes into a system that is as coherent as possible. It can also be an opportunity to involve all stakeholders in the drive towards universal coverage of people-centred PHC and to clarify their roles and responsibilities.7
As for donors, they must ensure the consistency of their funding with national policy; align themselves with national objectives of moving towards UHC and the funding mechanisms chosen to achieve it; avoid creating parallel funding systems that do not facilitate the implementation of a coherent, efficient, and equitable strategy for universal coverage of PHC; and be more transparent about their funding.7

Universal coverage of people-centred PHC is a process that is built over time; we must change the mode of interaction between those who finance health so that they have a coherent vision of the whole, transparency of data on the mechanisms of health financing, harmonised processes, and centralised and active management of the ministry of health.

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