# Foundational Reforms for Financing and Delivery of Primary Healthcare Collaborative

## Report on the First In-Person Meeting
## April 23-26, 2024

JOINT LEARNING NETWORK
For Universal Health Coverage

# Acknowledgments

This document summarizes discussions at the first in-person meeting of the Foundational Reforms for Financing and Delivery of Primary Healthcare (PHC) Collaborative facilitated by the Joint Learning Network for Universal Health Coverage (JLN). The JLN is an innovative network of practitioners and policymakers from around the world who collaboratively solve implementation challenges and develop practical tools to help countries work toward universal health coverage. More information is available at www.jointlearningnetwork.org.

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# Introduction

The Foundational Reforms for Financing and Delivery of Primary Healthcare (PHC) Collaborative brings together representatives from 14 member countries of the Joint Learning Network for Universal Health Coverage (JLN) that are advancing health system reforms to strengthen PHC. They include representatives from ministries of health (MOHs), national health insurance agencies, and subnational health authorities as well as PHC managers and supply chain managers. Over a two-year period—October 2023 to September 2025—they are working to identify practices to improve financing and delivery of PHC services and address bottlenecks. The collaborative focuses on practices at the intersection of national policies and actions and the ability of PHC providers to improve access to and use of PHC resources.

From April 23-25, 2024, 75 participants met in Nairobi, Kenya, for a learning exchange titled "Getting the Right Mix of Inputs to the PHC Level, and Using PHC Resources Effectively, for High-Quality PHC Services." On April 26, participants from five of the countries that are concurrently implementing primary care networks (PCNs) participated in a learning exchange facilitated[1] by the USAID-funded Health Systems Strengthening Accelerator titled "Financing PHC Through PCNs" to discuss common PCN financing challenges and opportunities. Table 1 lists the objectives of each learning exchange.

## Table 1. Meeting Objectives

| | April 23-25<br>**"Getting the Right Mix of Inputs to the PHC Level, and Using PHC Resources Effectively, for High-Quality PHC Services"** | | April 26<br>**"Financing PHC Through PCNs"** |
|---|---|---|---|
| **COUNTRIES** | » Botswana<br>» Burkina Faso<br>» Colombia<br>» Ghana<br>» Ethiopia<br>» Indonesia<br>» Kenya | » Liberia<br>» Lebanon<br>» Malaysia<br>» Mongolia<br>» Nigeria<br>» Philippines<br>» Vietnam | » Colombia<br>» Ghana<br>» Indonesia<br>» Kenya<br>» Philippines |
| **MEETING OBJECTIVES** | » Understanding how countries can get sufficient resources for PHC that are aligned with population health needs and translated into PHC inputs<br>» Exploring enablers, obstacles, and barriers to getting resources to PHC providers<br>» Identifying countries that have overcome obstacles to getting more resources to PHC providers<br>» Identifying key questions for the collaborative's joint learning agenda | | » Deepening understanding of common challenges with PCN financing across the five countries, along with the root causes<br>» Sharing promising practices and collaboratively problem-solving<br>» Identifying future learning priorities, including development of a knowledge product |

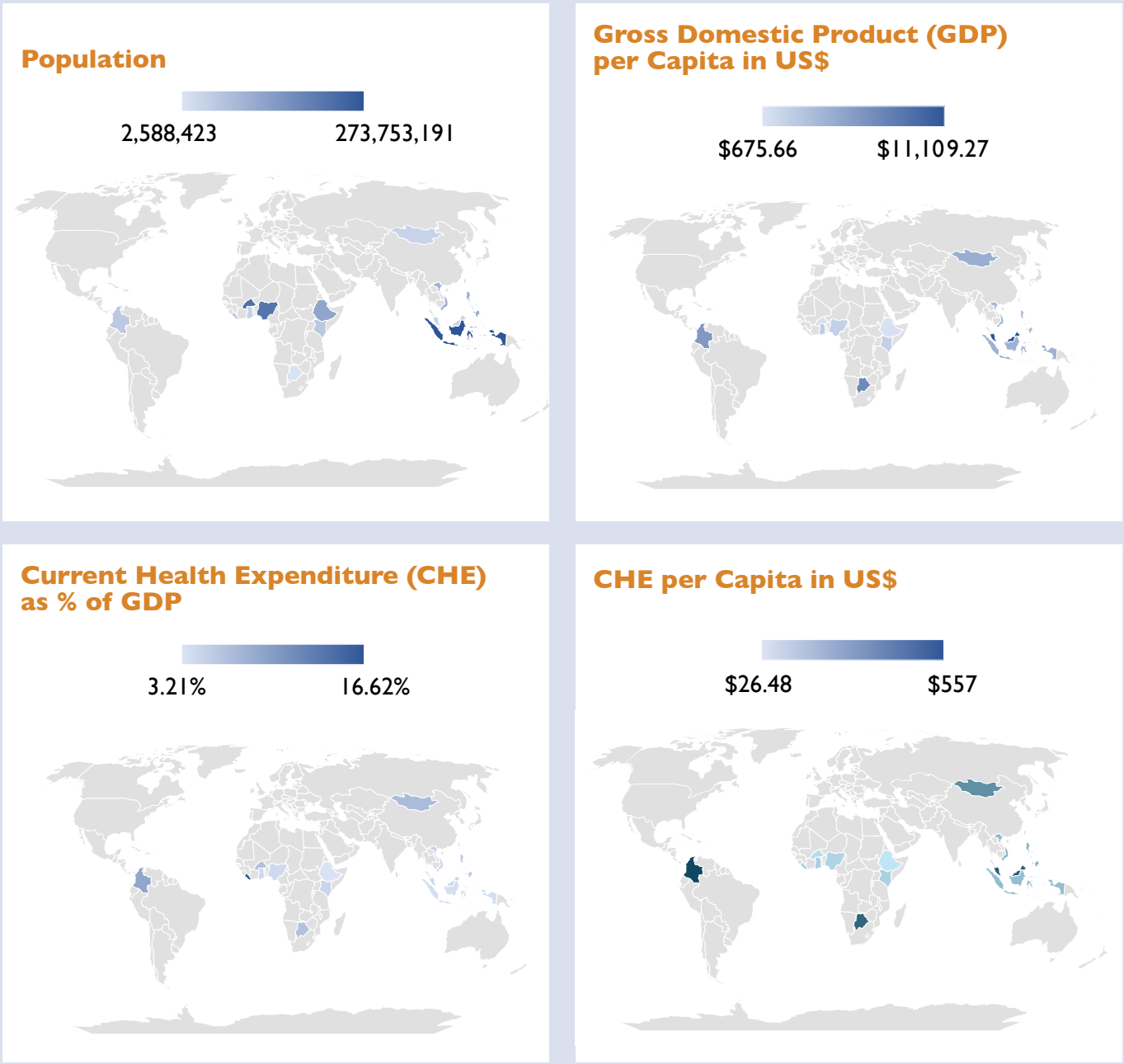
[1] The learning exchange brings the countries together to learn from one another, collaboratively problem-solve, and build global knowledge on how to strategically purchase and deliver PHC through PCNs.

# Characteristics of PHC Systems in the Participating Countries

The 14 JLN member countries that are part of the collaborative have varying income levels, population sizes, and health expenditure levels. (See Figure 1.) Most are in the early stages of structural reforms to improve how PHC service delivery is organized and financed, while others are at more mature stages of reform and are refining existing systems to improve population health outcomes.

## Figure 1. Country Indices (2021)

Countries in the collaborative: Botswana, Burkina Faso, Colombia, Ghana, Ethiopia, Indonesia, Kenya, Liberia, Lebanon, Malaysia, Mongolia, Nigeria, Philippines, and Vietnam




*Source: Global Health Expenditure Database*

The countries also differ in their definition of PHC, which can be influenced by the service delivery levels and configurations and the PHC services and interventions that they cover. As a first step in the collaborative's work, participants agreed on a common working definition of PHC. (See Box 1.)

Other key differences and commonalities among the 14 countries include:

- **The countries differ in how they organize PHC delivery to improve access to essential services and use resources more effectively.** While half of the countries have predominantly public PHC providers, the other half have a mixed health system. The five PCN-implementing countries have introduced models of service delivery that share resources across facilities to improve service delivery.

## Box 1. A Working Definition of PHC

**The collaborative members adopted a definition of PHC as "a service delivery platform from which a broad range of essential services and interventions are provided at the community level."**

The *service delivery platform* includes the facilities and subnational levels that receive PHC resources, including in-kind inputs (human resources, medicines, supplies, equipment, and infrastructure operations and maintenance) and funds for PHC services.

The *range of essential services and interventions* is defined by the country's essential services package.

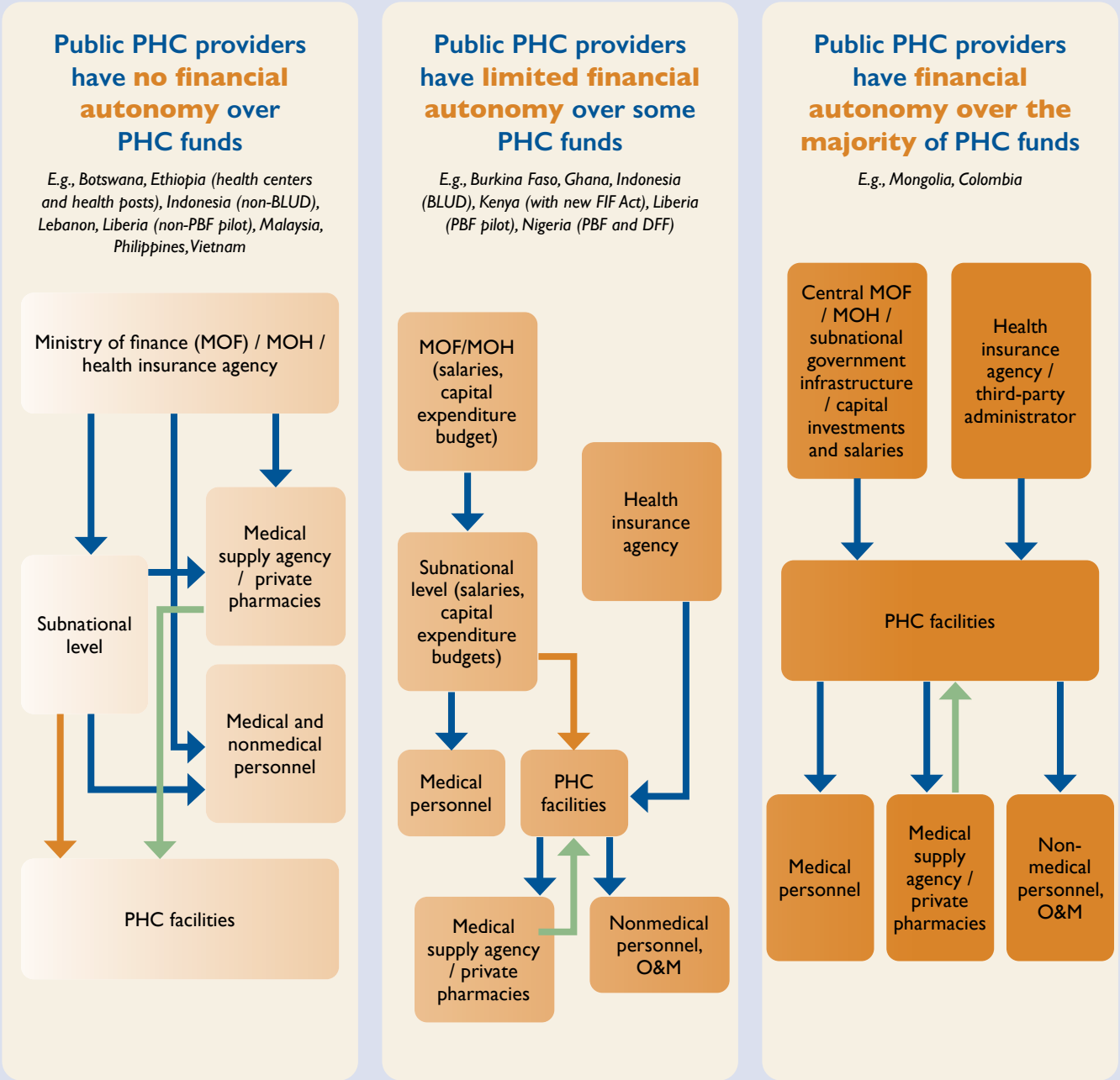
The *community level* is the level at which a target population accesses the essential services and population-based interventions.

- **In most of the countries, subnational levels of government have the authority to manage PHC resources.** Nine of the countries have decentralized systems of government that grant decision-making authority over PHC to the subnational level. Greater decentralization can create opportunities to be nimble and more responsive to communities. For example, service delivery can be more tailored to community needs and approaches can be used to increase PHC resources at the subnational level.
- **Financial autonomy of PHC facilities is uncommon among the countries.** Facility financial autonomy is described as decision-making authority to generate and/or receive, spend, and account for funds from any source of PHC funds. Only two countries, Colombia and Mongolia, give public PHC providers autonomy to fully manage all non-wage PHC resources and internally generated revenue. Another six countries—Burkina Faso, Ghana, Indonesia, Kenya, Liberia, and Nigeria—give some or all public PHC facilities limited autonomy to use non-wage PHC resources and internally generated revenue.
- **The countries differ in their purchasing arrangements and provider payment systems for PHC.** Most of the countries have fragmented sources of PHC funds, including MOH budgets, national health insurance funds, local government allocation, and external donor funds. More than half of the countries had out-of-pocket spending greater than 35% of total health expenditure, contributing to catastrophic health spending and impoverishment. Most of the countries also have a mix of provider payment systems, leading to incoherent incentives for providers. An opportunity exists to use provider payment as a tool to incentivize effective use of PHC funds.

# Key Insights from the Meeting

Participants mapped the flow of PHC financing through their health systems and discussed ways to enhance the use of PHC resources. The three main types of funding flows are depicted in Figure 2.

## Figure 2. Main Types of PHC Funding Flows to Public PHC Providers




In-kind inputs (e.g., medicines, supplies, O&M, renovations, equipment)

PHC funds

Medicines

- BLUD = Badan Layanan Umum Daerah (regional public service agency)
- FIF = facility improvement financing
- PBF = performance-based financing
- DFF = direct facility financing
- O&M = operations and maintenance

## Addressing the Root Causes of Low and Fragmented PHC Financing

The importance of PHC, including its role as an entry point for advancing universal health coverage (UHC), has gained increasing recognition globally. But this recognition has not been matched with adequate resources. PHC continues to receive a low share of public spending, particularly in low- and low-middle-income countries, where PHC spending ranges from about US$5 to US$25 per capita annually.[2] Low levels of prepayment, coupled with low public financing of PHC, can lead to high out-of-pocket spending and a weak health system that cannot provide high-quality health services. This can result in perverse incentives to create parallel channels or vertical programs, each with a separate financing stream, for specific diseases or interventions, such as immunization and the prevention and treatment of HIV, tuberculosis, and malaria. In some countries, efforts to expand coverage for certain segments of the population have led to the proliferation of social/national health insurance and community-based health insurance schemes. These vertical programs and separate insurance schemes have worsened the fragmentation of PHC funds and made it difficult to organize and deliver patient-centered PHC services.

Addressing the root causes of low PHC funding and fragmentation requires strong political will and leadership and long-term systemic efforts to improve the macroeconomic and fiscal environment.

Participants shared examples of how their countries are working to address these root causes:

- **Ethiopia's Sustainable Development Goals Performance Fund.** Following the country's adoption of the 2030 Agenda for Sustainable Development and the Sustainable Development Goals (SDGs) in 2015, Ethiopia mainstreamed and aligned its health sector development strategies with the SDGs. The MOH manages a pooled funding mechanism into which donors contribute, enabling the MOH to make federal grants that primarily go to PHC services. This helps reduce fragmentation of funding and consolidates resources from the government and donors into a single pool.
- **Mongolia's evidence-based reforms to increase PHC funding.** Mongolia increased PHC funding based on technical assessments conducted over 10 years by the MOH using JLN toolkits for costing, provider payment assessment, and benefits design. This has resulted in a fourfold increase in the PHC capitation payment rate since 2020, and more resources overall flowing to PHC providers.
- **The Philippines' efforts to decentralize health service delivery.** In 1991, the Philippines passed legislation to grant subnational levels more authority over the delivery of public services, including health services. This decentralization was not fully implemented, and the central government retained significant control. In addition, the share of national resources that was supposed to flow to subnational levels to support decentralized functions was contested in court, resulting in the Mandanas ruling of 2019,[3] which increased the pool of public funds allocated to the subnational level. To support decentralization, the UHC Act of 2019 aimed to integrate local health systems into province-wide and city-wide health systems, with a public-led health care provider network built on a foundation of PCN. Implementation of the ruling has increased available resources at the subnational level, and innovations have been tested to empower local governments to ringfence health resources in a special health fund.

[2] Hanson K, et al. Lancet Global Health Commission on financing primary health care: putting people at the centre. *The Lancet Global Health*. 2022; 10(5):e715–e772. https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(22)00005-5/fulltext.

[3] The Mandanas ruling resulted from petitions requesting that the basis of computation of the Internal Revenue Allotment (IRA) for local government units not be limited to "national internal revenue taxes" collected by the Bureau of Internal Revenue but also include collections (customs duties) by the Bureau of Customs.

## Addressing the Consequences of Low and Fragmented PHC Financing

While noting the long-term actions needed to address the root causes of low and fragmented PHC financing, the meeting participants also explored feasible short-term approaches to increase resource allocation to PHC and the use of PHC resources at the provider level. They shared seven approaches and specific examples of each.

- **Reorganizing and integrating service delivery to "pull" more resources to PHC.** Participants also described their improvements to referral systems and gatekeeping to allow for better integration between PHC and higher levels of care and reduce the number of patients lost to follow-up between the levels.
    - Colombia, Ghana, Indonesia, Kenya, and the Philippines are at varying stages of implementing PCNs that allow for horizontal or vertical integration[4] and sharing of resources to improve service delivery.
    - In Colombia, which has implemented PCNs for more than three decades, previous fragmentation of health services led to patients traveling within and across provinces to access needed health care services. Now, PHC providers and PCNs in Colombia have full autonomy to distribute and use their financial resources according to local priorities, directly pay staff, and manage endowments, supplies, medicines, equipment, and infrastructure improvements. PHC facilities receive capitation payments for the affiliated population and share some functions at the PCN level, such as procurement of commodities.
    - Ethiopia is improving PHC delivery at health posts by upgrading infrastructure and staffing to create comprehensive health posts and incorporating community health extension workers. Comprehensive health posts will expand the range of priority services they offer, such as skilled childbirth care and addressing birth complications. In some regions, communities have committed to matching federal resources for upgrading health posts.
- **Making provider payment more strategic.** This includes implementing systems and policies for selecting, designing, and implementing provider payment and setting payment rates to enhance resource allocation to PHC, allow the linking of payment to services in the benefit package, and create incentives for PHC providers to deliver high-quality services.
    - Lebanon, which is recovering from an economic crisis while also grappling with a huge refugee population, defined an essential health care package that includes services for migrant, vulnerable, and displaced populations. The economic crisis resulted in a large drop in PHC financing that also affected the quality of care. Using a World Bank loan, the Lebanese government is making the benefit package available at public and private PHC facilities while piloting capitation as the provider payment system.
- **Increasing provider autonomy to allocate and use resources and respond to provider payment incentives.** The level of provider autonomy at PHC facilities ranges from some to all decision-making authority in areas such as financing (budgeting, financial management, internal allocation of funds, assets and investments, and retention and use of surpluses), personnel (staffing levels and mix, hiring and firing, and compensation), and service delivery (partnerships or networking with other providers). The more areas in which providers have decision-making rights, the more flexibility they have to respond to incentives within the provider payment system. Greater autonomy also enables providers to determine the right mix of services and inputs—medicines, staffing, community outreach, equipment, and supplies—based on what is needed at the facility and the best way to serve the community. A challenge for all countries is finding the right balance between autonomy and accountability. The benefits of autonomy may outweigh the risks of misappropriation of public resources, and the general perception among the participants at the meeting was that PHC providers are not likely to misuse funds if well-defined accountability measures are put in place. Participants discussed the need to better describe facility financial autonomy arrangements and the accountability and system requirements for the different levels of autonomy (as shown earlier in Figure 2).

[4] *Horizontal integration* refers to integration across the same level of care (e.g., multiple health centers working together as a unit), while *vertical integration* is integration across different levels of care (e.g., health centers and PHC hospital or health center and community health workers).

- Nigeria balances accountability with provider autonomy under the Basic Health Care Provision Fund (BHCPF) by ensuring that all facilities develop business plans and use the plans for financial reporting and to track efficiency in health spending. PHC facilities submit monthly reports, and periodic audits are conducted by the state and federal levels.
- Kenya's Kisumu County reported a decrease in maternal mortality attributed to the use of PCNs, which allowed sharing of resources between facilities and greater financial autonomy for facilities to improve responsiveness to local needs. Between 2012 and 2023, autonomy was limited for most PHC providers, with resources consolidated in the county revenue account and lengthy approval processes to spend PHC resources. Implementation of Kenya's 2023 Facility Improvement Financing Act will facilitate the flow of resources to the PHC facility level and expanded the decision rights of PHC providers to determine spending based on local needs.
- Although in most of the countries PHC facilities do not have autonomy to manage funds, some countries give them latitude to determine how to use the resources they generate. For example, Ethiopia's PHC providers develop plans and budgets for resources they generate; they are managed at the *woreda*, or district, level.[5] Ghana, Burkina Faso, and Kenya have bulk procurement through a central medical store, and PHC providers have drawing rights to access their allotment of medical commodities and supplies.

» **Improving financial and organizational management capacity.** Strong skills in facility management, personnel management, financial management, and information technology (IT) are critical to both the clinical and operational aspects of a health facility. They are supported by digital and mobile tools and systems that provide PHC managers with the data and information they need on morbidity patterns, availability of medicines, forecasting for planning and budgeting, and accounting for public resources.

- Burkina Faso's e-*Gratuité* platform tracks services use and claims arising from the *Gratuité* program[6]—a user fee replacement policy for maternal and child health services. Both public and private providers use the platform. Civil society organizations support monitoring by reviewing *Gratuité* claims and escalating discrepancies (overpayment and underpayment) for action by the MOH. Semiannual audits by a joint team from the MOH and Ministry of Finance check resource use compliance at the facility and subnational levels.

» **Adopting resource allocation criteria to determine how resources flow to geographic areas.** Since most of the countries give subnational levels responsibility for some health functions, including PHC, objective criteria are needed to ensure that resources are equitably shared across subnational levels and address health disparities across geographic areas. Participants discussed how resource allocation formulas can be used in "horizontal allocation" to ringfence resources for health and direct more resources to PHC.

- Kenya uses equity indicators in its horizontal revenue-sharing allocation formula, which is set by the Commission on Revenue Allocation and applies for at least three years. The formula uses criteria to adjust for equity and level of development, directing more national resources that can be allocated to health to less developed areas.
- Botswana is considering decentralizing more roles to district health management teams to expand their decision-making authority over health functions, including PHC. This would create a need for objective criteria for equitable resource allocation across regions and districts based on disease burden and population health needs.

[5] The *woreda* level in Ethiopia is equivalent to the district level.

[6] In 2016, Burkina Faso introduced *Gratuité*, a user fee replacement policy, to increase access to and use of health services for women and children under age 5.

- **Using service contracts/agreements with PHC providers to set expectations and standards.** Service contracts can make explicit what is expected of providers and specify service delivery standards for both public and private providers.
    - Malaysia engages both public and private providers for its PeKa B40 scheme, which is administered by the nonprofit ProtectHealth Corporation. The scheme offers a well-defined benefit package to the bottom 40% of the population by income, including noncommunicable disease (NCD) screening. By standardizing targets and objectives across both the public and private sectors, ProtectHealth establishes clear expectations for service delivery. The scheme uses databases that encompass data from both public and private facilities to monitor resource allocation and service utilization. PeKa B40 has not only enhanced the reach and efficiency of health care services but has also strengthened the overall health care infrastructure and created opportunities for more public-private partnerships, including the successful National COVID-19 Immunisation Programme.
- **Engaging with the population as advocates for accountability and increased PHC funding.** Interventions to increase PHC utilization are useful only if communities are aware of the available services and willing to use them. Participants from Colombia, Indonesia, and Lebanon highlighted the need for ongoing community engagement to build trust in PHC facilities and direct beneficiaries to PHC facilities so they do not bypass them to access care in hospitals, which is more expensive. Communities can also be engaged in budgeting processes so they can advocate for more public resources for PHC at the community level.

## Factors That Help Improve PHC Resource Use and Health Outcomes

For PHC to function well, it needs to be well resourced with sufficient inputs—human resources, medicines, IT systems, equipment, and infrastructure. In addition, strong governance systems and regulatory frameworks are needed to facilitate the planning and availability of the inputs. Strong central and subnational systems are required to harmonize and create coherence in the implementation of national policies.

- **Kenya passed national legislation in 2023 to strengthen the legal and regulatory foundation for PHC reorganization, improve resource use at the PHC facility level, advance digitization, and align funding sources for PHC under the Social Health Insurance Fund.** Previously, counties followed their own laws, resulting in patchy implementation of national policies. Of 47 counties, only 10 had access to internally generated revenue, while 16 counties could access part of their internally generated revenue.[7] Some counties had a patchwork of legislation granting autonomy to PHC facilities, with different rules for approvals and accountability arrangements. The national-level legislation created a common framework for subnational implementation, eliminated the need for subnational legislation, and allowed for more harmonious implementation nationwide.
- **The Malaysian MOH negotiates with vendors and sets up lump sum contracts for the procurement of medicines.** This enables PHC facilities to buy medicines at a better price, ensuring that they can use resources more efficiently.
- **Vietnam manages the quality of care through regulatory tools and service contracts between Vietnam Social Security and health facilities.** The social insurance agency uses similar processes when contracting with public and private facilities, creating parity for public and private providers.

Health systems need to be flexible and dynamic, learning and improving as health priorities evolve. Implementers must recognize that policy adjustments do not occur in a vacuum; they need to consider politics and the political economy in order to engage all stakeholders at the national and subnational levels.

[7] ThinkWell Kenya Brief 12: Facility Autonomy in the Age of Devolution (https://thinkwell.global/wp-content/uploads/2023/05/Kenya-Brief-12_Facility-autonomy-2023.pdf).

## Getting Resources into the Hands of PHC Providers

Although most of the 14 countries give PHC facilities some limited authority to make decisions about how to use and allocate resources, participants expressed interest in learning more about expanding that authority and discussed the potential benefits—including expanded access to PHC, maternal and child health services, and NCD services and lower maternal mortality, as illustrated in the examples below.

- **Mongolia developed a roadmap to address challenges with its mix of provider payment methods, based on a 2014 provider payment assessment.** One recommendation from the assessment was a shift from input-based to population-based parameters in defining budgets and budget caps, to better reflect population health needs, and refinement in the design of the diagnosis-related group payment system and capitation payments. From 2015 to 2022, Mongolia increased its capitation rate for PHC services fourfold, introduced adjusters to the capitation design (age, gender, urban/rural), and consolidated its performance indicators. This has contributed to an improvement in health indicators, including the number of women having more than six prenatal visits at the PHC level, the proportion of children receiving a full dose of pentavalent vaccines, and the number of patients receiving care at the PHC level. Facilities that achieve all performance targets within a given month receive a 20% bonus, increasing their funding and incentivizing high-quality care.
- **Colombia's Cauca Province reduced maternal mortality through the use of PCNs, with some PCNs reducing the rate to zero.** These improvements are attributed to efficient resource use, effective accountability mechanisms, and strong community involvement in the delivery of high-quality and culturally appropriate health services.
- **Kenya's Kisumu County saw improvements in health outcomes as a result of PCNs and community engagement to increase resources going to PHC providers.** The 2022 Kenya Demographic and Health Survey reported that the percentage of women in the county with a skilled birth delivery reached 98%, compared to the national average of 89%, and 90% had a postnatal check in the first two days of birth, compared to the national average of 78%.[8]

When the changing nature of PHC is met with flexibility in financing and service delivery arrangements, PHC managers can respond to changing disease burdens and community health needs. In Kenya, multidisciplinary teams at the PCNs are meeting community health needs and using PHC resources to address the growing NCD burden. Mongolia is addressing growing demand for NCD services differently, by introducing an NCD-focused benefit package and moving NCD screening down to the PHC level.

PCNs have enabled innovation and flexibility in Kisumu County, Kenya, to enable improvements. County managers are implementing PCNs that emphasize communication and dialogue with the community and have enhanced commodity supply systems through the use of drone technology. These changes have been fueled by increased funding to PHC levels and provider autonomy to make decisions on how to use the funds. Kisumu County has seen a 30% reduction in maternal mortality, from 540 per 100,000 live births to 390, which is partly attributable to innovations in the delivery and financing of PHC.

[8] Kenya National Bureau of Statistics (KNBS) and ICF. 2023. Kenya Demographic and Health Survey 2022: Volume 1. Nairobi, Kenya, and Rockville, MD: KNBS and ICF. https://dhsprogram.com/publications/publication-fr380-dhs-final-reports.cfm

## Defining Good System Performance and Measuring Progress

All countries in the collaborative report some level of digitization of health information systems to track and monitor results, although the mix of paper-based and automated data collection varies widely. System fragmentation and the large numbers of indicators in use across service areas make it difficult for countries to use the data to make decisions about how best to use limited PHC resources.

PHC managers should establish clear objectives based on their health system's goals and priorities and start with existing systems for measuring progress, even as they aspire to build more complex and automated systems. This can generate the evidence necessary to encourage additional resource allocations for PHC. Participants said that their countries are using various data sources to improve monitoring, design new programs, and enhance service delivery.

- **The Nigerian government has allocated 1% of consolidated revenue for the BHCPF and increased investments to strengthen the capacity of PHC workers in service delivery and PHC monitoring.** Providers develop strategic planning tools, including business plans and annual quality improvement plans, that must align with national plans. The plans must detail how funds will be used, and providers must submit monthly reports to account for spending against the plans. These measures have facilitated monitoring of how PHC resources are used.
- **Malaysia identifies emerging health challenges using the National Health & Morbidity Survey, which is conducted every five years.** Data from the surveys identified challenges with undiagnosed and untreated NCDs among the bottom 40% of income earners. This informed the design of PeKa B40, which includes screening for and treatment of NCDs. By contracting with both public and private providers, ProtectHealth can shift services provided under PeKa B40 to private providers and reduce the long waiting times at public facilities. The government tracks progress and maintains oversight of resources that flow to both public and private providers using a web-based integrated information system managed by ProtectHealth.
- **Kericho County in Kenya follows a digitized PCN standard known as smartPCN.** Community health promoters use an electronic community health system and toolkit to provide and record community services, helping to generate accurate data on the number of patients visited. It also improves efficiency for patients who need facility-based services because their information is already available, facilitating the record retrieval process. Managers use the data to track diseases prevalent in the county and identify outbreaks early. The digital system is used to claim insurance reimbursements, track logistics, and request additional resources that are needed at the facility level. County-level smartPCN managers have recorded a doubling of revenue from health insurance funds. Challenges with the system, such as electricity access and maintenance of digital tools, have yet to be fully resolved, but the county is considering installing solar-powered generators to mitigate the power challenges.
- **Burkina Faso's public and private providers report services offered under the *Gratuité* scheme and claims processed through the e-*Gratuité* platform, which is linked to the DHIS2 health management information system.** The e-*Gratuité* system collects consumption, expenditure, service quantity, claims, and other data types from the central level. This gives managers oversight so they can intervene and make course corrections. Additional tracking is conducted via audits of resource use conducted every six months. An ongoing pilot of eight electronic data collection systems, including e-*Gratuité*, aims to create a "minimal digital ecosystem" to improve integration and strengthen oversight, planning, and resource allocation at the regional and central levels. For *Gratuité* in particular, this approach may help increase the scheme's efficiency, reduce fraud, reduce stockouts, and improve equity in the disbursement of scarce funds.
- **Mongolia is enhancing decision-making by consolidating performance indicators into a few key indicators that provide a broad view of health system performance.** Mongolia reduced the number of indicators over 10 years from more than 100 to fewer than 10 indicators, which are linked to performance-based payments. This required reaching consensus among stakeholders on the indicators to focus on.

# Using PCNs to Get More Out of Limited PHC Resources

PCNs are networks of PHC providers who collaborate to provide high-quality primary care to patients using a coordinated approach. Five of the countries have introduced PCNs to improve PHC coordination, access, quality, and efficiency. PCNs have operated in Colombia for 40 years, while PCNs are scaling up in Ghana and Kenya, piloting in the Philippines, and in the early pre-implementation phase in Indonesia. Although PCNs may look different in each country, they share the objectives of improving access to PHC by making better use of resources through streamlined functions and better use of information to make decisions across an entire population.

The five countries shared some common challenges with PCNs—some of which stem from the networks being a newer model of service delivery—and many regulatory and financing instruments still need to be developed or tailored to the specific needs of PCNs. Government agencies need to create a hospitable ecosystem in order for PCNs to achieve their objectives. Other ongoing challenges include creating the right resource allocation and resource flows to address subnational inequities and establishing the appropriate authority and capacity (especially for financial management). Other issues that must be addressed include the decision-making rights of hubs within PCNs relative to those of affiliated providers, clarifying roles within the network, and facilitating resource sharing among the facilities.

Because of the relative novelty of PCNs, much more learning needs to happen to support the countries implementing them, as well as documenting and sharing of their experiences for broader dissemination. More information from the PCN learning exchange can be found at this link.

# Looking Ahead at Continued Learning

The first meeting energized the group and created interest in continued joint learning in the remaining period of the collaborative. Collectively, the group identified approaches in seven areas to help improve resource allocation, funds flows, and use of resources at the PHC level:

- Service delivery organization and integration
- Provider payment
- Provider autonomy
- Financial and organizational management
- Resource allocation formulas and approaches
- Service agreements/contracts
- Engagement with the population

The participants also defined key topics for future learning, learning modalities, and proposed knowledge products to further efforts to implement foundational reforms to PHC. The facilitation team synthesized them into a learning agenda that was validated by participants in July 2024. As described in Annex 1, the three topics of focus going forward are:

- Developing resource allocation formulas and approaches that generate and ringfence sufficient resources for health (and PHC in particular)
- Designing provider payment mechanisms that offer providers incentives to align their behavior with health system goals and deliver high-quality care
- Giving providers more autonomy to use PHC resources effectively and in alignment with local priorities

Other topics of high interest were financial and organizational management, PCN financing, and medicines for PHC. The R4D technical facilitation team will communicate these to the JLN network manager for consideration in future learning collaboratives. The technical facilitation team will also seek opportunities to address these learning needs. Box 2 summarizes key insights from participants that emerged from discussions at the meeting.

### Box 2.
### Key Insights from the Meeting

- Despite the different challenges the countries face, they share the goal of financing PHC efficiently and effectively.
- Short-term steps are possible while waiting for longer-term policy changes.
- Countries have ongoing experiments and pilots for joint learning, including *e-Gratuité* in Burkina Faso, special health funds in the Philippines, PeKa B40 reforms in Malaysia, networks of practice in Ghana, and Indonesia and Mongolia's pay-for-performance models for PHC facilities.
- Options are available for sustainable ringfencing of PHC resources, as in Ethiopia and the Philippines.
- Increasing provider autonomy entails getting resources to the PHC level, giving providers the latitude to use the resources effectively, and ensuring accountability for effective use of resources.
- Data and evidence can help make a case for and demonstrate the results of effective use of PHC funds.
- Community participation matters.

# Annex 1. Learning Agenda

| | Proposed Questions | Subquestions | Countries | Learning Modalities | Proposed Knowledge Products |
|---|---|---|---|---|---|
| RESOURCE ALLOCATION | **What higher-level resource allocation decisions are needed for PHC, from the national level down to the subnational level?** | » Are subnational levels adequately resourcing PHC?<br>» What resource allocation criteria are needed for PHC financing, from the national to the subnational level? | Colombia<br>Ethiopia<br>Philippines | » Webinars<br>» In-person learning exchange | » PHC financing learning brief<br>» Case studies<br>» Repository/ compendium of PHC resource allocation strategies for decentralized settings |
| PROVIDER PAYMENT | **How can provider payment mechanisms be designed to achieve health system objectives (e.g., quality of care, sustainable financing, achievement of key performance indicators)?** | » How can PHC payment be linked to key performance indicators or pay-for-performance?<br>» How can provider payment mechanisms be designed for preventive and promotive services?<br>» How can the benefit package be matched to provider payment to reduce out-of-pocket spending?<br>» How can capitation be designed for PHC payment? | Botswana<br>Burkina Faso<br>Ethiopia<br>Ghana<br>Indonesia<br>Kenya<br>Lebanon<br>Malaysia<br>Nigeria<br>Vietnam | » Refresher webinars on the JLN tools and how they have been used<br>» Group problem solving | » Repository/ compendium of provider payment mechanisms for PHC (e.g., capitation, benefit packages, pay-for-performance indicators) |
| PROVIDER AUTONOMY | **What is an adequate level of provider autonomy over PHC resources at different levels of the health system (e.g., subnational vs. facility level)?** | » Is there a continuum for provider autonomy? What are the accountability arrangements for each level of the continuum? Can countries move along the continuum and get to the right balance?<br>» What accountability arrangements are appropriate, and how would they differ for rudimentary vs. digitized information systems?<br>» What are the prerequisites for adequate provider autonomy?<br>» What managerial skills are needed for effective financial management? | Botswana<br>Indonesia<br>Kenya<br>Lebanon<br>Liberia | » Webinars<br>» In-person learning exchange<br>» Collaborative problem solving (e.g., LabStorm) | » Learning brief on the continuum of provider autonomy and accountability arrangements<br>» Country case studies |

# Annex 2. Participant List

| Country | Name | Affiliation |
|---|---|---|
| **Botswana** | Sandra Maripe | MOH |
| | Mildred Masiga | MOH |
| | Onalenna Mokena | MOH |
| | Realeboga Radimo | MOH |
| | Thamiso Sebolao | MOH |
| **Burkina Faso** | Francis Bamogo | Technical Secretariat for Health Financing Reforms, Ministry of Health and Public Hygiene (MOHPH) |
| | Wasso Wenceslas Koita | General Directorate of Sectoral Studies and Statistics, MOHPH |
| | Haoua Ouedraogo | Central Purchasing of Essential and Generic Medicines |
| | Boezemwendé Ouba Kabore | Directorate of Health Promotion and Education, MOHPH |
| | Daniel Yerbanga | Regional Directorate of Health and Public Hygiene, MOHPH |
| **Colombia** | Flor Nelly Ante | Secretaría de Salud del Cauca |
| | Beatriz Bohórquez | Secretaría de Salud del Cauca |
| | Carolina Camargo | Secretaría de Salud del Cauca |
| | Vivian Rivera | Secretaría de Salud del Cauca |
| **Ethiopia** | Amanuel Haileselassie Gebremedhin | MOH |
| | Muluken Argaw Haile | Ethiopia Health Insurance Service |
| | Aklog Gethet Kibret | MOH |
| | Mengesha Magdelawit | MOH |
| **Ghana** | Badu Agyemang | Health Facilities Regulatory Agency |
| | Daniel Adin Darko | National Health Insurance Authority |
| | James Duah | Christian Health Association of Ghana |
| | Maureen Martey | MOH |
| | Alberta A. Biritwum Nyarko | Ghana Health Service |
| | John Ekow Otoo | Eastern Regional Health Directorate |
| **Indonesia** | Dewi Kurniawati | Kota Kediri District Health Office |
| | Febriansyah Budi Pratama | MOH |
| | Rahmad Asri Ritonga | BPJS Kesehatan (national social security agency) |
| | Tedo Arya Trisnanto | BPJS Kesehatan |
| **Kenya** | Beatrice Amboko | KEMRI-Wellcome Trust Research Programme |
| | Fredrick Angwenyi | MOH |
| | Hajara Busaidy | County Government of Kwale |
| | Gregory Ganda | County Government of Kisumu |
| | Salim Hussein | MOH |
| | Aden Hussein Ibrahim | County Government of Garissa |
| | Jacob Kazungu | Kenya CCG, World Bank |
| | Mercy Irene Kimani | MOH |
| | Claver Kimathi | County Government of Isiolo |
| | Betty Langat | County Government of Kericho |
| | Valeria Makory | MOH |
| | Roselyn Mungai | County Government of Nakuru |
| | Jarred Nyakiba | MOH |
| | Ahmednadhir Omar | County Government of Garissa |
| | Robert Rapando | Council of Governors |
| | Esther Wabuge | World Bank |
| | Elizabeth Wangia | MOH |

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|---|---|---|
| **Lebanon** | Lama El Aridi | Project Management Unit, Lebanese Ministry of Public Health (funded by the World Bank) |
| | Ismail Fawaz Hicham | Ministry of Public Health |
| **Liberia** | Marvin J. Gbartoe | River Cess County Health Team, MOH |
| | Vera G. Mussah | MOH |
| **Malaysia** | Premila Devi Jeganathan | MOH |
| | Najwa Binti Ahmad Hamdi | MOH |
| | Mohd Hazayri Bin Jamaluddin | Primary Health Branch, Kuala Lumpur and Putrajaya Health Department |
| | Rima Marhayu Binti Abdul Rashid | MOH |
| | Azah Binti Abdul Samad | Seksyen 7 Shah Alam Health Clinic |
| **Mongolia** | Batbayar Ankhbayar | National Health Insurance Agency and Economic Finance Department, MOH |
| | Battsooj Batchuluun | UB City Health Department (provincial) |
| | Gerelmaa Jamsran | Board, Rural PHC Provider Association |
| | Gerelt-Od Namdag | Department of Policy and Planning, MOH |
| **Nigeria** | Musa Abubakar | Gombe Contributory Health Insurance Scheme |
| | Kinikanwo Green | Rivers State Primary Healthcare Management Board |
| | Abubakar Muhammad Kurfi | National Health Insurance Authority |
| | Uzoma Chukwuonye Nwankwo | Federal Ministry of Health |
| | Shamsuddeen Aliyu Sa'ad | National Primary Healthcare Development Agency |
| **Philippines** | Kathrine Joyce D. Flores | Bureau of Local Health and Systems Development, Department of Health |
| | Mary Antonette Y. Remonte | Office of the Chief Executive Officer and Chief Operating Officer |
| | Francisco Sarmiento III | Primary Care Provider Network |
| | Lilia Rose Say-awen | Cordillera Administrative Region |
| | Ambella G. Taruc | Cotabato City |
| **Vietnam** | Nguyen Thi Thang | Health Strategy and Policy Institute |
| | Thanh Thuy Phan | MOH |
| **Partners** | Martin Alilio | USAID Office of Health Systems |
| | Stephen Duku | USAID Ghana Mission |
| | Meredith Kimball | Gates Ventures |
| | Joseph Anthony Lachica | USAID Philippines Mission |
| | Tracey McNeill | Bill & Melinda Gates Foundation |
| | Meshack Ndolo | Bill & Melinda Gates Foundation |
| | Wangari Ng'ang'a | Bill & Melinda Gates Foundation |
| | Stephen Pope | Bill & Melinda Gates Foundation |
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| **Technical Facilitators** | Cheryl Cashin | R4D |
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