

Financing Primary Health Care: How JLN Member Countries Allocate Resources to Improve Care and Enhance Equity



Resource allocation—the rules, criteria, and systems for distributing public funds to various sectors, including health—is a critical component of health budgeting systems. This brief summarizes the resource allocation practices of the 14 member countries of the Foundational Reforms for Financing and Delivery of Primary Health Care (PHC) Collaborative, a peer-to-peer learning collaborative of the Joint Learning Network for Universal Health Coverage (JLN). It describes approaches that countries can adopt to reduce the barriers to effective resource allocation and ensure that sufficient resources are available for people-centered PHC services.

Primary health care (PHC) is the backbone of universal health coverage (UHC). Investing in PHC not only promotes more equitable access to care but also improves system efficiency, particularly when resources are scarce. As external funding for low- and middle-income countries declines, governments must critically assess how to adequately finance PHC while capturing the efficiency gains that come from making PHC a priority. Even without identifying new funding sources, countries can strengthen PHC by setting priorities and allocating funds more strategically.

The effectiveness of PHC depends heavily on the amount of funding allocated to it, how equitably that funding is distributed, how efficiently it reaches providers, and how much discretion providers have in spending it. In many countries, PHC is chronically underfunded and health funding allocation mechanisms favor hospitals, diverting resources away from PHC providers. Allocations are often based on historical costs and are constrained by rigid line-item or input-based budgeting systems that entrench inefficiencies and inequities.

Even when explicit allocations are made for PHC, they must be supported by structures and frameworks that ensure more transparent and data-driven allocation processes. Technical and political decisions underlie the visibility of PHC within budget formulation and execution, along with clear institutional roles and responsibilities for securing PHC funding and tracking and reporting on its use.

Strategically allocating resources to PHC, by making PHC more visible in budgets, involves applying population-based and needs-based formulas, linking funding to performance, and using evidence-based priority setting to equitably redistribute existing resources, mobilize new funds, and improve efficiency.

Determinants of Low PHC Financing

Across the 14 JLN collaborative countries, PHC financing varies, but on average PHC receives less than 40% of total health expenditure allocated to providers. Most resources are directed to hospitals and specialized care, even in low-resource settings. Several factors contribute to this persistent underfunding, including unclear institutional responsibility for PHC, limited visibility of PHC in budgeting processes, low priority given to PHC, and the effects of budget formulation procedures. Moreover, the structure of governance, whether centralized, decentralized, or devolved, can significantly shape how resources are allocated to PHC.

The determinants of low PHC financing are summarized below.

- » **Fragmented sources of PHC funds and mixed allocation processes.** In the collaborative countries, general revenue taxation remains the predominant source of PHC financing, complemented by national health insurance (e.g., Ghana, Indonesia, the Philippines, Colombia, and Vietnam), earmarked donor funds in vertical programs or special funds (e.g., Liberia, Burkina Faso, Ethiopia), and dedicated health levies (e.g., Nigeria's Basic

Health Care Provision Fund). The source of funds often shapes the budgeting approach—whether top-down, bottom-up, or a hybrid. Where facilities participate in budgeting and planning, allocations are more likely to reflect community health needs and local priorities.

- » **Low priority and visibility of PHC.** Fragmentation of PHC funding across multiple programs and departments can obscure PHC during the budget formulation process. When PHC is not a clear priority, resources tend to favor hospital infrastructure and specialized services that attract political attention. Estimating the resources required to finance a PHC benefit package (as in Ghana’s preventive and promotive package) and making that visible in the budget (as in Mongolia’s program-based budget) can support allocation and tracking of funds for PHC.
- » **Fragmented institutional responsibility for PHC.** When PHC functions are fragmented across multiple agencies and departments within ministries of health, ownership and accountability are weakened. Without clearly defined institutional responsibility for PHC, securing adequate funding and systematically tracking progress for PHC often become peripheral concerns during budgeting. In many JLN countries, dedicated institutional “homes” for PHC are limited. Instead, subnational governments frequently have primary responsibility for PHC delivery, with varying capacities and fiscal autonomy.
- » **Limitations of centralized, decentralized, or devolved systems.** The type of governance system also affects PHC allocations. In centralized systems (e.g., Botswana, Malaysia, and Vietnam), PHC resources are allocated mainly through the national budget, promoting equity and stability but often limiting flexibility to address local needs. Decentralized systems (e.g., Colombia and Mongolia) share allocation authority between the central and regional levels, allowing for local adaptation but sometimes resulting in fragmented and uneven PHC funding. Devolved systems (e.g., Kenya and the Philippines) transfer full control of PHC funding to subnational governments, making PHC more responsive to local needs but also exposing it to weak local fiscal management capacity or governance. In Kenya, for example, facility-level revenue retention through the Facilities Improvement Financing Act has inadvertently led to the crowding out of PHC resources at the county level.

Resource Allocation Mechanisms Used by the Collaborative Countries

Countries use a variety of mechanisms to allocate resources for health, including earmarked funds and conditional grants, as shown in Table I. (In some of the countries, the mechanisms indicated in the table also apply to resource allocation to and within subnational levels.)

Table I. Mechanisms Countries Use to Allocate Resources for Health

Country	Historical Allocation + Incremental Adjustments	Population-based Allocation	Program-based Allocation	Needs-based Allocation	Geographic or Formula-based Allocation
Botswana	X				
Burkina Faso	X				
Colombia		X		X	X
Ethiopia		X			X
Ghana	X	X	X		
Indonesia	X	X	X		X
Kenya		X	X		X
Lebanon	X				
Liberia	X				
Malaysia	X				
Mongolia			X	X	X
Nigeria	X	X			
Philippines	X				
Vietnam	X				

Allocation mechanisms can have both positive and negative effects on meeting health objectives, so some countries use multiple mechanisms to increase PHC funding. Objective allocation criteria (such as population-based, needs-based, or equity-adjusted formulas) can help ensure that resources are distributed equitably and address health disparities across geographic areas. Some countries also use conditional grants, performance or equity weights, and earmarks to cascade national priorities to the subnational level.

- » **Historical allocation + incremental adjustments.** Funds are distributed based on previous years' budgets, inputs, or historical costs and past spending patterns, with minor adjustments. In Botswana, Malaysia, and Burkina Faso, health budgets are based on historical costs with incremental adjustments.
 - **Pros:** This allocation mechanism is commonly used and is simple and predictable. It also ensures standardization and accountability to the ministry of health (MOH) and ministry of finance (MOF).
 - **Cons:** This mechanism creates rigidity and constrains effective matching of the budget to sector priorities. It can also perpetuate and entrench inefficiencies and inequities between geographic areas and does not account for changing health needs. For example, allocations that favor wealthy areas will continue if equity is not a consideration in the allocation process. This mechanism can also reinforce lack of transparency, with subnational stakeholders and facility managers not knowing the allocation criteria and having to negotiate to get local needs met.
- » **Population-based allocation.** Population-based formulas allocate funds based on the number of people in a region or district and can be weighted for age, gender, facility remoteness, service delivery indicators, and/or outcomes. Kenya's 2023 Primary Health Care Act and Nigeria's Basic Health Care Provision Fund apply explicit population-based formulas that account for population size and geographic needs.
 - **Pros:** This mechanism is more transparent and objective than historical allocation and aligns funding with population size rather than inputs or existing infrastructure, which would favor urban areas with more health facilities.
 - **Cons:** It requires accurate data on population size and adjustment factors / weighting criteria to ensure transparent and fair allocation across primary care facilities. It does not factor in differences in health needs without further adjustments and can risk underfunding areas with higher disease burdens.
- » **Program-based allocation.** Program-based allocation (including earmarks and conditional grants) is structured around programs or service areas and dedicates funds for specific programs (e.g., PHC, maternal health) to link funding to priorities and outcomes. Program-based budgets are used in Ghana, Kenya, Indonesia, and Mongolia. Conditional grants are funds transferred from the central government to lower levels that are tied to meeting specific conditions or delivering specific services (e.g., immunization, maternal care). Earmarks are funds that are legally or administratively designated for specific programs or purposes (e.g., the Sustainable Development Goals Fund in Ethiopia).
 - **Pros:** National governments can use these mechanisms to "protect" resources for PHC and ensure that national objectives are served by subnational activities and high-priority services are funded.
 - **Cons:** This approach can perpetuate fragmentation, which can crowd out funding for services that are not designated as high priority.
- » **Needs-based allocation.** This mechanism distributes funding based on health indicators such as burden of disease, poverty level, geographic disparities, or facility density (as in Colombia and Mongolia).
 - **Pros:** This mechanism promotes equity by directing funds to underserved or high-need areas and can reduce geographic disparities.
 - **Cons:** It requires quality data on disease burden, poverty indices, and so forth.

- » **Geographic or formula-based allocation.** This mechanism uses formulas and adjustment criteria that account for population demographics (population size, age structure), epidemiology (disease burden), health needs, and geography (rural/urban, remoteness). Formulas can also take into account service coverage or cost of service delivery. Kenya uses a county revenue allocation formula to allocate the national budget to subnational units (counties). The formula is based on a set of parameters designated by the Commission of Revenue Allocation and includes population size, poverty, geographic size, and equal-share distribution.
 - **Pros:** This mechanism is transparent and objective and can incorporate multiple equity factors.
 - **Cons:** It requires high-quality data and may face resistance from leaders and others with influence if it redistributes resources away from areas with significant political and social power. The complexity of the formula can also limit understanding and acceptance.

Key Insights from the Collaborative

A global consensus is forming—supported by evidence—that PHC can deliver cost-effective care that reduces long-term burdens on health systems and enhance equity, especially for rural and underserved populations. This recognition has not been matched with adequate resources, however. The JLN collaborative members agree that addressing the root causes of low resource allocation to PHC requires strong political will and both long- and short-term reforms. Their key insights include:

- » **PHC is the backbone of UHC and the foundation of equitable, cost-effective health systems.** Given existing resource envelopes, countries can improve health outcomes by gradually shifting resources to PHC to reach more people with the basic services that address the majority of health needs.
- » **Improving health equity is a key objective for many governments.** To achieve equitable access to PHC services, public financing should be the primary source of PHC funding. Evidence shows that increases in government spending on health lead to expanded service coverage and lower out-of-pocket spending.
- » **Transparency about allocation methods can help manage pushback against redistribution of resources.** Governments can clearly define PHC—specifying which programs, services, or populations need more funding—and improve tracking of PHC spending. They can start with evidence routinely generated by their health systems to identify geographies with poorer health outcomes and use resource allocation mechanisms to distribute funds more equitably.
- » **Escalating health care costs and shrinking external donor funding are significantly limiting PHC funding.** Countries with large portions of their health sector supported by external funding must urgently adopt public financial management (PFM) policies and tools to protect resources for PHC and help capture the efficiency gains that come from PHC. PFM rules that govern budget formulation can support countries in shifting from traditional allocation mechanisms that perpetuate inequities to mechanisms that consider population health needs and demographics.
- » **Governments can use resource allocation methods to create incentives for subnational governments to support national priorities.** In settings where resources are not allocated directly to facilities, governments can include facility managers in budget formulation and planning, to ensure that budgets take into account the unique needs of communities.

Resource allocation can be both a financing tool and a governance and management tool that defines the budgetary space for PHC and ensures its visibility. Strategic resource allocation can improve health outcomes by fostering equity and increasing access, quality, and value for money.

Table 2 summarizes the allocation practices of four JLN member countries.

Table 2. Allocation Practices of Four JLN Member Countries

	Botswana	Ghana	Malaysia	Mongolia
Funding Sources for PHC	General taxation (government), medical aid schemes, private insurance, out-of-pocket (OOP) payments, development partners	General government funding from taxes, national health insurance reimbursements, user fees (OOP), donor support	General taxation (MOH), ProtectHealth schemes	General taxes, Health Insurance Fund, OOP payments for unreimbursed medicines
Allocation Processes for PHC	Centralized and top-down via MOH and Ministry of Local Government and Rural Development; inputs consolidated into the baseline budget; facility inputs in annual plans for recurrent revenue and expenditure; some considerations for population size, service utilization and disease burden for donor-funded programs	Bottom-up and top-down—health facilities prepare annual plans and budgets for approval by district and regional health directorates; MOF budget allocation for PHC goes through MOH and Ghana Health Service to PHC providers	Top-down via MOH/MOF incremental budgeting; facilities submit budget requests but allocations are centralized	MOH transfers funds to health insurance organizations for capitation payments—80% transferred monthly and 20% based on performance assessment; local governments finance PHC facility operations, transferring funds to facilities' treasury accounts for use according to facility expenditure plans
Allocation Mechanisms Used	Mainly historical and input-based central budget allocations with administrative ceilings; needs-based allocation formula for subnational levels has been planned	Historical budgets with program ceilings; population-based allocation to regions and program-based budgeting	Historical trends, program ceilings; ProtectHealth fees/tariffs set administratively	Capitation allocation formulas that include age, geography, risk-based population adjustment factors (children, women of reproductive age, older adults), location-based risk adjustments (remoteness)

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