How can Low-and-Middle-Income countries overcome bottlenecks in the flow of funds to Primary Health Care (PHC) providers? – Experiences from members of the Joint Learning Network for Universal Health Coverage (JLN)

While it is widely accepted that public funding should be the predominant source of health resources for more equitable health financing, most low and lower-middle income countries (LMICs) do not allocate adequate public resources. Low public spending on health constrains resources available to primary care providers and increases fragmentation and inefficiency in service delivery.

The growing consensus to strengthen PHC as the backbone for UHC, means that countries are looking for ways to address the root-causes of weak PHC system financing and service delivery, and ways to do more with the available resources.

The Joint Learning Network for Universal Health Coverage (JLN) is a practitioner-to-practitioner network of 39 countries with the shared objective to make progress towards UHC. The JLN Foundational Reforms for Financing and Delivery of PHC collaborative (Foundational Reforms Collaborative) brings together 14 of these countries[1] making incremental changes to the foundations of PHC to improve how resources reach primary care providers. The countries share practical experiences, engage in collective problem solving, share lessons and exchange ideas on the reforms ongoing in their countries.

The collaborative members have identified seven (7) actions and levers their countries are taking to address the challenges to effective PHC:

1. **Adopting resource allocation criteria to determine how resources flow to geographic areas**. Most countries within the collaborative give subnational levels responsibility for some health functions, including PHC. Objective criteria are needed to ensure that resources are equitably shared across subnational levels to address health disparities across geographic areas. Equitable "horizontal allocation" principles can ringfence resources for health and direct more resources to PHC.
2. **Making provider payments more strategic:** Countries are using different approaches to select, design, and implement provider payment methods and setting payment rates to enhance flow of resources to primary care providers. They are also linking payment to services in the benefit package to create incentives for primary care providers to deliver high-quality services.

[1] Botswana, Burkina Faso, Colombia, Ethiopia, Ghana, Indonesia, Kenya, Lebanon, Liberia, Malaysia, Mongolia, Nigeria, Philippines, Vietnam

3. **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.
4. **Reorganizing and integrating service delivery to 'pull' more resources into PHC**: Countries are using different approaches to reorganize their service delivery systems and increase direct investments into PHC. For example, several Collaborative member countries are at varying stages of implementing Primary Care Networks (PCN) that allow for horizontal or vertical integration[2] and sharing of resources to improve service delivery.
5. **Increasing provider autonomy to allocate and use resources and respond to provider payment incentives**: The level of decision-making authority at PHC facilities in areas such as financing, personnel, and service delivery varies across countries. The more areas in which providers have decision-making rights, the more flexibility they have to respond to incentives within provider payment systems and respond to the changing needs of the communities they serve.
6. **Improving financial and organizational management capacity.** PHC facility managers need strong skills in facility management, personnel management, financial management, and information technology (IT), to enable them respond to incentives of provider systems to meet the needs of the populations they serve.
7. **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. This requires ongoing community engagement to build trust in primary care facilities so communities do not bypass them to access expensive care in hospitals. Communities can also be engaged in budgeting processes so they can advocate for more public resources for PHC at the community level.

At the 2025 International Health Economist Association Conference, practitioners and technical facilitators will review the evidence from four JLN member countries on how they are deploying these actions to manage the consequences of low PHC resources within their countries to improve health outcomes. Workshop participants will reflect on their country's journeys to UHC through strengthening of primary care services and examine challenges and the levers available to improve outcomes.

The session will be broken into two parts: a facilitated panel discussion with implementers from four JLN collaborative countries and an interactive group session with all participants to discuss and reflect on country's journeys to building robust and equitable PHC systems.

[2] 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 across different levels of care e.g., health centers and PHC hospital or health center and Community Health Workers

Panel Discussion

Four countries from the collaborative will discuss reforms and levers to improve financing and delivery of PHC services. In this session, **Indonesia, Ethiopia, Kenya and the Philippines** will describe the practical steps they are taking to tackle fragmentation in resource allocation to PHC. They will also discuss how they are increasing primary care providers' autonomy to utilize resources to meet the changing needs of the populations they serve. The countries are at varying stages of reforms and will discuss successes, challenges and lessons.

Indonesia: Since 2007, Indonesia has implemented two major reforms to improve autonomy of public health providers and reduce fragmentation in health coverage with the introduction of *Badan Layanan Umum Daerah* (BLUD) and the national insurance programme, Jaminan Kesehatan Nasional (JKN). BLUD aims to increase the flexibility and autonomy of hospitals to provide efficient and effective services to the community. In 2014, Indonesia consolidated multiple public insurance schemes under a single pool through JKN managed by a single insurer Badan Penyelenggara Jaminan Sosial Kesehatan (BPJS-K). Indonesia will discuss the effects of consolidation of the funding pools, harmonizing the main purchasing functions, how implementation of BLUD has increased autonomy of *Puskesma*s and how the reforms are impacting PHC financing and service delivery.

Ethiopia: The MOH manages a pooled funding mechanism into which donors contribute, enabling the MOH to make federal grants that primarily go to PHC services. The country is also improving PHC delivery at health posts by upgrading infrastructure and staffing to create comprehensive health posts and incorporating community health extension workers. Ethiopia will discuss how they have consolidated different sources of funds to reduce fragmentation and are increasing allocation to PHC services.

Kenya: In 2023, Kenya passed the PHC Act to strengthen the legal and regulatory foundation for PHC reorganization. Amongst these, the Facility Improvement Financing (FIF) Act seeks to improve flow of resources to primary care providers and align funding sources for PHC under the Social Health Authority. Previously, counties followed their own FIF laws, resulting in patchy implementation of national policies. The Kenya representative will discuss the successes and challenges across counties and the lessons being implemented to address the early bottlenecks.

Philippines: 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 national resources that were supposed to flow to subnational levels to support decentralized functions was contested in court resulting in the 2018 Mandanas increasing the share of resources flowing to

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. Implementation of the Mandanas ruling has increased available resources at the subnational level, and innovations are being tested to empower local governments to ringfence health resources in a special health fund. Philippines will share lessons from the reforms on increasing allocation to subnational levels and how the innovations are improving the flow to PHC providers.

Session objectives:

- Share JLN member country experience and lessons on allocating PHC resources and improving funds flow to primary care facilities

Expected outcomes:

- Disseminate the learnings and knowledge products from the collaborative to a global audience

Participatory Session

Workshop participants will break up into 5 groups. The session is designed for participants to examine the levers available to address the root-causes of their country's PHC performance and reflect on their country's journey to strengthening PHC, increasing the share of funds allocated to PHC, improving how and when funds flow to providers and the opportunities to utilize them.

Group 1	Group 2	Group 3	Group 4	Group 5
Dr. Cheryl Cashin & Rachel Gessel	Dr. Amebella (Amy) Taruc & Luis Pulido	Dr. Selamawit Getachew Hiruy, and Agnes Munyua	Dr. Mercy Wanjala & Adwoa Twum	Ratu Martiningsih, Ali Ghufron Mukti & Aditia Nugroho

Participants will review the seven systematic levers or actions countries are using to address the consequences of low PHC funding, identify if these reforms resonate within their settings and share other systematic reforms being implemented in their countries. Group facilitators will use systematic levers infographic to moderate discussions.

Session objectives:

- Engage with session participants to gather lessons on resource allocation and provider autonomy practices in their countries

Expected outcomes:

- Document lessons from session participant countries to incorporate into the collaborative knowledge products.

Agenda – Sunday, 20th July 2025 | 8:30am – 12:00pm

Time	Activity	Facilitator/Presenter
8:30 am 5 mins	Opening and framing of the session: • How important domestic public resources for PHC is, within the current challenges of dwindling external resources which may shift external funding to non-traditional funding approaches (such as collaborative learning) and away from routine health system inputs.	Adwoa Twum
8:35 am (70 mins) 5 mins - Framing 50 mins - Conversation 15 mins	Panel Discussion: Cheryl will frame the session, providing evidence on how the levers are being used to address the consequences of low and fragmented PHC financing, with particular emphasis on the levers of resource allocation and provider autonomy. She will pose questions to collaborative members to reflect on how the levers are being implemented within their context. Questions and reflections from the audience.	 Dr. Cheryl Cashin Country representatives: Prof. Ali Ghufron Mukti, and Ms. Ratu Martiningsih (**Indonesia**), Dr. Selamawit Getachew Hiruy (**Ethiopia**), Dr. Mercy Wanjala (**Kenya**), Dr. Amebella Taruc (**Philippines**)
9:40 am **15 mins**	**Break**	
10:00 am 50 mins	Group Session: Break out into 5 groups of 5 participants each. Participants will examine and reflect on the infographics on the levers to address low and fragmented public financing for PHC services. Illustrative questions to facilitate discussions:	Group Facilitators Participants

	• What services are described as PHC in your country and which of them are funded by public resources? And which are funded through external/private sources? • What reforms are ongoing in your country to address the bottlenecks of low and fragmented funding for PHC? • Which of the levers resonate with your country's context? How are they being implemented to improve PHC systems? • How do you encourage flexibility in PHC facility spending to respond to community needs? • Brainstorm feasible solutions to address these bottlenecks and increase funds flow and use to PHC providers. • What is the research agenda for PHC financing in your country/institution?	Tools: Template to review and document country experience.
30 min	Report out from group session: highlights and key learnings	Luis Pulido
15 mins	Q&A	
15 mins	Wrap-up and Key Messages	Agnes Munyua
3.5 hours		