How Can Countries Overcome Bottlenecks to Primary Health Care Provider Fund Flows and Provider Autonomy?

Experiences from Members of the Joint Learning Network for Universal Health Coverage (JLN)

July 20, 2025

1PM - 4PM (GMT +7)

Singaraja (2, Bali International Convention Centre)

IHEA 2025 Congress

Bali, Indonesia

July 19 - 23

RESULTS FOR DEVELOPMENT

IHEA INTERNATIONAL HEALTH ECONOMICS ASSOCIATION

JOINT LEARNING NETWORK For Universal Health Coverage

Join at menti.com | Use code 8956 4292

Mentimeter

Go to

www.menti.com

Enter the code

8956 4292

Or use QR code

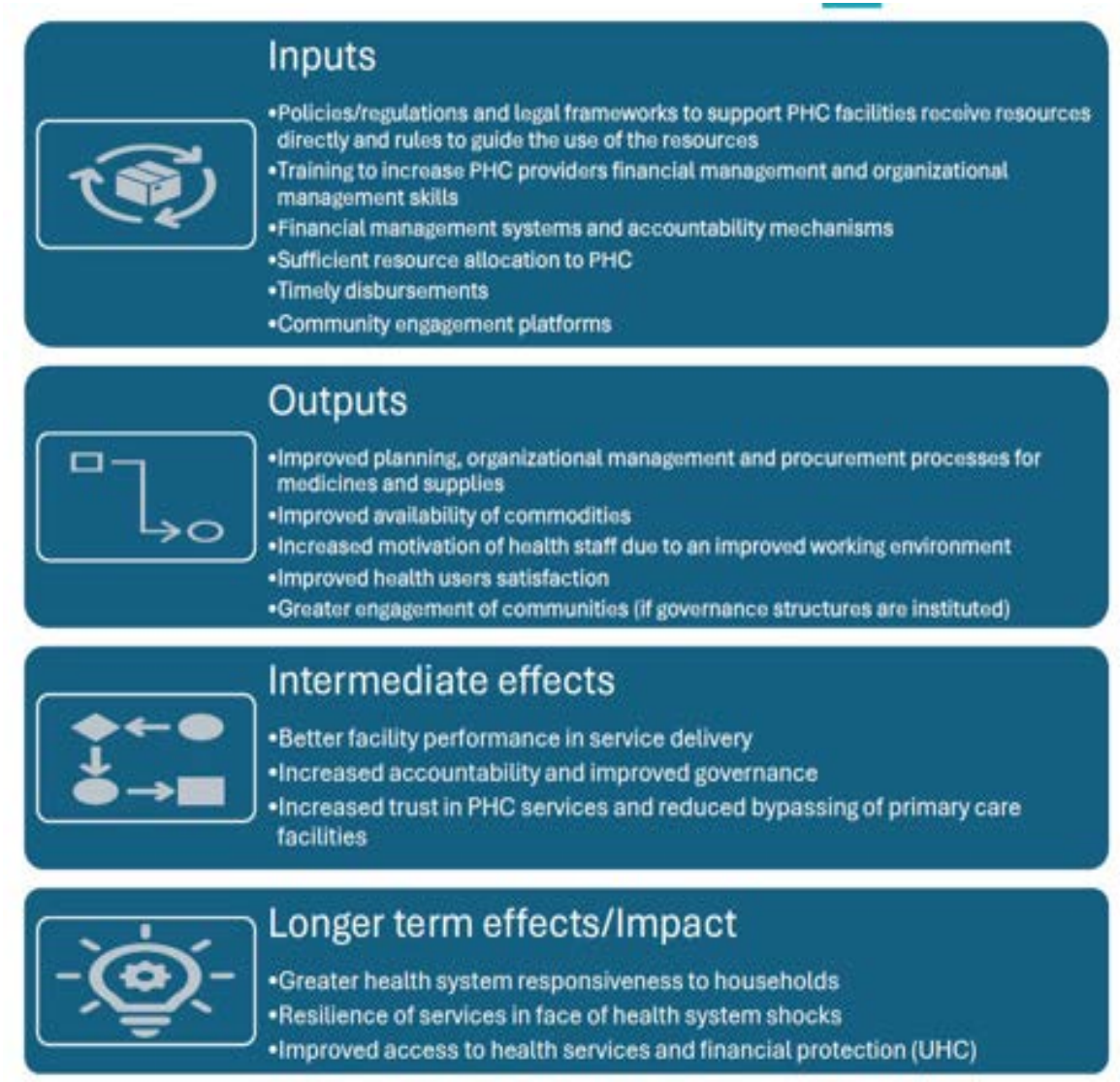
WELCOME AND OPENING REMARKS

Dr Agnes Munyua

IHEA HIGH-LEVEL AGENDA

July 20th, 2025		
Time	**Activity**	**Facilitators/Presenters**
1:00 – 1:05 pm	Opening and Framing of the Session	Agnes Munyua
1:05 – 1:20 pm	Overview of the Foundational Reforms Collaborative	Adwoa Twum
1:20 – 2:30 pm	Panel Discussion: Country Experiences on Overcoming Bottlenecks to PHC Funding	Agnes Munyua – **Moderator** **Panelists** Prof Ali Ghufron Ratu Martiningsih Dr Selamawit Getachew Dr Mercy Wanjala Dr Amy Taruc Dr Joe Kutzin – **Discussant**
2:30 – 2:45 pm	Break	
2:45 – 3:35 pm	Breakout Sessions: Country Reflections on Increasing Funds Flow to PHC Facilities	Technical Facilitation Team
3:35 – 4:15 pm	Report Back from Breakout Groups	Dr Luis Bernal Pulido
4:15 – 4:25 pm	Closing Reflections and Key Messages	Dr Joe Kutzin
4:25 – 4:30 pm	Final Wrap-Up and Next Steps	Agnes Munyua

PROPOSED THEORY OF CHANGE FOR PHC PROVIDER AUTONOMY



OVERVIEW OF THE FOUNDATIONAL REFORMS FOR FINANCING AND DELIVERY OF PRIMARY HEALTH CARE COLLABORATIVE

COLLABORATIVE OVERVIEW

- JLN is a network of practitioners and policy makers from 37 countries.
- 2-year collaborative from Oct

  2023 – Sept 2025
- 14 countries* at different stages of PHC reforms
- Developed a learning agenda of three workstreams: **resource allocation**, **provider payment mechanisms** and **provider autonomy**

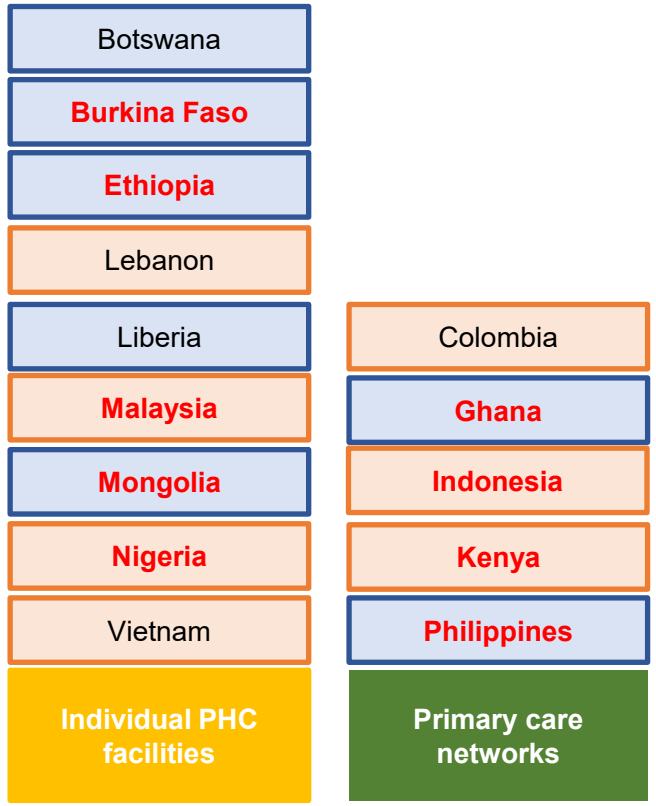
*Botswana, Burkina Faso, Colombia, Ethiopia, Ghana, Indonesia, Kenya, Lebanon, Liberia, Malaysia, Mongolia, Nigeria, Philippines, Vietnam.

OVERVIEW OF PHC FINANCING IN THE 14 COUNTRIES.

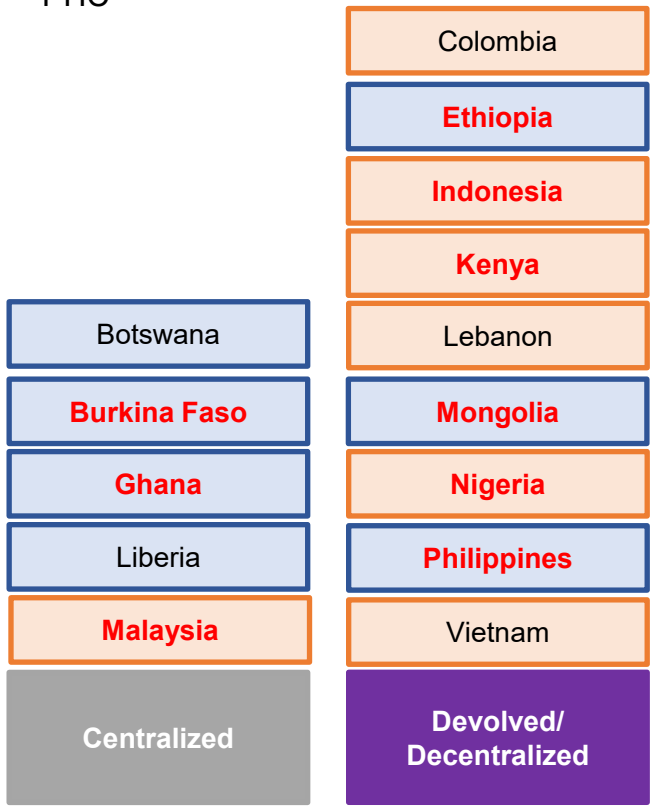
PHC SERVICE DELIVERY CONFIGURATIONS

- Half the countries have predominantly public providers >55%
- Half the countries have a mixed health system

- Five countries are testing new service delivery configurations to improve service delivery and efficiency in resource use

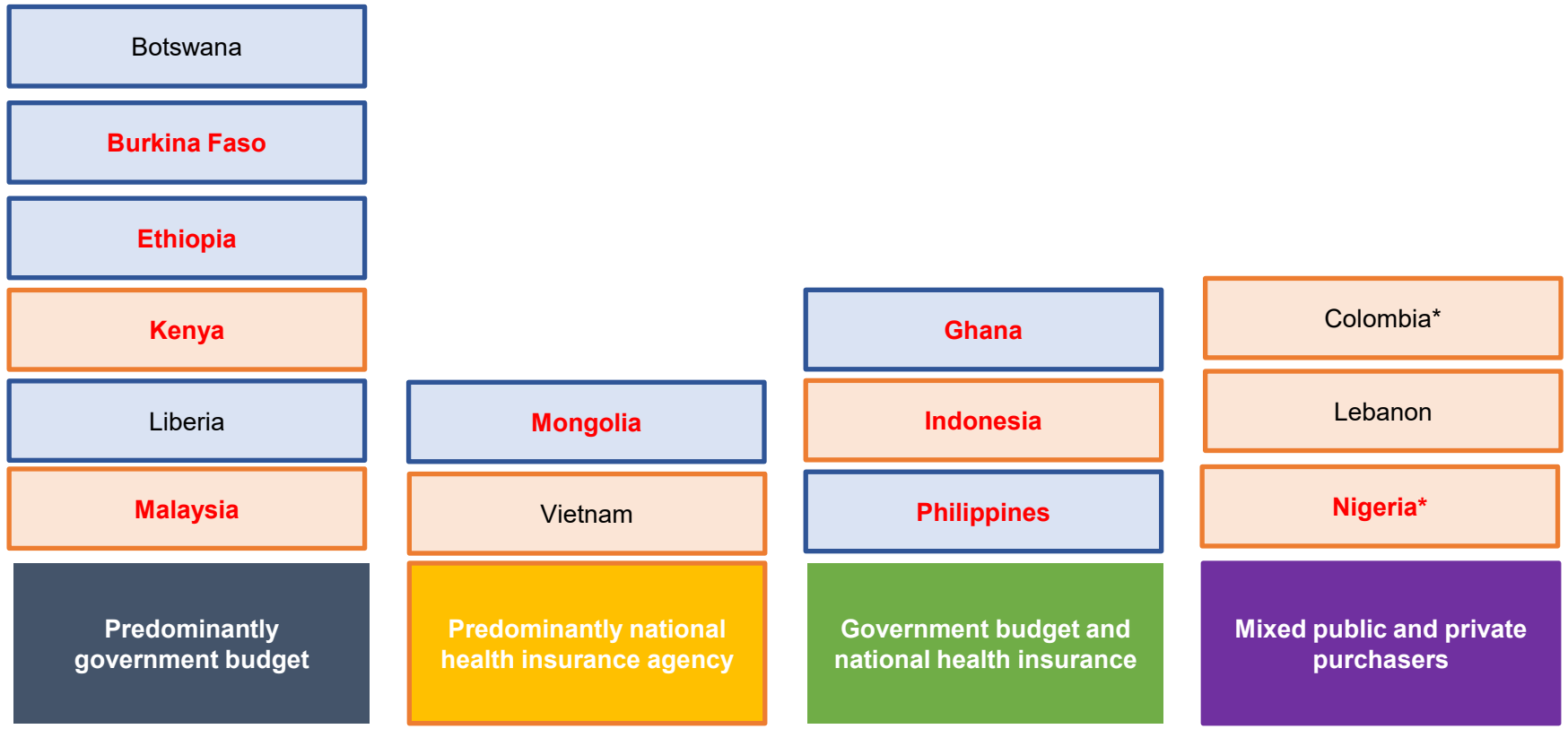


- Most countries have a decentralized/devolved system of government
- Sub-national levels have significant responsibilities for PHC



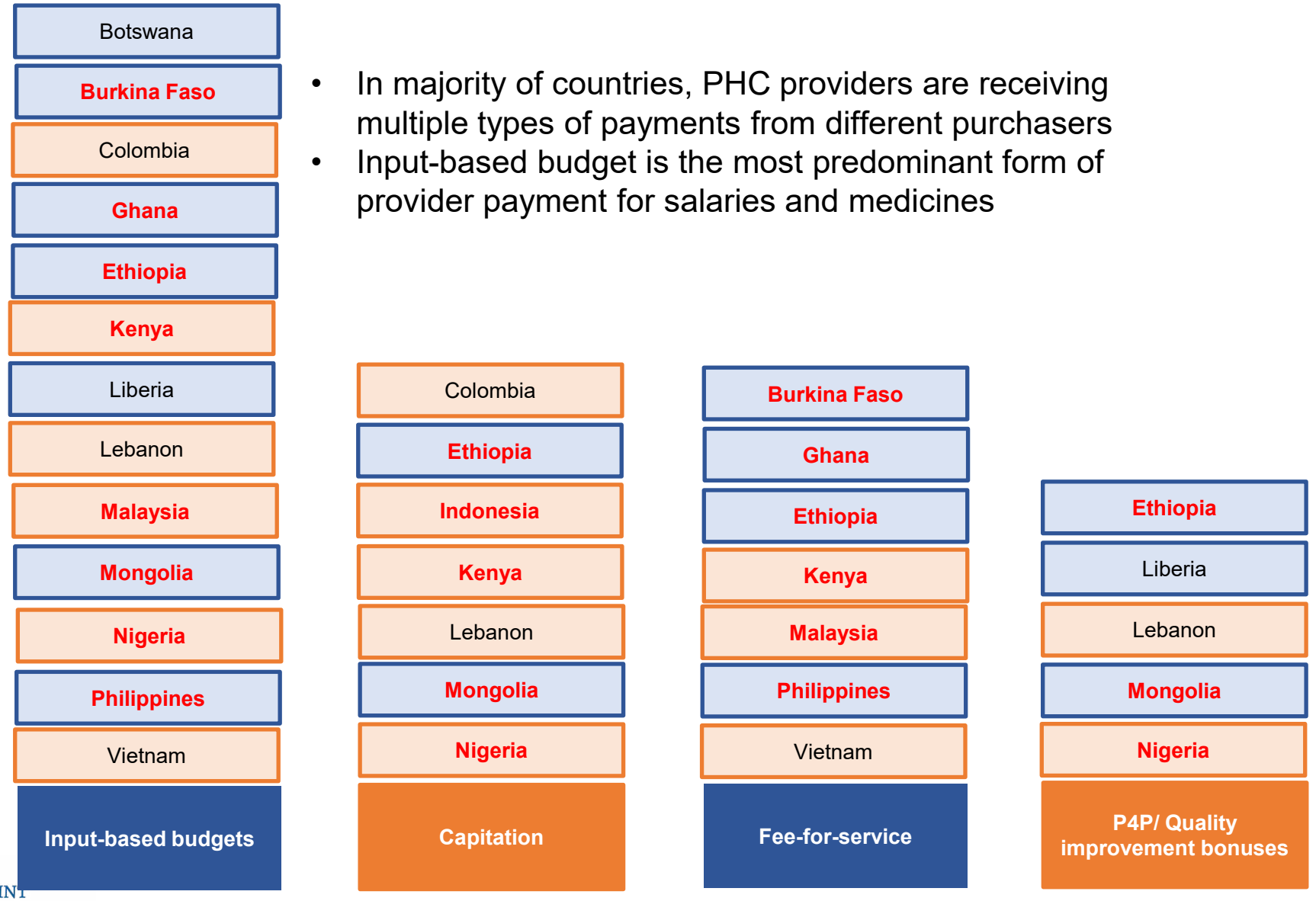
PREDOMINANT PURCHASING AGENCIES OF PHC CARE

- Purchasing of PHC is fragmented across multiple agencies in most countries
- Predominant purchaser of pooled funds is a government agency in most countries either national/social health insurance or through the government budget

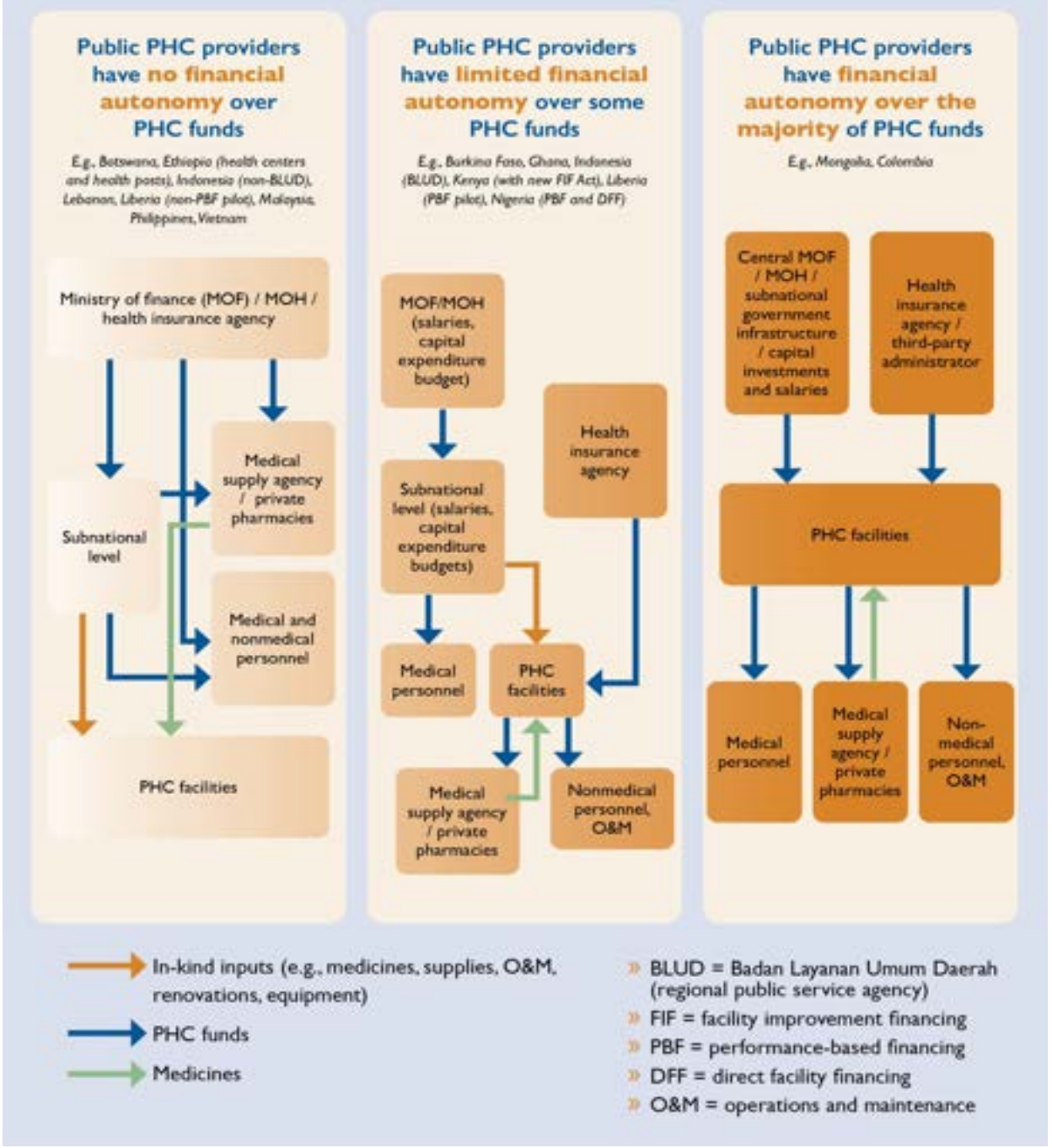


HOW ARE PROVIDERS PAID FOR PHC?

- In majority of countries, PHC providers are receiving multiple types of payments from different purchasers
- Input-based budget is the most predominant form of provider payment for salaries and medicines



HOW DO FUNDS FLOW TO PHC LEVEL?



DO PHC PROVIDERS HAVE THE DECISION SPACE TO USE THEIR RESOURCES FLEXIBLY?

PHC providers have no financial autonomy for PHC funds

- e.g. Botswana, Ethiopia (Health centers and health posts)*, Indonesia (non-BLUD), Liberia (non-pilot), Malaysia, Philippines, Vietnam
- Capital investments, salaries, medicines and O&M managed by central government and/or regional/ district
- Facilities do not have bank accounts
- IGR generated from insurance payments are channeled to the sub-national local government e.g. Puskemas for non-BULD facilities in Indonesia, district for Liberia & Malaysia, LGU in Philippines, commune for Vietnam
- Facilities that collect IGR for user fees must channel to district e.g. Ethiopia must consolidate resources at woreda

PHC providers have limited financial autonomy for some PHC funds

- e.g. Burkina Faso, Ghana, Indonesia (BLUD), Kenya (with new FIF Act), Liberia (PBF pilot) Nigeria (PBF & DFF)
- Infrastructure/capital investments and salaries paid by local government or central MOH or public service agency
- Facilities have bank accounts
- Allowed to use insurance payments to buy medicines as per essential medicines list, minor renovations, casuals and some non-medical personnel (Ghana and Philippines)

PHC providers have financial autonomy for majority of PHC funds

- e.g. Mongolia, Colombia
- Infrastructure/capital investments and some salaries paid by local government or central MOH
- Facilities have bank accounts
- Salaries, supplies, O&M paid for by PHC facility. *Medicines usually provided at pharmacies

Exceptions exist e.g. Ethiopia PHC hospitals have more financial autonomy but health centres and health posts are under the woreda, Indonesia has BLUD facilities with expanded financial autonomy and non-BLUD under the Puskesmas, Liberia is piloting financial autonomy with some PBF facilities but majority of health facilities have no financial autonomy under districts.

SEVEN ACTIONS AND LEVERS TO ADDRESS 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. 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.

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.

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

5. Increasing provider autonomy to allocate and use resources and respond to provider payment incentives: The level of decision-making authority at PHC facilities varies across countries. The more areas in which providers have decision-making rights, the more flexibility they have to respond to incentives.

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.

PANEL DISCUSSIONS: PRACTICAL EXAMPLES FROM COUNTRIES ON OVERCOMING BOTTLENECKS TO RESOURCES FLOWING TO PHC FACILITIES

INDONESIA

Social Security Administering Body

Prof. Ali Ghufron Mukti, M.D., M.Sc., Ph.D., was appointed as President Director of Indonesia's Social Security Administering Body for Health (BPJS) on February 19, 2021. He is a former vice minister of health and one of the founding members of the Joint Learning Network.

Prof Ghufron has held several faculty positions including dean of the faculty of medicine, head of public health division, director of the medical center, and director of the health graduate program on health financing and health insurance management — all at the University of Gadjah Mada, Indonesia.

INDONESIA

Ministry of Health

Ratu Martiningsih (Marti) is a Senior Policy Analyst at the Center for Health Financing, Ministry of Health, Indonesia. She has nearly two decades of experience in health financing and service delivery at both national and regional levels. Currently, she leads the team responsible for funding primary health care facilities and is actively engaged in developing provider payment policies, as well as conducting intensive monitoring and evaluation to ensure effective and efficient implementation, particularly within the National Health Insurance (JKN) program.

Marti holds a degree in Dental Medicine and a Master's in Health Service Management from the University of Indonesia. She is certified in Health Insurance (AAAK, CHIA) and Long-Term Care Financing.

ETHIOPIA (SELAMAWIT)

Ministry of Health

Dr. Selamawit Getachew is a Medical Doctor and Project Manager and currently works as a Health System Strengthening Advisor to the Ministry of Health in Ethiopia. She has over a decade of professional experience in the health sector, with a strong focus on health financing and system reform. She is an advocate of efficient, equitable and sustainable provider payment mechanisms that enhance healthcare delivery. Her strategic guidance and technical expertise play a vital role in advancing the country's health system reforms and resilience.

KENYA

Kenyan Family Physician

Dr Mercy N. Wanjala is a Kenyan Family Physician with experience spanning both national and subnational levels in policy, research, clinical care and project management. She is currently serving Sub-County Medical Officer of Health for Mbeere South in Embu County, where she oversees a 33-facility primary-care network. She brings more than a decade's experience in clinical service and health-system management, complemented by an MBA in Healthcare Management . Mercy also lectures on primary-health-care systems and leadership at Kabarak University and the University of Global Health Equity, Rwanda, grounding her policy work in day-to-day frontline realities.

PHILIPPINES

Department of Health

Dr Amebella (Amy) Taruc is a Medical Officer V and Chief, Local Health Support Division (LHSD) Department of Health - Center for Health Development SOCCSKSARGEN Region.

With more than 20 years of extensive public health service, she adeptly leads the provision of technical guidance and support for Local Government Units Health Programs across the SOCCSKSARGEN Region. She meticulously oversees the planning, implementation, and monitoring of national health initiatives, robustly ensuring strengthened local health systems.

Her pivotal work guarantees equitable access to quality health services, profoundly benefiting all communities throughout the SOCCSKSARGEN Region, South Cotabato, Philippines.

TEA BREAK

BREAKOUT SESSION

Guidance

- Participants will reflect on the previous sessions and share lessons from their countries on increasing funds flow to PHC facilities.
- Each group will be moderated by a lead facilitator and note takers who will begin with brief introductions (name, institution, country) and facilitate the conversation using the guiding questions on the last column. The group will also nominate a speaker who will present the key take aways in plenary.

FACILITATORS

Group	Facilitators/Note Takers
1	Dr. Amebella (Amy) Taruc, Luis Pulido & Rachel Gessel
2	Dr. Selamawit Getachew Hiruy & Agnes Munyua
3	Dr. Mercy Wanjala, Joe Kutzin & Adwoa Twum
4	Ratu Martiningsih, Ali Ghufron Mukti & Aditia Nugroho

PARTICIPANTS

Group	Participants
1	Pratyasha Acharya Carmen Schakel Debarshi Bhattacharya Febriansyah Budi Pratama Steve Cohen
2	Alia Luz Serena Sonderegger Evelyn Kabia Briony Pasipanodya Dwi Puspasari
3	Wala Kamchedzera Mazda Novi Mukhlisa Carol Obure Maarten Oranje Nurul Maretia Rahmayanti
4	Julienne Clarize Lechuga Benson Obonyo Gopal Sekhar Oluwatosin Ademola Mina Febriani

GROUP REPORT & QUESTIONS

Dr Luis Bernal Pulido

CLOSING REFLECTIONS AND KEY MESSAGES

Dr Joe Kutzin

WRAP UP

JOINT LEARNING NETWORK
For Universal Health Coverage

THANK YOU