Save the Children

PRIMARY HEALTH CARE FIRST

Strengthening the foundation for universal health coverage

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Every child has the right to a future. Save the Children works in the UK and around the world to give children a healthy start in life, and the chance to learn and be safe. We do whatever it takes to get children the things they need – every day and in times of crisis.

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Cover photo: Veronica and her son Stephen wait to be seen by the doctor at a health centre in Kenya's Bungoma County. (Photo: Ilan Godfrey/Save the Children)

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Glossary

GDP	gross domestic product
GGE	general government expenditure
MDGs	Millennium Development Goals
PHCPI	Primary Health Care Performance Initiative
SDGs	Sustainable Development Goals
THE	total health expenditure
UHC	universal health coverage
WHO	World Health Organization

Primary health care expenditure

According to the Primary Health Care Performance Initiative (PHCPI) working definition, primary health care expenditure includes:

1. all expenditures for primary health care services
2. expenditures for primary health care preventative services
3. a proportion of administrative expenditure (based on the ratio of primary health care service expenditure and non-primary health care expenditure).[1]

Executive summary

Universal health coverage (UHC) promises a world in which all people have access to the health services, vaccinations and medicines they need, without risk of financial hardship. A world where the right to health is realised for the 400 million people who currently lack access to basic, primary health care.

The global community has committed to work together to deliver UHC by 2030 under the Sustainable Development Goals (SDGs). The challenge now is to translate aspirations to UHC into achievements.

The SDGs have given fresh momentum to the UHC movement. Recent progress, and modelling published by Save the Children in 2015 show that with the right reforms, even low- and middle-income countries can afford UHC.[2] While the SDGs establish clear targets, they do not provide guidance for countries plotting their journey toward UHC. There is no one-size-fits-all approach: countries need to choose the pathway that best meets the needs of their people – a pathway that they can finance and follow to deliver good-quality, affordable health care to all. Nevertheless, there are common strategies that can help all countries expand and improve access to health services.[3]

WHY PRIMARY HEALTH CARE?

Primary health care is the first point of contact between a community and its country's health system. The World Bank estimates that 90% of all health needs can be met at the primary health care level.[4] Investment in primary health care is a cost-effective investment for UHC – it helps reduce the need for more costly, complex care by preventing illness and promoting general health.[5] Investing to build quality, accessible and equitable primary health care services is the most practical, efficient and effective first step for countries working to deliver UHC.

PRIMARY HEALTH CARE EXPENDITURE

Understanding how much is being spent on PHC is not straightforward – variations in national budget design, service packages and delivery mean that country level research is essential.

National Health Accounts bear little practical resemblance to budget allocations, and primary health care allocations may not be easy to locate in budgets. In practice, budget expenditure is much lower than allocations. Lack of transparency remains a real challenge for citizens, civil society and practitioners seeking to improve the health system and hold governments to account.

Despite limited and patchy data, research to date has identified some key trends.

Primary health care is underfunded and has not been prioritised by donors or governments. Current health funding typically focuses on vertical health issues and higher-level secondary and tertiary health care. This leaves limited funds for strengthening primary health care. Recent WHO modelling on the cost of achieving the SDG health targets found that the majority (57%) of funds should go to primary health care.[6] However, data from 31 countries shows that just one-third (33%) of government health expenditure goes to primary health care.[7]

Patients are picking up the bill. Preliminary findings based on analysis by the PHCPI found that the median contribution of governments to PHC expenditure was 17%. Donors contributed the same amount and households a massive 59%.[8] WHO has found that catastrophic health expenditure and impoverishment is higher where out-of-pocket spending exceeds 15% of total health expenditure.[9]

How funds are spent matters as much as how much is spent. WHO has identified significant

differences in health outcomes between countries spending similar amounts and evidence of impressive gains with health spending as low as $40 per capita.[10]

Health spending targets have been framed in a range of ways. 2017 modelling by WHO set a price tag on achieving the SDG health targets at $271 per person in low- and middle-income countries, each year.[11] Based on WHO calculations, Chatham House now recommends that countries spend 5% of GDP or at least $86 per person on essential health services each year, most of which are provided at the primary health care level.[12] Per person spending targets are regularly revised but based on averages that do not take into account differences in the cost of goods and services between and within countries. While there is no substitute for accurate national costings, calls for around 5% of GDP to be spent on health have been relatively consistent since the 1980s.

KEY FINDINGS AND RECOMMENDATIONS

1. **No country will achieve UHC without first delivering primary health care for all. Investing in strong primary health care systems that deliver high-quality, accessible services free at the point of use should be the first priority for the global community as we work toward UHC by 2030.**
2. **The global UHC movement must match momentum with leadership.** World health leaders should work to develop a roadmap to help guide national governments, civil society, donors and the private sector as we work together to achieve UHC.
3. **There is no one path to UHC.** Countries should clearly define and cost their own essential health service packages and detailed pathways to UHC.
4. **UHC is an ambitious but affordable dream.** Governments should mobilise domestic resources to increase investment in primary health care.
5. **There is no substitute for public investment.** Governments should create fiscal space to increase health budgets and to raise their investment for primary health care systems to 5% of GDP.
6. **How money is spent may be as important as how much is spent.** All countries can make progress towards UHC by improving the way they spend money. Countries should work to increase efficiencies in the way they spend health funds.
7. **The international community still has a role to play. External support should seek to strengthen primary health services.** The 5% of GDP/$86 per person target for primary health care expenditure provides valuable guidance to donors on where to prioritise spending and apply pressure to countries that can spend or raise more domestic revenue.
8. **Country context matters.** Governments and donors should invest in national and sub-national research and budget analysis.
9. **We cannot measure what we don't know.** Governments must improve budget transparency.
10. **Primary health care is about serving communities.** Governments and donors should support community and civil society to participate in planning and to advocate for increased investment in primary health care.

About this report

UHC is core to Save the Children's child survival strategy, an essential component of our campaign to reach Every Last Child and a key mechanism for delivering on our centenary commitment to prevent 4.9 million deaths from pneumonia among children under five.[13]

In 2017, with the support of the Bill & Melinda Gates Foundation, Save the Children and civil society partners delivered a project investigating how primary health care is being funded and promoted as countries work towards UHC. Research, capacity-building and advocacy was carried out in four countries – Nepal, Myanmar, Sierra Leone and Zimbabwe – and through global level advocacy and assistance to smaller projects in Bangladesh, Burkina Faso and Tanzania. The project focused on investigating gaps in data and understanding current budget allocations and expenditure on primary health care, to create a stronger evidence base for future advocacy. Findings from that country research are presented in Chapter 4.

While strengthening primary health care has long been a core component of the health agenda, research into primary health care expenditure has been limited. This report brings together existing data and recommendations on primary health care expenditure with findings from national research. In presenting national-level research and data gaps, this report also outlines some of the challenges faced by researchers seeking to better understand primary health care expenditure.

SCOPE OF THE REPORT

The focus of this report is on primary health care expenditure – the current state of spending, how much should be spent and strategies to increase it. Health care delivery systems and facilities, financing strategies, training and support for health workers, enabling laws and policies, and the way primary funding is spent are critical to achieving UHC. While these areas are beyond the scope of this report, all warrant further research, action and investment. Save the Children will publish a report on UHC financing in 2018.

METHODOLOGY

This report combines findings and case studies based on research conducted in the participating countries with evidence drawn from a global-level literature review. National research used mixed methods including analysis of National Health Accounts and national budgets, focus group discussions and key informant interviews. Research also considered national health challenges – such as reproductive, maternal, newborn and child health, and early pregnancy in Sierra Leone; and increasing understanding of primary health care funding and expenditure arrangements in new electorates created by Nepal's transition to federal governance.

Mylene and her daughter, Mary Anne, outside their home in Manila. Mary Anne is being treated by a local health worker for malnutrition and diarrhoea.

PHOTO: CARLO GABUCO/SAVE THE CHILDREN

1 Universal health coverage: the right to health in action

Health is many things: a key determinant of development, a fundamental human right and an essential building block for growing successful economies. Under international human rights law, all people have the right to the 'highest attainable standard of physical and mental health'.[14] Universal health coverage (UHC) is that right in action. In a world with UHC, all people will have access to the health services, vaccinations and medicines they need, without facing financial hardship.

THE RIGHT TO HEALTH

All people have the right to health. The Convention on the Rights of the Child and the International Covenant on Economic, Social and Cultural Rights both recognise the universal right to "the highest attainable standard of physical and mental health" regardless of race, sex, gender, age, religion, political views or economic status.[15]

The Convention on the Rights of the Child specifically recognises the role of primary health care. Article 24 requires states to "ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care" and to "combat disease and malnutrition, including within the framework of primary health care". All countries except the USA have ratified or acceded to the Convention on the Rights of the Child.

In 2015, all countries committed to work towards achieving UHC by 2030 under Sustainable Development Goal (SDG) 3 on good health and wellbeing. Inclusion in the SDGs has given fresh momentum to the UHC movement, while recent progress, and modelling by Save the Children show that with the right reforms UHC is an 'affordable dream' for all.[16] Yet with no clear roadmap for reaching this goal and 400 million people without access to good-quality primary health care, UHC continues to be dismissed by many as merely aspirational.[17]

Differences between countries' existing services, available funds, and political and geographical contexts mean there is no one-size-fits-all approach. Nevertheless, as this report shows, there are common strategies that can help all countries expand and improve access to health services.

SUSTAINABLE DEVELOPMENT GOAL 3: GOOD HEALTH AND WELLBEING[18]

Under target 3.8, by 2030, all countries will: *Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.*

2 Primary health care: the first point of contact

Investment in primary health care is an effective and efficient first step towards UHC. The World Bank estimates that 90% of all health needs can be met at the primary health care level.[19] Good-quality, comprehensive primary health care helps reduce the need for more costly, complex care by preventing illness and promoting general health.[20] This is why Save the Children and a growing coalition of health advocates are calling on countries and donors to strengthen primary health care systems for UHC.

WHY PRIMARY HEALTH CARE?

In 2010 the WHO used the World Health Report to signal a return to health systems strengthening, calling for primary health care "now more than ever".[21]

Strong primary health care services are crucial to early diagnosis and delivering preventative, curative and palliative care across the life-course. Primary health care is a first line of defence against communicable diseases and the biggest killers of pregnant women, mothers, children and adolescents. A 2013 review of health outcomes in 102 low- and middle-income countries found that better access to primary health care was associated with longer life-expectancy and lower infant and under-five mortality, even after income and spending were controlled for.[22] Strong primary health systems are associated with more equitable health outcomes between people of different socio-economic status.[23] Primary health care

A child is vaccinated at a Save the Children health and nutrition outreach site in northern Kenya.

PHOTO: COLIN CROWLEY/SAVE THE CHILDREN

providers are essential gatekeepers, guiding people through the health system and improving efficiency by directing patients to the most appropriate and affordable services. The World Bank estimates that just 10% of medical conditions require more complex treatment in hospitals or specialist care.[24]

BROKEN PROMISES

The global community has a long history of lapsed deadlines and broken promises on primary health care. In 1978, countries committed to deliver "health for all" by the year 2000. The Declaration of Alma-Ata proclaimed the responsibility of governments to provide health care for their people, with primary health care as the foundation for ensuring health for all.[25]

The Alma-Ata deadline came and passed, replaced by specific disease targets under the Millennium Development Goals (MDGs). The MDGs fundamentally reshaped the health agenda, leading to significant gains against particular health indicators. But a review of progress under the MDGs revealed wide inequities in access to health care and in health outcomes. In his introduction to the final *Progress for Children* report for the MDG era, UNICEF Executive Director, Tony Lake wrote:

> *For all our progress, we have failed millions of children: the most vulnerable children, to whom we owe our greatest efforts… As the global community comes together around the Sustainable Development Goals, we should set our sights first on reaching the children left behind as we pursued the MDGs.*

WHAT IS PRIMARY HEALTH CARE? THE ALMA-ATA DEFINITION

In 1978 the International Conference on Primary Health Care published a broad definition of primary health care in the Declaration of Alma-Ata.[26] The definition states that:

> *Primary health care is essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. … It is the first level of contact of individuals, the family, and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first elements of a continuing health care process.*

The definition recognises that what primary health care looks like may be quite different depending on the country you are in – it could be delivered through local health clinics, community health workers, general practitioners or in a hospital. According to the declaration, primary health care covers the following minimum package of services:

- education on prevention, treatment and control of common health problems
- promotion of food supply and proper nutrition
- adequate supply of safe water and basic sanitation
- maternal and child health care including family planning
- immunisation against major infectious diseases
- prevention and control of locally endemic diseases
- appropriate treatment of common diseases and injuries
- provision of essential drugs.

In practice, many countries have translated this definition into packages of essential health services.

The Alma-Ata is a principled definition that addresses quality of health care, equity in access, community participation, and social and economic development. Delivering primary health care to the standard set out in the Alma-Ata definition requires adequate funding to ensure quality, equitable coverage and elimination of out-of-pocket spending through services that are free at the point of use.

A BRIEF HISTORY OF PRIMARY HEALTH CARE

1948 **The WHO Constitution and the Universal Declaration of Human Rights**

The Universal Declaration sets out the right to the highest attainable standard of health. Under the WHO Constitution, all members recognise health as "one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition".

1966 **International Covenant on Economic, Social and Cultural Rights**

The Covenant recognises the right to the highest attainable standard of physical and mental health.

1978 **Alma-Ata Declaration**

The Declaration sets out a comprehensive definition of primary health care and calls for health for all by 2000.

1979 **Selective primary health care – a step backwards?**

Assistant Professor Dr Julia Walsh and Director of Health Sciences at the Rockefeller Foundation Dr Kenneth Warren define a selective primary health care approach as an interim step to delivering the Alma-Ata primary health care model. This approach regarded Alma-Ata as unrealistic, and left out the equity and health systems strengthening components of the earlier model.

1987 **Bamako Initiative – Co-financing and an attempted return to Alma-Ata**

Benin, Guinea and Mali introduce a return to comprehensive primary health care with community management and co-financing of essential health services through public providers. While some outcomes are positive, user fees are found to be inequitable and countries struggle to take the model to scale.[27]

1989 **Convention on the Rights of the Child – a child-centred right to health**

The Convention recognises the right of all children to the highest attainable standard of health with a specific emphasis on primary health care services.

2000 **The MDGs replace "health for all"**

The deadline for achieving health for all under the Alma-Ata Declaration passes and the MDGs introduce targets for specific health outcomes including HIV, TB and malaria.

2015 **From the MDGs to the SDGs**

Countries commit to achieving UHC by 2030 under SDG 3 on good health and wellbeing.

2030 **Deadline for achieving UHC**

BACK TO WHERE WE STARTED?

Nearly 40 years after the Alma-Ata Declaration, the world is again calling for countries to invest in and strengthen primary health care. The 2014–15 Ebola outbreak showed that investment in 'vertical' health issues – including specific diseases – has failed to build health systems capable of responding to unexpected crises. Without strong primary health care and referral systems, diagnosis and disease control were slow and facilities were quickly overwhelmed.[28]

The commitment to achieve UHC by 2030 under the SDGs has galvanised renewed support for a health agenda based around holistic systems building.[29] In practice, many countries have pre-empted these global commitments by investing in essential health services packages and community-level health care. Some countries, including low- and middle-income countries, have made significant progress towards UHC through the introduction of national health insurance schemes and by abolishing user fees. But challenges remain. Governments and donors have failed to support investment in primary health care. As a result, public health systems are underfunded, and suffer from health worker shortages and drug stock-outs.

Narom has a check-up with midwife Seoung, who is part of an outreach midwifery team that goes to villages in Stung Treng Province, Cambodia.

PHOTO: DAVID WARDELL/SAVE THE CHILDREN

3 Primary health care expenditure: challenges, targets and steps in the right direction

The Alma-Ata Declaration provides a broad and widely supported vision for primary health care. But understanding and calculating primary health care expenditure requires a national definition that includes services, and delivery modes and sites. These expenses must then be capable of being traced to identifiable budget line allocations and expenditure audits. This chapter documents research challenges and data gaps, as well as key trends in primary health care expenditure, and promising practice in countries are already strengthening primary health care.

CHALLENGES TO UNDERSTANDING PRIMARY HEALTH CARE EXPENDITURE

Primary health care allocations are not always easily identified in national budgets – making budget-tracking difficult. While some countries, such as Zimbabwe, have a 'primary health care' budget line, other countries, like Myanmar, only have line items such as 'vehicles', 'rent' and individual medicines. The MDGs and donor priorities mean that many countries' budgets are constructed around vertical health issues with distinct lines for HIV, TB, malaria and reproductive, maternal and child health, which can be addressed at the primary, secondary and tertiary health care levels. Decentralisation of health services and funding also means that health financing and expenditure are increasingly managed and recorded at the local government level. In Nepal, where budget allocations are made direct to hospitals delivering both primary and secondary health care services, calculating primary health care expenditure for this report required a weighting process to estimate the proportion of hospital spending going to provision of primary health care. Defining primary health care to identify expenditure was among the most significant challenges for national-level research conducted for this project.

Budget execution is often lower than allocations. Many governments report allocations but do not examine budget execution. Despite concerns about inadequate funding, health budget underspend is common. 10–30% of annual health allocations in Africa are not spent for a range of reasons, including inflexible allocations to things clinics don't need, poor management and flow of funds, and fraud.[30] Focus group discussions with rurally based health advocates in Zimbabwe found that although clinics at the local authority level submit detailed funding requests to the central government each year, much of the money owed is never received in part due to lack of funds. This results in stock-outs and unpredictability, leaving local authorities to raise revenue to fill funding gaps.[31]

National Health Accounts and national budget information are not the same. WHO Member States are expected to submit National Health Accounts, based on standard methodology, to enable WHO to develop internationally comparable records of health resources.[32] However, National Health Accounts are based on different data and definitions from national budgets and records of expenditure. As a result, their respective numbers are different. For example, research conducted in Zimbabwe as part of this study calculated primary health care expenditure reported under the National Health Accounts at

$262.39 million in 2015. National budget allocations for the same period were far less at $42.929 million, and just $38.271 million was reported spent.

This study does not seek to compare the data but to reflect concerns over the relevance of National Health Accounts to local-level programming and accountability. Country-level advocates argue that National Health Accounts do not bear a practical resemblance to national budget documents. This limits the value of National Health Accounts data for advocacy to local and national governments. These differences also highlight the limitations of relying on global analysis based on National Health Accounts for country-level programming.

Lack of budget transparency is a real challenge to understanding expenditure and holding governments to account. In 2017, the Myanmar government only made two of eight critical budget documents publicly available. At the same time, the citizens' budget – a reform intended to increase public knowledge of budget content – only accounted for 47% of health budget allocations.[33]

Researchers in Zimbabwe have noted that although a primary health care budget line under the country's programme-based budgeting framework simplified their analysis, it does not allow for a more detailed breakdown of what services, for example, allocations are made to.

WHAT IS BEING SPENT ON PRIMARY HEALTH CARE?

Understanding how much money is being spent on primary health care is not straightforward. Data on primary health care expenditure is limited. National variations in budget design, service packages and delivery arrangements mean that country-level research is essential to get a better picture of expenditure on primary health care. However, even national-level analysis provides an incomplete picture for countries with decentralised health financing arrangements. The Primary Health Care Performance Initiative (PHCPI) is working to address gaps in knowledge, including through the collection of data against primary health care vital signs.[34] Despite limited and patchy data, research to-date has identified some key trends.

Primary health care has not been prioritised for funding by either donors or governments. Current health funding typically focuses on vertical health issues and higher-level secondary and tertiary health care. This leaves limited funds for strengthening primary health care systems. Recent WHO modelling on the cost of achieving the SDG health targets found that the majority (57%) of funds should go to primary health care services.[35] The PHCPI examined primary health care expenditure in 31 countries based on National Health Accounts data.[36] Preliminary findings indicate that just

A newborn baby is immunised by a nurse at a dispensary in Kenya.

PHOTO: ALLAN GICHIGI/SAVE THE CHILDREN

one-third (32.9%) of government health expenditure goes to primary health care, meaning that two-thirds go to non-primary health care services including secondary and tertiary care.

PHCPI's comparisons show that the median contribution of governments to primary health care service expenditure is 17%. Donors contribute the same amount. This low prioritisation by governments and donors has been partly driven by donor priorities aligned to the MDG targets. Funding secondary and tertiary care services without investing in primary health care and a strong referrals system can result in patients seeking basic health services through more expensive hospital-based services, further draining the health system of limited resources.[37]

Patients are picking up the bill

In many countries, government and donor spending does not cover the cost of primary health care, leaving patients to pay the difference. This makes households a significant contributor to primary health care expenditure through out-of-pocket payments. PHCPI's analysis found that the median out-of-pocket expenditure on primary health care is 59%.[38] This amounts to more than twice the 15–20% maximum contribution Chatham House recommends households spend on all health care (primary, secondary and tertiary care).[39]

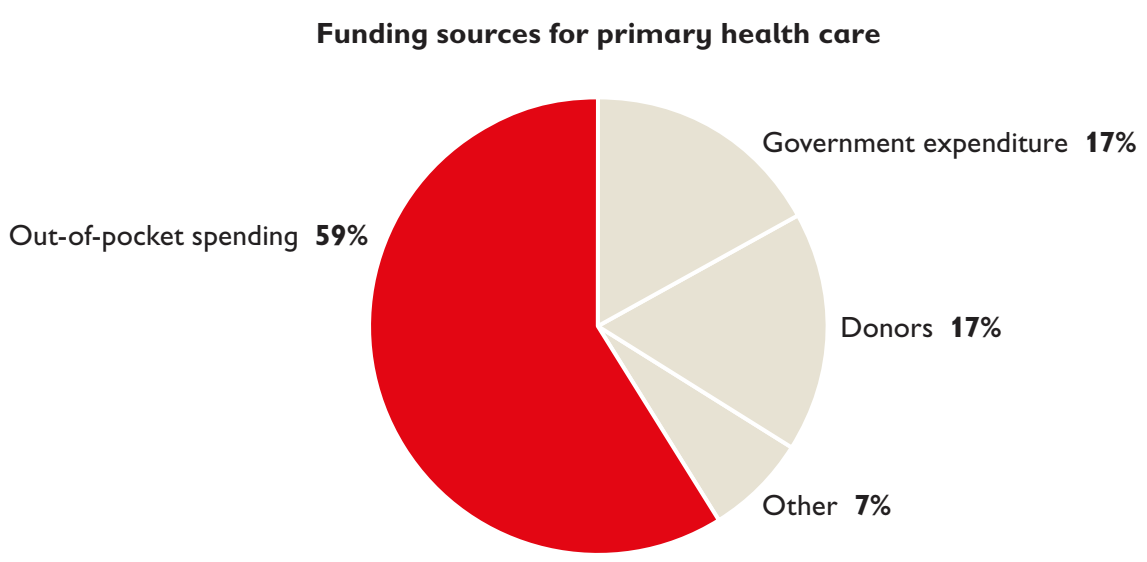
Out-of-pocket expenditure, including formal or informal user fees, creates a deterrent to health seeking, and is a particular obstacle for women, children and poor people, who are among the greatest users of primary health care. The Bamako Initiative has taught us that user fees are highly inequitable, denying access to health care to the poorest people and pushing poor households further into poverty.[40]

HEALTH SPENDING TARGETS: SEARCHING FOR A MAGIC NUMBER

Health spending targets have been framed in a range of ways – based on per person spend in dollars, and relative to government expenditure or GDP. Isolating *primary* health care expenditure, however, is a new approach. As a result, comparable data is limited.

In 2001, African Union countries committed to spend 15% of general government expenditure (GGE) on health. In 2014, Chatham House modelling estimated that low-income countries would need to spend an average minimum of $86 per person or 5% of GDP to deliver priority health services, whichever is greater.[41] Priority health services are mostly delivered at the primary health care level. As such, this report treats the latest Chatham House target as one for primary health care expenditure. Chatham House also argues this money should come from government, rather than a combination of sources such as out-of-pocket payments and the private sector.

PATIENTS ARE PICKING UP THE BILL FOR PRIMARY HEALTH CARE



The latest modelling comes from a 2016 study of 67 low- and middle-income countries, which estimates the cost of achieving the SDG health goals (including UHC, and specific goals on sexual and reproductive health). The study found that meeting the targets would require countries to spend a total of $271 per person or 7.5% of GDP to cover primary, secondary and tertiary health care. This would be a substantial increase on current levels of spending for many countries. The study found that, on average, countries need to spend $58 more per person.[42]

The SDGs anticipate international cooperation to assist lower-income countries. The Chatham House $86 per person or 5% of GDP target provides some guidance on which countries donors should assist. By basing the target on GDP rather than government expenditure, the recommendation encourages greater efforts towards increasing government revenue, primarily through taxation. Identifying a minimum per-person spend also allows donors to see which countries currently do not have the GDP to fund primary health care adequately without external assistance. Chatham House argues that all middle-income countries should be able to achieve these targets without external assistance.[43]

Despite ongoing revision of per person targets (see box below), the 5% of GDP target has shown relative longevity, reappearing in recommendations as far back as the 1980s and again in 2009, 2010 and 2014.

HEALTH SPENDING TARGETS OVER TIME

2001 **African Union countries** committed to allocate 15% of GGE to health under the Abuja Declaration.[44]

2009 **High-level Taskforce on Innovative International Financing for Health Systems** estimated that health expenditure in low-income countries would need to increase to $54 per person by 2015 to achieve the MDG health goals.

2010 **The High-level Task Force** revised its target up, to $60 per person per year by 2020 in low-income countries. WHO recommends total health expenditure (THE) at a rate of 5% of GDP and 6% of GGE.

2014 **Chatham House** revises the High-level Taskforce figure for low-income countries to at least $86 per person on 'priority' health services or 5% of GDP from government expenditure in low- and lower-middle-income countries.[45]

2017 **WHO** publishes a 'price tag' for achieving the SDG health targets. WHO estimates that achieving UHC by 2030 will require countries to spend an average $58 more per person and a total of $271 per person each year on primary, secondary and tertiary health care in low- and middle-income countries.[46]

Based on 2012 figures, only 14% of governments in low- and lower middle-income countries and 29% of upper middle- and high-income countries have met the Abuja Declaration target (15% of GGE).[47] All high-income governments spend at least $86 per person but just 33 lower middle-income countries and two low-income countries have met that benchmark.[48] Many feel that global benchmarks are unrealistic and create an obstacle to practical planning, while others find benchmarks, like the MDGs and SDGs, valuable guiding targets. Recent findings suggest that there is 'no magic number', but all countries an improve coverage by increasing public spending, even where it falls short of the $86 per person target or SDG price tag.[49]

PROMISING PRACTICE

The SDGs have created fresh momentum for work towards UHC. Many countries are already strengthening their primary health care systems in a range of ways. This section highlights examples of promising practice at the country level.

Clearly defining, costing, funding and delivering essential packages of health services

Essential packages of health services should incorporate basic health treatment and prevention and routine immunisation, and should include sexual, reproductive, maternal, newborn, child and adolescent health services across the continuum of care. These are effectively primary health care packages. National health policies in many countries already define a package of essential health services. Domestic costings of these packages provide a practical alternative to global benchmarks that take into account contextual factors, such as the cost of labour and relative purchasing power, rather than relying on international averages. Buy-in from ministries of finance is essential. Zimbabwe, for example, has defined and costed its essential package of health services at $76 at the district level and $16 at the community clinic level, per person, per year. Myanmar is in the process of costing an essential package of health services for introduction from 2018.

Increasing fiscal space to invest in primary health care

Research shows that to achieve UHC, health systems must rely predominantly on public revenue that is prepaid, mandatory and pooled, including budget allocations and mandatory contributions to health insurance.[50] Basing targets on GDP rather than government expenditure recognises the possibility that governments can increase fiscal space by increasing revenue through progressive taxation, particularly payroll and luxury taxes, as well as pooling and improved efficiency. Earmarking of sin taxes for health is increasingly common – for example, Nepal earmarks tobacco taxes for use on tobacco-related diseases. For many countries, increasing revenue will require work to build the

NO MAGIC NUMBER, BUT SMALL INCREASES CAN MAKE BIG IMPROVEMENTS

A recent report on health spending targets by WHO found that performance varies significantly, including across countries with similar levels of spending and particularly among those spending less than $40 per person.[51] In most regions, 50% of countries reduced their reliance on out-of-pocket spending despite spending far below 5% of GDP on health. Thailand, for example, introduced UHC at a time when the country was spending just 2.2% of GDP on health.

The WHO report found that:

- Countries with all levels of income and spending can make progress towards UHC by improving the way they spend money.
- Service coverage improves quickly as public funding increases to $40–$60 per person.
- Financial protection from catastrophic or impoverishing out-of-pocket health spending only improves significantly where public spending exceeds $200 per person – improvements in financial protection require more costly and complex changes to policy, institutional governance and management.

HOW MUCH SHOULD WE SPEND ON HEALTH?

Recommended spending benchmarks		VS	Median current spending[56]	
Chatham House global benchmark for spending on *primary* health care in low- and lower-middle-income countries.[52]	$86 per person, per year		Current total health expenditure	$56.80 per person, per year
WHO recommended total health expenditure to achieve the SDG health targets in low- and middle-income countries.[53]	$271 per person, per year			
Chatham House global benchmark recommends that 5% of GDP should be spent on primary health care where that amounts to at least $86 per person. Where necessary donors should contribute to help countries reach that rate.[54]	5% of GDP		Government health expenditure	1.5% of GDP
			Donor health expenditure	0.7% of GDP
Recommended maximum percentage of *total* health expenditure from out-of-pocket payments.[55]	15–20%		Primary health care expenditure from out-of-pocket payments.	59%

tax base and taxation systems, though review of the Addis Taxation Initiative showed that low- and middle-income countries can and have made real progress in increasing domestic revenue through taxes, with assistance to improve transparency, fairness and efficiency.[57]

Achieving greater efficiency in health spending

Absolute levels of public spending on health are critical for progress on UHC, but there is significant scope to make progress towards UHC through greater efficiency in spending.[58] Governments can improve budget execution through better public financial management, as has been done in Zimbabwe through the introduction of a public financial management system. And governments can reduce inefficiencies through measures like the use of single purchasers, as Nepal has done to save money on medicines.

Improving financial protection by abolishing user fees for basic health care or introducing mandatory health insurance schemes

Nepal has abolished user fees for its basic health services package; many other countries, such as Burkina Faso and Sierra Leone, are progressively reducing user fees through free health care for high-needs groups such as children and pregnant women. Some countries, including Thailand and Rwanda, have successfully increased financial protection through the introduction of national health insurance schemes, demonstrating that pooling funds and cross-subsidisation through mandatory membership and government subsidies for the poor can deliver UHC, even in low- and middle-income countries. However, charging of unauthorised user fees is common. Where cost exemptions are already in place, efforts must be made to ensure they are applied effectively and consistently. Health facilities must be given the

resources necessary to respond to the needs of the population with quality care and without imposing unauthorised charges to cover costs.

Engaging communities

Community engagement and social accountability are core components of the comprehensive Alma-Ata primary health care model. Communities can make valuable contributions to the governance and monitoring of health services and delivery. In Zimbabwe, community health committees have been an effective form of oversight and have helped improve the quality of health services by communicating patient needs to centralised health administrators.[59]

The *Revitalising Health for All* project examined primary health care programmes in a number of countries and found that well-trained and supported community health workers can help improve equitable access to primary health care.[60] In Iran, community health workers, or *behvarz*, double as activists for patients, and have increased access to basic health services and have reduced barriers for women seeking health care through the provision of female health workers. A study in Bihar, India found that accredited social health activists – female community health workers employed as part of the National Health Mission in India – were particularly effective in reaching underserved children in one of the fastest growing and least developed states in the country. Ethiopia has also had success with its Health Services Extension Program, which has increased services by training civil servants to deliver a package of 16 health services in their communities.

PATH's Advocacy for Better Health project in Uganda aims to improve the availability, accessibility and quality of health and social services by mobilising communities to hold decision-makers accountable for health-related commitments. Citizen-led advocacy and social accountability efforts have resulted in increased budget allocations for health, the arrival of water or electricity at facilities, improved staffing levels, reduced absenteeism and important infrastructure developments, such as staff housing, operating theatres and maternity wards. The programme is now being delivered across 35 districts.[61]

Increased engagement with civil society is an important first step towards strengthening community governance, communication between patients and administrators, and the quality of service delivery.

Community health volunteer Lucas checks up on Robert, nine months old, at his home in Turkana county, Kenya. A day earlier, Robert's mother, Lydia, had taken him to a health centre, where he was diagnosed with pneumonia and prescribed liquid antibiotics and paracetamol.

PHOTO: JONATHAN HYAMS/SAVE THE CHILDREN

4 Country snapshots

This chapter provides a summary of findings from research conducted in five countries to encourage greater investment in strengthening primary healthcare systems as a first step towards UHC.

Save the Children conducted budget analysis in Nepal, Myanmar, Sierra Leone and Zimbabwe to:

- coordinate research to generate evidence for advocacy
- bring civil society organisations together to form alliances for improved primary health care
- build capacity among civil society organisations to advocate for increased investment in primary health care
- engage with governments to increase understanding of primary health care expenditure and its critical role in working towards UHC.

An additional three countries – Bangladesh, Burkina Faso and Tanzania – received smaller grants to conduct in-country research on primary health care expenditure and to share their findings.

FIVE COUNTRIES, FIVE PRIMARY HEALTH CARE SYSTEMS

Different country contexts created opportunities and obstacles in each of the study countries. This section analyses common policy trends and political challenges. The subsequent section presents key findings from research conducted in grant countries through a series of country profiles. These profiles demonstrate how differences in the country contexts inform those countries' distinct approaches to primary health care, and their respective pathways to UHC, and the barriers they must overcome as they work towards 2030.

HEALTH SYSTEMS IN TRANSITION

The projects in Myanmar and Nepal were implemented during periods of significant transition, with Nepal moving to a federal system of government in 2017 and decentralising health governance, and Myanmar working towards the introduction of an essential package of health services. Sierra Leone is still in the process of rebuilding health systems and civil society alliances after facilities were closed during the Ebola outbreak.

These changes mean that some circumstances described in the research will change. For example, line item budgeting in Myanmar will be replaced by programme-based budgets. And in Nepal, concerns over poor budget execution at the central government level may be addressed by decentralisation.

Changing circumstances also created important entry points for advocacy, and highlighted the need for sustained engagement with government. In Nepal, transfer of health management to new levels of government created an opportunity to build partnerships and capacity among officials taking on new responsibilities, and to shape health priorities in support of primary health care from the outset. In Myanmar, review findings in relation to the need to prioritise investment in primary health care – after years of underinvestment – in favour of more complex services provided an important basis for engagement in discussions around the essential package of health services.

Advocacy activities and civil society strengthening in Nepal and Zimbabwe were interrupted by elections. Advocacy was considered inappropriate during election campaigns and was limited in some cases by laws against convening public meetings. In both countries, this resulted in an approach to advocacy that was more strongly focused on building government capacity for quality programming. In Zimbabwe, this prioritised the provision of data on current expenditure, investment required to reach key benchmarks and opportunities to increase fiscal

space. For Nepal, this work centred on providing officials in districts new to health budgeting and management with an introduction to primary health care policy and expenditure, UHC and health financing options.

PROGRESS

Study countries were at different points in their progress towards UHC and support for primary health care.

Abolishing user fees

Of the study countries, Nepal had made the most significant progress in terms of providing financial protection to people seeking basic health services. As a result of its abolition of fees for basic health services, most catastrophic health expenditure is restricted to the secondary and tertiary levels.

Bangladesh has also abolished user fees, but in practice, lacks the funds to provide free health care to all. Unauthorised fees are widely charged.

Sierra Leone has abolished user fees for children under five, pregnant women and lactating mothers, but cost continues to be a barrier to accessing services, particularly for women. This suggests that unauthorised fees are also common in Sierra Leone.

Pooled funding and cross-subsidisation through insurance

Nepal has introduced a non-compulsory national health insurance scheme, the Social Security Health Benefits Scheme, and legislation for staged implementation of a compulsory scheme was passed this year. The current scheme covers around 5% of the population. The new scheme will be progressively introduced, beginning with civil servants, and premiums for the poor will continue to be subsidised by government.

Bangladesh is also piloting health insurance schemes with the aim of building to a national scheme, and in Zimbabwe the Ministry of Health and Child Care recognises the need to introduce a national health insurance scheme. Both countries, however, face opposition from the public. While Zimbabwean opposition largely stems from concern at the ability of the government to manage the scheme, in Bangladesh key informants described opposition based on the belief that government should pay for all health services and citizens should not be required to contribute through premiums.[62]

Rights to health at the national level

The Nepali health system was designed around the Alma-Ata Declaration and has maintained a strong focus on primary health care and the principles set out in that document. The 2015 Constitution recognises a right to basic health care for all citizens. Similarly, in Zimbabwe the government has defined and costed an essential health benefits package and enshrined the right to health in its Constitution.

Support for primary health care was most nascent in Myanmar. While the 2008 Constitution recognises a right to health, this is subject to the terms of national health policy. To date, investment in the health sector has favoured higher-level health services, and an essential package of health services will not be fully implemented until 2021. Lack of transparency remains a significant challenge for understanding and strengthening primary health care in Myanmar. The country continues to use line-item budgeting with inflexible allocations to specific goods. While this may improve accountability, line-item budgeting limits efficiency by preventing reallocation within programmes and makes determining the cost of primary health care a lengthy process. The establishment and costing of an essential package of health services will likely be accompanied by transition to a more flexible system, such as programme-based budgeting, at least in relation to those services.

DOMESTIC RESOURCES AND HEALTH FINANCING

Lack of funding to primary health care services was due to both disproportionate spending on other aspects of health and a general lack of funds. In Zimbabwe, despite significant investment in primary health care, 90% of funds went to staff costs, leaving little to support services, and continuing poor fiscal performance limits capacity to raise revenue. Nepal struggles to find adequate funds for health in the context of ongoing earthquake recovery, and analysis of health financing reveals that a small increase in tobacco tax is one of very few options for increasing revenue.

Health financing strategies for increased domestic resource mobilisation therefore remain an essential priority. In the meantime, there continues to be a place for donors in shifting support from vertical health issues to systems investments.

HEALTH CARE EXPENDITURE IN STUDY COUNTRIES VERSUS GLOBAL BENCHMARKS

Annual total health expenditure

Bangladesh	Myanmar	Zimbabwe
$37 per person	$15 per person	$60 per person

SDG health goals price tag in low-and middle-income countries

$271 per person

Annual primary health care expenditure

Nepal	Sierra Leone	Zimbabwe
$10 per person (2015)	$41.30 per person (2013)	$15 per person

Recommended spend by government in low-and lower-middle-income countries

$86 per person

Country profile: Zimbabwe – Leading the way with essential health services

The Zimbabwean Constitution recognises the right of every citizen to primary health care through the right to basic health care services (including reproductive health care) and requires the State to take reasonable measures within its available resources to progressively guarantee that right.[63] These basic or district core health services are primary health care services and are set out under the Essential Health Benefits Package – a prioritised set of services including maternal health, child health, communicable and non-communicable diseases.

BASIC PACKAGE OF CORE HEALTH SERVICES FOR THE PRIMARY CARE LEVEL

Maternal health care
- adolescent sexual and reproductive health services
- family planning including prevention of parent-to-child transmission (PPTCT) of HIV services
- antenatal care including PPTCT of HIV services
- delivery care including emergency obstetric and newborn care services
- postpartum care including PPTCT of HIV services

Non-communicable disease control
- eye conditions
- ear, nose and throat conditions
- mental health
- injuries, accidents and emergencies
- diabetes
- hypertension and cardio-vascular diseases
- common cancers
- chronic obstruction respiratory diseases
- acute and chronic renal disease

Child health care
- neonatal care
- immunisation
- integrated management of neonatal and childhood illnesses
- newborns and young infant services
- essential nutrition package
- growth monitoring and promotion
- disability services
- diarrhoea
- paediatric HIV

Communicable disease control
- HIV/AIDS and sexually transmitted infections
- tuberculosis
- malaria
- diarrhoeal diseases

KEY FINDINGS

- Zimbabwe has achieved 70% primary health care coverage by spending almost $60 per person, per year (total health expenditure).[64]
- Despite returns for investment in primary health care, the majority of government health expenditure went to hospital care at the secondary and tertiary levels – community-level health care received less than 15%.
- 36% of primary health care expenditure comes from the Zimbabwean government – more than donors, private households and corporations contribute. However, nearly 90% of those government funds go to staff costs, leaving little for service improvement or delivery.
- Donors are strong supporters of primary health care in Zimbabwe. But donor support is expected to reduce over time and is often skewed towards vertical health issues like HIV, TB and malaria, rather than strengthening the health system for UHC.
- Out-of-pocket spending disproportionately affects poor households. In 2015, 25% of primary health care expenditure came from private out-of-pocket spending. Although this average is lower than out-of-pocket spending in many countries, it resulted in catastrophic health expenditure in 7.6% of households. The impact on low-income families was significantly worse, with 22.0% of poor households experiencing catastrophic health expenditure.
- Fragmentation of funding pools is a major challenge for cross-subsidisation, raising revenue and increasing purchasing power in Zimbabwe.
- The Ministry of Health and Child Care pilot 'programme-based budgeting' classification has made it possible to organise budgets around services. However, budget disbursement is incomplete.

Country profile: Myanmar – A health system in transition

The National Health Plan 2017–2021 aims to achieve UHC by strengthening the country's health systems.

The main goal of the National Health Plan is to extend access to a basic Essential Package of Health Services to the entire population by 2021 while increasing financial protection.

UHC by 2030

The UHC movement has been gaining momentum in Myanmar since the nation re-entered the global community with a civilian government in 2011. The National Health Plan 2017–2021 sets out the country's intended path towards UHC, beginning with the introduction of an essential package of health services from 2018. The package will cover the primary health care services and interventions that the poor and vulnerable need most. Myanmar health care leadership recognises that providing quality essential health services with improved access is critical to the sustainable development of the country.

A SNAPSHOT OF MYANMAR'S BUDGET, HEALTH CARE EXPENDITURE AND HEALTH SYSTEMS

- Lack of transparency is a major barrier to understanding investment in primary health care in Myanmar, to identifying new sources of funds and to holding the system to account. It also makes meaningful engagement by civil society in policy development and programme monitoring difficult. Myanmar rates just 6/100 for public participation in budgeting, though transparency is improving.[65] A Citizens' Budget is now published every year, to help the public and civil society understand allocations, although the 2017/18 Citizens' Budget does not provide sufficient detail to identify primary health care expenditure.
- Government spending for health in Myanmar has grown significantly since 2011/12, from 1,723 Kyat ($1.27) to 20,379 Kyat ($15.05) per person (based on estimated population of 50.5 million in 2011 and 52.8 million in 2016).[66] In 2014, 50% of total health expenditure came from out-of-pocket spending, down from 81% in 1995.[67]
- Low spending as a proportion of existing funds suggests that there is fiscal space to further increase funding for health by prioritising it more highly. Government funding for health increased from 1.14% of total government expenditure to 3.65% between 2011/2012 and 2015/2016, and from 0.2% of GDP in 2009 (the lowest in the world) to more than 1% in 2014.[68]
- Current public-sector health services focus on tertiary care, which means station hospitals and below have historically received less support. This underinvestment has led to shortcomings in service availability, readiness and coverage. It is estimated that key aspects of primary health care, including prevention and public health, accounted for just 8.3% and 8.9% of expenditure by the Ministry of Health in 2012 and 2013 respectively.[69] The National Health Plan recognises that efforts to improve the primary health care system should seek to strengthen key pillars including human resources, infrastructure, service delivery and health financing.
- The current public financial management system does not support performance improvement. Myanmar uses line-item budgeting, which focuses on inputs, as opposed to programme-based budgeting. This limits flexibility to spend based on emerging needs. Performance objectives are based on financial expenditure rather than encouraging better outcomes. Budget oversight is poor and public expenditure review is overdue – the country was rated 25/100 in relation to auditing in 2015.[70]

THE FUTURE OF PRIMARY HEALTH CARE IN MYANMAR

Introduction of the essential package of health services will substantially alter budgeting arrangements for health expenditure in Myanmar. Implementation of the package represents an opportunity for reform to improve efficiency through programme-based budgeting and transparency through clear costing. This will, in turn, produce stronger data for policy development and evidence for civil society to use in advocacy and to hold the government and service providers to account. Crucially, the essential package of health services will realign spending priorities to shift focus from tertiary to primary health care as a foundation for UHC and efficient referral processes.

Country profile: Nepal – Reaching the unreached with primary health care

Primary health care has been a central organising principle for the Nepali health system since the country signed the Alma-Ata Declaration in 1978. The National Health Sector Strategy 2015–2020 outlines the country's commitment to achieving UHC through an ongoing focus on primary health care and a new commitment to equity through its 'reaching the unreached' strategy. Nepal abolished user fees for basic health services in 2008 to improve access to services and health-seeking behaviour. In 2015, the new constitution recognised the right to health (including the right to free basic health services from the State) and that no person should be deprived of emergency health care and every citizen shall have equal access to health services.

KEY FINDINGS

- Total health expenditure has sharply decreased in Nepal as a percentage of government spending, from 7.2% in 2007/2008 to 3.8% in 2016/2017, indicating a shift in priorities away from health (although the amount in monetary terms has not fallen). This in part reflects increased investment in infrastructure following the 2015 earthquake, though spending had already decreased to 5.8% of government spending in 2013/2014.
- Primary health care expenditure is $10 per person per year, far short of the $86 per person recommended by Chatham House. Total government spending on health as a percentage of GDP is 1.6% or $14 per person, per year. This falls short of the 5% minimum spend on *primary* health care. Primary health care receives around 71% of funding, which is relatively high as a proportion of overall health funding compared with many other countries.
- Adequately funding primary health care in Nepal requires an increase in available revenue and there are limited options for increasing funding to meet health needs without increasing GDP.
- Donor funding for primary health care is falling. This funding is typically controlled by donors through direct payments, so does not reflect the government of Nepal's focus on primary health care. Poor compliance with reporting requirements by donors makes tracking the use of donor funding difficult.
- Abolition of user fees has had a positive impact on access to and uptake of services. However, there is evidence that user fees continue to be charged informally in some instances.
- Catastrophic health expenditure is increasing. Although the government finances a package of essential medicines, stock-outs occur, forcing patients to pay for medicine from private pharmacies.
- Smart procurement practices introduced in 2017 are expected to save 25% on the cost of essential medicines through pooled purchasing, and may help address drug stock-outs.

MOVING TOWARD A NATIONAL HEALTH INSURANCE SCHEME

The abolition of user fees at the primary health care level means that the bulk of out-of-pocket and catastrophic health spending occurs at the secondary and tertiary levels. The $10 per person that government invests in primary health care each year remains far too low to deliver quality, universally accessible basic health care.

To improve financial protection and increase funding, the government of Nepal is working towards implementation of a compulsory national health insurance scheme. The Social Health Security Scheme is now being piloted in 24 districts. This scheme has achieved 5% population coverage in each district. To address problems with adverse selection caused by the voluntary scheme, the Social Health Security Act was passed this year. The revised scheme will require all members of families to be enrolled – membership will cost $25 per family and each person will receive up to $500 in benefits each year. Implementation will be phased, beginning with civil servants, and government will continue to subsidise premiums for the poor.

Country profile: Sierra Leone – Putting women and children first in the wake of Ebola

The Constitution of Sierra Leone states that the government shall create policy to ensure that "there are adequate medical and health facilities for all persons, having due regard to the resources of the State" and that "the care and welfare of the aged, young and disabled shall be actively promoted and safeguarded".[71]

The 2014–15 Ebola outbreak was a devastating reminder of the importance of strong primary health care systems in protecting people from infection, halting the spread of disease and saving lives. Recognising the need to build comprehensive health services with sufficient funding, staff and equipment, to deal with everyday problems as well as infectious disease outbreaks, the Sierra Leone government developed the Health Sector Recovery Plan 2015–2020. The plan introduces a revised Basic Package of Essential Health Services aimed at making a standard set of services available across the country.

KEY FINDINGS ON PRIMARY HEALTH CARE EXPENDITURE

- The average annual spend on primary health care per person was $41.30 in 2013[72] – far short of the Chatham House $86 per person recommendation. The majority of those funds come from out-of-pocket spending.[73] Public health expenditure has fallen. Total government health expenditure as a percentage of GDP fell from 2.4% in 2010 to 1.9% in 2014, taking Sierra Leone even further below the 5% of GDP recommendation.[74]
- The government of Sierra Leone has given greater priority to primary health care than many others, but primary health care still receives too little funding compared with secondary and tertiary services. 42% of total government expenditure on health goes to primary health care.[75] Recent modelling by WHO to develop a price tag for the SDG health targets suggests that 57% of investment should be dedicated to services at the primary health care level.[76]
- Out-of-pocket payments are a major barrier to accessing health services in Sierra Leone. In 2014, 61% of total health expenditure came from households[77] – three times the maximum percentage of health expenditure that Chatham House recommends should come from out-of-pocket spending. 67% of women in Sierra Leone report barriers to accessing primary health care due to out-of-pocket costs (2012).[78]
- Sierra Leone is increasing financial protection through the Free Health Care Initiative. With the assistance of donors, the country has been delivering health care free to children under five, and pregnant women and lactating mothers through all public health facilities, though 'under-the-table' user fees continue to be charged and create barriers to access. Sierra Leone has the highest rate of maternal mortality in the world – one in 17 mothers faces a lifetime risk of death associated with childbirth.[79]
- To increase investment in primary health care, Sierra Leone will need to increase revenue, yet no data on tax collection in Sierra Leone is currently available. 5% of GDP in Sierra Leone currently does not amount to the recommended $86 per person minimum spend on primary health care. This should make Sierra Leone a priority country for donor assistance.

BARRIERS TO ACCESSING HEALTH SERVICES REPORTED BY WOMEN IN SIERRA LEONE

76% report barriers to accessing health services

67% report financial barriers

39% report distance to services as a barrier

18% report getting permission to access services as a barrier

17% report not wanting to attend health services as a barrier

Country profile: Bangladesh – Strong foundations and implementation challenges

Bangladesh has made important progress toward SDG 3 by establishing a strong legal and policy foundation for UHC. Bangladesh has committed to deliver the right to the highest attainable standard of physical and mental health under the International Convention on Economic Social and Cultural Rights and the Convention on the Rights of the Child.[80] This means taking steps "to the maximum of its available resources" (individually and through international assistance) to progressively realise the right to health. The Constitution of Bangladesh recognises the importance of ensuring this right for all by requiring the government to improve health outcomes and address rural inequalities.[81]

The national *Health, Nutrition and Population Strategic Investment Plan 2016–2021* furthers this commitment and recognises the importance of investing in primary health care through an Essential Service Package. The package covers primary health care services and some emergency obstetric care, and is supposed to be provided free to all Bangladeshi citizens. The country has also developed a health financing strategy and is currently piloting social health insurance schemes in three districts.

These policies and commitments demonstrate clear political will and strategic planning. However, funding and translating these policies into reality remains a challenge.

PRIMARY HEALTH CARE EXPENDITURE AND INEQUALITIES IN BANGLADESH

- Inequalities in health outcomes between rural and urban areas, genders, and people of different economic status and levels of education highlight the need for more differential budgeting. This is necessary to inform efforts to expand services and financial protection – in order to improve access, equity and utilisation of services for UHC.
- Total health expenditure in Bangladesh amounts to just $37 per person each year. This falls far short of the $86 per person or 5% of GDP that Chatham House recommends spending on primary health care. Although health expenditure as a proportion of total government expenditure is relatively high at 23%, it has decreased from 37% 20 years ago (1997).[82]
- Out-of-pocket payments are a major barrier to access for marginalised groups. Health costs account for 22% of economic shocks for households.[83] Bangladesh has one of the highest out-of-pocket spending rates in the world, with 67% of total health expenditure met by private households.[84] This is more than triple the recommended maximum 20% that out-of-pocket payments should contribute to health expenditure.[85]
- Policy requires free delivery of basic health services, yet 80% of Bangladeshis report making payments for health care.
- Implementation and funding of policies have been the principle challenge to strengthening primary health care. Nevertheless, progress is being made and external donors have provided some support to expand access to primary health care services, with a particular focus on children and hard-to-reach economically and geographically marginalised groups.
- Those working towards UHC also face systemic barriers, including rigid public financing processes inherited from the colonial era, lack of human resources for health, political interference, and poor monitoring and supervision to ensure quality of care.

$0
Amount Bangladeshis should be charged for essential health services since user fees were abolished

20%
Recommended maximum percentage of health care expenditure that should come from out-of-pocket spending[86]

67%
Proportion of health expenditure from out-of-pocket spending in Bangladesh[87]

80%
Percentage of Bangladeshis who report paying for health services[88]

5 Towards UHC by 2030

The SDGs have created fresh momentum for countries to improve access to health care through the UHC target. But without a clear roadmap, we are wasting precious time and already limited resources. The cost of these inefficiencies is measurable not just in dollars and minutes, but in the lives of the poorest and most marginalised people, particularly women and children.

UHC is an ambitious but affordable goal. Investing to build quality, accessible and equitable primary health care services is the most practical, efficient and effective first step for countries. It is right that the global community supports countries to define their own pathways to UHC and their priorities. However, the way that UHC will be measured under the SDGs shows that investment in strengthening primary health care is an urgent priority for saving lives and delivering the right to health for all.

KEY FINDINGS AND RECOMMENDATIONS

1. **No country will achieve UHC without first delivering primary health care for all: Investing in strong primary health care systems that deliver high-quality, accessible services, free at the point of use, should be an urgent priority for the global community as we work towards UHC by 2030.** The right to health and the principles of the Alma-Ata Declaration should continue to guide the health agenda as the global community works to deliver the SDGs.
2. **The global UHC movement must match momentum with leadership: World health leaders should work to develop a roadmap** to help guide national governments, civil society, donors and the private sector as we work together to achieve UHC. All countries can benefit from shared evidence and experience.

PHOTO: JONAS GRATZER/SAVE THE CHILDREN

At Queen Elizabeth Hospital, Malawi, mothers of preterm babies are trained in 'kangaroo mother care' – an effective technique to help meet a premature baby's basic needs for warmth, nutrition, stimulation and protection from infection.

3. **There is no one path to UHC: Countries should clearly define and cost their own essential health service packages and detailed pathways to UHC.** These packages should reflect the Alma-Ata Declaration and must include sexual, reproductive, maternal, newborn, child and adolescent health to deliver preventative, curative and palliative services to save lives across the continuum of care. While global spending targets are valuable, national costings create opportunities to increase efficiency and improve impact, based on local needs.

4. **UHC is an ambitious but affordable dream: Governments should mobilise domestic resources to increase investment in primary health care.** Public financing is the most reliable and equitable source of health financing. To achieve UHC, health systems must rely predominantly on public revenue. Governments can:
   - increase revenue through prepaid, mandatory and progressive taxation
   - pool funds to increase purchasing power and create mandatory health insurance schemes that meet health costs through cross-subsidisation.

5. **There is no substitute for public investment: Governments should work to create fiscal space to increase health budgets and investment in primary health care systems to 5% of GDP.** Even modest increases in expenditure have been shown to significantly improve service coverage.

6. ***How* money is spent may be as important as *how much* is spent.** All countries can make progress towards UHC by improving the way they spend money. Countries should identify and reduce financial/purchasing inefficiencies, including through better execution of budgets and data systems improvements.

7. **The international community still has a role to play: External support should seek to strengthen primary health services.** Lower-income countries will continue to need external assistance as they progressively realise the right to health. The 5% of GDP/$86 per person target for primary health care expenditure provides valuable guidance to donors on where to prioritise spending and apply pressure to countries that can spend or raise more domestic revenue. Donors should shift from funding vertical health issues to building resilient and sustainable health systems and maximising impact through better pooling and coordination of funding with national investment.

8. **Country context matters: Governments and donors should invest in national and sub-national research and budget analysis.** The details of how a country's health system is governed and funded, how its budget is framed as well as geographical, epidemiological and demographic factors shape the pathways available to countries working towards UHC. National Health Accounts often bear little relevance to national budget data, and even national-level data will mask internal inequalities, particularly in decentralised systems. Local data should guide policy development and monitoring of progress.

9. **We cannot measure what we don't know: Governments must improve budget transparency** by making all essential budget documentation publicly available and tracking spending through detailed expenditure review. Citizens' budgets, whether produced by government or external bodies, are a valuable tool for improving public understanding of how governments are spending their money.

10. **Primary health care is about serving communities: Governments and donors should support community and civil society to participate in planning and to advocate for increased investment in primary health care.** Donors and the government should:
    - support the inclusion of community and civil society organisations on local health governance bodies
    - build civil society capacity to conduct budget analysis and advocacy through training and by sharing evidence
    - engage community based organisations in monitoring of service delivery.

Endnotes

[1] PHCPI, 'Per capita primary health care expenditure', PHCPI, 2017. Available at: https://phcperformanceinitiative.org/indicator/capita-current-primary-health-care-expenditure-usd#?loc=&viz=0&ci=false

[2] Sen, A, 'Universal health care: the affordable dream', *The Guardian*, 6 January 2015, https://www.theguardian.com/society/2015/jan/06/-sp-universal-health care-the-affordable-dream-amartya-sen; Save the Children, *Within Our Means: Why countries can afford universal health coverage*, Save the Children, 2015, https://resourcecentre.savethechildren.net/library/within-our-means-why-countries-can-afford-universal-health-coverage

[3] Kutzin, J. 'Anything goes on the path to universal health coverage? No', *Bulletin of the World Health Organization*, 2012. Available at: http://www.who.int/bulletin/volumes/90/11/12-113654/en/

[4] Doherty G and Govender R, 'The cost effectiveness of primary care services in developing countries: A review of international literature', Working Paper No. 37, Disease Control Priorities Project, World Bank, WHO and Fogarty International Centre of the US National institutes of Health, 2004, https://www.researchgate.net/publication/242783643_The_Cost-Effectiveness_of_Primary_Care_Services_in_Developing_Countries_A_Review_of_the_International_Literature Henceforth 'World Bank Report'.

[5] See Starfield B, Shi L, Macinko J, 'Contribution of primary care to health systems and health', *Milbank Q*, 83, 2005, 457–502

[6] Stenberg K, Hanssen O, Tan-Torres Edejer T et al. 'Financing transformative health systems towards achievement of the Sustainable Development Goals: A model for projected resource needs in 67 low- and middle-income countries', *The Lancet*, 5.9, 2017, 875–887. Henceforth: 'SDG Price Tag'.

[7] Wang, H and Maele, N. 'Primary health care expenditure analysis' (Preliminary findings presented at Primary Health care and Budget Advocacy Consultation, delivered 13 March 2017). Bill & Melinda Gates Foundation, 2017

[8] PHCPI, 2017 – see endnote 1

[9] Xu, K, Evans, DB and Zeramdini, R et al. 'Household catastrophic health expenditure: a multicountry analysis', *The Lancet*, 362, 2012, 311–117.

[10] Jowett M, Brunal MP, Flores G and Cylus J, Spending Targets for Health: No magic number, (Health Financing Working Paper No. 1), World Health Organization, 2016. Available at: http://apps.who.int/iris/bitstream/10665/250048/1/WHO-HIS-HGFHFWorkingPaper-16.1-eng.pdf

[11] Stenberg K, Hanssen O, Tan-Torres Edejer T et al, 2017 – see endnote 6

[12] Mcintyre DM, 'Shared Responsibilities for Health: A Coherent Global Framework for Health Financing', Final Report of the Centre on Global Health Security Working Group on Health Financing. 2014

[13] *Every Last Child: The children the world chooses to forget*, Save the Children, 2016, https://www.savethechildren.org.uk/content/dam/global/reports/education-and-child-protection/every-last-child.pdf; *Fighting for Breath: A call to action on childhood pneumonia*, Save the Children, 2017, https://www.savethechildren.org.uk/what-we-do/policy-and-practice/our-featured-reports/fighting-for-breath

[14] Convention on the Rights of the Child 1989, Article 24; International Covenant on Economic, Social and Cultural Rights 1966, Article 12

[15] Convention on the Rights of the Child 1989, Article 24; International Covenant on Economic, Social and Cultural Rights 1966, Article 12.

[16] Sen, A, 2015 and Save the Children, 2015 – see endnote 2

[17] *Tracking Universal Health Coverage: First global monitoring report*, WHO and World Bank, 2015, http://apps.who.int/iris/bitstream/10665/174536/1/9789241564977_eng.pdf?ua=1

[18] Sustainable Development Goal 3, United Nations, 2015. Available at: https://sustainabledevelopment.un.org/sdg3 (accessed 10 October 2017)

[19] Doherty G and Govender R, 2004 – see endnote 4

[20] See Starfield B, Shi L and Macinko J, 2005 – see endnote 5

[21] World Health Report: Primary health care – Now more than ever, WHO, 2010

[22] Hsieh VC, Wu JC, Wu TN et al, 'Universal coverage for primary health care is a wise investment: Evidence from 102 low- and middle-income countries', *Asia Pacific Journal of Public Health*, 27.2, 2015, NP877-86, https://www.ncbi.nlm.nih.gov/pubmed/23858519

[23] See Starfield B, Shi L and Macinko J, 2005 – see endnote 5

[24] Doherty G and Govender R, 2004 – see endnote 4

[25] Declaration of Alma-Ata International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978

[26] Declaration of Alma-Ata International Conference on Primary Health Care – see endnote 25

[27] 'Spotlight on: The Bamako Initiative – Putting communities in charge of health services in Benin, Guinea and Mali', World Bank Group, available at: http://openknowledge.worldbank,org/bitstream/handle/10986/986/978082135681_Spot%20Bamako.pdf (accessed 10 October 2017)

[28] *A Wake-Up Call: Lessons from Ebola for the world's health systems*, Save the Children, 2015

[29] Save the Children, 2015 – see endnote 28

[30] *Public Financing for Health in Africa: From Abuja to the SDGs*, WHO, 2016, http://apps.who.int/iris/bitstream/10665/249527/1/WHO-HIS-HGF-Tech.Report-16.2-eng.pdf

[31] Focus group discussion with civil society advocates in Zimbabwe, 27 August 2017

[32] Health Accounts and universal health coverage (webpage), WHO, 2017, available at: http://www.who.int/health-accounts/universal_health_coverage/en/

[33] Open Budget Survey: Myanmar, International Budget Partnership, 2015, http://apps.who.int/iris/bitstream/10665/249527/1/WHO-HIS-HGF-Tech.Report-16.2-eng.pdf

[34] PHCPI, 'Indicator Library', 2017. Available at: https://phcperformanceinitiative.org/content/indicator-library

[35] Stenberg K, Hanssen O, Tan-Torres Edejer T et al, 2017 – see endnote 6

[36] Burkina Faso, Benin, Cambodia, Cameroon, Comoros, Côte d'Ivoire, Democratic Republic of Congo Djibouti, Gabon, Gambia, Ghana, Mauritania, Namibia, Niger, Nigeria, Papua New Guinea, Philippines, Sao Tome and Principe Seychelles, Sierra Leone, Sri Lanka, Tanzania, Uganda, Vietnam and six other countries that had not approved identification at the date of presentation: Wang, H and Maele, N. 'Primary health care expenditure analysis' (Preliminary findings presented at Primary Health care and Budget Advocacy Consultation, delivered 13 March 2017). Bill & Melinda Gates Foundation, 2017

[37] Save the Children, *A Common Cause: Reaching every woman and every child through Universal Health Coverage*, Save the Children, 2016

[38] Save the Children 2016 – see endnote 37. Findings are considered preliminary as PHCPI may alter the definition of primary health care expenditure used in future analysis.

[39] Centre on Global Health Security Working Group on Health Financing, *Shared Responsibilities for Health: A coherent global framework for health financing*, Royal Institute of International Affairs, 2014, https://www.chathamhouse.org/sites/files/chathamhouse/field/field_document/20140521HealthFinancing.pdf Henceforth: "Chatham House Report".

[40] Ridde V, 'From institutionalization of user fees to their abolition in West Africa: a story of pilot projects and public policies', BioMed Central Health Services Research, 15.3, 2015

[41] Centre on Global Health Security Working Group on Health Financing, 2014 – see endnote 39

[42] Stenberg K, Hanssen O, Tan-Torres Edejer T et al, 2017 – see endnote 6

[43] Mcintyre DM, 2014 – see endnote 12

[44] Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases 2001, OAU/SPS/ABUJA/3, http://www.un.org/ga/aids/pdf/abuja_declaration.pdf

[45] Centre on Global Health Security Working Group on Health Financing, 2014 – see endnote 39

[46] Stenberg K, Hanssen O, Tan-Torres Edejer T et al, 2017 – see endnote 6

[47] Jowett M, Brunal MP, Flores G et al, 2016 – see endnote 10

[48] Jowett M, Brunal MP, Flores G et al, 2016 – see endnote 10

[49] Jowett M, Brunal MP, Flores G et al, 2016 – see endnote 10

[50] Jowett M, Brunal MP, Flores G et al, 2016 – see endnote 10

[51] Jowett M, Brunal MP, Flores G et al, 2016 – see endnote 10

[52] Centre on Global Health Security Working Group on Health Financing, 2014 – see endnote 39

[53] Stenberg K, Hanssen O, Tan-Torres Edejer T et al, 2017 – see endnote 6

[54] Centre on Global Health Security Working Group on Health Financing, 2014 – see endnote 39

[55] Centre on Global Health Security Working Group on Health Financing, 2014 – see endnote 39

[56] Wang, H and Maele, N, 2017 – see endnote 7

[57] International Tax Compact, Addis Tax Initiative Monitoring Report 2015, 2015

[58] Jowett M, Brunal MP, Flores G et al, 2016 – see endnote 10

[59] Key informant interview with Community Health Working Group, Zimbabwe, 27 August 2017

[60] Labonte R, Sanders D, Packer C et al, *Revitalizing Health for All: Case studies of the struggle for comprehensive primary health care*, University of Toronto Press, 2017

[61] PATH, "Advocacy for Better Health", 2017, available at: http://www.path.org/publications/detail.php?i=2689

[62] Save the Children primary health care expenditure workshop, 26 July 2017, Harare, Zimbabwe

[63] Constitution of Zimbabwe 2013, Article 76

[64] Zimbabwe National Health Accounts 2015

[65] International Budget Partnership, 2015 – see endnote 33

[66] World Bank Data: Myanmar, available at: http://data.worldbank.org/country/myanmar

[67] World Health Organization Global Health Expenditure Database – National Health Accounts Myanmar

[68] Myanmar National Health Plan 2017–2021

[69] Myanmar National Health Accounts, 2012–13

[70] International Budget Partnership, 2015 – see endnote 33

[71] Constitution of Sierra Leone 1991, Article 8(3)

[72] Based on National Health Account data assessed the Primary Health Care Performance Initiative assessment tool. Available at: http://phcperformanceinitiative.org/sub-saharan-africa/sierra-leone

[73] Centre on Global Health Security Working Group on Health Financing, 2014 – see endnote 39

[74] Centre on Global Health Security Working Group on Health Financing, 2014 – see endnote 39

[75] Centre on Global Health Security Working Group on Health Financing, 2014 – see endnote 39

[76] Stenberg K, Hanssen O, Tan-Torres Edejer T et al, 2017 – see endnote 6

[77] World Health Organization Global Health Expenditure database, available at: https://data.worldbank.org/indicator/SH.XPD.PUBL?end=2014&start=1995&view=chart

[78] Demographic Health Survey, Sierra Leone, 2012

[79] Trends in Maternal Mortality 2010–15, WHO, UNICEF, UNFPA, World Bank Group and United Nations Population Division, 2015

[80] International Covenant on Economic, Cultural and Political Rights, Art 2, 12; Convention on the Rights of the Child, Art 24

[81] Constitution of the People's Republic of Bangladesh 1972, Articles 16, 18(1)

[82] Bangladesh National Health Accounts

[83] Bangladesh Health Watch, 2012

[84] Government of Bangladesh, 2017

[85] Bangladesh Health Watch, 2012

[86] Mcintyre, 2014 – see endnote 12

[87] Government of Bangladesh, 2017

[88] Bangladesh Health Delivery Survey, 2003

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