

HEART

HEALTH & EDUCATION ADVICE & RESOURCE TEAM

Helpdesk Report: Health budgets for primary health facilities

Date: 15 June 2016

Query: What is the recommended proportion (%) of an annual national health budget in sub-Saharan Africa for the maintenance of primary health facilities, (i.e. district level hospitals and below – clinics – rural and urban)?

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1. Overview

This helpdesk response aimed to discover what the recommended proportion of an annual national health budget in sub-Saharan Africa is for the maintenance of primary health facilities. From both a rapid review of the evidence available and from correspondence with experts in public health financing, it is clear that **no such recommendation exists**.

In light of the lack of a specific recommendation, this report presents some background information on health budgeting. It provides a brief history of health system strengthening, including the 1978 Alma Ata Declaration that called for primary health care to be included as part of a comprehensive national health system, and the 2001 Abuja Declaration, which pledged to set a target of allocating at least 15% of each national budget to improve the health sector annually (Mills, 2009; OAU, 2001; WHO, 2011).

Some budgeting options are discussed, which may help overcome the challenges of primary health provision, such budget allocation adjustment. Examples are provided from Tanzania, Uganda and Chile (WHO, 2008).

In Kenya, a health reform was launched in 2005, aiming to strengthen primary health care services in order to facilitate the provision of low-cost and accessible services in rural areas. Specific targets for reallocation of expenditures included increasing expenditures on rural health facilities and preventive health by 15%, increasing allocation for drugs in these facilities by 18%. The reform also targeted reducing expenditures on the national hospital by 3.8%. Efforts to increase allocation of funds towards districts is encouraged (Glenngård and Maina, 2007).

Research from Ghana has shown that resource allocation decisions are complicated and based on many factors. Human resources for health, capacity, donor involvement in the health sector, and commitment to promote equity have considerable influence on resource allocation decisions. A transparent, needs based system that includes consideration of capacity is required (Asante and Zwi, 2009).

The findings of a high-level taskforce focused on innovative international financing for health systems are included. Based on their analysis of the situation, the taskforce advised that government health expenditure should prioritise cost-effective services (Mills, 2009).

One study focused on Burkina Faso explores the possibility of expanding access to primary care without additional budgets. The authors found that the cost of providing primary health services are not linear. Improved access to primary care does not necessarily mean dramatic cost increases. While some extra budget is needed to expand access, increases to budgets can be found to be moderate (Marschall and Flessa, 2008).

A health care sustainability framework is presented, which includes a diagnostic tool for understanding the sources of expenditure increase. Although the framework was primarily devised for high income contexts, but contains some useful information for low and middle income contexts (Birch et al., 2015). Evidence from health systems focused systematic reviews is presented. A key argument relevant to this query is that further research is needed into the integration of primary health services (Lewin et al., 2008).

The helpdesk then presents two key resources. Firstly the Primary Health Care Performance Initiative (PHCPI) and secondly the High Level Taskforce for Innovative International Financing of Health Systems. PHCPI is a partnership focused on knowledge sharing to catalyse improvements in primary health care (PHC) in low- and middle-income countries. Data is presented from two indicators for countries from sub-Saharan Africa – firstly on the percent of government health spending dedicated to primary health care (PHC), and secondly on per capita primary health care expenditure. A comparison of the two indicators is also presented. The High Level Taskforce aimed to strengthen health systems in the 49 poorest countries in the world. The findings of the taskforce were published in May 2009. Although it is now disbanded, the papers they produced provide some relevant information relating to the financing of primary care in low income settings.

This report then provides a list of abstracts to key publications, as well as web links. Finally, it presents the comments of a few experts who work on health financing in varying capacities at various universities and the World Health Organization.

2. Health budgeting

Background

In the period of independence in the 1960s and 1970s, many developing countries entered a phase of health system strengthening. They aimed to expand networks of basic health services through public sector investment. The 1978 Alma Ata Declaration called for the launch and sustaining of primary health care as part of a comprehensive national health system. The approach to strengthening the health system as a whole was superseded by the emergence of selective primary health care, where specific high-priority diseases and highly cost-effective interventions were prioritised. Despite the two approaches being best seen as complementary, tension between broad systems strengthening and support to specific diseases has persisted (Mills, 2009).

The Abuja Declaration was made by countries in the Organisation of African Unity (now African Union) countries in April 2001, and pledged to set a target of allocating at least 15% of each national budget to improve the health sector annually. The Declaration came as a response to the devastating impact of HIV/AIDS, tuberculosis and other infectious diseases were having on the continent (OAU, 2001). Although the declaration does not make reference to the recommended proportion of an annual national health budget set aside for primary health facilities, it has been included here as relevant background information on health budgets.

Ten years after the Abuja Declaration, the WHO reported that 26 countries have increased the proportion of total government expenditures allocated to health. However, only Tanzania has achieved the Abuja Declaration target of allocating at least 15% of their national budget to health. 11 countries were found to have reduced their relative contributions of government expenditures to health during the same period. In the other nine countries, there is no obvious increase or decrease (WHO, 2011). For decades, health agendas have been built around specific diseases and interventions rather than around the broader health systems. This has contributed to a better appreciation of the burden of disease affecting poor countries, but has also led to the fragmentation of the governance of the health sector, diverting attention from important issues, including the organisation of primary care. This trend has shaped the way funds are channelled, leading to a disproportionate investment in disease programmes in aid-dependent countries, diverted the attention of ministries of health away from the planning of primary care and the public's health (WHO, 2008).

Budget options

Budget allocation adjustment may be required to reflect the challenges of providing health care to hard-to-reach populations. In 2004 Tanzania adopted a revised formula for fund allocation to districts. Data on population size and under-five mortality were included as a proxy for disease burden and poverty level. Adjustments were made for the differential costs of providing health services in rural and low-density areas. Similarly, allocations to districts under Uganda's primary health care budget factor in the districts' Human Development Index and levels of external health funding, in addition to population size. Districts with difficult security situations or lacking a district hospital received supplements. In Chile, primary health care reforms led to budget allocation remaining on a capitation basis, but being adjusted using municipal human development indices to reflect the isolation of underserved areas (WHO, 2008).

Evidence from Kenya shows challenges exist regarding budget allocation and health policy. A reform was launched in 2005, which included a strategy is to strengthen primary health care services in order to facilitate the provision of low-cost and accessible services in rural areas. In the Kenyan Public Expenditure Review (PER) 2005 specific targets for reallocation of expenditures in order to focus priority programmes include:

- Increasing expenditures on rural health facilities and preventive health by 15%;
- Increasing allocation for drugs for rural health facilities by 18%;
- Reducing expenditures on Kenyatta National Hospital by 3.8%.

Current budgeting practises in Kenya constitute a problem of gaps and delays in allocation and disbursement of funds at the district level. Thereby the control over financial resources at district level becomes weak. Ongoing efforts towards the allocating of funds towards districts might help solving the issue of low absorption capacity at the district level (Glenngård and Maina, 2007).

A study into the factors influencing resource allocation decisions and equity in the health system of Ghana reports that the decision to allocate resources to a particular health jurisdiction or facility may be based on a broad range of factors, sometimes not reflected in the resource allocation formula. It was found that the availability of human resources for health, local capacity to utilise funds, donor involvement in the health sector, and commitment to promote equity have considerable influence on resource allocation decisions and affect the equity of funding allocations. A more transparent resource allocation system in Ghana is called for. The system must respond to needs and take into account key issues such as capacity constraints, the inequitable human resource distribution and donor-earmarked funding (Asante and Zwi, 2009).

A high-level taskforce on innovative international financing for health systems reported that a high proportion of government health expenditure is spent on hospitals. A high share of

health budgets is spent on higher-level hospitals. They report that one study found that all levels of public hospitals in developing countries absorbed a mean of 60% of recurrent public health expenditures. Further to this, in Belize, Indonesia, Kenya, Zambia and Zimbabwe, tertiary hospitals accounted for 45-69% of total public expenditure on hospitals. Data from South Africa indicates that tertiary and regional hospitals accounted for nearly 60% of total public hospital expenditure, with tertiary hospitals alone accounted for nearly one fifth of total public health expenditure. In light of the findings, the taskforce advised that government health expenditure should prioritise cost-effective services (Mills, 2009).

Marschall and Flessa (2008) explored the possibility of expanding access to primary care without additional budgets, using data from Burkina Faso. Through an investigation of the fixed and variable costs associated with primary care facilities, their analysis demonstrates that increased utilisation of primary health facilities increases the total costs incurred, but that this increase does not necessarily have to be at a linear rate. The evidence suggests that the total provider costs of primary care would hardly rise if the coverage of the population were increased as the highest variable costs were found to be drugs, which are fully paid for by the customers. The majority of other costs are fixed. The governmental budget needed for primary facilities would therefore hardly rise if coverage increased. Reforms that aim to improve access to primary care should not necessarily result in a dramatic increase in the costs of the health care services. They conclude that expanding access to primary care is not possible without additional budgets - but the increase can be very moderate.

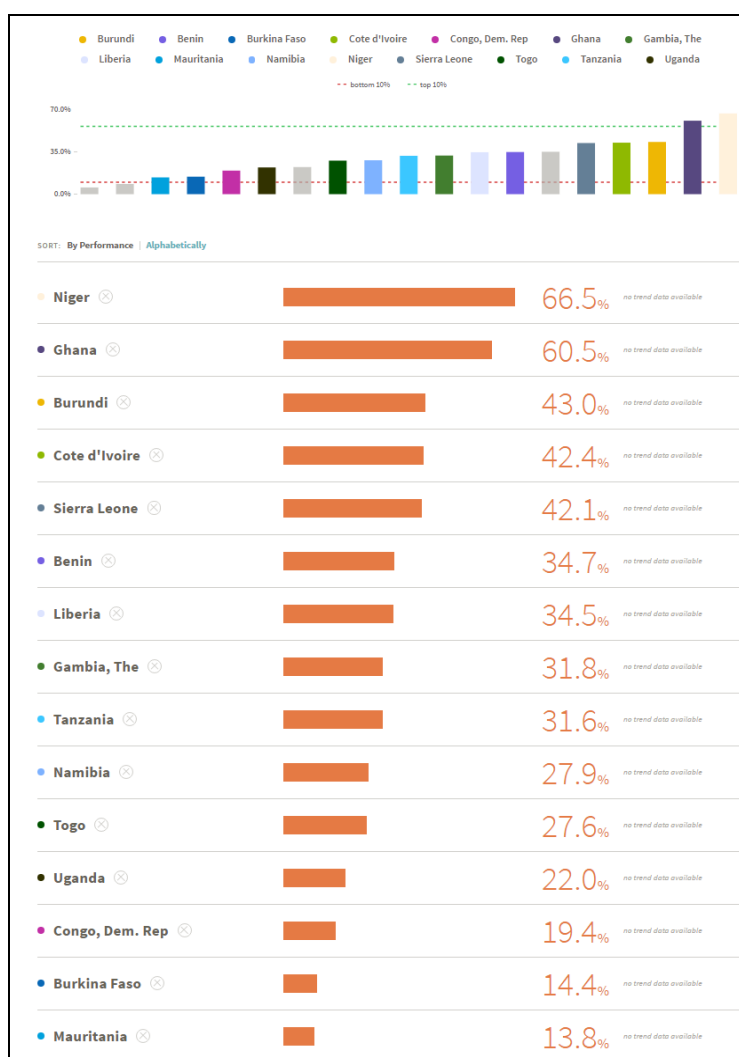
Financial sustainability of publicly funded health care systems is a challenge in many countries and contexts. Evidence suggests increases in health care spending are not necessarily linked to increases in need for care. Birch et al. (2015) present an alternative view of financial sustainability, which suggests problem areas include a failure to understand the needs for care in populations and a lack of integration of planning and management functions for health care expenditure, health care services and the health care workforce. A Health Care Sustainability Framework is presented, which is based on disaggregating the health care expenditure into separate planning components. Within the framework, population health needs are included as a determinant of health care requirements. A diagnostic tool for understanding the sources of expenditure increase is included. Although the framework was devised primarily for high income countries, its theoretical basis is equally applicable to low and middle income countries and contexts.

An overview of the systematic reviews available that focus on health systems arrangements and implementation strategies for delivery of primary health care reports that although evidence is sparse, some progress has been made. There is currently an evidence gap which must be addressed. Rigorous evaluations must be implemented. The evidence base must be strengthened, synthesised, and embedded into account in policy and practice. A key point reported from the evidence was that although multiple vertical programmes can lead to service duplication, fragmentation, and inefficiency, the effects of strategies to integrate primary health care services have not been assessed adequately. Further research is needed. Also, quality improvement strategies have been shown to have important, although modest, effects on primary health care quality (Lewin et al., 2008).

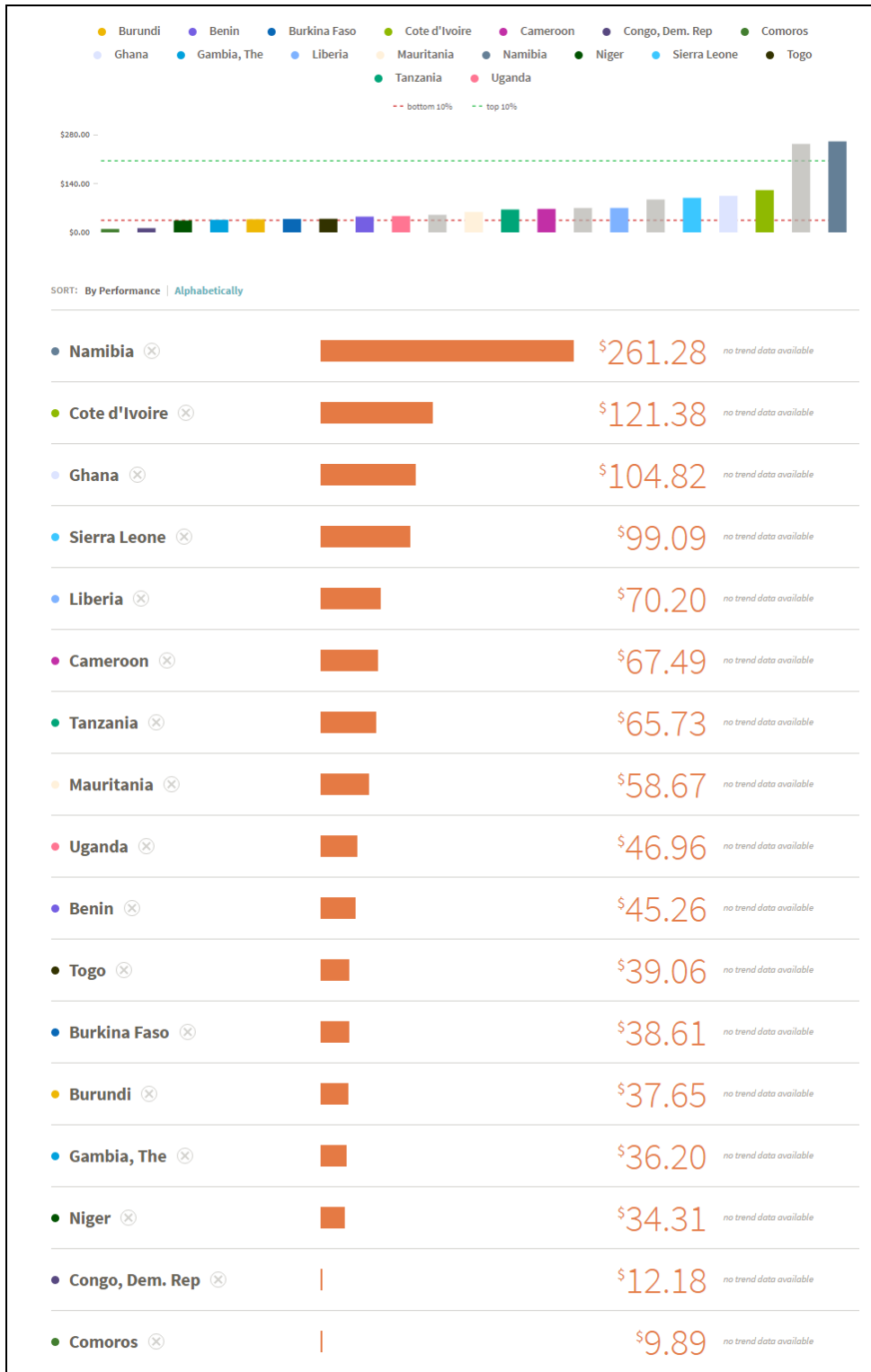
3. Key resources

The Primary Health Care Performance Initiative (PHCPI)
<http://www.phcperformanceinitiative.org/>

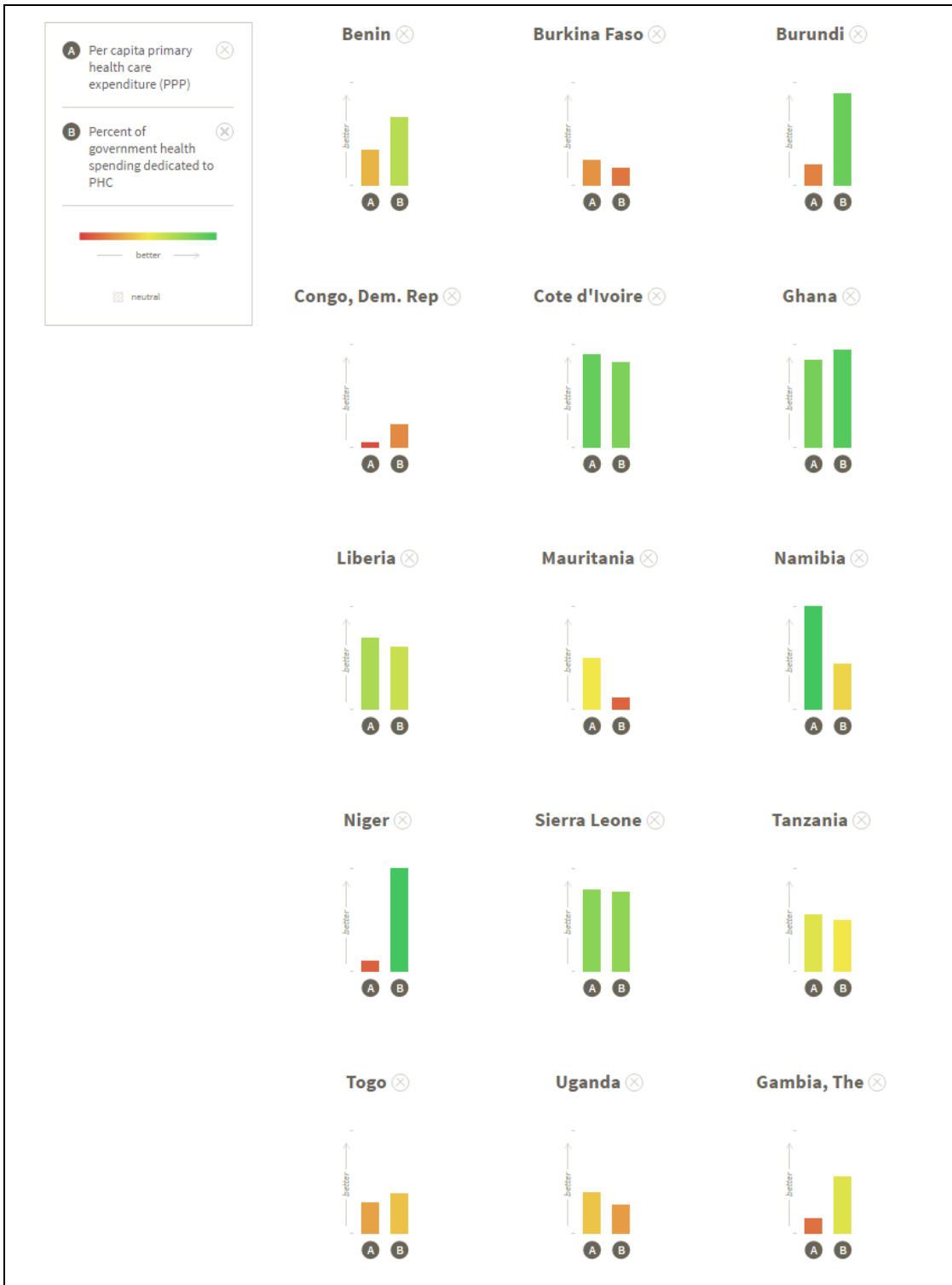
The Primary Health Care Performance Initiative (PHCPI) is a partnership that brings together country policymakers, health system managers, practitioners, advocates and other development partners to catalyse improvements in primary health care (PHC) in low- and middle-income countries through better measurement and knowledge-sharing. PHCPI aims to help countries track key performance indicators for their PHC systems, identifying which parts of the system are working well and which ones are not. This will enhance accountability and provide decision-makers with essential information to drive improvements. An indicator relevant to this query is the percent of government health spending dedicated to PHC, which measures the percent of government health spending that is specifically dedicated to primary health care. This core health financing indicator reflects government investment in and commitment to primary health care and enables increased accountability of governments on their primary health care investments. The figure below shows the percent of government health spending dedicated to PHC for 15 countries in sub-Saharan Africa:



Another indicator that may be of interest is the per capita primary health care expenditure. Total primary health care spending per person is measured in purchasing power parity (PPP) and contributes to the understanding of the priority and importance a country and population places on primary health care. The figure below shows the per capita primary health care expenditure (PPP) for 17 countries in Sub-Saharan Africa:



The following figure compares the indicators of per capita primary health care expenditure (PPP) and percent of government health spending dedicated to PHC for sub-Saharan African countries:



High Level Taskforce for Innovative International Financing of Health Systems
<http://www.internationalhealthpartnership.net/en/about-ihp/past-ihp-meetings/high-level-taskforce-for-innovative-international-financing-of-health-systems/>

The High-Level Taskforce on Innovative International Financing for Health Systems was launched in September 2008 to help strengthen health systems in the 49 poorest countries in the world. Chaired by UK Prime Minister Gordon Brown and World Bank President Robert Zoellick, the Taskforce released its Recommendations in May 2009, identifying a menu of innovative financing mechanisms to complement traditional aid and bridge the financing gaps which compromise attainment of the health-related MDGs. The Taskforce completed its work in September 2009 and at the UN General Assembly in New York City, launched new initiatives to raise more money, and use money more effectively, to improve health care for women and children around the world.

4. Bibliography and abstracts

Asante A, Zwi A. 2009. Factors influencing resource allocation decisions and equity in the health system of Ghana. Public Health; 123 (5)
<http://www.sciencedirect.com/science/article/pii/S0033350609000389>

Allocation of financial resources in the health sector is often seen as a formula-driven activity. However, the decision to allocate a certain amount of resources to a particular health jurisdiction or facility may be based on a broader range of factors, sometimes not reflected in the existing resource allocation formula. This study explores the 'other' factors that influence the equity of resource allocation in the health system of Ghana. The extent to which these factors are, or can be, accounted for in the resource allocation process is analysed. This study employed an exploratory design focusing on different levels of the health system and diverse stakeholders. Data were gathered through semi-structured qualitative interviews with health authorities at national, regional and district levels, and with donor representatives and local government officials in 2003 and 2004. The availability of human resources for health, local capacity to utilize funds, donor involvement in the health sector, and commitment to promote equity have considerable influence on resource allocation decisions and affect the equity of funding allocations. However, these factors are not accounted for adequately in the resource allocation process. This study highlights the need for a more transparent resource allocation system in Ghana based on needs, and takes into account key issues such as capacity constraints, the inequitable human resource distribution and donor-earmarked funding.

Birch S, Murphy G, MacKenzie A, Cumming J. 2015. In place of fear: aligning health care planning with system objectives to achieve financial sustainability. Journal of Health Services Research & Policy; 20 (2)
<http://www.ncbi.nlm.nih.gov/pubmed/25504826>

The financial sustainability of publicly-funded health care systems is a challenge to policymakers in many countries as health care absorbs an ever increasing share of both national wealth and government spending. New technology, ageing populations and increasing public expectations of the health care system are often cited as reasons why health care systems need ever increasing funding, as well as reasons why universal and comprehensive public systems are unsustainable. However, increases in health care spending are not usually linked to corresponding increases in need for care within populations. Attempts to promote financial sustainability of systems such as limiting the range of services is covered or the groups of population covered may compromise their political sustainability as some groups are left to seek private cover for some or all services.

In this paper, an alternative view of financial sustainability is presented which identifies the failure of planning and management of health care to reflect needs for care in populations and to integrate planning and management functions for health care expenditure, health care services and the health care workforce. The authors present a Health Care Sustainability

Framework based on disaggregating the health care expenditure into separate planning components. Unlike other approaches to planning health care expenditure, this framework explicitly incorporates population health needs as a determinant of health care requirements, and provides a diagnostic tool for understanding the sources of expenditure increase.

Glenngård H, Maina T. 2007. Reversing the trend of weak policy implementation in the Kenyan health sector? – A study of budget allocation and spending of health resources versus set priorities. Health Research Policy and Systems; 5 (3)
<http://www.biomedcentral.com/content/pdf/1478-4505-5-3.pdf>

Policy implementation in the context of health systems is generally difficult and the Kenyan health sector situation is not an exception. In 2005, a new health sector strategic plan that outlines the vision and the policy direction of the health sector was launched and during the same year the health sector was allocated a substantial budget increment. On basis of these indications of a willingness to improve the health care system among policy makers, the objective of this study was to assess whether there was a change in policy implementation during 2005 in Kenya. Budget allocations and actual expenditures compared to set policy objectives in the Kenyan health sector was studied. Three data sources were used: budget estimates, interviews with key stakeholders in the health sector and government and donor documentation.

Budget allocations and actual expenditures in part go against policy objectives. Failures to use a significant proportion of available funds, reallocation of funds between line items and weak procurements systems at the local level and delays in disbursement of funds at the central level create gaps between policy objectives and policy implementation. Some of the discrepancy seems to be due to a mismatch between responsibilities and capabilities at different levels of the system. The authors found no evidence that the trend of weak policy implementation in the Kenyan health sector was reversed during 2005 but ongoing efforts towards hastening release of funds to the districts might help solving the issue of low absorption capacity at the district level. It is important, however, to work with clear definitions of roles and responsibilities and well-functioning communications between different levels of the system.

Lewin S, Lavis J, Oxman A, Bastías G, Chopra M, Ciapponi A, Flottorp S, García Martí S, Pantoja T, Rada G, Souza N, Treweek S, Wiysonge C, Haines A. 2008. Supporting the delivery of cost-effective interventions in primary health-care systems in low-income and middle-income countries: an overview of systematic reviews. The Lancet; 2008, 372 (9642)
[http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(08\)61403-8.pdf](http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(08)61403-8.pdf)

Strengthening health systems is a key challenge to improving the delivery of cost-effective interventions in primary health care and achieving the vision of the Alma-Ata Declaration. Effective governance, financial and delivery arrangements within health systems, and effective implementation strategies are needed urgently in low-income and middle-income countries. This overview summarises the evidence from systematic reviews of health systems arrangements and implementation strategies, with a particular focus on evidence relevant to primary health care in such settings. Although evidence is sparse, there are several promising health systems arrangements and implementation strategies for strengthening primary health care. However, their introduction must be accompanied by rigorous evaluations. The evidence base needs urgently to be strengthened, synthesised, and taken into account in policy and practice, particularly for the benefit of those who have been excluded from the health care advances of recent decades.

Marschall P, Flessa S. 2008. Expanding access to primary care without additional budgets? A case study from Burkina Faso. The European Journal of Health Economics; 9

<http://www.ncbi.nlm.nih.gov/pubmed/18197447>

The aim of this study is to demonstrate the impact of increased access to primary care on provider costs in the rural health district of Nouna, Burkina Faso. This study question is crucial for health care planning in this district, as other research work shows that the population has a higher need for health care services. From a public health perspective, an increase of utilisation of first-line health facilities would be necessary. However, the governmental budget that is needed to finance improved access was not known. The study is based on data of 2004 of a comprehensive provider cost information system. This database provides the actual costs of each primary health care facility (Centre de Santé et de Promotion Sociale, CSPS) in the health district.

The authors determine the fixed and variable costs of each institution and calculate the average cost per service unit rendered in 2004. Based on the cost structure of each CSPS, the total costs can be calculated if the demand for health care services increased. We conclude that the total provider costs of primary care (and therefore the governmental budget) would hardly rise if the coverage of the population were increased. This is mainly due to the fact that the highest variable costs are drugs, which are fully paid for by the customers (Bamako Initiative). The majority of other costs are fixed. Consequently, health care reforms that improve access to health care institutions must not fear dramatically increasing the costs of health care services.

Mills A & High Level Taskforce for Innovative International Financing of Health Systems. 2009. Constraints to Scaling Up and Costs Working Group 1 Report

http://www.internationalhealthpartnership.net/fileadmin/uploads/ihp/Documents/Results_Evidence/HAE_results_lessons/WORKING%20GROUP%201%20REPORT%20-%20Constraints%20to%20Scaling%20Up%20and%20Costs.pdf

At a high-level event in New York on 25 September 2008, world leaders called for an additional US\$30 billion to save 10 million lives: 3 million mothers and 7 million children. Stronger health systems are critical to saving these lives, and building these systems will require more resources from the international community. For this reason a High Level Taskforce on Innovative International Financing for Health Systems (the Taskforce) was announced. Its objectives are to contribute to filling national financing gaps to reach the health MDGs through mobilising additional resources for health systems; increasing the financial efficiency of health financing; and enhancing the effective use of funds. The purpose of this report is to address the health systems strengthening needed in 49 low-income countries to achieve the health MDGs, with a special emphasis on redressing gaps in services related to those MDGs considered to be neglected, namely MDGs 4 (reduce child mortality) and 5 (improve maternal health).

OAU. 2001. The Abuja Declaration on HIV/AIDS, tuberculosis and other related infectious diseases. OAU, Addis Ababa

http://www.un.org/ga/aids/pdf/abuja_declaration.pdf

The Abuja Declaration was made in response to the impact of HIV/AIDS, tuberculosis and other related infectious diseases on the people of the African continent. It was made in April 2001. A target of allocating at least 15% of each national budget to improve the health sector annually was pledged.

WHO. 2008. World health report - Primary health care: now more than ever. WHO, Geneva
<http://www.who.int/whr/2008/en/>

Why a renewal of primary health care (PHC), and why now, more than ever? Globalisation is putting the social cohesion of many countries under stress, and health systems are clearly not performing as well as they could and should. People are increasingly impatient with the inability of health services to deliver. Few would disagree that health systems need to respond better – and faster – to the challenges of a changing world. PHC can do that.

WHO. 2011. The Abuja Declaration: Ten Years On. WHO, Geneva.
http://www.who.int/entity/healthsystems/publications/abuja_report_aug_2011.pdf

In April 2001, the African Union countries met and pledged to set a target of allocating at least 15% of their annual budget to improve the health sector and urged donor countries to scale up support. Years later, only one African country reached this target. Twenty-six countries had increased the proportion of government expenditures allocated to health and 11 had reduced it. In the remaining nine countries there was no obvious trend up or down. Current donor spending varies dramatically.

5. Additional information

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