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Commitment and innovation on the road to people-centred PHC financing

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The *Lancet Global Health* Commission on financing primary health care (PHC)[1] recognises that adequately financing PHC will be crucial to meet the target of SDG 3—ie, to ensure healthy lives and promote wellbeing for all at all ages by 2030.[2] However, we still remain far off that goal, and the COVID-19 pandemic has set us back even further, badly disrupting many essential services that were not directly related to COVID-19, particularly in the realm of PHC such as mental health and maternal and child health.[3] And with an uneven global economic recovery, many countries' health budgets will face a period of austerity.[4]

The Commission highlights that the way health care is financed, particularly PHC, is exclusionary and underfunded. It calls for countries to invest more and better in PHC. The most progressive way to fund PHC is by mobilising additional pooled public funding. This is because out-of-pocket payments in low-income and middle-income countries (LMICs) are the most significant barrier in access to health care yet they still remain the largest share of public financing in low-income and lower-middle-income countries at 41% and 42%, respectively.[3] In most LMICs, it is argued that additional public funding can be mobilised through increasing general tax revenue that is then allocated to PHC. However, the weakness in tax revenue mobilisation in low-income countries means a reduced capacity to fund public spending compared to higher-income countries—the mean tax–GDP ratio in low-income countries is 12%, compared with nearly 30% in high-income countries.[5] The additional tax could be generated by improving the collection of existing taxes, increasing the tax base, and expanding the number and types of taxes levied. The Commission recognises that LMICs face significant challenges collecting tax revenues, thus we need to introduce more progressive taxation such as increasing solidarity levies for financing PHC in LMICs, akin to the funding structure of UNITAID, which has raised US$1·25 billion from hypothecating airline taxes to global health. Additionally, international cooperation is needed to tackle illicit financial flows, which, according to the United Nations Conference on Trade and Development (UNCTAD), amounts to $88·6 billion every year in Africa alone.[6]

Another problem the Commission mentions in financing PHC is the inadequate, declining, and fragmented donor funding. While LMICs can explore ways to increase their tax revenue to pool public resources together, donor funding for health is essential for low-income countries. Yet donor funding typically neglects the whole-of-society approach to health essential for PHC in favour of targeting specific disease programmes—in low-income countries an average of 65% of donor assistance is allocated to infectious and parasitic diseases and donor contributions tend to operate off-budget, undermining the ability for health ministries to plan and manage these resources alongside domestic funding to fund PHC.[3] Nonetheless, bilateral and multilateral aid remains essential in low-income environments until at least 2030, and with improvements in PHC expenditure data, donors could increase funding for PHC through an improved global system of multilateral support that weans the donor community off vertically-supported programmes and towards routine services.

However, with aid and tax revenue not enough to meet the global health financing shortfall, there need to be alternatives to increase the overall envelope of borrowing in LMICs. Typically LMICs are reluctant to acquire more debt to invest in health care and other global public goods because the current form of deficit financing is more suitable for capital rather than recurrent expenditures. Therefore, to help LMICs finance PHC we ought to consider creating an innovative financing facility for health that is able to leverage guarantees from high-income countries, which, combined with grants, could raise significantly more additional resources for poorer countries than traditional forms of borrowing from multilateral development banks.[7] The COVID-19 pandemic was a revelation in showing the importance of health funding in LMICs, so now this window of opportunity must be capitalised on by creating more innovative forms of borrowing for LMICs that can leverage more and provide the funding at an affordable rate.

Ultimately, to be able to take on more financing, LMICs will need to commit to a sectoral plan for PHC and the overall health-care sector while committing to reform and investment. The *Lancet Global Health* Commission recommends that countries adopt a blended payment model, adaptable to country context but with capitation at its centre, to prioritise reducing out-of-pocket payments.

Governments should also commit to tackling the inefficiencies in health spending—the 2010 World Health Report stated that there were inefficiencies equivalent to 20–40% of health spending.[8] Improvements in digital technologies offer hope in reducing the inefficiencies in health spending by providing more data. However, the most effective way to increase the health budget is through the government budget, and that requires the political will to start prioritising health budgets more, and new forms of innovative finance can encourage that political will by providing more resources at a concessionary rate.

We declare no competing interests.

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