**Editorial – Financing Primary Health Care in Low- and Middle-Income Countries: A research and policy agenda**

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In 2022 the Lancet Global Health Commission on Financing Primary Health Care (PHC) set out to generate new insights into how countries could design their health financing arrangements to help shift health systems towards people centred PHC.(1) At $3 per capita in low-income countries and $16 per capita in lower-middle income countries, public spending on PHC in low and middle income countries (LMICs) falls far short of any estimate of the spending needed to provide universal access to people-centred PHC. But the Commission also demonstrated that it is not enough just to spend more: governments also need to ensure that those additional resources are allocated equitably, protected as they flow through the system to reach frontline PHC providers, address the problems of fragmented funding, which add burdensome reporting requirements and send confusing signals to providers, and that the mechanisms by which providers are paid for PHC should send the right incentives for people-centred care.

Critically, this is an area where novel approaches to health services and systems research are required. Robust evaluation of the impact of changes in financing arrangements has an important role, but impact evaluation study designs are often not practical and take a long time to deliver results. Implementation research conducted in partnership with government officials that offers timely feedback on how policies are unfolding and using evidence to adjust them, is also likely to be valuable. New ways of tapping into the tacit knowledge of policymakers, and systematising this so that it can be the basis for others' learning, are needed. Several initiatives have demonstrated how this type of policy learning can be enabled. These include policy dialogues such as those supported by the European Observatory on Health Systems and Policies,(2) new models of technical assistance driven

by the Strategic Purchasing Africa Resource Centre,(3) and the technical initiatives supported by the Joint Learning Network for Universal Health Coverage.(4) Embedded research approaches, in which researchers are part of implementation and decision making bodies(5) can also help to ensure that research questions are formulated to address decisionmakers' needs, and speed up the process of using evidence to inform policy changes.

The Commission provided a series of recommendations for how financing arrangements can better support PHC. For example, some countries such as India have designed insurance arrangements for the poor to cover the costs of hospital care, but we argued that pooling arrangements should start with covering PHC to protect households from unpredictable out-of-pocket costs at the time of illness. We identified that allocating more resources to PHC requires making PHC more visible in government health budgets, and that in some countries, it has been possible to use innovative budget rules to increase and earmark resources for PHC.(6) Purchasing arrangements that define an entitlement to a PHC benefit package and use provider payment and contracting arrangements to reinforce this access, can help prioritise PHC and ensure that resources do not drift back up the system and patients are not inadvertently re-directed to hospitals. Challenges such as bottlenecks in public financial management that mean that resources do not reach frontline providers, can be overcome by novel ways of channelling funds directly to facilities. For example, the Direct Facility Funding approach used in Tanzania(7) offers the possibility of providing PHC providers with discretionary cash to enable them to improve local service delivery.

From the many meetings and discussions that have followed the launch of the report,(1) a number of areas have emerged where further operational experience and evidence gathering are needed. Here we highlight four of these.

First, operationalising provider payment for PHC. The Commission concluded that a blended provider payment method with capitation at its core is the best way to pay PHC providers. But knowing when the underlying system is ready to move away from input-based budgets, which are easier to administer and control, is critical; and some countries face more fundamental PFM challenges that must be addressed before provider payment reform makes sense. Operationalising the shift to capitation involves a number of critical decisions, such as who should be the fundholder (individual providers or a higher level, e.g. the municipality as in Chile(8) and Brazil(9)), whether the capitation payment should include salaries, how to manage population registration, and how to make this work in urban settings where provider markets are complex yet regulatory capacity is often minimal.

Second, paying for and providing public health services. WHO's operational framework for PHC(10) recognises that PHC includes essential public health functions. But other than recognising the importance of ensuring that these "common goods for health"(11) are prioritised in government spending there is little evidence about how these functions are organised and financed in different settings, and even less normative guidance on the optimal ways to ensure that these functions are adequately resourced. With substantial new global resources being committed to pandemic preparedness in response to the COVID-19 pandemic,(12) it will be important to strengthen the global evidence base on how to

channel funds to PHC-level public health services and the financing arrangements that will enable their appropriate use.

Third, financing medicines for PHC. Out-of-pocket spending remains about 50% of all PHC expenditure in LMICs,(1) and most of this private spending is on medicines. PHC financing arrangements have failed to provide reliable access to essential medicines, forcing individuals to purchase them from private pharmacies or medicine sellers, which can have serious consequences for those with chronic conditions. Financing arrangements for medicines in PHC are expected to provide financial protection and efficient use of resources, but more evidence is needed on how essential medicines can be best included in PHC benefit packages and the effectiveness of different models of provision. Novel approaches to providing publicly funded medicines, such as through e-prescription and e-pharmacy need further exploration.

Fourth, the political economy of financing PHC. The Commission devoted considerable effort to considering the political economy of PHC financing and noted that PHC often lacks professional and political support, and that prioritising PHC is essentially a political choice. There is need for better understanding of the political strategies that have proven successful in reorienting health systems towards PHC and learning lessons about political tactics from outside the health sector.

PHC financing is an area where there are excellent opportunities for cross-country learning, as low- and middle-income country health systems find themselves having to manage increasing burdens of chronic conditions. Two issues illustrate this potential for health system convergence. First, we used evidence from experiences of selected high-income countries to argue that capitation payment is well-suited to paying for PHC. Second, there is wide recognition that more integrated service delivery, with PHC at its core, is needed to tackle the challenges that health systems across the globe are facing. How to best pay for an integrated approach remains an area where research is needed across all levels of economic development.

In all settings, finding ways to spend more, and spend better, on PHC will take a significant political commitment, as well as novel technical solutions. More collaboration and learning both between researchers and policymakers, and across contexts, will be needed if we are to rise to this challenge.

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