

## Technical Note Plenary 3 Reaching the frontlines? Why is it so hard?

### INTRODUCTION

The purchasing component of the health financing function requires decisions to be made about what health services (personal, non-personal and public health functions) will be purchased or provided, where those services should be available, and how they will be paid for. These components are critical for efficiency and quality, in terms of doing the right things, in the right places, and doing them right. However, inequalities and inequities (the inequalities deemed to be unfair) are considered less frequently in terms of purchasing, so they are the focus of this session.

A number of inequalities can be observed, but the background work for this Forum suggests that the following three can be considered as inequitable:

- Differences in entitlements to guaranteed service packages across people and groups unless justified by differences in need;<sup>1</sup>
- Differences across peoples and groups in the availability and quality of universally guaranteed personal health services unless justified by differences in need;
- Differences across people and groups in the availability and quality of core public health functions unless justified by need.<sup>2</sup>

Between them these inequities associated with purchasing contribute to inequities in effective coverage with needed interventions and financial protection, the Universal Health Coverage (UHC) outcomes.

Redressing existing inequities associated with purchasing is critical to moving closer to UHC and, in higher income settings, maintaining the gains made in the past. However, redressing inequity is only one of the objectives of social policy and of purchasing – improving efficiency is also critical, for example, and may at times come into conflict with the desire to improve equity. To help guide policy-makers in this process, we suggest three unacceptable trade-offs that should be avoided when making purchasing decisions:

1. Introduce high cost, low population benefit interventions to a universally guaranteed service package before close to full coverage with low cost, high benefit services is achieved;

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<sup>1</sup> Need in terms of both health and protection from financial catastrophe.

<sup>2</sup> Core public health functions have been defined in different ways, but include non-personal health services such as population-based prevention and promotion, outbreak readiness, and governance among others.

2. Increase the availability and quality of personal health services that are universally guaranteed in ways that exacerbate existing inequalities unless justified by differences in need;
3. Increase the availability and quality of core public health functions in ways that exacerbate existing inequalities unless justified by differences in need.

### **FOCUS OF THIS PLENARY SESSION**

There has been considerable work undertaken on how to choose, or add to, a universally guaranteed essential package of services, mostly using forms of explicit decision-making criteria including cost-effectiveness analysis. There has also been considerable work, over decades in fact, pointing out that in many low- and lower-middle income countries, secondary and tertiary care take up a disproportionate part of the government health budgets, while frontline (primary and community level) services are under-resourced. People requiring these services cannot get them or must spend out of pocket - and sometimes travel long distances – to receive them.

This creates inequities in that the poorest households have access only to the level of the publicly funded health system that is the least well-funded. Moving resources to the frontlines where they are most needed, therefore, features high on the policy agenda in many countries. Explicitly defining a guaranteed benefits package and identifying where the guaranteed services is important, but not sufficient. There are considerable political barriers to shifting resources from higher levels to lower levels of care, and linked to that, frontline services are often very weak at absorbing and using additional resources effectively.

This session starts from the premise that many governments have given a commitment to spending more on frontline services and considers key constraints that are preventing it happening. A panel of government officials will present their experiences on how they have gone about addressing these constraints.

The range of issues that will be discussed include:

- Why is it so hard to shift financial and human resources away from tertiary and secondary care?
- How to strengthen supply chains such that drugs and commodities are available at the frontlines?
- Is it more difficult to spend on frontline services in decentralized systems?
- Which provider payment mechanisms are most effective in channeling resources to frontlines?
- How to ensure integration of primary and secondary/tertiary care and avoid overuse of care at too high a level?