Budget Approval Dynamics: Why Primary Health Care Is Frequently Deprioritized

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Abstract

Primary Health Care (PHC) is a key driver to achieving equitable health systems and making progress towards Universal Health Coverage (UHC) goals. Despite this, across Low- and Middle-Income Countries (LMICs), PHC is often systematically underfunded, not due to lack of policy commitments but due to how budgets are developed and allocated, negotiated and approved. The budget approval stage within public financial management (PFM) remains one of the least documented and most under-analyzed phases of the budget cycle, resulting in limited understanding of why planned resources fail to materialize in the final approved (WHO, 2024).

In this policy brief Amref Health Africa draws on evidence from nine countries Kenya, Tanzania, Uganda, Zambia, Malawi, South Sudan, Ethiopia, Senegal, and India to demonstrate that PHC allocations are regularly weakened during the budget approval stage. The findings reveal that PHC under-funding is not only driven by fiscal constraints but rather by other systemic factors within the budget cycle. Political incentives have a greater preference for infrastructure, hospitals and curative services over preventive and promotive care. Additionally, heavy donor dependence weakens domestic prioritization and institutional budget structures often limit the visibility and protection of the PHC allocations. These factor together with budget execution inefficiencies and limited influence of the public inputs disadvantage the PHC financing decisions at the budget approval stage.

The study concludes that strengthening PHC financing requires a clear shift from the narrow focus on resource mobilization to broader view on the budget cycle to ensure that policy makers address the gaps in allocation processes, institutional incentives and political dynamics. Policy reforms must therefore target the full budget cycle, paying attention to the budget approval stage where key allocation decisions are made.

Key Insights: PHC is not failing due to lack of evidence, but because existing budget systems and political incentives systematically work against it.

Introduction

Primary Health Care (PHC) is globally recognized as the foundation for resilient, equitable and efficient health systems. It plays a central role in delivering essential services, promoting prevention and advancing both Universal Health Coverage (UHC) and national health goals. Stronger financing of PHC systems are crucial for improving health system performance, reducing inequalities and enhancing the capacity of health systems to be more resilient even with the growing population health needs (Rajan, 2023)

Despite global health commitments such as the Alma-Ata and Astana declarations there is still a significant gap between policy aspirations and financing realities. Low- and Middle-Income Countries (LMICs) often demonstrate commitment to PHC through national policies and health strategies however this does not always translate to adequate financing. Further evidence shows that current PHC spending in many LMICs is extremely low with as little as $ 3 per capita in low income countries and around $ 16 in LMICs settings. This falls short of what is required to deliver an acceptable package of services that are universal and people centered. The scale of the gap would require substantial and sustained additional investment estimated at $ 25- $32 per capita annually across LMICs, and with even greater needs in the poorest countries (Hanson, 2022)

However, PHC financing gaps should not just be seen as results of the constrained space. Emerging evidence indicates how resources are allocated, negotiated, defended and protected within the budget cycle is absolutely important. The budget approval stage remains under-analyzed, limiting understanding of how PHC allocations are altered through the legislative process (Rodríguez, 2023). This study therefore examines PHC financing through a political economy lens, focusing on how political incentives, institutional systems and budget process shape allocation decisions.

Methodology

Study Design and Scope

This study adopts a comparative qualitative political economy approach across LMICs. The assessment covered nine purposively selected countries that Amref Health Africa has a close working relationship with: Kenya, Tanzania, Uganda, Zambia, Malawi, South Sudan, Ethiopia, Senegal, and India. These countries were chosen to reflect diversity in health system structures, levels of decentralization, fiscal space, and reliance on external financing, as well as to leverage existing programmatic engagement and contextual expertise among the authors.

Data sources include:

- 18 Key informant interviews with policy-makers, health officials and stakeholders.
- Targeted literature review peer reviewed publications, policy documents, budget reports and institutional analysis
- The analytical framework conceptualizes PHC budget outcomes as a result of interacting but distinct process across three domains structural drivers, institutional dynamics and budget approval process while recognizing feedback effects across the budget cycles.
- Structural drivers: political incentives, fiscal constraints, donor dependence which influence these drivers interact but exert influence through different mechanisms
- Institutional factors: budget visibility, legislative capacity, stakeholder influence
- Budget approval process: political bargaining, reprioritization, trade-offs

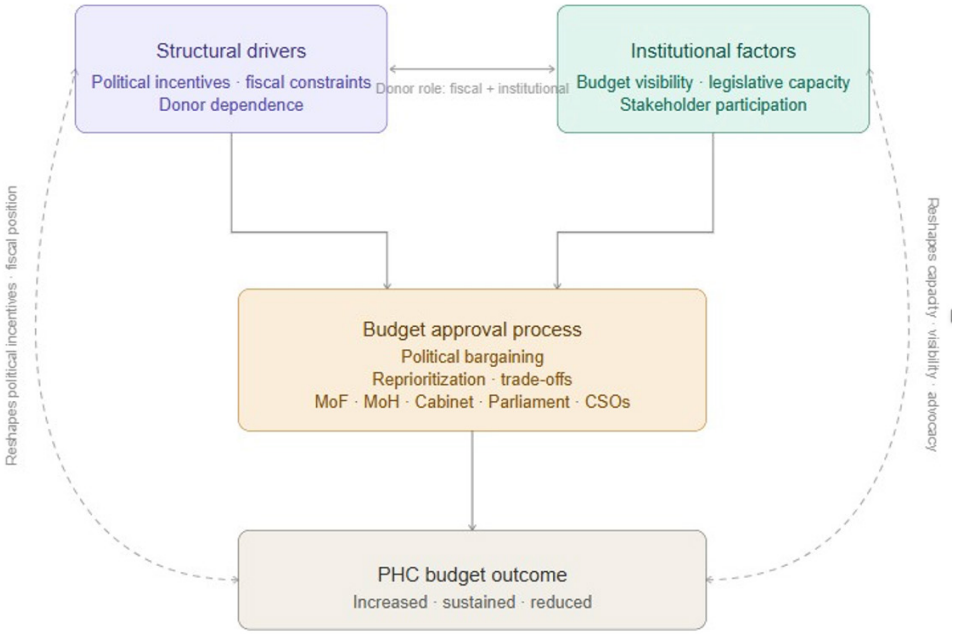

Figure 1: Analytical Framework for Health Budget Cycles. Source: By Amref Health Africa Authors

This framework enables analysis of how political economy factors influence PHC financing decisions across the budget cycle.

Data Analysis

Qualitative data from KIIs were analyzed thematically. Emerging themes were iteratively coded and grouped into key domains, including: Political incentives and visibility; Fiscal constraints; Institutional capacity and governance; Stakeholder participation and influence. These themes were triangulated with findings from the literature review to identify consistent cross-country patterns and contextual variations.

Limitations

First, the sample of countries and respondents was purposive and relatively small, limiting the generalizability of findings. Second, the number of KIIs per country was limited, which may not fully capture within-country variation. Third, reliance on qualitative data introduces the potential for respondent bias and subjective interpretation.

Finally, documentation gaps particularly in accessing disaggregated, approved budget data constrained the ability to systematically compare budget changes across countries. Despite these limitations, the study provides valuable exploratory insights into an under-researched stage of the budget cycle and highlights important avenues for further empirical investigation.

Together, these dynamics shape the extent to which PHC commitments are maintained or eroded during budget approval, ultimately influencing the alignment between policy priorities and actual resource allocation.

Findings: Why PHC is Cut During Budget Approval

The findings are organized through a political economy lens that examines the inter-play of drivers, institutional factors and budget process to shape PHC financing outcomes. Across the target countries, a consistent pattern emerges: PHC is most vulnerable during budget approval stage, where competing priorities often lead to revision on the allocations, reduced, or reallocated. At this point, PHC frequently lacks the visibility, political backing and advocacy strength needed to safeguard its funding.

Overall, the analysis demonstrates that PHC financing decisions are driven less by technical planning and more by political, institutional and fiscal dynamics that play out during budget negotiations. These factors converge in predictable ways and are reflected across six thematic areas, highlighting a systematic gap between policy commitments and actual PHC financing decisions.

Political incentives favor visible investments over PHC

Across all nine countries, budget approval decisions are more political than technical. The legislatures often seen to favor investments in hospitals, infrastructure and equipment's that are more tangible and politically marketable results.

- **In Kenya and Tanzania**, health budgets have consistently favored infrastructure expansion and hospital upgrades, with comparatively lower allocations to frontline PHC service delivery.
- In India, approximately 20% of the national health budget is directed toward tertiary
- institutions, compared to about 37% to the National Health Mission, the main PHC platform illustrating continued imbalance toward higher-level care.
- **In Zambia and Uganda,** policymakers reported that parliamentary debates tend to focus on new facilities and equipment, which are easier to justify politically to constituents

Across contexts, respondents consistently noted that PHC investments such as community health services, preventive care, and primary-level facilities lack political visibility. As a result, they are frequently deprioritized during final budget negotiations. Preventive and community-based PHC despite strong evidence of cost-effectiveness is systematically deprioritized during budget negotiations (Rodríguez D. C., 2023)

Cross Country Insights: Visible infrastructure is more politically rewarding compared to PHC service delivery priorities (preventive, community health).

Donor dependence weakens domestic PHC prioritization

In several countries including Uganda, Malawi, Zambia, Senegal and South Sudan, PHC financing depends heavily on external partners.

- Donor funding supports essential PHC inputs such as commodities, workforce and service delivery interventions,
- Governments assume PHC is "already funded" reducing the incentives and urgency to domestic allocations.

Domestic allocations stagnate or decline, undermining sustainability, national ownership of PHC systems and sustainability (Moosa, 2022)

Cross Country Insights: Donor support while essential can un-intentionally create a substitution effect where governments underinvest in PHC

Fiscal pressures crowd out PHC funding

Our findings highlight that macro-economic constraints further the under-funding of PHC across countries :

- Malawi and Ethiopia face tightening fiscal conditions and expenditure ceilings restrict new health investments,
- **Kenya:** Despite increases in PHC allocations yet this funding covers only 60–70% of estimated need indicating persistent gaps.

PHC as a result disproportionately affected because of its dependent on recurrent expenditure while capital expenditure is often protected through loans and earmarked financing arrangements (OCHA, 2024)

Cross Country Insights: In constrained fiscal environments, PHC being recurrent and less politically protected and hence more likely to be protected.

PHC is often invisible within budget systems

Across country, institutional features of budgeting systems weaken PHCs visibility and protection:

- Is embedded within broader health allocations
- Lacks dedicated or traceable budget lines

Examples:

- **Uganda and Senegal:** PHC allocations are spread across programs and appear as aggregated budget lines, making them difficult to track,
- **Ethiopia and South Sudan:** financing is highly fragmented financing streams across different funding streams hence reducing the transparency and visibility.

Low visibility reduces accountability, traceability and allows “silent reallocations” during budget approval (CEHURD, 2025)

Cross Country Insights: When PHC is not explicitly defined or visible within budgets, it becomes easier to deprioritize without scrutiny.

Fragility and competing priorities sideline PHC

Countries facing fragile and conflicts or even competing priorities further constraint constraints resource allocation mechanisms,

- **South-Sudan:** due to prolonged conflicts and low public financing to health distorts available resources towards security and stabilization priorities, crowding out long-term health investments such as PHC,
- **Senegal:** sub-national units and fiscal pressures such as growing debt burden, similar dynamics exist where competing development priorities reduce sustained focus on PHC

The weak institutional capacity limits oversights and enforcement, while budgeting processes become reactive and hence short-term view (Widdig, 2022)

Cross Country Insights: In fragile settings, PHC is deprioritized because it requires sustained investment, whereas political priorities favor immediate stabilization needs.

Participation mechanisms have limited influence

Across countries, despite the existence of formal participatory processes, we noted that they had limited influence on the final budget decisions.

- **Uganda:** The civil society presented 47 recommendations however only 3 were adopted,
- Kenya, Tanzania, and India show similar patterns, where participation exists in form but not influence

Budget decisions are driven more by political bargaining than public health needs (WHO, Programme budgets in health: Country evidence and reform assessments (2017–2021), 2021)

Cross Country Insights: Public participation was noted to be tokenistic, and hence led to limited influence on approved budgets

Cross Country Integrated Synthesis

Across countries, a clear and consistent pattern emerges on how the political economy factors affect allocations. PHC is systematically disadvantaged because:

- » It is less visible politically than infrastructural investments,
- » It is perceived as externally funded and hence deprioritized using domestic financing,
- » It relies more on recurrent financing, making it more vulnerable under fiscal pressure,
- » It lacks clear institutional visibility within budget systems,
- » It is deprioritized in fragile and politically constrained environments,
- » Despite existence, participation mechanisms are too weak to influence budget outcomes.

These factors converge significantly during the budget approval stage, where final allocations and approval decisions are shaped through political bargains and trade-offs. PHC allocations are reduced, reallocated or even deprioritized demonstrating the existing gap between policy commitments and financing decisions.

Insights: The factors converge significantly during the budget approval stage, where final allocations and approval decisions are shaped through political bargains and trade-offs

Discussion

The study sought to gain understanding on the approval stage of the budget cycle and how this affects PHC financing with experiences from nine countries (eight in Africa and 1 in Asia). Findings from this study align with global evidence demonstrating that PHC financing are shaped by political, institutional and PFM dynamics and not just fiscal constraints alone. While global health policies and national health strategies position PHC as a priority and foundational to UHC, the study highlights that the final PHC budgets decisions are driven more by political and not technical considerations.

Political prioritization and visibility bias: The finding preference for politically attractive priorities is consistent with findings from the Lancet commission that demonstrated that allocations tend to shift towards hospital-based and curative services over preventive and community based PHC (WHO, Programme budgets in health: Country evidence and reform assessments (2017–2021). , 2021) .WHO further emphasis that budget allocation is highly a political decision where incentives, accountability pressures and consideration for competing priorities interplay (Stenberg, 2019)As a result, PHC budgets are often passed without a lot interrogation during the budget approval stage what the study refers to us ‘salient or quiet’ reallocations further reinforcing the gap between policy commitment and financing decisions.

Fragmentation and donor dependence: Findings on the donor dependence agree with concerns raised by both WHO and Lancet Commission on the fragmentation of PHC financing especially in LMICs. It further discusses that multiple funding flows, and high reliance on external funding for priority PHC interventions weakens the opportunities for integration and creates additional systemic inefficiencies that affect PHC delivery systems. It then alters the national prioritization of health expenditure due to the view that that’s a cost already met (WHO, Programme budgets in health: Country evidence and reform assessments (2017–2021), 2021). The study affirms the understanding that external funding while off-budget generates a substitution effect with governments reducing their own share of financial contribution to PHC, hence weakens domestic ownership of PHC.

Fiscal pressures and allocation trade-offs : While the fiscal pressures effect on general budgets is well established, especially in LMICs where there are challenges from rising debt and a constrained fiscal space. The study collaborates with evidence from WHO and World-Bank that beyond the size of the resources available there are also concerns on how resources are allocated (Stenberg, 2019) Parliamentary decisions-making process prefers development rather recurrent expenditures, reflecting deeper incentives within the public budget system. Political actors have a stronger incentive to support visible investments which can be directly attributed to their constituencies and are more tangible investments.

Development budgets therefore enjoy some immunity and protection while recurrent expenditures are more vulnerable to budget cuts, introducing structural bias against PHC.

Institutional visibility and budget framing: One of the key findings of this study, is the emphasis on the need for institutional visibility of PHC within the budget systems. Multiple analysis from WHO demonstrate that aggregated budgets weakens the link between health expenditure and health systems performance further weakening transparency and accountability.] When PHC funding is obscured within the broader budget categories or scattered across different funding streams or programs, it becomes more difficult to track, defend, protect and

support during the budget approval stage. Invisible budgets are easier to alter downwards further disadvantaging PHC financing decisions and implementation.

Systemic inefficiencies: Our findings further collaborate with global evidence on budget execution through studies by WHO and World Bank where PFM systemic inefficiencies result in under-spending on health budgets. Reports on under expenditure due to multiple factors such as fund flow and procurement delays, weak coordination among government agencies and sectors, poor cash flow often show that health sectors fail to utilize the allocated amounts by 13% and parliament was to make decisions guided by budget execution reports it further disadvantages PHC approval decision (Rodríguez D. C., 2023)

Our study adds an important insight by highlighting that resource shortfalls may be attributed to early stages of the budget cascading the implementation challenges at the budget execution stage. Policy-makers therefore need to have a full-view of the budget cycle rather than paying attention to only the implementation challenges.

Low influence of the public participation and accountability mechanisms: Although the limited influence of public participation and accountability mechanisms have been identified as a challenge in literature, WHO has emphasized on the importance of transparency, stakeholder engagement and accountability in budgeting evidence shows that these mechanisms remain tokenistic (Stenberg, 2019). In real-life budget decisions are shaped by political factors that have limited use of technical evidence or public input. This reflects the gap between formal accountability and actual decision-making hence limits the effectiveness of public input in influencing PHC financing decisions.

Recommendation	Details
Strengthen political prioritization of PHC	• Elevate PHC within national and political agenda • Develop evidence-based advocacy communication
Strengthen legislative scrutiny and ownership	• Build capacity of parliamentary health committees • Require justification for reallocations affecting PHC • Institutionalize PHC as a protected budget priority
Alignment of donor and domestic financing of PHC	• Develop co-financing strategies through integration of external funding into national systems • Seek to progressively increase domestic allocation for PHC • Align external funding with national budget frameworks
Protect PHC allocation	• Introduce PHC budget protection mechanism even within recurrent expenditure • Strengthen legislative engagement • Use political economy insights to guide reforms
Strengthen accountability and participation	• Link public input to formal decision-making processes • Require governments to respond to stakeholder submissions • Support civil society budget monitoring

Conclusion

PHC under funding is not simply a financing gap but rather a governance and political economy challenge. Sustainable progress towards UHC and national goals will require more than mobilizing more money for PHC but rather also reforming how PHC financing decisions are made, negotiated, defended and implemented. PHC is the platform that provides health for all and especially majority of the population in a country. Strengthening PHC financing therefore requires a deliberate focus on the institutions, incentives and power dynamics that shape the outcomes of the budget.

About Amref Health Africa

Amref Health Africa is the largest Africa-based international health development organization, operating in more than 30 countries and driving a continental agenda for community-led health systems transformation. The organization prioritizes resilient, integrated primary health care (PHC) and action on the social determinants of health, positioning PHC as the foundation of equitable and sustainable health systems.

Through its Transform Strategy (2023–2030), Amref advances health sovereignty by strengthening domestic health financing, improving resource stewardship, and supporting the transition to nationally owned, locally driven systems aligned with country priorities. The Health Systems Strengthening Directorate anchors this shift, providing technical leadership to drive policy reform, system alignment, and delivery of accountable, community-centered PHC systems across Africa

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