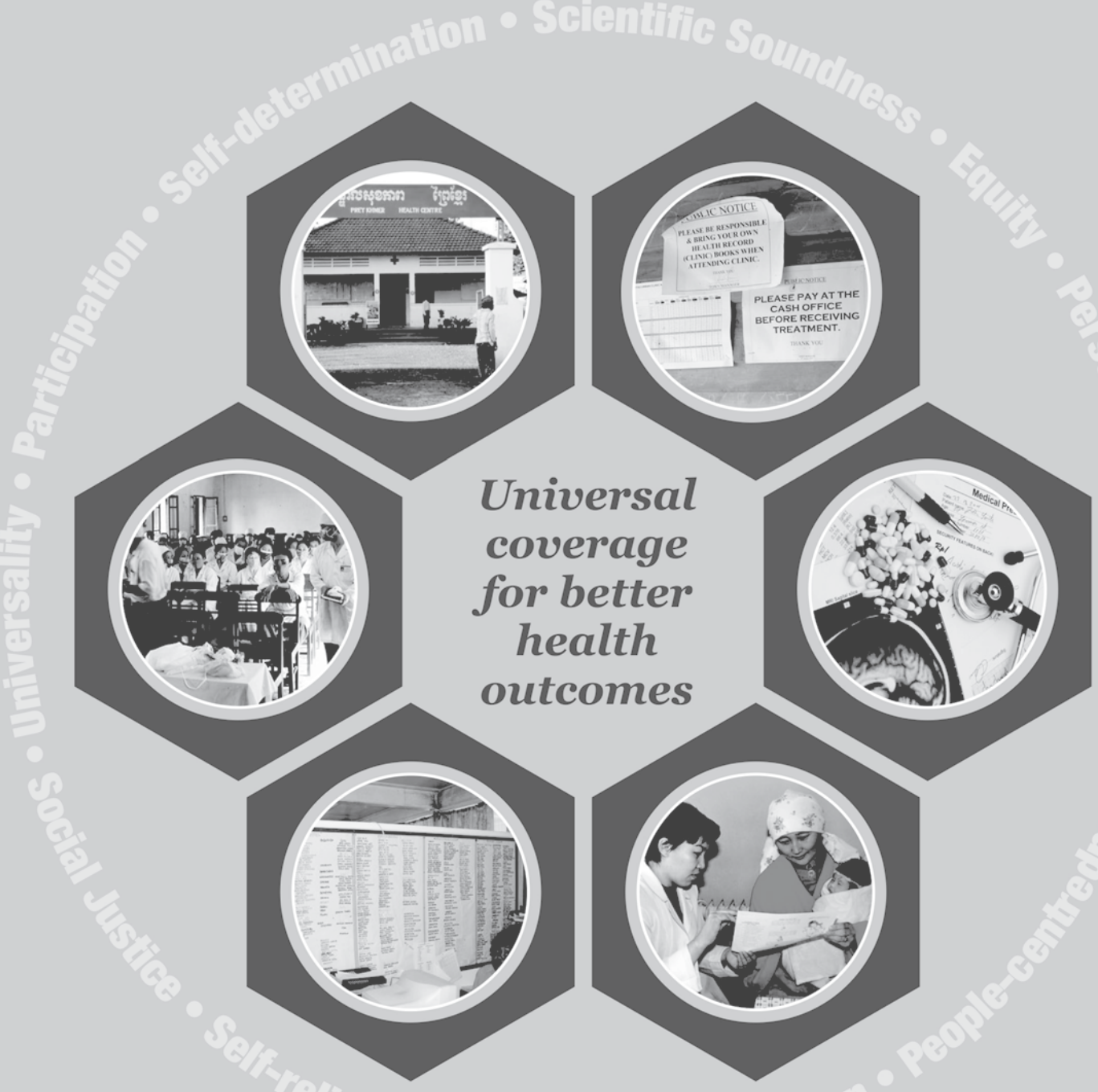
Western Pacific Regional Strategy for Health Systems Based on the Values of Primary Health Care

Self-determination • Scientific Soundness • Equity • Personal Responsibility • People-centredness • Community Protection • Self-reliance • Social Justice • Universality • Participation •

Universal coverage for better health outcomes

World Health Organization
Western Pacific Region

Western Pacific Regional Strategy for Health Systems Based on the Values of Primary Health Care



World Health Organization
Western Pacific Region

WHO Library Cataloguing in Publication Data
Western Pacific regional strategy for health systems based on the values of primary health care.

1. Health systems plans. 2. Primary health care. 3. Regional health planning. 4. Universal coverage.

ISBN 978-92-9061-501-9 (NLM Classification: WA 541)

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Foreword

Health systems throughout the Western Pacific Region are under stress. Strong and effective health systems are needed to achieve sustainable improvements in health outcomes and other important health goals, such as the health-related Millennium Development Goals. The *World Health Report 2008* reaffirmed the values of primary health care in achieving equitable and accessible health systems. By adopting the *Western Pacific Regional Strategy for Health Systems Based on the Value of Primary Health Care,* the Member States of the Western Pacific Region have identified equity, social justice, universality, people-centredness, self-determination, scientific soundness, personal responsibility, participation, self-reliance and community protection as key values for their health systems.

There is sufficient evidence to show that health systems based on the values of primary health care do better at achieving the four goals of health systems: improved health and health equity, universal coverage with financial risk protection, responsiveness to the population's desires for health services, and efficient use of resources.

This strategy provides evidence-based guidance and options for Member States on organization and use of resources related to each of the health system building blocks including the connections between them. It is necessary to look at health systems in a holistic fashion.

Strategy alone is not enough. Moving from strategy to action is even more important. Robust planning processes and sound management practices at all levels of the health system are crucial.

The Member States of the Western Pacific Region and their health systems are diverse. Each Member State will determine its own path towards the vision of 'Universal Coverage for Better Health Outcomes' defined in this strategy. WHO is committed to assist them in that endeavour.

Shin Young-soo, MD, Ph.D.
Regional Director


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Executive Summary

The WHO Constitution states that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being". Effective and efficient health systems contribute to the progressive realization of that right. Health systems do better at attaining that standard if they are underpinned by core values such as equity, social justice, universality, people-centredness, community protection, participation, scientific soundness, personal responsibility, self-determination and self-reliance. Values such as these have been a part of the primary health care agenda since they were articulated in the *Declaration of Alma-Ata* adopted at the International Conference on Primary Health Care in 1978. Although there are wide variations in political, social and health systems both globally and within the Western Pacific Region, there is an increasing body of evidence that proves adherence to these core principles or values leads to better health systems and better health outcomes.

Evidence-based statements about international norms for health systems may help national leaders navigate among competing interests in the health sector. The *Western Pacific Regional Strategy for Health Systems Based on the Values of Primary Health Care* provides guidance that may assist national decision-makers overseeing the design and implementation of health systems adapted to their particular situations.

The people of the Western Pacific Region deserve to live their lives in the highest state of health possible. While there can be no guarantee of individual health, all people have a right to quality health services that are available, accessible, affordable and acceptable.

The four goals of a health system are:

(1) health, both the absolute level across the entire population and equity across socioeconomic groups;
(2) social and financial risk protection in health;
(3) responsiveness and people-centredness;
(4) efficiency.

Thirty years after the *Declaration of Alma-Ata*, a worldwide process of reflection on primary health care (PHC) culminated in *The World Health Report 2008: Primary Health Care, Now More Than Ever*. It concluded that countries that have organized their health systems on PHC principles have achieved better health outcomes in relation to the funds expended than those countries with health systems that are not based on PHC values. The report also found that the goals and values of PHC are as valid as they were in 1978.

Primary health care is closely related to but not synonymous with primary care. A strong primary care system is the foundation for a health system based on PHC values, but secondary and tertiary services that connect to the primary care system are also vital.

Four areas of reform, policy and action that foster the development of PHC-oriented health systems are described in *The World Health Report 2008*: (1) universal coverage intended to improve health equity and financial risk protection; (2) service delivery that is people centred, responsive and supports universal coverage; (3) leadership aimed at making health authorities more reliable and accountable to those they serve; and (4) public policy implemented across all sectors in ways that promote and protect the health of communities and individuals. People and their participation remain at the centre of PHC. Different countries and areas have plotted their own paths towards PHC implementation using different routes and concepts, such as universal coverage or "Healthy Islands" initiative.

A whole-of-system approach based on the values of primary health care is proposed as the most effective and sustainable way of strengthening health systems. The WHO framework of six building blocks for health systems strengthening is used as a tool to analyse health systems, although other frameworks are available. The important issue is that health systems are analysed holistically. Key issues in each of the six building blocks include:

(1) **Leadership and governance** – policy frameworks and health planning, managing the health sector, accountability and transparency, generating and interpreting information, building coalitions outside the health sector, and aid effectiveness.
(2) **Health care financing** – increasing investment and public spending, aid effectiveness, efficiency, prepayment and risk pooling, provider payment methods, safety nets, evidence for policy-making, and monitoring and evaluation.
(3) **Health workforce** – preparing the workforce with sufficient numbers, skill mix and quality with appropriate deployment; enhancing

performance through job descriptions, codes of conduct, adequate support systems, including remuneration, and supportive supervision, and an enabling work environment that includes lifelong learning and accountability; and managing migration and attrition.

(4) **Medical products and technologies** – rational selection and use, affordable pricing, sustainable financing, ensuring access, coherent supply and management, quality assurance, capacity-building, improving safety and supporting research.

(5) **Information and research** – national strategic planning, utilization, avoidance of duplication, sufficient disaggregation, monitoring of health system performance, research to meet national needs, and appropriate use of information technology.

(6) **Service delivery** – definition of the service delivery model, emphasis on primary health care teams, management, integrated service delivery packages at multiple levels adapted to socioeconomic reality, patient safety and infrastructure.

A set of core indicators agreed upon internationally or regionally is proposed for each building block. Adaptation of the indicators to individual Member States will be needed, including setting targets that are relevant to the country context. Additional indicators developed specifically by each Member State to fit its own situation and management needs are desirable.

A value-based strategy alone is not enough. The move from strategy to action is crucial. Each Member State has a responsibility to define its national health policy or strategy and the means through which policy and strategy are translated into action at the operational level. Details will be specific to each Member State, although the values will be universal.

Management of health services is a core function. It requires an adequate number of managers, sufficient skills, an enabling work environment and functional support systems. In low-resource settings, choosing priorities so that resources are expended on those actions that provide the greatest health gains is particularly important. This is crucial if the Millennium Development Goals are to be met.

Each Member State must determine its own path towards the vision it defines for its own health system so that its people progressively realize the right to health. That path is likely to include an ongoing process of policy dialogue, a robust national health strategy and planning process, and the will to take strategy on to implementation in a feasible and realistic manner.


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1 Background

1.1 Purpose

The WHO Constitution states that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition".[1] Health systems are an important, although not the only, contributor to the progressive realization of that right.

Defining core values for a society's health system can assist in identifying strategic actions that lead to realization of the right to health. Core values to be considered for a health system include equity, social justice, universality, people-centredness, community protection, participation, scientific soundness, personal responsibility, self-determination and self-reliance (see Box 1). These values have been identified through regional consultations. The exact emphasis may vary in different settings. Values such as these have been a consistent part of the primary health care agenda since the *Declaration of Alma-Ata* was adopted at the International Conference on Primary Health Care in 1978.[2]

Box 1. Core Values for Primary Health Care

- Equity
- Social justice
- Universality
- People-centredness
- Community protection
- Participation
- Scientific soundness
- Personal responsibility
- Self-determination
- Self-reliance

Decisions about health systems are primarily made within nations, although globalization and external funding have led to some exceptions. Governments have a fundamental responsibility for oversight or stewardship of the health sector even in settings where a government is not solely responsible for health service financing and delivery. International normative guidance can play a role in informing the national decision-making process. Such guidance may assist national decision-makers in navigating among the competing interests and staying on course as political winds shift. Defining long-term goals and aspirations is crucial because the building of a robust health system is a long-term undertaking.

1 World Health Organization. *Constitution of the World Health Organization*. 1946. Available at http://www.who.int/governance/eb/who_constitution_en.pdf

2 *Declaration of Alma-Ata*. International Conference on Primary Health Care. Alma-Ata, USSR, 6-12 September 1978. Available at http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf

The WHO Regional Committee for the Western Pacific, at its fifty-ninth session in September 2008, adopted resolution WPR/RC59.R4.[3] In the resolution, the Committee requested WHO to develop, through a process of consultation with Member States, a regional strategy for strengthening health systems, based on the guiding principles and core values of primary health care and informed by the outcomes of the ongoing and midterm reviews of the implementation of existing strategies and other related technical work, and present this strategy in 2010 to a high-level meeting and to the Regional Committee. The *Western Pacific Regional Strategy for Health Systems Based on the Values of Primary Health Care* is the result of that process. It is the intent of the Regional Strategy to provide normative guidance on health systems strengthening, primarily to policy-makers in Member States, but also to WHO and development partners. The Strategy was endorsed at the sixty-first session of the WHO Regional Committee for the Western Pacific in October 2010 (see Annex 1).[4]

1.2 Regional context

Member States of the WHO Western Pacific Region are diverse. Some have large populations; others have small populations. Some are continental land masses; others dispersed coral atolls. Some have negative population growth rates and/or rapidly ageing populations, while others have high fertility rates. Urbanization is occurring in most States, although several are still predominantly rural. The Region includes some of the highest per capita incomes in the world, but some of the countries in the Region are still in the low-income category. Political systems are also diverse. Health outcomes vary widely, with some countries enjoying the world's longest life expectancies and thus ageing populations, while others have unacceptably high rates of maternal and child mortality and relatively low life expectancy. Noncommunicable diseases are the largest part of disease burden, although the control of communicable diseases remains a major challenge.

Health systems in the Region are under stress. They must respond to a changing world. New challenges, such as the health impact of climate change, are occurring, while older challenges, such as tuberculosis, remain unresolved. In some places, accelerating cost inflation is a major problem. In others, service coverage is not yet universal or universality is under

3 Western Pacific Region of World Health Organization Resolution WPR/RC59.R4. Available at http://www.wpro.who.int/rcm/en/archives/rc59/rc_resolutions/WPR_RC59_R4.htm

4 Western Pacific Region of World Health Organization Resolution WPR/RC61.R2. Available at http://www.wpro.who.int/rcm/en/rc61/rc_resolutions/WPR_RC61_R2.htm

threat due to an increasing reliance on user charges. At the same time, there are concerns about a loss of confidence in health systems.[5]

Technology and specialization have contributed greatly to improvements in health. However, an excessive and sometimes inappropriate reliance on technology and specialization is fuelling cost inflation, undermining the continuity of care, creating risks to patient safety and making health systems less people-centred. A robust health system is appropriate, affordable, acceptable and accessible. In many settings, these characteristics are under threat.

Even though the health systems of the Region and the challenges they face vary greatly, there are shared challenges, values and aspirations. A few of the common challenges are poorly regulated marketization of the health sector; excessive reliance on user fees and the sale of drugs or diagnostics to finance health systems; migration of health workers, both internal and external; the need to adapt and become more resilient to climate change; a need to better harmonize traditional and Western systems of medicine; an over-reliance on technology and specialization with a relative neglect of primary care; and rapid demographic, political and economic changes with resulting effects on the social and environmental determinants of health. A desire for improved population health and the progressive realization of the right to health is a key shared aspiration.

The specifics of each Member State will lead to different responses in determining how the right to health is translated into action. Health systems action occurs mainly within countries. Some countries do have greater similarities, sometimes based on geography, such as smaller island states in the Pacific, or on the level of economic development. When useful, potential actions based on the *Western Pacific Regional Strategy for Health Systems Based on the Values of Primary Health Care* are discussed using those groupings. However, an underlying assumption remains that the values underpinning good health systems are universal.

1.3 Primary health care, now more than ever

Primary health care (PHC) has been an organizing principle for many health systems around the world and within the Western Pacific Region. PHC has contributed greatly to improving health outcomes, even if there is still much to be accomplished. The original *Declaration of Alma-Ata* was issued in 1978. Implementation has been imperfect and the ambitious

5 *People at the centre of health care: harmonizing mind and body, people and systems*. Geneva, World Health Organization, 2007. Available at http://www.wpro.who.int/publications/PUB_139789290613169.htm

goal of "Health for All" by the year 2000 has not been fully achieved. However, the consensus is that those countries that have organized their health system on PHC principles have achieved better health outcomes in relation to the funds expended, and that the goals and values of PHC are as valid today as they were in 1978.[6, 7]

This does not mean that the PHC concept has remained unchanged. There is a constant need for adaptation to changing circumstances. PHC is now viewed more broadly than it was 30 years ago. The changes in emphasis include: achieving universal access and coverage; a focus on the entire population, especially the disadvantaged; recognition of the need for a healthy global and local environment; working within a mixed system of public and private health provision; providing a continuum of care over a lifetime; and recognizing that a PHC approach provides value for money, not low-cost care.[8]

Primary health care is closely related to but not synonymous with primary care. Primary health care encompasses a public health approach as well as individual care at primary, secondary and tertiary levels. A strong primary care system is the foundation for a health system based on PHC values. But secondary and tertiary services are also vital and must connect to the primary care system, following the same set of values (see Box 2).

Box 2. Primary Health Care and Primary Care

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community.*

Primary care is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

Primary health care has primary care at its core but the principles and values of PHC extend to all aspects of primary, secondary and tertiary care, and public health—throughout the entire health system.

A robust health system needs clear PHC values and strong primary care. PHC is the engine for change. A recent systematic review confirms that there is a considerable evidence base showing that strong primary care contributes to overall health system performance (quality, efficiency and equity) and to health.#

* Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, 1978

\# Kringos D. et al. The breadth of primary care: a systematic literature review of its core dimensions. BMC Health Services Research, 2010, 10(1):65.

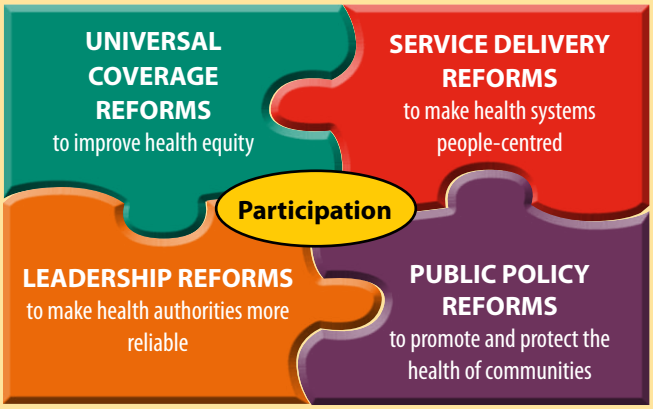
6 Starfield B., Shi L., Macinko J. Contribution of primary care to health systems and health. *The Milbank Quarterly*, 2005; 83(3): 457-502.

7 Kringos D. et al. The breadth of primary care: a systematic literature review of its core dimensions. *BMC Health Services Research*, 2010, 10(1): 65. Available at http://www.biomedcentral.com/content/pdf/1472-6963-10-65.pdf

8 *The World Health Report 2008. Primary health care: now more than ever*. Geneva, World Health Organization, 2008: XV. Available at http://www.who.int/whr/2008/whr08_en.pdf

A series of meetings held around the world reaffirmed the continued validity of the PHC concept. The work of two major commissions—the Commission on Macroeconomics and Health and the Commission on the Social Determinants of Health—have added further definition to the health challenges of the 21st century.[9, 10] In October 2008, on the 30th anniversary of the original *Declaration of Alma-Ata*, *The World Health Report 2008: Primary Health Care, Now More than Ever* was launched. It suggested that core values should underpin the organizing principles of all health systems. If the values and principles are followed, then health systems are more likely to contribute to maximizing the health benefit achieved with the resources available.

Box 3. Policy Directions to Focus Health Systems on PHC



Policy dialogue is part of PHC. The *World Health Report 2008* describes four areas of reform, policy and action that foster the development of PHC-oriented health systems. These areas of reform and action go beyond the health sector alone. They are: (1) universal coverage aimed at improving health equity and financial risk protection; (2) service delivery for both personal and non-personal services that is people-centred, responsive and supports universal coverage; (3) leadership aimed at making health authorities more reliable and accountable to those they serve; and (4) public policy implemented across all sectors in ways that promote and protect the health of communities and individuals. Health is promoted in all policies. People and their participation remain at the centre of primary health care (see Box 3).

1.4 Millennium Development Goals

Challenges—new and old, internal and external—exist in the global health environment. The Millennium Development Goals (MDGs) are a globally agreed upon set of development targets. Five of the eight MDGs relate directly to health. If the MDGs are to be achieved by their 2015 target, the performance of health systems in many countries will need to improve. Particularly, the MDGs related to maternal mortality and child mortality are at risk of not being achieved in several countries in the Region unless health system performance improves.[11] However, the health sector cannot act alone. Intersectoral action on health, as articulated by the Commission on

9 Commission on Macroeconomics and Health. *Macroeconomics and health: investing in health for economic development.* Geneva, World Health Organization, 2001. Available at http://whqlibdoc.who.int/publications/2001/924154550X.pdf

10 Commission on Social Determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health.* Geneva, World Health Organization, 2008. Available at http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf

11 Office of Prime Minister of Norway. *2009 Report on the Global Campaign for Health MDG's*. Oslo, 2009. Available at http://www.who.int/pmnch/topics/mdgs/20090615_glhealthcampaignrep/en/index.html

Social Determinants of Health, is needed.[12] An emphasis on education is of particular importance.

The global public health architecture is increasingly complex, putting cooperation in the health sector at risk. There are new and different partners, such as global health initiatives and private foundations. Many problems require solutions that must be implemented across borders. The new partners in the health sector have been beneficial, although they have increased the risk of fragmentation. The increase in partners makes it even more important that each Member State have its own vision, policy and plan for the health sector, a plan based on a core set of values.

12 *Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health*. Op cit.

2

Vision: Universal coverage for better health outcomes

The people of the Western Pacific Region deserve to live out their lives in the highest state of health possible. While there can be no guarantee of individual health, all people have a right to quality health services that are available, accessible, affordable and acceptable.

Member States of the Region have made a commitment to the progressive realization of those ideals.

Health care systems that are organized following the principles/values of primary health care do better at improving health outcomes, achieving universal coverage with financial risk protection, and achieving the most health gains relative to the money invested in health systems, than do systems not based on PHC principles/values. It is the intent of the Region to foster systems that reflect the values of primary health care.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3 Goals of a health system

The four goals of a health system are:

- health, both the absolute level across the entire population and equity across socioeconomic groups;
- social and financial risk protection in health;
- responsiveness and people-centredness;
- efficiency. [13, 14]

Improving population health is the overarching goal. Health status should be measured over the entire population and across different socioeconomic groups. The safety of populations must be protected from existing health risks and emerging health risks. There should be preparations for resilience to future but still unknown health risks. Health systems should strive for equity in health. Inequitable disparities in health are to be minimized. Sources of inequitable disparity in health may include income, ethnicity, occupation, gender, geographic location and sexual orientation, among others. There are significant variations in health outcomes across the world, within the Region and within countries. Countries and regions with relatively similar socioeconomic status may have quite disparate health outcomes. The way health systems are organized contributes to this disparity. Disparities are most effectively reduced when they are recognized and their minimization is an explicit national goal.

An ideal health system will provide social and financial risk protection in health and be fairly financed. Paying for health care should not impoverish individuals or families. All health systems must be financed, and there must be adequate funding in the system to provide essential services. A WHO definition of a fairly financed health system is one that does not deter individuals from receiving needed care due to payments required at the time of service and one in which each individual pays approximately the same percentage of their income for needed services.[15] A health financing system that deters people from seeking needed services or impoverishes individuals and families will worsen health outcomes.

13 *Everybody's business: strengthening health systems to improve health outcomes. WHO's framework for action.* Geneva, World Health Organization, 2007. Available at http://who.int/healthsystems/strategy/everybodys_business.pdf

14 *The World Health Report 2000*. Health systems: improving performance. Geneva, World Health Organization, 2000. Available at http://www.who.int/whr/2000/en/whr00_en.pdf

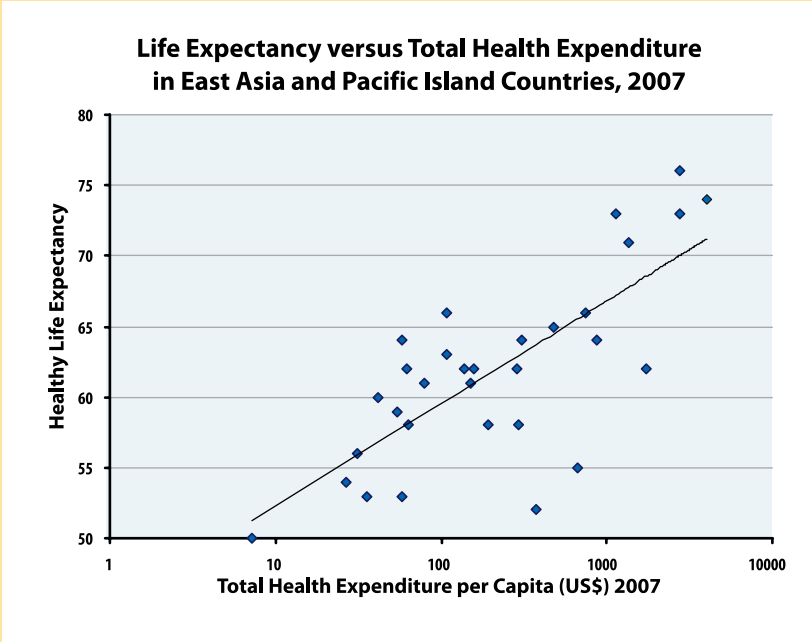
15 *Ibid*.

Responsiveness and people-centredness represent the concept that the health system provides services in the manner that people want or desire and engages people as active partners. It embodies values of respectfulness, non-discrimination, humaneness and confidentiality. Health systems have an obligation to respond to the legitimate non-health desires and expectations of the population. Responsive health systems maximize people's autonomy and control, allowing them to make choices, placing them at the centre of the health care system.

Improved efficiency is also a desired outcome of a health system. People and populations have a legitimate expectation of receiving the maximum health gain for the money they and their society invest in health. There are large variations in health costs across the world and the Region, even among countries with similar socioeconomic status and similar health outcomes. Part of the variation can be attributed to the efficiency of health systems. Health systems oriented towards primary health care have been shown to provide better health outcomes for the money invested.[16, 17, 18] The chart below presents some of the variations in health expenditure versus life expectancy that occur in the Western Pacific Region. Differences in health systems efficiency and organization may contribute to these variations (see Box 4).

Box 4. Policy priorities have a large influence beyond per-capita spending

The organization and management of health systems influence the health outcomes that can be gained with the funds invested. The graph shows that countries in the Region spending relatively similar amounts of money per capita have quite different levels of health, based on life expectancy. The differences cannot be attributed only to the health system, but certainly differences in how health systems are organized contribute to that difference. "Low-income, high well-being" countries have adopted policies that not only reduce inequality but also increase overall health and well-being. Each point on the graph represents a country in the Region.



Source: World health statistics 2007. Geneva, World Health Organization, 2007. Available at www.who.int /whois/whostat2007

16 *Starfield B., Shi L., Macinko J. Op cit.*

17 *The World Health Report 2008*. Op cit.

18 *Kringos D. et al. Op cit.*

A whole-of-system approach

4

WHO has defined a health system as "all organizations, people and actions whose primary intent is to promote, restore or maintain health". Good health services are further defined as those which "deliver effective, safe, quality personal and non-personal interventions to those who need them, when and where needed, with minimum waste of resources". [19]

Health systems are complex. It is useful to analyse health systems by looking at their component parts or functions. This helps identify bottlenecks to successful implementation and interventions that can lead to improvement. For the system to function optimally, all parts must be balanced and coordinated. The weakest part of the system may actually determine the outputs from that system.

WHO has specified a framework with six building blocks that can be used as a tool for analysis of a health system (see Figure 1). The six blocks are leadership, human resources, information, medical products and technology, financing, and service delivery. Intermediate outputs lead to the desired health outcomes. This is not a new concept and other schemata with different groupings can be used, although most are relatively similar.[20,21,22]

The point is not to concentrate only on the individual blocks or that there is one correct schema for a health system. An adequate analysis encompasses the entire health system to the extent possible. Actions to be taken must be evaluated for their potential effects on the functioning of the entire system and ultimately for their effect on health outcomes. All parts of a health system are interrelated, and dynamic interactions, both anticipated and unanticipated, are to be expected.

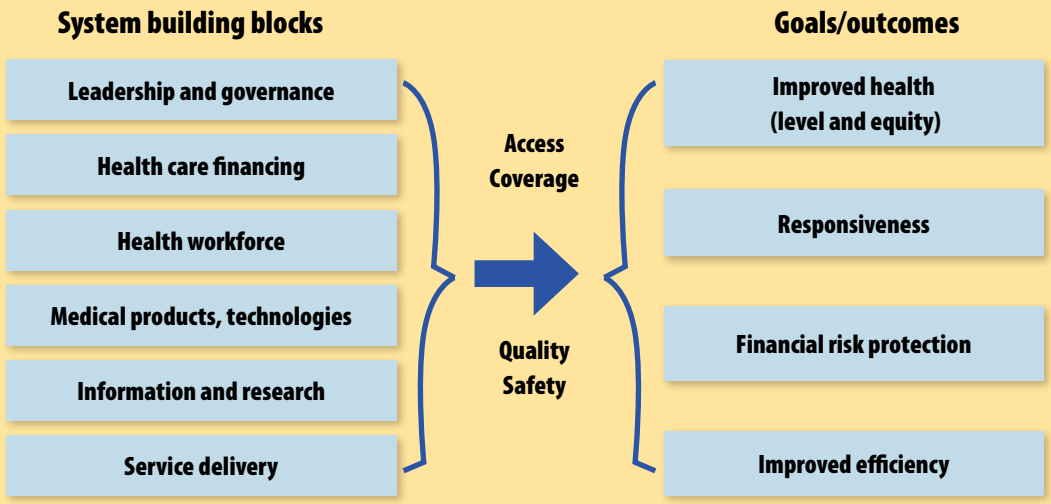
19 *Everybody's business: strengthening health systems to improve health outcomes. WHO's framework for action. Op cit.*

20 Roberts M. et al. Behavior. *Getting health reform right: a guide to improving performance and equity.* Oxford University Press, Inc., 2008: 281–305.

21 World Health Organization Maximizing Positive Synergies Collaborative Group. An assessment of interactions between global health initiatives and country health systems. *The Lancet*, 2009, 373(9681): 2137–2169.

22 Kleczkowski B., Roemer M., Van Der Werff A. *National health systems and their reorientation towards health for all*. Geneva, World Health Organization, 1984. Available at http://whqlibdoc.who.int/php/WHO_PHP_77.pdf

Figure 1. The health systems framework



THE SIX BUILDING BLOCKS OF A HEALTH SYSTEM: AIMS AND DESIRABLE ATTRIBUTES

- Leadership and governance involve ensuring strategic policy frameworks exist and are combined with effective oversight, coalition-building, the provision of appropriate regulations and incentives, attention to system-design and accountability.
- A good health financing system raises adequate funds for health in ways that ensure people can use needed services and are protected from financial catastrophe or impoverishment associated with having to pay for them.
- A well-performing health workforce is one which works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances, i.e. there are sufficient numbers and mix of staff, fairly distributed; they are competent, responsive and productive.
- A well-functioning health system ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and scientifically sound and cost-effective.
- A well-functioning health information system is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health systems performance and health status.
- Good health services are those which deliver effective, safe, quality personal and non-personal health interventions to those who need them, when and where needed, with minimum waste of resources.

There is often strategic tension between different approaches within health systems. Examples of potential tensions are the relative emphasis on specialized services versus generalist services; the degree to which referrals are managed to encourage rational care versus freedom of choice of providers; the allocation of resources between public, preventive health care and personal, curative care; and the relative balance between disease-specific control programmes and more integrated services. Defining core values for a health system helps balance these tensions.

A well-functioning health system is able to support a continuum of care, both personal and non-personal, throughout the life cycle. Interventions are focused on how they contribute to improved health outcomes using the best and most feasible scientific methods available. Services must be designed, implemented and assessed from the perspective of the users of services. The health systems framework is meant to ensure that dynamic interactions are considered across the entire system and to minimize the risk of neglecting important parts of the system during any analysis or intervention.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A robust health system based on PHC values

A robust health system provides the right services, both personal and population-based, in the right places, at the right times to all of those who are in need of those services. Both public health and personal health perspectives are included. Preventive, promotive, curative, rehabilitative and palliative services are also included. Intersectoral action in health and action on the social determinants of health are fostered. For the sake of analysis, the six building blocks are used to describe the characteristics of a health system based on PHC values, always recognizing that health systems are holistic in nature.

A common set of values based on primary health care and the right to health underpin the *Western Pacific Regional Strategy for Health Systems Based on the Values of Primary Health Care*. Those values are shared by all Member States in the Region. The path to implementation of those values and realization of those rights will take different paths in different Member States. There is potential advantage in grouping countries in similar situations and with similar challenges to help determine priorities for interventions. A grouping of countries according to income status and whether they are from Asia or the Pacific islands is presented in Annex 4. Where it is helpful, guidance in the following sections includes a brief analysis of different interventions based on different groupings. However, detailed decision-making will still need to be done in each Member State to meet its own particular needs.

Indicators

Health systems performance assessments are an important part of designing and managing a robust health system based on primary health care values. To assess progress, indicators that can be measured over time are needed. Targets for those indicators are highly desirable. Targets are usually most meaningful when they are set according to the needs and situation of individual Member States. However, there are times when global or regional targets can be agreed and are useful. If there are agreed regional targets, they have been included in the Strategy. Two types of indicators are proposed for this Regional Strategy: (1) a set of global indicators; and (2) a set of national indicators that are tailor-made within each Member State to meet its specific needs.

Global indicators

Global indicators are a relatively small set of indicators that are standardized and collected in a similar way in all Member States. It is recommended that all Member States include them in their health information systems. Global indicators are meant to be useful for managing the health system within a Member State, but they also allow for cross-country and cross-region comparisons. The usefulness of cross-country and cross-region comparisons makes it necessary that the Regional Strategy, to the extent possible, recommends globally agreed indicators.

A multi-agency working group has been developing a toolkit for measuring health systems strengthening. The *Measuring Health Systems Strengthening and Trends* toolkit proposes generic, global indicators for each of the six building blocks, recognizing that this occurs as part of a whole-of-system approach. The toolkit was published in October 2010 and the working group encourages its use.[23] The indicators from the toolkit are presented in Annex 2A. Where regionally agreed indicators and targets have been set in addition to those in the toolkit, e.g. in health care financing, these are presented along with the global toolkit indicators.

The monitoring of health systems performance requires a more comprehensive assessment than only looking at health systems issues. A framework for monitoring and evaluation of health systems is proposed which includes measurements for: (1) inputs and processes in the health system; (2) outputs; (3) outcomes; and (4) impact. The framework has a balance of disease- or programme-specific indicators with general health systems indicators. The framework includes suggested sources of data in each of the four areas. It also includes a proposed core set of indicators under the four areas of interest. The framework and core indicators are presented in Annex 2B. The framework is consistent with the health systems toolkit described in the previous paragraph.

National indicators

Individual Member States will almost certainly identify additional indicators that are relevant for their own setting. A larger, tailor-made set of national indicators that allows progress to be tracked over time is needed as a management tool within each Member State. It is important that the global indicators be included within the national set of indicators to the extent

23 *Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies*. Geneva, World Health Organization, 2010. Available at http://www.who.int/healthinfo/systems/monitoring/en/index.html

possible. Targets, for the most part, will need to be set by each Member State. In some instances, such as for health care financing and the MDGs, both regional and global targets and indicators have been developed and adopted. Adaptation to specific country settings often will be necessary.

5.1 Leadership and governance

Leadership and governance of health systems, sometimes called stewardship, is a complex and critical part of the health system and arguably the most important.[24] Even when governments are not the main provider or financer of health services, the governance role remains. The rules of engagement for state, private and non-state actors in the health sector with the people of a country are the responsibility of the

Box 5. Healthy Islands

First drafted by the Ministers of Health of Pacific Island Countries in 1995, the Healthy Islands concept unifies efforts for health promotion and health protection in island countries. It provides a framework within which health issues are analysed, prioritized and implemented in order to achieve a healthy state on the islands, as reflected in the lives of children, adults and the aged. A healthy island is one that is committed to and involved in a process of achieving better health and quality of life for its people, and healthier physical and social environments in the context of sustainable development.

Providing information to schoolchildren and teachers as part of the Tafea Province malaria assessment survey undertaken by the national Vector Borne Disease Control Programme, Ministry of Health, Vanuatu, assisted by the PacMI Support Centre

http://www.uq.edu.au/news/?article=15873

Success of Healthy Islands initiatives is strongly linked to community commitment and buy-in from health-related organizations and institutions at the highest level.

Healthy Island initiatives take various forms. Some countries have focused on the control of specific diseases or health problems, such as malaria control in the Solomon Islands. Others have focused on environmental health and health promotion initiatives (Fiji) or on water supply and sanitation through community development (Tonga). Others still have implemented community-based health promotion projects (Cook Islands, Kiribati, Niue, Samoa and Tuvalu).

The priority is to assist countries to build their human resource base and health system infrastructure. Without a foundation based on effective programme management, efficient logistics and procurement, and robust monitoring and evaluation, it will not be possible to roll back malaria, island by island and region by region, in the Pacific.

Partners will engage with a variety of community-based organizations, women's groups, churches and other civil society groups to ensure that key components of the expanded malaria programme in each country are implemented in ways which are locally appropriate and acceptable to communities.

Source: Types of Healthy Settings. World Health Organization. Available at http://www.who.int/healthy_settings/types/islands/en/index.html

24 *The World Health Report 2000. Op cit.*

government, bearing in mind that access to necessary health care is a basic human right that people of a country hold and governments bear a duty to ensure.[25]

Privatization, commercialization and marketization of the health sector within an inadequate regulatory framework are risks to the development and sustainability of equitable health systems.[26] If a strong regulatory framework exists and is enforced, privatization, commercialization and marketization can contribute to increasing universal access to health services. However, market forces alone will not lead to equitable and universal access to health services. The realization of equitable access may occur in stages, but it should remain a constant goal for all health care systems.

Leadership and governance in health extends beyond the health sector. A key part of PHC is the recognition that the determinants of health extend beyond the health sector and there is a need for intersectoral action. "Healthy public policy", "health in all policies", "healthy settings", and "Healthy Islands" are some of the ways this idea is expressed within the Region (see Box 5).

Core governance responsibilities have been identified.[27] The exact responsibilities and priorities in emphasis will vary between Member States. The core responsibility areas include:

- development of health sector policies, strategies and frameworks that fit within broader national development policies;
- national health plans that are the implementation guide for health policy core responsibility "areas" in many settings;
- capacity for leadership and governance that extends to all levels of the health systems, as appropriate;
- management of health sector through law, regulation, accreditation and standard setting, including state and non-state actors, both profit and non-profit (standards can be national, regional and even international at times);
- accountability and transparency to the public – governance of the health sector is done in cooperation with, but not under the control of, key stakeholders such as professional associations and commercial interests;
- generation and interpretation of intelligence and information, particularly in the area of policy;

25 United Nations Committee on Economic, Social and Cultural Rights (CESCR). General comment no. 14: the right to the highest attainable standard of health (Art. 12 of the Covenant). *Adopted at the Twenty-second Session of the Committee on Economic, Social and Cultural Rights; 25 April – 12 May 2000*. Geneva, 2000. Available at http://www.unhcr.org/cgi-bin/texis/vtx/refworld/rwmain?docid=4538838d0&page=search

26 As used in this Strategy, privatization refers to private, non-state ownership which can be either for-profit or not-for-profit; commercialization refers to enterprise within the health system that is for-profit; and marketization refers to the use of market mechanisms such as contracting and social marketing which can be either for-profit or not-for-profit. Distinctions can be blurred, for example when publicly owned institutions become involved in commercial activity.

27 *Everybody's business: strengthening health systems to improve health outcomes. WHO's framework for action. Op cit*.

- coalitions outside the health sector with a wide variety of stakeholders; and
- implementation of an aid effectiveness agenda in line with the Paris Declaration on Aid Effectiveness, Harmonization and Alignment in those settings where overseas development assistance is an important contributor to the health sector.[28] Primary responsibility for implementing aid effectiveness lies with national governments, but it requires wide-scale cooperation by all stakeholders.

In many settings, a national health strategy or national health plan will be the point where the core values of the health system of the country are expressed. Targets to be achieved for health outcomes and the health system within a specified time frame are often part of national health strategies and plans. For the most part, national health strategies and plans are embedded within the overall national development planning process of a country, if such a process exists.

National health policies, strategies and plans have taken on increased importance in recent years. The drivers of this trend are many, including an increasing recognition that robust policy, strategy and planning processes are needed so that activity within national health systems is country-led. It is also increasingly important that with the wide variety of health stakeholders, there be a unifying vision for the health system.

Some Member States have opted for decentralization as an organizing principle. Decentralization is primarily a political decision to which the health sector must adapt. Decentralization presents both opportunities and challenges for health systems governance. Linking national strategy and policy with local planning and implementation is sometimes difficult. Local authorities are sometimes not sensitive to the need for rapid reporting and control of infectious disease. Defining the respective roles and authorities of the various actors, including government at different levels, is required. Building the capacity for individuals and systems to carry out those roles is often necessary. Assuring that both capacity and resources to fulfil mandates exist is a key responsibility of leaders. Decentralization offers the opportunity to increase responsiveness and efficiency as management decisions are made closer to actual implementation sites, but it requires that managers in decentralized units are empowered to fulfil their responsibilities, and that they are accountable to the people they are meant to serve.

5.2 Health care financing

Health care financing systems must deal with the collection of sufficient funds to ensure adequate financing, pooling of funds to share risk, and purchasing of services to encourage efficiency and effectiveness. Good health financing systems raise adequate funds in ways that ensure people can use needed services and are protected from financial catastrophe or impoverishment associated with having to pay for those services.[29] The sources of funds may be from general taxation, social insurance,

28 The Paris Declaration on Aid Effectiveness. Paris High-Level Forum. Paris, France, 2 March 2005. Available at http://www.oecd.org/dataoecd/11/41/34428351.pdf

29 *Everybody's business: strengthening health systems to improve health outcomes. WHO's framework for action. Op cit.*

earmarked taxes and even external aid, as long as the principles of prepayment and risk-pooling are honored.

User fees in both the public and private sectors in Asia have led to a high rate of impoverishment due to health care expenditures. Fees at the point of service act as a deterrent to seeking necessary health care and have encouraged irrational health care provision through supplier-induced demand. In addition to the problematic methods of financing, in many Member States, there is inadequate total health expenditure and inadequate government expenditure on health.

The *Health Financing Strategy for the Asia Pacific Region (2010–2015)* analyses the health care financing situation. Eight strategic areas have been identified. These are:

- increasing investment and public spending on health;
- improving aid effectiveness in health for those Member States where international assistance is a significant part of health care financing;
- improving the efficiency of the health care system through rationalizing health expenditures to achieve better value for money and particularly addressing inequity, inefficiency and low quality;
- increasing the use of prepayment and risk-pooling;
- improving provider payment methods so there are incentives to contain costs, modify consumer demand, and provide incentives for rational use, e.g. capitation payment, performance-based pay, incentives for use of certain services;
- strengthening safety-net mechanisms for the poor and vulnerable—public financing aimed at the poor and vulnerable is frequently captured by the less poor unless special care is taken to target the most vulnerable;
- improving evidence and information for policy-making with an emphasis on measuring equitable financing and access;
- improving monitoring and evaluation of policy changes. [30]

While the eight strategic areas are applicable in most Member States in the Region, several are of more relevance to specific groupings of countries. Increasing investment and public spending in health is crucial for low- and middle-income Asian countries. Greater use of prepayment and risk-pooling is also important for these countries as out-of-pocket expenditure tends to dominate. In the Pacific island countries and high-income countries, governments tend to allocate a reasonable amount of funds to health, and the focus might be more on better use of existing resources. The focus on aid effectiveness is really relevant only for those Pacific island countries and low-income Asian countries receiving substantial aid.

30 *Health financing strategy for the Asia-Pacific region (2010-2015)*. Manila, World Health Organization, 2009. Available at http://www.wpro.who.int/internet/resources.ashx/HCF/HCF+strategy+2010-2015.pdf

5.3 Health workforce

Health workers are all people engaged in actions whose primary intent is to protect and improve health.[31] The health workforce is often the largest expenditure within a health system and one of the most important variables in health systems performance. Preparing the workforce, enhancing the performance of the workforce, and managing migration, both internal and external, as well as attrition within the workforce are tasks that all health systems must accomplish.[32] These tasks usually involve multiple other sectors, such as education, both the public and private sectors, the civil service authorities, and immigration authorities to name just a few.

Each Member State would benefit from having a comprehensive strategy and plan for preparing and managing the health workforce in its totality, recognizing that not all factors are in the control of the health sector. The strategy should focus on having a workforce suited to the service delivery model and service delivery packages of that country. The workforce model must be feasible and affordable. Feasible in the sense that the numbers and types of workers planned can actually be produced and affordable in that they can be paid within the fiscal space available to the health system. Both the public and private health workforce must be considered. A long-term view of the values and direction of the health system is necessary. Changes in health workforce numbers and skill mix take years, even decades, to implement. Major changes in types of cadres or their proportions are resource intensive and often disruptive in the short term. Minimizing the number of major workforce changes is desirable, although the system should not be overly rigid so that innovation is stifled.

A *Regional Strategy on Human Resources for Health (2006–2015)* provides guidance within the Region.[33] A regional framework for action in human resources for health is being developed to update and guide implementation from 2011 to 2015.

5.3.1 Preparing the workforce

A health system oriented towards primary health care requires the correct number, mix and quality of health care workers deployed to the appropriate locations. Those workers must be able and willing to provide comprehensive and continuous services where the need is greatest. There are several guiding principles for preparing a workforce.

- Health care workers from underserved populations, such as ethnic minorities and rural and remote areas, are frequently underrepresented within the health professions. Women, particularly in some cadres, are also often underrepresented.

31 *Everybody's business: strengthening health systems to improve health outcomes. WHO's framework for action.* Op cit.

32 *The World Health Report 2006. Working together for health*. Geneva, World Health Organization, 2006. Available at http://www.who.int/whr/2006/whr06_en.pdf

33 Regional strategy on human resources for health (2006-2015). Manila, World Health Organization, 2007. Available at http://www.wpro.who.int/publications/PUB_978+92+9061+2445.htm

Training programmes often need to be designed to attract students from underserved populations and to correct imbalances.

- A varied set of skills is needed and an appropriate skill mix needs to be defined for each country to fulfil its service delivery obligations in both the curative and public health arenas. This distribution of health workers within a country to areas of higher need or relative shortage is often as important as the absolute numbers of health workers.

- Teamwork is crucial in a PHC-oriented health system. Thus, training programmes need to foster the ability to work as a member of a team.

- Training is more appropriate when it is carried out, at least in part, in a setting that is similar to where the student will eventually work. Meaningful primary-level experience for all trainees, even those who become sub-specialists, can be beneficial in developing a holistic team approach to health services.

- Quality standards for training institutions through methods such as accreditation can make a major contribution to having a skilled health workforce.

- The number of health workers trained in each cadre and the number of health workers that can be employed need to be in balance. It is clearly harmful to have shortages of health workers. It is also potentially harmful to train more health workers than the system can absorb as it is likely to lower the quality of training, frustrate families and graduates, and may lead to health care cost inflation through supplier-induced demand.

- The ratio of generalist physicians to specialist physicians is an important variable in the ability of systems to deliver PHC-oriented services. An excess of specialization increases the risk of fragmentation and discontinuity of services, tends to favour urban over rural services, and contributes to cost inflation. For reasons of status, economic incentives and unclear career paths, many countries have trained an insufficient number of generalist physicians, such as family medicine specialists.

- The ratio of physicians to nursing personnel is an important variable in the ability to deliver PHC-oriented services. Large parts of the Region have an inadequate number of nurses as compared to doctors. This limits the ability to deliver continuous and comprehensive services as a team, tends to favour urban areas over rural areas, and also contributes to cost inflation. The status of nursing in relation to medicine needs to be improved in many settings and the shifting of tasks to well-prepared nurses, nurse practitioners, and other mid-level practitioners is a strategy that can be more fully developed to provide more universal coverage at an affordable cost.

- Volunteer health workers can be a useful part of a health system. This may be even more important in the future with ageing populations and an increased need for community services. However, volunteer health workers must have a clear role in the service delivery model and their training, supervision and remuneration, either direct or indirect, must be well planned and managed.

- Informal caregivers, who are often family members and women, play an important part in providing services within all health systems. Their role should be acknowledged. The formal sectors should be willing to work with them and even facilitate their activities as appropriate for the national setting.

5.3.2 Enhancing the performance of the workforce

Maintaining a high-performing workforce is a complex and continuous process. Single interventions, be it training or incentives, will not be successful by themselves. Job-specific interventions, basic support systems and an enabling work environment have been identified as important determinants of health worker performance.[34]

Several key elements for the enhancement of workforce performance have been identified.

- Job-specific interventions include clear job descriptions, norms and codes of conduct, matching skills to tasks and supportive supervision.

- Support systems include appropriate remuneration that rewards performance in primary health care. In parts of the Region, health worker pay is too low. Support systems also include ensuring that information and communication to workers, particularly those in underserved areas, is adequate. Information technology is making this more feasible in more places. Infrastructure and supplies that allow the service delivery model to function are essential. Primary care services must receive a fair share of the budget.

- New interventions should not be introduced without considering the capacity of the workforce to absorb those interventions. This is particularly important in countries where overseas development assistance is prominent.

- An enabling work environment can motivate health workers as much as pay. Such an environment includes lifelong learning or continuous education, effective team work, and providing those who are held to be accountable in systems with enough authority and resources so they can actually do their jobs.

34 The World Health Report 2006. *Working together for health. Op cit.*

5.3.3 Managing migration and attrition within the workforce

The number of health care workers will continuously ebb and flow with workers leaving the service, either temporarily or permanently. The attrition can be natural, from retirement and ageing, or premature, from people changing professions or migrating. The migration can be external but also internal, often from underserved areas, such as rural regions or urban slums, to better served more affluent urban areas. Migration strategies for both source and receiving countries and regions are needed.

Several key elements for managing migration and attrition have been identified.

- Countries and regions experiencing net outflows of health workers must adjust their training to the need and demands of migration and attrition. Improving local conditions may help stem excessive outflow. Countries experiencing net inflows must treat migrant health workers fairly, adopt responsible recruitment policies, and potentially provide support to human resource development in source countries. An *International Code of Practice on International Recruitment of Health Personnel* has been adopted as a guide for Member States.[35]

- Health workers must be protected from occupational violence and occupational-related disease.

- Flexibility in working hours and adapting to the needs of part-time workers can allow more workers to stay in the health care system. Certain benefits which accommodate family needs, such as day care, can allow more workers to stay in the system.

- Retirement rates and health workforce ageing must be monitored so that adaptation in training and retention can be done.

- Anticipated migration must be part of the planning process for numbers of trainees.

- Health worker remuneration reform usually must be done in the context of overall civil service reforms.

Low-income countries typically need to focus on issues of health worker shortages (a goal of 2.3 nurses/midwives/doctors per 1000 population is a bare minimum target), limited investment in the health workforce and the lack of regulatory oversight. Middle-income countries are seeing a rapid increase in the number of health training institutions, imbalances in distribution and skill mix, uncontrolled growth of the for-profit private sector, and the pushing of skilled workers from rural to urban settings and jobs overseas. High-income countries have a bias towards specialization, an

35 World Health Assembly resolution WHA63.3, agenda Item 11.5. Available at http://apps.who.int/gb/e/e_wha63.html

increase in for-profit private sector growth and the pulling of skilled health workers from lower-income countries. The Pacific island countries have issues of skill mix, distribution, remuneration, reliance on overseas training, budgets with little fiscal space to accommodate health worker demands for higher pay and a small workforce that is quite vulnerable to disruption by the loss of even a small number of health workers.

5.4 Medical products and technologies

A robust health system oriented towards primary health care strives to ensure equitable access to essential medical products and technologies that are quality assured, safe, efficacious and cost-effective. It promotes the use of these essential medical products and technologies in a scientifically sound and cost-effective manner.[36]

Strategies and policies to inform and guide decision-making about medical products and technologies at the national level are desirable. Ad hoc introduction of medical products and technology runs the risk of being neither safe nor cost-effective. Decision-making on the introduction of medical products and technology should be guided by assessments of efficacy and cost-effectiveness.

5.4.1 Medical Products

The *Regional Strategy for Improving Access to Essential Medicines in the Western Pacific Region (2005–2010)* includes strategies and actions in eight areas. These are intimately involved with service delivery models, human resources, health care financing, and leadership and governance. The eight areas are:

- rational selection of medicines to meet the needs of the population often based on the WHO Model List of Essential Medicines;
- rational use of medicines;
- affordable pricing of medicines;
- ensuring access to medicines in light of globalization and TRIPS (trade-related intellectual property rights) for certain countries in a manner that promotes access while promoting innovation;
- sustainable financing of medicines in ways that promote rational use and affordability;
- coherent supply and management systems for drugs;

36 *Everybody's business: strengthening health systems to improve health outcomes. WHO's framework for action. Op cit.*

- quality assurance of medicines, including counterfeits and substandard drugs; and
- monitoring and evaluation of access to essential medicines.[37]

A regional framework for action on access to essential medicines for 2010–2015 is in the process of development. It will update the actions from the Strategy.

5.4.2 Essential Health Technology

Health technologies are developed to solve a health problem and improve the quality of life. Health technology includes diagnostics and laboratories, diagnostic imaging, medical devices, blood transfusion and transplantation, and, increasingly, eHealth. Health technology, properly implemented and used, is a major contributor to improved health outcomes. Improper use of health technology can be a contributor to poor health outcomes and a driver of unnecessary cost inflation. Health technology is intimately involved with the service delivery package, the service delivery model, human resources, and health care financing.

The *Asia Pacific Strategy for Strengthening Health Laboratory Services (2010–2015)* calls on each Member State to develop a national plan for laboratory services. There are seven strategic elements in this Strategy, namely:

- establish a coherent national framework for laboratory services;
- finance health laboratory services in a sustainable manner;
- build capacity for laboratory services;
- ensure the quality of health laboratory services;
- promote the rational use of laboratory services;
- improve laboratory safety; and
- support research and ethics in laboratory settings.[38]

In addition to the Regional Laboratory Strategy, regional and global normative guidelines are currently available for organ transplantation and blood safety.[39,40] Other aspects of health technology are discussed under service delivery in Section 5.6.

37 *Regional strategy for improving access to essential medicines in the Western Pacific Region 2005-2010*. Manila, World Health Organization, 2005. Available at http://www.wpro.who.int/publications/PUB_9290611855.htm

38 *Asia Pacific strategy for strengthening health laboratory services 2010-2015*. Manila, World Health Organization, 2010. Available at http://www.wpro.who.int/publications/PUB_9789290614296.htm

39 *Design guidelines for blood transfusion facilities*. Manila, World Health Organization, 2008.

40 *WHO guiding principles on human cell, tissue and organ transplantation*. World Health Organization Executive Board, 123rd session, 26 May 2008. Available at http://apps.who.int/gb/ebwha/pdf_files/EB123/B123_5-en.pdf

Some of the problems that low-income countries are particularly vulnerable to include difficulties from health care financing through the sale of medicines and diagnostics that harms both universal coverage and their rational use. Other issues include inefficient procurement and delivery systems, inadequate regulation, the presence of counterfeit and fake medicines, and unlicensed drug selling. Middle- and high-income countries tend to have the most difficult problems with balancing the need to control costs with introducing new technology. The Pacific island countries have difficulties with competitive pricing, maintaining a skilled cadre of managers, particularly in smaller States, and handling the difficult logistics of supplies.

5.5 Information and research

Generating and using information and research in a strategic fashion are critical elements of robust health systems. Good governance at all levels is dependent on information and research. Gathering information should reflect core values such as universality, equity and the broader social determinants of health, as well as the more traditional epidemiologic indicators revolving around morbidity, mortality, resources and health outcomes. Timeliness and quality of information and research also rely on adequate infrastructure, sufficient training and capacity, functioning data flows and reliable processes for data sharing between systems. Information and research must aim to inform policy and management.

5.5.1 Information

The key elements in information systems include:

- Appropriate health information system policy should be created and implemented to govern the ownership, access, sharing, security and use of information and research.
- A national health information strategy and plan should guide how information is generated and used. The Strategy should include the entire health system, both state and non-state. It will outline the methods used to generate information and include both facility and population-based sources of data.
- A coordinating mechanism is needed to support the full range of information databases, systems and research across health. Promotion of open standards in both hardware and software to align and harmonize national health information systems with international norms is important.
- Sufficient resources for training, incentives, supervision and infrastructure of health information systems data quality, analysis and use, plus technical skills to operate and maintain electronic-based systems, should be included in the overall Strategy.

- Information will be used and interpreted at the level where it is collected. It will also be passed upwards and aggregated for overall supervision, monitoring and planning, and best practices will be disseminated and promoted.
- Parallel and duplicative reporting systems are to be avoided to the degree possible. This requires considerable time and negotiation, particularly in countries where external donors are prominent or there is a tradition of highly fragmented services.
- Information will be disaggregated sufficiently to identify and monitor equity in access and health outcomes for potentially underserved populations, e.g. by socioeconomic status, age, sex, sexual preference, ethnicity, geographic location or occupation.
- Health system performance should be monitored using an agreed set of objectives with indicators so that comparisons can be made over time between regions and facilities within countries and between countries, where appropriate.

Information technology offers much promise for improving the quality and accessibility of health information, although information technology by itself will not make a dysfunctional information system work. Information technology should be appropriate, applicable and sustainable and should be subjected to cost-effectiveness analyses and health technology assessments.

5.5.2 Research

The key elements in research include:

- Research in health and health systems will relate to the burden of disease in the specific setting.
- Research will support the core values of primary health care, such as decreasing inequity, and will connect to managerial and policy-making processes. Even in resource-constrained settings, internal resources should be allocated to research, including health systems research.[41]
- Research will conform to national and international standards on research ethics where appropriate.
- Mechanisms for translating research into practice are needed.

The status, gaps, priorities and ongoing strengthening activities of national health information systems across the Region vary considerably. In most low- and lower-middle-income countries, carefully developed and implemented national health information system strategic plans with clearly defined data collection and use

41 The Mexico Statement on Health Research. *Ministerial Summit on Health Research*. Mexico City, Mexico, 16–20 November 2004. Available at http://www.who.int/rpc/summit/agenda/en/mexico_statement_on_health_research.pdf

arrangements from subnational to more centralized levels will improve the overall structure and reliability of the health information system. A focus on basic health information and statistics capacity development and trained staff retention for data analysis at central and local level needs to be maintained.

Middle- and high-income countries may be positioned for increasing adherence with data standards and advancing interoperability within the national health information system that will improve integration of data collection and allow more comprehensive use of information. Sustainable training programmes, including continuous quality improvement, should be incorporated into more comprehensive health information systems operational plans. Attention might need to be given to the ability to track individual patients over time and across various locations and services within the health system.

For most Pacific island countries with relatively small populations, information and research support should be simplified to support basic needs to make informed decisions. Recommending new approaches or enhancing the existing health information systems should be able to accommodate all minimum essential requirements based on readily available tools and solutions, while still following good planning, design and implementation processes.

5.6 Service delivery

People and their needs are at the centre of robust health care systems. A people-centred service delivery model responds to the medical and epidemiological needs of people, but also to their legitimate expectations for services. What people want and expect from their health care system is important. Service delivery includes both public and curative health and both personal and non-personal services. It incorporates all levels from individuals and households through to tertiary services.

5.6.1 Service delivery model

Each Member State has a responsibility to define, either implicitly or explicitly, its desired service delivery model, i.e. who delivers what services where, for both personal and population-based health services. Service delivery models will vary depending on the setting and prior national experience. However, those societies that have developed a strong primary health care model have tended to generate superior health outcomes at lower or equivalent cost. Primary care is the foundation for a health system based on PHC, but it is not all of PHC. Secondary and tertiary services must also be included, with connections to primary care, in ways that reinforce PHC values.

Primary health care-oriented service delivery provides an initial contact with the system that is easy to understand and easy to access. It also provides an ongoing relationship, comprehensive care, continuity of care and care across the entire life cycle. Successful primary care models tend to depend on multidisciplinary teams and often have multi-skilled practitioners who can offer services across a broad spectrum, including the more social and public health aspects of care. For physicians, family medicine may be an entry point. Alternative models using a combination of other primary specialists, such as paediatricians, obstetricians and physicians/internists, may be considered, but somehow they must relate as a team and provide a unified service. Nurses, nurse practitioners, medical assistants, laboratory and imaging technicians, social workers and others, depending on the setting, will be both members and leaders of primary care teams. In some settings, community health workers, either paid or voluntary, may be a part of this system.

The service delivery model will be based on a nation's needs, history and preferences. An equitable balance between primary care services and secondary/tertiary services must be defined and financially supported. The role that community-based services play varies considerably. If the role is major, they must be planned and supported and connect with the formal health system. The relative balance between state and non-state providers, both private and not-for-profit, is a crucial decision. Public health services and personal services for prevention, promotion, palliation and rehabilitation are part of the service delivery model. The tendency has often been to pay lip service to primary care, but to invest in secondary and tertiary services.

Barriers to access should be analysed, particularly for vulnerable groups. Barriers to access due to gender, ethnicity, socioeconomic status and a range of other issues are most effectively addressed when explicit strategies to overcome them exist.

The primary care team or provider will typically be the first and the continuing contact for most people. The primary care team or provider should connect seamlessly to secondary and tertiary referral care, with two-way communication between levels. Such communication is particularly problematic when the management of primary care and referral services is separated. Mobile and remote populations present a particular challenge to ensuring continuity of care across multiple settings.

A blurring of the separation between primary, secondary and tertiary care occurs when primary services are weak and therefore bypassed and referral institutions become a point of entry into the system. This escalates costs and is inefficient. The gatekeeper concept to promote rational referral is sometimes controversial, but incentives for both providers and patients to follow referral systems, if they are functioning, may be beneficial for the overall efficiency/equity of the system. The balance between patient choice and efficiency/equity will be set in each society.

Traditional and complementary and alternative medicine (TM/CAM) is a major part of care provision in many Member States. There is wide diversity in the nature of TM/CAM practice in the Region. In some areas, it has been built up over centuries of practice. In others, the introduction is more recent. In some settings, the providers or practitioners have formalized training, some in accredited institutions. In other settings, the knowledge is transferred informally through family links or from teacher to student through apprenticeship. In some settings, TM/CAM practitioners are often the first providers to whom patients turn for many problems. TM/CAM is integrated with allopathic or Western medicine to varying degrees. There are potential benefits to free and open communication between practitioners or providers of TM/CAM and allopathy, such as mutual referral. In some settings, it may be appropriate to include TM/CAM practitioners as part of the primary health care team. Issues, such as regulation, accreditation, reimbursement and establishing an evidence base for TM/CAM, are complicated and require careful consideration before integration can be fully achieved.[42] The decisions about the role of TM/CAM in health systems need to be individualized for each national setting consistent with its own values.

5.6.2 Service delivery packages

Each nation needs to define the package of services or mix of services that is desirable and feasible to be delivered at each level, including at households and in communities. In a centralized system of government-financed and government-provided services, the defined service delivery package actually becomes the implementation plan. In highly decentralized and/or privatized systems, the service delivery package serves more as a guideline. However, the goal should be to eventually tie the delivery of a quality service package as a standard for licensing, accreditation and reimbursement.

The overall resource envelope must be considered, meaning that difficult decisions will have to be made. Both personal and non-personal services are part of the package. Public health must not be neglected in relation to curative, individual services. The package must be designed to meet the most pressing health needs that are feasible to be tackled. Mechanisms to adjust the package in a timely fashion as scientific and economic realities change are needed. The contents of the package will vary from country to country. Economic analysis is an important tool for defining an equitable service delivery package, although not the only one.

5.6.3 Quality and patient safety

Quality and safety are important intermediate outcomes. Low-quality services at best waste resources and at worst cause poorer health outcomes. Unsafe medical care is a

42 *Regional strategy for traditional medicine in the Western Pacific Region*. Manila, World Health Organization, 2002. Available at http://www.wpro.who.int/publications/pub_9290610115.htm

major source of morbidity and mortality throughout the world.[43] Often the emphasis has been on the quantity or coverage of services and quality is something added to a system after coverage has been achieved. Quality is often perceived as expensive. Both of these ideas are misconceptions. One working definition of quality in a health service is "the degree to which health services for individuals and populations increases the likelihood of desired health outcomes and are consistent with current professional knowledge".[44] This concept is relevant to all levels of service and all levels of socioeconomic development.

Health systems have an obligation to incorporate quality improvement and patient safety into their institutional arrangements and daily routine. Documentation of quality improvement should be incorporated into the information system. Quality improvement has both a voluntary and a mandatory component. Both approaches should be fostered. Robust quality improvement may eventually be part of the criteria for licensing, accreditation and reimbursement.

Box 6. No care without quality

While countries often focus on increasing the quantity of health care—e.g. the number of immunizations or consultations or the rates of coverage—health care can be useless, wasteful or even harmful if it is not appropriate for the particular condition and consistent with the best medical knowledge. Thus paying attention to the quality of health care is not a luxury that only high-income countries can afford, but another pillar of the health service system that has a profound impact on the cost-effectiveness and equity of interventions. Indeed, quality of care is a key element of the intangible technical progress that explains so many of the health improvements of the past 50 years. While more resources will support improvements in quality, such improvements are possible even with few resources.

"... the quality of health care is not a luxury that only high-income countries can afford, but another pillar of the health service system that has a profound impact on the cost-effectiveness and equity of interventions."

Poor quality care is endemic in many health systems, whether in low-, middle-, or high-income countries. The problem of poor health care quality is not the fault of isolated health professionals or solely attributable to limited resources. Rather, quality problems are systemic and are consequences of gaps in knowledge and inadequate communication, training, supervision and incentives. These problems persist when organizations providing health care are unable to monitor the quality of care and take corrective action.

Source: Jamison D.T. et al., eds. Priorities in Health. New York, Oxford University Press, 2006.

43 *World alliance for patient safety: progress report 2006-2007*. Geneva, World Health Organization, 2008. Available at http://www.who.int/patientsafety/information_centre/documents/progress_report_2006_2007.pdf

44 Kohn, T., Corrigan, J., Donaldson, M. *To err is human: building a safer health system*. Washington, D.C., National Academy Press, 2000. Available at http://www.nap.edu/openbook.php?isbn=0309068371

5.6.4 Infrastructure including equipment

Infrastructure development and maintenance are a driving force behind service delivery, quality and cost. Each country will benefit from clear guidelines on what constitutes appropriate, affordable and feasible infrastructure in their health care system. Those guidelines should be applicable to both the public and the private sector. Minimum standards appropriate to economic reality need to be defined.

Maintenance and recurrent costs must be accommodated as part of the infrastructure budget. Resilience to climate change and resilience to emergencies are relatively new criteria for choosing infrastructure. Standards which guide the introduction of new and expensive infrastructure are desirable. The guidelines must be able to adapt to changing scientific reality and not stifle innovation. Environmental friendliness and energy efficiency are of increasing importance globally and also as a method of cost control.

Low-income countries will need to focus on defining a service delivery model and package that is feasible and affordable within the limits of both financial and human resources. The core package may be relatively limited and is likely to emphasize maternal and child health interventions. The core package, even if simple, should be delivered universally and with sufficient quality. Middle- and high-income countries may concentrate on providing service delivery models and packages that meet the increasing demands of the public, maintain a public health focus and control costs. Pacific island countries have a good record on universality and affordable coverage but are struggling to deal with the demographic transition and provide noncommunicable diseases control, something which requires more continuity of care and prevention than their current model delivers.


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6

Moving from strategy to action

Health policies and strategies based on core values are important. As important as policies and strategies are, the actions that lead from them are even more important. Ultimately, it is the health outcomes that follow from that action that really matter. All actions that influence health or the health system should be analysed through the prism of a holistic approach to health systems based on the values of primary health care.

The Western Pacific Region is diverse. The health sector context is changing rapidly with socioeconomic development and globalization. Strategies and actions decided upon now may not be appropriate in the future. Flexibility and the ability and willingness to recalibrate the system in the future are important. However, if a core set of values underpin decision-making, it is more likely that change can be accommodated more successfully.

6.1 National health policy and planning processes

Each country needs to develop its own health planning and policy processes to fit its own needs. However, there are core principles that apply almost universally.

6.1.1 A sound policy process that reinforces core values

There is considerable variation in national health strategy and policy processes. In some settings, there is no single guiding document and national health policy and strategy is more implicit based on years of accrued experience, legislation and tradition. This Regional Strategy provides guidance for core values to be considered for inclusion in national health strategy and policy development processes. It also discusses some of the attributes of a robust national health policy and strategy process, which have been further elaborated from other sources. Some of the most important attributes of robust policy and strategy processes are:

- building consensus on a sound situation analysis;
- broad consultative processes involving essentially all stakeholders;

- a mechanism for high-level endorsement of the process;
- priorities are determined through consultative processes;
- alignment with other relevant national development policies;
- country ownership.[45, 46]

6.1.2 National policy must be realistic and able to be translated into operational-level action

As important as policy and strategy are, most of the activities that affect the daily lives of people occur at a much lower level. The aspirations of national policy often fail to be realized. Much is lost as national policy is translated into actual activity at the operational level. There are many reasons for this. Some key attributes of realistic planning processes are those that are:

- developed by the people who will implement them;
- compatible with the resources and capacities that exist;
- anchored through long-term political and legal commitments;
- able to link strategic and operational planning;
- addressing the concerns of the middle levels of the health sector;
- enjoying commitment from multiple stakeholders both inside and outside government.

Capacity without resources will not lead to improved health outcomes. The same is true of resources without capacity. Both must be assessed realistically and plans made to use that capacity and those resources in the most equitable and efficient manner. Ideally, this planning will involve those who are at the level of implementation. Managers at the implementation level should be empowered to carry out those tasks. Capacity-building may be necessary. Care must be taken to ensure that capacity-building efforts do not undermine implementation. Capacity-building should truly build total system capacity, rather than just capturing capacity for one activity while neglecting others.

6.1.3 Comprehensive, balanced and coherent planning linked to subnational plans

A whole-of-system approach calls for activity at all levels of the health system across the set of building blocks used for analysis. The routes of connection between different levels of the system need to be open and well understood by all involved. The

45 *Joint assessment of national health strategies and plans: combined joint assessment tool and guidelines*. International Health Partnership (draft July 2009). Available at http://www.internationalhealthpartnership.net/CMS_files/documents/joint_assessment_guidelines_EN.pdf

46 *A framework for national health policies, strategies and plans*. Manila, World Health Organization, 2010. Available at http://www.wpro.who.int/rcm/en/rc61/documents/

strategic, policy and planning processes in each country should lead to a definition and understanding of the roles and responsibilities at each level and whether that level has both the resources and the capacity to fulfil that role. Interventions and activities should be adjusted to work within that capacity, while working on both short- and long-term efforts to increase both capacity and resources, if needed. The planning process must also link the overall plan with disease-specific plans and programmes within the sector.

The levels to be considered for roles and responsibilities differ in different settings but are likely to include: individuals and households; communities; primary level; secondary level; tertiary level; and managerial units at all levels, such as district health offices and ministries of health. The roles and responsibilities cut across both curative and public health. They also involve intersectoral action, particularly at the managerial levels.

Formal planning for operational units within governments is often done on a yearly or biennial basis, frequently tied to the fiscal cycle of the government. The monitoring process for the plan should be carried out at regular intervals throughout the implementation period. Re-planning based on the results of monitoring is often necessary and should be an option available to managers, if justification can be given.

6.1.4 Private sector requires special consideration

Planning in more highly privatized systems is much more diffuse. Influencing the behaviour and performance of private systems often depends on combining both incentives (e.g. reimbursement, continuing education, promotion and recognition) and sanctions (e.g. licensing, regulation and fines). If the roles and responsibilities of all actors in the system are well understood, accountability for outcomes can be stronger, and action to improve both outcomes and accountability is more likely. However, such accountability requires that accurate information exists and the managers are sufficiently empowered to perform their roles.

6.2 Management as a core function at all levels

Management of health services is a core function. Management occurs at all levels from community to facility to mid-level and at provincial and national levels. The degree of responsibility and authority at each level will vary from country to country. However, management at the operational level, where services are actually delivered, is crucial.

Box 7. Management Matters, Not Just Resources

Service delivery depends on having necessary resources (staff, drugs, equipment, information, etc.), but it also depends to a large degree on how those resources are managed. The success of any organized health programme, in any country, depends on effective management. Many health systems worldwide face a lack of competent managers. Weakness in managerial capacity, especially at peripheral levels, has been widely cited as a constraint to scaling up or improving health services and a factor limiting the capacity of the health sector to address inequity.

Managers are a vital component of the health workforce. If they are not present in sufficient numbers and with appropriate skills, the system cannot function. They are needed at all levels of services and facilities to support implementation of national health plans.

Health managers - an invisible backbone for health systems

Managers should spend a substantial part of their time managing resources and partnerships to ensure provision of services needed by the population. Other important management functions include: respectful and non-hierarchical modes of communication, participatory strategies that actively engage staff and the community, collaboration and teamwork, partnerships between departments, agencies and sectors, and the ability to learn and adapt to health system and contextual changes.

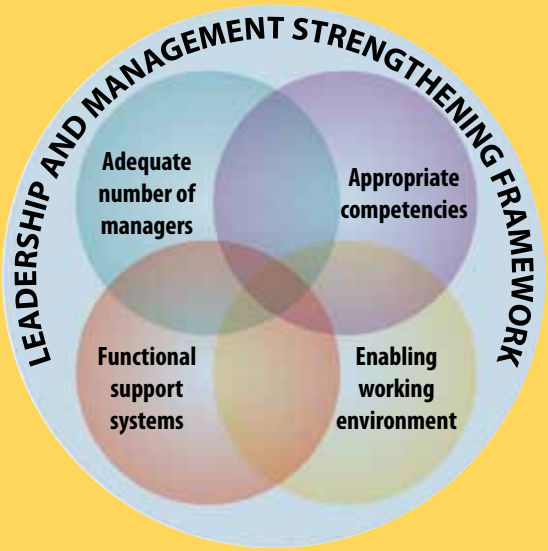
Key management posts are those where the decisions and actions taken have greatest impact on improving coverage and quality of service delivery. These posts should be identified and properly described and formalized in terms of clarity of role, authority and expected performance; the competencies required; job descriptions based on these; linkages between levels; and appropriate salary packages.

Where and how you train managers make a difference

Years of relying upon formal management courses have not delivered concrete results. One reason is that front-line managers have not been supported to translate training into actions at the workplace. Different aspects of management competencies are developed in different ways. *Knowledge* can be gained in the classroom; *skills* are built through action learning and at the workplace; while *attitudes* are shaped with experience and depend on the local social and work environments. Management competencies will be learnt most effectively if training takes place where people work, with the team that works together and when it addresses what they experience daily in their jobs.

On the job, with their team and where they work.

OVERALL ACTIONS TO STRENGTHEN HEALTH SYSTEMS



Training alone is not enough

Even with action learning and on-the-job training to develop competencies, improvements in service delivery will only occur if managers have the necessary resources, support systems and an enabling work environment. Strengthening management must be seen in the context of overall health system strengthening. Management training alone cannot overcome major system weaknesses, especially lack of resources.

Source: Management for health services delivery. World Helath Organization. Available at http://www.who.int/management/en

Management does not occur in a vacuum. There must be national leadership and a management strengthening framework within which individual managers operate. The key elements that must be present for successful management have been identified as:

- adequate numbers of managers;
- managers with the appropriate skills;
- an enabling work environment;
- a functional support system.[47]

Referral and supervisory systems must be defined as part of the management structure. Training alone rarely resolves managerial problems, particularly when managers are not empowered with adequate resources or authority. Delivering on PHC reforms requires a sustained management capacity across levels of the system. [48]

6.3 Planning and management, even more crucial in low-resource settings if the Millennium Development Goals are to be met

Planning and management are even more crucial in low-resource settings. All service delivery requires good management, but when resources are scarce, skilled managers are needed even more. Getting the best health results from scarce resources necessitates careful priority setting, use of cost-effective interventions that benefit the most people, and correct targeting so that those with the greatest needs are reached. A public health approach is even more crucial in low-resource settings.

One of the ironies is that low-resource and high-need settings often have the least -skilled and least-experienced managers. When managers are inexperienced, it is even more important that there be strong functional support systems for them to work within. Supportive supervision by experienced managers using the principles of mentoring is needed in order to gradually increase the capacity to manage.

Setting priorities so that resources are expended on those actions that provide the most health gain are crucial. One reason that some countries achieve good health results with low spending is that interventions, such as clean drinking water and preventive care, can be provided almost universally at relatively little cost. Managers at all levels need to understand national and local health goals, the values that underpin them, and how the goals and values influence the allocation of resources when making service delivery choices. Potential tensions arising from those choices, such as striving for efficiency and achieving equity in health, or trade-offs between individual rights and the needs of the community, must be balanced.

47 Management for health services delivery. World Health Organization. Available at http://www.who.int/management/en/

48 *The World Health Report 2008. Op cit.*

In low-resource settings, it is desirable that the service delivery model and service delivery package be defined from household level upwards. It should include both personal and non-personal services, and includes promotion, prevention, cure and treatment, and rehabilitation. Accessibility, affordability, acceptability and availability of services of sufficient quality are key. The package should be universal, or if not yet universal, there should be a potential path to achieving that goal. In some low-resource settings, the feasible universal package may be quite limited.

An issue in many countries is the middle class, which frequently demands a level of service that is not feasible to be provided for the entire population. In many settings, the more affluent population is able to capture a disproportionate share of the public resources for health as compared to the poor. It is the role of the government to target public resources where the most health gain is achieved for the resources expended. This frequently means targeting public resources on low-income and underserved populations, which usually have the least political voice. That being said, the system must have a method for being responsive to the claims of the middle class. This requires considerable political and bureaucratic skill to balance competing demands. However, it must be done in a way that does not divert resources away from the areas of highest need.

Historically, there has been a tension between so-called vertical and horizontal approaches to health systems and primary health care, particularly in countries where aid is a major part of the sector. All health systems have vertical and horizontal components. The emphasis should be on what works while not losing sight of the fact that the health system must deal with the entire spectrum of human health.

The Millennium Development Goals is a set of targets that have been internationally adopted through the United Nations Millennium Declaration. While the MDGs are aimed at all countries, they are particularly relevant to the low-income countries with excessively high rates mortality and morbidity. High child and maternal mortality are particularly distressing in parts of the Western Pacific Region.

In settings where maternal and child mortality are still unacceptably high, cooperative work with various development partners takes on extreme importance. To achieve the MDGs in a timely and sustainable fashion, new ways of working that facilitate cooperative work across agencies and disciplines are needed.

Key issues to consider in low-resource settings include:

- National- and peripheral-level planning must be linked.
- Upgrade management at peripheral levels.
- Supportive supervision is needed where managers are less experienced or skilled.

- Rigorous priority setting is even more crucial in low-resource settings and is likely to include items that are not traditionally medical.
- A clear service delivery model that is feasible must be defined.
- A service package that is feasible and has the potential for being delivered universally must be defined and be the highest priority.
- Methods to avoid capture of public resources by the better off are needed, while still planning to meet their legitimate needs.
- Methods to integrate services in ways that make use of external funds more efficiently must be sought.
- Better cross-programme collaboration is necessary if there are to be effective services at grassroots level across the continuum of care.

Box 8. Strengthening Primary Health Care in the Lao People's Democratic Republic

A comprehensive primary health care programme has been in place in the remote Sayaboury province since 1991. It has achieved impressive results. Between 1996 and 2003, health facility utilization tripled, maternal mortality dropped 50%, and infant and child mortality dropped to less than one third the national average. These impressive changes were the result of a suite of interventions, coupled with modest but sustained support. Key interventions included: provincial and district management strengthening (training; regular supervision and performance assessment); training and regular supervision of dispensary staff, village health volunteers and traditional birth attendants; construction and upgrading of dispensaries; staff development opportunities and incentives such as free medical treatment for volunteers; provision of essential equipment and seed capital for the revolving drug fund. Technical and financial support were provided throughout the 12 years. The external financial investment, roughly US$4 million, was equivalent to US$1 per person per year.

Source : Perks C., Toole M.J., Phouthonsy K. District health programmes and health-sector reform: case study in the Lao People's Democratic Republic. Bulletin of the World Health Organization. 84(2):132–138, 2006.

Health care systems that are organized following the principles of primary health care do better at improving health outcomes, achieving universal coverage with financial risk protection, and achieving the most health gains relative to the money invested in health systems, than do systems not based on PHC principles. It is the intent of this Strategy to foster systems that reflect the values of primary health care.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7 Commitments

Strong health care systems based on the values of primary health care are the most efficient and effective way that health systems can contribute to both improved and equitable health outcomes.

Each Member State in the Western Pacific Region commits itself to the development of a strong and robust health system based on the values of primary health care. Each Member State will define its own path towards achievement of that vision. Member States are committed to an ongoing public policy dialogue on the vision for their health system. This dialogue will be open, two-way and continuous. Each Member State commits to developing and updating national health strategies that articulate that vision. A strong connection must be made from national strategy to implementation at the level of the users of services. National and subnational health plans in many settings provide a framework for activities to achieve and maintain the vision articulated in national strategies. Whether the national health strategy is implemented through incremental change or a more sweeping health sector reform depends on the context within each Member State. Member States will make an effort to communicate with and disseminate to relevant stakeholders the core elements of this strategy.

The World Health Organization commits itself to providing technical cooperation as requested to facilitate this process. WHO will work with Member States to develop and further refine norms and standards for health systems. Health policy development and health planning will play an important role within the WHO programme. WHO is committed to assisting countries in developing methods of health systems performance assessment that are tailored to their specific needs and providing cross-national comparative assessments where appropriate. WHO will be an advocate for health systems strengthening based on the values of primary health care and, where appropriate, will play a convening and honest broker role. WHO across its own programmes will develop a more integrated, health systems approach in its support to Member States. WHO will work with Member States to make the Regional Strategy available in appropriate languages within the Region.


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Annex 1

WORLD HEALTH ORGANIZATION | ORGANISATION MONDIALE DE LA SANTÉ

R E S O L U T I O N

REGIONAL COMMITTEE FOR THE WESTERN PACIFIC | COMITÉ RÉGIONAL DU PACIFIQUE OCCIDENTAL

WPR/RC61.R2
13 October 2010

WESTERN PACIFIC REGIONAL STRATEGY FOR HEALTH SYSTEMS BASED ON THE VALUES OF PRIMARY HEALTH CARE

The Regional Committee,

Mindful that a health system consists of all organizations, people and actions intended to promote, restore or maintain health, and that a good health system delivers effective, safe and quality interventions, when and where needed;

Recognizing that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being and that health systems are an important contributor to the realization of that right;

Acknowledging that strengthened health systems contribute to the realization of the right to the highest attainable standard of health and the achievement of global health goals, such as the Millennium Development Goals;

Reaffirming that strong health systems based on the values of primary health care and focused on a vision of providing universal coverage for quality health services can be an efficient and effective way to contribute to improved and equitable health outcomes;

…/

Noting that the values of primary health care to be considered for health systems, as contained in the Western Pacific Regional Strategy for Health Systems Based on the Values of Primary Health Care, include equity, social justice, universality, people-centredness, community protection, participation, scientific soundness, personal responsibility, self-determination and self-reliance;

Further noting that there are existing strategies in the areas of health financing, laboratory services, access to essential medicines, human resources for health, noncommunicable diseases and emerging diseases, and that these are consistent with the Western Pacific Regional Strategy for Health Systems Based on the Values of Primary Health Care;

Recognizing that the Regional Strategy builds upon and is consistent with *The World Health Report 2000 — Health Systems: Improving Performance; The World Health Report 2006: Working Together for Health; Everybody's Business: Strengthening Health Systems to Improve Health Outcomes;* and *The World Health Report 2008 — Primary Health Care: Now More Than Ever*;

Acknowledging that health systems are complex and diverse and that no single model of health systems strengthening is suitable for all countries and areas,

1. ENDORSES the Western Pacific Regional Strategy for Health Systems Based on the Values of Primary Health Care; [1]

2. URGES Member States:

(1) to commit to the development of strong and robust health systems based on the values of primary health care, leading to universal coverage of quality health services as each Member State defines its own path towards achievement of that vision;

…/

[1] Document WPR/RC61/5.

(2) to conduct an ongoing public dialogue on the national vision for their health system and to update health strategies and policies at appropriate times to articulate that vision;

(3) to disseminate, as appropriate, to relevant stakeholders the core elements of the Regional Strategy;

3. REQUESTS the Regional Director:

(1) to provide technical cooperation as requested by Member States to facilitate implementation of the strategy;

(2) to work with Member States to develop and further refine indicators and guidelines for health systems;

(3) to work with Member States in developing methods of health systems performance assessment that are tailored to their specific needs;

(4) to advocate for health systems strengthening based on the values of primary health care and, when appropriate, convene Member States and other stakeholders;

(5) to promote a more integrated health systems approach in WHO's support to Member States;

(6) to report periodically to the Regional Committee on implementation of the strategy.

Fourth meeting, 13 October 2010
WPR/RC61/SR/4

Annex 2A

HEALTH SYSTEMS INDICATOR TOOLKIT

Measuring Health Systems Strengthening and Trends: A Toolkit for Countries was developed by a working group under the leadership of WHO and the World Bank.

Further details are available at: http://www.who.int/healthinfo/systems/monitoring/en/index.html

INDICATORS PROPOSED FOR WESTERN PACIFIC REGIONAL STRATEGY FOR HEALTH SYSTEMS BASED ON THE VALUES OF PRIMARY HEALTH CARE

a. Leadership and governance

The monitoring and evaluation of governance of the health sector are part of a comprehensive health information system. The science of health system governance monitoring is not as long standing and well developed as other types of monitoring. However, there are useable frameworks and indicators available.[49] The indicators are more subjective than other health indicators, and actual data are often not present in international databases. A commitment to monitor governance, particularly in areas such as equity, may in itself facilitate improved governance and improved equity. Nevertheless, three indicators are presented for consideration.

Indicator No. 1: Policy Index Score

- Consists of 10 items scored either 0 or 1, leading to a maximum score of 10. The index measures the availability of the following policies: national health strategy, essential medicines list, drug procurement policies, national strategic plan for TB, national malaria strategy, completion of the UNGASS HIV/AIDS policy index, comprehensive reproductive health policy, multi-year plan for immunization, key health sector documents published, and mechanisms for client input such as surveys. Member States may want to consider other policy documents, such as presence of PHC policies, which are more relevant to their setting.

49 Toolkit for monitoring health systems strengthening. *Op cit*.

Indicator No. 2: Marker Indicators of Governance

- health worker absenteeism rates
- proportion of government funds which reach district-level
- stock-out rates of essential drugs
- proportion of informal payments in the public health care system
- proportion of pharmaceutical sales that are counterfeit
- existence of effective civil society organizations.

Indicator No. 3: An index of overall health sector governance

- Use of the World Bank's annual Country Policy and Institutional Assessment (CPIA), which is a composite measure of governance across all sectors.

b. Health care and financing

Indicator No. 1

- total health expenditure (THE) per capita in international and US$

Indicator No. 1a

- general government health expenditure as a proportion of total government expenditure

Indicator No. 2

- ratio of household out-of-pocket payments for health to total health expenditure

The following four indicators and targets are not in the HSS toolkit, but from the *Strategy on Health Care Financing for Countries of the Western Pacific and South-East Asia Regions (2006–2010)*:

- out-of-pocket expenditure should be less than 30%–40% of total health expenditure
- total health expenditure should be at least 4%–5% of total gross domestic product

- at least 90% of the population is covered by prepayment and risk-pooling schemes that provide significant social protection, and
- close to 100% of the vulnerable population is covered by social assistance and safety-net programmes.

c. Health workforce

Indicator No. 1

- Number of health workers per 10 000 population

Indicator No. 2

- Distribution of health workers: by profession/specialty, region, place or work and sex

Indicator No. 3

- Annual number of graduates of health professions education institutions per 100 000 population.

d. Medical products and technology

Indicator No. 1

- Percentage of facilities that have all tracer medicines and commodities in stock on the day of visit and in the last three months supplemented by median proportion of tracer drugs that are in stock on the day of the visit and in the last three months.

Indicator No. 2

- Ratio of median local medicine price to international reference price for core list of drugs

- NB: There was no indicator for essential health technology or laboratory. It is proposed that a third indicator be added regionally:

Indicator No. 3

- Existence of a national laboratory policy and strategic plan based on a robust situation analysis.

e. Information and research

Indicator No. 1

- Presence of components of a Health Information Performance Index (HISPIX) which is a summary measure based on the binary (yes/no) measure of 29 standardized indicators available in the public domain.

NB: The information in Appendix 2B may actually replace this measure.

f. Service delivery

Indicator No. 1

- Number and distribution of health facilities per 10 000 population

Indicator No. 2

- Number and distribution of in-patient beds per 10 000 population

Indicator No. 3

- Number, proportion, and distribution of health facilities with basic service capacity per 10 000 population

Indicator No. 4

- Number of out-patient department visits per 10 000 population

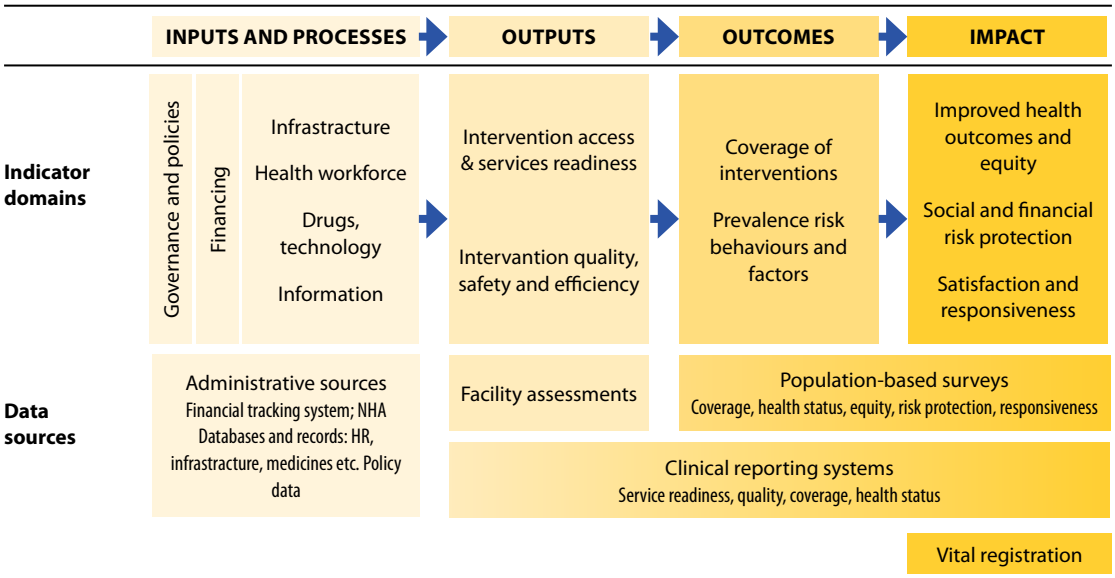
Indicator No. 5

- Service quality standard to be selected locally

Annex 2B

MONITORING AND EVALUATION OF HEALTH SYSTEMS REFORM

A general framework



Indicators: WHO core set

INPUTS AND PROCESSES	OUTPUTS	OUTCOMES	IMPACT
Health financing	***Service access and readiness***	***Coverage of interventions***	***Health status***
Total health expenditure per capita	Tracer medicines availability in health facilities	Antenatal care (4+ visits)	Life expectancy at birth
Health workforce	Median price ratio for tracer medicines	Skilled birth attendance	Child mortality (under-5)
Health workers per 10,000 population	Outpatient visits per person per year	DPT3 immunization coverage	Maternal mortality ratio
Annual number of graduates of health training institutions per 100,000 population	***Service quality, efficiency and safety***	Contraceptive prevelance	Mortality by major cause of death by sex and age
Infrastructure and IT	Facilities that meet with minimum infection control standards (%)	Children with ARI to health facility	TB prevalence in population
Health facilities per 10,000 population	TB treatment success rate (DOTS)	Children with diarrhoea receiving ORT	HIV prevalence among adults
Hospital beds per 10,000 population	30 day hospital case fatality rate AMI and stroke	Household ITN possession	Notifiable diseases (IHR)
% of doctors using electronic health records	Waiting time to elective surgeries: cataract	Cervical cancer screening (20-64 years)	***Financial risk protection***
	Surgical wound infection rate (% of operations)	ARV therapy	Out of pocket as % of total health expenditure
		ARV prophylaxis among HIV+ women	
		Health insurance	
		Risk factors and behaviours	
		Tobacco use (adults)	
		Access to safe water	
		Access to improved sanitation	
		Low birth weight among newborns	
		Breastfeeding exclusively for 6 months	
		Obesity in adults	
		Children under 5 who are stunted	
		Condom use at last higher risk sex	

WHO list of core indicators

No	Indicator	Additional dimension	Data sources (Preferred; Alternative)	M&E level; area/topic	Target*	Comparable data availability**	
						HIC	LMIC
SYSTEM INPUTS & OUTPUTS							
1	Total health expenditure per capita		National health accounts; Expenditure review	Input; financing	●●	good	fair
2	General government expenditure on health as % of total government expenditure		National health accounts; Expenditure review	Input; financing	●●	good	fair
3	Health workers per 10,000 population	Doctor, nurse/ midwife; urban - rural	Administrative records, census, facility assessment	Input; human resources	●●	good	poor
4	Percent of deaths that are registered	Percent of births that are registered	Administrative records	Input; information	●●●	good	fair
5	National health strategy having the main attributes (IHP+)		Review of national health strategy	Input; governance	●●●	–	–
6	Health facilities per 10,000 population	Hospital beds per 10,000 population	Administrative records	Output, access	●●	good	fair
7	Tracer medicines availability in health facilities	Public - private	Facility assessment	Output, access	●●●	poor	fair
8	Median price ratio for tracer medicines	Public - private	Facility assessment	Output, access	●●●	poor	fair
9	Outpatient visits per person per year	Hospital admission rate	Facility reports, facility assessment	Output, utilization	●	fair	poor
10	TB treatment success rate		Facility reports	Output, quality; TB	●●●	good	good
11	30-day hospital case fatality rate acute myocardial infarction	Stroke	Hospital records	Output, quality; NCD	●●	fair	poor
12	Waiting time to elective surgery: cataract	Coronary angioplasty (PTCA), hip replacement	Hospital records	Output, access; NCD	●●	poor	poor
13	Surgical wound infection rate (% of all surgical operations)		Hospital records	Output, quality	●●●	poor	poor

No	Indicator	Additional dimension	Data sources (Preferred; Alternative)	M&E level; area/topic	Target*	Comparable data availability**	
						HIC	LMIC
COVERAGE & RISK FACTORS							
14	Antenatal care coverage (4+ visits)	ANC coverage (1+ visits)	Survey, facility reports	Outcome; MNCH	●●●	poor	fair
15	Skilled birth attendance	Institutional delivery rate	Survey, facility reports	Outcome; MNCH	●●●	fair	fair
16	DPT3 Immunization coverage	Measles, HiB	Survey, facility reports	Outcome; MNCH	●●●	good	good
17	% of need for family planning satisfied	Contraceptive prevalence	Survey, facility reports	Outcome; MNCH, RH	●●●	poor	fair
18	Children with ARI taken to health facility	Received antibiotics	Survey	Outcome; MNCH, pneumonia	●●●	poor	fair
19	Children with diarrhea receiving ORT	With continued feeding	Survey	Outcome; MNCH, diarrhea	●●●	poor	fair
20	ITN use among children	ITN use among pregnant women, Household ITN possession	Survey	Outcome; MNCH, malaria	●●●	NA	fair
21	ARV therapy among people in need		Facility reports	Outcome; MNCH, HIV	●●●	poor	fair
22	ARV prophylaxis among HIV+ women (PMTCT)		Facility reports	Outcome; MNCH, HIV	●●●	poor	fair
23	Cervical cancer screening (20-64 yrs)	Breast cancer screening (50-69 yrs)	Survey, facility reports	Outcome; NCD	●●●	good	poor
24	Condom use by young people (15-24 years old) at last higher risk sex	Adults (15-49 years old)	Survey	Outcome; HIV/STI	●●	poor	fair
25	Population using improved drinking water sources	Urban - rural	Survey	Outcome; Env. Health	●●●	good	fair
26	Population using improved sanitation facilities	Urban - rural	Survey	Outcome; Env. Health	●●●	good	fair
27	Tobacco use (adults)	Youth (13-15), Male - female	Survey	Outcome; NCD	●●●	good	fair
28	Low birth weight among newborns		Survey, facility reports	Outcome; MNCH	●●	fair	poor
29	Breastfeeding exclusively for 6 months	Initiation first hour	Survey	Outcome; MNCH	●●●	poor	fair
30	Obesity in adults (over 15)	Overweight	Survey	Outcome; NCD	●●	fair	poor

No	Indicator	Additional dimension	Data sources (Preferred; Alternative)	M&E level; area/topic	Target*	Comparable data availability**	
						HIC	LMIC
31	Children under 5 who are stunted	Underweight; overweight; wasted	Survey	Outcome; MNCH, NCD	●●	good	good
32	Alcohol: Heavy episodic drinking		Survey	Outcome; NCD	●●●	fair	fair
HEALTH STATUS							
33	Life expectancy at birth	Life expectancy at age 65, Male - female	Death registration; survey, census	Impact, all	●	poor	fair
34	Child mortality (under-5)	Neonatal, infant, perinatal	Death registration; survey, census	Impact; MNCH	●●●	fair	fair
35	Maternal mortality ratio		Death registration; survey, census, facility reports	Impact; MNCH	●●●	good	good
36	Mortality by major cause of death by sex and age	Top 20 major causes of death, ICD based	Death registration; facility reports, survey	Impact; all	●	poor	fair
37	TB prevalence in population	TB notification rate, TB incidence	Survey, facility reports	Impact; TB	●●	poor	fair
38	HIV prevalence among 15-24 years old	HIV incidence among adults 15-49 years old	Sentinel facilities, survey	Impact; HIV	●●	poor	fair
39	Notifiable diseases (IHR)		Disease surveillance reports	Impact; all	●●●	good	poor
FINANCIAL PROTECTION							
40	Out of pocket as % of total health expenditure	% of households impoverished annually by out-of-pocket payments	National health accounts; survey	Impact; protection	●●	good	fair

* Classification of "target":

●●● clearly set

●● can be set

● unclear/difficult to set

** HIC: High-income countries

LMIC: Low- and middle-income countries

Annex 3

LISTING OF RELEVANT GLOBAL AND REGIONAL STRATEGIES

World Health Reports

The World Health Report 2000. Health systems: improving performance. Geneva, World Health Organization, 2000. Available at http://www.who.int/whr/2000/en/whr00_en.pdf

The World Health Report 2006. Working together for health. Geneva, World Health Organization, 2006. Available at http://www.who.int/whr/2006/whr06_en.pdf

The world health report 2008. Primary health care: now more than ever. Geneva, World Health Organization, 2008: XV. Available at http://www.who.int/whr/2008/whr08_en.pdf

Regional Strategies

Health Financing Strategy for the Asia Pacific Region (2010–2015). Manila, World Health Organization, 2009. Available at http://www.wpro.who.int/internet/resources.ashx/HCF/HCF+strategy+2010-2015.pdf

Regional Strategy on Human Resources for Health (2006–2015). Manila, World Health Organization, 2007. Available at http://www.wpro.who.int/publications/PUB_978+92+9061+2445.htm

Regional Strategy for Improving Access to Essential Medicines in the Western Pacific Region (2005–2010). Manila, World Health Organization, 2005. Available at http://www.wpro.who.int/publications/PUB_9290611855.htm

Asia Pacific Strategy for Strengthening Health Laboratory Services (2010–2015). Manila, World Health Organization, 2010. Available at http://www.wpro.who.int/publications/PUB_9789290614296.htm

Regional Strategy for Traditional Medicine in the Western Pacific Region. Manila, World Health Organization, 2002. Available at http://www.wpro.who.int/publications/pub_9290610115.htm

Annex 4

GROUPING OF COUNTRIES AND AREAS GEOGRAPHICALLY AND BY INCOME

	Pacific island countries and areas	Asia
Low-income country	Papua New Guinea, Solomon Islands	Cambodia, the Lao People's Democratic Republic, Mongolia, Viet Nam
Low middle-income country	Fiji, Kiribati, the Marshall Islands, the Federated States of Micronesia, Samoa, Tonga, Vanuatu	China, the Philippines
Upper middle-income country	American Samoa, the Commonwealth of the Northern Mariana Islands, Palau	Malaysia
High-income country	French Polynesia, Guam, New Caledonia	Australia, Brunei Darussalam, Hong Kong (China), Japan, Macao (China), New Zealand, the Republic of Korea, Singapore
Uncategorized	Cook Islands, Nauru, Niue, the Pitcairn Islands, Tokelau, Tuvalu, Wallis and Futuna	

Source: Social determinants of health. Health in Asia and the Pacific. New Delhi, World Health Organization, 2008: 7-33. Available at http://www.wpro.who.int/publications/Health+in+Asia+and+the+Pacific.htm

WHO Western Pacific Region
PUBLICATION
ISBN-13
978 92 9061 501 9

Regional Strategy for Health Systems Based on the Values of Primary Health Care

Vision:
Universal coverage for better health outcomes

Core values of PHC:

- Equity
- Social justice
- Universality
- People-centredness
- Community protection
- Participation
- Scientific soundness
- Personal responsibility
- Self-determination
- Self-reliance

World Health Organization
Western Pacific Region

The core values of PHC underpin effective, efficient and equitable health systems.

Leadership and governance

Government has responsibility for the people's health.

Health financing

Cost of health care should not increase poverty. Resources to primary care are essential.

Health workforce

Innovative staff deployment and incentives for people-centred, continuous and close-to-client care.

Medical products and technology

Access to safe essential medicines and technologies is the right of every patient.

Information and research

Use information for decision-making. Disaggregated information needed to monitor inequity.

Service delivery

Realistic service delivery model for integrated services close to the people and responsive to their needs.

World Health Organization
Western Pacific Region

www.wpro.who.int