Universal Health Coverage: Moving Towards Better Health

Action Framework for the Western Pacific Region
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Action Framework for the Western Pacific Region
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ABBREVIATIONS

ADB  Asian Development Bank
CHIPS Country Health Information Profiles (Western Pacific Region)
DHIS2 District Health Information System version 2
DRGs diagnosis-related groups
FFS fee for service
HIIP Health Information and Intelligence Platform
HMIS Health Management Information Systems
ICT information and communications technology
IHP+ International Health Partnership
IHR International Health Regulations (2005)
M&E monitoring and evaluation
MDGs Millennium Development Goals
m-health mobile health
NCD noncommunicable disease
SARS severe acute respiratory syndrome
SDGs Sustainable Development Goals
SFFC spurious/falsely-labelled/falsified/counterfeit
STI sexually transmitted infection
TB tuberculosis
UHC universal health coverage
UNAIDS Joint United Nations Programme on HIV/AIDS
WHO World Health Organization
FOREWORD

Over the past decade, Member States in the WHO Western Pacific Region have made significant health gains with increased commitments to advance Universal Health Coverage (UHC). UHC is a vision of all people obtaining quality health services without suffering financial hardship. As a goal of health sector development, UHC is one of the targets of the Sustainable Development Goals (SDGs). UHC also serves as the foundation for the health SDGs while contributing to other SDGs as a pathway to equitable and sustainable health outcomes and resilient health systems.

While working to maintain health gains in the Region, we are constantly faced with new challenges. These challenges are increasingly complex, often spurred by changing demographic and epidemiological profiles, emerging diseases, economic volatility and reduced external funding, among other factors.

At the same time, many Member States are experiencing rapid socioeconomic development, with a corresponding rise in people’s expectations and demands for more and higher-quality health services.

At the sixty-sixth session of the Regional Committee for the Western Pacific, Member States adopted a resolution on UHC (WPR/RC66.R2) and endorsed Universal Health Coverage: Moving towards Better Health — an action framework that provides guidance for Member States to accelerate progress towards UHC and some SDGs.

There is no one-size-fits-all plan to achieve UHC. However, the framework calls on Member States to realize the vision of better health by taking a comprehensive, whole-of-system approach.

The framework supports Member States to develop their own UHC road maps by tailoring a group of interconnected actions as part of their national health policy and planning processes. To that end, the framework identifies 15 action domains under five interrelated attributes of a high-performing health system: quality, efficiency, equity, accountability, and sustainability and resilience.

Member States are not meant to adopt all of the actions at the same time. They are encouraged to select a combination of actions based on their unique context to address their health needs over time according to their ability.

In developing its own road map, each Member State should assess its progress towards UHC, identify gaps, select entry points and opportunities for change, cultivate an enabling environment and intersectoral collaboration across government
and for stakeholder engagement, ensure financial sustainability, and continue to monitor and evaluate progress.

Member States at all levels of development can take steps to advance UHC. WHO is committed to facilitate Member States’ actions to make UHC a reality.

Working together, we can help the Region’s 1.8 billion people access good-quality and affordable health services and enjoy the highest attainable standard of health as a basic human right for all.

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

Background

Universal health coverage (UHC) – defined as all people having access to quality health services without suffering the financial hardship associated with paying for care – is the overarching vision for health sector development (WHO, 2013a). Over the past decade, Member States of the Western Pacific Region have made significant health gains and commitments to UHC. Many Member States are addressing in their health system reforms the essential attributes of high-performing health systems: quality, efficiency, equity, accountability, sustainability and resilience.

However, the Western Pacific Region faces challenges posed by changing epidemiological and demographic profiles, urbanization and migration, climate change, emerging diseases, and disparities within countries. Sustainable financing is needed along with responsive services. Progress towards UHC needs to be accelerated.

In 2012 and 2013, an extensive review of the six Western Pacific Region health systems strategies highlighted Member States’ desire for a whole-of-system approach to health system development and their commitment to advance UHC. A 2014 progress report on UHC to the Regional Committee for the Western Pacific (WHO, 2014a) also emphasized the importance of country-specific approaches to UHC in national health policies and strategies.

Universal Health Coverage: Moving Towards Better Health is an action framework that has been developed to support countries in realizing this vision of better health through UHC. It outlines shared principles of UHC and reflects the values of the World Health Organization (WHO) Constitution, the Health for All agenda set by the Alma-Ata Declaration in 1978 and multiple World Health Assembly resolutions.

Essential attributes and actions for UHC

There is no one-size-fits-all formula to achieve UHC, as health systems necessarily reflect their social, economic and political contexts, as well as historical decisions about national priorities. Universal Health Coverage: Moving Towards Better Health provides a platform for strategic advancement of UHC. Fifteen action domains are outlined across the five essential health system attributes (Table 1). These attributes are reflected in health policy objectives across the Region, while the actions echo country, regional and global experiences.
The action domains are intended to guide countries in developing country-specific road maps towards UHC, recognizing that the choice and combination of actions will be considered in the context of national needs and capacities. Member States are encouraged to prioritize multiple actions that are mutually reinforcing and embed them in their national health policies and reforms as they move towards attainment of the UHC vision and the Sustainable Development Goals (SDGs).

**TABLE 1. Health system attributes and action domains for UHC**

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<th>HEALTH SYSTEM ATTRIBUTES</th>
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**Quality**

The quality and safety of health services delivered at individual and population levels are fundamental to improving population health. Member States face barriers to quality and safety, leading to overuse, underuse or misuse of services and resources. These issues can be addressed by strengthening regulations and the regulatory environment, developing effective and responsive individual and population-based systems and services, and engaging individuals, families and communities.
Efficiency

Efficiency is about maximizing output from a given level of input. Making the best use of existing health service resources is important, because no country has sufficient resources to address all the health needs of its population. Developing efficient health services increases health resource availability; however, greater investments may also be needed as a starting point to improve efficiency. Efforts to improve health system efficiency could include ensuring health system design meets population needs, incentivizing appropriate provision and use of services, and enhancing managerial efficiency and effectiveness.

Equity

Equity is the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically. Health equity can only be achieved when every individual has the opportunity to attain his or her full health potential. Inequities in health are determined by social, economic and environmental factors, many of which lie beyond the health sector. Reducing health inequities is challenging, but necessary to ensure social justice along with improved overall health outcomes. Key actions to achieve health equity include implementing financial protection mechanisms to reduce any economic barriers to accessing health services, promoting connectivity between health and social protection, ensuring access to quality services by disadvantaged groups, and applying non-discrimination as a broader social policy.

Accountability

Health systems are comprised of many stakeholders that are accountable to each other. Accountability entails obligations of stakeholders to provide information and justify their decisions and actions, and the imposition of sanctions and rewards. In any governance arrangement, health sector leadership and vision must be established to set expectations and drive health system performance. Legislative and regulatory arrangements are also central to good accountability systems. Good governance and maintaining feedback mechanisms to obtain information for improving performance entail strengthening management and institutional processes. Priority actions for improving accountability include strengthening government leadership and rule of law for health, engaging in partnerships for public policy, and ensuring mechanisms for transparent monitoring and evaluation.
Sustainability and resilience

Health systems should be designed for long-term sustainability, ensuring they can reliably meet current and future health needs of the population. Resilience is the ability of health systems to cope with internal and external shocks and recover quickly, as well as continuing to prepare for and adapt to changing environments. Disasters, emerging diseases and economic volatility pose serious threats to public health security and the ability of health systems to respond to such events. To ensure resilience for combating shocks and sustaining progress, Member States need to enhance public health preparedness, develop community capacity for health protection and promotion, and ensure health system adaptability and sustainability.

Monitoring progress

Monitoring progress towards UHC at local, regional and global levels helps countries determine where they stand and provides evidence to inform policy. Monitoring at the regional level will be guided by a monitoring framework, which takes into account the Millennium Development Goals (MDGs), the SDGs and the Global Reference List of 100 Core Health Indicators (WHO, 2015a). Monitoring at the country level should be guided by the country-specific UHC road map.

The way forward

Member States

Member States have affirmed their commitment to advancing UHC and incorporated UHC objectives in their national health policies and reforms. Identifying novel entry points unique to their own environment and seeking opportunities for change will enhance this progress.

While the actions outlined address challenges faced generally by Member States in the Region, they are not ready-made for specific country situations. Each Member State should assess country progress towards achieving UHC, identify gaps and select strategic entry points and opportunities for change, design and implement a country-specific UHC road map as part of the national health policy and planning process or health sector reform, cultivate an enabling environment across government for success, ensure financial sustainability, develop stakeholders’ capacities for engagement, and monitor and evaluate progress.
The country-specific road map depends on the history, political economy, available resources and expectations. With limited resources, Member States always have to make trade-offs in prioritizing investments in health, which are taken within the context of their burdens of disease, institutional capacities and levels of community engagement, among other factors. Member States will not be able to address all of the action domains at the same time. However, through appropriate sequencing, governments can demonstrate the leadership and direction that are critical to guiding health systems towards achieving equitable and sustainable health outcomes.

**WHO Regional Office for the Western Pacific**

WHO Regional Office for the Western Pacific is deeply committed to UHC as the overarching vision for health sector development in the Western Pacific Region. The Regional Office will continue to support Member States to advance towards UHC through facilitating high-level multisectoral policy dialogue, providing technical support, building country capacity and platforms for sharing regional experience, engaging with development partners to support the national planning process and ensure donor funding alignment with national health priorities, and establishing a regional platform for reporting progress and exploring solutions to move faster towards UHC among Member States, technical experts and development partners.
Introduction

Healthy people spur healthy economies. Strong health systems are necessary to achieve healthy populations. At present not everyone has access to health services, including prevention and health promotion, to achieve and maintain good health. Social determinants of health shape the patterns of health in communities as well as access to services. Without healthy populations, sustainable development is imperilled.

There is global recognition of the fundamental role of healthy populations to sustain economic development, as seen by the inclusion of health indicators in the post-2015 development agenda (Global Health Strategies, 2012). Consequently, investing in effective health systems is key to safeguard development gains and to attain greater economic progress. At the heart of universal health coverage (UHC) lies effective health systems that place patients, families and communities at the centre.

The World Health Organization (WHO) defines "universal health coverage" to mean that all people can access quality health services, without suffering financial hardship associated with paying for care (WHO, 2013a). UHC is a journey rather than an end goal. Given diverse sociopolitical and cultural contexts and capacities, there
is no standard formula for UHC in all countries in the Western Pacific Region. However, all countries can take actions to accelerate progress towards UHC, or to maintain their gains. Even in countries where health services have traditionally been accessible and affordable, governments need to constantly strive to respond to the ever-growing health needs of their populations and other threats, including developing financial sustainability to endure economic shocks. Clearly, UHC remains a health and socioeconomic imperative in all countries in the Region.

High-performance health systems are characterized by five attributes: quality, efficiency, equity, accountability, sustainability and resilience. Achieving UHC requires actions that support the achievements of these attributes. Countries in the Western Pacific are at different stages of health systems development and have been strengthening health system foundations through work on six health system building blocks, which underpin the priority action domains of UHC and are needed to achieve outcomes and impact (Fig. 1). Taking a whole-of-system approach with more integrated service delivery and strengthened primary care ensures health systems are placing individuals, families and communities at the centre.

FIGURE 1. Relationship between health systems building blocks, attributes and action domains leading to UHC
UHC in the Western Pacific Region

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.

— Sixty-third session of the Regional Committee for the Western Pacific, 2010

VISION

Universal health coverage for better health outcomes

The Western Pacific Region is home to one quarter of the world’s population. The Region is undergoing economic transition, which is creating tremendous change in health. Globalization, urbanization, technological innovation, environmental change and shifting demographics are creating opportunities that make better health possible. But these same forces can also increase the complexity of health problems and complicate the process of developing and implementing solutions in an equitable and timely manner. There has been significant progress made in trying to reach the Millennium Development Goals (MDGs) for child health and communicable diseases with many countries and areas in the Western Pacific Region expected to achieve their 2015 targets. For example, HIV incidence has decreased in many countries, such as Cambodia, Malaysia, Papua New Guinea and Viet Nam, and tuberculosis targets have been reached. Compared to other regions, the Western Pacific Region is on track to achieve nearly all of the health-related MDGs (WHO, 2014a).

Sustaining the gains made and addressing new challenges, such as noncommunicable diseases (NCDs), viral hepatitis, antimicrobial resistance and ageing populations, will be equally if not more important in the years to come. For example, the major NCDs represent more than 80% of all deaths in the Region (WHO, 2014b), while the top 10 countries with the highest rate of diabetes globally are in the Pacific (World Bank, 2014). In addition, over 100 million people suffer from mental disorders in the Region, with 500 suicides occurring per day in the Region (WHO, 2014b). Health systems in the Region are increasingly challenged to provide all people with access to quality health services that do not leave anyone vulnerable to financial hardship from personally paying for needed health care.
In the Asia Pacific region, an estimated 105 million people suffer financial catastrophe, and more than 70 million are impoverished, because of health-care costs (WHO, 2009). Many countries are still heavily reliant on out-of-pocket payments in order to finance their health systems. Moreover, 900 million people in the Western Pacific live on less than US$ 2 a day (Asian Development Bank and World Trade Organization, 2011). These individuals and families have no or little access to health care. For many countries in the Region, per capita government allocations for health remain low. This situation can push large numbers of households into poverty due to ill health and out-of-pocket spending for health care. In addition, these factors threaten to impede economic progress and may even reverse recent gains in development status. In the Pacific, countries face economic volatility with significant portions of their funding coming from donors.

Efforts to improve the efficiency of service delivery and obtain more value for the money are essential as Pacific island countries face unpredictable and reduced donor funding streams. The mobilization of more domestic funding for health and more efficient use of resources are fundamental to accelerating progress towards UHC. Using WHO’s framework for health systems strengthening (WHO, 2007a), the Western Pacific Region developed six regional strategies and frameworks for action specifically in the areas of essential medicines and technologies, human resources for health, health financing, laboratory services, traditional medicine, and health systems strengthening based on the values of primary health care. At the sixty-third session of the Regional Committee for the Western Pacific in 2010, Member States and WHO jointly articulated a vision of “universal health coverage for better health outcomes”.

**VISION**

Universal health coverage for better health outcomes

*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.*

– Sixty-third session of the Regional Committee for the Western Pacific, 2010

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In 2012–2013, an extensive review was conducted on the six regional health systems strategies. Findings from the review showed that health system strategies and frameworks provided guidance for countries in developing their country-specific policies, strategies and health sector reform plans. Adaptations to the individual country’s context were often necessary during implementation (WHO, 2013b). The review also confirmed Member States’ common desire for a whole-of-system approach to health system strengthening and their commitment to advancing UHC to meet the needs of different country contexts and rapidly changing environments.

In 2014 a regional progress report on UHC was presented to the Regional Committee. The progress report highlighted the roles of government and the importance of equity, efficiency, accountability and country-specific approaches to advancing UHC through the implementation of national health plans (WHO, 2014c). The review also showed the importance of adopting a whole-of-system approach to health system development and ensuring that strategies are adapted to country contexts. From this perspective, country-specific actions for UHC will be the focus of future work, supported by evidence on individual health system performance and international lessons learnt on health systems and policies.

UHC is not a new concept. Member States of the Western Pacific Region have made significant health gains and commitments to UHC over the past decade. Many are addressing the five attributes of high performing health systems – quality, efficiency, equity, accountability, sustainability and resilience – in their national policies and plans and making great strides in their ongoing health sector reforms. Progress has been made in strengthening health system stewardship, improving financial protection, ensuring equity in access to quality health services and using resources efficiently.

However, challenges remain and progress towards UHC needs to be accelerated. Health service demands are growing and changing, driven by population mobility and population growth in some countries, environmental pressures from natural and human-induced disasters, the emergence of new diseases and re-emergence of previously controlled diseases, growth of NCDs, and higher expectations from populations to have quality health services. These pressures, along with new medical technologies and inadequate preventive measures, contribute to the rising cost of health care.
BOX 1. Articulating aspirations for UHC in national health policies and strategies in the Western Pacific Region

Across all levels of development, almost all Member States in the Western Pacific Region have embraced the UHC goal. An analysis of national plans and policies developed between 2005 and 2015 highlighted the different ways Member States have articulated these aspirations.

Cambodia: “Provide stewardship for the entire health sector and to ensure supportive environment for increased demand and equitable access to quality health services in order that ALL the peoples of Cambodia are able to achieve the highest level of health and well-being.” Ministry of Health, Cambodia, 2008

Fiji: “To provide high-quality health-care delivery services by a caring and committed workforce with strategic partners...facilitating a focus on patient safety and best health status for all of the citizens of Fiji.” Ministry of Health, Fiji, 2011

The Lao People’s Democratic Republic: “Reach UHC by 2025”; “a sector-wide/systematic approach to achieve a common goal – affordable, reliable, accessible health service to all Lao people.” Ministry of Health, Lao People’s Democratic Republic, 2014


Mongolia: “…responsive and equitable, pro-poor, client-centred and quality services.” Ministry of Health, Mongolia, 2005


The Philippines: “The implementation of Universal Health Care shall be directed towards ensuring the achievement of the health system goals of better health outcomes, sustained health financing and responsive health system by ensuring that all Filipinos, especially the disadvantaged group in the spirit of solidarity, have equitable access to affordable health care.” Department of Health, Philippines, 2010

Samoa: “Promotion of appropriate and affordable health services which enables EQUAL access by ALL the people of Samoa.” Ministry of Health, Samoa, 2008

Viet Nam: “UNIVERSAL health insurance coverage by 2014”; “Continue to develop a health-care system towards equity, efficiency and development, improving quality of care, meeting the growing and diverse needs for health care.” Ministry of Health, Viet Nam, 2010
2. Purpose and structure of this document

Member States are striving to improve their health systems and sustain progress in coping with the constant demand for better health. The Western Pacific Region is strongly committed to attaining the vision of UHC for better health outcomes. This document, created with input from Member States and experts, is designed to support countries to put together their own pathways to realize this vision of better health through UHC.

This document identifies 15 action domains and related priority actions, organized along the five essential attributes of high-performance health systems (Table 1). Countries can use these strategically to advance UHC. The actions summarized under each domain are based on country experiences in this Region and beyond, and reflect the values of the WHO Constitution, the Health for All agenda set by the Alma-Ata Declaration in 1978, and the principles and strategies for health system development.

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                          | 1.2 Effective, responsive individual and population-based services  
                          | 1.3 Individual, family and community engagement |
| 2. EFFICIENCY            | 2.1 Health system architecture to meet population needs  
                          | 2.2 Incentives for appropriate provision and use of services  
                          | 2.3 Managerial efficiency and effectiveness |
| 3. EQUITY                | 3.1 Financial protection  
                          | 3.2 Service coverage and access  
                          | 3.3 Non-discrimination |
| 4. ACCOUNTABILITY        | 4.1 Government leadership and rule of law for health  
                          | 4.2 Partnerships for public policy  
                          | 4.3 Transparent monitoring and evaluation (M&E) |
| 5. SUSTAINABILITY AND RESILIENCE | 5.1 Public health preparedness  
                                  | 5.2 Community capacity  
                                  | 5.3 Health system adaptability and sustainability |
The action domains and priority actions are also a further specification of how work on health system building blocks relates to achievement of health system attributes (Annex 1). As such, they provide a menu for countries to align with their country-specific priorities and needs. Countries in the Western Pacific Region are at different stages of attaining UHC, with diverse sociopolitical and economic contexts and capacities. Strategic selection of a sequence and a combination of actions will help countries address immediate needs while providing a pathway for the future.

All action domains are relevant to health systems at all stages of development, although the degree of emphasis may vary as health systems mature. Health systems with more limited resources may offer only essential medicines and basic health services, focusing on achieving priority health goals through essential public health services and primary care. Maturing health systems can expand the range of services offered and allocate resources towards ensuring improved quality. More advanced health systems can be expected to offer more comprehensive service coverage, including more specialized services at all levels of the health system. Resources may be allocated for developing greater adaptive capacity to address new and emerging health challenges. The drivers of control should include community participation and feedback.

There is no one-size-fits-all formula for achieving UHC. However, the 15 action domains and related specific actions identified in this document provide an entry point for countries to "mix and match" in customizing their approach to UHC. Member States are encouraged to design their own unique road map to better health by prioritizing multiple actions that are mutually reinforcing and to embed them in their national policies or health sector reform action plans. UHC is the overarching vision for health sector development, and these action domains and actions can guide countries in moving faster towards realizing that vision.
3. Essential attributes, action domains and key actions for UHC

**ATTRIBUTE 1 QUALITY**

Quality encompasses the safety and effectiveness of both individual and population-level interventions. Quality also implies a satisfactory experience for the user. Poor quality of services includes the overuse, underuse or misuse of health services and resources, often co-existing in the same system. Improving quality of services requires a people-centred and integrated health service delivery system. By adopting such a system, services become more responsive to individuals and communities (WHO, 2015c).

Quality and safety issues are receiving increasing attention by Western Pacific Region countries. Concerns for quality are reflected in the *Action Agenda for Antimicrobial Resistance in the Western Pacific Region* and the *Action Plan for Healthy Newborn Infants in the Western Pacific Region (2014–2020)*. Strengthening legislation and regulation has been identified as a top priority to improve quality. Most countries in the Western Pacific Region have professional certification or licensing systems. There are some concerns with enforcement of such systems and continuing professional development. A lack of regulation and/or enforcement puts people at serious risk, and exposes the health system to higher costs. In 2014, for example, unsafe injection practices by an unlicensed and untrained service provider resulted in an outbreak of HIV in a Cambodian province (Ministry of Health, Kingdom of Cambodia, WHO & the Joint United Nations Programme on HIV/AIDS [UNAIDS], 2015). The event triggered a comprehensive review of health workforce regulations among other measures. Over-the-counter sales of antibiotics contributing to drug resistance have also been a great challenge for many countries, including China, the Lao People’s Democratic Republic, the Philippines and Viet Nam.

Improvement also depends on having additional parameters in place. Evidence-informed protocols, processes to review how well services have been delivered, and service models designed around the needs of patients and communities should also be considered. Clinical practice guidelines are increasingly being used across the Region, including in Australia, China, Japan, New Zealand, the Republic of Korea and Singapore. These are also linked to provider payment systems in some coun-
tries. However, at the institutional level, there remains a need to develop a culture of continuous quality improvement using sound information about individual and population health to drive improved service delivery.

Interventions that engage and empower individuals, families and communities are also required to ensure safe and effective health services through appropriate use and improved satisfaction. Promoting health literacy is also critical to transforming health systems to provide quality, people-centred and equitable care, and much attention has been given to this in both high-income countries, such as Australia, and developing countries, such as China. This requires users to be able to access information about the health system, its services and other patients’ experiences to make informed health-care decisions, and to contribute to policy-making, decision-making, monitoring and accountability.

Key action domains and priority actions

**ACTION 1.1 Regulations and regulatory environment**

Governments regulate health services and systems to improve service quality and health outcomes, ensure equity and access, protect the public, promote social cohesion and increase economic efficiency (WHO, 2015d). Regulations set minimum standards on health service delivery in terms of the human resources, infrastructure, medicines and health technologies, as well as the way people are treated when seeking health services.

1. **Enforce health workforce regulation.**
   a. Mandate registration and licensing of health professionals as requirements for entry to practice.
   b. Upgrade health workforce competencies through continuing professional development linked to relicensing and maintain updated, publically available registries of licensed professionals.
   c. Strengthen accreditation mechanisms for educational institutions and programmes.
   d. Define clear standards and processes for registration and integration of foreign-trained health professionals and traditional medicine practitioners.
2. Strengthen national regulatory authorities for medicines and health technologies.
   a. Adapt and implement internationally accepted regulatory standards on efficacy, safety, quality and use of medicines and health technologies.
   b. Incorporate quality assurance in manufacturing, procurement and distribution mechanisms for essential medicines and health technologies, including traditional medicines.
   c. Establish post-market surveillance mechanisms to detect, report and recall medicines and health technologies that are determined to be spurious/falsely-labelled/falsified/counterfeit (SFFC).

3. Adopt service standards for health facilities and infrastructure.
   a. Use licensing and accreditation of health facilities as a benchmark for setting facility standards.
   b. Certify whether buildings are safe from disasters (floods, fires, earthquakes, etc.) and compliant with national regulations.
   c. Provide each health facility with access to safe utilities and basic amenities and ensure that they meet minimum standards in sanitation and for infection prevention and control.

4. Legislate to protect patient rights.
   a. Put in place informed consent mechanisms at all levels of service delivery.
   b. Assure confidentiality of and promote patient rights to access patient records, including information on diagnosis and all biomaterials.
   c. Strengthen security of online applications, patient records, databanks and individual insurance claims, where applicable.

BOX 2. Regulating health practitioners in the public interest – the Australian experience

Australia’s system for health workforce regulation has gone through a transformation in the past five years, moving from state- and territory-based arrangements to a national scheme. The objectives of the national scheme are protection of the public; workforce mobility within Australia; high-quality education and training; rigorous and responsive assessment of foreign-trained practitioners; facilitation of access to services in accordance with the public interest; enabling a flexible, responsive and sustainable health workforce; and enabling innovation. The Australian multi-professional system of health practitioner regulation commenced in 2010 and registers more than 630,000 health practitioners across 14 health profession boards including Chinese medicine practitioners and Aboriginal and Torres Strait Islander health practitioners. The 14 health professional disciplines regulated under the Australian National Registration and Accreditation Scheme (NRAS) are self-funded through registration and annual renewal fees from professionals.
The Australian Health Practitioner Regulation Agency (AHPRA) supports the work of 14 regulatory Boards. AHPRA, as one national organization with one legislation framework, manages the annual registration of all registered health practitioners through harmonized national registration standards, including continuing professional development, and codes and guidelines for advertising, mandatory reporting and conduct. AHPRA also sets professional standards to enter professions, provides accreditation for education pathways to registration, manages notifications concerning about fitness to practise and maintains national registers. APHRA developed a transparent, accessible registered health workforce database through national online registers, instead of 94 sources as in the past.

A single National Code of Conduct for unregistered health practitioners as an alternative to registration/regulation of health professionals under NRAS has recently been approved by governments. The national code sets standards of conduct and practice for all health-care workers who are not registered under the NRAS and will provide for national prohibition orders to ensure information on unsafe practices by workers is available nationwide. This provides universal protection for the community at no direct cost to the health-care workers from any person purporting to deliver a health-care service.

**BOX 3. Reducing spurious/falsely-labelled/falsified/counterfeit (SFFC) medicines in Cambodia**

Cambodia’s Ministry of Health and the Department of Drugs and Food have been actively collaborating with national enforcement agencies, nongovernmental organizations, Interpol, WHO and other partners to reduce the circulation of poor-quality medicines in Cambodia. In 2005, Cambodia established the Inter-Ministerial Committee to Fight against Counterfeit & Substandard Medicines. The Inter-Ministerial Committee consists of Cambodia’s ministries of Agriculture; Commerce; Economy and Finance; Education, Youth and Sport; Forestry and Fisheries; Health; Information; Interior; and Justice.

By November 2011, through the Inter-Ministerial Committee, Cambodia closed over 99% of illegal pharmacy outlets, greatly reducing the number of outlets selling illegal, counterfeit medicines. In addition, poor-quality medicines are being de-registered to curb sale and distribution of products not meeting quality standards. Intensive monitoring showed that regulatory actions successfully reduced the proportion of samples that failed quality testing from 7.4% in 2006 to 0.7% in 2011. (Krech et al., 2014).

**BOX 4. Improving access to affordable vaccines in China and Viet Nam**

Effective immunization programmes need safe, effective, quality-assured and affordable vaccines. Historically few multinational companies had the capacity to produce quality-assured vaccines that met international standards, but often at a high cost.

As more companies from China and Viet Nam and other emerging economies obtain WHO pre-qualification for vaccines, competition will increase among producers, and likely reduce prices in the global market. Quality of vaccines is particularly important because they are used on a population-wide basis and usually given to healthy infants.
The WHO pre-qualified stamp of approval means that these vaccines are consistently safe, effective and of high quality, and thus recommended for bulk purchase by the United Nations Children’s Fund (UNICEF) in 152 low- and middle-income countries, and Gavi, the Vaccine Alliance – which funds vaccines in 73 of these countries – and other agencies.

National regulatory agencies play a vital role in this process, as they review clinical trials conducted by companies, the production facilities and processes of the manufacturer to make certain they meet international standards. Once a new vaccine is registered, every lot is chemically and biologically tested before being released for local sale or export by the national regulatory agency and monitored for safety.

After an extensive evaluation and continuous reassessment process, WHO certified the China Food and Drug Administration and the Drug Administration of Viet Nam as having fully equipped national regulatory systems that ensure the safety and effectiveness of the vaccines they produce and use. Through the certification process, WHO can assure purchasers and users of the vaccine of its quality, safety and effectiveness.

National regulatory system strengthening in the above cases has not only benefited national immunization programmes but also increased the global supply of quality and safe vaccines, which increases access to affordable vaccines for developing countries.

**ACTION 1.2 Effective, responsive individual and population-based services**

Effective, integrated, people-centred health services (including at the individual and population levels) rely on the availability and accessibility of a competent, responsive health workforce that is accepted by the community. Safe and effective services can be ensured through evidence-informed protocols and systems to monitor performance at both individual and population levels.

1. **Build and maintain a competent workforce of multidisciplinary teams.**
   a. Develop a competent, multidisciplinary health workforce with professional skills and ethical practices that meet individual and population health needs.
   b. Create a conducive environment for interdisciplinary collaboration including the integration of traditional and complementary medicine, as appropriate.
   c. Incentivize people-centred, ethical and clinically competent performance.
2. Implement evidence-informed protocols and interventions at individual and population levels.
   a. Implement regulatory interventions for key health protection areas such as water and sanitation, environmental health, road safety, tobacco control, food safety and others.
   b. Design and implement appropriate integrated service delivery models, effectively linking primary care with hospital and post-hospital care (home or community care, palliative services, long-term care).
   c. Put in place a system to adopt and update necessary public health standards, health service delivery protocols, clinical practice guidelines and/or pathways.

3. Use individual and population-level health information for health improvement.
   a. Enhance disease and risk factor surveillance systems to enable timely and effective intervention and evaluation.
   b. Maintain patient record systems and use them for service coordination and planning.
   c. Institute systems for continuous quality improvement, including using quality and safety indicators

**BOX 5. Reaching out to health workers to improve and maintain their competencies: Pacific Open Health Learning Net (POLHN)**

Pacific Open Learning Health Net (POLHN) evolved from a partnership of Pacific ministries of health and WHO, and was established in 2003 to address the need for continuing professional development (CPD) opportunities and up-to-date health information. POLHN aims to improve the quality and standards of practice of health professionals in the Pacific through an e-learning network of academic institutions such as Fiji National University, Pacific Paramedical Training Centre, Penn Foster and others.

POLHN provides a fully equipped, Internet-linked network of more than 47 centres in 14 Pacific island countries to enable health professionals to upgrade their knowledge and skills without leaving their communities. POLHN has reached a total user volume of approximately 10,000 users. The self-paced courses in medical laboratory sciences, emergency care and health promotion have gained popularity, with around 700 new students enrolling each year. The flexible nature of these courses allows students to complete the course at their own pace.
Implementing regulatory measures for tobacco control in Fiji

As part of its commitment to the WHO Framework Convention on Tobacco Control, Fiji amended its tobacco control laws with the 2010 Tobacco Control Decree and the 2012 Tobacco Control Regulations. Within the Ministry of Health and Medical Services, Fiji also established a tobacco control enforcement unit to make tobacco control laws more effective. The unit has contributed to Fiji’s efforts to eliminate illicit trade of tobacco.

The Ministry of Health and Medical Services also implemented the national Quit, Breathe, Live Well campaign to support smoke-free public settings, and has trained nearly all nurses and other health worker staff on tobacco cessation interventions in primary health-care centres (Government of Fiji Gazette Supplement, 2013).

ACTION 1.3 Individual, family and community engagement

People can achieve their fullest health potential if they are able to take control of factors that determine their health (WHO, 1986). Individual, family and community engagement has a direct and positive impact on the safety and quality of health services, and ultimately on health outcomes (Harding & Preker, 2003; WHO, 2007b). Mechanisms are needed at the institutional and system levels to monitor and manage user experiences and provide feedback. This will improve health system responsiveness to the needs of the individuals and communities.

1. Improve health literacy and capacity for health decision-making.
   a. Engage individuals and communities in health decision-making, including health promotion and disease prevention, diagnostic and treatment options, and rehabilitation, through effective health education.
   b. Create a platform for individuals, mass media and health advocacy groups to exchange information and engage with providers and relevant stakeholders.

2. Adopt a systematic approach to monitor patient experience for service improvement.
   a. Establish a system for families and communities to give feedback on the patient journey, for example through patient experience surveys.
   b. Institute conciliation and resolution mechanisms for medical error, complaints and concerns, with involvement of affected patients’ representatives.
c. Encourage and support patient advocates and advocacy groups to raise important public health concerns and awareness among the public, policymakers and providers.

3. Empower patients and families through self-efficacy and peer-support groups.
   a. Support patients and their families to make informed decisions.
   b. Promote the creation of peer support groups to share knowledge and experience.

**BOX 7. Engaging patients to improve quality and safety of health care**

Patients for Patient Safety is a global initiative emphasizing the patient voice with respect to improving safety at all levels of health care. Malaysia used several approaches to engage patients starting with the establishment of a national Patient Safety Council with community representatives in 2003. A national Patient for Patient Safety Initiative (PFPSM) launch took place in 2014. The Malaysian Ministry of Health then produced several guidelines on patient safety including the Malaysian Patient Safety Goals. A national media campaign on patient safety called Together for Safety was launched to increase public awareness. In 2013, the Ministry of Health passed an administrative order to establish patient safety committees in health facilities.

PFPSM promotes partnership between patients, health-care providers and consumers to enhance patient safety. Malaysia also launched a pilot project involving 14 hospitals (Ministry of Health Malaysia, 2015).
Making the best use of available resources is as important as mobilizing additional resources for health. Efficiency implies doing the right things, doing them correctly and adapting to the changing environment over time.

Improving efficiency in health services enables the system to get more output from the same level of resources. The 2010 World Health Report reveals that 20–40% of available resources are wasted in the health sector across low-, middle- and high-income countries (WHO, 2010a). Sometimes, to improve efficiency, more investment is needed. Cost control is an important objective in many countries. However, efficiency is about more than just saving money; it is about getting better health outcomes within a given level of resources.

The major inefficiencies in the Western Pacific Region include unbalanced distribution of resources within the health system; incentives for inappropriate use of services, medicines and health technologies; substandard quality of services; and weak institutional management.

In resource-constrained countries, such as Cambodia and the Lao People’s Democratic Republic, where health expenditure per capita is less than US$ 100, insufficient investment in basic health services, low staff salaries in public facilities, and fragmented service delivery and funding streams are major contributors to inefficiency. In most of the Region’s developing countries, external funding for health declines with economic growth. Meanwhile, development empowers citizens to expect and demand better health services. Today, many low- to lower-middle-income countries are trying to mobilize more domestic resources and develop strategies to improve the coordination and integration of priority public health programmes within the health system, while reducing their dependence on foreign aid.

In several middle-income countries, such as China and Viet Nam, health resources are heavily skewed towards tertiary care. In addition, the lack of regulation and oversight for both public and private sectors, and misalignment of incentives for providers are key factors causing inefficiency. Hospitals induce demand to maximize their income by overprescribing medicines and overusing high-cost technologies, while primary health facilities are not able to meet patients’ needs and expectations due to the lack of infrastructure, skilled health workers, medicines and equipment. This typifies the mismatch between facility- and system-level efficiency, where hospitals are run efficiently to maximize their revenue while system-level efficiency is sacrificed, especially in primary care.
In high-income countries such as Australia, Japan and the Republic of Korea, cost control is critical to sustain progress in health systems strengthening and to meet the new demands posed by changing demographic profiles, disease patterns, cost of technologies and economic shocks. In most Pacific island countries, managerial capacity at the institutional level is a major challenge. The need to improve the financial management skills and performance of health workers, as well as the health information system infrastructure for better planning and decision-making, is paramount. Given key health system challenges, such as the rapidly growing magnitude of the NCD crisis in Pacific island countries, shifting resources from hospitals to community- and primary-level care and improving coordination and management across the different levels of service can gain efficiency at all levels.

**Key action domains and priority actions**

**ACTION 2.1 Health system architecture to meet population needs**

Rational allocation of resources to ensure primary care and prevention serves as the foundation of an efficient health system. Evidence suggests that a majority of those reported ill sought care at the primary level with only a limited number requiring tertiary care [Leung, et al., 2005; Green, et al., 2001]. In rapidly changing environments, primary care functions require stronger integration and coordination with different disease and health programmes, as well as with different levels of care. Assessment of population needs based on the burden of diseases and their socioeconomic impact can guide health resource allocation and determine necessary levels of investment from public and private sectors. Governments should allocate their budgets effectively, within fiscal constraints, and provide incentives and regulatory drivers to encourage or limit private investment in certain geographic areas and on certain type of services. Facilities must be adequately staffed and workforce planning should consider labour market dynamics. Both the number of health workers and the skill mix need to be considered in meeting population needs.

1. Define the core service packages and delineate the roles of health institutions at different levels of the system.
   a. Ensure sufficient funding for core public health functions.
   b. Establish and maintain core service packages for different levels of facilities.
c. Strengthen primary health care, institutionalize coordination mechanisms across different levels and types of services, and adopt people-centred service delivery models.

2. Make more resources available for public health, primary-level services and disadvantaged population groups.

a. Prioritize public health and primary-level services in health budget allocations.

b. Increase public funding for health, particularly for prevention and primary care.

c. Mobilize more resources for health through innovative revenue generation, such as tobacco and alcohol taxation.

d. Design better targeting methods to ensure government subsidies reach disadvantaged population groups.

e. Ensure coherence in financing (funding flow) and service delivery, and promote coordination between different disease and specific health programmes, as well as donor initiatives.


a. Define the roles of, and provide incentives for, non-state service providers, including community-based, faith-based, for-profit and not-for-profit providers to contribute to health system objectives.

b. Develop a policy framework and legislation to ensure a balanced approach to private sector investment and the quality of health services.

c. Apply tight regulation to private health insurance and limit it as a supplementary role to public financing schemes.

**BOX 8.** Designing the national public health service package in China

In China, one health reform strategy is intended to ensure equitable access to public health services for all the population. In 2009, the Ministry of Health developed a national public health service package which expanded over time to include more services. As of 2014, it includes 11 public health interventions and primary services, such as resident health record management, health education, immunization, maternal and child health care, infectious disease reporting, NCD management and mental health management. Subnational authorities can add additional services based on their local public health needs.

The public health service package is delivered at township hospitals and village health centres in rural areas and at community health centres in urban areas. All services included in the package can be accessed without any payments or co-payments. The package is co-funded by central and local governments. The level of funding increased from 15 yuan per capita in 2009 to 35 yuan in 2014, and is expected to increase to 40 yuan in 2015.
**BOX 9. Developing integrated service delivery packages in the Solomon Islands**

Since 2011, the Solomon Islands Ministry of Health and Medical Services has been developing a Role Delineation Policy that reflects the Government’s strategy of strengthening services to rural populations while responding to changing health service needs. This policy direction was further affirmed in 2013 when the Universal Health Coverage approach was adopted as the Government’s main health sector strategy. The policy reclassified the five levels of the health system into four: rural health centre, area health centre, provincial hospital and national referral hospital, with the lowest-level facility classification (nurse aide post) being phased out.

In 2014, the Ministry of Health and Medical Services in collaboration with development partners embarked on a process to develop Integrated Service Delivery Packages. These packages specify essential services to be delivered at each level of the health system and the staffing, drugs, equipment and infrastructure required at the different types of facilities to provide services. These packages were developed with national programme directors and staff to reflect the strategic direction of each programme before technical content was internationally peer reviewed by experts from WHO and other development partners.

Subsequently, a secondary assessment process was started through consultations with both clinical and public health staff from the national, provincial and community level to further refine the packages and ensure they were implementable, as well as to identify the requirements for implementation. The process was also used to define the role of each type of health facility and link the different facilities and levels together as a functional system.

The process of development highlighted a number of challenges for moving towards the Government’s vision of a strong, affordable and efficient health system that improves population health status.

**BOX 10. Investing in the health workforce to improve accessibility to services – the Lao People’s Democratic Republic experience**

The Lao People’s Democratic Republic has a health workforce crisis, with less than 2.3 doctors, nurses and midwives per 1000 population. Not surprisingly, the country has a persistently high maternal mortality ratio. Despite health personnel shortages, the public sector lacked the capacity to recruit available trained health workers.

The *Health Sector Reform Framework* to 2025, adopted in 2013, prioritized scaling up the health workforce. As a result of high-level commitment and advocacy, the Ministry of Home Affairs allocated 4000 staff posts for the health sector in 2014, compared to only 1045 posts in 2013. Considering the total health workforce was 17,636 in 2013, this represents a significant increase and enabled the recruitment of existing trained health professionals. Approximately 3000 posts were allocated to health centres and district-level facilities to improve access to health services in remote and rural areas. Current challenges include ensuring sustainability of scale-up efforts and retention of health workers in rural and remote areas.
ACTION 2.2 Incentives for appropriate provision and use of services

People respond to incentives. Once the system design is established, the correct incentives are needed so that people can access and move through the system to receive appropriate, effective and timely care. For prevention, both supply- and demand-side incentives play important roles because often individuals consider population-based prevention services a lower priority than clinical services. The way providers, both public and private, are paid affects the range and amount of services they provide, as well as the quality of the services. Non-financial incentives, such as career development opportunities and merit-based rewards, also affect individual health worker behaviour. Furthermore, strengthening management and promoting rational use of medicines and health technologies can reduce inefficiencies and wastage within the health system.

1. Use provider payment mechanisms and other incentives to foster appropriate behaviour.
   a. Apply a set of mixed payment methods to optimize service quality and cost controls, and closely monitor the impact of different payment mechanisms to make adjustments over time.
   b. Use payment methods strategically to motivate providers to retain and refer people to the appropriate level of care, and align different payment methods to avoid overuse or underuse or inappropriate use of services and to promote good-quality care.
   c. Provide financial and non-financial incentives to recruit and retain health workers to serve in remote and less-developed geographical areas and for disadvantaged communities.

2. Leverage price and benefit package design to encourage provision of desired services and avoid unnecessary use of services.
   a. Use pricing mechanisms to promote provision of preventive services and primary care.
   b. Provide incentives for people to seek preventive services and strengthen the referral system.
   c. Set appropriate patient cost-sharing arrangements to avoid bypassing of primary care without compromising access to needed services by the poor.
3. Improve management and rational use of medicines and health technologies.
   a. Make essential medicines and technologies affordable through public funding.
   b. Use a scientific evidence-based approach, such as health technology assessments, to support decision-making on investing in high-cost medicines and health technologies.
   c. Ensure rational use of medicines and health technologies through a mix of interventions of educational, managerial and regulatory approaches.
   d. Reduce inefficiencies and wastage during procurement, storage and delivery through transparent and accountable mechanisms.

**BOX 11. Using appropriate provider payment mechanisms to align financial incentives with health policy objectives**

The common provider payment mechanisms include line budget allocation, fees for service, capitation and case-based payment. No payment model is perfect, and making changes to the ways providers are paid is complex and contentious. Countries may use a mix of provider payment methods to mitigate the negative impact of each. For example, the fee-for-service (FFS) payment method encourages providers to provide more services to meet population needs, but FFS can also result in over-servicing and increasing costs. FFS is commonly used in China, Japan, the Lao People’s Democratic Republic, the Republic of Korea and Viet Nam. FFS in Japan is tightly controlled and in the Republic of Korea it is closely monitored to mitigate its negative impact. However, in the other countries, FFS is one of the main factors for the rapid increase in health expenditures. Capitation is a common method for paying for outpatient services in Mongolia and the Philippines. Capitation is effective in controlling costs but may lead to under-treatment and/or over-referrals of patients to upper levels even when higher levels of care are not needed.

Case-based payment, including diagnosis-related groups (DRGs), is used in Australia, Japan, the Philippines, the Republic of Korea, Singapore and Viet Nam by a health insurance fund for inpatient services. Although case-based payment controls unit costs, this method often results in a high readmission rate. Some countries use case-based payment combined with a global budget to control the total cost, such as New Zealand.

The choice of an appropriate provider payment model in a particular context may depend on the overall institutional and organizational context of health systems, the broader health financing system, the capacity of management and health workers, and the strength of the health information system. Monitoring performance is critical for making changes to provider payment methods over time.
**BOX 12. Promoting the rational use of antimicrobials in Kiribati**

The Kiribati Ministry of Health and Medical Services published the first *Kiribati Antibiotic Guidelines* in 2013 to ensure antimicrobials are prescribed and used appropriately (Ministry of Health and Medical Services, Kiribati, 2013). Antimicrobials are the most commonly used medicines in the country. However, Kiribati has prescribers from diverse educational backgrounds trained in Cuba, Fiji and Australia, with differing practices. Hence, it was important to develop a standard treatment guideline based on the latest evidence for common infections in Kiribati.

The inappropriate use of antimicrobials not only leads to drug resistance and failure in prevention and treatment of life-threatening infections but also hinders timely access to these essential medicines. High-patient demand on antimicrobials even when not needed and overuse often lead to stock-outs. Hence, patients most in need may not be able to have access to treatment.

Kiribati has aligned the Essential Medicines List to the first *Kiribati Antibiotic Guidelines*, which is used as a basis for procurement and distribution of medicines to health facilities. The Ministry of Health and Medical Services has also distributed the guidelines to health facilities in the country to ensure that antimicrobials are prescribed only when needed in correct doses for the right duration.

**BOX 13. Health technology assessment – Australia’s experience**

Australia has sought to introduce policies that make health investments more efficient through the provision of cost-effective and evidence-based health care. Understanding the approaches used to make coverage decisions, including disinvestment in lower-value technologies, is essential to this policy analysis.

Australia supports health technology assessment as an invaluable tool to ensure that those who pay for health technologies and associated health services obtain acceptable value for money. This is because health technology assessment directly addresses the primary objective of any health-care system – to improve health outcomes – and the primary constraint of any health-care system – the limited ability to pay for unlimited demand.

In Australia, health technology assessments are used to define the goods and services financed collectively under universal health scheme arrangements. In 1990, Australia became the first jurisdiction in the world to systematically request information on cost-effectiveness when deciding whether to fund medicines on its Pharmaceutical Benefits Scheme. This extension beyond information on comparative safety and clinical effectiveness represented the first complete health technology assessment approach applied systematically to health-care resource funding decisions. Health technology assessments are now also being applied systematically to decisions to fund other types of health-care interventions in Australia, such as medical services and vaccines.
ACTION 2.3  Managerial efficiency and effectiveness

System-level efficiency cannot be fully realized without managerial efficiency and effectiveness at the facility level. Managerial efficiency and effectiveness involve using the minimum necessary level of resources to achieve organizational objectives. Health service delivery is complex and requires a comprehensive set of skills to manage a health workforce, procure medicines and health technologies, manage financial resources, contract with fund holders (such as health insurance agencies), and ensure the safety and quality of services, all while caring for patients. However, managerial efficiency is not only about the managers of the facility. The government plays a central role in creating an enabling environment for effective management to improve performance.

1. Encourage all providers to be efficient through managed autonomy.
   a. Establish clear rules and regulations for accountability, monitoring, and effective reward and sanction methods for autonomous health facilities.
   b. Increase autonomy in human resource management to enhance skill mix and improve performance.
   c. Allow flexibility in financial management to optimize inputs to improve productivity.

2. Improve overall management capacity and skills to meet requirements in the changing environment.
   a. Augment health managers’ capacity for all aspects of management, including staff productivity and performance, financial management, infrastructure maintenance, contracting and procurement.
   b. Require managerial skills as a key competency for recruiting and advancement in management posts.
   c. Cultivate a motivating environment and provide managerial and administrative support for health workers to improve performance.

3. Strengthen information systems and effective use of information and communications technologies (ICT).
   a. Build strong information system infrastructure and take advantage of continuing ICT development.
   b. Collect and analyse information regularly on financing, human resources, workload and patient flow in order to monitor performance, identify issues or problems and improve decision-making.
BOX 14. Strengthening Fiji’s health information systems and use of ICT

Fiji’s health information systems, both electronic and paper-based, provide much of the information required to guide both clinical and management decision-making. There is a well-embedded system for collecting core public health data. For clinical care, Fiji has a unique national health number linked to each electronic patient record, which is used across all major hospitals, some subdivisional hospitals, and with the potential to extend to all hospitals and major health centres. Since the hospital patient management information system also records births and deaths linked to each unique national health number, the system provides the basis for a fully integrated womb-to-tomb, patient-focused medical record system, which can be used to support comprehensive continuity of care (Ministry of Health & Medical Services, 2013).

The patient information system application is web based, with the Consolidated Monthly Returns Information System including both the public health information system and hospital maternal and child health monthly returns. Further launches and enhancements involve telemedicine technology, the Fiji health research portal and the Fiji national data repository (Ministry of Health & Medical Services, 2015).
ATTRIBUTE 3  EQUITY

Equity is the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically. Health equity is achieved when everyone has the opportunity to attain their full health potential and no one is disadvantaged from doing so because of their social, economic, demographic or geographic circumstances.

Countries in the Region have achieved impressive health gains in recent decades. However, these gains remain unequally distributed and have largely failed to reach the poor and other marginalized or socially excluded groups. As a result, persistent and growing inequalities in health are increasingly evident, both between and within countries.

Health inequities are largely attributed to social determinants of health, such as social, economic and environmental factors that lie beyond the health sector. In the Federated States of Micronesia, the urban population is more than four times more likely to access sanitation than the rural population. Underserved populations face significant barriers to access. Out-of-pocket expenditure is more than 40% of total health expenditure in some countries, such as Cambodia, the Philippines and Viet Nam. Inequities are also seen in the use of services. Births attended by a skilled attendant are less likely among women with no education or low levels of education. They are more likely among women living in urban areas than those living in rural areas, with large rural–urban gaps observed in some countries, such as the Lao People’s Democratic Republic and the Philippines. In countries where information on affordability is available, adults from the richest households are routinely found to have the best access to long-term treatment.

Failure to ensure all groups can access effective, quality and affordable services is driving some ongoing high-priority communicable disease risks, e.g. drug-resistant malaria and tuberculosis, and vaccine-preventable diseases, so failing to provide access puts the whole population at risk in the Region. This has posed great challenges to the countries in the Greater Mekong Subregion, such as in Cambodia, China, the Lao People’s Democratic Republic and Viet Nam. If countries have significant pockets of the population, such as migrants, without such access, these priority diseases will remain unable to be effectively controlled.

Action is required on both supply- and demand-side barriers to access health services, including financial barriers, geographical barriers, lack of knowledge, information and awareness, and the poor quality or lack of responsiveness of the
health system. In addition, measures need to be in place to prevent discrimination against individuals and communities on the basis of sex, age, disability, ethnic origin, employment or income status, sexual orientation and gender identity, and health status. These concerns are well reflected in the Regional Strategy to Stop Tuberculosis in the Western Pacific 2011–2015 and the Regional Agenda for Implementing the Mental Health Action Plan 2013–2020 in the Western Pacific. Many countries in the Region, such as Cambodia, China, Fiji, the Lao People’s Democratic Republic, Mongolia, the Philippines and Viet Nam, are experimenting with ways to reduce other out-of-pocket payments. UHC also requires mobilizing adequate resources for health through partnership with other sectors, such as through linkages with social protection.

Key action domains and priority actions

**ACTION 3.1 Financial protection**

High out-of-pocket expenditure creates barriers to access services and can lead to financial hardship for people. Among the poor, even small costs can effectively deny access. Ensuring financial protection requires addressing financial barriers to care including both direct and indirect costs such as transportation expenses, income loss and time costs.

1. **Reduce financial and non-financial barriers to access.**
   a. Increase prepayment on health, including through government general revenue and statutory health insurance, and reduce the service cost to patients.
   b. Use prepayment to minimize catastrophic expenditure for life-saving interventions.
   c. For population-level health services, target underserved populations, areas or health conditions.
   d. For individual-level services, introduce subsidies for both direct and indirect costs to improve health service uptake by those who cannot afford to pay, in particular on primary care.
   e. Reduce fragmentation of financing schemes and benefit packages to maximize solidarity.
2. Strengthen appropriate connections between health financing and other social protection schemes.
   a. Understand the impacts of health financing and social protection schemes, especially for vulnerable populations like older people, women, those with disabilities, children and the poor.
   b. Build potential synergies by linking financial protection mechanisms in health with broader social protection mechanisms.

**BOX 15. Approaches to financial protection in the Western Pacific Region**

Countries have taken different approaches to provide financial protection and improve equity in access based on their specific institutional, economic and societal context. Below are some examples:

- **Health equity funds (HEF)**
  Started in 2000 in Cambodia – and later introduced in the Lao People’s Democratic Republic – health equity funds are autonomous, district-based schemes that reimburse health facilities for the cost of user-fee exemptions at public health facilities provided to the identified poor and also subsidize the costs of transport and food required during health-seeking episodes. As of 2014, HEF covers 90% of the poor population in Cambodia. More than half of the funding comes from development partners, but the Government is strongly committed to increasing domestic funding to sustain HEF.

- **Subsidization of insurance premiums for the poor in social health insurance schemes**
  China’s Government is subsidizing about 80% of the health insurance premium for the rural population. In Japan (National Security of Population and Social Security Research, 2014) central and local governments subsidize vulnerable populations, including people from low-income households and older people. The Republic of Korea (Jones, 2010), has a Medical Aid programme for the poor. The Philippines subsidizes households from the poorest income quintile to enrol in the national health insurance programme, the Philippine Health Insurance Corporation, or PhilHealth (PHIC, 2013). Viet Nam pays the full social health insurance premium for people from households below the poverty line and partial premiums for those from near-poor households (Van Tien et al., 2011). The newly revised health insurance law also exempts the poor from co-payments when using services.

- **Making high-priority public health services free to all at point of care**
  Many countries exempt some high-priority services (e.g. childhood immunization and tuberculosis) from user charges for all population groups. The Lao People’s Democratic Republic developed a national policy for free maternal and child health services for all mothers and under-5 children with funding support from the national government and external partners (World Bank, 2013a). China developed a basic health-care package (Box 8) provided free of cost to all of the population.
• Publicly funded health insurance scheme

Australia operates a publicly funded universal health care scheme – Medicare – to provide access to medical and hospital services for all Australian residents and certain categories of visitors to Australia (AIHW, 2014). Residents are entitled to subsidized treatment from medical practitioners, eligible midwives, nurse practitioners and allied health professionals who have been issued a Medicare provider number, and can also obtain free treatment in public hospitals. Similar mechanisms exist in New Zealand.

**ACTION 3.2 Service coverage and access**

To reduce health inequities, universal measures to increase access need to be combined with selective measures that provide extra support to the most disadvantaged, vulnerable groups. Merely scaling up existing services in the expectation that the benefits will eventually trickle down to excluded groups is unlikely to succeed. Proactive steps are needed to ensure that marginalized groups benefit at least as much as the rest of the population.

Socially disadvantaged groups use health services less because they typically face multiple barriers to access to needed services, including geographical barriers, language or cultural barriers, lack of knowledge, information and awareness, and the lack of responsiveness of the health system. Supply-side barriers limit service availability and thereby access while demand-side barriers influence the capacity and willingness of individuals, families or communities to seek or use services. Evidence suggests that demand-side barriers may be as important as supply factors in hindering patients, families and communities from obtaining needed services.

1. **Improve equitable access to services.**
   a. Ensure primary-level facilities receive adequate and timely flow of funds.
   b. Improve the accessibility of health services through prioritizing investments towards underserved populations and the health conditions that affect them the most.
   c. Increase health worker availability and accessibility from and in underserved populations through training, modification of their scope of practice, and provision of incentives for improved recruitment and retention in underserved areas.
d. Monitor equity-focused targets for both individual and population-level interventions.

2. Catalyse appropriate demand for services.
   a. Target information and education towards underserved populations and support advocacy efforts and participatory mechanisms to improve service design, access and responsiveness.
   b. Provide targeted financial incentives, including vouchers or conditional cash transfers, matched with adequate supply to improve use, especially of preventive and routine services.
   c. Extend the use of m-health/e-health applications and services by frontline workers to facilitate access by underserved areas or groups.
   d. Partner with civil society and patient support groups to improve health literacy and appropriate service use.

**BOX 16. Recruiting students locally and scholarships with bonding arrangements – Does it work to improve access in rural and remote areas?**

The Ministry of Health, Labour and Welfare of Japan has been working with prefectures, as well as universities and hospitals, to reduce regional disparities in access to health care with a range of strategies, such as encouraging more doctors to work in remote regions.

The Jichi Medical University, set up in 1972 to promote health services in remote regions and improve the welfare of local residents, has played a major role in these strategies (NIPH, unpublished). In a joint initiative involving all the prefectures in Japan, the university operates as an educational corporation with a unique scholarships model whereby prefectural governments sponsor students from each of the country’s 47 prefectures in return for the students’ commitment to work for nine years after graduating at a specific nominated public hospital or other facility in their home prefecture (Matsumoto et al., 2010). The scheme has proven successful in delivering health-care services to residents of remote islands and mountainous regions. Upon recognizing Jichi Medical University’s success, the Japanese Government decided to impose a rural quota for certain number of students in many medical schools with a commitment to serve in the prefecture in which the university is located (Ono et al., 2014).

**BOX 17. Increasing maternal and child health service coverage in the Philippines**

The Government of the Philippines is reducing health inequities in the health system by increasing access to health services for vulnerable populations through targeted approaches. In 2009, the Philippine Health Insurance Corporation (PhilHealth), the national single-payer social health insurance agency, started providing reimbursements for maternal care and newborn care packages amounting to 8000 Philippine pesos. Substantial efforts were placed on increasing membership by subsidizing premiums for the poor. From 2008 to 2013 an increase of births in health facilities was recorded from 44% to 61%.
In 2007, the Philippines embarked on a programme called Pantawid Pamilyang Pilipino Program, or 4Ps, to make cash transfers to poor households, conditional upon investments in child education and health and use of maternal health services. By mid-2012, the programme covered approximately 3 million households and an improvement in child immunization coverage was observed. Improving access to health services, especially in underserved areas, can work to enhance maternal and child health service coverage [World Bank, 2013b].

**ACTION 3.3 Non-discrimination**

Discrimination can come in many forms – through health laws, policies and practices or through their implementation – and stem from a variety of backgrounds such as cultural, social, gender and ethnic. Because the root of discrimination is often multi-faceted, tackling discrimination requires a comprehensive approach.

Attention to sociocultural barriers to access, including addressing gender, ethnicity and stigma due to health status, is needed to address discrimination. Staff attitudes and skills are also a critical area of action. Beyond building the capacity of individual staff members, system-wide actions are needed to ensure that laws, policies and practices do not directly or indirectly discriminate against individuals or population groups and that these laws, policies and practices support patient confidentiality. Adjustments to policies and practices should not wait until they are requested by disadvantaged groups, but should be systematically considered at all stages of health planning and implementation.

1. Foster respectful care.
   a. Change organizational policies and culture to reduce discrimination of patients in health facilities.
   b. Improve cultural competence and gender sensitivity of health workforce to instil people-centred values and practices in both individual and population level services.
   c. Implement mechanisms and processes to dispel stigma in the community and in service delivery settings related to particular health conditions (e.g. tuberculosis, HIV, mental illness, disability) or social or economic status.
2. Provide legal protection.
   a. Develop policies to ensure compliance with agreed international conventions (such as the United Nations Convention on the Rights of the Child, the Convention on the Rights of Persons with Disabilities and the Convention on the Elimination of All Forms of Discrimination against Women).
   b. Use legislation as a tool to ensure non-discrimination in health services and in society due to health or social or economic status.

3. Create opportunities for vulnerable groups to have a voice.
   a. Consult with relevant communities about health policies and programmes, taking care that the consultation sites and formats suit communities’ needs, literacy levels and cultural preferences.
   b. Partner with civil society organizations and use mechanisms, such as patient reference groups, health consumer groups, village health committees and others, to consult those whose voices are heard less often, such as older people, migrants, people from ethnic minority groups and people with disabilities or stigmatized health conditions.

BOX 18. Fostering respectful care for women during deliveries in Cambodia

A project on Improving Maternal and Newborn Care through Midwifery Capacity Development (2010–2015) between the Ministry of Health, Cambodia, and the Japan International Cooperation Agency (JICA) promoted respectful care at the National Maternal and Child Health Center (NMCHC) in Phnom Penh and the Provincial Hospital in Kampong Cham. One Japanese midwife who made repeat visits to delivery rooms in NMCHC over 15 years described the change in health-care practices by February 2015 as follows: “I was very impressed how health staff devoted themselves to caring for the women. This was a transformation.” (Chhay, 2015). Women on delivery beds were no longer exposed, but now covered with blankets, and their privacy enhanced through drawn curtains. A local midwife instructed a student to not rush the patient: “Don’t be in a hurry. How many minutes can you wait until the placenta is delivered? It has only been five minutes since the baby was born. The bleeding is not much, we can wait and see.” A husband had taken time off from work to comfort his wife during childbirth, something previously unthinkable. Another woman bounced on a balance ball while her sister held her hand in reassurance.

According to a JICA survey, 77% of midwives trained reported that they now always encourage family members to stay with women in the delivery room; 68% reported encouraging women to drink or eat during labour; and 86% reported supporting women in finding their most comfortable position during labour (Terminal Evaluation Team, 2015). Similarly, exit interviews with mothers revealed that 95% felt secure and safe during delivery. One woman commented: “My midwife listens to me”. Of 131 mothers surveyed, 119 said they would want to return to the same hospital for their next delivery.

Although challenges remain, a transformation has begun in strengthening respectful care.
In the Philippines, people affected by leprosy have formed formal and informal groups and networks that engage in activities including self-care of disability, treatment partners, mutual support, income generation and scholarships for their children (Cunanan, 2012). More than 20 people’s organizations and other stakeholders have formed the Coalition of Leprosy Associations in the Philippines (CLAP) to strengthen the social movement to eliminate the stigma and discrimination associated with leprosy. The coalition provides a platform for advocacy and lobbying on issues such as economic deprivation and social exclusion. It is also a formal structure through which people affected by leprosy can participate in the process of planning, designing, implementing and evaluating policies on leprosy care.

The recognition of leprosy as a multisectoral and multidisciplinary concern led to formation of the national coalition. People affected by leprosy are now seen not only as clients receiving services but also partners with a key role in addressing the social dimensions of the disease and supporting leprosy control.
ATTRIBUTE 4 ACCOUNTABILITY

Health systems are comprised of many stakeholders that are accountable to each other to discharge certain responsibilities. These stakeholders include health providers (public and private), health users, legislatures, regulatory bodies, government central agencies, insurance companies and industry.

Accountability systems are broadly concerned with requiring stakeholders to provide information and justify their decisions and actions in return for rewards or sanctions. These systems, which help shape incentives and disincentives, influence the behaviour of relevant stakeholders and ultimately improve health system performance, are core to good governance. Accountability mechanisms also include contractual and partnership arrangements, the media, and influential networks or coalitions, and leadership.

Considerable variation exists in governance arrangements across countries in the Region, posing differing challenges. Countries with centralized decision-making processes need to appropriately accommodate the diverse needs across subnational jurisdictions and groups. In decentralized countries, such as Papua New Guinea and the Philippines, the capacity at the subnational level is critical to the accountability system, which involves different functions across the subnational levels. In any governance arrangement, health sector leadership and vision must be established to set expectations and drive health system performance.

Regardless of the specific governance systems, legislative and regulatory arrangements are central to good accountability systems. Some countries have routine reform, while others need to strengthen institutionalization of such processes. Countries not only need appropriate laws and policies, but for those laws and policies to be implemented effectively. In all countries, the ability to drive regulatory implementation in an effective way is important in setting incentives for behaviour. Good governance and feedback mechanisms to obtain information for improving performance entail strengthening management and institutional processes. Robust information systems and reporting of public information (as seen countries such as Australia, New Zealand and the Republic of Korea), timely surveillance and sound analysis and research also play an important role in making evidence-informed policy decisions.

Accountability entails health sector leadership to convene actors around shared interests. The growing complexities of global health necessitate multisectoral partnerships for public policy to act on the social determinants of health. Increasingly,
countries are recognizing shared interests across sectors for improved health and societal well-being, for example as seen in the *Action Plan to Reduce the Double Burden of Malnutrition in the Western Pacific Region (2015–2020)*, the *Action Plan for Healthy Newborn Infants in the Western Pacific Region (2014–2020)*, and the *Action Agenda for Antimicrobial Resistance in the Western Pacific Region*. However, strengthening accountability will require consistent and sustained efforts by government leaders and other stakeholders. Government leaders have an important role in fostering accountability through the establishment of rules and norms for institutional behaviour, prioritizing resources, transparent monitoring of performance and stimulating demand for information. The availability of reliable and relevant information, as well as the capacity and willingness to enforce sanctions, will determine the effectiveness of accountability systems.

**Key action domains and priority actions**

**ACTION 4.1** Government leadership and rule of law for health

Government is ultimately responsible for the overall performance of a country’s health system and the welfare of the population. This requires vision, intelligence and influence. Strong leadership is needed to manage the many factors that shape health, secure the basic needs and rights of the population, coordinate coherent policy responses across sectors, and ensure sustainable development.

All people, institutions and entities, including the government, are accountable to laws that are publicly promulgated, enforced and independently adjudicated, and which are consistent with international norms and standards. When governments are not the main provider or financer of health services, the governance role is equally important to leading the entire health system, including public and private sectors.

1. **Set the vision for health sector development and ensure sufficient resources for health.**
   a. Develop and implement a health policy or plan that addresses the health sector as a whole, including state and non-state actors and across health and disease programmes.
   b. Create mechanisms and processes to enable health policy-makers to plan and lead across the whole health sector and include all stakeholders.
c. Use legislation and incentives to manage the health sector covering state and non-state actors, both for-profit and not-for-profit.

d. Mobilize sufficient resources for health and increase government investment in health.

e. Coordinate external partners to harmonize and align aid agendas with national health policies and plans.

2. Strengthen the rule of law and regulatory institutions.

a. Undertake periodic legislative review and law reform through a participatory process and to ensure policy coherence and alignment with international standards.

b. Strengthen regulatory institutions and enhance institutional accountability through risk- and performance-based regulatory implementation and involving civil society in monitoring policy compliance.

c. Establish accountability mechanisms with clear responsibilities and authorities, sufficient resources to fulfil the mandates and consequences for the results at all levels of the health sector to ensure transparency, protect integrity, and avoid conflicts of interest.

d. Prevent corruption and promptly address violations of the rule of law through mechanisms such as external auditing and improved procurement.

3. Build leadership and management capacities.

a. Build leadership across all levels of the health system to champion high-performing health systems.

b. Strengthen management competencies across the different levels of the health system, especially in decentralized settings at the local level, to manage different types of institutions, including autonomous hospitals and non-state sectors.

**BOX 20. Strengthening leadership and governance capacity**

The WHO Regional Office for the Western Pacific initiated Health Promotion Leadership Training (ProLead) in 2004 (WHO, n.d.a). ProLead aims to create a critical mass of leaders in health promotion who can advocate and adapt global best practices to their local context.

An evaluation of ProLead in 2012 demonstrated a broadening of participants’ understanding of health promotion, and an improvement in their analysis, advocacy and collaboration skills. The programme broadened links within ministries of health, across government sectors, and extending to community organizations and partners, fostering a network with the potential to become a global movement. ProLead showed that with enlightened leadership, policy and systems change is possible.
ProLead’s impact in strengthening government leadership can be seen in the steady emergence across the Region of sustainable structures and financing for health promotion (Fawkes et al., 2012). Several countries (e.g. the Lao People’s Democratic Republic, Malaysia, Mongolia, Samoa, Tonga and Viet Nam) that have participated in ProLead have established health promotion foundations or tobacco control funds, which have helped to mobilize more funding for health while reducing the demand for tobacco consumption. Samoa recently passed its Health Promotion Foundation bill. Others are advocating the use of tobacco and alcohol taxes for health promotion.

China launched national ProLead in 2014 to build the capacity of leaders in health promotion, tobacco control and health reform. One participant in the first module of the China National ProLead in September 2014 remarked: “I used to focus on very specific and narrow issues in my work. As a result of ProLead, I have learned to think like a leader, to have a clear vision, strategy and plan, and to communicate this to achieve my goals.”

**BOX 21. Developing a health sector gender policy in Papua New Guinea**

Gender inequality in Papua New Guinea takes many forms. High rates of gender-based violence – among the highest worldwide – have enormous health consequences for women and girls, including increased vulnerability to HIV and other sexually transmitted infections (STIs). High maternal mortality, low access to reproductive health services and high under-nutrition persist, especially for rural women. Women’s literacy rates are significantly lower than men’s. Safety concerns hinder girls’ school attendance. Having ratified the Beijing Platform for Action, the Government is obliged to mainstream gender perspectives into all its policies and programmes.

The Papua New Guinea Government adopted its health sector gender policy in 2013. The policy seeks to incorporate a gender perspective into health programmes. It is part of wider efforts to promote gender equality to tackle critical issues such as violence against women, which is widespread, and HIV, which is on the rise. The policy was finalized through broad-based consultation, drawing on expertise from various sectors. “It was crucial to bring together all stakeholders, to generate ownership and strengthen our response,” said Dr Lahui Geita, Technical Adviser, Family Health Services, National Department of Health. “The policy will guide the Family Support Centre programme and an improved public health response to violence against women.” Its implementation will enable application of a gender lens to identify underlying causes of health inequalities and serve as a basis to take remedial action.
ACTION 4.2 Partnerships for public policy

Ensuring better health for a population requires partnerships with diverse stakeholders. A win-win approach across sectors can bring health, social and economic benefits. Changing health needs are altering the roles of the public and private sectors and civil society; in turn, this necessitates a transition from centralized to participatory governance. As communities have a say in national and local health policies and programmes, strengthening their role in the decision-making process can better address their health needs.

1. Secure intersectoral collaboration across government.
   a. Identify priority entry points to place health on the national development agenda through high-level multisectoral policy dialogue.
   b. Convene and collaborate with other government sectors to develop and implement public policies and action, including urban development, food safety, environment and trade, to achieve public health objectives.
   c. Safeguard global and regional public health interest and promote public goods through foreign policies and trade agreement negotiations.

2. Work with non-state partners on shared interests for health.
   a. Identify shared interests and align agenda across nongovernmental partners to realize mutual benefits.
   b. Articulate clear roles, responsibilities and accountability requirements, and create a platform to share information and monitor actions.

3. Empower communities to participate in decisions and actions that affect them.
   a. Engage communities to shape health policy, set priorities for the use of resources and provide oversight for policy implementation and service delivery.
   b. Strengthen civil society capacity to participate in the policy-making process by ensuring adequate technical and financial resources.

BOX 22. Multi-stakeholder partnerships in public policy for better outcomes

22.1. Reducing road traffic deaths through regulation on helmet use in Viet Nam
Traffic accidents were the second leading cause of mortality in Viet Nam, with motorcycle riders accounting for about 67% of all road traffic deaths. This led Viet Nam to enact a new motorcycle helmet law in 2007. A multisectoral National Traffic Safety Committee
established in 1997 led the development, implementation and monitoring of the law, though the Ministry of Transportation remained as the lead government agency (Passmore et al., 2010). The resolution focused not on health itself, but on improving road safety and alleviating traffic congestion, which can benefit health. As a result, helmet use jumped from less than 30% to over 95%, saving an estimated 1500 lives, or more, and preventing almost 2500 serious injuries. These successes were driven by efficient management of policy change, including through approaches that reduce barriers, ensuring strong political and legislative work, research and collaboration with media, and forging strategic operational alliances (WHO, 2013d).

22.2. Responding to NCDs through regional and national declarations

In May 2011, the president of Palau declared a state of health emergency on NCDs and ordered the Ministry of Health to take immediate action. Participants at the first meeting of the National Emergency Committee on NCDs in October 2011 included Ministry of Health staff and the president, who called on participants to join the “war on NCDs”. Activities agreed on included organizing a national summit on NCDs in early 2012 and drafting an NCD action plan. The Palau Declaration is part of a wider trend among Pacific island countries and areas to use emergency powers (normally reserved for discrete events and immediate crises) to direct attention [including by donors] to NCDs, “a slow-moving health catastrophe”. Palau was one of the first countries to follow up on the resolution by the Pacific Island Health Officers’ Association (PIHOA) declaring a regional state of health emergency and calling for similar national declarations (PIHOA, 2010). PIHOA is a non-profit organization led by and representing the collective interests of the ministers, secretaries and directors of health of the United States Affiliated Pacific Islands (USAPI). The PIHOA, Palau and subsequent declarations exemplify whole-of-government and whole-of-society responses to the social determinants of NCDs (WHO, 2013d).

BOX 23. Institutionalizing a community voice in health-care decision-making in New Zealand

New Zealand has institutionalized community participation in the health sector in order to recognize the principles of the Treaty of Waitangi – the foundation of the contractual relationship between Māori and the Crown – acknowledge the importance of social and cultural acceptability of health services, and improve health outcomes.

The New Zealand Public Health and Disability Act 2000 requires that district health boards involve Māori and other population groups in decision-making, planning and delivery of health and disability services. Some district health board members are elected by their communities ensuring community representatives, including Māori, are on all district health and primary health organization boards. District health boards also undertake consultations with community groups about their health needs. The presence of small community-based nongovernmental organization health providers, a number of them Māori, ensures strong community involvement in governance and planning. Consumers can express any complaints to the Health and Disability Commissioner.
ACTION 4.3 Transparent monitoring and evaluation (M&E)

Close monitoring and evaluation at all levels of a health system is crucial to provide timely and reliable information and identify priorities for action. Transparent, effective monitoring and evaluation and open access to information are the foundation for accountability. They enable people to put available information to good use so that they are better informed and able to engage with the health system. Reliable information and capacity to generate and use evidence are essential to inform policy-making.

1. Develop efficient health information systems and streamline information flows.
   a. Strengthen facility- and population-based data and surveillance information systems at national and local levels.
   b. Improve data quality, analysis, transfer and use through assessment, quality assurance tools, improved statistics and analytical techniques.
   c. Harmonize data collection and reporting efforts and consolidate the national information infrastructure.
   d. Collect, analyse and use information that is disaggregated by relevant social stratifiers, such as socioeconomic position, sex, age, ethnicity/race and geographical location, for planning, decision-making and implementation.

2. Facilitate open access to information.
   a. Establish mechanisms and a legal environment for fostering access to information generated by governments, health facilities, insurance organizations and procurement agencies.
   b. Make data available on financial resources, expenditures, health service indicators and health indicators in a timely manner and user-friendly formats to improve health system performance.
   c. Engage civil society organizations and communities in a participatory process for data generation, interpretation and transfer.

3. Strengthen institutional capacity for health policy and systems research and translation of evidence into policy.
   a. Invest in institutions that undertake high-quality health policy and systems research to evaluate the impact of health policies.
   b. Improve capacity and skills in knowledge generation and translation to inform policies and programmes.
**BOX 24. Developing the health information system and public reporting in the Republic of Korea**

The health information system of the Republic of Korea has evolved significantly over time. Starting with improving vital statistics, the Republic of Korea has developed and implemented various kinds of health-related surveys and panel studies. The National Health Insurance claims database is one of the unique features of the Republic of Korea’s health information system. It has been mandatory for health-care providers to report claims to the claim review agency. After 2000, all the claims are processed at one agency (the Health Insurance Review and Assessment Agency [HIRA]) which is independent from the insurer. The claims database is linked with each health facility, which makes it available to monitor and evaluate the health-care services provided. A drug utilization review system provides prescribing doctors and pharmacists with real-time information of the kinds of pharmaceuticals a patient is taking, drug side-effects and contraindications. The drug utilization review is intended to prevent unnecessary or harmful drug utilization and reduce health expenditure on pharmaceuticals (WHO, 2015e).

Recently, the Republic of Korea has focused on public disclosure of health information to the general public and the health research community. As the Government has progressively widened the coverage of disclosure of public information, many public databases have become accessible. In the case of health information, for example, operational details of day care facilities, information on hospitals, and overdue payments or state health insurance are publicly available.

**BOX 25. Placing UHC monitoring and evaluation at the heart of health sector reform in the Lao People’s Democratic Republic**

The Ministry of Health of the Lao People’s Democratic Republic, with the support of the National Assembly, embarked on a health sector reform process in 2012 to achieve the MDGs by 2015 and UHC by 2025 (WHO, ADB AEHIN, 2014). The Ministry of Health is implementing a web-based reporting platform using District Health Information System version 2 (DHIS2) as an effective M&E tool to provide timely and reliable health system data to policy-makers. The system was first implemented in five southern provinces in early 2014, and subsequently expanded to all 18 provinces by March 2015.

DHIS2 captures routine data from health facilities and allows real-time aggregation at the district, provincial and national levels. By using the tool, standard report forms were developed nationwide, embedded with an analytics engine to aggregate and process all indicators and data elements in the system to generate comprehensive and reliable reports with minimum processing time. DHIS2 is now regarded as a data management tool that provides a means to facilitate understanding of the health situation and aid decision-making for planning and programme implementation purposes. These efforts have also underlined the importance of strong leadership from the Ministry of Health, coordination of support from development partners and other government bodies, and clarity of goals in the health reform strategy.
**BOX 26. Strengthening domestic research capacity to generate and use evidence for policy-making**

Many health policies and systems issues are highly contextual. Strong domestic capacity in problem-oriented health policy and systems analysis and research can improve the process, content and implementation of health policies on the path to UHC.

Institutional capacity in the Region has significantly expanded over the last two decades. These function as stand-alone institutes (e.g. China, Malaysia and Viet Nam), or as divisions within research institutions (e.g. Cambodia and the Lao People’s Democratic Republic), in both state-run and private universities (e.g. China, Mongolia and the Philippines). There is also a trend towards establishing research or analysis units within ministries of health.

The Ministry of Health in Viet Nam set up the Health Strategy and Policy Institute in 1998 through a prime-ministerial decree, while Malaysia established the Institute for Health Systems Research in 2002 under the umbrella of the National Institute of Health. In Cambodia and the Lao People’s Democratic Republic, the ministries of health established national institutes of public health in 1997–2000, having divisions for Health Service Development and Support, and Health Systems Research, respectively.

The China National Health Development Research Center (formerly known as the China Health Economics Institute), a research institution established in 1991 under the leadership of the then-called the Ministry of Health (now the National Health and Family Planning Commission, NHFPC) (Meng et al., 2004), is a national think-tank providing technical consultancy to health policy-makers. China also has a network of health policy research institutions, both as part of the NHFPC and located in major universities at national and provincial level. A similar network of institutes – a Center for Health Development within the Ministry of Health – is seen in Mongolia.
A high-performing health system does not just provide optimal health services to meet population and individual needs and achieve optimal health outcomes. It does so in a sustainable way that ensures future generations will continue to benefit from the health system. A sustainable health system is also resilient. Resilience is the ability to cope with and recover quickly from internal and external shocks, and to prepare for and adapt to changing environments.

Health systems are currently challenged to respond to ageing populations, rising health services costs, the NCD epidemic, emerging infectious disease threats, outbreaks and pandemics, disasters (natural and human-induced), health workforce crises and rising expectations of communities. The Region has been the source of outbreaks such as severe acute respiratory syndrome (SARS), avian influenza (H7N9) and Nipah virus.

Home to one quarter of the world’s population, the Western Pacific Region is undergoing rapid urbanization and the formation of megacities. Two of the top five megacities are located in the Region (Tokyo and Shanghai). Projections indicate that by 2030 Tokyo, Shanghai and Beijing will be among the top five largest megacities, and 11 of the 41 megacities globally will be in the Western Pacific Region [UN DESA, 2015]. The Region is also ageing at an increasing rate as seen in China, Hong Kong SAR (China), the Republic of Korea, Singapore and Viet Nam. In recognition of these issues, the Region has adopted the Regional framework for action on ageing and health in the Western Pacific Region (2014–2019) and the Healthy Urbanization: Regional Framework for Scaling Up and Expanding Healthy Cities in the Western Pacific Region 2011–2015.

The Western Pacific Region is the most disaster-prone region in the world. Climate change and rising sea levels pose special problems for Pacific island countries and low-lying areas of other countries. If health facilities are not safe in design, with essential utilities and services located away from high-impact areas, they will not only be impacted themselves, they will also be unable to provide the response needed in the aftermath of events related to any hazard. If surveillance systems are not robust, and health workers are not adequately equipped to respond to emerging diseases, the economic development of the country can be slowed or even reversed. High-performing health systems are more likely to successfully respond to these challenges.
Major advances in health and health services over the past two centuries have come at a cost, with health expenditure outstripping economic growth in many countries. Focusing only on improving the efficiency of health services is not likely to lead to sustainable health systems in the future. Resilience calls for countries to anticipate and adapt to foreseeable health system challenges and the accompanying fiscal pressures by adjusting the models of health services financing and provision, and to use the opportunities of modern technology to provide more access to the most needed services for more people. Over the long term, resilience is fundamental to health system survival.

To achieve sustainable and resilient health systems for the future, societies must reshape health services to reduce the disease burden by helping people to stay healthy and empowering them to manage their health. Health systems can encourage and incentivize healthier lifestyles, foster environments and infrastructure, such as transport and communication, that facilitate and safeguard equitable population health services, and actively engage with populations to engender community resilience and preparedness.

Working towards sustainable health systems in the Western Pacific Region may also require reforms in health financing and service delivery. Some countries will need to transition away from donor dependency and unpredictable funding levels, fragmented service provision, over-reliance on out-of-pocket payments and a health workforce relying on unsustainable incentives. Countries need to undertake reforms creatively, using integrated, people-centred service delivery and financing innovations and be flexible and adaptive enough to withstand economic volatility.

Key action domains and priority actions

**ACTION 5.1 Public health preparedness**

Sustainable health systems need to be prepared for unexpected crises. This requires systems and infrastructure that function reliably in a range of conditions. Quick access to additional capacity enables a fast and effective response to, and recovery from, disruptive events [United Kingdom Cabinet Office, 2011]. Public health security across and within countries necessitates robust and effective disease surveillance and response systems. The appropriate and timely management of population health risks also depends on effective national capacities and intersectoral and international collaboration.
1. **Strengthen capability to detect and respond to diseases or conditions with the potential to become a major public health concern or emergency.**
   a. Continue to build the International Health Regulations (2005) core capacities within the framework of the *Asia Pacific Strategy for Emerging Diseases*.
   b. Establish effective permanent public health security and response capacity and manage specific health risks across sectors, such as emerging infectious diseases, food contamination and radioactive substances, in all public settings.

2. **Develop cross-sectoral partnerships and plans for disaster risk management.**
   a. Implement, according to national and local contexts, priority actions selected from the *Western Pacific Regional Framework for Action for Disaster Risk Management for Health* across all four phases of disaster risk management for health (prevention, preparedness, response and recovery).
   b. Assess and monitor standards of infrastructure and functional safety and invest in safe and flexibly designed facilities, including retrofitting of existing structures to better meet future needs.
   c. Coordinate the deployment of resources across all sectors (human resources, communications, transport, water, shelter and other stockpiles) that are critical in emergency response.

3. **Devise and test business continuity plans.**
   a. Identify and manage the risks of anticipated service changes, or service interruption, and improve functionalities and efficiency in the face of potential threats.
   b. Delineate core basic health services at each level and document the location of critical health resources for emergency responses – human resources, medicines, technologies and logistical supplies.

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**BOX 27. Strengthening multisectoral collaboration in Mongolia**

Several countries in the Western Pacific Region, including Mongolia, have developed plans for multisectoral collaboration between human and animal health sectors, among other sectors.

With livestock husbandry comprising a large part of its agricultural economy and increasing public health risks from diseases of animals, Mongolia is taking a collaborative approach to managing zoonotic diseases. In February 2010, the country established an intersectoral coordination committee on zoonoses. The committee involves the Ministry of Health and Sports, the Veterinary and AnimalBreeding Agency of the Ministry of Food and Agriculture and Light Industry, the National Emergency Management Agency, the Ministry of Nature and Environment, the General Agency for Specialized Inspection and WHO.
The intersectoral coordination mechanism expanded to incorporate more work on food safety, emergency management and the effects of climate change on zoonotic diseases. The human and animal health sectors have developed joint operational plans, including a long-term risk reduction plan for 2011–2015, a prioritization exercise and risk assessment of 29 zoonotic diseases, and review and revision of standards, procedures and communication strategies (WHO, 2014d).

**BOX 28. Improving risk communications in Solomon Islands and the Philippines**

Countries in the Western Pacific Region are prone to natural disasters, such as flash flooding, typhoons and earthquakes. Both Solomon Islands and the Philippines have strengthened their risk communications in responding to and recovering from natural disasters.

In April 2014, Solomon Islands was hit with unprecedented flash flooding. The Government declared a state of emergency in Honiara and the rest of Guadalcanal province, with nearly 52,000 people affected across the country.

The Solomon Islands Ministry of Health and Medical Services addressed the health concerns of the affected communities and those in evacuation centres. With WHO support, the Ministry’s Health Promotion Department mobilized human resources and worked with development partners to make critical health information available to the public in a timely manner. Health promotion volunteers were dispatched to communities and evacuation centres to deliver health messages. In addition, Solomon Islands also provided risk communications to affected communities through a media forum with the health sector and local media personnel (WHO, 2014d).

In the massive emergency response following Typhoon Haiyan, the Philippine Department of Health and partners including WHO focused on re-establishing basic health services across the large devastated stretch of the Visayas, in the central Philippines. At the same time, planning commenced for repair and reconstruction of more resilient facilities and systems.

A key issue in the immediate aftermath of the typhoon was the inability to communicate properly from affected areas and the resulting lack of coordination. To better prepare for future events, the Department of Health began the process of setting up Emergency Operations Centres (EOCs) in vulnerable regions. The centre serves as the technical, information and management hub from which response operations are coordinated during public health events. The centre also serves as a venue for preparedness planning and normal daily operations.

With support from WHO, the Department of Health established and strengthened EOCs in the office of the Health Emergency Management Bureau in Manila, as well as centres for health development. The critical need is to ensure appropriate capacity and capability to communicate with the regional centres for health development and a Department of Health and Health Emergency Management Bureau joint operations centre in Manila. Now EOCs have been provided with satellite terminals and radio equipment, in addition to information technology and collaborative work tools to enhance communication and analytical capacity.
ACTION 5.2  Community capacity

Healthy communities are able to take actions in managing health hazards, risks and disasters. Empowering communities to improve their health and fitness improves their resilience and contributes to health system sustainability as well as their ability to be an effective partner in any crisis response. Enabling communities to respond to basic health needs, and regularly engaging them in planning and practice contributes to overall resilience and capacity for recovery.

1. **Enhance community capacity for disease management and health promotion.**
   a. Develop and engage community organizations, employers and employees in all forms of prevention and protection against the main communicable disease and NCD risk factors and injuries.
   b. Work with communities and other sectors to implement prevention and health promotion interventions using the healthy settings approach.
   c. Support the development of self-management capacity for priority health conditions, particularly for populations with a lower level of access to services.

2. **Promote community participation and readiness for disaster risk management.**
   a. Build community awareness, readiness and skills for disaster prevention, preparedness, response and recovery.
   b. Increase the efficiency, effectiveness and impact of emergency response to disasters at the community level.
   c. Foster effective cross-sectoral partnerships and collaboration with local governments to support a robust culture of health resilience where individuals and community groups actively participate in community disaster prevention, preparedness, response and recovery.

**BOX 29. Engaging communities in health promotion, nutrition and disaster risk management in Samoa**

Samoa has been actively engaging its communities in health promotion, nutrition and public health preparedness. Led by the Ministry of Health, the Samoa Outreach Nutrition Pilot Project is a sector-wide initiative that aims to strengthen primary health-care services in nutrition and growth monitoring, and raise awareness of their importance at the village level (Mott McDonald, 2015). Key partners include the National Health Service and Ministry of Women, Community and Social Development (MWCSD). Supported by the Ministry of Health, the MWCSD is also working with the Community Women’s Committee to organize household sanitary inspections to raise awareness of health promotion of basic hygiene and preparedness during natural disasters.
In developing a national health surveillance and an International Health Regulations division in the Ministry of Health, the Samoa Disaster Management Office supports the preparation of national drills and monitoring the implementation of the national disaster preparedness plan. The office works across multiple sectors and stakeholders. In addition, the Ministry of Health finalized its Climate Adaption Strategy for Health, which provides an operational framework to build a climate-resilient health sector response, in collaboration with the Ministry of Environment and WHO.

**ACTION 5.3  Health system adaptability and sustainability**

Maintaining sustainable and resilient health systems is the overarching responsibility of governments. Protecting the interests of the whole population requires foresight, operational readiness and flexibility in mobilizing and using resources. Mechanisms should be in place to involve stakeholders in decision-making processes so that the health system continues to meet population needs in a changing environment.

1. **Develop foresight capabilities.**
   a. Establish a surveillance and forecasting system and systematically monitor key indicators to predict changing health patterns and issues and prepare responses to minimize and manage future risks.
   b. Explore adaptable and sustainable technology innovations that can better meet the increasing and changing health needs of the population.
   c. Identify alternative service delivery models that address changing health priorities and retrain or expand health workforce skills accordingly.

2. **Leverage resources for health through cross-programme and inter-institutional linkages.**
   a. Reduce reliance on donor funding and increase domestic funding to ensure financial sustainability and ability to withstand economic volatility.
   b. Decrease fragmentation across the health sector and improve coordination and integration of vertical programmes in the health system.
   c. Institute governance mechanisms that facilitate flexible deployment of financial, logistics and human resources as new health needs emerge.
3. Institutionalize participatory governance.
   a. Create deliberative and advisory mechanisms for ongoing stakeholder input into health planning and decision-making.
   b. Take coordinated action among key stakeholders to address anticipated health challenges.

**BOX 30. Preparing and planning for the future through a whole-of-government approach: Centre for Strategic Futures, Singapore**

Strategically placed long-term, whole-of-government thinking and planning capabilities may be critical to deal with future challenges and opportunities.

Singapore’s Centre for Strategic Futures (CSF) was established in 2009 in the Prime Minister’s Office and evolved from Singapore’s initial future planning efforts in the late 1980s (Ho, 2010). The centre’s location, at the heart of Government, enables it to reach across different agencies and departments. The centre serves as a think-tank within the Government. The centre is able to pursue open-ended, long-term futures research on issues of strategic importance, even issues not perceived to be urgent, and experiment with new foresight methodologies.

CSF contributes to strategic futures work in many sectors including health. The centre partners with the Ministry of Health to discuss future planning for health, and links other Government agencies on cross-sectoral issues affecting health. Long-term planning, beyond the usual five- to 10-year horizon, is critical when tackling slow-onset challenges, such as an ageing population and disruptive innovations that challenge existing paradigms.

In the early 2000s, the Prime Minister’s Office identified rapid developments in technology and information systems as a potential disruptive innovation in health care, and tasked the Infocomm Development Authority of Singapore to review how information technology developments can revolutionize health care. It published a report in 2006 that outlined how information systems development and technology investments can strengthen the health-care system to become more sustainable and future ready. The report triggered a national effort to build a National Electronic Health Record system accessible by all public health-care institutions, which was successfully implemented in 2012.
4. Monitoring framework for UHC

Monitoring progress towards UHC is integral to achieving desirable health outcome goals. Most countries in the Region have or are developing some kind of monitoring framework that takes into account their national priorities and population needs. As a whole-of-system approach to improving health system performance, UHC monitoring can be integrated into or built upon existing monitoring frameworks that track overall health system performance. Countries should take into account their unique contextual factors – epidemiological and demographic profiles, health system, level of economic development, and population demands and expectations – when designing what should be monitored and tailoring measures to reflect their needs. At the same time, given the widespread and growing interest in moving towards UHC, incorporating internationally or regionally standardized indicators is strategic (WHO & World Bank, 2013).

The regional UHC monitoring framework is coupled with a proposed and updated set of UHC-oriented regional core indicators to provide information on inputs and processes, outputs, reach and outcomes, and impacts across the health sector and other sectors.

Alignment of the Western Pacific Region Country Health Information Profiles (CHIPS) core indicators or UHC indicators for the Region with the proposed indicators to monitor the health-related SDGs is necessary for global reporting consistency. At the same time, they address common challenges across the Region – NCDs, quality and safety, equity, health systems performance – as well as the unfinished business of the MDGs including maternal and child health, tuberculosis, HIV/AIDS and malaria. The indicators are likewise aligned with the Global Reference List of 100 Core Health Indicators (WHO, 2015a) to comply with global reporting requirements, maximize use for national policy and planning, and minimize the reporting burden on countries. The majority of these proposed UHC indicators and their data requirements are incorporated within CHIPS and existing country monitoring systems in the Region.
BOX 31. Framework to monitor health systems performance, UHC and the SDGs in the Western Pacific Region (in development)

Through a WHO and Asian Development Bank collaboration, a regional UHC monitoring framework is in development. The framework will guide the measurement of progress on UHC in the Western Pacific Region. The framework builds upon the Western Pacific Region Country Health Information Profiles (CHIPS) for monitoring health situations and trends, and presents an opportunity to revisit the Western Pacific Region core indicators and orient them more closely to better track progress and accountability in achieving UHC. The new framework is based upon health-related targets and proposed indicators from the SDGs and an expansion of the International Health Partnership (IHP+) framework for health systems performance (WHO, 2011a). It considers key elements of other global and national health monitoring frameworks including those for quality (WHO, 2015b) and social determinants of health (WHO, 2010b). The framework captures crucial health sector inputs and interventions and health-related initiatives from other sectors that jointly contribute to better coverage and reach of health services and financial risk protection to attain the highest possible levels of well-being and health for populations. The framework also highlights and is linked to the UHC action domains through the five essential health systems attributes: quality, efficiency, equity, accountability, and sustainability and resilience.

UHC monitoring framework

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<thead>
<tr>
<th>Inputs &amp; Processes</th>
<th>Outputs</th>
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<td>Health financing</td>
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<td>People-centredness</td>
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<td><strong>Health financing</strong></td>
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<tr>
<th>Other sectors</th>
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<td>Governance and policies</td>
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<td>Financing</td>
<td>Housing</td>
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<td>Infrastructures &amp; technologies</td>
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<td>Social inclusion</td>
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<td>Disability</td>
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<th><strong>Lifestyle factors and practices</strong></th>
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<td>Resilience</td>
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**BOX 32. Options for UHC monitoring**

Each country should be guided by its national health policies, priorities, strategies and capacity for implementing its national M&E framework and measuring UHC. The UHC M&E framework and the UHC core indicator set are intended to assist countries in strategically augmenting their M&E frameworks and core indicators for health policy and planning, and measuring health systems performance. UHC indicators may be bundled into core, expanded and optimal sets, arranged according to a life-course approach below or through a health system development view to highlight monitoring different packages of health system services and interventions at each level of health system maturity. Countries have the flexibility of tailoring their indicator set by adapting the level of detail and selecting the monitoring framework.

**Monitoring UHC through the life course**

National monitoring of UHC must be responsive to country needs and prioritized actions towards UHC. National monitoring must rely on country-defined targets and indicators to track progress and help ensure accountability for UHC. The collection, management and reporting of reliable data must build on existing country monitoring mechanisms while pursuing opportunities to use ICT tools and solutions to add efficiencies in progress tracking, in presenting and in communicating results for action.
BOX 33. Innovative dashboards for monitoring universal health coverage

Infographics and visualization tools or monitoring dashboards to track progress towards UHC based on country-specific health policies, strategies and priorities are being increasingly used across the Region. A customizable UHC dashboard will be developed in the Health Information and Intelligence Platform (HIIP) [http://hiip.wpro.who.int]. The dashboard will provide regional-level intelligence of country-specific UHC situations using Western Pacific Region-compiled data and indicators from country and global databases.

National UHC monitoring dashboards have also begun to be developed. In Cambodia the dashboard is based on the country’s web-based health management information system (HMIS) (Ministry of Health, Cambodia, 2015), demographic and health surveys (DHS) and socioeconomic surveys (SES), etc. In the Lao People’s Democratic Republic the dashboard will be a new feature in the District Health Information System version 2 (DHIS2) which is currently being scaled up (Ministry of Health, Lao People’s Democratic Republic, 2014). The Philippines launched its UHC dashboard in 2013, with a core set of 19 UHC indicators to track financial risk protection, equity, service quality and coverage, and infrastructure improvements (Department of Health, Philippines, 2013). Setting targets and visualizing progress towards UHC using the regional monitoring framework, core indicators and monitoring dashboards are helping countries target and implement interventions for better health.

UHC dashboard: example from Cambodia
5. The way forward

Member States

Western Pacific Region Member States have repeatedly affirmed their commitment to “health for all”. UHC is one way health systems can contribute to this global health vision and is a hallmark of a government’s commitment to improving the well-being of all its citizens. Good governance and government leadership are fundamental to progressing towards, establishing and steering the vision for health sector development. They are also required in providing sufficient financial and human resources and in efforts to address the social determinants of health.

The UHC pathway is country specific, depending on a country’s history, political economy, available resources and expectations. No country has sufficient resources to meet all of the health needs for all of its people. Countries are always having to make trade-offs. When countries develop their UHC road maps, they will need to prioritize their investments in health to address their health needs within the context of their limited resources, burdens of disease, institutional capacities and levels of community engagement, among other factors. Multiple stakeholders are involved across various sectors and levels, which can also make the prioritization process more complex in decentralized settings.

The action framework of Universal Health Coverage: Moving Towards Better Health is not prescriptive. Rather, it facilitates the selection of the right mix of actions for countries in the short- and medium-term to accelerate progress towards UHC. Nonetheless, all countries should ensure the identification of core services, sufficient funding, an appropriate health workforce, adequate infrastructure and available essential medicines.

It is important to understand challenges, issues and options to address them using evidence-informed planning and decision-making processes. In deciding which actions to take, countries may consider the connections between different actions and how they reinforce one another. Examples of how countries may address specific challenges and issues show the combination of actions that may be taken and linkages across actions and attributes (Annex 2). While it is critical to have a country specific road map for UHC, this is not a stand-alone document. It is to be incorporated into their current and future health policies and strategies, including any aspects of health reform.
Member States are requested to:

1. Assess their current situation and identify problems, challenges and their root causes.

2. Establish a shared vision, cultivate enabling policy and institutional environments, and engage with the Ministry of Finance and other relevant ministries, civil society and development partners, to ensure that UHC is fully realized in their country.

3. Use this action framework as a reference, identify opportunities, select strategic entry points and develop specific actions to address gap, strengthen health systems, and advance towards UHC.

4. Design and implement a country-specific UHC road map using the action domains and strategic actions to guide ongoing health policy and health sector reform as part of the national health policy and planning process.

5. Ensure financial sustainability for health systems, including increasing domestic funding for health and securing predictable external funding.

6. Monitor and evaluate progress and actively seek opportunities to accelerate progress towards UHC.
WHO Regional Office for the Western Pacific

WHO remains deeply committed to UHC as a top priority and the overarching vision for health sector development. WHO will continue to strengthen its own capacity and seek feedback to improve its way of working to meet the increasing and changing demands from the Member States in their advancement towards UHC.

Priority WHO actions are to:

1. Facilitate high-level multisectoral policy dialogues with in-country stakeholders during the national health policy and planning process.

2. Provide technical support to health system development, working towards a more integrated approach across health and disease programmes.

3. Build country capacity and facilitate experience sharing, joint learning and technical support among countries.

4. Engage with development partners at country, regional and global levels to support the national planning process and ensure donor funding alignment with national health priorities.

5. Advise countries on emerging international and regional consensus and good practices for UHC.

6. Establish a regional platform (mechanism) for reporting countries’ progress and exploring solutions to progress faster towards UHC among Member States, technical experts and development partners.
GLOSSARY OF KEY TERMS

Business continuity plan
A plan that documents a business continuity management process. The plan would serve as a guide in preparing all levels and groups of society for an emergency. It should be based on a risk assessment of the potential effect of an emergency on the ability to maintain or expand operations. The risk assessment should include consideration of vital components outside the specific organization, such as the resilience of supply chains for essential goods and services. The plans can be used to manage business interruptions, including significant absences of staff or disruption of supplies (WHO, 2013c).

Catastrophic health expenditure
A situation where a household faces financial hardship because of paying for needed health services through out-of-pocket payment. It is defined in relation to a household’s capacity to pay. The commonly used threshold is health payments in excess of 40% of household consumption expenditure net of paying for subsistence needs, e.g. food. Catastrophic expenditures can result from expensive, infrequent events such as hospital care, as well as from low-cost, high-frequency events such as those associated with chronic conditions.

Civil society
Civil society is seen as a social sphere separate from both the state and the market. The increasingly accepted understanding of the term civil society organizations is that of non-state, not-for-profit, voluntary organizations formed by people in that social sphere. This term is used to describe a wide range of organizations, networks, associations, groups and movements that are independent from government and that sometimes come together to advance their common interests through collective action. Traditionally, civil society includes all organizations that occupy the “social space” between the family and the state, excluding political parties and firms. Some definitions of civil society also include certain businesses, such as the media, private schools and for-profit associations, while others exclude them (WHO, n.d.b).

By definition, all such civic groups are nongovernmental organizations, in that they are organizations not affiliated with government. However, in practice, the term nongovernmental organizations is used to describe non-profit making, non-violent organizations, which seek to influence the policy of governments and international organizations and/or to complement government services [such as health and education]. They usually have a formal structure, offer services to people other than their members, and are, in most cases, registered with national authorities. Nongovernmental organizations vary hugely in their size, scope of activity and goals. They may operate nationally, or internationally, or they may be small community-based organizations (CBOs) that aim to mobilize, organize or empower their members, usually in a local area. There are issues of transparency, accountability, and rights of representation around nongovernmental organizations, particularly international ones (WHO, n.d.b).
Community
A specific group of people, often living in a defined geographical area, who share a common culture, values and norms, and are arranged in a social structure according to relationships, which the community has developed over a period of time. Members of a community gain their personal and social identity by sharing common beliefs, values and norms, which have been developed by the community in the past and may be modified in the future [WHO, n.d.c].

Complementary/alternative medicine (CAM)
The terms “complementary medicine” or “alternative medicine” are used interchangeably with traditional medicine in some countries. They refer to a broad set of health-care practices that are not part of that country’s own tradition and are not integrated into the dominant health-care system. [See definition under “Traditional medicine”.

Disadvantaged and vulnerable groups
These terms are applied to groups of people who, due to factors usually considered outside their control, do not have the same opportunities as the general population, and are at a higher risk of poverty and social exclusion. Examples might include unemployed people, refugees, minorities, the homeless, those struggling with substance abuse, mental illness, disabilities, isolated older people and children all often face difficulties that can lead to further social exclusion [WHO, n.d.e]

Disaster risk management
The systematic process of using administrative directives, organizations, and operational skills and capacities to implement strategies, policies and improved coping capacities in order to lessen the adverse impacts of hazards and the possibility of disaster [United Nations, 2009].

Health education
Health education comprises consciously constructed opportunities for learning involving some form of communication designed to improve health literacy, including improving knowledge, and developing life skills that are conducive to individual and community health.

Health education is not only concerned with the communication of information, but also with fostering the motivation, skills and confidence (self-efficacy) necessary to take action to improve health. Health education includes the communication of information concerning the underlying social, economic and environmental conditions impacting health, as well as individual risk factors and risk behaviours, and use of the health-care system. Thus, health education may involve the communication of information, and development of skills which demonstrates the political feasibility and organizational possibilities of various forms of action to address social, economic and environmental determinants of health [WHO, 1998].
Health literacy

Health literacy represents the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health.

Health literacy implies the achievement of a level of knowledge, personal skills and confidence to take action to improve personal and community health by changing personal lifestyles and living conditions (WHO, 1998).

By improving people’s access to health information, and their capacity to use it effectively, health literacy is critical to empowerment. Health literacy is itself dependent upon more general levels of literacy. Poor literacy can affect people’s health directly by limiting their personal, social and cultural development, as well as hindering the development of health literacy.

Health promotion

Health promotion is the process of enabling people to increase control over their health and to improve their health.

Health promotion represents a comprehensive social and political process, it not only embraces actions directed at strengthening the skills and capabilities of individuals, but also action directed towards changing social, environmental and economic conditions so as to alleviate their impact on public and individual health (WHO, n.d.f)

Health service

Any service (i.e. not limited to medical or clinical services) aimed at contributing to improved health or to the diagnosis, treatment and rehabilitation of sick people (WHO, n.d.g)

Health system

(i) All the activities whose primary purpose is to promote, restore and/or maintain health; and (ii) the people, institutions and resources, arranged together in accordance with established policies, to improve the health of the population they serve, while responding to people’s legitimate expectations and protecting them against the cost of ill-health through a variety of activities whose primary intent is to improve health (WHO, n.d.g)

Healthy settings

Healthy settings, the settings-based approaches to health promotion, involve a holistic and multidisciplinary method which integrates action across risk factors. The goal is to maximize disease prevention via a whole-system approach. The settings approach has roots in the WHO Health for All strategy and, more specifically, the Ottawa Charter for Health Promotion. Healthy settings key principles include community participation, partnership, empowerment and equity (WHO, n.d.h). Healthy settings refers to an approach to promoting the health of whole communities where the primary focus is on creating and maintaining healthy living conditions and associated lifestyles across the whole setting, directing attention to structural and organizational change and development, rather than to the health related behaviours of individuals (WHO, 2002).
Integrated health services
These are health services that are managed so as to ensure that people receive a continuum of health promotion, disease prevention, diagnosis, treatment and management, rehabilitation and palliative care services, through the different levels and sites of care within the health system, and according to their needs throughout the life course [WHO, n.d.g]

Long-term care
Long-term care refers to the provision of services for people of all ages with long-term functional dependency. Dependency creates the need for a range of services, which are designed to compensate for their limited capacity to carry out activities of daily living. Dependency also results in difficulties in accessing health care and in complying with health-care regimes. It impacts on the ability of the individual to maintain a healthy lifestyle, and to prevent deterioration in health and functional status [WHO, 2003].

Nongovernmental organizations
An independent, national or international organization. These organizations may be run either for profit or not for profit (see definition under "civil society").

Non-state sectors
Non-state sectors are all providers who exist outside of the public sector, whether their aim is philanthropic or commercial, and whose aim is to treat illness or prevent disease. These include private-for-profit (commercial) and private non-profit formal health-care providers, and traditional and informal practitioners [WHO, 2005].

Out-of-pocket expenditure
Out-of-pocket health payments refer to the payments made by households at the point they receive health services. Typically these include doctor’s consultation fees, purchases of medication and hospital bills. Although spending on alternative and/or traditional medicine is included in out-of-pocket payments, expenditure on health-related transportation and special nutrition are excluded. It is also important to note that out-of-pocket payments are net of any insurance reimbursement.

People-centred care
People-centred care refers to care that is focused and organized around the health needs and expectations of people and communities rather than on diseases. People-centred care extends the concept of patient-centred care to individuals, families, communities and society. Whereas patient-centred care is commonly understood as focusing on the individual seeking care – the patient – people-centred care encompasses these clinical encounters and also includes attention to the health of people in their communities and their crucial role in shaping health policy and health services [WHO, n.d.g].
Prepayment

Prepayment is payment made in advance, such as general tax, payroll tax or health insurance contributions, for health services. Prepayment has certain advantages over out-of-pocket payment, such as disconnection between the use of services and the payment, often according to capacity to pay, in particular though general taxation and payroll tax; prepayments are pooled so that the healthy subsidizes the sick and the rich subsidize the poor.

Primary care

Primary care refers to the first level of care encountered by the population through a health-care provider or practitioner such as primary care physicians or general practitioners (WHO, n.d.g).

Primary health care

Primary health care refers to the broader term stretching from the first level of care encountered by the population, the range of activities within the health sector offered by providers, a political movement, and the philosophy based on the principles found in the Alma-Ata Declaration: equity, participation, intersectoral action, appropriate technology and a central role played by the health system.

Public health preparedness

Public health preparedness refers to the ability of nations, states and communities to identify, prepare for, respond to, contain and recover – in both the short and long term – from public health incidents (Centers for Disease Control and Prevention, 2011).

Rule of law

The rule of law is a principle of governance in which all people, institutions and entities, public and private, including the government, are accountable to laws that are publicly promulgated, equally enforced and independently adjudicated, and which are consistent with international human rights norms and standards. It requires, as well, measures to ensure adherence to the principles of supremacy of law, equality before the law, accountability to the law, fairness in the application of the law, separation of powers, participation in decision-making, legal certainty, avoidance of arbitrariness, and procedural and legal transparency (United Nations, 2004).

Secondary care

Health care provided by a specialist on an ambulatory or inpatient basis, usually following a referral from primary care (WHO, 2004).

Social protection

Social protection is a key component of social policy and is concerned with preventing, managing, and overcoming situations that adversely affect people’s well-being. It helps individuals maintain their living standard when confronted by contingencies such as illness, maternity, disability or old age; market risks, such as unemployment; as well as economic crises or natural disasters.
For some countries, social protection has emerged as a policy framework for addressing poverty and vulnerability especially in contexts where chronic poverty and persistent deprivation exists (UNRISD, 2010).

**Spurious/ falsely-labelled/ falsified/ counterfeit (SFFC) medicines**

SFFC medicines are defined differently in different countries.

In general SFFC medicines refer to medicines that are deliberately and fraudulently mislabeled with respect to identity and/or source (WHO, 2011b).

**Tertiary care**

The provision of highly specialized services in ambulatory and hospital settings (WHO, 2004).

**Traditional medicine**

Traditional medicine is the sum total of the knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness (WHO, n.d.d).

**Universal health coverage**

Universal health coverage means all people receiving the health services they need, including health initiatives designed to promote better health (e.g. anti-tobacco policies), prevent illness (e.g. vaccinations), and provide treatment, rehabilitation and palliative care (e.g. end-of-life care) of sufficient quality to be effective while at the same time ensuring that the use of these services does not expose the user to financial hardship (WHO, n.d.g).

**Whole-of-system approach**

A whole-of-system approach implies a strategic and integrated approach to planning and delivering health services to a population. This approach considers the components and functions of the health system and their interrelatedness in determining how to achieve the best possible health outcomes.
REFERENCES


65


WHO. [2010b]. Western Pacific regional strategy for health systems based on the values of primary health care. Manila, Philippines: WHO Regional Office for the Western Pacific.


UNIVERSAL HEALTH COVERAGE: MOVING TOWARDS BETTER HEALTH – ACTION FRAMEWORK FOR THE WESTERN PACIFIC REGION


## Annex 1. Mapping action domains with health system building blocks

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<td>2.1 Health system architecture to meet population needs</td>
<td>3.1 Financial protection</td>
<td>5.1 Public health preparedness</td>
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<td>3.2 Service coverage and access</td>
<td>5.3 Health system adaptability and sustainability</td>
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<td>4.2 Partnerships for public policy</td>
<td>5.2 Community capacity</td>
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Annex 2.

Illustrations of the application of mixing action domains for addressing commonly faced challenges in the Region

A. BUILDING TRUST IN THE GOVERNMENT AND HEALTH SYSTEM

Trust is an intricate element underpinning the achievement of universal health coverage (UHC). Trust in the health system promotes accountability; however, if money allocated to health is not used correctly then the trust between the health sector, the public and the government is undermined. To gain the public’s trust, governments must be transparent about how funds are spent and accountable for how spending translates into better access and quality of health services. Trust must exist across several levels, including the trust of the general public in the government to provide affordable, quality health-care services, and trust within the government itself and across all sectors to collaborate and effectively manage the health system.

Public engagement is critical when building trust in the health system. This engagement should not be overlooked when developing health plans (Action domain 1.3). Planning should prioritize access to quality services, such as enforcing standards, taking into account patient expectations (Action domain 1.1). Strengthening health workforce competencies through education and health workforce regulation ensures delivery of quality services and fosters trust (Action domain 1.2). Transparency also requires that people have ready access to timely and reliable information on service quality and cost, health system performance and treatment options. Information and evidence sharing is therefore vital to build trust in the health system (Action domain 4.3). Transparency strengthens confidence in the government and, in turn, drives quality improvement and responsiveness to the communities it is meant to serve. Hence, transparency and accountability are closely linked.

Governments should not over-promise on the services that are provided under the umbrella of UHC. Identifying and providing a package of basic, essential, good-quality services that can be implemented realistically and consistently can increase confidence in the health system. Over time these actions will generate increasing trust, and ensure that the system is performing to its full potential, providing value for money, and instilling quality, paving the way towards UHC.

B. PROVIDING INTEGRATED, PEOPLE-CENTRED SERVICES

Integrated people-centred health services are managed and delivered so as to ensure that people receive a continuum of health
promotion, disease prevention, diagnosis, treatment and management, rehabilitation and palliative care services, through the different levels and sites of care within the health system, and according to their needs throughout the life course. Care is focused and organized around the health needs and expectations of people and communities rather than on diseases. Integrated people-centred health services are especially critical for chronic diseases.

The management of diabetes exemplifies the importance of coordinating and integrating services so that medical care and patient self-management continue through the patient’s life and complement each other. Caring for diabetes patients requires a multidisciplinary team providing a coordinated range of services spanning prevention, health promotion and lifestyle modification to screening, diagnosis, clinical care, management of co-morbidities, rehabilitation and palliation. The aim is to ensure well-orchestrated, continuous, comprehensive and timely care that (hopefully) reduces the overuse and misuse of services and leads to better outcomes and quality of life at reduced cost.

From the system perspective, the management of diabetes requires appropriate system design to facilitate effective delivery of services, including aligning financing with service delivery models [Action domain 2.2] and ensuring the safety and efficacy of new medicines and technologies [Action domain 1.1]. Enhancing health literacy among patients and their families as well as health and social workers promotes greater community engagement in chronic care and helps to ensure that services are safe and effective [Action domain 1.3]. These actions should be supplemented by health information systems that use data from patient records to inform quality improvement, improve service coordination, and support better health outcomes [Action domains 1.2 and 4.3].

C. INCREASING PRIMARY CARE UTILIZATION

Primary care is at the core of UHC. It assures people-centred care over time for a community, accessibility to receive care when it is first needed, comprehensiveness of care so that only rare or unusual manifestations of ill health are referred elsewhere, and coordination of care such that all facets of care (wherever received) are integrated. Primary care highlights prevention and encompasses effectiveness, safety, people-centred services, comprehensiveness, continuity and integration. Having a strong primary care system, usually the first point of contact for patients, ensures continuity of care and facilitates navigation through the health system at all levels. As the cornerstone of a strong health-care system, primary care requires sufficient financial and human resources to meet the needs of the population.

As countries in the Western Pacific Region evolve socioeconomically and demographically, their citizens are increasingly demanding equitable and sustain-
able health services that necessitate strengthened health systems starting at the primary care level. Yet, there is a considerable and growing imbalance between primary and specialty care within the Western Pacific Region. Low primary care utilization can be attributed to a variety of reasons: on one hand, rapid advances in medical technology drive up the demand for hospital-based specialist services, while on the other hand, unserved or underserved populations may be reluctant to seek services. Significantly higher incentives for specialists relative to primary care health professionals also contribute to the current imbalance, and make hospital-based practices more attractive. Other challenges include limited services, drugs and resources available in rural primary care settings, ageing populations, and the public’s lack of confidence in the quality of health services delivered at the primary care level.

Shifting health service utilization from the hospital setting to primary care requires strengthening the health workforce in terms of skill mix, competencies, and distribution. Incentivizing performance, and recruiting and retaining health workers to serve in underserved areas (Action domains 1.2, 2.2 and 3.2) are crucial to improving the quality, efficiency, and equity of primary care. Countries may also take actions to reduce financial and non-financial barriers to access (Action domain 3.1), strengthen the gatekeeping system, and reconfigure the system design to delineate the roles of health institutions at different levels of the health system (Action domains 1.2 and 2.1). From the demand side, improving health literacy and health education, and engaging with individuals, families, and communities (Action domains 1.3 and 3.2) can also help to improve primary care utilization. Moreover, it is important to mobilize sufficient resources for public health and primary-level services and to maintain financial sustainability, recognizing that increasing primary care utilization results in financial gains, better overall health outcomes, and improved health equity (Action domains 2.1 and 5.3).

D. REDUCING CROWDING IN HOSPITALS

Overcrowding in hospitals is a challenge that affects both high- and low-income countries in the Region. The root causes for this phenomenon are wide-ranging, and include inaccessible and low-quality primary care, low levels of trust in primary care health workers, poorly designed financial incentives that favour hospital-driven health-care services, the lack of effective gatekeeping mechanisms, and inefficient inpatient management resulting in prolonged hospital stays and/or multiple readmissions.

Actions are needed at both the inpatient and outpatient settings to reduce overcrowding in hospitals. Building a competent primary care workforce to provide good quality community-based health-care services (Action domains 1.1 and 1.2) and establishing incentives for providers
to work at the primary care level [Action domain 2.2] are supply-side interventions that can alleviate the overcrowding of hospitals. Adjusting the system architecture to meet population needs more efficiently requires defining core service packages and delineating the appropriate level of service provision by instituting a gatekeeping system for proper referrals and care integration [Action domain 2.1]. Demand-side strategies include enhancing population health literacy and engaging individuals, families and communities to increase understanding of their health needs, and the appropriate places to access care [Action domain 1.3]; and shifting utilization towards primary care through incentives like rebates for insurers for prevention [Action domain 3.2] and through increased public funding for prevention and primary care [Action domain 2.1].

E. DEALING WITH REDUCED DONOR FUNDING

The countries in the Western Pacific Region are undergoing rapid improvements in their economies, with very few still classified as low-income countries by the World Bank. Consequently, donor support is diminishing in the Region. Most countries are graduating out of Gavi support, while the Region has seen significant decreases in investment from the Global Fund to Fight AIDS, Tuberculosis and Malaria. Many bilateral donors are also reducing the size of their aid packages. However, improving economies have not necessarily translated into a commensurate increase in government investment in health and many countries are foreseeing large financial gaps between the demand for health services and the resources to supply these services.

Improving efficiency within the system design [Action domain 2.1] helps address the major issues. Financial pressures highlight the need for integrating vertical services into the health system, defining core priority services, mobilizing additional resources for health (possibly through innovative methods like sin taxes), and leveraging the private sector more effectively to fill in service gaps.

To ensure that the above actions can take place effectively, it is important to increase managerial capacity, and develop proper incentives for the system and personnel [Action domains 2.2 and 2.3]. Transparent, accurate and reliable data are needed to help decision-makers make appropriate, evidence-based decisions and to adjust as needed during this process of integration of services [Action domain 4.3].

Strong government leadership in guiding the transition from donor to domestic funding for health is essential, fostering national ownership and increasing accountability [Action domain 4.1]. Underpinning all these actions are the core principles of sustainability and resilience – both in terms of financial and programmatic sustainability [Action domains 5.1, 5.2 and 5.3].