PRIMARY HEALTH CARE IN THE WESTERN PACIFIC REGION –
LOOKING BACK AND FUTURE DIRECTIONS
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ABBREVIATIONS

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<tbody>
<tr>
<td>ASEAN</td>
<td>Association of Southeast Asian Nations</td>
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<tr>
<td>CHW</td>
<td>community health worker</td>
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<td>DHS</td>
<td>Demographic and Health Surveys</td>
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<td>GDP</td>
<td>gross domestic product</td>
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<td>GP</td>
<td>general practitioner</td>
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<td>HRSA</td>
<td>Health Sector Reform Agenda (Philippines)</td>
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<td>ICT</td>
<td>information and communications technology</td>
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<tr>
<td>KAP</td>
<td>knowledge, attitude and practices</td>
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<td>MCH</td>
<td>maternal and child health</td>
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<td>MDG</td>
<td>Millennium Development Goal</td>
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<td>MICS</td>
<td>Multiple Indicator Cluster Survey</td>
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<tr>
<td>NCD</td>
<td>noncommunicable disease</td>
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<tr>
<td>NGO</td>
<td>nongovernmental organization</td>
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<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
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<tr>
<td>OOP</td>
<td>out-of-pocket</td>
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<tr>
<td>PEN</td>
<td>Package of Essential Noncommunicable Disease Interventions</td>
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<td>PHC</td>
<td>primary health care</td>
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<tr>
<td>PHO</td>
<td>Primary Health Care Organisation (New Zealand)</td>
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<td>PICs</td>
<td>Pacific island countries and areas</td>
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<tr>
<td>RMNCAH</td>
<td>reproductive, maternal, newborn, child and adolescent health</td>
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<tr>
<td>SARS</td>
<td>severe acute respiratory syndrome</td>
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<tr>
<td>SDG</td>
<td>Sustainable Development Goal</td>
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<tr>
<td>TB</td>
<td>tuberculosis</td>
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<td>WASH</td>
<td>water, sanitation and hygiene</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<td>UHC</td>
<td>universal health coverage</td>
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<td>UHC TAG</td>
<td>Technical Advisory Group on Universal Health Coverage</td>
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EXECUTIVE SUMMARY

Background
The Western Pacific Region of the World Health Organization (WHO) is home to one quarter of the world’s population. There is a high level of diversity across the Region, with countries broadly categorized as advanced economies, transition economies, and the Pacific island countries and areas (PICs). Despite this diversity, the Region is experiencing some common epidemiological, governance and demographic trends. These include population ageing and mobility, rapid urbanization, decentralization, persistent inequities despite rapid economic growth, unfinished agendas in reproductive health and infectious disease control, rise of noncommunicable diseases (NCDs) and increased environmental threats. Balanced against these threats are opportunities presented by the revitalization of the primary health care (PHC) values of equity and social solidarity, through a renewed regional focus on the values of PHC as part of a multisectoral commitment to universal health coverage (UHC). This report presents a policy and strategy overview of the experience of PHC over the last 10 years (Section 1) and discusses options for future policy directions (Section 2).

Methods
Literature was sourced purposively from three major sources – the database of the WHO Regional Office for the Western Pacific, national health plans and policies, and selected peer-reviewed literature related to PHC policy and strategy (see Annex on methods).

Main findings

Looking back. Over the last 10 years, countries across the Western Pacific Region have continued to experience rapid social, economic and epidemiological changes. One in every two people in the Western Pacific Region now lives in urban areas, and this trend towards urbanization is set to continue. The double burden of communicable diseases and NCDs is evident across all country categories, with chronic disease management and climate change adaptation becoming of increasing public health concern. Inequities in terms of access to PHC is a common trend reported across the Region, with socioeconomic status, ethnicity and geographic location all strongly correlated with levels of access to health care. Main health system gaps contributing to these inequities are inadequate health workforce numbers, mix and skills for primary care – particularly in rural and remote and urban poor settings, and lack of adequate health expenditures on PHC. The private sector and nongovernmental organizations (NGOs) in many country settings are continuing to emerge as strategic partners in provision of PHC, and countries are implementing varying models of decentralization that are having significant impacts on health system governance. Strategy implementation demonstrates highly adaptive responses by both governments and other stakeholders (see Section 1.1.2). These include: renewed political commitments to UHC; health financing initiatives to offset financial barriers to access; decentralized health planning and budgeting processes; innovations in models of multisectoral collaborations for Healthy Cities, Healthy Islands and climate change adaptation; and forging of new alliances and partnerships at the community level. Good practice examples of how countries are responding at a policy level to these changes are outlined in this report (see Section 1.2.1).
Future directions. Reorientation of PHC towards more pro-equity, efficient, decentralized and people-centred services; a focus on prevention of NCDs; health security and adaptation to climate change; and expansion of the capacity for use of information and communications technology are major future directions for the Western Pacific Region. Given the diversity in levels of economic and institutional development across the Region, future directions will also entail a continued focus on women’s and children’s health and infectious disease prevention and control. Potential policy levers to support these policy directions include enhancement of political commitment and mandates for UHC, improved social protection, national health insurance and decentralized planning and budgeting processes, health service access across the life cycle, and building of new partnerships and alliances at the community level and across sectors. The health sector will combat the double burden of diseases by improving integration of services; building capacity for decentralized planning and budgeting; designing more people-centred services; building health alliances with local governments, community organizations, families, and with the traditional medicine sector; as well as by spreading more widely the application of information and communication technologies. Emphasis of the people-centred vision of PHC is mainly on the shared roles of community health workers, community nurses and midwives, allied health workers, traditional medicine practitioners and primary care doctors in applying a multidisciplinary team-based approach to supporting PHC services for the population.

Conclusion

A strengthened decentralized and people-centred vision of PHC will refocus strategies on prevention and promotion, as well as prepare systems for responding to emerging environmental threats and the rise of NCDs. It will also support the completion of unfinished agendas in the areas of reproductive, maternal, neonatal, child and adolescent health, and infectious disease control. A more people-centred and multisectoral public health vision of PHC will increase the capability of societies, health systems and communities to better adapt to the 21st century pressures of rapid social and environmental change.
1.1 Strategy guiding PHC development in the Western Pacific Region in the last decade

1.1.1 Political and technical rationale and mandate

Political rationale. The World Health Report (2008) reflected on 30 years of primary health care (PHC) implementation post Alma-Ata. The main values of the Declaration of Alma-Ata – equity, solidarity and social justice – were the main lens through which this 2008 report critiqued the implementation status of PHC across the globe. While recognizing the gradual expansion of global health programmes and reduction in preventable mortality, this report also highlighted the lack of responsiveness of health systems to social change and remarked on the growing inequalities in access and health outcomes between countries, as well as between social groups within countries. So what evidence is there in the Western Pacific Region of inequalities and social change, and either responsiveness or nonresponsiveness of health systems to such changes?

The Western Pacific Region displays a high level of diversity in culture and levels of social and economic development. There are 37 countries and areas in the Region, and the Region has been subclassified according to various developmental and cultural characteristics. Overall, the Region is home to 1.9 billion people, which is almost one quarter of the world’s population. The countries in the Region can be broadly categorized as advanced economies, transition economies, and small Pacific island countries and areas (PICs). However, although there is great diversity in levels of development across the Region, countries are experiencing similar social, demographic and epidemiological trends to a striking degree, all of which provide a powerful political and technical case for regional PHC reform.

In the realm of politics itself, there is evidence that the decentralization of power across the Region is altering the context for health systems provision and management. In many country settings, the rapid emergence of private and civil society actors – due to increasingly fragmenting models of service provision – has added layers of complexity to health management and regulation roles. Decentralization in such settings as Cambodia, Mongolia, Samoa and Viet Nam is greatly expanding the roles of local government in health services management, financing and provision. In more open and pluralistic social systems, political leaders utilize the policies of universal health coverage (UHC) to seek mandates from the population to govern, and as a means to promote social justice. In more centralized social systems, increased economic growth and rising inequalities pose a threat to social stability. In these settings, efforts for UHC provide a political rationale by which governments can seek policy prescriptions for promoting social stability or social justice.

Rapid economic growth across the Region in all of the country typologies is expanding opportunities for improved living standards and increased investment in health. China has experienced consistently high rates of economic growth in recent years. Between 2008 and 2016, the growth in China’s gross domestic product (GDP) has ranged from a high of 10% per annum to a low of 6%. Similar rates of growth are being experienced in Cambodia (ranging from 5.9% to 6.9% GDP growth between 2010 and 2016) and Viet Nam (ranging from 4% to 5% GDP growth between 2008 and 2016). Although these economic growth rates present opportunities for expansion of investment in PHC, such trends can also present a threat to equity of health-care access and outcomes. Whether it is the urban poor in Cambodia or Mongolia, or indigenous minorities in Australia, New Zealand or Viet Nam, there is concern expressed in policy and planning documents, as well as in population-based health surveys,
of the extent to which ethnicity, location or socioeconomic status are associated with lower health-care access and poorer health outcomes. Prioritizing such groups has been highlighted in the recent Tokyo Declaration on UHC, which identified that the most vulnerable groups such as women and children, refugees and migrants, and marginalized, stigmatized and minority populations should be placed at the centre of the UHC and PHC agendas. These cases of socially determined health inequities provide a political rationale for implementation of PHC strategies to target resources and services towards the needs of the most vulnerable population groups.

In the realm of demographics, there are two major trends that are reshaping PHC in the 21st century in the Western Pacific Region. These include ageing of the population and high rates of population mobility in the form of both urbanization and cross-border migration (for example, in the Mekong countries and PICs). Longer life expectancies, increasing obesity rates, and low physical activity rates are associated with escalating health-care costs for chronic diseases management and long-term care. The shift of populations from rural to urban areas across the Region is dramatic, and there are no indications that rates are slowing. As of 2010, 45.6% of the population in Asia and the Pacific were living in urban areas, and this figure was projected to increase to 50% by 2026. Both demographic developments provide a powerful rationale for a focus of modern PHC on development of models of both rural and urban health. Equally significant, the ageing population necessitates a reorientation of the PHC approach towards chronic diseases prevention and management, to better balance the traditional maternal and child health (MCH) and communicable disease control model of PHC with a model of service delivery that caters to the needs of communities across all age groups.

In the realm of environmental change, climate change impacts and humanitarian disasters present an ongoing challenge for health policy-makers. No society is unaffected by climate change, but the PICs are particularly vulnerable to its effects. The greatest climate-related effects include trauma from extreme weather events, heat-related illnesses, compromised safety and security of water and food, vector-borne diseases, zoonoses, respiratory illnesses, psychosocial ill health, noncommunicable diseases (NCDs), population pressures and health system deficiencies. Whether climate-induced effects are primary (direct trauma or injury), secondary (expansion of vectors) or tertiary (related to collapse in public service provision), PHC services are likely to be at the forefront of attempts to both mitigate and adapt to the effects of climate change.

The other aspect of environmental change that provides a powerful rationale for rethinking models of PHC in the 21st century is the rapid rates of urbanization and growth in the size of slum populations. In cities such as Phnom Penh in Cambodia and Ulaanbaatar in Mongolia, close to 50% of the population are living in slums. Lack of adequate public health infrastructure in these settings, and the movement of unregistered migrants into cities and towns, is leading to overcrowding, poor sanitation and social marginalization. In addition to the risks of chronic diseases and social instability, there are also risks to communicable disease emergence, whether of existing vaccine-preventable diseases (such as measles and diphtheria) or to emerging diseases such as influenza strains like H1N1 or severe acute respiratory syndrome (SARS). PHC will therefore play a vital role in disease surveillance and primary prevention and control of communicable diseases in these increasingly densely populated urban poor areas.

Balanced against this movement towards urbanization across the Region is the need to maintain public services in rural and remote areas, as previously central command economies (as was historically the case in Cambodia, China, the Lao People’s Democratic Republic, Mongolia and Viet Nam) give way to more decentralized and market-oriented models of governance. Although decentralization and
devolution should ideally strengthen health systems by transferring both decision-making and resources to subnational levels, this approach has also been associated with limited institutional capability for regulation and monitoring of decentralization reforms by central agencies, as well as with limited planning, budgeting and coordination capacity at subnational levels, which the experience of Cambodia, Papua New Guinea and the Philippines adequately illustrates. As an additional qualification, although rural areas have traditionally been underserved by public health services, the trend towards increased concentration of economic wealth and health human resources in urban areas has the potential to exacerbate urban/rural inequities. It provides a powerful rationale for a policy focus on rural and remote health, as well as on subnational institutional capacity-building for planning, budgeting, and monitoring and evaluation, and reinforces the role of public policy in offsetting the market concentration of health resources in cities and towns.

**Technical rationale – regional PHC strategy.** In 2009, the resolutions of the WHO Regional Committee for the Western Pacific on PHC and health systems reaffirmed that PHC, access and equity were the guiding principles for strengthening of health systems. These values were reaffirmed based on the rationale that services need to be better adapted to health needs of populations, “especially the poor and other vulnerable and socially excluded groups.” A major outcome of the above-mentioned consultation with Member States was the development of the *Western Pacific Regional Strategy for Health Systems Based on the Values of Primary Health Care (2010).* This strategy outlined four goals for a health system – equitable health outcomes, social and financial risk protection, people-centred service delivery and improved efficiency. It identifies public policy instruments to enable the realization of the Alma-Ata values of social justice in health, and includes a health financing strategy and a social protection approach, the definition of a universally accessible essential health package of services, and both human resources and essential medicines planning processes to ensure universal and equitable access. The strategy recommends development of country-specific UHC road maps incorporating public policy actions across the six health systems building blocks. This revisioning of PHC in terms of a systems and UHC approach is in response to fragmentation of health systems associated with overemphasis on vertical programme management; it is also an expression of the planning need to better coordinate public services in a more pluralistic and decentralized context for delivery of public services.

**Technical rationale – regional health system strategies.** The regional strategy on PHC and health systems had at its centrepiece a strategic focus on universal access and health outcomes, and further refines this approach in the *Universal Health Coverage: Moving Towards Better Health Action – Action Framework for the Western Pacific (2016).* This framework emphasizes both efficiency and equity, and defines UHC as “all people having access to quality health services without suffering the financial hardship associated with paying for care.” This strategy outlines five health system attributes for UHC that include quality, efficiency, equity, accountability, and sustainability and resilience. *The Regional Action Agenda on Achieving the Sustainable Development Goals in the Western Pacific (2017)* outlines four broad areas for action, including identification of country objectives and measures for monitoring, actions targeting areas of inequity (including the social determinants of health and understanding perspectives of communities), development of leadership skills (in areas of engaging other sectors and effective use of policy levers), and development of institutional capacity (for raising the priority of health in the development agenda). Given the interconnectedness of health and development challenges, there is a strengthened rationale for collaborative partnerships across sectors of government, diverse stakeholders and communities. A common theme in these strategic frameworks is the importance of the concept of integration, and of adopting a “whole-of-systems” approach rather than a “building block” approach to health systems strengthening.
To achieve the goal of universal access and better health outcomes, the Western Pacific Region has committed to supporting Member States to implement more robust upstream health management systems. Examples of these include the Health Financing Strategy for the Asia Pacific Region (2010–2015), the Human Resources for Health: Action Framework for the Western Pacific Region (2011–2015), the Essential Medicines Strategy (2005–2010) and the Regional Strategy for Traditional Medicine in the Western Pacific (2011–2020). The emphasis on “social protection” in health financing, “health workforce retention” in regional health human resource planning, and “universal access” in the essential medicines strategy all
provide examples of the gradual shift in emphasis of PHC strategy. Firstly, governments are increasingly applying public policy instruments to target resources to areas of highest need and highest impact. Although there is still a notion of “health for all” in the UHC approach, there is also a stronger element in these regional strategies of “health first for those who need it most.” Secondly, while recognizing that the main health impacts derive from downstream rural and remote area service provision, these strategies increasingly emphasize the high value of upstream institutional health system approaches (policies, plans, procedures, regulations) in problem-solving gaps to implementation of PHC strategy, as well as sustaining programmes over the medium to longer term.

Technical rationale – regional programmatic and disease prevention and control strategies. An important epidemiological development in recent years has been the emergence of NCDs. The Regional Action Plan states that the major NCDs (cardiovascular diseases, diabetes, cancers and chronic respiratory diseases) account for more than 80% of all deaths in the Region. More than 100 million people suffer from mental disorders in the Region, with depressive disorders alone responsible for 5.73% of the regional disease burden. In Australia, nine out of 10 deaths are due to chronic diseases. In Samoa, NCDs now account for 43.3% of total health-care expenditure, which is a common trend across the PICs. Even in countries in the Western Pacific Region that have been dominated by agendas of communicable disease control and reproductive health, there are indications now that NCDs are placing significant pressures on health resources. In Papua New Guinea, the last National Health Plan reports that, in relation to hospital admissions, communicable disease conditions make up 32% of all admissions, obstetric and maternal conditions 35%, and NCDs now make up 18% of all inpatients. A recent costing of the new National Health Plan (2016–2020) in Cambodia demonstrates that national investment in the prevention and management of NCDs will escalate from 5% of programme costs in 2016 to 17% by 2021. The policy challenges are formidable, given that the 2030 Agenda for Sustainable Development is calling for a one third reduction in NCD-related premature deaths and of suicide mortality by 2030.

The regional response has been to convene the Regional Consultation on Strengthening NCD Prevention and Control in Primary Health Care in 2012 and to develop the Western Pacific Regional Action Plan for the Prevention and Control of NCDs (2014–2020). Many of the interventions outlined in this strategy focus on upstream regulatory or legal measures to control tobacco and alcohol, as well as promotional programmes to alter diets and exercise patterns. There is also emphasis on primary care interventions for such conditions as diabetes and cardiovascular disease. Unlike the original Alma-Ata Declaration period when flagship programmes such as immunization, family planning, and water and sanitation could be delivered through community-based primary care programmes, the prevention and management of NCDs presents a far more complex and formidable challenge entailing working across a range of institutions, age groups and sectors. The impact of free movement of goods and services as expressed through globalization policies and trade agreements means that solutions cannot always be found solely within homes, health facilities, or even within national borders. For this reason, this strategy recognizes the value of a Health in All Policies approach incorporating policy actions in the areas of education, trade, food, alcohol, urban development and climate change.

Even though most prevention and control gains in NCDs are external to the health sector, the strategy – while recognizing this limitation – also expresses the intent to mobilize health sector–specific actions in support of NCD prevention and control. Specifically, this involves developing and implementing the WHO global recommendations for the Package of Essential Noncommunicable (PEN) Disease Interventions for Primary Health Care in Low-Resource Settings that can be scaled up through the primary care system to promote health throughout the life-course. The emphasis on “essential packages” reflects the increased
targeting of resources that is characteristic of the post–Alma-Ata age. While recognizing the intersectoral nature of PHC, the emphasis on UHC also recognizes the value of actions that are within the span of control of ministries of health.

A critical way to maintain the resilience of PHC systems is to empower communities with information on how to prevent and manage conditions. For this reason, in Samoa, health promotion must remain “the mainstay of national NCD management and control.” The National Health Plan of Samoa also emphasizes the importance of closer working relationships between village mayors and traditional healers, including building on the relationship to support improved referral pathways to hospitals. Across the PICs, the Healthy Islands vision first enunciated by ministers from the PICs in 1995 have, over subsequent years, noted that, while there is a growing burden of NCDs, infectious diseases and the threat of their re-emergence is a continuing problem. This points to the need for health systems to adopt an integrated approach to this double burden of disease, including a strong public policy emphasis on prevention and promotion.

In China, the Healthy China Plan 2030 strategizes a similar adaptive response to the public health and economic threats posed by the NCD epidemic. There is a strong emphasis in this plan on social and behavioural change to support prevention activities at the grass-roots level, as well as committing to early screening and diagnosis for chronic diseases. In New Zealand, the new national health strategy emphasizes bringing integrated chronic diseases care closer to communities through PHC organizations, and a multidisciplinary primary care system that is socially networked with a family model of care. In Australia, a multisectoral approach to tobacco control (in regulation, fiscal control and social marketing) has seen a reduction in the rate of smoking in adults from 35% in 1980 to just 13% in 2013, resulting in significant declines in rates of coronary disease and stroke. These cases illustrate that policy settings are adapting by shifting the span of strategic and operational control over health affairs beyond ministries of health to engage other sectors, agencies and communities in responding to altered patterns of epidemiology, demography and climate.

In summary, the regional strategies described above cut across regional PHC, management systems, and disease prevention and control programmes. The strategies are well aligned, to the extent that all emphasize the value of institutional capacity-building (policies, plans, regulations, procedures), strengthening of health systems (integrated service delivery), community participation and control, responsiveness to increased demographic and epidemiological complexity, and improved integration of services into essential services packages, with vulnerable populations as a priority. The concept of UHC is central to current discussions on PHC; as exemplified by the focus on rural retention in human resources planning and social protection in health financing, the push for UHC is increasingly targeting the needs of the most vulnerable.

1.1.2 Strategy implementation

In the advanced economies, governments are proposing policy solutions in response to pressures for public–private collaborations, prevention and management of chronic diseases, care of the aged, and improved models of community partnering and engagement. Health systems in these settings are characterized by “general practitioner” models of primary care. Increasing the level of connectedness between the community sector and professional health sector for NCD prevention and management is one area for policy development in more developed country settings such as in Australia, Japan, New Zealand and the Republic of Korea. Given the trends in epidemiology towards an increasing burden of chronic diseases, there is a need to refocus away from models that rely solely on the PHC provider as a gatekeeper to secondary and tertiary care, to a model based more on prevention and promotion through
“partnering” with communities to select services that are most responsive to their needs (see Section 2.4). Given the social determinants linked to high rates of obesity and related chronic diseases, there is evidence in these developed country settings of development and implementation of laws, policies and strategies that engage multiple sectors in tackling such issues as air quality, tobacco control (Australia, Japan, Malaysia, Republic of Korea) and healthy cities (Australia, Japan, Malaysia, Republic of Korea). Given trends in urbanization and threats posed by climate change, these intersectoral approaches to PHC are set to continue. Escalating health-care costs associated with ageing of the population and prevalence of chronic diseases is placing pressures on health-care budgets and policies to continue to provide services through national health insurance systems. A common theme in these settings is the use of tax-based financing, complemented by private health insurance mechanisms, to provide universal coverage for regularly reviewed schedules of medical and public health-care benefits (refer to Section 1.2.1 on good practices for examples of national health insurance in Australia and New Zealand).

The implementation of PHC strategy in transition economies indicates how far the implementation strategy has transitioned from the Alma-Ata vision of PHC in the early 1980s. China was one of the pioneer countries for implementation of the Alma-Ata strategy, and in the early years, made significant gains in maternal and child mortality reductions due to its implementation of community-based health-care programmes. Rapid social, economic and political reforms radically shifted the context for PHC systems. Following market-based reforms in the 1980s, there was inadequate government funding and reduced support of public health-care providers, leading to unintended policy consequences of increasing costs, lower access to care, widening inequities, and a depletion of the health-care workforce. In the last 10 years, there have been major policy responses by the Government of China. In 2009, the Government approved guidelines for reform of the health-care system and published an action plan of targets. The five targets were: medical insurance coverage; an essential medicines programme; a process of health system reform to strengthen human resources availability at the grass-roots level; investments in promotion of public services, including for NCDs; and a programme of hospitals reform, all of which offset the negative impacts of commercialization of health care. In 2016, the Government of China also developed the Healthy China Plan 2030, which acknowledged the impacts of urbanization, ageing and the rise of NCDs on the PHC system.

The same policy stresses and innovations have been evident in Mongolia. The country transitioned from a centrally planned economy to an open liberal market-oriented system from the early 1990s. Since that time, the Government has initiated policies to adapt the health sector to these wider political and social reforms. Rapid urbanization (50% of the population now resides in the capital city) and widening inequalities have been associated with an influx of unregistered rural migrants into the margins of cities. In response, the Government transitioned the PHC system into a mixed public–private health-care model (family group practices), which, according to the 2011 Health Act, were renamed family health centres (FHCs). These centres are private organizations but fully funded by the government budget using a risk-adjusted capitation payment method. In rural areas, soum health centres are managed through local government. These policy developments in Mongolia reflect many of the social changes and related health policy developments across the Region, where “mixed public–private” systems for PHC operate through state-funded budgets, with increased roles for local government and private interests in governing and financing the sector.

The Philippines is one of the first countries that implemented PHC in the Region. Since its adoption of the Alma-Ata Declaration, impressive gains have been achieved by the health sector, particularly in the transformation of health service delivery and the introduction of community-based health programmes.
In 1991, a landmark transition to a decentralized health service delivery system extended some basic care particularly to rural regions of the country, although it did not challenge the preeminence of urban centres in the provision of hospital and specialist-based services. At the turn of the millennium, the Health Sector Reform Agenda (HSRA) introduced key reforms in five general areas: public health, hospitals, regulation, financing and the local health systems. Significant improvements were noted in terms of access to health services, but widening disparity in the health outcomes of the population across geographic, social, economic, and even cultural domains remains a nagging concern. “Kalusugang Pangkalahatan” (universal health care) became the tagline at the end of the era of the Millennium Development Goals (MDGs) that later evolved into UHC with a new tagline: Boosting Universal Health Care via Formula One Plus – a “transparent, inclusive, coordinative, and synergistic” agenda. To date, the UHC bill is gaining momentum and is expected to impact the areas of health financing, service delivery network, regulation and governance of the health sector.

Cambodia provides an interesting case of how countries might adopt an incremental approach to attainment of UHC. In the early postconflict period (1990s and early 2000s) the country focused on processes of health system development and reform that included the development of a health coverage plan (that specified an essential medical benefits package) and the establishment of a national health planning system. A charter on user fees was produced in 1996. When it emerged that patterns of utilization were shaped by the limited capacity of the population to pay for services, the Government, in collaboration with nongovernmental organizations (NGOs), established a network of health equity funds to offset financial barriers to access. There is now ongoing policy discussion about consolidating these various community-based social protection schemes into a National Social Security Fund. The policy challenges will always remain complex in a setting like Cambodia, which has very wide social inequalities and where the private sector remains the first choice for primary care.

The transition economies are also demonstrating capacities for stepping towards national health insurance and intersectoral collaborations. Both the Philippines and China are reported to have good models for healthy cities frameworks. A major focus of the Healthy China plan is prevention and promotion, through emphasis on healthy lifestyles and physical fitness, the development of healthy cities, and the development of a national smoke-free law. China, the Philippines and Viet Nam have all instituted national health insurance laws and have long-term plans to achieve universal coverage through tax-based financing for provision of a universally accessible defined medical benefits package.

In the PICs, both Papua New Guinea and Fiji have been challenged by depletion of health human resources in rural and remote areas. This problem has been exacerbated in the Papua New Guinea setting through limited local government capacity to plan, manage and finance local area health service delivery, leading to initiation of policy responses in the areas of health planning and human resource planning (see Section 1.2.1 for Papua New Guinea case study). Similar obstacles have been reported in the case of Fiji, where early successful implementation of the PHC vision was later hampered by shortages of health workers in village health posts, and weak central-level monitoring and resource allocation. The national health plan reports increased vulnerability of the population to NCDs and significant financial barriers to health-care access. As in Papua New Guinea, the response of many PHC services in Fiji has been to initiate programmes of costs recovery (fees for service) to offset the impact of inadequate operational budgets. In response, the National Health Plan has committed to establishing a health financing unit, as well as proposing to expand fiscal space through annual increments of 0.5% of GDP that is invested in health care. Other major developments in the Fiji health system include decentralization of management to divisional level, establishment of an NCD unit to manage the epidemiological transition,
and reorientation of PHC services towards NCD prevention and control. More broadly across the Pacific, the healthy islands framework recommends a more integrated health systems approach that aims to address the double burden of communicable diseases and NCDs, and includes a strong emphasis on prevention and promotion. This implementation pathway is driven by the observation that PICs have shown some mixed results in health indicators in the last decade, with health expenditures also stagnating due to slow rates of economic growth and decreasing donor funding. A recent analysis of UHC in these countries demonstrated major implementation priorities as being increasing the share of resources allocated to lower-level health facilities and improving managerial capacity to ensure that these resources reach primary care facilities.

Common themes across all country categories are processes of decentralization and forging of public–private partnerships through models of decentralized planning and budgeting and contracting, such as the family health centre model in Mongolia, the district contracting model and decentralized annual operating planning system in Cambodia, and the contracted not-for-profit Primary Health Care Organization (PHO) in New Zealand. In China, the plan proposes a contract-based provision by family doctors, and development of the “gatekeeping role” of PHC providers for referral. In Australia, private sector general practitioners (GPs) provide public services through the Medicare National Insurance System. In Papua New Guinea, the Government enters into agreements with churches in the country to support service delivery in rural and remote areas. The Papua New Guinea Government also proposes to implement a set of Provincial Health Authority reforms, which will integrate the provincial health system into a single management authority, along with a plan to support facility-level budgeting and direct health facility financing. In the Philippines, health services have been devolved to local government units (locally elected officials) since the early 1990s, with the central Department of Health retaining roles in policy-making and regulation. In Solomon Islands, a model of decentralization is being proposed whereby resources will be allocated to the provincial level. This will require the development of provincial planning and budgeting processes, as well as a stronger partnership at that level with other parts of government, churches, businesses, NGOs and local members of parliament. A common theme in these models of decentralization is the requirement for strengthening of subnational governance, planning, budgeting and financial management capacity.

The Alma-Ata Declaration of 1978 has outlined (under Article VII) elements of the PHC intervention package, including MCH; family planning; adequate food supply and proper nutrition; immunization; and water, sanitation and hygiene (WASH) education. Over recent years, these elements have evolved significantly and expanded to encompass a broad range of integrated packages of reproductive, maternal, newborn, child and adolescent health (RMNCAH) through the life-cycle/continuum of care approaches. Other policy implementation themes include strategizing of NCD treatment and prevention, improvements in access to essential medicines, and measures to increase human resource availability and retention.

1.1.3 Making a difference

In terms of accessibility and outcomes, overall, the performance of the Western Pacific Region for the seven Sustainable Development Goal (SDG) indicators of RMNCAH is higher than the overall global performance. The regional rates for maternal and child mortality are already below the global SDG targets, and the Region has reached 90% of demand for modern family planning methods. Maternal mortality remains a concern in the Lao People’s Democratic Republic and Papua New Guinea, where rates remain close to or above 200 deaths per 1000 live births. Twenty-five countries across the Region have skilled delivery rates of over 70%.
Regional incidence rates for infectious diseases are lower than global rates, although there is wide diversity in disease rates across the Region. In some countries, incidence of tuberculosis (TB) remains very high. The rate of new HIV infections among adults is five times higher in Papua New Guinea and three times higher in Malaysia and Viet Nam than the current regional rate of 0.1 new HIV infections among adults 15–49 years old per 1000 uninfected population. The incidence of TB in all high-income countries is below the regional rate of 95 cases per 100 000 population. However, some lower-income and upper-middle-income countries report TB incidence higher than the regional rate. These countries include Cambodia, Kiribati, the Marshall Islands, Papua New Guinea and the Philippines, with incidence above 300 cases per 100 000 population in 2016.2

For NCDs, although regional premature mortality is below the global rate, there is once again wide diversity in outcomes across the Region, with eight countries having at least 1.5 times above the regional value of 17% (i.e. probability of dying from chronic diseases between the age of 30 and 70). Although the baseline report observes that the Region outperforms global rates for eight health-related SDG indicators, the report also observes that eight countries have extremely high values for child malnutrition. One area where only limited difference is being made is in the regional mortality rate attributable to household and ambient air pollution, which is almost 50% higher than the global rate.2

In terms of efficiency and equity, the Region has designed a UHC index to measure accessibility and efficiency of services. The baseline report observes that the UHC service coverage index increases with the income levels of countries. It also observes that the index does not capture data relevant to quality, safety, equity and patient-centredness. Only a small group of countries conducts population surveys that disaggregate data according to such social variables as gender, ethnicity and socioeconomic status, making it difficult for many countries to measure the impact of policy or resource allocation on inequity reductions.

In summary, evidence from the SDG and UHC baseline report demonstrates improved service accessibility and coverage, particularly in relation to RMNCAH and prevention and control of infectious diseases. Much of these gains are attributable to investment in primary care, where most health-care contacts are made (immunization, family planning, antenatal care). The UHC service index demonstrates that more developed countries have a higher index score for NCD management. A set of country profiles of SDG and UHC progress is also available online and provides 2018 assessments of status of the SDG goals and progress towards attainment of UHC.64

1.1.4 Contextual diversity

As observed earlier, there is wide contextual diversity across the Region related to political traditions, level of economic development, and the pace of the demographic and epidemiological transition. The following outlines some strategies by which the countries in the Region navigate this contextual diversity.

Applying regional policy and planning mechanisms. The application of regional policy consultations, UHC frameworks and the SDGs and targets provides a mechanism by which countries can enter into regional dialogue on the interface between global health resolutions and commitments and the realities of national social and political contexts (refer to beginning of Section 1.1.2 for more detail).

Developing UHC road maps. One of the implications of the UHC approach is that, although the goals of UHC may remain consistent across the Region, the pace and nature of the reforms will be variable
depending on the political, social and epidemiological conditions in each country setting. For example, the breadth and depth of the social safety net will vary according to the level of political commitment and resource availability in each country. The pace at which a country implements a national health insurance law will be dependent on a country’s institutional capability to provide oversight for such a nationwide scheme. Implementation of complementary private or social health insurance schemes is also reliant on the size of a formal economic sector, which is highly variable across the Region. Community participation models are highly variable across the Region and are dependent on the character of national social institutions and traditions of PHC, with some countries implementing models that include community health workers (CHWs) (Cambodia, Lao People’s Democratic Republic, Samoa and Viet Nam) and others relying more on establishment of primary care institutional and provider networks (Australia and New Zealand). The level of integration of traditional medicine into formal health systems is also highly variable, with well-established models in China, the Republic of Korea and Viet Nam, and developing models of integration in Malaysia, Mongolia and Samoa. The UHC road map infers that, although the policy destination remains the same across the Region (universal access to care without financial hardship), each country in the Region adopts its own pathway to reach this destination based on national conditions and institutional capabilities.

**Tailoring benefits packages to local conditions.** The medical and public health benefits package is highly variable across the Region based on several factors. The first is epidemiological and demographic conditions, which may provide some variations between countries based on disease burden, extent of ageing of the population, and capacity of the country to invest in secondary and tertiary care. Depending on levels of political commitment and capacity of governments to invest, the benefits package could extend beyond treatments to referral support, including transport and accommodation. The medical benefits packages in Australia (including both medical and pharmaceutical benefits) include covering higher-end treatments for oncology, cardiology and renal failure, for example. In contrast, in Cambodia, the essential health benefits package – as a reflection of epidemiological, demographic and economic conditions – emphasizes MCH and communicable disease control services. In China, the Healthy China 2030 Plan commits to design of both an essential service delivery package as well as a major public health service package, both of which will be developed based on an assessment of the economic burden of disease. This emphasis on essential packages not only reflects the commitment to UHC in health policy and planning, but also indicates an expressed policy commitment to better integration of services.

**Applying national health policy and planning processes.** The most comprehensive way by which countries manage contextual diversity in relation to UHC is integration of PHC strategy into national policy and planning frameworks. This enables the UHC approach to be adapted to national conditions. In Papua New Guinea, for example, the realities of decentralization, as well as low retention of a rural and remote health workforce, means that UHC impacts are reliant on development of local government capabilities to manage and finance services, as well as on the capability of decentralized institutions to place and retain staff in remote areas. National health plans (for example, in Cambodia, China, Papua New Guinea, Samoa and Viet Nam) are how governments express political commitment to UHC, mobilize resources to finance the policy direction, and then – through strategizing – determine the pace and character of PHC reforms.

In this discussion, we have made the case that contextual diversity between countries has been relatively well managed through UHC road maps, defining the medical benefits packages based on local conditions, and engaging national policy and planning processes to align PHC service delivery to national strategies and conditions. However, the persistence of very wide inequities within countries between different
population groups raises questions about the extent to which countries are adequately managing contextual diversity within their own borders. This is demonstrated by the fact that population-based surveys across the Region illustrate very wide inequities of access and outcome based on geographic location, socioeconomic level and ethnic status. In Cambodia, successive Demographic and Health Surveys (DHS) in 2010 and 2014 have confirmed that access to facility delivery, antenatal care and immunization services is strongly correlated with both location and socioeconomic status, including in the ethnic minority provinces in the east of the country. In the Philippines, the DHS in 2013 found that children from the poorest families are more than twice as likely to die before the age of 5 as those from the wealthiest families. Findings such as these will necessitate a much finer tailoring of PHC strategy to meet the needs of these vulnerable groups.

1.1.5 Resilience

We nominate four main factors below that have tested the resilience of PHC systems. These are: the health human resource crisis, global financial crisis, urbanization, and commercialization of health care. The section on future directions outlines the potential for PHC systems to demonstrate resilience in response to the effects of climate change (see Section 1.2.1).

Health workforce development needs. Commercialization of health care tests the resilience of PHC systems, as it has contributed to a depletion of health human resources in rural and remote areas in China, Cambodia, Viet Nam, Papua New Guinea and across the Pacific. This depletion of health human resources has been exacerbated by the outmigration of health workers from some subregions (particularly from the Pacific and South-East Asia) to more developed countries in the Region, such as Australia and New Zealand, where migrant health workers are addressing shortages in specialist expertise in rural and remote areas. Analyses of low retention of the health workforce in rural areas has been attributed to a host of factors relating to financing, educational opportunity, professional development and regulatory capacity. Governments are responding to this problem through development of human resource policies and plans, and the design of rural retention strategies such as recruiting quotas for medical students from underserved areas in Viet Nam and the Lao People’s Democratic Republic, or by developing rural-based regional training colleges for nursing as in Cambodia. Similar initiatives were implemented in the Philippines, such as the innovative medical and health sciences programme of the University of the Philippines, which is designed to address health human resources shortage in the rural, depressed and underserved communities. Other deployment programmes for public health practice (for human resources such as nurses, medical technologists, dentists and midwives) were put in place to fill the gaps in human resources for health in far-flung communities. The Healthy China Plan has set targets for retention and proposes that by 2030 all communities will be within 15 minutes’ distance of a primary care facility, with a registered nurse density of 4.7 per 1000 population.

Urbanization and commercialization of health care. A major disturbance to the state-governed rural model of PHC in the 21st century is linked with the demographic pressures of urbanization and the commercialization of health care. In terms of urbanization, one in every two citizens in the Western Pacific Region lives in cities, and the Region is home to nine of the 29 megacities (cities with populations greater than 10 million) on the planet. In China, at the launch of the Alma-Ata Declaration in 1980, 19% of the population resided in urban areas. By 2017, this figure had increased to 58.9% (and had advanced from 45% in 2007). Similarly, Mongolia is now (in 2017) 74% urbanized, compared to 63% urbanized in...
In terms of commercialization of primary care services, the GP model of care is common across the Region, particularly in the more advanced economies. Even in a transition economy such as Cambodia, the majority of the population (both urban and rural) first seeks out a private practitioner for primary care. In response to these twin pressures of commercialization and urbanization, policy-makers are being tested to design governance models for urban health that encompass public providers, private providers, civil society agencies and local governments, and design services for populations that are highly mobile, often not registered by civil or health authorities, or are congregated in densely populated slum areas with high public health and environmental risks.

Bypass of primary care directly to hospital services is a common problem in many countries, with outpatient services at major provincial referral hospitals often taking up primary care roles.

The global financial crisis. The global financial crisis was the most significant economic downturn since the last Great Depression of the 1930s, and therefore had a significant impact on the functioning of health-care systems across the Region. Evidence has shown that as GDP contracts, government investment in health (as a percentage of GDP) also contracts. Public sector austerity measures associated with the global financial crisis have meant that public health budgets have been reducing, even in high-income countries, resulting in very high out-of-pocket (OOP) expenditures on health. In the PICs, revenues for PHC are stagnating or decreasing due to modest economic growth as well as decreasing donor funding. The main adaptive mechanism of the population is to increase household expenditures on health care. The main adaptive response of governments across the Region has been to develop health financing and social protection strategies, as well as to aim for higher levels of efficiency with health-care expenditures. These policy responses are highly variable based on country settings, but include such interventions as legislation of free PHC in Papua New Guinea, establishment of health equity funds for the very poor in Cambodia, and steps towards institutionalization of national health insurance mechanisms in China and Viet Nam. They have, however, resulted in a modest rebound in domestic government expenditure on health as a percentage of total current health expenditure from 49% in 2008 to 56% in 2015. The regional strategy on health financing, as outlined earlier, provides an illustration of how external threats to PHC – though posing a policy threat – can also provide a strategic opportunity to strengthen the resilience of systems to social change.

1.2 Success stories in the last decade

1.2.1 Good practice experience

Australia – Securing universal political support for UHC. The national health insurance system (referred to as Medicare) was established from the mid-1970s, and a related Pharmaceutical Benefits Scheme was subsequently established. Both schemes provide universal access by the Australian population to an annually reviewed schedule of medical and pharmaceutical benefits. The scheme is financed through a general taxation levy on all incomes and is supplemented by financing through private health insurance mechanisms. The scheme has proved to be vastly popular with the voting electorate, to the point now where political support for UHC can now be considered “universal.” The success of this approach has influenced the establishment of a National Disability Insurance Scheme, which aims to finance the ongoing home care needs of persons with disabilities across the nation through general taxation. The case from Australia illustrates potential political pathways for securing UHC, through securing of bipartisan political support for nationwide coverage of essential health interventions, pharmaceutical benefits and disability insurance.
Cambodia – Reducing maternal and child mortality through expanding development partnerships. The impact of the civil war and its aftermath had a devastating impact on the health workforce in Cambodia, with very few doctors and nurses surviving the totalitarian regime in 1975–1979. Following the United Nations-sponsored election in 1993, the country undertook a programme of health sector recovery and rehabilitation that included the development of a health coverage plan, installation of a nationwide health planning system, and implementation of models of district-level health contracting. From the early 2000s, development of models of community-based financing (referred to as health equity funds) expanded access to services for the poorest segments of the community. Other developments in PHC included widespread implementation of priority programmes through health centres linked to networks of village health workers, and introduction of midwifery payments for facility-level deliveries, and incorporating traditional medicine services into the recently revised minimum package of activities. At all times, the PHC movement of government health workers, NGOs, traditional medicine practitioners and development partners was effectively coordinated through the Ministry of Health, and at the subnational level, with community service delivery coordinated through health centre management committees and village health support groups. Outcomes included vastly improved coverage of priority interventions and attainment of the MDGs for both maternal and child mortality reduction by 2010. Despite ongoing problems with quality of care, regulation of the private sector and financial barriers to access, the transformation of Cambodian health and the health sector over the last 20 years is a remarkable story of the enduring value of partnerships between government, development partners, civil society and community-level health workers.

China – PHC policy responses to social and economic transitions. Following introduction of market-oriented reforms from the 1980s, the health system became associated with high health-care costs, low quality of care, high patient OOP expenditure, and inequalities between and within urban and rural areas. In addition to these economic impacts, social changes have contributed to a rise in NCDs. Cardiovascular disease, cancer, diabetes and chronic respiratory illnesses now account for about 80% of China’s annual deaths. The International Diabetes Federation estimated that there were 109.6 million diabetes cases in China in 2015, and this number is predicted to rise to 150.7 million by 2040. In response to these public health threats, a programme of health reform was initiated from 2009 to expand insurance coverage, establish a national system of essential medicines, provide essential public health services for all, pilot public hospital reform, and emphasize the central role of primary care services. A PHC network was strengthened to include community health centres and health stations in urban areas, as well as township health centres and village clinics in rural areas, providing services ranging from health education, disease prevention, basic public health services, communicable disease and NCD management, and rehabilitation services. The overall reform approach is to build a community-based PHC system so that patients can access health services for less costly care, which involves shifting from a hospital-based model towards delivery in PHC settings. The benefits of traditional Chinese medicine in PHC are also being reinforced, by linking these traditional approaches to prevention, rehabilitation and treatment of chronic and acute diseases. Although challenges remain with the prevention and management of NCDs, there are other public health concerns, including male smoking rates and mortality attributed to household and ambient air pollution. China is progressing well with RMNCAH and malaria elimination, although the agenda for infectious disease
control remains unfinished. The coverage of essential health services as measured through the UHC index is now 76 (with the lowest in the Region reported as 40 and the highest greater than 80).2 Given that the population in China comprises over half the population of the Region, this health system and public health recovery in the country is a significant global health achievement and illustrates the power of flexible public policy response to social and economic change.

Malaysia – Adapting PHC delivery to the rise of NCDs. In Malaysia, the Ministry of Health clinics provide four components of PHC: curative, preventive, promotional and rehabilitative services. Access in remote areas is expanded through use of mobile clinics.57 Malaysia, with relatively lower health expenditures, has been able to achieve levels of health outcomes compared to high-income countries, spending about 4–5% of its GDP on health, compared to an average of 11.6% in high-income countries. Such success has been attributed to the Government’s targeted expansion of rural primary care and effective intervention programmes in high-priority areas such as MCH.88 Despite these successes, the health system in Malaysia is confronted by social and demographic changes, which include rapid urbanization, emergence of a large private medical sector, and the growth of NCDs. Several reform measures have been introduced, including training more health-care personnel, and increasing health promotion in relation to NCDs and their risk factors (including health warnings on tobacco advertising).87 The strength of the PHC system in Malaysia has been in the community-based MCH services, which have increased the coverage of skilled providers even in the remote rural areas of the country. This system is now being utilized to respond to the emerging NCD public health challenge. Multidisciplinary PHC teams have been introduced and services have adapted to more integrated approaches (with PHC teams including a mix of family medicine specialists, GPs, physiotherapists, occupational therapists, nurses, assistant medical officers and nutritionists). As with the experience of MCH services, the success of programmes is dependent on health care volunteers from the community who are community-nominated and are trained in the basic principles of healthy living, and the epidemiology of NCDs. Apart from educating and advocating for healthy lifestyles, they are also trained to conduct blood sugar tests, body mass index and blood pressure measurements, and to read and interpret results from these screening tests.89 A programme referred to as KOSPEN (Komuniti Sihat Perkasa Negara) aims at bringing NCD risk factor interventions to the community level through use of trained volunteers to function as change agents and facilitate healthy living practices in the community, as well as by referring high-risk cases to nearby health clinics for further investigation and management.90

New Zealand – Building PHC organizations for integrated primary care. New Zealand has a tax-funded health-care system, with almost 9.5% of GDP invested in health, and only 12.6% of this amount invested through OOP payments.91 From the early 2000s, a PHC strategy shifted the public funding of services from fee-for-service reimbursement to capitation-based payments.57 The basic organizational unit of the new PHC strategy is the Primary Health Care Organisations (PHOs) – NGO that contract with primary care practitioners, and have an average enrolment of about 150 000 patients.57 There are currently 32 of these organizations, which contract for services with a network of higher-level district health boards. The funding formula of the PHO is population-based, but is also weighted according to age, gender, rurality and socioeconomic status (including ethnic status for the indigenous Maori and Pacific populations).57 Although most services are provided by GPs and nurses, the Government places emphasis on development of multidisciplinary teams, so that communities have access to a wider range of providers and services.92 As nonprofit institutions, PHOs involve both communities and providers in governance, and seek to reorient the PHC model from not only responding to those individuals who actively seek care but to also organizing services around
the needs of defined populations. Recent surveys have illustrated very high health standards and outcomes in New Zealand when compared globally. Ninety per cent of New Zealanders reported they are in good, very good or excellent health in 2014, which is the highest percentage reported in the Organisation for Economic Co-operation and Development (OECD). Eighty per cent of adults reported they are satisfied with the care they receive, and life expectancy for New Zealanders is 79.5 years for males and 83.2 years for females, both above the OECD average.

**Papua New Guinea – Developing national policy responses to the impacts of decentralization.** Access to PHC in Papua New Guinea is challenging, given the mountainous geography and diversity of languages and cultures, and barriers to transport and communications. These challenges are reflected in the very high maternal mortality ratio (above 230 per 100,000 live births). Despite several years of economic growth, fiscal space for health has narrowed, placing significant strain on health-care budgets. The country has undergone a process of decentralization, whereby local governments at provincial and district levels have taken on increasing responsibilities to plan, finance and manage health-care services. These transformations have interrupted the reliable flow of finance to peripheral facilities. User fees in some primary care locations have been gradually introduced to offset the impact of irregular state financing. In response, Papua New Guinea passed legislation abolishing user fees and providing free access to PHC and selected hospital services. The Government has also developed a human resource policy that commits to expanding production of human resources, as well as strategizing ways to retain staff in rural and remote areas. The Government has established a new health planning system that aims to obtain closer collaboration between the central government and local governments. All these policy initiatives indicate high levels of political and technical commitment, although the challenge remains of developing organizational capacity to translate policy commitments into action at the local government level.

**Philippines – Tax reforms laws on health.** The Tobacco and Alcohol Tax Reform – otherwise known as the Sin Tax Law – was a landmark legislation in 2012 that paved the way for not only reducing consumption of alcohol and tobacco, but also generating money for health. It was primarily a health measure with revenue implications, but more fundamentally, it is a good governance measure. The Sin Tax Law: helps finance the Health Facility Enhancement Program on upgrading health facilities in local government units, and the UHC programme of the Government; simplified the current excise tax system on alcohol and tobacco products; fixed long-standing structural weaknesses; and addresses public health issues relating to alcohol and tobacco consumption. Likewise, raising taxes on sugar-sweetened beverages – a first in Asia – is a strategic move for the country because the revenue to be generated from the Sin Tax Law has the potential to be utilized for health-promoting purposes.

**Samoa – Responding to NCDs through a PHC-oriented approach.** The CHW model is being applied by Samoa to respond to the rise of NCDs in that country. The country is adapting the WHO PEN protocols into local contexts by developing a model of community-based NCD early detection and management. The programme was launched through high-level political commitment in 2014 and commenced with a demonstration project in two villages in 2015 and is currently now under expansion. Village women’s committees are trained to provide screening and management of NCDs and risk factors, and the village women run health awareness and promotion activities (on tobacco, alcohol, sugar, salt and physical activities). This case study from Samoa highlights the way in which countries can build on the traditions of the Alma-Ata CHW model to reinvigorate community-level action to address changing patterns of epidemiology.
Solomon Islands – Health sector reform for revitalization of PHC. Solomon Islands has experienced many of the health system barriers and social challenges that are common across the Region. These include: fragmentation of service, very uneven service access across provinces, poor resource flow to peripheral facilities, and bypass of primary care facilities by the population direct to referral hospitals. In response to these system challenges, the Solomon Islands Ministry of Health and Medical Services has been developing a role delineation policy since 2011 that reflects the Government’s strategy of strengthening services to rural populations while responding to changing health service needs. 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, which specifies essential services to be delivered at each level of the health system as well as the staffing, drugs, equipment and infrastructure required at the different types of facilities to provide these services. Subsequently, a secondary assessment process was started through consultations with both clinical and public health staff from the national, provincial and community levels 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. These reforms in Solomon Islands are illustrative of similar UHC reforms across the Region, which are characterized by role delineation for facility levels, and the specification of essential service packages and resource requirements for universal coverage.

Viet Nam – Expanding access to PHC through legislation for financial risk protection mechanisms. Viet Nam provides a very interesting case of the long road to UHC through gradual development of a national health insurance system. As a socialist country, Viet Nam financed the health system through general tax revenues and provided PHC free of charge to the population. However, following the Doi Moi economic reforms that opened the country to free markets in the 1980s, a market also developed for private health care. These more general economic reforms triggered health sector reforms that included the introduction of user charges and health insurance, regulation of private practice in health care, and opening of the pharmaceutical market. These had the unintended consequences of increasing OOP expenditures and thereby impacting accessibility by the poor to services. The Government of Viet Nam then enacted a series of health insurance reforms to ensure universal access. To reduce OOP payments on health care, the Government introduced a social health insurance decree in 1992, which enabled insurance for civil servants and all formal sector employees. In 1998, the Government promulgated another decree on health insurance (Decree 58/1998/ND-CP) that unified all provincial health insurance funds into a single national health insurance fund. However, the nonformal sector was still excluded from the insurance system. User fee exemption systems for the poor were introduced as early as 1994, and Decree 63 in 2005 stated that all poor must enrol in compulsory health insurance with government funds subsidizing their premium. A health insurance law issued in 2008 affirmed this system, and by 2009, all provinces had implemented the law. In 2005, the National Assembly promulgated the Law on Education, Health Care and Protection for Children, which stipulated that all children under 6 years of age were to be provided free health care. The case of Viet Nam illustrates the value of legislative mechanisms in guiding and mandating universal coverage to PHC by the population.
1.2.2 Regional data to support PHC analysis

The Western Pacific Region of WHO has established a regional monitoring framework for both SDGs and UHC. The framework sets out the priority areas to guide action to 2030 and provides the basis for indicator selection by each Member State. This framework has four overarching monitoring domains comprising a total of 88 indicators. The four domains are: health impact, the determinants of health, UHC and health system capacity. All four domains are of high relevance to PHC, with the UHC domain incorporating three indicator subdomains of financial protection, health service coverage, and accessibility and use.

FIGURE 3. SDG and UHC Regional Monitoring Framework

The aim of monitoring SDGs and UHC is to ensure that progress reflects each country’s epidemiological and demographic profile, health system design and level of development, as well as the demands and needs of its population. The regional data have very high relevance for PHC, given that the SDG Agenda has a focus on equity, with “UHC acting as a unifying platform.” An important aspect of equity analysis is the disaggregation of data according to social and economic exposures such as age, sex, socioeconomic status, wealth, education level, place of residence and ethnicity. Currently, monitoring using disaggregated data is applied in Cambodia, the Lao People's Democratic Republic, Mongolia,
the Philippines, Vanuatu and Viet Nam, principally through population-based surveys such as DHS and Multiple Indicator Cluster Surveys (MICS).  

Surveillance systems are widespread across the Region, and include outbreak, sentinel, risk factor and demographic surveillance. Demographic surveillance includes birth and death registration systems. The development of birth registration systems is taking on increasing significance, given the high rates of urbanization and migration across the Region. Surveillance systems include regional systems for reporting of communicable and vaccine-preventable diseases. These systems have been highly successful in enabling countries to position their own public health status relative to the situations in neighbouring countries. Common regional challenges to data collection for SDG and UHC include the limited availability of data, insufficient disaggregation of data, and poor data quality and reliability. Implementation of fragmented and independent information systems is widespread across the Region, as is limited information infrastructure and tools, as well as capacity to apply health information for health planning purposes.

The Region provides additional sources of health information to complement the regional SDG and UHC analysis. The main function of the Asia Pacific Observatory on Health Systems and Policies is to expand knowledge and evidence on health systems in the region. This collaboration of international agencies, researchers and academic institutes provides case studies from 28 countries in Asia and the Pacific. Both the Republic of Korea and Solomon Islands, for example, have recent health system reviews, as well as policy briefs on different aspects of PHC. The system of National Health Accounts and related Global Health Expenditure Database contain information from countries on trends in health financing, which include data on OOP payments and social protection, both of which are critical to the development of a more equitable model of PHC. The WHO Global Health Observatory consolidates health indices from multiple sources to provide a comprehensive data repository on health for countries and regions.

In the era of the traditional Alma-Ata model of PHC, knowledge, attitude, and practice (KAP) surveys and health-seeking behaviour studies have been common approaches to more qualitative analysis (or combined qualitative and quantitative analysis). The need for integrated “people-centred” care for chronic diseases related to ageing and mental health conditions, as well as the measurement of quality of health care, will shift the emphasis in data collection somewhat towards more qualitative assessments of the perceptions of the community and health workers of population health, the quality of health-care systems and standards of public health.

The Countries of the Region, through their national health information systems, disaggregate data at the subnational level to provide a broader picture of within-country geographic inequities. For example, in Papua New Guinea and the Federated States of Micronesia, subnational data are available online and demonstrate considerable variation in immunization coverage across provinces and states. Data on other dimensions of health inequity are not routinely collected. Disaggregation of data by gender is not widely applied through routine health information systems. Ethnicity and socioeconomic status are only measurable through population-based surveys, and as outlined earlier, only six countries in the Western Pacific Region implement such surveys. The focus on UHC will therefore require more widespread application of disaggregated data collection, equity analysis of health care delivery, and more in-depth qualitative analysis of demand-side factors affecting health services access (such as analysis of financial barriers to health-care access, gender analysis, and equity or rights-based analysis).
PART 2
LOOKING FORWARD
2.1 Future directions for PHC in the Western Pacific Region

This section will draw on the UHC framework, SDG report and health financing strategy to identify potential strategies and targets for the Region.

Reorientation of PHC service delivery to NCD prevention and care. Across countries from different income groupings, NCDs have become a high-level public health policy priority. Problems that countries currently and historically have experienced with NCD prevention and management relate to lack of political commitment, human resources and finance, and absence of technical guidelines. All countries report a lack of human resources for mental health as a major factor contributing to the limitation of mental health programmes and services. In seeking policy solutions, countries in the Region are recommending increased awareness of NCD risk factors, budget allocations for PEN, adoption of PEN into nationwide guidelines (including guidance for primary care staff), and regular and adequate supply of essential medicines. In the PICs more generally, the strategic focus of ministries across this Region is to adopt the "right service delivery models at the PHC level, with a particular focus on integration of both public health and clinical services and improving coverage of noncommunicable disease (NCD) services." The health sector strategy in Vanuatu "highlights the importance of outreach services to improve early diagnosis and management of NCD and to provide affordable, local access to health services for people in isolated rural areas." In Samoa, a recent project evaluation has highlighted the value of the potential role of traditional healers as advocates for NCD prevention, as well as partnering with health professionals to raise the awareness of the population to threats posed by NCDs.

Given the vastly increased pressures on health budgets presented by the rise of NCDs, an important future focus for the Region will be on primary care and prevention. In many ways, less developed countries are quite well positioned to act, given the long record of accomplishment in community health networks and outreach systems. In settings such as Cambodia, the Lao People’s Democratic Republic and Viet Nam, for example, there have always been strong links established between networks of CHWs and professional health providers. It is operationally feasible in these countries to combine a model of MCH and communicable disease control with NCD prevention, management and community-level rehabilitation. This level of connectedness between the community sector and professional health sector for NCD prevention and management is one area for policy development in more developed country settings such as in Australia, Japan and New Zealand, as well as in Samoa. These community-level linkages are critical to the achievement of the regional mission for NCD prevention and management, which is to scale up effective interventions “through health-promoting environments.” This approach is reinforced by the dominant areas of action for NCD prevention and control that have been committed to by Member States, which includes tobacco control, alcohol consumption, physical activity, dietary measures, UHC and the enabling environments associated with these future directions (healthy cities, islands and villages). The fact that road traffic injuries are the leading cause of death for persons aged between 15 and 44 in China, that the prevalence of overweight or obesity (body mass index > 25) for women is close to 60% in Australia and 70% in Fiji, or that 2.2 million deaths in the Western Pacific Region in 2016 were attributable to air pollution, illustrates the importance of adopting both a medical and broader public health policy approach to address the social determinants of NCDs. It necessitates a whole-of-society and whole-of-government public health strategy, which begins with high-level political commitment, and ends with community-level partnerships between health professionals and community networks.
Developing a pro-equity focus for PHC strategy. One of the defining features of the Alma-Ata PHC approach was the universal application of the essential components of PHC, and its implementation through government health systems linked to networks of CHWs located in rural villages across the country. As outlined in this report, the Region has diversified epidemiologically, demographically and socially. A “monolithic” rural vision of PHC is no longer adequate to match the complex public health needs of populations and the equally complex policy challenges of national governments. Out of the monolithic rural model of PHC steered by the state has emerged the complex and diverse models of mixed public–private health-care systems, delivering public services in contexts shaped by economic growth, urbanization, increased migration, and ageing of the population. One study of barriers to health care in Japan, Australia, Republic of Korea and Hong Kong AR (China) demonstrated evidence of an “inverse care law”, whereby populations “with the highest levels of healthcare need…often have the poorest access to services.” The inequalities generated by these social changes – and the opportunities provided by modern communications technologies to voice these inequalities – are resulting in a sharply increased focus by governments and partners on issues of health equity. This means not only tailoring UHC strategy to specific national pathways, but also to subnational pathways, to better meet the needs of vulnerable or marginalized groups, including remote and unreached populations, indigenous minorities and the urban poor. For example, the Basic Design for Peace and Health of the Ministry of Foreign Affairs of Japan states that it is important to “focus attention on social determinants of health and offer inclusive and tailored assistance that will contribute to better health of vulnerable groups.” Likewise, the New Zealand Health Strategy observes that an important focus for the universal health services are “tailored approaches…for some individuals and population groups so they can access the same level of service and enjoy the same outcomes as others.” Both the Papua New Guinea and Solomon Islands Health Sector Strategic Plans highlight the high risks to public health associated with closure of primary care clinics in some rural and remote locations, and the related strategic need to prioritize human resources and logistical support for these locations.

Future directions will require promotion of UHC by tailoring the PHC strategy to the needs of specific hard-to-reach or unreached subpopulation groups. This can be achieved through additional policy focus on building capacity for subnational local government and health sector decentralized planning, budgeting, and monitoring and evaluation processes, so that resources can be allocated equitably to areas of highest need.

Reorientation of PHC to more people-centred care. The complexity and diversity in modernizing societies in the Western Pacific Region will necessitate new partnership models for PHC, by building alliances with private sector agencies, NGOs, local government, community organizations and intersectoral agencies. This networking of social and organizational capital has the potential to address many of the emerging social trends that we have raised in this report, such as urbanization, ageing, and chronic diseases prevention and management. Although partnerships with development agencies and multiple sectors are also critical to PHC, it is the partnerships forged at the community level that are likely to yield the most sustainable improvements in health-care networks for PHC. Developing a network of support for PHC also reinforces the resilience of health systems to sudden external impacts such as financial or environmental crises. For example, in New Zealand and Hong Kong SAR (China), patient representatives are required to be on district health boards and hospital boards, while in Singapore, providers conduct focus group discussions to understand the needs and expectations of patients and their families. People-centredness can also be applied to not only base service delivery on people’s perceptions, but also to base community health improvement on people’s actions. This is the basis of the “family-centred” health-care model practised in indigenous minority settings in Australia and New Zealand, where care models are based on the principle that parents bring health expertise at both family and systems level. Family doctors should be the coordinators, managers and leaders of
professional PHC teams. Development of family medicine is a top priority for workforce development for PHC in the Western Pacific Region.

Another variant of the people-centred approach is that of “community engagement”, whereby community representatives (usually in the form of community health volunteers) are utilized to directly provide health services at the community level, which is an approach that has been instrumental in the control of malaria in the Lao People’s Democratic Republic and elimination of malaria in Vanuatu. Partnerships at the community level can be further solidified through more participatory health governance models, whereby, as in Cambodia, local community representatives jointly govern health facilities with providers through health centre management committees. In Australia, the aboriginal community-controlled health services sector focuses on prevention, early intervention and comprehensive care to improve health outcomes for aboriginal people. This system is based on a model of family-centred PHC and provides team-based care for families or households, often through outreach services. Across the PICs, as outlined earlier, the Healthy Islands vision emphasizes more integrated health services to confront the double burden of communicable diseases and NCDs, as well as a Health in All Policies approach to mitigate the risks posed by climate change. Better integration of traditional medicines with PHC systems is also one measure implemented by countries to build community-level partnerships. Many countries, including China, Malaysia and the Republic of Korea, have established models to integrate traditional medicine into PHC to provide more culturally sensitive health-care services. Member States that have recently established regulations on traditional medicine practitioners include Australia, Malaysia and Samoa. All these approaches are well aligned with the recent World Health Assembly resolution on strengthening of integrated, people-centred health services. As these examples illustrate, emphasis of the people-centred vision of PHC is mainly on the shared roles of CHWs, community nurses and midwives, allied health workers, traditional medicine practitioners and primary care doctors in a multidisciplinary team-based approach to supporting PHC services for the population.

Expanding capacity for use of information and communications technology for PHC. PHC relies on connectivity and information sharing across primary, secondary and higher levels; “e-health” refers to the use of information and communications technologies (ICT) for health and is intended to assist in improving the flow of information, through electronic means, to support the delivery and management of health services. Thus, e-health is an enabler and can improve the quality, access and efficiency of care, if properly applied. E-health can be used to improve the timeliness and accuracy of reporting and to facilitate disease monitoring and surveillance. E-health also has a role in distance learning and in assisting with rapid response in emergencies. Given the experience in the Western Pacific Region of decentralized health systems, e-health systems can be used to improve the ability to plan, budget and deliver services. A systematic review of use of e-health for HIV treatment and care in Asia and the Pacific found that use of e-health (via text messaging, instant messaging, social media, and health promotion websites) served to increase rates of HIV testing and retesting. A subset of e-health activities includes m-health, which refers to ICT solutions reliant on more mobile technologies, and has been viewed as an important strategy to promote more patient-centred care, especially in lower-income country settings where large-scale ICT infrastructure may be less common. ICT can also facilitate more patient-centred care through the use of electronic health records, which allow access by both health professionals and families to patient care records. Technology and artificial intelligence will be increasingly used in assisting in the training, consulting and other professional work of family doctors, especially those practising in rural and remote areas.
Health security and adapting to the impacts of climate change. PICs are among those most vulnerable due to changing weather patterns. This results in increased health risks such as traumatic injuries and deaths relating to heatwaves, disruption of ecological systems, and the potential for social dysfunction related to disruption to health services or population displacement. These are further compounded by the limited health system and multisectoral capacity to manage and adapt to these risks. These risks are highlighted in atoll nations such as Kiribati, where the combination of factors of high fertility rates, overcrowding, limited land area, low elevation, and the threat posed by rising seas, all of which – besides exposing the population to high health risks – also expose the population to the risk of forced relocation. The resilience of societies and systems is a function of their capacity to mitigate impacts and adapt health and social systems to ecological change. In the Pacific, as outlined in the Healthy Islands vision and Madang Commitment towards Healthy Islands, PICs are implementing a range of policy initiatives, including a Health in All Policies approach; improving safety and security of food and water, as well as of sanitation and hygiene facilities; increasing capacity for health emergency risk management; enhancing surveillance for climate-sensitive diseases; and testing and evaluating climate-based early warning systems. Given the elevation of climate-related NCD risk associated with threats to food security, nutrition and mental health, as well as with risks associated with vector-borne diseases and water supplies, climate change in the Pacific reinforces the rationale for an integrated health systems and health-in-all policies approach. Due to the impacts of climate change and its potential for exacerbation of humanitarian emergencies and population movement across Asia and the Pacific, health security will also be high on the agenda of Member States of the Western Pacific Region in the coming 10 years.

In summary, decentralized planning and budgeting, reorientation of PHC towards more pro-equity and people-centred services, a focus on prevention and control of NCDs, expansion of opportunities related to health security, and adaptation to climate change and expanding capacity for use of ICT are major future directions for the Western Pacific Region.

2.2 Policy and strategy levers for change

We recommend four leveraging policy influences in the four areas below, to facilitate progress towards attainment of UHC and strengthened PHC goals.

Strengthening health planning and budgeting. National-level policy and planning processes form the basic template by which countries make steps towards attainment of UHC, as is the case in Cambodia, China, Japan, Papua New Guinea and Viet Nam. Such plans typically contain details of the medical benefits and public health package and the beneficiaries of social protection strategy. Such plans also contain monitoring and evaluation frameworks, which should document the main indicators/targets for attainment of UHC. Given the national commitments to UHC and processes of decentralization across the Western Pacific Region, these national policy directions can act as important policy levers by which to build capacity of subnational health authorities to plan and implement primary care services for populations within their catchment area.

Citizen engagement and Health in All Policies. Evidence throughout this report has highlighted the social and environmental determinants of health-related events such as obesity, poor air quality, road traffic trauma and the threats posed by climate change. Responding to these events will require a whole-of-society programme of action that goes well beyond the borders of a ministry of health and a medical primary care system (although equally recognizing what results can be achieved within the span of
control of health ministries). This being the case, a vital policy and strategy lever for change are processes of citizen engagement and Health in All Policies, so that awareness of accountabilities for PHC financing, actions and outcomes extends beyond the health professions into the realm of political, community and family decision-making.

**Linking health policy to political agendas.** As discussed earlier in this report, as governments search for electoral mandates, or alternatively, look for social policies to maintain social stability, health can become a very high political priority. Constitutions, laws and policies are all government instruments by which UHC commitments can be made. In the interest of either political mandates or social stability, health planners can utilize higher-level political mandates to leverage technical and financial support for UHC (see Section 2.3 for more detail). Countries can also use processes of legislation and budgeting to facilitate multisectoral and multistakeholder collaboration.\(^1\)

**Linking health investment to better health outcomes and economic growth.** A substantial body of literature is now emerging on the impact of investment in health on economic growth. The principal means by which growth is stimulated is in the increased productivity of the population generated by enabling children to reach their full potential. Both vaccination\(^2\) and programmes to reduce stunting\(^3\) have been reported to have this effect. Health planners can leverage support from ministries of finance and nonstate investors through presentation of information on the links between health investment and economic growth. The *Regional Action Agenda on the SDGs for the Western Pacific* recommends that the health sector utilize the policy lever of “sound and persuasive evidence of the social and economic benefits of investing in health to advocate for resources from both public and private sources.”\(^4\) Tracking of health expenditure in support of UHC policy goals is also an additional instrument by which to leverage resource support for PHC.

### 2.3 PHC and political agendas

There are four main political agendas for which the development of PHC-oriented health systems can have an important impact: growth and productivity, social stability and justice, health security, and mandates for UHC.

**Growth and productivity.** Growth and increased productivity are central political agendas for nation states. PHC-oriented systems are crucial to growth and productivity as the focus on prevention and primary care reduces higher-end health-care costs, supports poverty alleviation, and enables individuals and communities to achieve their full productive potential through access to services such as family planning, immunization, and nutrition programmes. A chief characteristic of national health plans across the Region is establishing this link between health development and social and economic development. The economic case for UHC has been reinforced by systematic reviews of public health interventions, which have confirmed that, not only are public health interventions (such as vaccination, water and sanitation, and injury prevention) cost-effective, they have also proven to be highly cost-saving (with a median return of investment of 14.3 to 1 for all public health interventions).\(^5\) In contrast, failure to invest in public health represents a “false economy” by generating additional costs for both health services and the wider economy through lost productivity of the population. Main political entry points here are building the evidence base for advocacy to political leadership and ministries of finance through development of economic analyses demonstrating the productivity gains and cost savings linked to investment in primary care.\(^6\)
Social stability and social justice. Increased growth and productivity is counterproductive from a political standpoint if the benefits of this growth are not distributed equitably across the nation. PHC-oriented systems in large part address this issue through facilitation of health preventive actions at the community level, as well as through organizing universal access to essential packages of services. PHC is therefore highly inclusive, as far as its effectiveness is measured by the extent to which service access is universal, affordable and involves the participation of communities in the design and delivery of care (patient-centred care). In contrast, weak or inequitable PHC systems are a threat to social stability, in that they contribute to inequalities of health access that may contribute to inequalities in socioeconomic status. DHS and MICS across the Region highlight the limited effectiveness of current PHC systems in addressing inequalities of health-care outcomes and access between socioeconomic groups and geographic regions within countries. As outlined in national health-care strategies and plans from Australia, Cambodia, China, Papua New Guinea and Viet Nam, extension of PHC-oriented systems is one means by which to address the political agenda of entrenched inequalities, and in doing so, promote the higher-level state political agenda of ensuring social stability and social justice through enabling universal access to public services. Potential political entry points here include the linking of PHC policy by health planners to the broader economic and social policy of the state, so that achievements generated through PHC can be viewed as a vehicle for achievement of higher-level state policy goals.

Health security. Given the cross-border health implications of globalization, climate change and migration, regional approaches to PHC policy development and best practice implementation will take on increasing significance in the next 10 years. Regional partnerships can be extended not only through regional mechanisms of international organizations and their Member States, but also through subregional geographic groupings, including the Greater Mekong Subregion, the Association of Southeast Asian Nations (ASEAN) and, in the PICs, through the Healthy Islands approach. In some countries, concepts of health security will see closer linkages established between health policy and foreign policy, as they seek to reinforce their domestic policy through building regional collaborations for management of global health issues such as climate change, refugee health, reproductive health, and control of both communicable diseases and NCDs. The main political entry point is here is the utilization of existing subregional political frameworks to facilitate joint policy and planning health security actions.

Political and legislated mandates for UHC. Political agendas are expressed through policy, legislation and constitutional mandates. Democratic systems also establish mandates through electoral processes. The level of importance of PHC systems in any country can be assessed by the extent to which countries enshrine UHC and PHC-oriented systems in constitutions, or through legislation or policy. The Regional UHC framework recommends using "legislation as a tool to ensure non-discrimination in health services and in society due to health or social or economic status." There is evidence across the Region that countries are increasingly making such high-level political commitments to PHC. In Australia, the national health insurance system (Medicare) is now the stated health policy of both main political parties, and the Government has recently enacted legislation for a national disability insurance scheme (funded through general taxation). In Japan, policy statements commit the country through both domestic and global health policy to a model of UHC. As stated throughout this report, the commitment by many countries to provision of an essential medical benefits package is testament to the Region’s overall commitment to UHC. China, for example, has committed through its national plan to the definition of an essential medical services and public health package that will be defined based on an assessment of the economic burden of disease, as well as specification of a basic insurance scheme to ensure high coverage by 2030. An important aspect of future policy directions in the Region will therefore be the increased expression of universal access to health services care and public
health as a fundamental political and social right, in much the same way as is the right of citizens to access an independent judicial system that is enshrined in constitutions, legislation or policy. In view of the role of electoral and legislative processes in securing mandates for UHC, increased advocacy by professional associations and other civil society groups regarding the right of citizens to UHC will increase political pressure for governments to meet their accountabilities towards the safeguarding of these rights. A further political entry point is through development of tighter regulatory mechanisms for UHC such as health insurance mechanisms, specification of medical benefits packages, and monitoring of health expenditure commitments by both national and subnational governments. Health regulation for UHC is an essential instrument by which to enforce accountability of levels of government to their populations to ensure their right to UHC.

2.4 Alliances and partnerships

One of the main themes of this report has been the impact of economic and social transformation post Alma-Ata on the level of complexity of society, demography and epidemiology. One way to manage complexity is to forge alliances and partnerships, to better navigate the complexities associated with managing public services in the context of rapid social change. Below we indicate five levels of partnership across the Region that all have impact on the coverage and quality of PHC-oriented systems.

Public–private partnerships. If there is one dominant trend over the last 20 years that has shaped the pattern of service delivery as well as of health-seeking behaviours, it has been the emergence of the private medical sector. Regardless of the political model governing countries, globalization, free trade and free movement of peoples has resulted in the emergence of a private for-profit medical sector in almost every country setting across the Region. Even in rural Cambodia, the private provider is the first point of contact for primary care. The challenge this transformation represents is how to adequately regulate and strategically partner with the private sector to achieve shared PHC goals (see Section 1.1.2 on strategy implementation for details). In countries across the Region, public–private partnerships have been formed to enhance the quality and accessibility of services. The pace of urbanization and economic growth across the Region is likely to accelerate these trends towards privatization. This being the case, improving the quality and reach of public–private partnerships will be a critical policy initiative for PHC in the next 10–20 years.

Public and civil partnerships. Equity of access and outcome is a priority policy concern in the Western Pacific Region. The urban poor, indigenous minorities and remote area populations all tend to experience lower access to public services. It is frequently the case that services fail to permeate every corner of society. In these cases, civil society organizations become very well placed to negotiate gaps in service delivery and facilitate communication between marginalized groups and the broader society. The role of churches in Papua New Guinea and reproductive health NGOs in Cambodia provide just some examples of how civil organizations play a vital role in bridging equity gaps between the broader society and socially disadvantaged populations. Given the pace of social change in the Region, these agencies will be critical partners in addressing health equity gaps in future years.

Local government partnerships. In the traditional era of Alma-Ata, the primary agency for health system management and financing has been a central ministry of health, reinforced by district-level management processes. In recent decades, there has been a major transformation of health governance in the Western Pacific Region. Both decentralization and devolution have been common features of
governance reform. Local government is taking up responsibilities for both management and financing of health-care services in such settings as the Philippines, Mongolia, Cambodia, Papua New Guinea and Viet Nam. In urban areas, local government is not only being tasked to finance and manage health-care services, but is also delegated authority for maintenance of public health standards for clean air, WASH and waste management. Local government also provides a means by which communities can engage with government to coordinate service delivery in the catchment areas. The increasing mobility and migration of populations in the modern age in countries such as Mongolia, the Philippines and China, also points to an increasing role for local government in civil and birth registration and health management information and communications.

**Local community partnerships.** One of the most successful interventions of the Alma-Ata period was the partnership formed between professional health workers and community-based health workers and volunteers. Networks of volunteers linked to primary care systems in Viet Nam, Cambodia and the Lao People’s Democratic Republic have made a vital contribution to public health gains in the areas of family planning, immunization and malaria control. This strategy has in large part been one of the major factors in the control and elimination of such diseases as tetanus, poliomyelitis (polio) and malaria. As we outline in the cases of Malaysia and Samoa in this report (see Section 1.2.1 on good practices), the strengthening of community health systems can be an effective means to reach UHC and achieve SDGs not only for RMNCAH priorities, but also for reaching vulnerable groups and for responding to emerging disease threats such as NCDs.

In developed country settings, although the GP model has been effective in expanding access to primary medical care, these countries have been less successful in adequately engaging with their communities to provide such care. In the 2035 health vision from Japan, planners observe that there is a level of “disconnectedness” between primary care providers and community networks. Given the declining fertility and ageing population in the country, putting in place models of stronger connection between health providers and community networks is considered by planners there to be critical to managing increasingly complex chronic care needs. In a similar vein, in Australia, although GP networks remain the backbone of the PHC system, there is a pressing need stated in the PHC Framework to link more strongly with other health professions and with community consumers and carers, and thereby reduce the risk of duplicated or fragmented care. One policy pathway here is the redesign of local governance mechanisms, such as Primary Health Networks, which became operational in 2015. These independent organizations, besides focusing on individual care, also aim to support more population-based approaches in such areas as health screening and checks, smoking cessation, exercise, weight reduction and diet, and coordination of care for chronic conditions such as diabetes and cardiovascular disease.

In the Republic of Korea, a recent quality review established that the system of community-level family medicine is underdeveloped. There is a need to refocus away from models that solely rely on the PHC provider as a gatekeeper to higher-level secondary and tertiary care, to a model more based on prevention and health promotion along with “partnering” with patients to select services that are most responsive to their needs. It is important to note that family medicine is the key specialty whose competencies and scope of practice allow comprehensive, coordinated and person-centred care that meets multiple medical needs for individual patients of all ages, families and communities over time. Family doctors – working with other primary health-care workers – can integrate patient needs for prevention, acute and chronic care across disease groups, in a way that centres care on the individual, family and their context. When appropriately trained and working within an adequately resourced clinical setting, family
doctors have been shown to be cost-effective, valuable, and able to improve health outcomes for entire populations. All countries in the Region have the potential to transform their health workforce by training more family doctors as a critical part of a multidisciplinary team providing integrated, people-centred PHC – the foundation of UHC.

Another model of community partnership being explored in the Region is in integration of traditional medicine with health systems. Traditional medicine practitioners are regulated as professional health workers like western medicine doctors in China, Hong Kong SAR (China), Mongolia, the Republic of Korea and Viet Nam, and in the PICs, community-based health workers may include traditional medicine practitioners/healers. These observations point to the need to reorient the traditional "social mobilization" and "community participation" approach of the Alma-Ata model of PHC towards a more mature model of community partnership and control that is better adapted to leading broader social and political movements to sustain prevention and health promotion activities in local communities.

**Intersectoral and international partnerships.** Factors such as the NCD epidemic, globalization, urbanization, and threats posed by climate change all provide powerful examples of the impact of the social and environmental determinants of health that are largely external to influence of the medical sector. It is for this reason that we see in major public health policy statements across the Region a conceptualization of PHC that is well beyond the borders of the medical system. For example, the Mongolian National Health Policy distinguishes public health policy from medical services policy and discusses the need for intersectoral action in such areas as housing, air, water and soil pollution, action on health law and responses to public emergencies, and safe working places. An openness to partnerships beyond the health sector is evident in Japan's statement on global development, which views international development assistance as not only a method for alleviating conditions in other countries, but is also viewed as a method for reinforcing the quality of domestic health policy, particularly through providing international support for emerging and re-emerging infectious diseases that are not confined by geography. Both approaches are suggestive of a much more open approach to development, with models of donor–recipient country relationships being transformed into more mature partnerships based on mutual capacity to contribute to both global and domestic health improvement. The setting of regional goals and targets for UHC (linked to global health targets and goals) can be one means by which countries can partner with international organizations to jointly track minimum levels of commitment towards attaining UHC. This is already taking place in terms of the SDG monitoring process. Policy frameworks (such as the Regional UHC Framework) also provide opportunities for sharing of best practices and lessons learnt from implementation of UHC and social protection strategies.

### 2.5 Learning from each other

Policy and strategy documents published through the WHO Regional Office for the Western Pacific point to the high level of communication established between governments across the Region. Given the social complexity and rate of social transition underway in the Region, it may be reasonable to consider how such learning can be extended to engage key partners and allies in health development, including civil society agencies, academic institutions, local governments, private providers and ethnic organizations. There are many examples presented throughout this report on how such alliances are forged with national governments within countries, but there is less evidence on how the benefits and challenges of such alliances are disseminated to other governments across the Region. Given the
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Integrated nature of PHC, the health systems approach is ideal for communicating how PHC systems can best adapt to the radically transformed social context across the Region. For this purpose, it may be valuable for countries to review best practices regionally in UHC and PHC and NCD prevention and control, with a view to publication of case studies of best practices.

One potential mechanism for reviewing best practice is the Technical Advisory Group on Universal Health Coverage (UHC TAG), which has been established since 2016 to assist Member States to learn from each other’s country experiences and advance the implementation of UHC in the Western Pacific Region, with a particular focus on health system governance and service delivery, and a view to prioritizing areas for development of UHC in the Region.

In summary, countries can better learn from each other by sustaining the regional approach to information sharing and policy commitment, engaging with a wider array of nongovernment partners during regional consultations, and disseminating and publishing best practice case studies in health system development (UHC, PHC, MCH/communicable disease control, and NCD prevention and control).

2.6 Measuring success

Earlier sections of this report outlined many of the ways in which regional mechanisms are utilized to measure success (see the first part of Section 2.2). These include regional policy consultation forums, the formation of regional strategies and reporting of communicable diseases and NCDs, and tracking of health expenditures and social protection. At the national level, many countries conduct population-based surveys to measure success, and these include DHS and MICS, as well as use routine health management information systems data for planning and surveillance purposes.

Monitoring progress towards UHC. The WHO Regional Office of the Western Pacific – in partnership with Member States – has developed a baseline report on Monitoring Universal Health Coverage and Health in the Sustainable Development Goals. The baseline report is designed as a starting point for cross-country comparisons and to encourage reciprocal learning between countries in the Region on UHC and the SDGs. The Region has developed a methodology that enables countries to adapt indicators to national epidemiological and demographic conditions. The Region has also developed an index of UHC that enables tracking of progress as well as enabling cross-country comparisons. Health service coverage is measured by the UHC index, which is a summary measure that combines 16 tracer categories and four main categories that include RMNCAH, infectious diseases, NCDs, and service capacity and access. A set of SDGs and UHC country profiles has also been developed that enables tracking of progress in countries from the baseline report.

Measuring equity and quality. Under the traditional Alma-Ata model of PHC, knowledge, attitude and practices (KAP) surveys and health-seeking behaviour studies have been common approaches to more qualitative analysis (or combined qualitative and quantitative analysis). In the era of UHC and modern communications, health systems and demand-side qualitative studies are likely to take on additional significance. The need for integrated coordinated care for NCDs, as well as the measurement of equity and quality of health care, will shift the emphasis in data collection towards more qualitative assessments of the perceptions of the community and health workers of population health and the quality of healthcare systems. The focus on UHC will require much more widespread application of disaggregated data collection and more in-depth qualitative analysis of demand-side factors effecting health services access.
Qualitative research will take on additional focus in the coming years due to the pro-equity health agendas of many countries and the trend towards more people-centred health-care services, where understanding the needs and perceptions of communities takes on additional significance. Qualitative research is also critical to deepening understanding of the demand-side factors limiting the capability of marginalized populations to access health-care services. Expansion of models of population-based surveys should also be facilitated across the Region, as these methods are being applied successfully by a subset of countries across the Region (such as in the Philippines and Cambodia) to track improvements in inequities to health-care access and outcomes.

**Measuring affordability, health expenditures and financial management capacity.** Given the renewed policy focus on financial barriers to health care in UHC policy discourse, tracking of OOP payments and social protection through health expenditure surveys and databases will be increasingly necessary for monitoring progress towards attainment of UHC goals. Given the trends towards decentralized planning and budgeting processes discussed throughout this report, a main measurement of success will be through assessments of financial management and planning capacity at middle levels of management and increasingly at the primary level of care.

**Measuring demographic and epidemiological trends.** Increased urbanization, population mobility and migration outlined throughout this report will necessitate increased emphasis on birth and civil registration systems, as well as on electronic individual health records. Most countries in the Region have close to or above 75% birth registration coverage and completeness of cause-of-death data is also high in most countries. Adequate birth and civil registration data are vital to the integrity of PHC-oriented systems, given that they are utilized for assessment of accurate population denominators and active search of public health risks at the community level. Globalization and increased mobility and migration have also increased the strategic significance of reporting of priority diseases. The International Health Regulations, or IHR (2005), were established in the Western Pacific Region in 2007 as a system that legally binds Member States to report on selected priority diseases. IHR (2005) has taken on additional health security significance in recent years due to the threat of emerging diseases in the Region, including SARS, avian influenza H1N1 and other influenza strains. Global, regional and national reporting of vaccine-preventable and infectious diseases by Member States have been critical to measuring the success of public health eradication, elimination or control of such diseases as polio, neonatal tetanus, measles, hepatitis B, HIV, malaria and TB. The success of such reporting provides a good model for the scaling up of systems to monitor NCD risk reduction as these threats to public health continue to expand. Equally important, in a selected group of less-developed countries, global and regional reporting of RMNCAH service access and outcomes (antenatal care, facility delivery, family planning access) have very high significance in terms of measuring public health success.
ANNEX – A NOTE ON METHODS

Given the very wide scope of the topic, a systematic literature search was not undertaken to develop this report. Instead, literature was purposively searched according to broad research questions identified by the World Health Organization (WHO) in its terms of reference for development of this report.

(1) Literature was sourced purposively from three sources:

(2) The database of documents on health services development from the WHO Regional Office for the Western Pacific (http://www.wpro.who.int/health_services/documents/en/).

(3) National health plans and policies through the Google search engine as well as from the WHO Regional Office for the Western Pacific.

Peer-reviewed literature through the PubMed database (https://www.ncbi.nlm.nih.gov/pmc/) using title search terms “primary health care” and “country title”. Literature was selected based on the observation of level of relevance between the literature content and the strategic topics and directions outlined in the WHO Western Pacific Region policy and strategy documents. This approach reflects the overall intent of the report, which is to demonstrate the strategic directions of the Region for primary health care in the coming 10 years.

This report will be subjected to an organizational peer-review process, whereby the draft document will be circulated to WHO colleagues who will review it and check for alignment with the outlines and terms of reference of the Regional Review. The Regional Office will consolidate the feedback, after which the draft will be revised and corrected.
ENDNOTES


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Note 2, see Introduction.


Note 2, see Introduction, p. 27.

Refer to successive Demographic and Health Surveys conducted in country settings such as the Philippines and Cambodia.

Note 2, see Introduction, p. 15.
