DRAFT

Regional Framework on the Future of Primary Health Care in the Western Pacific

World Health Organization
Western Pacific Region
Contents

Abbreviations 9

Executive summary 11

1. Introduction 14
   1.1 Alignment with global and regional frameworks and strategies 15
   1.2 Goal of the Regional Framework 15
   1.3 Structure of document 16

2. Current status of primary health care in the Western Pacific Region 17
   2.1 Health outcomes 17
   2.2 Health services access 21
   2.3 Health system capacity 25
      2.3.1 Health financing 25
      2.3.2 Service utilization and delivery capacity 27
      2.3.3 Demand-side challenges to PHC service delivery 29

3. Rationale and context for a regional framework on PHC 32
   3.1 Regional diversity 32
   3.2 Health needs in the Region are changing. 32
   3.3 Future context 37
      3.3.1 Economic and fiscal outlook 37
      3.3.2 Rise in availability and use of digital technology 38
      3.3.3 More literate populations with greater access to information 39
      3.3.4 Changes in the lived environment 39

4. New regional framework for PHC 41
   4.1 Scope and functions of PHC 41
   4.2 Attributes of PHC 43
      4.2.1 People and community centred 44
      4.2.2 Continuity, lifelong engagement 46
      4.2.3 High quality and equitable 47
      4.2.4 Integrated 49
      4.2.5 Innovative 51
   4.3 Strategic actions to build the future of PHC 52
      4.3.1 Build appropriate service delivery models 53
      4.3.2 Empower individuals and communities to participate in health 59
      4.3.3 Build a diverse fit-for-purpose PHC workforce 62
      4.3.4 Realign PHC financing 66
      4.3.5 Create a supportive and enabling environment 69
## 5. Moving forward with PHC reform

5.1 Key considerations for Member States in undertaking PHC reform

5.1.1 Understand the health needs and system performance today and in the future

5.1.2 Identify feasible entry points for reform

5.1.3 Engage and consult

5.1.4 Set up or designate governance mechanism(s) for the reform process

5.1.5 Design the system that will deliver the vision of PHC

5.1.6 Develop a plan for PHC reform

5.1.7 Implement and scale up

5.1.8 Measure and learn

5.2 WHO’s role in working with Member States

5.3 Monitoring and evaluation of the Framework

## References
### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHE</td>
<td>current health expenditure</td>
</tr>
<tr>
<td>COVID-19</td>
<td>coronavirus disease</td>
</tr>
<tr>
<td>DALY</td>
<td>disability-adjusted life year</td>
</tr>
<tr>
<td>NCSs</td>
<td>noncommunicable diseases</td>
</tr>
<tr>
<td>PHC</td>
<td>primary health care</td>
</tr>
<tr>
<td>PICs</td>
<td>Pacific island countries and areas</td>
</tr>
<tr>
<td>RMNCH</td>
<td>reproductive, maternal, newborn and child health</td>
</tr>
<tr>
<td>SDGs</td>
<td>Sustainable Development Goals</td>
</tr>
<tr>
<td>TB</td>
<td>tuberculosis</td>
</tr>
<tr>
<td>UHC</td>
<td>universal health coverage</td>
</tr>
<tr>
<td>VAHS</td>
<td>Victorian Aboriginal Health Service</td>
</tr>
<tr>
<td>WASH</td>
<td>water, sanitation and hygiene</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
Executive summary

The World Health Organization (WHO) Western Pacific Region is diverse in its geography, ethnicities and levels of economic development, with 37 countries and areas that are home to more than 1.9 billion people, encompassing both the world’s most populous countries and remote Pacific island nations. The Region also is undergoing demographic, epidemiological and socioeconomic transitions, leading to a shift in population health needs and changes in patterns of ill-health and health-seeking behaviours. As countries and areas in the Region refocus on transforming health systems to meet these emerging challenges, strengthening primary health care (PHC) will be essential. The October 2021 high-level panel discussion on PHC at the WHO Regional Committee for the Western Pacific reiterated the commitment of Member States to building strong health systems focused on PHC by outlining:

- the importance of PHC reform to address the dynamic health needs of the countries in the Region;
- the lessons from the coronavirus disease (COVID-19) pandemic on the centrality of PHC as part of preparedness for and response to public health emergencies;
- the opportunities the pandemic provided to drive system transformation; and
- the key requirements to build PHC for a future that focuses on population health and well-being.

This Regional Framework on the Future of Primary Health Care in the Western Pacific builds on existing global and regional frameworks to provide pathways to strengthen PHC and make it operational across the Western Pacific.

In the past two decades, health service access and health outcomes have improved across the Region – Member States have made strides towards universal health coverage (UHC) and demonstrated significant improvements in health outcomes such as healthy life expectancy, as well as reductions in premature mortality and maternal and child mortality. However, these improvements are not equitably distributed across populations, and even higher-income countries and settings continue to face challenges that impede their ability to realize optimal health outcomes, achieve UHC and progress towards the Sustainable Development Goals.

These challenges – current and future – encompass several dimensions. There is an ongoing shift in the burden of disease, with noncommunicable diseases (NCDs) being the leading cause of mortality and morbidity across the Western Pacific Region, where the main NCD risk factors remain prevalent, including tobacco use, physical inactivity, the harmful use of alcohol and poor diets. While there has been progress in the control of communicable diseases in the Region, this progress has stalled in the past decade. Pockets of communicable conditions of high incidence such as tuberculosis remain. There has also been an increase in the ageing population. The proportion of people over 60 years old in the Region is projected to double by 2050, which will increase demand and costs for health services.

The health consequences of environmental degradation also continue to rise, with an estimated 2.2 million deaths from air pollution in the Region every year. The health impact of climate change will be felt by all countries and areas in the Western Pacific Region. But some are affected more than others, with poorer nations and low-lying areas, especially Pacific island countries and areas (PICs), more vulnerable to sea-level rise and severe weather events. Further, as the COVID-19 pandemic has demonstrated, health security threats such as emerging infectious disease outbreaks, among other
Annex

environmental and food-related threats, constitute ever-present dangers to the health and well-being of communities across the world. Inequities in access persist, with more people in the Region facing financial hardship in securing health services. Differences in gender, ethnicity and geography continue to produce unequal health outcomes across the Region.

Currently, many health systems do not have the capacity to deliver for present or future health needs. This deficiency exists for several reasons. Across the Region, government spending on health still varies widely. Overall, the levels of PHC spending remain suboptimal and underreported. Health workforce shortages further constrain the capacity to deliver and expand services, with persistent disparities between rural, remote and hard-to-reach areas compared with capital cities and other urban centres. Many delivery systems continue to be fragmented in terms of programmatic services, with limited coordination across various tiers of care that often remain delinked from other care services. A large proportion of services is delivered through private providers, but those services are rarely accounted for – or planned for – in health policy. While the digital age has enabled greater access to information, the quality of this information and its accessibility vary widely. There are deep-rooted inequities in literacy, access to technology and other resources throughout the Region, and the digital infrastructure is significantly underdeveloped in many countries.

To achieve high-quality and effective PHC, a paradigm shift is needed in the way PHC systems are designed, funded, managed and delivered to enable them to meet the challenges faced by health systems in the Region. This will mean building systems that not only treat ill health, but also maintain well-being. These systems must provide services that meaningfully engage communities to address the specific, dynamic needs of various demographic groups and marginalized populations along their life course. These services must be focused on the most effective approaches that can be delivered efficiently. These systems also must link and connect clients with services across sectors, and the services they provide must harness and build on innovative technologies.

This Regional Framework on the Future of Primary Health Care in the Western Pacific redefines the scope of PHC: as comprehensive services, consisting of a community-based system with a continuum of services from health promotion to early detection to curative and rehabilitative care, delivered through multidisciplinary teams, in line with local needs and requiring the coordinated efforts of society.

The Regional Framework also outlines five key characteristics of a PHC system:

1. It is people and community centred, providing services that are personalized and even predictive, taking account of the whole person and providing people with reliable and contextually appropriate information and the support they need to make decisions and participate in their own care; it also involves stronger community engagement, including with indigenous populations and other vulnerable groups, in planning, developing and delivering services and implementing policies.

2. It is continuous, involving repeated interaction between an individual and a consistent team of professionals, improving communication and trust and enabling tailored care over the life course, with information systems that provide access to reliable, complete and timely information for providers, and coordinated care.

3. It is equitable and high quality, a system that optimizes health care in a given context by consistently delivering care that improves or maintains health outcomes, by being valued and trusted by all people. In many ways, achieving this vision for PHC will involve the construction of a new social contract dedicated to the provision of and financing for common goods for health.
4. It is integrated, enabling a seamless transition to both higher levels of the health system (the wider and diverse medical neighbourhood) and to other sectors, community services and supports.

5. It is innovative, encouraging providers to work with communities and individuals to continuously consider new models of care and service delivery, including through the use of research, evaluation and digital technologies.

This Regional Framework outlines five sets of strategic actions that Member States can consider and adapt to their contexts to achieve comprehensive, continuous and high-quality PHC:

1. They must build appropriate models of service delivery that are tailored to local contexts, including through the use of integrated service networks and multidisciplinary care, empanelment, progressive expansion of service packages, linkages with social welfare services and use of complementary digital technology, among others.

2. They must enable individuals and communities to contribute to planning, decision-making and policy direction, as well as in the design and delivery of activities and strategies that allow individuals and families to more intentionally manage their own health and well-being.

3. They must build a diverse PHC workforce and provider base that is closely aligned with the needs of communities, through the incorporation of workforce optimization methods such as task-shifting, workforce expansion and incentivization, effective training and education of PHC workers for the future, engagement of private providers, building a digital workforce, and establishing effective workforce education systems.

4. They must redesign and realign health financing to reduce the financial pressure of health care on the population and make health systems financially sustainable in the future. This could be by prioritizing public financing for PHC (including for essential public health functions), reducing public financial bottlenecks, and reforming strategic purchasing to incentivize population health and primary care services. This can lead to a service model that is more affordable and, hence, more sustainable.

5. They must create a supportive and enabling environment to drive and guide action on PHC reform by revising legal, policy and regulatory frameworks to support integrated and participatory services, strengthening health services management and coordination, establishing community participation, establishing monitoring and learning mechanisms, investing in the provision of digital infrastructure, driving the adoption of digital technology, and putting in place monitoring mechanisms that promote learning and improvement.

Member States seeking to further their progress on PHC reform can consider adopting key high-level processes to help guide their planning and decisions. Alongside the communities they seek to support, they must assess population health needs and evaluate health system performance to diagnose the gaps in their own context. They also must identify the appropriate entry point for reform through dialogue and engagement with citizens and stakeholders, within and across health, on reform opportunities. In addition, they must design, plan and implement reforms by prioritizing the actions with the greatest potential for impact and sequence the planned actions appropriately to create momentum. Finally, they must take steps to measure outcomes and performance using the right metrics, review performance based on evidence and adapt strategies as needed.
Annex

1. Introduction

Since the Declaration of Alma-Ata in 1978, the vision of primary health care (PHC) has been a health system that provides comprehensive, accessible and high-quality equitable care for all. In the intervening years, its interpretation and implementation have varied across countries, including those in the World Health Organization (WHO) Western Pacific Region. Over the past two decades and with the adoption of the Sustainable Development Goals (SDGs), access to health services and outcomes have improved across the Region. However, these improvements are not equitably distributed across populations. As a result, even higher-income countries and settings still face challenges that impede their ability to achieve optimal health outcomes.

The demographic, epidemiological and socioeconomic transitions underway in the Region are leading to a shift in population health needs, as well as changes in the pattern of ill health and health-seeking behaviour. For the Future: Towards the Healthiest and Safest Region, the shared vision of WHO work with Member States and partners in the Western Pacific Region, identifies four thematic priorities: 1) health security, including antimicrobial resistance; 2) noncommunicable diseases (NCDs) and ageing; 3) climate change, the environment and health; and 4) reaching the unreached. These priorities will require a people-centred, integrated service approach, as exemplified by PHC.

The coronavirus disease (COVID-19) pandemic has demonstrated the critical nature of strong primary care, particularly as it extended beyond an acute health emergency. The pandemic has offered opportunities to further reorientate health systems towards PHC. As countries and areas in the Western Pacific Region refocus on the goal of achieving universal health coverage (UHC), strengthening primary care will be essential. This will mean building systems that can deliver on the following:

- a system that not only treats ill health but also maintains well-being;
- services that address the specific and dynamic needs of various demographic groups and marginalized populations along the life course;
- services focused on the most effective approaches that can be delivered efficiently;
- systems that can link and connect clients with services across sectors; and
- services that can harness and build on innovative technologies.

A high-level panel discussion on PHC at the October 2021 session of the WHO Regional Committee for the Western Pacific led to overwhelming endorsement of the need for strong PHC, particularly in the aftermath of the COVID-19 pandemic. Member States provided key recommendations to guide the development of the new framework on PHC:

- Reimagining PHC for the future will require making such care integral to new health plans and strategies and adapting to new health challenges. This is particularly important now for several reasons, including: the increasing burden of NCDs and chronic conditions, requiring different modalities of care; ensuring financial sustainability of the health system in the future by intervening as early as possible in the health continuum; a need to transition from an episodic and disease-based approach to health care to continuous and lifelong engagement; and the need to reach all people, especially the vulnerable, while limiting financial risk.
The COVID-19 pandemic demonstrated the importance of PHC in response, management and immunization activities. Besides the vital role PHC played in maintaining essential health services, the pandemic also led to innovations in PHC being fostered and scaled up, such as telemedicine initiatives, online scheduling and prescriptions, and augmented health information systems capacity.

In building PHC for the future, new models of service delivery are required, underpinned by changes in health workforce management, financing and enabling environments, especially leveraging digital technologies. PHC reorientation should be driven by the community, incorporating individualized and predictive care with the entire range of preventive, promotive, curative, rehabilitation and palliative care, all linked to other services such as social care and nutrition.

### 1.1 Alignment with global and regional frameworks and strategies

This *Regional Framework on the Future of Primary Health Care in the Western Pacific* builds on existing global and regional frameworks to provide pathways to make strong PHC operational in countries in the Region. The 2016 regional framework, *Universal Health Coverage: Moving Towards Better Health – Action Framework for the Western Pacific Region*, outlines the key attributes required for a health system to move towards UHC, along with main action domains to guide country implementation. The *Declaration of Astana* in 2018 reaffirmed the global commitment, redefining the vision of PHC in the 21st century. In addition, the global operational framework, *Primary Health Care: Transforming Vision into Action*, outlines 14 action areas to achieve the vision of PHC as the cornerstone for UHC.

This Regional Framework on PHC aligns with and integrates the recently endorsed *Regional Action Plan on Healthy Ageing in the Western Pacific*, as well as the *Regional Framework on Nurturing Resilient and Healthy Future Generations in the Western Pacific*. It also provides a delivery platform for the concurrent draft frameworks to be considered in October 2022 at the seventy-third session of the WHO Regional Committee for the Western Pacific, such as the *Regional Action Framework on Reaching the Unreached in the Western Pacific (2022–2030)*; the *Regional Framework on Noncommunicable Diseases* and the *Regional Framework for the Future of Mental Health in the Western Pacific 2023–2030*.

### 1.2 Goal of the Regional Framework

This Regional Framework aims to provide a conceptualization and create a vision of strong PHC in the next decade, as well as set out actions for Member States to adapt it within their context.

It is targeted primarily at policy- and decision-makers in Member States of the WHO Western Pacific Region. However, its contents are written to be useful to all stakeholders to gain an understanding of the shared vision of the Region, and to act as an advocacy tool for joint investment and action in PHC towards the SDGs.
Annex

1.3 Structure of the document

This document is organized in five chapters, the first of which is this introduction. The second chapter outlines the regional PHC performance. The third chapter makes the case for a regional framework to strengthen PHC, based on the future context and health challenges facing the Region. The fourth chapter outlines the proposed Regional Framework: what PHC should entail, what PHC should look like if the vision is achieved and suggested strategic actions. The fifth chapter highlights how Member States can take this Regional Framework forward, as well as WHO support for implementation.
2. Current status of primary health care in the Western Pacific Region

The Western Pacific Region has seen remarkable improvements in health outcomes in recent decades. The populations of some countries in the Region are rapidly ageing, with an increasing burden of noncommunicable and chronic conditions, while others are still facing a significant burden of disease from “traditional” health threats, including infectious diseases and infant and maternal mortality.

This chapter will outline the current situation in the Western Pacific Region in terms of health outcomes and structural challenges, the state of existing health systems, access to services and resources available to ensure appropriate health care is available to the Region’s people, and some of the persistent inequities and barriers to achieving UHC.

2.1 Health outcomes

*Life expectancy and healthy life expectancy have increased in the past two decades.*

Between 2000 and 2019, life expectancy in the Region increased from 72.4 to 77.7 years, while healthy life expectancy increased from 64.3 to 68.6 years.¹ This progress has created new health challenges: the emergence of new health security threats and the ever-present risk of health emergencies; changing lifestyles, consumption patterns and rapid urbanization that have led to an increase in NCDs; and air pollution, climate change and other environmental changes that put people’s health at risk.

*Dramatic improvements are seen in maternal mortality and child mortality, while premature mortality due to NCDs shows little progress.*

The maternal mortality ratio fell from 75 deaths per 100 000 in 2000 to 41 deaths per 100 000 in 2017. The Western Pacific is the second lowest of all WHO regions (behind the European Region). However, some countries are still lagging, with the maternal mortality ratio in Cambodia, Papua New Guinea and the Philippines still higher than the regional average of 41 per 100 000.¹

Neonatal mortality fell by over 78% in the Region between 2000 and 2019, currently standing at 5.8 per 1000 live births for the Region. Meanwhile, under-5 child mortality fell from 35 to 13 per 1000 live births.¹ Under-5 mortality also has dropped considerably since 2000, but the declines are less dramatic than for maternal mortality or neonatal mortality. This may mean there is a greater need to focus on quality of care, rather than just making services available.²

The probability of premature death in the Region from the four major NCDs – cancer, cardiovascular disease, chronic respiratory diseases and diabetes – has declined from 21.3% in 2000 to 15.6% in 2019.¹ However, this progress has been uneven, with many countries still higher than the regional average. In *The Lancet NCD Countdown 2030,*³ only three high-income countries from the Western Pacific Region (New Zealand, the Republic of Korea and Singapore) were on track to achieve the SDG target on premature mortality from NCDs. Progress across middle-income countries in Asia and the Pacific is very slow. For example, in Papua New Guinea, women are three to seven times more likely to die from NCDs before the age of 70 than those in higher-income countries; and for men in Fiji, Kiribati and Mongolia, the probability of dying from NCDs is among the highest globally.

The Western Pacific Region contains about 25% of the world’s population but bears 41% of the world’s deaths related to air pollution, contributing to deaths from multiple NCDs, such as ischaemic heart
disease, stroke, chronic lung disease and lung cancer. Deaths from both household air pollution (1.2 million) and ambient/outdoor air pollution (1 million) cause 2.2 million premature deaths annually in the Western Pacific, the highest share of any WHO region.4

**Noncommunicable diseases have progressed to become the largest contributors to morbidity.**

Reflecting the limited progress in reducing mortality due to NCDs seen above, the top four contributors to morbidity are NCDs and injuries (in terms of disability-adjusted life years, or DALYs) in the Region (Fig. 1), while the contribution of communicable, maternal, neonatal and nutritional diseases to morbidity has decreased considerably since 2000.

**Fig. 1. Change in contribution of the top 10 disease conditions to DALYs (%) in the Western Pacific Region (2000–2019)**

DALY: disability-adjusted life year


More than 215 million people in the Western Pacific are affected by mental health conditions, making mental disorders among the leading causes of disease burden in the Region and the world. Depressive disorders in the Western Pacific alone are responsible for more than 5% of the regional burden of disease, and roughly one third of suicides in the world are reported from the Region.

**Progress in NCD risk factors is limited.**

There has been some progress in the Region on tobacco control – smoking prevalence in the Western Pacific has been reduced from 30% to 26% over the past three decades. By 2025, the number of smokers is projected to decline by 21 million compared to a decade ago.5 However, tobacco smoking in the
Annex

Region remains higher than the global average: one third of cigarettes consumed globally are smoked in the Western Pacific.

The regional outlook for other risk factors is less promising. For example, the prevalence of overweight has tripled since 1975, and the rate of obesity has increased more than sixfold – with women at higher risk for both in middle-income countries and men at higher risk in high-income countries. Further, more than four in every 10 people in the Region do not get enough physical activity.5

Alcohol consumption per capita in the Region, at 7.3 litres per year, is also higher than the global average of 6.4, with Australia, Cook Islands and New Zealand topping the list for highest consumption.

**Communicable disease incidence has declined, but progress has stalled in the past decade.**

Overall, the Western Pacific Region achieved the 2015 targets of the Millennium Development Goals for HIV, immunization, malaria and tuberculosis (TB). For instance, TB incidence in the Region has declined from 135 per 100 000 population in 2000 to 95 per 100 000 in 2020.1 Deaths from malaria remain low compared to other WHO regions, although they have plateaued to between 3000 and 4000 deaths per year since 2010.1 The Region has maintained polio-free status since 2000 and has continued to significantly reduce the prevalence of hepatitis B infection among children. As of September 2019, nine countries and areas in the Region have been verified as having achieved measles elimination, and five have been verified as having achieved rubella elimination.6

Yet progress made remains uneven, and in several countries – especially those with the weakest health systems – the prevalence of some communicable diseases, such as hepatitis, HIV and TB, remains high.

**As with child mortality, childhood wellness indices have improved significantly in the past two decades.**

Stunting in children aged under 5 years has gone down from 22.2% in 2000 to 9.3% in 2020, whereas underweight prevalence among children under 5 years has been reduced from 8.6% in 2000 to 2.3% in 2020 (Fig. 2). Still, Cambodia, the Lao People’s Democratic Republic, the Marshall Islands, Papua New Guinea, the Philippines, Solomon Islands and Vanuatu all had stunting rates higher than 25% in 2020.

**Fig. 2. Stunting and underweight prevalence among children under 5 years of age in the Western Pacific Region (%) (2000–2020)**
Health outcomes are unequal.

Despite the improvements noted above, differences in gender, ethnicity and geography continue to produce varying health outcomes across the Region, with women having a higher life expectancy than men in all countries across the Region. Large gaps in morbidity and mortality exist between men and women, with men faring worse across all indicators in most countries. Men’s risk from premature mortality from NCDs is 50% higher than that of women in most countries of the Region, and across the Region men are up to five times more likely than women to die in road traffic crashes.

An incremental association between undernutrition and household wealth is apparent in countries across the Region, although the degree of economic inequity varies from country to country and according to the form of undernutrition (stunting or wasting) (Fig. 3). Maternal education is also a major determinant of undernutrition, with fewer years of maternal education associated with undernutrition among children.

Fig. 3. Stunting prevalence among children under 5 years of age by wealth quintile (latest available data)

In terms of population risk factors for NCDs, gender is among the key differentiating variables. Men tend to fare worse on behavioural risk factors, such as alcohol consumption and tobacco use, and have higher values for raised blood glucose and elevated blood pressure. On the other hand, women tend to rank lower on physical activity and be at higher risk for overweight and obesity than men in the Region’s middle-income countries. Evidence suggests that the reasons for these differences are likely related to gendered social roles, with women spending more time on caring responsibilities and men having greater occupational exposure to physical work.

Childhood obesity, an increasingly prominent risk factor across the Region, is also closely associated with household wealth. In Cambodia, which has a low overall prevalence of childhood overweight and obesity, children in the wealthiest households were more than twice as likely to be overweight or obese as those in the poorest households. In Mongolia, where 10.5% of children aged under 5 years were overweight or obese in 2019, the prevalence of overweight and obesity was only 20% higher among children from wealthy households compared with those in the poorest households.
Differences in social and environmental determinants of health continue to produce unequal health outcomes. The mortality rate attributed to exposure to unsafe water, sanitation and hygiene, or WASH, services ranges from less than 0.1 deaths per 100,000 people in Australia, Brunei Darussalam and Singapore to 16.7 deaths per 100,000 people in Kiribati.7 Similarly, while developed countries of the Region have near universal access to safe drinking water, access to at least basic drinking water is patterned across urban–rural divides in poorer countries: those in urban areas are more likely to have at least basic access to drinking water, while those in rural areas are most likely to have limited drinking water supply, which means requiring more than 30 minutes to collect water from an improved source. Similar disparities are visible across rural–urban divides for access to sanitation services and handwashing facilities.7

What this means for PHC

Despite progress in recent decades, the state and trajectory of health outcomes in the Western Pacific Region highlight much about current PHC performance. The high and growing burden of NCDs and their risk factors across the Region suggests there is inadequate focus on prevention and early detection, which is the cornerstone of PHC-focused approaches. The bulk of health spending and resource allocation globally remains concentrated in curative care and medical goods, while preventive health care for NCDs remains largely under-resourced, particularly in low- and middle-income countries.8 Furthermore, stalled progress on communicable diseases and maternal and child health in multiple countries despite improved access suggests a need for addressing both the organization and quality of existing systems of care. There are multiple reasons to believe a PHC-focused approach can facilitate improvement in health outcomes. Significant evidence exists to demonstrate that primary care improves health outcomes. Several reviews demonstrate how the supply of primary care physicians is associated with a reduction in all-cause mortality.9 Continuity of care, a core primary care function, was associated with a reduction in all-cause mortality in nine countries in 16 studies. There is also evidence that PHC services are a useful platform for implementing interventions that improve mental health outcomes related to depression, anxiety and suicide.10

2.2 Health services access

Progress in health outcomes can be linked to the status of health service access in countries. Overall, up to 60% of people living in some countries of the Region lack coverage with essential services, and more than one in five households in some countries of the Region spend more than 10% of their income on health care.7

The UHC Service Coverage Index was formulated to monitor progress for SDG indicator 3.8.1 (coverage of essential health services). It is a unitless scale from 0 to 100 (where 100 is universal coverage) and is computed based on the geometric mean of 14 indicators in four categories of service coverage: reproductive, maternal, newborn and child health (RMNCH); infectious diseases; NCDs; and service capacity and access.11
Annex

The Region is performing well on service access, but coverage across the Region is much lower for NCDs than for RMNCH or communicable diseases.

While the Western Pacific Region had an overall UHC Service Coverage Index value close to 80, more than half the countries in the Region have an index value lower than 60. Advanced economies such as Australia, the Republic of Korea and Singapore all score over 80 and have achieved close to universal service coverage across their countries; for island states such as the Federated States of Micronesia and Solomon Islands and transitional economies such as the Lao People’s Democratic Republic and Papua New Guinea, service coverage values stand below 50.1

Looking deeper at the sub-indices of the UHC Service Coverage Index, the Region continues to score high (> 80) for RMNCH and communicable diseases, although this hides disparities across countries and across different services. For instance, immunization coverage for diseases such as measles remains a challenge in several parts of the Region, with countries such as the Lao People’s Democratic Republic, Papua New Guinea and Samoa having less than 60% coverage of the first dose of the measles-containing vaccine in 2020. Unmet demand for modern contraceptives continues to be a problem for multiple countries across the Region; for multiple small island states and transitional economies in 2020, less than half of demand for family planning was satisfied with a modern contraceptive method. And while most countries in the Region have all or most births attended by skilled health personnel, several transitional economies, including the Lao People’s Democratic Republic, Papua New Guinea and the Philippines, remain far from achieving universal skilled birth attendance.1

Service coverage for NCDs across the Region is far less when compared to other areas, both regionally (UHC Service Coverage Index score 62) and for individual countries, many of which (including multiple small island states) score less than 40 on the UHC Service Coverage Index. When looking at specific services, coverage of preventive services such as cervical cancer screening also remains uneven across the Region, ranging between 10% and 50%, with the exception of higher-income countries such as Australia and New Zealand where coverage is 70% or higher.1

On the other hand, financial protection worsened in the Region over the past two decades.

Financial protection is one core aspect of UHC. Alongside the improvements in health service coverage, the Western Pacific Region has recorded the fastest increases in catastrophic health spending. The proportion of the population in the Region with spending on health greater than 10% of their household budget grew from around 10% in 2000 to 20.2% in 2017. (Fig. 4).11 The Western Pacific Region now has the highest number of people and the highest percentage of the population with out-of-pocket expenditures exceeding 10% their household budget in the world.12
Annex

Fig. 4. Population with expenditure on health greater than 10% of household income over time, by WHO region

![Population suffering financial hardship by WHO regions (%)](chart)


The top five countries in the Region with households spending more than 10% of their income on health – among the few for which data are available – are China (24%), the Republic of Korea (12%), Japan (10.5%), Viet Nam (8.5%) and Mongolia (7.2%). On the other hand, numerous smaller countries, such as PICs, are not reflected in regional trends because primary data are not available on household spending.

According to Tracking Universal Health Coverage: 2021 Global Monitoring Report, while a lack of recent data currently precludes a detailed impact assessment, the COVID-19 pandemic is likely to significantly worsen financial protection globally, including causing a higher incidence of catastrophic spending, worsening impoverishment and higher rates of missed care due to financial barriers. The factors behind this include public health and social shocks, increases in unemployment and informality, supply and demand shocks in the economy, and overall declines in consumption and investment due to the global recession in 2020, causing continued losses in household income among the poorest quintiles.

**Inequity in service access persists.**

Health-care utilization also shows variation by demographic group, with institutional delivery showing marked differences according to wealth quintile (Fig. 5). For instance, in the Lao People’s Democratic Republic, women in the wealthiest households are four times more likely than those in the poorest households to give birth in a health facility. In both the Lao People’s Democratic Republic and Papua New Guinea, women in urban areas were nearly twice as likely to have an institutional delivery than those in rural areas. Also, immunization coverage showed variations by level of maternal education in many countries (Fig. 6), despite the provision of free immunization services.
Annex

Fig. 5. Percentage of births delivered in a health facility, by wealth quintile, in select countries in the Western Pacific Region (2018)


Fig. 6. Full immunization coverage among 1-year-old children by maternal education (latest available data)


What this means for PHC

The data around service access suggest that, despite progress in expanding coverage, many PHC systems in the Region still struggle to ensure an equitable delivery of services across population groups. Service coverage in many countries does not adequately reflect the changing disease burden, with coverage for NCDs far lower than that for communicable diseases and RMNCH. In many developing
country contexts, PHC systems are still unable to ensure universal immunization, suggesting gaps in community outreach and immunization access following rapid socioeconomic, migratory and demographic changes. The regional state of financial risk protection also suggests serious imbalances in the distribution of access, with catastrophic spending on health in the Western Pacific Region averaging among the highest in the world, a figure likely to have worsened since the pandemic. Variation in access based on geography and wealth suggests an urgent need for primary care systems to focus on equity in a way that is aligned with ongoing urbanization and demographic changes.

2.3 Health system capacity

2.3.1 Health financing

As detailed in the previous section, catastrophic health spending and the resultant impact on household savings and debt continue to be major factors pushing people into poverty in the Region. Ensuring affordability of access to health care remains among the principal health challenges facing countries in the Region.

Prioritization of health in government spending remains low.

However, significant regional variations characterize both the volume of health spending and the degree of government contribution to spending on health and PHC. Government spending on health in the Region varies from over 20% of general government expenditure in Japan to below 4% in the Lao People’s Democratic Republic and the small Pacific island country of Vanuatu.

For several countries, this percentage also has gone down in recent years: in Mongolia, government health spending as a proportion of total government expenditure went down from 7.7% in 2010 to 6.8% in 2019; in Tonga from 10.1% in 2010 to 7.5% in 2019; and in Vanuatu from 6.8% in 2010 to 5% in 2019.13

Government health schemes account for a large proportion of current health expenditure (CHE) in most countries in the Region (Fig. 7). Compulsory insurance schemes comprise a large proportion of CHE in high-income countries such as in Japan and the Republic of Korea, and a smaller proportion in China, Mongolia and Viet Nam. Out-of-pocket expenditure still accounts for over 40% of CHE in Cambodia, the Lao People’s Democratic Republic, the Philippines and Viet Nam. Voluntary health-care schemes, including voluntary private and non-profit insurance, account for a very small proportion of CHE across the Region.
Annex

Fig. 7. Breakdown of current health expenditure by source of revenue in the Western Pacific Region (2019)


**PHC spending lags even in countries with data.**

Only eight countries from the Region report PHC expenditures separately: Cambodia, China, Fiji, the Lao People’s Democratic Republic, Malaysia, Samoa, Tonga and Viet Nam. Out of those eight, Fiji reports the highest government expenditure on PHC as a percentage of total government health expenditure at 60%, while China reports the least at 17%. The widespread absence of reported data on government PHC expenditure, however, is a reminder that monitoring of PHC expenditures must be improved across the Region as a policy and data priority going forward.

While there are limited data on health spending since the onset of the COVID-19 pandemic, early estimates from 22 countries during the pandemic indicate that health spending rose substantially in 2020, compared to previous years. Despite this, health spending as a share of overall government expenditures decreased in 15 out of 22 countries, as overall government spending grew at a faster rate than health spending. However, these results are largely from high-income countries, and spending patterns in most low- and middle-income countries remain unknown.

**Public health functions remain underfunded and reliant on external financing.**

Financing for essential public health functions, such as prevention and public health services, tends to be low in many countries in the Region. Typically, clinical treatment absorbs most available resources, while prevention and public health activities – for example, maternal and child health, family planning, immunizations, prevention of communicable diseases and NCDs, and screening and surveillance – have been under-resourced. In most countries, the state budget for public health functions is underfunded due to both hospital-centric health financing priorities and weak planning and budgetary advocacy at the local level. Many developing countries in the Region are highly dependent on external funding for
financing priority public health programmes, including global health initiatives such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and Gavi, the Vaccine Alliance, as well as bilateral partners. Several countries in the Region are in the process of transitioning away from long-term donors, which requires planning and financing.14

2.3.2 Service utilization and delivery capacity

**Based on current performance, many PHC systems in the Region will struggle to meet rising health needs.**

There is considerable variation across contexts for service utilization in terms of outpatient visits per capita, ranging from more than 16 in 2016 in Japan and the Republic of Korea to fewer than four in the Lao People’s Democratic Republic and Viet Nam.15 Overall, however, outpatient utilization has risen across most contexts in the Region over the past 15 years, particularly in China (over 120%), followed by Viet Nam (30%) and the Republic of Korea (24%).

Use of private providers for outpatient services also remains high in developing countries in the Region – including Cambodia, the Lao People’s Democratic Republic and the Philippines – but continues to be largely ignored or unregulated in health policy in many contexts.16

**Health workforce shortages, maldistribution and infrastructure gaps constrain capacity to deliver and expand services.**

The WHO Western Pacific Region on aggregate ranks lower than the Region of the Americas and the European Region on medical doctor, nurse and midwife density but higher than the African, Eastern Mediterranean and South-East Asia regions. There is considerable variation among Member States in terms of health workforce density in the Region, with some PICs such as the Federated States of Micronesia, Solomon Islands and Vanuatu, as well as larger transitional economies, such as Cambodia, having one nurse/midwife per 1000 population, with the Lao People’s Democratic Republic at 1.19 per 1000 population and Papua New Guinea at 0.453 per 1000 population.1

Similarly, in terms of medical doctor density, seven out of 15 countries in the Region that have reported workforce data since 2016 have less than one physician per 1000 population. Overall, nine out of 26 countries and areas in the Region that recently reported workforce data do not meet the SDG index threshold of 4.45 physicians, nurses and midwives per 1000 population.17

Adequacy and sufficiency of health-care infrastructure also remain widely divergent across the Region. Availability of clean water and sanitation in health facilities remains a concern, as data indicate that under 50% of facilities in rural or remote areas have access to basic WASH services.18

The maldistribution of the health-care workforce also remains a significant bottleneck in many countries in the Region, with rural areas often underserved in terms of availability of health-care personnel. Geographical challenges are often a primary reason for such distributional issues, particularly in countries with rural and remote populations thousands of kilometres from major population centres.

**Services are often not available at the PHC level.**

Several countries have conducted facility assessments at the PHC level and identified a lack of essential drugs, equipment and diagnostic capacity as barriers to quality services.19 A 2019 Mongolia study...
Annex

around quality and access to PHC service (by the Ministry of Health, the Mongolian National University of Medical Sciences and the WHO country office) found satisfaction was average, and although access indicators, such as affordability and equity ranked higher, acceptability scored low. The service availability index was 47.0% for family health centres and 88.3% for soum (administrative division) health centres, having been skewed by the health infrastructure index (43.8%) and the health workforce index (42.3%). The general readiness index of primary health centres was found to be 66.7% and 76.9% in family health centres and soum health centres, respectively, indicating a need for focus and improvement.

The predominant barrier to accessing NCD services, such as diagnosis and treatment of diabetes, is poor availability of services at the PHC level in lower-middle-income countries and PICs,20 especially rural and remote areas or low socioeconomic areas, particularly those with ethnic minorities.21 In terms of human resources, both a shortage of sufficient skilled workers, as well as training gaps, pose a barrier to effective coverage of PHC in the Region.22 Although lack of a skilled PHC workforce has been highlighted across a few countries, specific challenges vary. A lack of training capacity in PICs is compounded by an exodus of the skilled workforce.23 Lack of infrastructure has hindered progress in delivering care, such as the absence of toilets, electricity and clean water. The lack of integration of services between primary and tertiary care, effective referral services and patient transport serve as barriers to effective PHC,24 leading to gaps in the coordination of care.25

Other challenges included a lack of standardized routines, procedures and guidelines or a lack of compliance with existing routines, procedures and guidelines; health-care worker competence; and a lack of referral or coordination mechanism among facilities. A lack of strong community engagement, leadership and engagement has led to an overall low quality of services.26

**Digital infrastructure and regulatory gaps constrain the potential of digital health services.**

Digital technologies play a critical and growing role across all aspects of health, particularly in improving PHC service access. However, digital divides among and within countries continue to prevent the realization of the potential of digital technology to deliver services. Countries in the Region have varying capacities to make use of digital technologies, including infrastructure challenges in internet connectivity and mobile/broadband, availability of technologies (for the country as a whole, and among population groups and subgroups), effective and interoperable data systems, workforce capability, digital literacy, trust in technology, capacity to fix problems when they arise and enabling legal frameworks.27 There is also a considerable gap among countries in terms of regulatory and legal capacities to implement digital frameworks, with only 45% of low-income countries reporting privacy legislation to protect personal information. Of the six WHO regions, the Western Pacific had the lowest percentage of countries with privacy legislation to protect personally identifiable information.27

**Progress remains uneven on health information systems to monitor services and performance.**

Many Western Pacific countries have made considerable progress with respect to developing health information systems that provide timely, reliable and actionable data – 85% of countries in the Region report moderate to sustainable systems for regular population-based health surveys.28 However, multiple gaps still remain that limit Member State capacity to review system performance and effectively plan and implement health policies based on accurate data. According to the WHO SCORE methodology, 30% of countries surveyed in the Region report nascent capacity for routine facility and community reporting systems, while 60% report nascent or limited capacity for systems to regularly
monitor service availability, quality and effectiveness. Further, 35% of countries in the Region report nascent or limited institutional capacity for analysis and learning.  

**Health commodities are not available consistently.**

Countries in the Region experience regular stock-outs of key vaccines. In many cases, these cause interruptions of immunization services due to a lack of stock monitoring and forecasting issues, global vaccine shortages, vaccine financing issues and delays in releasing national funds for timely vaccine purchasing. Furthermore, many countries face the problem of outdated or non-functional cold-chain equipment, gaps in national procurement mechanisms and a lack of pooled procurement mechanisms in the Region.

**Health security capacity**

According to the WHO *International Health Regulations Monitoring and Evaluation Framework,* the Western Pacific Region ranks highly on several core capacities required for effective health security. These include scores of 91 for surveillance, 88 for infectious disease response, 88 for coordination, 88 for risk communication, 88 for laboratory capacity and 80 for preparedness (each of these being the highest score of any region in these fields), as well as high scores for human resources, food safety and human resources.† Areas where much ground remains to be covered include comprehensive legislation referring to an adequate legal framework to enable implementation of the International Health Regulations (2005), zoonosis (mechanisms to respond to diseases transmissible from vertebrate animals to humans), and chemical and radio-nuclear emergencies.†

Even as the world focuses on limiting the damage from COVID-19, longer-term health security risks continue to evolve and threaten social well-being. Eight of the most disaster-prone countries in the world are in the Western Pacific Region. Both floods (more common in Asian countries) and cyclones and storms (to which island countries are particularly prone) have increased in frequency and severity in recent decades. Now 8.7 million people are internally displaced in the Region every year.‡ Other public health emergencies that pose looming health risks include outbreaks of influenza and botulism and climate-related disasters, such as floods, tropical cyclones and volcanic eruptions.

### 2.3.3 Demand-side challenges to PHC service delivery

A study commissioned by the Regional Office for the Western Pacific reviewed literature identifying common barriers faced by communities in accessing health-care services at the PHC level in the Region. These explored the challenges reported through several dimensions outlined below.

**Acceptability.** There was a perception of poor quality and a lack of trust seen across a range of PHC services from vaccination to TB treatment, with many patients citing that perception as the reason they

---

* The International Health Regulations (2005), known as IHR (2005), are an international legal instrument with measures for preventing the transnational spread of infectious diseases adopted by the Fifty-eighth World Health Assembly in 2005 through Resolution WHA58.3. They constitute the legal framework that defines national core capacities, including at points of entry, for the management of acute public health events of potential or actual national and international concern, as well as related administrative procedures.

† The perception of accuracy of high regional scores for core capacities should be tempered with the observation that the regional scores are skewed by reporting of high compliance from advanced economies, while nine countries (including multiple small island states) did not report data for the framework, and a further five countries scored between 0% and 25% on implementation status of core capacities.
Annex

bypass higher tiers of care. Poor attitudes and poor behaviour of health workers was apparent in reviewed literature as a cause of poor acceptability of services. This included discrimination against less-abled people and ethnic minorities, perceived lack of empathy, and one-way didactic communication. Services were perceived as not being culturally and gender-sensitive services, such as where religious concerns around potential prohibited contents of vaccines were not adequately addressed and where cultural inhibitions exist around male workers with female patients. Loss of trust in PHC services has also been triggered by events such as reported adverse events following immunization, as was seen in China, the Philippines and Samoa. Lastly, some individuals have a reduced perception of risk; for instance, women who have had multiple pregnancies not seeing the need for further antenatal care, or diabetic patients who are asymptomatic who do not perceive their condition to warrant health care.

Accessibility. Lack of transport, long distances and the condition of roads served as barriers, especially for rural and remote populations. Additionally, language, for example the absence of communication material in local language, and cultural barriers such as required male chaperones for health visits, along with requirements for permission from family, hampered access. Long waiting times and inflexible clinic times have also been documented as reasons for decreased access. Access for vulnerable populations such as daily wage workers have especially been difficult as they risk lost income or unemployment. Further, communities have indicated the lack of awareness or knowledge about the service availability or whether specific services were covered in the benefit package as a factor in forgoing care or inability to receive care as expected.

Affordability. The cost of accessing services remains a main barrier to services, especially for the poor and vulnerable. This includes the out-of-pocket cost of treatment and medicines, transport costs, and informal payments, as well as the opportunity costs of lost income. For example, several studies reported significant travel and opportunity costs in seeking diabetes care at the PHC level. When coupled with concerns about the range or quality of diabetes services at this level, these were sometimes cited as justification for bypassing to higher levels of care, or seeking care in the private sector. The cost of maintenance medicine is a considerable challenge in several countries, including the Philippines, where a significant proportion of the population report not buying all their prescription medicines because they are too expensive. Financing arrangements have a large role in creating the enabling environment for strengthening primary care. Hospital-centric funding, lack of adequate funding for community outreach and the shortage of funds for the primary level have been highlighted as a significant barrier to improving the availability and quality of PHC services in many countries.

What this means for PHC

The data and evidence around health system capacity in the Western Pacific Region show both evidence of progress and the shortcomings in PHC capacity in the Region. Low and underreported spending on PHC across the Region suggests both low prioritization and a dearth of monitoring of PHC expenditures, which make interventions difficult to plan. The rise in outpatient service utilization continues to grow in varying degrees across most countries, suggesting a need to ramp up PHC service capacity. Workforce shortages (including for nurses and midwives) and infrastructure gaps, particularly for primary care and population-health-focused facilities, point to an imbalance in the distribution of resources between tertiary and specialized care, on the one hand, and primary care, on the other. PHC-focused approaches like continuity of care can help address this imbalance in capacity as they have been shown in research to reduce hospitalizations, avoidable admissions and emergency
Further, considerable evidence exists to suggest that human resource investment in community health workers reduces maternal, child and neonatal mortality in lower-middle-income countries. Overall, the status of health outcomes, access and system capacity in the Region all point to the need for regional efforts to strengthen PHC. A significant and persistent NCD mortality and morbidity burden sits alongside low service coverage for NCDs, suggesting both a misallocation in coverage and an inadequate focus on health promotion, preventive health care and early detection aligned with the disease burden. Worsening levels of financial protection and rising catastrophic spending in the Region call attention to the public financing gaps, particularly for population health functions, and the absence of appropriate risk protection and health-purchasing mechanisms for primary care. Rising outpatient visits, including high levels of private sector outpatient usage, suggest the existence of rising demand, which many primary care systems are under-resourced and under-equipped to meet. The pandemic and other mounting health security risks call attention to the need for strengthening preparedness, integrated surveillance and response mechanisms.
Annex

3. Rationale and context for a regional framework on PHC

While all countries in the Western Pacific Region are unique, they are experiencing strikingly similar social, demographic and epidemiological trends, which provide a strong case for PHC reform. These include rapidly ageing populations, surging rates of NCDs, continued threats from infectious disease, and unacceptably high rates of maternal and child mortality, as well as the impacts of rapid and significant urbanization, climate change and environmental degradation.

While each country needs to determine its own path to address these challenges, a shared pursuit towards a collective agenda for PHC is critical if the global goals are to be achieved: 1 billion more people benefiting from UHC; 1 billion more people better protected from health emergencies; and 1 billion more people enjoying better health and well-being. Making progress towards the Region’s four thematic priorities in For the Future – namely health security, including antimicrobial resistance; NCDs and ageing; climate change, the environment and health; and reaching the unreached – demands a much stronger focus on PHC systems that not only fight disease but also promote health and improve outcomes for the most vulnerable.

3.1 Regional diversity

The Western Pacific Region is incredibly diverse in its geography, ethnicities, political systems and levels of economic development. Its 37 countries and areas are home to more than 1.9 billion people, and the Region includes some of the world’s most populous countries and several of its largest megacities, as well as the smallest and most remote PICs. Countries in the Region cover a diverse political and economic spectrum, from highly advanced industrialized economies to countries that are in transition (with economies moving from state-run to more market-led systems) with federal systems of government and highly decentralized systems.

How health systems respond to the Region’s shared challenges depends on each country’s own unique context, capacity and health system model. Countries can share and learn from one another, as well as foster home-grown solutions to the challenges they face and in caring for their most vulnerable. The different approaches of Member States to the COVID-19 pandemic have provided key lessons for PHC, including: the helpfulness of strategic and operational partnerships with the private sector; the rapid and effective reorganization of PHC services; the recognition of the value and skills of a more diverse workforce; and the significant role of technology as an enabler.

3.2 Health needs in the Region are changing

The Region is undergoing demographic transition, with more ageing countries.

The Western Pacific Region has one of the fastest-growing older populations in the world, with decades of health improvements resulting in longer life expectancy and declining fertility rates. More than 240 million of the 700 million people aged 65 years and over in the world live in the Western Pacific Region, with this number expected to double by 2050. Of this, more than 84 million people are aged 75 years or older in the Region, and this number is expected to triple by 2050. Within the next 20 years, more than one in four people in the Region will be over the age of 65.
Annex

The transition from an ageing to aged society took approximately 60 years for Australia and New Zealand and 24 years for Japan. However, countries such as Viet Nam are expected to make this shift in less than 20 years. Even countries in the Region with relatively young populations, such as Malaysia and the Philippines, still have subpopulations that are ageing more rapidly than others, for instance among different ethnic groupings or across different provinces.

Population ageing has far-reaching impacts across all sectors of society and requires whole-of-society change to maximize the health and well-being of older adults, their social opportunities and the contribution they make to society. Reorientation of existing health systems towards PHC is thus critical to mitigate the demographic challenge so that the health needs of all age groups are addressed: firstly, to keep people in good health when they are younger so that they can age in wellness; secondly, with people living longer, PHC would be able to manage chronic conditions better for longer periods of later life; and finally making it financially sustainable to manage people at lower tiers of care, thus reducing the burden on hospitals.

Changes in burden of disease with increasing NCDs and completing the communicable disease agenda

As highlighted above, NCDs were the largest contributor to mortality and morbidity in the Region from 2000 to 2019. This is due to an ageing population, lifestyle changes and changes to living environments. These have a significant impact on quality of life across the life course, cause premature mortality, and place significant pressure on health systems and services and society as a whole. The increasing burden of NCD morbidity is a barrier to continued economic development and progress and will result in significant health, social and economic costs, if the status quo remains unchanged.

While NCDs have surpassed communicable diseases in the Region in terms of disease burden, many countries are likely to continue to face additional burdens into the next decade from continued threats from new and existing infectious diseases and unresolved challenges with maternal and infant mortality. This will cause a double burden of disease that places health systems under significant strain as they need to maintain their ability to prevent and manage traditional health threats, such as communicable disease outbreaks, while at the same time investing in preventing NCD risk factors and strengthening NCD care and management.

Addressing the risks posed by NCDs must involve both a reorientation of health systems to focus on prevention and the long-term continuum of care, as well as a whole-of-society approach that uses a combination of fiscal, economic and social policy to mitigate risk factors. This underscores the importance of reforming and aligning health systems to cater for existing and future needs via a PHC approach.

This is especially essential for three reasons. First is the epidemiological and demographical shifts towards multi-morbidity caused by NCDs and the need for a people-centred approach embedded in a strong PHC. Second is the need for multisectoral action – a critical component of PHC – throughout

---

² A population is considered to be ageing when more than 7% of people are 65 years or older and aged when more than 14% of people are 65 years or older.
Annex

the care continuum from promotion, prevention, treatment, rehabilitative and palliative care. Finally, there is the need for the community to be at the epicentre of NCD care and management.

**Mental health needs likely to persist in the medium term**

Mental health issues contribute to the significant burden of NCDs in the Western Pacific Region and share a number of the same modifiable risk factors, such as substance abuse, the harmful use of alcohol and sedentary lifestyles. However, the level of mental health investment, human resources and support in many countries is low, making it difficult for many people to get the support they need.\(^{48,49}\)

The COVID-19 pandemic exposed and exacerbated the significant mental health issues in the Region due to fears of the virus and concerns about its impact on vulnerable loved ones, adapting to working or schooling from home, loss of employment, and lack of physical contact with friends, colleagues and loved ones. Increased prevalence of psychological distress among health-care staff as a result of the pandemic has also been reported.\(^{50}\)

The mental health needs facing countries are projected to continue to rise due to factors such as population ageing, natural disasters, and the dramatic changes in social norms and values that have accompanied globalization and rapid economic development, as well as continued health security threats.\(^{49}\)

A recent review highlighted opportunities to improve mental health access in the wake of the pandemic by fully integrating mental health into UHC, enhancing access to psychosocial interventions, taking multisectoral approaches and strategically addressing the social determinants of mental health, leveraging digital technologies, engaging people with lived experiences, and addressing inequity by targeting the needs of neglected populations such as children, people with disabilities and displaced populations.\(^{50}\)

The above underscores the importance of investing in PHC to enable the integration of sustainable mental health services into existing health-care services, alongside the need to strengthen mental health promotion, increase efforts to reduce modifiable risk factors and augment treatment.

**Health impacts of climate change, environmental pollution and degradation**

The effects of climate change and environmental degradation on health affect all countries in the Western Pacific Region; however, some are more impacted than others. For example, poorer nations, low-lying areas and PICs are more vulnerable to effects such as sea-level rise and severe weather events, leading to increased inequities among countries. With the renewed emphasis on economic growth, continued high levels of urbanization, growing energy demands and resulting stresses on the environment across the Region, climate change and environmental pollution pose a serious threat to health in the Western Pacific.

Climate change is leading to increases in the frequency and severity of extreme weather events, such as floods, cyclones, typhoons, droughts and heatwaves. These, in turn, contribute to a diverse range of health challenges for the Region, such as increases in the transmission of vector-borne and waterborne diseases, food insecurity, drinking-water scarcity, injury and loss of life due to weather events, psychosocial impacts on individuals and communities, and NCDs via air pollution and extreme
temperatures. In addition to the impact on health, extreme weather events due to climate change can damage or destroy health facilities and disrupt essential services when they are needed the most.

Climate change affects food security – as well as its availability, accessibility and utilization – and overall systems stability. Besides this, it has an impact on livelihood, food production and distribution channels having profound implications on human health. This is currently resulting in crop failures, new mutations of pests and diseases, and the loss of livestock making people vulnerable and their food systems insecure, especially for those living at the coasts and in PICs. Additionally, low income in urban areas will add to food insecurity and other disruptions at a time when there is a lack of adequate social safety nets, including health coverage. This risks possible internal and international migration from conflicts and unrest triggered by climate change by both food-exporting and food-importing countries, cascading into a multitude of challenges for the people and the system that aims to serve them.

Between 2030 and 2050, climate change is estimated to cause an additional 250,000 deaths each year globally. A 2020 report on the state of the climate in the South-West Pacific, which includes Australia, New Zealand, the Philippines, Singapore and PICs, shows that sea surface and ocean temperatures in parts of the South-West Pacific are increasing at more than three times the global average rate, and that small island developing states are increasingly vulnerable to climate change, with incomes highly linked to fisheries, aquaculture and tourism. The health impacts of climate change and environmental degradation often fall disproportionately on poorer countries, and within countries, marginalized and vulnerable groups are more likely to face these challenges.

Preventing and mitigating the impacts of climate and environmental change on health means urgent investment is needed, including building climate-resilient PHC systems and associated health facilities, training the workforce, catalysing actions across many other sectors beyond health and keeping the communities at the centre of all policy and practices.

**Continuing health security challenges**

Countries and areas in the Western Pacific Region will continue to be vulnerable to emerging infectious diseases including pandemics, food safety issues, food and water insecurity, severe weather events and other natural disasters, such as earthquakes. Eight Western Pacific countries are among the most susceptible in the world to disasters due to natural hazards, from floods to cyclones and storms, and the increase in severe weather events experienced across the Region as a result of climate change is estimated to displace more than 8.7 million people every year.

A high level of mobility and connections across the globe, highly urbanized and rapidly ageing populations, as well as the effects of climate change, serve to hasten the spread of disease and compound its effects for populations, often devastating local and national economies and undermining progress towards wider health and development goals, including health equity.

The pandemic illustrated that countries that prioritize and resource UHC systems, while simultaneously strengthening public health capacities needed to address health threats, were more successful and resilient in the face of COVID-19. Some of the structures developed during the pandemic response have been sustained. This can include the provision of health services in structures outside health facilities, such as screenings, testing and use of intermediate set-ups for improved triage, monitoring
Annex

and referrals. PHC is essential to make the health system effectively deliver quality, essential and routine health-care services to avoid further preventable illness and death both during and beyond the pandemic. Thus, it is of essence, given the perennial health security challenges and the recent experience with the COVID-19 pandemic, that there is harmonization between essential public health functions and PHC. Strong PHC is needed as it effectively and equitably limits disease spread through essential public health functions, such as diagnosis, contact tracing and immunization, that address the needs of the community. Integration between public health and primary care as components of the PHC approach remain the strongest defence against current and future public health threats.56

COVID-19 also highlighted the need for health systems to be resilient. Resilience is defined as the ability of individuals, organizations and systems to bounce back to an equilibrium phase after a disruptive event, and the ability to adapt when faced with pressure and challenges, and some form of reorganization or revitalization as a response to the disruption.57 In health care more specifically, it is the capacity to adapt to challenges and changes at different system levels in order to maintain high-quality care.57 However, despite its necessity in light of the variability and complexity in health-care systems, not all adaptations enhance resilience.58 Therefore, it is important to consider short-term adaptations to meet immediate concerns and long-term adaptations needed to reorganize for systemic improvements. Going forward, this balance among short-term adjustments, long-term reorganization and innovations59 would help in institutionalizing lessons from the pandemic about making systems and processes resilient to disruptions.

Existing unreached populations even in well-performing systems

Health inequities in the Western Pacific Region include avoidable differences in health status, access to services, population risk factors, social and environmental determinants, and differences in social, political and economic factors.

Despite the projected reductions in communicable diseases in the coming decade, existing inequities in health access and outcomes are likely to persist unless directly addressed. This means that the burden of infectious conditions and conditions related to maternal and child health may persist in some population groups that are more vulnerable or who face barriers to health service use.

Despite rapid growth, improvements in living standards and increased investment in health care in recent decades, there are persistent inequities across a wide range of health outcomes for different population groups within and between countries in the Western Pacific Region.5 Equitable access to PHC is strongly correlated with socioeconomic status, geographic location and ethnicity for most countries.

To tackle inequities, a full understanding of their magnitude and determinants across social, economic, demographic and other variables is necessary. However, only a small group of countries in the Region currently conduct population surveys that disaggregate data by variables such as socioeconomic status, gender or ethnicity, making it challenging for many countries to measure the impact of policy or resource decisions on health equity.60 This must change to achieve the goal of UHC built on the foundation of PHC.

Putting marginalized or vulnerable groups at the centre of the PHC and UHC agenda and applying a gender and equity lens to all work are critical to addressing inequitable outcomes and improving the
health of all people in the Western Pacific Region. Reconfiguring existing health systems towards a PHC approach would subsequently result in increased recognition of and attention towards health equity and the upstream factors impacting health, which is essential to reducing inequities alongside a more intentional approach of first supporting the health of people who need it the most.

3.3 Future context

3.3.1 Economic and fiscal outlook

While the Western Pacific Region has seen unprecedented economic growth over the past two decades, growth has not been equitably distributed, and the COVID-19 pandemic and its associated economic impact has taken a significant toll across economies in the Region, leaving no country unaffected. However, country-level economic recovery is expected to be uneven, with fluctuating growth in countries across the Region through 2024 (Fig. 8).

Fig. 8. Per capita gross domestic product growth (1996–2024)

As countries ease public health measures in the aftermath of the pandemic, economic activity is likely to increase, leading to a rebound in growth trajectories over the medium to long term. However, the COVID-19 pandemic has taught the world that the next pandemic, which can cause another global financial crisis, is always just around the corner. The austerity measures that tend to follow global financial crises often result in contractions in health investments across countries, a greater focus on system efficiency and higher out-of-pocket health-care expenses for people. The level of impact on health spending depends on what can be offset by other sources of funding and how each government prioritizes health versus other budget priorities.

An increasing prevalence of chronic conditions and longer life expectancy, compounded by an ageing population, are increasing health, economic and social costs for individuals, health systems and society at large. People with chronic conditions often have multiple morbidities with lengthy and expensive
treatment and the possibility of lowering their income-earning capacity. This would be of increasing importance to some countries in the Western Pacific Region transitioning from lower-middle-income to upper-middle-income status, and from upper-middle-income to high-income countries. If unchecked, this trend of rising health-care costs will continue for the foreseeable future and soon become unsustainable, derailing commitments and progress towards UHC and SDG targets.

The burden of increased health and economic costs from chronic disease is often hardest to bear for the countries that can least afford it. If health systems are to be sustainable, all Member States need to adopt a PHC approach to their health systems and work with sectors beyond health to significantly strengthen investment towards health promotion and chronic disease prevention, while at the same time funding more personalized health care that empowers individuals and communities to maintain and improve their own health and well-being.

3.3.2 Rise in availability and use of digital technology

Increases in technological innovation and access to digital technology across a wide range of domains have enabled significant advancements in the provision of health care, resulting in greater numbers of people having access to services and data that might previously have been out of reach or unaffordable. The potential effects of digital technology on health are varied. They include: access to health information (or misinformation); improved models of service delivery; enhanced access to care; early detection of disease; technology that supports self-management of health and disability conditions; improved integration, knowledge and learning, for example through electronic health records and big data; and the ability to address specific service delivery challenges, such as for remote communities or for people with disabilities. Most recently with COVID-19, technology’s role in facilitating health-care delivery has been strengthened in many jurisdictions with spectacular rapidity in some cases, such as the move to virtual or telehealth consultations and the use of technology to support home monitoring in New Zealand.

However, disparities exist between and within countries in access to digital technologies and their ability to make use of them. Across the wider Asia and Pacific region, approximately half of the population has no internet access, exacerbating inequalities and leaving populations more vulnerable. Although increasing, the overall proportion of the population using the internet in PICs remains low at less than 40%. Meanwhile, countries in the Region that also belong to the Organisation for Economic Co-operation and Development – such as Japan, New Zealand and the Republic of Korea – have a population internet use greater than 90%. Within countries, there are differences in internet use among older people belonging to different socioeconomic groups and a rural–urban gap. In addition, lower-income and geographically more remote settings remain disconnected, benefiting the least from technological advances.

Strategic investment in information and communications technology is an essential enabler to ensure more people benefit from UHC and they are better protected from health emergencies and enjoy better health and well-being. Looking to the future, increased momentum in use of digital technology can be expected to augment PHC across the Region, especially in the use of big data, artificial intelligence, wearables and their integration into clinical and patient decision-making, enhanced diagnostic tools, triage and monitoring systems, and more convenient consultation options. Accelerated by the COVID-19 pandemic, technology in certain settings and with the right enabling environment has been shown to have potential in transforming the way care is delivered, especially at home or in very remote
settings. These innovations need to be tested, supported and scaled up with their impact measured so that service delivery models can be improved. With technology enabling increased collection and use of data for health decision-making, there is a need to mitigate issues around privacy, ownership of data and ethical concerns to maintain public trust.

### 3.3.3 More literate populations with greater access to information

Population literacy is critical to ensuring that people have the knowledge, information and tools necessary to support good health and to improve their control over modifiable social determinants of health.\(^{68}\)

There has never been greater access to information than in the current digital age; however, the quality of information and access vary widely, with inequities in literacy and access to technology and other resources meaning that many people across the Western Pacific cannot access the benefits of information equally. In the Western Pacific Region, population literacy is increasing from one generation to the next. Young people aged 15 to 24 years record 99% literacy levels,\(^{69}\) and this is likely to remain high for those growing into young adulthood over the next decade and a half.

Health delivery historically has an asymmetry of information that puts recipients of care at a disadvantage. Increasing population literacy coupled with increasing availability of information digitally, as outlined above, will lead to greater amounts of health-related information in people’s hands, thus reducing the imbalance.

While greater health literacy is desirable for the future of PHC, there are risks of misinformation and disinformation, particularly through digital platforms, which may also require capacity resources from the system to combat and differentiate between the right and wrong types of information. Greater health literacy will have impacts on the health-seeking behaviours of communities and may embolden them to demand greater participation in health, including in what services are delivered and what type of care is provided for their specific conditions.

A PHC-oriented system with active and meaningful community engagement would bring greater benefit, with people being empowered to play an active role in improving their own health, engage successfully with other community action on health and push governments to meet their commitments.

### 3.3.4 Changes in the lived environment

The growth of urban populations creates both challenges and opportunities in achieving improved health outcomes and equity. While many countries have benefited from well planned and controlled development, rapid and unchecked growth elsewhere has amplified many public health challenges and increased health inequalities, as many cities struggle to meet the increased demand for essential infrastructure and services.\(^{70}\) Urbanization can bring a wide range of advantages for many people in the form of proximity to health services, improved water and sanitation services, and increased employment and social opportunities. However, this requires the right infrastructure in cities to realize these benefits.

Within the Western Pacific Region, countries have experienced unprecedented migration and urbanization with about 60% of people in the Region now estimated to be living in urban areas.\(^{71}\) Since 1980, China’s urban population increased from around 19% of the population to more than 60% in 2020. In the same period, Mongolia went from 52% urbanized to more than 68%.\(^{72}\) Some countries and
Annex

areas in the Region are highly urbanized; for example, Japan at 92% and Guam at 95% in 2020. Of the 33 megacities in the world, nine are located in the Western Pacific Region, including the most populous. While the trend of urbanization is expected to continue, the pace of urbanization is expected to slow into the future. From 2020 to 2050, the percentage of the population living in urban areas in the Region will grow from 60% to 68.2%.

Increases in population density in urban areas, can lead to an increase in people living in slum conditions due to a lack of adequate infrastructure to support population growth. An estimated 332 million urban slum dwellers are located in East and Southeast Asia. While the percentage of urban populations living in slums has declined steadily in recent decades, countries such as Cambodia still have 45% of their urban population living in slums, down from 78.9% in 2005. Urban slum dwellers experience significant exposure to environmental hazards such as air pollution, overcrowding, poor WASH facilities, limited access to health and other essential services, and social marginalization. This increases the risk of outbreaks of new and existing infectious diseases, including COVID-19, influenza outbreaks and existing vaccine-preventable diseases, such as measles and diphtheria, as well as worsening chronic mental and physical health conditions.

Policy- and decision-makers in health need to work with a wide range of cross-sectoral actors, including urban planners, housing, WASH and social services, to develop plans, as they remain cognizant of the local demographic changes. With investments into new, diverse and environmentally resilient facilities, existing infrastructure would need to be repurposed to adapt better to the context. Going forward, PHC will continue to play a critical role in disease surveillance, and primary prevention and control of communicable diseases in densely populated urban poor areas. This work needs to be balanced with continuing to provide services to non-urban areas to ensure that urban–rural inequities are not exacerbated.

---

§ Those living in housing that is characterized as non-durable or overcrowded, or that lacks access to improved water or sanitation or security against eviction (in World Urbanization Prospects – the 2018 revision)
4. New regional framework for PHC

PHC systems need a transformation in the way they are funded, managed and delivered in order to urgently meet the challenges faced by the Western Pacific Region. A continuing focus on “hospital-based, disease-based and self-contained ‘silos’” curative care models undermines the ability of health systems to provide universal, equitable, high-quality and financially sustainable care. This narrow view also misses opportunities to reduce the burden of disease through primary prevention and health promotion, as well as the potential benefits of intersectoral collaboration that address the broader determinants of health.

The vision is of empowered populations having the highest achievable quality of life through a PHC system that delivers quality comprehensive services across the life course, which are equitably distributed and responsive to people and their communities.

This chapter outlines a future state for PHC in the Western Pacific Region. The three main sections cover: the scope and functions of PHC (section 4.1); the characteristics of a strong PHC system (section 4.2); and the main strategic actions that countries can take to reform PHC in their context (section 4.3).

4.1 Scope and functions of PHC

The Declaration of Astana calls for renewed efforts on three components of PHC:

- Meeting people’s needs across the life course through prioritizing comprehensive and integrated delivery of quality health services – including promotive, protective, preventive, curative, rehabilitative and palliative services – and essential public health functions.
- Systematically addressing the determinants of health through multisectoral policies and action.
- Empowering individuals, families and communities to optimize their health as advocates for policies that promote and protect health and well-being, as co-developers of health and social services, and as self-carers and caregivers.

These components provide information on the range of services and functions needed in a modern comprehensive PHC system, one that meets the needs of all individuals and communities throughout their life course. Many PHC systems have a narrower scope, focusing mainly on episodic acute intervention, with less resources spent on primary and secondary prevention and well-being management that could reduce the impact of preventable illness. This selective approach has persisted in many lower-middle-income countries, in part supported by growth in disease-specific and often “siloeled” global health funds.

Comprehensive PHC services cover a continuum from health promotion and disease prevention to early detection and management of conditions, including curative, rehabilitative and palliative care (Fig. 9). It includes activities that focus on the maintenance or achievement of well-being (physical and mental), as well as the treatment and management of health conditions, and coordination across health pathways from home and community to hospital services. The scope of PHC also includes social well-being. As per the second component of PHC highlighted in the Declaration of Astana, this may include services...
that collaborate with providers from other sectors, such as welfare, housing and education, as well as governance, leadership, advocacy and policy.

**Fig. 9. Comprehensive PHC, scope and functions**

Overall, more comprehensive primary care systems help to reduce spending, reduce hospital service utilization and improve patients’ experience of care. They also are associated with better outcomes for patients and populations and promote greater equity.\(^{78,79}\)

**What does “comprehensive” look like in PHC systems?**

As an example, the Southgate Model of comprehensive PHC in Australia (as conceptualized in Fig. 10) demonstrates many of the components of the Declaration of Astana, in particular the emphasis on empowering individuals and communities to manage their own well-being and the focus on primary and secondary prevention, as well as on acute illness.
Fig. 10. The Southgate model of comprehensive PHC

CPHC = comprehensive primary health care


The case study from Japan (Box 1) provides an illustration of a comprehensive PHC programme. This frailty-care project uses teams of people from a range of health and social disciplines to support their patients and provides services that focus not only on medical management of their condition, but also on the risk factors and determinants of health that lie outside of their current illness, such as diet, physical activity and community connection.

Box 1. Frailty care in Japan

Frailty care in Japan aims to provide a continuum of comprehensive care. While there are specific interventions (focused on clinical and physical activity) targeted to high-risk individuals, there is also a multidisciplinary, multisectoral approach that aims to impact on everyday life of all older people. Home-based services delivered by interprofessional teams include frailty prevention and management for both the older patient and their family caregiver, who is often another older person. Older people collecting their prescriptions from a community pharmacist can have a frailty assessment and consultation with the pharmacist and be referred for services. Various community-based programmes, run by and for older people, promote social participation, physical activity and healthy eating.


4.2 Attributes of PHC

This section provides guidance on the characteristics of PHC as a system: the qualities and attributes of its services and activities (Fig. 11). Providers, policy-makers and leaders should be committed to
Annex

delivering high-quality, equitable, integrated and people-centred care. Individuals and communities should be active participants in all decisions about their health and well-being, as well as in the planning and prioritization decisions. PHC should be a learning system that is responsive and dynamic to meet the needs of the people and their communities.

**Fig. 11. Attributes of PHC**

4.2.1 People and community centred

In the context of an entire life course, and the multitude of health and well-being issues that may occur, people are “patients” interacting directly with a health provider for a relatively small amount of time. A people- and community-centred approach recognizes that individuals, families and communities are the experts in terms of their own health needs and broader social and cultural context.

At the individual level, people-centred care means that consumers and their families are active participants in the management of their own well-being, including decision-making with their clinical care team.

This participatory approach is also required at the community level. Community participation reflects obligations under a right-to-health framework and democratic principles, which require an explicit emphasis when considering the voices of marginalized and disadvantaged populations. The *Declaration of Alma-Ata* and the *Ottawa Charter for Health Promotion* feature individual and collective participation as a key principle of public health services. Community participation can be defined as:

>a process by which people are enabled to become actively and genuinely involved in defining the issues of concern to them, in making decisions about factors that affect their lives, in formulating and implementing policies, in planning, developing and delivering services and in taking action to achieve change.⁸⁰
This participation helps bridge gaps and build trust and respect between policy-makers and health providers and the communities they serve.\(^\text{81}\) It serves to gauge expectations, identify health needs and priorities, as well as empower people and communities to be an active part of planning and implementation, and to hold leaders accountable for their commitments.\(^\text{82}\)

In practice, community participation in PHC systems is challenging.\(^\text{83}\) Planners should ask:

- Who participates (inclusivity)? Communities are not monolithic, and there are often vulnerable groups within communities that should be represented in decision-making.
- How do they participate (intensity)? What channels and mechanisms are available to allow for a wide range of participatory methods, taking into account people’s capacity and time?
- How are discussions and decisions linked with policy or public action (influence)?

These questions help assess the power imbalances within existing structures and also highlight potential opportunities. The goal is for communities to meaningfully contribute to the leadership and governance of the health system, to define health and social needs and their priorities, to inform decisions around planning, and to be part of the implementation and delivery of services.

**What does “people and community centred” look like in PHC systems?**

Implementing people- and community-centred care requires fundamental changes in our approach to health care, rethinking how services are organized, managed and delivered and shifting from “What is the matter with you?” to “What matters to you?”\(^\text{84,85}\) Individuals and families are equal decision-makers and empowered (Box 2):

- to make care decisions in partnership with health and social workers;
- to prevent ill health, manage conditions and maintain well-being, considering their own goals and context;
- to hold their own health information and share this with others in their care team, with permission;
- to have no distinction between physical, mental or social health, and have the same expectation of quality of care and service provision for all; and
- to have personalized care, with assessment and planning specific to the individual.

In the context of the community (Box 3), whether defined by locality, condition or minority membership, being community-centred means that these groups are also empowered:

- to inform the planning, prioritization, and delivery of health and social services for their locality or group, including services focused on maintaining wellness for those not needing acute or chronic health care;
- to see that the information and experiences of consumers and groups are collected to inform continuous quality improvement;
- to participate in decentralized decision-making, with devolved accountability to ensure services are more responsive to community needs;
- to see meaningful investment in the capability and capacity of communities and existing community health and social workers; and
- to offer their own well-being and health promotion interventions, such as schools and workplaces supporting healthy eating and physical activity.
## Annex

### Box 2. Facilitating a people-centred approach

The CHOICE Project in New South Wales, Australia, developed an innovative shared decision-making and peer support service to empower young people to make informed and preference-based decisions about their own mental health care. The project adopted a collaborative approach to decision-making, empowering young people to be involved in making decisions about their own care, assisted by peer support workers and an electronic decision aid that facilitated shared decision-making. Young people who participated felt more involved in their assessment, and this was important in reducing decisional conflict and increasing young people’s satisfaction about their care.


### Box 3. Enabling community participation and ownership in Samoa

Community engagement with health systems relies on trust, and it is particularly important for marginalized groups that services are delivered by people who are connected with their communities. Community health workers are one example of how communities can be directly involved in PHC both in lower-resource settings and in higher-income countries. The COVID-19 pandemic has highlighted the importance of maintaining a strong health workforce within the community that can support continued delivery of primary care services as well as activities specific to the pandemic, such as screening, contact tracing, immunization outreach, and so on. Community health workers have traditionally had skill sets in maternal and child health services; however, their contribution extends to: epidemic response; detection and management of communicable diseases such as HIV, malaria and TB as well as NCDs, including hypertension, diabetes and mental illness; palliative care; and medical and social support for older people. In addition, their role as community leaders, role models and champions may be underestimated.

In Samoa, women’s groups (*Komiti Tumama*) have historically played a vital role in the delivery of public health and improving access to health services. In an attempt to reinvigorate the role of *Komiti Tumama*, the Government, together with WHO, launched a demonstration project in 2015: NCD early detection and self-management through community participation, or PEN Fa’a Samoa. Village *komitis* play a key role in outreach, ensuring early detection and increased awareness of NCD risk factors, together with established processes of referral to district health facilities for treatment and follow-up. The programme has achieved a high level of population screening coverage in villages where the *Komiti Tumama* played a key role. A key strength of the programme is that it is organized within the traditional governance structure of villages.


### 4.2.2 Continuous, lifelong engagement

Continuity in primary care has traditionally been defined as the repeated interaction between an individual person and a single practitioner, with this contact strengthening understanding of each other’s views and priorities, improving communication and trust, and over time enabling more tailored care for individuals.

However, in the context of the broad and comprehensive scope of PHC, “continuity” is likely to involve a team approach whereby the skills of multiple providers across a variety of settings are utilized to provide more timely access to a broader range of expertise and services, allowing flexibility for health systems in meeting the needs of their populations.
What does “continuous” look like in PHC systems?

For people and their families, the experience of continuity of care is the “perception that providers know what has happened before, that different providers agree on a management plan, and that a provider who knows them will care for them in the future.”

PHC systems that provide a high level of continuity for their patients and communities have:

- **Informational continuity.** Health information systems that provide access to reliable, complete and timely information for providers across the system in all ranges of settings.
- **Management continuity.** Consumers have a sense of security and predictability about their care, and the care plans reflect their own context, values and preferences. Services are integrated and coordinated (see Box 4).
- **Relational continuity.** There is a stable pattern of care with a consistent team of professionals that are easily accessible; these providers are familiar and trusted.

### Box 4. Continuity and Health Care Home (HCH) models of care

In New Zealand, the HCH model is shifting more traditional reactive systems of general practice towards more proactive, team-based approaches focusing on the individual needs of patients and whānau (extended family) throughout their lives. Originating in the United States of America, and developed in response to workforce shortages, ageing populations and increasing demand on services from chronic conditions, HCH models in New Zealand are now in more than 200 general medical practices. The model covers four domains: 1) provision of unplanned and urgent care, 2) ensuring proactive care for individuals with complex needs, 3) enabling systematic routine and preventive care, and 4) maximizing business efficiency. The model has been refined for New Zealand’s local context and enhanced for equity and the Treaty of Waitangi, and it includes processes such as triaging patients to ensure appointments are available to those who need them most, virtual consultation options, and a more proactive and partnership approach to caring for people with long-term conditions. Evidence is emerging from the New Zealand context that HCH models are associated with significant increases in primary care access, better care for long-term conditions, decreased emergency department presentations and lower rates of ambulatory sensitive hospitalizations.

**Sources:***


### 4.2.3 Equitable and high quality

In a paper published by *The Lancet Global Health*, Kruk et al. defined a high-quality health system as “one that optimizes health care in a given context by consistently delivering care that improves or maintains health outcomes, by being valued and trusted by all people, and by responding to changing population needs.”

High-quality care is safe, effective, timely and efficient, and improving the quality of care is foundational work for UHC initiatives. Evidence suggests that there are several strategies involving coverage, financing, service delivery and governance arrangements that can, if implemented, have positive economic impacts on the delivery of primary care services, including arrangements such as worker task-shifting and telemedicine. In lower-middle-income countries, the delivery of inadequate and poor-quality care is common across conditions, with a disproportionate burden experienced by
Annex

those already vulnerable. Improving the quality of health systems could prevent millions of deaths annually, and research is imperative to help understand and guide how to transform low-quality systems.

Equity is primarily considered a dimension of quality; however, in the context of persistent and pervasive disparities in health outcomes and health-care quality itself – both within and between countries – equity demands explicit attention.

Health equity is the absence of unfair, avoidable or remedial differences in health outcomes and access among groups of people, whether those groups are defined socially, economically, demographically, geographically or by other dimensions, for example, sex, gender, ethnicity, disability, sexual orientation and vulnerable populations. Care that is inequitable – providing a different quality of health care for some groups compared to others – or a system that produces systematic disparities in health outcomes is not high quality.

Equity is central to the SDG call for “just, rights-based, equitable and inclusive action to address today’s challenges and promote growth, social development and environmental protection for all”. Health equity is achieved when the conditions are created for everyone to be able to attain the highest level of health and well-being throughout their life spans. The economic, health, social and environmental cost of not addressing health equity is high, ongoing and far-reaching.

What does “equitable and high quality” look like in PHC systems?

- Delivering high-quality care requires careful planning, continuous monitoring, quality assurance and evaluation processes, and a commitment to improvement and equity. It necessitates actions at all levels, from policy through to service delivery and outcome measurement. Quality of care and payment policies are designed to achieve equity, holding the health-care system accountable through public monitoring and evaluation, and supported with adequate resources.
- PHC systems focused on quality and eliminating health inequities prioritize health and social data collection and aim to continuously improve the collection and reporting of disaggregated health data. Monitoring progress of the quality of care requires sustained attention for both health and wider social, economic, political, environmental and cultural determinants in order to enable the tracking of progress against SDGs and serves to focus PHC improvement efforts.
- Cross-sectoral work addressing the broader determinants of health and other structural factors causing health inequity or barriers to access is a priority. Determinants of health for individuals and communities are addressed with coordinated approaches, integrated funding streams, and shared accountability metrics across health and social sectors (Box 5).
- Institutional bias based on race, ethnicity, citizenship or other factors, within and outside of health care, is confronted. Health equity is championed across leadership, with dedicated resources and processes for health equity activities, including interventions designed for and with those already experiencing health inequity.
4.2.4 Integrated

Integration requires the coordination of services and providers for a given individual, as well as the collaboration and connection with sectors outside health and in other parts of the health system. For individuals, coordinated and integrated care increases patient satisfaction, improves perceived quality of care and facilitates access to services.\textsuperscript{94,95} At the system level, integrating services and ensuring alignment of goals between sectors is both effective and efficient, reflecting the gains made from working synergistically.

Efforts to increase integration will:

- reduce incentives that encourage unnecessary utilization, instead focusing on health and well-being outcomes;
- increase the contribution of the non-medical, allied health and social services workforce; and
- create strong relationships and connections between health and social providers, that allow it to respond rapidly in time of crisis. This is relevant both for the individual at the centre, but also for community-level events, such as outbreaks or civil defence threats.\textsuperscript{54}

Comprehensive PHC requires multiple providers in a variety of settings, and people-centred care means that any door is the right door to access care. A primary care network includes all service providers that interact with the individual, including social and specialized care providers, with the person and their community being the nexus (see Fig. 12).

---

**Box 5. Increasing health equity through the social determinants of health**

Countries in the Western Pacific Region, including Fiji, Malaysia and Palau, have made a strategic shift to a health promotion agenda tied to social determinants and intersectoral action. Health committees for multisectoral collaboration on NCDs have been established in Cambodia, Fiji, Malaysia and Mongolia, and Viet Nam has had a strong focus on intersectoral action for injury prevention with the transport industry. In Vanuatu, community and nongovernmental organizations are incorporating the community in the design of food and nutrition interventions. In different ways, these activities help to shift from focusing mainly on disease-specific programmes to more integrated approaches, addressing the wider determinants of health through intersectoral action, increasing inclusion of NCDs and their risk factors in health sector plans, and a deliberate focus on those groups already experiencing inequity.

While the concept of integration within and between health services is familiar, PHC systems must also consider their role in social well-being and public health. Many Member States already undertake public health tasks or preventive interventions within primary care settings, for example, early detection of disease through screening, early interventions to tackle risk factors such as smoking or physical inactivity and preventing disease through immunization. There is also increasing activity in working with non-health sectors to tackle structural determinants of health such as housing or transport (see Box 6).

However, a public health approach also requires a shift in how PHC operates, not just in what it does. A public health perspective requires looking beyond a provider’s specific patient panel, to consider the needs of a broader population based on geography or other membership, including surveillance, health and social need. It also requires the empowerment of communities to participate in planning and decision-making, as well as collaboration with community groups and leaders.

**Box 6. Healthy Homes Initiative New Zealand**

The New Zealand Healthy Homes Initiative is a partnership among multiple government departments and agencies, including the Ministry of Health, the Ministry of Business, Innovation and Employment, the Energy Efficiency Conservation Authority and the Ministry of Social Development.

Its aim is to provide warm, dry and healthy housing for low-income or otherwise vulnerable families and pregnant women in order to improve their health outcomes and in particular to reduce the risk of acute rheumatic fever in their children. Regional health services are instrumental in identifying eligible people and supporting the delivery of the interventions, which include housing insulation, heating and other material benefits to create a healthier home for these families. Findings from an evaluation of the initiative show that it has resulted in fewer medicines dispensed, fewer general practitioner visits and fewer admissions to hospital for children referred to the service.

What does “integrated” look like in PHC systems?

Integrated networks of health-care providers often have: shared information and care records, plans, and platforms; communication technology; integrated care pathways; evidence-based best practice protocols; co-located providers; and multiprofessional team meetings. These are some of the factors included in the principles put forward by Suter et al. In addition to the tenets of people-centeredness and the provision of comprehensive services across the care continuum, they provided the following principles for integration of health systems:

- geographic coverage and rostering, responsibility for an identified population;
- standardized care delivery through interprofessional teams using evidence-based guidelines and protocols;
- performance management, commitment to high-quality services, evaluation and continuous improvement;
- information systems to collect, track and report activities and to enhance communication and information flow;
- organizational culture, commitment and leadership;
- physician integration, including buy-in;
- governance structures, with comprehensive membership from stakeholder groups, including those responsible for delivering PHC, and supportive structures to enhance coordination; and
- financial management, equitable funding and mechanisms that promote teamwork and health promotion.

Box 7 provides an example of care integration in Cambodia.

<table>
<thead>
<tr>
<th>Box 7. Integrating HIV and reproductive health services through multidisciplinary teams in Cambodia</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 2007 review on HIV in Cambodia found significant barriers to pregnant women testing for HIV and found that HIV-positive pregnant women and exposed infants were often lost to follow-up before being provided with antiretroviral therapy. In response, a linked-response intervention was developed in five districts that created strong referrals between a district hospital hub offering a full package of services, satellite sites offering comprehensive prevention and support activities, and linked health centres. The intervention also strengthened links between community-based organizations and health facilities, trained guides to help women navigate the system and involved women with HIV as resource people in the communities. Sexually transmitted infection/HIV indicators and follow-up dramatically improved after the intervention was implemented.</td>
</tr>
</tbody>
</table>

4.2.5 Innovative

A learning system is one that seeks to continuously improve and remodel, using evidence from research, insights from data analytics, constant engagement with end users and innovations in technology. In the context of fiscal constraints and increasing health and social needs, innovation should be a mainstay of PHC and providers and communities should work together to continuously consider new models of care and service delivery.
Annex

Advanced and new investigative and therapeutic technologies are improving the effectiveness of care. Big data, artificial intelligence and analytic techniques, including machine learning, allow more precise and personalized approaches, as well as improved population monitoring and planning. The widespread uptake of digital devices by individuals and families has the potential to significantly reduce barriers to access care and improve engagement, as well as reduce inequities. Virtual platforms, which have seen an increase in overall use and acceptance during the COVID-19 pandemic, can connect an individual with general or specialized care, as well as support communication and collaboration among providers, and allow clinicians to provide care from alternative locations. Their design and use must be people-centred to ensure acceptability and uptake.

The integration of research and evaluation activities, and the growth of effective innovations, are also features of a PHC learning system. There are significant gaps in the body of research around PHC, and it can be difficult to find quantitative evidence to support initiatives. Similarly, there are barriers to spreading good ideas, effective interventions and recent insights among providers and regions. When there are significant changes in service design, there needs to be explicit investment into their evaluation and, if indicated, their embedding and dissemination to others.

What does “innovative” look like in PHC systems?

Innovation requires a supportive environment, including leadership, governance and policy settings that allow change, as well as health providers that are open to new and different ways of working. In particular, innovative systems and organizations have:

- cultures that drive and reward innovation through awards, funding, education and work programmes, and dissemination opportunities;
- strong information governance that allows the handling and sharing of confidential patient data;
- relationships with clinicians and communities that allow them to lead and contribute to innovation planning and delivery;
- processes and structures that allow them to take advantage of innovations and technological advancement in other sectors and to work with private providers;
- processes that support the navigation of regulatory issues, procurement, and testing and evaluation in a clinical environment; and
- access to support for the dissemination and scaling up of successful innovations.

4.3. Strategic actions to build the future of PHC

While the diversity of the Western Pacific Region makes it difficult to use a uniform set of recommendations for achieving comprehensive PHC, there are nonetheless certain high-level processes and strategic principles Member States can consider and adapt that can facilitate their reform efforts. This section outlines some actions categorized under five main areas for Member States to consider (Fig. 13), namely:

1. Build appropriate models of service delivery
2. Empower individuals and communities to participate in health
3. Build a diverse fit-for-purpose health workforce
4. Realign PHC financing
5. Create a supportive and enabling environment.
4.3.1 Build appropriate service delivery models

Choosing and building the appropriate model of care is critical to achieve comprehensive and people-centred PHC. Models of care must be tailored to local contexts: the model that might work in developing countries with limited public sector capacity will likely significantly differ from what could work in a higher-income country. This is true even within decentralized countries with heterogenous provinces and districts. However, there are some overarching avenues of action for PHC-oriented service delivery models that can be adapted based on local settings.

**Empanelling populations to providers or networks**

To build accountability for results in PHC, Member States could consider entrusting the health of defined communities to specific teams or networks through the process of empanelment. Empanelment entails the assignment of individual patients or populations to individual primary care providers, teams or facilities, which encourages providers and teams to take responsibility for a holistic approach to the health of the people under their care. Member States can consider compulsory or voluntary provider assignments, which can be based on geography or individual choice.

**Improving service coordination through multidisciplinary teams and/or networked models of care**

Building a PHC ecosystem that is coordinated, people centred and accountable requires delivery models that are agile and responsive to the population’s changing health needs.

---

**Note:** A model of care is a conceptualization of how services are delivered. It involves the organization of providers and services, the legalization of roles and responsibilities of different platforms, establishment of processes of care and referral, identification of roles and responsibilities along care pathways, and linkages to social services.
Annex

Member States can consider the following:

- Establish service networks rather than rely on single providers. This means bringing together a group of providers with formal linked arrangements and having them operate as one entity. This can allow for a wider array of services that are either co-located or offered at various service points within the network. This should be underpinned with information-sharing across the network so that individuals can be guided to the relevant service points along their care journey in an efficient manner.

- Organize PHC delivery through multidisciplinary teams (also discussed in section 5.1.2) with a mix of co-located services, spread across a linked and well-coordinated provider network with better targeting.

- Strengthen referral pathways to hospital-based services, including through integrated multi-tiered networks. This could be through measures to ensure gatekeeping at the primary care level with clear protocols for referral or through the establishment of delivery networks that provide coordinated care from community to specialist levels.

- Rethink and restructure the role of hospitals in the service delivery network towards a flexible role that embraces joint responsibility with other care providers at varying tiers of care for public health with integrated care pathways (Box 8). Fully integrating hospitals with ambulatory and primary care is a very important link to ensure a continuum of care for patients.99

- Progressively expand provider networks to include other types of institutionalized care, rehabilitation and therapeutic care, and support services, as well as with day care, home-based and nursing services.

- Integrate public health functions with primary clinical services with clear roles and responsibilities for local health authorities. Public health professionals can be inducted into primary care and work partnerships established between them and PHC providers, for example sharing insights, data and research for disease prevention efforts. Member States can consider including public health elements (such as screening and health promotion) and incentives in service agreements with providers to enable the transition in focus from curative to preventive care.100
Improving accessibility of services beyond routine modalities to reach vulnerable and at-risk groups

- Evaluate barriers to health access and service utilization; strengthen relationships between the health sector and communities to build trust and mutual respect, recognizing that many vulnerable populations have historically had challenging experiences in accessing and using public services.
- Explore options for establishing service points outside of traditional health facilities that could be staffed by volunteers or community workers and offer greater accessibility. These could be a basis for non-health community-based services such as for wellness and meditation or to assist people with special needs or older people (through social prescribing).
- Consider changing up working hours across providers within a network to provide more options for the communities as well as providers.
- Incrementally facilitate access to services closer to where people live as health system capacity matures. These may be through home- and community-based services, primary care in long-term care facilities, step-down units for rehabilitation in local hospitals, or the use of digital platforms. Other options include connecting community health workers with facility-based staff, because this could improve the quality of services offered by the former and also play a vital role in linking communities to facilities and delivering population-based services.
- For areas with particularly challenging access, consider the use of mobile health services to fill this gap.

Expanding service packages progressively

Depending on capacity, Member States should progressively build onto their service packages to include the full range of services from promotion and prevention to treatment, rehabilitation and palliative care services.

Actions to strengthen service packages should:
Annex

- Include coverage for a wide range of communicable diseases and NCDs in PHC service packages. Incorporate personal services of priority public health programmes over time particularly for countries moving towards transition from external aid. Progressively include NCDs and mental conditions, starting with preventive services and adding on some diagnostic and management of stable cases, while maintaining the role delineation between PHC and specialist care.
- Ensure the provision of essential medicines and commodities as part of the service package. This could be through purchasing arrangements to cover the cost of medicines through in-facility or external pharmacies and similar vendors, using the negotiating power of the purchaser to keep medicines prices affordable. Explore mechanisms, such as drug revolving funds, to sustain supply at the provider level. Also, consider options like centralized procurement for efficiencies of scale.
- Target expansion of service packages to the needs of different phases of the life course – infants and children, older children and adolescents, adult men and women, and older people. Member States can sequence this benefit package expansion as each stage achieves scale.
- Explore inclusion in service packages of other types of care not usually seen as part of PHC, such as palliative care, rehabilitation services, and traditional and complementary medicine, as well as health-promoting services such as nutrition counselling or those services targeted at lifestyle behaviour changes.
- Continue to invest in and strengthen essential public health functions that will serve as a basis for building resilient health systems and enhancing population health (Error! Reference source not found.).

Box 9. Viet Nam’s initiatives to strengthen Commune Health Centres (CHCs)

In Viet Nam, the district health system plays an important role in providing primary care and essential public health functions. Prior to 2016, it consisted of three separate bodies: 1) district hospitals (providing basic curative care including inpatient care); 2) district health centres (providing public health and preventive services); and 3) district health offices under the district People’s Committee, which manage all commune health stations (CHSs). Thus, CHSs, which were supposed to serve as primary care providers, were managed by the district health centre and received technical guidance from district hospitals. This heavily divided and fragmented district health system was not effective in building capacity for CHSs. Since 2016, the Government decided to merge the district hospital and the district health centre, which provided only preventive services, into one unified entity called the “district health centre” whose role is to cover public and preventive health and curative health care comprehensively for the entire population in each district. It took Viet Nam almost five years to re-establish this multifunctional district health system and restore the Government’s focus on the grassroots health-care system. The COVID-19 pandemic has revealed once more the vital roles of the district health system as the backbone in the provision of essential health-care services, including COVID-19-related services, and in the national health security system. The Government and health authorities at all levels are now discussing ways to further strengthen this system, with key issues for discussion including how to structure, manage, and govern this system, how to improve the quality of this system, and how to secure adequate public funding to make this system equitable and sustainable.


Leveraging the private sector providers to expand access

Many countries in the Western Pacific Region have mixed health systems with both public and private providers. When developing policies for the health workforce, Member States should begin to plan for
the health system as one, with strategies that can leverage the private sector, which often provides a large proportion of services to the population. Excluding them from PHC policy or delivery models reduces the capacity to scale services.

Member States can consider the following:

- Address issues around dual practice, which remains a challenge in many Member States with mixed health systems, causing conflicts of interest and suboptimal care. This could be addressed through policy interventions including incentives such as non-practising monetary allowances, financial restrictions, and regulatory instruments such as prohibitions and measures on licenses to increase their alignment to national PHC priorities. Where dual practice is a viable policy option, all provisions related to this should be made explicit to providers. Monitoring the extent of dual practice will also be critical to understand the true coverage of the provider base.
- Incorporate private providers within empanelment strategies and within integrated health networks, and explore incentives to increase their alignment to national PHC priorities.
- Explore options for contracting with the private sector under new or existing purchasing mechanisms in order to leverage on the existing private sector service delivery infrastructure.

**Establishing systems for improving quality of care**

Evidence suggests that poor quality of care is now responsible for more deaths in low- and middle-income countries than lack of access. Quality of care is essential for improving performance, maintaining trust, ensuring the sustainability of the health system, and guaranteeing that all efforts and resources invested in facilitating access to and delivering care are translated into improving people’s health. Quality care requires careful planning that involves and engages key stakeholders, including users.

Member States can consider the following:

- Develop national standards for ensuring quality of PHC services as well as systems to operationalize and monitor adherence to those standards at local levels.
- Develop mechanisms for governance and accountability for quality of care, including the institution of primary care quality teams and focal persons.
- Promote and facilitate platforms for the in-depth review of quality management with providers and communities and plan improvement strategies.
- Establish or strengthen measurement platforms for PHC service quality, including patient experience, on a routine basis as part of broader health quality monitoring.

**Harnessing the use of digital platforms for service delivery**

Digital technology can help to fill access gaps in service delivery by complementing – not replacing – in-person services. Electronic patient information systems and use of digital technologies can enable more predictive care for both individuals and populations, strengthening promotion and prevention rather than just treating and managing existing conditions.
Annex

Member States can consider the following:

- Facilitate the adoption of new and appropriate health technologies—those that can facilitate patient-centred care such that services can be provided closer to home, and can support access to care from a broad range of practitioners or more specialized care than would normally be able to be provided (Box 10).
- Include telehealth and other e-health platforms in care pathways to increase the reach of services and enable increased responsiveness (Box 11).
- Take policy steps to boost access to technologies ranging from smartphones and wearable gadgets to software applications and home assistants, among other options, for providers, facilities, patients and the broader population.
- Boost the use of electronic patient health records for members of multidisciplinary PHC teams and service networks, which can help improve patient safety and quality of care by improving access to information, real-time teamwork, collegial support and good decision-making, particularly between workers based in the community and those in facility-based PHC.
- Promote the use of digital platforms to bring more specialized care closer to communities through mechanisms such as digital sharing of images and clinical information to support diagnosis and treatment options; mobile technology, wearables and artificial intelligence for remote assessment for some health conditions; and digital point-of-care investigations and diagnostics, for example, for diabetes and other conditions, for rapid analysis and time-critical treatment.

†† Among the technologies that Member States can prioritize are virtual consultation options such as videoconferences, telephone calls or messaging that can connect health workers remotely to people and communities needing support for a range of health-care needs and can also improve communication among health workers and with patients. During the COVID-19 pandemic, many countries introduced or accelerated their use of telemedicine, particularly virtual consultations, as a way to provide health care safely and minimize virus transmission.

---

Box 10. Remote patient monitoring in Singapore COVID-19 Community Care Facilities

Singapore set up Community Care Facilities to cater to patients who are COVID-19 positive but at low risk of developing respiratory complications. These patients were isolated and safely cared for in such facilities until they tested negative for COVID-19. The patients were taught to self-measure vital signs – temperature, heart rate, blood pressure and oxygen saturation – which were then automatically transmitted three times per day to a central dashboard, monitored by health-care staff from the Woodlands Health Campus. When a reading is out of range, it is immediately flagged in the system and responded to by health-care staff.

Building stronger linkages beyond health sector to social services

Improving health outcomes and health equity requires a renewed focus on tackling the social and economic determinants of ill health and considering health in all policies.

To operationalize multisectoral collaboration and address the social and economic determinants of health, Member States should consider the following:

- Coordinate with social sectors to provide non-health social care services, either through joint work at local levels or through formal network mechanisms. Types of relevant social services with which linkages should be established include, but are not limited to, gender and child protection services, disability support, rehabilitation support and social welfare services, among others. Joint work between health and social care professionals can be achieved by establishing shared working environments through one-stop shops, where clinical and community-based professionals are brought together at one site or centre, organized according to local needs.
- Work to create interface roles – both clinical and non-clinical – within the model of service delivery to bridge gaps between patients and health and non-health providers. Personnel in interface roles should be deployed at “pinch points” or intersections of primary, secondary and social care, and provide system navigation support for patients and carers trying to access care in complex networked systems of health and social care.
- Where interface points have been established between health and non-health services, incrementally harmonize systems for patient data, personnel and resource flow.

4.3.2 Empower individuals and communities to participate in health

Meaningful participation should include enabling contributions to decision-making and setting policy direction, as well as activities and strategies that allow individuals and families to more intentionally manage their own health and well-being.
Expanding mechanisms for community and public participation in accountability and planning

Often, community participation in health governance is limited to civil society participation in high-level technical working groups; that is, mechanisms that often have limited participation from communities themselves.

To enable greater voice and participation from communities, Member States can consider the following:

- Increase the role of communities in planning and decision-making with mechanisms to engage a broader spectrum of civil society and communities and to feed their concerns and suggestions back into the policy- and decision-making processes, as was done in the Republic of Korea during the past reform of the benefit package (Box 12). This may require investment, including training, to raise the capabilities of community leaders and groups.
- Improve community access to information via awareness campaigns, system “report cards” and scorecards, and social audits, as well as institutions to facilitate civil engagement. This must include clear communication on entitlements to be provided by the system.
- Promote structures and processes at all levels of the health system that can function as representative, legitimate mechanisms for community-led oversight and accountability in the planning and implementation of health services. Options include participation of community-elected representatives as full members of facility or district management structures or establishing a community advisory board that has a formal role in providing oversight of health services.
- Involve vulnerable communities in policy processes by having evidence-based information systems in place to ensure that targeting is appropriate, accurate and transparent.

Box 12. Citizen participation for benefits coverage reform in the Republic of Korea

In 2012, the Republic of Korea established the Citizen Committee for Participation, a lay citizens’ council, to inform priority-setting and benefits coverage. This occurred after public requests for expanded benefits coverage were aired as the early 1980s and following an initial expansion of benefits coverage in 2005. This expansion triggered a series of public debates regarding the criteria by which coverage decisions were made and culminated in the creation of the Citizen Committee, which makes recommendations to the Health Insurance Policy Committee on service priorities. This has been largely successful, with the Citizen Committee participating in revising benefits coverage decisions.


Using behavioural insights and social listening to elicit population and community preferences and needs

Listening to communities is essential both for planning interventions and services and to ensure the responsiveness of the system to the communities. Member States can explore various mechanisms to do this. While community surveys or meetings have been the traditional approach, these may be less accessible settings for some groups of people.

Member States can consider the following:

- Establish or strengthen platforms to listen to and learn from communities (Box 13). Options include conducting community forums, meetings and surveys to listen to, learn from and
address concerns raised by community representatives. In these spaces, it is important to ensure that those who may be marginalized within the community should have safe and open spaces to share their insights.

- Use a variety of platforms in community engagement, including online and offline mechanisms, to elicit a diverse and representative set of insights, which includes people who do not have access to or are uncomfortable with the internet and digital tools.
- Explore the use of key informant interviews or focus groups to ensure marginalized voices are heard.
- Explore ways to incorporate the use of digital health technologies to improve social listening and enable behaviour change through preventive and promotive measures.
- Where digital platforms are in mass use, consider social listening (the collection of data from social platforms or forums) to obtain information from those groups less likely to engage formally. A greater number of health-care services internationally are utilizing social media in their communication strategies. In China, more than 75% of hospitals were using the Chinese social media sites Sina Weibo or WeChat – providing opportunities for engagement and communication.¹¹⁰

**Box 13. WHO EARS platform**

WHO launched the Early AI-assisted Response with Social Listening (EARS) in response to the COVID-19 pandemic. This platform captured real-time data from online conversations in public forums, such as Twitter, blogs and message boards, from 30 countries, and analysed the data using machine learning. The intelligence gained helps to understand the impact of the pandemic in different populations and identify where people need more information or support.


**Providing resources to individuals and families for self-care and self-management**

There is evidence that self-management of interventions has an impact in decreasing health service utilization, in particular for those people with chronic respiratory and cardiovascular diseases.¹¹¹ The management of long-term conditions traditionally involves pharmacological treatment and lifestyle recommendations that are disease focused and generic, such that they are not specific to the individual, and these regimes tend to have low compliance. Understanding and prioritizing the need for regular medication can also be challenging, especially for conditions that are asymptomatic.

To ensure that individuals and communities are empowered to manage their health needs, Member States can consider the following:

- Provide access to their own health records, including results of investigations.
- Promote and provide tools and information (digital and non-digital) to help individuals understand exacerbations of their conditions, and how to safely manage their symptoms.
- Promote and support the use of models and guidelines that incorporate multiple risk factors to provide more individualized risk assessment and treatment approaches (Box 14).
- Train and engage workers from local communities and trusted champions to support education and management activities.
- Partner directly with communities and/or cultural subgroups to support them to develop their own initiatives that fit better within their norms.
Providing resources and support to individuals and communities to maintain healthy lifestyles and mental well-being

Lifestyle choices, such as reducing tobacco use or adhering to a healthier diet, can be difficult to address, particularly given their need to be sustained over time. To enable this shift to maintaining better well-being in general, making healthy choices should be as effortless as possible. Incentives can be explored that could be financial or non-financial to create health social norms (also highlighted in section 4.2.5). Incentives can be in the form of financial subsidies, such as physical activity mes, “green prescriptions”, reduced costs for fruit and vegetables, or subsidies for landlords to install clean heating.

Member States may consider the following:

- Facilitate the use of personal health devices and mobile health applications to enable the collection of individual health and social data, and to provide an opportunity to deliver more tailored interventions, including using artificial intelligence. The roll-out of digital health interventions should take into account digital literacy and connectivity rates of the target populations.
- Create or identify high-quality information and resources on approaches for populations to healthy lifestyles and mental well-being that can be targeted at different demographic groups.
- Ensure that information and resources on maintaining healthy lifestyles and mental well-being are provided in modalities that are understandable and accessible by people who may have barriers due to language, literacy, location or disability.
- Support community leaders and influencers with training and resources in communication and other strategies to motivate behaviour change.
- Encourage workplaces, businesses, schools and other community settings to support healthy lifestyles and mental well-being through context-specific communication strategies and behavioural “nudges”.
- Build future and current leaders who can be champions for healthy lifestyles and mental well-being as well as participants in the PHC workforce.

4.3.3 Build a diverse fit-for-purpose health workforce

To achieve effective PHC-oriented health systems and respond flexibly to increasing demand for health care, Member States need to closely align the PHC workforce with the needs of communities.112
The final set of actions to sustain the PHC workforce depends on the unique contexts of each country, the needs of the populations they serve and country capacities.

Optimizing the existing PHC workforce

The PHC workforce varies across the Western Pacific Region and depends on each country’s unique context, resource availability and investment capacity. While there is no single optimum model for the composition of PHC teams, they should involve a wide range of professions and skills. Expanding PHC teams takes time and resources, so a focus on maximizing the utilization, productivity and performance of the existing workforce is critical.

Member States can consider the following:

- Optimize the skill mix in PHC teams through task-sharing or -shifting,‡‡ which can ensure responsive services with fewer resources. Member States can take steps to move specific tasks to existing health workers to increase the efficient use of the workforce, freeing up time for higher-level health professionals and addressing bottlenecks in service delivery. This can involve transferring tasks between existing members of PHC teams (for example, from doctors to nurses and health assistants) or the creation of additional roles to extend workforce capacity (for example, community health workers and allied health workers supporting people in the management of their chronic conditions).

- Expand existing roles of specific workforce cadres (Box 15). For example, the use of registered nurses and other health workers in care coordination can be effective in improving access to appropriate treatment, improving clinical outcomes and quality of care, improving communication with the PHC team, increasing patient safety, and reducing unplanned readmissions. A range of other roles (for example, community health workers and medical assistants) can be expanded to include other functions with training and ongoing support.

- Promote the use of multidisciplinary teams in health facilities that optimize the skill mix, enabling team members to realize the full scope of their professional knowledge and practice, avoiding underutilization of worker skills, and harnessing collaboration and complementarity between different types of health and social workers.‡

---

**Box 15. Enabling nurses in advanced roles**

There is a sizeable body of literature supporting the unique contribution of advanced nursing roles such as nurse practitioners, advanced practice nurses and midwives from various regions around the world. Although nurses take on a variety of roles and responsibilities that extend well beyond their basic training, nurses in advanced roles have lacked consistency in nomenclature, scope of practice, the role of regulation, qualifications and education. Demand for these roles is high in the Western Pacific Region, and work is needed to collate and highlight best practices on advanced role development and collaboration across different sociocultural contexts and through dialogue among nurses to clarify advanced nursing roles.


‡‡ Task-shifting is a process of moving specific non-statutory tasks to other occupations with shorter training courses and fewer qualification requirements, while ensuring appropriate levels of training and support to ensure safe practice and quality care.
Annex

Expanding the PHC workforce

Doctors and nurses alone cannot meet all their patients’ primary care needs; thus, a wider range of team members is needed to support the management of health conditions, strengthen efforts to prevent ill health, promote well-being and address workforce shortages.

Member States need an expanded view of the PHC team, including optimizing the existing workforce by expanding the scope of practice with an emphasis on roles – such as non-clinical roles – that support promotion, prevention and well-being to ensure the sustainability and effectiveness of PHC responses into the future.

Member States should consider the following:

- Extend PHC teams beyond traditional PHC roles to include new roles such as coordinators, case managers and new specialties, and involve professions from other sectors given the multisectoral nature of PHC. A multidisciplinary PHC workforce might include general practitioners, nurses and nurse practitioners, community health workers, counsellors, mental health specialists, physiotherapists, podiatrists, health promoters, and those with expertise in engaging people and communities, such as community development specialists or anthropologists (Box 16). They may work together as part of the same organization or come together from multiple organizations.

- Establish or strengthen existing community health worker programmes. Facility-based PHC alone cannot reach the underserved or adequately respond to the needs of communities. This must include strategies for retention and options for regular training, some remuneration and effective supervision.

Box 16. Allied health supporting chronic conditions in primary care

Chronic lower back pain is an example of a common condition that may be best delegated to allied health professionals. In the United Kingdom of Great Britain and Northern Ireland, the professional workforce delivering primary care is currently being broadened, resulting in multiple primary care service models as alternatives to traditional care led by general practitioners. These include first-contact practitioners, typically physiotherapists, with extended skill sets who can assess and provide management plans for patients with musculoskeletal conditions, as well as nurse practitioners and physician associates who provide first contact and triage.

Advancing these kinds of solutions in the Western Pacific Region requires models of primary care that support greater community participation and the breakdown of professional barriers, extended professional scopes, payment models that align with service models, and referral processes to enable direct access to a range of health professionals. These solutions are just some of the design elements needed to support increased interprofessional practice and allied health input into primary care.

Adapting health worker recruitment to reflect community needs

More effectively reaching underserved populations and those with unmet needs requires a workforce that better reflects the populations they are serving, as well as increased community outreach roles working directly within communities.

Member States can consider the following:

- Adopt strategies that promote workers who are representative of the communities they work in, especially community health workers, and are able to engage with them culturally and linguistically (Box 17).
- Actively work to increase gender diversity in the health workforce, especially in management and leadership roles to give more options for individuals to interact at their level of comfort.

Incentivizing and promoting workforce performance

PHC workforce performance is more likely to improve when a coherent combination of strategies is employed.

Member States can consider the following:

- Put in place well-designed performance management systems to improve worker performance, including mechanisms such as individual performance-based contracts and mechanisms and incentives for supportive supervision.\(^{116}\)
- Develop incentives for workforce motivation and satisfaction that can involve measures such as developing appropriate competency levels that can attract requisite talent where it is required, establishing clarity of roles and expectations for workers through formal guidelines and agreements, and ensuring adequate remuneration, performance incentives and career pathways for sustained commitment.
- Establish robust supervision practices that can ensure available personnel resources are utilized effectively.
- Use existing or develop new workforce policies to manage the distribution of providers, ensuring access to hard-to-reach settings and populations.
- Leverage the local knowledge and expertise of PHC teams through more decentralized design, implementation and improvement of health workforce policies to help identify workforce solutions\(^{117}\) and include community perspectives.

Reforming PHC training and education for the future

Appropriate education and ongoing training of PHC workers are critical to developing the desired future workforce and responding to community and population needs. In many contexts, the traditional processes of training the health-care workforce are ill-suited to changing health needs, and Member States need to urgently address this issue.

Member States can consider the following:

- Establish comprehensive in-service training programmes to upskill the workforce and maintain technical knowledge for service delivery. These should cover the broad range of services
Annex

included in the benefit package, particularly for areas of new focus such as needs of ageing populations and chronic conditions.

- Include capacity-building for using digital service delivery platforms. Health workers should be trained on the use of devices and/or platforms before they are rolled out. Easy availability of refresher training in connection with updates to the software or devices should be ensured.
- Provide opportunities for improved integration through interprofessional training across health, social and community work occupations, for example, via joint learning opportunities that can help to internalize shared values across different occupations, build teamwork and increase understanding between professions.\textsuperscript{112}
- Explore options such as micro-credentialling to improve health knowledge for non-medical personnel who are part of the new multidisciplinary PHC workforce.
- Adopt competency-based training models for pre-service training and include in curricular options for interprofessional education.
- Include principles of health-care quality in pre-service and in-service training and continuous professional development of health-care workers.
- Train the health workforce, including community health workers, in community engagement and outreach methods, especially targeting vulnerable and hard-to-reach populations.
- Build health worker capacity in non-medical skills such as communications, teamwork, and emotional and cultural sensitivity. This can be initiated through short, specialized courses for the existing workforce, while making it part of pre-service curricula for future inductees.

<table>
<thead>
<tr>
<th>Box 17. National Rural Generalist Pathway – Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td>In response to advice from a national rural health commissioner in 2018, the Australian Government developed a National Rural Generalist Pathway – a dedicated medical training pathway to attract, retain and support rural generalist doctors. Rural generalists are general practitioners who provide primary care services and emergency medicine and have training in additional skills such as obstetrics, anaesthetics and mental health services. The pathway recognizes the extra requirements and skills of rural generalists and supports them to meet the diverse health needs of regional, rural and remote communities.</td>
</tr>
</tbody>
</table>

Establishing an information system for the health workforce

Understanding the availability and distribution of the workforce is a critical management tool that is essential in optimizing the provision of PHC services.

Member States can consider the following:

- Establish a health workforce information system to provide the evidence to assess and make decisions about the profile, production, deployment, distribution and productivity of the health workforce.
- Use existing data within and across the health sector for better planning and management of the PHC workforce.\textsuperscript{112}
- Expand metrics to reflect the desired future profile of the PHC workforce and include clinical and non-clinical roles, a range of social care functions, and multisectoral contributions in the analysis and planning.
4.3.4 Realign PHC financing

Many services delivered through PHC have great population impact, often beyond their direct effects on health. As such, Member States should dedicate financing to the extent possible from public budgets. Reimagining PHC will require adapting health financing to make providers more responsive to policy goals, achieve the outcomes of improved health and well-being, and increase accountability to the populations served. There is a critical need for sustaining and increasing the revenue for the health sector without putting additional pressure on the people.

*Prioritizing public financing for PHC, especially for essential public health functions*

Reorienting PHC systems towards health promotion and prevention means that countries cannot rely on market-based solutions. Investing in public health functions through domestic resources is a critical strategy for improving health and equity outcomes and for building resilient and responsive health systems.

Member States can consider the following:

- Increase allocations for PHC in health budgets and prioritize financing for services focused on health promotion and prevention.
- Provide funding for core population-based health functions or interventions that are essential to the health and well-being of entire societies, including integrated disease surveillance systems, disease prevention and public health policies and strategies, health and environmental regulations, regulatory systems, and public health and emergency management institutions.
- Account for and track PHC expenditures within health budgets to make appropriate decisions about resource distribution and prioritization levels of care in the financing systems.

*Promoting greater pooling of resources for health and PHC*

Pooling of resources for PHC is essential in managing risk across various segments of the population, from rich to poor, healthy to less healthy and so on. However, it is also important in ensuring greater flexibility for providers to manage resources when they receive funding through one pool rather than fragmented funding streams that require different rules and reporting requirements.

To achieve this cohesion and coordination in financing PHC, Member States can consider the following:

- Depending on context, merge separate financing schemes that cover different population groups, to the extent possible, as this would provide a cross-subsidy across different groups of the population, with varying levels of health needs and/or wealth status, and would also streamline funding and revenue flows to providers.
- Explore options, where multiple schemes are unavoidable, for virtual or intermediate pooling with harmonized benefits/entitlements and provider payment approaches.

*Reforming benefits/entitlements and strategic purchasing*

Member States should accompany public financing with purchasing and payment mechanisms that foster a reorientation in models of care for PHC (Box 18). Many health financing systems are also poorly structured to pay for health promotion services, particularly for people who are not deemed ill, and financing schemes such as national health insurance are often focused on reimbursement of curative
services rather than prevention and promotion. This must change to achieve one of the main functions of PHC, which is to help people achieve the best quality of life, regardless of their current health status.

Member States can consider the following:

- Design purchasing schemes that progressively include a comprehensive spectrum of individual and population-wide services and interventions across the life course with inclusion of promotive, protective, preventive, resuscitative, curative, rehabilitative and palliative care services, across service delivery platforms.
- Include coverage for essential medicines in PHC service packages covered by relevant financing schemes. Depending on the maturity of the financing system, increasingly limit reimbursement for medicines separately from the cost of care for relevant conditions but explore bundled case payments. Ensure consistency and alignment of incentives with the payment approaches for services and medicines at hospitals and higher-level care.
- Design and implement appropriate provider payment methods to create the incentives for the use of PHC services and shift service delivery out of hospitals, such as higher reimbursement rates. This is likely to require a blend of provider payment methods with capitation at its core.
- Where service networks exist, increasingly move to global payments at a network level rather than to individual providers.
- Expand purchasing mechanisms to include services from private providers. Utilize purchasing mechanisms that pay for results focused on health system objectives related to care coordination, quality, health improvement and efficiency. This can be added as part of blended payment mechanisms.
- Tie incentives and payment for results to services targeting vulnerable people and communities to enhance equity.
- Ensure that purchasing and payment systems are based on robust monitoring systems and that roles of providers and service delivery platforms are clearly delineated.

**Box 18. Prioritizing PHC in health financing in Mongolia**

In Mongolia, the priority is on PHC for both spending from the government budget and health insurance funds. Though the Ministry of Health is piloting a project to link a small part of its budget to health policy objectives, the health insurance funds are specifically allocated for four major areas of health interventions, as outlined by the health insurance law: rehabilitation, home-based care, day care and diagnostics. How to define and pay for PHC within the framework for these four major areas and how to fund it for efficient and effective interventions are some of the ongoing challenges.


**Reducing public financial management bottlenecks**

Bottlenecks in and over bureaucratic public financial management processes can stifle the ability to spend effectively and efficiently even where the funding is adequate. Member States should explore avenues for better utilization of existing PHC funds with improved PFM measures by learning lessons from settings that have faced similar challenges.

To do this, Member States can consider the following:
• Improve operational planning and budgeting capacity for PHC providers with clear objectives and indicators linked to budgets and budget cycles for improved priority-setting.
• Improve the flow of funds to the “last mile” by streamlining transfer mechanisms and increasingly adopting direct fund flows to providers.
• Grant better financial autonomy and flexibility to service providers and delivery networks to manage and retain a proportion of income received for more efficient coverage of costs and inputs, understanding this will require appropriate oversight to ensure that providers maintain the public health objectives and keeping in mind that enabling community participation in facility management can also be useful to ensure responsiveness of provider decisions to the population.
• Streamline budget requirements, such as spending rules and reporting requirements, across various revenue streams, and consider reducing earmarks on specific funds at the subnational level.

4.3.5 Create a supportive and enabling environment

Building leadership for PHC at all levels of the system

PHC policies and leadership are closely intertwined; without leadership, both within and outside the government, to promote and establish the policies and goals of the health system, successful establishment or reform of PHC system policies are unlikely. Leadership in PHC involves inclusion and capacitation of a wide array of actors from planners and political leaders to providers, users and communities to create a robust system with effective stewardship and accountability at multiple levels.118,119

Member States can consider the following:

• Enable a network of political leadership for PHC and public health by identifying and supporting political champions for PHC within parliaments, assemblies and other representative institutions that can guide PHC policy and ensure financial and administrative support systems.
• Create national and subnational institutions that can help develop integrated policy leadership by bringing together an array of government and nongovernmental leaders.
• Sustain PHC leadership into the future by building the capacity of young leaders in PHC policy-making, transdisciplinary learning, qualitative and quantitative research, health finance, and participatory governance.
• Build the capacity of community leaders to participate in local health decision-making, carry out community-level health promotion and health improvement initiatives, and engage in citizen-led feedback and accountability processes for PHC services.
• Include modules on PHC governance, encompassing its multidisciplinary dimensions, in core curricula for training of public health leaders.

Revising and updating the legal, policy and regulatory frameworks that support integrated and participatory services

Appropriate governance and institutional arrangements are required to drive and guide action on PHC reform. One of the key challenges with governance frameworks for PHC in many countries is that governments have tended to focus on public sector service delivery. This approach is no longer
Annex

appropriate given the growing range of actors in the health system and increasingly high proportion of health care being provided by the private sector across the Region.

Member States can consider the following:

- Embrace a broader institutional and regulatory outlook that fully engages the private sector and other sectors and stakeholders.
- Update legislative and policy frameworks to support the service delivery model, create space for greater participation and ensure accountability of the system.
- Strengthen regulatory frameworks and capacity for PHC services and the workforce, routinely updating guidelines based on evidence in order to improve quality of care and rebuild trust in the system.
- Update and revise regulatory and legal frameworks to facilitate improved access and distribution of medicines and supplies into countries by easing barriers.
- Leverage legislation and policy to promote services for vulnerable population groups, including women, minorities, refugees, immigrants and indigenous groups, among others.

**Strengthening health services management and coordination**

Building system capacity for managing health services is increasingly essential, particularly as health systems move towards greater degrees of decentralization.

To address this, Member States can consider the following:

- Improve communication and coordination across teams within national and local health authorities to reduce “siloed” service delivery and programme implementation, ensuring streamlined processes for information-sharing between national and local managers that reduce parallel policy instructions.
- Build capacity for management of health services, particularly mid-level managers at subnational levels, to allow administrators the appropriate institutional and financial foundation to plan for and manage the health system for achieving population-level health outcomes. This is especially important in decentralized contexts, but also for systems with less local autonomy.
- Increase decision-making space for local mid-level managers at provincial or district levels to adapt and draw from innovations in the field by developing formalized mechanisms that are representative for feedback and participatory governance.

**Establishing or strengthening monitoring mechanisms that promote learning and improvement**

Health policies are often structured around long-term plans with rigid pre-established objectives, with little room for diverting from intended policy pathways. To build systems that are responsive to changing population needs, however, there is a need to engage in evidence-based learning from experiences of policy failure and adapt strategies according to evolving scenarios.120

To build learning systems, Member States can consider the following:

- Establish regular review processes that can take place at network, district, provincial and/or national levels for closer assessment of on-the-ground service delivery performance, outlining key metrics for PHC performance and areas for improvement – with the understanding that these assessments can also be used to highlight emerging health needs or delivery risks and opportunities, as well as key areas for improvement (New Zealand approach in Box 19).
• Encourage flexibility to change and amend policies in a dynamic way in response to evidence, as it is crucial to have flexibility to change direction and stop implementation of interventions where they do not work as intended or lead to unforeseen negative impacts, and include adequate provisions of pilot and experimental learning, among others. Governments need to align incentives to encourage innovation and out-of-the-box solutions.  

• Increase support for PHC implementation research that goes beyond quantitative data analysis to understand the process bottlenecks that limit system performance.

• Enable mechanisms for relevant indigenous and local delivery solutions to be identified, piloted and brought to scale to strengthen resilience and minimize reliance on external support.

• Build human resource capacity for learning systems, equipping personnel with the capacity to collect, collate, analyse and act upon information from various sources to help improve the system.

Box 19. Health performance measurement in New Zealand

In 2016, New Zealand initiated the Systems Level Measure Framework for health system performance measurement. This was an augmented iteration of the country’s Integrated Performance and Incentive Framework and was aimed to catalyse a whole-of-system approach that required inter-organizational collaboration.

Alliances at the local level between health-related nongovernmental organizations and the Government were designated to plan and improve health outcomes of the population. This was a transition from more output and process targets, and it reaffirmed a commitment to integration of health services. Some of the challenges related to how to attribute changes (improvements or otherwise) in health outcomes within the (outcomes) framework, when strategies are implemented collaboratively. More importantly, there were varying collaborative efforts in different areas, and the limits to which change in outcomes could be demonstrated depended on funding arrangements within the health system.


Working with sectors beyond health to drive improvements in the determinants of health

Ensuring greater physical and social well-being for the population requires addressing several determinants of health that are out of scope for the health sector. The characteristics of the environment play a role in enabling healthy choices, such as the ability to be safely physically active and access nutritious food, and conversely may perversely encourage risky activities, such as providing ready access to alcohol and tobacco.

This will require a greater degree of engagement with other sectors to promote these strategies and create the right settings for populations to flourish. Many lessons have been learnt on this from the response to the COVID-19 pandemic.

To encourage working with sectors beyond health, Member States can consider the following:

---

88 WHO has developed a health data technical package with essential interventions that can help policy-makers take stock and take measures to strengthen existing health information systems.
Annex

- Collaborate with finance, justice and other sectors to advocate for and introduce upstream fiscal measures such as health taxes on unhealthy substances to drive behaviour modification.
- Advocate for national policies to influence healthy social norms or enable a supportive environment, for example legislation to support smoke-free settings.
- Work with cities and infrastructure planners to facilitate healthy settings and healthy cities objectives, including settings that support safe physical activity, better nutrition habits, etc.
- Engage with the agriculture sector to promote localized research and knowledge on food and nutrition to support healthy diets.

Investing in inclusive PHC infrastructure and logistics

Infrastructure has remained critical in the provision of health services, even as some countries expand the use of digital platforms. These include the health facilities that are the main access points, both fixed and mobile, as well as patient transport services, which can be the difference between life and death for those in more remote settings.

Member States can consider the following:

- Work with sectors beyond health to coordinate the provision of adequate and appropriate water, sanitation and hygiene, telecommunication, or power infrastructure in existing health facilities that meet the required standards.
- Ensure that all physical service locations can be made more inclusive with access for less-able-bodied people.
- Establish or strengthen appropriate patient transport to facilitate care coordination and access for urgent care. This is also relevant where the services of a provider with specific expertise is shared across several facilities.
- Put in place minimum standard facilities for infection prevention and control, such as equipment for sterilization, safe sewage and other medical waste management, and other protective equipment, as these are proven to lead to significant improvements in health outcomes.121
- Plan any new infrastructure investments to areas and populations that are in most need, taking into consideration the dynamic and diverse nature of population distribution across different parts of the national and subnational levels, and ensuring that infrastructure is appropriate for the setting.
- Consider the environmental footprint for new infrastructure investments, opting for more sustainable approaches, such as renewable energy.
- Consider investments to make existing PHC infrastructure more resilient to disasters or providing shelter zones, particularly in settings that are at most risk for environmental disasters.
- Jointly monitor and evaluate with community participation, so that maintenance and decisions around upgrades can have local ownership to ensure sustainability of investments.

Providing the infrastructure and processes to drive digital adoption for health information and service delivery

Harnessing information technology infrastructure to support PHC and the health system in general will require significant investment by Member States. To ensure effective use of existing and new digital platforms, Member States must address the required infrastructure, legal frameworks and regulatory capacities to advance digital technology for health, while mitigating the risks including that of inequity.
To fully optimize the benefits of digital technologies for health, Member States can consider the following:

- Establish or scale up access to information technology infrastructure within the health system and for PHC providers. This could range from low-tech options such as the help line in Papua New Guinea (Box 20) to more advanced platforms, depending on country capacity and context.
- Update or develop legal frameworks for data governance to ensure that the use of digital technology is safe and of high quality, promotes equity, and accords with ethical and human rights principles, including that the privacy of individuals is respected and their personal data protected from misuse for which the role of governments is pivotal.
- Assess carefully how digital health technologies will be integrated into existing health-care systems, and their impact on workflows, the delivery of services and the daily routines of health workers. Adopt change management processes for digital technology adoption to maximize its acceptability, feasibility and overall uptake.
- Where possible, explore the potential to establish linkages with foundational digital infrastructure – such as health management information systems, logistics management information systems, electronic medical records, and registries of the health workforce, health facilities and health conditions – to effectively combine different digital health interventions across various areas. Also consider ways to leverage existing common digital architecture, such as identity authentication systems and terminology services, which collectively or in part can make implementation of digital interventions harmonized and far less burdensome, and make systems interoperable. Where possible, integration with the national identification number systems should be explored.
- Establish platforms to build the capacity of the public for the use of digital tools and expand digital literacy, especially for disadvantaged groups.66
- Put systems in place for situations where connectivity or electricity may be lacking or unreliable; this may include providing solar chargers or preconfiguring the digital system to function both offline and online.
- Consider investing in research and development for the expanded use of digital innovations.

**Box 20. Tele-counselling hotline in Papua New Guinea**

The *Kaunselin Helpim Line* is a toll-free telephone line that provides counselling and advice on family violence, including sexually transmitted infections and HIV. It can be called at no cost. The service links with more than 350 service providers across the country, helping the tele-counsellors locate and refer clients to a range of services they may need.

5. Moving forward with PHC reform

5.1 Key considerations for Member States in undertaking PHC reform

Taking this Regional Framework on the Future of Primary Health Care in the Western Pacific forward will require that Member States engage in the PHC reform process, whether incrementally or through a larger-scale transformation process. Reforming PHC will often demand bold action from policy-makers to tackle changes in complex systems, such as national health systems. Member States can consider the points below in embarking on a reform process. While not necessarily outlined as a linear policy process, these considerations can help guide the decisions made along the journey to the future of PHC.

The key principle that guides this Regional Framework is that any country can take steps to improve PHC services and how populations experience the health system, regardless of their situation, economic state or other local context. While some countries are further along in the journey of strengthening PHC, no country has achieved the ideal system. All Member States remain on this journey to system transformation for a stronger future.

5.1.1 Understand the health needs and system performance today and in the future

Understanding the current performance of the system with regard to PHC and the health status of the population is an important step in any reform process. This forms the baseline to monitor progress while also providing clues as to what issues will need to be addressed to make an impact on the ground. To the extent possible, such a diagnostic process should be embedded in national or subnational policy processes and linked to national health plans or strategies. They should include quantitative indicators and qualitative information or in-depth evaluations to better understand the drivers of performance.

Member States can explore the following:

- An assessment of the projected health needs in the future, given the trends in health outcomes and disease burden, as well as projected changes in the demography in the upcoming decade or two. Where capacity exists, this should also incorporate data beyond the health sector to analyse information collected by other sectors and to explore the economic, social and environmental trends and outlook for their context. This process should involve an assessment of both the expected demand for and capacity of supply of health care in the future.
- Key questions relating to the system’s present health performance – that is, how well the existing system contributes to improved health of the population overall – as well as the capacity of the health system to meet the future health needs of the population. Policy-makers can look to determine whether the system is facilitating improved health of individuals throughout their life course and how the availability of health services is distributed across the overall population. This should also explore whether any groups are particularly impacted by specific illnesses or conditions or facing specific barriers to accessing services, among others.
- What needs to change to optimize system performance to meet the future health needs. This involves understanding the deeper drivers of any suboptimal performance by developing a categorization of key factors that may explain variations in health system performance and digging deeper until root causes are identified. Each proposed root cause would represent a hypothesis that can be tested. Some of the factors could encompass questions of financing, such as low levels of revenue collection or leakages in the system of disbursement that are affecting
service delivery. Others could have to do with stewardship issues, such as challenges relating to distributing capacities within or a lack of adequate coordination with non-health sectors. There could also be factors related to human and physical resources, such as capacity gaps in key areas of service delivery or lack of physical infrastructure availability in geographically remote regions.

5.1.2 Identify feasible entry points for reform

Reforming health systems is not always the result of a long-term plan. There can be multiple routes to effective PHC reform. More often, countries make use of opportunities on the horizon to drive larger changes in the system. Member States can identify these opportunities or key changes that are in the pipeline and can be leveraged to build commitment or momentum for PHC reform. These opportunities could be within the health sector, such as revision of public health laws, social health insurance reform or benefit package revision. PHC reform could also be driven by reforms beyond the health sector, such as for e-governance and public finance management or broader decentralization efforts. Entry points could also arise from the need to address broader issues facing the health system, such as: spiralling health-care costs amid rising pharmaceutical costs and an inadequate focus on preventive health care, reorienting a health delivery infrastructure still focused on communicable diseases towards addressing NCDs, or replacing dwindling donor contributions to health financing with public funds amid economic and budgetary constraints. PHC reform could also be in response to performance issues that the community is experiencing, including long waiting times, perception of poor quality and the preference for doctors over other cadres of health workers. Regardless of the platform or driver, these opportunities can be leveraged to initiate PHC transformation, with the right commitment.

Member States should identify reform priorities for their context that can have the highest degree of impact and address the issues with the potential to bring the greatest system improvement.

5.1.3 Engage, consult and communicate

When embarking on a reform process, there are often many interest groups that may be affected or have a role to play in different ways. As such, it is critical to engage and consult with all stakeholders, starting as early as possible and constantly building consensus and ownership on the reform design.

Mapping and engaging stakeholders should include the key groups that are likely to be affected by PHC reform, such as provider interest groups, bureaucrats, budgetary institutions and actors, political leadership, beneficiaries, and external actors. This must also include listening to the communities and beneficiaries of PHC services to understand their needs and expectations for the future. This will involve skills in participatory facilitation, collective dialogue and community outreach. Considering the multisectoral nature of PHC, other sectors should also be included in the consultative process.

Based on the analysis of the various interests and positions of stakeholders, policy-makers can plan strategies to build consensus and address concerns in each stakeholder category. Policy-makers can consider establishing or strengthening institutional forums for multistakeholder collaboration and action at the national, subnational and local levels. This provides an ongoing opportunity for continuous engagement through the reform design and roll-out. It may be useful to identify champions for PHC reform across different sectors and among local administrative authorities to help advocate for political commitment and/or keep the reform objectives on the policy agenda.
Finally, this stakeholder engagement needs to translate to a strong communication strategy as the reform planning and implementation get underway. The communication strategy will aim to explain the agreed reform strategies in easy-to-understand language to stakeholders, such as the beneficiary communities and the service providers. It also prepares all parties for the changes that are in the pipeline and manages dissent before it becomes entrenched.

5.1.4 Set up or designate governance mechanism(s) for the reform process

Effective stakeholder management and sustained commitment for reform is built upon mutual trust. This requires transparency as well as mechanisms for accountability – political, financial and administrative – that may need a governance mechanism for a reform process, such as a steering group with technical capacity and local knowledge, which includes wide representation from different stakeholder groups. This must draw from the needed technical expertise based on the key drivers of the reform. It must also draw from those with relevant local knowledge, rather than depending on external experience that may not be germane to the national or subnational context.

Member States may also consider platforms to foster the meaningful participation of communities in the governance of the reform and design of PHC policies, programmes and services intended to benefit them. This is especially relevant for disenfranchised and marginalized groups. Particular attention should be made to ensure their participation in decision-making processes at all stages of policy or programme development, from agenda-setting to evaluation of the work.

5.1.5 Design the system that will deliver the vision of PHC

Initiating an activity as complex as system reform requires some planning and design of the key interventions selected. Drawing from the first round of consultations outlined above, the scope and nature of the reform can be designed. This will be based on the vision of strong PHC agreed by all stakeholders, comprised of the key features of the system to achieve the national health objectives. This must consider the duration within which the reform is planned, as well as the findings from the current situation of the health system and the population’s health.

The design of PHC services considers how these services will be provided in the future context, aligned with the estimates of future health needs and demands, as well as future scenarios in the country. This includes the expected economic outlook and its impact on the fiscal space for health and PHC, the feasibility of digital or other technologies, and consideration of the social evolution of the population. This means the possibility of changes in health-service-seeking behaviour by a population with economic growth, greater health literacy, and the availability of information through the internet and other sources.

The service design should outline what services are to be provided to the population, as well as the basics of how services should be organized. In brief, this could include the specifics of the service package for PHC, as well as what is best delivered at different types of service points, such as health centres, public health providers or other non-health service points. Decisions should be made on how providers are linked, whether in a network arrangement or smaller multidisciplinary teams of providers. This must also involve consideration of any particularly vulnerable groups that need additional efforts to tailor service access.
Finally, the design of PHC services considers roles and responsibilities across the national health authorities versus the roles and responsibilities of subnational managers: How much decision space is available for mid-level managers? And how will the actions of the different levels be coordinated for appropriate oversight and to maintain accountability?

5.1.6 Develop a plan for PHC reform

The service and system design becomes the basis for building a road map for implementation. Planning for reform should outline the main steps to achieve the service and system design. It includes thinking about whether the current workforce situation will be adequate to meet the new service design, or what changes are required in the way the health workforce is trained, recruited and managed, and what potential there is to expand the workforce with non-medically trained personnel. While increases in the health workforce may not be feasible for all Member States in the short term, consideration can be given as to how to make better use of the existing workforce, how non-medically trained workers can be deployed to take on non-clinical roles, and other forms of task-sharing or -shifting.

A clear mapping of potential sources for the resources to finance the reform should also be conducted, whether seeking additional budget allocation, or reprogramming existing budgets or other payment mechanisms. Additional resources may be in short supply in some settings; however, small-scale improvements can still take place in the absence of a large infusion of funds.

Taking stock of the planned contextual actions will be important. For example, plans to expand the use of digital health provision must consider the overall digital infrastructure and any plans for scaling up across the country.

As for any planning process, it is important to apply the similar principles of priority-setting and identify the interventions that are most likely to deliver on the intended objectives, considering capacity and affordability.

5.1.7 Implement and scale up

With the best-laid plans, implementation – especially large-scale reform – can still be overwhelming. Sequencing and phasing the planned activities are critical to ensure that foundational interventions are implemented before those that require more advanced systems. For larger or decentralized settings, conducting smaller pilots in selected districts and provinces may prove useful to iron out any wrinkles before scaling up across the country.

Implementing in a phased manner also helps to maintain momentum for a long-term reform, as there are smaller wins and successes along the way that can sustain/reinvigorate commitment.

5.1.8 Measure and learn

Ensuring a means to monitor PHC reform implementation and recalibrate as needed is essential. Monitoring, evaluation and review of health progress and performance help to ensure that priority actions and decisions are implemented as planned against agreed objectives and targets. One key issue is to embed PHC reform monitoring in a country’s national monitoring and evaluation processes to prevent fragmentation and ensure coherence with the overall health system performance monitoring.
Annex

Member States can explore the following:

- First, select what will be measured and how, through inclusion in the health system results monitoring framework, or the establishment of one where it does not currently exist. This also requires selecting key metrics that can take the pulse of the reform process and outcomes, and point to where more in-depth evaluation is needed, whether at the national, subnational, community or facility levels. These should be aligned with the key objectives of the national health strategy as it relates to PHC.
- Use various modalities for data collection – realist approaches, quantitative data collection and analysis, and in situ implementation research – to ensure that bottlenecks and unforeseen outcomes are identified and addressed.
- Utilize health sector review mechanisms, such as health summits, to review progress on the reform agenda, focusing on lessons to improve implementation. To the extent possible, there should be as much focus on what is not working well as what is successful. This gives the platform to explore ways to adapt or amend implementation processes to get back on track. It also offers learning opportunities to understand factors that influence or block successful implementation.
- Continue to listen to communities and give a voice to various stakeholders in monitoring, as well as to highlight instances of good innovation at the local level that can be scaled up in other parts of the system. This provides motivation to managers, providers and communities to continue to work together to solve challenges.
- Throughout implementation, ensure continuous learning and adaptation for improvement. This calls for flexibility in policies, plans and frameworks to allow and encourage an environment in which innovation thrives.
- Integrate indicators on participatory methods into monitoring, evaluation and learning tools used in policy-making to evaluate how equitable the policy-making and implementation process is.

5.2 WHO’s role in working with Member States

WHO is deeply committed to PHC as a top priority, essential to the overarching vision for health sector transformation and UHC progress. This is evident in the focus on PHC in the WHO Thirteenth General Programme of Work 2019–2023 and as well as For the Future: Towards the Healthiest and Safest Region, the shared vision of WHO work with Member States and partners in the Western Pacific. WHO will continue to strengthen its capacity and improve its ways of working, as outlined in the operational shifts in For the Future, to meet the changing demands from Member States as they work to strengthen PHC.

Priority actions for WHO in working with Member States include the following:

1. Work across all three levels of the Organization to provide the tailored technical assistance to Member States in a coordinated manner.
2. Facilitate high-level policy advocacy to maintain PHC on the political agenda across the Region and beyond. Promote inclusion of PHC-specific stakeholders during in-country policy and planning processes.
3. Build country capacity, where required, and facilitate joint learning and technical support among countries.
4. Engage with development partners at the country and regional levels to support the national reform priorities and its implementation, including facilitating financing alignment, based on context.

5. Provide evidence-based technical advice to countries on the emerging international and regional consensus and best practices for PHC.

6. Build a reserve of technical assistance through networks of experts, technical partners and collaborating centres.

7. Provide tailored country support for design, planning and implementation of PHC reform, including the identification of entry points and existing opportunities that can be leveraged.


9. Support platforms (mechanism) for sharing country progress and experiences, and facilitating peer learning, across countries within the Western Pacific Region as well with other WHO regions.

10. Leverage existing regional mechanisms such as meetings of the WHO Regional Committee for the Western Pacific and the UHC Technical Advisory Group to update regional performance on PHC.

5.3 Monitoring and evaluation of the Framework

Within the context of this Regional Framework on the Future of Primary Health Care in the Western Pacific, WHO proposes to work with Member States to draw from the national measurement processes to monitor the roll-out and implementation of the Regional Framework.

This Regional Framework is aligned with the Operational Framework for Primary Health Care: Transforming Vision into Action, jointly developed by WHO and the United Nations Children’s Fund. As such, the regional implementation of PHC will be measured using the recently launched Primary Health Care Measurement Framework and Indicators: Monitoring Health Systems through a Primary Health Care Lens.\textsuperscript{122} This sets out tiered indicators for countries to select from, based on their context and health information system maturity for national monitoring. However, it also proposes 13 indicators for global and regional monitoring. These will be adopted to monitor regional PHC performance. The WHO Regional Office for the Western Pacific will also progressively build consensus on any additional indicators, based on evolving regional needs during the lifetime of this Regional Framework.

The Regional Office will work with WHO country offices to support Member States in setting up or strengthening monitoring of PHC performance in alignment with this Regional Framework and with their national context. WHO will also work with Member States to prepare a regional assessment of PHC performance regularly for consideration by the Regional Committee for the Western Pacific.
Annex

References

5. For the future: towards the healthiest and safest region – a vision for WHO work with Member States and partners in the Western Pacific. Manila: World Health Organization Regional Office for the Western Pacific; 2020 (https://apps.who.int/iris/handle/10665/330703).


Annex


Annex


83. McEvoy R, Tierney E, MacFarlane A. ‘Participation is integral’: understanding the levers and barriers to the implementation of community participation in primary healthcare: a qualitative study using normalisation process theory. BMC Health Serv Res. 2019 Dec;19(1):515.


Annex


119. Governance and leadership: primary health care policies. Washington (DC): Primary Health Care Performance Initiative; 2019
Annex


